

Formative Evaluation of Improvement of Mother and Child Health Services in Uzbekistan

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Final Report

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We are hopeful that the recommendations of this evaluation will help the Ministry of Health and the Donors' community to further enhance national capacity.

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ABBREVIATIONS

ADB	Asian Development Bank
AWP	Annual Work Plan
BABIES	Birth weight, Age, Boxes, Interventions, Evaluation System
BCC	Behavioral Change Communication
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
BFHII	Baby Friendly Health Institutions Initiative
CIMCI	Community Integrated Management of Childhood Illness
CRB/s	Central Rayon Hospital/s
CS	Caesarian Section
CSP	Child Survival Package
DQA	Data Quality Audit
EC	European Commission
ENC	Essential Newborn Care
EPC	Effective Perinatal Care
EU	European Union
FG/FGD	Focus Group/Focus Group Discussion
FUAT	Follow-Up After Training
GD/GDP	Growth Monitoring/Growth Development Monitoring
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
GP	General Practitioner
HIMCI	Hospital Integrated Management of Childhood Illness
HM	Health Management
HP/s	Health Provider/s
IEC/BCC	Information, Education Communication/ Behavioral Change Communication
IFI	International Finance Institutions
ILBD	International Life Birth Definition
IM/IMS	Integrated Monitoring/ Integrated Monitoring System
IMCHS	Improvement of Maternal and Child Health Services
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IYCF	Infant and Yung Child Feeding
JMT	Joint Monitoring Team
LB	Live Births (denominator for MMR, NMR, IMR and U5MR)
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MTEF	Mid Term Expenditure Framework

NCC	Newborn Community Care
NGO	Non Governmental Organization
NMR	Neonatal Mortality Rate
NR	Newborn Resuscitation
NSP	Newborn Survival Package
Ob/Gyn	Obstetrics and Gynecology
PHC	Primary Health Care
PIMCI	Primary Integrated Management of Childhood Illness
PPP	Purchasing Power Parity
PSC	Project Steering Committee
QI	Quality Improvement
QoMNHC	Quality of Maternal and Newborn Hospital Care
RF	Results Framework
SVP	Rural Primary Care Unit
TOT	Training of Trainers
U5MR	Under five (5) Mortality Rate
UHES	Uzbekistan Health Examination Survey
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

COUNTRY CONTEXT

Uzbekistan is a landlocked Central Asian country with approximately 30 million people. 37% of the population is estimated to live in urban areas and more than 10% are children below five years of age. In Uzbekistan, steady progress has been made on improving the health, nutrition and wellbeing of mothers and children since gaining the independence in 1991.

The under-five mortality rate fell from 74 to 36 per 1000 live births between 1990 and 2009¹. However, challenges remain and further improvements are required with a more holistic approach, embracing maternal and child health (MCH), nutrition and wellbeing. The neonatal mortality rate at 26 per 1000 live births is 2.5-3.5 times higher if compared to EU states². 79% of infant deaths occur during the first 30 days of life due to avoidable causes³, despite 95% of deliveries are attended by health professionals. The poor quality of maternal, perinatal and early neonatal care is contributing to a high rate of newborn and maternal deaths (maternal mortality is 24 per 100,000 live births⁴).

Over the last decade, several reforms have been implemented to increase the health system's efficiency, including: reorientation of primary health care, improvement of emergency care and introduction of a basic package of services. Despite such gradual changes, Uzbekistan's health system retained many features of "Semashko's model" and the sustainability of the modernization process is not reflected in its governance.

The stewardship function of the Ministry of Health (MoH) is focused on centralized management rather than on policy making and regulation. The reform has been focusing on improving the infrastructure and hardware component and less on improving health care providers' skills. Thus it did not bring the desired change in the **quality of care** in its dimensions of safety, effectiveness, patient responsiveness and counseling along the continuum from preconception to adolescent care, particularly care around birth. The concentration of health workers is very high with 134 health providers for every 10,000 people – 5 times more than WHO standards⁵. However, the distribution is uneven, their skills are variable and they are underpaid.

At the same time, the reform has done little to ensure **equitable** access to and use of services, thus, leaving the room for disparity on morbidity and mortality especially in economically and geographically deprived regions. A recent comparative analysis of MICS 2006 data concludes that under-five and child mortality rates are at least 20% higher in rural areas compared with urban areas and 70% higher among the poorest quintile as compared to the richest.

The **Health financing** system primarily involves input-based allocation and disregards actual performance and outcomes. According to WHO estimates, the total health expenditure stands at 169 US\$ PPP per capita, out of which public health expenditures account for only 42%⁶. Though state-guaranteed contributions are the major source of health sector's financing, they are mainly utilized on salaries and operational costs. Out of pocket expenditures by families amount for around 60% of the average medical costs, which greatly contributes to raise access barriers and hinder the use of services by the needy part of the population. A

¹ http://www.unicef.org/infobycountry/uzbekistan_statistics.html

² http://ec.europa.eu/health/ph_information/dissemination/echi/echi_05_en.pdf

³ Ibid

⁴ http://www.childinfo.org/maternal_mortality_countrydata.php

⁵ <http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2>

⁶ Integrated Mother and Child Health Services in Uzbekistan, Inception Report, 2008

recent UNICEF study on child poverty found that 38% of children with common illnesses in poor families are not taken to health facilities because of the unaffordable costs.

PROJECT DESCRIPTION

In 2003, the Government initiated a sector reform programme to improve maternal and child health services. The Programme, supported by World Bank, ADB, UNICEF, WHO, UNFPA and others, addressed the gaps within the primary health care, supply and in-service training systems.

With technical support from UNICEF, the Ministry of Health (MOH) piloted the innovative Newborn Survival Programme in Ferghana region. The objective was to develop evidence-based training materials on newborn care, neonatal resuscitation, perinatal healthcare surveillance and the International Live Birth Definition and to introduce them through systematic training and supervision. The evaluation showed that the package had an impact on reducing neonatal morbidity and mortality. The latter recommended scaling up the Ferghana model in transitional health systems with established primary care and referral systems⁷. The MOH and UNICEF worked together to plan the expansion and scale-up in other 8 regions. Additional components of child survival, health management and the introduction of maternal child healthcare were included in pre-service training.

As a result of this process and in a partnership between MoH, UNICEF and financial support by the European Commission, the “*Improvement of Mother and Child Health Services (IMCHS)*” project was designed, aiming at improving health care providers’ skills on quality of care in eight regions of Uzbekistan.

Overall Objective of the project was to support Uzbekistan in meeting the targets of the Millennium Development Goals numbers 4 and 5, with a focus on improving the quality of Mother and Child Health care.

Project’s Specific Objective was to support the implementation of Uzbekistan’s national healthcare reforms through expanding the application of the WHO Live Birth Definition, together with strengthening newborn care and improving the quality of maternal and child health care by developing skills and capacity in pre-natal and newborn care at the hospital level and the management of childhood diseases at the primary health clinics.

Expected Results were:

1. Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics.
2. Improved quality of care during delivery and post natal care in all hospitals and maternity centres
3. WHO “live birth definition” universally applied
4. Reporting and monitoring system of births improved.
5. Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated)
6. Public awareness of “best practice in child care in general” is raised

The project commenced in July 2008 and was completed within thirty six months in July 2011. The IMCHS Project has been implemented in close partnership with national and international partners active in MCH sector⁸.

⁷Zulfiqar A Bhutta – Evaluation of Newborn Survival Training Programme in Ferghana Region, Uzbekistan.

⁸ WHO, WB, ADB, UNFPA, GIZ, JICA, USAID etc.

PURPOSE, OBJECTIVES, METHOD AND SCOPE OF EVALUATION

After the Ferghana Region pilot phase being evaluated successful and replicable, the project under analysis contributed to expand the Fergana model to 8 out of 14 regions. The selection of the project regions was based on the sorrow analysis of the other partner targeted regions. The IMCHS project has been implemented in the time period of July 2008 – July 2011 with EU funding.

In order to inform the second phase, UNICEF Uzbekistan commissioned external formative evaluation of the IMCHS project in September, 2011 with the purpose to assess successes, shortcomings and replicability of already completed IMCHS project, as well as to analyze its potential to inform and influence the MCH sector reform. The findings and recommendations provided in this report will be used to inform the next steps for nationwide scale-up of the intervention, as well as to advocate for policy amendments and the strategic planning in the framework of the sector reform. In addition, the report will be used to adjust the strategy and maximize the impact and improve the design for the second phase of the project in convergence with other sectors.

The evaluation findings and recommendations will be used to inform the next steps for nationwide scale-up of the intervention, as well as to advocate for policy amendments and the strategic planning in the framework of the sector reform. In addition, the report will be used to adjust the strategy and maximize the impact and improve the design for the second phase of the project in convergence with other sectors. The findings of the evaluation will be used by MOH, UNICEF, WHO, EU, UNFPA and other partners.

The evaluation focused on assessing the IMCHS project's current and potential contribution to the improvement of MCH sector reform. Each evaluation criterion was analyzed from the perspective of assessing the project activities' implications on:

- **Final beneficiaries:** caregivers, families, mothers and children;
- **Service providers:** health care professionals whose capacity has been built (including doctors, midwives, patronage nurses, health facility managers);
- **Sub-national decision-making level:** Regional health authorities and Hokymiats (local governments)
- **National decision-making level:** national authorities and key stakeholders (Ministry of Health, Ministry of Finance, Cabinet of Ministers, WHO, UNFPA, WB, ADB, USAID, EC, GIZ).

The evaluation followed established OECD DAC evaluation criteria⁹. Each Project component outcome was evaluated against DAC criteria and each criterion was rated on the scale from zero to three, where three is the best. Weights were attributed to each of them and weighted average calculated.

To translate the questions for the evaluation and the contextual issues, the Evaluation Framework (EF) was developed which structures the issues and questions as indicators that can be measured or assessed during the evaluation. The latter also identifies the sources of information and the methods the evaluation team applied, the range of documents reviewed and key informants interviewed for each question.

Apart from Evaluation Framework the Project Results Framework was designed in order to assess attainment of stated targets for Project outcomes and outputs and Project's contribution towards achievement of the higher level outcomes.

The evaluation methodology comprised a mix of site visits and observation, face-to-face semi structured interviews of key informants, focus group discussions, desk-based research and review of existing reports, documents and secondary data.

⁹ The DAC Principles for the Evaluation of Development Assistance, OECD (1991) <http://www.oecd.org/document/22>

For key informants interviews the topic guides were developed based on the Evaluation Framework to help ensure systematic coverage of questions and issues. The interview topics have been selected around the evaluation questions, but grouped and targeted according to the organization and/or individual being interviewed.

The Focus Group Discussions (FGDs) were carried out for a) master trainers, b) trained PHC physicians and nurses, trained hospital practitioners, d) trained practitioners on quality control, e) patronage nurses and f) beneficiaries in both regions visited. In total the team carried out 8 FDG in two Project target areas (Namangan and Samarkand). For each FDG the guides were designed. FGD guides for service providers reflected questions relevant to evaluation criteria, while FGD guide for service consumers was oriented towards measuring consumer satisfaction with the services, perceptions of improved quality of MCH service provision and demand for services.

The four major sources of data were used during the evaluation process: people, site visits to a sample of oblasts supported by the IMCHS program, documents and information system.

The design of the evaluation methodology considered ethical issues and applied number of approaches such as i) kept evaluation procedures¹⁰ as brief and convenient as possible to minimize disruptions in respondents work process; ii) in order to allow participants to make an informed decision they were information about the purpose of evaluation and final outcome as well as on the process and duration of interview and/or FGD; iii) the respondents were also ensured about the confidentiality of the source for obtained information and allowed them to retain from answering the questions posed in case they felt uncomfortable to respond; iv) key informants were interviewed face to face without presence of other individuals while for the FGD, the grouping (physicians, nurses, beneficiaries etc) has been applied to encourage open discussion around the evaluation questions by avoiding presence of their superiors; and v) collected and analysed information as well as reported findings are accurate and impartial.

The evaluation was a joint and participatory process involving the team of three MOH experts, accompanied the evaluation team during the field visits and semi-structured interviews. For the validation of the preliminary findings and recommendations the team met key MOH staff and Project steering committee members. In General all stakeholders agreed on the main findings of the evaluation as well as noted provided recommendations for further consideration in their respective projects. The evaluation team incorporated stakeholder's comments for final formulation of the evaluation findings and recommendations. Specifically, relevant stakeholders were given the opportunity to comment on the draft evaluation report and the final evaluation report reflects these comments and acknowledged any substantive disagreements.

FINDINGS AND CONCLUSIONS

RELEVANCE

NATIONAL DECISION MAKING LEVEL:

National data on burden and causes of diseases affecting children in their first years of life and the baseline assessment of HPs performance on MNCH delivery care substantiate the remarkable effort undertaken by the IMCHS project that provided training to primary, secondary and tertiary level health care providers on evidence-based interventions in newborn and child health care.

SERVICE PROVIDER LEVEL:

¹⁰ FGD and Semi-structured interviews

Project addressed the shortcomings of MCH human resources and invested in the development of the critical mass of trained MCH providers in 8 selected Oblasts. Through the delivery of the MCH training package to the HPs and health managers the project facilitated changes in the MCH service structure and service provision processes. Health managers who underwent training in HM were prone to support needed changes at health facility level, and were willing to allocate budget for medical supply. Consequently, management training should be always carried out before any other training on clinical skills improvement. Moreover, the training duration and the topics covered have to be extended as well as the selection of participants has to be given a priority.

FINAL BENEFICIARIES:

Special emphasis was given to community empowerment activities by provision of interpersonal communication training to patronage nurses. Proper counseling, delivery of information and education of mothers aimed at demand creation for quality child care and health seeking behavior.

EFFECTIVENESS

PROJECT IMPLEMENTATION STRUCTURE:

Coordination: Establishment of the Project Steering Committee, led by the MOH, ensured coordination of MCH reform inputs from all partners involved in the MCH reform activities. To avoid duplication of efforts the Joint Action Plan (JAP) has been developed under the leadership of the MOH/PSC and UNICEF and technical inputs from the partners. While the JAP is informative and has been effectively used by the MOH and partners in planning their activities, it has certain shortcomings for Government's strategic coordination and planning purposes as it lacks the mapping of all reform activities as well as information on the guaranteed funding (state/donor) per type of activity.

The MOH has certain limitations with regards to effective Donor coordination. It still has not managed to galvanize and lead Donors and partners to support its national MCH strategy, because the ministry not only needs effective coordination tools and processes but it also capable staff, which is currently in short supply. The coordination meetings mostly serve as a venue for information sharing only and rarely address implementation problems and/or assess specific results achieved by various projects. Decisions, guidance and follow up actions are frequently missing.

Project Implementation Team: The achievements attained by the project would have not been possible without strong project implementation team. The effectiveness of the "paring approach" applied for the training component of the project has to be acknowledged. For each training module the MOH staff was assigned as a coordinator, being in charge of planning, supervision and reporting. The given arrangement at the one hand ensured effective communication and cooperation with the MOH and on the other supported national capacity building. Moreover, it enhanced linkages between national and local level professionals and facilitated knowledge and experience sharing.

Project M&E System: The IMCHS project used number of M&E tools.

Results Framework: In order to monitor and evaluate project performance the Results framework (RF) has been developed and updated on annual basis. However, effective use of this tool was limited due to the following deficiencies: a) for most indicators baseline data, targets, as well as means of verification are not defined. These shortcomings restricted project to monitor effectiveness of the project interventions, analysis and timely utilization of corrective measures; b) the project was shorthanded to use selected national statistical data for appropriate planning and monitoring effectiveness of project interventions.

FUAT: The FUAT tool is instrumental for the regular monitoring of the training effectiveness and change in practices, identification of weaknesses being it systemic, knowledge, skills and or processes as well as informing the decision makers on the required actions and ensures effective deployment of evidence based treatment practices. Whilst FUAT system has been acknowledged by the MOH, local health authorities and health professionals to be a useful tool for application of new treatment practices, its implementation had certain shortcomings that further hindered the effectiveness of the given system, which in its term was hampered by lack of supplies and structural barriers. Delays in FUAT implementation and poor applications of corrective measures by facility management and local authorities in response to findings have been observed during evaluation.

IMS: IMS was introduced by the project in exchange of the FUAT system due to the cost efficiency concerns of the latter. While from financial perspective this was the right strategy for the project to collect required outcome indicators, IMS cannot be seen as a substitute for the FUAT system. IMS and FUAT both being the monitoring tools used by the local health systems, require adequate financing. Based on the results of the evaluation, IMS is implemented but not financed by the local budgets which in its terms limit the coverage as well as motivation of experts to effectively perform the task.

NATIONAL DECISION MAKING LEVEL:

Legislative support - In support of the MCH reform implementation, the intervention influenced the legislative base formation. MOH decrees were issued per each module of the MCH training package. Nevertheless the certain shortcomings which adversely effected the implementation have been identified. Delays in issuing program specific legislative documents appeared to be a bottleneck for timely implementation of the IMCH package. Poor harmonization of the legislative base supporting MCH reform has been noted as another impediment to effective project implementation.

Introduction of International Life Birth Definition - At present all institutions nationwide report life births according to the ILBD, but have not yet being integrated into the routine Medical and State statistics systems.

National Drug Formulary - To ensure implementation of the MCH package, the MOH amended the National Drug formulary according to the medications being proposed in the MCH training package. Though absence of registration for particular drugs recommended by the treatment guidelines limits their availability in medical facilities and consequently impedes effective utilization of new treatment guidelines.

Certification of Health Professionals - The project advocated for the integration of the MCH treatment guidelines in the certification questionnaire for physicians. The certification system, the way it operates at present assesses only the knowledge of the physician, while practical capabilities are not examined. The FUAT and IMS clearly show that even in those facilities where majority of professionals are trained application of practical skills remains still below the desired levels, especially in EPC and HIMCI.

Integration of MCH training package in pre-service education system - Integration of the MCH training package into the pre-service training curricula is a good example of the project's effective advocacy. At present the Samarkand Medical Institute has modified their curricula, which will ensure that country will shortly produce the workforce of general practitioners who have been trained in evidence based treatment techniques. Whilst this is an effective step forward, it is not sufficient to ensure the production of adequately trained health workforce for the system.

Development of the national training capacity - Project has heavily invested in the development of the National MCH training capacity by training of trainers and establishment of practical training centers on national and local levels. While the project succeeded to create a national and sub-national training

capacity (human and infrastructure), this capacity is not utilized either by the pre-service, or by the post diploma and continuous professional education systems.

SUB-NATIONAL LEVEL:

Involvement of the MOH staff on the national and local levels as well as of professionals from Republican Institutions ensured building of the ownership at the national and local levels as well as building national MCH training capacity. Close working relationship and collaboration with the local level health authorities was one of the main determinants of project effectiveness, however, effectiveness of such approach could have been maximized by required capacity building of local health authorities as well as facility managers in general health management prior to training of the health professionals. Project failed to advocate for improved financing of the MCH facilities which would have otherwise served as a guarantee for effective implementation of the new treatment guidelines at the facility level. Although the Project always used the opportunities (through Regional Health Managers Training where Deputy Chief of Social Affairs from Oblast and Rayon Hakim were trained) to advocate for leveraging resources from Hokymiats, more direct project advocacy targeted towards hokymiats for adequate financial support of the project activities could have been beneficial for effective implementation of the evidence based MCH service package on the facility level. In addition, evaluation revealed lack of capacity of local and health facility managers to collect and analyze the performance data and consequently take decisive steps for further improvement of MCH service performance.

SERVICE PROVIDERS:

The MCH training package was highly successful to improve service provider knowledge, but application of the new skills by trainees was less than expected due to the lack of essential equipment, medicines and support systems to fully apply new treatment guidelines; old treatment stereotypes that formed societal norms of the quality of care limited physicians to practice new skills; resistance to change of non-trained physicians, managers as well as representatives of medical education system has been identified as another impediment for effective utilization of the new treatment practices.

Notwithstanding of identified problems, there is a significant improvement in the field of newborn and child survival when comparing findings from FUAT and IM with baseline data but remains still below the target.

The Project supported training of the patronage nurse system and equipped them with interpersonal communication skills in different areas of child care. At a glance the given system is the most effective in delivering information and educating mothers and caregivers. However, certain areas of potential system effectiveness risks have been identified. Only 14% of patronage nurses deployed at PHC system have been trained. Small pool of trained nurses paired with heavy workload, lack of communication materials and absence of transportation will generate limited change.

BENEFICIARIES:

During the FGD mothers noted the changed attitudes of the health workers. Many of them particularly stressed the friendly attitude of doctors and patronage nurses, but also expressed willingness to obtain more information about home-based care, rational nutrition, and information on disease prevention.

The positive trend in the reduction of beneficiaries' cost as a result of the effective interventions of IMCHS project is obvious. The data provided by the medical facilities visited shows dramatic decrease in costs of treatment. While these data is encouraging, not all facilities targeted under the project collect and analyse data. The absence of the national and or local level data limits evaluation team to assess the degree of

intervention's effectiveness. The team was unable to solicit data on that substantiate a decrease of private out-of-pocket expenditures on health, and consequent increased utilization of the services.

The assessment of the progress against the plans shows that implementation of the IEC/BCC activities started later and actually was implemented during the last year of the project. At the same time the level of engagement at the policy and decision making level can be considered ineffective as the project failed to build the productive working relationship with the Institute of Health and Medical Statistics in the process of production and distribution of BCC materials, when one of the functions of this institution is to produce the printing materials for health promotion and healthy life style for the whole population. Moreover, the institute being the member of the task force for the development of the IPC, preferred to work in isolation of the project. Nonetheless, the interventions directed towards improvement of counseling shows positive trends for selected indicators. Should more indicators being measured as part of the M&E and or being available from special surveys, rating effectiveness of given intervention would have been easier.

EFFICIENCY

USE OF RESOURCES:

The detailed evaluation of the efficiency of resource use was constrained by two main factors. Absence of the programmatic budget limited evaluators' ability to analyze the resource use against project component/activity outputs and outcomes. Although there was a possibility to work out main costs of interventions for further analysis and comparison with the costs of similar activities supported by other donors, performance of this exercise was not possible due to: a) time and resource intensity of the task; b) the evaluation time constraints, and c) unwillingness of other donor organizations to share the costs of selected interventions.

Despite above outlined limitations, the evaluation team managed to roughly analyze training costs. Although alternative information on the training costs from other partners were not made available the evaluation team thinks that the project's training cost ranks high in comparison to the training costs in other former soviet countries¹¹.

SERVICE PROVIDERS:

Cascade training approach - has been deployed by the project in order to use available resource in the most efficient manner as well as target critical mass of professionals with the MCH training package. The given approach worked effectively and served the purpose of creation critical mass of trained health professionals though had certain weakness that questions the efficiency of trainings and need to be addressed in the second phase of the project. Poor guidance provided to local health authorities on the trainee selection criteria resulted in non-trained local and facility managers in some locations which had negative implications on the effective implementation of the new treatment schemes and subsequently on the efficiency of the training program. The effectiveness of cascade training was also hindered by uneven coverage of facility and oblast HPs with training packages. Insufficient coverage resulted in low performance hindering the cost-efficiency of the intervention. Training courses organized locally (oblast), without UNICEF/EU project support, are shorter in duration compared to the ones carried out with project support. Furthermore, these trainings are not certified thus the participants are not entitled to utilize these training hours for career development purposes and lack motivation to be trained.

¹¹ For example: Georgia spent 13 – 20 Euros per participant/ per day for 10 day training program. Printing costs accounted for 5-10% of total training costs. Armenia spent 17-27 Euros per participant/per day for 10 day training program.

Peer to peer training system (trained professional training the peer in the same facility) was limited to only information sharing and lacked theoretical and practical training elements. There was a shortage of the training materials. Materials received by the trained professionals in some instances were kept by them at home and were not readily available for their peers. These trainings lacked the practical application of the new skills due to the training time limitations as well as due to the scarcity of adequate number of patients. All these problems slowed down effective implementation of the reform in target oblasts and facilities.

FUAT and IMS - were used to monitor trainee performance. The results of both monitoring rounds show neither significant performance improvements nor impact of monitoring mechanisms in the improvement of weak areas, such as NR/ENC, EPC and HIMCI. FUAT according to its design was more instrumental to influence the positive performance through supportive supervision, but failed to meet cost efficiency criteria when practice improvement against resources spent is compared. The assessment of IMS efficiency, although being three times cheaper than FUAT, still needs to be assessed in the second phase.

BENEFICIARIES:

The overall distribution of trained medical personnel at PHC level in piloted 8 Oblasts is uneven and varies for GPs (53%-69%) and employed patronage nurses (14%). The patronage nurses system cannot reach the targeted population efficiently, the frequency of visits vary from one visit each month or two months. Therefore, the inter-personal communication package and the patronage nurses' system efficiency can be graded as moderate in terms of reaching the target groups and increasing their knowledge on child caring as compared to the absorbed resources. The resources spent on production of communication materials, which in fact were not enough for the required level of dissemination, cannot justify being efficient.

SUSTAINABILITY

NATIONAL LEVEL:

MOH ownership is present in all project components. Integration of project strategic directions in the higher level national policies serves as a prerequisite for sustainment of the MOH ownership and leadership in promoting MCH reforms. The Deputy Minister of Health responsible for MCH sector being the chairman of the PSC ensures MOH permanent presence. Appointment of the MOH staff as coordinators of MCH training package modules guarantees availability of critical mass of professionals in the MCH field.

Integration of the MCH package into the certification system as well as in pre-service education system is an important element of sustainability, though not sufficient. As mentioned above, the certification system measures only the theoretical knowledge of practicing HPs and cannot substantially influence the practice patterns. Integration of the MCH training package into pre-service education system piloted in Samarkand Medical Institute may not ensure sustainability of this system if not expanded to other Medical Institutes in the country. Moreover, physicians are not the only health providers being involved in MCH service provision. Adequate actions are required for integration of the MCH training package into the pre-service education of nurses, midwives and health managers.

Furthermore, the MCH training capacity, human and infrastructure, built by the project cannot be sustained if not integrated and utilized into the post diploma and continuous education systems as keeping the project established training system as an independent vertical system raises the risks of the non-sustainability.

LOCAL LEVEL:

Ownership at the local level is uneven. Even in those oblasts where the ownership is strong, managers have limited leverage to mobilize resources in support of the reform implementation. This problem cannot be only attributed to the weak leadership of certain managers; rather to the budget formulation process established in the country which limits local authorities to influence budget allocations. As a result, funding of trainings initiated by local authorities as well M&E activities are deficient. Systems in place cannot function effectively without adequate funding and is difficult to sustain.

Evaluation revealed that effective implementation of the MCH program is also jeopardized by the lack of basic general health management skills and knowledge that would enable them to analyze and use data for planning resources and priority action. The Health Management trainings provided by the project proved to be effective only in some cases thus the mitigation of sustainability risks locally requires more system oriented interventions and cannot be limited only to programmatic interventions.

SERVICE PROVIDERS:

Gaps along the continuum of care are observed. Not all facilities have supportive environment to apply the new patient management guidelines and protocols. This is why children's caretakers and pregnant women still prefer Oblast hospitals where they can find quality health care, while their ailments and conditions can be managed at PHC or Rayon hospital level. Self-referral to regional hospitals is slowly declining, but still present. Furthermore, in absence of supportive structural environment where to practice, even trained HPS lose their new acquired skills and continue to practice in old fashion.

The low penetration of new treatment approaches is further deteriorated by the high levels of trained human resource dropout rates as suggested by anecdotal evidence.

For the time being, practicing trained HPs show high moral and motivation, which are mainly sustained by the enthusiasm of applying new practices, supportive supervision and better relation with patients that show gratitude for the improved service. However, in the long run motivation might deteriorate, especially if basic, necessary changes will not take place, such as regular supply of needed medication and upgrading of infrastructures as well as introduction of financial and nonfinancial motivation schemes to influence physicians' behavior.

As the delivery of MCH trainings is a vertical system utilized only by the international projects, integration of these trainings into the continuous professional education system should be addressed. Moreover, ensuring the long term sustainability of the evidence based treatment approaches requires that the medical education system produces well trained physicians, nurses, mid-wives as well as managers which has been partially addressed by the project.

BENEFICIARIES:

The newborn and child survival approach implies the implementation of evidence-based interventions which limits invasive medical practices and unnecessary prescription/administration of multiple drugs. This approach was new to patients and caregivers who were used to value aggressive medical intervention, poly pharmacy and hospital based treatment rather than PHC. Although the initial mistrust of patients and caregivers towards those HPs who have adopted the new approach is gradually decreasing, but still persists supported by deep-seated beliefs and habits in the community as well as HPs who still practice in old-fashion medicine.

On the other hand, uneven quality of services, despite the deployment of trained HPs, discourages patients to attend primary level health facilities, and prefer to receive services at secondary or even tertiary level health facilities. Absence of health facility and HP performance evaluation to practice new treatment protocols and counseling skills, have consequent negative implication on quality of MCH services and its

sustainability, as well as effects mothers and caregivers access and use of quality MCH services and continuity of care.

The projects approach to influence beneficiary behavior through patronage nurse system proved to be effective in delivering correct information concerning when and where to go to seek medical care. However, low coverage of patronage nurses with interpersonal communication training, poor funding, lack of transportation means, and absence of caregiver’s educational materials may undermine the its sustainability.

The FGD with patronage nurses and beneficiaries revealed that the right information might not reach the right person. Culturally, the family structure foresees a strong role for mothers-in –laws as main family decision makers in issues of child bearing, feeding and treatment, which usually are not targeted by communication and awareness interventions.

And finally affordability of health services significantly affects access to the health services. There are documented examples of reduced costs of health care where evidence-based interventions have been implemented. In the due time, this should also reflect to family expenses for health care that can be potentially reduced by reducing the number of prescribed drugs and hospital admission stay.

COHERENCE

The project is fully coherent with the National, EU and UNDP policies.

Based on the findings of the evaluation the Project has been rated as **Satisfactory**. Detailed ratings of main evaluation criteria are summarized as: Relevance and Coherence – *Highly Satisfactory*, Effectiveness, efficiency and Sustainability – *Moderately Satisfactory*.

RECOMMENDATIONS

Looking holistically at MCH sector of Uzbekistan and its needs which are consistent with UNICEF’s global mandate, and reflecting on lessons learnt through implementation of IMCHS Project, the evaluation team arrived at major recommendations for UNICEF support as it embarks on its second phase of the project:

GENERAL RECOMMENDATIONS FOR UNICEF:

Continue support of GOU MCH sector - In MCH sector, UNICEF is recognized as one of the leading agencies. This confirms its legitimacy and the capacity to continue work in MCH area. For the next phase of the IMCHS project, UNICEF needs to carefully chose the critical niche and craft its activities in a way to balance available funding with the efficiency and effectiveness of the program in mind.

Enhance advocacy - The new challenges identified, in the section below, will require promotion of greater linkage and partnership through strengthening of the UNICEF Country Office (CO) technical capacity in the health policy advice. When selecting final set of interventions for the new project phase, attention has to be paid to CO capacity. Some recommended actions might demand specific technical expertise, which require additional resourcing. Moreover supporting research and analysis of the MCH sector performance will be instrumental for effective advocacy. Building on “what’s already working” will help to influence the government policy decisions.

Enhance monitoring function –Enhance the project M&E system with the aim to integrate, synergize and link the achievements of individual outputs within and in-between outcomes and for the project as a whole. End-line targets for outcomes and outputs have to be defined at the design stage as well as gender related performance indicator measurement needs to be included in the Results Framework.

Attention to risk identification and planning mitigation measures -Identification of potential risks and respective mitigation measures need to be defined and incorporated in the new project design.

Gender Mainstreaming in project design and Implementation - Consider increasing attention to gender equity/equality goals in design and implementation of project activities by a) gender-relevant research, background analysis or assessments, and consultations with female and male clients as part of the design process; b) ensure gender-equitable participation in different aspects of the project activities; c) develop sex-disaggregated data for indicators and targets and include gender criteria in evaluation of the activity progress and impact. Greater attention needs to be paid to gender issues, including gender statistics, gender specific advocacy and education.

Capitalize on the “pairing approach” for project management – Positive experience of the project management arrangements applied requires further extension in the second face.

SPECIFIC RECOMMENDATIONS:

Though UNICEF is well positioned to influence the MCH policy in the country, success of the MCH services will very much depend on going beyond the MCH sector and targeting other health sector policy areas. While bellow outlined recommendations are not explicitly targeted for UNICEF assistance, evaluation team considered listing the most important system building blocks requiring intervention on the national level in order to ensure that UNICEF interventions are sustained and ensures access to quality MCH services to the population. The main body of the report also provides information on the level of prioritization as well as desired time-frame per each recommendation listed bellow.

