Uzbekistan • Tajikistan • Turkmenistan • Kyrgyzstan

Final Evaluation

of the

Healthy Family Program

Expanding Maternal and Child Health and Reproductive Services in Uzbekistan, Tajikistan, Turkmenistan, Kyrgyzstan

October 1, 2002 – September 30, 2007

A USAID Funded Project
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ACRONYMS

ACNM	American College of Nurses and Midwives
ANC	Antenatal Care
ARC	American Red Cross
ARI	Acute Respiratory Infection
BCC	Behavior Change Communications
BF	Breast Feeding
BLSS	Basic Life Saving Skills
CAR	Central Asia Republics
CDC	Center for Disease Control
CDD	Control of Diarrheal Diseases
C-IMCI	Community IMCI
CS	Child Survival
CtC	Child-to-Child
CTO	Cognizant-Technical Officer
DD	Diarrheal Disease
EOC	Emergency Obstetric Care
ENMC	Essential Newborn Maternal Care
FAP	MoH Health Post
Feldsher	Physician assistant
FP	Family Planning
FSU	Former Soviet Union
GIK	Gift-in-Kind
GM	Growth Monitoring
HF	Health Family
HFP	Healthy Family Project
HFF	Health Facility Farm
HFA	Health Facility Assessment
HH	Household
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HM	Health Monitor
HMIS	Health Management Information Systems
HOPE	Project HOPE
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IP	Infection Prevention
IUD	Intra Uterine Device
KPC	Knowledge, Practice & Coverage Survey
LSS	Life Saving Skills
M&E	Monitoring & Evaluation
MCH	Maternal & Child Health
MCPC	Management of Complications in Pregnancy and Childbirth
MNH	Maternal & Neonatal Health
MNC	Maternal & Newborn care
MoH	Ministry of Health
MPS	Making Pregnancy Safe
NR/NC	Newborn Resuscitation/Newborn Care
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PEPC	Promotion Effective Prenatal Care
PVO	Private Voluntary Organization
RCS	Red Crescent Society
RC	Red Crescent
RDF	Revolving Drug Fund
RH	Reproductive Health
SC	Save the Children
SM	Safe Motherhood
STI	Sexually Transmitted Infection
SVA	MoH Health Center
SUB	MoH Rural Hospital
TAG	Technical Advisory Group
TFGI	Futures Group International
TOT	Training-of-Trainers
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VDC	Village Development Committees
VP	Village Pharmacies
WHO	World Health Organization
WRA	Women of Reproductive Age
WSG	Woman Support Group

I. Executive Summary

In the fall of 2002, a consortium of six organizations was awarded a 5-year, $22 million dollar cooperative agreement to expand and strengthen maternal, child and reproductive health in Uzbekistan and Tajikistan. The goal of the ***Healthy Family Program*** was to "*Improve the health and reproductive health of more than 1 million mothers and children in Uzbekistan and Tajikistan through improvement in service delivery and community mobilization.* In June of 2003 Healthy Family expanded to Turkmenistan and added an additional consortium partner, and in September of 2004 Kyrgyzstan was also incorporated. The program was implemented in selected districts of Kashkadarya and Surkhandarya Provinces (i.e. Oblasts) in Uzbekistan, Khatlon Province in Tajikistan, Batken Province in Kyrgyzstan and in all 5 provinces in Turkmenistan.

The seven consortia members included Project HOPE – the prime and principal implementer in Uzbekistan and Kyrgyzstan; Save the Children - the principal implementer in Tajikistan; American Red Cross/Red Crescent – implementer of community mobilization activities in Uzbekistan and Tajikistan; Abt Associates - the sole implementer in Turkmenistan; Futures Group - manager of policy development and NGO grants activities in Uzbekistan and Tajikistan; and JHPIEGO and American College of Nurse Midwives - technical partners engaged in development of curricula and training of health workers in improved maternal and neonatal care practices in Uzbekistan (JHPIEGO) and Tajikistan (JHPIEGO and ACNM)

Overall the program was a significant technical success reaching more than 1,158,601 women of reproductive age and children under 5 and achieving 81% of the program targets. The program's strongest focus was on improving the skills of health workers at primary and secondary tier facilities as well as program interventions targeted at province and district level hospitals in the areas of IMCI, antenatal care, safe delivery, neonatal care, post-natal care, infection prevention, family planning and STIs. This was achieved through a cascade training approach whereby local and regional staff persons were trained as trainers and then supported to conduct follow-on training and monitoring within their area of management. In general, the MoH and health facility staff in all countries appreciated the comprehensiveness of the training that, in most cases, included both theory and practice. HF also expanded training beyond the strict technical skills to include topics such as quality assurance and adult learning methodology. In general, the targeted provinces and districts reported reductions in child and maternal mortality as well as reductions in morbidity which they attribute to the interventions of this program.

At the community level, the program was managed differently in each country but in most cases, took advantage of local community leadership or structures to help expand knowledge and improve practices of the local population. In Kyrgyzstan, the proposed community component was not implemented and in Turkmenistan it was limited to district level education campaigns connected to service delivery activities. Even without the community component in Kyrgyzstan, knowledge and behavior among community members improved. A key advantage in the Central Asian Republics is the extensive reach of the health care system into even the most rural communities. This has provided excellent opportunities to use health facilities as a platform for public education and health promotion. Indeed, an important part of the technical training focused on improving the skills of health care workers as health *educators* which the evaluators believe contributed significantly to increased knowledge.

Another crucial piece of the Healthy Family design was the alignment of interventions with current health care changes and priorities at the national level. All principal interventions were also components of national level health care reform strategies. As such, the HF districts served as pilots. They were supported at the national level and in turn, helped to inform national level policy. In Uzbekistan and Tajikistan, Healthy Family played an even greater role at the national level by supporting the creation and providing technical assistance to policy groups (called Core

Groups). These groups were instrumental in formulating key health care policies. Through this effort, Healthy Family assisted the government of Uzbekistan in formulating 10 national health policies, including policies related to Safe Motherhood, IMCI and Infection Prevention, and assisted the government of Tajikistan in formulating policies on Infection Prevention as well as strategies on Contraceptive Security and Reproductive Health.

Other successful strategies were the introduction of IMCI training to community health facility nurses – particularly important given the heavy out-migration of physicians; translation of curriculums and educational materials into local languages, the successful establishment of sustainable emergency transportation funds in Tajikistan and extensive support provided for breastfeeding promotion in general and BFHI certification more specifically.

In spite of these successes, the program did face some major challenges and setbacks. Midway through the program, Healthy Family experienced a significant and unanticipated drop in funding. This reduction was due to factors outside the control of the program and USAID's Central Asia Mission. Overall, the project received only 68% of the original anticipated funding. As a percentage Project HOPE, SC, ARC and the Futures Group lost a third of their budget while the remaining partners lost little to nothing. As a result of these reductions, Futures Group and ARC, who were expected to provide support for the full 5 year period, terminated their activities in 2006. Save the Children decided not to expand into additional districts as planned and Project HOPE limited their community interventions in Uzbekistan and reduced the number of expansion districts. Budget cuts also had a significant impact on human resources.

In addition, there were a number of management issues the program had to contend with. Given that Healthy Family was a large program spanning four countries, seven partners and with expenditures of more than 15 million dollars, management proved to be a daunting task. As it was, the lead implementing agency, Project HOPE, had little experience at the time in managing consortia or in implementing programs of this magnitude. A lack of detailed planning as well as poor communication and interaction with partners created significant challenges to collaboration. Some of the partners also exhibited poor internal management and lack of responsiveness to the needs of Project HOPE as prime or to the overall program which contributed to strained relationships and difficulties in collaboration. Finally, the way in which budget cuts were managed by USAID only served to exacerbate the problems of management and partner relations. The net effect was a tendency toward de-segmentation of the program with each partner and country program working in relative isolation from the others, only coordinating when necessary. This is in stark contrast to the original intent of the consortia, which was to create a "synergy team". In fairness, Project HOPE made a concerted effort to improve communication after management concerns were raised during the mid-term evaluation and coordination at some levels did improve. However, the program never achieved true coalescence and to the end was perceived by the prime and partners as four separate programs under one name. While many of the technical achievements are commendable, it is unknown what results might have been accomplished had there been more effective and cohesive collaboration among partners.

II. Program Description and Assessment of Results

A. General Assessment

In the fall of 2002, a consortium of six organizations was awarded a 5-year, $22 million dollar cooperative agreement to expand and strengthen maternal, child and reproductive health in Uzbekistan and Tajikistan. The goal of the ***Healthy Family Program*** was to "*Improve the health and reproductive health of more than 1 million mothers and children in Uzbekistan and Tajikistan through improvement in service delivery and community mobilization.* In June of 2003 Healthy Family expanded to Turkmenistan and added an additional consortium partner, and in September of 2004 Kyrgyzstan was also incorporated. The program was implemented in selected districts of Kashkadarya and Surkhandarya Provinces (i.e. Oblasts) in Uzbekistan, Khatlon Province in Tajikistan, Batken Province in Kyrgyzstan and in all 5 provinces in Turkmenistan (see map below).

In Uzbekistan and Tajikistan, the project was to be implemented in two phases. In Phase I, three districts were selected in Uzbekistan and five in Tajikistan in order to reach a target population of 0.5 million mothers and children under five years old. In Phase II, the number of districts was to be doubled in order to reach the goal of 1 million mothers and children. In Turkmenistan, the Healthy Family project complemented other funding (Zdrav Plus), and the overall package of funding targeted a total of 10 districts. However, the centralized nature of assistance and the political environment in Turkmenistan dictated that the program operate at the national level thus making it more difficult to ascertain just how many people actually benefited. In Bakten Province in Kyrgyzstan the project targeted two districts with a total beneficiary population of 149,000.

The seven consortium members and their anticipated roles and activities were as follows:

Project HOPE (HOPE): Responsible for overall project management (prime) and principal implementing partner in Uzbekistan and Kyrgyzstan. Interventions managed by Project HOPE included coordination of clinical staff training in child, maternal and reproductive health based on international standards of practice. They were also responsible for pharmaceutical and equipment procurement.

Save the Children (SC): Principal implementing partner in Tajikistan. Interventions managed by Save the Children included coordination of clinical staff training in child, maternal and reproductive health based on international standards of practice, development of Village Development Committees (VDC), establishment of emergency transport funds (ETF), support for Child-to-Child programming, revolving drug funds, health facility farms and hearth activities.

Abt Associates (Abt): Sole implementing partner in Turkmenistan. Interventions managed by Abt Associates included coordination of clinical staff training in child and maternal health based on international standards of practice as well as technical and material support for community health education campaigns.

American Red Cross (ARC): Community partner with Project HOPE in Uzbekistan and Save the Children in Tajikistan. ARC was responsible for community mobilization activities in Uzbekistan and complementing SC community based activities in Tajikistan.

The Futures Group (FG): Implementing partner in Uzbekistan and Tajikistan. The Futures Group directed policy development activities and managed a small grants program in both countries.

JHPIEGO: Technical assistance partner in Uzbekistan and Tajikistan. JHPIEGO was responsible for development of curricula, materials and TOTs in reproductive, maternal and newborn health and Infection Prevention.

American College of Nurse Midwives (ACNM): Technical assistance partner in Tajikistan. ACNM was responsible for training in Life Saving Skills (LSS), a training similar to Making Pregnancy Safer (MPS) applied by JHPIEGO in Uzbekistan.

Before discussing results it is important to note that the program experienced a significant and unanticipated drop in funding announced by USAID in the third year of the project. This reduction was due to factors outside the control of the program and USAID's Central Asia Mission. Table 1 and 2 show anticipated vs. actual obligations during the 5-year program by organization (Table 1) and by country (Table 2). Overall, the project received 68% of the original anticipated funding. As a percentage Project HOPE, SC, ARC and the Futures Group lost a third of their budget while the remaining partners lost little to nothing. As a result of these reductions, Futures Group and ARC, who were expected to provide support for the full 5 years terminated their activities in 2006 (See Chart 1: Timeline). SC in response to the budget cuts decided not to expand into Phase II districts and Project HOPE limited their community interventions in Uzbekistan and reduced the number of districts in Phase II. Cuts also had a significant impact on human resources which will be discussed later. As Table 2 shows, only Uzbekistan and Tajikistan were directly affected by the budget cuts.

Table 1: Anticipated vs Actual USAID Funding per organization

Organization	Anticipated	Actual
Project HOPE	11,549,983	7,372,632
Save the Children	4,992,981	3,502,120
ARC	1,999,985	1,378,414
Abt Associates	438,878	438,878
Futures Group	2,772,887	1,904,068
JHPIEGO	1,021,384	899,832
ACNM	210,351	193,928
Total	**22,986,349**	**15,689,872**

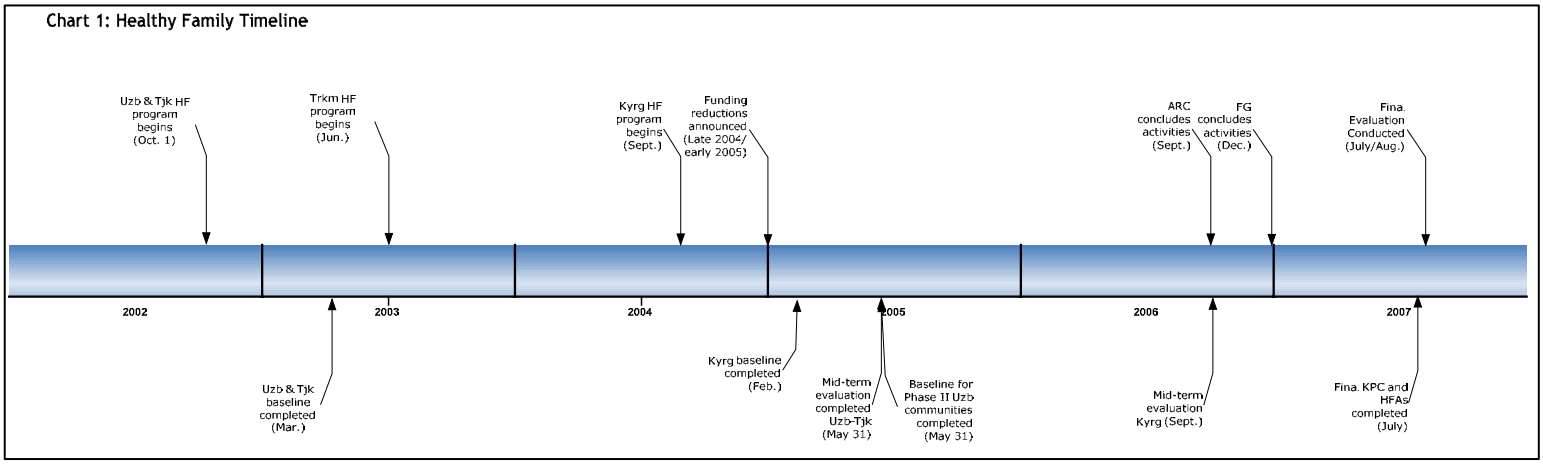
Table 2: Anticipated vs Actual USAID Funding per country

Country	Anticipated	Actual
Uzbekistan	13,371,763	8,596,251
Tajikistan	8,457,586	5,936,621
Turkmenistan	499,000	499,000
Kyrgyzstan	658,000	658,000
Total	**22,996,349**	**15,689,872**

The following timeline indicates the major program milestones. Overall, the Uzbekistan and Tajikistan programs had approximately 4 years and three months of program implementation between baseline and final evaluations.

The Turkmenistan project had 4 years of implementation (no community-based surveys or HFAs undertaken) and Kyrgyzstan activities were undertaken for 2 years and 4 months between baseline and final.

Chart 1: Healthy Family Timeline



Over the 5-year period of the grant, the Healthy Family program actually exceeded its goal by reaching an estimated 1,158,601 women of reproductive age (WRA) and children under five with improved service delivery and community mobilization (Table 3). Although this includes two countries not contemplated in the original proposal, it is a tremendous achievement considering the budget reductions discussed above.

Table 3: Population reached by Healthy Family

Country	WRA	Children U5	Total
Uzbekistan	374,863	180,761	555,624
Tajikistan	96,358	55,040	151,398
Turkmenistan	232,495	70,000	302,495
Kyrgyzstan	109,132	39,952	149,084
Total	**812,848**	**345,753**	**1,158,601**

In addition to the number of people reached, the evaluation team assessed the quality and impact of the program. In total, Health Family partners defined, monitored and evaluated the program using 46 separate indicators grouped in four categories: child health, maternal and newborn health, reproductive health and policy (Table 4). Health facility assessments and KPC community-based surveys were used to track progress. In addition to data collection and analysis, this evaluation team conducted extensive interviews and site visits in all four countries. Over a 3-week period, the team (3 external evaluators, 2 Project HOPE staff, 1 USAID representative) met with more than 300 national, province and district-level health staff, women's group members and community development committee members in all target districts (with the exception of Turkmenistan where only national level staff were interviewed) – See Annex A for list of meetings held. It is on the basis of this information that the program was assessed and conclusions drawn.

Table 4: HEALTHY FAMILY PROJECT TABLE OF INDICATORS

Key

Locale: = community; ✚ = health facility; ☐ = target not met

Type: = behavior; ☺ = knowledge; = training; = policy

Category	No.	Indicators	Locale	Type	Uzbekistan - Phase 1				Uzbekistan - Phase 2				Tajikistan				Kyrgyzstan				Turkmenistan			
					BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target
CHILD HEALTH	1	Percent of sick children age 0-23 months who received increased fluids during an illness in the past two weeks.			-	-	42	40	8	62	47	40	-	-	-	-	-	-	-	-	-	-	-	-
	2	Percent of infants age 0-5 months who were exclusively breastfed during the last 24 hours.			36	68	73	40	22	65	63	40	43	70	80	60	20	-	76	50	-	-	-	-
	3	Percent of mothers who continue or increase breast feeding and feeding food at home during childhood illness			-	-	-	-	-	-	-	-	24	62	74	50	-	-	-	-	-	-	-	-
	4	Percent of women who can correctly state two or more signs of childhood illness that indicate the need for treatment by a health care provider.		☺	26	81	95	65	50	76	97	65	21	95	87	70	7	-	94	40	-	-	-	-
	5	Percent of parents who know the dangerous symptoms according to WHO IMCI recommendations.		☺	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	67	40
	6	Percent of families with a sick child <5yrs receiving proper counseling on treating/caring according to WHO IMCI recommendations	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	51	40
	7	Percent of providers following IMCI (check for danger signs, assess main symptoms, assess for nutrition and immunization status, check for other problems, classify conditions, and identify and initiate treatment.	✚		0	70	72	50	0	77	70	50	-	-	-	-	3	-	58	50	-	-	80	60
	8	Percent of providers who prescribe appropriate (WHO/UNICEF guidelines) treatment for childhood ARI/pneumonia	✚		-	-	-	-	-	-	-	-	20	-	53	50	-	-	-	-	-	-	-	-
	9	Percent of providers who prescribe appropriate treatment for diarrhea	✚		-	-	-	-	-	-	-	-	2	-	60	40	-	-	-	-	-	-	-	-
	10	Percent of children who attend clinics have weight plotted on growth charts	✚		-	-	-	-	-	-	-	-	1	21	57	40	-	-	-	-	-	-	-	-
	11	Number of family doctors and feldshers trained in WHO IMCI Protocols	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	137	-	946	846
	12	Number of family nurses trained in the WHO IMCI Module "Counsel the Mother"	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	520	517
		Total Child Health Targets Met*			**4 out of 4**				**4 out of 4**				**6 out of 6**				**3 out of 3**				**5 out of 5**			

*Given only for indicators that have both final and target values.

Table 4: HEALTHY FAMILY PROJECT TABLE OF INDICATORS

Key
Locale: = community; ✚ = health facility; ☐ = target not met
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Category	No.	Indicators	Locale	Type	Uzbekistan - Phase 1				Uzbekistan - Phase 2				Tajikistan				Kyrgyzstan				Turkmenistan			
					BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target
MATERNAL & NEWBORN HEALTH (Including Infection Prevention)	1	Percent of mothers with children under two who can cite at least two danger signs during pregnancy		☺	35	-	82	70	37	80	93	-	-	-	-	-	22	-	46	40	22	-	52	-
	2	Percent of mother with children under two who can cite at least two danger signs during the post-partum period		☺	-	-	-	-	-	-	-	-	-	-	-	-	9	-	14	30	-	-	-	-
	3	Percent of villages who have emergency transportation plans and emergency transport funds in place			-	-	-	-	-	-	-	-	0	64	74	60	-	-	-	-	-	-	-	-
	4	Percent of mothers with children under two reporting 3+ focused ANC visits during last pregnancy			73	-	70	80	64	89	88	80	21	46	72	60	-	-	-	-	-	-	-	-
	5	Percent of normal pregnancies managed according to WHO protocols	✚		3	-	45	40	0	75	59	40	-	-	-	-	11	-	6	50	-	-	-	-
	6	Percent of health facility staff correctly manage normal pregnancies	✚		-	-	-	-	-	-	-	-	0	-	44	40	-	-	-	-	-	-	-	-
	7	Percent of normal deliveries managed according to WHO protocols	✚		18	85	78	40	0	59	61	40	-	-	-	-	0	-	2	50	-	-	-	-
	8	Percent of health facility staff correctly manage deliveries	✚		-	-	-	-	-	-	-	-	33	-	81	55	-	-	-	-	-	-	-	-
	9	Percent of OB complications managed according to WHO protocols	✚		4	67	70	30	0	16	52	30	-	-	-	-	-	-	-	-	-	-	-	-
	10	Percent of women after delivery managed according to WHO protocols	✚		2	87	40	50	5	68	52	50	-	-	-	-	0	-	13	50	-	-	-	-
	11	Percent of health facility staff correctly manage postnatal care	✚		-	-	-	-	-	-	-	-	4	-	52	40	-	-	-	-	-	-	-	-
	12	Number of family nurses trained on the Safer Pregnancy Module	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	420	420
	13	Number of population receiving information from providers trained in WHO MPS/SM	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	42,000	35,000
	14	Number of providers trained in WHO MPS/SM	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	102	100
	15	Percent of those providers trained in WHO MPS/SM that correctly answer the MPS/SM post-test indicators of knowledge	✚	☺	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	76	75
	16	Percent of pregnant women who receive information and counseling on prenatal care from their care provider trained in WHO MPS/SM	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	100	100
	17	Number of providers who provide prenatal care, who received training on providing improved antenatal care, information, and counseling to pregnant women based on WHO-MPS standards	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	102	100
	18	Percent of health facilities that use 0 5% chlorine solution for decontamination	✚		-	-	82	70	0	100	93	70	-	-	-	-	-	-	-	-	-	-	-	-
	19	Percent of health providers in maternity houses that correctly site 5 steps of correct routine hand washing according to international (JHPIEGO) standards	✚	☺	-	-	-	-	-	-	-	-	-	-	-	-	-	-	42	50	-	-	-	-
	20	Percent of health providers in maternity houses that can correctly cite when they should wash hands in maternity houses according to international (JHPIEGO) standards	✚	☺	-	-	-	-	-	-	-	-	-	-	-	-	-	-	34	50	-	-	-	-
	21	Percent of health providers demonstrating that proper hand washing before and after attending a patient according to international (JHPIEGO) standards	✚		-	-	-	-	-	-	-	-	-	-	-	-	-	-	46	30	-	-	-	-
		Total Maternal and Newborn Health Targets Met*			**5 out of 7**				**6 out of 6**				**5 out of 5**				**2 out of 8**				**6 out of 6**			

*Given only for indicators that have both final and target values.

Table 4: HEALTHY FAMILY PROJECT TABLE OF INDICATORS

Key
Locale: = community; ✚ = health facility; ☐ = target not met
Type: = behavior; ☺ = knowledge; 🕮 = training; 🗎 = policy

Category	No.	Indicators	Locale	Type	Uzbekistan - Phase 1				Uzbekistan - Phase 2				Tajikistan				Kyrgyzstan				Turkmenistan			
					BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target	BL	MT	Final	Target
REPRODUCTIVE HEALTH	1	Percent of women of reproductive age, who do not want are unsure whether they want another child, are using (or whose partners are using) a modern contraceptive.			54	72	76	75	60	76	75	75	36	40	91	50	-	-	-	-	-	-	-	-
	2	Percent of women of reproductive age, who are not planning to have any children in the nearest 1 year who are using (or whose partners are using a modern contraceptive.			-	-	-	-	-	-	-	-	-	-	-	-	52	-	50	70	-	-	-	-
	3	Percent of men, who do not want are unsure whether they want another child, are using (or whose partners are using) a modern contraceptive.			38	72	72	60	43	62	44	60	57	45	53	75	-	-	-	-	-	-	-	-
	4	Percent of women of reproductive age who report at least one place where they can obtain a modern contraceptive.		☺	68	94	92	-	81	-	96	-	-	-	-	-	87	-	89	95	-	-	-	-
	5	Percent of women of reproductive age who can cite at least two signs of STI's in women		☺	15	68	76	40	21	60	79	40	-	-	-	-	16	-	43	40	-	-	-	-
	6	Percent of women who can cite at least two signs of STIs in men?		☺	-	-	-	-	-	-	-		1	75	64	50	-	-	-	-	-	-	-	-
	7	Percent of men who can cite at least two signs of STIs in men.		☺	21	75	80	40	22	65	75	40	-	-	-	-	-	-	-	-	-	-	-	-
	8	Percent of youth who can correctly state two ways to prevent an STI		☺	-	-	-	-	-	-	-	-	3	60	59	25	-	-	-	-	-	-	-	-
	9	Percent of providers conducting STI screening, appropriate services including treatment, referral, and counseling.	✚		4	19	18	20	0	27	11	20	0	46	67	25	0	-	0	30	-	-	-	-
	10	Percent of women of reproductive age who received child spacing/family planning counseling and services.	✚		32	55	70	60	42	79	75	60	12	66	73	40	35	-	48	60	-	-	-	-
		Total Reproductive Health Targets Met*			**5 out of 6**				**4 out of 6**				**5 out of 6**				**1 out of 5**				**N/A**			
POLICY	1	Number of health policies instituted or revised to conform to international standards/best practices.	✚	🗎	Policy values are not district specific - all shown under Phase II				0	-	10	3	-	-	3	3	-	-	-	-	-	-	-	-
	2	Number of pilot rayon partners (rayon MOH, trainers, supervisors) who demonstrate ability to plan, implement and supervise trained personnel and who will be available and who would plan, further train and supervise project activities without assistance.	✚	🗎					0	-	7	4	-	-	-	-	-	-	-	-	-	-	-	-
	3	Number of local NGOs demonstrate the ability to plan, implement and supervise project activities including health trainings, activities and events.	NGO						-	-	-	-	-	-	2	2	-	-	-	-	-	-	-	-
		Total Policy Targets Met			**N/A**				**2 out of 2**				**2 out of 2**				**N/A**				**N/A**			
Percent of Total Targets Met					**82.4%**				**88.9%**				**95%**				**37.5%**				**100.0%**			

*Given only for indicators that have both final and target values.

With regard to the indicators, it is important to note some parameters and limitations. Not all 46 indicators were used in each country – consortia members had developed some, or in the case of Turkmenistan all, of their own indicators. In this regard, some indicators were unique to each country. Also, during the 5-year program, indicators were eliminated, added or refined. The evaluators used those indicators that were finalized and submitted to USAID after recommendations from the midterm evaluations, with the exception of Turkmenistan program whose indicators were ultimately chosen for the final evaluation.. In the case of Turkmenistan, indicators are primarily process-level and provided little insight into the effectiveness or impact of the program. There were also weaknesses in the data gathering process which was managed individually by each implementing partner (Project HOPE, SC and Abt) with no external oversight of the process. While this may be appropriate in smaller programs, a project of this size and scope warranted the use of an external M&E consultant(s) to guide and monitor the process. This would have helped to ensure objectivity, uniformity in methodology and would have minimized errors in collection and tabulation experienced during the process. In spite of these limitations, the evaluation team felt that the results of the quantitative assessments generally reflected the information gathered and observations made during the qualitative assessment. With the aforementioned limitations in mind, Healthy Family reached or exceeded 81% of its projected targets overall.

Technically, the program's strongest focus was on improving the skills of health workers at primary and secondary tier facilities as well as program interventions targeted at province and district level hospitals. This was achieved through a cascade training approach whereby local and regional staff persons were trained as trainers and then supported to conduct follow-on training and monitoring within their area of management. This proved to be an extremely successful strategy with HF providing financial, logistical and on-going technical support. In general, the MoH and health facility staff in all countries appreciated the comprehensiveness of the training that, in most cases, included both theory and practice. HF also expanded training beyond the strict technical skills to include topics such as quality assurance and adult learning methodology.

Important achievements:

- Reached 1.1 million women of reproductive age and children under 5;
- Met or exceeded 81% of project targets;
- Used frequently used community health facilities as a platform for education;
- Introduced IMCI training for nurses, midwives and physician assistants;
- Aligned interventions with national level policy and helped formulate national policy in Uzbek. & Tajik.

At the community level, the program was managed differently in each country but in most cases, took advantage of local community leadership or structures to help expand knowledge and improve practices of the local population. In Kyrgyzstan, the proposed community component was not implemented and in Turkmenistan it was limited to centrally supported education "campaigns". However, even in Kyrgyzstan, knowledge and behavior of community members improved. A key advantage in the Central Asian Republics is the extensive reach of the health care system into even the most rural communities. This provided excellent opportunities to use health facilities as a platform for public education and health promotion. Indeed, an important part of the technical training focused on improving the skills of health care workers as health *educators* which the evaluators believe contributed significantly to increased knowledge.

Another crucial piece of the Healthy Family design was the alignment of interventions with changes in current health care strategies and priorities at the national level. All principal interventions were also components of national level health care reform strategies. As such, the HF districts served as pilots. They were supported at the national level and in turn, helped to inform national level policy. In Uzbekistan and Tajikistan, Healthy Family played an even greater role at the national level by supporting the creation and providing technical assistance to policy groups (CORE groups). These groups were instrumental in formulating key health care policies. Through this effort, Healthy Family assisted the government of Uzbekistan in formulating 10 national policies, including policies related to Safe Motherhood, IMCI and Infection Prevention and assisted the government of Tajikistan in formulating policies on Infection Prevention as well as strategies on Contraceptive Security and Reproductive Health.

i. Child Health

Table 5: Number and percent of child health targets reached

Category	Uzbekistan Phase I	Uzbekistan Phase II	Tajikistan	Kyrgyzstan	Turkmenistan
Child health targets reached	4/4 (100%)	4/4 (100%)	6/6 (100%)	3/3 (100%)	5/5 (1000%)

In the area of child health, Healthy Family met 100% of its program targets. These included both community-level knowledge as well as clinician adherence to international standards of practice. Training of health facility workers in IMCI was a centerpiece of the child health initiatives in all four countries. Within Central Asia, the many years of Soviet rule created a large pool of skilled physicians, nurses and midwives but their skills were seriously outdated by the time of the collapse of the Soviet Union. With tighter budgets and few training opportunities in the post-Soviet period, health indicators, including morbidity and mortality, began to deteriorate. IMCI was seen as a practical and relatively cost-effective means of improving the health status of children and aligning health worker practices in Central Asia with international standards. Healthy Family support for IMCI training coincided with WHO and UNICEF's effort to assist CAR in developing and piloting health care reform. In the context of child health this translated to the adaptation and integration of IMCI into the primary health care structure.

In all four countries, districts selected under Healthy Family were considered "pilots" for IMCI. It is important to note that other entities such as UNICEF and the Asian Development Bank were also supporting their own pilot districts. Within the overall effort to assist countries in the rollout of IMCI Healthy Family made three significant and unique contributions. The first was the translation of the IMCI curriculum, course materials and forms into the local language (i.e. Turkmen, Uzbek, Tajik and Kyrgyz). Up until the implementation of Healthy Family, these materials were only available in Russian. This was not an impediment to training most physicians as most have a command of the Russian language. However, Russian-only materials did limit access to training and health education for other health professionals and the local population. Healthy Family increased access and rollout of IMCI by translation of materials into local languages. In some of the countries, ADB and UNICEF are now using these translations in addition to, or in place of, the Russian documents.

The second major contribution was to extend training to physician assistants, midwives and nurses. In all four countries, Healthy Family has adapted IMCI training for use by other health facility staff. This has provided multiple benefits including assurance in uniformity of treatment, fostering a team approach to care at the facility level and ensuring sustainability given the high out-migration of physicians to Russia and Kazakhstan.

Finally, HF complemented its technical training support with extensive community education interventions in Uzbekistan, Tajikistan and to a more limited degree in Turkmenistan. Education provided by health care workers, village development committees, women's groups and child-to-child programs included identification of danger signs; home-treatment; and prompt health care seeking. These were considered by health staff in *all* countries to be highly successful and contributed to increases in attendance at primary and secondary tier facilities and decreases in severe cases seen at province and district level hospitals. Healthy Family has supported this effort through training, community outreach and BCC materials development in

local languages. Indicators for knowledge and behavior change show significant improvements since program inception.

Another important element of the child health strategy was breastfeeding (BF) promotion. Healthy Family supported BF promotion through development and distribution of materials, training health care workers in promotion and counseling and assisting hospitals to achieve BFHI (Baby-Friendly Hospital Initiative) certification. In total 19 hospitals (18 in Uzbekistan and 1 in Kyrgyzstan) received BFHI certification through the support of this project and an additional hospital in Kyrgyzstan is likely to become certified.

ii. Maternal and Newborn Health

Table 6: Number and percent of maternal and newborn targets reached

Category	Uzbekistan Phase I	Uzbekistan Phase II	Tajikistan	Kyrgyzstan	Turkmenistan
Maternal and Newborn targets reached	5/7 (71%)	6/6 (100%)	5/5 (100%)	2/8 (25%)	6/6 (100%)

In the area of maternal and newborn health, Healthy Family averaged 79% attainment of program targets. These included both community-level knowledge as well as health provider adherence to international standards of practice. Activities in maternal and newborn care concentrated in three areas – 1) antenatal care; 2) safe delivery and newborn care and 3) infection prevention. In the CAR, attendance at antenatal consultations was generally high however, like child health, meaningful dialogue between the provider and client was limited. In addition to updating ANC knowledge and skills, HF training helped practitioners to educate the mother about danger signs, nutrition, birth planning and emergency transport. Most providers commented on the improved relationship between themselves and the mothers. Trainings built participant's confidence and taught them the importance of using ANC visits as an opportunity for education.

A highlight in the area of MNH is the Village Development Committees in Tajikistan which, through the HF program, created village-level emergency transport funds. In the communities visited, the evaluators found that the funds were readily used and replenished making it both a valuable health asset and sustainable.

Training in safe delivery and newborn care included management of normal and complicated deliveries, essential neonatal care, and neonatal resuscitation. The new standards of practice, according to those interviewed helped them improve pregnancy outcomes by reducing drug-induced labor, reducing caesarean births and episiotomies, increasing the level of monitoring through partographs and providing a more positive and supportive environment for the mother, child and family. In Uzbekistan, newborn resuscitation activities also coincided with a revision in the definition of live births based on WHO standards. This meant that neonatologists were now attempting resuscitation of babies once thought to be miscarried or stillborn. Similar reforms are taking place in Kyrgyzstan, Turkmenistan, and Tajikistan.

Breastfeeding was really a cross-cutting component incorporated into most HF activities including antennal and postnatal care. As already mentioned, 19 hospitals (18 Uzb/1 Krygz) have been certified as Baby Friendly through this project. Through this and other promotion activities, the Healthy Family program helped to create strong community and facility-based advocates for breastfeeding and exclusive breastfeeding.

While new mothers and newborns were not the exclusive beneficiaries of the Infection Prevention (IP) training that occurred under this project, maternal hospitals were the primary focus of this activity and hence it is included under this section. IP activities included training in sterilization, disposal of medical waste, use of protective gear, the importance of early reporting of hospital acquired infections, and hand-washing. IP activities were implemented in Uzbekistan, Kyrgyzstan and Tajikistan. One positive outcome seen in two of the hospitals in Kyrgyzstan was a significant *increase* in the number of hospital acquired infections that were reported. Prior to the training, the norm was to avoid reporting infections for fear of reprisal. Now that infections are being reported, staff can get on top of them earlier and limit transmission.

iii. Reproductive Health

Table 7: Number and percent of reproductive health targets reached

Category	Uzbekistan Phase I	Uzbekistan Phase II	Tajikistan	Kyrgyzstan	Turkmenistan
Reproductive Health targets reached	5/6 (83%)	4/6 (66%)	5/6 (83%)	1/5 (20%)	N/A

Healthy Family implemented reproductive health activities in Uzbekistan, Tajikistan and Kyrgyzstan. In the area of reproductive health, the program averaged 63% attainment of program targets including percent of women receiving FP counseling services, usage, and identification of signs of STIs (See Table 4). Trainings were conducted on contraceptive counseling, method mix, and syndromic approach to STIs. Prior to the program the principle (and often only) contraceptive method offered in target districts in all three countries was the IUD. Through the provision of additional methods as well as training of practitioners on their application, HF has expanded the number of options available to women. Practitioners in all three countries assert that with the availability of other methods and training on use, preferences have changed with more women opting for the pill and Depo Provera. In Kyrgyzstan, cycle beads have also been introduced by Project HOPE with support from the Swiss Development Cooperation, and are being selected by some women. In the case of Uzbekistan and Tajikistan, the evaluation also shows that overall contraceptive use has increased by 25 percent or more. Methods are being provided through USAID, the German Development Bank, UNFPA and donated under the HF project. Methods are offered at no cost and the question remains how this will continue once external support for these efforts cease. STI education and training was not a major component of the program and many facilities lack the equipment and skills necessary to identify infections. However, it is a crucial topic given heavy seasonal migration of CAR males to Russia for work.

iv. Policy

Table 8: Number and percent of policy targets reached

Category	Uzbekistan Phase I	Uzbekistan Phase II	Tajikistan	Kyrgyzstan	Turkmenistan
Policy targets reached	N/A	2/2 (100%)	2/2 (100%)	N/A	N/A

Policy interventions were not originally contemplated in the initial proposal but were added in the first year, at the direct request of USAID. The Futures Group, who was originally selected to manage an NGO grants component, was tasked with assisting the MoH in Uzbekistan and Tajikistan in the development of policies

that support evidence-based approaches to maternal and child health. In both countries policy development groups (Core Groups) and Technical Assistance Groups (TAGs) were established with the assistance of the project. The MoH in both countries expressed great appreciation of the technical, financial and logistical assistance provided in this area and felt it was instrumental in developing good policy. In total 10 policies were developed in Uzbekistan supporting IMCI, and reforms in the areas of safe motherhood, neonatal care and infection prevention. In Tajikistan, the program supported the development of national standards on infection prevention as well as strategic plans in reproductive health and contraceptive security (See Annex G for Policies developed with support of HF).

v. Monitoring and Evaluation

Monitoring was an integral component of the program in Uzbekistan, Tajikistan and Kyrgyzstan. Generally, once a participant completed training in an area, he or she would receive 3-4 monitoring visits conducted jointly by HF project staff as well as local MoH trainers and supervisors. This was not only a learning opportunity for the individual being monitored but also for the trainers/supervisors who were learning how to provide supportive supervision. These visits utilized various techniques including observation, exit interviews and checklists to determine whether or not new practices were being employed. In Uzbekistan, HF found that they achieved better compliance by withholding certification until after the *first* monitoring visit. Monitoring visits were realized using project vehicles and fuel. How to sustain monitoring activities once the program ends has not been seriously considered and could be a critical problem as there is no internal MoH budget to support it in any of the countries. In Turkmenistan, the program had to depend on data from MoH monitoring visits as program staff was not permitted to conduct monitoring visits independently from the MoH. In collaboration with WHO, efforts have been made to support the MoH in improving the monitoring process.

In Uzbekistan, HF also developed a training database which helps district mangers monitor personnel trained by identifying trainees to be monitored, monitoring results and gaps. In addition they developed a parallel health information database to enable district managers and heads of MCH services to more effectively monitor activities and results. Part of this database included the BABIES Matrix, a CDC MPS assessment tool for birth related data. While proven to be helpful at the local level, it has not been endorsed at the national level and therefore, is unlikely to be sustained.

Province and district MoH staff members in Uzbekistan, Tajikistan and Kyrgyzstan were also key participants in the baseline and final evaluations which involved 30-cluster community based surveys as well as Health Facility Assessments. A real problem with the overall evaluation process was that it lacked any uniformity. From the start the program, Project HOPE could not build consensus around a core set of indicators and in addition, each principal implementing partner (HOPE, SC, ARC and Abt) employed their own procedures for conducting baselines and final evaluations. This resulted in challenges acquiring and evaluating accurate data and lack of clarity in indicator definition and interpretation.

vi. Sustainability

One of the most basic but crucial steps in the design of this program was to align program interventions with those already being endorsed by each country's government under emerging or ongoing health reform strategies. This step alone guarantees at minimum that all those trained under this program will be both

permitted and encouraged to continue to use their new skills beyond the life of the program. In all four countries, IMCI has been incorporated into medical school training and post-service training programs. Assistance provided by HF in the policy arena in Uzbekistan and Tajikistan also means that the program will be contributing to health impact well beyond the life of the program and well beyond the geographic limits of the program.

The evaluation team does have concerns that the day-to-day monitoring and support provided (financed) by the project will diminish, perhaps substantially, because there has been no real planning for district and provinces to assume these costs. The program has also donated medications and contraceptives that the MoH will have to re-supply. In Kyrgyzstan and Turkmenistan this should be less of a problem as recently launched national health insurance plans will help to offset these costs. Tajikistan, the poorest of the four countries may have the biggest challenge in this area. Moreover, the program failed to engage local province and municipal leaders in Tajikistan who are actually responsible for financing health activities (salaries, fuel, drugs, etc.).

Adapting IMCI training such that it can be employed by nurses and other non-physicians has also been key to its sustainability. In Kyrgyzstan, for example, half the doctors that have been trained in IMCI have left the country for more lucrative opportunities in Russia and elsewhere. This pattern is being played out to some degree or another in all of the countries. Training across disciplines at primary and secondary tier facilities helps to ensure that new standards in care will be applied regardless of who the provider may be.

At the community level, the HF project has had a significant impact on the knowledge and behavior of mothers. Through continual reinforcement much of the information disseminated by the program will likely become part of the conventional wisdom at the local level sustained by the positive results families are seeing in their lives and the lives of their neighbors. In the case of Uzbekistan and Tajikistan, Healthy Family has worked through local leadership, in addition to health facility staff, in order to promote and support changes at the community level. Getting local leadership on board is not only important to motivating community members but also having respected champions of healthy behavior once the program ends. The evaluation team anticipates that some of the community groups formed or supported by the project (i.e. VDCs, women's groups, Mahallas) will continue to be active and some, without continual motivation and support, will become defunct. Those that continue to function will do so because they see themselves as community problem-solvers with a role that is broader than health promotion. This is likely to be the case in Tajikistan where many of the 197 VDCs formed manage emergency transportation funds in addition to providing health education.

vii. Conclusions and Lessons Learned

Overall, from a technical standpoint, Healthy Family was a successful program showing mostly positive results in all four countries. Some general conclusions and lessons learned that can be drawn from the technical aspect of the program are as follows:

Conclusion #1: In all four countries, the program interventions were synchronized with new, national level reforms in standards of practice for maternal and child health. This facilitated support for district-level program activities from the national level and in turn, provided national policy and decision-makers with pilots under which the new reforms could be tested. The interventions supported by Healthy Family will

continue to be supported by the governments of the four countries because they were and are part of the governments' own strategies.

