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

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

Final Evaluation Report

Project Duration: October 1, 2002 – September 30, 2007

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December 2007

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AKNOWLEDGMENTS

The principal author of this report would like to express her appreciation to Project HOPE-Uzbekistan's CS staff who gave so generously of their time and effort to improve the health and well being of the women and children of Navoi Region (or Oblast) in Uzbekistan. In like manner, they provided tremendous support and direction during the final evaluation process through their participation in interviews and assessments, data analysis and feedback. The author is also grateful to those who supported the FE team during the evaluation process and made the work possible, including the directors and staff of the Navoi Oblast and Rayon Health Departments. These stakeholders made important contributions to this report and their observations and comments contributed to the success of the evaluation.

Additional thanks go to those who conducted the final surveys and quantitative tools found in the FE: Abdunabi Kuchimov, Program Manager for the CS project, Zafar Alimjanov, Monitoring and Evaluation specialist and the entire CS team. Thanks also goes to Ruth Madison, Technical Advisor for CS projects in the Millwood office, whose facilitation skills and experience with CS projects greatly enhanced the Final Evaluation process. A special thanks also to Sabohat Ergasheva and Seda Aleksanyan for their hard work in organizing the final evaluation briefings and the associated logistics for the evaluation activities.

The Navoi Project HOPE staff has demonstrated tremendous initiative and teamwork throughout their work with this project. They have been enthusiastic, capable and as open to new initiatives as they have been to share the results. It has been a real honor to be part of this team for a short time and I thank them for their openness, insight and generous hospitality.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ARSH	Adolescents' Reproductive and Sexual Health
ARI	Acute Respiratory Infection
AVSC	Association of Voluntary Contraception (now known as Engender Health)
ADB	Asian Development Bank
BCC	Behavioral Change and Communication
BF	Breast Feeding
BFHI	Baby-Friendly Hospital Initiative
BL	Baseline Survey
C-IMCI	Community-IMCI
CAR	Central Asian Republics
CDD	Control of Diarrheal Disease
CHP	Child Health Promotion
CHW	Community Health Worker
CI	Confidence Interval
COMH	Central Oblast Maternity House
CRMH	Central Rayon Maternity House
COH	Central Oblast Hospital
CRH	Central Rayon Hospital
CS	Child Survival
CSHGP	Child Survival and Health Grant Program
CYP	Couple Years of Protection
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
EBF	Exclusive BreastFeeding
EPI	Expanded Program on Immunization
FAP	Feldsher midwife post
FGD	Focus Group Discussions
FP	Family Planning
GP	General Practitioner
HD	Health Department
HF	Healthy Family
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HOPE	Health Opportunities for People Everywhere
ICD*10	International Classification of Disease, 10^{th} edition
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
INGOs	International non governmental organizations
IMR	Infant Mortality Rate
IUD	Intrauterine Device
KPC	Knowledge, Practice, Coverage
LAM	Lactational Amenorrhea Method

LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MHC	Mother's Home Card
MOE	Ministry of Education
MOH	Ministry of Health
M&E	Monitoring and Evaluation
MPS	Making Pregnancy Safer
MSG	Mother Support Group
MTE	MidTerm Evaluation
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OHD	Oblast Health Department
PEPC	Promoting Effective Perinatal Care
PHC	Primary Health Care
Prikaz	Official (Government) order or decree
PTP	Peer to Peer Counseling
QA	Quality Assurance
QI	Quality Improvement
RDH	Rayon Health Department
RH	Reproductive Health
SC	Steering Committee
SM	Safe Motherhood
SOW	Scope of work
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
SUB	Rural community hospital
SVA	Rural physician ambulatory
SVP	Rural physician post
TAG	Technical Advisory Group
TWG	Technical Working Group
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age
YFS	Youth-Friendly Services

A. Summary

Project HOPE's child survival (CS) project in the Navoi Oblast of Uzbekistan is an extension of a child survival project that began in 1999. The current project, *Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan,* is the second phase of the original project and was extended from October 2003 to September 2007. The in-country portion of this final evaluation was conducted in July and August 2007.

The purpose of the Project HOPE's CS project in Uzbekistan was to: (a) reduce the mortality and morbidity in children under five and women of reproductive ages and (b) increase adolescents' knowledge about reproductive and sexual health. The CS project directly targets an estimated 36,716 children ages 0-5 years; 77,479 women of reproductive age (15-49 years old), and 25,505 adolescents (16-18 years of age). The Project has introduced and expanded the use of standard case management protocols in: IMCI. Making Pregnancy Safer and Family Planning interventions, through which the project intervened in the following areas. ARI/Pneumonia Control (10%), Control of Diarrheal Diseases (10%), Child Nutrition (10%), Breastfeeding Promotion (10%), Maternal/Newborn Care (30%), and Family Planning (30%).

By all accounts, the project has been quite successful. As the table in the following section shows, many of the objectives have either been achieved or surpassed. Furthermore, and perhaps more importantly, the project has successfully influenced the Oblast Health Department (OHD) and Rayon Health Departments (RHD) to adopt such strategies as IMCI and the Making Pregnancy Safer program, as their own and are implementing those programs in other parts of the country. In addition, some of the materials developed by the project are now being used by UNICEF and other INGOs in other areas of the nation. The partnership between the project staff, the OHD and the RHDs is very strong and the project has made tremendous strides in building the capacity of the health department staff. This is one of the most important achievements of the project.

Other noteworthy achievements include the organization and implementation of a community health promotion strategy by training local makhalla and other informal leaders who are then supervised by the Rayon Women leaders. These leaders have the responsibility of organizing and overseeing family health promotion at the community level. The project has successfully coordinated the leaders' community awareness work with that of the patronage nurses who have also received updated training by the CS project to deliver MCH and FP home care services.

The following achievements are most noteworthy:

- Organization and support of 32 types of training courses: 4-IMCI, 4-BF, 7-Safe Motherhood, 3 FP, and 4 ARH; 1 MPS +RH; 3 BF+ c-IMCI; 2 Community Health Promotion; 1 Database Management.
- 2,215 of health professionals trained – 493 - Safe Motherhood; 709 – IMCI and BF-C-IMCI; 538 – Breastfeeding; 475 – Family Planning.
- 1,811 adolescents directly exposed to reproductive health information.
- Development, production, and distribution of health education materials including a Mothers Home Card (added to Prikaz 425) and 32-page pocket guide including the IMCI 16 key practices.

- Development and support of several training centers.
- Development of protocols at local and national levels in support of IMCI, maternal and neonatal health care and family planning.
- Streamlined Quality Improvement program that includes participation from the MOH counterparts.
- Seven hospitals and two PHCs Certified as "Baby-Friendly", each with mothers support groups, private room for counseling and group meetings.
- Support for International Breastfeeding Week.
- Initiation of and support to New Parents Schools.
- Joint prikaz (government directive) between MOH and MOE to support adolescent reproductive health activities facilitated by the project.
- The community health promotion strategy developed by the CS project has become a tool for the local government to implement prikaz (decree) 242.
- ARH Guidelines developed by CS project and local partners (MOH and MOE) accepted at national level and recommended to be replicated in other regions.
- IMCI booklet and posters developed by project accepted by other INGO projects including "Healthy Family Project" in Uzbekistan and in the CAR.
- SM and IMCI trainers trained by CS Project have replicated the training to other oblasts and countries (Kyrgyzstan).
- Quality Improvement Seminars provided by project and Zdrav Plus (a USAID funded project, implemented by Abt Associates) trained 70 providers from 11 PHCs during three seminars.
- Trained 24 oblast and rayon HIS staff to manage child birth and mortality database.

Many of the activities initiated by this CS project have already been "sustained" by the MOH and are being scaled up in other parts of the oblast as well as other parts of the country, including IMCI and the Making Pregnancy Safer initiative. Because the OHD and RHD are an integral part of this project, all lessons learned are automatically shared with them and applied by them to other rayons. In addition, there are requests to extend the ARH training to schools in the non pilot rayons. Before closing the CS project, the CS team should assist the oblast health and education departments with a plan to extend programs to other areas.

Conclusions

- The FE has shown that the CS team has not only accomplished the activities that were proposed in the DIP, but have surpassed many of them. One of the main factors for such impressive achievements has been the close collaboration with the OHD and RHDs. In some cases, Project HOPE was a catalyst for passage of government prikazes, and in some other cases, it demonstrated new ideas and approaches, which the government is considering implementing.

- The majority of the indicators achieved were at the service delivery level with complementary indicators and strategies at the community level. Since the Uzbek health system has a large infrastructure that reaches the majority of the population, this dual-pronged approach has been successful. Thus, Project HOPE's strategy to work through the OHD, RHDs and communities was

appropriate in this context, and Project HOPE should be highly praised for its work.

- At the time of the MTE, the community component of the project had only reached the diagnosis and design stage, and some field testing. It had not progressed beyond that because the CS team was too busy carrying out a large number of training activities, and also because the strategies proposed for community mobilization such as working with grandmothers, demanded a great deal of effort from the team. Also, the community mobilization strategy presented challenges in scale up, as it is a relatively new concept in Uzbekistan and required more thought and planning in order to be implemented. Fortunately after the MTE, Project HOPE's regional technical advisor was able to provide assistance to the team in developing an action plan for mobilizing communities. This plan included work with existing partners including, patronage nurses and leaders in the rayons and oblasts whose responsibility it was to educate families about preventive health topics and provide links to the health facilities. Although late in starting, this part of the project is impressive because it dovetails nicely with exisiting local government structures. Specifically, the community mobilization activities support Governmental decree #242, which uses community based volunteers for information dissemination. It is hoped that these activities will be sustained.

- The main recommendation is that if resources become available, it would be important for the oblast HD to continue strengthening this community component. Although the government supports the need for community work, there is not much experience in the country for doing it and HOPE has only been supporting community activities for a year and a half.

- The project was successful in implementing a wide variety of training activities to support each of the CS interventions. Project HOPE was appropriately monitoring the quality of the trainings at the time they were provided (via pre and post tests), and in addition moved beyond training to monitor and supervise the quality of service delivery by assessing the performance of health workers in delivering services on regular 6-8 month intervals. One of the big successes of the training program has been the upgrading of patronage (visiting) nurse skills, thus increasing their motivation to conduct home visits. Although not able to train all of the nurses, the project was able to train a substantial enough number to make an impact. These nurses seem to be having a strong effect on increasing access to health care at the community level. If additional financial resources become available for this region, it is recommended that donors consider strengthening this component.

- Another question is if the oblast will be able to continue the well organized monitoring system that has been put in place by the CS and Oblast team. A suggestion from the FE team is to encourage monitoring from the rayon levels since monitoring from the oblast level may be too cumbersome. In order to get this process started, the team recommends the project hold planning meetings with each of the rayon HDs and develops plans and agendas for continued monitoring visits.

B. Assessment of Results and Impact of the Project

1. Results: Summary Chart

Results from the baseline, the mid-term and the final surveys are compared below with project targets. While the same methodology was used for the baseline and final surveys, the midterm used LQAS and only interviewed mothers of children under 2 years of age. The other surveys measured all the target populations including mothers of children under 2, women of reproductive age, and adolescents. As the primary target group of the project, mothers with children under 2 years of age (those evaluated in LQAS at midterm) received more education interventions than the other target groups and that may explain why some of their results are higher than those from the final survey.

Progress Towards Achievement of Program Objectives:

Indicators	KPC Baseline* (Feb 2004)	KPC MTE** (May 2005)	KPC FE* (June 2007)	Target 2007
Integrated Management of Childhood Illness (IMCI)				
Percent of mothers of children aged 0-23 months who know at least TWO signs of childhood illness that indicate the need for treatment	48.6%	73.8%	95.3%	68%
Percent of mothers who know at least TWO signs childhood diarrhea that indicate the need for treatment/referral	36.9%	65.1%	96.0%	58%
Percent of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	31.8%	32.6%	47.1%	60%
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	15.0%	42.7%	58.8%	40%
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	19.0%	51.0%	50.0%	30%
Percent and total number of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source	88.1%	38.9%	80.0%	90%
Breastfeeding				
Percent of children aged 0-23 months who were breastfed within the first hour after birth	62.6%	85.2%	93.1%	85%
Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours	19.8%	58.2%	60.3%	45%
Percent of children aged 20-23 months who are still breastfeeding	33.9%	12.5%	66.8%	45%
Percent of infants aged 0-5 months who were fed breastmilk only in the last 24 hours	62.7%	80.1%	90.0%	85%
Number of health facilities currently certified under the National participation in the Baby-Friendly Hospital Initiative (BFHI)	3	5	5	5
Safe Motherhood and Neonatal Care				
Percent of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24	99.8%	100.0%	99.7%	100%

Indicators	KPC Baseline* (Feb 2004)	KPC MTE** (May 2005)	KPC FE* (June 2007)	Target 2007
months of age				
Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	54.1%	61.7%	73.4%	70%
Percent of mothers who know at least TWO signs of danger during pregnancy that indicate the need for treatment	46.9%	74.0%	97.0%	70%
Percent of mothers who had at least one postpartum check-up	76.9%	95.1%	98.7%	92%
Family Planning				
Adequate Birth Interval Between Youngest Surviving Children: Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child	48.3%	86.9%	84.7%	68%
Percent of WRA who report that women are likely to get pregnant halfway between two menstrual periods	9.3%	72.8%	45.7%	45%
Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing	72.6%	91.5%	72.8%	85%
Percentage of respondents who report discussing FP issues with somebody in the past 12 months	56.2%	82.5%	65.7%	75%
Counseling: Percentage of family planning clients who receive counseling on contraceptive choices, common side effects, and when to return for follow-up	62.7%	77.2%	86.6%	78%
**** Baseline and Final Evaluation indicators were collected using a Cluster Sampling Methodology*** ***** MTE indicators were collected using LQAS methodology*** ****** The change is calculated relative to the baseline value and then the movement towards or away (-) from the objective***				

2. Results: Technical Approach

a. Overview of the Project

Project HOPE implemented CS-19 Phase 2 (2003–2007) of the USAID/CSHGP entitled, "Increasing the Quality of Child Survival and Maternal Care Services Project in the Navoi Oblast of Uzbekistan." Project HOPE worked with the Navoi Oblast Health Department to improve child health, safe motherhood and reproductive health services in four rayons (districts).

This extension project covers four rayons - the two rayons that comprised the original Phase 1 of the project (1999–2003) - Navoi and Kiziltepa, and the extension rayons of Konimeh and Nurata, which were added during Phase 2. The four rayons are predominantly rural, but the project also carried out activities in the oblast capital, Navoi City.

The Navoi Oblast has been an area of considerable need. When the project began, the statistics on childhood mortality estimated the rate to be 62 per 1,000 for the five-year calendar period between 1998-2002. Neonatal mortality was 34 per 1,000 and post-neonatal mortality 28 per 1,000, suggesting that there had been little change over the

previous ten years.[1] Maternal mortality in Navoi is the highest in the country[2].

The country has an extensive network of medical services; however, there is an overall lack of supervision and continuing education to provide health staff with new or improved knowledge and skills. Stocking health care facilities with necessary equipment and drugs to provide preventive and curative services was a challenge, but a new World Bank and ADB project is being implemented to address those issues. In general, medical personnel wait for patients to seek care. The patronage nurses, who carry out home visitsand have a good understanding of the population, provide a limited number of health services and counseling but otherwise refer patients to the health facilities.

The CS project targeted an estimated 36,716 children 0-5 years of age, 77,479 women of reproductive age (15-49 years old), and 25,505 adolescents ages 16-18 years. Indirectly, the project's work at the oblast level supported an additional 35,949 children 0-5 years of age, 81,241 women of reproductive age (WRA), and 28,335 adolescents, ages 16-18.

The Navoi CS project has sought to: (a) reduce the mortality and morbidity in children under five and women of reproductive age and: (b) increase adolescents' knowledge of reproductive and sexual health by partnering with the Oblast and Rayons' Health Departments. The project has introduced and expanded the use of standard case management protocols in: Making Pregnancy Safer; Family Planning interventions; and IMCI. The level of effort for each intervention is as follows: ARI/Pneumonia Control (10%), Control of Diarrheal Diseases (10%), Child Nutrition (10%), Breastfeeding Promotion (10%), Maternal/Newborn Care (30%), and Family Planning (30%).

The focus of the second phase has been on capacity building, training, MOH systems strengthening and training of the makhallah leaders. A Maternal and Child Health Steering Committee, created during the first phase of the project, played an active role in Phase 2 of the project with the creation of four technical working groups: maternal health, child health, adolescent reproductive health and community health promotion. Technical working groups are comprised of key decision makers in the MOH, makhallah administrations, local and international NGOs, and community members.

b. Progress Report by Intervention Area

Project HOPE has successfully worked with the Oblast Health Department, the four target Rayon Health Departments, Makhallah leaders, and four training centers in Navoi City. Project HOPE strengthened the Oblast and Rayon Health Departments through the Oblast Steering Committee and the four active Technical Working Groups – the IMCI, Maternal/RH, adolescent reproductive health, and community health promotion working groups. The steering committee is composed mainly of policy level decision makers, whereas the technical working groups are made up of technical experts. The purpose of the technical working groups will be discussed further in section 3.

Project HOPE assisted in the development and equipping of training centers, and the development of protocols at the local and national levels related to IMCI, maternal and

[1] Uzbekistan Health Examination Survey 2002. Analytical and Information Center, MOH, State Department of Statistics, ORC Macro.
[2] Ibid.

neonatal, and family planning. The results of these efforts are that 4,181 MOH participants were trained at the various levels of the health system. In addition 422 makhalla leaders and trainers were trained.

To follow up on the training activities and to monitor results, Project HOPE introduced and systematized a monitoring system to observe the quality of service delivery, provide additional on-site training, give feedback to the health teams about how to improve their services, and develop plans to overcome identified weaknesses. Monitoring was conducted by integrated teams from the oblast, rayons and the project. The teams were composed of trainers and other experienced staff who conducted the monitoring visits every 6 to 8 months.

IMCI (ARI/ Pneumonia, Diarrheal Disease, Nutrition)

IMCI (Integrated Management of Childhood Illness) was the strategy used to address child morbidity and mortality related to ARI/pneumonia, diarrheal disease and nutrition. IMCI training started in 1999 under the Phase 1 project, which represented the first IMCI training to be conducted in the country. The project implemented the first training in Navoi and later held courses in Bukhara and Samarkand. IMCI is now being taught in 6-7 regions of the country.

Objectives: (1) Increase the proportion of mothers who recognize fast breathing and chest in-drawing as signs of pneumonia; (2) Increase the proportion of children with signs of pneumonia who were assisted by a trained health provider; (3) Increase the ORT use rate; (4) Increase the percentage of mothers who recognize danger and dehydration signs; (5) Increase the percentage of mothers who give their child more/equal amounts of liquids during diarrhea; (6) Increase the number of mothers who continued feeding the child during a diarrhea episode; and (7) Increase appropriate complementary feeding practices after six months of age; i.e., quantity and quality of foods, breastfeeding first then foods, and introduction of micronutrients (Fe, iodine and Vitamin A.).

Main Strategies and Activities: Project HOPE has sought to improve access to and quality of child health services by emphasizing health education and preventive measures at the home level. The project strategies included: a) increase medical staff skills and knowledge, b) facilitate organization of work through health system strengthening and c) increase health awareness at the community level. Activities to achieve these objectives included: (1) developing IMCI training curricula and training plans for both the 11-day WHO standard IMCI training for health professionals, and a three-day Community-IMCI (C-IMCI); (2) developing and implementing a Makhallah/ Community-Based IMCI program which included the dissemination of the 16 key practices through health education and IEC materials; (3) developing a training curricula and a training plan for primary health care workers (patronage nurses and feldshers); and (4) emphasizing quality improvement of monitoring and supervision at the health facility level; and (5) implementing a client-focused approach to providing child health information and services.

KPC Results on ARI/pneumonia, Diarreheal Disease Control and Child Nutrition

Indicators	Baseline Feb 2004		MTE (May 2005)		KPC FE* June 2007	
	%	CI	%	CI	%	CI
Percent of mothers of children aged 0-23 months who know at least TWO signs of childhood illness that indicate the need for treatment	48.6%	±4.8	73.8%	±6.23	95.3%	±2.4
Percent of mothers who know at least TWO signs childhood diarrhea that indicate the need for treatment/referral	36.9%	±4.6	65.1%	±6.47	96.0%	±2.3
Percent of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	31.8%	±19.5	32.6%	±12.14	47.1%	±16.8
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	15.0%	±14.9	42.7%	±13.87	58.8%	±16.5
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	19.0%	±16.4	51.0%	±11.48	50.0%	±16.8
Percent and total number of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source	88.1%	±8.3	38.9%	±11.16	80.0%	±24.8

Project HOPE conducted several training courses in IMCI for GPs and pediatricians. One course was a five-day *IMCI Training of Trainers* for participants who were selected among those who took the 11-day IMCI training course. The TOT course was conducted in Navoi by master trainers from the National Pediatric Institute. The IMCI TOT course was directed towards rayon-level general practitioners and pediatricians who would continue as trainers of health providers in their region. The course covered the principals of adult education, how to organize training courses that included theory and practice, and how to use the Trainers' Guidelines and Participant Modules. During Phase 2, thirty-six (36) pediatricians and general practitioners from the four rayons (Karmana, Konimeh, Kizeltepa and Nurota) were trained and currently, are active trainers. In Navoi at the Oblast Children's Hospital, a training center was established to sustain training, which is now wholly supported by the government (previously supported by the project). Also to keep the center active, the oblast has provided an IMCI specialist to work with the Center. This is the only region in Uzbekistan with a chief IMCI specialist, whose position was created to coordinate IMCI training and monitoring activities.

During this Phase 2 project, 135 health providers from four rayons participated in the standard 11-day IMCI training course on IMCI. Feldshers (physcians assistants) were trained to provide services where doctors do not work. A total of 462 HPs received the 11-day training during the two projects. The objectives were to train HPs on proper IMCI case management, including referral, counseling and follow up.

During the second half of the Phase 2 project, the staff realized that there was a problem with the doctors at rayon and oblast hospitals who had not received IMCI training. When patients were referred from IMCI trained HPs at primary care facilities to these hospitals, they encountered the old style doctors who were not familiar with IMCI practices and gave patients messages that conflicted with IMCI protocols about care of the sick child. To address this imbalance, the project decided to provide hospital IMCI training to

hospital staff. In 2006, four training courses were conducted which trained 66 health providers. The project coordinated with the National Pediatric Research Institute in Tashkent which arranged the training using certified trainers and WHO manuals that were adapted by the IMCI working group. There has been definite progress in the adaptation of IMCI protocols by health providers and the FE team was able to verify that this training was important in improving the quality of hospital care. However, the project was not able to train all the hospital providers and interviews at the PHCs confirmed that there are still problems with hospital referrals.

During the first phase and the early part of the second phase of CS Navoi, a three-day C-IMCI course for patronage nurses[3] was offered using an adapted WHO IMCI training curriculum. The adaptation was carried out by Project HOPE, the Pediatric Institute, and UNICEF in Tashkent. Since there had been no standard C-IMCI course curriculum to use, it was necessary to adapt the curriculum which was based on 8 of the 16 IMCI key family messages for healthy growth and development of children. This process required some special adaptations as the C-IMCI audience is usually CHWs and not patronage nurses. The course consisted of a reduction in the standard IMCI content with a focus on management of diarrhea and pneumonia, growth monitoring, nutrition and micronutrients education, and adult education techniques. After the midterm evaluation, the project decided to extend the C-IMCI training to five days by combining the standard C-IMCI training with the two-day breastfeeding training that was also being provided by the project. Previously, the two courses were offered separately and the project decided it was more efficient to combine them. Also the project monitors realized that the nurses needed stronger breastfeeding and nutrition counseling skills. A total of 671 patronage nurses were trained from the four rayons. This includes three nurses from each primary health facility and represents 58 percent of the nurses in the project rayons. Since the project did not have enough resources to train all the nurses, the plan was for the trained nurses to reproduce the training for the other nurses who were unable to participate in the original trainings. Thus, when the project and oblast conduct monitoring visits to the facilities, they monitored all nurses, assuming that all nurses present had received some training. During interviews at the facilities, the FE team found that in some PHCs, the nurses had received updates from their trained colleagues but not all nurses received updates. One observation is that adult learning methodologies should have been included along with the C-IMCI training to facilitate the replication of trainings. To conduct all the C-IMCI training, the project trained a total of 76 trainers: 36 are local trainers and 22 are from the pilot rayons. An additional nine are from the non-pilot rayon in Navoi oblast and the rest are from other regions that have IMCI programs.

For the 11-day IMCI training, the project started with the eight WHO manuals that had been translated to Russian. These were adapted and translated to Uzbek. Training materials for all courses included the following didactic materials: videos, transparences, posters, flip charts, dolls, models, color paper, photos, among other materials. For all courses, manuals and other IEC materials were distributed as well.

To reinforce the 16 key practices among mothers with young children, the project distributed the 32-page pocket-sized booklet, "*If You Want Your Child Healthy*". This

[3] Patronage nurses have 3 years of college education. Main responsibilities include community education and home visits. Usually, patronage nurses work 3 hours at SVP and 3 hours visiting homes.

booklet, which was developed during Phase 1 of the project, contains information about the IMCI key messages. Patronage nurses interviewed for this evaluation reported that they regularly use the booklet to promote behavior change and that the women respond well to both the counseling provided by the patronage nurses and to the information in the booklets. The nurses confirmed that almost all families in the target rayons have a booklet. The success of the booklet is evidenced by the fact that it has been reprinted and distributed in other regions of the country by partner organizations such as Counterpart International and the Project HOPE USAID funded Healthy Family Project. Many mothers interviewed during the FE had this booklet as well as others distributed by the project (BF, diarrhea, etc.) and it was obvious by the way they responded to questions that they had read and understood the information contained therein.

All of the training took place in the Oblast Health Department IMCI training site at the Navoi Oblast Child Hospital, which was established during the Phase 1 with project support.

Patronage nurses play a key role in promoting the household behaviors related to the treatment and prevention of ARI/pneumonia, diarrheal disease and child nutrition. These providers know everyone in their catchment area personally including knowledge of each family member's health status, especially those children due for immunizations and women in need of prenatal care visits. According to the job description, a patronage nurse is supposed to visit every new born child in the rayon at least once a week for 12 months and each child 13–60 months of age at least twice a month. Pregnant women are visited at least twice a month. Patronage nurses also work in teams with other health staff in PHC centers and facilitate referrals to health facilities as well as recommend home visits from other health providers.

Patronage nurses examine ill children but do not prescribe antibiotics. Most practices examined for this evaluation appeared appropriate and in accordance with IMCI protocols. During FE interviews, it was revealed that before receiving the training, most patronage nurses did make the required home visits, but they did not provide in depth home care because they had not been trained with practical skills to complete these tasks. They simply inquired if everything was OK with a child and if not, they referred them to a facility for follow up. After receiving the IMCI training, patronage nurses were able to provide check-ups for mothers and children as well as education and counseling.

The focus group discussions with mothers of children under two years of age showed that mothers know about danger signs in sick children. They mentioned frequent vomiting, seizures, increased temperatures, unconsciousness, worsening of general condition, loss of appetite, etc., as instances in when they should look for care. In those cases, the usual response is to call the field doctor or patronage nurse. Mothers reported that they received this information from health providers, through brochures provided by the project and the IMCI booklet, *"If You Want Your Child Healthy"*. It was also noteworthy that during interviews with community leaders, they indicated that there had been no childhood deaths this year and they believed it was because families now knew what to do when a child is sick.

Beyond working with the patronage nurses, implementation of the community mobilization component of IMCI was delayed in part because the project team was

initially preoccupied organizing IMCI training. In addition, implementing behavior change at the community level is a foreign and difficult idea to conceptualize for the project staff and their Uzbek counterparts, and Project HOPE did not recognize the extent to which this would affect timely implementation of the community mobilization plan. To address this, in January 2005, Project HOPE brought back the outside consultant [4] who had conducted a community assessment in Phase 1, to assist the Navoi CS team and their MOH partners in developing a community mobilization strategy based on the original research. The consultant developed an ambitious plan that was refined and field-tested by the project. Project HOPE's Central Asia Regional Program Officer, based in Kazakhstan, then followed up with the project, helping the team to develop materials, action plans and training courses for community leaders (see section 3 for details).

Project HOPE has carried out several campaigns on diarrhea management and breastfeeding practices. During these campaigns, the project organized contests to reward and publically recognize families that had the best practices in breastfeeding and home-based diarrhea management. Recently, the project organized competitions between mother-in-law groups from different areas. This was a very innovative and effective strategy and the oblast media (local TV, newspapers and radio broadcast) have provided good coverage of all the event thus increasing knowledge of appropriate child care .

Project HOPE has addressed *quality improvement of IMCI service delivery* by carrying out monitoring visits at all health facilities in the project rayons twice a year. Monitoring visits are conducted by members of the IMCI Technical Working Group (TWG), with participants from Project HOPE and MOH counterparts and the visits include a series of checklists and interviews to be conducted at the facility. After the monitoring visit, the team provides feedback regarding the results to health providers and a decision is made regarding whether additional onsite training is needed. The project then conducts refresher training on areas found to be problematic during the monitoring visit.

One of the dilemmas for implementing IMCI effectively is the need to provide the essential medicines recommended for the different protocols. The FE team found that some of these medicines were not available at the primary care facilities and project staff inicated that there is a lack of essential medicines at all levels of the health care system. In addition, because not all doctors at hospital levels are trained in IMCI, sometimes patients receive conflicting information on the need for medicines for common childhood ailments. This presents a challenge to IMCI trained doctors who are sometimes mistrusted by mothers and other caregivers when they don't prescribe as much medicine as the old Soviet hospital-based system recommends.

Next Steps/Recommendations:

Although the CS project is ending, if additional resources should become available, the FE team would recommend the following:

- As mentioned above, one of the concerns is that IMCI training is uneven. Currently most of the primary care personnel have received the training but it

[4] Judi Aubel, PhD, MPH. Consultancy Report: "Development of an integrated community health promotion strategy." Navoi Child Survival Program. Project HOPE. Jan. 11 to 19, 2005. Navoi, Uzbekistan

was not provided at the same time to all primary care groups (nurses and doctors) nor was it provided at hospital levels until 2006. Therefore, the FE team would recommend that future training be planned and provided to similar levels of care within a short timeframe. Also it is recommended that more hospital IMCI training be provided to the other hospital providers in the rayons and oblast.

- The project staff and providers interviewed indicated the need for a standard refresher training course based on the findings from the monitoring visits conducted by project staff, TWG and MOH.

- Two child care prikaz's (MOH directives) are in the process of having IMCI added to them. Prikaz 538, which deals with the organization of inpatient child care and was changed to include hospital IMCI, has been approved. Prikaz 537, which deals with outpatient child care and will include the 11-day IMCI training, has not yet been approved but is in the revision stage. Having these prikazes approved will help in lobbying MOH health departments to implement IMCI. Though there will still be problems acquiring funding to provide the training in order to comply with the revised prikazes, at least when the investigators come from the central MOH to review the programs, they will now include the IMCI standards. Therefore, it is recommended that the project encourage passage and dissemination of both these prikazes as soon as possible.

- It is advisable that in addition to furthering IMCI training, the project should encourage the MOH to provide and prescribe the IMCI essential medicines at the PHC services.

Breastfeeding Promotion

Objectives: (1) Increase the percentage of mothers who exclusively breastfeed their infants for the first six months; (2) Increase the percent of infants being breastfed during the first hour of birth; (3) and Increase the percent of newborns that have skin-to-skin contact with the mother immediately after birth for at least 30 minutes.

Main Strategies and Activities: Project HOPE seeks to achieve the breastfeeding objectives by improving the quality of mother and newborn care provided by health workers. The strategy includes (1) assisting hospitals gain Baby-Friendly Hospital Certification, which includes the WHO "10 Steps to Successful Breastfeeding;" (2) Forming Breastfeeding Support Groups at maternity houses; (3) implementing a behavior change strategy that involves makhallah/community-based groups when developing an intervention with grandmothers, Mullah-Bibis, and other community leaders; (4) participation in and endorsement of an annual "Breastfeeding Week" activities, organized and implemented by the MOH and collaborating agencies; (5) the provision of TV and VCR sets to the new rayon maternity houses; and (6) monitoring adherence to Baby-Friendly protocols at maternity houses.

KPC Results on Breastfeeding and Child Nutrition

Indicators	Baseline Feb 2004		MTE (May 2005)		KPC FE* June 2007	
	%	CI	%	CI	%	CI
Percent of children aged 0-23 months who were breastfed within the first hour after birth	62.6%	±4.6	85.2%	±5.15	93.1%	±1.8
Percent of infants aged 0-5 months who were fed breastmilk only in the last 24 hours	62.7%	±9.0	80.1%	±9.74	90.0%	±3.9
Percent of children aged 20-23 months who are still breastfeeding	33.9%	±12,1	12.5%	n/a	66.8%	±6.4
Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours	19.8%	±8,2	58.2%	±10,97	60.3%	±6.4
Number of health facilities currently certified under the National participation in the Baby-Friendly Hospital Initiative (BFHI).	3		5		5	

Project HOPE has accomplished all the targets that were proposed in the DIP. The project has also shown steady progress and improvement of breastfeeding practices in the target population.

Project HOPE translated the standard WHO Baby-Friendly Hospital Initiative (BFHI) curricula, "*Consultation on Breastfeeding*" into Uzbek, including the trainers and participants' manuals, and these were subsequently adopted by the Healthy Family Project and UNICEF for use in other parts of the country. With support from UNICEF, the National Pediatric Institute also asked Project HOPE staff to serve as trainers and to conduct monitoring/certification sessions. The project also developed a leaflet and poster on breastfeeding practices for lactating mothers.

Project HOPE has successfully worked with the four project rayons and oblast maternity houses to certify them as "Baby-Friendly." The 10 Steps that a hospital needs to comply with are based on quality standards, which means that hospitals have to improve the delivery of services to an optimal standard. In addition, Project HOPE regularly monitored and supervised all certified hospitals providing additional assistance and making adjustments in refresher training based on the monitoring results. The certification process has motivated the Oblast Health Department Chief to declare that all hospitals in the Navoi oblast must be certified as Baby Friendly. This goal surpasses the objectives stated in the DIP and is an indicator of sustainability that was not anticipated. In addition to the four maternity hospitals, two pilot SVPs were also certified as Baby Friendly during the second half of the project.

In 2004 at the end of Phase 1, the project found that despite all the training in breastfeeding, not all BF practices were being implemented by providers. For example, according to trained Oblast maternity and reproductive health physicians, only 20 percent of mothers initiated BF within the first half hour of birth (this was in the new rayons). During monitoring visits, the project encountered that the neonatologists in the hospitals advocated separating newborns from the mother and giving them formula instead of promoting breastfeeding. After several training programs and a big push from the Oblast Health Department, the project managed to change the attitudes of practitioners so that they now support EBF.

A lesson learned from the Phase 1 was that since the project only provided hospital level BF training for providers, mothers weren't adequately counseled at home on breastfeeding nor were they counseled at the PHCs, where they were seen for prenatal and postnatal care. Therefore, during the first half of Phase 2 the CS Project concentrated on training PHC health providers, to introduce exclusive and continuous breastfeeding practices. It did so by conducting several training courses related to breastfeeding as shown in the table below, during which a total of 538 health professionals were trained.

Type of course	Numbers/types of Participants	Training Objectives
Five day course on BF counseling	42 MDs, midwives and nurses	Improve breastfeeding counseling skills and principles of baby-friendly hospital
Five day BF TOT	35 maternity house physicians and midwives	BF counseling, adult education techniques, group dynamics; training event planning and implementation on Baby-Friendly Hospital certification; and formation of BF support groups
Three day "Counseling on Breastfeeding"	445 pilot rayon maternity house physicians and midwives and nurses	Improve breastfeeding counseling skills and principles of baby-friendly hospital
Three day course on BF follow up and monitoring	16 hospital level physicians an midwives	Prepare Technical Working Group members to monitor the Baby Friendly Hospitals, to analyze results, to make decisions based on the results, to standardize the monitoring instruments and methods.
TOTAL trained on Breastfeeding	**538 health care providers**	

During the second half of the project, the Navoi CSP staff trained GPs and nurses to support and counsel patients about breastfeeding during antenatal and postpartum visits. Initially, project staff believed that the nutrition session in the IMCI training was enough for the providers to adequately counsel mothers about breastfeeding. The project staff soon discovered that GPs needed counseling skills training in order to talk to and convince the mothers of the importance of breastfeeding and how to breastfeed successfully. A total of 372 visiting nurses received the five-day course of breastfeeding and IMCI and 67 who received TOT training.

The training materials used included the Uzbek version of *Counseling on Breastfeeding Guidelines* produced by WHO and UNICEF; a handout on adult education techniques;

the criteria for hospitals to be certified as Baby-Friendly; and other teaching materials such as slides, transparences, video movies, and mannequins.

The project and the Oblast Health Department (OHD) have started a technical committee on Baby-Friendly Hospital certification whose primary responsibility is to oversee the education provided to mothers and the certification process at the oblast and pilot rayon levels. The OHD has recently created other Baby-Friendly committees for the non-pilot rayons. In addition, all certified hospitals supported by the project have developed *mothers' support groups* and have set up a private room for counseling and group meetings.

To monitor adherence to the Baby-Friendly Hospital protocols, a monitoring team was formed by specialists from the Pediatric Research Institute, Project HOPE staff, counterparts from oblast health department, and trainers from the target rayons. Monitoring/supervision visits are conducted every six months as required by the local prikaz, or directive. Monitoring instruments include interviews with health providers (five questionnaires) to determine BF counseling knowledge and skills; observation of counseling sessions; document reviews and client exit interviews.

The Oblast Health Department certified two more hospitals in 2006 in the rayons not covered by the project. In addition, the Oblast health Department Chief has added a step 11 for the baby-friendly process, a mechanism by which already certified maternity houses will not be re-certified unless they first help other maternities or PHC level health facilities in the oblast to be certified as "Baby-Friendly."

Community-based IMCI activities were carried out primarily by patronage nurses through home visits. The FE focus groups with patronage nurses showed that they visit the homes of newborn infants once a week up to the first year of life, as well as pregnant women at least twice a month. Breastfeeding promotion and education is part of their home-visit plan of activities.

Focus group discussions conducted among mothers of children less than one year old revealed that mothers believe that if they exclusively breastfed their children for six months, they could be protected from pregnancy (LAM) and their children will be protected from different diseases. This is a good indication that the education mothers are receiving has stressed the importance of breastfeeding for both the baby's health and for family planning. Mothers also reported reading the 32-page child health booklets as well as the "Essentials of Breastfeeding" booklet.

Project HOPE did not work with Mullah-Bibis (formal religious leaders) as was proposed in the DIP, because it was found that the religious leaders do not deliver health messages to the family, and they are not permitted to talk about sensitive topics (such as breastfeeding) in public. However, as a result of the community assessment and strategy developed, the project decided to work with formal and informal makhalla leaders in the community health component. The government of Uzbekistan has released a prikaz (directive) which gave *community leaders* the main responsibility for providing health education to families. The team felt that given that a prikaz is a governmental order, the community leaders might also include a political agenda in completing their education tasks. Therefore, the project team decided to support these formally-selected leaders, but

expand training to include other informal, but naturally effective community leaders as well. As will be discussed in section 3, these leaders have proven themselves to be effective messengers for creating awareness of BF and other preventive health practices among community members.

Each year, Project HOPE supports and endorses the International Breastfeeding Week. A week of activities is organized with the rayon governments, the oblast and rayon health departments, makhalla committees and NGOs. Activities include poster design competitions, broadcasting video tapes (produced by Zdrav Plus (Abt Associates) and the Healthy Family projects) through the local media and in maternity houses. The media also support events by delivering messages in local newspapers, among other educational activities.

Because of all the training the HPs at the four rayon primary health centers have received, they could easily be certified as baby friendly. The monitoring and KPC results show that these PHCs could meet certification requirements. However due to cost requirements of bringing certifiers from the Central level, the certification of the PHCs hasn't been done.

At the national level, EBF is only 22 percent. The MOH has set a goal of establishing baby friendly programs in all PHCs and wanted to increase EBF to 60 percent. To date, the project has achieved 90 percent EBF in its rayons.

Lessons Learned /Recommendations – Breastfeeding

- A key lesson learned was that breastfeeding training at the hospital level alone was not enough - the project also needed to train primary level providers who can provide education and counseling to antenatal and postpartum mothers.

- Another lesson validated in the grandmothers research activities, was that community traditions such as giving water and sheep fat to newborns negatively affect exclusive breastfeeding.

- Some maternity houses (hospitals) need 2-3 months to be certified, others need a year in order to overcome attitudes opposed to the 10 steps for BF certification.

The main recommendation, if resources become available, is that the oblast Continue Breastfeeding Training. The FE team recommended continuing training health providers to be coordinated by the Oblast Health Department and TWGs. Also, breastfeeding promotion and education need to continue reinforcing the concept of exclusive breastfeeding, since the team has detected that social influences at the community and family levels may be changing the concept of exclusivity; the team has also found out that not all women (mothers-in-laws especially) understand that exclusivity means not giving the child sweets, water nor any kind of food, no matter the amount. While tremendous strides have been made through community education and the work of the trained patronage nurses, the community program has only been going for a year and may need reinforcement.

Safe Motherhood/Newborn Care (SM/NC)

Objectives: (1) Increase the number of mothers who received/buy iron supplements while pregnant; (2) Increase the percent of mothers who had at least one postpartum check-up; and (3) Increase the percent of mothers who know the danger signs during pregnancy, delivery and postpartum that indicate the need for treatment.

Main Strategies and Activities: To achieve these objectives, the following activities were planned: (1) conduct training courses for health providers (Ob/Gyns, GPs, neonatologists, midwives and nurses) at both in patient and out patient care levels; (2) conduct TOTs and then train health staff on Safe Motherhood; (3) improve health provider's knowledge and practices regarding the SM protocols, and in particular, communicating essential information to patients; (4) monitor Health Providers' behaviors during supervisory visits; (5) Involve technical working group (TWG) members in making changes that facilitate a health provider carrying out the Safe Motherhood guidelines (for instance, the TWG will analyze the primary health facility monitoring reports); (6) At the makhallah level, carry out an integrated makhallah-based MCH strategy, which consisted of key messages in prenatal, delivery, neonatal and postpartum care; and (7) focus on improving the quality of SM service delivery through close monitoring and supervision of service delivery and the makhallah levels.

KPC Results on Perinatal Care

Indicators	Baseline Feb 2004		MTE (May 2005)		KPC FE* June 2007	
	%	CI	%	CI	%	CI
Percent of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	99.8%	±4.0	100.0%	-	99.7%	±0.6
Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	54.1%	±4.8	61.7%	±7.03	73.4%	±5.0
Percent of mothers who know at least TWO signs of danger during pregnancy that indicate the need for treatment	46.9%	±4.8	74.0%	±5.54	97.0%	±1.9
Percent of mothers who had at least one postpartum check-up	76.9%	±4.0	95.1%	±2.61	98.7%	±1.3

Since the beginning of the project in 1999, there have been many changes to maternal and neonatal health protocols in Uzbekistan. Project HOPE has always been a leader in this area and from the beginning, adopted and adapted WHO standard Safe Motherhood[5] materials and protocols. In summary, the name and focus have slightly changed from Safe Motherhood to Making Pregnancy Safer, reducing maternal mortality and improving the quality of maternal and neonatal health services has been a priority since 2003. Recent laws bring old Soviet practices up to date with standard practices.

Project HOPE began to introduce the New Parents' Schools in 2004, which happened just before Prikaz 425 was passed. This prikaz includes the formation of New Parents' Schools, which used to focus on new mothers only, but now also includes a focus on the family responsibility. The purpose of the Parents' Schools is to educate expectant parents about pregnancy, delivery, postpartum and newborn care, breastfeeding, family planning, and use of mother home cards. Currently, Project HOPE has supported the formation of

[5] New WHO/Euro maternal/neonatal care package is called Making Pregnancy Safer – and this is the standard package that the project follows.

75 parents' schools at primary health care facilities, which is 91.46% of all PHC facilities.

Some of the mothers of children under one year of age interviewed in the focus groups attended the New Parents' Schools. The discussions showed that in general, mothers are satisfied with the perinatal services they have received. Mothers have obtained information about the prenatal period as well as what to expect during labor and delivery. Women also reported that they were informed about different possible delivery positions, the importance of skin-to-skin contact with the newborn and were happy to have the opportunity to choose to have their partner participate during delivery.

The Parents' School consisted of establishing a counseling area (called Parents' School Corner) in the health facility, where the expectant parents receive counseling from midwives and Ob/Gyns. The education and counseling manual covers six topics: (1) pregnancy and physiological changes during pregnancy; danger signs during pregnancy and the development of the fetus; (2) labor and delivery and danger signs during delivery; (3) new born care; (4) breastfeeding; (5) family planning; and (6) post-partum care.

The Parents' School also includes a set of take-home materials, a doll for practicing breastfeeding positioning, posters and a registration book. Also, the technical working group and Project HOPE staff has carried out poster design competitions among health providers, and the best posters were displayed at the Parents' school corners.

Project HOPE funded and supported an intensive training program for health providers at different levels of the health system. The project used adapted evidence-based medicine protocols for Uzbekistan when available and when there was no adapted version, the project used the standard WHO/Safe Motherhood protocols on antenatal care, management of normal delivery, management of labor and delivery complications, post-partum care, and care of the newborn.

All training activities at the Oblast level were carried out in the SM training center developed by the OHD and Project HOPE under OHD's Prikaz, with funds provided by Project HOPE for equipment. The training center is used for breastfeeding, safe motherhood and HIV/AIDS training (supported by the Global Fund), and OHD meetings. Currently, the training agenda showed a high level of facility utilization. In addition, Project HOPE created two new training rooms in new rayons during the second phase and all trainings at the rayon level were conducted in these and two old rayons training rooms. There is also a completely stocked and equipped training room at the Nurses Association. The Association will continue providing training after the Navoi CS project ends, as they have the materials and trainers available and believe they can cover additional costs through their membership fees.

The following table summaries the courses and seminars conducted on Safe Motherhood:

Type of Training	Numbers and Types of Participants	Training Topics
Eight-day theory and practice on Making Pregnancy Safer (MPS)	128 hospital level physicians and midwives	Improve knowledge and skills on antenatal, delivery and postnatal care, use of partograph, management of main obstetrical complications, MPS package promotion
Nine-day course on IMPAC	36 hospital level Ob/GYNs	Improve knowledge and skills on management of emergency obstetric care
Five-day TOT on SM	17 Maternity house physicians/midwives	Improve skills on SM and teaching/adult education skills
Three-day course on MPS follow up visits and monitoring	17 hospital level physicians and midwives	Train local and regional specialist-supervisors on PEPC monitoring; to identify problems and barriers; devise solutions; provide information about performance; standardize supervision and monitoring
Five-day training on SM	235 primary health care physicians, general practitioners and midwives	Provide standard information on antenatal and postnatal care; referral system; how to setup "parents schools", newborn home care, management of some complications during prenatal and postnatal periods
Four day TOT	13 PHC maternity house physicians and midwives	Improving training skills; adult education skills
Three-day course on follow-up supervision and monitoring at PHC level	17 local specialist supervisors	PEPC monitoring, identification of problems and barriers, devise solution, provide information about performance, standardized supervision and monitoring
Essential Neonatal Care	36 local health providers of Maternity Houses	Improve knowledge and skills of local health providers on neonatal care and neonatal resuscitation
TOTALS	**499**	

The materials utilized were the guidelines for trainers on "Essential antenatal, delivery and postnatal care/PEPC", WHO 2002; and handouts on adult education principles; Protocol of MOH on management of hypertensive syndrome during pregnancy, delivery and postnatal period; "Guideline on effective assistance during pregnancy and labor;" partographs of special cases, diagnostics of pelvic inflammation diseases and STIs, diagnostics and treatment of sepsis; slides, transparences and video tapes; and mannequins.

Iron supplementation among pregnant women is an essential part of safe motherhood. A question was posed to women during the mid-term regarding actual consumption of iron by pregnant women. However, the KPC results show that increasing percentages of women (54 at baseline and 73 at FE) bought or received iron tablets during pregnancy. Informal interviews during the FE confirmed that women had taken the iron during their

pregnancies. However as pointed out in the mid-term, neither the project, nor the MOH have any control over iron supplementation, because they do not distribute them.

The same community mobilization strategy described in the above sections was adopted for the safe motherhood intervention as well.

As part of this FE evaluation, focus group interviews of mothers of children under one year of age demonstrated that mothers know about danger signs and had complete information about complications including bleeding, edema, low abdominal pain, and early rupture of amniotic fluids. This improved knowledge of danger signs is also evidenced in the KPC findings (see above). The FE team believes that the the reason the mothers knowledge improved was due to the project's improved counseling skills training of patronage nurses and GPs. The FE team believed this because when these results were compared to the MTE findings, it showed dramatic knowledge gains (47 to 97 percent increased knowledge of danger signs)

In 2005, Project HOPE adapted a Mother's Home Card incorporating lessons learned from the Mothers' Home Cards developed by the German aid agency, GTZ, in Namangan Oblast. Use of the mother's home card falls in line with Prikaz 425 on antenatal care which includes the promotion and use of the Mother Home Card (MHC). The card covers medical check up history, messages on danger signs, exclusive breastfeeding, post partum contraception, iron tablets for 90 days, and newborn care. The last week of the MTE (October 7), the MOH invited Project HOPE/Navoi to present the adapted MHC to a national group of experts. Project HOPE pilot tested the card with the Navoi OHD and RHD personnel, and it was then adopted by the MOH at the national level and recommended for use by all the oblasts.

At the national level, the Safe Motherhood Initiative has a multi-agency Technical Working Group (TWG) that coordinates and strengthens its implementation. The CS project team has participated occasionally in this national TWG. In Navoi, the CS team has worked in close collaboration with the TWG for the training of health providers, monitoring safe motherhood implementation, and to make decisions regarding the implementation of the program in the oblast. Participants on the Navoi TWG are staff of the Oblast and Rayon Health Departments and Project HOPE.

The MOH used Navoi to field-test a protocol for the perinatal period under Prikaz 425, which includes antennal consultation protocols and newborn care, which was officially implemented at the end of 2005.

Institutionalizing semiannual monitoring and supervision visits has been a great achievement of the CS Project. The instruments utilized consisted of a set of questionnaires and checklists adapted from the WHO's Safe Motherhood Health Facility Assessment. All health facilities are visited by the TWG. The purpose of monitoring is: (1) to reinforce training and provide additional in-service training; (2) health facility assessment with a reduced number of questionnaires; (3) review data and make decisions to address identified weaknesses in any program area.

According to interviews with project area Ob-Gyns, one of the improvements resulting from the training is fewer C-sections and hospital infections. The Obs believe this is

because the practitioners are more knowledgeable about how to handle complicated pregnancies and deliveries. Also, the role of midwives in managing normal deliveries has increased after training. Before, all normal deliveries were managed by the Ob-Gyns. Now the use of partographs has allowed nurses and GPs to identify manageable complications earlier and this has helped increase the number of normal deliveries. The use of partographs allows nurses to track labor progress and alert doctors promptly if there are unusual progressions or changes. This in turn, allows the physician to deal with the problem before it becomes complicated, which then requires a C-section. The HPs and the makhalla leaders indicated that they believe there is less morbidity and mortality among newborns and mothers. Also, the increased presence of partners at deliveries has reduced complaints about the service in the maternity houses. Several of the practitioners commented on improved working conditions due to the implementation of the national policies and standards. In 2003, Project HOPE encouraged the MOH to change and improve the prikaz's related to breastfeeding, newborn care and management of hospital deliveries. In 2005, the MOH also developed antenatal standards based on WHO standards, which made it easier for the project to implement SM in PHC facilities.

The project and Health Department staff in the oblast and rayons believe that the monitoring process has been very useful for improving and upgrading services. They also believe that the monitoring visits will continue as they are leaving strong teams in place and enough materials for both in patient and outpatient monitoring to continue.

Challenges and Recommendations:

- One of the challenges that the FE team sees is whether the oblast will be able to continue the strong monitoring of services that has existed to date. Currently, the monitoring has been conducted from the oblast level and is usually a 1-2 day process with several teams. The work is very thorough with interviews, reviews and checklists. A recommendation made by the team is that the Oblast Health Department organize supervision activities from the rayon levels, rather than trying to organize teams and logistics from the oblast levels. They could also consider reducing the number of monitoring instruments to make the monitoring process shorter and more practical.

  If possible, it is recommended that the Project HOPE staff work with the Oblast HD to organize agendas and teams at the rayons so that such a monitoring system is left in place before the project closes.

- The MOH has been slow in approving prikazes related to safe motherhood, and there is a need to approve protocols and standards for emergency obstetric care. The MOH has approved two sets of protocols (for eclampsia and hemorrhage) but there are 10 more waiting for approval. In some desperate circumstances, HPs have used WHO protocols but it is dangerous to use protocols that are not officially approved by the MOH, so there needs to be encouragement for approving the outstanding prikazes.

- There has been considerable debate within the MOH regarding the definition of live birth. Currently, Uzbekistan's policy is that live birth begins at 28 weeks and if a baby is born before then it is considered a natural abortion or stillbirth. There

is pressure to change this criterion to meet international standards in the ICD 10, which state that live birth begins at 22 weeks. Although UNICEF and ADB projects are equipping facilities to handle premature births, many practitioners are concerned that the new live birth definition will be approved before they receive the equipment and training to manage these premature births. In anticipation of acceptance of the new criteria which is supposed to take place in 2008, and at the request of the MOH, Project HOPE staff has printed the ICD 10 guidelines for each health facility.

If possible, it is recommended that Project HOPE staff try to assure that systems are in place for proper equipping of maternity facilities for premature births in the Navoi Oblast before the close of project.

- Continue Training Health Providers. Project HOPE should be commended for implementing such ambitious training plans to improve safe motherhood and newborn care interventions. These trainings have also strengthened the capacity of the Oblast Health Department and TWG to conduct training. As with the monitoring, it would be helpful if Project HOPE staff could work with the Oblast to leave a training plan in place for all the new personnel who will need training. As indicated above, the Nurse's Association has already indicated that they are planning for the SM training needed for new nurses and appears to have the resources for this. Since new nurses are coming on board frequently, this training plan is important.

- One of the recommendations from the mid-tem evaluation concerns why there are delays in obstetrical care seeking behavior on the part of community members and at the facilities. The MTE recommended that the project conduct operations research to find out more about the causes of the delays, but the project did not have the resources to conduct this study. If future resources become available, this study would be worth conducting, for although the MMR has come down since the beginning of the project, it is still quite high when compared to neighboring countries. Below is the recommendation from the MTE:

<u>Women's perceptions of obstetrical complications:</u> In general terms, the perception of women about an obstetrical complication is very subjective. Usually, signs and symptoms are either overestimated or underestimated. In addition, the decision making process to seek medical attention is not well understood by project staff or by the TWG. It is recommended that the project conduct qualitative studies to determine why some women arrive late to receive the proper level of care. The project should determine the main causes for the Four Delays: (1) the time it takes to recognize the obstetrical problem; (2) the time it takes from the recognition of the problem to the decision to seek medical help; (3) the time it takes from home to the nearest health facility that provides essential obstetric care; or (4) the time it takes from the arrival of the patient to the health service until she receives medical attention.

The reasons may vary in rural remote areas from more accessible areas. The researchers need to discover where the main problems are and propose feasible solutions. What seems evident is that the PHC level in rural areas is unable to handle any severe obstetrical complication and furthermore, the PHC provider could delay the proper level

of care. PHC providers need to act promptly, but also need transportation and emergency drugs and training to prepare patients for referral. These are additional reasons why an emergency obstetric care prikaz is needed.

Family Planning

See Section 3, Family Planning, for Flex Fund-supported activities.

c. New Tools or Approaches

Project HOPE has used several strategies that it utilized within the CS project that are both innovative and that are being adopted by the national level, the OHD and RHDs.

Project HOPE has implemented a comprehensive monitoring plan that reinforces training at the service delivery level. This approach has consolidated what health providers have learned during the trainings. It allows the TWG to identify strong and weak areas that need further inputs and/or in-service training. It also focuses on delivering quality services and taking a comprehensive approach to the health system. Since the mid-term evaluation, the project has encouraged the OHD and RHD to take stronger roles in the evaluations but as mentioned above, there are still concerns about how the monitoring will be continued after the CS Navoi project ends.

Project HOPE has also brought specialized technical assistance through a participatory research study to determine the informal communication mechanisms at the community and family levels; it identifies the family "gate-keeper" and the person(s) who makes the decisions to seek medical care, and who provides information on health related issues. The study particularly highlighted the role of grandmothers or mothers-in-law and their role in influencing healthcare seeking behavior. This information has been used as the basis of the community mobilization component, which focused on Women Leaders as the key government organization to lead the community health education component. During this process, the CS project staff has learned about qualitative assessment methodologies and anthropological approaches to address community health issues.

Project HOPE used additional non-CS funds to develop behavior change communication (BCC) materials for the Navoi project which have been reproduced and disseminated by other partner organizations both in the country and throughout the Central Asian Region. Project HOPE has taken advantage of this opportunity to develop materials with leading expert groups in the country such as the National Pediatric Institute and the Technical Working groups, UNICEF, and USAID partner organizations (the Healthy Family Project and Zdrav Plus). The strategy also includes learning from existing, successful materials developed by local and international NGOs. During the second half of the project, an adolescent RH booklet for parents was developed and printed. The purpose was to involve parents of adolescents in project activities and to obtain the support of parents for ARH education activities. The booklet includes key ARH messages and 17,000 copies of the booklets were printed in Uzbek and 3,000 were printed in Russian and have been widely distributed by the project. During the FE, many adolescents, community leaders and teachers referred to the booklet as a useful tool for talking with parents on such sensitive topics as adolescent reproductive health.

The first IMPAC training was conducted during the second half of Phase 2. Seventeen Ob/Gyns from maternity houses received the nine-day IMPAC training by Professor Karimova, who is President of the Association of OB/GYNs, at the SM Center. Modern methods for Management of Complications in Pregnancy and Childbirth were presented and demonstrated to participants. As a result of this training, monitoring tools on IMPAC were also developed and used.

Although not originally developed by the CS project, a WHO Decision-Making Tool for Family Planning Clients and Providers was translated into Uzbek by the project team and local health providers. This tool is a decision-making aid for clients and a job-aid and reference manual for health providers that includes evidence-based technical information on 14 family planning methods. Included in each section are medical eligibility criteria, side-effects, when to start, and how to use each method. There is also a one page client hand-out with helpful pictures and key points, and a corresponding page for providers with key points and detailed reference information. Two hundred and fifty (250) copies of the guideline were printed and distributed among FP/RH providers.

A Making Pregnancy Safer (MPS) guideline for visiting nurses was developed in 2007. The purpose of this guideline was to improve counseling skills and it was used during the four-day MPS/RH training course along with the other training materials. The first MPS/RH training, using the new guideline was conducted for 17 visiting nurses in Karmana rayon on March 15-18, 2007.

Recently, a four-day "New Electronic Technology for Data Collection and Analysis" training was conducted on February 15-18, 2006. Twenty four (24) data specialists of OHD/RHDs participated in the seminar from all Navoi Oblasts and learned how to manage data on childbirth and death rates according to the ICD-10 definitions, using a Microsoft Access program tool. The first follow up support was provided a month after the training by the OHD's chief data specialist and Project HOPE's HIS specialist. To date, all the project rayons are able to use this tool, thus preparing them for new government orders that will be changing the live birth definition to conform with the ICD-10 definition.

Other guidelines developed in the past two years include guidelines and training curricula for the Community Health Promotion program as well as CHP monitoring tools. Also, in collaboration with Abt association (ZdravPlus) the project launched a Quality Improvement strategy at 19 primary care facilities. To help the two organizations supervise activities, a QI monitoring tool was also developed.

3. Results: Cross-Cutting Approaches

a. Community Mobilization

The community mobilization activity took a long time to launch. This is not surprising given that there are few models or resources in the country from which to design a community mobilization component that is truly focused on community ownership, and that was outside the old-soviet campaign approach..

