CURATIO INTERNATIONAL FOUNDATION

PROGRESS IN REDUCING HEALTH SYSTEM BOTTLENECKS TOWARDS ACHIEVING THE MDG 4: EVALUATION OF UNICEF'S CONTRIBUTION IN FIVE CEE/CIS COUNTRIES

FINAL REPORT

REGIONAL KNOWLEDGE AND LEADERSHIP AREA 6
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ABBREVIATIONS

ADB	Asian Development Bank
AEFI	Adverse Events Following Immunization
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ARR	Annual Rates Of Reduction
AWP	Annual Work Plans
BABIES	Birth Weight Group and Age-At-Death Boxes for an Intervention Evaluation System
BBP	Basic Benefit Package
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
C4D	Communication for Development
CCD	Child Care and Development
CEB	Council of Europe Development Bank
CEE	Central and Eastern Europe
CIF	Curatio International Foundation
CIS	Commonwealth of Independent States
CMD	Control of Micronutrient Deficiencies
CMPD	Centre for Micronutrient Programme Development
CMYP	Country Multi-year Plan
CO	Country Offices
CPAP	Country Programme Action Plans
CPD	Country Programme Documents
DAC	OECD Development Assistance Committee
DD	Diarrheal Diseases
DFID	UK Department for International Development
DHS	Demographic Health Survey
DPs	Development Partners
DPT3	Diphtheria, Pertussis, Tetanus the Third Dose
DR	Document Review
ECD	Early Childhood Development
EmOC	Emergency Obstetric Care
ENC	Essential Newborn Care
ENMR	Early Neonatal Mortality Rate
EPC	Effective Perinatal Care
EPI	Expanded Programme On Immunization
ET	Evaluation Team
EU	European Union
FEP	Family Education Program
FF	Flour Fortification
FFL	Facts for Life
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
GBP	Guaranteed Benefit Package

GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GI	Group Interviews
GIZ	Gesellschaft für Internationale Zusammenarbeit
GP	General Practitioner
GTZ	German Agency For Technical Cooperation
HIV	Human Immunodeficiency Virus
HR	Human Resources
IDA	International Development Agency
IDD	Iodine Deficiency Disorders
IDI	In-Depth Interviews
IEC	Information, Education Communication
ILBD	International Live Birth Definition
IMCI	Integrated Management Of Childhood Illness
IMR	Infant Mortality Rate
IR	Inception Report
JICA	Japan International Cooperation Agency
KAZ	Kazakhstan
KFW	German Development Bank
KYG	Kyrgyzstan
M&E	Monitoring and Evaluation
MCE	Multi-Country Evaluation
MCH	Maternal Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MLD	Moldova
MMR	Maternal Mortality Ration
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MoRES	Monitoring Results for Equity Systems
MOU	Memorandum of Understanding
MTR	Mid-Term Review
NGOs	Non-Governmental Organizations
NMR	Neonatal Mortality Rate
NPRS	National Poverty Reduction Strategy
Ob & Gyn	Obstetrics & Gynaecology
OECD	Organisation For Economic Co-operation and Development
OOP	Out-of-pocket Payment
ORS packet	Oral Rehydration Salt packet
PHC	Primary Health Care
PMTCT	Prevention Of Mother-to-child Transmission
PNC	Postnatal Care
PNMR	Post Neonatal Mortality Rate
PPP	Purchasing Power Parity
RBB	Results-Based Budgeting
RKLA	Regional Knowledge and Leadership Agenda

RO	Regional Office
RWP	Rolling Work Plans
SDC	Swiss Development Cooperation
SIDA	Swedish International Development Agency
SPSS	Statistical Package for the Social Sciences
SRB	Serbia
SWAP	Sector wide approach
ToC	Theory Of Change
TransMonEE	Transformative Monitoring for Enhanced Equity
U5MR	Under-five Mortality Rate
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency For International Development
USI	Universal Salt Iodization
UZB	Uzbekistan
VAD	Vitamin A Deficiency
WB	The World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

Background

Advancing health gains and reducing child mortality in the Central and Eastern Europe/Commonwealth of Independent States (CEE/CIS) countries require better functioning health systems capable of delivering equitable and quality health services for mothers and children. The identification of barriers and bottlenecks arising on the supply and/or demand side, and their timely removal or reduction are pre-requisites for implementing effective public health intervention. Since the 1990s UNICEF has been assisting CEE/CIS countries to overcome these barriers, improve the performance of health systems, and assure effective coverage with Maternal, Newborn and Child Health (MNCH) services to achieve the Millennium Development Goals (MDGs). At the beginning of new millennium, in light of the changing social-economic situation in these countries, UNICEF programming in the CEE/CIS changed from an emergency service delivery mode to a more up-stream health systems approach, aligning itself with global efforts to modernize health systems and improve the quality of service delivery.

Objective, Scope and Methodology

UNICEF's Regional Office (RO) for the CEE/CIS commissioned this Multi-Country Evaluation (MCE) to a) document progress in reducing under-5 and infant mortality and morbidity and to generate lessons on how this was accomplished; b) inform programmes aimed at scaling-up evidence-based and equity focused interventions; and c) enable better partnering with national governments to advance the child health and rights agenda.

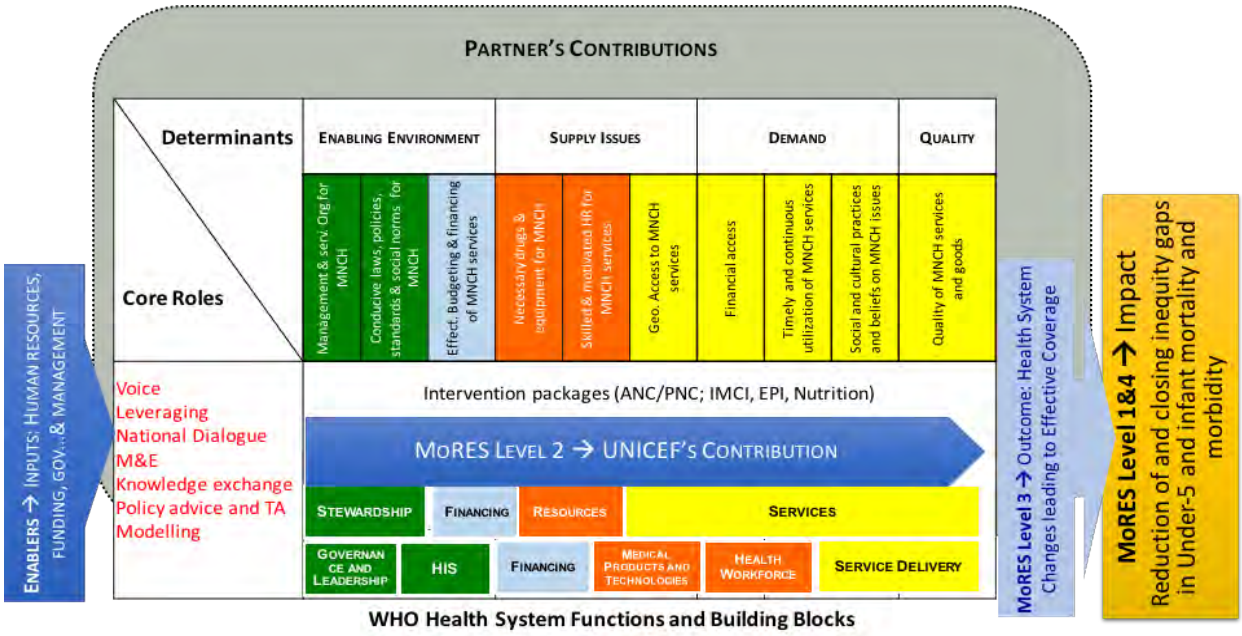
As the focus, scale and impact of UNICEF-supported programmes and interventions varied among countries in the region, the geographical scope of the evaluation focused on five countries that had the largest and the most innovative health programmes supported by UNICEF (Kazakhstan, Kyrgyzstan, Moldova, Serbia and Uzbekistan). The period covered by the evaluation included 12 years from 2000 – 2012, and was conducted by Curatio International Foundation in 2014-2015. It focuses primarily on UNICEF-supported MNCH interventions that have the potential to positively influence neonatal and child health outcomes through enhanced health systems.

The prime beneficiaries of this evaluation are policy makers and programme managers, both within UNICEF and in governments, partner organizations and academia. The evaluation is based on the Theory of Change (ToC) for UNICEF's regional approach to reduce and close the equity gap in under-5 and infant mortality and morbidity in the CEE/CIS. The ToC, presented in Figure 1 and developed by the Evaluation Team (ET), uses the reconstructed generic ToC elaborated by the UNICEF RO. The generic ToC combines WHO's essential health system functions approach--used in UNICEF programming prior to 2010-2011--with the equity-focused Determinant Analytical Framework (MoRES) approach introduced thereafter. The ToC stipulates that UNICEF-supported country programmes should aim at strengthening health systems and addressing bottlenecks in effective coverage with MNCH services. In pursuing this goal, UNICEF programmes in the evaluation countries target a range of evidence-based interventions across the continuum of care and various delivery platforms, most of which can be grouped across several key "intervention packages" - ***Antenatal, Neonatal and Perinatal Care (ANC/PNC); Integrated Management of Childhood Illnesses (IMCI); Extended Programme of Immunization (EPI) and Nutrition***. The delivery of any programme intervention grouped into an "intervention package" for upstream programme engagement requires inputs – or "enablers" – such as human and financial resources, and governance and management mechanisms provided by UNICEF. The intervention package (or elements of it) had to be delivered through UNICEF's seven core roles: *the "voice" for children and adolescents; leveraging resources from public and private sectors; facilitating national dialogue concerning child-friendly social norms; monitoring and evaluation; policy advice and technical assistance; enabling knowledge exchange;* and *modelling*.

The application of these interventions to address health services barriers or bottlenecks could be mapped onto MoRES determinants (*e.g. enabling environment, supply, demand, quality);* health system functions *(e.g. stewardship, financing, resources, services*); and/or health system building

blocks (*e.g. leadership and governance, health information systems, health financing, essential medical products and technologies, health workforce, health service delivery, and community ownership and partnership*). The ET added the last building block – community ownership and partnership – to WHO's six building blocks, drawing on the framework presented in *The Lancet*'s Every Newborn Survival Series (2014).

Figure 1: The reconstructed Theory of Change for the Multi-Country Evaluation



The ToC also implies that UNICEF contributions towards reducing bottlenecks (MoRES Level 2) and achieving health system changes (MoRES Level 3) are delivered in the broader context of their partners' contributions. If properly identified bottlenecks in MNCH service coverage are well addressed by UNICEF and consequently result in system changes, these changes are expected to lead to the reduction or eventual elimination of equity gaps, and to a sustainable reduction of child and infant morbidity and mortality (MoRES Level 4).

The ToC adopts the fundamental UNICEF-promoted concept that bold and sustainable achievements in reducing child mortality and morbidity can only be achieved by reducing equity gaps (including gender inequality) and by upholding the human rights of mothers and children served by the health systems that UNICEF intends to change. Therefore, the ToC implies that unless changes in health systems are equity-focused and facilitate the realisation of fundamental human rights, sustainable improvements in child health outcomes may not be achieved.

Considering the above, the key objective of this evaluation is to assess how successful UNICEF was in delivering evidence-based "intervention packages" through its core roles, and in contributing to the required changes in the health systems and communities (MoRES Level 3) by addressing the relevant bottlenecks, and to achieve better child health outcomes. To employ the ToC and answer evaluation questions, the ET used a five-step approach, depicted in Figure 2, and included more detailed explanations in the main body of the report.

Figure 2: The Evaluation Steps for the ToC

The evaluation framework for the MCE was based on the ToC and aimed at establishing the impact, relevance, effectiveness, efficiency, sustainability, rights-based approach and gender equity of UNICEF's contribution, in line with the MoRES determinants framework. The MoRES framework consists of: creating an enabling environment starting from the development and implementation of

conducive social norms, policies and legal framework; the allocation and use of expenditures as well as effective management and coordination at national and sub-national levels; and identifying, prioritising and overcoming bottlenecks that hamper the availability (*supply*), affordability, adequacy, continuity (*demand*) and *quality* in the use of MNCH services. Prior to the introduction of the MoRES framework, bottlenecks across the MoRES determinants were not explicitly identified *per se* in UNICEF documents, although they were mentioned as problems to be solved and barriers to be addressed in order to scale up the interventions. Therefore, the ET had to "retrofit" the UNICEF-supported interventions prior to the year 2010 onto the respective bottlenecks across the MoRES determinants, to ensure consistency in comparing UNICEF's and its partners' performance over the period concerned. Furthermore, due to the difficulty in attributing specific bottlenecks, the ET combined (a) "social norms" with the "conducive laws, policies and standards" determinant, and (b) "effective budgeting and financing" with the "financial access" determinant. No bottlenecks were found that could be specifically attributed to the "timely and continuous utilization" determinant.

The evaluation methods included site visits (up to 10 visits were conducted), face-to-face in-depth interviews and group interviews with 291 respondents in the evaluation countries, and desk-based research, including a review of existing reports (616 country specific documents and 51 regional level documents were reviewed) and other available data from national-level or international/regional sources. Qualitative data was complemented by a secondary analysis of quantitative data where relevant and appropriate.

Key Evaluation Findings

Impact on health status of children

During the evaluation period, the Under-five Mortality Rate (U5MR) declined by 47.9% in the CEE/CIS and by 48.4% in the evaluation countries, outpacing the global trend in child mortality decline and creating good prospects for the MDG4 target (reduce child mortality) to be achieved. This progress was greater in reducing deaths among children 1-59 months of age than for neonates, with reduction rates of 58% and 42% respectively. Due to the reductions achieved in IMR and U5MR, more than **193,000** children under five were saved in the evaluation countries during the period 2000-2013. At the same time there was a downward trend in the CEE/CIS for the incidence of Acute Respiratory Infections (ARI) and Diarrhoeal Diseases (DD), pneumonia and influenza. In the evaluation countries, the incidence of DD was reduced by 72% and acute respiratory infections, pneumonia and influenza by 55% for children under five. However, the trends in key indicators of child health prevalence rates--stunting and underweight--were less clear. The trend was inconsistent for stunting prevalence, and it was impossible to establish the statistical significance of the slight decline observed in underweight prevalence.

While a decline in the U5MR and Infant Mortality Rate (IMR) was observed in all countries of the CEE/CIS region, the pace and size of the reduction differed: The CEE and the European part of the CIS were more successful in reducing child mortality, while most of the Central Asian and Caucasus countries except Kazakhstan reported lower average annual rates of decline. Along with inter-country differences, significant intra-country *geographical* differences in trends appeared for the key child health indicators in the countries evaluated. In Kazakhstan, Kyrgyzstan, Serbia and Uzbekistan some regions fared distinctly better in reducing child mortality rates than others. IMR for infants born to richer and better-educated mothers were reduced at a higher rate and as a result, *education*- and *wealth*-related equity gaps widened across the evaluation countries. The U5MR equity gap in all five counties remained unchanged. Improvements in child health were slower for deprived *ethnic* groups (for example Roma in Serbia) and for other marginalised population groups in some countries, such as migrant workers. However, the elimination of education- and wealth-related gaps in stunting and malnutrition prevalence may indicate a positive trend. Due to an absence of adequate data it was difficult to establish whether a gender gap in MNCH existed in the evaluation countries. Overall, most of the trends for these key child health indicators in the CEE/CIS and the evaluation countries are consistent with those observed globally, and more specifically in other Low and Middle Income Countries (LMICs).

Neonatal mortality declined for all disease-specific causes, with the number of deaths caused by diarrhoea and pneumonia declining at the highest rate, and deaths caused by congenital anomalies

declining at the lowest rate. The number of disease-specific causes of mortality for children aged 1-59 months also declined for all causes, with Annual Reduction Rates (ARRs) above the global average, ranging from 2.7% for AIDS to 6% for meningitis. The stillbirth rate remained almost constant throughout the evaluation period.

The evaluation findings indicate that the most at-risk children requiring priority attention in the CEE/CIS belong to the following stratifiers:

1. Children born in poor and less-educated families. In particular, those residing in rural areas and who experience ethnic or social deprivations are still at a greater risk of dying;
2. Stillborn babies, whose numbers have remained almost unchanged for the last 15 years;
3. Infants dying before their first birthday, particularly neonates, who account for 46% of under-5 child deaths occurring in the evaluation countries and who are dying from preventable causes; and
4. Children who live in countries and/or sub-national entities that are lagging behind and have mortality rates 2 to 3 times higher than the CEE/CIS regional average.

It appears that a sizable part of the reductions in child mortality, and the remaining gaps in the CEE/CIS (and more specifically in the evaluation countries), can be partially explained by the variations observed in socio-economic determinants/factors.

Relevance

UNICEF programming specifically targeted the following: two of the three leading causes of neonatal mortality, which determined 74% of all neonatal deaths; four of the five leading causes of deaths among children aged 1 to 59 months, accounting for 49% of deaths occurring in this age group; and two of the three leading causes of infant and under-5 morbidity. UNICEF programmes targeted these causes of mortality and morbidity through evidence-based interventions combined in "intervention packages".

UNICEF successfully identified almost all key bottlenecks that limited effective coverage in all the evaluation countries. A total of 396 bottlenecks were identified for all intervention packages supported by UNICEF and across 15 thematic areas. In terms of MoRES determinants, the highest number of bottlenecks was identified in "management and service organisation" (120), "skilled and motivated HR" (68) and "conducive laws, policies, social norms and standards" (57). The lowest number of bottlenecks was identified for "geographical access" (4). UNICEF and its partners attempted to focus on almost all (99%) identified bottlenecks over the evaluated 12-year period.

UNICEF, in cooperation with its partners, carried out up to 2000 programmatic activities in the five countries over the evaluated period to address identified health system bottlenecks. The relevance and effectiveness of these programmatic activities were graded using "addressing scores" assigned to specific bottlenecks across the intervention packages and presented in more detail in the findings section (Chapter 4).

Maternal and child health was high on national policy agendas in all five countries, and the overall goals supported by UNICEF programmes were well aligned with national development strategies. UNICEF engaged in continuous dialogue with national governments and international partners, and actively participated in health strategy development processes to ensure adequate prioritisation of MNCH issues. These included a rights-based approach and equity at national levels, and aligning their global, regional and national strategic goals and objectives with each country's national sectoral strategies and policies.

Up to 185 national and local partners participated in UNICEF programme design, implementation and evaluation in the countries studied. The legislative and executive branches of the governments, and development partners from IFIs and UN agencies were the most active partners involved at all stages of these programmes. Overall partner engagement was highest at the implementation and design stages, but less so in monitoring & evaluation. UNICEF initiated, led or was actively engaged in partnerships with host governments, UN Agencies (WHO, UNFPA), IFIs and bilateral partners (the World Bank, ADB, EU, JICA, SDC KfW, GIZ, CIDA, USAID, GAVI, GFATM, Soros Foundation, etc.). These partnerships were critical in triggering and sustaining the necessary health system and community-

level changes, and for scaling up interventions included within the IMCI and ANC/PNC intervention packages. Private sector partners were most successfully engaged in programmes that supported the Nutrition package (Flour Fortification and Salt Iodisation) and outreach to vulnerable populations (Telenor in Serbia). Only a small number of civil society organizations--that commonly represented UNICEF beneficiaries-- and professional associations (in Serbia) were involved, mostly at the implementation stage.

System level changes

The ET assessed UNICEF and its partners' joint performance in inducing systemic and community-level change through addressing critical bottlenecks using "addressing scores" assigned to specific bottlenecks across the intervention packages. The evaluation findings show that UNICEF independently and/or in cooperation with its international and national partners managed to "fully address" 284 bottlenecks (71.7%). This denotes that the right and appropriate scope, target groups and scale of programmes were used. In the case of 94 bottlenecks (23.7%), where the correct and appropriate scope and/or target groups were used but scale was limited to pilot and/or fragmented activities at subnational/national level, the bottlenecks were considered "partially addressed". For 18 bottlenecks (4.5%), considered "not addressed", the interventions were isolated, with inappropriate scope and/or target groups and inadequate scale.

Overall, most bottlenecks were addressed and necessary system level changes were induced for the Nutrition intervention package (with 83% fully addressed). Up to 73% of bottlenecks were fully addressed for the EPI intervention package. UNICEF and its partners were least successful in addressing bottlenecks in the IMCI and ANC/PNC intervention packages, with 8% and 6% of the respective bottlenecks not being addressed and only 64% being fully addressed. More details about resulting system-level changes across the MoRES determinants are presented in the main report.

Enabling Environment.

Conducive laws, policies, standards and social norms. UNICEF and its partners' joint performance inducing system level changes was remarkable for this determinant, as 94% of the bottlenecks identified were fully addressed. As a result, conducive legislative and policy frameworks for all UNICEF-supported intervention packages (ANC/PNC, IMCI, EPI, Nutrition) were established in most of the evaluation countries. Some examples include salt iodization and flour fortification laws, legislative adherence to the international code of marketing for breast-milk substitutes, Presidential decrees and decrees by Cabinets of Ministers approving national maternal and child health policies and strategies, inclusion of MNCH services into basic health packages financed by the state, Ministerial decrees approving immunization programmes, IMCI introduction and institutionalization, etc. These legislative acts also stipulated the establishment of appropriate MNCH care standards and guidelines for micronutrient supplementation, antenatal and perinatal care, and the integrated management of childhood illnesses at hospital, ambulatory and community levels.

Management and Service Organization. Effective coordination mechanisms (national and sub-national) for MNCH issues were created in most of the evaluation countries. The most notable are the Maternal and Child Health (MCH) working group under the Sector Wide Approach in Kyrgyzstan, the MCH Coordination Council in Uzbekistan and the Primary Health Care (PHC) reform group in Moldova, all of which operated with the leadership or active participation of UNICEF. However, challenges posed by weak managerial capacity in the health sector, specific to the region, were not fully addressed (17% of bottlenecks were only partially addressed). The document review and interviews reflected the widespread nature of this problem. A lack of adequate undergraduate and postgraduate education for health management professions, which are at a nascent stage, create major structural challenges for providing qualified health care managers. This situation consequently triggers further challenges--weak managerial capacity: a) for transforming new policies into action; b) for adequately monitoring service delivery and resulting outcomes or taking corrective measures; and c) for adequately planning and delivering services at the scale needed. This is compounded by high staff turnover within the Ministries of Health and district health departments or their equivalents, which further minimizes the impact of donor investment.

Effective budgeting and financing. Financial accessibility has improved as economies grew, and public spending on health care increased several times in each of the evaluation countries, reaching and

surpassing levels that allow adequate financing for essential health services (above 64 PPP$ per capita). These developments led to a reduction in financial barriers to service access in all the evaluation countries. Essential MNCH services became included in publicly financed basic benefit packages. Despite these achievements, however, challenges remain to increase the low levels of government spending on PHC and decrease relatively high out-of-pocket payments for outpatient drugs.

Supply

Geographical access barriers found in many countries were most pronounced and explicitly identified in Kazakhstan, which is a vast, sparsely populated country. During the evaluation period UNICEF and its partners appear to have addressed these barriers well, and although similar barriers may also exist in Kyrgyzstan, UNICEF and its partners did not explicitly identify or address them.

Drugs and necessary supplies emerged as a critical bottleneck in the early period of the evaluation. In some instances (e.g. in Serbia, Kyrgyzstan, Uzbekistan), a humanitarian response to emergency situations was required to supply necessary drugs, vaccines, medical materials and equipment. This bottleneck was initially addressed by donors and UNICEF. During the early evaluation period, close to 55% of the resources managed by UNICEF were spent on necessary drugs and inputs, compared to 22% in later years. Susbsequently, active engagement with national governments allowed UNICEF to gradually shift this responsibility to national budgets, and a decade later drugs and other necessary inputs became widely available in health care facilities. Nevertheless, poor and marginalized groups continue to face challenges to accessing outpatient drugs for MCNH services unless the drug package is fully funded by the government, includes a sufficient breadth of medications and is delivered free to socially vulnerable groups (ethnic minorities, poor, disabled, etc). However, Kazakhstan, Serbia and Moldova appear to have addressed this issue relatively well.

Skilled and motivated human resources. The availability of qualified human resources remained high for the CEE/CIS region as a whole and for the evaluation countries specifically, with population ratios of doctors, nurses and midwives well above WHO's minimal threshold - 230 per 100,000 population. UNICEF and its partners invested significant resources in capacity development for physicians and nurses providing MNCH services in all the evaluation countries. However, system-level challenges remain, largely due to low staff motivation at the primary care level; the low quality of undergraduate and postgraduate education, particularly in the Central Asian region; inadeqauate human resources planning resulting in over-production of some specialists and under-prduction of others (e.g. paediatricians in Serbia), and a shortage of staff in rural areas caused by regional migration and ageing. While UNICEF and its partners tried to tackle these issues, the bottlenecks still remain and have not been fully addressed.

Demand

Overall improvements have been made concerning social and cultural practices and beliefs about MNCH. This includes an awareness of and demand for services in the evaluation countries. However a few knowledge gaps remain, and some even widened during the evaluation period. A decade of work with the communities has helped to address a significant part of the demand barriers for ANC/PNC and EPI interventions, but it was less successful for IMCI and Nutrition interventions.

Quality and effective coverage

The evaluation findings indicate an improvement in quality and/or effective coverage delivered through addressing the bottlenecks in specific ANC/PNC, EPI, Nutrition, and IMCI intervention packages. At the same time, no improvements were observed in low birth weight and stunting rates, which indicates there is an insufficient quality or scale of nutrition interventions. The indicator has worsened for contraception use among women of reproductive age, which is an important measure of family planning and has a proven effect on reducing child mortality (although the intervention itself is not within UNICEF's direct mandate). In general, the quality of services and coverage proved particularly complex and challenging, and thus received the lowest addressing score. Several factors were at play, including: a) inadequate infrastructure and equipment that still pose a risk to patients in some areas, despite significant investment; b) poor infection control practices; c) poor compliance with clinical standards and guidelines; d) absence of quality management systems; and a lack of indicators to monitor service quality on a routine basis.

Improvements in quality coverage for antenatal and delivery services were accompanied by reductions in inequity. The poorest and least-educated women from rural areas and marginalized ethnic groups (e.g. Roma in Serbia) gained greater access to more-qualified medical personnel for delivery services and received adequate care, including tests and HIV counselling. More poor and lesser-educated mothers took children with suspected pneumonia to an appropriate health provider. Urban-rural inequities were reduced for iodised salt consumption. Contraception use showed very low levels of inequities, for example where education, wealth and urban-rural indicators are concerned. However, urban-rural and wealth-related disparities in effective health coverage still remain and challenge many households in terms of physical and financial access to health services in all the evaluation countries.

Poor, less-educated and rural residents have the least knowledge about health issues, which most likely impedes timely access to needed care and exposes them more to risk behaviour. Some of the evaluation countries still have a fair number of pregnant women who do not make an adequate number of antenatal visits. This has a potentially negative impact on their pregnancy outcomes. Disadvantaged groups across all countries do not seem to have benefited from increased antenatal visits, as they often choose not to use them—and when they do, they have less access to doctors compared to the richer population groups. Poor households are still less likely to use iodised salt. Consequently, more attention needs to be paid to social vulnerability to improve effective coverage of these groups.

UNICEF's contribution

According to the ToC, the extent of UNICEF's contribution depends on its achievements in identifying critical health system bottlenecks in effective coverage for the evidence-based MNCH interventions, and addressing them through its core roles. Therefore, the likelihood that such system/community level changes occurred, and that they occurred with UNICEF's contribution, was determined by looking at: (a) the extent to which bottlenecks in a given intervention package (and the included sub-packages) were addressed, as measured by the average bottleneck addressing score; (b) the extent of UNICEF's contribution to the implementation process for the given intervention packages, as measured by the average contribution score organised by core roles; and c) by the relative share of resources devoted by UNICEF to fulfil these core roles. Using this framework, the ET established plausible evidence for a strong likelihood of system/community level changes with UNICEF contribution over the entire evaluation period for all intervention packages. However, the level of UNICEF's contribution varied according to package and from country to country.

Voice for children. Over 10% of UNICEF's distinct programme interventions (218 out of 1988) in the evaluated countries advocated for child health issues. The same share of UNICEF's resources was allocated to this core role. Through this core role UNICEF was a lead advocate and lobbyist for bringing MNCH issues to the top of the public policy agenda in all countries evaluated. Evidence shows that UNICEF was regarded as a highly competent and reliable partner by policy makers and key national stakeholders and thus had a unique opportunity to influence the MNCH policy process. Through this core role UNICEF collaborated with legislative and executive branches of government at national and local levels and with opinion leaders and community organizations to address many of bottlenecks and induce system changes. These interventions included such determinants as conducive laws, policies, standards and social norms as well as social and cultural practices and beliefs. Issues included exclusive breastfeeding; prenatal and newborn care; proper nutrition; and immunization. However, no mechanisms were identified through which UNICEF facilitated the inclusion of children's voices and views in MNCH programme design, implementation or M&E.

Facilitating national dialogue. When exercising the "voice for children" was brought into the public agenda, UNICEF engaged a wide range of actors, in all the evaluation countries, in a national dialogue to facilitate the development of child-friendly norms and standards. This was achieved through national and sub-national round tables, consultations and thematic working groups with wide stakeholder participation, including civil society and beneficiary representatives. This core role was applied to all intervention packages in all the countries evaluated. Activities supporting national dialogue commonly preceded the development of key legislation, policies and standards for MNCH. Over 100 UNICEF-supported activities were classified as facilitating national dialogue. UNICEF spent close to 3% of its financial resources in fulfilling this core role.

Enabling knowledge exchange. Over 25% of all UNICEF-supported activities (507 out of 1988) were identified under this core role. UNICEF used up to 22% of its total resources in the evaluation countries to fund knowledge exchange activities, which were dominant in the middle of the evaluation period. UNICEF-supported knowledge exchange of best practices and approaches in MNCH at international, national and sub-national levels helped to shape MNCH policies and standards in the five countries. A range of initiatives – including maternal and child health situational analysis; numerous independent studies; costing studies; and other publications produced by UNICEF headquarters, RO and COs; international and regional study tours; and regional conferences on priority MNCH issues – were instrumental in generating the interest and ownership of national and local policy makers for these issues. The many trainings for health providers across all intervention packages were also classified as knowledge exchange, and most of the funds devoted to this core role were spent on trainings. Overall, this core role encompassed the highest number of UNICEF-supported activities; it engaged the second highest amount of their financial resources, and was critical for capacity building to create sustainable system-level change.

Policy advice and technical assistance. This was one of UNICEF's most frequently used and most-resourced core roles, making up 22% of its activities and 25% of its funds. Custom-tailored policy advice and technical assistance provided to national and sub-national governments primarily supported the development of skilled and motivated staff, the development of conducive laws, policies, standards and social norms, and improved management and service organization. Almost all respondents from the evaluated countries underscored the timeliness and high quality of UNICEF policy advice and technical assistance. This core role was essential for ensuring that the MNCH service models promoted by UNICEF were institutionalized and sustainable, by establishing relevant institutions and mechanisms and creating conducive legislative and policy frameworks.

Modelling. Modelling was the most frequent and resourced core role during the initial phase of the evaluation period. UNICEF allocated up to 45% of total funding in the first four to five years of the evaluation period to this core role. Modelling was used to demonstrate the effectiveness of internationally recognized approaches for organizing and delivery MNCH services. The resulting evidence was used to facilitate national dialogue and provide custom-tailored policy advice for required changes in legislation, policies, standards and national budgets. Over the evaluation period, modelling received 13% of total UNICEF allocations, which were mainly spent on essential drugs and technologies, training human resources and organizing services in pilot sites.

Monitoring and evaluation. M&E was among UNICEF's most frequently used core roles (455 out of 1988 UNICEF-supported activities), yet with a relatively modest funding allocation (12%). UNICEF closely monitored programme implementation using different tools and approaches, including 156 research studies, surveys and mid-term and final evaluations of its programmes/projects. These provided data to inform course corrections during implementation, as well as programme design during the same--or for the next--CPAP period. UNICEF showed remarkable performance in adopting 9 out of every 10 of the 140 recommendations produced by its monitoring and evaluation efforts. According to key informants, UNICEF was instrumental in building local capacities in all the countries evaluated for implementing MICS and DHS studies, institutionalising the development statistics tool "DevInfo" in state statistical offices, and in building local technical capacity to implement situation analysis, programme-specific evaluations and studies. However, the health system performance and health system strengthening assessment frameworks and toolkits that were used in a number of CEE/CIS countries over the past decade were not consistently applied and/or institutionalised in any of the countries evaluated, to generate the information necessary to monitor health system level changes methodically. Furthermore, while MICS and DHS surveys were successfully institutionalised in the countries evaluated, and are currently conducted with the active participation of the national statistical agencies, the limitations of MICS (sample sizes and as a result, the number of cases captured) did not allow for statistically sound comparisons between countries or over time, for most of the indictors. This would have established true inter-country variations and changes over the evaluation period. Furthermore, in its current design MICS loses its value-added for a country for a lack of standardized analytical modules that allow comparisons across MICS waves without significant investment.

At the same time, UNICEF rarely monitored the status of a health system or community level change that it helped to achieve, and discontinued its support afterwards. As a result, the absence of

consistent and routine system-level data constrained the ET's efforts to explore the precise scale of the changes and how sustainable the achieved system- or community- level changes were, over time. These aspects are important to monitor, as the ET discovered cases when some of the beneficial system- or community- level achievements were rolled back due to a changed economic, social or political environment and/or to lost ownership (decreased health spending, enabling legislation abolished), or to a fact that lack of uptake of an intervention was not continued after funding dried up from UNICEF and/or from other development partners. Declining population knowledge abouton the danger signs of pneumonia, and the increasingrising anti-immunisation sentiment that, which resulted in slightly declining immunisation coverage rates duringover the evaluation period, may represent cases of such "unsustainable" change.

Leveraging. The least utilised core role was leveraging, which was employed in most cases to carry out activities in the Nutrition (35) and ANC/PNC (11) intervention packages. This core role received a comparatively small share of total UNICEF allocations (5%) . However, this data should be interpreted with caution, as successful leveraging is not merely the result of a stand-alone programme activity/intervention, but accomplished through a set of activities and interventions carried out over an extended period, often using other core roles. For example, successful leveraging of government resources to finance MNCH services under the Basic Benefit Package (BBP) in Kazakhstan, Moldova and Serbia required multiple forms of UNICEF engagement. These included monitoring & evaluation (obtaining evidence regarding financial access bottlenecks for children and women); disseminating evidence and advocating for policy change and an increase in public health expenditures through "voice for children"; facilitating national dialogue; and facilitating condusive policy and legislation through knowledge exchange; as well as policy advice and technical assistance.

Changes in the relative importance of its core roles over the evaluation period – from modelling/piloting to enabling knowledge exchange and eventually to policy advice and technical assistance – characterises UNICEF's approach well as it assisted partner governments to achieve sustainable system changes through demonstration, empowerment, knowledge transfer and capacity building, culminating with institutionalisation.

Sustainability

The goals and objectives of UNICEF programmes that support delivery of the priority intervention packages were fully aligned with national development and sectoral policies in all the evaluation countries. By facilitating the adoption of enabling laws, regulations, standards, guidelines, and undergraduate and postgraduate curricula for each of the intervention packages, UNICEF ensured further integration of its programmes into national policies in all five countries.

UNICEF successfully advocated for the inclusion of essential MNCH interventions in the Basic Benefit Packages financed by national budgets in all the countries. However, not all components of UNICEF-supported programmes were fully integrated in national budgets. Due to financial constraints, some were not able to fully upgrade all MNCH facilities, adequately finance all drugs (in the benefit package and at the facility level) or the supplies and equipment necessary for ANC/PNC and IMCI, or to sustain the continuous education process for medical personnel.

Most UNICEF-supported pilot models (74%) were scaled up nationally, and even more (87%) were incorporated in national policies or systems. Only 7% of the pilot models were unsustainable, and the rest were implemented at a sub-national level. UNICEF also ensured the financial sustainability of the scaled models through upfront and continuous engagement with government officials and open and frank dialogue about the need to assume financial responsibility. This was supported with relevant evidence and, where necessary, strong advocacy. As a result, 3 out of every 5 pilot models were incorporated in national budgets after scale-up and continued after the completion of UNICEF support.

UNICEF actively engaged with seven UN agencies, 21 other development partners and four private sector partners, and leveraged additional resources for UNICEF-supported programmes or programme areas that most likely exceeded the resources expended by UNICEF by several times. The ET identified 77 UNICEF attempts to leverage resources, most of which were concluded successfully. Leveraging was effectively used to scale up pilots and assure the national rollout of UNICEF-initiated and/or -supported programs, which most likely created strong preconditions for sustainability.

Qualitative evidence indicates that UNICEF's own investments in the MNCH sector had a high return, as: (a) the results achieved in addressing effective coverage bottlenecks with a major or significant contribution from UNICEF look impressive, considering their investments in MNCH accounted for less than 8% of Oversees Development Assistance (ODA) spending on MNCH and less than 1% of the overall ODA spending on health; and (b) the majority of key informants interviewed, who represented partner governments and leading development partners in all the evaluation countries, invariably assessed UNICEF as playing a leading role in MNCH, and--in some cases--in broader health system reforms.