- **Enhancement of the MOH Evidence Based Policy Formulation and Coordination Functions through:**
 - Development of an effective donor coordination framework
 - Establishment of Strong Secretariat
 - Provision of Technical Expertise and support to coordination function
 - Institutionalization of Joint program reviews
 - Development of comprehensive evidence based National MCH strategy
- **Harmonization of legislation for effective implementation of MCH Reform through:**
 - Rigorous analysis of the Health legislation
 - Harmonization of MCH related legislation
- **Elaboration and Implementation of the MCH Workforce Development Strategy**
 - Development of the MCH Workforce Strategy
 - Integration of the MCH package into pre service, post diploma education as well as continuous professional education systems
 - Continue targeting HPs with MCH training package through continuous professional education system
 - Reform Licensing and Certification systems
- **Enhancement of the MCH Service Quality Assurance Function**

- Modernization of existing M&E system through consolidation into the internal and external MCH service audit systems through development of the legislative base, allocation of adequate funding of the audit system; supporting capacity building of the National, Oblast, District and Facility Health Managers in application of the new MCH service performance audit system.
- ***Strengthening of the MCH Health Information System***
 - Institutionalization of the ILBD and assurance of accurate reporting of all MCH indicators through institutionalization of the Data Quality Audit (DQA) System
 - Build national and local capacity in MCH data analysis
- ***Strengthening of National Information, Education and Communication Function***
 - Support effective IEC activities through development and approval of National MCH sector communication strategy and implementation plan and budget
 - Expand partnership to other public institutions in support of the public information, education and communication activities by establishment of the inter-ministerial working group and signing of memorandum of understanding with lead public institutions and partners on implementation of the national MCH communication strategy.
 - Establish close collaboration and partnership between international partners and the Institute of Health and Medical Statistics by development and approval of integrated MCH communication annual implementation plan and budget covering all IMCHS planned activities and ensure MOH cost-sharing arrangements

I. INTRODUCTION

BACKGROUND AND CONTEXT OF THE PROGRAM

Country situation

Uzbekistan is a landlocked Central Asian country with approximately 30 million people. 37% of the population is estimated to live in urban areas and more than 10% are children below five years of age. In Uzbekistan, steady progress has been made on improving the health, nutrition and wellbeing of mothers and children since gaining the independence in 1991.

The under-five mortality rate fell from 74 to 36 per 1000 live births between 1990 and 2009¹². However, challenges remain and further improvements are required with a more holistic approach, embracing maternal and child health (MCH), nutrition and wellbeing. The neonatal mortality rate at 26 per 1000 live births is 2.5-3.5 times higher if compared to EU states¹³. 79% of infant deaths occur during the first 30 days of life due to avoidable causes¹⁴, despite 95% of deliveries are attended by health professionals. The poor quality of maternal, perinatal and early neonatal care is contributing to a high rate of newborn and maternal deaths (maternal mortality is 24 per 100,000 live births¹⁵).

Over the last decade, several reforms have been implemented to increase the health system's efficiency, including: reorientation of primary health care, improvement of emergency care and introduction of a basic package of services. Despite such gradual changes, Uzbekistan's health system retained many features of "Semashko's model" and the sustainability of the modernization process is not reflected in its governance.

The stewardship function of the Ministry of Health (MoH) is focused on centralized management rather than on policy making and regulation. The reform has been focusing on improving the infrastructure and hardware component and less on improving health care providers' skills. Thus it did not bring the desired change in the **quality of care** in its dimensions of safety, effectiveness, patient responsiveness and counseling along the continuum from preconception to adolescent care, particularly care around birth. The concentration of health workers is very high with 134 health providers for every 10,000 people – 5 times more than WHO standards¹⁶. However, the distribution is uneven, their skills are variable and they are underpaid.

At the same time, the reform has done little to ensure **equitable** access to and use of services, thus, leaving the room for disparity on morbidity and mortality especially in economically and geographically deprived regions. A recent comparative analysis of MICS 2006 data concludes that under-five and child mortality rates are at least 1.2 times higher in rural areas compared with urban areas and 1.75 higher among the poorest quintile as compared to the richest.

The **Health financing** system primarily involves input-based allocation and disregards actual performance and outcomes. According to WHO estimates, the total health expenditure stands at 169 US\$ PPP per capita, out of which public health expenditures account for only 42%¹⁷. Though state-guaranteed contributions are the major source of health sector's financing, they are mainly utilized on salaries and operational costs. Out of pocket expenditures by families amount for around 60% of the average medical costs, which greatly

¹² http://www.unicef.org/infobycountry/uzbekistan_statistics.html

¹³ http://ec.europa.eu/health/ph_information/dissemination/echi/echi_05_en.pdf

¹⁴ Ibid

¹⁵ http://www.childinfo.org/maternal_mortality_countrydata.php

¹⁶ <http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2>

¹⁷ Integrated Mother and Child Health Services in Uzbekistan, Inception Report, 2008

contributes to raise access barriers and hinder the use of services by the needy part of the population. A recent UNICEF study on child poverty found that 38% of children with common illnesses in poor families are not taken to health facilities because of the unaffordable costs.

Project overview

In 2003, the Government initiated a sector reform programme to improve maternal and child health services. The Programme, supported by World Bank, ADB, UNICEF, WHO, UNFPA and others, addressed the gaps within the primary health care, supply and in-service training systems.

With technical support from UNICEF, the Ministry of Health (MOH) piloted the innovative Newborn Survival Programme in Ferghana region. The objective was to develop evidence-based training materials on newborn care, neonatal resuscitation, perinatal healthcare surveillance and the International Live Birth Definition and to introduce them through systematic training and supervision. The evaluation showed that the package had an impact on reducing neonatal morbidity and mortality. The latter recommended scaling up the Ferghana model in transitional health systems with established primary care and referral systems¹⁸. The MOH and UNICEF worked together to plan the expansion and scale-up in other 8 regions. Additional components of child survival, health management and the introduction of maternal child healthcare were included in pre-service training.

As a result of this process and in a partnership between MoH, UNICEF and financial support by the European Commission, the “*Improvement of Mother and Child Health Services (IMCHS)*” project was designed, aiming at improving health care providers’ skills on quality of care in eight regions of Uzbekistan.

Overall Objective of the project was to support Uzbekistan in meeting the targets of the Millennium Development Goals numbers 4 and 5, with a focus on improving the quality of Mother and Child Health care.

Project’s Specific Objective was support the implementation of Uzbekistan’s national healthcare reforms through expanding the application of the WHO Live Birth Definition, together with strengthening newborn care and improving the quality of maternal and child health care by developing skills and capacity in pre-natal and newborn care at the hospital level and the management of childhood diseases at the primary health clinics.

Expected Results:

7. Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics.
8. Improved quality of care during delivery and post natal care in all hospitals and maternity centres
9. WHO “live birth definition” universally applied
10. Reporting and monitoring system of births improved.
11. Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated)
12. Public awareness of “best practice in child care in general” is raised

For more details of results please see Annex 5: Results Framework

¹⁸Zulfiqar A Bhutta – Evaluation of Newborn Survival Training Programme in Ferghana Region, Uzbekistan.

Logic of the Project Design

Project components	Logic of the design
1. Coordination	The nature, complexity and scope of the project require a Project Steering Committee (PSC) for coordination with national and international partners. The PSC's aim is to contribute to the effective project implementation by assuring broader political commitment and ownership and facilitating appropriate, timely and comprehensive re-actions to new challenges throughout the duration of the project. At a later stage, the PSC also started acquiring a role of linkage between the project and related policy change processes within the sector reform. In this framework, the MoH has mainstreamed project interventions like IMCI, Breast Feeding, Growth and Development, Newborn Care and Effective Perinatal Care into the MCH system.
2. Training centers	This component includes the renovation and equipping of training centres in each of the target regions. The objective is to facilitate locally-based training to reach the highest possible number of health professionals and, at the same time, to contribute to strengthening MoH's capacity for decentralized in-service training.
3. Training materials	Training materials (based on WHO standards) were adapted to the local context and integrated with the previously piloted evidence-based approach. Training materials are also updated in case of adoption of relevant new protocols. Evidence-based clinical protocols were adapted as needed for improving the management of specific problems.
4. Training of trainers	The training strategy includes the creation of a team of qualified national and regional trainers, with the objective to organize cascade trainings, coaching and mentoring and create a sustainable system with national and regional pools of trainers. The cadre of trainers, spread across the country could serve as catalyst of change in their regions, districts through training, coaching, mentoring and advocacy.
5. MCH package in pre-service training	Despite the heavy focus on in-service training, the Project also addresses the issue of up-grading the pre-service Medical Institutes' curriculum, by incorporating the evidence-based approaches in MCH (newborn and child survival packages) while providing education to medical undergraduates and postgraduate students.
6. Training of health providers	<p>The key component of the project is the capacity building of health providers in line with the piloted WHO standard protocols and clinical guidelines. Health providers include doctors, nurses and midwives working in primary, secondary and tertiary healthcare facilities as well as health managers. The training strategy encompasses:</p> <p>Newborn Survival Package, addressing quality of care for pregnant women and new-born babies. It includes: Effective Perinatal Care, Neonatal Resuscitation, Essential Newborn Care, Baby Friendly Hospital Initiative and nationwide expansion of ILBD.</p> <p>Child Survival Package addressing major causes of early childhood morbidity and mortality by focusing on out-patient and inpatient healthcare. It includes: Integrated Management of Childhood Illnesses, promoting breastfeeding and infant/young child feeding, growth monitoring and prevention and control of micronutrient deficiencies.</p>

Health Management and Quality Improvement for health managers addressing the quality of supervision, recording and reporting following standard protocols.

7. Certification

The main objective of the certification is to standardize quality of health providers’ competency. The competency-based test and certification system complements the training component and reinforces its outcome, thus ensuring basic level of quality. The training completion certificate is provided by the Ministry of Health with attestation from Tashkent Institute of Postgraduate Medical Education (TIPME)

8. Monitoring and quality improvement

The monitoring and quality improvement component aims at building the capacity of health managers to provide supportive supervision and solving the challenges faced by health providers and facilities in service delivery. The monitoring system includes: the joint monitoring and supportive supervision system (Follow Up After Training – FUAT) and the Quality of Hospital Care for Mothers and New-borns system – QoMNHHC).

9. Communication and awareness

Communication and awareness raising is crucial to ensure successful project implementation and sustain the results. This component aims at creating an enabling environment for skill application and behavioural change, thus making results more sustainable at all levels, from the policy level to the beneficiaries.

Project duration:

Thirty six months - July 15, 2008 to July 14, 2011. The 36 months project is the scale up stage of the Ferghana Newborn Survival Model pilot project (2003-2006).

The role and contributions of UNICEF and other stakeholders to the programme/project

UNICEF along with international development partners has been assisting the Government of Uzbekistan in its efforts to reform health sector and improve maternal and child health services. The current Project is built on these successes and the lessons learnt from previous MCH projects. The Project includes efforts to coordinate and seek synergies in the ongoing activities with partners that support the national MCH programme. Their role in the development of the sector is summarized in the Table 1 below.

Table 1: IMCHS Partners

Partners	Role	Activities	Geographical Location
MoH, National Medical Institutes and Regional Health Departments	Main implementing partners. Key departments within the MoH contribute in different ways and levels of responsibility.	Coordination Legislation Policy Development M&E Certification Training	Nation wide
WHO	Member of the Steering Committee provides technical input on quality assurance and monitoring;	Technical assistance to MoH on health sector. Effective Perinatal Care –	Nation wide

	participates in the Joint Monitoring Team (JMT), together with MoH, and UNICEF	Making pregnancy safer. IMCI, MCH and Reproductive Health. HIV/AIDS - PMTCT	
UNFPA	Supports the safe motherhood and effective perinatal care (EPC) programme by providing technical input and logistic support.	Improvement of maternal health care. Emergency Obstetric Care – Capacity building and logistic support.	Nationwide Andijan & Djizzak
ADB	Through its Health 2 Project has implemented activities parallel to IMCHS project in the other six regions, including basic equipment in maternities. ADB closed its health portfolio in mid-2011.	Strengthening Women and Child Health services. Equipments for 13 Oblasts Maternity Wards and 179 Rayon level maternities. Financial management system Blood safety Training of 800 SVPs	Nationwide maternity equipment support. SVP trainings in Bukhara, Fergana, Karakalpakstan, Kashkadarya, Khorezm, and Tashkent
The World Bank	Supports General practitioners and nurses in Primary Healthcare. The World Bank Health 3 Project has been recently approved which is focused on secondary health care at the district level.	Infrastructure development of PHC facilities. Supply of equipments to PHC level. Quality improvement and monitoring of PHC facilities. Training of General Practitioners. Health care financing and management system.	Nationwide
GIZ	Focuses on the improvement of the quality of nursing education, maternal passport, standardization, certification and nutrition intervention in two Regions	Maternal Passport Quality of Education Training of HPs Standardization Certification and Licensing	Andijan, RK
UNICEF	Primary partner provides technical support to the Project. UNICEF is complementing healthcare support through its regular programme in six additional regions; implements effective perinatal care (EPC) training and integrated monitoring of the implementation of ILBD nationwide	Training Capacity Development Training HPs and Health Managers ILBD Communication and awareness M&E Certification Pre-service Education	Samarkand, Namangan, Andinjan, Djizzak, Navoi, Syrdarya, Syrdarya, Kashkadarya

PURPOSE, OBJECTIVE AND SCOPE OF EVALUATION

Purpose of the Evaluation

After the Ferghana Region pilot phase being evaluated successful and replicable, the project under analysis contributed to expand the Fergana model to 8 out of 14 regions. The selection of the project regions was based on the sorrow analysis of the other partner targeted regions. The IMCHS project has been implemented in the time period of July 2008 – July 2011 with EU funding. The purpose of the present evaluation is to assess successes, shortcomings and replicability of this model, as well as to analyze its potential to inform and influence the MCH sector reform.

The evaluation findings and recommendations will be used to inform the next steps for nationwide scale-up of the intervention, as well as to advocate for policy amendments and the strategic planning in the framework of the sector reform. In addition, the report will be used to adjust the strategy and maximize the impact and improve the design for the second phase of the project in convergence with other sectors.

The findings of the given evaluation will be used by:

- **MoH:** To review the current maternal and child health policies and develop a comprehensive and evidence-based MCH reform strategy. This structured assessment will help to identify the gaps and bottle-necks analysis and results will be used for better planning on MCH sector performance.
- **UNICEF:** To evaluate partnership and intervention as a whole and inform their adjustment for better results in the MCH sector with an equitable approach. To inform its advocacy strategies and support the MoH in the development of an evidence-based reform process.
- **WHO, UNFPA and other partners:** To review their partnership around the MCH sector and adjust accordingly to achieve the organizational and UNDAF targets.
- **European Commission** – To review the current partnership on MCH sector reform in line with the National Policy, developmental agenda and EC strategy for Uzbekistan. Results can be used for adjustment and future planning for EC strategy.
- **Other donors:** To review and evaluate support strategies to the MCH sector reform in the country.

Evaluation Objective

The project is now bridging from the first to the second phase. The latter will further expand the Fergana model from 8 to all regions in the country and will focus on institutional strengthening, capacity development and community empowerment for equitable, quality and continuous access to health care. This intervention will more and more be integrated within the strategic framework of the ongoing maternal and child health sector reform.

In order to inform the second phase, an evaluation of the first phase is now required to assess successes, shortcomings and the replicability of this expanded model to nationwide scale and its contribution to evidence-based policy change within the MCH sector reform.

Scope of the Evaluation

In general terms, the evaluation focused on assessing the IMCHS project's current and potential contribution to the improvement of MCH sector reform. Each evaluation criterion was analyzed from the perspective of assessing the project activities' implications on:

- **Final beneficiaries:** caregivers, families, mothers and children;
- **Service providers:** health care professionals whose capacity has been built (including doctors, midwives, patronage nurses, health facility managers);
- **Sub-national decision-making level:** Regional health authorities and Hokymiats (local governments)
- **National decision-making level:** national authorities and key stakeholders (Ministry of Health, Ministry of Finance, Cabinet of Ministers, WHO, UNFPA, WB, ADB, USAID, EC, GIZ).

EVALUATION METHODOLOGY

Evaluation Criteria

The IMCHS project evaluation followed established OECD DAC evaluation criteria¹⁹. Table # 2 below summarizes those criteria.

Table 2: Evaluation Criteria

Criterion	Questions
Relevance	<ul style="list-style-type: none"> • What is the relevance of the intervention in terms of advocating for and facilitating the national MCH sector reform? • The extent to which the training component is appropriate in response to the training needs of the target groups? • To what extent is the intervention relevant in terms of contributing to improve children and mother's wellbeing and health seeking behavior?
Efficiency	<ul style="list-style-type: none"> • The extent to which the project resources were used in most economical manner to achieve its objectives. Available resources were adequate to meet project objectives. • To what extent has the project contributed to the visibility of the donor in the country and among the different stakeholders and beneficiaries? • To what extent is the intervention effective in facilitating the MCH sector reform in respect to policy change, quality improvement and governance re-structuring of the health system in line with relevant WHO standards? • To what extent has the project contributed to regional health authorities and medical institutes to promote the MCH packages (Newborn, Child Survival), informed decision making on resource mobilization and sustainable planning in line with Health Management's international standards? • How effective is the intervention in improving service providers' knowledge and skills in all project components (New-born Survival package, Child-Survival package, Health Management and Quality Improvement package, and Inter-personal Communication package) against the indicators set in the log frame and in line with the correspondent WHO standards? • To what extent have trained service providers (individuals) modified their regular practices related to all project components against set indicators and in line with WHO standards? Which are enabling/constraining factors that facilitated/hindered this behavioral change? • In the MCH facilities where trained service providers work, to what extent have regular practices related to all project components been modified in line with the relevant WHO standards? • To what extent has the intervention contributed to improve the overall resource management in

¹⁹ The DAC Principles for the Evaluation of Development Assistance, OECD (1991) <http://www.oecd.org/document/22>

	<p>the concerned health facilities? Especially as a consequence of reduced hospitalization, rational use of drugs and early recovery from sickness.</p> <ul style="list-style-type: none"> • To what extent has there been an improvement in quality of care during delivery and post-natal care in the health facilities included in the project? • To what extent has the Inter-personal communication package (training module and communication materials) effectively contributed to strengthen patronage nurses' counseling capacity? And to what extent are they effective as a channel to strengthen caregivers' knowledge? • To what extent is the M&E system (including FUAT and QoMNHC) effective in reinforcing skill application and tracking? • To what extent do beneficiaries perceive any overall change in the health conditions of mothers and children in the community/family? Especially as a consequence of improved health care provision, preventive and promotive health measures, practicing of early seeking medical care during sickness, decrease of health services' costs for beneficiaries? • To what extent has the intervention contributed to reduce beneficiaries' costs for accessing MCH services? Especially as a consequence of reduced hospitalization, rational use of drugs, reduced side-effects and early recovery from sickness. • To what extent have beneficiaries increased the frequency of their visits as a result of perceived improvement in MCH care services' quality and as a result of reduced costs and access barriers? • To what extent have beneficiaries improved their child care and health seeking practices as a consequence of improved counselling?
Effectiveness	<ul style="list-style-type: none"> • Does the IMCHS project use the resources in the most economical manner to achieve its objectives? Are the available resources adequate to meet project needs? • To what extent is the cascade training system, including the Follow-Up After Training system, efficient in terms of resource absorption as compared to the results achieved? • To what extent are the inter-personal communication package and the patronage nurses system efficient in terms of reaching the target groups as compared to the absorbed resources?
Sustainability	<ul style="list-style-type: none"> • To what extent do MoH and other concerned government agencies demonstrate ownership over the different project components (Newborn and child survival packages) and correlated aspects? • To what extent is the project inserted into the MCH sector reform strategy, so that MoH's ownership over the Newborn and Child survival packages can lead to their incorporation into national policies and therefore assure sustainability of the results achieved? • To what extent do MoH, Oblast Health authorities and regional hokymiats demonstrate ownership and capacity for resource mobilization to be able to self-support and consolidate the achievements and the expansion of the project within their regions? • To what extent are the behavioural changes among health providers expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their capacity to continuously provide quality and equitable MCH services? • To what extent are the behavioural changes among beneficiaries expected to last? What are the bottlenecks and gaps along the continuum of care that hinder the capacity of mothers and caregivers to access and use quality MCH services for themselves and their children?
Coherence	<ul style="list-style-type: none"> • The extent to which the project contributes to and is in line with national policies and priorities of the MCH sector. • To what extent the project facilitates synergies and avoids duplications with interventions and strategies promoted by other UN agencies and development partners within the MCH sector and its reform. • To what extent the project is in line with and contributes to the donor's objectives for the Uzbekistan social sector

Each Project component outcome was evaluated against DAC criteria. Each criterion was rated on the scale from zero to three, where three is the best. Weights were attributed to each of them and weighted average calculated according to the Table 3 below by the evaluation team.

Table 3: Assessment of Overall Project Performance

	Rating (0–3) A	Weight (%) B	Weighted Average C = A * B
Relevance		20%	
Effectiveness		25%	
Efficiency		25%	
Sustainability		20%	
Coherence		10%	
Overall Rating		100%	

Highly Satisfactory (HS): Overall weighted average is greater than 2.7; **Satisfactory (S):** Overall weighted average is between 1.6 and less than 2.7; **Moderately Satisfactory (MS):** Overall weighted average is between 0.8 and less than 1.6; **Unsatisfactory (US):** Overall weighted average is less than 0.8.

Evaluation Design

To translate the questions for the evaluation (as provided in the TOR, Annex 5) and the contextual issues, the Evaluation Framework was developed by the evaluation team structuring the issues and questions as indicators that can be measured or assessed during the evaluation (see Annex 3.1). The Evaluation Framework also identifies the sources of information and the methods the evaluation team applied, the range of documents reviewed and key informants to interview for each question. The framework has been seen as being part of a process rather than simply an end product to ensure there is clarity and agreement about what is required and how the evaluation structure and methodology are derived from that.

Apart from the Evaluation Framework the Project Results Framework (RF) (Annex 4) was used which demonstrates how project activities eventually results in achieving its objectives—kind of a road map that shows project’s final destination and how the project will get there. Therefore in order to assess attainment of stated targets for Project outcomes and outputs and Project’s contribution towards achievement of the higher level outcomes the evaluation has carefully assessed data provided in the RF.

Methodology

The evaluation methodology comprised a mix of site visits and observation, face-to-face semi structured interviews, focus group discussions, desk-based research and review of existing reports, documents and secondary data. Summary of Methods are outlined below:

Desk Review: Review of documents was a major part of the evaluation. The list of documents reviewed by the evaluation team is listed in Annex 1.

Semi-structured Interviews:

Semi-structured Interview tool was used for the key policy makers on the national, oblast and rayon level, development partners involved in reforming MCH service provision and quality improvement reforms, as well as other stakeholders such as Medical Education Institution, MCH service provider institution Administrative staff, etc. The list of key informants is provided in the Annex 2.

Prior to visiting key informants, semi-structured interview topic guides were developed based on the Evaluation Framework (Annex 3.1) to help ensure systematic coverage of questions and issues. The interview topics have been selected around the evaluation questions, but grouped and targeted according to the organization and/or individual being interviewed (Annex 3.2).

Appreciative enquiry – An approach that will seek to explore successes and positive experiences in dialogue with individuals and groups of people and have been applied in order to strengthen understanding of why something worked well, and how success might be replicated.

Field Analysis - a useful and quick visual tool used to gain an overview of the different forces driving or resisting change that the project is trying to bring. Using Force Field Analysis helped to analyze the forces working for and against a policy and its realization.

Focused Group Discussions (FGDs) - were conducted for MCH service providers, trainers and consumers in selected two project regions for inter-personal communication skills of service providers for improved counseling. The FGDs were carried out for a) master trainers, b) trained PHC physicians and nurses, trained hospital practitioners, d) trained practitioners on quality control, e) patronage nurses and f) beneficiaries in both regions visited. In total the team carried out 8 FDG in two Project target areas (Namangan and Samarkand).

For each FDG the FGD guides was designed (Annex 3.3). FGD guides for service providers reflected questions relevant to evaluation criteria, while FGD guide for service consumers was oriented towards measuring consumer satisfaction with the services, perceptions of improved quality of MCH service provision and demand for services.

Triangulation of findings - examination of data from the above sources have been carried out to arrive at conclusions and formulate recommendations.

While designing the evaluation methodology, the evaluation team considered ethical issues and applied the following approaches:

- i) We tried to keep evaluation procedures (FGD and Semi-structured interviews) as brief and convenient as possible to minimize disruptions in respondents work process;
- ii) To ensure that potential participants can make an informed decision we provided them with information about the purpose of evaluation and final outcome as well as on the process and duration of interview and/or FGD. The team also ensured respondents about the confidentiality of the source for obtained information and allowed them to retain from answering the questions posed in case they felt uncomfortable to respond;
- iii) Key informants were interviewed face to face without presence of other individuals. As for the FGD, the grouping has been applied to encourage open discussion around the evaluation questions by avoiding presence of their superiors. The FGDs were held separately for physicians, nurses, beneficiaries etc.
- iv) The evaluation team collected and analysed information as well as reported findings accurately and impartially.

Data Sources

The four major sources of data: people, site visits to a sample of oblasts supported by the INCHS program, documents and information system were used during the evaluation.

- **People** - Individuals were consulted through individual interviews and focus groups;
- **Site visits** - two sites Samarkand and Namangan Oblasts supported by the program were visited. The sites have been chosen by UNICEF Country Office according to the following criteria: one urban

and one rural oblast; both oblasts close to the capital due to time constraints; one oblast where full set of interventions have been implemented and another with some; one oblast where the monitoring has not been done recently.

- **Documents:** List of reviewed documents attached to the report
- **Quantitative Analysis:** The team utilized quantitative analysis to examine changes in selected but comparable indicators from available data.

Stakeholder Involvement

The evaluation was a joint and participatory process involving the MOH team of experts. The team of three MOH experts, selected by the ministry accompanied the evaluation team during the field visits and semi-structured interviews. The evaluation benefited immensely from incites provided by the MOH team.

For the validation of the preliminary findings and recommendations the team met key stakeholders. Importantly the team leader met Deputy Minister of Health in charge of MCH sector and shared evaluation results. The Deputy Minister agreed on the findings as well as on all recommendations outlined in respective section of the report. Apart from the MOH stakeholders the findings and recommendations were presented and discussed with the international partners²⁰, members of the Project Steering Committee. In General all stakeholders agreed on the main findings of the evaluation as well as noted provided recommendations for further consideration in their respective projects.

The evaluation team incorporated stakeholder's comments for final formulation of the evaluation findings and recommendations. Specifically, relevant stakeholders were given the opportunity to comment on the draft evaluation report and the final evaluation report reflects these comments and acknowledged any substantive disagreements.

LIMITATIONS OF EVALUATION

The time allocated for the evaluation activities to be carried out in country on the one hand and the volume of evaluation activities on the other hand, limited team's choice for the selection of the regions for the field visit. Therefore, the evaluation team developed specific selection criteria outlined in the evaluation methodology, based on which the UNICEF selected Samarkand and Namangan Oblasts. The team is not confident, that given selection would adequately reflect the situation in other project target regions.

Another limitation of the given evaluation was the selection of the participants for the FGDs by the local health authorities. The team was bound to held the FGDs with the participants being present for the FGDs. The only exception was with the beneficiary FGDs, where the evaluators randomly invited beneficiaries for FGDs being present at the MCH facilities during our visit.

Evaluation Team

The evaluation team comprised of three experts. There role and responsibilities are given in the Table 4 bellow. Their professional backgrounds are described in Annex 6.

²⁰ GIZ, JAICA, WHO, ADB & WB Project Implementation Center, Safe the Children, etc

Table 4: Evaluation Team composition, experience and responsibilities

Position	Name	Responsibilities
Lead Evaluator	Tamar Gotsadze, MD., PhD	Evaluation Team Leader responsible for overall design, planning and preparation of the evaluation report
Co-evaluator	Chiara Zanetti, MD., MPH	Responsible for evaluating training component
Co-evaluator	Maia Makharashvili, MD., MBA	Responsible for evaluating of IEC/BCC component, field data collection and data analysis

I. EVALUATION FINDINGS

RELEVANCE

This section examines relevance of the interventions to address the problems of stakeholders on all four levels and summarizes the information derived from the key informants and through FGDs. Evaluation findings presented below are structured in a way to provide answers to the questions outlined for the given criterion in the Table 2 and Evaluation Framework (Annex 3.1).

National Decision Making Level

Relevance of the intervention in terms of advocating for and facilitating the national MCH sector reform

The Project interventions were directed towards mitigating the following problems of the MCH sector present prior to the project commencement:

- **High Mortality Rates** - In the Republic of Uzbekistan, the official UNICEF data records Under Five Mortality Rate (U5MR) to be 36/1000 (2009), while Infant Mortality Rate (IMR) is 32/1000 live births (2009). In 1991, U5MR and IMR were 74/1000 and 61/1000 Life Birth (LB) respectively. Estimated Neonatal Mortality Rate was 17/1000 live births in 2006. The highest child mortality rates have been observed among rural children²¹.
- **Poor Birth Registration** – The 2002 Uzbekistan Demographic Health Survey (UDHS) documented an infant mortality rate of 61.7 per 1,000 live births whereas Government data put the rate at 16.7 per 1,000. The reason for the large discrepancies is that official estimates apply Soviet criteria for live births whereas the UDHS and similar surveys use current WHO recommendations which differ substantially from Soviet criteria. However, the large discrepancies cannot be explained by differing criteria for live births alone. The UDHS infant mortality rate should also be taken with a grain of salt. The UDHS rate was calculated using a random sample and assessed only that sample of the population. Another sampling method might have yielded different results. Registration problems related to concealing information on infant mortality by health workers, underreporting of and delays in registration (by parents) of deaths at vital statistics offices are other factors contributing to discrepancies between the two infant mortality rates.
- **Leading causes of mortality** - Prematurity and low birth weight (39%), birth asphyxia and birth trauma (24%) and neonatal infection (19%) are the leading causes of newborn babies' mortality. Among infants' deaths, 50.7% occurs in the perinatal period. Furthermore, 50% of newborn who die are full-term babies with a birth weight of more than 2,500 grams, and 85% of these deaths happen in the first day of life²². In Uzbekistan, more than 95% of deliveries are attended in hospitals, however poor management of labour by health professionals (HPs), inadequate skills in newborn care, and lack/insufficient supplies and equipment are likely to largely contribute to newborn deaths. In 2006, respiratory infections and pneumonia were responsible for 41% of infant deaths and 42% of U5 deaths²³. Although 2006 perinatal mortality rate (10.8/1000 LB) has almost halved

²¹ The World Health Organization / Regional Office for Europe. Report on Assessment of The Quality of the Hospital Care for Children in Uzbekistan. M.D., Professor Ekaterina Stasii. Tashkent, October 2008

²² Baseline Survey Report "Improvement of the Mother and Child Health Services in Uzbekistan"; Tashkent Institute of Postgraduate Medical Education. The Ministry of Health of the Republic of Uzbekistan. June – August 2009

²³ WHO/Europe jointly with the Ministry of Health of Uzbekistan and the Republican Center of Pediatrics, Uzbekistan. "A review of health system barriers

from 1991, conditions occurring during perinatal period are still the second cause of U5 deaths (27%)¹. Diarrhea accounted for 6% of deaths among U5 population group³.

- **High Morbidity Rates** -The overall morbidity rate in the age group 0-5 years old has progressively increased from 630 to 721 per 100,000 among which respiratory diseases plays a leading role (43%)⁴.
- **Low Breastfeeding Rates** -The estimated proportion of children exclusively breastfed for the first five complete months of life is 26.4% (2006). According to Uzbekistan Health Examination Survey (UHES, 2002) findings, 18% of children aged less than 5 years were stunted²⁴(Height for Age) and 7% suffered from moderate or severe malnutrition (Weight for Height). Under-nutrition was more common among rural children and children from low-income families.
- **Lack of Standard Treatment Guidelines and Need in Health Professionals Knowledge Increase** -The Baseline Survey² carried out in the eight regions covered by the UNICEF/EU project pointed out the need to upgrade knowledge and skills of health professionals (HPs) working in the Maternal, Newborn and Child Health (MNCH) services, at hospital as well as Primary Health Care (PHC) level. The results showed that only 34% of the sampled neonatologist working in maternity wards followed the standard protocol of neonatal resuscitation. In maternity wards, the newborn babies' temperature was measured in correct and timely manner only in 39% of cases. Only 32% of children admitted to hospital for pneumonia were receiving the correct antibiotic treatment according to IMCI protocol. At PHC level, 34% of General Practitioners (GPs) were able to correctly determine the early signs of infection in infants 0 to 2 months of life. Furthermore, only 37% of GPs were capable to correctly diagnose common illnesses, such as pneumonia and diarrhea, and to prescribe the appropriate treatment to babies aged 2 to 59 months.
- **Need in increase of mother's knowledge** - Finally, according to interviews' results, only a low proportion (28%) of mothers attending the clinic for their sick children were able to identify two early symptoms of pneumonia and diarrhea on children.