The project contracted an anthropological consultant, Judy Aubel,PhD, who conducted a study in 2003, which indicated that there were local resources in the country from which to develop a community health promotion strategy. They brought her back in 2005 during Phase 2 to develop a strategy based on the previously conducted research. She outlined what traditional groups to work with and suggested the project use both formal and informal leaders with a focus on grandmothers. Based on this, the Project HOPE staff completed an analysis of the socio-cultural dynamics affecting maternal and child health in Navoi. Project staff realized that they should develop training and educational events that are participatory, interactive, and that methodologies such as story telling are more acceptable modes of information transmission in traditional Uzbek communities. The project team developed a BEHAVE matrix plan and a strategy to move forward on a BCC plan. At the time of the MTE, the staff completed guidelines that included twelve areas of intervention and over 50 health messages. These guidelines proposed working with both formal (i.e., those chosen by prikaz to work in health promotion) and non-formal community leaders and utilization of six channels of communication: video tapes (6 films); stories without an end (2 on diarrhea, 1 on BF, 1 on FP, and 1 on iron tablets); pictures and discussions; stories from personal experience/discussion; small group discussions; and lectures. At the time of the MTE, the team realized that the staff needed assistance on how to operationalize the planned and rather complicated community strategy. At that time, the Project HOPE Regional Program Director helped the project redefine and simplify the community mobilization plan. With her help, the project was able to operationalize the plan and develop a three-part training manual for community leaders. The manual has sections that deal with 1) how to work with community groups, 2) adult education methodology, and 3) key information messages. The CAR Program Director also worked with the project team to develop additional brochures and booklets. The manual included nine health topics and each had different colors. In addition to the manuals, the trained leaders were provided with materials for developing open ended stories, role plays, discussions and videos.

The next step was to select three leaders from each makhalla. One was from the Religious Council and two other informal leaders were selected. A special training binder was developed whereby sections could be removed and used for educational activities as needed. The leaders were taught how to organize meetings, using adult education strategies, how to pick target audiences to educate (mothers of children under 2, WRA, adolescents) and each leader was given a form for planning education sessions and recording actual activities. The leaders planned and recorded activities on a six-month planning instrument that was developed by Project HOPE and the FE team observed that the planning instrument was being used by the leaders to track planned and accomplished educational tasks by educational subject and number of participants. This tool is useful for monitoring and supervision. Each volunteer leader provided two educational meetings per month (six per makhalla total) and then brought their reports to the meetings with the chief of the women's committee at the rayon level, showing the methodologies used and discussing what strategies were effective and which ones were not.

The Chief of the Women's Committees at the rayons monitored and supported community activities. The project works closely with the Deputy Oblast Governor who is also the Chief of Women's issues and on the Steering Committee. She also oversees the work of the Women Chiefs at the rayons and receives their reports, which include the work of the community leaders trained by the project. In this way, the project has

integrated the work of the community leaders into the work of the local government structure. The Deputy Governor and Women Leaders are responsible for implementing Prikaz 242, which is to increase health knowledge among families at all levels. Having the women leaders supervise the work of the community leaders has provided a built in supervision system; this activity will also be sustained because the women leaders are part of the government system. Another advantage of the women leaders is that they tend to be older women and have a lot of influence with the mother-in-laws and grandmothers as well as the community leaders.

Between March 2006, when the community strategy began, and January 2007, the project held 24 seminars in the four rayons and trained leaders from 126 of the 127 makhallas. In all, there were 16 trainers composed of individuals from the Deputy Regional Governors's office, different chiefs from the rayons, project staff, and trainers from the RH and IMCI training centers as well as others. Altogether 391 leaders have been trained, thanks to the CS Navoi project.

In addition to the education system put in place with the community leaders and the Women Chiefs/leaders, by strengthening the patronage nurses skills, the project has completely linked the community and families with the local primary health services. The counseling skills training allowed the nurses to do more antenatal, postpartum, family planning and breastfeeding education with mothers in their homes. The mothers and WRA interviewed by the FE team commented that they were receiving education from community leaders and the nurses. Women had been counseled and provided with educational materials that they had with them. Both leaders and mothers commented that they thought there was better acceptance of family planning, recognition of danger signs in pregnancy and child health. Both groups commented that they had not had severe cases of diarrhea in their communities or infant or maternal deaths during the previous year.

Overall the educational and training materials are considered very useful and user friendly. The mother's home card (discussed above) was accepted by the MOH as an appendix to the national prikaz for antenatal care.

In addition, members of the FE team pointed out that that the educational methods and strategies can be used by leaders in other sectors of their work besides health. These skills include use of stories, video discussions, role plays and how to select target groups for education activities.

Lessons Learned

- Initially, the project had difficulty in recruiting community leaders for training and relied on the chiefs of the makhallas or the women's committee to make recommendations. Unfortunately, some of the leaders that were recommended were elderly, respected individuals who could not easily learn the teaching methodologies. After three groups (of the 24) were trained, the project asked the health providers to recommend leaders for training and it turned out that they had better results with them.

- Before the end of the project, the team will hold a conference to share community strategies to promote health. They will invite representatives from the city and non pilot rayons including individuals form the women's committees, health institutions and health promoters from the non pilot areas.

- In order to stimulate more learning among communities, the project decided to hold poster drawing competitions on different health themes (breastfeeding, STIs, diarrhea prevention, etc.) for different groups (grandmothers, nurses, etc). The project found that when local health providers made posters themselves, it gave them a sense of ownership of the education process even if they weren't very artistic. The FE team noticed several "home made" posters at the health facilities during the field visits.

Conclusions and Recommendations

- The older women community leaders appear to be great for working with mothers and grandmother groups. They know most of the families in their makhallas and are respected members of the community. For this reason, older women appear to have had a positive impact on health knowledge among mothers of children under 2 and WRAs. However, because of their age, the FE team verified that they are not as able to reach adolescents, who the leaders readily agree respond better when receiving ARH information from their peers.

- It is often difficult for community leaders to organize education activities right after training because of other community commitments, such as seasonal agricultural campaigns. Therefore it is important during training to teach participants how to integrate their educational activities into the other seasonal activities. One example would be to take advantage of community gatherings, like traditional weddings, as an opportunity for educating the participants.

- Currently, there are only a small number of male leaders. If resources become available and further work is done in this area, it is recommended that strategies be developed to recruit more men and develop educational sessions that specifically target men. Men are key decision makers in the households and therefore need to be educated as well about preventive health.

- Project staff has been concerned about the older ages of the formal community leaders. They seem to understand key messages but lack teaching skills. When the project conducted its first monitoring sessions, they found knowledge to be low so they encouraged the leaders to study more and now seem to think their levels have improved. The FE evaluators are not as concerned about whether the leaders have in depth knowledge of the health subjects because the role of the leaders is really one of making community members aware of preventive health and then directing them to the patronage nurses or the health facilities in a timely manner when there are problems. In order to be effective, however, periodic updates of the training tools, such as new stories, pictures, videos, etc., need to be incorporated. It is recommended that the project work with the oblast and rayon women chiefs to help them develop a plan for updating tools.

- There is a need for the government and Oblast health and women's issues department leaders to create a team that can lead future trainings in community methodology for new formal leaders. There is also a need to provide refresher training for makhalla leaders. This team should also take responsibility for updating community teaching materials and tools.

b. Behavior Change Strategy

The BCC strategy includes the following elements:

1. A community mobilization component discussed above.
2. Expanded work with patronage nurses that includes several training seminars - MPS/FP and IMCI/BF.
3. Campaigns for diarrhea control, breastfeeding, reproductive health, Making Pregnancy Safer, acute respiratory infection, ARH.
4. IEC materials creation and distribution.
5. ARH TOT and training.

Evaluation/observations:

The BCC strategy presented in the DIP was unclear, which lead to confusion over expectations at the field level and delayed development of the BCC activities.

While for the most part Project HOPE has used or adopted existing IEC materials, some materials were developed especially to achieve the project's objectives. These include the child health booklet that was distributed to all families; a maternal health card that contains health messages; and several educational materials for the adolescent program. There were also posters, leaflets and brochures developed or adopted for each of the intervention areas. The materials, in some cases, were developed with partner institutions, such as the National Pediatric Institute or borrowed from other projects such as Zdrav Plus and were distributed among partner organizations and programs, such as the Healthy Family project.

The content of the materials was reviewed by partner institutions in the country. All materials were developed in the appropriate language (Uzbek) and were adapted as needed. A complete listing of educational materials developed and adopted by the project and a description of quantities produced and activities is located in Annex D.

Project HOPE has worked with patronage nurses to provide education and counseling in the homes while visiting families with pregnant women and young children. The capacity of the patronage nurses and their counseling activities have greatly increased since the implementation of the community strategies after the mid-term evaluation.

Next Steps/Recommendations:

- As noted in the previous section, the materials and tools will need periodic updating and reprinting. It has been suggested that the Oblast HD, Women's Issues department and the Health Institute be asked to take responsibility for this. It is recommended that the project staff try to organize a meeting of these groups to address this issue before the project closes.

c. Capacity Building Approach

i. Strengthening the PVO Organization

The Navoi CS Project has provided Project HOPE a wealth of valuable lessons during its eight-year duration. Through this project, Project HOPE learned that implementing community development and community mobilization activities in the former Soviet Union requires more guidance and creativity than in other parts of the world. The concept of empowering and enabling community members to take charge of their health is totally foreign in this part of the world and has required special effort on the part of the project team.

Attention to detail in providing guidance on such things as sample selection for LQAS or KPC surveys, FP and IMCI counseling and monitoring practices. Project HOPE-Uzbekistan has learned that preventive activities introduced in Navoi can have an impact at the national level including: the ARH guidelines that were developed by Project HOPE that included a trainers manual, a participants manual and a reference book; also the mothers Home Card was attached as an appendix to the national antenatal policy and; the IMCI materials developed with the National Pediatric Institute have been used not only in Uzbekistan but in Project HOPE's project in Krygystan. In addition, the CS Navoi project was a basis for the Healthy Family Program, which has been conducted in two southern Oblasts in Uzbekistan as well as all Central Asian Republics except Kazahkstan. Through the CS Navoi project, Project HOPE has strengthened its own programs in the region, contributed to changes in the country as well and become a major player in public health program implementation in Uzbekistan.

ii. Strengthening Local Partner Organizations

The focus of the project has really been in building the capacity of its local partners. The Oblast and Rayon Health Departments have been the main partners in implementing this project. Project HOPE has developed some strategies that are both innovative and could be shared with other organizations. The overall approach of working directly with the Oblast and Rayon Health Departments to improve their capacity is something that Project HOPE has lead in Uzbekistan and may be one of the main reasons that Project HOPE is the only US-based NGO still operating in Uzbekistan. All of Project HOPE activities and interventions are based on this approach.

An example of this collaboration was witnessed in the meetings where the FE results were presented, where Project HOPE asked Oblast and rayon chiefs to interpret the information, and the Oblast Chief asked the health workers to make a commitment to follow up on CS project activities after Project HOPE ends activities in Navoi. In addition, Project HOPE will disseminate and discuss the FE report and recommendations in a collaborative manner with the OHD and Steering Committee, stressing the areas that need their continued attention.

Project HOPE assisted the OHD to upgrade the technical level of the health providers at both rayon and makhallah levels. In the OHD Chief's own words, Project HOPE staff

has worked hand-in-hand with the OHD and RHD health teams. Now the Oblast and rayon health teams know how to supervise and monitor their work. The project has prepared many monitoring specialists. Additionally, the project has encouraged health teams to add training rooms to their rayon and oblast health departments and in doing so, the project has equipped the OHD and RHD teams with materials and trained trainers. Now there are also teachers who can teach ARH topics, which did not exist before the project. Likewise, the capacities of the women leaders have been strengthened. After the training they have received they can coordinate and monitor activities whereas before they could not teach or organize classes or attract community members from the target groups. The same is true for the patronage nurses who did not really have the practical skills to provide home care before and now make regular visits and provide services and counseling to all families with pregnant women and young children.

Project HOPE has led the KPC and LQAS implementation in the country through both projects, the Navoi CS and the Healthy Family.

Project HOPE developed IEC materials for child, maternal care and adolescent health activities. Project HOPE has used local expert groups such as the National Pediatric Institute, UNICEF, WHO and PRIME II. The strategy also includes learning from existing materials developed by local and international NGOs like Zdrav and Healthy Family Project. Also, Project HOPE has made the final materials available to a wide variety of organizations working in the area of maternal and child health in the country.

The opportunities to consolidate lessons learned and best practices of the CS Navoi project and distribute them locally through the national working groups, and internationally through channels such as CORE and CSTS will be of great benefit to the CS community.

One drawback in the relationship with the OHD is that Project HOPE could not avoid providing the resources the MOH lacked. This is always one of the trade-offs between the sustainability Project HOPE was trying to create in the project versus the reality of the resources the OHD was lacking.

Some lessons learned through the partnerships with the health system include:

1) When training health practitioners, it is important to involve the key officials (heads of departments) in the process so that they will support the new training that their staff is receiving. Otherwise the new methodologies will not be a priority for them and it will be difficult to implement the new health practices.

2) A second lesson concerns the community strategy, which originally called for having the project hire a rayon coordinator for each district. The project decided that it would be more sustainable if they worked through the existing system of women leaders whose job was to provide health education to makhalla families.

iii. Health Facilities Strengthening

As mentioned in the project interventions sections, the project has trained hundreds of MOH personnel. Project HOPE has assisted the OHD and RHDs to carry out a health

facility assessment. In addition, Project HOPE has adapted monitoring tools (see Annex H) to regularly assess the quality of the clinical interventions, which include the evaluation of the health worker's performance delivering project interventions, and cover 100 percent of project facilities.

The project staff indicated that at the beginning of the project it was hard to implement use of the partograph. But eventually the project received the support of the chief Ob-Gyn at the Oblast maternity house who saw the utility of the tool and insisted on reviewing the previous day's pantographs every morning. The FE team noticed that Ob-Gyns and midwives mentioned the utility of pictographs and how the information provided on the partographs has allowed the midwives to take more active roles in deliveries and better track progress during pregnancies.

During the past year, the project has also worked with Zdrav Plus to implement a Quality Improvement strategy in 10 PHC facilities. This methodology has taught providers how to employ a team approach and use self-monitoring to improve the quality of services.

iv. Strengthening Health Worker Performance

As described in Section b. Progress Report by Intervention Areas, the major emphasis of the project has been to train health providers of all levels of the health system through training of trainers, training courses and seminars.

In addition to courses and seminars, Project HOPE has institutionalized monitoring and supervision visits that include assessment of health providers' knowledge and the delivery of health services. The tools utilized are described in the reports by intervention, but included questionnaires to determine the health providers' knowledge; observation checklists to assess the delivery of health services, and exit interviews. The results of monitoring visits were fed-back to the services soon after the visit and served to improve the delivery of CS interventions. One of the monitoring decisions made by the project occurred after training visiting nurses. When they realized that they could not train all the nurses since they only had funds for three from each facility, they asked that the trained nurses teach their untrained colleagues at their home facilities. Therefore to see how well this approach had gone, the monitors decided to randomly monitor all nurses as well as other practitioners during their visits. The results indicated that in many cases the training information and tools had been shared with colleagues. Some of the untrained colleagues took interest and studied the materials and even surpassed the results of their trained colleagues. In other cases, the project staff felt that the trained nurses needed more teaching skills in order to better train their colleagues.

In discussing the monitoring needs after the project closes, the project staff believed that continuing to monitor PHC activities from the Oblast level with large teams may be unrealistic for the OHD to pursue. Instead they thought that monitoring should be coordinated from the rayons. The staff has talked to the rayons about this suggestion and the need to build monitoring capacity among staff to perform the inspections. However, once the CS Navoi project ends, staff is unsure of the rayons ability to continue these activities.

Lessons Learned/Recommendations

As mentioned above, a lesson learned was when the project realized it was unable to train all the patronage nurses (there are 71,000 total with high turnover), the project decided to train three nurses per facility, giving them skills and materials to train the other nurses at their stations. Some shared the information with other nurses and others did not. The lesson learned was that it might have been better to add one more day to the training that included teaching skills to facilitate replication of the training to the untrained nurses.

Another lesson is that key decision makers such as chief nurses, PHC chiefs, chief Ob-Gyns and pediatricians, should be included in training and monitoring so that the activities will be followed up. The project is trying to involve these individuals in the activities now but they think more effort needs to be made.

v. Training

Project HOPE's purpose has been to strengthen the capacity of the Oblast and Rayon Health Departments. To this end, Project HOPE developed an extensive training program, focusing on the training of MOH personnel in IMCI, Safe Motherhood and Family Planning, including the development of an adolescent reproductive health education and services program.

As it has been described in detail in the Sections B and 4, the project included many training courses which allowed it to meet most of it's targets for the life of project. Much of the training has been institutionalized by the OHD and RHDs. OHDs have their own training rooms and centers that are fully equipped with materials and equipment including computers and databases to monitor training. Health departments also have their own training and monitoring teams in place. In fact, the Oblast has placed its own IMCI training coordinator at the training center and the nursing association has its own funds with which to continue training activities. What is left now is the need for a training plan to be developed by the OHD and RHDs for maintenance of training activities including updates, refresher courses and monitoring. They also need continued reinforcement of the skills that have been learned in the classrooms. Since the project staff turned the training responsibilities over to the MOH, they are not sure how often the training databases are reviewed or used for planning future training.

d. Sustainability Strategy

Project HOPE has implemented a highly sustainable strategy for delivering health services in Navoi. Rather than implement child survival activities, Project HOPE is working with the OHD and RHDs to improve their capacity to manage personnel and resources in Navoi to deliver high quality services.

At the oblast level, Project HOPE has assisted in the formation of Technical Working Groups; has strengthened the training centers; has strengthened the school education program on adolescent sexual and reproductive health; and has extended project activities through local NGO counterparts. Lastly, at the oblast and rayon level, Project HOPE trained master trainers (TOT) to train health providers and field staff in the project interventions and adult education techniques.

At the rayon level, Project HOPE trained teachers on adolescent sexual and reproductive health; has strengthened monitoring, follow-up and supervision visits for the health delivery level; and has unified information based on key indicators and decision-making through the TWGs.

At the community and makhallah level, Project HOPE trained patronage nurses in CS interventions and counseling skills; promoted integrated and multidisciplinary visits to PHC facilities; and strengthened schools to provide sexual and reproductive health through brochures, booklets, and other materials.

The oblast level activities have been accomplished completely. The main impact Project HOPE had was on the OHD, where there is evidence of mutual collaboration and development of action plans. The next step is to collaborate with the OHD to submit project proposals for funding.

The main efforts were directed to the rayon and makhallah level, where Project HOPE worked in close collaboration with the health providers and their teams consisting of doctors, nurses, patronage nurses and makhallah leaders. Almost all training sessions were directed to this level, which included monitoring and supervision.

The community level began late but received considerable focus during the second half of the project. Although it took a long time, the strategy was well thought out, particularly in terms of sustainability. By selecting and training community leaders as health promoters instead of hiring CHWs, the project avoided creating a parallel system that would have no support after the program closed. Now the way the project is organized with trained community leaders providing health awareness messages who are supervised by trained Women Leaders from the rayon system, the project is again helping the government fulfill its own mandates. The Wmen Leaders are responsible for implementing Prikaz 242 to educate families about health. The only concern is that because this part of the project is late in starting, the FE team wonders if there will be enough support from the Oblast level to continue providing needed refresher training, monitoring and supervision.

To address sustainability concerns, the project's Steering Committee conducted an exercise on sustainability "after HOPE" in January 2007. The committee divided into groups (MH, CH, ARH) and each wrote plans and divided responsibilities for listed training, monitoring and other activities and commitments to follow-up.

There were no formal sustainability objectives or phase over plans but the work plan always included sustainability as a key element. One of the main purposes of the second phase project was for HOPE to phase out and hand over its activities to the Health Departments. For this reason, the training responsibilities were handed over to HD staff during the second half of the project, with only minimal financial support provided by the project.

4. Results: Family Planning

Objectives: (1) Increase the number of women/couples with a birth interval at least 24 months after the previous surviving child; (2) Increase the number of women/ adolescent/ couples' knowledge of the reproductive cycle; (3) Increase the number of non-pregnant women who desire no more children to space births and are using a modern method of FP; and (4) Increase the number of family planning clients who received counseling on contraceptive choices, common side effects, and when to return for follow-up.

Percent effort: 30%

Main Strategies and Activities: (1) Implement TOTs and train health staff in family planning; (2) explore the possibility of continuing surgical contraception (minilap) training for health providers; (3) BCC and makhalla/community-based work focused on WRA and their partners by initiating sessions to orient makhalla committees and leaders in reproductive health and family planning; (4) Adolescents' Reproductive and Sexual Health (ARSH) to increase adolescents' knowledge about sexuality and reproductive health and to develop an adolescent-friendly health services strategy; (5) BCC and makhalla/community-based to increase knowledge of reproductive health and sexuality; and (6) focus on improving the quality of FP service delivery through training, community education and close monitoring and supervision.

Adolescents' Reproductive and Sexual Health (ARSH): This component had two primary purposes: (1) to increase adolescents' knowledge about sexuality and reproductive health and (2) to develop adolescent-friendly health services.

KPC Results on FP and child spacing

Indicators	Baseline (Feb 2004)		MTE (May 2005)		KPC FE* June 2007	
	%	CI	%	CI	%	CI
Adequate Birth Interval Between Youngest Surviving Children: Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child	48.3%	±18.2	86.9%	±6.13	84.7%	±5.8
Percent of women of RA who report that women are likely to get pregnant halfway between two menstrual periods	9.3%	±2.8	72.8%	±8.21	45.7%	±5.6
Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing	72.6%	±4.6	91.5%	±5.67	72.8%	±9.3
Percentage of respondents who report discussing FP issues with somebody in the past 12 months	56.2%	±4.7	82.5%	±5.71	65.7%	±5.4
Counseling: Percentage of family planning clients who receive counseling on contraceptive choices, common side effects, and when to return for follow-up	62.7%	±5.8	77.2%	±5.86	86.6%	±6.8

Project HOPE successfully worked with several members of the TWGs, Oblast and Rayon Health Departments and PHC services to provide family planning training courses and to implement 6-8 month monitoring visits. The RH training courses conducted by the project are shown below. In total, 475 health providers were trained in Reproductive Health.

Type of Training	Numbers and Types of Participants	Training Topics
3 day TOT	16 Ob/Gyns, midwives, and GPs	Improved skills on RH and teaching/adult education skills
4 day training on RH and counseling (Note that in the DIP this was anticipated to be a 5-day course)	221 Ob/Gyns, GPs, midwives, and feldshers	General counseling skills and informed consent, screening tests, provision of contraceptive methods, including method delivery and follow-up; management of secondary effects; Health information system and information management.
4 day RH course	238 Patronage nurses	Content MPS and RH includes above plus antenatal and postpartum skills.

In the DIP, reproductive health training for the patronage nurses was planned to be separate from the maternal health care course; however great as the need was to train patronage nurses, this methodology has been fused with basic outreach antenatal and postpartum care topics.

Other activities successfully completed by the program include: completion of baseline, mid-term and final KPC surveys, dissemination of KPC results to all stakeholders, development of the DIP, finalization of collaborative agreements with all partners (TWG and training center), and completion of joint supervisory visits with TWG staff.

The results of the baseline and final data surveys are not legitimately comparable with those of the MTE survey because the profiles of the respondents were not the same. In the baseline and final surveys, the respondents were women of child bearing age, while the mid-term evaluation interviewed mothers of children under two years of age. Hence, the higher MTE results might simply reflect differences in the surveyed populations. In any case, the final results though generally not as high as the MTE show definite gains in FP knowledge and behaviors. Although the percent of women using modern methods did not change much from the baseline (72 percent), the percent of women who reported receiving counseling on contraceptive choices, their side effects and when to return for follow-up increased by more than 25 percent. This is a good indication that the percentage of women informed about contraceptive choice rose significantly during the project. The team pointed out that there has been real progress in the area of informed choice. Before the project women used contraception because they were pushed to use it but now they know about the different methods. Progress of informed choice is evidenced by the fact that women can now list the advantages and disadvantages of the different methods. Now if women are asked why they use the IUD, they can tell you all the disadvantages of the other methods for them and the advantages for using the IUD and

when they should come to have it checked. Before the CS project, women were unable to provide this level of detail regarding the IUD. The staff also believes that the HPs are becoming more communicative and doing a better job of discussing contraceptives with patients. The staff noted that before the project, the HPs were a real barrier to informed choice. The pre and post tests from the training courses evidence this, showing that many of them believed the myths about the different methods and propagated those myths to clients.

The project and HD staff also indicated that quality of care improved, thanks to the project. Counseling of clients improved through the provision of educational materials and improved counseling skills delivered by trained HPs. The counseling skills were greatly improved through the monitoring and supervision visits. Having standards and protocols for new acceptors and continuing users also helped improve care. The project also developed posters on counseling steps that are easy and clear to follow and assist HPs in providing care. Results of the monitoring visits, have indicated that clients are more satisfied with services, that there are fewer stock outs of contraceptives, and that there is improved counseling by visiting nurses for both FP and antenatal care (before they did not provide this counseling). Also, according to project monitoring data 91.4% of all 83 SVPs offer mothers classes for antenatal care, which includes information about FP.

The project and HD staff believe that FP access has improved because of improvements in the supply system and informed choice. Before this project (2001-2) health facilities had supplies of contraceptives but less access because women weren't informed and practitioners did not counsel them on the various FP methods available. Also now thanks to the World Bank and ADB primary care program, there are more local level SVPs in the oblast providing primary care.

The most preferred FP method in the project area is still the IUD. The following table depicts the distribution of FP method utilization in Navoi:

Which of FP methods do you use or used before	**Baseline (Feb 2004)**	**MTE (May 2005)**	**KPC FE* June 2007**
Pill	15.7%	11,11%	14.4%
IUD	86.3%	64,33%	70.8%
Injection (DepoProvera)	13.2%	21,05%	16.8%
Norplant	N/a	1,17%	N/a
Sterilization	4.4%	2,34%	5.6%
Condom	12.9%	1,75%	13.6%
Spermicides	0.3%	0,00%	1.2%
Calendar method	13.5%	1,17%	17.2%
LAM	59.6%	5,85%	38.0%

While the use of IUDs has decreased since the baseline, it is still the preferred method. There is a small increase in the use of injectables but the other methods are more or less at the same levels of use. When interviewed by the FE team, women stated that while they had been informed about other methods they preferred the IUD because they believed it to be effective and convenient – i.e., they did not have to be reminded every day to use it or have it changed or reapplied every three months. The additional questions

added to the final KPC also showed that 99 percent of women of reproductive age knew of three or more modern methods of contraception. Interviews also showed that women who were using other methods were using them because they had had problems with the IUD. In other words their first choice was still the IUD. Because the FE team was concerned that the bias for the IUD might be coming from the providers, we asked about this and the GPs admitted that they had more faith in the IUDs and did not fully trust the other methods. Project staff and some health department staff indicated that they thought there was informal pressure coming from higher levels of the government to encourage use of sterilizations and IUDs. However, the FE team was unable to verify further details. According to project staff and interviews with the Ob-Gyns, at the start of the project, there had been a few instances where women were found to have as many as three IUDs inserted at one time. The project staff believes this happened because there was a requirement that all women who delivered at Maternity Houses should have an IUD inserted within five days. Later when women went to the PHC for follow-up care, HPs would insert another one or two – depending on the number of visits the woman made. Fortunately the project corrected this situation in Navoi by asking that the maternity Houses not stock IUDs but give them to the PHCs to insert during postpartum visits.

The MTE evaluation noted that there had been shortages of contraceptives particularly condoms at the health facilities. However, this situation improved with more monitoring and the project and HD staff worked with SVP facilities to train a staff member in logistics management. The oblast RH center staff has developed a table for calculating stocks for the rayons. The FE team found during field visits that there were adequate contraceptives at the health facilities visited. According to project and HD staff, contraceptive supplies are monitored and maintained by the MOH and HDs. Contraceptives are free of charge because they are donated by UNFPA and due to the regular monitoring of services, the primary care facilities have been able to plan and program adequate supplies. Despite this, the project staff still has concerns about stockouts as they think the people responsible for logistics at rayon and oblast levels haven't been trained correctly. Logisticians at the rayon and oblast levels base their estimates of the needs at each SVP on the numbers of WRA in each makhalla without taking into account actual demand levels that are calculated at the SVPs. One concern raised by this situation is that some of the remote rural clinics have had problems maintaining condom stocks, which is problematic as there appears to be an increasing demand for condoms.

The project realizes that free supplies of contraceptives will not always be available and worries that the heavy reliance on the IUD method may impede donations of other types of contraceptives.

The project complied with the Mexico City Policy by not funding any abortion services or providing any training related to abortion. Also, as discussed throughout this report, there was extensive attention paid to and training about informed consent. In addition, the FE team observed numerous posters about the advantages and disadvantages of FP methods at all facilities visited (Tiahrt Amendment).

An important lesson learned by the project was the importance of training the visiting nurses to take a more active role in home based preventive health care. Patronage nurses have proved to be a key link between the communities and the health services.

As described in the maternal care section, Parents' Schools also serve to educate new parents about LAM and modern family planning methods.

Adolescents' Reproductive and Sexual Health (ARSH):

A portion of the ARH activities have been funded by the Swiss donor associated with Project HOPE, the Foundation for Partnerships in Health. The CS project has partnered with the MOH, MOE MOHSSE, the Oblast Health Department, Oblast Public Education and OSSPED, the Healthy Family Project (Project HOPE) and other NGOs.

As mentioned at the beginning of this section, the objectives of the ARH activities were to: 1) Increase the knowledge about reproductive and sexual health among targeted adolescents; 2) Decrease the percent of targeted adolescents having unprotected sex; and 3) Increased knowledge among targeted adolescents who know how to correctly use a condom.

The project worked to support the following program components: 1) Support the Educational Sector in implementation of ARH education activities; 2) Support the Health Sector in establishment of Adolescent friendly health services; 3) Support creation of a network of all sectors involved into ARH promotion; 4) Increase community awareness of ARH.

During the CS project, Project HOPE educated a large number of adolescents through formal school classes and peer educators. The Adolescent Health Center at the Oblast level and centers at the four rayons now offer services as a result of the Youth Friendly Initiative. The work also involved school teachers and almost all community leaders. To accomplish those activities, Project HOPE has developed and offered four types of training events for adolescents and peer educators. These activities included:

Type of Course	Participants	Objectives
A five-day TOT course on "adolescent reproductive and sexual health	394 health providers and school teachers responsible for "ARH" classes and counseling	to improve the health providers' and teachers' knowledge about adolescent reproductive health topics and to develop their skills in providing classes about ARH; to inform health providers about youth friendly service requirements; and to teach health providers to provide youth friendly counseling on reproductive measures.
Four-day "Peer to peer" course on peer education	405 Peer educators	to provide correct adolescent reproductive health information through peer educators. Includes counseling skills.
Two-day course on ARH	1012 students and youth	Taught principals of ARH includes physiology of RH system, consequences of early marriage, advantages and disadvantages of modern contraceptives, prevention of

		STI/HIV and safe sex practices.
3 day course for establishing Youth friendly services	17 ob-gyns and youth health providers	Taught principals of youth friendly services and youth counseling skills.
Summer camp	140 adolescents	

In summary, a total of 394 adult trainers, 405 peer educators and 1,527 adolescents have been trained.

In general, adolescents do not have the opportunity and/or willingness to discuss their reproductive health problems with adults. The project identified two types of adolescents; those who just feel shy about talking about "ARH" with adults, and those who do not believe adults can help them. The Project HOPE team believes that boys and girls prefer to get information on reproductive and sexual health from their peers, and feel more confident talking with them about intimate issues. This belief was confirmed by the FE team when the interviewed adolescents, community leaders and teachers. The evaluation's focus group discussions with adolescent boys and girls demonstrated that boys do talk about RH with their peers, while girls talk with peer-educators, except when they have a problem; they go to a health provider or discuss the issues with a relative. Although providers and adolescents stated that some youth are sexually active, it is difficult to verify this through the surveys. Expectations from society on sexual experience are dichotomous: youth are expected to be virgins before marriage but at the same time, boys are expected to be experienced sexually before marrying. Boys are encouraged to have their first sexual experience with a prostitute and many often contract STIs.

The project developed instruments for monitoring youth-friendly services (YFS). The monitoring helped evaluate effectiveness, friendliness, accessibility and the quality of YFS services. It also helped determine if the service management was adequate; define the work of health providers; define service conditions; identify the clients' opinions of the quality of services; and elucidate the strengths and weaknesses of the services.

Project HOPE has used the following materials for training of trainers, and for educating adolescents:

- "Adolescents reproductive and sexual health" – training manual, school book and informational source for health providers and school teachers responsible for providing ARH classes and counseling (developed by Project HOPE/CS/USAID/Navoi, Project HOPE/HF/USAID/Tashkent, Oblast Reproductive Health Centre, Oblast Adolescents Reproductive Health Polyclinic staff, approved by Uzbekistan MOH Deputy Chief).
- Short films: "Abortion prevention", "Menace of early marriage", "STI prevention", "and Drug addiction prevention" (developed by Project HOPE/CS/USAID/Navoi and Navoi City administration).
- "Peer to peer" – guidelines for peer educators (developed by Project HOPE/CS/USAID/Navoi staff).
- Short films on: "Modern contraception methods," the cartoons "Karate Kids – HIV/AID prevention", and "Karate Kids –drug addiction prevention" (borrowed from "Rainbow", Kyrgyz Project working with adolescents).

- An adapation of the ARH booklet " Me and my world" after conducting FGDs with rural parents and teenagers.
- "Answers on some interesting for adolescents questions"- adolescents brochure is developed by National "Health" Institute, "Navoi Oblast Reproductive Health Center", Project HOPE/CS/Navoi.
- Short films developed by peer educators through competitions. Used peer educators as actors.

Project HOPE has distributed all educational and reference materials to the school libraries, so that there will be permanent resources available at the schools. The Administrators interviewed talked about the importance of the materials in providing information to teens who may not want to talk to adults about RH but will read the materials.

Youths interviewed for this evaluation stated that they like the ARH centers for services and counseling. They use the counseling services, the library and they acquire contraceptives for themselves and friends. Youth stated that they often get contraceptives or counseling for friends who are too embarrassed to come for services. Some youth still have problems asking for services as they feel there's a stigma attached to young people engaging in sexual activity. The adolescents stated that they had complete confidence in the health providers at the ARH Center and had even tested them for confidentiality. The peer counselors said they felt comfortable counseling peers themselves and when they had questions they consulted the HPs at the center. They said they would also go to the SVPs for general health consultation but preferred the youth centers.

Rayon and Navoi city youth said they liked all the ARH instruction and that it was the first time that anyone had openly talked to them about puberty and sexuality. They particularly liked the sessions about "physiology and the RH cycle," "creating a healthy family," "contraception," "advantages of delaying sexual debut and abstinence" and "how to prevent STIs and HIV." Both the students and the teachers commented that before having these classes, boys and girls did not communicate very well. Now that they have had the ARH classes together and learned to discuss this issue among themselves, they have a better understanding of what it means to be male and female. The teacher administrators also noted that now if they organize an event about early marriage all students are interested and come to discuss it openly. Students are not as shy as before and ask questions easily. Teachers also noticed that after the ARH classes, the boys were more respectful of the girls. When asked what changes they would like in the ARH classes, the students responded that they would like for the trained teachers to have more leeway to teach ARH classes. They indicated that untrained teachers who did not understand the purpose of ARH often put up barriers to the classes or did not let them or the peer educators distribute materials. Since the ARH classes aren't required classes, it is more difficult to insist on having the classes- particularly if parents object. Students wanted to have more information about sexual organs, fertile cycle, anti-retrovirus therapy, oncological diseases and how to behave during the honeymoon. They also said they wanted to know more about contraceptives.

The FE found that in the rayons the administrators of the health facilities do not support the ARH trained HPs in providing youth friendly services. It's not a focus area for them, and although they provide counseling, they don't stock contraceptives. They do have a

hotline and provide check-ups. This situation arises because in the rayon polyclinics, only the Ob-Gyns provide contraceptives and the ARH specialists are pediatricians. The pediatricians refer to the OB-Gyns but because the Obs are not trained to be youth friendly, most of the adolescents don't go to them for care.

The project only began talking to parents about sex education when the community health component began in 2006. By then, project staff recognized the religious and cultural barriers to talking about ARH. The administrators indicated that about half of their vocational students come from rural areas that tend to be more traditional and do not understand the purpose of ARH. Administrators and the students believe that there is a need to convince parents to let teachers and providers talk to the students about ARH. The administrators believe that the women leaders cannot really do this as they are too old to reach the adolescents and do not seem real comfortable talking to the parents about ARH. When the FE team asked community leaders about the parents, they responded that they gave them the parents' brochure to read and seemed to think that was enough.[6]

The Director of the ARH Center reported that the number of adolescents seeking services at the ARH center is increasing, and that confidentially is being stressed. They also stated that HPs liked the training and that before the training it had been hard to talk to the adolescents. Now with their counseling skills, the youths come easily. Also waiting times are shorter and youth appreciate the anonymity as the MDs don't discuss the visits with parents or ask students for their names when they come. Before the project intervention, boys did not come for services, but how there are a large number who come with friends. Also before they did not have a center but the Oblast renovated the current facility they're in and HOPE provided furniture, computers and materials.

Next Steps/Recommendations:

- If resources become available, it would be useful to investigate further why the IUD is the preferred method among practitioners and what can be done to persuade provider that it would be better to recommend a variety of methods to family planning users.

- Another issue that was raised by the FE team was the high prevalence of anemia in Uzbekistan. One question raised by the FE team is whether this high rate of anemia is associated with or contributed to by the high use of the IUD among women.

- Although there has been much progress about informed choice of contraception, the FE team feels that there needs to be a concerted effort made to maintain this focus. There needs to be continued training about informed choice and counseling

[6] Parents brochure for city and pilot rayons entitled «If there is a teenager in your house» brochure. It was developed by Republic "Health" Institute, Navoi Oblast ARH Center and Project HOPE/CS/USAID/Navoi staff). 20 000 copies printed of which 19 900 copies were disseminated.

methods. It is recommended that the Steering Committee and Oblast HD continue to encourage this training.

- If the government wants to encourage ARH in the schools, it would be important to have it offered as a required credited class so that it will be offered regularly.

- There is a demand and need for more peer education training as there is high turnover in the schools. If possible, it would be advisable for Project HOPE to organize a peer education training plan with the MOE and the RH Center. They already have trainers, peer educators, volunteers and a training center so this should be easy to do.

- It would be useful to involve the school administrators in ARH promotion to get them more involved in promoting ARH teaching.

- Pay more attention to adolescent services in the rayon polyclinics. Try to encourage the Ob-Gyns to work better with the youth friendly practitioners. Also recommended is that the Oblast ARH staff support the rayon youth centers. It would help if the Oblast arranged regular meetings with rayon RH specialists on the provision of youth services. Also it would be useful to advertise the youth services in the rayons as they did at the Navoi Center by providing the center addresses and hotline numbers on the brochures.

- The teachers want to implement the ARH program in the non-pilot rayons as they've had several requests. This could be done through the ARSH center in Navoi together with the Oblast education center. It is recommended that Project HOPE coordinate a meeting between the Oblast education and Health departments to plan for such an activity.

- There is also a continuing need to educate parents about ARH. It would be useful to organize meetings between parents, the health center staff, the education sector and makhalla sectors. Project HOPE can help the education sector organize an agenda and plan for such a meeting.

C. PROGRAM MANAGEMENT

1. Planning

Project HOPE had a satisfactory planning process to develop the DIP. Project HOPE headquarters and Navoi staff worked collaboratively to obtain baseline information and use the information for designing the DIP. Then, HOPE Navoi involved the Oblast and Rayon Health Departments, makhalla leaders, NGOs and trainers to provide additional information and input to the DIP.

Groups involved in planning include the MOH and all partners, including the USAID/Uzbekistan representative who spent two days collecting data through FGDs.

In addition, the project held quarterly meetings with the Steering Committee members where the staff present the objectives for the past quarter discuss progress and plan activities for the next quarter with specific dates and responsibilities. The staff use the DIP work plan as a basis for the quarterly activity planning. The workplan is a useful guide but each quarter the activity details need to be filled in.

The DIP workplan was changed quite a bit after the mid-term evaluation. Activities were added such as the community health promotion component, database management on child births and deaths. Another gap that was filled after the midterm evaluation was the addition of Quality Improvement strategies that were implemented at 10 primary health centers.

Another change from the original DIP was the formation of four technical working groups whose mandates are technical not political. Their role is to provide technical input to the project and review activities.

2. Staff Training

Project HOPE staff has participated in the following training events.

- Technical training in KPC survey methodology using cluster sampling and LQAS – project manager, the HIS manager and the IMCI Coordinator.
- Qualitative survey methodologies, community-based education through story-telling – project staff.
- Computer technology and MSOffice software 1 ½ hours a day for about a month for all staff.
- English classes with private teacher to some key staff, and a Peace Corp volunteer provided English classes for everyone.
- The staff responsible of reproductive health, family planning and ARH attended a national TOT course on reproductive health at the National Reproductive Health Center.
- The IMCI coordinator was trained in hospital IMCI.
- The IMCI coordinator and IEC specialist other staff also attended the C-IMCI regular IMCI training by WHO and National Pediatric Institute.
- The Maternal and Neonatal Health Coordinator attended the GHC conference in Washington DC and "Child Survival and Health Mini-University II" in John Hopkins Bloomberg School of Public Health in Baltimore, in 2003, and visited other training sites and health facilities in the USA for three weeks. Also attended Youth and Health sessions at the Global Health Council meetings in Washington DC.
- RH staff attended breastfeeding training, TOT and monitoring courses provided by Project HOPE in 2004.
- Program manager and IMCI coordinator attended Adult Education Methods training provided by HOPE in 2004.
- The Program manager and Administrator attended Financial report training provided by USAID/ Uzbekistan.
- The SM staff attended IMPAC training sponsored by PH in Tashkent in 2006.
- Community staff attended a HOPE seminar on CHP.
- SM/ARH, IMCI and data management staff attended summer MCH and Adolescent health training sponsored by WHO in Italy in 2006 and 2007.

- The ARH staff attended HIV/AIDS prevention and Interactive teaching courses at the East West AIDS Foundation in 2006.
- The program manager and Data manager attended project design, evaluation and KPC training courses offered by CSTS in 2006.
- The project staff received Quality Improvement training provided by Project HOPE and Zdrav Plus in 2006 2007.
- The ARH specialist and data manager attended the American Austrian Foundation for medical seminars in 2007.

The CS staff appreciated the training and felt that it helped them improve their job performance. For a complete list of staff training and dates, please see attachments.

The project manager believed that the training contributed to increased skills on the part of the staff, allowing them to become more and more independent and able to manage their own sections. At the beginning of the project, the staff asked the program manager about every step, but staff now has the confidence to make most decisions on their own.

The program manager was very creative in his use of training resources. He had a limited budget for international training but he was able to find many appropriate training opportunities that either offered scholarships or did not charge for the training and thus was able to stretch the training opportunities for all the staff. There were a total of eight international training events during the last two years of which only two were programmed. In addition, the program manager attended the annual leadership meetings at Project HOPE headquarters in Millwood, Virginia. He felt these meetings were particularly useful because in addition to the updating meetings, he was able to attend a number of management related seminars which were relevant to his role in the project. Also, Project HOPE organized regional public health meetings which were helpful, particularly when they were in Uzbekistan and a number of staff could attend.

The program manager states that a major lesson learned was that if he were to do the project again, staff development would be his first priority. This is because he learned that he could not manage everything in a project like this by himself. He felt it was critical to develop the staff's skills so they could manage their own areas appropriately. He felt that a big lesson learned was that he should not have waited so long to send the staff to the international and other training courses that provided them with program skills (he had waited until the last two years of the project before sending them for training). He thinks it would have been best to do this earlier in the project and bring the staff up to speed so they could take on more activities earlier on. For example, the HIS specialist's updated KPC skills have been useful for the final KPC but it would have been even more useful to have used the skills at the midterm.

3. Supervision of Program Staff

Project HOPE has a satisfactory system in place to manage the activities of the field staff from its U.S. headquarters. Staff supervision is based on the Project HOPE personnel manual that was reviewed and implemented. The manual includes an annual performance evaluation form which is conducted for all staff in order to adjust changes in scopes of work and deliver promotions. In addition, the program manager was able to attend Project HOPE's annual meetings or "Fall Leadership Conferences," where topics

covered included guidelines for staff performance evaluation and other management related subjects. The program manager reviewed the performance of all CS project staff and his performance is reviewed by the Regional Director for the CAR region. The staff seemed to think the current management system works fine for them. Each program area is managed by designated staff who supervises the work and reports to the director. This team approach is also useful for developing the quarterly workplans and for discussion during bi-weekly staff meetings. The program manager sees his job as integrating the key areas of work and staff from the different program areas and coordinating activities among them, such as site visits and training activities.

The project has one administrative project back-stop at Project HOPE headquarters, who provides financial, administrative and technical backstopping, monitors program activities and obtains and distributes reference materials. The CAR Operations Accountant provides financial analysis and budgetary assistance.

Earlier in the project there had been a need for more expertise with monitoring and evaluation and the project had difficulty recruiting HIS staff. After the midterm evaluation, the team was able to identify an HIS person who was able to organize and analyze project data.

4. Human Resources and Staff Management

The staff of Project HOPE is very competent and has achieved great results during the life of the project. There has been little staff turnover; only the administrator assistance/translator and the M&E Coordinator had been replaced. The reasons for leaving were personal, and did not compromise Project HOPE's level of commitment to sound management of personnel.

Policies and procedures form HOPE headquarters are regularly updated and reviewed by the project manager.

Unfortunately, given that Project HOPE is the only U.S. based (health) Private Voluntary Organization (PVO) operating in Uzbekistan and the other major project they have had there is closing at the same time as this one, there are not a lot of job opportunities for staff to transfer to after the project closes. The IMCI coordinator was the Chief Oblast Pediatrician before joining the project and will return to this role when the project ends, which augers well for continuation of the IMCI program. The other staff is actively searching for new positions and many have received job inquiries.

5. Financial Management

The budget for the project has been adequate to accomplish project objectives. The spending of the budget by line item is on track, due to vigilant work plan adherence by the field staff. In addition to the CS funding, the project received funding from the Swiss donor associated with Project HOPE. Additional donor funding was procured by Project HOPE headquarters for adolescent reproductive health and other related activities.

At the time of the mid-term evaluation, the financial backstopping from headquarters had been somewhat challenging, with the provision of non-user-friendly reports. One of the challenges is that Project HOPE does not follow the USAID grant budget fiscal year cycle; Project HOPE's fiscal year begins on the first of July. The HOPE-Center regional

backstop officer has been very accommodating, however, in trying to help interpret the reports. The CS program manager had hoped to have clearer breakouts of line item expenditures but this was not possible to do with Project HOPE's accounting system.

Currently, systems are in place for local and regional government to continue community health activities, monitoring, database management and training activities. In addition, the ARH center and the IMCI, SM and other training centers will continue operations, as staff is paid by the government.

Project HOPE headquarters helped the project plan for sustainability of interventions from the beginning by making sure that the project used existing government staff whenever possible instead of hiring parallel workers. They also instituted training and community education programs that could be easily continued by these staff, by making sure the training and education centers were equipped and adequately stocked with reusable materials. Thus, all the interventions were centered around support of existing or planned MOH services and infrastructure.

6. Logistics

Because of the good working relationship the project has with the MOH/ Oblast Health Department, the MOH has provided office space for the project at no charge and also pay electricity, heat and water for the project. In fact, the Oblast and the project moved into a new modern office building a year ago. The project bought office furniture and equipment during the first phase and the only office expenses incurred in Phase 2 were for phone and internet. The project purchased one vehicle through project funds, received another one from the Swiss Development Corporation support and received another used vehicle from USAID after the HF project ended in Uzbekistan.

The project indicates that it has had enough logistics to make work effective and sustainable. There has been enough equipment support that will be turned over to the Oblast HD when the CS project ends, if approval is granted by USAID.

7. Information Management

The project implemented a comprehensive monitoring system to report on indicators in IMCI, SM, RH, BF, ARH, and Quality Improvement strategy. The HIS specialist of the project had previously worked on the Healthy Family project (a five-country, MCH project funded by USAID) and replicated successful parts of the M&E system to the CS Navoi Project. During his tenure with Healthy Family project, the HIS specialist attended several trainings to increase his knowledge of project interventions and skills in monitoring activities. These trainings included LQAS training and also attended an IMCI, Safe Motherhood, BF, RH, Infection Prevention monitoring trainings sponsored by Project HOPE and the KPC training in Washington, DC (Dec, 2006) sponsored by USAID CSHGP. Additionally, the HIS specialist was awarded a scholarship by the American-Austrian Foundation to attended a two week public health training in Trieste, Italy in July 2006. The seminar provided him an understanding of public health approaches to maternal, child and adolescent health, and how to improve quality

assessment. Additionally, the HIS specialist participated in a Family Medicine seminar sponsored by Duke University which took place in Salzburg, Austria in July 2007, which also strengthened his knowledge of primary healthcare approaches.

Monitorings, as monitoring visits were called, were an all day event, conducted at one facility at a time, and were conducted every 6-8 months. The monitorings were divided into two visits: the first visit would cover IMCI and breastfeeding and the second visit would cover reproductive health and Safe Motherhood. Health professionals were randomly selected to be 'monitored' and these included nurses trained by the CS project and those that were not trained by the project but who were expected to be trained by trained nurses. Monitorings were a multi-demension exercise utilizing observation, interview, knowledge and treatment tools to ensure that health providers were applying appropriate protocols for all project intervention areas and that mothers understood the counseling being provided by health workers. Specific monitoring forms were created for each intervention and consisted of the following tools: self assessments or checklists for the GPs and nurses, exit interviews with moms, pre and post tests administered to health professionals, and a review of health cards and medical records for application of standard case management of IMCI. All results from the information gathered through these methods were entered into a database for future analysis and decision making. Information on indicators was collected from all four rayons which allowed the monitoring team to determine which facility needed refresher training and on which intervention themes. For example, in the analysis of data in the monitoring visit that took place in December 2005, results revealed that only 59.8%[9] of providers were measuring the weight of a sick child again and recording it in the growth chart. Project staff immediately conducted follow up visits to facilities to refresh their knowledge of proper IMCI protocols regarding growth monitoring. In the same monitoring visit, data revealed that only 35.9 percent[10] of doctors encouraged mothers to provide additional food to the sick child. By the last year of the project, monitoring visits indicated that 82.4 percent of doctors encouraged mothers to provide additional food to the sick child [11]. Again, project staff used this information to decide about when to conduct follow up sessions with health providers on proper implementation of IMCI protocols. Health professionals underwent a three-day training course to learn how to perform the self assessments. All of this was part of the quality improvement initiative. Quality improvement teams are present in all SVPs and use information from the monitorings to analyze trends and discuss challenges confronting their facility.

During the midterm evaluation, USAID requested that the CS Navoi project begin to work closely with other USAID funded projects to increase synergies and maximize dissemination of lessons learned and innovative approaches that might benefit both projects. The CS Navoi project began collaborating with Abt Associates which is implementing the Zdrav Plus project in Quality Improvement strategy (See 'Quality of Service' section under Section E for more details). Sustainability of monitorings may present a few challenges to MOH but they have begun monitoring activities on their own, which is quite encouraging. The MOH sees the value in the information provided from the monitoring visits and are currently conducting monitorings, but not with the same intensity as the project. Instead of spending an entire day to monitor a SVP, MOH staff

[9] Project Monitoring Data, IMCI, December 2005
[10] Ibid.
[11] Project monitoring data, April 2007

monitors approximately five SVPs in the span of one day, which averages out to the MOH staff only spending about 1-2 hours in each SVP and they are not analyzing all intervention areas as the project has done.

In terms of operations research, the project has conducted focus groups with key informants, led by researcher, Dr. Judi Aubel. The objective of the operations research was to identify the role and influence of family members in Uzbekistan society and determine who the primary decision makers are in the traditional family. Several separate focus groups with grandmothers/mothers in law, young women, and men were conducted and the results revealed that grandmothers and mothers in law are actively involved in child rearing and decisions regarding infants and children. Using the information gleaned from the qualitative studies, Dr. Aubel returned to Uzbekistan to assist the CS team in developing the IEC materials and strategy, ensuring that simple, participatory and traditional approaches be used. The team developed several methodologies, including open ended stories, video discussions, face to face discussions, and role playing to introduce maternal child health topics. Visual aids were also used to explore the differences and characteristics of 'happy' or 'sad' families. For example, a picture showing a 'happy' family (well fed children, proper housing, grandmother, husband present) was contrasted with a 'sad' family (malnourished child, single mother, many children). Participants were then asked to describe what were the characteristics that determined if a family was 'happy' or 'sad'. These methodologies have been found to be well received by the target population, as well as with grandmothers and mothers-in -law.

In qualitative investigations with mothers, MOH staff, doctors, and other project stakeholders, all individuals interviewed were quite aware of the project and quite supportive of project activities. Even during the presentation of final evaluation results to the stakeholders in Navoi, all commented that this project was the government's project and did not view the project as an external project. In depth interviews with the OHD statistician revealed that the project has been instrumental in assisting the MOH in implementing Prikaz 31, which calls for Uzbekistan to adapt the ICD 10 manual with the live birth definition. The MOH approached Project HOPE for assistance in adapting the definition.

Project HOPE assisted in the creation of the local Centers for IMCI, SM and RH in several ways, including the provision of furniture, visual demonstration and training materials, plaster molds and computer equipment. After the midterm evaluation, all data collected from monitoring visits were incorporated into the monitoring database of these Centers. Project HOPE shared the methodology for conducting monitoring visits (including the monitoring tools), processing and analyzing of monitoring data with the corresponding Centers and key personnel within the Navoi OHD. Project HOPE also provided assistance to the Navoi OHD in the implementation of the childbirth and mortality database (following ICD 10 definition) in the entire Navoi region and now the OHD is effectively using this database routinely in their work.

8. Technical and Administrative Support

During the first half of the project, staff received several technical and administrative assistance visits. These included external consultants to conduct the baseline survey,

development of the DIP as well as the community-based assessment and strategy development. They also received visits from headquarters and the CAR Program Director.

Before the MTE, some monitoring and evaluation technical assistance was provided through a virtual class (Elluminate™) conducted by Project HOPE headquarters. However, the staff noted that this session was not enough to address M&E system design and implementation issues. In particular, the problem with selecting sampling units for the LQAS methodology was not resolved during the midterm evaluation, which used this methodology for the KPC.

During the MTE, project staff indicated that they were fairly well acquainted with Child Survival, IMCI, Safe motherhood and Family Planning intervention strategies, but that they did not have enough experience nor technical support in financial management, Quality Improvement, BCC, and M&E strategies and methodologies. So during the second half of the project, the M&E director from Project HOPE headquarters visited the team to assist the project in the design of the final KPC survey. Staff from HOPE headquarters also assisted in solving the LQAS sampling problem. After this assistance, the project decided that instead of only monitoring the health practitioners, they would also monitor the health facilities as a whole. The monitoring indicators and tools included forms from WHO, checklists, direct observation and tests of HP knowledge.

Also after the mid-term evaluation, the project collaborated with the Zdrav Plus Project (Abt Associates) that provided quality assurance training to 10 PHC facilities in the project area.

The project also received help from the Regional and Deputy Program Manager from Project HOPE headquarters. Also the CS Program Manager spent several days at HOPE HQ receiving briefings and support from the finance manager, the regional director, the maternal-child health director and administrative officers. The project also had quite a bit of support from the regional technical advisor in the development of the BCC materials and activities and application of the community strategy developed by consultant, Judy Aubel. The M&E strategies for the program improved when the HIS officer was hired after the MTE.

According to project interviews, the project staff received most of the support it requested.. This support was either provided by HQ or arranged by them. In addition to technical assistance needs, the project staff also participated in several external training events, which greatly enhanced their skills (see staff training section).

9. Mission Collaboration

Project HOPE Uzbekistan consults regularly with USAID/Tashkent at a variety of levels. The CS Project Manager, Dr Abdunabi Kuchimov, had regular communication with the USAID Project Management Specialist/Health, Shukhrat Aripov until he left in 2007. Also as a result of the MTE recommendation, Dr. Kuchimov attends quarterly meetings at the USAID Mission. He has presented the MTE results, lessons learned and other products created by the project.

The Mission commented during the FE that the CS project has been very helpful to them because its close collaboration with the Oblast Health Department helped USAID understand what the country needs were at local levels. The mission also feels that the CS project fits well with its Strategic Objective that focuses on strengthening primary care with an emphasis on Maternal-Child Health.

10. Management Lessons Learned

The key management lesson discussed by the project manager was he would have done more of the national and international staff training activities during the first two years of the project. He felt that the training prepared the staff to take on necessary responsibilities for project implementation and that it would have been best to implement this earlier.

Another lesson the program manager learned was how helpful it was to delegate management tasks to his qualified staff. He found that it was more efficient to delegate management of the intervention areas to the specialists for each intervention area (IMCI, SM, ARH and CM). That way tasks were accomplished in a timely manner and the overall management burden did not fall entirely on him. The FE team realized from the excellent organization of the project and the enlightened management style of the program manager that he had also benefited from the management courses and TA that he had received from HOPE headquarters.

Another management lesson concerns the development and use of the Technical Working Groups (TWGs). The program manager realized that he would need buy-in and support from the local Oblast and rayon health departments if his objective to strengthen government services was to be realized. One strategy that proved useful was to develop the TWGs. These working groups were composed of technical experts from the different districts and regions and included chief pediatricians, chief Ob-Gyns, master trainers and expert monitoring specialists. Their purpose was: to discuss achievements and obstacles for implementation of the program strategies; help with the development of quarterly work plans; review monitoring results and develop conclusions and recommendations; help with the design of main events (i.e., conferences poster competitions etc.); review IEC materials, review program updates and develop ways to share them with other local HPs.

D. OTHER ISSUES IDENTIFIED BY THE TEAM

No issues outside of the realm of the DIP or the final evaluation were identified by the evaluation team.

E. CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations pertain to the overall results and attainments of the Navoi CS project, since most sections of the report discuss specific recommendations. The purpose of this section is to identify key project processes and activities that have proven to be effective and to provide overall lessons learned and recommendations that can be used if resources and opportunities become available to continue this work in the future.

Overall design, project interventions and key indicators

The Navoi project is the result of two CS projects and several years of work with the Oblast and Rayon Health Departments. After the first project, two more rayons were added, as well as a large family planning component, which included an innovative program with the adolescent population in the four rayons and Navoi City. At the time of the MTE, the team leader, who also assisted the Navoi CS team to develop the DIP, thought that the project was too ambitious and tried to convince the staff to reduce the number of activities and strategies proposed, but the CS team was confident in what they could achieve. The FE has shown that the CS team not only accomplished the activities that were proposed in the DIP, but have surpassed some of them. One of the main factors for achieving such impressive work has been the close collaboration with the OHD and RHDs. In some cases, Project HOPE was a catalyst for passage of government prikazes, and in some other cases, it demonstrated new ideas and approaches, which were adopted by the government.

The majority of the indicators achieved were at the service delivery level with complementary strategies at the community level. Since the Uzbek health system has a large infrastructure that reaches the majority of the population, this dual pronged approach was successful. Thus, Project HOPE's strategy to work through the OHD, RHDs and communities was the right one, and Project HOPE should be highly praised for its work.

The MTE team revised the project objectives, targets and percent effort for each program intervention. The new indicators were more focused in quality of service delivery and less on access indicators, since Uzbekistan does not have a major problem with access to health services. (see MTE Attachment B. Changes in the Objectives).

At the time of the MTE, the community component of the project had only reached the diagnosis and design stage, and some field tests. It had not progressed beyond that, because the CS team was too busy carrying out a large number of training activities, and also because the strategies proposed for community mobilization; such as working with grandmothers, would demand a great deal of effort from the team. Also the strategy itself did not give adequate direction regarding how it could be scaled up throughout the project rayons during the remaining time of the project. Unlike the health services system, community mobilization is a relatively new concept in Uzbekistan and required more thought and planning in order to be implemented. Fortunately after the MTE, Project HOPE's regional technical advisor was able to provide the help needed in order to help the team develop an action plan for mobilizing communities. This plan included work with existing structures, patronage nurses and leaders in the rayons and oblasts whose responsibility it was to educate families about preventive health and provide the link to the health facilities. Although late in starting this part of the project is impressive because it has been thought through so that it fits within local government structures and supports the governmental decree 242 to use community based volunteers and therefore it will, hopefully, be sustained.

The main recommendation is that if resources become available, it would be important to continue strengthening this community component. Although the government supports

the need for community work , there is not much experience in the country for doing it and the HOPE supported community activity has only been going for a year and a half. There is a need for the government and Oblast health department to create a team to provide future training of new formal community leaders. This team also needs to update teaching materials and tools. Another suggestion is to involve the Health Institute staff, a government agency, and ask them to oversee and continue strengthening the link between health services and the communities, particularly now that Project HOPE is leaving.

Training Activities

The project was successful in implementing a wide variety of training activities to support each of the CS interventions. Project HOPE was appropriately monitoring the quality of the trainings at the time they were provided (via pre and post tests), and in addition moved beyond the trainings to monitor the quality of service delivery by assessing the performance of health workers in delivering services. Learning from their experience, the project changed its monitoring system from that of monitoring health providers to monitoring whole facilities. This allowed the team to make a broader assessment of not only personnel but also the systems at the facilities and client satisfaction. The quality improvement strategies developed during the last part of the project were also noteworthy in terms of improving individual facility capabilities for monitoring and making decisions to improve care. Unfortunately, this training was not able to be extended to all facilities. If more resources become available in the future, this is an area the project should focus on.