Human rights-based approach and gender equality

Gender equality was partially incorporated into the planning and evaluation of UNICEF-supported programmes, though in only two evaluation countries. The human rights-based approach was not explicit in MNCH programming, although programmes implicitly or explicitly declared the goal of ensuring the rights to survival, development, and growth. Retrospectively, several critical interventions (e.g. support to birth registration, ILBD introduction, breastfeeding promotion etc.) could be considered as a human rights-based approaches. Rights-based programming was more pronounced in HIV/AIDS programmes and for children affected by HIV.

Most of the monitoring and evaluation reports that were analysed, starting from the year 2000, claimed that M&E was conducted in a participatory and ethical manner with full respect to human rights and gender- specific and sensitive issues. However, the ET was not able to establish the validity of this statement, nor whether the planning and implementation of UNICEF programmes were performed in this manner.

UNICEF in its programme documents used the terms "vulnerable, marginalised and hard-to-reach population groups" in a general manner, without clearly defining and identifying the population groups that the term entailed within a given country context. This limited UNICEF's ability to plan and carry out interventions benefiting these groups. Roma children in Serbia were the only exception to this trend.

As a crosscutting theme, gender equality was implemented in a significant proportion of UNICEF country interventions but largely restricted to educational activities. Very few, if any, gender equality activities were found in the area of MNCH before the year 2011. An equity focus was part of UNICEF's monitoring efforts, although it was not adequately present in all programmes and crosscutting issues, which may have prevented an appropriate programme focus on the remaining equity gaps.

While UNICEF was one of the first UN agencies to have a clear gender mainstreaming policy, which is unique in combining a focus on increased equality in programming with a life cycle and rights-based approach, the actual reflection of this theme in the MNCH health portfolio of programmes in the evaluated countries was only evident at the very end of the evaluation period. It also appears that gender sensitivity in MNCH needs to be more specifically defined, for example by developing appropriate qualitative indicators or providing more programmatic guidance. Moreover, for future programming, UNICEF might consider completely phasing out gender considerations in health for children from 0 to five years old, since gender issues inevitably and naturally appear in Early Childhood Development programmes. This approach would avoid unnecessary and disputable issues such as gender considerations in addressing Under-5 mortality and morbidity, and instead make universality the main criterion for this age group. It shoud be noted that this does not implies the shift in UNICEF's focus from the gender norms that affect the lives of children from this age group, such as selective contraception, early marriages and childbearing.

Conclusions and Lessons Learned

Conclusions

There has been a positive change in the reduction of infant and under-5 mortality and morbidity over the period 2000 to 2012 in the countries evaluated. However, the trends in key child health indicators across geographical, ethnic, gender and other socio-economic stratifiers in the CEE/CIS and the evaluation countries were uneven, and some groups remain outliers. The most at-risk children belong to several of these outlier groups and require priority attention in the evaluation countries and more

generally in the CEE/CIS. The trend in reducing the specific causes of child mortality in the evaluation countries was generally positive, but there was significant variability in the pace of change, for different causes. Along with health system-related interventions and factors, many other factors or socioeconomic determinants most likely contributed to the change in infant and under-5 mortality and morbidity in the CEE/CIS and the evaluation countries.

UNICEF-supported programmes invariably addressed the most important causes of infant and under-5 morbidity and mortality in all the evaluation countries, with the exception of causes related to the preconception period. Mortality and morbidity causes originating in the antenatal period were also less addressed. UNICEF identified and attempted to address all of the most important bottlenecks in effective coverage by MNCH services. UNICEF-supported programmes were mostly successful in identifying and applying the right interventions (activities), with the appropriate scope, target groups and scale to address these health system bottlenecks. UNICEF-supported programmes were well aligned with national development and sectoral priorities in all the evaluation countries, including those upholding fundamental human rights and tackling inequities.

Although it was not always the highest contributor in monetary terms, UNICEF invariably played an active, if not a lead, role in all the evaluation countries within most of the partnerships forged to promote MNCH issues and define wider health sector policies. UNICEF applied considerable efforts to involve relevant partners in programme design, implementation and evaluation. Partnerships were most successful with host governments, UN agencies and multilateral and bilateral development partners, as well as those formed for the implementation of IMCI, ANC/PNC (with World Bank, ADB, EU, KfW, GIZ, SDC, CIDA, USAID, JICA) and Nutrition (private sector actors, The World Bank, ADB, DFID, Soros Foundation) packages. However, the representation of UNICEF beneficiaries in this process was relatively small, limiting the potential for realising the human rights-based approach through the participation of rights holders.

UNICEF-supported programmes, using all core roles, most likely made a significant contribution to achieving the required system and community level changes in the countries evaluated. Modelling, enabling knowledge exchange, monitoring & evaluation and policy advice & technical assistance were the core roles most frequently used and/or the most resourced and carried out.

There is a high likelihood that UNICEF-supported programmes contributed to reducing bottlenecks, which ensured effective coverage of priority MNCH interventions along the continuum, in particular those most relevant to the CEE/CIS region. This is evidenced by improved coverage indicators in all the evaluation countries, and by the evaluation findings.

Results were mixed in the case of reducing the equity gaps in MNCH service coverage, to which UNICEF has likely contributed. Some gaps narrowed but others widened. Subsequently, there were significant inter- and intra-country disparities, and some marginalised groups remained outside of effective coverage by critical MNCH interventions.

The findings indicate a high likelihood that the reduction in effective coverage bottlenecks and the resulting improvements in effective coverage with evidence-based interventions contributed to a reduction in disease- specific mortality for perinatal conditions, ARI, DD, and meningitis. These reductions appear to be positively associated with an overall reductions in NMR, PNMR, IMR, and U5MR in the evaluation countries. However, it was impossible to establish a causal probability between the reduction of bottlenecks and a reduction of deaths due to congenital conditions and injuries.

Financial resources for UNICEF-supported programmes were allocated according to identified priorities and bottlenecks. UNICEF performed well in monitoring programme implementation using different tools and approaches and acted on 9 out of every 10 recommendations generated by programme evaluations.

Most UNICEF-supported programmes were integrated into national policies and budgets, however UNICEF was somewhat more successful in assuring programme integration into national policies than into national budgets. They succeeded in assuring the scale-up of pilots and their inclusion in national policies and/or systems by progressively and systematically applying UNICEF core roles from modelling/piloting to knowledge exchange and to policy advice and technical assistance.

UNICEF-supported programmes were mostly successful in leveraging resources and partnerships. However, while the evaluation was able to collect strong qualitative evidence of leveraging efforts, obtaining a precise monetary dimension was impossible. This negatively affected the ability of the ET to make quantitative evaluations for return on investment. According to the qualitative findings of the results and key informants' assessments, the return on UNICEF's investments in MNCH appear more than satisfactory--two out of every three programmes continued after UNICEF support ended.

Any emphasis on gender equality was largely absent and the human rights-based approach to programming was only partially incorporated into UNICEF-supported programme planning, implementation and evaluations. UNICEF claimed that the monitoring and evaluation of supported programmes was mostly performed in a participatory and ethical manner, with full respect to human rights and gender specific and sensitive issues. However, evidence of such performance with regards to programme planning and implementation was limited and at times impossible to obtain.

With a few exceptions (e.g. Roma in Serbia and Moldova), MNCH programmes supported by UNICEF largely failed to define marginalised, vulnerable and hard-to-reach groups clearly for programmatic purposes, or to focus interventions towards these groups. Gender equality was not mainstreamed in UNICEF programming up until the very end of the evaluation period, however UNICEF did monitor the equity effects of its interventions using population-based surveys and routine statistics.

As a cross-cutting theme, gender appeared in a significant proportion of UNICEF country interventions but was largely restricted to educational activities. Very little, if any, focus on gender was found in MNCH.

The ToC proved to be a useful tool both for creating and evaluating UNICEF-supported programmes. However, when analysing the data on programme interventions provided by the UNICEF Country Offices (CO) from the evaluation countries, the ET found a wide variation among COs in in how they attributed UNICEF-supported programme interventions to the relevant core roles (for example, capacity building) and the MoRES determinants they target. Furthermore, the ET was unable to attribute specific bottlenecks observed in any of the evaluation countries for two out of ten MoRES determinants ("enabling social norms" and "continuous utilisation of services"). As described earlier, leveraging is achieved using other core roles, while allocating resources for other activities is simpler and more direct. The UNICEF RO might consider issuing guidance to help define a uniform approach for operationalizing the MoRES determinants framework and core roles approach at the country level. This will improve the evaluability and cross-comparability of results achieved at country levels. The guidance developed by the UNICEF RO, which was further revised by the ET for this evaluation, may serve as a starting point.

Lessons Learned

Factors explaining success

Evaluation findings on the effectiveness and efficiency of the UNICEF-supported programmes indicate that while the size of financial allocations for UNICEF-supported programmes may influence the achievement of results, they are not always a determining factor. For example, UNICEF spent only a fraction of its resources (0.5%) on reducing bottlenecks in effective budgeting and financing while achieving tangible results in the reduction of financial access barriers to MNCH services. These results were largely obtained by enlisting the sustained engagement of governments and development partners who brought substantial financial resources to the table. UNICEF-secured partner engagement to facilitate national dialogue demonstrated how workable solutions/models, building capacities and ownership through knowledge exchange, as well as supporting the institutionalization of system change through quality policy advice and technical assistance, can be successful. To improve results when development resources available to the CEE/CIS region are diminishing, UNICEF should intensify efforts to mobilise the right governmental, non-governmental and development partners through a balanced mix of core roles.

UNICEF's skills and its approach to health system-level changes may have been critical factors for success as well. Their approach included the concept that health systems are complex-adaptive systems to which a linear "input - output – outcome" perspective is rarely applicable. Instead, the nature of health systems requires an ongoing engagement that accounts for path dependence, and

acts on feedback loops and emergent behaviours within the system, and responds through modified/adjusted activities. UNICEF used such approches well, and they featured prominently in all country programmes for different intervention packages over the evalaution period.

Beyond MNCH

Evaluation results show that while UNICEF's efforts to strengthen health systems targeted "traditional" MNCH areas where their experience and expertise were regarded as superior by host governments and key development partners, it had broader effects on wider health systems in the countries studied. For example, the Health System Strengthening (HSS) activities to implement IMCI in Moldova and Uzbekistan strongly influenced the course of the national PHC and health financing reforms in these countries. Therefore, UNICEF's efforts to create an enabling environment for system-level changes, within specific intervention packages targeting MNCH services, can help formulate a model for HSS interventions that uses MNCH as an entry point to wider HSS, and that will benefit other health sector priorities.

What did not work well

Despite the existence of toolkits for health system performance and for strengthening assessments, they were not consistently applied and/or institutionalised to rigorously monitor system-level changes in any of the evaluation countries. Systematic efforts should be applied to develop UNICEF and partner governments' capacities to assess health system performance.

UNICEF was not always successful when addressing health financing and health service delivery system bottlenecks independently or--in certain cases-- even with their development partners who are traditionally active in health reforms (World Bank, USAID, EU). This was mainly true for the lower income countries evaluated--Uzbekistan and Kyrgyzstan. The case studies show that in these countries several factors negatively affect the flexibility of health systems and their capacity to change, for example limited government spending on health, low staff motivation and frequent turnover of public health managers. Global evidence suggests that these challenges are pervasive in many LMICs and that more sustainable approaches towards HSS must be created.

Recommendations

The evaluation recommendations draw on the findings, conclusions and lessons learned, were developed in a participatory manner and were validated with the RKLA Reference Group. The recommendations are grouped in five blocks:

① Sharpen equity-focus of UNICEF's programming

- Facilitate multisectoral approaches across health, social, education and other sectors, as appropriate to adequately address socioeconomic determinants of child health:
  - ⇒ Looking through lens of socioeconomic determinants of health, help countries define and prioritize marginalized/vulnerable groups and define approaches to meet their need;
  - ⇒ Assist countries to develop and cost health, nutrition, social and other benefits focused for priority interventions (e.g. essential MNCH services, drugs, vaccines, etc.) focused on priority marginalized/vulnerable groups, which has to also inform equity focused budgeting;
  - ⇒ Refine in-country mechanisms to reach marginalized/vulnerable;
- Empower communities and civil society to better voice the needs of children and monitor government's performance in delivering services, especially to marginalized groups.

② Consolidate and advance the gains in child health

- Help countries to further improve quality of neonatal care on all levels through better care coordination
- Help countries advance child health, development and well being, and, where possible, the identified women and maternal health issues through whole family approach
- Help countries to develop and implement comprehensive national nutrition policies

- Help countries to assure sustainability of national immunization programmes and assure universal inclusion of pneumococcus and rotavirus vaccines in national immunization schedules
- Help Countries to develop context-specific multi-sectoral program for child injury prevention.

③ Where possible, consider not sufficiently addressed underlying causes of child mortality and morbidity

- Advocate for a greater attention to preconception and antenatal health of women, through:
    - ⇒ Advocating governments to improve ANC/reproductive health through enhanced and well coordinated joint programming, implementation and evaluation with UNFPA and WHO, where appropriate;
- Advocating for development and delivery of greater benefits to marginalized pregnant women through integrated social and health programming, including nutrition sensitive and specific interventions.

④ Address persisting bottlenecks at health system and community levels

- Help countries to enhance national/sub-national monitoring systems through:
    - ⇒ Improving vital registration and analysis, with emphasis on cause of child death analysis;
    - ⇒ Monitoring health related inequities, especially among marginalized/vulnerable groups;
    - ⇒ Monitoring service quality across continuum of MNCH care;
    - ⇒ Assessment of health system performance
- Help countries to put in place quality improvement systems for MNCH services
- Strengthen referrals between levels of care for high-risk pregnant women, newborns and children with emphasis on marginalized/vulnerable groups
- Help countries to enhance in-country management capacity through sustainable approaches to support national and sub-national implementation of necessary laws, policies and standards

Help countries to continue work on family and community targeted C4D to address critical gaps identified by the evaluation.

⑤ General Recommendations

- Revise and adjust regional ToC for RKLA 6 in light of the findings of this evaluation;
- Elaborate guidance for COs to facilitate operationalization of the MoRES framework with a clear methodology for classifying and attributing programme interventions across the core roles and the MoRES determinants. Also consider modifying the MoRES determinants framework and core roles. Namely:
    - ⇒ Eliminate “Timely and continuous utilization” and merge “social norms” with “cultural practices and believes” and
    - ⇒ Better define “capacity development” within the core roles (suggested to add to “knowledge exchange”) and where it belongs.
- Enhance UNICEF’s planning and financial accounting/management systems to allow for close linkages between the MoRES determinants, core roles and the programme expenditure for adequately tracking programme implementation across these dimensions.
- Improve utility of MICS/DHS surveys on a country level by developing user-friendly and web-based analytical tools, consider the possibility of establishing linkages with databases such as WHO EURO Health For All.

CHAPTER 1. INTRODUCTION

1.1 STRUCTURE OF THE FINAL REPORT

Chapter 1 – The **Introduction** of the final report provides an overview of UNICEF programmes in the evaluated countries during the period 2000 – 2012, and presents the purpose, objectives and scope of this evaluation. **Chapter 2 –Evaluation Object** describes the context in terms of socio-economic, health and health systems situations and trends in the CEE/CIS and the evaluated countries; it summarizes the Theory of Change (TOC) for UNICEF's regional approach to reduce and close the equity gap in under-five and infant mortality and morbidity in the CEE/CIS and evaluated countries; and presents UNICEF's key stakeholders and partners in the CEE/CIS and the countries evaluated. **Chapter 3 – Evaluation Methodology** summarizes the *final* methodological approach used in the evaluation, including data collection methods, sources, and the data triangulation and analysis process. It also presents the quality assurance process, evaluation limitations, stakeholder involvement and participation in the evaluation, as well as ethical considerations. **Chapter 4 – Evaluation Findings** presents results across six evaluation criteria: impact, relevance, effectiveness, efficiency, sustainability, a human rights approach and gender equity within UNICEF-supported programmes in the evaluated countries. **Chapter 5 – Evaluation Conclusions** summarizes the conclusions and lessons learned, grouped according to the evaluation criteria. **Chapter 6 - Evaluation Recommendations** provides recommendations that emerged from the evaluation, for UNICEF and the evaluated countries.

1.2 EVALUATION PURPOSE, OBJECTIVES AND SCOPE

The fast-changing social, economic and political environment in the CEE/CIS region created a growing demand for UNICEF to produce and manage knowledge about the situation of children and effective policy models in carefully selected priority areas. This led to the establishment of the *Regional Knowledge and Leadership Agenda* (RKLA). The RKLA focuses on key priority result areas and provides a framework through which UNICEF can engage with governments to identify results. The framework includes evidence that their cooperation has resulted in a progressive realization of child rights, while reducing equity gaps; evidence that national systems for children have achieved levels of performance equivalent to international standards; and national experience that can be shared across borders, thus facilitating horizontal cooperation.[1]

As described in the next subsection, UNICEF health and nutrition programmes in the CEE/CIS have varied substantially in scope and content across countries and programming cycles during the last decade, although they have all focused on strengthening health systems and effective coverage. Available evidence suggests that the results achieved in improving child health in CEE/CIS countries over the last decade were also uneven. Consequently, it is increasingly important for UNICEF's Regional Office (RO) for the CEE/CIS to make a systematic evaluation of which programmatic approaches and interventions succeeded and/or failed to produce tangible results in terms of health system changes (outcomes) and improved child health (impact).

To generate knowledge that can inform country discussions, UNICEF commissioned this *Multi-Country Evaluation* (MCE) with the **purpose** to "show evidence to what extent UNICEF has been effective and efficient in pursuing those strategies, and--drawing from lessons learned from the past--how UNICEF should further carry out programming".[2] The evaluation projected to look at both national and sub-national system level changes to a) document progress in reducing under-5 and infant mortality and morbidity, and generate lessons on how this was accomplished; b) inform programmes aimed at scaling up evidence-based and equity-focused interventions; and c) enable better partnering with

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1 UNICEF 2013. Regional Analysis Report 2012. Regional Office for Central and Eastern Europe and The Commonwealth of Independent States (CEE/CIS). Geneva

2 Progress in Reducing Health System Bottlenecks towards Achieving the MDG 4 Goal: Evaluation of UNICEF's Contribution in five CEE/CIS Countries. Terms of Reference. 2013

national governments to advance the child health and rights agenda. The **evaluation objectives**[3] are as follows:

1. To document results in terms of changes in access to MNCH services (enhanced coverage of children with proven health services packages and interventions) and reduction of equity gaps;
2. To assess how system-level changes (enabling environment, supply and demand, and quality of MNCH services) led to these results; and
3. To document the contribution of UNICEF in addressing health system level bottlenecks.

A reduction in under-five and infant mortality rates by 2/3 between 1990 and 2015 is one of the specific targets (4) of the Millennium Development Goals (MDG). Consequently, a reduction in morbidity from the leading causes of under-five and infant mortality is critical to achieving the MDG target. UNICEF's global and regional health and nutrition strategies embodied commitments to helping countries achieve the child mortality MDG over the entire evaluation period.[4] These strategies are reaffirmed in the Global Strategy for Women's and Children's Health, and the Every Woman Every Child movement led by UN Secretary-General Ban Ki-moon, launched during the United Nations Millennium Development Goals Summit in September 2010.

Compelling evidence provided by UNICEF shows that without an equity focus to achieving MDGs, it would be impossible to achieve the MDG targets or to reduce the gap between children from better-off and most impoverished families. It would also be impossible to eliminate urban-rural differences in children's health outcomes, disparities that are still largely present in the region. In "Narrowing the Gap to Meet the Goals", UNICEF has argued that an equity-focused approach is both right in principle and right in practice, and this has become the basis for the renewed organizational focus on equity globally.[5]

The CEE/CIS countries, including those that were evaluated, have all ratified the Convention on the Rights of the Child and have committed to the MDGs. Ensuring the survival and development of the child and the child's right to enjoy the highest attainable standard of care by reducing under-five and infant mortality and morbidity was high on the national agendas. It was also a main focus of UNICEF programming in these countries as evidenced from the review of UNICEF's regional strategies for CEE/CIS, including the latest: "Keeping Our Promise to Children: An Agenda for Action". Therefore, the evaluation assesses UNICEF's contribution to the impact outcomes (overall trends in under-5 and infant mortality and morbidity 2000-2012 and equity gaps) and the system level outcomes, by assessing the potential influence of external factors and social determinants (education, wealth status, place of residence, etc).

The lessons learned from this evaluation are also expected to contribute to global knowledge about effective programmatic interventions that affect health systems, close the equity gap and reduce child mortality and morbidity. It is well known that the achievement of MDG4[6] and MDG5[7] is significantly constrained by weaknesses in the health systems in many developing countries. Consequently, any results from programmatic interventions that contribute to strengthen health systems and alleviate system bottlenecks, or to change community practices and improve effective coverage, offer opportunities to further reduce child mortality and morbidity.

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3 Following consultations with the UNICEF RO, the evaluation objectives were slightly modified from those presented in the MCE ToR during the inception phase of the evaluation.

4 Global Strategy for Infant and Child Feeding, WHO/UNICEF, 2003; Joint Health and Nutrition Strategy for 2006-2015, UNICEF, 2005

5 "Narrowing the Gap to Meet the Goals." UNICEF http://www.unicef.org/media/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf

6 Millennium development Goal 4 focuses on reducing child mortality and sets the following target: Reduce the under-five mortality rate by two thirds between 1990 and 2015.

7 Millennium development Goal 5 focuses on improved maternal health and sets the following targets: Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and Target 5.B. Achieve, by 2015, universal access to reproductive health.

The CEE/CIS countries made significant progress in reducing IMR and U5MR, yet there are still large inter-country and intra-country disparities that need attention. Therefore, if the evaluation generates evidence for effective equity-focused programming, it can benefit programmes and interventions supported by UNICEF that are aimed at reducing the equity gap in the region and globally.

Since the focus, scale and impact of UNICEF-supported programmes and interventions vary between countries, the **geographical scope of the evaluation** focuses on *five countries*, which have the largest and most innovative health programmes supported by UNICEF according to UNICEF RO. These include Kazakhstan, Kyrgyzstan, Moldova, Serbia and Uzbekistan. These countries differ in terms of size, baseline socio-economic development and child health indicators. They also differ in the format and scale of their UNICEF programmes, which allowed the ET to identify programme approaches that worked or did not work in diverse country settings. The evaluation period covered 12 years from 2000 – 2012, and was chosen for two reasons. According to the Terms of Reference (ToR) of the MCE, this evaluation period coincided with major health reform processes taking place at the time in the selected countries, and the duration of programme interventions allowed sufficient time to measure their results.

The evaluation primarily focused on UNICEF-supported, MNCH-related interventions with a potential to positively influence neonatal and child health outcomes through enhanced health systems. (Interventions that focused on reproductive and pre-pregnancy periods were beyond the scope of the evaluation.)

The prime beneficiaries of this evaluation are policy makers and programme managers, both within UNICEF and in governments, partner organizations and academia. Furthermore, better documentation of the results and identification of the most effective strategies and interventions in given contexts will be helpful for UNICEF when mobilizing additional resources for further reductions in avoidable child deaths, both in the region and globally. The results of the evaluation may further inform and influence the development of UNICEF-supported country cooperation programmes.

1.3 OVERVIEW OF UNICEF HEALTH AND NUTRITION PROGRAMMES IN THE EVALUATED COUNTRIES

UNICEF's programmes in health and nutrition have supported CEE/CIS countries to achieve the MDGs since the 1990s. However, by the beginning of the new millennium, in light of the changing social-economic situation in these countries, UNICEF programming in the CEE/CIS changed from emergency, service delivery and project modes to a more up-stream health systems approach, aligning itself with overall efforts to modernize and improve the quality of health services.[8] Since 2000, UNICEF has focused on assisting CIS/CEE partner countries to ensure access to and increase the quality of the most effective Maternal, Newborn and Child Health (MNCH) interventions for their populations.

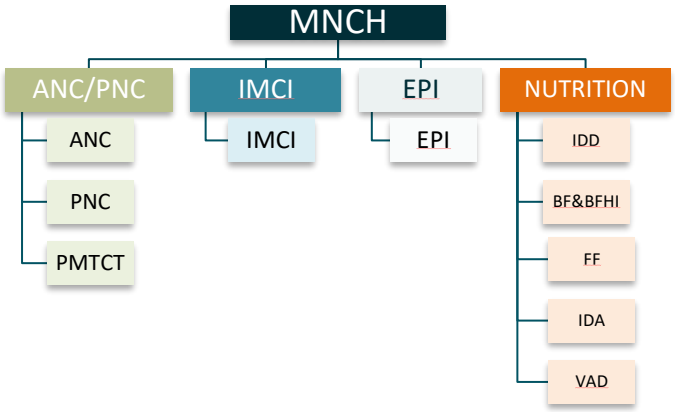


Figure 3: Key Intervention Packages

UNICEF-supported country programmes aimed at strengthening health systems and addressing bottlenecks in effective coverage by MNCH services. In pursuing this goal, UNICEF programmes in the five countries evaluated (Kazakhstan, Kyrgyzstan, Moldova, Serbia and Uzbekistan) targeted a range of

[8] Progress in Reducing Health System Bottlenecks towards Achieving the MDG 4 Goal: Evaluation of UNICEF's Contribution in 5 CEE/CIS Countries. Terms of Reference. 2013

evidence-based interventions across the continuum of care and various delivery platforms, most of which can be grouped across several key "intervention packages"[9] presented in Figure 3.

These intervention packages include:

- The **Antenatal, Neonatal and Perinatal Care (ANC/PNC) package** along with interventions directed at the improved coverage with ANC/PNC services. This also encompasses interventions for the Prevention of the Mother to Child Transmission of HIV/AIDS (PMTCT).
- The **Integrated Management of Childhood Illnesses (IMCI) package,** which consists of interventions directed towards the introduction of IMCI at Primary Health Care (PHC) and hospital levels. It also includes a third, community component of the package covering a better parenting initiative, family education, patronage nursing, early childhood development (ECD), etc.
- The **Extpanded Programme of Immunization (EPI) package** that includes all activities related to EPI (campaigns and communication, new vaccine introduction, safe injection, adverse effects following vaccination - AEFI, strengthening the cold chain, waste management etc).
- The **Nutrition package,** which consists of interventions for the prevention and management of Iodine Deficiency Disorders (IDD), Iron Deficiency Anaemia (IDA), Vitamin A Deficiency Disorders (VAD), supporting Food Fortification (flour, salt, oil) (FF), Breastfeeding and Baby Friendly Hospital Initiative (BF& BFHI), and other cross-cutting nutritional issues, such as growth monitoring and supplementary feeding.

A review of UNICEF programmes in the five evaluated countries shows that a programmatic shift took place as mentioned above, but was not fully completed in the evaluated period (2000 – 2012), and that the programmes implemented in the "project mode" coexisted with programmes supporting the "upstream health systems approach". The scope and scale of the "projects"-- involving direct purchase and/or delivery of pharmaceuticals, medical supplies, other commodities and equipment by UNICEF-- varied from country to country, and ranged from a modest (e.g. Kazakhstan) to a sizable (e.g. Serbia) share of country programmes. The commodities and equipment purchased to support the four intervention packages are included in their respective packages, whereas others are grouped under "other package". A significant share[10] of these "downstream" projects related to the emergency/humanitarian responses in Serbia (up to the year 2002) and Kyrgyzstan (2009-2010). UNICEF spent the remaining share of downstream funding on the pharmaceuticals, supplies and commodities necessary to implement various pilot models in the evaluated countries.

The content of UNICEF country programmes also varied across individual country programming (CPAP) cycles. ANNEX 2 presents a detailed list of programmes grouped in the intervention packages by CPAP cycles. While implementing its programmes in the CEE/CIS, UNICEF worked with a wide range of partners and stakeholders at regional, national and sub-national levels.

[9] For a detailed discussion on grouping in "intervention packages" see ANNEX 1

[10] For example, during 2000-2002 up to USD 2.3 million was spent as an emergency response in Serbia for procuring fuel for winterization, medicines, supplies, vehicles, vehicle spare parts, vaccines, etc

CHAPTER 2. CONTEXT AND EVALUATION OBJECTIVES

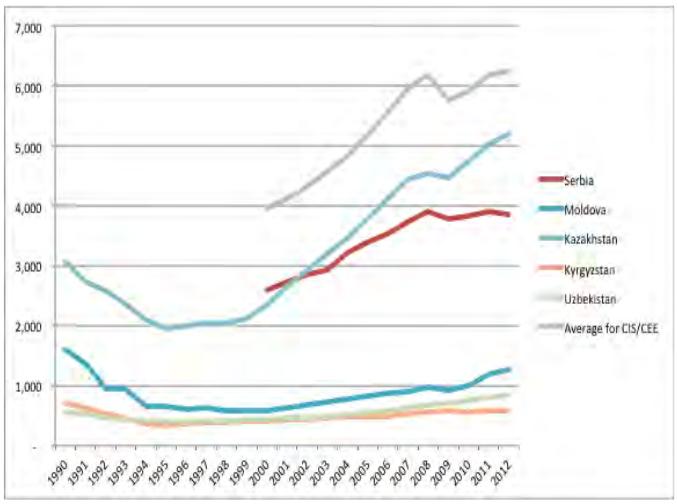
2.1 THE CONTEXT FOR EVALUATION

This subsection of the final report provides an overall description of the socio-economic, health and health policy and system trends in the CEE/CIS region during the period evaluated. More details are provided for each country in ANNEX 4.

2.1.1 SOCIO-ECONOMIC CONTEXT AND DEMOGRAPHIC TRENDS IN THE CEE/CIS AND THE EVALUATED COUNTRIES

The CEE / CIS region has developed in a unique way since the dissolution of the Soviet Union and the fall of the Berlin Wall. The transition from a centrally planned economy to a market economy caused major shifts in the socio-economic conditions of these societies, leading to a rise in poverty and income inequality. The proportion of people living in extreme poverty (on less than a dollar a day) jumped from less than 1% of the population in the CIS countries and South-Eastern Europe in 1990 to 5.5% and 1.3% respectively in the two sub-regions in 2004. Patterns of economic transition also differed within the region. Most of the CIS countries experienced deep economic recession during the first decade of transition, while CEE countries recovered rapidly (except for several former Yugoslav countries, including Serbia), and surpassed their pre-transition level of economic output during the first few years of transition.

Figure 4: GDP per capita (constant 2005 prices) for the evaluated countries and the average for the CEE/CIS region in 1990-2012



Source: UNICEF Regional Office for CEE/CIS, TransMonEE 2014

From 2002 to 2012, the CEE/CIS region faced significant political and socio-economic developments, which saw 12 of the 21 countries and territories where UNICEF is present move to the upper-middle income level. By 2012, only three countries in the CIS were still considered as low-income countries, two of which (Kyrgyzstan, Uzbekistan) are objects of the current evaluation (see Figure 4). However, developments both in the CEE and CIS sub-regions did not fully benefit the most marginalized, vulnerable and disadvantaged groups, and equity gaps widened.[11] While extreme poverty decreased back to pre-transition levels, overall income inequalities continued to rise throughout the region.[12] Vulnerable groups of children continue to live in extreme poverty, including children in families with four or more children; those from rural areas; those with special needs; those from ethnic minorities, such as Roma; and children left behind because of emigration.[13]

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11 Simai M., 2006. Poverty and Inequality in Eastern Europe and the CIS Transition Economies. DESA Working Paper No. 17.

12 The Millennium Development Goals Report 2007: For CIS and South-Eastern Europe, an Up-and-Down ride. United Nations. 2007

13 Regional Analysis Report. UNICEF Regional Office for CEE/CIS 2012.

Continuing economic hardships, ageing populations and Labour migration have disrupted social protection systems. These systems often fail to provide minimum protection to children, and average social assistance spending amounts to a mere 1.6 % of GDP[14] in the region. Even though children are more likely to be poor, they are less likely than adults to receive any kind of social assistance. New services for family and child support still mainly cover urban areas, leaving many groups unreached, including children in rural areas, children in rapidly expanding urban spaces and shanty towns, and the children of migrant workers. Limited budgets for social protection translate into a lack of skilled social workers and case managers to reach and help the most vulnerable families.

Table 1: Selected socio-economic indicators for the evaluated countries for the earliest and latest years available during the period evaluated

Country	GDP per capita in PPP		Gini Coefficient		Unemployment %		Fertility Rate		Poverty Level (%)	
	BP	EP	BP	EP	BP	EP	BP	EP	BP	EP
Kazakhstan	4,796	13,917	33.7	28.6	10.4	5.3	1.8	2.6	46.7	3.8
Kyrgyzstan	1,337	2,402	30.8	33.4	13.9	8.4	2.4	3.2	39.9	38.1
Moldova	1,470	4,182	37.9	30.6	8.5	7.4	1.6	1.5	29	16.6
Serbia	5,768	11,554	32.7	29.7	12.1	23.9	1.5	1.5		24.6
Uzbekistan	1,448	4,789	33		6.9	4.9	2.6	2.3		16

Source: The World Bank World Development Indicators 2014 (BP – Baseline Point, EP – End Point)

2.1.2 BOTTLENECKS IN HEALTH SERVICE COVERAGE

Advancing health gains and reducing child mortality in CEE/CIS countries require better functioning health systems capable of delivering equitable and quality health services for mothers and children. The identification of barriers and bottlenecks arising on the supply and/or demand side, and their timely removal/reduction are pre-requisites for implementing any effective public health intervention and assuring effective coverage with Maternal, Newborn and Child Health (MNCH) services. Equitable and effective coverage means that all groups of the target population have access to quality services according to their needs and regardless of their capacity to pay. If a population can access quality health services that match their needs, then access translates into improvement of the population's health and consequently reduces morbidity and mortality. Therefore, understanding the gaps between the physical availability of services and effective coverage, differences in coverage and bottlenecks in different groups and geographic areas, are critical for equity-focused programming.

The availability of health facilities and geographic accessibility was never a major problem in the CEE/CIS, including in the evaluated countries, when compared to other parts of the world. The network of health facilities in these countries was often characterized by overcapacity and significant inefficiencies, particularly at the hospital level. However, persistent problems existed around geographic access to skilled personnel, essential equipment and drugs at the Primary Health Care (PHC) level and in rural district hospitals/maternities throughout the CIS. This situation included four of the five evaluated countries (Kazakhstan, Kyrgyzstan, Uzbekistan, and Moldova), and potentially contributes to the equity gaps observed in MNCH health outcomes.

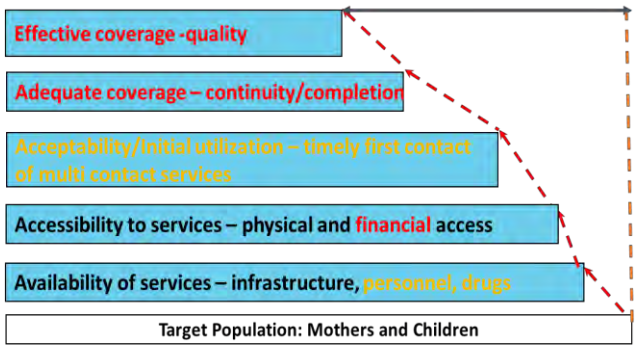
Furthermore, during the transition of the early 1990s, budget austerity measures implemented by governments meant they shifted substantial financial burdens from the state to the population. Increasingly, patients had to cover costs out-of-pocket, including essential drugs, medical personnel salaries and other costs related to health care. That also imposed significant financial access barriers on users, and disproportionately affected the poor and disadvantaged.[15] A review of inequities in MNCH in CEE/CIS identified that large income inequalities and out-of-pocket expenditures for health services were the major drivers of inequities in maternal and child health outcomes in the region. Consequently, inequities in accessing the continuum of care for women and children are important

[14] The World Bank, The Jobs Crisis: Household and Government Responses to the Great Recession in Eastern Europe and Central Asia. World Bank, 2011.

[15] Dixon A., Langenbrunner J., Mossialos E. Facing the challenges in health financing in *Health system in transition: learning from experience.* WHO 2004

determinants of mortality and health status. Financial access was further compounded by deterioration in the quality of health services, which also drove many people away from health care facilities. As a result, hospital acute care rates initially plummeted from around 23-24% in 1990 to 13-14%[16] in 2000 in these countries, although they have picked up slowly since. Outpatient utilization rates per person per annum declined from 7.6 visits in 1990 to 6.1 in 2000.[17] Even given the previous commonly erroneous statistics based on out-dated clinical protocols—there was a decline in utilization coverage as well as in adequate coverage (continuity of coverage) and in effective coverage, as the quality of services worsened.[18] (See Figure 3) However, economic recovery and political-economic stabilization since 2000 have most likely affected health service utilization rates positively, which are now rising.

Figure 5: Reported MNCH service bottlenecks in the selected countries



Adapted from *Tanahashi T. Bulletin of the World Health Organization, 1978, 56 (2)* http://whqlibdoc.who.int/bulletin/1978/Vol56-No2/bulletin_1978_56(2)_295-303.pdf

Highlighted in red are the coverage bottlenecks in most of the selected

Finally, effective utilization was also impacted by social norms and social and cultural practices and beliefs. These are either passed down as traditional practices (e.g. gender related utilization differences in some of the Central Asian countries[19]), or they emerged during transition e.g. anti-vaccination campaigns.

The combination of deteriorating public health, out-dated health care systems, increasing private payments and popular dissatisfaction with health care services, forced many governments to embark on health system reforms in the 1990s. During the early days, most reforms focused primarily on making health services more efficient to reduce the burden on public expenditures. These reforms included the consolidation of hospitals, introduction of new service delivery models (e.g. GPs, family doctors), health system financing changes and provider payment methods. Reforms defined the governments' and individuals' responsibilities, helped by a clear Basic Benefit Package, etc.[20] Although public health was noted as a reform priority in many official documents, there were a number of common weaknesses, including low prioritisation and insufficient capacity. In the area of public health interventions this was particularly true for promoting healthy lifestyles and health information, for example in nutrition, ECD, HIV prevention, etc. and also for communicating risks. These gaps resulted in insufficient knowledge and inadequate care-seeking behaviour of parents and caregivers, which obviously diminished effective coverage.

