PROJECT HOPE

Healthy Lifestyles for Women and Children Program in Jalalabat Oblast, Kyrgyzstan

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Detailed Implementation Plan

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Jalalabat Oblast, Kyrgyzstan
Project duration:
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ACRONYMS

ADB	Asian Development Bank
APHA	American Public Health Association
ARI	Acute Respiratory Infection
BFHI	Baby-friendly Hospital Initiative
BME	Biomedical Engineer
BF	Breastfeeding
CAR	Central Asia Region
CDD	Control of Diarrheal Diseases
CORE	The Child Survival Collaborations and Resources Group
CSTS	Child Survival Technical Support Project
CS	Child Survival
CYP	Couple Year Protection
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FAP	Feldshar-Midwifery Post serving 500-2,000
FGP	Family group practice (internist, pediatrician, and OB/GYN working together, receiving a capitation fee)
FGD	Focus Group Discussions
FP	Family Planning
GHC	Global Health Council
GM	Growth Monitoring
GIK	Gift-In-Kind
GOK	Government of Kyrgyzstan
HIF	Health Insurance Fund
HFA	Health Facility Assessment
HQ	Headquarters
HIS	Health Information System
IMCI	Integrated Management of Childhood Illness
KAFP	Kyrgyz Alliance of Family Planning
KPC	Knowledge, Practice, and Coverage
LAM	Lactational Amenorrhea Method
MCH	Maternal and Child Health
MPS/PEPC	Making Pregnancy Safe/Promotion of Effective Perinatal Care
MOH	Ministry of Health
NGO	Non-Governmental Organization
OR	Operations Research
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Salt
PEPC	Promoting Effective Perinatal Care
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
PVO	Private Voluntary Organization
SCW	Sexual Commercial Worker
SES	Social Epidemiological System
SPW	Social Patronage Workers
SUB	Rural hospital with 20-50 beds serving 20-25,000
STI	Sexually Transmitted Infection
SVA	Rural physician clinics (physician, pediatrician, OB/GYN, dentist, nurse, midwife) serving 6,000-10,000
TOT	Training-of-Trainers
TRM	Technical Reference Materials
VHB	Village Health Bank
WHO	World Health Organization
W/MCH	Woman/Maternal Child Health
WRA	Women of Reproductive Age

A. Executive Summary

Project HOPE plans on implementing a four-year program aimed at improving the health status of children under five and women of reproductive age in the Oblast of Jalalabat, Kyrgyzstan. The program follows a successful model from Project HOPE's Child Survival (CS) project in Navoi, Uzbekistan, and builds upon lessons learned in the implementation of that four-year program, which was recently awarded for another four years as cost extension until 2007.

The program will be working with the populous Jalalabat Oblast (Region) in Southern Kyrgyzstan. This region is of vital strategic interest for the United States and its allies. Despite the importance of its location, the oblast has very limited international development assistance. In this period of transition from a Soviet Republic to an Independent State, Kyrgyzstan's lack of natural resources has contributed to dramatic economic decline and deterioration in general conditions, including health.

The population of Jalalabat is about 905,314, including 20,256 children under one; 91,064 children under five; and 201,274 women of reproductive age (MOH statistics, 2002). Of these, the project is expected to reach approximately 60%. The oblast consists of eight rayons and four major urban centers, with about 700,000 people living in rural areas, where the economy is largely agricultural. While the number of providers and service delivery points is relatively high, infrastructure is now in very poor condition, facilities are ill-equipped, medicines and supplies are in short supply, and the level of provider skill and motivation is low.

Statistical indicators in Kyrgyzstan provide an extremely misleading picture of the national health status relative to its neighbors in the Eurasia region, and particularly as they relate to the status of young children. While the official infant mortality rate in Jalalabat is 19/1,000 lives births (similar to the national rate), the actual rate is likely to be much higher, using standard international classifications rather than the old Soviet definitions still employed in the Kyrgyz system. Twelve percent of children under five in this region are moderately to severely underweight; an underlying factor in many infant and childhood deaths. Primary causes of infant mortality in the target area are perinatal causes, respiratory infections, and infectious diseases. With regard to Maternal Health, one of the project rayons reported 61 % anemia among pregnant women in 2002. Primary causes of maternal mortality in the country are pregnancy-induced hypertension/toxemia, hemorrhage, and thromboembolism.

The program goal is to reduce morbidity and mortality rates of children under five and women of reproductive age in the Oblast of Jalalabat. The overall approach will be to strengthen and improve the quality of existing local health care services and delivery systems; to increase community and consumer involvement and participation in health care maintenance decisions affecting them directly; and to scale up and replicate successful CS activities in other oblasts of Kyrgyzstan.

Specific program interventions and level of effort include: maternal and newborn care (30%), maternal and child nutrition (15%), breastfeeding (10%), child spacing (10%), sexually-transmitted infections (10%), immunization (5%), control of diarrheal disease (10%), and pneumonia case management (10%). Given the size and population of the project area, certain activities will be implemented oblast-wide, targeting all 316,677 beneficiaries, while others will target select rayons (districts) within the oblast.

Key objectives include the following: improve the quality of antenatal, postpartum, and emergency obstetric care; increase women's knowledge regarding pregnancy danger signs and care-seeking; improve maternal nutrition during pregnancy and lactation; increase the number of women and children consuming iodized salt; pilot-test Vitamin A program for women post-partum and children under the age of six; increase the number of women and adolescents making knowledgeable family planning decisions; increase the number of pregnant women tested and treated for STIs, and increase knowledge of men, women and youth about STIs; increase the percentage of newborns and infants who are exclusively breastfed; increase the number of "baby-friendly" maternities in the oblast; increase the percentage of sick children who are managed using IMCI guidelines; improve the management of children with acute and persistent diarrheal episodes; improve management of children with pneumonia and other ARIs; improve the cold chain and local cold-chain.

The program focuses on community education and empowerment, and the development of sustainable quality services and delivery systems by building the capacity of local partner agencies, rather than through direct service provision. This will be accomplished through organizational training-of-trainer sessions; joint planning, implementation, and evaluation exercises; special training in supervisory skills; and training in key data collection methodologies.

Project HOPE's primary partners in this effort include the central Ministry of Health and MOH technical institutes; the Social Patronage System (nurses and social workers who provide health services and education in the home and communities); family practice groups (physicians who provide primary health care services from FGPs); association of FGPs and Jalalabat Department of the Kyrgyz Alliance for Family Planning (whose staff and volunteers have already been trained as trainers for community-based interventions in other technical areas). At the local level, HOPE will work closely with oblast and rayon health officials, service providers, and semi-formal community committees. Nationally, the program will collaborate with Abt Associates, the World Health Organization, and other international agencies, and will share expertise resources with Project HOPE's CS program in Uzbekistan as well as HOPE's tuberculosis management program, which has ongoing activities in Kyrgyzstan and the four other former Soviet Central Asian Republics.

This program falls under the New Project Category, with $1.300,000 from USAID, matched with $533, 333 from Project HOPE. The project began on September 30, 2002 and is scheduled to end on September 29, 2006.

The original project was discussed with the USAID/Kyrgyzstan Project Management Specialist Tatiana Dermentieva. The draft proposal was reviewed by Mary E. Skarie, USAID/CAR Almaty, Public Health Management Specialist and her comments addressed.

The main author of this Detailed Implementation Plan (DIP) was Marguerite Joseph, Consultant, working with Dr. Anara Dolotova, Program Director, and Dr. Bettina Schwethelm, Director of Maternal and Child Health Programs, Project HOPE. Dr. Schwethelm is now the Director of Project HOPE/Switzerland.

The contact person for Project HOPE is Sarah E. Porter, MCH Program Manager, Russia and Central Asia Office.

B. CSHGP Data form
Including Rapid Catch indicators

See previous three pages inserted.

C. Description of DIP Preparation Process

The steps taken to prepare this DIP included several key activities. A comprehensive Knowledge, Practice, and Coverage (KPC) Survey was conducted targeting women with children under the age of 2 years, women in reproductive age, men, and youth. A sample of 300 from each group was obtained. In addition to this, a Health Facility Assessment (HFA) including twenty instruments was also conducted in a total of 14 health facilities; 2 in the Oblast and 6 across the two project rayons. Subsequent to this month-long quantitative data collection activity, Project HOPE staff and consultant undertook a four-day qualitative study in the program project rayons. Six Focus Group Discussions (FGDs) were held in both the Asky and the Bazakorgon Rayons. In this forum program staff and consultant talked to a total of 28 health facility service providers, 33 mothers of young children, 22 men, 8 grandmothers, 25 youth and 14 community leaders. To culminate this work, a two-day planning workshop was held that included the participation of 32 individuals coming from the central Ministry of Health, the oblast and rayon health services, program partners and staff. The Baseline Assessment report is included in Appendix 1; and the list of DIP workshop participants, along with the agenda and working groups is included in Appendix 2.

Program activities undertaken since the award began with the recruitment and hiring of a Program Director, Dr. Anara Dolotova and 5 technical and 2 administrative staff, plus 2 drivers and a guard. See Appendix 3 for CVs pf all key staff. Project HOPE subsequently located and renovated office space office in an unused wing of the Children's Hospital. Also achieved during this start-up period was the procurement of necessary office and program supplies and equipment, as well as vehicles. Program staff received orientation on program priorities and strategies as outlined in the proposal, and participated in some training activities. Meetings with partners were held and discussions around the issue of partnership, responsibilities and contributions of each partner.

D. Revisions from Original Proposal

The main table included in the M&E section of the original proposal was revised and further detailed. The new table, which became the work plan for the first two years as required in the DIP guidelines, includes intermediate results (outcomes), as well as specific results and process indicators for the same range of interventions originally proposed. The target area remains the same. See Appendix 4 for the map of the target area. In addition, a revised budget is included, which reflects the new Project HOPE's NICRA with USAID approved on May 7, 2003. See Appendix 5 for the Memorandum of Understanding with the MOH and Project HOPE.

Detailed Implementation Plan

1. Program Monitoring and Evaluation Plans

1. a. Current Information System- The current health information system (HIS) includes medical assistants (Feldshars) working in FAPs, and nurses and midwives working at Family Group Practitioner Centers. These personnel are responsible for submitting a detailed monthly report on their specific maternal and child health activities and cases.

For maternal health, the data collected includes the name of each woman who delivered a baby in the catchment area, the age of the woman, date of childbirth, location of childbirth, gender of child, birth registration number from the local administration office, the date of the registration, the date of previous delivery, the name of the child and its birth weight. This information is compiled by the Chief family practitioners at the end of the month, and brought into the Health Information Center located at the Rayon's Family Medicine Center. The Information Center's HIS team (3 in the Aksy Rayon and 2 in Bazarkorgan), sits down with each family practitioner and goes over all the data and each report very carefully. Sometimes the Feldshar comes in with the family practitioner to discuss some of the information being submitted.

For child health, immunization data on each child is kept in a family notebook, compiled and submitted directly by the nurse or midwife provider, and not by the supervising family practitioner – although the FGP does check this information before it is submitted. This information is submitted to the Rayon Sanitation and Epidemiology Station, not to the Information Center.

For the outpatient treatment of the ill child or adult, the family practitioners complete a report on client visit and treatment provided. These particular reports are also sent on to the Information Center at the end of each month for health insurance coverage purposes. The FGP does not retain a copy at the center. This information is retained within a visit notebook at the center where service was rendered.

The next level of reporting is done by the Rayon Health Information Center and Rayon Sanitation and Epidemiology Station. The prior produces a Quarterly Report compiling the 3-month activity per Chief FGP. This information includes the total number of births, number of deaths, number of deaths under age 14, number of deaths under 1 year, number of deaths under 2 years, mortality ratio per 1000 live births, early neonatal deaths (within the first 24 hours), and the number of deaths in the home. A written, detailed report on the cause of death is also done to complete this information. The later, among other things, is responsible for EPI activities. Through the monthly reports, which include the number of births, they are able to produce quarterly statistics on EPI coverage in the rayon.

The Director for the Family Medicine at the Rayon level reviews quarterly reports and writes his own commentary and analysis on Rayon activities and information. Data for each quarter is compared with data from previous quarters and the previous year as well. This report is sent on to the Oblast HIS Center, the Oblast Family Medicine Center and the Health Insurance Fund. Copies of this report are also shared with the Chief FGPs at the Oblast level. At the end of each year, an annual report is submitted and distributed in the same fashion.

The intention of the program is to supplement this HIS and not have a separate, parallel information system. With regard to the outreach component, information on home visits and outreach is currently being reported also, and notes on the visit and the case are taken. As the CS program will expend effort and resources in support of home visits and community level activities, it will also request that outreach workers write reports describing their activities, highlighting achievements for the month and challenges faced. A monthly meeting will give these workers the opportunity to discuss the month's activities and reflect on important issues. The full-time Training Supervisor will submit a compiled report to Project HOPE and a copy of this report will also be given to the Rayon Health Information Centers. Data for the program will be complementary, rather than overlapping.

At present, facility-based data is combined with community-based data because the outpatient health providers responsible for each catchment area, keep and collect data, and report on these maternal and child health events and coverage, even though, for example, the delivery took place in a maternity house, or a death occurred in a hospital.

1.b. Monitoring Tools – At the community level, Participatory Rural Appraisal (PRA) Problem Solving tools and methodologies will be used as a strategy to begin the process of developing increased ownership and responsibility for health. Quality Assurance tools such as supervision checklists will also be developed by the program for household and community level activities. These tools will be developed by program staff with input from headquarters and the MOH partners at the Oblast and Rayon levels. They will be field-tested and produced by program staff and partners. The program will also support the use of the facility and community-based IMCI monitoring indicators. As per the guidance given in the USAID/GH/HIDN/CSHGP Technical Reference Materials (TRMs), the facility-based indicators will measure information on how children are assessed, classified, treated and caretakers are counseled. There will be periodic direct observation of provider practice and exit interviews with mothers or other caretakers of sick children. A baseline Health Facility Assessment (HFA) was conducted to look at availability of drugs, supplies, equipment among other things; program staff will collect key systems-related information during regular monitoring visits. Community based indicators for monitoring will develop household checklists which will give information on breastfeeding, complementary feeding, (vitamin A supplementation will be reported with the immunization data), disposal of feces and hand-washing practices, care and treatment during illness, and antenatal care. Other monitoring tools that will be used by the project include tools produced by WHO partners in the PEPC (Promoting Effective Perinatal Care) project, in collaboration with Project HOPE technical assistance staff from the headquarters office.

1.c. Data Collection:

1.c.1. Sources of data – Maternal and child health data and information on activities will be obtained through the existing prior-mentioned monthly and quarterly data collection system and information, and through the tools used by the project. Household surveys were conducted to collect baseline information and more in-depth food consumption surveys will be conducted during this first program year. A mid-term evaluation will be conducted by the end of the second year of the program to measure the accomplishments of benchmarks and to assess that the methodology and

approaches for program activities are working towards the accomplishment of those same benchmarks. A final evaluation will be conducted at the end of the program to assess program results and potential impact that could be attributable to the program.

1.c.2. Process to determine population denominator- Eligible women, children and newborns will all be able to enter and participate in the program by virtue of the fact that there is very close monitoring of all pregnant women and childbirths. As previously mentioned, the local administration office registers all births and deaths, and maintains very up to date information on the population. Each of the feldshars and nurse/midwife maternal and child health providers for a catchment area also maintain very clear information on the number of households and locations that they are responsible for. Through them, and the program outreach workers, it is expected that a maximum number of eligible women, children and newborns will participate in the program.

1.c.3. System for data collection – The system for data collection was described earlier. As a partner to the local rayon MOH, the program will also compile monthly data and to ensure data quality, will cross-check the quarterly reports produced by the rayon with this monthly data.

1.c.4. Participate in data collection – The Training Supervisor, will be responsible for collecting information on monthly home visits and community-based activities. Program staff responsible for technical assistance and oversight for IMCI, Safe Motherhood and Reproductive Health will also review data collected and have the opportunity to discuss it with health service providers at different levels. Program beneficiaries will be encouraged to be more actively involved in data collection and aware of what is happening in their neighborhoods and communities. Some neighborhoods have women who are already very active and helpful to service providers in this regard.

1.d. How and by whom data will be analyzed and used – MCH data collected is already discussed and analyzed to a certain degree by the Chief FGPs and the Health Information Center, and likewise the Feldshars/Nurses discuss immunization reports and information with the Sanitation and Epidemiology Station in each rayon. During a weekly meeting between the Out-patient Services (Family Medicine), Inpatient Services and the Sanitation and Epi Station, there is information-sharing, and data and cases are discussed and analyzed also. The Director of Family Medicine also does an analysis in his quarterly and annual reports. The program staff will schedule monthly meetings with the Outreach Worker teams to discuss the reports and monitor progress. To improve program processes and performance, in addition to monitoring progress, the program manager and staff will also establish monthly rayon level meetings that will include the participation of the Director and Deputy Director of Family Medicine, representation from the Sanitation and Epidemiology Station, the head of the HIS team, as well as the Chief FGPs. The program will also schedule quarterly meetings at the Oblast level, with the participation of the Director of Family Medicine of the two project rayons, and other NGOs or interested parties, as an opportunity for information-sharing and discussion.

Results of this data will be shared with the home office on a quarterly and annual basis. The PVO headquarters will share this information and analysis with the larger PVO community as the opportunity arises.

Program results as it relates to reduced morbidity and mortality in the project rayons will be shared with the central MOH as well – both by the Oblast partner in regular reporting, and by Project HOPE through annual reports and the mid-term evaluation. It is the intention of the program to use the results for advocacy in country because there are very few Oblasts that have had the opportunity to implement either PEPC for Safe Motherhood, or IMCI for child health. As Vitamin A supplementation will also be a pilot activity, not currently part of MOH policy, the program will help the rayons to document the experience and lessons learned, as well as assess the potential impact of this intervention on health statistics.

One area in which the program hopes to assist its partners, is that of increasing and improving information-sharing, feedback and communication between communities and health facilities. In this vein, the program will schedule quarterly or bi-annual meetings with communities to discuss data and assist community members to benefit from it.

1.e. Methods that will be used to monitor and improve the performance of health workers, quality and coverage – The first task of the program with regard to performance and quality will be to assist the local MOH partner with defining and communicating standards of care. Quality of care will be part of training for each intervention and will invite provider participation in defining this. Program staff will also talk to customers/clients, to get their perspective, viewpoint and expectations with regard to quality of care. In terms of monitoring, methods will include supervision with the use of checklists to observe health provider performance, and feedback and discussion of issues. These issues will also be reviewed and discussed in monthly staff meetings. Periodic (quarterly or bi-annually) exit interviews with clients will be used to complement supervision and feedback, allowing for more complete assessment process. Monitoring of health worker performance will be done for both outreach work as well as for the facility-based IMCI, maternal and reproductive health interventions. Coverage will be monitored through the review of monthly reports and data. As number of births, family name and registration information is done systematically, this will facility the program's ability to obtain the maximum coverage for activities. Another method that will be used to encourage the improvement of health worker performance is rewarding quality of performance through competitions. This method has been used in Project HOPE's Uzbekistan - Navoi CS program.