Lesson Learned #1: In countries where programs have an opportunity to work with reform-minded governments, designing interventions that specifically support and inform such reforms are likely to have the best chance for sustainability.

Conclusion #2: The program's support for IMCI has been an important success and a critical tool for physicians, physician assistants and nurses working at primary and secondary tier facilities. Because they now have the skills to more accurately diagnose, the medicines to treat and the means to educate mothers, it is resulting in more patients being seen earlier in their illness, a reduction in critical cases seen at province level hospitals, and more effect treatment that relies less on antibiotics. Ultimately, they believe this has contributed to reduced mortality seen within communities. Focus on training non-physician staff has helped to ensure sustainability and uniformity in treatment.

Lesson Learned #2: In the CAR, where there is a high ratio of health staff to population, but where health providers have limited resources for diagnosing and treating patients, IMCI is an ideal method for improving health outcomes of children. IMCI should continue to be supported – especially training of non-physician health personnel that are more abundant and less likely to leave.

Conclusion #3: Training undertaken by this program to improve antenatal care, delivery and post-natal care was highly valued by participants and are believed to have significantly contributed to improved mother's knowledge on danger signs and improved hospital-related care during delivery and neonatal periods. Staff members at these facilities believe that their new skills have made pregnancies safer and reduced mortality with some evidence provided by facilities to support this claim.

Lesson Learned #3: Application of WHO standards for Making Pregnancy Safer (as well as LSS) provide a positive pathway for improving pregnancy and delivery outcomes in countries where antenatal coverage and physician assisted births are high.

Conclusion #4: The increased availability and variety of contraceptive methods provided under this program, as well as training in Family Planning counseling, has helped to expand the number of users. The question remains however, how clinics can continue to provide these methods free of cost once this and other programs stop providing contraceptive supplies. In Uzbekistan and Tajikistan, this is being addressed at the national level, (with HF support) through the development of a national contraceptive security plans but it was not clear to the evaluation team how or when that would be rolled out.

Lesson Learned #4: Contraceptive mix, access and availability, along with trained counselors are key ingredients to improving family planning in the CAR. Future programs will need to find means by which clinics can continue to offer a variety of methods at low-cost or no-cost to clients.

Conclusion #5: Knowledge and behavioral change objectives were achieved via two pathways – community mobilization efforts and clinic-provided education and health promotion. Mobilization efforts in Uzbekistan and Tajikistan made effective use of community leadership (teachers, mullahs, political leaders) to promote and support targeted knowledge and behavioral change objectives. In Tajikistan, the creation and local management of emergency transportation funds provided an added resource which helped minimize one barrier to health seeking behaviors. Turkmenistan conducted educational campaigns

to achieve similar community-based objectives but due to lack of data, it is not clear how effective this strategy was. In all four countries the evaluation team concluded that training and use of clinic staff as health promoters was an excellent approach that contributed to successful community level knowledge and behavioral change. This was due to the fact that populations in the CAR have good access to clinics and use them regularly. Clinic staff overwhelmingly concurred that the change in knowledge and behavior within the community was central to the positive health outcomes witnessed.

Lesson Learned #5: Identification, recruitment and support of local leadership for community-level behavioral change is crucial whether forming new groups such as VDCs or utilizing existing structures such as the Mahallas. In the case of the CAR, knowledge and behavioral change can also be achieved through health education and promotion at the clinic level given the high level of access and use.

Conclusion #6: The structured monitoring activities employed by the program were important tools that ensured skills were appropriately applied. In addition, they provided province and district-level supervisors with hands-on training in objective and supportive monitoring techniques. Unfortunately, in Turkmenistan, there was no structured monitoring component conducted by the program and only limited information provided by the government. As such little can be said about whether or not skills have been adequately applied and/or what results were achieved due to the training. Regarding evaluations, the program could have done a much better job to ensure that the quality of data gathering and analysis was consistent and thorough across countries.

Lesson Learned #6: All programs that support skills-based training should also ensure adequate attention and support is given to field-based monitoring as a means of assessing the quality of the training, addressing gaps and providing support to health care workers in the environments in which they work. With regard to quantitative evaluations, a program of this size and scope should always use an outside consultant(s) to oversee and manage the data gathering and analysis process.

Conclusion #7: Many of the activities supported by Healthy Family project will continue in large measure due to what has already been stated in Conclusion #1. The added technical assistance given by the project for policy development was also a crucial step in helping the governments of Uzbekistan and Tajikistan work through the technical arguments and parameters of introducing evidence-based standards within their borders. This has reinforced the notion of national ownership of the program and its practices. Sustainability of activities and outcomes will however, also depend on financing by community, government or external sources. Unfortunately, little attention has been given to how district-level activities will continue once HF financing for those activities are discontinued.

Lesson Learned #7: When feasible, health programs should reinforce and support national level policy development. Programs should also build in a sustainability assessment well before the project ends so that it can begin to work with local partners in laying the foundations for transition and eventual assumption of responsibilities and costs.

B. Uzbekistan

Initiated in 2002, Healthy Family Uzbekistan was among the first, and was the largest of the four-country program. Project HOPE, the prime for Healthy Family, was the principal implementing partner for Uzbekistan activities. Also partnering with Project HOPE in Uzbekistan was the American Red Cross who was responsible for community mobilization and health education; JHPIEGO who was responsible for Making Pregnancy Safer (MPS) and Infection Prevention (IP); and the Future's Group, responsible for the NGO Grants program and policy reform.

The HF Project model in Uzbekistan was based on the successful Project HOPE Navoi Child Survival Project also implemented in Uzbekistan. The HF Project was implemented in two priority provinces: Surkhandarya and Kashkadarya. A total of 10 districts, three in each of the two provinces during the first half of the 5 year project (Phase I), and an additional 2 in each of the two provinces during the second half (Phase II), were identified for these activities. The original plan was to work in a total of 6 districts during Phase II, but this was modified due to budget cuts. At the provincial level, the project established strong partnerships with the MoH, getting their buy-in and involvement in project planning, health provider training, quality improvement and monitoring activities. At the national level the project worked in close collaboration with WHO and the Zdrav Plus Project contributing to policy dialogue. HF created a Core Group of policy makers to ensure support and buy-in from the various government departments involved in approving health policy and to facilitate future prospects for country-wide roll out of evidence based strategies. In addition to receiving training and capacity-building in policy development from the program, this group also proposed 10 policy documents/government decrees/national modules for IMCI, MPS, IP, and RH for government approval. A national level Technical Advisory Group (TAG) was also a project initiative that facilitated these developments. Support at the policy level coincided and facilitated the approval process for trainings and the use of evidence based strategies being piloted in the project districts.

Working with the provincial and district MoH health staff in Surkhandarya and Kashkadarya Provinces, the Healthy Family Uzbekistan Project focused on two main strategies: 1) training of health care providers in international guidelines/protocols for service improvement, including quality of care and communication with clients; and 2) community mobilization to increase knowledge and behavior change within the population.

Based on the quantitative data available to the evaluation team as well as the qualitative interviews conducted during the final evaluation, the evaluation team concluded that the Uzbekistan project was extremely successful. The Uzbekistan project achieved 14 out of 17 indicators in Phase I districts, and 16 out of 18 in Phase II districts. Qualitative interviews with staff and partners at the national, provincial, district, health facility and community level provided evidence of the project's contributions. These, included improving health provider knowledge, skills and performance in all the project components; development and strengthening of HIS and databases; supervision and monitoring; and, community mobilization, education and capacity building. District managers as well as child and maternity hospital heads believe the project positively contributed to changes in health outcomes including reduction in child morbidity and hospitalizations for ARI and diarrhea, reduced trauma during delivery and post partum hemorrhage, reduced cases of asphyxia and infections in newborns, improved newborn care and breastfeeding practices.

The evaluation team also observed that in the Uzbekistan and CAR context, where the population has a high level of education and literacy, projects can achieve knowledge and behavior change with relatively limited effort and

resources. Strategic interventions such as training health providers in communication skills, developing IEC posters and distributing brochures to all households show evidence of having promoted behavior change. A unique feature of CAR is the abundance of doctors, clinical nurses and visiting/family nurses. They are all engaged in home visiting as part of their daily routine, providing counseling, education and follow-up. Armed with training and educational materials, and in collaboration with existing community structures and trained community leaders and activists, health staff persons were significant forces in community health promotion. A consistent comment during the final evaluation interviews was that there are fewer cases of illness because mothers have learned and adopted preventive practices. Moreover, health care providers see fewer cases of severe illness because mothers can now identify danger signs early, manage home care more effectively and seek appropriate care.

An important element of the HF project in Uzbekistan, as affirmed by national level MoH officials, was the involvement of national MoH leaders and experts as stakeholders in the project. This not only enabled the project to influence policy dialogue and reform necessary for the implementation and eventual roll-out of evidence based IMCI, MPS and RH strategies, but it also gave the project activities added visibility. This created a base for HF priorities and strategies for scale-up to other districts and provinces through other funding sources such as the Asian Development Bank (ADB) and the World Bank (WB). One example of an HF activity that will be utilized country-wide by ADB is the training of nurses in C-IMCI.

In addition to health provider training and community mobilization, HF had an NGO strengthening component led by the Futures Group. Due to the unfavorable political environment for NGOs, and reduced funding, this component was phased out after the midterm. The reach of this component (less than 20,000 people) relative to the cost meant that it was not a cost effective strategy given the focus of the program. But it is clear that from an institution building standpoint, the NGOs benefited from the capacity building activities undertaken. During the evaluation, it was reported that some of these NGOs are still working (in collaboration with UNICEF and the World Bank). A visit confirmed that at least one of the two NGO resource centers developed by the project was still open.

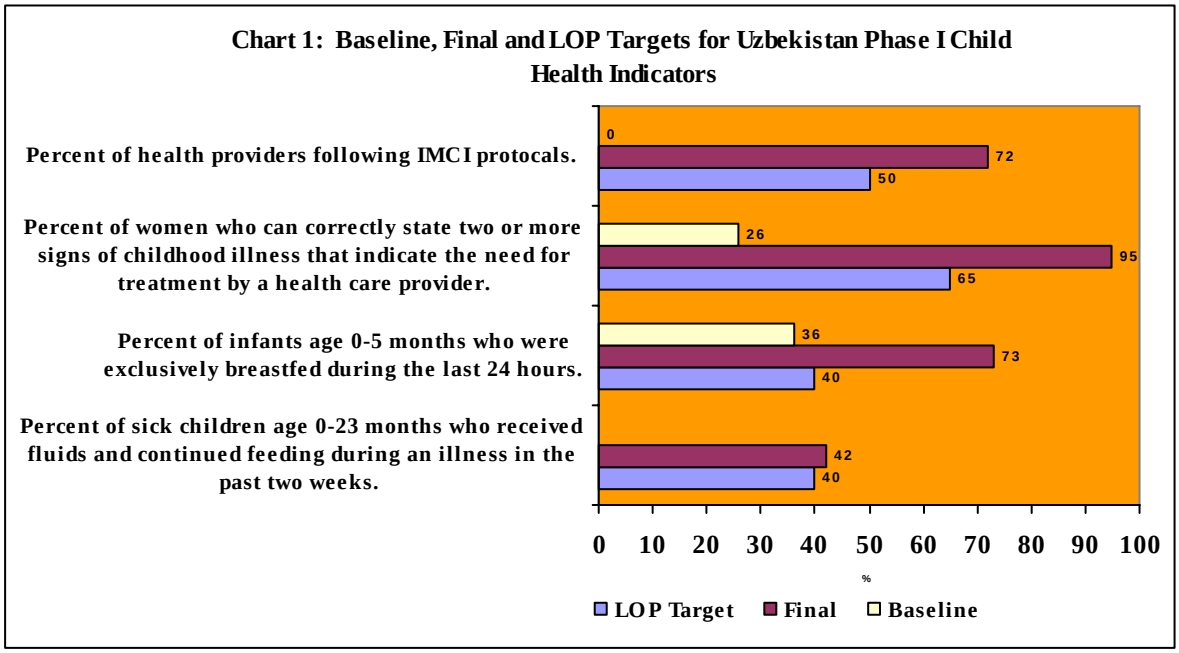
Project HOPE also complemented HF Project activities with large provisions of drugs, medical equipment, supplies and contraceptives. The total match for Uzbekistan came to approximately $14, 795,931 (including provisions of Hepatitis B vaccine and Vitamin A capsules). However, some of the donations were not directly related to the project technical areas of work. The project also received private donor funding to support the training of health providers working in Afghan refugee communities in the provincial capital of Termez. Another important source of funds was the Academy for Educational Development which helped the HF project with training community volunteers in Phase II districts. ARC, who managed the community mobilization component in Uzbekistan also contributed $214,345 in match.

The Healthy Family project in Uzbekistan faced various challenges: 1) difficulties with implementation at the beginning because national policies and decrees were not in place to support many of the project activities; 2) a smaller community component, and decreased number of trainers and monitoring specialists trained in Phase II districts because of the reduced budget; 3) the peculiarities of the national policies made it hard to collect reliable data; 4) distance to some of the peripheral level sites (150-200 km) made it difficult to regularly monitor; 5) access to mountainous communities was difficult in the winter months; and, 6) MoH staff turnover (reasons for departure include: leaving to start their own small business or pharmacy, going on maternity leave, and immigrating to Russia).

When trainers and district managers were asked what improvements/changes they would suggest for ongoing projects, some mentioned the length of certain trainings was too short, i.e., C-IMCI should be 8-10 days rather than only 4 days, and more time should be allocated for Breastfeeding and IP training. Another comment was the fact

that the project used local trainers to train trainers, rather than international experts as they did in Phase I. One district manager suggested that for this cadre, it is very important to use international experts so that the transfer of knowledge to those who will themselves be training others is not compromised.

i. Child Health



Note: data has been derived from KPC and HFA data. There is no baseline data available in Phase I for fluids and feeding during illness.

All four child health indicators surpassed their targets in Phase I communities, and Phase II districts reflected similar results (See Table 4). The HF Uzbekistan strategies for child health, like all program intervention areas, included both a health provider and a community component. With the objective of improving child health services and introducing evidence-based international standards, the project focused on training doctors in IMCI and nurses in Community-IMCI following the WHO guidelines and protocols. In the six Phase I districts, the project conducted a TOT for 38 doctors (as well as other staff), who subsequently helped to implement 11-day training workshops for a total of 350 doctors. More than two years later in the 4 Phase II districts, the project conducted IMCI training for 579 doctors by trainers trained during Phase I. Nurses, midwives, physician assistants and a few doctors (944 total) participated in 4-day training workshops for C-IMCI in Phase I and 442 health care providers were trained in Phase II (total = 1,450 trained in C-IMCI). Additional child health interventions included the training of 12 and 14 Monitoring Specialists for Phase I and Phase II districts respectively, as well as training 19 doctors, primarily from the referral hospitals, in Hospital IMCI (H-IMCI). H-IMCI training was a need identified by the project because referral hospitals treat more complicated childhood illnesses. With the initial support of WHO, the HF Uzbekistan and Zdrav Plus Programs collaborated on the development of a 10-day training module for Hospital IMCI. HF was subsequently able to co-share on training expenses with the Asian Development Bank (ADB). As the latter is relatively new, several interviewees mentioned that more work needs to be done in this area. At the province level in particular, this need was expressed.

The project provided a number of nutrition-related trainings during both phases including breastfeeding (1,404); anemia and nutrition (226); and Vitamin A (123) (See Annex E for complete list of trainings and participants). Breastfeeding certification was an important project activity that resulted in Baby-Friendly certification of 11 hospitals and primary health care facilities in the Province of Surkhandarya and 7 in Kashkadarya, for a total of 18. Posters of the 11 steps for BFHI were clearly visible in all health facilities visited. Uzbekistan added an 11th step to the 10-step process which stipulates that certified hospitals must promote BF certification in at least two outpatient clinics or SVPs. WHO commended Surhandarya as the province demonstrating the greatest leadership in this area.

District Managers, hospital heads, IMCI trainers and health providers interviewed by the final evaluation team all provided specific examples of how the training they received helped them in their job performance. A consistent comment was that the IMCI training made their jobs easier and that they were better able to diagnose illness by following the IMCI algorithm. All mentioned that as a result of the training in communication skills, they were better able to communicate and foster stronger relationships with their patients. Managers and supervisors mentioned that health workers were friendlier. Several of the providers interviewed also mentioned that they could count breaths and diagnose pneumonia when doing home visits (without any instruments). They also check the supply of ORS in the home (health facilities ensure they have at least two packets). All providers mentioned that they now prescribe fewer drugs and that this makes families happier since they spend less money on treatment.

Based on interviews, access to IMCI drugs at the main hospitals usually was not a problem because although Health facilities receive only 7 of the 13 IMCI recommended drugs (which are provided free of charge to the population), people are able to purchase the others at private pharmacies. But getting these additional drugs in rural communities can be a problem because there is little access to private pharmacies. Overall, IMCI has been an effective strategy with regard to drug access because it has reduced the overall number of drugs needed to treat childhood illnesses.

In addition to health facility staff, Healthy Family worked with a total of 229 community committees (locally referred to as *Mahallah Committees* which are supported by the government of Uzbekistan), and trained 1,783 community volunteers. These volunteers conducted numerous health education sessions and according to the Red Cross, reached approximately 100,000 community members, including women, men and youth groups in each of the communities. Soon after getting activities off the ground in Phase II pilot districts, ARC was phased out due to budget cuts. Project HOPE staff took over the community component changing the strategy in order to accommodate a smaller budget. Unlike the Red Cross, Project HOPE did not have staff and vehicles based in the pilot districts. They worked closely with the district authorities *(Hokimiats)* and engaged them in the process of community mobilization and responsibility for health. Each community was asked to identify three of their most active representatives. Among the resource persons identified were religious leaders, women leaders, committee chairmen and activists. The project conducted a TOT for 29 community members, and subsequently organized various 4-day training workshops on community health for 449 community resource persons. Training sessions for men, women and religious leaders were held separately so that participants could feel completely comfortable. With support from the *Hokimiat*, these community resource persons were encouraged to work with the community and women's committee structure to initiate health education activities, including community theatre, events and home visits. According to both the local authorities and committee members interviewed during the final evaluation visits, they meet regularly and the local authority gives them regular guidance and support with community education activities. *Hokimiat*, representatives participated in the community health trainings

conducted for community leaders as well as ARC training on how to conduct activities in the community and social mobilization.

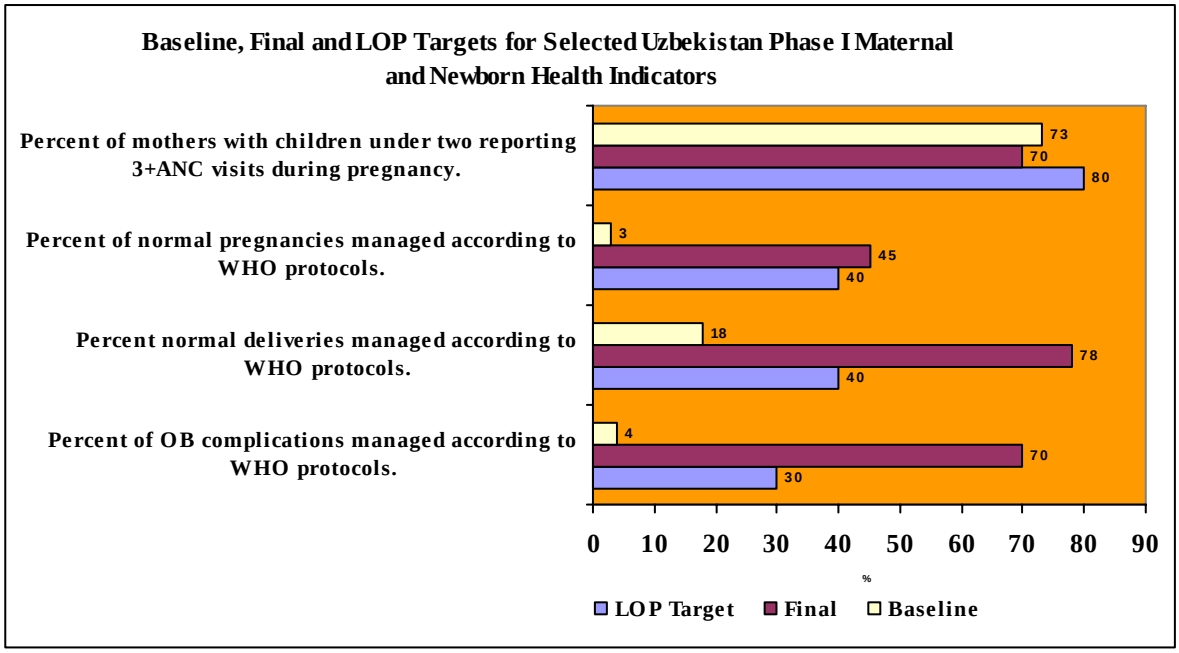
Knowledge and behavior change were also addressed through four two-month long health campaigns in Phase I which covered breastfeeding, ARI, RH and diarrhea. Media included radio, television and newspapers. In Phase II, the project conducted one campaign covering all topics, and a couple of 10-day campaigns targeting Committee counselors, key persons in the local administration and health care providers. The HF Program developed, pre-tested, revised and distributed IEC materials, including booklets and various posters. As previously discussed, the availability of information that mothers, grandmothers and other household members were able to keep at home, access to 'health corners' with educational materials in health facilities, and health providers who routinely visit households (specifically targeting households with newborns and children under five) provided a strong base for improved knowledge and behavior change. Committee members and activists reported positive results including a reported reduction in IMR from 21.4/1000 to 14.6/1000 in the district of Kasbi and by 4% in the district of Denau. They attributed this to the population receiving the same messages from health providers, community leaders, and written material.

All communities visited during the final evaluation activity had a 'Healthy Family Corner' which was the office and meeting place of the Community Committee. These corners were decorated with health booklets and pamphlets, posters and pictures of community events and activities. The evaluation team was told that community members like to come to look at the posters and read the materials. Throughout the evaluation, there were consistent comments from both providers and community members regarding the value of having educational materials.

Community mobilization with health facility involvement during Phase I also led to the development of Community Emergency Transportation Plans. Transportation Funds were established in both close and distant communities; transport was identified for every neighborhood street; and some communities apparently went as far as developing a list of blood donors. The local authority working with communities confirmed that these were still in place for the most part, but there has been no real follow-up by the project to look at exactly how many of them actually exist and function. The province of Kashkadarya has mountainous areas with dispersed communities located as far as 200 km from the provincial capital. These communities are sometimes completely cut off during the winter months, and only the lowest level health facilities with one or two health providers cover those catchment areas. It is clear that the population in these areas has not benefited as much as the others. This concern was also expressed by the local authority who works with Community Committees. The local NGO partnerships positioned the project to fill this gap, but as previously mentioned, due to budget cuts, the project could not put more effort into this area.

ii. Maternal and Newborn Health

*There are a total of 7 indicators for Maternal and Newborn Health applied in Uzbekistan Phase I districts(see Table 4)



The Maternal and Newborn Health interventions in Phase I had similar positive results as the Child Health interventions with the exception of antenatal (no improvement) and postnatal care (10% under target) indicators in Phase I. In Phase I, the project only conducted two training workshops on antenatal care which covered 20% of eligible personnel. During Phase II, there was greater effort in this area with demonstrably better results (See Table 4). The evaluation team's observation was that targets for the management of normal pregnancies as well as normal and complicated deliveries, did not appear to have been very ambitious considering the project's level of effort in these areas (particularly with the MPS technical partner JHPIEGO). Project staff explained that they lowered some of the indicator targets due to concerns about the impact of budget cuts. Staff also emphasized the fact that the WHO monitoring standards are too rigorous and thus it is not easy to achieve high scores on the percent of trained personnel following protocols, i.e. if a health provider doesn't follow even one part of the protocol, it means they have not followed the protocol. In the case of normal delivery, all 8 different steps have to be followed; for complicated delivery, all 6 steps; and antenatal care, all 7 steps have to be followed.

Another indicator not included in the table is the percent of women post delivery managed according to WHO protocols. Only Phase II districts achieved the 50% target. In Phase I the mid-term result for this indicator was 87% but only 40% at final. Project staff suggested this was because practices were fresh for Phase I health providers at mid-term but that the project did not work intensely in Phase I districts in the second half of the project.

MPS training for health providers was based on evidence-based international standards with the goal of training all eligible doctors, nurses and midwives working in the pilot districts. The project trained 16 providers as Making Pregnancy Safer trainers ; 68 in MPS (main course); a total of 204 in Management of Complications in Pregnancy and Childbirth (MCPC) (18 and 12 day courses for Phase I and II respectively); 45 in as Antenatal Care trainers; 465 in Antenatal Care; 152 in Normal Delivery; 142 in Essential Neonatal

Care; 27 Neonatal Resuscitation trainers; 259 in Neonatal Resuscitation; and 23 in MPS monitoring. In addition, the Project introduced MCPC and IP to medical universities and colleges, whereby they also trained 77 doctors and midwives at medical universities and colleges. For Phase I and II, a total of 91 health providers were trained in as IP trainers; 796 were trained in IP and 39 were trained in IP monitoring. The technical contribution of JHPIEGO was substantial. They supported the development of the various training packages, manuals, handbooks, and standards for implementation, monitoring and evaluation. The Technical Advisory Group organized by the HF project was also instrumental in supporting this work and for pushing ahead MCPC and IP into pre-service trainings. The involvement of professors from national medical institutes and MoH specialists and epidemiologists helped to overcome bureaucracy and facilitated policy development and program implementation. In turn, the aforementioned institutions benefited from project support in the form of training, laptops, LCD projectors and mannequins for trainings.

During Phase I of the project, the MoH, with the support of the Healthy Family Project, Centers for Disease Control and UNICEF, introduced the International Live Birth Definition in various provinces across the country. This is a critical step in proactive resuscitation of newborns (1500 grams and above) leading to more lives saved. Covering the entire Kashkadarya province, the project conducted a one-day LBD training for 13 pathologists as well as 3-day training for 147 doctors and midwives; and supported a TOT monitoring training with national level trainers. MCH Managers from pilot districts reported that 3 newborn lives were saved this year as a result of health providers using the new LBD. The use of these guidelines also provides a more accurate picture of perinatal mortality than the current Uzbekistan guidelines which have a lower cut off point.

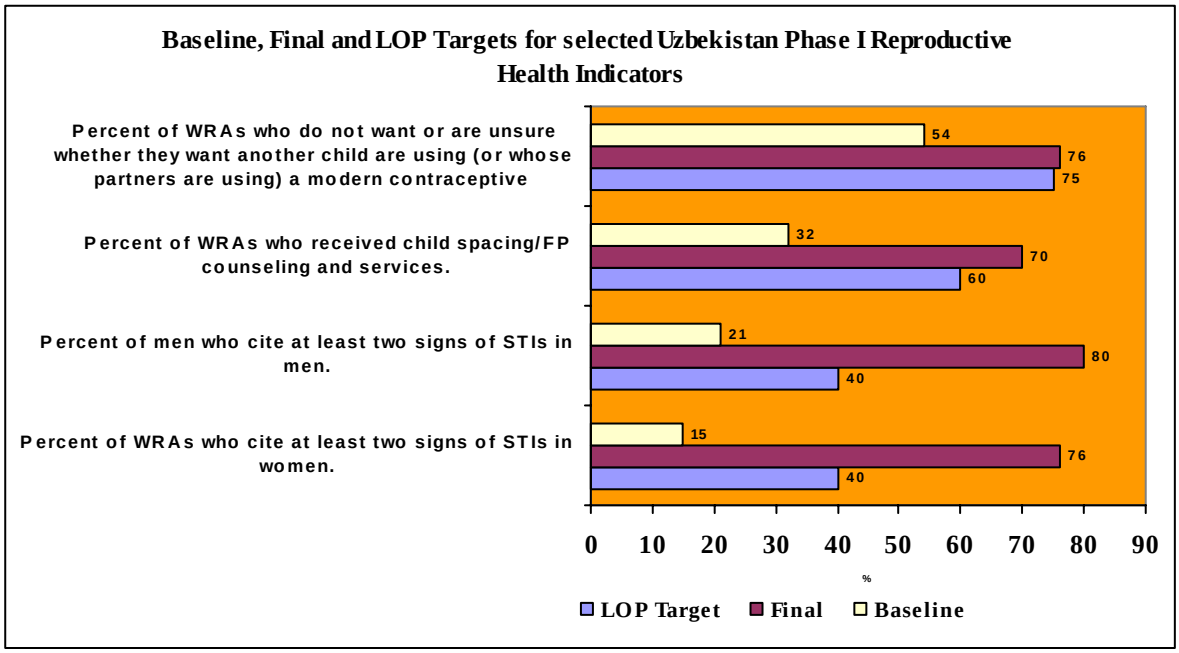
With regard to MPS training, Ob/Gyns and midwives in all the districts visited said that they make greater use of the partograph as a result of the training (e.g. Denau district reported 20% use in 2005 and 80% use n 2006). The partograph is posted on the wall of the health provider study room and in some delivery rooms. Interviewees reported that their new skills in managing the third stage of labor had contributed to reducing trauma and cases of hemorrhage. These changes were noted by all maternity ward providers interviewed, and were supported by the project database (post-partum hemorrhage decreased from 6% to 1% in Phase I districts, and from 20% to 3% the Phase II districts). Significant reductions in complicated deliveries, perineal rupture, blood transfusions intensive newborn therapy and asphyxia were also noted. Health staff cited many changes in the delivery ward including the reduction in medicines used during delivery; allowing mothers to choose the position they want for delivery; support for partner assisted delivery; reduced umbilical cord infections and decreased sepsis. Health staff, mother and community members all noted that after delivery, newborns are placed on the mother's chest (skin to skin) for immediate breastfeeding; whereas previously newborns were often kept apart from the mothers and given water or artificial supplements.

According to visiting nurses and community volunteers/activists, pregnant women are prioritized for home visits and provided with key health messages on danger signs during pregnancy and maternal nutrition. They are also told about delivery options. In collaboration with the Zdrav Plus Project, HF developed educational materials for pregnant women.

Infection Prevention (IP) was integrated with the maternal health interventions. According to the project data, the IP target indicator (percent of health facilities that use 0.5% chlorine solution/bleach for decontamination) went from 0% at baseline to 93% at the final in Phase II districts. In Phase I, the final was 82% (no baseline). Previously, instruments were soaked for 3-5 hours in much higher concentrations, rather than the current 10 minutes in 0.5% solution. This has reduced skin irritation and contributed to

substantive cost-savings as well. MPS protocols have reduced maternity stays from the previous 8-11 days, to 3-5 days which also helps to reduce hospital acquired infections. Providers stated that they now use protective gear (masks, glasses, gloves, and plastic gowns). Prior to the training, they did not wear glasses, and their gowns were made of cloth. According to several health providers interviewed, the maternity ward prioritized for supplies and therefore stockouts have not been an issue.

iii. Reproductive Health



*There are a total of 6 indicators for Reproductive Health applied in Uzbekistan (see Table 4)

With the exception of *percent of providers providing STI screening and appropriate services,* Healthy Family Uzbekistan either met or surpassed RH targets for Phase I and Phase II. Again, it does appear that some of the RH targets, i.e., knowledge of STI signs in men and in women, were not overly ambitious considering the fact that these were knowledge rather than behavior change indicators. Less obvious, but also slightly conservative, was the target for the FP indicator on counseling and service provision (target reductions explained previously). Virtually all eligible staff received training in reproductive health. The STI screening indicator which failed to meet its 20% target went from 4% and 0% at baseline to 18% and 11% for Phase I and II districts respectively. Project staff reported that while health providers received high scores for their own clinical services, not all patients received the full set of services, due to the absence of a laboratory, lack of reagents, the patient's inability to pay for expensive STI drugs at pharmacies, and issues related to working with the vertical STI and HIV systems.

Health provider trainings for reproductive health included a TOT for 50 participants; training workshops for a total of 620 (Phase I) and 191 (Phase II) Ob/Gyns, midwives and nurses; and a training on monitoring for 16 participants. During Phase I, a training on RH/STI for adolescents was provided to 16 Ob/Gyn participants, as well as a Peer to Peer education for 132 school boys and girls. The adolescent component was later eliminated due to funding cuts.

Prior to the National Reproductive Health Strategy and Action Plan, the IUD was the only contraceptive available. Through the support of Healthy Family and other projects, the MoH was able to expand the options offered to include oral pills, Depo Provera and condoms. Providers interviewed said that as a result of the training they received, they were able to counsel clients on all methods and more clients have opted for methods other than the IUD. Providers in two health facilities reported that they now have 30% and 40% of their FP clients using alternatives to the IUD. The sustainability of the contraceptive supply is an issue however. Currently, the districts depend on USAID, UNFPA and German Development Bank to supply contraceptives. The USAID provision of contraceptives to the project provinces was valued at almost US$1,000,000.

In response to a request from the MoH, and with the support of the Global Fund and UNICEF, the HF Project also conducted training in the Prevention of Mother to Child Transmission (PMTCT) of HIV. The training targeted 79 doctors in both provinces and districts (including non-pilot districts). The training also provided doctors with information on how to use rapid tests, treatment with ARVs, consultation, counseling and protection in the workplace. Most cases of HIV/AIDS have been identified as coming from specific areas (the provincial capital of Termez, and the district of Denau) due to the fact that these are crossroads for drug trafficking. Both Surkhandarya and Kashkadarya provinces are planning to set up several Voluntary Counseling and Testing Centers, and expect to receive Rapid Tests and AntiRetroviral Drugs from the Global Fund. District managers, HF and USAID have recognized that PMTCT is an area that needs additional effort. Overall, in-country knowledge and capacity is weak and this is a gap that needs to be addressed in future programming.

At the community level, under the leadership of the Committee Counselor, and with the support of health providers, trained community volunteers/activists addressed issues such as STIs in group discussions with men, women and youth during Phase I. The Red Cross was even able to collaborate with the Education department to work in schools. Community volunteers reported that they use skits as a means to transmit messages, followed by facilitated group discussion. A strategy to increase male involvement has been to address things that concern them directly, i.e., STIs. Focus group discussions with men conducted by the project revealed that men think RH is the responsibility of women; there is a lack of communication between couples on the subject; and as a rule, men do not go to health facilities. FGDs with women also revealed that some use contraceptives in secret. With the idea of addressing some of these issues, the project developed STI brochures specifically for men and developed campaigns targeted towards educating men. Due to budget cuts there were fewer of these campaigns in Phase II, but the recruitment of Imams for community mobilization in the second Phase was very strategic and some have become champions for health and STI prevention.

iv. Policy

Healthy Family assisted in the development of 10 national level policies. Although policy development was not a part of the program at the beginning, it did not take the program leadership long to realize that without this component they would have little success with the implementation of evidence-based international standards at the pilot district level. With the expertise of the Futures Group, HF was well placed to take on this activity. The program created a Core Group made up of 5-7 national policy makers including senior members of the MoH, Ministry of Education, Ministry of Justice, Ministry of Social Protection and Labor and the Ministry of Finance, and the Cabinet Ministry. Creating a multi-sectoral group was a strategic move on the part of the project because health policy reform and the approval of health-

related decrees involved non-health government officials as well. International organizations were not members of the Core group, but were invited to participate as advisors. These included USAID, WHO, Zdrav Plus, UNICEF and UNFPA.

The policy initiative undertaken by the project, according to a Core Group member interviewed, first and foremost built the capacity of their group members in policy development. The group benefited from a series of trainings in each of the following areas: policy and policy structure, strategic planning for RH, advocacy, gender equity, and contraceptive security. The project also put together a Technical Advisor group made up of specialists who helped to contribute to technical discussions and facilitated policy dialogue. Although it was reported that the working groups established under these bodies were more active than some of the various ministry Core group members, the hard work and commitment demonstrated by many of these health experts (MoH and other) led to substantive achievements in this area.

Some of the policies/decrees that the project helped to develop were for IP, LBD, antenatal care, pediatric care and, most recently, H-IMCI. All decrees are based on international standards of practices. With the leadership of Project HOPE and JHPIEGO, the IP protocol may be considered among HFs most successful efforts. This was extended country-wide and is being replicated in Tajikistan where they also passed a similar decree. Although the project recently passed a decree on H-IMCI, there is no specific national decree on IMCI. Doubts about IMCI raised by UNICEF in-country have brought the issue of national policy on IMCI to the forefront, even though officially, the MoH has been in support of IMCI and it is currently being rolled out across the country.

At the provincial level, HF facilitated the implementation of national policies supported by disseminating copies of the decrees, organizing orientation meetings at the provincial and district levels to introduce the new decrees and training.

In addition to decrees, the policy initiative led to the creation of a booklet on Contraceptive Security, a national reproductive health strategy (still under the consideration of the Cabinet of Ministers) a draft law for reproductive rights and a concept paper of EBM (already approved by the government). A full list of the decrees and policy papers that HF helped support can be found in Annex G.

v. Monitoring and Evaluation

The project M&E strategy was found to be quite strong consisting of 3 elements – (1) HIS system development, collection and analysis; (2) training in monitoring and supportive supervision; (3) training in assessment and evaluation methods including BFHI certification self-assessment, 30-cluster surveys and LQAS. In addition to the above, HF also developed a training database to help district mangers monitor trainees by tracking monitoring results and gaps. The latter was recognized as a very useful tool which was shared with the other HF countries as well as other projects based in Uzbekistan. The project also installed a Community database in each district local government. Data is collected and reported to them by the salaried Committee Counselor each month. The database allows the district to monitor the number, type and locale of community education activities. The Deputy Mayors have been responsible for managing this database and producing quarterly reports.

With respect to strengthening data gathering and analysis, the project created a database that could be used as an instrument for data analysis since all data was typically calculated manually. Achieving national level

endorsement to use and produce report from this database may be a challenge because data is manipulated regularly due to political pressure. Nevertheless it was clear to the evaluation team that this database has served as a model and learning opportunity for the districts involved. It enabled district managers and heads of MCH services to increase accuracy of data, track trends that directly reflect quality of care, health provider practices, population health knowledge and behavior, and to make data-based decisions. Part of this database included the BABIES Matrix, introduced in 8 of 10 pilot districts (2 districts had a change in key personnel and chose not to use it). The BABIES Matrix is a CDC assessment tool for birth related data. According to District MCH managers interviewed, the matrix allows them to maintain accurate records of delivery outcomes, and more importantly, to identify deficiencies. They found that the biggest problems occur during the antenatal period, and this information helped them to address problems in this area. Districts in Kashkadarya province pilot tested the International LBD, which provided another area of change in health information. Health providers received training to revise how data on miscarriages, still births and live births is recorded. The project also helped them link the database on birthrate and mortality so that the district MoH can do further analysis. Despite the difficult environment at the provincial and national levels for improving data quality, the project has been able to use the data coming from this system to inform and influence discussions, policy dialogue and decision-making.

Monitoring training outcomes was another integral part of the program. Initially HF certified providers immediately after completion of training. This was changed when project staff realized that certified providers were not always following all the new protocols in their workplace. Thereafter, certification of trainees was postponed until after an initial monitoring visit. Some health workers required up to 3-4 monitoring visits before they were able to be certified. Project-supervised monitoring for antenatal care, RH and IMCI was limited to one observation for each participant conducted after the first month of training, due to the extensive number of trainings and budget limitations. Follow-up monitoring was conducted 6/7 months post training for a random sample of participants. For MPS, IP and BF, whole-site monitoring was conducted once every 6 months for each facility. To compensate for the fact that the project could not systematically conduct a monitoring visit for each trainee once certified, the project partners decided to invite monitoring specialists to participate in some of the routine supportive supervision visits. A 5-day training on supportive supervision conducted in each of the provinces for key staff served as a good complement to the training in monitoring and reportedly has already shown results.

Monitoring for all project components included observation and patient exit interviews. Antenatal and C-IMCI components also included a written test of health provider knowledge, while RH provider knowledge was assessed through observation. For C-IMCI the monitoring included interviewing the mother of a child <5 in the neighborhood assigned to the patronage nurse. Both antenatal and MPS monitoring included a review of facility records. The MPS and IMCI components included stock checks of equipment, drugs and supplies. MPS monitoring was the most extensive as it also included interviews with the Ob/Gyn, neonatologist, and midwife, as well as the maternity heads on training and refresher, and a review of the use of standard protocols. Most of the monitoring was based on MoH-adapted WHO guidelines. The project developed a summary checklist to facilitate scoring for all except the MPS component.

Healthy Family conducted baseline, midterm and final assessments of facilities as well as community-level assessments of knowledge and practices. The baseline and final used HFA and KPC survey methodologies for the facility and community components respectively. All data collection, entry, validation and analysis were managed and conducted by Project HOPE staff. As already noted in the general results section, the evaluators feel that given the scope of the project, the final HFA and KPC survey should have been managed by an external consultant to ensure consistency and objectivity across all countries.

vi. Sustainability

Clearly, the work achieved by Healthy Family at the policy level discussed above will go a long way to ensure continued support for the health provider training and other interventions supported by HF. In addition, the project achieved a very high degree of buy-in from MoH and local government partners in the two provinces, and was able to introduce IP and MCPC curricula into medical schools. The positive results seen in Phase I (please refer to previous tables), demonstrate a degree of sustainability as the project had withdrawn most of its support to those districts almost 3 years ago. It is also notable that project information has been shared beyond the pilot districts through the monthly medical councils that all districts participate in – midwives, Ob/Gyns, pediatric etc. The evaluation team was told that health providers from the non-pilot districts are also required to implement the new national policies and decrees. As such, they use the monthly medical councils to learn from those who have received training and often photocopy materials and sections of the HF training modules. One strategy used in the province of Kashkadharya is to have trainers from the pilot districts attached to non-pilot districts to share project learning. The provincial MoH reported making extra copies of some of training videos, such as hand washing practices for IP and processing the umbilical cord, to assist health provider learning in non-project districts. One provincial local government representative said that they used some of the project IEC materials in non-pilot district communities, making duplicate copies with computers.

MOH Staff in the targeted provinces have clearly seen the value of the project interventions and are using the experiences to assist other districts. For example, in preparation for the opening of a new children's hospital in a non-pilot district, the Kashkadarya Provincial MoH asked that trainers trained by the HF assist them. Because districts need to present data at medical councils, key personnel have an added incentive to ensure that supervision/monitoring visits are conducted. In so doing, every district is all too aware how it compares to others. As the project only worked in 5 of 14 districts in Kaskhadarya and 5 of 14 in Surkandharya, managers interviewed mentioned that they would be happy to have the project's assistance in the other districts. Demand was created in non-project districts where staff have solicited capacity building and health improvement support.

MoH staff turnover is an issue that affects sustainability. In the 6 Phase I districts, the Healthy Family project was able to train over 90% of the health providers. But project staff estimated that there was considerable health provider turnover since the trainings were conducted in the first half of the project. In the 4 Phase II districts, project staff estimated that approximately 90% of the doctors currently working received training in IMCI and 70% of visiting nurses received training in C-IMCI.