With support from UNICEF, WHO and other bilateral and multi-lateral donors, the evaluated countries focused on improving effective coverage. They started by reducing financial access barriers, improving the availability of staff and increasing the quality of facilities. They optimized the system according to available resources (developing a team approach, defining roles and responsibilities, introducing mentoring and supervisory systems, integrating different levels of health systems, introducing results-based planning, etc), and trained personnel, while upgrading clinical guidelines.

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16 WHO Health for All Database 2014

17 Averages are presented for the four former Soviet Union countries and do not include Serbia. Source: WHO Health for All Database 2014

18 McKee M., Fidler A. Reforming the continuum of care in Health systems in transition: learning from experience. WHO 2004

19 Cashin CE, Borowitz M, Zuess O. The gender gap in primary health care resource utilization in Central Asia. Health Policy Plan. 2002 Sep;17(3):264-72

20 Ibid.

There was an increased focus on information to communities, communication and education campaigns. The results for the countries evaluated are found in subsequent chapters.

2.2 THEORY OF CHANGE

In this subsection of the report, we present a short description of the Theory of Change (ToC) that underlies UNICEF's approach in the countries selected for the evaluation.

UNICEF's ToC for a regional approach to reduce and close the inequity gap in infant and under-five mortality and morbidity in the CEE/CIS developed from the reconstructed generic ToC provided in the MCE ToR. The generic ToC combines WHO's essential health system functions[21] approach used in UNICEF programming prior to 2011, combined with the equity-focused Determinant Analytical Framework (MoRES) approach introduced following a pivotal UNICEF study entitled "Narrowing the Gaps to Meet the Goals". The generic ToC (see ANNEX 15. Terms of Reference for the Evaluation) was modified for the current evaluation according to programme interventions and core roles adopted by UNICEF in the CEE/CIS region and in each evaluated country. The ET further adapted the ToC to reflect WHO's modified health system building blocks approach[22,23] as an additional framework for the health system bottleneck analysis. See the resulting ToC diagram in Figure 6.[24]

Figure 4 shows that any programme intervention grouped into an "intervention package" for upstream programme engagement would require "enablers" such as human resources, financial resources, various inputs and governance, as well as management mechanisms provided by UNICEF. The intervention package (or elements of it) has to be delivered through UNICEF's seven core roles: *a "voice" for children and adolescents; monitoring and evaluation; policy advice and technical assistance; leveraging resources from the public and private sectors; facilitating national dialogue towards child friendly social norms; enabling knowledge exchange; and modelling/piloting*. The application of these interventions to address health service barriers or bottlenecks can be mapped onto MoRES determinants (e.g. enabling environment, supply issues, demand barriers, quality assurance); health system functions (e.g. stewardship, financing, resources, services); and health system building blocks (e.g. leadership and governance, health financing, health workforce, essential medical products and technologies, health services delivery, health information systems and community ownership and partnership).[25] The ToC also means that UNICEF delivers its contributions (MoRES level 2) towards reducing bottlenecks and achieving health system changes (MoRES Level 3) in the broader context of the partner's contribution. If UNICEF adequately addresses the identified bottlenecks in MNCH service coverage, resulting in system changes, these changes can lead to the reduction or eventual elimination of equity gaps and a sustainable reduction of child and infant morbidity and mortality (MoRES Level 4).

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21 "The world health report 2000 - Health systems: improving performance". WHO. 2000

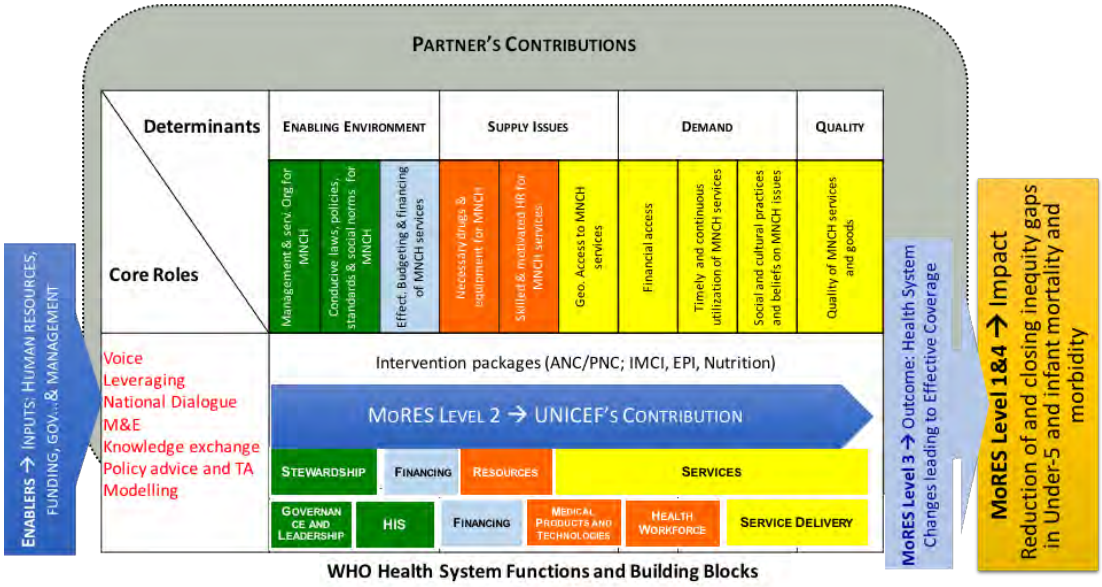
22 Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. WHO 2007.

23 Dickson et al. Every Newborn: health-systems bottlenecks and strategies to accelerate scale-up in countries. May 20 2014. Lancet http://dx.doi.org/10.1016/ S0140-6736(14)60582-1.

24 The ToC diagram was modified from the version presented in the Inception Report by adding the seven health system building blocks as an additional dimension to be used by the ET for effective bottleneck analysis.

25 This "dual mapping" allows retro-fitting any programme intervention delivered prior to the formal adoption of the MoRES approach to the particular bottleneck under the MoRES determinant and the relevant bottleneck that this intervention strived to address.

Figure 6: Theory of Change (ToC) Diagram[26]



The key objective of the current evaluation was to assess how successful UNICEF was in delivering evidence-based intervention packages through its core roles, and in contributing to required changes in the health systems and communities (MoRES Level 3). UNICEF delivered the packages by addressing the relevant bottlenecks to achieve better child health outcomes. However, most UNICEF interventions in the evaluated period were designed prior to the introduction of the MoRES determinant framework, core roles and the regional ToC. Therefore, the ET adapted these interventions to the MoRES determinants and, in consultation with UNICEF Regional and Country Offices, assigned the programmatic activities supporting these interventions to the relevant core roles ex post.

Human Rights, Gender Equality and Equity: The ToC adopts the fundamental concept adhered to by UNICEF that bold and sustainable achievements in reducing child mortality and morbidity can only be achieved through the reduction of equity gaps (including gender equality). This means upholding the human rights of the mothers and children served by the health systems that UNICEF intends to change. Therefore, the ToC implies that unless health systems are equity-focused, sustainable improvements in child health outcomes will not be achieved. An equity-focused health system means that access to care by rich and poor, men and women, is equal, and that the health system delivers quality health services to all on an equal basis. Hence, any health system changes triggered by UNICEF's contribution should be analysed though equity and human rights lenses to establish how successful these changes were. For example, studies show that poor and rural residents in the CEE/CIS region face significant financial access barriers to care, partly because of out-of-pocket payment systems, which emerged after the dissolution of the Soviet Union.[27]

Additionally, limited public spending led to a decline in the supply of necessary human resources, especially in remote and hard-to-reach areas. Structural problems in public finance management systems led to regional inequities and negatively affected regional health outcomes. This evaluation seeks to assess equity gaps (in terms of gender, income level, region, education level etc.) that may have existed in the systems prior to 2000, and whether UNICEF's programming addressing health system bottlenecks was conscious of such equity gaps. It also assesses whether the programmes were

[26] For this evaluation, due to the difficulty in attributing with relevant bottlenecks, the determinants "enabling social norms" and "financial access" presented as stand-alone determinants in the generic Theory of Change of UNICEF's Regional Approach (See Annex 10), were merged, respectively, with "enabling laws, policies & standards" and "effective budgeting and financing".

[27] Balabanova D., Roberts B., Richardson E., Haerpfer C., McKee M. Health Care Reform in the Former Soviet Union: Beyond the Transition. Health Services Research Volume 47, Issue 2, pages 840–864, April 2012

adequately calibrated to protect the human rights to health and gender equality, to assure better access to care, and to reduce other equity gaps in service utilisation and, consequently, in health outcomes.

The "operationalization" of the ToC presented for the evaluation is further discussed in the methodology, summarised in the next chapter: **Chapter 3. Evaluation Methodology**.

2.3. KEY STAKEHOLDERS AND THEIR CONTRIBUTIONS

UNICEF's contributions in the evaluated countries were made in close partnership with national governments, UN agencies (UNFPA, UNAIDS, WHO), other development partners (The World Bank, EU, ADB, GAVI, GFTAM, bilateral donor organizations, etc.), NGOs, wider civil society and private entities. Partners' contributions added to UNICEF contributions, thus inducing system level changes to achieve MNCH health and equity results. ANNEX 3 presents key partners and stakeholders, with a short description of their roles and contributions across UNICEF-supported interventions.

CHAPTER 3. EVALUATION METHODOLOGY

This chapter summarises the methodology used for answering the evaluation questions and accomplishing the evaluation objectives. See ANNEX 5 for more details.

3.1 OVERALL APPROACH

The evaluation framework for the MCE is based on the reconstructed ToC described in Section 2.2 (see Figure 6). It aims to establish the impact, relevance, effectiveness, efficiency, sustainability, and attention paid to rights-based and gender equity approaches, which describe UNICEF's contribution in line with the MoRES determinants framework. These six evaluation criteria were selected according to the MCE ToR.[28] The first five represent OECD/DAC evaluation criteria,[29] widely used for evaluating development assistance, and the sixth –a rights-based and gender equity approach – was chosen at the recommendation of the United National Evaluation Group (UNEG).[30] The MoRES framework consists of:

- creating an enabling environment, starting from the development and implementation of conducive policies and legal framework and promoting child-friendly social norms;
- adequately allocating and using expenditures, as well as effectively managing and coordinating at national and sub-national levels; and
- identifying, prioritizing and overcoming bottlenecks that hamper the availability, affordability, adequacy and continuity in the use of MNCH services, according to both supply and demand-driven determinants.

The Evaluation Team created a matrix (see ANNEX 6) that links the evaluation criteria and questions to the chosen indicators, data sources and methodologies. The findings in Chapter 4 are organized according to this matrix. The evaluation matrix also helped to develop the evaluation tools and approaches to data collection and analysis.

Due to the complex nature of the evaluation and its anticipated limitations, UNICEF suggested a "step-by-step" approach with three phases. *The first phase* involved

- developing the Theory of Change and the evaluation approach, methodology and tools;
- assessing the availability, scope and quality of data; and

[28] Progress in Reducing Health System Bottlenecks towards Achieving the MDG 4 Goal: Evaluation of UNICEF's Contribution in 5 CEE/CIS Countries. Terms of Reference. 2013

[29] The DAC Principles for the Evaluation of Development Assistance, OECD (1991)

[30] Integrating Human Rights and Gender Equality in Evaluation -- Towards UNEG Guidance. Guidance Document. UNCEG 2011

- validating the key determinants of inequity and trends at the impact and outcome levels.

The results of this phase informed the draft Inception Report and helped: i) to refine the evaluation questions; ii) to identify key documents, data sources and stakeholders; iii) to summarize what is already known from the desk review phase; and iv) to define the evaluation plan and tools.

The second phase entailed

- further refinement of the methodology by narrowing down the evaluation approach, and
- an examination of country-specific programme interventions and their impact, including UNICEF's specific roles.

This phase also involved a pilot country visit to Kazakhstan to test the proposed evaluation approach and tools in the field. This yielded lessons that informed the final version of the inception report.

The third phase included

- the actual implementation of the evaluation in the remaining four countries, and
- the production of this final MCE report.

3.2 OPERATIONALIZING THE THEORY OF CHANGE

To operationalize the Theory of Change and to measure UNICEF's contribution, the ET has used the process depicted in Figure 7:

Figure 7 Evaluation steps to operationalize ToC

1. As a first step, the ET developed intervention-specific flowcharts for each evaluated country. These flowcharts are based on a document review and subsequent conceptualisation, coding, and categorisation of interventions and UNICEF's contribution to these interventions. This approach draws on the premise that health systems are complex-adaptive systems.31,32 The ET did not to take a linear "input – output-- outcome" perspective, but rather accounted for the complex adaptive nature of health systems, due to which non-linear changes may occur in the health systems of the evaluated countries and over the evaluated programme cycles. During the country visits the ET obtained qualitative data (through additional document review, in-depth and group interviews and site visits) about the context, processes, inputs, outcomes and interactions that emerged as a result of UNICEF-supported interventions and the health system changes they may have caused when addressing identified bottlenecks. This in turn may have facilitated changes in effective coverage with MNCH services. The ET employed a "grounded approach" for the analysis of qualitative data, which entailed describing phenomena such as path dependence, feedback loops and emergent behaviour. This helped to uncover some relevant lessons for designing and carrying out interventions to deliver effective "intervention packages". It also helped to illustrate how different, interconnected factors may have affected each other over time, and how these interactions may have determined the outputs and outcomes observed.

As noted earlier, most UNICEF-supported interventions in the evaluated countries can be designated (or retrofitted) to four major evidence-based intervention packages. Any other country-specific interventions that do not belong in these four were included in a separate group termed "other

31 Gruen, R.L., et al., Sustainability science: An integrated approach for health-programme planning. The Lancet, 2008. 372: p. 1579-1589.

32 Paina L., Peters DH. Understanding pathways for scaling up health services through the lens of complex adaptive systems. Health Policy and Planning 2012;27:365–373

interventions", which were noted but not evaluated. The ET developed a "master list" that allowed them to link UNICEF-supported programme interventions in the evaluated countries to these four intervention packages or to "other interventions". Intervention package flowcharts for each country tracked the implementation of the respective packages over the entire evaluation period (see ANNEX 12).

2. As a second step, the ET coded the interventions onto UNICEF's core roles and MoRES determinants. Inducing a desired system change requires a set of programme interventions across the continuum of MNCH care that target bottlenecks across the MoRES determinants. Therefore, **the delivery of an intervention package in any country was considered a collection of multiple programme interventions (activities). The MCE evaluation focused on the learning that emerged from the delivery of these interventions through UNICEF-supported programmes**. These intervention packages in all evaluated countries were--and are--delivered by UNICEF through its core roles. The intervention flowcharts informed the ET's approach to coding interventions onto UNICEF's core roles. Each intervention was assigned a specific code, and a special database was created for further analysis (see the summary table in ANNEX 12).

3. As a third step, each UNICEF-supported intervention package, or elements thereof, was mapped onto the health system bottlenecks to identify which bottlenecks it was trying to address. The summary table presenting the intervention packages mapped across the most common bottlenecks under the MoRES determinants and the health system building blocks is included in ANNEX 10. Maps were created separately for each intervention package.

4. As a forth step, the ET assessed the *joint* performance of UNICEF and its partners in addressing and reducing/eliminating the identified bottlenecks using an "addressing score". An addressing score was assigned to each bottleneck identified by the ET using the following scale: *fully addressed,* when the scope, target groups and scale were appropriate to eliminate or substantially reduce the bottleneck (addressing score "2"); *partially addressed,* when scope and target groups were appropriate, but scale was limited to a pilot and/or to a subnational level (addressing score "1"); and *not addressed*, where the scope or target group was not appropriate (addressing score "0"). An example of this scoring system is provided in Text Box 3 on page 52.

5. As a fifth and last step, to assess how UNICEF addressed the bottlenecks and induced necessary system change, a "contribution score" ranging from 1 to 3 was assigned along each intersection of the core roles with bottlenecks. A score of 3 represented a "critical/major" contribution by UNICEF, and a 1 represented a "marginal/minimal" contribution. To assign this score, the ET developed a convention to ensure consistency across its members (see

Table 2). Depending on the timeframe of the UNICEF intervention, the ET assigned a contribution over one or several country programming cycles. As a result, a summary matrix was composed to evaluate UNICEF contributions to health system level changes when addressing service coverage bottlenecks. At this stage, the **median** contribution scores were calculated across MoRES determinants. Such matrices were completed for each intervention package in each country included in the MCE. A summary of the results is presented in **Chapter 4 – Evaluation Findings (**see Table 11 on page 55).

Table 2: Criteria for UNICEF contribution assessment

Assessment of Contribution	Determining Criteria relative to UNICEF's core role
Major/critical	UNICEF (a) Initiated (alone or in partnership) the process (for all core roles, except leveraging resources); (b) Remained an active player throughout the process (for all core roles); (c) Successfully leveraged resources (only for leveraging, where applicable); and (d) Process resulted in a national scale-up/institutionalisation (only for modelling and M&E).
Significant	UNICEF (a) Joined the process (for all core roles, except leveraging resources); (b) Contributed to any critical phases of the process (for all core roles); (c) Was not instrumental in leveraging resources (only for leveraging); and (d) Process resulted in at least sub-national scale-up (only for modelling and M&E).
Marginal/minimal	UNICEF (a) Joined the process (for all core roles, except leveraging resources); (b) Was not an active player in the process (for all core roles); (c) Was not instrumental in leveraging resources (only for leveraging); and (d) Process results only determined at local level without national or sub-national scale-up (only for modelling and M&E).

3.3. MEASURING RESULTS OF OVERCOMING THE BOTTLENECKS AND INDUCING SYSTEM-LEVEL CHANGES

The ET employed qualitative and quantitative approaches to measure the results in overcoming bottlenecks. For quantitative measurement, the ET used a slightly modified Tanahashi model with five domains of coverage (Figure 3 on page 21) to assess country results in overcoming barriers and bottlenecks in effective coverage with MNCH services. This was carried out mainly by obtaining the available indicators for Evaluation Question (EQ) 13 of the evaluation matrix. See the results in section 4.3.2 of the **Chapter 4 Evaluation Findings**. As noted, UNICEF's and its partners' performances in addressing the bottlenecks were assessed using the bottleneck "addressing score". Indicators EQ.14 and EQ.15 were applied from the evaluation matrix to support the qualitative measurement of whether UNICEF and its partners correctly identified and attempted to address the bottlenecks in effective coverage. UNICEF's contribution in addressing each bottleneck through its core roles received a "contribution score". Consequently, the databases created by the ET for this evaluation produced specific pivot tables across multiple dimensions (across intervention packages, MoRES

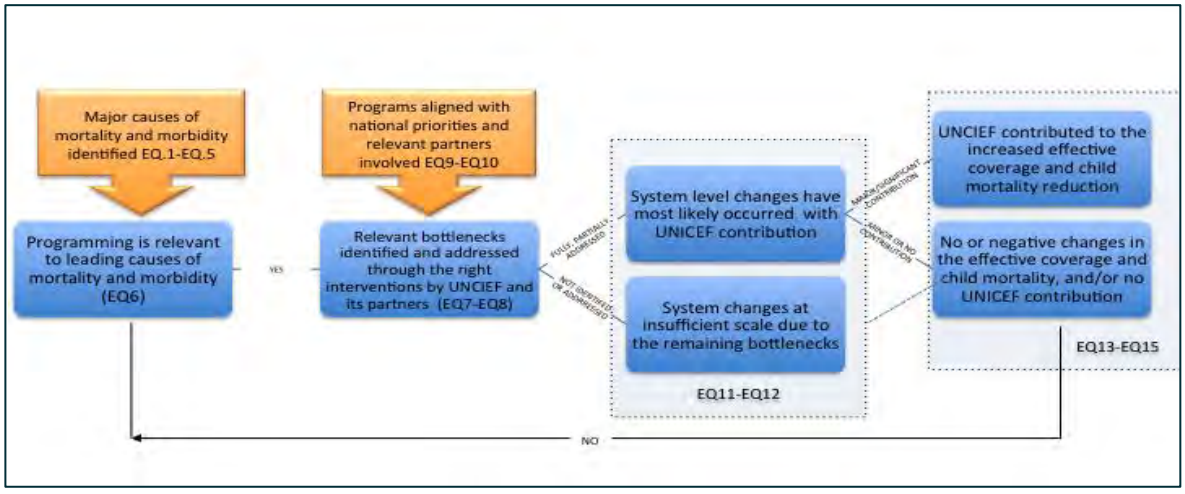
determinants, health system building blocks and UNICEF core roles). These pivot tables present the results of UNICEF's contribution in overcoming bottlenecks in the evaluated countries. The likelihood that a UNICEF contribution helped to overcome bottlenecks was determined by looking at: (a) the extent that a bottleneck addressed by a given intervention package (and included sub-packages) was addressed, measured by the *average addressing score*, (b) the extent of UNICEF's contribution to the implementation process for a given intervention package, measured by the *average contribution score* organized around core roles, and c) the relative share of resources devoted by UNICEF to fulfil these core roles. In other words, the higher the average addressing score for specific bottlenecks under a given package, the higher the probability that critical bottlenecks were removed and that a required system/enabling environment change had taken place. Similarly, high average contribution scores and higher shares of resources devoted to the same intervention package meant a high probability that UNICEF as an organisation played a critical or significant role in this change.

3.4 DERIVING CONCLUSIONS ABOUT EVALUATION OBJECTIVES

Figure 8 presents a logical construct that follows the ToC of the UNICEF regional approach for linking evaluation findings responding to the relevant evaluation questions. This logical construct is used to draw conclusions on the following three objectives of the MCE:

1. To document results in terms of changes in access to Maternal, Newborn and Child Health (MNCH) services (enhanced coverage of children with proven health services packages and interventions) and reduction of equity gaps;
2. To assess how system level changes (enabling environment, supply, demand, and quality of MNCH services) led to these results; and
3. To document UNICEF contributions to addressing health system bottlenecks.

Figure 8: Logical construct for achieving the three objectives of the MCE



3.5 EVALUATION METHODS

To undertake the analysis described earlier, the ET used a mixed-method approach to ensure the validity of findings through data analysis and triangulation, based on the systematic cross-comparison of findings by data sources and by data collection methods. Methods included a site visits (up to 10 were conducted); face-to-face in-depth interviews and group interviews involving 291 respondents in the evaluated countries; and desk-based research, including a review of existing reports. This included up to 616 country- specific documents and 51 regional level documents and other available data (see ANNEX 7 for the detailed list of the reviewed documents and ANNEX 8 for the list of individuals interviewed). A secondary analysis of quantitative data complemented qualitative data where relevant and appropriate. ANNEX 5 presents the evaluation methods used for the evaluation criteria and for each evaluation question, along with more details about the evaluation methodology.

3.6 EVALUATION LIMITATIONS

The ET encountered several important evaluation limitations: (a) It was impossible to establish a counter-factual study, due to the length of the evaluation period; (b) it was impossible to obtain reliable data for equity and gender based analysis from routine statistics, making DHS and MICS the only possible sources for such analysis; (c) DHS and MICS data were not always comparable across countries and over time; (d) WHO's health system framework was not universally applied, while UNICEF Core Roles and MoRES determinants were introduced at the later stage of the UNICEF programming, as a result, the UNICEF country teams and the ET had to "retrofit" UNICEF-supported programmes/interventions to core roles and MoRES determinants. This led to inconsistency across UNICEF country offices in retrofitting these programmes in the initial dataset provided to the ET; (e) no explicit or implicit bottlenecks were identified for three out of ten MoRES determinants ("enabling social norms", "financial access" and "ability to timely and continuous service utilization"); and (f) financial data on public financing and leveraged funds from other development partners were sometimes unavailable and/or of poor quality (structure), particularly for the earlier years of the evaluated period.

The ET worked to address these limitations (a) by using trend analysis and triangulation of quantitative and qualitative data to substitute micro dataset analysis of MICS and DHS survey databases, and suggested conducting such quantitative analysis as a standalone exercise, and providing terms of reference for this exercise; (b) by re-coding the programmes/interventions using the more consistent approach described earlier in this chapter; (c) by using qualitative data to substitute or complement missing or flawed financial data; (d) by dropping or merging the determinants without identified bottlenecks into other determinants (e.g. "timely and continuous utilisation" was dropped as a determinant, while "social norms" were included under "enabling laws, policies and standards", and "financial access" was merged with "effective budgeting and financing"). ANNEX 5 provides more details on the evaluation limitations and mitigation strategies.

CHAPTER 4. EVALUATION FINDINGS

This chapter presents the evaluation findings organized around broad assessment areas. Section 4.1 discusses the impact on the health of children in CEE/CIS and evaluated countries during 2000-2012. Section 4.2 focuses on the relevance of UNICEF's supported programmes, and Section 4.3 addresses effectiveness-related issues. Sections 4.4 and 4.5 cover implementation efficiency and programme sustainability issues. Section 4.6 concludes the chapter by discussing the findings that relate to human rights and gender related issues.

4.1 IMPACT ON THE HEALTH STATUS OF CHILDREN IN CEE/CIS AND THE EVALUATED COUNTRIES

In this section of the Report, we evaluate the overall impact on child health during the evaluation period (2000-2012) by looking at child, infant and neonatal mortality trends in the countries in question. We examine child morbidity by primarily focusing on stunting and underweight indicators, due to the morbidity data limitations in routine national statistics and DHS/MICS surveys. Consequently, this section addresses evaluation questions one to five:

EQ.1. Has there been positive change in the reduction of infant and under-5 mortality and morbidity during the period 2000 to 2012?
EQ.2. What are the trends in these key child health indicators across geographical, ethnic, gender and other socio-economic stratifiers?
EQ.3. What are the trends in reducing mortality and morbidity specific causes, also disaggregated by other socio-economic stratifiers?
EQ.4. Who are the remaining outliers in terms of key child health indicators, disaggregated by geographical, ethnic and other socio-economic stratifiers?
EQ.5. What other factors, for example, social determinants on health (education, unemployment, poverty etc.), that contributed to change infant and U5 mortality and morbidity?

Initially we present data on U5 mortality by unpacking cause-specific mortality for children who are 1-59 months old, to identify progress achieved and remaining gaps. Thereafter we describe trends in infant and neonatal mortality and look deeper at cause-specific mortality during the first month of life. Finally, we conclude the section with morbidity data that describes changes in stunting and underweight prevalence. Where data permits, we also present indicators through a gender equality and equity lens and try to relate the trends observed in the evaluated countries to the broader region, to see how changes within countries could reflect those observed in the region.

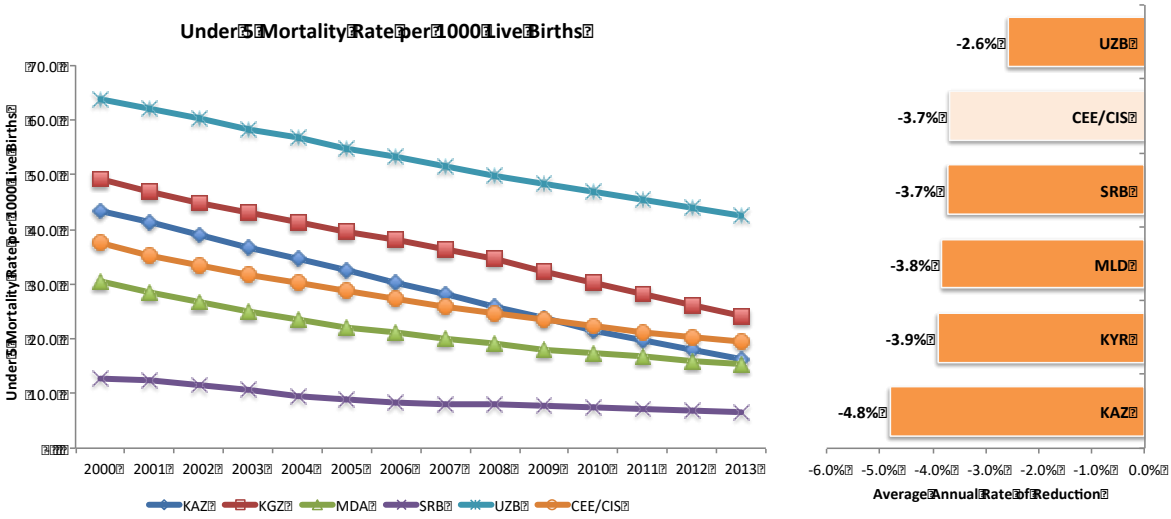
4.1.1 TRENDS IN UNDER-5 MORTALITY

During the early years of transition, the CEE/CIS[33] region faced many challenges, including the deterioration of child health, although a slow recovery occurred thereafter. Under-5 mortality in the CEE/CIS region declined by 47.9% between 2000 and 2013,[34] indicating good prospects for reaching MDG targets by 2015. However, the progress in reducing child mortality was not uniform. CEE countries and the European areas of the CIS dealt with the transition challenges more successfully, while others – mainly in Central Asia— and Caucasus, except Kazakhstan - lagged behind. Some countries still have mortality rates that are two to three times higher than the regional average.

[33] Here "CEE/CIS" refers to those countries where UNICEF works.

[34] a) Where data permits we present recent findings beyond 2012. b) The data presented are based on median estimates by the UN Inter-agency Group for Child Mortality Estimation that was released September 16, 2014.

Figure 9 Progress in under-five mortality

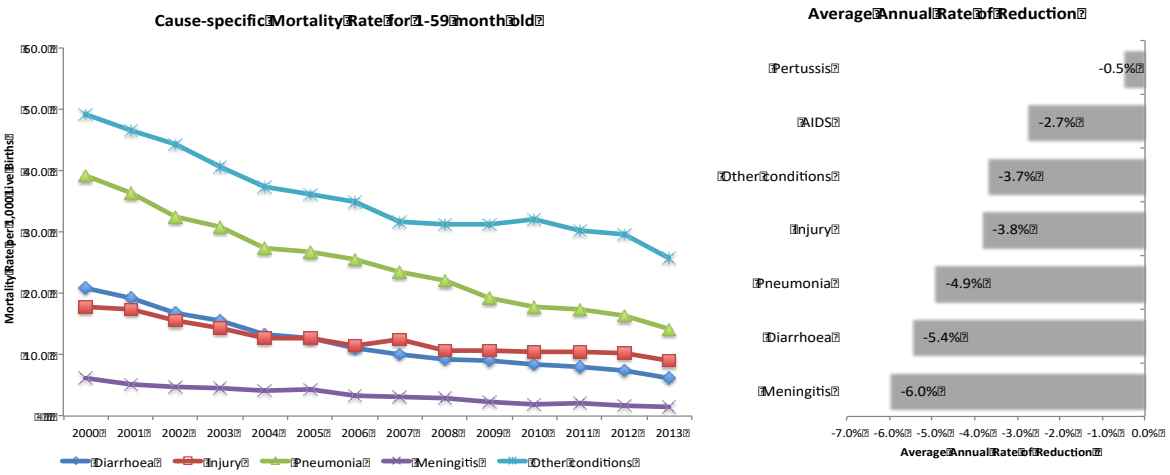


Source: The UN Inter-agency Group for Child Mortality Estimation, 2014

We estimated that 655,000 U-5 child deaths (not including stillbirths) occurred in the period 2000-2013 in the evaluated countries, 49% of which occurred during the neonatal period. Although under-five mortality slowly declined in all countries, it did so at different rates. Kazakhstan achieved the highest average *Annual Rate of Reduction* (ARR) in under-five mortality rates – 4.8%, followed by Kyrgyzstan, Moldova, and Serbia – 3.9%, 3.8% and 3.7% respectively. Uzbekistan had the lowest ARR -2.6%. During the same period, under-five mortality fell globally at an average ARR of 3% per year, and 3.7% in the CEE/CIS region. Thus, all countries in our sample, except Uzbekistan, performed better than the world average in reducing under-five mortality rates, and performed comparably or better than the regional average (

Figure 9). Overall, an estimated 193,000 children under five were saved as a result of the under-five mortality reductions in the evaluated countries over the period 2000-2013.

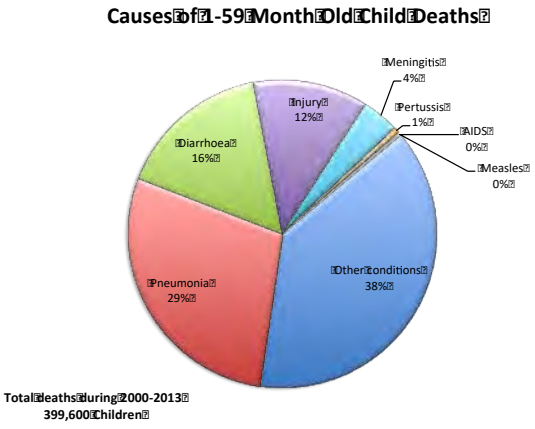
Figure 10:Trends in cause-specific mortality among 1-59 month olds



Source: Estimates based on data from Liu et al, 2014

Mortality reductions occurred throughout the continuum from birth up to the fifth birthday. However, the highest reduction (58%) was achieved for 1-4 year-olds, followed by the post-neonatal period (49%). The lowest reduction, although significant in size, was noted for neonates (42%).[35] Nevertheless, in 2013 although close to 46% of total child deaths in the evaluated countries were neonatal deaths, this is lower than the CEE/CIS average (56%).

Figure 11: Major causes of death for 1-59 month- olds during 2000-2013 (Liu et al. 2014)



Cause-specific mortality was separately analysed through pooled data for all five countries and separately for the neonates (0-27 days old) presented in Figure 15 on page 34 and children aged 1-59 months (Figure 11). We have estimated close to 399,600 child deaths for those between 1-59 months in the studied countries in the period 2000-2013. Known causes were: pneumonia--responsible for 29% of deaths, followed by diarrhoea (16%), injuries (12%) and meningitis (4%). Vaccine-preventable diseases (i.e. pertussis and measles) were responsible for less than 1% each. Causes for the remaining 38% were not reported, and the share of unreported causes grew from 37% in 2000 to 43% in 2013. Such a case-specific mortality structure means that the evaluated countries have considerably higher mortality rates for pneumonia and diarrhoea than the average in MDG Developed Regions. However, they are comparable to cause-specific mortality rates reported in the MDG Region of Caucasus and Central Asia.[36] The large percentage of unreported causes poses challenges going forward.

Figure 12 Comparison of cause-specific mortality reduction in evaluated countries and countries of Central Asia and Caucasus (Liu et al. 2014)

35 Based on median estimates by The UN Inter-agency Group for Child Mortality Estimation released on September 16th 2014.

36 Supplement to: Liu L, Oza S, Hogan D, et al. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. Lancet 2014; S0140-6736(14)61698-6.

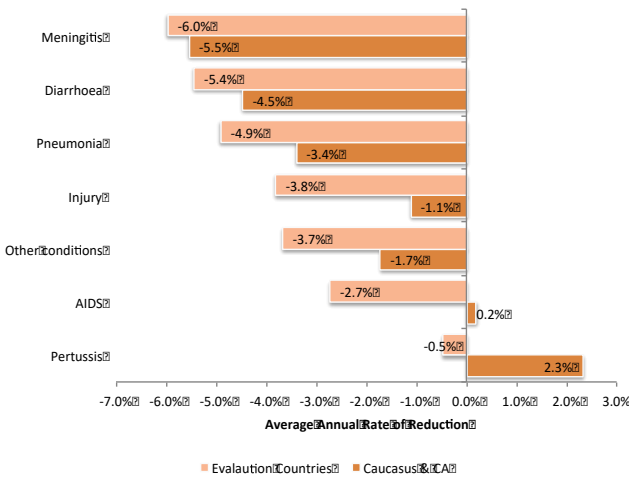
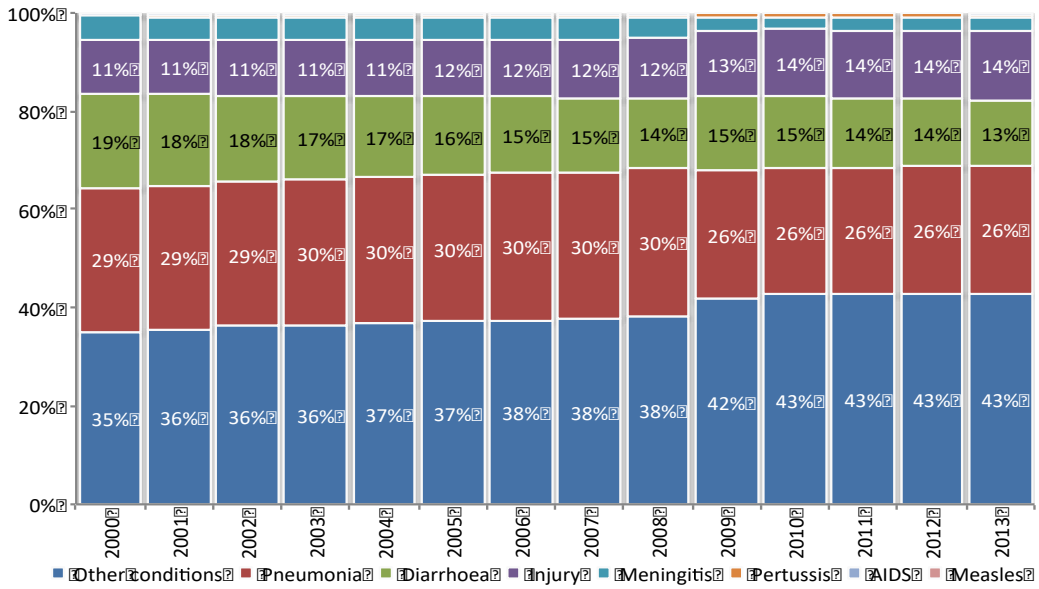


Figure 12 also reveals that the pace (i.e. ARR) of cause-specific mortality reduction was fastest for meningitis (6%), followed by diarrhoea (5.4%) and pneumonia (4.9%). Deaths due to injury and other conditions diminished at comparable rates: ARR- 3.8% and 3.7% respectively. Finally, these countries managed to reduce deaths due to AIDS at an average annual rate of 2.7%. When the evaluated countries and their average ARRs were compared with the ARRs reported for Central Asia and Caucasus[37] (see Figure 12), we noted comparable patterns for some diseases across two country groups, as well as slight differences. Nevertheless, the countries evaluated were able to reduce almost all causes of child death with higher ARRs than the average rates reported for Central Asia and the Caucasus.