1.f. Project plans for ongoing assessments – The program plans to do training pre and post tests, and include post training follow-up support and facilitation at the work site. In addition to this, regularly scheduled facilitative supervision will allow for ongoing assessments of the health provider. The program will introduce the COPE methods of self and peer assessment that will engage providers in the assessment process.

1.g. Tools that will be used to promote quality of service – The program will be working in technical areas that already have training curriculum, guidelines, protocols and algorithms. This is the case with IMCI, whereby the MOH in Kyrgyzstan has worked with WHO to adapt the training materials and methods, although the program will work with it's local partner to adapt the list of Key Family Practices (WHO/UNICEF) for Community-Based IMCI for use by outreach workers and health providers conducting home visits. The WHO PEPC program has been initiated and adapted by the MOH in Kyrgyzstan. A training curriculum for this program is also available to Project HOPE who will support this activity, and obtain the draft guidelines for monitoring

developed in neighboring Uzbekistan. The program can also make use of the technical information and guidance on Lactational Amenorrhea Method (LAM) available through EngenderHealth. Guidelines, and training curricula for child-spacing, and counseling for reproductive health are also available through EngenderHealth. Examples of this are a training packet for men's Reproductive Health and a training guide for counseling the postabortion client. The program will be introducing the Syndromic Management of Sexually Transmitted Infections in the one project rayon that is not currently following this. A treatment protocol for Syndromic management already exists, and this will be used for supervision and monitoring of quality. Engender Health's Guide to Common Symptoms for STIs is also a tool that would be useful to health workers who receive this training.

The above-mentioned guidelines will be used for training and training follow-up activities, and these technical guidelines will also be used as reference for routine supervision activities that assess health worker performance.

1. h. How M&E skills of local staff and partners will be assessed and strengthened – Monitoring and Evaluation will be an integral part of the program and has begun with the development of program objectives and specific indicators. Program staff and partners had the opportunity to review and discuss these objectives and indicators at the DIP Planning Workshop, and local MOH partners also participated in KPC and HFA training and data collection activities. This beginning was a learning process for both program staff and partners, and the activities were successfully completed. This will pave the way for continued partnership in this area. In additional to staff and partner participation in the upcoming mid-term and final evaluation activities, another opportunity to assess and strengthen their skills, the program will be developing monitoring and process indicators (benchmarks and targets) that both staff and partners will be keeping track of during the life of the program. This routine monitoring will be assessed by both the providers, supervisors and managers during monthly and quarterly meetings, which will allocate time for review and discussion on these issues. These monitoring activities are expected to contribute to M&E capacity-building of program staff and partners. The fact that the MOH has a strong HIS, and that supervisors and directors are already in the habit of analyzing and discussing data, will facilitate the programs ability to succeed in this area as well.

1.i. Operations research ideas that will be carried out during the program- The operations research that the program will undertake will firstly look at frequency of supervision and usefulness of various supervision checklists and supervision styles, and secondly, compare various approaches to reach youth and men with RH education.

2. Summary of Baseline and Other Assessments

2.a. Types and methodology of baseline assessments- The program conducted a comprehensive KPC survey and a Health Facility Assessment. The KPC survey was carried out by HOPE field staff, with participation from the MOH staff at the rayon level in early April 2003. To conduct the survey, a 30-cluster sampling methodology was chosen along with parallel random sampling, which included four groups: mothers of children under the age of two, women of reproductive age (15-49 years), youth (16-18 years), and men. A sample of 300 interviews from 95 villages was taken for each group.

In addition, a Health Facility Assessment was conducted following BASICS's model for the sick child; WHO Safe Motherhood Needs Assessment; Family Planning; and STIs. The assessment included 14 different health facilities from 21 administrative units at different levels.

2.b. **KPC Survey – Key findings**

General Information
- 99% of mothers and WRAs had a secondary education and higher;
- 100% of men had a secondary education or higher;
- 5.7% of mothers work outside of the home to earn money.

Breastfeeding and Child Feeding
- 43% mothers practiced immediate breastfeeding within 30 minutes;
- 39% mothers breastfed between 30 minutes and 8 hours;
- 93% mothers gave colostrum;
- 13% mothers exclusively breastfed for the first 6 months;
- Children age 6-9 months, foods ate in the last 24 hours: 21% milk products; 10% fruit juices; 25% carrots; 21% eggs; 31% meat;
- 52% children weighed in the last four months.

Control of Diarrhea
- 17% children had diarrhea in the last two weeks preceding the survey;
- 6% mothers gave ORS; 6% gave home fluids;
- 44% mothers gave pills or syrup;
- 72% mothers breastfed same as usual;
- 19% mothers breastfed more than usual.

Pneumonia
- 33% children had cough in the last two weeks preceding the survey;
- 8% children had difficult breathing;
- 10% children had fast breathing;
- 23% children had fever;
- 60% mothers breastfed same as usual;
- 28% mothers breastfed more than usual;

Maternal and Newborn Care
- 79% mothers attended ANC within first trimester;
- 57% mothers received information on danger signs;
- 54-77% mothers received advice on STDs, immunization, child spacing, breastfeeding, delivery preparation;
- 51% mothers could site at least two danger signs; 14% men;
- 39% mothers took iron during pregnancy, but only 2%took for >90 days;
- 58% received post-partum visit;
- 39% mothers cited at least two danger signs during 7 days after delivery; 27% men;
- 22% women cited at least two danger signs during labor and delivery, 6% men;

- 99% infants were weighed at birth.

Child-Spacing
- 61% Source of information is television;
- 44% WRAs using modern FP;
- 71% of users using IUD;
- 90% WRAs had spaced birth greater than 24 months;
- 70% WRAs knowledge of at least two methods of FP; 54% men; 23% youth;
- 77% women knew where they could get FP methods; 56% men; 45% youth;
- 30% men sited condoms as FP method that they use.

STI
- 93% had heard of STIs; both WRAs and men;
- 17% WRAs had knowledge of STI symptoms in a male; 39% men; 11% youth;
- 24% WRAs had knowledge of STI symptoms in a female; 13% men; 4% youth;
- 10% WRAs had knowledge of symptoms absence; 7% men; 3% youth;
- 78% WRA knowledge of treatment place; 83% men; 60% youth;
- 37% WRAs had knowledge of at least two STI prevention methods; 39% men; 22% youth.

HFA – Key Findings

Staffing and Training
- There is shortage of health care providers, especially physicians, in the project target rayons.
- Health care providers have demonstrated incomplete knowledge on warning signs during pregnancy, delivery and after delivery.
- Health care providers rarely demonstrate satisfactory knowledge and skills of sick children management.
- The majority of health care providers have not received professional trainings in the last 5 years.

Equipment and Supply
- There is a shortage of basic equipment and supply important to implement Safe Motherhood and especially IMCI strategy.
- Health care facilities are under-utilized by the population.

Infection Prevention
- A majority of health care facilities the health workers do not follow all appropriate disinfecting and cleaning protocols.
- Most of the health facilities in villages do not have adequate clean water supplies.

In addition, Focus Groups Discussions (FGDs) were conducted among key stakeholders and beneficiaries of the project. See Appendix 6 for the results of the FGDs.

Health Status: Fourteen maternal deaths were reported in the Jalalabat Oblast in 2002 (MMR 64/100,000). One of these was in Aksy, and three in the Bazarkorgon Rayons. (MMR of 40 and 93,2/100,000 respectively). According to the autopsy reports in Bazarkorgon, maternal deaths were due to pre-eclampsia- a high risk patient who lived far from health services and did not comply with recommendations; kidney failure – a pregnant patient who had a pre-existing nephritis problem; and undetected TB, complicated by meningitis - a pregnant patient who sought treatment, was hospitalized for several weeks but misdiagnosed; thus did not receive treatment for TB. She was able to deliver a premature infant 3 days before she finally died. There have been no maternal deaths reported for the first quarter of 2003 in either of the two project rayons. All of the above data comes from the MOH, as does the information below.

As it is discussed below under section 2.e. Maternal and Newborn policies, it is difficult to get clear and reliable statistics for IMR because of the differences between the International nomenclature for defining death, as compared to that of the old Soviet system, and thus, Kyrgyzstan. The following is the information obtained from MOH statistics. But as mentioned in the proposal, it is expected that the numbers are much higher. There have been a total of 8 infant deaths reported for the period of Jan-April of this year in the Aksy Rayon. Three were due to birth anomalies (including Down Syndrome and RH factor), three were due to pneumonia, two were perinatal/early neonatal deaths within the first 24 hours of life due to trauma during hospital delivery and reportedly related to quality of care. Of the 21 child deaths in Bazarkorgon during the first quarter of 2003, 6 were perinatal (1-6 days), 5 were neonatal (7-28) days and 7 were infant (28 days-11 months). Eight died from pneumonia, while the others died from asphyxia, congenital anomalies and delivery trauma. All died at the hospital. In the Jalalabat Oblast, the number of deaths under 1 for 2002 were 420 - IMR 19/1000; Barzarkorgon had 64 deaths in 2002 - IMR 19.9/1000, and 21 in 2003 (IMR 23.6/1000); Aksy had 36 infant deaths, including still births, in 2002 - IMR 14,4/1000.

The statistics on the number of births for Aksy and Bazarkorgon obtained at those levels, differ from the information obtained on births for Aksy and Bazarkorgon at the oblast level. The numbers obtained from the Oblast HIS are much higher. This is likely due to the fact that rayon residents might be doing some in and out migration, and may end up delivering their babies in Jalalabat town - and thus not be counted in the rayon statistics, even though they are originally from there. This also makes it a little difficult to accurately calculate the IMR within rayons.

According to the KPC survey, of the 143 children under the age of two in Aksy whose measurements were taken, 47% were stunted. In Bazarkorgon, of the 121 children, 49% were stunted. MOH statistics give a figure of 23% undernutrition for < 1 year olds in Bazarkorgon and 6% for Aksy although the latter is questionable because living conditions are pretty much the same. The oblast level figure is cited at 7.5%.

Baseline findings with country context and constraints - As per the baseline findings, and unlike many developing countries, the program's population has a very high level of education, access to television and radio (for the most part), and reportedly a great desire for information in the form of written materials; something that is sorely lacking. Having taken care of people's every need, the Soviet medical system of old, also would have been the primary reason why women are in the habit of using services for maternal and newborn health. (As seen above with antenatal attendance, the

fact that 100% of infants were born in the hospital, and that most women space their children through the use of family planning methods).

On the other hand, the transition from a communist system where everything and everyone was essentially taken care of, to dealing with the constraints of being an independent state whose economy is not thriving, there are now any number of barriers to adequate health care. Without the guaranteed work on the state farms, the rural population finds itself in a position of having to bring in a salary or income through other means – such as planting their own products and trying to sell them. Kyrgyzstan is not a country rich in natural resources, and with its relatively new state of independence, this is something that is now having an impact on all of its citizens. With increasing poverty has come a deterioration of the health facility infrastructures, services, and things like public transportation, which is less available, and to some, another barrier to care-seeking.

The government's introduction of a cost-recovery system has been met with great reluctance on the part of the population, as trying to comprehend and deal with new fees for different types of services and drugs, they are simultaneously dealing with the removal of government subsidies in every other aspect of their lives as well. Health workers report that a big problem they are facing is the fact that they are serving a population that does not always seek services because of these new costs. When they do see patients who are sick and need care, the patients usually cannot afford to buy the medicines prescribed. Thus, the health provider is often left unable to help his/her patients.

Health providers themselves are also frustrated, with some perhaps feeling little incentive to do a good job. Although all of the doctors interviewed during FGDs seemed very active, one FAP health facility was found to be completely closed during working hours. Community members in that particular village insinuated that this was not an unusual occurrence. Health workers report earning between about 500 and 700 Soms, or $11-$16 a month. Small amounts of money from their salary is even taken up-front; something workers do not feel is right, but can't do anything about. Contributing to overall lack of satisfaction of health workers is the fact that they have a lot of patients under their responsibility (1 FGP per 4,000 pop., as opposed to the 1 per 1,500 as per MOH Order # 101). Health workers report that they are not always able to find the time to do much community outreach or home visits. This also explains why the level of knowledge on STIs, danger signs during and after pregnancy, and child feeding in the population, for example, is fairly low. As per the baseline study, practices are not very good either, with very little exclusive breastfeeding taking place, and the fact that household case-management of diarrheal episodes and pneumonia is quite poor.

Quality of care issues are being raised more and more, with WHO and UNICEF having spent a number of years working on the introduction of more modern and up-to-date protocols for case-management in maternal, child health and disease control. Training of MOH personnel across the country is aimed at addressing this issue.

2.c. Coverage Estimates - Coverage estimates for maternal and child health are very good for the most part. According to the baseline survey 76% of women received prenatal care during the first trimester of pregnancy, as per the above, an equal number received advice, all women delivered at the maternity house or rural hospital. 58% of mothers received post-natal care home visits.

Unfortunately of the thousands of women who were pregnant in 2002, only 1 woman in the project rayons is recorded as having been tested for syphilis (Oblast statistics).

The Sanitation and Epidemiology Station at the Aksy Rayon show that of the total deliveries (2,292) in 2002, 98.9% received DPT3, 97.9% OPV3, and 99.9% are recorded as having received the measles vaccine or the MMR vaccine at age 1. Bazarkorgon also reports 98.8% coverage for DPT3, 99.3% OPV3, but only 79% coverage for measles due to the fact that the vaccine was not available at one point. Tetanus toxoid vaccine for pregnant women is not part of the national policy. Growth monitoring is done every month by nurses working in the FAPs and FGPs. Child weights and heights are taken and mothers are told whether or not their child is growing well. Mothers are more disciplined about attendance during the first year of the infant's life, not understanding the importance of continuing with this much beyond this period. As per the above, only 52% of 151 mothers who answered this question had been weighed in the 4 months prior to the survey.

FP coverage is fairly good, with 43% using modern methods. Only 24 sterilizations were performed in Bazarkorgon in 2002; 2 with the mini-lap kit, and the rest after C-Sections. Six have been done so far in 2003, only one of which was with the mini-lap kit. Thirteen sterilizations were done in Aksy in 2002, and 2 in 2003; all after C-Sections.

Coverage in terms of insurance for drugs, is minimal, with hardly more than 553 prescriptions in the Bazarkorgon Rayon filled through the National Insurance Fund during the year 2002. For a total population of approximately 126,523, this seems grossly inadequate. Over 40 prescriptions were reportedly not even filled because there was an error in the prescription itself.

2. d. Disease Surveillance data – According to the Sanitation and Epidemiology Station responsible for disease surveillance in the Aksy Rayon, the source of this information is usually the feldshar nurses based out in the FAP health facilities. A phone call or information is immediately sent to this unit and if it is something that can be handled by the outpatient, Family Medicine Center, the Sanitation and Epi Station does not have to get closely involved. This department reports a typhoid outbreak with a total of 25 cases in the last five years and 2 in the last year. They also report 1 case of malaria. Also mentioned was a Diphtheria epidemic a number of years ago, and a nation-wide campaign vaccinated the entire adult and child population. Bazarkorgon reports about 5 cases of typhoid a year, some dysentery and seasonal Hepatitis A. For the latter, there was a serious epidemic two years ago, with about 1700 cases. They had close to 400 cases last year. Bazarkorgon also reports about 59 cases of low grade measles, potentially due to nomadic groups traveling during certain months of the year.

2.e. MOH policies/strategies/current services -

Table 1: Health Facilities by Rayon

Name of Rayon	Territorial Hospital	Rural Hospitals (SUB)	Family Group Practices	FAP	Total
Asky	1	6	15	29	51
Bazarkorgon	1	3	16	17	37
Total	2	9	31	46	88

Table 2: Health Providers by Rayon

Name of Rayon	Doctors	Medical Assistants, Feldshars	Nurses	Midwives	Assistants of Sanitarian Doctor	Medical Assistant-laboratorian	Total
Aksy	126	29	416	61	16	8	656
Bazarkorgon	121	17	589	34	18	15	794
Total	247	46	1,005	95	34	23	1,450

Maternal and Newborn Care – Although Making Pregnancy Safe/Promoting Effective Perinatal Care (MPS/PEPC) has been introduced by WHO, and two training-of-trainer (TOT) activities have taken place (the first was in April 2002 followed by one in February of 2003), the implementation of this protocol is far from being well under way. Participants of this WHO training, and leaders in obstetrics and gynecology have written some new guidance as a result of this training, but this has so far been limited to prenatal care and normal delivery, and not yet been put into practice. The current services continue to be less than ideal. Old standards do not allow for a clear distinction between normal physiologic and pathologic pregnancy events, and protocols for managing high-risk pregnancies and obstetric and newborn complications are outdated. The latter is also confirmed by the fact that several early neonatal deaths in the last year or so are reported due to trauma during delivery. The length of post-partum stay is 3 days for a normal delivery and longer for others.

The differences between international nomenclature and Kyrgyz on the definition of stillbirths, live births, and miscarriage, versus premature delivery have been noted. One particular difference is that of 28 weeks rather than the international 21 weeks as a marker separating a miscarriage and a stillbirth. Another difference may be that of defining what is actually a premature delivery, and not a still birth.

The German GTZ has recently donated equipment towards maternal and neonatal care in the oblast and rayons. Among the list of 44 items are gynecological arm-chairs, operating lamps and tables, respiratory systems "Savina", electric-surgery block, ultrasound, anesthesia devices, monitors, incubators and beds with heating "Babythem 8004." GTZ is also expected to give the oblast and the two project rayon level 1 ambulance car each at some point in the near future.

Prenatal women are seen relatively systematically, although delayed care-seeking and missed appointments, are not unusual because visits are not free of charge. Health workers do categorized patients as high or low risk, and encouraged them to prepare for childbirth – making sure to save up enough money to cover the costs and traveling up to the rayon maternity hospital ahead of time, if necessary. All maternity hospitals are located within the main hospitals – i.e. the territorial hospitals in the rayons. The cost of necessary things for delivery, like cotton, syringes, lamp, notebook etc, is

cheaper if they deliver at the rural SUP hospitals, so that a delivery can range anywhere between 250-1000 Soms, or $5.7 - $22.7.