Current data on burden and causes of diseases affecting children in their first years of life¹ and the assessment of HPs performances on MNCH delivery care substantiate the remarkable effort undertaken by the IMCHS project that provided training to primary, secondary and tertiary level health care providers on evidence-based interventions in newborn and child health care.

Service Providers

Development of a critical mass of trained health workforce utilizing evidence based approaches

Several interventions packages have been proven cost-effective in reducing U5MR, and the implementation of a package is more effective than implementing single interventions. However, the intervention package/s significantly impacts the intended beneficiaries only when their implementation reaches a large proportion of the target population.²⁵

to implementation of the strategy of integrated management of childhood illnesses in Uzbekistan". November-December 2008.

²⁴ MICS, 2006

²⁵ Neonatal Survival Series. The Lancet 2005. Child Survival Series. The Lancet 2003.

In the Ferghana pilot project, the implementation of a package of essential newborn care, perinatal audit and resuscitation training has brought encouraging results on related outcomes²⁶. Such positive finding supported the scaling up of the intervention to further eight oblasts. Three main interventions packages have been implemented during the IMCH project life: the **Newborn Survival Package (NSP)** and the **Child Survival Package (CSP)** and **Health Management Package (HMP)**. These packages are in line with the continuum of care approach, which foresees the provision of care across place/level of care (families and communities, outreach services, and clinical services) and time (pre-pregnancy, pregnancy, peri and post natal/neonatal period and childhood). NSP, CSP and HMP packages were implemented in all eight regions covered by the project.

Newborn Survival Package (NSP).

Evidence Based interventions on neonatal care are incorporated into one NSP: Effective Perinatal Care (EPC), Neonatal Resuscitation (NR), Essential Newborn Care (ENC), BFHI, and the introduction of the ILBD. The package addresses the quality of care in hospitals.

Furthermore, IMCHS project planned core training and capacity building activities have included the improvement of MCH services management and quality. This objective was reached by providing training to mid-level healthcare managers (chief pediatricians, obstetricians, maternity managers, and heads of health departments) at oblast and rayon level of 14 oblasts.

Child Survival Package (CSP).

Evidence-based interventions on child survival are combined into one CSP: Integrated Management of Childhood Illnesses (IMCI), promoting breastfeeding and newborn care at the community level, infant/young child feeding (IYCF), growth development monitoring (GDM/GM), prevention and control of micronutrient deficiencies (iron deficiency anemia, iodine and vitamin A deficiencies). The package primarily focuses on the out-patient level of healthcare in rural and urban areas such as policlinics and SVPs.

Within the frame of the UNICEF/EC project, a participatory quality improvement approach (QI) has been organized and introduced in the eight oblast covered by the project. The model was first piloted in eight (8) regional perinatal centers. The QI approach included a participatory assessment of the quality of hospital care for mothers and newborn babies using the Quality of Maternal and Newborn Hospital Care (QoMNHHC) tool developed by WHO, which has been adapted to the Uzbekistan context^{27 28}. A team of national assessors was trained to use the new assessment tool in order to identify key areas of pregnancy, childbirth and newborn care that need to be improved.

The Interpersonal Communication (IPC)/Behavioral Change Communication (BCC) strategy was implemented in 2010 in four regions (Samarkand, Sardariya, Namangan and Djizzak). The strategy aimed at promoting positive behaviors for survival and development of children at HH level through improving IPC and counseling skills of Patronage Nurses.

²⁶ Zulfiqar A. Bhutta, Shukhrat Rakhmaninov, Arustan Joldasov. "Evaluation of the newborn survival training program in Fergana Oblast, Uzbekistan". Final Report. Aga Khan University & UNICEF (Uzbekistan). February 2008

²⁷ Tamburlini G., MD PhD, UNICEF Consultant. "CQI in MNC care in Uzbekistan. Report of reassessment of 4 Regional Maternity Centers". April 1-15, 2011.

²⁸ Stelian Hodorozea, Audrius Mačiulevičius, Irina Stepanova. "Assessment of the safety and quality of hospital care for mothers and newborn babies in Uzbekistan". March 25, 2010.

Table 6: Proportion of trained MCH HPs from total number of MCH HPS employed in eight project oblasts

	% coverage	Range (%)
Obstetricians	13	6-19
Neonatologists	50	19-87
Midwives	5	1-5
GP Doctors	61	53-69
Pediatricians	31	
Patronage Nurses	15	

Source: Data from M&E Reports, UNICEF Office Uzbekistan

The IMCHS project has also provided: refresher training and monitoring on ILBD²⁹ to all 14 regions; BABIES Matrix refresher training to 10 regions; support for EPC training of trainers and training of national trainers for four regions not covered by the UNICEF/EU project; and health managers training and monitoring to 6 regions that are not among the ones targeted by project activities as well as IPC for patronage nurses.

The initially planned number of HPs to be trained by the UNICEF/EU project has been increased by 25% according to needs and requests from the concerned oblasts and MoH. The number of HPs who underwent training largely exceeded the original plan, as shown in the table below.

The organization of the training courses foresaw the administration of a pre-and-post test to the participants in order to assess their knowledge prior and after exposure to the topics. In doing so, the project aimed at assessing the effectiveness of training. The cut-off-point for effectiveness was set at 70% of training participants who scored at least 75 in the post test.

Table 5: Number of Trained Health Personnel

MCH training packages	To be trained	Trained	Variance
NSP	4,609	4,914	7%
CSP	8,832	8,965	2%
ILBD	1,250	1,060	-15%
BABIES	102	153	50%
HM	1,220	1,270	4%
QoMNHC	-	201	NA
BCC	-	863	NA
TOTAL	16,013	17,426	9%

Source: Data from M&E Reports, UNICEF Office Uzbekistan

In the first year of training (2009), the pre-test score was noticeably low in every component (NR, ENC, EPC, BFHI, HIMCI, PIMCI, GDM, BF Counseling), ranging between 36% in ENC that was the lowest score, and 60 in GDM that was the highest one. The average score was 47%³⁰. Similar pre-test scores were observed in the second year bunch of trainings' participants (2010). The average score was 49%³¹; the lowest score was 40% in Breast Feeding counseling, the highest was 57% in Primary IMCI for GPs and GDM.

As far as relevance of the project training component is concerned, pre-test results were consistent with previous studies' findings substantiating the need for upgrading knowledge and skills of HPs providing MCH care.

Training methods were tailored to fit an audience of professionals, who appreciated the innovative approach *"We heard about this programs in 2005 -Newborn Survival Package- but we received only theoretical part and never used in practice, but these trainings enabled us to understand, accept and implement these new technologies"*³².

²⁹IDLB-International Definition of Live Births: Newborns weighing 500 grams and with 22 weeks of gestation (instead of the 1,000 grams and 28 weeks that was required under the former system) are registered as births; live births if showing signs of life or stillbirths if there are no signs of life at the time of delivery. Previously they were considered miscarriages or stillborns, even if signs of life were present at the time of delivery.

³⁰ Improvement of the Mother and Child Health Services in Uzbekistan. Year 1 narrative report. Reporting period: July 2008 – June 2009.

³¹ Improvement of the Mother and Child Health Services in Uzbekistan. Year 2 narrative report. Reporting period: July 2009 – June 2010

³² Quotes from Focus Group/FG at Multi Profile Children Center, Namangan. Group of trainees, doctors and nurses

Finally, most of the time health managers who underwent UNICEF/EU training in HM were prone to support needed changes at health facility level, and were willing to allocate budget for medical supply. Consequently, management training should be always carried out before any other training on clinical skills improvement³³.

Changing structures and processes of the service delivery

The capacity building component of IMCHS project contributed to the regionalization process by providing expertise to different levels of the health system. The health system reformed model, aimed at streamlining the use of resources at each and every care delivery level, foresees quite rigid rules for patients' referral that limits unnecessary referrals from HPs and patients' self-referral to high level of care. Rural primary care Units-SVPs (or polyclinics/outpatient departments in urban area) is the first point of contact for patients. When needed, patients are referred from primary to the secondary level of care (Central Rayon Hospitals-

"Training made health managers to ask money for the right use"

Interview with the Deputy Head of Oblast Health Authority of Namangan

CRBs). The secondary level provider's duty is to assess the need for referring patients to the tertiary level, which includes a number of specialized hospitals (Perinatal and Child centers).

The training component of the UNICEF/EU project has aimed at building the HPS capacity to deal with patients according to the level of care and to timely refer the patient according to protocols and guidelines.

Community was also included in the program through educating the health personnel to provide adequate information to patients/caregivers on

medical and preventive care.

At Primary Health Care (PHC) and policlinics, the introduction of the Integrated Management of Childhood Illnesses (IMCI) strategy was meant to facilitate and simplify the correct management of childhood diseases-diagnosis by symptoms and related treatment, counseling for mothers/caregivers and appropriate referral. Breast Feeding (BF) and Growth Development Monitoring (GDM) training targeted SVPs and policlinic personnel as well. The BCC/IPC program, which is addressed to patronage nurses, complements IMCI by teaching and fostering appropriate behavior in caregivers and family members.

Hospital IMCI (HIMCI) was to enhance theoretical and practical skills of pediatricians working at oblast and rayon hospitals. NR/ENC and PEC addressed HPs working in Children and Perinatal Centers (pediatricians, neonatologists, obstetricians, midwives, nurses) at oblast and rayon level, which are supposed to manage at risk/complicated cases. The implementation of the Baby Friendly Hospital Institutions Initiative (BFHI) goes across different level of the health system (Maternities, maternity wards, policlinics and SVPs). The nationwide adoption of ILBD definition and the use of BABIES Matrix have enhanced, and shall further improve, the quality and use of data for analyzing causes of service's inefficiency and mismanagement of cases.

Data from Namangan Regional Multi Profile Children Hospital show the decline of patients' self referral from 62% in 2009 to 56% in 2010. The result is ascribed to the improved management of patients at PHC level, and to the increased trust of the population in PHC HPs, as consequence of IMCHS training courses. Furthermore, the number of hospitals with available oxygen supply in the admission departments, a HIMCI standard, has increased from 65% in 2009 to 84% in 2010. This result is mainly due to trained hospital health managers, who allocated funds for oxygen and other medical supplies from the facility annual budget.

³³ Interview with the Deputy Head of Namangan Health Department

Maternal Mortality Ratio (MMR) in Namangan oblast has slightly decreased from 23.8‰ (9 cases) in 2010 to 22.5‰ (8 cases) in 2011. The number of deliveries attended at the Namangan Branch of OB/Gyn Scientific Research Center has increased from 5,707 in 2010 to 6,706 in 2011 (first 9 months). The improved referral of pregnancies at risk has contributed to the overall increasing of deliveries in the center. The proportion of pre-term deliveries has risen from 9.5% (574 cases) in 2010 to 16% (741 cases) in 2011. In 2011 (first 9 months) 787 pre-term live births were recorded in the first 9 months, while in 2010 (first 9 months) the pre-term live births were 571.

Final Beneficiaries

In support of project’s overall objective to reduce Maternal and Child mortality by filling the knowledge gap in child caretaking, the relevant IEC/BCC interventions have been targeted at general public (clients and beneficiaries of health services – primarily women and children); decision makers (project stakeholders - the MOH, health managers at the national, oblast and rayon levels) as well as grassroots and mid-level health personnel, through building communication and counseling skills. Special emphasis was given to community empowerment activities by provision of interpersonal communication training to patronage nurses. Proper counseling, delivery of information and education of mothers aimed at demand creation for quality child care and health seeking behavior.

“After the trainings we notice interval between deliveries, early pregnancy is decreasing, mothers who received info from HPs started advocating their peers. Pregnant women receive a lot of info from us, anemia decreases among pregnant women, and we also give info on sexually transmitted diseases. Parents are interested to follow up growth and development of their children, they become more attentive”;

“We explain significance of breastfeeding to mothers and mothers start to feed more. Before they used to breast feed by hours per schedule but now they breastfeed anytime upon baby’s requests, breastfeeding is very time consuming. Fathers become more responsible”

Quotes from trained health professionals FGD

“Visits of patronage nurses helped us to learn how to breastfeed our babies, how to identify danger signs of diseases, when to immunize etc.

More importantly they helped to educate our mother- in laws who preached us to use herbal remedies and feed a child with yogurt”

“I was so pleased to receive comprehensive information about the disease of my child and when the doctor explained that she was treating my kid with new method which does not require too many medicines that I had to buy.”

“It would be much easier for us to have printed information material so that we can look in when needed”

Quotes from Beneficiary FGD

Interviewed HPs report significant, positive behavioral change towards health among the population as consequence of IEC/BCC intervention. This was also confirmed by group of mothers met during the FGDs.

However, education and communication activities need to be strengthened. As reported in the IMCHS Narrative Report (July 2009-June 2010)), 76% of mother of babies aged up to three months, who were interviewed during FUAT visits about breastfeeding status, were still exclusively breastfeeding their infants. The proportion declined to 31% by the infants’ age of six months. The group of interviewed mothers cannot be considered a representative sample of the population; however, these findings might give a hint

on mothers’ breastfeeding practice.

EFFECTIVENESS

This section focuses on the evaluation of the IMCHS effectiveness by looking at:

Project Implementation Structure

Government Commission for effective implementation of MCH Reforms

In April 2009 the Inter-sectoral Government commission has been established by the Presidential Decree to ensure: elaboration of the MCH Reform implementation plan for the years 2009-2013; coordination of all stakeholder activities; and organization of communication and awareness rising activities. The commission is chaired by the prime minister and comprise of 24 members from different sectoral ministries including the Deputy Minister of Health responsible for MCH and other public institutions.

In response to the Presidential Decree the 5 year MCH Reform implementation plan was approved by the Presidential Decree # PP-1144 in July 2009. The given plan identifies main strategic reform directions and activities; time frame; responsible entities; required budget as well as funding sources. The total approved budget of the 5 year plan is 44,973.1 million Sums and 99,968.4 thousand USD. The plan is heavily dependent on the international aid.

Project Steering Committee

The MOH managed to mobilize aid from international organization and donor community in support of its MCH reform implementation. There are number of partners implementing MCH reform activities (Table 1). In order to effectively manage international funding and avoid duplication of efforts and waste of money the Project Steering Committee (PSC) was established. The PSC is chaired by the Deputy Minister of Health responsible for the MCH and is composed of all partners involved in the MCH sector.

To avoid duplication of efforts the Joint Action Plan (JAP) has been developed under the leadership of the MOH/PSC and UNICEF and technical inputs from the partners. The JAP entails information about types of activities per partner, geographical targeting and time frame. While the JAP has been informative and was effectively used by the MOH and partners in planning their activities, it has certain shortcomings for Government's strategic coordination and planning purposes:

- **Difficult to use for MOH strategic planning** - The JAP structural design limits the MOH to assess available contribution as well as identify gaps for the successful implementation of the five year MCH reform plan.
- **Absence of the guaranteed funding levels per type of activity** – ensured funding per each activity of the partner organization is not indicated in the JAP which restricts the MOH to identify funding gaps and address it accordingly.

The PSC meetings mostly serve the information sharing purpose, with no review of projects/programs and adequate assessment of achievements/challenges. Rarely these meetings are also used to request Donor funding for emerging MOH priorities/issues, with no consideration given to the latter's contribution towards the achievement of the national strategy and or program goals and objectives.

The minutes of the PSC meetings do not include any decisions; follow up actions or agreements reached during the meeting. The team observed a deficiency in the capacity of the MOH to synthesize and analyze the information received from Donors and develop follow-up strategies/ actions/requirements/ etc.

Apart from weakness described, the PSC is shorthanded to practice strategic coordination due to the lack of adequate tools enabling monitoring, analyzing or adequately planning Donor support.

It is however recognized that the Government's capacities to effectively perform aid coordination functions need to be strengthened. One of the main challenges is a large number of actors with differing practices, rules and habits of donor-driven development program. In addition, the focus on aid effectiveness is relatively recent and it is difficult to keep pace with emerging knowledge within this field.

In summary:

- The MOH has certain limitations with regards to effective Donor coordination. It still has not managed to galvanize and lead Donors and partners to support its national MCH strategy, because the ministry not only needs effective coordination tools and processes but it also needs capable staff, which is currently in short supply.
- The coordination meetings are limited to only information sharing and rarely address implementation problems and/or assess specific results achieved by various projects. Decisions, guidance and follow up actions are not reported in the meeting minutes.

Project Implementation Team

The achievements attained by the project would have not been possible without strong project implementation team. The core UNICEF project team was represented by one expatriate health professional being in charge of entire UNICEF health program; one National Health Officer and three Project Assistants. The team was assisted by key staff of C4D, M&E and operations departments.

The effectiveness of the "paring approach" applied for the training component of the project has to be acknowledged. For each training module the MOH staff was assigned as a coordinator, being in charge of planning, supervision and reporting. The given arrangement at the one hand ensured effective communication and cooperation with the MOH and on the other supported national capacity building. Moreover, it enhanced linkages between national and local level professionals and facilitated knowledge and experience sharing.

Project M&E System

The IMCHS project has established a relevant and functioning monitoring and evaluation system through advocating for institutionalization of this system into the State structures.

Results Framework

In order to monitor and evaluate project performance the Results Framework (RF) has been developed and updated on annual basis. ***However, effective use of this tool was limited due to:***

- ***Weaknesses in RF design*** - For most indicators the RF lacks baseline data and targets, as well as means of verification. These shortcomings restricted project to monitor effectiveness of the project interventions, analysis and timely utilization of corrective measures.
- ***Lack of required and accurate national data*** – The project was shorthanded to use selected national statistical data for appropriate planning and monitoring effectiveness of project interventions.

- Weaknesses of the MOH health workforce national register, limited project’s ability to plan and assess the level of oblast HP coverage with the IMCH training package. As a result, in some instances the training monitoring reports indicate that more than 100% of deployed HPs were trained, while the data on availability of the patronage nurses are not readily available. In order to address this shortcoming the project offered support to the MOH in development of the HR software. It is notable that at the moment of evaluation the MOH has already piloted the new software in four districts and plans to advanced it country wide by end of 2011.
- Absence of disaggregated data on new born death according to preventable causes appeared to be another example. The project failed to obtain required data either from the medical statistics or from the ILBD registration centre. The evaluation team was not able to detect any effort made by the project to address the given problem.

Follow Up After Training (FUAT)

Monitoring and evaluation of knowledge and skills applied into medical/nursing practice is a key element of the quality improvement process since M&E results provide information for planning sound actions to improve clinical practice. The M&E has been integrated in every training and capacity building activity of the project. Specific training has been provided to national and local trainers as well as oblast and rayon health managers in order to enable them to use the M&E instruments, and to facilitate the integration of such process and instruments into the health system. Moreover, the introduction of BABIES Matrix in maternities and maternity wards was instrumental to enhance perinatal services quality.

Application of the acquired skills into daily practice by the health providers was performed through follow-up after training and supportive supervisory visits. The FUAT function was mainly performed by Oblast level teams represented by local trainers, MCH managers and oblast level experts. Special decree issued by the Oblast health authorities in support of FUAT activities approved locally developed facility monitoring plans and composition of the FUAT teams. Members of the monitoring team were responsible for implementation of the plan as part of their regular job and report to local health authorities on the findings. The Implementation of the FUAT was supervised by the national experts, representatives of the MOH.

“Due to regular monitoring we learn a lot”

“The monitoring was supportive, if there were some shortcomings in our work we were explained how to improve”;

“There are internal monitoring teams which visit our facilities and observe our work and if there is room for improvement they give us recommendations”

Quotes from trained health professionals FGD

With project support special evaluation tools have been developed based on WHO recommended standards, including observation, checking of the patients’ records, journals of attendance, and questionnaires for interviews of health workers and patients as well as provision of supportive supervision.

The FUAT tool is instrumental for the regular monitoring of the training effectiveness and change in practices, identification of weaknesses being it

systemic, knowledge, skills and or processes as well as informing the decision makers on the required actions and ensures effective deployment of evidence based treatment practices. Whilst FUAT system has been acknowledged by the MOH, local health authorities and health professionals to be a useful tool³⁴ for application of new treatment practices, its implementation had certain shortcomings that hindered the effectiveness of the given system. Namely:

³⁴ Data from Key informants and FGDs

- **Delays in FUAT implementation** – Monitoring of the skills’ application in clinical practice was planned to be performed two times within project life: six weeks after the completion of the training, followed by a second round trainings and FUAT, six months apart. Delayed (8-12 months) initiation of the FUAT activities has been observed by the evaluation team. Possible reasons named were i) shortage of trainers to run in parallel; ii) delay in approval of the FUAT procedure from MOH; and iii) mobilization of the workforce for the cotton harvest. Based on the responses of key informants as well as FGD with trained physicians, delays in FUAT initiation adversely effected timely application of the newly acquired skills into practice and introduction of changes in facility structure, procedures and health workers’ behaviour.
- **Poor applications of corrective measures in response to findings** – As per decree, the findings were reported to and discussed with the health facility management and local health authorities as well as plans for further improvement outlined. Nonetheless, response from the management was uneven across the oblasts resulting in poor practice indicators.
- **Cost efficiency of separate FUAT visits for each training module** - According to the project design separate tools have been developed for each training module as well as separate FUAT visits planed and implemented. Whilst given approach allows the expert teams to complete more detailed evaluation as well as provide supportive supervision, in financial terms is an expensive intervention. The project has assessed effectiveness and efficiency of the given approach and by end of the project shifted from FUAT towards integrated monitoring system (IMS).

Integrated Monitoring System

IMS has been introduced by the project to replace the FUAT system due to the cost efficiency concerns of the latter. The new proposed M&E system combined as well as substantially modified all FUAT tools. Moreover, changes have been introduced in the composition of the team. The MOH established the joint monitoring team (JMT), represented by the national experts in each area of the IMCH package as well as UNICEF and WHO representatives. The JMT functions included - conducting quarterly field visits in selected training centers and health faculties, dissemination of the findings of these visits, oblast level debriefing meetings and submission of findings to the project steering committee (PSC). All parties (MoH, WHO and UNICEF) are collectively responsible for co-ordination of monitoring activities and ensuring their effective implementation. While JMT undertakes its activities on the quarterly basis, integrated monitoring on local levels should have more regular character and be mainly carried out by local monitoring teams. If JM selects facilities based on the main criteria of facility having trained HPs, the locally administered IM carries out monitoring visits to the facilities with low performance scores.

While from financial perspective this was the right strategy for the project to collect required outcome indicators, IM system cannot be seen as a substitute for the FUAT system, though have prospects to be effective and efficient as:

- **Coverage** - FUAT intends to monitor performance and provide supportive supervision to each HP and every health facility with trained HPs in a given geographical area, whereas IMS targets only health facilities with trained HPs that rank low on performance.
- **Effectiveness** - Theoretically, FUAT can be considered as an effective tool facilitating quick change in practice right after trainings, but in practice it does not show to be effective and efficient as data from both monitoring rounds records minor changes in performance indicators.

- **Effectiveness of each system in building local ownership and monitoring capacity** – FUAT is a tool, which is mainly carried out by local experts and is not easy to be integrated into the local health service performance monitoring system. Its application on regular basis and rigorous analysis of data will promote informed managerial decision making of local health authorities, however

“The organization of work is occasionally inadequate, one has to do everything, all neonatologists have to work for the whole oblast, and at the same time we have to do our work”

“We go to rayons we all go there on our own expenses, all our services are free, we go there to help them, but we also have to provide service in our centre because we have all necessary conditions for effective work here”

Quotes from trained health professionals FGD

sustainment of such system will be cumbersome due to the financial resources it require. On a contrary to FUAT, the IMS is a tool which should be used once for a while to measure overall MCH service performance on a national level, while locally it can be applied regularly and directed to poor performing facilities. Integration of the IMS into the regular local monitoring system is possible as will require less financial resources that can be easily mobilized from the local health budget.

IMS and FUAT both being the monitoring tools used by the local health systems, require adequate

financing. Based on the results of the evaluation, IMS is implemented but not financed by the local budgets. Local experts report that neither their travel not work time is reimbursed. The absence of IMS adequate funding limits the facility coverage as well as motivation of experts to effectively perform the monitoring task.

National Decision Making Level

Project through its advocacy efforts influenced implementation of the MCH reform.

Legislative support

In support of the MCH reform implementation, the intervention influenced the legislative base formation. MOH decrees were issued per each module of the MCH training package; nevertheless the apparent shortcomings which adversely effected its implementation have been identified.

- **Delays** - The evaluation team observed delays in issuing program specific legislative documents that appeared to be a bottleneck for timely implementation of the IMCH package. This problem has been brought to evaluators’ attention in Samarkand oblast. Physicians of the FGD named absence of the MOH decree that hinders effective implementation of PIMPC.
- **Poor harmonization of health legislation** - poor harmonization of the legislative base supporting MCH reform has been noted as another impediment to effective project implementation. Poor coherence of MOH decrees issued for implementation of the IMCH package creates problems to service providers. In addition lack of harmonization of the new MOH decrees with the decrees of the Sanitary Department further complicates application of the treatment guidelines in practice.

Introduction of International Life Birth Definition (ILBD)

The project interventions supported the introduction of ILBD. At present all institutions nationwide report life births according to the ILBD. The ILBD registration is yet a vertical system and is reported to the Republican Institute of Pediatrics, while the Institute of Health responsible for medical statistics reports data according to the old definition. The evaluation team has been informed that according to the MOH Decree

issued recently, the ILBD registration system will be fully integrated into the routine Medical and State statistics systems.

National and Hospital Drug Formulary

To ensure the implementation of the MCH package, the MOH amended the National Drug formulary according to the medications being proposed in the MCH training package. *However absence of obligatory registration for particular drugs recommended by the treatment guidelines limits their availability in medical facilities thus impedes effective utilization of new treatment guidelines.*

Certification of health personnel

The project advocated for the integration of the MCH treatment guidelines in the certification questionnaire for physicians. At present the certification system assesses only the knowledge of the physician, while practical capabilities are not examined. The FUAT and IMS clearly show that even in those facilities where majority of professionals are trained application of the practical skills remains still low. Modernization of the certification system by adding evaluation of the practical skills will serve as additional motivation for the effective deployment of the MCH package in practice.

“We have only one Ambu bag in our facility and we tried hard to find out whether there were possibilities to purchase them, though we failed. Should we have additional equipment it could help us to increase our efficiency even more” “There is no oxygen in some health facilities”; “There is no penicillin”

Quotes from trained HPs FGDs in Samarkand and Namangan Oblasts

“Supplies are not enough, equipment is not enough, there is lack of drugs, the supply is not sufficient, we have to purchase drugs and medicine for our own money”

Quotes from semi-structured interviews with Obstetricians and midwives

Integration of MCH package in the pre-service training curricula

Integration of the MCH training package into the pre-service training curricula is a good example of the project’s effective advocacy. At present the Samarkand Medical institute has modified their curricula, which will ensure that the country will shortly produce the workforce of general practitioners who have been trained in evidence based treatment of children and mothers.

Development of the National Training Capacity

The project has heavily invested in the development of the National MCH training capacity by training of trainers and establishment of practical training centers on a national and local levels. *While the project succeeded to create a national and sub-national training capacity, this capacity is not utilized either by the pre-service, or by the post diploma medical education systems.*

Sub-national decision-making level

Ownership among regional health authorities and medical institutes to promote the MCH packages

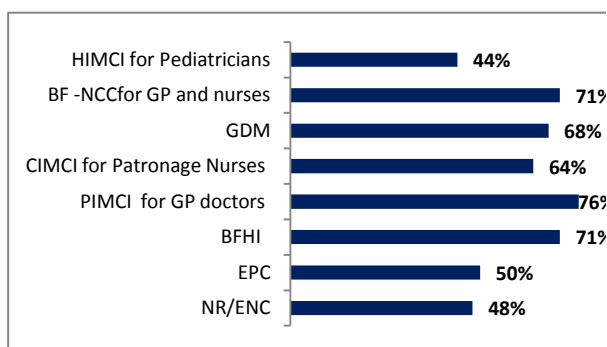
The project supported creation of the local ownership at oblast and rayon levels through training and monitoring capacity building, *though demonstrated ownership is uneven due to the following factors:*

- **Lack of knowledge and understanding** – Selection of trainees locally was performed by the health authorities in cooperation with facility managers. In those regions and facilities where MCH managers have not been targeted by the training program, poor ownership and delays in implementation are observed.
- **Weak leverage capabilities** – Local health authorities lack the leverage to mobilize additional financial resources in support of structural improvements, availability of required equipment and uninterrupted supply of medicines. The decentralization of health system financing puts hokymiats responsible for local health budget formulation. Interviews with key informants revealed that the role of local health authorities in formulation of the budget is limited to only collection of the facility based annual budgets, while the budget amendment according to the MOF approved budget ceilings are performed by hokymiats without consulting with the local health authorities.
- **Limited ability to conduct analysis** – evaluation revealed lack of capacity of local and health facility managers to collect and analyse the performance data as well as take decisive steps for further improvement of MCH service performance.

Service Providers

Effectiveness of Intervention in improving service providers' knowledge and skills in all the project components and in modifying regular practices

Figure 1: FUAT Results



The aim of implementing extensive training to the MCH HPs was the improvement of the quality of MCH care provided at primary, secondary and tertiary health facility level. The effectiveness of the UNICEF/EU training component in providing knowledge (theoretical skills) was assessed through the administration of a pre-and-post test to the participants. The cut-off-point for effectiveness was set at 70% of participants who scored at least 75 in the post test. As mentioned in relevance chapter of the report, the pre-test score was significantly low in every module (NR, ENC, EPC, BFHI, HIMCI, PIMCI, GDM, BF Counseling), with an average score of 47 in the first year of trainings and 49 in the second one. In

the post-test, an average of 90% of participants (first and second year) scored more than 75, proving the effectiveness of training in imparting knowledge.

Monitoring of the skills' application in clinical practice included the after-training follow up (FUAT) to be performed two times within project life: six weeks after the completion of the training, followed by a second round six months apart. The desired target was set at 60% of trained HPs correctly applying the acquired skills. A number of indicators were chosen to thoroughly assess each package. The FUAT data clearly show that *in some areas the desired target of 60% was not achieved. The low level of skill application was recorded for NR/ENC, EPC, and HIMCI 48%, 50% and 44% respectively.*

Identified reasons hindering the correct application of acquired skills are:

Lack of equipment and medications - There is a lack of essential equipment, medicines and support systems to fully apply new treatment guidelines. Absence of supportive environment are either due to the lack of

"We have only one Ambu bag in our facility and we tried hard to find out whether there were possibilities to purchase them, though we failed. Should we have additional equipment it could help us to increase our efficiency even more" "There is no oxygen in some health facilities"; "There is no penicillin"

Quotes from trained HPs FGDs in Samarkand and Namangan Oblasts

"Supplies are not enough, equipment is not enough, there is lack of drugs, the supply is not sufficient, we have to purchase drugs and medicine for our own money"

Quotes from semi-structured interviews with Obstetricians and midwives

(number and type of administered medicines) and considered the service quality as non satisfactory. Dissatisfaction often resulted in transferring patients to the physicians and a facility were old treatment schemes were practiced. As a result of project interventions societal norms are gradually changing.

"At first we did not believe that is possible to provide treatment with such simple things. In Pneumonia cases it was difficult to shift from infusions to tablets. Treatment with Gentamycin was difficult as we were not sure about right dosage"

Quotes from trained HPs FGDs in Namangan Oblast

"Trust in new treatment schemes is low in non-trained physicians. Moreover, there is a resistance to change in Professors and doctors from education institutions"

Chief Doctor of the Samarkand Oblast Children Hospital

Lack of self-confidence - was named by trained physicians during the FGD discussions.

Notwithstanding of identified problems, there is a significant improvement in the field of newborn and child survival when comparing findings from FUAT and IM with baseline data (Table 7).

management's ownership, leadership capabilities, lack of knowledge and understanding of the importance and benefits of the evidence based treatment practices, or lack of leverage to mobilize required resources.

Community attitude and behavior - Old treatment stereotypes that formed societal norms of the quality of care limited physicians to practice new skills. Parents were dissatisfied with the change in treatment patterns

"There were some challenges in implementing new skills and knowledge, parents who were used to a great number of injections were defensive but now about 80% of parents understand new standards"

Quotes from trained HPs FGDs in Samarkand and Namangan Oblasts

"Mothers at first also said we were not doing anything and they blamed us in not helping them, but now people's understanding and acceptance increased"

Quotes from semi-structured interviews with Obstetricians and midwives

Resistance to change – Resistance to change of non-trained physicians, managers as well as representatives of medical education system has been identified as another impediment for effective utilization of the new treatment practices.

