

Final Evaluation

**Azerbaijan Child Survival Project: Building Partnerships,
Saving Lives**

Yardimli, Lerik and Masalli Districts of Southern Azerbaijan

Cooperative Agreement No. HFP-A-00-01-00014-00

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Despite the best efforts of both the project and headquarters staff, factual errors may persist in the report. They must be considered the responsibility of the principal author who tried to grasp the complexity of the environment in a short period of time.

Acronyms

ARI	Acute Respiratory Infection
CDD	Control of Diarrheal Disease
CHE	Community Health Educator
HH/C-IMCI	Household/Community-Integrated Management of Childhood Illnesses
CS	Child Survival
CSP	Child Survival Project
CSTS+	Child Survival Technical Support
DHA	District Health Authority
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis and Tetanus
EBF	Exclusive Breastfeeding
Feldsher	Semi-equivalent to Nurse Practitioner/ Physician's Assistant
HFA	Health Facilities Assessment
HIS	Health Information System
HQ	Headquarters
IDP	Internally Displaced Persons
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IRD	International Relief and Development (a partner agency on this project)
KPC	Knowledge Practice Coverage (Survey)
LAM	Lactation Amenorrhea Method (family planning)
LGA	Local Government Authority
LOP	Length of Project
LQAS	Lot Quality Assurance Sampling
M/M	Mentor/Mobilizer
MCH	Maternal Child Health
MOH	Ministry of Health
MTE	Mid-term Evaluation
NGO	Non-Government Organization
ORS	Oral Rehydration Solution
PCM	Pneumonia Case Management

PHC	Primary Health Care
POET	Participatory Organizational Assessment Evaluation
SDM	Standard Days Method of Family Planning
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization
WRA	Women of Reproductive Age

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CHILD SURVIVAL AND HEALTH GRANTS PROGRAM PROJECT SUMMARY

Last Updated: Sep-21-2006

Mercy Corps

Azerbaijan

General Project Information:

Cooperative Agreement Number: HFP-A-00-01-00041-00

Project Grant Cycle: 17

Project Dates: 9/30/2001 - 9/29/2006

Project Type: Standard

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Funding Information:

USAID Funding: (US \$): \$1,299,983 PVO Match:(US \$) \$432,659

Project Information:

Description:

MC and its partners put primary focus on strengthening the ability of caretakers (primarily grandmothers and mothers, together with male family decision makers) and communities to increase their responsibility for the health of mothers and children. The project focuses on creating new community-level mechanisms and networks which facilitate health information transfer and promote preventive behaviors. Actions are based on community-collected health information. Community-based preventive actions are coupled with improvement in the quality and utilization of primary health care through training and mentoring of fieldshers, midwives, and physicians as first level health care providers in communities. The estimated level of effort is 20% PCM, 20% CDD, 25% MNC, 20% nutrition (breastfeeding support), and 15% child spacing, with IMCI, which is just about to be piloted in the project area, used as a major approach.

Location:

The CSP site is the remote mountainous Yardimli and Lerik districts, and the mountainous quarter of the Masally district, in southern Azerbaijan along the border with Iran.

Project Partners Partner Type Subgrant Amount

Ministry of Health Collaborating Partner

General Strategies Planned:

- Private Sector Involvement
- Advocacy on Health Policy
- Strengthen Decentralized Health System
- Information System Technologies

M&E Assessment Strategies:

- KPC Survey
- Health Facility Assessment
- Organizational Capacity Assessment with Local Partners
- Organizational Capacity Assessment for your own PVO
- Lot Quality Assurance Sampling
- Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

- Mass Media
- Interpersonal Communication
- Peer Communication
- Support Groups

Groups targeted for Capacity Building:

- PVO Non-Govt Partners
- Other
- Private Sector
- Govt Community

US HQ (General)

US HQ (CS unit)

CS Project Team

Dist. Health System

Health Facility Staff

Health CBOs

Interventions/Program Components:

- Nutrition (5 %)
- Pneumonia Case Management (20 %)
- Control of Diarrheal Diseases (20 %)
- Maternal & Newborn Care (25 %)
- Child Spacing (15 %)
- Breastfeeding (15 %)

Target Beneficiaries:

- Infants < 12 months: 2,597
- Children 12-23 months: 2,597
- Children 24-59 months: 7,761
- Children 0-59 months: 12,955
- Women 15-49 years: 38,535
- Population of Target Area: 58,000

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	22	290	7.6%	4.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	60	134	44.8%	14.1
Percentage of children age 0-23 months whose births were attended by skilled health personnel	267	300	89.0%	11.2
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0	0
Percentage of infants age 0-5 months who were	41	77	53.2%	19.7

exclusively breastfed in the last 24 hours				
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	28	54	51.9%	23.4
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0%	0.0
Percentage of children age 12-23 months who received a measles vaccine	121	144	84.0%	16.1
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0%	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	260	300	86.7%	11.2
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	14	66	21.2%	14.9
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	82	300	27.3%	7.8
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	212	300	70.7%	10.8

Comments for Rapid Catch Indicators

Maternal TT shots are not part of the medical protocols of Azerbaijan, thus was not tracked. The communities targeted by this project are not at risk of malaria, so bed net use was not tracked.

A. EXECUTIVE SUMMARY

Project Goal and Objectives: The goal of Mercy Corps' Azerbaijan Child Survival Project, *Building Partnerships, Saving Lives*, is to work through its partners, the Ministry of Health (MOH) and International Relief and Development (IRD), to reduce maternal and child morbidity and mortality in the project districts over October 1, 2001 and September 31, 2006.

The major objectives are: 1) sustained changes in care-giving and health seeking behavior; 2) improved quality of health services; 3) increased number of community health initiatives; 4) improved support of primary health care (PHC) by the District Health Authority (DHA) and; 5) increased health programming capacity within Mercy Corps itself.

The project's technical mix includes: Pneumonia Case Management (PCM) at 20% level of effort (LOE); Control of Diarrheal Disease (CDD) at 20% LOE; Maternal and Newborn Care (MNC) at 25% LOE; Breastfeeding at 20% LOE; and Child Spacing at 15% LOE. The introduction of IMCI is included as the integrating strategy for facility and community level intervention.

Main Accomplishments of the Project: According to the project Health Information System (HIS, see Annex), the project has achieved a significant reduction of child and infant mortality in the project villages. Over the life of the project, child mortality has decreased by almost 80% and infant mortality by 70%. There was an increase in the infant mortality rate (IMR) during the last year of the project (2005-2006) over the previous year, but overall, the IMR was still lower than the rates for the three prior years. Project staff believes that the higher rate was due to the addition of many remote and difficult to reach smaller villages during the last year, where access to care seems to be more difficult particularly during the winter season. Nevertheless, these figures indicate important improvements in health status.

The final KPC survey captured important improvements in knowledge and behavior in project villages. The project met or surpassed most of its target indicators in focus as well as non-focus villages. For example, 100% of mothers sought treatment for children experiencing cough and rapid breathing (baseline: 40%), 69% of women continued to increase the amount of breastfeeding when children had diarrhea (baseline: 52%), 87% of women recognized two or more signs of childhood illness that indicate a need for treatment (baseline: 55%) and 70% of women made at least two prenatal visits to a health facility during pregnancy (baseline: 32%).

Quantitative Highlights from Baseline to Final Evaluation:

Indicator Definition	Percentage (%)			
	Baseline	MTE	Final	Target
Proportion of mothers who sought appropriate medical treatment for their child with cough and rapid breathing (or chest in-drawing)	40.0	92.7	100	55
Proportion of mothers who made at least two prenatal care visits during pregnancy	32.3	66	70	37
Proportion of women using modern contraceptives (among those who do not desire children in next two years)	4.6	-	24	10
Proportion of children age 12-23 months who are vaccinated	11.9	-	81.25	0
Increase from 0% to 30% the percentage of caretakers who recognize at least one symptom of dehydration	-	-	70	30

Document that 30% of newborns received immediate breastfeeding after birth	15.3	51	83	30
Increase from 0% to 40% the percentage of physicians and feldshers applying IMCI protocol	-	-	89	40
Increase to 40 % the percentage of physicians, feldshers, and midwives providing appropriate family planning activities to men/women presented to the health facility	0	-	100	40
Proportion of children age 0–23 months whose births were attended by skilled health personnel	69.3	-	89	76.2
Proportion of infants age 0–5 months who were exclusively breastfed in the last 24 hours	14.5	-	53	30
Proportion of mothers of children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	5.7	-	27	-

Priority Conclusions: If the project were to continue, the next phase should focus on 1) improving more facilities, and 2) further strengthening the capacity of health facility staff. There is a need to expand IMCI training to all providers and to provide essential supervision and updates.

The CSP has not spent enough time in its targeted Lerik communities, having only started in this district after the mid-term evaluation. Further activities should focus on increasing VHC and overall community capacity and self-confidence in Lerik.

There are some issues with regard to complementary feeding, which was not an intervention area for this project, but it was included in the KPC at the time of the baseline and final. Further activities in the target area should focus on complementary feeding for children under five years old, emphasizing key messages around diet diversity, frequency of feeding and continuation of breastfeeding until about two years of age.

The diarrhea intervention of this project has been successful within its design. It has decreased use of antibiotics and IVs to treat childhood diarrhea and increased use of oral rehydration solution (ORS) and home available fluids. The project was less successful with increasing the amount of food offered a child during diarrhea, but this must be viewed within the context of sub-optimal complementary feeding practices in Azerbaijan. This essential element of home management could use more attention.

The supply of essential medicines and contraceptives remains in question at the close of the project. While further support is needed in terms of continued provision of essential medicines, it is critical that future health efforts in Azerbaijan focus on strengthening the MOH to better manage and assure supplies of quality medicines to these rural communities.

Finally, the experience of this evaluation points to the need to consider follow-on funding options for innovative projects such as this in countries such as Azerbaijan which are not ready to go to national level scale with child survival type activities. USAID does not currently offer a lot of complementary mechanisms for this type of work. It would be useful for CSHGP to explore ways to integrate the child survival project product into other USAID funding mechanisms, both centrally and at the mission level.

This report was written using CSHGP 2005 Final Evaluation Guidelines.

B. ASSESSMENT OF RESULTS AND IMPACT OF THE PROGRAM

B1. Results: Summary Chart

Child Survival Project, Southern Azerbaijan
 Knowledge, Practices and Coverage Survey
 Project Indicators 13 May 2006

Indicator Definition	%				
	Baseline	MTE	Final	Target	Survey
Proportion of mothers who sought appropriate medical treatment for their child with cough and rapid breathing (or chest indrawing)	40.0%	92.7%	100%	55%	KPC
Proportion of mothers who are aware of at least two pregnancy-related danger signs	4.7%	41.7%	45%	30%	KPC
Proportion of mothers who made at least two prenatal care visits during pregnancy	32.3%	66%	70%	37.1%	KPC
Proportion of children with diarrhea in the last two weeks who received appropriate home case management	11.4%	44.8%	61%	40%	KPC
Proportion of mothers who continued or increased amount of breastmilk given during episodes of diarrhea in the last two weeks	52.6%	87.5%	69%	--	KPC
Proportion of women using modern contraceptives (among those who do not desire children in next two years)	4.6%	-	24%	10%	KPC
Proportion of mothers stating both cough and rapid breathing as danger signs of childhood illness	2.3%	-	3%	20%	
Proportion of children age 12-23 months who are vaccinated	11.9%	-	81.25%	0%	KPC

	Baseline	Midterm	Final	Target	Survey
Increase from 0 to 30% the number of caretakers who recognize at least one symptom of dehydration	-	-	70%	30%	SSS
Document that 80% of women can name at least one natural family planning method	0%	-	54.5%	80%	SSS
Document that 30 % of newborns received immediate breastfeeding after birth	15.3%	51%	83%	30%	KPC
Increase from 0 % to 40 % the % of physicians and fieldshers applying IMCI protocol	-	-	89%	40%	HFA
Increase to 40 % the % of physicians, fieldshers, and midwives providing appropriate family planning activities to men/women presented to the health facility	0%	-	100%	40%	HFA

	%				
	Baseline	Midterm	Final	Target	Survey
Rapid Catch Indicator Definition					
Proportion of children age 0–23 months who are underweight (-2 standard deviations from the median weight-for-age)	11.2%	-	8%	-	KPC
Proportion of children age 0–23 months who were born at least 24 months after the previous surviving child	37.6%	-	45%	-	KPC
Proportion of children age 0–23 months whose births were attended by skilled health personnel	69.3%	-	89%	76.2%	KPC
Proportion of infants age 0–5 months who were exclusively breastfed in the last 24 hours	14.5%	-	53%	30%	KPC

Proportion of infants age 6–9 months receiving breastmilk and complementary foods	53.8%	-	52%	-	KPC
Proportion of children age 12–23 months who received a measles vaccine	33.3%	-	84%	-	KPC
Proportion of mothers who know at least two signs of childhood illness that indicate the need for treatment	55.3%	88.2%	87%	-	KPC
Proportion of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks (among all sick children)	9.9%	67.7%	21%	40%	KPC
Proportion of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks (among those sick children who were not being exclusively breastfed)	9.8%	67.7%	21%	40%	KPC
Proportion of mothers of children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	5.7%	-	27%	-	KPC
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	-	-	71%	-	KPC

B2. Results: Technical Approach

Overview

Location

Azerbaijan is located in the Caucasus Mountains between Russia in the north and Iran in the south, and has been experiencing economic decline since the break-up of the Soviet Union in the early 1990s. A protracted war with Armenia following the break-up also contributed to social and economic hardships, resulting in declines in the quality of health services, education and social infrastructure, as well as impoverishment of large sectors of the population.

Mercy Corps' USAID funded Child Survival Project (CSP) was the first international non-government organization (NGO) project in the southeastern region of Azerbaijan. This area has a large Taylish ethnic minority population, which maintains more "traditional" values and lives a more conservative Islamic lifestyle than in other parts of Azerbaijan. As in any culture, these values shape gender roles and interactions. The target population is 58,000, which includes 19,000 children under five years of age and 39,000 women of reproductive age (WRA). This is a rural population with high levels of secondary education among men and women, and higher levels of university education among men. However, the population has come to again rely to subsistence agriculture, day labor at low wages and out-migration in order to survive the economic decline of the country.

The mountainous districts of Yardimli and Lerik make up the core CSP site, with an additional number of villages located in the neighboring district of Masalli (see map in annex). These districts are in isolated parts of the country with widely disbursed communities difficult to access due to limited infrastructure and rugged road conditions. They have been largely neglected by the resource-strapped government that is still coping with a significant internally displaced persons (IDP) population in other regions. During the winter, 30% of the target villages are inaccessible due to a combination of poor roads and extreme weather conditions.

The project works in 283 villages in the three target districts. It works with 129 focus villages (larger villages) with all interventions including Village Health Committee (VHC) development, training and support of Community Health Educators (CHEs), formation and education of women's groups as well as training and support of health facility personnel. It provides community education and, when requested, supports VHC development and health educator couples training and development in the other villages.

Health Status

The infant mortality rate has been steadily increasing since 1990, when it was at 19.9 per 1000 births. UNICEF (2000) reports IMR to be 83/1000 (2000) and the USAID funded CDC reproductive Health Survey (2001) report an IMR of 79/1000. The MOH morbidity and mortality records report high rates of infection, particularly from pneumonia. Maternal mortality is poorly tracked and no deaths have been reported in the child survival project areas. This is largely due to maternal death being considered criminal in all cases, and fear on the part of families and health facility staff to accurately report maternal deaths. Although the official maternal mortality ratio for the nation is reported to be 37.6/100,000 (2000), UNICEF estimates it at 79/100,000 (2000).