Maternal and Child Nutrition – MOH policy concerning iron supplementation for pregnant women is 120 ml. of iron and 50 ug of folic acid weekly. Unfortunately the supply of iron is more or less limited to those who are willing to pay for it. So although 61% of pregnant women in Aksy, and 57% in Bazarkorgon are diagnosed as being anemic, systematic distribution of iron folate is not done. ADB recently supported the fortification of flour produced by a Jalalabat plant (Azret-Aiyub) through the "Improvement of nutrition of Vulnerable Mothers and Children in Asia at Transitional Economic Period," Project which is for a duration of 1 year. They will be fortifying flour with iron, zinc, Vitamin B and folic Acid. The cost of this flour will be the same as that of the other flour. There is no Vitamin A supplementation program, although UNICEF in Kyrgzstan is planning to initiate a supplementation program in some areas, including the Jalalabat Oblast. Vitamin A supplementation is not a part of MOH policy. The value and benefits of Vitamin A have been discussed, and the MOH fully supports the idea of pilot testing the distribution of capsules in the program area. Iodine deficiency is a serious problem in Kyrgzstan, and something that the MOH is very well aware of. A very recent oblast-wide study (USAID, ADB, and the Family Medicine Center) of 126,486 families showed that only 74,867 (59%) consume iodized salt. Although policy is in support of adequate iodization and preservation of salt produced in the country, the companies iodizing salt have different levels of competency and capacity. Contraband salt coming in through the borders is readily available, and for the most part, government officials have not been able to control this. Testing of salt has been done at the community and household level and education and information in this regard has become an MOH priority. The above-mentioned ADB project will also be supporting Jalalabat with the iodization of salt. They will provide equipment to a private enterprise to increase their capacity to carry out this process.

Breastfeeding – The central and local MOH and service providers promote immediate breastfeeding, exclusive breastfeeding for six months and persistent breastfeeding for a period of two years. Training and TOT on breastfeeding took place relatively recently and the practice of giving the newborn to his/her mother for immediate breastfeeding is quite new. There are a total of thirteen centers that have already been certified and ten more close to certification. Two of these maternity houses are in the Jalalabat Oblast, and they have received certification as Baby-Friendly hospitals by UNICEF. Currently, all babies delivered at the maternity hospitals are almost immediately given to mothers for breastfeeding. Although a couple of mothers in FGDs did report breastfeeding several hours after birth, rather than immediately, it is not clear why this was the case.

IMCI – IMCI has been adopted and adapted in Kyrgyzstan by the central MOH, who worked closely with WHO on this strategy. 5-8 day trainings have already taken place in some of the oblasts, including Jalalabat, and been supported by SdravPluz USAID and the World Bank at the FGP Centers. Besides them, IMCI has been successfully piloted in 3 rayons, where WHO and UNICEF provided both the training and the drugs. They are in the process of starting Community-based IMCI in these project areas, beginning with translating the training materials for this component into the Russian and Kyrgz languages. The Asian Development Bank (ADB) also plans to support the implementation of IMCI in 12 project rayons across the country. Three of those are in the Jalalabat Oblast, (Chatkal, Toktogul, Togus-Toro), separate from the child survival program area. Training of family practitioners now includes 11 days for IMCI – across the country. ADB, like Project HOPE

activities, will complement existing training of doctors with the training of midlevel health providers, and also assist with increasing access to drugs. MOH has included 12 of the 13 IMCI drugs in the essential drugs list, all of which can be partially covered by the insurance fund. This, unfortunately, is not available to the majority of the population.

Control of Diarrheal Disease- Family practitioners report having received a lot of training in the last years, through WHO, UNICEF and the MOH, in the control of diarrheal diseases. Oral rehydration packets are readily available and free of charge in every FAP. ORS corners or rooms exist in most health facilities, and mothers have received education on home preparation of ORS. Home visits by health care workers is very much a part of service provision and as a rule, sick children and adults have access to a health provider both at the facility and community level. It is not clear that this is always the case though, because outreach to more remote locations is limited by transportation issues. An important cause of diarrhea in children is evident by the fact that a good majority of program villages have not had running water for a while, and are forced to use river water for household consumption and use. The level of awareness of this as a problem is high, and during FGDs it was a point raised by women, leaders, men, youth and health facility workers alike.

ADB in collaboration with the rayon administrations of Aksy and Barzarkorgon, is in the process of remedying this problem with a multi-year project that will give access to all villages that currently have no access to water. (Aksy currently reports 80% without proper access. Bazarkorgon reports close to half of their population without access, although others may have water pipes that are in disrepair as well. Another evident problem contributing to diarrheal diseases is sanitation and hygiene. Although most households have an outdoor latrine, they are often not kept in good condition.

Pneumonia Case Management,
Health workers also say that they have received training in pneumonia case management through UNICEF and the MOH. Despite this, the issue of drugs remains critical. Drug supplies are limited, but more serious, is the fact that most people do not have access to insurance coverage for these drugs. In a project rayon population estimated at 126,523, only 553 prescriptions were filled through the Insurance Fund in 2002. Of these, many were not filled due to an error in the prescription itself. People are unable or unwilling at times, to pay for treatment and report a lack of clarity about which services or drugs have fees and which don't. Since the transition from the Soviet system, fees for service and drugs have become an important barrier to proper case-management. Going without any treatment or only doing partial treatment is common practice. Family Practitioners in FGDs expressed great frustration at this situation because they cannot help patients who don't have money, and this makes them feel inadequate and helpless to do their job properly.

Immunization- The Sanitation and Epidemiology Stations follows the international standards for EPI schedule and have successfully included Hepatitis B vaccine in this program. They report that nurses have received refresher training in vaccine administration and cold chain maintenance. The cold chain, unfortunately, is less than ideal, with as many as eight of the outlying health facilities reporting that refrigerators are out of order. Some FGP centers use refrigerators belonging to individual doctors or community leaders, mixing food items with vaccines, and potentially affecting their potency. Thanks to UNICEF, the program area is well covered with vaccines and vaccine thermoses. The MOH is responsible for supplying cotton and alcohol, the deficit of which is

sometimes a problem. Mothers coming in to have their children vaccinated are often required to pay a small sum, although the Sanitation and Epidemiology Stations seemed to be unaware of this.

Child Spacing – A Reproductive Health and Rights law is in place, established by a Working Group, signed and published by the President and Parliament of Kyrgyzstan. This law supports individual and family rights to informed choice for contraceptives, independent choice on the number of children and women's rights to sterilization. Family Planning contraceptives are generally available; the supply supported by UNFPA. This supply, however, is not always adequate, depending on the rayon. Barzarkorgon Rayon health facility workers reportedly have a very good supply as they are a pilot in the ZdravPlus (USAID) Project, and have extra support for family planning. Whereas health workers in the Aksy Rayon often run out of their supply before they get more. IUD is the most popular method practiced although clients often complain about lower back aches and heavy bleeding. Oral pills are also available, but clients generally have very little knowledge about them and there is no real push to promote this method. Condoms are not used by couples for child spacing purposes, and sterilization is only available in limited places: the maternity hospitals at the oblast, the maternity hospital in Bazarkorgon, and at the maternity hospital in Aksy. In the latter, tubal ligations were done only for women who have had a C-Section as they do not have the equipment or the training to do it otherwise. This service is not available in the 9 rural hospitals across the two project rayons.

Two local NGOs work in reproductive health – Ulgu, in the Aksy Rayon through Counterpart International support, and the Rainbow Center, financed by the Swiss Corporation Office, which covers the Jalalabat, Osh and Batken Oblasts. The latter is staffed with 3 people, and they work with approximately 15 volunteers between the ages of 14 and 24. NGOs work in the area has place more emphasis on AIDS in particular, but there is also education and training on STIs, and increasingly FP as part of reproductive health.

Sexually Transmitted Infections - Trainings on the Syndromic Management of STIs in Kyrgyzstan, were done several years ago with the idea to address the needs of remote FAP health facilities where there is no access to laboratory services for disease diagnosis. FGPs in Bazarkorgon have all received training in Syndromic Approach of Sexually Transmitted Infections. None have received training in Aksy. The benefits and drawbacks to Syndromic Management was something that was an issue, and the cost of treatment is also something of great pertinence here. The fact that cost of treatment to the client is higher when using Syndromic Management protocols was raised – particularly in view of the fact that the availability and accessibility of drugs is already critical.

Although the MOH retains a policy of confidentiality, family practitioners will often use the local authority or community leaders to follow- up on a client who may not be keeping appointments, and even though they don't necessarily give out confidential information, this contributes to the general lack of trust that men, for one, reported during FGDs. Women, on the other hand, did not seem to have this concern.

All women are required to have about 100 soms during pregnancy for prenatal analysis such as syphilis testing and ultra sound. Systematic testing of pregnant women twice during their pregnancy – once in the first visit and once at 30 weeks of pregnancy, is done in Bishkek, Jalalabat and at the Rayon level. These lab services are not currently available at the FGP and FAP levels, even though

FGPs do other lab work. Clients from these levels who have some financial means, have their blood sample transported by the health provider to the Rayon level for diagnoses. They are obliged to pay for the transportation costs and this is also a barrier for many women.

At the Rayon, Oblast and STI department levels, the protocol is to test for syphilis through the use of simple reactive agents first. If the test should come out positive, they then do a more elaborate test on that blood sample. MOH policy assures free testing for pregnant women. But in reality, women are paying 30 soms, twice during the pregnancy, for these tests. An x-ray of the husband's chest is supposed to be taken for TB detection, as they do not want to x-ray the pregnant woman. But this is not usually done. In Jalabat city 6 health facilities such as the Maternity House, Human Reproductive Center, Hospitals who do testing and send positive results to the STI Unit who does further testing. Two places at the Rayon level do testing – Laboratory for the Outpatient services and the one for the Inpatient Services. Laboratory services are available at the SUP, rural hospital level, but they have not been trained to test for syphilis, and the reactive agents are not available at these levels.

IEC activities in reproductive health are conducted by the Center for Health Strengthening under the MOH. They have an affiliate in Jalalabat. A local NGO, Tais +2, is active in STI work with commercial sex workers and IV Drug Users in Jalalabat also. They currently have one CSW trainer and are happy to establish collaboration with Project Hope in the two project rayons. There is an AIDS Center (MOH) in Jalalabat. They do training in schools, and at the community level through a peer education program. UNDP, UNFPA, and UNAIDS-CAR also support HIV/AIDS work.

2.f. Overall quality of existing services

The Ministry of Health of Kyrgyzstan is responsible for the national programs for TB, HIV/AIDS and STI prevention, Safe Drinking Water, and the Social Epidemiological System (SES). The newly created Health Insurance Fund (HIF) is merged under the MOH, giving the MOH the power to contract with providers and develop standards of care, while assuring equity of access to the population. The health reform has focused on 1) restructuring the health delivery system and strengthening primary health care – an attempt to move resources from the hospital to the PHC; 2) increasing population involvement; 3) new provider payment systems—the development of family practice groups that are reimbursed with a per capita fee; and, 4) new management information systems[1]. More than 400 family group practices (FGPs)—consisting of a pediatrician, OB/GYN, and internist trained in family medicine—have been established nationally to deal with the most common health problems at the primary care level. FGPs are paid a capitated rate per enrollee by the HIF and compete for patients. A National Family Group Practice Association and the National Family Medicine Training Center were established to support these efforts.

Oblast- and rayon-level health facilities are administered by the oblast and local governments, not the central MOH. The Ministry of Health does not have a technical and administrative team responsible for health services and public health in the oblast. The Chief of the Union Oblast Hospital manages the oblast and has two deputies (outpatient services and inpatient services) and two coordinators (one for maternal and one for pediatric health). The Chief and his/her Deputies

[1] O'Dougherty, S, et al. Zdrav Reform – Option Period Final Report – June 1, 1998 – June 30, 2000. USAID/Almaty, July 2000, p. 16

provide oversight to all primary and secondary facilities and public health activities of the MOH. It was the impression of the Project HOPE team that the new system has not yet developed protocols and policies to facilitate internal management. There was also a pervasive lack of MOH protocols, prikaz, and other orders at the local level to provide structure and guidance to the health services. The National FGP Association and the National Family Medicine Training Center have affiliates in Jalalabat. However, according to the Abt representative in Bishkek, Jalalabat has only one trainer. On the whole, substantial additional inputs are needed to establish this new system in the rural areas.

According to oblast health statistics for 2000, there are 1,475 physicians and 6,505 midlevel health providers in Jalalabat staffing an oblast children's hospital, maternity, and STI clinic; four city hospitals; eight central rayon hospitals (CRHs) (one in each rayon); 28 rural hospitals (SUBs); 48 clinics (SVAs); 163 feldshar-obstetrical points (FAPs); and 139 groups of family doctors. Zdrav reform efforts are gradually replacing all FAPs with family practice groups, and rural village hospital beds are being changed to day beds, in an effort to separate primary health care and in-patient hospital services. However, FGPs are still mainly confined to urban areas. The Asian Development Bank and World Bank are supposed to provide equipment for new FGPs in the rural and urban areas, respectively, but apparently this process has not yet started. In addition, there are 141 social patronage workers (SPWs) funded by the oblast and UNFPA (until 2002). These workers are mainly nurses and social workers, each responsible for about 30 high-risk families which they visit every week.

Despite the fact that there are many providers and service delivery points in the oblast, compared to districts of similar size in other parts of Asia, Africa, or the Americas, there are significant barriers and constraints to care-seeking. Recent decreases in medical consultations have been attributed not to improved health status, but to the following factors[2]:

- Facilities are poorly equipped and sometimes closed.
- Medications, supplies, and services are lacking.
- The government emergency transport system is only minimally functional.
- Providers lack motivation, due to very low, and sometimes unpaid, salaries.
- Clinical knowledge, skills, and existing protocols are outdated.
- Patients must pay substantial out-of pocket payments and semi-official user fees.

2.g. Rapid CATCH Indicators

The following table summarizes the Rapid CATCH indicators that the project was able to compute. Mid-term and final evaluations will make the attempt to collect all the necessary data for a complete set of CATCH indicators.

[2] Bauer, A., et al. A generation at Risk – *Children in the Central Asian Republics of Kazakhstan and Kyrgyzstan*. Online edition. April 1998. & European Observatory on Health Care Systems. *Health Care Systems in Transition – Kyrgyzstan*. 2000.

Table 3: Rapid CATCH Indicators

Indicator	Numerator	Denominator	Question Reference
1. % of children aged 0-23 months with low weight (weight for age) (<2Z)	8/260 3.2%	260	Gm31-gm35
2. % of children aged 0-23 months who were born at least 24 months after the previous surviving child	Children aged 0-23 months born at least 24 months after the previous surviving child	Total children 0-23 months in the study	Not investigated
3. % of children aged 0-23 months whose birth was attended by a doctor or nurse	98% 293/298	298	Dnb1
4. % of mothers of children aged 0-23 months that received two doses of dT vaccine during the last pregnancy, according to health card	N/A	N/A	Not investigated
5. % of infants aged 0-5 months who received breast milk only in the past 24 hours	13% 9/71	71	Bn6a
6. % of children aged 6-9 months who received breast milk and complementary feeding in the past 24 hours	87% 45/52	52	Bn6a – bn96p
7. % of children aged 12-23 months with all recommended vaccines at the moment of their first birthday according to the growth monitoring card	N/A	N/A	Not investigated
8. % of children aged 12-23 months that received the MMR vaccine according to the growth monitoring card	Children aged 12-23 months that received the MMR according to the growth monitoring card	Total children 12-23 months in the study	Not investigated
9. % of children aged 0-23 months who slept under an impregnated mosquito net the previous night	N/A	N/A	Not investigated
10. % of mothers of children aged 0-23 months that know at least two signs of childhood illnesses indicating the need for treatment	47% 141/300	300	SC11-SC18
11. % of children aged 0-23 months that received more liquids and continued feeding during diarrhea episode in the last two weeks	36% 18/50	50	D1-D5
12. % of children aged 0-23 months that received more liquid and continued feeding during an illness with cough in the last two weeks	31% 31/100	100	RI1, RI7- RI9
13. % of females of reproductive age who know at least two ways to prevent STIs-HIV/AIDS	37% 111/300	300	STI2
14. % of mothers of children aged 0-23 months who report washing their hands with water and soap before the preparation of meals, before feeding children, after defecation and after tending a child that has defecated	N/A	N/A	Not investigated

3. Program Description by Objective, Intervention and Activities

Table 4: Estimated Program Effort by Intervention

Intervention	% of Total Effort
Maternal and Newborn Care	30%
General Nutrition (including micronutrients)	15%
Breastfeeding Promotion	10%
Control of Diarrheal Disease	10%
Pneumonia Case Management	10%
Immunization	5%
Child Spacing	10%
STI/HIV/AIDS Prevention	10%
Total	100%

Table 5: Program Site Population

Population Age Group	Number in Age Group In oblast	Number in Age Group In Project Rayons
Infants (0-11 months)	20,256	4,853
Children < 2 years	40,789	10,647
Children 0-71 months old	132,000 (approx.)	30,000 (approx.)
Women (15-49 years)	201,274	53,618
Youth and Adults (15 yrs. & older)	550,695	131,295
Total Population	905,314	227,124

Source: MOH Oblast and Rayon Administration, 2003.

3.a. Maternal and Newborn Care

Desired Result: Improved Quality of Maternal and Newborn Care and Target Population Knowledge

Intermediate Results (Outcomes):

1. Improve the quality of antenatal and postpartum care by MOH and FGP providers.
2. Increase the capacity of physicians and midwives to provide standardized quality essential and emergency obstetric care.
3. Increase the capacity of physicians to provide quality newborn care.

4. Increase MOH and FGP provider capacity to diagnose and appropriately treat/refer pregnant and post-partum women and neonates with danger signs.
5. Increase the knowledge of women and family members about danger signs during the prenatal, post-partum, and neonatal period that require immediate and appropriate care-seeking.

In relation to the Child Survival and Health Grants Program: The above program objectives all contribute the achievement of CSHGP's Strategic Objective1: Enhanced NGO capacity to deliver development services in select USAID countries; IR1.1: Strengthened operational, technical and financial capabilities of NGOs and cooperatives (to carry out results-oriented trainings); IR1.2: Expanded linkages among NGOs, networks, and public and private sector institutions (local partners will help with trainings) ; IR1.3: Wider and more effective learning and dissemination by development partners and PVC of tested innovations, best practices, lessons learned and standards (through both training, quality assurance, and outreach activities). The objectives also assist with achieving SO2: Increased mobilization of U.S. development resources; IR 2.1: Increased operational and technical capacities of select PVOs (because this program is ambitious and covers several different sectors, the experience is expected to make a marked contribution to Project HOPE capacity); and IR 2.2: Expanded collaboration between PVOs and corporations.

Approach

Following Project HOPE's Uzbekistan model, the Kyrgyzstan Child Survival Program will also work with oblast and rayon maternity houses, and rural hospitals to improve the quality of obstetric care; including antenatal, delivery and post-partum, as well as newborn care. This will be done through training and support for the WHO Promotion of Effective Perinatal Care program. The program will develop strategies to address the issue of health provider motivation as well.

