Final Evaluation Report

"Child Survival and Health Program for Kvemo Kartli and Imereti, Georgia"

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Despite the best efforts of the consultant, ACTS Georgia staff and the CS project, factual errors may appear in the report. They must be considered the responsibility of the principal author, who has tried to grasp a complex environment in a very short time.

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A. List of Acronyms

AAFP	American Acad. of Family Physicians
ACTS	A Call to Serve
ALSO	Advanced Life Support Obstetrics
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavioral Communication Change
BF	Breast Feeding
BFH	Baby-Friendly Hospital
CDEM	Center for Disaster and Emergency Medicine
CIF	Curatio International Foundation
CMO	Chief Medical Officer
CORE	The Child Survival Collaborations and Resources Group
CS	Child Survival
CSP	Child Survival Program
CSHGP	Child Survival Health Grant Program
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
DOSA	Discussion-Oriented Self- Assessment
ECD	Early Child Development
EOP	End of Project
EU	European Union
FE	Facility Assessment
FGD	Focus Group Discussion
FP	Family Planning
GAIN	Global Alliance For Improved Nutrtion
GMA	Georgian Medical Association
GNMC	Gudharshi National Medical Center
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rates
JSI T&R	John Snow Inc. – Training and Research Institute
KPC	Knowledge, Practice, Coverage
LOE	Level of Effort
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MFA	Maternity Facility Assessment
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Measles, Mumps and Rubella
MMSG	Mother-to-Mother Support Groups
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MoLHSA	Georgia Ministry of Labor, Health and Social Affairs
MP	Medical Personnel
NCDC	National Center for Disease Control
NCDC	National Communicable Disease Center
NGO	Non-Governmental Organization
OB/GYN	Obstetrics/Gynecology
ORS	Oral Re-hydration Salt
ORT	Oral Re-hydration Therapy
PHR	Partners for Health Reform
PVO	Private Voluntary Organization
RH	Reproductive Health
RV	Reaction of Vasserman
SDS	State Department of Statistics
SO	Strategic Objectives
SPSS	Statistical Package for the Social Sciences
STI	Sexually-transmitted Infection
TRM	Technical Reference Materials
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VRF	Vishnevskaya-Rostropovich Foundation
WRA	Women of Reproductive Age
WHO	World Health Organization

B. Executive Summary

1. Brief description of the project and its goals and objectives

A Call to Serve (ACTS) International and its affiliate, ACTS Georgia are completing implementation of a five-year Child Survival Program (CSP). This is the first CSP in Georgia and the project targets 37,648 children less than five years and 144,648 women of reproductive age in the Kvemo Kartli region and in cities of Chiatura and Zestaphoni in Imereti region. The goal of the "Child Survival and Health Program for Kvemo Kartli and Imereti, Georgia" is to reduce maternal, neonatal infant and child morbidity and mortality. The goal is being achieved through three principal objectives:

1. Improved quality of maternal and child health services.
2. Improved behavior and maternal and child health practices within households, the community and among health care professionals and health managers.
3. Increased availability of M/C health care services and increased access to adequate standard case management.

2. Main Accomplishments of the Project

ACTS has implemented the first successful health program in Kvemo Kartli region. ACTS selected Kvemo Kartli at the request of the USAID Georgia Mission. The CSP targets 144,648 women of childbearing age and 37,995 children under five, for a total beneficiary population of 182,644. Individual- and community-level interventions were conducted in focus areas, targeting underserved minority populations. In focus areas, ACTS worked with 9 maternity facilities, 10 polyclinics and 60 ambulatories across 63 sub-districts in two regions (Kvemo Kartli and 2 cities of Imereti). The CSP worked in close collaboration with the Georgian Parliament, Department of Public Health and MoLHSA. As a result, successful legislations have been passed that have had positive impact on improving health in these regions. A diverse and broad-based stakeholder network at national, regional and local levels has been developed. Physicians have been trained in IMCI, breastfeeding and WHO Baby-Friendly hospital standards and Rustavi has become the first Baby-Friendly certified hospital in the area. Social inequality for women in Kvemo Kartli is less of a barrier due to FGDs and other innovative approaches used to engage young mothers.

Overall Progress Made in Achieving Project Objectives: ACTS made significant progress in reducing maternal, infant and child mortality through community programs and behavior change interventions. The CSP successfully reached underserved and isolated communities and garnered a high level of community support, as evidenced by the final KPC survey results. There have been significant increases in exclusive breastfeeding (16 %-79 %), infants that are immediately breastfed after birth (40%-70%) and percentage of children under 2 years old offered more fluids during illness (56%–88%). Fifty percent of hospitals have been designated as "baby-friendly." The KPC shows significant improvements (80 to 100%) in management of ARI and diarrhea using IMCI protocols. During the five year program, ACTS provided first line antibiotics for the treatment of children's ARI and pneumonia.

Main Constraints, Barriers and Challenges: The invasion of Georgia by Russia in August 2008 closed off transport to the Kvemo Kartli region and stopped project activity for several months. Transportation was a barrier that limits access to care. Women have traditionally

been hard to reach due to social inequality and cultural restrictions. Lack of sufficient mortality tracking data in rural and remote regions is a challenge.

Capacity-Building Effects of the Project: Health worker performance, knowledge and skills increased as a result of project interventions. ACTS provided training in BFH to the regional Maternity Hospital in Rustavi, the center of Kvemo Kartli region. ACTS also provided training to the primary health facilities in breastfeeding and IMCI to improve access and quality of health services.

Lessons Learned: The most important lesson learned has been the impact of active involved populations in health interventions whose cultural, language, social and religious traditions have isolated them for generations.

Sustainability: Having engaged a broad network of representative stakeholders from every facet of the community will have a positive effect on long-term sustainability and continued activity, as will the creation of an educational climate for young women that is engaging and helpful, while respecting cultural values. ACTS progress in both arenas has been notable.

Table 1: Summary of Major Project Accomplishments

1. Improved quality of M/C survival services.
2. Improved behavior and maternal and child health practices within households, the community and among health care professionals and health managers.
3. Increased availability of M/C health care services and increased access to adequate standard case management.

Inputs	Activities	Outputs	Outcome	Goal
IEC and BCC Materials development Training mothers of children U5 and women of reproductive health (Monitoring and supervision Refresher meetings)	Launching community sessions Conduction of Healthy Moms for Healthy Kids Festivals Media coverage	2449 mothers of children U5 and women of reproductive health trained Two festivals, total number of participants around 3,700 10 local TV spots 100 health professionals trained	Improved knowledge of prenatal, newborn and U5 children care Increased coverage of population and increased participatory activities of the major stakeholders and target population Increased awareness of the CS project activities and increased coverage of population	Reduce mortality rates for children under 5
Development of training materials and booklets Training of the regional and district health staff at regional and district health system Monitoring and supervision Follow-up sessions	Launching training of medical personnel of Maternity Hospital and pediatric outpatient clinics in Rustavi in IMCI, BFHI, BF Conduction of follow-up visits every 5 months	257 medical professionals trained (120 pediatricians at the outpatient clinics – IMCI; 137 members of regional Maternity Hospital – BFHI	Increased maternal and newborn health knowledge, capacity building of the local medical staff)	Reduce mortality rates for children under 5

C. Assessment of Results and Impact of the Project

1. RESULTS: TECHNICAL APPROACH

a. Brief Overview of Project

The goal of the "Child Survival and Health Program for Kvemo Kartli and Imereti, Georgia" is to reduce maternal, neonatal infant and child morbidity and mortality in the Kvemo Kartli region and in the cities of Chiatura and Zestaphoni in the Imereti region. The total population of the target area is 535,546. This CSP has aimed to reach three of Georgia's most vulnerable health groups –mothers, infants and children under five years of age within the country's two most economically depressed areas. This CS Project targets approximately 37,648 children less than five years of age and 144,648 women of reproductive age (15 to 49 years)**.**

The program goal is being achieved through three principal health objectives:

1. Improved quality of maternal and child survival services.
2. Improved maternal and child health care behavior and practices within households, the community and among health care professionals and health managers.
3. Increased availability of M/C health care services and increased access to adequate standard case management.

The interventions include: Maternal and Newborn Care (MNC) 25%, Breastfeeding Promotion (20%), Nutrition (15%), Case Management of Diarrhea (25%) and Case Management of Pneumonia (15%), with the latter two combined into one intervention area: Management of ARI/Pneumonia and Diarrhea (40%). Three crosscutting strategies are being used to achieve the program objectives: (1) Behavior Change Communication (BCC) approaches; (2) Institutional Capacity Building; and (3) Partnership Development for Social Mobilization. Integrated Management of Childhood Illness (IMCI) is applied in the delivery of childcare services.

Local partners include:

- *A Call to Serve-Georgia (ACTS-Georgia),* affiliate of ACTS International, is the Grantee and key partner for planning, coordinating, monitoring and evaluating all field activities and interventions, in consultation with the ACTS headquarters office.
- *The Ministry of Labor, Health and Social Affairs of Georgia (MoLHSA)* is the key government partner that works with ACTS International and ACTS Georgia on a national level to assist with coordination and management of the project.

Contributing partners include:

- *Claritas XXI* assisted in implementing program strategies, by organizing IMCI training in the two project regions through a network of trained providers key to child survival.
- *Vishnevskaya-Rostropovich Foundation (VRF)* assisted the project by identifying community leaders and facilitating mobile teams to ensure immunization coverage for the region. VRF also collaborates with ACTS in conducting joint community training.

- *Government of Georgia (GOG) is the main ACTS stakeholder.* Government administrative bodies at the regional and local level have been involved in the process of community mobilization, playing a critical role in the development of networks on the local level. The long-term sustainability of the CSP depends on the MoLHSA and public health department adoption of the CS strategies piloted in ACTS CSP Kvemo Kartli to be piloted nationwide. Active participation in the pilot has been a learning experience for ACTS, the GOG and the national Georgian Fortification Program.

b. Summary M&E Table

Included on the following pages.

SUMMARY M & E WITH EXPLANATION OR REFERENCE						
Objectives	**Indicators**	**Baseline Estimate**	**Final Estimate**	**Final Target**	**Confidence Intervals**	**Explanation or Reference**
Improve Perinatal services and maternal and newborn care	% of mothers who know at least 4 danger signs of pregnancy	8%	28.1%	30%	±4.5	Achieved
	% of mothers able to report at least two neonatal danger signs	14.7%	64.2%	55%		Achieved
	Infants <6 months of age that were exclusively breastfed in the last 24 hours	16.1%	49.4%	50%		Achieved
	% of children 0-22 month of age placed with the mother immediately after birth	5%	52.5%	30%		Achieved
Improved breastfeeding practice and nutritional status of children	% of infants aged 0-5 months who were fed breast milk only in the last 24 hours	16.1%	79.7%	50%		Achieved
	% of children receiving breast milk up to 23 months	37.2%	47.2%	60%	±5.5	Not achieved. The FGD indicated, that though mothers are well aware of the benefits of breastfeeding up to 23 months of age, they prefer to return to their work because that is "economically feasible"
	% of children who were breastfed within the first hour after birth	39.5%	69.7%	85%	±6.2	Not achieved. There is inertia among the medical personnel especially in rural HF, which are still sticking to the Soviet standards even though they have been trained about breastfeeding. It seems ACTS was too optimistic when setting 85% target. However 30% increase demonstrates that the tendency is changing in a positive direction,

SUMMARY M & E WITH EXPLANATION OR REFERENCE						
Objectives	**Indicators**	**Baseline Estimate**	**Final Estimate**	**Final Target**	**Confidence Intervals**	**Explanation or Reference**
Continued: Improved breastfeeding practice and nutritional status of children	% of pregnant women and mothers who received breastfeeding counseling during antenatal car	47.2%	78.3%	85%	±6.4	Achieved.
	% of health facilities designated Baby Friendly	0%	50%	50%		Achieved
Improved feeding practices for improving child nutrition and child growth	% of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours	41.7%	55%%	85%	±5.8	Not achieved. Another indicator showed knowledge of mothers about complementary feeding was 85%. The FGD indicated that the majority of mothers preferred to breast feed for 6-7 months then put the baby on solid food and return to work to earn money for her family
	% of mothers who knew correct complementary feeding practices	40%	97.5%	85%		Achieved
	% of households who know how to use and store iodized salt	0%	61.1%	65%	±6.0	Achieved
Continued: Improved feeding practices foe improving child nutrition and child growth	% of medical staff assessing growth using growth chart during a child's sick visit	0%	36%	60%	±5.0	Not achieved (data were obtained from follow-up visits). The majority of doctors insisted that they were experienced enough to assess the child's growth through visual exam.
	% of medical staff who were asked and explained proper complimentary feeding practices	40%		85%		
	% of health facilities where correct nutritional counseling is implemented	0%		50%		

SUMMARY M & E WITH EXPLANATION OR REFERENCE						
Objectives	**Indicators**	**Baseline Estimate**	**Final Estimate**	**Final Target**	**Confidence Intervals**	**Explanation or Reference**
Improved management of ARI/Pneumonia and diarrhea utilizing IMCI protocol	% of children 0-23 months with diarrhea in the last 2 weeks who were offered more fluids during the illness	56.3%	88.1%	85%		Achieved
	% of mothers who know at least two danger signs of childhood illnesses that indicate the need of referral to health care services	64.2%	85.3%	85%		Achieved
	% of children aged 0-23 months with diarrhea in the last two weeks who were offered catch-up feeding	35%	77.4%	85%	±6.4	Not achieved. The FGD discussion demonstrated the need to increase education efforts but unfortunately the war actions of August, 2008 significantly decreased accessibility of the certain districts of the region for several months. The statistically significant 42.4% increase (35% to 77.4%) is a remarkable achievement given that with the decreased accessibility the ACTS team had immediately following the 2008 war. This Child Survival program is the first ever to be implemented in Georgia. This final target set in 2003 may have been extremely optimistic.
Continued: Improved management of ARI/Pneumonia and diarrhea utilizing IMCI protocol	% of children who were examined for four common danger signs by HF staff	15%	90%	80%		Achieved (Data from R-HFA survey)

SUMMARY M & E WITH EXPLANATION OR REFERENCE						
Objectives	**Indicators**	**Baseline Estimate**	**Final Estimate**	**Final Target**	**Confidence Intervals**	**Explanation or Reference**
	% of health care providers who assessed for frequent breathing during sick child consultation for children U5 years of age	3.8%	80%	30%		Achieved (R-HFA survey)
	% of health care providers who assessed for chest retractions during sick child consultation for children U5 years of age	3.8%	80%	30%		Achieved (R-HFA survey)
	% of health care providers who properly classified dehydration degree during sick child consultation for children U5 years of age	3.8%	100%	30%		Achieved (R-HFA survey)
	% of PHCF that have ORT Corner	0%	100%	50%		Achieved (R-HFA survey)
	% of PHCF that have IEC-counseling materials on IMCI	20%	100%	100%		Achieved (R-HFA survey)
	% of health facilities that have essential drugs and medicines to deliver IMCI services	0%	100%	80%		Achieved
	% of Health Centers with improved performance on correct diagnosis and treatment according to IMCI protocol for sick child consultation for children U5 years of age	13%	100%	80%		Achieved (Data from R-HFA survey)

Constraints

Constraints and Barriers with the GOG included absence of national standard guidelines and case management protocols; hence, maternal and neonatal care is not performed to a uniform standard. Physician training and assessments are provided through bilateral funding by NGOs, resulting in multiple trainings that vary in results. Physicians hold many certificates yet still are unable to implement standard core practices. Physician salaries are low and often not paid on time. The results of on-going health sector reform makes it difficult for the Government to set aside full funding to cover public health costs, while transitioning from public service to a combined private and public health care system. Greater coordination of efforts among bilateral and international PVO Programs needs to be addressed. As Georgia moves forward in developing its health system, the number of domestic and foreign collaborators working in the country has increased. This has required greater organizational collaboration between all agencies working in a region. Often bilateral development agencies (U.S., Swiss, Sweden, Japan, Britain) work on related, but uncoordinated programs, putting strain on regional officials who are required to provide the assistance. Since 1992, ACTS has been a leader in cooperation meetings. The ACTS GAIN program is an example of one nationwide program being implemented quickly and cost-effectively.

The nature of behavior change interventions makes an "evidence-based" approach difficult to track. The CSP needs to adopt modifications to improve BCI measurement and provide FGDs, based on tangible feedback; and modify training sessions at the community level. There are limited evidence-based practices in place (e.g., partographs used just 9% of the time).

The Maternity Facility Assessment (MFA) conducted by ACTS during the first half of the project at six Kvemo Kartli maternity facilities (refer to MTE attachments) documents the need for essential neonatal resuscitation equipment. Respiratory problems are the leading cause of neonatal death. These findings were supported by a general national, MICS, survey in 2005 by UNICEF. In both surveys all hospitals surveyed lacked necessary neonatal resuscitation equipment. The study found that healthy term babies die each year due to cold (lack of baby warmers) in the delivery suite. After the mid-term evaluation the project made use of the CSTS software and manual for HF Assessments and was conducting the final HFA at the time of the FE. Unfortunately the final results and analysis were not available at the time of the FE evaluation, though some of the results were available later and noted for the summary M and E table as indicated below. The HFA results are more relevant to project activities dealing with mothers and children under 5, as they focus on the outpatient ambulatories and clinics instead of the maternity hospitals.

Programmatic issues included a general lack of awareness about community health prevention and education needs in the health system. The project identified a need to involve public health system staff in prevention activities both at the clinics and in the communities. Under the Soviet health system all care was facility based so health workers were not aware of community and prevention related techniques. There were also a number of issues identified in trying to convince women to meet together in the communities for education, particularly in the Azeri communities where women customarily do not leave the household. In addition, the Azeri women tended to

seek care across the border in Azerbaijan where care was more accessible, rather than at the health centers in Georgia.

c. Progress Report by Intervention Area

Project progress in the four intervention areas was measured through a KPC instrument administered at the baseline and at the final evaluation. Results are indicated in the table above. At the mid-term and during the project, progress was monitored through an LQAS survey (see midterm report for details).

ACTS has made significant progress toward reducing maternal, infant and child mortality as documented by the KPC survey. They met or surpassed many of their targets and of those not achieved, many were close to the planned target. There were several difficulties in meeting the desired targets and in implementing the project. One had to do with the invasion of Georgia by Russia in 2008, which stopped project activity for several months. It caused the main roads to be closed and travel to the districts to be restricted. In addition, there were a large number of internally displaced persons (IDPs) who had to be housed and treated for problems, which took up MOH personnel time. Another issue was that due to weakening of the dollar, there was a shortfall of funding, which led to cutbacks in personnel. This is discussed in the management section of this report. During the last half of the project only the Child Survival Project Manager and her assistant conducted the community education and training with assistance from volunteers when available.

As can be seen from the above Summary M and E table, knowledge and practice of maternal and newborn care improved significantly during the project period. Of note was the dramatic increase in exclusive breastfeeding among project participants (going from 16% to 50%). Though there was improvement in breastfeeding up to 23 months (from 37% to 47%) and among infants breastfed within the first hour of birth (40% to 70%), the project did not reach its targets. It may be that some of the targets were set too high, given the circumstances in Georgia. Part of the problem with newborn breastfeeding is that rural health personnel, despite training, are reluctant to change Soviet standards of bottle-feeding. This indicates that more follow-up training with HF personnel is needed. Physicians did not always counsel mothers about breastfeeding during prenatal visits, though there was a definite increase in the percent of women who where counseled (increase from 47% to 78%). In addition, the project achieved its objective of having 50 percent of hospitals qualifying as “baby-friendly.”

Although it did not reach its target of 85%, the percentage of pregnant women who were counseled on breastfeeding increased significantly from 47 to 78 percent. This points to success of training and follow-up with Kvemo Kartli health facility staffs. It seems project staff had a harder time convincing mothers to introduce solid foods at 6 months despite the fact that 98 percent of mothers knew the correct complementary feeding practices. When asked about these mothers stated that they preferred to continue breastfeeding only for economic reasons. Though not reaching the 65% target, 61% of households knew how to use and store iodized salt compared to 0% at baseline.

The project had difficulty convincing health facility staff to use growth charts for monitoring child development, stating they preferred to assess visually. It appears the practitioners also did not counsel mothers about nutrition and complementary feeding, pointing to a need for further follow-up training of health professionals.

The project met or surpassed most of its targets for improving IMCI management of pneumonia and diarrhea. Children were offered more fluids during diarrhea episodes, mothers recognized at least 2 danger signs indicating a need to go to the health centers and 90 percent of children were examined for danger signs in the facilities. Also practitioners checked for frequent breathing and chest retractions during consultations for ARI. Practitioners also properly classified dehydration. Also according to preliminary HFA results, a 100 percent of facilities had ORT corners, IEC counseling materials and were adequately stocked with essential drugs for IMCI related services. According to the preliminary HFA results, all centers had improved their sick child consultation practice.

In summary, despite tremendous difficulties and limitations of resources, the CS project was able to make substantial gains in a region that according to government and USAID sources, has been traditionally difficult to work in. If additional resources were to become available, it would be useful to not only reinforce professional and community education in the Kvemo Kartli area but also consider expanding the model to other areas. ACTS success in applying its community mobilization strategies in another region for the government's immunization activities is evidence of this.

d. New Tools or Approaches

Among the successful innovation techniques developed to engage people and build trust for the CSP in the targeted regions was the building of a broad-based stakeholder network. Although this strategy is not new to CS projects, this inclusive technique was innovative for Georgia. It is broad-based and includes both community leaders and religious leaders whom the community knows and trusts. Focus Group Discussion (FGD) was used, as a method for qualitative monitoring as well as education and it is a new skill that the ACTS team has gained during this CSP. FGD are new to the young women and grandmothers in Kvemo Kartli, a historically isolated area where women have never before participated outside the home in such activities. Also new to Georgia was the involvement of the MOH and public health departments in the community-based training which was critical to program success. Community festivals held in Bolnisi and Dmanisi that disseminated MCH messages were the first festivals offered since the fall of communism in 1991. The events included dances, songs, sports competitions, award ceremony and traditional foods. Participants were diverse and included several different ethnic groups. The project was asked to conduct other festivals in Tetrai Tskaro and Rustavi but did not have the resources and materials to do more of them. Three health fairs were held in Kvemo Kartli, with Georgian military health units and the U.S. Military training and equipment health unit providing medical staff, equipment and medical testing equipment. Incentives helped to recruit participants to events and activities. Forms and posters were translated into the Azeri language; and health care professionals served as interpreters to overcome language barriers.

In order to better monitor activities, the project also conducted exit interviews at the clinics to determine why the patients were coming to the doctor and if they were coming more frequently now. Some said they learned of the services through television and radio or friends but about 10 to 15 percent said they went because of what they had learned from project related activities.

Other new activities indirectly related to project activities is the work that ACTS has done in the area of salt iodization. In 2000 at the request of health providers in Kutaisi, which is a sister city of Columbus (where ACTS is based), ACTS conducted a thyroid study of secondary school children and discovered marked deficiencies. As a result the Columbia community sent 120,000 boxes of iodized salt to Kutaisi (enough for 5 years). ACTS repacked the salt in annual household portions. Now ACTS imports salt from Austria; then through the government, the salt is distributed to women of reproductive age and children. Also ACTS spearheaded a universal salt iodization law requiring that all imported salt to be iodized.

2. Results: Family Planning – N/A

3. Results: TB – N/A

4. Cross-cutting Approaches

(a) Community Mobilization

Successes and Lessons Learned:

According to interviews and reports, the biggest impact of the project appears to have been made through the community education activities. This includes meetings with women's groups assisted by health facility staff. The project conducted roughly 10 educational visits per month in the 9 project districts. One PowerPoint curricula was used and repeated at each session. After presentation, there would be question and answer sessions with discussion. Other mobilization activities include the Health Fairs and the health festivals held by the project in Bolnisi and Dmanisi. These festivals were a good opportunity to build preventive health awareness among the populations in these areas. They were well attended and supported by schools, local politicians, local businesses and the municipalities.

Community mobilization activities have empowered women through what the project calls focus group discussions (FGDs) and education sessions. The project implemented focus groups during the initial part of the project to elicit behavioral practice information. Because they found it to be a useful tool, they continued having discussion groups as a regular part of its community education program. The discussion groups have encouraged women to use healthcare services during pregnancy, childbirth and the postpartum period. This is a government priority and although other areas of Georgia have high rates of hospital births, the Kvemo Kartli area had not. During interviews, local practitioners reported that as a result of the community education activities, hospital deliveries have increased, as has exclusive breastfeeding. These reports have been confirmed by the KPC

findings. Discussion groups have served as a medium for identifying barriers that prevent pregnant women and mothers from seeking care, such as transportation, cost factors and cultural preferences. They have also served as a means for educating participants about how normal deliveries and obstetric emergencies are managed at the health facilities. The meetings provided an opportunity for promotion of behavior change strategies to prevent maternal and child health problems through early recognition of warning signs, followed by referrals to health facilities for treatment. Information gathered from these sessions was synthesized and later used by ACTS to advise the government on how to implement quality assurance systems and partnership agreements between health and referral facilities, government, NGOs, international PVOs and donors.

The KPC findings and FE interviews indicate that community response in these hard to reach areas has been positive. The health facility personnel report that increased numbers of mothers attend four or more ANC visits as well as actively participating in the FGDs. Program activities were regularly monitored and modified based on LQAS monitoring and FGD findings. The MTE mentioned an interest in developing men's groups but unfortunately ACTS was unable to embark on this area due to budget constraints (foreign exchange difficulties) and the 2008 war, which distracted the population from project activities for several months.

As a testament to ACTS strengths in community mobilization, in the fall of 2008, ACTS was asked by UNICEF (who had support from the Rostopovich Foundation) to collaborate along with other NGOs in a measles and rubella immunization campaign. ACTS was asked to cover a neighboring region, Samtskhe- Javakheti, which is primarily Armenian speaking and achieved 90 percent coverage. The ACTS methodology consisted of applying the same stakeholder based strategy used in the CS project of using local representatives from the district health department, district education, journalists, public health directors and epidemiologists to assist in mobilization activities and meetings. Meetings were held in each Sacrebulo (adminstration of 5 villages). They selected schools as meeting places between stakeholders and communities as teachers and doctors have influence and engender trust. As a result of these meetings, most of the regional population participated in the measles campaign and achieved the highest level of coverage (90%) of all regions.

Constraints/Barriers Identified:

The main barriers that the CSP staff have encountered in efforts to educate women in these communities include cultural restrictions and inability to reach household decision makers. In response, ACTS held focus group discussions (FGDs) with community women. Over time, this forum expanded to include women of reproductive age and interested family members. The FGD topics have included pregnancy, gestation, health and wellness, ANC, importance of hospital deliveries, infant feeding and care. Three Power Point presentations were used to instruct the groups. The first one shows intrauterine fetal development and pregnancy care with case studies. The two others are entitled "Five Recommendations for Pregnant Moms" and "Nine Recommendations for Mothers of Children under-five." The membership has been expanded to include Mother-to-Mother Support Groups and Female Family Member Discussion Groups. The FE team

monitored several of these presentations and found them to be creative and informative, with active involvement of participants. The local health facility staffs have also become involved in the sessions providing instruction and answering questions. This involvement has encouraged participants to be more open to attending health facilities for preventive services and deliveries.

As noted above, the government and other organizations such as UNICEF are recognizing the community mobilization skills implemented by ACTS. Even though the CS project is ending, ACTS is committed to Georgia and will try to continue its activities in the region. However, ACTS will need additional support if it is to continue CS activities at the community level.

(b) Communication for Behavior Change

Successes and Lessons Learned:

Much of the project's activities have been directed to behavior change of families, community leaders, political officials and health care staff by increasing awareness of preventive health behaviors and practices in recognizing pregnancy and infant care related warning signs and when to seek treatment. Community leaders have also received training in community IMCI including aspects of prevention and care as part of the BCC approach. Mothers and grandmothers are also encouraged to attend education sessions.

BCC strategies and activities have grown during the life of the CSP. Education messages have focused on the need to increase immediate registration of new births, the number of ANC visits per pregnancy, immunizations, facility deliveries and visits for illness. Having expanded the areas for birth registration to churches and encouraged the development of a voucher program, which rewards mothers for attending four ANC visits and delivery at a healthcare facility free of charge, contributed to meeting BCC goals.

In community education sessions, the use of immunization cards was encouraged, as well as open discussion of home deliveries. By addressing the subject of home births and scheduling visits for pregnant mothers to view birthing areas at hospitals, community members began to feel more comfortable with health facility services. The challenge has been convincing community members of the benefits of delivery in a healthcare facility without interfering with traditional beliefs and cultural practices.

Education sessions regarding home deliveries also focus on standardizing a list of recommended supplies to have available for a home delivery "birthing kit". Mothers are also being taught to recognize danger signs for childhood illness and encouraged to visit healthcare facilities in a manner that respects tradition and culture. These education sessions are also targeting men, since they influence decisions made on behalf of children and family members.

As can be found in the Annex 11.2, ACTS has held numerous focus group discussions or community education sessions with mothers of children under 5.

As a result of BCC interventions, comparisons between the baseline and the FE indicate several improvements in behavior that were identified in the 2007 baseline survey and Maternity Facility assessment. The surveys found negative attitudes and opinions related to local physicians and hospitals, concerns surrounding the use of vaccines and practice of breastfeeding. This process of focus group discussion, assessment of results and modification of future community sessions became a standard methodology for educating communities. In accord with BCC strategies, emphasis was directed at a clearer presentation of why choices in behavior have better or worse outcomes.

One of the main objectives shared by all stakeholders was the introduction of community IMCI as a mechanism for increasing community knowledge of child health and safe motherhood, as well as building bridges between health professionals and community members through improved communication. Local government officials value the community work provided by ACTS. Their frequent participation in ACTS training sessions and other events as well as the fact that local government officials provide facilities for community education sessions without charge demonstrates their active support. To enhance the working relationship with stakeholders, ACTS asks them to review information provided and includes community representatives in this review process. In addition, stakeholders are provided with a work plan of activities and invited to participate with ACTS in monitoring the plan. The stakeholders are supplied with a list of training activities and results from the baseline KPC. Annual LQAS results have been in use for monitoring program activity and included in both annual reports. ACTS CSP staff received LQAS training on-line, through the Johns Hopkins University outreach-training program in conjunction with CSTS.

Primarily, the CSP engages mothers, mothers-in-law and pregnant women in-group and individual education sessions based on concerns generated through the LQAS monitoring surveys, the DIP, KPC and issues raised during community focus group sessions. As the CSP education program was implemented, additional needs for information and counseling were identified and added to the curriculum. The Community-based focus is based on modified UNICEF IMCI training and CSTS components of empowerment.

One of the innovative activities that the ACTS CSP Team initiated is the “Healthy Moms for Healthy Kids” festivals which were conducted in Dmanisi and Bolnisi. They were described in the media as covering about 10 percent of the populations in the two sites. Participants learned about improved health practices and behaviors based on themes of nutrition and health. The ACTS Team organized the festivals in collaboration with USAID, World Vision, Alliance for Improved Nutrition of Georgia(GAIN), Tbilisi Lions Club and the Dmanisi and Bolnisi municipalities. Stakeholders included high school students and teachers. All contests and skits focused on CS messages and were prepared with active participation of the local Public Health centers, schoolteachers and upper level students. The festivals also were a venue for distribution of educational pamphlets developed by ACTS. The festivals also received extensive media coverage by local TV and radio stations, which allowed them to significantly increase the audience. Four additional health fairs were conducted in collaboration with the US military. During these fairs, free examinations and health screenings were provided and healthy behavior

sessions were conducted. About 10,000 inhabitants of the four villages were covered through screenings and educational messages. Unfortunately due to the war and changes in the US military policy, these approaches were not continued during the second half of the project.

The CSP staff regularly analyzes focus group data to determine breastfeeding attitudes and practice and barriers to other healthy behaviors that can be addressed through education sessions and motivational techniques. Concerns raised during the FGDs have been used to determine knowledge gaps on breastfeeding and to gather information about factors that influence women's decisions regarding breastfeeding and child health. As can be seen from KPC results, the project has had success in increasing exclusive breastfeeding.

ACTS successful competed for the Global Alliance for Improved Nutrition (GAIN) flour fortification award Georgia become only the 18th country in the world to receive this award three year $1.5 million award to provide technical assistance to the milling professionals to develop and implement the first fortification of flour with any additive. The ACTS GAIN program for Georgia focused on the 18 largest flourmills in Georgia. Each milling over 100 tons of flour a day. As this program draws to a successful close, the procedure for adding iron and folic acid premix, the food grade equipment has been designed, manufactured, installed and monitored through on site laboratories have been completed. ACTS set up at each mills an independent reference laboratory where assays will be performed regularly. During this three years implementation program ACTS demonstrated the reliable iron and folic acid enrichment was possible, educated the Georgian people about the benefits of iron and folic acid fortification and is now engage with the health committee of the parliament in passing legislation to permanently ensure all flour milled in Georgia is fortified with iron and folic acid. The benefit to the Georgia women and children will be documented in future years by improved health and will aid Georgia on this road to meeting the 2015 millennium development goals number 3 and 4. The expected July 2010 passage of the Georgian law on flour fortification was delayed due to political opposition activities, which completely shut down all parliament activities July - November 2009. ACTS has taken the lead in iron and folic acid enrichment of flour in Georgia through the GAIN project (discussed below).

The MTE noted that there was a pervasive problem with helminthes in children under 5 throughout the project areas. Unfortunately funding has not been available for ACTS and MoLHSA to conduct a survey of the situation. ACTS however, has succeeded in convincing the Georgian CDC to include worm prevention along with hand and vegetable washing as part of training for new public health staff. ACTS also incorporated information about helminthes in its education sessions provided to mothers and pregnant women.

(c) Capacity Building Approach

At the professional level, during the course of the project, ACTS has supported IMCI training in Rustavi at the Polyclinics. A total of 120 pediatricians were trained at two regional outpatient polyclinics and 160 Maternity Hospital personnel obtained knowledge

and skills in IMCI and BFHI. Breastfeeding was added to the IMCI curriculum to stress its importance and encourage health professionals to advocate for BF when treating patients. The clinic based IMCI course is designed to help health workers acquire new skills to manage sick children more effectively. Health workers sometimes find it difficult to begin using these skills when they return to their home health facilities. Often they need help in applying what they have learned during the course to their regular work environment. Follow-up visits by IMCI trainers are an essential component of the IMCI training process. The follow-up visit is designed to support the transfer, application and reinforcement of new skills acquired during training. At least one follow-up visit was conducted for all participants within four-to-six weeks of the training course in order to assist health workers and health facilities with the transition to integrated case management. Objectives of the follow-up visits were: (1) Improvement in accepted clinical skills of the trained medical staff; (2) Identification of the problems faced by medical staff; (3) Analysis of the results and improvement in implementation of the program; and (4) Assessment of essential equipment available.

During the follow-up visits, a trainer/ supervisor can assist health workers to apply their recently acquired knowledge and skills and overcome workplace challenges. Follow-up methods include supervising medical staff during patient visits, reviewing medical records and patient charts maintained by medical staff, questioning caregivers after their visits and practice skills learned if there is time. Follow-up observations are recorded on special forms developed by WHO that are later used to summarize information on two final reporting forms. The ACTS supported IMCI course in Rustavi was conducted in 2006, the follow-up conducted between November 6th and 15th of that year. During the follow-up visit, benefits of the IMCI program identified by the doctors included:

- Easy to understand and use;
- Provides precise diagnoses;
- Details are foreseen by the program;
- Refers patients to hospitals when necessary;
- Reduces the necessity of therapy with antibiotics that are not approved;
- Reduces the frequency of complications and hospitalization;
- Important for children survival; and
- It's economical both for population and state.

During interviews at the time of the FE, the polyclinic staff commented that although not all recommended procedures were adopted, it was evident that the medical staff had learned new skills for managing childhood illnesses such as diarrhea and pneumonia. They also commented that the quality of trust between doctors and patients had improved significantly. This was evidenced by a big increase in office visits. Most importantly, they noted that the medical staff now understands how to communicate effectively with parents. In addition, parents are now taking a more active role in their children's care and recognize the contribution of breastfeeding for their children's health. As the project has continued, there is more and more evidence that mothers are aware of pregnancy danger signs and childhood illness. At baseline the mothers did not know about danger signs but now the final survey shows that most are aware of danger signs and symptoms. The encouragement and increase of regular prenatal visits by expectant mothers has exposed

them to education about breastfeeding early in their pregnancy and thus increased the likelihood of adoption. Both the polyclinic and the maternity hospital are "baby-friendly" with the staff understanding the health benefits of breastfeeding. Formula use is not advertised or encouraged.

According to interviews, the staff at the baby-friendly Maternity Hospital is very supportive of breastfeeding. They commented about the changes in the patients. The parents are more educated and there has been a significant increase in the number of breastfeeding mothers. Post partum hemorrhage has decreased, which has been the main cause of maternal mortality. There is concern about the need for on-going motivation of staff to work towards maintenance of baby-friendly status. They noted the staff needs to hear repeated messages. Updates are important. They also commented that it is easier for the Georgians to understand these messages than the Azeris, who tend to be more traditional and less accepting of new practices.

ACTS conducted a facility assessment together with the Public Health School in Tbilisi using students as volunteer interviewers. This was done at facilities in Bolnisi and Dmanisi at the beginning of the project. Though it was not the kind of HFA usually conducted by CS projects, they mainly reviewed the management of the facilities. The purpose was to better understand how to strengthen the links between the facilities and the local communities. During the second year, ACTS brought in neonatologists from the University of Missouri to review the status of equipment inventories and training of neonatology care at the clinical facilities. Their findings formed part of the project objective to improve neonatal care capacity. ACTS replaced equipment and other lifesaving essentials with the support of a grant from the US State Department. They planned to use the CSTS HFA tool for the final assessment. However that had not been done at the time of the final evaluation so could not be compared (though some data was available for the report).

As part of its sustainability strategy, ACTS provided training in BFH to the regional Maternity Hospital in Rustavi, the center of Kvemo Kartli region. At the same time ACTS provided training to the primary health facilities in breastfeeding and IMCI (discussed above) to improve access and quality of health services.

Capacity building of partners in the area of management:
One of the capacity building areas that the CS project has focused on includes strengthening/ updating partner management practices such as teamwork, delegation of authority, internal options and autonomy. These skills improve day-to-day functioning of the organization. The partners are local NGOs: Tanadgoma, Claritas XXI and MOH primary care facilities. Efforts focused on developing a team approach, setting mutual goals and sharing lessons learned through joint efforts for achieving project objectives. For example, Tanadgoma has been trained in community mobilization skills. In addition, links between the Tanadgoma NGO and local primary care facilities have been established, which allowed them to develop joint community mobilization strategies including involvement of community members into interactive activities such as organizing and conducting community education sessions, focus group discussions and

organization of the "Healthy Moms for Health Kids" Festivals with participation from major stakeholders and the target population. "Claritas XXI" apart from providing training for medical personnel (IMCI, BFHI) jointly with ACTS Georgia and consultants from local primary health care facilities, developed and published a booklet from the series of "Young Moms' Library" and "Taking Care of Pregnancy, Newborns and Children U5" which was distributed through the network of primary health care facilities, in the course of Project interventions and during festivals.

Application of Technical Knowledge and Skills

One of the objectives of the project has been to enable its staff, partners and beneficiaries to gain the requisite knowledge and skills in key child survival intervention areas. The interventions included provision of BCC knowledge and skills to the staff of primary health care facilities to be able to better communicate with the members of community and thus increase the efficacy of counseling pregnant mothers and mothers of children U5. During project implementation, it was obvious to project staff that the large number of medical terms used by physicians was unknown to the target population and was hindering the impact of counseling. This in turn, contributed to patients being unable to follow recommendations properly. ACTS provided materials for community education sessions to the staff of primary health care facilities and conducted pilot trainings at seven of the facilities to develop their community teaching skills. As a result, seven nurses and physicians from these facilities volunteered to participate in educational sessions providing information related to maternal and child health. At the same time the trained staff volunteered to participate in preparation and organization of the "Healthy Moms for Healthy Child" Festivals. They assumed the responsibility of working with the upper grade school children and teachers. They helped them develop short scripts for the sketches staged at the Festival as well as develop recipes for complementary feeding of children 6-12 months for the contest for best cook. As a result, primary health care facilities participating in pilot trainings reported to the evaluators that they had observed improvements in behavior of pregnant women and mothers of children U5. They indicated that women were coming to facilities for prenatal care earlier than previously and bringing children on time for vaccines. Previously there had also been resistance to registering births but since the community education activities have been conducted, parents now understand that if their babies are not registered, there will not be enough vaccines for them in the clinics. Although ACTS is not the only organization promoting birth registration in their areas, they can certainly take some for the credit for the increased registrations.

Networking and Partnership Development

The evaluation team found that ACTS has formed strong relations with other local organizations operating in Georgia. As a result of medical personnel trainings 120 pediatricians from two regional outpatient clinics and 160 Maternity Hospital personnel obtained updated knowledge and skills in IMCI and BFHI. According to the IMCI trainers interviewed, follow-up visits are routinely practiced to review the quality of work practiced in those facilities and they have found the skills vastly improved with a particular emphasis on breastfeeding. Major stakeholders at various levels (Ministry of Labor, health and Social Affairs, Regional authorities including the Governor of the

region, Local health facilities managers, district authorities and local Public Health Centers), attended the project launch and have continued to work closely with ACTS CSP. In July 2006 there was a regional Maternal and Child Health Improvement section within the Child Survival Project Conference in which ACTS International and ACTS Georgia staff participated along with local authorities, representatives of partner organizations, University of Georgia, "Clarita's XXI", heads of village administration, representatives of the regional communities, pediatricians and obstetricians-gynecologists. As a result, a strong network has been formed, which contributed to success of on-going CS interventions. As a further indicator of strong partnerships, based on the experience gained during the implementation of the Project, an Agreement on Cooperation between the University of Georgia, Tbilisi and ACTS International was signed in June 2009 with the aim to further develop the joint partnership implying the following:

1. Using the research-and-practical capabilities of the University of Georgia to improve administrative management in the sphere of health care (research, analysis, recommendations);
2. Professional training of the staff of ACTS International to increase their competence;
3. Contributing to postgraduate training for the students of the University of Georgia and if needed, provide assistance for their employment;
4. Implementation of joint research and applied projects using the material-and-technical basis of the University of Georgia and ACTS International supported by relevant resources.

The goal of this Agreement is to improve the learning capacity of the grantee organization.

ACTS also developed a partnership with the ongoing GAIN Project on flour fortification with iron and folic acid, which has contributed to the nutritional component of CS Project (and is referred to in other sections of this report). Another partnership activity was the implementation of Health Fairs organized by ACTS Georgia in partnership with MoLHSA, United States Navy medical personnel and Public Health Department within the framework of the U.S. Military Community Outreach Program. Most of these took place before 2006. The success of the Health fairs prompted MoLHSA to start series of its own Health Fairs in the Kvemo Kartli region later on.

Other capacity building of local partners: Local government officials have provided complementary facilities for training courses and invite ACTS to provide training and education. ACTS has also been asked to deliver health messages at local celebrations and events. To build its relationship with stakeholders, ACTS has involved all stakeholders in a review process for the programs that CSP staff provides to the communities. In addition, stakeholders are given a plan of activities and invited to join ACTS in monitoring the plan. They are also given a list of education activities and CSP reports.

ACTS Georgia is providing leadership in MCH for collaborating partners by providing them with training for integrating CSP activities with their own. The established working

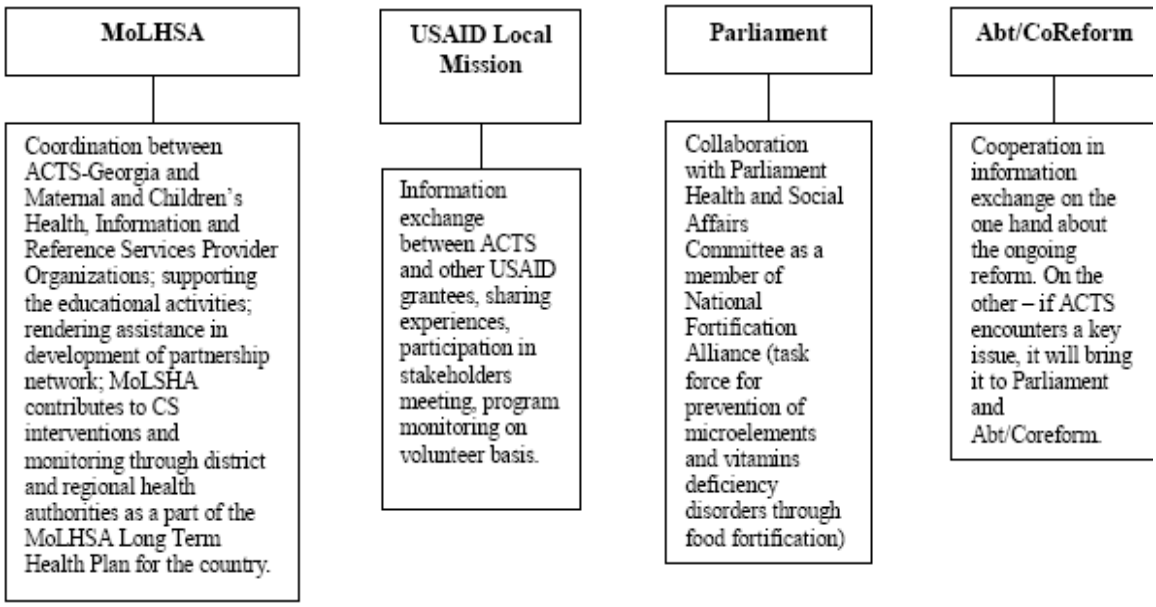
relationship between ACTS and MoLHSA has allowed them to strengthen services in project areas and provide input through national conferences and scientific meetings.