The Health Facility Assessment (HFA) conducted by the project in 2001 verified that there were essentially no drugs and very little availability of basic equipment and supplies throughout the target

area. Some of the peripheral facilities were no longer functioning. The project also found that the district hospital and the polyclinics had few patients and little equipment and supplies. At the same time “informal” payments to health workers makes the cost of service difficult for local villagers. As a result, the inadequate infrastructure, provider capacity and limited patient accessibility all contributed to poor quality of service.

Goals and Objectives

The goal of the CS project is to work through its partners, mainly the MOH and International Relief and Development (IRD), to reduce maternal and child morbidity and mortality in the project districts by the end of the project period.

The major objectives are: 1) sustained changes in care-giving and health seeking behavior; 2) improved quality of health services; 3) increased number of community health initiatives; 4) improved support of primary health care by the District Health Authority (DHA) and; 5) increased health programming capacity within Mercy Corps itself.

The project’s technical mix includes: Pneumonia Case Management (PCM) at 20% level of effort (LOE); Control of Diarrheal Disease (CDD) at 20% LOE; Maternal and Newborn Care (MNC) at 25% LOE; Breastfeeding at 20% LOE; and Child Spacing at 15% LOE. The introduction of IMCI is included as the integrating strategy for facility and community level intervention.

Program Strategy

The key program strategies focused on updating health facility provider skills in the project’s technical areas, and providing community education using a group education format, all in the targeted project districts:

The strategies are integrated through the following cross-cutting efforts:

- Behavior change education and support targeting women with children under five and working with family decision-making structures to improve home care and promote care-seeking at peripheral health facilities;
- Strengthening individual and community level mobilization for maternal and child health priorities. This includes a community-based Health Information System (HIS) used to keep track of health indicators and motivate community members, and promotion of community involvement through women’s and men’s groups and Village Health Councils (VHCs);
- Training of midwives, feldshers and physicians as first line community health care providers to improve quality of care and case management;
- Strengthening the DHA’s capacity to use health information, integrate services with community-based facilities and facilitate processes that encourage communities to engage in health decision-making;
- Strengthening Mercy Corps Azerbaijan’s involvement in health, child survival and global health programming, as well as contribute to international child survival programming.

Progress by Intervention Area

During the initial stage of the CS project, the senior staff focused on training central level and field staff and education of community members in the focus villages. This training of the field staff –

the Mentors and Mobilizers (M/M) – by project staff is what prepared them for their roles as primary implementers of community activities for local villagers. Men were selected as educators because it was culturally unacceptable for women to work outside the home or travel between villages. Other field staff that has been trained, primarily by the Mentors and Mobilizers, includes the Community Health Educators (CHE), who are couples working closely with Village Health Committees (VHCs) in focus villages. Their job is to conduct house-to-house education, mobilize women for mother's group meetings, assist with the group education and follow-up with home visits to mothers in the community. The woman CHE have primary responsibility for educating women in the homes, and the man, generally a husband, brother or other male relative to the woman, accompanies her and discusses women's and children's health issues with men in the household.

The M/M division of labor was that the Mentors (who are medical doctors) coach and upgrade training of the local health care professionals and the Mobilizers (who are university educated professionals in other fields) work with and educate the Village Health Councils (VHCs), Community Health Educators (CHEs) and community members. Both Mentors and Mobilizers have gained experience through different community education activities that made use of the new skills they learned through project training (see section B3, for details). The activities are organized in such a way so that in addition to the upgraded training and education given to district health professionals and selected CHEs, the M/M follows-up with on-the-job coaching and supervision in the focus villages. The M/M teams have also been very active in formation of the Village Health Councils, coaching them on their roles and working with them in the formation of women's groups. The CHEs are members of the VHC and work with them to actively recruit women for meetings. The CHEs have made maps of the village which include each family, its members and their health risk status. They keep a registry of village births and deaths and report this to the M/M on a weekly basis. This information is forwarded to the HIS Coordinator.

After the mid-term evaluation, the project focused on expansion of activities in Lerik District and on the non-focus villages. The project expanded rapidly from work in 116 primarily focus villages in Yardimly and Masalli through June of 2004 to work in 243 focus and non-focus villages in Lerik, Yardimly and Masalli in 2005, thus reaching a total of 283 focus and non-focus villages through May of 2006.

By the Mid-term, there had been substantial improvements in Yardimly and Masalli as was documented through the KPC survey. Given the logistical difficulties the project encountered in reaching the 83 focus villages that they were then working in, the CSP staff were dubious that they could maintain these gains if they were to expand so drastically into the large number of remaining villages in Lerik during the last two years of the project. Although all the results may not have been as high, there were still significant gains and most of the targets were met or surpassed. As can be seen from the results of the final KPC survey (see table above and annexes) and its comparison with the baseline and mid-term KPC surveys, there have been substantial gains in knowledge and practice during the life of the project. Below are some of the key findings.

Pneumonia Case Management

At the final evaluation it was found that 100% of mothers interviewed in the project districts were able to recognize danger signs of pneumonia and had sought appropriate treatment for their children with cough and rapid breathing (or chest in-drawing). By the end of the project, 10,139 (2004-2006) and 5,300 women (2002-2004), a total of 40% of WRA in the project area, had been trained to recognize and manage respiratory infections. The final Health Facility Assessment found

that 89% of facilities reviewed had acute respiratory management protocols, which none of them had at the baseline.

The project HIS data indicate that although the major cause of child and infant deaths is still attributed to acute respiratory infections (ARI), the numbers are greatly reduced.

The KPC did find that there was no change in baseline and final percentages (3%) of the proportion of mothers who reported that both cough and rapid breathing were danger signs of childhood illness. However the staff concluded that there may have been some confusion in the way the question was asked on the three KPC surveys, as 37% of mothers reported that either cough or rapid breathing were danger signs.

Control of Diarrheal Disease

Of children in the project area with diarrhea, 61% were treated appropriately at home at the time of the final evaluation, compared with 11% at the baseline. Also, 69% of mothers continued or increased the amount of breast milk given to infants during diarrhea episodes of the previous two weeks (compared with 52% at baseline). In addition 70% of caretakers were able to recognize at least one symptom of dehydration. Although it was not asked at the baseline, the final KPC found that 71% of mothers of children under two years old wash their hands before food preparation, before feeding children, after defecation and after attending a child who had defecated. During the project 20,537 women, 53% of all WRA in the target area, were educated to recognize danger signs of diarrhea and appropriate home management of diarrhea. The final HFA survey found that 100% of facilities had diarrhea management protocols.

These findings, together with comments by health providers and community members, indicate high uptake levels for the education provided by this project, and that this education did in fact result in substantial behavior change at the household level. Project participants consistently remarked on a noticeable decrease in child morbidity related to diarrhea, and attributed this decrease to better home management.

Maternal and Newborn Care

In the CSP districts, 70% of pregnant women attended at least two prenatal visits (32% at baseline) and 45% of women were aware of two or more pregnancy-related danger signs (compared with 5% at baseline). The KPC data indicate that the number of children zero to 23 months whose births were attended by skilled professionals rose from 69% to 89% over baseline. Between 2003 and 2006, over 10,418 women were educated about safe motherhood including recognition of danger signs during pregnancy, delivery and post partum.

Unfortunately because the government insists that there is no maternal mortality and penalizes individuals who do report it, it was very difficult to obtain any statistics about maternal deaths in the project districts.

Nutrition

The final KPC found that 83% of women in the project area immediately breastfed their infants after delivery, compared with 15% at baseline. The proportion of infants zero to five months old who were exclusively breastfed within the previous 24 hours also increased from 14.5% at baseline to 53% at final. By May 2006, 10,291 women were educated through women's group discussions about the importance of early initiation of breastfeeding and exclusive breastfeeding.

Although the project did not focus on complementary feeding or other aspects of child nutrition, it is interesting to note that KPC data show a drop in percentage of children zero to 23 months of age who were underweight from 11.2% at baseline to 8% at the final. The evaluation team attributes this decrease to improved exclusive breastfeeding rates.

Child Spacing

The final survey found that 83% of women knew of one natural family planning method. In addition, the proportion of women using modern contraceptives, among those not desiring children in the next two years, increased from 4.6% at baseline to 24% at the final. Likewise, the proportion of children aged zero to 23 months who were born at least 24 months after the previous surviving child increased from 37.6% to 43%. Between 2004 and 2006, 12,524 women have received education about child spacing, primarily LAM and the Standard Days Method, from project staff. The final KPC also documented that the percentage of health professionals providing appropriate family planning services to clients at health facilities increased from 0% at baseline to 100% during the final evaluation.

The final evaluation team found many women expressing interest in and requesting family planning methods. Although many women stated that they preferred modern methods such as the IUD, pills or condoms, most indicated they had learned the Standard Days Method (SDM) and used it as a back-up, because the supply of modern methods is unreliable. Although USAID is working on improving supply through its Reproductive Health Project, there is a question about whether contraceptives will continue to arrive in the remote project area villages once Mercy Corps is no longer there to facilitate distribution.

A study of the SDM conducted by the project at the suggestion of Georgetown University, found that although there was a core group of SDM users who really liked the method, there were others who preferred a calendar method that they had been taught previously. The calendars they use are quite decorative and the project staff wondered if the SDM beads might be used more frequently if they were designed with more attractive materials.

Integrated Management of Childhood Illness (IMCI)

Although there was some delay on the part of the MOH in the implementation of IMCI training at facilities, the CS project actively advocated for this together with other NGOs and supported the training for health facility staff in specific districts. The training was conducted by trained MOH staff shortly after the mid-term in 2004. The CS project supported training of several health facility staff members from the project districts.

Despite the delay in IMCI training, the KPC survey found that 87% of mothers in project districts were able to identify at least two signs of childhood illness that indicate a need for treatment, compared with 55% at baseline. The final KPC survey found that the percentage of physicians and fieldshers that applied IMCI protocols increased from 0% to 89% by the end of the project.

The final evaluation team included a WHO IMCI Master Trainer who had participated in the adaptation of the WHO protocols for Azerbaijan and trained the MOH IMCI trainers in 2004. The evaluation team found that the health facility personnel were not only happy with the IMCI training received but mentioned it as potentially the most useful of all the training. It was useful because it provided specific user-friendly guidelines on diagnosis and treatment, particularly for providers who had not specialized in child health. They particularly appreciated that the protocols had specific

recommendations for treatment of different childhood diseases using drugs that were commonly available and less expensive. The concerns raised by the team were that not all providers interviewed had received IMCI training, and that some of the providers interviewed were not as diligent about sticking to the drug protocols as would be hoped. The CS staff explained that not all providers had received IMCI training because it had only been offered during selected times in each of the districts and not all providers had been able to attend. The project did not have resources to provide more than one complete IMCI training. Staff also explained that although there had been a follow-up session in two of the three districts, because the MOH had not fully adopted IMCI, there was no system for on-going supervision and practical review of standards. As a result, adherence to the protocols was not as rigorous as needed.

New Tools or Approaches

Perhaps the most interesting new approach used by the CSP, which is discussed in detail in other sections of this report, is the use of male Mentors and Mobilizers to teach women's groups. Given the closed nature of the communities in the project areas, it was not possible to employ women to cover health activities in multiple communities. However, through extensive training and coaching, the CSP senior staff was able to prepare the male Mentors and Mobilizers to teach sensitive subjects such as breastfeeding and family planning to community women. As a first step, the M/M teams began by teaching the health subjects to the men and older women in the communities that they approached. After a time, the male community members realized that the information was really important for mothers and began sending their wives and daughters to the education sessions. The elder women support this, as they too came to understand the importance of the health messages for mothers in their communities. The M/M teams were also supported by health education couples (CHEs) in focus communities.

Useful tools developed by the project include lesson plans for teaching community IMCI. The plans were as extensive as those used for training professionals and included content, objectives and materials for working with community groups.

B3. Results: Cross-cutting Approaches

a. Community Mobilization

One of the strongest accomplishments of the project is its community mobilization activities. When the project began working in Yardimli and Masalli, the M/Ms concentrated their efforts on forming VHCs. Each team began by approaching the formal and informal village leaders. These were the Executive Committees and municipal representatives, which are formal government leadership structures; and the informal leaders including the Aksakhals, Mullahs and Seyds, who are mostly religious leaders. The senior staff instructed the M/M teams to include all Mahalas (geographic neighborhood structures) and Tayfas (cultural-based clan structures) in the community though most had only one Mahala per village because of the small size of the villages. M/Ms asked these leaders to help organize community meetings where the program goals were presented and the community was asked to elect members for the VHC. These committees were made up of local leaders and the designated health educator couple, always a man and a woman who were usually related. Inclusion of the Tayfas members was strategic because these form the basic community network and if some members benefit from the CS activities, they will tell the other members of the Tayfas and those individuals will begin coming to the meetings as well. The CS staff taught the CHE and VHC

members that they should implement the recommended health practices within their own families first, and then others would follow their example. They called it the CS “positive deviance” strategy.

The M/M field staff actively supported formation of the VHCs in 78 villages where members have been elected by community members. The project developed a Policy Guideline document for the formation, selection and appointment of the VHC. In addition Mercy Corps signed Memorandums of Understanding with each of the VHCs, clearly describing the complementary roles and responsibilities of the communities and the project.

In villages where there was no CHE couple, the M/M team would work through the traditional community structure to organize and support the VHC activities. They also involved the health facility personnel, who were always included in the VHCs as non-voting members. The health facility staff provided leadership on health issues and the VHC was a useful network for keeping abreast of community health issues.

The VHC members and CHE couples have been very effective in organizing women’s education groups in the communities. They also help to alert women of the upcoming meetings and make sure the women attend. The M/M commented that initially it was very difficult to get women to come to the meetings and that the VHCs helped tremendously in this effort. Though they say that at times it is still difficult to have the groups meet regularly or to find regular meeting places. Education focuses on teaching caregivers to recognize danger signs of diseases and offer appropriate home management and care giving during illness.

The VHCs also organize the health festivals held periodically in the different villages. During these festivals, children conduct performances that address different maternal and child health issues in their villages. There are puppet shows, concerts and question-and-answer sessions. Some of the local officials make presentations and project staff supports the efforts with “prizes” and other assistance for festival activities. Initially when the project began supporting the festivals, they contracted with a local theater group in Masalli to provide “educational theater” in the communities. However, the staff later decided that it would be more cost effective and useful to have the community members themselves develop the health messages and performances. To date, there have been 64 health fairs in the project districts.

During the fall of 2005, the CS project applied the Rifkin model to assess the VHCs’ sustainability potential, and where they currently rested on several dimensions of sustainability. The results ranked 62% of the VHCs in the promising medium category, meaning that they are progressing in identifying community needs, mobilizing available resources and effectively leading and managing community members. Regarding the project objective of having VHCs that successfully manage at least one health related action; the sustainability assessment found that most VHCs had managed at least two: distribution of health education materials and mobilization of women to participate in education meetings.

The project staff has had success in breaking down gender barriers in the villages where they are working and creating regular access to the women’s groups. One of the major barriers that the project encountered was the severe restriction on women’s mobility and decision-making authority. The all male Mentors and Mobilizers were able to first gain the respect of men in the communities, and then received their permission to address the female populations. The project required that 25% of VHC members be women. But now women make up 30% to 40% of the VHC membership and are actively taking part in gathering their peers together for education sessions. In one instance, the women have taken over the VHC and told the men that they are no longer needed

on the council! While this is less than ideal in terms of community participation and gender inclusivity, it is certainly an example of increased decision making authority by women in that community. This particular VHC is now engaged in establishing itself as an NGO.