To complement the above, Project HOPE and partners will also implement an outreach program to improve beneficiary knowledge, practices and compliance. Community outreach will include group discussions and education, meetings, competitions and home visits. The program will promote the creation of Village Health Committees, (they do not currently exist), and also involve religious leaders, both male and female, to promote and support the transfer of key messages. Materials development or adaptation, production, and systematic distribution will increase the program potential and a mass media campaign using radio and television will also cover all program intervention areas. This outreach strategy will be used for all of the program interventions discussed in this DIP.

Current knowledge and practices, care-seeking. Knowledge with regard to maternal health appears be quite good with women in Focus Group Discussions revealing that they do understand the importance of care during pregnancy. When asked what things are important to take into consideration, mothers replied that they should not work as hard; mentioning that carrying water and working in the fields was too much. They said that they should get enough rest, while at the same time stay relatively active (the latter during pregnancy). But financial challenges that families are facing are critical; with the burden on women being quite high. Surviving on a subsistence, agriculture-based economy, more and more women are being forced to take on the responsibility of not only planting and harvesting on their small plots of land – which is labor intensive, but they are also taking the responsibility of bringing in income by working in the 'bazaar' where they can sell their agricultural products, among other things. In Soviet times, they would just work on collective

farms and earn an adequate salary. Those farms have since closed, of course, and much of the population is left jobless, and looking to grow and sell their own agricultural products for sustenance and to replace that income. So in practice, women continue to work hard up until close to childbirth, and in addition to the prior-mentioned, also have to carry water from the river or other water source, cook and take care of children and the household. Both women and men say that husbands are willing to help out with baby-sitting. They also know that women should not be lifting heavy burdens or carrying heavy buckets of water. But help in these areas is only really forthcoming when the woman is already very far along in her pregnancy.

Although people tend to be passive rather than proactive, (a legacy from the Soviet era), prenatal care attendance is relatively good. Unfortunately the cost of visits, and sometimes the distance to the nearest health facility, contributes to mothers occasionally missing appointments, and the fact that some seek care after the first trimester of pregnancy – 34% according to the KPC. Virtually all mothers deliver at the rayon maternity hospital, or the rural, SUP hospitals as an alternative, and often closer location to where they live. A very few reportedly deliver at home either unintentionally, or because they cannot afford to pay the fees, but we did not encounter this in the KPC sample. Mothers mentioned that it was the common practice for their newborn to be placed next to them and breastfed within the first hour of birth.

With regard to knowledge and practices after childbirth, mothers mentioned the importance of getting enough rest and getting help from their husbands, parents and siblings. In Kyrgyzstan, it is in fact common practice for a new mother to spend forty days at her parent's home after childbirth. If a mother is dealing with her second or third child, she will rarely go back to her parents home because she has responsibilities in her own. She will tend to get help from her husband during the earlier part of the post-partum period, but is soon obliged to return to her normal activities.

Traditional beliefs tend to be quite harmless, such as the woman staying away from cords during pregnancy so that the umbilical cord does not get caught around the infant's neck during delivery, avoid stepping over ditches, stepping over their husbands legs, not cutting their hair and holding on to their husbands handkerchief during childbirth. Mothers also mentioned that it was not good to hate. Jealousy of someone else would also give you a baby girl and not a boy.

Interventions and Activities

Training - As discussed in the Section 2, and as is the case in Uzbekistan, the main issue in the target area is one of quality of services rather than one of access. As the WHO PEPC model has not yet been widely implemented, and current practices and skills are not up to international standards for quality of care, the focus of this intervention will be on health service providers. After an initial orientation and planning meeting, the program will start off with a TOT, and implement a training program that is expected to go on for an extended period of time. Personnel involved in labor, delivery and newborn care at the oblast level and across the two rayons, will be a potential 43 FGP's, 100 nurses in FGP's (including midwives), 2 trainers in Family Medicine Training Center and 20 Ob/Gyns & Neonatologist/Pediatricians and 8 midwifes in Oblast Maternity House in Jalalabat town. In 2 target project rayons personnel involved in prenatal and postpartum care are 80 FGPs , and 46 Feldshars and 27 midwifes FGPs and 17 Ob/Gyn, neonatologist, 63 midwifes in SUB's and rayons Maternity Houses.

The orientation and planning meeting will involve national level MOH, international consultants, Project HOPE Uzbekistan staff and international agencies such as, WHO, UNICEF, USAID, ZdravPlus who has been supporting the oblast with obstetric care. The Project HOPE HQ technical advisor for this component will travel to Kyrgyzstan and give additional technical assistance to the PEPC TOT participants in preparation for the training activities. A WHO consultant (if he/she is available) will accompany the national trainers for the initial TOT. The TOT participants will include the Chief Oblast Ob/Gyn for Inpatients, the one for Outpatients, the Oblast Chief for Neonatology, the Rayon Chiefs for Inpatients (Maternity Hospital) and Outpatients, and Neonatology as well. Also invited to participate in this TOT activity, if he/she wishes or needs it, will be the National level Chief Ob/Gyn in Bishkek, who will be newly nominated. Other participants of the TOT will be two members of the Oblast Family Medicine Training Center, and naturally, Project HOPE's Maternal and Child Health Specialists.

The two-week PEPC training (one week-theoretical, one week-practical) will target all Maternity Hospital doctors and midwives at the oblast level, (approximately 35), as well as a potential 54 Ob/Gyns and midwives working across the two target project rayons. The DIP Working Group also felt that it is important to train FGPs and Feldshars as well, because they are actively caring for pregnant and postnatal mothers. Training for the latter will be adapted, and limited to fit their needs. The Uzbek, Navoi Program has assisted with the adaptation of PEPC for this cadre of workers, and the Kyrgz Program should be able to benefit from this, and other experiences that they have gained. An active exchange between the two programs will facilitate this.

Training emphasizes the use of evidence-based protocols, and covers antenatal care - including dealing with anemia, bleeding, and hypertension; labor and delivery - including the use of partograph, complications of delivery, obstructed labor, active management of 3rd stage, induction of labor; post-partum care – including the health of the mother, newborn care and resuscitation, and post-partum depression. With new PEPC protocols, one improvement will be that husbands can be with their wives during delivery if they wish, as deliveries will not take place in the delivery room, but in the private room where the women normally stay while awaiting delivery.

20 Social Patronage Workers (SPW) from each of the two project rayons, integrated into the CS program to implement specific community outreach activities, will receive a full three weeks of basic training covering maternal and newborn care, and the other program intervention areas. The Training Supervisor, also integrated into the CS program to oversee and supervise the outreach activities, will be the lead trainer and work with the assistance of the Project HOPE Maternal Health Specialist, as well as the specialists for the other interventions.

Outreach - An outreach program will also be implemented to reach women of reproductive ages, mothers, husbands and families, with the intention of increasing their knowledge, encouraging good and more consistent practices and care-seeking, and importantly, increase their sense of responsibility and pro-activeness when it comes to health. SPWs will be responsible for initiating community activities and conducting home visits. Part of their job for this intervention will be to help assure the registration of all pregnant women – something that is already part of the system, but only happens once a woman goes in for their first antenatal check-up. SPWs, with the

assistance of program staff, will be mandated with the creation of Village Health Committees. The development of these committees is expected to be a strategy that will facilitate community education, involvement, ownership and decision-making with regard to health. Specific to maternal and newborn care, is the expectation that these committees will also assure the availability of emergency transportation. Through existing community member resources, it is possible to find vehicles in the community. With commitment from community leaders, birth planning with respect to an obstetric emergency is very possible, and as ambulance transportation from health facilities is often a problem, or can result in serious delays in obstetric care, this backup plan will be able to fill this gap – contributing to a reduction in morbidity and mortality due to obstetric problems.

The SPWs will essentially be ready to start community outreach work before PEPC and IMCI training really get underway and completed. They will be trained during the months of July (Year 1), and will be able to start working in August.

Feldshars (Medical Assistants) from the FAP health facilities and Family Practitioners from the FGPs also do home visits when they are not seeing patients at the clinic. They report difficulties reaching certain villages because of the lack of transportation, and frustrations with the fact that their patients have limited financial resources and cannot, or do not always comply with the prescribed treatment. The CS program specialists will continue to work with these service providers after the PEPC training, encouraging them and supporting their work with on-site TA, feedback and the initiation of an employee incentive program.

Material development/Mass Media - This activity will include the production or adaptation of brochures, leaflets and posters. The team from the Center for Health Strengthening will lead this activity, as they are responsible for all IEC in the Oblast. They are a part of the MOH and provide information to the population and health providers, and develop mass media messages and programs, working with radio, and television.

A Working Group for each intervention area, including Project HOPE staff will assist the Center with this task, particularly with key message development. As this program is essentially following the CS Uzbekistan model, it is likely that most of the messages will be the same for this and the other program interventions, so that educational materials used in that program can be translated into Kyrgz for our 68% Kyrgz-speaking population, while retaining copies to be distributed in the Uzbek language, since approximately 32% of the population in the program area is Uzbek. Both languages are spoken almost interchangeably in this Oblast. As a large majority of our population, is not only literate but has reportedly received secondary education and higher (98% women and mothers, 50% men), it is a big advantage for the program, and will allow for the widespread and systematic distribution of the above-mentioned educational materials to program beneficiaries.

Key Messages:

For providers:

- Following evidence-based protocols for managing pregnancy, delivery, the post-partum period and the neonate reduces morbidity and mortality.

For target population:

- The importance of care-seeking from the first trimester of pregnancy;
- Information on pregnancy, post-partum and newborn danger signs;
- Care of the newborn, and necessary conditions in the home for the newborn.

Commodities/Provisions: To facilitate outreach activities, Project HOPE will provide SPWs, FAPs and FGPs with a shoulder bag. The FAP and FGPs will also be provided with equipment to measure blood pressure, a stethoscope, a thermometer, measuring tape to monitor growth during pregnancy, and all three types of providers will receive a watch after their training, to help them time breathing for ARI and pneumonia cases. In addition, they will be given a booklet that list all medications that will be available free of charge during the program period, to facilitate care of the patient. Also provided will be new Maternal Health Cards, (or Healthy Lifestyles for Women Cards) containing their history, prenatal services, and educational information about micronutrients, food consumptions, hygiene and physical habits, as well as danger signs during pregnancy and post-partum. Mothers after delivery will receive a Child Health Card (or Healthy Lifestyles for Children Card), containing their immunization coverage, growth monitoring, and educational information about breastfeeding, child feeding, childcare and danger signs.

In addition to the above, the Project will donate a vehicle for use of the Training Supervisor and other Program Specialists to facilitate outreach activities and supervision, particularly assisting SPWs in reaching locations that are more remote, or a long distance from the center.

Equipment for maternal and newborn care including neonatal resuscitation has already been donated by the German government through GTZ. They have covered all health facilities in the program area. The CS program will be contributing MCH care equipment as needed.

The availability of drugs for perinatal care does not seem to be a problem in and of itself. The costs to the patient tend to be the main barriers to care-seeking, but in the case of E-Moc, expenditures will be made.

3.b. Maternal and Child Nutrition

Desired Result: Improved Maternal and Child Health and Nutrition

Intermediate Results (Outcomes):

1. Improve maternal nutrition during pregnancy and lactation.
2. Increase the number of women that consume iron folate during pregnancy and lactation.
3. Increase the number of women and children that use iodized salt.
4. Pilot test the provision of one megadose of Vitamin A to women immediately post-partum.
5. Pilot test the provision of Vitamin A to children 6-71 months of age

In relation to the Child Survival and Health Grants Program: The above program objectives contribute the achievement of CSHGP's Strategic Objective1: Enhanced NGO capacity to deliver

development services in select USAID countries; IR1.1: Strengthened operational, technical and financial capabilities of NGOs and cooperatives (partnering on service delivery and behavior change); IR1.2: Expanded linkages among NGOs, networks, and public and private sector institutions (local partners will help with training); IR1.3: Wider and more effective learning and dissemination by development partners and PVC of tested innovations, best practices, lessons learned and standards (through both training, service delivery and outreach activities). The objectives also assist with achieving SO2: Increased mobilization of U.S. development resources; IR 2.1: Increased operational and technical capacities of select PVOs; and IR 2.2: Expanded collaboration between PVOs and corporations (matching grants for vitamin A and iron folate and potentially Village Bank projects for IGAs).

Approach

The program's approach to achieving the above results will also include training. Training for maternal nutrition, micronutrients and more in-depth information on breastfeeding and child nutrition, will be added to what participants of IMCI training will receive.

The success of this particular intervention will depend heavily on the community outreach which will include activities as described under maternal and newborn care - the creation of Village Health Committees, and work with religious leaders, the distribution of informational and educational materials, and use of the mass media to transfer messages. A food consumption study

Current knowledge and practices, care-seeking. The good level of knowledge with regard to care during pregnancy does not necessarily translate into practices. Mothers in FGDs mentioned that it was important them to eat a good variety of foods and get enough vitamins, but in light of the current financial crisis that people are facing, it is unlikely that mothers and families are able to prioritize this. A variety of fruits and vegetables are indeed available through the spring, summer and autumn; particularly apples. Some families are able to can and preserve fruits as well. But much of this is not actually being consumed by the household, particularly because of the need for additional income. It is widely reported that many families have nothing to eat but bread and tea much of the time.

Both mothers and grandmothers mentioned anemia as a problem. Most attributed this to poor diet. Some women think that it is also due to eating chalk, which is a common practice in certain areas. Others attributed it to when there is not enough of an interval between pregnancies. Although 40% of mothers interviewed in the KPC survey said that they received iron folate tablets, only one mother had taken tablets for more than 90 days. Health facility providers report that there is no systematic distribution and consumption of iron folate, despite the MOH policy that supports this. As previously mentioned, women are obliged to pay for this, and this is the main barrier. Black tea, an inhibitor for iron-absorption, is consumed with every single meal, in every single family, as part of a long tradition. Green tea that does not inhibit the absorption of iron, tends to be consumed more by men and older people particularly for the health benefits, and after eating fatty foods. It is also a seasonal drink; consumed more during the hot summer months, rather than the cold winter months when people want to drink black tea.

Through the use of an intern who will be working with the CS program during the next months, the program has planned to conduct more in-depth research through a 7-day and a 24 hour recall study, on actual food consumption of pregnant and lactating mothers in the program area.

Infant feeding practices do not include exclusive breastfeeding. Only 9% of mothers with children <6 months in the KPC exclusively breastfed, and this was confirmed in the Focus Group Discussions where they said that they usually add boiled water or tea to the baby's diet in the first six months. Many will also give the baby bread, softened with water, porridge containing flour, oil and sometimes sugar, or cookies crumbled up in milk. Those who feel that they do not have enough breast milk, and those who can't breastfeed at all, will give the infant cows milk as well. A traditional custom, not practiced by all, is the use of a piece of fat as a pacifier for the infant to suck on. This is often kept inside a cloth, pinned to the child's clothing or stuck into something so that the child cannot swallow it.

UNICEF, Academia of Nutrition of Kazakhstan and the Kyrgyz Scientific Research Institute of Obstetrics and Pediatrics undertook a child nutrition study in two rayons: one in the north (Naryn Oblast), and one in the south (Osh Oblast). A 50-Cluster sample of 250 women and 252 children between the ages of 6 months and 5 years were studied. Among other things, the report concluded that there were no real differences in food consumption patterns across the country; i.e. North versus South. The information coming out of this report will be used as a reference for the child nutrition component as well.

Traditional beliefs are more superstitious than anything. Among them is the belief that women should not eat camel or rabbit meat during pregnancy. As mutton and milk products are the main source of protein, this is not really a problem. There are no reported taboos for child nutrition, although mothers believe that children identified with rickets (caused by a Vitamin D deficiency) should be given turtle eggs.

Interventions and Activities

Training - Training for maternal nutrition, micronutrients including iron and iodine-deficiency diseases, the benefits of Vitamin A, and child nutrition including breastfeeding, will be given to the outreach Social Patronage Workers as part of the three-week basic training which their supervisor, the Training Supervisor, and the Program Specialists are responsible for. Additional trainings will be done for this category of worker once a year, and monthly meetings with their supervisor and program staff will be an opportunity to review some of this technical information as well.

The Feldshars and FGPs are already well aware of maternal nutrition needs, and they will all be participating in the IMCI training that includes child nutrition and breastfeeding.

Outreach – As part and parcel of the maternal and child health components, the outreach activities for maternal and child nutrition will reach women of reproductive ages, mothers, husbands and families. Through the 40 total SPWs in the program area, frequent outings for home visits and community based activities, will encourage increased servings of the staple food, and other foods if possible, for pregnant and lactating women and young children, and the push families to prioritize nutrition and micronutrients to reduce morbidity and mortality in this target group. WRAs, mothers and other family members will receive information and education on iron-rich foods, iron-absorption enhancers and inhibitors and discuss the importance of not taking iron

tablets around the time that they are drinking tea. Families will also receive information about the benefits of Vitamin A, iodine and the importance of using iodized salt.

The outreach program will elicit the involvement of the local Administrative Units, gaining their support to promote the increased production of vegetable and fruit in home gardens, and the issue of family consumption of things such as apples, particularly for pregnant/lactating mothers and young children. Issue such as the increasing use of chemical pesticides for agricultural production should also be raised.

Testing and Control of salt being sold in the bazaar, and salt consumed at the household level has reportedly been done by the Sanitation and Epidemiology Unit. It is not clear how often or rigorous this activity is, but the program will seek their continued support in this area, in collaboration with the local government administration. Education on the use of iodized salt will be done at both the household and community levels, including education on proper storage and preservation of the iodine in the salt.

Material development/Mass Media – As discussed above, and like all other interventions in this CS program, the maternal and child nutrition component will also include the production or adaptation of brochures, leaflets and posters. The team from the Center for Health Strengthening in the Jalalabat Oblast will lead materials development, production and mass media campaigns. As mentioned before, they will work with the Working Group for this component, including program specialists. One of the advantages of dealing with a well educated population is the fact that although the materials developed will avoid inundating people with too much information; the outreach workers and program staff will be able to give people enough information to fully understand basic standards of care. And they are fully capable of absorbing this – hopefully facilitating behavior change.

As a follow up to this activity, a WHO and UNICEF -supported Child Health brochure was developed, including key messages about nutrition and child feeding, danger signs, as well as space to record child immunizations. The CS program will probably use this same card as it was developed for country-wide use.

Key Messages:

For provider:

- There should be systematic provision of iron folate to all pregnant women for a duration of 6 months during the pregnancy and 3 months post-partum, as per the MOH and WHO protocols.