Compared to 2000, by 2013 up to 13,000 more children aged 1-59 months survived annually. Nevertheless, approximately 16,700 deaths still occurred in this age group annually, out of which pneumonia caused 26%, followed by injuries (14%), diarrhoea (13%) and meningitis (3%). Unidentified conditions were responsible for 43% of cases, limiting the possibility of selecting cause-specific interventions. See Figure 13 for more details as well as for the changes in structure of cause-specific mortality.

Figure 13 Changes in cause-specific mortality for infants aged 1-59 months during 2000-2013 (Liu et al. 2014)



4.1.2 TRENDS IN INFANT MORTALITY

37 No comparable figure for UNICEF's CEE/CIS Region was available here or throughout this sub-section.

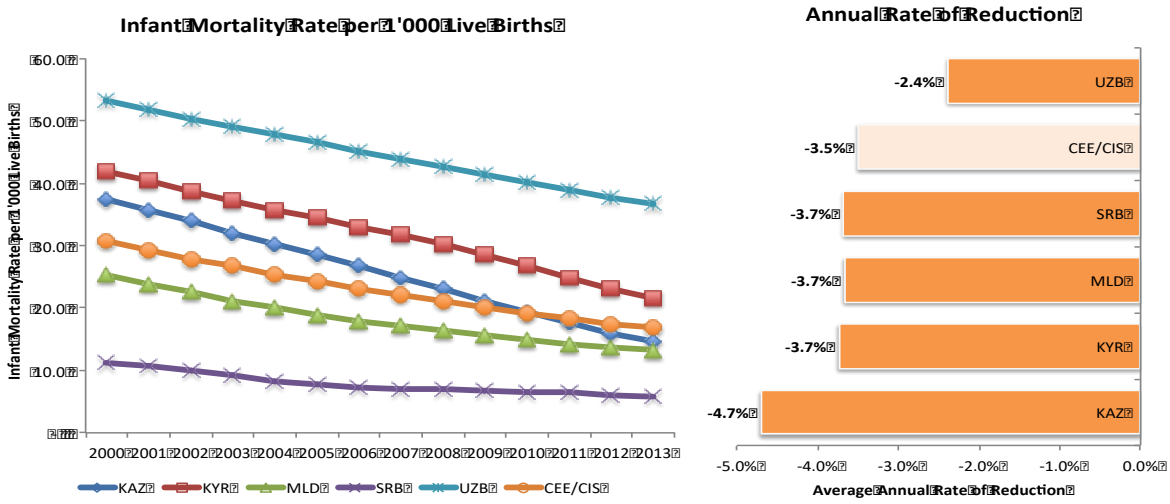
Along with declining U5MR, the CEE/CIS region also made progress in reducing infant and neonatal death rates (IMR and NMR respectively). As noted earlier, infant and neonatal mortality declined in the countries evaluated, with a slightly higher pace observed during the post-neonatal period. In this section, we attempt to unpack trends in infant mortality reductions by looking closely at neonatal and post-neonatal death rates and changes observed. We also analyse cause-specific mortality among children 0-27 days old.

Due to the reductions achieved in infant mortality over the period 2000-2013, we estimated that in 2013 approximately 23,000 infants aged 1-12 months were saved that year in the countries evaluated. The annual number of infant deaths declined from around 41,500 in 2000 to 32,500 per annum.

Overall, infant mortality decreased in all countries, but progress differed. Kazakhstan was able to reduce infant mortality at an annual rate of 4.7%, followed by Kyrgyzstan, Moldova, and Serbia with ARR 3.7%, while Uzbekistan lagged behind with ARR 2.4% (see

Figure 14). Thus every country except Uzbekistan progressed with higher ARR than for the CEE/CIS region as a whole, which was 3.5% for the same period.[38]

Figure 14 Trends in Infant Mortality[39]



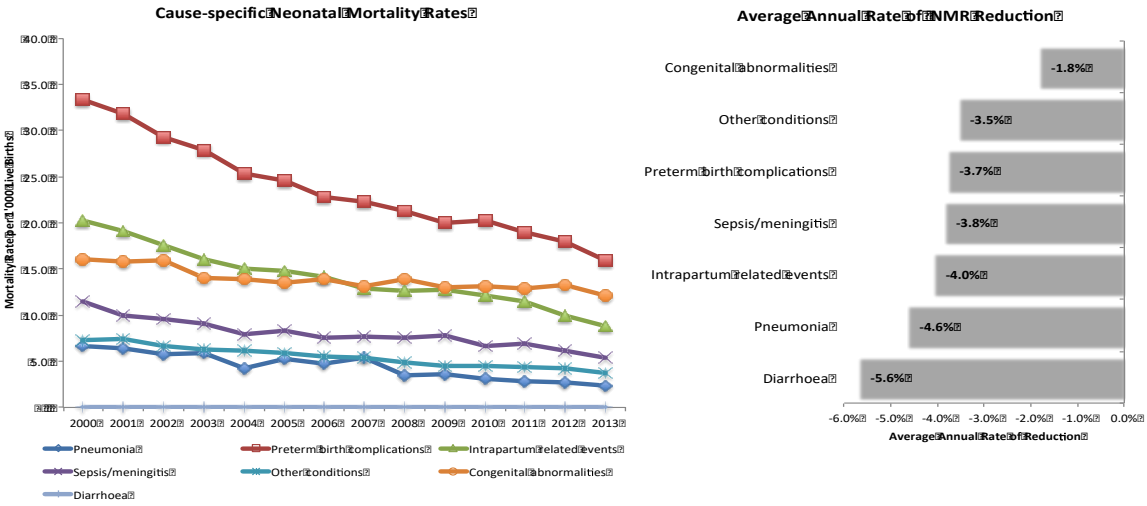
Source: The UN Inter-agency Group for Child Mortality Estimation. 2014

Figure 15 Cause-specific mortality trends for neonates during 2000-2013[40]

[38] The UN Inter-agency Group for Child Mortality Estimation, released September 16, 2014 www.childmortality.org (Last accessed on December 16, 2014)

[39] Ibid 28

[40] Supplement to: Liu L, Oza S, Hogan D, et al. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. Lancet 2014; S0140-6736 (14)61698-6.

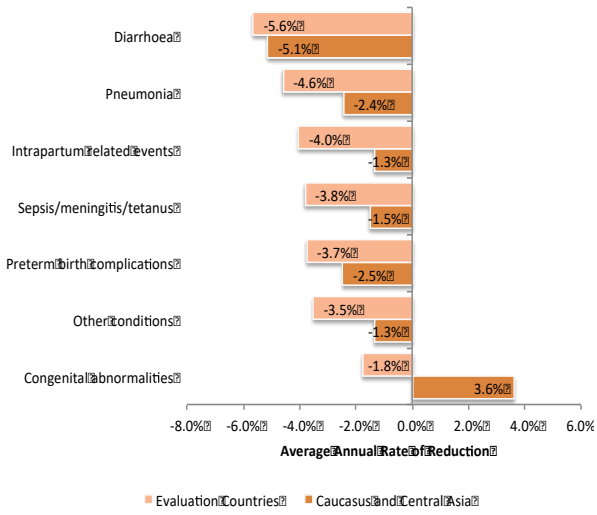


Source: Estimates based on the data from Liu et al, 2014

In terms of neonatal deaths, 36% were due to pre-term birth complications,[41] 21% to intrapartum related events, 17% to congenital abnormalities, 4% to pneumonia, and 9% to other conditions. In terms of a cause-specific mortality structure, the countries evaluated compare favourably with the causes reported for the Caucasus and Central Asia.

Figure 16 Comparison of cause-specific neonatal mortality reduction between evaluated countries and countries of Central Asia and the Caucasus (Liu et al. 2014)

Over the evaluation period, a decline in neonatal mortality was observed for all causes, although the pace differed. While the highest average ARR of 5.6% was noted for diarrhoea, it should be pointed out that diarrhoea was responsible for less than 1% of all deaths in this age group. Therefore, its reduction had a marginal impact on neonatal mortality.



The second highest ARR was for pneumonia (4.6%), followed by intra-partum related events (4%), sepsis/meningitis (3.8%), preterm complications (3.7%) and congenital abnormalities (1.8%). The progress achieved by the evaluation countries outperformed the countries of the Caucasus and Central Asia by reporting higher ARRs across the different causes of neonatal mortality. (See

Figure 16).

Looking at the 2013 birth cohort in the countries studied, 33% of neonatal deaths were due to preterm birth complications, 22% to congenital abnormalities, 21% to intra partum-related events and 13% were due to sepsis/meningitis. The contribution of pneumonia to neonatal death fell from 4% to 3%, while other conditions determined around 9% of all deaths (see

[41] Case definitions for neonatal deaths are sourced from Oza S., Lawn JE., Hogan DR., Mathers BC., Cousensa SN. Neonatal cause-of-death estimates for the early and late neonatal periods for 194 countries: 2000–2013. Bull. WHO 2015;93:19–28.

Figure 17 for more details). This underlines the importance of improving intra partum and early neonatal care, along with the need to reduce preterm birth rates, which stood at around 5.2% per 100 live births, without obvious reductions during the evaluation period. In addition, there is a continuing need to address congenital abnormalities and sepsis/meningitis.

Figure 17 Changes in cause specific mortality for infants 0-27 days old during 2000-2013 (Liu et al, 2014)

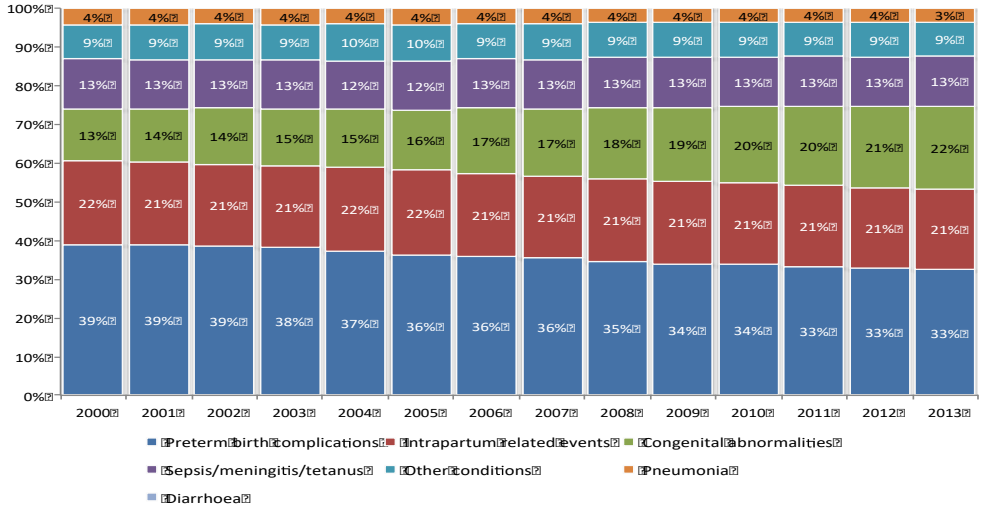
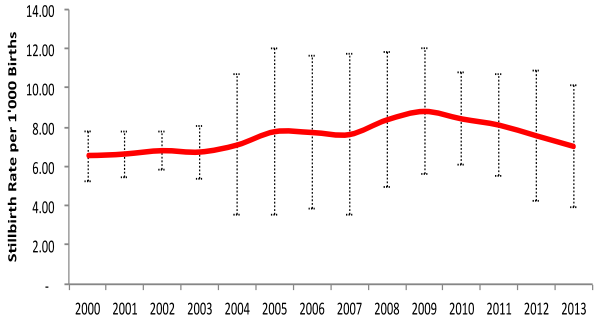


Figure 18 Stillbirth rates[42]



Source: Estimates based on the data from Liu et al 2014

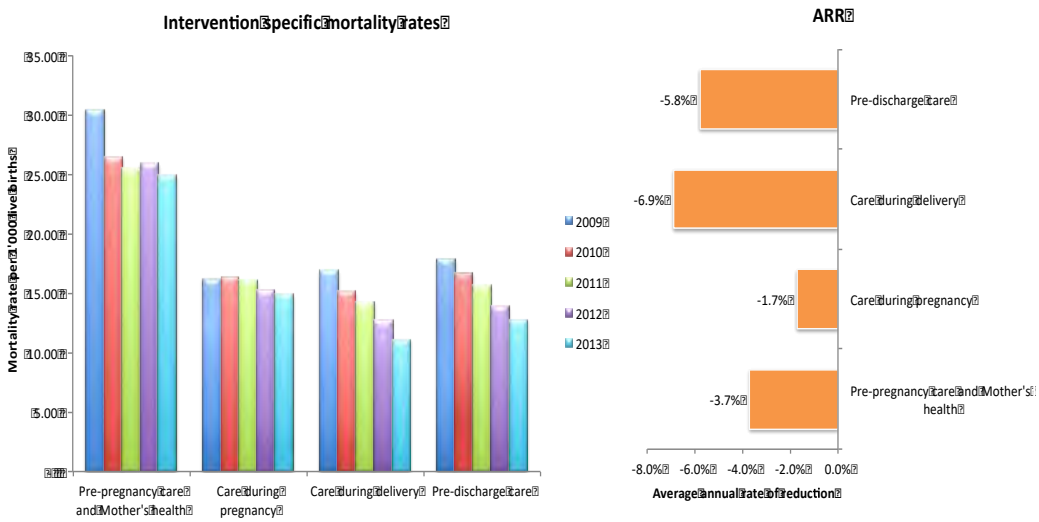
While there was notable progress in reducing child mortality, stillbirth rates remained unchanged over the evaluated period, fluctuating between 6.5 and 8.8 per 1000 births each year with an average of 7.5 per 1000 births. Compared to the achievements in neonatal and infant mortality rate reductions, the rate of stillbirth remains high and deserves further attention.

We also looked at changes in birth weight and time-of-death-specific mortality rates by using BABIES tables, introduced with the help of UNICEF, in close cooperation with the CDC US. See results in Figure 19.

Figure 19 Changes in intervention-specific mortality rates[43]

[42] Stillbirth rates do not include data from Uzbekistan, as it was only available for initial seven years and data reliability was also questionable, therefore the line on the chart presents four country averages for a given year with standard deviation.

[43] The chart reflects the BABIES data from Kazakhstan, Kyrgyz Republic, and Moldova. Uzbekistan data, while obtained, was not used to data quality and completeness concerns noted in the reports for various years.



Source: Compiled from BABIES database for Kazakhstan, Kyrgyzstan and Moldova by the evaluation team

This tool was proposed by CDC US[44] to monitor and evaluate interventions focused on pre-pregnancy i.e. the health of a future mother, and care during pregnancy and delivery, as well as pre-discharge care. Our analysis reveals that the highest annual rate of reduction (6.9%) was noted in the mortality rates related to the quality and effectiveness of delivery services, and could be attributed to interventions to improve these services. The second notable area of progress was in mortality reductions resulting from the improved quality and effectiveness of pre-discharge care, i.e. mortality among babies who weighed above 1500 g during the 28 first days of life. The annual rate of mortality reduction achieved for these babies was 5.8%, which indicates the effectiveness of interventions aimed at improving the quality of services provided to newborns in hospitals. The least progress was noted for mortality rates related to pregnancy care delivered on an outpatient or inpatient basis, which had an ARR of 1.7%. Most of these services are provided on an outpatient basis, which indicates a lack of significant progress for this level of care provision. It was also interesting to note reductions in mortality related to pre-pregnancy care and mother's health, which had an ARR of 3.7%. Consequently, the data from BABIES and the data in
Figure 17 related to the causes of neonatal deaths corroborate and reinforce each other.

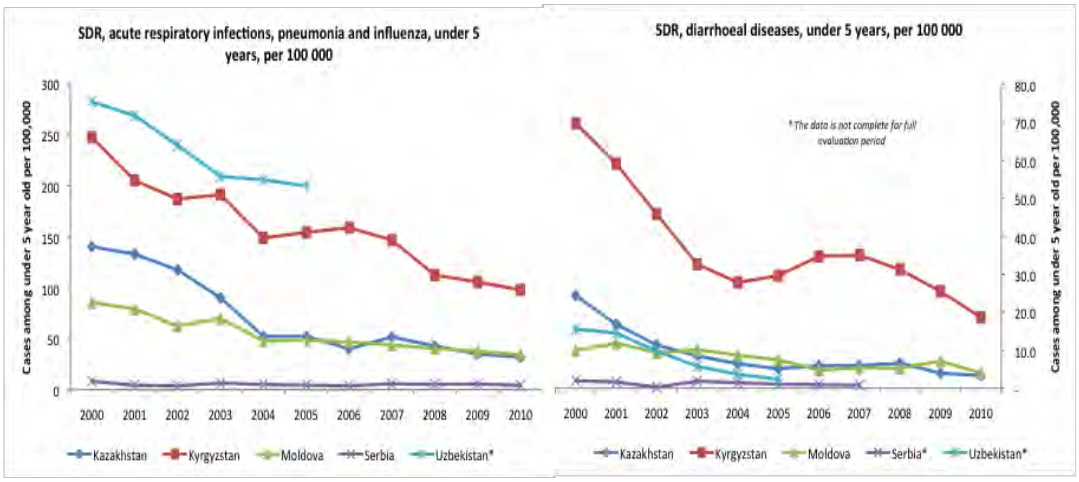
4.1.3 CHILD MORBIDITY

Analyses of morbidity trends in the CEE/CIS, including the evaluated countries, reveal progress in reducing morbidity caused by diarrhoeal diseases and acute respiratory infections, pneumonia and influenza. The incidence of diarrhoeal diseases fell by 72% and acute respiratory infections, pneumonia and influenza by 55% during this period. However, the reduction rates varied between countries (see

Figure 20).

Figure 20 Changes in Under-5 Morbidity caused by diarrhoeal diseases and acute respiratory infections, pneumonia and influenza

[44] Lawn J., McCarthy BJ., Ross SR. The Healthy Newborn: A Reference Manual for Programme Managers. CARE/CDC.



Source: Health for All Database. WHO European Region, 2014

Stunting and underweight trends were estimated using the DHS/MICS data presented in Table 3. Average stunting prevalence rates across the five countries do not reveal a clear trend. In fact, the variable picture within the countries causes a significant bias in the five-country average. Concerning underweight prevalence, country-specific trends are consistent across the sample, with the exception of Serbia, and reveal a slight reduction from baseline. However, due to the lack of statistical tests we cannot be definite about the trend.

Table 3 Stunting and underweight prevalence[56,57]

	Baseline	Midpoint	Endpoint
Stunting prevalence 5-country average %	12.0	11.0	10.0
KAZ	9.7	12.8	13.1
KYG		13.7	17.7
MLD		8.4	6.4
SRB	5.1	5.4	6.3
UZB	21.1	14.6	
Underweight prevalence 5-country average %	4.4	3.5	2.4
KAZ	4.2	5.1	3.8
KYG		3.4	2.7
MLD		4.3	2.2
SRB	1.9	1.6	1.7
UZB	7.8	5.1	

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

4.1.4 EQUITY AND GENDER EQUALITY DIMENSION OF CHILD MORTALITY AND MORBIDITY

As noted in earlier sections, income, geographical and ethnic inequalities have not been adequately addressed and remain a problem in the CEE/CIS region.[45]

Consequently, we have pooled data from the five countries to look at IMR and U5MR changes through an equity lens. Demographic Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) reports were used for this purpose, where available. We compiled equity related indicators across three time points: a) baseline, covering surveys in the period 1996-2000, b) midpoint, which included all surveys implemented in 2005-2006 and c) endpoint, capturing findings from 2010-2014 surveys. On that basis, we calculated average equity ratios for the five countries, as presented in Table 4.

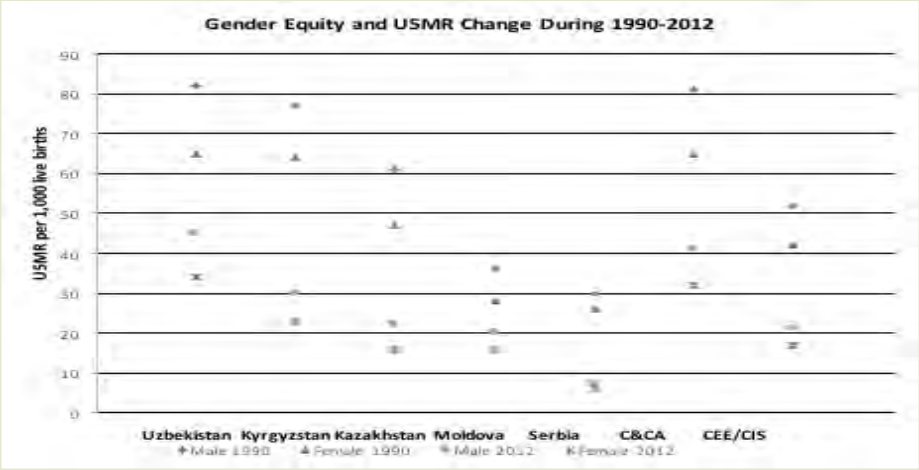
Table 4: IMR and U5MR Related Equity Ratios[46]

	Baseline	Midpoint	Endpoint
Infant Mortality equity ratio			
Education (lowest vs. highest)	1.3	1.3	1.7
Wealth (poorest vs. richest)	n.a.	1.3	1.7
Rural vs. Urban	1.3	1.1	1.1
Under-five Mortality equity ratio			
Education (lowest vs. highest)	1.3	1.6	1.7
Wealth (poorest vs. richest)	n.a.	1.4	1.4
Rural vs. Urban	1.3	1.3	1.1

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

Figure 21 looks at changes in U5MR among males and females over the course of the past two decades. The CEE/CIS region overall--and Kyrgyzstan, Kazakhstan and Moldova[47]in particular--did manage to reduce gender gaps, as shown by comparing 1990 levels to those of 2012. However, Uzbekistan largely failed to address gender issues, and the gap that existed 20 years ago remains almost unchanged.

Figure 21: Gender equality gap in U5MR in the evaluated countries and CEE/CIS, 1990-2012



[45] The Millennium Development Goals Report 2007: For CIS and South-Eastern Europe, an Up-and-Down ride. United Nations. 2007

[46] Baseline reflects surveys implemented during 1996-2000, midpoint represents surveys from 2005-2006 and end point refers to survey data from 2010-2012. The ratios reflect averages across five countries.

[47] Moldova data for 1990 includes Transdnistria information, while later data are reported without this territory.

Source: TransMonee 2014

In addition to mortality related indicators, the ET also looked at stunting and underweight prevalence through an equity lens using DHS/MICS survey data, where available. Equity ratios, presented in Table 5, reveal a slight reduction, especially after the midpoint, for stunting prevalence. As for underweight equity ratios, a declining trend is more pronounced across all three dimensions. While earlier we reported a lack of significant progress on reducing stunting and underweight prevalence, these findings certainly reveal progress made on equity, as the observed inequities were reduced and/or almost eliminated.

Table 5: Stunting and Underweight Prevalence Equity Ratios[48]

	Baseline	Midpoint	Endpoint
Average for all countries			
Stunting Prevalence (%)			
Education (lowest vs. highest)	1.8	1.9	1.6
Wealth (poorest vs. richest)	n.a.	1.8	1.7
Rural vs. Urban	1.6	1.3	1.1
Underweight Prevalence (%)			
Education (lowest vs. highest)	2.8	2.6	1.2
Wealth (poorest vs. richest)	n.a.	2.4	1.6
Rural vs. Urban	1.4	1.3	0.9

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

Most of the trends for these key child health indicators in the CEE/CIS and the evaluation countries are consistent with the trends observed globally, and more specifically in other LMIC. First, poorer and less-educated groups systematically exhibit considerably higher childhood mortality rates than better-off citizens in virtually all LMICs according to available data. Secondly, childhood mortality inequities within these countries are an important problem, in addition to the well-known inequities between countries. Thirdly, inequities in infant mortality are generally greater than those in under-five child mortality. For two-thirds of LMICs, the majority of inequities in under-five mortality consist of inequities in infant mortality.[49] Finally, relative inequities in childhood mortality tend to increase when overall childhood mortality levels fall.[50]

There is a complex interrelation between the socioeconomic determinants and their combined effect on proximate determinants directly affecting child mortality.[51] Numerous inter- and intra-country studies find a strong association between child mortality and various socioeconomic determinants: household income/wealth,[52,53,54] maternal education,[55,56] fertility rates,[57] sanitation and access to

[48] Baseline reflects surveys implemented around 1996-2000, midpoint represents surveys from 2005-2006 and end point refers to survey data from 2010-2014. The ratios reflect averages across five countries. Serbia was not included in the analysis as the data was only available for the end-point.

[49] Houweling, T.A.J, Kunst A.E., Socio-economic inequalities in childhood mortality in low- and middle-income countries: a review of the international evidence. Br Med Bull (2010) 93 (1): 7-26. doi: 10.1093/bmb/ldp048

[50] Victora CG, Vaughan JP, Barros FC, et al. Explaining trends in inequities: evidence from Brazilian child health studies. Lancet 2000;356:1093-1098.

[51] Houweling, T.A.J, Kunst A.E., Socio-economic inequalities in childhood mortality in low- and middle-income countries: a review of the international evidence. Br Med Bull (2010) 93 (1): 7-26. doi: 10.1093/bmb/ldp048

[52] Cleland J, Bicego G, Fegan G . Socioeconomic inequalities in childhood mortality: the 1970s to the 1980s. Health Transit Rev 1992;2:1-18.

[53] Gwatkin DR, Rutstein S, Johnson K, et al . Socio-economic Differences in Health, Nutrition, and Population. Washington: The World Bank; 2000.

[54] Wagstaff A. Socioeconomic inequalities in child mortality: comparisons across nine developing countries. Bull World Health Organ 2000;78:19-29

clean water and electricity,[58] level of integration for minority population groups,[59,60] public health expenditures and access to health services.[61,62,63]

These and other studies also demonstrated relationships between socioeconomic determinants. For example, households with lower incomes occupy more deprived regions, and economic status has a strong relationship with maternal education levels.[64] The relative importance of socio-economic determinants to child mortality risks varies according to the socioeconomic development of a country--countries with the same income level may demonstrate wide differences in child health outcomes. Recently-conducted comprehensive analysis of data from 144 LMICs over 20 years showed that economic growth, while being an important engine for the country's progress, is not in itself sufficient, and accounts for only 12% of the reduction of child mortality in LMIC between 1990 and 2010. Health-sector investments and health system strengthening accounted for around half the under-five mortality reduction, while the remaining gains resulted from tackling other socioeconomic determinants, for example improved levels of education, women's political and socioeconomic participation and environmental management (e.g. access to clean water), and reduced levels of fertility and poverty. As expected, income inequalities within countries had a negative impact on child mortality.[65]

It thus appears that a sizable share of the reductions in child mortality and the remaining gaps in in the CEE/CIS--more specifically in the evaluation countries--might be explained by variations in the socioeconomic determinants/factors, namely:

- Sustained economic growth since the year 2000 reduced poverty levels and income inequities in three (Kazakhstan, Moldova, Serbia) out of the five countries evaluated, but failed to reduce the socioeconomic inequity in Kyrgyzstan and Uzbekistan. Even in these three better performing countries, economic growth outpaced the decrease in social inequalities and poverty levels. One of the key reasons for this is that growth was not inclusive and benefited some sections of the population and some regions more than it did others, so did not sufficiently reduce income related or geographical inequities across and within countries. These developments are consistent with the picture of widening income and geographic inequities in child mortality since 2000 in the evaluation countries.

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55 Moser KA, Leon DA, Gwatkin DR. How does progress towards the U5MR millennium development goal affect inequalities between the poorest and least poor? Analysis of demographic and health survey data. BMJ. 2005;331:1180–2. doi: 10.1136/bmj.38659.588125.79

56 Barros FC, Victora CG, Scherpbier R, Gwatkin D. Socioeconomic inequities in the health and nutrition of children in low/middle income countries. Rev SaudePublica. 2010;44:1–16. doi: 10.1590/S0034-89102010000100001.

57 Victora CG, Barros FC, Huttly SR, Teixeira AM, Vaughan JP. Early childhood mortality in a Brazilian cohort: the roles of birthweight and socioeconomic status. Int J Epidemiol. 1992;21:911–5. doi: 10.1093/ije/21.5.911

58 Anand S, Bärnighausen T. Human resources and health outcomes: cross-country econometric study. Lancet. 2004;364:1603–9. doi: 10.1016/S0140-6736(04)17313-3.

59 Li J, Luo C, de Klerk N. Trends in infant/U5MR and life expectancy in Indigenous populations in Yunnan Province, China. Aust N Z J Public Health. 2008;32:216–23. doi: 10.1111/j.1753-6405.2008.00219.x.

60 Mosley WH, Chen LC . An analytical framework for the study of child survival in developing countries: Child Survival: Strategies for Research. Popul Dev Rev 1984;10:25-45.

61 Wang L. Determinants of U5MR in LDCs: empirical findings from demographic and health surveys. Health Policy. 2003;65:277–99. doi: 10.1016/S0168-8510(03)00039-3.

62 Gwatkin DR, Rutstein S, Johnson K, Suliman E, Wagstaff A, Amozou A. Socio economic differences in health, nutrition, and population within developing countries: an overview. Washington DC: World Bank;2007.

63 Kruk M.E., Galea S., Prescott M., Freedman L.P. Health care financing and utilization of maternal health services in developing countries Health Policy Plan. (2007) 22 (5): 303-310

64 Barros FC, Victora CG, Scherpbier R, Gwatkin D. Socioeconomic inequities in the health and nutrition of children in low/middle income countries. Rev SaudePublica. 2010;44:1–16. doi: 10.1590/S0034-89102010000100001

65 ShyamaKuruvilla et al; Success factors for reducing maternal and child mortality**.** *Bull World Health Organ* 2014;92:533–544doi: http://dx.doi.org/10.2471/BLT.14.138131

- Almost universal access to primary and secondary education has been maintained throughout the CEE/CIS. However, during the evaluation period, equitable access to higher education deteriorated in many of these countries, particularly in Central Asia, negatively affecting maternal education levels, especially for the poor and marginalized. This possibly resulted in the widening education gaps observed in infant mortality indicators in the evaluated countries;
- Fertility levels have increased in all Central Asian countries, while they declined in the CEE and the European parts of the CIS, including Serbia and Moldova. Increased fertility rates in Kazakhstan, and Kyrgyzstan may have negatively affected the pace of child mortality reduction.
- Access to clean water and sanitation has improved in the CEE/CIS, especially in some of the Central Asian Countries, where there were access problems at the beginning of the period evaluated. By 2012 almost 90% of households had improved water supply sources, which may have positively affected the incidence of diarrhoeal diseases.
- Although slowly improving, poor governance, corruption and the low participation of women in political processes continue to affect the policy environment in many CEE/CIS countries, including those within this evaluation. This may pose challenges to further reducing child mortality in these countries.

4.2 RELEVANCE OF UNICEF'S SUPPORTED PROGRAMMES IN THE COUNTRIES EVALUATED

In this section we assess the relevance of UNICEF-supported programmes across several dimensions by addressing evaluation questions 6 to 10:

EQ.6: Have UNICEF-supported programme(s) addressed the most important causes of infant and under-5 morbidity and mortality?

EQ.7: Were the most important bottlenecks in effective coverage with MNCH services identified and addressed by the UNICEF-supported programme?

EQ.8: Were the right and appropriate interventions identified, prioritised and applied by the UNICEF-supported programme(s), including scope, target groups and scale, to address health system bottlenecks?

EQ.9: Were UNICEF-supported programme(s) aligned with the national development and sectoral priorities?

EQ.10: Were relevant partners, including beneficiaries, involved in programme design, implementation and evaluation?

The findings are presented in separate subsections for each evaluation question, except for evaluation questions 7 and 8, which are combined into one subsection.

4.2.1 UNICEF PROGRAMMING AND THE MOST IMPORTANT CAUSES OF CHILD MORTALITY AND MORBIDITY

Commitments to helping countries achieve the child mortality MDG target are embedded in UNICEF's global and regional health and nutrition strategies covering the entire evaluation period.[66] These commitments are reaffirmed in the Global Strategy for Women's and Children's Health, and the Every Woman Every Child movement launched during the United Nations Millennium Development Goals Summit in September 2010. They were further developed in Committing to Child Survival: A Promise Renewed, which is a global movement launched in 2012 to end preventable child deaths by accelerating progress on maternal, newborn and child survival.[67] These strategies prescribed that UNICEF focus on the leading causes of child mortality and morbidity in its programming to help countries achieve MDGs 4 and 5.

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[66] Global Strategy for Infant and Child Feeding, WHO/UNICEF, 2003; Joint Health and Nutrition Strategy for 2006-2015, UNICEF, 2005

[67] http://www.apromiserenewed.org/A_Promise_Renewed.html

A review of the situation assessment/analysis (SITAN) documents, country programme action plans (CPAPs) and country programme documents (CPDs) revealed that the analysis of the leading causes of child mortality and morbidity were invariably present in all these documents, and served as a starting point for UNICEF programming and prioritization of interventions in all countries throughout the evaluation period.

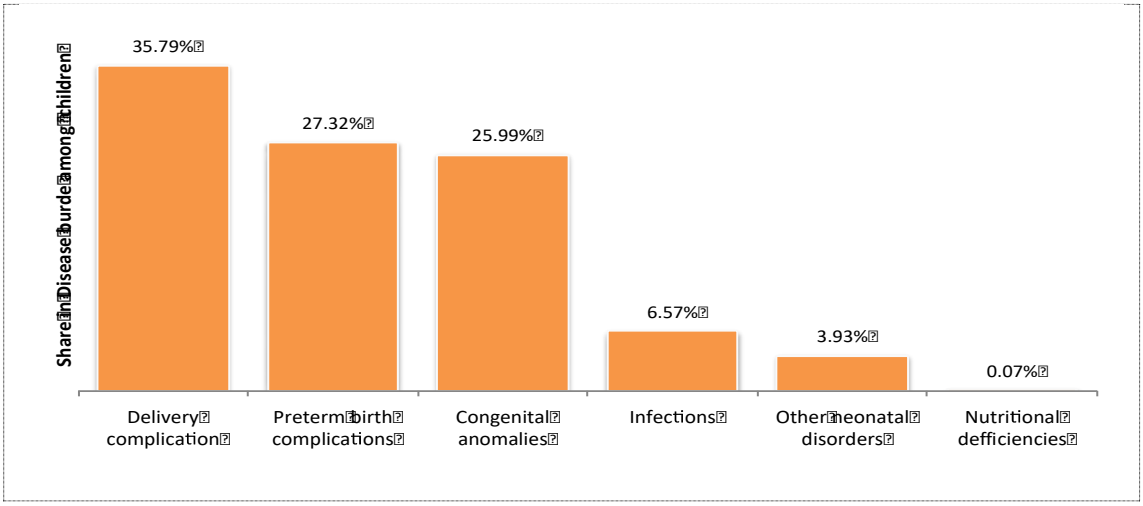
> "UNICEF could identify the priority issue and target it in the most efficient way." ***Source: Key informant, parliamentarian, Kyrgyzstan***

Drawing on the data presented in section 4.1.1 Trends in Under-5 Mortality, the leading causes of under-five child mortality and morbidity in the evaluation countries can be grouped in the following way (Table 6).

Table 6 Causes of mortality and disease burden

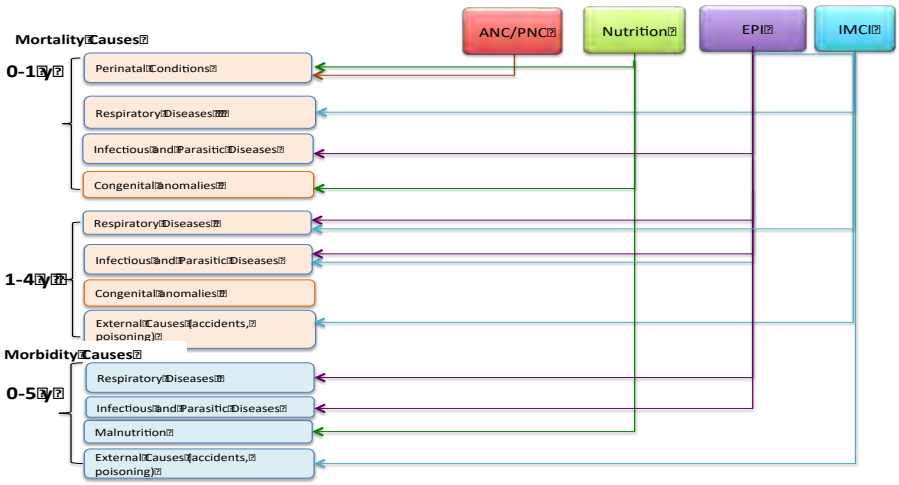
Neonatal period (0-27 days)	Children aged 1-59 months
Causes of mortality	
1. Perinatal Conditions (intra partum related events, preterm birth complications) – 57%	1. Pneumonia – 29%
2. Congenital abnormalities – 17%	2. Diarrhoea – 16%
3. Infections (sepsis, meningitis, pneumonia, tetanus and diarrhoea) – 17%	3. Injuries and accidents – 12%
	4. Meningitis – 4%
	5. Vaccine preventable diseases < 1%
	6. Other conditions – 38%
Contribution to Disease Burden[68]	

[68] Global Burden of Disease Study 2010. Global Burden of Disease Study 2010 (GBD 2010) Results by Cause 1990-2010 - Country Level. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2013.