Although most managers interviewed showed confidence about being able to maintain the project gains (continuing with training, monitoring, supportive supervision and reproducing IEC materials), discussions with other key informants such as the trainers suggested that the pilot districts are likely to face some challenges due to district MoH budget and logistical limitations. In April 2007, the project facilitated a 1- day workshop in each province on sustaining supportive supervision. Sustainability has also been discussed during Steering Committee meetings. Although no formal sustainability plans have yet been established, depending on priorities, there are potential local resources. The local government does have a budget, and since some government representatives are key members of the project Steering Committee, they were familiar with project activities from the beginning. The most encouraging possibility for both scale-up as well as sustainability of certain project components is the confirmation that the ADB and the World Bank

will be supporting the MoH with funds for training in H-IMCI, neonatal resuscitation and C-IMCI for patronage nurses across the country.

The evaluators noted a high level of enthusiasm among the community volunteer/activists. This enthusiasm, and the high level of literacy which increases the populations' access to information, combined with reported community demand for health education materials, have all the makings for encouraging and sustaining behavior change in the community. Although it is likely that there will be a shortage of IEC materials since these were supplied by the project, both providers and community volunteers have maintained existing materials in good condition and have even creatively replicated posters by hand. Health provider home visits will also support continuity and reinforce health messages. On the other hand, project staff indicated that not all communities have strong linkages with the health system—especially communities located in isolated, mountainous areas. Community mobilization and interaction with health care providers has been a challenge in these communities, which will continue to be disadvantaged.

vii. Conclusions and Lessons Learned

Conclusion #1 The project made a significant contribution towards the development of policies that, in turn, supported project interventions in maternal, child and reproductive health services in the pilot districts and provinces.

Lesson Learned #1: Having a policy component can be an important strategy for reinforcing health service practices at the implementation level. All project designs should seriously consider how to effectively engage the national level when implementing local pilot projects.

Conclusion #2: Project training (incorporating both theory and practice), providing certification after trainees have demonstrated proficiency post training, and the use of specific monitoring tools by HF were effective strategies for improving service quality and delivery in Uzbekistan. The project successfully increased the technical capacity of health workers in the target provinces and districts which led to improved quality of services in maternity, child and reproductive health.

Lesson Learned #2: Quality post-service training of health staff and follow-up monitoring are key interventions for upgrading skills, improving service delivery and ultimately impacting health outcomes in countries that have a high number of skilled health providers.

Conclusion #3: The development and distribution of IEC materials for maternal, child and reproductive health in the Uzbek language greatly facilitated health education and behavior change in the population. The evaluation team feels that the IEC/BCC activities at the health facility and community level resulted in improved health behaviors including breastfeeding practices, early identification of danger signs, improved household management of illness and increased use of family planning.

Lesson Learned #3: In the context of a population with high literacy and education levels, access to health education materials can greatly contribute to both awareness building and behavior change when coupled with interpersonal communication through health providers and community volunteers. Availability of IEC/BCC materials in local languages and use of mass media also enhance dissemination. Future projects should incorporate these elements in similar country situations.

Conclusion #4: Project-supported community mobilization activities through community committees (*Mahallahs*) were credited with establishing linkages between communities and the health system. Women's Committee members involved in the project were enthusiastic and devoted to supporting IEC/BCC, demonstrating ownership and pride in communities understanding of their responsibility for health. Budget cuts caused a reduction in the community component and lessened the impact in more remote communities.

Lesson Learned #4: Communities should always be active participants in issues that affect their health. Creating closer ties between the formal health system and community and helping communities take a more active role in health issues is always a worthwhile endeavor.

Conclusion #5: At the district level, the project was able to introduce new concepts in health information systems and then use the data for problem identification and management decision-making. This contributed to improved health care provision and quality of services in the pilot districts. The HF HIS data helped inform policy dialogue and decision-making at the national level, and thus pushed the policy reform and development agenda. Unfortunately, it is unlikely that this HIS system will be adopted at the national level.

Lesson Learned #5: Ongoing projects should contemplate working on the issue of data and health service strengthening at the national level as well as the provincial and district levels. New systems should involve MoH staff and should ensure accurate statistics and relevant information for required government reporting.

Conclusion #6: The sustainability of project gains will depend on the continued training of new health providers, continued support of monitoring activities, and support for such things as IEC material development. As the district MoH budgets are limited, additional support will have to be sought, such as from the national government, local government or external sources.

***Lesson Learned #6*:** Well before the program comes to a close, significant strategizing should occur with all stakeholders to help determine how and if activities can be continued once program financial and technical support ends.

C. Tajikistan

Tajikistan was one of the original countries of The Healthy Family Program that began in October 2003 with an approved budget of $8,457,586 for five years of operation. However, as in the case of Uzbekistan, the Tajikistan budget was reduced by one third midway through the program. Healthy Family was implemented in Khatlon province in the southwestern region bordering Uzbekistan and Afghanistan. This area was chosen because of its poor health status resulting from poverty, effects of civil war, drought, single parent households and economic migration (to other parts of Central Asia and Russia).

The total population of Khatlon province is 1,267,000 and Healthy Family worked in 3 zones (Shartuuz, Kurgan Tube, and Kulob). These zones represent roughly 40 percent of the Province and cover 197 villages. Save the Children was the primary HF implementing partner in Tajikistan responsible for management and administrative support. SC worked in collaboration with The American Red Cross/Red Crescent (ARC) and Futures Group (FG) and in technical partnership with the American College of Nurse Midwives (ACNM) and JHPIEGO, a women's health global partnership program affiliated with Johns Hopkins University. Project oversight and some technical support were provided from Project HOPE in Tashkent. The project also worked with the SC Child Survival (CS) Project in Panjikent, Tajikistan to conduct baseline assessments and develop appropriate interventions. Some of the successful interventions of the SC Panjikent CS project were incorporated in the planning for HF Tajikistan, including Child-to-Child, village development committees and revolving drug funds.

Interventions were conducted at three levels: health policy, health care facilities/providers and the community. Facility-focused interventions were designed to improve health care provider skills and medical site infrastructure (equipment and supplies) at primary and secondary-tier facilities (FAPs-medical houses and SVAs-rural ambulatories) and to a limited extent, regional and central province staff. The planned community level interventions were multi-faceted and included: increasing local NGO capacity, creating village development committees (VDCs) and groups for women, men and youth, training health volunteers, implementing Child to Child programs in the schools, establishing Health Facility Farms, Emergency Transport Funds (ETF) and Revolving Drug Funds (RDF).

Community mobilization was a major component of all Tajikistan HF interventions. This was a combined effort of SC and ARC, although it became the sole responsibility of SC after ARC withdrew in 2006 due to funding cuts. Village Development Committees (VDCs) were at the core of this work. VDCs were organized at the beginning of HF project. VDCs were developed in all 197 villages. These consisted of 7-15 members including village leaders such as teachers, imams and collective farm managers, FAP staff, and women. They were elected to represent different parts of the village and mobilized to address community health issues. Issues ranged from mobilizing the neighborhood to clear debris, moving latrines so they did not contaminate rivers and other communal water sources, working to eradicate malaria, encouraging good hygiene and adoption of family planning and raising money for the health clinic. A major contribution of the VDCs was the development of Emergency Transport Funds (ETF) which were collected from the community and made available to women and others in need of transport to hospital or medications. These funds were borrowed in an emergency and paid back in 2-3 weeks. For those who truly could not afford to repay, the loan was forgiven. Cars and drivers were identified, and in many cases posted at the FAP, so that everyone would know who to contact in an emergency. The amount of money collected was relatively small but suited to the needs of the village. VDCs met on a monthly basis to discuss health issues and administer funds. All VDCs interviewed by the evaluation team showed the ETF log books and provided minutes of meetings. They indicated they would continue to meet after the end of the project, although perhaps not as

frequently. They also said that the ETF would continue. As of the writing of this report, eighty three of the active VDC activities have been handed over to the MOH (43 percent of all VDCs).

The Child-to-Child (CtC) activities were based the successful program developed as part of the SC Child Survival project in Panjikent, Tajikistan CtC was implemented over 250 schools and reached over 6,600 students. This program worked with teachers and trained students to provide IEC/BCC activities with peers and in the community. This became a prized role and there were more students interested in training than the program could accommodate.

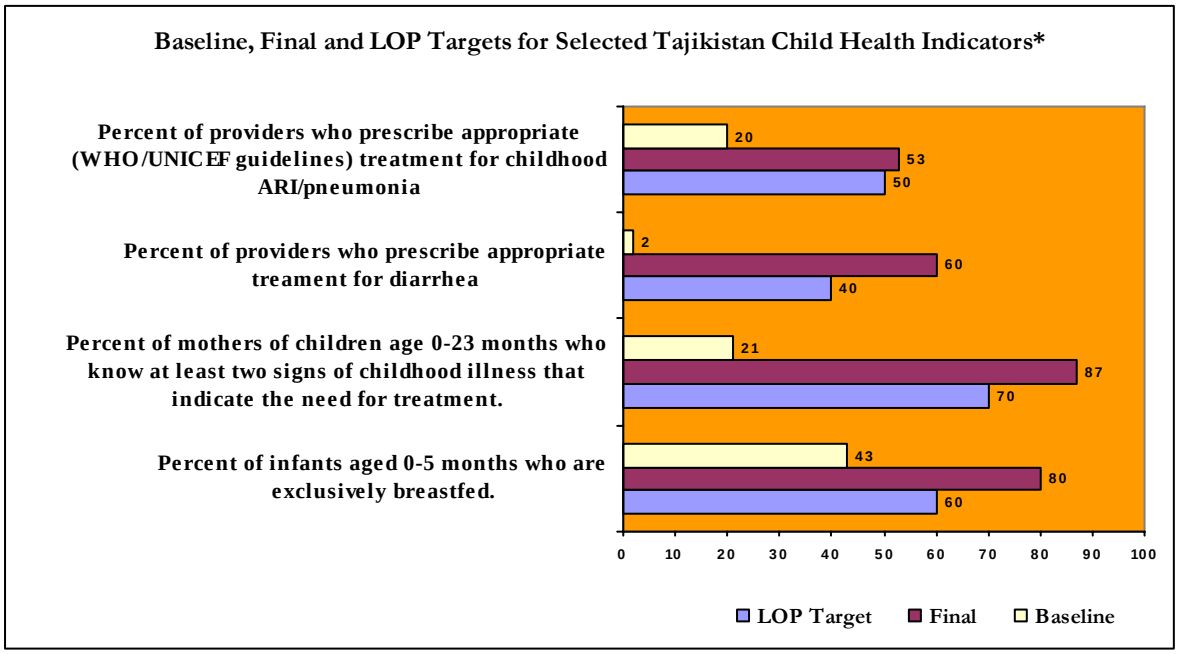
Some interventions such as village pharmacies (VP), revolving drug funds (RDF) and health facility farms (HFF) were not as successful. Village pharmacies and RDFs required MoH licensing which did not occur. Five HFFs were initially established and then stopped when USDA funding ended. The breadth of community interventions was extensive and there may have been too many different types of approaches, especially with the funding cuts.

Mostl of the 17 indicators used to evaluate Healthy Family Tajikistan were met, with most exceeding their targets. This high level of performance was likely due to the multifaceted approach of the program. All levels of the health care system and community were engaged in HF Tajikistan. Many of the targets were reached by the midterm assessment, suggesting that this approach was very effective. With a few exceptions, these performance indicators were supported in the final evaluation.

The evaluation team found an overall high level of satisfaction among health providers for the project and quality of trainings. Health providers also felt there had been a significant improvement in services as a result of the trainings, supplies and other support provided by HF. Health policy was also a major focus in Tajikistan focusing on IP and Contraceptive security. The community groups also felt the program made significant contributions. They reported they were more informed about taking care of themselves and their children and received better services at the health facilities. This resulted in higher utilization of health facilities for antenatal, delivery, sick and well child care.

Many community and health facility- level interventions that were begun, could not be completed due to funding cuts. This included translating IP and C-IMCI protocols to Tajik, TOT for C-IMCI, other support for IMCI, and the Futures Group work with national policy development.

i. Child Health



*There are a total of 6 indicators for Child Health applied in Tajikistan (see master table)

The focus of child health activities in Tajikistan was to improve health provider skills for common childhood illnesses as well as improve community knowledge and behavior. Initially training was on treatment of diarrheal diseases and ARI because IMCI was not yet being implemented in country. Eventually, HF districts were selected as pilot sites for the Integrated Management of Childhood Illnesses approach (IMCI) which became the focus in the second half of the project. HF used national trainers from Dushanbe (trained by UNICEF or WHO) to conduct training in Khatlon. Save the Children covered all the expenses related to training, logistics, materials, per diems, manuals and other costs. The project translated all IMCI materials into Tajik (formerly only available in Russian) including community health education pamphlets. These materials are being used at the national level and are considered a major contribution.

In total, 180 health facility staff received IMCI training (IMCI, C-IMCI, IMCI monitoring and/or TOT), including 102 doctors, 35 nurses, 38 physician assistants and 5 other professionals. All training was reported by number of participants so individuals who participated in multiple trainings are counted more than once. Because IMCI was not approved by the government until 2005, the training in the first two years was on specific childhood diseases resulting in training for 664 staff—ARI (207), CDD(221), Malaria (210), and Positive Deviance (26). Disease specific training was fairly evenly distributed among doctors, nurses and physician assistants. There are currently 1718 health professionals working in pilot areas of Khatlon (352 doctors and 1,366 midwives, nurses and physician assistants) According to the HF SC director there were many more health workers at the beginning of the project, but some of those trained migrated to other countries.

The evaluation team met the directors of two IMCI Training Centers, two national level MoH child health directors and several health practitioners who received IMCI training and their responses were resoundingly positive. The national level staff said that HF provided major support to IMCI. At present 25% of the 67 regions are covered, and the MoH wants to provide training to all regions; however resources are limited. . Staff said there was a commitment to continuing IMCI training through other funding sources such as the

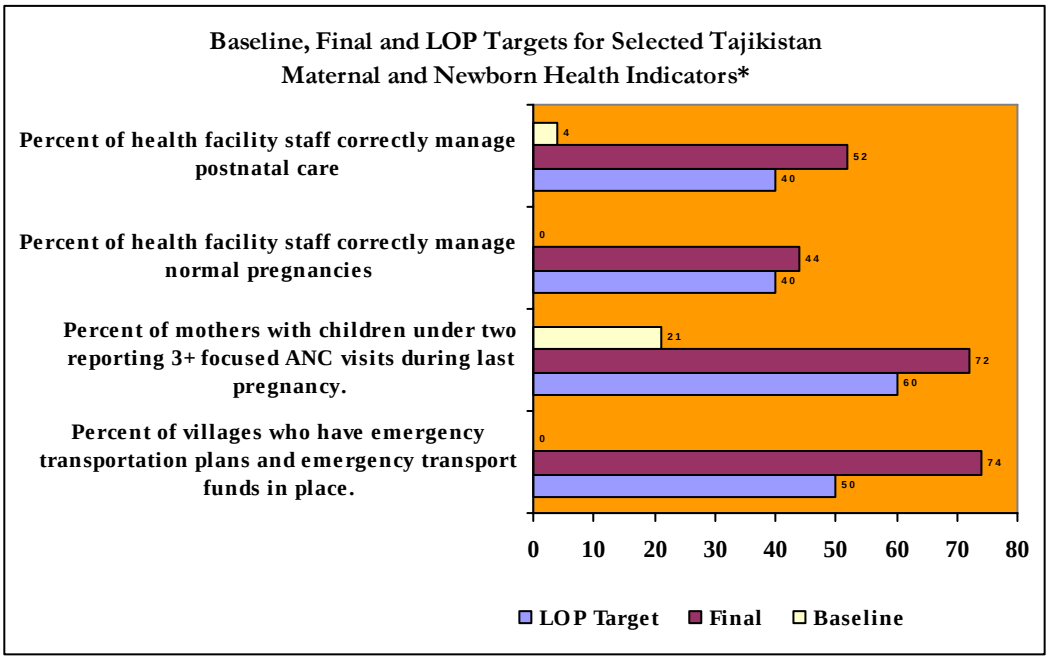
MoH and UNICEF. They reported that monitoring was useful for identifying gaps in service and training. Healthy Family also provided almost $10,000,000 in material support in the form of medical equipment, supplies, books and cash for purchase of medications. This was $2 million over the required match. The majority (97%) was donated by Project HOPE while funds to purchase medication came from Save the Children. There is currently a shortage of medications (confirmed in the field) and the MoH hopes that funding will come through Japan Humanitarian Aid to cover this shortfall.

Staff generally identified two critical dimensions to the training—diagnosis and treatment through the use of IMCI protocols and patient communication and education techniques. The health care providers interviewed liked the protocols (these were always shown to the evaluation team) because they helped staff remember to ask all the questions and diagnose and prescribe appropriately. Protocols may be particularly appropriate in a system where specialists, who are not familiar with presentation and treatment of common childhood illnesses, are working as general practitioners. The perspective of many of the practitioners and patients was that the change in the way doctors interacted with patients significantly contributed to improving outcomes. Many doctors said that they didn't realize the impact of discussing the problem and treatment with patients/families and said they changed their behavior from just prescribing to interacting and educating. It was felt by provincial and district staff that the decreases in child mortality were in large part due to IMCI training, community education and improved treatment.

There were no IMCI indicators for health provider performance in Tajikistan because IMCI was not approved or piloted when the grant was written. Therefore treatment of ARI and diarrhea were examined specifically and demonstrated considerable improvement over baseline, especially for diarrhea. Evaluation visits to medical posts documented the availability of ORS and rehydration treatment areas which staff attributed to the HF program. They noted that previously all children in need of rehydration had to go to the central district hospital. The ARI target of 50% was just reached and may have been more successful if required medications had been consistently available. The other indicator related to IMCI was the percent of children attending clinics with weight monitored on growth charts. While the HFA showed a major improvement over baseline (from 0% to 57%), this could not be substantiated by the evaluation team, who observed stock outs of individual child growth charts and the lack of scales at several clinics.

The MoH also felt that HF played an important role in creating community awareness and improving health behaviors. Exclusive breastfeeding (EBF) and mothers' awareness of child illness danger signs were considered two important achievements in this area. Health staff reported the importance of practical BF information in the training—positioning, latching on, and importance of immediate BF. Community groups always included EBF as one of the outcomes of HF. Women in these communities already breastfed so it may be there was a "readiness" to accept EBF. By the end of the project, almost all (95%) women knew at least two signs of childhood illness that indicate a need to seek treatment and 74% of women continued BF at home during a child's illness (compared to 24% at baseline). The strength of these community level findings are a tribute to the success of the community education and participation through the VDCs, health volunteers, CtC, women's, men's, and youth groups.

ii. Maternal and Newborn Health



*There are a total of 5 indicators for Maternal and Newborn Health applied in Tajikistan (see Table 4)

Maternal and newborn health activities in Tajikistan focused on improved antenatal care at primary care facilities, improved antenatal and delivery care at second-tier facilities, training of maternity, territorial and province-level hospital staff in international standards for maternal and newborn care, and infection prevention (IP). The community level interventions focused on increasing women's utilization of antenatal services and hospital deliveries and the creation of Emergency Transport Funds (ETF) to assist poor women purchase medicines and access transport for hospital deliveries.

The vast majority of Village Development Committees now manage ETFs as a result of this program. The evaluation team reviewed several VDC log books for these funds and found that they were maintaining a positive balance and were used frequently. In most cases the funds have been operating for the last 18 months and were used 16-20 times. In most communities visited, those who use the funds are asked to repay within 2 weeks to 1 month. If one cannot repay the loan, the community is asked for donations to replenish the account. These funds are not only used for emergency transport for pregnant women but also to purchase medicines and other health needs. This intervention was extremely successful and has proven thus far to be sustainable.

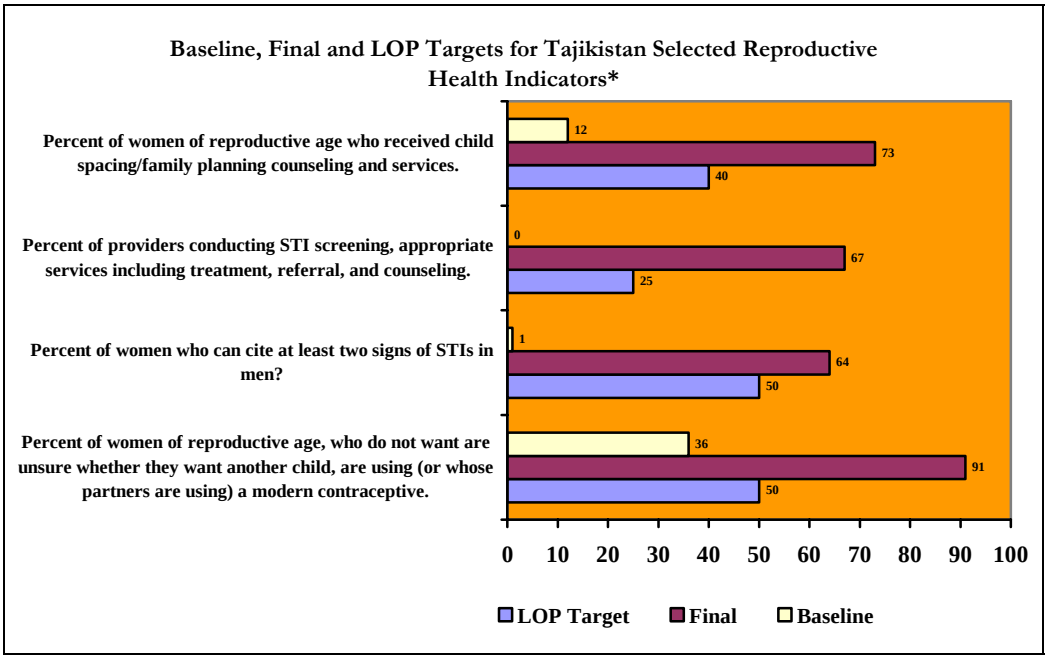
In total, 753 health facility staff members were trained in maternal/newborn care (Basic Life Saving Skills, LSS Refresher, TOT LSS, Safe Motherhood and Infection Prevention, TOT IP). These were mostly nurse/midwives (497) and doctors (187) but also included physician assistants (34), epidemiologists (15, only IP training) and other professionals (20). LSS TOT was conducted by the American College of Nurse Midwives (ACNM) which also provided supervision of the monitoring and evaluation of the trainers and initial groups of trainees.

The percent of women with 3 or more antenatal visits increased from 21% at baseline to 76% by the final evaluation—far exceeding the target of 50%. Because of changes in the way health care was financed and

the low incomes of most rural women, antenatal care utilization decreased in the post Soviet period. Therefore, this increase represents a major accomplishment and suggests that the improved quality of care and increased knowledge among women regarding the importance of ANC resulted in women feeling that antenatal care is worth the investment. Staff at FAPs have recommended that all women deliver at the maternity hospital and found they were doing fewer home deliveries (the range was 10-40% home deliveries in the evaluation site visits). Health providers and community members stated that they were more aware of the risks of pregnancy for women and the need for appropriate care.

Doctors and nurses/midwives appreciated both the training and delivery kits and reported that they were better able to educate women and their families. Staff at the SUBs that conduct deliveries as well as staff at the maternity hospitals appreciated the new approach to "free" deliveries (the ability of the woman to choose her delivery position) and the involvement of families in the delivery. They felt they were providing a much higher quality of care, were reducing unnecessary interventions such as drugs to induce labor and episiotomies all of which were resulting in fewer infections and complications. Again, the emphasis on how to communicate with women and families as well as the new diagnostic and treatment knowledge were equally valued.

ii. Reproductive Health



* There are a total of 6 indicators for Reproductive Health applied in Tajikistan (see Table 4)

The reproductive health training provided by HF in Tajikistan focused on family planning (FP) and the reduction of STIs through barrier methods. Three-hundred and thirty –seven providers were trained in RH, most of whom were nurses/midwives (222). Thirty doctors and 85 physician assistants received FP or FP Counseling training. Journals tracking contraceptive utilization were introduced in primary medical units, and at some sites individual records for women were used (HF helped the MoH make copies of this form for health facilities). All FAP staff visited for the evaluation were able to state the number of WRA and the numbers of women using specific types of contraception. The increase in provision of RH services and use of contraceptives fell just short of 100%, a remarkable achievement given the baseline. Interviews with FP users and health care providers suggested that the increased FP use is attributed to a desire to limit

family size due to economic conditions and the availability and promotion of contraceptive choice (previously IUDs and abortions were the only methods promoted by MoH). Healthy Family, through USAID donations, provided oral contraceptive pills, condoms, Depo Provera, and IUDS, gained government support of FP, and improved health provider skills. Contraceptives were generally available at health sites visited by the evaluation team. Healthy Family contributed to this availability in October of 2003 and then again in March 2006. The total amount of contraceptive units distributed by the project was: 129,538 of Femenal, 17,026 of Copper-T, 57,676 of Depo Provera, and 755,436 condoms. MoH staff indicated that government and UNFPA supplied contraceptives were reallocated to other districts since HF areas were supplied through the program. One major effect of HF was the shift in contraceptive usage from IUDs to condoms and Depo. MoH staff indicated that HF was effective because of both community mobilization activities as well as staff training. The 91% contraceptive prevalence was an almost 3-fold increase over baseline and this change was evidenced in health staff and community interviews which noted decreasing family size. This probably reflects an overall trend in Tajik society which started in the mid 1990s.

STI education, prevention, identification and treatment were also improved by the HF project, although STI treatment resources were not discussed in the final evaluation interviews. The Khatlon Province RH Director reported that STIs are managed at the HIV/AIDS Center. At one FAP a member of the evaluation team was shown records demonstrating that all pregnant women are screened for HIV and all men returning from Russia are also screened. There was documentation of broad dissemination of community and health provider education about the prevention and treatment of STIs. The indicators support this with an increase from 1% to 64% of women being able to cite at least 2 signs of STIs in men. Further community awareness was demonstrated by the increase in youth who can identify at least 2 signs of STIs from 3% to 59%.

iv. Policy

Policy development and advocacy was a major component of HF-Tajikistan in the first half of the grant. Futures Group (FG) was the partner responsible for this activity, creating an inter-sectoral working group and providing technical assistance and documentation for Tajik legislation. FG worked closely on reproductive health and infection prevention helping the government to develop protocols and providing financial support, advocacy and technical assistance. This resulted in two strategic plans and one Decree (Prikaz), including the National RH Strategic Plan (2004), Contraceptive Security Plan (2005) and MOH Prikaz #272 "On Implementation of National Infection Prevention Standards" (2005). JHPIEGO was instrumental in gaining government support for the IP Prikaz.

FG representatives expressed concern that policy work was eliminated at the midterm without any strategic planning and the participation of FG. It was felt that the policy initiative had already accomplished more in Tajikistan than Uzbekistan and that it was short-sighted to eliminate this component when it has been so effective.

v. Monitoring and Evaluation

Monitoring took place on two levels: the performance of trained health care providers; and, the community-based activities. MOH trainers (trained by the HP project) were responsible for monitoring the performance

of the health providers trained. HF staff often accompanied MOH staff during monitoring visits and HF supported monitoring through the provision of vehicles, per diem and fuel. While monitoring is considered part of the MoH responsibility, it may be difficult to continue without funding for transportation to field sites. Most budget items (including fuel for transportation) are provided through the municipal government (Hukumat) and *not* the MoH; yet, there was no engagement of the municipal government to support program activities. IMCI and LSS monitoring was conducted according to different schedules and is discussed below; monitoring documentation for FP was not available.

All LSS training participants were required to have 4 monitoring visits (1 each quarter) after training. These did not always occur on schedule because health workers were not always on site when monitors came. Some trainees did not receive any monitoring because they were no longer working or on maternity leave (10%). For those who were monitored for 4-5 observations, many of the visits occurred over a 2 year period. Monitoring incorporated observation, client interviews, and equipment and stock checks. Standard forms and checklists were used. The evaluation team had access to monitoring reports for LSS in Vakhsh District for August 2006 (the last month of monitoring for LSS). Of the 10 health practitioners monitored, only one was performing according to standard. The rest needed improvement in one or more of the following areas: use of the partograph, IP, practice skills of LSS, and referral. Since these problems were identified in the last monitoring, it is not clear what steps were taken for improving LSS skills.

IMCI training was completed by 139 health workers, and monitoring visits were made to 118. Results of these visits were sent to the national IMCI Center. The evaluation team reviewed the most recent IMCI monitoring for Kurgan Tube zone (Feb 12-March, 2007). The 33 worker/patient observations that were monitored represented 86% of those trained in KT. The summary of findings indicates that there were problems with equipment, medicines and health worker performance: 30% did not have functioning scales; immunizations were given on selected days due to problems with electricity and vaccine storage; only 6 of the 11 IMCI medicines were available at most sites (ORS was universally available). The following errors were identified in treatment: 15% wrongly prescribed antibiotics; 24% wrongly evaluated danger signs; and 30% did not make a referral appointment.

Community activities were tracked through log books which were kept by the VDC. The health monitors checked these log books when they went for community visits and training. All VDCs and village level clinics produced these log books during the FE site visits. In all cases they seemed complete and up to date.

Healthy Family conducted baseline, midterm and final assessments of facilities as well as community-level assessments of knowledge and practices. The baseline and final used Health Facility Assessment (HFA) and KPC survey methodologies for the facility and community components respectively. All data collection, entry, validation and analysis were managed and conducted by Save the Children staff. The evaluators feel that given the scope of the project, the final HFA and KPC survey should have been managed by an external consultant to ensure consistency and objectivity across all countries.

vi. Sustainability

Because HF has worked at the policy as well as health care and community levels, many of the HF interventions will likely be sustained. FAP staff said they would continue to provide services because "it was a habit." National policy, developed through the efforts of the CORE Group and work of FG and

JHPIEGO, supports maternal/newborn and reproductive health initiatives. MoH has skilled trainers in most of the key areas and there is a commitment to continue training. Communities have a well developed infrastructure to support community mobilization, awareness and behavior change. VDCs were an important contribution that will be sustained—all VDCs interviewed said they would continue their work, including ETF. The major difficulty in Tajikistan is the very limited financial resources available through the government, which means that medical supplies, equipment, medicines and contraceptives may not be available and that monitoring of health provider skills may be limited due to transport costs. Most of the people interviewed by the evaluation team said they would continue the activities that had no additional cost but were concerned that HF improvements might be lost if there were no contraceptives or IMCI medications available. Because of the key funding role of local governments (Hukumat), it is critical that they be involved in planning and educated about the importance of health to the social and economic functioning of their communities.

vii. Conclusions and Lessons Learned

Conclusion #1. LSS and IMCI trainings were an appropriate and effective means to improve the quality of care for women and children, producing demonstrable changes in practice. Health staff believed these contributed to reductions in mortality. However, proper supervision and monitoring was heavily dependent upon project resources. No consideration was given by the project to strategic engagement of municipal and district level government structures responsible for financing these activities in the future.

Lesson #1. Given the extent of primary health worker training as well as the extensive reach of health facilities in the country, improving health worker skills is a prudent investment of resources that will pay significant dividends. Future projects should intentionally design institutional strengthening within the Hukumat and Jamoat (district and local governments) responsible for funding health facilities so that health is seen as a local funding priority.

Conclusion #2. Community mobilization efforts were effective tools that improved knowledge, increased healthy behaviors and reduced illness. The broad representation of VDCs (teachers, religious leaders, political leaders, health providers and women) ensured that the community heard the same messages disseminated through multiple venues (schools, mosques, village meetings). The Emergency Transportation Funds were an effective, regularly used and sustainable means of addressing community health emergencies. While the level of knowledge among the women's and CtC groups was mixed, these were also important venues for discussing sensitive topics such as family planning.

Lesson #2. Creating behavioral change programs that utilize existing community leadership as well as a variety of venues and target groups is an effective strategy for educating the public and influencing behavior.

Conclusion #3. The Revolving Drug Fund, which had been successfully used in SC's Panjikent CS project, was not continued due to lack of proper procedural approval. This was a lost opportunity as it would have increased access to medicines, thereby filling a large gap in health service provision.

Lesson #3. Future projects should seriously reconsider initiating a revolving drug fund while making sure they have all the necessary approvals prior to initiating activities. (This might be integrated with ETF, which is currently used for medicines as well as emergency transport)

Conclusion #4. Health provider training in all interventions resulted in greater knowledge, skills, and ability to communicate more effectively with patients. This increased awareness and demand for these services. Material support (refrigeration, clinic maintenance, heat) for improved clinical care is a problem due to the lack of MoH resources.

Lesson #4. In low resource settings with large numbers of health providers, improved provider skills and health education are relatively sustainable low-cost interventions. Interventions with costs (refrigeration, equipment maintenance, medications and supplies) require community and local government involvement to identify mechanisms for sustainability.

D. Turkmenistan

Turkmenistan was the third of the Central Asian Republic countries to be included in the Healthy Family Program. The Healthy Family Program initiated operations in Turkmenistan July 1, 2003 with an accumulated budget of $499,000 for four years of operation. As Turkmenistan was not a part of the original proposal, each year, the HF Project was left uncertain as to how much funding they would end up getting from year to year. Abt. Associates, already in-country implementing the ZdravPlus Project on health reform since 2000, was identified as the strategic implementing partner for Healthy Family activities. Since the start-up of the HF Project in 2003, the two USAID-funded projects have fused and become a joint effort being implemented by one team sharing objectives and cost-sharing on items such as salaries and materials (for example, 33% of staff salaries were covered by Healthy Family and 67% by ZdravPlus). However the HF funds did provide all of the financial support for the implementation of 6 of the 9 key activities undertaken since 2003: 1) IMCI Physician Training (Turkmen State Institute Teachers); 2) IMCI Nurse Training; 3) H-IMCI Training (Medical School teachers); 4) IMCI Pre- service; 5) MPS/ Antenatal Training; and 6) MPS/PEPC training. Technical preparation, review, planning and material development for these trainings were supported by ZdravPlus staff and consultants based at the regional headquarters office and elsewhere.

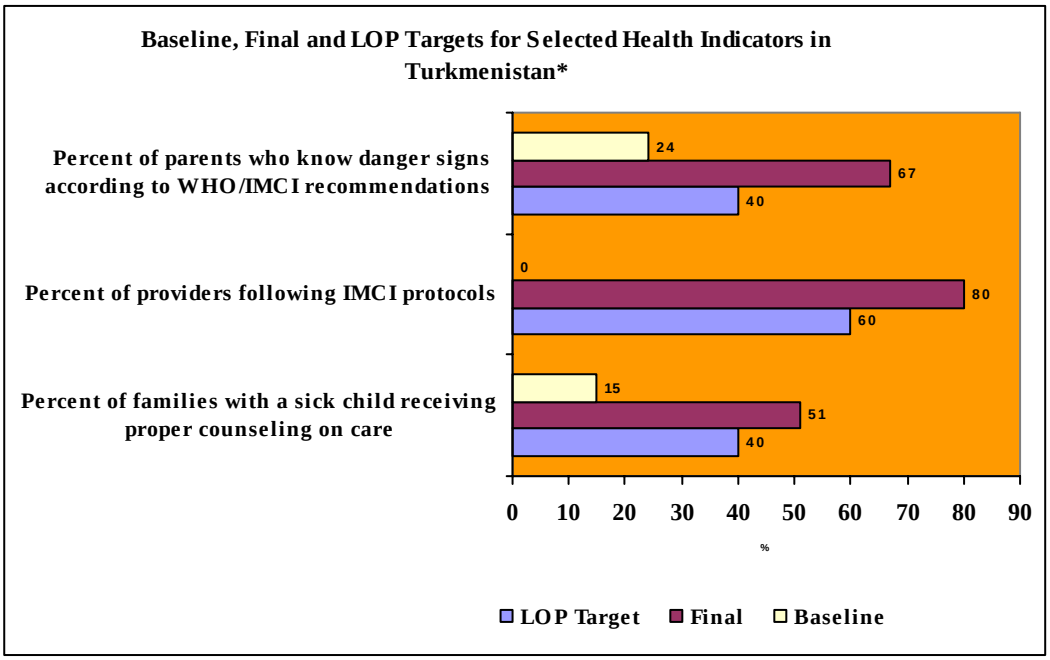
Health organizations working in Turkmenistan are generally donors (WHO, UNICEF, UNFPA) who have been supporting the Ministry of Health technically and financially to develop and implement MCH strategies and clinical protocols. The HF/ZdravPlus project focus has been to assist with the implementation of these strategies, concentrated in 11 pilot districts from all five provinces in the country. All external partners work primarily through the MCH Institute, who has overall responsibility for technical oversight of MCH services in-country. Like the other HF Project countries, improving the capacity of health service providers was the focal point of the Turkmenistan HF Project. In addition to this, the project also co-financed health education campaigns targeting mothers of children under five years of age. The MoH Information Center and the National MCH Institute were involved in technical oversight for this component

It is clear from the final evaluation interviews with staff from the MCH Institute and health facilities, that the HF Project is highly appreciated and well perceived by the national counterpart in country. The evaluation team found key partners and trained health providers to be very satisfied with the assistance that the project has provided. An important strategic development during the life of the project (undertaken with the collaboration of WHO) has been the support of IMCI training for family nurses as well as the family doctors. IMCI has been adopted for both pre and post service training of doctors. The project has translated the pre-service training text book for IMCI from Russian to Turkmen which facilitates extension of IMCI. The 'Keeping Children Healthy' IEC campaigns also appear to have had a good degree of success, as evidenced by pre and post campaign test results and health provider observations of improved health knowledge and behavior in the population.

Because outside agencies have generally not been allowed to collect data in Turkmenistan, other than pre and post training and campaign tests, the project was limited to measuring 5 process, not outcome, indicators. But in view of the nature of the partnership, the project also considers MOH monitoring indicators as well. Overall, monitoring and evaluation in the Turkmenistan program was weak; partly, but clearly not altogether due to the political constraints. There has also been a lack of clarity and confusion around project indicators and targets, and changes made very close to the time of the final evaluation. But the MoH asserts the project has had a positive impact: citing health facility reports which show reduced morbidity and mortality, and decreased hospitalization due to childhood

illness. In qualitative interviews held with health providers trained by the project, the evaluation team consistently heard that project training had been a tremendous help to them and that the educational materials distributed to mothers during campaigns have increased mother's knowledge and behavior around infant/child care, and danger signs.

i. Child Health



* There are a total of 5 indicators for Child Health applied in Turkmenistan. This is 2006 monitoring data as the 2007 evaluation data was not available at the time of the qualitative evaluation (see Table 4)

As mentioned above, the work in the area of child health in Turkmenistan is a collaborative effort between the different agencies in country and the Ministry of Health. WHO has been working at the policy level since 1995. As of 2007, with the support of the ZdravPlus/Health Family Project and UNICEF, IMCI has been implemented in 11 out of 60 districts (5 districts in 3 provinces). As of the final evaluation 890 doctors had been trained. By the end of the project extension in December 2007, it is anticipated that the project will have completed 45, two-week courses for family doctors in IMCI reaching 97% (946) of the doctors eligible for training in the pilot districts. In 2005, the MoH approved a 6-day training course for family nurses. This is expected to have a significant impact as nurses are a first point of contact for the population. As of July, 437 nurses had already been trained. By September 2007, it is anticipated that 517 (53%) nurses will have completed the course. With the latter two trainings the project achieved the two respective training indicators, surpassing their target on the number of doctors trained. In addition to the above, an important achievement has been the integration of IMCI in the pre-service training of doctors. The project co-supported the training of 35 Turkmen State Institute teachers and 15 medical school teachers representing all 5 of the country's medical schools. It also provided these institutions with televisions and VCRs to facilitate training of doctors in IMCI.

Before the start-up of the HF project, training of IMCI trainers was conducted with the assistance of ZdravPlus, to support Turkmenistan's rollout of IMCI. This facilitated the subsequent development of IMCI centers on the initiative of IMCI trainers in Serdar and Gubadag district MCH hospitals in Balkan and Dazhogus Provinces respectively. These centers are supported by local IMCI trainers (5 on average), including the MoH Provincial Coordinators who have the responsibility for child health care. HF provided materials for IMCI Supervision training supported by UNICEF. The Director for the MCH Institute is in fact the National Coordinator for IMCI. Although the evaluation team was not able to meet with him, a meeting was held with the IMCI course Director, Alexander Junelov, as well as one of the Provincial Coordinators. The course Director believed that initiation of the HF Project was timely as it coincided with the government's acceptance of evidence revealing high levels of child morbidity and mortality in the country. At the time of the project's inception the MOH was very receptive to new child health strategies. Both the above-mentioned individuals and the health providers interviewed told the evaluation team that they were very appreciative of the training methodology because it included both theory and practice. This is something that they never had experienced before.

Monitoring data was collected with the support of WHO in July 2007, but was not available for the evaluation team. Health care providers interviewed by the evaluation team reported that using the algorithm checklist for diagnosing childhood illness makes their work easier. The trainings increased their knowledge and skills including how to listen for breaths without special devices during home visits; how to diagnose pneumonia without taking x-rays; reduced use of drugs and injections for treating illness; how to communicate better with their clients. The MCH Institute notes that IMCI training is particularly beneficial because many of the doctors who became family physicians as a consequence of health care reforms are not pediatricians by training. IMCI training has finally enabled many of these physicians to feel comfortable and competent treating childhood illness. It should be noted though that among the challenges mentioned during the evaluation visit is staff turnover including physicians migrating to Russia.

According to the MoH staff interviewed, access to drugs is not an issue. According to them, districts receive a supply of essential drugs. Part of the UNICEF support to Turkmenistan is the provision of drugs, and they are in fact supplying the whole country with 5 or 6 different drugs. Pilot districts are receiving additional medicines from UNICEF for the implementation of IMCI. However, the evaluation team had no means to confirm availability at the local level. In 1996, along with the introduction of family physicians as part of the health reforms, the government also put in place a health insurance policy. This is available to the entire population at the cost of approximately 4 cents a month, and is promoted by all health providers. Those who are employed give 2% of their salary for this coverage. This insurance enables the population to receive a 90% discount all prescription drugs.