For the target population:

- All women during pregnancy should take iron folate tablets as prescribed during a period of 6 months, and three months post partum. (The latter due to the fact that the prevalence of anemia is virtually at 100%.);

- Foods rich in iron should be consumed with foods rich in Vitamin C and not with foods known to prevent iron absorption (i.e. tea);
- Households should purchase iodized salt to assure the health and full intellectual capacity of newborns and young children;
- Exclusive breastfeeding for the first 6 months affords multiple benefits to the mother and infant.
- Children 6-23 months need three nutrient dense meals and two snacks per day, in addition to breast milk.
- Pregnant and Lactating mothers should eat an additional service of the staple food every day. Vitamin A, in addition to the prevention of blindness, boosts infant and children's immune system.

Commodities/Provisions: To facilitate maternal and child nutrition in the case of iron-deficiency anemia which is a problem for close to one hundred percent of our target population, Project HOPE will be obtaining iron folate from donated drugs, and Vitamin A capsules for supplementation will also be provided as a donation from the Sight and Life Foundation. With the provision of the new Maternal Health Cards, (or Healthy Lifestyles for Women Cards) containing the mother's history and prenatal services, the iron supply to the mother will be recorded. Breastfeeding mothers after delivery, will receive one dose of 200,000 IU of Vitamin A, and this will be recorded in the Child Health Card (or Healthy Lifestyles for Children Card), along with the child's Vitamin A and immunization coverage. Infants under the age of 6 months who are not being breastfed will receive one dose of 50,000 IU of Vitamin A. All infants 6 to 12 months will receive one dose of 100,000 IU, and children 1-6 years of age will receive two doses of 200,000 IU.

The above are the commodities required for the intervention, and although this support is not necessarily sustainable after the end of the program, it is considered of vital importance to the program achieving its objectives. It is hoped that these maternal and newborn care interventions, including nutrition, will be a pilot activity that can influence policy and MOH priorities.

Table 6: Vitamin A Supplementation

Target Area	Infants <6 months not breastfeeding (estimated at 5%)	Infants 6 -12 months	Children 1 – 6 years	Post-natal Mothers	Total post-natals & children 1-6 yrs.
Aksy and Bazarkorgon Rayons	**126** @ 1 dose = **126 capsules 50,000 IU**	**2,512**@ 1 dose = **2,512 capsules 100,000 IU**	**32,354** @ 2 doses = 64,708 capsules 200,000 IU	**5,025**@ 1 dose = 5,025 capsules 200,000 IU	**69,733 capsules 200,000 IU**
Total for 3 years	**378 capsules 50,000 IU**	**7,538 capsules 100,000 IU**	194,124 capsules 200,000 IU	15,075 capsules 200,000 IU	**209,199 capsules 200,000 IU**
Total for 3 years w/ 5% (for margin of error & pop. Increase)	**397 capsules 50,000 IU**	**7,915 capsules 100,000 IU**	203,830 capsules 200,000 IU	15,829 capsules 200,000 IU	**219,659 capsules 200,00 IU**

3.c. Breastfeeding

Desired Result: Improved Child Health and Nutrition

Intermediate Results (Outcomes):

1. Increase the percent of newborns that are breastfed within one hour of birth.
2. Increase the percent of infants under six months that are breastfed exclusively for the first 6 months.
3. Continue breastfeeding on demand until two years of age.
4. Increase the number of maternities that are certified to be baby-friendly in the Oblast.

In relation to the Child Survival and Health Grants Program: The above program objectives contribute to the achievement of CSHGP's IR1.1: Strengthened operational, technical and financial capabilities of NGOs and cooperatives; IR1.2: Expanded linkages among NGOs, networks, and public and private sector institutions; IR1.3: Wider and more effective learning and dissemination by development partners and PVC of tested innovations, best practices, lessons learned and standards – for some of the same reasons identified in the previous sections. They also assist with achieving IR 2.1: Increased operational and technical capacities of select PVOs; and IR 2.2: Expanded collaboration between PVOs and corporations.

Approach

As per the other interventions, training will also be a means to achieve the above results. Training will aim at certifying maternity hospitals as baby-friendly, and increase baby-friendly practices in rural hospitals since they also deliver babies on a regular basis. Training will also create a cadre of health providers able to better advice and assist mothers with breastfeeding issues.

Behavior Change Communication strategies will include targeted support at the community level for exclusive breastfeeding, which was found to be only 9% in the program area. SPWs home visits and support group development will be key to having an impact in this area.

Current knowledge and practices, care-seeking. Immediate breastfeeding soon after childbirth is now commonly practiced in Kyrgyzstan. The indicator used during the baseline was unfortunately changed from the standard one hour, to 30 minutes (as is the current training in country), but nevertheless the results were positive – 49% mothers breastfed within the first 30 minutes, and 39% breastfed between 30 minutes and 8 hours. One person in a FGD even mentioned that sometimes the child is put on the breast before the umbilical cord is cut. When asked about what they thought of colostrums, mothers agreed that this is important and talked about immediate breastfeeding being a normal biological practice because that is what cows, sheep and other animals do.

According to the mothers in the FGDs, most have been told by the health provider that they should exclusively breastfeed their baby until the age of six months.(Although this may not be the case everywhere and may be the reason why many mothers follow traditional habits, and do not exclusively breastfeed). Nevertheless, it is clear that the ones who do receive information on exclusive BF, have not received adequate information and education on this issue.

Most mothers believe that their infant needs additional food, and grandmothers are a particular influence in this regard. They instruct young mothers to follow the traditional practices, and these are based on things like the fact that a mother's milk might look 'thin' and not white or yellow enough to be providing adequate nutrition for her child, or such beliefs as when a woman's breast are small, she will not have enough milk to nourish the infant. And if the infant should cry not too long after having been breastfed, this confirms that he/she is still hungry and needs additional food.

As a rule, related to the religious tradition, mothers are at home for the first 40 days after birth. They really should not go back to work, and should not be seen outside of the house, particularly after dark. A few mothers can stay home for several months, but this is not the majority as it is usually necessary for the mother to work at the bazaar in order to help support the family. If mothers live close to their place of work, they will go home during the day to breastfeed their infant. If they don't, they will leave the infant under the care of someone else, and the infant will receive other foods. Infants are rarely taken along to the bazaar with the mother. Those working in the fields will sometimes take the infant with them, but it is more often the case that they will leave the infant with another family member. Fields, allocated to families by the local government administration, are not always located close to people's homes.

Persistent breastfeeding does not appear to be a problem. Mothers in discussions said that they breastfed for at least a year; but mostly they continue bf until the child has reached age two – both boys and girls alike.

Interventions and Activities

Training – Training for Baby-Friendly Hospital Certification, will begin in July 2003. UNICEF trainers conduct 3 and 5 day trainings, and the program will likely use both training programs as per the needs. The development of a core group of trainers in the Jalalabat Oblast and target rayons will facilitate the training of all essential health providers, including rural hospital staff over a period of time. As there is only one maternity hospital in each rayon, many women living far from the center actually deliver their babies at the rural hospitals instead.

As certification of the Oblast level Maternity Hospitals has already taken place, the first group trained through the CS program will be maternity hospital workers in the Aksy Rayon – on breastfeeding and the preparation for Baby-Friendly certification. Although the training activity, itself is not more than a week, it is expected that the Maternity House will only be ready for certification in 2004. Hospitals are required to nominate a coordinator, carry out a set of instructions and make changes in preparation for certification. This can sometimes take up to several months. Training for Barzarkorgon will take place sometime in 2004, and certification nomination of a coordinator the maternity hospital may not actually be ready for certification until 2005. Further discussions with the UNICEF trainers may enable the program to get this down much sooner. This component will also benefit from Project HOPE's Navoi experience in Uzbekistan because they have had quite extensive success in this area.

Training for health providers, including doctors from the SUP rural hospitals, Feldshars and FGPs will begin with a TOT workshop in the first quarter of Year 2. This training is expected to go on for

at least a year, reinforcing information that these providers have already received and emphasizing counseling techniques, discussion on the benefits of exclusive bf, and advice to mothers and families, particularly as it relates to barriers to exclusive breastfeeding. SPWs will receive similar technical information and training – during their 3-week basic training program; with additional training in select areas when necessary.

Outreach – The outreach work for this component will likely involve more home visits, and specifically target mothers with newborns. These mothers and family members will need this extra support and advice as they have not been convinced of the need for this, and achieving behavior change for this intervention will be a challenge. As there are women in neighborhoods who are very active, the program will encourage breastfeeding mothers to form support groups, and SPWs, with the assistance of Program Specialists, will schedule opportunities for group discussions on breastfeeding.

Pregnant women who, for the most part, already receive informing on breastfeeding, (77% according to the KPC), will also get information and education at the community level in preparation for their newborn. SPWs will do community-based IEC activities to target WRAs, men and grandmothers as well, and these will also include key messages on immediate and persistent breastfeeding, as well as the importance of nutrition for the lactating mother, as previously discussed. The Village Health Committee will be involved in organizing some of these activities – including assisting with the data collection for the competitions, which will be between villages within administrative units, between administrative units within each rayon, and between rayons. These competitions will be a part of the BCC strategy for all program components. As with the above components, community and religious leader involvement will be sought.

Feldshars and FGPs also going out to do home visits will also add their support in this area.

Material development/Mass Media – Materials on breastfeeding are already being used in the Uzbekistan CS program, and are also available through UNICEF and WHO. The program, as per the other interventions, will assess existing material for this component, and develop and produce more as necessary, in collaboration with the team from the Center for Health Strengthening in the Jalalabat. Brochures, leaflets, health cards and posters will be made available at the health facility and community level, and mass media campaigns will also be conducted.

Key Messages:

- New mothers should breastfeed soon after birth to maximize the benefits of breastfeeding for their own health and that of the infant;
- Colostrum has essential immuno-protective components, protecting the newborn against diseases and acting as a first vaccine;
- Breast milk is the best and only necessary food for the first 6 months of life;
- During child illness, mothers of breastfeeding infants should give the same or more breast milk than usual;
- Even during the hot summer months, breast milk provides sufficient liquid and nutrients to the young infant, if infants are allowed to breastfeed on demand throughout the day and night;

- Breastfeeding affords good protection against pregnancy during the first 6 months, as long as the mother breastfeeds exclusively or almost exclusively, on demand day and night, and as long as the mother continues to be amenorraehic.

Commodities: Commodities that may be necessary for the certification of baby-friendly maternity hospitals can be procured through UNICEF or located in-country.

3.d. IMCI

Desired Result: Improved Quality of Child Health Care

Intermediate Results (Outcomes):

1. Increase the percent of children that are managed using IMCI guidelines at polyclinics, FGPs and FAPs.

In relation to the Child Survival and Health Grants Program: The program objectives of this CS project all contribute to the achievement of three USAID Global Health Bureau's Strategic Objectives (SO) 1: Increased use by women and men of voluntary practices that contribute to reduced fertility.; SO 2: Increased use of key maternal health and nutrition interventions; and SO 3: Increased use of key child health and nutrition interventions. The Integrated Management of Childhood Illness (IMCI) approach will play a significant role in the implementation of program activities that will contribute to the above SOs throughout the life of the project and beyond. The program already started an initial IMCI orientation workshop in the target Oblast. See Appendix 7 for details.

Approach

Training is of course, the key component for this intervention and will include both the Family Practitioners and Feldshars as well. Some of this will be done in collaboration with the ZdravPlus project, which is using World Bank funds for some of the training in the Jalalabat Oblast. The program will be able to make use of the WHO/UNICEF-translated G-IMCI training materials for the second phase of training. Staff and partners from this program will take the opportunity to visit the Uzbekistan program to learn about their experiences and lessons learned.

Current knowledge and practices, care-seeking. Please refer to the following sections on diarrhea, pneumonia and immunization, in addition to the previous sections on nutrition and breastfeeding.

Interventions and Activities

Training – IMCI training activities are scheduled to begin in June of 2003, with a TOT for Jalalabat Oblast; as per the decisions that came out of the IMCI Orientation and Planning Workshop in February. Training activities for the Aksy Rayon FGPs, are partially funding by the World Bank and ZdravPlus, who are supporting training, as part of their program with the Oblast FGP Training Center. Project HOPE will collaborate with them by supporting transportation, per diem and hotel accommodation for the 38 Aksy participants scheduled to receive this training in September. Prior to this, beginning in July, the Bazarkorgon Rayon, will have 33 FGPs participate in training, in groups of 9 people, with the potential of two trainings per month. As Bazarkorgon was not scheduled to participate in the prior-mentioned FGP Training Center activities, their training will take place at the Project HOPE Training Center located in the project office, with the clinical portion

on site with inpatients at the nearby hospital. It is the hope that an IMCI Training Center can be created, staffed by MOH IMCI specialists and where Oblast IMCI activities can be coordinated. Rayon level trainings for 17 Medical Assistants (Feldshars) in Bazarkorgon, and 29 in Aksy will be conducted at the rayon training centers being developed by the project in collaboration with the local Family Medical Centers. Feldshars are also responsible for diagnosing and treating patients as part of their normal activities.

Community-Based IMCI key messages will be included in the 3 week basic training for SPWs and additional training and technical support will be scheduled as needed.

Outreach –This activity will complement the training of health facility providers, raising awareness about prevention and danger signs, and mobilizing communities, through the Village Health Committees, to be prepared for emergency transportation. As the cost of medicines has been a barrier to care-seeking in recent years, it will be important for SPWs, in addition to the FGPs and Feldshars, to make it general knowledge that medicines will be freely available for the sick child. The C-IMCI component will include all but malaria, as the latter is not a part of the national program.

Material development/Mass Media – Please refer to the previous components.

For **Key Messages** please refer to the IMCI related illnesses in the other sections.

Commodities/Provisions: To facilitate the integrated management of the sick child the program will obtain 6 or 7 of the 13 IMCI drugs, through a donation. The Asian Development Bank is currently in discussions with the Kyrgz government about support 100% of drugs in 12 project rayons. If all goes well, they would also support the program area with the other IMCI drugs needed. This support for IMCI drugs is envisaged for the program period, but as with the micronutrient component, it is not clear how much financial access the population will have to these drugs once they have to start paying for them again. Twelve of these drugs are currently available in the country, and subsidized for the few individuals that are actually covered by the insurance fund.

3.e. Diarrheal Disease Control

Desired Result: Improved Quality of Child Health Care for Diarrheal Diseases

Intermediate Results (Outcomes):

1**.** Improved management of children with acute and persistent diarrheal episodes.

In relation to the Child Survival and Health Grants Program: Please refer to the above section.

Approach

Like the other program components, the approach will be two-fold: training and outreach. In addition to this, the program population will greatly benefit from and Asian Development Bank

Water Project that is replacing and repairing broken pipes and bringing water to numerous communities in Jalalabat Oblast, including the CS program project target rayons.

Current knowledge and practices, care-seeking. All participants of FGDs complained about the lack of access to clean water or piped water in most communities. Water pipes and systems have deteriorated and repairs and replacements have as a general rule, not been done. Many people in rural areas are forced to use river water as a drinking source and complain that they are getting this drinking water from the same place where others are washing clothes. As the number one problem raised in discussions with community members and health providers, it would appear that people are aware of the importance of this to their health. There was no mention of chlorination of water and program staff state that this is not a common practice.

As previously mentioned, hygiene and sanitation conditions are deplorable, with many households having questionable latrine facilities. Hand-washing is reportedly done whenever a person comes in from outside, including the latrine. Mothers even mentioned that breasts should be cleaned before the baby suckles. Religion also dictates that hands are supposed to be washed before touching an infant. In practice, some of this may be more or less symbolic at times though; done with a few drops of water, rather than washed properly with soap.

Parents say that for episodes of diarrhea they use oral rehydration solution from a packet Only 6% in the KPC concur with this. 42% gave pills or syrup, also mentioned in the FGDs – indicating a lack of proper knowledge about care for diarrheal episodes. Some prepare a home remedy of water, sugar and salt. As far as care-seeking, all said that they seek assistance from a doctor if they feel that they can't treat the diarrhea.

Interventions and Activities

Training – Training for this intervention will be included under IMCI training of family practitioners and Medical Attendants. SPWs will receive training on this as part of their training, starting in the third quarter of Year 1.

Outreach – It will be vital for program outreach workers and health providers to emphasize that exclusive breastfeeding is important in the preventive of diarrheal diseases, and to link the issue of hygiene, sanitation, water and food consumption with diarrheal diseases as well.

The outreach program will elicit the involvement of the local Administrative Units and the newly created Village Health Committees; gaining their support for sanitation and hygiene in the community, cleanliness in the home and hand-washing. SPW visits to communities will be an opportunity to remind families about these issues. Currently the responsibility for sanitation falls under the Sanitation and Epidemiology Station, who focuses only on public places such as the bazaar, restaurants and street cleaning.

Material development/Mass Media – As per previous sections.

Key Messages:

- Exclusive breastfeeding for the first 6 months is on of the best ways to prevent diarrhea;

- Parents, caretakers and children should wash their hands with soap, after using the latrine and before handling or consuming food;
- Children with diarrhea should receive the same or more breast milk, liquids, and semi-solid foods in small quantities;
- Children should get an extra meal/snack during the recovery period;
- Children with dysentery, dehydration, or persistent diarrhea should be assessed at the health facility.

Commodities/Provisions: UNICEF will continue to provide ORS packets to the program area in the years to come. It is not clear how long this assistance will continue. For the necessary IMCI-related drugs, needed for dysentery, refer to previous section. The program will also provide beds to upgrade ORS corners for those health facilities who need them.

3.f. Pneumonia Case Management

Desired Result: Improved Quality of Child Health Care for Pneumonia

Intermediate Results (Outcomes):

1. Improved management of children with pneumonia and other ARIs.
2. Increase care-seeking behavior of mothers with children under 5 with signs of ARI/pneumonia

In relation to the Child Survival and Health Grants Program: Please refer to IMCI above.

Approach

The program's approach to achieving the above results will also include training. Training for maternal nutrition, micronutrients and more in-depth information on breastfeeding and child nutrition, will be added to what participants of IMCI training will receive.

The success of this particular intervention will depend heavily on the community outreach which will include activities as described under maternal and newborn care - the creation of Village Health Committees, and work with religious leaders, the distribution of informational and educational materials, and use of the mass media to transfer messages.

Current knowledge and practices, care-seeking. When asked during FGDs what they considered as danger signs for a child, almost everyone – men and women alike – mentioned cough and fever. The normal treatment for a cough will be to rub alcohol or ointment on the chest to give it some warmth. The common practice for the treatment of fever is to cover the child's body with alcohol as well. In view of these current practices, prompt care-seeking is likely to be an issue – also noted in autopsy reports. In Bazarkorgon, 8 deaths were reported as being due to pneumonia. Of the 5 that were well documented, 2 them appeared to have been late in care-seeking, and one was a mis-diagnosis on the part of the Feldshar, who thought that the infant had a simple ARI. Pediatricians also mention that patients will come in after the infant/child has had a fever for a day or two, and learn that he/she has had a cough since many days before.