UNICEF programmes supported evidence-based intervention packages that targeted the most important causes of child mortality and morbidity, as shown in Figure 22.

Figure 22: Child mortality and morbidity causes and intervention packages



The interventions across the continuum of care and care delivery platforms included in these packages implemented in the evaluation countries are presented in ANNEX 2.

Table 7: Causes of child mortality and UNICEF programme targeting

Causes of Mortality	UNICEF Programmes Targeting the Causes
Neonatal 0-27 days	
Perinatal Conditions	***Well Targeted*.** Perinatal conditions as a number one cause of a neonatal mortality were targeted by UNICEF programmes through the set of interventions grouped in the ANC/PNC intervention package. UNICEF programmes helped all the evaluation countries to develop policy and legislative frameworks, assess the quality of perinatal services and promote the delivery of the Effective Perinatal Care (EPC), Emergency Obstetric Care (EmOC) (in the selected countries) and Neonatal Resuscitation. This covered essential midwifery, obstetric and neonatal care, as well as a number of areas of special care, such as pre-eclampsia, postpartum haemorrhage, perinatal asphyxia, infection control and timely provision of the relevant level of hospital care for mothers and newborns. However, UNICEF programming was less prominent in promoting interventions on an antenatal level through the ANC "sub-package" directed towards the prevention of deaths from preterm birth and other pregnancy complications. UNICEF-supported policy work on national maternal and child health policies/strategies included measures to improve antenatal care, among other issues. Other programmatic interventions to improve antenatal services were only provided in the selected countries in cooperation with other development partners: under the PHC reform initiative in Moldova (with the World Bank but especially with SDC); in mother and child health programmes in Uzbekistan (with USAID and EU); in Kyrgyzstan as part of a joint DFID/UNICEF/MoH programme on ensuring equitable access of vulnerable women and children to health services in the southern part of the country; and in the integrated maternal and child

	health programme in Serbia. UNICEF also addressed perinatal causes of death by supporting specific interventions under the Nutrition package that prevent preterm and low birth weight complications by promoting micronutrient supplementation and FF targeting pregnant women (among other population groups); and the early initiation of breastfeeding through BFHI and promoting exclusive breastfeeding for newborns. The Nutrition package was comprehensively supported by UNICEF in four out of five of the evaluation countries. In Serbia support was limited only to BF& BFHI and IDD.
Congenital abnormalities	***Not Targeted Systematically***. Congenital abnormalities, the second leading cause of neonatal mortality, was not targeted by UNICEF programming through any specific intervention package, as pre-conception health was not explicitly included as a focus area in UNICEF's regional and country programmes. However, iron foliate and other micronutrient supplementation included in the Nutrition package, and support to the high quality antenatal care through the ANC sub-package, may be regarded as programmatic interventions preventing deaths due to congenital abnormalities.[69]
Neonatal Infections (sepsis, meningitis, pneumonia, tetanus and diarrhoea)	***Well Targeted.*** Infections (including respiratory infections, pneumonia, diarrheal and parasitic diseases, meningitis and sepsis) are the third leading cause of neonatal mortality (0-27 days), and the first leading cause of post-neonatal mortality and child morbidity (aged 1-59 months). In the neonatal period, they can be avoided by treating maternal infections during pregnancy, ensuring a clean birth, care of the umbilical cord and immediate, exclusive breast-feeding. All of these measures were supported through the ANC/PNC, IMCI and Nutrition packages, which were included in UNICEF's programming in all the evaluated countries. In addition, UNICEF helped countries to build their PMTCT programmes and to assure adequate prevention of HIV vertical transmission. The EPI package of interventions targeted vaccine preventable infections in both the neonatal and postnatal periods. Post-natal period infections were addressed through UNICEF's programmatic support with help from interventions included in the IMCI (in all the evaluation countries) and Nutrition packages (in all countries except Serbia). The IMCI package also included interventions that help prevent accidents and injuries, another leading cause of child mortality and morbidity
Children aged 1-59 months	
Pneumonia	
Diarrhoea	
Meningitis	
Vaccine-preventable diseases	
Injuries and accidents	***Not Targeted Systematically.*** Injuries and accidents were not explicitly targeted by any of the intervention packages supported by UNICEF in the health sector. However, some of the UNICEF-supported capacity development programmes for health personnel (e.g. in Serbia) and Communication for Development (C4D) activities, along with UNICEF-supported programmes in other sectors, promoted accident and injury prevention related to road traffic accidents, violence against children, unsafe environments, safe behaviour skills during disasters, etc.
Other conditions	***Not targeted Systematically***

"With UNICEF's assistance we were able to address key causes of child morbidity and mortality. To note a few, immunization and IMCI programmes were the most important interventions, mostly supported by UNICEF." *Source: Key Government informant, Kazakhstan*

ANNEX 2 presents a more detailed description of the programme interventions targeting the specific causes of child morbidity and mortality by country and by CPAP period. It shows that UNICEF's programming in all the evaluation countries was similar, in targeting the most important causes of child mortality and morbidity by supporting specific intervention packages. However, there were certain variations from country to country.

The human rights based approach, gender equality and equity issues were embodied in most of the UNICEF programming.

4.2.2 RELEVANCE OF UNICEF-SUPPORTED PROGRAMMES AND INTERVENTIONS TO MNCH SERVICE BOTTLENECKS

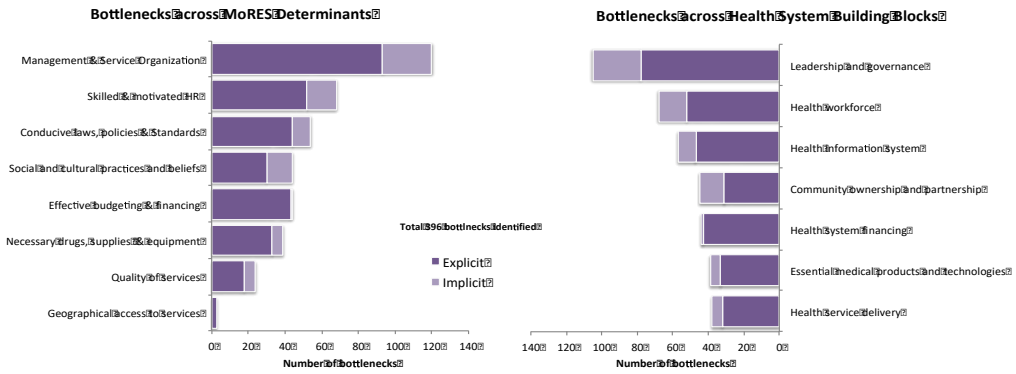
To respond to EQs 7 and 8, we have compiled an extensive database of health system coverage bottlenecks "explicitly" or identified and addressed by UNICEF in the evaluation countries during the evaluation period. UNICEF pointed out explicit bottlenecks as such in the programmatic documents[70]

[69] WHO. Congenital Abnormalities. Fact Sheet N370. 2014. Available at http://www.who.int/mediacentre/factsheets/fs370/en/ . Accessed on January 31, 2015.

[70] Prior to the introduction of the MoRES framework, UNICEF documents had not explicitly identified the bottlenecks *per se*, however they were mentioned as problems to be solved and barriers to be addressed in order to scale up the interventions. For the purposes of this evaluation, the ET classified such cases as "explicitly identified" bottlenecks.

and in the database; implicit bottlenecks--although not stated in the programmatic documents--were judged by as implied, based on a review of UNICEF programmatic activities in the country. Bottlenecks were linked to an intervention package, and then mapped across MoRES determinants.[71] As a next step, the ET identified priority interventions under each intervention package that targeted the respective bottlenecks and entered them in the same database. Additional codes linked the bottlenecks and interventions with seven health system building blocks and 15 thematic areas.[72] See ANNEX 10 for the most common bottlenecks and priority interventions mapped in this manner. The database includes 396 bottlenecks explicitly or implicitly identified by UNICEF in the evaluation countries. Further analysis of the bottleneck database shows that the highest numbers of bottlenecks were for the building blocks of "leadership and governance" and "health workforce" for all intervention packages in all countries. If assessed across MoRES determinants, the most bottlenecks were in "management and service organization", followed by "skilled and motivated staff" and "conducive laws and policies" (see Figure 23).

Figure 23: Number of bottlenecks according to MoRES determinants and health system building blocks



Considering the extensive network of health facilities inherited by the CEE/CIS countries in the 1990s, it is not surprising that the fewest bottlenecks were in "geographical access to health services". These were identified only in Kazakhstan, and due to the poor urban/rural distribution of health facilities and the long distances between health care providers. No bottlenecks that can be specifically attributed to "timely and continuous utilisation of services" were identified in the evaluation countries.

Findings derived from the document review and in-depth interviews show that UNICEF and its partners attempted to address almost all the identified bottlenecks during the evaluation period, although some exceptions occurred in specific countries.

4.2.3 ALIGNMENT OF UNICEF PROGRAMMING WITH NATIONAL POLICIES

> "UNICEF is a big authority in the country and helps to influence policies related to MCH… UNICEF always participates in the development of the national health policy and national programmes." ***Source: Key Government informant, Kazakhstan***

The Evaluation Team reviewed up to 35 national policies and strategies in the evaluation countries throughout the evaluation period, to clarify the alignment of UNICEF's own global, regional and national programme goals and objectives with the goals and objectives supported by national policies and strategies. The results of this assessment for the most important national policies and strategies is presented in . The table shows that UNICEF's programme goals and objectives were mostly aligned with national development strategies.

[71] "Effective budgeting and financing" was merged with the "financial access" determinant. No bottlenecks were found that can be specifically attributed to the determinant "timely and continuous utilization".

[72] Using the framework presented in Lancet's Every Newborn Survival Series (2014), WHO's six health system building blocks were amended to include a seventh--"community ownership and partnership".

Table 8. The table shows that UNICEF's programme goals and objectives were mostly aligned with national development strategies.

Table 8: Alignment of UNICEF programmes with national and sectoral development strategies in the evaluated countries

DEVELOPMENT /SECTORAL POLICY OBJECTIVES	UNICEF Programme alignment with the national objectives
Kazakhstan	
Strategic Development Plan for 2001-2010	Partially Aligned
Strategic health sector development plan for RK 2001-2010	Fully Aligned
Strategic health sector development plan for RK 2010 - 2020	Fully Aligned
Kyrgyzstan	
Manas Health Reform Programme 1996 - 2006	Partially Aligned
National Poverty Reduction Strategy 2003-2005	Not Aligned
National Health Reform Programme "ManasTaalimi" 2006-2010	Partially Aligned
National Poverty Reduction Strategy 2007-2010	Fully Aligned
National Health Reform Programme "Den Sooluk" 2012-2016,	Fully Aligned
National Strategy 2013-2017	Fully Aligned
Moldova	
National Poverty Reduction Strategy for RM 2004-2006	Partially Aligned
National Poverty Reduction Strategy for RM 2007-2010	Partially Aligned
National Health Policy 2007 -2021	Fully Aligned
National Strategy for Health System Development 2008-2017	Fully Aligned
National Poverty Reduction Strategy for RM 2008-2011	Fully Aligned
Serbia	
National Poverty Reduction Strategy 2002	Fully Aligned
National Health Policy 2002 - 2015	Fully Aligned
Uzbekistan	
Interim PRSP 2005-2010	Fully Aligned
Welfare Improvement Strategy2008-2010	Fully Aligned

A specific country example:

Text Box 1**.**

Text Box 1: Alignment of UNICEF Programmes with national strategies/policies – Kyrgyzstan

CPAP-1 (2000-2004): The main policy document that governed health reform processes since 1996 was The Manas Health Reform Programme (1996-2006). The Manas radically restructured the health policy through introducing new financing mechanisms, introducing the establishment of a State Guarantee Benefit Package, strengthening primary care and hospital downsizing. However, there was a limited emphasis on MCH and financial sustainability. "Access to quality services" was identified as one of the goals of the first National Poverty Reduction Strategy (NPRS) for 2003-2005. This national development strategy did not identify mothers and children as a priority group, however it mentioned the increase of iodine and iron deficiency disorders among children and iron deficiency anaemia among mothers as a burning issue. There was no mention of MDGs in the NPRS-1. Overall, UNICEF programmes for the period 2000-2004 were judged as "partially aligned" with the Manas programme and "not aligned" with the first NPRS strategic goals.

CPAP-2 (2005-2011) - The overall goals of the UNICEF country programme 2005-2010 were the realisation of the rights of every child and achievement of the MDGs. In 2006 the Government approved the National Health Care Reform programme of Kyrgyzstan «ManasTaalimi» for 2006-2010. This was first sectoral strategic document to include achievement of the MDGs as one of the key strategic goals of national health policy. All of the strategic objectives defined for the second National Poverty Reduction Strategy (NPRS) or Country Development Strategy for 2007-2010 – such as reducing poverty, ensuring access to education, protecting the health of the population, creating favourable living conditions, and protecting the most vulnerable citizens – coincided with the MDGs. MCH was included as a priority area. It also aimed to ensure access for poor and vulnerable women and children to resources and quality social services. Thus, the ET determined that UNICEF programmes were fully aligned with the NPRS 2007-2010 strategic goals and objectives.

CPAP-3 (2012-2016) - Programme preparation was based on the 2008 midterm review, the 2012-2015 midterm programme of the Government of the Kyrgyzstan, and the 2010 United Nations country analysis report, complemented by the 2010 UNICEF Situation Analysis. The country team's decision to proceed with UNDAF and Country Programme preparation was made after consultations with the President of Kyrgyzstan. UNICEF held several planning meetings with line ministries and non-governmental organization (NGO) partners and donors, ensuring that the Programme complemented other initiatives and partnerships to support government priorities. The country programme was developed in line with national priorities in the health SWAp, National Health Reform Programme "Den Sooluk" (2012-2016), Multi-Agency National Action Plan for Child Protection. The programme is fully included in the Millennium Declaration, Millennium Development Goals and UNICEF's medium-term strategic plan. Thus UNICEF programmes were judged as "fully aligned" with both national development and sectoral strategies for this period.

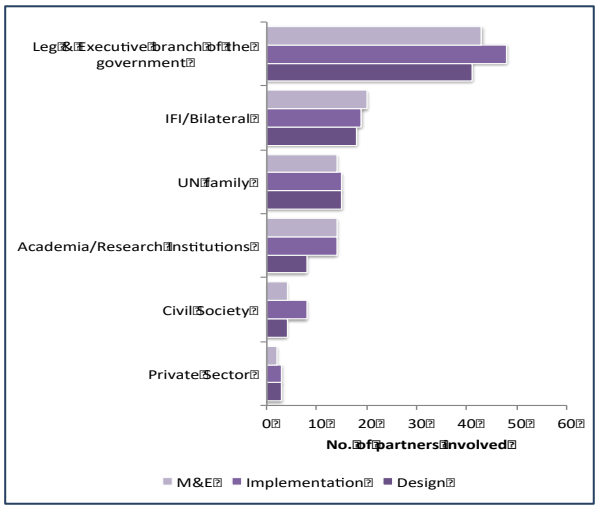
A human rights approach was partially or fully included in UNICEF programming for the evaluation countries (see

Table 14 on page 70). Adherence to the child's right to health is considered one of the overarching national development goals, as all the evaluation countries ratified the Convention of the Rights of the Child prior or during the evaluation period. Tackling **inequities** in health as one of the means for the poverty eradication was also a shared objective of the UNICEF programmes and national development strategies. UNICEF failed to adequately reflect the **gender inequality** issues at the programming stage in the evaluated countries (see

Table 14 on page 70). Thus UNICEF programme goals and objectives can be considered as *partially or fully aligned* with the relevant national development goals in ensuring fundamental human rights and equity reduction, and *not aligned* in targeting gender inequality.

4.2.4 PARTNER AND STAKEHOLDER ENGAGEMENT IN UNICEF PROGRAMMING

Figure 24: Partner engagement in programming



UNICEF ensured wide participation by different partners and stakeholders in its programme design, implementation, and monitoring & evaluation in all the countries studied (See Figure 24 and ANNEX 3). The legislative and executive branches of the governments and the development partners from UN agencies and IFIs were the most actively involved partners in all stages of the UNICEF programmes. However, civil society and private sector participation was less prominent. Civil society organisations commonly representing the beneficiaries were mostly involved at the implementation stage. Overall partner engagement was highest in the implementation and design stages, and less so in monitoring & evaluation, particularly for the EPI intervention package. Low participation of rights holders (children, youth, their families, marginalized groups and other beneficiaries) and their representatives (civil society organisations) in the design and M&E of UNICEF programmes may indicate flaws in UNICEF's implementing a rights-based approach, as well as gender equality and equity in the evaluation countries.

"The EPC programme was initiated by WHO and supported by UNICEF and UNFPA in different regions. Lessons learned were jointly discussed with the MoH. All three UN agencies distributed tasks carefully. The TA was by WHO, while UNICEF led more on trainings in regions. Although we had good coordination among ourselves, there is room for improvement. Better cooperation and openness in information sharing is desired…" ***Source: UNFPA key informant, Kazakhstan***

"Safe Motherhood is a good example of coordination and partnership between different international partners. Project Hope, ZdravPlus, UNFPA, WHO, and UNICEF were the main partners supporting programme implementation. UNICEF advocacy led to the adoption of the MoH Decree #500, which integrated SM elements and allowed implementation. Project Hope helped develop training materials and curricula and supported trainings in three pilot regions. Trainings were implemented by all partners in different regions of the country." ***Source: National SM Coordinator, key informant, Uzbekistan***

"We work closely and collaborate with UNICEF. Experts from our University are always involved in situation analyses, research and surveys, MICS etc. Last year we worked on the perinatal health situation analysis led by UNICEF" ***Source: Key Informant, Medical University, Serbia***

"UNICEF was one of the main partners among ADB, WHO and KAN in the area of flour fortification and salt iodization in all Central Asian Countries."- "UNICEF was a lead agency in USI and FF" ***Source: Key Government informant, Kazakhstan***

"UNICEF support in improving access to services to Roma is exceptional. UNICEF trained and fully equipped Roma health mediators as well as provided legal support for registration and obtaining insurance (health cards) for Roma families, in close partnership with us. All these efforts have led to the improved health status of Roma children and their mothers." ***Source: Key Informant, NGO "Proxis", Serbia***

"…UNICEF played "first violin" in the PHC reform process; their experience in PHC piloting helped a lot in defining the MCH package and primary care overall." ***Source: key informant, partner organization, Moldova***

Although it was not always the highest contributor in monetary terms, UNICEF was a principal agency in all the evaluation countries. It invariably played an active, if not lead, role in most of the partnerships forged to promote MNCH issues and to define wider health sector policies. The key informants representing host governments and key development partners often highlighted the role played by UNICEF as critical or "defining". ANNEX 3 shows that by using various core roles, including voice for children, facilitating the national dialogue, enabling knowledge exchange and policy advice and technical assistance, UNICEF selected appropriate international and national, public and private partners to enhance

its programmes and support all intervention packages. As evidenced from the document review and key informant interviews, the most effective and successful partnerships were formed to implement IMCI, ANC/PNC packages (with WHO, UNFPA, the World Bank, ADB, EU, USAID, KfW, GIZ, JICA, SDC, DfID, Soros Foundation) and Nutrition packages (private sector actors, ADB).

4.3 EFFECTIVENESS OF UNICEF'S PROGRAMMES IN THE EVALUATED COUNTRIES

In this section of the Report, we present findings on the effectiveness of UNICEF programmes in the evaluated countries by answering questions 11 to 15:

EQ.11: Have UNICEF-supported programme (s) contributed to achieving the required changes, as per the Health System blocks/the Enabling Environment?
EQ.12: Was UNICEF able to ensure that all relevant determinants at the health system level (policy, legislation, financing, management) were tackled, both through its direct intervention and by convening and advocating with partners?
EQ.13: Have UNICEF-supported programme (s) contributed to eliminating bottlenecks in ensuring effective coverage of priority MNCH interventions along the continuum, in particular those most relevant to the CEE/CIS region?
EQ.14: Was the equity gap in coverage by MNCH services reduced? What groups of society remain unreached, or disaggregated by place of residence, wealth, gender and ethnicity?
EQ.15: Has the reduction in bottlenecks contributed to reducing disease-specific mortality (caused by ARI, DD, asphyxia, prematurity, etc.), and if so, could it be positively associated with overall reductions in ENMR, PNMR, IMR, and U5MR?

Relevant findings are organised in several sub-sections that generally follow the evaluation questions above, however full answers to these questions are provided in the Conclusions of this Report.

4.3.1 UNICEF PROGRAMMATIC CONTRIBUTION TO CHANGE IN HEALTH SYSTEMS AND ENABLING ENVIRONMENT

As noted earlier, the Theory of Change of UNICEF's engagement stipulates that **systemic and/or community-level changes are attempted through UNICEF programme interventions supported by their core roles**. The evaluation findings presented in previous sections revealed that, in accordance with a long-standing strategic approach by all UNICEF's global and regional strategic documents since 1995, the organization supported a wide range of evidence-based interventions. Their primary objective was addressing health system bottlenecks and the social determinants of health to activate the desired health system changes and to create an enabling environment for better maternal and child health. The focus of UNICEF's support in the evaluated countries was to strengthen health systems. This can be retroactively classified as aimed primarily at system bottlenecks within MoRES determinants, to ensure

(a) physical access to Maternal, Newborn and Child Health (MNCH) services (equipped facilities, skilled and motivated human resources, and information);

(b) financial accessibility (including access to essential drugs, vaccines and other commodities and evidence- based interventions through government financed Basic Benefit Package - BBP);

(c) improved quality of MNCH services (quality of care); and

(d) effective implementation of demand-side interventions (increasing knowledge of families on case management and referral in the case of most common childhood illnesses and changing socio-cultural norms preventing utilisation of the MNCH services).

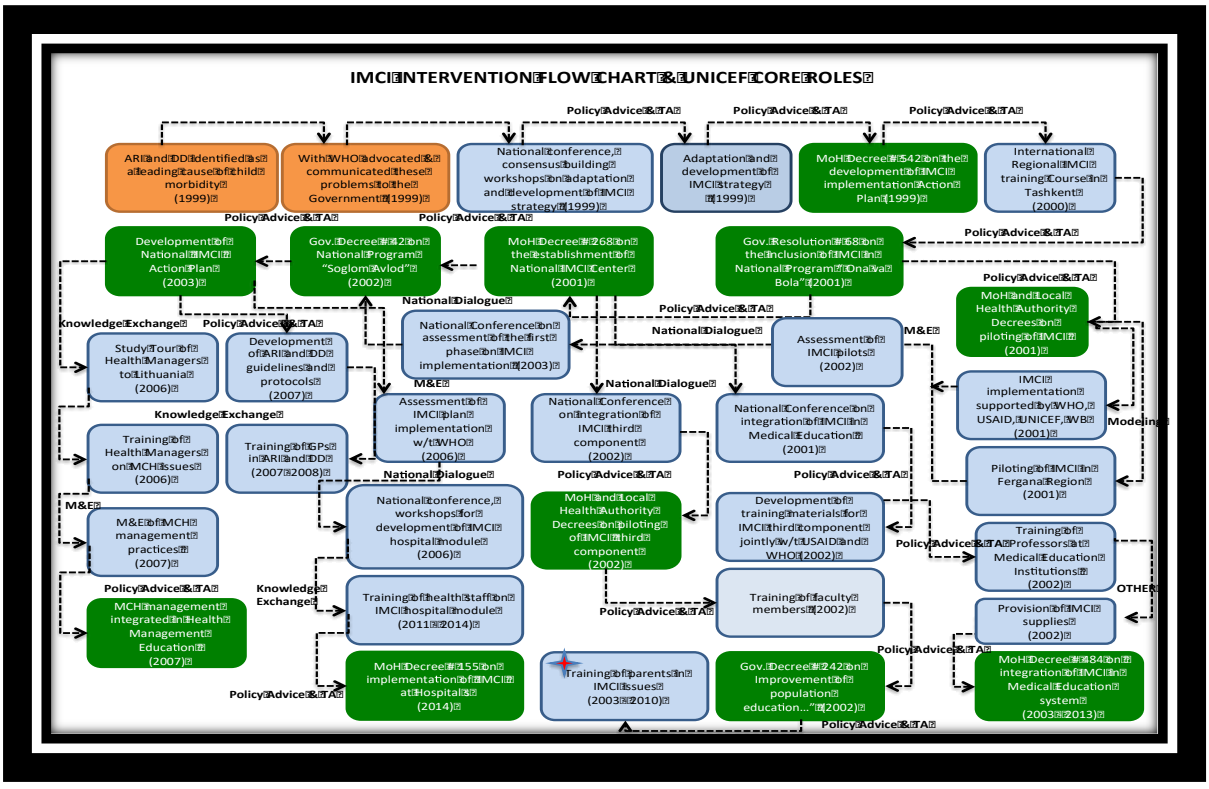
In addressing the bottlenecks identified, UNICEF programmes aimed to create an enabling environment through the desired system and community level changes. These include influencing social norms, adopting laws and policies, improving coordination and management, ensuring adequate budget allocations, and facilitating changes in the national health information systems and supporting population-based surveys (MICS). While addressing the bottlenecks and inducing systemic

change, UNICEF focused on evidence-based "intervention packages" through its programmes using its core roles. To capture the complex process of implementing "intervention packages", the ET developed flowcharts to map and validate UNICEF core roles and to develop narrative descriptions of implementation for each intervention package, and in certain cases for each sub-package. See examples of such pathways with implementation flowcharts and narrative "stories" describing how UNICEF used its core roles in Text Box 2 and Figure 25.

Text Box 2: IMCI Implementation in Uzbekistan

Starting with the end of the 1990s, several organizations played an active role in IMCI implementation in Uzbekistan, although UNICEF and WHO were the ones to initiate early dialogue with the government and with leading national experts (UNICEF in its core role - **facilitating national dialogue**). The initial sensitisation of opinion leaders, followed by extensive technical assistance and implementation support, largely offered by UNICEF (**policy advice and TA**) and in-country partners such as WHO, Project HOPE, Abt Associates (the last two were implementing USAID-supported programmes during 2000-2008), EU (2008-2011), ADB and the World Bank, were critical contributors within this process (**leveraging**). Collaborative efforts, well coordinated by the government, led to a pilot implementation of the IMCI in selected regions (**modelling**) during the early years, and to eventual nation-wide scale up throughout the country with the financial support provided by the EU (**leveraging**). UNICEF-supported piloting and eventual scale-up, both of which entailed numerous steps implemented sequentially or in parallel. Steps included the initial sensitisation of opinion leaders (**facilitating national dialogue**); adapting international IMCI guidelines to the local context (**policy advice and TA**); empowering national "champions"; creating a critical mass of individuals (both at national and sub-national levels) who became agents of change (**voice for children and knowledge exchange**); continually sourcing and deploying leading regional or global experts for TA (**policy advice and TA)**; elaborating national policy and regulatory documents, such as ministerial decrees, presidential orders and government resolutions (**policy advice and TA**); providing necessary inputs to deliver the intervention (scales, drugs, consumables, training aids, etc.) (**modelling**); the gradual integration and eventual institutionalisation of training programmes in state institutions charged with providing continuous education to doctors and nurses (**policy advice and TAand knowledge exchange**); and effective, continuous and sustained coordination with the government and partners. As an active player throughout the process and a major contributor of necessary assistance inputs, UNICEF contributed significantly to IMCI implementation in the country.

Figure 25: Example of a flowchart for the implementation of UNICEF-supported intervention packages



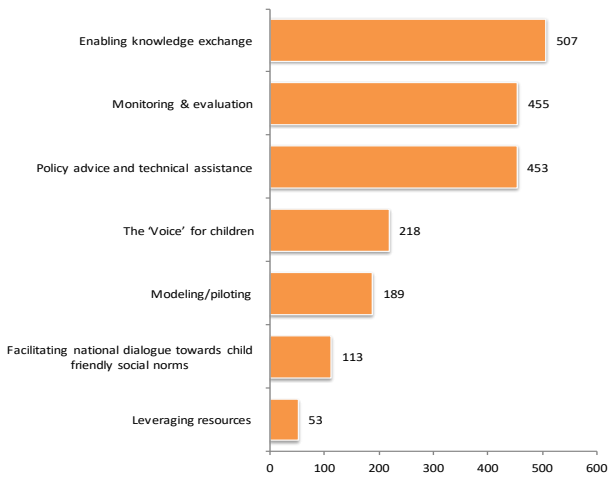
As noted in the Methodology section, the ET produced similar narrative descriptions and flowcharts for all intervention packages and in all the evaluation countries. See ANNEX 12.

This activity allowed the ET to establish that UNICEF delivered 1,988 distinct programme activities/interventions through its seven core roles in all five evaluated countries over the evaluation period. In delivering these interventions, they most frequently used the following core roles: "enabling knowledge exchange", "monitoring & evaluation" and "policy advice and technical assistance". The least utilised core role was "leveraging", which was usually employed for the Nutrition (35) and ANC/PNC (11) intervention packages. However, this finding should be interpreted with caution, as successful leveraging is not merely the result of a stand-alone programme activity/intervention. Instead, leveraging is accomplished through a set of activities and interventions delivered over an extended time, often using other core roles. For example, successful leveraging of government resources to finance MNCH services under the Basic Benefit Package (BBP) in Kazakhstan, Moldova and Serbia required UNICEF's engagement through "monitoring & evaluation" (obtaining evidence regarding financial access bottlenecks for children and women); disseminating evidence and advocating for policy change and an increase in public health expenditures through "voice for children"; "facilitating national dialogue" and facilitating enabling policy and legislation through "knowledge exchange" and "policy advice and technical assistance". Similarly, government resources were successfully leveraged for immunization in Uzbekistan, through "facilitating national dialogue" and providing "policy advice and technical assistance".

Table 9: Frequency of UNICEF core roles used across intervention packages and sub-packages in all evaluated countries, 2000-2012

Intervention Packages and Subpackages	Core Roles							
	Policy advice and technical assistance	Modeling/ piloting	Enabling knowledge exchange	Facilitating national dialogue	Monitoring & evaluation	The 'Voice' for children	Leveraging resources	Grand Total
ANC/PNC	120	65	166	29	99	26	11	516
PMTCT	27	9	32	7	5	4	3	87
PNC	93	56	134	22	94	22	8	429
EPI	42	4	66	4	51	23	3	193
EPI	42	4	66	4	51	23	3	193
IMCI	121	69	126	12	86	35	4	453
CCD	13	2	18	3	8	9		53
EMERGENCY PEDIATRICS	1	2	6	1	2			12
IMCI	107	65	102	8	76	26	4	388
NUTRITION	170	51	149	68	219	134	35	826
BF&BFHI	17	2	39	12	49	21	2	142
FF	30	22	24	20	27	40	13	176
IDA	34	14	27	8	30	14	4	131
IDD	58	5	41	22	82	47	14	269
VAD	31	8	18	6	31	12	2	108
Grand Total	**453**	**189**	**507**	**113**	**455**	**218**	**53**	**1988**

Figure 26: Frequency UNICEF used core roles in delivering intervention packages



To evaluate UNICEF and its partners' *joint* performance to induce systemic and community level changes by addressing critical bottlenecks, the ET assessed the scope, target groups and scale of interventions supported by UNICEF core roles. This produced a "bottleneck addressing score" described in the methodology section of this Report. An "addressing score" was assigned to each bottleneck identified by the ET, using the following scale: *fully addressed,* when the scope, target groups and scale were appropriate (a score of "2" was assigned); *partially addressed,* when the scope and target groups were appropriate but the scale was limited to a pilot and/or to a subnational level

(score of “1”); and *not addressed*, when the scope or target was not appropriate (score of “0”). An example of the addressing score assignment for one of the countries is presented in

Text Box 3.

Text Box 3: Addressing Health System Bottlenecks in Uzbekistan

Inadequate financing of perinatal services - UNICEF identified this bottleneck in its programmatic documents, however it did not address the financing issue of the new perinatal service provision in the country. The financing of perinatal service providers at each level largely remained unchanged. The WB, ADB, or other major development partners did not address this very important bottleneck in the provision of effective perinatal service coverage. As a result, the ET assesses this bottleneck as “not addressed”.

Staff turnover and weak capacity in MCH health departments at regional and sub-regional level affect the overall quality of MCH management – in order to address this specific bottleneck, UNICEF-supported health service management trainings (right scope) for health managers and decision makers (right target group), and trainings were eventually scaled up to the national level. However, no measures were undertaken to address the issue of staff turnover (motivation), thus the ET assessed the bottleneck as “partially met”.

Absence of referral links for MNCH services – in order to address this bottleneck, in the first CPAP period UNICEF initiated a dialogue and leveraged partners, which resulted in the establishment of an enabling legal environment to improve referral links between MCH service providers. By the second CPAP, with USAID funding for MNCH services ending, UNICEF covered the entire country with cascade training of health providers, which included referral algorithms. By the end of the CPAP cycle, a situation analysis for mothers and children provided evidence that the referral system for MNCH services is functional and operated by the government. The ET assessed the bottleneck as “fully addressed”.

The results of the bottleneck addressing scores were compiled in a special database, which revealed that UNICEF and its partners have managed to fully address 284 (71.7%) of the bottlenecks and partially address 94 (23.7%). Only 18 (4.5%) bottlenecks were not addressed at all.

Figure 27 presents the frequency that bottlenecks were addressed by the intervention packages and the determinants.

Figure 27 Bottlenecks addressed by intervention packages and MoRES determinants

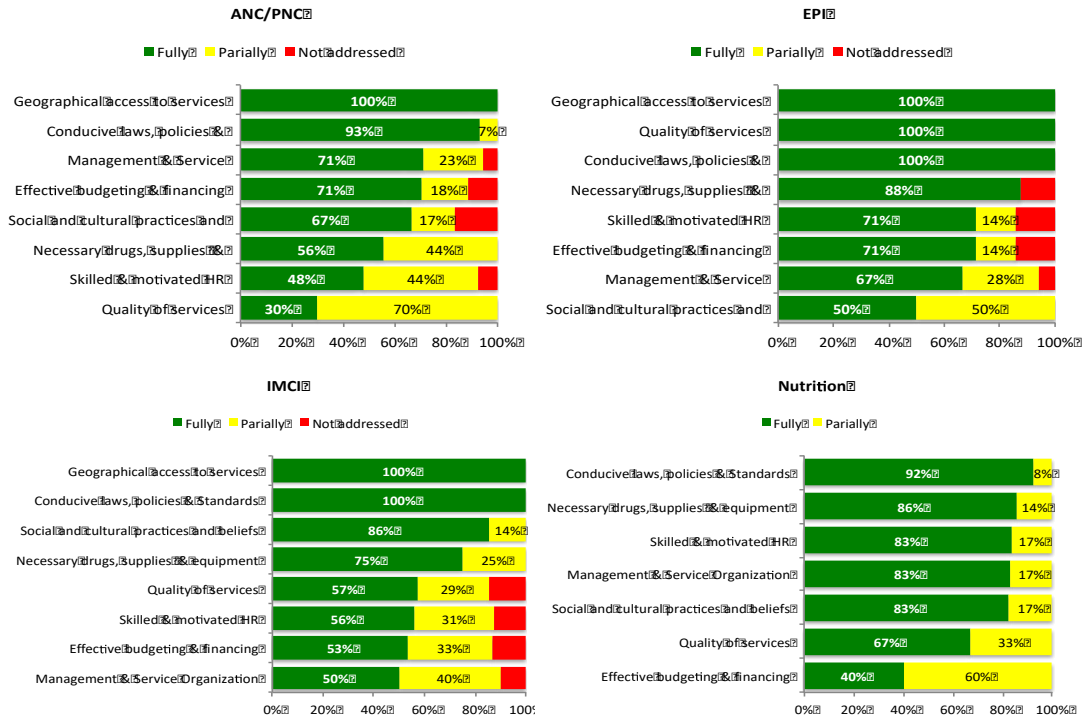


Table 10 presents an average addressing score for a given bottleneck along with the colour-coded bottleneck addressing scores for each intervention package across MoRES determinants. These scores are not absolute measures, but an attempt to convert codified qualitative information into a relative measure, which must be interpreted with caution. The score values have meaning only when evaluated relative to the values assigned to other bottlenecks and/or to a package, reflecting relative progress in addressing identified bottlenecks by UNICEF and its partners.