"Only few of us at SVPs and Policlinics have been trained. We do our best to educate caregivers in our respective catchment areas however, our colleagues lacking the counseling skills and knowledge are shorthanded"

...No transportation is provided for home visits. Depending on the distance on average we undertake 5-7 visits and spend around 30 minutes per visit"

"...Mother's behavior does change. The trust in patronage nurses increased substantially. Even mother in laws begin to listen to us and change their old stereotypes"

"...There is a lack of information, education materials. Mothers ask for leaflets and brochures as they believe that illustrated information materials will help them a lot to use knew knowledge"

Quotes from FGD with Patronage nurses at Samarkand Oblast

Table 7: Comparative analysis of Practice indicators

Indicator	Baseline	FUAT	IMS
Correctly resuscitate newborn (NR)	34%	39%	56%
Monitor newborn temperature (ENC)	39%	57%	64%
NR/ENC (composite indicator)	NA	48%	59%
Treatment of pneumonia with correct antibiotics (HIMCI)	32%	51%	49%
Danger signs recognition (PIMCI)	34%	82%	87%

Source: Data from M&E Reports, UNICEF Office Uzbekistan

Effectiveness of inter-personal communication package to strengthen patronage nurses' counseling capacity

The Project supported training of the patronage nurse system and equipped them with interpersonal communication skills in different areas of child care. A task force (led by MOH and comprised of MCH Department, Institute of Health, Institute of Pediatric, WHO and UNICEF) worked to develop the IPC training module and guidelines for facilitators. The trainees had the opportunity to receive theoretical knowledge as well as practice counseling skills in order to facilitate the process of counseling and informing the parents on key practices.

At a glance the given system is the most effective in delivering information and educating mothers and caregivers. However, certain areas of potential system effectiveness risks have been identified:

- **Level of Coverage** - The project managed to train only 15% of patronage nurses deployed at PHC system in project target areas. According to the FGD with patronage nurses only 1 or 2 nurses at SVPs and Policlinics were trained (as agreed by the MOH and planned by the project). Though trained ones do their best to perform, their colleagues are shorthanded due to the lack of adequate knowledge and skills.
- **Workload and supportive systems** - ability of patronage nurses to target all households in the catchment area is difficult due to the absence of transportation. Each nurse performs 5-7 home visits per working day and spends on average 20-30 minutes per visit. Trained nurses manage to pay at least one visit per household per annum. In the society were the old stereotypes informal institute of "Mother in Laws" are long rooted and strong, one counselling session per year cannot influence the behaviour. Moreover, shortage of the information materials further contributes to slowing down the process of caregiver's education and makes behaviour change difficult.

The evaluation team was not able to more precisely evaluate the effectiveness of the given system as the project failed to monitor and report on "*% of babies who undergo timely well-baby check-ups in each catchment area of SVPs*".

Final Beneficiaries

Beneficiary Perceptions about the improvement of MCH services

The effectiveness of interventions like training of the patronage nurses in order to improve the quality of services to safeguard child health is obvious and also correlates with the main health indicators of child health.

Baseline survey recorded that 94% of babies within one month of delivery are taken to GP doctors for the medical checkup, but only 34% of General Physicians correctly ascertain the early signs of infection in newborn babies. However after project interventions, (M&E report 2011) 68% of trained GPs can correctly apply their skills for newborn care.

During the FGD mothers reported the changed attitudes of the health workers. Many of them particularly noted the friendly attitude of the doctors and patronage nurses, but also expressed willingness to obtain more information about home-based care, rational nutrition, and information on disease prevention. Majority of them who took part in the focus group discussions were able to recall the main messages regarding breast feeding, hand washing, diarrhea management, danger signs in U5 children and pregnant women. They confirmed that the information they receive is very useful in their daily life and they try to adhere to advice given by their patronage nurses.

Intervention effectiveness in reducing costs of MCH treatment and improving access and utilization of services

The positive trend in the reduction of beneficiaries' cost as a result of the effective interventions of IMCHS project is obvious. The data provided by the medical facilities, oblast level reports and results of monitoring shows dramatic decrease in costs of treatment. Main determinants for reduced costs are:

DATA ON ASTHMA TREATMENT IN NAMANGAN CHILDREN HOSPITAL

Indicator	Before	After	% of change
Average # of drugs prescribed per patient	9	1	-89%
ALOS (days)	13	5	-62%
Complications	5%	0%	-100%
Average cost of treatment (Sum)	50,000	6,000	-88%

GENERAL DATA OF NAMANGAN OBLAST CHILDREN HOSPITAL

Indicator	2009	2010	% of change
# of intramuscular injections	91,193	46,391	-49%
# of intravenous injections	75,320	20,144	-73%
Frequency of use of IV needles and catheters	212	37	-83%
# of admissions to pediatric ward	9,210	10,421	13%

GENERAL DATA OF SAMARKAND OBLAST CHILDREN HOSPITAL

Indicator	2008	2010	% of change
ALOS	7,3	6,7	-8%
ALOS in Resuscitation Department	3,2	1,9	-41%
Average # of drugs prescribed per patient/per day	7,2	3,0	-58%
Average # of drugs prescribed per patient/per day in Resuscitation Department	11,2	4,0	-64%
Share of patients when IV needles and catheters were used	49,1%	0,7%	-99%
Mortality	1,5%	0,8%	-47%
Use of sedative medications	645	200	-69%

Decrease in Average Length of Stay (ALOS) – Although the evaluation team was not able to obtain data for all project target facilities and oblasts, nevertheless decrease in ALOS ranging between 42%-62% has been reported by both Children Hospitals visited in Samarkand and Namangan oblasts.

Rational Use of Drugs - both health facilities report decrease in average number of prescribed medicines per patient per day and it varies from 64% to 89%. Use of sedative medication has reduced by 69% in Samarkand Children's Hospital.

Decline of complications – 100% decline of complication occurring in Asthma cases treated according to the new protocol was reported by Namangan Children Hospital.

“About 6 years ago sick child had to stay for about 10-15 days in hospital and a lot of drugs and were prescribed”

“Before studying in these trainings we used to prescribe a lot of analyses which in its term increases stress of a child and mothers, but now, according to new treatment guidelines we prescribe lab test only according to medical necessity”

“.....unfortunately still there is about 20% usage of injections to decrease high temperature but we explain that Paracetamol is enough and that rubbing can be done with water only before it was done with spirit”

“Before antibiotics were given for seven days after caesarean section, even when cases were not complicated. After the training: de-medicalization, waiting tactics gave effective outcome as for baby so for mother as well, cost-effective, change in the attitude, strict decrease in blood support (blood transfusion), pregnant have less drugs, vaginal examinations have decreased., volume of surgery decreased, ladies who had surgery (CS) before now give birth by themselves (normal delivery)”

Quotes from the FGD for trained health professionals

Reduction in frequency of IV manipulations – Samarkand Children Hospital reports 99% decline.

Change in practice has also been confirmed by trained health professionals during the FGDs. Most of the informants noted rational use of drugs and decrease in invasive manipulation rates.

While these data is encouraging, not all facilities targeted under the project collect and analyse data. These two hospitals are

models from which an effective medical culture can be spread to the other oblast health facilities.

The absence of national data has limited the evaluation team to assess the degree of intervention’s effectiveness. The team was also unable to solicit data to substantiate a decrease of personal (out-of-pocket) expenditure on health, and consequent increased utilization of the services. Collection of such data as part of national reporting and /or project M&E system would have been beneficial though was not originally considered.

Effectiveness of counseling on improved child care and health seeking practices

The assessment of the progress against the plans shows that implementation of the IEC/BCC activities started later and actually the intervention was implemented during the last year of the project. At the same

- ❖ 72 % mothers have knowledge on dose, time and days to give the prescribed medicine to her child and 57% could correctly tell the three rules of the home treatment.
- ❖ Immunization coverage accounts for 95%;
- ❖ Exclusive Breastfeeding rates for children in first month after birth increased by 30 % in new 8 Oblasts than that of baseline MICS 2006 (26 %);

time the level of engagement at the policy and decision making level can be considered ineffective as two main institutions involved in the health promotion in Uzbekistan, the Institute of Health and Medical Statistics and the Ministry of Education were not taken into account as main stakeholders.

The project failed to build the productive working relationship with the Institute of Health and Medical Statistics in the process of production and distribution of BCC materials, when one of the functions of this

institution is to produce the printing materials for health promotion and healthy life style for the whole population. Moreover, the institute being the member of the task force for the development of the IPC, preferred to work in isolation of the project.

Nonetheless, the interventions directed towards improvement of counseling shows positive trends for selected indicators. Should more indicators being measured as part of the M&E and or being available from special surveys, rating effectiveness of given intervention would have been easier.

EFFICIENCY

This section of the evaluation report examines whether the program resources have been used efficiently in order to achieve the project outputs.

Use of Project Resources

Original project budget was 3.8 million Euros out of which 92% was made available by the EU and remaining 8% was UNICEF contribution. The project was flexible to accommodate MOH request for expanding the training package to more health professionals due to the increased demand on trainings. In response to this

query UNICEF increased its share of funding by 34% from its regular resources (103,910 Euros).

Table 8: IMCHS Project Budget Execution as of August 8, 2011

Budget Line Items	Total Expenditure	Share of Total	Actual vs. Planned
Human Resources	2 142 870	54%	16%
Travel	563 780	14%	-5%
Equipment and Supplies	405 662	10%	-3%
Local Office costs	44 277	1%	-51%
Other Costs and Service	463 698	6%	5%
Other Costs	54 641	1%	15%
Contingency	0	0%	-100%
Admin costs	257 245	7%	3%
Grand Total	3 932 172	95%	3%

In order to assess the efficient use of resources the project team analyzed the most recent budget execution report made available by the project team (Table 8). According to the same table 95% of revised budget has been executed. It was noticeable that 54% of the total amended budget (2 142 870 Euros) was spent on human resources under Human Resource expenditure category

which covered Salaries (50%) and per-diems related to trainings and M&E (50%). 56% of salary expenditures were allocated only to cover the MOH national technical experts being deployed in the project, 27% for the project expatriate staff and another 18 % for international experts. Investing in the national capacity building always proves the efficiency of resource use as serves as a sustainment factor. Having international expertise on a board, though being expensive is another prerequisite for the effective implementation of the project and the support of national human resources capacity building process.

The travel costs which represents 14% of the total expenditure, though being 5% less than the originally planned amount indicates the level of project support provided for a) implementation of the training program in selected project target areas; b) HP participation in trainings; and c) monitoring of the project implementation progress and quality assurance. The lion share of the travel budget (76%) was used to enable HPs participation in the training program, 6% for the project local staff travel and remaining portion for monitoring and supervision purposes. Although the given expenditures were justified, attainment of selected project specific objectives and targets were partially met.

Another budget line that caught evaluators' attention is communications and awareness raising costs. According to the original and executed budget, only 2% was allocated for the support of such activities. The Attainment of the project result "Public awareness of best practice in child care in general is raised" requires more funds to be allocated towards these activities. Eventually, the project spent only 67% of the allocated budget. A reason for under spending given by the project team was delays in implementation of the given component. This is well reflected on the level of public awareness attained by the project.

The project managed to maintain 7% of total budget expenditure on administrative costs, while the original budget was increased by 3%.

The detailed evaluation of the efficiency of resource use was constrained by two main factors:

- **Input Based Budget** - absence of the programmatic budget limited evaluators' ability to analyse the resource use against project component/activity outputs and outcomes.
- **Limited time, resources and willingness to share** - Although there was a possibility to work out main costs of interventions for further analysis and comparison with the costs of similar activities supported by other donors, performance of this exercise was not possible due to: a) time and resource intensity of the task; b) the evaluation time constraints, and c) unwillingness of other donor organizations to share the costs of selected interventions.

Despite above outlined limitations, the evaluation team managed to roughly analyze training costs. According to the calculations made by the project staff (for 10 days training), on average training cost per participant per day accounts for about 51 Euros out of which 30% is spent on printing training materials. Although alternative information on the training costs from other partners were not made available the evaluation team thinks that the given cost ranks high in comparison to the training costs in other former soviet countries³⁵. Whilst this statement has to be treated with caution, given analysis will help the project to design and negotiate cost sharing arrangements for the second phase of the project which will allow more rational use of available resources as well as will help to gradually hand over the funding to the MOH.

Service providers

Efficiency of the cascade training system

Building the national and local level training capacity was the project's specific objective. In order to attain project's main objectives in the most expedient manner, a cascade training approach has been adopted. The given approach ensures rapid transfer of responsibility from project staff to government master trainers and to local trainers. The entire training process was meant to create a network of knowledgeable professionals able to independently carry on further training courses, supervision and monitoring of activities at health facility level. This should have assured quality of health care delivery and its sustainability. As a result, in a rather short time a critical mass of trained health workforce has become available to provide effective evidence-based MCH interventions.

The implementation of UNICEF/EU project's training component activities included: training of master (national) and local trainers (pediatricians, neonatologists, obstetricians, health managers) and training of selected HPs working at hospital (obstetricians, neonatologists, pediatricians, nurses, midwives) and primary (GPs, patronage nurses) level. Trainees were supposed to pass on the acquired knowledge and skills to the other non-trained-colleagues at workplace through peer-to-peer tutoring/teaching.

The training of trainers (TOT) activity produced 70 master/national trainers, of which six (6) were management trainers for health management, and 595 local (oblast and rayon) trainers, a proportion of which were management trainers for health management³⁶. Master trainers were involved in reviewing and

³⁵ For example: Georgia spent 13 – 20 Euros per participant/ per day for 10 day training program. Printing costs accounted for 5-10% of total training costs. Armenia spent 17-27 Euros per participant/per day for 10 day training program.

³⁶ The initially planned number of local trainers was 334, of which 84 were local/oblast trainers for health management . Later, the number of local trainers increased to 595, but the proportion of trainers for health management is not specified.

“The duration of training was enough but we would like to study even more and we are glad that our certificate is recognized and it is considered when we pass examination for upgrading our professional category”.

Quotes from Focus Group

updating the training material. They were proposed by MoH and selected according to their competencies and availability to travel to other oblasts and rayons for monitoring and supervising the trainees along with local trainers. Master trainers benefitted from international consultants coaching and supervising, whenever their presence was requested in some areas of new competency and skill development. Training local trainers, supervising/facilitating training activities run by local trainers, and performing post-training follow up and monitoring are among the

master trainers’ responsibilities.

Local trainers, from oblast and rayons, were responsible for implementing training courses for HPs, follow up and monitoring post-training activities. A proportion of trainers were trained in order to use the QoMNHC tool within the QI approach (QI) in maternity centers.

All training courses provided by the UNICEF/EU project were certified by MoH and recognized at national level for career development³⁷, which in its term served as an incentive to be trained. Trainees were selected by the oblast Health Office to attend the training course that fitted their professional qualification.

“There is a need for all care providers to be trained in evidence-based interventions in order to homogenize the approach to child care. Health professional from the first aid, emergency aid and infectious disease specialists should also be trained in order to implement unique system and apply one standard”

“...also professionals of the sanitary epidemiological service prescribe different from ours treatment for diarrhea, because they were not trained we still have some disagreements regarding diagnosis and treatment of patients”

Quotes from Focus Group Discussions

The given approach worked effectively and served the purpose of creation critical mass of trained health professionals though had certain weakness that questions the efficiency of trainings and need to be addressed in the second phase of the project. These are:

- **Poor guidance on the selection criteria** - Although delegation of the trainee selection authority ensures building of local ownership, no clear cut guidance has been provided by the MOH and/or the project on the targeting and selection criteria. As a result in some oblasts local and facility managers have not been reached which had negative implications on the effective implementation of the new treatment schemes and subsequently on the efficiency of the training program.

³⁷ HPs are assigned to a category/level that contribute to determine their salary. In order to maintain or upgrade their category/level, doctors have to attend a minimum of 288 hours of professional upgrading courses within 5 years. Nurses are requested to attend a minimum of 44 hours within 5 years.

- **Uneven coverage** - The effectiveness of cascade training was also hindered by uneven coverage of facility and oblast HPs with training packages. In some cases at the hospital only three persons are trained while only one treats the patient, while other two are from the facility administration. While it is well understood that training of management staff should be given a priority, it is naive to believe that only one trained physician can make a desired change in practice. The coverage levels provided in the Table 8³⁸ clearly indicates that coverage varies from 6% to 87% for different HPs and different training packages. It is considered by the evaluation team that insufficient coverage contributes to low performance thus hindering the cost-efficiency of the intervention.
- **Local trainings are shorter in duration and are not certified** - Training courses organized locally (oblast), without UNICEF/EU project support, are shorter in duration compared to the ones carried out with project support. Furthermore, these trainings are not certified thus the participants are not entitled to utilize these training hours for career development purposes. The evaluation team attempted to obtain the number of training courses organized locally, but apparently such information is not recorded in the project M&E database.

“The received training was not enough to enable me to implement on-the-job training
duty schedule does not overlap with other non-trained HP working in the same health facility
 I do not leave training materials at the HF when I’m not on the job as I do not want to lose it, is too precious for my work”
 ... It cannot be named as training but more as information sharing. It gives only theoretical information which without practice is deficient
 ...There is limited number of patients in our facility to practice, practice should be carried out at the Oblast level health facility were there are a patients with different diagnosis and level of severity.

Quotes from Focus Group Discussions

Figure 2 : Coverage of Health Providers Trained by IMCHS Project in 8 Oblasts

Training Package/HPs	Total # working	Total # Trained	Coverage
NR/ENC			
# of Ob/Gyn	2 486,00	484,00	19%
# of Neonotoligists	683,00	591,00	87%
# of Midwives	12 864,00	692,00	5%
# Neonatal Nurses	-	758,00	NA
EPC			
# of Ob/Gyn	2 486,00	152,00	6%
# of Neonotoligists	683,00	129,00	19%
# of Midwives	12 864,00	140,00	1%
# Neonatal Nurses		12 864,00	NA
BFHI			
# of Ob/Gyn	2 486,00	316,00	13%
# of Neonotoligists	683,00	291,00	43%
# of Midwives	12 864,00	511,00	4%
# Neonatal Nurses		12 864,00	NA
P IMCI			
# of GPs	3 264,00	2 254,00	69%
H IMCI			
# of pediatricans	3 822,00	1 191,00	31%
C IMCI			
# of GPs	3 264,00	1 742,00	53%
GDM/NCC			
# of GPs	3 264,00	1 742,00	53%
# of patronage nurses	13 213,00	1 802,00	14%

- **Shortcomings of Peer to peer training** - the cascade training also envisioned that trained HPs would further trickle down the acquired knowledge and skills to peers in their facilities. This would have ensured the efficient use of technologies and the consequent reduction of treatment cost.. However, peer to peer education, if any, was held during the working hours when HPs have to perform their regular duties. Therefore the time devoted for the training was limited to 15-20 minutes and had only the information sharing character. Such peer-to-peer trainings lacked the practical application of the new skills due to time limitations as well as to the scarcity of adequate patients. Another shortcoming identified was the lack of access to training materials

- **Financial constraints** - The health authorities interviewed by the

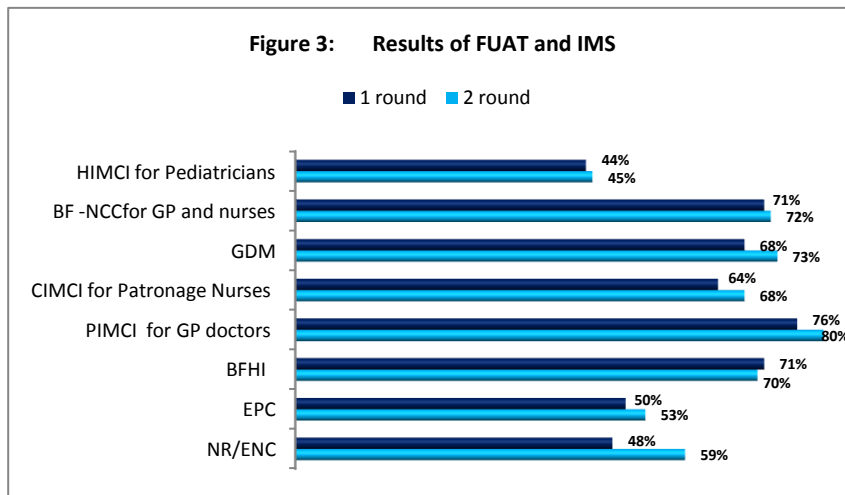
³⁸ Source: M&E reports , UNICEF Uzbekistan Country Office

evaluation team expressed their concerns about financial and organisational constraints that hinder the replication of training activities without IMCHS project support. Financial resources are not sufficient to pay off national (travel expenses and per diem) and local trainers, as well as to ensure provision of needed training material. All these problems slowed down effective implementation of the reform in target oblasts and facilities.

Efficiency of the FUAT and Integrated Monitoring System

The FUAT was designed to supervise and support the application of knowledge and skills into medical practice of the HPs who underwent IMCHS project training courses. During FUAT visits, each component of the training was assessed separately. This entailed the presence of certain number of local trainers/supervisors whose responsibility was to carry out the supervision, and national trainers whose role was to supervise the quality of work of trainers/supervisors. Great effort was devoted to train national and local trainers in supervisory process and methods. Furthermore, in order to avoid bias in the monitoring process, trainers/supervisors did not assess the HPs who were trained by them, but performed FUAT visits in a different oblast. Oblast health authorities were engaged in the monitoring as well. A complete FUAT visits were planned for 10 days. All the process was effective in terms of reaching the stated objectives, but extremely resource (human and financial) consuming. It has been estimated that the cost for one FUAT round for one training component per oblast (e.g. PIMCI) was 14,000 USD.

The IMS, which replaced FUAT, aims at monitoring all the components of service delivery: human resources



(doctors and nurses) as well as other services (i.e. laboratory, drugstore) that contribute to the quality of care delivered. The monitoring is performed by trainers/supervisors from the same oblast and monitored by the national trainers. A complete IM round lasts 5 days. The outcome monitoring report, which is prepared after each visit, is shared with local decision-makers in the attempt of overcoming the

problems that prevent the full implementation of the newborn and child survival strategies. The estimated cost of one IM round per oblast, which covers all training component (newborn and child survival) is 4,000 USD. The IMS has chances to become part of the routine supervision system at local (rayon, oblast) level, where supervisory and monitoring mechanisms are already in place, such the regional monitoring team, and the focal point persons for maternal and child health.

The results of both monitoring rounds show neither significant performance improvements (see Figure 3) nor impact of monitoring mechanisms in the improvement of weak areas, such as NR/ENC, EPC and HIMCI. The Inadequate use of monitoring results for follow-up action planning; lack of local authority and health facility managers capacity to design and implement corrective measures as well as to mobilize resources

either from their own budget or from outside for structural changes; poorly performed local refreshment and peer to peer trainings; resistance to change are among the reasons behind the lack of satisfactory results of monitoring visits.

To conclude, FUAT failed to meet efficiency criteria. IMS is less costly than FUAT however its efficiency still needs to be assessed in the second phase.

Final beneficiaries

Efficiency of inter-personal communication and the patronage nurses system

Based on data provided by the project, at PHC level and SVP, 14% of employed nurses and 53% -69% of GP's are trained in IMCI and GDM/NCC. Among them, 60% of nurses and 76% of GPs correctly apply their skills. As aforementioned, patronage nurses are able to visit the target population once in one or two months. Therefore, the efficiency of the inter-personal communication package, implemented by the patronage nurses, can be graded as moderate in terms of reaching the target groups and increasing their knowledge on child caring as compared to the absorbed resources.

The BFHI program has a strong component of BCC. Within the 8 oblasts covered by the project, 31 maternity wards, 5 maternities, 17 Polyclinics, 55 SVPs are already certified as BFHI. The certification process

Table 9: Coverage of PHC level with interpersonal communication trainings

	Total Number working	Total Trained	Covered percent
P IMCI			
# of GPs	3 264	2 254	69%
GDM/NCC			
# of GPs	3 264	1 742	53%
# of patronage nurses	13 213	1 802	14%

Source: Training Reports, M&E

foresees 10+1 steps, or components, that health institution have to comply with to be certified as BFHI. The eleventh component is the requirement for each maternity to work with and supervise two polyclinics or two SVPs. This step is to ensure that women who delivered in the maternity are properly followed up and counseled, especially in exclusive breastfeeding for the infant first six months of life. Data reported by the responsible for BFHI program show 85% of exclusive BF in the certified maternities/maternity wards and 75% of exclusive breast feeding in the SVPs where the BFHI is implemented. Peer-to peer education is one of the certification's components. It

concerns a group of mothers, living in the health facility catchment area, who voluntarily provide training on breastfeeding to other women. This process is supported by HPs who are trained in counseling and education of pregnant women and mothers.

The resources also were spent on producing tools and materials for service providers such as the patronage nurses, GPs and pediatricians who have a direct contact with the families and who are available at the SVP or the Rural Health Points to interact with mothers and care givers. Communication materials have been produced, distributed and used by families and care givers to get vital information about a package of behaviors they need to practice at home to protect children from illness and ensure the wellbeing of pregnant women and nursing mothers. Through these materials they also learn how to recognize danger signs in pregnancy or among children <5 years of age and how to seek timely medical assistance. However the number of produced materials is not sufficient to cover the whole targeted population. Total number of produced communication materials is 2000 flip charts, 300,000 mother's card and 2000 danger signs posters printed and distributed. At the FGD the beneficiaries stated that none of them received Mother

cards, but saw it at PHC faculties. In conclusion, the resources spent on production of communication materials, which in fact were not enough for the required level of dissemination, were not used efficiently.

SUSTAINABILITY

National decision-making level:

Ownership of the MOH and other concerned government agencies

MOH ownership is present in all project components. Integration of project strategic directions in the higher level national policies serves as a prerequisite for sustainment of the MOH ownership and leadership in promoting MCH reforms. The Deputy Minister of Health responsible for MCH sector being the chairman of the PSC ensures MOH permanent presence. Appointment of the MOH staff (representing different public health entities) as coordinators of MCH training package modules guarantees availability of critical mass of professionals in the MCH field.

In April 2010 the government officially endorsed the nationwide introduction of ILBD and this has been one of the major achievements of the international community in the country. The ILBD Registration Centre located in the MoH has started the collection of statistics on birth and deaths of babies providing the health professionals and the decision-makers with information on areas requiring attention. The MoH continues to implement the state programs on 'Improvement of the health culture of the population' (Decree No 1096) and on 'Strengthening of reproductive health of population and building a healthy generation' (Decree No 1144). Both programs include activities from the current project and therefore will be continued by the state. However, if national and sectoral support is in place, there is no evidence of this in specific budgetary policies at least in regions.

Integration of the MCH package into the certification system as well as in pre-service education system is an important element of sustainability, though not sufficient. As mentioned above, the certification system measures only the theoretical knowledge of practicing HPs and cannot substantially influence the practice patterns. Integration of the MCH training package into pre-service education system is piloted in Samarkand Medical Institute. It is difficult to speak about sustainability of this system if no expansion takes place.

Moreover, physicians are not the only health providers being involved in MCH service provision. Adequate actions are required for integration of the MCH training package into the pre-service education of nurses, midwives and health managers.

Furthermore, the MCH training capacity, human and infrastructure, built by the project cannot be sustained if not integrated and utilized into the post diploma and continuous education systems as keeping the project established training system as an independent vertical system raises the risks of the non-sustainability.

MoH, Oblast Health authorities and regional hokymiats ownership and capacity for resource mobilization

Ownership at the local level is uneven. Even in those oblasts where the ownership is strong, managers have limited leverage to mobilize resources in support of the reform implementation. This problem cannot be only attributed to the weak leadership of certain managers; rather to the budget formulation process established in the country which limits local authorities to influence budget allocations. As a result, trainings initiated by local authorities as well M&E activities are not financed from the oblast budgets and have a voluntary character. Systems in place cannot function effectively without adequate funding and is difficult to sustain.

Little or no actions were taken by the MoH and other health-related state organizations and local administrations on the key challenges discussed at various meetings. Monitoring results revealed a need for resolving problems that prevent health professionals to apply new practices (lack of hygiene, antiseptics water systems; shortage of essential medicines, consumables, oxygen) in a full and sustainable way. No training plans for 2011 were shown during the visit to the Oblast Health Authority and medical institutions in organization of cascade training using the trainers available. Despite the economic benefits that new practices are bringing to health facilities (budget savings of up to 20-25%), neither the local health Authorities and the MoH nor the hospital administrations have so far decided to allocate part of the saved resources to the continuation of training in their regions. Training is taking place on a much lower scale and mainly within the hospitals, leaving health professionals in remote areas aside. Also, supervision is still carried out by donors as oblast and rayon managers do not have the resources to conduct regular supervision for skills reinforcement.

Evaluation revealed that effective implementation of the MCH program mostly relies on personalities in management positions, their awareness as well as on their individual effort. Most of health managers lack the basic general health management skills and knowledge that would enable them to analyze and use data for planning resources and priority action.

IMCHS project Health Management (HM) trainings have been proven effective, in some cases, to enhance local managers capabilities, which led to appropriate budget allocation. The increased availability of oxygen in hospitals has been reported as an example of improved management. During HM training, participants (mainly obstetricians and pediatricians, chief of departments) are exposed to IMCI topics (with special focus on HIMCI) so that they become aware of and understand the need for the hospitals to be equipped according to international standards in order to manage patients in an effective and efficient way. However, the possibility to appropriately equip the hospitals resides upon both wise management and resources availability which is in most cases are lacking.

The mitigation of sustainability risks locally requires more system oriented interventions and cannot be limited only to programmatic interventions.

Gaps along the continuum of care that hinder the service quality and Sustainment of Health provider behavioral changes

Gaps along the continuum of care are observed. Not all facilities have supportive environment to apply the new patient management guidelines and protocols. This is why children’s caretakers and pregnant women still prefer Oblast hospitals where they can find quality health care, while their ailments and conditions can

“...I can provide survival of a. Neonatologists make 500 grams babies to survive, this is our main motivation”

“Before nurses used to be executors only, but now we can give advice. Now our services are more demanded from community and this motivates us to work ”

Quotes from Focus Group Discussions

be managed at PHC or Rayon hospital level. Self-referral to regional hospitals is slowly declining, but still present. According to the national regulations, public health facilities are not subject to licensing which otherwise could have ensured that MCH facilities meet all required licensing standards.

Furthermore, in absence of supportive structural environment where to practice, even trained HPS lose their new acquired skills and continue to practice in old fashion.

In some areas only few professionals are trained and peer to peer education failed to achieve desired results. The low penetration of new treatment approaches is further deteriorated by the high levels of trained human resource dropout rates.

For the time being, practicing trained HPs show high moral and motivation, which are mainly sustained by the enthusiasm of applying new practices, supportive supervision and better relation with patients that show gratitude for the improved service. Some HPs, mainly nurses, verbalized their feeling of self-confidence that has been boosted by both the expansion of their knowledge and competency due to the training and application of skills into practice. In doing so, they have gained the trust of the patients/caregivers who appreciate the benefits coming from the new approach. In the long run motivation might deteriorate, especially if basic, necessary changes will not take place, such as regular supply of needed medication and upgrading of infrastructures.

Those who practice are not rewarded for changed behavior which may result in deterioration of staff motivation, if not adequately addressed. Apart from ensuring supporting work environment, it is desired that financial and nonfinancial motivation schemes are applied to influence physicians’ behavior.

In order to improve quality of MCH services, the country requires expansion of targeting of MCH work force. Resources that are required to meet the training targets across the country will be difficult to mobilize only from international partners if public and private funding is not consolidated. As the delivery of MCH trainings is a vertical system utilized only by the international projects, integration of these trainings into the continuous professional education system will ensure that this system is sustained and is financially viable. This will help the MOH to tap not only donor funding, but also public as well as private resources.

Ensuring the long term sustainability of the evidence based treatment approaches requires that the medical education system produces well trained physicians, nurses, mid-wives as well as managers which has been partially addressed by the project.

Gaps along the continuum of care that hinder the capacity of mothers and caregivers to access and use quality MCH services and Sustainment of Beneficiary behavioral changes

The newborn and child survival approach implies the implementation of evidence-based interventions where the severity of the child ailment is classified by symptoms that are correlated to a specific patient's management that includes medical advice, medical treatment and/or referral to higher level of care. The strategy includes guidelines, protocols and the essential drugs lists. This approach limits invasive medical practices (intra-venous and intra-muscular therapy) and the unnecessary prescription/administration of multiple drugs to the same patient. This approach was new to patients and caregivers who were used to value aggressive medical intervention, poly pharmacy and hospital (secondary and tertiary care) based treatment rather than PHC.