Interventions and Activities

Training - Training for this intervention, as with diarrhea, will be included under IMCI. SPWs will receive training on this as part of their training as well.

Outreach – Emphasis will be on prevention and on prompt care-seeking. Immunizations coverage will be promoted to reduce the incidence of pneumonia from certain pathogens such as measles and pertussis, and Hepatitis B; although compliance is very high and this is generally not a problem. Messages will also include the benefits of exclusive breastfeeding, adequate complementary feeding and Vitamin A coverage.

Material development/Mass Media – As with other materials, the program will focus on key danger signs and the issue of prompt care-seeking.

Key Messages:

- Danger signs for pneumonia, including rapid or difficulty breathing
- Importance of prompt care-seeking for danger signs
- It is important to continue giving the child breast milk, food and fluids during illness
- Importance of vaccination coverage

Commodities/Provisions: Essential drugs for IMCI as per IMCI section, watches to time rapid breathing.

3.g. Immunization

Desired Result: Improved Use of Health Care Resources

Intermediate Results (Outcomes):

1. Establish improved cold chain maintenance/repair skills at the local level.
2. Improve family knowledge about and responsibility for immunization.

In relation to the Child Survival and Health Grants Program: The above program objectives all contribute to the achievement of CSHGP's IR1.1: Strengthened operational, technical and financial capabilities of NGOs and cooperatives; IR1.2: Expanded linkages among NGOs, networks, and public and private sector institutions (local partners on training and outreach); IR1.3: Wider and more effective learning and dissemination by development partners and PVC of tested innovations, best practices, lessons learned and standards (IEC and outreach). They also assist with achieving IR 2.1: Increased operational and technical capacities of select PVOs; and IR 2.2: Expanded collaboration between PVOs and corporations (matching funds for cold chain refrigerators etc).

Approach

As per the above objectives, the program will expend its effort on assisting the local MOH partner with maintaining a proper cold chain from the rayon level to the FAP health facilities. Education about vaccines and the EPI program will also increase people's general knowledge and personal sense of responsibility for the care of their infants.

Current knowledge and practices, care-seeking. Current knowledge about vaccines is virtually non-existent, with mothers and families saying that they basically depend on the EPI nurse to tell them when to come for their vaccines. Although care-seeking is usually affected by the issue of cost-of-service, and mothers complained about having to pay a fee to have their child vaccinated, this does not seem to have had an impact on vaccination coverage. As mentioned earlier in the report, the latter is excellent.

Interventions and Activities

Training – Training for this intervention will be minimal and mainly target the Social Patronage Workers. Both project rayons have a very good vaccination program and EPI nurses have been given refresher training in the fairly recent past. The Sanitation and Epidemiology Stations also have a video on the technical aspects of vaccination, available for this personnel.

Outreach – As mentioned above, outreach will focus on population education.

Materials Development - Educational material and information will be adapted or produced by the program, in the form of leaflets. The Child Health Card will also contain information on immunization.

Key Messages:

- Importance of immunization for the prevention of childhood diseases;
- Vaccine preventable diseases, (poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles); including EPI schedule

Commodities/Provisions: The program will procure 8 refrigerators from non-federal matching funds – 5 of which will go to Aksy and 3 of which will go to Bazarkorgon. UNICEF has been providing the rayons with vaccine thermoses. Some of these are old and may have to be replaced. Project HOPE may be able to obtain donated cotton and alcohol for the program, making it possible for children to get immunizations at no cost to the family. Donated Vitamin A capsules for a pilot supplementation program will also be procured, as discussed in the nutrition section, and will be distributed as part of the EPI program. The dosages will be recorded in the Child Health Card. The dose given to the mother will also be recorded in this card.

UNICEF assistance to Kyrgyzstan is expected to be long term. The donations of cotton and alcohol will not necessarily be sustainable after program end, but it is hoped that the government will assure sufficient supplies so that health workers do not feel obliged to charge a fee for the EPI services. It is not clear whether or not some workers might be doing this unnecessarily to earn additional income.

3.h. Child Spacing

Desired Result: Target population is better informed about personal health care rights and responsibilities.

Intermediate Results (Outcomes):

1. Increase the percent of WRA who choose surgical contraception as their family planning method after completing their desired family size.
2. Improved knowledge among adolescents about modern FP methods and know where to obtain them.
3. Improved knowledge among men about modern FP methods.

In relation with CSHGP's IRs – Similar to the remarks made under the maternal and child nutrition section with regard to program involvement in service delivery and behavior change contributing to CSHGP's SOs and IRs.

Approach The approach for this component will be similar to the others. The CS program will aim to fill the gaps in the existing program and services – by training, involving teachers, religious leaders and youth. This is expected to increase accessibility to sterilization, increasing access, information and support to youth, increasing information and counseling on methods to women, and increasing male participation.

Current knowledge and practices, care-seeking. Current use of FP is relatively high- approximately 43%. All FGD target groups responded that it was important to have a 2-3 year space between childbirths, and they tend to practice this as well. Knowledge of family planning methods, with the exception of the IUD that has been well promoted and used across the country for a long time, is very sketchy. In general there are doubts and fears surrounding the oral pill. Men did say that they used condoms – outside of the home. The desired age at marriage, sited by all FGD groups, tended to be around 20 for girls and 24-25 for men. Most felt that childbearing should follow within a year or two, and the desired family size varied from 2 to 4. Those who mentioned a smaller family size, for the most part, felt this way because of the economic situation in the country. None of the groups felt that premarital sexual relationships were a good idea for women – including youth who, for the most part, seem to want to wait for marriage. Youth did express a desire and need for more information. Most do not get information from their parents, or have any source for advice and individual counseling on these issues. They are only told that they should not have sex before marriage. Some youth are only recently having access to this information through health talks given by health providers who visits schools from time to time, and through a couple of local projects. Youth peer educators in the Aksy Rayon are excited about their work, but receive a lot of flack from school teachers who do not tend to be in support of these activities.

Traditional beliefs/customs. Men do not generally get involved in women's reproductive health and issues. Decisions are usually made by women, who communicate this to their spouses. Men tend to concur with their wives decisions on child spacing. Men themselves do not consider vasectomy as an option, as the responsibility for child spacing is considered to be the woman's. Communication about reproductive health issues can take place between mothers and daughters and fathers and sons, but not the other way around, because of religious traditions.

Interventions and Activities

Training – A TOT of oblast and rayon maternity hospital staff in sterilization (tubal ligation for women) will be conducted at the maternity hospitals in Aksy and Bazarkorgon. As mentioned before Aksy currently only has the capacity to conduct sterilizations after C sections, and Bazarkorgon does extremely few minilap sterilizations and this can be greatly increased. These Ob/Gyns will then train Ob/Gyns who are working in the rural SUP Hospitals to increase access to this service as well. There are 6 SUPs in Aksy and 3 in Bazakorgon, and although training can cover doctors in all of these sites, we are uncertain about whether the program will be able to provide mini-lap kits for every hospital.

Training will also target youth; adding one more training team to what already exists in Aksy and creating two training teams for Bazarkorgon where apparently no activities of this kind are taking place. A TOT for school teachers will also be done in collaboration with the Rainbow Center, in order to do some education, awareness-building and sensitization about adolescent's need for information and reproductive health services.

Training for health providers – will be done by the Kyrgz Association for Family Planning and the Trainers from the FGP Training Center as well. Training for both the Feldshars and FGPs will include an emphasis on filling the gaps with regard to contraceptive methods risks and side effects, issues surrounding fears and misinformation about certain methods, the introduction of Lactational Amenorrhea Method, sensitivity to the needs of youth, as well as encouraging the establishment of youth-friendly practices. The 40 SPWs will also be trained, particularly for youth-friendly counseling. 46 Feldshars, and 80 FGPs will be targeted for this training.

Outreach – Outreach to women and families conducted by SPWs in the line of their work will be done through both home visits and group discussions. Home visits will be opportunities to counsel women on choices; educating them about LAM, and letting them know about sterilization as an option for couples who have completed their families, for those who have contraindications or are high risk and don't want to get pregnant again, families who have limited financial means, or anyone else. Community-based activities will provide the population, including men, with more information on methods, and the general benefits of child spacing.

The Osh-based Rainbow Center training and peer education program fits into the scope of the CS program, and thus will be able to assist Project HOPEs focus on increasing youth access to information and support. With groups of trainers/peer educators in each rayon, SPWs, trained and sensitized teachers, the program will be able to implement various different types of outreach and peer support activities. Finding venues for youth to access information and facilitate counseling and group discussion will be a priority. The Training Centers that will be established at the Project HOPE Jalalabat office, and most particularly the ones in Aksy and Bazarkorgon, will be sure to be youth-friendly and resourceful to them.

The existence of the Ulgu Project Office and Center in Aksy will also complement program activities, and program staff will use them as a resource to maximize impact for this and the STI components.

Material development/Mass Media –This will be done as per the previous sections, with a focus on targeted messages for men and youth. The program will also be sure to include information on Emergency contraceptive that is available in Bishkek and could potentially be made available in program area through UNFPA. This would contribute to reducing the number of abortions that are used as a FP method.

Educational material that has already been developed by Engender Health, the ZdravPlus Project and UNFPA. These will be reviewed and adapted only if necessary. Materials that have been produced specifically targeting men and youth will be of special interest. Materials have also been developed in the Uzbekistan child survival program and many of those can also be translated and adapted for Kyrgyzstan, as with many of the other program areas.

Key Messages:

- Advantages of child spacing, including better health for both mother and child;
- Child spacing methods, including LAM, sterilization and other under-used methods

Commodities/Provisions: 2 mini-lap kits will be provided through a Master trainer and professor from Bishkek National Kyrgyz Medical Academy, and potentially more through matching funds. The program will also look at assisting with the provision of anesthesia like lidocaine and antiseptics such as betadine to lower the costs of sterilization to the patients. Condoms may also be provided; potentially from Project HOPE in-kind donations.

Family Planning contraceptive methods are currently being provided by UNFPA across the country. The ZdravPlus, USAID project also distributes contraceptives in project rayons. Although supplies are not always completely adequate, UNFPA support is long-term.

3.i. Sexually Transmitted Infections

Desired Result: Target population is better informed about personal health care rights and responsibilities.

Intermediate Results (Outcomes):

1. Increase the number of pregnant women tested and treated for syphilis and other common STIs;
2. Increased knowledge of men, women, and youth about symptoms and treatment of STIs;
3. Increased knowledge among men and women on how to avoid getting STIs.

In relation to the Child Survival and Health Grants Program: Same as above.

Approach

The program focus for this intervention will be on STIs and not so much on HIV/AIDs because this is already well covered as discussed in Section 2. There will be the aforementioned collaboration with the Rainbow Center and the Ulgu Project. A third partnership, with the local NGO, Tais +2, will assist the program with training for STIs, and to reach commercial sex workers and IV Drug Users in the project target rayons. They currently have one CSW trainer and are happy to establish a collaboration with Project HOPE in the two rayons.

The program will introduce the Syndromic Approach for all FAPs, who are far from the rayon centers and lab services. Training will target those who have not previously been trained in syndromic management, and provide refresher for those who need it. The MOH has also agreed that making the reactives available to these health facilities would be a good strategy to increase the number of pregnant women getting tested for syphilis.

Outreach activities will also be part of the approach, and as with the child spacing component - aim to fill the gaps in the existing program and services and involve teachers, religious leaders and youth.

Current knowledge and practices, care-seeking. Current knowledge about STIs is very low for both men, women and youth. As per the findings cited previously, only 17% of women knew at least two STI symptoms in a male and 24% knew of them in women. 39% men knew of signs of STIs in men, with only 13% knowing two signs in women. Youth knew even less 11% male symptoms and 4% female. Women do not have a problem seeking care; men seem to be concerned about confidentiality say that they only talk to doctors that they know personally - sometimes getting a referral to see a specialist.

Interventions and Activities

Training –Collaboration with Rainbow Center will start with additional training of peer educators in Aksy Rayon, as was discussed in the child spacing component. The same peer educators will be used for both. For STI training school teachers will participate in a 3-day training that will include TOT skills, and youth peer educators will receive a 4-day training.

Training for health providers – It is expected that the 46 Feldshars and relevant FGPs, as per the previous discussing, will be trained to include an emphasis and sensitivity to the needs of youth, and youth-friendly services. The 40 SPWs will also be trained for counseling and IEC.

For testing of maternal syphilis, and syphilis testing for other clients as well, the program will train feldshars at the FAP level to do the test themselves. They will be provided with the chemical reactive so that they don't have to travel to the FGP, which takes them on to the rayon level. The lab workers at the FGPs will also be trained so that the testing can be done right on location for their clients as well.

Outreach – Religious leaders (men) have access to the male population every Friday, and spend a lot of time talking and counseling them on life issues. Women religious leaders meet with several different community groups about twice a month. These leaders are very active and sought after. It is an opportunity for the project to use their influence and transfer important messages. The program

will involve them as part of the IEC strategy, involving them in STI education, child-spacing, and all other components of the project. The local authority or administration, also has a lot of influence on people's behavior and program staff will seek their involvement at every level. They will be asked to participating in meetings supporting STI activities and write letters of support when necessary – particularly as it relates to involving schools where directors or teachers might be reluctant. The local Ministry of Education will also key in this regard.

SPW are expected to increase early diagnosis of STIs through their contacts during home visits and at the community level. They are a resource for community members and as social workers, generally have a very good relationship with people in villages.

The Osh-based Rainbow Center, as previously mentioned, will be a key partner in the implementation of this component, as will be Ulgu and Tais +2. Please refer back to the discussion under Child Spacing for the details.

Material development/Mass Media –This will be done as per the previous sections, making sure to target men and youth in message development, but not forgetting that women also have very little information on STIs. It is certain that educational material have already been developed by other agencies. The program will look into this, and as per the other components, proceed from there. Mass media will also be used for this intervention.

Key Messages:

- Reduce high-risk sexual behavior – including decreasing the number of partners, postponing sexual activity, consistent use of condoms;
- Increase treatment seeking for STIs and TB

Commodities/Provisions: The program will be procuring reactives and the necessary supplies for syphilis testing. Although this is not something that can continue beyond the life of the program, MOH support for this, will hopefully translate into policy change and continued support for this service. Condoms may also be provided through in-kind donations as mentioned previously. And they are also provided by UNFPA, as mentioned above, and other AIDs prevention projects.

Supervision and Quality Assurance (all intervention areas)

As mentioned in the M&E Section, supervisory tools for quality assurance, specifically checklists, will be developed by the program for household and community level activities in every program component. They will be based on tasks or duties, actions, key questions and key messages that SPWs should be including in their day to day work per intervention area.

Tools developed by Engender Health and other reproductive health programs could be replicated or adapted for the child-spacing and STI components of the CS program, while supervision and follow-up monitoring for IMCI at the facility level, will use the supervisory checklists developed by WHO; measuring information on how children are assessed, classified, treated and caretakers are counseled.

Supervision and follow-up monitoring for the Safe Motherhood PEPC program will also be based on a draft monitoring tool that is being tested in Uzbekistan. This particular supervisory tool, like the one for IMCI, will also be based on the protocols for diagnosis and perinatal care that are covered in the training.

All supervisory tools will be adapted or developed where necessary, and particularly in the case of the community outreach work, in collaboration with the local MOH partner – the Chief of Outpatient Services from both rayons will be nominated. The CS program Working Groups that have participated in program planning during this start-up period, will also be consulted. All new or adapted supervisory checklist and other quality assurance tools such as observation checklist, client exit interviews or other methods will be field tested first. As mentioned earlier in the DIP, supervision or monitoring visits will also look at health facility systems issues such as drug supply and essential materials.

The Social Patronage Workers, seconded to the program on a need-be basis, from the existing rural hospitals and feldshar-obstetrical points of the MOH, will be responsible for collecting information on frequent home visits and community-based activities. Although the SPWs are currently not receiving salaries from the MOH due to lack of funding, HOPE will sustain health outreach to the communities by compensating SPWs for their work on specific outreach activities within the realm of the project objectives. The full-time Training Supervisor will schedule weekly supervision of these outreach activities. She will be assisted by the Program Specialists on staff, who will give ongoing technical, quality assurance and supervisory support for all program activities. Supervision activities will include the review of data collected and feedback to the different health service providers involved.

Training: Please note that the local NGOs that will be used for training are in fact training institutions with an expertise and a mandate in this area. They provide this service when they have funding or are paid by a partnering institution like Project HOPE to conduct training activities. The CS Program therefore, is not looking at the issue of these organizations absorbing training curricula into their own programs, nor is there a plan to monitor the capacity of these organizations. A capacity assessment will be done in the second year of the program, but limited to the MOH partner who's capacity with training and follow-up will certainly be monitored and strengthened by this program.

With regard to the Training Centers: The MOH Family Medicine Center at the oblast level already has a training center where FGPs have been receiving training primarily through bi-lateral funding. A Training Center at each of the two rayons will also be developed within the MOH Family Medicine Centers there, in order to accommodate trainings at that level, and minimize travel time and need for accommodation for the large numbers of trainees that will be involved over the program period. The Project HOPE office Training Center was proposed as an alternative site because the office is large, and because the program, which will be dealing with other training partners, cannot always depend on the availability of the oblast FMC that conducts year-round trainings covering all of the rayons in the oblast. Recent discussions with the local MOH partner have resulted in an interest in creating an IMCI-specific Training Center also. This development is due to the fact that the oblast would like to undertake extensive training and follow-up of various levels of personnel for IMCI, and for this to eventually be an oblast-wide activity.

With regard to Outreach and PRA techniques: The program is working with a population that has a high level of education and awareness, despite their resistance to the transitions that are happening in their country. Although some of the local organizations may not have use Participatory Rural Appraisal techniques in their work, they are familiar with participatory training and adult training methods. The introduction of Venn diagrams, or matrices for example, should not be a problem and although community members are probably not accustomed to participating in these kinds of activities, there are indications that this would be quite successful. In the baseline FGDs and meetings, we found that people tended to be very participatory, verbal and forthcoming.

Sustainability: Objectives and activities under this are outlined in the following work plan template.

In relation to the Child Survival and Health Grants Program: The program objectives CSHGP's Strategic Objective1: Enhanced NGO capacity to deliver development services in select USAID countries; IR1.1: Strengthened operational, technical and financial capabilities of NGOs and cooperatives; IR1.2: Expanded linkages among NGOs, networks, and public and private sector institutions; IR1.3: Wider and more effective learning and dissemination by development partners and PVC of tested innovations, best practices, lessons learned and standards. They also assist with achieving SO2: Increased mobilization of U.S. development resources; IR 2.1: Increased operational and technical capacities of select PVOs; and IR 2.2: Expanded collaboration between PVOs and corporations.