The evaluators were told several times that VHC meetings were the first instance in which all sectors of the village structure met together to discuss common issues. One of the Mentors commented during interviews that now people in Yardimly, Lerik and Masalli believe that health education can make a difference. They did not believe this when the project started. People always wanted more doctors and hospitals in order to be healthy now they realize there's a new way to maintain their health and that it can be done through their own efforts. Several of the VHCs have become very active and are interested in addressing other issues facing their communities beyond health issues. To date 10 VHCs have established community funds to meet local needs. Several communities have been asking Mercy Corps to provide them with more training and education on income generation and community mobilization. Unfortunately, Mercy Corps has not had the resources or mandate to do this.

Lessons Learned: Perhaps the most critical lessons learned in the area of community mobilization was the importance of having male community specialists whose activities benefited women's and children's health. Project staff believes that in this conservative society, having men leading the maternal child health (MCH) effort guaranteed at least 50% of the project's success.

The project staff also commented that when they began the mobilization activities, some of the individuals that were attracted to the VHCs and other community activities were mainly interested in accumulating resources for themselves. These individuals left early. Those that stayed with the project had a "fire inside" and went on to develop themselves and many of them have gone on to become elected officials. Many individuals who were not traditional leaders have risen to positions of leadership that might not have done so without the project.

The project staff has also learned that the women from these regions are not shy about talking or participating in community events once given the space to do so. In fact, they have become active lobbyists for their children's health. Staff also realized that contrary to previous impressions, the men really were deeply concerned about the health of the women. They just didn't know how to improve their health conditions other than taking a strong protective role.

Demand and Plans for Sustainability: Unfortunately because Mercy Corps will be closing its operations in the Southern Region, there is little likelihood that they will be able to maintain activities once the CS project ends in September 2006. Although the communities have made great progress during the two to four years that the CS project has been in their areas, there is still work to be done. According to the sustainability assessment (Rifkin model) mentioned above, only 8% of community VHCs were at a point where they could be considered self sufficient and able to move forward without outside assistance. Although the bulk of the VHCs (62%) are well on their way to developing sustainable activities to maintain themselves, they still need some outside guidance and direction.

During the evaluation several possibilities for further support were being explored by Mercy Corps staff. Possible support may be available from other USAID funded projects that may begin operating in the region, partially because of all the progress that has been achieved under this cooperative agreement. ACTS Georgia, who participated on the evaluation team and also has a CS project in Georgia, is also interested in opening a chapter in Azerbaijan and is exploring ways that they might be able to extend support for project activities.

In communities where the VHCs have strong linkages with municipalities, there is a good possibility that health structures and activities will be sustained. The same is true of communities where the health facilities are established and actively providing leadership. In other communities, they may not have these links but there are interested individuals who value what they've learned and will maintain the activities. Mercy Corps has made an effort to inform the communities that it is really up to them to make things happen regarding their own development and that it is unlikely that another organization is going to come and do this for them. Of course, the evaluators were told everywhere that the communities and the district health teams really want Mercy Corps to stay there. They really value what Mercy Corps has helped them achieve and believe they need a little more support for them to put structures in place that will allow the changes to become more permanent.

b. Communication for Behavior Change

Most of the project communication activities have included health festivals held in the villages, education of VHCs and women's groups and distribution of printed leaflets, posters and flipcharts. As mentioned above, the project initially contacted a theater group to present health messages at festivals but later decided to have community members perform activities. According to the Mentors and Mobilizers, sponsorship of the health festivals helped a tremendous amount in their achieving access in the communities.

During the first year of the project the staff developed, printed and distributed information leaflets on the following five subjects:

- Description of the Child Survival Project
- Essential Drugs
- Vaccinations
- Acute Respiratory Infections
- Diarrhea Home Management
- Safe Motherhood
- Family Planning

While the Mentors have mainly worked with the health providers, the Mobilizers have worked with the VHCs and women's groups. The Mobilizers use project developed posters and flipcharts to generate discussion about project intervention areas. Then after the session, they distribute pamphlets with key messages of what was discussed. The Mobilizers are very proud of what they have achieved in educating the village women and noted that when they began working, the women would not look at them or speak. Now they can't get them to stop talking! Many of the women admitted to the evaluators that they enjoyed the meetings not only for the education but also for their social interaction value. They don't often have opportunities to interact socially in the community. During the final KPC survey when field testing the questionnaire in a non intervention village in Masalli, the staff discussed the project activities with some of the men there. When they asked the men if they would send their wives and daughters to health education meetings they said "No." When asked why not, the men responded that the women needed to stay home and take care of them. The staff was surprised to see such a traditional perspective given the village's proximity to intervention villages. So even though some neighboring villages (particularly in Yardimly and Lerik)

are learning about the project and asking to receive the same education, it is clear that there are still communication barriers between men and women.

At the midterm when asked about difficulties, the M/M responded that it was difficult to teach village women the lessons, that it required a lot of repetition. They blamed this need for repetition on the women's education levels. However, the evaluators found that many of the women had at least a high school level education. By the time of the final evaluation, the M/Ms seemed to have mastered the adult education process and received rave reviews from the communities.

The project has also developed a number of brochures on the six intervention areas to be handed out at the education sessions. According to the M/M, these brochures are not self explanatory and require that the M/M explain them to the participants, particularly the early ones, which were revised after the mid-term. According to the project staff these early brochures were not pre-tested before distribution and appear to have a lot of writing and explanation rather than succinct messages. Later in the project and with the help of consultants, the project developed education modules and brochures on Breastfeeding and Safe Motherhood. The project staff particularly liked the Breastfeeding training and materials development process. Those brochures were pre-tested and are more focused on key messages. Likewise the Safe Motherhood pamphlet is well received. The revised brochures have better more colorful designs and printed key messages. All the materials appeared to be liked by the communities. The CSP also included pictures of local people on the materials which people liked. The written messages were clear and printed in both the Latin and Cyrillic alphabets.

There are no local mass media activities in the districts. The project found that there are no local radio or TV stations. In follow-up to the mid-term recommendations the project arranged to make regular contributions to the local newspapers highlighting project activities and health events. Recently when the government ran a measles campaign for adults which was not as successful as anticipated, they discovered that coverage had been much better in the southern districts. When the MOH investigated why so many individuals knew where to go they were told that most found out where to go for the vaccinations by reading it in the newspaper. The CSP had included an article about the campaign in their regular articles. Some of the communities themselves have printed stories about Mercy Corps' activities in the region. The newspaper articles seem to be useful for reaching men in the villages whereas the women appear to be reached more through the project brochures and posters.

The project has also made use of video tapes on family planning during the last two years of the project. This has been a useful audiovisual aid for women's group and community education sessions. The calendars with pictures of local people and health messages were also very popular.

Because the village health educators keep a registry of births and deaths and report it regularly to the project, the project is well aware of any changes in health status. In addition the project conducts sentinel surveillance activities every six months. During the first year, the staff noticed a high number of newborn deaths in two villages. They notified the VHCs of this problem and they and the communities asked the project to retrain the local midwives. The project also expanded its safe motherhood education in these areas.

Lesson Learned: According to the staff, the most surprising lesson learned by the project is that men really are very concerned about the health of their women and children, although this attitude is more a reflection on the senior staff than on the men. The challenge was helping them understand

what they could do to improve conditions. Once the CSP was able to convince them of the project's benefits, they were very supportive.

Another lesson stressed by the staff was the importance of the extensive training provided to the M/Ms by senior project staff. The project devoted a considerable amount of time for training the M/Ms and included role plays, team building and group teaching exercises as part of the training. The evaluators concluded that this extensive training may be responsible for the successful job performance among the M/Ms as well as accounting for the fact that none of them have left the project throughout the entire five years.

An important lesson learned was that the Mentors, though more knowledgeable technically (since they are doctors), did not make the best community educators. Their language was too technical and they did not spend enough time explaining the health concepts. So after the first year, the CSP switched roles and had the Mobilizers teach with Mentors as technical back-up. The M/M teams learned use a less didactic teaching style in favor of discussion-based learning sessions using picture based teaching aids such as the flip charts and posters. Cross visits with other projects in Tajikistan and other parts of Azerbaijan were also helpful. They learned how other projects had dealt with and overcome similar circumstances to those encountered in the CSP region and became inspired to try new approaches.

Sustainability of BCC Changes: When the evaluators asked villagers whether they thought they would continue with their healthy practices, they overwhelmingly responded that they would. The CS staff also believes that the behavioral changes will continue after the CSP ends. They see that people now know how to take care of their children's health and have seen positive results. They know through their improved health and the HIS reports given to the VHCs that the project has worked and therefore they will maintain healthy practices.

In villages that have improved their maternal and child health behaviors, their neighboring villages see the progress and are encouraged to try the same practices. When the evaluation team visited the Yardimly referral hospital, they were told that they are seeing fewer dehydrated children now. Now a majority of women start breastfeeding immediately rather than waiting the customary three days. In the mothers' group meetings, a few of the mothers commented that they thought their younger children who had been breastfed early were healthier than some of the older ones who had not been exclusively breastfed.

The BCC activities were monitored through the standard monitoring and supervision system used by the project (see section C3). This included regular planned and surprise visits to project villages.

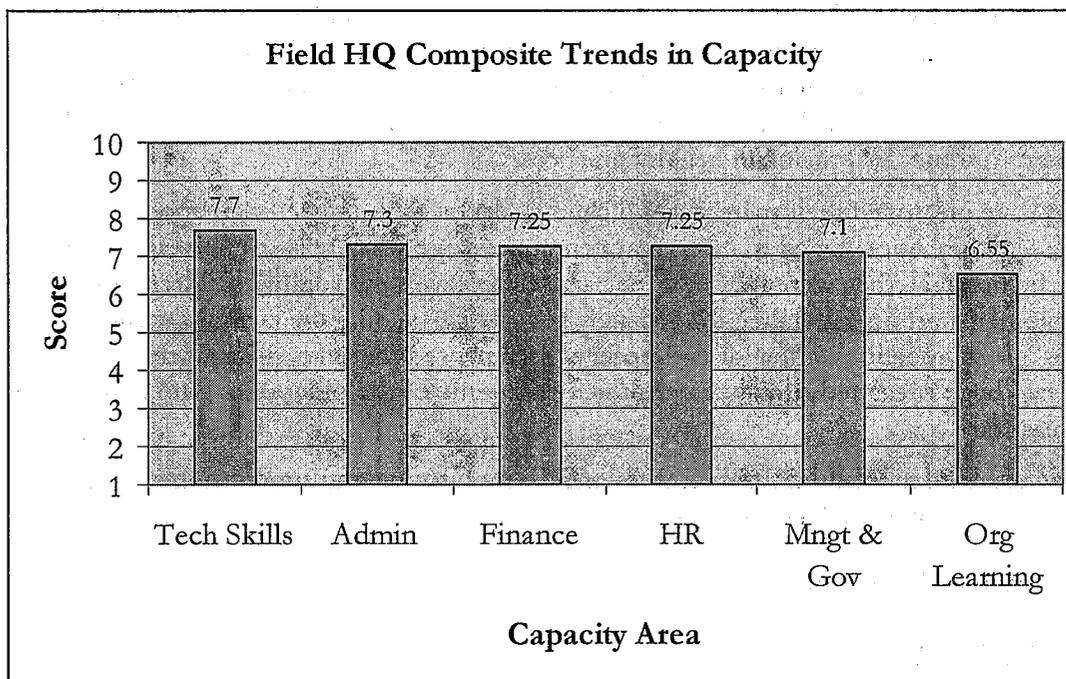
c. Capacity Building Approach

Strengthening the PVO Organization

The fifth, and final, objective of this Child Survival grant was to increase Mercy Corps' capacity to implement highest quality maternal and child health programming, over the life of the grant. To track these capacity improvements, Mercy Corps undertook two Institutional Strengths Assessments; the first in 2001 to measure a baseline of the agency's capacity, and the second in 2006 to compare to the 2001 measure, look at areas of improvement and identify areas of new or ongoing weakness. The 2006 ISA was undertaken without support from an external evaluator or facilitator; this section the evaluation report was written by HQ backstop staff as there was neither time nor money to contract an external consultant to facilitate and analysis the agency's work on this

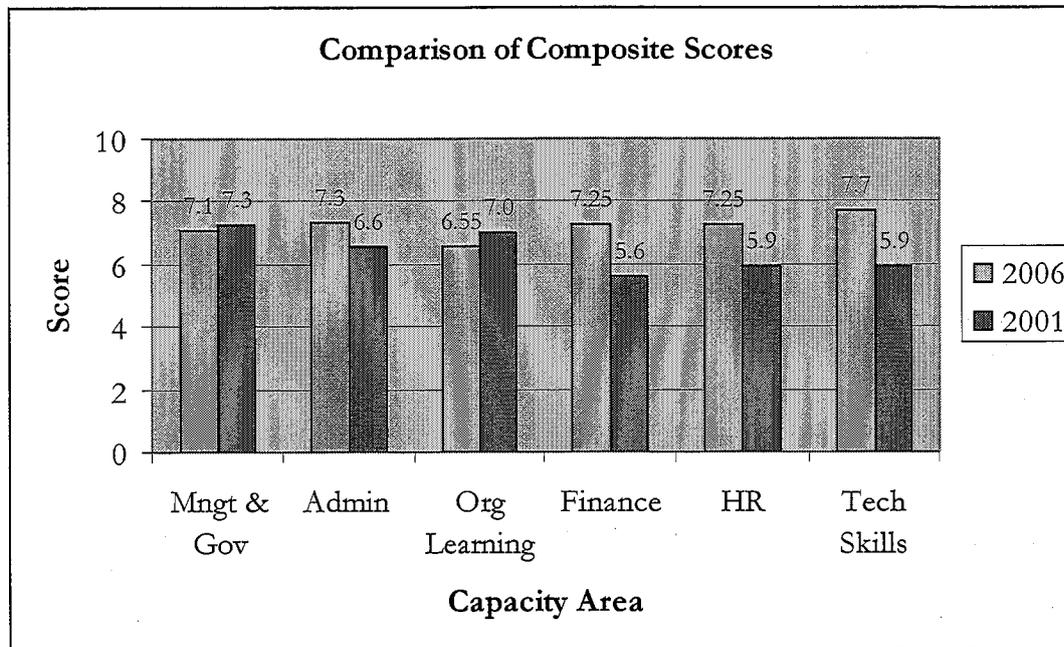
objective. Between 2001 and 2006, the depth of understanding of public health programming among Mercy Corps staff has deepened, and Mercy Corps have a more sophisticated team today than it did in 2001. As a result, respondents to the 2006 ISA may be more demanding of themselves and the agency, and more open to self-criticism. In addition, Mercy Corps' overall health portfolio is larger, and more diverse, with more grants in more offices and proportionately fewer of these grants from CSHGP. The greatest increase in capacity between 2001 and 2006 is seen in technical skills and knowledge, which is exactly where one would want to see the greatest improvement.

Since undertaking an Institutional Strengths Assessment in 2001, Mercy Corps has made tremendous gains in key capacity areas, particularly finance and human resources. The table below describes Mercy Corps areas of highest to lowest capacity based on the results of the 2006 ISA. It is important to note that in no area does our capacity fall below the critical threshold of six (6), which indicates that the PVO being examined is in serious threat of underperforming in a particular capacity area. While technical skills and knowledge and administration infrastructure and procedures remained the areas of greatest capacity, our capacity in finance moved from lowest capacity in 2001, to third highest capacity in 2006. This reflects a tremendous investment by the agency in strengthening both field and HQ finance systems. The other "big mover" between 2001 and 2006 is human resources, which moved from fifth position, to forth strongest capacity area.



The table below compares composite scores for Mercy Corps' capacity in each area in 2001 with a composite score from 2006. These scores are calculated as the average of both field and HQ responses to questions in these sections. Overall, our capacity increased or remained about the same in the capacity areas of management and governance, administration infrastructure and procedures, finance, human resources and use of technical knowledge and skills. A slight decrease was seen in organizational learning, the only capacity area to demonstrate a decrease. A possible explanation of this decrease is that in 2001, Mercy Corps did not have an organizational vision for what it meant to

be a learning organization. Today, in 2006, we have a joint vision, and are thus more aware of current shortcomings in achieving that vision.