With regard to maternal education, there was a significant increase in knowledge on danger signs for childhood illness (from 24% to 67%) by the 2006 assessment. Information, Education, and Communication (IEC) is considered to be a big part of the Healthy Family/ZdravPlus projects and the explicit strategy was to directly connect the education campaigns to service delivery improvements. Since 2004, Healthy Family and ZdravPlus together have supported the implementation of 13 "Keeping Children Healthy Campaigns" (24 total campaigns have been conducted since the beginning of the ZdravPlus Project in 2002) Campaigns are implemented over a two-month period, and the theme tends to be one what is relevant to the season, i.e. diarrhea campaigns are conducted during the summer months when there are a lot of cases of diarrhea in children, and ARI campaigns are conducted during the winter months. Campaigns are initiated with the training of family nurses in the specific campaign theme. The HF-supported campaigns were conducted in 5 districts and included 6 on Diarrhea, 4 on Nutrition, 2 on ARI and 1 women's contest initiated by one

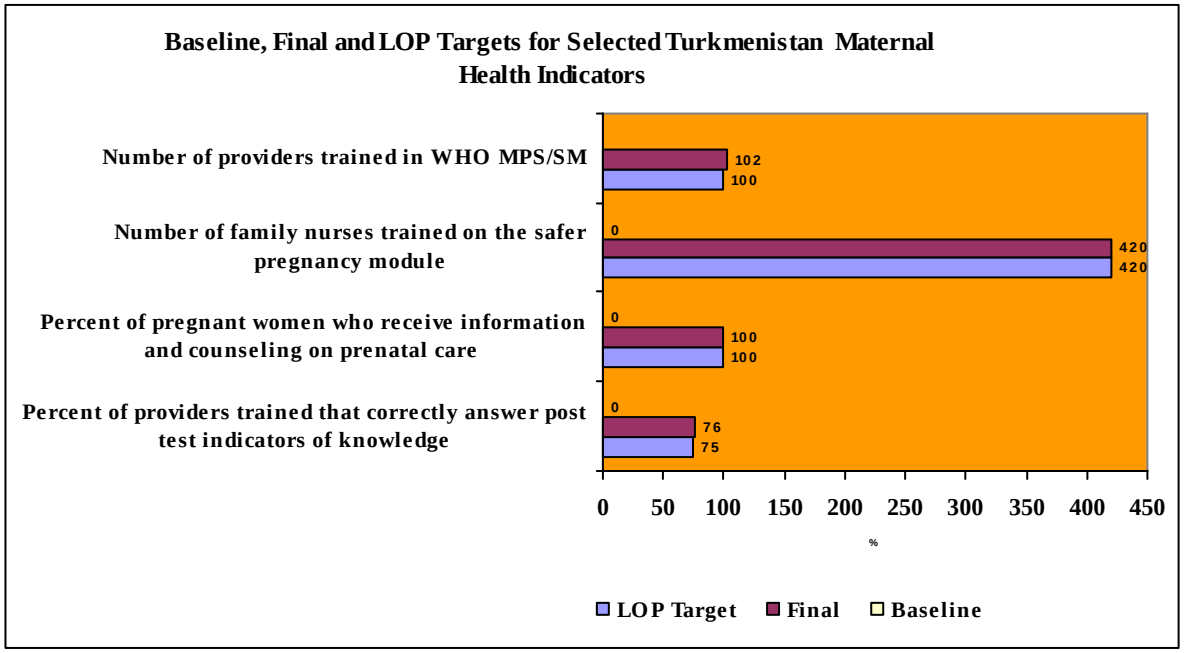
community. The project has documented the involvement of approximately 560 nurses and 40,000 women in the campaign activities undertaken. The campaigns were described to the evaluation team as one of the project's success stories.

At the beginning of the campaign activities in 2002, educational pamphlets and posters were developed with the assistance of the technical specialists from the Abt Regional Office in Kazakhstan, in collaboration with the MoH Information Center. Materials were pre-tested through focus groups and per the campaign theme, sent to the provincial health information center for distribution to all health facilities in the district targeted for the campaign. As the HF/ZP budget has been limited, the distribution of educational materials continues to be limited to the campaigns (although posters were visible in health facilities visited). HP/ZP staff report that UNICEF was able to develop and distribute more health education materials through the use of some of the images created by the project.

It should be noted that health promotion in the form of IEC campaigns is a traditional form of educating the population for behavior change in Central Asia. Although the evaluation team did not consider the campaign post tests results conducted right at the end of each campaigns to be an adequate measure of knowledge or behavior change, hospital staff believe they have contributed to reduced cases of diarrhea and ARI, and reduced number of hospitalization due to severe illness in the pilot districts. For example, in Sedar district, the number of cases hospitalized for ARI dropped from 274 in 2002 to 89 in 2006 and diarrheal cases decreased from 1,136 in 2002 to 606 in 2006. In Gubadag district, hospitalized diarrheal cases decreased from 1,041 in 2002 to 1,013 in 2004. (The latter is also due to the change in treatment protocol. Providers use ORS rather than performing more complicated treatment of cases with IV fluids etc in clinics). The MCH Institute also reports fewer infant/child deaths within 24 hours of hospitalization as a sign that mothers are identifying danger signs early, and not waiting until it is too late to seek help. They also report having very good results for breastfeeding in the pilot districts (40% increase) According to the Regional Coordinator and health providers interviewed, this is attributed to the population's increased knowledge and ability to identify danger signs early on, and their knowledge of care during illness (including the management of diarrhea cases at home with ORS).

Unfortunately, the evaluation team was not able to meet with community members due to government restrictions. In terms of behavior change, the evaluation team was told that there are no real barriers to behavior change in the population as most of the recommendations fit with the traditional Turkmen practices (pre-Soviet Union). In the absence of any real study it is difficult to conclude whether or not this is in fact the reality; what barriers may exist, or to what extent they have been surmounted.

ii. Maternal and Newborn Health



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There are a total of 6 indicators for Maternal and Newborn Health applied in Turkmenistan (see Table 4)

The main activity undertaken so far for maternal and newborn health was a healthy pregnancy component specifically targeting family nurses. This used a training of trainers (TOT) strategy, where 20 nurses were trained as trainers who then trained others. The training content included negotiation skills, effective communication, and topics such as nutrition during pregnancy, danger signs, and care for newborns, among other things. Community education for this component involved the distribution of two booklets: "Waiting for the Baby", and "Nutrition of pregnant and breastfeeding women".

Five of the six HF Project Maternal and Newborn Health indicators were process indicators and one was training post-test. The project achieved all five of the indicators with targets. Most of the MNC indicators are new, coinciding with the newly adopted Live Birth Definition (LBD) and National Plan for Safe Motherhood and the formal undertaking of MPS by the project this year. Training on WHO's Making Pregnancy Safer is in the beginning stages (first training took place in June 2007). Two additional project indicators not highlighted in the table above include: size of population receiving information from providers trained in WHO MPS/SM (for which the target was achieved) and number and percent of providers who provide prenatal care, who received training on providing improved antenatal care, information, and counseling to pregnant women based on WHO MPS/SM (See Table 4). The last indicator had no target.

The Safe Motherhood plan calls for the eventual training of 741 Ob/Gyns and 1,067 Obstetricians. As the ZdravPlus project does not end until 2009, they are in the process of developing plans for the continued support of the MoH with the training of eligible health care providers.

iii. Policy

Efforts at policy development in Turkmenistan are mostly undertaken by WHO, although the HF Project and other partners collaborated in these efforts. A decree for Hospital IMCI was approved in June 2006. A Hospital-IMCI (H-IMCI) working group was then established and the WHO guidelines were approved along with a strategy and plans for implementation. Decree #115, approving nurse training in IMCI, was passed in November of 2006. The project also supported the adoption of the International Live Birth Definition (LBD) and the development of a new program for National Safe Motherhood Program which were both achieved in 2007.

iv. Monitoring and Evaluation

Monitoring and evaluation under this HF country project was clearly very weak. It is not a component that appears to have been given much thought or effort. Targets set at the beginning of the project were changed two months prior to the final evaluation conducted in July, and in addition to this, it was also at that late point in the project that staff revisited the issue of how they were measuring their indicators. It should be noted though that the collection of qualitative and quantitative data by international agencies in Turkmenistan has generally not been permitted. Interviews on the issue of M&E and indicators suggest that the ZdravPlus reform project region-wide does not have the same rigorous M&E that is the norm in USAID child survival projects. The start-up of HF activities in Turkmenistan, or the joining of HF with ZP, was an opportunity for the HF to use its influence to negotiate a minimal level of impact data gathering (as they were doing this in the other 3 HF countries). But Abt, as an implementing partner, is very protective about maintaining its good relationship with the Turkmenistan government, and has not been very open to much involvement or intervention from the Healthy Family prime, Project HOPE. Needless to say, the political situation was not unknown to the donor, and as such, it is clear that the key players also accepted that the project would use MoH monitoring data as a measure of project results. The MoH representative reports that monitoring is conducted routinely every quarter. The project supported three monitoring activities in 2007. Routine HIS data from the pilot districts is shared to a very limited degree (upon request and usually only percentage increase or decrease for one or two indicators).

The project did in fact have an opportunity to review some population data because pre and post test IEC campaign surveys were conducted in 2002-2004, and again in 2005-2007. A comparison of the pre or post tests taken over the years could show changes in mother's knowledge and health behavior (several districts had two diarrhea, ARI or Nutrition campaigns during the LOP; one in the earlier years and a second one in the later years). But as previously mentioned, M&E was not an area of strength for either the project or its staff. Although post test data for either trainings or IEC campaigns are not necessarily worthwhile measures of skills, long-term knowledge or behavior, as these are things that should be measured over time, this is data that continues to be collected by the project in Turkmenistan. Comparing campaign data would have perhaps shown some interesting results, but not even this was possible because data collection and analysis were done at the district level by the government partner without any project participation or oversight. As an afterthought, project staff requested to check the completed survey questionnaires, but they did not receive all of them and the database used by the MoH at one point was no longer available.

v. Sustainability

An indicator for the sustainability of IMCI is the integration of IMCI in the medical school curriculum. But this in fact contradicts a statement from the WHO representative that the government has yet to develop a policy on IMCI, or express its intent to roll out IMCI beyond the 11 pilot districts being supported by the international agencies and is not contributing any money towards this activity. The MCH Institute did mention that one of their challenges is that they do not have a budget for IMCI training, and will continue to need outside support for this activity. They did mention though, that there is a department within the MCH Institute that provides an annual course for in-service training. Each province is supposed to identify providers who should participate in this training.

Although UNICEF is providing drugs to support the implementation of IMCI, the evaluation team was informed that all medicines currently being provided by UNICEF are on the government's list of essential drugs supplied to health facilities and they do not expect that it will be a problem for the MoH to assume responsibility once UNICEF support is withdrawn. The IMCI course director also reports that the MoH is trying to produce drugs locally including plans to produce low osmolarity oral rehydration solution in the near future.

The project strategy used for the implementation of the 'Keeping Children Healthy' campaigns involved the local authorities and the Ministry of Education as well. Within the existing system, local authorities are responsible for working with the communities. They manage their own budget and make decisions on the use of the budget. So if they prioritize such things as IEC material development and dissemination, they could allocate a small amount of money to this. These entities have played a key role in the campaign competitions and events, and according to project staff, are interested in supporting this activity in collaboration with the district health managers. In 2006, one district (Lebap) was so enthusiastic about these campaigns and competitions that they initiated a Women's Contest around health issues with winners awarded prizes.

vi. Conclusions and Lessons Learned

Conclusion #1: Support for IMCI training by the program was timely, filling a critical gap that had been identified and recognized by the MoH. The program exhibited good coordination with the government (MoH and MCH Institute) and other partners (WHO and UNICEF) which was critical to the success of the project as all partners were working towards the same goals and in the same pilot districts.

Lesson Learned #1: It is clear that developing a strong partnership with the government ministries, as well as collaboration and coordination with other institutions, contributes to stakeholder buy-in and sustainability.

Conclusion #2: Health care worker and supervisor reports support the conclusion that project training has increased health worker capacity to diagnosis and treat cases, improved their communication skills, reduced the number of drugs prescribed and made their job easier.

Lesson Learned #2: Increasing the technical capacity of health care workers is a worthwhile endeavor as it contributes to the quality of service provision, which benefits the population. In view of the fact that most

health workers in Turkmenistan have not been trained using evidence based international standards, it is important for international agencies to continue to support health provider training

Conclusion #3: Reports of reduced morbidity and mortality and hospitalization for cases of illness, support health provider belief that the availability of educational materials and improved communication between service providers and clients/households has led to increased knowledge on prevention and danger signs, as well as care of the sick child by mothers.

Lesson Learned #3: In a context where there are very high rates of literacy and routine service provider outreach to households, improving communication skills of health workers and the development and distribution of IEC materials to households, can result in both knowledge and behavior change in the population.

Conclusion #4: Due to the political environment of the country, the Healthy Family Project was unable to elaborate an M&E system that accurately measured project outcomes. But it is possible that the HF may have been able to use its good standing to negotiate such things as M&E.

Lesson Learned #4: Although it was evident to project managers that the conditions under which they are working in Turkmenistan are unique, taking the example of another government partner in-country, it appears that the project can use some of its leverage to encourage the importance of data for monitoring and analysis within their programming.

E. Kyrgyzstan

The Healthy Family Program initiated operations in Kyrgyzstan in October of 2004 with an approved budget of $658,000 for three years of operation. The Kyrgyzstan program was not affected by the budget cuts that affected both Uzbekistan and Tajikistan. From completion of baseline in February of 2005 to completion of the final population and facility-based surveys in July of 2007 the program had little more than 2 years and 3 months of operation. It was implemented in the Batken province in the southern most region of the country. This area was chosen for a number of reasons including comparatively poor health indicators, lack of international assistance, large population concentrations and a history of political instability. The entire population of Batken province is 402,797. While initially designed to cover only one district, ultimately the Healthy Family concentrated efforts in two of the province's three districts, Batken and Leilek, with Leilek having been included specifically at the request of the MoH. Project HOPE was the only HF implementing partner conducting activities in Kyrgyzstan. Supervision and technical support was provided from Tashkent. As with the other HF countries, interventions primarily focused on improving the skills of health care providers at primary and second-tier facilities (FAPs and FPGs) and, to a lesser extent, province-level health providers, administrators and hospital staff. Unlike the HF programs in Uzbekistan and Tajikistan, the Kyrgyzstan project did not implement a community mobilization or policy component.

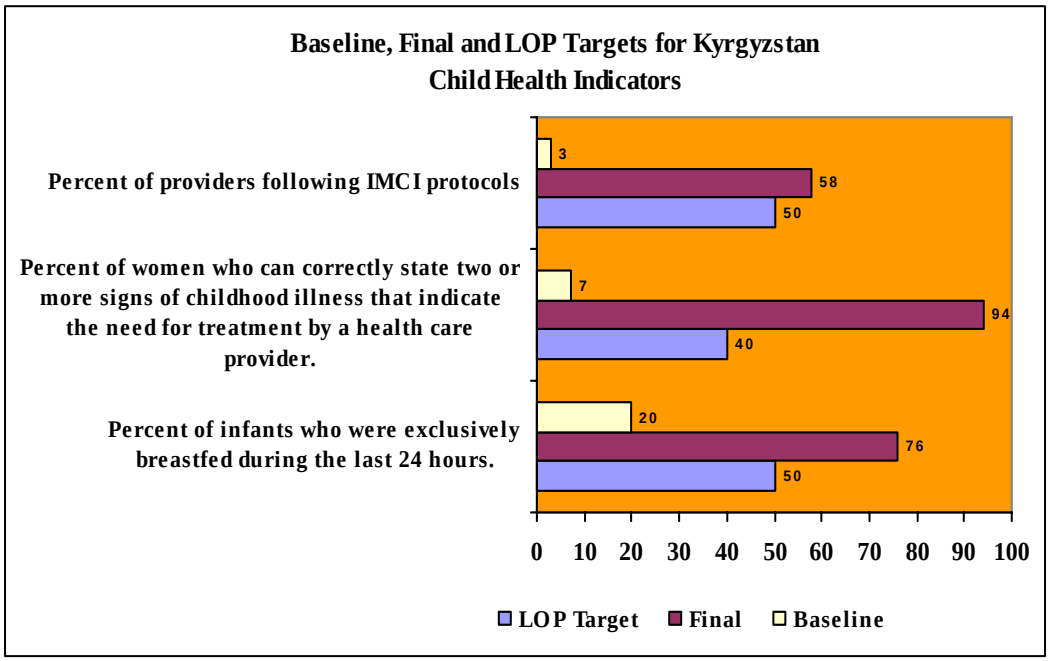
The evaluation team found an overall high level of satisfaction among health providers for the program and the quality of trainings received. As of August, 2007 there had been 1,222 participants (many are the same individuals participating in multiple trainings) in one or more of the twenty skill-based trainings conducted under this project (see Annex E for full list of trainings). Healthy Family utilized both Uzbekistan HF staff as well as national-level Kyrgyzstan trainers (trained by WHO, JPHIEGO and others) to conduct TOT and direct training of Bakten Province health providers. Recipients consistently characterized the trainings as practical, detailed and appropriate. Within facilities, HF employed a strategy of inclusion by providing the same or similar training across disciplines. For example, training in antenatal care was not just offered to midwives but also to doctors and nurses. This ensured patients received consistent messages and similar care during their pregnancy irrespective of the provider attending to their need. In effect, it created a team approach to care that did not exist before.

Of the 16 indicators used to evaluate Health Family Kyrgyzstan, 6 (37.5%) have met or exceeded their targets. Most of the unmet targets are in the areas of Maternal and Newborn Health and contraceptive use. The more limited success in Kyrgyzstan was likely the consequence of the short period of implementation, migration of trained providers outside the program areas and a change in national leadership which delayed training in RH/FP. Also, it is important to note that training coverage of facility staff was much higher in Uzbekistan than in Kyrgyzstan as a result of budget, project design and time period. As such, the Health Facility Assessment (HFA) in Kyrgyzstan, which is applied randomly, was evaluating many individuals who had not been trained whereas that was not the case in Uzbekistan. Review of Kyrgyzstan's monitoring data (which only focuses on staff who have received training) indicates good adherence to standards. In general, final evaluation interviews and observations found knowledge, attitude and visible signs of improvements consistent with the quality of care sought under this project. Moreover, providers at all levels were seeing the same kind of impact. They asserted that as a result of the improved quality of care, service utilization at primary and secondary facilities has increased, frequency of severe childhood illness seen at territorial and province-level hospitals has decreased, and fertility and child mortality has decreased. In a number of the facilities, specific data was shared to support those assertions however the team has no way of determining their validity.

The Project HOPE Kyrgyzstan technical staff did feel that it was a mistake to remove the community component originally envisioned for this project and voiced their concerns to Tashkent. There is some discrepancies about why it was removed. According to the former COP for Healthy Family, the community component was removed due to poor initial progress by Kyrgyzstan staff on the clinical components. He said that at the time, the original intent was to delay the community component rather than eliminate it all together. The Tashkent technical manager stated that it was removed to financially accommodate adding another district at the request of the MoH. Regardless of the reason, the Kyrgyz team seemed to have little say in it and the component was never initiated. The evaluation team feels that in spite of the understandable challenges, it would have been worthwhile to figure out a means of keeping that component in tact and initiated from the start – especially given the short time span of the Kyrgyzstan project. The fact that management and technical staff in Tashkent were not as comfortable in community mobilization as they were in clinical interventions may have also influenced their decision. Improvements were seen in some of the community-level indicators which the team believes can be attributed to the high level of access and use of facilities by the target population. Under this program, facility staff had been trained to be more proactive in community education and health promotion during antenatal and child-health related visits.

The team also feels it may have helped the program to have had stronger ties at the national level early on in the planning and implementation. While the project's initiatives were closely aligned with health care reforms, there was initially no substantial coordination with the MoH in Bishkek. This changed in December of 2006 when Project HOPE hired a Country Representative. It was clear from the evaluation interviews that national level MoH officials were well informed about project activities with some having visited the program.

i. Child Health



As indicated in chart above, all three Child Health indicators showed substantial improvements over baseline values, surpassing their targets. The exclusive focus of child health activities in Kyrgyzstan was to introduce, refresh and support monitoring of health care providers in the use of integrated management of

childhood illnesses (IMCI). While Kyrgyzstan officially adopted IMCI protocols in 1999, the costly trainings did not come about until years later. Trainings were linked to financial and technical assistance provided by Asian Development Bank, UNICEF, as well as the Healthy Family Program. In Batken Province, most doctors had received some IMCI training prior to Health Family but it was felt that refresher training was warranted. The principle activity of Healthy Family in this area however would be the training of nurses, midwives and physician assistants in the IMCI protocol (this was a shortened course and was referred to as *C-IMCI*). This was unique as no other organization had developed an IMCI training for this level of staff. Gulmira Najimidinova, Director of the National IMCI center stated that Health Family was the *only* program training nurses in IMCI in the country. She felt that this was not only important but strategic given that many doctors were leaving Kyrgyzstan for more lucrative opportunities in Russia. In addition, the project translated all IMCI materials into Kyrgyz (formerly only available in Russian). Both UNICEF and Asian Development Bank, according to Ms. Najimidinova, have now begun using these translated materials.

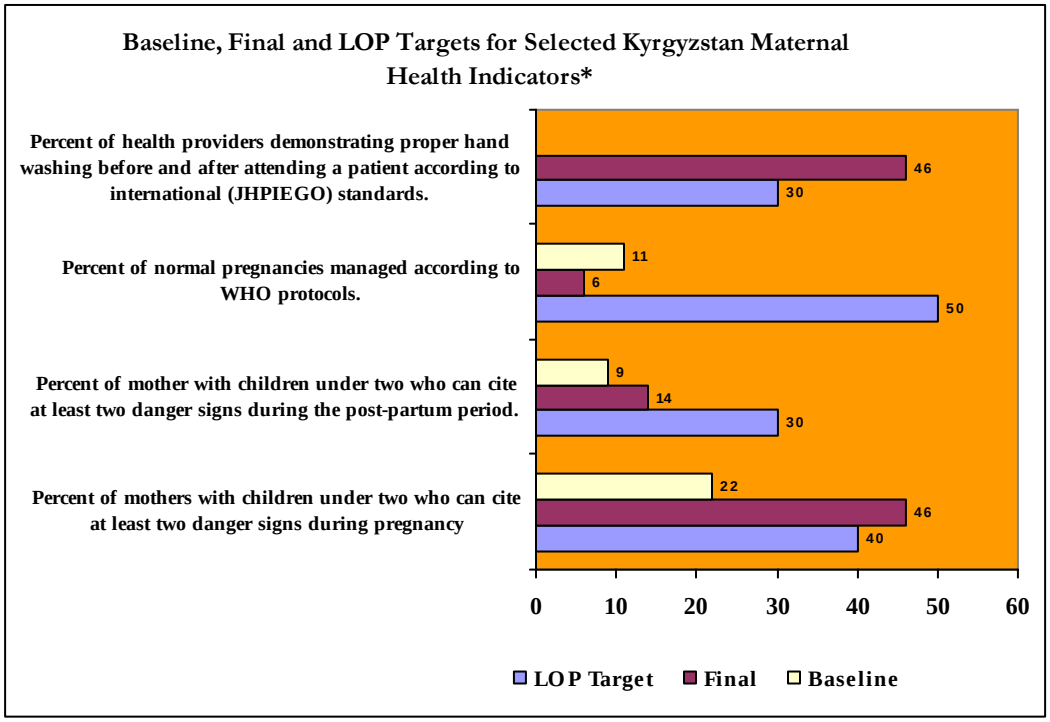
In total, 253 health facility staff in the two pilot districts received some form of IMCI training (complete, refresher, C-IMCI, or TOT) lasting in duration from 4 to 11 days. This included 105 doctors, 8 physician assistants and 136 nurses and midwives. Training coverage represents 90% of all doctors, 20% of physician assistants and 60% of nurses and midwives within the two districts. However, Dr. Ajitov, Head of the Association of Family Group Practitioners in Bakten, suggests that the coverage of physicians is misleading. Of the 83 doctors he has recorded as receiving IMCI training, only 39 remain in the province – the rest have migrated to Russia.

The evaluation team met with several health practitioners who did receive IMCI training and their response was resoundingly positive. When asked what they do differently as a result of the training evaluators were consistently told that the practitioners spend more time with mothers explaining the diagnosis, asking questions and educating them on health care and prevention of illness. The IMCI forms help facilitate this process as providers must ask questions of the mother in order to properly fill out the required IMCI forms. In the facilities visited by the evaluation team, the IMCI forms were observed and were found integrated into individual patient files (notebooks). A number of practitioners mentioned that they liked IMCI because it improved their capacity to "classify" illnesses. Prior to IMCI, primary and second-tier facilities (FAPs and FPGs) were limited in their ability to diagnose. As a default, antibiotics were routinely prescribed and/or patients were referred to higher level facilities (Territorial and Province Hospitals). Not only have providers reduced their use of antibiotics but they have also witnessed an increase in consultations at the primary care facilities as mothers gain greater confidence in the capacity of their local providers. Moreover, mothers are more informed about the danger signs of illnesses and thus seek care more frequently and earlier. Consistent with this finding, hospitals noted a *decrease* in severe childhood illnesses seen at their facilities which they also attribute to more timely identification of illness by mothers and effective treatment at the FAP and FPG levels. At Kulundu Territorial Hospital, the pediatric ward has actually decreased the number of beds from 40 to 20 in part due to the decreased demand.

The other two child health indicators (identification of danger signs and exclusive breastfeeding) shown in the table above well exceeded their targets and can be attributed to greater attention given to health education and promotion by facilities. In Kyrgyzstan, immunization coverage and women receiving one or more prenatal consultations is almost 100% (UNICEF - 2005). Health facility staff interviewed mentioned that they regularly take advantage of immunization and antenatal visits to reinforce the key messages they were trained to provide within the IMCI methodology.

Seventy-one (71) health facility staff members were trained in BFHI (Baby-Friendly Hospital Initiative) including 24 doctors, 4 hospital administrators and 33 nurse/midwives. Healthy Family staff coordinated preparation for certification by helping the two pilot maternities in organizing all 10 BFHI steps. Through trainings and follow-up support Healthy Family assisted Leilek Maternity Hospital in getting certified and are in the process of assisting Kulundu Maternity Hospital in meeting the standards for certification. The only weak point observed was Step 10 in the BFHI, initiation of breast-feeding support groups. While providers indicated the presence of these groups they tended to be more clinic directed activities than community based, and did not appear to have a lot of structure to them. However, looking only at BFHI underestimates the intensity of focus on breastfeeding which was a central theme in many of the trainings (i.e., IMCI, antenatal care, family planning, newborn care, etc.) for all levels of health facilities (FAPs, FPGs hospitals). Interestingly, the evaluation team found just as many doctors who were enthusiastic about breastfeeding as nurses and midwives – once again a testament to the cross-training approach and support for this particular activity. Healthy Family also supported breastfeeding promotion through the production of pamphlets and posters in Kyrgyz, Uzbek and Russian languages. Practitioners consistently reported increased exclusive breastfeeding in their coverage areas from 60-70% prior to the project (though the baseline indicated 20%) to 80-90% now based on their own estimates. Final KPC survey results show that exclusive breast feeding increased from 22 to 76 percent as indicated in the chart above.
Improvements in exclusive breastfeeding may have also been influenced by a major breastfeeding campaign implemented just one month prior to the evaluation. This campaign was supported through matching funds Project HOPE received from the Swiss Development Corporation.

ii. Maternal and Newborn Health



* There are a total of 8 indicators for Maternal and Newborn Health applied in Kyrgyzstan (see Table 4)

The Kyrgyzstan program achieved only 2 of the 8 targets set for Maternal and Newborn health. Of the targets not achieved, 3 were associated with delivery management, 1 related to mother's knowledge of

danger signs during the post-partum period and 2 related to hand washing (IP). Maternal and newborn health activities in Kyrgyzstan focused on improved antenatal care at primary and second-tier facilities as well as training of maternity, territorial and province-level hospitals in international standards for maternal and newborn care. Training at all facility levels (FAPs, FPGs, and Hospitals) was conducted on international standards for infection prevention and breastfeeding promotion – including support for certification in Baby Friendly Hospital Initiative (BFHI).

In total, 101 health facility staff members were trained in antenatal care including 25 doctors, 3 hospital administrators, 1 physician assistant and 72 nurse/midwives. The first 6-day training course began in June of 2006 and the most recent training was completed in June of 2007. As with IMCI, the trainings in antenatal care strongly reinforced the opportunity created by the ANC visits to educate and inform mothers on a variety of pregnancy-related issues. While there are actually fewer antenatal visits today than during the Soviet period (4 to 5 visits as compared to 12 or more!) staff felt the visits are now more informed for both mother and provider as a result of the training. Most of the practitioners interviewed say they now talk to mothers about danger signs during pregnancy and help them plan for their upcoming delivery. In consonance with new standards in delivery care, they discuss with mothers what to bring to the hospital, encourage active participation by the father and other family members, talk about breathing and pain management during delivery, and initiate discussion of post-partum issues such as breastfeeding and family planning. In Akaryk village, they even conduct special meetings for young fathers and mothers to help prepare couples for the delivery. The successful progress seen in mother's knowledge of danger signs during pregnancy can be attributed to this effort. The target for knowledge of danger signs during the post-partum did not increase substantially because no training in post-partum care had been conducted.

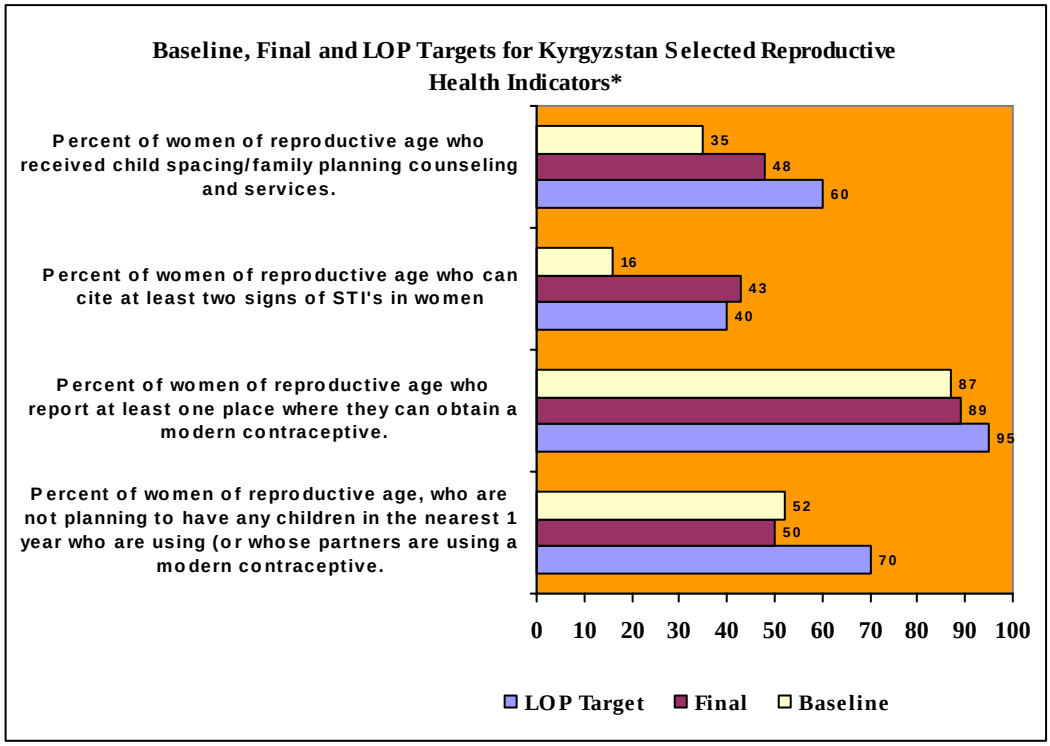
One hundred and forty eight (148) participants have received training in safe delivery and newborn care practices based upon the WHO Making Pregnancy Safer (MPS) initiative. Courses included management of normal and complicated deliveries, neonatal resuscitation, newborn care and live-birth definition. Collectively, 60 doctors, 9 hospital administrative staff and 67 nurses/midwives participated in these trainings. This is a relatively small number compared to those trained in Uzbekistan and Tajikistan which may explain the poor performance in this intervention. In addition, political changes at the national level unfortunately delayed training in delivery management until April of 2007 which left little time for monitoring and honing new skills prior to the final HFA conducted in July. In spite of the results, the evaluation team observed conditions in the maternity and territorial hospitals consistent with the training received including neonates rooming-in with mothers, freshly painted delivery rooms and delivery positions posted on the walls. At Kolundu Territorial Hospital (Leilek District) they even had an exercise ball in the delivery room for mothers to use during labor. Practitioners appreciated the systematic approach of the trainings and learned there was much they could do even with limited resources. They actively use partograms now and refrain from inducing labor medically unless necessary.

Initially, Health Family's infection prevention initiative was only going to be rolled out in the maternity hospitals of the project regions in Batken. However, the Ministry of Health requested HF support in piloting a more extensive training in infection prevention and control in all inpatient health facilities of Batken Oblast in order to test compliance with a recent decree on IP approved at the national level. The project obliged while continuing to focus on hand washing practice and technique at all level of facilities. In total, 271 staff members were trained on IP including 64 doctors, 6 physician assistants, 12 administrative staff and 171 nurse/midwives. At Bakten Hospital, a number of changes were made including a central sterilization department, improved methods of disposal of medical waste and improved hand washing techniques with instructions posted at all hand washing facilities. The IP Coordinator for the hospital also

said there has been a dramatic change in the reporting of Hospital Acquired Infections (HAI). Prior to the training, hospital staff would tend to hide such incidents for fear of retribution. Staff members are now strongly encouraged to report infections in a timely manner to limit further spread. In 2005, prior to training, there were only 4 reported HAIs at the hospital. In 2006, post-training, that number jumped to 37. Leilek Territorial Hospital also reported an increase in the HAI rate from 5% to 20%. Two of three indicators for IP were not met and could indicate the need for follow-up and reinforcement.

With regard to the IP training, there was some resentment at the national level when Project HOPE decided to utilize Uzbek trainers during the initial IP training rather than Kyrgyz national level trainers. Overall, the evaluation team concluded that Project HOPE management and technical staff in Uzbekistan overlooked the capacity of Kyrgyz (staff and others) and had a general lack of sensitivity toward the relational dynamics between Uzbeks and Kyrgyz. The Kyrgyz staff felt that Uzbek staff projected an attitude of superiority and were at times condescending in their treatment of Kyrgyz staff. The atmosphere this created had a negative impact on the overall management of the Kyrgyzstan project (see Project HOPE management). To Project HOPE's credit, once objections were raised regarding use of Uzbek IP trainers, all subsequent trainings were conducted by Kyrgyz trainers. Another oversight was that although the local IP coordinator selected to coordinate these activities was from the oblast SES, the project did not engage the Sanitary Epidemilogical Service (SES) at the national level from the beginning in its IP activities in spite of the fact that they have jurisdiction over IP matters within health facilities. This has caused some conflict between facilities who were adopting the new practices and the SES. This conflict actually reflects a broader jurisdictional issue within the MoH as IP rests with the Republican Center for Infection Control (RCIC) rather than the SES. However, it would have been helpful for the program to involve the SES in both training and monitoring activities in order to show respect for their authority and have them be part of the support structure for sustaining improvements.

iii. Reproductive Health



* There are a total of 5 indicators for Reproductive Health applied in Kyrgyzstan (see Table 4)

The Healthy Family Project trained 159 staff on contraceptive counseling, method mix, and syndromic approach to STI treatment between July of 2005 and August of 2006. Those trained included 19 doctors, 4 physician assistants and 136 nurses/midwives. In the two years of operation, the project was able to improve provider's knowledge on STIs and increase the number of facilities providing family planning counseling but failed to increase contraceptive use (see chart). This later result appeared inconsistent with what the evaluation team heard from providers in the field who believe usage *has* increased – especially with the wider selection of options available. According to HF staff, 93% of all facilities in the province have contraceptives available and are distributed at no cost. All the clinics visited by the team seemed well stocked. Contraceptives have been provided to the MoH through USAID and UNFPA. In addition, Project HOPE through USAID donations has provided $94,926 in contraceptives in addition to purchasing $10,000 worth of SDM cycle beads through a Swiss-funded project. Methods available include the pill, Depo Provera, condoms, SDM cycle beads and IUDs. Brochures describing the options were also provided by the project to help families consider which options would work best for them. Nurses take the brochures during home visits and discuss family planning (each nurse is responsible for visiting a sector of the community and time is built into their work week for making those visits). This is probably one area where a strong community mobilization component would have been helpful. Project HOPE's Country Representative for Kyrgyzstan felt that working with religious leaders in the community would have helped to increase usage.

One challenge for the program was that the MoH had distributed new methods to clinics (all except IUDs are new) prior to staff receiving training on their use. This fostered some early negative views on the

methods. Despite this, many of the health providers interviewed asserted that there have been significant changes in the number of users of new methods with the pill and Depo Provera being popular options.

iv. Policy

Unlike the Uzbekistan and Tajikistan project, Healthy Family Kyrgyzstan did not include a policy component. However, Kyrgyzstan was already well on its way to transforming its health policy when the project began. In 1996, the Kyrgyzstan government approved the 10-year Manas National Health Care Reform Program which has now transitioned to its second 10-year phase - Manas taalimi. The project aligned itself with interventions already supported under the reform (IMCI, MPS, IP, etc.). In effect, Healthy Family has helped finance the rollout of those reforms and contributed to the national dialogue on effectiveness. This has further informed future policy development. In 2006, for example, the MoH conducted a national assessment of IMCI pilot activities to determine strengths, weaknesses and next steps. Based on the success of these activities, the government has now integrated IMCI into pre and post-service training for physicians and incorporated IMCI drugs into their essential drug list. The level and frequency of dialogue between Healthy Family and national policy makers was not strong during the first half of the project but increased when Project HOPE hired a Country Representative based in Bishkek. It will be important as the project comes to a close for the frequency of dialogue between HF and national MoH to increase in order to ensure the project's experience is not lost and materials developed under the project are shared at this level– especially regarding IMCI training for nurses.

v. Monitoring and Evaluation

All major technical trainings included special TOTs targeted toward province and district-level supervisors. In addition to developing a cadre of local trainers, this also helped to prepare senior regional health staff for monitoring activities. Project HOPE facilitated joint monitoring visits (local trainer/supervisors and Project HOPE staff) every 2nd, 3rd and 6th month after a training. Monitoring incorporated observation, client interviews and equipment and stock checks. Standard forms and checklists were used for monitoring activities and to document results. The evaluation team reviewed the latest monitoring reports for antenatal care and IMCI (July, 2007) which shows that 70% of trained staff performed all steps required for antenatal care and 86% of the health facilities reviewed had more than 2/3 of staff treating patients according to the IMCI protocols. Each monitoring report provided recommendations for follow-up and was submitted to Province and National MoH officials. For example, the team discovered problems with providers correctly filling out IMCI forms for children under 2 months of age. As a consequence, with the MoH the project created new IMCI forms for children <2 months for health providers. In Leilek, the district trainer/supervisor interviewed had just conducted an antenatal monitoring visit *without* the assistance of Project HOPE. They provided the transport and fuel for the monitoring activities from within their own budget. They reported that they will continue monitoring without assistance.

Healthy Family conducted baseline, midterm and final assessments of facilities as well as community-level knowledge and practices. The baseline and final applied HFA and KPC survey methodologies for the facility and community components respectively. Province and district level health staff members participated in all of the evaluations and were given 2-3 day trainings prior to the baseline and final. All surveying, data entry and analysis were managed by Project HOPE staff. The evaluators feel that given the

scope of the project, the final quantitative HFA and KPC surveys should have been managed by an external consultant to ensure consistency and objectivity across all countries.

vi. Sustainability

The alignment of project activities with national level health care reform initiatives will help ensure that many of the new procedures and skills supported by this project will be sustained. The support by the MoH for these new activities is tangible. The inclusion of IMCI into pre services training, IMCI drugs into the essential drug list and the establishment of a full-time infection prevention coordinator at the provincial hospital are just a few examples of their commitment to reform. The greatest threat to sustainability is the high attrition rate of family physicians who seek better opportunities outside the country. More than half of the physicians trained in IMCI in Batken have left. For this reason alone, Health Family's focus on nurse training was a smart and prudent strategy.

vii. Conclusions and Lessons Learned

Conclusion #1: The trainings provided to primary and second-tier facility staff in IMCI, antenatal care, breastfeeding and family planning were well received, appropriate to the level of care and perceived to have had a positive impact by the providers themselves. With extensive reach of facilities into communities and high rates of usage in Kyrgyzstan, the facilities also offered a good platform for educating mothers.

Lesson Learned #1: In a human resource-rich health care environment with extensive community coverage, interventions that focus on improving staff skills can be an effective means of improving quality of care and increasing knowledge among mothers.

Conclusion #2: The skill-building strategies employed by the program (alignment of training with MoH policies, TOTs for local supervisors/administrators, joint monitoring, training across disciplines, and CIMCI for nurse/midwives) were sound approaches that increase the likelihood of sustainability and broad application beyond the life of the project.

Lesson Learned #2: Program design should always take into account not just the promise of an innovation but the means by which that innovation can be sustained beyond the project period.

Conclusion #3: The Healthy Family project missed an opportunity to implement a more integrated program when they eliminated the community component. While it is true that the facility-based training appears to have had positive impact on mothers' (primary facility users) knowledge and behavior, it is not apparent that it had an impact on FP practices or change within the broader community (husbands, mother-in-laws, community leaders, etc.).

Lesson Learned #3: While countries which have an extensive network of health facilities along with high facility usage can be a good platform for targeted community health education, it cannot substitute for good community health promotion and mobilization which have been proven worldwide to be critical for broad-based community behavioral change.

III. Program Management

A. Overall Program Management

Management of the Healthy Family program was a challenging and sometimes contentious process. It was a large program spanning four countries, seven partners and with a budget of more than 15 million dollars. Providing management for such an activity would be a daunting task for any organization. As it was, the lead implementing agency, Project HOPE, had never before primed such a large and complex project. A lack of detailed planning, poor communication, and a less than participatory style of engagement of partners created an atmosphere of resentment and distrust particularly during the first half of the project. Some of the partners also exhibited poor internal management and lack of responsiveness to the needs of Project HOPE as prime or to the overall program, which also contributed to strained relationships and poor collaboration. Finally, the way in which budget cuts were managed by USAID only served to exacerbate the problems of management and partner relations. The net effect was a tendency toward de-segmentation of the program with each partner and country program working in relative isolation from the others, only coordinating when necessary. This is in stark contrast to the original intent of the consortia, which was to create a "synergy team". Project HOPE made a concerted effort to improve communication after management concerns were raised during the mid-term evaluation and coordination at some levels did improve. However, the program never achieved true coalescence and to the end was perceived by the prime and partners as four separate programs under one name. While many of the technical achievements are commendable, more comprehensive and sustainable results might have been accomplished had there been effective and cohesive collaboration among partners.

i. Planning and Coordination

When the RFA was announced in June of 2002, both Project HOPE and Save the Children (SC) appeared to be strong candidates given their on-the-ground presence in Uzbekistan and Tajikistan respectively. In addition, both had active USAID-funded child survival grants upon which Healthy Family interventions could be modeled. Other organizations were invited to help fill the technical gaps. In retrospect, the consortium was larger than necessary with duplication of skill sets among some of the partners. For example, in Tajikistan, the American Red Cross was invited by Project HOPE to implement some aspects of the community mobilization component (training of local RC volunteers, women's and men's groups). At the same time, SC would be working in the very same communities implementing other aspects of community mobilization (i.e., VDC, CtC, etc.). In effect, both organizations were going to the same locations, at the same time, to conduct similar trainings and, in many cases, targeting the same individuals since members of these groups tended to overlap. While both organizations coordinated effectively together, ARC did not offer unique contributions to community mobilization beyond those of SC. ACNM and JHPIEGO are another example. Both were conducting training to improve management of pregnancy, delivery and post-delivery periods and while their methodologies varied somewhat (LSS vs. MPS), both are based on international standards for making pregnancy safer. Careful consideration of these aspects might have resulted in a smaller, more manageable and more effective consortia.

The original proposal submitted by Project HOPE on behalf of the partners stated that "A more definite implementation plan that has input and buy-in from all of the partner agencies will be submitted with the DIP". However, this did not happen. In part, this was due to pressure from USAID to quickly collect

baseline data, submit country plans and begin spending money. This was perhaps one of the biggest strategic errors of the program as a DIP would have provided a critical opportunity to develop an overarching framework, establish the necessary management and coordination mechanisms and generate "buy-in" by all partners in order to create the synergy team envisioned. It was apparent even from the first annual report that the country-based programs had developed their own results and indicators and were already on their way to managing separate programs. The mid term evaluation team identified this same gap and recommended that a DIP be developed. Unfortunately rumors that the budget would be significantly cut made it difficult for any of the partners to plan individually or collectively for future activities (there wasn't even money to support the DIP workshop).