One of the big successes of the training program has been the upgrading of skills and motivation of the patronage nurses. Although the project was not able to train all of them, it was able to train a substantial enough number to make an impact. These nurses seem to be having a big effect on community family care. It is recommended if more resources become available, that donors consider strengthening this component.

Another question is if the Oblast will be able to continue the well organized monitoring system that has been put in place by the team. While it can be argued that this system was installed to serve the project by being able to detect progress and challenges and make adjustments to the strategy as needed, the monitoring is now viewed by health providers and oblast as a very important piece of their work and most want it to continue. The problem is that it requires resources to do it. A suggestion from the FE team is to encourage monitoring from the rayon levels since the oblast level may be too cumbersome. In order to get this process started, the team recommends that the project hold planning meetings with each of the rayon HDs and develop plans and agendas for continued monitoring visits.

Identify "Best Practices"

Good examples of successful intervention activities were examined during the Final evaluation. The introduction of the Baby-Friendly certification had immediate positive effects at health centers; the OHD committed itself to certify all hospitals in the oblast. Another good example is the adolescent education program that was implemented throughout the schools in the four project rayons. These best-practices are being

replicated and the school administrators would like to take the ARH programs to other schools in the region.

Although it has begun recently, the community strategy and program using trained community leaders who are supervised by the women leaders, is a new practice for Uzbekistan. The activities are being hailed as very helpful and complementary to health services. The FE found that leaders and HPs stated there was increased use of all services and that there had been no child deaths during the year. The women leaders are getting requests to expand this training and practice to other regions. If resources become available this is a methodology that would be useful to replicate in other regions.

Quality of service delivery

The project, together with the OHD, has improved access to basic CS interventions in the four rayons and Navoi city. The project also improved quality of care through the introduction of a thorough supervision and monitoring system conducted every 6-8 months that focused on improved quality of service. In addition, the CS project collaborated with the Zadrav Plus Quality Improvement project to bring the QI methodology to 10 SVPs in the rayons. These SVPs underwent the five steps of training and planning and practiced the self assessment methods. Zdrav Plus conducted an evaluation after three months and found that the CS SVPs had been able to implement the QI methodology more easily than SVPs in other regions of the country. Unfortunately, the CS project is ending and it is unclear whether Zdrav Plus will be able to continue supporting the SVPs. Again, if resources were to come available, it would be worthwhile not only continuing to work with the 10 SVPs but to also extend the methodology to other SVPs in the Oblast.

The project has made a good start in improving the quality of services in the Oblast. However, there is an on-going need for follow-up and the project has received requests to bring their training and TA to the other rayons. As stated above, the CS staff will try to encourage continued monitoring activities from the rayon levels but at this point it is unclear if that will be done regularly. The rayons and SVPs that are not doing so need to be encouraged to use their data for making decisions about services and quality and to expand use of self assessment methodologies such as are being encouraged by the QI project.

ATTACHMENTS

A. Evaluation Team Members and Their Titles
B. Evaluation Assessment Methodology
C. List of Persons Interviewed and Contacted
D. List and Description of IEC Materials used by the Project
E. Staff Development and Training
F. Final KPC Survey Report
G. Project Data Sheet Form – Updated Version
H. Monitoring Tools

Attachment A. Evaluation Team Members and their Titles

1. Abdunabi Kuchimov – Program Manager
2. Nigora Muratova – MH Coordinator
3. Nuriddin Shaymanov – IMCI Coordinator
4. Lilya Djelilova – IEC specialist
5. Nasiba Bozorova – Midwife
6. Zafar Alimdjanov – HIS specialist
7. Nurdida Mardanova - ARH specialist
8. Sabokhat Ergasheva – Administrator
9. Seda Aleksanyan – Secretary/translator
10. Komil Boboev – driver
11. Ravshan Alimov – driver
12. Ruth Madison - Technical Advisor, HQ Representative
13. Sandra Wilcox – External Consultant

Attachment B. Evaluation Assessment Methodology

The Final Evaluation Team consisted of the Project HOPE Navoi staff members, a headquarters representative and the external evaluator.

The final evaluation used two main sources of information; a KPC survey based on the 30 cluster methodology recommended by CSTS and a qualitative evaluation using USAID guidelines conducted by the project team, the headquarters representative and the external consultant.

Project HOPE staff developed the FE survey questionnaires and the external consultant developed the FGD and in-depth interview guidelines. A two day briefing of the project was held for the consultant and HQ representative. Another day was spent planning field visits and preparing instruments. Field interviews and focus groups were held during three days using two teams. After the field visits were completed, project staff and the consultant conducted further interviews, then reviewed and analyzed findings listing strengths, challenges and recommendations for each intervention area. Preliminary results were presented to the project Steering Committee which included Oblast and rayon directors and chief medical officers. A debriefing was also held with the USAID Health Advisor in Tashkent to discuss preliminary findings.

In addition to the collection of the cross sectional survey and qualitative information, the external evaluator received the following documents from Project HOPE: 1) project proposal, 2) DIP, 3) annual work plans, 4) examples of training plans, 5) health information system forms, 6) monitoring and evaluation instruments, 7) mid-term evaluation report, 8) a qualitative Community Study about grandmothers (2003), final evaluation of the ARH component (2006).

C. List of Persons Interviewed and Contacted

Navoi Child Survival Program Final Evaluation Meeting Schedule.

July 2007

Day	Time	Team	Person / group	Venue
July 26	10.00	1	Mothers of children <5: Focus-group discussion;	Konimeh, Chordara
	10.00	2	Mothers of children <5: Focus-group discussion;	Nurota, Gazgon
	14.00	2	Navoi Regional ARH Center staff;	City, ARH Center
	14.00	1	Adolescents: Focus-group discussion;	City, ARH Center
	16.30	1+2	Nazokat Ahmedova – Karmana rayon Administration Deputy Hokim (Head), Head of Region Women's Committee;	Karmana rayon (Administration)
July 27	9.00	2	Pediatricians (Child Health): Focus-group discussion;	City, IMCI Center
	9.00	1	Ob/Gyn (Maternal Health) Focus-group discussion;	City, SM Center
	11.00	1	ARH program Teachers: Focus-group discussion;	City, CS office
	11.30	2	Isomiddin Nodirov, OHD, Deputy Head, Chief of Statistics Department;	City, OHD
	15.00	2	GPs: Focus-group discussion;	Karmana, Jaloyir
	15:30	1	WRA: Focus-group discussion;	Kiziltepa, Zarmitan
	18.00	All	Abdurahmon Nosirov – MOH Navoi OHD, Head;	City, OHD
July 28	9.00	2	Karmana rayon ARH room;	Karmana CRH
	9.30	2	WRA: Focus-group discussion;	Karmana, CRH
	9.30	1	Makhalla leaders: Focus-group discussion;	Nurota, makhalla
	11.30	2	Trainers for all interventions: Focus-group discussion;	City, RH Center
	14.00	1	Muharram Murodova – Navoi OHD, Deputy Head, Chief Nurse;	City, Nurses Association
	14.30	1	Nurses: Focus-group discussion;	City, Nurses Ass.
	15.00	2	Adolescents: Focus-group discussion;	Karmana, Hazora
July 30	15.00	2	Shuhrat Urakbayev – MOE Navoi OSSPED, Head Deputy;	City, OSSPED
	17.00	All	Musallam Ibragimova, Navoi Region Administration Deputy Hokim (Head), Head of Region Women's Committee;	City, Oblast Hokimiyat (Administration)
August 3	9.00	1	Klara Yadgarova – MOH, Deputy Minister on MCH;	Tashkent
	9.00	2	Asya Tolipova –Republican IMCI Center, Director;	
	11.00	1	Nilufar Rahmanova – Abt Associates, Zdrav+ Program, QI Manager;	
	11.00	2	Sarah Porter – Project HOPE, MCH/RH Program, Program Director;	
	After-noon	All	Benjamin Mills – USAID Tashkent, Medical Programs Director;	

Navoi Child Survival Program Final Evaluation Meetings Participants. July 2007

Day	Time	Team	Person / group	Venue
July 26	10.00	1	Mothers of children <5: Focus-group discussion; • SVP Chordara Chief, GP – Sadaf Togayeva • + mothers	Konimeh, SVP Chordara
	10.00	2	Mothers of children <5: Focus-group discussion; • SVP Gazgon Chief, GP – Dilbar Hojiyeva • + mothers	Nurota, SVP Gazgon
	14.00	2	Navoi Regional ARH Center staff; • Ob/Gyn - Sultanoy Siddikova • Midwife – Ibodat Kodirova	City, ARH Center
	14.00	1	Adolescents: Focus-group discussion; • Adolescents	City, ARH Center
	16.30	1+2	• Nazokat Ahmedova – Karmana rayon Administration Deputy Hokim (Head), Head of Region Women's Committee;	Karmana rayon (Administration)
July 27	9.00	2	Pediatricians (Child Health): Focus-group discussion; • IMCI Center Director – Nurmuhammad Alhamov • OHD Chief Pediatrician – Ravshan Kalimbetov • Oblast Childrens' Hospital Chief Doctor – Nizom Siddikov • Karmana rayon Chief Doctor Deputy on MCH Istat Himmatova • SVP Chordara Chief, GP – Sadaf Togayeva • Nurota Rayon Polyclinic paediatrician – Nigora Gaybullayeva	City, IMCI Center
	9.00	1	Ob/Gyn (Maternal Health) Focus-group discussion; • Oblast Maternity House Chief Doctor – Gulom Aslanov • Kiziltepa Rayon Chief Ob/Gyn – Salima Adizova • Konimeh Rayon Chief Ob/Gyn – Azamat Hojiyev • Oblast RH Center Chief, Ob/Gyn – Muhabbat Melikulova	City, SM Center
	11.00	1	ARH program Teachers: Focus-group discussion; • Nurota Social-Economy college Chief Deputy on culture and education issues – Saida Soliyeva • Navoi city building construction college Chief Deputy on culture and education issues – Holbibi Sadinova • Karmana agriculture college Chief Deputy on culture and education issues – Oliya Fayziyeva • Navoi city Medical college Chief Deputy on culture and education issues – Gulchehra Mingliyeva	City, CS office
	11.30	2	• Isomiddin Nodirov, OHD, Deputy Head, Chief of Statistics Department;	City, OHD

	15.00	2	GPs: Focus-group discussion; • SVP Zarafshon Chief, GP – Saida Abdiyeva • SVP Madaniyat Chief, GP – Millioner Hayitov • SVP Malikrabot Chief, GP – Soliha Sharopova	Karmana, Jaloyir, SVP Zarafshon
	15:30	1	WRA: Focus-group discussion; • SVP Zarmitan Chief, GP – Jamila Atoyeva + WRA	Kiziltepa, SVP Zarmitan
	18.00	All	• Abdurahmon Nosirov – MOH Navoi OHD, Head;	City, OHD
July 28	9.00	2	Karmana rayon ARH room; • Karmana rayon ARH room Chief, Ob/Gyn – Anvar Iriskulov	Karmana, CRH, Polyclinic
	9.30	2	WRA: Focus-group discussion; • Karmana rayon Women's consultation Chief, Ob/Gyn – Gulnora Ahmedova • + WRA	Karmana, CRH, Polyclinic
	9.30	1	Makhalla leaders: Focus-group discussion; • Rayon "Makhalla" Fund Chief Erkin Jurakulov • Rayon Chief on religious and enlightenment issues Gulruh Togayeva • +Makhalla leaders	Nurota, makhalla
	11.30	2	Trainers for all interventions: Focus-group discussion; • SVP Chordara Chief, GP – Sadaf Togayeva • Oblast RH Center Chief, Ob/Gyn – Muhabbat Melikulova • Navoi Regional ARH Center Ob/Gyn – Sultanoy Siddikova • Nurota Polyclinic pediatrician Nigora Gaybullayeva • Karmana Rayon CRH Ob/Gyn – Gavhar Hujamova • Oblast Maternity House Chief Nurse – Niyara Ablyalimova	City, RH Center
	14.00	1	• Muharram Murodova – Navoi OHD, Deputy Head, Chief Nurse;	City, Nurses Association
	14.30	1	Nurses: Focus-group discussion; • Nurses	City, Nurses Ass.
	15.00	2	Adolescents: Focus-group discussion; • Makhalla Hazora, Deputy on religious and enlightenment issues – Orzigul Rahmonova • SVP Hazora Chief, GP – Burhon Hasanov • + Adolescents	Karmana, SVP Hazora
July 30	15.00	2	• Shuhrat Urakbayev – MOE Navoi OSSPED, Head Deputy;	City, OSSPED
	17.00	All	• Musallam Ibragimova, Navoi Region Administration Deputy Hokim (Head), Head of Region Women's Committee;	City, Oblast Hokimiyat (Administration)
August 3	9.00	1	• Klara Yadgarova – MOH, Deputy Minister on MCH;	Tashkent
	9.00	2	• Dilbar Mahmudova – Republican Pediatrics Scientific-Research Institute, Director;	

	11.00	1	• Nilufar Rahmanova – Abt Associates, Zdrav+ Program, QI Manager;	
	11.00	2	• Sarah Porter – Project HOPE, MCH/RH Program, Program Director;	
	After-noon	All	• Benjamin Mills – USAID Tashkent, Medical Programs Director;	

D. List and Description of IEC Materials

Information about IEC materials

№	Title of IEC material	Developed	Accepted by	Audience	Quantity	Distributed in	Activities provided to community members	
Activities on IMCI								
1.	Poster: **«Nutrition of healthy and seek children under 5»**	2002	Ministry of Health, Scientific Research Institute of Pediatrics , Republic "Health" Institute	Caretakers of children under 5	400	HFs, infant schools, mahalla	1 phase	2 phase
		2005			400		▪ Distribution of the brochures to mothers/caretakers through trained on 3 day C-IMCI seminar patronage nurses on their area. ▪ Conduction of orientation meetings for mahalla formal and informal leaders (9 meetings, 113 participants) with the aim of informing them about the brochure. ▪ Conduction of Competition **«If you want your child to be healthy»** (15- Competitions on mahalla level 4 – Competitions on Rural area unit level (Village development Committee) 1- Competition between rayons in the oblast	▪ Distribution of posters to HFs, infant schools, mahalla. ▪ Distribution of the brochures in new pilot rayons through patronage nurses, mahalla and maternity houses. ▪ Distribution of the brochures to mothers/caretakers through trained on 5 day C-IMCI and BF seminar patronage nurses on their area. ▪ Distribution of 2 kind of posters and brochure on CHP seminars for each pilot rayon mahalla ▪ Distribution of the brochure is continuing in pilot rayons' maternity houses during mothers discharge from the maternity houses
2.	Poster: **«Common danger signs in children»**	2002			400			
		2005			400			
3.	Brochure: **«If you want your child be healthy»**	2002		Family with the child under 5	30000	HFs, Patronage nurses distributed to woman recently confined during discharge from the hospital		
		2005			2100			

4.	Leaflet: **«Keep your child from diarrhea! »**	Zdrav/Plus 2004	Ministry of Health, , Republic "Health" Institute	Family with the child under 2	30 000	HFs, Patronage nurses	• Conduction of Diarrhea Company from April to September Annually from 2004. Goal of the activity to decrease mortality among children under 5 in Oblast and to improve prophylactics measures at the places. Trained HPs, makhalla leaders, rayons "Health" Centers representatives are involved into the activity. The activity was planed according to Oblast Government decree. Reports about the activity are sent to CRH and OHD • Conduction of orientation meeting. Work plan was developed. Due to the plan 621 HPs from pilot rayons were trained and got IEC materials about diarrhea • Distribution of the following materials: 23015 copies of Leaflet **«Attention! Diarrhea!» to all families with the children under** 2; 500 copies of Poster: **«Diarrhea prevention»,** 981 copies of Leaflet **«Attention! Diarrhea!»,** 500 copies of Leaflet **«Keep your child from diarrhea!» to** HFs, infant schools, makhallas • Distribution of leaflets in CHP seminars to each participant • Demonstration of **«First Sense»** Film and 6 short films due to the work plan through the Oblast TV; in HFs, summer sanitary camps, makhallas • Spreading information about diarrhea prevention through Oblast TV on Sundays, seasonably.
5.	Poster: **«Diarrhea prevention»**			Caretakers of children under 5	500	HFs, infant schools, makhallas .	
6.	Booklet: **«Attention! Diarrhea! »**	2004	OHD,Navoi oblast brunch of "Health" Institute		1000		
7.	Leaflet: **«Keep your child from diarrhea! »**	2005			500		
8.	Film **«First Sense»** (About Diarrhea**)**	Zdrav/Plus 2004 Ministry of Health, , Republic "Health" Institute		Caretakers of children under 5	1	Oblast TV Nurita rayon TV	
9.	Film **«Golden fish»** (about ARI)				1		• Demonstration of "Golden fish" Film and other short films due to the work plan through the Oblast TV; in HFs, makhallas • Spreading information about respiratory infections prevention through Oblast TV on Sundays, seasonably.
Activities on BF							
10.	Poster: **«Breast feeding advantages»**	2004	Ministry of Health, , Republic				Conduction of BF week annually. Goal of the activity to: BF promotion **Objectives:** ▪ **To increase % of mothers practicing 6 month exclusively breastfeeding** ▪ To increase % of practicing LAM ▪ To increase % of mothers continuing breastfeed a child until 2 years

11.	Leaflet: **«Long and pleasant breastfeeding bases»**	2004		Family with the child under 2	25 000	d to woman recently confined		
12.	Film **«First-born»** (about advantages of breast milk)	2004 Zdrav Plus			1	Oblast TV, Nurota rayon TV. Baby Friendly Clinics	Demonstration of Films is going on in accordance with work plan through Oblast TV and Nurota rayon TV; in Baby Friendly Clinics; in makhallas	
13.	Film on BF advantages **«Она сути -куёш нури»**	2005 Healthy Family Project HOPE			1			
Activities on ARH								
14.	Poster: **«Risky behavior prevention»**	2004	Ministry of Health, , Republic "Health" Institute, Project HOPE	Adolescents at the age of 16-18	200/200	HFs, schools	Materials development	Development, testing, printing and dissemination of posters to HFs, Navoi city and pilot rayons schools Development, testing, printing and dissemination of adolescent brochure to Navoi city schools adolescents Poster competition among Navoi city schools on such topics as: STI, Contraceptive methods and Risky Behavior Prevention in the Palace of Culture "Farhad"; premiere of ARH short films was conducted at the place for 800 adolescents
15.	Poster: **«STI signs»**	2004			200/200			
16.	Brochure for adolescents **«Me and my world»**	2004			2600 /5500			
17.	Short film -1 **"Early marriages prophylactics"**	2004	Ministry of Health, , Republic "Health" Institute, Project	To Adolescents	18-Navoi city schools 1-Oblast TV 24- vocational schools 134- Oblast Government, Rayons Government, makhalla		-	Short films scenario Competition Demonstration of short films through the Oblast TV Dissemination of tapes and CDs with short films to Navoi city schools and Navoi city and pilot rayons vocational schools, makhallas Dissemination of tapes and with short films to "Health"
18.	Short film -2 **"Prevention of adolescents Abortions"**	2004					-	

19.	Short film -3 **"STI Prevention"**	2004					-	
20.	Short film -4 **«Drug addiction prevention»**	2004					-	
21.	Brochure for adolescents: **«Answers on some interesting for adolescents questions»**	2005			8100	Schools/vocational schools makhallas	Development, testing, printing and dissemination of adolescents brochure for city and pilot rayons adolescents	
		2006			3000 37000			
22.	Brochure for parents: **«If there is a teenager in your house»**	2006	Ministry of Health, , Republic "Health" Institute	For parents	20 000	Schools/vocational schools makhallas	Development, testing, printing and dissemination of parents brochure for city and pilot rayons parents who has adolescent children at the age of 16-18	
23.	Poster: **«STI Prevention»**			For adolescents	400	Schools/vocational schools	Development, testing, printing and dissemination of ARH posters for city and pilot rayons schools/vocational schools	
24.	Poster: **«HIV/AIDS transmission ways»**				400			
Activities on RH								
25.	Poster: **«Do you know your opportunities in FP?»**	2005 Здрав/Плюс	MOH	To WRA	200	HFs, makhallas	Poster Competition on Modern contraceptive methods Meeting with the community, conversation about Modern contraceptive methods and STIs	Community meetings, conversation about modern contraceptive methods, STI, HIV/AIDS Poster Competition on Modern contraceptive methods and STI in Primary Health Care level and between CRH departments of pilot rayons
		2005 Здрав/Плюс			400			

26.	Leaflet: **«Healthy Family Planning»**	1phase - 2003 2phase - 2005			1phase - 50 000 2phase - 25 000	HFs, Patronage nurses	Printing and dissemination of the **«Healthy Family Planning»** Leaflet to WRA in pilot rayons Karmana -18442 copies Kiziltepa -31358 copies Dissemination on RH trainings	Printing and dissemination of the **«Healthy Family Planning»** Leaflet to WRA in pilot rayons Nurota -19260 Konimeh -9760 Dissemination on RH and CHP trainings
27.	Film: **"Family Happiness"** (about RH)	2004 Zdrav Plus			1	Demonstrated by Oblast and Nurota rayon TV due to work plan	-	Demonstration of the short film in CRHs, Maternity Houses and makhallas Objectives: ▪ to increase interval between deliveries ▪ to inform community about modern ▪ contraceptive methods; their advantages and disadvantages
Activities on SM								
28.	**Mother's Passport**	2005	MOH	To pregnant w-n	15 000	HFs maternity welfare centre, midwife	-	Mother's Passport development, testing, printing and dissemination to pilot rayons pregnant women
29.	Poster: "**Danger signs in pregnancy"**	2005		To community	400	HFs, makhallas	-	Poster Competition on SM During the activity: - HPs get new information and skills, shared experience, improve quality of visual aids in HF -developing posters HPs seek and learned new information about the issue -Mass Media is involved into promotion of the topics Printing of all IE materials and distribution to HFs and makhallas of the pilot rayons Trained volunteers (formal and informal leaders) from makhallas provide regular meetings with the community and use all mentioned IEC materials
30.	Poster: **«Healthy nutrition pyramid»**	2005			400		-	
31.	Poster: **«Anemia Prevention»**	2005			400		-	
32.	Film **«Simple truth»** (about anemia)	2004 Zdrav Plus					-	Demonstration of the film through Oblast and Nurata rayon TV; demonstration in CRHs, Maternity Houses, makhallas with the aim of anemia prevention

33.	Brochure **«Facts for Life»**	1993г. UNICEF, WHO, UNESCO, UNFPA, UNAIDS, World Bank	2006 2007	To community	500 350	HFs, makhalla		Uses as informational source on key issues: SM; BF; RH; Child development; Correct nutrition and growth; Immunization; Diarrhea; ARI; HIV/AIDS etc. Dissemination to Primary Health Care level and hospitals-98; To makhallas-127; Village Development Committee-32, 391 – to CHP trainings participants Dissemination to patronage nurses in RH, BF and C-IMCI trainings

E. Staff Training

Staff Development Tracking Sheet

Name (Last Name, First Name)	Name of Event/Class	Begin Date mm/dd/yy	End Date mm/dd/yy	Host Organization	Paid by HOPE (Y/N)
Nigora Muratova	Adolescents Reproductive and Sexual Health" peer to peer TOT course	November 3, 2003	November 6, 2003	Project HOPE/Jalalabad	Y
Mardanova Nurdida	"Adolescents Reproductive and Sexual Health" TOT course	December 15, 2003	December 19, 2003	Project HOPE	Y
Bozorova Nasiba	"Adolescents Reproductive and Sexual Health" TOT course	December 15, 2003	December 19, 2003	Project HOPE	Y
Shaymanov Nuriddin	LQAS methodology training	March1, 2004	March 10, 2004	Project HOPE	Y
Abdunabi Kuchimov	LQAS methodology training	March1, 2004	March 10, 2004	Project HOPE	Y
Mardanova Nurdida	"Adolescents Reproductive and Sexual Health" peer to peer TOT course	March 10, 2004	March 13, 2004	Rainbow/Adolescents Informational Center/Kirgizia & Project HOPE	Y
Mardanova Nurdida	"ARH Monitoring and follow up" course	May 21, 2004	May 24, 2004	Project HOPE	Y
Muratova Nigora	**Youth & Health**	**May 31, 2004**	**June 4, 2004**	**Global Health Council, The USA, Washington, D.C**	**Y**

Muratova Nigora	**Child Survival and Health Mini-University II**	**June 7, 2004**	**June 11, 2004**	**Johns Hopkins Bloomberg School of Public Health**	**Y**
Bozorova Nasiba	"40 hours Breastfeeding" training	September 6, 2004	September 10, 2004	Project HOPE	Y
Bozorova Nasiba	"Breastfeeding" TOT course	September 20, 2004	September 24, 2004	Project HOPE	Y
Djelilova Lilya	LQAS methodology	September 27, 2004	September 30, 2004	Project HOPE	Y
Mardanova Nurdida	“LQAS” course	September 27, 2004	October 1, 2004	Project HOPE	Y
Bozorova Nasiba	“LQAS” course	September 27, 2004	October 1, 2004	Project HOPE	Y
Djelilova Lilya	"Reproductive Health" TOT course	October 12, 2004	October 16, 2004	Project HOPE	Y
Bozorova Nasiba	“Reproductive Health and counseling provision” course	October 12, 2004	October 15, 2004	Tashkent Governmental Reproductive Health Center & Project HOPE	Y
Mardanova Nurdida	“Reproductive Health and counseling provision” course	October 12, 2004	October 15, 2004	Tashkent Governmental Reproductive Health Center & Project HOPE	Y
Bozorova Nasiba	"Reproductive Health" TOT course	November 29, 2005	December 3, 2004	Project HOPE	Y
Bozorova Nasiba	"Breastfeeding" monitoring course	December 13, 2004	December 16, 2004	Project HOPE	Y

Shaymanov Nuriddin	Adult Education Methodology	December 20, 2004	December 22, 2004	Project HOPE	Y
Abdunabi Kuchimov	Adult Education Methodology	December 20, 2004	December 22, 2004	Project HOPE	Y
Bozorova Nasiba	"Safe Motherhood and prenatal care" monitoring course	February 7, 2005	February 16, 2005	Project HOPE	Y
Nigora Muratova	Methodology of confidential inquiry of Maternal Mortality and Morbidity	February 28, 2005 –	March 4, 2005	UNFPA/WHO workshop, Tashkent	Y
Shaymanov Nuriddin	Hospital IMCI TOT	May 23, 2005	May 28, 2005	WHO	N
Sabokhat Ergasheva	Financial Meeting	June 3, 2005	June 3, 2005	USAID	Y
Abdunabi Kuchimov	Financial Meeting	June 3, 2005	June 3, 2005	USAID	Y
Bozorova Nasiba	Essential antenatal, prenatal and postnatal care" TOT course	June 7, 2005	June 10, 2005	Project HOPE	Y
Abdunabi Kuchimov	Technical Support in Sustainability Planning	August 8, 2005	August 17, 2005	Project HOPE/Jalal-Abad Child Survival Program	
Djelilova Lilya	IMCI TOT course	August 22, 2005	August 24, 2005	WHO	N
Shaymanov Nuriddin	IMCI TOT course	August 19, 2005	August 24, 2005	WHO	N
Alimdjanov Zafar	Using of BABIES Matrix training	October 24, 2005	October 27, 2005	Project HOPE	Y
Mardanova Nurdida	“Reading and Writing for Critical Thinking” TOT course	November 21, 2005	November 25, 2005	Tashkent Center for Modern Education Technologies	N

Abdunabi Kuchimov	**Salzburg Public Health seminar**	**April 2, 2006**	**April 8, 2006**	**American Austrian Foundation, Inc. (AAF)**	**N**
Seda Aleksanyan	Regional Meeting	May 14, 2006	May 17, 2006	Project HOPE	Y
Sabokhat Ergasheva	Regional Meeting	May 14, 2006	May 17, 2006	Project HOPE	Y
Nigora Muratova	IMPAC	May 22, 2006	May 31, 2006	Project HOPE/Tashkent Medical Advanced school	Y
Shaymanov Nuriddin	CHP seminar	June 19, 2006	June 21, 2006	Project HOPE	Y
Muratova Nigora	**Summer Public Health course of the European School for Maternal, Newborn Child and Adolescent Health**	**July 17, 2006**	**July 28, 2006**	**WHO Collaborating Centre for Maternal and Child Health. Burlo Garofolo Pediatric Institute**	**Y**
Mardanova Nurdida	**Summer Public Health course of the European School for Maternal, Newborn Child and Adolescent Health**	**July 17, 2006**	**July 28, 2006**	**WHO Collaborating Centre for Maternal and Child Health. Burlo Garofolo Pediatric Institute**	**Y**

Alimdjanov Zafar	**Summer Public Health course of the European School for Maternal, Newborn Child and Adolescent Health**	**July 17, 2006**	**July 28, 2006**	**WHO Collaborating Centre for Maternal and Child Health. Burlo Garofolo Pediatric Institute**	**N**
Mardanova Nurdida	HIV/AIDS prevention TOT course	October 1, 2006	October 3, 2006	East-West AIDS Foundation	N
Mardanova Nurdida	"Basis of Interactive teaching process" TOT course	October 30, 2006	November 3, 2006	AIDS Foundation East West	N
Kuchimov Abdunabi	**Program Design, Monitoring and Evaluation (PDME) training**	**December 4, 2006**	**December 12, 2006**	**CSHGP Backstop Institute**	**Y**
Alimdjanov Zafar	**KPC Training of Survey Trainers training**	**December 4, 2006**	**December 14, 2006**	**CSHGP Backstop Institute**	**Y**
Muratova Nigora	Quality Improvement training	December 5, 2006	December 7, 2006	Project HOPE	Y
Shaimanov Nuriddin	Quality Improvement training	December 5, 2006	December 7, 2006	Project HOPE	Y
Bozorova Nasiba	Quality Improvement training	December 21, 2006	December 23, 2006	Project HOPE	Y
Alimdjanov Zafar	Quality Improvement training	December 21, 2006	December 23, 2006	Project HOPE	Y
Djelilova Lilya	Quality Improvement training	January 23, 2007	January 26, 2007	Project HOPE	Y
Nigora Muratova	Reproductive Health' Quality Improvement	May 28, 2007	June 1, 2007	Zdrav/Plus&MOH	Y
Bozorova Nasiba	KPC Survey Training	June 12, 2007	June 14, 2007	Project HOPE	Y

Djelilova Lilya	KPC Survey Training	June 12, 2007	June 14, 2007	Project HOPE	Y
Mardanova Nurdida	**Salzburg Adolescent Medicine seminar**	**June 10, 2007**	**June 16, 2007**	**American Austrian Foundation, Inc. (AAF)**	**N**
Alimdjanov Zafar	**Salzburg Family Medicine seminar**	**July 2, 2007**	**July 7, 2007**	**American Austrian Foundation, Inc. (AAF)**	**N**
Shaymanov Nuriddin	**Summer Public Health course of the European School for Maternal, Newborn Child and Adolescent Health**	**July 2, 2007**	**July 14, 2007**	**WHO Collaborating Centre for Maternal and Child Health. Burlo Garofolo Pediatric Institute**	**Y**

Definitions

Name of Event/Class: List the title or subject of the class, conference, workshop, training, or other event attended

Begin Date: List the date that the event began

End Date: List the date that the event ended

Host Organization: List the name of the organization that is hosting the event. For example, for the Spring Leadership Conference, list Project HOPE. For health systems strengthening training provided by Zdrav Plus, write ZdravPlus. Do not put where the event was held, but rather who organized and lead the event.

Paid for by Project HOPE: Did Project HOPE pay for the professional development training or did the participant receive sponsorship/scholarship or funding from an alternative source? Yes or No.

F. Final KPC Survey Report

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

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

Final KPC Report

Project Duration: October 1, 2002 – September 30, 2007

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
AVSC	Association of Voluntary Contraception (now known as Engender Health)
ADB	Asian Development Bank
BCC	Behavioral Change and Communication
BF	Breast Feeding
BFHI	Baby-Friendly Hospital Initiative
BL	Baseline Survey
CAR	Central Asian Republics
CDD	Control of Diarrheal Disease
CI	Confidence Interval
COMH	Central Oblast Maternity House
CRMH	Central Rayon Maternity House
COH	Central Oblast Hospital
CRH	Central Rayon Hospital
CS	Child Survival
CSHGP	Child Survival and Health Grant Program
CYP	Couple Years of Protection
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FAP	Feldsher midwife post
FE	Final Evaluation
FGD	Focus Group Discussions
FP	Family Planning
GP	General Practitioner
HF	Healthy Family
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HOPE	Health Opportunities for People Everywhere
ICD*10	International Classification of Disease, 10^{th} edition
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
INGOs	International non governmental organizations
IMR	Infant Mortality Rate
IUD	Intrauterine Device
KPC	Knowledge, Practice, Coverage
LAM	Lactational Amenorrhea Method
LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MHC	Mother's Home Card
MOE	Ministry of Education
MOH	Ministry of Health

MOHSSE	Ministry of Higher Secondary Special Education
M&E	Monitoring and Evaluation
MPS	Making Pregnancy Safer
MSG	Mother Support Group
MTE	Mid Term Evaluation
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OHD	Oblast Health Department
PEPC	Promoting Effective Perinatal Care
PHC	Primary Health Care
Prikaz	Official (Government) order or decree
PTP	Peer to Peer Counseling
QA	Quality Assurance
QI	Quality Improvement
RDH	Rayon Health Department
RH	Reproductive Health
SC	Steering Committee
SDM	Standard Days Method
SM	Safe Motherhood
STIs	Sexually Transmitted Infections
SOW	Scope of Work
STD	Sexually Transmitted Disease
SUB	Rural community hospital
SVA	Rural physician ambulatory
SVP	Rural physician post
TAG	Technical Advisory Group
TWG	Technical Working Group
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

Project HOPE conducted the final KPC survey in four project rayons (districts) of the Navoi Oblast (region) in June 2007. This was the conclusion of the second Child Survival project awarded to Project HOPE for work in this region. A survey conducted in March 2004 served as a final survey for the first project and baseline for the current project. The results of these surveys are presented and compared in this report.

Project HOPE began its activities in Uzbekistan in 1998. Its Child Survival activities have included work with mothers of children under two, women of reproductive age, adolescents and communities. Oblast and rayon level management committees as well as monitoring and evaluation systems have been important tools for institutionalizing project gains and encouraging replication of lessons learned and best practices for other rayons in the oblast as well as the national level.

For the KPC surveys the methodology used was a cross sectional study conducted at the household level. To collect the information, three questionnaires were developed for: 1) mothers of children under 24 months of age; 2) women of reproductive age (15-49); and 3) the adolescent population, which is characterized in Uzbekistan as those 16-18 years of age. The study questionnaires were developed by Project HOPE based on the KPC 2000+ and the Flexible Fund questionnaires for the different intervention areas. The questionnaires were then tailored to address the different interventions in the project areas. The household level questionnaires were translated into Uzbek and used by interviewers during the survey. The sample populations for the final survey were a) 300 mothers of children under 24 months of age; b) 300 women of reproductive age and; c) 300 adolescents 16-18 years of age.

As demonstrated in this report, significant improvements in health knowledge and behavior occurred in all project intervention areas during the life of the project. For example, the percent of children born at least 24 months after the previous surviving child almost doubled during the life of the project. Likewise, levels of exclusive breast feeding increased by 30 percent and the levels of children 6-9 months who breastfed and received complementary foods increased from 20 to 60 percent. Also levels of children 12-23 months who were fully vaccinated rose from 50 to 81 percent. In addition, findings indicate that preventive health knowledge levels in intervention areas rose significantly during the time of the project. Knowledge gains were made in all project areas including recognizing danger signs for pregnancy, diarrhea, pneumonia and STIs. Significant knowledge was also gained concerning how to prevent transmission of STIs and HIV/AIDS (rising from 36 to 96 percent) among women of reproductive age. There is also evidence that mothers and WRA received improved counseling on sick child care and family planning, which lead to better child care and higher use of family planning methods beginning during post partum periods. Significant gains in knowledge were made by adolescents in the area of STI and HIV/AIDS prevention. There is also evidence that sexually active adolescents are using condoms correctly. By the time of the final evaluation, 83 percent of adolescents could name at least three contraceptive methods.

I. INTRODUCTION

Project HOPE began its activities in Uzbekistan in 1998, and opened a country office within the National Tuberculosis Institute on October 4, 1998. The TB Management project collaborates actively with USAID, CDC, WHO and the World Bank, and partners with the Ministry of Health (MOH), National TB Institutes and Universities. The program provided and installed the equipment for the National Laboratory, and has been training and monitoring TB doctors in DOTS in Fergana Valley, Andijan, Samarkand and Tashkent Oblasts and may gradually expand this geographical coverage.

Project HOPE's CS-15 project started in December 1999 in the Navoi Oblast. A small add-on IEC/BCC project which was part of a nine-country community IMCI effort financed by GlaxoSmithKline, complemented the project. The purpose of the project was to develop a "parent reminder tool" also known as the Child Health booklet. This booklet teaches new parents how to: 1) recognize common child health danger signs; 2) manage common childhood illnesses at home; 3) prevent common childhood illnesses and; 4) provides them with breastfeeding and complementary feeding instructions and an immunization schedule.

In September 2002, a Project HOPE led consortium, including Save the Children, the American Red Cross, the Futures Group, JHPIEGO, and the American College of Nurse Midwives, was awarded a five-year cooperative agreement "Expanding Maternal and Child Health and Reproductive Health Services in Uzbekistan and Tajikistan (MCH/RH)" or the "Healthy Family Project" by USAID-CAR. For this new program, Project HOPE and Save the Children used their existing USAID/ Global Health supported CS-15 and CS-18 projects in Uzbekistan and Tajikistan, respectively as models to scale up successful approaches and innovations to USAID-CAR priority oblasts and zones of these countries.

In accord with national laws, Project HOPE has established agreements with the MOH and other Government offices to implement assistance and development programs in Uzbekistan.

The CS-19 (expansion) project has built on the successes of the CS-15 project with the purpose of expanding and institutionalizing the CS intervention activities into two new rayons (districts) in the Navoi Oblast (region). Previously the project worked in two Rayons, now they work in four. Navoi City is approximately a six-hour drive from Tashkent. Approximately 90 percent of the oblast is desert. The oblast consists of eight Rayons and two urban centers, and approximately 278 makhallas (municipalities), some of which contain nearly 500 families. Navoi is primarily an industrial oblast and a major source of gold and other minerals (mined in Zarafshan). The four districts where the project is located, focus on agriculture (e.g. Kiltepa), or depend on herding along with nomadic Kazakh populations who live in yurts without electricity, gas or running water. Many Kazakhs are moving back to Kazakhstan because the government has promised them land, good salaries and additional benefits. Approximately 80 percent of the

population in the oblast is Uzbek or Kazakh and 20 percent are Russian. The majority of the population is Muslim, but religious practices and beliefs are not obvious in daily life.

The CS-19 project comprises both Child Survival and Reproductive Health interventions, including work with adolescents, target groups, community leaders and mothers-in-law in order to promote greater community involvement. Oblast and rayon level management committees and monitoring and evaluation systems have continued to be important in institutionalizing project gains and capturing replicable lessons for the rest of the region and the country.

2. Background and Description of the Problem

The Oblast (regional) Health Department (OHD) is led by the oblast chief and his technical team. Tertiary-level specialty hospitals are located in Navoi City. Rayons have their own administration and manage a health system consisting of a central rayon hospital (CRH), polyclinics in the rayon capital, SUBs (rural hospitals that are gradually being phased out), SVPs (Village Health Centers with general practitioner [GPs] and midlevel providers), and the FAPs (health posts staffed by a feldsher) that are also being phased out in all but the most rural areas. Before the project, most of these rural providers had not received refresher courses on primary health care, though they are the sole source of care for mothers and children. During Soviet times, many providers were Russians and many of them have returned to Russia after the fall of communism in 1992. The capacity of the remaining health workers was very low. Essential medications were not generally available at health facilities, but are free-of-charge for hospitalized children, and therefore provide a strong incentive for referral. A network of home-visiting nurses (patronage nurses) from the MOH and the Red Crescent Society provide home care and support to special groups (new mothers, large families, the disabled and/or chronically ill, elderly), but lacked health education materials and guidance about how to counsel patients. Roads in the target area can be impassable during summer and winter months, making emergency transport difficult. Temperature changes are extreme, and water, electricity, and phone services are not consistently available.

The 2001 Navoi Oblast statistics provide a picture of the poor health status of young children and women of reproductive age that the project encountered at the start of activities. The Oblast Health Department (OHD, 2001) reported that the IMR in Navoi was 17/1,000 live births (similar to the official national rate), but the actual rate was probably at least three times higher, using standard international definitions. ARIs, diarrheal diseases, measles, anemia, and malnutrition account for 55 percent of under five deaths; the remainder being due to neonatal and peri-natal conditions (19 percent), other infections (12 percent), non-infectious diseases (9 percent), and trauma (5 percent) (OHD, 2001). The poor nutritional status of young children (12 percent of children under five are moderately to severely underweight and 84 percent are anemic) is an underlying factor in many infant and childhood illnesses and deaths (OHD, 2001). According to the oblast health department (2000), 12 percent of under-five deaths occur at home, compared to 8 percent for all of Uzbekistan (NPRI, 2001). An additional 20 percent of

deaths took place during the first day of hospitalization (compared to 11 percent for Uzbekistan [OHD and NPRI, 2001]).

Navoi has had one of the highest maternal mortality rates in the country at 73/100,000 live births compared to a national rate of 34/100,000 live births (MOH, 2001). Ninety-five (95) percent of pregnant women are anemic (39 percent severely anemic) - a strong contributor to perinatal and maternal deaths (MOH, 2001). Primary causes of maternal mortality are pregnancy-induced hypertension/toxemia, hemorrhage, and infection.

While health conditions have improved in the Navoi districts during the project period, the preceding section served to summarize existing conditions at the start of the project.

3. Problem Solution

In order to address the above health problems in the four rayons, Project HOPE's goals for CS-19 were to (1) reduce the mortality and morbidity in children under five and women of reproductive age; (2) Consolidate and institutionalize effective approaches in the CS-15 target area and scale these up to include other oblast rayons; and (3) Continue to develop innovative, effective, and efficient approaches that could be adapted and scaled up in Project HOPE's MCH/RH projects in Uzbekistan and Kyrgyzstan.

During the life of the project, Project HOPE continued to consolidate achievements in its CS-15 pilot rayons, Navoi and Kiziltepa focusing on (a) testing and implementation of SM/FP/IMCI; (b) strengthening the sustainability of other interventions through continued oblast mentoring and capacity building; increased community involvement; monitoring, supervision, and impact assessments; and performance-based refresher trainings for providers; and (c) developing additional innovative approaches. In the two new extension Rryons, Konimeh and Nurata, Project HOPE implemented the project interventions, including (a) TOT development; (b) provider training; (c) development of supervision and monitoring systems; and (d) extensive community IEC/BCC, utilizing NGO and media involvement.

4. Final KPC Objectives

The objectives of the KPC survey like the baseline study, were to provide Project HOPE and counterparts with information on the following issues:
At the household level:

- Changes in knowledge and practice of mothers of children under two years of age about their reproductive health, and the proper role of child health interventions; target groups for health education action messages; and assess coverage rates for main reproductive and child health services;
- Changes in knowledge and practice of women of reproductive age regarding their reproductive and sexual health; and access and coverage of family planning services;
- Changes in knowledge and practice of boys and girls of 16-18 years of age regarding their reproductive and sexual health; abortion, STDs, HIV/AIDS and family planning services.

The final KPC analysis and results demonstrate how knowledge and health practices were improved during the life of project. A comparison with baseline indicators is presented along with results so the reader can view the levels of change that have occurred, thanks to the project.

II. METHODOLOGY

As with the baseline study, the methodology used for the final KPC survey was a cross sectional study at the household level. By repeating the study at the end of the project, it highlights the project's success in communicating health messages to women, men and family, and training community and facility-based health providers in quality reproductive, maternal and child health services.

(An LQAS survey was administered at the time of the mid-term but there were problems with the sampling and it only measured information from mothers of children under 2. It did not oversample for any of the specific populations. Therefore, this report only compares the findings of the baseline and final surveys which used the same, comparable methodologies. Findings of the LQAS will be included in the final evaluation report.)

1. The Questionnaires

To collect information at these two levels, three questionnaires were developed for: (1) mothers of children under 24 months of age, (2) women of reproductive age, and (3) the adolescent population. The questionnaires were developed by Project HOPE based on the KPC 2000+ and the Flexible Fund's questionnaires for the various intervention areas. The questionnaires were then customized to make the finalized versions appropriate to the actual projects interventions and the project areas.

The questionnaires for the household level were translated into Uzbek, and the questions were applied in Uzbek at the time of the interviews.

2. Sample Size and Study Population

The selected sample population was based on the following calculations:

Household level questionnaires

- 300 Mothers of children less than 24 months of age; 300 women of reproductive age, and 300 adolescent 16-18 years of age. Thus a total of 900 interviews were carried out in the pilot rayons, Navoi and Kiziltepa, and the two new extension rayons, Konimeh and Nurata.
- Oversampled for the breastfeeding questions by selecting an additional 468 mothers of children under 24 months of age to answer a short BF questionnaire.
- WHO 30-Cluster Study, where p=0.5, d=0.1 and z=95percent (Henderson, et al., 1982).
- List of communities under the NGOs coverage area.
- Random selection of first household -- next was the third household.

3. Study Implementation

The final survey process included the design of the household level questionnaires, based on the questionnaires used at baseline and their translation into Uzbek. Some additional indicators that were added at the mid-term were also added to the final questionnaire. The team of surveyors was comprised of the Project HOPE team, health providers from the oblast and rayon-level health facilities, and community members. The team and its supervisors carried out the first validation of the questionnaire translation. This was conducted at the end of the 3-day training in a non-project rayon. By the end of the training, Project HOPE and supervisors developed an action plan to implement the survey.

Project HOPE staff provided further support in monitoring and implementing the study. They entered data into an analysis package (Epi-Info) and carried out the overall analysis.

Once the final evaluation has been completed, Project HOPE will organize a series of meetings with the various steering committees and working groups that the project has been working with (adolescent health, maternal health, child health) to present the final results and discuss further steps. The meetings will include supervisors and interviewers, oblast and rayon department chiefs, and community members and leaders.

III. RESULTS

Key Indicators

TABLE 1. *KEY INDICATORS: THE RAPID CORE ASSESSMENT TOOL ON CHILD HEALTH (CATCH)*	**Baseline 2004 %**	**CI**	**Final KPC 2007 %**	**2007 CI**
Sentinel Measure of Child Health and Well-being				
1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)			7.7	±3.0
Prevention of Illness/Death				
2. Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	48.3	±18.2±	84.6	±5.8
3. Percentage of children age 0–23 months whose births were attended by skilled health personnel	98.1	±1.3±	99.3	±0.9
4. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child**				
5. Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	62.7	±9.0	90.0	±3.9
6. Percentage of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	19.8	±8.2	60.3	±6.4
7. Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday***	50.3	±7.2	81.3	±6.9
8. Percentage of children age 12–23 months who received a measles vaccine***	88.1	±4.7	82.1	±6.8
9. Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	No malaria areas		No malaria areas	
10. Percentage of women of reproductive age who cite at least two known ways of reducing the risk of HIV infection	36.5	±4.7	84.0	±4.1

11. Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defection, and after attending to a child who has defecated				
Management/Treatment of Illness 12. Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	48.6	±4.8	95.3	±2.4
13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	22.7	±17.5	64.4	±14.0

** The Uzbekistan MOH does not provide TT to pregnant women, only immunoglobulin to suspected cases of tetanus infection.
*** The MOH does not provide immunization cards to families; therefore, except during the final KPC where the project did review clinic cards, the above indicators were calculated based only on the mothers' recall.

The results from the final survey will be presented in three sections, each section devoted to a specific component of reproductive, maternal and child health. The first section will discuss the results of mother-child health issues; the second section will discuss reproductive and family planning aspects; and the third will discuss adolescent reproductive and sexual health issues. The first questionnaire will examine the responses of 300 mothers of children under two years of age, the second will examine 300 responses of women of reproductive age (15-49 years of age), the third will examine 300 responses of the adolescent population (16-18 years of age). Moreover, each section will attempt to examine the following issues:

- What services are being offered and where do people seek assistance in case of illness? Has this changed since the beginning of the project?
- What new services are offered?
- What are the current knowledge and practices in the community that may be affecting demand and utilization of health care services and has this changed?
- How have health services increased coverage and quality to better reach their target populations?

SECTION 1. IMCI AND SAFE MOTHERHOOD INTERVENTIONS (MOTHERS OF CHILDREN LESS THAN 24 MONTHS OF AGE)

a. Mother's Background Characteristics

Because the demographic characteristics of the project rayons have not changed during the life of the project, this part of the KPC was not repeated during the final survey. This background information is taken from the baseline survey results.

Table 1 shows some of the basic characteristics of the mothers of children less than 24 months of age sample population. Of the women interviewed all (100 percent) had some level of education, and 7.9 percent had only primary education. There were no significant differences among the four rayons.

When asked about what language interviewees feel most comfortable communicating with, Uzbek was the most common language used (90.6 percent) followed by Kazakh (7.2 percent) and then by Tajik (5.0 percent). When comparing the new and old rayons, in Konimeh and Nurata, 14.5 percent of the population felt more comfortable communicating in Kazakh. However, there was an overlap of results, meaning that although people can speak more than one language, Uzbek is the most preferred language for communicating.

When examining the nature of the head of household, 66.3 percent reported that the respondent's father-in-law is the head of the family, meaning also that the majority of the population lives in an extended family context. Over thirty percent (30.3) reported that their husbands were the heads of the household. The majority of women interviewed were housewives, and a small percent (3 percent) being salaried workers. There were no significant differences when comparing old and new project rayons.

Finally, the average age of the women interviewed was 26 years old, and 11 months was the average age of their youngest child.

TABLE 2. GENERAL CHARACTERISTICS OF THE INTERVIEWED MOTHERS: SCHOOLING, LANGUAGE, HEAD OF HOUSEHOLD, AND OTHER CHILD CARETAKERS

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420)***	***(n=300)***
Highest level of education attained				
Primary	11.0	4.8	7.9	
Incomplete secondary	27.3	35.9	31.6	No data
Secondary/special secondary	54.1	52.6	53.3	
Higher	7.7	6.7	7.2	
Language interviewees feel most comfortable communicating				
Uzbek	99.0	82.1	90.6	
Tajik	5.2	4.8	5.0	No data
Kazakh	0.0	14.5	7.2	
Russian	0.5	0.0	0.2	
Head of household				
Mother (respondent)	1.0	3.3	2.2	
Husband/Partner	31.6	29.0	30.3	No data
Relative	1.9	0.5	1.2	
Father in law	65.5	67.1	66.3	
Work outside of home to earn money and type of work:				
Housewife	96.2	97.6	96.9	
Handicrafts	0.0	0.0	0.0	No data
Harvesting/Field Worker	0.0	0.0	0.0	
Shop Keeper/Street Vendor	0.0	0.0	0.0	
Salaried Worker	3.8	2.4	3.1	
Continuous Variables	***Average (n=210)***	***Average (n=210)***	***Average (n=420)***	***Average (n=300)***
Age of mothers (years)	25.7	26.9	26.3	26.4
Age of children under two (months)	11.4	10.5	11.0	10.7

b. Breastfeeding Promotion and Infant/Child Nutrition

An important component of infant health is the prompt initiation of breastfeeding and exclusive breastfeeding until the infant is six months of age (World Health Organization). This practice significantly reduces disease and malnutrition in infants. Of the mothers interviewed during the final evaluation, 93 percent initiated breastfeeding in the first hour after birth as compared with 62.6 percent at baseline. Ninety (90) percent of women with infants less than six months of age reported they were exclusively breastfeeding at the time of the interview (Table 3) as compared with 62.7 percent at baseline.

The World Health Organization also recommends gradually introducing solid/semi-solid foods to infants at six months of age, and that the mothers continue breastfeeding until the infant is two or more years of age. The introduction of solid/semi-solid foods is an important step in infant growth, and it is important that mothers know how and when to introduce foods to their infants. The percentage of infants aged six to ten months old that were being given solid foods was 60.3 percent, up significantly from 19.8 percent at baseline. Also, the majority of infants between 20 and 23 months of age (66.8 percent) were still being breastfed. This is up from 33.9 percent at the baseline. During the life of the project, the number of mothers that are exclusively breastfeeding and feeding for longer periods has jumped dramatically. The complementary feeding rate has also improved, all of which denote important improvements in child nutrition.

It is noteworthy that the project oversampled for these questions to obtain reliable numbers about breastfeeding and young children's complementary feeding practices.

TABLE 3. ***BREASTFEEDING AND INFANT/CHILD NUTRITION***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	% (n=208)	***% (n=209)***	***% (n=417) CI***	***% (n=753)***
Breastfeeding Initiation: Percent of children aged 0-23 months who were breastfed within the first hour after birth	81.7	43.5	62.6 ±4.6	93.1±1.8
	% (n=48)	***% (n=62)***	***% (n=110) CI***	***(n=231)***
Exclusive Breastfeeding Rate: Percent of infants aged 0-5 months who were fed breastmilk only in the last 24 hours	81.3	48.4	62.7 ±9.0	90.0±3.9
	% (n=49)	***% (n=42)***	***% (n=91) CI***	***(n=224)***
Complementary Feeding Rate: Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours	8.2	33.3	19.8 ±8.2	60.3±6.4
	% (n=36)	***% (n23=)***	***% (n=59) CI***	***(n=205)***
Continued Breastfeeding: Percent of children aged 20-23 months who are still breastfeeding	36.1	30.4	33.9 ±12.1	66.8±6.4
Continuous Variables	***Average (n=209)***	***Average (n=208)***	***Average (n=417)***	***(n=219)***
Times infant/child eat semi-solid foods yesterday during the day or at night	3.0	2.7	2.8	4.4

Although the question was not asked during the baseline survey, the project did ask about duration of skin-to-skin contact at the final survey since this indicator had been added

during the project. As can be seen from the information below, the project's key message about skin-to-skin contact seems to have reached the mothers.

Desired Result:

Adopt/Strengthen appropriate feeding practices for improving child nutrition and growth.

Indicators	FE % (n=300) CI
Skin-to-skin contact for at least 30 minutes in the first hour after delivery	**90.3%±3.3**

c. Childhood Immunization

In Uzbekistan, immunization cards are kept at health services. Families do not possess any type of written information about their children's immunization status. Although some programs are trying to change this situation by providing immunization cards to the beneficiary population, this has not occurred in the project areas. Therefore parents and caretakers are not able to easily keep track of what vaccines and doses their children have received. As a result, both the baseline study and the final survey obtained information as recalled and reported by the mother. These data are confusing for although immunizations were not the main focus of this project, according to the KPC final survey, the percentages of children who received DPT1 and who received measles dropped from the baseline figures, as well as those who received full EPI coverage. Part of the explanation is that these percentages are based on mother's recall and not immunization cards but there is quite a difference from the levels reported at baseline.

However, because the mother's recall results showed low levels of immunization, the project decided to cross check the accuracy of these reports by reviewing the immunization records at the primary health clinics and these results were noted here below. Table 4 displays the immunization status of children 12-23 months of age according to verified records at the health centers. However, the results may not be strictly comparable to the baseline results as the baseline was based on mothers recall. See footnote for KPC data recorded from mother's recall.

The one figure that was lower than the baseline was for measles coverage. One explanation for this is that measles is only administered in the rayons twice a year and the project staff thought that this percentage would be higher if they had measured three months later. Also when examining the table it is evident that at baseline the old rayons, which are close to Navoi city and have more access to regular immunizations, had higher levels than the new rayons whose coverage is similar to the final levels for all four rayons. With the new figures, it is clear that the DPT1 coverage has stayed high, full coverage moved from 50 percent to 81 percent and BCG coverage was slightly higher than baseline.

TABLE 4. CHILDHOOD IMMUNIZATION				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007[1]***
	percent (n=96)	***percent (n=89)***	***percent (n=185) CI***	***% (n=298)***
EPI Access*: Percent of children aged 12-23 months who received DPT1	94.8	97.8	96.2 ±2.8	96.7±3.2
Measles Vaccination Coverage*: Percent of children aged 12-23 months who received measles vaccine	94.8	80.9	88.1 ±4.7	82.1±6.8
EPI Coverage I*: Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday	58.3	41.6	50.3 ±7.2	81.3±6.9
BCG Vaccination Coverage*: Percent of children aged 12-23 months who received BCG vaccine	99.0	92.1	95.7 ±2.9	99.2±1.6

d. Childhood Illness

One of the main objectives of the community IMCI strategy is to educate mothers to recognize signs and symptoms of severe childhood illness so that they know when it is necessary to seek the services of a health provider. At the time of the final evaluation, 95.3 percent of mothers recognized at least two of those signs (up from 48.6 at baseline), and 96 percent recognized at least two danger signs when children have diarrhea (up from 36.9).

Diarrheal illnesses were not prevalent in the communities interviewed at the time of the baseline survey. Because the survey was not conducted during the diarrhea season, only 5.2 percent of the mothers interviewed in the baseline study reported that their child (under 2 years of age) had been ill with diarrhea in the last two weeks (Table 5). Although the final survey was conducted during the diarrhea season, the project did not oversample for diarrhea cases and the number of cases is still relatively low (34), though the percent of cases had increased slightly from 5.2 to 11.3 percent. When interviewed, many community leaders believed that because of improved health practices, they are not seeing severe forms of diarrhea in children even during the diarrhea season.

Mothers with children under two years of age who had been ill with diarrhea in the last two weeks before the interview were asked about the eating and drinking practices of their children during that period. While 58.8 percent of the mothers said their children drank the same amount of fluids or more fluids than usual (up from 15 percent at baseline), 50 percent (19 percent at baseline) of the children ate the same amount of food or more food than usual.

*These are results from immunization records at service centers as the mothers reported KPC results were lower than expected: According to the oral KPC survey: 81.5% of mothers said their children 12-23 months had been vaccinated with DPT1; 43.9 said their children 12-23 months had been vaccinated for measles and; 34.5 reported receiving full vaccination schedule. 99% said their children received BCG vaccine.

In order to prevent dehydration, which often occurs in children with diarrheal illnesses, oral rehydration therapy (ORT) is the recommended treatment for all children with diarrhea. Of the mothers who sought treatment, oral rehydration therapy increased from 31.8 percent at baseline to 47.1 percent at the final.

It is interesting to note the influences regarding care seeking decision making. At the time of the baseline survey, the key decision makers for seeking care were the respondent (mother), 58 percent and the mother-in-law 47 percent, with the husband at 29. At the time of the final evaluation, the mother was a little higher at 67 percent, the husband had increased to 40 percent and the mother-in-law had dropped to 37 percent. This may be a reflection of educational strategies that are directed towards the couples. There has also been an effort to empower mothers to make decisions about their children's care.

TABLE 5. ***CHILDHOOD ILLNESS & DIARRHEA CASE MANAGEMENT (DCM)***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420) CI***	***percent (n=300) CI***
Maternal Knowledge of Child Danger Signs: Percent of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	65.2	31.9	48.6 ±4.8	95.3 ±2.4
Maternal Knowledge of Child Danger Signs: Percent of mothers who know at least two signs childhood diarrhea that indicate the need for treatment	54.3	19.5	36.9 ±4.6	96±2.3
Percent of children who had diarrhea in the last two weeks prior to the survey	4.8	5.7	5.2 ±2.1	11.3±3.6
	percent (n=10)	***percent (n=12)***	***percent (n=22) CI***	***percent (n=34) CI***
ORT Use During a Diarrheal Episode: Percent of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	50.0	16.7	31.8 ±19.5	47.1 % ±16.8
Increased Fluid Intake During a Diarrheal Episode: Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	37.5	0.0	15.0 ±14.9	58.8 %±16.5
Increased Food Intake During a Diarrheal Episode: Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	22.2	16.7	19.0 ±16.4	50±16.8
Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	30.0	16.7	22.7 ±17.5	64.4±14.0
Care-seeking for Diarrhea: Percent of children aged 0-23 months with diarrhea in the last two weeks whose mothers sought outside advice or treatment for the illness	0.0	0.0	0.0	0.0
	% (n=10)	**% (n=12)**	**%(n=22) CI**	**%(n=45) CI**
Percentage of sick children age 0-23 months who received increased fluids and continued to feeding during any illness in the past two weeks	30.0	16.7	22.7±17.5	64.4±14.0

	%(n=10)	%(n=12)	%(n=22)	%(n=300)
Care seeking decision making: Person who decided seeking outside advise or treatment for the illness				
Respondent	50.0	66.7	58.8	67.0
Husband/Partner	37.5	22.2	29.4	40.0
Respondent's Mother	0.0	0.0	0.0	2.0
Mother-in-law	37.5	55.6	47.1	37.0
Friends/Neighbors	0.0	0.0	0.0	0.3

At the time of the baseline survey, acute respiratory illness (ARI), especially pneumonia, was one of the most prevalent health problems in the communities interviewed. Of the mothers interviewed, 54 percent said their child had suffered from some type of lower respiratory illness with rapid breathing and chest in drawings in the two weeks prior to the interview (Table 6). Eighty-eight (88) percent of mothers sought some type of treatment for their child's illness. The final evaluation was not conducted during ARI season. However the knowledge level of mothers was much higher at the final evaluation: 85 percent of mothers knew at least one danger sign and could indicate a need for treatment. As evidence of this awareness, despite it not being the season for ARI and a low number of cases, 80 percent of mothers of children 0-23 months who had cough or fast breathing within the previous 2 weeks, took the children to a health facility for treatment. As with the diarrhea cases, mothers interviewed reported that the key decision makers for seeking treatment were the husbands, next the mother and then the mother-in-laws, but this is from a small number of respondents and may not reflect the reality.