In relation to access of supplies and medicines: In essence, the government of Kyrgzstan does not have a problem access supplies and medicines. As mentioned before, much support in this regard has come from USAID, GTZ, ADB, WHO and UNICEF. The problem comes with the consistency of supply for the entire country, and not just pilot or strategic oblasts that are covered periodically by a partner. Drugs can and do come in, but when there is no special program support, they necessarily have to be paid for through a cost-recovery system. Challenges and constraints related to costs and fees for service were discussed earlier. Population-wide services such as the EPI program are technically free because the vaccines are supplied by UNICEF, but people are often charged for cotton and syringes. The government is not prepared, nor have they prioritized taking on the cost of other programs such as the supplementation of iron folate to pregnant women, and Vitamin A to under 6 year olds. Thus access and availability is an issue. Through the aforementioned partnerships and the new one with Project HOPE which will involve participation in orientation and planning meetings, quarterly reviews/meetings, various assessments and evaluation, it is hoped that there will be more and more opportunity for the central government and the MOH to reflect on these needs and modify their budgets wherever possible. Pilot activities may potentially influence supply and access issues in terms of the aforementioned, Vitamin A, iron folate, and cost-sharing policies for IMCI drugs.

MATERNAL AND NEWBORN CARE (30%)

Desired Result: Improved Quality of Maternal and Newborn Care and Target Population Knowledge

Intermediate Results (Outcomes):

(1) Improve the quality of antenatal and postpartum care by MOH and FGP providers.
(2) Increase the capacity of physicians and midwives to provide standardized quality essential and emergency obstetric care.
(3) Increase the capacity of physicians to provide quality newborn care.
(4) Increase MOH and FGP provider capacity to diagnose and appropriately treat/refer pregnant and post-partum women and neonates with danger signs.
(5) Increase the knowledge of women and family members about danger signs during the prenatal, post-partum, and neonatal period that require immediate and appropriate care seeking.

Results Indicators	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of MOH and FGP staff use internationally accepted, evidence-based protocols for delivering quality antenatal and post-partum services.	0%	50%	**M:** Provider observations and supervision with implementation of new protocols, Review of patient charts, Training pre- and post-tests scores, Case reviews of maternal and newborns deaths in an educational, non-punitive manner, and as a basis for lectures and a learning tool, Exit interviews, Supervisory checklists, **E:** BL and Final KPC/HFA Survey
(2) % of deliveries managed according to partograph specifications;	12%	50%	
(3) % of OB/GYNs using adapted WHO protocols of medications and procedures to manage high-risk pregnancies (pregnancy-induced hypertension/toxemia, ante- intr- and postpartum hemorrhage, and infections).	46%	70%	
(4) % of pregnant women managed in accordance with adapted WHO protocols.			
(5) % of health providers counseling women on danger signs during the pregnancy, delivery, post-partum and neonatal periods, that required immediate and appropriate care seeking.	10%	60%	
(6) % of women who know about danger signs during the prenatal, post-partum, and neonatal period that required immediate and appropriate care-seeking.	31%	70%	
(7) % of men who know about danger signs during the prenatal, post-partum, and neonatal period that required immediate and appropriate care-seeking.	13%	40%	
Process Indicators:			

(1) Doctors and midwives working in maternal health receive training in the Prevention of Promotion of Effective Perinatal Care. (2) Pregnancy (normal and common complications), delivery, post-partum, maternal nutrition, and newborn health brochures available at all FGPs, hospitals . (3) 100 % of SPWs receive training on consultation principles for men and women about danger signs during pregnancy, delivery, postpartum and neonatal periods that required immediate and appropriate care seeking and about early antenatal care - seeking. (4) Coverage of 80% population by IEC activities about maternal and newborn health in all villages and at the household levels; (5) Supply 70 % of pregnant women with Antenatal Care Cards;	0 % 0 % 0 % 0 % 0 %	75 % 100 % 100 % 80 % 70 %	**M**: Quarterly and Annual Program Reports, Training HIS, Supervisory checklists; **E:** MT and Final Evaluation Reports.

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										
Orientation meeting with national level participants.					X				Project HOPE	Awareness and Involvement of all key stakeholders.
TOT training for participants from different levels.					?				WHO & local PEPC Trainers assisted by Project HOPE	Availability of PEPC trainers in the Oblast
Development and Production of Health Education Materials							X	X	Oblast IEC team assisted by Working Group & Project HOPE	Information and Education available to beneficiaries and partners.
Rayon Level *(FAPs, FGPs, local NGOs, and community groups)*										
Establishment of Training Centers within Rayon Family Medicine Center				X					Director of Rayon Family Medicine, Training Supervisor assisted by Program Specialist	Training site available for training activities at the rayon level.
Training of SPW (Outreach Workers)					X				Training Supervisor, assisted by Program Specialist	Outreach workers trained in maternal/newborn

Training of health practitioners (in-patient and outpatient) including midwives, in PEPC.						X	X	X	Local PEPC Trainers assisted by Project HOPE.	Potential 37 Ob/Gyns & Neonatologist/Pediatricians + 71 midwives and 71 FGPs, 19 feldshars and midwives Out – Patients in the 2 projectt rayons will be trained in PEPC.
Provide booklets, posters and educational material for health providers and education center.								X	Project HOPE in collaboration Oblast IEC team	Informational and Educational materials available in health facilities.
Provision of Iron folate, balance scales, height measuring sticks, stethoscopes, blood pressure, watch-clocks or timers, thermometers and document carriers for FGPs and FAP.					X	X			Project HOPE	IMCI case-management supplies available for outreach home visits.
Provide 3 telephones at SUP hospitals in each rayon to facilitate communication for emergency care.				X					Project HOPE	Improved communication within rayon.
Establish to Certify Baby-Friendly Maternity Houses				X	X	X	X	X	MOH/UNICEF, assisted by Project HOPE	Certified, Baby Friendly Maternity Hospitals available to program beneficiaries.
Meeting on the rayon level with local rayon authorities					X	X	X	X	Training Supervisor and Program Specialist	Cooperation between Project HOPE and local authorities and support to the health village committees
Community/Household Level *(Community Volunteers)*										
Education to pregnant women, WRAs, men and youth and about danger signs/symptoms during pregnancy, & timely care-seeking, delivery options with new PEPC.					X	X	X	X	SPW, Feldshars, FGPs	Population in 125 program villages informed and educated about maternal and newborn care.
Prenatal mothers will be provided with prenatal care cards. Key messages and information for mothers will be on the back of the card.								X	Provision by Project HOPE, Distribution by Feldshars, FGPs.	Pregnant women will have prenatal care card with documentation of history and visits in 125 program villages.
Support for continued registration of pregnant women during the first trimester.						X	X	X	SPWs, Feldshars, FGPs	Increased care seeking of pregnant women during the first trimester of pregnancy in 2 project rayons.
Village Health Committees develop emergency transportation plans					X	X	X	X	SPWs assisted by Project HOPE	Emergency transportation available in 75% of program villages.

MATERNAL AND CHILD NUTRITION (15%)

Desired Result: Improved Maternal and Child Health and Nutrition

Intermediate Results (Outcomes):

(1) Improve maternal nutrition during pregnancy and lactation.
(2) 1ncrease the number of women that consume iron folate during pregnancy and lactation.
(3) Increase the number of women and children that use iodized salt.
(4) Pilot test the provision of one megadose of Vitamin A to women immediately post-partum.
(5) Pilot test the provision of Vitamin A to children 6-71 months of age

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of pregnant and lactating women adding an additional full serving per day of the staple food.	tbd	tbd	**M:** Survey of pregnant and lactating women including 24 hour recall, Survey on household usage of iodized salt, "Healthy Lifestyles for Women and Children" Cards; **E**: BL and Final 24 hour recall and household survey.
(2) % of women consuming adequate iron folate during pregnancy;	2%	40%	
(3) % of families with children under two consume iodized salt;	tbd	tbd	
(4) % of women taking Vitamin A supplementation (200,000 IU) immediately after birth;	0%	80%	
(5) % of children 6-71 months receiving two Vitamin A supplements per year	0%	80%	
Process Indicators:			
(1) % of mothers with prescription of Vitamin A in exchange cards;	0%	80%	**M**: Quarterly Program Reports; Supervisory checklists; **E:** MT and Final Evaluation Report.
(2) % of families who are informed about the importance of Vitamin A for women and children 6-71 months;	0%	80%	
(3) % of women with knowledge about nutrition during pregnancy, child nutrition, iodine deficiency and iodized salt in all program villages and at the household level.	0%	70%	

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										

Training on Maternal and Children nutrition for the participants of different levels								X	Project HOPE, UNICEF	Increased information and mobilization at the Oblast Level about micronutrients and Vit. A
Research activity on food consumption by pregnant and lactating mothers. Disseminate and publish results.									Project HOPE	Report on food consumption practices in program area.
Development and production of educational materials and brochures for population and for health providers and pharmacies.									Oblast IEC team assisted by Working Group & Project HOPE	Information and Educational materials available to beneficiary population.
Rayon Level *(FGPs, FAPs, local NGOs, and community groups)*										
Training of health providers, including SPWs on micronutrients, including iron,Vitamin A, iodized salt.								?	Training Supervisor assisted by Program Specialist	71 FGPs, 46 Feldshars, 40 SPWs trained on micronutrients.
Distribution of technical/education material -posters, brochures, leaflets to health-facilities.									Project HOPE	Information and material available at health facilities.
Testing and Control of salt being sold in the bazaar, salt at the household level.				X	X	X	X	X	Sanitation and Epidemiology Unit in collaboration with Training Sueprvisor, local government Administration	More rigorous regulation of salt for the prevention of iodine deficiency disease.
Community/Household Level *(Outreach workers, Health Providers, Leaders)*										
IEC group discussion activities about maternal nutrition and micronutrients during pregnancy targeting total family (mothers, fathers, adolescents and youth).						X	X	X	SPWs assisted by Project HOPE.	96 program communities informed and educated about nutrition and micronutrients.
Distribution of educational materials to each household.								X	SPWs	Informational Materials available in 96 program villages.
Promote the use of iodized salt in the households and in community meetings. Educate on proper storage and preservation of iodized salt.								X	SPWS assisted by Project HOPE	Increased use of iodized salt in 2 project rayons.
Distribution of Vitamin A capsules to postnatal mothers within 8 weeks, infants not receiving breast-milk, children 6 -71 months.					X	X	X	X	EPI nurses.	In 2 project rayons, postnatal mothers and children up to 6 years will have access to free Vitamin A supplementation.
Distribution of iron folate supplementation to pregnant and postnatal women					X	X	X	X	Feldshars, FGPs, midwives	In 2 project rayons, prenatal mothers will have access to free iron folate supplementation to combat anemia.

BREASTFEEDING (10%)

Desired Result: Improved Child Health and Nutrition

Intermediate Results (Outcomes):

(1) Increase the percent of newborns that are breastfed within one hour of birth.
(2) Increase the percent of infants under 6 months that are breastfed exclusively for the first 6 months.
(3) Continue breastfeeding on demand until two years of age.
(4) Increase the number of maternities that are certified to be baby-friendly in the Oblast.

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of newborns breastfed within 30 minutes after birth; (2) % of infants breastfed exclusively for the first six months of life; (3) % of children 20-23 months still breastfeeding	43 % 13 % 30 %	70 % 50 % 60 %	**M**: Formative Research Report; Maternity statistics at baby-friendly facilities; Partner agency training HIS, "Healthy Lifestyles for Women and Children" Cards. **E:** BL, MT, and Final KPC Surveys
Process Indicators:			
(1) % of health providers trained in BF practices. (2) All Maternity Houses in program area are certified as Baby-Friendly Establishments. (3) % of population covered by IEC activities about BF in all program villages and at the household level. (4) % of FAPs, SUBs and FGPs with informational – educational materials on BF (5) % of mothers targeted by IEC activity on BF with help of SPWs and health providers	0 % 0 0 % 0% 0 %	90 % 2 90 % 100 % 80 %	**M:** Quarterly and Annual Reports, Training HIS, Supervision Checklists; **E:** MT and Final Evaluation Reports, Final HFA.

Major Activities	*Year 1*				*Year 2*				Personnel Responsible	Output/Outcome of Activity Desired
	1	2	3	4	1	2	3	4		
Oblast Level *(MOH and local NGO partners)*										
Information Sharing with MOH			?	?	X	X	X	X	Project HOPE, MOH	Program partners kept abreast of program activities -opportunity for feedback.
Rayon Level *(FGP, FAP, local NGOs, and community groups)*										
Train maternity hospital workers on breastfeeding and preparation for certification as Baby-Friendly for 2 pilot rayons.				X	X	X	X	X	UNICEF, MOH trainers	Staff in 2 Maternity hospitals are trained in bf and hospitals are certified.
Breastfeeding + TOT for breastfeeding				?					CS Project HOPE, Navoi, UNICEF/MOH trainers	Oblast and Rayon level trainers available for continued training.
Training of health providers at the SUPs and other facilities that also deliver babies.					X	X	X	X		Baby friendly activities are implemented in rural hospitals in 2 project rayons.
Training of SPWs about breastfeeding				X					Training Supervisor assisted by Program Specialist	40 SPWs trained in breastfeeding.
Community/Household Level *(Community Volunteers)*										
IEC targeting pregnant women, lactating mothers, and WRAs on breastfeeding, including nutrition.					X	X	X	X	SPWs	Populations in 96 communities informed and education on breastfeeding.
Health Village Committee Active in bf support activities					X	X	X	X	SPWs, Training Supervisor and Program Specialists	Mothers and families mobilized for bf – particularly exclusive bf.
Community and religious leader involvement					X	X	X	X	SPWs, Training Supervisor and Program Specialists	Religious leaders in 2 project rayons pass on key messages and advice in support of bf.
Distribution of Educational Materials						X	X	X	SPWs	96 program villages have access to educational material on breastfeeding.

COMMUNITY IMCI (NOT INCLUDING NUTRITION)

Desired Result: Improved Quality of Child Health Care

Intermediate Results (Outcomes):

Increase the percent of children that are managed using IMCI guidelines at polyclinics, FGPs, and FAPs.

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of trained providers following IMCI guidelines/protocols at polyclinics and FPG	0 %	70%	**M**: Provider observations, Client exit interviews;
(2) % of SPWs providing adequate consultation to mothers on danger signs of diseases of children under 5.	0 %	30 %	
(3) % of health providers citing at least 2 danger signs of an ill child	33 %	65 %	**E:** BL and Final HFA Surveys
(4) % of health providers mark off a child's weight in the weight's curve and consult mothers on physical development problem of children.	0 %	50 %	
(5) % of population at the households level will be informed about danger signs and essential home practice of taking care of child at home;	0 %	80 %	
Process Indicators:			
(1) % of trained doctors and nurses on IMCI	0 %	90 %	
(2) % of trained SPWs on IMCI	0 %	100 %	**M:** Quarterly and Annual Program Reports, Training HIS; Supervisory checklists;
(3) % of Training Centers with adequate minimum equipment	0 %	90 %	
(4) % of FGDs and FAPs supplied with informational – educational materials on IMCI.	0 %	90 %	**E:** MT and Final Evaluation Report.

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										

IMCI Training for core group of providers from which TOTs will be selected.					X				MOH and local expert Trainers and WHO Consultant-trainer from Kazahkstan	18 FGPs from Jalalabat trained in IMCI; 10/12 Trainers selected.
Development of IMCI Training Center on the oblast level.				X	X	X	X	X	Project HOPE, oblast health administration	Training Center available in Jalalabat for CS program activities.
Translation and/or adaptation of C-IMCI materials					X	X	X	X	Project HOPE, Center for Health Strengthening, assisted by Working Group	Information on danger signs and home-based management of childhood illness available to program beneficiaries.
Rayon Level *(FAPs,FGPs, local NGOs, and community groups)*										
Training of FGPs and Feldshars in Aksy and Barkorgon Rayons.				X	X				Trainers developed through TOT	80 FGPs and 46 Feldshars in the pilot rayon trained in IMCI.
Provision of posters, IMCI guidelines and technical materials to health facilities					X	X	X	X	Project HOPE and MOH	31 FGP Centers and 46 FAPs will be provided with materials to guide their work and inform patients.
Training of SPWs in danger signs and home-based management						X			Training Supervisor assisted by Program Specialists	40 SPWs trained in IMCI danger signs.
Community/Household Level (*Community Volunteers)*										
Implementation of C-IMCI activities					X	X	X	X	SPWs	96 program communities are informed and education on C-IMCI.
Village Health Committee involved in organizing transportation					X	X	X	X	SPWs, Training Supervisor, assisted by Program Specialists	Transportation to facilitate care seeking is available in 75% of program villages.

CONTROL OF DIARRHEAL DISEASES (10%)

Desired Result: Improved Quality of Child Health Care for Diarrheal Diseases

Intermediate Results (Outcomes):

Improved management of children with acute and persistent diarrhea episodes

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of children aged 0-23 months with diarrhea in the last two weeks who received ORS and/or recommended home fluids (RHF);	12%	60%	**M:** Training HIS, "Healthy Lifestyles" card
(2) % of health-providers providing counseling for mothers on diarrhea case management for children under 5;	0 %	50 %	**E:** BL, MT, and Final KPC Surveys.
(3) % of children aged 0-23 months with diarrhea in the last two weeks whose mothers sought outside advise or treatment for the illness;	0 %	50 %	
(4) % SPWs providing training to mothers and/or caretakers on diarrhea case management at home;	0 %	30 %	
Process Indicators:			
(1) % of IEC activities on diarrhea case management at the household level.	0 %	80 %	
(2) % of SPWs trained on danger signs and treatment of diarrheal cases in children under 5;	0 %	90 %	**M:** Quarterly Program Reports, Supervisory checklists; Client exit interviews;
(3) % of health care providers trained on management of diarrhea cases in children under 5;	0 %	80 %	
(4) % of IEC activities target for the community and religious leaders about the importance of usage of pure drinking water and preventive measures on water pollution;	0 %	60 %	**E:** MT and Final Evaluation Reports.
(5) % of population in the target rayons reached by IEC program activities	0 %	80 %	

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										
Procurement of a donated selection IMCI drugs				X					Project HOPE	Treatment for dysentery available free of charge to program beneficiaries.