Abt Associates, the implementing partner in Turkmenistan, was also resistant to conforming to a framework outside of what they were already doing under Zdrav Plus. In many respects, USAID, Abt and others saw Healthy Family – Turkmenistan simply as a means to augment the existing Zdrav Plus budget (Abt didn't even use the name "Healthy Family" for the first part of the program). Abt also asserts that their program had to be treated differently given the extensive government approval process and control over program implementation in Turkmenistan. This meant they had less flexibility in conforming to activities and data gathering requested by Project HOPE. The evaluation team however felt that personality differences and mistrust equally contributed to their resistance. This was not helped when in August of 2005, Project HOPE submitted an unsolicited proposal to USAID to expand Healthy Family activities in Turkmenistan (with PH as primary implementer) without informing Abt Associates of their intent. Ultimately, they could not get Turkmenistan government approval and had to relinquish the funds to Abt to conduct activities on behalf of Healthy Family. A more transparent and collaborative effort at partnership on both sides could have made interchanges more productive and less acrimonious.

Kyrgyzstan was added to Healthy Family in 2005. Development, planning and initial baseline activities were directed by the Project HOPE office in Tashkent. While Project HOPE had a successful ongoing Child Survival program in Jalalabat (in Kyrgyzstan) there was very limited participation by Kyrgyz staff in the design and initial baseline activities despite their expertise and local knowledge. Technically, this was a missed opportunity but more significantly it contributed to a sense by Kyrgyz staff that the Uzbeks thought of themselves as "the experts" who didn't need Kyrgyz input. This tension between technical and management staff in Uzbekistan and the field team in Kyrgyzstan would continue throughout the program and was not conducive to effective management (see Project HOPE management section).

Annual work plans were developed and the organizations did meet once a year in the field (as well as various meetings at different partner headquarters). Feedback provided by partners suggests that these meetings were both helpful and appreciated. However, not all the partners were represented in all of the meetings. ACNM stated that they were provided funding to attend the planning meeting in the first year but not in any of the subsequent years. Part of the problem was that there was no common basket of funds for covering group activities such as coordination meetings and evaluations. Future large consortia efforts should consider having a set of line items to cover common costs such as meetings and evaluations that would ensure necessary coordination and uniformity in assessment methodology.

ii. Human Resources

Challenges in staff recruitment and turnover also hampered efforts of some of the program partners. Save the Children and ARC in particular had a difficult time recruiting and retaining program managers which resulted in leadership vacuums and delays in program start-up. During the 5 year program, SC has had no fewer than three permanent and one interim program manager. Among the principal implementing partners (HOPE, SC, ARC, Abt), none of the original program managers held their positions throughout the life of the program. On a case by case basis, this is not out of the ordinary given the relatively long time period of the grant but nonetheless, this did create some challenges. Additionally, the Chief of Party for Project HOPE was on a 3-month leave for language training during the middle of the project which, according to USAID's CTO, left a vacuum in program management. There were, however, a number of field staff members within each organization who have been involved in Healthy Family since its inception (some of whom had been promoted to Program Manager positions). This has helped to provide continuity and institutional memory. Futures Group and ACNM both felt that their components of the project were adequately staffed.

It is also important to note that staffing challenges were strongly influenced by budget cuts mid-way through the program. One of SC's expatriate program managers left due to budget cuts and in Project HOPE, both the Deputy COP and the Home office Program Manager backstopping positions were eliminated. The position of the COP was filled by the individual at Project HOPE's headquarters who had backstopped as Program Manager. When she transitioned to the field, in effect, three positions were reconstituted into one.

iii. Technical Support

Each organization provided its own internal technical backstopping support for HF operations with Project HOPE providing overall technical coordination. Project HOPE Tashkent staff made a number of field visits to Tajikistan, Turkmenistan and Kyrgyzstan but these visits focused primarily on management or budget-related issues. In addition, Project HOPE Tashkent provided technical training for its staff in Kyrgyzstan and consulted with SC Program Manager on monitoring and evaluation in Tajikistan. There were no real opportunities for field technical teams from the different programs to get together to share ideas, exchange materials and discuss challenges. This could have been helpful in creating more of a shared vision and exchange of experiences.

iv. USAID Collaboration

The RFA "Expanding Reproductive Health and Maternal and Child Health Services in Uzbekistan and Tajikistan" was announced by USAID's Regional Mission for Central Asian Republics in June of 2002. Put into context, this was part of an overall increased package of foreign assistance in the region in part resulting from global State Department priorities and collaboration of these two countries in support for the war in Afghanistan. The original proposal focused almost exclusively on Uzbekistan and Tajikistan targeting provinces that bordered Afghanistan. Turkmenistan was also included for a small amount of funding within the original RFA. To the misfortune of the program, priorities shifted and political relationships between the U.S. and Uzbekistan became strained. As a result, anticipated funding levels for the program were not realized and the 22 million dollar health program was ultimately reduced to 15.5 million.

In the beginning of 2005, USAID notified Project HOPE that the Healthy Family budget would likely be cut. While this was a blow to the program, the larger frustration was that USAID never gave a definitive response as to how much and when funds would be cut. According to the current CTO, USAID did not want to commit itself to a particular funding level if by chance additional funding could be found. If USAID committed to a lower funding level and afterwards more money was allocated it would have had the effect of country programs being "over budget". Whatever administrative inconvenience this may have averted, it created a major challenge in planning and management among the partners. USAID should have provided guidance based on the best information available allowing the program to plan appropriately. In addition, there were significant delays in the pipeline with annual allocations being pushed further and further into the fiscal year. This only heightened the level of anxiety and uncertainty about funding.

USAID's Cognizant Technical Officer for the cooperative agreement was first based out of Almaty (Kazakhstan) and then out of Tashkent. Since the program's inception three individuals have held this position. Ben Mills, the current CTO, participated as part of the evaluation team. In spite of the size and scope of the agreement, USAID's involvement has been quite limited. There have been only a few site visits by the various CTOs to Khatlon in Tajikistan and to southern Uzbekistan. There have been additional visits by local USAID representatives in each of the countries. For security reasons, it was prohibitive for expatriate USAID staff to visit Batken, Kyrgyzstan. The Healthy Family grant was signed as a cooperative agreement which limits USAID involvement to approval of key staff, approval of annual work plans and monitoring progress. However, having known some of the management problems early on, it would have been helpful for USAID to offer support in navigating problematic management issues in order to mitigate the challenges that developed. In addition, instead of pressuring the consortium to submit individual country plans soon after the approval, they should have instead insisted on a detailed implementation plan as originally intended.

v. Finance and Administration

As prime, Project HOPE was responsible for all reporting to the donor. From the perspective of Project HOPE headquarters, all financial and technical reporting by partners was timely and efficient. However Project HOPE field staff was responsible for gathering that information from partners which was not always as simple. Internally, Project HOPE considers Healthy Family as a tremendous learning experience which helped them improve their systems. Accountability, tracking and sub-grant agreements are all areas that have improved as a result of managing this program.

At the regional level, a number of partners felt that Project HOPE's management style was more about policing compliance than participatory engagement. Communication was often unidirectional focusing on what partners were required to provide Project HOPE. At times, these requirements seemed excessive such as the requirement to provide weekly updates on planned activities (which was not required by the donor). There was also a sense of lack of transparency – especially related to budget decisions. Again, this could have been averted if USAID had provided clear and consistent messages to Project HOPE and its partners.

vi. Conclusions and Lessons Learned

Conclusion #1: The absence of a detailed implementation plan as well as the inexperience of Project HOPE in managing a consortium contributed to the lack of cohesiveness, poor communication and conflicts among consortia members.

Lesson Learned #1: A detailed implementation should always be developed at the start of a project of this size and scope. The plan should include a common results framework, common set of indicators and mechanisms for inter-organizational communication and decision-making.

Conclusion #2: Partner selection created redundancy in skill sets and extra management burdens. Fewer partners could have performed equality as well, if not better, while reducing the prime's management and administrative burden.

Lesson Learned #2: While coordination should be broadly employed, partnerships should be selective. Partnerships should be entered into to complement skill sets while avoiding duplication.

Conclusion #3: Lack of clear communication by USAID regarding budget cuts created confusion and anxiety that not only affected planning but also negatively affected relationships between the prime and its partners.

Lesson Learned #3: USAID should provide partners with the best available information regarding anticipated funding levels so that they can plan accordingly.

Conclusion #4: There was no common basket of funds for group activities such as coordination meetings and evaluations. This added to the sense that these were four separate projects and reduced opportunities for relationship development, planning and consensus building.

Lesson Learned #4: Future large consortia efforts should consider having a set of line items to cover common costs such as meetings and evaluations.

B. Project HOPE

In addition to overall management responsibilities as prime, Project HOPE was the primary implementer of activities in Uzbekistan and Kyrgyzstan. In both countries prior to Health Family, Project HOPE had ongoing child survival programs which provided the experiential base for some of the interventions designed for the Healthy Family program. In both Uzbekistan and Kyrgyzstan, the Ministry of Health was the principal partner. Project HOPE held initial discussions at the national and provincial level in both countries in order to solicit MoH's input and support. What Project HOPE did very well was to align project interventions with those supported by the MoH through each country's health reforms. In a practical sense, Healthy Family assisted the MoH in piloting reforms in the targeted districts and thereby provided an experience base which could be used to gauge the effectiveness of reforms and inform further policy development. In Uzbekistan, the level of involvement was even greater as key Project HOPE staff participated in policy level discussions through the Core Group, the entity which was formed by Healthy Family to assist the MoH in developing policies.

Project HOPE demonstrated flexibility in making their program design responsive to requests by the MoH for changes. In Kyrgyzstan, for example, the MoH requested that Project HOPE work in Leilek District in addition to Batken. They also requested that Project HOPE expand the scope of their IP training to cover all of the new protocols that were recently established and to fund training outside the project area. In both cases Project HOPE adjusted their program accordingly. Overall, the level of coordination and engagement between Project HOPE and the MoH during project planning and implementation was excellent.

Up through May of 2006, Healthy Family supported a Chief of Party and Deputy Chief of Party who provided oversight and management support for program activities, with additional oversight by Project HOPE's Regional Director. At headquarters the program was supported by the Program Manager, CAR MCH Programs. With cuts in funding, the COP, Deputy COP and Program Manager positions were combined. The previous Program Manager, CAR MCH Programs then moved from Millwood, Virginia to fill that position and the position in Millwood was eliminated. As of June 2006, technical support was provided by the Director, Health of Women and Children.

Replacement of the COP and Deputy positions with a Project Director Position does not appear to have had a negative impact on program management. In some ways, the new COP was more involved than her predecessors in the day-to-day details of program implementation, which helped to resolve some lingering problems. With regard to technical staff, Project HOPE maintained a cadre of highly skilled and dedicated individuals that were instrumental in helping the organization achieve it's objectives.

Challenges did exist in relationships between the Kyrgyz team and the management and technical staff in Uzbekistan. There was a tendency to micromanage the program from Tashkent with technical support staff in Uzbekistan assuming de facto supervisory roles of their Kyrgyz counterparts. Substantive management engagement from Tashkent appeared justifiable initially as the COP and Deputy had limited confidence in the capacity of their first Program Manager in Bakten. However, in general there was a feeling by the Kyrgyz staff that their Uzbek colleagues disregarded their competencies and perceived them as technically inferior. This idea was reinforced by the limited input the Kyrgyz child survival staff had in design and decision-making for the program. Project HOPE Jalalabat staff was not asked to participate in the proposal design of the Healthy Family project even though they were probably the best informed about implementing health programs in Kyrgyzstan. Tashkent also unilaterally decided to remove the community component despite the objections of Batken staff. There was some confusion over precisely why this was done but what is clear is that the Kyrgyz management and staff had no involvement in

the decision-making process. After the Regional Coordinator (for Batken) was dismissed, Kyrgyz staff had to request authorization from Uzbek *technical* staff for local travel and other day-to-day activities. (This was still occurring even after Project HOPE hired new and more qualified Program Manager and a Country Representative). This level of micro-management was halted by Project HOPE's COP and Director, Health of Women and Children after they learned of this practice during the mid-term. The evaluation team felt that these issues could have been avoided or better resolved had there been a more open and participatory level of engagement of the Krygz colleagues by Tashkent with regard to decision-making.

Aside from these challenges, Project HOPE managed Healthy Family activities and resources extremely well, especially in lieu of the almost 4 million dollar reduction (32%) in the program budget. In addition, Project HOPE was very effective in providing matching funds and in-kind support to complement program activities. In all, this support totaled close to 15 million dollars. USAID's CTO felt that Project HOPE's relationship with the government, compliance with local laws, technical capacity and financial support made the organization's leadership one of the project's greatest strengths.

C. Save the Children

SC was the primary implementing partner for HF activities in Tajikistan. Like Project HOPE, SC also had prior experience with a child survival program in Panjikent and planned to incorporate some of the interventions developed there (RDF, ETF, and VDC mobilization) into Healthy Family. SC was involved in planning Healthy Family from the inception of the project. Having ARC as a community mobilization partner for SC in Tajikistan was decided primarily by Project HOPE based on experience they had had with ARC in Uzbekistan. SC worked in collaboration with ARC on community mobilization and with the Futures Group on health policy and NGO development. Based on in-country discussions, the perception was that the project was really designed at the headquarters level and this resulted in local staff having to make the pieces fit together after the grant was funded. Save the Children built its interventions around the community level interventions developed in Panjikent and utilized PH (Tashkent) and ACNM and JHPIEGO as technical partners for the health facilities training since SC had limited experience in this area. At the HF national/policy level, it seems that initially there were public conflicts between SC and PH about funding and program direction. These were less apparent after the first year. The mechanism for communicating between SC and its two Tajik partners (ARC & FG) was based on relationships between the local leadership for each organization who negotiated how they would work together. Just as there was vertical program development by country, there was also vertical development by organizational partners within country. While SC played a leadership role, this may have been diminished by the multiple changes in the Program Manager (PM) over the grant period. In total there were 4 PMs during the 5-year program. Some of this turnover was attributed to inability to get Project HOPE to approve individuals that SC proposed for this position. The relationship between Save the Children and Futures Group seemed dependent on the Program Manager position and was stronger after the first year of Healthy Family. SC and ARC were able to coordinate their activities in community mobilization locally and often went out together to do training.

By the end of the project, a major strength of SC was its close collaboration with the MoH in health policy and primary health care strengthening. This is significant because initially SC did not have strong relationships with the Ministry of Health and worked primarily through Futures Group. SC worked with MoH to coordinate health provider training in LSS, ARI, CDD, malaria, RH, and maternal newborn care. They provided logistical support, materials, transportation and per diems to MoH trainers for health provider training courses. This was a successful

strategy since it utilized existing resources with expertise in content and the local situation. This also helped ensure sustainability of training through MoH.

SC headquarters was involved in the development of the original proposal and participated in Millwood meetings about HF progress. During the first year of the program, SC's headquarters was substantially engaged in start-up efforts but this diminished significantly as the program progressed. Support seemed to be primarily technical backstopping, coordination with Project HOPE on administrative matters and participating in coordination meetings.

SC had well qualified zonal coordinators and health monitors, most whom had been involved since the beginning of the project. The midterm funding cuts resulted in significant staff turnover and major reductions in program activity which also affected morale. The turnover at the Program Manager level may have contributed to the lack of consistency in M&E. The M&E process experienced a number of changes, including at the time of the final evaluation. Based on monitoring and training reports, it seems there was inconsistency in data collection and entry in the different zones. This was also reflected in the evaluation team's concerns about data reliability and validity in the final evaluation.

Some of the concerns evidenced about the overall HF project management were repeated at the country level, i.e., the need for more effective planning, collaboration and participation in program decisions including funding. Some of these were directly a result of the funding difficulties and communication problems presented elsewhere, others had to do with SC as the prime within the country, relationships between organizations in country and between SC and Project HOPE.

D. Futures Group

The Futures Group was brought on as a partner under Healthy Family only to manage the NGO Grants program. There was no plan at the beginning of this partnership to take advantage of their expertise in policy, even though it seems quite obvious in retrospect that the HF would need to join forces with other international agencies in-country to push this agenda. They needed to do so in order to facilitate the implementation of international, evidence-based protocols and standards in their pilot districts. Per discussions during the final evaluation, it was a big adjustment for the different HF partner staff to find themselves working under one roof: one led by Project HOPE in Uzbekistan, and the other led by Save the Children in Tajikistan. The Future's Group program manager shared her time between the two HF country offices. Each organization was used to working quite independently, had their own working styles, and it reportedly took a little time for staff to really view themselves as part of one project while at the same time representing their individual organizations.

In terms of human resources, the Future's Group had a Policy Coordinator (33% time for Tajikistan and 67% for Uzbekistan), a technical advisor (100% Uzbekistan), a program assistant (short-term assignment), and a policy consultant for each country. The latter worked part-time initially, then full time when the scope of work broadened. Future's Group also had one Small Grants coordinator in each of the two Uzbekistan provincial offices, and one in Tajikistan. This staff worked with a total of 24 local NGOs (10 in Uzbekistan and 14 in Tajikistan). Future's Group staff shared office equipment and logistics as part of the Uzbekistan project team. In Tajikistan they had their own office equipment, but did get support from Save the Children with logistics.

The team in-country reportedly received a good deal of technical support from their headquarters office in Washington. Technical support from Futures Group headquarters was provided to the project through the Program Manager. Technical specialists from headquarters focused on such things as contraceptive security, strategy planning on RH, analysis of the Uzbekistan Health Examination Survey results, and the capacity building trainings for the Core Group members on policy approaches and tools. The latter were very interested in learning from other country experiences with policy development as well. Technical specialists and the Program Manager came two or three times a year at the beginning of the policy development work. This was subsequently reduced because of budget cuts.

Financial reporting to the project prime was done once a month from FG headquarters, consisting of compiled local office and headquarters expenses. Technical reports were submitted on a quarterly basis based on a template approved by the HF/Project HOPE management. The Futures Group generally did not have cash flow problems until towards the end of their contract when they had to deal with new bank policy issues.

E. JHPIEGO

JHPIEGO contributed significantly to the program's success. As a technical partner in MPS and IP in both Uzbekistan and Tajikistan, it was necessary for JHPIEGO to work closely with the two respective country implementing partners, Project HOPE and Save the Children. JHPIEGO was responsible for technical training and support in MPS and IP and it was the implementing partners that took the primary responsibility for most of the coordination, planning, administration and logistics. As such, the JHPIEGO experts were very much part of HF team in those countries, and report that the partnerships were good ones. Even when JHPIEGO funding ended, their Master Trainer was invited by Project HOPE to participate in the monitoring of newly trained health providers during Phase II of the project.

Human Resources for JHPIEGO consisted of a Master Trainer and 3 expert, part-time consultants in Uzbekistan. The consultants included the Deputy Director of the Taskent Medical Academy, the Ob/Gyn Division Head, and an Assistant Professor in the same department. There was also one consultant in Tajikistan who was a professor in the Tajikistan Medical Academy. The Master Trainer managed the JHPIEGO-led activities on the ground, and planned for the technical assistance of the part-time consultant trainers as needed. She received support with trainings from a headquarters co-trainer who came on several occasions to assist with the trainings in Uzbekistan and Tajikistan. As a technical, rather than implementing partner on the project, JHPIEGO did not have to cover any expenses. All local Uzbekistan and Tajikistan activity-related expenses were covered by Project HOPE and SC respectively.

F. ABT Associates

As it relates to planning and program design, the Abt Associates-led Turkmenistan program was relatively unique in that in addition to being a technical partner to the MoH, they were also considered as a donor similar to UNICEF in-country. Despite strong central control and government restrictions on international organizations, an anathema to most NGOs, it was quite evident that the Healthy Family Project enjoyed a good collaborative relationship with the MoH. The fact that the project (in collaboration with WHO, leading this process in-country) was able to help

the government move towards adoption of international, evidence-based protocols and standards is, in itself, an achievement. A positive observation is that the good relationship that ZdravPlus had already established with the government did not change when Healthy Family joined the project two years later (in 2003). From an internal point of view, Project HOPE would have liked to have made more of a technical contribution to the project than they were able to. Per interviews conducted during the final evaluation, it is clear that Abt Associates was very guarded with the project, and with the special relationship that they had developed with the government of Turkmenistan. A more open and collaborative relationship among the partners, with sharing and input in the area of M&E in particular, would have served to guide HF program activities, and enabled them to assess progress even within the existing government restrictions, i.e. IEC campaign results were collected by the local district partners, but the information is not very useful because data collection was undertaken too soon (right at the end of campaigns), and analysis was also a problem. It should be noted though, that the HF Chief of Party did visit the project in Turkmenistan several times after its inception, and to the credit, in the last year or so, there has been quite a bit of communication and dialogue around project indicators and an effort made by the current COP to strengthen this component of the project.

Since the start-up of the Abt. Associates- managed Zdrav Plus project in 2000, there have been several different Program Managers. The first Program Manager was on the ground in Ashgabad, Turkmenistan through the first year with Healthy Family, and subsequent to that, there were 2 other Program Managers based in Almaty, Kazakhstan. Until 2005, the team in Turkmenistan was very small; limited to the Country Manager, 1 program coordinator and an assistant. But in addition to this, the project had technical advisors based in the headquarters office in Kazakhstan who were directly responsible for program planning and came regularly to conduct trainings and develop/adapt IEC material etc. In 2005, the country office increased their staff and had a total of 3 program coordinators. Per interviews, there are a couple of weaknesses that can be identified in the area of human resources and management: 1) the program team in country did not receive any kind of orientation on the HF project, and thus did not have a clear picture of the overall program and program activities in any of the other HF countries; 2) the program team in-country did not receive a debriefing from program managers when they returned from annual HF meetings, nor did they ever have a chance to see HF program documents until recently; 3) the program team in country coordinates and manages program activities but all technical advisors are based outside the country (in Kazakhstan).

The evaluation team met with the Turkmenistan country staff, and it is evident that the current Country Manager has developed good cohesiveness among program staff in the office. There is a good level of communication between staff, and staff morale appears high. As the team is still relatively small, all program coordinators and administrative staff report directly and are supervised by the Country Manager.

The budget coming from the Healthy Family Project is sent directly to the Abt. Associates Almaty, Kazakhstan headquarters. The Turkmenistan office keeps track of which activities and project expenses funded by HF specifically. Like all the other partners, Abt. Associates submitted financial reports to Project HOPE every month.

G. The American Red Cross

The American Red Cross (ARC) was an implementing partner in Uzbekistan with Project HOPE and in Tajikistan with Save the Children. Their primary role was community mobilization, utilizing the ARC and community volunteer networks of the Red Crescent societies in Uzbekistan and Tajikistan. The role of ARC was different in each country. Their role in Uzbekistan was to provide the community mobilization component to complement the

facility level work of PH. This included capacity development with "mahallah" village committees, creation of women's support groups, health education with visiting nurses, village health events and campaigns and developing community level health education materials. Their role in Tajikistan was to complement SC's community mobilization interventions by training and supervising health volunteers, women's, men's and youth groups. SC was responsible for the VDCs, CtC and health education materials. ARC and SC coordinated their work in communities, often going out together to conduct training and supervise activities. When the grant funding ended for ARC, SC continued to support the community activities initiated by ARC. ARC was involved in the project design from its inception. This was primarily at the HQ level and local staff involvement was incorporated as HQ requested.

Based on interviews, the perception was that the project was designed and implemented in a top down and "silo" approach which resulted in local staff having to make the pieces fit together after the grant was funded. The ARC staff person the first year of the grant said that most of his time was spent "on the road" trying to negotiate how things would work at the community level. The relationship between ARC and SC in Tajikistan was dependent on the relationships between the local in-country directors and varied over time as directors of both programs changed. The major reason that ARC/RC Societies were identified for community mobilization was the network of volunteers at the community level. This network did exist, but the level of commitment and involvement varied by community, so in all places there were adults and youth who might have been involved in a single training in first aid, food distribution, or disaster preparedness but that might have been their only involvement. Also, the local RC heads were not directly involved and didn't understand why they weren't included since the country RC is a federation of local organizations.

ARC in Central Asia had experience with European donor led projects, as well as one USAID project funded the year before in Kazakhstan. Some in country staff interviews suggested that working with the stringent requirements of USAID was a new experience for them. The HF project was in areas where ARC did not have as much experience with large projects, so it was hard for ARC volunteers and local governance structure to understand what was involved. To mobilize volunteers, it was necessary to provide food and transport stipends, funds for materials, notebooks, t-shirts. ARC had to use this strategy in both countries. ARC helped facilitate Year 1 data collection and used this as an opportunity to develop capacity in local RC organizations and communities. In Tajikistan, ARC staff felt there was duplication of effort because SC already had community mobilization experience and in fact was conducting community mobilization activities concomitantly.

ARC experienced considerable staff turnover, especially when the grant funding became less secure. As the budget was reduced, fewer staff had to manage more program activity. While all of the community indicators were achieved in Tajikistan and in Phase I in Uzbekistan, ARC central and country staff expressed concern about the sustainability of the programs they initiated citing the importance of creating permanent structures at the village level. Since the RC local organizations are recognized by the Tajik government, it was felt that they might provide a mechanism for supporting the ETF because they are able to establish bank accounts whereas the VDCs have no official standing. Staff indicated that ARC contributed between $55,000-$75,000 more than its cost share just to keep their activities going in Year 3 before it pulled out of the grant. Finally, all ARC staff indicated that the baseline data collection in the first year was focused on documenting the indicators for the grant, rather than conducting a DIP which would have resulted in more local involvement and strategic planning. This was identified as a major weakness of the overall project.

H. ACNM

ACNM was contracted under the project specifically to address the training of midwives in Life Saving Skills (LSS). ACNM had already been working in Tajikistan with other NGOs and was brought on at the request of SC. ACNM had no office or staff presence in Tajikistan and depended entirely on SC to manage logistics, in-country planning and identification of participants. SC also assisted the local trainers in cascading the training to others midwives and provided follow-up and monitoring. ACNM's trainer came out to Tajikistan to do initial planning and then again to conduct the first TOT. ACNM was very complimentary of the work done by SC stating that they would not have been able to accomplish what they did without their assistance. SC hired an LSS coordinator to assist with this effort. Just after completion of the second training of trainers, ACNM was notified that their budget would be cut. This was upsetting as they now had a group of trainers ready to expand rollout of the training but with no budget to do so. As a result, the new trainers were directed to help support monitoring of those already trained and ACNM with ACNM forfeiting any further trips in order to support this activity.

SC staff had informed the evaluators that the government of Tajikistan was no longer supporting LSS but W.H.O. MPS standards (such as those implemented by JHPHIEGO in Uzbekistan). From a practical point of view, both LSS and MPS advocate for and support the same international standards (use of partogram, active management of 3rd stage of labor, etc.) so the training and manuals developed are not irrelevant. However, it is problematic in that there is a perception of a difference within the MoH. It would have been helpful for ACNM and SC to have been more engaged at the national level on this issue in order to ensure that there was a solid understanding of what LSS was.

While both ACNM and JHPHIEGO training was excellent it is not clear why the consortia brought on two partners with technical skills in the same area. It was said that ACNM was brought on because of their experience in Tajikistan and JHPHIEGO likewise for their experience in Uzbekistan. However, JHPHIEGO was contracted to support IP activities in Tajikistan and could have easily supported the MPS activities as well. While ACNM had experience in Tajikistan, they had no physical presence and depended on their local partners for coordination in-country.

IV. Conclusions and Lessons Learned

The following is the complete list of *general* technical and management conclusions and lessons learned drawn from each of those respective sections. For a country-specific list of technical conclusions and lessons learned, please refer to the specific country sections of the report.

i. Technical

Conclusion #1 The project made a significant contribution towards the development of policies that, in turn, supported project interventions in maternal, child and reproductive health services in the pilot districts and provinces.

Lesson Learned #1: Having a policy component can be an important strategy for reinforcing health service practices at the implementation level. All project designs should seriously consider how to effectively engage the national level when implementing local pilot projects.

Conclusion #2: Project training (incorporating both theory and practice), providing certification after trainees have demonstrated proficiency post training, and the use of specific monitoring tools by HF proved to be sufficient for improvements in service quality and delivery in Uzbekistan. The project successfully increased the technical capacity of health workers in the target provinces and districts which led to improved quality of services in maternity, child and reproductive health.

Lesson Learned #2: Quality post-service training of health staff and follow-up monitoring are key interventions for upgrading skills, improving service delivery and ultimately impacting health outcomes in countries that have a high number of skilled health providers.

Conclusion #3: The development and distribution of IEC materials for maternal, child and reproductive health in the Uzbek language greatly facilitated health education and behavior change in the population. The evaluation team feels that the IEC/BCC activities at the health facility and community level resulted in improved health behaviors including breastfeeding practices, early identification of danger signs, improved household management of illness and increased use of family planning.

Lesson Learned #3: In the context of a population with high literacy and education levels, access to health education materials can greatly contribute to both awareness building and behavior change when coupled with interpersonal communication through health providers and community volunteers. Availability of IEC/BCC materials in local languages and use of mass media also enhance dissemination. Future projects should incorporate these elements in similar country situations.

Conclusion #4: Project supported community mobilization activities through community committees (*Mahallahs*) were credited with establishing linkages between communities and the health system. Women's Committee members involved in the project were enthusiastic and devoted to supporting IEC/BCC, demonstrating ownership and pride in communities understanding of their responsibility for health. Budget cuts caused a reduction in the community component and lessened the impact more remote communities.

Lesson Learned #4: Communities should always be active participants in issues that affect their health. Creating closer ties between the formal health system and community and helping communities take a more active role in health issues is always a worthwhile endeavor.

Conclusion #5: At the district level, the project was able to introduce new concepts in health information systems and then use the data for problem identification and management decision-making. This contributed to improved health care provision and quality of services in the pilot districts. The HF HIS data helped inform policy dialogue and decision-making at the national level, and thus pushed the policy reform and development agenda. Unfortunately, it is unlikely that this HIS system will be adopted at the national level.

Lesson Learned #5: Ongoing projects should contemplate working on the issue of data and health service strengthening at the national level as well as the provincial and district levels. New systems should involve MoH staff and should ensure accurate statistics and relevant information for required government reporting.

Conclusion #6: The sustainability of project gains will depend on the continued training of new health providers, continued support of monitoring activities, and support for such things as IEC material development. As the district MoH budgets are limited, additional support will have to be sought, such as from the national government, local government or external sources.

Lesson Learned #6: Well before the program comes to a close, significant strategizing should occur with all stakeholders to help determine how and if activities can be continued once program financial and technical support ends.

ii. Management

Conclusion #1: The absence of a detailed implementation plan as well as the inexperience of Project HOPE in managing a consortium contributed to the lack of cohesiveness, poor communication and conflicts among consortia members.

Lesson Learned #1: A detailed implementation should always be developed at the start of a project of this size and scope. The plan should include a common results framework, common set of indicators and mechanisms for inter-organizational communication and decision-making.

Conclusion #2: Partner selection created redundancy in skill sets and extra management burdens. Fewer partners could have performed equality as well, if not better, while reducing the prime's management and administrative burden.

Lesson Learned #2: While coordination should be broadly employed, partnerships should be selective. Partnerships should be entered into to complement skill sets while avoiding duplication.

Conclusion #3: Lack of clear communication by USAID regarding budget cuts created confusion and anxiety that not only affected planning but also negatively affected relationships between the prime and its partners.

Lesson Learned #3: USAID should provide partners with the best available information regarding anticipated funding levels so that they can plan accordingly.

Conclusion #4: There was no common basket of funds for group activities such as coordination meetings and evaluations. This added to the sense that these were four separate projects and reduced opportunities for relationship development, planning and consensus building.

Lesson Learned #4: Future large consortia efforts should consider having a set of line items to cover common costs such as meetings and evaluations.

Annex A: List of Persons Interviewed

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Kyrgyzstan				
Wed. July 25th	Wed. July 25th	Wed. July 25th	Wed. July 25th	CB, JL, BK
Wed. July 25th	Wed. July 25th	Wed. July 25th	Wed. July 25th	CB, JL, BK
Wed. July 25th	Wed. July 25th	Wed. July 25th	Wed. July 25th	CB, JL, BK
Wed. July 25th	Wed. July 25th	Wed. July 25th	Wed. July 25th	CB, JL, BK
Wed. July 25th	Wed. July 25th	Wed. July 25th	Wed. July 25th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Thu. July 26th	Thu. July 26th	Thu. July 26th	Thu. July 26th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri.	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
July 27th				
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Fri. July 27th	Fri. July 27th	Fri. July 27th	Fri. July 27th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Sat. July 28th	Sat. July 28th	Sat. July 28th	Sat. July 28th	CB, JL, BK
Mon. July 28th	Mon. July 28th	Mon. July 28th	Mon. July 28th	CB, JL, BK

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Tajikistan				
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/ KT city	Save the Children	Inomjou – Zonal Coord. for Kulob Faizullo – Zonal Coord. for Shaertuz Mairam – Health Monitor ICT Shoista – Health Monitor Zuhro – Health Monitor Kurbonov Nurullo – MIS Assistant Nadazimova – Zonal Coord. of KT Thasanova Yaueilo – Health Monitor for KT Ikzorhova Dulfolnon Health Monitor Badargaeva Jamila – Health Monitor and CtC Trainer Kosimova Saodat – Health Monitor for KT	C. Bessenecker J. Lewis
Fri. July 20	Khatlon Oblast/ Vasksh Rayon	Mahubab (NGO Grants Recipient)	Slagzeeageeeds Opoca Xogniereba Frapouat Monmoba Mexpu Mpenepu T.U.	C. Bessenecker
Fri. July 20	Khatlon Oblast/ Kurgan Tube	Oblast IMCI Center	Dr. Abdunasulov Mnzoumar	C. Bessenecker

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
	Rayon/KT City			
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/KT City	Futures Group	Alisher Jolilov - Former FG Small Grants Coordinator	C. Bessenecker
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/KT City	Save the Children	Shodiya Mirhayolorova – Project Manager	C. Bessenecker
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/KT City	MoH, Khatlon Oblast	Dolier Soolik Kozikovich – Oblast Deputy Director until 1 month ago, now working with ADB	J. Lewis
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/KT City	MoH, Khatlon Oblast	Rayhona Mirzoev, Oblast Reproductive Health Director	J. Lewis
Fri. July 20	Khatlon Oblast/ Kurgan Tube Rayon/KT City	MoH, Khatlon Oblast, Central Maternity Hospital	Jamilya Sultanova Marlynda Kurbanova LSS Trainers	J. Lewis
Sat. July 21	Khatlon Oblast/ Vasksh Rayon/ Qunghurot Village	Village Development Committee	Karim Foron - Chief of VDC Urozali - Teacher (Resp. for CtC) Marjikol - Midwife (and ARC volunteer) Juma - Mullah Vurbonoi - Nurse Urosgul - Treasurer Jumagul Bibimulla Aidinoi - Pensioner Sonia - Women's group leader Gulbafen - Housewife	C. Bessenecker
Sat. July 21	Khatlon Oblast/ Vasksh Rayon/ Qunghurot Village	Child-to-Child Program	Urozali – Tacher and CtC Coordinator	C. Bessenecker
Sat. July 21	Khatlon Oblast/ Vasksh Rayon/ Qunghurot Village	FAP (Village Health Post)	Karim Foron – Nurse Marjikol - Midwife	C. Bessenecker
Sat. July 21	Khatlon Oblast/ Vasksh Rayon/ Qunghurot Village	ARC	Marjikol – Midwife and ARC Volunteer	C. Bessenecker
Sat. July 21	Khatlon Oblast/ Vasksh Rayon/ Qunghurot Village	Women's Group	Sonia – WG Leader (Others)	C. Bessenecker
Sat. July 21	Khatlon Oblast/ Vasksh Rayon	District IMCI Center	Yokhshieva Bodomgul – Director	C. Bessenecker
Sat. July 21	Khatlon Oblast/Vaksh Rayon/Ruzobod Village	FAP and VDC	Zaytuna, Nurse – FAP Tohir – chief VDC VDC Members: Yaticha, Risolat, Mahtov, Tariza, and Oympocho	J. Lewis
Sat. July 21	Khatlon Oblast/Vaksh	Vaksh Regional Hospital	Hamrogul Odinaev – Director Abdurahim Amirhonov – Deputy	J. Lewis

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
	Rayon		Director	
Sun. July 22	Khatlon Oblast/ Kulob Rayon	Central District Hospital	Mahmadrazar Sharipovich Talbakov – Director	C. Bessenecker
Sun. July 22	Khatlon Oblast/ Kulob Rayon	Central District Hospital	Dr. Rajab – Surgeon	B. Kittle
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Ofolico Village	Village Development Committee	Jalilov Zarif - Teacher (Deputy head to VDC) Odinaev - Member (also works at district hosp) Goibov - Head of Mahalla Bobiev Ismatullo - Religious Leader Nazarov Azam - Head of VDC Nemater Gulchehra – Midwife	C. Bessenecker
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Ofolico Village	FAP (Village Health Post)	Nemater Gulchehra – Midwife	C. Bessenecker
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Ofolico Village	Women's Group	2 Members	B. Kittle
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Ofolico Village	Child to Child Program	2 Child Promoters (Girls 17 and 18)	B. Kittle
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Kulob City	Tanzimgar (NGO Grants Recipient)	Iskandarsho Mirzorv - Director	C. Bessenecker
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Kulob City	Kulob Central Maternity Hospital	Dr. Mannoeu – Infection Prevention Coordinator	B. Kittle
Sun. July 22	Khatlon Oblast/ Kulob Rayon/ Kulob City	Kulob Central Maternity Hospital	Dr. Odil Hidirov – Infection Prevention Trainer	J. Lewis
Sun. July 22	Khatlon Oblast/Kulob Rayon/Kulob City	IMCI Center (but met at Rayon Children's Hospital because Dr. working there on Sunday	Dr. Pulod Hayotov – IMCI Director	J. Lewis
Sun. July 22	Khatlon Oblast/Kulob Rayon/Mirapoq Village	FAP and VDC	Oygha Turaseva, midwife Mahin Komilova, nurse, head of FAP VDC members: Asalmo Odinaeva, Davlat Kholov, member, Bunaysha Botipova, Valoyat Jalilova Volunteers: Gulnova Sultonova, Manzara Sharipova	J. Lewis
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Shaimiri Village	FAP (Village Health Post)	Safarov Kholmurod Sharipovich – Director Yodgorova Shahzoda – Midwife	C. Bessenecker
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Shaimiri	Women's Group	Shoihlo Sarvinoz Hafiza	C. Bessenecker

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
	Village		Amina Gulruhsor	
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Shaimiri Village	Village Development Committee	Safarov Kholmurod Sharipovich Yodgorova Shahzoda – Midwife Sharopova Saltonat Ikromov Amrohon	C. Bessenecker
Mon. July 23	Khatlon Oblast/ Muminibod Rayon	Central District Hospital	Roxikov Saidamir – Deputy Chief	C. Bessenecker
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Boggiahabib Village	Village Development Committee		B. Kittle
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Boggiahabib Village	FAP	Sharafniso Odinaeva, midwife, Head Rano Ibrohimova, nurse Safarmo Pitmalova, midwife	J. Lewis
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Boggiahabib Village	Child to Child Program (Girls)	Gulbahor, Sadaf, Hursheda, Nazokat, Matluba, Shukrona; most were 18 years old	J. Lewis
Mon. July 23	Khatlon Oblast/ Muminibod Rayon/ Boggiahabib Village	Women's Group		B. Kittle
Mon. July 23	Khatlon Oblast/ Kulob Rayon/ Boggiahabib Village	Men's Group		B. Kittle
Tue. July 24	Dushanbe	National IMCI Center	Lola Bobokhodjiera - Director	B. Kittle
Tue. July 24	Dushanbe	USAID	Aziza Khamidova	B. Kittle
Tue. July 24	Dushanbe	ARC/RC	Yousaf Hayat Regional Health Delegate for Central Asia and Caucasus International Federation Previously SC HF Program Manager	J. Lewis
Tue. July 24	Dushanbe	National MoH, MCH/RH Departments	Shamsiddin Kurbonov, Chief, RH Obidjon Aminov, Health of IMCI Observation Center Mahmad-Sharif Atoev, Chief, Mother and Child	J. Lewis
Tue. July 24	Dushanbe	Former Futures Group Policy/CORE group member (now with CARE)	Gulnora Baimuradova	J. Lewis

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Turkmenistan				
Thur July 19th	Ashgabat	WHO	Bakhtygul Karrieva	MJ, SP, BM
Thur July 19th		UNICEF	Dilara Ayazova	MJ, SP, BM
Thur July 19th		ZdravPlus	Myakhri Eyeberdieva	MJ, SP, BM
Thur July 19th			Merdan Bayramow	MJ, SP, BM
Thur July 19th			Natalya Basova	MJ, SP, BM
Thur July 19th		USAID	Ashley Moritz	MJ, SP, BM
Thur July 19th			Elena Samarkina	MJ, SP, BM
Thur July 19th		UNFPA	Guzel Hojayeva	MJ, SP, BM
Thur July 19th		ZdravPlus	Ayna Allaberdieva	MJ, SP, BM
Fri July 20th	Ashgabat (ZdravPlus Office)	MCH Institute	Alexander Junelov	MJ, SP, BM
Fri July 20th		Akhal Health Department	Alma Shakulova	MJ, SP, BM
Fri July 20th	Akhal Velayat (Ruhabat Etrap)	Health Center "Herrikgala Oba"	Dr O. Aymuhammet	MJ, SP, BM
Fri July 20th			Dr A Tatowa	MJ, SP, BM
Fri July 20th		House of Health "Gurtly Oba"	Dr Ogulabat Annageldiyewa	MJ, SP, BM
Fri July 20th	Ashgabat	ZdravPlus	Natalya Basova	MJ, SP
Fri July 20th			Myakhri Eyeberdieva	MJ, SP,
Fri July 20th		MCH Institute	Dr Gul Murykowa	MJ, BM
Sat July 21st	Ashgabat	ZdravPlus	Natalya Basova	MJ, SP
Sat July 21st			Myakhri Eyeberdieva	MJ
Sat July 21st			Maya Atadzhanova	SP

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Uzbekistan				
Mon. July 23	HF Termez Office	HF Termez Staff	Bakhtiyor Shainazarov, Oblast Coordinator	MJ, SP, BM
Mon. July 23			Mekhribon Tursunova, RH Specialist	MJ
Mon. July 23			Dilorom Kenjaeva, M&E Specialist	MJ
Mon. July 23		HF National Staff	Fakhriddin Nizamov, Program Manager	MJ
Mon. July 23			Nosir Abdullaev, Deputy Program manager	MJ
Mon. July 23			Barno Musaeva program training specialist	MJ
Mon. July 23			Fazil Eshankulov admin assistant	MJ
Mon. July 23		Surkhandarya Oblast Health Department, Oblast Steering Committee member	Abdusalom Ziyaev, Deputy Head	BM
Mon. July 23		Surkhandarya Oblast Hokimiyat, Oblast Steering Committee member	Mavluda Kabulova, Deputy Hokim	MJ
Mon. July 23		Surkhandarya Oblast Red Crescent Society, Oblast Steering Committee member	Sharofat Narbaeva, Chair	SP
Mon. July 23		Oblast Children's Hospital, Oblast Steering Committee member	Yuliya Ruziyeva, Head Physician	MJ
Tue. July 24	Drive from Termez to Denau	HF Termez Staff	Bakhtiyor Shainazarov, Oblast Coordinator	MJ, BM
Tue. July 24			Mekhribon Tursunova, RH Specialist	MJ
Tue. July 24			Dilorom Kenjaeva, M&E Specialist	MJ
Tue. July 24	Denau Central Rayon Hospital	Rayon Health Department	Yunus Uroqov, Head Physician	BM
Tue. July 24			Mamlakat Tudaeva, Deputy Head	SP
Tue. July 24		Denau Rayon Hokimiyat	Mukaddas Safarova, Deputy Hokim	MJ
Tue. July 24		Trainers	Rano Khamidova, SVP Pediatrician	MJ, BM
Tue. July 24			Umar Meliboev, CRH Head Pediatrician	SP
Tue. July 24			Harima Rakhmatulina, Polyclinic Pediatrician	BM
Tue. July 24			Musharaf Khodoinazarova, CRH Ob-Gyn	MJ