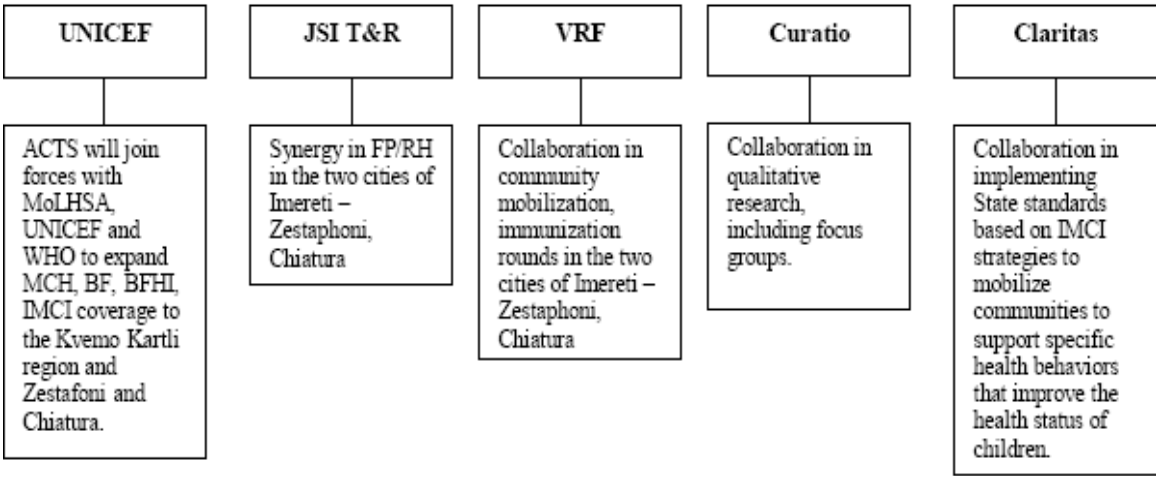
Strengthening local partner organizations has been accomplished through the continuous sharing of CSP information, training and services. In addition to signing a Memorandum of Understanding (MOU) with the MoLHSA on March 25th, 2005, successfully negotiated agreements with CSP partners included:

- Ministry of Labor, Health and Social Affairs (MoLHSA) of Georgia and its Public Health Department
- CRPA/Claritas XXI (for BFHI and IMCI training)
- Women Wellness Care Alliance "HERA" (West Georgia)
- Union for Social Protection of Citizens of Georgia "Tanadgoma"
- Vishnevskaia-Rostropovich Foundation (VRF) for the Health and Future of Children in Georgia (NGO in Kvemo Kartli) (funded immunizations)

At the start of the project, a capacity assessment was completed to determine the training needs of program staff and partners after agreements were in place. A pre-implementation workshop was held to orient partners to the program and to encourage commitment from a larger group of stakeholders**.** Participants in the two-day workshop included health center staff, rayon (district) health facilities staff, regional health department staff, district and commune chiefs and representatives from health-related PVOs working in targeted regions. The workshop informed stakeholders about the CSP, explained how the program fit with ACTS' other community development activities and helped ACTS gather stakeholder input regarding implementation issues. The workshop was successful in building participation, cooperation and ownership in the CSP and provided helpful feedback for planning early activities, in particular the KPC baseline survey.

Diagram 1: Roles and Responsibilities of the Local Partners





No changes have been made from the roles and responsibilities outlined in the DIP.

The MTE found that throughout the first half of the project, partners had been involved in considerable capacity building activities at all levels, especially through their participation in Health Facilities/Health Worker Strengthening (training), quality improvement, supervision/ supportive supervision, establishing links with the communities, materials/equipment and strengthening of meetings. Since then, as evidenced through the KPC and the evaluation interviews, local partner capacities have continued to increase to meet CSP organizational objectives and goals, including expanding skills for qualitative and quantitative data collection. Challenges that will be faced after the project ends include continued monitoring of program activities; however, the increased data collection skills acquired by local partner organizations should make this manageable. Also there will no longer be funding for continued training and education activities, though ACTS hopes to be able to continue some activities through private funding.

(d) Health Systems Strengthening:

Health Facilities strengthening: ACTS conducted an assessment of MCH equipment and staff skills at the time of the MTE. The ACTS International MTE Team members from the University of Missouri conducted a facility review. Concerns were raised regarding equipment, sterile conditions and the physical condition of the facilities visited. While these reports are of professional quality, their relevance to the CSP was not directly related to the DIP implementation and the MTE exercise. ACTS International and the U.S. Department of State have on-going agreements to address facility equipment upgrades and the replacement of related maternity and infant care and resuscitation essentials. A Health Facility Survey, results of which were used during the second half of the project, was completed in the following locations:

- Dmanisi Ambulatory and Polyclinic Unit, maternity hospital
- Bolnisi Pediatric Polyclinic and Maternity Hospital

The HFA raised concerns regarding the health facilities need for a sustainable store of equipment, especially since asphyxia accounts for 36% of fetal deaths. All hospitals had

rubber suction bulbs to help clear airways following delivery. Needs for laryngoscopes and suction adaptors for endotracheal tubes for meconium deliveries were identified. Since the MTE, ACTS has supplied facilities with these materials (through another funding source and program); and the CSP has focused on promoting the creation of a standardized equipment list. ACTS has continued to work on finding alternate funding to continue upgrading facilities in the project area.

Strengthening Health Worker Performance: As discussed above, during the first part of the project, ACTS supported training of medical personnel in IMCI, BF Hospital and Breast Feeding (See chart that follow

Table 3: Health Worker Trainings Conducted in Rustavi

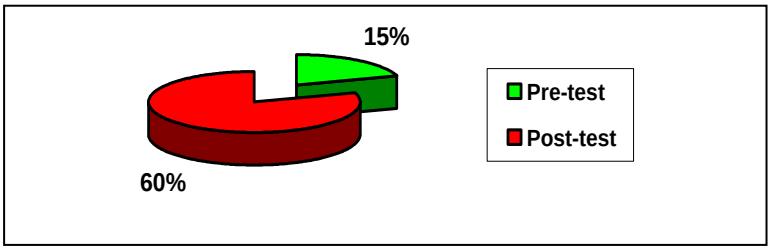
Trainings Conducted of Medical Personnel in Rustavi	Quantity	Facilities	Category of Trained Personnel	Number of People Trained	Duration of Training	Person Days of Training
1) IMCI	3 courses	Prophylactic Centers # 1 & 2	Doctors and Nurses	137	11 Days	1,507 Person days
2) BFHI	3 courses	Maternity House	Pediatric Doctors	60	5 Days	350 Person days
3) Breastfeeding	2 courses	Maternity House	Pediatric Doctors	60	5 Days	350 Person days
Interventions	**8 courses**	**6 training sites**	**MDs & RNs**	**257**	**21 days**	**2,207 Person days of training**

The project attempts to respond to gaps between performance standards and actual performance by introducing MCH related training for health personnel, using guidelines developed and/or recommended by the WHO Child and Adolescent Health Department. These standards are being applied to both preventive health and management of illnesses. IMCI serves as a main strategic approach to the problem of under five morbidity and mortality. Following IMCI guidelines improves case management skills of health workers by improving performance of referral facilities. As a result of training conducted, health facilities are using the List of Essential Drugs complying with Eleventh WHO Model List of Essential Drugs to manage illness. Although ACTS had intended to continue supporting IMCI training in Kvemo Kartli throughout the project, it was discovered shortly after the mid-term that there was a new UNICEF initiative to sponsor country-wide IMCI training through Claritas. So after the MTE, ACTS decided to focus more on community education and improving relationships with local health facilities. However, ACTS did train the numbers of individuals planned for in the DIP.

A four-day seminar for community representatives was held on the basis of Pediatric Clinic of Rustavi region on November 8th through 12th, 2006. Twenty-eight community representatives attended the seminar that was held by the trainers: K. Sharangia, M. Beleshadze and N. Gumbaridze. Special attention was dedicated to: safe motherhood, breastfeeding, early child development, healthy nutrition, immunization, diarrhea, cough

and cold and patient rights. Among seminar participants were representatives of medical staff, teachers, students, housewives and community counsels. The majority of participants were unaware of the information on the issues discussed at the seminar. The population became acquainted with state guarantees and patient rights. Pre- and post-testing was conducted.

Diagram 2: Pre- and Post-Test Results



The MTE had made some recommendations regarding introduction of partographs for monitoring labor and delivery. Partographs have not previously been part of the Georgian OB practice. ACTS conducted a pilot for this in 2006 and found the health practitioners slow to adopt this tool. After the above-mentioned visit from the University of Missouri, School of Medicine in 2006, a recommendation was made to develop OB standards of care that also included use of partographs. The concept of medical standards of care is new to Georgia so it has taken some time for the medical community to accept this idea. However, recently standards of OB care, which includes the use of partographs, have been approved by the Georgian Medical Association of OB/Gyns and are awaiting the signature of the Minister of Health. Following this, ACTS will work with the MOH and OB Society physicians to conduct a pilot study showing the effects of step-wise introduction of the standards and then use the participating physicians to promote their use to others. ACTS also plans to introduce the use of partographs in the medical school training program.

Given ACTS ongoing relationship with the MoLHSA, the new University of Georgia and its continued collaborations between them and the University of Missouri, it appears that ACTS will be continue influencing medical and public health institutions even after the CS project ends.

(e) Policy and Advocacy:

As part of its CS advocacy efforts, ACTS Georgia became a member of the monthly coordinating meetings of the Kvemo Kartli Region Governor's Office. Participants include local authorities at regional and district levels and local and international NGOs, PVOs active in the region. From observations made during the FE, it is clear that ACTS has much support from the Governor who offered to assist ACTS in airing educational information on local media targeting the Azeri migrant population. He also offered to provide the messages himself for television. ACTS is also a member of the Alliance for Improved Nutrition for Georgia in the Georgian parliament, which developed a law for flour fortification. ACTS was a member of the parliament committee, which developed and adopted a law on universal salt iodization. ACTS participated in the development of

policies for the State Health Insurance Fund. It provided the data from the KPC baseline survey to WHO and MOHLASA to be used for Georgian health policy development.

Specifically, ACTS has contributed to the passage of the following national laws: in 2005, ACTS worked with an alliance of organizations to advocate for the passage of the iodization of salt law. In 2006, as a result of ACTS program to fortify flour with iron and folic acid (funded by GAIN), parliament passed a preliminary national policy to allow flour fortification. In 2009, based on results of ACTS' flour fortification program, parliament is considering a law requiring all flour milled in Georgia to be fortified. (3 months of protests shut down parliament when the bill was to be addressed).

Regarding Ministry of Labor, Health and Social Affairs (MoLHSA) policy changes in 2006, ACTS successfully advocated for free birth registration, which also helped improve records of neonatal deaths. During this period ACTS worked with the Georgian Medical Association and Georgian OB Association to advocate for a maternal-newborn care package that included 4 prenatal visits, free delivery and free home visits to the mother and newborn within the first 24 hours of delivery.

ACTS made the KPC results available to policy makers. They were also published in the "Dissemination Package of Nutrition Issues" produced my WHO and the MOH. The government decided to use the KPC as a model for regular surveys that they do.

One of the other things that ACTS has achieved has been to open the door for other organizations to work in Kvemo Kartli. When USAID directed ACTS to work in the region, they indicated that no other NGOs had been able to work there successfully. As a result of ACTS' facilitation, other NGOs are slowly beginning to work in the region.

(f) Contribution to Scaling Up:

Given that this is a new entry project that, because it was inexperienced with CS, had a slow start-up, spent its time advocating with communities, public health staffs and local and national government to introduce improved CS knowledge and practices, scaling up of its activities was not an objective of this project. However, an example of expansion of community mobilization strategies applied in Kvemo Kartli to another area was demonstrated when UNICEF asked ACTS to join in an effort to expand MMR vaccination in the country. ACTS covered the province of Samtskhe-Javakheti, a district with a large Armenian population. ACTS applied similar mobilization techniques to those used in Kvemo Kartli and were very successful, achieving higher MMR coverage levels than any other district. The USAID Mission in Armenia is funding a flour fortification program in Armenia 2010 and hired ACTS to provide technical assistance.

The other activity that appears to be in the process of being scaled up as a result of ACTS pilot project, is the above mentioned flour fortification project supported by GAIN. Once approved by parliament, all flour milled in Georgia will be required to be fortified with iron and folic acid.

(g) Equity:

A major focus of the ACTS CS project has been to target the marginalized Azeri population living in Kvemo Kartli, many of whom do not speak Georgian. Another isolating factor is that the Azeris are predominantly Muslim, while the Georgians are Christian. Many of this population migrate between Georgia and Azerbaijan as well so it is often difficult to maintain regular contact with them. To address this, ACTS used a dual approach of 1) directly working with Azeri women through community education activities addressing maternal-child health; and 2) printing health education materials in Azeri language and disseminating them among the population. As a result of project activity, members of the Azeri population participated in the health festivals. As the project continued, more and more Azeri women participated in educational activities. Local health practitioners noted that they also began using health services (prenatal and deliveries) on a more regular basis, particularly the younger ones. They believed ACTS educational efforts made women aware of the free services being offered. Although the USAID mission pointed out that ACTS was not the only organization working on improving maternal-child health in Georgia, the work that ACTS did with the Azeri minority population was unique as the other organizations did not target this marginalized population.

The focus of ACTS community programs is to empower young mothers to take active roles in health care. During its education sessions, ACTS stressed the importance of female decision making in the family with regard to children's health.

As mentioned elsewhere, the Governor of Kvemo Kartli is particularly interested in reaching the Azeri population, he has developed relationships with the governor and local mayors that border Kvemo Kartli (in Azerbaijan) and in the fall the governor will be launching public service announcements about maternal health to be broadcast by TV and radio stations in Azerbaijan. As part of festival activities, ACTS has also worked with a Georgian/Azeri singing group to develop health messages set to popular song lyrics. This is the first of its kind in Georgia.

(h) Sustainability Strategy:

ACTS has made a priority of engaging stakeholders in the CS program. This includes families as well as service providers and officials. ACTS has worked to create an environment where it is acceptable and valued for young women to be informed and knowledgeable about their health and that of their children. In addition the communities where health fairs and health festivals have been held are now better informed about MCH and preventive health practices. It is anticipated that the individuals will sustain these new behaviors and communities after the CSP ends.

At this point ACTS has not been able to win further funding from USAID. So ACTS is pursuing private funding to continue support in the CS project areas. ACTS is committed to maintaining its presence in Georgia and will continue looking for support for its activities.

In addition, the training and education received by health professionals in Kvemo Kartli as well as the regional hospitals will sustain a high level of health care practice in

Georgia. ACTS will attempt to continue providing refresher training and updates for staff in the CS project areas.

The changes, in the laws pertaining to health that ACTS has worked to bring along through its legislative work, will be sustained. As mentioned above, as part of a separate activity that impacts preventive maternal and child health, ACTS will continue working with the Tbilisi State Medical School to upgrade it's medical school training programs and the University of Georgia (Tbilisi)new school of public health to incorporate quantitative and qualitative monitoring and evaluation training.

As noted, local staff and partners have been involved with the CSP sustainability strategy with regard to personnel, operational project costs and financial planning throughout the project. Alternative funding options were used to cover aspects of the CSPs, specifically with the provision of sustainable essential equipment in health facilities. The next steps in the project will be to determine alternative funding through local partners, so as not to rely solely on ACTS International and whatever private funding can be raised. No formal sustainability design methodology was used for this project.

D. Changes in the Grantee Organization Capacity (New Partner Grantees Only)

Participation in the CSHGP provided ACTS the opportunity to strengthen its institutional capacity by adapting to USAID requirements and altering its financial and accounting procedures as well as its reporting formats. In addition, learning to implement and use the KPC and LQAS surveys as measurement tools and for providing feedback of results to stakeholders during the past 5 years has done a lot to enhance ACTS visibility and expertise. The development and use of focus groups to monitor activities as well as identify concerns, questions and barriers proved a useful tool.

ACTS did not conduct an organizational assessment as planned in 2004 due to the Georgian revolution and change of leadership.

Unfortunately due to some of the unforeseen circumstances, such as the weakening of the dollar and the political crisis in 2008, the project funding was not sufficient for the planned 5-year project. As a result staffing and activities had to be cut back during the second half of the project.

The CS monitoring and evaluation training for ACTS headquarters and field staff has provided ACTS with another invaluable tool which it is applying to other activities.

In mid-2009, ACTS signed an agreement with the University of Georgia (Tbilisi) to develop a public health curriculum in conjunction with the University of Missouri that will include quantitative and qualitative assessment. In addition, Kvemo Kartli will be used as a field site for MS and PhD students. Although additional funds are required, it is anticipated that once established, the program would provide a sustainable impact on public health in Georgia. (See Annex 11.8 for agreement).

E. MISSION COLLABORATION

Project objectives and overall strategy were discussed and negotiated in detail with the USAID local mission USAID/Caucasus in Tbilisi, Georgia. The Mission Health Advisor was also informed about the goals and objectives of the project. In addition, presentations and discussions were conducted during the USAID health grantees meetings on November 11, 2004; February 23, 2005; and March 7, 2005.

The USAID country objectives are designed to increase education and access to improved health care for women and children. The CS project contributes to this objective by implementing MCH interventions in targeted areas. ACTS implementation of IMCI training in the regional facilities complements Mission efforts.

The FE team met with Dr. Anne Patterson, Office Director and Dr. Tamar Sirbiladze, Health and Social Development Project Officer, during the FE evaluation visits. They explained that although the project had a slow start up due to unfamiliarity with the DIP process and unawareness of USAID accounting procedures, once it started, they were very pleased with the project. Of note, was the project's ability to adapt to the changing political and economic conditions in Georgia. USAID had asked ACTS to work in the Kvemo Kartli area because it was so marginalized and other projects had been unable to achieve much success in the region, so they were pleased with all that ACTS was able to accomplish. They indicated that the Mission will not be funding CS kinds of activities in the future as all the funding will be going to support the government's health care privatization program. However they did encourage ACTS staff to stay in touch with the Mission and with the new Cooperating Agency (once awarded) that will be managing the privatization program as there may be a role for ACTS in this. They mentioned that ACTS had not been in regular contact with the mission regarding the upcoming new project and encouraged them to do this, as they might be able to advise them about opportunities.

F. Contextual Factors

One of the biggest difficulties that the project has faced was the civil unrest experienced in Georgia as a result of the Russian invasion of South Ossetia during August of 2008. Although the project area was not invaded, the main road to the area was closed. As a result, the community meetings were stopped, the district offices were closed and the project had to cancel the festival planned for Tetra Tzeri and other activities. Also because there were a large number of people displaced, it added to the confusion. All the district administrators and partners were tied up with the IDPs and it took some time to get the districts focused on health activities again.

Regarding additional resources, the Rastropovich Foundation funded immunization activities in the project areas during years 2004 - 2006. After 2006 the funding from the foundation stopped and the Public Health Department was supposed to pick up but has not so far.

The CSP also has received technical support through the CSGHP, such as additional training from Namita Agaravat after the 2005 DIP conference. They also received training from CSTS

and mini-University conferences, also attending operations research training and several monitoring and Evaluation workshops. They also attended CORE's BEHAVE training.

The CSP did not work directly with other USAID projects, although they did collaborate with JSI in the Imereti regions in the area of reproductive health education.

G. Conclusions and Recommendations

Although the CSP did not reach all its targets, it came pretty close to most of them and as mentioned, they may have been too ambitious in setting targets given circumstances and conditions. The project had a slow start-up that is not unusual for a new entry project as there are a lot of new financial systems to put in place as well, as well as technical needs in completing KPC and DIP requirements. Other difficulties that occurred after the mid-term were the Russian invasion of South Ossetia in 2008 and the consequent stoppage of activity in the CSP region for several months.

In spite of the difficulties, the CSP met most of its targets and has developed a trained network of public health workers in the Kvemo Kartli region, as well as in Chiatura and Zestaphoni. ACTS has also developed solid relationships with the MoLHSA, the Georgian CDC and University of Georgia. Through these relationships, ACTS is influencing health policy and laws throughout Georgia. However, there is still much work to be done in the CSP project areas. As indicated, community education needs to be reinforced to encourage more use of services and preventive home care. In addition, more follow-up of training given to public health workers is also advised. As with other post Soviet states, much of this preventive health training is new to Georgia and needs reinforcement. In fact the ACTS CSP is the last child survival grant in the Central Asian former Soviet republics and unless the CSTS focus changes, there may not be more funding for this region. While much has been gained in Georgia from the CS experience, there is still much to do. ACTS will pursue funding in order to continue the CS activities in the regions where it works but the USAID mission is no longer supporting community based programming. Therefore ACTS is in the process of looking for other sources of funding to continue its work in Georgia.

Assuming that ACTS will continue working in Kvemo Kartli and if they are able to continue working on maternal and child health activities, the team has the following recommendations based on findings, interviews and lessons learned.

- Physician Skills Improvement and Sustainability: The project has been and will continue to work with the MoLHSA to develop an evidence-based continuous medical education program for physicians that would include training follow-up and direct observation of practice. Discussions were on going and at the time of the FE. It is also recommended that ACTS work to assure that there is more IMCI follow-up in the project areas. The IMCI Trainer voiced concerns that after the mid-term, ACTS devoted more attention to community education and not as much to professional education. The assumption was that other institutions would be addressing IMCI training. In either case, ACTS may be able to stimulate the organizations doing IMCI training to provide more follow-ups in the project areas.

- Community Education: Changes in community education session content should continue to be based on the field experiences, continued FGDs and survey results. Also recommend that the groups expand to include other family participants, such as mothers-in-laws, fathers and grandfathers. These were planned for after the MTE but were not realized due to other priorities and staff cutbacks. One of the recommendations that arose during discussions with health facility staff was that ACTS make use of trained ambulatory care nurses to help with community education activities. Some nurses are already participating and this does facilitate the relationships between community and facilities and also encourages women to attend prenatal and childcare clinics. However, for facilities where the nurses are not involved in education, it would require that ACTS provide training and follow-up. Project staff noticed that nurses needed to learn how to talk to and counsel patients. They stressed this need for teaching and counseling skills.
- Behavior Change and Capacity Building: All post Soviet countries were part of the same health care system. It was very useful for ACTS staff to visit the Mercy Corps program in Azerbaijan and it would be useful to conduct some follow-up review meetings with other CSPs that have operated in the region. At this point there are no CSPs in the post Soviet countries. It would be informative if CSTS or CORE conducted an assessment to see what the impact has been from these projects that no longer operate in the region. ACTS Georgia will continue its partnership and dialogue with MoLHSA, as national health sector reform is designed and implemented.
- Train Local participants as leaders**.** One of the concerns the CS project had was the need for more staff to conduct community education. Due to budget constraints, ACTS had to cut back on staff during the second half of the project. The Health Coordinator does a good job of teaching local community groups but it would be beneficial to have more community educators. Presently the Health Coordinator is the only community educator in the project. In discussions with the communities during the FE, it was suggested that ACTS could train some of the knowledgeable local women to lead education sessions. This model has been practiced successfully elsewhere and could be a solution, especially now that the CSP is ending. Some of the women are quite educated and interested and could be trained as mobilizers to deliver the CS messages as well as follow-up in their communities with women who need more motivation. Ideally these individuals would be volunteers that could regularly interact with the polyclinic personnel who are responsible for health care in the area. Since ACTS will continue its presence in Georgia, it might be possible for them to periodically meet with such volunteers and health personnel to review progress and provide non-material incentives.
- Need for more print education materials. It was clear from discussions with education session participants and health facility personnel that they would like to have access to more educational materials. The Georgians have a high reading level and there is evidence that pamphlets are passed on to others once distributed. The project developed a couple of pamphlets for the festivals and health fairs that were useful and comprehensive but did not have the funding to produce more. Also UNICEF has produced a childcare pamphlet that is well received among mothers. Future budgets should include funding for printing multiple copies of educational materials. Feedback also indicated that materials with more pictures that describe health practices would be most useful.
- Involvement of local administration: One of the key lessons learned was the need to involve the local administrators in the project – particularly the head of district

administration. The project learned that when they did this, then the local government staff would help by generating local resources for project purposes. For example, in the beginning they needed electric power to run the LCD projector. The project staff learned that if they informed the local authorities of when they would visit, the power was made available to them. The local authorities also helped with the festivals, supplying transport for people from villages, decorations, improvements of facilities and food for the cooks. ACTS needs to continue building these relationships.

- Exit interviews: One of the new tools that the project developed was the use of exit interviews at project facilities and festivals. The purpose was to determine if there had been any impact. The asked why they came to the doctor, if they came earlier this time for prenatal or child care, how they learned about the services etc. From these they determined that about 15 percent of the time they came because of project activity. This is a useful tool that can help monitor impact of program activity and the team recommends that ACTS continue with this.
- Future bilateral: In general ACTS has done a thorough job of developing trust and relationships in the Kevmo Kartli, Zestaphoni and Chiatura areas. It takes a long time to develop relationships and gain the support of local health personnel, administrators and community leaders. In addition, ACTS has acquired numerous skills through its work with the CSP – an example being the community mobilization skills it used to help with the UNICEF sponsored immunization activity in a neighboring region. ACTS will continue to operate in Georgia and it would be helpful if they could find a way to collaborate with the new mission funded bilateral project. Discussions with mission staff indicated that although their focus will be on the private sector, there will be training and other needs where ACTS might be able to collaborate. It is recommended that ACTS follow-up with the new contractor to see if they might be able to make use of ACTS skills and professional contacts.

ANNEXES

ANNEX 1 – RESULTS HIGHLIGHT

- Throughout project implementation ACTS piloted some innovative strategies based on lessons learned and consultations with stakeholders. These included the Health Fairs and Health Festivals, as well as the community IMCI training of medical staff from the 7 outpatient clinics in the project areas.

- A promising practice was the participation of trained health facility staff in the community education sessions. These included presentations of materials on child safety and prevention of helminthes. These materials were developed based on the project's community education approach.

- The KPC and focus group discussions indicated that the biggest barriers to achieving behavior change were: 1) misunderstandings between health personnel and the population resulting from use of unfamiliar medical terminology and lack of good counseling skills to explain treatment instructions. 2) This was particularly true for the Azeri populations that do not speak Georgian and need materials printed in Azeri in order to understand the preventive health messages.

- To address these concerns, the CS project developed presentations that included CS messages in popular understandable language. ACTS also translated the messages into Azeri and disseminated the materials to the population. In addition, the CS project regularly held focus group discussions in the communities to identify key factors hindering behavior change and identify gaps in knowledge. At the same time ACTS trained staff from the 7 project polyclinics in community IMCI. They then jointly developed educational presentations on prevention of helminthes and child safety. They then joined the regular community education program being implemented by the CS project and lead discussions.

- The thematic Health Festivals were another novelty. These involved all stakeholders including high school pupils and teachers. All contests and sketches focused on CS messages and were developed through active participation of public health center staff, teachers and pupils. The festival events attracted large numbers of people from towns and surrounding villages. The project developed special IEC booklets with CS messages. Unfortunately there were not enough for distribution in the regular community education sessions. The media actively participated in the events covering the festivals through local TV and radio. Festivals were conducted in two districts and involved about 10 percent of the local population. The project estimates that it reached 40 percent of the target population through media messages. An additional 5 percent were reached through the trained medical personnel.

- Health fairs that included mass screening of village populations along with counseling on issues of safe motherhood, reached a total of 10,000 inhabitants in the four villages where they were held.

ANNEX 2 – List of Presentations Related to the Project

Name of Event	Date and Location	Attendant(s)	Presented Paper/Poster
17th World Conference of Family Doctors in conjunction with the American Academy of Family Physicians Scientific Assembly; WONCA	October 13-17; Orlando; USA 2004	G. Tsilosani, R. Tataradze	Academic Issues of Family Medicine in Georgia: Tbilisi-Columbia, MO Partnership; The AAFPs Role in Promoting Family Practice in Georgia – "Physicians with Heart"; Family Medicine Development Issues in the Countries of Transition Period: Example of Georgia. Dr.Tatradze and Dr. Tsilosani completed the first level and instructor course for ASLO and were certified to teach the course in Georgia. ACTS Georgia translated all course material and slide presentations to allow the course to be taught in Georgian.
Review of action plan for Food and Nutrition in Georgia.	May 16, 2005.	R. Tataradze	Healthy Diet Pyramid Presentation - Poster
USAID/CSTS technical workshop/ Johns Hopkins Mini-University	Baltimore, Maryland, USA in June 2005.	T. Blair, G.Tsilosani, , R. Tataradze, E. Suladze, G. Kharabadze	DIP draft Presentation; Panel discussion: Innovative Approaches to Maternal and Newborn Health
Health Alliance "Round Table" Meeting Ministry of Health	Tbilisi, Georgia November 25, 2005	R. Tataradze	Role of Physical Exercise in the Control and Prevention of Chronic Diseases
European Conference on Chronic Disease Prevention	Marina Congress Center Helsinki, Finland December 8-10, 2005	R. Tataradze	The Role of the WHO Countrywide Integrated Non-communicable Diseases Intervention (CINDI) Network in Chronic Disease Prevention: Experience in Georgia;
Regional Conference "Preventing Chronic Disease – International and National Perspectives"	Tbilisi, 29-30 November, 2006	G. Tsilosani, R. Tataradze	The experience gained through the countrywide integrated noncommunicable disease intervention (CINDI) programme - National Health Challenges: Georgia Statistics and Current National Programs on Chronic Disease. Co-Presentation by Dr. Revaz Tataradze, National Health Challenges: Georgia Statistics and Current National Programs on Chronic Disease.

Name of Event	Date and Location	Attendant(s)	Presented Paper/Poster
CSHGP New Grantees meeting at John Hopkins University.	October, 2004, Washington, USA	T. Blair, G. Tsilosani, R. Tataradze, E. Suladze	Organized training sessions
Meeting of the drafting group for the development of the European Strategy on Non-communicable Diseases Planning Consultation Meeting with participation of representatives WHO/EURO, MoLHSA/Public Health Department, WHO Country Office in Georgia, CINDI Georgia	Tbilisi, Georgia, 1-2 February 2006;	R. Tataradze	Oral Presentation "BCA for Strengthened Capacity for Integrated NCD Prevention and Control in Georgia"
23th annual meeting of the CINDI Programme Directors Alberta CINDI Demonstration Showcase Event; CINDI Technical workshop on Monitoring and Evaluation of Programmes of the Integrated NCD Prevention and Control	16-17 October, 2006; 18 October, 2006; 19-20 October, 2006	G. Tsilosani, R. Tataradze	Oral Presentations "Health Behavior Surveys in Georgia"
CINDI-WHO meeting on Future Development of Policy at the European Level	Montreal, Canada, December 8-10, 2004	R. Tataradze	Organized training sessions
Rustavi Coordinating Meeting organized by the Government of Kvemo Kartli Region and attended by the representatives of NGOs and International Organizations implementing their projects in the Region.	September 14, 2005 Rustavi, Georgia; Kvemo Kartli Governor's Office	R. Tataradze Tamar Lobzhanidze	Organized training sessions

Name of Event	Date and Location	Attendant(s)	Presented Paper/Poster
Advanced Life Support in Obstetrics (ALSO) provider and instructor courses in Georgia within the framework of "Physicians with Heart," a Partnership of the American Academy of Family Physicians, the American Academy of Family Physicians Foundation and "Heart to Heart International" supported by a grant to ACTS-Georgia from USAID to fund materials and travel for 60 doctors throughout the country to attend this course	November, 2004; Tbilisi, Georgia	T. Blair, G. Tsilosani, R. Tataradze,	Dr.Tatradze and Dr.Tsilosani were course instructors who certified 32 first level participants and 19 instructors. AAFP granted MoHLSA and ACTS authority to replicate this AAFP proprietary course material for the Georgian seminars.
Inaugural Eurasia District Conference & Expo International Organization of Operating Millers - IAOM and The Flour Fortification Initiative (FFI)	November 10-12, 2006 in Istanbul, Turkey at The Marmara Hotel	T.Ukleba	Organized training sessions
The WHO Healthy Cities program Healthy Urban Planning, Basic Training	World Health Organization, Regional Office for Europe; WHO Centre for Urban Health and Governance; the Municipality of Kadikoy and Municipality of Milan – as lead city of the Sub-Network on Healthy Urban Planning. Kadikoy-Istanbul, Turkey 15-16 Feb, 2007	T.Lobjanidze R. Tataradze, V. Tsilosani	Presenting Borjomi for WHO Healthy Cities program

Name of Event	Date and Location	Attendant(s)	Presented Paper/Poster
Meeting of WHO National Counterparts for the European Strategy for the Prevention and Control of Non-communicable Diseases (NCD)	2-3 May, 2007; London, United Kingdom	R.Tataradze	Oral Presentation: "Strengthening NCD Prevention in primary care in Georgia
National Center of Disease Control and Public Health Training-Seminar for Health Educators: Diet, Nutrition, Prevention of Non-communicable diseases	September 11, 2007 Tbilisi, Georgia	R. Tataradze	"Double Burden of Chronic Diseases in the Countries of Restricted Economic Possibilities"
Investing in People Workshop, USAID Site Visit: Health Partnerships at National Center of Disease Control and Public Health	October 3, 2007 Tbilisi, Georgia	R. Tataradze	"Non-communicable Diseases (NCD) in Georgia"
5th International Conference on Behavioral Risk Factor Surveillance	24 – 26 October, 2007; Rome, Italy; National Centre for Epidemiolog, Surveillance and Health Promotion	R. Tataradze G. Tsilosani	"Towards Behavioral Risk Factor Surveillance System: Georgian Experience" (R. Tataradze); " Study of children eating habits-the starting point for surveillance to prevent Noncommunicable Chronic Diseases (NCD) " (G. Tsilosani) http://www.epicentro.iss.it/passi/pdfconf/25/AFTERNOON_2/2.Tsilosani.pdf

ANNEX 3: Project Management Evaluation

A. Planning

The groups involved in DIP planning were USAID Tbilisi, JSI T&R Institute, Curatio, Abt/CoReform, VRF, UNICEF, MoLHSA/Parliament and "Claritas". Project objectives have remained consistent with those listed in the DIP:

1. Improved quality of maternal and child survival services
2. Improved behavior and household health practices, in the community and among health care professionals and health managers
3. Increased availability of Maternal Child Health (MCH) care services and increased access to standard case management.

All partners and stakeholders were given copies of objectives. During project start up, two workshops were conducted for all parties explaining project goals, objectives and strategies.

The translated project outline was distributed and issues were discussed and input received during these workshops.

The initial plan as suggested by stakeholders was to form volunteer teams of community educators. However, in practice it turned out that this plan was unrealistic given the difficult economic circumstances of most Azeri families in the region that did not allow them time for volunteer activity. So it was decided to increase the number of community education sessions, focus groups and to arrange health Fairs and Festivals. They also worked with local media. They also involved local medial personnel in providing community IMCI.

A project conference held with stakeholders and the target population in 2006 helped gain more input for achieving better results.

Perhaps one of the bigger issues in DIP planning was the need to pay more attention to budgeting. For example, it was not made clear to the project that they needed to budget for consultants and activities associated with the mid-term and final evaluations. This added to funding difficulties for the project.

Another recommendation is that new projects have an opportunity to visit other CS projects early in the process. ACTS considers their visit to the Mercy Corps project in Azerbaijan in 2005 to have been very valuable and wished it could have occurred earlier.

Staff Training

The current CSP is the first for the country of Georgia and also the first such USAID grant project for ACTS. Being the pioneer in this area has required that ACTS train and support the headquarters and field staff and introduce the project to the Georgian government, including the MoLHSA, the Georgia Parliament and newly created Georgian CDC. There are three levels of training that have been provided. Training has been provided for the ACTS board of directors and headquarters staff in areas of financial and program reporting requirements to enable effective project oversight. Headquarters and field staff attended a new grantee orientation (2004), a private meeting with Liza Buckner, USAID Washington (2004), subsequent meetings on financial and compliance training (2005-2007). A 2007 financial training was provided for headquarters accountant by headquarters staff.

Key members of the ACTS field team (chief medical officer, program director and program manager) have attended specialized trainings, including: USAID/CORE training in KPC/LQAS (2003), USAID new grantee orientation (2004), Mini-University (2004), Update training (2005). The field office program manager provides training for Georgia staff and community volunteers involved in program implementation and evaluation. Eteri Suladze, Program Manager, trained the KPC survey supervisors (initial survey in 2005 and for the MTE in 2007). Eteri was trained in 2003 in a 2-week intensive USAID CSTS/CORE training in the U.S., along with one headquarters staff on KPC and LQAS survey technique. In addition, Ms. Suladze provided the trainings for the focus group leaders. ACTS consultant, Dr. Keti Shrangi has been trained and certified (maintains this certification at her own expense) by the WHO BF Hospital certification program. Dr. Shrangi trains ACTS Georgia and local hospital staff in targeted areas.

ACTS staff has received numerous trainings as part of the CSP experience. They have also benefitted from quite a bit of technical assistance provided by CSTS. A list of training received is provided in the table below.

Trainings and Workshops of CS Team			
Name	**Date & location**	**Attendant(s)**	**Certificate**
KPC2000 Training of Survey Trainers Course	June 11-21, 2002 Curamericas, CORE Group, Myrtle Beach, SC (USA)	E. Suladze C. Schultz	KPC2000 Survey Trainer
Training Course "Fund Raising"	February 19-20, 2003 Third Sector "Horizonti" Foundation, Tbilisi, Georgia	M. Klibadze	Certificate of Completion
Training Course "Program Evaluation"	May 20-21, 2003 Third Sector "Horizonti" Foundation, Tbilisi, Georgia	M. Klibadze	Certificate of Completion
Training Course "NGOs Sustainability and Auxiliary Entrepreneurship"	December 11-12, 2003 Third Sector "Horizonti" Foundation, Tbilisi, Georgia	M. Klibadze	Certificate of Completion
Training Course "Program Evaluation"	May 20-21, 2003 Third Sector "Horizonti" Foundation, Tbilisi, Georgia	E. Suladze	Certificate of Completion
Advanced Life Support in Obstetrics (ALSO) Courses: Provider and Instructor	October, 2004, Orlando, USA	G. Tsilosani R. Tataradze	Providers and Instructors
Annual Child Survival and Health Mini-University	June 6-10, 2005 John Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA	T. Blair G. Tsilosani R. Tataradze E. Suladze	Certificate of Participation
Training Course: "Organizational management"	December 19-23, 2005. Third Sector "Horizonti" Foundation, Tbilisi, Georgia	M. Klibadze	Certificate of Completion
Evidence Based Public	September 26-29, 2005. WHO CINDI Training Course, Schruns, Austria	G. Tsilosani R. Tataradz	Certificate of Completion
A 10-day workshop on developing and writing an operations research proposal	May 1, 2006 – May 12, 2006. The Office of Population and Reproductive Health in collaboration with the Population Council, CORE group and CSTS, Washington DC, USA	T. Blair G. Tsilosani R. Tataradze	Certificate of Completion
Workshop on	March 9, 2007	R. Tataradze, T.	Certificate of

Trainings and Workshops of CS Team			
Name	**Date & location**	**Attendant(s)**	**Certificate**
Nutrition and NCD. Discussion and evaluation of possible tools and communication channels for Food Based Dietary Guidelines Dissemination Package	Turkey	Ukleba, G. Tsilosani,	Attendance
1st International meeting on Micronutrient Forum "Consequences and Control of Micronutrient Deficiencies"	April 15-18, 2007 Istanbul, Turkey	R. Tataradze, T. Ukleba, G. Tsilosani	Certification
Training Seminar for Health Educators: Diet, Nutrition, Prevention of Non Communicable Diseases	September 11, 2007, Tbilisi, Georgia, National Center of Disease Control and Public Health	R. Tataradze	
Investing in People Workshop, USAID Site Visit: Health Partnerships	October 3, 2007, Tbilisi Georgia, NCDC	R. Tataradze	Oral Presentation: NCD in Georgia
7-Day MPH Course	December, 2007-January, 2008 On-line training	E. Suladze	Certificate of Completion
7-Day Monitoring & Evaluation Manager	October, 2008 On-line training	G. Tsilosani	Certificate of Completion
7-Day MPH Course	December, March, 2009 On-line training	G. Tsilosani	Certificate of Completion

Trainings of Medical Personnel			
Name	**Date & location**	**Attendant(s)**	**Remarks**
BFHI training	April 5-9; 10-14; 25-29, 2006, Rustavi Maternity Hospital	Physicians, nurses	Conducted by "Claritas"
IMCI Training	April 5-15; April 25-May 5; May 8-May 18, 2006 Rustavi Treatment-and-Prophylactic Centers #1 and #2	Pediatricians	Conducted by "Claritas"
Child Healthy	May 8-12; 13-17, 2006	Pediatricians	Conducted by

Trainings of Medical Personnel			
Nutrition Training (with special accent on Breastfeeding)	Rustavi Treatment-and-Prophylactic Centers #1 and #2	Maternity Hospital staff	"Claritas

Health Fairs			
Name	**Date & location**	**Participants**	**Target population**
Health fair, Combined Medical Outreach	November 11, 2005, village of Gachiani, Tetri Tskaro District, Kvemo Kartli	Dr.Dunkan – Family Physician Dr.Shalton. – Anesthesiologist – practiced as a General practitioner Mike Gonzales – Surgery Nurse Dr.Revaz Tataradze – ACTS MCH Division Director Eteri Suladze – ACTS CS Project Manager Mzia Klibadze – Assistant of Project Manager Tamar Lobjanidze – ACTS CS Coordinator in Kvemo Kartli Region	Residents of the village of Gachiani, pregnant women, children U5
Health fair, Combined Medical Outreach	December 15, 2005, village of Koda, Tetri Tskaro District, Kvemo Kartli	Dr. Mark Duncan (family Phisician) Mike Gonzalez (nurse) Richard Klima (medic) Dr.Revaz Tataradze – ACTS MCH Division Director Eteri Suladze ACTS CS Project Manager Mzia Klibadze Assistant of Project Manager Tinatin lomidze	Residents of the village of Koba, pregnant women, children U5

Health Fairs			
		Assistant of MCH Division Director Tamar Lobjanidze – ACTS CS Coordinator in Kvemo Kartli Region Vato Tsilosani – Public Health Specialist Bacho Sharashenidze Computer Assistant (operator)	
Health Fair	March, 15, 2006 Village of Irganchai, Dmanisi District	Physicians from various medical facilities of Tbilisi, ACTS CS staff members and representatives of GUSS. Basing on the data provided by ACTS CS team after meeting with community in the village of Irganchai local authorities requested Georgian University of Social Sciences (GUSS) and MoLHSA to organize Health Fair for the children of Irganchai village. In response to this request GUSS provided medical service to the children of the village of Irganchai in Dmanisi district.	Entire population of the village of Irganchai

Festivals

Name	Date & location	Participants	Target population
Healthy Moms for Healthy Kids Festival	May 17, 2006; Dmanisi	ACTS CS staff, Dmanisi district administration, school children, teachers, parents, Resource center, Public Health Center	Population of Dmanisi district
Healthy Moms for Healthy Kids Festival	May 19, 2007; Bolnisi, Bolisi district	ACTS CS staff, Bolnisi district administration, school children, teachers, parents, Resource center, Public Health Center, local Puppet Theater	Population of Bolnisi district

B. Supervision of Project Staff

The Field Office Director and the Vice President of ACTS/ Georgia supervise the office and staff. The system is informal as it is a small staff. Supervision of activities is mainly conducted through weekly staff meetings where activities and documents are reviewed and plans made for the coming week. The FE team found the supervision system adequate for the small number of professional staff.

Management systems in place to coordinate the activities of program staff and CSP include:

- Weekly staff coordination meetings
- Monthly and quarterly reports of the senior program staff to the Program coordinator and Chief Medical Officer (CMO) and the HQ backstop
- Monthly timesheets to ACTS HQ
- Monthly and Quarterly financial reports to ACTS HQ
- Quarterly Match contributions to ACTS HQ
- Routine constraint identification with cause and effect analysis

Regarding MOH partner staff in the districts, ACTS Georgia staff has implemented the CSP in regions of Georgia that are hard to reach. Historically the Kvemo Kartli area has been difficult to work in for new programs implementing behavior change interventions. ACTS Georgia has been able to engage the population by selecting and training regional staff that can deliver culturally appropriate programming among the diverse populations that reside in these areas.

C. Human Resources and Staff Management

All job positions for the CSP are filled, personnel procedures are in place and job descriptions are located at HQ. Field staff members submit monthly time sheets that include their volunteer time and monthly program reports. As found during site visits in program areas, personnel are highly motivated to support program goals. Attention and professional development is provided to staff through orientations, staff meetings, workshops and trainings, which in turn creates a sense of program ownership. Staff turnover has not been an issue during the program period. However, due to budget difficulties, some of the field staff had to be let go after the mid-term evaluation. The budget difficulties were related to the declining value of the dollar and a four-fold increase in petrol prices. Fortunately, the remaining staffs are committed to the project and have agreed to be paid on a contract basis or work as volunteers.

Professional development is provided to staff increasingly through e-learning programs as well as through orientations, workshops, trainings, which in turn creates ownership of the program. Plans to assist staff find paying jobs after the cessations of the CSP are in place.

D. Financial Management

ACTS financial management procedures appear to be consistent throughout the project period. ACTS HQ using OMB Form 270 and wire transferred to the ACTS GEORGIA BANK account in Tbilisi Georgia draws funds. The ACTS HQ backstop, the ACTS Grants Manager and the HQ accountant also prepare quarterly financial reporting using OMB Form 269. All quarterly forms have been submitted on time.

The total USAID funding for the five-year project is $1,094,527. The project had spent most o f this by the end of year 4 and will have spent it all by the end of the project. ACTS had planned to pay a match of 29% that was $454,000. However because of the financial issues the match increased to $869,797 that is 44.5 percent of the total project budget. From April 2007, electronic transfer providing an electronic paper trail pays all salaries.

The decline of the US dollar affected the CS project funding for Georgia. The value of ACTS CS funds dropped 50 percent in terms of buying power. This required that ACTS raise additional funds and streamline their operations.

Table 4: CSP Staff Positions and Level of Effort

Management Plan					
Position	**No.**	**Affiliation**	**Main Duties**	**LOE (%)**	**Paid/ Volunteer**
PVO – HQ					
Chief Medical Officer	1	ACTS Int'l.	Technical oversight and support for project; Lead DIP preparation, communicates with USAID.	20%	Paid
Fiscal Officer	1	ACTS Int'l.	Processes cash drawdowns, transfers cash to the field; prepare SF269 and monitors country finance and budget.	50%	Paid
Administrative Assistant	1	ACTS Int'l.	Backstop program management and service point of contact for program related issues.	50%	Paid
Field Office					
Project Coordinator	1	ACTS – Georgia	Provides general oversight for project.	100%	Paid
CS Country Director	1	ACTS – Georgia	Provides project directions and programming guides.	100%	Paid
Project Manager	1	ACTS – Georgia	Overseeing planning, implementation and evaluation of the project activities.	100%	Paid
Financial Officer	1	ACTS – Georgia	General accounting duties, petty cash functions, completes general ledger.	100%	Paid
Office Manager	1	ACTS – Georgia	Executes routine administrative staff	100%	Paid
Project Director's Assistant	1	ACTS – Georgia	Assists project director and project manager in office administrative work including all required paper work, data entry into computer, organization of work meetings and workshops on the suites	100%	Paid
District Coordinators	4	ACTS – Georgia	Coordination of project activities at the district level, development of work plans, coordinating with IMCI and MNC coordinators, ensuring training facilities and supplies delivery to training sites.	100%	Paid
IMCI Coordinator	1	Claritas	Training events planning, calendar scheduling, coordination of materials preparation, adaptation of curricula, conduction of trainings.	50%	Paid
MNC Coordinator	1	Claritas	Training events planning, calendar scheduling, coordination of materials preparation, adaptation of curricula, conduction of trainings.	50%	Paid

E. Logistics

ACTS has had 17 years experience managing relief related logistics in Georgia. With this experience, ACTS was able to easily manage the logistics of getting antibiotics into Georgia for children with ARI/ pneumonia as well as related materials needed by the CSP.
Organizing the KPC logistics for 30 cluster samples was a new experience but worthwhile and required new skills.

The project did not purchase vehicles for the office. The FE team observed that there were sufficient office logistics including computers, furniture and supplies available for project activity.

While the original DIP did not include plans for purchase of hospital equipment or facility restoration, site visits prior to and during the MTE report indicated a need for these items. ACTS believed that purchase of these needed items might motivate MoLHSA partners to restore other facilities outside the CSP area. One challenge is that the Health Information System (HIS) does not collect data on health worker performance; however, through routine site visits by CSP and local partner staff this aspect has been observed.