TABLE 6. ***ACUTE RESPIRATORY INFECTIONS***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420)CI***	***% (n=300) CI***
Maternal Knowledge of Child Danger Signs: Percent of mothers who know at least one sign childhood respiratory illness that indicate the need for treatment	18.1	11.9	15.0 ±3.4	85.3 ±4.0
Percent of children with cough and fast/difficult breathing in the last two weeks prior to the survey	57.4	51.6	54.1 ±4.8	3.3 ± 2.0
	percent (n=27)	***percent (n=32)***	***percent (n=59)***	***% (n=10)***
ARI Care-seeking: Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source	85.2	90.6	88.1 ±8.3	80 ± 24.8

e. Maternal and Newborn Care

Respondents were asked questions concerning the care they sought and received during their last pregnancy.

Both at baseline and final surveys, ninety nine (99) percent of the women interviewed had attended a health service for at least one prenatal exam during their last pregnancy (Table 7). It is interesting that the final KPC found that of these, 83 percent had 8 to 12 visits or more and an additional 13 percent had 5-7 visits, which means that 96 percent of pregnancy women received at least five visits. The Uzbekistan MOH does not provide Tetanus Toxoid to pregnant women, but only immunoglobulin to suspected cases of infection. Most (97%-90%) women reported to live less than one hour away from health center, which facilitates attending prenatal care visits. Little more than half had received iron supplementation at baseline but this increased to 73.4 percent by the final. Most of these women had received orientation and counseling during pregnancy, but only 47 percent knew danger signs during pregnancy at baseline. By the final evaluation, 97 percent of women were able to name danger signs in pregnancy.

Ninety eight (98) percent at baseline and 99 percent at final reported that a trained health professional had attended their delivery. Whereas 69 percent placed the baby right besides the mother after delivery at baseline, this percent jumped to 94 by the final survey.

At baseline, 77 percent of women interviewed had had a postpartum check up and by the time of the final survey, 99 percent of women had gone for pp check-ups.

In sum, although the women in the Navoi region have traditionally attended maternal care services, it appears that the quality of that care and the resulting attendance at post partum services have improved remarkably.

Maternal Care

*TABLE 7. **CARE DURING PREGNANCY, DELIVERY AND POSTPARTUM***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420) CI***	***percent (n=300)CI***
CARE DURING PREGNANCY				
Prenatal Care Coverage: Percent of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	100.0	99.5	99.8 ±0.4	99.7 ±0.6
Iron Supplementation Coverage: Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	65.6	42.6	54.1 ±4.8	73.4 ±5.0

Prenatal Care Counseling: Counseling given to pregnant women on last pregnancy by theme				
Delivery preparations	94.7	94.0	94.4	99.3
Breastfeeding	95.2	78.6	87.7	92.6
Child spacing/FP	90.3	76.2	84.0	92.3
EPI	76.3	66.1	71.7	88.0
Danger signs of pregnancy	81.6	63.1	73.3	90.3
STIs Prevention	81.6	57.1	70.9	87.6
Prenatal Care Geographical Access: Percent of pregnant women who report living less than ONE hour from nearest health facility	97.6	96.7	97.1 ±1.6	89.7percent
Maternal Knowledge of Pregnancy Danger Signs: Percent of mothers who know at least TWO signs of danger during pregnancy that indicate the need for treatment	60.5	33.3	46.9 ±4.8	97percent ±1.9
DELIVERY AND IMMEDIATE NEWBORN CARE				
Delivery by Skilled Health Personnel: Percent of children aged 0-23 months whose delivery was attended by a skilled health personnel	100.0	96.2	98.1 ±1.3	99.3 ±0.9
Placement at Birth: Percent of children aged 0-23 months who were placed with the mother immediately after birth	82.4	55.7	69.0 ±4.4	94.0 ±2.7
POSTPARTUM CARE				
Postpartum Contact: Percent of mothers who had at least one postpartum check-up	89.0	64.8	76.9 ±4.0	98.7 ±1.3
Postnatal Care Counseling: Counseling given to postpartum women on last pregnancy by theme				
Breastfeeding	99.0	93.5	96.3	98.3
Lactational Amenorrhea Method	68.9	43.3	56.3	52.3
Family planning	63.6	52.7	58.3	80.3

Although the baseline only asked mothers about knowledge of 2 pregnancy danger signs, the final survey also asked about knowledge of three danger signs. The results are below.

Indicators	FE % (n=300) CI
Percent of mothers who know at least three signs of danger during pregnancy that indicate the need for treatment	**89.0%±3.5** In the Baseline results table mothers requested to mention two signs: Result for FE: 97.0%±1.9

f. Post partum Child Spacing

Of women interviewed, 70 percent at baseline and 75 percent at final started using a FP method right after the last delivery. The percent of post partum mothers who started using FP methods within six weeks of delivery jumped from 37 percent at baseline to 56 percent at the final. This percentage increase of about 20 percent may be reflective of better quality of services and attendance at post partum care.

TABLE 8. CHILD SPACING				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420)CI***	***percent (n=250)CI***
Birth Spacing: Percent of mothers who started using a FP method after last delivery	78.6	62.4	70.5 ±4.4	75.2 ±5.4
	percent (n=165)	***percent (n=131)***	***percent (n=296)***	***percent (n=188)***
Time when mothers started using FP method:				
During first 6 weeks	44.2	28.6	37.5	56.4
After 7 weeks	54.5	70.6	61.5	39.4
Other	1.3	0.8	1.0	4.3

SECTION 2. FAMILY PLANNING: WOMEN OF REPRODUCTIVE AGE (15-49 YEARS OLD)

a. Women's Background Characteristics

Ninety-nine (99) percent of the reproductive age women interviewed had some level of education and 7.4 percent at baseline and 9.4 at final had higher education levels. Also a higher percentage had completed secondary by the final than had at baseline. Ninety-three (93) percent felt more comfortable speaking Uzbek and the average age was 32 years.

TABLE 9. GENERAL CHARACTERISTICS OF THE INTERVIEWED MOTHERS: SCHOOLING, LANGUAGE, HEAD OF HOUSEHOLD, AND OTHER CHILD CARETAKERS				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=209)	***percent (n=209)***	***percent (n=418)***	***percent (n=300)***
Highest level of education attained				
Primary	1.9	0.5	1.2	0.0
Incomplete secondary	30.6	27.3	28.9	6.7
Secondary/special secondary	58.9	66.0	62.4	83.7
Higher	8.6	6.2	7.4	9.7
Language interviewees feel most comfortable communicating*				
Uzbek	96.7	90.9	93.8	No data
Tajik	3.3	8.6	6.0	
Kazakh	0.0	0.0	0.0	
Russian	0.5	1.0	0.7	
Continuous Variables	***Average (n=210)***	***Average (n=210)***	***Average (n=420)***	***Average (n=300)***
Age of interviewed women	30.9	32.5	31.7	32.0

***** Note: Given that multiple answers were allowed, the table represents the number of respondents, not responses.

b. Reproduction and Child Spacing

At baseline, 48 percent of the population had a birth interval of at least 24 months between their last two children. This had increased to 84 percent by the time of the final evaluation. Also even though this was not a project indicator, it is interesting that the percent of children born at least 36 months after the previous child increased from 13 at baseline to 28 at final, indicating that spacing is being extended beyond 24 months in a number of cases. At the baseline, when women interviewed were asked whether there are days in which women are most fertile, 36.9 percent responded affirmative, but only 9.3 percent of these reported that those days are halfway between menstrual cycles. However, by the time of the final evaluation, 80 percent affirmed that there were fertile periods in their cycle and of these 46 percent knew when it was.

TABLE 10. ***REPRODUCTION AND CHILD SPACING***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007 Total***
	percent (n=14)	***percent (n=15)***	***percent (n=29) CI***	***percent (n=32) CI***
Adequate Birth Interval Between Youngest Surviving Children: Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child	50.0	46.7	48.3 ±18.2	84.4 ±12.6
Adequate Birth Interval Between Youngest Surviving Children (Less Stringent Criteria): Percent of children aged 0-23 months who were born at least 36 months after the previous surviving child	21.4	6.7	13.8 ±12.6	28.1 ±15.6
	percent (n=210)	***percent (n=210)***	***percent (n=420)***	***percent (n=300)***
Knowledge of the Reproductive Cycle: Percent of women who report that there are days in their menstrual cycle when are most likely to get pregnant	30.5	43.3	36.9 ±4.6	79.7 ±4.6
Knowledge of the Reproductive Cycle: Percent of women who report that women are likely to get pregnant halfway between two menstrual periods.	11.9	6.7	9.3 ±2.8	45.7 ±5.6

c. Knowledge and Ever Use of Contraception

At baseline, when women were asked about knowledge of FP methods, where to obtain them and if she ever used them, IUD, LAM pills and injectables were the methods commonly known. Emergency contraception and male sterilization were the least known. By the time of the final, most modern methods and where to obtain them were known (female sterilization, pill, IUD, injectables, condoms and LAM). Again, emergency contraception and male sterilization were least known. The same trend was observed when asked about where to obtain them and if ever used. The percentage of women who know where to obtain at least one method is close to hundred percent, and although the method mix is still dominated by a preference for the IUD, the percentage of women using the IUD has come down from 86 to 70 percent. Use of injectables has increased from 13 to 17 percent. It appears that use of LAM has dropped from 60 to 38 percent but at the same time, use of standard days method (SDM) has increased from 13 to 17

percent and use of rhythm or periodic abstinence has increased from 11 to 20 percent. Other methods such as female sterilization, condoms, foam, and emergency contraception appear to have increased slightly. Hence, there continues to be good physical access to FP services, and a larger variety of methods are being used, though there continues to be a preference for the IUD.

*TABLE 11. KNOWLEDGE OF FP METHODS; WHERE TO OBTAIN THEM; AND EVER USED A FP METHOD**

Indicators	Total			June 2007		
				percent		
	percent (n=420)			(n=300)	(n=250)	(n=250)
	knows	obtain	Used	knows	obtain	Used
Female Sterilization	69.2	59.1	4.1	85.0	87.6	5.6
Male Sterilization	12.5	8.6	0.3	32.7	33.2	0
Pill	80.5	75.4	15.7	97.0	98.0	14.4
IUD	98.3	96.6	86.3	99.3	98.8	70.8
Injectables	79.6	75.7	13.2	98.7	96.4	16.8
Condom	64.4	58.0	12.9	90.7	88.8	13.6
Foam or Jelly	16.6	12.8	0.3	42.0	44.0	1.2
Lactational Amenorrhea (LAM)	81.3	80.6	59.6	80.7	88.4	38.0
Standard Days Method	48.8	44.5	13.5	73.7	72.8	17.2
Rhythm or Periodic Abstinence	28.6	27.8	11.3	62.3	67.2	20.4
Withdrawal	44.7	43.2	22.5	63.3	68.0	18.8
Emergency Contraception	9.9	8.6	1.1	39.0	42.0	2.8

d. Access to Family Planning

At both the baseline and final evaluations, 97 percent of the interviewed population reported to know a source of FP methods within their communities and 93 and 91 percent respectively, reported living within 5 km. of a FP distribution point.

TABLE 12. ACCESS TO FP SERVICES AND DISTANCE FROM SDP

Indicators	Navoi & Kiziltepa	Konimeh & Nurata	Total	June 2007
	percent (n=197)	percent (n=199)	percent (n=396) CI	percent (n=300) CI
Access: Knowledge of sources of child spacing methods within interviewees' communities	97.6	97.6	97.6 ±1.5	97.0 ±1.9
Access: Percentage of population who live within 5 km of a family planning/reproductive health service delivery point	95.4	91.0	93.2 ±2.5	91.3 ±3.2

e. Use of Family Planning

At both the baseline and final surveys, 73 percent of women of reproductive age, who do not want another child in the next two years and were not pregnant were using a FP method. This figure is slightly higher than the national rate for contraceptive use among married women according to the 2002 DHS which was 67.7 percent, 69 percent for urban and 65 percent for rural women[2]. When observing the method mix, the IUD continues to be the most widely used though the 82 percent baseline figure has dropped to 70 percent use by the time of the final. This method is followed by female sterilization (up from 3.3 percent to 6.4 percent), the pill (up from 1.5 to 6 percent) and injectables (up from 2.2 to 6.4). Use of all methods has shown an increase since the baseline. Use of LAM has also increased. At baseline, 62 percent of women interviewed had received proper counseling (including contraceptive choice, common side effects, and when to return for follow-up); this increased to 86 percent by the final survey which reinforces the fact that counseling and informed choice is increasing at the service delivery level, and may be having some effect in improving the method mix.

TABLE 13. ***CHILD SPACING INDICATORS***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=178)	***percent (n=190)***	***percent (n=368) CI***	***percent (n=88) CI***
Contraceptive Use Among WRA Who Want to Limit or Space Births: Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing	73.6	71.6	72.6 ±4.6	72.8 ±9.3
	% (n=178)	**% (n=190)**	**% (n=368) CI**	**% (n=233)**
Contraceptive Use: Current of FP methods by type*				
Female Sterilization	2.3	4.3	3.3	6.4
Male Sterilization	0.0	0.0	0.0	0.0
Pill	1.5	1.4	1.5	6.0
IUD	87.1	78.4	82.7	70.8
Injectables	2.3	2.2	2.2	6.4
Implants	0.0	0.0	0.0	0.0
Condom	3.0	2.2	2.6	3.0
Foam/Jelly	0.0	0.7	0.4	0.0
Lactational Amen. Method	1.5	2.2	1.8	4.7
Standard Days Method	1.5	2.2	1.8	0.9
Periodic Abstinence (Other Than Standard Days	0.8	0.7	0.7	1.7
Withdrawal	0.0	6.5	3.3	3.0
	percent (n=131)	***percent (n=136)***	***percent (n=267) CI***	***percent (n=97) CI***
Counseling: Percentage of family planning clients who receive counseling** on contraceptive choices, correct use of method accepted, common side effects, and when to return for follow-up	73.5	52.2	62.7 ±5.8	86.6 ±6.8

[2] Uzbekistan Health Examination Survey 2002. Preliminary Report. Ministry of Health of Uzbekistan, State Department of Statistics, MEASURE DHS+ ORC Macro. May 2003.

Continuous variable	*Average (n=131)*	*Average (n=136)*	*Average (n=267)*	*Average (n=235)*
Average duration of respondent's or husband/partner has been using CURRENT METHOD in months	42.4	40.3	41.4	41.4

*Note: Given that multiple answers were allowed, the table represents the number of respondents, not responses.

**Note: "Adequate counseling" is defined as whether client has received information on: a) contraceptive choices, b) correct use of the method accepted, c) common side effects, and d) when to return for follow-up services, however, the current survey, only collected data on options "a," "c" and "d."

f. Diffusion of Family Planning Messages

More than half (56 percent at baseline and 66 percent at final) of women interviewed had discussed FP issues in the previous year. It is interesting that at baseline the most common person talked to were friends, followed by husband or partner. Whereas at the final, a large majority (82 percent) said they conferred with husband or partner followed by mothers-in-law (33), and friends were hardly mentioned. At the final, 89 percent of women reported that they had been visited by a health worker to discuss family planning, which was up from 57 at baseline, and 84 percent (up from 60) had visited a health facility. While the most popular media for receiving family planning messages at baseline was television, and even though it continues to be an important information source, by the time of the final survey, health fairs were even more popular (up by 30 percentage points). In sum, it appears that women are discussing family planning more with their husbands and that they are getting a significant amount of FP information from health fairs.

TABLE 14. ***DIFFUSION OF FAMILY PLANNING MESSAGES***

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420) CI***	***percent (n=300) CI***
Percentage of respondents who report discussing FP issues with somebody in the past 12 months	63.3	49.0	56.2 ±4.7	65.7 ±5.4
	percent (n=122)	***percent (n=102)***	***percent (n=224)***	***percent (n=197)***
Persons respondents have chosen to discussed FP issues in the past 12 months:				
Husband/Partner	46.7	41.2	44.2	82.7
Mother	6.6	10.8	8.5	11.7
Father	0.8	0.0	0.4	0.5
Sister(S)	24.6	17.6	21.4	17.3
Brother				12.7
Daughter	7.4	2.0	4.9	3.0
Son	2.5	1.0	1.8	0.0
Mother-in-law	11.5	21.6	16.1	33.5
Friends/Neighbors	69.7	68.6	69.2	2.5
Makhalla activists				3.0
Other				1.5

	percent (n=210)	*percent (n=210)*	*percent (n=420)*	*percent (n=300) CI*
Percentage of respondents who reported that were visited by a health worker to talk about family planning	71.7	43.1	57.2 ±4.7	89.0 ± 3.5
Percentage of respondents who reported that visited health a health facility for care of herself (or her child)	69.0	52.4	60.7 ±4.7	84.3 ±4.1
Percent of respondents who have seen or heard any messages about family planning by any of the following means				
Radio	20.4	13.5	17.3	11.7
Newspaper	29.6	25.8	27.9	32.0
Television	73.5	77.3	75.2	60.0
Health Fair	69.9	38.7	55.7	85.3
No visit				1.0
Other				0.0

Additional indicators measured at the Final survey only:

Although not measured at baseline, one can see that by the time of the final survey, 80 percent of mothers with children under 12 months had received adequate family planning counseling according to Flex Fund criteria, 99 percent of WRA knew at least three modern FP methods, there was a 14 percent unmet need for family planning among married women or women in union.

Indicators	**FE %±CI**
Percentage of mothers with children less than 12 months who received counselling about birth spacing**	80.3%±4.5 (n=300)
Percentage of women of reproductive age (WRA) 15-49 who have heard about at least three modern methods of family planning** Type of method: the program may be interested in knowing what methods people have heard about, especially if the program is interested in introducing it or increasing its use (for example, LAM, IUDs, SDM, etc) This indicator added to Project indicators list as FF indicator	98.7%±1.3 (n=300)
Unmet Need for Family Planning** (The indicator is limited to women in union/married. If you are working in a context where there is widespread sexual activity outside of marriage or stable unions, you might want to consider calculating the percentage of sexually active unmarried women with an unmet need for family planning.)	13.8%±4.6 (n=217)

***** Rapid Catch

****** FF Required

g. HIV/AIDS and Use of Condoms

At the baseline and final surveys, 97 and 99 percent of the WRA in the surveyed areas had heard about HIV/AIDS. Ninety-six (96) percent (up from 36.5 percent at baseline) reported knowing at least two ways to avoid AIDS. Ninety-six (96) percent (90 at BL) admitted that it can be transmitted from mother to son, and 83 percent (76 at BL) believed it occurs during pregnancy, 31 percent (21 at BL) during delivery and 74 percent (47 at BL) during breastfeeding. The DHS-2002 reported that 90.1 percent of the population had ever heard about HIV/AIDS (93.5 percent urban and 87.9 percent rural).

During the life of the project, there has been a significant increase in knowledge among women of reproductive age in the project rayons concerning HIV/AIDS transmission and how to prevent it.

TABLE 15. HIV/AIDS PREVENTION AND USE OF CONDOMS

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420) CI***	***percent (n=300) CI***
Percent of respondents who ever heard of an illness called AIDS	98.6	95.7	97.1 ±1.6	99.3 ±0.9
	percent (n=207)	***percent (n=201)***	***percent (n=408)***	***percent (n=263)***
Respondents Knowledge of HIV/AIDS Prevention: Percent of respondents who know of at least two ways of avoiding HIV/AIDS transmission (abstain from sex, use condoms, avoid contact with contaminated blood)	33.8	39.3	36.5 ±4.7	95.8 ±2.4
	% (n=207)	**%(n=201)**	**% (n=408)**	**% (n= 300)**
Percent of respondents who know that the HIV can be transmitted from mother to son	90.3	91.5	90.9 ±2.8	96.3 ±2.1
Respondents who know that HIV can be transmitted during:				
Pregnancy	74.9	77.6	76.2	82.7
Delivery	21.4	21.9	21.6	31.0
Breastfeeding	41.2	47.0	47.0	74.7
	percent (n=5)	***percent (n=4)***	***percent (n=9)***	
Percent of respondents who used condom during last sexual intercourse with other than spouse/stabile partner	83.3	100.0	90.0	No data

SECTION 3. ADOLESCENT HEALTH (16 -18 YEARS OF AGE)

a. Respondent's Information

Four hundred twenty (420) adolescents were interviewed during the baseline (36 percent boys and 63 percent girls) and 300 at the final (43 percent boys and 57 percent girls), 80 percent at baseline and 86 percent at final were going to a school and most (92 percent) felt more comfortable communicating in Uzbek. The average age of the adolescents interviewed at both baseline and final surveys was 16 years.

Respondent's Information

TABLE 16. GENERAL CHARACTERISTICS OF THE INTERVIEWED ADOLESCENT: SCHOOLING, LANGUAGE AND AGE

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420)***	***percent (n=300) CI***
Gender of interviewees				
Boys	34.3	39.5	36.9	43.0
Girls	65.7	60.5	63.1	57.0
Currently school/lyceum/college/institute attendance by gender	80.6	86.7	83.9	89.9
Boys	76.6	78.0	77.3	84.8
Girls				
Language interviewees feel most comfortable communicating	96.7	89.0	92.9	No data
Uzbek	4.8	5.2	5.0	
Tajik	1.0	4.3	4.3	
Kazakh	1.9	1.0	1.0	
Russian				
Continuous Variables	***Average (n=210)***	***Average (n=210***	***Average (n=420)***	***Average (n=300)***
Age of adolescents				
Boys	16.5	16.4	16.5	16.9
Girls	16.7	16.8	16.7	16.9

b. Family Size and Marriage

Cultural family traditions and values in Uzbekistan are of extreme importance, and an important one concerns marriage. At the baseline, 64 percent of adolescent boys believed that they themselves should choose the person they marry, while 46 percent of adolescent girls believed they should choose their husband; on the other hand, 15 percent of boys believe their parents should choose, while 24 percent of girls believed the same.

When adolescents were asked what they would do if a girl became pregnant, 87 percent of the boys responded that they should marry her, while 76 percent of the girls believed the same thing. Six (6) percent of the boys would seek abortion services while 9 percent of the girls would.

When asked about the ages that men and women should get married, adolescents responded 22 years of age for men and 20 for women. When asked at what age they believed that couples were actually getting married, they indicated ages 21 for men and 19 for women; there were small differences between what they thought should be the age of marriage and the actual age, meaning that adolescents do not believe early marriage is a problem. Finally, when adolescents were asked about the ideal number of children to have in a family, both stated that three is the appropriate number.

Unfortunately there was no follow-up data collected on these attitudes during the final survey so we do not know if the opinions changed during the life of the project.

TABLE 17. ADOLESCENTS' PERCEPTION OF FAMILY SIZE AND MARRIAGE				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	percent (n=210)	***percent (n=210)***	***percent (n=420)***	***no data***
Marriage: Adolescent perception as to who should decide whom to marry:				
For Boys				
Choose own husband/wife	63.9	65.1	64.5	No data
Parents should decide	15.3	15.7	15.5	
Both	20.8	19.3	20.0	
For girls				
Choose own husband/wife	44.2	49.6	46.8	No data
Parents should decide	29.7	19.7	24.9	
Both	26.1	30.7	28.3	
Marriage: Adolescents preferred options when getting pregnant/getting a girl pregnant				
For boys				
Marry her	86.9	87.3	87.1	No data
Abortion	8.2	5.6	6.8	
Other	4.9	7.0	6.1	
For girls				
Marry him	76.3	77.1	76.7	No data
Abortion	11.3	8.3	9.8	
Other	12.4	14.6	13.5	
Continuous Variables	***Average (n=210)***	***Average (n=210)***	***Average (n=420)***	***June 2007***
Age of Marriage: Adolescents' perception of the appropriate age.				
men should marry	22.5	22.4	22.5	No data
women should marry	20.6	20.1	20.3	
Age of Marriage: Adolescents' perception of the age men and women are currently marrying:				
men	21.1	22.3	21.7	No data
women	19.1	19.2	19.2	
Ideal Number of Children: Adolescents' perception of the ideal number of children for a family:				
For boys	3.2	3.3	3.2	No data
For girls	3.1	3.1	3.1	

c. Knowledge of FP Methods and Where to Obtain Them

Table 18 shows that at the time of the baseline survey adolescents had very limited knowledge of FP methods and where to obtain them. The most widely known FP method was the IUD with 84 percent, but the second most known was pills at 42 percent, then the numbers continued decreasing for all other FP methods. In contrast, by the time of the final survey, adolescent knowledge increased dramatically particularly of modern methods such as pills (74 percent), IUDs (83 percent), injectables (72 percent) and

condoms (68 percent). Similar percentage levels showed that adolescents also knew where to obtain them. Fifty (50) percent knew about female sterilization and where to obtain it but fewer (20-28 percent) knew about the "natural" methods, such as LAM, standard days, rhythm and withdrawal – though knowledge levels were higher than at baseline (5-8 percent). About 20 percent also knew about emergency contraception and where to obtain it, which was higher than baseline (4 percent).

According to the final KPC interviews, only a small percent of adolescents have used contraception with .4 using the pill, .8 using of IUD and 4.4 using condoms.

*TABLE 18. **KNOWLEDGE OF FP METHODS; WHERE TO OBTAIN THEM; AND EVER USED A FP METHOD***

Indicators	***Total***			***June 2007***		
				percent		
	percent (n=420)			**(n=300)**	**(n=250)**	**(n=250)**
	knows	**obtain**	**Used**	**knows**	**obtain**	**Used**
Female Sterilization	35.6	29.1	n/d	49.7	50.4	0.0
Male Sterilization	6.8	2.7	n/d	31.0	29.6	0.0
Pill	42.7	41.3	n/d	78.3	74.0	0.4
IUD	84.0	74.0	n/d	83.3	76.8	0.8
Injectables	34.5	31.4	n/d	72.0	66.0	0.0
Condom	27.8	27.4	n/d	68.0	64.8	4.4
Foam or Jelly	1.8	0.9	n/d	20.0	21.2	0.0
Lactational Amenorrhea (LAM)	8.9	8.5	n/d	25.3	27.2	0.0
Standard Days Method	7.8	8.1	n/d	28.0	25.6	0.0
Rhythm or Periodic Abstinence	6.0	7.6	n/d	23.0	20.8	0.0
Withdrawal	5.0	4.5	n/d	20.0	20.8	0.0
Emergency Contraception	3.9	4.5	n/d	21.7	19.6	0.0

The adolescents were asked about sexual attitudes regarding FP use and knowledge of the reproductive cycle. At baseline, 17% of the boys replied that women should decide what FP method to use and 33% of boys indicated that is a decision of both, while 34% of the girls replied that woman should decide and 32 percent with both partners. By the time of the final survey, these responses had changed some with 24 percent of boys saying that girls should decide the method and 44 percent saying it was the decision of both partners. However, 55 percent of girls thought that the methods should be the woman's decision and only 32 percent continued to think (same as baseline) it should be the decision of both partners. So this seems to indicate that by the end of the project, both boys and girls are recognizing the importance of the woman's role in FP decisions.

When asked about knowledge of the reproductive cycle at the time of the baseline study, only 3% of the boys knew that there are days when women are more likely to get pregnant, and only .13% of the girls, and when specifically asked when those days were, only 1.9% of the boys knew it was half way between menstrual cycles, and 0.8% of the girls. In contrast, by the time of the final survey, 42 percent of boys and 60 percent of

girls knew that there is a period in the menstrual cycle when women are more likely to get pregnant and 26 percent of boys and 40 percent of girls correctly stated when it was. These findings also attest to the program's success in educating adolescents about their reproductive health.

TABLE 19. FP METHOD DECISION AND REPRODUCTIVE CYCLE KNOWLEDGE

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Adolescents perception as to whom should decide what FP method to use:				
For boys				% (n=129)
Woman	19.7	16.0	17.8	23.6
Man	29.6	33.3	31.6	30.2
Both partners	36.6	30.9	33.6	44.3
For girls				% (n=171)
Woman	35.6	32.3	34.0	55.3
Man	8.9	13.4	11.1	7.1
Both partners	28.9	37.0	32.8	31.9
Knowledge of the Reproductive Cycle: Percent of boys and girls who know that there is a period when women are more likely to get pregnant:				
For boys	2.8	4.8	3.9	41.9% (n=171)
For girls	13.8	12.6	13.2	59.6% (n=171)
Knowledge of the Reproductive Cycle: Percent of boys and girls who report that women is likely to get pregnant halfway between two menstrual periods:				
For boys	1.4	2.4	1.9	25.9% (n=171)
For girls	0.7	0.8	0.8	39.8% (n=171)

d. Initiation of Sexual Life and Family Planning

Table 20 shows the adolescent perception as to when to start sexual relations and the importance of being virgin at the time of marriage. These responses regarding appropriate ages for sexual debut have not changed much in the duration of the project. Likewise, the importance of a girl remaining a virgin until marriage is slightly higher than at baseline for both boys and girls. Only a few adolescents had initiated sexual life, though there are a few more at the final (boys 11.6%) than at the baseline (boys 5.8%) thus the number of people using FP methods was very small (10 at baseline and 18 at the final). The percentages of FP users were equally divided between boys and girls.

TABLE 20. INITIATION OF SEXUAL LIFE				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
Continuous variable	***Average % (n=210)***	***Average % (n=210)***	***Average % (n=420)***	***% (n=300)***
Sexual Initiation: Adolescents perception of the age men and women can start sexual activity:				
Men	18.1	17.2	17.7	19.3
Women	18.6	18.2	18.4	20.7
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Sexual Initiation: Adolescents perception of the importance for a woman to be virgin until marriage				
For boys:				% (n=129)
Important	91.7	84.3	87.7	93.0
Not Important	6.9	7.2	7.1	3.9
Don't Know	1.4	7.2	4.5	3.1
For girls:				% (n=171)
Important	92.0	93.7	92.8	96.5
Not Important	5.8	2.4	4.2	2.9
Don't Know	2.2	4.0	3.0	0.6
Family Planning: Percent of adolescents with active sexual life by gender:				
Boys	11.1	1.2	5.8	11.6
Girls	0.0	0.8	0.4	1.8
	% (n=8)	***% (n=2)***	***% (n=10)***	***% (n=18)***
Family Planning: Percent of adolescents using contraception:				% (n=15)
Boys	37.5	100.0	44.4	66.7
Girls	0.0	100.0	50.0	% (n=3) 66.7
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Percent of adolescent who reported that his/her close male friends had sexual intercourse with prostitutes, according to				% (n=129)
Boys	24.6	10.4	16.9	33.3
Girls	15.2	7.6	11.5	% (n=171) 12.4

e. Teenage Pregnancy

At both the baseline and final surveys, there were no girls with a past pregnancy, and most (95 percent at BL and 90 percent at FE) did not agree that having sex would make them more popular among their peers.

TABLE 21. TEENAGE PREGNANCY: QUESTIONS ONLY FOR GIRLS AND QUESTIONS FOR BOYS AND GIRLS				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Teenage Pregnancy: Percent of girls who have ever been pregnant	0.0	0.0	0.0	0.0
Teenage Pregnancy: Perception of adolescents who agree or disagree with the following statement: "Having sex while I'm a teenager would be a way to be popular"				
For boys:				% (n=129)
Disagree	88.9	92.7	90.9	86.0
Not Sure	5.6	1.2	3.2	2.8
Agree	5.6	6.1	5.8	11.2
For girls:				
Disagree				% (n=171)
Not Sure	96.4	95.3	95.8	90.2
Agree	1.4	3.1	2.3	2.1
	2.2	1.6	1.9	7.7

f. Abortion

According to the DHS 2000[3], total abortion rates (TAR) for all of Uzbekistan is 0.9 abortions per woman (0.9 in rural and 1.1 in urban areas). The baseline and final surveys attempted to ask questions about abortion prevalence, but were only able to obtain information about perceptions of abortion practice. As noted in table 22, at the baseline, 52% of boys and 57% of girls thought abortion was common among adolescent friends. By the time of the final survey, the percentages had dropped a bit with 43 percent of boys and 37 percent of girls thinking that abortion was common among teenagers.

TABLE 22. FREQUENCY OF ABORTION				
Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Abortion: Adolescents perception that abortion is common among teenage girls: According to boys:	54.2	50.6	52.3	% (n=129 43.4
According to girls:	60.1	54.3	57.4	% (n=171) 37.4

g. Sexually Transmitted Infections

One of the main purposes of educating adolescents about reproductive health, is for them to protect themselves when initiating sexual activity and therefore, knowing and preventing STI is key. During the baseline survey, 76% of adolescent respondents had heard about the existence of sexually transmitted infections (STIs), however, 97.8% were

[3] Uzbekistan Health Examination Survey 2002. Preliminary Report. Ministry of Health of Uzbekistan, State Department of Statistics, MEASURE DHS+ ORC Macro. May 2003.

referring to HIV/AIDS; the second highest percentage was for syphilis (12.3%); and when asked specifically about HIV/AIDS, 91.9% responded that they knew the disease; 44.2% could name at least two ways of transmitting HIV/AIDS and 54.1% mentioned at least one way of preventing infection. Only 19.3% knew what a condom was and out of those, only 26.5% knew how to use one.

By the time of the final survey, 95 percent of the adolescents had heard of STIs. Of these 91 percent spontaneously reported knowing of HIV/AIDS, 47 percent knew of syphilis and 17 percent knew of gonorrhea. Less was known about Chlamydia, genital herpes and hepatitis but still more than at the baseline (6-8 percent versus 1-2 percent). The percent of adolescents who could name at least 2 ways HIV/AIDs is transmitted has increased from 44 to 91 and the percent of respondents who know at least one way to prevent HIV/AIDs transmission rose from 54 to 84. Although there was no data in this section of the final survey about knowledge of condom use, there was a question asking for steps in condom use, noted in the extra indicators below that were added to the final survey, which indicates that 17 percent of adolescents or 50 of 300 respondents could name at least 6 steps of correct condom use. This is actually a higher number and percent of respondents than the 21 (or 26.5% of n=81) out of 420 who stated that they knew how to use condoms at the baseline. Also, information in table 18 indicates that 68 percent of adolescent respondents know about condoms, 64 percent know where to obtain them and that 4.4 percent actually use them.

TABLE 23. KNOWLEDGE OF STIS AND PREVENTION

Indicators	**Navoi & Kiziltepa**	**Konimeh & Nurata**	***Total***	***June 2007***
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Adolescents Knowledge of STIs: Percent of respondents who have heard about STIs	81.9	71.4	76.7	94.7
	% (n=170)	***% (n=146)***	***% (n=316)***	***% (n=284)***
STIs adolescent respondents spontaneously reported knowing:				
Gonorrhea	1.8	0.0	0.9	17.3
Syphilis	14.7	9.6	12,3	46.7
Genital Herpes	0.6	0.7	0.6	4.0
Hepatitis	3.5	0.7	2.2	8.3
Chlamydia	1.8	0.0	0.9	6.0
HIV/AIDS	97.1	98.6	97.8	91.0
Condiloma				1.0
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Adolescents Knowledge of HIV/AIDS: Percent of respondents who have heard about HIV/AIDS	95.2	88.6	91.9	97.7
	% (n=200)	***% (n=186)***	***% (n=386)***	***% (n=293)***
Adolescents Knowledge of HIV/AIDS Transmission: Percent of adolescent respondents who can name at least two ways how HIV/AIDS is transmitted	34.5	33.9	44.2	90.7
Adolescents Knowledge of HIV/AIDS Prevention: Percent of respondents who can name at least ONE way to prevent HIV/AIDS transmission	61.0	46.8	54.1	84.3
	% (n=210)	***% (n=210)***	***% (n=420)***	***% (n=300)***
Adolescents Knowledge of HIV/AIDS Prevention: Percent of adolescent respondents who report knowing what is a condom	20.5	18.1	19.3	No data

	% (n=43)	*% (n=38)*	*% (n=81)*	*% (n=300)*
Adolescents Knowledge of HIV/AIDS Prevention: Percent of adolescent respondents who report knowing how to use a condom	35.6	15.8	26.5	No data

Additional Indicators added to the Final Survey

Because not all the Flex Fund required questions had been measured in the baseline survey, they as well as other indicators were added for the final KPC survey to show additional levels of achievement. The indicators listed below show that about 83 percent of targeted adolescents surveyed can name at least three contraceptive methods and; 48 percent can name at least three signs of STIs; 80 percent can name at least two means of protecting themselves from STIs. Eighty three (83) percent of sexually active adolescents report using a condom during last sexual intercourse, which is well beyond the target of 50 percent. Almost 17 percent (target 15) could correctly name six steps associated with correct condom use.

Indicators	FE %± CI
Percent of targeted adolescent population who can name at least three methods of contraceptive methods**	82.7%±4.3 (n=300)
Percent of targeted adolescent population who can name at least 3 signs of STIs	48.0%±5.7 (n=300)
Percent of targeted adolescent population who can name at least 2 means of protecting themselves against contracting STIs	80.3%±4.5 (n=300)
Percent of targeted adolescent population report having used (or whose sexual partner used) a condom during last sexual intercourse (**Target=50%)**	83.3%±21.1 (n=12)
Percent of targeted adolescents who can correctly name at least 6 steps associated with correct use of a condom **(Target - 15%)**	16.7%±4.2 (n=300)

***** Rapid Catch

****** FF Required

GENERAL CONCLUSIONS

The findings in this report demonstrate that significant improvements in health behavior occurred in all project intervention areas during the life of the project. For example, the percent of children born at least 24 months after the previous surviving child almost doubled during the life of the project. Likewise, levels of exclusive breast feeding increased by 30 percent and the levels of children 6-9 months who breastfed and received complementary foods increased from 20 to 60 percent. Also levels of children 12-23 months who were fully vaccinated rose from 50 to 81 percent. The percentage of sick children who received increased fluids and food during illness increased from 23 to 64 percent and use of ORT during diarrhea episodes rose from 31 to 47 percent. In addition, findings indicate that preventive health knowledge levels in intervention areas rose significantly during the time of the project. Knowledge gains were made in all project areas including understanding of danger signs for pregnancy, diarrhea, pneumonia and

STIs. Significant knowledge was also gained concerning how to prevent transmission of STIs and HIV/AIDS (rising from 36 to 96 percent) among women of reproductive ages. There is also evidence that mothers and WRA received improved counseling on sick child care and family planning, which lead to better child care and higher use of family planning methods beginning during post partum periods. Significant gains in knowledge were made by adolescents in the area of STI and HIV/AIDS prevention. There is also evidence that sexually active adolescents know how and are using condoms. By the time of the final evaluation 83 percent of adolescents could name at least three contraceptive methods.

In sum, significant improvements in health behavior and knowledge levels were evidenced by the target populations (mothers of children under 2, women of reproductive ages and adolescents) in this study.

Project HOPE, Navoi, Uzbekistan
FINAL EVALUATION.

Questionnaire 1: IMCI and Safe Motherhood Interventions

All questions are to be addressed to a mother with a child less than 24 months of age

Identification number:	……..[____ / ____ / ____]
Rayon (1= Karmana; 2=kiziltepa;3=Konimeh ; 4=Nurota) Mahallla's name…… Cluster number……	……[ ] _____ ……[/]
Interview date (day/month/year)……	……[____ / ____ / ____]

Informed Consent

Hello, my name is _____ and I am working for the Navoi Oblast health Department. We are conducting a survey about your health and of your child. We would very much appreciated your participation in the survey, since this information will help us improve the existing health services. The survey is going to take us about 30 minutes to complete

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.
All discussed information will be keep confidentially.

At this time, would you like to ask me anything about the survey?

Name of mother (interviewee) Age of mother in years	_____ ……[/]
How many children living in this household are under age two?	……[/]
Name of youngest child (under 24 months of age)……	_____

Child's Background Characteristics

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Birth date (day/month/year)…… [____ / ____ / ____]		
1A	Classification by child's age	0-5 month.....1 6-9 month.....2 20-23 month.....3 Other.. 4	
2	Do you have elder child than (name)	YES .....1 NO 2	→ **5**
3	If Yes, his/her date of birth [____ / ____ / ____]		
4	Birth spacing	Less 24 months (23 months 29 days)……..1 24 months and more……2	
5	Child weigh	___ ___, ___ kg	
6	Child height	___ ___, ___ cm	

Breastfeeding and Infant/Child Nutrition

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
7	**Did you ever breastfeed (NAME)?**	**YES..... 1** **NO 2**	**—<12**
8	**How long after birth did you first put (NAME) to the breast?**[1]	**IMMEDIATELY/WITHIN FIRST HOUR AFTER DELIVERY ..... 1** **AFTER THE FIRST HOUR ..... 2** DON=T KNOW..... 3	
9	During the first three days after delivery, did you give (NAME) COLOSTRUM?	YES..... 1 NO ..... 2 DON=T KNOW..... 8	
10	During the first three days after delivery, did you give (NAME) anything else to eat or drink before feeding him/her breastmilk?	YES..... 1 NO ..... 2 DON=T KNOW..... 8	
11	Are you currently breastfeeding (NAME)?	YES..... 1 NO 2	
12	I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night. Did (NAME) have. . . READ EACH OF THE FOLLOWING AND PLACE A CIRCLE EACH ITEM CONSUMED.	BREAST MILK.....A INFANT FORMULA……..B ANIMAL MILK……C PLAIN WATER..... D OTHER LIQUIDS.....E MASHED, PUREED, SOLID OR SEMI-SOLID FOODS.....F Anything else_____G SPECIFY	
13	How many times did (NAME) eat semi-solid (mashed or pureed) food yesterday during the day or at night? IF 7 OR MORE TIMES, RECORD >7'.	NUMBER OF TIMES……{ } DON=T KNOW……..8	

Childhood Immunization

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
14	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?	YES.....1 NO.....2 DON=T KNOW.....8	➔16
15	Please tell me if (NAME) received any of the following vaccinations		
15A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES.....1 NO.....2 DON=T KNOW.....8	
15B	Polio vaccine, that is, drops in the mouth?	YES.....1 NO.....2 DON=T KNOW.....8	➔15E ➔15E
15C	When was the first polio vaccine received, just after birth or later?	FIRST 15 DAYS AFTER BIRTH .....1 LATER 15 days 2	
15D	How many times was the polio vaccine received?	NUMBER OF TIMES……{ }	
15E	DPT vaccination, that is, an injection given in the thigh or buttocks, (sometimes at the same time as polio drops)?	YES.....1 NO.....2 DON=T KNOW.....8	➔15G ➔15G
15F	How many times?	NUMBER OF TIMES……{ }	
15G	**An injection to prevent measles?**	**YES.....1** **NO.....2** **DON=T KNOW.....8**	

Childhood Illness

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
16	Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? RECORD ALL MENTIONED.	DON=T KNOW……A LOOKS UNWELL OR NOT PLAYING NORMALLY..B NOT EATING OR DRINKING……C LETHARGIC OR DIFFICULT TO WAKE……D HIGH FEVER……E FAST OR DIFFICULT BREATHING……F VOMITS EVERYTHING……G CONVULSIONS……H DEHYDRATION……I BLOOD IN STOOLS……J OTHER _____.....K (SPECIFY)	
16A	Correctly answers	If any 2 and more answers from B-J……1 Less than 2……2	

Diarrhea Case Management (DCM)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
17	Has (NAME) had diarrhea in the last 2 weeks?	YES.....1 NO .....2 DON=T KNOW.....8	➔ **25** ➔ **25**
18	What was (NAME) given to treat the diarrhea? Anything else? RECORD ALL MENTIONED.	NOTHING ..... A FLUID FROM ORS PACKET..... B HOME-MADE FLUID..... C PILL OR SYRUP ..... D INJECTION ..... E (IV) INTRAVENOUS.....F HOME REMEDIES/ HERBAL MEDICINES……G OTHER_____ H (SPECIFY)	
18A	Correctly using of fluids	If answer A or/and B……1 Another……2	
19	When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS.....1 SAME.....2 MORE .....3 CHILD NOT BREASTFED.....4 DON=T KNOW.....88	
20	When (NAME) had diarrhea, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME.....2 MORE .....3 NOTHING TO DRINK.....4 DON=T KNOW.....88	
21	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS.....1 SAME.....2 MORE .....3 NOTHING TO EAT.....4 DON=T KNOW.....88	
22	Did you seek advice or treatment from someone outside of the home for (NAME=S) diarrhea?	YES.....1 NO 2	➔ 25

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
23	Where did you go for advice or treatment?	HEALTH FACILITY OBLAST HOSPITAL ..... A CENTRAL RAYON HOSPITAL ..... B CENTRAL RAYON POLYCL..... C RURAL HOSP (SUB) ..... D SVP..... E SVA.....F FAP..... G DON'T KNOW/DON'S REMEMBER..... H OTHER SOURCES TRADITIONAL PRACTITIONER……I SHOP……..J PHARMACY……..……K COMMUNITY DISTRIBUTORS……L FRIEND/RELATIVE……M OTHER _____ N (SPECIFY)	
23A	Take sick child to health facility / health provider	If any from answers A-G ……1 Another ……2	
24	Who decided that you should go there for (NAME=S) illness? RECORD ALL MENTIONED.	RESPONDENT ..... A HUSBAND/PARTNER..... B RESPONDENT=S MOTHER..... C MOTHER-IN-LAW ..... D FRIENDS/NEIGHBORS ..... E OTHER _____F (SPECIFY)	
25	What signs/symptoms would cause you to seek advice or treatment for (NAME)'s diarrhea?	DOESN'T KNOW……..A VOMITING……B FEVER……..C DRY MOUTH, SUNKEN EYES, SUNKEN FONTENELLE, DECREASED URINE OUTPUT (DEHYDRATION)……D DIARRHEA OF PROLONGED DURATION (AT LEAST 14 DAYS)……E BLOOD IN STOOL……F LOSS OF APPETITE……G WEAKNESS OR TIREDNESS……..H OTHER……I (SPECIFY)	

Acute Respiratory Infections

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
26	Has (NAME) had an illness with a cough at any time in the last two weeks?	YES ..... 1 NO ..... 2 DON=T KNOW..... 8	 →33 →33
27	When (NAME) had an illness with a cough, did he/she have trouble breathing or breathe faster than usual with short, fast breaths?	YES ..... 1 NO ..... 2 DON=T KNOW..... 8	 → 33 → 33
28	Did you seek advice or treatment for the cough/fast breathing?	YES ..... 1 NO 2	 → 32
29	How long after you noticed (NAME=s) cough and fast breathing did you seek treatment?	SAME DAY ..... 0 NEXT DAY..... 1 THREE OR MORE DAYS 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
30	Where did you go for advice or treatment?	HEALTH FACILITY OBLAST HOSPITAL ..... A CENTRAL RAYON HOSPITAL ..... B CENTRAL RAYON POLYCL..... C RURAL HOSP (SUB) ..... D SVP ..... E SVA .....F FAP..... G DON'T KNOW/DON'S REMEMBER..... H OTHER SOURCES TRADITIONAL PRACTITIONER……I SHOP…….. J PHARMACY……K COMMUNITY DISTRIBUTORS……L FRIEND/RELATIVE……M OTHER _____ N (SPECIFY)	
30A	Take sick child to health facility / health provider	If any from answers A-G ……1 Another ……2	
31	Who decided that you should go there for (NAME=S) illness? RECORD ALL MENTIONED.	RESPONDENT..... A HUSBAND/PARTNER..... B RESPONDENT=S MOTHER ..... C MOTHER-IN-LAW..... D FRIENDS/NEIGHBORS..... E OTHER _____F (SPECIFY)	
32	Which medicines were given to (NAME) ? RECORD ALL MENTIONED	NOTHING ..... A ASPIRIN ..... B PANADOL..... C AMOXICILLINE..... D ERITHROMICINE ..... E AZITROMICIN.....F OTHER_____ G (SPECIFY) DON'T KNOW..... H	
33	What are the signs/symptoms of respiratory infection that would cause you to take (name of child) to a health facility? RECORD ALL MENTIONED	FAST OR DIFFICULT BREATHING…….A CHEST INDRAWING……..B LOSS OF APPETITE……..C FEVER……..D COUGH……E OTHER _____ F (SPECIFY) DON'T KNOW..... G	
34	When (NAME) had an illness with a cough, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS.....1 SAME.....2 MORE.....3 CHILD NOT BREASTFED.....4 DON=T KNOW.....88	
35	When (NAME) had an illness with a cough, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME.....2 MORE.....3 NOTHING TO DRINK.....4 DON=T KNOW.....88	
36	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS.....1 SAME.....2 MORE.....3 NOTHING TO EAT.....4 DON=T KNOW.....88	

Home Care

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
37	Has (NAME) had any other illnesses at any time in the last two weeks?	YES ..... 1 NO ..... 2 DON=T KNOW..... 8	 →41 →41
38	When (NAME) had this illness, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS.....1 SAME.....2 MORE.....3 CHILD NOT BREASTFED.....4 DON=T KNOW.....88	
39	When (NAME) had this illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME.....2 MORE.....3 NOTHING TO DRINK.....4 DON=T KNOW.....88	
40	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS.....1 SAME.....2 MORE.....3 NOTHING TO EAT.....4 DON=T KNOW.....88	
41	Who are deciding that you should go there for (NAME=S) illness? RECORD ALL MENTIONED.	RESPONDENT ..... A HUSBAND/PARTNER..... B RESPONDENT=S MOTHER ..... C MOTHER-IN-LAW..... D FRIENDS/NEIGHBORS ..... E OTHER _____F (SPECIFY)	

Prenatal Care

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	Did you see anyone for prenatal care while you were pregnant with (NAME)? IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	OBLAST HOSPITAL..... A CENTRAL RAYON HOSPITAL..... B CENTRAL RAYON POLYCL ..... C RURAL HOSP (SUB) ..... D SVP..... E SVA..... F FAP..... G TRADITIONAL PRACTITIONER ..... H OTHER_____ I (SPECIFY) NO ONE.....J	 —<45
43	How many times did you see someone for care during (NAME)'s pregnancy?	NUMBER OF TIME……{ }	
44	During your prenatal check, were you counseled on the following:	**YES NO** Delivery preparations.....1 2 Breastfeeding.....1 2 Child spacing/FP .....1 2 EPI.....1 2 Danger signs of pregnancy.....1 2 STI Prevention 1 2	
45	When you were pregnant with (NAME) did you take iron tablets?	YES..... 1 NO ..... 2 DON=T KNOW.....8	
46	How far are you from the nearest health facility?	METER ……..[___ / ___ / ____] Km……..[___ / ___ / ____]	
46A	Classification of distance	5 km and less……..1 5 km and more……2 DON=T KNOW……3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
47	How would you get there? RECORD ALL RESPONSES.	WALK..... A CAR ..... B ANIMAL..... C BICYCLE..... D TRACTOR..... E OTHER_____ F (SPECIFY)	
48	How long would it take you to get there?	LESS THAN 1 HOUR.....1 1 TO 3 HOURS .....2 MORE THAN 3 HOURS.....3 DON=T KNOW.....8	
49	Who would decide that you should go there, in case of health needs? RECORD ALL MENTIONED.	RESPONDENT ..... A HUSBAND/PARTNER..... B RESPONDENT=S MOTHER..... C MOTHER-IN-LAW ..... D FRIENDS/NEIGHBORS ..... E OTHER _____F (SPECIFY) DON=T KNOW……G	
50	What are the symptoms during pregnancy indicating the need to seek health care? RECORD ALL MENTIONED.	CONVULSIONS .....1 HEAVY AND CONTINUOUS VOMITING..2 VAGINAL BLEEDING.....3 SEVERE ABDOMINAL PAIN.....4 FEVER .....5 FOUL SMELLING DISCHARGE.....6 DIMINUTION OR STOPPING MOVEMENTS OF FETUS.....7 SWELLING OF THE BODY/HANDS/FACE ……..8 HEADACHE ……..9 EARLY WATER BREAK……..10 SHORTNESS OF BREATH.....11 OTHER_____12 I (SPECIFY) DON=T KNOW.....13	
50A	Named danger signs	2 signs……..1 3 and more……2 Less than 2……3	
51	Where is the first place you would you go for care if you had these symptoms?[1]	OBLAST HOSPITAL..... A CENTRAL RAYON HOSPITAL..... B CENTRAL RAYON POLYCL..... C RURAL HOSP (SUB) ..... D SVP..... E SVA..... F FAP.....G TRADITIONAL PRACTITIONER ..... H DON'T KNOW/DON'T REMEMBER .....I OTHER _____ ..J (SPECIFY)	

Delivery and Delivery Attendants

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
52	Where did you give birth?	OBLAST HOSPITAL..... A CENTRAL RAYON HOSPITAL..... B CENTRAL RAYON POLYCL..... C RURAL HOSP (SUB) ..... D SVP..... E SVA..... F FAP..... G DON'T KNOW/DON'T REMEMBER ..... H OTHER _____ ..I (SPECIFY)	
53	**Who assisted you with (NAME=S) delivery?** [1] **RECORD ALL MENTIONED.**	**HEALTH PROFESSIONAL** **DOCTOR ..... A** **NURSE/MIDWIFE..... B** **TBA/MOMO..... C** **OTHER _____ D** **(SPECIFY)**	
54	Where was (NAME) put immediately after birth?	UPON THE MOTHER ..... A BESIDE THE MOTHER..... B INFANT BED/SWADDLE TABLE ..... C BATHED ..... D TAKEN TO ANOTHER ROOM ..... E OTHER _____ ..F (SPECIFY) DON'T KNOW/DON'T REMEMBER…….G	→54A →55 →55 →55 →55 →55 →55
54A	How much time after birth?	IMMEDIATELY/WITHIN 30 MINUTES OF FIRST HOUR AFTER DELIVERY……1 AFTER THE FIRST HOUR..... 2	

Postpartum Care

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
55	After (NAME) was born and you left the hospital, did anyone check on your health again?	YES ..... 1 NO..... 2	**→ 58**
56	How many days or weeks after you left the health service for delivering did the first check take place? RECORD >00' DAYS IF SAME DAY.	DAYS AFTER DEL…… { } WEEKS AFTER DEL…… { } DON=T KNOW 0	
57	Where did you go for the health checks? [1]	OBLAST HOSPITAL……A CENTRAL RAYON HOSPITAL……B CENTRAL RAYON POLYCL……C RURAL HOSP (SUB)……D SVP……E SVA……F FAP……G DON'T KNOW/DON'T REMEMBER……H OTHER _____.....I (SPECIFY)	
58	At that time, did the person check on (NAME)=s health as well?	YES ..... 1 NO..... 2	
59	During your postpartum check, were you counseled on the following? RECORD ALL MENTIONED	BREASTFEEDING……A LACTATIONAL AMENORRHEA METHOD (LAM)……B FAMILY PLANNING……C OTHER _____.....D (SPECIFY) DID NOT COUNSELED……E	
60	After (NAME) was born, did you start to use a method of family planning?	YES……1 NO……2	→finish
61	Did you start to use the method within the first 6 weeks of after the first 6 weeks following (NAME's) birth?	6 WEEKS OR EARLIER……1 7 WEEKS OR LATER……2 DON'T KNOW……3 DON'T APPLY……4	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
62	Which method are you (or your husband/ partner) using?	FEMALE STERILIZATION……..…1 MALE STERILIZATION……..…2 PILL……...3 IUD……4 INJECTABLES……5 IMPLANTS……6 CONDOM……7 FEMALE CONDOM……8 DIAPHRAGM……..…9 FOAM/JELLY……10 LACTATION AMEN. METHOD……..…11 STANDARD DAYS METHOD……12 PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……..13 WITHDRAWAL……..……..14 OTHER……..…15 (SPECIFY)	

THANK YOU!

Project HOPE, Navoi, Uzbekistan
FINAL EVALUATION.

Questionnaire 2: Family Planning

All questions are to be addressed to a woman of reproductive age (15-49 years old)

Identification number:	……[____ / ____ / ____]
Rayon (1= Karmana; 2=kiziltepa;3=Konimeh ; 4=Nurota) Mahallla's name…… Cluster number……	……[ ] _____ ……[/]
Interview date (day/month/year)……	……[____ / ____ / ____]

Informed Consent

Hello, my name is _____ and I am working for the Navoi Oblast health Department.. We are conducting a survey about your health. We would very much appreciated your participation in the survey, since this information will help us improve the existing health services. The survey is going to take us about 30 minutes to complete

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.
All discussed information will be keep confidentially.

At this time, would you like to ask me anything about the survey?

Woman's Background Characteristics

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Name of woman (interviewee)	_____	
1	How old were you at your last birthday?	AGE IN COMPLETED YEARS [/]	
2	What is the highest level of school you attended: primary, secondary, or higher?	PRIMARY……..1 SECONDARY unfinished…….2 SECONDARY……3 HIGHER……..4	

Reproduction and Child Spacing

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
3	Have you ever given birth?	YES……..1 NO……2	➔ **8**
4	How many children have you given birth to? Include any children born alive, including those who cried or showed signs of life but did not survive.	TOTAL NUMBER OF CHILDREN EVER BORN ALIVE…… └___┘___┘	
5	How many children living in this household are under five years of age?	NONE……..0 ONE CHILD……..1 TWO CHILDREN……2 THREE OR MORE……..3	➔ **8** ➔ **8**
6	How many of those children are your biological children?	ONE CHILD…… 1 TWO CHILDREN……2 THREE OR MORE……3	➔ **8**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
7	What is the date of birth of your two youngest children?	YOUNGEST CHILD DATE OF BIRTH i__i__i i__i__i i___i___i___i___i DAY MONTH YEAR	SECOND YOUNGEST CHILD DATE OF BIRTH i__i__i i__i__i i___i___i___i___i DAY MONTH YEAR
7A	Birth spacing	Less 24 months (23 months 29 days)……..1 24 months and more……2	
8	Are there days in your menstrual cycle when you are most likely to get pregnant?	YES……1 NO……2	→ 10
9	When is a woman more likely to get pregnant between two menstrual cycles?	JUST BEFORE HER PERIOD BEGINS……1 DURING HER PERIOD……..2 RIGHT AFTER HER PERIOD HAS ENDED….3 HALFWAY BETWEEN TWO PERIODS……..4 OTHER_____5 (SPECIFY) DON'T KNOW……6	

Knowledge and Ever Use of Contraception

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or avoid a pregnancy.

ASK THE QUESTION 10 (FIRST COLUMN):

Which ways have you heard about?

FOR EACH METHOD LISTED MENTIONED SPONTANEOUSLY, CIRCLE "1" (YES) IN THE COLUMN C1 TO INDICATE THAT WOMAN HAS HEARD OF METHOD. THEN PROCEED DOWN THE LIST OF METHODS, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE "1" IN COLUMN C1 IF THE METHOD IS RECOGNIZED, AND CODE "2" IF NOT RECOGNIZED.

THEN, FOR EACH METHOD WITH CODE "1" IN COLUMN C1, ASK **BOTH** QUESTIONS C2 AND C3 "DO YOU KNOW OF A PLACE YOU COULD OBTAIN (METHOD)?" AND "HAVE YOU EVER USED (METHOD)?" FOR BOTH THESE QUESTIONS, CODE "1" IF THE ANSWER IS "YES" AND CODE "2" IF THE ANSWER IS "NO".