One area of the ISA which was not fully repeated in 2006 was evaluation Mercy Corps' capacity in key technical areas (question 68 of the ISA Self-Assessment Guide). Interestingly, aside from backstop staff who participated in the ISA, participants did not feel qualified or able to score Mercy Corps' capacity in specific technical areas of child health. Even participants who are heavily engaged in health programming were not able to articulate Mercy Corps capacity in health programming to the level of technical interventions.

Based on these comparisons to 2001 and on the detailed analysis of each capacity section of the ISA, a primary focus for the Health Unit at Mercy Corps needs to be **eliciting health project participation in organizational learning activities and dialogue within the agency.** In addition, the following specific areas need more attention from Mercy Corps:

- Health backstop staff and field managers regularly receive training in project/program management
- Strategies and tools to foster substantive involvement of local partners and communities in design, monitoring and evaluation of projects/programs
- Translation of key project documents into national languages for use by local staff, local partners and community members
- Information technology training for field managers
- Facilitating field staff to access all resources and capacities existing at HQ in a variety of technical areas including health facility assessments, organizational capacity building, behavior change, monitoring and evaluation, sustainability, operations research and qualitative research. The field is largely not aware of what support is available in these capacity areas.

- Timely recruitment of field staff for new and ongoing projects and strengthening policy and practice around retention or “bridging” of quality staff between grant cycles
- Offering more opportunities for field staff to provide feedback on the performance of health backstop staff
- Dialogue with field offices on how to make HQ visits more supportive and encouraging for field staff, including scheduling annual visits with all countries with health programming

Conclusions:

In 2001, Mercy Corps undertook analysis of its institutional capacity in two technical areas: health and civil society. These reports, along with observations and field feedback from its first leadership conference (Edinburgh, 2000) sparked a series of reforms and changes within the operational structure of the agency which have contributed to improvement in finance, human resources and organizational learning. It is clear from the results of this 2006 ISA that Mercy Corps today has a much improved capacity to successfully manage and implement the highest quality health programs. While communication challenges remain between headquarter health unit staff and field managers, system and procedural gaps that were barriers to performance in 2001 no longer exist. Dissemination of technical information and support is now the greatest challenge facing the agency, reflecting improvements in finance and administrative systems (so that these are no longer the greatest challenges), and the awareness of country offices of the need to invest in monitoring and evaluation, and implement state-of-the-art interventions to improve health. Implementation of this Child Survival grant allowed Mercy Corps’ health backstop staff to undertake guide the agency through two ISAs. These assessments helped shape and measure capacity building efforts within the agency; this grant has strengthened Mercy Corps’ capacity (both internally perceived and actual capacity) to design, implement, monitor and scale-up health programming in different regions of the world.

Strengthening Local Partner Organization

The main implementing partner has been the district level Ministry of Health or Local Health Authority (LHA). At first it was difficult for the project to work with the government. The MOH initially insisted that the project work in the IDP area in the western area of the country. When the CSP explained that they could not do this, the government tried to close it. The MOH called a meeting with the directors of the Local Health Authorities (LHA) from Yardimly, Lerik and Masalli and asked them if they thought they needed such a project in their districts. The Lerik Head Doctor stated they did not need the project, which is why the project started in Yardimly and Masalli and did not go into Lerik until 2004. It is interesting that during the final evaluation, the Lerik Head Doctor made it very clear to the team that he did not want the CSP to end and explained in detail how helpful the project’s support had been to the district. He felt that that the CSP had not had enough time to complete its work in Lerik and that district facility staff and communities still needed more education and training support from the project.

At the beginning of the project, the staff conducted a capacity assessment of the District Health Organization in Yardimly using the Participatory Organization Evaluation Tool (POET). They found that the capacity was low but it left room for improvement through training and the training results have been positive. The facilities were old and decaying and too large for their needs. There was a lack of equipment and supplies and most of the health personnel had not received any training since they began working for the District Health Authorities (15 – 30 years ago). Because the project has publicized its work in Yardimly and Lerik to the central level health officials and other

benefactors in Baku, there have been many visits by donors to the project site. As a result the MOH has felt compelled to support the district health offices in the region. In 2004 it found funds to help rehabilitate the Yardimly facility, it has supplied it with some needed equipment and it is sending more supplies and essential medicines.

Another achievement in the area of partner strengthening has been the establishment of training centers in the District Hospitals at both Yardimly and Lerik. The district MOH offices agreed to provide necessary furniture for the training centers and allow the project to use the facilities for all project activities. The CSP provided basic materials for the renovation and the village members provided the manpower. These renovation activities have contributed to good working relationships with the district MOH offices. It also allows the project to have a free and always available space for training events in the districts.

The project has been particularly successful in generating match funds to improve facilities in the project districts (see below).

The district also has a responsibility to supervise local health personnel at the lower level facilities. In the past the supervision has not been done due to lack of transportation. As project activities developed, particularly IMCI, the project staff facilitated district personnel in making visits to supervise fieldshers and midwives with the Mentors. The project is currently facilitating delivery of needed drugs and supplies to district facilities through an agreement it has with IRD.

Health Facilities Strengthening/Local Partner Strengthening

Perhaps the biggest improvements in the health facilities have resulted from match donations. These donors were encouraged to participate by Mercy Corps' country level staff. During the last two years of the project, four new facilities were constructed and three were rehabilitated through donations from the Japanese government. In addition, eight facilities had at least one room rehabilitated for training, VHC meetings or education purposes. This last was provided through match funds to Mercy Corps from a private donor, Catherine Bunting of Baltimore, Maryland. The improvement in structures has had a major impact on the quality of care in the CSP area. Many providers interviewed commented that although the upgraded training they received was critical for improving their skills and confidence, having a functioning facility really allowed them to apply those skills and helped community members have greater confidence in staff skills. Women were more likely to come to the facilities now that there was a private place for them to be seen; previously they had seen the Doctor in their homes with all their relatives around. Several providers interviewed commented that their status had improved as a result of having a real facility to see patients in and it allowed them to be more effective in lobbying with district health personnel for supplies and medications. Before, when they asked the district office for supplies the officials asked where they were going to keep such materials. Now, they have an answer to this question!

The project also received a donation of several used computers from Stat Oil. Communities in Lerik and Yardimly received two computers each. The communities had to assure that they had trained people who knew computer technology and could teach computer use. In the communities selected computer teachers were available to do this. The communities also had to assure a stable supply of electricity. The communities in Lerik bought generators with community funds to assure this. As a result, the MOE gave these communities more computers; six computers were given to a Ministry of Education youth center in Masalli. The computers are available to the public through the center.

The project has provided training and follow-up on-the-job training through the mentors to the doctors, feldshers and midwives at the district health facilities in the project area. In addition, now the midwives and female community health educators are more active in providing family planning and maternal and child health education in the villages rather than the Mentors and Mobilizers. Also the local health providers are appointed as non-voting members of the VHCs and are active in the health education and other activities.

The biggest challenge in working with the district and area level providers is the strong vertical structure of the government services. District officials are reluctant to make decisions without approval from the central level. As a result, project staff often has to run back and forth between the two levels to get approvals for activities. Although there was a five-year health reform project in the region that was supported by UNICEF and the World Bank, the effort seems to have fallen short of achieving decentralized services.

Regarding sustainability, the project believes that in facilities that have been strengthened, the services will be maintained. They have equipment in place, trained personnel and in many communities the VHCs are working to sustain drug supplies. The VHC is the key link between the health facilities and the communities. Health providers are members in almost all of the VHCs.

One lesson learned by the project is that despite their attempt to provide good quality training, it is difficult to work with the older feldshers who have not really worked much in the last few years and are neither interested in nor required to update their skills. However, because of successful community mobilization and education efforts, some villagers are now demanding that these feldshers start working and providing services. There is a shortage of health providers in these districts and it is difficult to recruit them given the poverty and remoteness of the area, which makes it unappealing to health workers. The previous head doctor in Yardimly lobbied the MOH to establish a nursing school in the area so they could recruit local individuals who would be likely to stay and work in the area. If the MOH had agreed to this, Mercy Corps would have helped organize it. In an unofficial survey Mercy Corps asked families if they would send their daughters for training and they said “yes” if it was locally based.

Strengthening Health Worker Performance

The main strategy used by the project to strengthen health worker performance has been training of district health professionals. The training activities are discussed in more detail below.

The health professionals interviewed by the team talked about what they had learned regarding preventive health practices in the five intervention areas and how important it was. Those that had accepted the use of non-injection medications also talked about the importance of not relying on IVs and injections. All the health workers stated that before this they had not received any updated training since their initial training which was in some cases 30 years ago. Providers also appreciate receiving reliable essential drugs from the CSP. Doctors commented that the large amount of counterfeit drugs on the market has seriously hampered their ability to treat illnesses by destroying community confidence in treatments that they offered.

When the project started, the district health personnel initially mistrusted the Mentors but as time has gone on, they have gained confidence now see the Mentors as their supporters and coaches. Once a month the district authorities hold meetings with the health professionals and Mentors to discuss progress. Even though they are from the project districts, the Mentors are seen as “experts” now because of the training they have received from the project.

Through the project, health facility staff has received a variety of trainings in rational drug use, IMCI, safe motherhood, breastfeeding, family planning and others. However, despite the training that's been provided, most providers have not benefited from all training events. For example, despite the rave reviews by providers that participated in the IMCI training, only about 60% of project area providers were able to attend the 11 day course. It is assumed that the health worker capacity will improve once the MOH formally adopts IMCI and provides the comprehensive training and follow-up supervision. The providers who have received IMCI training really liked it because of the integrated approach, the detailed diagnosis and treatment options described and the clear instructions on how to treat each stage of illness with readily available drugs.

An example of how the training has affected health providers was mentioned by one of the doctors who described how he was called to deal with a complicated delivery in his village. The placenta had not been expelled. The doctor had recently completed safe motherhood and breastfeeding training, so his immediate reaction was to tell the mother to put the baby to her breast. After a short while the placenta was delivered and the bleeding stopped. The doctor said that this was a real testament to the importance and validity of the training he'd received and it improved his confidence.

Another example is that before the CSP, immunization levels in the districts were very low. The providers were given a long list of contraindications against vaccinating children. This meant that most children were not vaccinated until they were over a year old. Now after receiving training from the CSP, the providers adhere to the WHO schedule, and 81% of children are fully vaccinated compared with only 12% at baseline.

The project has been trying to introduce updated standards in the project districts but this effort is complicated by the fact that everything needs to be approved at the central levels. However, with the IMCI training that Mercy Corps and other PVOs sponsored, the MOH is planning to introduce IMCI throughout the country. This will include updated IMCI - related standards and protocols.

Training

Training has been the CS project's core activity and is continuously implemented on different levels. The first level is for project Mentors and Mobilizers who are the primary implementers of activities in the field. The second level is for the Community Health Educators, Village Health Committees and community members who are the primary targets for education activities in the villages. The third level is for the MOH staff including doctors, feldshers and midwives who work in the district health care facilities.

Training for Mentors and Mobilizers

During the first year of the project, the senior staff provided a series of training activities to develop the capacities of the Mentors and Mobilizers to be effective teachers and change agents in the project villages. These training courses included:

- Adult Learning
- Building Leadership Skills
- Community Empowerment and
- Conflict Management

The trained Mentors and Mobilizers provide regular educational sessions for community members, particularly the VHCs and women's and men's groups, in each of the respective villages. In order to be able to deliver appropriate and consistent health messages, all the Mentors and Mobilizers also received training in the following areas:

- Recognition and Management of Respiratory Infections,
- Management of Diarrhea at Home
- Promotion of Rational Drug Use
- Breastfeeding Promotion
- Safe Motherhood
- Child Spacing
- Vaccinations

In addition to the initial training, the M/Ms also have received updated training every year in the different technical areas (see training schedule in Annex). For example, in 2004 they received training updates in ARI, child spacing, immunizations and rational drug use (RDU). In 2005, they received updates on diarrhea, safe motherhood, child spacing, TB and both clinical and household/community integrated management of childhood illnesses (HH/C-IMCI).

The senior staff developed or adapted the training curricula for training the Mentors and Mobilizers (see chart for sources). Based on the curricula, they then developed a series of lesson plans for the Mentors and Mobilizers to use when conducting education in the villages.

Training of MOH Staff

The Health Facility Assessment conducted at the beginning of the project showed that health workers had not received updated training in 10 to 15 years. Likewise they did not have access to updated materials or the internet.

The central level of the MOH decided in October 2002 that it had to approve training plans directed at all levels of MOH staff. This included training being conducted by NGOs. Their preference was that only the MOH training packages and only their Master-trainers be used for the training. The difficulty for the NGOs has been the availability (or non-availability) of master trainers and timely decisions on the part of the MOH to make trainers available.

Despite these obstacles, the project adjusted to this requirement and coordinated with the central level to arrange training of district health professionals through its Master-trainers in all the necessary topics. Only training on rational drug use was organized by the project since the MOH master trainers do not provide this.

Beginning in year two through the present, the district health providers participated in the following training:

- Refresher training on safe vaccination practices and promotion of the national Immunization Calendar. All health providers were trained theoretically and also received practical training during the vaccination campaign. During the first year of the project, all MOH staff in the region, as well as Mentors, received training from the chief epidemiologist from Baku in accord with MOH guidelines.

- As a field test, Mentors received a three-day training on Community IMCI. All the IMCI materials have been adapted to Azeri conditions and the MOH used this as an opportunity to field test the materials.
- Three-day training on Breastfeeding promotion and the Baby Friendly Hospital Initiative.
- Refresher training on Rational Drug use and essential medicines. Doctors are still fond of using injections for most illnesses and this perpetuates a demand on the part of communities. In addition there is an over use of antibiotics because of both over- prescription and patient demand. Although there is on-going training on this subject for MOH staff, there needs to be greater effort placed on this theme.
- During the first year of the project, training was provided by IRD to senior staff on Rational Drug Use using WHO protocols. The CSP trainers then provided the training to 90% of doctors and feldshers in the CSP project sites. Drugs are also provided through IRD to the districts as a donation to the CS project and are dispensed to the health centers by the project.
- Training on child spacing, including LAM and SDM was provided in 2004 and 2005.

The project organized and supported IMCI training for 16 providers in 2004 in Masalli and Yardimly, 34 providers in 2005 in all three districts and 19 providers in Lerik in 2006.

Training for Community Health Educators and community members

The trained Mentors and Mobilizers provided regular educational sessions and group discussion in their assigned communities. The education is targeted to mothers of children under five, though initially the project found it necessary to work with village men and older women including mothers-in-law and grandmothers, first in order to then be allowed access to the younger mothers. The formation of the VHCs was helpful for this purpose as the influential members were able to convince families to send the younger mothers to the women's group meetings.

In each focus village, the project has hired and trained a couple (usually husband and wife or brother and sister) designated by the community to serve as CHEs. They are trained by the M/M team and have responsibility for supporting and following-up on education and promotion activities in the villages. They actively organize women's participation in education sessions. They also provide follow-up education and educational materials during home visits. The M/M teams trained the Community Health Educators in the following areas:

- Home management of ARI including recognition of danger signs
- Home management of diarrhea including recognition of danger signs
- National immunization calendar and importance of childhood vaccination
- Appropriate case management using essential drugs instead of injections
- Promotion of exclusive breastfeeding and early initiation of breastfeeding
- Child spacing, particularly the lactational amenorrhea method and Standard Days Method
- Safe Motherhood
- Tuberculosis

- Household/Community IMCI

After each training session, the CHEs distribute color printed information leaflets with key health messages related to the topics discussed. The take-home printed materials, including posters, are an additional means for disseminating health messages throughout the community. General communications research has shown that one printed document is seen on average by 10 people. As mentioned in the BCC section, the project revised some of the leaflets designed early in the project in order to make them more straightforward and focused.