F. Information Management

The routine system includes collection of data by facility-based staff that is recorded on standard reporting forms at the public health district level that are sent to higher levels in the system. Relevant data has been used to monitor and evaluate elements of program performance and progress towards CSP targets. The advantage of this method is that it uses routine systems and does not require additional resources. At the same time the official statistical data frequently differ from data of other surveys, so monitoring cannot be based only on official data, as the quality of the data is questionable.

The M&E plan is based on a series of data sources and methodologies that are complementary and provide information at the different levels of the health system as well as the community-based activities. Each project intervention has a particular M&E plan and each uses different M&E instruments and methodologies. Progress toward achievement of objectives and outcomes is measured through baseline and final population-based surveys in years 1 and 5. LQAS monitoring surveys continue to be used to evaluate effectiveness of the BCC strategy efforts. Annual evaluations continue to help refine messages and improve intervention design.

Progress toward program objectives is measured through quantitative and qualitative research during the project. There are several M&E components. Monitoring systems have been in place throughout the duration of the program, based on the BASICS HFA tool and LQAS methodologies. Data generated during the CSP includes a mix of:

- Field visits to MoLHSA facilities, focus groups and various implementations sites;
- Interviews with MoLHSA officials, government partners, political stakeholders, clinic personnel, mothers attending clinics during facility hours, OB/GYN doctors who attend pregnant women for ANC services and polyclinic staff;
- Multiple interviews with mothers and focus group participants;
- Training observations;
- LQAS surveys;

- Agencies, facility sources and FGD qualitative assessments were conducted; and
- ACTS community groups were interviewed for participation and on focus group topics.

The use of KPC and LQAS survey methodologies was new to Georgia, particularly using them as monitoring tools to detect progress. For this reason it took some time to convince stakeholders of the utility of such methods. However by the end of the project, the FE team saw that the stakeholders now view the M and E findings as a "report card" of the activities conducted, allowing them to better understand how behavior and attitudes have changed among health professionals and community members.

The ACTS CSP used the data collected to revise strategies and provide community, facility and service providers with special assistance to reduce maternal and neonatal mortality and to expand the training and community outreach programs. For example, lessons learned from FGDs were used to revise community session content. Initially the project reviewed results of LQAS, KPC and focus groups conducted after the KPC and MTE in every district to review progress and identify needs. After the MTE, the project relied on informal focus groups to monitor behaviors and attitudes and then adjust the education and training programs accordingly. Some behaviors have been harder to change than others. For example, the Azeri women believe that wrapping babies in plastic wrap keeps them warm and is good for them. Of course it has caused a number of skin problems. This subject came up in the FGDs resulting in a long discussion. Some of the women were difficult to convince. However, after these discussions, the doctors reinforced the message in the clinics. Slowly things are improving. Another issue that was identified in the baseline KPC was that most women did not practice exclusive breast feeding, saying that they didn't have time. Through the education sessions and support from health facility personnel, people now understand the importance of EBF and are not making the excuses they used before.

The project also conducted exit interviews at several of the health facilities to determine how/why people had decided to use the services. They discovered that about 15 percent had heard about it from project sources.

The project also shared the KPC results with the Government of Georgia through MoLHSA who also uses it for making decisions at national and regional levels. The data is also included as part of the Minister of Health's report to WHO.

G. Technical and Administrative Support

The project received substantial support from CSTS – particularly at the beginning. CSTS helped with the DIP, reports, any issues with the KPC or LQAS monitoring and analysis. Particular help was received from Jennifer Luna and Leo Ryan from CSTS and Namita Agravat at USAID.

During the second year of the project, the ACTS team participated in three technical assistance workshops. They were:

- Two separate web-based, multi-part M & E training sessions by Bill Weiss, JHU and Don Carlo, Project Hope.

- Quantitative evaluation and operation research training provided by CSTS/CORE and USAID.
- A BEHAVE workshop led by Bonnie Kittle and coordinated by CORE

ACTS also attended the mini-University twice, once before the grant application in order to better understand the application process and requirements. In addition the CS project manager attended a 10-day KPC training program before the grant was awarded.

ACTS has focused on building the capacity of its local partner, the MoLHSA and selected health care facilities of the two target regions, to deliver and sustain the delivery of effective and high quality MCH programs. Training among all levels of health care personnel, professional medical organizations and administrators of health care facilities has taken place cooperatively with the MOH (Resource Improvement, Training and NGO Development). ACTS International secured other donor support to cover costs of commodities for the five-year program. These costs constituted a portion of the project's cost share.

H. Management Lessons Learned

One of the lessons learned related to project planning concerns the realization that the project had when they discovered that the Azeri families in the project area were reluctant to allow their women to spend time in education meetings outside the home. Involving mother eventually solved this in laws and grandmothers in the sessions. The project also provides small incentives donated by the Lions Club to participants to further convince families to let them participate.

Other management skills included the institution of weekly staff meetings as a method for supervising staff activities as well as receiving group input for project activities. They also encouraged group problem solving and teamwork.

There were some project costs that ACTS had not realized they were responsible for when the project DIP was designed, such as the costs for the MTE and FE. These costs were eventually covered through additional match funds, but the project learned from this experience and recommends that all expected costs be clearly spelled out for New Entry grantees.

I. Strengthening the Grantee Organization

As noted in other areas of this report, ACTS International has benefitted substantially from the training and capacity building it has received as a CSHGP grantee. Its capacity to conduct monitoring and evaluation of project activities has benefitted other projects it is working with.

As a result of CS, ACTS International and ACTS Georgia now participate in international educational forums that provide worldwide sharing of information and research essential to child survival. ACTS is now part of the US coalition for child survival. Of course ACTS International has increased its capacity by establishing a board level child survival committee with the goal of helping integrate child survival values and information in all ACTS work. As a result of the project, ACTS created a Division of Maternal and Child Health. The co-chairs of this division sit on the Board of Directors as non-voting members.

This committee is developing a plan for improvement of neonatal care in Georgia. This will include training of Georgian physicians at the University of Missouri, upgrading of the essential equipment needed at all 8 maternity facilities in Kvemo Kartli, follow-up review of trained physicians by U of Missouri faculty in Georgia.

As a result of ACTS improved programming capacity, the staff worked in partnership with the Georgian parliament to receive a $1.5 million grant to pilot an iron and folic acid flour fortification program.

ACTS staff, particularly the project coordinator, has used their new capabilities and skills to help partners develop proposals and other documents using useful techniques such as the logical framework. ACTS also used the community mobilization skills gained from CSTS training when working with UNICEF in one of the non-project regions to mobilize for a national immunization campaign. ACTS International has also received medicines and vaccines from its other projects that the CSP has been able to use and donate to project health facilities. They also were able to secure two ambulances for two of the project districts (Dmanisi and Tetra Tzeri).

Specific areas that have been strengthened that were also noted in the MTE include the following:

Strengthening of the Grantee Organization has been accomplished by addressing the goals of: a) expanding organization-wide programming capacity in Child Survival, Reproductive Health and MCH; b) developing partnerships with other NGOs, particularly those with strong community presence in the targeted rural areas; and c) building staff capacity to design, implement and evaluate evidence-based practice in Child Survival and Reproductive Health. Capacity-building progress within the grantee organization has included the development of monitoring systems, increasing competence and skill levels of program staff and establishing a new program office.

ACTS International and ACTS Georgia have worked in the health arena in Georgia for more than 10 years. ACTS became the first U.S. NGO in Georgia and has worked closely with the MoLHSA, the Georgian National Center for Disease Control and Public Health and with U.S. PVOs working in Georgia. A unique quality of ACTS International and ACTS Georgia has been its sustained directorship and staffing, resulting in continuity of programming, community relations and reliable memory. ACTS Georgia has undertaken a development role in the health arena (i.e., supporting of the Georgian Medical Association and the National Georgian Family Physician's Association, providing advisory services to Parliamentary Committees and to the MOH), as well as in NGO development and establishment of nation-wide health-related coalitions (Cardiovascular Prevention Committee, Health Promotion Alliance). This phase of Georgia's adjustment, which has created both the need and the opportunity for ACTS International to expand efforts in humanitarian aid and development, includes undertakings toward sustainable, community-based health programs in MCH.

To develop the capacity of the staff to measure program change, a three-day staff orientation workshop was organized between January 12th and 14th, 2005. The objectives of this

workshop included: (1) Discussion and review of activities to determine what worked well and design strategies to improve weaker areas; (2) Briefing on key objectives and strategies; and (3) Informing staff about the upcoming KPC survey, timeline and logistics. The goal of this workshop was to prepare the staff to effectively implement the project using the key approaches.

Other trainings have included: CORE-based web education, Three-part Monitoring and Evaluation (LQAS) – on-line access to CSTS quality tools for implementation, management and measurement of CSP, CORE/USAID/CSTS meetings and training (e.g. Core spring and fall meetings), BEHAVE training, CSTS operation research training, in-country training by ACTS HQ staff and consultants and USAID mission coordinating meetings special events and presentations (e.g. World Health Day).

ACTS International has provided technical expertise to ACTS-Georgia for program evaluation, building upon well implemented monitoring systems that ACTS-Georgia has developed to track program outputs. ACTS International assists its local office in expanding skills in quantitative and qualitative data collection for effective program development. ACTS International supports enrichment of staff through on-the-job training, exchange visits to other Child Survival projects, participation in U.S.-based public health program training; and university exchange programs and scholarships to build its skills for maternal and child health projects as well as participation in CORE Group activities.

A Division of Maternal and Child Health has been created at headquarters, with a non-voting representative on the ACTS Executive Board through the Division Director, who participates in all strategic planning processes undertaken by the full Board and the President. This Division provides coordinated oversight for MCH programs generated by ACTS International and ACTS Georgia for Georgia, as well as for other countries of interest. The major challenge for ACTS Georgia CSP is linkage with facilities and partners for continued technical support.

A new Georgian field office was leased to increase capacity of ACTS to implement the CSP. Several factors were considered in selection of an appropriate office space (e.g., size, cost, security and availability of electricity and telephone services). The central field office is located in Tbilisi and readily accessible to staff. Within the program area, the field offices were open and their location was chosen so that they are easily accessible to beneficiaries and partners. Some basic items were procured, including, computers, printers, radios (HF and/or VHF), furniture and stationary. Program vehicles were also purchased at the start of the program with matching funds. The new office space allowed the CSP to develop a reference library to provide technical manuals and other publications on child survival, maternal and child health, evaluation and needs assessment, among other topics (including CSTS, CORE and the BEHAVE reference materials). The Tbilisi State Medical School among other Georgian entities is using by the CSP staff and the Maternal and Child Health Resource Library in Georgia.

J. Other Issues Identified by the ACTS Team

Innovative Ideas

The community health fairs are the most widely successful events in ACTS' CSP. Historically, coma the Georgian culture had many celebrations and festivals. However under Soviet rule and the economic decline following the break-up off the Soviet Union, there has been the absence of Festivals and fairs for nearly two decades. ACTS has found an enormous enthusiasm for these events, including a grassroots participation in the planning and developing of various programs within the fairs and festivals. The events not only promoted the CSP principles, but engender community pride and identity. The multi-generation volunteers invest hundreds of hours planning and implementing a successful festival. Through dramas, puppet shows, teen theaters and demonstrations, Georgians receive information about maternal and child care, breastfeeding, nutrition, hygiene, immunizations and wellness including preventive measures for diarrhea and pneumonia. Throughout the Kvemo Kartli region, due to word of mouth interest, majors of surrounding communities are requesting assistance for health festival planning. This grassroots interest forms a foundation of sustainability from this community investment.

Promising Practice

Positive behavior changes for health are reinforced through the use of ACTS educational pictorial booklets. During FGD anecdotal evidence overwhelmingly shows that those who receive booklets are using them. Frequently, participants request new healthcare measures they would like covered in future publications. ACTS has been able to revise booklets adding information as requested by the target population.

ANNEX 4 Monitoring and Evaluation Plan

Included on the following pages.

MONITORING AND EVALUATION PLAN
PRINCIPLE OBJECTIVES:

- Improved **QUALITY** of M/C survival services.
- Improved **BEHAVIOR** of household/community on maternal and child health.
- Increased **AVAILABILITY** to M/C health care services and increased **ACCESS** to adequate standard case management.

Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for Process*	*Method*	*Frequency*	*Baseline value/ Benchmarks 06, 07, 08*	*EOP Target*	*Interventions*
MATERNAL AND NEWBORN HEALTH								
Improved perinatal services and maternal newborn care.	Household/ Community	1 P	Percent of mothers who know at least 4 signs of danger during pregnancy that indicate the need for treatment.	KPC LQAS	MT, FE	5.4% 8%; 15%; 25%	30%	• Training of community leaders and health care professionals. • Educational sessions with community. • Dissemination of IEC materials among community.
		2 P	Percent of mothers/family members able to report at least two known neonatal danger signs	KPC LQAS	MT, FE	14.7% 15%; 30%; 45%	55 %	
	Facility	1 R	Percent of deliveries that use partograph to manage labor. *	KPC LQAS	MT, FE	0% 5%; 20%; 30%	40%	• Training of health care professionals. • Monitoring process. • Provision with standard protocols of care.
		2 R	Percent of staff skilled in management of birth asphyxia	HFA – Health facility observation	Annually	22% 28%; 35%; 45%	50%	

MONITORING AND EVALUATION PLAN
PRINCIPLE OBJECTIVES:

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- Increased **AVAILABILITY** to M/C health care services and increased **ACCESS** to adequate standard case management.

Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for Process*	*Method*	*Frequency*	*Baseline value/ Benchmarks 06, 07, 08*	*EOP Target*	*Interventions*
MATERNAL AND NEWBORN HEALTH								
		3 R	Percent of children 0-23 months of age placed with the mother immediately after birth.	KPC LQAS	MT, FE	5% 10%; 20%; 25%	30%	
		4 P	Percent of professionals recognizing signs of danger of delivery.	HFA Health facility observation	MT, FE	5% 10%; 25%; 40%	50%	
	District/ Region	1 R	Percent of health care facilities that Implement M/C Strategy and referral protocols	HFA tool	Annually	0% 20%; 50%; 75%	90%	• The revision and updating the protocols of care and referral • Training of Health Care professionals
		2 P	Number of trained medical staff in MNC	Health Facility Visits and Staff attendance records	FE	10% 20%; 40%; 60%	70%	

- The partograph is a vital tool for providers who need to be able to identify complications in child birth in a timely manner and refer patient to an appropriate facility for treatment

MONITORING AND EVALUATION PLAN
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- Increased **AVAILABILITY** to M/C health care services and increased **ACCESS** to adequate standard case management.

Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for Result or Outcome and P for Process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
BREASTFEEDING AND BFHI								
Improved Breast-feeding Practice and nutritional status of children.	Household/ Community	1 R	Percent of infants aged 0-5 months who were fed breast milk only in the last 24 hours.	KPC LQAS	MT, FE	16.1% 20%; 30%; 45%	50%	• Training of community leaders, Mother- to-Mother support groups and health care professionals. • Educational sessions with community. • Dissemination of IEC materials among community.
		2 R	Percent of children receiving breast milk up to 23 months.	KPC LQAS	MT, FE	37.2% 40%; 45%; 55%	60%	
	Facility	1 R	Percent of children, aged 0-23 months who were breastfed within the first hour after birth.	KPC LQAS	MT, FE	39.5% 50%; 60%; 75%	85%	• Training of health care professionals. • Monitoring process. • Provision with standard protocols of care. • Provision IEC materials.
		2 P	Percentage of pregnant women and mothers who received breastfeeding counseling during antenatal care.	KPC LQAS	MT, FE	47.2% 50%; 60%; 75%	85%	

MONITORING AND EVALUATION PLAN
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Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for Result or Outcome and P for Process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
BREASTFEEDING AND BFHI								
	District/ Region	1 R	Percent of health facilities designated Baby Friendly	Facility external assessment	MT, FE	0% 25%; 50%; 50%	50%	• Implementation 10 steps of BFHI through training activities and audit visits.
		2 R	Percent of compliance of Georgian Law "On Protection and Promotion of Breastfeeding and Regulation of Artificial Feeding".		MT, FE	25% 30%; 50%; 65%	75%	• Introduction of Georgian Law to district authorities and mass media and marketing network • Monitoring of Law violations

MONITORING AND EVALUATION PLAN
PRINCIPLE OBJECTIVES:

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- Increased **AVAILABILITY** to M/C health care services and increased **ACCESS** to adequate standard case management.

Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
NUTRITION								
Improved feeding practices for improving child nutrition and child growth.	Household /Community	1 R	Percent of infants aged 6 – 9 months who received breast milk and solid foods in the last 24 hours.	KPC LQAS	MT, FE	41.7% 45%; 60%; 70%	85%	• Training of community leaders, Mother-to-Mother support groups and health care professionals. • Educational sessions with community. • Dissemination of IEC materials among community.
		2 P	Percent of mothers who know correct complementary feeding practice	KPC LQAS	MT, FE	40% 50%; 65%; 75%	85%	
		3 P	Percent of households who know how to use and store Iodized salt	KPC LQAS	MT, FE	0% 10%; 35%; 50%	65%	
	Facility	1 R	Percent of medical staff assessing child growth and using growth chart during a child's sick visit.	HFA and Follow up observation	Annually	0% 10%; 30%; 50%	60%	• Training of health care professionals; monitoring process. • Provision with standard protocols of care. • Provision IEC materials
		2 P	Percent of medical staff who were asked and explain proper complementary feeding practices.	HFA and Follow up observation	Annually	40% 50%; 60%; 75%	85%	

MONITORING AND EVALUATION PLAN
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Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
NUTRITION								
	District/ Region	1 R	Number of health facilities where correct nutritional counseling is implemented	HFA and Follow up observation	MT, FE	0% 10%; 30%; 45%	50%	• Providing facilities with existing laws concerning nutrition practices – "Iodized salt", "bread fortification with Iron"

MONITORING AND EVALUATION PLAN
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Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
ARI/PNEUMONIA AND DIARRHEA								
Improved management of ARI/ Pneumonia and diarrhea utilizing IMCI protocol.	Household/ Community	1 R	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness.	KPC LQAS	MT, FE	56.3% 65%; 75%, 80%	85%	• Training of community leaders and health care professionals. • Educational sessions with community. • Dissemination of IEC materials among community.
		2 P	Percent of mothers who know at least two signs of childhood illness that indicate the need of referral to health care services	KPC LQAS	MT, FE	64.2% 70%; 75%; 80%	85%	
		3 R	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered catch-up feeding	KPC LQAS	MT, FE	35% 45%; 60%; 75%	85%	
	Facility	1 R	Percent of children who were examined for four common danger signs.	HFA Follow-up Observations (FUO)	Annually	15% 25%; 50%; 70%	80%	• Training of health care professionals. • Monitoring process. • Provision with standard protocols of care. • Provision of facilities IEC materials.
		2 R	Percent of health care providers who assessed for frequent breathing during sick child consult for children under five years of age.	HFA FUO	Annually	3.8% 10%; 20%; 25%	30%	
		3 R	Percent of health care providers who assessed for chest retractions during sick child consult for children under five years of age.	HFA FUO	Annually	3.8% 10%; 20%; 25%	30%	

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Specific Objectives	*Level*	*N & Type*	*Indicator Type indicates R for result or outcome and P for process*	*Method*	*Frequency*	*Baseline value Benchmarks 06,07,08*	*EOP Target*	*Interventions*
ARI/PNEUMONIA AND DIARRHEA								
		4 R	Percent of health care providers who properly classified dehydration degree during child sick consult for diarrhea for children under five years of age	HFA FUO	Annually	3.8% 10%; 20%; 25%	30%	
	District /Region	1 P	Percent of Primary Health Care facilities that have ORT Corner.	HFA FUO	MT, FE	0% 20%; 35%; 45%	50%	• Formation of structure of IMCI Management and Supervision.
		2 P	Percent of Primary Health Care facilities that have IEC-counseling materials on IMCI.	HFA FUO	MT, FE	20% 50%; 75%; 90%	100%	
		3 R	Percent of health services that have essential drugs and medicines to deliver IMCI services.	HFA FUO	MT, FE	0% 25%; 50%; 75%	80%	
		4 R	Percent of health centers with improved performance on correct diagnosis and treatment according to IMCI protocol for sick consults for children 0 to 5 years of age.	HFA FUO	MT, FE	13% 25%; 50%; 70%	80%	

MANAGEMENT PLAN					
Position	**No.**	**Affiliation**	**Main Duties**	**LOE (%)**	**Paid/ Volunteer**
PVO - HQ					
Chief Medical Officer	1	ACTS International	Technical oversight and support for project; Lead DIP preparation, communicates with USAID.	20%	Paid
Fiscal Officer	1	ACTS International	Processes cash drawdowns, transfers cash to the field, prepares SF269, monitors country finance and budget.	50%	Paid
Administrative Asst.	1	ACTS International	Backstop program management and service point of contact for program related issues.	50%	Paid
Field Office					
Project Coordinator	1	ACTS - Georgia	Provides general oversight for project.	100%	Paid
CS Country Director	1	ACTS - Georgia	Provides project directions and programming guides.	100%	Paid
Project Manager	1	ACTS - Georgia	Overseeing planning, implementation and evaluation of the project activities.	100%	Paid
Financial Officer	1	ACTS - Georgia	General accounting duties, petty cash functions, completes general ledger.	100%	Paid
Office Manager	1	ACTS - Georgia	Executes routine administrative staff	100%	Paid
Project Director's Assistant	1	ACTS – Georgia	Assists project director and project manager in office administrative work including all required paper work, data entry into computer, organization of work meetings and workshops on the suites	100%	Paid

MANAGEMENT PLAN					
Position	**No.**	**Affiliation**	**Main Duties**	**LOE (%)**	**Paid/ Volunteer**
Field Office					
District Coordinators	4	ACTS – Georgia	Coordination of project activities at the district level, development of work plans, coordinating with IMCI and MNC coordinators, ensuring training facilities and supplies delivery to training sites.	100%	Paid
IMCI Coordinator	1	Claritas	Training events planning, calendar scheduling, coordination of materials preparation, adaptation of curricula, conduction of trainings.	50%	Paid
MNC Coordinator	1	Claritas	Training events planning, calendar scheduling, coordination of materials preparation, adaptation of curricula, conduction of trainings.	50%	Paid
Partners					
BF and Nutrition coordinator	1	Claritas	Training events planning, calendar scheduling, coordination of materials preparation, adaptation of curricula, conduction of trainings	50%	Paid
Public Health Advisor	1	Health Services Research Center	Guidance in developing activities related to behavior change	50%	Paid
TA consultants for community mobilization	2	Caucasus Social Marketing Association	Guide through developing community mobilization process	50%	Paid
Community Mobilizers	4	Tanadgoma, NGO	Facilitate community mobilization.	20%	Paid
Health Facilities	7	District head doctors	Facilitate intervention activities.		Volunteers
Government Leaders	4	MoLHSA	Participate in project planning and evaluation.		Volunteers

Annex 5: Work Plan Table

Objectives/Activities	Objective Met	Activity Status
Improved perinatal services and maternal newborn care Improved breastfeeding practice and nutritional status of children Improved breastfeeding practice and nutritional status of children Improved feeding practices for improving child nutrition and child growth Improved adequate management of ARI/ Pneumonia and diarrhea utilizing IMCI protocol.	Yes	Completed
Activity 1: Adapting IEC materials, translating them in Azerbaijan and Russian language and printing.	Yes	Completed
Activity 2: Training of CL on MCH.	Yes	Completed
Activity 3: Training of MMSG.	Yes	Completed
Activity 4: Health facility assessment		
Activity 5: Training on BFHI	Yes	Completed
Activity 6: Training on MNC	Yes	Completed
Activity 7: Training on BF.	Yes	Completed
Activity 8: Media involvement	Yes	8 TV programs, 8 type informational newsletter (10,000 each)
Activity 8: IMCI Follow-up visits	Yes	Completed: regularity: Every 5 months

Maternal and Newborn Care (25%)

Program Goal: To create sustainable interventions to reduce maternal, neonatal infant and child morbidity and mortality in Kvemo Kartli region and the cities of Chiatura and Zestaphoni in the Imereti region.

Specific Objective: Improved perinatal services and maternal newborn care.

Indicators (with Measurement Method):

- Indicator 1: Percent of mothers who know at least four signs of danger during pregnancy that indicate the need for treatment. (KPC, LQAS)
- Indicator 2: Percent of mothers/family members able to report at least two known neonatal danger signs. (KPC, LQAS).
- Indicator 3: Percent of deliveries that use partograph to manage labor. (KPC, LQAS).
- Indicator 4: Percent of staff skilled in management of birth asphyxia. (HFA, Observation)
- Indicator 5: Percent of children, 0-23 months of age placed with the mother immediately after birth (KPC, LQAS).
- Indicator 6: Percent of professionals recognizing signs of danger of delivery. (HFA, Observation)
- Indicator 7: Percent of health care facilities that implement M/C Strategy and referral protocols. (HFA).
- Indicator 8: Number of trained medical staff in MNC (Health Facility visits, staff attendance.)

Major Activities	Objective Met?	Activity Status
Household/Community		
• Qualitative research	**Yes**	**Completed**
• Adapting IEC materials, translating them in Azerbaijan and Russian language and printing.	**Yes**	**Completed**
• Selection of community leaders (CL).	**Yes**	**Completed**
• Selection of mother- to- mother support groups (MMSG).	**Yes**	**Completed**
• Training of CL on MCH.	**Yes**	**Completed**
• Training of MMSG.	**Yes**	**Completed**
• Sessions conducted by CL.	**Yes**	**Completed**
• Talks conducted by MMSG.	**Yes**	**Completed**
• Assessment of CL and MMSG activities.	**Yes**	**Completed**
Health Facility		
• Health facility assessment.	**Yes**	**Completed**
• Printing of training materials: ✓ BFHI ✓ MNC ✓ BF	**Yes**	**Completed**
• Training on BFHI.	**Yes**	**Completed**
• Training on MNC.	**Yes**	**Completed**
• Training on BF.	**Yes**	**Completed**
• Audit of maternity houses.	**Yes**	**Completed**
District		
• Orientation meetings.	**Yes**	**Completed**
• Mass Media Component.	**Yes**	**Completed**
• Launch of Project	**Yes**	**Completed**

Breastfeeding and BFHI (20%)

Program Goal: To create sustainable interventions to reduce maternal, neonatal infant and child morbidity and mortality in Kvemo Kartli region and the cities of Chiatura and Zestaphoni in the Imereti region.

Specific Objective: Improved breastfeeding practice and nutritional status of children.

Indicators (with Measurement Method):

- Indicator 1: Percent of infants, aged 0-5 months that were fed breast milk only in the last 24 hours. (KPC and LQAS).
- Indicator 2: Percent of children receiving breast milk up to 23 months. (KPC, LQAS)
- Indicator 3: Percent of children aged 0-23 months who were breastfed within the first hour after birth. (KPC and LQAS)
- Indicator 4: Percentage of pregnant women and mothers who received breastfeeding counseling during antenatal care. (KPC, LQAS).
- Indicator 5: Percent of health facilities designated "baby friendly." (Facility external assessment).
- Indicator 6: Percent of compliance of Georgia Law "On Protection and Promotion of Breastfeeding and Regulation of Artificial Feeding."

Major Activities	Objective Met?	Activity Status
Household/Community		
• Qualitative research	**Yes**	**Completed**
• Adapting IEC materials, translating them in Azerbaijan and Russian language and printing.	**Yes**	**Completed**
• Selection of community leaders (CL).	**Yes**	**Completed**
• Selection of mother- to- mother support groups (MMSG).	**Yes**	**Completed**
• Training of CL on MCH.	**Yes**	**Completed**
• Training of MMSG.	**Yes**	**Completed**
• Sessions conducted by CL.	**Yes**	**Completed**
• Talks conducted by MMSG.	**Yes**	**Completed**
• Assessment of CL and MMSG activities.	**Yes**	**Completed**
Health Facility		
• Health facility assessment.	**Yes**	**Completed**
• Printing of training materials: ✓ BFHI ✓ MNC ✓ BF	**Yes**	**Completed**
• Training on BFHI.	**Yes**	**Completed**
• Training on MNC.	**Yes**	**Completed**
• Training on BF.	**Yes**	**Completed**
• Audit of maternity houses.	**Yes**	**Completed**
District		
• Orientation meetings.	**Yes**	**Completed**
• Mass Media Component.	**Yes**	**Completed**
• Launch of Project	**Yes**	**Completed**

Nutrition/Micronutrients (15%)

Program Goal: To create sustainable interventions to reduce maternal, neonatal infant and child morbidity and mortality in Kvemo Kartli region and the cities of Chiatura and Zestaphoni in the Imereti region.

Specific Objective: Improved feeding practices for improving child nutrition and child growth.

Indicators (with Measurement Method):

- Indicator 1: Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours. (KPC and LQAS)
- Indicator 2: Percent of mothers who know correct complementary feeding practice. (KPC and LQAS)
- Indicator 3: Percent of households who know how to use and store iodized salt (KPC, LQAS).
- Indicator 4: Percent of medical staff assessing child growth and using growth chart during child's sick visit. (HFA, Follow up observation).
- Indicator 5: Percent of medical staff who was asked and explains proper complementary feeding practices. (HFA, Follow- up observation)
- Indicator 6: Number of health facilities where correct nutritional counseling is implemented. (HFA, follow up observation).

Major Activities	Objective Met?	Activity Status
Household/Community		
• Qualitative research	**Yes**	**Completed**
• Adapting IEC materials, translating them in Azerbaijan and Russian language and printing.	**Yes**	**Completed**
• Selection of community leaders (CL).	**Yes**	**Completed**
• Training of CL on MCH.	**Yes**	**Completed**
• Sessions conducted by CL.	**Yes**	**Completed**
• Assessment of CL activities.	**Yes**	**Completed**
Health Facility		
• Health facility assessment.	**Yes**	**Completed**
• Printing of training materials: ✓ BFHI ✓ MNC ✓ BF	**Yes**	**Completed**
• Training on IMCI	**Yes**	**Completed**
• IMCI Follow-up Visits	**Yes**	**Completed**
District		
• Orientation meetings.	**Yes**	**Completed**
• Mass Media Component.	**Yes**	**Completed**
• Launch of Project	**Yes**	**Completed**

ARI /Pneumonia and Diarrhea (40%)

Program Goal: To create sustainable interventions to reduce maternal, neonatal infant and child morbidity and mortality in Kvemo Kartli region and the cities of Chiatura and Zestaphoni in the Imereti region.

Specific Objective: Improved adequate management of ARI/ Pneumonia and diarrhea utilizing IMCI protocol.

Indicators (with Measurement Method):

- Indicator 1: Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness (KPC, LQAS).
- Indicator 2: Percent of mothers who know at least two signs of childhood illness that indicate the need for referral to health care services (KPC, LQAS).
- Indicator 3: Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered catch-up feeding (KPC, LQAS).
- Indicator 4: Percent of children who were examined for four common danger signs (HFA, Follow up observation).
- Indicator 5: Percent of health care providers who assessed for frequent breathing during sick child consult for children under five years of age (HFA, Follow up observation).
- Indicator 6: Percent of health care providers who assessed for chest retractions during sick child consult for children under five years of age (HFA, Follow up observation).
- Indicator 7: Percent of health care providers who properly classified dehydration degree during sick child consult for diarrhea for children under five years of age (HFA, Follow up observation).
- Indicator 8: Percent of primary health facilities that have ORT Corner (HFA, Follow up observation).
- Indicator 9**:** Percent of primary health facilities that have essential drugs and medicines to deliver IMCI services (HFA, Follow up observations).
- Indicator 11: Percent of health care facilities with improved performance on correct diagnosis and treatment according to IMCI protocol for sick consults for children 0-5 years of age (HFA, Follow up observation).

Major Activities	Objective Met?	Activity Status
Household/Community		
• Qualitative research	**Yes**	**Completed**
• Adapting IEC materials, translating them in Azerbaijan and Russian language and printing.	**Yes**	**Completed**
• Selection of community leaders (CL).	**Yes**	**Completed**
• Sessions conducted by CL.	**Yes**	**Completed**
• Training of CL on MCH.	**Yes**	**Completed**
• Assessment of CL.	**Yes**	**Completed**
Health Facility		
• Health facility assessment.	**Yes**	**Completed**
• Printing of training materials: ✓ IMCI	**Yes**	**Completed**
• Training on IMCI.	**Yes**	**Completed**
• IMCI Follow-up visits.	**Yes**	**Completed**
District		
• Orientation meetings.	**Yes**	**Completed**
• Mass Media Component.	**Yes**	**Completed**
• Orientation meetings.	**Yes**	**Completed**

Annex 6: Rapid CATCH Table

Indicator	Baseline Estimate	MTE Estimate	Final Estimate
Underweight Children: Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)			
Kvemo Kartli (1)	4.2%	0%	17.9%
Kvemo Kartli (2)	7.6%	0%	18.7%
Chiatura and Zestaphoni	1.4%	0%	2.6%
Birth Spacing: Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child			
Kvemo Kartli (1)	61.8%	0%	60.0%
Kvemo Kartli (2)	30.6%	0%	30.5%
Chiatura and Zestaphoni	49.4%	0%	50.9%
Delivery Assistance: Percentage of children age 0-23 months whose births were attended by skilled health personnel			
Kvemo Kartli (1)	99.7%	0%	98.7%
Kvemo Kartli (2)	94.0%	0%	98.0%
Chiatura and Zestaphoni	99.7%	0%	100.0%
Maternal TT: Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child			
Kvemo Kartli (1)	0%	0%	0%
Kvemo Kartli (2)	0%	0%	0%
Chiatura and Zestaphoni	0%	0%	0%
Exclusive Breastfeeding: Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours			
Kvemo Kartli (1)	17.1%	0%	85.5%
Kvemo Kartli (2)	18.2%	0%	74.3%
Chiatura and Zestaphoni	14.0%	0%	78.4%
Complimentary Feeding: Percentage of infants age 6-9 months receiving breast milk and complementary foods			
Kvemo Kartli (1)	17.1%	0%	48.3%
Kvemo Kartli (2)	18.2%	0%	49.1%
Chiatura and Zestaphoni	14.0%	0%	65.7%
Full Vaccination: Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday			
Kvemo Kartli (1)	59.0%	0%	0%
Kvemo Kartli (2)	48.8%	0%	0%
Chiatura and Zestaphoni	71.9%	0%	0%
Measles: Percentage of children age 12-23 months who received a measles vaccine			
Kvemo Kartli (1)	59.0%	0%	0%
Kvemo Kartli (2)	48.8%	0%	0%

Indicator	Baseline Estimate	MTE Estimate	Final Estimate
Chiatura and Zestaphoni	71.9%	0%	0%
Bednets: Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)			
Kvemo Kartli (1)	0%	0%	0%
Kvemo Kartli (2)	0%	0%	0%
Chiatura and Zestaphoni	0%	0%	0%
Danger Signs: Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment			
Kvemo Kartli (1)	77.7%	0%	71.3%
Kvemo Kartli (2)	50.5%	0%	84.0%
Chiatura and Zestaphoni	63.1%	0%	100.0%
Sick Child: Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks			
Kvemo Kartli (1)	62.2%	0%	92.6%
Kvemo Kartli (2)	60.0%	0%	80.5%
Chiatura and Zestaphoni	46.7%	0%	100.0%
HIV/AIDS: Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection			
Kvemo Kartli (1)	45.2%	0%	49.7%
Kvemo Kartli (2)	4.6%	0%	11.3%
Chiatura and Zestaphoni	19.9%	0%	79.7%
Handwashing: Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated			
Kvemo Kartli (1)	61.8%	0%	69.7%
Kvemo Kartli (2)	48.1%	0%	40.0%
Chiatura and Zestaphoni	14.3%	0%	92.7%

Annex 7: Final KPC Report

People Helping People Build A Free And Peaceful World

IMPROVEMENT AND EXPANSION OF CHILD SURVIVAL STRATEGIES IN KVEMO KARTLI REGION: A PILOT PROJECT
Final KPC
March-April, 2009

A CALL TO SERVE (ACTS) INTERNATIONAL
A CALL TO SERVE (ACTS) GEORGIA/GEORGIA

***Partner Organizations*: Ministry of Labor, Health and Social Affairs of Georgia; Health Policy Department, MoLHSA, Maternal and Child Health Division, MoLHSA, Mother-Child Nutrition and Wellness Association- Claritas XXI, Women Wellness Center, Union for Social Protection of Citizens of Georgia "Tanadgoma"**

***Authors:* Dr. Giorgi Tsilosani, Dr. Revaz Tataradze, Ms. Eteri Suladze and Dr. Eka Kupatadze, under the leadership of Dr. Patricia Blair**

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Project District coordinators:
Dr. Tamar Lobzhanidze, Dr. Nato Mamageishvili.

List of Abbreviations

ACTS	A Call to Serve
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavioral Communication Change
BF	Breast Feeding
BFHI	Baby-Friendly Hospital Initiative
CDD	Control of Diarrheal Disease
CS	Child Survival
CSP	Child Survival Program
CSHGP	Child Survival Health Grant Program
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
FP	Family Planning
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Results
KPC	Knowledge, Practice, Coverage
LOE	Level of Effort
LQAS	Lot Quality Assurance Sampling
M/C	Maternal/Child
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMR	Measles, Mumps and Rubella
MMSG	Mother-to-Mother Support Groups
MNC	Maternal and Newborn Care
MoLHSA	Georgia Ministry of Labor, Health and Social Affairs
NGO	Non-Governmental Organization
ORS	Oral Re-hydration Salt
ORT	Oral Re-hydration Therapy
PVO	Private Voluntary Organization
SD	Standard Deviations
SPSS	Statistical Package for the Social Sciences
STI	Sexually-transmitted Infection
TRM	Technical Reference Materials
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VRF	Vishnevskaya-Rostropovich Foundation
WRA	Women of Reproductive Age
WHO	World Health Organization

Table of Contents for Final KPC Report

Executive Summary

Three KPC (knowledge, practice, coverage) cluster surveys were conducted in March 27 – April 13, 2009 on 900 respondents (30 clusters each). Respondents were inhabitants of Kvemo Kartli and cities of Chiaturta and Zestaphoni in the Imereti regions of Georgia. Total of the following 33 locations, urban and rural, in 7 districts were targeted: Gardabani District: city of Gardabani, villages: Varketili, Tsalaskuri, Martkopi, Sartichala, Karajalari, Nazarlo, Ponichala and Rustavi; Marneuli District: City of Marneuli, villages: Kuschi, Sabirkendi, Molaogli, Baidari, Kizil-Ajlo and Kirmizkendi, Tsereteli; Bolnisi District: City of Bolnisi, villages: Zveli Kveshi, Kvemo Bolnisi, Talaveri, Nakhiduri and Kazreti settlement; Dmanisi District: City of Dmaisi, villages: Dmanisi settlement, Bazaklo and Kizil-Kilisa; Tetri Tskaro District: City of Tetri Tskaro, villages: Vashlovani and Manglisi settlement; Tsalka District: villages of Takilisa and Kaburi; Chiatura District: Chiatura; Zestaphoni District: Zestaphoni. All the respondents were females. Their age ranged from 15 to 45 years, mean age being 25.6, SD 5.5. 47.4% of the respondents were younger than 25. By ethnic composition Kvemo Kartli region is distinguished by significant number of Azerbaijani population residing predominantly in several rayons of the region. 78.9% of entire Azerbaijani population in Georgia resides in Kvemo Kartli (224,676 out of 284,761 Azerbaijanis residing in Georgia according to the 2002 census). During the preliminary visits to the region and meeting with local governmental bodies and medical professionals it was found out that one of their major concerns was the language barrier leading to certain difficulties in communication with and information delivery to this cohort of population. Considering the importance of this problem and its potential impact on the health knowledge level, it was decided to subdivide the entire region into two parts: one part (sub-region 1) included the areas with no language barrier and the other (sub-region 2) – those with language barrier. Each of 2 sub-regions of Kvemo Kartli region and the two cities in Imereti region were considered as a separate study unit (sub-region 3). The sampling frame for the cluster sampling was used to determine cluster sites in each of sub-regions: Cluster sites were defined at random using Systematic Sampling approach and the households within the clusters were chosen using random drawing of the street names for cities and the “spin the bottle” method for the villages.

The final KPC questionnaire was revised to match cover all problem issues revealed by the baseline KPC survey and agreed with CSTS with additional complementary revised modules offered by CSTS team. Local partners and stakeholders were consulted to ensure maximal elimination of the possible obstacles in the process of interviewing.

7 interviewers and 3 supervisors underwent a four-day training, with the last day devoted to field-testing. Teams consisting of 2 or 3 interviewers and one supervisor were formed and a logistic plan was developed. Average length of the interview was 45 minutes; duration of data collection was 18 days. Each team was assigned a schedule for the entire 18-day period. Supervisors were responsible for the accuracy and completeness of the questionnaires. The data were analyzed using SPSS version 8.0, software. Indicators were calculated for the entire target areas and for the three sub-regions. Twice skilled data managers entered the data into SPSS file. Two files were then merged and sorted by number. Then every 10-th pair was checked for correspondence.

The result obtained from KPC survey allowed evaluation of the results of the interventions implemented within the 5-year life of the Project. The major areas of interventions as defined by DIP were: Maternal & Newborn Care, Breastfeeding, Nutrition, Diarrhea and Pneumonia. The Levels of effort for each intervention area were distributed as follows:

- Maternal & Newborn Care – 25%
- Breastfeeding Promotion – 20%
- Nutrition – 15%
- Management of Diarrhea – 25%
- Case Management of ARI/Pneumonia – 15%

Rapid Catch Indicators For Total Project Area

Rapid Catch Comparison Total Chart A		2005 Total Baseline	2005 Confidence Limits	2009 Final Estimate	2009 Confidence Limits
1	Percentage of children 0-23 months who are moderately	8.8%	±2.9	8.2%	±2.9
2	Percentage of children 0-23 months who were born at least 24 months after the previous surviving child	44.3%	±9.2	48.5%	±5.6
3	Percentage of children aged 0-23 months whose birth were attended by skilled health personnel	97.8%	±6.5	99.4%	±6.5
4	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	NA+	NA	NA	NA
5	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	16.1%	±7.2	79.7%	±12.4
6	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	41.7%	±10.7	55%	±13.0
7	Percentage of children age 12-23 months who are fully vaccinated before the first birthday (children who received OPV3, DPT3, measles)	NA**	NA	NA	NA
8	Percentage of children age 12-23 months who received measles vaccine	N/A	N/A	N/A	N/A
9	Percentage of mothers who know at least two signs of childhood illness that indicate the need for	64.2%	±6.1	85.3%	±6.5

Rapid Catch Comparison Total Chart A		2005 Total Baseline	2005 Confidence Limits	2009 Final Estimate	2009 Confidence Limits
	treatment				
10	Percentage of sick with diarrhea children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	56.3%	±18.9	88.1%	±21.2
11	Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection	23.9%	±4.2	46.9%	±5.5
12	Percentage of mothers of children 0-23 months who wash their hands with soap before after defecation and after attending to a child who defecated	41.6%	±5.3	67.4%	±6.2

- *** Georgia Immunizes children based on the schedule utilized by Western developed nations. The final childhood immunization of measles is given at age 24 months.**
- **** Children are fully immunized when they receive their final vaccination of measles at 24 months of age.**
- **+ All mothers are fully vaccinated during prenatal period.**

Rapid Catch Indicators by Sub-Regions

Sub-Region 1		Numerator	Denominator	Estimated Percentage	Confidence intervals
1	Percentage of children 0-23 who are underweight	19	242	7.9%	±4.9
2	Percentage of children 0-23 who were born at least 24 months after the previous surviving child	57	95	60.0%	±8.1
3	Percentage of children aged 0-23 months whose birth were attended by skilled health personnel	298	300	99.3%	±11.3
4	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	N/A	N/A	N/A	N/A
5	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	71	83	85.5%	±21.3
6	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	28	58	48.3%	±22.0
7	Percentage of children age 12-23 months who are fully vaccinated before the first birthday (children who received OPV3, DPT3, measles)	N/A	N/A	N/A	N/A
8	Percentage of children age 12-23 months who received measles vaccine	N/A	N/A	N/A	N/A
9	Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	252	300	84%	±22.0
10	Percentage of sick with diarrhea children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	25	27	92.6%	±37.6
11	Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection	149	300	49.7%	±9.8
12	Percentage of mothers of children 0-23 months who wash their hands with soap before feeding children, after defecation and after attending to a child who defecated	209	300	69.7%	±10.8

Sub-Region 2		Numerator	Denominator	Estimated Percentage	Confidence intervals
1	Percentage of children 0-23 who are underweight	37	198	18.7%	±8.1
2	Percentage of children 0-23 who were born at least 24 months after the previous surviving child	53	156	33.9%	±11.8
3	Percentage of children age 0-23 months whose birth were attended by skilled health personnel	297	300	99%	±11.3

4	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	N/A	N/A	N/A	N/A
5	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	52	70	74.3%	±22.6
6	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	27	55	49.1%	±22.7
7	Percentage of children age 12-23 months who are fully vaccinated before the first birthday (Children who received OPV3, DPT3, measles)	N/A	N/A	N/A	N/A
8	Percentage of children age 12-23 months who received measles vaccine	N/A	N/A	N/A	N/A
9	Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	216	300	72%	±10.9
10	Percentage of sick with diarrhea children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	33	41	80.5%	±30.0
11	Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection	34	300	11.3%	±5.2
12	Percentage of mothers of children 0-23 months who wash their hands with soap before feeding children, after defecation and after attending to a child who defecated	120	300	40.0%	±9.1

Sub-Region 3		**Numerator**	**Denominator**	**Estimated Percentage**	**Confidence intervals**
1	Percentage of children 0-23 who are underweight	5	265	2.6%	±1.9
2	Percentage of children 0-23 who were born at least 24 months after the previous surviving child	56	110	50.9%	±16.3
3	Percentage of children age 0-23 months whose birth were attended by skilled health personnel	300	300	100%	±11.3
4	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	N/A	N/A	N/A	N/A
5	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	69	88	78.4%	±20.4
6	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	44	67	65.7%	±22.5

7	Percentage of children age 12-23 months who are fully vaccinated before the first birthday (children who received OPV3, DPT3, measles)	N/A	N/A	N/A	N/A
8	Percentage of children age 12-23 months who received measles vaccine	N/A	N/A	N/A	N/A
9	Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	300	300	100%	±11.3
10	Percentage of sick with diarrhea children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	16	16	100%	±11.3
11	Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection	239	300	79.7%	±11.1
12	Percentage of mothers of children 0-23 months who wash their hands with soap before feeding children, after defecation and after attending to a child who defecated	278	300	92.7%	±11.3

Project Indicators and Results

Note: Immunization Calendar of Georgia is different from that for developing countries being closer to the Immunization Calendar adopted by the developed countries. In Georgia the recommended age for measles vaccination is 12 months. The rapid catch question talks about full immunization before the first birthday. For this reason this question was considered as non-applicable for this survey.