Translation and /or adaptation of existing C-IMCI educational materials					X				Project HOPE, Center for Health Strengthening, assisted by Working Group.	Information on danger signs and home-based management of childhood illness
Rayon Level *(FGPs local NGOs, and community groups)* Municipality Level *(MINSA, Public and Private Facilities, local NGOs, and community groups)*										
SPWs training for diarrhea prevention and home-based case management.						X			Training Supervisor assisted by Program Specialists.	40 SPWs trained in prevention of diarrhea and case-management.
Collaboration from Sanitation and Epi Unit in community clean-up, and proper maintenance of latrines., and education on site for latrines				X	X	X	X	X	SPWs	Improved sanitation and hygiene conditions in 2 pilot rayons.
Provision of drugs for IMCI, including dysentery				X					Project HOPE	Treatment for dysentery is available free of charge to program beneficiaries.
Community/Household Level *(Community Volunteers)*										
Information about home-based case-management to each family with children under 5 will be given to all families. (Targeting women, men, grandmothers, and older siblings).					X	X	X	X	SPWs, Feldshars, FGP,	Target population informed and educated on management of diarrhea.
Involve community and religious leaders to promote use of clean water and prevention of pollution of river –defecation, through dead animals					X	X	X	X	SPWs, Feldshars, Village Health Committee, Training Supervisor and Program Specialists	Community sensitized and mobilized for diarrhea prevention.
Involve Health Committee and look at issue of clean water and purification					X	X	X	X	SPWs, Training Supervisor, assisted by Program Specialists	Community mobilization in 2 project rayons.
Training on use of ORS packets at the household level.						X	X	X	SPWs, Feldshars	Mothers in 125 program villages correctly trained on ORS.
Distribution of Educational Materials					X	X	X	X	SPWs, Feldshars	125 program villages have access to materials on diarrhea.

PNEUMONIA CASE MANAGEMENT (10%)

Desired Result: Improved Quality of Child Health Care for Pneumonia

Intermediate Results (Outcomes):

(1) Improved management of children with pneumonia and other ARIs
(2) Increase care-seeking behavior of mothers with children under 5 with signs of ARI/pneumonia

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks whose mothers sought medical care for the illness;	35%	70%	**M:** Training HIS, "Healthy Lifestyles" Card;
(2) % of mothers with knowledge of at least 2 danger signs of ARI/pneumonia for children under 5	47 %	70%	**E**: BL, MT, and Final HFA Surveys
(3) % of health care providers with knowledge of at least 2 danger signs of ARI/pneumonia for children under 5;	33 % 0 %	65 % 50 %	
(4) % of children aged 0-23 months receiving appropriate treatment and counseling for ARI/pneumonia;	0 %	30 %	
(5) % SPWs providing counseling on danger signs of pneumonia;			
(6) % of population in the target rayons informed about ARI/pneumonia	0 %	80 %	
Process Indicators:			
(1) % of IEC activities in management pneumonia and ARI in pilot rayons	0 %	80 %	
(2) % of trained health care providers on dangers signs and pneumonia case management	0 %	90 %	**M**: Quarterly and Annual Program Reports, Supervisory checklists; Client exit interviews;
(3) % of families with children under 5 covered by SPWs' activities on pneumonia case management;	0 %	90 %	
(4) % of primary health care providers with timers;	0 %	50 %	**E**: MT and Final Evaluation Reports.
(5) % of FGDs and FAPs with educational information materials;	0 %	90 %	

Major Activities	***Year 1***	***Year 2***	**Personnel Responsible**	**Output/Outcome of Activity Desired**

	1	2	3	4	1	2	3	4		Desired
Oblast Level *(MOH and local NGO partners)*										
Procurement of a donated selection IMCI drugs				?					Project HOPE	Treatment for ARI and pneumonia available free of charge to program beneficiaries.
Translation and /or adaptation of existing C-IMCI educational materials					X				Center for Health Strengthening assisted by Working Group and Project HOPE	Information on danger signs and home-based management of childhood illness
Rayon Level *(FGPs, FAPs,and local community groups)*										
Provision of Feldshars and FGPs to assist them with timers breathing for ARI and pneumonia assessment.					X	X	X	X	Project HOPE	80 FGPs and 46 Feldshars able to time breathing in cases of ARI/pneumonia.
Provision of Educational materials in the form of posters, leaflets and brochures.					X	X			Project HOPE	Informational and Educational materials available at the HF and community level in 125 villages.
Training of SPWs in dangers signs and home-based case-management.						?			Training Supervisor assisted by Program Specialists	40 SPWs trained in danger signs and Home-based PCM.
Provision of drugs for Standard Case Management of pneumonia				?					Project HOPE	Treatment for ARI and pneumonia cases accessible free of charge in 125 program villages.
Community/Household Level *(Community Volunteers)*										
Education and information to families with children under five about danger signs, care -seeking, and case-management of ARI and pneumonia.						X	X	X	SPWs, Feldshars	Information and education available in 125 program villages.
Distribution of educational materials.						X	X	X	SPWs, Feldshars	Information and education available in 125 program villages.
Involvement of religious and other leaders, active women in promotion of improved child care.						X	X	X	Training Supervisor assisted by Program Specialists, SPWs	Increased attention and importance given to program messages.
Village Health Committee assures the availability of transportation to support care seeking.						X	X	X	SPWs, assisted by Training Supervisor	Emergency transportation available in 75% of project area.

IMMUNIZATION (5%)

Desired Result: Improved Use of Health Care Resources

Intermediate Results (Outcomes):

(1) Establish improved cold chain maintenance/repair skills at the local level.
(2) Improve family knowledge about, and responsibility for immunization

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of mothers/caretakers who are aware of immunization schedule for their children and know about diseases that can be prevented by immunization;	0 %	75 %	**M:** Quarterly and Annual Program Reports;
(2) % of health care providers counseling mothers with children aged 0-23 months on immunization;	25 %	50 %	**E**: BL and Final KPC/HFA Surveys.
(3) % of SPWs providing counseling for mothers/caretakers in the target rayons on immunization;	0 %	30 %	
(4) Cold chain improved in the target rayons	N/A	N/A	
Process Indicators:			
(1) % of IEC activities on immunization in all target villages	0 %	80 %	
(2) % of SPWs trained on immunization schedules;	0 %	90 %	**M**: Quarterly and Annual Program Reports,
(3) % of households with children aged 0-23 months with Child Health Cards that contain information about immunization for children;	0 %	80 %	Supervisory Checklists;
(4) % of FGDs and FAPs with informational education materials on immunization;	0 %	90 %	**E**: MT and Final Evaluation Reports.
(5) % of SPWs trained on principles of consultation on immunization	0 %	90 %	

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										

Develop and produce Child Heath Cards						?			Center for Health Strengthening with Working Group and Project HOPE	Child Health Cards available to population.
Develop and produce informational/Educational material						?			Center for Health Strengthening with Working Group and Project HOPE	Informational and Educational materials available to target population.
Rayon Level *(FAPs, FGPs, local NGOs, and community groups)*										
Donation of cotton and alcohol provision to assist with immunization									Project HOPE	Immunizations available free of charge in 125 program villages.
Training for SPWs on immunization.						?			Sanitation and Epi. Stations/Training Supervisor, Program Specialists	40 SPWs trained on vaccine preventable diseases and immunization schedule.
Community/Household Level (*Community Volunteers)*										
Provision of health card for children under 2, with information on back of card about nutrition and danger signs.						X			Project HOPE	Provision of health cards with child immunization data. Educational messages available to 125 villages.
IEC activities at the village level.						X	X	X	SPWs	125 villages educated and mobilized for immunizations.
Distribution of educational materials						X	X	X	SPWs	125 villages with increased access to information on child immunizations.

CHILD SPACING (10%)

Desired Result: Target population is better informed about personal health care rights and responsibilities.

Intermediate Results (Outcomes):

(1) Increase the percent of WRA who choose surgical contraception as their family planning method after completing their desired family size.
(2) Improved knowledge among adolescents about modern FP methods and know where to obtain them.
(3) Improved knowledge among men about modern FP methods.

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) % of WRA who have had tubal ligations;	0%	5%	**M:** Hospital data, Quarterly and Annual Program Reports;
(2) % of adolescents who can cite at least 2 modern FP methods;	23%	60%	
(3) % of adolescents who know where to obtain modern FP methods;	45%	65%	
(4) % of men who can cite at least 2 modern FP methods;	54%	70%	**E**: BL and Final KPC Surveys.
(5) % of women and men using modern FP methods	47%	65%	
Process Indicators:			

(1) # of friendly-youth RH site in each rayon; (2) % of trained providers who can counsel adolescents on modern FP methods: a. SPW; b. FGDs and health-providers of Maternity House; c. Feldshars; d. Teachers – volunteers at all schools of pilot rayons; e. Teenagers-volunteers at all schools of pilot rayons; (3) % of trained providers who can counsel WRA on modern FP methods: a. SPWs; b. FGDs and health-providers of Maternity Houses; c. Feldshars; (4) % of FAPs, FGDs and Maternity Houses with informational education materials; (5)% of schools with informational education materials; (6) % of population in target areas with informational education materials.	0 0% 40% 0% 0% 0% 0% 40% 0% 50% 0% 5%	2 100% 60% 100% 90% 100% 100% 60% 100% 100% 20% 40%	**M**: Quarterly and Annual Program Reports, Supervisory Checklists; **E**: MT and Final Evaluation Reports. 40 trained volunteers; 46 trained feldshars; 94 trained doctors; 113 trained teachers; 300 trained teenagers – volunteers in pilot rayons.

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										
Adapt existing educational materials targeting men, women and youth.					X				Center for Health Strengthening, Project HOPE, Oblast Human Reproductive Center, Rainbow Center	Informational and Educational material available to program beneficiaries and partners.
Liaise with religious leaders				X					Project HOPE, State Commission on religion and local administration	Religious leader support and promotion of child spacing.
Collaborate with Rainbow Center for training of volunteers on FP					X				Project HOPE, « Rainbow Center», «Ulgu», Training Supervisor	School teachers and teenagers-volunteers trained on FP in all schools of project rayons.

Collaborate with Oblast and Rayon Education and Culture Departments to involve school teachers and teenagers – volunteers in program activity					X				Project HOPE, Training Supervisor, Oblast and rayon Departments of Education and Culture	Informational- educational work in all schools of the pilot rayons
Rayon Level *(FAPs, FGPs, local NGOs, and community groups)*										
Liaise with Religious leaders				X					Training Supervisor, SPWs, Feldshars and Program Specialists	Religious leader support and promotion of child-spacing.
Training of SPWs in child spacing, contraceptive methods and counseling				X					Training Supervisor and Program Specialists	
Training on use of mini-lap for sterilization for Aksy and Bazarkorgon				X					Local consultant from Bishkek from the National Kyrgyz. Medical Academy	16 OB/GYNs trained in use of mini-laps for sterilization.
Provision of mini-lap kit to Aksy Rayon				X					Consultant from National Kyrgyz Medical Academy/Project HOPE	Sterilization only available after C-section in Aksy rayon
Training in FP counseling and youth friendly services: b. of FGDs, FMCs and SUBs; c. of Feldshars (midwives and nurses); in two pilot rayons.							X	?	Oblast Human Reproductive Center, FGP Training Center assisted by Project HOPE	Adequate FP Counseling available at FAP level
Community/Household Level *(Community Volunteers)*										
Health Committee support in IEC education					X	X	X	X	SPWs, Training Supervis or and Program Specialists	Increased IEC education and community mobilization in 125 program villages.
Distribution of educational materials					X	X	X	X	SPWs	Increased access to information in 96 program villages.
Involvement of religious and other leaders in promoting child spacing and planning family size.					X	X	X	X	Training Supervisor and Program Specialists, Feldshars	Religious leader support for program messages.
Youth Peer Educators Trained						X	X	X	Rainbow Center in Osh, NGO «Ulgu», Project HOPE	2 teams of volunteers + NGO «Ulgu» in will train peer education and training at all schools in all project rayons.

TOT for young teachers						X	X	X	Rainbow Center in Osh, Project HOPE	54 schools in Aksy and 60 in Bazarkorgon Rayons will have access to information on STIs/AIDS through the team (teacher+2 teenagers-volunteers)

SEXUALLY TRANSMITTED INFECTIONS (10%)

Desired Result: Target population is better informed about personal health care rights and responsibilities.

Intermediate Results (Outcomes):

(1) Increase the number of pregnant women tested and treated for syphilis and other common STIs.
(2) Increased knowledge among men, women, and youth about symptoms and treatment of STIs.
(3) Increased knowledge among men and women on how to avoid getting STIs.

Results Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) Increase knowledge among men about STIs:			**M:** MOH statistics; "Health lifestyles for Women and Children" card;
d. in men;	39,3%	65%	
e. in women;	12,7%	45%	
f. of a-symptomatic clinical case of women.	6,7%	40%	
(2) Increase knowledge among women about STIs:			**E:** BL and Final KPC Surveys.
g. in men;	17%	55%	
h. in women;	24%	70%	
i. of a-symptomatic clinical case of women.	6,7%	40%	
(4) Increase knowledge of youth about STIs:			
a. How to avoid STIs;	22%	65%	
b. in men;	10,7%	40%	
c. in women;	4,3%	30%	
d. of a-symptomatic clinical case of women.	2,7%	20%	
Process Indicators:			

(1) Establishment one youth-friendly RH site per rayon; (2) % of IEC activities about STIs in all program villages.	0 30%	2 60%	**M**: Quarterly and Annual Program Reports, training HIS; **E**: MT and Final Evaluation Reports.

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										
Work closely with Oblast and Rayon Venereal and Dermatological Department and involve their specialists in program planning.					X				Project HOPE	Collaboration between local experts and program.
Develop and produce IEC materials.					X				Center for Health Strengthening (also from Rayon level)	Informational and Educational materials available to program beneficiaries and partners.
Work with religious leaders.				X					Project HOPE	Religious leaders council and advise hundreds of constituents during weekly gatherings.
Mass media messages about STI/ HIV.						X	X	X	Center for Health Strengthening, Oblast HIV Center, Project HOPE with Rayon Venereal Department	Messages about STI/HIV/AIDS on TV, radio, and in newspapers
Collaboration with Rainbow Center on training activities.					X	X			Project HOPE	Rainbow Center train youth peer educators, teachers, CSWs.
Involve Oblast Education and Culture Department in IEC strategy and promotion of Program.						X			Project HOPE	MOE attends promotional meetings with key school Directors and requests support and participation in program.
Involve local authorities in program promotion.					X				Oblast Director of Family Medicine/Project HOPE	Local authorities supporting program.
Rayon Level *(FGPs, FAPs, local NGOs, and community groups)*										
Train on testing for syphilis: e. Feldshars, nurses and midwives; f. and FGPs of pilot rayons.							?	?	FMC, Oblast Human Reproductive Center, Project HOPE	Access to STI treatment in 46 HF catchment areas previously without access

Train SPWs in STI/HIV/AIDS				X					Training Supervisor and Program Specialists and STI center workers, Human Reproductive Center	40 SPWs trained
Involve local authorities in program promotion.				X	X	X	X	X	Training Supervisor and Program Specialists	Local administrative units involved in the two project rayons
Work with men and women religious leaders.				X	X	X	X	X	Training Supervisor, SPWs, assisted by Program Specialists	Religious leaders across the program area will support program with counseling and advise to their constituents and community groups.
Mass media production and message development.						X	X	X	Center for Health Strengthening at the Rayon level, Project HOPE, STI/HIV Center	2 Rayons covered
Community/Household Level (*Community Volunteers)*										
Involve Health Committee in IEC strategy and education.					X	X	X	X	SPWs, Feldshars and Training Supervisor	125 Program villages covered
Education of population on dangers of STIs (WRA, men, youth) at household and community level.					X	X	X	X	SPWs, FGPs, Feldshars, Village Health Committee, religious leaders and Training Supervisor	125 Program villages covered
Work with religious leaders both male and female to help with key messages and counseling.					X	X	X	X	SPWs	Religious leaders across the program area will support program with counseling and advise to their constituents and community groups.
Distribution of Educational materials.					X	X	X	X	SPWs, Feldshars, Village Health Committee, religious leaders	125 Program Villages with access to information about STIs.
Involve local authorities in program promotion.					X	X	X	X	Training Supervisor and Program Specialists	Local administrative units involved in the two project rayons

TOT training for young teachers.						X	X	X	Rainbow Center in Osh	54 schools in Aksy and 60 in Bazarkorgon Rayons will have access to information on STIs/AIDS.
Youth Peer Educators Training.						X	X	X	Rainbow Center in Osh	2 teams of volunteers + NGO «Ulgu» in will train peer education and training at all schools in all project rayons.

SUSTAINABILITY

Desired Result: MOH and partners are able to serve the population more effectively.

Intermediate Results (Outcomes):
1) MOH officials at all levels and providers informed about national health policies and engaged in developing new local policies;
2) Partners participate actively in planning and Working Group activities;
3) Partners support quality-improved services;
4) Communication skills improved at all levels.

Indicators:	Targets		**Measurement Method(s)** M: Monitoring; E: Evaluation
	Baseline	Final	
(1) Necessary decrees (Prikaz) and policies in place and easily available at all levels to promote compliance with new protocols, guidelines and procedures; (2) Routine quarterly planning, implementation and review meetings; (3) Training registers in place and used to monitor progress of training activities and training needs; (4) Pervasive changes in communication patterns (supervisor-provider, provider-client).			**M:** Quarterly and Annual Program Reports, Training HIS, Exit interviews, Key Informant interviews; **E:** MTE and Final Evaluation Reports.

Major Activities	***Year 1***				***Year 2***				**Personnel Responsible**	**Output/Outcome of Activity Desired**
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**		
Oblast Level *(MOH and local NGO partners)*										
Oblast level MOH and NGO partners participate in orientation workshops and planning meetings.		X	X	X					Project HOPE	Forum for review, decision-making & initiation of new policies and protocols

MOH and partners participate in Quarterly Review meetings					X	X	X	X	Project HOPE, MOH	Routine review and planning.
Establishment and use of Training HIS.				X	X	X	X	X	Project HOPE, MOH	Tracking of training activities and training needs.
TOT on communication and counseling as part of technical trainings for IMCI, PEPC. Introduction of new supervision techniques.				X	X				Project HOPE, MOH and WHO Trainers	Improved communication between supervisor-provider & provider-client.
MOH Partner capacity Assessment (oblast and rayon levels).						X			MOH partner, Project HOPE, Consultant	Results on capacity assessment with which to problem solve and plan for improvement.
Rayon Level *(FGPs, FAPs, local NGOs, and community groups)*										
Rayon level key MOH's staffs participate in orientation workshops and planning meetings.		X	X	X					Project HOPE	Forum for review, decision-making & initiation of new policies and protocols
Representatives from Rayon level MOH participate in Quarterly Review meetings.					X	X	X	X	Project HOPE, MOH	Routine review and planning.
Establishment and use of Training HIS.				X	X	X	X	X	Project HOPE, MOH	Tracking of training activities and training needs.
Training on communication and counseling as part of technical trainings for IMCI, PEPC, Child-Spacing and STIs. Introduction of new supervision techniques to supervisors.								X	Project HOPE, MOH and WHO Trainers	Improved communication between supervisor-provider & provider-client.
Community/Household Level (*Community Volunteers)*										
Increased contact and communication with providers at the household and community level.					X	X	X	X	SPWs, Feldshars, FGPs	Improved communication between provider-client in 125 program villages.