The project staff, together with the VHCs, organized a number of Health Festivals in order to draw attention to health priorities. Initially most of these festivals were held in Yardimli villages, though later they were also held in Lerik. During festivals, all community members had an opportunity to participate in health related events and activities including listening to health messages through question and answer sessions and performances by village children; galleries of pictures drawn by village children on health topics, and different health focused games. These festivals became very popular because they are among the only community-wide where women and children play active roles. Staff reported that women and children respond to the question and answer sessions held during Health Festivals, demonstrating they have learned the risk factors associated with different maternal and child health problems.

By the time of the mid-term in 2004, more than 26,000 community members participated in CSP education activities. Between the mid-term and May 2006, 57,331 community members received education through the CSP throughout the project districts. Thus, after the mid-term when the CSP stepped up its efforts to expand into Lerik and to reach larger numbers of non focus villages, they actually reached more than double the number of community members than they had during the first half of the project.

Please see training tables in Annex for details about people trained and training topics covered.

Although the MOH and other PVOs have no plans for follow up training or supportive supervision of providers after the CSP closes, Mercy Corps is confident that the Mentors and Mobilizers who live in the districts as well as the health facility staff who received the training will continue to use their new skills and knowledge.

d. Sustainability Strategy

To date the project is reasonably on track with its sustainability plans as outlined in the DIP. The following points outline its current sustainability status of project indicators:

- Appropriate care giving and seeking behaviors among target caregivers: recognizing danger signs and other improved family practices. *According to the final KPC survey and sentinel surveillance surveys, there is good evidence of improved care giving practices for childhood illnesses and maternal care such as ARI and CDD, safe motherhood, breastfeeding and contraception as well as immunizations (see annex and section 1).*
- Improved quality of services provided by physicians, feldshers and midwives: increased capacity of health staff to diagnose and treat using international standards (WHO). *To date, over 300 health professionals have received training from the project. The final HFA revealed that three district facilities now offer all services within the CSPs technical intervention areas; personnel have received training; diagnostic and treatment guidelines are available in CSP technical areas; and essential drugs are available in most facilities. All the health professionals interviewed commented on how much the training had improved their performance. When*

the IMCI training is fully implemented in the districts, there will be additional focus on health staff performance according to WHO standards.

- *Institutions empowered to develop and sustain systems for promoting change in positive health behaviors. There is some progress in this area, as mentioned in other sections of this report. About 70% of the VHCs in the project districts support more than one community health initiative; have become active in negotiating with health facilities regarding health needs; and are actively organizing community events and women's groups around health concerns. Also, VHCs are now acting as oversight bodies for community health and so far, 31 VHC members have been elected to municipal office thus demonstrating the strengthened relationships between VHCs and local government. By selecting and training Mentors and Mobilizers who live in the target districts, there is now a pool of trainers in each district.*
- *DHA negotiating for their needs with the central MOH and potentially seeking external funding in addition to central appropriations. Although there is no evidence of the DHAs seeking external funding apart from the central MOH, there is evidence of progress being made in the districts' abilities to get more support from the central level MOH. The CS project has brought a focus of attention from outside donors and central level MOH officials because of the publicity that the project generates among donors. As a result, the central MOH is paying more attention to the districts. Funds have been made available in Yardimly to paint and rehabilitate the obstetrics-gynecology and the pediatrics wards. In addition, extra equipment is being provided to the district hospitals in all the CSP districts.*
- *Successful elements of the CSP replicated by MOH and other health agencies in Azerbaijan. An example of this successful replication is the organization of a mass measles campaign (see Section 1 for details) as a result of measles cases in Yardimly. The project staff together, with district and central MOH staff, immunized the whole district of Yardimly in 10 days, ensuring fully vaccinations were provided, not just measles vaccination. When other districts and NGOs heard about the effort, they replicated. Finally, and perhaps most importantly for creating a path to improved child health in Azerbaijan, the CSP areas were the first to implement all three components of IMCI – facility, community/household and essential drugs. This is being studied by the central MOH and WHO to determine which aspects of the experience can be scaled up to the national level.*

Another contribution to sustainability is the composition of the project's staff, which is all Azeri nationals, except at HQ. The project used expatriates only as temporary advisors during the start-up period, and consultants for strengthening critical technical areas during implementation or for evaluations. Ultimately, this adds to an enhanced managerial and technical capacity nationally and increases a currently small national pool of community-based health experts.

Other sustainability goals planned and discussed in the DIP have not happened, or will not happen before the project closes. These include training for DHAs and communities on how to conduct fund raising activities. There is demand for this in some of the communities and they have asked Mercy Corps for more training but unfortunately neither Mercy Corps nor other agencies have income generation or fund raising projects working in the project districts. Mercy Corps made strong efforts to interest other agencies in the project districts. During the final evaluation USAID/Baku indicated that they were talking about the project opportunities with other USAID contractors that might be interested in working in the region. ACTS Georgia, who participated on the evaluation team, also indicated that they would be interested in expanding their activities into Azerbaijan and in providing some support for the CSP activities after USAID support ends.

Although the project has not phased out completely from focus villages, it did encourage the village structures to take over the coordination of health activities. Ultimately, this will prove how sustainable the VHCs are. The project has not really developed its exit strategy. Until the fall of

2005, the staff had intended to prepare another CSHGP application to continue activities in the region. But Mercy Corps made a decision to drastically reduce its presence in Azerbaijan so is not able in continue support for the CSP activities. It was only after this decision was made that the staff made a concerted effort to inform the CSP communities of Mercy Corps' withdrawal from Azerbaijan and the need for them to assume responsibility for sustaining activities.

In December 2004, the Project Director attended the Child Survival Technical Support Plus (CSTS+) "Sustainability Skills Building" workshop. Then in 2005 she extended the sustainability concepts and training to the CSP senior staff and they decided to conduct the same workshop with the major CSP partners: the DHA, local authorities and community members. The major conclusions of the workshop were that 1) the authorities and communities were very supportive of the CSP activities and asked the project to apply for an extension; 2) Mercy Corps suggested, and Yardimli district offered to pilot, the idea of forming an oversight "Health Advisory Committee" for each district to advise the DHAs. This committee would be composed of community VHC members; 3) the project presented its "sustainability dashboard" which outlined the progress being made in the districts in six sustainability areas. The participants analyzed steps to take to best strengthen the current status of their sustainability indicators, and proposed the development of a local NGO that could take over during the final year of the project. Unfortunately, the district Head Doctor who had been most supportive of developing and piloting the advisory committee was replaced, and the effort has come to a stop. For the same reason, the CSP was not able to help VHCs and communities develop into local NGO.

Initially, the CSP had planned to phase out the Mentors and Mobilizers in Yardimli during year four, but because there was still much to be done with the non-focus villages and because their role had been so important in achieving results, the staff decided to keep them on until the end of project.

Cost recovery pilot programs are not going well in Azerbaijan, and Mercy Corps has not pursued this in the CS project. The MOH stopped officially charging for services, though health providers often require under the table payments for services. The CSP considers that it's most sustainable impact will be through the behavior changes resulting from the project interventions, mainly through continued education of improved health practices and utilizing the new community structures such as the VHCs and women's groups.

As discussed in the community mobilization section of this report, with the improved quality of services and education activities, there has not only been an increased demand for preventive services, families now actively seek out the providers for preventive services.

B4. Results: Family Planning and Tuberculosis

This grant did not include family planning or tuberculosis interventions.

C. PROGRAM MANAGEMENT

C1. Planning

The three senior staff that makes up the project planning team include: Uma Kandalayeva, Project Director; Khuraman Hasanova, Training Coordinator and Field Coordinator and Afat Mammadova, HIS Coordinator. Until the fall of 2005, there was a fourth staff member who was the Field Coordinator, Tahir Hajiyev, who left to take a position in Baku with the MOH. Around that time, Dzamila Dzarrahova, who was the HIS Coordinator left to take a job with UNICEF.

At the beginning of the project the DIP was prepared by the Project Director, the Mercy Corps Health Coordinator and the headquarters backstop. The team spent a lot of time in separate planning workshops with Head Doctors, obstetrician-gynecologists, pediatricians, and other health personnel defining problems, needs and deciding what needed to be done. The DIP team also conducted several formative research activities examining behaviors and beliefs about newborn and child care.

Originally the project had planned to work with UNICEF and UNFPA as partners in the immunization and child spacing/family planning areas. Around the time of the DIP preparation, both UNICEF and UNFPA decided not to work in the target area. This may have been the result of realizing that the government did not want the CSP to work in the south at that time.

Much time and effort was spent on DIP preparation and the project staff has relied on it extensively throughout the life of the project. They indicated that it is very practical and detailed and covers all the program areas. The staff indicated that the major problem with the project design was that it covered too broad a geographic area, given the logistical and transportation difficulties of working in such mountainous districts. Although the project tried to reduce the scope of the project at the time of the mid-term, they were unable to due to stipulations in their cooperative agreement. So they did the best they could but did not go into Lerik district until the last two years and therefore were not able to work at the same depth as they did in the other districts.

The project's senior national staff team develops yearly work plans and, based on these, prepares detailed quarterly work plans. These quarterly plans are based on their monitoring of project activities and information provided by the Mentors and Mobilizers. The Mentors and Mobilizers prepare monthly plans and reports based on their activities and those of the CHEs in the villages. Based on the results of the monthly activities noted in the reports, they then make plans for the next month. These monthly plans are submitted to the project senior staff and they show exactly where they will be working during each day of the month. The senior staff uses these plans to then determine their own complementary activities as well as training and supervision visits. Copies of the monthly work plans and reports are also given to the district Head Doctors so that they can facilitate distribution of vaccines and other supplies or accompany the M/Ms on field visits.

In general most of the activities are in accord with those planned in the DIP. As mentioned above, due to initial lack of support from the MOH, the IMCI activities had to be postponed but the CS project did implement this training in the fall of 2004 and now the MOH is planning to expand IMCI nationally.

One of the interesting questions that rose in the DIP review was why the project had not included immunizations as an intervention area. It had not been included because the Local Health Authorities indicated that there was 98% coverage in the project areas. Of course, when the project conducted the baseline KPC they discovered that only 11% of children under two years old were fully vaccinated. As noted, the project had hoped that UNICEF would collaborate by providing vaccines and training, but UNICEF pulled out of the agreement prior to DIP finalization. Mercy Corps organized and supported district training on immunizations through private funding from the Rastapovich Foundation and was able to interest the central MOH in supporting immunization efforts in the districts. For project staff, a lesson learned from this is that projects should not rely on proposed partners to conduct important aspects of programming.

The field staff does a good job of monthly tracking of births and deaths, through the project HIS. This, together with the information from the sentinel surveillance studies conducted biannually,

keep staff, communities and MOH partners apprised of health conditions and needs in the villages. The Mentors do a good job of monitoring activities in the field, using project checklists to monitor activities conducted by the CHEs. Mentors also use a checklist system to monitor health providers. There is a checklist to follow-up on training activities in the field, and senior staff use checklists to monitor work done by the M/Ms. Senior staff reviews the M/M monthly work plans and then make one planned visit to each team per month. They also make surprise visits in order to keep the staff on their toes.

C2. Staff Training

As discussed in above, project staff at all levels have received extensive training. Since training of local health providers and education of community members in project districts is the prime project activity, training of project staff is a priority. As mentioned initially, senior staff and field staff received training on adult learning, leadership skills, community empowerment and conflict management. The purpose of this training was to make them more effective change agents in the district communities. Afterwards the staff received training in the technical areas in which the project was involved. These included, ARI, CDD, Breastfeeding, Safe Motherhood, Rational Drug Use, Immunizations, TB, IMCI and Child Spacing. The staff used this training to educate village committees and caregivers on how to better manage their health. The Training Coordinator developed lesson plans for the CHEs to use when conducting education in the villages.

Other kinds of training included a cross visit by the Project Director and Field Coordinator to Tajikistan, where Save the Children has a CS project. The conditions of the project and the site are similar to the project in Azerbaijan so it was deemed relevant. The Project Director found the visit useful for replicating best practices, such as development of VHCs, and for networking with other agencies working in CSHGP. The Training Coordinator also attended a Principles of Adult Education workshop in Edinburgh, Scotland that was sponsored by Mercy Corps, and the HIS coordinator attended a Mercy Corps BEHAVE Framework training in Turkey in 2004. These trainings were integrated into the CS project's training plan, and cascaded down to first line staff. Several senior staff and Mentors and Mobilizers also participated in two site visits to the central region of Azerbaijan to observe and discuss the reproductive health projects being run by Save the Children and IRD. During the first year of the project, the Training Coordinator received community health training through the American Council of Education. Overall, Mercy Corps has tried to support training opportunities for the staff by providing training resources directly, by facilitating other support for staff development or by allowing the staff to take time away from regular job duties for training.

Regarding effects beyond the project, it is useful to note that the former HIS Coordinator who left to take a job with UNICEF is using her experience to educate her new employer about and promote Household/Community IMCI. Likewise the former Field Coordinator who now works with the MOH is educating them about community based health programming. Also during the evaluation, the Training Coordinator was offered a job as a Monitoring and Evaluation Specialist with the Global Fund because of her CSP experience working with KPC surveys, LQAS, sentinel surveillance and regular program supervision.

In general, the CS project has paid attention to staff training needs, which has been a useful method for maintaining staff motivation as well as building human resources in PHC in Azerbaijan.

A lesson learned about staff development is that the senior staff spent a lot of time during year one training the M/Ms before sending them out to work in the villages. The Project Director maintains

that this made a difference in the level of confidence that male staff had when they started to work in the communities with women's groups. The evaluation team also wondered if the amount of time devoted to training may have contributed to the high level of staff retention and commitment to the project.

C3. Supervision of Program Staff

When the project began, the Project Director stressed the importance of field supervision. She organized regular supervision schedules and would sometimes conduct surprise visits to the field to observe senior staff. As time has gone on and she is more confident of her staff's abilities, she tends to supervise more through team meetings and discussion. This occurs during weekly planning sessions and other problem-solving meetings. The staff works very closely together and appears to have open discussions about whatever problems or issues arise. There appears to be a healthy and free flow of information and sharing of project activities. Staff that was interviewed by the evaluators all seemed to be satisfied with the supervision and management style of the director.

The field staff is supervised by the senior staff in accord with the monthly plans of activities that are submitted by the M/M teams with input from the health educators. The senior staff organizes planned and surprise visits to coincide with the monthly plans. The M/Ms that were interviewed were very pleased with the supervision and other support that they receive from the senior staff. At the mid-term, one of the Mobilizers was made a Deputy Field Coordinator and took responsibility for overseeing activities in Yardimly since the Field Coordinator needed to spend more time in Lerik. The M/M teams also supervise the health educators and support the health providers in the districts. The health providers interviewed by the team seemed particularly appreciative of the support and new information that the Mentors were providing, though initially they had been suspicious of them.

The senior staff voiced concern at the mid-term that with the need to expand coverage to all the non-focus villages in the three districts and a limited number of field staff, that they would lose some of the quality of education and services that the field staff have been able to promote and oversee when working with the smaller number of focus villages. They were worried that since the M/M teams would be focusing on the whole district, less effort would be spent on reinforcing the improved health practices and behaviors in the original villages. While this may have been the case, and at the FE staff indicated that they did not think they had spent enough time in Lerik villages, there was still much progress made in Lerik and the Yardimly villages seem to have maintained their advances.