HPs reported an initial mistrust of patients and caregivers towards those who have adopted the new approach and was not injecting medicines or overprescribing them. Although this attitude has declined, but still persists, supported by deep-seated beliefs and habits in the community as well as HPs who still practice in old-fashion medicine.

On the other hand, not all level health facilities offer quality care. Lack of medical supplies and poor infrastructure, despite the deployment of trained HPs, might discourage patients to attend primary level health facilities, and increase their mistrust to them. So, patients and caregivers tend to prefer secondary or even tertiary level health services, especially now that the improved quality of maternal and child services at regional level is well known.

Absence of health facility and HP performance evaluation to practice new treatment protocols and counseling skills, have consequent negative implication on quality of MCH services and its sustainability, as well as effects mothers and caregivers access and use of quality MCH services and continuity of care.

The projects approach to influence beneficiary behavior through patronage nurse system proved to be effective in delivering correct information concerning when and where to go to seek medical care. However, low coverage of patronage nurses with interpersonal communication training, poor funding, lack of transportation means, and absence of caregiver's educational materials may undermine the its sustainability.

Lack of awareness and education at community level play also an important role. The FGD with patronage nurses and beneficiaries revealed that the right information might not reach the right person. Culturally, the family structure foresees a strong role for mothers-in-laws as main family decision makers in issues of child bearing, feeding and treatment, which usually are not direct targets for communication and awareness interventions. The findings of FGDs with patronage nurses revealed that indirectly the latter influence the set stereotypes of mother in laws, though suggested that direct targeting of this group will be beneficial. Thus appropriate information and education, along with the sustained quality of health care delivery are critical to develop, in order to increase and maintain the demand for health services.

Affordability of medical care in Uzbekistan has been reported to be one of significant barrier to access of the health services. There are documented examples of reduced costs of health care where evidence-based interventions have been implemented. In the due time, this should also reflect to family expenses for

health care that can be potentially reduced by reducing the number of prescribed drugs and hospital admission stay.

COHERENCE

Project contribution and coherence with national policies and priorities for the MCH sector

The IMCHS Project was instrumental in advocating and facilitating the national MCH sector reform. The government of Uzbekistan is working for poverty reduction, improving the food security and providing quality health care. The project under consideration supports the government strategy on health sector reform that contributes to the **Welfare Improvement Strategy** objective of “*significant improvement in the quality of services in education, health and other socially significant sectors*”. The project informed the health system reform focusing on maternal and child health which has been reinforced by two Presidential resolutions signed in 2009 aimed at improving the maternal and child health, including awareness raising in households and communities about raising a physically and intellectually developed generation by 2013. This shows the highest level of political commitment and ownership for a sustainable system in the maternal and child health sector. The health sector reform supported by this action accelerates access and utilization of quality health care to more than three fourth of the population living in rural areas.

In 2009, the Government adopted the **Nutrition Improvement Strategy (NIS)**. Even though this strategy still largely focuses on multi micronutrient deficiency, there is also attention towards promotion of rational nutrition behavior for the population in general and children in particular.

The project also supports the human resource development activities as well as contributes towards provision of the quality health care services through institutionalizing effective monitoring system. This is in line with the human development priority of NIP for addressing the essential needs of the population focusing on primary health care with equity i) increasing access and utilization of quality primary health care by population living in remote areas to accelerate achievements of health related MDGs ii) strengthening health systems in order to institutionalization of innovative, cost effective and efficient health care provision with international standards iii) enhancing the capacity of the Ministry of Health and its authorities on public health notion. The IMCHS project through behavioral communication change approaches supports the improvement of the knowledge and skills of the parents on child caring, rearing and feeding practices that shall empower the rural families for health and wellbeing of the children.

Project synergy with interventions and strategies of UN agencies

The project is coherent with UNDAF (2005-2009 and 2010 – 2015) with priority area on enhancing essential services for maternal and child health. It also contributes to achieve the results related to Focus Area 1 of UNICEF’s Medium Term Strategic Plan: Young Child Survival and Development. This is reflected in the Country Program Document and related Action Plan for 2010-2015, signed by the Government and UNICEF and aiming at: by 2015, the health system provides quality services for mothers and children in line with adopted legislative and normative frameworks aligned with international standards.

Project synergy and coherence with the donor’s objectives for the social sector in Uzbekistan

Project is fully in line with the EC strategy for the Central Asian Countries. It has been implemented within the frames of the cooperation between MOH of GIZ, UNICEF and EC. The project also contributed to enhancement of living standards of rural population which is the key objective of EU National Indicative

Program (NIP 2011-2013) focusing on actions leading to reduction of poverty levels and social inequality³⁹. This goal can be achieved only through the healthy population who can contribute on economic growth. Therefore, the investment in the health sector reform and improving the nutritional status of vulnerable population is the most cost effective investment for sustainable human development and economic growth of the country by making a healthy and economically productive citizen.

Project demonstrated high level of synergy and coherence with donor finance activities illustrated in the Table 10 below.

Table 10: IMCHS Project Synergy w/t Other Donor Financed Projects

Organization/Partner	Area of Intervention	UNICEF Input	Partner Input
ADB/Women and Child Health Project. UNFPA/GIZ	Training of MCH specialists on Effective Perinatal Care in Karakalpakstan, Khorezm and Bukhara 72 participants	International Trainers and training materials	- National Trainers and participants cost. UNFPA- Khorezm and Bukhara GIZ – Karakalpakstan
ADB/Women and Child Health Project and WHO	National Conference on Improvement of Quality of Hospital Services, Provided to Children – 80 pediatricians from 14 Regional Hospitals	Travel and DSA one night 40 participants from Regional Hospital	ADB- International consultants and conference materials WHO: Trainees’ food, lease of premises, Organizational Committee Per Diem
ADB/Women and Child Health Project	Training of MCH Specialist on Basics of the Evidence Based Medicine and implementation of clinical guidelines	Local expenses for Tashkent, Kashkadraya, Khorezm, Bukhara, Fergana Oblast participants	ADB- Development of presentations, handouts, accommodation for the consultant and consultant’s fee.
ADB/Women and Child Health Project	Training on use of neonatal equipments	Travel and DSA for International Consultants	ADB- Training materials and local participants cost

HUMAN RIGHTS BASED APPROACH (HRBA):

The project document is silent on how it addresses the HRBA issues, though the project interventions are targeted towards both the right-holders as well as duty-barriers.

Main actors acting as duty-barriers such as MOH, Oblast Health Authorities and health service providers have been identified during the project design. The project interventions were designed to close the most important capacity gaps of the duty-bearers to be able to meet their duties and were directed towards building their capacity in coordination and partnership, evidence based policy formulation and regulation, quality service provision through institutionalization of the modern treatment guidelines. The project ensures duty-barrier’s involvement in the design, implementation and M&E activities.

Mother and children (under five years) were identified as key right holders. The project identified what interventions/activities were required to close the most important capacity gaps of the right-holders to be able to claim their rights interventions and thus were directed towards ensuring that they get improved access to best quality of health care, are empowered with adequate knowledge and information and their health

³⁹ European Commission: Central Asia DCI Indicative Programme 2011-2013

status is improved. Nonetheless, there is no evidence that key actors have been involved on the project design, planning, implementation and monitoring phases.

Although the project did not particularly focused on selecting the regions based on the indicators such as share of poverty, health status of right holders and/or access barriers, eventually it targeted 53% of the country's population and almost 34% of disadvantaged individuals living in the 8 project regions and with MMR ranging from 17.4 to 49.7 per 100,000 life birth (Table 11) while the national MMR accounted for 30.8 per 100,000 life birth. This selection proves that although the project has not explicitly used the RBA, but project interventions were targeted at poor and disadvantaged regions with relatively high MMR.

Table 11: Main Data on Project Target Regions

Project Regions	Poverty rate	Total population	Proportion of disadvantaged population	MMR
Andijan	23,1	9,5	8,5	21,30
Namangan	33,4	7,9	10,2	30,60
Samarkand	23,9	11,2	10,4	17,40
Jizzakh	29,6	3,7	4,3	25,00
Kashkadarya	41,0	8,5	13,5	24,40
Navoi	26,3	2,9	3	49,70
Syrdarya	32,6	2,4	3	34,70
Surkhandarya	34,6	7,3	9,8	23,80
Targeted Population				53%
Share of disadvantaged population targeted by the project				33.5%
National MMR (2005)				30.8

Source: UNDP Human Development Report, 2006

There was no built-in gender-differentiation in the project design although by promoting BFHI the project indirectly reached the male partners attending the child birth. Observed predominance of females on training courses was mainly guided by the gender composition of the national health workforce. The majority of Course Directors were female but they have been selected on merit bases.

EPC training provided skills aimed at improving care provided to pregnant women and mothers. This has contributed to reducing the occurrence of events that affect female health. Improving health status of mother and children has been one of the achievements of the project.

Project targeted females - both as participants in the capacity building programme as well as beneficiaries of improved quality health services. Mothers' knowledge and skills have been shown to have improved and this has been reflected in improved MCH indicators. There is a strong likelihood of greater gender equality as a result of the project as the new knowledge increases the empowerment of females as mothers.

The project's Overall Objective is to help Uzbekistan meet MDGs 4 and 5 (Reduce Child Mortality and Improve Maternal Health respectively). Through its work in pilot hospitals as well as provided trainings will ultimately benefit women and children of all classes, ethnic background and wealth etc. Therefore, although the project does not explicitly address human rights issues, its results and impact will improve the health of mothers and children at all levels.

SUMMARY OF EVALUATION FINDINGS AND CONCLUSIONS

Relevance

National Decision Making Level:

National data on burden and causes of diseases affecting children in their first years of life and the baseline assessment of HPs performance on MNCH delivery care substantiate the remarkable effort undertaken by the IMCHS project that provided training to primary, secondary and tertiary level health care providers on evidence-based interventions in newborn and child health care.

Service Provider Level:

Project addressed the shortcomings of MCH human resources and invested in the development of the critical mass of trained MCH providers in 8 selected Oblasts. Through the delivery of the MCH training package to the HPs and health managers the project facilitated changes in the MCH service structure and service provision processes. Health managers who underwent training in HM were prone to support needed changes at health facility level, and were willing to allocate budget for medical supply. Consequently, management training should be always carried out before any other training on clinical skills improvement.

Final Beneficiaries:

Special emphasis was given to community empowerment activities by provision of interpersonal communication training to patronage nurses. Proper counseling, delivery of information and education of mothers aimed at demand creation for quality child care and health seeking behavior.

Effectiveness

Project Implementation Structure:

Coordination:

Establishment of the Project Steering Committee, led by the MOH, ensured coordination of MCH reform inputs from all partners involved in the MCH activities. To avoid duplication of efforts the Joint Action Plan (JAP) has been developed under the leadership of the MOH/PSC and UNICEF and technical inputs from the partners. While the JAP is informative and has been effectively used by the MOH and partners in planning their activities, it has certain shortcomings for Government's strategic coordination and planning purposes such as a) difficult to use for MOH strategic planning purposes; b) it lacks the information on the guaranteed funding per type of activity.

The MOH has certain limitations with regards to effective Donor coordination. It still has not managed to galvanize and lead Donors and partners to support its national MCH strategy, because the ministry not only needs effective coordination tools and processes but it also needs capable staff, which is currently in short supply.

The coordination meetings are limited to only information sharing and rarely address implementation problems and/or assess specific results achieved by various projects. Decisions, guidance and follow up actions are frequently missing and most importantly accountability to MOH is lacking.

Project Implementation Team:

The achievements attained by the project would have not been possible without strong project implementation team. The effectiveness of the “paring approach” applied for the training component of the project has to be acknowledged. For each training module the MOH staff was assigned as a coordinator, being in charge of planning, supervision and reporting. The given arrangement at the one hand ensured effective communication and cooperation with the MOH and on the other supported national capacity building. Moreover, it enhanced linkages between national and local level professionals and facilitated knowledge and experience sharing.

Project M&E System

Results Framework:

In order to monitor and evaluate project performance the Results framework (RF) has been developed and updated on annual basis. However, effective use of this tool was limited due to:

- For most indicators the RF lacks baseline data and targets, as well as means of verification. These shortcomings restricted project to monitor effectiveness of the project interventions, analysis and timely utilization of corrective measures.
- The project was shorthanded to use selected national statistical data for appropriate planning and monitoring effectiveness of project interventions.

FUAT: The FUAT tool is instrumental for the regular monitoring of the training effectiveness and change in practices, identification of weaknesses being it systemic, knowledge, skills and or processes as well as informing the decision makers on the required actions and ensures effective deployment of evidence based treatment practices. Whilst FUAT system has been acknowledged by the MOH, local health authorities and health professionals to be a useful tool for application of new treatment practices, its implementation had certain shortcomings that hindered the effectiveness of the given system. Delays in FUAT implementation and poor applications of corrective measures in response to findings have been observed during assessment.

IMS: IMS has been introduced by the project in exchange of the FUAT system due to the cost efficiency concerns of the latter. While from financial perspective this was the right strategy for the project to collect required outcome indicators, IM system cannot be seen as a substitute for the FUAT system.

IMS and FUAT both being the monitoring tools used by the local health systems, require adequate financing. Based on the results of the evaluation, IMS is implemented but not financed by the local budgets which in its terms limit the coverage as well as motivation of experts to effectively perform the task.

National Decision Making Level:

Legislative support - In support of the MCH reform implementation, the intervention influenced the legislative base formation. MOH decrees were issued per each module of the MCH training package. Nevertheless the certain shortcomings which adversely effected the implementation have been identified: a) delays in issuing program specific legislative documents that appeared to be a bottleneck for timely

implementation of the IMCH package. Poor harmonization of the legislative base supporting MCH reform has been noted as another impediment to effective project implementation.

Introduction of International Life Birth Definition - At present all institutions nationwide report life births according to the ILBD, but have not yet being integrated into the routine Medical and State statistics systems.

National Drug Formulary - To ensure implementation of the MCH package, the MOH amended National Drug formulary according to the medications being proposed in the MCH training package. However absence of obligatory registration for particular drugs recommended by the treatment guidelines limits their availability in medical facilities thus impedes effective utilization of new treatment guidelines.

Certification of Health Professionals - The project advocated for the integration of the MCH treatment guidelines in the certification questionnaire for physicians. The certification system the way it operates at present assesses only the knowledge of the physician, while practical capabilities are not examined. The FUAT and IMS clearly show that even in those facilities where majority of professionals are trained application of practical skills remains still low, especially in EPC and HIMCI.

Integration of MCH training package in pre-service education system - Integration of the MCH training package into the pre-service training curricula is a good example of the project's effective advocacy. At present the Samarkand Medical institute has modified their curricula, which will ensure that the country will shortly produce the workforce of general practitioners who have been trained in evidence based treatment of children and mothers. Whilst this is an effective step forward, it is not sufficient to ensure the production of adequately trained health workforce for the system.

Development of the national training capacity - Project has heavily invested in the development of the National MCH training capacity by training of trainers and establishment of practical training centers on national and local levels. While the project succeeded to create a national and sub-national training capacity, this capacity is not utilized either by the pre-service, or by the post diploma medical education systems.

Sub-national Level:

Involvement of the MOH staff on the national and local levels as well as of professionals from Republican Institutions ensured building of the ownership at the national and local levels as well as building national MCH training capacity. Close working relationship and collaboration with the local level health authorities was one of the main determinants of project effectiveness, however, effectiveness of such approach could have been maximized by required capacity building of local health authorities as well as facility managers in general health management prior to training of the health professionals.

Project by its design failed to advocate for improved financing of the MCH facilities which would have otherwise served as a guarantee for effective implementation of the new treatment guidelines at the facility level. Absence of the project advocacy directed towards hokymiats for adequate financial support of the project activities has been served as one of the bottlenecks for effective implementation of the evidence based MCH service package on the facility level.

In addition, evaluation revealed lack of capacity of local and health facility managers to collect and analyze the performance data as well as take decisive steps fur further improvement of MCH service performance.

Service Providers:

The MCH training package was highly successful to improve service provider knowledge, however application of the new skills by trainees was less than expected due to: a) a lack of essential equipment, medicines and support systems to fully apply new treatment guidelines; b) old treatment stereotypes that formed societal norms of the quality of care limited physicians to practice new skills; d) Resistance to change of non-trained physicians, managers as well as representatives of medical education system has been identified as another impediment for effective utilization of the new treatment practices.

Notwithstanding of identified problems, there is a significant improvement in the field of newborn and child survival when comparing findings from FUAT and IM with baseline data but still bellow the target.

The Project supported training of the patronage nurse system and equipped them with interpersonal communication skills in different areas of child care. At a glance the given system is the most effective in delivering information and educating mothers and caregivers. However, certain areas of potential system effectiveness risks have been identified. Only 29% of patronage nurses deployed at PHC system have been trained. Small pool of trained nurses pared with heavy workload and absence of transportation will generate limited change.

Beneficiaries:

During the FGD mothers noted the changed attitudes of the health workers. Many of them particularly noted the friendly attitude of the doctors and patronage nurses, but also expressed willingness to obtain more information about home-based care, rational nutrition, and information on disease prevention.

The positive trend in the reduction of beneficiaries' cost as a result of the effective interventions of IMCHS project is obvious. The data provided by the medical facilities, oblast level reports and results of monitoring shows dramatic decrease in costs of treatment. While these data is encouraging, not all facilities targeted under the project collect and analyse data. The absence of the national data limits evaluation team to assess the degree of intervention's effectiveness. The team was also unable to solicit data on that substantiate a decrease of personal (out-of-pocket) expenditure on health, and consequent increased utilization of the services.

The assessment of the progress against the plans shows that implementation of the IEC/BCC activities started later and actually was implemented during the last year of the project. At the same time the level of engagement at the policy and decision making level can be considered ineffective as two main institutions involved in the health promotion in Uzbekistan, the Institute of Health and Medical Statistics and the Ministry of Education were not seen as main stakeholders. Nonetheless, the interventions directed towards improvement of counseling shows positive trends for selected indicators. Should more indicators being measured as part of the M&E and or being available from special surveys, rating effectiveness of given intervention would have been easier.

Efficiency

Use of Resources:

The detailed evaluation of the efficiency of resource use was constrained by two main factors. Absence of the programmatic budget limited evaluators' ability to analyze the resource use against project component/activity outputs and outcomes. Although there was a possibility to work out main costs of interventions for further analysis and comparison with the costs of similar activities supported by other donors, performance of this exercise was not possible due to: a) time and resource intensively of the task; b)

the evaluation time constraints, c) vacant position of UNICEF Chief Operations Officer, and d) finally unwillingness of other donor organizations to share the costs of selected interventions.

Despite above outlined limitations, the evaluation team managed to roughly analyze training costs. Although alternative information on the training costs from other partners were not made available the evaluation team thinks that the given cost ranks high in comparison to the training costs in neighboring countries.

Service Providers:

Cascade training approach - has been deployed by the project in order to use available resource in the most efficient manner as well as target critical mass of professionals with the MCH training package. The given approach worked effectively and served the purpose of creation critical mass of trained health professionals though had certain weakness that questions the efficiency of trainings and need to be addressed in the second phase of the project. Poor guidance provided to local health authorities on the trainee selection criteria resulted in non-trained local and facility managers in some locations which had negative implications on the effective implementation of the new treatment schemes and subsequently on the efficiency of the training program.

The effectiveness of cascade training was also hindered by uneven coverage of facility and oblast HPs with training packages. Insufficient coverage resulted in low performance hindering the cost-efficiency of the intervention. Training courses organized locally (oblast), without UNICEF/EU project support, are shorter in duration compared to the ones carried out with project support. Furthermore, these trainings are not certified thus the participants are not entitled to utilize these training hours for career development purposes and lack motivation to be trained

Peer to peer training system (trained professional training the peer in the same facility) was limited to only information sharing and lacked theoretical and practical training elements. There was a shortage of the training materials. Materials received by the trained professionals in some instances were kept by them at home and were not readily available for their peers. Such trainings lacked the practical application of the new skills due to the training time limitations as well as due to the scarcity of adequate patients. All these problems slowed down effective implementation of the reform in target oblasts and facilities.

FUAT and IMS - were used to monitor trainee performance. The results of both monitoring rounds show neither significant performance improvements nor impact of monitoring mechanisms in the improvement of weak areas, such as NR/ENC, EPC and HIMCI. In summary, FUAT failed to meet efficiency criteria, while assessment of IMS efficiency, although being less expensive than FUAT, still needs to be assessed in the second phase.

Beneficiaries:

The overall distribution of trained medical personnel at PHC level in piloted 8 Oblasts is not high. Moreover, the patronage nurses system cannot reach the targeted population efficiently, the frequency of visits vary from one visit each month or two months. Therefore, the inter-personal communication package and the patronage nurses' system efficiency can be graded as moderate in terms of reaching the target groups and increasing their knowledge on child caring as compared to the absorbed resources. The resources spent on production of communication materials, which in fact were not enough for the required level of dissemination, cannot justify being efficient.

National Level

MOH ownership is present in all project components. Integration of project strategic directions in the higher level national policies serves as a prerequisite for sustainment of the MOH ownership and leadership in promoting MCH reforms. The Deputy Minister of Health responsible for MCH sector being the chairman of the PSC ensures MOH permanent presence. Appointment of the MOH staff as coordinators of MCH training package modules guarantees availability of critical mass of professionals in the MCH field.

Integration of the MCH package into the certification system as well as in pre-service education system is an important element of sustainability, though not sufficient. As mentioned above, the certification system measures only the theoretical knowledge of practicing HPs and cannot substantially influence the practice patterns. Integration of the MCH training package into pre-service education system piloted in Samarkand Medical Institute may not ensure sustainability of this system if not expanded to other medical institutes in the country. Moreover, physicians are not the only health providers being involved in MCH service provision. Adequate actions are required for integration of the MCH training package into the pre-service education of nurses, midwives and health managers.

Furthermore, the MCH training capacity, human and infrastructure, built by the project cannot be sustained if not integrated and utilized into the post diploma and continuous education systems as keeping the project established training system as an independent vertical system raises the risks of the non-sustainability.

Local Level

Ownership at the local level is uneven. Even in those oblasts where the ownership is strong, managers have limited leverage to mobilize resources in support of the reform implementation. This problem cannot be only attributed to the weak leadership of certain managers; rather to the budget formulation process established in the country which limits local authorities to influence budget allocations. As a result, funding of trainings initiated by local authorities as well M&E activities are deficient. Systems in place cannot function effectively without adequate funding and is difficult to sustain.

Evaluation revealed that effective implementation of the MCH program is also jeopardized by the lack of basic general health management skills and knowledge that would enable them to analyze and use data for planning resources and priority action. The Health Management trainings provided by the project proved to be effective only in some cases thus the mitigation of sustainability risks locally requires more system oriented interventions and cannot be limited only to programmatic interventions.

Service Providers

Gaps along the continuum of care are observed. Not all facilities have supportive environment to apply the new patient management guidelines and protocols. This is why children's caretakers and pregnant women still prefer Oblast hospitals where they can find quality health care, while their ailments and conditions can be managed at PHC or Rayon hospital level. Self-referral to regional hospitals is slowly declining, but still present. Furthermore, in absence of supportive structural environment where to practice, even trained HPS lose their new acquired skills and continue to practice in old fashion.

The low penetration of new treatment approaches is further deteriorated by the high levels of trained human resource dropout rates.

For the time being, practicing trained HPs show high moral and motivation, which are mainly sustained by the enthusiasm of applying new practices, supportive supervision and better relation with patients that show gratitude for the improved service. However, in the long run motivation might deteriorate, especially if basic, necessary changes will not take place, such as regular supply of needed medication and upgrading of infrastructures as well as introduction of financial and nonfinancial motivation schemes to influence physicians' behavior.

As the delivery of MCH trainings is a vertical system utilized only by the international projects, integration of these trainings into the continuous professional education system should be addressed. Moreover, ensuring the long term sustainability of the evidence based treatment approaches requires that the medical education system produces well trained physicians, nurses, mid-wives as well as managers which has been partially addressed by the project.

Beneficiaries

The newborn and child survival approach implies the implementation of evidence-based interventions which limits invasive medical practices and unnecessary prescription/administration of multiple drugs. This approach was new to patients and caregivers who were used to value aggressive medical intervention, poly pharmacy and hospital based treatment rather than PHC. Although the initial mistrust of patients and caregivers towards those HPs who have adopted the new approach is gradually decreasing, but still persists supported by deep-seated believes and habits in the community as well as HPs who still practice in old-fashion medicine.

On the other hand, uneven quality of services, despite the deployment of trained HPs, discourages patients to attend primary level health facilities, and prefer to receive services at secondary or even tertiary level health facilities. Absence of health facility and HP performance evaluation to practice new treatment protocols and counseling skills, have consequent negative implication on quality of MCH services and its sustainability, as well as effects mothers and caregivers access and use of quality MCH services and continuity of care.

The projects approach to influence beneficiary behavior through patronage nurse system proved to be effective in delivering correct information concerning when and where to go to seek medical care. However, low coverage of patronage nurses with interpersonal communication training, poor funding, lack of transportation means, and absence of caregiver's educational materials may undermine the its sustainability.

The FGD with patronage nurses and beneficiaries revealed that the right information might not reach the right person. Culturally, the family structure foresees a strong role for mothers-in –laws as main family decision makers in issues of child bearing, feeding and treatment, which usually are not targeted by communication and awareness interventions.

And finally affordability of health services significantly affects access to the health services. There are documented examples of reduced costs of health care where evidence-based interventions have been implemented. In the due time, this should also reflect to family expenses for health care that can be potentially reduced by reducing the number of prescribed drugs and hospital admission stay.

Coherence

The project is fully coherent with the National, EU and UNDP policies.

CONCLUSIONS

Based on the findings of the evaluation the Project has been rated as **Moderately Satisfactory**. Detailed ratings of main evaluation criteria are summarized in Table 11 below.

Table 12: Project Rating

Criteria	Scores	Rating
Relevance	2,9	Highly Satisfactory
Effectiveness	1,4	Moderately Satisfactory
Efficiency	1,5	Moderately Satisfactory
Sustainability	1,3	Moderately Satisfactory
Coherence	2,7	Highly Satisfactory
Overall Project Rating	2,0	Satisfactory

Highly Satisfactory (HS): Overall weighted average is greater than 2.7; **Satisfactory (S):** Overall weighted average is between 1.6 and less than 2.7; **Moderately Satisfactory (MS):** Overall weighted average is between 0.8 and less than 1.6; **Unsatisfactory (US):** Overall weighted average is less than 0.8.

IV. LESSONS LEARNED

This section of the report outlines main lessons learned that should be taken into account for the effective design and implementation of the next phase of the project and relevant interventions. Moreover, these lessons are more of general character that could be equally applicable to the projects implemented outside of the IMCHS project's host country. Building on the experiences of previous projects and/or countries will mitigate the risks of further failures or ineffectiveness.

One programme vs. multiple projects:

The evaluation confirmed the effectiveness of packaging projects in one programme (NR/ETC, IMCI, EPC etc) as it shows to be cost effective, accountable and more result based.

Patronage nurses – Soldiers of the MCH services:

Targeting patronage nurses on the SVP level by trainings in interpersonal communication as well as other modules of the MCH training package served as main determinant of the improved caretaker's knowledge and health seeking behavior. The FGD of the beneficiaries revealed, that Patronage nurses played a vital role in changing mother in law's departure from old child feeding and caretaking stereotypes and thus lifting the pressure on mothers to follow culturally accepted caretaking and feeding practices.

Top down approach in training of Oblast health workforce:

The findings of the evaluation clearly articulated that effectiveness of the MCH reform implementation is very much dependant on the ownership and leadership of the Oblast, District and facility level. In Oblasts and districts, where health managers were trained before the training of health professionals, the implementation was much easier and quick.

Issuance of respective MOH Decree prior to training speeds up and makes the implementation of new guidelines easier:

The findings of the evaluation revealed that application of the IMCI techniques on the PHC level has been delayed and faced problems due to the absence of the respective MOH decree. The team was informed by PHC physicians during focused group discussion that the decree has been processed and is expected to be signed and distributed shortly.

Strong M&E capacity building Component

Establishment of the strong M&E capacity within the country as well as for the project is a vital intervention for measuring reform implementation status; results achieved as well as inform the future corrective measures when required. Weaknesses identified during the evaluation, such as design of the RF, lack of sorrow analysis of the FUAT and IMS results, left the project shorthanded for effective advocacy interventions.

Cascade training method

The cascade training method used in the project helped to train a critical mass of HPs in a limited time period however effectiveness of this model was hampered by lack of financial and organizational support from the local authorities. The case of Uzbekistan should not be considered as a failure, rather be used to promote the given method in similar circumstances but with pre-approved and guaranteed financial and organizational support either from national or local health authorities.

Effectiveness and efficiency of HP trainings

In order to ensure effectiveness and efficiency of any training intervention in the health delivery system, the targeting strategy should be given an importance. The evaluation of the IMCHS project clearly demonstrated that the following aspects have to be taken into account at the design and implementation stage such as:

- ***Bringing Professors from High Medical Education Institutes early on a board*** - Effective deployment of the evidence based treatment practices at facility level has been severely affected by ignorance and resistance of Professors and Lead specialists of high medical education institutions towards new treatment methodologies proposed by the WHO MCH training package. Apart from resistance which slowed down the implementation, in some instances they had negative impact on the institutionalization of new treatment guidelines by providing conflicting messages to practitioners. The example of Samarkand Multi-profile Children's Hospital can serve as good example for further consideration.
- ***Targeting facility managers and local health authorities prior to HP training*** -will ensure local ownership and support for deployment of the new practices
- ***Targeting of the critical mass of HPs at local and facility levels*** – will influence speed of the practice change and improvement of outcomes on facility and local levels.

Building Sustainability elements into the design

The given project clearly demonstrated the benefits of the sustainability elements which were considered at the project design stage. Specifically, integration of the MCH training package into the pre-service training curriculum as well as in the national certification system is a good example. It is strongly recommended that such approach is deployed for any intervention planned by the project which will ensure, that the governments being assisted by the development aid projects will have systems in place that would allow them to continue activities without external support.

V. RECOMMENDATIONS

Looking holistically at MCH sector of Uzbekistan and its needs which are consistent with UNICEF's global mandate, and reflecting on lessons learnt through implementation of IMCHS Project, the evaluation team arrived at major recommendations for UNICEF support as it embarks on its second phase of the project:

General Recommendations for UNICEF

- Recommendation: 1** *Continue support of GOU MCH sector* - In MCH sector, UNICEF is recognized as one of the leading agencies. This confirms its legitimacy and the capacity to continue work in MCH area. For the next phase of the IMCHS project, UNICEF needs to carefully chose the critical niche and craft its activities in a way to balance available funding with the efficiency and effectiveness of the program in mind.
- Recommendation: 2** *Enhance advocacy* - The new challenges identified, in the section bellow, will require promotion of greater linkage and partnership through strengthening of the UNICEF Country Office (CO) technical capacity in the health policy advice. When selecting final set of interventions for the new project phase, attention has to be paid to CO capacity. Some recommended actions might demand specific technical expertise, which require additional resourcing. Moreover supporting research and analysis of the MCH sector performance will be instrumental for effective advocacy. Building on "what's already working" will help to influence the government policy decisions.
- Recommendation: 3** *Enhance monitoring function* –Enhance the project M&E system with the aim to integrate, synergize and link the achievements of individual outputs within and in-between outcomes and for the project as a whole. End-line targets for outcomes and outputs have to be defined at the design stage as well as gender related performance indicator measurement needs to be included in the Results Framework.
- Recommendation: 4** *Attention to risk identification and planning mitigation measures* -Identification of potential risks and respective mitigation measures need to be defined and incorporated in the new project design.
- Recommendation: 5** *HRBA and gender mainstreaming in project design and Implementation* - Consider increasing attention to gender equity/equality goals in design and implementation of project activities by a) gender-relevant research, background analysis or assessments, and consultations with female and male clients as part of the design process; b) ensure gender-equitable participation in different aspects of the project activities; c) develop sex-disaggregated data for indicators and targets and include gender criteria in evaluation of the activity progress and impact. Greater attention needs to be paid to gender issues, including gender statistics, gender specific advocacy and education.
- Recommendation: 6** *Capitalize on the "pairing approach" for project management* – Positive experience of the project management arrangements applied requires further extension in the second face.

Specific Recommendations

Though UNICEF is well positioned to influence the MCH policy in the country, success of the MCH services will very much depend on going beyond the MCH sector and targeting other health sector policy areas. While bellow outlined recommendations are not explicitly targeted for UNICEF assistance, evaluation team considered listing the most important system building blocks requiring intervention on the national level in order to ensure that UNICEF interventions are sustained and ensures access to quality MCH services to the population.