10	Which ways have you heard about?	C1 PROBE: Have you heard of (METHOD)?	C2 Do you know where to obtain (METHOD)?	C3 Have you ever used (METHOD)?
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
B	MALE STERILIZATION Men can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
C	PILL Women can take a pill every day to avoid becoming pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
D	IUD Women can have a loop or coil placed inside them by a doctor or nurse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
E	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
F	CONDOM Men can put a rubber sheath on their penis before sexual intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
G	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2

H	LACTATIONAL AMENORRHEA (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
I	STANDARD DAYS METHOD A woman who is sexually active abstains (or uses a condom) on days 8 through day 19 each menstrual cycle	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
J	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
K	WITHDRAWAL Men can be careful and pull out before ejaculation	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
L	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
M	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES……1 → NO……..2 If yes, _____ (SPECIFY)	YES……1 NO……..2	YES……1 NO……..2
10A	Number of known methods	3 and more……..1 Less than 3 ……..2		

Access to Family Planning

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	Please tell me where could I obtain a method of family planning in your community RECORD ALL MENTIONED.	OBLAST HOSPITAL……A CENTRAL RAYON HOSPITAL……B CENTRAL RAYON POLYCLINIC……..C RURAL HOSP (SUB)……..D SVP……E SVA……F FAP……G DON'T KNOW/DON'T REMEMBER….H OTHER _____I (SPECIFY)	**H→ 14**
12	How far away from your home is the place you can obtain a method of family planning: 5 kms or less or more than 5 kms?	5 KMS OR LESS ……1 MORE THAN 5 KMS……..2 DON'T KNOW…… 3	
13	How long does it take you to get to the place where you can obtain a method of family planning?	LESS THAN 1 HOUR…….. 1 1 HOUR UP TO TWO HOURS…….2 2 HOURS UP TO 4 HOURS…….3 MORE THAN 4 HOURS……4	

Desire for Future Children

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
14	Are you currently pregnant?	YES……1 NO……..2 UNSURE……8	**→ 31**
15	Do you want to have a/another child?	YES……..1 NO……..2 DON'T KNOW……..8	**→ 17** **→ 17**
16	When do you want to have your next child?	WITHIN 2 YEARS……..1 MORE THAN 2 YEARS FROM NOW...2 UNSURE WHEN……..8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
17	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES……1 NO…….. 2	→ **19**
18	Can you please tell me the reason you are not using a method? RECORD ALL MENTIONED	NOT MARRIED……A FERTILITY-RELATED REASONS NOT HAVING SEX……B INFREQUENT SEX ……C MENOPAUSAL/HYSTERECTOMY……D SUBFECUND/INFECUND……E POSTPARTUM AMENORRHEIC……F BREASTFEEDING……G FATALISTIC……H RESPONDENT OPPOSED……I HUSBAND/PARTNER OPPOSED……J OTHERS OPPOSED……K _____ (SPECIFY) RELIGIOUS PROHIBITION……L KNOWS NO METHOD……M KNOWS NO SOURCE……N METHOD-RELATED REASONS/ HEALTH CONCERNS……O FEAR OF SIDE EFFECTS…… P LACK OF ACCESS/TOO FAR……Q COSTS TOO MUCH……R INCONVENIENT TO USE……S INTERFERES WITH BODY'S NORMAL PROCESSES……T OTHER_____U (SPECIFY)	**After all answers** Skip to 31
19	Which method are you (or your husband/ partner) using?	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……C IUD……D INJECTABLES……E CONDOM……F FOAM/JELLY……G LACTATIONAL AMEN. METHOD……H STANDARD DAYS METHOD……I PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)……M WITHDRAWAL……N OTHER_____O (SPECIFY)	→ **20** → **21** → **22** → **22** → **22** → **26** → **26** → **26** → **26** → **27** → **27**
20	Before your sterilization, were you told that you could not have any (more) children because of your operation?	YES……1 NO……2	→ **22** → **22**
21	Before the sterilization operation, was your husband (or partner) told that he would not be able to have any (more) children because of the operation?	YES……1 NO……2 DON'T KNOW……3	→ **25** → **25** → **25**
22	At the time you first started to use (CURRENT METHOD), were you told about side effects or problems you might have with the method? IF STERILIZED, ASK: At the time you were sterilized, were you told about side effects or problems you might have with the operation?	YES……1 NO……2	→ **25**
23	Were you <u>ever</u> told by a health or family planning worker about side effects or problems you might have with the method?	YES……1 NO……2	
24	Were you told what to do if you experienced side effects or problems?	YES……1 NO……2	
25	Were you told when you should return for follow-up (or when someone should be back to see you?)	YES……1 NO……2	

26	When you obtained (CURRENT METHOD) from (SOURCE OF METHOD) were you told about other methods of family planning that you could use? IF USING LAM OR STANDARD DAYS METHOD, ASK: "When you first learned (METHOD) were you told about other methods of family planning that you could use?"	YES……..1 NO……..2	
27	Were you <u>ever</u> told by a health or family planning worker about other methods of family planning that you could use?	YES……..1 NO……..2	
28	For how long have you (or your husband/partner) been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously? IF STERILIZED, ASK: In what month and year was the sterilization performed?	i__i__i i__i__i i___i___i___i___i DAY MONTH YEAR WRITE >44' IN >DAY= COLUMN IF DON'T KNOW/DON'T REMEMBER	
29	Where did you obtain (CURRENT METHOD) when you started using it? IF THE WOMAN OR HER HUSBAND/PARTNER WAS STERILIZED, ASK: Where were you (your partner) sterilized? IF THE WOMAN IS USING LAM OR THE STANDARD DAYS METHOD, ASK: Where did you learn to use your method?	OBLAST HOSPITAL……A CENTRAL RAYON HOSPITAL……..B CENTRAL RAYON POLYCLINIC……..C RURAL HOSP (SUB)……..D SVP……E SVA……F FAP……G DON'T KNOW/DON'T REMEMBER….H OTHER _____I (SPECIFY)	
30	Before using (CURRENT METHOD), did you ever use another method of family planning?	YES……..1 NO……..2	

Diffusion of Family Planning Messages

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
31	In the past 12 months, have you discussed family planning with your husband or partner, friends, neighbors, or relatives?	YES……1 NO……..2	→ **33**
32	With whom? Anyone else? RECORD ALL PERSONS MENTIONED	HUSBAND/PARTNER……A MOTHER……..B FATHER…… C SISTER(S)……D BROTHER(S)…… E DAUGHTER……..F SON…… G MOTHER-IN-LAW……..H FRIENDS/NEIGHBORS……I MAHALLA ACTIVISTS……..J OTHER……..K (SPECIFY)	
33	In the past 12 months, have you discussed the number of children that you want with your husband or partner?	YES……1 NO……..2 DOES NOT HAVE HUSBAND/PART…3	
34	In the past 12 months, were you visited by a community health worker/promoter or did staff member at the health facility (during visiting of health facility) talked to you about family planning?	YES……1 NO……..2	
35	In the past 12 months, have you visited a health facility for care for yourself (or your child?)	YES……1 NO……..2	

36	In the past month, have you seen or heard any messages about family planning from the following means? RECORD ALL MENTIONED RADIO? NEWSPAPER? TELEVISION? HEALTH FAIR?	RADIO……A NEWSPAPER……B TELEVISION……C HEALTH FAIR……D NO……E OTHER……F (SPECIFY)	

Sexual Activity

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
37	Are you currently married or living with a man?	YES, CURRENTLY MARRIED……1 YES, LIVING WITH A MAN……..2 . NO, ……3 REFUSED TO ANSWER ……4	→ **42**
38	When was the last time you had sexual intercourse? RECORD 'YEARS AGO' ONLY IF LAST INTERCOURSE WAS ONE OR MORE YEARS AGO. IF 12 MONTHS OR MORE, RECORD ANSWER IN YEARS	DAYS AGO……1 ☐☐ WEEKS AGO……..2 ☐☐ MONTHS AGO……3 ☐☐ YEARS AGO……4 ☐☐	
39	What is your relationship to the man with whom you last had sex?	SPOUSE/COHABITATING PARTNER……1 MAN IS BOYFRIEND/FIANCE…..2 BELOVED PERSON……3 CASUAL AQUAINTANCE……..4 PROSTITUTE……5 OTHER_____6 (SPECIFY)	
40	The last time you had sex, was a condom used?	YES……1 NO ……..2	→ **42**
41	What was the main reason a condom was used on that occasion?	TO PREVENT STI/HIV…… 1 TO PREVENT PREGNANCY……2 TO PREVENT BOTH STI/HIV AND PREGNANCY……3 DOESN'T TRUST PARTNER/ PARTNER HAS OTHER PARTNERS..4 PARTNER INSISTED……..5 OTHER _____ 6 (SPECIFY) DON'T KNOW……..7 REFUSED TO ANSWER……8	

Sexually Transmitted Infections

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	Have you heard about infections that can be transmitted through sexual intercourse?	YES……1 NO……2	➔ 50
43	What kind of STIs do you know?	GONORRHEA……A SYPHILIS……B GENITAL HERPES……C HEPATITIS……D CHLAMYDIA……E HIV/AIDS……F OTHER_____ G (SPECIFY) Don't know……H	
44	In a male or female, how do you know that he/she has such an infection? Any others? RECORD ALL MENTIONED	LOWER ABDOMINAL PAIN……A GENITAL DISCHARGE/DRIPPING……B FOUL SMELLING DISCHARGE……C BURNING PAIN ON URINATION……D FREQUENT URINATION……E REDNESS/INFLAMMATION IN GENITAL AREA……F PAIN/SWELLING IN GENITAL AREA……G GENITAL SORES/ULCERS……H GENITAL WARTS……I BLOOD IN URINE……J IMPOTENCE……K INFERTILITY ……L OTHER _____M (SPECIFY) DON'T KNOW……N	
45	Named symptoms	3 and more……1 Less than 3 ……2	
46	Where could patient with STI go to be treated for such an infection? Any others? CIRCLE ALL MENTIONED.	PRIVATE HOSPITAL……A DISTRICT HOSPITAL……B PRIVATE PRACTITIONER……C SVP (RURAL MEDICAL PUNCT) ……D POLYCLINIC……E SUB……F SVA……G FAP……H TRADITIONAL PRACTITIONER……I TBA……J VENEREAL DISPENSARY……K GYNECOLOGIST……L REPRODUCTIVE CENTER……M OTHER_____N (SPECIFY) DON'T KNOW……O	
47	Is there anything a male or female can do to avoid getting an STI?	YES……1 NO……2 DON'T KNOW……8	
48	How can you avoid getting an STI? Anything else? CIRCLE ALL MENTIONED.0	0ABSTAIN FROM SEX……A USE CONDOMS……B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER……C AVOID CONTACT WITH PROSTITUTES……D AVOID CASUAL SEX……E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS……F AVOID SHARING RAZORS,BLADES……G OTHER _____H (SPECIFY) DON'T KNOW……I	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
49	Named methods	2 and more……..1 Less than 2 ……..2	

HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
50	Have you ever heard about HIV/AIDS?	YES……..1 NO……..2	 ➔ **57**
51	Do you know transmission ways of HIV/AIDS?	SEXUAL WAY……..A BLOOD TRANSFUSION……..B FROM MOTHER TO CHILD……..C OTHER_____D (SPECIFY) DON'T KNOW……..E	
51A	Named ways	If named two ways from the answers A,B,C……..1 Less than 2……..2	
52	Can the virus that causes AIDS be transmitted from a mother to a child?	YES.....1 NO…… 2	 ➔ **54**
53	How the virus can be transmitted from a mother to a child? RECORD ALL MENTIONED.	During pregnancy……..A During delivery……..B During breastfeeding……..C	
53A	If mother is HIV positive is it possible to avoid her child from HIV infection	YES.....1 NO.....2 DON'T KNOW 8	
54	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES.....1 NO.....2 DON'T KNOW 8	 ➔ **56** ➔ **56**
55	What can a person do? Anything else? RECORD ALL MENTIONED.	ABSTAIN FROM SEX……..A USE CONDOMS……..B LIMIT SEX TO ONE PARTNER.....C AVOID SEX WITH PROSTITUTES……..D AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS ……..E AVOID CONTACTS WITH NARCOTICS USERS……..F AVOID CONTACT WITH CONTAMINATED BLOOD NEEDLES FOR INJECTIONS OR TRANSFUSION…. G AVOID SHARING RAZORS, BLADES….. . . . . …. . . . H AVOID SEX WTH SAME GENDERS……..I AVOID BLOOD TRANFUSION……..J OTHER _____ K DON'T KNOW……..L	
55A	Named methods	2 and more……..1 Less than 2 ……..2	
56	Can a person who has AIDS be cured?	YES.....1 NO.....2 DON'T KNOW 3	

Topics for Health Education

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
57	Where have you received the information about contraception, HIV/AIDs and STI? CIRCLE ALL MENTIONED.	HEALTH PROVIDER……..A PARENTS……..B FRIENDS.....C RELATIVES……..D BROTHER/SISTER……..E BOOKS/LEAFLETS ……..F NEWSPAPERS ……..G TV ……..H RADIO ……..I TEACHER……..J MAHALLA ACTIVIST……..K OTHER_____ L (SPECIFY) DON'T KNOW/ DON'T REMEMBER……..M	

SECTION: CERVICAL AND BREAST CANCER

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
58	Did you get any routine test of your health status during last 24 month?	YES.....1 NO.....0	➔ **59**
58A	If yes, what kind?	Blood test……1 Syphilis test……2 Smear test……3 Urine test……4 Breast exam……5 Other_____96 Don't know……88	
59	Have you ever been screened for Cervical cancer?	YES.....1 NO…… 0 Don't know……88	➔ **61**
60	What kind method/test was used?	Vaginal smear test .....1 Colposcopy .....2 Vaginal speculum exam.....3 Other._____ _____96	
61	What kind symptoms of the precancerous lesions of cervix have you heard?	Unknown vaginal bleeding/ grume……..1 Low abdominal pain .....2 Other_____ _____96 Don't know……88	
62	Can such precancerous lesions of cervix happen without any symptoms in women?	YES.....1 NO……0 DON'T KNOW……88	
63	Do you know about major cause of cervical cancer?	Viral infection……..1 Other_____ _____96 Don't know……88	
64	Have you had a breast exam during last 12 month made by health provider?	YES.....1 NO…… 0	➔ **66**
65	Have you referred by health provider for the X-Ray breast exam during last 2 years?	YES.....1 NO…… 0	
66	Did you give yourself a breast exam during last 12 month?	YES.....1 NO…… 0	

THANK YOU FOR PARTICIPATING IN THE SURVEY

Project HOPE, Navoi, Uzbekistan
FINAL EVALUATION.

Questionnaire 3: Adolescent Health

All questions are to be addressed to adolescents 16 -18 years of age

Identification number:	……[____ / ____ / ____]
Rayon (1= Karmana; 2=kiziltepa;3=Konimeh ; 4=Nurota) Mahallla's name…… Cluster number……	……[ ] _____ ……[/]
Interview date (day/month/year)……	……[____ / ____ / ____]

Informed Consent

Hello, my name is _____ and I am working for the Navoi Oblast health Department. We are conducting a survey about your health. We would very much appreciated your participation in the survey, since this information will help us improve the existing health services. The survey is going to take us about 30 minutes to complete

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.
All discussed information will be keep confidentially.

At this time, would you like to ask me anything about the survey?

Name of young men or woman (interviewee)……	_____
How old were you at your last birthday? → END IF <16 or > 18 YEARS	AGE IN COMPLETED YEARS ……[/]
Gender (1=male; 2=female)……	……[ ]

Respondent's Information

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Have you ever attended school?	YES……1 NO……2	→ **7**
2	What is the highest level of school you attended: primary, secondary, or higher?	PRIMARY……1 INCOMPLETE SECONDARY SECONDARY/SPECIAL SECONDARY……2 HIGHER……3	
3	Do you attend any kind of school/institution now?	YES……1 NO……2	→ **7**
4	Where do you study?	SCHOOL……1 LICEY……2 COLLEGE……3 INSTITUTE/UNIVERSITY……4 OTHER_____8 (specify)	
5	Did you study the lessons on "Healthy life and family"?	YES……1 NO……2	→ **7**
6	Did you study on these lessons the theme on adolescent's reproductive health?	YES……1 NO……2	

Teenage Pregnancy

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
7	Are there any reasons why pregnancy/childbirth should be avoided when you are a teenager?	YES……1 NO……2 DON'T KNOW/DON'T REMEMBER……8	→ **9** → **9**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
8	What are the reasons? (PROBE Anything else?) RECORD ALL MENTIONED	HIGH BLOOD PRESSURE……A QUICK SWELLING……B STOP GROWING OF FETUS……C EARLY DELIVERY….D ABORTION……E ANEMIA OF MOTHER AND NEWBORN….F BORN OF DIFECTIVE BABIES……G COMPLICATED DELIVERIES CAN BE CAUSE OF MATERNAL DEATH……..H DON'T KNOW……I OTHER_____J (SPECIFY)	

Knowledge and Ever Use of Contraception

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
9	Are there days in woman's menstrual cycle when she is most likely to get pregnant?	YES……1 NO……2 DON'T KNOW……3	 **→ 11** **→ 11**
10	When is a woman more likely to get pregnant between two menstrual cycles?	JUST BEFORE HER PERIOD BEGINS……1 DURING HER PERIOD……2 RIGHT AFTER HER PERIOD HAS ENDED….3 HALFWAY BETWEEN TWO PERIODS……..4 OTHER_____5 (SPECIFY) DON'T KNOW……8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or avoid a pregnancy.

ASK THE QUESTION 11 (FIRST COLUMN):

Which ways have you heard about?

FOR EACH METHOD LISTED MENTIONED SPONTANEOUSLY, CIRCLE "1" (YES) IN THE COLUMN C1 TO INDICATE THAT WOMAN HAS HEARD OF METHOD. THEN PROCEED DOWN THE LIST OF METHODS, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE "1" IN COLUMN C1 IF THE METHOD IS RECOGNIZED, AND CODE "2" IF NOT RECOGNIZED.

THEN, FOR EACH METHOD WITH CODE "1" IN COLUMN C1, ASK **BOTH** QUESTIONS C2 AND C3 "DO YOU KNOW OF A PLACE YOU COULD OBTAIN (METHOD)?" AND "HAVE YOU EVER USED (METHOD)?" FOR BOTH THESE QUESTIONS, CODE "1" IF THE ANSWER IS "YES" AND CODE "2" IF THE ANSWER IS "NO".

11	Which ways have you heard about?	C1 PROBE: Have you heard of (METHOD)?	C2 Do you know where to obtain (METHOD)?	C3 Have you ever used (METHOD)?
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
B	MALE STERILIZATION Men can have an operation to avoid having any more children	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
C	PILL Women can take a pill every day to avoid becoming pregnant	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
D	IUD Women can have a loop or coil placed inside them by a doctor or nurse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
E	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
F	CONDOM Men can put a rubber sheath on their penis before sexual intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2
G	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse	YES……1 → NO……2	YES……1 NO……2	YES……1 NO……2

H	LACTATIONAL AMENORRHEA (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
I	STANDARD DAYS METHOD A woman who is sexually active abstains (or uses a condom) on days 8 through day 19 each menstrual cycle	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
J	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
K	WITHDRAWAL Men can be careful and pull out before ejaculation	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
L	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant	YES……1 → NO……..2	YES……1 NO……..2	YES……1 NO……..2
M	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES……1 → NO……..2 If yes, _____ (SPECIFY)	YES……1 NO……..2	YES……1 NO……..2
11A	Number of known methods	3 and more……..1 Less than 3 ……..2		
12	Who should decide what method to use? CIRCLE ONLY ONE ANSWER	WOMAN……1 MAN……2 BOTH PARTNERS……3 MOTHER-IN-LAW……4 RELATIVE……5 DOCTOR/NURSE……6 TBA……7 OTHER_____8 (SPECIFY)		

Initiation of Sexual Life

13	In what age woman and man can start sexual life?	AGE IN YEARS WOMEN ……[/] AGE IN YEARS MEN……[/]	
14	Nowadays, how important is it for a woman to be a virgin until she gets married? WOULD YOU SAY IT IS……	IMPORTANT……..1 NOT IMPORTANT……..2 DON'T KNOW……..3	
15	Do you know of any sexual intercourse with prostitutes among your male close friends?	YES……1 NO……2	

Family Planning

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
16	Are you sexually active?	YES……1 NO……..2	**→ 21**
17	Are you using contraception?	YES……1 NO……..2	**→ 21**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
18	Which method are you using?	FEMALE STERILIZATION……A MALE STERILIZATION……B PILL……C IUD……D INJECTABLES……E IMPLANTS……F CONDOM……G FEMALE CONDOM……H DIAFRAGM……I FOAM/JELLY/SPERMICIDES……J LACTATIONAL AMEN. METHOD……K STANDARD DAYS METHOD……L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS)… ……M WITHDRAWAL……N OTHER_____.O (SPECIFY)	
19	Do you know disadvantages of methods you mentioned?	YES……1 NO……2	
20	Did you use the condom during your last sexual contact?	YES……1 NO……2	
21	Could you name the steps of correct using of condom?	Should be obtain from the health facility/drugstore……,1 Should pay attention on the warranty period……2 Packing safety……3 Packing should be open by hands, no sharps/nails……4 Using during sexual intercourse ……5 To insure no air inside by fingers……6 Using only during erection of penis……7 To take off more far from female genitals by fingers……8 To avoid spilling of sperm to tie in a bungle and waste..9 To not using Vaseline or any lubricates ……10 To use one time only……11	
21A	Correctly named steps	6 and more……..1 Less than 6 ……2	

Teenage Pregnancy: Questions only for Girls

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
22	Have you ever been pregnant?	YES……1 NO……2	**➔25**
23	How old were you when you got first pregnancy?	AGE IN YEARS..... ……[/] DON'T KNOW..... ……00	
24	What was the result of pregnancy?	ABORTION ……1 MISCARRIAGE ……2 LIVE BIRTH ……..3 OTHER_____4 (SPECIFY) DON'T KNOW/DON'T REMEMBER……5	

Reproductive and sexual rights

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
25	Do you know you had reproductive and sexual rights?	YES……1 NO……2	**➔27**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
26	I am going to read you your reproductive and sexual rights, please tell me which ones you are familiar with RECORD ALL MENTIONED	THE RIGHT ON LIFE ……A THE RIGHT ON INDIVIDUAL SAFETY AND LIBERTY.B THE RIGHT ON EQUALITY……C THE RIGHT ON INDIVIDUAL LIFE……D THE RIGHT ON FREEDOM OF WORLD VIEW……...E THE RIGHT ON RECEPTION OF INFORMATION AND KNOWLEDGE……..F THE RIGHT ON FAMILY PLANNING……...G THE RIGHT TO HAVE A CHILD……H THE RIGHT ON RECEPTION HEALTH SERVICES……I THE RIGHT ON PROTECTION FROM VIOLENCE……J OTHERS_____K (SPECIFY) DON'T KNOW ……L	
27	Tell me if you agree or disagree with the following statement: "Having sex while I'm a teenager would be a way to be popular"	DISAGREE ……1 NOT SURE ……2 AGREE ……3	
28	About how many of your friends have had sexual intercourse?	NONE OF THEM……1 A FEW OF THEM……2 ABOUT HALF OF THEM……3 MOST OF THEM……4 ALL OF THEM……5 DON'T KNOW	

Abortion

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
29	In your opinion, how common is abortion in your area among teenage girls that get pregnant?	NOT COMMON……1 SOMEWHAT COMMON……2 VERY COMMON……3 DON'T KNOW……4	
30	What are the complications of the abortion?	DEATH……A STERILITY ……B INFLAMMATORY DISEASES OF GENITAL ORGANS……C COMPLICATED DELIVERIES IN FUTURE. ……D VAGINAL BLEEDING……E TO GET INFECTION……F DESTROYING OF MENSES ……G UTERUS INJURY……H OTHERS_____I (SPECIFY) DON'T KNOW……J	

Sexually Transmitted Infections

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
31	Have you heard about infections that can be transmitted through sexual intercourse?	YES……1 NO……2	**➔ 38**
32	What kind of STIs do you know?	GONORRHEA……A SYPHILIS……B GENITAL HERPES……C HEPATITIS……D CHLAMYDIA……E HIV/AIDS……F OTHER_____ G (SPECIFY) Don't know……H	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
33	In a male, how do you know that he has such an infection? Any others? RECORD ALL MENTIONED	LOWER ABDOMINAL PAIN……A GENITAL DISCHARGE/DRIPPING……B FOUL SMELLING DISCHARGE……C BURNING PAIN ON URINATION……D FREQUENT URINATION……E REDNESS/INFLAMMATION IN GENITAL AREA……F PAIN/SWELLING IN GENITAL AREA/SCROTUM……G GENITAL SORES/ULCERS……H GENITAL WARTS……I BLOOD IN URINE……J IMPOTENCE……K INFERTILITY ……L OTHER _____M (SPECIFY) DON'T KNOW……N	
33A	Named symptoms	3 and more……1 Less than 3 ……2	
34	In a female, how do you know that she has such an infection? Any others? CIRCLE ALL MENTIONED.	LOWER ABDOMINAL PAIN……A GENITAL DISCHARGE/DRIPPING……B FOUL SMELLING DISCHARGE……C BURNING PAIN ON URINATION……D FREQUENT URINATION. …… E REDNESS/INFLAMMATION IN GENITAL AREA……F PAIN/SWELLING IN GENITAL AREA……G GENITAL SORES/ULCERS……H GENITAL WARTS……I BLOOD IN URINE……J INFERTILITY……K OTHER _____ L (SPECIFY) DON'T KNOW……M	
34A	Named symptoms	3 and more……1 Less than 3 ……2	
35	Where could patient with STI go to be treated for such an infection? Any others? CIRCLE ALL MENTIONED.	PRIVATE HOSPITAL……A DISTRICT HOSPITAL……B PRIVATE PRACTITIONER……C SVP (RURAL MEDICAL PUNCT) ……D POLYCLINIC……E SUB……F SVA……G FAP……H TRADITIONAL PRACTITIONER……I TBA……J VENEREAL DISPENSARY……K ADOLESCENTS' DOCTOR/GYNECOLOGIST……L ADOLESCENTS' REPRODUCTIVE CENTER……M OTHER_____N (SPECIFY) DON'T KNOW……O	
36	Is there anything a male or female can do to avoid getting an STI?	YES……1 NO……2 DON'T KNOW……8	➔38 ➔38
37	How can you avoid getting an STI? Anything else? CIRCLE ALL MENTIONED.	ABSTAIN FROM SEX……A USE CONDOMS……B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER……C AVOID SEX WITH SEX WORKERS……D AVOID CASUAL SEX……E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS……F AVOID SHARING RAZORS,BLADES……G OTHER _____H (SPECIFY) DON'T KNOW……I	
37A	Named methods	2 and more……1 Less than 2 ……2	
38	Have you visited any health facility during last 12 months	YES……1 NO……2	

HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
39	Have you ever heard about HIV/AIDS?	YES……1 NO……2	➔ **46**
40	Do you know transmission ways of HIV/AIDS?	SEXUAL WAY……A BLOOD TRANSFUSION……B FROM MOTHER TO CHILD……C OTHER_____D (SPECIFY) DON'T KNOW……E	
40A	Named ways	If named two ways from the answers A,B,C……1 Less than 2……2	
41	Can the virus that causes AIDS be transmitted from a mother to a child?	YES……1 NO……2	➔ **43**
42	How the virus can be transmitted from a mother to a child? RECORD ALL MENTIONED.	During pregnancy……A During delivery……B During breastfeeding……C	
43	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES……1 NO……2 DON'T KNOW……8	➔ **45** ➔ **45**
44	What can a person do? Anything else? RECORD ALL MENTIONED.	ABSTAIN FROM SEX……A USE CONDOMS……B AVOID SEX WITH PROSTITUTES……C AVOID CASUAL SEX ……D AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS ……E AVOID CONTACT WITH CONTAMINATED BLOOD NEEDLES FOR INJECTIONS OR TRANSFUSION……F AVOID SHARING INSTRUMENTS FOR TATTOO OR PIERCING ……G AVOID SHARING RAZORS, BLADES…… H OTHER _____ I DON'T KNOW……J	
45	Can a person who has AIDS be cured?	YES……1 NO……2 DON'T KNOW……8	

Topics for Health Education

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
46	Where have you received the information about contraception, HIV/AIDs and STI? CIRCLE ALL MENTIONED.	HEALTH PROVIDER……A PARENTS……B FRIENDS/CLASSMATE……C RELATIVES……D BROTHER/SISTER……E BOOKS/LEAFLETS ……F NEWSPAPERS ……G TV ……H RADIO ……I TEACHER……J MAHALLA ACTIVIST……K PEER EDUCATOR ……L OTHER_____M (SPECIFY) DON'T KNOW/ DON'T REMEMBER……N	
47	How do you understand the term Safe sex life? CIRCLE ALL MENTIONED.	USING CONTRACEPTION METHODS……A STAY FAITHFUL TO ONE PARTNER……B AVOID SEX WITH SEX WORKERS……C AVOID CASUAL SEX……D OTHER_____E DON'T KNOW……F	

THANK YOU FOR PARTICIPATING IN THE SURVEY

Project HOPE, Navoi, Uzbekistan
FINAL EVALUATION.

Questionnaire 4: BF Interventions

All questions are to be addressed to a mother with a child 0-5, 6-9, 20-23 months of age

Identification number:	……..[____ / ____ / ____]
Rayon (1= Karmana; 2=kiziltepa;3=Konimeh ; 4=Nurota) Mahallla's name…… Cluster number……	……[ ] _____ ……[/]
Interview date (day/month/year)……	……[____ / ____ / ____]

Informed Consent

Hello, my name is _____ and I am working for the Navoi Oblast health Department. We are conducting a survey about your health and of your child. We would very much appreciated your participation in the survey, since this information will help us improve the existing health services. The survey is going to take us about 30 minutes to complete

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.
All discussed information will be keep confidentially.

At this time, would you like to ask me anything about the survey?

Name of mother (interviewee) Age of mother in years	_____ ……[/]
How many children living in this household are under age two?	……[/]
Name of youngest child (under 24 months of age)……	_____

Child's Background Characteristics

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Birth date (day/month/year)……	[____ / ____ / ____]	
1A	Classification by child's age	0-5 month.....1 6-9 month.....2 20-23 month.....3 Other.. 4	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
2	**Did you ever breastfeed (NAME)?**	**YES..... 1** **NO 2**	**—<7**
3	**How long after birth did you first put (NAME) to the breast?**[1]	**IMMEDIATELY/WITHIN FIRST HOUR AFTER DELIVERY ..... 1** **AFTER THE FIRST HOUR ..... 2** DON=T KNOW..... 3	
4	During the first three days after delivery, did you give (NAME) COLOSTRUM?	YES..... 1 NO ..... 2 DON=T KNOW..... 8	
5	During the first three days after delivery, did you give (NAME) anything else to eat or drink before feeding him/her breastmilk?	YES..... 1 NO ..... 2 DON=T KNOW..... 8	
6	Are you currently breastfeeding (NAME)?	YES..... 1 NO 2	
7	I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night. Did (NAME) have. . . READ EACH OF THE FOLLOWING AND PLACE A CIRCLE EACH ITEM CONSUMED.	BREAST MILK.....A INFANT FORMULA……..B ANIMAL MILK……C PLAIN WATER..... D OTHER LIQUIDS.....E MASHED, PUREED, SOLID OR SEMI-SOLID FOODS.....F Anything else_____G SPECIFY	
8	How many times did (NAME) eat semi-solid (mashed or pureed) food yesterday during the day or at night? IF 7 OR MORE TIMES, RECORD >7'.	NUMBER OF TIMES……{ } DON=T KNOW……..8	

THANK YOU!

G. Project Data Sheet Form

Child Survival and Health Grants Program Project Summary

Dec-27-2007

Project HOPE
(Uzbekistan)

General Project Information:

Cooperative Agreement Number:	**FAO-A-00-99-00026-01**
Project Grant Cycle:	**19**
Project Dates:	**(9/30/2003 - 9/29/2007)**
Project Type:	**Cost XT**
PROJECT HOPE Headquarters Technical Backstop:	**Bonnie Kittle**
Field Program Manager:	**Dr. Abdunabi Kuchimov**
Midterm Evaluator:	**Marcelo Castrillo**
Final Evaluator:	**Sandra Wilcox**
USAID Mission Contact:	**Benjamin Mills**

Field Program Manager Information:

Name:	**Dr. Abdunabi Kuchimov**
Address:	18, Tolstoy street Navoi City 210100
Phone:	011-998-79-7702434
Fax:	011-998-79-7702433
E-mail:	akuchimov@projecthope.org

Funding Information:

USAID Funding:(US $): $1,299,851 **PVO match:(US $)** $434,958

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no data on child malnutrition was collected, or malaria or handwashing.
posed to "last all their

Project Information:

Description:

This cost extension project's goals are to reduce the mortality and morbidity in children under five and women of reproductive age and to increase adolescents' knowledge about reproductive and sexual health.
Interventions include breastfeeding/baby-friendly hospital initiative; acute respiratory infections; control of diarrheal disease and child feeding (integrated under the IMCI Initiative); family planning/reproductive health; and SM/PEPC.

Project HOPE will continue providing technical support to the Oblast and Rayon Health Departments by means of:
1) training Oblast/Rayons' staff key child survival and reproductive health interventions;
2) adapting, field-testing and expanding standard case management protocols; and
3) developing and field-tested training curricula. In addition, for the new project,
4) will develop a Makhalla-based strategy, by identifying Makhalla-level organized groups and leaders and training them in key health interventions, and
(5) improve monitoring and evaluation at service and community levels.

Location:

Navoi Oblast, Republic of Uzbekistan

Project Partners	Partner Type	Subgrant Amount
Ministry of Health	Collaborating Partner	

General Strategies Planned:

Strengthen Decentralized Health System
Information System Technologies

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques

Behavior Change & Communication (BCC) Strategies:

Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	PVOs/NGOs (Int'l./US) Local NGO Networked Group	(None Selected)	National MOH Dist. Health System Health Facility Staff Other National Ministry	Health CBOs

Interventions/Program Components:

Nutrition (10 %)
(IMCI Integration)
(HF Training)
- Comp. Feed. from 6 mos.
- Cont. BF up to 24 mos.
- Maternal Nutrition

Pneumonia Case Management (10 %)
(IMCI Integration)
(CHW Training)
(HF Training)
- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (10 %)
(IMCI Integration)
(CHW Training)
(HF Training)
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

Maternal & Newborn Care (30 %)
(CHW Training)
(HF Training)
- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Control of post-partum bleeding
- Emergency Transport

Breastfeeding (10 %)
(CHW Training)
(HF Training)
- Promote Excl. BF to 6 Months
- Intro. or promotion of LAM
- Support baby friendly hospital

Family Planning (30 %)
(CHW Training)
(HF Training)
- Knowledge/Interest
- Male Reproductive Health
- Youth FP Promotion
- Quality Care
- FP/HIV integration
- Community Involvment
- Access to Methods

Target Beneficiaries:

Infants < 12 months:	8,101
Children 12-23 months:	5,921
Children 24-59 months:	24,990
Children 0-59 Months	39,012
Women 15-49 years:	86,636
Population of Target Area:	315,962

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	23	300	7.7%	4.3
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	127	150	84.7%	15.8
Percentage of children age 0-23 months whose births were attended by skilled health personnel	298	300	99.3%	11.3
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0%	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	208	231	90.0%	12.8
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	135	224	60.3%	12.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	122	150	81.3%	15.7
Percentage of children age 12-23 months who received a measles vaccine	123	150	82.0%	15.7
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0%	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	286	300	95.3%	11.3
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	16	34	47.1%	28.5
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	278	287	96.9%	11.6
Percentage of mothers of				

children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0%	0.0

Comments for Rapid Catch Indicators

1) At the time the DIP was written CS project implementers were given the option to not collect data on indicators that were not related to project interventions. Hence
2) The MOH of Uzbekistan does not give pregnant women tetanus shots unless she has a home birth - which is rare. All tetanus shots are given to children that are sup
lives".

H. Monitoring Tools

The General Monitoring Results on the "Safe Motherhood" Program in the Maternal Complex

Check-list

Date_____ Name of the facility_____

Form №	Content	Quantity of the observed criteria	Quantity of the implemented criteria	
			Absolute #	%
Form №1	Introduction of the "Safe Motherhood" program			%
Form №2	Knowledge and skills of OB/GYNs			%
Form №3	Knowledge and skills of neonatologists			%
Form №4	Knowledge and skills of midwives			%
Form №5	Conversation with mother			%
Form №6	Existence of proper protocols and WHO recommendations			%
Form №7	Statistics, record documentation and epidemiology of the observation results			%
Form №8	Medical supply of HF according to WHO recommendations			%
Form №9	Events on education and personnel training			%
Form №10	Equipping and expenditure of the materials			%
MNC1	Percentage of the normal deliveries according to WHO protocols			%
MNC2	Percentage of the complicated deliveries according to WHO protocols			%
MNC3	Percentage of women whose post delivery state is observed according to WHO			%
MNC4	Percentage of infants whose post delivery state is observed according to WHO			%
	Total			%

Evaluation List of the follow-up Observation of the health facilities on the Hospital IMCI strategy

Date of conduction:……/……./…….. **Oblast, rayon…….**

Experts ……..…… Name of the facility **…….**

№	**Indexes-indicators**	YES=1 NO=0 No need □
	Knowledge of personnel	
1	Testing procedure of the medical workers, the average sum on all tested medical workers (0=<11; 1 score=12-14; 2 scores=15-17; 3 scores=18-20 right answers)	
	Sorting of children, medicine supply and equipment	
2	Emergency aid organized properly for sorting of children (CL 1)	
3	The correct rendering of emergency medical aid (CL 2)	
4	Existents of main medicines for children in the admission department at the time of observation (CL 3)	
5	Existents of main medicines for children in the children department at the time of observation (CL 4)	
6	Existents of the equipment and expenditure materials for oxygen supply in the admission department (CL 5)	
7	Equipment and the system of oxygen supply are in operational status (CL 6)	
8	The main laboratory analyses are carrying out (all 5 types) (CL 7)	
	Accordance to the standards of IMCI strategies	
9	Pneumonia classification (SAF 1)	
10	Oxygen prescription (SAF 2)	
11	Pneumonia treatment (all stages of severity) (SAF 3)	
12	Valid prescription of antipyretic remedies for fever (SAF 4)	
13	The children nutrition status is carrying out (SAF 5)	
14	General quantity of prescribed remedies and administration way of the medicine (SAF 6)	
15	Validity of hospitalization of children with pneumonia (SAF 7)	
16	Differentiated diagnostics of the obstructive syndrome (SAF 8)	
17	Prescription at the obstructive syndrome (SAF 9)	
18	Patients with diarrhea diagnosis or any other diagnosis accompanying dehydrated are evaluated at the existents of dehydrate syndrome (SAF 10)	
19	Rehydration is carried out for Patients with diarrhea diagnosis or any other diagnosis accompanying dehydrated are evaluated at the existents of dehydrate syndrome (SAF 11)	
20	The status of nutrition for children is carried out (SAF 12)	
21	The general quantity of prescribed preparations and the way of inputting the prescribed preparations (SAF 13)	
	Total: scores	

Scores: total right/23*100%

General score in percentage_____

Evaluation List no the Follow-Up Observation of Medical Workers Trained on IMCI

Check-list

Oblast …… **Rayon…….**
Monitor …… **Medical Worker……..**
Date of conduction:…… **Name of the facility…….**

Was he/she trained at the special seminar or not?: yes =1 no=0

№	**Indexes-indicators**	YES=1 NO=0 No need □
	Information on the patient evaluation	
1	Greeting of the mother	
2	Filling up general data of the child.	
3	The patient was evaluated correctly by all symptoms of danger	
4	The patient was examined by the existents of 3 main symptoms (cough, diarrhea, fever)	
5	The patient was examined according to the throat problems	
6	The patient was examined according to the ear problems	
7	The patient was examined according to nutrition and anemia problems	
8	The weight of the patient was examined correctly using growth chart	
9	Vaccination status was examined correctly	
10	Mothers with children under two years of age were interviewed on the breastfeeding and additional nutrition.	
	Skills of medical workers	
11	Was the sick child sent to the in-patient health facility IF he/she has had the complicated classification?	
12	Was the patient prescribed IF he needs in oral preparations (antibiotics/ORS/iron preparations/paracetamol	
13	Was the child evaluated and his mother consulted If a sick child is more than 2 and he needs in nutrition evaluation.	
14	Was the mother instructed about the additional fluid and food when the child is sick and when to return immediately.	
	Mothers consultation	
15	Were the main skills used at the time of consulting: listening and asking	
16	Encouragement	
17	Recommendations	
18	Checking mother’s knowledge	
	Knowledge of mothers	
19	The mothers know how much, how many times and how many days the oral preparation must be consumed.	
	Conclusion	
20	The correct evaluation of sick child	
21	The correct classification of sick child	
22	The correct prescription for treatment	
23	The consultation is appropriate	
24	Appropriate knowledge of mothers	
25	Existence of functioning post of oral rehydration	
	Total evaluation	

General score in percentage ……

Evaluation List on the Follow-Up Observation in the Maternal Complexes by the IMPAC Strategy

Date:……/……./…….. **Oblast, rayon/city…….**

Name of the Maternal Complex.....…….

Experts…….....…….……

№	**Indexes - Indicators**	YES=1 NO=0 Scores
	Knowledge of personnel	
1	Testing process of medical workers: average sum of all tested medical workers (0=<20; 1 point=21-25; 2 points=26-30; 3 points=31-36 answers)	
	Observation of skills of medical workers	
2	Skills evaluation of the abdominal aorta squeeze. OBSIM-1	
3	Evaluation of the bimanual squeezing of uterus. OBSIM-2	
4*	Delivery managing skills. OBSIM-3, OBSIM-4	
5	Skills of managing of post delivery period, medical examination (of mother and child) and basic care. OBSIM-5	
6	Skills of newborn infant examination (<12 hours). OBSIM-6	
7	Skills of newborn infant examination (>12 hours). OBSIM-7	
8	Evaluation of the manual vacuum aspiration procedure (MVA). OBSIM-8	
9*	Evaluation skills of executing of bed test OBSIM-9	
10	Evaluation skills of the Emmet's operation. OBSIM-10	
11	Managing of labor with pelvic presentation of baby. OBSIM-11	
12	Vacuum extraction evaluation. OBSIM-12	
13*	Evaluation of the manual separation of placenta. OBSIM-13	
14*	Evaluation of the neonatal intensive care. OBSIM-14	
15*	Skills evaluation on HELLP syndrome. OBSIM-15	
16*	Skills evaluation on the of baby shoulders dystocia. OBSIM-16	
17*	Skills evaluation of delivery stimulation.OBSIM-17	
18	Skills evaluation of the delivery problem solving by the means of obstetrics pincers adjustment. OBSIM-18	
19*	Evaluation of managing of the pregnant women with light pre-eclampsia OBSIM-19	
20*	Evaluation of managing of the pregnant women with complicated pre-eclampsia. OBSIM-20	
21*	Evaluation of managing of the pregnant women with impending or developed eclampsia. OBSIM-21	
22*	Skills evaluation of emergency aid while post-delivery bleeding. OBSIM-22	
23*	Skills evaluation of emergency aid at the septic state. OBSIM-23	
	Total: quantity of scores	

Quantity of scores/24*100%

General indicator in percentage _____

Evaluation List no the Follow-Up Observation of Medical Workers Trained on Breastfeeding

Check-list

Time of monitoring____/_____/_____ **Health Facility name _____**

Oblast _____ **Health worker name _____**

Rayon _____ **Name of the monitor _____**

The age of the interviewing child **Was health worker trained on seminar?:**

(in months): ___ ___ **Yes=1, No=0**

№	**Indicator**	**Yes=1, No=0,** Improper ①
1	The proper usage of the BF history (BFO7)	
2	Has the HP examined the mother's breasts? (BFO8)	
3	Evaluation of the right apposition of the breast? (Was the BF observation form used? (BFO9)	
4	The ability of HP in giving the right and proper advice? (BFO10)	
5	The effective usage of communication skills during the consultation (BFO15)	
6	HP was tested: (0=<55%; **1**=55%-69%; **2**=70-84%; **3**=85-100%)	
7	The mother began breast feeding as soon as she delivered, within first hour. (BFI-2)	
8	Does the mother still continue breastfeeding at the time (BFI-3)	
9	Giving complimentary semi-solid (solid) nutrition including breastfeeding (BFI-6)	
10	The proper conception of mothers about only breastfeeding term (BFI-7)	
11	The immediate skin-to-skin contact of infant and mother within 30 minutes after delivery. (BFI-9)	
12	Visiting the house of the delivered mother within a month by HP (BFI-10)	
13	Supporting the proper information and advices on breastfeeding by HP during home visit. (BFI-12)	
14	The effective usage of the book named " The principles of long and effective breastfeeding" (item №6)	
	Total answers 1 and ①	
	Percentage:	%

The items 7 and 11 are not considered while making the total calculation!

(Total score of the correct answers is 14)

14 ----------100% X= total*100/14= __,_%
Total------- X

Questionnaire for mothers with children under two years of age at the frame of the monitoring for breastfeeding program carried out for primary healthcare health providers

Questionnaire Identification number_____	**FOR OFFICE USE ONLY RECORD # _ _ _ _**

Oblast_____

Rayon_____

Name of the facility_____

Date _____/_____/_____

Full name of the interviewer _____

Full name of the health provider _____

INTRODUCTION AND CONSENT

Hi, my name is _____I work on behalf of the Project HOPE. We are having questionnaire process about maternity and child health. We would be very glad if you take part in this questioning. I'd like to talk to you about your health. The information given by you will be very helpful in the planning of the medical service for the population. Usually it takes 10 minutes to answer the questions.

It is up to you to take part in this questionnaire, you can decide if you should answer the question or not. Nevertheless, we hope you will participate in the questionnaire, because your opinion is very important for us. Are you going to ask us anything right now? Aren't you against?

NAME OF THE MOTHER_____ SEX OF THE CHILD: (1 = male; 2 = female) → ☐

NAME OF THE CHILD_____ DATE OF BIRTH: _____/_____/_____
day month year

AGE OF THE CHILD (in months): ___ ___

(stop the interview if the child's age is more than two years of age)

CLASSIFICATION ACCORDING TO THE AGE (0-6 months) ☐

(0-23 months) ☐

SECTION A: Background information of the respondent (BI)

NO.	Questions and Filters	Category Code	Skip
BI-1	Level of your education:	None.....1 Primary.....2 Secondary.....3 Secondary specialized .....4 Higher.....5	
BI-2	Do you work outside of home? If "YES", Where do you work?	Housewife/don't work.....1 Permanent work.....2 Seasonal work…….....3	→ BFI-1
BI-3	Who takes care (NAME) when you are away home?	Mother / respondent.....1 Husband / Partner .....2 Older children.....3 Relatives_____ .....4 (Specify) Neighbors/ Friends .....5 Maid/ Kindergarten .....6 others_____.....96 (specify)	

NO.	Questions and Filters	Category Code	Skip

Knowledge and skills on breastfeeding (BF)

BFI-1	Do you ever breastfeed your (NAME)?	YES ..... 1 NO 0	 → BF7
BFI-2	Where and when did you begin breastfeeding your (NAME)? *Be attentive while listening the answer and mark the most appropriate answer*	_____ _____ _____ _____ AS SOON AS AFTER DELIVERING, WITHIN FIRST HOUR ..... 1 NO 0	
BFI-3	Do you still breastfeed your (NAME)?	YES ..... 1 NO 0	→ BF5
BFI-4	If you do not breastfeed, tell the reason of it. *Write the answer.*	_____ _____	
BFI-5	What kind of nutrition did you give to your (NAME) within the last 24 hours? *Mark only one version without reading the answers*	Only breastfeeding ..... 1 Breastfeeding+ complementary ..... 2 Other food without breastfeeding 3	→ BF7 → BF7
BFI-6	If you feed your (NAME) with additional food except breastfeeding, what kind of consistence is it? *Be attentive while listening the answer and mark the most appropriate answer*	Breastfeeding + semisolid (solid) nutrition..1 Other versions 2	
BFI-7	How do you understand the meaning of "Only breastfeeding? *Write the answer and decide if the mother define that meaning correctly:*	_____ _____ _____ YES ..... 1 NO 0	
BFI-8	Was your (NAME) put on your abdomen as soon as you delivered?	YES ..... 1 NO 0	 → BF10
BFI-9	How long was your baby on your abdomen? *Be attentive while listening the answer and mark the most appropriate answer*	Within 30 minutes of the first hour, the skin-to-skin contact ..... 1 Wrong 0	
BFI-10	Has the visiting nurse visited you within a month after you had delivered?	YES ..... 1 NO 0	 → **end**
BFI-11	Has the visiting nurse supported you with the information of breastfeeding?	YES ..... 1 NO 0	 → **end**
BFI-12	If she supported you with that information, what particularly topics did you discuss with her/him?	_____ _____ _____ _____ _____	

NO.	Questions and Filters	Category Code	Skip
		_____ _____	
	Write the answer and decide if the medical provider gave proper information about breastfeeding:	YES ..... 1 NO..... 0	

Show the book, brochure

QUESTION	YES	NO	DETAILED ANSWERS
1. Have you ever seen the book named "The principles of long and efficient breastfeeding"?			Stop if the answer is "no".
2. Do you have this very book?			
3.How do you like the appearance and the book itself?			Why?
4.Which part of the book you think is the most interesting?			If "yes" which one?
5. In your opinion, what other information we can add in this book? Or what kind of information we must cut?			If "yes" which one?
6.*For Monitors*: According to the above answers, give a summary of the efficient usage of the book and brochure among mothers.			

Thank you!

BFOBS

BREASTFEEDING CONSULTATION OBSERVATION FORM

Monitoring date:	_____/_____/_____	Oblast		Rayon	
Name of the HP:			Name of the facility:		
Name of the observer:			Date of birth of the child	____/_____/_____	

Age of the child ___ ___ months Time of the consultation start: ___ ___

	INDICATOR	Evaluation
BFO1.	Identification the nutrition of the child at present time?	YES .....1 NO 0
BFO2.	Identification the state and activeness of the child?	YES .....1 NO 0
BFO3.	Identification the pregnancy, delivery, first breastfeeding experience?	YES .....1 NO 0
BFO4.	Identification mother's state and family planning?	YES .....1 NO 0
BFO5.	Identification the former experience of breastfeeding?	YES .....1 NO 0
BFO6.	Identification the attitude and support of family members towards the BF?	YES .....1 NO 0
BFO7.	Identification of the correct usage of BF history (mark "yes" if from 6 items 4 items were fully carried out)	YES .....1 NO 0
BFO8.	Has the health provider examined the breast?	YES .....1 NO .....0 IMPROPER 1
BFO9.	Evaluation of the correct apposition for the breastfeeding? The usage of the BF observation form?	YES .....1 NO 0
BFO10.	The ability of HP in giving the right and proper advice?	YES .....1 NO 0
	Evaluation of communication skills using:	
BFO11.	Answering and listening?	YES .....1 NO 0
BFO12.	Encouraging?	YES .....1 NO 0
BFO13.	Advising?	YES .....1 NO 0
BFO14.	Checking?	YES .....1 NO 0
BFO15.	The effective usage of communication skills during the consultation: (mark "yes" if from 4 items 3 items were fully carried out correct)	YES .....1 NO 0

The time of consultation end _____ DURATION_____

Test Questions on Breast Feeding

1. What are the advantages of breast feeding?
2. What are the advantages of mouth milk?
3. What do you understand under *exclusive breast feeding*?
4. What is the correct time to start feeding a child under exclusive breast feeding with additional food?
5. Which is the correct way of feeding a child between 6 to 12 months?
6. What is the correct way of feeding a child between one to two years old?
7. Please, name the indicators of the correct breast feeding?
8. Please, name the sings of a child being correctly positioned for the breast feeding
9. What are the reasons for the breast getting rigid?
10. What are the causes of the pain in breast nipple?
11. What are the rules of lactation amenorrhea?
12. Please, name the causes of not having enough milk
13. What would be your advice to a mom to increase the amount of milk?
14. What are the true signs of child not getting enough milk?

COMMUNITY HEALTH PROMOTION PROGRAM IMPLEMENTATION ON MAHALLA LEVEL

CHECKLIST

Oblast _____ Rayon _____

Curator _____ Fukarollar yig'ini_____

Date of conduction _____ Name of mahalla

_____

№	**Indicators**	**Yes=1, No=0,** N/a=①
1	Appropriate management of registration book (Tool - 1) on educational sessions conduction	
2	Level of knowledge of trained leader (Tool – 2) (0=<55%; 1=55%-69%; 2=70-84%; 3=85-100%)	
3	Level of learning key messages gotten by participants in the sessions (Tool – 3, KM-1) (0= 0-19%; 1= 20-39%; 2=40-59%; 3=60-100%)	
4	Understanding of given information in the sessions (Tool -3, SI-7)	
5	Level of using trainer skills by trained mahalla leader (Tool – 4, item 1)	
6	Level of using interactive method of communication during the sessions (Tool – 4, item 2)	
7	Level of explanation of themes by trained mahalla leader (Tool – 4, item 3)	
	Total sum of 1 and ① /11 and %	

Events logbook

#	Date	Topic	Used methodology*	Venue	Participants #	Name, Surname	Comments
1.						**1.**	
						2.	
						3.	
						4.	
						5.	
						6.	
						7.	
						8.	
						9.	
						10.	
2.						**1.**	
						2.	
						3.	
						4.	
						5.	
						6.	
						7.	
						8.	
						9.	
						10.	
						11.	
						12.	
						13.	

* 1- Story without an End; 2 – Video and Discussion; 3 – Photo and Discussion; 4 – Scenic Play and Discussion.

Plan and carrying out of Events. For 6 months

#	Topic	Methodology	October				November				December				January				February				March			
			Plan		In fact		Plan		In fact		Plan		In fact		Plan		In fact		Plan		In fact		Plan		In fact	
			1*	2**	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
1.	Exclusively breastfeeding	Story without an End																								
		Video and Discussion																								
		Photo and Discussion																								
2.	Breastfeeding and complementary feeding	Story without an End																								
		Photo and Discussion																								
3.	Pneumonia	Video and Discussion																								
		Photo and Discussion																								
		Story without an End																								
4.	Diarrhea	Video and Discussion																								
		Photo and Discussion																								
		Story without an End																								
5.	Danger signs during pregnancy and what is needed to do	Photo and Discussion																								
		Scenic Play and Discussion																								
6.	Cycled changes in our body	Photo and Discussion																								
7.	Childbirth spacing and contraception	Story without an End																								
		Video and Discussion																								
		Photo and Discussion																								
8.	Adolescence and adolescence age problems	Video and Discussion																								
		Scenic Play and Discussion																								
9.	Complications of STDs, STDs prevention	Video and Discussion																								

1-Date of planned/conducted event** * 2-Planned/participated persons number**

Navoi, Uzbekistan
M&E.
Instrument 1: Management of registration book on educational sessions conduction.

I.

#	Date	Topic	Place of conduction	Number of participants	Method of giving information			
					1	2	3	4
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

1-Story without end; 2 – Video discussion; 3 – Picture discussion; 4 – Sketch playing and discussion

II. Presence of current plan on educational sessions conduction Yes No

CHPP: Test for mahalla leaders.

List of questions

1. How do you understand the term “Exclusively breastfeeding”?
2. What answer is not right for explanation of advantages of breastfeeding?
3. How we should correctly feed the baby under 6 months old?
4. Identify the correct answer for feeding of child in age from six months to 1 year.
5. What kind of meal we should give to child in age from 1 year to 2 year?
6. What are the general dangerous sings for child’s life?
7. What answer is not the sign of cold?
8. What kind of signs appearance are evidence necessities of taking child with cold to health provider urgently?
9. Identify the correct answer for care after child with cold at home.
10. What kind of signs appearance are evidence necessities of taking child with diarrhea to health provider urgently?
11. Identify the signs of dehydration.
12. Identify the answer for using correct method of Rehydron solution preparation for child with diarrhea at home.
13. What kind of signs appearance are not evidence necessities to appeal to health provider during pregnancy?
14. What kind of signs appearance are evidence necessities to appeal woman to health provider in the period after childbearing?
15. What kind of modern contraception methods do you know?
16. What intergeneric (child spacing) interval should be occur if woman is healthy?
17. In a male, how do you know that he has the STD?
18. In a female, how do you know that she has the STD?
19. What can a male or female do to avoid getting an STD?
20. What days of menstrual period are more likely to get pregnant?

Tool – 3

INTERVIEW WITH PARTICIPANT OF EDUCATIONAL SESSION OF CHPP IN MAHALLA

ID # _____

Viloyat (Oblast)_____ **Tuman (Rayon)_____**

Date of interview _____/_____/_____

Name of mahalla _____

Name of fukarolar yig'ini _____

Name of interviewer (monitor)_____

Informed Consent

Hello, my name is _____ and I am working for the rayon hokimiyat department of women. We are conducting a questioning survey regarding community health promotion. We would very much appreciated your participation in the survey, since this information will help mahalla leaders in planning and improving activities on community health promotion. The survey is going to take us about 10 minutes to complete.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.

At this time, would you like to ask me anything about the survey?

PREFACE

Your name _____	Your age (In full years) ___ ___ Sex: Female ☐ Male ☐
FOR MONITORS: Define, which target group aimed for	1. Caretakers for children under 5 years old 2. Females in fertile age 3. Adolescents

SECTION SI: INFORMATION ON EDUCATIONAL **S**ESSIONS CONDUCTION IN MAHALLA

№	Questions and filters	Category codes	Skip
SI **1**	Have you heard about conducting educational sessions on health promotion by mahalla leaders?	YES……1 NO……..0	If "NO", stop the interview
SI **2**	Did you participate in such educational sessions yourself?	YES……1 NO……..0	If "NO", stop the interveiw
SI **3**	If "Yes": When did you participate in such educational session last time? *(Mark the most appropriate answer)*	1. During last 2 weeks 2. During last month 3. During last 1-3 months 4. Other_____	

№	Questions	Answers
SI **4**	What's the last educational session topic's name? (For monitors: *Listen the participant's answer carefully and mark the most appropriate answer*)	1. Exclusive Breastfeeding 2. Breastfeeding and complementary feeding 3. Pneumonia 4. Diarrhea 5. Dangerous signs during pregnancy and what need to do 6. About age-specific changes of our body 7. Child spacing and contraception 8. Adolescence and age-related problems 9. Consequences of sexual-transmitted diseases
SI **5**	Who conducted the session? (For monitors: *Listen the participant's answer carefully and mark the most appropriate answer*)	1. Prepared mahalla leader 2. Health provider 3. Other_____
SI **6**	In what way the information was given? (For monitors: *Listen the participant's answer carefully and mark the most appropriate answer*)	1. Video-demonstration and discussing 2. Story without end 3. Picture discussion 4. Sketch playing and 5. Other_____
SI **7**	Insofar understandable was the given information ?	1. Good 2. Not so good 3. Bad 4. Quite incomprehensible --- If answer 1 – Good, then mark ……..…1 For others ….....0

SECTION KM: DIGESTION OF **K**EY **M**ESSEGES BY THE PARTICIPANT

KM-1	What key messages did you learn during last educational session? *(What else?)* (For monitors: *enter to needed box and mark the certain key messages*)	
	Pregnant women, mothers with children, which are feeding breastmilk and their grandmother or mother in low For monitors: count up % X/4_____	**Session 1. 2. 3.** 1. Mothers, your baby needs ONLY breastmilk for the first 6 months. No other liquid or food is needed. 2. Mothers your baby wants your breast immediately, give baby breastmilk within one hour of birth. 3. The volume of your breastmilk producing depends on how often do you feed with breast; usually each mother can feed her child herself. 4. Usually breastmilk prevents your newborn and young baby from the dangerous illness. Breastfeeding can also increase the interrelation between mother and baby and maternal love.