Unfortunately, because the project is ending it is unlikely that supervision systems will continue unless another agency decides to pick up support of the M/Ms and their work. The Local Health Authority intends to continue monitoring the health facility staff through their monthly meetings and will continue supervision of cold chain and vaccinations. Because of all the facility rehabilitation and upgraded training of personnel, the Local Health Authorities are paying more attention to district services and staff. The one system that was adapted beyond the program was the cold chain and vaccination system. After considerable effort on the part of the Project Director, the central MOH provided support to the district immunization systems in the CSP areas and this is now being replicated in other districts.

C4. Human Resources and Staff Management

Originally the senior staff included the Project Director, the Field Coordinator, the Training Coordinator and the HIS Coordinator. However in the fall of 2005, the Field Coordinator left the project and that position was turned over to the Training Coordinator, who worked closely with the Field Coordinator and whose training responsibilities were winding down. All senior staff members are physicians with many years experience in their respective fields.

As indicated in the previous section, work moral remains strong among the staff, and has been so over the life of the project. There is evidence of strong teamwork and cooperation between senior staff and community-based staff.

Project start-up was delayed in Lerik due to both accessibility and motivation of the DHA to participate in project activities. However, the evaluators found the Lerik M/M team and the DHA were very enthusiastic about the project and pleased with their progress. They clearly would like the project to continue there.

There are job descriptions for all staff that delineate their roles and expectations. Senior staff has annual personnel reviews. The Project Director is reviewed by the HQ backstop and the Mercy Corps's Country Director in Azerbaijan. She reviews the senior staff and the Field Coordinator reviews the field staff. There was an issue regarding salary scales of senior staff. Originally it was proposed that the only staff to come from Baku would be the Project Director and that the other senior staff would be hired from Masalli. However, as it turned out the entire senior staff is hired from Baku, thus the planned salary ranges were lower than market competition. To compensate for this, the project has managed to house three key staff in the project offices in Masalli and supplies two daily meals for staff. The project director was able to adjust the budget to provide salary increases for these staff after the mid-term.

The project has a letter of support signed by the Ministry of Health

The CS project trained 80 couples as Community health Educators who participate in the men's and women's groups and provide follow-up home visits. These visits are done on a monthly basis. These CHEs were originally paid a small stipend to cover expenses but as of the last year of the project, the CSP stopped this and made the positions strictly volunteer though they continued providing non financial incentives such as training. The CHE couples are supervised by Mobilizers. The Mobilizers use a checklist to monitor CHE activity and review a community report form which summarizes vital statistics and the results of the surveillance surveys among other important information. The Mentors mentor at least one health provider, a physician, feldsher or midwife, in the villages that have facilities. The Mentors and Mobilizers are supervised by the Field Coordinator and Deputy Field Coordinator (see above).

The HQ backstop has many years experience in community-based public health and Child Survival and is backstopping other CS projects. The Project Director is a pediatrician with an MPH from the US. She is fluent in Russian, English and Azeri and has previous project experience with the IFRC. The Training Coordinator/ Field Coordinator is a pediatrician with experience in other NGOs as a trainer and community development specialist. The HIS Coordinator is also a pediatrician with experience as a master trainer for the MOH.

The project director spends two days a week in Baku to facilitate coordination with the MOH and USAID as well as Mercy Corps' central office. She very actively solicits technical reference materials

that she can share with the team in Masalli. She is particularly sensitive to passing on new documents from the MOH.

There has been very little staff turnover since the beginning of the project. The only staff to leave were two Training Coordinators who left during the first year because both won scholarships to study for master's degrees in the U.S. Afterwards there was little turnover until the last year when the Field Coordinator and the HIS Coordinator left for jobs with the MOH and UNICEF. Once it was decided that the project would not be applying for an extension, these staff understandably decided to pursue other options. The Project Director has been actively trying to help staff secure employment, and is weighing options for herself but has not yet made any decisions.

At this time, the project has no plans for transitioning field staff to other paying jobs after the project. Unemployment is still high in the districts and it is unlikely that the field staff would find other similar jobs unless another project employs them.

C.5 Financial Management

Funds for project activity are drawn from Mercy Corps' headquarters through an on-line transfer to Baku. From there funds are distributed to the CSP as needed in the form of petty cash and payroll and bank transactions to the bank's closest field branch in Lencoran district.

The CSP Accounting and Administration Officer is the prime staff person responsible for disbursements ensuring that rules in the Mercy Corps Financial Manual and USAID regulations are adhered to. The Mercy Corps Baku Director of Finance provides primary oversight, and ensures that expenses stay within budget. Unfortunately, there have been some changes in financial oversight as Mercy Corps's large umbrella grant, the Azerbaijan Humanitarian Assistance Program, closed during 2005 and several personnel left. This caused confusion and new personnel did not understand the old reporting systems. Mercy Corps headquarters is also implementing a new procurement and accounting system which is overly cumbersome for the CSP. Staff stated that it is good for transparency but not real user friendly and unrealistic for their field conditions.

The procurement procedures are in line with USAID regulations. The major CSP partner is the DHA and there are no cash transfers to the DHA. Mercy Corps has put in place systems to assure that there are transparent inventory controls prior to supplying them with pharmaceuticals and equipment.

During the mid-term review it was decided that some of the budget line items need to be readjusted. More funds need to be shifted to the transportation and salary categories. This was done, and in fact Mercy Corps helped by providing additional match resources for fuel and vehicles.

At this point, there are no plans to finance CSP activities beyond September 2006. The CSP did receive support for sustainability planning through the CSTS workshop attended by the Project Director (see section B3 for details). As a result of the project's sustainability workshop, the Local Government Authorities (LGAs), VHC representatives and communities planned to start their own local NGO to sustain project accomplishments after the CSP. However the leadership at the LGAs changed and the plans were not realized.

C6. Logistics

Mercy Corps received equipment and supplies through the project, in addition to purchasing three vehicles with matching funds. Equipment includes computers and office furniture as well as regular supplies of office supplies for field staff.

The major logistical problem was the unanticipated demand for transportation. Mercy Corps had not anticipated the number of vehicles required and difficulties of transportation that the project would face in the southern districts. The roads are very difficult, particularly in winter when 30% are unusable. Automobiles appear to be the only form of transportation available in the districts. Originally the project had anticipated renting vehicles for field staff in the districts but that was not possible and as a result, having a car became a criterion for selection of field staff. Needless to say, most of the M/M cars are in need of constant repair. Also, Lerik is quite a bit further by road than Yardimly and the focus on Lerik during the second half of the project increased the project office transport costs.

Mercy Corps addressed the transportation problem after the midterm by providing the project with three new vehicles and additional funding to cover fuel and maintenance costs using match funds.

As Mercy Corps and the CSP will not be continuing, most of its systems will not be maintained. However the MOH will maintain the immunization system in the districts. Some essential drugs will also be provided to health facilities and distributed through the monthly meetings. Also, drugs are available to communities where the VHCs have collected funds and transferred them to the MOH for payment of supplies. The CSP has been distributing drugs and supplies they receive through IRD to health facilities, but there is no institution available to continue this once the CSP closes.

C7. Information Management

A community-based health information system (HIS) was put in place by the project to track basic vital statistics and health related information from project sites. The CHEs in the villages register all births and deaths in their villages through home visits, and verbal autopsy in the case of child death. In smaller villages where there are no CHEs, the reporting is either carried out by an "active person" in the community or by the M/Ms, without the community mapping that is done by the CHEs in larger villages. CHEs also fill out statistical forms and convey them to the Mentors and Mobilizers, who regularly report the information to the HIS Coordinator. All of this collected information is computerized and when results are obtained, the HIS Coordinator analyzes the under-five mortality cases (see section A of this report). This information is discussed with the Mentors and Mobilizers, the Head Doctors in Yardimly, Masalli and Lerik, and the district health providers.

Although this information is accurate, it is not always appreciated. The Yardimly Head Doctor was very happy to receive the information and used it to lobby the central MOH for more support in his district. However, from what the evaluators observed in Lerik, the DHA seems to hold the official position that there are no cases of child mortality in his area, despite the regular reports he receives from the CSP. Under the Soviet system, Health Authorities were punished if there were any deaths in their areas. Officials remain reluctant to report any mortality figures even though it damages credibility and makes services planning difficult. However, the project has made headway on this, particularly in Yardimly, and even if officials cannot deviate from the official position, they appreciate knowing the real situation and being informed of progress. The training and follow-up assistance provided by the project via the Mentors has helped the providers develop patient registration systems at their health clinics from which they can document their activities.

The project staff also collects information on community involvement in education activities. All the M/Ms report the number of participants educated in community sessions to the HIS Coordinator. They also record the subjects taught and number of days. These data are compiled regularly and give the staff an opportunity to monitor coverage of the educational sessions, link it with any changes in observed behavior and plan future activities.

The project has used a very thorough system for deciding in which villages to intervene. For example after selecting the Mentors and Mobilizers for Masalli district, the project had them conduct an assessment of 32 villages (25%) in the district. The results were compared to pre-determined criteria, and based on the results, nine villages were selected as focus villages for intervention. In each of the nine villages, CHEs were selected, trained and began working with the VHC to gather villagers for group sessions and collect vital statistics. The same selection process for focus villages happened in Yardimly and Lerik.

The village assessment included the following information:

- Village census with age and gender distribution
- Availability and conditions of the health, educational and public facilities
- Number of people employed in facilities
- Supplies to the public facilities and source
- Main sources of income of the population
- Availability of roads, their condition and distance from the health center
- Availability of water and electricity at the health center

The project also conducts sentinel surveys every six months to assess attitude and behavior changes that are occurring in the project sites by screening all mothers of children under two in randomly selected villages. The surveys are completed within five days, with two more days to analyze data. The surveillance data are used to determine how successful the training and educational efforts have been, and whether they need to adjust the training schedules on intensity on any topic. After the sentinel site survey in year two, the staff determined that there was a need for refresher training in diarrheal disease because the people were not able to answer the questions appropriately.

The project also determined from the vital statistics data that there were a high number of newborn deaths in two of the villages in Yardimly during the first year. Staff decided to focus educational efforts on safe motherhood in these villages and also provide additional training to the midwives. The statistics improved afterwards with no neonatal deaths in the last three years. During the last year when the VHC from Tukla in Masalli was reviewing census data, they discovered a high number of neonatal deaths. As a result the VHC collected funds to send pregnant women to health facilities for prenatal care and deliveries.

Overall the HIS is efficient for recording vital statistics and child health data in the CSP villages. The difficulty lies in tracking families that migrate in and out of the districts. As can be seen in the statistical information recorded by the project (see annex) there is some discrepancy between project census data and that recorded officially by the districts. This may result from differences in accounting for migratory populations.

C8. Technical and Administrative Support

The project has brought in two consultants to assist with training and education. The first consultant worked with the team to develop the breastfeeding training curriculum. She also oversaw and observed a training session using the new curriculum. The consultant also helped them design lesson plans for the M/Ms to use in educating villagers about breastfeeding. She helped them design and pretest leaflet handouts as well. This consultant worked very well with the staff and it

shows because this is the training that has been best received by the project. According to the M/Ms this training is well received in the villages too, despite the fact that villagers and health providers initially stated they did not need help in this area. As noted in earlier in this report the number of women who reported practicing immediate breastfeeding increased from 15% at baseline to 83% at the final KPC.

The second consultant worked in a similar way with the staff to develop the safe motherhood curriculum. She also helped them develop a brochure and lesson plans for the M/Ms to use in the communities. There were more difficulties in the curriculum design with this consultant but it eventually was completed. The safe motherhood leaflet is very well received among villagers.

The headquarters CS backstops have been very supportive of the project and staff seemed pleased with their assistance. They conduct one to two site visits per year and are in constant touch with the project director through email. The backstops help arrange for consultants and other technical assistance when needed. They also actively seek training opportunities for staff. They have seen to it that someone from the project attends the yearly training sessions sponsored by Mercy Corps's HQ. The backstops arranged for the Project Director and Training Coordinator to visit the CS project of Save the Children in Tajikistan early on and later helped the Project Director attend the CSTS sustainability training.

C9. Mission Collaboration

The USAID Senior Technical Advisor for Health participated in the FE and the evaluation team also met with her and another Health Officer in Baku. In general the mission believes that the CSP has greatly contributed to its Strategic Objective of promoting "Increased use quality health care services and practices." The CSP's work in promoting IMCI through AHAP partners and work with the MOH to roll it out in Azerbaijan is an example of this. IMCI was built into the RFA for the recently awarded PHC project. The government was interested in it because of the experience of the CSP and the availability of a translated and adapted curriculum and nationally approved guidelines. There have been several joint meetings with the MOH, USAID, PHC and CSP staff to plan the roll out and it is drawing on the CSP experience.

In general the mission has a good relationship with the CSP and draws on their expertise. Recently when the Government and US Embassy were having trouble finding out about a reported Avian Flu death in Masalli, USAID asked the Project Director to look into it. The project staff investigated and tracked the death to a Masalli village, discovering that the death had been due to childbirth complications. Since there is no official maternal mortality reporting, the official cause had been listed as Avian Flu.

The mission believes that working with the CSP has been a lesson for them. They are learning to work across sectors in trying to find USAID funded projects that can benefit from and continue the work of the CSP in the Southern Region. At the time of the FE they were working to have the CHF Civil Society and Governance Project pick up support of project villages in Lerik and Yardimli. Their thinking is that if the community structures and organizational capacities are strengthened, then there will be pressure by the VHCs to strengthen the health services as well. Originally, CHF was not planning to work in both of these districts but after visiting them and seeing how much work the CSP has done in terms of community mobilization, they have decided to target these districts.

The USAID staff indicated that they would like to have a formal close-out of the CSP acknowledging its multiple accomplishments and link it to an introduction of the CHF activities in the region. They spoke of having the US Ambassador participate as well as other officials. They felt it was important for the communities to understand that USAID was not leaving the region. The mission is also talking to the other offices about securing infrastructure support for schools and health facilities in the Southern Region.

All this being said, the Mission's understandable main concern is who will take over distribution of medicines from IRD to District health facilities now that Mercy Corps is leaving. There was some discussion that if ACTS Georgia is able to open an office in the country then they may be able to handle this.

From discussion, it is clear that the Mission is taking an active interest in sustaining the gains made by the CSP. They recognize its innovative successes and the fact that it was the first project to strengthen MOH services in non-refugee areas.

C10. Management Lessons Learned

It is clear that the end of this project that its successful implementation depended largely on the dedication of its staff. Given that the management team was composed mainly of women who were working in a region where women typically did not work outside of the home, made was initially very difficult to gain credibility. The Project Director felt that this was a job that required 110% of the staff's time. It was not a job that ended promptly at five in the evening every day, and she felt that not everyone could live on this schedule – particularly those who were from Baku. It was possible to have a full time effort because the senior staff lived and worked together in Masalli during the week. There was little to do there besides work, so everyone worked long hours.

The Project Director also recognized the importance of team spirit and devoted time to building this. Much time was spent on team building during the initial training sessions on leadership, adult learning, conflict resolution etc. They also spent time building team spirit during annual workshops, celebrating birthdays, holidays etc. This strategy appears to have paid off, given the high staff retention rate sustained by the project.

Another lesson was how to deal with government officials. The Project Director learned how not to take “no” for an answer. She recognized that the government officials were operating under old Soviet rules and that they would publicly not admit to the existence of health problems. However, she also learned that if you could talk to these officials privately that they did realize that there were serious problems and they would do what they could to support the addressing these problems from behind the scenes. It was also important for the government officials to understand that the project was not competing with them and that it was there to work with them to solve problems. This occurred when they had a measles outbreak in the project area and asked the MOH to help. At first in a public meeting the MOH said that there were no measles cases. Later the then Deputy Minister called and told the Project Director that he believed her and asked how he could help. He promised vaccines but asked that she not report this. He did provide the vaccines, cold boxes and allowed Mercy Corps to introduce vitamin A supplement during vaccination, and smoothed the way with the District health Authorities. The Project Director stated that she appreciates how high level government officials are often not free to act and are dependent on their political environment, but she now knows there is a way to work with them.