Enhancement of the MOH Evidence Based Policy Formulation and Coordination Functions

The Project Steering Committee, an advisory organ of the Ministry, is composed of members represented by ministry, donor and implementing agencies. Moreover, the Chairman of the PSC, being the member of the Government Commission on MCH Reform, can be instrumental to influence the political decisions of the government on MCH policy agenda. The challenge facing the PSC is to strengthen the evidence based policy formulation capacity, therefore next phase of the IMCHS project can be instrumental in provision of technical and financial assistance for building the analytical capacity of the MOH to better equip the PSC with evidence for policy advice formulation.

Coordination is another important function of the PSC. At this level of development the committee succeeded to map all ongoing MCH related donor financed activities and monitors its implementation progress, however, it lacks a holistic view of all actions and resource requirements in order to ensure achievement of the MCH Reform goals and sustainability of already produced outputs. Thus the project support in further enhancement of effective coordination is highly desired.

Effective Donor coordination and Aid integration into the National policies and priorities requires the transfer of ownership of aid programs from Donors to the Institutions of the recipient country. The coordination and management of aid by the Government is an essential first step towards National ownership of developmental cooperation. Therefore, if the MOH wants to see effective Donor coordination, it has to take a leading role and address several existing weaknesses through:

Recommendation	Responsibilities		Priority	Time Frame
	GOU	UNICEF		
Development of an effective donor coordination framework	The MOH lacks a good framework for Donor coordination and with the approved MCH Sector Strategy (2009-2013) the opportunity emerges to use the strategy document as a framework for streamlined donor support. If accepted, Donor assistance has to be mapped onto strategy priorities and Donor projects have to be coordinated in a manner so as to achieve strategy objectives. This would also permit effective monitoring and assessment of	Project can play a pivotal role in further enhancement of the coordination mechanism through provision of technical and financial assistance.	High	Short Term

	<p>Donor support towards achieving the strategy objectives.</p> <p>The Donor Mapping Exercise is a resource management tool, consisting of two components: a) an online database which enumerates the activities of Donors, funding resources and b) an analytical report reviewing and the contribution of these activities to the overall MCH Strategy.</p> <p>This will allow the MOH to have: a) based on the updated MCH strategic implementation plan mapped all required inputs, resources, timeframe and monitoring and evaluation framework b) ongoing donor and state supported activities; c) gaps for resource mobilization and d) by monitoring the performance indicators be able to identify problems, discuss them and collectively define measures for further interventions.</p>			
Establishment of Strong Secretariat	<p>While the MCH strategy could serve as a framework for coordination, a strong “secretariat” housed within MoH will be required for donor coordination. The secretariat should have clear policies, procedures and powers to assure adequate assistance for the MOH in coordinating Donor efforts. It is doubtful that without Donors' financial and technical assistance, and willingness, such a secretariat to emerge. Therefore the MOH has to strive to mobilize Donor support for the establishment of this secretariat and its empowerment. Donor assistance will also be essential to attract the human resources required for this unit</p>	<p>Project can consider provision of technical and financial assistance for the formation of the secretariat as well as development of the policies and procedures.</p>	High	Short Term
Provision of Technical Expertise and support to coordination	<p>Contracting an International Advisor to ensure the provision of day-to-day advisory services, as well as, mentorship, on-the-job training and guidance to</p>	<p>Provide financial support. In the case of resource constraints, an alternative option could be the use of bilateral Donors on a rotation basis, who would play this</p>	High	Short Term

function	the chairman, TWG, secretariat and other key staff of the Ministry.	role and assist the committee in setting an agenda, monitoring various project performances, facilitating discussions and formulating practical and implementable decisions.		
Institutionalize Joint program reviews	Institutionalization of Joint program reviews would be fundamental to ensure increased ownership by the MOH of Donor financed projects. Specifically, the enhancement of MOH leadership and program performance assessment capabilities and the improvement of the harmonization of public and Donor financed activities. For this purpose it is recommended that the MOH signs the Memorandum of Understanding (MOU) with Donors active in the sector, develops and carries out annual joint program review plans and presents the findings at the Donor coordination meetings.	Capitalize on experience generated from the first phase and provide technical assistance to the MOH for the development of the joint evaluation procedures and evaluation protocols.	High	Medium Term

Harmonization of legislation for effective implementation of MCH Reform

The evaluation revealed a need in harmonization of the health legislation. Ensuring supportive legal environment will serve as a step forward for effective implementation of the MCH reform. MOH needs to immediately initiate rigorous analysis of the legislation to address all shortcomings.

Recommendation	Responsibilities		Priority	Time Frame
	GOU	UNICEF		
Analysis and Harmonization of MCH related legislation	Conduct analysis of the MOH legal documents and ensure harmonization. The MOH may consider to establish the legal working groups for this purpose	Consider provision of financial and technical support	High	Short to Medium Term

Elaboration and Implementation of the Long Term National MCH Policy and MCH Workforce Development Strategy

The Government acknowledged the shortcomings of the MCH sector human resources and has already initiated interventions for building adequate human resource capacity for the sector. International partners have been instrumental in provision of support to the government. Activities directed towards retraining of MCH human resources became the most popular activity supported. In addition, the Government has initiated revision of the pre and post service education systems. While all these activities will ensure formation of the professional cadres for the sector, it will require heavy investments in the sector.

Uzbekistan ranks high on the number of physicians per 1000 population and faces the problems with geographical distribution of the human resources. Retraining of MCH workforce so required for improvement of the quality of MCH services requires substantial investments which will be difficult to finance, therefore efficient use of resources is recommended. The given evaluation revealed that there is around 5% drop out of trained HPs. It is obvious that there is an urgent need for elaboration of health workforce development strategy. The latter should address production, deployment and continuous professional development of health personnel. While such strategy is needed for entire health sector, initially the government can develop it only for the MCH sector.

Another important strategic policy document that requires to be prioritized on the MOH agenda is the development of the evidence based comprehensive National MCH Policy. The latter should revisit the MCH Program developed by the Government and revise in line of the current sector challenges including the MCH workforce development strategy.

Recommendation	Responsibilities		Priority	Time Frame
	GOU	UNICEF		
Development of the Long Term National MCH Strategy	MOH to develop evidence based long-term MCH policy Mobilize technical assistance from international partners for the development of the strategy which addresses: Production of the new generation of MCH workforce, rightsizing of existing MCH human resources, rightsizing of the MCH service providers, infrastructure, budget, regulation of the MCH sector etc.	Provide technical assistance	High	Short-Term
Development of the MCH Workforce Strategy	Mobilize donor support to support MCH workforce strategy development which addresses: a) workforce planning, b) reforms required for pre-service and post diploma education for health managers, physicians, GPs, midwives and nurses; c) continuous professional development system design, d) certification, e) remuneration and incentives	NA	High	Medium Term
Integration of the MCH package into pre service, post diploma education as well as continuous	Formulate and approve detailed implementation plan and budget for integration of the MCH package into the pre service, postgraduate and continuous	<u>Pre-service Education System:</u> Support integration of the MCH package in the pre-service education curricula for	Medium	Medium Term

<p>professional education systems</p>	<p>education systems.</p> <p>Regularly monitor implementation progress</p>	<p>physicians, nurses and mid-wives</p> <p><u>Postgraduate Education</u></p> <p>Support integration of the MCH package in the post graduate education curricula for physicians</p> <p><u>Continuous Professional Education</u></p> <p>Support Institutional design and development of the continuous professional education system (CPES).</p> <p>Refinement of the cascade training approach by integration into the continuous professional education system.</p> <p>Development of guidelines on the selection of trainees at all levels of service provision, geographical location and facilities</p> <p>Support the MOH in the development of the country wide training plan</p> <p>Elaborate and Introduce cost-sharing arrangements (trainee/CPES/Project)</p>	
<p>Reform Licensing and Certification systems</p>	<p>The Government is recommended to Integrate the MCH service performance indicators in the licensing system of private MCH health service providers.</p> <p>The current certification system measures only theoretical knowledge of physicians, while FUAT and IM indicate low performance levels. The MOH is recommended to reform existing certification system by adding performance measurements to be generated by the national health statics system.</p>	<p>Jointly with WHO and international experts assist the government in reforming the licensing and accreditations systems.</p>	<p>Medium Long Term</p>

Enhancement of the MCH Service Quality Assurance Function

Assurance of the population access to quality MCH service is important for attainment of the MDGs. MCH service quality (application of the evidence treatment protocols in practice) was measured by FUAT and IMS tools used by the project. Comparative analysis of these tools conducted by the evaluation team revealed

that both tools have pros and cons⁴⁰ in terms of their effectiveness, efficiency and the prospects for sustainability. Therefore the MOH is advised to modernize existing M&E system through consolidation and refinement of these tools and design of external and internal MCH service quality audit system. Proposed system will have the following benefits: a) it will enhance ownership at facility, district, oblast and national levels, b) created MCH service quality audit capacity will improve evidence based managerial decision making at facility and local levels, as well as evidence based policy development on a national level; c) will require less financial resources; d) benchmarking of HPs and health facilities will increase the competition and motivate them to better perform; and finally all the above will ensure improved access to quality MCH services.

Recommendation	Responsibilities		Priority	Time Frame
	GOU	UNICEF		
Modernization of existing M&E system through consolidation into the internal and external MCH service quality audit systems	Refinement of design of the National, Oblast, District and facility level MCH service audit system.	Jointly with WHO provide technical assistance to the MOH in design of the MCH service quality audit system.	High	Short to Medium Term
	Development of the internal and external audit functions, human resource requirement, procedures, protocols, and reporting forms and follow up action plan sample.	Support capacity building activities of the National, Oblast, District and Facility Health Managers in application of the new MCH service performance audit system		
	Ensure adequate funding of the audit system.	Biannually analyze MCH facility performance benchmarking reports from project target oblasts, identify problems and plan corrective measures.		
	Development of the legislative base for effective implementation of the audit system	Support dissemination of the annual MCH service quality audit reports.		
	Introduction of the facility and medical personnel's performance benchmarking on the facility, District, Oblast and National level			
	Support capacity building of the National, Oblast, District and Facility Health Managers in application of the new MCH service performance audit system			
	Development and dissemination of the annual reports			

⁴⁰ See Section "Effectiveness"

Strengthening of the MCH Health Information System

The MOH was successful in introduction of the ILB definition and institutionalization of reporting the ILB nationwide. At present ILB is reported to the ILB center and is not yet integrated in the national health statistics as well as in state statistical analysis. The MOH Decree has been issued recently which will insure the integration of the ILBD into the national statistical systems starting from 2012.

Apart from ILBD there is a need for routine reporting on key MCH indicators. MOH is advised to integrate some of the MCH indicators, currently being monitored by the project into the routine reporting forms. Moreover, in order to ensure accuracy of MCH data collection, the MOH is recommended to build the capacity of the Data Quality Audit (DQA) at national and local levels. The project can be instrumental assisting the government in this endeavor.

Building MCH analytical as well as evidence based policy and managerial decisions making capacity at national and local levels is another area requiring government attention. Based on the evaluation findings the MOH lacks the capacity of data analysis which leaves the latter shorthanded for the evidence based policy formulation. Present Health Statistical Reports is informative, recording changes of selected indicators over the years, but does not contain analysis which attempts to explain reasons behind reported changes. The MOH is recommended to build the national and local capacity for MCH data analysis with the assistance from international partners. This will help the sector to plan further interventions based on the evidence, as well as leverage additional resources for the sector.

Recommendation	Responsibilities		Priority	Time Frame
	GOU	UNICEF		
Institutionalization of the ILBD and assurance of accurate reporting of all MCH indicators through institutionalization of the Data Quality Audit (DQA) System	Monitor ILBD integration into the national health statistics reporting system and apply corrective measures when required.	Provide technical assistance to the MOH for:	High	Short Term
	Revise routing reporting forms by integration of selected MCH indicators	a) Integration of selected MCH indicators into the routine reporting forms; b) Building DQA capacity at national and local levels through provision of support in design of the DQA system procedures and protocols for all MCH related as well as training of relevant staff		
	Design, approve and implement DQA system			
Build national and local capacity in MCH data analysis	Design and placement of the analytical function within the MOH structure;	Support the MOH in the development of the national and local MCH data analysis capacity through provision of technical assistance as well as training of respective staff on both levels.	Medium	Medium to Long Term
	Build national and local MCH analytical capacity through provision of customized training on data analysis, report writing, presentation skills, preparation of the Policy briefs and papers, etc.	Improve partnership with Institute of Health and Medical Statistics		
		Support in organization of the annual MCH conferences.		

Organize annual conferences on the findings of the MCH data analysis and proposed future actions

Strengthening of National Information, Education and Communication Function

Strengthening of National Information, Education and Communication function is another area recommended to be addressed. Sustainability of population’s knowledge and change of behavior can only be achieved with well functioning national system, a system which is cross sectoral. At present all project interventions directed towards communication and awareness rising were mainly designed and implemented with limited involvement of the partner public institutions.

Namely, the Institute of the Health and Medical Statistics regularly develops and distributed IEC materials nationwide. Due to the poor partnership established by the project with this public entity IMCH package has not been integrated in the produced informational materials. Effective cooperation and partnership will be mutually beneficial and ensure efficient use of public and donor financial resources, coverage expansion through printed and electronic media resources, as well as access to the national and regional air time.

MOH is advised to facilitate development of the national MCH sector communication Strategy and implementation plan which will help the government to better coordinate donor and state activities and avoid duplications and overlaps.

MOH can use the leverage of the Government Commission on MCH Reform and ensure formation of the inter-ministerial MCH communication working group. The latter has to be charged with the function of approving inter-sectoral annual working plans and budget of the national MCH communication strategy, monitor its implementation, assessment of the strategy effectiveness and elaboration of decisions on required revisions.

Recommendation	Responsibilities		Priority	Time Frame
	GOU	IMCHS Project		
Support effective IEC activities	Develop and approve National MCH sector communication strategy and implementation plan.	Support development of the new MCH communication strategy through provision of the technical assistance	High	Medium Term
	Establish TWG represented by key experts and international partners	Support the implementation of MOH “peer to peer” initiative in the project target regions		
	As part of the National MCH sector communication strategy support the introduction of the peer to peer education system on the community level (Mother to mother) and using the influence of the “mother in law institute” in favor of			

	MCH related IEC as well as community leaders (mothers/mother in laws)			
Expand partnership to other public institutions	<p>Expand partnership to other public institutions (Ministry of Communication, Ministry of Education, etc) in support of the public information, education and communication activities by establishment of the inter-ministerial working group.</p> <p>Sign memorandum of understanding with lead public institutions and partners on implementation of the national MCH communication strategy.</p>	<p>Assist the MOH in the design of the inter-ministerial working group's scope of work, in design of the annual implementation plans and budgets for the national MCH communication strategy</p> <p>Provide financial support for implementation of selected intervention</p>	High	Short Term
Establish close collaboration and partnership between international partners and the Institute of Health and Medical Statistics	<p>MOH to issue a decree that regulates cooperation and collaboration forms between Institute of Health and Medical Statistics and international partners.</p> <p>Memorandum of Understanding is signed between the Institute of Health and Medical Statists and international partners active in health sector (with particular emphasis on MCH sector)</p> <p>Develop and approve integrated MCH communication annual implementation plan and budget covering all IMCHS planned activities and ensure MOH cost-sharing arrangements</p>	<p>Assist the MOH in formulation of the scope of cooperation and collaboration between Institute of Health and Medical Statistics and international partners</p> <p>Jointly with the Institute of Health and Medical Statistics develop integrated annual MCH communication implementation plan and budget with cost-sharing arrangements.</p>	High	Short Term

ANNEXES:

Annex 1: List of Document for Desk Review

1. Available publications on Uzbekistan MCH sector reform
2. UNICEF CPD, CPAP, AWP (annual work plans), Regional and Global Strategies on MCH.
3. Report on Ferghana Region Pilot
4. Project proposal, inception report, and logical framework of IMCHS phase 1.
5. Project documents and reports for the period 2008-2011, including Quarterly “Narrative ” and “Mission report”
6. IMCI, EPC, ILBD, NR, BABIES, GDM, BF training module, materials for health providers
7. Trip reports of relevant UNICEF programme staff
8. Different Decrees issued by the Government of Uzbekistan in relation to MCH sector reform.
9. Result Oriented Monitoring Mission (ROM) reports
10. Reports and documents published by other partners like WHO, The World Bank and ADB Health Two Project.
11. EU global health policy, EU Central Asia Strategy etc.
12. Other, identified during the evaluation.
13. IMCHI Project JMC - Joint Monitoring Reports.
14. Assessment tool for the quality of hospital care for mothers and newborn babies;
15. Assessment of the safety and quality of hospital care for mothers and newborn babies in Uzbekistan;
16. CQI in MNC Care in Uzbekistan, Report of reassessment of 4 Regional Maternity Canters, April 2011;
17. Steering Committee Meetings Reports;
18. Communication for Development Strategy for IMCH Project;
19. Assessment Report on Outcomes of Inter-personal Communication Training;
20. External Evaluation of Family Education Project December 2005;
21. Integrated Monitoring (IM) reports by regions;
22. United Nations Development Assistance Framework (UNDAF) for the Republic of Uzbekistan, 2010-2015;
23. Welfare Improvement strategy of Uzbekistan, 2008-2010.

Annex 2. List of People Met

UNICEF

Jean-Michel Delmotte UNICEF Representative
Oyunsaihan Dendevnorov-Deputy Representative, UNICEF
Hari Krishna Banskota Chief of Health Section
Savita Varde-Naqvi – Chief Communication for Development, UNICEF
Silvia Mestroni – M&E
Alisher Makhkamov-Health Officer
Kamola Safaeva-Health officer, UNICEF
Bakhodir Rahimov-Nutrition officer, UNICEF;
Nazir Abdulaev-Consultant for M&E of the project, UNICEF;
Natalia Korovina- Finance Assistant

Government Institutions

Asamidin I.Kamilov- Deputy Minister, Ministry of Health of the Republic of Uzbekistan
Akhmedova Dileram Ilkhamova - Head of MCH Department, MOH
Diyora Arifdjanova – Head of Maternity Division of MCH Department
Zukhulmor D. Mutalova - Director of Institute of Health and Medical Statistics, MOH
Mirodil Baymukhamedov - Director, e-health Development Center, MOH
Damin A. Asadov - Head of Public health and Health Management, Tashkent Institute of Postgraduate Medical Education, MOH
Rakhimov Timur-Head of Human resource Department, MOH
Khashimov Bakhtior Aribjanovich - Head of Finance Department
Damina Abdurakhimovna - Director of Health Management, Course, MOH
Rakhimov Abdumalik Abdurashovich - Deputy of Namangan Oblast Health department, Namangan Oblast Multi Profile children hospital
Uvonov Ulugbek-Deputy head of MCH Samarkand Oblast
Aziziov Momatkul Kurbanovich-Head of Samarkand Multi-profile Children Hospital

Implementing Partners/ Service Providers

Umarova Zukhra Sultanova-Course director on ILBD, BaBies
Salikhova Kamola Shavkatovna-Director of Course on BGM.BaBies
Djubatova Roza Spanova – Course director, IMCI, Head of Republican Scientific and research center of Pediatrics
Umalova Malika Shatolinovna - Course Director on EPC/NR
Aripoljanova Diera Burievna - Head of Obstetric Division
Ismailova Shoirra - Scientific research institute of Pediatrics, trainer on breastfeeding component
Akhmedova Inobat – Scientific research institute of Pediatric, IMCI trainer
Abdujabbarova Zulfiya – Scientific research institute, IMCI and BF trainer
Ishniyazova Nodira – Scientific research institute, BF trainer
Shagiyasova Djamilya – Scientific research institute, IMCI trainer
Dadabaeva Luiza – Republican Perinatal Centre, Trainer ILBD and BABIES
Kasimova Nodira- Republican Perinatal Centre , head of department of newborn pathology, NR/ENC, EPC, ILBD trainer
Daminova Gulya – head of resuscitation department and newborn anesthesiology, national trainer of NR
Chief Doctor of Namangan Branch of Scientific Research Institute of Obstetrics and Gynecology ;
Namangan Oblast Center of Maternal and Newborn Care
Esambaeva M. Chief Doctor - Namangan Uchkurgan Medical Centre;
Khamidova Ya - Deputy of Mother and Child Care Department, Namangan Uchkurgan Medical Centre;

Donors/Implementing Agencies

Fakhriddin Nazamov-National Professional Officer health Systems WHO Country Office Uzbekistan
Yason Tengiz Bae Son – Save the children CD-steering Committee
Igor Vikhrov- Program Manager, Save the children in Uzbekistan-Steering Committee
Nigora Karabaeva-MoH JPIB coordinator of the WCHD project, ADB-Steering Committee
Nigora Muratova-CIZ, Health System Development Coordinator-Steering Committee
Dilban Sulaimanova-JICA program Officer, Steering Committee
Takuya Kamata, Country Manager, The World Bank

Annex 3. Evaluation Tools

Annex 3.1: Evaluation Framework

Criterion	Questions	Indicators	Sources of data	Methods
RELEVANCE				
R1	What is the relevance of the intervention in terms of advocating for and facilitating the national MCH sector reform?	Degree of congruence between project strategy and stakeholders priorities and needs (including national targets for MCH sector).	<p>Documents: Government of Uzbekistan (GoU) MCH policy y related documents, laws, Decrees , Orders etc.) Regional Global Strategies on General project documents (IMCHS Project Documents; UNICEF CPD, CPAP, Work Plans). Other Donor Agencies relevant documents related documents (WB Health III Project ADB Health Project UNFPA CPAP USAID project Documents) Monitoring and previous evaluation documents.</p> <p>Key Informants MOH MCH Department MOH HR Development Unit MOH Medical Education Unit Oblast Health Units Institute of Health and Medical Statistics Medical Education Institutions</p>	<p>Desk Review</p> <p>Semi-Structured Interviews</p>
R2	To what extent is the training component appropriate in response to the training needs of the target groups?	<p>Level of HPs knowledge prior to training exposure.</p> <p>Proportion of trained Health Professionals (HPs) who correctly practice skills in MCH services .</p>	<p>Documents Planning and general project documents. Training modules and materials by component (IMCI, EPC, ILBD, NR, BABIES, GDM, BF-WHO standard modules adapted to the local context by MoH, UNICEF and WHO). Monitoring and previous evaluation documents. Project monitoring database.</p> <p>Key Informants MCH Managers Trained HPs.</p>	<p>Desk review</p> <p>FDGs</p>
R3	To what extent is the intervention relevant in terms of contributing to improve children and mother’s wellbeing and health seeking behavior?	<p>Utilization of MCH services (number of at risk pregnancies follow up/delivery at appropriate level of care; patients correctly referred to health facility).</p> <p>Proportion of exclusively breastfed infants (0 to 5 complete months).</p> <p>Proportion of Mothers and Children deaths in the</p>	<p>Documents Monitoring and previous evaluation documents. Planning and general project documents (Project inception reports phase 1 and phase 2). Project monitoring database. BCC /IPC package. Data/reports from health facilities. Available administrative data.</p> <p>Key Informants Women attending health</p>	<p>Desk Review</p> <p>Semi-Structured Interviews</p> <p>FDGs</p>

		health facilities where trained HPs are deployed.	services. Health facilities managers and HPs.	
EFFECTIVENESS				
EF 1	To what extent is the project governance structure suitable to implement in an effective, transparent and participatory way and to promote upstream policy change in the area of concern? To what extent has the project contributed to the visibility of the donor in the country and among the different stakeholders and beneficiaries.	Level of Coordination and coordination mechanisms in place MoH development of Decrees/regulations and other official documents/plans supporting/consolidating the MCH policy implementation and fostering cooperation among development partners. National, local and project related M&E Structure, practice and outcomes Project management structure, staffing, level of partnership with national institutions Evidence of developing, testing models and supporting scale up.	Documents SOW of Project Steering Committee, minutes of meetings, Joint Action Plan GoU MCH policies and documents Decrees (National and Oblast) concerning MCH policy implementation. IMCHS project document and evaluation reports (Quarterly Narrative and Mission reports). Key Informants MOH Deputy Minister MOH MCH Department Medical Education Institutions Local Health Authorities WHO, WB, ADB, GIZ, UNFPA, JAICA, etc. Facility Managers HPs	Desk Review S Semi-Structured Interviews FGD
EF 2	To what extent is the intervention effective in facilitating the MCH sector reform in respect to policy change, quality improvement and governance re-structuring of the health system in line with relevant WHO standards?	Proportion of concerned health facilities that adopted ILBD. MoH Decrees per training modules component. Proportion of certified training courses. Level of practice of new treatment guidelines at facility level Integration of MCH curricula into pre-service training curricula.	Documents GoU MCH policies and documents. IMCHS project document, M&E and training reports ILBD and Medical Statistics data Facility based data Key Informants MOH Deputy Minister MOH MCH Department MOH HR Development Unit MOH Medical Education Unit MOH Certification Department Medical Education Institutions Training Courses Directors	Desk Review Semi-Structured Interviews FGD
EF 3	How effective is the intervention in improving service providers' knowledge and skills in all project components (Newborn Survival package, Child Survival package, Health Management and Quality Improvement package, and Inter-personal Communication package) against the indicators set in the log frame and in line with the correspondent WHO standards? To what extent have trained service providers (individuals) modified their regular practices related to all project components against set indicators and in line with WHO standards? Which are enabling/constraining factors that facilitated/hindered	Proportion of trainees scoring 75 or more in post-training test. Proportion of trained HPs who correctly manage perinatal, newborn and child health problems according to protocols. Proportion of Maternities applying ILBD for recording perinatal outcome. Proportion of Maternities applying BABIES matrix. Proportion of certified BFHI	Documents IMCHS project document, M&E and Training Reports. Data/information from health facilities records. Key informants Regional Health Centers Local Health Officials Health Managers Trained HPs. Training courses Directors Mothers (caregivers)	Desk review Semi-structured interviews FGD Field visit

	<p>this behavioral change? In the MCH facilities where trained service providers work, to what extent have regular practices related to all project components been modified in line with the relevant WHO standards? To what extent has the intervention contributed to improve the overall resource management in the concerned health facilities? Especially as a consequence of reduced hospitalization, rational use of drugs and early recovery from sickness?</p> <p>To what extent has there been an improvement in quality of care during delivery and post-natal care in the health facilities included in the project? To what extent has the Inter-personal communication package (training module and communication materials) effectively contributed to strengthen patronage nurses' counseling capacity? And to what extent are they effective as a channel of strengthen caregivers' knowledge?</p> <p>To what extent is the M&E system (including FUAT and QoMNH)C) effective in reinforcing skill application and tracking?</p>	<p>institutions.</p> <p>Proportion of low birth weight newborn babies registered.</p> <p>Proportion of survival among low birth weight newborn babies.</p> <p>Proportion of trained Health Managers applying MCH indicators for official recording,</p> <p>Proportion of reduced drugs' utilization, length of stay and proportion of complications per specific disease/medical condition.</p> <p>interviewed caregivers who report improved engagement with patronage nurses.</p> <p>Proportion of patronage nurses who underwent IPC training.</p> <p>Proportion of caregivers' who received information at hospital discharge time. Documented changes (improvement/deterioration) in application of skills into medical practice of the HPs who underwent IMCHS training courses.</p> <p>Match of training outcomes (FUAT), supervisors and trained HPs opinions, and services users point of view.</p>		
EF 4	<p>To what extent do beneficiaries perceive any overall change in the health conditions of mothers and children in the community/family? Especially as a consequence of improved health care provision, preventive and promotive health measures, practicing of early seeking medical care during sickness, decrease of health services costs' for beneficiaries? To what extent has the intervention contributed to reduce beneficiaries' costs for accessing MCH services? Especially as a consequence of reduced hospitalization, rational use of drugs, reduced side-effects and early recovery from sickness? To what extent have beneficiaries increased the frequency of their visits as result of reduced costs</p>	<p>Interviewed beneficiaries who perceive improvements in quality of maternal and child health care.</p> <p>Proportion of at risk deliveries attended at regional (referral) hospitals.</p> <p>Pattern of self-referral to regional hospitals.</p> <p>Proportion of mothers who exclusively breastfeed their infants (0 to 5 complete months of life).</p> <p>Proportion of mothers showing appropriate knowledge on child homecare (administering drugs, rules of home treatment).</p>	<p>Documents. IMCHS project document and M&E reports. Data/information from health facilities records.</p> <p>Key Informants Beneficiaries Trained HPs</p>	<p>Desk review</p> <p>FGD</p> <p>Field visits</p>

	and access barriers? To what extent have beneficiaries improved their child care and health seeking practices as a consequence of improved counseling?			
EFFICIENCY				
EFF 1	Does the IMCHS project use the resources in the most economical manner to achieve its objectives? Are the available resources adequate to meet project needs?	Spending capacity according to timeline. Proportion of budget allocation to national capacity building. Assessment of the recourse use against achieved outcomes Comparison of project training costs with the training costs of partners	Documents IMCHS project document and evaluation reports. Budget execution report. Key informants Concerned UNICEF Office personnel Partner organizations	Desk review Cost analysis
EFF 2	To what extent is the cascade training system efficient in terms of use of resources as compared to the results achieved?	Numbers of actually trained HP (national and local) against number of planned. Availability of set criteria for trainer's selection. Proportion of HPs covered by training activities. Proportion of trained HPs who implement peer-to-peer training. Number of HPs trained through peer to peer training sessions. Number of trainings locally organized (without project support).	Documents IMCHS project document, M&E and Training Reports. Key informants Regional Health Centers Local Health Authorities Health facility Managers Trained HPs. Training courses Directors Partners' project documents for comparison of training delivery systems utilized Partners' information on number of targeted beneficiaries by partners using different and or similar training delivery systems Partners' information on activity unit cost comparison for different training delivery systems Partners' information on training outcomes - comparative analysis of outcomes from different and/or similar training delivery systems.	Desk Review Semi-structured interviews FGDs
EFF 3	To what extent are the inter-personal communication package and the patronage nurses system efficient in terms of reaching the target as compared to the absorbed resources?	Proportion of nurses who underwent IPC training. Proportion of nurses who correctly apply acquired skills. Number of and time allotted to home visits. Proportion of interviewed mothers who report to have benefitted from home visits.	Documents Project inception reports (phase 1 and 2), Results framework. Project monitoring database. Key Informants Trained HPs (Patronage Nurses). Beneficiaries	Desk Review FGDs
SUSTAINABILITY				
S1	To what extent do MoH and other concerned government agencies demonstrate ownership over the different project components (Newborn and Child Survival packages) and correlated aspects? To what extent is the project inserted into the MCH sector reform strategy, so that MoH's ownership over the Newborn and	Evidence of MoH Officials/MoH Staff holding leading position within project components. Evidence demonstrating National ownership (legislation, policies, strategy, implementation plan, state budget allocations for MCH reform	Documents National Policy documents MCH and Health Reform Policy Documents PSC meeting minutes Legal documents Key Informants	Desk Review Semi-Structured Interviews

	Child Survival packages can lead to their incorporation into national policies and therefore assure sustainability of the results achieved?	activities) Integration of MCH training package into national (pre-service and post diploma) education system of health professionals (doctors, nurses, midwives, and health managers). Integration of the MCH package into the certification system Adequate public funding	MOH respective departments Medical Institutes MOH HR Development Unit MOH Medical education Department MOH Certification Department MOH Financial Department	
S2	To what extent do MoH Oblast Health authorities and regional hokymiyats demonstrate ownership and capacity for resource mobilization to be able to self-support and consolidate the achievements and expansion of the project within their regions?	Number of training courses requested by Oblast and Rayon health managers. Number of training locally organized. Number of supportive supervision rounds. Evidence of formulated action plans (FUAT, IM, and QoMCHS) and action taken/implemented.	Documents Project inception reports (phase 1 and 2), logical framework. Project monitoring database. Previous evaluation reports. MCH budget forecasts Local MCH budgets Key Informants Regional Health Authorities Health Managers Trained HPs	Desk review Semi-Structured Interviews
S3	To what extent are behavioral changes among health providers expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their capacity to continuously provide quality and equitable health services?	Rate of HPs turnover Evidence of working environment enabling HPs to correctly practice skills. Available incentive mechanisms for health personnel retention	Documents M&E reports. Key Informants Regional Health Authorities Health Managers Trained HPs	Desk review Semi-Structured Interviews FGDs Field visits
S4	To what extent are the behavioral changes among beneficiaries expected to last? What are the bottlenecks and gaps along the continuum of care that hinder the capacity of mothers and caregivers to access and use quality MCH services for themselves and their children?	Availability/proportion of trained patronage nurses. Availability of culturally appropriate educational material aimed at family/community. Proportion of health facilities providing quality health care in the concerned area.	Documents M&E and training reports . Key Informants Trained HPs Beneficiaries	Desk Review FGDs
COHERENCE (C)				
C 1	To what extent is the project contributing to and in line with national policies and priorities for the MCH sector	Match of project's objectives, strategy, activities and results to stakeholder priorities and needs.	Documents MCH, Health Reform Policy Documents and Plans. GoU's MCH policies and documents (Health Sector Reform Document, State MCH Policy and strategic Plan). Regional Global Strategies on MCH Documents; UNICEF CPD, CPAP, Work Plans). Key Informants MOH respective Departments Partners	Desk Review Semi-Structured Interviews
C 2	To what extent is the project facilitating synergies and avoiding duplications with interventions and strategies promoted by other UN agencies and development partners (IFIs, EU member states, others) within the MCH sector and its reform?	IMCHS training package implemented in regions not covered by the project, by other development partners. Evidence of an established system supporting coordination among UN agencies and development	Documents PSC meeting minutes Joint Action Plan Partner supported Project documents EU regional strategy UNDAF etc.	Desk Review Semi-Structured Interviews

		partners.	Key Informants MOH respective Departments Partner's UNICEF Project Staff	
C 3	To what extent is the project in line with and contributing to the donor's objectives for the social sector in Uzbekistan (EU global health policy, EU Central Asia Strategy etc.)?	Match of project's objectives to other donors objectives targeting the social sector.	Documents WHO MCH and Health Strategy EU global health policy EU Central Asia Strategy Key Informants MOH respective Departments Partner's UNICEF Project Staff	Desk Review Semi - Structured Interviews
Human right based approach				
HRBA	To what extent does the project incorporate the HRBA to programming?	Program document clearly spells out HRBA elements	Documents Planning and general project documents (IMCHS Project Documents; UNICEF CPD, CPAP, Work Plans).	Desk Review
	To what extent does the project consider the equity approach (i.e. focus on most deprived areas, areas with high prevalence of critical under-5 and maternal morbidity and mortality, low income families) and facilitate the reduction of access barriers to MCH services by the target group?	Pilot region selection criteria Gender balance in trainees, trainers, Training coordinators	Key Informants Training Course Directors Institute of Health and Medical Statistics	Semi-structured interviews.
	To what extent does the project consider gender equality as key criteria throughout the planning and implementation?	Gender targeted Communication Strategy Gender disaggregated M&E and statistical data	UNICEF HPs Beneficiaries	FDGs
	To what extent is the project facilitating the use of HRBA to inform policies and planning within the MCH sector at central and sub-national level?	Increased number of pregnant women who exercise the right of delivering in a friendly environment. Evidence of promoting information flow between health providers and beneficiaries (in order for the latter to exercise their rights for health Increased proportion of at risk pregnancies treated at the appropriate health care level. Proportion of interviewed women who perceived the improved quality of care.		