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
Underweight children	Percentage of children 0-24 months severely underweight	2.9%	2.5%	7.0%	0%
	Percentage of children 0-24 months moderately underweight	8.9%	7.9%	18.7%	2.6%
Overweight children	Percentage of children 0-24 months severely overweight	20.0%	20.2%	16.7%	22.3%
	Percentage of children 0-24 months moderately overweight	20.4%	18.2%	11.1%	29.4%
Vitamin A	Percentage of children 6-23 months who received a dose of vitamin A in the last 6 months	N/A	N/A	N/A	N/A
Breastfeeding Reception of colostrum	Percentage of breastfed children	91.6%	91.0%	89.3%	94.3%
	Percentage of children 0-11 months breastfed immediately after delivery	52.5%	48.8%	48.0%	59.3%
	Percentage of children 0-11 months breastfed during the first hour following birth	17.2%	13.6%	12.3%	24.2%
	Percentage of children 0-11 months breastfed after one hour	21.8%	29.6%	27.4%	10.4%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
Exclusive breastfeeding	Percentage of children 0-5 months exclusively breastfed	49.4%	48.2%	42.8%	55.7%
	Percentage of children aged 0-5 months who were exclusively breastfed during last 24 hours	79.7%	85.5%	74.3%	78.4%
Breastfeeding accompanied w/complementary feeding (0-5 months infants)	Percentage of children aged 0-5 months who received water in addition to breast milk during last 24 hours	31.8%	33.8%	34.6%	27.5%
	Percentage of children aged 0-5 months who received sweet water, tea, soup in addition to breast milk during last 24 hours	12.5%	11.3%	26.9%	2.9%
	Percentage of children aged 0-5 months who received juice in addition to breast milk 24 hours	9.4%	9.9%	7.7%	10.1%
	Percentage of children aged 0-5 months who received animal milk in addition to breast milk during last 24 hours	2.6%	0%	9.6%	0%
	Percentage of children aged 0-5 months who received baby food during last 24 hours	9.4%	14.1%	11.5%	2.9%
	Percentage of children aged 0-5 months who received fresh fruit and vegetables during last 24 hours	8.3%	14.5%	10.0%	1.1%
	Percentage of children aged 0-5 months who received potato during last 24 hours	6.6%	3.6%	8.6%	8.0%
	Percentage of children aged 0-5 months who received grain food during last 24 hours	8.7%	4.8	15.7%	6.8%
	Percentage of children aged 0-5 months who received fresh dairy products during last 24 hours	7.9%	15.7%	5.7%	2.3%
	Percentage of children aged 0-5 months who received meat, poultry, fish during last 24 hours	4.1%	0%	11.4%	2.3%
	Percentage of children aged 0-5 months who received food prepared on butter, oil or fat during last 24 hours	1.7%	2.4%	2.9%	0%
	Percentage of children aged 0-5 months who received food prepared from vegetables during last 24 hours	2.9%	2.4%	2.9%	3.4%
	Percentage of children aged 0-5 months who received pumpkin or carrot during last 24 hours	0.8%	1.2%	1.4%	0%
	Percentage of children aged 0-5 months who received kidney beans or soy beans during last 24 hours	0%	0%	0%	0%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
Breastfeeding and complementary food consumption in children aged 6-9 months	Percentage of children aged 6-9 months who received juice in addition to breast milk 24 hours	32.4%	40.0%	33.4%	27.5%
	Percentage of children aged 6-9 months who received animal milk in addition to breast milk during last 24 hours	10.8%	10. 0%	10.0%	11.8%
	Percentage of children aged 6-9 months who received baby food during last 24 hours	23.4%	33.3%	23.3%	17.7%
	Percentage of children 6-9 months who received breast milk and at least one type of complimentary food during the last 24 hours	55.0%	48.3	49.1%	65.7%
	Percentage of children 6-9 months who are still breastfeeding	61.7%	51.7%	54.6%	76.1%
	Percentage of children aged 6-9 months who received fresh fruit and vegetables during last 24 hours	48.9%	62%	43.6%	41.8%
	Percentage of children aged 6-9 months who received potato during last 24 hours	46.1%	31.0	45.5%	59.7%
	Percentage of children aged 6-9 months who received grain food during last 24 hours	55.0%	63.5%	36.4	71.7
	Percentage of children aged 6-9 months who received fresh dairy products during last 24 hours	31.7%	55.2%	14.6%	25.4%
	Percentage of children aged 6-9 months who received meat, poultry, fish during last 24 hours	21.1%	25.9%	16.4%	20.9%
	Percentage of children aged 6-9 months who received food prepared on butter, oil or fat during last 24 hours	27.2%	24.1%	27.3%	29.8%
Breastfeeding and complementary food consumption in children aged 6-9 months (Continued)	Percentage of children aged 6-9 months who received food prepared from vegetables during last 24 hours	35.6%	32.8%	31.0%	41.9%
	Percentage of children aged 6-9 months who received pumpkin or carrot during last 24 hours	10.6%	19.0%	14.6%	0%
	Percentage of children aged 6-9 months who received kidney beans or soy beans during last 24 hours	2.2%	0%	3.6%	3.0%
Breastfeeding and complementary feeding in children aged 10-23 months	Percentage of children aged 10-23 months who received breast milk during last 24 hours	25.0%	22.0%	18.9%	35.9%
	Percentage of children aged 10-23 months who received water in addition to breast milk during last 24 hours	83.3%	80.0%	84.8%	84.6%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
	Percentage of children aged 10-23 months who received sweet water, tea, soup in addition to breast milk during last 24 hours	67.5%	57.2%	75.8%	69.2%
	Percentage of children aged 10-23 months who received juice in addition to breast milk 24 hours	40.0%	54.3%	27.3%	38.5%
	Percentage of children aged 10-23 months who received animal milk in addition to breast milk during last 24 hours	15.8%	8.6%	9.1%	25.0%
Nutrition status assessment in children aged 10-23 months	Percentage of children aged 10-23 months who received baby food during last 24 hours	10.6%	12.6%	6.9%	13.1%
	Percentage of children aged 10-23 months who received fresh fruit and vegetables during last 24 hours	50.7%	54.7	41.7%	57.3%
	Percentage of children aged 10-23 months who received potato during last 24 hours	57.8%	42.1%	58.3%	74.5%
	Percentage of children aged 10-23 months who received grain food during last 24 hours	64.7%	58.5%	55.4%	82.8%
	Percentage of children aged 10-23 months who received fresh dairy products during last 24 hours	45.7%	54.7%	41.7%	40.7%
	Percentage of children aged 10-23 months who received meat, poultry, fish during last 24 hours	48.9%	44.0%	41.2%	63.5%
	Percentage of children aged 10-23 months who received food prepared on butter, oil or fat during last 24 hours	45.7%	45.3%	40.6%	52.4%
	Percentage of children aged 10-23 months who received food prepared from vegetables during last 24 hours	41.1%	34.6%	32.0%	59.3%
	Percentage of children aged 10-23 months who received pumpkin or carrot during last 24 hours	14.0%	17.0%	18.9%	4.8%
Assessment of iodized salt availability, consumption and awareness status	Percentage of household that use iodized salt	61.1%	57.7%	25.7%	100%
Assessment of iodized salt availability, consumption and awareness status	Percentage of mothers who knew that iodine deficiency is dangerous	70.9%	80.3%	32.7%	99.7%
	Percentage of mothers who think that using iodized salt will help to prevent some diseases	70.9%	80.0%	33.0%	99.7%
	Percentage of mothers who think that using iodized salt is good for child's health	70.9%	80.3%	32.7%	99.7%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
	Percentage of mothers who think that using iodized salt is good for mother's health	74.3%	84.1%	51.2%	86.0%
Knowledge of danger signs of childhood illnesses	Percentage of children 0-23 months who were sick in the past 2 weeks and were offered more fluid during recovery from the illness	88.1%	92.6%	80.5%	100%
	Percentage of mothers who can cite at least 2 danger signs in children	85.3%	84.0%	72.0%	100%
	Percentage of mothers who can cite at least 4 danger signs in children	9.5%	27.3%	18.7%	18.3%
	Percentage of mothers who cited "fast/difficult breathing" as a danger sign in children	28.4%	13.0%	6.7%	65.7%
	Percentage of children 0-23 months with diarrhea in the last 2 weeks	9.3%	9.0%	13.7%	5.3%
	Percentage of children 0-23 months with bloody stool in the last 2 weeks	0%	0%	0%	0%
	Percentage of children 0-23 months with cough in the last 2 weeks	18.2%	18.7%	16.0%	20.0%
	Percentage of children 0-23 months with difficult breathing in the last 2 weeks	5.8%	6.3%	4.0%	7.0%
	Percentage of children 0-23 months with high fever in the last 2 weeks	13.8%	14.7%	16.3%	10.3%
	Percentage of children 0-23 who had ARI during the last two weeks	24%	25%	20%	27%
	Percentage of children treated for ARI	94.0%	92.9%	84.9%	100%
	Percentage of mothers with children 0-23 months with ARI who sought medical treatment on the day of onset of the symptoms	31.6%	34.5%	38.1%	24.6%
	Percentage of mothers with children 0-23 months with ARI who sought medical treatment on the next day after onset of the symptoms	43.0%	34.5%	23.8%	63.9%
	Percentage of mothers with children 0-23 months with ARI who sought medical treatment two days after the onset of the symptoms	14.0%	18.2%	11.9%	11.5%
	Percentage of mothers with children 0-23 months with ARI who sought medical treatment three or more days after the onset of the symptoms	8.9%	7.3%	23.8%	0%
	Percentage of mothers with children 0-23 months who went first for treatment to the hospital	17.9%	17.9%	17.0%	18.7%
	Percentage of mothers with children 0-23 months who went first for treatment to the Ambulatory	6.0%	1.8%	11.3%	5.1%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
	Percentage of mothers with children 0-23 months who went first for treatment to the Outpatient clinic	64.3%	67.9%	45.3%	78.0%
	Percentage of mothers with children 0-23 months who went first for treatment to other health facility	0%	0%	0%	0%
	Percentage of mothers with children 0-23 months who went first for treatment to the traditional practitioner	1.2%	0%	3.8%	0%
	Percentage of cases where decision maker for seeking medical aid for ARI was a respondent	63.5%	63.6%	41.8%	80.9%
	Percentage of cases where decision maker for seeking medical aid for ARI was a husband	16.1%	8.9%	19.6%	9.0%
	Percentage of cases where decision maker for seeking medical aid for ARI was a respondent's mother	5.5%	7.8%	0%	7.3%
	Percentage of cases where decision maker for seeking medical aid for ARI was a respondent's mother-in-law	15.5%	9.1%	41.8%	1.5%
	Percentage of cases where decision maker for seeking medical aid for ARI was a respondent's relative/neighbor	0.5%	0%	0%	1.5%
Management of diarrhea	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks	9.3%	9.0%	13.7%	5.3%
Management of diarrhea (breast feeding)	Percentage of mothers who breastfed the child when he/she has a diarrhea less than usual	6.0%	3.7%	7.3%	6.3%
Nutrition status assessment in children aged 10-23 months	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks who received oral rehydration solution (ORS) and/or recommended home fluids	46.4%	51.9%	34.2%	68.8%
Management of diarrhea, medical care seeking behavior hand washing practices	Percentage of mothers with children 0-23 months who can correctly prepare the ORS from package	39.2%	53.0%	21.3%	43.3%
Management of diarrhea	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks who were offered more fluids during the illness	88.1%	92.6%	80.5%	100%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks who were offered the same amount or more food during the illness	77.4%	92.6%	63.4%	87.5%
Management of diarrhea (Continued)	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks who whose mothers sought outside advise or treatment for the illness	76.2%	81.5%	68.3%	87.5%
	Percentage of mothers who usually wash hands with soap before food preparation, before feeding the children, after defecation and after attending to a child who has defecated	67.4%	69.7%	40.0%	92.7%
Prenatal Care Counseling	Percentage of mothers who saw physician during the last pregnancy	88%	98.0%	95.3%	100%
	Number of visits to health care providers	5.24 times	5.82 times	5.08 times	5.24 times
	Percentage of mothers who received at least 2 Tetanus Toxoid (TT) injections (recall) before the birth of the youngest child 0-23 months	N/A	N/A	N/A	N/A
	Percentage of women who got advise on delivery preparation	86.7%	82.0%	78.7%	99.3%
	Percentage of women who got advise on breastfeeding	78.3%	72.0%	63.7%	99.3%
	Percentage of women who got advise on symptoms dangerous for pregnancy	69.8%	64.7%	45.7%	99.0%
	Percentage of women who got advise on EPI	66.7%	61.7%	55.0%	83.3%
Knowledge of danger signs of pregnancy complications	Percentage of women who indicated high fever as a symptom prompting to seek medical care during pregnancy	51.9%	35.3%	46.0%	74.3%
	Percentage of women who indicated bleeding as a symptom prompting to seek medical care during pregnancy	58.1%	47.0%	32.7%	94.7%
	Percentage of women who indicated shortness of breath as a symptom prompting to seek medical care during pregnancy	40.9%	35.7%	20.3%	66.7%
	Percentage of women who indicated swelling as a symptom prompting to seek medical care during pregnancy	40.8%	33.3%	19.3%	71.3%
Knowledge of danger signs of pregnancy Complications	Percentage of women who indicated other causes as symptoms prompting to seek medical care during pregnancy	34.2%	56.7%	41.0%	5.0%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
(Continued)	Percentage of women who did not know any symptoms prompting to seek medical care during pregnancy	8.7%	7.78%	17.7%	0.67%
Care seeking preferences	Percentage of women who named women's consultation as a health facility where to go in case of having the above symptoms	54.3%	44.0%	25.0%	9 4.03%
	Percentage of women who named a hospital as a health facility where to go in case of having the above symptoms	28.9%	40.7%	39.0%	7.0%
	Percentage of women who named policlinic as a health facility where to go in case of having the above symptoms	9.4%	13.04%	15.08%	0.3%
	Percentage of women who named village ambulatory as a health facility where to go in case of having the above symptoms	4.9%	2.0%	12.7%	0.0%
	Percentage of women who named friends/relatives as advisors where to go in case of having the above symptoms	0.4%	0.3%	1.0%	0.40%
	Percentage of women who named traditional healer as an advisor where to go in case of having the above symptoms	0.3%	0%	1.0%	0%
	Percentage of women who named other sources where to go in case of having the above symptoms	0.3%	1.0%	0%	0%
Delivery	Percentage of women who gave birth in maternity hospital	99.1%	99.3%	98.0%	100%
	Percentage of women who gave birth at home	0.6%	0.7%	1.0%	0%
	Percentage of women who gave birth in ambulatory	0%	0%	0%	0%
	Percentage of women who gave birth in midwife post	0%	0%	0%	0%
	Percentage of women who gave birth elsewhere	0%	0%	0%	0%
	Percentage of women were attended by a physician on delivery	98.9%	98.7%	98.0%	100%
	Percentage of women were attended by a midwife/nurse on delivery	0.9%	1.0%	1.7%	0%
	Percentage of women were attended by a traditional birth attendant	0.3%	0.34%	0.67%	0%
	Percentage of women were attended by a family member on delivery	0%	0%	0%	0%
	Percentage of women were named other persons	0%	0%	0%	0%

Indicators	Description	Total	Sub-Region 1 %	Sub-Region 2 %	Sub-Region 3%
Postpartum Care	Percent of mothers able to report at least two known maternal danger signs during the postpartum period	56.9%	50.3%	33.3%	87.0%
	Percent of mothers able to report at least two known neonatal danger signs	64.2%	67.3%	42.0%	83.3%
HIV/AIDS	Percentage of women aged 15-49 who did not know even one right way to avoid HIV infection Percentage of women aged 15-49	8.0%	11.7%	12.3%	0%
	who knew two or more ways of HIV prevention	46.9%	49.7%	11.3%	79.7%

Project Accomplishments: KPC RESULTS Comparing End of Program Results to the Baseline

Objectives	Indicators	Baseline Estimate	Final Estimate	Confidence Limits	Final Target	Explanation or Reference
Improved perinatal services and maternal and newborn care	% of mothers who know at least 4 danger signs of pregnancy	5.4%	28.1%	±4.5	30%	Achieved within the confidence limits.
	% of mothers able to report at least two neonatal danger signs	14.7%	64.2%		55%	Achieved
	% of infants <6 months of age that were exclusively breastfed in the last 24 hours	16.1%	49.4%		50%	Achieved
	% of children 0-22 month of age placed with the mother immediately after birth	5%	52.5%		30%	Achieved
Improved breastfeeding Practice and nutritional status of children	% of infants aged 0-5 months who were fed breast milk only in the last 24 hours	16.1%	79.7%		50%	Achieved
	% of children receiving breast milk up to 23 months	37.2%	25.0%	±5.5	60%	Not achieved. FGD conducted immediately after obtaining KPC data demonstrated

Objectives	Indicators	Baseline Estimate	Final Estimate	Confidence Limits	Final Target	Explanation or Reference
						that because of economic crisis resulting from the 2008 war, women preferred to wean the children of 10-23 months of age to devote more time to bread winning.
	% of children who were breastfed within the first hour after birth	39.5%	69.7%	±6.2	85%	Not achieved. However 30% increase demonstrates that the tendency is changing in positive direction. There is a certain inertia among the medical personnel especially in rural HF, which are still sticking to the Soviet standards even though they have been trained about breastfeeding. It seems ACTS was too optimistic when setting 85% target.
	% of pregnant women and mothers who received breastfeeding counseling during antenatal care	47.2%	78.3%	±6.4	85%	Achieved within confidence limits We did have 31% increases. When asked why women were not counseled on breastfeeding the primary health care some (not all) physicians explained that they would be counseled at the maternity hospitals. And though the guidelines required them to counsel mothers they believed it

Objectives	Indicators	Baseline Estimate	Final Estimate	Confidence Limits	Final Target	Explanation or Reference
						"waste of time".
Improved feeding practices for improving child nutrition and child growth	% of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours	41.7%	89.2%		85%	Achieved
	% of mothers who knew correct complementary feeding practices	40%	97.5%		85%	Achieved
	% of households who know how to use and store iodized salt	0%	61.1%	±6.0	65%	Achieved within the confidence limits. Note the extreme differences in the 3 sub-regions with a range 26%-100%. The impact of community festival education as well as ACTS work where the ACTS delivered iodized salt to Imeriti cities including Kutaisi over the last 10 years
Improved management of ARI/Pneumonia and diarrhea utilizing IMCI protocol	% of children 0-23 months with diarrhea in the last 2 weeks who were offered more fluids during the illness	56.3%	88.1%		85%	Achieved
	% of mothers who know at least two danger signs of childhood illnesses that indicate the need of referral to health care services	64.2%	85.3%		85%	Achieved
	% of children aged 0-23 months with diarrhea in the last two weeks who were offered catch-up feeding	35%	77.4%	±6.4	85%	Achieved within the confidence limits.

Background

Georgia is situated in the central and western region of Caucasus; Southwest by Turkey and west by the Black Sea border Georgia north by Russia, east by Azerbaijan and south by Armenia. The territory of Georgia is 69.5 thousands sq. km. Total length of the border is 1968.8 km, land – 1,660.4 km, see borders- 308.4 km. In geographic terms Georgia belongs to neither Europe nor Asia. In cultural terms it is neither West nor East. It has distinct language, customs and traditions. The 1990s were the most critical years in the latest history of Georgia since they marked the period of fundamental changes in political, economic and social life of the country.

The region of Kvemo Kartli consists of six rayons or districts: Gardabani, Marneuli, Tetri Tskaro, Bolnisi, Dmanisi and Tsalka. The administrative center of Kvemo Kartli, Rustavi, is situated just 25 km from the Georgian capital, Tbilisi and the towns of Marneuli and Gardabani are also close to the capital (at distances of 39 km and 42 km respectively). The western rayons of Kvemo Kartli (Dmanisi, Tetri Tskaro and Tsalka) are not only more remote from Tbilisi geographically, but are also rather mountainous; the town of Tsalka is situated approximately 1,500 meters above sea level.

The three principal national minorities concentrated in Kvemo Kartli are Azerbaijanians, Armenians and Greeks. Azerbaijanians are by far the most numerous of the three sub-regions; according to the 2002 census, 284,761 Azerbaijanians live in Georgia (6.5% of the population) and 78.9% of these live in Kvemo Kartli. According to the same census, Azerbaijanians form an absolute majority of the population of Marneuli, Bolnisi and Dmanisi rayons and more than 40% of the population in Gardabani rayon.

Rayon	Georgians	Azerbaijanians	Armenians	Greeks	Russians
Gardabani	53.20%	43.72%	0.93%	0.21%	0.87%
Marneuli	8.04%	83.10%	7.89%	0.33%	0.44%
Teteri Tskaro	68.3%	12.0%	10.0%	3.2%	5.7%
Bolnisi	26.82%	65.98%	5.81%	0.59%	0.56%
Tsalka	12.02%	9.54%	54.98%	21.97%	0.60%
Dmanisi	31.24%	66.76%	0.52%	0.78%	0.56%

Vegetable growing is the main economic activity and potatoes are the main crop. Jonathan Wheatley indicated that 126,000 tons of potatoes were produced in Kvemo Kartli in 2000, which made up 41.8% of all potatoes produced in Georgia. In the same year Kvemo Kartli produced 25.4% of all vegetables produced in Georgia. In the same year, Kvemo Kartli produced 25.4% of all vegetables produced in Georgia. Fruit and grain (mainly wheat and maize) production is significant especially in the Gardabani and Marneuli rayons. Livestock breeding also plays an important role in the local economy, especially in the mountainous regions where hayfields make up a large proportion of agricultural land.[1] As for poverty in Kvemo Kartli, 78 percent (3/4) of the population lives under the poverty line and 1/3 in extreme poverty.[2]

[1] Jonathan Wheatley, *Obstacles Impeding the Regional Integration of the Kvemo Kartli Region of Georgia;* EUROPEAN CENTRE FOR MINORITY ISSUES (ECMI) Working Paper #23, February 2005

[2] Progress Report, Economic Development and Poverty Reduction Program (EDPRP), Tbilisi, January 2005

Since 1995 GOG is conducting an ambitious reform of health care system As a result of past and ongoing reforms MoLHSA acquired the following structure:

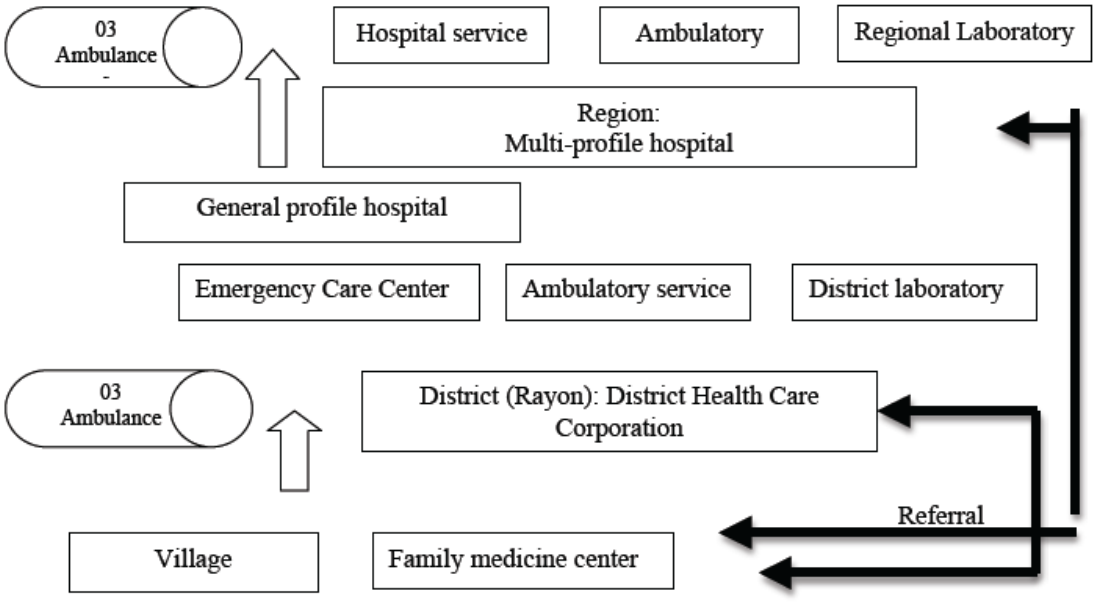
Structure of Ministry of Labor Health and Social Affairs

Maternal and Child health remains one of the priorities in health policy of Georgia. According to WHO office in Georgia it cooperates with the government of Georgia within the framework of Biennial Collaborative Agreement (BCA) for 2006-2007 signed in September 2005. One of the priorities on which this agreement is focused is "Strengthening mother and child health services and promoting environmental safety."[3] Within the framework of the ongoing reform the mission and goals of the Ministry of Labor, Health and Social Affairs have been formulated as follows:

Mission: Sustainable development of human resources in the sphere of Labor, health and Social Affairs through development and implementation of the state policy.
Goal: Development of high quality, just and accessible social system for all citizens of the country through stage-wise and consistent implementation of the reforms in health care.[4]

The current concept of the ongoing reform as related to the state owned medical facilities envisages the following model of health service providing:[5]

Implementation of Child Survival Project coincided with the period of major shifts in health care system, which required continuous adaptation and revision of CS interventions tactics, while maintaining major strategy of the project.



[3] http://www.ungeorgia.ge/eng/WHO.php
[4] http://www.mohgov./ge/
[5] Health Care Reform Concept, MoLHSA, October, 2006

According to the data provided by the department of Statistics of the Ministry of Economic Development of Georgia infant mortality rate per 1000 live births had been almost stable during the time period from 1970 to 2004 comprising 23.6 on average. 2005-2007 years were characterized by decrease in this value so that in 2007 the infant mortality rate was as low as 13.3 on average. The data provided by the Ministry of Labor, health and Social Affairs of Georgia demonstrated that maternity mortality rate in Georgia was one of the highest among the European region during the period of 1997-2004. In 2005 maternal mortality rate decreased almost twice and became 23.4 per 100,000 live births. The tendency continued in 2006-2007 (23.0 and 20.2, respectively).[6] Among the maternal diseases, which preceded the pregnancy or developed during pregnancy, complicating pregnancy, delivery and the puerperium period, anemia (6,824 cases), infections of genitourinary tract (2,709 cases) and thyroid gland pathologies (2,118 cases) were leading. The number of home deliveries is significantly decreased. The total number of stillbirths in 2007 has decreased by 9.7% compared to 2006. In 77.1% of the total number of registered stillbirths the weight of fetus was less than 2,500 grams.

In Kvemo Kartli region registered stillbirths rate in 2007 was 11.1, registered infant mortality rate for 4.9, early neonatal deaths were 4.2, perinatal mortality rate per 1000 live births was15.3.[7] Compared to the similar data for 2003 these data are a little increased (10.7, 4.6, 14.0, respectively). This fact is explained with introduction of free of charge birth registration in 2005, which improved the registration rate in the country on the whole and in Kvemo Kartli region in particular. The introduction of free delivery services increased the number of women delivering in health facilities

National Policies Regarding Maternal and Child Health

The theme for the UN-sponsored World Health Day 2005 was “make every mother and child count.” This is also the title of the WHO World Health Report for 2005, in recognition of the renewed global commitment to address the challenging problems associated with morbidity and mortality of women and infants in the developing world, underscoring the “importance of improving heath, particularly the health of mothers and children, as an integral part of poverty reduction.” Declines in socio-economic conditions in Georgia over the past fifteen years, along with deterioration in the health service delivery system, have had negative results for the health of both mothers and infants here. One of the most critical challenges facing the country today is reversal of decreasing mortality among mothers and infants.

Health policy-makers and planners in Georgia are addressing this concern with maternal and child health by placing priority on improvement of maternal and child health indicators, allocating state resources to critical health services for pregnant women and children up to the age of three years and prioritizing actions to ensure that Georgia moves towards achievement of the Millennium Development Goals.

[6] Health and Health Care, Statistical Year Book, Georgia 2007, MoLHSA of Georgia, National Center for Disease Control and Public Health, Tbilisi, 2008
[7] Ibid

Improvement of maternal and child health is stated as the first priority of health care in the National Health Policy of Georgia, which cites the current negative demographic situation in the country as a key justification for ensuring that the heath of mothers and children are protected. Maintenance of good health among infants and children is presented as key to "the formation of healthy, harmoniously developed, socially active new generations."

State Health Programs

Provisions are made in state supported health programs for ensuring that all women in the country have access to four antenatal visits, as well as delivery services in a maternity hospital, free of charge. In addition, basic care for newborns and children up to the age of three years is also provided for. The allowances for provision of this care under state programs are as follows:

State Ambulatory Program

Women receive state-supported antenatal care through this program. Provision of geographically and financially affordable ambulatory service and decrease of morbidity are stated as the two expected results of the program. Availability of health services, acceptance by the population of ambulatory care, accountability, comprehensiveness of ambulatory medical service and coordination and continuity of ambulatory services are listed as indicators of the success of the program.

Pregnant women are entitled to register for and receive antenatal care in accordance with the WHO-approved, four visit regimen. The description of the four visits in the approved 2005 state program document coincides with the WHO visit protocols and these consultations are largely undertaken by Ob/Gyn and midwifery staff of Women's Consultation Centers and Maternity Hospitals. The State Ambulatory program covers antenatal care visits at 13, 20-22, 30-32 and 36 weeks of pregnancy. The protocol for each visit includes oral history, clinical examination and recommended lab tests. The current protocol calls for screening for both syphilis and HIV, as well as performing an ultra-sound examination during the second visit. Counseling on nutrition, self-care during pregnancy, danger signs of pregnancy, breastfeeding and postpartum family planning are included in the visit protocols.

Women determined to have one or more predetermined "risk factors" are identified during the first visit and referred for more specialized care and/or further testing, if required. This additional care is not covered under the state program and charges for services are determined by the internal standards of the concerned facility.

Post-partum care is also included under the State Ambulatory Program and includes three home visits from a doctor and/or a nurse during the first 42 days after discharge from the Maternity Hospital. The first visit is scheduled on the sixth day after discharge.

On registering her pregnancy, a woman is provided with a voucher, through the Women's Consultation Center, which entitles her to delivery services in a licensed Maternity Hospital. While individual facilities were previously contracted to provide the package of maternity

services, the voucher system now entitles a woman to choose to receive care from any licensed facility and provider. Facilities are reimbursed by the state on reporting that these services were provided.

State Program of In-patient Assistance to Population (Hospital Care)

Under the "voucher system" described above, women are entitled to receive care during delivery at one of the country's 100 licensed Maternity Hospitals. The package of services for normal and assisted delivery includes essential care for the newborn as well and referral for both obstetric and neonatal complications.

The stated aims of the obstetric assistance component of the State Hospital program are provision of geographic and financial access to quality obstetric care and decrease in the incidence of perinatal and maternal morbidity and mortality. The program description only states that basic obstetric care and care of the newborn are covered under the program; the cost of any additional services and procedures are to be borne by the patient.

The state program also provides for detection of phenylketonuria in newborns and consultation for families carrying the pathological phenylketonuria gene. Finally, women who are diagnosed with sepsis are also entitled for lifesaving treatment under the obstetric program.

Referral assistance (Obstetrics, Neonatology)

The component of the State Hospital program entitled "referral assistance" is aimed at the provision of life-saving medical assistance to pregnant women belonging to a high risk group, to women during delivery and to infants, with the aim of decreasing of maternal and child mortality. Safe delivery, management of complicated cases of pregnancy, neonatal care, creation of an adequate system of monitoring parturient women, in-patient service of children under three and management of acute cases are all intended to be covered through the program of referral assistance.

Another component of the state program is: Providing Medical Care to the children aged 0-3 years. This component covers medical care for children aged 0-3 years and emergency care.

Project Goals and Objectives

Project Goals: Sustained reduction of under five mortality, infant and maternal mortality rate in Kvemo Kartli Region

Project Objectives:

- Improved **Quality** of M/C survival services and increased quality of care on household level;
- Improved **Behavior** of community, health care professionals and health managers on maternal and child health.
- Increased **Access t**o M/C health care services and increased accesses to adequate standard case management

Intervention Activities

Areas of intervention of the project were defined as follows:

- Maternal & Newborn Care
- Breastfeeding
- Nutrition
- Pneumonia
- Diarrhea

Intervention activities related to intervention area include:

- Improving **Quality** of M/C survival services and quality of care at household level
- Improving **Behavior** of community, health care professionals and health managers on maternal and child health.
- Increasing **Access** to M/C health care services and accesses to adequate standard case management

Objectives of the KPC Survey

Defining the final data for maternal and child health indicators to evaluate the impact of performed interventions including:

- Collection of final data on the health and nutrition status of children under five and women of reproductive age;
- Identifying health behavior change patterns;
- Enhance the capacity of ACTS staff in planning, conducting, data collection and analysis of KPC surveys
- Development of the final KPC report with discussion of the obtained results and lessons learned

Process and Partnership Building

Successful conduction of any survey especially health related KPC requires cooperation at various levels such as governmental, local administration and community. Considering the above said ACTS has formed strong and durable relations with other local organizations and actors relevant to its mission. The presentation of the project launching in the region involving all major stakeholders at various levels (Ministry of Labor, health and Social Affairs, Regional authorities including the Governor of the region, Local health facilities managers, district authorities and local Public Health Centers), conduction of the regional Maternal and Child Health Improvement within the Child Framework of Child Survival Project Conference in July, 2006 at which participated ACTS International and ACTS Georgia staff, local authorities, representatives of partner organization University of Georgia, "Claritas XXI", heads of village administration, representatives of the region communities, pediatricians, obstetricians-gynecologists contributed to building of strong and durable partnership network. As a result a strong partnership network has been formed, which significantly contributed to success of final KPC survey. Within the framework of An Agreement on Cooperation between the University of Georgia and ACTS International the students of the University of Georgia participated in preparing and conduction of final KPC survey. Five year participatory implementation of the Project allowed to actively involving Kvemo Kartli regional and district actors in the implementation of the final KPC survey. Local authorities and primary healthcare stakeholders helped to develop optimal logistics for conduction of the survey, which allowed to conduct the survey with less human resources, since interviewers and supervisors teams were able to interview more respondents within a given period of time, thanks to the information provided by the above stakeholders on the hours and days when the target population of the region could be found at their homes (with due regard to the season, which is particularly true for rural population engaged in field work). The time-table of field works for each district and interview sites as well as the best routes between the interview sites selected through random sampling frame provided by local partners helped to develop logistic plan and determine the optimal timing for visiting the target sites and households. The local partners also provided interpreters (volunteers) to communicate with Azeri population. As a rule they were local ambulatory nurses well trusted and respected in their communities. This indirectly helped to overcome the reluctance of Azeri women and their husbands and/or mothers-in-law to give interview to the interviewers.

In March-April, three 30-cluster KPC surveys were conducted in the two target regions of Georgia (Kvemo Kartli and cities of Chiatura and Zestaphoni from the Imereti region).

Methods

Questionnaire

The KPC questionnaire was adapted from KPC2000+ with revised modules as recommended by the CSTS team. The questionnaire consisted of 57, mostly closed questions as opposed to the baseline KPC questionnaire consisting of 99 questions. 42 questions have been removed from the questionnaire after consultations with CSTS team because the results of baseline survey demonstrated that in the fields covered by those questions the situation was positive and did not require special attention.

Sampling
By ethnic composition Kvemo Kartli region is distinguished by significant number of Azerbaijanian population residing predominantly in several rayons of the region. 78.9% of entire Azerbaijanian population in Georgia resides in Kvemo Kartli (224,676 out of 284,761 Azerbaijani residing in Georgia according to the 2002 census).[8] Language barrier remained one of the major concerns. Considering the importance of this problem and its possible impact on the health knowledge level, it was decided to subdivide the entire region into two parts: one part (sub-region 1) included the areas well integrated into Georgian society and the other (sub-region 2) – those poorly integrated. Total of 33 interviewing sites were targeted in both sub-regions. Each of 2 sub-regions of Kvemo Kartli region and the two cities in Imereti region were considered as a separate study unit (sub-region 3). The sampling frame for the cluster sampling was used to determine cluster sites in each of sub-regions: Cluster sites were defined at random using Systematic Sampling approach and the households within the clusters were chosen using random drawing of the street names for cities and the "spin the bottle" method for the villages.

Training
In March, 2009 7 interviewers and 3 supervisors underwent a four-day training, with the last day devoted to field-testing. The KPC supervisors were members of the project, while interviewers were hired from the Institute of Policy Studies (IPS) and University of Georgia (Public Health School). All interviewers had at least 2 years experience in interviewing and conducting surveys. All interviewers were females.

Data collection
All the respondents were females. Their ages ranged from 15 to 45 years, with the mean age being 25.6, SD 5.5. 300 (33.3%) of the respondents in Kvemo Kartli belonged to sub-region 1, 300 (33.3%) – to sub-region 2 and 300 (33.3%) of the respondents – to sub-region 3.

The respondents were visited at their homes and face-to-face interviews were conducted. When permitted, the interviewers and/or supervisors weighed and measured the height of infants.

Teams consisting of 2 or 3 interviewers and one supervisor were formed and a logistic plan was developed. Average length of the interview was 45 minutes; duration of data collection was 16 days. Each team was assigned a schedule for the entire 16-day period. Supervisors were responsible for the accuracy and completeness of the questionnaires. Reserve interviewing sites (streets in the towns and villages in the rural area) were randomly selected if the mother of the child in the given cluster was not at home, or if the cluster site did not contain enough households with children less than 23 months, or if the mother refused to give interviews. A total of 36 respondents refused to be interviewed, resulting in a refusal rate of 4%. In case of refusal the interviewers moved to the next household until the 10 respondent clusters were filled.

[8] Jonathan Wheatley *Obstacles Impeding the Regional Integration of the Kvemo Kartli Region of Georgia,* EUROPEAN CENTRE FOR MINORITY ISSUES (ECMI) Working Paper #23, February 2005

Data Analysis

The data was analyzed using SPSS version 8.0 software. Indicators were calculated for the entire target areas and for the three sub-regions. The head of statistical department of the Research Institute of Therapy, Dr. Eka Kupatadze, performed technical report on data tabulation and percent distribution of questionnaire indicators.

Quality control procedure during data entry
Twice skilled data managers entered the data into SPSS file. Two files were then merged and sorted by number. Then every 10-th pair was checked for correspondence.

Results

Survey was carried out in 33, urban and rural settlements of the eight 7 districts of targeted regions:

1. **Kvemo Kartli region:** Gardabani District: City of Gardabani, villages: Varketili, Tsalaskuri, Martkopi, Sartichala, Karajalari, Nazarlo, Ponichala and Rustavi; Marneuli District: City of Marneuli, villages: Kuschi, Sabirkendi, Molaogli, Baidari, Kizil-Ajlo, Kirmizkendi and Tsereteli; Bolnisi District: City of Bolnisi, villages: Zveli Kveshi, Kvemo Bolnisi, Talaveri, Nakhiduri and Kazreti settlement; Dmanisi District: City of Dmaisi, villages: Dmanisi settlement, Bazaklo, Kizil-Kilisa; Tetri Tskaro District: City of Tetri Tskaro, villages: Vashlovani and Manglisi settlement; Tsalka District: villages of Takilisa and Kaburi.

2. **Imereti region:** Chiatura and Zestaphoni

Table 1: Distribution of respondents in areas

#	District	Frequency	Percent %
1	**Marneuli**	170	18.9%
2	**Dmanisi**	50	5.6%
3	**Bolnisi**	70	7.8%
4	**Gardabani**	160	17.8%
7	**Tetri Tskaro**	20	2.22%
6	**Tsalka**	10	1.1%
7	**Rustavi**	120	13.3%
8	**Zestaphoni**	200	22,2%
9	**Chiatura**	100	11.11%
	Total	**900**	**100.0**

Of 900 children aged 0-23 months, 241 were 0-5 months of age; 180 were 6-9 months and 479 were 10-23 months. Distribution by sub-regions:

- **0-5 months:** sub-region 1 was N=83; sub-region 2 was N=70; sub-region 3 was N= 88.
- **6-9 months:** sub-region 1 was N=58; sub-region 2 was N=55; sub-region 3 was N= 67;
- **10-23 months:** sub-region 1 was N=159; sub-region 2 was N=175; sub-region 3 was N= 145.

General Information

The KPC documented that family size varied from 3 to 16 members (M=5.4; SD=1.8). The largest families were encountered among population of sub-region 2, with their average size being 5.7 members (SD 1.8). Then came sub-region 3 households, with an average of 5.3 members (SD 1.9). The smallest families were encountered among population of sub-region 1, with an average of 5.2 members (SD 1.8).

Nutritional Deficiencies

The children aged 0-23 months in target regions were assessed according to the WHO weight-for-age standards for severely underweight children (-3SD) and moderately underweight children (-2SD). The mothers were asked to provide the information on the weight and length of a child at birth. 4 mothers of boys and 4 mothers of girls didn't know weight of a child at birth. 468 mothers of boys and 424 mothers of girls were able to report the weight of a child at birth. The weight of the boys at birth varied from 1.60 kg to 5.60 kg (M=3.36; SD=0.52). The weight of the girls at birth varied from 1.50 kg to 4.90 (M=3.28; SD=0.43).

Only 705 mothers allowed weighing their children (363 boys and 342 girls). 195 mothers refused to allow the interviewer to weigh the child.

Table 2. Nutrition status of children %

#	Sub-regions	Severely under-nourished	Moderately under-nourished	Mean	Over-nourished	Heavily over-nourished
1	Sub-region 1 N=242	2.5	7.9	51.2	18.2	20.2
2	Sub-region 2 N=198	7.0	18.7	46.5	11.1	16.7
3	Sub-region 3 N=265	0	2.6	45.7	29.4	22.3
	Total N=705	**2.9**	**8.9**	**47.8**	**20.4**	**20.0**

The average percentage of severely underweight children among the three sub-regions is 2.9% versus 4.0% in 2005. However, there is a significant difference between the sub-regions. While the percent of severely underweight children in sub-region 1 was 2.5, the same index for sub-region 2 was nearly as high as 7.6. The lowest value was observed in the sub-region 3, which was 0%. The same situation is observed with moderately undernourished children. The highest value 18.7 was recorded for sub-region 2, the lowest 2.6% for sub-region 3 and 7.9% for sub-region 1. On the whole, the KPC findings related to 0 – 23 months old children feeding practices in the target regions revealed comparatively low levels of malnourishment. At the same time the percent of overweight children was higher, though not so high as during the baseline survey (+3SD – 20.0% on average versus 43.4% in baseline survey, with 20.2% versus 42.6% in sub-region 1; 16.7% versus 42.6% in sub-region 2; and 22.3% versus 55.6% in sub-region 3.)

Immediate Breastfeeding

The overwhelming majority (99.1%) of births of 0-23 month old children occurred in maternity hospitals, 99.4% of deliveries were attended by a physician and/or nurse. 69.7% versus 39.5% in 2005 of newborns were breastfed within the first hour (52.5% were breastfed immediately after delivery and 17.2% within the first hour after delivery). Unlike the baseline study the difference between the sub-regions is not as pronounced as during the baseline survey: 62.4% in sub-region 1 versus 48.7% in 2005; 60.3% in sub-region 2 versus 62.6% in 2005; and 83.5% in sub-region 3 versus 18.2% in 2005. In the course of project implementation, particular emphasis was made in the Chiatura and Zestaphoni cities in the Imereti region. These cities exhibited the lowest percentage of children breastfed during the first hour following birth.

Exclusive Breastfeeding

The baseline KPC data on exclusive breastfeeding demonstrated that only 16.1% of children up to 6 months of age were exclusively breastfed: 17.1% in sub-region 1, 18.2% in sub-region 2 and 14.0% in sub-region 3. The final survey demonstrated more than twofold increase in the percentage of exclusively breastfed children: 48.2% in sub-region 1, 42.8% - in sub-region 2 and 55.7% - in sub-region 3. Of the 241 mothers who had children in the age range of 0-5 months, 79.7% reported as having given only breast milk to the child aged 0-5 months during last 24 hours. Only 14.5% of infants aged 0-5 received fresh fruit and vegetables versus 22.9% during baseline KPC survey; 9.4% - potatoes; 8.7% versus 17.5% in 2005- grain food (wheat, corn, rice, etc); 7.9% versus 17.5% in 2005 - dairy products; 4.1% versus 6.3% in 2005 - meat, poultry, fish; 1.7% versus 6.3% in 2005 - food prepared on butter, oil or fat; 2.9% versus 4.9% in 2005 - food prepared from vegetables; other kinds of food (pumpkin, carrots, kidney beans, soy) –0.8% versus 4.4% in 2005.

Continued Breast and Complementary Feeding

71.1% versus 48.8% in 2005 of children aged 6-9 months and 29.9% versus 30% of children aged 10-23 months were still breastfed. Of total of 11 children aged 6-9 months 99 (89.2% versus 41.7% in 2005) received at least one solid food together with breast milk. 31.3% of children aged 6-9 months ate meat or fish and 64.1% meat, fish, poultry and cheese.

Use of Iodized Salt

Iodine deficiency disorder (IDD) is a serious health problem for Georgia. Traditionally Georgia has been a high endemic country for IDD due to geographic and environmental factors. Since the early 1990s, as a result of economic and political turmoil, as well as environmental changes, the country's population became especially vulnerable to iodine deficiency. In 1996, the State IDD Elimination Program was launched as a joint effort of the Georgian Government and international partners. The initiative has led to some remarkable achievements; however, IDD in Georgia still remains as a major public health concern."[1] On February 25, 2005 a "Law of Georgia *On Prevention of Diseases Caused by Iodine, Other Micronutrients and Vitamins Deficiency"* came into force in Georgia. Item 2 of Article 4 of Chapter II of the Law states: "Import of non-iodized salt to Georgia is forbidden with the exception of the cases envisaged by Item 1 of Article 5 of this Law saying "Non-iodized salt can be imported to Georgia: a) For medical reasons; b) For technical reasons to be used in production of non-food products".

Introduction of iodized salt to the market as well as nation-wide campaign explaining the benefits of using iodized salt contributed to significant increase of its consumption and in Kvemo Kartli region and cities of Chiatura and Zestaphoi of Imereti region, the advocacy for using and correct storing of the iodized salt conducted within the framework of Child Survival project resulted in increase of the iodized salt consumption from 38.0% in 2005 to 61.1% in 2009. According to the data of the Public

Health Department of Imereti region, 40% of children were found to have advanced thyroid disease due to iodine deficiency. In response A Call to Serve International has carried out three salt drives and iodine saltboxes were sent to Imereti region from Columbia.

Over 20 metric tons of iodinated salt was distributed to the families with children aged 2-16 years. ACTS delivered 5 containers of 20 ton each resulting in 100tons iodized salt each year for 2000, 2001, 2002 2003, 2004 and 2005. It is noteworthy that in the Imereti region, where ACTS conducted educational and applied interventions, 100% of the respondents reported that they were using iodized salt in their households. As a result, the iodine deficiency disorders in children significantly decreased.

The iodized salt was produced in Ukraine. In all households, which were using iodized salt the respondents demonstrated knowledge of its correct storing (in closed containers) 70.9% knew that iodine deficiency is dangerous. 70.9% considered that using iodine salt would help prevent some illnesses. 70.8% knew that using iodized salt is good for a child's health. Note the extreme differences in the 3 sub-regions.

In 2009 Sub Region 1 = 57.7%
Sub Region 2 = 25.7%
Sub Region 3 = 100 %

Total for all CS program areas = 61.1% had iodized salt at home. The impact of community festival education as well as ACTS' work over the last 10 years where the ACTS delivered

iodized salt to cities in the rayon of Imeriti in addition to Kutaisi, Imeriti which is the Columbia MO Sister City where ACTS International is located.