Table 10: Average scores for addressing bottlenecks for intervention packages across MoRES determinants and health system blocks

MoRES Determinants	ANC/PNC	EPI	IMCI	NUTRITION	Average
Conducive laws, policies, standards & social norms	1.93	2.00	2.00	1.92	1.94
Management & Service Organization	1.66	1.61	1.40	1.83	1.68
Effective budgeting & financing	1.59	1.57	1.40	1.40	1.50
Necessary drugs, supplies & equipment	1.56	1.75	1.75	1.86	1.74
Skilled & motivated HR	1.41	1.57	1.44	1.83	1.54
Geographical access to services	2.00	2.00	2.00		2.00
Social and cultural practices and beliefs	1.50	1.50	1.86	1.83	1.73
Quality of services	1.30	2.00	1.43	1.67	1.46
Average	**1.58**	**1.65**	**1.55**	**1.83**	**1.67**
Health System Building Block	**ANC/PNC**	**EPI**	**IMCI**	**NUTRITION**	**Average**
Leadership and governance	1.77	1.79	1.60	1.84	1.77
Health system financing	1.59	1.57	**1.40**	**1.40**	1.50
Health workforce	**1.41**	1.57	**1.44**	1.83	1.54
Essential medical products and technologies	1.56	1.75	1.75	1.86	1.74
Health information system	1.63	1.50	1.50	1.89	1.72
Health service delivery	1.56	2.00	1.55	1.71	1.61
Community ownership and partnership	1.50	1.56	1.86	1.83	1.73
Average	**1.58**	**1.65**	**1.55**	**1.83**	**1.67**

Figure 25 and Table 10 reveal that IMCI and ANC/PNC packages had the highest share of partially or not addressed bottlenecks, and overall received the lowest addressing scores, of 1.55 and 1.58

respectively. The nutrition package, which had the highest share of fully addressed bottlenecks, has the highest score (1.83).

> "UNICEF played a major role in the institutionalization of IMCI in the country. Their assistance was well blended with advocacy, training, provision of essential medicines (at the beginning of program) and for building national and local capacities." ***Source: UNFPA key informant, Kazakhstan***
>
> "UNICEF people know how to work with the parliamentarians, who need information and clarifications of issues to see the problem from different angles-- and UNICEF does it very well." ***Source: key informant, parliamentarian, Kyrgyzstan***
>
> "The regionalization of perinatal care is one of the successes of the Moldova health system and this is a UNICEF contribution." ***Source: key informant, partner organization, Moldova***
>
> "UNICEF has "opened the eyes" of the facility managers, and they show in practice how things should be done." ***Source: key informant, partner organization, Kyrgyzstan***

From the document reviews and interviews, it was obvious that UNICEF's work on *conducive laws, social norms, policies & standards* was significant and almost fully addressed most of the bottlenecks under this MoRES determinant. This was largely determined by their unique position among development partners due to a long-standing history of engagement with national governments, and because of national stakeholders' perception of UNICEF as a technically competent and strong advocate of MNCH issues.

Drugs and necessary supplies emerged as a critical bottleneck in the early days. In some instances it required a humanitarian response (e.g. Serbia, Kyrgyzstan, Uzbekistan) to supply necessary drugs, vaccines, medical materials and equipment. This was initially addressed through donor and UNICEF-funded supplies. For example, during the early CPAP period, close to 55% of UNICEF-managed resources were spent on drugs and inputs, compared to 22% during later CPAP years. Active engagement with national governments allowed UNICEF to gradually shift this responsibility onto national budgets, and a decade later drugs and the necessary inputs became widely available in health care facilities. Nevertheless, the challenges of accessing outpatient drugs for MCNH problems remain for the poor and marginalized groups unless the drug package is fully funded by the government and includes a sufficient breadth of needed medications and is delivered to the socially vulnerable groups effectively (ethnic minorities, poor and disabled, etc.). Kazakhstan, Serbia and Moldova appear to have addressed this issue relatively well.

> "The Immunisation communication campaign is not efficient; there is scepticism towards immunization among policy makers. There are refusals due to counter indications from providers side, which is increasing mainly in urban areas; effective action should be taken.**" *Source: Key informant, partner organization,* Moldova**
>
> "Even among health personnel there are those who do not vaccinate their children. UNICEF and the MOH have to re-educate health and media representatives on the benefits of immunization. Unfortunately, immunization related issues were left out of media education." ***Source: Key informant, Serbia***

A decade of work with the communities also helped to address demand barriers related to *social and cultural practices and behaviours*, although with different degrees of success for ANC/PNC and EPI on one hand, and IMCI and Nutrition on the other. The influence of the anti-vaccination lobby in a number of CEE/CIS countries, including Moldova and Serbia, may have been one of the factors negatively affecting this determinant. *Geographical access* barriers were only identified in Kazakhstan, which has a sparsely populated and vast land area. However, over the course of a decade these barriers seem to have been well addressed by UNICEF in partnership with the Government and other development partners.

The low addressing score for *management and service organization* deserves attention. Challenges posed by weak managerial capacity in the health sector are specific to the region and have not been fully addressed. Document reviews and interviews showed that the problem is widespread, and it was evidenced by the frequency of this bottleneck (see chart where priority bottlenecks are listed in Figure 23 on page 45). The lack of adequate undergraduate and post-graduate education for health management, which only emerged recently as a speciality and is at the nascent stage, creates major structural challenges for the supply of qualified health care managers. Consequently, further

challenges are posed by weak managerial capacity to: a) translate new policies in action; b) adequately monitor service delivery and the resulting outcomes and take corrective measures; and c) adequately plan for and implement services at the scale needed. All of this is compounded by high staff turnover within the MoH and district departments. This further minimizes the impact of donor investments.

Finally, *the quality of services* was one of the least mentioned bottlenecks, but proved quite complex and challenging to improve, and so has received the lowest addressing score. Several factors are at play, including: a) inadequate infrastructure and equipment, which--despite the significant investments made--still pose a risk to patients in some areas; b) poor infection control practices; c) poor compliance with clinical standards; and d) absence of quality management systems and lack of indicators.

Besides the MoRES determinants, we also looked at the bottlenecks through the health system building blocks, in Table 10 on page 53 (lower table). Our analysis reveals that UNICEF and its partners insufficiently addressed the *health system financing* bottleneck for IMCI and Nutrition packages, while their work supporting the *health workforce* received lower addressing scores for ANC/PNC and IMCI.

The lower score for *health system financing* was perhaps determined by the consistently low level of government spending on PHC and the relatively high out-of-pocket payments for outpatient drugs that a significant part of the population still faces in some of the evaluation countries (Kyrgyzstan and Uzbekistan). In Serbia, while UNICEF assisted the national and local governments to create an enabling environment for improved access to MNCH services, budget cuts at the local level have somewhat undermined efforts to completely eliminate this bottleneck, although it has been significantly reduced. Similarly, the low level of public financial support to provide vitamin A supplements and micronutrients in Uzbekistan and the Kyrgyzstan largely determined the low addressing scores.

A number of systemic challenges still affect all countries. These include low staff motivation at the primary care level; low quality undergraduate and postgraduate education, particularly in the Central Asian region; a shortage of staff caused by regional migration; and low access in rural locations. While UNICEF and partners tried to tackle these issues, the bottlenecks remain and have not been fully addressed.

To evaluate UNICEF's specific contribution (independently of its partners) through its core roles in delivering intervention packages to address bottlenecks and reduce systemic change, the ET used an evaluation database compiled from flowcharts and narrative descriptions. The document review and interviews allowed an evaluation of UNICEF's contribution to a given intervention sub-package and to fill in the database with scores for their contribution to addressing the bottlenecks for scale-up of these intervention packages. ANNEX 12 presents the justifications for assigning contribution scores to UNICEF core roles for each intervention package and each country. This database helped provide an average contribution score for a given package and MoRES determinant. Findings showed that for all packages and across all determinants, UNICEF's contribution varied between significant =2 and major/critical =3, proving they were an active player throughout the evaluation period, and that they made serious contributions to address key bottlenecks within MNCH services. Table 11 on page 55 provides average contribution scores according to intervention package across MoRES determinants, and further confirms that UNICEF played an active role throughout the evaluation period and, in partnership with other donors and national governments, made significant and/or critical contributions. In *relative* terms, UNICEF's contribution score was weakest under the IMCI package for skilled and motivated staff and necessary drugs and supplies. However, the scores have to be interpreted carefully as their contribution was still above a significant level. To simplify the contribution score findings, the ET also developed a different form for to present the results, provided in Figure 28.

Table 11 UNICEF's contribution according to MoRES determinants and intervention packages

MoRes Determinants	ANC/PNC	EPI	IMCI	NUTRITION	Grand Total
Conducive laws, policies & Standards	2.87	2.67	2.81	2.85	2.84
Management & Service Organization	2.93	2.59	2.50	2.81	2.75
Effective budgeting & financing	2.78	2.67	2.67	3.00	2.75
Skilled & motivated HR	2.94	2.66	2.35	2.62	2.65
Necessary drugs, supplies & equipment	3.00	2.90	2.15	2.93	2.81
Social and cultural practices and beliefs	2.95	2.57	2.59	2.88	2.79
Quality of services	2.98	2.50	2.50	2.62	2.67
Grand Total	**2.92**	**2.63**	**2.51**	**2.78**	**2.74**

Figure 28: UNICEF contribution across intervention packages

The ET used the bottleneck addressing scores in conjunction with the scores for UNICEF's contribution to interpret the evaluation findings. After doing so, the team noted that despite the fact that UNICEF did not take the lead in efforts to address the *effective budgeting and financing* bottleneck (except in Moldova), their contribution to addressing this bottleneck for the IMCI and Nutrition packages was major/critical, yet the bottleneck received a relatively lower addressing score (1.4 out of 2). In this case it was mainly UNICEF's partners, particularly the development banks, that worked with the government to reform health financing. Similarly, the *quality of services* for ANC/PNC and IMCI received low scores--1.3 and 1.43 respectively--and bottlenecks under the *skilled and motivated staff* determinant for ANC/PNC packages and IMCI were addressed to a lesser degree, as they received 1.41 and 1.43 respectively. These scores hide significant inter-country variability, although we will not delve into details, as the focus of the evaluation is five countries and not country-specific. The yellow-coloured cells in Figure 26 above indicate relatively greater progress in addressing bottlenecks, and green indicates significant progress made by UNICEF programmes.

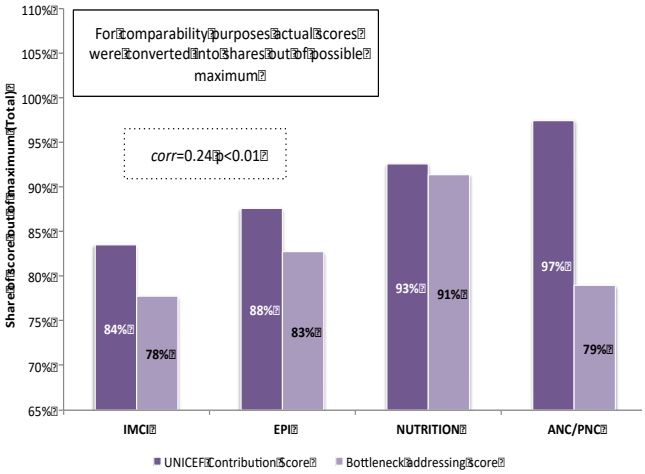
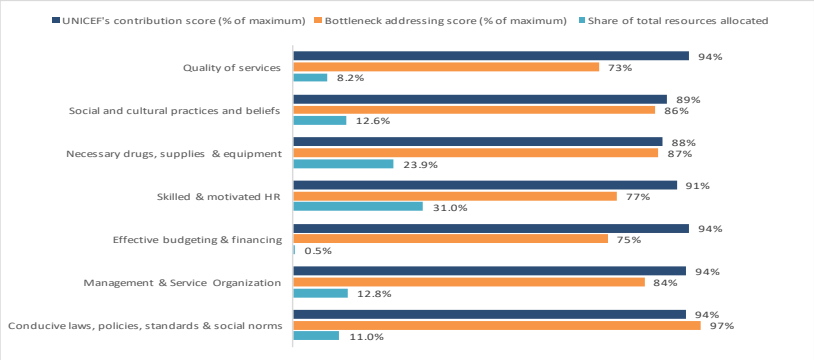


Figure 29 Correlation between bottleneck addressing score and UNICEF's contribution score

Overall, there is a weak but positive and statistically significant correlation between the addressing scores and the contribution scores i.e. a higher UNICEF contribution score most likely meant a higher bottleneck addressing score. The only exception was the ANC/PNC package that had UNICEF's highest contribution score, but had a low bottleneck addressing score. This probably determined the low correlation coefficient (see Figure 29).

The ET also looked at a possible correlation between the bottleneck addressing score and the resources spent by UNICEF. The ET found that the least-resourced determinants were those with relatively low addressing scores. For example, "effective budgeting and financing" and "quality of services" had the lowest average addressing scores, and received the least allocations. Out of the four determinants, which include the highest numbers of bottlenecks identified, three received the highest allocations. However, a very weak correlation (close to none) was found between UNICEF's resource allocation and the relative success in addressing the bottlenecks, when all determinants were considered (r=0.04, p<0.001). This is not surprising, for two reasons: 1) The ET gave the weakest rating to the evidence about UNICEF's financial resources (see ANNEX 14); and 2) UNICEF's own financial resources directed towards specific bottlenecks may have been small compared to the investments by national governments and/or other development partners targeting the same bottlenecks. This was certainly the case for bottlenecks addressed under "effective budgeting and financing" determinants (see Figure 28).

Figure 30: Bottleneck average addressing score, UNICEF average contribution score and share of UNICEF resources spent by MoRES determinants



Almost one-third of all resources were spent on addressing bottlenecks for "skilled and motivated human resources", which is justifiable considering the resource requirements for conducting large- scale and extended training for medical personnel who provide MCHN services. Yet this determinant received the third lowest addressing score among all the determinants addressed. It is also notable that if this determinant is excluded, the correlation between the resources devoted and the bottleneck addressing score becomes strong (r=0.59, p<0.000).

4.3.2 CHANGES IN INDICATORS OF EFFECTIVE COVERAGE BY MNCH SERVICES DURING THE EVALUATION PERIOD

According to the ToC, achieving necessary systemic and community level changes through addressing bottlenecks to effective coverage should lead to an improvement in effective coverage by MNCH services. Therefore, this sub-section looks at how the population's coverage by MNCH services was affected during 2000–2012 in the countries evaluated. The results of the data analysis presented in ANNEX 13, while mixed, mostly show improvement across all domains of the Tanahashi framework for effective coverage (including availability, accessibility, contact, and adequate and quality coverage). Inequities were also reduced across multiple indicators. More specifically:

1. **The availability of services** and **qualified human resources**[73] remained high for the CEE/CIS region as a whole and for the evaluation countries specifically, with population ratios of doctors, nurses and midwives well above WHO's minimal threshold of 230 per 100,000 population.[74] Nevertheless, some structural changes were observed: doctor/population ratios increased for general practitioners in Kyrgyzstan, Kazakhstan and Uzbekistan, while initially high ratios of specialists declined. This concerned obstetricians, gynaecologists and paediatricians in all countries except Kazakhstan; nurses in Kyrgyzstan, Uzbekistan and Moldova; and midwives in Kyrgyzstan and Moldova. These reductions in specialists could be due to the introduction of family medicine models in these countries, with the exception of Serbia, which maintains the old system. The reductions are most likely caused by inadequate human resources planning and by emigration.

2. **Ensuring financial accessibility.**[75] Public spending on health care increased several times in all the evaluation countries, to levels that allow adequate financing of essential health services, i.e. above 64 PPP$ per capita.[76] This translated into increased financial accessibility to all health services, as private out-of-pocket health expenditures declined in three of the five evaluation countries (Kazakhstan, Kyrgyzstan, Uzbekistan). Financial accessibility to MNCH appears to have improved even in Serbia and Moldova, where the share of out-of-pocket payments did not reveal a positive trend, as facility-based MNCH services and essential supplies and drugs were included in the state financed BBPs in all the evaluation countries. This ensured mostly free access to these services. However, the financial accessibility of drugs, including those needed for adequate ANC and IMCI, remain a challenge in Kyrgyzstan and Uzbekistan. Here access to ANC and IMCI drugs is a significant financial burden for households, and the poorest groups of the society are not as well-protected. [77,78,79]

3. **The knowledge, attitudes and practices in MNCH and the demand for services** in the evaluation countries showed overall improvement, although gaps remain. Available data on proxy indicators show an improvement in attitudes, practices and demand for critical MNCH care. Fewer pregnant women forgo antenatal care and more of them complete four or more antenatal visits; timely breastfeeding is initiated for more newborns; more children with suspected pneumonia are taken to an appropriate health provider; and more children with diarrhoea are treated with oral rehydration therapy along with continued breastfeeding/feeding. Nevertheless, knowledge gaps still remain and even widened during the evaluation period. In particular, mothers' knowledge of the danger signs for pneumonia in children has declined, following an initial increase achieved before the year 2000. This could affect the timely use of qualified help and effective coverage. Nevertheless, we have seen improved practices in care-seeking for suspected pneumonia that could be the result of reduced financial access barriers and improved supply.

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73 The availability of infrastructure was not considered a relevant coverage dimension for the CEE/CIS since all post-socialist countries inherited an extensive network of health facilities. Measuring changes in the availability of essential supplies was not possible in this evaluation due to an absence of data.

74 Working Together for Health, the World Health Report 2006. World Health Organization, Geneva 2006.

75 As noted in the MCE TOR, geographic access to health services was not considered relevant for CEE/CIS. However, our findings indicate some overall improvement in already-high geographic access to services.

76 The WHO Commission on Macroeconomics and Health has estimated the cost of the essential health services package that includes all evidence-based MNCH interventions to be 64 USD per capita (for lower middle income countries), well below the current public spending levels on health in the evaluated countries

77 Barriers and facilitating factors in access to health services in the Republic of Moldova. Copenhagen, WHO Regional Office for Europe, 2012

78 Kassim. A. 2014. Health system financing reforms and its impact on access to health care in low and lower middle income countries of WHO European Region: A systematic review. Master's Thesis Public Health School of Medicine Faculty of Health Sciences University of Eastern Finland. http://epublications.uef.fi/pub/urn_nbn_fi_uef-20140858/urn_nbn_fi_uef-20140858.pdf

79 Evaluation of the organization and provision of primary care in Serbia. Primary care in WHO European region. World Health Organization 2010

4. **Ensuring quality of services.** There were some improvements observed in this final dimension of effective coverage. Skilled birth attendance has remained at a very high level in all the evaluation countries, with more deliveries attended by more qualified medical personnel (doctors vs. midwives, nurses). Doctors also deliver more perinatal care. More children aged 0-5 months are exclusively breastfed, although higher levels would be desirable; more children with suspected pneumonia are treated with antibiotics; and more households on average consume iodised salt. Most women receive an adequate level of antenatal care, for example, they have their blood pressure measured and urine and blood samples taken and tested. Immunization coverage[80] remains high. These results indicate an improvement in effective coverage through addressing the bottlenecks for specific ANC/PNC, EPI, Nutrition, and IMCI intervention packages. At the same time, low birth weight and stunting rates showed no improvements. This indicates an insufficient quality or scale of nutrition interventions. The indicator has worsened for contraception use by women of reproductive age, which is an important measure of family planning and a preconception intervention that has a proven impact on child mortality.

Table 12 summarizes results for key effective coverage indicators. The highlighted yellow and pink areas reveal insufficient or inadequate effective coverage where gaps remain.

Table 12: Selected effective coverage indicators across intervention packages

Indicator	BL	MP	EP	Change
ANC/PNC				
Person providing antenatal care - Doctor	77.6	93.2	89.7	12.0
No antenatal care received	3.0	1.5	1.4	-1.5
Person assisting at delivery - Doctor	75.2	86.2	86.9	11.7
Current use of contraceptives (any method)	62.7	54.5	51.9	-10.8
IMCI				
Child with suspected pneumonia taken to any appropriate HC Provider	69.5	69.5	70.8	1.3
Antibiotic treatment of suspected pneumonia		47.5	72.8	72.8
Use of ORS packet	21.2	17.7	49.2	28.0
Oral rehydration therapy with continued feeding	19.8	50.4	56.1	36.3
Knowledge of the two danger signs of pneumonia	67.2	30.4	16.7	-50.5
Nutrition				
Timely initiation of breastfeeding with 1 hour of birth	29.6	55.5	75.7	46.1
Exclusively breastfed 0-5 month old children		22.4	34.5	12.1
Percentage of households consuming adeuqately iodized salt	43.5	70.3	64.9	21.4
Percent of live births below 2500 g	5.7	5.4	5.0	-0.7
Enviromental Factors				
Use of improved drinking water	91.2	92.6	93.3	2.0

Source: Compiled by the Evaluation Team from MICS and DHS databases (1996-2014)

These positive results corroborate findings presented in Section 4.3.1 on achievements in targeting the most important "improving effective coverage" of bottlenecks and may help to explain findings presented in section 4.1 on the impacts achieved in child mortality and morbidity. According to our findings on addressing the bottlenecks, UNICEF was more successful in "improving effective coverage" for (a) interventions included in EPI, IMCI, and Nutrition packages targeting mortality and morbidity both in neonates (Nutrition) and in 1-59 month-old children; and (b) the interventions of intra partum, neonatal and post-neonatal periods included in the PNC sub-package. UNICEF was less successful with those interventions included in the ANC sub-package targeting antenatal care, where--despite some quality coverage improvements--equity gaps have widened. These findings are consistent with the BABIES analysis from the three evaluation countries, which indicates improved effective coverage for intra-partum, neonatal and post-neonatal hospital care, and slow progress in coverage for the antenatal period. Unchanged stillbirth and preterm birth rates may also support the conclusion that constraints remain in equitable effective coverage with antenatal care.

UNICEF programmes did not sufficiently support the implementation of interventions targeting congenital abnormalities, injuries and accidents which are accountable for 17% of neonatal deaths and 12% of deaths of children 1-59 months, respectively. Deaths from these causes declined at a lower rate than for causes targeted by UNICEF's programmes. There may be two explanations for this:

[80] Only data on crude coverage is available in the evaluation countries

In general, mortality due to congenital abnormalities and injuries is more difficult to prevent and is less amenable to health interventions; and 2) effective coverage with relevant interventions was inadequate (i.e. folic acid and multi-micronutrient supplementation in preconception and pregnancy for preventing congenital abnormalities). Findings partially corroborated the second explanation that revealed gaps in effective coverage by antenatal services. At the same time, BABIES data from the three evaluation countries showed notable improvements in intervention coverage aimed at mothers' health and pregnancy care. As suggested by WHO,[81] country-specific documents showed that donor support aimed at improved mother's health and pre-pregnancy care focused on: a) promotion of family planning and contraceptive use, which declined from 2000; b) assessment and management of STIs; c) HIV prevention; and d) balanced diet, including iodized salt. Consequently, significant donor support, particularly from UNFPA and UNICEF, and general socio-economic developments most likely contributed to these improvements. However, there was a failure to adequately address such important causes of neonatal deaths as congenital anomalies.

4.4 EFFICIENCY OF UNICEF PROGRAMMES IN THE EVALUATED COUNTRIES

This section looks at some of the dimensions of efficiency in UNICEF-supported programmes in the countries evaluated, and attempts to answer two questions requested by UNICEF:

EQ16. Has the allocation of resources for UNICEF-supported programmes been done in the most cost-benefit manner?

EQ19. Was programme implementation appropriately monitored and evaluated, and how were the results used?

Due to data limitations, during the inception stage of the assignment the ET suggested not to evaluate two other questions, EQ17 and EQ18:

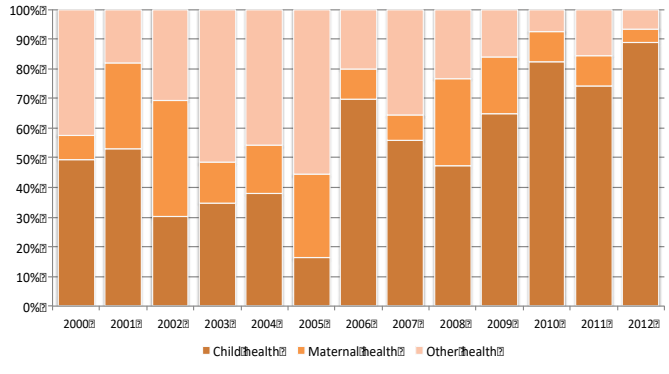
EQ17. Have UNICEF budgets and resources been adequately used to address priority bottlenecks? In other words, could we have the same programme results with fewer resources (economic and technical efficiency)? **Not Evaluated**

EQ18. Was the programme implemented according to the initial timeline? Were there delays in implementation and what were the reasons for that? **Not Evaluated**

To answer EQ.16, we looked at different data sources, using the OECD DAC database to evaluate the overall allocation of resources for MNCH programmes within UNICEF's health portfolio. Results are presented in Figure 29. According to the ODA database, overall reported spending on health programmes in the five countries during the period 2000-2012 amounted to $19.4 million, out of which $13.2 million was spent on MNCH. Over time, UNICEF devoted a greater share of its health resources to MNCH interventions.

Over all, health-related ODA allocations have grown at a significant pace in the past decade (see Figure 32). MNCH allocations in the five countries were on average 7.8% of the total ODA spending on health. Since UNICEF focuses on children, they managed to secure 11% of all ODA MNCH spending for these countries.

Figure 31: UNICEF expenditures on health in five countries



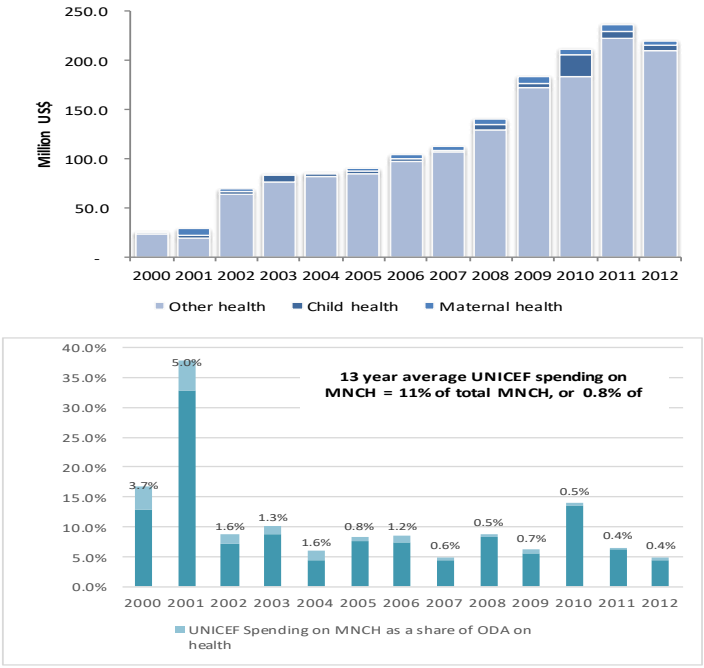
Source: OECD DAC Database 2014

However, UNICEF Country Offices (CO) in the evaluation countries report far greater figures spent on MNCH services during the period 2000-2012, or approximately $46 million. When trying to understand

and Newborn Health. Second edition.

how these funds were spent, the ET faced challenges because the existing financial data coding and storage systems used by UNICEF did not allow the ET to capture detailed information on resources consumed by staff and consultant costs. This limited our ability to attribute labour costs to certain interventions. Activity-specific detailed financial data was only available from AWP/RWPs, which are planning rather than accounting tools. The financial data did permit the ET to compare resource allocation across UNICEF programmes supporting delivery of intervention packages in the evaluation countries (as presented earlier). However, this did not lead to any conclusions on costs and benefits, or on economic or technical efficiency. Nevertheless, some conclusions were made on resource allocations across priority bottlenecks in scaling up these interventions.

Figure 32 UNICEF investments and ODA assistance to health in the evaluated countries, 2000-2012



Source: OECD DAC Database 2014

Additionally, data was not available for EQ18, as annual reports and MTR do not systematically reflect these data, and the timeliness of selected activities is reported only sporadically. The sheer number and complexity of programme activities supported by UNICEF does not allow for summary judgments on the timeliness and efficiency of implementation, for example for standalone projects with defined implementation timelines. Furthermore, UNICEF programmes have faced diverse challenges, from conflicts and security disruptions to the imposition of presidential veto on laws promoted by UNICEF. These factors were so country-specific that it was impossible to systematise them or detect an overall trend about timeliness in order to draw lessons.

4.4.1 RESOURCE ALLOCATIONS OF UNICEF-SUPPORTED PROGRAMMES

Resource allocations of UNICEF-supported programmes were analysed using financial data from UNICEF, assuming total allocations of $46 million in the evaluation countries over the evaluation period. When looking at the distribution of the financial resources spent by UNICEF on MNCH activities, it is apparent that the IMCI and ANC/PNC packages were the most supported, with 32.2% and 28.4% of financial resources respectively. Nutrition interventions followed, with 24.7%, and EPI received the least financial support at 14.7% (see

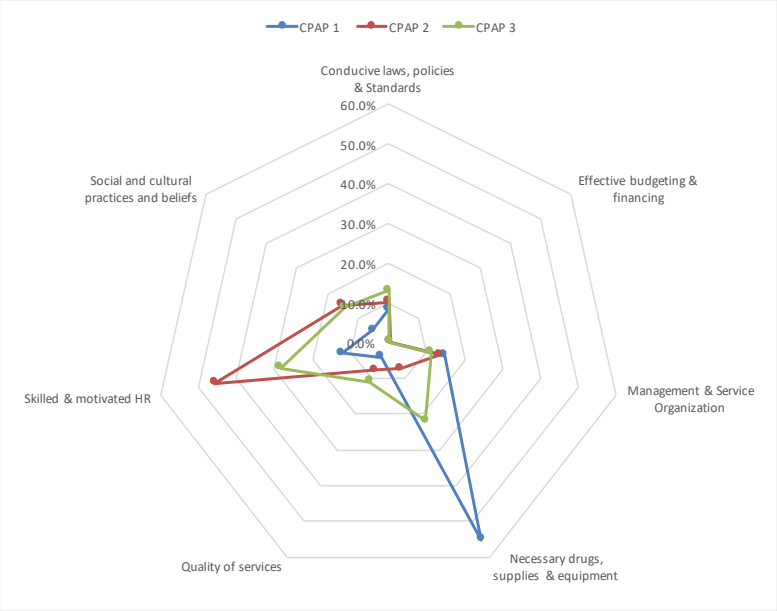
Table 13). Most resources were spent on skilled and motivated staff (31%), followed by necessary drugs and supplies (23.4%). However, the distribution of resources within the intervention packages varied significantly. ANC/PNC and IMCI consumed most of the resources spent on skilled and motivated staff, while nutrition interventions consumed the highest amount (7.3%) for drugs and necessary supplies. Spending levels for other packages were lower. EPI received the lowest share (5.1%). (See Table 13) Management and service organization and social and cultural practices were the next most important areas, and received 12.8% and 12.6% respectively. The smallest amount of resources was devoted to the improvement of effective budgeting and financing (0.5%). UNICEF resource allocations across CPAP periods show that more than half of all resources (55%) were expended on necessary drugs and supplies during the first CPAP cycle. This decreased dramatically in the second CPAP to 7% of all UNICEF resources in the same period. The change coincided with UNICEF's transition from humanitarian and downstream projects to upstream programming in the countries evaluated. The increase in relative spending (up to 21% of all funds) on this determinant in

the third CPAP period is associated with supporting EPI programmes in Uzbekistan (polio emergency) and Moldova (measles outbreak), and providing necessary inputs for large-scale pilots under ANC/PNC and Nutrition packages in Kyrgyzstan, Moldova and Uzbekistan.

Table 13 Resource allocation by intervention package and MoRES Determinants

Intervention Packages	Conducive laws, policies, standards & social norms	Management & Service Organization	Effective budgeting & financing	Skilled & motivated HR	Necessary drugs, supplies & equipment	Social and cultural practices and beliefs	Quality of services	Grand Total
ANC/PNC	2.5%	3.7%	0.3%	12.2%	5.6%	1.0%	3.2%	28.4%
EPI	0.9%	3.0%	0.1%	2.9%	5.1%	1.9%	0.9%	14.7%
IMCI	5.0%	2.4%	0.1%	11.8%	5.9%	5.6%	1.4%	32.2%
NUTRITION	2.6%	3.8%	0.0%	4.1%	7.3%	4.1%	2.7%	24.7%
Grand Total	**11.0%**	**12.8%**	**0.5%**	**31.0%**	**23.9%**	**12.6%**	**8.2%**	**100.0%**

Figure 33: Resource allocation by MoRES Determinants and CPAP cycles

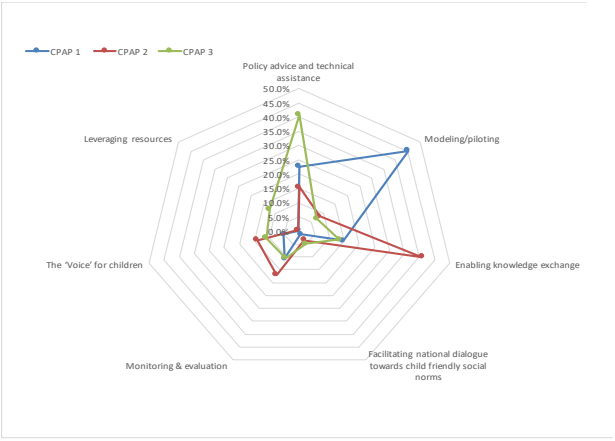


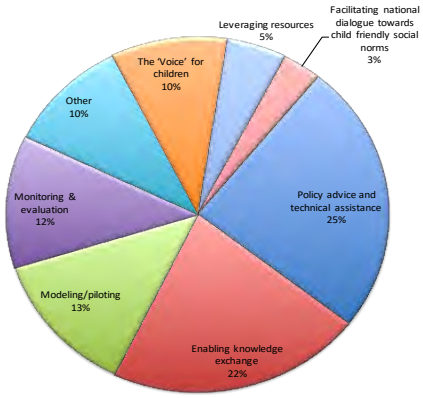
The resources spent on quality of services (8.3%) were unequally distributed among intervention packages. ANC/PNC and Nutrition consumed the lion's share while IMCI and EPI received much smaller amounts. When funding allocated towards the bottlenecks was correlated with bottleneck frequencies [see chart where priority bottlenecks are listed in Figure 23 on page 45], we noted a weak, but statistically significant, positive correlation (*r=0.30, p<0.01)*. However, the reliability of these findings is weak, as the ET did not rate the quality of the financial data as adequate (see ANNEX 14).

The ET also looked at resource allocation by UNICEF's core roles, which were retrofitted to the activities listed in the annual work plans. This analysis is presented in Figure 31, showing that during the first CPAP cycle the largest amount of resources was spent on "modelling/piloting" (45%). The second CPAP was dominated by spending on "enabling knowledge exchange" (41%), while in the last cycle UNICEF dedicated most resources to "policy advice and technical assistance" (41%).

These findings indicate that UNICEF was gradually shifting its core roles to support the systemic and community change cycles in the evaluated countries from demonstration (modelling) to learning (knowledge exchange through trainings, study tours, etc.), to institutionalisation (through policy advice and technical assistance).

Figure 34 Resourcing core roles for the evaluated period and by CPAP cycles





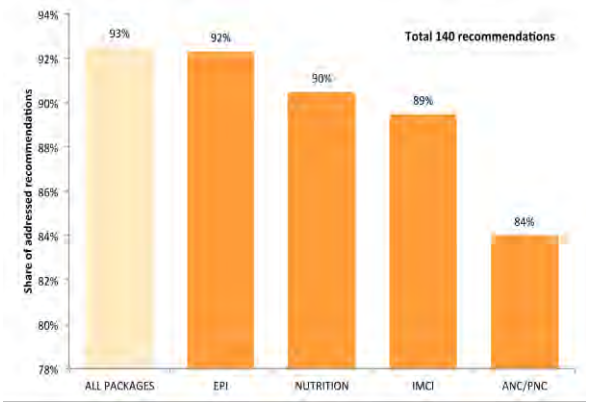
Over the entire evaluation period, UNICEF devoted most resources to policy advice and technical assistance. All funds spent on this core role were primarily used for developing skilled and motivated staff (8.14%), developing conducive laws, policies and norms (7.94%), and improving management and service organization (4.22%) (data are not shown).

The next-best-resourced core role was "enabling knowledge exchange" (22%). Out of this amount, the largest share (19.7%) went to developing skilled and motivated staff. The resources used for modelling (13%) went mainly to finance necessary drugs, supplies, and equipment for the pilot sites (8.95%). Relatively modest amounts were devoted to the development of skilled and motivated staff (1.83%) and improving the management and service organization necessary for piloting (1.24%).

4.4.2 MONITORING AND EVALUTION OF UNICEF-SUPPORTED PROGRAMMES

UNICEF used different tools and approaches to closely monitor programme implementation. Annual progress reports outlined main results/achievements under each programmatic area, resources mobilized and utilized, future plans as well as challenges faced during implementation. Although implementation problems were well documented, corrective measures were less-addressed. Furthermore, in the first half of the evaluation period, annual progress reports results were more output-based, while later, after UNICEF's introduction of Results-Based Management Practices, program/project-related indicators were measured and recorded. The design of ongoing and new country programmes was largely informed by the annual reporting along with Mid Term Reviews (MTR).