Annex 3.2 Semi-Structured Interview Questionnaire Guide

Organization	Respondent	Interview Questions
MOH	MCH Department	R1; EF1; EF2; S1; S3; S4; C1; C2; C3
MOH	Finance /Budget Department	R1; S1
MOH	Medical Education Department	R1; EF1; EF2; S1; S4 C1; C2; C3
MOH	Human resource Department	R1; EF2; S1; S4; C1; C2; C3
Regional Health Authority		R1; EF1; EF2; EF3; EFF2; ; S1; S2; S3; S4
Health Facility Managers		R1; R2; R3; EF3; EFF2; ; S1; S2; S3; S4
UNICEF		EFF 1; ; S3; S4; C1; C2; C3
Medical Institutes		R1;EF1; ; EF2; S4
Partners		EF1; EFF 1; EFF2; ; S3; S4; C1; C2; C3

Annex 3.3 FGD Guides

Annex 3.3.1 FGD Guide for Trainers (Obstetricians, Neonatologists, Pediatricians, MCH Managers)

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review - We are here to evaluate the training and monitoring component supported by the IMCHS Project
5. Ask questions

Which training package/subject were you involved in?

Relevance

- Does the IMCHS project approach fit the local context and take into consideration the Country's needs? Why?
- Central to the ICHS program is the training component with specific training packages, protocols and guidelines.
Why HPs working at hospital and PHC level needed to be exposed to this specific program for improving MCH care delivery in Uzbekistan?

Effectiveness

- Does the IMCHS training component provide the knowledge and skills needed for HPs to adopt and apply appropriate medical/nursing practices? Why?
- Considering MCH care delivery at hospital and PHC level, which services have more chances to improve in the short run as result of training and monitoring activities? Why?
- Considering MCH care delivery at hospital and PHC level, which services have less chance to improve in the short run as result of training and monitoring activities? Why?
- Is the monitoring system (Follow Up Post Training-FUAT and Quality of Mother and Newborn Health Care-QoMNH) able to provide trained HPs support to apply acquired skills, and reliable information and data for decision makers to the state of art of MCH services and care delivery? Why do you say this?

Efficiency

- IMCHS Monitoring and Quality Improvement component is meant to facilitate and ensure quality MCH care delivery.
National Monitoring Teams (NMT) have been established to follow up trained HPs, in order to facilitate and ensure quality MCH care delivery. Are they (NMT) performing as required to monitor and support HPs? Why?

Impact

- IMCHS project focuses on improving the quality of Mother and Child health care. In doing so, has the project brought some improvement also in the management of health facility resources? Why do you say so?
- In the health facility that you supervise and monitor, has the quality of care for mothers and children improved? Why do you say so?

Sustainability

- Are you reimbursed for the services provided (training and monitoring)? Specify the source and reimbursement method.
 - Are you willing to continue your activity as Master Trainer? If not please specify why.
 - What is needed, if any, to keep the capacity building process (training and monitoring) working when the IMCHS project support ends?
6. Ask if they would like to add further comments.
 7. Bring the meeting to a close by summarizing the main points.

Thank you.

Annex 3.3.2 FGD Guide for Service Providers (Obstetricians, Pediatricians, Neonatologists, Nurses, Midwives, Patronage Nurses, GPs)

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review - We are here to evaluate the training and monitoring component supported by the IMCHS Project
5. Ask questions

Which training package did you attend?

Relevance

- Are training contents (including protocols and guidelines) suitable for the Uzbekistan MCH care delivery system? Why?
- Was this training pertinent to your current daily work? Why?
- Before attending the training, did you feel the need to upgrade your knowledge and skills? Why? In which field/s?
- Do patients appreciate the improvement of quality care in your health facility? Why do you say this?
- Since you started applying the acquired skills, is there any noticeable improvement in the health status of the patients/community who attends your health facility? Why do you say this?

Effectiveness

- Do you feel that the training enabled you to fully apply, in your daily practice, what you have learnt? Why ?
- How often do you apply the acquired skills and knowledge into work practice?
- Were you reluctant to accept new practices/procedures (reluctant to change)? Which ones? Why?
- Did the acquired knowledge and skills affect (could be both, positively and negatively) your self confidence and the value you put on your daily work? Why?
- What is the significance, if any, of providing MCH quality care?
- Is there a supportive supervision and monitoring system in place (FUAT and QoMNHHC)? Is this system able to support you to apply acquired skills, and reliable information and data for decision makers? Why? Please describe. What is your involvement in the monitoring process?

Efficiency

- IMCHS Monitoring and Quality Improvement component is meant to facilitate and ensure quality MCH care delivery.
National Monitoring Teams (NMT) have been established to follow up you (trained HPs) in order to facilitate and ensure quality MCH care delivery. Are they (NMT) performing as required? Why?

Impact

- IMCHS project focuses on improving the quality of Mother and Child health care. In doing so, has the project brought some improvement also in the management of health facility resources? Why do you say so?
- In your health facility, has the quality of care for mothers and children improved? Why do you say so?

Sustainability

- At the work place, are there some conditions that prevent you to correctly practice your skills? (i.e. non-confident in skills despite training, shortage/lack of basic equipment/amenities, drugs, time constraints, referral etc.). Please, describe.
- Are you receiving any incentive/did you expect to be incentivized/awarded for delivering quality MCH services? Please, describe.

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you

Annex 3.3.3 FGD Guide for Beneficiaries

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review - We are here to evaluate the training and monitoring component supported by the IMCHS Project
5. Ask questions

Relevance

- What kind of information do you want or need to receive as a mother/caregiver on child care?
- What are the ways you would like to receive that information?
- What was the content and form of information you've received on child care;
- Was the content of materials easy to understand and practical?

Efficiency

- Is the communication package relevant to your demands?
- Can you describe the visit to patronage nurse, duration and process of the visit and topics of counselling if you received it?
- What kind of topics did nurse cover during communication on children's care: provide information? or /and show examples or/and give you an example for practice?

Effectiveness

- What is the primary form of communication that moves you to action?
 - a. Flip chart on key child feeding, caring and health seeking practices;
 - b. mother card
 - c. posters
 - d. examples
 - e. practice
 - f. Other, please specify
- How often do you apply acquired skills and knowledge into practice?
- Did you/ or other family members receive adequate information on child care? And who provided this information?
- How long it takes the counselling on child care? Do you think that duration of the counselling and the content is sufficient?

Sustainability

- What are the main problems you face in getting the quality MCH services for mothers and children?
- What was the frequency of visiting health facility during the pregnancy and after delivery?
- Do you have to pay for MCH services? If yes, do you pay out of the pocket directly to the doctor, or to the cash office of the medical facility?
- Are you satisfied with MCH services received? Why?

Annex 3.3.4 FGD Guide for Trainers in QoMNH

8. Introduction to the objectives of the research
9. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
10. Ask people to describe who they are and say few words about themselves
11. Introduce the topic under review - We are here to evaluate the training and monitoring component supported by the IMCHS Project
12. Ask questions

Relevance

- Before attending the training, did you feel the need to upgrade your knowledge and skills?
- Was this training pertinent to your current work and why?
- Was the training content easy to comprehend?
- Did you like trainers? Why (for both, yes and no)?
- Did you like the way the training was delivered (training methodology)? Why (for both, yes and no)?
- Do you feel that the training enabled you to fully apply, in your practice, what you have learnt?

Effectiveness

- How often do you apply the acquired skills and knowledge into work practice?
- In your daily practice, which are the fields where you feel more confident now (after having been exposed to training)? Why?
- Which are the fields where you feel less confident (after having been exposed to training)? Why?
- Did the acquired knowledge and skills affect (could be both, positively and negatively) your self confidence and the value of your daily work? How? Please give examples.
- What is the attitude of colleagues who were not exposed to training towards changing delivery care practices you have introduced in the work place?
- Do you believe that using QoMNH tool can improve the quality of MCH services? Why (give an example)?

Efficiency

- Do you think that duration of the training was sufficient? Time allotted to theoretical and practical sessions was enough?
- Did you receive adequate information for further reference?
- Do you think that environment in which the training was delivered was adequate? Why (for both, yes and no)?

Sustainability

- At the work place, are there some conditions that prevent you to correctly practice your skills?

- How do you use the findings of the QoMNHC? Give an example
- Are you willing to continue using the acquired knowledge and skills on a regular basis? Why (for both, yes and no)?
- What are your motivations to use QoMNHC tool?
- Are you receiving any incentive for delivering quality MCH services (i.e. monetary, participation to other courses, award for best practices, etc.)?

13. bring the meeting to a close by summarizing the main points

Thank you

Annex 4: Results Framework

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
<p>Wider Objective</p> <p>To support Uzbekistan to meet the targets of Millennium Development Goals numbers 4 and 5⁴¹</p>	Reduced child and maternal mortality brought in line with the target of the MDGs.	State Medical Statistics	<p>MMR</p> <p>65.4 (1990)</p> <p>U5MR</p> <p>65.3 (1991)⁴²</p>	<p>75% decrease by 2010 from 1991 rates</p> <p>decrease by 1/3 from 1991 rates by 2010</p>	<p>30⁴³ (2008)</p> <p>36.1 (2009)</p>	Met Both indicators are on track
<p>Specific Objective</p> <p>To support the implementation of Uzbekistan's national healthcare reforms through expanding the application of the WHO Live Birth Definition, together with strengthening newborn care and improving the quality of maternal and child health care by developing skills and capacity in pre-natal and newborn care at the hospital level and the management of childhood disease at the primary health clinics.</p>	1.All institutions nationwide reporting in accordance with LBD	MoH Prikaz April 2010 and Data from ILBD Center	100% (Range 95-45) (2006)	All institutions	100%	Partially Met ILBD is reported by all institutions but not yet integrated into regular Medical Statistics form and State Statistics report
	2. Increased number of low birth weight babies registered (as result of ILBD),	Record from ILBD Registration Center	15,881 (2007)	increased number of low birth weight babies registered using ILBD (no target set)	34,794 (2010)	Met Number of registration of Low birth Weight Registration increased by 119 % between 2007 and 2010

⁴¹ Reduction of child mortality by ⅓ of the 1990 rate and reduction of maternal dead by ⅓ of the 1990 rate.

⁴² Improvement of Maternal and Child Health in Uzbekistan, v.26, March, 2008

⁴³ Trends in maternal mortality: 1990–2008, Estimates developed by WHO, UNICEF, UNFPA and The World Bank

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
	3. Change in distribution of perinatal mortality (as result of improved reporting) ⁴⁴	Record from ILBD Registration Center	18/1000 live births (2007)	N/A	16/1000 live births (2010)	Partially Met The decreasing trend is observed, though no target was not set at the beginning of the project
	4. Reduction of newborn death from preventable causes such as asphyxia, sepsis and hypothermia.	Record from ILBD Registration Center	11/1000 live births (2007)	N/A	10/1000 live births (2010)	Partially Met The decreasing trend is observed, though no target was set at the beginning of the project. No disease specific breakdown is available
	5. Increased use of clinical protocols and other international accepted procedures	Periodic monitoring	N/A	N/A	67% (2010) for all guidelines	Met
	6 Increased and correctly use of IMCI algorithm to access and manage the common childhood illnesses	Periodic monitoring FUAT and IMS	Danger signs recognition - 34% Treatment of pneumonia with correct antibiotics – 32%	60% from the baseline	Danger Signs – PIMCI: FUAT- 82%,IMS- 87% Treatment of pneumonia with correct antibiotics - HIMICI FUAT – 52% , IMS- 51%	Partially Met

⁴⁴ Stillborn will reduce, neonatal will increase.

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
1. Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics.	1. 1. Out of 9,858 health professional trained in New Born Survival (4,465) and Child Survival (5,393) ⁴⁵ components 70% (new born- 3,155 and child survival – 3,773) successfully complete the competency test with 75% score in post – test.	Trainings Reports	NA	Health professional trained in New Born Survival (4,465) and Child Survival (5,393) ⁴⁶ components 70% (new born- 3,155 and child survival – 3,773) successfully complete the competency test with 75% score in post –test.	<p>Trained in Newborn Survival – 4,914 (NR/ENC- 2,525, EPC - 670, BFHI- 1,719).</p> <p>Trained in Child Survival: 8,964 (P/CIMCI- 4,229.GDM/B FC- 3, 544, HIMCI – 1,191).</p> <p>Post test score : more than 75%</p> <p>Composite in Newborn Survival - 85% (Range 77-88) – 4,199</p> <p>Composite in Child Survival - 91% (Range 83-98) – 8,976</p>	<p>Met</p> <p>Newborn survival target exceeded by 10%</p> <p>Child survival target exceeded by 66%.</p>

⁴⁵ New Born Survival participants: NR/ENC – 2,530, EPC – 480 & BFHII – 1,455. Child Survival – IMCI, IYCF, Growth Monitoring and Exclusive Breast feeding – 3,850, Hospital IMCI – 1,543. Here 3,850 health providers are divided into two components - 3850 GP doctors and nurses are trained for PIMCI/CIMCI and similarly additional 3850 GP doctors and nurses are trained for GDM/BF . In this condition total trainee in child survival components are 9243

⁴⁶ New Born Survival participants: NR/ENC – 2,530, EPC – 480 & BFHII – 1,455. Child Survival – IMCI, IYCF, Growth Monitoring and Exclusive Breast feeding – 3,850, Hospital IMCI – 1,543.

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
	1.2. At least 60% of the certified health professional correctly manage the common perinatal, new born and child health problems following standard protocols	FUAT results IM results	Newborn survival: NR – 34 % ENC – 39 % Child Survival: Danger signs recognition - 34% Treatment of pneumonia with correct antibiotics – 32%	60% of certified health professional correctly manage the common perinatal, new born and child health problems following standard protocols	FUAT: composite 61% (Range 44-71%) Newborn Survival : NR – 39% ENC – 57% Child Survival : Danger signs – 82% Severe Pneumonia treatment : 51% IMS-composite 64% Range (45-80%) Newborn Survival : NR – 56% ENC – 64% Child Survival : Danger signs – 87% Severe Pneumonia treatment : 49%	Partially Met Lowest in HIMCI 44 & 45. EPC- 51 & 53. Reasons for HIMCI are given above. Reasons for EPC was in pilot stage. There were systemic, structural and supply barriers also to correctly practice the learned skills.
	1.3. Proportion of babies of each catchment SVP attends timely well-baby checkups; follow up visits to SVPs and timely referral to hospitals if needed	Exit interview during FUAT	94% visit all babies within 28 days of	All newborn babies within 30 days of delivery	Not Measured	Not measured

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
13. Improved quality of care during delivery and post natal care in all hospitals and maternity centres	2. 1. Out of 3,010 health staff trained in new born life saving skills (EPC- 480 & NR/ENC-2,530), 60% (EPC- 288 & NR/ENC-1,520) of them correctly practice established protocols of essential perinatal care, neonatal resuscitations and essential newborn care.	Monitoring tools and reports	NR – 34 % ENC - 39 % EPC – N/A	60% (1808)	NR – 56% ENC – 64% EPC – 53%	Partially Met
	2.2. Exclusive breastfeeding rates for children in first month after birth increased by 30% in new 8 oblasts than that of baseline of MICS 2006 (26%).	MICS	26% (2006)	30% increase	Data of MICS 2011 is in process of tabulation	NA
	2.3. 68 maternity wards,8 maternities, 32 polyclinics and up to 900 SVPs in targeted 8 oblasts are certified as “Baby Friendly Health Institute Initiative (BFHII)”	Monitoring tools and reports	23 maternities	Maternities – 8 Maternity wards -68 ; Poly clinics - 32 ; SVPs – 80; (SVP target revised)	Maternities - 5; Maternity wards – 31; Poly clinics - 17; SVPs - 55	Partially Met
14. WHO “live birth definition” universally applied	3. 1. All health professionals (ILBD- 1,250 and BABIES- 102) score more than 75% in post training competency test.	Trainings Reports	100% maternities apply. Knowledge on ILBD Criteria 72-98%	ILBD-1,250 BABIES- 102	1,213 HP providers trained (ILBD – 1, 060, BABIES – 153). 90% of the target met. 96% scored more than 75 in Post-test of ILBD and BABIES	Met
	3.2 100% of institutions in nationwide applying the ILBD consistently and correctly.	Reports from national ILBD Center	N/A	100%	The MoH issued Prikaz No 56 in April 2010 to apply ILBD in nationwide perinatal outcome reporting.	Partially Met

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
15. Reporting and monitoring system of births improved.	4.1. 100% of institutions in nationwide applying the ILBD protocol consistently and timely reporting birth records.	Reports from national ILBD Center	100%	100%	100% reporting to national ILBD Center	Met
	4.2. Out 1,220 health managers trained on Health Management and Quality Improvement (HM/QI) 80% (730) is correctly applying MCH indicators for official reporting during Oblast and Rayon Health Department Collegiums	Monitoring tools and reports	57%	80% - 730	78% (1270/991) trained health managers correctly apply MCH indicators for official reporting	Met
16. Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated)	5.1. Formally endorsed Pre-service curriculum introduced in at least in one Medical Institute	MoH report on implementation of revised curriculum	N/A	At least 1 Medical Institute	The curriculum has been revised and approved by MoH. Seventy teachers from 7 Medical Institutes were trained. The curriculum has been introduced in Samarkand Medical Institute. Thirty seven teachers from this Institute are trained.	Met
17. Public awareness of "best practice in child care in general" is raised.	6.1. 40% of parents/families that can identify early signs of major childhood illnesses and complications.	Caregivers exit interview during follow up visits. – FUAT Reports	NA	40% care givers	FUAT exit interview shows, 72 % mothers have knowledge on dose, time and days to give the prescribed medicine to her child and 57% could correctly tell the three rules of the home treatment.	Met

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
Result #1. Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics.						
R1.1.0 Develop Joint Action Plan for national MCH programme	1.1 The Project steering committee with national and international partners is established	ToR and Minutes of PSC	None	Functional PSC	Achieved in Quarter 1. Regular quarterly meetings held.	Met
	1.1.2 A joint action plan on national MCH developed	A joint Action Plan (JAP)	None	Activities implemented as per JAP	Activities implemented as per JAP in partnership with WHO, ADB.UNFPA & GIZ. – QoMNHC, EPC, MCH monitoring, training on neonatal equipments	Met
R1.2.0 Set up 1 national training center and 5 new training centers and upgrade 3 existing training centers in 8 Oblasts.	1.2.1 Operational 9 training centres (Tashkent -1 & Oblasts -8)	Operational 9 training centers (Tashkent 1 & Oblasts -8)	None	9 training Centers operational	17 Training centres -16 Training centers renovated and equipped - 1 Training center in Navoi equipped .	Met Target exceeded by 77%
R1.3.0 Review and update training materials using international STEs	1.3.1. 14,000 sets of updated training materials for new born, child survival and health management printed.	Availability of training materials.	None	14,000 sets	20,000 Sets of training materials printed and distributed.	Met Target exceeded by 42%. More training materials were required due to increase number of participants, training materials in Uzbek and Russian and provided to Medical Institutes.

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R1.4.0 Endorse training courses and training plans through MOH decree	1.4.0. MoH decree on endorsement of training materials and training plan.	MOH Decree	NA	MOH Decree issued	MoH issued the letters (Forms) on selection of participants and training dates.	Met
R1.5.0 Identify and train master and local trainers.	1.5.1. 70 master trainers and 366 local trainers trained ⁴⁷ .	Training reports	NA	70 master trainers 366 local trainers	665 national and local trainers trained.	Met Target exceeded by 52%. More trainers needed to conduct simultaneous trainings and post training monitoring and to develop the critical mass of trainers at oblast level.
	1.5.2. Trained master trainers and local trainers conduct training and monitoring of Oblast and Rayon participants.	Training Reports	None	Not Set	Based on the training reports trainings were implemented in all 8 oblasts	Met
R1.6.1 Training of 2,530 health providers in newborn resuscitation and essential newborn care from 8 new Oblasts.	1.6.1. 60% (1,518) of trained health providers correctly practice established protocols of Neonatal Resuscitations and Essential Newborn Care in their health care settings	1.Report Training 2.Monitoring tools and reports	NR – 34 % ENC - 39%	60% (1,518)	Composite – 60% (1,515 /2,525) NR – 56% ENC – 64%	Met
R1.6.2. 480 health providers from oblast perinatal centers and 2 rayon facilities from each oblast in Effective Perinatal Care (8 Oblasts).	1.6.2. 60% (290) of trained health providers correctly practice established protocols of Effective Perinatal Care in their health care settings.	Monitoring tools and reports	NA	60%	EPC – 53%	Partially Met

⁴⁷ Master trainers means National level trainers and local trainers means Regional/Oblast level trainers. **Master Trainers 70** = EPC – 10, NR/ENC – 16, ILBD – 8, BFHII – 8, Hospital IMCI – 4, Extended IMCI/IYCF/GMP/BF – 18. HM/QI – 6. **Local Trainers 366**: EPC- 42, NR/ENC – 48, ILBD – 32, BFHII –32, Hospital IMCI – 32, Extended IMCI/IYCF/GMP/BF – 96. HM/QI - 84

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R1.6.3. 1,455 health workers from maternities and maternity wards (including on-job training) in Baby Friendly Health Institute Initiatives (BFHII).	1.6.3. 60% (875) of trained health providers correctly practice breast feeding counselling skills in their health care settings.	Monitoring tools and reports	NA	60% (875)	67% (1115/1719) correctly practice BF counseling skills.	Met The target exceed by 18%.
R 1.6.4. 3,850 primary care health care workers from Polyclinics and SVPs trained in Child Survival Package (includes- IMCI, IYCF, Growth Monitoring, and Exclusive Breastfeeding).	1.6.4.1. At least 60% (1,310) of the trained health care workers correctly manage the common child health problems in Polyclinics and SVPs following IMCI algorithm.	1.Report BL 2.Monitoring tools and reports	Danger signs : 32% Main Symptoms - 34%	60% (1,354)	80% (1,803/2,254) trained GP doctors correctly practice IMCI algorithm. Danger signs : 87% Main symptoms : 96% Nutritional status – 63% Immunization status – 90%	Met The target exceed by 14%.
	1.6.4.2. 50% of babies of each catchments SVP attend timely well-baby checkups; follow up visits to SVPs and timely referral to hospitals if needed	Exit Interview in FUAT	94%	50% of babies in SVP catchment area	No data is available about number of check-ups, however Immunization record shows more than 95% immunized in first month of life as per national protocol.	Met
	1.6.4.3.1 Exclusive breastfeeding rates for children in first month after birth increased by 30% in new 8 oblasts than that of baseline (26%) of MICS 2006.		26% (MICS 2006)	30% increase	Results MICS 2011 now is tabulation	NA
	1.6.4.3.2. 68 maternity wards, 8 maternities, 32 polyclinics and up to 900 SVPs in targeted 8 oblasts are certified as “Baby Friendly Health Institute	Monitoring tools and reports, BL reports	Total 23 health facilities certificated as BFHI	Maternities – 8 Maternity wards -68 Poly clinics - 32 SVPs – 80	Maternities - 5 ; Maternity wards – 31; Poly clinics - 17 ; SVPs - 55	Partially Met

Initiative (BFHII)"						
Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R 1.6.5 1,543 health workers in hospitals trained on IMCI and basic pediatric care in 8 Oblasts	1.6.5 At least 60% (925) of the trained health care workers correctly manage the common child health problems in 8 oblast hospital following IMCI algorithm.	Monitoring tools and reports,	Treatment of pneumonia with correct antibiotics – 32%-	60% (680)	45% paediatricians practice HIMCI protocol Severe pneumonia – 49% Diarrhea (some and severe dehydration) – 37% Very severe disease like convulsion 49%	Partially Met
R 1.6.6. Monitor the application of knowledge and practical skills in all for Effective Perinatal Care (14 Oblasts), Neonatal Resuscitation /Essential Newborn Care and Child Survival Package in 8 new Oblasts.	1.6.6. At least 2 monitoring visits organized in hospitals, maternity centres and polyclinics and targeted SVPS.	Monitoring Reports	None	At least 2 monitoring visits organized	Two monitoring visits organized in Project 8 Oblasts FUAT – Following WHO protocol after 8 – 12 weeks of training. Integrated Monitoring – Last part of project 2011.	Met
Result # 2 improved quality of care during delivery and post natal care in all hospitals and maternity centres						
R2.1. Recruit Quality Improvement (QI) Expert (International STE)	2.1. Training of National QI teams with updated QI technical manual.	Availability of updated QI technical manual and trainings report.	NA	Not Set	Four international STEs were recruited to review the CQI materials (WHO approved QOMNHC tool) and conduct trainings. 12 national and 24 oblast trainers trained to implement CQI system in pilot maternities.	Met

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R2.2. Prepare QI manual	2.2. Technical QI manual developed by STE by reviewing and updating existing materials	Availability of MOH approved QI technical manual.	NA	Updated QI Manual developed and approved	Technical QI based on WHO's standard MCH QI indicators – QOMNHC tool was adopted in Uzbek context and approved by the MoH.	Met
R2.3. Select the model MCH facilities for piloting Continuous Quality Improvement (CQI) systems (one facility per oblast)	2.3. One Oblast level facility (Central Hospital/Perinatal Centre) from each Oblast selected for piloting CQI system (8 model facilities).	Documentation of selection process	NA	8 oblast level Maternities selected for piloting CQI	9 Maternities (1- Tashkent and 8 in Oblasts)	Met
R 2.4. Conduct theoretical and on-job training of CQI teams from selected facilities in QI	2.4. 160 key health staff (local STE, managers/chief specialists) from selected pilot health facilities trained in CQI.	Training reports	NA	160 individuals trained in CQI	201 key health staff trained from eight Oblasts and RPC Tashkent.	Met The target exceeded by 25%
R 2.5 Support the piloting of the CQI systems	2.5. All 8 model health facilities practicing CQI system as part of model for learning.	Monitoring reports	NA	8 maternities practicing CQI	The post training evaluation showed all 9 selected maternities are implementing QOMNHC tool	Met
R 2.6. Study legislation to determine requirements for certification (as part of Quality Assurance)	2.6. Institutionalization of MCH training and capacity building certification system by engaging Institute of Physicians Post diploma Education and the National Institute of Health	Analysis of legislation	NA	Analysis of legislation	Study of legislation completed by Tashkent Post Graduate Medical Education (TIPME).	Met
R 2.7. Develop and agree specifications for trained health workers certification management software	2.7. Technical specification certification management software developed with MoH approval.	MoH decree on certification management software development	NA	Certification management software specification approved by the MOH	The specification was developed as per TIMPE's recommendation. But was not processed due to the cost and other hardware components to be provided.	Not Met

Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R 2.8. Prepare bidding document and contract and award contract for development of software	2.8. Certification management software developed through bidding process.			Certification management software procured through competitive bidding	Could not achieve Alternate proposal: Agreed to pilot HR software developed by MoH and requested IT Director of MoH to submit approved proposal.	Not Met
R 2.9. Test the management software in selected oblasts/rayons	2.9. Testing of software in at least 2 targeted Oblast and 20 targeted Rayons	Monitoring of test results and use of available data base.	NA	At least 2 Oblasts and 20 Rayons	Could not achieve: No proposal was submitted by MoH for piloting despite repeated requests.	Not Met.
R.2.10. Install and operationalize the certification management software	2.10.1. Evaluation of the relevance, efficiency, effectiveness and sustainability of the software.	Evaluation report.	NA	Software evaluated	Could not achieve as software was not piloted. This component was dropped and Trained Health Professionals certified their training credit hours by TIMPE.	
	2.10.2. Dissemination of evaluation report to MoH and other partners/ stakeholders.	Proceedings of dissemination workshop.	NA	Software Evaluation report distributed and comments received from stakeholders		
	2.10.3. MOH, Institute of Physicians Post diploma Education and the National Institute of Health agree to scale up this software at national scale.	Evidence of MOH interest to scale up reflected in communication between UNICEF and MOH.	NA	Software is scaled up nationally		
Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
Result # 3. WHO “live birth definition” universally applied						
R 3.1. Conduct refresher trainings	3.1. 70% health professionals trained in ILBD (1,253) and BABIES (102) score	Competency pre and post test scores on ILBD refresher	NA	ILBD 70% (877) BABIES 70%	1,213 Health providers trained. 90% of the target met. 96% scored	Met

on ILBD	more than 75% in post training competency test.	training		(72)	more than 75 in Post-test of ILBD and BABIES.	
R3.2. Monitor application of ILBD	3.2. 100% institutions nationwide applying the ILBD consistently and correctly nationwide.	ILBD Center Report	100% (Range 95-45)	All maternities	100%	Partially Met ILBD has been institutionalized. Ministry of Health issued order (Prikaz) №56 in April 2010 , on introducing ILBD in all Maternities.
Result # 4. Reporting and monitoring system of births improved.						
R 4.1. Train 1,212 health managers on MCH on oblast and rayon level in all 14 Oblasts	4.1. Out 1,220 key health managers trained on Health Management and Quality Improvement (HM/QI) 80% (854) local health managers are applying MCH indicators for official reporting during Oblast and Rayon Health Department Collegiums	BL report	58%	Local Health Managers 80%(854)	78% (991/1,270) correctly apply MCH indicators on Official Reporting.	Met
Result # 5. Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated)						
R 5.1. Organize national seminar on evaluation of current curricula	5.1 Curricula evaluation conducted through national seminar.	Seminar Report	NA	Curricula evaluation conducted through national seminar.	Used the evaluation report of ADB consultant which was presented in seminar.	Met
R.5.2. Establish working group from representatives of medical academia and recruit international STE for revision of academic curricula and training of teachers	5.2. A technical working group established and a national and one international short term expert hired to assist on revision of academic curricula	Consultancy Reports	NA	Technical working group (TWG) established and is fully operational	A technical working group established and national expert contracted. The MoH did not agree to hire international expert.	Partially Met
Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R.5.3. Review academic curricula for under and postgraduate medical education and prepare changes in the	5.3. At least two means for introducing evidence based approaches in existing MCH curricula developed by working	TWG reports on changes	NA	Means (at least 2) for introduction of evidenced based approaches in MCH	Working group developed the revised curriculum without extending the	Met

curricula	group			curricula adopted	credit hours	
R.5.4. Organize national conference to discuss and agree proposed changes	5.4. Around 45 academicians, experts and other stakeholders attend a conference to discuss and recommend proposed change.	Conference Resolution	NA	Conference recommended changes formulated	The conference was organized in November 2009 and more than 90 academicians attended from 8 Medical Institutes.	Met
R.5.5. Endorse revised curricula through decree (MOH and MOE).	5.5. Draft decree for proposed changes and means for changes submitted MoH and MoE.	Ministerial Decree(s)	NA	Conference recommended changes approved	The MoH approved the curriculum and issued Decree for teachers training.	Met
R.5.6. Train cadre of teachers in teaching revised curricula	5.6. 21 teachers from 7 medical institutes trained on revised curricula.	Training Reports	NA	21 teachers from 7 medical institutes	70 teachers from the 7 Medical Institutes took part in the trainings. (Medical Institutes of Tashkent, Andijan, Namangan, Bukhara, Samarkand, Kashkadraya, and Khorezm)	Met
R 5.7. Introduce (or Pilot) the revised curricula in one selected health institute.	5.7. At least one medical institute introduced revised curricula by September 2009.	?????	NA	In one medical institute	Introduced in the Samarkand Medical Institute in September 2010.	Met
Result # 6. To raise public awareness of "best practice in child care in general".						
R 6.1. Create communication team including key resource people	6.1. Communication team with key resources person established by February 2009	Communication team TOR and charter	NA	Communication Team established	UNICEF established Program Communication Section headed by International professional.	Partially Met
Objectives/Results	Indicator	Means of Verification	Baseline	Target	Status	Comment
R 6.2. Develop communication strategy	6.2. Communication strategy with health and general messages developed in line with EC visibility strategy by March 2009	Availability Communication Strategy and approved BCC materials by MoH.	NA	Communication Strategy developed	The communication strategy as a component of behaviour change communication	Met

					on (BCC) was developed	
R 6.3. Implement the strategy	6.3. Communication strategy implement from April 2009	Communication Strategy implementation progress report CS monitoring Report	NA	Communication Strategy Implemented	Piloted in rural primary health care centres (SVPS) of Samarkand, Syrdariya, Namangan and Djizak Oblasts. 863 patronage nurses trained.	Partially Met Implementati on started only in 2010

Annex 5: Terms of Reference

UNICEF UZBEKISTAN

TERMS OF REFERENCE FOR CONSULTANTS AND CONTRACTORS

Title: *Evaluation of Improvement of Mother and Child Health Services Project in Uzbekistan for the implementation period July 2008- June 2011.*

I. BACKGROUND

Country situation

Uzbekistan is a landlocked Central Asian country with approximately 30 million people. 37% of the population is estimated to live in urban areas and more than 10% are children below five years of age. In Uzbekistan, steady progress has been made on improving the health, nutrition and wellbeing of mothers and children since gaining the independence in 1991.