Immunization

Immunization Calendar of Georgia is different from that for developing countries being closer to the Immunization Calendar adopted by the developed countries. In Georgia the recommended age for measles vaccination is 12 months. The rapid catch question talks about full immunization before the first birthday. The measles immunization serves more accurately as the full immunization indicator for Georgia. During the past few years, significant steps to improve the immunization coverage in Georgia have been implemented. USAID mission in Georgia for almost 15 years now is supporting an immunization program. The current UNICEF grant continues to provide supplies and project support to the National Immunization Program in Georgia. Supply provision involves procurement of routine immunization vaccine/syringe supplies for under-2 child vaccination, while the project support component covers implementation of the EPI program communication, M&E and Capacity Building components. UNICEF implements the EPI project in Georgia. The project works in close partnership with the key national partners - the National Centre of Disease Control (NCDC) and the Public Health Department (PHD) of the Ministry of Labor, Health and Social affairs (MLHSA). Routine EPI supplies - BCG, OPV, DPT, DT and Measles vaccines, AD syringes and safety boxes for under-5 child vaccination have been continuously provided through UNICEF country office. In addition, Hepatitis B has been provided through the global funds. The coverage data for Measles nationwide in 2004 were 86.8**%** Measles containing Vaccines (Measles and MMR). In 2007 immunization coverage nationwide was 97.0% and in Kvemo Kartli region this value was 96.3% versus 59.9% in 2005. [9]

Integrated Management of Childhood Illnesses

Knowledge of danger signs requiring treatment of the child: 85.3% of mothers versus 64.2 in 2005 were able to check at least two symptoms of childhood illnesses that needed treatment. The most identifiable symptom of illness was high fever and second was looking ill. 84.0% of mothers from sub-region 1 versus 77.7% in 2005, 72.0% of mothers from sub-region 2 versus 50.5% in 2005 and 100% of mothers from sub-region 3 versus 63.1% in 2005 were able to report at least 2 danger signs.

[9] Health and Health Care, Statistical Year Book, Georgia 2007, MoLHSA of Georgia, National Center for Disease Control and Public Health, Tbilisi, 2008

Table 3. Knowledge of danger signs of childhood diseases

#	Danger signs	Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
		%	%	%	%
1	High fever	73.3	72.3	98.0	81.2
2	Looks unwell	70.0	60.0	95.7	75.2
3	Vomits everything	27.3	20.0	58.7	35.3
4	Difficult to wake	18.3	11.0	57.3	28.9
5	Fast or difficult breathing	13.0	6.7	65.7	28.4
6	Not eating or drinking	15.3	7.0	56.3	26.2
7	Convulsions	6.3	0.3	53.0	19.9
8	Other	10.7	15.7	1.3	9.2
9	Don't know	1.0	3.0	0	1.3

Final Findings for Respiratory Diseases

Acute respiratory diseases are one of the leading causes of infant morbidity in Georgia. Total of 205 respondents (22.78%) confirmed that during the past two weeks their children had one, two or three of the following symptoms: coughing, fast breathing or high fever. The majority of the children (81.95%) were coughing, with 38.0% encountering difficulties in breathing during coughing.

Of those 205 respondents total of168 (94.0%) mothers indicated that they treated their child for ARI. Of those who treated the child 158 named the time when they began treatment. 31.6% started treatment on the first day 43.0% did this the next day after noticing the symptoms, 14.0% after 2 days and 8.9% after 3 or more days.

Diagram 1. Treatment of acute respiratory disease during past two weeks in sub-regions

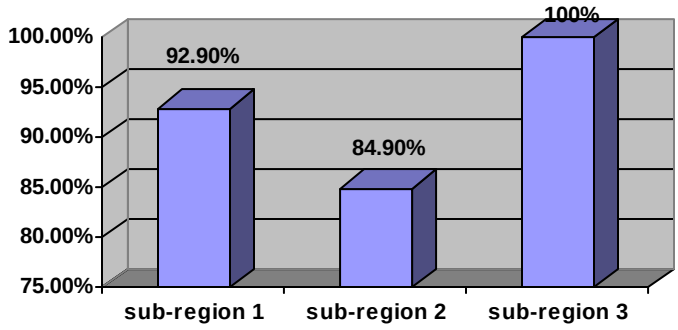


Table 4. Time before beginning of treatment

#	Sub-region	First day	Next day	After two days	After three or more days	Did not specify time	Total
1	Sub-region 1	19	19	10	4	3	**55**
		34.5	34.5	18.2	7.3	5.5	**100%**
2	Sub-region 2	16	10	5	10	1	**42**
		38.1	23.8	11.9	23.8	2.4	**100%**
3	Sub-region 3	15	39	7	0	0	**61**
		24.6	63.9	11.5	0	0	**100%**
	Total	**50**	**68**	**22**	**14**	**4**	**158**
		31.6	**43.0**	**14.0**	**8.9**	**2.5**	**100%**

All 168 respondents out of 205 who went for the treatment identified the place of treatment. Among them the majority went to policlinics (64.3%).

Table 5. Place where medical assistance was obtained %

#		Sub-region 1 N=56	Sub-region 2 N=53	Sub-region 3 N=59	Total N=168
1	Hospital	17.9	17.0	18.7	17.9
2	Ambulatory	1.8	11.3	5.1	6.0
3	Outpatient clinic	67.9	45.3	78.0	64.3
4	Other health facility	0	0	0	0
5	Traditional practitioner	0	3.8	0	1.2

200 mothers of 205 whose children got sick during last two weeks indicated that, the decision to seek medical assistance in most cases (63.5%) was made by respondent, 15.0% husbands, 15.5% mother-in-laws, 5.5% mothers, 0.5% other persons (Respondents could check more than one person) as the main decision-maker.

Table 6. Who made decision for treatment of a child % (Respondents could check any number of answers.)?

#	Group		Respondent	Husband	Mother	Mother-in-law	Relative, Neighbors
1	Sub-region 1 N=77	N	49	15	6	7	0
		%	63.6	19.5	7.8	9.1	
2	Sub-region 1 N=55	N	23	9	0	23	0
		%	41.8	16.4	0	41.8	0
3	Sub-region 1 N=68	N	55	6	5	1	1
		%	80.9	8.8	7.3	1.5	1.5
	Total N=200	**N**	**127**	**30**	**11**	**31**	**1**
		%	**63.5**	**15.0**	**5.5**	**15.5**	**0.5**

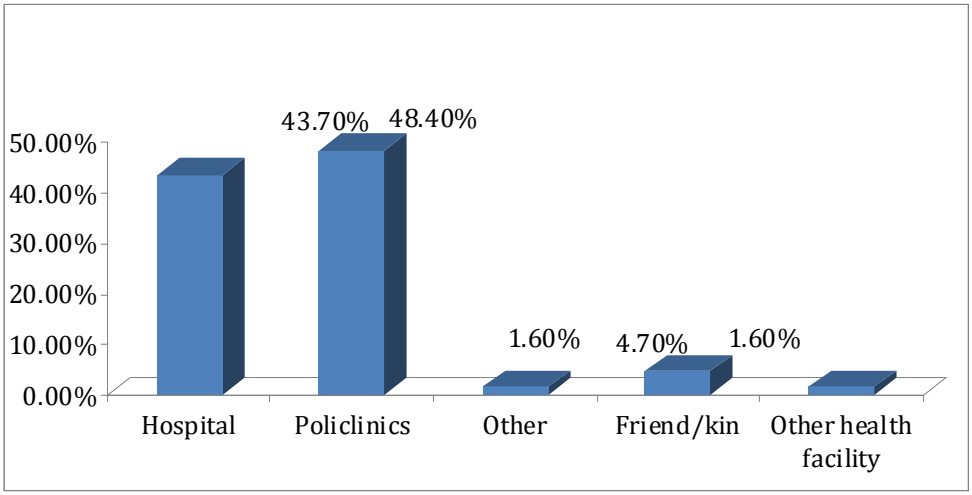
Final Data for Diarrhea Management

Only 84 mothers (9.3%) reported that their child had symptoms of diarrhea during past two weeks. 47 (56%) mothers whose children had diarrhea were breastfeeding. Among them 50.0% indicated that during the illness they gave the child the same amount of milk, 38.2% gave more milk, while 8.8% gave less milk and 3.0% said they did not know. The majority (61.9% versus 47.1% in 2005) of mothers gave more liquid to the child during the illness. 27.4% gave the same amount, 9.5% versus 12.9% in 2005 - lesser amount, 1.2% did not know. 17.9% of mothers versus 50.6% in 2005 decreased feeding the child during the illness. 48.8% versus 25.9% in 2005 gave the same amount of food, 3.6% did not give any food and 29.9% versus 2.4% in 2005 gave more food. Total percentages that gave more liquids during diarrhea was 92.6% versus 56.3% of sub-region 1, 80.5% versus 42.1% in 2005 of sub-region 2 and 100% versus 41.2% in 2005 of sub-region 3. Hence nutritional management during illness is significantly improved after the completion of the project.

Respondents who had a child with diarrhea during last two weeks were asked to indicate what kind of treatment they gave to their child.

76.2% of mothers whose children had symptoms of diarrhea sought medical advice. 64 mothers indicated the source of medical assistance. Majority of them (48.4%) went to the outpatient clinic.

Diagram 2. Place where medical assistance was obtained (Respondents could check any number of answers).



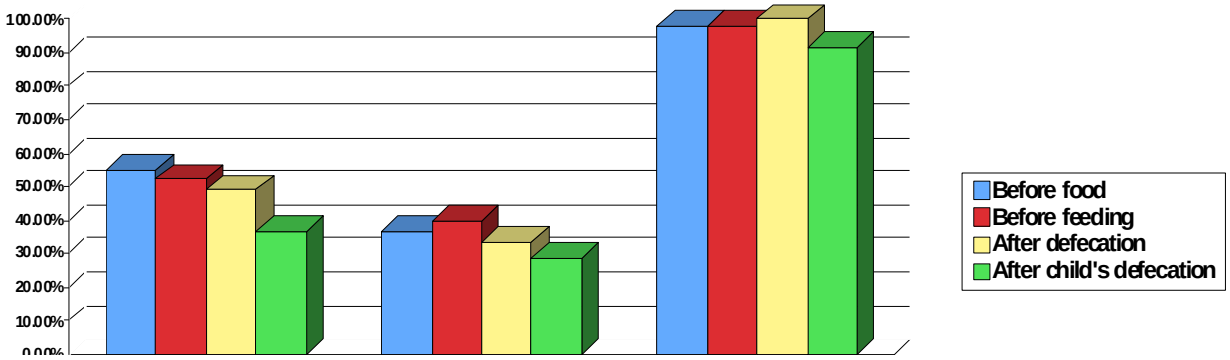
In regard to those children who got treatment, the decision to seek medical assistance in most cases (59.6%) was made by respondent, 17.0% husbands, 21.3% mother-in-laws, 1.1% mothers and 1% traditional healer as the main decision-maker.

39.2% knew how to prepare ORS or similar solution. Most knowledgeable were inhabitants of sub-region 1 - 45.2% and sub-region 2 – 43.3%. The knowledge of preparing and using of ORS in sub-region 3 significantly increased from 6.3% in 2005 to 39.2% in 2009.

Preventive Behaviors for Diarrhea

Respondents were asked to check when they usually washed hands with soap. Most often respondents washed hands before cooking and feeding children.

Diagram 3. Occasions of washing hands



The survey questions referred mostly to the pre and post natal care of children under 24 month of age. Age of the targeted children varied from 0 month to 23 months. Mean age of the studied children was 11.07 month, SD=6.8. From targeted children 52.4% (472) were boys and 47.6% (428) girls.

361 respondents reported having at least two children (95 in Sub-region 1, 156 in Sub-region 2 and 110 in Sub-region 3). 166 mothers reported the spacing of at least 24 months between the two successive children (57 in sub-region 1 -60.0%; 53 – in sub-region 2 – 33.3%; and 56 – in sub-region 3 – 61.6%).

46.5% of respondents said that there was a service nearby which could counsel on good spacing between the children. The counseling on child spacing received 32.7% in sub-region 1, 19.3% - in sub-region 2 and 87.7% in sub-region 3.

Anthropometry

Mothers were asked to provide the information on the weight and length of a child at birth. 468 mothers of boys and 424 mothers of girls could report the weight. The weight of the boys at birth varied from 1.6 kg to 5.6 kg (M=3.36; SD=0.52). The weight of the girls at birth varied from 1.5 kg to 4.9 kg (M=3.28; SD=0.43).

The data on present weight of only 705 children (363 boys 342 girls) were obtained, as mothers of 195 children did not allow interviewers to weigh the child.

The children were assessed according to WHO age for weight standards as severely underweight (-3S.D. from Median or less), underweight (-2 S.D.) Median, overweight (+2S.D.) and heavily overweight (+3 S.D. or more).

Table 6. Nutrition status of children %

#	Sub-region	Severely under-nourished	Under-nourished	Mean	Over-nourished	Heavily Over-nourished
1	Sub-region 1 N=242	2.5	7.9	51.2	18.2	20.2
2	Sub-region 2 N=198	7.0	18.7	46.5	11.1	16.7
3	Sub-region 3 N=265	0	2.6	45.7	29.4	22.3
	Total N=705	**2.9**	**8.9**	**47.8**	**20.4**	**20.0**

421 mothers of the boys and 392 mothers of the girls knew the length of the child at birth. The length of the boys at birth varied from 42 cm to 57 cm (M=50.7; SD=2.24). The length of the girls at birth varied from 41 cm to 56 cm (M=50.23; SD=1.72).

The data on the length of only 615 children (313 boys, 302 girls) were obtained, as mothers of 285 children did not allow interviewers to measure the child.

Table 7. Length of children at the time of interview and increase after birth in cm

#	Sub-region	-3 S.D	-2 S.D	-1 S.D	Mean	+1 S.D	+2 S.D	+3 S.D
1	Sub-region 1 N=188	17.0	12.2	21.3	32.5	9.6	3.7	3.7
2	Sub-region 2 N=162	33.3	10.5	17.9	21.6	9.9	3.7	3.1
3	Sub-region 3 N=265	4.9	6.0	15.1	60.8	7.9	2.3	3.0
	Total N=615	**16.1**	**9.1**	**17.7**	**41.8**	**8.9**	**3.1**	**3.3**

Maternal and Newborn Care

The overwhelming majority (99.1%, N=892) of mothers were examined during pregnancy. Of those 880 (or 98.65%) respondents were examined by doctor, 0.45% (N=4) - by nurse and 0.9% (N=8) - by midwife. On average women were examined 5.24 times (SD=1.998), number of examinations ranged from 1 to 12.

86.7% or 780 versus 59.5% or 536 respondents in 2005 stated that during taking examination they got advice on pre - and postnatal care. Most often advice was given in regard to the delivery and then on breastfeeding (78.3%).

Table 8. Getting advice on pre/postnatal care during examination in sub-regions %

#	**Advice topic**	Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
		%	%	%	%
1	On delivery preparations	82.0	78.7	99.3	86.7
2	On breastfeeding	72.0	63.7	99.3	78.3
3	On Child spacing	32.7	19.3	87.7	46.5
4	On danger signs of pregnancy	64.7	45.7	99.0	69.8
5	On immunization program	61.7	55.0	83.3	66.7

More advice is provided in sub-region 3 than in other sub-regions in all respects of care. The least instructed were women from sub-region 2.

Knowledge of danger signs of pregnancy

The respondents were asked to name the symptoms that prompt to seek medical assistance during pregnancy. The most frequently named symptoms were bleeding (56.%) and high fever (51.9%). The number of mothers who did not know any danger signs of pregnancy decreased from 19.0% in 2005 to 8.; 7% in 2009. 28.1% of women versus 5.4% in 2005 could name 4 danger signs of pregnancy.

Table 9. Symptoms prompting to seek medical assistance during pregnancy % (Respondents could name any number of symptoms

#		Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
		%	%	%	%
1	Fever	35.3	46.0	74.3	51.9
2	Shortness of breath	35.7	20.3	66.7	40.9
3	Bleeding	47.0	32.7	94.7	58.1
4	Swelling of the body	33.3	19.3	71.3	40.8
5	Other	56.7	41.0	5.0	34.2
6	Don't know	7.7	17.7	0.67	8.7

Table 10. Mothers who know at least 4 danger signs of pregnancy

#	Sub-region	N	%
1	Sub-region 1 N=300	63	21.0
2	Sub-region 2 N=300	45	15.0
3	Sub-region 3 N=300	145	48.3
	Total N=900	**253**	**28.1**

In case of having the symptoms the majority (54.3%) reported visiting Women's Consultation Centers.

Table 11. Visits to solve health problems in case of symptoms during pregnancy in groups

#		Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
		%	%	%	%
1	Hospital	40.7	39.0	7.0	28.9
2	Outpatient Clinic	13.0	15.0	0.3	9.4
3	Women's consultation	44.0	25.0	94.0	54.3
4	Village ambulatory	2.0	12.7	0	4.9
5	Neighbor/ Relative	0.3	1.0	0	0.4
6	Other	1.0	0	0	0.3

Delivery

Majority (99.1%) of infants were born in maternity hospital, 0.3% - in ambulatory and 0.6% were born at home. Only 5 births were reported to take place at home versus 33 cases in 2005. Attendance of childbirth by professionals was high in all sub-regions (98.9%).

Knowledge of danger signs of postpartum period

Respondents were asked to check what they considered as danger signs after delivery that should indicate the need of medical check.

Table 12. Danger signs after delivery % (Respondents could check any number of answers.)

#	**Danger Signs**	Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
		%	%	%	%
1	Fever	37.7	41.3	92.3	57.1
2	Excessive bleeding	54.3	31.3	89.0	58.2
3	Smelly vaginal discharge	29.0	12.3	59.0	33.4
4	Other	37.0	30.3	4.0	23.8
5	Could not name	16.0	32.7	0	16.2

In the category other most often were named: pain (95), mastitis (52), back pain (18), blood pressure (12), tonus (12). 56.9% of mothers (N=512) knew at least two post-partum danger signs.

Table 13. Mothers able to report at least two known maternal danger signs during the postpartum period.

#	Sub-region	N	%
1	Sub-region 1 N=300	151	50.3
2	Sub-region 2 N=300	100	33.3
3	Sub-region 3 N=300	261	87.0
	Total N=900	**512**	**56.9**

Respondents also were questioned about the dangerous signs of illnesses of newborn. The danger signs based on the respondents' answer were ranked in the following way: the highest incidence was noted for the category: a child is passive, then came poor eating, fast breathing was the third most frequently cited sign, redness around the cord was reported by 24.3% of mothers; 3.7% failed to name even one sign and in 39.1% the mothers named other signs.

Health Behavior

Table 14. Knowledge of neonatal danger signs

#		Sub-region1 Christian N=300 %	Sub-region 2 N=300 %	Sub-region 3 N=300 %	Total N=900 %
1	Poor feeding	50.3	42.7	54.0	49.0
2	Fast breathing	16.3	7.7	75.3	33.1
3	Not active	61.3	39.7	50.0	50.3
4	Redness around the cord	11.7	4.7	56.7	24.3
5	Red /discharging eyes	6.0	4.3	43.3	17.9
6	Other	54.0	51.3	12.0	39.1
7	Don't know	2.3	8.7	0	3.7

Category other was quite numerous. It mostly consisted of the following problems: fever (219), crying (119), abdominal pain (34), coughing (28), earache (18), vomiting (11).

Table 15. Mothers able to report at least two known neonatal danger signs

#	Sub-regions	N	%
1	Sub-region 1 N=300	202	67.3
2	Sub-region 2 N=300	126	42.0
3	Sub-region 3 N=300	250	83.3
	Total N=900	**578**	**64.2**

64.2% of mothers (N=578) knew at least two danger signs of newborns illnesses.

HIV/AIDS

69.0% of respondents reported that they have heard about HIV/AIDS. Most knowledgeable were Sub-region 1 respondents (87.0% have heard about AIDS) and the least Sub-region 2 respondents (40.3% versus 36.5%), in between were respondents of sub- region 3 (79.7% versus 76.4%).

Knowledge on ways reducing the risk of HIV infection was significantly increased: only 8.0% (N=72) could not name even one right way of avoiding HIV infection versus 56.9% registered by baseline KPC in 2005.

Diagram 4. Number of mothers who does not know even one right way for avoiding HIV infection

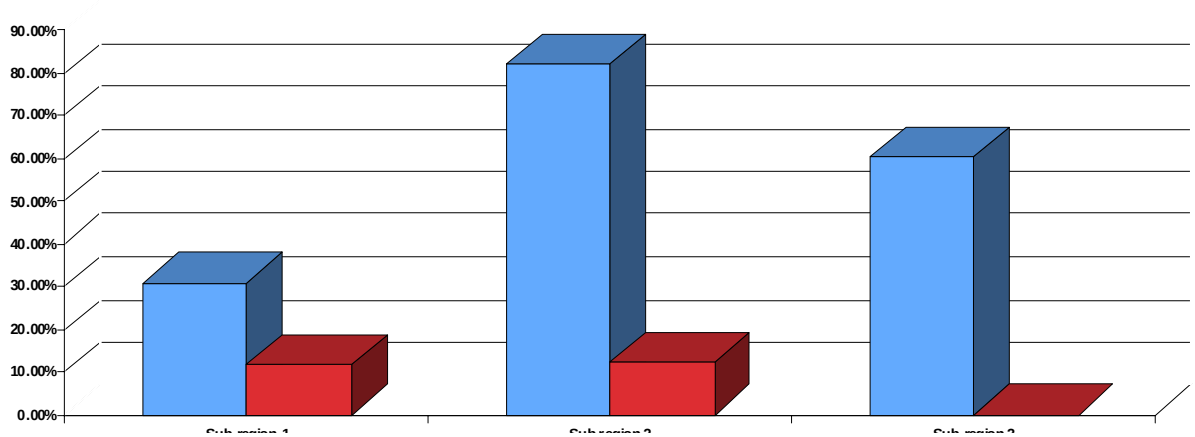


Table 16. Number of mothers who know two and more ways for avoiding HIV infection

#	Sub-region	%
1	Sub-region 1 No 300	49.7
2	Sub-region 2 No 300	11.3
3	Sub-region 2 No 300	79.7
	Total No 900	**46.9**

Health Related Behavior and Information

42.0% versus 2.7% in 2005 reported that they visited doctor, 4% versus 15.8% in 2005 - a nurse, 0.9% midwife, 0.8 healers during past month.

Table 17 Visit to health care providers during the last month

#	Provider		Four or more times	One-three times	No visit	Total
1	Doctor	N	47	331	522	**900**
		%	5.2	36.8	58.0	**100**
2	Nurse	N	0	36	864	**900**
		%	0	4.0	96.0	**100**
3	Midwife	N	0	8	892	**900**
		%	0	0.9	99.1	**100**
4	Traditional Healer	N	0	7	893	**900**
		%	0	0.8	99.2	**100**

The respondents were asked to list the reasons for not visiting a doctor. The major reason was lack of out-of pocket money (93.5% of the respondents); 3.25% reported unavailability of

transport means; 0.32 named husbands not permitting to go to the doctor and 1.3% named other reasons.

Table 18. Reasons for not visiting doctor

#	Reason	Frequency	%
1	Did not have money to pay visit	289	93.5
2	Transportation was not available	10	3.25
3	Husband did not permit	1	0.32
4	Other household member did not permit	4	1.3
5	Other	5	1.63
	Total	**309**	**100**

Information sources:
Respondent were asked to give as many answers as they liked concerning the source of information or advice on health and nutrition. Majority (82.9% versus 70.9% in 2005) declared that they got advice from doctor and then mother-in-law (36.9% versus 26.6% in 2005).

Table 19. Source of information/advice on health and nutrition

#	Source	Frequency	%
1	Doctor	746	82.9
2	Nurse/Midwife	26	2.9
3	Traditional Healer	2	0.2
4	Husband	25	2.8
5	Mother/Mother-in-law	332	36.9
6	Sister	5	0.6
7	Grandparent	16	1.8
8	Aunt	8	0.9
9	Friend/Neighbor	25	2.8
10	Village Superior	0	0
11	Other	47	5.2

Majority of respondents, 44.3% got some kind of health message from health worker, 43.1% from TV, 9.3% from newspaper and 3.4% from radio. Television proved to be most often cited source of information in sub-region1 (54.7%), next came health provider (30.0%), whereas in sub-region 3 the overwhelming majority of the respondents (89.7%) named a doctor as the major source of information, TV was named in 50.3% of cases. For sub-region 2, the most cited source of information was TV – 24.3%, then health provider – 13.3%.

Table 20. Sources of getting health message in by sub-regions

#	Provider		Sub-region 1 N=300	Sub-region 2 N=300	Sub-region 3 N=300	Total N=900
1	Radio	N	14	12	5	**31**
		%	4.7	4.0	1.7	**3.4**
2	Newspaper	N	36	5	43	**84**
		%	12.0	1.7	14.3	**9.3**
3	Television	N	164	73	151	**388**
		%	54.7	24.3	50.3	**43.1**
4	Health worker	N	90	40	269	**399**
		%	30.0	13.3	89.7	**44.3**

Respondents were asked to show birth certificates of the child. 98.8% of children had birth certificates.

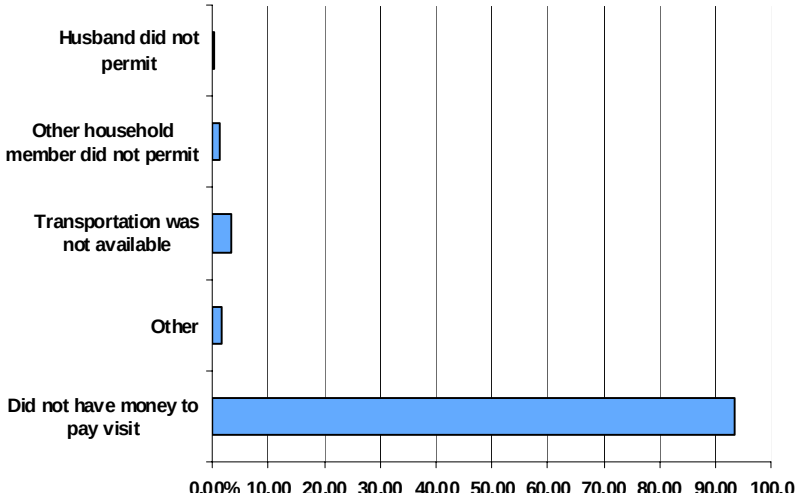
Respondents were asked to recall the cases during the recent year when they were ill and wanted to get medical aid but did not visit health facility. They were asked to check in a provided list of five reasons the reason of not visiting facility.

Quite a high proportion of respondents, 34.4% declared that they wanted to visit health facility, but were not able to do this. In all there were 309 of such respondents (87 in sub-region 1, 115 in sub-region 2 and 107 in sub-region 3). All of them named the reason for not going to health provider. Most often it was lack of money (93.5%).

Table 21. Reasons for not visiting doctor

#	**Reason**	**Frequency**	**%**
1	Did not have money to pay visit	289	93.5
2	Transportation was not available	10	3.25
3	Husband did not permit	1	0.32
4	Other household member did not permit	4	1.3
5	Other	5	1.63
	Total	**309**	**100**

Diagram 5. Reasons for not visiting doctor



Discussion

Data obtained in final KPC survey were compared to relevant data from various sources of information. Unfortunately the latest data for 2008 have not been published yet, so the latest data available belong to 2007 (Health and Health Care, Statistical Year Book, Georgia, 2007). More detailed data are published in MICS Georgia, 2005, UNICEF.

The following key indicators have been compared with official data: Breastfeeding (average for entire Georgia)

1. Breastfeeding started during the first hour after birth: 62.4% (Statistical Year book)
2. Total number of breastfed children: 96.1% (newborns), 57.9% at the age before 3 months.

Diagram 6. Percent of children who were underweight:

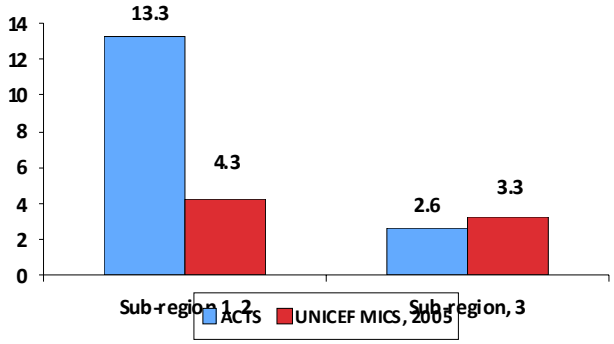
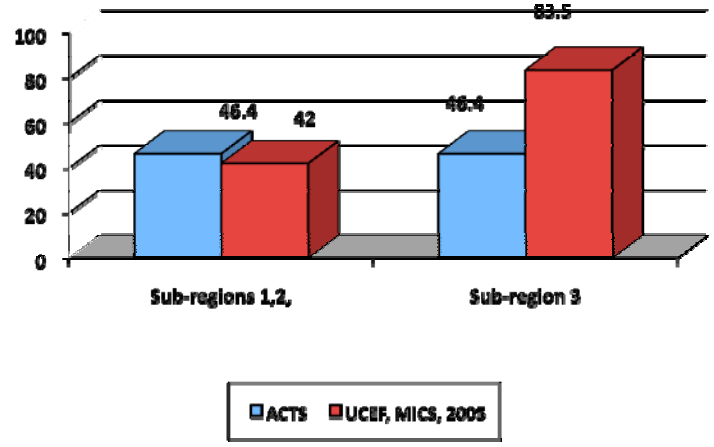


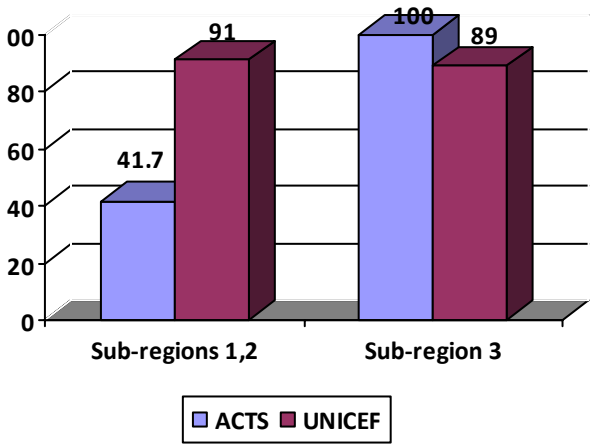
Diagram 7. Percent of children breastfed within the first hour after birth:



Exclusive breastfeeding: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 10.9% of children were exclusively breastfed in 2005. According to ACTS data on average for entire target area 59.7% of children aged 0-5 months were exclusively breastfed.

Continued breastfeeding: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 19.6% of children were breastfed up to 23 months in 2005. According to ACTS data on average for entire target area 25.0% of children were breastfed up to the age of 23 months.

Diagram 8. Iodized salt consumption



Use of ORS: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 39.9% of the children with diarrhea during the last two weeks received ORS. According to ACTS data on average for entire target area 46.6% of children with diarrhea in the last two weeks received ORS.

Increased fluids during diarrhea: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 36.5% of the children with diarrhea during the last two weeks received increased fluids. According to ACTS data on average for entire target area 88.1% of children with diarrhea in the last two weeks received increased amount of fluids.
Care seeking for ARI: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 73.6% of the children with frequent and difficult breathing were taken to health provider in 2005. According to ACTS data on average for entire target area 94.0% of children with suspected pneumonia were taken to health facility.

Immediate hospitalization: knowledge of danger signs, prompting immediate referral to health facility:

Diagram 9. Comparison of UNICEF, 2005 data and ACTS final KPC data for Sub-regions 1 and 2

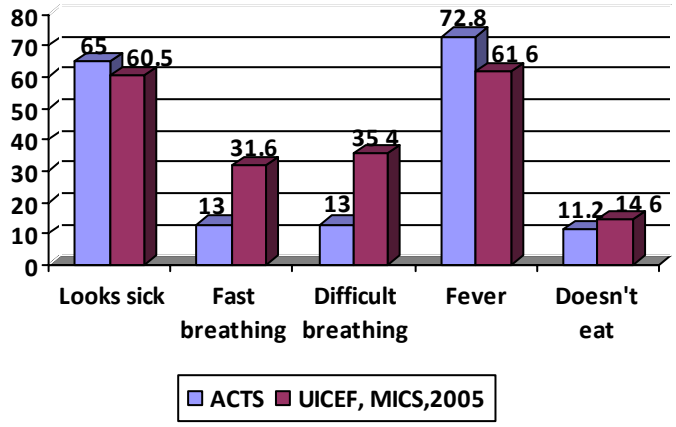


Diagram 10. Comparison of UNICEF, 2005 data and ACTS final KPC data for Sub-region 3

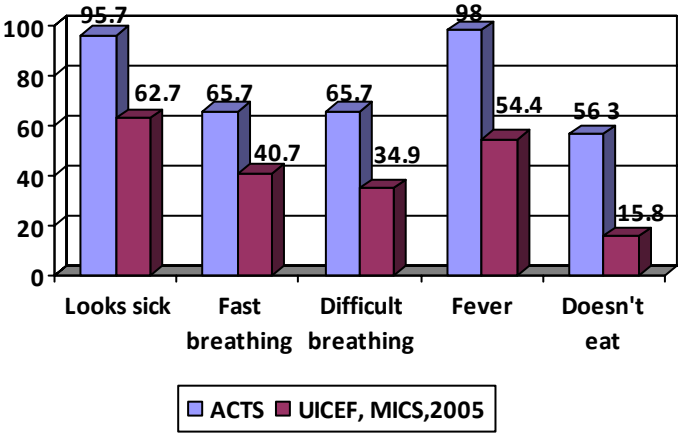
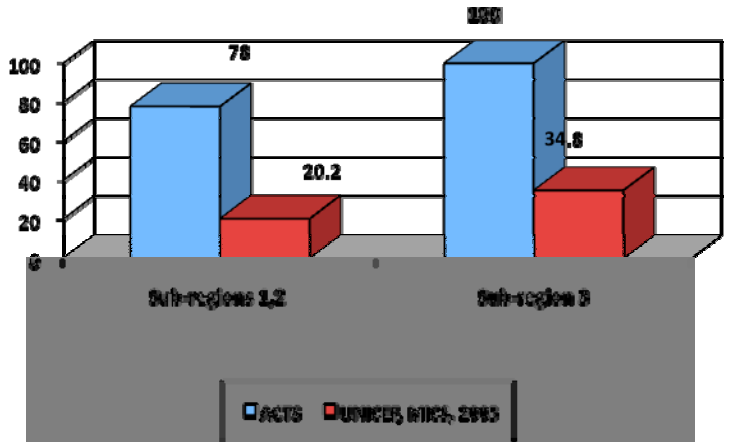
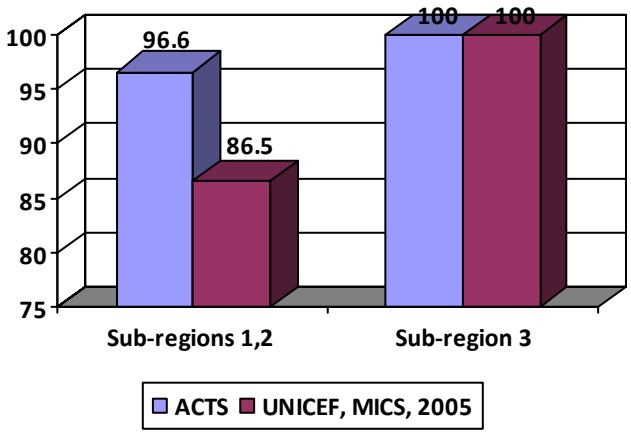


Diagram 11. Knowledge of at least 2 danger signs of childhood illnesses (%)



Antenatal care:

Diagram 12. Percentage of mothers who were examined by a doctor during last pregnancy



Skilled attendant delivery: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, a medical professional attended on average 98.3 % deliveries in 2005. According to ACTS data, medical professionals attended on average for entire target area 98.9% of deliveries.

Institutional deliveries: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, 2005 on average 95.5 % deliveries occurred in maternity hospitals in 2005. According to ACTS data on average for entire target area 99.1% of deliveries occurred in maternity hospitals.

Birth registration: Only average data for entire Georgia are available in official statistics including UICEF MICS and Health and Health Care Statistical Year Book, 2008. According to UNICEF MICS and Statistical Yearbook, on average 91.9% of children had birth registration in 2005. According to ACTS data on average for entire target area 98.8% children had birth registration.

HIV/AIDS knowledge: Only average data for entire Georgia are available in official statistics including UICEF MICS. According to UNICEF MICS, on average 15% of mothers had comprehensive knowledge on HIV/AIDS in 2005. According to ACTS data on average for entire target area 46.9% of mothers had knowledge on HIV/AIDS.

Annex 8: Evaluation Team Members and Titles

1. Sandra Wilcox, MPH	Team Leader and external evaluator
2. Patricia Blair, MD	ACTS Chief Medical Officer and HQ backstop
3. Eteri Suladze	CS Project Manager
4. Giorgi Tsilosani MD, PhD	President, ACTS Georgia, CMO of CSP
5. Revaz Tataradze MD, PhD	MCH Division Director of CS Project
6. Guram Amiridze MD	Vice President, ACTS Georgia
7. Temur Ukleba MD	GAIN Project Manager
8. Mzia Kilbadze	Project Manager Assistant
9. Nato Mamageishvili MD	Imereti District Coordinator
10. Dodo Iashvili	Translator
11. Tamar Lobjanidze	Kvemo Kartli District Coordinator

Annex 9: Evaluation Assessment Methodology

FE Evaluation Process

In preparation for the CSP FE, the consultant worked with the ACTS Georgia and ACTS HQ Teams to determine the FE process. A review of project documents (Detailed Implementation Plan [DIP], Annual Reports, Mid-Term Evaluation and Related Documents) was conducted. The external consultant arrived in Georgia on June 7th. The consultant met with ACTS staff to discuss issues and received an overview of the project. She then prepared an interview guide for the planned field visits. FE roles and responsibilities were delineated with ACTS staff, interviews were conducted with MoLHSA and medical facilities staff. Stakeholders and partners were invited to serve as evaluation team members. A participatory approach was used. There was also a meeting with the USAID Mission health staff and the Governor of Kvemo Kartli. The FE included field visits to MoLHSA district and regional facilities, focus group meetings at project sites; interviews with MoLHSA officials, government partners, political stakeholders, clinic personnel, ACTS community groups, mothers attending clinics during facility hours, OB/GYN doctors who attend pregnant women for ANC services and polyclinic staff; multiple interviews with mothers and focus group participants. The team also collected training data and analysis from agencies, facilities and FGDs. Interviews were conducted to assess individual knowledge of CSP indicators. Results were assessed using a final KPS survey that was compared with baseline findings. The external consultant spent the 19th and 20th of June reviewing findings with the ACTS evaluation team and soliciting materials needed for the final evaluation report.

Due to delays in receipt of KPC results and other documents, the report was not finalized until January 2010.

Annex 10: List of Persons Interviewed & Contacted during Final Evaluation

CS Project Final Evaluation Visits

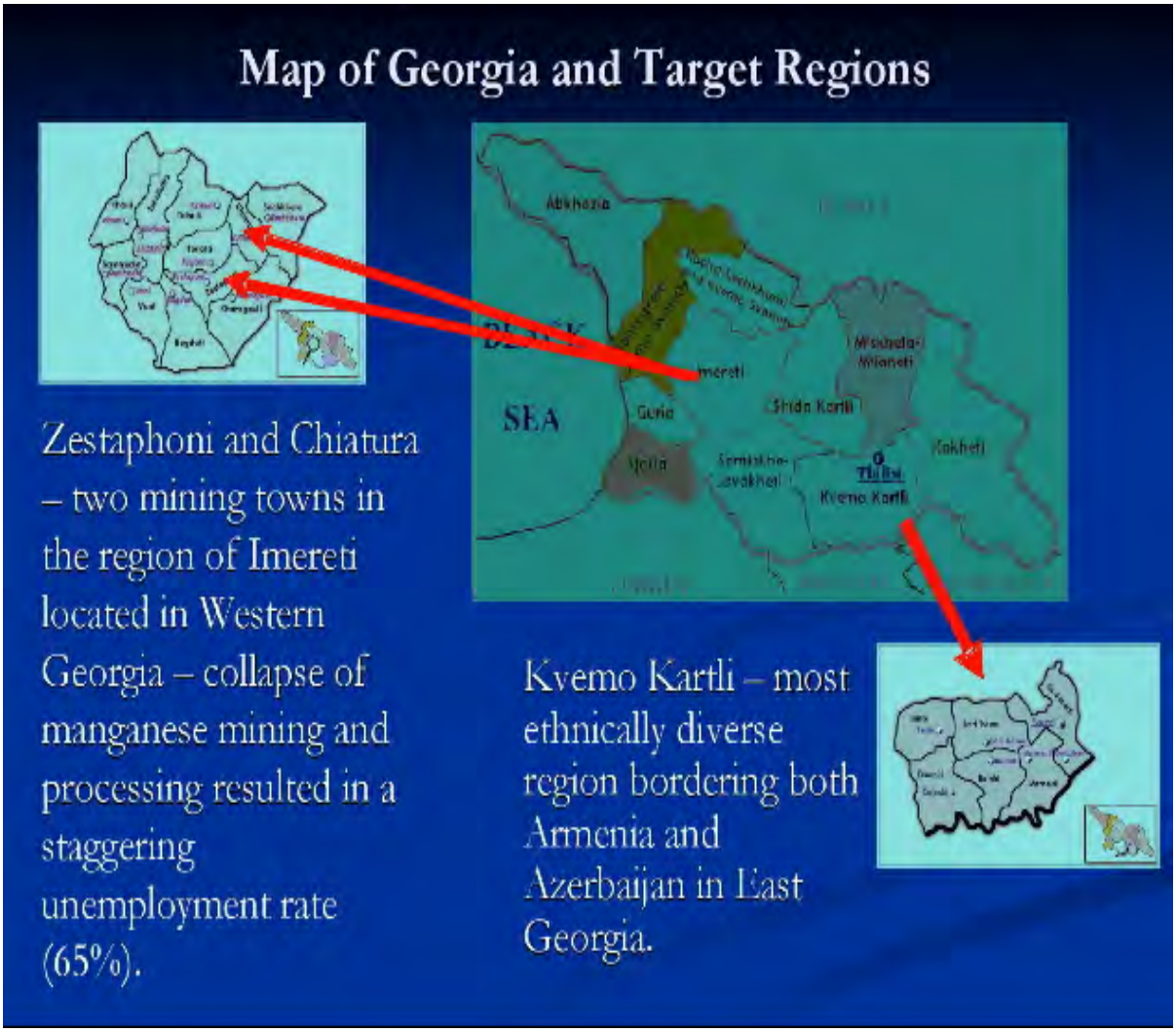
Date of the meeting	Location	Participants
June 10, 2009	Rustavi, Governor's Office	Governor of Kvemo Kartli Region Mr. David Kirkitadze, Deputy Governor Mr. Zakaria Darchiashvili Dr. Sandra Wilcox, CS Project Evaluator Dr. Patricia J. Blair, CMO (backstop); Dr. Giorgi Tsilosani, Field Office CMO Dr. Guram Amiridze, Vice president, ACTS Georgia Dr. Temur Ukleba, GAIN Project Manager Ms. Eteri Suladze, CS Project Manager
June 10, 2009	Rustavi fortified Flour Mill "Progress"	Dr. Sandra Wilcox, CS Project Evaluator Dr. Patricia J. Blair, CMO (backstop); Dr. Giorgi Tsilosani, Field Office CMO Dr. Temur Ukleba, GAIN Project Manager Ms. Eteri Suladze, CS Project Manager Mr. Zaza Orjonikidze, Production Manager
June 11, 2009	City of Bolnisi, Bolnisi district; Pediatric Policlinics	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Ms. Mzia Klibadze, Project Manager Assistant Head of District Public health Center, Dr. Maka Mamardashvili; Nurse of the Policlinic, Nino Mushkudiani Pediatrician Lia Tsintsadze
June 11, 2009	Dmanisi district, village of Amamlo	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Ms. Mzia Klibadze, Project Manager Assistant Community mobilizer Feride Ismailova Village nurse Narmina Iskanderova Representatives of community (mothers of children u5 and pregnant moms) – 15 women (Azeri population, community meeting)
June 12, 2009	City of Marneuli, Marneuli region, Maternity Hospital	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Community mobilizer, Maternity Hospital Epidemiologist Dr. Nana Kuchukhidze, Director of Maternity Hospital Dr. Marine Pataridze

Date of the meeting	Location	Participants
June 12, 2009	National CDC and PH	Dr. Sandra Wilcox, CS Project Evaluator Dr. Patricia J. Blair, CMO (backstop); Dr. Giorgi Tsilosani, Field Office CMO Dr. Revaz Tataradze, Medical Director of CS Project Dr. Levan Baramidze, MPH, Deputy Head of National CDC
June 15, 2009	City of Tetri Tskaro, TT district, FGD	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Ms. Mzia Klibadze, Project Manager Assistant Dr. Chabuka Ioseliani, Head of the District Public health Center; 7 representatives of target population, Focus Group Meeting
June 15, 2009	ACTS office	Dr. Sandra Wilcox, CS Project Evaluator Dr. Giorgi Tsilosani, Field Office CMO Dr. Revaz Tataradze, Medical Director of CS Project Ms. Eteri Suladze, CS Project Manager Dr. Zaza Bokhua, Advisor of the Minister of Health of Georgia in the sphere of Maternal and Child Health and Postgraduate Training of Medical personnel, Secretary General of Georgian Ob-Gyn Association
June 16, 2009	Dmanisi district, village of Gantiadi, Community meeting (18 representatives of target population)	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Ms. Mzia Klibadze, Project Manager Assistant Ms. Mzia Devnozashvili, social worker Nurse Sveta Vasilieva
June 16, 2009	Dmanisi district; Dmanisi Pediatric Policlinic	Dr. Sandra Wilcox, CS Project Evaluator Ms. Eteri Suladze, CS Project Manager Ms. Mzia Klibadze, Project Manager Assistant Dr. Elisabed Katsitadze, Chief Physician of the Policlinic
June 17, 2009	Rustavi Maternity Hospital, Rustavi Pediatric Clinic at Rustavi Medical-Diagnostic Center #2	Dr. Sandra Wilcox, CS Project Evaluator Dr. Revaz Tataradze, CS Medical Director Dr. Ketavan Sharangia, WHO IMCI Coordinator, NGO “Claritas” Trainer Dr. Alexander Borovkov, Director of Maternity Hospital;