	Mothers with children, which are feeding breastmilk, caretakers after children under 5 For monitors: count up % X/3_____	**Session 4. 5.** 1. Mothers, your baby needs ONLY breastmilk for the first 6 months. After 6 months your baby needs a complimentary feeding. 2. Mothers your baby 6-9 months is ready for more foods. Give breastmilk and semi-solid foods. 3. Mothers your baby can benefit from breastmilk up to 23 months. Keep giving breastmilk to your baby until 23 months and give other food 5 times per day.
	Caretakers after children under 5 For monitors: count up % X/7_____	**Session 6. 7. 8.** 1. Mothers, fast or difficult breathing, and a sinking chest are danger signs for pneumonia. If you see these signs, take your child to the health clinic. Following signs are the evidence to take your child to the health clinic urgently. 2. Breathing is fast than usually 3. Child has a difficult or suffocate breathing 4. Child has a sinking low part of chest or abdomen 5. Child has a cough more than 2 weeks 6. Child cannot feeding breast or to drink 7. Child has a very often vomiting
	Caretakers after children under 5 For monitors: count up % X/17_____	**Session 9. 10. 11.** If you see the following signs, take your child to the health provider urgently. If you can define the showed sings in time and take your child to the health provider you will save the life and healthy of your child. 1. Diarrhea 2. Blood in the stool 3. Lethargic or unconscious 4. Vomit everything 5. Fever or feels hot 6. Not able to brestfeed, to drink or drinking poorly 7. Status becomes worse, restless or capricious more than usually Signs of dehydration: 8. Debility 9. Weakness and drowse 10. Restless, irritable 11. Low volume of urina or tawny coloure of urina 12. Low weight 13. Dry mouth, thirst 14. Sunken eyes 15. Bulging fontanelle 16. Mothers your child NEEDS fluids and food when sick to help recover quickly. Give more home made fluids and/or rehydron/ORS for child with diarrhea. 17. For child under 6 months who are feeding breastmilk give boiled water or rehydron/ORS together with breastmilk

	Pregnant women and her family members For monitors: count up % X/9_____	**Session 12. 13.** Women, you have to know the following dangerous signs during pregnancy, if one or more of these signs appear address to health provider immediately: 1. Convulsions 2. Visual impairment 3. Vaginal bleeding 4. Difficult breathing 5. Headache 6. Quick incipient and evanescent edema 7. Fever 8. Severe abdominal pain 9. Changing in fetus movements
	Women in fertile age, adolescents-lasses For monitors: count up % X/4_____	**Session 14.** 1. A woman's most fertile period for getting pregnant is 10^{th} to 17^{th} days after your last period. 2. A woman's most fertile period for getting pregnant is the days in the middle between two menstruations 3. You and your partner can talk about the choices for family planning together. Your patronage nurse or family doctor can advise you about family planning choices.Тўлиқроқ маълумотга эга бўлишни истасангиз патронаж хамшира ёки шифокорга мурожаат қилинг. 4. You and your partner can talk about the choices for family planning together. Especially in the days of most fertile period for getting pregnant.
	Women and men in fertile age, adolescents For monitors: count up % X/6_____	**Session 15. 16. 17.** 1. Pregnancy of woman in age under 18 or more than 35 can increase the dangerous for her health and/or for fetus' health. 2. Families, 24 months is a healthy rest period for mothers between pregnancies to give a healthy rest to mothers and to have a healthy child. 3. Pregnancies and then labor more than 4 times could have dangers for the mothers' health. 4. There are a lot of safety contraceptive methods. Have counseling with health providers. 5. The family planning is a responsibility of males and females both. Each person have to be informed about useful information related health. 6. Each local health facility have got the following contraceptives: ▪ Condom ▪ Tablets ▪ Injections ▪ IUD

	Parents with children-adolescents For monitors: count up % X/4_____	**Session 18. 19.** 1. Each parent have to keep in mind that the purpose of sexual education not pushing adolescents to be sexual active, the purpose is to prevent the unwanted pregnancy, STI, AIDS infection and other problems. 2. The most effective and right way to prevent the unwanted pregnancy, STI, AIDS infection is sexual abstinence or chastity! 3. Prevention of the unwanted pregnancy is usage of contraceptives. The local health facility have got the following contraceptives: ▪ Preservatives ▪ Tablets ▪ Injections ▪ IUD 4. It is advised you to read the schoolbook "Adolescents' reproductive and sexual health" and "Answers for some interesting to adolescents questions" brochure which is distributed in schools for your child. These sources of information include the topics about prevention of unwanted pregnancy, what to do in case of abortion and other useful information. The responsibility of each parent is good comprehension of such problems and their prevention. It is necessary to keep in mind that for adolescent the most intimate in the light and black days are parents.
	Parents with children-adolescents Women and men in fertile age For monitors: count up % X/17_____	**Session 20/** General signs of sexually transmitted diseases: 1. Objectionable odor foamy and purulent discharges from the genitals 2. Burning and itching in the genital area 3. Abnormal vaginal bleeding 4. Rash and warts in the genital area 5. Pain during passing water 6. Pain in the low part of abdomen 7. Headache, weakness, fever 8. Loss weight For the prevention of the sexually transmitted diseases: 9. Using preservative 10. Abstinence of the sexual intercourse 11. Limitation with the one sexual partner 12. Avoid of the casual sexual relations 13. Avoid of the sexual contacts with 14. Avoid of using of non-sterile medical equipment and shaving things 15. Avoid of sex during treatment period 16. The purpose of giving information to adolescent on STD and AIDS is to increase the skills of prevention dangers of STI, AIDS, to avoid of the unprotected sexual contact. Remind them the general and prevention ways of the sexually transmitted diseases.

		17. It is necessary to underline that the most effective and right way to prevent the unwanted pregnancy, STI, AIDS infection is sexual abstinence or chastity!

SI **8**	How is possible to improve this sessions?	_____ _____ _____ _____ _____ _____ _____ _____

THANK YOU FOR THE PARTICIPATION IN CONVERSATION!

Navoi, Uzbekistan
M&E.
Instruments 4: Observation for conduction of educational sessions with community
The Form is used as part of evaluation of mahalla leader's skills

Oblast:_____	**Rayon:_____**
Date of conduction:_____	**Name of mahalla_____**
Interviewer_____	**Mahalla leader:_____**

Evaluate skills of mahalla leader **on the following:**

Criteria	**Was observed/ unacceptably** «√»	**Was not observed** «√»
ITEM 1 - TRAINER SKILLS		
Selection of adequate place for conducting session		
Selection of target audience in accordance with theme		
Greeting of the session participants		
Introducing with: goal and session theme		
Telling about session duration		
Communication		
Motility		
Gesticulation		
Listening skills		
Speech sound level		
Intonation		
Actor skills		
Energy		
Stimulation of audience		
Communication with difficult participants		
Solving a problem with boredom		
Work with talkers		
Assistance during work small in groups		
Encouragement of participants		

Creating well coordinated process		
Giving «key messages»		
To show interest in follow up promotion of «key messages» by listeners		
For using 10 steps – 1 point.	**Total** «√» **«_____»**	**Point_____**

ITEM 2 – USING OF INTERACTIVE METHODS OF TEACHING		
ENERGIZERS		
MINI - LECTURE		
WORK IN SMALL GROUPS		
BRAIN STORM		
DEMONSTRATION		
PRACTICES		
CASE STUDY		
ROLE PLAYING		
GROUP DISCUSSION		
USING VISUAL AIDS		
DAY SUMMING UP		
EXPLANATION (during the session there must be used at least 3 interactive methods).	**Total** «√» **«_____»**	**Point_____**
POINT 3 – EXPLANATION OF THEME		
Clear knowledge and understanding of a goal of the session		
The theme is explained in understandable way		
Detail explanation of main paragraphs of the theme		
Clear and available answering to the listeners' questions		
Asking questions for defining level of theme understanding материала		
Clear determination of tasks		
Using practices on strengthening /repeating of learned themes		
Using of summing up method		
For using 4 steps – 1 point.	**Total** «√» **«_____»**	**Point_____**

The evaluation list on the follow-up for the monitoring of Community-IMCI program

Check-list

Time of monitoring____/_____/_____ **Health Facility name _____**

Oblast _____ **Health worker name _____**

Rayon _____ **Name of the monitor _____**

The age of the interviewing child **Was health worker trained on seminar?:**

(in months): ___ ___ **Yes=1, No=0**

№	**Indicators**	**Yes=1, No=0,** Improper ①
	Information about child	
1	The health of a child was asked **(1-1.6)**	
2	The dangerous symptoms for baby's life were explained **(2-2.4)**	
3	Applying to a physician at any case of baby's illness were explained **(3-3.4)**	
4	Treatment the child from cough and cold at home were explained **(5-5.5)**	
5	The rules of preventing cold were explained **(6-6.5)**	
6	Treatment the child from diarrhea at home were explained **(8-8-5)**	
7	The rules of preventing diarrhea were explained **(9-9.6)**	
8	The information about the problems because of the improper feeding were explained **(10.1)**	
9	Consultation on feeding according to a child's age were explained **(12-14.5)**	
10	The information about the importance of the vaccination were explained **(15)**	
11	The information about anemia were explained **(16-16.3)**	
12	Using skills and experience while consulting**: (the average of 19.1-19.4 is >75%)**	
13	HP was tested (examined): (0=<55%; 1=55%-69%; 2=70-84%; 3=85-100%)	
	Knowledge of mothers	
14	Knowledge of mothers on necessity to visit to physician in case if there are symptoms of the illness and danger of a baby's life **(See: CHUND 5: SC-1)**	
15	Knowledge of mothers on taking care after a sick child **(See: CHUND 5: RI 7, 8, 9 (VN 7, 8, 9) / (D 4, 5 да – answer: more than usual/3)**	
16	Using book (point №6)	
	Total answers 1 и ①	
	Percentage:	%

(Number of the correct answers is 18)

18 ----------100% X= total*100/18= __,_%
Total------- X

Consultation Observation form for monitoring of Community-IMCI program

date:	**oblast**		**rayon**	
Interviewer :		**Name of the facility**		
Full name of the nurse:				

Child's age ___ ___ month Start time of the consulting: ___ ___

№	Question	Answer		Code	
1	**Was the question given about the health of the child?**	Yes	No	1	2
1.1	**Difficult breathing / Cough / Cold**	Yes	No	1	2
1.2	**Diarrhea**	Yes	No	1	2
1.3	**Fever**	Yes	No	1	2
1.4	**Ear problems**	Yes	No	1	2
1.5	**Sore throat problems**	Yes	No	1	2
1.6	**Other problems**	Yes	No	1	2
2	**Information on the general symptoms of danger:**				
2.1	If the child can not drink or breastfeed?	Yes	No	1	2
2.2	Frequent vomiting?	Yes	No	1	2
2.3	Convulsions?	Yes	No	1	2
2.4	Sleeping more than usual or being unconscious?	Yes	No	1	2
3	Was it explained that a child with any disease should be delivering to the physician?	Yes	No	1	2
3.1	If a child's condition gets worse?	Yes	No	1	2
3.2	If he has a high temperature?	Yes	No	1	2
3.3	If the child can not drink or breastfeed?	Yes	No	1	2
3.4	If the child's excrements are liquid and frequent than usual/if there is blood	Yes	No	1	2
4	**If a child has a cough and cold?**	Yes	No	1	**2 Go → 6**
4.1	Frequent/Difficult breathing?	Yes	No	1	2
5	**Treatment the child from cold at home conditions:**				
5.1	Was it explained how to treat/eliminate cough and soften sore throat?	Yes	No	1	2
5.2	Was the dose of paracetamol explained?	Yes	No	1	2
5.3	Was it explained to drink more liquid than usual?	Yes	No	1	2
5.4	Was it explained to feed more meals than usual?	Yes	No	1	2
5.5	Not to give any antibiotics without physician prescription?	Yes	No	1	2
6	**Preventing cold?**	Yes	No	1	2
6.1	Proper nutrition?	Yes	No	1	2
6.2	To keep distance from sick people?	Yes	No	1	2
6.3	To wear a child warmly?	Yes	No	1	2
6.4	Only breastfeeding until 6 months?	Yes	No	1	2
6.5	To have immunization in proper time?	Yes	No	1	2
7	**If a child has diarrhea?**	Yes	No	1	**2 Go → 9**
7.1	If the excrements is liquid and frequent?	Yes	No	1	2

№	Question	Answer		Code	
7.2	If the excrements is with blood?	Yes	No	1	2
8	**Treatment the child from diarrhea at home conditions:**				
8.1	Continue breastfeeding daily and nightly, frequent and longer?	Yes	No	1	2
8.2	Was it explained to drink more liquid than usual?	Yes	No	1	2
8.3	Was it explained to feed more meals than usual?	Yes	No	1	2
8.4	The preparation and usage of rehydron?	Yes	No	1	2
8.5	Not to give any antibiotics without physician prescription?	Yes	No	1	2
9	**Preventing diarrhea?**				
9.1	Only breastfeeding until 6 months?	Yes	No	1	2
9.2	Only give boiled water?	Yes	No	1	2
9.3	To wash hand after toilet and before having meal?	Yes	No	1	2
9.4	How to use cup and a tea-spoon?	Yes	No	1	2
9.5	To fight with insects?	Yes	No	1	2
9.6	The rules of giving complementary food?	Yes	No	1	2
10	**Nutrition:** ***(give necessary consultation according to the age of a child)***				
10.1	The reasons/problems causing wrong feeding?	Yes	No	1	2
11	**0 – 6 months:**				
11.1	Was the phrase “Only breastfeeding” explained?	Yes	No	1	2
11.2	Was it explained the advantageous of breastfeeding both for mother and baby?	Yes	No	1	2
12	**6 month – 1 year:**				
12.1	Was it explained the necessity of complementary feeding?	Yes	No	1	2
12.2	The rules of giving additional food?	Yes	No	1	2
12.3	How to use payola (cup) and kosacha (bigger cup)?	Yes	No	1	2
12.4	Effective feeding?	Yes	No	1	2
12.5	Using local food?	Yes	No	1	2
12.6	Recommendations on cooking for child?	Yes	No	1	2
12.7	Was it explained not to give tea?	Yes	No	1	2
13	**1 – 2 year:**				
13.1	Recommendations on feeding?	Yes	No	1	2
13.2	Effective feeding?	Yes	No	1	2
13.3	Using local food?	Yes	No	1	2
13.4	Recommendations on cooking for child?	Yes	No	1	2
13.5	Was it explained not to give tea?	Yes	No	1	2
14	**2 year and more:**				
14.1	Recommendations on feeding?	Yes	No	1	2
14.2	Effective feeding?	Yes	No	1	2
14.3	Using local food?	Yes	No	1	2
14.4	Recommendations on cooking for child?	Yes	No	1	2
14.5	Was it explained not to give tea?	Yes	No	1	2
15	**The importance of immunization?**	Yes	No	1	2
16	**Anemia:**				
16.1	Problems occurring from anemia?	Yes	No	1	2
16.2	Preventing anemia?	Yes	No	1	2
16.3	Was it explained not to give tea?	Yes	No	1	2
17	**Were the consultations given on how to care after baby for his/her effective developing?**	Yes	No	1	2

№	Question	Answer		Code	
18	**Was it explained to prevent accidents?**	Yes	No	1	2
19	**Using skills and experience while consulting:**				
19.1	Asking and listening?	Yes	No	1	2
19.2	Encouragement?	Yes	No	1	2
19.3	Giving advices?	Yes	No	1	2
19.4	Examining?	Yes	No	1	2

The end of the consultation time____ ____ duration ____ ____ (in minutes)

Show the book, brochure

Question	Yes	No	Additional answers
1. Have you ever seen the book "If I want my baby to be healthy"?			If "no"-end.
2. Do you have this book?			
3. Did you like the appearance and the book itself?			Why?
4. Which part of this book you consider the more interesting?			If "yes", which one?
5. In your opinion what kind of other information should be added in this book? Or what kind of information should be cut out?			If "yes", which one?
6. For monitoring: Basing on the above answers for questions, give a summary of effective using of handout materials handed to mothers.			

Thank you!

The questionnaire for mothers for the monitoring of Community-IMCI program

OBLAST _____

RAYON_____

NAME OF THE FACILITY _____

DATE OF THE QUESTIONNAIRE GIVEN _____/_____/_____

FULL NAME OF THE MONITOR _____

FILL NAME OF THE HEALTH PROVIDER _____

INTRODUCTION AND CONSENT

Hi, my name is _____I work on behalf of the Project HOPE. We are having questionnaire process about maternity and child health. We would be very glad if you take part in this questioning. I'd like to talk to you about your health. The information given by you will be very helpful in the planning of the medical service for the population. Usually it takes 10 minutes to answer the questions.

It is up to you to take part in this questionnaire, you can decide if you should answer the question or not. Nevertheless, we hope you will participate in the questionnaire, because your opinion is very important for us. Are you going to ask us anything right now? Aren't you against?

MOTHER'S NAME _____

AGE (full year) ___ ___

NAME OF THE CHILD_____

SEX OF THE CHILD: (1 = boy; 2 = girl) → ☐

DATE OF BIRTH: _____/_____/_____
date month year

AGE OF THE CHILD (in months): ___ ___

(Stop the interview if the child's age is more than 5)

Additional information

_____

_____

_____

SECTION A: INFORMATION ABOUT THE RESPONDENT (BI)

NO.	QUESTIONS AND SELECTORS	CATEGORY CODE	PASS
BI-1	Level of your education:	No education.....1 Primary.....2 Secondary.....3 Secondary specialized.....4 Higher education.....5	
BI-2	Do you work anywhere beside your household? If "yes", where?	Housewife/don't work anywhere.....1 Working constantly.....2 Working seasonally.....3	→ SC-1
BI-3	Who takes care after your (NAME) when you are at work?	Herself.....1 Husband / partner.....2 Elderly children.....3 Relatives _____.....4 (identify) Neighbors / friends.....5 Server / in the kindergarten.....6 others_____.....96 (identify)	

SECTION D: SICK CHILD (SC)

NO.	QUESTIONS AND FILTERS	CATEGORY CODE	PASS

SC-1	Sometimes your baby gets sick and you have to see a doctor. What symptoms as they occur could be cause to apply to a doctor immediately? **MARK ALL VERSIONS OF ANSWERS GIVEN TO THE QUESTION**	I DON'T KNOW…….....88 IF HE GETS WORSE….....1 IF HE CANNOT BREASTFEED OR DRINK….....2 SLEEPING MORE THAN USUAL/ INHIBITION…3 HAVING HIGH TEMPERATURE…....…….……..4 FREQUENT AND DIFFICULT BRETH…….……5 FREQUENT VOMITING.....6 CONVULSIONS……..…...…….……...7 HAVING COGH AND COLD ……..……8 FREQUENT AND LIQUID FAECES OR BLOOD IN THE FAECES….....……..9 OTHERS _____ 96 (identify) OTHRES _____ 97 (identify)	

SECTION RI: RESPIRATORY INFECTION (RI)

NO.	QUESTIONS AND FILTERS	CATEGORY CODE	PASS
RI-1	Have you noticed a cough in your (name) during last two weeks?	YES.....1 NO .....0 I DON'T KNOW 88	→VN1 →VN1
RI-2	Have you ever noticed your (name) difficult breathing while coughing or frequent breathing than usual?	YES.....1 NO .....0 I DON'T KNOW 88	
RI-3	Have you gone to anywhere when your (name) had difficult breathing while coughing or frequent breathing than usual?	YES.....1 NO 0	→RI-6
RI-4	After your (name) began coughing when did you go to a doctor?	ON THAT SAME DAY .....0 THE NEXT DAY .....1 TWO DAYS LATER.....2 3 AND MORE DAYS LATER.....3	
RI-5	Who did you apply in order to treat your baby? **MARK ONLY ONE ANSWER**	PHYSICIAN.....1 HEALTH PROVIDER.....2 FELDSHER .....3 HEALER ……..…..…..….....4 FRIEND/RELATIVE .....5 OTHERS_____ 96 (IDENTIFY) I DON'T KNOW/I DON'T REMEMBER 88	
RI-6	What did you use to treat your baby from cough?? **MARK ALL VERSIONS OF ANSWERS GIVEN TO THE QUESTION**	NOTHING .....1 DRUGS PREPARED AT HOME.....2 MEDICINES OR SYRUP .....3 INJECTION.....4 BOILED DRUGA OF HEALER'S METHODS.....5 I DON'T KNOW/I DON'T REMEMBER...88 OTHERS_____ 96 (identify)	
RI-7	When your child (name) had a cough did you breastfeed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH .....3 I DON'T BREASTFEED.....4 I DON'T KNOW 88	
RI-8	When your child (name) had a cough did you give him/her liquid as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH .....3 I DON'T GIVE LIQUID.....4 I DON'T KNOW 88	
RI-9	When your child (name) had a cough did you feed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH .....3 I DON'T FEED .....4 ONLY BREASTFEEDING .....5 I DON'T KNOW.....88	

SECTION (VN) WORK OF THE PATRONAG NURSE

NO.	QUESTIONS AND FILTERS	CATEGORY CODE	PASS

VN1	When did the patronage nurse visit your house last?	DURING THE LAST WEEK.……1 A WEEK BEFORE……...……2 2 WEEKS BEFORE …….……..3 3 WEEKS BEFORE..……...…4 4 AND MORE WEEKS BEFORE …...5 DIDN'T VISIT……..… ……6 I DON'T KNOW ……..……..88	 →VN3 →VN3
VN2	When he visited your place what kind of information did he give?	COUGH AND COLD ……1 DIARRHEA…….…….…….2 ANEMIA…….…….……3 NUTRITION…….……..…….4 DANGEROUS SYMPTOMS .5 I DON'T KNOW ……..88	
VN3	What do you do to prevent cough and cold?	PROPERLY FEEDING.....1 ONLY BREASTFEEDING UNTIL 6 MONTH.....2 TEMPERING THE BABY….....3 KEEP DISTANCE FROM SICK PEOPLE….....4 WEAR HIM IN WARM CLOTHES.....5 USE SEPARATE DISHES….....6 I DON'T KNOW.....88 OTHERS_____ 96 (IDENTIFY) OTHERS_____ 97 (IDENTIFY)	
VN4	What methods and ways to eliminate and to make the cough less serious?	BREASTFEEDING. .....1 WARM BOILED WATER.....2 WARM MINERAL WATER….....3 OTHERS_____ 96 (IDENTIFY)	
VN5	What kind of medicines should be taken in order to make the temperature low?	PARACETAMOL…… ……1 ASPIRIN…… ……2 ANTIBIOTICS……..3 INJECTION…….…… ……4 O DON'T KNOW……88 OTHERS_____ 96 (IDENTIFY)	
VN6	How much paracetamol do you give to make the temperature lower? ***(evaluate the mother's answers according to the child's age)***	CORRECT……...…1 INCORRECT……..……2 I DON'T KNOW …….88	
If you didn't enter the section of RI (respiratory infection) ask mother the following questions			
VN7	When your child (name) had a cough did you breastfeed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH.....3 I DON'T BREASTFEED.....4 I DON'T KNOW.....88	
VN8	When your child (name) had a cough did you give him/her liquid as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH.....3 I DON'T GIVE LIQUID.....4 I DON'T KNOW.....88	
VN9	When your child (name) had a cough did you feed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL.....2 MUCH.....3 I DON'T FEED .....4 ONLY BREASTFEEDING .....5 I DON'T KNOW.....88	

SECTIOND: DIAREA (D)

N.	QUESTIONS AND FILTERS	CATEGORY CODE	PASS
D-1	Have you noticed the symptoms of liquid faeces of your child?	YES .....1 NO I DON'T KNOW.....88	 →D-3 →D-3
D-2	What did you give from diarrhea? What else? **CIRCLE ALL ANAMED SYMPTOMS**.	NOTHING.....1 ORS POCKET LIQUID.....2 HOME PREPARED LIQUID .....3 MEDICINE OR SYRUP .....4 INJECTION .....5 INTROVENUES.....6 OTHER HOME PREPARED MEDICINES AND DRUGS……...7 OTHERS_____ 96 (IDENTIFY)	
D-3	When your child (name) had a diarrhea did you breastfeed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL .....2 MUCH.....3 I DON'T BREASTFEED.....4 I DON'T KNOW.....88	
D-4	When your child (name) had a diarrhea did you give him/her liquid as usual, more or less than usual?	LITTLE.....1 AS USUAL .....2 MUCH.....3 I DON'T GIVE LIQUID.....4 I DON'T KNOW.....88	
D-5	When your child (name) had a cough did you feed him/her as usual, more or less than usual?	LITTLE.....1 AS USUAL .....2 MUCH.....3 I DON'T FEED .....4 ONLY BREASTFEEDING .....5 I DON'T KNOW.....88	
D-6	Did you ask anybody about the treatment of diarrhea when your (name) got diarrhea?	YES .....1 NO.....0	 →D-8
D-7	Where will you go in order to treat or have a consultation about this disease? MARK ONLY ONE ANSWER	Oblast hospital..... 1 Rayon hospital..... 2 Rayon polyclinic ..... 3 SUB..... 4 SVP ..... 5 SVA..... 6 Feldsher post ..... 7 HEALER..... 8 FRIEND/RELATIVE..... 9 OTHERS_____ 96 (IDENTIFY) I DON'T KNOW/DON'T REMEMBER88	
D-8	**What should be done in order to prevent diarrhea?** **MARK ALL VERSIONS OF ANSWERS GIVEN TO THE QUESTION**	WASHING HANDS BEFORE HAVING A MEAL .....…1 WASHING HANDS AFTER TOILET.....…2 DRINK BOILED WATER….……...3 EAT WASHED FRUIT AND VEGATEBLES.....….4 BURY A CHILD'S FAECES/OR DROP IN TO THE TOILET……5 STRUGGLE AGAINST INSECTS ……..6 ONLY BREASTFEEDING UNTIL 6 MONTHS…….……7 KEEP CHILD'S THINGS CLEAN……..…..8 GIVING VARIOUS NEW FOOD……..…..…….9 WASHING HANDS BEFORE COOKING .....……..10 WASHING A CHILD'S HANDS BEFORE FEEDING HIM……...11 OTHERS_____96 (IDENTIFY) I DON'T KNOW…….....88	

THANK YOU!

Evaluation Questions for C-IMCI Program Monitoring for Visiting Nurses

1. How will you act if a mother doesn't pay much attention while you are talking to her?

2. How do you have to proceed in order not to loose the contact during conversation?

3. Please, name general danger signs (signs of child illnesses that are risky to a child's life)

4. What signs of a child with pneumonia require treatment?

5. What signs a child with pneumonia who has being treated at home should have in order to re-visit a doctor?

6. What signs of a child with diarrhea require treatment?

7. Identify the correct way of preparing the rehydron solution.

8. How the Rehydrone should be taken?

9. What should be the correct amount of food provided to a child with diarrhea?

10. What much of liquid should be provided to a child with diarrhea?

11. What is the correct action to prevent dehydration in an infant with diarrhea, who has been under exclusive breast feeding?

12. Please, name signs of dehydration?

13. What actions should be taken in order to prevent diarrhea?

14. Where one has to refer when ones child gets seek?

Family Planning Consultation Interview

Date of monitoring:		Rayon (Karmana-1, Kiziltepa-2,Konimekh-3, Nurota-4 :			
Name of the facility					
Interviewer:		Respondent name		Respondent age:	

Instruction for an interviewer:

Family planning consultation interview will be conducted with a woman of fertile age at the place where patronage health provider (visiting nurse) is working:

Hi. My name is _____. I'm from project HOPE. We would like to know your (women) opinion on the services of the facility promoting family planning program and the consultations given to you as well. I have several questions to you and I'd be very grateful if you share your time for me. I'll non write your name. the information given by you will be kept in secret. We don't mind if you do not want to answer our questions.

№	Questions and filters	Answers	Skip
1	Have you ever heard about healthy family planning?	Yes .....1 NO.....0	
2	Which of the modern contraceptive ways or prevention of undesirable pregnancy do you know? Please, count.	Tablet /pill ……..……..1 IUD ……..……2 Injections (Depo Provera)..……..…3 Norplant ….……..…….…..4 Women sterilization...…….…...5 Preservative..…….6 Spermicides..…….7 Natural rhythm…….…….. ……...8 LAM…….....9 Others (specify)_____.....96	
		YES if more than 2.....1 NO if less than two.....0	
3	Have you used any ways of contraceptive ways?	Yes ..... 1 No..... 0	→9
4	Which contraceptive ways have you used or are you using? MARK ALL ANSWERED VERSIONS	Tablet /pill ……..……..1 IUD ……..……2 Injections (Depo Provera)..……..…3 Norplant ….……..…….…..4 Women sterilization...…….…...5 Preservative ..…….6 Spermicides ..…….7 Natural rhythm…….…….. ……...8 LAM…….....9 Others (specify)_____.....96	
5	When visiting your place has the medical provider ever asked you if you face any problems in using the contraceptive methods?	Yes ..... 1 No..... 0	
6	Have you had any problems while using contraceptive methods **Probe:** (You were going to consult with the medical provider)?	Yes ..... 1 No 0	→11
7	What is the most problematic when you used this method? (mark only one problem)	Acute pain in stomach.....1 Acute headache.....2 Acute breast pain …….....3 Acute bleeding.....4 Disorder of menses periods …….....….5 Rushes …….....….6 Nausea .....…7 Dizzy .....…8 Indifference to sex.....9 Getting fat…….....10	

№	Questions and filters	Answers	Skip
		Others (specify).....96	
8	Were you satisfied with the medical worker's advice or treatment in order to solve your problem?	Yes ..... 1 No..... 0	
9	Has the medical worker recommended you about some contraceptive methods?	Ҳа, тавсия/маслахат берди…..…1 Йўқ.....0	→13
10	Which contraceptive method did the medical worker discussed with you about? MARK ALL THE ANSWERED VERSIONS	Tablet /pill ……..……..1 IUD ……..……2 Injections (Depo Provera)..……..…3 Norplant ….……..…….…..4 Women sterilization...…….…...5 Preservative ..…….6 Spermicides ..…….……7 Natural rhythm…….. ……...8 LAM…….....9 Others (specify)_____.....96	
11	***About the above answered methods:*** **a** Did the medical provider show you how to use the method?	YES…….…….....1 NO…….....0 DO NOT KNOW..….....88 THE QUESTION IS NOT PROPER …….....87	
	b. Did the medical provider explain the possibility of side effects ?	YES…….…….....1 NO…….….....0 DO NOT KNOW..…..….....88	
	c. Was it explained what should be done if the problems occur?	YES…….…….....1 NO…….….....0 DO NOT KNOW..…..….....88	
	d. Was it explained that the very method prevents STDs and AIDS	YES…….…….....1 NO…….….....0 DO NOT KNOW..…..….....88	
12	Were you warned about the following visit to your house by the health provider?	YES…….…….....1 NO…….….....0 DO NOT KNOW/DO NOT REMEMBER..…..….....88	
13	Did you talk with health provider about STDs and AIDS?	YES…….…….....1 NO…….….....0 DO NOT KNOW..…..….....88	
14	How can be identified the existents of sexual transmitted diseases of men? Any other? MARK ALL THE ANSWERED VERSIONS	Pain in the lower part of stomach..... .....……1 Dropping secretion from male sexual organ .....2 Unpleasant smell of secretion .....3 Burning sensation while urination.....4 Frequent urination .....5 Getting reddish or rub of sexual organ.....6 Pain and oedema around sexual organs or…….....7 Pain / sores on sexual organs..... 8 Warts on sexual organs ..... 9 Blood in urine..... 10 Sexual impotence ..... 11 YES if more than 2…….....1 NO if less than 2.....0	

№	Questions and filters	Answers	Skip
15	How can be identified the existents of sexual transmitted diseases of women? Any other? MARK ALL THE ANSWERED VERSIONS	Pain in the lower part of stomach.....……1 Dropping secretion from male sexual organ .....2 Unpleasant smell of secretion .....3 Burning sensation while urination.....4 Frequent urination .....5 Getting reddish or rub of sexual organ.....6 Pain and oedema around sexual organs or…….....7 Pain / sores on sexual organs.....8 Warts on sexual organs .....9 Blood in urine.....10 No symptom .....11 Sterility.....12 YES if more than 2…….....1 NO if less than 2.....0	
16	Can the STDs be without any symptoms?	YES.....1 NO/Do not know…….....0	
17	Is there any prevention way to avoid both men and women STDs?	YES.....1 NO/Do not know…….....0	→**20**
18	What must man or woman do to prevent themselves from STDs? Any other? MARK ALL THE ANSWERED VERSIONS	Keeping himself/herself from sexual contact.. ..... 1 Using preservation ..... 2 Having an only sexual partner ..... 3 Limiting the number of sexual partners..... 4 No contact with prostitutes ..... 5 No contact with people who have several sexual partners …6 No exchange with shaving articles.. ..... 7 YES if more than 2…….....1 NO if less than 2.....0	
19	At whay period of menses cycle there is more possibility of being a woman pregnant?	In the middle of menses cycle.....1 As soon as the menses cycle is over.....2 Before the beginning of menses cycle.....3 Do not know /do not remember.....88 Others 96 YES if the 2nd version was answered.....1 NO if other versions.....0	
20	How long should a woman expect the following pregnancy after delivery?	Months _____ YES if the period after delivery is 24 months.....1 NO if other versions.....0	

Show the book, brochure

QUESTION	YES	NO	DETAILED ANSWERS
1. Have you ever seen the leaflet "Family Planning"?			STOP if the answer is NO.
2. Do you have this book?			
3. Do you like the cover and the book itself?			Why?
4. Which part do you think is more interesting for you?			If YES, which one?
5. In your opinion what other information should be added or cut?			If YES, which one?
6. For monitors: According to the above answers decide if the women are using the book effectively.			

Thank you for your interview!

Evaluation List on monitoring on Reproductive Health of Visiting (Patronage) nurses

Oblast _____ Rayon _____

Leader _____ Medical worker_____

Date _____ Facility name _____

№	Indicators	Yes=1, No=0, inappropriate ①	
1	Greeted a woman with respect.		
	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient?		
2	Explained the woman that the information she has given during the interview will be kept in secret?		
3	Had a very briefly talk providing the necessary information for her and asked question concerning only the topic.		
4	Provided about the all methods of contraception, their effect of mechanism. Advantageous and disadvantageous?		
5	Used visual aids, such as posters, pictures, samples of contraceptives, plaster cast and at the same time was able to make the listener be interested and participate?		
6	Explained all necessary information about STDs?		
7	Corrected any problems unclear to the patient?		
8	Asked the patient if he/she is satisfied with the method she had chosen and continuous using it? Asked the occurring problems?		
9	Asked the patient to show how she uses chosen contraception method and asked to show again if it was necessary in order to be confirmed in the correct usage.		
10	Checked if there is any side effects of the contraception? Recommended to have necessary procedures or to go to a more qualified specialist in case of necessity?		
11	Explained the patient that she/he can stop and if wants not to use that method at any time again.		
12	Explained the patient when to come for the second examination? Asked to go to a medical provider if some problems and questions occur?		
13	Fixed the dates and time of following visits?		
14	Saw off the woman politely and asked to come to the physician at any time she needs.		
15	FPCEI = №2 Which modern contraceptive ways do you know? Please, count.		
16	FPCEI = №5		
17	FPCEI = №8		
18	FPCEI = №11		
19	FPCEI = №14		
20	FPCEI = №15		
21	FPCEI = №18		
22	FPCEI = №19		
23	FPCEI = №20		
24	Were tested: (0=<55%; 1=55%-69%; 2=70-84%; 3=85-100%)		
25	Using the book (item №6)		
	Total sum of 1 and ① /27 and %		

TEST QUESTIONS FOR PATRONAGE NURSES
ON REPRODUCTIVE HEALTH

1. What types of contraceptives can be used immediately after delivery?
2. What types of contraceptives can be used after the six-week period after delivery?
3. When should a woman who wants take COC shall start doing it for the first time?
4. Instruction on taking COC :
5. If a woman forgets to take one or two pills then she has to:
6. Which of the followings belongs to side effects of COC?
7. Please, give the correct description of Depo-Provera:
8. DMPA injection is done every:
9. A Copper T 380 type IUD shall be taken out or replaced, according to will of the woman, after the following period of time
10. 10 . The following types of women may not have IUD:
11. If a woman with IUD can not feel thread of the IUD after a menstrual cycle, she has to:
12. Natural methods include the followings:
13. LAN is effective in the following case:
14. Who may use the Standard Days Method?
15. The advantages of the Standard Days Method does not include:
16. What is the most important feature of condoms?
17. Disadvantages of the spermicides include:
18. The signs of STD in a woman include:
19. Which of the followings is important in providing consultation on sterilization?
20. Sterilization is recommended to the following types of women:

home visit

Consulting by the Patronage (Visiting) nurses Family Planning program

Date of monitoring:		Oblast		Rayon	
Name of the facility					
Observer:		Medical Provider:			

	Steps\ duties	yes/no	
	General skills of Consulting		
1	Greeted a woman with respect.	1	0
	Kept patience while talking with a woman, did not interrupt her and listened her attentively.	1	0
2	Showed respect and didn't criticize her.	1	0
3	Knows all the about contraceptive methods very well.	1	0
4	Explained the woman that the information she has given during the interview will be kept in secret.	1	0
5	Had a very briefly talk providing the necessary information for her and asked question concerning only the topic.	1	0
6	Used visual aids, such as posters, pictures, samples of contraceptives, plaster cast and at the same time was able to make the listener be interested and participate.	1	0
7	Asked open questions.	1	0
8	Sexual transmitted diseases (STDs): • Symptoms at women • Symptoms at men • The evidence of STDs without symptoms • Where to apply if there are symptoms of STDs • Ways of prevention	1	0
9	Gave the opportunity to a woman to ask a question, was very laconic while speaking, gave the correct and proper recommendations.	1	0
10	Explained the information by different ways until she was confirmed that she supplied the woman with necessary conception.	1	0
11	Asked the women to repeat the given information in order to be confirmed in her strong knowledge.	1	0
	Women using contraceptive methods		
1	Has a woman's life, her mode of life been changed since she had visited the physician. Whether it was asked the reason of changing the contraception methods or stop using them at all.	1	0
2	Asked the woman whether she is satisfied with the chosen contraception method and whether she continuous using them.	1	0
3	Asked the woman to show how she uses chosen contraception method and asked to show again if it was necessary in order to be confirmed in the correct usage.	1	0
4	Identified if here are some problems while using the contraception. Instructed the woman more deeply if it was necessary.	1	0
5	Helped the woman to be calm in case if she had expected more negative effect from chosen contraceptive method.	1	0
6	Answered the woman's questions.	1	0
7	Write necessary prescriptions (and recommendations) for getting more contraceptives.	1	0
8	Fixed the following visiting dates and time.	1	0
9	Left the woman's place politely and asked to come to the physician at any time she needs.	1	0
10	**Used skills communications during the interview:**	1	0
	Asking and listening?		
	Encouraging?		
	Advising / recommending?		
	Examining?		

Evaluation List on Reproductive Health consultation in out-patient health facility

Oblast _____ Rayon _____

Monitor _____ Medical worker_____

Date _____ Facility name _____

№	**Indicators**	**Yes=1, No=0,** N/a ①
1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient?	
2	Explained the woman that the information she has given during the interview will be kept in secret?	
3	Had a very briefly talk providing the necessary information for her and asked question concerning only the topic.	
4	Provided information about the all methods of contraception, their effect of mechanism. Advantageous and disadvantageous?	
5	Used visual aids, such as posters, pictures, samples of contraceptives, plaster cast and at the same time was able to make the listener be interested and participate?	
6	Gave an opportunity to the patient to ask questions?	
7	Asked the women to repeat the given information in order to be confirmed in her strong knowledge by giving open questions and showing it in the practice	
8	Explained all necessary information about STDs?	
9	Corrected any problems unclear or wrong information to the patient?	
10	Identified the objective of the reproductive health of the patient, gathered the patient's general and reproductive anamnes and identified the accuracy while using contraceptive methods at the somatic state?	
11	Provided the necessary information of chosen contraceptive methods (its advantageous and disadvantageous, effectiveness, mechanism, using, applying to a specialist in case if some dangerous symptoms occur.	
12	Explained the patient about the effectiveness of chosen contraceptive methods in preventing or not preventing from STDsand if it is necessary using preservatives additionally.	
13	Explained the patient that she /he can stop and if wants not to use that method at any time again.	
14	Explained the patient when to come for the second examination and to ask about the chosen method? Asked to go to a medical provider if some problems and questions occur?	
15	Informed the patient about the getting spare contraceptive method he/she has chosen?	
16	Concrete (chosen) method:_____ Informed and about the qualities of the concrete method?	
17	The patient is satisfied with the method chosen and continous using it?Asked if there are any problems or not?	
18	Asked the woman to show how she uses chosen contraception method and asked to show again if it was necessary in order to be confirmed in the correct usage.	
19	Checked if there are any negative sides of the contraception? Recommended to have necessary procedures or to go to a more qualified specialist in case of necessity?	
20	FPCEI = №2 СОШ What kind of modern contraceptive methods do you know? Please, list.	
21	FPCEI = №5	
22	FPCEI = №8	
23	FPCEI = №12	
24	FPCEI = №15	
25	FPCEI = №16	
26	FPCEI = №19	
27	FPCEI = №20	
28	FPCEI = №21	
29	Were tested: (0=<55%; 1=55%-69%; 2=70-84%; 3=85-100%)	
30	Using the book (Interview: item №6)	
	Total sum of 1 and ① /32 and %	

MAIN SKILLS AND STEPS OF THE FAMILY PLANNING CONSULTING

Observation form

Monitoring date:		Oblast		Rayon	
Name of the facility					
Observer:		Medical worker:			

Type of consultation _____ Method of contraception_____

	steps\objectives	YES/NO	
	General skills of consulting		
1	Kept patience while talking with a patient, did not interrupt her and listened her attentively.	1	0
2	Showed respect and didn't criticize the patient.	1	0
3	Knows all the about contraceptive methods very well.	1	0
4	Explained the patient that the information she has given during the interview will be kept in secret.	1	0
5	Had a very briefly talk providing the necessary information for her and asked question concerning only the topic.	1	0
6	Used visual aids, such as posters, pictures, samples of contraceptives, plaster cast and at the same time was able to make the listener be interested and participate.	1	0
7	Asked open questions.	1	0
8	Sexual transmitted diseases (STDs): • Symptoms at women • Symptoms at men • The evidence of STDs without symptoms • Where to apply if there are symptoms of STDs • Ways of prevention	1	0
9	Gave the opportunity to a woman to ask a question, was very laconic while speaking, gave the correct and proper recommendations.	1	0
10	Explained the information by different ways until she was confirmed that she supplied the woman with necessary conception.	1	0
11	Asked the women to repeat the given information in order to be confirmed in her strong knowledge.	1	0
	<u>Primary consultation</u>		
1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself.	1	0
2	Briefly explained about the influence mechanism of all FP methods	1	0
3	Explained the advantageous and disadvantageous of every method	1	0
4	Identified the patients preference in using the contraceptives and asked if he possess the informatio method chosen by him.	1	0
5	Corrected any wrong and unclear information	1	0
6	Answered any question if the patient	1	0
	Consultation on the method (secondary)		
1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself.	1	0
2	Identified the objective of the reproductive health of the patient, gathered the patient's general and reproductive anamnesis and identified the accuracy while using contraceptive methods at the somatic state?	1	0
3	Asked the patient about the knowledge of the chosen contraceptive method, corrected the wrong information.	1	0

reception

4	Briefly explained about the influence mechanism of contraceptive methods: • Effectiveness • influence mechanism • usage • advantageous and disadvantageous • negative sides • Unsafeness from STDs • Necessity preservative usage additionally • Apply to the specialist as soon as some dangerous symptoms occur	1	0
5	Emphasized: it's the patient's preference in using or not using the contraceptive methods.	1	0
6	The medical worker checked if the patient is confident in using the chosen contraceptive method.	1	0
7	Instructed the patient about the usage of contraceptive methods by the following questions: • The rules and techniques of using the method • Applying the physician as soon as some problems occur. • The place of getting more contraceptives • What to do in case not breaking the rules of usage • Answered the patients questions	1	0
8	Asked the patient to repeat the instruction and answered all the questions.	1	0
9	tablets: -measuring blood pressure -examining for pregnancy -asking about smoking or not smoking -unclear vaginal bleeding IUD: - gynecologic examination -examining for pregnancy -clarifying the date of the last pregnancy - Hb level - Pap-test Injections: -measuring blood pressure --examining for pregnancy -unclear vaginal bleeding - chronic liver failure Surgery: -surgery in the part of stomach -examining for pregnancy -identifying chronic diseases Preservatives: - asking about allergy for latex Spermicides: - asking about complications during last pregnancy - asking about allergy status Natural rhythm: - asking about complications during last pregnancy - menses status	1	0
10	Explain the patient when to come for the second examination. Recommended to come to the specialist if there are some problems.	1	0
11	Saw off the patient politely and asked to come at any time.	1	0
	Repeated Consultation(tertiary)		
1	Met the patient with respect and asked them to have a seat and feel comfortable.	1	0
2	Has a woman's life, her mode of life been changed since she had visited the physician. Whether it was asked the reason of changing the contraception methods or stop using them at all.	1	0
3	Asked the woman whether she is satisfied with the chosen contraception method and whether she continuous using them.	1	0
4	Asked the woman to show how she uses chosen contraception method and asked to show again if it was necessary in order to be confirmed in the correct usage.	1	0
5	Identified if here are some problems while using the contraception. Instructed the woman more deeply if it was necessary.	1	0
6	Helped the woman to be calm in case if she had expected more negative effect from chosen contraceptive method.	1	0
7	Answered the woman's questions.	1	0
8	Write necessary prescriptions (and recommendations) for getting more contraceptives.	1	0
9	Fixed the following visiting dates and time.	1	0
10	Saw off the patient politely and asked to come at any time.	1	0

Test Questions for Ob-Gyn, GP, and Midwifes

1. What types of contraceptives might be applied right after delivery?
2. What types of contraceptives might be applied in 6-weeks period after delivery?
3. What is the right time to use IUD after giving a birth?
4. The breast feeding may not be considered as an effective contraceptive if:
5. Instructions on using COC:
6. What is the right time for a woman who wants to start taking COC?
7. If a woman forgets to take one or two tablets she has to:
8. Which of the followings is more characteristic to COCs' side effects?
9. Prior to Depo-Provera injection a doctor has to make sure that a woman does not have:
10. Usage of progestin pills is prohibited if:
11. What is the right description of Depo-Provera?
12. When a woman may get IUD?
13 . The following types of women may not use IOD:
14. If a woman with IUD can not feel its threads after an menstrual cycle she has to:
15. In using IUD the caution is not required if:
16. How may sexually active person protect himself/herself from HIV/AIDS?
17. The followings belong to STD signs in women:
18. In case of unavailability of lab facilities, how can one be checked for STDs?
19. What is the procedure to take low dosage (30-35) AOK for immediate contraception?
20. Which of the followings is important in giving advices on sterilization?
21. Is sterilization advised to the following women?

home visit

Evaluation list on monitoring of out-patient work by the "Safe Motherhood" program

(Postpartum care)

Check-list

Monitoring date:		oblast:		Rayon:	
Medical worker:		Facility name:			
Monitor:		Type of consultation: delivered woman (infant under1,5 months):			

Post natal period			
№	**Indicators (source)**	**Yes=1, No=0,** inappropriate①	
1.	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient (OPSO1)		
2.	Asked about the woman's state. Had a very briefly talk, only necessary information. Asked clear and proper questions. Asked open questions. Made the woman be interested in giving questions. (OPSO2-3)		
3.	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions. (OPSO4)		
4.	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant. (OPSO5)		
5.	Fixed the time of the following visit and explained how many times she should visit health facility after delivery. (OPSO6)		
6.	Explained the dangerous symptoms for mother and a baby. Used "mother's home book" for it. (OPSO7)		
7.	Explained the importance of breastfeeding. Asked if there are problems of breastfeeding and give recommendations. (OPSO8)		
8.	Explained about the nutrition of thepegnant/delivered women. (OPSO9)		
9.	At this visit all the necessary examinations have been carried out. (OPSO15-17)		
10.	Explained about the possible dangerous symptoms of post natality. (OPSO11)		
11.	Explained about the dangerous symptoms during the taking care of the baby. (OPSO12)		
12.	Informed where to go in case if there are dangerous symptoms. (OPSO13)		
13.	Informed how to take care of the baby. (OPSO14)		
14.	Gave necessary recommendations about the contraception methods after delivery.. (OPSO18)		
15.	Used communication skills during the interview. (OPSO19)		
16.	Having a conversation about the differences between deliveries. (OPI 3c)		
17.	The knowledge of the woman after delivery. (OPI 4)		
18.	The knowledge of the woman about the possible dangerous symptoms of babies. (OPI 5)		
19.	Satisfaction of the patient after visiting the specialist. (OPI 7)		
20.	Test: 55-70%=1 score, 71-85%=2 scores, 86-100%=3 scores		
21.	Having recommended protocols of postnatal period of ЖССТ (OPSO, OPI 8)		
22.	The medical workers work and uasage with the "Mother's home book". (OPSO7)		
23.	The objective visits of the pregnant women (more than 3 times) (OPI 20)		
24.	The gap difference between the previous and a just born baby must be 24 and more months. (OPI 10)		
	Total sum of 1 and ① is/25 and %		%

For monitoring: the question №24 is not considered at the time of summing and making percentage.

Observation for consultation by the "Safe Motherhood" program

(delivered woman)

MONITORING DATE:		Oblast		Rayon:	
Medical worker:		Facility name:			
Monitor:		Type of consultation: delivered woman (infant under1,5 months):			

The delivered woman should visit the doctor at least once during 1,5 months, or the visiting nurse should visit her during a week.

	steps\objectives	**practice yes=1, no=0,** inappropriate ①
	GENERAL SKILLS OF CONSULTATION	
OPSO1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient (OPSO1)	
OPSO2	Asked about the woman's state. Had a very briefly talk, only necessary information. Asked cleat and proper questions.	
OPSO3	Asked clear and proper questions. Asked open questions. Made the woman be interested in giving questions	
OPSO4	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions	
OPSO5	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant.	
OPSO6	Fixed the time of the following visit and explained how many times she should visit DPM after delivery.	
OPSO7	Explained the dangerous symptoms for mother and a baby. Used "mother's home book" for it.	
OPSO8	Explained the importance of breastfeeding. Asked if there are problems of breastfeeding and give recommendations	
OPSO9	Explained about the nutrition of thepegnant/delivered women. (1-if the answers from 9a – 9g, otherwise – 0)	
OPSO9a	Feeding with bread and bread production, rice, potato, whet products several times a day.	
OPSO9b	Feeding with fruits and vegetables, greens which are rich in vitamins several times a day.	
OPSO9c	Feeding with dairy products which contain less oil.	
OPSO9d	Feeding with oily less meat or wheat vegetables.	
OPSO9f	Feeding with sweets and oily products less than it was asked	
OPSO9g	Not to drink tea or Coca-Cola after having meal	
OPSO10	If there are any dangerous symptoms of the delivered woman or of the baby was sent to the facility immediately	
OPSO11	Explained about the possible dangerous symptoms of post natality (1- if two answers from 16a to 16c,otherwise– 0)	
OPSO11a	The temperature is above 38°C, fever	
OPSO11b	bleeding	
OPSO11c	Unpleasant smell of excretions	
OPSO12	Explained about the dangerous symptoms during the taking care of the baby. (if 6 from 17a - 17h , otherwise – 0)	
OPSO12a	Rare breastfeeding	
OPSO12b	Шайтонлаш	
OPSO12c	Frequent or difficult breathing	
OPSO12d	Getting red or pus of the umbilical	
OPSO12e	Changing the body temperature	
OPSO12f	Weakness and excitement	
OPSO12g	Diarrhea or vomiting	

OPSO12h	Getting blue the palm and foot/around the mouth		
OPSO13	**Where to go if there are dangerous symptoms**		
OPSO14	INFORMED THE WOMAN HOW TO TAKE CARE OF THE BABY (SWADDLING, BATHING, MAKING MASSAGE, WHAT TO DO WHEN THE BABY CRYING)		
OPSO15	Checked the breast and its tops		
OPSO16	Examined woman's stomach and measured the uterus height in order tobe confirmed in shortening if uterus bottom.		
OPSO17	Examined secretion		
OPSO18	Gave necessary recommendations about the contraception methods after delivery		
OPSO18a	Asked the patient about the reproductive aim. Identified the somatic state of the patient in order to be care in using the contraception methods and in collecting the patient's general and reproductive anamnesis.		
OPSO18b	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant.		
OPSO18c	Informed about STDs		
OPSO18d	Briefly informed about all methods of FP and their mechanism.		
OPSO18e	Explained about the advantageous and disadvantageous of each method.		
OPSO18f	Asked the patient about the method she was interested and asked if she needs the informatior method chosen.		
OPSO18g	Asked the patient about the information of the chosen contraceptive method and corrected the wrong information.		
OPSO18h	Asked the patient to repeat the given information and responded all the unclear questions and misunderstandings.		
OPSO18i	Explained when to come for the following examination. Emphasized the necessity of the visit if any problems or questions occur.		
OPSO19	**Using communication skills during consultation:**		
	Asking and listening?		
	Encouraging?		
	Advising?		
	Checking?		

PNC OUT-PATIENT INTERVIEW **home visit**

Interview with mother on the post natal care by the "Safe Motherhood" program monitoring

Monitoring date:		oblast:		Rayon:	
Medical worker::		Facility name:			
Monitor:		Type of consultation: delivered woman (infant under1,5 months):			

OPI 1	When did you deliver? *Write the answer in months. Write «-» if she does not know*	_____months
OPI 2	When did the medical worker visit you for the first time after delivery? (After you have left the facility?) *Write the answers in days*	_____ weeks

OPI 3	I'D LIKE TO KNOW ABOUT THE SERVICE TO YOU DURING THAT CHILLA PERIOD. DID THE MEDICAL WORKERS DO THE FOLLOWING PROCEDURES? *Ask about the each procedure*	*Mark only one answer for each procedure*
{OPI 3a}	WERE Fe AND FOLIC ACID RECOMMENDED	**1** YES **0** NO
{OPI 3b}	WERE THE INSTRUCTIONS GIVEN ABOUT THE PROPER NUTRITION	**1** YES **0** NO
{OPI 3c}	HAD THE WOMEN CONVERSATION WITH FAMILY ABOUT THE CHILD SPACE INTERVAL	**1** YES **0** NO
{OPI 3d}	WHAT WAS TOLD ABOUT SEXUAL TRANSMITTED DISEASES?	**1** YES **0** NO
{OPI 3e}	WAS IT EXPLAINED HOW YOU SHOULD GET TO THE FACILITY IN CASE OF THE EMERGENCY	**1** YES **0** NO
{OPI 3f}	WERE YOU INFORMED ABOUT ONLY BREASTFEEDING	**1** YES **0** NO
{OPI 3j}	INFORMED YOU HOW TO TAKE CARE OF THE BABY (SWADDLING, BATHING, MAKING MASSAGE, WHAT TO DO WHEN THE BABY CRYING)	**1** YES **0** NO

OPI 4	AFTER WHAT KIND OF DANGEROUS SYMPTOMS YOU MUST GO TO THE DOCTOR? *Mark all the answered versions*	FEVER.....1 BLEEDING.....2 UNPLEASANT SMELL EXCRETIONS .....3 OTHRES_____.....96 (specify) DON'T KNOW 88 *IF 2 AND MORE CORRECT ANSWERS .....1* *ON OTHER CASE.....0*
OPI 5	WHAT KIND OF DANGEROUS SYMPTOMS SHOW YOU THAT YOU MUST GO TO THE DOCTOR? *Mark all the answered versions*	RARE BREASTFEEDING.....1 CONVULSIONS.....2 FREQUENT OR DIFFICULT BRETHING.....3 GETTING RED OR PUS OF THE UMBILUCAL CORD .....4 CHANGING OF THE BODY TEMPERATURE.....5 WEAKNESS OR EXCITEMENT.....6 DIAHHREA OR VOMITTING.....7 GETTING BLUE OF THE PALM AND FOOT OR ARROND THE MOUTH.....8 *IF 2 AND MORE CORRECT ANSWERS .....1* *ON OTHER CASE.....0*

OPI 6	DO YOU KNOW WHERE YOU SHOULD GO IFTHE DANGEROOUS SYMPTOMS APPEARA?	**1** YES **0** NO
OPI 7	ARE YOU SUTISFIED OF TODAY'S VISIT OF THE MEDICAL WORKER?	**1** YES **0** NO
OPI 8	**FOR MONITORS:** According to the answers N 3-7 identify if the way of writing protocols based on WHO is correct during the postnatal period?	**1** YES **0** NO
OPI 9	Do you have other children besides this baby?	**1** YES **0** NO (OPI 11)
OPI 10	How old is the youngest? (if it is necessary identify the date of birth)	24 months and more…….. **1** Less than 24 months…… **0**

It is necessary to check mother's home book if possible.

PNC OUT-PATIENT INTERVIEW **home visit**

The pregnant woman had to visit the specialist at least 3 times. **(order №425 table, according to gestation age).**

	To examine the last pregnancy correctly	**Ҳа=1, Йўқ=0,** inappropriate①
OPI 11	At what time of your last pregnancy did you visit the specialist? *Mark **1** if the pregnancy was not more than 12 weeks, otherwise **0***	
OPI 12	How many times was your blood pressure measured? *(the blood pressure must be measured at each visit)* *mark**1**if 3 and more, otherwise **0***	
OPI 13	HOW MANY TIMES THE HEART PALPITATION OF YOUR PREGNANCY WAS MEASURED? *(The heart palpitation and the fetus movement is measured after 18-20 weeks)* *mark **1** if 3 and more, otherwise **0***	
OPI 14	Was your weight and height measured / your weight of body index? *mark**1** if 3 and more, otherwise **0***	
OPI 15	How many times was your uterus bottom measured? *mark**1** if 3 and more, otherwise **0***	
OPI 16	How many times did you have analysis for Hb? *mark**1** if 3 and more, otherwise **0***	
OPI 17	Do you know your blood rhesus and blood group? 1 YES 0 NO	
OPI 18	Were you told about the results of your HIV, syphilis, gonorrhea, захм, hepatitis B analyses? 1 YES 0 NO	
OPI 19	How many times did you have urine analyses? *mark**1** if 3 and more, otherwise **0***	
OPI 20	**For monitors:** Considering the above OPI 11-19 and MHB **How many visits were the objective visits of the pregnant woman?** *mark**1**if 3 and more, otherwise **0***	

THANK YOU FOR YOUR INTERVIEW, IF YOU HAVE ANY QUESTION WE ARE HAPPY TO ANSWER

TEST QUESTIONS FOR OB-GYNS, GPs, AND MIDWIVES ON SAFE MOTHERHOOD

1. Which of the followings is not responsibility of the HP at a Village Health Post (VHP-SVP)?

2. Which infections do not affect pregnancy?

3. What signs and symptoms may indicate pregnancy?

4. In conduct of routine medical checks of pregnant women with pregnancy for more than 16 weeks what checks should be conducted each time?
5. Which of the following changes do not belong to natural changes that are characteristic to pregnancy?
6. Which of the followings does not belong to advantages of using the Mother Home Card

7. What criterion is used to diagnose severe pre-eclampsia?

8. The causes of bleeding during the first trimester of pregnancy include:

9. The effective records in medical records (primary health care level) shall be as follows:

10. What danger signs, during pregnancy, imply necessity of seeing a doctor? (name any six)

11. What danger signs during postpartum period indicate to necessity for immediate medical assistance? (name any four)

12. What procedures are required to treat anemia?

13. What should a patronage nurse bring with her in her visits to a house of a pregnant women?

home visit: pregnant woman

Evaluation list on monitoring of out-patient work by the "Safe Motherhood" program

(Pregnant woman)

Check-list

Monitoring date:		Oblast :		Rayon:	
Medical worker:		Facility name:			
Monitor:		Consultation type: first pregnancy			

Antenatal/postnatal period		
№	**indicators (sources)**	Yes=1, No=0 inappropriate①
1.	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient (OPSO1)	
2.	Asked about the woman's state. Had a very briefly talk, only necessary information. Asked proper and appropriate questions. Made the woman be interested in giving questions (OPSO2-3)	
3.	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions.	
4.	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant.OPSO5)	
5.	Fixed the time of the following visit and explained how many times she should visit health facility after delivery.(OPSO6)	
6.	Explained the role of the woman and mahalla for the safety life of her future baby and used the "Mother's home book". (OPSO7)	
7.	Explained the importance of breastfeeding. Asked if there are problems of breastfeeding and give recommendations.(OPSO8)	
8.	Explained about the nutrition of thepegnant/delivered women. ((OPSO9)	
9.	Examined all necessary things at the time of the visit. (OPSO11)	
10.	Explained and advised the woman where to deliver? (OPSO12)	
11.	Explained about the possible dangers during pregnancy (OPSO14)	
12.	Explained about the possible dangerswhile delivering. (OPSO15)	
13.	Explained about the possible dangers after delivery (OPSO16)	
14.	Explained about the possible dangerswhile taking care of the baby. (OPSO17)	
15.	Explained where to go if there are dangerous symptoms. (OPSO18)	
16.	Explained about the advantageous of her partner participance during the delivery. (OPSO19)	
17.	Gave advice about contraception methods after delivery. (OPSO20)	
18.	Used communication skills during consultation:(OPSO21)	
19.	Knowledge of the woman about the dangerous symptoms at the period of pregnancy (OPI 6)	
20.	Knowledge of the woman about the dangerous symptoms while delivering(OPI 7)	
21.	Knowledge of the woman about the dangerous symptoms of postnatal period (OPI 8)	
22.	Knowledge of the woman about the dangerous symptoms at the period of taking care of the baby (OPI 9)	
23.	Satisfaction of medical worker's visit. (OPI 12)	
24.	Test: 55-70%=1 score, 71-85%=2 scores, 86-100%=3 scores	
25.	Writing the pregnancy state in the protocol based on ЖССТ recommendation (OPSO 1-20, OPI 13)	
26.	Using the mother of "mother's home book" (item #6)	
27.	Working of the medical worker with "Mother's home book"	
	Total sum 1 and ① is /29 and %	%

OUT-PATIENT INTERVIEW **home visit**

Interview with pregnant women by "Safe Motherhood" program monitoring

Date of monitoring		Oblast:		Rayon:	
Medical worker:			Name of the facility		
Monitor :			Consultation type: pregnant woman		

We are studying the service in your facility organized and we'd like you to answer our several questions.
We will not write your name and will keep information given by you in secret.