The under-five mortality rate fell from 74 to 36 per 1000 live births between 1990 and 2009⁴⁸. However, challenges remain and further improvements are required with a more holistic approach, embracing maternal and child health (MCH), nutrition and wellbeing. The neonatal mortality rate at 26 per 1000 live births is 2.5-3.5 times higher if compared to EU states⁴⁹. 79% of infant deaths occur during the first 30 days of life due to avoidable causes⁵⁰, despite 95% of deliveries are attended by health professionals. The poor quality of maternal, perinatal and early neonatal care is contributing to a high rate of newborn and maternal deaths (maternal mortality is 24 per 100,000 live births⁵¹)

Over the last decade, several reforms have been implemented to increase the health system's efficiency, including: reorientation of primary health care, improvement of emergency care and introduction of a basic package of services. Despite such gradual changes, Uzbekistan's health system retained many features of "Semashko's model" and the sustainability of the modernization process is not reflected in its governance. The stewardship function of the Ministry of Health (MoH) is focused on centralized management rather than on policy making and regulation.

The reform has been focusing on improving the infrastructure and hardware component and less on improving health care providers' skills. Thus it did not bring the desired change in the **quality of care** in its dimensions of safety, effectiveness, patient responsiveness and counselling along the continuum from preconception to adolescent care, particularly care around birth. The concentration of health workers is very high with 134 health providers for every 10,000 people – 5 times more than WHO standards. However, the distribution is uneven, their skills are variable and they are underpaid.

At the same time, the reform has done little to ensure **equitable** access to and use of services, thus, leaving the room for disparity on morbidity and mortality especially in economically and geographically deprived regions. A recent comparative analysis of MICS 2006 data concludes that under-five and child mortality rates are at least 20% higher in rural areas compared with urban areas and 70% higher among the poorest quintile as compared to the richest.

⁴⁸ http://www.unicef.org/infobycountry/uzbekistan_statistics.html

⁴⁹ http://ec.europa.eu/health/ph_information/dissemination/echi/echi_05_en.pdf

⁵⁰ Ibid

⁵¹ http://www.childinfo.org/maternal_mortality_countrydata.php

The **Health financing** system primarily involves input-based allocation and disregards actual performance and outcomes. According to WHO estimates, the total health expenditure stands at 169 US\$ PPP per capita, out of which public health expenditures account for only 42%. Though state-guaranteed contributions are the major source of health sector's financing, they are mainly utilized on salaries and operational costs. Out of pocket expenditures by families amount for around 60% of the average medical costs, which greatly contributes to raise access barriers and hinder the use of services by the needy part of the population. A recent UNICEF study on child poverty found that 38% of children with common illnesses in poor families are not taken to health facilities because of the unaffordable costs.

Project overview

In 2003, the Government initiated a sector reform process to improve maternal and child health services, by addressing the gaps in primary health care, supply and in-service training. In this framework, the MoH, with UNICEF's support, piloted the innovative Newborn Survival Programme in Fergana region, with the objective to introduce evidence-based training materials on newborn care, neonatal resuscitation, perinatal healthcare surveillance and the International Live Birth Definition.

The evaluation of this pilot showed that the package had an impact on reducing neonatal morbidity and mortality and recommended scaling-up the Fergana model in transitional health systems with established primary care and referral systems⁵². In a joint effort by MoH and UNICEF, the scale-up was planned, and, in this framework, the **"Improvement of Mother and Child Health Services (IMCHS)"** project was designed. With financial support by the European Commission, the first phase of the project has been implemented and has contributed to the scale-up in 8 regions. The second phase will boost the nationwide expansion and focus on institutional strengthening, capacity development and community empowerment for equitable, quality and continuous health care.

Overall objective of the project: To support Uzbekistan to meet the targets of Millennium Development Goals numbers 4 and 5.

Specific Objective: To support the implementation of Uzbekistan's national healthcare reforms through expanding the application of the WHO Live Birth Definition (ILBD), together with strengthening newborn care and improving the quality of maternal and child health care by developing skills and capacity in pre-natal and newborn care at the hospital level and the management of childhood disease at the primary health clinics.

Expected results:

1. Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics.
2. Improved quality of care during delivery and post natal care in all hospitals and maternity centres
3. WHO "live birth definition" universally applied
4. Reporting and monitoring system of births improved.
5. Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated)
6. Public awareness of "best practice in child care in general" is raise

Logic of the project design:

⁵² Zulfiqar A Bhutta – Evaluation of Newborn Survival Training Programme in Ferghana Region, Uzbekistan.

	Logic of the design
1. Coordination	The nature, complexity and scope of the project require a Project Steering Committee (PSC) for coordination with national and international partners. The PSC's aim is to contribute to the effective project implementation by assuring broader political commitment and ownership and facilitating appropriate, timely and comprehensive re-actions to new challenges throughout the duration of the project. At a later stage, the PSC also started acquiring a role of linkage between the project and related policy change processes within the sector reform. In this framework, the MoH has mainstreamed project interventions like IMCI, Breast Feeding, Growth and Development, Newborn Care and Effective Perinatal Care into the MCH system.
2. Training centers	This component includes the renovation and equipping of training centres in each of the target regions. The objective is to facilitate locally-based training to reach the highest possible number of health professionals and, at the same time, to contribute to strengthening MoH's capacity for decentralized in-service training.
3. Training materials	Training materials (based on WHO standards) were adapted to the local context and integrated with the previously piloted evidence-based approach. Training materials are also updated in case of adoption of relevant new protocols. Evidence-based clinical protocols were adapted as needed for improving the management of specific problems.
4. Training of trainers	The training strategy includes the creation of a team of qualified national and regional trainers, with the objective to organize cascade trainings, coaching and mentoring and create a sustainable system with national and regional pools of trainers. The cadre of trainers, spread across the country could serve as catalyst of change in their regions, districts through training, coaching, mentoring and advocacy.
5. MCH package in pre-service training	Despite the heavy focus on in-service training, the Project also addresses the issue of up-grading the pre-service Medical Institutes' curriculum, by incorporating the evidence-based approaches in MCH (newborn and child survival packages) while providing education to medical undergraduates and postgraduate students.
6. Training of health providers	The key component of the project is the capacity building of health providers in line with the piloted WHO standard protocols and clinical guidelines. Health providers include doctors, nurses and midwives working in primary, secondary and tertiary healthcare facilities as well as health managers. The training strategy encompasses: Newborn Survival Package , addressing quality of care for pregnant women and new-born babies. It includes: Effective Perinatal Care, Neonatal Resuscitation, Essential Newborn Care, Baby Friendly Hospital Initiative and nationwide expansion of ILBD. Child Survival Package addressing major causes of early childhood morbidity and mortality by focusing on out-patient and inpatient healthcare. It includes: Integrated Management of Childhood Illnesses, promoting breastfeeding and infant/young child feeding, growth monitoring and prevention and control of micronutrient deficiencies. Health Management and Quality Improvement for health managers addressing the quality of supervision, recording and reporting following standard protocols.
7. Certification	The main objective of the certification is to standardize quality of health

	providers' competency. The competency-based test and certification system complements the training component and reinforces its outcome, thus ensuring basic level of quality. The training completion certificate is provided by the Ministry of Health with attestation from Tashkent Institute of Postgraduate Medical Education (TIPME)
8. Monitoring and quality improvement	The monitoring and quality improvement component aims at building the capacity of health managers to provide supportive supervision and solving the challenges faced by health providers and facilities in service delivery. The monitoring system includes: the joint monitoring and supportive supervision system (Follow Up After Training – FUAT) and the Quality of Hospital Care for Mothers and New-borns system – QoMNHC).
9. Communication and awareness	Communication and awareness raising is crucial to ensure successful project implementation and sustain the results. This component aims at creating an enabling environment for skill application and behavioural change, thus making results more sustainable at all levels, from the policy level to the beneficiaries.

Project duration:

The project is the scale up stage of the Fergana Newborn Survival Model pilot project (2003-2006). It is implemented in two consecutive phases. Phase one has a duration of thirty six months - July 2008 to July 2011. Phase two is expected to start in the last quarter of 2011 and last till 2014.

Project partners:

MoH, National Medical Institutes and Regional Health Departments are the main implementing partners. Key departments within the MoH contribute in different ways and levels of responsibility.

WHO, as a member of the Steering Committee, provides technical input on quality assurance and monitoring. It also participates in the Joint Monitoring Team, together with MoH, and UNICEF.

UNFPA provides technical support to the safe motherhood and Effective Perinatal Care component.

ADB, through its Health 2 Project, implements activities parallel to IMCHS project in the other six regions, including basic equipment in maternities. ADB is exiting the Health Sector in mid-2011.

The World Bank supports General practitioners and nurses in Primary Healthcare. The World Bank is planning the Health 3 Project which is focused on secondary health care at the district level.

USAID provides technical support to Health2 project on the quality improvement component.

GIZ supports the improvement of nursing education quality, maternal passport, standardisation, certification and nutrition intervention in two Regions.

UNICEF provides overall technical support to the Project. UNICEF is complementing healthcare support through its regular programme in six additional regions, specifically with the Effective Perinatal Care training and integrated monitoring of the implementation of ILBD nationwide.

Contribution to national priorities and UNICEF-Government programmatic framework:

The project contributes to the Welfare Improvement Strategy (poverty reduction strategy) and to the health sector reform process initiated by Ministry of Health in 2003. It is part of the UNDAF framework (2005-2009 and 2010-2015) with priority area on enhancing essential services for maternal and child health. It contributes to achieve the results related to Focus Area 1 of UNICEF's Medium Term Strategic Plan: Young Child Survival and Development. This is reflected in the Country Program Document and related Action Plan for 2010-2015, signed by the Government and UNICEF and aiming at: by 2015, the health system provides quality services for mothers and children in line with adopted legislative and normative frameworks aligned with international standards.

II. PURPOSE OF THE EVALUATION

As mentioned, the project is now bridging from the first to the second phase. The latter will further expand the Fergana model from 8 to all regions in the country and will focus on institutional strengthening, capacity development and community empowerment for equitable, quality and continuous access to health care. This intervention will more and more be integrated within the strategic framework of the ongoing maternal and child health sector reform.

In order to inform the second phase, an evaluation of the first phase is now required to assess successes, shortcomings and the replicability of this expanded model to nationwide scale and its contribution to evidence-based policy change within the MCH sector reform.

The evaluation will be a joint and participatory process involving the key stakeholders (WHO, UNFPA, GIZ, ADB/WCHP, WB/Health 2 Project)) within the MCH sector. The findings will be mainly used by the project partners – MoH, UNICEF, and the EC – in their different capacities and functions:

- To adjust their plans and strategies within phase 2, based on lessons learnt and good practices.
- To review, based on the evidence produced by phase 1, relevant maternal and child health policies as well as the strategies for the MCH sector reform.
- To review their partnerships and coordination within the project and inform adjustments for better results in the MCH sector.

III. SCOPE AND FOCUS

The evaluation should cover the first phase of the project (July 2008 – May 2011). It should focus on the OECD/DAC criteria of relevance, effectiveness, efficiency and sustainability, as well as additional criteria of interest to UNICEF including Results Based Management (embedded into the other criteria), Coherence and Human Rights Based Approach to Programming. Most of the criteria should be analyzed from the perspective of the following orbits of influence of the intervention:

- **Final beneficiaries:** caregivers, families, mothers and children;
- **Service providers:** health care professionals whose capacity has been built (including doctors, midwives, patronage nurses, health facility managers);
- **Sub-national decision-making level:** Regional health authorities and Hokymiats (governments);
- **National decision-making level:** national authorities and key stakeholders (Ministry of Health, Ministry of Finance, Cabinet of Ministers, WHO, UNFPA, WB, ADB, USAID, EC, GIZ).

Relevance:

National decision-making level:

- What is the relevance of the intervention in terms of advocating for and facilitating the national MCH sector reform?

Service providers:

- To what extent is the training component appropriate in response to the training needs of the target groups?

Final beneficiaries:

- To what extent is the intervention relevant in terms of contributing to improve children and mother's wellbeing and health seeking behavior?

Effectiveness:

- To what extent is the project's governance structure suitable to implement in an effective, transparent and participatory way and to promote upstream policy change in the areas of concern?
- To what extent has the project contributed to the visibility of the donor in the country and among the different stakeholders and beneficiaries?

National decision-making level:

- To what extent is the intervention effective in facilitating the MCH sector reform in respect to policy change, quality improvement and governance re-structuring of the health system in line with relevant WHO standards?
- Sub-national decision-making level:
- To what extent has the project contributed to regional health authorities and medical institutes to promote the MCH packages (Newborn, Child Survival), informed decision making on resource mobilization and sustainable planning in line with Health Management's international standards?

Service providers⁵³:

- How effective is the intervention in improving service providers' knowledge and skills in all project components (New-born Survival package, Child-Survival package, Health Management and Quality Improvement package, and Inter-personal Communication package) against the indicators set in the log frame and in line with the correspondent WHO standards?
- To what extent have trained service providers (individuals) modified their regular practices related to all project components against set indicators and in line with WHO standards? Which are enabling/constraining factors that facilitated/hindered this behavioural change?
- In the MCH facilities where trained service providers work, to what extent have regular practices related to all project components been modified in line with the relevant WHO standards?
- To what extent has the intervention contributed to improve the overall resource management in the concerned health facilities? Especially as a consequence of reduced hospitalization, rational use of drugs and early recovery from sickness.
- To what extent has there been an improvement in quality of care during delivery and post-natal care in the health facilities included in the project?
- To what extent has the Inter-personal communication package (training module and communication materials) effectively contributed to strengthen patronage nurses' counselling capacity? And to what extent are they effective as a channel to strengthen caregivers' knowledge?
- To what extent is the M&E system (including FUAT and QoMNH) effective in reinforcing skill application and tracking?

⁵³ NOTE: to the extent possible, the answers to these questions should be disaggregated by: category of health provider (doctor, midwife, patronage nurse, manager); their gender; level of health care facility (primary, secondary and tertiary); administrative region.

Final beneficiaries:

- To what extent do beneficiaries perceive any overall change in the health conditions of mothers and children in the community/family? Especially as a consequence of improved health care provision, preventive and promotive health measures, practicing of early seeking medical care during sickness, decrease of health services' costs for beneficiaries?
- To what extent has the intervention contributed to reduce beneficiaries' costs for accessing MCH services? Especially as a consequence of reduced hospitalization, rational use of drugs, reduced side-effects and early recovery from sickness.
- To what extent have beneficiaries increased the frequency of their visits as a result of perceived improvement in MCH care services' quality and as a result of reduced costs and access barriers?
- To what extent have beneficiaries improved their child care and health seeking practices as a consequence of improved counselling?

Efficiency:

- Does the IMCHS project use the resources in the most economical manner to achieve its objectives? Are the available resources adequate to meet project needs?

Service providers:

- To what extent is the cascade training system, including the Follow-Up After Training system, efficient in terms of resource absorption as compared to the results achieved?

Final beneficiaries:

- To what extent are the inter-personal communication package and the patronage nurses system efficient in terms of reaching the target groups as compared to the absorbed resources?

Sustainability:

National decision-making level:

- To what extent do MoH and other concerned government agencies demonstrate ownership over the different project components (Newborn and child survival packages) and correlated aspects?
- To what extent is the project inserted into the MCH sector reform strategy, so that MoH's ownership over the Newborn and Child survival packages can lead to their incorporation into national policies and therefore assure sustainability of the results achieved?

Sub-national decision-making level:

- To what extent do MoH, Oblast Health authorities and regional hokymiats demonstrate ownership and capacity for resource mobilization to be able to self-support and consolidate the achievements and the expansion of the project within their regions?

Service providers:

- To what extent are the behavioural changes among health providers expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their capacity to continuously provide quality and equitable MCH services?

Final beneficiaries:

- To what extent are the behavioural changes among beneficiaries expected to last? What are the bottlenecks and gaps along the continuum of care that hinder the capacity of mothers and caregivers to access and use quality MCH services for themselves and their children?

Coherence:

- To what extent is the project contributing to and in line with national policies and priorities for the MCH sector and its reform?
- To what extent is the project facilitating synergies and avoiding duplications with interventions and strategies promoted by other UN agencies and development partners (IFIs, EU member states, others) within the MCH sector and its reform?
- To what extent is the project in line with and contributing to the donor’s objectives for the social sector in Uzbekistan (EU global health policy, EU Central Asia Strategy etc.)?

Human right based approach (HRBA):

- To what extent does the project incorporate the HRBA to programming?
- To what extent does the project consider the equity approach (i.e. focus on most deprived areas, areas with high prevalence of critical under-5 and maternal morbidity and mortality, low income families) and facilitate the reduction of access barriers to MCH services by the target group?
- To what extent does the project consider gender equality as key criteria throughout the planning and implementation?
- To what extent is the project facilitating the use of HRBA to inform policies and planning within the MCH sector at central and sub-national level?

Specific recommendations required:

- a. Recommend future directions and adjustments for the implementation of phase 2, including the nationwide scale-up.
- b. Based on the evidence produced, recommend key directions and strategies for strengthening the ongoing maternal and child health sector reform, as a component of the 2nd phase of the project.
- c. Recommend refinements in coordination mechanisms within the project and the MCH sector.
- d. Identify areas of good practice and lessons learnt that can serve as reference for the above points.

IV. INFORMATION SOURCES

Planning and general project documents

- Project inception report and logical framework of IMCHS phase 1 and phase 2 (jointly developed by MoH, UNICEF and EC);
- UNICEF CPD, CPAP, Work Plans, Regional/Global Strategies on MCH (internal documents)
- Training modules and materials by component (IMCI, EPC, ILBD, NR, BABIES, GDM, BF) (WHO standard modules adapted to the local context by MoH, UNICEF and WHO).

Monitoring and previous evaluations

- Evaluation report on Fergana Region Pilot conducted by a UNICEF-hired independent consultant (Z. Bhutta, Aga Khan Medical University – Karachi, Pakistan);
- Baseline study for IMCHS conducted by Tashkent Postgraduate Medical Institute under MoH;
- Result-Oriented Monitoring Mission reports, based on the monitoring conducted by external consultants hired by the donor (EC);
- Project documents and reports, including Quarterly “Narrative ” and “Mission report” (UNICEF internal monitoring documents);
- Project’s monitoring database, including FUAT (Follow Up After Training) findings (joint monitoring conducted by MoH, UNICEF, WHO);
- QoMNHC (Quality of hospital care for mothers and new-borns system) report, based on the independent monitoring conducted by a UNICEF-hired consultant (G. Tamburlini, Burlo Pediatric Hospital – Trieste, Italy);

- Available administrative data (from MoH and/or State Statistics Committee) and survey data (MICS) on relevant indicators.

Other relevant information sources will include relevant Government Decrees and available policy and planning documents on MCH sector and its reform.

V. PROCESS AND METHODOLOGY

The evaluation process and methodology should include:

1. Inception phase including:

- In-depth desk review of available documentation as mentioned in paragraph IV;
- Preliminary discussions with the commissioning team, to facilitate an in-depth common understanding of the conceptual framework, refining the evaluation questions and adjusting data collection methods, tools and sources;
- Inception report, including an Evaluation Matrix for each finally agreed evaluation question, to be presented to the Technical Working Group (see section VII and VIII).

2. Data collection phase, including:

- An appropriate mix, and reasons for selection, of Focus Group Discussions and In-depth interviews with key health care providers, health managers, community leaders, course directors, MoH officials, Steering Committee members, regional governments and departments of health, donors and development partners.
- A review – to the extent possible – of sample health facilities documents and records.

The identification of sample stakeholders and areas to be covered during data collection phase, including decisions related to the use of control groups and other methodological details should be defined during the inception phase.

3. Analysis and reporting phase. Following the completion of the fact-finding and analysis phase, a draft report (in English) should be submitted to be shared with key partners and validated.

VI. EVALUATION TEAM

The evaluation will be conducted by two international evaluators who will be working in compliance with the present Terms of Reference. Given the specific technical nature of the project under evaluation, the evaluators will be accompanied by three national experts nominated by MoH with different areas of medical expertise (IMCI, Newborn package and Child Survival package).

The international evaluators shall act independently and have the following qualifications:

Expertise	Lead evaluator	Co-evaluator
Background	International MCH expert with experience in Public Health Extensive experience in development evaluation	Extensive experience in development evaluation International expert in Health economics
Level	P5 level	P4 level
Work experience	At least 15 years	At least 12 years

Language ⁵⁴	English, Russian is an asset	English, Russian is an asset
Expertise	Lead evaluator	Co-evaluator

- Experience in quantitative and qualitative data analysis and report preparation;
- Familiarity with MCH care system in Central Asia - experience in Uzbekistan is an asset;
- Experience in evaluating UN or bilateral/multilateral cooperation projects;
- Fluency in English with working knowledge of Russian language is an asset.

VII. STAKEHOLDER PARTICIPATION

A Technical Working Group under the Steering Committee will be established and chaired by the MCH Department of MoH. Its purpose will be to oversee and coordinate stakeholders' involvement throughout the evaluation process. The MoH and key development partners are contributing to the planning stage. The data collection will require a joint effort of these stakeholders in collaboration with the international evaluators.

The analysis and reporting stage will require constant interaction with the Technical Working Group that will coordinate discussions for validation and feedback. Finally, the Group will also lead the preparation and implementation of a follow-up plan. Its purpose will be to disseminate the report and facilitate a strategic evidence-based dialogue around the key findings and their implications for the second phase of the project and the sector reform.

VIII. ACCOUNTABILITIES

The **two international evaluators** will lead the evaluation process in all its stages (see section V); coordinate with the national experts when required and provide agreed deliverables and inputs for discussion to UNICEF and the Technical Working Group. In line with contractual requirements, the evaluators will report and be accountable to UNICEF Head of Health section and M&E Officer.

The **national technical experts** will mainly support the design and implementation of the data collection phase, by bringing in specific expertise and knowledge of the local context.

The **Technical Working Group** will oversee and coordinate the evaluation process as above described. It provides feedback to the evaluators when required coordinates the involvement of the different stakeholders and reports to the Steering Committee on the different phases of the evaluation.

UNICEF will provide liaison with the international evaluators and national experts, the Technical Working Group and other stakeholders, and provides technical support and other resources.

IX. EVALUATION SCHEDULE

Activities	Lead evaluator	Co-evaluator
Desk review of documents, online discussions with commissioning team	5 working days	5 working days
Design of the data collection phase and relative tools and	5 working days	5 working days

⁵⁴ For non-Russian speaking evaluator, an independent translator will be provided for the in country and field work

preparation of inception report		
Data collection field work (in-country)	10 working days (in-country)	10 working days (in-country)
Analysis of findings and draft report preparation	5 working days	5 working days
In-country draft report validation (in-country)	3 working days (in-country)	
Finalization of the report	5 working days	
Total Working days	33 days	25days

X. DELIVERABLES

- Inception report, including detailed methodological design and Evaluation Matrix, based on desk review and discussions.
- Draft Evaluation Report to be submitted for validation.
- Final Evaluation Report in line with UNICEF Evaluation Standards.

NOTE: The report should include: executive summary, description of the evaluation methodology, assessment of the methodology (including limitations), findings, analysis, conclusions, lessons learned and recommendations for Phase 2. The Annexes to the report should contain the TORs, data collection instruments and other relevant information. The report should be provided in both hard copy and electronic version in English.

- Complete data sets (database, filled out questionnaires, records of interviews and FGDs, etc.)

Deliverables' quality and ethical considerations

Adequate measures should be taken to ensure that the process responds to quality and ethical requirements as per UNICEF Evaluation Standards⁵⁵.

As per UNEG Standard and Norms⁵⁶, evaluators and national experts should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relationships with all stakeholders. Furthermore, they should protect the anonymity and confidentiality of individual information.

The evaluators and national experts should respect the confidentiality of the information they handle during the assignment. They are allowed to use documents and information provided only for the tasks related to these terms of reference.

XI. PROCUDERS AND LOGISTICS

The evaluators will be assisted with logistics related to the assignment. During in-country visits, they will be provided with office space, vehicle for site visits and official meetings, logistic support for meeting's coordination, VISA procedures and interpreter. Laptops or computers will not be provided.

UNICEF will cover the travel from the place of residence to Uzbekistan and back and any in-country travel related with the evaluation process. Any travel shall be undertaken only upon receipt of an approved Travel Authorization from UNICEF. Based on mutual convenience, UNICEF will either purchase or send the ticket or transfer funds to the consultant's account to purchase the ticket locally. Tickets must only be purchased after communicating the cost to UNICEF and receiving written approval. Air travel will be as per UNICEF rules: the most direct, most economical route.

⁵⁵ http://www.unicef.org/evaldatabase/files/UNICEF_Eval_Report_Standards.pdf

⁵⁶ www.uneval.org

80% of the Daily Subsistence allowance (DSA) will be transferred to the evaluators before travel start. DSA is to cover expenses associated with boarding, lodging and for travel days as per UNICEF rules. In case the evaluators incur in approved travel-related costs, such as for air travel, visas, etc., final settlements of such expenses will be made upon submission of all required documents.

XII. PAYMENT SCHEDULE

30% of the fees and 80% of the DSA will be paid before start of the mission to Uzbekistan.

The rest of the payment shall be made only upon submission of deliverables (70% of fees) and upon submission of trip report and all related documents (20% of DSA).

Please note that, in compliance with national Uzbek laws, no cash will be paid in the country.

XIII. PROCESS OF APPLICATION:

Qualified evaluators interested in the consultancy should submit a proposal with approximate methodological process of evaluation, estimated cost, time line, and curriculum vitae with three references, completed United Nations Personal History Form (P-11 Form) to tshirvanova@unicef.org by 10 July, 2011.

Annex 6: Summary of Evaluation Team Member's Expertise

Lead Evaluator

Tamar Gotsadze MD., PhD - has over 15 years experience in the design and implementation of Health Reforms in developing countries; provision of policy advice to Ministry of Health's top management for the a) development and implementation of national policies and strategies, b) structural and organizational changes of the ministry and reform implementation entities c) design, management, monitoring, and evaluation of health systems at national, regional, district, and rural health facility levels; d) provision of technical support to the government in coordination, planning, development of implementation strategies and action plans of the programs.

Her area of sector specific expertise includes: health financing, Primary Health Care and Hospital Sector reform and facility management, health Insurance, health workforce planning and development, Public health etc. Tamar's professional knowledge is enriched by wide range of country experiences such as Georgia, Azerbaijan, Armenia, Ukraine, Romania, Kirgiz Republic, Kazakhstan, Tajikistan and Namibia. She has worked with WB, UNICEF, WHO, UNFPA, TGF, USAID, USG/DTRA and other International NGOs.

Tamar also has rich experience in project design, management, M&E, development of survey methodologies and analysis. She has completed several assignments related to project/program evaluation, institutional capacity assessments, is a principle author of recently completed three major surveys in Georgia such as survey on "Price, Availability and Affordability of Medicines", "Factors influencing prescription practices" as well as survey on "Corporate Health Insurance Satisfaction".

She also possesses sound knowledge and work experience in health service provision in her role of CEO of Primary Health Care network and insurance operations being a Deputy General Director of Aldagi/BCI responsible for health claims management, provider network management and customer services.

In addition, she has over 4 years of teaching experience at Georgian University being an Associated Faculty, as well as co-author and an instructor for Health Claims Management, Health Underwriting and Managed Health Care training courses at recently established Insurance Professional Education and Consulting Center.

Contact Information: tgotsadze@gmail.com

Co- Evaluators

Maia Makharashvili, MD., MBA – holds MBA from Frankfurt School of Finance and Management (Hospital and Healthcare Management Program), MPA from Georgian Institute of Public Affairs and MD from Tbilisi Medical Institute. Maia has an extensive experience in designing MCH sector reform, evaluation of the quality of perinatal and postnatal services, development of guidelines and treatment protocols, training of service providers in effective perinatal care (EPC), costing of MCH services, design of the MCH human resource development strategy, and conducting clinical audit. In Reproductive Health sector she has worked on RH policy and strategy development; legislation review and development of the legislative amendments; development of the guidelines and design of the guideline implementation processes; designing the message guides for service providers and clients; designing the Monitoring and Evaluation framework and supervised the RH activity implementation.

In quality assessments and M&E Maia's experience extends to development of the quality assessment tools and techniques; design of the service quality assurance strategy; training of providers in clinical audit practices; development of the pilot accreditation standards; design of the accreditation processes and development of the MCH service performance measures metrics; training of providers in performance management; risk identification and planning and implementation of corrective actions.

Contact Information: maiageo@yahoo.com

Chiara Zanetti, MD., DTM&H, MPH, OB&GYN - has spent more than 15 years working in Developing Countries. Her main areas of professional competence are planning, management and monitoring in Maternal, Neonatal and Child Health (MNCH), Accelerated Child Survival and Development (ACSD), Public Health (PH), Maternal Health and Emergency Obstetric Care (EmOC), Nutrition, Emergency Preparedness and Response.

During her professional career, she has been engaged in population and facility based surveys aimed at establishing baseline data and assessment of the health status of the target population as well as its accessibility to health services under routine and emergency conditions. Under five year old children and women in reproductive age were among the main groups targeted by these assessments.

Chiara has also participated to the implementation of a two years academic program (Master of Public Health and Primary Health Care Diploma) developing extensive experience in human resources capacity building, namely: curriculum development, teaching and training facilitation, development of guidelines and protocols, and operational research in public health.

Chiara has worked with International NGOs and UN agencies (WHO and UNICEF) in Africa (Ethiopia and Angola), Middle East (Egypt, West Bank and Gaza Strip), Southeast Asia (The Philippines), and lived in South Asia (India).

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