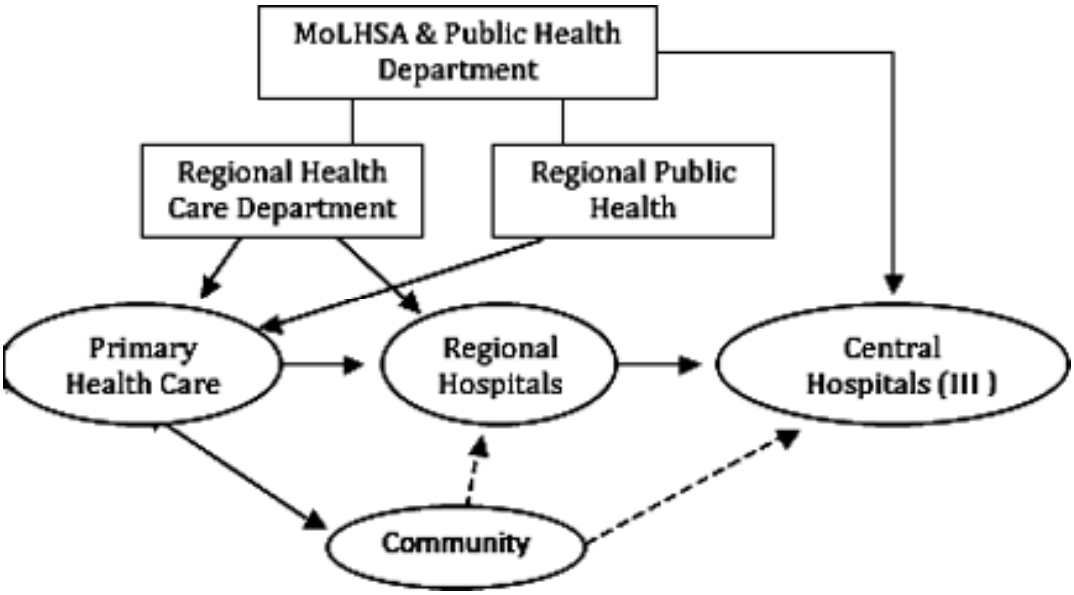
Date of the meeting	Location	Participants
		Dr. Vasil Menteshashvili, Head of Women's Consultation; Dr. Manana Kapanadze, Director of the Center Dr. Rusudan Adamia, Head of Pediatric Clinic
June 18, 2009	Imereti Region, City of Zestaphoni, Pediatric Outpatient Clinic	Dr. Sandra Wilcox, CS Project Evaluator Dr. Nato Mamageishvili, district coordinator in Imereti Tamar Makharashvili, Chef Physician, pediatricians of the clinic and 2 mothers of children U5
June 19, 2009	Local Mission of USAID	Ms. Anne Petterson, PhD, Office Director Dr. Tamar Sirbiladze Health and Social Development Project Manager Dr. Sandra Wilcox, CS Project Evaluator Dr. Giorgi Tsilosani, field office CMO Dr. Revaz Tataradze, CS Medical Director Ms. Eteri Suladze, Project Manager
June 19, 200	ACTS office CS staff meeting	Dr. Sandra Wilcox, CS Project Evaluator Dr. Giorgi Tsilosani, field office CMO Dr. Revaz Tataradze, CS Medical Director Ms. Eteri Suladze, Project Manager Ms. Mzia Klibadze, Project Manager Assistant Ms. Nato Mamageishvili, Imereti District Coordinator

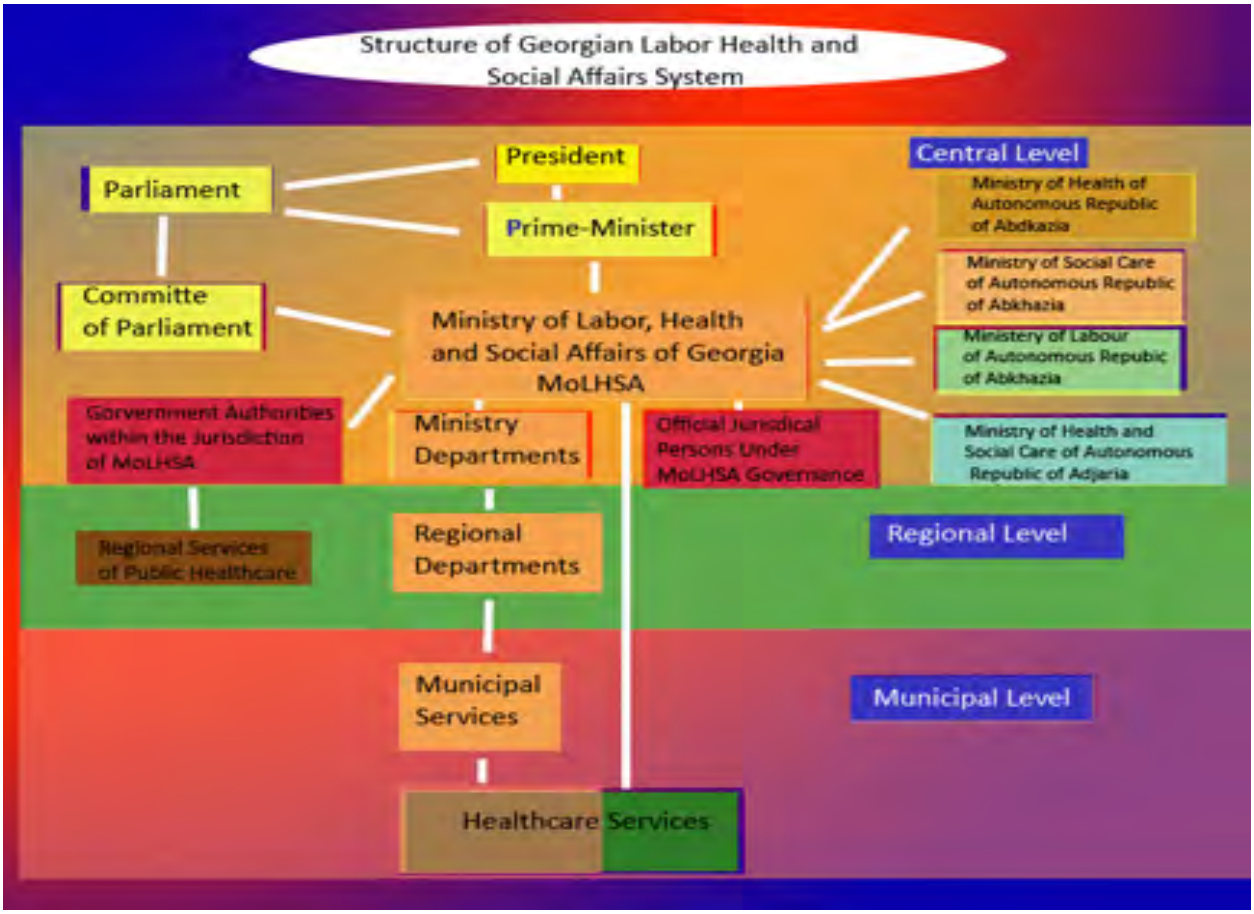
Annex 11: Special Reports and Additional Documents

Annex 11.1 Map of Georgia and Target Regions



Annex 11.2 Georgian Project MoLHSA Political Structure





Annex 11.3 Community Education Meetings 2006-2009

Community Meetings March 2006 – September 30, 2006

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Dmanisi District Village of Mashavera	03.03.06	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Dmanisi District Village of Amamlo	13.03.06	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Dmanisi District Village of Irganchai	24. 03.06	Pregnant mothers, mothers of children U5 and women of reproductive age	15
Dmanisi District Village of Gomareti	04.04.06	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Bolnisi District, Village of Darbazi	12.04.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Bolnisi District, Village of Kveshi	20.04.06	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Bolnisi District, Village of Bolnisi	10. 05.06	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Bolnisi District, Village of Talaveri	18. 05 .06	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Marneuli District, Village of Shulaveri	25.05.06	Pregnant mothers, mothers of children U5 and women of reproductive age	9
Marneuli District, Village of Sadakhlo	08.06.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Marneuli District, Village of Tsereteli	19 .06.06	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Marneuli District, Village of Shaumjan	27.06.06	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Gardabani District, Village of Lemshveniera	06.07.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10

Gardabani District, Village of Vakhtangisi	17.07.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Gardabani District, Samgori settlement	28.07.06	Pregnant mothers, mothers of children U5 and women of reproductive age	9
Gardabani District, Village of Jandara	08.09.06	Pregnant mothers, mothers of children U5 and women of reproductive age	13
Tetri Tskaro, Village of Assureti	29.09.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10

Imereti Region, Chiatura, Zestaphoni			
Location	**Date**	**Participants category**	**Number of participants**
Chiatura	15.03.06	Pregnant women and women of reproductive age	11
Chiatura	12.04.06	Pregnant women and women of reproductive age	10
Chiatura	16.05.06	Pregnant women and women of reproductive age	10
Chiatura	22.06.06	Pregnant women and women of reproductive age	10
Zestaphoni	28.06.06	Pregnant women and women of reproductive age	12
Zestaphoni	04.07.06	Pregnant women and women of reproductive age	12
Zstaphoni	13.07.06	Pregnant women and women of reproductive age	10
Zestaphoni	21.09.06	Pregnant women and women of reproductive age	11

Community Meetings October 2006 – September 2007

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Dmanisi District, City of Dmanisi	06.10.06	Pregnant mothers, mothers of children U5 and women of reproductive age	22
Dmanisi District, Village of Mashavera	18.10.06	Pregnant mothers, mothers of children U5 and women of reproductive age	18
Dmanisi District, Village of Didi Dmanisi	28.10.06	Pregnant mothers, mothers of children U5 and women of	10

		reproductive age	
Dmanisi District, Village of Irganchai	07.11.06	Pregnant mothers, mothers of children U5 and women of reproductive age	20
Dmanisi District, Village of Amamlo	16.11.06	Pregnant mothers, mothers of children U5 and women of reproductive age	18
Bolnisi District, City of Bolnisi	23.11.06	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Bolnisi District, Village of Kveshi	04.12.06	Pregnant mothers, mothers of children U5 and women of reproductive age, doctors and nurses of outpatient clinic	23
Bolnisi District, Village of Bolnisi	11.12.06	Pregnant mothers, mothers of children U5 and women of reproductive age, doctors and nurses of outpatient clinic	20
Bolnisi District, Kazreti settlement	26.12.06	Pregnant mothers, mothers of children U5 and women of reproductive age	13

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Bolnisi District, illage of Samtsverisi	15.01.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	18
Bolnisi District, Village of Poladauri	25.01.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	17
Bolnisi District, Village of Nakhiduri	09.02.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	22
Marneuli District, Village of Kapanakhchi	12.02.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	23
Marneuli District, Village of Agmamedlo	23.02.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	16
Marneuli District, Village of Kurtliar	12.03,07	Pregnant mothers, mothers of children U5 and women of reproductive age,	18
Marneuli District, Village of Tamarisi	22.03.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	19

Marneuli District, City of Marneuli	30 .03.07	Pregnant mothers, mothers of children U5 and women of reproductive age, staff of pediatric outpatient clinic	25
Marneuli District, Village of Keshalo	03.04.07	Pregnant mothers, mothers of children U5 and women of reproductive age	15
Gardabani District, City of Gardabani	18.04.07	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Gardabani District Village of Martkopii	27.04.07	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Gardabani District Village of Norio	10.05.07	Pregnant mothers, mothers of children U5 and women of reproductive age	16
Gardabani District Village of Nazarlo	22.05.07	Pregnant mothers, mothers of children U5 and women of reproductive age	17
Gardabani District Village of Muganlo	31.05.07	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Gardabani District Village of Poichala	06.06.07	Pregnant mothers, mothers of children U5 and women of reproductive age	20
Tetri Tskaro District, City of Tetri Tskaro	20.06.07	Pregnant mothers, mothers of children U5 and women of reproductive age	17
Tetri Tskaro District, Village of Asureti	29.06.07	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Tetri Tskaro District, Village of Golteti	06.07.07	Pregnant mothers, mothers of children U5 and women of reproductive age	23
Tetri Tskaro District, Village of Tsintskaro	11.07.07	Pregnant mothers, mothers of children U5 and women of reproductive age	18
Tetri Tskaro District, Village of Kosalari	27.07.07	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Tetri Tskaro District, Village of Koda	21.09.07	Pregnant mothers, mothers of children U5 and women of reproductive age	22
Tetri Tskaro District, Village of Samshvilde	26.09.07	Pregnant mothers, mothers of children U5 and women of reproductive age	14

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Tsalka District, City of Tsalka	24.04.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	15
Tsalka District, Village of Bektasheni	16.05.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	10
Tsalka District, Village of Nardevani	21.06.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	12
Tsalka District, Village of Aiazma	09.07.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	11
Tsalka District, Village of Bashkovi	24.09.07	Pregnant mothers, mothers of children U5 and women of reproductive age,	14

Imereti Region, Chiatura, Zestaphoni			
Location	**Date**	**Participants category**	**Number of participants**
Chiatura	10.10.06	Pregnant women and women of reproductive age	17
Chiatura	20.10.06	Pregnant women and women of reproductive age	16
Chiatura	06.11.06	Pregnant women and women of reproductive age	11
Chiatura	17 11.06	Pregnant women and women of reproductive age	13
Chiatura	08.12.06	Pregnant women and women of reproductive age	15
Chiatura	30.01.07	Pregnant women and women of reproductive age	10
Chiatura	20.02.07	Pregnant women and women of reproductive age	14
Zestaphoni	07.03.07	Pregnant women and women of reproductive age	20
Zestaphoni	12.04.07	Pregnant women and women of reproductive age	13
Zestaphoni	23.05.07	Pregnant women and women of reproductive age	12
Zestaphoni	14.06.07	Pregnant women and women of reproductive age	15
Zstaphoni	18.07.07	Pregnant women and women of reproductive age	22
Zestaphoni	12.09.07	Pregnant women and women of reproductive age	15

Community Meetings October 2007 – September 2008

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Gardabani District, Village of Akhtala,	February 11	Mothers of Children U5; Ob-Gyns from Gardabami outpatient clinic	20
Gardabani District, Village of PataraLilo	February 12	Mothers of Children U5	22
Gardabani District, Village of Tsinubani	February 13	Mothers of Children U5	19
Gardabani District, Village of Kveseti	February 14	Mothers of Children U5	18
Gardabani District, Village of Dideba	February 15	Mothers of Children U5	20
Gardabani District, Village of Kensal	February 24	Mothers of Children U5	19
Gardabani District, Village of Jandiri	February 25	Mothers of Children U5	23
Gardabani District, Village of Varketili	March 10	Mothers of Children U5	20
Gardabani District, Village of Nasaguri	March 10	Mothers of Children U5	23
Gardabani District, Village of Karajalari	March 11	Mothers of Children U5	15
Gardabani District, Village of Akhali Samgori	March 11	Mothers of Children U5	20
Gardabani District, Village of Mukhrovani	March 12	Mothers of Children U5	20
Gardabani District, Village of Vaktangisi	March 12	Mothers of Children U5	17
Gardabani District, Village of Tslaskuri	March 13	Mothers of Children U5	18
Gardabani District, Village of Mukhrovani	March 14	Mothers of Children U5	15
Bolnisi District, City of Bolnisi	March 5	Mothers of Children U5	20
Bolnisi District, City of Bolnisi	March 6	Mothers of Children U5	22
Bolnisi District, City of Bolnisi	March 7	Mothers of Children U5	20
Bolnisi District, City of Bolnisi	March 26	Pediatricians and Ob Gyns of Bolnisi Outpatient clinic	7
Bolnisi District, Village of Ratevani	April 4	Mothers of Children U5, Teachers of Ratevani School,	29 (24 students, 5

		8-10th grade students	teachers)
Bolnisi District, Kazreti settlement	April 8	Mothers of Children U5	18
Bolnisi District, Village of Kveshi	April 10	Mothers of Children U5	20
Bolnisi District, Village of Disveli	April 11	Mothers of Children U5	23
Bolnisi District, Village of Tandzia	April 18	Mothers of Children U5	22
Marneuli District, Village of Kvemo Kulari	May 21	Mothers of Children U5	19
Marneuli District, Village of Norgiuli	May 21	Mothers of Children U5	22
Marneuli District, Village of Khojorni	May 22	Mothers of Children U5	17
Marneuli District, Village of Seidkhojalo	May 22	Mothers of Children U5	21
Marneuli District, Village of Akhali Mamudlo	May 23	Mothers of Children U5	19
Marneuli District, Village of Enikendi	May 24	Mothers of Children U5	20
Marneuli District, Village of Tsereteli	May 25	Mothers of Children U5	16
Marneuli District, Village of Jankhoshi	May 26	Mothers of Children U5	23
Marneuli District, Village of Gulbari	May 26	Mothers of Children U5	18
Marneuli District, Village of Sioni	May 27	Mothers of Children U5	20
Marneuli District, Village of Akhkula	June 2	Mothers of Children U5	20
Marneuli District, Village of Patara Beglari	June 3	Mothers of Children U5	20

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Marneulii District, Village of Tsopi	June 4	Mothers of Children U5	22
Marneulii District, Village of Araflo	June 5	Mothers of Children U5	22
Marneulii District, Village of Dashtapa	June 6	Mothers of Children U5	20
Marneulii District, Village of Zemo Kulari	June 16	Mothers of Children U5	20
Marneulii District, Village of	June 17	Mothers of Children U5	22

Budionovka			
Marneulii District, Village of Kirikhlo	June 18	Mothers of Children U5	21
Marneulii District, Village of Kachcgani	June 19	Mothers of Children U5	22
Marneulii District, Village of Didi Muganlo	June 20	Mothers of Children U5	20
Marneulii District, Village of Muganlo	June 24	Mothers of Children U5	21
Tsalka District, City of Tsalka	July 22	Mothers of Children U5	22
Tsalka District, Village of Bediani	July 22	Mothers of Children U5	20
Tsalka District, Village of Dashbashi	July 23	Mothers of Children U5	20
Tsalka District, Village of Ashkala	July 23	Mothers of Children U5	21
Tsalka District, Village of Kizilikilisa	July 24	Mothers of Children U5	21
Dmanisi District, Village of Gantiadi	July 25	Mothers of Children U5	22
Dmanisi District, Village of Irganchai	July 25	Mothers of Children U5	22
Tetri Tskaro District, Village of Gvevi	July 7	Mothers of Children U5	22
Tetri Tskaro District, Village of Gvevi	July 9	Mothers of Children U5	23
Tetri Tskaro District, Village of Ipnari	July 15	Mothers of Children U5	20
Tetri Tskaro District, Village of Tbisi	July21	Mothers of Children U5	12
Tetri Tskaro District, Village of Goltetii	July 21	Mothers of Children U5	10

Imereti Region			
Location	**Date**	**Participants category**	**Number of participants**
Chiatura	December 24, 2007	Mothers of Children U5 pediatricians from city outpatient clinic	20 mothers; 2 pediatricians
Zestaphoni	December 19, 2007	Mothers of children U5; One Ob-Gyn from Women's Consultation	22 mothers, 1 Ob-Gyn
Chiatura	June 11, 2008	Mothers of children U5	18 mothers
Zestaphoni	June 17, 2008	Mothers of children U5	15 mothers

Community Meetings October 2008 – June 2009

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Tetri Tskaro District, Village of Akhalsopeli	November 17	Mothers of Children U5; village ambulatory nurse	16
Tetri Tskaro District, Village of Napudzvrebi	November 24	Mothers of Children U5	15
Tetri Tskaro District, Village of Samshvilde	November 28	Mothers of Children U5; village ambulatory nurse, family doctor	20
Marneuli District, Village of Shulaveri	December 4	Mothers of Children U5;	15
Tetri Tskaro District, Village of Akhalsopeli	December 11	Mothers of Children U5; village ambulatory nurse	18
Tetri Tskaro District, Village of Amlivi	December 15	Mothers of Children U5; village ambulatory physician and nurse	20
Gardabani District, Village e of Varketili	January 09,09	Mothers of Children U5; village ambulatory doctor and 2 nurses	16
Gardabani District, Village of Patara Lilo	January 14,09	Mothers of Children U5; village ambulatory doctor and a nurse	20
Dmanisi District, Village of Javakhi	February 5,09	Mothers of Children U5; village ambulatory nurse	14
Dmanisi District, Village of Tnusi	February 9,09	Mothers of Children U5	16
Bolnisi District, Village of Akaurta	February 11, 09	Mothers of Children U5	12
Bolnisi District, Village of Kvemo Arkevani	February 13, 09	Mothers of Children	15

Annex 11.4 Focus Group Discussions

FGD March, 2006

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Regional Center, Rustavi (Georgian group)	March 6	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Regional Center, Rustavi (Georgian group)	March 6	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Gardabani (Azeri group)	March 7	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Marneuli (Azeri group)	March 8	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Dmanisi (Georgian group)	March 9	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Tetri Tskaro (Georgian group)	March 12	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Tetri Tskaro (Azeri group)	March 12	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Bolnisi (Georgian group)	March 13	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Bolnisi (Azeri group)	March 13	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Imereti			
Zestaphoni (Georgian group)	March 15	Pregnant mothers, mothers of children U5 and women of reproductive age	14

FGD September, 2007

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Regional Center, Gardabani (Azeri group)	September 5	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Regional Center center, Gardabani (Georgian group)	September 5	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Regional Center center, Marneuli (Azeri group)	September 6	Pregnant mothers, mothers of children U5 and women of reproductive age	13
Regional Center center, Marneuli (Geogian group)	September6	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Bolnisi (Georgian group)	September7	Pregnant mothers, mothers of children U5 and women of reproductive age	8
Bolnisi (Azeri group)	September 7	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Tetri Tskaro (Georgian group)	September10	Pregnant mothers, mothers of children U5 and women of reproductive age	9
Kvemo Kartli Region			
Tetri Tskaro (Azeri group)	September 10	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Regional Center, Dmanisi (Georgian group)	September 11	Pregnant mothers, mothers of children U5 and women of reproductive age	14
Dmanisi (Georgian group)	September11	Pregnant mothers, mothers of children U5 and women of reproductive age	8
Imereti			
Chiatura	September 14	Pregnant mothers, mothers of children U5 and women of reproductive age	12

FGD December 2008, January 2009

Kvemo Kartli Region			
Location	**Date**	**Participants category**	**Number of participants**
Regional Center center, Tetri Tskaroi Georgian group)	December 5, 08	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Gardabani District, Village of Tazakendi (Azeri group)	December 8, 08	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Marneuli District, Village of Zemo Kulari (Azeri group)	December 18, 08	Pregnant mothers, mothers of children U5 and women of reproductive age	12
Marneuli District, Village of Khikhani (Azeri group)	January 13, 09	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Marneuli District, Village of Tserakvi (Georgian group)	January 16, 09	Pregnant mothers, mothers of children U5 and women of reproductive age	10
Marneuli District, Village of Azizkendi (Azeri group)	January 22, 09	Pregnant mothers, mothers of children U5 and women of reproductive age	11
Marneuli District, Village of Akhali Samgori (Georgian group)	January 23, 09	Pregnant mothers, mothers of children U5 and women of reproductive age	12

Annex 11.5A. Comparison 2007/2010 Dmanisi Clinics and Maternity Hospital Health Facilities Assessment

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
1	Population covered by the service of HF	Head, Elisabed Katsitadze	Head, Elisabed Katsitadze	Head Svetlana Vibliani	Head Svetlana Vibliani		
1.1	Village, community	25 and >	25 and >	25 and >	25 and >		Stable pop
1.2	Population	24 000 and >	24 000 and >	26 000	26 000		
2 #	Organization and Management of HF						
2.1	Presence of activity schedule	No	Yes	No	Yes		
2.2	Are the work hours identified	No	No	No	No		
2.3	Number of HF staff servicing population during the work hours	20	24	-	15		
6	Average number of work hours/per HF staff/day	7 hr	8 hr	5 hr	8 hr		
7	Is there a staff member who is permanently receiving phone calls?	Yes	Yes	No	Yes		Maternity hospital develop Phone hot line
2.6	If not, why	-		There is no need			Acts helped raise awareness
8	Are the staff members trained to fulfill more than one types of work?	Yes	Yes	No	Yes		Maternity hospital introduced Cross training of staff
9	Who inspects HF?	External Health Evaluation Team*	External Health Evaluation Team*	External Health Evaluation Team*	External Health Evaluation Team*		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
1	Of those from local HF body?	d/r PHC	d/r PHC	d/r PHC	d/r PHC		
3.2	What is the periodicity of inspection?	Daily	Daily	Monthly	Monthly		
3.2 #	Who else and how often?	Annually MoLHSA regional department inspector, Social Fund, Narcological Inspection, Chamber of Control Taxation Inspection, NCDC	Annually MoLHSA regional department inspector, Social Fund, Narcological Inspection, Chamber of Control Taxation Inspection, NCDC	Annually MoLHSA regional department inspector, Social Fund, Taxation Inspection	Annually MoLHSA regional department inspector, Social Fund, Taxation Inspection		
4	How (what are the methods used) does the inspector of district health care departments conduct the inspection?						
4.1	Through direct observation	Yes	Yes	-	Yes		
4.2	By collecting data	Yes	Yes	Yes	Yes		
4.3	Using control checklist	Yes	Yes	No	Yes		Ob guideline introduced At national level with check List items
4.4	By detecting violations	Yes	Yes	No	Yes		Guidelines provide basis

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
							for Standardizing what is a violation
4.5 #	Through discussion	Yes	Yes	No	No		Future goal for ACTS
5.	Does the HF submits monthly reports to the district (local) Health care Department	Yes	Yes	Yes	Yes		
5.1	What kind of report?	Written programmatic	Written programmatic	Written	Written		
5.2	Who of high qualification physicians come to inspect?	Nobody	Specialists from Regional Departments of MoLHSA	Nobody	Specialists from Regional Departments of MoLHSA		
5.3	How often?	-	Bi-annually	-	Bi-annually		
5.4	How does the high qualification physician conduct the inspection?	-		-			
	Observation Data collection Control Checklist Detection violations Discussion	-	Yes Yes Yes	-	Yes Yes Yes		
6	Does the HF have respective seating?	Yes	Yes	No	No		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
17	Is drinking water available for the patients?	Yes	Yes	Yes	Yes		
18 #	Does the facility have ORS corner	Yes	Yes	No	Yes		ORS corner is definite improvement
19	Is there a toilet?	Yes, clean	Yes, clean	Yes, but dirty and half destroyed	Yes, newly renovated		Significant infection control improvement
20	Does the HF have a maintenance staff?	Yes	Yes	Yes	Yes	Electrician, logistic	Electrician, logistic
21	Does the HF have a night guard?	No	No	Yes	Yes		Increase patient safety
22	Does the HF have cleaning and working instruments?	Yes	Yes	Yes	Yes		
	Service Availability						
23	(a) Sick Child Care	Every week day	Every day	Every week day	Every day		On week-ends a team of the doctor and a nurse are on duty
	(b) Immunization (EPI and tetanus)	Tuesday	Tuesday	Per need basis	Per need basis		
	(c) Antenatal care	Every week day	Every week day	Per need basis	Per need basis		
	(d) Child spacing counseling	Every week day	Every week day	No	Per need basis		
	(e) Adult consultation	Every week day	Every week day	No	Every Monday		
	(f) Emergency care	Every week day	Every week day	Per need basis	Per need basis		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	(ambulance)						
	(g) Education and prevention	Every week day	Every week day	No	No		
	Muse of Services						
24 #	Children unber 5 years of age: Number of patients examined last month for the following complains:	Fever, helmintosius, nutritional deficiencies, iodine deficiency, ARI	ARI, diarrhea, helmintosis, allergic response to food,				Need focus group follow up
25	Other- Total number of examinations during the last month	80	75	30	22		
	Physical persons	76	62	30	22		
26	Consultation on antenatal care	29	15	10	5		
27	Counseling on child spacing (for women, for men)	5	8	20	12		
28	Consultation on STD	0	2	0	1		
29	Consultation on diseases (for women, for men)	15/7 (f/m)	21/10 (f/m)	5/0	3/0		
1	(Total number of patients of all ages) Number 207						
2	Deliveries: Normal physiologiuca; complicated Caesarian section, home delivery which complicated and a qualified obstetrician			177 0	156 0	Every case, which supposedly may require C-section as a rule is	Every case, which supposedly may require C-section as a rule is referred to

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	<u>was invited</u>					referred to regional or Tbilisi maternity hospital	regional or Tbilisi maternity hospital
#	<u>Outreach activities</u>						
30	How often is the team conducting outreach activities?	Once annually	Once quarterly	No	No		
31	Who is conduucting outreach activities?	Neurologis, Otolaryngologist, Pediatrician etc.	Neurologis, Otolaryngologist, Pediatrician etc.	-			
32	Is EPI the only reason for outreach activities?	No	No	-			
33	Is health education an integer part of outreach activities?	Yes	Yes	-			
34	Is vitamin A distributed during the outreach activities?	No	On need basis	-			
	What is the periodicity?	-	On need basis				
	Recording						
35	Does the patients' registration journal exist?	Yes	Yes	Yes	Yes		
36	Does the HF have the antenatal care registration journal (including tetanus shots?)	No	Yes	No	No		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
37	Does the HF have immunization registration journal?	Yes	Yes	Yes	Yes		
38 #	Does the HF have laboratory tests registration journal?	Yes	Yes	No	Yes		
39	Information recorded in registration journals						
1	Name of the Patient	Yes	Yes	Yes	Yes		
2	Patient Personal Number	Yes	Yes	No	Yes		Improvement
3	Patienmts age (birth date)	Yes	Yes	Yes	Yes		
4	Infants/problem	Yes	Yes	Yes	Yes		
5	Diagnosis	Yes	Yes	Yes	Yes		
6	Treatment (including prescribed medicines)	Yes	Yes	Yes	Yes		
7	Appointing observation visit	Yes	Yes	No	No		
	Backfeed information is recorded in:	Patient's case story	Patient's case story	Form # 27	Form # 27		
	Information on Patient's Personal Card	No	Yes	-	-		
40	Does the child's yellow card contain information on Vitamin A?	No	No	No	No		
41	Are the data on the	Yes	Yes				

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	child's growth recorded during every visit to HCC?						
42 #	Does the mother's pink card contain information on tetanus vaccination?	No	No	No	No		
	Instructions on Clinical Management						
43	Do the HCC personnel have the Manual issued by MoLHSA?	No	Yes	No	Yes		
44	Does there exist disease management algorithm for the below listed pathologies?	No	Yes	No	Yes		
1	a)ARI	Yes	Yes	No	Yes		
2	Diarrhea	Yes	Yes	No	Yes		
3	Fever	No	Yes	No	Yes		
4	Reproductive health	No	Yes	No	No		
5	Other	Yes	Yes	No	Yes		
	Materials on information, education, communication Please list	N					
	Hygiene, diarrhea	No	Yes	No	Yes		
	Malaria/bednets	No	No	No	No		
	e) Denge's fever	No	No	No	No		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	v) Nutrition/Vitamin A	No	Yes	No	No		
	z) Parasites	No	Yes	No	No		
#	Breastfeeding	No	Yes	No	Yes		
	T) Antenatal care	No	Yes	No	No		
	k) Child spacing	No	Yes	No	Yes		
	l) STD/HIV/AIDS	No	Yes	No	Yes		
	m) Iodized salt	No	Yes	No	No		
46	Is there any system to record the disease epidemic?	Yes	Yes	No ???	Yes		According to the new guidelines such system has been introduced since 2008
	Is there village to Health care Center notification system	Yes	Yes	Yes	Yes		
	Is there regional Health care Center to Public Health Care Center notification system	Yes	Yes	Yes	Yes		
47	Describe the system	Telephonogram, written notification	Telephonogram, written notification	Telephonogram, written notification	Telephonogram, written notification		
48	Does the patient receive educational	No	Yes	-			Major change implemented

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	information during each visit?						
49 #	Does the Health Care personnel conduct personal group educational meetings (discussions) with the population	Yes	Yes	-			
	Where are these sessions conducted	At HF, village ambulatories	At HF, village ambulatories	-			
	What is the periodicity of the sessions?	Quarterly	Monthly	-			More frequent review
	If the sessions are not conducted, please explain why	-		-			
50	Pharmaceutical and equipment resources	Very poor	Satisfactiry	Poor for equipment, satisfactory for medicines	Poor for equipment, goodfor medicines		Update equipment needs remain
51	Does the Health Care Center register pharmaceuticals?	Yes	Yes	Yes	Yes		
52	Did you have the lack of the above listed medicines during the last 30 days. If yes, what was the reason	Yes	No	No	No		
54	What contributed	Financial reasons		-			

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	to the lack of pharmaceuticals						
55 #	Do the Health Care Centers have warehouses to store mediciens and medical supplies?	Yes	Yes	Yes	Yes		
56	If not, where are they sttored?	In the pharmacy's back room					
57	Is there any problem in supplying pharmaceuticals	Yes	No	No	No		
58	Cold Chain materials, Information						
1	Refrigerator	Yes	Yes	Yes	Yes		
	Thermometer in the fridge	Yes	Yes	Yes	Yes		
	Daily map of the freezer temperature	Yes	Yes	Yes	Yes		
	Cold box	Yes	Yes	Yes	Yes		
	Cold box thermometer	No	Yes	No	Yes		
	Daily map of the cold box temperature	No	Yes	No	Yes		Improved documentation
	Vaccines transportation box	Yes	Yes	No	No		
	Vaccines transportation box	No	Yes	No	No		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	thermometer						
	Do you have information on vaccine storeroom	Yes	Yes	Yes	Yes		
#	Do you have relevant syringes and needles for immunization imunizaciisaTvis	Yes	Yes	Yes	Yes		
	Do you have sterilizers for needles and syringes?	Yes	Yes	Yes	Yes		
***	Equipment and resources						
59	Availability in the HC Center						
	Of the following equipment	Basically no					
60	Reimbursement of rendered services	Yes	Yes	Yes	Yes		
	a) Is there the system of reimbursement of service cost?	Yes	Yes	Yes	Yes		
	b) Are the prices for the service clearly defined?	Yes	Yes	No	Yes		
	c) Comments			No			
	Is there Health	No	Yes	No	Yes		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	Care Center Management Committee						
#	a) How often does the Committee meets	On the need basis	On the need basis	- On the need basis	On the need basis		
	b) Attendance						
	Plans for service cost reimbursement	Salary 40%, Indirect expenses 55%, profit 5%	Salary 40%, Indirect expenses 55%, profit 5%	Co-payment through vouchers	Co-payment through state insurance		12 % increase in payment
	Budget	62 000 GEL	73,000 GEL	75,000 GEL	88,000 GEL		
	Comment	Village program 50000; Miniciupal -6000;	Internal income - 6000.	Voucher Program	Out-of-pocket payment		The system of state voucher payment has been annulled by the end of 2009
62	Health Center Feedback Committee (service or a unit responsible for the feedback)	-					
	Attendance	-		-			
	Plans for expenses reimbursement	-		-			
	Budget	-		No			
	Comments	-		-			
63	Description of Health Care Center			3 Departments			
	a) General information about the	Satisfactory	Good	Unsatisfactory	Satisfactory		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	Center activities: Degree of observing relevant Hygiene						
#	b) Equipment needed		Ultrasound unit	Basic profile	Basic profile		
	c) Comment			Extremely poor	Satisfactory		
	a) Problems	Replacing old outdated and non-functioning equipment; Lack of heating; poor motivation of the physicians, insufficient number of nurses, lack of necessary medicines; lack of relevant transportation means; poor condition of the building; poor communication	Replacing old outdated and non-functioning equipment; Extremely poor condition of the building, which became even worse than in 2006 due to heavy floods in spring of 2008;	Damaged ceiling, outdated poorly functioning equipment; insufficient funding; sanitary-and-hygienic problems; low motivation of the physicians	Insufficient funding, continuing problems with equipment		
	b) Requiers:	Capital renovation, re-equipment with working modern equipment; better medicines supply	Capital renovation, re-equipment with working modern equipment; better medicines supply	Support and assistance to restore management and central authority	Increasing funding. for-equipment		

COMPARISON 2007/2010 FOR DMANISI CLINICS AND MATERNITY HOSPITAL HEALTH FACILITIES ASSESSMENT							
Questions		Dmanisi ambulatory-and-policlinic unit 2007	Dmanisi ambulatory-and-policlinic unit 2010	Dmanisi maternity hospital 2007	Dmanisi maternity hospital 2010	Note 2007	Note4 2010
	c) Questions						
#	d) What kind of trainings are required	Management; Diseases management	Educational activities among population at the PHC level	Management;	Trainings to increase profession-al skills;		
	e) Additional comments	Exchange Program with the Univeristy of Missorui Neonatology urgently requested					

2007

U of Missouri School of Medicine External Evaluation Team performed survey
Dr. Laura Hillman, Neonatalogist, Associate Professor Child Health.
Randal Floyd, Ob-Gyn Professor and Director High Risk Obstetrics Program

Annex 11.5B Comparison 2007/2010 Bolnisi Clinics and Maternity Hospital Health Facilities Assessment

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
1	Population covered by the service of HF	Head, Marina Devnizashvili	Head, Marina Devnizashvili	Head Darejan Chkhetiani	Head Darejan Chkhetiani		
	Village, community	9 and >	9 and >	9 and >	9 and >		
	Population	11 000, of those	7 000 on contract	76 000	76 000		
2	Organization and Management of HF	Yes	Yes	Yes	Yes		
2.1	Presence of activity schedule	Yes	Yes	No	Yes		
2.2	Are the work hours identified	No	Yes	No	Yes		
2.3	Number of HF staff servicing population during the work hours	20	23	25	25		
6	Average number of work hours/per HF staff/day	7,5 hr	8 hours	Not available	8 hours		
7	Is there a staff member who is permanently receiving phone calls?	Yes	Yes	No	Yes		
2.6	If not, why	-		Physicians have cell phones			
8	Are the staff members trained to fulfill more than one types of work?	No	Yes	Yes	Yes		
9	Who inspects HF?	External Health Evaluation Team*	External Health Evaluation Team*	External Health Evaluation Team*	External Health Evaluation Team*		
1	Of those from local HF body?	B/R PHC, HC department	District HC Department	b/r PHC	Regional HC Department		
3.2	What is the periodicity of inspection?	Every 2nd week	Every 2nd week	Monthly	Monthly		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
3.2	Who else and how often?	Annually MoLHSA regional department inspector,	Twice annually - Social Fund	Annually MoLHSA regional department inspector, Social Fund, Narcologi-cal Inspection,	Annually MoLHSA regional department inspector, Social Fund, Narcological Inspection,		
4	How (what are the methods used) does the inspector of district health care departments conduct the inspection?						
4.1	Through direct observation	Yes	Yes	Yes	Yes		
4.2	By collecting data	Yes	Yes	Yes	Yes		
4.3	Using control checklist	No	Yes	Yes	Yes		
4.4	By detecting violations	No	Yes	Yes	Yes		
4.5	Through discussion	No	No	Yes	Yes		
5.	Does the HF submits monthly reports to the district (local) Health care Department	Yes	Yes	Yes	Yes		
5.1	What kind of report?	Written programmatic	Written programmatic Statistical	Statistical, financial	Written programmatic, Statistical, Financial		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
5.2	Who of high qualification physicians come to inspect?	Nobody	Specialists from Regional HC Department, District Public Health Care Center specialists	Nobody	Specialists from Regional HC Department, District Public Health Care Center specialists		
5.3	How often?	-	Every 6 months	-	Quarterly		
5.4	How does the high qualification physician conduct the inspection?	-		-			
	Observation Data collection Control Checklist Detection violations Discussion	-	Yes Yes - Yes Yes Yes	-	Yes Yes Yes Yes Yes No		
6	Does the HF have a respective seating?	No	Yes	Yes	Yes		
17	Is drinking water available for the patients?	Yes	Yes	Yes	Yes		
18	Does the facility have ORS corner	Yes	Yes	Yes	Yes		
19	Is there a toilet?	Yes, clean	Yes, clean	Yes, clean	Yes, clean		
20	Does the HF have a maintenance staff?	Yes	Yes	Yes	Yes	Electrician, logistic, plumber	
21	Does the HF have a night guard?	Yes	Yes	No	No		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
22	Does the HF have cleaning and working instruments?	Yes	Yes	Yes	Yes		
	Service Availability						
23	(a) Sick Child Care	Every week day	Every week day	Per need basis	Per need basis		
	(b) Immunization (EPI and tetanus)	Friday	Friday	Per need basis	Per need basis		
	(c) Antenatal care	-	-	Per need basis	Yes		
	(d) Child spacing counseling	-	Yes	Per need basis	Yes		
	(e) Adult consultation	Every week day	Every week day	Per need basis	Every week day		
	(f) Emergency care (ambulance)	Every week day	Every week day	Per need basis	Per need basis		
	(g) Education and prevention	Every week day	Every week day	Per need basis	Every week day		
	Muse of Services						
24	Children unber 5 years of age: Number of patients examined last month for the following complains:	Diarrhea - 5 ARI -15 High fever – Nutritional deficiency -1;	Other Allergic dermatitis - 8 Lymphadenitis 2 Rakhitis-1	Per need basis	Per need basis		
25	Other- Total number of examinations during the last month	1 676	1554	300	325		
	Physical persons	-	135	270	189		
26	Consultation on antenatal care	-	-	No	35		
27	Counseling on child spacing (for women, for men)	-	25	No	42		
28	Consultation on STD	-	15	200-240	300		
29	Consultation on diseases (for women, for men)	0-1 - 174; 1-3 - 330;	3-15 - 1182	-	-		
1	(Total number of patients of all ages) Number __2100_____	-					

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
2	Deliveries: Normal physiologiucal; complicated Caesarian section, home delivery which complicated and a qualified obstetrician was invited			665 549 -	687 672 -		
	Outreach activities						
30	How often is the team conducting outreach activities?	Every month	Every month	Once annually	Biannually		
31	Who is conducting outreach activities?	Pediatrician and others	Pediatrician and others	Ob-Gyn, physician, echoscopes	Ob-Gyn, physician, echoscopy specialist		
32	Is EPI the only reason for outreach activities?	No	No	No	No		
33	Is health education an integer part of outreach activities?	Yes	Yes	Yes	Yes		
34	Is vitamin A distributed during the outreach activities?	No	Per need basis	No	Per need basis		
	What is the periodicity?	Monthly	Monthly	Annually	Biannually		
	Recording						
35	Does the patients' registration journal exist?	Yes	Yes	Yes	Yes		
36	Does the HF have the antenatal care registration journal (including tetanus shots?)	No	Yes	No	Yes		
37	Does the HF have immunization registration journal?	Yes	Yes	Yes	Yes		
38	Does the HF have laboratory tests registration journal?	Yes					

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
39	Information recorded in registration journals						
1	Name of the Patient	Yes	Yes	Yes	Yes		
2	Patient Personal Number	Yes	Yes	Yes	Yes		
3	Patienmts age (birth date)	Yes	Yes	Yes	Yes		
4	Infants/problem	Yes	Yes	Yes	Yes		
5	Diagnosis	Yes	Yes	Yes	Yes		
6	Treatment (including prescribed medicines)	No	Yes	Yes	Yes		
7	Appointing observation visit	No	No	Yes	Yes		
	Backfeed information is recorded in:	PHC, Police	District HC Department, PHC Center, Police	District HC Department	District HC Department PHC Center		
	Information on Patient's Personal Card	No	Yes	-	Yes		
40	Does the child's yellow card contain information on Vitamin A?	No	No	-	-		
41	Are the data on the child's growth recorded during every visit to HCC?	Yes	Yes	-	Yes		
42	Does the mother's pink card contain information on tetanus vaccination?	No	No	-	-		
	Instructions on Clinical Management						
43	Do the HCC personnel have the Manual issued by MoLHSA?	No	Yes	Yes	Yes		
44	Does there exist disease management algorithm for the below listed pathologies?			Yes	Yes		
1	a)ARI	Yes	Yes	Yes	Yes		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
2	Diarrhea	No	Yes	Yes	Yes		
3	Fever	Yes	Yes	Yes	Yes		
4	Reproductive health	No	Yes	No	Yes		
5	Other	Nutrition					
	Materials on information, education, communication Please list						
	Hygiene, diarrhea	Yes	Yes	-	Yes		
	Malaria/bednets	No	No	-	No		
	e) Denge's fever	No	No	-	No		
	v) Nutrition/Vitamin A	No	No	-	Yes		
	z) Parasites	Yes	Yes	-	Yes		
	Breastfeeding	Yes	Yes	Yes	Yes		
	T) Antenatal care	ara					
	k) Child spacing	Yes	Yes	Yes	Yes		
	l) STD/HIV/AIDS	No	Yes	Yes	Yes		
	m) Iodized salt	Yes	Yes	No	Yes		
46	Is there any system to record the disease epidemic?	No	No	Yes	Yes		
	Is there village to Health care Center notification system	Yes	Yes	Yes	Yes		
	Is there regional Health care Center to Public Health Care Center notification system	No	Yes	Yes	Yes		
47	Describe the system	Telephonogram, urgent written notification	Telephonogram, urgent written notification	Telephonogram, urgent written notification	Telephonogram, urgent written notification		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
48	Does the patient receive educational information during each visit?	No	Yes	Yes	Yes		
49	Does the Health Care personnel conduct personal group educational meetings (discussions) with the population	No	Yes	No	Yes		
	Where are these sessions conducted	No	At the HF	No	At the HF, Village ambulatories		
	What is the periodicity of the sessions?	-	Every 2 months		Every month		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
	If the sessions are not conducted, please explain why	The old rules did not include such requirement for Maternity Hospitals		The Soviet system envisaged the so-called sanitary-and-educational activitiesfor population. It was in the physicians' and nurses job description. However because of extremely low salaries and ambiguiies in HC Legislation,medical personnel was not properly motivated to do educational work among the population			
50	Pharmaceutical and equipment resources	Rather poor	Significantly improved for pharmaceuticals, still unsatisfatory for equipment	Rather poor	Significantly improved both for pharmaceutials an equipment		
51	Does the Health Care Center register pharmaceuticals?	Yes	Yes	Yes	Yes		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
52	Did you have the lack of the above listed medicines during the last 30 days. If yes, what was the reason	No	No	Yes because of poor supply of state covered medicines	No		
54	What contributed to the lack of pharmaceuticals			Insufficient state funding and high prics of medicines, which the majority of local population could not afford			
55	Do the Health Care Centers have warehouses to store mediciens and medical supplies?	Yes	Yes	Yes	Yes		
56	If not, where are they sttored?	In the pharmacy's back room					
57	Is there any problem in supplying pharmaceuticals	Yes	No	No	No		
58	Cold Chain materials, Information						
1	Refrigerator	Yes	Yes	Yes	Yes		
	Thermometer in the fridge	Yes	Yes	Yes	Yes		
	Daily map of the freezer temperature	vs	Yes	vs	Yes		
	Cold box	Yes	Yes	Yes	Yes		
	Cold box thermometer	Yes		No			
	Daily map of the cold box temperature	Yes	Yes	Yes	Yes		
	Vaccines transportation box	Yes	Yes	Yes	Yes		
	Vaccines transportation box thermometer	No	Yes	No	Yes		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
	Do you have information on vaccine storeroom	Yes	Yes	Yes	Yes		
	Do you have relevant syringes and needles for immunization imunizaciisaTvis	Yes	Yes	Yes	Yes		
	Do you have sterilizers for needles and syringes?	Yes	Yes	Yes	Yes		
***	Equipment and resources						
59	Availability in the HC Center						
	Of the following equipment	Yes	Yes	Yes	Yes		
60	Reimbursement of rendered services	Yes	Yes	Yes	Yes		
	a) Is there the system of reimbursement of service cost?	Yes	Yes	Yes	Yes		
	b) Are the prices for the service clearly defined?	Yes	Yes	Yes	Yes		
	c) Comments	-		-			
	Is there Health Care Center Management Committee	No	Yes	No	Yes		
	a) How often does the Committee meets		Once a month	Once every three months	Once every three months		
	b) Attendance			Yes			

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
	Plans for service cost reimbursement	Salary 40%-50%, Indirect expenses 45-55%, profit 5%	Salary 40%-50%, Indirect expenses 45-55%, profit 5%	Salary 40; Medicines 30; Laboratory-10 Indirect expenses -40-45% Profit – 5-10%	Office-25 Profit-10	Salaries 35% Office expenses – 15% Laboratory – 10% Indirect expenses – 30% Profit – 10%	
	Budget			250 000 GEL			
	Comment			Social fund 120 000; Municipal prog.-88 000;	Internal standards 60 000.	Internal standards 60 000.	
62	Health Center Feedback Committee (service or a unit responsible for the feedback)	-	Health information unit	Yes, 2 nurses from registration office	Yes, 2 nurses from registration office		
	Attendance	-		-			
	Plans for expenses reimbursement	-		-			
	Budget	-		-			
	Comments	-		-			
63	Description of Health Care Center	13 Departments	10 Depatments	4 Departments	4 Departments		
	b) General information about the Center activities: Degree of observing relevant Hygiene	Satisfactory	Good	Very good	Excellent		
	b) Equipment needed	Available, in poor condition	Available in good condition	Modern, more advanced equipment	Modern, more advanced equipment		

#	Questions	Bolnisi pediatric policlinic2007	Bolnisi pediatric policlinic 2010	Bolnisi Maternity Hopsital2007	Bolnisi Maternity Hopsital2010	Note 2007	Note4 2010
	c) Comment						
	a) Problems	Pediatric instruments and equipment; diagnostic equipment, adequate amount of medicines	Need in more modern equipment	Quality of medical service, optrimization	Though in general the quality of medical service improved, it still needs further optimization in management		
	b) Requiers:						
	c) Questions						
	d) What kind of trainings are required	Management;	Diseases management at the PHC level	Financial and Administrative management	Patients education methods		
	e) Additional comments						

Annex 11.6A Rapid Health Facility Assessment 2009

Health Facility Assessment Report

Child Survival Program for Kvemo Kartli and Imereti, Georgia
USAID/CHSHP COOPERATIVE AGREEMENT # GHS-A-00-04-00025-00

Implemented by:
A Call to Serve (ACTS) International

Rapid Health facility Assessment for Quality and Access at the Primary Health Care Level

Final Report, September, 2009

Marneuli, Gardabani, Dmanisi, Bolnisi, Tetri Tskaro Districts and the city of Rustavi, Kvemo Kartli Region

Table of Contents

List of Acronyms

ANC	Antenatal Care
CHW	Community Health Worker
CSHGP	Child Survival and Health Grants Program
CSTS	Child Survival Technical Support
DHO	District Health Officer
DPT	Diptheria, Pertussis and Tetanus
GMP	Growth Monitoring and Promotion
HC	Health Center
HFA	Health Facilities Assessment
HW	Health Worker
KPC	Knowledge, Practice and Coverage
MNC	Maternal and Newborn Care
MoLHSA	Ministry of Labor, Health and Social Affairs
PNC	Postnatal Care
QA	Quality Assurance
TT	Tetanus Toxoid
WHO	World Health Organization

I. INTRODUCTION

Purpose of the Assessment

The purpose of this Rapid Health Facilities Assessment tool is to assess the functioning of the primary health care units (outpatient clinics and ambulatories) within the project area in Georgia. This tool makes it possible to generate a *minimum* set indicators of quality and access, especially insofar as these support community-based child health programming.