INTERVIEW WITH PREGNANT WOMAN

OPI 1	HOW LONG ARE YOU PREGNANT? *WRITE THE ANSWER IN MONTHS. write «-» if doesn't know*		_____MONTH
OPI 2	At what time of your pregnancy week did you visit the facility for the first? *Write the answers in weeks*		_____ WEEK
OPI 3	WERE YOU INFORMED THAT YOUR PATNER CAN PARTICIPATE IN YOUR DELIVERY?		**1** YES **0** NO
OPI 4	PLEASE, COUNT THE ADVANTAGEOUS THE PARNER PARTICIPANCE IN THE DELIVERING *MARK "1" IF THE ANSWER IS 2 AND MORE, OTHERWISE «0»*	1. the process of delivery will take less time 2.less opportunities in using anesthetic means 3. less necessity in using 4. less necessity in using delivery procedures 5. less necessity surgery involvement	**1** YES **0** NO

	I'D LIKE TO KNOW ABOUT ALL THE MEDICAL SERVICES OF THIS FACILITY DURING YOUR BEFORE AND AFTER PREGNANCY. DID THE PATIENTS HAVE THE FOLLOWING PROCEDURES? *ASK ABOUT EACH PROCEDURE*	Mark only one answer for each procedure
{OPI 5a}	WERE Fe AND FOLIC ACID RECOMMENDED	**1** YES **0** NO
{OPI 5b}	WERE THE INSTRUCTIONS GIVEN ABOUT THE PROPER NUTRITION	**1** YES **0** NO
{OPI 5c}	DID YOU HAVE A TALK ABOUT THE DELIVERING PLACE	**1** YES **0** NO
{OPI 5d}	EXPLAINED THE ADVANTAGEOUS OF THE DELIVERING IN THE FACILITY	**1** YES **0** NO
{OPI 5e}	Informed you about the role of the woman and mahalla for your baby's health?	**1** YES **0** NO
{OPI 5f}	HAD THE WOMEN CONVERSATION ABOUT THE GAP DIFFERENCES BETWEEN DELIVERIES AND FAMILY	**1** YES **0** NO
{OPI 5g}	WHAT WAS TOLD ABOUT SEXUAL TRANSMITTED DISEASES?	**1** YES **0** NO
{OPI 5h}	Explained you how to get to the facility in case of emergency	**1** ҲА **0** ЙЎҚ
{OPI 5i}	Explained you about breastfeeding advantageous	**1** YES **0** NO

OPI 6	At what kind of dangerous symptoms in the period of pregnancy you should see a specialist? *Mark all versions of the answers*	CONVULSIONS.....1 EYESIGHT DESTROY.....2 BLEEDING.....3 DIFFICULT BREATHING.....4 HEADACHE.....5 FREQUENT APPEARING AND DISAPPEARING OEDEMA 6 FEVER.....7 STRONG PAIN IN STOMACH.....8 CHANGING THE FOETUS MOVEMENT.....9 CONSCIOUSNESS.....10 ANY HURTS WHILE FELLING OR BEATING.....11 OTHERS_____.....96 (SPECIFY) DO NOT KNOW.....88	
		IF THREE AND MORE ANSWERS.....1 *OTHERWISE.....0*	

OPI 7	WHAT KIND OF DANGEROUS SYMPTOMS MAY OCCUR WHILE DELIVERING? *Mark all versions of the answers*	CONVULSIONS.....1 FEVER..... 2 BLEEDING..... 3 UNPLEASANT SMELL OF SECRETIONS.....4 DELIVERING MORE THAN 12 HOURS ..... 5 IF PLACENTA ARE NOT SEPARATES IN 30 MINUTES .... 6 OTHERS_____..... 96 (IDENTIFY) DO NOT KNOW ..... 88 *IF 2 AND MORE ANSWERS.....1* *OTHERWISE.....0*
OPI 8	What kind of dangerous symptoms make you go to a specialist after delivery? *Mark all versions of the answers*	FEVER.....1 BLEEDING.....2 UNPLEASANT SMELL OF SECRETIONS.....3 OTHERS_____.....96 (IDENTIFY) DO NOT KNOW 88 *IF 2 AND MORE ANSWERS.....1* *OTHERWISE.....0*
OPI 9	What kind of dangerous symptoms of baby show that you must go to a specialist? *Mark all versions of the answers*	RARE BREASTFEEDING.....1 CONVULSIONS.....2 FREQUENT/DIFFICULT BREATHING.....3 GETTING RED OR PUS OF THE UMBILUCAL CORD.....4 CHANGING OF THE BODY TEMPERATURE.....5 WEAKNESS OR EXCITEMENT.....6 DIAHHREA OR VOMITING.....7 GETTING BLUE OF PALMS, FEET, AND AROUN MOUTH...8 *IF 2 AND MORE ANSWERS.....1* *OTHERWISE.....0*
OPI 10	IF THERE ARE DANGEROUS SYMPTOMS WHERE YOU SHOUL GO?	**1** YES **0** NO
OPI 11	WERE YOU INFORMED ABOUT CONTRACEPTION METHODS AFTER DELIVERING?	**1** YES **0** NO
OPI 12	ARE YOU SATISFIED WITH TODAY'S MEDICAL WORKER'S VISIT?	**1** YES **0** NO
OPI 13	**FOR MONITORS:** According to № OPI 1-4, 7, 8, 10-12 woman's answers find out if the woman's pregnancy written in protocol based on WHO?	**1** YES **0** NO

SHOW THE BOOK, BROCHURE

OUT-PATIENT INTERVIEW **home visit**

QUESTION	YES	NO	DETAILED ANSWERS
1. Have you ever seen “mother’s home book”?			Stop if the answer is no
2. Do you have the same note book?			
3. Do you like the cover and the note book itself?			Why?
4.Which part do you consider is the most interesting for you?			If ‘yes” which one?
5.In your opinion what kind of information should added or cut?			If ‘yes” which one?
6.For monitors: According to the above answers identify how efficient the women use the note book?			
7.for monitors: Check the women’s note books and evaluate the medical worker’s work.			

Thank you for your interview with us. If you have any questions we are happy to answer!

SM: OUT-PATIENT SERVICE OBSERVATION **home visit**

Observation form for health providers' consulting skills for pregnant women by the "Safe Motherhood" program.

Monitoring date:		oblast:		Rayon:	
Medical worker:		Facility name:			
Monitor:		Type of consultation: pregnant woman			

The objective visits of the pregnant woman must be at least 3 times

	Steps \Objectives	Practice yes=1, no=0, inappropriate ①
	General skills of consultation	
OPSO1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient	
OPSO2	Asked about the woman's state. Had a very briefly talk, only necessary information.	
OPSO3	Asked proper and appropriate questions. Made the woman be interested in giving questions	
OPSO4	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions.	
OPSO5	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant.	
OPSO6	Fixed the time of the following visit and explained how many times she should visit DPM after delivery.	
OPSO7	Explained the role of the woman and mahalla for the safety life of her future baby and used the "Mother's home- book".	
OPSO8	Explained the importance of breastfeeding. Asked if there are problems of breastfeeding and give recommendations.	
OPSO9	Explained about the nutrition of thepegnant women. (mark 1if answered from 9a-9g, otherwise – 0)	
OPSO9a	Feeding with bread and bread production, rice, potato, whet products several times a day.	
OPSO9b	Feeding with fruits and vegetables, greens which are rich in vitamins several times a day.	
OPSO9c	Feeding with dairy products which contain less oil.	
OPSO9d	Feeding with oily less meat or wheat vegetables.	
OPSO9f	Feeding with sweets and oily products less than it was asked above	
OPSO9g	Not to drink tea or Coca-Cola after having meal	
OPSO10	If there are any dangerous symptoms of the delivered woman or of the baby was sent to the facility immediately	
	Consulting on the pregnancy conduction **For monitors:** **to conduct this type of consultation the medical worker should examine a pregnant woman**	
OPSO11	**Were all necessary examinations and analyses carried out at this time of the woman's visit?** (summarize considering the pregnancy period and other factors) (11a – 11d)	
OPSO11a	Examined the woman's blood pressure	
OPSO11b	Examined woman's stomach and measured the bottom of uterus height (beginning from the 24 week the bottom of uterus height must be equal to the bottom of uterus height of gestation period (in cm)	
OPSO11c	Identified the state of pregnancy. 9it is done at each visit after second part period of pregnancy) and beginning from the 36 week identified entrance baby's head into small pelvis minor.	
OPSO11d	Examined the heart palpitation of the pregnancy (the period is more than 18 weeks)	

OPSO12	**The medical worker recommended the woman about the place of the delivery and explained how to deliver in the**	
OPSO13	**Informed the woman about the physiological** (mark 1 if 5 answered from13a-13j 5, otherwise – 0)	
OPSO13a	Feeling sickness at the beginning period of the pregnancy	
OPSO13b	Felling pain in the tops of breast and leaking milk at the end period of pregnancy.	
OPSO13c	No menses	
OPSO13d	Getting dark of pigment spots on the skin	
OPSO13e	Overweighting to 10-12 kg	
OPSO13f	Getting tired at the end of pregnancy.	
OPSO13g	Constipation	
OPSO13h	Frequent urination	
OPSO13i	Getting the uterus bigger (growing)	
OPSO13j	Pains in the small of the back	
OPSO14	**Explained about the possible dangers of the pregnancy period**. (mark I if 8 answered from 14a-14j, otherwise – 0)	
OPSO14a	Having secretion (blood, having amniotic water before the time)	
OPSO14b	Changing the movement of the foetus (more or less often than usual)	
OPSO14c	Constant headache, poor eyesight, getting dark before eyes, the dark spots becoming bright	
OPSO14d	Having fever and if the temperature is 38°C or above	
OPSO14e	Falling down and having any types of hurts in the part of stomach	
OPSO14f	Strong pains in the stomach	
OPSO14g	Sudden appearing and disappearing oedema.	
OPSO14h	Unconscious	
OPSO14i	Convulsions	
OPSO14j	Difficult breathing	
OPSO15	**Explained dangerous symptoms during having delivery** (if the period of pregnancy is more than 32 weeks) (if 5 answered from15a –15f– 1, otherwise – 0)	
OPSO15a	Convulsions	
OPSO15b	if the temperature is 38°C or above	
OPSO15c	Bleeding	
OPSO15d	Having deliveries more than 12 hours	
OPSO15e	NO separation of placenta during 30 minutes	
OPSO15f	Having unpleasant smell or pus of secretions	
OPSO16	**Explained about the possible post natal dangerous symptoms** (mark 1 if 2 answered from 16a - 16c,otherwise – 0)	
OPSO16a	if the temperature is 38°C or above, fever	
OPSO16b	Bleeding a lot	
OPSO16c	Having unpleasant smell or pus of secretions	
OPSO17	**Explained how to take care of the baby and possible dangerous symptoms.** (mark 1 if 6 answered from 17a - 17h, otherwise – 0)	
OPSO17a	Rare breastfeeding	
OPSO17b	Convulsions	
OPSO17c	Frequent or difficult breathing	
OPSO17d	Getting red or pus of the umbilical cord	
OPSO17e	Changing of body temperature	
OPSO17f	Weakness and excitement	
OPSO17g	Diarrhea and vomiting	
OPSO17h	Getting blue of the palm, foot, and around mouth	
OPSO18	**Explained where to go if there are dangerous symptoms.**	
OPSO19	**Explained about the advantageous of her partner participance during the delivery.**	
OPSO20	**Gave advice about contraception methods after delivery.**	

OPSO21	**Used communication skills during consultation:**		
	Asking and listening?		
	Encouraging?		
	Advising?		
	Checking?		

TEST QUESTIONS FOR OB-GYNS, GPs, AND MIDWIVES ON SAFE MOTHERHOOD

1. Which of the followings is not responsibility of the HP at a Village Health Post (VHP-SVP)?

2. Which infections do not affect pregnancy?

3. What signs and symptoms may indicate pregnancy?

4. In conduct of routine medical checks of pregnant women with pregnancy for more than 16 weeks what checks should be conducted each time?
5. Which of the following changes do not belong to natural changes that are characteristic to pregnancy?
6. Which of the followings does not belong to advantages of using the Mother Home Card

7. What criterion is used to diagnose severe pre-eclampsia?

8. The causes of bleeding during the first trimester of pregnancy include:

9. The effective records in medical records (primary health care level) shall be as follows:

10. What danger signs, during pregnancy, imply necessity of seeing a doctor? (name any six)

11. What danger signs during postpartum period indicate to necessity for immediate medical assistance? (name any four)

12. What procedures are required to treat anemia?

13. What should a patronage nurse bring with her in her visits to a house of a pregnant women?

reception

Evaluation list on the monitoring of trained health providers by "Safety Motherhood" program
(In-patient part of the post natal care)

Check-list

Monitoring date:		Oblast:		Rayon:	
Medical worker:		Facility name:			
Monitor:		Consultation type: pregnant woman			

Antenatal/ Postnatal period		
№	**Indicators (source)**	Yes=1, No=0 Inappropriate ①
1.	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient (OPSO1)	
2.	Asked about the woman's state. Had a very briefly talk, only necessary information. Asked clear and proper questions. Asked open questions. Made the woman be interested in giving questions. (OPSO2-3)	
3.	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions. (OPSO4)	
4.	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant. (OPSO5)	
5.	Fixed the time of the following visit and explained how many times she should visit facility after delivery. (OPSO6)	
6.	Explained the role of woman and mahalla for her baby's health. Used "Mother's home book" (OPSO7)	
7.	Explained the importance of breastfeeding. Asked if there are problems of breastfeeding and give recommendations. (OPSO8)	
8.	Explained about the nutrition of thepegnant/delivered women. (OPSO9)	
9.	At this visit all the necessary examinations have been carried out.	
10.	Explained the woman where to deliver and recommended to deliver in the facility и. (OPSO12)	
11.	Explained about physiological changes during pregnancy (OPSO13)	
12.	Explained about the possible dangerous symptoms during pregnancy. (OPSO14)	
13.	Explained about the possible dangerous symptoms while delivering. (OPSO15)	
14.	Explained about the possible postnatal dangerous symptoms (OPSO16)	
15.	Informed where to go in case if there are dangerous symptoms. (OPSO13)	
16.	Explained about the advantageous of the partner presence while delivering (OPSO18)	
17.	The focus visits of the pregnant woman should be more than 3 times (PPR 2)	
18.	The postnatal period is being carried out correctly (PPR 15)	
19.	Knowledge of the woman about postnatal period (OPI 6)	
20.	Knowledge of the woman about the dangerous symptoms of the baby (OPI 7)	
21.	Knowledge of the woman about pregnancy period. (OPI 8)	
22.	Knowledge of the woman about dangers while delivering (OPI 9)	
23.	Satisfaction of the medical worker's visit. (OPI 12)	
24.	Test: 55-70%=1score, 71-85%=2 scores , 86-100%=3 scores	
25.	The pregnancy situation of the woman is written according to the ЖССТ recommendation (OPSO 1-18, PPR1-14, OPI 13)	
26.	Using the "Mother's home book" (item №6)	
	Total sum of 1 and ① is /28 and %	%

Evaluation consultation skills list on the program "Safety Motherhood" (In-patient part of the post natal care)

Monitoring date:		Oblast:		Rayon:	
Тиббиёт ходими:		Facility name:			
Monitor:		Consultation type: 1st pregnancy/ 2nd pregnancy (infant under 1,5 months)			

The delivered woman should visit the doctor at least three times during her pregnancy.
The delivered woman should visit the facility at least once within 1,5 month or the visiting nurse should visit her during a week.

	steps\objectives	Yes=1, No=0, N/a ①
	GENERAL SKILLS OF CONSULTATION	
OPSO1	Met the patient/Spouses with respect and asked them to have a seat and feel comfortable. Introduced herself. Kept patience while the talk. Didn't interrupt the patient?	
OPSO2	Asked about the woman's state. Had a very briefly talk, only necessary information.	
OPSO3	Asked clear and proper questions. Asked open questions. Made the woman be interested in giving questions	
OPSO4	Explained the information in different ways. In order to be confirmed in the obtaining the information asked the woman to repeat the given instructions	
OPSO5	Used visual aids (postures, brochure, books, album) and at the same time made the woman be interesred and participant.	
OPSO6	Fixed the time of the following visit and explained how many times she should visit DPM after delivery	
OPSO7	Used the "mother's home book" and explained the role of the woman and mahalla	
OPSO8	Explained the importance of breastfeeding.	
OPSO9	Explained about the nutrition of thepegnant/delivered women. (1-if the answers from 9a – 9g, otherwise – 0)	
OPSO9a	Feeding with bread and bread production, rice, potato, whet products several times a day.	
OPSO9b	Feeding with fruits and vegetables, greens which are rich in vitamins several times a day.	
OPSO9c	Feeding with dairy products which contain less oil.	
OPSO9d	Feeding with oily less meat or wheat vegetables	
OPSO9f	Feeding with sweets and oily products less than it was mentioned above	
OPSO9g	Not to drink tea or Coca-Cola after having meal	
OPSO10	If there are any dangerous symptoms of the delivered woman or of the baby was sent to the facility immediately	
	CONSULTATION ON CONDUCTIONG PREGNANCY	
OPSO11	**Were all necessary examinations and analyses carried out at this time of the woman's visit?** summarize considering the pregnancy period and other factors) (11a – 11e)	
OPSO11a	Examined the woman's blood pressure	
OPSO11b	Examined woman's stomach and measured the bottom of uterus height (beginning from the 24 week the bottom of uterus height must be equal to the bottom of uterus height of gestation period	
OPSO11c	Identified the state of pregnancy. 9it is done at each visit after second part period of pregnancy) and beginning from the 36 week identified entrance baby's head into small pelvis minor.	
OPSO11d	Examined the heart palpitation of the pregnancy (the period is more than 18 weeks)	
OPSO11e	Measured the woman's weight and observed her dynamics (the weight should be to 10-12 more than her own weight)	
OPSO12	**The medical worker asked the woman to find out the place to deliver and advised to deliver in the facility (in 36 weeks)**	
OPSO13	Gave the woman information on the physiological changes (1 score if answered 5	

	from 13a-to13j – 1,otherwise– 0)	
OPSO13a	Feeling sickness at the beginning period of the pregnancy	
OPSO13b	Feeling sickness at the beginning period of the pregnancy	
OPSO13c	No menses	
OPSO13d	Getting dark of pigment spots on the skin	
OPSO13e	Overweighting to 10-12 kg	
OPSO13f	Getting tired at the end of pregnancy.	
OPSO13g	Constipation	
OPSO13h	Frequent urination	
OPSO13i	Getting the uterus bigger (growing)	
OPSO13j	Pains in the small of the back	
OPSO14	**Explained about the possible dangers of the pregnancy period**. (mark I if 8 answered from 14a-14j, otherwise – 0)	
OPSO14a	Having secretion (blood, entrance baby's head into small pelvis minor.)	
OPSO14b	Changing the movement of the foetus (more or less often than usual)	
OPSO14c	Constant headache, poor eyesight, getting dark before eyes, the dark spots becoming bright	
OPSO14d	Having fever and if the temperature is 38°C or above	
OPSO14e	Falling down and having any types of hurts in the part of stomach	
OPSO14f	Strong pains in the stomach	
OPSO14g	Sudden appearing and disappearing oedema.	
OPSO14h	Unconscious	
OPSO14i	Convulsions	
OPSO14j	Difficult breathing	
OPSO15	**Explained about the possible post natal dangerous symptoms** (if the pregnancy is more than 32 weeks) (mark 1 if 2 answered from 16a - 16c,otherwise – 0)	
OPSO15a	entrance baby's head into small pelvis minor.	
OPSO15b	if the temperature is 38°C or above	
OPSO15c	Bleeding a lot	
OPSO15d	Having delivery more than 12 hours	
OPSO15e	NO separation of placenta during 30 minutes	
OPSO15f	Having unpleasant smell or pus of secretions	
OPSO16	**Explained about the possible post natal dangerous symptoms** (mark 1 if 2 answered from 16a - 16c,otherwise – 0)	
OPSO16a	if the temperature is 38°C or above, fever	
OPSO16b	Bleeding a lot	
OPSO16c	Having unpleasant smell or pus of secretions	
OPSO17	Explained where to go if there are dangerous symptoms**.**	
OPSO18	Explained about the advantageous of her partner participance during the delivery.	

OUT-PATIENT INTERVIEW **reception**

Interview with out-patient pregnant/delivered women on "Safe Motherhood" program

Monitoring date:		Oblast:		Rayon:	
Medical worker:		Facility name:			
Monitor:		Consultation type: pregnant woman			

We are studying the service in your facility organized and we'd like you to answer our several questions.
We will not write your name and will keep information given by you in secret.

INTERVIEW WITH PREGNANT WOMAN			
OPI 1	HOW LONG ARE YOU PREGNANT? *WRITE THE ANSWER IN MONTHS. write «-» if doesn't know*		_____months
OPI 2	At what time of your pregnancy week did you visit the facility for the first? *Write the answers in weeks*		_____ weeks
OPI 3	WERE YOU INFORMED THAT YOUR PATNER CAN PARTICIPATE IN YOUR DELIVERY?		**1** YES **0** NO
OPI 4	PLEASE, COUNT THE ADVANTAGEOUS THE PARNER PARTICIPANCE IN THE DELIVERING *MARK "1" IF THE ANSWER IS 2 AND MORE, OTHERWISE «0»»*	1. the process of delivery will take less time 2.less opportunities in using anesthetic means 3. less necessity in using 4. less necessity in using delivery procedures 5. less necessity surgery involvement	**1** YES **0** NO
OPI 5	I'D LIKE TO KNOW ABOUT ALL THE MEDICAL SERVICES OF THIS FACILITY DURING YOUR BEFORE AND AFTER PREGNANCY. DID THE PATIENTS HAVE THE FOLLOWING PROCEDURES? *ASK ABOUT EACH PROCEDURE*		Mark only one answer for each procedure
{OPI 5a}	WERE Fe AND FOLIC ACID RECOMMENDED		**1** YES **0** NO
{OPI 5b}	WERE THE INSTRUCTIONS GIVEN ABOUT THE PROPER NUTRITION		**1** YES **0** NO
{OPI 5c}	DID YOU HAVE A TALK ABOUT THE DELIVERING PLACE		**1** YES **0** NO
{OPI 5d}	EXPLAINED THE ADVANTAGEOUS OF THE DELIVERING IN THE FACILITY		**1** YES **0** NO
{OPI 5e}	Informed you about the role of the woman and mahalla for your baby's health?		**1** YES **0** NO
{OPI 5f}	HAD THE WOMEN CONVERSATION ABOUT THE GAP DIFFERENCES BETWEEN DELIVERIES AND FAMILY		**1** YES **0** NO
{OPI 5g}	WHAT WAS TOLD ABOUT SEXUAL TRANSMITTED DISEASES?		**1** YES **0** NO
{OPI 5h}	Explained you how to get to the facility in case of emergency		**1** YES **0** NO
{OPI 5i}	Explained you about breastfeeding advantageous		**1** YES **0** NO
OPI 6	At what kind of dangerous symptoms you should see a specialist? *Mark all versions of the answers*	CONVULSIONS .....1 EYESIGHT DESTROY .....2 BLEEDING .....3 DIFFICULT BREATHING .....4 HEADACHE .....5 FREQUENT APPEARING AND DISAPPEARING OEDEMA 6 FEVER.....7 STRONG PAIN IN STOMACH .....8 CHANGING THE FOETUS MOVEMENT .....9 CONSCIOUSNESS .....10 ANY HURTS WHILE FELLING OR BEATING .....11 OTHERS_____.....96 (SPECIFY) DO NOT KNOW .....88 *IF THREE AND MORE ANSWERS.....1* *OTHERWISE.....0*	

OPI 7	What kind of dangerous symptoms of baby show that you must go to a specialist? *Mark all versions of the answers*	RARE BREASTFEEDING.....1 CONVULSIONS.....2 FREQUENT/DIFFICULT BREATHING.....3 GETTING RED OR PUS OF THE UMBILUCAL CORD.....4 CHANGING OF THE BODY TEMPERATURE.....5 WEAKNESS OR EXCITEMENT.....6 DIAHHREA OR VOMITING.....7 GETTING BLUE OF PALMS, FEET, AND AROUN MOUTH.....8 *IF 2 AND MORE ANSWERS.....1* *OTHERWISE.....0*
OPI 8	At what kind of dangerous symptoms in the period of pregnancy you should see a specialist? *Mark all versions of the answers*	CONVULSIONS .....1 EYESIGHT DESTROY .....2 BLEEDING .....3 DIFFICULT BREATHING .....4 HEADACHE .....5 FREQUENT APPEARING AND DISAPPEARING OEDEMA 6 FEVER.....7 STRONG PAIN IN STOMACH .....8 CHANGING THE FOETUS MOVEMENT .....9 CONSCIOUSNESS .....10 ANY HURTS WHILE FELLING OR BEATING .....11 OTHERS_____.....96 (SPECIFY) DO NOT KNOW .....88 *IF THREE AND MORE ANSWERS.....1* *OTHERWISE.....0*
OPI 9	WHAT KIND OF DANGEROUS SYMPTOMS MAY OCCUR WHILE DELIVERING? *Mark all versions of the answers*	CONVULSIONS .....1 FEVER..... 2 BLEEDING ..... 3 UNPLEASANT SMELL OF SECRETIONS.....4 DELIVERING MORE THAN 12 HOURS..... 5 IF PLACENTA ARE NOT SEPARATES IN 30 MINUTES.... 6 OTHERS_____..... 96 (IDENTIFY) DO NOT KNOW ..... 88 *IF 2 AND MORE ANSWERS.....1* *OTHERWISE.....0*

OPI 10	IF THERE ARE DANGEROUS SYMPTOMS WHERE YOU SHOUL GO?	**1** YES **0** NO
OPI 11	WERE YOU INFORMED ABOUT CONTRACEPTION METHODS AFTER DELIVERING?	**1** YES **0** NO
OPI 12	ARE YOU SATISFIED WITH TODAY'S MEDICAL WORKER'S VISIT?	**1** YES **0** NO
OPI 13	WERE YOU INFORMED ABOUT CONTRACEPTION METHODS AFTER DELIVERING?	**1** YES **0** NO
	ARE YOU SATISFIED WITH TODAY'S MEDICAL WORKER'S VISIT?	

Show the book, brochure

QUESTION	YES	NO	DETAILED ANSWERS
1. Have you ever seen "mother's home book"?			Stop if the answer is no
2. Do you have the same note book?			
3. Do you like the cover and the note book itself?			Why?
4.Which part do you consider is the most interesting for you?			If 'yes" which one?

5.In your opinion what kind of information should added or cut?			If ‘yes” which one?
6.For monitors: According to the above answers identify how efficient the women use the note book?			

Thank you for your interview with us. If you have any questions we are happy to answer!

PRENATAL/POSTNATAL RECORDS **reception**

Monitoring date:		Oblast:		Rayon:	
Medical worker:		Facility name:			
Monitor:		Consultation type: 1st pregnancy/ 2nd pregnancy (infant under 1,5			

EVALUATION WOMAN'S MAP OF PREGNANCY AND "MOTHER'S HOME BOOK" (MHB)
THE PREGNANT SHOULD HAVE THREE OBJECTIVE VISITS. **(MOH ORDER №425 of the table, according to gestation age).** The delivered woman should visit the facility at least once within 1,5 months after delivery or the patronage nurse should visit her.

	Protocols on the conduction of the pregnancy	**Yes=1, no=0,** inappropriate①
PPR 1	Do you have information on each visit of the woman?	
PPR 2	How many times the objective visits of the pregnant woman were mentioned on the pregnancy map? *Mark **1*** if more than 3 times, otherwise ***0 (if the gestation period is appropriate)***	
PPR 3	On the individual map of the pregnancy visit what initial periods were shown according to the MHB ? *Mark1 if the pregnancy period is until 12 weeks, otherwise **0***	
PPR 4	How many times was the blood pressure measured and was it written in MNB? *(The blood pressure should be measured at each visit)* *Mark 1 if three and more times, otherwise 0*	
PPR 5	How many times the heart palpitation was checked? *(the palpitation and movement are identified at the 12-18 week)* *Mark 1 if three and more times, otherwise 0*	
PPR 6	How many times was the weight measured? *Mark 1 if three and more times, otherwise 0*	
PPR 7	Was the woman's height measured/was the weight calculated in index? *Mark 1 if one and more times, otherwise 0*	
PPR 8	How many times the height if the uterus bottom was measured? *(after 24 weeks the height of the uterus bottom must be equal to the period of pregnancy. It must identified only by one person)* *Mark 1 if three and more times, otherwise 0*	
PPR 9	How many times the position of the foetus and the previous part of the foetus was examined and written in?	
PPR 10	Was the results of Hb mentioned? *(the analusis for Hb must be taken at the 1st and 4th visit. In necessary cases it can be taken repeatedly?*	
PPR 11	Is the rhesus of blood and the group of the blood clear?	
PPR 12	Was the result of syphilis analysis mentioned? *(must be mentioned at the first visit)*	
PPR 13	How many times the urine analysis taken? *Mark 1 if three and more times, otherwise 0*	
PPR 14	Was the treatment duration from anemia with Fe and Folic acid prescribed correctly? (Fe must be 120 мg and folic acid must be 0,4 мg per a day and this treatment procedure must last 3 months)	
	Protocols of the postnatal period (for monitors: summarize after considering 5 protocols)	
PPR 15	Was the protocols of postnatal period conducted correctly? *(give the correct summary after considering items "a-i")*	
a.	Is there information about the state of the woman in the protocol, any complains	
b.	Is there any problems of breastfeeding mentioned?	
c.	Was the blood pressure measured?	
d.	The in formation about breast?	
e.	While examining the part of the stomach is there notice about the shortanage of the uterus height of the bottom?	
f.	Information about bleeding?	
g.	Notices about postnatal contraception?	
h.	Notice about the process of the implementation if the woman chose BIV method?	
i.	Was the time of the following visit fixed?	

TEST QUESTIONS FOR OB-GYNS, GPs, AND MIDWIVES ON SAFE MOTHERHOOD

1. Which of the followings is not responsibility of the HP at a Village Health Post (VHP-SVP)?

2. Which infections do not affect pregnancy?

3. What signs and symptoms may indicate pregnancy?

4. In conduct of routine medical checks of pregnant women with pregnancy for more than 16 weeks what checks should be conducted each time?
5. Which of the following changes do not belong to natural changes that are characteristic to pregnancy?
6. Which of the followings does not belong to advantages of using the Mother Home Card

7. What criterion is used to diagnose severe pre-eclampsia?

8. The causes of bleeding during the first trimester of pregnancy include:

9. The effective records in medical records (primary health care level) shall be as follows:

10. What danger signs, during pregnancy, imply necessity of seeing a doctor? (name any six)

11. What danger signs during postpartum period indicate to necessity for immediate medical assistance? (name any four)

12. What procedures are required to treat anemia?

13. What should a patronage nurse bring with her in her visits to a house of a pregnant women?

Project HOPE, Navoi, Uzbekistan
Monitoring and evaluation/school level
"Adolescents reproductive and sexual health"
Checklist

Oblast:_____	**Rayon/city:**_____
Date:_____	**Name of educational department (sch. number):**_____

№	Checklist for "ARH" educational services Characteristics	«Yes» 1	«No» 0
	Educational Institution Administration support in program implementing		
1	Realization of ARH classes at the educational institution (**DIR – 1)**		
2	Knowledge about governmental degree/local administration orders depending on ARH classes realization **(**make a conclusion relying on **DIR – 2, 3)**		
3	Adequate usage of specialists **(**make a conclusion relying on **DIR – 5, 15)**		
4	Realization of parents' meeting devoted to "Reproductive health and healthy family creation" educational program importance (make a conclusion relying on **DIR – 13, 14)**		
5	HPs involvement in ARH classes realization **(**make a conclusion relying on **ADOL – 9, 9; DIR – 5)**		
6	"Adolescents reproductive and sexual health**"** participant's manual availability at educational institution library **(**make a conclusion relying on **ADOL – 7; DIR - 7)**		
7	"Adolescents reproductive and sexual health**"** participant's manual usage during ARH classes **(**make a conclusion relying on **ADOL –5, 6; TEACH - 7)**		
8	Possibility in taking home "Adolescents reproductive and sexual health" participant's manual for home reading **(**make a conclusion relying on **DIR – 11, ADOL- 8)**		
	"ARH" classes' provider's qualification		
9	Participated in special "Adolescents reproductive and sexual health" course **(TEACH –2)**		
10	Knowledge about governmental degree/local administration orders depending on ARH classes realization **(make a conclusion relying on TEACH – 3, 4, 5)**		
11	"Adolescents reproductive and sexual health" manuals usage in making ARH classes plan **(make a conclusion relying on TEACH – 6)**		
12	Knowledge about interactive teaching methods **(TEACH – 9)**		
13	Interactive teaching methods usage during the classes **(make a conclusion relying on OBS Part - 1, TEACH – 10)**		
14	"Reproductive health" term understanding **(TEACH – 12)**		
15	Knowledge about consequences of adolescents pregnancy **(TEACH – 14)**		
16	Knowledge about consequences of abortion **(TEACH – 15)**		
17	Knowledge about modern contraceptive methods **(make a conclusion relying on TEACH – 16, 17, 18, 19)**		
18	Knowledge about STI signs **(TEACH – 20)**		
19	Knowledge about ways of STI prevention **(TEACH – 21)**		
20	Knowledge about ways of HIV/AID transmission **(make a conclusion relying on TEACH – 22, 23)**		
21	Knowledge about ways of HIV/AID prevention **(TEACH – 24)**		
	Adolescents knowledge		
22	"Reproductive health" term understanding **(ADOL – 11)**		
23	Knowledge about modern contraceptive methods **(ADOL – 15)**		
24	Knowledge about STI signs **(ADOL – 16)**		
25	Knowledge about ways of STI prevention **(ADOL – 17)**		
26	Knowledge about ways of HIV/AID transmission **(ADOL – 18)**		
27	Knowledge about ways of HIV/AID prevention **(ADOL – 19)**		
	Total mark		%

Monitors:_____

Project HOPE, Navoi, Uzbekistan
Monitoring and evaluation/school level
Instrument 1: "Adolescents reproductive and sexual health"
All questions are to be addressed to educational institution administration.

Oblast:_____ **Rayon/city:_____**

Name of educational
date:_____/_____/_____ **department:_____**

Interviewer:_____ **Respondent: _____**

Informed Consent

Hello, my name is _____ and I am working with Oblast Health Department/Oblast Public Education Department/Oblast Colleges Department. Oblast Health Department/Oblast Public Education Department/Oblast Colleges Department jointly are going to monitor quality of measures taken due to "Reproductive health and healthy family creation" educational program at your educational institution. Within the aim we need to carry out a survey with you. The survey is going to take us 20 minutes to complete.

Information related to "Adolescents Reproductive Health" classes

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Do you have any classes on reproductive health for 10 -11 class formers (first, second year students) at your educational institution?	a) Yes b) No (a – 1 point)	
2	Do you know about governmental degree/local administration orders depending on which "Reproductive health and healthy family creation" educational program was entered on 10 -11 class formers (second, third year students) educational program? **(identify if the administration have known about governmental degree/local administration orders)**	a) Yes b) No (a – 1 point)	
3	How many hours devoted for "Reproductive health and healthy family creation" educational program annually?	a) 16, 17 hours b) don't know/don't remember c) other (identify)_____ _____	
4	How the provision of reproductive health classes is registered at your educational institution?	a) In class journal b) Don't know/don't remember c) Other (identify)_____	
5	What is the trade of person provided ARH classes at your educational institution?	a) Psychologist b) Biology teacher c) HP d) Other:_____ (c– 1 point)	
6	Has the person any certificate or another document which can testify his (her) participation in special "Adolescents reproductive health" course?	a) Yes, certificate given in "Adolescents reproductive and sexual health" seminar organized by OHD, OPED and Project HOPE b) No c) Don't know/don't remember d) Other (identify)_____ _____	
7	Is there any manual on adolescents reproductive health available at your educational institution library? **(make sure that any manual is available in the**	a) Yes b) No (a – 1 point)	→10

	library)		
8	Can you tell the name of the manual on adolescents reproductive health available at your educational institution library? **(identify the name of available manual)**	a) "Adolescents reproductive and sexual health" participants manual b) Other:_____ _____	
9	Is the quantity of the available manual enough for your educational institution?	a) Yes b) No c) Don't know/don't remember	
10	What is the total number of 10 - 11 class formers (second, third year students**)** at your educational institution? **(identify the correct number)**	a) Identify _____	
11	Have the students of the educational institution possibility to take the manual home for reading?	a) Yes b) No (a – 1 point)	
12	Do you provide meetings for 10-11 class formers (second, third year students**)** at your educational institution?	a) Yes b) No	
13	Has the parents' meeting devoted to "Reproductive health and healthy family creation" educational program importance been provided at your educational institution?	a) Yes b) No (a – 1 point)	→15
14	Have you got any written guideline or protocol which can testify the provision of parents' meeting devoted to "Reproductive health and healthy family creation" educational program importance? **(If the answer is "Yes" look through the protocol)**	a) Yes b) No (a – 1 point)	

Identify the following information

15	**Staff Positions**	**Person's full name**	**Taught on «Adolescents reproductive and sexual health» course (put the mark «√»)**	**Haven't been taught on «Adolescents reproductive and sexual health» course (put the mark «√»)**
	Psychologist			
	Health provider			
	"Reproductive health and healthy family creation" lessons providing teacher			

Project HOPE, Navoi, Uzbekistan
Monitoring and evaluation/school level
Instrument 3: "Adolescents reproductive and sexual health"
All questions are to be addressed to adolescents 16-18 years of age

Oblast:_____	**Rayon/city:_____**
Date:_____/_____/_____	**Name of educational department:_____**
Interviewer: _____	**Respondent: _____**

Informed Consent

Hello, my name is _____ and I am working with Oblast Health Department/Oblast Public Education Department/Oblast Colleges Department. We are going to monitor quality of "Reproductive health" classes providing at your educational institution. Within the aim we need to carry out a survey with you. The survey is going to take us 20 minutes to complete.

Information related to "Adolescents Reproductive Health" classes

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	How old were you at your last birthday?	AGE IN COMPLETED YEARS ……[/]	
2	What form (course) are you in?	a) Form 10 b) Form 11 c) Third year student d) Second year student	
3	Did you have any classes on reproductive health at your educational institution? (If the answer is "Yes" define the name of the classes provider)	a) Yes b) No c) Don't know	→10 →10
4	What topics did you discussed during the classes? **(Read the topics and mark the discussed ones)**	a) Reproductive and sexual health b) Anatomy and physiology c) Body changes d) Friendship. Love. Relationship with boyfriend/girlfriend. e) Consequences of adolescent pregnancy f) Abortion consequences g) Contraceptive methods h) STI i) HIV/AID and its prevention j) Violence. Violence prophylactics. k) Risky behavior (alcoholism, smoking, drug addiction) l) Don't remember m) Other (identify)_____ _____	
5	Do you use any manual on reproductive health during the classes?	a) Yes b) No (a – 1 point)	→7
6	Can you name the manual? **(identify the name of manual)**	a) "Adolescents reproductive and sexual health" b) Don't remember c) Other (identify the name)_____ _____ (a – 1 point)	
7	Have you seen any manual on adolescents reproductive health at the library of your educational institution? (**If the answer is "Yes" identify the name of manual)**	a) Yes, "Adolescent reproductive and sexual health" b) No (a – 1 point)	→9
8	Can you take the manual home to read?	a) Yes b) No c) Don't know (a – 1 point)	
9	Have the health provider ever attendee your reproductive health classes?	a) Yes b) No c) Don't know (a – 1 point)	

10	Have you ever attended health facility during the classes?	a) Yes b) No (a – 1 point)	

Knowledge on reproductive health

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	(Now I want to ask you some questions about topics you studied during reproductive health classes*)* How do you understand the "reproductive health" term?	a) Reproductive health is not only the absence of reproductive system diseases; it is total physical, mental and social development. b) Other: (identify)_____ _____ _____ (a – 1 point)	
12	Please can you name the reproductive and sexual rights?	a) THE RIGHT FOR LIFE b) THE RIGHT FOR INDIVIDUAL SAFETY AND LIBERTY c) THE RIGHT ON EQUALITY d) THE RIGHT ON INDIVIDUAL LIFE AND CONFIDENTIALITY e) RIGHT ON FREEDOM WORLD VIEW f) THE RIGHT ON RECEPTION OF INFORMATION AND KNOWLEDGE g) THE RIGHT OF FAMILY PLANNING h) THE RIGHT TO HAVE A CHILD i) THE RIGHT ON RESEPTION HEALTH SERVICES j) THE RIGHT ON SCIENTIFIC ACHIVEMENTS USE k) THE RIGHT ON PARTICIPATION IN SOCIAL MEETINGS l) THE RIGHT ON PROTECTION FROM VIOLENCE m) Don't know (3 right answers – 1 point)	
13	Can you name consequences of adolescents' pregnancy? **(the question is non applicable for 10 formers)**	a) Blood pressure increasing b) Hypostasis c) Fetus hypoplasia d) Premature birth e) Miscarriage f) Mother and child anemia g) Handicapped child birth h) Difficult confinement can lead to mother's mortality i) Don't know j) Other (identify)_____ _____ _____ (3 right answers – 1 point)	
14	Can you name consequences of adolescents' abortion? **(the question is non applicable for 10 formers)**	a) Menstrual irregularities b) Reproductive organs diseases c) Bleeding d) Injuries to uterus e) Contamination f) Sterility g) Mortality h) Don't know/don't remember i) Other(identify)_____ _____ (3 right answers – 1 point)	
15	Can you name contraceptive methods? **(the question is non applicable for 10 formers)**	a) Oral contraceptives b) Injectable c) Emergency contraceptives d) Spermicides e) Natural family planning f) Condom g) IUD h) Don't know/don't remember i) Other (identify)_____ _____	

		(3 right answers – 1 point)	
16	Can you name the signs or symptoms suggest that a person has sexually transmitted infection? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Discharge from penis/vagina b) Burning pain or itching in penis/vagina c) Sores or warts on penis/vagina d) Swelling in groin region e) Reddening in penis/vagina f) Rapid urination g) Painful urination h) Low part abdominal pain i) Don't know/don't remember j) Other (identify)_____ _____ (3 right answers – 1 point)	
17	Can you say what should one do to avoid getting STI's? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Abstinence b) Using condom c) To have one partner d) Avoiding multiple sex partners e) Avoiding sexual intercourse with prostitutes f) Avoiding occasional sexual intercourse g) Don't know/don't remember h) Other (identify) (3 right answers – 1 point)	
18	Please can you mention all the ways in which a person can get HIV/AIDs? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Sexual intercourse b) From a mother to a child c) Blood transfusion d) Don't know/don't remember e) Other (identify)_____ _____ (a, b, c – 1 point)	
19	Can you say what should one do to avoid getting HIV/AID? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Abstinence b) Using condom c) Avoiding multiple sex partners d) Avoiding sexual intercourse with prostitutes e) Avoiding use of unsterile needles f) To have individual instruments of manicure, pedicure and hygiene g) Don't know/don't remember h) Other (identify)_____ _____ (3 right answers – 1 point)	
20	What does "safe-sex" mean to you? **(Don't read. Probe by asking "Anything else?" and circle all that apply.)**	a) STIs prophylaxis b) Avoiding unwanted pregnancy c) Don't know/don't remember d) Other (identify)_____ _____ (a, b – 1 point)	
21	Have you heard your peers conducting classes/meetings or seminars on reproductive health at your educational institution?	a) Yes b) No c) Don't know d) Other (identify)_____	
22	Would you like to participate in a special training on training peer educators on adolescents' reproductive health?	a) Yes b) No c) Don't know/don't remember d) Other (identify)_____	
23	Could you tell the reason?	Identify: _____ _____ _____	

Rayon/city:_____	**Name of the educational institution** _____

Show the brochure

Question	Yes	No	Full answers
1. Have you ever seen the brochure “Answers for some interesting to adolescents’ questions”?			If the answer is “No” end the interview
2. Do you have the kind of brochure?			
3. Do you like the brochure’s design?			What for?
4. What topic seems most interesting to you?			Identify?
5. What topics should be added to the brochure to your opinion? What topics should be deleted from the brochure to your opinion?			Identify?
6. for monitors: Relying on answers make a conclusion about brochure’s adecuate usage.			

THANK YOU FOR PARTICIPATING!

Project HOPE, Navoi, Uzbekistan
Monitoring and evaluation/school level

Instrument 2: "Adolescents reproductive and sexual health"
All questions are to be addressed to the ARH classes' provider.

Oblast:_____	**Rayon/city:_____**
date:_____/_____/_____	**Name of educational department:_____**
Interviewer:_____	**Respondent: _____**

Informed Consent

Hello, my name is _____ and I am working with Oblast Health Department/Oblast Public Education Department/Oblast Colleges Department. Oblast Health Department/Oblast Public Education Department/Oblast Colleges Department jointly are going to monitor quality of measures taken due to "Reproductive health and healthy family creation" educational program at your educational institution. Within the aim we need to carry out a survey with you. The survey is going to take us 20 minutes to complete.

Common information related to "Adolescents Reproductive Health" classes

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	***What is the trade of person provided ARH classes at the educational institution***	a) HP b) Psychologist c) Biology teacher d) Other: (identify)_____	
2	Did you participate in any course or seminar devoted to adolescents reproductive health?	a) Yes b) No c) Don't remember d) Other (identify)_____ (a – 1 point)	

Now I want to ask you about ARH classes you provide at the educational institution

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
3	Do you know about governmental degree/local administration orders depending on which "Reproductive health and healthy family creation" educational program was entered on 10 -11 class formers (second, third year students) educational program? **(identify if the person have known about governmental degree/local administration orders)**	a) Yes b) No (a – 1 point)	
4	How many hours devoted for "Reproductive health and healthy family creation" educational program annually?	a) 16, 17 hours b) don't know/don't remember c) other (identify)_____ _____ (a – 1 point)	

5	What topics should be discussed during ARH classes due to your work plan? **(Look through the work plan and 10-11 form (second, third year students) journals and compare the topics with the ones given in governmental degree - 32)**	**10 – form program:** a) "Reproductive health". "Adolescence" b) "Parents' health is a future child health" c) "Anatomy and physiology" d) "STI", "HIV/AID" e) "Drug addiction and its influence on human health" f) "Luck of iodine" g) "tuberculosis" h) "Risky behavior" i) Don't remember j) Other (identify)_____ **11 – form program:** a) "Citizens' health protection" governmental degree of Republic of Uzbekistan b) "Healthy marriage is a foundation of healthy generation" c) "Human's body immunity" d) "Mother and child health protection is national policy of Republic of Uzbekistan" e) "extragenital diseases" f) "Contraceptive methods usage technology" g) "Pregnancy and pathological pregnancy" h) "Breastfeeding advantages" i) don't remember j) Other (identify)_____	
6	What manuals or guidelines do you use in making lesson plan? **(make sure in manuals or guidelines availability)**	a) "Adolescents reproductive and sexual health" – trainers' manual b) "Adolescents reproductive and sexual health" – informational source for trainers c) "Adolescents reproductive and sexual health" – participants manual d) None e) Other (identify)_____ _____ (a, b, c – 1 point)	
7	Do the students use "Adolescents reproductive and sexual health" – participants manual during the classes?	a) Yes b) No (a – 1 point)	→9
8	Identify the reason	_____ _____	
9	What interactive teaching methods do you use during the classes?	a) "Energizers" b) Role playing c) "Brainstorming" d) Group discussion e) Small group work f) Demonstration g) Mini lection h) Real life story study i) Don't know/don't remember j) Other(identify)_____ (5 right answers – 1 point)	
10	How do you build up the friendly creative atmosphere during the classes?	a) Listen to the speaker attentively b) Do not criticize the speaker whatever he (she) says c) Gve free rein in communication to everyone d) Motivate participants e) Setle down disagreements in friendly manner f) Don't know/don't remember g) Other (identify)_____ (3 right answers – 1 point)	

Knowledge on Reproductive health issues

№	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	In your opinion, what can we have as the result of sexual education?	a) Sexual education leads to adolescents' sexual activity; they try practice the knowledge they got. b) Sexual education is a part of moral education; it helps to develop responsibility in adolescents for their own health and actions. c) Don't know/don't remember d) Other (identify)_____	
12	How do you understand the "reproductive health" term?	a) Reproductive health is not only the absence of reproductive system diseases; it is total physical, mental and social development. b) Other: (identify)_____ _____ _____ (a – 1 point)	
13	Please can you name the reproductive and sexual rights?	a) THE RIGHT FOR LIFE b) THE RIGHT FOR INDIVIDUAL SAFETY AND LIBERTY c) THE RIGHT ON EQUALITY d) THE RIGHT ON INDIVIDUAL LIFE AND CONFIDENTIALITY e) RIGHT ON FREEDOM WORLD VIEW f) THE RIGHT ON RECEPTION OF INFORMATION AND KNOWLEDGE g) THE RIGHT OF FAMILY PLANNING h) THE RIGHT TO HAVE A CHILD i) THE RIGHT ON RESEPTION HEALTH SERVICES j) THE RIGHT ON SCIENTIFIC ACHIVEMENTS USE k) THE RIGHT ON PARTICIPATION IN SOCIAL MEETINGS l) THE RIGHT ON PROTECTION FROM VIOLENCE m) Don't know/don't remember (5right answers – 1 point)	
14	Can you name consequences of adolescents' pregnancy?	a) Blood pressure increasing b) Hypostasis c) Fetus hypoplasia d) Premature birth e) Miscarriage f) Mother and child anemia g) Handicapped child birth h) Difficult confinement can lead to mother's mortality i) Don't know j) Other (identify)_____ _____ (4right answers – 1 point)	
15	Can you name consequences of adolescents' abortion?	a) Menstrual irregularities b) Reproductive organs diseases c) Bleeding d) Injuries to uterus e) Contamination f) Sterility g) Mortality h) Don't know/don't remember i) Other(identify)_____ _____ (4right answers – 1 point)	
16	Can you name contraceptive methods?	a) Oral contraceptives b) Injectable c) Emergency contraceptives d) Spermicides e) Natural family planning f) Condom g) IUD	

		h) Don't know/don't remember i) Other (identify)_____ _____ (3 right answers – 1 point)	
17	Can you name advantages of contraceptives?	a) Condom protects from pregnancy and STIs b) Condom protects from HIV/AID c) OC protect from pregnancy and abate pain during m-cycle d) Emergency contraception protects from pregnancy after unsafe sexual intercourse e) Don't know/don't remember f) Other (identify)_____ _____ (3 right answers – 1 point)	
18	Can you name disadvantages of contraceptives?	a) Condoms incorrect usage leads to their quality fall-off b) None of contraceptive methods protects from STIs except condom c) OC can lead to nausea and headache d) You can forget to take pill in time e) IUD doesn't protect from STIs f) Some of contraceptive methods can influence on m-cycle g) Don't know/don't remember h) Other (identify)_____ (4 right answers – 1 point)	
19	Can you give the information about emergency contraception?	a) The method can protect from unwanted pregnancy after unprotected sexual intercourse and violence b) Emergency method do not protect from STIs c) Pills can be taken in 72 hours after unprotected sexual intercourse d) The total doze of ethinyl estradiol in taken pills shouldn't be less than 100 microgram e) IUD can be used in 5 days after unprotected sexual intercourse f) Don't know/don't remember g) Other (identify)_____ _____ (3 right answers – 1 point)	
20	Can you name the signs or symptoms suggest that a person has sexually transmitted infection? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Discharge from penis/vagina b) Burning pain or itching in penis/vagina c) Sores or warts on penis/vagina d) Swelling in groin region e) Reddening in penis/vagina f) Rapid urination g) Painful urination h) Low part abdominal pain i) Don't know/don't remember j) Other (identify)_____ _____ (4right answers – 1 point)	
21	Can you say what should one do to avoid getting STI's? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Abstinence b) Using condom c) To have one partner d) Avoiding multiple sex partners e) Avoiding sexual intercourse with prostitutes f) Avoiding occasional sexual intercourse g) Don't know/don't remember h) Other (identify) (3right answers – 1 point)	
22	Please can you mention all the ways in which a person can get HIV/AIDs? **(Probe by asking "Anything else?" and**	a) Sexual intercourse b) From a mother to a child c) Blood transfusion	

	circle all that apply.)	d) Don't know/don't remember e) Other (identify)_____ _____ _____ (a, b, c – 1 point)	
23	Can you name the situations when HIV/AIDs can be transmitted from a mother to a child? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Pregnancy b) Delivery c) Breastfeeding d) Don't know/don't remember e) Other (identify)_____ _____ (a, b, c – 1 point)	
24	Please can you mention all the ways in which a person can get HIV/AIDs? **(Probe by asking "Anything else?" and circle all that apply.)**	a) Abstinence b) Using condom c) Avoiding multiple sex partners d) Avoiding sexual intercourse with prostitutes e) Avoiding use of unsterile needles f) To have individual instruments of manicure, pedicure and hygiene g) Don't know/don't remember h) Other (identify)_____ _____ (3 right answers – 1 point)	
25	What does "safe-sex" mean? **(Don't read. Probe by asking "Anything else?" and circle all that apply.)**	a) STIs prophylaxis b) Avoiding unwanted pregnancy c) Don't know/don't remember d) Other (identify)_____ _____ (a, b – 1 point)	

THANK YOU FOR PARTICIPATING!

Project HOPE, Navoi, Uzbekistan
Monitoring and evaluation/school level
Instrument 4: "Adolescents reproductive and sexual health"
The form is used as a part of ARH classes' provider skills evaluation

Oblast:_____	**Rayon/city:_____**
date:_____/_____/_____	**Name of educational department:_____**
Interviewer:_____	**Respondent: _____**

Evaluate ARH classes provider skills due to the criteria:

Interactive teaching methods usage skills	**Yes / NA "1" "□"**	**No "0"**
Part 1 – Interactive teaching methods usage		
Energizers (limbering-up)		
Mini lection		
Small group work		
«Brainstorming»		
Demonstration		
Practical exercises		
Real life story study		
Role playing		
Group discussion		
Visual aids usage		
Flips and markers usage		
Summing-up		
Reminding: at least 3 kinds of interactive teaching methods should be used during a lesson	**3 and more methods– "1" point Otherwise – "0" point**	
Part 2 – New information explanation		
Fully understand the purpose of giving information		
Give questions to identify the level of adolescents' existing knowledge on new theme before the explanation		
Explain new information in simple and clear way		
Pay special attention to main points of new theme		
Write main points of new theme on the blackboard		
Suggest adolescents to record main points of new theme in their note-books		
Give simple and clear answers on adolescents questions		
Give adolescents questions to identify the level of new theme understanding		
Give adolescents clear tasks		
Use practical tasks on strengthening new information		
Make a conclusion in the end of the lesson		

Reminding: at least 6 kinds of criteria should be used during a lesson	**6 and more methods– "1" point Otherwise – "0" point**	
Part 3 – Trainer's skill		
Communication with the audience		
Eye contact usage		
Energy		
Mimicry usage		
Listening skills		
Appropriate level of voice		
Appropriate level of intonation		
Dramatic skills		
Adolescents' activation		
Work with "difficult" adolescents		
Solution of boredom problem		
Building up friendly creative atmosphere		
Preparing program for adolescents' presentations		
Supporting adolescents' during small group work		
Supporting adolescents' during presentations		
Motivation of the small groups' members		
Creation of harmonious working posses		
Reminding: at least 10 kinds of criteria should be used during a lesson	**10 and more methods– "1" point Otherwise – "0" point**	

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

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

Flexible Fund Final Report

Project Duration: October 1, 2003 – September 29, 2007

Submitted to:
USAID/GH/HIDN/NUT/CSHGP
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December 2007

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ARSH	Adolescent Reproductive and Sexual Health
ADB	Asian Development Bank
BCC	Behavioral Change and Communication
BF	Breast Feeding
CI	Confidence Interval
CS	Child Survival
CSHGP	Child Survival and Health Grant Program
DIP	Detailed Implementation Plan
FGD	Focus Group Discussions
FP	Family Planning
GP	General Practitioner
HD	Health Department
HF	Healthy Family
HP	Health Provider
HIV	Human Immunodeficiency Virus
HOPE	Health Opportunities for People Everywhere
IMCI	Integrated Management of Childhood Illness
INGOs	International non governmental organizations
IUD	Intrauterine Device
KPC	Knowledge, Practice, Coverage
LAM	Lactational Amenorrhea Method
MOE	Ministry of Education
MOH	Ministry of Health
MOHSSE	Ministry of Higher and Secondary Special Education
MPS	Making Pregnancy Safer
MTE	Mid Term Evaluation
NGO	Non-Governmental Organization
OHD	Oblast Health Department
PEPC	Promoting Effective Perinatal Care
PHC	Primary Health Care
Prikaz	Official (Government) order or decree
RDH	Rayon Health Department
RH	Reproductive Health
STIs	Sexually Transmitted Infections
STD	Sexually Transmitted Disease
SVP	Rural physician post
TWG	Technical Working Group
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

Introduction

Project HOPE's child survival project, *Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan*, was an extension of a previous child survival project that began in 1999. The current project continued activities from October 2003 to September 2007. The purpose of the HOPE CS project in Uzbekistan was to: (a) reduce the mortality and morbidity in children under five and women of reproductive ages and (b) increase adolescents' knowledge about reproductive and sexual health. The CS project directly targets an estimated 36,716 children ages 0-5 years; 77,479 women of reproductive age (15-49 years old), and 25,505 adolescents (16-18 years of age). The Project has introduced and expanded the use of standard case management protocols in IMCI, Making Pregnancy Safer and Family Planning interventions.

Based on qualitative and quantitative assessments conducted as part of the final evaluation, it can be said that the CS project has been quite successful. As the Table in the following section shows, many of the objectives have either been achieved or surpassed. Furthermore, and perhaps more importantly, the project has successfully influenced the Oblast Health Department (OHD) and Rayon Health Departments (RHD) to adopt such programs as IMCI and Making Pregnancy Safer, as their own and these health departments are implementing those programs in other parts of the country. Additionally, some of the materials developed by the project are now being used by UNICEF and other INGOs in other areas of the nation.

The partnership between the project staff and the OHD and the RHDs is very strong and the project has made tremendous strides in building the capacity of the health department staff on a myriad of technical issues, which is one of the cardinal achievements of the project.

Additionally, the project has been in the vanguard in training community leaders, teachers, and peers on adolescent reproductive health issues. The strategy of working with vocational schools as well as high schools was commended by the Ministry of Education in Navoi as an innovative strategy to reach adolescents not attending traditional high schools.

The following adolescent reproductive health (ARH) achievements are most noteworthy:

- Organization and support of four ARH courses,
- Training of 475 health professionals in family planning,
- 1811 adolescents directly exposed to reproductive health information,
- Development and support of several training centers,
- Development of protocols at local and national levels in support of family planning,
- Joint prikaz (government directive) between MOH and MOE (Ministry of Education) to support adolescent reproductive health facilities supported by the project, and
- ARH Guidelines developed by CS project and local partners (MOH and MOE) accepted at national level and recommended to other regions.

Many of the programs initiated by this project have already been "sustained" by the MOH and are being scaled up in other parts of the Oblast and to other parts of the country as a direct result of this project. In addition, there have been requests to extend the ARH training to schools in the non-pilot rayons.

Main Strategies and Activities: (1) Implement TOTs and train health staff in family planning; (2) explore the possibility of continuing surgical contraception (minilap) training for health providers; (3) BCC and makhalla/community-based work focused on WRA and their partners by initiating sessions to orient makhalla committees and leaders in reproductive health and family planning; (4) Adolescents Reproductive and Sexual Health (ARSH) to increase adolescents' knowledge about sexuality and reproductive health and to develop an adolescent-friendly health services strategy; (5) BCC and makhalla/community-based work to increase knowledge of reproductive health and sexuality; and (6) focus on improving the quality of FP service delivery through training, community education and close monitoring and supervision.

Family Planning and Child Spacing

The overall objectives of the program as relates to family planning, child spacing, and knowledge on reproductive health issues are detailed below:

Objectives: (1) Increase the number of women/couples with a birth interval at least 24 months after the previous surviving child; (2) Increase the number of women/ adolescent/ couples' knowledge of the reproductive cycle; (3) Increase the number of non-pregnant women who desire no more children to space births and are using a modern method of FP; and (4) Increase the number of family planning clients who received counseling on contraceptive choices, common side effects, and when to return for follow-up. The level of effort the CS project dedicated to FP and child spacing was 30%.