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Tue. July 24			Lola Nazarova, CRH Ob-Gyn	MJ
Tue. July 24	Denau RH/Antenatal Polyclinic	Health Facility Staff	Shafat Karimova, Head Physician	BM
Tue. July 24			Polyclinic staff	BM, MJ, SP
Tue. July 24	Community visits	Mahallah Committee	Lola Abdullaeva, Mahalla counselor	MJ
Tue. July 24		Mahallah Committee	Mahalla counselor	BM
Tue. July 24		SVP "Kuchakly"	Doctor, staff, "volunteers" and patients	BM, MJ, SP
Wed. July 25th	Muzrabad Central Rayon Hosp	Rayon Health Department	Mavluda Badalova, Head Physician	BM
Wed. July 25th		Muzrabad Rayon Hokimiyat	Fotima Normamatova, Deputy Hokim	MJ
Wed. July 25th		Trainers	Turgun Mahmudov, MD	MJ
Wed. July 25th			Nargiza Rahimova, MD	SP
Wed. July 25th			Abdusattor Bayirov, MD	SP
Wed. July 25th			Iroda Turopova, midwife	MJ
Wed. July 25th	CRH Maternity Hospital	Staff	Turgun Makhmudov, Chief Ob-Gyn	BM
Wed. July 25th			Nargiza Rahimova, Neonatologist	MJ
Wed. July 25th			Zulfiya Chief Midwife	SP
Wed. July 25th			O.R. Nurse	SP
Wed. July 25th			Midwives	SP
Wed. July 25th			Neonatal nurses	SP
Wed. July 25th			Iroda Shoimova,Polyclinic Gyn	SP
Wed. July 25th		Red Crescent Society	Rovshan Sodikov, Former RCS Rayon Coordinator	MJ, SP
Wed. July 25th		Mahallah "Nozimov"	Ten women activists, former support group	SP, BM
Wed. July 25th			Hayriddin Rahimov, -Mahalla Chair	MJ, SP,
Wed. July 25th			Hadicha Choriyeva, Mahallah Counselor	MJ, SP,
Wed. July 25th		SVP "Nozimov"	Doctor, Nurse, patient	SP, BM
Wed. July 25th			Six young mothers	BM
Thu.	HF Karshi office	Staff	Yuldosh Eshonkulov – oblast	MJ

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
July 26th			coordinator	
Thu. July 26th			Zafar Aminov – M&E specialist	MJ
Thu. July 26th			Hilola Osmonova – IEC specialist	MJ
Thu. July 26th			Yulduz Hamidova – Administrador	MJ
Thu. July 26th			Larisa Agobobyan – JHPIEGO	MJ
Thu. July 26th		Kashkadarya Oblast Khokimiyat	Mrs. Inobat Karimova Deputy Hokim	SP, MJ
Thu. July 26th		Oblast Health Department	Mrs. Umida Gazieva, MD, first deputy	MJ, SP
Thu. July 26th		Oblast Red Cress Society	Mrs. Zulfiya Sherova, Chef accountant	FN
Thu. July 26th		Trainers	Mrs. Lochina Allayeva, MD	MJ, SP
Thu. July 26th			Mrs. Elnora Jumanazarova, MD	SP
Thu. July 26th			Mrs. Mavzhuda Shoyimova, MD	SP
Thu. July 26th			Mrs. Dilfuza Rakhmonova, MD	SP
Fri. July 27th	Chirakchi, maternity house		Mrs. Dilbar Shaymanova, MD	SP
Fri. July 27th	Kitab	Rayon Hokimiyat	Mr. Luqmon U. Gafforov, Hokim of rayon	SP
Fri. July 27th			Mrs. Lola Urokova, deputy hokim	MJ, SP
Fri. July 27th	Kitab, CRH	Central Rayon Hospital (CRH) Head Doctor	Mr. Baraka Abdullayev, MD	MJ
Fri. July 27th		Deputy Head Doctor on motherhood and childhood protection	Mrs. Sabokhat Hamdamova, MD	MJ
Fri. July 27th		Chief Obs.-Gyn.	Mrs. Mavlyuda Karimova, MD	MJ
Fri. July 27th		Trainers	Mr. Khudoynazar Khayitov, MD	SP, FN
Fri. July 27th			Mrs. Musallam Rakhmonova, MD	SP, FN
Fri. July 27th			Mrs. V. Adzhitarova, MD	SP, FN
Fri. July 27th			Mrs. G. Khalilova, MD	SP, FN
Fri. July 27th	Community visits	Women's Committee Chief	Mrs. B. Khakullova	MJ, SP
Fri. July 27th		Volunteer	Mrs. S. Zhurayeva	MJ, SP
Fri. July 27th		Volunteer	Mrs. S. Samarova	MJ, SP

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Fri. July 27th		Volunteer	Mrs. G. Turdiyeva	MJ, SP
Fri. July 27th		Makhallya Committee Secretary	Mrs. M. Eshimova	MJ, SP
Fri. July 27th		Volunteer	Mrs. Sh. Abdullayeva	MJ, SP
Fri. July 27th		Makhallya Committee Chief	Mrs. N.Botirova	MJ, SP
Fri. July 27th		Women's Committee Chief	Mrs. Z. Khaydarova	MJ, SP
Fri. July 27th		Volunteer	Mr. Akhad Islomov	MJ, SP
Fri. July 27th		Children's Polyclinic Head Doctor	Mr. Rakhmatov, MD	MJ, SP
Fri. July 27th		Head Doctor, Rural Doctoral Post (RDP) Sariosiyo	Mrs. Sh. Nasrullayeva, MD	MJ, SP
Sat. July 28th	Kasbi Rayon	Hokim of Kasbi rayon	Mr. Farkhod K. Sharipov	SP, MJ
Sat. July 28th		Deputy Hokim on women's issues in Kasbi rayon, Member of Oblast Steering Committee	Mrs. Barno Ochilova	MJ, SP
Sat. July 28th		Central Rayon Hospital (CRH) Head Doctor. Member of Oblast Steering Committee	Mr. Hamit Ergashev, MD	MJ
Sat. July 28th		Deputy Head /motherhood and childhood protection	Mr. Shukhrat Zhabborov, MD	MJ
Sat. July 28th		Chief Obs.-Gyn.	Mr. Gavsiddin Murodov, MD	SP
Sat. July 28th		Trainers	Mr. Uraz Aralov, MD	SP, FN
Sat. July 28th			Mr. Abbos Hasanov, MD	SP, FN
Sat. July 28th			Ms. Dilnavoz Abdullayeva, midwife	SP, FN
Sat. July 28th			Mr. Shukhrat Omonov, MD	SP, FN
Sat. July 28th			Mr. E. Bozorov, MD	SP, FN
Sat. July 28th	Community visit	Makhallya Committee Chief	Mr. K. Imatov	MJ
Sat. July 28th		Women's Committee Chief	Mrs. Zhabborova	SP
Mon. July 30th	Taskent	HF Project Training Specialist	Barno Musaeva	MJ
Mon. July 30th		Former HF Program Manager	Mavzhuda Babamuradova -	MJ

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Mon. July 30th		Chief of the RH Center, Tashkent	Staff	MJ
Mon. July 30th		Former Director of National Pediatrics Institute, CORE Group member	Dilbar Makhmudova	MJ
Mon. July 30th		Head of WHO in Uzbekistan	Michel Tailhades	MJ
Mon. July 30th		Former HF, Futures Group Program Mgr./Policy Coordinator	Nazokat Kasymova	MJ
Tue.. July 31st		ADB Representative	Nigora Karabayeva	JL
Tue.. July 31st		Chief of MCH Department, MoH. CORE Group member	Klara Yadgarova	MJ, CB
Tue.. July 31st		Former ARC staff	Rowan Vagner	JL
Tue.. July 31st		ZdravPlus Project	Nilufar Rakhmatova	JL
Tue.. July 31st		UNICEF	Shukhrat Rakhimdjanov	CB
Tue.. July 31st		Chief of OB/GYN Department, TMA	Najmiddinova Dilbar,	MJ
Wed-Thur. August 1st-2nd		HF Program Manager	Fakhriddin Nizamov, Program Coord	MJ
Wed-Thur. August 1st-2nd		HF Deputy Program Manager	Nosir Abdullaev, Deputy Prog Coord	MJ
Wed. August 1st	Projet HOPE Offices	Project HOPE	Sarah Porter, COP/HF Project Director	C. Bessenecker, J. Lewis
Thur. August 2nd	Hotel	USAID	Benjamin Mills, Cognizant Technical Officer	C. Bessenecker

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
Headquarters and other non-country based staff				
June 26th	Phone Interview	Project HOPE	Debbie Reister, Regional Director for Russia/Eurasia	C. Bessenecker
June 26th	Phone Interview	Project HOPE	Mary Ann Seday, Director of Monitoring and Evaluation	C. Bessenecker
June 26th	E-mail questionnaire	Project HOPE	Doug Palmer, Former COP of Healthy Family	C. Bessenecker
July 5th	Phone Interview	Abt Associates	Sheila O' Dougherty, Regional	C. Bessenecker

Date	Location Oblast, Rayon, Communty)	Group or Entity	Person(s) Interviewed	Evaluator(s)
			Zrav/Plus Director	
July 5th	Phone Interview	ACNM	Annie Clark, Senior Technical Advisor	C. Bessenecker
July 9th	E-mail questionnaire	The Futures Group	US-Based Project Manager	C. Bessenecker
Mon. July 23	E-mail questionnaire	Project HOPE	Doug Egnew, Chief Compliance Officer	C. Bessenecker
July 30th	E-mail questionnaire	American Red Cross	Augustine Gill- Senior Field Representative for Central Asia, Caucasus, Pakistan and Turkey	C. Bessenecker
August 9th	Phone Interview	Save the Children	Erik Starbuck, Senior Technical Advisor	C. Bessenecker

Annex B: 3-Day Final Evaluation Planning Agenda

FINAL EVALUATION 3 DAY PLANNING AGENDA

Day	Time	Activity	Objective/Outcome	Who needs to participate?	Who facilitates?	Notes
DAY 1	9:00-9:30	**Introductions:** Team members present themselves, their backgrounds, experience and (internal evaluators) involvement with HF project.	Getting to know the team.	All team members	Chris	
	9:30-10:00	**USAID requirements for FE:** Describe contractual requirements for FE, deadlines, donor use of FE and rationale for FE team composition and format	To understand necessary compliance issues associated with conducting the evaluation	All team members	Ben	
	10:00-10:15	**Break**				
	10:15-11:15	**Team-defined requirements for FE:** Within the parameters established by USAID, team should define what it would like to achieve/learn from this evaluation. Who is the audience, what do we need to get out of it, how can it best be used in pursuit of the project's objectives.	To ensure FE meets the needs of HF partners and beneficiaries	All team members	Chris	Any special inquires from this section should be incorporated into the terms of reference/FE outline if not already addressed.

	11:15-12:15	**Project presentations:** Start with brief overview of project objectives and presentation of results - matrix of baseline, mid-term and final eval. Afterwards, each PM should present their piece of the larger program reviewing in greater detail the specific objectives, achievements, strategies, and challenges pertaining to their region/technical area. Greater emphasis should be on activities since the mid-term.	To summarize project achievements relative to the proposed targets and provide background that will help evaluators better understand the environment under which the program operates.	All team members	Program Director and Project Managers	Program Director and Managers should be prepared to provide an overview as indicated within the 3.5 hours allotted. Suggested that Turmenistan goes first followed by Kyrgystan, Tajikistan and Uzbekistan.
	12:15-1:15	**Lunch**				
DAY 1	1:15-3:45	**...continuation of Project presentations**				During the presentations, the Evaluation Team should take note of any information they'd like to request from staff and make that request at the end of their presentation. Someone should make note of it on flipchart paper. To the extent possible, staff should try to fulfill that request by the following day.
	3:45-4:00	**Break**				
	4:00-5:30	**Review of Terms of Reference/Written Evaluation Outline:** Review in detail the final evaluation format, questions to be answered and define sources for information.	To clarify the specific information that needs to be gathered and how that information will be presented in the final evaluation report.	All team members	Bonnie/Chris	During this process, incorporate inquiries from the team-defined requirements for the FE. Chris to provide matrix to help identify the information requested, what the souce(s) will be and when it will be provided/gathered.

	5:30-6:30	**Finalize list of key informants and site visits:** Based on the initial list generated by project staff, team will confirm final list of individuals and sites that will be visited.	To ensure adequacy in scope and depth of perspective that will help evaluators meet USAID and team defined requirements for the FE. T		Marguerite	This needs to be completed on day 1 so that some advance notice and confirmations can be made.
	6:30-7:00	**Wrap-up**	To summarize Day 1 accomplishments and review Day 2 activities.	All team members	Chris	Time can be extended if any of the Day 1 activities take longer than expected. This is also the time to review any information requests made during the day.
DAY 2	9:00-11:00	**Interview/Evaluation Process:** After establishing what information needs to be gather, who it will come from, discuss the best process/methods for conducting the interviews and site evaluations.	To establish consensus on best approach(es) for conducting interview/site assessments.	All team members	Chris	
	11:00-11:15	**Break**				
	11:15-1:00	**Interview Guide Development:** Break into team to develop data gathering tools	To review or develop data gathering tools that will facilitate the information gathering process and provide some uniformity across teams.	All team members	Marguerite	Tools or process may vary depending on type of individual/entity being interviewed; country and activity being evaluated. May divide into groups to accomplish this task
	1:00-2:00	**Lunch**				
	2:00-4:00	**Plenary review and finalize data gathering tools.**		All team members	Marguerite	

	4:00-5:30	**I.D. of Interviewers:** Discuss how interviews will be divided amongst team members.	To clarify division of labor for efficiency and logistical purposes.	All team members	Marguerite	
	5:30-6:00	**Wrap-up**	To summarize Day 2 accomplishments and review Day 3 activities.	All team members	Chris	Time can be extended if any of the Day 2 activities take longer than expected. This is also the time to review any information requests made during the day.
DAY 3	9:00-10:00	**Logistics:** Review of travel teams, transport, translation, accommodations and country-level coordination	To clarify who's going where, when and how.	All team members	Sarah	First activity on Day 3 just in case any last minute issues arise that can be addressed during course of the day.'
	10:00-11:00	**Section breakdown:** Breakdown evaluation components in terms of LOE and approximate page limits.	To visualize the mechanics of translating FE activities into final end product	Evaluation Team	Chris	
	11:00-11:15	**Break**				
	11:15-1:00	**Writing responsibilities:** Determining ownership of sections and setting deadlines for first drafts	Clarifying point persons for each section of the evaluation	Evaluation Team	Judy	Each point person will not only be responsible for writing the first draft but ensuring all the appropriate data has been gathered (via staff and evaluators) in order to write their sections.
	1:00-2:00	**Lunch**				
	2:00-3:30	**Format and Style:** Discussion of style and format to be used in writing document.	To establish a degree of uniformity in preparation of the document	Evaluation Team	Bonnie	
	3:30-4:30	**Loose ends:** Resolve any lingering issues, receive any/all information requested from staff; finalize any logistical issues.	Ensure all issues have been addressed.	All team members	Chris	

	4:30-5:00	**Wrap-up**	To summarize Day 2 accomplishments and review Day 3 activities.	All team members	Chris	Time can be extended if any of the Day 2 activities take longer than expected. This is also the time to review any information requests made during the day.

Annex C: CVs of External Evaluators

Christopher P. Bessenecker, M.P.H.

Mailing Address: **817 Bush Street, San Diego, CA. 92103**
Telephone: **(619) 961-7920**, *Email:* **chris@ker-mor.com**

Qualifications Summary

With 17 years of hands-on experience in emergency, transitional and development programs, in areas as diverse as child survival, food security, water and sanitation, HIV/AIDS, and organizational capacity building, I have had the fortune of both learning and contributing to the fields of international public health and community development. I have lived and worked overseas for more than 8 years in a diverse set of environments assuming a range of responsibilities from building latrines to organizational leadership.
Each experience has offered me the tremendous rewards of helping others while continuing to broaden and deepen my understanding of our world and the human condition.

Professional Experience

Public Health Consultant *July 1993 - Present* Private consultant in the areas of humanitarian assistance, food security, HIV/AIDS, child-survival, water and sanitation, hygiene, diarrheal disease and other MCH issues. Recent consultancies have included development of a $20 million proposal to expand organizational efforts to support refugees along the Thai/Burmese border for the *American Refugee Committee (ARC),* leading organizational emergency response to Asian tsunami in Aceh, Indonesia for *Project Concern International (PCI),* project design proposal for expansion of an existing protracted relief and recovery program for orphans and vulnerable children (OVC) in Zambia *for PCI,* research and development of a paper documenting evidence of multi-sectoral links to child survival for *Child Survival Collaboration and Resources Group (CORE),* transitional Country Director in Honduras for *PCI,* and development of training materials in community-based Integrated Management for Childhood Illnesses (CIMCI) for *CORE*.
Vice-President for Program Operations and Development: *January, 1996(entered as Program Officer) – June 2003 – Project Concern International, San Diego, California:* Provided technical assistance to PCI international and field offices in the areas of food security, child-survival, water and sanitation, hygiene, diarrheal disease and other MCH issues with direct supervisory responsibility for programs in El Salvador, Guatemala, Nicaragua, Honduras, Bolivia and Indonesia. Responsibilities also included providing organizational direction and policy decision-making as a member of PCI's Global Leadership Team. I was responsible for proposal development efforts for various successful, multi-million dollar USAID grants in many PCI countries and subsequently fostering these programs to meet the highest standards for quality, consistent with the organizations philosophy, core values and strategic
direction.
Team Leader: *December, 1994 - June, 1995 - International Rescue Committee, Burigi Settlement, Tanzania:* Responsible for coordination and supervision of all humanitarian relief and development activities in a camp for Rwandan and Burundian refugees.
Such activities included preventative and curative health, maternal-child health, water, sanitation, food distribution, self-reliance projects, shelter management, facilities construction, and education. Provided supervision and support for seven professional expatriate staff, five Tanzanian nationals, and several dozen refugee employees. Served as I.R.C. liaison to the Tanzanian government and refugee leaders.
Program Coordinator: *February- December, 1994 - Center for Environmental Resource Management, University of Texas at El Paso, El Paso, Texas:* Served as Co-coordinator of the Bi-national Water Disinfection and Hygiene Education Project for Low-Income Border Communities. Conducted rapid hygiene needs assessment of families in low-income areas of El Paso/Ciudad Juarez.
Based on that assessment, developed a community based model to reduce household contamination of drinking water, increase water disinfection practices, and improve overall hygiene in U.S. and Mexican peri-urban communities.

Program Consultant: *February - August, 1993 - U.S. Agency for International Development (USAID)/ Water and Sanitation for Health Project (WASH), Washington, D.C.:* Organized and managed Central American regional workshop on wastewater management sponsored by U.S.A.I.D./W.A.S.H.

Health Sector Consultant: *March - August, 1992 - United Nations Children's Fund (UNICEF), Honduras*
Served as principle investigator for the first multi-agency national latrine survey which provided key information regarding latrine use, maintenance, design and operation.

Education

M.P.H. University of Texas-Health Science Center at Houston Graduate Program at El Paso - 1993-94. (U.S. Peace Corps Fellows) Concentration on environmental and international health.
B.A. Political Science and Sociology, University of Iowa - 1984-88 Concentration on Third World development and politics; functional vs. conflict approaches to social and political behavior.
Languages English – Native speaker; Spanish - Fluent; French – Beginner

Judy Lewis

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AREAS OF SPECIALIZATION:

Medical Education
Maternal and Child Health
Medical Sociology
International Health

EDUCATION:

M. Phil., Yale University, 1973 – (ABD) Met all requirements except dissertation for Ph.D.

Graduate Study, Department of Sociology, University of Illinois, Urbana, 1968-1969

B.S. with Honors in Sociology and with High Distinction, University of Iowa, (February) 1968 Thesis: "Self Disclosure and Self Concept."

PRESENT EMPLOYMENT:

Director of Community Based Education, 1984 - present
Professor, Department of Community Medicine 2003 – present
Professor, Department of Pediatrics 2003 - present

PREVIOUS FACULTY POSITIONS:

Associate Professor:
Department of Community Medicine, 1992 – present
Department of Pediatrics, (secondary appointment) 2002 - 2003

Assistant Professor:
Department of Community Medicine, 1983 – 1992
Department of Pediatrics, 1980-2002

Instructor: Department of Pediatrics, and Department of Behavioral Sciences and Community Health, University of Connecticut, 1973 - 1979

TEACHING EXPERIENCE:

DIRECTOR, COMMUNITY-BASED MEDICAL EDUCATION PROGRAM:

Course Director:
SELECTIVES: 4th year 2 month required independent project in research, education or intervention based in laboratory, curriculum development, clinical or community settings. Chair course committee, develop opportunities for students, evaluate proposals, presentations and papers, 1994-present

Curriculum Chair/Director CBE (current responsibilities):
Developed and implemented an integrated 4-year curriculum for medical students in medical school curriculum. Community Based Education activities related to course themes of health promotion and wellness in Year 1; chronic

illness in Year 2; community resources for patient care and an oral and written project for the Multidisciplinary Ambulatory 8 month Experience in Year 3; research and intervention in Year 4; and learning about community health and resources and participating in community service programs throughout all 4 years. Linkages have been established with more than 350 community programs in Connecticut. Chair of Community Curriculum Planning Committee, which sets policy for these required educational activities. Also, includes working with students in local and international community health electives, 1994–present

Director MD-MPH Program: Meet with interested students (including DMD and medical residents), serve as advisor for all students until thesis topic area is defined; and serve as thesis advisor for many students. Help students plan an integrated approach and appropriate time frame for completion of curriculum.

CBE Director, responsibilities for the period of 1984-1996

Course Director:

PRINCIPLES OF CLINICAL MEDICINE (First year didactic component of Clinical Medicine Curriculum). Required course in new integrated medical school curriculum; administrative and shared curriculum responsibility for 22 faculty in 10 groups providing clinical skills education in communication, history, physical examination, health promotion, and community health, 1995-1996

Course Director:

INTRODUCTION TO CLINICAL MEDICINE **A** (Subject Committee for first year students): "Introduction to Health and Illness from the Patient Perspective". Required course for first year medical students fall semester (September-December). Developed the course in 1984, administrative responsibility included working with 12-15 clinical programs and 80 patients living in the community (students individually matched with patients), curriculum development, course evaluation and direct teaching responsibility for 24 students in three classes of 8 medical students each, 1984 - 1994

Co-Chair: PRIMARY CARE CLERKSHIP. Required 8-week clinical clerkship in community-oriented primary care. Primary administrative and curriculum responsibility for multi-site, multi-track clerkship. Forty percent of clerkship curriculum was community-based including a community experience and project. Developed community experience and base of over 60 agencies in the greater Hartford area: bimonthly newsletter established fall, 1990. On going curriculum and faculty development, course evaluation and direct teaching responsibility for several core seminars, as well as individual student precepting for Primary Care Project requirement, 1982-1995

MPH Practicum:

Director, 1991-1995. Supervised 30-35 MPH students per year in Practicum, an independent community-based applied learning experience. Major supervision provided to each student and evaluation based on written analysis. Directed approximately 25% of practicum students as member of Practicum Advisory Committee, 1996-2000. Continue to advise 5-7 practicum students a year 2001-present.

MPH Faculty Advisor:

Advise entering students as well as theses, 1987-present

Chair: Community Service Oversight Committee (faculty, student, community representatives) developed guidelines for community service graduation requirement, created service opportunities, and evaluated completion of requirement, 1991 – 1996

Faculty: International and Immigrant Health: The Example of Haiti (with B. Gebrian), 2005

Faculty: Women's Reproductive Health Issues; 2005-present

Faculty: Exploring the Experience of People with Disabilities (with J. Delucia and A. Ardolino); 2003-present

Faculty: Global Literature and Women's Health Elective (with Sawsan Abdel-Razig); 2003; (with Benakar Batista) 2005

Faculty: HDH Special Topics Sessions "Race, Ethnicity and Health," with S. Brown; 2001-present

Faculty: 1st Year Medical Elective in International and Community Health Research Methods I (with S. Schensul) 1996-present

Faculty: 2nd Year Medical Elective in International and Community Health Research Methods II (with S. Schensul) 1997-present

Faculty: 2nd Year Medical Elective in International Health with S. Schensul, 1990-1994

Faculty: Center for International Health Studies (CICHS) International Training Program; sessions on community-based education and community health in Hartford, maternal and child health, health education and promotion; as well as providing consultation on individual participant projects, 1988–2001

Faculty: 1st Year Social and Behavioral Science Course Family and Health Seminar with C. Pfeiffer, 1990

Faculty: Maternal and Child Health, 3 credit course in MPH Program (20 students per class), 1987 and 1991

Advisor: 2nd year medical student research projects and 4th year electives; MPH essays and theses, 1974-present

Chairperson: School Health Component of Child Development Rotation (3rd yr. Pediatric residents) University of Connecticut, 1981-1982

Lecturer/Curriculum Committee:
Social and Behavioral Science Subject Committee (1st year medical and dental students), lecturer and seminar faculty, University of Connecticut, 1974 - 1978

Teaching Assistant:
Race and Ethnic Relations, Yale University, 1971

Teaching Assistant:
Sociology of Leisure, Sociology of Family, University of Illinois, 1968-1969

Teaching Assistant:
Social Psychology, University of Iowa, 1967-1968

<u>RESEARCH, TRAINING GRANTS AND CONSULTATION:</u>

GRANTS AND RESEARCH PROJECTS:

Co-Director: Education and Training Core, Center for the Elimination of Health Disparities Among Latinos, based at Storrs under R. Perez-Escamilla, ($8.25 million) 2005-2010

Co-PI and Consultant: KOMBIT USAID Child Survival Grant to Haitian Health Foundation focusing on maternal newborn health in rural Haiti ($2,014,923) 2004-2009

Co-PI: Aetna Foundation Grant to Hispanic Health Council to work with CBE on faculty and curriculum development in cross cultural skills ($25,000) 2004-2005; renewed ($20,00)for 2005-2006

PI: Kaiser-Permanente Teaching Fund Grant Award to develop a Collaborative Community Based Cross Cultural Education Event, University of Connecticut Medical School ($1000), 2000-2001

Co-PI: Community Health Education for Local Initiative Groups, (with S. Schensul) USAID Counterparts Organization, Ashgabat, Turkmenistan ($32,000), April 2001

PI: PRISMS, Medical Student Personal and Professional Development Workshop Grant, Gold Foundation ($4915), 1999-2000

PI: Health Professions Schools in Service to the Nation Program, phase 2 Mentor-Mentee Grant with University of Puerto Rico, service–learning and community based education development ($5000), 1998-1999

PI: Health Professions Schools in Service to the Nation Program, 3-year multidisciplinary service-learning curriculum development grant ($70,000), funded by The Pew Charitable Trusts, the Corporation for National Service and the Health Resources and Services Administration, 1995-1998

Co-PI: Youth and Sexual Risk in Sri Lanka (with S. Schensul et. al.), International Center for Research on Women, Phase II: Women and AIDS Program ($95,000), 1994-1997

PI: Connecticare Fund, support for medical student health education project in sixth grade classrooms in Hartford Public Schools ($4200), 1995

Co-PI: Join-In! Grant from CADAC, Connecticut Department of Public Health Addiction Services, to design a curriculum model for medical student education about alcohol and substance abuse prevention, treatment, and community resources ($5,000), 1993

Director: Evaluation of Medical Home Program - A 3 year pilot program to link low income children with primary care providers, funded by the Hartford Foundation for Public Giving as part of a grant to the Hartford Primary Care Consortium, 1991-1995

Co-PI: Triangle Program (with R. Peeters and T. Silva), collaboration between the Universities of Connecticut, Antwerp (Belgium), and Peradeniya (Sri Lanka); funded by the Belgian ABOS and the European Community to provide training in health social science research to faculty from the University of Peradeniya. Responsibilities included grant development, participant selection, curriculum design, lecturing, and individual consultations for two month-long training workshops and during the intervening year of project implementation (11 projects conducted by 12 University of Peradeniya faculty), 1989-1992

Co-PI: University of Connecticut-University of Haiti, Medical Student Education in Community Health Project (with S. Schensul), sponsored by USAID ($25,000). Responsibilities included curriculum development, teaching, field precepting, and data analysis supervision, 1988-1989

Participant: Faculty Exchange Program between the University of Connecticut and the University of Peradeniya, Sri Lanka, sponsored by USIA. Worked with Peradeniya faculty in Connecticut and made two site visits to Sri Lanka to work on various research proposals; conducted a family planning study with Peradeniya faculty; 6 month sabbatical leave, 1986-1988

PI, Director: Model School Health Project, funded by the Robert Wood Johnson Foundation ($1,055,137) to the Department of Pediatrics, University of Connecticut Health Center. Responsibilities included grant development, model program design, supervision of clinical and evaluation staff, and liaison with state and federal agencies. Developed primary pediatric and dental care service delivery model for two elementary schools in Hartford serving approximately 2000 children. Created organizational and financial foundation for school based health clinics in Hartford Public School System that has supported services up to the present time; grant funding, 1975-1982

Project Director:
A Method for Monitoring the Quality of Care of Pediatric Nurse Associates, research project, funded by the Nursing Research Branch of U.S. Department of HEW to the Department of Behavioral Sciences, University of Connecticut Health Center. Responsible for sample recruitment, data collection, project management, and data analysis, 1973-1975

Research Director:
Program and staff evaluation for community mental health agency, Adolf Meyer Zone Center, Illinois Department of Mental Health, 1968-1969

Research Associate:
Community Health Care Center Plan, New Haven, Connecticut, November 1971-February 1972

Research Assistant:
Career of Mental Patient Study, University of Iowa, 1967

CONSULTATION/TRAINING:

Workshop Facilitator and Consultant to Women and Health Task Force of the Network: Towards Unity for Health (funded by Global Health Education, Training and Service, GHETS, 2003 to present.

Consensus Building Group to Develop Cultural Competency Curricular Modules, Office of Minority Health, Department of Health and Human Services, and American Institute of Research, Washington, D.C. March 18-19, 2002

Faculty and Mentor for Community Campus Partnerships for Health (CCPH) Advanced Service Learning Institute in Soquel, CA, January 26-29, 2002.

Community Campus Partnerships for Health (CCPH) consultant for Fan Fox and Leslie R. Samuels Foundation, Evaluation of the Urban Health Initiative of the New York Academy of Medicine, 2001-2002.

World Health Organization, Western Pacific Region, Short-Term Consultant on Child Health and Rehabilitation, Malaysia, March, 1999

Robert Wood Johnson Foundation, National School Health Program, 1978-1982

Community Life Association, Neighborhood Life Center Evaluation Project Hartford, Connecticut, 1974-1976

United Newhallville Mental Health Referral Service, New Haven, Connecticut, 1970

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EDUCATION:

MPH, Tulane University School of Public Health and Tropical medicine, International Health Planning and Evaluation/Health Education - May, 1987.
BA, Syracuse University, International Relations - May, 1985.
Training Workshops: Reproductive Health and Development (Gates Institute for Pop. and RH), Community Based Family Planning, Maternal and Newborn Care, AIDSCAP/Lessons Learned, Nutrition and Micronutrients, Pneumonia Case Management, Integrated Management of Childhood Illness, Quality Assurance, Program Evaluation, Participatory Rural Appraisal and Participatory Learning and Action, Knowledge Practice and Coverage Survey Methodology, Child Survival Project Manager's, Emergency Preparedness and Disaster Assessment - 1996-2006.

PROFESSIONAL EXPERIENCE:

November 2003 – July 31st 2006 **CARE International, ACQUIRE Project - Global**

Senior Technical Advisor for Community Linkages. Provide technical and programmatic assistance to the projects funded under ACQUIRE, particularly in the area of community mobilization around Family Planning/Reproductive Health information and service utilization, the building and development of community participation and ownership as stakeholders in health, and strengthening of linkages between communities and health facilities. Support the design, implementation, monitoring and evaluation of the ACQUIRE projects in different countries, as well as facilitate the sharing of lessons between ACQUIRE partners and other actors. Where projects are located in Africa, and Latin America, ensure close communication and collaboration of efforts at the country and ACQUIRE headquarters level. Development of technical and guidance material on community mobilization and participation for implementing partners and ACQUIRE staff, conduct trainings and strengthen the technical skills of field partner staff in the design, implementation, use of participatory tools and techniques, monitoring and evaluation of community FP/RH programs Maintain relationships with donors in the regions. ACQUIRE country experiences include Kenya, Tanzania, Guinea, Bolivia and Honduras.

April 2002 – October 2003

Independent Consultant. Health, Child Survival, FP/RH and HIV program planning, design, proposal writing, training and capacity-building, assessments and evaluations; including qualitative **a**nd quantitative research, data analysis and reporting.
September 2001 – March 2002

Save the Children, Vietnam

Program Specialist. Responsible for the overall management, technical guidance and capacity-building support to the Vietnam Field Office health and education programs. Supported staff in strategic planning, program development and design, proposal writing, monitoring and evaluation. Also played a lead role in coordinating SC Alliance activities in Emergency Preparedness and Response.

January – August 2001 **Save the Children, Nicaragua**

Deputy Field Office Director. Responsibilities included: Overall program planning, monitoring and supervision, quality control, documentation and budget management; new program development, team-building, networking with government Ministries, local and international NGOs, donor liaison and reporting. Programmatic areas of focus: Health and Child Survival, Food Security, Water and Sanitation, Early Childhood Education, and Emergency Response.

October 1995 - December 1999 Africare, Washington DC

Regional (Southern Africa) Health and Child Survival Program Manager/Headquarters. Program areas included: HIV/AIDS/STI prevention and management, family planning, maternal health, nutrition, food security, and child survival. Responsibilities included: Identifying program development opportunities, design and proposal writing, donor networking, program support, field staff and consultant recruitment. Technical assistance to programs in the field included: development of detailed work and implementation plans, budget development and oversight, training, establishment of monitoring and information systems, quantitative and qualitative data collection, co-leading mid-term and final evaluation activities, liaising and collaborated with government Ministries, local and international NGOs and community based organizations. **Extensive work and program support in the following countries: Burkina Faso, Ivory Coast, Tanzania, Malawi, Zimbabwe, Zambia, Angola, Mozambique, South Africa.**

May 1990 - December 1994 International Child Care, Haiti

Program Coordinator, Southern Haiti. Responsible for the Regional Office of Les Cayes (total staff of 32), including the management and technical oversight of the Community Health Promotion and Child Survival Projects. Directly supervised 9 administrative and technical staff, and recruited 20 project personnel over the period of almost 5 years. Managed annual budgets totaling $400,000; monitored monthly expenditures, assessed petty cash reports. Technical support included: the supervision of baseline survey and population census activities, needs assessments and community analysis; training of health personnel in non-formal education techniques; organizing and assisting with training seminars for community-based volunteers and Traditional Birth Attendants; assistence with the establishment of health posts for vaccination, education and growth monitoring services; assistence with community organization efforts in water and sanitation, income-generating activities, and adult literacy.

October 1987- December 1989 MOH, Western Samoa, South Pacific

Assistant Project Manager for the MCH/FP Project, Family Welfare Section. (Peace Corps Volunteer). Responsible for the overall management and technical oversight of project activities. Program support included: supervision of MCH/FP public health nurses in the rural areas; distribution of contraceptives and MCH materials to 50 rural health centers; monitoring record-keeping by nursing staff, organizing training seminars for service –providers; establishing follow-up of family planning dropouts; designing and implementing MCH/FP health education activities for women's groups; launching audio-visual education activities; developing a health education bulletin board and health information handouts for antenatal and family planning clients.

April 1986 - October 1987 **Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana.**

Research Assistant. Department of Biostatistics & Epidemiology

LANGUAGE ABILITY:
English (Native); French (Native); Spanish (Fluent); Haitian Creole (Fluent);
Kiswahili (Fair).

Annex D: Interview Guides

COMMUNITY QUESTIONAIRRE GUIDE
[VDC, Mahalla, Schools]

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

Community Mobilization

1. What things happened in this community as a result of HF?

2. Did this (group) exist before HF?
If yes, does it receive government support?
If yes, from another NGO/grant?

3. Who are the people who participated (group)? (#, ages, gender, occupation, villages/areas represented, leadership roles in community)

4. How often did your (group) meet? Are the minutes of meetings?

5. How did you get people to come to your meetings? (word of mouth, announcements,

6. How did you get people to come to your meetings? (word of mouth, announcements, food, tea…)

7. What things about your meetings worked well?

8. What would have made the meetings, getting people to the meetings better?

9. What projects did your (group) work on? (Tj: BP and ETF&P; Uz?

10. What were the outcomes of these projects?

11. Which projects worked well? Why?

12. Which projects did not work so well? Why?

13. Are there other NGO projects going on in this area? What are they?

14. Will your (group) continue to meet?

If yes, how often, how will people meet?
What will you need to do to make sure they will continue to participate?
If no, why not?

15. Will your projects continue after the HF grant ends?

16. Who is responsible for making sure this happens?

17. How is your group involved?

18. Are there other organizations in your community that will help make the projects happen in the future?

19. In # years do you think these activities will still be happening?

Why or why not?

Communication for Behavioral Change [*for CtC]
(Tj was IMCI incorporated in community level? Some of the topics, EBF, BF during illness)

20. Did you attend health education sessions?*

21. What were the topics?*

22. Did you share this learning with other people (adults, children, women)?*
How did you do this?*

23. Do you think community practices (from topics above) changed as a result of this project?

24. Could you give some specific examples of how this changed?

25. What made this work?

26. What were the problems? What did you do about them?

27. In # years do you think that people will still be doing (bf during illness, using contraception, preventing STI, EBF, taking sick child to health clinic….)?

Capacity Building – Strengthening Local Partner Organizations

28. Has your (group) taken any action to fix problems identified through HF?

29. Please give examples (hand washing stations at school or health facility, transport funds for sick children, or moms…have they expanded on these?)

Capacity Building – Health Facility Strengthening

30. Where is the closest hcf (lhcf)?

31. Who is director of lhcf?

32. Do you/your group meet with staff from lhcf?
If yes, how often?

33. Do they ask your group to give comments/suggestions on what they are doing/planning?

Capacity Building – Health Worker Performance

34. What kinds of contraceptives can you get at the health clinic?

35. For what problems do people take their child to the health clinic?

36. Why should pregnant women go to the health clinic?

37. Has this changed since HF?
How?

38. What does the visiting nurse do when she visits?
Has this changed?
How?

CORE/TAG QUESTINAIRRE GUIDE

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

Programmatic Interventions

1. What is your role/activities?

2. What is your relationship(involvement) with the project?

3. How long have you been involved with the project?

4. Have you visited the project sites/activities?

5. What is your opinion of the project approach/design to work at the Oblast level?

6. Has the project had an impact at the national level? (Explain).

7. What are the project's contribution's to the health reform process?

8. Has this grant influenced/effected other implementing agencies or government partners?

9. What do you recommend for future activities of this nature (proposals)? *(Core only*).

Communication for Behavioral Change

1. Are you aware of the project's health education activities, and what they were attended to accomplish?

2. (Rayon Level) Do you feel that the project accomplished behavioral change at the community level?

Capacity Building – Strengthening Local Partner Organizations

1. What kind of training/workshops have you benefited from through the HF project?

2. How have project activities such as roundtables/meetings contributed to your capacity?

Policy

1. How did the HF project influence national policy?

2. Has the project had an impact at the national level? (Explain).

Sustainability Strategy

1. What plans do you have to continue with activities after the end of the project?

2. What challenges will you face to continue with activities (such as training, monitoring and supervision)? (what they will and will not be able to support with current resources).

3. Do you think that you will continue to function after the end of the project? (Explain).

(Doctors, nurses, feldshars, midwives, patronage nurses)

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

1. How long have you worked here? _____
2. Do you know what the Healthy Family was trying to achieve? Correct / Incorrect
3. Did you receive any training by the Healthy Family project? YES NO
4. If yes, what trainings did you participate in?

IMCI
Rep. Health
Antenatal care
Nutrition and Anemia
Normal delivery
Management of complications during delivery
C-IMCI
PMTCT
H-IMCI
Infection Prevention
Live birth definition
Tools of improving management of health care services (baby matrix)
Supportive supervision
Essential newborn care
Neonatal resuscitation
Other _____

5. What skills/knowledge did you learn from these training courses?

6. In your opinion, how beneficial were these trainings to you?

7. Have you been in able to use any of the skills /knowledge in your current work?

YES NO

8. If yes, which new skills do you use the most?

9. Is there anything that prevents you from using your new skills and knowledge related to the Healthy Family training you received? (like availability of supplies, drugs, materials)

10. What other skills would you like to learn that would help improve your work?

11. Do you have all the materials, supplies, and drugs that you need to do your work?

12. After your training, did any one come and check your work? YES NO

13. If yes, did you receive feedback regarding your work? YES NO

14. Was that visit useful in your opinion? YES NO

15. Did the project provide you with any materials or supplies to help you with your work?

16. If yes, what materials?

17. Were these useful?

18. Do you still have any of these materials?

For Patronage Nurses

1. Please describe your work at the community level? (How often do you go, what do you do, who do you meet, for what reasons, what services do you provide?)

2. In order for the pregnant woman to be healthy what behaviors do they need to have?
Antenatal consultations
Delivery at maternity house or at home with a health provider
Proper nutrition during pregnancy
Seeking care if they see danger signs (esp. Anemia)

3. In order for a baby to be healthy, what behaviors does a mother need to have?
Exclusive breastfeeding up to 6 months
Vaccination
Care seeking in case of danger signs
Give more or same feeding if the baby is sick
Beginning complementary feeding after 6 months

4. What do you do to promote these behaviors among mothers?
Home visits
Group health education
Hand out promotional materials
make referrals to the health facility
other

5. Did the training you received by the Healthy Family project help you to promote these behaviors? YES NO

6. If yes, in what ways?

7. In the last week how many community visits did you make? ____

8. In the last week how many young children did you see? _____

Doctors

Nurses

Midwives

MOH QUESTINAIRRE GUIDE

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

Programmatic Interventions

1. Are you aware of what the project was trying to achieve?

2. What is your role/activities?

3. What is your relationship (involvement) with the project? Have you been kept informed about project plans and activities?