Figure 35: Share of evaluation recommendations addressed



To evaluate how effectively monitoring informed the program/CPAP adjustments, we analysed UNICEF country programme Mid Term Reviews (MTR) and some project specific evaluation reports, which provided an initial list of 140 recommendations included in these documents. Further desk review of documents, including management responses to recommendations and the respective action plans and in-country interviews helped identify the share of recommendations addressed by UNICEF during implementation. Further**Error! Reference source not found.** details the results of our analysis, which reveal that UNICEF acted on nine out of ten recommendations. ANC/PNC-related recommendations showed the lowest rate (84%), compared to other packages. However even 84% is a significantly high rate, and confirms that UNICEF was attentive to the findings of the reviews and/or evaluations, and considered them in its programme work.

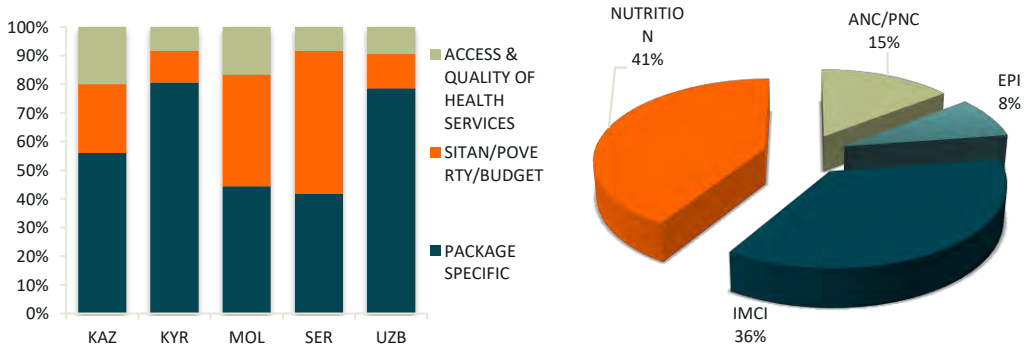
According to key informants in all evaluated countries, UNICEF was instrumental in building local capacities for implementation of MICS and DHS studies, institutionalization of DevInfo in state statistical offices as well as building local technical capacity in implementation of situation analysis, programme-specific evaluations and studies.

During the evaluation period over 150 studies and research projects were completed out of which 64% were programme-related (baseline, MTR, evaluations) and 23% of the studies were situation analyses of women and children, marginalized groups, child poverty, financing for health and social sectors, etc. Up to 13% examined the access and quality of health services.

> "UNICEF has a bottom-up approach, identifies problems at the lowest level and addresses them in a systematic way. UNICEF always looks for evidence, their every step is justified by best practices; during piloting continuous assessments and learningexercises were done that guided their further actions." ***Source: key informant, partner organization, Moldova***

The highest shares of specific intervention package research were noted in Uzbekistan and Kyrgyzstan, whereas studies devoted to MCH situation analysis and poverty were higher in Serbia and Moldova. Research resources were divided as follows: 41% of package-specific research was devoted to the nutrition intervention package and looked at micronutrient deficiency, iodized salt and fortified flour markets, and utilization levels, etc.; 36% was related to the assessment of the IMCI package implementation, KAP of parents on child rearing and feeding practices, ECD, etc.; 15% of the studies under the ANC/PNC package assessed maternal, infant and child mortality and evaluated implementation of ILBD, birth registration and PMTCT interventions. The lowest share of studies were carried out for the EPI package and the mostly assessed cold chain (Kazakhstan, Kyrgyzstan, Serbia) and vaccine management (Uzbekistan), safe immunization practices (Moldova), and KAP of population and health workers on routine immunization practices (Moldova, Kyrgyzstan).

Figure 36: Research, studies and evaluations performed during the evaluation period



Findings and results of these activities largely informed UNICEF's advocacy and programming efforts and facilitated systemic changes in evaluation countries. Good examples of how the research findings influenced government and policy maker decisions are discussed in the following section.

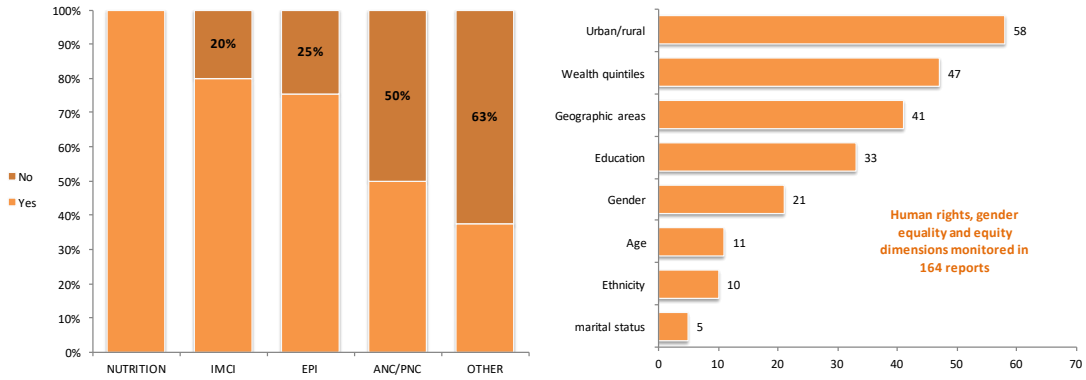
To evaluate human rights-based, gender equality and equity monitoring practices, the desk review identified 162 study/survey reports produced over the evaluation period, which were to be used to monitor human rights based, gender equality and equity dimensions of the programme implementation. Out of these documents, fourteen had no relevance to rights-based, gender and equity issues (e.g. cold chain assessment, assessment of the quality of different services at a facility level, or cost-benefit analysis of food fortification, etc.). The evaluation team was unable to locate 49 out of the remaining 148 documents (33%), as they were missing from UNICEF country libraries. Consequently, only 99 reports were analysed to inform our findings, which was an adequate sample size for the ET. Figure 37 (on the left side) presents the share of the documents that have monitored rights-based, gender and equity dimensions for a given

> "…. proof of the effectiveness of any proposed changes through studies and evaluations, as UNICEF does, is critical for integrating changes at the system level …."
>
> ***Source: Key informant, partner***

"intervention package". Nutrition-related studies closely monitored inequities, including those attributed to the rights-based approach (the poor and deprived ethnic groups) and to gender.

For ANC/PNC interventions, only half of the studies looked at the data through these lenses. The "other" group refers to the documents that are not relevant for a specific "intervention package" but were crosscutting in nature. The equity focus was lacking in at least two out of every three reports.

Figure 37 Monitoring human rights, gender equality and equity indicators by UNICEF



We also conducted a content analysis on the reports addressing equity issues to see which human rights based, gender equality and equity dimensions were most frequently monitored by UNICEF. The findings are detailed in Figure 37 (on the right hand side), showing that the most frequently evaluated dimensions were urban-rural differences, wealth related inequalities, and sub-national/regional differences, followed by education and gender. Age, ethnicity, and marital status received less attention in the documents--and consequently in UNICEF's monitoring of human rights--than gender equality and equity.

4.5 SUSTAINABILITY OF UNICEF'S PROGRAMMES IN THE EVALUATION COUNTRIES

The sustainability of donor-supported public health interventions by incorporating them into national policies and budgets was, and remains, a critical issue for the development community.

Consequently, evaluating the sustainability of UNICEF's support was a critical part of this work. However, due to the scale and scope of the evaluation, looking at specific programme elements and/or evaluating the sustainability of each project was neither feasible nor necessary. Consequently, the evaluation team looked at two critical domains: a) the sustainability of "intervention packages" supported by UNICEF and by other donors (where plausible attribution to UNICEF support was possible with the help of a contribution score); and b) the sustainability of pilots supported by UNICEF, where UNICEF was the only player to initiate pilots with the government--and to eventually scale up with or without support from other partners.

> "UNICEF's advocacy, for example for anaemia prevention and technical support, the Presidential Decree on folic acid, iodine and vitamin A supplementation for all pregnant women and children, was approved. Starting from 2010 the supplements were introduced nationwide and are provided free of charge twice during pregnancy to women in rural areas."
>
> ***Source: Key Government informant, Uzbekistan***

Consequently, in this section we describe evaluation findings that answer EQ.20 to EQ.26:

EQ.20 Are UNICEF-supported programmes integrated into national policies and budgets?

EQ.21 Have UNICEF-developed models/pilots been scaled up and incorporated into national policies and/or systems?

EQ.22 Have UNICEF-assisted programmes been successful in leveraging resources and partnerships?

EQ.23 What was the return on investment ratio? What additional funding to MNCH-focused interventions was promoted through UNICEF programme(s)?

EQ.24 Do the programmes continue after the conclusion of UNICEF support?

EQ.25 What were the critical elements that made the programme sustainable (or which did not make it sustainable)?

"UNICEF's assistance was crucial in opening "Nutrition" chairs in all medical institutes and universities which teach breastfeeding and issues related to the control of micro deficiency disorders. These themes are also included in the postgraduate education system… The centre of Healthy Feeding has been opened on a national level financed by local budgets, and will be in charge of education for medical personnel." ***Source: Key Government informant, Kazakhstan***

"Based on UNICEF's advocacy and technical support, a Presidential Decree on folic acid, iodine and vitamin A supplementation for all pregnant women and children was approved. Starting from 2010, supplementation was introduced nationwide and supplements are provided free of charge twice during pregnancy to pregnant women in rural areas". ***Source: Key Government informant. Uzbekistan***

EQ.26 Are other partners supporting MNCH programmes supported by UNICEF?

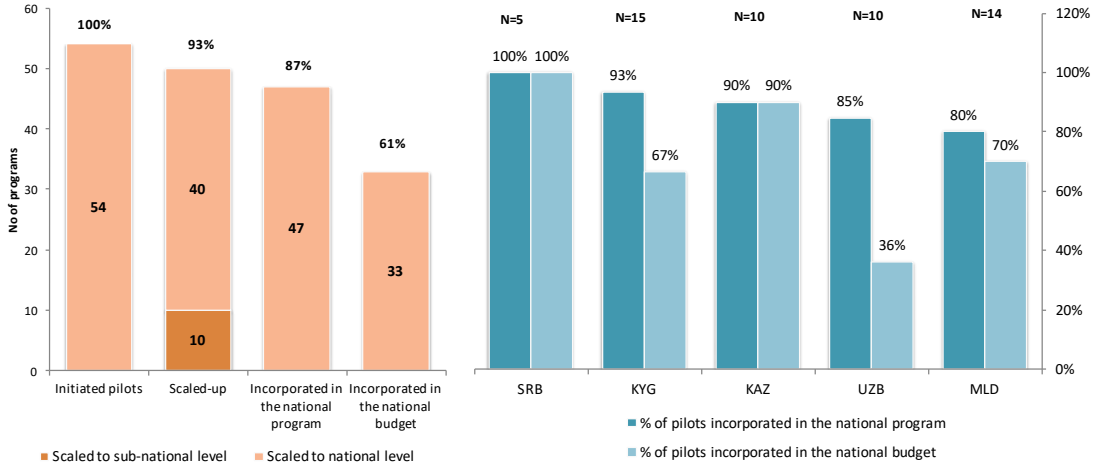
Overall, the document review and interviews helped to identify fifty-four pilot programmes that could be traced from piloting to scale-up and were initiated and supported by UNICEF over the evaluation period. Obviously, this number does not include initiatives that are still in a pilot phase. Out of these pilots, 93%--or 50 programmes--were taken to a scale (see

Figure 38 for more details), either on a sub-national level (n=10) or nationally (n=40). Eventually, 87% of the pilots were incorporated into national policies and programmes, and 61% were incorporated into the national budgets.

Looking at country experiences after scale-up (see

Figure 38 chart on right), incorporating pilots in the national policies and programmes was more successful than incorporation into national budgets. This was more challenging in poorer countries than richer. Furthermore, the low rate of programme incorporation into national budgets across the five countries (61%), was largely driven by an outlier i.e. the lowest rate found in Uzbekistan, while other poorer countries were relatively more successful in assuming programme support by the national budget.

Figure 38 Piloting and scaling up UNICEF-supported interventions



In addition to national resources, UNICEF actively leveraged additional resources from other development partners and the private sector. Examples of UNICEF efforts are detailed in Text Box 4 on page 66 and ANNEX 11, which describes 77 cases of UNICEF's attempts to leverage resources, out of which most were concluded successfully. As a result, leveraged funds from the development partners

and private sector matched or exceeded UNICEF's own investments (the examples presented in ANNEX 11 alone amount to over $45 million).[82]

"UNICEF's role in strengthening EPI services in the country and assisting the public procurement of vaccines through UNICEF channels is one kind of the valuable assistance received".

"With UNICEF's support, NR has been scaled up nationally. NR is included in undergraduate, postgraduate and CME programmes. Faculty members were trained at universities and colleges, and the regional training capacity was built for CME. However the funding of CME trainings still remains externally financed (UNICEF/EU)." ***Source: Key Government informant, Uzbekistan***

"*Hallo baby*, a telephone consultation service, started in Belgrade in 2001 and is gradually expanding. At present, telephone-counselling services exist in 16 Dom Zdravljas. Since 2014 *Hallo Baby* in Belgrade is financed by the health insurance fund and is fully integrated in the system." ***Source: Key informants, Belgrade Public Health Institute, Serbia***

Considerably higher amounts were leveraged from national governments in those countries where MNCH services were included in the BBPs (Kazakhstan, Moldova, Serbia). Leveraging permitted effective scale-up of pilots and assured the national rollout of UNICEF initiated and/or supported programmes. This likely created strong pre-conditions for sustainability. While the evaluation was able to collect strong qualitative evidence of leveraging efforts, it was impossible to obtain reliable monetary figures. This limited our ability to evaluate the return on investment. However, the ET considers that, overall, UNICEF's own investments in the MNCH sector had a high return, for two reasons. (a) The results achieved in addressing effective coverage bottlenecks with a major or significant contribution from UNICEF look impressive, considering that UNICEF investments in MNCH accounted for less than 8% of ODA spending in MNCH and less than 1% of the overall ODA spending on health. (b) The majority of key informants in all the evaluation countries who represented partner governments or leading development partners invariably assessed UNICEF's role as leading in MNCH, or--in some cases--in broader health system reforms.

Text Box 4: Successful Leveraging in Kyrgyzstan

In Kyrgyzstan the Sector Wide Approach (SWAp) – a new form of cooperation between the Government and donors – was established in 2006. Government and donor funds raised at the national level support priorities in the health sector strategy. In Kyrgyzstan, considerable assistance has been provided by donors such as the WB, KfW, DfID, SDC, GIZ, Sida, Global Fund, GAVI, UN Agencies, WHO, USAID and ADB as pooled budget support or parallel financing. UNICEF became a leading partner of the SWAp MNCH group at the end of 2007, and has played a strategic role since then in coordinating donors, as well as planning and leveraging resources to fill existing gaps in MCH financing. The SWAp MNCH group is regarded as the most successful SWAp working group. The Joint Annual Review of the SWAp in 2010 highlighted the strategic role of UNICEF in the process, especially through the integration of maternal and child health as a priority of health sector reform **(Voice; Facilitate National dialogue)**.

Examples of how the UNICEF-led SWAp MNCH group helped to formulate priorities for donor-supported programmes (Leveraging) include:

- WB support to results-based financing in perinatal care and child health ($11 million);
- KFW support to improvement of quality of medical services for newborns (4.6 million Euros);
- GTZ support to improvement of quality of medical services based in maternity hospitals (a total of $2 million over 2 years); and
- In 2011, the MNCH Working Group under the SWAp headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for a child nutrition programme.

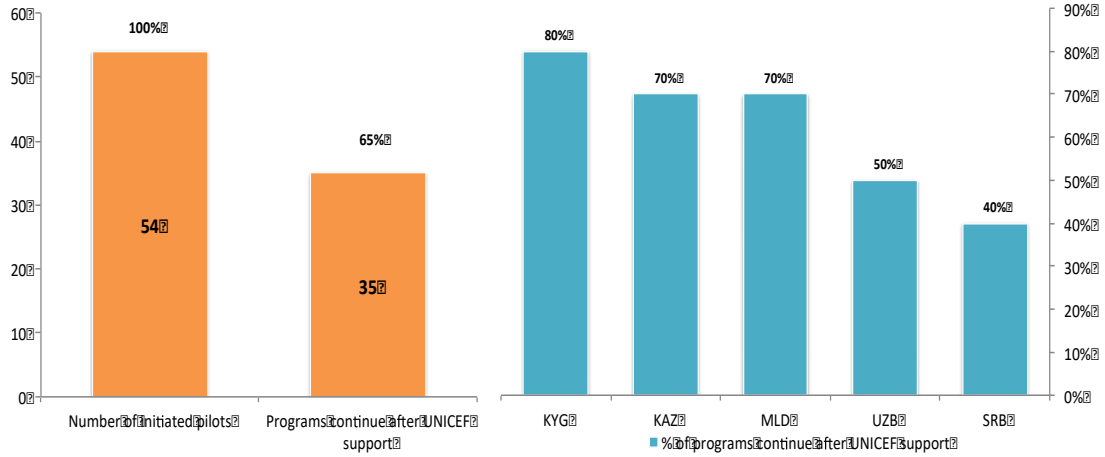
Partners and the Government acknowledge the strategic role of UNICEF in coordinating the process, mobilizing resources and turning maternal and child health into a key priority of the Kyrgyz health reform process.

Looking at the pilot experiences the ET noted that almost two out of every three programmes supported by UNICEF continued, supported by the governments after UNICEF support ceased (see Figure 39). This indicator is even higher in a sizable sub-sample of the evaluation countries, where

[82]However,the long recall period of the evaluation could possibly impose bias on these findings, as *unsuccessful* efforts were not well documented by UNICEF but were mostly recalled by respondents.

seven or eight out of every ten programmes continue to be fully supported and sustained by the governments. The seemingly low proportion of pilots that continued after UNICEF's support ended can be explained by the fact that two out of five pilots are still ongoing and it is too early to assess their sustainability.

Figure 39 Sustainability after UNICEF withdrawals



When evaluating sustainability, we looked at both fiscal and programmatic sustainability--including the non-fiscal capacity of the government to ensure continuity of activities and services in the long run.

Non-fiscal capacity includes social, political, structural, and technical capabilities, which are critical for sustaining and delivering public health interventions at scale. The document review and interviews helped to single out critical factors that most likely contributed to achieving sustainability for most interventions that were supported by UNICEF (alone or in partnership). These factors included:

> "UNICEF's approach to implementing changes at the systemic level, such as curricula update in undergraduate and postgraduate education, is key for the sustainability of changes." ***Source: Key informant, Partners organization,*** **Moldova**

A. **Achieving fiscal sustainability** was a priority focus in UNICEF programming rather than an afterthought, which is common for many donors.[83] For example, in terms of EPI supplies, UNICEF played a significant role in purchasing and supplying vaccines and cold-chain inputs in the early years, but gradually helped to shift the responsibility for routine vaccine purchases onto government budgets. Similarly, with the help of costing and other sponsored studies, UNICEF worked with the governments to ensure that ANC/PNC care and IMCI services and necessary inputs became part of the *Guaranteed Benefit Package* (GBP) paid by the government and delivered at no cost or with marginal co-payment to the population. Moreover, most micronutrient supplementation and food fortification programmes shifted to the government and local economy without significant financial dependence on UNICEF. Consequently, although during early years close to 67% of UNICEF support was spent on necessary drugs, supplies and equipment, during the latter years the focus shifted towards the provision of technical assistance for human resource development, management and service organization and service quality improvement. Thus, UNICEF **transitioned from project/programme support to technical support.**

B. **Political support, which translated into policy, regulatory and legal change**. Generating political support and investing heavily with the government were key elements throughout the programmes during the evaluation period. UNICEF made informed and upfront investments of

[83] Due to global financial challenges, many donors e.g. GFATM, PEPFAR, decided to "graduate" countries from their support without adequate preparatory work being undertaken prior to graduation. Consequently, graduation from and sustainability of donor support programmes are gaining significant attention.

time and resources to generate political support that eventually led to the necessary policy, regulatory and legal changes. Consequently, close to 11% of all resources spent by UNICEF on MNCH were dedicated towards generating political support and enacting conducive laws, policies, and regulatory standards. One of the most vivid examples of their success in generating political support is described in Text Box 5.

C. **Balancing flexibility/adaptability with the need for standardisation**. UNICEF effectively employed the piloting-monitoring/evaluating-learning-adjusting and advocacy continuum, which helped to adapt intervention packages to each country context. UNICEF used emerging learning from pilots to develop service/care/intervention standards, subsequently reflected in national laws and regulations. For example, in all five countries, UNICEF alone or in partnership with other development agencies, helped countries adopt new clinical guidelines and define service organization and provision standards, including monitoring systems (e.g. for EPI, IMCI, ANC/PNC, Nutrition and food fortification, BABIES, ILBD, BFHI, etc).

Text Box 5: Generating Political Support for Flour Fortification in Kazakhstan

UNICEF was a critical player in promoting food fortification in the evaluation countries. Amongst other things, UNICEF played a key role in generating evidence of and advocating for the need of food fortification in front of national government and food producers, representing the public and private sectors.

In Kazakhstan, UNICEF supported the development of legislation on mandatory flour fortification with iron and folic acid. To promote the development and adoption of the law, UNICEF financed cost-benefit and cost-efficiency analyses of food fortification and used the findings in its advocacy efforts. All of this led to preparing a law on mandatory flour fortification, which had been opposed by certain groups. To counteract this opposition, UNICEF collaborated with the Kazakh Academy of Nutrition and ADB to renew advocacy and communication activities, using meetings with stakeholders, interviews and press conferences. They also disseminated information kits on the benefits of food fortification on the health of pregnant women and young children. Key audiences were senators, government officials, state agency heads, NGO leaders, media editors and journalists. Messages were delivered at special events, including high-profile conferences in the Senate and involving UNICEF's Goodwill Ambassador on Nutrition. In spite of all the efforts, the President vetoed the mandatory flour fortification component of a new law on 'Food Safety', which was passed by Parliament in May 2007. Undoubtedly, this hampered implementation. However, further acceleration of advocacy efforts and greater mobilization of supporters, especially politicians in the parliament and senate, helped to convince the President. Eventually the law was passed and flour fortification became mandatory in Kazakhstan.

D. **Building and sustaining strong organizational capacity** was another priority focus for UNICEF, which helped to develop and institutionalise certain functions within government departments. These included fortified food surveillance/monitoring, disease surveillance, etc, which were reinforced by the necessary legislation and regulations. Similarly, in almost all countries, UNICEF helped to develop training materials and a core group of national trainers, then eventually transfer them to an appropriate educational institution. Currently most country governments fund this function out of the state budget. In that way, UNICEF achieved **transfer of ownership** to the host government, which is an essential precondition of sustainability.

E. **Community/stakeholder involvement** and **empowerment of change agents.** Training and empowering leading specialists and stakeholders were distinct features of UNICEF's support in all five countries. These stakeholders played a critical role in bringing contextual understanding and helping UNICEF to adapt international approaches to the local context. They also assisted the timing and pacing of implementation in a way that minimised the power of opposing voices, while increasing local acceptability. For example, ILBD introduction in Uzbekistan took a long time[84] because it was introduced slowly, alongside the old Soviet definition of a live birth. For

[84] Kyrgyzstan adopted ILBD in 2004, Moldova and Kazakhstan in 2008, while Uzbekistan officially moved to the international definition only in 2014.

several years, the country collected information using both standards. The evidence collected by UNICEF enabled change agents to mute opposition to introducing ILBD, as change would show a spike in infant mortality, which was seen as a threat due to its political sensitivity. The strategy proved effective, and finally ILBD was introduced in Uzbekistan in 2014.

Text Box 6 provides an example of the sustainable implementation of IMCI in Moldova, briefly detailing the specific steps and outcomes.

Text Box 6: Sustainable implementation of IMCI in Moldova

UNICEF's assistance supporting IMCI initiatives in Moldova was multidimensional. It addressed a)necessary national policy and legislative changes; b) training curricula and materials and delivering trainings in partnership with national institutions, including the creation of an initial cadre of national trainers from the change agents; c) costing out the necessary inputs for IMCI and advocating the government to include these inputs in the national budget; d) developing information, education and communication materials for IMCI; e) partnering with the World Bank and SDC, and leveraging resources and increasing coverage by the interventions on a national scale; and f) monitoring progress and institutionalising a monitoring and evaluation system. The outcomes span a ten-year period:

- IMCI training materials are fully integrated in the higher and post-graduate education curricula. They are continuously updated when new evidence emerges, and delivered by the national institutions funded out of state budget. This assures the continuous production of trained human resources from undergraduate and post-graduate training institutions;
- The necessary drugs for IMCI are included in the essential list of medicines, funded by the national insurance company and offered at no cost to children under five, which secures free and uninterrupted access to drugs for children in need;
- Medical providers throughout the country have accepted IMCI as an approach to treat and care for ill children, and all facilities follow this approach when delivering services. Staff and all other inputs needed to maintain the continuous delivery of services are fully funded out of national sources;
- IMCI-related indicators have become part of the PHC provider performance monitoring and performance-based incentive payments used by the national insurance company. They include a set of indicators related to IMCI, which allows for continuous tracking of the service provision on a facility level;
- Information, education, and communication materials developed with UNICEF support are available in almost all PHC facilities, and the authorities are reproducing these to educate the public who attend PHC facilities.

Currently UNICEF's support to IMCI in Moldova is minimal, as the government and national institutions have fully assumed most responsibilities. They continuously deliver IMCI services to the population, and all children under 5 years benefit from them. Similar trends were observed in other countries, though with diverse results.

4.6 HUMAN RIGHTS-BASED APPROACH AND GENDER EQUALITY IN UNICEF PROGRAMMES

This section of the report focuses on evaluation questions 27 to 30:

EQ.27. Were the Human Rights Based Approach to programming and Gender Equality incorporated into programme planning, implementation and evaluation?

EQ.28. Were the planning, implementation and monitoring of evaluated programmes performed in a participatory and ethical manner, with full respect to human rights and gender-specific and gender-sensitive issues?

EQ.29. Did the programme(s) pay attention to the effects of these on marginalized, vulnerable and hard-to-reach groups?

EQ.30. How were gender issues integrated as a crosscutting theme in programming, and did the programme(s) give sufficient attention to promoting gender equality and gender-sensitivity?

To answer these questions, we initially conducted an extensive desk review with the help of a specifically designated consultant. The results of the analysis were eventually validated with the key informants during the country visits. The outcomes related to EQ.27 are detailed in

Table 14, and reveal that human rights-based programming was present to some degree in all phases of UNICEF-supported MNCH programmes. However, gender issues were largely lacking in the field of MNCH, although they featured prominently in the education and child protection parts of UNICEF's work.

Table 14 Human rights-based approaches and gender equality issues in UNICEF programmes

	KAZ	KYG	MLD	SRB*	UZB
Planning phase					
Human rights-based approaches	Yes	Partial	Partial	Partial	Partial
Gender equality issues	Partial	Partial	No	No	No
Implementation phase					
Human rights-based approaches	Partial	Partial	Partial	Partial	Partial
Gender equality issues	No	No	No	No	No
Evaluation phase					
Human rights-based approaches	Partial	No	Partial	Partial	Partial
Gender equality issues	Partial	No	Partial	No	No

* In Serbia the HRBA was well reflected for Roma minorities at all phases

The human rights-based approach was not explicit in MNCH programming, although the programmes did implicitly or explicitly declare the goal of ensuring rights to survival, development, and growth. Consequently, these rights were to be realised through several critical interventions across the life cycle. Examples include: improvements in birth registration as one of the fundamental means for realising a child's rights; the introduction of the WHO live birth definition to enable better tracking of lost children and saving more lives; and the promotion of essential newborn care packages, IMCI, PMTCT, breastfeeding and universal salt iodization and flour fortification. Rights-based programming was more pronounced in HIV/AIDS programmes and for children infected with HIV.

UNICEF used a lifecycle approach in its programmes, which implies the right to survival, growth, and development for particularly vulnerable children (up to the age of five years). However, UNICEF did not clearly define vulnerability, and consequently could not clearly specify or monitor MNCH interventions focused on the most vulnerable.

Text Box 7: A sample quote about vulnerability

> ... Children remain a particularly vulnerable group. They consistently face a higher risk of poverty than adults do, and certain areas of well being for children still require great improvements. Equity is a concern, with stark differences persisting between different groups of children in the country, particularly between those living in different regions. Further efforts are required to focus on-going social policy reforms on the rights and needs of children from the most vulnerable groups and those living in poverty. UNICEF Document.

"Vulnerability" is a term widely used in UNICEF vocabulary, programme documents and reports. Women and children in general terms are considered vulnerable parts of the population (Text Box 1). UNICEF documents also use terms like "especially vulnerable" and "particularly vulnerable" or "most highly vulnerable" when describing a group with distinctive features. A sample description of vulnerability is presented in Text Box 7. Consequently, "vulnerability" in the MNCH programme and evaluation documents is used as a general term, without a clear definition or identification of population groups to whom this term applies in a given country context. Therefore, MNCH programmes supported by UNICEF largely failed to define these groups for programmatic purposes or to focus MNCH interventions on these groups where necessary.

UNICEF documents do not often use the term "marginalised", however, when mentioned, the term mainly describes women using drugs, homeless people or migrants. It is rarely used for children. "Hard-to-reach populations", although mentioned, are similarly not well defined. Most importantly, the toolbox of UNICEF health programme managers is not rich in guidance on which interventions to use or how to deliver them to these groups, if and when they are identified.

As described in Figure 37 on page 64, UNICEF monitored "equity", although differently for different packages and with different levels of attention to the various equity dimensions. These findings were presented earlier and will not be repeated here.

As a cross-cutting theme, gender equality was implemented in a significant proportion of UNICEF country interventions but restricted to educational activities. Very few, if any, were found in the area of MNCH. While UNICEF was one of the first UN agencies to have a clearly defined gender mainstreaming policy--unique in combining a focus on increased equality in programming with a life cycle and rights-based approach--a UNICEF global evaluation conducted in 2008 found that these

policies were not systematically implemented.[85] Most likely the findings of this evaluation triggered country programme gender assessments, implemented in 2009/10. These assessments eventually led to the UNICEF Regional Office adopting a comprehensive approach to operationalise the corporate Strategic Priority Action Plan for organisational transformation on gender equality in CEE/CIS.[86] This triggered processes at the country level. Consequently the country programmes began to focus more on gender disparities and gender mainstreaming in line with the regional and global guidance. In the earlier programmes, the ET had noted that gender equality issues were not duly reflected in the MNCH component, and that gender parity issues were mainly restricted to the education part of UNICEF's programme portfolio.

Although gender-focused and gender-sensitive programming was largely lacking, UNICEF facilitated gender disaggregated data collection and reporting through the surveys. However, the evaluation team only found that gender disaggregated data analysis informed MNCH-related interventions in 21 out of the 99 reports it analysed.

[85] *Evaluation of Gender Policy Implementation in UNICEF*. United Nations Children's Fund, New York, 2008

[86] Regional analysis report 2010. Regional office for Central and Eastern Europe and Commonwealth of Independent States (CEE/CIS). Geneva, February 2011.

CHAPTER 5. EVALUATION CONCLUSIONS AND LESSONS LEARNED

In this section of the Report, we summarise the evaluation conclusions and present them in sub-sections referring to the seven evaluation criteria: *impact, relevance, effectiveness, efficiency, sustainability, human rights approach and gender*. Under each sub-section, the conclusions are constructed as answers to the specific evaluation questions. The key lessons learned from the evaluation are presented in a separate subsection.

5.1 IMPACT ON HEALTH STATUS OF CHILDREN IN CEE/CIS AND THE EVALUATION COUNTRIES

EQ1. There was a positive change in the reduction of infant and under-five mortality and morbidity over the period 2000 to 2012.

During the evaluated period, U5MR declined by 47.9% in CEE/CIS and by 48.4% in the evaluated countries, outpacing the global trend in child mortality decline and creating good prospects for achievement of the MDG4 target.[87] This progress was more prominent in the reduction of deaths among 1-59 month-old children than for neonates, with reduction rates of 58% and 42% respectively. Due to the reductions achieved in IMR and U5MR, more than **193,000** under-five year old children in the evaluation countries were saved in the period 2000-2013.

Furthermore, during the evaluated period a positive trend was observed in the declining incidence of ARI, DD, pneumonia and influenza in the CEE/CIS. In the evaluation countries, the incidence of DD plunged by 72% and acute respiratory infections, pneumonia and influenza by 55%, among children under five. However, trends in key indicators of child health – stunting and underweight prevalence rates – for the evaluated period were either inconsistent for stunting prevalence, or it was impossible to establish the statistical significance of the slight decline observed in underweight prevalence.

EQ2. The trends in these key child health indicators across geographical, ethnic, gender and other socio-economic stratifiers in the CEE/CIS and the evaluation countries were uneven.

While declines in U5MR and IMR were observed in all countries of the CEE/CIS region, the pace and size of reductions differed: The CEE and the European part of the CIS were more successful in reducing child mortality rates, while others – most of the Central Asia and Caucasus countries, except Kazakhstan – reported lower rates of decline. The evaluated countries mirror this trend: the average annual rate of reduction was the highest and the resulting child morality indicators were the lowest in Serbia and Kazakhstan, with Uzbekistan showing the least positive trend. Along with inter-country differences, significant *geographical* intra-country differences for the key child health indicators are evident throughout the CEE/CIS[88] and in the evaluation countries. For example, in Kazakhstan, Kyrgyzstan and Uzbekistan some regions fared distinctly better in reducing the child mortality rates than others. Urban/rural inequity has slightly declined for both U5MR and IMR in the evaluation countries, however the statistical significance of this decline is unknown. IMR rates for infants born to richer and better-educated mothers fell at a higher rate and as a result, *education*- and *wealth*-related equity ratios worsened: in IMR they widened across the evaluation countries, while the U5MR equity gap remained unchanged. The CEE/CIS region overall, and Kyrgyzstan, Kazakhstan and Moldova in particular, did manage to reduce *gender* inequity gaps over the period 2000-2012. However, Uzbekistan largely failed to address gender inequities, and the gap that existed 15 years ago remains almost unchanged. Child health improvement was much slower for deprived *ethnic* groups (for example Roma in Serbia) and for other marginalised population groups in some countries, such as migrant workers.[89] At the same time, the elimination of education- and wealth-related gaps in stunting and malnutrition prevalence found in the evaluation countries may indicate a strong positive trend in this area for the CEE/CIS. It is notable that most of

[87] MDG 4: Reduce child mortality

[88] TransMonEE (Transformative Monitoring for Enhanced Equity) database at www.transmonee.org

[89] Child Well-Being at a Crossroads: Evolving challenges in Central and Eastern Europe and the Commonwealth of Independent States. Innocenti Social Monitor 2009. UNICEF

the trends for these key child health indicators in the CEE/CIS and the evaluation countries are consistent with those observed globally, and more specifically in other LMIC.

EQ3. The trend towards reducing specific causes of child mortality in the evaluation countries was generally positive, yet with significant variability in the pace of decline, for different causes.

Neonatal mortality declined for all disease-specific causes, with the number of deaths caused by diarrhoea and pneumonia declining at the highest ARR, and deaths caused by congenital anomalies declining at the lowest ARR. The number of disease-specific causes of mortality for children aged 1 – 59 months also declined for all causes, with ARRs above the global average, ranging from 2.7% for AIDS to as high as 6% for meningitis. The stillbirth rate remained almost constant throughout the evaluation period.

EQ4. The remaining outliers in terms of key child health indicators in the CEE/CIS and the evaluation countries include:

1. Children who are born in poor and less educated families, particularly those residing in rural areas and who experience ethnic or social deprivations, are still at a greater risk of dying;
2. Stillborn babies, whose numbers remained almost unchanged for the last 15 years;
3. Infants dying before their first birthday of preventable causes, particularly neonates, who account for 46% of under-five children deaths occurring in the evaluation countries; and
4. Children who live in countries that are lagging behind, and/or sub-national entities that achieved the least progress in the key child health indicators and have mortality rates two to three times higher than the CEE/CIS regional average.

The most at-risk children are those who belong to several of the above-mentioned stratifiers and require priority attention in the evaluation countries and more generally in the CEE/CIS.

EQ5. Along with health system-related interventions and factors, numerous other factors, or socioeconomic determinants, have most likely contributed to the change in infant and under-five mortality and morbidity in the CEE/CIS and the evaluation countries.

It appears that a sizable share of child mortality reduction and the remaining gaps in the CEE/CIS and more specifically in the evaluation countries can be partially explained by variations in socioeconomic determinants/factors. Namely:

- Uneven economic growth, which benefited some sections of the population and some regions more than others, and did not sufficiently reduce income and geographical inequities across and within countries;
- The deterioration of equitable access to higher education in many CEE/CIS countries, particularly in Central Asia, which negatively affected maternal education levels, especially for the poor and marginalised;
- Increased fertility levels in all Central Asian countries, with declining rates in the CEE and the European part of the CIS;
- Improved access to clean water and sanitation in CEE/CIS in some of the Central Asian countries where there was a problem at the beginning of the evaluation period; and
- Poor governance, corruption and low participation of women in political processes, which--although slowly improving--continue to affect the policy environment in many CEE/CIS countries, including the evaluation ones. This may pose challenges to further reductions of child mortality in these countries.

5.2 RELEVANCE OF UNICEF-SUPPORTED PROGRAMMES IN THE EVALUATION COUNTRIES

EQ6. The UNICEF-supported programmes invariably addressed the most important causes of infant and under-5 morbidity and mortality in all the evaluation countries, with the exception of causes related to the preconception period, which were not addressed. **Mortality and morbidity causes originating in the antenatal period were also less addressed.**

UNICEF programming specifically targeted two of the three leading causes of neonatal mortality, which determined 74% of all neonatal deaths; four of the five leading causes of death among children aged 1 to 59

months, accounting for 49% of deaths occurring in this age group;[90] and two of the three leading causes of infant and under-five morbidity. UNICEF programmes targeted these causes of mortality and morbidity through evidence-based interventions through the intervention packages.