The objectives of the health facility assessment are:

1. To determine the current knowledge and practices of health workers at outpatient clinics and community health workers regarding the assessment and management of sick children.
2. To use the information for assessment of CS interventions impact at the primary health care level during the life of the project
3. To use the information to develop recommendations and demonstrate the gaps in ensuring quality of care at the primary health level facilities, including staffing, clinic organization, equipment requirements, drug and material supplies, and case-management practices, training and supervision of outpatient health workers and community health workers.

Results of the assessment and feedback have been forwarded to the Ministry of Labor, Health and Social Affairs (MoLHSA) of Georgia, Head of Public Health Centers of the relevant districts and health facilities surveyed to be taken into consideration. The scope of the assessment covered the following issues:

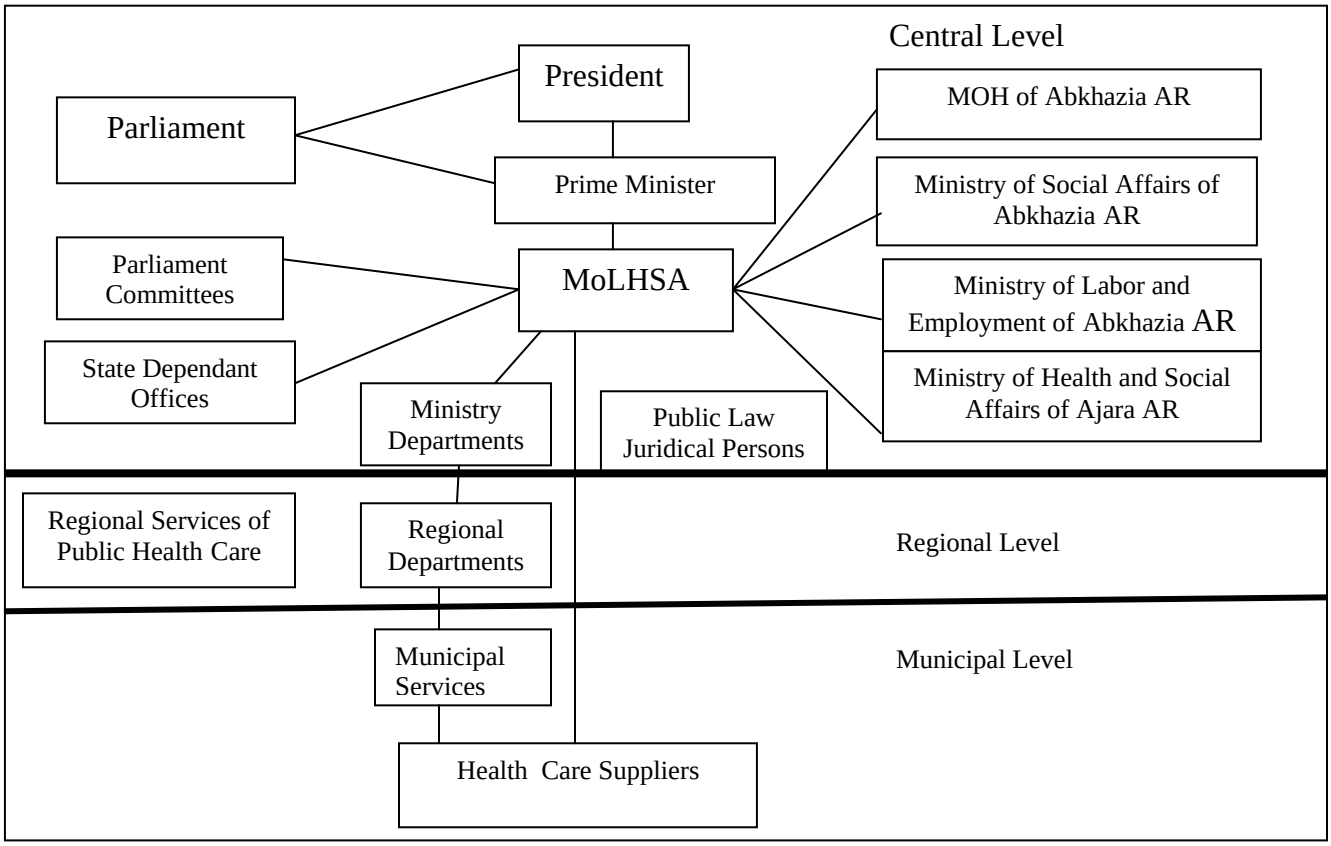
- Health worker and CHW training
- Health worker and CHW supervision
- Availability of essential equipment and drugs
- Health facility management practices like recordkeeping, supervision and training

Description of Child Survival Program for Kvemo Kartli and Imereti Regions of Georgia

The CS Project in Georgia was launched on October 1, 2004. This five-year project was awarded through the USAID Child Survival and Health Grants Program's (CSHGP) new partner category. The Projects served Georgia's most vulnerable health groups- women of reproductive age and children under 5 year of age within the country's two most economically depressed regions – Kvemo Kartli in the southern border area and Imereti (two cities) – in the western area. The project benefited 38,000 children under-five in the Kvemo Kartli Region and two cities of Imereti Region of Georgia. The program uses innovative community-based strategies to address the factors contributing to the high maternal and under-five mortality. Interventions included Nutrition a (15% effort), Pneumonia (15% effort), Control of Diarrheal diseases (25% effort), Maternal and Newborn Care (25% effort) and Breastfeeding (20% effort).

Georgia Health System

The Health System of Georgia, which is currently in the process of reforming by the moment of conduction of this survey has the structure shown on the following page.



The Georgian government provides PHC through a range of services:

- General health centre (in Georgia commonly referred to as ambulatory services)/outpatient network staffed by general practice doctors at village/rural level. On average, there is one doctor and one nurse per 2,000 people.
- Specialized health centers (created by regional dispensaries and polyclinics housing teams of specialists).
- Reformed PHC centers (known as family medicine centers) with family doctors who have received additional training (will cover not more than one-third of the outpatient service needs).
- An ambulance network.
- A public health network.

It should be stressed that since independence from the former Soviet Union in 1991, the health sector has been through a number of different policy directions. First, in the mid-1990s, came the move to decentralize health care and develop a health insurance system, funded by a $14 million package from the World Bank. However, most people were unaware of their new rights, so continued to pay informal fees charged by medical staff at the point of use.

More recently, health policy has been almost completely overhauled, from a publicly owned

system aiming to provide universal access to good-quality basic medical care, to one that has been brought into line with a national economic policy based on privatization of public services.

From 2004 to 2006, the PHC Master Plan I provided the framework for reform. Funded by the World Bank, the EU and the UK Department for International Development (DFID) and developed in consultation with key stakeholders, it aimed to provide universal access to quality basic medical care through a publicly owned and managed system. It was based on the principle that no one would be more than 15 minutes away from a PHC centre. It also included plans to re-train all medical staff delivering PHC and to rehabilitate facilities.

However, in 2006, the government decided to reassess this plan, arguing that it was too expensive and ambitious – for instance, the promise of '15-minute access' was considered unrealistic, given that many people live in mountain regions where roads are poor.

In fact, the government sees privatization of public services as a necessary precondition for successful reform and for overcoming the constraints of public financing: '*The government has its arguments for choosing this model. The main reason is that the government does not have sufficient funds to operate the public system well.' (Statement by an official working in the Georgian health administration, 2 April 2008)*

In January 2007, the MoLHSA, together with the State Minister's office, presented the new strategy, the *Main Directions in Health 2007–2009***.**The new strategy set out four main objectives to:

- ensure overall affordability of basic health services and protect the population from catastrophic financial health risks
- ensure quality of care by creating a sound regulatory environment
- ensure greater access to quality medical care by continuous development of medical infrastructure and competent human resources
- increase efficiency in the health system by building advanced management systems and capacity in the Ministry and institutions under its structure.

In 2007 the government developed a new master plan, which aims to introduce a private PHC system, based on insurance. It is important to note that the plan has not been adopted.

In 2007, a pilot program began to be implemented, subsidizing health insurance for people below the poverty level. It included all types of services, PHC as well as hospital, but did not cover expenses for pharmaceuticals. In March 2008, the Georgian Health Minister announced the government's priorities until 2012, as part of the framework of the Program of the Government of Georgia 2008–2012, 'United Georgia without Poverty'. ***One of the biggest problems with health policy is the fact that reforms initiated under different governments have been inconsistent, often contradictory and not evidence-based.*** [10]

The latest published model of the Primary Health Care is described as follows:
Primary Health Care envisages providing ambulatory services to the population residing in close

[10] (**Health-Care Reform in Georgia *A Civil-Society Perspective: Country Case Study*** , Oxfam International Research Report, May 2009

vicinity from the health facility. Basic ambulatory services are provided by a family physicians/nurses through home visits, at the Family Medicine Centers, outpatient clinics and ambulatories. The basic ambulatory services cover: a)medical consultations; b)basic functional-and-diagnostic laboratory tests, which are not requiring advanced laboratory-and-diagnostic equipment. The team compiled from one family doctor and one nurse are responsible for providing ambulatory services at the village level. In accordance with the new model all specialists involved in ambulatory services (including family doctor and ambulatory staff) are subjected to the state licensing. Location of the primary health care unit is determined based on the principle of optimal geographical accessibility. Village ambulatories staff involves various profile specialists. Primary Health Care model is based on family medicine notion with a family doctor playing major role. One family doctor serves 2000 patients. The doctor-nurse ratio in future is planned to be 1:2. Retraining of all family doctors and nurses is planned to be finished by the end of 2010.[11]

By the moment of survey conduction the primary health care network in the project area had 6 Pediatric Outpatient District Clinics (one per each district in Kvemo Kartli) plus two pediatric outpatient clinics in the regional center – Rustavi and another two pediatric polyclinics in Chiatura and Zestaphoni, respectively. Each district has its own Primary Health Care Department. Depending on the size of the District the number of village ambulatories vary from three to 17. Each village ambulatory serves from two to 10 villages. The number of villages correspond with the number of administrative sub-units within the district. The inclusion of villages into administrative sub-units depends on the geographical location of those villages with the maximum distance of enclosed villages from the relevant sub-unit not exceeding 5 km. Each district center has a multi-profile hospital and maternity hospital.

Table 1: List of Primary Health Services in Program Area (Kvemo Kartli Region)

District	2002 Census Population	Regional/ District Hospitals	Outpatient clinics	Village Ambulatories	Number of villages covered/ population
Rustavi (regional center)	116,384	2	3	-	-
Dmaisi	29,307	1	1	4	55
Bolnisi	74,339	2	2	6	46
Gardabani	114,348	2	2	18	47
Marneuli	118,221	2	2	22	72
Tsalka	24,397	1	1	8	41
Tetri Tskaro	26,896	1	1	10	76
TOTAL	503,892	11	12	68	337

Facility-based health services in the Program area include 11 District Hospitals (including Maternity Hospitals), 12 District Polyclinics and 68 ambulatories (Health posts). All supervision and policy oversight is the authority of the Ministry of Labor, Health and Social Affairs

[11] medportal.ge/officialuri_informatia/reforma/pirveladi_jandacva.pdf

At the community level, the Community Health Worker (CHW) or "family doctor" plays an important role in the national strategy for primary health care. This position has been introduced since 2008. CHWs are being trained to treat basic illnesses and to do health education and other preventive activities in their communities together with representatives of Public Health departments of the district. The salaries of "family doctors" are covered by the MoLHSA, hence their services are free for village population. Supervision of CHWs as well as other primary health care facilities is performed through regular licensing procedures conducted by the Regulations Department of MoLHSA. CHWs report to and receive their drug/supply kits from health centers, on a monthly basis. Both, medical personnel and medical facility are subjected to regular licensing for legal functioning.

II. METHODS

A R-HFA was implemented from July 1 to July 21, 2009. The survey was conducted in the 30 health centers in the program area, which are located in Dmanisi, Marneuli, Bolnisi, Gardabani, Tetri Tskaro districts of Kvemo Kartli Region. The list of the first level health facilities have been compiled after interviewing The Head of Regional Service of Public Health Care. As a result it became possible to perform planning for the entire RHFA, build partnership with District health officials, select a team members and develop logistic plan for survey conduction based on the information on location of health facilities and population in the catchment areas. A simple random sample has been used to sample the above 30 health facilities. All health facilities in target regions have been assigned codes from 001 to 082 Then by using 2-digit random numbers table 30 unique numbers from 001 to 082 have been chosen and the target health facilities have been determined.

Partnership Building

Successful conduction of any survey especially health related requires cooperation at various levels such as governmental, local administration and community. Considering the above said ACTS team compiled a Project Description document in Georgian and distributed it to various departments of MoLHSA, Public Health Department of Georgia and Parliament Commission for Medical Issues. This was followed by meetings and consultations with the Minister of Labor, Health and Social Affairs and his deputies and the heads of relevant Departments. The interview with the Head of Regional Services of Public Health Care in Kvemo Kartli Region was conducted to compile the full list of primary health care facilities in the region. Basing on the recommendation provided by MoLHSA as well as many year experience of ACTS working with various structures in Kvemo Kartli and Imereti regions a list of community health workers (relevant to "family doctor" term used in Georgia) has been compiled. Considering the ongoing reform and the process of selecting, re-training and appointment of the "village doctors", which was not finished yet, the number of re-trained and working community health workers y the time of survey conduction was one at each health facility. Therefore total of 30 community health workers have been interviewed. The MoLHSA provided a list of physicians to participate in the survey as surveyors and consultants together with medical staff of ACTS Georgia. The regional authorities helped in developing the logistic plan for visiting health facilities. District public health officers assisted ACTS in overcoming the reluctance of the medical staff of health facilities to conduct the survey, since initially it was perceived as some sort of inspection, which could jeopardize their position. It took time and efforts of ACTS, local administration and public

health workers to assure them that the survey was only to measure the accessibility and quality service in the region and develop recommendations for the head of health facilities and MoLHSA without specific indications of the facility.

Two health staff of ACTS and four medical professionals recommended by MoLHSA have been trained to compile two teams consisting from two interviewers and one supervisor each. The four day training of survey and data entry team has been conducted in accordance with the instructions of the Manual: *RAPID SERVICE PROVISION ASSESSMEN FOR QUALITY AND ACCESS AT THE PRIMARY HEALTH CARE LEVEL*. The relevant logistic and budgetary adjustments have been developed. The Project Manager facilitated the training, survey implementation and data analysis.

Instruments Used and Their Adaptation
The survey instrument was based on the Rapid Service Provision Assessment tool that CSTS+ has developed for use in CSHGP projects. The tool has five modules:

- Clinical Observation – Six Sick Children
- Exit Interviews – Caretakers of Six Sick Children
- Health Worker Interview
- Health Facility Checklist (Infrastructure, Drugs and Supplies)
- CHW/family doctor interview

The questionnaires have been discussed at the training and adapted (Optional questions have been removed from the questionnaires). These instruments are included in Annex 11. These adaptations have been approved by MoLHSA district staff and representatives of Public Health Care Departments.

Training
The Program Manager and Program Manager Assistant conducted the training. The Public Health Departments representatives from each district attended the training and participated in adaptation of the questionnaires. The list of participants is provided in Annex 10. The HFA training was conducted in Tbilisi office of ACTS Georgia.

The training schedule was the same as provided in the Manual. The second part of each training day was devoted to classroom review and role playing. A special attention of the second half of the last day of the training was devoted to developing itinerary, travel schedule and evaluation of the training.

Information Collected
This assessment evaluates the first level health facilities (polyclinics and village ambulatories or health posts) for Maternal, Neonatal and Child Health services involving the assessment, treatment of children with most common illnesses (diarrhea and acute respiratory tract infections. Malaria is not the issue in the target regions of Georgia); the availability of essential infrastructure, equipment and supplies in health facilities with special emphasis on MCH services; the quality of management processes in facilities involving training, supervision and record keeping in the first level health facilities.

Any infant or child presenting to a health facility with cough or difficulty breathing, or diarrhea was included in this assessment. The geographic accessibility of health services for all communities of the Project area was defied using the ≤5 km criterion implying that the health provider can be found within the radius of ≤5 km.

Sampling Methodology

The assessment involved sampling of three universes: first-level HCs, sick child consultations/exit interviews and CHWs. There are total of 82 health facilities in the target regions, 14 of those are polyclinics/diagnostic centers and 68 village ambulatories/health posts.

Hospitals were excluded as program intervention only includes the first level health facilities.

One checklist for facility inputs was applied in every facility. To complete the HW questionnaire, the surveyors interviewed the HW most experienced in caring for sick children.

Exit Interviews: Six cases of sick child care were observed in each sampled health facility. These were the cases attended either by the only provider of sick child care in the facility or by the provider with the most experience present on the day of the survey. The sample was designed to include 6 x 30 = 180 observations.

CHW interview. Total of 30 CHW/"family doctors" have been interviewed. As it has been explained above, the CHW by the time of the survey conduction were available only in the villages, which had the health posts (one per village) because of the ongoing process of training of "family doctors" under the conditions of current Health Care Reform, which is being conducted by MoLHSA of Georgia. The reform envisaged dramatic increase of the number of "family doctors" by the end of 2010, so that every village with population more than 500 had its own family doctor.

Data Collection

Data was collected by HFA teams of three people each. Each team consisted of a supervisor (who supervised the data collectors) and two other team members who specialized in the collection of the data from the forms (See Annex …. for the survey teams and data collection schedule). Each team collected data from one facility per day. The teams arrived at the scheduled facilities by 9 a.m. and stayed till the end of the work day. One interviewer was doing observations and another completed the exit interviews. Then one interviewer interviewed community health worker, while the other surveyor was filling the health facility checklist

Cases Observed and Caretakers Interviewed: In each facility visited, surveyors observed clusters of six consecutive eligible cases of consultation for care of sick children and interviewed their caretakers immediately after they left the consultation room. Criteria for eligible cases included age (child 0-59 months), illness (respiratory problem, or diarrhea) and caretaker consent. Total of 180 caretakers were interviewed in 30 health facilities and the data of 180 observations and caretakers interviews have been entered into the Observation and Exit Interview databases. Sufficient numbers of sick children were available at the day of the survey to fulfill the sample size expectation.

CHWs Assessed: Thirty CHW or "family doctors" have been interviewed in the villages with ambulatories. It was difficult to make any sampling, since the institute of CHW/family doctors is in the process of establishing in Georgia and in Kvemo Kartli Regio the number of trained CHW/family doctors is very limited. Ideally one CHW/family doctor should serve 1500 population. Hence in some villages there may be 2 or three CHW, while in others with population less than 1500 one CHW can serve two or more villages. The training of CHW/family doctors is being conducted on a stage-wise basis and by the time of survey conduction the local Public Health Departments provided the list of 30 CHW who had at least three months experience of working in the villages. CHW were interviewed after the other data collection was complete.

Data Entry and Analysis

All data were entered into R-HFA data entry and analysis program by the end of each survey day and the entries were double checked by the Project manager for errors ad corrections. All frequencies and indicators were constructed as per the HFA manual.

The survey team reviewed each indicator, identified issues regarding quality/limitations of the data, made general assessment of validity of the findings and developed feedback to the relevant health facilities, district health care authorities and MoLHSA. The feedback document stressed all positive findings and at the same time mentioned the observed problems and possible ways of their solving.

III. RESULTS

Core Indicators

Twelve core indicators have been included in the assessment. These 12 indicators covered the following areas and domains of the assessment:
Areas: Access; Inputs; Processes, Performance
Domains:
Service Availability; Staffing; Infrastructure; Supplies; Drugs; Information System; Training; Supervision; Utilization; HW Performance: Assessment; HW Performance: Treatment; HW Performance: Counseling.

Findings on Access

Access to health services is 100% mainly thanks to the existing network of village ambulatories, which are geographically located in the village within 5 km zone from nearest villages. Each HC has a catchment area that includes an average of 6 villages. Hence 100% of accessibility. In addition in rural areas since 2005 is functioning an ambulance service , which allows quick and timely delivery of medical aid even in remote villages as well as ensures transportation of patients to district , regional or republican hospitals I case of necessity.

Service Availability

Currently operating national calendar of preventive vaccinations was approved in 2003.
Within the framework of this calendar children are vaccinated on 9 major manageable infections: tuberculosis, diphtheria, tetanus, whooping-cough, poliomyelitis, virus hepatitis, measles,

mumps and German measles (since 2004). According to the latest data immunization coverage on average was 95%.

All health centers sampled provide sick child consultations on average for 26.3 days a month and 4 days - direct outreach services for sick children about once per week. All HF provide vaccination service, on average 21.7 days a month and have outreach once weekly. 63% of the HFs provide growth monitoring at the facility. 100% of HFs organized GMP outreach services, mostly on a weekly basis. Only 17% of HF can offer delivery services. Such low value of this indicators is explain by the fact, that in the system of Health Care of Georgia the specialized health facilities (Maternity Hospitals, which belong to the second line HF and hence were not included into the survey) are in charge of providing delivery services. According to KPC survey 99.1% of deliveries occurred in Maternity Hospitals. The primary Health care facilities (mainly outpatient clinics) provide delivery services only in emergency cases, when for some reasons a mother fails to reach Maternity hospital in time.

HF- Child Health

Table 1. Results for Access Indicators

Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements	Index Value (% avg. HF attainment)	Instrument
ACCESS	**OVERALL**	Geographic Access	% population with year-round geographic access (within 5 km. or one hour) to an authorized provider of curative child health services		**100%**	DHO Form
	1 CHILD	Service Availability - Child	% HF that offer all three basic child health services (growth monitoring, immunization, sick child care)	**63%**		HW Interview
	1 ANC	Service Availability - ANC	% HF that offer ANC at least once a week	**100%**		HW Interview
	1 NEO	Service Availability - Delivery	% HF that offer delivery services on all days	**17%**		HW Interview

Only 63% of health facilities could offer three basic child health services. Because of the ongoing reform and staff re-training as well as re-equipping process not all health facilities surveyed could provide the above services. Whereas immunization and sick child care was offered in 100% of HF, in 6 HF the growth monitoring was not done. After finishing the interview, ACTS discussed this issue with relevant health workers. All of them indicated, that they could determine the child's growth rate by eye, they claimed that they would have entered the data into register in case of stunting.

Inputs

Staffing

Only 10% of HF had all staff providing clinical services on the day of survey. As it has been mentioned above, because of the ongoing reform and retraining of medical personnel not all staff members were available at the day of survey.

Infrastructure

90% of all HF surveyed had all essential infrastructure, which was functioning properly. None of the HF had at least one overnight stay bed, which is due to the fact that the infrastructure of Primary Health Care Units, which has remained from the Soviet times did not envisage overnight stay in policlinics and ambulatories – in case of necessity for overnight stay the patients were referred to relevant units at the hospitals. Only 10% of HF had 24 hour coverage – and all of them were outpatient clinics. I all facilities there was a functioning emergency communication, mainly through mobile phones. As it has been mentioned above, because every district has well functioning ambulance service (all ambulance cars are located in the district center and from where they are immediately sent to the relevant villages on emergency call, the primary health facilities does not have their own emergency vehicles. Power supply situation in the region is significantly improved - 97% of health facilities had electricity from the grid or a generator with fuel. 97% had usable client latrines and water from protected water source. 90% of HF had auditory and visible privacy.

None of the health facilities had all essential supplies to support maternal-newborn health on day of the survey. Average health facility attainment for this indicator was 79%. While district outpatient clinics were well supplied, village ambulatories often lacked one or more items listed in the questionnaire. However the situation is improved compared to baseline data in relation to partographs. Whereas in the beginning of the projects partographs were practically absent in the primary health care facilities, during the final evaluation only 3 (10%) health facilities did not have partographs.

None of the health facilities had all essential supplies to support antenatal care present on day of survey. This was due to the fact that injection of tetanus toxoid to all pregnant women is not practiced in Georgia.

None of the health facilities had all line medications for child health present on day of the survey. That is explained by the fact that the incidence of malaria in the target region is negligibly low, hence the lack of first line anti-malarial drugs.

Only 30% of HF had HF all essential delivery & neonatal drugs present on day of survey, which is again explained by the fact that the majority of births (99.4%) occurred in maternity hospitals, which have all essential delivery and neonatal drugs.

Table 2. Results for Inputs Indicators

Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements	Index Value (% avg. HF attainment)	Instrument
INPUTS	**2**	Staffing	% HF with all staff who provide clinical services working on the day of survey	**10%**	**72%**	HW Interview
	3	Infrastructure	% HF in which all essential infrastructure is present and functioning on day of the survey (**improved water source; functional latrine for clients**; **setting allowing auditory and visual privacy;** power; communication equipment; emergency transport; overnight beds)	**90%**	**61%**	HF Checklist
	4 CHILD	Supplies - Child	% HF with all essential supplies to support child health on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	**100%**	**100%**	HF Checklist
	4 MNC	Supplies - MNC	% HF with all essential supplies to support maternal-newborn health present on day of the survey (partograph, vacuum extractor, resuscitation device, weighing scale, antibiotics and baby wraps)	**0%**	**79%**	HF Checklist
	4 ANC	Supplies - ANC	% HF with all essential supplies to support antenatal care present on day of survey (blood pressure machine, tetanus toxoid vaccine, hemoglobin reagents, syphilis testing kit and albastix for protein)	**0%**	**132%**	HF Checklist
	5 CHILD	Drugs - Child	% HF with all first line medications for child health present on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line antiamalarial, vitamin A)	**0%**	**44%**	HF Checklist
	5 MNC	Drugs - MNC	% HF with all essential delivery & neonatal drugs present on day of survey (i.e., oxytocin, antibiotics for newborn sepsis and eye infections), vitamin A)	**30%**	**73%**	HF Checklist

Processes

The HFA used three indicators to evaluate quality of processes in the HFs: maintenance of the information system; supervision; and training. While all HF maintained up-to-date records on sick U5 children, some of them did not have reports in last 3 months, which was explained by the ongoing reform of primary health care and changes in routine procedures related to information system. There was uncertainty whether their health facility would be merged with a larger unit or closed within the framework of health facilities optimization process. Below is provided a table for the processes indicators.

Not everywhere the data use was well evidenced (15% of HF). However in majority of HF the summary graphics have been available and in some HF there was also the schedule of staff meetings on the wall.

The quality of supervision was more or less good. Of those receiving a visit in the past 3 months, they reported the following supervision components: Observed cases (16/30), reviewed receiving feedback (16.30), provided updates (5/30), discussed problems (22/30) and checked drugs (19/30).

All HF personnel received in-service training in child health and maternal neonatal care and all health facilities received at least one external supervision in the last 3 months.

Table 3. Results for processes indicators

Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements	Index Value (% avg. HF attainment)
PROCESSES	**6 CHILD**	Information System - Child	% HF that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HF: have report in last 3 months and evidence of data use	**0%**	**80%**
	6 MNC	Information System - ANC	% HF that maintain up-to-date records of antenatal care (TT, blood pressure, expected date of delivery) & deliveries (present & up to date)	**0%**	**133%**
	7 CHILD	Training - Child Health	% HF in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	**100%**	
	7 MNC	Training - Maternal-Neonatal Care	% HF in which interviewed HW reported receiving in-service or pre-service training in maternal neonatal care in last 12 months	**57%**	
	8	Supervision	% HF that received external supervision at least once in the last 3 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	**100%**	

Performance

Utilization of curative services of the HF is one of the important indicators of HF functioning. The survey revealed that82.5% had more the one sick child encounter per U5 in the catchment area. Only 54.5% of HF had ≥2 ANC visits per estimated number of births per catchment area. However, the KPC survey demonstrated that on average number of prenatal visits was as high as 5.24 times (varying from 1 to 12 visits). This discrepancy can be partially explained by the fact that according to KPC data, the overwhelming majority of women choose to go for prenatal visits to the maternity hospitals (28.9%), outpatient clinics (9.4%) and/or women's consultations (54.3%), not village ambulatories (4.9%). Quality of service was satisfactory. HW performance indicators related to child assessment demonstrated that in 80% of HF key assessment tasks were

routinely performed. As for HF performance related to the treatment of the sick child, the percentage of HF where treatment was routinely appropriate to diagnosis was 100%, which is the result of the trainings received as is indicated by the Process Indicators. In 97% of HF caretakers were able to correctly describe how to administer all prescribed drugs to the child.

Table 4. Results for Performance Indicators

Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements	Index Value (% avg. HF attainment)
PERFORMANCE	**9 CHILD**	Utilization of Curative Services	Annualized number of clinical encounters for sick children per U5 population (% HF with ≥ 1 sick child encounter per U5 in catchment area)	**82.5**	
	9 ANC	Utilization of ANC Services	Annualized number of ANC visits per estimated number of births (%HF with ≥ 2.0 ANC visits per estimated number of births in catchment area)	**54.5**	
	10 CHILD	HW Performance (Assessment)	% HF where key assessment tasks are routinely performed (check presence of general danger signs, assess feeding practices, assess nutritional status, check vaccination status)	**80%**	**92%**
	11 CHILD	HW Performance (Treatment)	% HF where treatment is routinely appropriate to diagnosis (for encounters in which at least one of the presenting problems was fever, breathing problem, or diarrhea)	**100%**	
	12 CHILD	HW Performance (Counseling)	% HF where caretakers whose child was prescribed an antibiotic, antimalarial, or ORS, correctly describe how to administer **all** prescribed drugs	**97%**	

Summary results of the survey are provided below in HF Child health Balanced Score Card (Fig. 1), HF MNC Balanced Score Card (Fig. 2); and CHW Balanced Score Card (Fig. 3).

Fig 1.

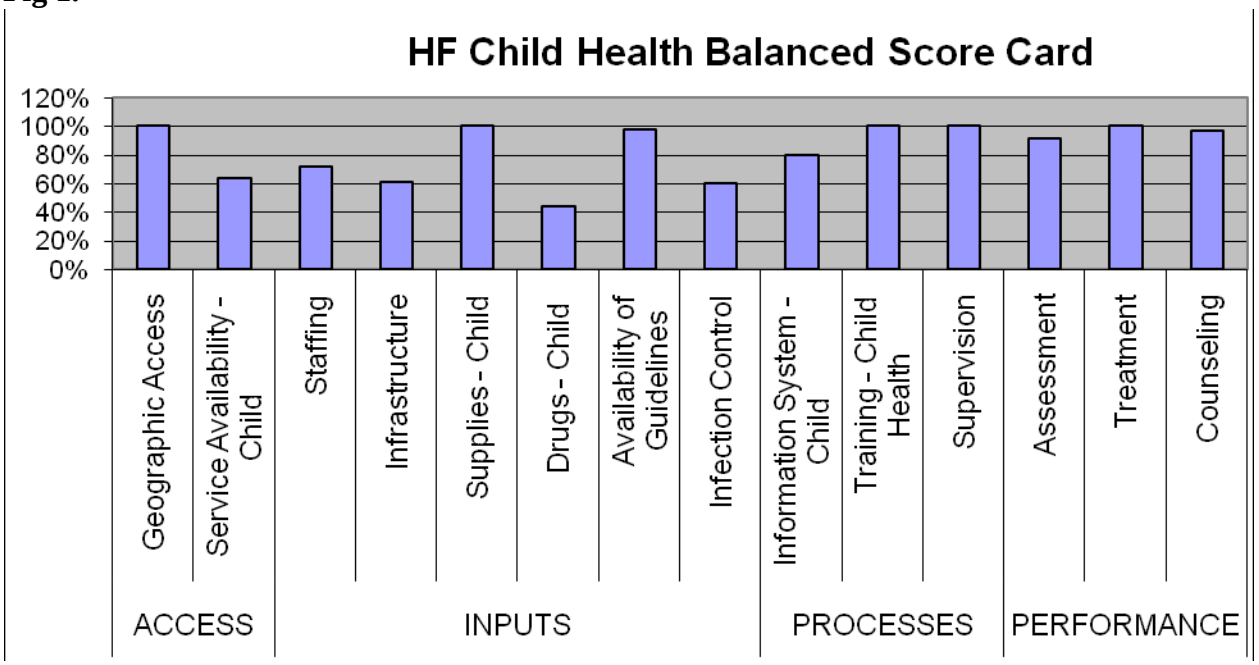

HF Child Health Balanced Score Card
120%
100%
80%
60%
40%
20%
0%
Geographic Access
Service Availability - Child
Staffing
Infrastructure
Supplies - Child
Drugs - Child
Availability of Guidelines
Infection Control
Information System - Child
Training - Child Health
Supervision
Assessment
Treatment
Counseling
ACCESS
INPUTS
PROCESSES
PERFORMANCE

Fig. 2.

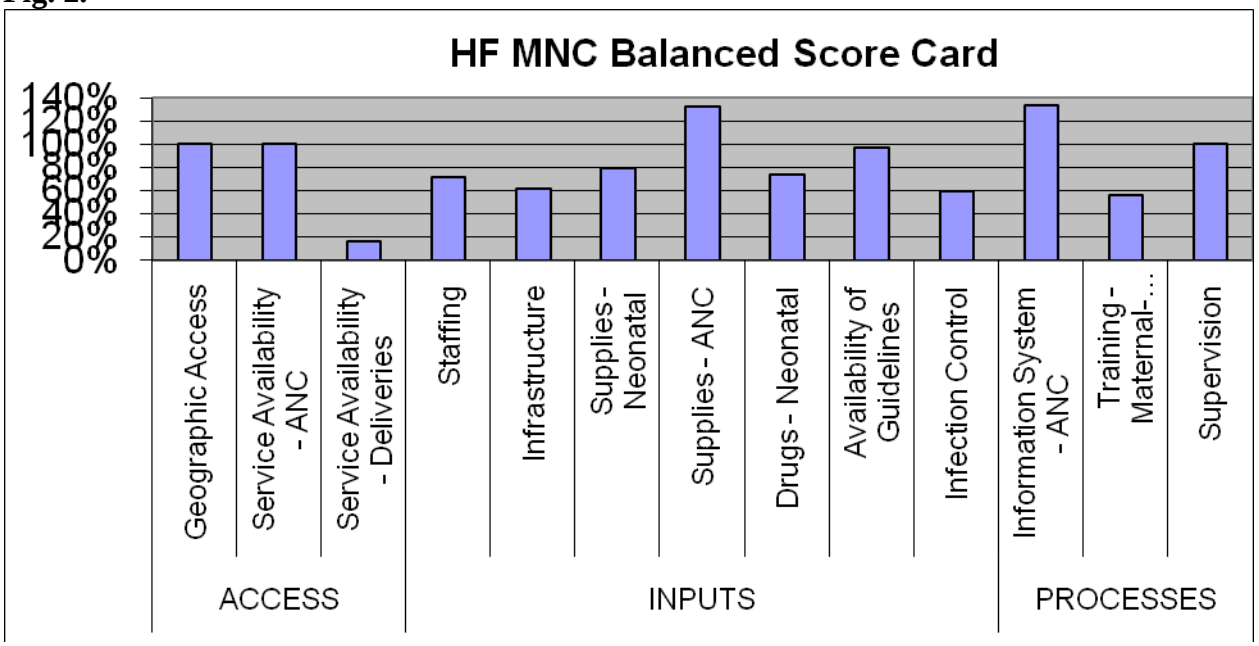
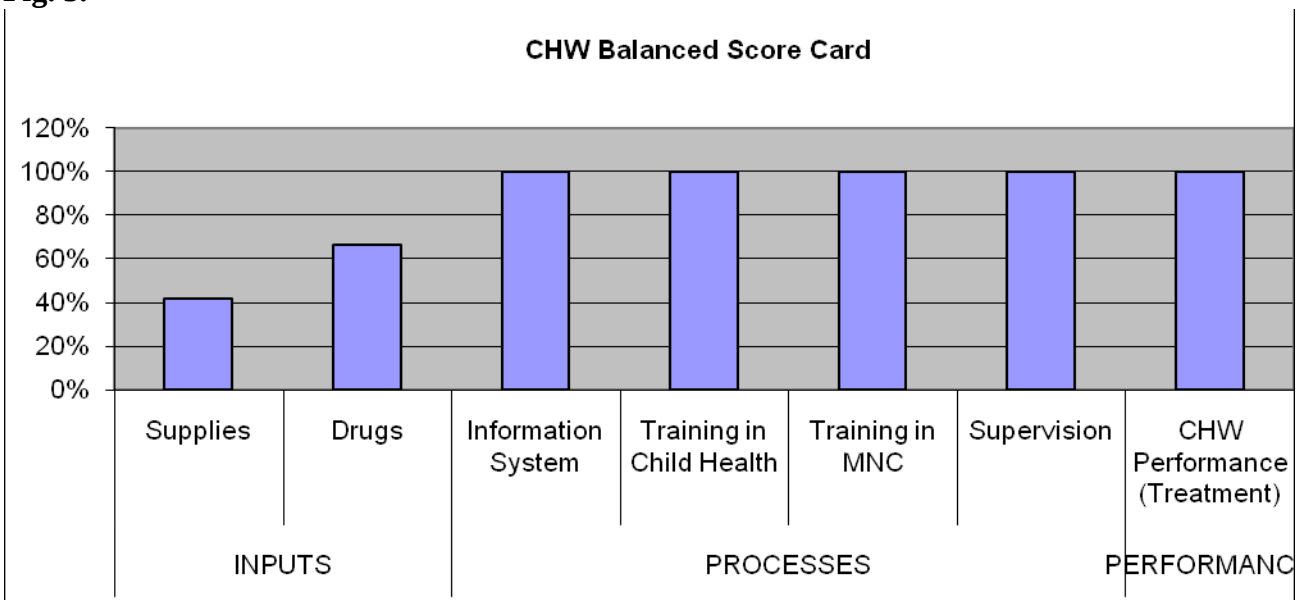

HF MNC Balanced Score Card
140%
120%
100%
80%
60%
40%
20%
0%
Geographic Access
Service Availability - ANC
Service Availability - Deliveries
Staffing
Infrastructure
Supplies - Neonatal
Supplies - ANC
Drugs - Neonatal
Availability of Guidelines
Infection Control
Information System - ANC
Training - Maternal-...
Supervision
ACCESS
INPUTS
PROCESSES

Fig. 3.



DISCUSSION

1. HF MNC

The summary findings demonstrated that whereas geographic access to health facility in the catchment area and service availability for ANC were 100% each, service availability for deliveries was only 17%. Such a low value for this indicator is explained by the fact that the primary health care facilities, which were the subject of this health facility Assessment are receiving deliveries only in emergency cases, when there is no time for the pregnant woman to reach a maternity hospital (99.1% of mothers interviewed during KPC survey reported maternity hospital as a place of delivery of their children).

The data provided by health Utilization and Expenditure Survey, 2007, indicated that in 2007 more than 80% of total population of Georgia could access a health facility within 15 to 30 minutes by normal means of travel to a facility. Situation in Kvemo Kartli significantly improved within the period of 2007 to 2009 because of wide scale road repair and laying activities as well as a result of introduction of free ambulance services for rural areas.

The supplies for antenatal care meet the requirement since for antenatal care the majority of women refer to the nearest primary health care units.

Because of intensive re-training program acting in Georgia as well as because maternal and child health is one of the priorities of MoLHSA, 100% of health facilities had relevant guidelines and as a result the information system for ANC is well developed in every HF covered by the survey, to which fact also contributes efficient supervision of the activities of the health facilities in question.

2. HF Child Health

Staffing remains a problem – only in 10% of HF had all clinical staff present on the day of survey. As it has been mentioned above, this is the result of re-training activities, which require the clinical stuff to stay in Tbilisi for 10 days.

While 90% of HF had relevant infrastructure with all essential elements (water, latrine, privacy), the average percent of infrastructure items present per HF was only 61%.

All 100% of HF had chlorine or other disinfectant, gloves, sharps container, syringes, needles and soap.

All HF had adequate training in management of child health, relevant supervision and counseling practices.

3. CHWs

The quality of CHW registers is good in all 100% of HF, which is the result of obtaining adequate training within the last 12 months. The data on supervision of CHW are also satisfactory – the supervision system functions in 100% of HF. Adequate treatment of the sick child is offered in 100% of HF surveyed. As for supplies of essential drugs, the first line antibiotics an ORS packages are available in all health facilities. However, because malaria cases are practically non-existent and the cases of dysentery are very rare and the patients with the signs of dysentery are generally referred to specialized Clinics for Infectious Diseases, the relevant first line medicines are not supplied to primary health facilities with exception of large district/ and/or regional outpatient clinic.

Annex 11.6B Health Facility Research Survey 2007

Health Facility Resource Survey Report

Child Survival and Health Program for Kvemo Kartli and Imereti, Georgia

Tbilisi, Georgia
2005-2006

U of Missouri School of Medicine
External Evaluation Team Consultants

Dr. Laura Hillman,
Neonatalolist Associate Professor Child Health

Dr. Randal Floyd,
Ob-Gyn Professor and
Director High Risk Obstetrics Program

Executors:

a) Dr. Revaz Tatradze, Eteri Suladze, Mzia Klibadze, Tamar Lobzhanidze
b) Dr. Ramaz Urushadze, ACTS stakeholder, head of Dmanisi local government
c) Volunteers: Tbilisi State Medical University bachelorship students from the Faculty of Public Health Marika Turmanauli, Manana Pantsulaia, Giorgi Chidrashvili

Primary Health Facilities Resource Survey
Dmanisi and Bolnisi districts of Kvemo Kartli
Conducted October 24-26, 2006

Health Facility Resource Survey Report

Table of Contents

Objective

Kvemo Kartli HF resource survey: Preliminary assessment to define quality dimensions

Methods and work structure:

Adapted questionnaire of HF management assessment, interviewers training, interviewing, analysis

Survey site:

Dmanisi Ambulatory and Polyclinic Unit, Maternity Hospital;
Bolnisi Pediatric Policlinic; Maternity Hospital;
Sampling principle – districts with low and high income, various types of HF ownership, primary health care facilities, women consultations-maternity houses.