Another lesson learned that goes beyond the immediate project deals with concerns about Muslim culture. Given the world climate and concern about conservative Islamic values, the director wanted to clarify that what they believed about the men not caring about women's health was not true. The staff found through the project that the men do care deeply about the health of their wives and daughters and they now believe that this is the motivation behind keeping the women in the house and not allowing them outside. The Project Director states that this experience broke her own stereotypes about the men in the region. She saw that they really do want to help improve women's and children's health, they just didn't know how. The project staff now realizes that the project was successful because they worked through the men and in conservative Islamic society if you convince the men to go along with you it's a powerful tool.

D. OTHER ISSUES IDENTIFIED BY THE TEAM

E. CONCLUSIONS AND RECOMMENDATIONS

According to the project Health Information System (HIS, see Annex), there appears to have been a significant reduction of child and infant mortality in the project villages. Over the life of the project, child mortality has been reduced by almost 80% and infant mortality by 70%. There was an increase in the IMR during the last year of the project (2005-2006) over the previous year, but the IMR was still lower than the rates for the three prior years. Project staff believed that the higher rate was due to having added many remote and difficult to reach smaller villages during the last year, where access to care may have been more difficult particularly during the winter season. Never the less these figures indicate important improvements in health status.

The final KPC survey captured important improvements in knowledge and behavior in project villages. The project met or surpassed most of its target indicators in focus as well as non-focus villages. For example, 100% of mothers sought treatment for children experiencing cough and rapid breathing (baseline: 40%), 69% of women continued to increase the amount of breastfeeding when children had diarrhea (baseline: 52%), 87% of women recognize two or more signs of childhood illness that indicate a need for treatment (baseline: 55%) and 70% of women made at least two prenatal visits during pregnancy (baseline: 32%).

However, there are areas where the project did not meet all its indicators. These areas may be partially attributable to confusion in the way KPC questions were asked in translation. For example the proportion of sick children who received increased fluids and continued feeding during illness increased from 10% to 21%, but the target was 40%. This finding seems to conflict with the other findings such as the one above indicating that 69% of mothers increased breastmilk given during diarrhea. Another indicator, the proportion of mothers stating both cough and rapid breathing as danger signs of childhood illness did not change. But it can be noted from the KPC report that the proportion of mothers stating that either cough or rapid breathing were danger signs was 37%.

The project has formed a strong group of 18 Mentor and Mobilizer (M/M) change agents in its three districts. According to final evaluation (FE) interviews, M/Ms evidenced changed attitudes towards health care, learned to speak effectively publicly and in groups and improved their self esteem as they are now seen as "experts" by the communities. According to interviews with M/Ms' family members conducted by the project, there were also great improvements in the ways that the M/Ms communicated with their wives, other female family members and women in general. A lesson learned through this project was the success of using male M/Ms to provide community education and to organize Village Health Committees (VHCs). Tremendous effort was made by project staff to train M/Ms to educate women's groups and VHCs on women's and children's

health. This was an innovative technique for working with conservative Islamic communities, and it has been amazingly effective.

From a sustainability assessment conducted by the project in 2005, there is evidence that 70% of VHCs have become active in not only promoting better public health in their villages, but also taking on other community problems and challenges. Among the VHCs established or strengthened by this project, 10 have organized their own community-funds to address community needs and are seeking technical assistance from other local and international NGOs in income generation. These funds are established through community contributions. Funds are often sought from members who have emigrated to urban areas from their communities for specific projects such as bridges, schools and roads; others are seeking training in community mobilization and proposal development.

During the last elections in October 2005, 31 VHC members were elected to the local municipalities. One VHC member was assigned to a national government position.

The training and education activities were all well received by participants from M/Ms to health facility staff. In particular, both groups appreciated the breastfeeding education they received. Women also liked the family planning education and consistently asked about improved availability of contraceptive methods and cycle beads.

The project has developed some innovative strategies in response to specific needs in the districts. For example, after discovering a measles outbreak in the project area, staff was successful in gaining the support of the central MOH (i.e, Baku level centralized national health authority) to launch and support a measles vaccination campaign in the three districts. This led to a full fledged nationwide immunization campaign covering all immunizations, not just measles. The project built on district's mobilization around measures to support the establishment of routine immunization.

Another innovation has been the use of health festivals centered on child survival themes to increase acceptance of project activities in the isolated villages. By the time of the FE, there had been 64 Health Festivals in project villages.

The IMCI training helped the feldshers develop registration systems for their clinics so that they are now able to document their services.

According to project training and education reporting figures, the project is reaching 60% to 80% of the women through village women's groups in the focus villages. These women are attending regular education sessions and developing strong social bonds.

The doctors interviewed considered the IMCI and the Rational Drug Use training particularly helpful. In addition, they appreciated the IMCI training because it provided specific guidelines for diagnosis as well as integrating child health services, so problems are caught early.

According to interviews the project is making progress in reducing the demand for injections and intravenous treatments in the project area, largely through community and facility Rational Drug Use training. In order to encourage rational drug use, the project distributes essential drugs, which are supplied through IRD, to project facilities. There is concern regarding how these drugs will be distributed once the CSP closes.

The CS project's promotion of activities and issues facing its target districts has forced the MOH to pay more attention to the district hospitals. The MOH has provided resources for painting and facility improvements, as well as sending needed equipment and supplies. In addition, the CSP has

secured donations from other donors, such as the Japanese government, to rehabilitate three health facilities and construct four from the ground up. Through Mercy Corps matching funds, the project has also rehabilitated at least one room in eight other facilities.

The introduction of community empowerment principles, including strengthening women's role in the community, were new concepts introduced into the project districts, and the VHC understanding of IMR has also increased. The VHCs now really own the community health process. They understand what was done to decrease IMR, and that this decrease was not only the result of improved health services. They understand that they as VHC members and the women's groups have made a difference. A lesson learned is that the community needs to be involved in all health related activities. Also the men, mother-in-laws and elders need to be involved since they are the key decision makers.

It appeared throughout the evaluation process that the Mentors and Mobilizers were conducting the bulk of the community education, with support from the volunteer Community Health Educators (CHEs). This is in contrast to the initial design of the project which envisioned the devolving responsibility for community education to be assumed progressively by the CHEs. Had this been done and given the addition of the large number of villages in the second half of the project, it is probable that the final indicators would have been stronger. The M/Ms were likely trying to cover too much area with education, and the results were not as strong as they could have been had the CHEs been used as the primary community based educators. While CHEs were only present in focus villages and therefore were not available to cover all the project areas, they could have assumed more responsibility in some of the older project areas in Yardimly and Masalli.

At this time, no further donor or Mercy Corps resources exist to continue the project's activities in Azerbaijan. In the event that additional resources were found to continue this type of work, the evaluation team developed the following recommendations, highlighting some of the central conclusions and recommendations of the FE.

If the project were to continue, the next phase should focus on 1) improving more facilities, and 2) strengthening the capacity of health facility staff. The CSP has created a strong demand for health services on the part of communities, and at this point the facilities are not adequate to address population needs. As stated in other sections of this report, most providers in the CSP districts have participated in some of the project's training programs but few have participated in all the training. There is a need to expand IMCI training to all providers and to provide essential supervision and updates.

The CSP has not spent enough time in the Lerik communities, having only started in this district after the mid-term evaluation. While time was sufficient to establish VHCs in all of Lerik's focus villages, time was insufficient to develop their capacity and self-confidence adequately, or to the levels seen in Masalli and Yardimly. Further activities should focus on increasing VHC and overall community capacity and self-confidence in Lerik.

There are some issues with regard to complementary feeding, which was not an intervention area but questions were asked about it in the KPC. Exclusive Breastfeeding (EBF) was a focal intervention area and was positively impacted by the CSP (increasing from 14.5% to 53%). However, the percentage of children zero to 23 months who are underweight changed little over the life of the CSP: from 11.2% to 8% (defined as minus two standard deviations from the median weight-for-age). This suggests that this change is largely due to changes in EBF practices. In addition, both male and female children displayed generalized stunting at both baseline and final

KPC. Qualitative information gathered during the final evaluation supports these findings. Mothers reported feeding children mostly grains and milk, with very few other protein sources and very few iron or vitamin A rich foods. Final KPC data indicate that only 46.2% of children six to 23 months old had eaten a vitamin A rich fruit or vegetables in the last 24 hours. In addition, complementary foods were not reported to be offered at the recommended five times per day, and many women reported offering food only once or twice each day. The KPC again supports these qualitative results with a mere 14.8% of children 6-23 months having eaten five times per day during the previous day. Further activities in the target area should focus on complementary feeding for children under five years old, emphasizing key messages around diet diversity, frequency of feeding and maintenance of breastfeeding until about two years of age.

The diarrhea intervention of this project has been successful within its design. It has decreased use of antibiotics and IVs to treat childhood diarrhea and increased use of ORS and home available fluids. There has been less success with increasing the amount of food offered a child during diarrhea, but this must be viewed within the context of sub-optimal complementary feeding practices in Azerbaijan. This essential element of home management could use more attention. With the solid foundation of home management of diarrhea that the project has already achieved and a growing understanding among doctors and feldshers about rational drug use, the project area offers a compelling context in which to demonstrate the effectiveness of zinc treatment of diarrhea in Azerbaijan. Further health work with these communities could easily include zinc, and provide important information on its integration into the Azerbaijan PHC environment.

The supply of essential medicines and contraceptives remains in question at the close of the project. The CSP had been supplying these items to partner health facilities and communities and at this time, the MOH is still not prepared to adopt this support itself. This is representative of a larger supply chain issue that is affecting the country. While further support is needed in terms of continued provision of essential medicines, it is critical that future health efforts in Azerbaijan focus on strengthening the MOH to better manage and assure supplies of quality medicines to these rural communities.

Finally, the experience of this evaluation points to the need to consider follow-on funding options for innovative projects such as this in countries such as Azerbaijan which are not ready to go to national level scale. The CSHGP has removed the cost extension category and PVOs are limited in the number of grants for which they can apply. The difficulty is that there are very few other funding options for follow-on projects. USAID does not offer a lot of complementary mechanisms for this type of work. It would be useful for CSHGP to explore ways to integrate its CS product into other USAID funding mechanisms, both centrally and at the mission level.

F. RESULTS HIGHLIGHT

Introduction and Scale Up of the Integrated Management of Childhood Illnesses (IMCI) in Azerbaijan.

Introduction: Beginning in 2004, Mercy Corps' Azerbaijan CSP worked intensively to help the MOH institutionalize IMCI in the country. Mercy Corps played a leading role in influencing country stakeholders including the MOH, the international NGO community and donor agencies to support the roll out of IMCI protocols around the country. An INGO coalition including Adventist Relief and Development, International Medical Corps, the International Rescue Committee, Save the Children US and lead by Mercy Corps came together in June 2004 to support and coordinate initial

IMCI training activities with the MOH and the WHO Europe office (the details are included into the Mid-Term report).

Current Status: To date, Mercy Corps is the only agency in Azerbaijan which has piloted all three components of IMCI. These Include:

Facility IMCI: A total of 75 health professional from the project's peripheral health care units were trained during the LOP, including follow-up supportive supervision as they implemented the IMCI protocols post-training.

Essential Drugs: A supply of essential pharmaceuticals; basic equipment; IMCI algorithms and materials; and necessary IMCI registration forms were distributed to all the trained providers.

Community/Household IMCI: Intensive training sessions on HH/C-IMCI were provided to the community members in the project sites during the last two years the project. This effort was very synergistic with the previous two years of community-based work which focused on key messages in the project's focal technical areas.

Plans for the Future: WHO- Europe is planning to conduct an evaluation of the IMCI experience within Azerbaijan in July 2006. This project's experience was selected as a key example for study by the MOH and WHO experts. The Project Director is preparing a presentation that includes an analysis of the work done by the INGO coalition members and specifically by this project for the forthcoming WHO evaluation workshop. Lessons learned by the project will have a major impact on development of the National IMCI strategy in Azerbaijan.

Mercy Corps overcame a number of obstacles in order to implement IMCI in Azerbaijan and its success in doing so is a testament to the strength and importance of this grant. Even though an IMCI pilot program was included in the original proposal, the plan fell apart in 2002 after training the first group of MOH trainers. UNICEF had backed out of the planned partnership with Mercy Corps in IMCI. Then in 2004, Mercy Corps's Project Director arranged with WHO Europe and the INGOs operating in Azerbaijan under the AHAP umbrella to provide updated training to the MOH trainers and to implement IMCI in selected districts, although the CSP was the only one to implement all three components. Now the MOH is exploring how to implement IMCI nationally based on these experiences that were spearheaded by the Mercy Corps CSP.

Reaching Women through Male Mobilizers and Educators

Among the major accomplishments of this grant is the creation of a pool of trained local professionals, Mentors and Mobilizers (M/M), living in the three CSP target districts in southern Azerbaijan. All M/Ms are local men, working in the communities in which they also live; all were raised in this regional conservative and predominately Muslim society; all have university degrees; none had any previous experience working with communities on MCH issues.

All 18 M/Ms were selected by the project's senior staff and tasked with raising community awareness about key health issues including breastfeeding, child spacing, pregnancy danger signs and home management of common childhood illness such as pneumonia and diarrhea. In this area, it is not common for women to work outside their homes, both because of tradition and because of a lack of employment opportunities; thus, men were the logical next "best bet" to take on community education responsibilities within the CSP. The project's M/Ms are a diverse group ranging in age from 26 to 48, and coming from a wide range of professional backgrounds including doctors, economists, an engineer, a lawyer, and even a poet and singer.

After intensive training provided by the project senior staff, M/Ms traveled to remote villages in teams of two (one Mentor and one Mobilizer) to facilitate community education sessions with mothers of all ages, including young mothers, covering topics such as prevention of diarrhea and pneumonia and the importance of early breastfeeding and immunization. The goal was to empower community members to take responsibility for their own and their children's health, with mothers stepping into a community leadership role around these issues.

For the M/M teams, it has not been an easy road to success. They faced a number of barriers, and were confronted daily by the poverty of the region, poor infrastructure, severe weather conditions, unreliable vehicles and treacherous road conditions. The doctors in the group needed to be retrained in up-to-date maternal and child healthcare methods, as well as receiving preventive health training and community empowerment skills for the first time. All the Mentors and Mobilizers underwent a long training process with extensive emphasis on role plays, interactive techniques and other adult learning principals.

One of the biggest challenges for M/Ms to overcome was the cultural barriers between men and women. In the southeastern region of Azerbaijan, cultural values and diametric gender roles prevail to create distance between men and women, with women largely only interacting with men from within their families – husbands, brothers and fathers. Initially, the M/Ms were uncomfortable speaking with women, and even found it difficult to make eye contact with the project's senior staff. They found it particularly difficult to teach women about their health needs and discuss sensitive or private topics such as breastfeeding and family planning. At first, it was difficult to get women to participate in training or to find meeting spaces in the communities. Now, not only do the community women enjoy the health education but also the social interactions, which they were never able to have before. Eye contact is plentiful, and questions are frequent.

Over the last four and half years, the M/M teams have overcome communication barriers that were both internal to them, and external within the communities the project targeted. They worked tirelessly to create a strong community health program, and their success is revealed in the dramatic decrease in infant and child mortality and morbidity rates document by the final KPC. M/Ms developed an incredible amount of love and respect for one another. They have overcome their anxiety and embarrassment of discussing sensitive health issues with women, and they confidently educate them about breastfeeding (including demonstrating good placement and attachment!), family planning and safe motherhood practices. They are not only welcomed but are viewed as experts in their communities.