4. How long have you been involved with the project?

5. Have you visited the project sites/activities?

6. What is your opinion of the project approach/design to work at the Oblast level? (*National level only)*

7. What changes have you seen, if any in health services since the beginning of the project *(Oblast and Rayon levels only).*

8. What are the project's contribution's to the health reform process? *(national level only)*

9. Has this grant influenced/effected other implementing agencies or government partners? (N*ational level only)*

10. What do you think are the project strengths?

11. What were the project weaknesses?

12. Were there areas that were not addressed by the project that should have been?

13. What do you recommend for future activities of this nature (proposals)?

14. Discuss results and factors influencing results (per country)

Communication for Behavioral Change

3. Are you aware of the project's health education activities, and what they were attended to accomplish?

4. (Rayon Level) Do you feel that the project accomplished behavioral change at the community level?

Capacity Building – Strengthening Local Partner Organizations

3. What kind of training/workshops have you benefited from through the HF project?

4. How have project activities such as roundtables/meetings contributed to your capacity?

Capacity Building – Health Facility

1. How has the project contributed to HF strengthening?

2. How have the outcomes of HFAs affected your planning and decision-making?

3. What curricula have been developed with the support of the HF project? (All levels)

4. What tools have been developed with the support of the HF project? (National technical staff, Olast). Are these being used in any other Oblast (national)? Are these being used currently? (project site). How often are these tools implemented?

5. What communication materials have been developed with the support of the project?

4. How has the capacity of your staff changed with the support of the project?

6. How do you monitor performance of trained personnel? (Oblast/Rayon supervisors)

7. What are you doing to maintain the skills of personnel? (Oblast/Rayon supervisors).

8. Do you have problems with lack of drug and equipment supplies? (Explain)

9. Have linkages been established between the HF and communities as a result of project activities? If yes, how?

Capacity Building – Health Worker Performance

1. Did training provided by the project result in improved health worker performance? If yes, explain. (Oblast and Rayon trainers, Managers)

2. Did monitoring activities result in improved health worker performance? If yes, explain. (Oblast and rayon levels).

3. What are barriers/problems to health workers performing according to training protocols?

Policy

3. How did the HF project influence national policy?

4. Has the project had an impact at the national level? (Explain).

Information Management

1. Was there a systematic way of collecting, reporting and using data at all levels?

2. Is your project staff sufficiently skilled to continue collecting data after the end of the project?

3. To what extent did the project strengthen government data collection systems?

Sustainability Strategy

4. What plans do you have to continue with activities after the end of the project?

5. What challenges will you face to continue with activities (such as training, monitoring and supervision)? (what they will and will not be able to support with current resources).

6. Do you think that you will continue to function after the end of the project? (Explain).

OTHER GROUP QUESTIONAIIRE GUIDE

Date		**Person(s) Interviewed**	
Location		**Person conducting interview**	

[INSERT GROUP NAME HERE]

Information Needed	**Suggested Questions or Queries**
Progarmmatic Interventions - Discuss the results and outcomes of the program as measured by comparison of the baseline and final evaluation surveys. - Describe factors affecting achievement of program objectives and outcomes. - For objectives not fully ahcievd, discuss contributing factors. - For each intervention, what are the main successes and lessons learned. - Describe how the lessons leanred will be applied to future activities. - Discuss potential for scale-up or expanindg the impact of intervention areas.	
Community Mobilization - How effective was the approach for community mobilization - Were the objectives met for community mobilization - What lessons were learned for future community mobilization efforts. - Is there demand in the community for program activities to continue? How was this measured? - What are the plans for sustaining these activities once the program closes? - Are the sustainability plans realistic - Summary of findings, conclusions and lessons learned.	
Communication for Behavioral Change - How effective was the approach for	

communication and behavior change? - Were the behavior change objectives met? - What were the lessons learned? - How will these behaviors be sustained one the program closes? - Are the sustainability plans realistic? - How was the impact of BCC interventions measured/evaluated? - Summary of findings, conclusions and lessons learned.	
Capacity Building – Strengthening the PVO (Collaborating Parners) - The external reviewers will assess the effectiveness of Project Hope in leading the consortium and the lessons learned. - How has this grant improved the capacity of Project HOPE to design and implement effective multi-partner projects? How have effects of this grant influenced other programs operated by the PVO? - Summary of findings, conclusions and lessons learned.	
Capacity Building – Strengthening Local Partner Organizations - Describe the outcomes of any assessment, formal or informal, conducted at the outset and conclusion of the program to determine the organizational capacities of local partners. - How have the organizational capacities of the local partner changed since the beginning of the program? What factors/interventions have most contributed to those changes? - What are the best practices and lessons learned in capacity building of local partners? - Summary of findings, conclusions and lessons learned.	
Capacity Building – Health Facility Strenthening - How effective was the approach for improved management and services at the health facilities? - What tools did the program use for health facility assessments? Were the tools effective	

for measuring change? - What were the lessons learned? - What are the plans for sustaining these activities once the program closes? Are the sustainability plans realistic? - Discuss linkages between these facilities and the communities. - Summary of findings, conclusions and lessons learned.	
Capacity Building – Health Worker Performance - How effective was the approach for strengthening health worker performance? - Were the performance objectives met? - What were the best practices and lessons learned? - What are the plans for sustaining health worker performance once the program closes? - Are the sustainability plans realistic? - Were the tools used to assess the results of improving health worker performance sensitive enough to measure change over the life of the program? - How did the program address the gaps between performance standards and actual performance? - Summary of findings, conclusions and lessons learned?	
Training - How effective was the training strategy? - Were the training objectives met? Estimate numbes and types of people trained. - What evidence is there that suggests that the training implemented has resulted in new ways of doing thins, or increased knowledge and skills of the participants? - What were the best practices and lessons learned? - What are the plans for sustaining these training activities once the program closes? - Are the sustainability plans for training realistic? - Summary of findins, conclusions and lessons learned.	
Sustainability Strategy - Were any sustainability goals and objectives	

articulated? How did the initial sustainability plan (if there was one) evolve through the implementation of the project? - What is the status of the phase-over plan, and is it on schedule? - Have the approaches to building sustainability been successful? - Summary of findings, conclusions and lessons learned.	

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

Red Crescent Staff and Volunteers
Oblast branch of Red Crescent - Uz- Tj

1. What was your position in the Red Crescent? Staff Volunteer

2. Are you still working for Red Crescent? YES NO

3. If not, why not?

4. How long did you work with the Healthy Family Project? _____

5. What were the objectives of the Healthy Family Project?

6. What was RC's role in achieving these objectives?

7. What strategies/activities did RC undertake in an effort to achieve these objectives?

8. Did any of these activities seek to change health behaviors among community member?

   YES NO DON'T KNOW

9. If so, what behaviors?

10. In your opinion, how effective were RC's efforts in helping to achieve the project objectives?

11. What evidence do we have that these efforts were effective?

12. In total, how many communities were eventually involved in all the RC activities.

13. What kind of support did the Red Crescent provide to the community groups?

14. Are any of the activities undertaken by the Red Crescent under the Healthy Family project still going on? YES NO DON'T KNOW

15. How many RC staff were trained by Healthy Family? ____

16. In what topics were the RC volunteers trained?

17. How many RC volunteers were trained in total? ____

18. Do you personally receive any training? YES NO

19. If yes, what training did you receive?

20. What materials, if any, did you receive as a RC volunteer?

21. What are you currently doing? (any work at the community level?)

22. In your current work are you using any of the skills that you learned through the Healthy Family/RC training?

23. In your current work are you using any of the materials that you received through Healthy Family/RC?

Small grants NGOs – Uz. and Tj.

Date		**Person (Name and Title) or Type of Group Interviewed**	
Country/ Location		**Person conducting interview**	

Check to see what the nature of the small grants was. What were they attempting to achieve? Behavior Change? Awareness Raising; etc.

1. What kind of assessments of the small grant NGOs were conducted and how was that used and by whom?

2. What training did you receive from Futures Group/Healthy Family?
   Management
   Interactive Skills/Strategic Planning Fund Raising (proposal Writing)

3. How many people in your NGO were trained? _____

4. What materials did you receive from the project?

5. Did you receive any equipment from the project? YES NO
   If so, what type?

6. What is the status of this equipment now?

7. What was the nature of your activity, funded by Futures/HF?

8. Is your NGO still operational? YES NO

9. If so, what type of activities are you currently implementing?

10. In what ways has the training you received by the Healthy Family project helped you in your current activities?

11. How did you measure the impact of your project?

12. In what other ways could the capacity of your organization have been improved?

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

STAFF

Programmatic Interventions

1. What are the objectives of the healthy family program in (country)?

2. What do you feel the program has accomplished?

3. What did you expect to accomplish but could not and why?

4. Are you familiar with the results of the final (or mid-term) survey?

5. [Talk about those indicators where targets were exceeded or not met] – Probe staff to get their understanding of why targets were exceeded or not met.

6. What could be done differently to better achieve the anticipated results?

7. If you were to continue program for another five years what intervention would you absolutely continue?

8. What would you do, but do differently.

9. What would you discontinue

Community Mobilization

1. What (if any) activities were conducted to mobilize communities in support of project objectives?

2. Who worked with those community partners?

3. How effective was the approach for community mobilization?

4. Do you think that the community was satisfied with program activities?

5. If yes, what evidence do you have that they were satisfied (if there is documentation such as community assessments – ask to see it)

6. Do you think that community mobilization activities had an impact on the program outcomes? - If yes, what evidence do you have that supports that belief. (Ask to see documentation if it exists)

7. If you were to continue doing community mobilization what would you do the same or differently and why?

Communication for Behavioral Change

1. What behavioral change activities were implemented and how? [be sure to probe to see if it is understood if they understand the difference between health promotion/education and behavioral change]?

2. How were you (HF partner) involved in the behavioral change activities?

3. [If indicators suggests certain behaviors changed dramatically or did not change much, probe staff to see why they think behaviors were or were not changed. If not already covered in sections above]

4. How will these behavior changes be sustained after the project activities end?

5. If you were to continue doing BCC what would you do the same or differently and why?

Capacity Building – Strengthening the PVO (Collaborating Parners)

1. Has this program helped strengthen you as an organization? [If yes, probe staff to describe how it has strengthened the organization]

2. Has there been any internal system or tools (admin/finance/tech) developed under Health Families that has been useful in other programs or areas of management?

Capacity Building – Strengthening Local Partner Organizations

1. How has this program strengthened the MOH (and/or other local partners)?

2. Do we have any evidence to show that they have been strengthened [ask to see documentation]

3. How have our partner's capacities change?

4. What factors/interventions have most contributed to those changes?

5. If you were to continue doing partner strengthening what would you do the same or differently and why?

Capacity Building – Health Facility Strengthening

1. How did this program contribute to strengthening health facilities?

2. How effective do you think the program was in strengthening health facilities?

3. How have improvements in health facilities been monitored and measured [ask to see any documentation that measures health facility strengthening]

4. If equipment was provided, what was provided and how has that improved services [ask to see any documentation that provides evidence that the equipment donations have helped improve services] How have our partner's capacities change?

5. What are the plans or means for sustaining these activities once the program closes?

6. If you were to continue doing partner strengthening what would you do the same or differently and why?

Capacity Building – Health Worker Performance

1. How did this program contribute to strengthening health worker skills?

2. How effective do you think the program was in strengthening health worker skills?

3. How have improvements in health worker skills been monitored and measured [ask to see any documentation that measures health facility strengthening]

4. What are the plans or means for sustaining and continuing skills development of staff?

5. If you were to continue doing health worker skills strengthening what would you do the same or differently and why?

Training

1. What was the training strategy for this program?

2. How effective do you think the training strategy was?
3. Were the training objectives met? [ask to see training plan vs. actual trainings conducted]
4. What evidence is there that suggests that the training implemented has resulted in new ways of doing things, or increased knowledge and skills of the participants?

5. What are the plans for sustaining these training activities once the program closes?

6. If you were to continue doing health worker skills strengthening what would you do the same or differently and why?

Sustainability Strategy

1. Was there any plan or strategy within the program design to address sustainability? [ask what it was]

2. How did the initial sustainability plan (if there was one) evolve through the implementation of the project?

3. What is the status of the phase-over plan, and is it on schedule?

4. If you had more time, would you do anything different to address sustainability?

Planning

1. Describe the program planning process among the HF partners. Who was involved? How often was it done?

2. Do you think that the planning process was collaborative?

3. Do you think the planning process was effective?

4. If you were to implement this program again, would you change they way planning is conducted and how?

Staff Training

1. Have staff been trained through this program? If so what trainings have they received?

2. What evidence is there that staff has applied these skills both within within the program and in another context?

3. What resources were dedicated to staff training?

4. What training do staff think could have received that would have helped improve their performance under this program that they did not receive?

Supervision of Program Staff

1. What kind supervision existed in this program [both Prim-to-Sub supervison and supervisory structures within each organization]

2. Is the supervisory system fully institutionalized and can it be maintained?

3. Has there been any efforts to strengthen supervision during the course of this project? If so, how?

Human Resources and Staff Management

i. How have staffing issues affect the project's implementation?

ii. Has the staffing pattern or structure changed during the life of the program. If so why?

iii. Have there been any interpersonal or staff related issues that you have experienced? If so, what?

iv. What has been the level of staff turnover throughout the life of the program and the impact it has had on program implementation?

Financial Management

1. How has project funding and the changed in project funding affected programs?

2. How were budget cuts managed internally and between Prime/Sub partners?

3. Could the budget cut process been bettered managed? If so how?

4. Were there any other problems associated with financial management internal to your organization or between sub/prime partners?

Logistics

1. What kinds of materials did the project need to purchase/procure for the program?

2. How effective was the procurement process/system?

3. What ways, if any, could procurement be improved?

Monitoring and Evaluation

[ASK THESE QUESTION SEPARATELY TO M&E PERSOM IF THEY EXIST]

1. Was there a systematic way of collecting, reporting and using data at all program levels within your organization? Cite examples of how program data was used to make management or technical decisions.

2. Has this program influenced or changed they way the MOH collects, reports and analyzed data? If so, how?

3. Do you have any evidence that data is being used for decision-making at various levels within the MOH? [ask to describe or see evidence].

4. What deficiencies or weaknesses do you think still exists within your own collection/use of data and within the MOH collection/use of data?

5. Did the program conduct or use special assessments, mini-survey focus groups, etc. to solve problems or test new approaches? Give examples of the research, use of data, and outcomes?

6. Do the program staff, headquarters staff, local level partners and the community have a clear understanding of what the program has achieved? If yes, how has information been disseminated/shared with them.

7. How have the programs monitoring and impact data been used beyond this program?

Technical and Administrative support

Within Consortia Organization

1. What level of technical and administrative support have you received from your regional or headquarters office [how frequent are visits, emails, telephone calls]

2. Beyond general backstopping, what assistance have you received from them that has positively contributed to the effectiveness or quality of this program?

3. How could regional or HQ improve their support to this program?

Between Prime/Sub

1. What level of technical and administrative support have you received from Project HOPE

2. Beyond general backstopping, what assistance have you received from them that has positively contributed to the effectiveness or quality of this program?

3. What challenges, if any, have there been in your relationship with Project HOPE and what factors do you think have contributed to that [ask them to be specific]

4. How could you as Sub better manage that relationship?

5. How could Project HOPE as Prime better manage that relationship?

STEERING COMMITTEE QUESTINAIRRE GUIDE

Date		**Person(s) Interviewed [Name/Position]**	
Location [Country/Oblast/Rayon/Community		**Person conducting interview**	

Programmatic Interventions

1. Are you aware of what the project was trying to achieve?

2. What is your role/activities?

3. What is your relationship (involvement) with the project? Have you been kept informed about project plans and activities?

4. How long have you been involved with the project?

5. Have you visited the project sites/activities?

6. What is your opinion of the project approach/design to work at the Oblast level? (*National level only)*

7. What changes have you seen, if any in health services since the beginning of the project *(Oblast and Rayon levels only).*
8. What are the project's contribution's to the health reform process? *(national level only)*

9. Has this grant influenced/effected other implementing agencies or government partners? (N*ational level only)*

10. What do you think are the project strengths?

11. What were the project weaknesses?

12. Were there areas that were not addressed by the project that should have been?

13. What do you recommend for future activities of this nature (proposals)?

14. Discuss results and factors influencing results (per country)

Capacity Building – Strengthening Local Partner Organizations

1. What kind of training/workshops have you benefited from through the HF project?

2. How have project activities such as roundtables/meetings contributed to your capacity?

Capacity Building – Health Facility Strengthening [Tech Members]

1. How has the project contributed to HF strengthening?

2. How have the outcomes of HFAs affected your planning and decision-making?

3. What curricula have been developed with the support of the HF project? (All levels)

4. What tools have been developed with the support of the HF project? (National technical staff, Olast). Are these being used in any other Oblast (national)? Are these being used currently? (project site). How often are these tools implemented?

5. What communication materials have been developed with the support of the project?

5. How has the capacity of your staff changed with the support of the project?

6. How do you monitor performance of trained personnel? (Oblast/Rayon supervisors)

7. What are you doing to maintain the skills of personnel? (Oblast/Rayon supervisors).

8. Do you have problems with lack of drug and equipment supplies? (Explain)

9. Have linkages been established between the HF and communities as a result of project activities? If yes, how?

Capacity Building – Health Worker Performance [Tech Members]

1. Did training provided by the project result in improved health worker performance? If yes, explain. (Oblast and Rayon trainers, Managers)

2. Did monitoring activities result in improved health worker performance? If yes, explain. (Oblast and rayon levels).

3. What are barriers/problems to health workers performing according to training protocols?

Sustainability Strategy

1. What plans do you have to continue with activities after the end of the project?

2. What challenges will you face to continue with activities (such as training, monitoring and supervision)? (what they will and will not be able to support with current resources).

3. Do you think that you will continue to function after the end of the project? (Explain).

Annex E: Trainings Conducted under Healthy Family

Number of trained HCW in Uzbekistan

Phase I

The type of the training and specialties of trained HCW	The number of trained HCW
IMCI	
Doctors	333
Nurses (various)	11
Other (lead specialists)	6
Total	**350**
Hospital IMCI	
Doctors	**19**
IMCI (ToT)	
Doctors	**38**
IMCI (monitoring)	
Doctors	9
Other (lead specialists)	3
Total	**12**
C – IMCI	
Nurses (patronage)	872
Midwives	17
Doctors (trainers, supervisors)	34
Total	**944**
C – IMCI (ToT)	
Nurses (patronage)	7
Midwives	1
Doctors	27
Other (lead specialists)	2
Total	**38**

RH/STI	
Doctors (Ob/Gyn)	232
Midwives	272
Nurses (various)	106
Other (lead specialists)	10
Total	**620**
RH/STI (ToT)	
Doctors (Ob/Gyn)	39
Midwives	1
Nurses (various)	4
Other (lead specialists)	6
Total	**50**
RH/STI (monitoring)	
Doctors (Ob/Gyn)	**16**
RH/STI (adolescents)	
Doctors (Ob/Gyn)	**16**
Peer to peer (adolescents RH/STI)	
Schoolboys	**132**
BF (main course)	
Doctors	52
Midwives	15
Nurses (various)	13
Other (lead specialists)	1
Total	**81**
BF	
Doctors	208
Midwives	248
Nurses (various)	592
Other (lead specialists, admin,staff)	23
Total	**1071**

BF (ToT)	
Doctors	15
Midwives	2
Nurses (various)	3
Other (lead specialists)	1
Total	**21**
BF (monitoring)	
Doctors	14
Midwives	2
Nurses (various)	1
Other (lead specialists)	6
Total	**23**
MPS (main course)	
Doctors	35
Midwives	22
Nurses (various)	3
Other (lead specialists)	8
Total	**68**
MPS (MCPC – 18 days)	
Doctors	43
Midwives	45
Nurses (various)	2
Other (lead specialists)	1
Total	**91**
MPS (MCPC for medical universities and colleges)	
Doctors	21
Midwives	1
Total	**22**
MPS (antenatal care)	
Doctors	85
Midwives	117
Nurses (various)	16
Total	**218**
MPS (antenatal care – ToT)	
Doctors	16
Midwives	7
Total	**23**
MPS (essential neonatal care)	
Doctors	90
Midwives	1
Nurses (various)	6
Other (lead specialists)	3
Total	**100**
MPS (neonatal resuscitation)	
Doctors	58
Midwives	40
Nurses (various)	31

Total	**129**
MPS (neonatal resuscitation – ToT)	
Doctors	**16**
MPS (ToT)	
Doctors	10
Midwives	6
Total	**16**
MPS (monitoring)	
Doctors	19
Midwives	4
Total	**23**
IP	
Doctors	405
Midwives	108
Nurses (various)	128
Other (lead specialists, SES)	60
Total	**701**
IP (ToT)	
Doctors	50
Midwives	13
Nurses (various)	9
Other (lead specialists, SES)	2
Total	**74**
IP (monitoring**)**	
Doctors	28
Midwives	7
Nurses (various)	3
Other (lead specialists, SES)	1
Total	**39**
Skills of using computers	
Doctors	14
Other (lead specialists)	2
Total	**16**

Management of the system of health services	
Doctors	17
Midwives	5
Other (lead specialists, SES)	3
Total	**25**
Application of Data Base	
Doctors	1
Midwives	1
Other (lead specialists)	2
Total	**4**
Anemia & Nutrition	
Doctors	138
Midwives	12
Nurses (various)	71
Other (lead specialists)	5
Total	**226**
Anemia & Nutrition (ToT)	
Doctors	27
Nurses (various)	5
Other (lead specialists)	1
Total	**33**
LQAS	
Doctors	21
Other (lead specialists)	6
Total	**27**
Vitamin A	
Doctors	67
Midwives	34
Nurses (various)	71
Other (lead specialists)	8
Total	**123**
Young parents school	
Doctors	12
Midwives	19
Nurses (various)	1
Other (lead specialists)	1
Total	**33**

Adult audient education	
Doctors	37
Midwives	7
Total	**44**
GRAND TOTAL Phase I	**5482**

Phase II

The type of the training and specialties of trained HCW	The number of trained HCW
C-IMCI	
Doctors	19
Feldsher	40
Midwives	2
Nurses (various)	376
Other (lead specialists)	5
Total	**442**
C-IMCI (ToT)	
Doctors	12
Feldsher	1
Nurses (various)	9
Other (lead specialists)	4
Total	**26**
Community Health Training	
Midwives	1
Other (community members)	449
Total	**450**
Community Health Training (ToT)	
Other (community members)	29
Total	**29**
IMCI	
Doctors	159
Other (lead specialists)	6
Total	**165**
IMCI (monitoring)	
Doctors	14
Total	**14**

MPS - MCPC -12 days	
Doctors	62
Midwives	41
Nurses (various)	3
Other (lead specialists)	7
Total	**113**
MPS - MCPC-colleges & universities	
Doctors	45
Midwives	7
Nurses (various)	1
Other (lead specialists)	2
Total	**55**
Antenatal Care & Normal Delivery (TOT)	
Doctors	15
Midwives	7
Total	**22**
Antenatal Care	
Doctors	89
Feldsher	2
Midwives	145
Nurses (various)	11
Total	**247**
Mortality and Birth rate Database management	
Doctors	5
Midwives	4
Nurses (various)	1
Other (lead specialists)	13
Total	**23**
BF	
Doctors	74
Feldsher	7
Midwives	51
Nurses (various)	116
Other (lead specialists)	5
Total	**253**
BF (ToT)	
Doctors	18
Midwives	4
Nurses (various)	3
Total	**25**

BF (monitoring)	
Doctors	12
Midwives	7
Total	**19**
IMCI-Care for Development	
Doctors	15
Feldsher	1
Midwives	1
Nurses (various)	2
Total	**19**
Seminar on training HCW on working with population	
Doctors	9
Nurses (various)	6
Other (lead specialists)	33
Total	**48**
BABIES Matrix	
Doctors	11
Midwives	1
Nurses (various)	1
Other (lead specialists)	7
Total	**20**
Facilitative supervision	
Doctors	13
Other (lead specialists)	20
Total	**33**
LBD - 1-day for pathologists	
Other (lead specialists)	13
Total	**13**
LBD	
Doctors	132
Midwives	2
Other (lead specialists, statistics specialists)	13
Total	**147**
Normal Delivery	
Doctors	38
Midwives	114
Total	**152**

Essential Newborn Care	
Doctors	31
Nurses (various)	11
Total	**42**
IP	
Doctors	34
Midwives	19
Nurses (various)	28
Other (lead specialists)	14
Total	**95**
IP (TOT)	
Doctors	8
Nurses (various)	1
Other (lead specialists)	8
Total	**17**
KPC interviewers preparation	
Doctors	4
Feldsher	1
Midwives	4
Nurses (various)	16
Other (lead specialists)	9
Total	**34**
HFA specialists preparation	
Doctors	31
Total	**31**
PMTCT	
Doctors	76
Other (lead specialists)	3
Total	**79**
Newborn resuscitation (TOT)	
Doctors	11
Total	**11**
Newborn resuscitation	
Doctors	76
Midwives	43
Nurses (various)	10
Other (lead specialists)	1
Total	**130**

RH	
Doctors	68
Feldsher	1
Midwives	108
Nurses (various)	12
Other (lead specialists)	2
Total	**191**
Standards, indicators and protocol development	
Doctors	12
Other (lead specialists)	1
Total	**13**
Hospital IMCI	
Doctors	59
Other (lead specialists)	5
Total	**64**
Hospital IMCI (ToT)	
Doctors	27
Other (lead specialists)	8
Total	**35**
GRAND TOTAL Phase II	**3057**

Number of trained HCW in Tajikistan

The type of the training and specialties of trained HCW	The number of trained HCW
ARI	
Medical assistant	75
Doctor-other	9
Pediatrician	50
Health visitor	54
Pediatrician	50
Post nurse	1
Midwife-maternity hall	1
Midwife-postnatal branch	1
Midwife-visitor	15
Total	**206**
CDD	
Doctor-other	10
Medical assistant	70
Midwife-postnatal branch	1
Midwife-visitor	17
Pediatrician	50
Health visitor	65
Gynecologist	4
Post nurse	2
Other	1
Total	**220**
Malaria	
Doctor-other	21
Medical assistant	42
Midwife-postnatal branch	1
Midwife-visitor	20
Pediatrician	45
Health visitor	71
Gynecologist	4
Neonatology's	1
Post nurse	5
Total	**210**
IMCI	
Doctor-other	9
Medical assistant	38

Midwife-visitor	5
Pediatrician	60
Health visitor	20
Main nurse	2
Post nurse	2
Head nurse	3
Total	**139**
Basic Life Saving Skills	
Medical assistant	8
Midwife-postnatal branch	10
Midwife-maternity hall	50
Midwife-visitor	94
Pediatrician	6
Health visitor	65
Gynecologist	40
Post nurse	6
Total	**279**
TOT Life Saving Skills	
Gynecologist	13
Midwife-visitor	1
Midwife-maternity hall	5
Midwife-postnatal branch	1
Total	**20**
Family Planning	
Doctor-other	6
Medical assistant	54
Midwife-visitor	54
Pediatrician	8
Health visitor	67
Gynecologist	3
Head nurse	3
Head midwife	1
Nurse-other	1
Midwife-maternity hall	1
Total	**198**
FP Counseling	
Doctor-other	3
Medical assistant	31
Midwife-visitor	54
Pediatrician	8

Health visitor	40
Gynecologist	3
Head nurse	2
Total	**141**
Life Saving Skills Refresher	
Doctor-other	1
Medical assistant	3
Midwife-visitor	60
Pediatrician	4
Health visitor	31
Midwife-maternity hall	12
Nurse-other	1
Post nurse	3
Midwife-postnatal branch	1
Total	**161**
Revolving Drug Fund	
Health visitor	48
Pediatrician	18
Medical assistant	69
Doctor-other	5
Midwife-visitor	48
Gynecologist	4
Total	**192**
Infection Prevention	
Gynecologist	43
Midwife-maternity hall	18
Midwife-postnatal branch	5
Health visitor	12
Doctor-other	49
Post nurse	8
Head nurse	8
Main nurse	11
Nurse-other	9
Epidemiologist	14
Medical assistant	20
Pediatrician	31
Main midwife	2
Epidemiologist	14
Head midwife	4

Other	16
Total	**264**
Positive Deviance	
Pediatrician	5
Other	10
Health visitor	4
Gynecologist	7
Total	**26**
IMCI-monitoring-5days	
Pediatrician	10
Total	**10**
IP-TOT	
Midwife-maternity hall	4
Gynecologist	3
Doctor-other	2
Epidemiologist	3
Neonatology’s	1
Head nurse	1
Total	**14**
Safe Motherhood	
Health visitor	22
Midwife-maternity hall	21
Midwife-visitor	32
Head nurse	1
Gynecologist	14
Post nurse	8
Midwife-postnatal branch	1
Doctor-other	1
Medical assistant	11
Pediatrician	4
Main midwife	3
Main nurse	1
Total	**119**
C-IMCI	
Family doctor	2
Other	5
Doctor-other	3
Nurse-other	3
Pediatrician	7

Total	**20**
IMCI-TOT-4days	
Pediatrician	**11**
Community Mobilization	
Doctor-other	8
Gynecologist	5
Pediatrician	3
Midwife-visitor	1
Health visitor	1
Other	1
Total	**19**

Training Table from the beginning of the project HOPE HF Batken

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
IMCI				
04.07.2005	11	Providers Family Medical Group Practitioners **(FGP-OB/GYN doctors-3, doctors of general practitioner-12, pediatrist- 3)**	18	4 National Trainers
08.08.2005	6	Providers FGP (**doctors of general practitioner -8, pediatrist-1, therapeutist-1**	10	1 National Trainer 1 Project Trainer
12.09.2005	6	**FGP, FMC, OFMC-9 doctors**	9	2 Project Trainers
03.10.2005	6	**(FGP- doctor neonatology-1, doctors of general practitioner -8, pediatrist-2)**	11	2 Project Trainers 1 Rayon trainer
28.11.2005	6	Providers Family Medical Group Practitioners **(FGP-OB/GYN-1, doctors of general practitioner-4, pediatrist-3, surgeon-1, administrator of health facility- 1)**	10	2 Project Trainers 1 Rayon Trainer
06.02.2006	11	**FGP, FMC- 7 doctors, administrator of health facility-1**	8	2 Project Trainers 1 Rayon Trainer
27.03.2006	6	**FGP- OB/GYN-1, doctors of general practitioner-3, pediatrist-5, administrator of health facility- 1**	10	1 Project Trainer 1 Oblast Trainer
14.05.2007	11	Doctors, Family doctors from Centers of Family Medicines, FAPs, FPGs **FGP, TH, FMC-OB/GYN-1, doctors of general practitioner-1,**	14	1 National trainer from Jalalabat 1 Project Trainer 1 Rayon Trainer

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
		pediatrist-2, Doctor another-9, Therapeutist-1		
TOTAL on IMCI		**DOCTORS-87 Administrator of health facility -3**	**90**	
IMCI FOLLOW UP				
14.11.2005	5	Providers of Family Medical Group Practitioners Specialists of the Project Dep. Head of Oblast Family Medical Center (**TH, OFMC, FGP, Project HOPE- nurse -1, ob/gyn-2**, **doctors of general practitioner-5, pediatrist- 2, surgeon-2, doctor-another-1**)	13	1 Project Trainer 1 National Trainer
19.02.2007	5	Family doctors, feldshers, family nurses from Centers of Family Medicines, FAPs, FPGs **(OFMC, FMC, FGP, FAP- nurses-4, head nurses-2, doctors of general practitioner-2, feldshars-2, another-1**)	11	1 National Trainer from Bishkek 1 Project Trainer
TOTAL on IMCI Follow up		**Nurses-7 Doctors-14 Feldshars-2 Another-1**	**24**	
IMCI – FAMILY NURSES				
14.07.2006	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(feldshars-2, nurses-9, midwives-7)**	18	2 National Trainers 1 Jalalabat CS Project Expert 1 Project Trainer
21.08.2006	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(FMC, FGP, FAP-nurses-3, patronage nurse- 1, head nurse-5, mifwife-1, patronage**	12	3 Rayon Trainers

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
		midwife-1, midwife of maternity hall-1)		
06.11.2006	6	**FGP- head of nurses-3, nurse/midwives-11**	14	3 Rayon Trainers 1 Project Trainer
20.11.2006	6	**FMC, FGP- head of nurses-6, nurses-6**	12	3 Rayon Trainers 1 Project Trainer
18.12.2006	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(FGP, FAP- patronage nurses-9, nurse-1, head of nurses-1, patronage midwife-1, feldhsar-1)**	13	3 Rayon Trainers 1 Project Trainer
26.02.2007	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(FGP, FAP- nurses-8, patronage nurses-3, head of nurses-1, patronage midwife-2, feldshar-1)**	15	3 Rayon Trainers 1 Project Trainer
26.03.2007	6	Family Nurses from Centers of Family Medicines, **FAPs, FPGs (feldhsar-1, nurses-14)**	15	3 Rayon Trainers
02.04.2007	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(FGP, FAP- patronage nurses)**	15	3 Rayon Trainers
23.04.2007	6	Family Nurses from Centers of Family Medicines, FAPs, FPGs **(FGP, FAP- patronage nurses- 13, head of nurses-2)**	15	3 Rayon Trainers
TOTAL on IMCI –Family nurses		**Feldshars-4 Nurse/midwives-125**	**129**	
IMCI – FAMILY NURSES -TOT				
20.07.2006	4	Doctors, Nurse FMGP, Feldshers **(nurses-3, feldhsar-2, doctors-4, midwives-1)**	**10**	2 National Trainers 1 Jalalabat CS Project Expert 1 Project Trainer
REPRODUCTIVE HEALTH/FAMILY PLANNING				
18.07.2005	5	Nurse FMGP, Midwives	17	2 Jalalabat trainers

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
		(FMC, FGP, FAP-patronage nurses-6, head of nurses-2, patronage midwives- 2, midwives of maternity hall- 3)		
22.08.2005	5	Nurses of FMGP, Midwives **(FGP, FAP- nurses-11, patronage nurses- 1, head of nurses- 2, midwife-1, patronage midwives-1, ob/gyn-2)**	18	3 Local Trainers 1 Project Trainer
12.09.2005	5	**FAP, FGP, FMC-feldshars-2, midwives-3, nurses-10**	15	3 Local Trainers 1 Project Trainer
10.10.2005	5	**TH, FGP- nurses-7, patronage nurses-3, patronage midwives-4, midwife of maternity hall-1**	15	3 Local Trainers 1 Project Trainer
08.11.2005	5	**FGP- nurses-8, patronage nurses-4, head of nurses-1, midwives-4, patronage midwife-1**	18	3 Local Trainers 1 Project Trainer
13.02.2006	5	**FGP, FAP-nurses-3, patronage nurses-8, head of nurses-1, midwife-1, patronage midwife-1, feldshar-1**	15	3 Local Trainers 1 Project Trainer
20.02.2006	5	**FGP- patronage nurses-7, head of nurses-1, midwife-1, patronage midwife-3, head of midwives-1**	13	3 Local Trainers 1 Project Trainer
06.03.2006	5	**FGP-patronage nurses-9, head of nurses-3, patronage midwives-6**	18	3 Local Trainers 1 Project Trainer
03.07.2006	5	**FGP- ob/gyn-1, doctors of general practitioner-16**	17	3 Local Trainers 1 Project Trainer
14.08.2006	5	**FAP, FGP-feldhsar-1, midwives-5, nurses-7**	13	3 Local Trainers 1 Project Trainer
TOTAL on RH/FP		**Feldshars-4 Doctors-19 Nurse/midwives-136**	**159**	

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
TOT in RH/FP				
25.07.2005	5	**FGP, FAP, OFMC-midwives-2, nurses-7**	**9**	1 Jalalabat Trainer 1 National Trainers
MONITORING of RH/FP				
05.12.2005	5	**FGP, OFMC, TH-nurses-3, patronage nurses-1, patronage midwives-2, head of midwives-1, doctor of general practitioner-1, feldshar-1**	**9**	1 National Trainer 1 Project Trainer
SAFE MOTHERHOOD-ANTENATAL CARE				
13.06.2006	6	Doctors, Nurses, Midwifes from Centers of Family Medicines, FAPs, FPGs **(doctors-9, midwives-7, administrator of health facility-1)**	17	
31.07.2006	6	Doctors, Nurses, Midwifes from Centers of Family Medicines, FAPs, FPGs **FMC, FGP, OFMC-patronage nurses-1, head of nurses-1, patronage midwives-3, ob/gyn-5, neonotology-1, doctor of general practitioner-5, pediatrist-1, administrator of health facility-1.**	18	Bozova, Kurbanova, Jumanazorova
08.01.2007	6	**FAP, FPG-patronage nurses-9, head of nurses-1, patronage midwives-2, midwives of maternity hall-2, doctor of general practitioner-3, pediatrist-2, feldshar-1**	20	2 Rayon Trainers 1 Project Trainer
12.02.2007	6	**FMC, FGP, FAP-patronage nurses-4, head of nurses-2, patronage midwives-3, midwives of maternity**	23	2 Rayon Trainers 1 Project Trainer

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
		hall-1, doctor of general practitioner-9, pediatrist-3, feldshar-1		
25.06.2007	6	**FGP, FMC, FMC, OFMC, FAP- nurses-4, patronage nurses-5, patronage midwives-4, midwives of maternity hall-5, doctor of general practitioner-3, therapeutist-1, administrator of health facility-1**	23	2 Rayon Trainers 1 Project Trainer
TOTAL on SM/ANC		**Doctors-25 Administrator of health facility-3 Feldshar-1 Nurse/midwives-72**	**101**	
SAFE MOTHERHOOD-TOT				
07.08.2006	5	**Deputy head of OFMC employer of Project HOPE, FGP, FMC-patronage midwives-1, ob/gyn-7, doctor of general practitioner-2, administrator of health facility-1**	**11**	2 National Trainers 1 National Trainer
SAFE MOTHERHOOD: NORMAL AND COMPLICATED DELIVERIES				
09.04.07	10	**TH, FGP, Project HOPE Midwives-12, nurses-3, doctors-6, another-1**	**22**	2 National Trainers from Bishkek 1 National Trainer from Osh 1 Rayon Trainer
INFECTION PREVENTION				
19.06.2006	6	**TH, BOJH-nurses-4, head of nurses-3, head of midwiwves-2, ob/gyn-2, doctors-4, surgeon-2, feldhsar-1, administrator of health facility-4**	22	2 National Trainers from Uzbekistan 1 National Trainer 1 Project Trainer from Uzbekistan
26.06.2006	2	**Medical Staff at Leilek Territorial Hospital (nurses-15, midwives-3, administrator of health facility-2, doctors-11)**	31	2 National Trainers

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
28.06.2006	2	Medical Staff of Sulukta Territorial Hospital **Nurses-20, midwives-3, doctors-9, administrator of health facility-1**	33	2 National trainers
30.06.2006	2	**TH, FGP-nurses-6, head of nurses-4, midwives of maternity hall -3, head of midwives-1, ob/gyn-1, doctor-1, neonotology-1, pediatrist-1, surgeon-2, feldshar-3, administrator of health facility-2**	25	2 National trainers
17.07.2006	2	Medical Staff of Aydarken Territorial Hospital **(nurses-34, midwives-3, administrator of health facility-1, doctors-6)**	44	2 National Trainers
19.07.2006	2	Medical Staff of Kajamjay Territorial Hospital **(nurses-33, midwives-2, doctors-5, administrator of health facility-1)**	41	2 National Trainers
22.07.2006	2	Medical Staff of Kuzul-Kuya **TH-nurses-33, midwives-4, doctors-11, feldshar-1, administrator of health facility-1**	50	2 National Trainers
22.01.2007	6	Medical Staff of Isfana **TH-nurses-13, midwives-3, doctors-8, administrator of health facility-1**	25	1 National Trainer from Bishkek 1 Project Trainer
TOTAL on IP		**Doctors-64 Feldhsars-6 Administrator of health facility-12 Nurse/midwives-179**	**271**	
INFECTION PREVENTION FOLLOW UP				

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
30.10.2006	5	Doctors, Nurse, Midwifes from Territorial Hospitals, Sanitary Epidemiological Station (SES) **(Nurses-1, midwives-1, doctors-7, administrator of health facility-1)**	**10**	1 National Trainer from Bishkek 2 Trainer from HOPE HF Uzbekistan
NEW BORN CARE				
14.08.2006	6	Doctors, Nurses, Midwifes from Territorial Hospitals **(nurses-7, midwives-7, doctors-7, administrator of health facility-1)**	22	2 National Trainers from Bishkek
29.01.2007	6	Doctors, Nurses, Midwifes from Territorial Hospitals **(nurses-13, midwives-5, doctors-7)**	25	2 National Trainers from Bishkek
TOTAL on NEW BORN CARE		**Doctors-14 administrator of health facility-1 Nurse/midwives- 32**	**47**	
NEWBORN RESUSCITATION				
24.04.2006	2	Maternity house providers TH- **(nurses-5, midwives-3, doctors-11, administrator of health facility-2)**	21	1 National Trainer 1 Project Trainer 1 Jalalabat Trainer
27.04.2006	2	Maternity house providers TH- **(nurses-6, midwives-6, doctors-8, administrator of health facility-2)**	22	1 National Trainer 1 Project Trainer 1 Jalalabat Trainer
TOTAL NR		**Doctors-19 administrator of health facility-4 nurse/midwives-20**	**43**	
BABY-FRIENDLY HOSPITAL - BREASTFEEDING				

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
13.06.05	5	Leilek Maternity House staff **(TH- nurses-4, midwives-2, doctors-9, administrator of health facility-2)**	17	2 National Trainers
22.06.05	3	**(TH- nurses-3, midwives-6, doctors-5)**	14	1 Uzbek Project Trainer 2 Rayon Trainers
27.06.05	3	**(TH- nurses-7, midwives-10, doctors-2)**	19	1 Project Trainer 2 Rayon Trainers
28.03.2007	3	Doctors, Nurses, Midwifes from Kulundu Territorial Hospital and Kulundu center of Family Medicine (**nurses-6, midwives-6, doctors-8, administrator of health facility-1)**	21	1 Rayon Trainers 1 Project Trainer
TOTAL BFHI		**Doctors-24 administrator of health facility-4 nurse/midwives-33**	**71**	
INTERNATIONAL LIFE BIRTH DEFINITION				
25.07.05	3	Health Providers responsible for infant death statistics, including pediatricians, ob/gyn, infectious disease spec, surgeons, managers **(TH, FMC, FGP-doctors-21, administrator of health facility-3, another-1)**	**25**	1 National Trainer 2 Osh oblast trainers
METHODS OF TEACHING ADULT AUDIENCE				
07.02.2007	3	Rayon trainers, employees of Republic Center of Infection Control, employees from IMCI Center, Project specialists **(RCIC staff – 10, National IMCI center-2, local trainers from Batken – 3, project specialists - 3)**	**18**	2 Trainers from HOPE HF Uzbekistan