KPC Statistics on FP and child spacing

Indicators	Baseline (Feb 2004)		MTE (May 2005)		KPC FE* June 2007	
	%	CI	%	CI	%	CI
Adequate Birth Interval Between Youngest Surviving Children: Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child.	48.3%	±18.2	86.9%	±6.13	84.7%	±5.8
Percent of women of RA who report that women are likely to get pregnant halfway between two menstrual periods.	9.3%	±2.8	72.8%	±8.21	45.7%	±5.6
Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing.	72.6%	±4.6	91.5%	±5.67	72.8%	±9.3
Percentage of respondents who report discussing FP issues with somebody in the past 12 months.	56.2%	±4.7	82.5%	±5.71	65.7%	±5.4
Counseling: Percentage of family planning clients who receive counseling on contraceptive choices, common side effects, and when to return for follow-up.	62.7%	±5.8	77.2%	±5.86	86.6%	±6.8

Project HOPE successfully worked with several members of technical working groups (TWGs), Oblast and Rayon Health Departments and PHC services to provide family planning training courses and to implement 6-8 month monitoring visits. The RH training courses conducted by the project are shown below. In total, 475 health providers were trained in Reproductive Health.

Type of Training	Numbers and Types of Participants	Training Topics
3-day TOT	16 Ob-Gyns, midwives, and GPs	Improved skills on RH and teaching/adult education skills
4-day training on RH and counseling (Note that in the DIP this was anticipated to be a 5-day course)	221 Ob-Gyns, GPs, midwives, and feldshers	General counseling skills and informed consent, screening tests, provision of contraceptive methods, including method delivery and follow-up; management of secondary effects; health information system and information management.
4-day RH course	238 Patronage nurses	Content MPS and RH includes above plus antenatal and postpartum skills.

In the DIP, reproductive health trainings for the patronage nurses were planned to be conducted separate from the maternal health care course; however as great as the need was to train patronage nurses, this methodology has been fused with basic outreach antenatal and postpartum care topics.

The results of the baseline and final data surveys are not legitimately comparable with those of the MTE survey because the profiles of the respondents were not the same. In the baseline and final surveys, the respondents were women of child bearing age, while the mid-term evaluation interviewed mothers of children under two years of age. Hence, the higher MTE results might simply reflect differences in the surveyed populations. In any case, the final results, though generally not as high as the MTE show definite gains in FP knowledge and behaviors. Although the percent of women using modern methods did not change much from the baseline (72 percent), the percent of women who reported receiving counseling on contraceptive choices (and associated side effects) and when to return for a follow-up visit increased by more than 25 percent. This is a strong indication that the percentage of women informed about contraceptive choice rose significantly during the project. The team also pointed out that there has been substantial progress in the area of informed choice. Before the project, women used contraception because they were pushed to use it but women now report they have information about the different methods. Progress of informed choice is evidenced by the fact that women can now list the advantages and disadvantages of the different methods. As a result of the project, if women are asked why they use the IUD, they can now discuss the disadvantages of the other methods for them and the advantages of the IUD. Additionally, women now know when they should come to have it checked. Before the project and the project interventions, many women could not provide this level of detailed information regarding the IUD. The project staff also believe that the HPs have improved their communication skills and are doing a better job of discussing contraceptives with patients. The staff noted that before the project, in many cases, the HPs themselves were a real barrier to providing informed choice. The pre and post tests from the training courses evidence this, showing that many HPs believed the myths about the different methods and shared their prejudices about different methods with their clients.

The project and HD staff have also indicated thanks to the trainings provided by the project, the quality of care improved. Counseling of clients has also improved through the provision of educational materials and improved counseling skills delivered by trained HPs. Counseling

skills were greatly improved through the monitoring and supervision visits provided by project staff. Having standards and protocols for new acceptors and continuing users has also helped improve care. The project also developed posters on counseling steps that are clear and easy to follow and assist HPs in providing care. From the monitoring visits, it has been found that clients are more satisfied with services, that there are fewer stock outs of contraceptives, and that there is improved counseling by visiting nurses for both FP and antenatal care (before they did not provide this counseling). Also, 91.4% of all 83 SVPs (rural physician posts) offer mothers classes for antenatal care, which includes information about FP.

The project and HD staff believe that FP access has improved because of improvements in the supply system and informed choice. Before this project, health departments had supplies of contraceptives but less access because women weren't informed of all the choices available and practitioners did not counsel them adequately. Additionally, thanks to the World Bank and ADB primary care program, there are more local level SVPs in the oblast providing primary care.

The most preferred FP method in Uzbekistan is still the IUD. The following table depicts the distribution of FP method utilization in Navoi.

Which of FP methods do you use or used before	**Baseline (Feb 2004)**	**MTE (May 2005)**	**KPC FE* June 2007**
Pill	15.7%	11.11%	14.4%
IUD	86.3%	64.33%	70.8%
Injection (DepoProvera)	13.2%	21.05%	16.8%
Norplant	n/a	1.17%	n/a
Sterilization	4.4%	2.34%	5.6%
Condom	12.9%	1.75%	13.6%
Spermicides	0.3%	0.00%	1.2%
Calendar method	13.5%	1.17%	17.2%
LAM	59.6%	5.85%	38.0%

While the use of IUDs has decreased a bit since the baseline, it is still the preferred family planning method. There is a small increase in the use of injectables but the other methods are more or less at the same levels of use. When interviewed by the FE team, women stated that while they had been informed about other methods they preferred the IUD because they believed it to be effective and convenient, i.e., they did not have to be reminded every day to use it. The additional questions added to the final KPC also showed that 99 percent of women of reproductive age knew of three or more modern methods of contraception. Interviews also showed that women who were using other methods were using them because they had had problems with the IUD. In other words their first choice was still the IUD. Because the FE team was concerned that the bias for the IUD might be coming from the providers, we asked about this and the GPs admitted that they had more faith in the IUDs and did not fully trust the other methods. Project staff and some health department staff indicated that they thought there was informal pressure coming from higher levels of the government to encourage use of sterilizations and IUDs. However the FE team was unable to verify further details. While not common place, at the start of the project, there had been instances where women were found to have as many as three IUDs inserted at one time. The project staff surmise that this was because there was a requirement that all women who delivered at Maternity Houses should have an IUD inserted within five days. Later, when women returned to the PHC for follow-up care, HPs would insert another one or two IUDs – depending on the number of visits! Fortunately, the project was

instrumental in correcting this situation in Navoi by asking that the Maternity Houses not stock IUDs but to provide them to the PHCs. Health workers at PHC would ascertain that there are no IUDs in a client before inserting one during post partum visits.

The MTE evaluation noted that there had been shortages of contraceptives, particularly condoms at the health facilities. However, this situation improved with increased monitoring and the project and HD staff worked with SVP facilities to train a staff member in logistics management. The oblast RH center staff have developed a table for calculating stocks for the rayons. The FE team found during field visits that there were adequate contraceptives at the health facilities visited. According to project and HD staff, contraceptive supplies are monitored and maintained by the MOH and HDs. Contraceptives are provided free of charge, because they are donated by UNFPA. Due to the regular monitoring of services, the primary care facilities have been able to plan and program adequate supplies. Despite this, the project staff still has concerns about stockouts because they think the people responsible for logistics at rayon and oblast levels are not calculating supply needs correctly. Some providers base their estimates of the needs at each SVP on the numbers of WRA in each makhalla without taking into account actual demand levels that are calculated at the SVPs. One concern raised by this situation is that some of the remote rural clinics have had problems maintaining condom stocks. There appears to be an increasing demand for condoms.

The project realizes that free supplies of contraceptives will not always be available and worries that the heavy reliance on the IUD method may impede donations of other types of contraceptives.

The project complied with the Mexico City Policy by not funding any abortion services or providing any training related to abortion. Also as discussed above there was extensive attention paid to and training about informed consent. In addition, the FE team observed numerous posters about the advantages and disadvantages of different FP methods at all facilities visited (Tiahrt Amendment).

A huge lesson learned by the project was the importance of training the visiting nurses to take a more active role in home based preventive health care. These nurses, also known as patronage nurses, have proved to be a key link between the communities and the health services.

Lastly, the new Parents' Schools also serve to educate recent parents on LAM and modern family planning methods.

Adolescents Reproductive and Sexual Health (ARSH):

The Adolescent Reproductive and Sexual Health component had two primary purposes: (1) to increase adolescents' knowledge about sexuality and reproductive health and (2) to develop adolescent-friendly health services. The strategies and main activities of the project as relates to ARH were to:

- Improve the knowledge, practice, and behavior of healthcare providers and teachers by preparing and implementing training curricula for school health providers and teachers; training of school health providers and teachers how to conduct adolescent RH classes in the schools; conduct regular and routine follow up and monitoring visits to ARH centers.

- Improve access to Youth Friendly Health Service of target population by establishing Youth Friendly Health Services; training health providers in the principles of providing Youth Friendly Health Services; conducting follow up and monitoring visits.

- Improve health, knowledge, practice, and behavior of adolescents aged 16-18 years old by conducting peer-to-peer training; developing and disseminating booklets and posters on ARH topics; broadcasting of short films on adolescent RH key messages.

- Create a supportive environment for improved health of target population (by influencing policy, local and social norms) by conducting orientation meetings with Oblast Educational Department teams and with vocational education department; train community/makhalla leaders on adolescent RH key messages and health promotion skills; provide follow up and monitoring of trained community leaders; develop and disseminate booklets for parents on adolescent RH key messages.

Part of the ARH activities have been funded by the Swiss donor associated with Project HOPE, the Foundation for Partnerships in Health. The CS project has partnered with the MOH, MOE, MOHSSE, the Oblast Health Department, Oblast Public Education and OSSPED, the Healthy Family Project, HOPE/ Tashkent and other NGOs in implementing ARH activities.

In order to adequately identify the situation of adolescent reproductive health in Navoi, Uzbekistan, the project conducted a baseline survey for CS activities and also included questions for adolescents. The objective of the survey conducted among adolescents was to assess their knowledge on reproductive health issues and HIV/AIDS prevention. The relevant results of the baseline appear in the table below:

Percent of targeted adolescent population (16-18) who can state that women are likely to get pregnant halfway between two menstrual periods.	1.3%
Percent of targeted adolescent population who can name at least three methods of contraceptive methods.	29.8%
Percent of targeted adolescent population can name at least 2 mechanisms of HIV transmission.	44.2%
Percent of targeted adolescent population who can name at least 2 means of protecting themselves against contracting STIs.	16.7%

Source: Baseline Survey of CS Program, Navoi, February 2004

The objectives of the ARH activities were to: 1) increase the knowledge about reproductive and sexual health among targeted adolescents, 2) decrease the percent of targeted adolescents having unprotected sex, and 3) increase knowledge among targeted adolescents who know how to correctly use a condom.

The project worked to support the following program components:

1) support the Educational Sector in implementation of ARH education activities,
2) support the Health Sector in establishment of adolescent friendly health services,
3) support creation of a network of all sectors involved into ARH promotion, and
4) increase community awareness of ARH.

During the CS project, Project HOPE educated a large number of adolescents through formal school classes and peer educators. The Adolescent Health Center at the Oblast level and centers at the four rayons now offer services as a result of the Youth Friendly Initiative. The work also involved school teachers and almost all community leaders. To accomplish those activities, Project HOPE has developed and offered four types of training events for adolescents and peer educators. These activities included:

Type of Course	Participants	Objectives
A five-day TOT course on 'adolescent reproductive and sexual health'	394 health providers and school teachers responsible for 'ARH' classes and counseling	To improve the health providers' and teachers' knowledge about adolescent reproductive health topics and to develop their skills in providing classes about ARH; to inform health providers about youth friendly service requirements; and to teach health providers to provide youth friendly counseling on reproductive measures.
Four-day 'peer-to-peer' course on peer education	405 Peer educators	To provide correct adolescent reproductive health information through peer educators. Includes counseling skills.
Two-day course on ARH	1,012 students and youth	Taught principals of ARH including physiology of RH system, consequences of early marriage, advantages and disadvantages of modern contraceptives, prevention of STI/HIV and safe sex practices.
Three-day course for establishing youth friendly services	17 Ob-Gyns and youth health providers	Taught principals of youth friendly services and youth counseling skills.
Summer camp	140 adolescents	

In summary a total of 394 adult trainers, 405 peer educators and 1,527 adolescents have been trained.

In general, adolescents do not have the opportunity and/or willingness to discuss their reproductive health problems with adults. The project identified two types of adolescents; those who just feel shy about talking about 'ARH' with adults, and those who do not believe adults can help them. The Project HOPE team believes that boys and girls prefer to get information on reproductive and sexual health from their peers, so would feel more confident to talk with them about intimate issues. This belief was confirmed by the FE team when the interviewed adolescents, community leaders and teachers. The evaluation's focus group discussions with adolescent boys and girls demonstrated that boys do talk about RH with their peers, while girls talk with peer-educators, except when they have a problem; they go to a health provider or discuss the issues with a relative. Although providers and adolescents stated that numbers of youth are sexually active, it is difficult to verify this through the surveys. It is a difficult situation for youth because they are expected to be virgins before marriage but at the same time boys are expected to be experienced. Therefore boys go to prostitutes and often contract STIs.

The project developed instruments for monitoring youth friendly services (YFS). The monitoring helped evaluate effectiveness, friendliness, accessibility and the quality of YFS

services; define if the service management is adequate; define the work of health providers; define service conditions; identify the clients' opinions of the quality of services; and elucidate the weaknesses and strengths of the services.

Project HOPE has used the following materials for training of trainers, and for educating adolescents:

- 'Adolescents reproductive and sexual health' – training manual, school book and informational source for health providers and school teachers responsible for providing ARH classes and counseling (developed by Project HOPE/CS/USAID/Navoi, Project HOPE/HF/USAID/Tashkent, Oblast Reproductive Health Center, Oblast Adolescents Reproductive Health Polyclinic staff, approved by Uzbekistan MOH Deputy Chief)
- Short films: 'Abortion prevention', 'Menace of early marriage', 'STI prevention', and 'Drug addiction prevention' (developed by Project HOPE/CS/USAID/Navoi and City administration).
- 'Peer-to-Peer' – guideline for peer educators (developed by Project HOPE/CS/USAID/Navoi staff).
- Short films on: 'Modern contraception methods,' the cartoons 'Karate Kids – HIV/AID prevention', and 'Karate Kids – drug addiction prevention' (borrowed from 'Rainbow', Kyrgyz Project working with adolescents).
- An adaptation of the ARH booklet 'Me and my world' after conducting FGDs with rural parents and teenagers.
- 'Answers on some interesting adolescents' questions - adolescents brochure is developed by National 'Health' Institute, 'Navoi Oblast Reproductive Health Center', Project HOPE/CS/Navoi.
- Short films developed by peer educators through competitions. Used peer educators as actors.

Project HOPE has distributed all educational and reference materials to the school libraries, so that there will be permanent resources available at the schools. The Administrators interviewed talked about the importance of the materials in providing information to teens who may not want to talk to adults about RH but will read the materials.

Youths interviewed for the final evaluation stated that they like the ARH centers for services and counseling. They use the counseling services, the library and they acquire contraceptives for themselves and friends. They stated that they often get contraceptives or counseling for friends who are too embarrassed to come for services. Some youth still have problems asking for services as they feel there is a stigma. The adolescents stated that they had complete confidence in the health providers at the ARH Center and had even tested them for confidentiality. The peer counselors said they felt comfortable counseling peers themselves and when they had questions they consulted the HPs at the center. They said they would also go to the SVPs for general health consultation but preferred the youth centers.

Rayon and Navoi city youth said they liked all the ARH instruction and that it was the first time that anyone had openly talked to them about puberty and sexuality. They particularly liked the sessions about 'physiology and the RH cycle,' 'creating a healthy family,' 'contraception,' 'advantages of delaying sexual debut and abstinence' and 'how to prevent STIs and HIV.' Both the students and the teachers commented that before having these classes boys and girls did not communicate very well. Now that they have had the ARH classes together and learned to

discuss among themselves, they have a better understanding of what it means to be male and female. The teacher administrators also noted that now if they organize an event about early marriage all students are interested and come to discuss it openly. They are not shy and ask questions easily. They also noticed that after the ARH classes the boys were more respectful of the girls. When asked what changes they would like in the ARH classes, the students responded that they would like for the trained teachers to have more leeway to teach ARH classes. They indicated that untrained teachers who did not understand the purpose of ARH often put up barriers to the classes or did not let them or the peer educators distribute materials. Since the ARH classes are not required classes it is more difficult to insist on having the classes particularly if parents object. Students wanted to have more information about sexual organs, fertile cycle, anti-retrovirus therapy, oncological diseases and how to behave during the honeymoon. They also said wanted to know more about contraceptives.

The FE team found that in the rayons, the administrators of the health facilities do not support the ARH trained HPs in providing youth friendly services, since it's not a focus area for them, and although they provide counseling, they don't stock contraceptives. They do have a hotline and provide check-ups. This conflict arises because in the rayon polyclinics, only the Ob-Gyns provide contraceptives but the ARH specialists are pediatricians. The pediatricians refer adolescents to the Ob-Gyns for contraceptive but because the OBs are not trained to be youth friendly, most of the adolescents do not go. The project has brought the issue of pediatricians being providers for the adolescents and the Ob-Gyn providing contraceptives to the Steering Committee meeting for discussion and it was decided that each of the PHC level health facilities and ARH centers/rooms should have three to four kinds of contraceptives available.

The project only began talking to parents about sex education when the community health component began in 2006. By then, the project staff recognized the religious and cultural barriers to talking to youth about ARH. The administrators indicated that about half of their vocational students come from rural areas that tend to be more traditional and do not understand the purpose of ARH. They and the students believe that there is a need to convince parents to let teachers and providers talk to the students. They believe that the women leaders cannot really do this as they are too old to reach the adolescents and do not seem real comfortable talking to the parents about ARH. When the FE team asked them about educating the parents on ARH, the leaders responded that they gave them the parents' brochure to read and seemed to think that was enough.[1]

The Director of the ARH center reported that the number of adolescents seeking services at the ARH center is increasing, and that confidentially on the part of providers is being stressed. Providers also stated that they enjoyed the training and that before the training, it had been hard to talk to the adolescents. Now with their counseling skills, the youths come easily. Also waiting times are shorter and they appreciate the anonymity as the MDs don't discuss the visits with parents or ask for their names. Before, boys did not come to the center, but how they have a large number who come with friends. Also before they did not have a center but the Oblast renovated the current facility they are in and HOPE provided furniture, computers and materials.

[1] Parents brochure for city and pilot rayons was entitled "If there is a teenager in your house". It was developed by Republic "Health" Institute, Navoi Oblast ARH Center and Project HOPE/CS/USAID/Navoi staff). 20, 000 copies were printed of which 19, 900 copies were disseminated.

Sustainability is a key component of the ARH activities and the project has worked on improving the capacity of existing governmental structure for ARH activities, which is already staffed and partially funded by the government. The project was responsible for creating two Youth Friendly Centers and three Youth Friendly Rooms in the targeted area. Two to three health providers and/or teachers from each school and vocational school were trained on how to conduct adolescents RH classes in the schools. A set of adolescents RH books were provided to the library of each school and vocational schools. The project has left each of the ARH facilities with trained health providers or/and teachers in each school and vocational schools and enough copies of training materials to sustain training activities in the schools. Almost all health facilities of the four pilot rayons were involved in adolescent RH trainings. There are 83 PHC level health facilities in the four rayons and Youth Friendly Health Center of Navoi city. In total, there are two Centers (Navoi city and Nurota rayon) and three rooms (in Karmana, Kiziltepa and Konimeh rayons) created by with assistance from the project. The MOH will assume responsibility for sustaining project activities and the Oblast ARH center in Navoi city will coordinate other ARH center/rooms activities under the supervision of the Oblast Health Department. The government has issued Prikazes (decrees) #242 and #32 which stipulate that 16-17 hours of ARH classes will be provided in the schools and vocational schools. According to these directives, OHD and Oblast Educational Departments will continue to support training and follow up activities. Additionally, the MOH recently issued a prikaz establishing youth friendly health services in the country and approved ARH standards. The Youth Friendly Initiative introduced by the CS Navoi project will be sustained by the MOH and OHD according to the aforementioned prikazes.

The project had requested that maternity houses not stock IUDs as there were reports in the project area that women were found to have more than one IUD inserted after delivery. Health workers were adamant in ensuring that that soon after delivery, a woman had an IUD inserted before leaving the maternity house. It was not clear how a woman could have more than one IUD inserted after a pregnancy, but the project wanted to reduce the risk of this occurring again by suggesting that IUDs only be stocked in the health facilities. The important issue to highlight is that thanks to the CS Navoi project, IUD use has decreased from 82.7% at baseline to 70.8% at the final evaluation, indicating that women are using other methods of contraceptive, thanks to the project's training on informed choice.

Please see the next page for the Core Indicators for Flexible Funding.

USAID Office of Population/Reproductive Health PVO/NGO Flexible Fund Core Indicators Project HOPE *Increasing the Quality of Child Survival and Maternal Care Services in Navoi Oblast of Uzbekistan*		
Key Result (KR) (or Objective): Increased FP Use and Improved FP/RH Practices		
Indicators	**Result**	**Source/Date**
KR1: Couple Years of Protection	8,564	Final KPC, July 2007
KR2: Number of New Users of Modern Contraception	5,231	Project Monitoring Data, April 2007
KR3: Contraceptive Use (prevalence rate)	72.8%	Final KPC, July 2007
KR4: Unmet Need for Family Planning	13.8%	Final KPC, July 2007
KR5: Adequate Birth Spacing	84.4%	Final KPC, July 2007
Result 1: Increased Knowledge and Interest (R1)		
R1.1 Percent of respondents who know at least three methods of family planning	98.7%	Final KPC, July 2007
R1.2 Percent of women with a child <12 months who received counseling about birth spacing	80.3%	Final KPC, July 2007
R1.3 Percent of respondents who report discussing family planning with their partner in the past 12 months	82.7%	Final KPC, July 2007
Result 2: Improved Quality of FP Services (R2)		
R2.1 Percent of family planning clients who receive adequate counseling	86.6%	Project Monitoring Data, April 2007
R2.2 Percent of facilities offering three or more modern family planning methods	75.9%	Project Monitoring Data, April 2007
Result 3: Increased Access (R3)		
R3.1 Precent of beneficiaries that live within 5 km of a FP service delivery point	91.3%	Final KPC, July 2007

R3.2 Percent of facilities reporting no stockouts in the last quarter	100%	Project Monitoring Data, April 2007
R3.3 Percent of respondents who report discussing FP with a health worker or promoter in the past 12 months	89%	Final KPC, July 2007
Result 4: Improved Social and Policy Environment for FP Services (R4)		
R4.1 Program Sustainability in Place		
Flexible Fund Program Cross- Cutting Indicator		
Number of beneficiaries	Infant <12months: 8,101 Children 12-23 months: 5,921 Children 24-59 months: 24,990 Women 15-49 years: 86,636 Population of Target Area: 315,962	

SUMMARY NOTES OF QUALITATIVE RESEARCH CONDUCTED AS PART OF FINAL EVALUATION OF PROJECT HOPE'S CS NAVOI, UZBEKISTAN JULY 2007

AREA	STRENGTHS	CHALLENGES	ADDITIONAL COMMENTS
IMCI	-B4 did not know how to treat children<5. -now more comfortable with treating children and feel communication skills are better - improved ability to work wth community - seen reduction in IMR since IMCI In pilot rayons where IMCI is implemented docs say they prefer it – Even though MOH inspectors use the old style approach – they still don't prohibit use of IMCI - thinks the 11 day trg is right – people don't get exhausted and has varied methods – as a tr organizer – timing was right. - less antibiotics prescribed – more economical and better care (though mothers don't believe its good care- also untrained HPs who provide long list of meds and when return home the SVP doc has – nuradeen – but mother goes to tk	-IMCI started in 2001-getting other docs to accept IMCI strategy – not all are trained (only 2-3 in Rayon are trained – after added hosp IMCI in 2006 it improved at Oblast and Rayon in patient. (b4 had trained primary and some peds of rayon - since all docs don't use IMCI – challenge bec pts get some treatment from IMCI docs but not in others. -ped research institute does IMCI coordination but doesn't do tr and monitoring – other MOH reps came to do a review and weren't IMCI trained – so difficult- - would have liked to have trained providers all at once but HOPE couldn't do that. – costly - some think should have longer training days – others 11 is too long – want diverse tr methods – more practicums	- if there is to be more IMCI tr. – would recommend tr of providers within a short period –so there is not a 2 yr gap btwn docs and nurses.(delayed because gov not ready for c-imci – so took a while to adopt – needed time to adapt for patronage nurses)- also there were no guidelines from WHO for c-imci – so developed from 8 of the IMCI 16 key messages – hard because c-imci targets CHWs not patronage nurses – so needed to target them. (judy aubel's research showed they could work with existing resources and their strengths.) -Would like a standard refresher course, now proj does based on monitoring. -IMCI is working well where HPs

	once a yr and phc docs all yr so mother trusts phc doc more.- at hosp level docs also given tr at pilot rayons and oblast so this conflict is better)	with patients. - moms suspicious of IMCI because docs gave less meds. - conflicting messages as see BF advertsing and no nat'l policy for BF. -lack of essential meds at the phc level observed but project says at all levels.	are trained – esp in remote areas. -prikaz 537, 538 for pHC and Hosp care includes IMCI- before not included in these child health prikazes for services and care. One prikaz existed before, now approved and signed 538 (org of inpt ch care services) and changed to include hosp IMCI – 537 not – is out pat no t approved .- will include 11 day tr of IMCI. – but will still be limited re funding even with MOH order but will at least get correct supervision from MOH.
SAFE MOTHERHOOD / RH	EBF – big strength – mothers and babies healthier – see fewer infections -sm training good as b4 had more c-sections-more knowledge of how to handle complicated pregnancies-better pp and antenatal care. -increased role of midwives after training (b4 all normal del were managed by ob-gyns – now after by using partgraphs have increased normal	-in future the challenge will be having a strong supervision by oblast HD. -infection prevention training –also need tr for H/A+ mothers. -most women still prefer IUD – easier, won't forget as with pill. Also GPs said they ahv e more faith in IUD than other methods. -IUD and sterilization use- first method offered isIUD and if comploications then offer other. COMMENT	Encourage MOH to conduct survey of anemia and IUD use. (problem in hosps have old equipment for measuring hemoglobin- so unsure if measures are correct) Continued training on informrd choice and counseling on methods. -encourage MOH

	deliveries – by using partogr can recognize earlier the complications of deliveries. -less morbidity and mortality of newborns (makhalla leaders also said fewer infant deaths) -increased presence of partners in delivery process reduces complaints about service – also less meds used in delivery-improved quality of ANC due to standards-b4 there were no standards of care but now have- makes work easier to follow. At beginning of proj hard to implement SM because no nat'l support but in 2003 it improved – because HOPE encouraged MOH to change pricazs for newborn, bf, delivery management in hospital. In 2005 MOH also dev'd antenatl standards according to WHO – easier for project to implement SM in hospitals. -at beginning of proj did bf first because prikaz for EBF already existed (1999) in 2000 only had 5 baby friendly clinics in Uzbekistan. In collab with Ped Institute started more. So after this easier since half of	world experience shows that some HPs push IUD but its not so good for client- pushing IUD is not good. -in some of the rural areas there's a high demand for condoms but there's a lack of spply. -some docs said they don't trust that the women will understand all the FP methods available so don't want to counsel about them-esp in rural area – too much information-communication problem. -one woman said anemia increased-could be due to IUD.	to approve protocols and standards for emergency obstetric care. They have 2 protocols: eclampsia and pp hemorrhage. Waiting for 10 more -MOH does not encourage devlmnt of local level protocols all devlpd at central moh level so waiting for 10 years are waiting for protocols – good the project conducted training and used WHO protocols-dangerous for HPs to use not approved protocols –if there's a death can't defend. -need to move to a new live birth definition consistent with international standards. Currently live birth starts at 28 weeks.1000 grams. ICD 10 definition is 22 weeks gestation and more than 500 grams and larger than 25 cms head circumference.

	SM strategy based on EBF. - monitoring is very helpful as able to correct any weaknesses and implement knowledge and practice. Said will continue monitoring. –are leaving a strong monitoring team in place. –have enough resources to continue all inpt and out pt to continue training. Have materials and trainers. -B4 SM tr did a lot of interventions that may have caused infections (frequent invasive vaginal tests) - pleased with tr as moms can deliver with more positions and vaginally encouraged. -use of FP: was encouraged early in pregnancy and during hosp stay and pp and lead to improved birth intervals - HP also trained on informed choice counseling-most moms interviewed believe birth spacing should be 3 yrs .-most moms know LAM conditions. -all facilities have posters of different methods and child care.		Now Under 28 weeks gestation is listed as stillbirth abortion. HOPE printed ICD guidelines for each HF at request of MOH. From 2008 will use the new live birth definition. ADB and UNICEF have agreed to equip all mat hosps with equipment for premature births. Now don't have equipment and this is concern. -if could make monitoring sustainable- not sure if oblast could do the monitoring but could maybe do it from the rayon level to look at key staff-only sm and rh takes 20 days – not sure MOH will continue.for time. mat house level not a problem but for phc could be problem for moh. – Nursing association will do the monitoring for visiting nurses and midwives. -ask chief of mat h about monitoring tools-ask if they're ready to use at national level**. –**

			Need to reduce the number of monitoring items and reduce the time.
ADOLESCENT RH	-Like the training. Ob-gyns at center said it was hard to talk to adolescents before the training – hard to get them to come to center. Now with counseling skills – adols come, also waiting time is shorter. Appreciate anonymity (don't discuss with parents don't give name). Teens can see whoever they want midwife or dr. - B4 boys didn't come but now have a lot and bring friends. B4 didn't have such a center but then Oblast renovated building and PH provided furniture and supplies and materials. SchoolAdministrators think the teacher training was useful. -peer educators very useful for reaching adolescents –hard to get students to talk to adults and vice versa. want more training as adolescents graduate. -peer educators like healthy lifestyle, contraception, physiology & RH cycle, sti/hiv because have learned about	-teachers: Voc schools don't use trained teachers all the time and HPs adequately. Don't allow them to teach RH as admin doesn't understand the purpose of the classes since they are not required classes. -peer educators are graduating and there is a need to train more. Concern re whether they wil do it without resources from Hope. -In rayons Admin of health facilities do not support trained HPs in providing friendkly services for adolescents. Not a focus area and may be uncomfortable. Don't have contraceptives for adolescents and do't think they need – only provide counseling and have hotline and p;rovide checkups but there are still problems in offering services bcuz h facilites don't support. In rayon polyclinics only the ob-gyns can provide contraceptive supplies and ARH specialists are pediatricians. They refer to ob-gyn and adol don't go and don't come back. Doctors and youth	-Need to give ARH as a credited class so that it will be given regularly. -continue peer education classes-PH should try to organize a PE training plan with MOE and RH center. (have trainers, PEs, volunteers and center). -involve administrators in ARH promotion to get them more involved in promoting ARH teaching. -pay more attn to adolescent services and support youth friendly services in rayon polyclinic. -need to advertise youth services(have done with brochure with hotline and address) at rayons the way they did at center in Navoi – but aside from lack of ads there

	prevention also learned the importance of abstinence. -teachers see a difference in students- now more open to discuss issues of early marriage, RH not afraid to discuss. Also trained students communicate more easily between boys and girls - before were separate and they have become friends. -really like the providers at the ARH center, use counseling, library, contraceptives for selves and friends. -the confidentiality practiced at ARH center has had a positive impact and increased use of services. Also like location of center as not too many people around. -after training gained more counseling skills and became more knowledgable than the teachers. -The ARH curriculum dev by PHope is the only one used at the national level (approved by MOH and suggested to other Oblasts that they use it). -PHope model of user friendly clinic was sustainable –knows UNFPA tried to use another model at University but didn't	expressed a need for more psychologists services specialized in adolescent issues. -started to work with parents only when community health promotion program started in 2006. Recogmnized religious and cultural brriers to talk about RH. Need to convince parent s to let teachers and providers talk to kids. Can't do it with the women leaders as too old to reach adolescents.	are services problems: recommend that Oblast ARH staff should support rayon youth friendly room services in advertising and improving services. (began oblast center in 2004 and rayon in 2005.) Oblast should arrange regular meeting with rayon RH specialist on the provision of youth friendly services. -teachers want help to implement the ARH program in other rayons. – could do through ARH center and Oblast ed center. PH can help coordinate a meeting between the oblast education and health department to plan such activity. -need tt create a network btwn health center, education and makhalla sectors – organize meetings with parents and ask ARH health specialists to meet with parents and involve ed sector as well. May need

	work. Also tried to use in students club but it wasn't integrated into existing structure but PHope model was integrated with MOH system. -deputy of education and Hakim womens director really like the materials. -adolescent book "Me and my World" is very popular and is being sold in Tashkent and other places. -like films and show on abortion consequences and stis. -this was first project to work on this issue – gov't decree in 2002-PH started in 2003. First who weren't afraid, first to get health and ed sectors together to address problem.		to offer the opportunity to allow students to opt out of RH if parents are opposed or similar strategies. – provide regular meetings for parents and involve in the triple party meeting above. PH can help the ed sector make an agenda for parents meeting and how to do it.
COMMUNITY-	Started in 2006. -set up to strengthen existing community health structure – trained existing nurses and community women leaders. -community leaders are located in community Therefore more sustainable Advantage of using leaders is that they know the community but HPs don's. -Women leaders at rayon level supervise work at many communities so built in	-women leaders are great for working with mothers -selection ofnon formal leaders for training was difficult – did not understand purpose and sent older individuals who couldn't read, sit etc. – therefore in the future could improve selection method – did this after 3 out of 24 seminards changed the strategy. - in distinction with HPs it is difficult to organize	- therefore important during training to teach theme during training to integrate activities into seasonal activities (trad weddings as was done in Nurata) -gov't and oblast HD should create a team for future trainings of new formal leaders in community methods. -this working

	supervision system. -in other regions of Uzbek ths training doesn't exist for community leaders. -big advantage of using the women leaders is that they are older and have a good in with othr Mother in laws and GMs. -Visiting nurses are key for linking health system with the community. Str of PH to create training curricula on MCH. Improved counseling skills of visiting nurses which allowed them to do more antenatal care and pp care bf, FP which brought more family involvement in HC system. -6 monthly activity plan of planned and completed activities in place. Observed that they are being used at community .Developed by Hope staff-useful for monitoring and supervision. -leaders noticed differences in use of FP use, birth spacing, recognizing preg danger signs, child danger signs. Leaders and mothers said do no t have severe diarrhea now. No deaths this year in community either IMR or MMR. -leaders said they have	activites by the trained people right after training as depends on other community commitments (seasonal agricultural campaigns)-therefore important during training to teach thme during training to integrate activities into seasonal activities. -challenge that couldn't involve more men in the activities. Have a small number but not enough. -ARH issue – community leaders have problem working with ARH.and convincing parents to permit it. -continuous refresher training of mahalla leaders- how will it be done? -need to plan updates of training tools – stories, pictures, videos etc. as will need later. - age of formal community leaders is sometimes a challenge. They understand the key messages but teaching skills are an issur. First monitoring showed knowkedge was low –so encouraged them to read more and knowledge was better.	group team should also take responsibility for updating community teaching materials and tools. -monitoring helps reinforce education of leaders- purpose of leaders is to generate awareness and get people to services for problems – not educate in depth. -to strengthen link btwn HP and community leaders would be good to involve health institute staff (in oblast and rayon) to do this. Until now Hope has done this.

	good training and education materials. -women leaders manage activities -monitoring is in place. Other project in a healthy family region was conducted by paid volunteers so not sustainable. -used interactive methodologies , stories without end –first used –all activities are based on uzbek traditions – asked people what they wanted told to use stories, films. -this activity was developed in accord with the governors decree 242-(community health promotion. -materials are useful, user friendly. Mother home card accepted by MOh as national appendix of order for antenatal care. Have materials for every intervention area, brochures, leaflets posters. All project activities were substantiated with IEC materials. -Be able to implement community strategy able to build link between health and community sector. -in all 4 rayons have community health promotion trainers who know adult ed methods. (16 trainers trained 391 leaders).		

	-eductional methods are tools that can be applied to other sectors of work besides health – examples stories, video discussion, role play, choosing target groups. - involvement of the nurses assoc is key strength as they will continue training nurses and monitoring. - used women's tendency to communicate and gave them something else to talk about !!		

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

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

Flexible Fund Case Study

Project Duration: October 1, 2002 – September 30, 2007

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December 2007

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ACRONYMS

AFRH	Adolescent Friendly Reproductive Health
AFRHS	Adolescent Friendly Reproductive Health Service
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CHP	Community Health Promotion
CS	Child Survival
CSHGP	Child Survival and Health Grant Program
CSTS	Child Survival Technical Support
HF	Healthy Family
HIV	Human Immunodeficiency Virus
HOPE	Health Opportunities for People Everywhere
IEC	Information, Education, Communication
IUD	Intrauterine Device
KPC	Knowledge, Practice, Coverage
MOE	Ministry of Education
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
OHD	Oblast Health Department
PHC	Primary Health Care
Prikaz	Official (Government) order or decree
PTP	Peer to Peer Counseling
RDH	Rayon Health Department
RH	Reproductive Health
STIs	Sexually Transmitted Infections
STD	Sexually Transmitted Disease
TOT	Training of Trainers
USAID	United States Agency for International Development
VC	Venerealogical Center
WHO	World Health Organization
YF	Youth Friendly
YFRHS	Youth Friendly Reproductive Health Services

Project HOPE CS Navoi Project - Flexible Fund Case Study

Background and Overview of Project Area

Uzbekistan lies in the middle of central Asia, sharing borders with Kazakhstan to the north, Kyrgyzstan and Tajikistan to the east, Afghanistan to the south, and Turkmenistan to the west. With a population of over 25 million, it is one of the most densely populated of the Central Asian Republics. Almost 2/3 of the population lives in rural areas, and over 36% of its population is younger than 15 years[1].

Despite having a relatively equitable health care system and being considered a mid-level country in terms of national income, Uzbekistan has excessively high infant, child and maternal mortality rates as compared with other countries in the region. Infant mortality rates are reported to be 62 per 1000, while maternal mortality registers 55 per 1000 live births (UHES, 2002). The total fertility rate of women in Uzbekistan is 2.9 children and CPR, registers at 24.4 per 1000 population[2].

Birth and death rates per 1000 population are 19.5 and 5.0 respectively in Navoi Oblast, 16.3 and 5.7 in Navoi city. There are 191,511 (23.7 %) women of reproductive age in the oblast and 20,175 in Navoi city. The Maternal Mortality Rate (MMR) is 63.9 per 100,000 live birth in the oblast and 66.6 per 100,000 in Navoi city[3].

The country describes itself as Muslim country but is not extremist. Traditional values are very important and family is the cornerstone of culture. It is not unusual to have a paternal or maternal grandmother living with the family. Grandmothers are one of the primary decision makers regarding child rearing. Cultural issues include women customarily having children early and the most popular family planning method in Uzbekistan is the IUD.

Navoi Oblast reflects the general characteristics of the population in Uzbekistan. Gender distribution is almost even with 0.3 % more males than females. Navoi city has a population of about 144,208, of whom approximately 10% (11,000) are adolescents between the ages of 15 and 17 years of age. [4]

Most people work at government establishments such as schools, hospitals, polyclinics, and banks. Apart from the government in the Navoi region, there are mining, chemical and cement industries that employ about 55,000 people. The literacy rate in the region is high, with 97% of children under 16 going to school.

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[1] CIA Factbook, Uzbekistan, 2001
[2] www.indexmundi.com
[3] Project HOPE, Final Evaluation CS Navoi, Uzbekistan, July 2007
[4] Ibid.

The Problem

In order to adequately identify the situation of adolescent reproductive health in Navoi, Uzbekistan, the project conducted a baseline survey for child survival (CS) activities and also included questions for adolescents. The objective of the survey conducted among adolescents was to assess their knowledge on reproductive health issues and HIV/AIDS prevention. The relevant results are of the baseline appear in the table below:

Percent of targeted adolescent population (16-18) who can state that women are likely to get pregnant halfway between two menstrual periods	1.3%
Percent of targeted adolescent population who can name at least three methods of contraceptive methods	29.8%
Percent of targeted adolescent population can name at least two mechanisms of HIV transmission	44.2%
Percent of targeted adolescent population who can name at least two means of protecting themselves against contracting STIs	16.7%

Source: Baseline Survey of CS Program, Navoi, February 2004

These precarious statistics stem partially from the fact that more than 25% of the women bearing children are under the age of 20. Classified as adolescents, this time of life is characterized for many by tremendous physical and emotional changes as well as heightened vulnerabilities, reflected partly in the rapidly increasing number of pregnancies and abortions in girls under 18 years of age. Adolescents in Uzbekistan often do not seek reproductive health services, fearing reprisals from family and community members. Discussion of adolescent reproductive health is taboo for teens, their parents and, oftentimes, health providers.

Project HOPE's studies on adolescent reproductive health issues illustrated that a low percentage of adolescents turn to health providers when they need advice and counseling on reproductive and sexual health. Focus group discussions further illuminated the adolescents' poor impressions of health care providers as 'inept' at providing quality Adolescent Reproductive Health (ARH) services, 'rude' to their patients, and potential 'threats' for leaking sensitive information to adults. Adolescents do not seek reproductive health services because customs and traditional views on child rearing do not facilitate open dialogue between adults and youth about sexual issues. These views are strong and many service providers hold similar opinions. Community leaders have lack of information and skills to give information regarding reproductive health to adolescents and their parents in a correct and straightforward manner. Relations concerning this issue are not established among education and health care workers, makhalla and Department of Internal Affairs. Parents are not sufficiently involved in sexual education of youth.

Of those adolescents brave enough to access reproductive health services, many are treated poorly and disrespected by health providers. With over 36% of the Uzbek population under 15 years old, adolescent reproductive health is an increasingly important component in the health

care system. Young women face risks of dying during pregnancy and giving birth that is up to five times higher than in women between ages 18 to 25.[5] As a result, the development of life skills is crucial to the future of this age group as well as training health providers, parents and teachers on adolescent reproductive health issues.

Steps Undertaken to Address the Problem

Following an assessment of health facilities, it was discovered that the need for Adolescent Friendly Reproductive Health (AFRH) services was great in Uzbekistan. Over a third of the population was not being adequately served by the health structure because of new approaches in the PHC reform where services by GPs and patronage nurses were organized but there were no established standards for providing RH services.

As part of the Child Survival Navoi project, in September 2003, Project HOPE expanded its activities in Navoi, Uzbekistan to include a focus on adolescent reproductive health (ARH). Project HOPE's Child Survival Project has successfully strengthened maternal and child health services and community health knowledge in Navoi over the past four years and the ARH activities focused on establishing youth friendly clinics in the pilot regions used as a "test case" for expanding adolescent health activities in the Navoi region as well as in other regions of Uzbekistan.

Project HOPE's contributions to the Uzbekistan Ministry of Health are timely, as a recent government *prikaz*, or decree (#32 and #242), has ordered a Reproductive and Sexual Heath component to be developed and standardized in all schools in the Republic. AFRH services were implemented in Navoi city and in four rayons: a) Oblast ARH center, Navoi city; b) Children Polyclinic, Karmana rayon; c) Adult Polyclinic, Kiziltepa rayon; d) Adolescents, students and youth at call-up age, City Center, Nurota rayon; e) Central Rayon Hospital, Konimekh rayon.

At the beginning of the ARH program, project staff began a search for national policies and standards regarding ARH provision. The MOH informed the project team that there were no national policies, standards, or protocols for ARH. Due to lack of national policies and standards for AFRH services, the project adapted international guidelines which were used for the implementation of services. Inputs were provided from the Republic ARH Center.

The activities on establishing Youth Friendly Reproductive Health Services (YFRHS) were implemented in collaboration with the MOH, especially under the supervision and in collaboration with the National ARH center staff. This arrangement allowed the project team to pilot the appropriateness of the 11 characteristics for YFRHS suggested by WHO Global Consultation in 2001 and discussed by the WHO experts group in Geneva in 2002. After these activities, the MOH instituted prikaz #562, entitled, "About the Implementation of Youth Friendly Initiative to the System of Health services" in December 2006, which established policies and standards for ARH provision.

[5] WHO fact sheet No 186 Dec. 1997

While training activities at the oblast level started in July 2004, Youth Friendly (YF) services at the rayon level began after the HPs training on ARH at the end of 2005, following an evaluation of the services done by Project HOPE in November 2005. Rooms were fully furnished and staff was trained on AFRH service management at the end of March 2006; IEC materials were distributed to the clinics by June 2006.

As with other Project HOPE activities, the ARH activities were designed to take a more preventive, public health approach rather than a mere clinical focus approach. The project worked to support the following program components:

1) Support the Educational Sector in implementation of ARH education activities.
2) Support the Health Sector in establishment of Adolescent friendly health services.
3) Support creation of a network of all sectors involved into ARH promotion.
4) Increase community awareness of ARH.

Activities involved in achieving the aforementioned components took place from August 2003 to May 2007, in collaboration with the MOH and Oblast Public Education Department, the Health Republic Institute and "Tarikat", the Children and Adolescents' Reproductive Health Republic Center, Navoi oblast Khokimiyat, Oblast Health Department, Oblast Public Education Department and Navoi Oblast Secondary – Special Professional Education Department.

One hundred and twenty nine (129) educational institutions and 126 makhallas throughout the four rayons were involved in the ARH program. Two centers and three YFRHS cabinets were created. Trainings included 'Adolescents reproductive and sexual health' for teachers and health providers (trained 525 specialists); 'Community health promotion' (trained 391 specialists); 'Peer-to-peer' (trained 405 peer educators) and others.

While activities at the oblast level started in July 2004 during Phase I of ARH program implementation, youth friendly services at the rayon level began at the end of 2005 during Phase II. The work on establishing AFRH service rooms in rayons started in November 2005 from the evaluation of reproductive health services which had been offered to adolescents at that time. The evaluation was conducted by Project HOPE and the Navoi Oblast Health Department (OHD) specialists. The results of the evaluation provided useful information in creating the steps needed to establish AFRH service rooms in rayons. AFRH service rooms in the following rayon HFs:

- Adult Polyclinic, Children Polyclinic, Kiziltepa rayon;
- Adult Polyclinic, Konimekh rayon;
- Adolescents, students and youth, City Center, Nurata rayon;
- Adult Polyclinic, Children Polyclinics, Karmana rayon.

The first AFRH clinic monitoring was conducted in Navoi city at the 'Children and Adolescents' Reproductive Health' Center in September 2005. The Center was established in July 2004 during the first phase of ARH program implementation.

Furthermore, the specialists of the facilities were trained and the rooms the specialists were using were refurbished and equipped. All Centers and rayon AFRH service cabinet HPs were recipients of trainings such as 'Adolescents reproductive and sexual health' which was a five-day TOT that took place in 2004 for Navoi Center HPs and in 2005 for rayon HPs; 'Organizing AFRHS' which was a three-day training that took place in 2006; and 'Developing AFRHS protocols' which was a three-day training that occurred in 2007.

To increase the quality of AFRH services in the selected facilities in the four rayons and in Navoi city, to motivate HPs to offer quality services, and to introduce them to international standards for YF facilities, a three-day training on AFRH services management was conducted in Navoi, for 15 HPs of the selected facilities, from March 30 to April 1, 2006.

During the CS project, Project HOPE educated a large number of adolescents through formal school classes and peer educators and also created a clinic for the youth population. The work also involved school teachers and some community leaders. To accomplish project objectives, Project HOPE developed and offered four types of training events for adolescents and peer educators. These activities included:

Type of Course	Participants	Objectives
A five-day TOT course on 'adolescent reproductive and sexual health'	394 health providers and school teachers responsible for 'ARH' classes and counseling	To improve the health providers' knowledge about adolescent reproductive health topics and to develop their skills in providing classes about ARH; to inform health providers about youth friendly service requirements; and to teach health providers to provide youth friendly counseling on reproductive measures.
Two-day courses at schools on 'adolescents reproductive and sexual health'	339 school teachers and health providers	To practice conducting 'ARH' classes; select the most active pupils to be trained as peer educators; to inform adolescents about reproductive organs physiology, including function of the organs; to educate of healthy lifestyle; to explain the importance of abstinence; to inform about consequences of initiating sexual activities early in life; to inform adolescents about the effects early marriage, pregnancy and abortion can have on their own life; to inform adolescents about modern contraceptive methods, advantages and disadvantages; to inform adolescents about STI and HIV/AID transmission and prevention; to educate adolescents on 'safe-sex' practices; about reproductive health rights; and to provide adolescents with information courses on reproductive health.
Four-day 'peer-to-peer' course on peer education	405 Peer educators	To provide correct adolescent reproductive health information through peer educators.

		Includes counseling skills.
Five-day monitoring courses for the adolescent education component.	specialist to monitor teachers, adolescents and peer educators	to develop/adapt monitoring tools; to define weakness and strengthening in program education; and to help teachers and peer educators to improve their work. All 105 schools in the project area were monitored.
Two-day course on ARH	1,012 students and youth	Taught principals of ARH includes physiology of RH system, consequences of early marriage, advantages and disadvantages of modern contraceptives, prevention of STI/HIV and safe sex practices.
Tow-day course for establishing youth friendly services	30 ob-gyns and midwives	Taught principals of youth friendly services and youth counseling skills.
Summer camp	140 adolescents	

In summary, a total of 733 adult trainers, 405 peer educators and 1,152 adolescents have been trained, thanks to the project.

The training was organized in agreement with the Republic ARH Center of Tashkent and the curriculum developed in strict cooperation with this institution.

During the field visits, all HPs interviewed showed their great appreciation for this training course, generally defined as essential for their practice within the AFRH clinic as evidenced below:

> *"After the training, we started to reorganize our medical service. We dedicated a room specifically for adolescents, we put a sign outside the door with the list of services provided to them, we gathered here all the IEC ARH materials that we had in different places, but most important we have learned to help adolescents who come here with STIs or who are pregnant before marriage or just come around to know more about sexual life, instead of condemning them… one of us is always available for our young clients…".*
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> ***Health provider at Karmana AFRH service***

Project Results:

- All the facilities offer medical and information services for youth only and are staffed by YF trained personnel.
- The oblast ARH Center and one of the rayon level Centers in Nurata are physically independent from other health services (located behind the adolescent polyclinic) while

the other four facilities offer a separate room for providing youth services within the polyclinic.

- All the facilities offer medical services, psychological counseling and educational materials; the Oblast AFRH service is equipped with a library, a computer with internet connection, and a photocopy machine.
- Peer educators are actively involved in the Navoi YF clinic: about 15-20 peer educators are regularly present on Mondays and actively support different educational activities carried out by the center in different locations.
- ARH promoters of the Oblast center cooperate with school ARH promoters, conducting ARH classes in different schools and with Makhalla leaders, facilitating community events in the nearest Makhalla. Kamolot, a local NGO, involves the YF promoters for different educational events.
- A telephone in the all but one AFRH facilities (a teen 'Hotline') is used to provide phone consultations and information to interested teens, while maintaining the anonymity of the caller.
- The Navoi AFRH center is well advertised in leaflets and T shirts.
- Navoi YF clinic satisfies the international criteria[6] of AFRH service clinic up to 95.4% [7].
- Technical support is provided to the AFRH services during monitoring and occasional visits to the center during other activities. The Oblast AFRH center is in charge of the implementation of the services in the rayons, but lack of transport is negatively impacting on the activity[8].

During the final evaluation of the CS Navoi project, several health providers openly shared their views on ARH in their facilities:

> *"The adolescent polyclinic has always had 10 counsellors on staff, but the [CS Navoi] project has introduced a new approach that makes ARH a normal issue that can be discussed and talked about… Things have changed in the last 10 years, and adolescents need and want to talk about sex, STIs and HI/AIDS. The project has just come on time and has been implemented in time, helping us to update our knowledge, our methodology and our views, in order to help our adolescents."*
>
> ***Director, Oblast AFRH center***
>
> *"When we started, we had 1 adolescent per week coming at the clinic. Now we may see more than 10 clients per day, who ask questions on STIs, pregnancy, contraception. Susie[9] who is a 20 year old girl, has been one of our first clients, and she is still using the services…"*
>
> ***Director, Oblast AFRH center***

[6] WHO, YFRHS Consultation, 2001

[7] CS Navoi project monitoring data, July 2006

[8] The Oblast ARH Center does not have their own transport or transport expenses in the budget to regularly visit rayons. The OHD also do not have enough money to provide to Oblast ARH Center specialists to visit rayons.

[9] Not her real name

Challenges

As can be imagined with a project seeking to increase adolescent reproductive health services in a traditional setting, there were challenges at various levels of program implementation.

Challenges in Health Sector:

- Non-existence of MOH polices or standards regarding AFRH services.
- Health care workers are not comfortable working with youth on issue of ARH.
- Health care workers are not sufficiently trained in adolescents' reproductive health issues.
- No systemized approach to adolescent service organization.
- Distrust on part of young people toward health care workers.
- Weak network of health facilities and international organizations working on adolescent reproductive health issues.
- Inability of health care workers to establish contact with youth outside health facility
- Problems with confidentiality.
- Problems with maintaining clients' anonymity.

Challenges in Education Sector:

- Lack of empathy for youth.
- Insufficient use of effective technologies to work with youth.
- Improper allocation of staff.
- Lack of resources.

Challenges in Community Sector:

- Customs and traditional views on bringing up of youth do not welcome open dialogue between adults and youth about sexual issues. These views are held both at the community level as well as at the facility level.
- Community leaders have lack of information and skills to provide information regarding reproductive health to adolescents and their parents in correct and straight forward manner.
- Working relationships regarding ARH were not previously established among education and health care workers, makhalla and Department of Internal Affairs.
- Parents are very uncomfortable speaking with their children about sex.

To overcome the above listed challenges, Project HOPE developed programs (in the form of meetings and trainings) for each sector to:

- ✓ Increase awareness of each sector in ARH issue,
- ✓ Increase knowledge and skills of providers in each sector,
- ✓ Develop educational and informational materials for educational process for HPs, teachers, adolescents, makhalla leaders and parents,
- ✓ Increase access to ARH health and education services by adolescents, and
- ✓ Create a network of all sectors and organizations deal to ARH services.

M&E System used to Monitor Results of Approaches

Project staff conducted qualitative monitoring of AFRH services bi-yearly in cooperation with OHD and the Oblast AFRH center. The draft version of AFRH service monitoring instruments was developed on August 22–30, 2005 by the children and adolescents reproductive health specialist at the Navoi oblast Center and CS Navoi staff. As it was the first time to conduct ARHS monitoring, the team decided to use the instruments as a pilot version and to continue revising the instrument after using the tool during monitoring visits. The questionnaires were then customized incorporating feedback from piloting the questionnaires. The following questionnaires or monitoring tools were developed:

1. Questionnaire for interview with the person responsible for quality services to adolescents on reproductive health and presence of necessary inventory at 'Youth friendly facility service' /Instrument 1 {See final KPC report annexes for all project monitoring tools.}
2. Questionnaire for HP of 'Youth friendly facility service' /Instrument 2
3. Questionnaire for interview with clients of 'Youth friendly facility service' /Instrument 3
4. Questionnaire for observation of visiting client of 'Youth friendly facility service' /Instrument 4
5. Checklist

The following materials were used to develop the questionnaires: A guide to Monitoring and Evaluating Adolescents Reproductive Health Programs/Tool Series 5, June 2000; Monitoring and Evaluation Plan/AYA June 2004; and Youth Friendly Facility Service -Guideline for Trainers, UNICEF, 2002.

Statistical data on service utilization and events organization are routinely collected by the OHD. OHD monitors activities related to improved ARH educational and medical services as this is now a national priority, being implemented under Goverment decree #242. All information is collected quarterly on activities which OHD reported to the MOH and Oblast Government. The project assisted on collecting information by providing technical support on conducting school-based, makhalla-based and health facility-based monitoring.

Project monitorings gathered mostly qualitative data but the project tracked some quantitative data, including number of trained students and number of conducted events in makhalla or schools by trained people. The table below shows the selected indicators for the different services provided by the AFRH centers, since the beginning of the programme 2004:

Navoi Youth Friendly Service – July 2004 to November 2006:

Services	Jul 2004-Dec 2004	Jan 2005-Dec 2005	Jan 2006-Nov 2006	Total
No. of youth using the facilities	900	4300	3500	8,700
No. of youth counseled	280	1400	1300	2,980
No. of youth medically checked up	620	2900	2200	5,720

No. of diagnosis	300	1700	1600	3,600
No. of STIs diagnosed	0	2	4	6
No. of youth requesting contraceptives	38	66	36	140
Oral contraceptive	10	11	7	28
Injectable contraceptive	6	11	9	26
Intrauterine device	1	12	8	21
Condom	21	32	12	65
No. of youth using the Hot line	65	248	262	575

Rayons Youth Friendly services	Karmana Jun 2006- Nov 2006	Kiziltepa Jun 2006- Nov 2006
No. of youth using the facilities	5517	5436
No. of youth counseled on contraceptive methods	3528	432
No. of check-ups	1499	5004
No. of diagnosis	1387	287
No. of STIs diagnosed	[e]	[e]
No. of Hotline calls	375	18 [f]

[e] STIs diagnosis is not done at the center because none of the centers has their own test laboratory and needed reagents. Clients are referred to vinearologic specialists for lab tests. In the case of STI suspicion, adolescents are referred to Venerealogical Center (VC), which is located in the center of Navoi city, not that far from the ARH center in Navoi city. VCs are also located in rayons too.

[f] Telephone hotline activated in September 2006.

Key Findings

Indicators	KPC Baseline (Feb 2004)	KPC FE (June 2007)	Target
Percent of targeted adolescent population (16-18) who can state that women are likely to get pregnant halfway between two menstrual periods. [10]	1.3%	35.3 %	40%
Percent of targeted adolescent population who can name at least three methods of contraceptive methods.	29.8%	82.7%	70%
Percent of targeted adolescent population can name at least two mechanisms of HIV transmission.	44.2%	90.7%	75%
Percent of targeted adolescent population who can name at least two means of protecting themselves against contracting STIs.	16.7%	80.3%	50%
Percent of targeted adolescent population report having used (or whose sexual partner used) a condom during last sexual intercourse.		55.6%	50%
Percent of targeted adolescents who can correctly name at least six steps associated with correct use of a condom.		16.7%	15%

Supporting Data

Footnotes throughout the report have indicated sources of data. The primary sources of information were used in the writing of this case study: the KPC baseline survey based on the 30 cluster methodology recommended by CSTS and the final evaluation, which included both qualitative and quantitative methodologies. Information from the project monitorings was also used for the case study.

Lessons Learned

- Beliefs, local traditions and customs need to be considered before designing ARH educational and informational materials.

[10] The project team discussed this indicator with the technical working group after conducting a school based monitoring. In the opinion of HPs, teachers and peer educators, the menstrual cycle is the most difficult concept to grasp. As most adolescent girls do not have a regular menstrual cycle at this age, it is difficult for them to count the time of halfway between two menstrual periods. This explains why most of adolescent girls do not pay much attention to this issue. Additionally, peer educators and AFRHS HPs felt that for adolescent girls who are not sexually active, they need not worry about when woman is more likely to get pregnant. These same individuals felt that those adolescents who are sexually active should use more effective contraceptive methods such as condoms.

- ❖ It is advisable to begin work with MOH, MOE, Public Prosecutor, Community, Youth organizations in rolling out ARH services.
- ❖ Ensure parents involvement through CHP strategy and the education sector.
- ❖ Include needed financial resources to improve AFRH service access, HPs performance and monitoring.
- ❖ Involve peer educators in AFRH service provision and monitoring.

Recommendations/Future Steps

- To increase acceptance of ARH in the schools, it would be important to have the subject offered as a required credited class so that it will be offered regularly.

- There is a demand and need for additional peer education training as there is high turnover in the schools. It would be advisable for Project HOPE to organize a peer education training plan with the MOE and the RH Center. Trainers, peer educators, volunteers and a training center already exist, so this recommendation would be easy to implement.

- It would be useful to involve the school administrators in ARH promotion and teaching.

- Pay more attention to adolescent services in the rayon polyclinics. Try to encourage the Ob-Gyns to work better with the youth friendly practitioners. Also recommended is that the Oblast ARH staff support the rayon youth centers. It would help if the Oblast arranged regular meetings with rayon RH specialists on the provision of youth services. It would also be useful to advertise the youth services in the rayons as they did at the Navoi Center by providing the center addresses and hotline numbers on the brochures.

- At the request of many, the teachers want to implement the ARH program in the non-pilot rayons. This could be done through the AFRH center in Navoi together with the Oblast education center. It is recommended that Project HOPE coordinate a meeting between the Oblast education and Health departments to plan for such an activity.

- There is also a continuing need to educate parents about ARH. It would be useful to organize meetings between parents, the health center staff, the education sector and makhalla sectors. Project HOPE can help the education sector organize an agenda and plan for such a meeting.