All the M/Ms were hired and came together with a desire to help their communities, and now are beginning to look beyond the success of Child Survival. They have asked for training in writing proposals for economic and business development projects. They believe that they can take the knowledge and skills that they have learned during Child Survival and apply it to other aspects of community development; and they are correct. They are incredibly proud that mothers and their children will live better and healthier lives because of their excellent work.

G. TOPICS WHICH DO NOT APPLY TO THIS GRANT

This grant did not have a local partner organization other than the Ministry of Health. Thus, the sections above which discuss increasing the capacity of a local partner overlap with sections discussing strengthening of the MOH.

H. OTHER RELEVANT PROJECT ASPECTS: COMMENTS HEARD DURING THE FE

From Mentors and Mobilizers

- “This project created a REVOLUTION IN OUR MINDS!”
- The VHC has changed from how it operated at the start of the project. Before, the VHC was always asking for material support. Now, they are able to identify problems and solutions on their own.
- The main difficulty at the start of the project was with eye contact with the women in the village. This was solved little by little, as their comfort increased and their interest in the material increased. The project started in all the communities working with men and mothers-in-law, which got things started on the right foot with the community. There were some women who made eye contact right away; this encouraged other women to do the same. Also, they asked questions. As the M/M visited with the villages over and over again, the women were able to relax and ask more questions.
- The next most useful training that they received was ToT (Principles of Adult Learning): they learned how to teach because they didn't have a background in this before. They learned techniques to use with adults. For example: if wrong answer is given by a woman, who right answer and support learning rather than tell them that they are wrong. It was so helpful to know how to teach people, and it was a huge personal development to not be embarrassed while giving a talk to a group of people.
- Project Strengths: Achieved a decrease of 60% in IMR! Increased women's education on child care.
- Health statistics give an opportunity to know differences between communities as well as what illnesses are killing children. This allows M/Ms to shape, streamline and target trainings to these topics.
- In one village they had high child mortality related to vaccine preventable causes (4-5 deaths from Measles). So they gave training in the village and clinics, explained immunization process and earned the people's trust. Now they have eradicated measles from the village.
- Women have changed their behavior because of education. In the past the women were told to vaccinate their children but didn't do it. Now they go to the facilities and provider's homes and demand services!

From Village groups and VHCs

- The big effect of working with Mercy Corps has been knowledge improvement.

The former CHE in this village was elected as Chief of the Municipality, and he quite eloquently expressed his appreciation of Mercy Corps' work in his village. During these 5 years, much has been done including 1) the clinic construction; 2) women received good knowledge and now they believe that they can take care to raise healthy families, they are confident; 3) Before Mercy Corps, Yardimli had the highest child mortality in the country. Now it has come down and they are proud of this. They have good health professionals, but now, in all the villages, they have well trained CHEs to support these health professionals. They have better coverage for emergencies and better human

resources. 4) Health Education Sessions are very understandable; 5) immunization campaigns-this was an issue that was raised from the villages, and was very well appreciated. Unfortunately, the project is going to end. They again expressed their thanks.

- Participating with Mercy Corps as a VHC allowed them to think and act around village issues, rather than just for their families
- UNESCO visited the village, and really liked their village maps. They hope/plan to work more with UNESCO.
- The VHC is most proud of the clinic they've built because they put a lot of labor and heart into it. All these accomplishments and team work create a real sense of pride, and they are glad that the IMR in their village is so low! The decrease in IMR is their greatest accomplishment, with construction of the clinic a close second.
- Before, mothers didn't know how to prevent illnesses in their children. Now, they have learned how to prevent illness, not just when to go to the doctor for an illness.
- Family planning was important, and very practical and healthy for the women.
- Before they had a high IMR, and after the CSP they exactly understand how education can decrease the IMR. Today, they appreciate the role that education has played.
- Women instead of men as M/M? Of course, would have been better with women! Women can discuss more openly issues like FP with other women.
- Of course, women would be better. BUT, no man would allow his wife to go be a teacher like a Mentor or Mobilizer.
- Re VHC membership: Have to depend on husband or mother-in-law as decision makers so that they can have permission to participate in the committee. This isn't a huge problem because their husbands are on the VHC as well.
- "In the start, we waited for Mercy Corps to do things; now we know that we need to do things ourselves." For example: water supply. But, they still need some extra help.
- VHC: reported that it is busy with "small stuff" including renovation of the roads, painting the health facility. They are very appreciative of the external health and said that "People in this community are awake now."
- These women want someone to care about unemployment in their villages. "We want to work and want our older children to be able to work here. The only source of income now is cutting trees, but you need 100s of pieces to earn \$2.00, and we worry about the environmental problems that cutting the trees will bring later. The lack of employment affects our health, as well."

From Head Doctors and Facility Health Providers

- The Head Doctor agreed that prevention of infectious diseases (diarrhea and ARI), and now to manage many diseases at home was very helpful to his team, as was Safe Motherhood for the midwife. The concepts and facts that they learned around breastfeeding promotion were "revolutionary" for them, and are very highly valued. Their ideas about breastfeeding changed from delaying 3 or 4 hours after birth to immediate breastfeeding and using kangaroo mother

care to keep the baby warm. They learned about the importance of the first milk (colostrums), to EBF for the first 6 months and the room the baby with the mother after delivery.

- Before, in the summer, they did lots of IVs for diarrhea; but now they hardly see any patients that need this during the summertime. He attributes this to ORS. An example is that they've reversed the breastfeeding advice that they used to offer to mothers of children with diarrhea. Before, the doctor would tell the woman to stop breastfeeding completely. Now that they say to continue and even increase breastfeeding, they see fewer cases of dehydration at the clinic
- Before, the women weren't using anything to space their pregnancies except abortions. These, they feel, have decreased because now they have access to and knowledge to use condoms and pills. Most abortions were done in Masalli or Lerik center
- Now we see lots of changes in how mothers handle their children. Example: completely different beliefs on importance of vaccination today than before the project. Breastfeeding is handled totally differently than it was before. Home management of diarrhea – now they are feeding a child with diarrhea! Newborns are warmed with Kangaroo Mother Care and are left with the mothers after delivery. Danger signs during pregnancy that require a response are responded to appropriately and quickly! The M/M added that before, ORS wasn't used even when the doctor prescribes it because it was considered to be "too salty" for the child and made the child vomit. Now, mothers know how to properly prepare and administer ORS to successfully treat a child with diarrhea.
- Do you think that the changes in attitude and behavior that you've observed will be maintained after the project ends? Why?
- Yes, because they've seen the benefits of these new behaviors. Now they know the practices, not just the theory, and this will ensure that they continue. The community trusts the health staff, and will follow their advice. They've seen that these new practices work, it has had a demonstrated health improvement impact in their communities already, so why wouldn't they continue??
- Training: Rational Drug Use was most useful training the doctor received, in addition to the 10 day IMCI training that was offered. He felt that IMCI was helping the country to transition out of the old Soviet time, and adopt European and International standards into their health practice. Before IMCI, they used many pills. Now that they've been trained in IMCI, the booklet helps them to make a better selection of what pills, and how long, and what is the best pill. The booklet allows easy diagnosis and treatment and they don't need a laboratory. It saves them time and expense in diagnosing a child.
- Midwife noted that in practice, they learned some new things about breastfeeding and LAM that were very important. They learned about delivery and know that the first rule is to put the baby to the breast to promote uterine contraction.
- Two people are using SDM, and had agreed with their husbands that it costs less and is very easy, so they'd use it.
- Several physicians remarked that the number of difficult cases has decreased because the community is aware of early warning signs and people (dads, mother in laws, and young moms) work together with a common shared knowledge base.

From CSP Staff

- “With a small team we did a very big job. At the beginning of the CSP, we could not believe we could do this job that was being asked of us! With 18 men we trained 280 communities – this is the first time this has been done – and with men!! – big lesson learned!”

From ACTS

- “The Mercy Corps CSP has made a lasting impact on each village far beyond the enhanced health awareness, the community development and participation and the trained stakeholder involvement.”
- “The Mentors and Mobilizers were educated, recognized, respectable persons from their communities. For example, in Lerik one of the mentors named Myrckamel was a respected person not only in his district but by the whole Muslim population because of his name (for Muslims Myr means descendent of Muhammad). So his presence made relationships and acceptance by communities in Lerik easier for the CSP.
- “All Mentors and Mobilizers mentioned to us that their status moved up during this project and now they are seen as ‘experts’ by the communities. So it seems to us that after finishing the project the M and Ms will continue their work as volunteers, which will contribute to the sustainability of the project.”
- “It was a revolution in our minds’ one of the VHCs told us because traditionally Muslim women only go outside for weddings and funerals. So they don’t have a chance to meet each other and spend time together sharing problems. So these women’s group meetings were very helpful to them for social interactions.”
- One feldsher told the Georgian ACTS staff that the two weeks when he attended IMCI training were equal to four years of medical studies- because it was so revealing and helpful.

I. PRESENTATIONS AND PAPERS PREPARED AND PRESENTED PERTAINING TO THIS CSP

Annex A: Quantitative Assessment for Final Evaluation

Please see attached file with KPC Report

Annex B. Final Evaluation Team Members

1. Sandra Wilcox, Team Leader External consultant
2. Kati Moseley, Mercy Corps Headquarters Mercy Corps Senior Health Program Officer
3. Uma Kandalayeva CS Project Director
4. Khuraman Hasanova CSP Training and Field Coordinator
5. Afat Mammadova CSP HIS Coordinator
6. Melinda Pavin USAID/Azerbaijan Technical Advisor for Health
7. Patricia Blair President, A Call to Serve (ACTS)
8. Ketevan Sharangia, IMCI Master Trainer, ACTS Georgia
9. Nana Gumbaridze IMCI Trainer, ACTS Georgia
10. Afag Gafarova Interpreter

Annex C. Assessment Methodology

The Final evaluation was conducted between May 24th and June 10th in Azerbaijan. The external consultant and Mercy Corps headquarters Senior Program Officer traveled to Baku Azerbaijan between May 23rd and 24th. The external consultant and the Mercy Corps headquarters Senior Health Program Officer met with the Mercy Corps Country Director, the CS project director and other country office staff in Baku on May 25th and 26th and reviewed plans for the FE. On the 26th, the CSP staff provided a briefing on the CSP attended by the USAID Health Officer. The briefing included project background, highlights, problems and achievements. On the 27th and 28th the team members reviewed documents, prepared evaluation tools and met with the ACTS Georgia team members.

On the 29th, the consultant, Senior Health programs Officer, the ACTS team and the CSP Senior staff traveled to the CS project office site in Masalli in southern Azerbaijan. There they met and discussed the agenda and planned activities for the week of site visits. It was decided that there would be two teams, with the ACTS team visiting different districts each day so as not to overwhelm the communities.

Between May 30th to June 2nd, the team visited villages, district hospitals, ex-com offices, District health Authorities, health facilities and Village Health Councils in the districts of Yardimli, Masalli and Lerik. Please see Annex D. for a complete list of places visited and people contacted. The USAID Technical Health Advisor joined the team for site visits on June 1st and 2nd.

On June 3rd the team met in the project office in Masalli to collect information, review and discuss findings and conduct a debriefing with the project team. The ACTS Georgia team left on June 2nd after providing a brief review of their observations and findings.

Late on June 3rd, the consultant, Project Director and Senior Health Program Officer returned to Baku. Between June 4th through 9th, they finished collecting information, reviewed preliminary KPC reports, interviewed CSP staff, interviewed USAID Mission personnel and conducted a brief review of findings and next steps with the CSP Director.

The Senior Health Program Officer and consultant departed Baku for the US on 9th and 10th respectively.

Annex D. List of Persons Interviewed and Contacted

PLACES VISITED AND PEOPLE INTERVIEWED DURING THE FINAL EVALUATION:

May 30, 2006:

Yardimly district center:

- Meeting with CSP Mentors and Mobilizers- 8 people
- Meeting with District Head Doctor- Dr. Nazim Nazarov

Arus village:

- Meeting with Village Health Committees and Village Health Educators-15 people
- Meeting with local village pediatrician – Dr. Vekil Sharbatov

Kuryadi village:

- Meeting with Village Health Committees-20 people
- Meeting with village midwife- Mafkura Mamedova
- Meeting with Village Health Educators.

Lerik district

Ambu village:

- Meeting with pair of Mentor and Mobilizer- Vagif Shukurov, MirKamal Veliev
- Meeting with local feldsher, VHC members, CHEs, mother's group- 11 people

May 31, 2006:

Lerik district center:

- Meeting with Mentors and Mobilizers- 8 people
- Meeting with District Head Doctor- Dr. Handam Tahirov

Pirasora village:

- Meeting with village doctor, Alibala Bayramov, and midwife, Zulfiya Nurmamedova
- Meeting with mothers group- 8 people

Siov village:

- Meeting with Village Health Committees, Village Health Educators- 15 people
- Meeting feldsher, Kamal Hasanov, and mother's group

Yardimly district:

Kurakchu village:

- Meeting with local Village Health Committees, Health Educators and mother's group- 11 people

June 1, 2006

Lerik district:

Zuvuj village:

- Meeting with Village Health Committees – 13 people
- Meeting with local health providers, specifically, doctors, midwife and feldsher.

Yardimly district:

Shikhlar village-

- Meeting with village Health provider and mother's group- 7 people

Masalli district:

- Badalan villages- Meeting with local health providers, physician, and 2 nurses.

June 2, 2006

Yardimly district:

Honuba village

- Meeting with village doctor, midwife, mother's group, VHC members- 13 people

Masalli district center:

- Meeting with CSP Mentor, Seidaga Hashimov, and District Head Pediatrician, Rasim Rahmanov

Hanalion village:

- Meeting with women group, , and VHC members- 14 people

Gulutapa village:

- Meeting with local health providers, HE and mother's group- 12 people

ANNEX E Training Conducted 2004-2006

2004	Masalli										Total		
	Yardimli					Lerik							
Topic	Community	HE	MM	MOH	Community	HE	MM	MOH	Community	HE	MM	MOH	
ARI	1557		8		532		2		5077	51	10		7237
Diarrhea	4238				800				4956				9994
Child Spac	4954	83	8	13	890	24	2	19					5993
Breastfeeding	105				81				885	36		23	1130
IMCI	2107	50		12	941	14		4					3128
Safe Motherhood	4155				499								4654
Immun													
RDU			4	51			1	9			5	36	106
Total	17116	133		88	3831	49		47	10918	87		80	32349
2005	Masalli										Total		
Topic	Community	HE	MM	MOH	Community	HE	MM	MOH	Community	HE		MM	MOH
ARI/	1279				309				1917				3505
Diarrhea	1488	52	8		396	7	2		1659	52	8		3672
Child Spac	632	24			318				1859	55	8	28	2924
Breastfeeding									1479				1479

2004	Yardimli						Masalli			Leik				Total
	Topic	Community	HE	MM	MOH	Community	HE	MM	MOH	Community	HE	MM	MOH	
IMCI	4474				6	930		2	9	2243		8	19	7691
Safe Motherhood			37	8			9	2		633	50	8	17	764
Inmun							11							11
TB			30	8							45	8		91
Total	7873		143		6	1953	27		9	9790	202		64	20067
2006	Yardimli						Masalli			Leik				Total
Topic	Com-ty	HE	MM	MOH	Community	HE	MM	MOH	Com-ty	HE	MM	MOH		
Child Spac		51			234				1456					1741
Breastfeeding														
IMCI	1644				539				1977			19		4179
Total	1644	51			773				3433			19		5920

ANNEX F: Community HIS Child and Infant Mortality Data

July03-June 04	July04-June 05	July05-May 06
from 57villages	from 243 villages	from 283 villages
67.32	37.53	25.02
25.74	14.59	19.5