Activities and functions:

Development of questionnaires based on the existing ones: Revaz Tataradze

Structuring the questionnaires – Eteri Suladze

Translation of the questionnaires – Mzia Klibadze

Processing and adapting the questionnaires, informing HF and preparing for survey through on-site visits – Ramaz Urushadze

Discussion of the questionnaires and interviewers training, conduction of the survey – Tamar Lobzhanidze

Survey contributors – volunteers Tbilisi State medical University bachelorship students, Faculty of Public Health Marika Turmanauli, Manana Pantsulaia, Giorgi Chidrashvili

Analysis – Tamar Lobzhanidze

Preparing and translation of presentation materials – Dr. Tamar Lobzhanidze, Eteri Suladze

	Name	Dmanisi ambulatory-and-policlinic unit	Dmanisi maternity hopsital	Bolnisi pediatric policlinic	Bolnisi Maternity Hopsital	Note
1	Population covered by the service of HF	Head, Elisabed Katsitadze	Head Svetlana Vibliania	Head, Marina Devnizashvili	Head Darejan Chkhetiani	
	Village, community	25 and >	25 and >	9 and >		
	Population	24 000 and >	26 000	11 000, of those 7 000 on contract	76 000	
2	Organization and Management of HF					
2.1	Presence of activity schedule	No	No	Yes	No	
2.2	. Are the work hours identified	No	No	No	No	
2.3	Number of HF staff servicing population during the work hours	20	-	20	25	
6	Average number of work hours/per HF staff/day	7 hr	5 hr	7,5 hr	Not available	
7	Is there a staff member who is permanently receiving phone calls?	Yes	No	Yes	No	
2.6	If not, why	-	There is no need	-	Physicians have cell phones	
8	Are the staff members trained to fulfill more than one types of work?	Yes	No	No	Yes	
9	Who inspects HF?	External Health Evaluation Team*	External Health Evaluation Team*	External Health Evaluation Team*		
1	Of those from local HF body?	d/r PHC	d/r PHC	b/r PHC, HC department	b/r PHC	

3.2	What is the periodicity of inspection?	Daily	Monthly	Every 2nd week	Monthly	
3.2	Who else and how often?	ally MoLHSA regional tment inspector, Social Narcological ction, Chamber of ol Taxation Inspection, C	Annually MoLHSA regional department inspector, Social Fund	Annually MoLHSA regional department inspector, Twice annually - Social Fund	Annually MoLHSA regional department inspector, Social Fund, Narcological Inspection,	
4	How (what are the methods used) does the inspector of district health care departments conduct the inspection?					
4.1	Through direct observation	Yes	-	Yes	Yes	
4.2	By collecting data	Yes	Yes	Yes	Yes	
4.3	Using control checklist	Yes	No	No	Yes	
4.4	By detecting violations	Yes	No	No	Yes	
4.5	Through discussion	Yes	No	No	Yes	
5.	Does the HF submits monthly reports to the district (local) Health care Department	Yes		Yes	Yes	

5.1	What kind of report?	Written programatic	Written	Written programatic	Statiustical, financial	
5.2	Who of high qualification physicians come to inspect?	Nobody	Nobody	Nobody	Nobody	
5.3	How often?	-	-	-	-	
5.4	How does the high qualification physician conduct the inspection?	-	-	-	-	
	Observation Data collection Control Checklist Detection violations Discussion	-	-	-	-	
6	Does the HF have a respective seating?	Yes	No	No	Yes	
17	Is drinking water available for the patients?	Yes	Yes,	Yes	Yes	
18	Does the facility have ORS corner		No			
19	Is there a toilet?	Yes, clean	Yes, but dirty and half destroyed	Yes, clean	Yes, clean	
20	Does the HF have a maintenance staff?	Yes	Yes	Yes	Yeas	Electrician, logistic
21	Does the HF have a night guard?	No	Yes	Yes	No	
22	Does the HF have cleaning and working instruments?	Yes	Yes	Yes	Yes	

	Service Availability					
23	(a) Sick Child Care	Every week day	Every week day	Every week day	Per need basis	
	(b) Immunization (EPI and tetanus)	Tuesday	Per need basis	Friday	Per need basis	
	(c) Antenatal care	Every week day	Per need basis	-	Per need basis	
	(d) Child spacing counseling	Every week day	No	-	Per need basis	
	(e) Adult consultation	Every week day	No	Every week day	Per need basis	
	(f) Emergency care (ambulance)	Every week day	Per need basis	Every week day	Per need basis	
	(g) Education and prevention	Every week day	No	Every week day	Per need basis	
	Muse of Services					
24	Children unber 5 years of age: Number of patients examined last month for the following complains:	Fever, helmintosius, nutritional deficiencies, iodine deficiency, ARI		Diarrhea - 5 ARI -15 High fever – Nutritional deficiency -1; Other Allergic dermatitis - 8 Lymphadenitis 2 Rakhitis-1	Per need basis	
25	Other- Total number of examinations during the last month	80	30	1 676	300	
	Physical persons	76	30	-	270	
26	Consultation on antenatal care	29	10	-	No	

27	Counseling on child spacing (for women, for men)			-	No	
28	Consultation on STD			-	200-240	
29	Dconsultation on diseases (for women, for men)			0-2 --- 174; 1-4 --- 330; 3-15 - 1182		
1	(Total number of patients of all ages) Number			-		
2	Deliveries: Normal physiologiuca; complicated Caesarian section, home delivery which complicated and a qualified obstetrician was invited		2004 – 92 2005 (IX) 52 IX-33		2004 - 452 2005(IX)-270 IX – 48;	
	Outreach activities					
30	How often is the team conducting outreach activities?	Once annually	No	Every month	Once annually	
31	Who is conduucting outreach activities?	Neurologis, Otolaryngologist, Pediatrician etc.	-	Pediatrician and others	Ob-Gyn, physician, echoscopes	
32	Is EPI the only reason for outreach activities?	No	-	No	No	
33	Is health education an integer part of outreach activities?	Yes	-	Yes	Yes	

34	Is vitamin A distributed during the outreach activities?	No	-	No	No	
	What is the periodicity?	-				
	Recording					
35	Does the patients' registration journal exist?	Yes	Yes	Yes	Yes	
36	Does the HF have the antenatal care registration journal (including tetanus shots?)	No	No	No	No	
37	Does the HF have immunization registration journal?	Yes	Yes	Yes	Yes	
38	Does the HF have laboratory tests registration journal?	Yes	No	Yes		
39	Information recorded in registration journals					
1	Name of the Patient	Yes	Yes	Yes	Yes	
2	Patient Personal Number	Yes	ara	Yes	Yes	
3	Patienmts age (birth date)	Yes	Yes	Yes		
4	Infants/problem	Yes		Yes	Yes	
5	Diagnosis	Yes	Yes	Yes	Yes	
6	Treatment (including prescribed medicines)	Yes	Yes	No		
7	Appointing observation visit	Yes	No	No		
	Backfeed information is recorded in:		Form # 27	PHC, Police		

	Information on Patient's Personal Card		-		-	
40	Does the child's yellow card contain information on Vitamin A?	No		No	-	
41	Are the data on the child's growth recorded during every visit to HCC?	Yes		Yes	-	
42	Does the mother's pink card contain information on tetanus vaccination?	No		No	-	
	Instructions on Clinical Management					
43	Do the HCC personnel have the Manual issued by MoLHSA?	No	No	No	Yes	
44	Does there exist disease management algorithm for the below listed pathologies?	No	No		Yes	
1	a)ARI	Yes	No	Yes	Yes	
2	Diarrhea	Yes	No	No	Yes	
3	Fever	No	No	Yes	Yes	
4	Reproductive health	No	No	No	No	
5	Other	Yes	No	Nutrition		
	Materials on information, education, communication Please list	No				

	Hygiene, diarrhea	No	No	Yes	-	
	Malaria/bednets	No	No	No	-	
	e) Denge's fever	No	No	No	-	
	v) Nutrition/Vitamin A	No	No	No	-	
	z) Parasites	No	No	Yes	-	
	Breastfeeding	No	No	Yes	Yes	
	T) Antenatal care	ara	ara	ara		
	k) Child spacing	No		Yes	Yes	
	l) STD/HIV/AIDS	No	No	No	Yes	
	m) Iodized salt	No	No	Yes	No	
46	Is there any system to record the disease epidemic?	Yes	No		Yes	
	Is there village to Health care Center notification system	Yes		Yes		
	Is there regional Health care Center to Public Health Care Center notification system	Yes		No		
47	Describe the system	Telephonogram, written notification		Telephonogram, urgent written notification	Telephonogram, urgent written notification	
48	Does the patient receive educational information during each visit?		-		Yes	

49	Does the Health Care personnel conduct personal group educational meetings (discussions) with the population	Yes	-	No	No	
	Where are these sessions conducted		-	No		
	What is the periodicity of the sessions?	-	-	-		
	If the sessions are not conducted, please explain why	-	-	?		
50	Pharmaceutical and equipment resources	***	***	***		
51	Does the Health Care Center register pharmaceuticals?	Yes	Yes	Yes	Yes	
52	Did you have the lack of the above listed medicines during the last 30 days. If yes, what was the reason	Yes	No		Yes	
54	What contributed to the lack of pharmaceuticals	Financial reasons	-			
55	Do the Health Care Centers have warehouses to store mediciens and medical supplies?	Yes	Yes	Yes	Yes	
56	If not, where are they sttored?	In the pharmacy's back room		In the pharmacy's back room	Yes	

57	Is there any problem in supplying pharmaceuticals	Yes	No	Yes	No	
58	Cold Chain materials, Information					
1	Refrigerator	Yes	Yes	Yes	Yes	
	Thermometer in the fridge	Yes	Yes	Yes	Yes	
	Daily map of the freezer temperature	Yes	Yes	vs	vs	
	Cold box	Yes	Yes	Yes	Yes	
	Cold box thermometer	No	No	Yes	No	
	Daily map of the cold box temperature	No	No	Yes	Yes	
	Vaccines transportation box	Yes	No	Yes	Yes	
	Vaccines transportation box thermometer	No	No	No	No	
	Do you have information on vaccine storeroom	Yes	Yes	Yes	Yes	
	Do you have relevant syringes and needles for immunization imunizaciisaTvis	Yesa	Yes	Yes	Yes	
	Do you have sterilizers for needles and syringes?	Yes	Yes	Yes	Yes	
***	Equipment and resources					
59	Availability in the HC Center					
	Of the following equipment	Basically no			Yes	

60	Reimbursement of rendered services	Yes		Yes	Yes	
	a) Is there the system of reimbursement of service cost?	Yes	Yes	Yes	Yes	
	b) Are the prices for the service clearly defined?	Yes	No	Yes	Yes	
	c) Comments	No	No	-	-	
	Is there Health Care Center Management Committee		No			
	a) How often does the Committee meets	On the need basis	-		Once every three months	
	b) Attendance				Yes	
	Plans for service cost reimbursement	Salary 40%, Indirect expenses 55%, profit 5%	Co-payment through vouchers	Salary 40%-50%, Indirect expenses 45-55%, profit 5%	Salary 40; Mmedicines 20; Laboratory-5 Office-25 Profita-10	
	Budget	62 000 GEL			250 000 GEL	
	Comment	Village program 50000; Miniciupal -6000; Internal income li-6000.			Sociasl fund 120 000; Municipal prog.-70 000; Internal standards 60 000.	

62	Health Center Feedback Committee (service or a unit responsible for the feedback)	-		-	Yes, 2 nurses from registration office	
	Attendance	-	-	-	-	
	Plans for expenses reimbursement	-	-	-	-	
	Budget	-	No	-	-	
	Comments	-	-	-	-	
63	Description of Health Care Center		3 Departments	13 Departments	4 Departments	
	c) General information about the Center activities: Degree of observing relevant Hygiene	Satisfactory	Unsatisfactory	Satisfactory	Very good	
	b) rEquipment needed		Basic profile		Modern, more advanced equipment	
	c) Comment		Extremely poor			

	a) Problems	Replacing old outdated and non-functioning equipment; Lack of heating; poor motivation of the physicians, insufficient number of nurses, lack of necessary medicines; lack of relevant transportation means; poor condition of the building; poor communication	Damaged ceiling, outdated poorly functioning equipment; insufficient funding; sanitary-and-hygienic problems; low motivation of the physicians	Pediatric instruments and equipment; diagnostic equipment, adequate amount of medicines	Quality of medical service, optrimization	
	b) Requiers:		Support and assistance to restore management and central authority			
	c) Questions					
	d) What kind of trainings are required	Management; Diseases management Educational activities among population at the PHC level	Management; Trainings to increase professional skills;	Management; Diseases management at the PHC level	Financial and Administrative management	
	e) Additional comments					

**** Special thanks to

U of Missouri School of Medicine External Evaluation Team performed survey
Dr. Laura Hillman, Neonatalogist Associate Professor Child Health
Dr. Randal Floyd, Ob-Gyn Professor and Director High Risk Obstetrics Program

Results

The medical institutions functioning at the Kvemo Kartli territory provide services to 497,530 population who receive both primary health care and specialized and hospital care. The form of ownership is difference: in Bolnisi, for example Pediatric Policlinic and maternity Hospital are under private ownership, whereas Dmanisi Pediatric Policlinic and Maternity House are under the state ownership in the form of LTD. The sphere of interests of the above two districts are more or less similar, though the private facilities are more interested in the end-results compared to the state-owned ones. Such a lack of unterest in the end-results in the state owned LTDs can be explained by instability in staff policy; often by low qualification of the personnel who are executing the State Order which is especially true for the personnel of remote villages and high mountain sites; to this add low salaries, population insolvency etc.

The PHC unit (Dmanisi policlinic) serves both adult and children of nearly entire Dmanisi district. At the primary health care level it can render specialized (neurological, cardiologic, endocrynologic and other) services. The support is provided by the Central State United Program of Ambulatory Support, municipal program etc. The Dmanisi district houses the population of 29,000. At the same time at the official places no posted lists with information about the available services covered by those programs are available, though the services are rendered to the population on demand any time of day and week day; hence there are no clear-cut instructions about the work hours. It should be taken into consideration that Primary Health care System of Georgia is in the process of reformation involving restructuring of PHC facilities, defining of the models of funding and allocation of professional staff on the background of continuous education and development of practical guidelines basing on the functions of PHC facilities outpatient clinics (for adults and children), ambulatories and medical units as well as maternity hospitals. Curent policy is directed to the amalgamation of medical facilities of all profiles at the district level. Considering the fact of various ownership forms it seems to be a difficult task since the medical facilities in private ownership may stay out of united state policy. We have studied two different facilities in Bolnisi district – Maternity House (private ownership) and Pediatric Policlinic (state ownership). In Dmanisi both similar facilities are 10% owned by the state.

Material-and-technical base is more preserved in private medical facilities and management in these facilities is more developed. At the same time it should be taken into consideration that the staff in state owned facilities is less motivated than in private ones.

During the face-to-face discussions the poor communication level between the medical personnel and population became evident. Language barrier, ethnic belonging, mode of life (such as wrapping babies in plastic films, lack of hygienic habits – hand-washing -, group outbursts of hepatitis A observed directly during the survey conduction etc., low level of trust) are basic barriers in relation to health care management. In addition deficiency of intra-facility management, lack of PHC facility orientation to the outcome result in ineffective management, lack of information technologies to educate the population on healthy life style as well as shortage of educational materials (leaflets, visual aids, booklets etc.) for population. However one shall take into consideration the specifics of residents of high mountain villages with no official working hours, week-end free time, official holidays (all these depend on agricultural

works to be done during the given period of time). There are many cases of rendering medical aid at home, "friendly" visits of the doctors to such patients, which are not registered because are informal and the aid is rendered on "friendly" basis. Lack of relevant guidelines and imperfectness of existing temporal standards resulting in a gap between the preventive-and-treatment activities as outlined in relevant instructions and existing realities. One of the major factors of imperfect functioning of the PHC facilities is poor funding, low salaries of the physicians and hence poor motivation.

Resuming the results of the survey the following have been found out:

1. Ambiguity of the State Policy in relation to the structure of PHC facilities resulting in the lack of basic practical manuals and respectively lack of relevant instructions ;
2. The fact of Health Facilities licensing does not automatically guarantee the necessary quality of medical services and activities;
3. Acute deficiency of relevant medical equipment and devices – existing equipment and devices as a rule are outdated, malfunctioning;
4. Acute deficiency of medical personnel professional education in the sphere of communication with population;
5. Lack of professional and preventive materials;
6. Very low level of knowledge about healthy life style and its advocacy among population;
7. Low level of health facility management;
8. Lack of united action outcome-oriented strategy for PHC facilities; ambiguity of detailed schemes outlining accomplishments; acute deficiency of relevant financial and PHC facility functioning management.

Since state-owned PHC facilities seem to experience particular difficulties, below is provided detailed analysis of Dmanisi PHC facilities survey.

Adapted questionnaire of "Health Care Facilities Resource Survey" has been used to asses PHC facilities in Dmanisi.

The questionnaire consisted of 63 questions covering:

- Name of the facility and its juridical status;
- Population within the are of its coverage;
- Human resources (amount of personnel and their qualification);
- Organization and management of HCF (accessibility, convenient working schedule- work hours of doctors, immunization dates etc.) ;
- What institutions are inspecting of the Health Care Centers activities, methods used and interval between two successive inspections;
- Type of reports generated by the Health Care Center and reporting frequency;
- Availability of relevant instructions at the Health Care Center;
- State of art related to hygiene issues (availability of cleaning lady, hygienic condition of toilets, availability of potable water and relevant cleaning materials and utensils);
- Does the work schedule of the medical facility envisage educational activities such as sick child care, immunization, antenatal care, child spacing?;

- Availability of outreach activities and frequency;
- Which members of the team are engaged in outreach activities?
- Whether outreach activities involve community education;
- Where and how are patients registered? (In special register books, what kind of information is entered);
- Availability of patients personal cards
- Availability of clinical management instructions;
- Availability of the system which records the cases of epidemic outburst (what kind of information is collected and where this information is forwarded);
- Pharmaceutical resources;
- Registration of medicines in the Health Care Center;
- If there is a problem with medicines supply (if yes, what are the reasons)
- Availability of system of service cost reimbursement;
- Management of Health Care Center
- Health Care Center Funding;
- General information on the activities of Health Care Center;
- Comments

When assessing the questionnaire the following was found out:

The functioning medical facilities on the territory of Dmanisi district provide services to 28 000 residents of the district. The medical facilities provide both primary health care and specialized health facilities services as well as in-patient services. Dmanisi outpatient clinic and maternity hospital are owned by the state.

PHC facility (Dmanisi outpatient clinic) serves adult and pediatric patients of the entire district. The facility is able to provide specialized (neurologist, surgeon, cardiologist, endocrinologist etc.) services at the primary health care level. United Program of Central State Ambulatory Aid and municipal program are in effect in the district.

Information indicating kind of services and schedule is not posted on the announcement boards. However the population can receive medical aid even on weekends and holidays which is indicative of lack of observance of work hours.

Medical infrastructure is not developed at all, even though there is a hospital, ambulatory-and-policlinic union – they are all equipped with outdated and not working equipment and devices.

By general assessment the area occupied by Dmanisi outpatient clinic is sufficient to provide services envisaged by Georgian legislation. However the building itself is in very poor condition with exception of a small part of it which was renovated as well as ambulance service station. The building is not heated, does not have permanent water and power supply, the waiting room does not have chairs and toys for waiting parents and children.

As for doctors' offices, they practically are devoid of any office furniture, available equipment is outdated.

Conclusions and Recommendations

Project Strengths

The ACTS CSP has worked with health facilities, international and local partners and community members during the implementation of projects aimed at the decrease of maternal and infant mortality. Throughout the project cycle, the CSP and local partner organization staff have trained people at the community level, treated people at government facilities, 62 out of 137 women have taken advantage of the voucher card system, mothers and pregnant women have been educated on child health issues such as recognizing difficulties during pregnancies and signs of infant and childhood illnesses requiring treatment by a trained healthcare provider within 24 to 48 hours. In addition, 11 FGDs were arranged to allow women to discuss and learn about issues related to MCH.

The Mid-Term Evaluation Team followed a rigorous and programmed technical approach, much of which was based on participatory approaches. The planning stages of the evaluation allowed for collaboration between MoLHSA officials and partners. During the major assessment period, the evaluation focus was on observations, client interviews, clinical reviews, record reviews and meetings with implementers and beneficiaries.

The LQAS KPC conducted during the MTE found that the behavior change indicators that were under the control of the mother changed in all regions. The most significant changes occurred in those regions where the ACTS CSP focused their educational training. In these regions the changes meet or exceeded the mid-term targets. In the regions where, because of limited resources, ACTS did not focus the training, the changes were less than the mid-term targets. Clearly these are the regions that ACTS CSP will focus on the last two years of the program, while sustaining gains in other regions.

Also noted is that in those situations where the young mother did not have control (e.g. in this culture taking the baby to the hospital involves the husband and mother-in-law making the decision) even when the mother knew what was best for the baby she was not always allowed to take the action. ACTS is considering how best to involve and educate these decision makers though Grandmothers and Dads clubs.

Challenges

The ACTS CSP Team should continue to focus on the community empowerment aspect of the project by further developing their discussion, assessment and analysis for implementation adjustment process using an on-going basis for quality improvements.

The commitment of the MoLHSA to continue in supporting role as a CSP partner and implementation agent should be strongly supported and involved with the ACTS CSP interventions and strategies. It may be necessary to review and update MOU agreements as the on-going health sector plan is developed. It is suggested that the close communication with MoLHSA partners and officials continue on a planned basis with a section of the ACTS annual report devoted to a summary of these collaboration meetings and possible MOU/agreement adjustment with continued communications.

The reported degree of growth stunting is at a 15% level and there is a high prevalence of marginal malnutrition warrants a dialogue with WHO, UNICEF and the MoLHSA regarding the possibility for adding a de-worming component to the project. This could be done either through a school program or as a community mechanism for reinforcing health messages through a practical observable intervention outcome. Treated persons see the expelled worm, which strengthens trust and increases the validity and credibility to additional health messages. It also may be feasible to add Vitamin A or other micronutrient components, which could later be assumed by the ministry.

Measuring BCI changes is a challenge as the concepts are more abstract to study. One possibility to measure behavior change is for the ACTS CSP Team to design a card system to present to each family member who has completed the FGD training. These family members would be instructed to present the cards when attending any clinic for ANC visits, check-ups for infants or children, or when seeking treatment for an illness. Each facility partner would collect the cards in a container and give them to ACTS and CSP partners on a monthly basis to measure the frequency of health center visits for a BCI measurement. Cards could relate to specific services by varying color.

The amount and type of training probably should be reviewed for application and especially for performance. Nearly every partner conducts training but the application of these training sessions appear fairly unclear. Recommendations are to review the comprehensive reorganization of training among partners, including the MoLHSA. This will assist in determining who is being trained for what in view of the national health sector reform.

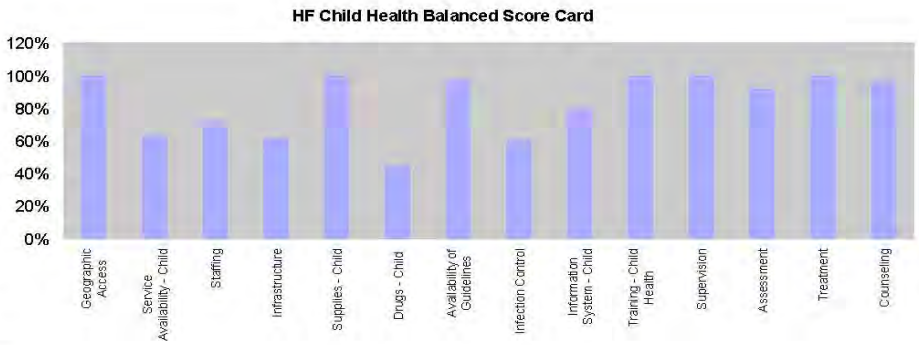
The MTE findings recommend that a training needs assessment could be done among targeted cohorts where the intervention group receives training with the intent to improve performance. An intervention would focus on the clinical partner training needs, performance needed and skills in conjunction with the population served and equipment available for use.

The professional assessment of staff and facilities completed by the two professionals should be carefully reviewed from the perspective of ACTS International and some criteria be designed for seeking resources and equipment where possible. While, it is not in the purview of the CSP to purchase equipment or restore aging facilities, it is apparent that improvements made by adding essential equipment and other clinic level institution needs will save lives and provide our MoLHSA partner with incentive to restore other facilities outside the CSP area.

Annex 11.7 ACTS 2009 Health Facilities Graphic Summary Based on CSTS 2009 Framework

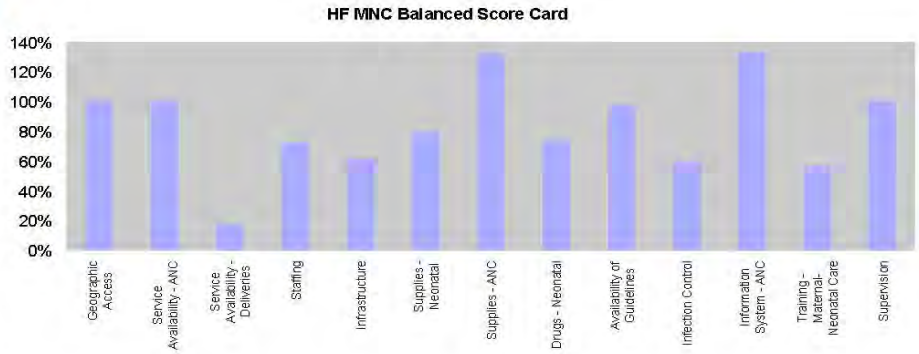
HF Child Health Balanced Score Card

Area of Analysis	Domain	Indicator Value
ACCESS	Geographic Access	100%
	Service Availability - Child	63%
INPUTS	Staffing	72%
	Infrastructure	61%
	Supplies - Child	100%
	Drugs - Child	44%
	Availability of Guidelines	97%
	Infection Control	60%
PROCESSES	Information System - Child	80%
	Training - Child Health	100%
	Supervision	100%
PERFORMANCE	Assessment	92%
	Treatment	100%
	Counseling	97%



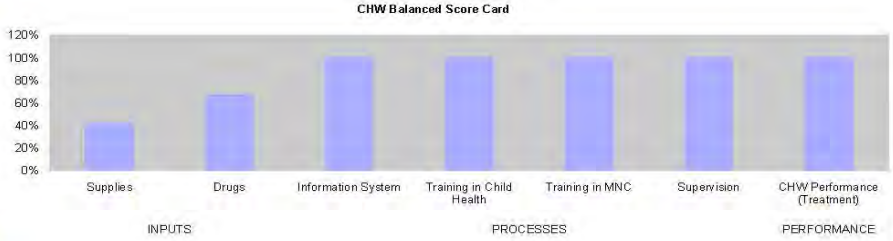
HF MNC Balanced Score Card

Area of Analysis	Domain	Indicator Value
ACCESS	Geographic Access	100%
	Service Availability - ANC	100%
	Service Availability - Deliveries	17%
INPUTS	Staffing	72%
	Infrastructure	61%
	Supplies - Neonatal	79%
	Supplies - ANC	132%
	Drugs - Neonatal	73%
	Availability of Guidelines	97%
	Infection Control	60%
PROCESSES	Information System - ANC	133%
	Training - Maternal-Neonatal Care	57%
	Supervision	100%



CHW Balanced Score Card

Area of Analysis	Domain	Indicator Value
INPUTS	Supplies	42%
	Drugs	67%
PROCESSES	Information System	100%
	Training in Child Health	100%
	Training in MNC	100%
	Supervision	100%
PERFORMANCE	CHW Performance (Treatment)	100%



Area of Analysis	Domain	Utilization Rate
UTILIZATION	Utilization of HF Curative Services (visits per U5 per year)	0.0
	Utilization of HF ANC Services (visits per birth)	0.4
	Utilization of HF Delivery Services (# per births predicted)	0.3
	Utilization of CHW Curative Services (visits per U5 per year)	0.0

Annex 11.8 Public Health School, University of Georgia Memorandum of Understanding

Agreement on Cooperation
(Memorandum)

Parties:

1. University of Georgia, LTD represented by its rector professor Manana Sanadze;
2. NGO ACTS International represented by its President, Dr. Patricia Joan Blair

Considering the fact that improvement and protection of the health of the population of Georgia is the strategic priority of the government as confirmed by the ongoing most important reforms in the sphere of health care, characterized by high tempo of activities directed to the introduction of the advanced forms of medical services and their delivery, it is evident that such activities require relevant administration of the health care processes both from the viewpoint of their funding and general united management.
Availability of relevant specialists with acknowledge and training complying with international standards as well as availability of professional working relationships based on intellectual and executive skills are crucial to achieve this goal.
New types of higher education facilities, advanced educational-and-research potential as well as development and introduction of adequate educational programs, qualified human resources required for deliverers of medical services to enable them to effectively manage local and branch systems are the prerequisites for development of such working relationships.
The parties share the idea that any initiative is fruitful provided it contributes to the harmonious development of the state and private sectors as well as recognize their mutual interest in improvement of health care management based on bringing up and use of relevant working resources and advanced research-and-practical experience.
Considering the above the parties are signing this Memorandum on Cooperation with the aim of its further development and expansion implying the following:

5. Using of the research-and-practical potential of the University of Georgia to improve administrative management in the sphere of health care (research, analysis, recommendations);
6. Professional training of ACTS Georgia staff to increase their competence;
7. Contributing to providing postgraduate training for the students of the University of Georgia and in case of necessity rendering assistance for their employment;
8. Implementation of the joint research and applied projects using the material-and-technical basis of the University of Georgia and ACTS International supported by relevant resources.

The term of this Memorandum is indefinite, its clauses are subjected to further improvement and revision upon the preliminary notification of the parties.
The parties believe that this Memorandum on Cooperation will contribute to implementation of one of the priorities of the country, viz., improvement and protection of the health of the population of the country and therefore are signing this Memorandum issued in two copies each of which will be stored by both parties.

On behalf of University of Georgia	On behalf of ACTS International
Signed on Georgian Document	*Signed on Georgian Document*
Professor Manana Sanadze,	Dr. Patricia Joan Blair,
Rector	President, ACTS International

Translated by Eteri Suladze. The translation complies with the original Dr. G. Tsilosani, President, ACTS Georgia

თანამშრომლობის შეთანხმება

(მემორანდუმი)

მხარეები:

1. შპს "საქართველოს უნივერსიტეტი" – წარმოადგენს რექტორი, პროფესორი მანანა სანაძე;

2. არასამთავრობო ორგანიზაცია "ექთს-ინტერნეიშენალი" – წარმოადგენს პატრიცია ჯოან ბლეერი

იმის შეგნებით, რომ ქვეყნის მოსახლეობის ჯანმრთელობის გაუმჯობესება და დაცვა წარმოადგენს ხელისუფლების სტრატეგიულ პრიორიტეტს, რომელსაც ახორციელებს ჯანმრთელობის დაცვის სფეროში მიმდინარე უმნიშვნელოვანესი რეფორმებით და რომელიც გამოირჩევა მოქმედების მაღალი ტემპებით, სამედიცინო მომსახურეობის წარმოებისა და მიწოდების უმაღლესი ფორმების დანერგვით, მოითხოვს ჯანდაცვითი პროცესების შესაბამის ადმინისტრირებას, როგორც დაფინანსების, ასევე ზოგადად ერთიანი მენეჯმენტის მიმართულებით.

ეს მიზანი კი, ვერ მიიღწევა ცოდნისა და მომზადების საერთაშორისო სტანდარტების მქონე შესაბამისი სპეციალისტების, ინტელექტუალური და საშემსრულებლო დონეზე არსებული პროფესიული შრომითი ურთიერთობების გარეშე.

დარწმუნებულნი, რომ ასეთი შრომითი რესურსების აღზრდა შეუძლებელია ახალი ტიპის უმაღლესი სასწავლებლების არსებობის, ახალი სასწავლო-სამეცნიერო პოტენციალისა და შესაბამისი საგანმანათლებლო პროგრამების მომზადებისა და განხორციელების გარეშე, სამედიცინო სერვისების მიმწოდებლები კი საჭიროებენ კვალიფიციურ ადამიანურ რესურსებს, რომლებიც ადექვატურად მოახდენენ ლოკალური და დარგობრივი სისტემების მართვას.

გაერთიანებულნი იდეით, რომ ყოველგვარი ინიციატივა ნაყოფიერია, თუ ემსახურება სახელმწიფო და კერძო სექტორის ჰარმონიულ განვითარებას და იმის აღიარებით, რომ გვაქვს ერთიანი ინტერესები ჯანდაცვის ადმინისტრირების გაუმჯობესებაზე, რომელიც დაფუძნებულია სათანადო შრომითი რესურსების მომზადებისა და გამოყენების, უახლეს სამეცნიერო –პრაქტიკულ გამოცდილებაზე.

მხარეები ხელს აწერენ მემორანდუმს ურთიერთთანამშრომლობის შემდგომი განვითარებისა და განვრცობის მიზნით, რაც უპირველეს ყოვლისა, გულისხმობს:

1. "საქართველოს უნივერსიტეტის" სამეცნიერო-პრაქტიკული, ინტელექტუალური პოტენციალის გამოყენებას ჯანდაცვითი სფეროს ადმინისტრირების გაუმჯობესების საკითხებში (კვლევა, ანალიზი, რეკომენდაციები);
2. "ექთს ინტერნეიშენალის" თანამშრომელთა პროფესიული წვრთნა, მათი კომპეტენციების ამაღლების მიზნით;

3. "საქართველოს უნივერსიტეტის" სტუდენტებისათვის ხელშეწყობას პროფესიული სტაჟირების გავლისა და საჭიროების შემთხვევაში მათი დასაქმების მიმართულებით;
4. ერთობლივი სამეცნიერო-კვლევითი და პრაქტიკული პროექტების წარმოება, რისთვისაც გამოყენებული იქნება, როგორც "საქართველოს უნივერსიტეტის", ასევე "ექთს ინტერნეიშენალის" მატერიალურ-ტექნიკური ბაზა და შესაბამისად ხელშეწყობილი იქნება სათანადო რესურსებით.

მემორანდუმის მოქმედების ვადა განუსაზღვრელია, ექვემდებარება პირობების შემდგომ გაუმჯობესებასა და გადახედვას, წინასწარი შეტყობინების საფუძველზე.

მხარეები დარწმუნებულნი არიან, რომ თანამშრომლობის მემორანდუმი ხელსშეუწყობს ქვეყნის ერთ-ერთი სტარტეგიული პრიორიტეტის – ქვეყნის მოსახლეობის ჯანმრთელობის გაუმჯობესებასა და დაცვას, ხელს აწერენ მას და ორ ეგზემპლარად ინახება მათთან.

შპს "საქართველოს უნივერსიტეტის"
რექტორი,

პროფესორი მანანა სანაძე

"ექთს ინტერნეიშენალის"
პრეზიდენტი

პატრიცია ჯოან ბლეერი

თბილისი, 12.06. 2009
შერატონ მეტეხი პალასი

Annex 11.9 Recommended Schedule for Primary Childhood Vaccinations in Developing Courntries

RECOMMENDED SCHEDULE FOR PRIMARY CHILDHOOD VACCINATIONS

Visit & Age	Vaccines
Visit 1: Birth	BCG OPV0 Hep B*
Visit 2: 6 weeks	DPT1 OPV1 Hep B Hib 1
Visit 3: 10 weeks	DPT21 OPV2 Hep B Hib 2
Visit 4: 14 weeks	DPT3 OPV3 Hep B Hib 3
Visit 5: 9 months	Measles Hep B Yellow Fever **

* Only three doses of hepatitis B vaccine are needed for full protection. Schedules vary by country.

** In countries where indicated

Recommended by WHO for developing countries.
Source: USAID 2003.

Behavior Change Perspectives and Communication Guidelines on Six Child Survival Interventions 2005 by Renata Seidel.

Annex 11.10 ACTS Festival Report

Health Festivals and Community Mobilization for Mass Campaign of Immunization in Georgia.

In 2007 ACTS entered its third year of implementation of CS Project in Kvemo Kartli region of Georgia. Experience and lessons learned within this period demonstrated the necessity to seek for the ways of community mobilization which would allow better coverage of the population compared to community meetings and activities of the trained community mobilizers. Our experience showed that while the trained Mother-to Mother support groups are indeed active in their villages and cities immediately after training with time their activity inevitably goes down succumbing to everyday needs and efforts required to take care of ones' families and earn their living. As a part of this project, which is working to create a sustainable intervention system for the improvement of the health of mothers, children and newborns, ACTS Georgia organized the festivals "Healthy Moms for Healthy Kids" with the support of the Georgian representation of USAID, World Vision, AING (Alliance for Improved Nutrition of Georgia), the Tbilisi Lion's Club and the Dmanisi and Bolnisi administrations. The aim of the event was to promote moms' and kids' health through behaviour change interventions including messages delivering, improving knowledge and active participatory appraisal. As a result of the analysis of the experience gained local Festivals focused on the major messages of CS strategies were considered as optimal tool to cover maximally large number of beneficiaries. The following arguments served as a justification of such approach:

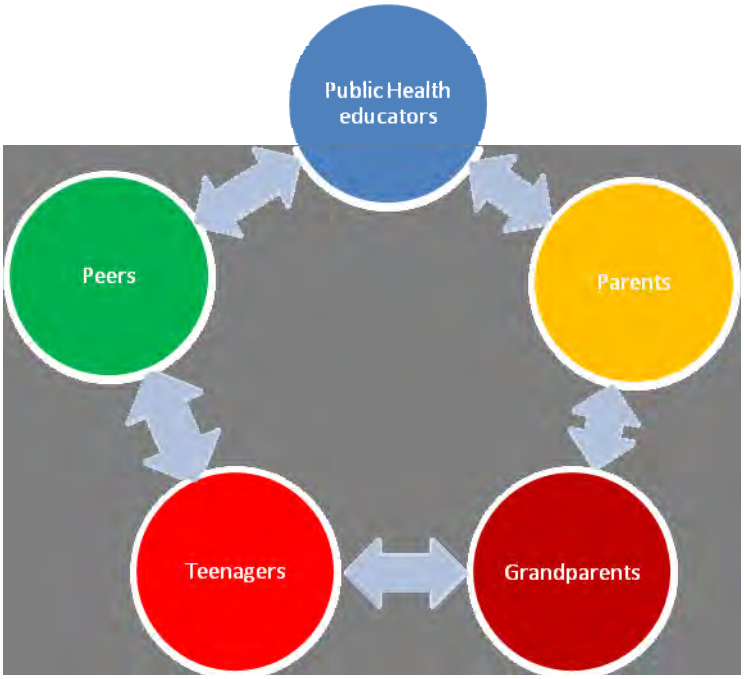
- Festivals are intensive, logistically complex undertaking that rely on multiple stakeholders, creating divergent expectations.
- Festivals tend to be rather exposed in the media, closely watched by the professionals, attractive to the sponsors and funded by the public authorities.
- *Celebratory* function of festivals stresses the benefits of the local community, such as increased social cohesion, self-awareness and consolidation of the civil society on the micro level.
- *Promotional* function of festivals is visible in their effort to encompass high percentage of district population;.
- *Educational* role of the festivals is revealed in their impact on the audience, participants, staff and volunteers.
- *Cost-effectiveness* – while each community meeting involving about 20 participants costs $200, the Festival attracting thousands of target population costs on average #2300. The dissemination packages are readily available to all participants and serve as additional educational materials.

The festival proved to be a success for the following reasons:

- The majority of population positively perceived the messages and the spirit of CS strategies to which fact testified active and voluntary participation both adult and teenager population;
- The population actively demanded for the information distribution package (booklets, leaflets, drawings etc.);
- The teachers and school children demonstrated vivid interest and creative approaches towards the major themes offered by ACTS, which is well reflected in the original scenarios and verses written by the children to convey the CS major messages in a popular and enjoyable form. It should be noted that ACTS offered them its own version

of rhymed messages with relevant musical accompaniment to be used in the sketches, but the interest of children was so great, they decided to rhyme and choose music for the messages themselves. And it shall be admitted that in some cases they did it better;

- In their sketches the pupils offered the following scheme of education:



This scheme demonstrates that the teenagers are willing to be actively involved in the process of obtaining information to be able to make cognitive decisions rather than blindly follow the others advise.

- The Festival attracted significant number of the district residents and thus ensuring the availability and accessibility of the CS messages to the large masses of people.
- To the success of the Festival testify the facts that quite a few teenagers would approach ACTS CS team with the request to actively involve them if ACTS was planning conduction of similar events in the district; The parents of some ten teenagers came specially to thank the organizers of the Festival since they saw significant changes in behavior of their children who were involved in the preparatory activities – kids would share the information they obtained at the workshops with their parents and in one case 15 year boy urged his pregnant elder sister to visit the doctor to "be on the safe side" as he put it. The mother telling this story was laughing – she was pleased her boy showed such consideration for his sister and eventually she did go for her prenatal visit to the local outpatient clinic.

The experience with health festivals was successfully used for community mobilization related to mass immunization against Rubella & Measles for the population aged from 6 to 27 years. The campaign was conducted jointly with UNICEF, WHO, National CDC and Ministry of Labor, Health and Social Affairs of Georgia. ACTS was implementing partner of UNICEF in Samtskhe-Javakheti region of Georgia. One of the most important tools of the

Festival was especially designed quiz composed of questions, which would show the preparedness of the population and their knowledge about the necessity and essence of immunization, viz. against Rubella and Measles. The results of the quiz were used as indirect tool to demonstrate the impact of educational activities using specially trained community mobilizers and volunteers on public opinion and willingness of the target population to be immunized. The baseline indicator before starting community moibilization activities in the region was 31% of population who were more or less aware of the necessity of immunization. The Festival demonstrated that by the end of the campaign 89% of those who participated in the quiz gave correct answers to the questions related to immunization. As a result 94% of total target population has been successfully immunized by the end of the campaign, whereas average numbers for other regions of Georgia hardly reached 50%, which necessitated prolongation of the immunization campaign in those regions.

Annex 11.10. Child Survival Program Relevance to Millennium Development Goals

1. **The Government of Georgia is a signer to the UN Millennium 8 Development Goals.** Goal four is to reduce child mortality and goal 5 is to improve maternal health significantly by 2015. The ACTS Child Survival Program is assisting Government of Georgia to measure and meet these key goals.

2. **CSP Relevance to USAID Georgia Mission Strategic Priorities.** ACTS CSP goals, program indicators and results are aligned with USAID Georgia Mission plans which are identified as the following strategic objectives (S.O.) and intermediate results (I.R.):

   SO 3.4 Increased use of social and health services and changed behavior;
   IR 3.4.2 Increased knowledge of health promoting practices;
   IR 3.4.3 Improved quality of health services; and
   IR 3.4.4 More effective health support system.

Annex 12. ACTS Mission Project: Georgia - ACTS - FY04 (2004-2009)

The CSTS Data Base is locked and will not accept data entry as a result the Data From cannot be printed. ACTS has all the information and is waiting for CSTS Database manager David Cantor to assist ACTS.

Message:

Rapid CATCH information has been successfully updated.

New Partner Project: Georgia - ACTS - FY04 (2004-2009)

Rapid CATCH Indicators: Final Evaluation

Status: ✔OK
Date Last Updated: 2009-12-02 04:56:19.167

Current Sample Type: 30 Cluster
Current Location Type: Disaggregated
Change the sample and location types on the Rapid CATCH Summary tab.

Instructions: Click on each indicator name to enter data for that indicator. Enter numerator and denominator only. Percent and confidence interval will be automatically calculated.

✔Underweight Children

Description: Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Final Evaluation Indicator Table for Underweight Children

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	19	242	7.9	± 4.9 %
Kvemo Kartli (2)	37	198	18.7	± 8.1 %
Chiatura and Zestaphoni	7	265	2.6	± 2.7 %

Birth Spacing

Description: Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Final Evaluation Indicator Table for Birth Spacing

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	129	215	60.0	± 12.3 %
Kvemo Kartli (2)	87	285	30.5	± 8.4 %
Chiatura and Zestaphoni	58	114	50.9	± 16.0 %

Delivery Assistance

Description: Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Delivery Assistance

Sub Area Name	Numerator	Denominator	Percent	Confidence Interval

			[Calculated]	[Calculated]
Kvemo Kartli (1)	296	300	98.7	± 11.3 %
Kvemo Kartli (2)	294	300	98.0	± 11.3 %
Chiatura and Zestaphoni	300	300	100.0	± 11.3 %

☑Maternal TT

Final Evaluation Indicator Table for Maternal TT

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	N/A	N/A	0.0	± 0.0 %
Kvemo Kartli (2)	N/A	N/A	0.0	± 0.0 %
Chiatura and Zestaphoni	N/A	N/A	0.0	± 0.0 %

☑Exclusive Breastfeeding

Description: Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Final Evaluation Indicator Table for Exclusive Breastfeeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	71	83	85.5	± 21.3 %
Kvemo Kartli (2)	52	70	74.3	± 22.6 %
Chiatura and Zestaphoni	69	88	78.4	± 20.4 %

☑Complementary Feeding

Description: Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Final Evaluation Indicator Table for Complementary Feeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	28	58	48.3	± 22.0 %
Kvemo Kartli (2)	27	55	49.1	± 22.7 %
Chiatura and Zestaphoni	44	67	65.7	± 22.5 %

Full Vaccination

Description: Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Final Evaluation Indicator Table for Full Vaccination

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	N/A	N/A	0.0	± 0.0 %
Kvemo Kartli (2)	N/A	N/A	0.0	± 0.0 %
Chiatura and Zestaphoni	N/A	N/A	0.0	± 0.0 %

Measles

Description: Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Final Evaluation Indicator Table for Measles

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	N/A	N/A	0.0	± 0.0 %

Kvemo Kartli (2)	N/A	N/A	0.0	± 0.0 %
Chiatura and Zestaphoni	N/A	N/A	0.0	± 0.0 %

Bednets

Description: Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Bednets

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	N/A	N/A	0.0	± 0.0 %
Kvemo Kartli (2)	N/A	N/A	0.0	± 0.0 %
Chiatura and Zestaphoni	N/A	N/A	0.0	± 0.0 %

Danger Signs

Description: Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Danger Signs

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	215	300	71.7	± 10.9 %
Kvemo Kartli (2)	252	300	84.0	± 11.2 %
Chiatura and Zestaphoni	300	300	100.0	± 11.3 %

Sick Child

Description: Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Final Evaluation Indicator Table for Sick Child

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	25	27	92.6	± 37.6 %
Kvemo Kartli (2)	33	41	80.5	± 30.0 %
Chiatura and Zestaphoni	16	16	100.0	± 49.0 %

☑HIV/AIDS

Description: Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for HIV/AIDS

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	149	300	49.7	± 9.8 %
Kvemo Kartli (2)	34	300	11.3	± 5.2 %
Chiatura and Zestaphoni	239	300	79.7	± 11.1 %

☑Handwashing

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

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Handwashing

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Kvemo Kartli (1)	209	300	69.7	± 10.8 %
Kvemo Kartli (2)	120	300	40.0	± 9.1 %
Chiatura and Zestaphoni	278	300	92.7	± 11.3 %

Enter comments:
Please enter any comments you have regarding your Rapid CATCH Indicator data, and include any information or variation from the standard definition of the indicator, such as different age cohort or denominator, and the reasons for the variation:

Save Rapid CATCH Indicator Data

Annex 13. Grantee Response to Final Evaluation

Physicians Skills Improvement and Sustainability

The recent adoption by the Georgian Association of Ob/GYN OB of guidelines for practice creates a new educational opportunity to updated training of OB physicians and introducing updated curricula in the Tbilisi State Medical School. ACTS coordinates the partnership between the University of Missouri, School of Medicine and the Tbilisi State Partnership and will work within this partnership to provide training opportunities, introduce IMCI into the medical school curricula.

Community Education

ACTS is seeking private funding to continue community education on maternal and child health
The FDGS participate were initially guarded in their responses as mutual trust develop they became more open. ACTS used their feedback to develop more effective written material and they began to understand that their active involvement resulted in the changes they needed.

ACTS Board of Directors is actively seeking funding to continue for these successful community health festivals, as well as funds to continue the CSP program in Kvemo Kartli.
ACTS will work to find the additional support to provide adequate involvement.

Behavior Change and Capacity Building

ACTS KPC and LQAS surveys were extensive 900 KPC surveys were conducted for each KPC Analysis was timely completed. Other national surveys such as the recently published UNICEF MICS survey conducted in 2005 and published four and a half years later in fall 2009, results in outdated information that cannot be used for policy decisions. ACTS in the future would like to pilot in Georgia the hand held device survey used successfully by the Red Cross and the

Salvation Army in Africa. This increased capacity would extend the application of evidence based decision making into several vital health areas.

Train local participants as leaders

ACTS has a long term commitment to the country of Georgia and will maintain our presence after the CSP has completed. ACTS will seriously consider the recommendation to continue meeting with volunteers and reviewing their progress and concerns. In addition ACTS will work to provide non material incentives such as certificate of acknowledgement. The copies will be sent to MOHLSA as well as the local and regional district health care authorities to inform them about human resource potential in the region.

Need for more print educational materials

ACTS will work with the local USAID mission and other donors to find funding for publishing And distribution of relevant printed materials at the community and medical professional levels.

Involvement of local administration

ACTS plans to continue conducting informational and educational sessions with local authorities (especially newly appointed and elected) to facilitate the motivation of more vigorous efforts within the maternal and child health sphere of the various communities/districts and regions.

Exit interviews

ACTS will develop a special form for reporting to the the health officials. This special form will document the results of the exit interviews in voicing the hopes and concerns of the communities and the health professionals.

Future bilateral

ACTS is working with the Government of Georgia and the NGO sector offering our experience in community mobilizers, activitive for joint implications of new project.