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
SUPPORT CURATOR AND IMPROVING QUALITY				
09.04.2007	5	Oblast and Rayon Health department (**administrator of health facility-4, doctors-8)**	**12**	1 Trainer from HOPE HF Uzbek istan
KPC				
15.02.2005		Doctors, Nurses, Midwifes, Oblast and Rayon Health Department, Project specialists **(nurses-1, doctors-6, administrator of health facility-1, another-2)**	10	1 Trainer from HOPE HF Uzbek istan
05.06.2007	3	Doctors, Nurses, Midwifes, Oblast and Rayon Health Department, Project specialists **(administrator of health facility-3, project specialists-2, nurses-3, doctors-2, another-4)**	14	1 Project Trainer from Bishkek
TOTAL KPC		**nurses-4, doctors-8, administrator of health facility-4, project specialists-2, another-6)**	**24**	
HFA				
15.02.2005		Doctors, Oblast and Rayon Health Department, Project specialists **(doctors-4, another-2,)**	6	1 Trainer from HOPE HF Uzbek istan
08.06.2007	2	Doctors, Nurses, Midwifes, Oblast and Rayon Health Department, Project specialists **(nurses-2, doctors-3, administrator of health facility-2, another-4)**	11	1 Project Trainer from Bishkek
TOTAL HFA		**Nurses-2, doctors-7, administrator of health facility-2, another-6)**	**17**	

Date of Training	# Days of Training	Type of Participant	# of Participant	Number & Origin of Trainers
TRAINING FOR FELDSHARS FOR GETTING PERMISSIOM OF REALIZING MEDICINES				
05.02.2007	12	Feldshers from FAPs of Leilek and Batken rayons **(feldshars-20)**	20	1 National Trainer from Bishkek
SUBTOTAL			**1122**	As in the Data Base on August 1, 2007

Healthy Family Project Cost-Sharing Turkmenistan (2003-2007)						
	Programs	**Total**	**HF**	**ZP**	**AED**	**UNICEF**
1	IMCI Physician Training	950	404 20 trainings per diem, participants/trainers, materials	staff time/logistic support	HF Paid for this	
2	IMCI Physician Training/ Care Development	35	35 1 training per diem, participants/trainers, materials	staff time/logistic support		
3	IMCI Nurse Training	517	517 26 trainings per diem, participants/trainers, materials	staff time/logistic support		
4	H-IMCI Training	15	15 1 training per diem, participants/trainers, materials	staff time/logistic support		
5	IMCI Pre- service	50	40 4 trainings training materials, and supplies	staff time/logistic support		per diem, participants, trainers
6	Healthy Pregnacy Training	420	140 21 trainings staff time/logistic support 9 trainings per diem, participants/trainers, materials 7 trainings staff time/logistical support	1 TOT/4 trainings w/ participant /trainer support staff time/logistic support staff time/logistic support	per diem,141 participants /trainers, materials	
7	MPS / Antenatal Training	102	102 4 trainings Local Expenses +WHO trainer	Logistics + Modules		
8	MPS/ PEPC	32	32 1 training per diem, participants, materials	3 WHO trainers, logistical support, local expenses		

9	Healthy Children Campaign	560	310 13 out of 24 campaigns IEC materials, staff time/logistics	 prizes, professional service,training expenses,staff time/logistic support		
	Grand Total	**2681**	**1595**			

*health providers trained only

Annex F: Tools Attributed to Healthy Family Project

Tools Attributed to Healthy Family Project Contributions

Country: Uzbekistan							
Tool/document (name/topic)	Date	Used By (audience)	Created/ Adapted/ Translated (C/A/T)	Printed/ Copied (P/C)	Source (if adapted or translated, indicate source documented)	Languages	Format (brochure, video, textbook, etc.)
«Towards the Conquest of Vitamin a Difficiency Disorders»	2004	For medical staff	T	C	"Towards the Conquest of Vitamin a Difficiency Disorders" by Donald S. McLaren, 1999	Russian	Guidelines
«Sight and Life»	2004	For medical staff	T	C	«Sight and Life» by Donald S. McLaren; Martin Frigg, 2001	Russian	Guidelines
Rational Nutrition and Anemia	2004	For primary level medical staff	-	P	WHO, UNICEF, ZdravPlus guidance	Uzbek	Guidelines for participants
Rational Nutrition and Anemia	2004	For medical trainers	-	P	WHO, UNICEF, ZdravPlus guidance	Uzbek	Guidelines for trainers
Consultation at Young Parents School	2005	For medical trainers	C	P	WHO guidance on Essential antenatal, perinatal and postnatal care 2002 WHO guidance on "Essential Newborns Care and Breast Feeding" "If you want your child be healthy" brochure for community, 2004	Uzbek	Guidelines
Essential Newborns Care and Breast Feeding	2004	For medical staff	-	C	WHO guidance on "Essential Newborns Care and Breast Feeding", 2002	Uzbek	Guidelines

Brief practical guidance on newborns resuscitation	2004	For neonatologists, OB/GYNs, anesthesiologists, pediatricians	-	C	Brief practical guidance on newborns resuscitation, WHO	Russian	Guidelines
Management of problems in newborns	2005	Guidance for doctors, nurses and midwives	T	P	WHO guidance	Russian	Guidelines
Adult Learning methodology	2004	Instructor's Educational methodological manual on counseling	-	C	Instructor's Educational methodological manual on counseling in the sphere of Family Planning "Consultation on Family Planning", AVSC International	Russian	Manual
Consulting patient on healthy family planning	2004	For medical staff	-	C	Consulting patient on healthy family planning, MoH, CS Navoi	Uzbek	Guidelines
Contraception: how to prevent unwanted pregnancy	2004	For medical staff	A	P	The album "How to plan a family", AVSC International, 1998	Uzbek	Album
Methodology of providing clinical skills for reproductive health specialists	2004	For clinician-trainers	-	C	Methodology of providing clinical skills for reproductive health specialists, JHPIEGO. 1996	Russian	Guidelines
Brief guidance on reproductive health and contraception	2004	For clinicians	-	C	Brief guidance on reproductive health and contraception, JHPIEGO, 1996	Russian, Uzbek	Guidelines
Reproductive and sexual health of adolescents	2004	For medical workers and teachers, conducting sessions on consulting adolescents	-	P	Reproductive and sexual health of adolescents CS Navoi, Healthy Family Project	Russian, Uzbek	Source of informational materials

Reproductive and sexual health of adolescents	2004	For seminar participants	-	P	Reproductive and sexual health of adolescents, MoH, CS Navoi, Healthy Family Project	Russian, Uzbek	Participant's manual
Reproductive and sexual health of adolescents	2004	For trainers	-	P	Reproductive and sexual health of adolescents, МЗРУз, CS Navoi, Healthy Family Project	Russian, Uzbek	Participant's manual
Prevention of STI transmitting from mother to child. Program and organizing course on this theme.	2007	For course organizers	-	P	WHO,CDC guidlenes 2004	Russian	Guidelines
Prevention of STI transmitting from mother to child. Pocket manual.	2007	For medical staff	-	P	WHO,CDC guidlenes 2004	Russian.	Guidelines
Infection Prevention	2004	For health facilities with limited resources	T	P	Guidance on "Infection Prevention" L. Tietjen and others. JHPIEGO	Russian	Guidelines
Infection Prevention	2005	For teachers of medical institutes and colleges	T/A	P	Guidance on "Infection Prevention" L. Tietjen and others. JHPIEGO	Russian	Manual for teachers of medical institutes and colleges
Infection Prevention	2005	For health workers	T	P	Guidance on "Infection Prevention" L. Tietjen and others. JHPIEGO	Russian	Participant's manual
Brief guidance on Infection Prevention	2004	For health workers	C	P	Guidance on "Infection Prevention" for health facilities with limited resources – L.. Tidgen and others. JHPIEGO	Russian	Guidelines
Brief guidance on Infection Prevention	2004	For health workers	C and T	P	Guidance on "Infection Prevention" for health	Uzbek	Guidelines

					facilities with limited resources – L. Tidgen and others. JHPIEGO		
Infection Prevention	2004	For health workers	-	C	Overview and practical training demonstration segments and safe practices in the operating room, 2003	English	Video
Standards on Infection Prevention in health facilities. Uzbekistan	2004	For health workers	C	P	International standards on Infection Prevention, WHO, CDC recommendations	Russian	List of the procedures performed by health worker
Tools on evaluation Infection Prevention practice in health facilities of Uzbekistan	2004	For health workers	C	P		Russian	Selection of check-lists
Guidelines on clinical training skills development	2005	For senior trainers	-	C	Guidelines on clinical training skills development, JHPIEGO	Russian	
Healthy newborn	2005	For program managers	-	C	Guidance on CDC	Russian	Reference guide
Essential antenatal, perinatal and postnatal care	2004	For health workers	-	C	Essential antenatal, perinatal and postnatal care, WHO, 2003	Russian	Reference guide
Essential antenatal, perinatal and postnatal care	2004	For health workers	T	P	Essential antenatal, perinatal and postnatal care, WHO, 2003	Uzbek	Reference guide
Preparedness to delivery and complications. Matrix of shared responsibility.	2004	For health workers of primary level.	T	P	Preparedness to delivery and complications. Matrix of shared responsibility.	Uzbek	Album
Guidance on effective care at pregnancy and childbirth	2004	For health workers	-	C	Guidance on effective care at pregnancy and childbirth. M.Enkin, 2003.	Russian	Guidelines

Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	2003	For health workers	-	C	Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	Russian	Participant's manual
Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	2005, second edition, revised	For health workers	T&A	P	Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	Uzbek	Participant's manual
Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	2005, second edition, revised	For health workers	T&A	P	Management of pregnancy in healthy women, management of normal deliveries, postnatal period and complications, Prime II	Russian	Trainer's manual
Management of complications in pregnancy and delivery	2003	For doctors and midwives	-	C	Management of pregnancy a nd delivery, Mogilevkina I.A.	Russian	Reference guide
Management of complications in pregnancy and delivery	2004	For doctors and midwives	T	P	Providing care during complicated pregnancy and delivery. Mogilevkina I.A.	Uzbek	Reference guide
Emergency care in obstetrical practice	2004	For trainers	C	P	Package of educational materials on providing care during complicated pregnancy and delivery, Guidance for trainers, JHPIEGO, 2002	Russian	Trainer's manual
Emergency care in obstetrical practice	2004	For participants	C	P	Package of educational materials on providing care during complicated pregnancy and delivery, Guidance for trainers, JHPIEGO, 2002	Russian	Participant's manual

Emergency care in obstetrical practice	2004	For participants	T	P	Emergency care in obstetrical practice, participant's manual in Russian.	Uzbek	Participant's manual
First obstetrical aid	2005	For nurses and midwives	T	P	Rendering emergency aid during complicated pregnancy and delivery. Guidance for midwives and doctors, WHO, 2000	Russian	Brief reference guide
Care during pregnancy, delivery, postnatal period and care for newborn	2003	For health workers	T	P	Care during pregnancy, delivery, postnatal period and care for newborn, WHO, 2003	Russian	Guidelines for clinical practice
Consulting on BF: educational course	2003	For trainer	-	C	Consulting on BF: educational course WHO, UNICEF, 1993	Russian	Guidelines for trainers
Consulting on BF: educational course	2003	For course listeners	-	C	Consulting on BF: educational course, WHO, UNICEF, 1993	Russian	Guidelines for listeners
Consulting on BF: educational course	2003	For course listeners	-	C	Consulting on BF: educational course, WHO, UNICEF, 1993	Uzbek	Transparency
Practice of protection, support and stimulation of Breast Feeding in pediatric health facilities	2007	For pediatricians and middle level health workers of pediatric outpatient-policlinic health facilities	C	P	The results of scientific researches and observations, Uzbekistan Research Institute of Pediatrics, materials WHO and UNICEF	Russian	
IMCI. Evaluate the condition and classify child in the age 2 months to 5 years	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Booklet-schemes
IMCI. Introduction	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants

IMCI. Evaluate the condition and classify child in the age 2 months to 5 years	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
IMCI. Define treatment	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
IMCI. Care for child	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
IMCI. Consult mother	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
IMCI. Management of child 1 week to 2 month	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
IMCI. Follow-up observation	2003	For health workers-pediatricians	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for participants
Manual of the trainer on modules	2003	For trainers	-	C	WHO and UNICEF materials on IMCI	Uzbek	Manual for trainer
In-patient services for children. Guidance for pediatric in-patient hospital doctors on management of widespread illnesses	2006	for pediatric in-patient hospital doctors	A	P	Pocket book of Hospital care for children, WHO, 2005	Russian	Guidelines
In-patient services for children. Guidance on management of widespread illnesses (H-IMCI)	2007	For trainer	C developed together with Zdravplus, IMCI Resource Center, pediatrics research institute	Printed	Pocket book of Hospital care for children, WHO, 2005	Russian	Guidelines

For child to be healthy	2003	For middle level health workers	C	P	Training materials on IMCI. WHO, UNICEF	Uzbek	Training manual
Consulting parents in the framework of C-IMCI strategy	2004	For trainers	C	P	Training materials on IMCI. WHO, UNICEF	Uzbek	Manual for trainers
For child to be healthy	2004	For community	C	P	Training materials on IMCI. WHO, UNICEF	Uzbek	Brochure
Recommendations for mothers on successful nutrition	2003	For community	C	P	Training materials on BF. WHO, UNICEF	Uzbek	Brochure
Waiting for baby. Health care during pregnancy	2004	For community	C together with ZdravPlus	P	Training materials on Safe Pregnancy. WHO	Uzbek	Booklet
Woman's position during delivery	2004	For community	C together with ZdravPlus	P	Training materials on Safe Pregnancy. WHO	Uzbek	Booklet
Assistance during delivery	2004	For community	C together with ZdravPlus	P	Training materials on Safe Pregnancy. WHO	Uzbek	Booklet
For peers	2004	For adolescents	C together with Republican RH Resource Center	P	Training materials on RH. WHO	Uzbek	Booklet
For women	2004	For women	C together with Republican RH Resource Center	P	Training materials on RH. WHO	Uzbek	Booklet
For men	2004	For men	C	P	Training materials on	Uzbek	Booklet

			together with Republican RH Resource Center		RH. WHO		
Towards safe sexual life	2004	For adolescents	C together with Republican RH Resource Center	P	Training materials on RH. WHO	Uzbek	Booklet
Women, your health is on your hands	2004	For women	C together with Republican RH Resource Center	P	Training materials on RH. WHO	Uzbek	Booklet
Forming healthy family	2004	For men	C together with Republican RH Resource Center	P	Training materials on RH. WHO	Uzbek	Booklet
Recommendations on feeding sick and healthy child	2004	For community	C together with Pediatrics Research Institute, ARC, MoH, Red Crescent Society of Uzbekistan	P	WHO materials.	Uzbek	Poster
If you see any of these signs, visit doctor	2004	For community	C together with	P	WHO materials.	Uzbek	Poster

immediately			Pediatrics Research Institute, ARC, MoH, Red Crescent Society of Uzbekistan				
You can prevent diarrhea	2004	For community	C together with Pediatrics Research Institute, ARC, MoH, Red Crescent Society of Uzbekistan	P	WHO materials.	Uzbek	Poster
Supporting breast feeding	2004	For community	C together with Pediatrics Research Institute, ARC, MoH, Red Crescent Society of Uzbekistan	P	WHO materials.	Uzbek	Poster
To the attention of men and women	2005	For community	C	P	Information from different sours about counseling	Uzbek	Poster
Reproductive Health	2004	For community	T	P	USAID RH Poster	Uzbek	Poster
First sense (diarrhea)	2003	For community	-	C	ZdravPlus together with MoH	Uzbek	Video film
IMCI. Sick child in the age 2 months to 5 years	2003	For health workers	-	C	WHO, UNICEF	Russian	Video film

Simple truth (anemia)	2003	For community	-	C	ZdravPlyus together with MoH	Uzbek	Video film
Cases in neonatal resuscitation	2004	For health workers	-	C	American Academy of pediatrics, American Heart Assosiatin, Asmund Laerdal Foundation	English	Video film
Film on Antenatal Care	2004		-	C	State program “Health of People”, ZdravPlus, USAID	Russian	Video film
Calendar 2005-2007	2004	For community	C	P	WHO materials	Uzbek	Calendar
H-IMCI. Management of widespread infection among children	2006	For health workers	-	C	WHO, UNICEF	Russian	Video film
IMCI. Management of children in the age of 1 week to 2 months	2004	For health workers	-	C	WHO, UNICEF	Russian	Video film
Tactics of management of children under 5 years in resuscitation units	2006	For health workers	-	C	WHO, UNICEF	Russian	Video film
Mama is better	2003	For health workers	-	C	WHO, UNICEF	Russian	Video film
User Guide Part I: Guide to Hand Ties and Instrument Ties Part II: A Guide to Basic Suturing Skills	2005	For health workers	-	C	Designed by Experience, Inc.	English	Video film

Country: TAJIKISTAN							
Tool/document (name/topic)	**Date**	**Used By (audience)**	**Created/ Adapted/ Translated (C/A/T)**	**Printed/ Copied (P/C)**	**Source (if adapted or translated, indicate source documented)**	**Languages**	**Format (brochure, video, textbook, etc.)**
Posters on Safe Motherhood, Sexual Transmissed Illnesses, Breast Feeding, Family Planing, Control Diarrhea Diseases, Acute Respiratory Illnesses, IMCI, Hygiene	2004	Primary health care facilities, shcools	Created/ Adapted/ Translated	Printed	Project HOPE, Care International, UNICEF	Tajik /Uzbek	Posters
LSS modules	2003	Primary health care workers	Adapted by MOH	Copied	Care International	Russian	Textbook
LSS modules	2004	Primary health care workers	Translated into Tajik	Printed	LSS modules on Russian	Tajik	Textbook
LSS logbook	2004	Primary health care workers	Created/ Adapted	Printed	LSS checklist	Tajik	Logbook
Registration Loogbooks (10 types)	2005	Health care workers	Created/ Adapted/ Translated by MOH	Printed	C/A/T by MOH	Tajik	Logbook
IMCI modules and booklet	2005	Primary health care workers	Translated	Printed	IMCI modules on Russian	Tajik	Textbook, video
National Infection Prevention Standards Guidelines	2005	Health care workers	Created/ Adapted	Printed	WHO IP standards	Russian	Guidelines
Safe Motherhood Protocols	2006	Primary health care workers	Adapted by MOH	Copied	Materials provided by MOH	Russian	Protocol

C-IMCI modules and booklet	2007	IMCI trainers, project staff and comminity volunteers	Adapted by MOH	Printed	Booklets provided by MOH	Tajik	Booklets

Country: Kyrgyzstan							
Tool/document (name/topic)	Date	Used By (audience)	Created/ Adapted/ Translated (C/A/T)	Printed/ Copied (P/C)	Source (if adapted or translated, indicate source documented)	Languages	Format (brochure, video, textbook, etc.)
Infection Prevention (IP) standards and tools	Februa ary, 2006	Health care providrers from Territorial Hospitals, Centers of Family Medicines, FAPs, FPGs.	IP standards and tools developed bt the HF project in Uzbekistan in cooperation with the Uzbek MoH and adapted to the MoH regulations in Kyrgyzstan	Printed	JHPIEGO	Russian	Textbook
C-IMCI training module	April, 2006	Family nurses from Centers of Family Medicines, FAPs, FPGs	It was created together with HOPE Child survival project, national	Printed (150 items)	n/a	Kyrgyz	Textbook

			IMCI Center				
C-IMCI bloc scheme	April, 2006	Family nurses from Centers of Family Medicines, FAPs, FPGs	It was created together with HOPE Child survival project, national IMCI Center	Printed (150 items)	n/a	Kyrgyz	Textbook
Instruction for family nurses	August, 2006	Family nurses from Centers of Family Medicines, FAPs, FPGs	Created	Printed (150 items)	n/a	Kyrgyz	Laminated poster
Instruction for parents	August, 2006	Child parents	Created	Printed (150 items)	n/a	Kyrgyz	Laminated poster

Country:Turkmenistan							
Tool/document (name/topic)	Date	Used By (audience)	Created/ Adapted/ Translated (C/A/T)	Printed/ Copied (P/C)	Source (if adapted or translated, indicate source documented)	Languages	Format (brochure, video, textbook, etc.)
Set of 8 WHO IMCI PHysicians Modules	2000	Physicians	Adapted and translated to Turkmen through Financial support form ZdravPlus		WHO IMCI Modules	Russian to Turkmen	Textbook, video
WHO IMCI Nurse Module	2004	nurses	Adapted and translated to Turkmen through Financial support form Healthy		WHO IMCI Nurse Module	Russian to Turkmen	Textbook, video

			Family/ZdravPlus				
WHO IMCI Medical Students Book	2005	Medical students	Adapted and translated to Turkmen through Financial support form Healthy Family/ZdravPlus		WHO IMCI Medical Students Book	Russian to Turkmen	Textbook,
WHO. ZdravPlus Safe Motherhood Training Modules	2007	Doctors and nurses in maternity houses	Translated to Turkmen through Financial support from Healthy Family/ZdravPlus				Textbook, video

Annex G: Policies Attributed to Healthy Family Project

Policy Documents/Prikazes Attributed to Healthy Family Project Contributions

Country: Uzbekistan						
Policy Documents/Prikazes (title)	**Date**	**Level of Approval**	**International Reference Standard**	**Major components/ requirements**	**Role of HF Project**	**Current status**
Decree No. 425 "On implementation of modern technologies on increasing the effectiveness of provision of care for pregnant women in the facililties of the primary level."	05.09.2005	National	Safe Motherhood WHO	ANC visits	Financial, TA, advocacy, piloting in HF area	Approved
Decree № 155 «On stationary aiding to the child population of the Republic of Uzbekistan»	10.04 2007	National	IMCI-WHO	Stationary aiding to the children at more widespread diseases on the primary level	Support of situation analysis, implementation, financial and technical assistance, Advocacy.	Approved
Decree № 307 «On the perfect infections prevention technology introduction into public health care services practice»	01.07.2004	National	Infection Prevention	Use of the most simple and low resource IP standards at medical institutions with limited resources.	Support of situation analysis, implementation, financial and technical assistance. Advocacy, Piloting in HF area.	Approved
Decree № 530 «On common ordering of anti-epidemic arrangements in treatment-and-preventive institutions»	31.10.2005	National	Infections Prevention	IP in medical institutions, current and final disinfection, techniques of disinfectant solution preparation	Advocacy	Approved
Decree № 500 «On maternity complexes (branches) work reorganization for increase of perinatal help and an intrahospital infections	13.11.2003	National	Safe Motherhood WHO	Management of the normal and complicated deliveries		Approved

prevention efficiency»						
A National RH Strategy for 2006-2015 and Action Plan for 2006-2011	N/A	National	Reproductive Health WHO	Describes arrangements and ways of Reproductive Health strategy implementation around the country	Support of situation analysis, implementation, technical assistance, Advocacy	Submitted to the Cabinet of Ministers of Uzbekistan 2006
A standard unified format for national Protocols, Standards and Clinic Guidelines in Uzbekistan was submitted and approved by the Ministry of Health/Academic Medical Council on	April 24, 2006 (#2058).	National	Quality of public health services Improvement	Helps health providers, students and teachers of IHE and high schools to understand terminology «Protocol», «Standard», «Clinical Guideline»	Support of situation analysis, implementation, technical assistance, Advocacy	Approved
EBM Policy in Uzbekistan		National	Quality of public health services Improvement	Improves medical aid rendering on the basis of national standards, reports and clinical guidelines adaptation.	Support of situation analysis, implementation, technical assistance, Advocacy	Pending
Live Birth Definition Decree № 77 MoH	February 28, 2007	National and oblast	Childhood. Perinatal, neonatal and postnatal help	Improves birth and mortality rates registration according to the live birth and mortality criteria	Support of situation analysis, implementation, technical assistance, Advocacy	Approved
National modules on IMCI strategy updating by new WHO data	June, 2007	National	IMCI-WHO	New global WHO recommendations are included into the training package for participants and trainers	Financial and technical assistance.	On going

Country: Tajikistan						
Policy Documents/Prikazes (title)	**Date**	**Level of Approval**	**International Reference Standard**	**Major components/ requirements**	**Role of HF Project (financial, protocol development, policy effort, TA, advocacy) All that apply**	**Current status**
National RH Strategic Plan of RT	2004	Government of RT	Safe Motherhood	Reproductive Health	Financial, TA, advocacy	Approved
Contraceptive Security Plan	2005	National	Safe Motherhood	Reproductive Health	Financial, TA, advocacy	Approved
Prikaz # 272 of MOH Republic of Tajikistan ”On Implementation of National Infection Prevention Standards”	2005	National	For all areas	National Infection Prevention Standards	Financial, TA, advocacy	Approved

Country: Kyrgyzstan						
Policy Documents/Prikazes (title)	Date	Level of Approval	International Reference Standard	Major components/ requirements	Role of HF Project (financial, protocol development, policy effort, TA, advocacy) All that apply	Current status
Decree No. 320 "On improvement activities of intrahospital infection prevention in the pilot hospitals of Batken oblast."	June 2006	National	Infection Prevention (IP)	IP trainings	IP development	Approved

Country: Turkmenistan						
Policy Documents/Prikazes (title)	Date	Level of Approval	International Reference Standard	Major components/ Requirements	Role of HF Project (financial, protocol development, policy effort, TA, advocacy) All that apply	Current status
1.MOHMIT Prikazes:" On the implementation of WHO IMCI Strategy through IMCI Training Courses" 2. Prikaz " On IMCI Pre-service Training 3. Prikaz "On WHO Hospital evaluation Mission"	Nov-ber, 2003, Nov-ber, 2004, Sept-ber,2005 February,November,2006 March, 2007 March,2005 November,2005 March,	1.The first Deputy of Minister 2.Velayat Health Department Head 3. Health facilities/ Houses of Health Directors			1. Healthy Family/ZdravPlus submitted SOW for a certain period of time to the MOHMIT through the USAID and the Mof FA. The tentative schedule of the implementation of HF/ ZP projects' programs used to be attached. The MOHMIT prepared draft Prikaz and discussed it with HF/ ZP projects' team as well as with the MCH Institute Management Team. All the details were to be agreed upon before the First Deputy Minister	Approved

4. Prikaz “On Hospital IMCI Implementation” 5. Prikaz “On WHO IMCI Program Implementation Evaluation”	December, 2006 June,2007				signed prikazes.	
Safe Motherhood National Program Prikaz”On PEPC and Antinatal Training Program Implementaion”	19.12.2006 March, 2007	National, Velayat, Etrap National Velayat, Etrap	Safe Motherhood	antenatal care, LBD, Prenatal classes, support during deliveries, postpartum care	Implementing partner in the roll-out of the trainings (financial support)	Approved

Annex H: Country Maps


KAZAKHSTAN
Ostrova Vozrozhdeniya
ARAL SEA
Komsomol'sk
Zhaslyk
Mŭnok
USTYURT PLATEAU
KARAKALPAKSTAN
Altynkul'
Chimbay
Takhtakupyr
Qunghirot
Nukus
Köneürgench
Caspian Sea
Beruni
Turtkul'
Urganch
Khiva
Turkmenistan
Dargan Ata
Kulkuduk
Mynbulak
Uchquduq
NAWOIY
Zarafshon
Qyzylorda
KAZAKHSTAN
Syr Darya
Zhambyl
Shymkent
KYRGYZSTAN
Tashkent
Chirchiq
Angren
Almalyk
Namangan
Andijon
Qŭqon
Farghona
Bekabad
Gulistan
Jizzakh
Nurata
Farish
Ozero Aydarkul'
BUKHARA
Gazli
Gizhduvan
Nawoiy
Kattakurgan
Bukhoro (Bukhara)
Kagan
Samarqand
Mubarek
Kasan
Kitab
Qarshi
Guzar
Chärjew
Amu Darya
Denau
Termez
Dushanbe
TAJIKISTAN
TURKMENISTAN
Mary
Garagum Canal
AFGHANISTAN
ISLAMIC REPUBLIC OF IRAN
UZBEKISTAN
National capital
Centre of autonomous republic or wiloyat
Town, village
Airport
International boundary
Autonomous republic and wiloyat boundary
Main road
Secondary road
Railroad
0 50 100 150 200 250 km
0 50 100 150 mi
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Wiloyat of Uzbekistan
1 Andijon
2 Bukhara
3 Farghona
4 Jizzakh
5 Khorazm
6 Namangan
7 Nawoiy
8 Qashqadaryo
9 Samarqand
10 Sirdaryo
11 Surkhondaryo
12 Tashkent
Map No. 3777 Rev. 6 UNITED NATIONS
January 2004
Department of Peacekeeping Operations
Cartographic Section


KAZAKHSTAN
Tashkent
Angren
TAJIKISTAN
Andizhan
Taboshar
Khujand (Leninabad)
Kokand
Kanibadam
Bekabad
Kayrakkum Reservoir
Chkalovsk
Isfara
Uroteppa
UZBEKISTAN
KYRGYZSTAN
Shahriostan
Panjakent
Ayni
Zeravshan
LENINABAD
Jirgatal'
Garm
Komsomolabad
Sicharog
Childara
Sayod
Lairon
Wakhio
Dushanbe
Obigarm
Tavildara
Dashtishur
Tursunzade
Kofarnikhon
Hisor (Gissar)
Nurek
Nurek Reservoir
Kalaikhum
Vanj
Khovaling
Dangara
Kulob (Kulyab)
Kalot
Rushan
Kalininabad
Qurghonteppa (Kurgan-Tyube)
Shuroabad
Moskovskiy
KHATLON
Kolkhozabad
Nizhniy Panj
Panj
Shaartuz
Shir Khan
Termez
Amu Darya
AFGHANISTAN
Feyzabad
Kudara
Lake Karakul'
CHINA
Rangkul'
Murgab
Lake Sarezskoye
KUHISTONI BADAKHSHON
(GORNIY BADAKHSHAN)
Dzhartyrabot
Shaymak
Vir
Buved
Khorugh
Kazidi
Vrang
Ishkashim
Pamir
PAKISTAN
Kholm (Tashkurghan)
Qonduz
Taloqan
Khanabad
National capital
Viloyati Autonomous (V.A.) or viloyat centre
Town or kishlak
Major airport
International boundary
Viloyati Autonomous (V.A.) or viloyat boundary
Main road
Secondary road
Railroad
0 25 50 75 100 km
0 25 50 75 mi
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Map No. 3765 Rev. 10 UNITED NATIONS
January 2004
Department of Peacekeeping Operations
Cartographic Section


TURKMENISTAN
KAZAKHSTAN
UZBEKISTAN
AFGHANISTAN
ISLAMIC REPUBLIC OF IRAN
CASPIAN SEA
DASHHOWUZ
BALKAN
AHAL
LEBAP
MARY
Nukus
Köneürgench
Kalinin
Dashhowuz
Urganch
Bekdash
Kara Bogaz Gol
Garabogaz Aylagy
Krasnovodskiy Poluostrov
Turkmenbashi (Krasnovodsk)
Ufra
Cheleken
Nebitdag
Aladzha
Koturdepe
Ostrov Ogurchinskiy
Okarem
Hasan Kuli
Kizyl Atrek
Chagyl
Kizyl Kaya
Oglanly
Gazanjyk
Kum Dag
Gyzylarbat
Bami
Khodzha Kala
Kara-Kala
Bakharden
Bakhardok
Yerbent
Darvaza
Buzmeyin
Ashgabat
Artyk
Kaakhka
Tedzhen
Dushak
Pravda
Babadayhan
Tedzhenstroy
Serakhs
Mary
Bayramaly
Iolotan'
Krasnoye Znamya
Sandykachi
Takhta Bazar
Kalai Mor
Gushgy
Uch Adzhi
Ravnina
Dargan Ata
Neftezavodsk
Farab
Chärjew
Repetek
Bukhoro
Samarqand
Amu Dar'ya
Kerki
Gaurdak
Kirova
Charshanga
Kopet Mountains
Chink Kaplankyr
Karakum
Amu Darya (Oxus)
Sariqamish Kuli
Garagum Canal
National capital
Welayat center
Town, kishlak
Airport
International boundary
Welayat boundary
Main road
Secondary road
Railroad
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Map No. 3772 Rev. 6 UNITED NATIONS
January 2004
Department of Peacekeeping Operations
Cartographic Section


KYRGYZSTAN
K A Z A K H S T A N
UZBEKISTAN
T A J I K I S T A N
C H I N A
CHUSKAYA OBLAST
TALAS OBLAST
DZHALAL-ABADSKAYA OBLAST
NARYNSKAYA OBLAST
ISSYK-KUL'SKAYA OBLAST
OSHSKAYA OBLAST
Almaty
Bishkek
Kara Balta
Tokmak
Talas
Shymkent
Tashkent
Angren
Tunuk
Cholpon-Ata
Tyup
Przheval'sk
Ysyk-Köl
Barskoon
Enilchek
Shyirak
Kara-Say
Toktogul
Toktogul Reservoir
Kara-Kul'
Ala-Buka
Tash-Kömür
Namangan
Andijon
Kok-Yangak
Jalal-Abad
Uzgen
Osh
Qŭqon
Gul'cha
Kyzyl-Kiya
Alay-Kuu
Sulyukta
Khaidarken
Ravat
Sary-Tash
Daraut-Korgan
Ugyut
Naryn
Kek-Aigyp
L. Song-Kel'
L. Chatyr-Kel'
Ysyk Köl
National capital
Oblast' center
Town, kishlak
Major airport
International boundary
Oblast' boundary
Main road
Secondary road
Railroad
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Map No. 3770 Rev. 6 UNITED NATIONS
January 2004
Department of Peacekeeping Operations
Cartographic Section

Annex I: Gifts-in-Kind

P I N I S S U E T O T A L S

09/30/02 thru 06/28/07

COST CTR	COUNTRY	PROGRAM	SHIP	DATE	PO VALUE	GIK VALUE	SHIP MAT.	TOTAL VALUE
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	015863	11/15/02	3,138.00	0.00	0.00	3,138.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	015865	11/19/02	158.00	0.00	0.00	158.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016031	02/19/03	1,830.00	0.00	6.77	1,836.77
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016092	03/17/03	38.65	0.00	0.00	38.65
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016099	03/21/03	36,712.40	0.00	183.00	36,895.40
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016239	05/12/03	211.50	0.00	0.00	211.50
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016247	05/13/03	44.95	0.00	0.00	44.95
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016299	06/06/03	17,265.00	0.00	0.00	17,265.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016312	06/26/03	51,428.54	0.00	614.54	52,043.08
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016350	06/26/03	287.24	0.00	0.00	287.24
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016501	08/04/03	202.56	0.00	0.00	202.56
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016502	08/18/03	15,102.00	0.00	0.00	15,102.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016511	08/12/03	6,300.00	0.00	25.83	6,325.83
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016596	09/25/03	2,325.47	0.00	0.00	2,325.47
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016735	12/10/03	4,483.95	0.00	0.00	4,483.95
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016749	12/23/03	134.95	0.00	0.00	134.95
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016811	01/14/04	296.10	0.00	0.00	296.10
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016888	02/18/04	150.00	0.00	0.00	150.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016957	04/09/04	3,584.00	0.00	29.54	3,613.54
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	016974	04/12/04	2,921.99	0.00	36.51	2,958.50
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017060	05/04/04	31.62	0.00	0.00	31.62
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017169	06/14/04	143,084.87	0.00	933.83	144,018.70
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017182	09/10/04	122,559.77	0.00	2,900.18	125,459.95
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017306	09/10/04	62,168.52	0.00	0.00	62,168.52
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017322	09/10/04	1,626.51	0.00	0.00	1,626.51
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017346	08/31/04	84.60	0.00	0.00	84.60
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017585	11/04/04	423.00	0.00	0.00	423.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017632	12/08/04	1,038.19	0.00	28.39	1,066.58
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017650	01/25/05	35,931.29	0.00	296.55	36,227.84
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017655	01/25/05	11,808.61	0.00	0.00	11,808.61
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017743	01/25/05	8,355.56	0.00	0.00	8,355.56
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017812	03/07/05	49,129.56	0.00	185.86	49,315.42
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	017853	03/07/05	0.00	0.00	0.00	0.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	018002	04/26/05	87.00	0.00	0.00	87.00
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	018818	05/08/06	394.80	0.00	0.00	394.80
6016119	UZBEKISTAN	USAID UZBEK/TAJIK MCH/RH	019379	05/25/07	53.58	0.00	0.00	53.58
TOTALS COST CENTER 6016119 (01363 6348)					583,392.78	0.00	5,241.00	588,633.78
6016133	UZBEKISTAN	MCH/RH (GIK)	016323	06/26/03	0.00	1,041.60	0.00	1,041.60
6016133	UZBEKISTAN	MCH/RH (GIK)	016557	08/18/03	0.00	1,646.96	0.00	1,646.96
6016133	UZBEKISTAN	MCH/RH (GIK)	016611	10/05/03	0.00	47,240.00	14.99	47,254.99
6016133	UZBEKISTAN	MCH/RH (GIK)	016751	01/02/04	0.00	12,689.60	0.00	12,689.60
6016133	UZBEKISTAN	MCH/RH (GIK)	017811	03/07/05	0.00	105.60	0.00	105.60
6016133	UZBEKISTAN	MCH/RH (GIK)	017862	03/09/05	0.00	0.00	0.00	0.00

P I N I S S U E T O T A L S

09/30/02 thru 06/28/07

COST CTR	COUNTRY	PROGRAM	SHIP	DATE	PO VALUE	GIK VALUE	SHIP MAT.	TOTAL VALUE
6016133	UZBEKISTAN	MCH/RH (GIK)	019031	09/27/06	0.00	2,739.00	23.23	2,762.23
6016133	UZBEKISTAN	MCH/RH (GIK)	019452	05/29/07	0.00	9,949.50	0.00	9,949.50
	TOTALS COST CENTER 6016133 (01363 8933)				0.00	75,412.26	38.22	75,450.48
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	016088	04/07/03	0.00	193,784.16	327.04	194,111.20
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	016500	08/15/03	0.00	2,308,897.89	0.00	2,308,897.89
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	016612	10/05/03	0.00	97,715.02	731.48	98,446.50
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	016942	04/09/04	0.00	209,363.70	36.51	209,400.21
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	016962	04/09/04	0.00	8,465.40	0.00	8,465.40
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017015	05/21/04	0.00	421,842.61	250.88	422,093.49
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017751	01/25/05	0.00	336,379.97	2,413.50	338,793.47
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017761	01/25/05	0.00	152,490.60	938.57	153,429.17
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017854	03/07/05	0.00	8,769.36	0.00	8,769.36
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017886	03/29/05	0.00	338,962.28	345.29	339,307.57
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	017909	03/29/05	0.00	18,900.00	0.00	18,900.00
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018222	08/26/05	0.00	253,554.12	124.84	253,678.96
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018397	10/19/05	0.00	220,205.39	537.84	220,743.23
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018665	03/21/06	0.00	1,041,184.44	614.61	1,041,799.05
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018673	03/21/06	0.00	63,742.50	0.00	63,742.50
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018691	03/21/06	0.00	1,067,883.12	774.28	1,068,657.40
601613A	UZBEKISTAN	MCH SURKHANDARYA OBLAST	018729	03/31/06	0.00	52,930.25	563.12	53,493.37
	TOTALS COST CENTER 601613A (01363 8933)				0.00	6,795,070.81	7,657.96	6,802,728.77
601613B	UZBEKISTAN	MCH KASHKADARYA	016089	04/07/03	0.00	117,521.76	137.26	117,659.02
601613B	UZBEKISTAN	MCH KASHKADARYA	016499	08/18/03	0.00	2,306,590.11	18,898.56	2,325,488.67
601613B	UZBEKISTAN	MCH KASHKADARYA	016613	10/05/03	0.00	108,766.45	697.41	109,463.86
601613B	UZBEKISTAN	MCH KASHKADARYA	016943	04/09/04	0.00	209,542.05	92.26	209,634.31
601613B	UZBEKISTAN	MCH KASHKADARYA	016963	04/09/04	0.00	8,107.29	0.00	8,107.29
601613B	UZBEKISTAN	MCH KASHKADARYA	017016	05/21/04	0.00	423,756.07	247.87	424,003.94
601613B	UZBEKISTAN	MCH KASHKADARYA	017728	01/24/05	0.00	340,303.90	2,480.54	342,784.44
601613B	UZBEKISTAN	MCH KASHKADARYA	017753	01/24/05	0.00	419,196.00	2,363.80	421,559.80
601613B	UZBEKISTAN	MCH KASHKADARYA	017855	03/07/05	0.00	8,769.36	0.00	8,769.36
601613B	UZBEKISTAN	MCH KASHKADARYA	017887	03/29/05	0.00	306,183.48	309.72	306,493.20
601613B	UZBEKISTAN	MCH KASHKADARYA	017910	03/29/05	0.00	12,600.00	0.00	12,600.00
601613B	UZBEKISTAN	MCH KASHKADARYA	018224	08/26/05	0.00	263,606.04	131.95	263,737.99
601613B	UZBEKISTAN	MCH KASHKADARYA	018398	10/19/05	0.00	133,392.14	649.20	134,041.34
601613B	UZBEKISTAN	MCH KASHKADARYA	018664	03/21/06	0.00	1,039,024.60	2,053.82	1,041,078.42
601613B	UZBEKISTAN	MCH KASHKADARYA	018669	03/21/06	0.00	1,903.50	0.00	1,903.50
601613B	UZBEKISTAN	MCH KASHKADARYA	018674	03/21/06	0.00	63,742.50	0.00	63,742.50
601613B	UZBEKISTAN	MCH KASHKADARYA	018690	03/21/06	0.00	1,067,594.94	0.00	1,067,594.94
601613B	UZBEKISTAN	MCH KASHKADARYA	018733	03/31/06	0.00	53,337.15	914.78	54,251.93
	TOTALS COST CENTER 601613B (01363 8933)				0.00	6,883,937.34	28,977.17	6,912,914.51

P I N I S S U E T O T A L S

09/30/02 thru 06/28/07

COST CTR	COUNTRY	PROGRAM	SHIP	DATE	PO VALUE	GIK VALUE	SHIP MAT.	TOTAL VALUE
6016219	TAJIKISTAN	USAID UZBEK/TAJIK MCH/RH	017197	09/10/04	45,291.36	0.00	0.00	45,291.36
6016219	TAJIKISTAN	USAID UZBEK/TAJIK MCH/RH	017302	09/10/04	126,450.98	0.00	1,116.55	127,567.53
6016219	TAJIKISTAN	USAID UZBEK/TAJIK MCH/RH	017323	09/10/04	23,053.80	0.00	0.00	23,053.80
6016219	TAJIKISTAN	USAID UZBEK/TAJIK MCH/RH	017639	12/14/04	21,281.73	0.00	7.09	21,288.82
6016219	TAJIKISTAN	USAID UZBEK/TAJIK MCH/RH	018920	06/08/06	128.50	0.00	0.00	128.50
	TOTALS COST CENTER 6016219 (01364 6348)				216,206.37	0.00	1,123.64	217,330.01
6016233	TAJIKISTAN	MCH/RH (GIK)	018210	07/28/05	0.00	97,457.47	152.66	97,610.13
	TOTALS COST CENTER 6016233 (01364 8933)				0.00	97,457.47	152.66	97,610.13
6038819	KYRGYSTAN	MCHRH	018675	02/27/06	15,868.63	0.00	57.73	15,926.36
6038819	KYRGYSTAN	MCHRH	019383	05/25/07	53.58	0.00	0.00	53.58
	TOTALS COST CENTER 6038819 (06025 6348)				15,922.21	0.00	57.73	15,979.94
6038833	KYRGYSTAN	MCHRH (GIK)	019393	04/25/07	0.00	71,577.00	0.00	71,577.00
	TOTALS COST CENTER 6038833 (06025 8933)				0.00	71,577.00	0.00	71,577.00
	REPORT TOTALS				815,521.36	13,923,454.88	43,248.38	14,782,224.62

END OF REPORT