EQ7. UNICEF identified and attempted to address all of the most important bottlenecks in effective coverage with MNCH services.

UNICEF successfully identified all of the key bottlenecks that affected coverage in all the evaluation countries. They identified bottlenecks in effective coverage for each intervention package they supported. A total of 396 bottlenecks were identified in the evaluation countries across 15 thematic areas and were mapped under MoRES determinants and health system building blocks.[91] For the MoRES determinants, the highest number of bottlenecks was identified for "management and service organisation" (120), "skilled and motivated HR" (68) and "conducive laws, policies, social norms and standards" (57). They identified the lowest number for "geographical access" (4). UNICEF and its partners attempted to address 99% of the identified bottlenecks.

EQ8. The UNICEF-supported programmes were mostly successful in identifying and applying the right interventions (activities), with the appropriate scope, target groups and scale to address health system bottlenecks.

UNICEF identified and applied up to 2000 programmatic activities in the evaluation countries over the evaluation period, to address the health system bottlenecks, in cooperation with its partners. The relevance of these programmatic activities was graded using "addressing scores" assigned to specific bottlenecks across the intervention packages supported by the UNICEF programmes. With these programmatic activities, UNICEF independently and/or in cooperation with its international and national partners managed to "fully address" 284 (71.7%) bottlenecks. This term denotes employing the right and appropriate scope, target groups and scale of programmes. "Partially addressed", meaning right an appropriate scope and/or target groups while scale was limited to pilot and/or fragmented activities at the subnational or national level. This included 94 (23.7%) bottlenecks. Eighteen (4.5%) bottlenecks were "not addressed", in other words, were isolated interventions with inappropriate scope and/or target group, and inadequate scale. UNICEF was most successful in addressing bottlenecks under the "geographic access" and "conducive laws, policies, standards & social norms" building blocks, where respectively 100% and 94% of bottlenecks were fully addressed. UNICEF was least successful in addressing bottlenecks under the "effective budgeting and financing" and "quality of services" determinants, with about 61% and 50% respectively fully addressed. These determinants also had the highest share of "not addressed" bottlenecks (about 11% and 4% respectively). "Effective coverage" bottlenecks under the "health financing" and "health workforce" building blocks are most common and challenging to address in other LMIC countries.[92]

All bottlenecks were addressed for the Nutrition intervention package, with 83% fully addressed. Up to 73% of bottlenecks were fully addressed for the EPI Intervention package. UNICEF and its partners were least successful in addressing bottlenecks for the IMCI and ANC/PNC intervention packages, with respectively 8% and 6% bottlenecks not being addressed and only 64% being fully addressed.

EQ9. The UNICEF-supported programmes, including those upholding fundamental human rights and tackling inequities, were well-aligned with national development and sectoral priorities in all the evaluation countries.

Maternal and child health was high on the national policy agendas in all five countries throughout the evaluation period, and the overall goals supported by UNICEF programmes were well aligned with national development strategies. UNICEF engaged with national governments and international partners in continuous dialogue, and actively participated in health strategy development processes to ensure the prioritisation of MNCH issues. These included rights-based approaches and equity at national levels and the alignment of

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[90] Up to 38% of mortality causes among these children were recorded as "unspecified", thus UNICEF has effectively targeted an even higher share of mortality in this age group.

[91] Leadership and governance, service delivery, financing, skilled and motivated human resources, medical products and technologies, information systems and population engagement.

[92] Dickson et al., for The Lancet Every Newborn Study Group. Health-systems bottlenecks and strategies to accelerate scale-up in countries. Lancet 2014; published online May 20. http://dx.doi.org/10.1016/S0140-6736(14)60582-1.

UNICEF's global, regional and national strategic goals and objectives with national sectoral policies and strategies.

EQ10. Not always the highest contributor in monetary terms, UNICEF invariably played an active, if not a lead role in most of the partnerships created to promote MNCH issues and define wider health sector policies in all the evaluated countries. UNICEF applied considerable efforts to involve relevant partners in programme design, implementation and evaluation. The most successful UNICEF partnerships included those with host governments, UN Agencies and multilateral and bilateral development partners and those formed for the implementation of IMCI, ANC/PNC (with World Bank, ADB, EU, SDC, KfW, GIZ, USAID, JICA) and Nutrition (private sector actors, ADB) packages. However representation of beneficiaries in this process was relatively small, limiting the potential for realising a human rights-based approach through participation of rights holders.

Up to 185 national and local partners were involved in UNICEF programme design, implementation and evaluation in the evaluation countries. The legislative and executive branches of the governments and development partners from IFI's and UN agencies were the most active partners involved at all stages of UNICEF programmes. Overall partner engagement was highest at the implementation and design stages and less so in M&E. The partnerships were critical for triggering and sustaining the necessary health system and community level changes and scaling up interventions included under IMCI and ANC/PNC intervention packages. Private sector partners were most successfully engaged in programmes supporting the implementation of the Nutrition package (Flour Fortification). Only a small number of civil society organizations, commonly representing beneficiaries, and professional associations (in Serbia) were involved, and mostly at the implementation stage.

5.3 EFFECTIVENESS OF UNICEF PROGRAMMES IN THE EVALUATION COUNTRIES

EQ11-12. The UNICEF-supported programmes most likely made a significant contribution to achieving required changes to the health system block/enabling environment in the evaluation countries. UNICEF used all core roles to induce the required system and community level changes, however modelling/piloting, enabling knowledge exchange, monitoring & evaluation and policy advice & technical assistance were the core roles most frequently used and/or the most resourced, and followed the pattern of UNICEF's approach to system level changes.

UNICEF achieved this important contribution by identifying the critical health system bottlenecks in effective coverage for the evidence-based MNCH interventions, and addressing them through its core roles. UNICEF worked in cooperation with its partners to tackle all the health system-level determinants: *conducive laws, policies, standards and social norms, management and service organization, effective budgeting and financing, skilled and motivated human resources, necessary drugs, supplies and equipment, quality of services and social and cultural beliefs*. However, UNICEF was least successful in addressing financing bottlenecks independently, and in certain cases even in partnership with the development partners traditionally active in health financing reforms (The World Bank, USAID, EU). Addressing the *quality of service* and *skilled and motivated human resource*s bottlenecks also met with unequal success across the evaluation countries.

To determine whether the high likelihood that such system/community level changes occurred, and that they occurred with UNICEF's contribution, the ET looked at three factors. (a) the extent to which bottlenecks for a given intervention package (and the included sub-packages) were addressed, measured by the *average bottleneck addressing score*; (b) the extent of UNICEF's contribution to the implementation process for the given intervention packages, measured by the average *contribution score* organised by core roles; and c) by the relative share of resources devoted by UNICEF to fulfil these core roles. In other words, the higher the average addressing score for specific bottlenecks under a given package, the higher is the probability that critical bottlenecks disappeared and that the required system/enabling environment change happened. Similarly, a high average contribution score and higher share of resources devoted to the same intervention package led to a high probability that this change was triggered and/or supported by UNICEF. Following this logic, the ET established a high likelihood of system/community level changes with a UNICEF contribution over the entire evaluation period, for all intervention packages in all the evaluation countries. However, the degree of achievement (as judged by the average addressing score) and the level of UNICEF contribution varied by packages and from country to country.

First, UNICEF appears to have been most successful in removing almost all bottlenecks and inducing required changes to scale up interventions. These included the promotion of exclusive breastfeeding, where progress in effective coverage was noted--although prevalence rates were not high; the baby-friendly hospital initiative; and the Nutrition package such as micronutrient supplementation, flour fortification and universal salt iodization. However, some bottlenecks remained across "quality of service" in three of the five evaluation countries and "effective budgeting and financing" in at least two of the five evaluation countries.

Second, the desired system/community level changes across all health system building blocks/enabling environments most likely took place for interventions supporting the extpanded programme of immunization (EPI package). However, notable change barriers remained under "social and cultural practices and beliefs" and "effective budgeting and financing" in some of the countries evaluated. UNICEF appears to have been less successful in removing bottlenecks to scaling up interventions in antenatal, intrapartum and postnatal care, which were included in the ANC/PNC package in two of the five evaluation countries. Bottlenecks in "effective budgeting and financing", "quality of services" and "skilled and motivated staff" weren't addressed in those countries and similar bottlenecks remain in the scale-up of IMCI interventions, and were most pronounced in three of the five countries.

Third, judging from the high contribution scores and the shares of devoted resources, UNICEF made significant efforts (through its core roles) to resolve the most challenging bottlenecks under the ANC/PNC package. This package consumed the second highest share of UNICEF resources and the highest average contribution score across packages. IMCI, consumed the highest share of UNICEF resources but the lowest contribution score. It was the same for the "skilled and motivated staff" and "quality of service" determinants, which received the highest share of resources, but UNICEF was unable to address these bottlenecks fully. UNICEF resources to tackle the "effective budgeting and financing" determinant were relatively modest. However, the bottlenecks under these determinants (i.e. health financing, health service delivery and health workforce building blocks) occur frequently in many LMICs,[93] where they have proved very challenging. Such blockages usually fall beyond the small-scale programmes supported by donors, and require collective and coordinated action by all, especially the government. In seeking system/community level changes, UNICEF convened and advocated with numerous partners (UNFPA, The World Bank, WHO, EU, GFATM, IPH, JICA, SDC, GIZ, ADB, USAID, GAVI, Soros Foundation), who made critical contributions in addressing over 10% of the total identified bottlenecks.

Fourth, the change in the relative importance of the core roles over the CPAP periods beginning from the modelling/piloting to the enabling knowledge exchange, and eventually to the policy advice & technical assistance characterises UNICEF's approach well. This process assisted partner governments to achieve a sustainable system change through demonstration, empowerment, knowledge transfer & capacity building, which culminated in institutionalization.

EQ13. There is a high likelihood that UNICEF-supported programmes contributed to reducing bottlenecks to ensuring effective coverage of priority MNCH interventions along the continuum. This is particularly true for those most relevant to the CEE/CIS region, given improved coverage indicators in all the evaluation countries and the significance of UNICEF's contribution. This was established by the findings presented in answers to EQ11-12.

Improved coverage was achieved in all CEE/CIS region-relevant dimensions of effective coverage, although inter- and intra-country variations persist. *The availability of services and qualified human resources* remained high for the CEE/CIS region as a whole and for the evaluation countries specifically, with population ratios of doctors, nurses and midwives well above WHO's minimal threshold of 230 per 100,000 population. *Financial accessibility improved* as public spending on health care increased several times in all the evaluation countries, to levels that allow adequate financing for essential health services above 64 PPP$ per capita. This led to reductions in financial barriers to services in all the countries evaluated. Knowledge, attitudes and practices on MNCH, as well as an awareness of and demand for services have shown overall improvement, although some knowledge gaps still remain and even widened during the evaluation period. Improvements were also observed in the final dimension of effective coverage – *the quality of services*. The evaluation shows an improvement in effective coverage delivered through addressing bottlenecks for specific ANC/PNC, EPI,

[93] Dickson et al. Every Newborn: health-systems bottlenecks and strategies to accelerate scale-up in countries. May 20 2014. Lancet http://dx.doi.org/10.1016/ S0140-6736(14)60582-1.

Nutrition, and IMCI intervention packages but no improvements for low birth weight and stunting rates. This indicates an insufficient quality or scale for the nutrition interventions. The indicator has worsened for contraception use among women of reproductive age--an important measure of family planning—and for preconception intervention--which impacts child mortality.

EQ14. The results achieved in the reduction of the equity gap in coverage by MNCH services--to which UNICEF has likely contributed--were mixed. While some gaps narrowed, other inequities widened. Significant inter- and intra-country variations exist, and marginalised groups of the population remain deprived of effective coverage by critical MNCH interventions.

Improvements in quality coverage for antenatal and delivery services were accompanied by reductions in inequity. The poorest and least educated rural women gained more access to more qualified medical personnel for childbirth services and received adequate care, including tests and HIV counselling. More poor and less-educated mothers now take children with suspected pneumonia to an appropriate health provider. Urban-rural inequities narrowed for iodised salt consumption.

Urban-rural and wealth-related disparities remain, and provide challenges to many households in terms of physical and financial accessibility to health services in all the evaluated countries. Poor, less educated and rural residents reveal the lowest level of knowledge, which most likely impedes timely access to needed care and may increase exposure to risk behaviour. Some of the countries evaluated still have a fair number of pregnant women who do not make an adequate number of antenatal visits. This can negatively impact their pregnancy and future child. Disadvantaged groups across all countries do not seem to have benefited from increased antenatal services, as they often opt not to use them. When they do use them, access to doctors is constrained compared to the richer groups. Poor households are still less likely to use iodized salt. Consequently, social vulnerability still needs attention to improve effective coverage of these groups.

EQ 15. The evaluation findings indicate a high likelihood that the effective coverage of bottlenecks and resulting improved effective coverage, with evidence-based interventions, contributed to reduce disease-specific mortality for perinatal conditions, ARI, DD, and meningitis. These reductions appear to be positively associated with overall reductions in NMR, PNMR, IMR, and U5MR.[94] However, the extent that reducing bottlenecks contributed to a reduction of deaths due to congenital conditions and injuries was impossible to establish.

A substantial reduction during the evaluation period took place concerning under-five and infant mortality, particularly for 1-4 year-old children. UNICEF programmes, aligned to national priorities, supported evidence-based MNCH interventions across the continuum of care and service delivery platforms, with proven efficacy[95] for six of the eight leading causes of neonatal mortality (up to 74%) and for about half of deaths for children aged 1-59 months. While part of the observed reduction in infant and under-five mortality might be associated with favourable changes in other socioeconomic determinants of child mortality, at least half of this reduction is likely due to health system and community level changes.[96] UNICEF, through its core roles, has most likely contributed to this trend by fully or partially addressing most of the bottlenecks for effective coverage through their evidence-based MNCH interventions that targeted the leading causes of child mortality and morbidity.

We also concluded that the reductions observed in cause-specific mortality rates were probably positively associated with reductions observed in NMR, IMR and U5MR. It is important to emphasise that we were only able to establish the *likelihood* of UNICEF's contribution and its plausible positive association with IMR and U5MR reduction. More sophisticated statistical and econometric analysis is required to establish a true association, however this exceeded the scope of this evaluation and implies a separate undertaking.[97] In Table 15 we summarise all our findings and conclusions for ease of understanding.

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94 Establishing a direct causal relation was not an objective of this evaluation.

95 Presented in Lancet Child Survival (2003), Lancet Neonatal Survival (2005) and Every Newborn Survival (2014) series.

96 ShyamaKuruvilla et al; Success factors for reducing maternal and child mortality**.** *Bull World Health Organ* 2014;92:533–544 doi: http://dx.doi.org/10.2471/BLT.14.138131

97 See Terms of Reference for Multicounty Analysis of Maternal Child Health Outcomes and their determinants in CEE/CIS Region. Annex 2 of the Inception Report for MCE.

Table 15: Findings used to determine the likelihood of UNICEF contribution to the reduction of bottlenecks and possible association with cause-specific mortality, NMR, IMR and U5MR

Period of life and Causes of Mortality	Relevant Programming	Bottleneck (s) Average Addressing Score	UNICEF Average Contribution Score to system/community level change and implementation of intervention package	Change in effective coverage with relevant interventions	Observed change in intervention specific mortality rate (ARR) in %	Observed change in disease specific mortality rate (ARR) in %	Likely contribution to the reduction in disease-specific mortality	Likely association with IMR and U5MR
Neonatal period 0-28 days								
Perinatal Conditions (intrapartum- related events, preterm birth complications)	**YES** - ANC/PNC, Nutrition	**Partially to fully addressed** – - ANC/PNC 1.58; - Nutrition 1.83	**Significant to Critical Contribution -** ANC/PNC - 2.92; Nutrition - 2.78	- **Improvement** in financial accessibility to antenatal, delivery and postnatal services (ANC/PNC)**;** - **Improvement** in quality and adequate coverage with antenatal care (ANC/PNC); - **Improvement** in quality coverage of neonatal and post neonatal care (ANC/PNC); - N**o change** in low birth weight (Nutrition); - **Decline** in quality coverage for pre-pregnancy care	- Pre-pregnancy care and Mother's health (-3.7); - Care during pregnancy (-1.7); - Care during delivery (- 6.9); - Pre-discharge care (-five.8)	- Preterm birth complications (-3.7); - Intrapartum related events (-4)	YES	YES
Congenital abnormalities	**NO**	NO	NO			-1.8	NO	NO
Infections (sepsis, meningitis, pneumonia, tetanus and diarrhoea, HIV)	**YES** - PNC, PMTCT, EPI and Nutrition	**Partially to fully addressed** – - ANC/PNC 1.58; - EPI 1.65; - Nutrition 1.83	**Significant to Critical Contribution -** ANC/PNC - 2.92; Nutrition - 2.78	- **Increase in** rural/urban, wealth and education inequities in knowledge and practices; - **Unchanged** urban/rural and wealth disparities in physical and financial accessibility of health services. - **Reduced income**, education, rural/urban inequities in quality coverage of delivery and antenatal care, iodised salt intake and contraception use.		- Pneumonia (-4.6); - Diarrhoea (-five.8)	YES	YES
Children 1-59 months old								
Pneumonia	**YES** - IMCI, EPI, Nutrition	**Partially to fully addressed** – - IMCI 1.55; - EPI 1.65; - Nutrition 1.83	**Significant to Critical Contribution -** ANC/PNC - 2.92; Nutrition - 2.78	- **Improvement** in financial accessibility to PHC and secondary care; - **Improvement** in utilization of outpatient services; - **Maintenance of** high immunization rates; - **Improvement in** quality coverage for pneumonia and diarrhoea treatment - **Improvement** in quality coverage for		-4.9	YES	YES

Period of life and Causes of Mortality	Relevant Programming	Bottleneck (s) Average Addressing Score	UNICEF Average Contribution Score to system/community level change and implementation of intervention package	Change in effective coverage with relevant interventions	Observed change in intervention specific mortality rate (ARR) in %	Observed change in disease specific mortality rate (ARR) in %	Likely contribution to the reduction in disease-specific mortality	Likely association with IMR and U5MR
Diarrhoea	**YES** - IMCI, Nutrition, EPI	**Partially to Fully addressed** – - IMCI 1.55; - EPI 1.65; - Nutrition 1.83	**Significant to Critical Contribution -** ANC/PNC - 2.92; Nutrition - 2.78	universal salt iodisation; - **Decline** in knowledge of danger signs of pneumonia		-five.4	YES	YES
Injuries and accidents	**NO**	NA	NA			-3.8	NO	NO
Meningitis	**YES** - IMCI, EPI, Nutrition	**Partially to Fully addressed** – - IMCI 1.55; - EPI 1.65; - Nutrition 1.83	**Significant to Critical Contribution –** - ANC/PNC - 2.92; - Nutrition - 2.78	**Reduced** income and education inequities in quality coverage for pneumonia treatment.		-6	YES	YES
Vaccine preventable diseases	**YES** - IMCI, EPI, Nutrition	**Partially to Fully addressed** - IMCI 1.55; EPI 1.65; Nutrition 1.83	**Significant to Critical Contribution -** ANC/PNC - 2.92; Nutrition - 2.78			NA	YES	YES

5.4 EFFICIENCY OF UNICEF PROGRAMMES IN THE EVALUATION COUNTRIES

EQ16. UNICEF allocated financial resources for programmes according to identified priorities and bottlenecks.

UNICEF devoted more financial resources to the determinants where the most bottlenecks were identified ($r=0.3$, $p<0.01$), which seems logical. The least-resourced determinants were those with relatively low addressing scores. For example, "effective budgeting and financing" and "quality of services" had the lowest average addressing scores and received the lowest allocations. Out of the four determinants (management and service organisation, skilled and motivated human resources, conducive laws and standards, and social cultural practices and believes) where the highest numbers of bottlenecks were identified and the most resources directed, three determinants received the highest addressing scores. Skilled and motivated human resources excepted. In other words, for the three other determinants, resource use and results were commensurate. However, a very weak correlation was found between resource allocation and the relative success in addressing bottlenecks when all determinants were considered ($r=0.04$, $p<0.01$). This implies that overall the amount of programme funding allocated by UNICEF alone was not a decisive factor in achieving the system/community level change required to eliminate bottlenecks.

When priority intervention packages are considered, IMCI and ANC/PNC received the highest allocations mainly because of the high number of bottlenecks detected, and the large-scale training components necessary to implement these packages.

EQ17. The evaluation team was unable to provide answers to this question due to data limitations.

Data limitations meant that the ET could not establish the economic and technical efficiency in UNICEF's use of budgets and resources when addressing the priority bottlenecks.[98]

EQ18. The evaluation team was unable to provide answers to this question due to a lack of data.[99]

EQ19. UNICEF performed well in monitoring programme implementation using different tools and approaches and acted on nine out of every ten recommendations generated by programme evaluations.

Along with the routine monitoring of programme implementation performed in accordance with the organizational guidelines, UNICEF carried out up to 156 studies, surveys and both mid-term and final evaluations of its programmes and projects. This informed the course corrections and programme designs in the same or in the next CPAP for all the evaluation countries. UNICEF showed remarkable performance in adopting nine out of every ten of the 140 recommendations produced by its monitoring and evaluation efforts.

5.5 THE SUSTAINABILITY OF UNICEF PROGRAMMES IN THE EVALUATION COUNTRIES

EQ.20 Most UNICEF-supported programmes were integrated into national policies and budgets. UNICEF was somewhat more successful in assuring integration in national policies than in national budgets.

As noted in the relevance section, the goals and objectives of UNICEF programmes that supported delivery of the priority intervention packages aligned fully with national development and sectoral policies in all the evaluation countries. By facilitating the adoption of enabling laws, regulations, standards, guidelines, and undergraduate and postgraduate curricula for each of the intervention packages, UNICEF ensured the further integration of its programmes into national policies in all five of the countries evaluated.

UNICEF successfully advocated for inclusion of essential MNCH interventions in Basic Benefit Packages financed by national budgets in all the countries. However, not all components of the UNICEF-supported programmes were fully integrated into national budgets. Due to financial constraints, not all countries were able to fully upgrade all MNCH facilities, adequately finance all drugs in the benefit package and on a facility level, to fund supplies and equipment for ANC/PNC and IMCI, and to sustain continuous education processes for medical personnel.

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[98] See also Annex 5. The Evaluation Matrix

[99] Ibid

EQ21. Overall, UNICEF succeeded in assuring the scale-up of pilots and their inclusion in national policies and/or systems.

Most of UNICEF-supported pilot models (74%) were scaled up nationally, and even more (87%) were incorporated into national policies or systems. Only 7% of the pilot models were unsustainable, and the rest were implemented at a sub-national level or continue today. UNICEF also ensured the financial sustainability of the scaled models, attained through upfront and constant engagement with government officials including open and frank discussions about the need to assume financial responsibilities. This dialogue was supported by relevant evidence and, where necessary, by strong advocacy. As a result, three out of every five pilot models were incorporated into national budgets after scale-up.

EQ22. UNICEF assisted programmes have been "mostly successful" in leveraging resources and partnerships.

UNICEF actively engaged with seven UN agencies, 21 other development partners and four private sector partners. They leveraged additional resources for UNICEF-supported programmes or programme areas that most likely exceeded by several times the level of their own resources. The ET identified 77 cases where UNICEF took measures to leverage resources, most of which were concluded successfully. The leveraging was used effectively to scale up pilots and to assure the national rollout of UNICEF-initiated and/or -supported programmes. This probably created strong pre-conditions for sustainability.

EQ23. While the ET was able to collect strong qualitative evidence of leveraging efforts, obtaining precise monetary dimensions did not prove possible. This negatively affected our ability to quantitatively evaluate return on investment. According to the qualitative findings of the results achieved and key informant assessments, the return on UNICEF investments in MNCH appear to be more than satisfactory.

The ET considers that UNICEF's own investments in the MNCH sector had high returns. This is apparent for two reasons: First, the results achieved addressing effective coverage bottlenecks with a major or significant contribution from UNICEF are impressive, considering that their investments in MNCH accounted for less than 8% of ODA spending and less than 1% of the overall ODA health expenditure. Secondly, the majority of key informants interviewed who represented partner governments and leading development partners in all the evaluation countries, invariably stated that UNICEF played a leading role in MNCH, and in some cases for broader health system reforms as well.

EQ24. Two out of every three programmes continued after the conclusion of UNICEF support.

The lack of adequate international benchmarks for sustainable public health programmes does not allow the ET to establish UNICEF's success rate objectively. However, inter-country comparisons certainly point to greater success in some countries (e.g. up to 80% of programmes continue in Kyrgyzstan) than in others. Overall, assuring that host governments support two out of every three initiatives is a significant achievement in the field of international development.

EQ25. A combination of critical elements made UNICEF programmes sustainable.

The answer to this question is elaborated in subsection **5.7. Lessons Learned**

EQ26. Several other partners supported MNCH programmes that were initiated with support from UNICEF.

The World Bank, GTZ, SDC and the EU continued support to PNC/ANC programme components in three out of the five evaluation countries. GAVI supported the EPI programme and GFATM upheld support to PMCTC in three countries, while the World Bank and DFID have continued to support nutrition programmes in one country.

5.6 HUMAN RIGHTS APPROACH AND GENDER EQUALITY WITHIN UNICEF-SUPPORTED PROGRAMMES IN THE EVALUATION COUNTRIES

EQ27. The Gender Equality component was largely absent, and a Human Rights-Based Approach to programming was partially incorporated into UNICEF-supported programme planning, implementation and evaluation.

Gender equality was partially incorporated into the planning and evaluation of UNICEF-supported programmes, but only in two evaluation countries. A human rights-based approach was not explicit in MNCH programming, although programmes implicitly or explicitly declared goals ensuring the right to survival, development, and growth. Retrospectively, several critical interventions supported by UNICEF (e.g. support to

birth registration, ILBD introduction, breastfeeding promotion, etc.) were considered as a human rights approach. Rights-based programming was more pronounced in HIV/AIDS programmes and for children affected by HIV.

EQ28. UNICEF claimed that the monitoring and evaluation of supported programmes was mostly performed in a participatory and ethical manner, with full respect to human rights, gender and gender-sensitive issues. However, it was impossible for the ET to obtain evidence of this within programme planning and implementation.

Most of the monitoring and evaluation reports that were analysed, starting from the year 2000, claimed that monitoring and evaluation was conducted in a participatory and ethical manner with full respect to human rights and gender-specific and gender-sensitive issues. However, the ET was not able to establish the validity of this statement, nor whether planning and implementing UNICEF programmes included these elements.

EQ29. MNCH programmes supported by UNICEF, with a few exceptions, largely failed to clearly identify marginalized, vulnerable and hard-to-reach groups for programmatic purposes or to focus interventions on these groups subsequently. However, they did monitor the equity effects of their interventions.

In its programme documents UNICEF used the terms "vulnerable, marginalized and hard-to-reach population groups" in a general manner, without ever defining or identifying who these groups were in a given country context. Roma children in Serbia and Moldova were the only exception to this trend. UNICEF's monitoring efforts were equity focused, although equity dimension was not adequately present in all programmes and crosscutting issues, which may have prevented appropriate programme focus on the remaining equity gaps.

EQ30. As a crosscutting theme, gender appeared in a significant proportion of the UNICEF Country interventions but was restricted to educational activities. Very little, if any, focus on gender was found in the area of MNCH.

While UNICEF is one of the first UN agencies to have created a clear gender mainstreaming policy—one which is unique in combining a focus on increased equality in programming with a life cycle and rights-based approach--the actual expression of this theme in MNCH country programmes was evident only at the very end of the evaluation period.

5.7. LESSONS LEARNED

1. When analysing the data on the programme interventions provided by the UNICEF Country Offices (CO) evaluated, the ET found a wide variation between COs in how they attributed UNICEF-supported programme interventions to relevant core roles (for example capacity building) and the MoRES determinants that they target. This made it impossible to attribute specific bottlenecks in any of the evaluation countries to two of the ten MoRES determinants: "enabling social norms" and "ability to timely and continuous utilisation". The UNICEF RO might consider issuing guidance to help define a uniform approach in operationalising the MoRES determinants framework and core roles approach and to improve the evaluability and cross-comparability of results achieved at country levels. Guidance developed by the UNICEF RO and further revised by the ET for this evaluation and supplied to the UNICEF COs might serve as a starting point for this exercise.

2. The Evaluation Team was able to establish only a *likelihood* (although high) of system changes through UNICEF's contribution, and that these changes have led to improved effective coverage through MNCH services and improved child health outcomes (mortality and morbidity). Beyond the general and well-known problems in determining *contribution* (not to mention attribution) of an intervention or a programme targeting populations and/or complex systems to an observed outcome, there were other, more amenable, factors at play. After collecting a wealth of qualitative and quantitative information, the ET was able to definitively establish that UNICEF contributed to some of the crucial elements of system changes (e.g. new laws, policy, standards, new coordination and service organization mechanisms, improved skills and knowledge, etc.). It was apparent that a generally positive trend in key child health indicators may be caused by the system level changes (if they indeed occurred). However, it was impossible to determine unequivocally whether (a) these *change elements* have indeed led to *sustainable* system changes or (b) that these changes

caused or *contributed* to the improved effective coverage and child health outcomes. This uncertainty is due to the following reasons:

- Despite the fact that health system performance and health system strengthening assessment frameworks[100,101] and toolkits[102] have been used in a number of the CEE/CIS[103,104] and LMIC[105] over the past decade, they have not been consistently applied[106] or institutionalised in any of the evaluation countries to generate the information necessary to monitor health system level changes systematically. UNICEF rarely monitored the status of a system or community-level change that it helped to achieve when they discontinued support afterwards. As a result, the absence of consistent system-level data impeded the ET from examining the precise scale of the changes, and how sustainable changes were over time. The latter aspect is important to monitor, as the ET discovered cases where some beneficial system or community level achievements were rolled back due to a changed economic, social or political environment or lost ownership (decreased health spending, enabling legislation abolished), or that taking up an intervention after funding from UNICEF or other partners dried up, was impossible. Cases of such "unsustained change" might include the declining population knowledge about the danger signs of pneumonia, and the rising anti-immunisation sentiment which have resulted in declining immunisation coverage rates over the evaluation period.
- While MICS and DHS are powerful tools for collecting important information on outcome (MoRES level 3 - system change) and impact (MoRES level 4),the data limitations encountered by the ET[107] did not allow for sound and statistically significant comparisons between countries or across time for most of the indictors, so that the ET could establish clear inter-country variations or changes over the evaluation period. As noted above, the ET has only presented and analysed the trends observed.

Considering that inducing and measuring system and community level changes is at heart of the Theory of Change of UNICEF's regional approach, the UNICEF RO should apply efforts to address these issues. Proposed measures are presented in the recommendations chapter of this Report.

4. The evaluation findings on the effectiveness and efficiency of UNICEF-supported programmes indicate that while the size of financial allocations may influence whether desired results are achieved, they are not always a decisive factor. Instead, the ET identified the following success factors:
   - **Targeting and addressing most ("the bulk") of the identified health system bottlenecks**.
   - **Understanding the concept that health systems are complex-adaptive systems** to which a linear "input - output – outcome" perspective is rarely applicable. Rather, the nature of health systems requires continuous engagement accounting for path dependence, feedback loops and emergent behaviours within the system.

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100 Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva: World Health Organization; 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 1April 2015).

101 Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization; 2010 (http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf, accessed 1 April 2015)

102 Measuring Health System Strengthening and Trends: A Toolkit for countries. WHO. June 2008. http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Introduction.pdf accessed 2 April 2015)

103 Case studies on health system performance assessment. A long-standing development in Europe. WHO 2012

104 Georgia Health System Performance Assessment. MoLHSA of Georgia. WHO 2009. www.euro.who.int/__data/assets/pdf_file/0012/43311/E92960.pdf accessed on March 18 2015.

105 Tashobaya C.K et al. Health systems performance assessment in low-income countries: learning from international experiences. Globalization and Health 2014, 10:5

106 Health system assessments elements are included in country health system reviews published by the European Observatory as Health in Transition series. At least one such review was produced for each of the five evaluation countries during the evaluation period. See for details ANNEX 8.

107 For a detailed discussion on the data limitations see ANNEX 5.

- **Using a balanced mix of UNICEF's core roles** to strengthen health systems, with priority attention to modelling/piloting, developing an enabling environment and facilitating knowledge exchange, monitoring & evaluation and policy advice & technical assistance. The same core roles have been instrumental in achieving success in another core role – leveraging resources as well.
- **Sustained engagement with partners** from governments and development organisations that allowed leveraging substantial financial resources. In most successful cases, UNICEF generated political momentum and secured partners' engagement through facilitating national dialogue, successfully demonstrating workable solutions/models, building capacities and ownership through knowledge exchange and supporting the institutionalisation of system change through high quality policy advice and technical assistance.

5. Evaluation results demonstrate that while UNICEF's HSS efforts targeted the "traditional" MNCH areas, which were where UNICEF's experience and expertise was regarded as superior by host governments and key development partners, these efforts had a broader effect on wider health systems in the countries studied. For example: Health System Strengthening (HSS) efforts for the implementation of IMCI in Moldova and Uzbekistan, had strongly influenced the course of the national PHC and health financing reforms in these countries. Hence, UNICEF's efforts described in this evaluation that sought to create an enabling environment for system level changes for specific intervention packages targeting MNCH services can provide examples for HSS interventions to use MNCH as an entry point to wider HSS that will benefit other health sector priorities.

CHAPTER 6. EVALUATION RECOMMENDATIONS

This chapter presents recommendations based on the findings, conclusions and lessons learned presented above. The recommendations are formulated in accordance with UNICEF-Adapted UNEG Evaluation Report Standards.

The ET has applied efforts to ensure the participatory approach in developing the recommendations based on the findings, conclusions and lessons learned presented above. The ET members validated the key preliminary findings and conclusions with UNICEF COs during the country visits. The recommendations were discussed and validated with the evaluation management committee (UNICEF RO) and the RKLA Reference Group. The evaluation recommendations focus on five priority areas:

1. Sharpen equity-focus of UNICEF's programming;
2. Consolidate and advance the gains in child health;
3. Where possible, consider not sufficiently addressed underlying causes of child mortality and morbidity;
4. Address persisting bottlenecks at health system and community levels;
5. General Recommendations.

1. Sharpen equity-focus of UNICEF programming

The equity concerns remain in under-5 mortality and, even more so, in infant mortality that have not been fully tackled during the evaluation period in the evaluation countries. Indeed, education and wealth related equity ratios even deteriorated and equity gaps widened. This, as suggested for other LMICs, may be caused by inequitable coverage with the relevant interventions[108]. Evidence for this inequitable coverage for critical MNCH interventions, possibly due to remaining bottlenecks in equitable financial access and skilled and motivated human resources across all packages, was found in the evaluation countries and presents an unfinished agenda for UNICEF programming in this region in future.

[108] Houweling, T.A.J, Kunst A.E., Socio-economic inequalities in childhood mortality in low- and middle-income countries: a review of the international evidence. Br Med Bull (2010) 93 (1): 7-26. doi: 10.1093/bmb/ldp048

Addressing remaining inequities related to socio-economic status, gender, residence and membership of certain ethnic or population groups would require: a) defining, finding and reaching out to these groups through well functioning national systems; b) securing improved access to health care; c) improving financial protection; d) improving nutritional status; and e) improvement of women's education, socioeconomic development and living conditions. This cannot be achieved only through health interventions but would require integrated approaches for health and other needs, within UNICEF's mandate, by closely coordinating with the partners involved in those sectors and also across the interventions within UNICEF's portfolio.

Consequently, UNICEF could contribute to the development of social protection systems by voicing the needs of families and children, similar to the programming approach towards Roma in Serbia and the new programming approach in Georgia, and through technical assistance and policy dialogue actively integrating health, nutritional and other needs in the social benefits offered to the marginalised groups of society. Active integration of the services in the social protection system would allow UNICEF not only to focus on continuum of care interventions, but also, through creative thinking and innovations, to deliver health gains to every child regardless of socio-economic, health, gender, and other status.

Achieving significant results in neonatal and child mortality and morbidity reduction would require increasing access to information for people, especially for marginalised and vulnerable groups and civil society, in order to take decisions, access health services and hold decision-makers accountable. Evidence-based policy making and programme planning through the active engagement of civil society and communities in generating evidence and policy making should be critical to assure health system responsiveness to the needs of public. This would require greater openness, transparency and active engagement and coordination with civil society and communities.

In order to achieve this, it is recommended that UNICEF should:

- Facilitate multisectoral approaches across health, social, education and other sectors, as appropriate to adequately address socioeconomic determinants of child health:
    - ⇒ Looking through lens of socioeconomic determinants of health, help countries define and prioritize marginalized/vulnerable groups and define approaches to meet their need;
    - ⇒ Assist countries to develop and cost health, nutrition, social and other benefits focused for priority interventions (e.g. essential MNCH services, drugs, vaccines, etc.) focused on priority marginalized/vulnerable groups, which has to also inform equity focused budgeting;
    - ⇒ Refine in-country mechanisms to reach marginalized/vulnerable;
- Empower communities and civil society to better voice the needs of children and monitor government's performance in delivering services, especially to marginalized groups

2. Consolidate and advance the gains in child health

Shifts in cause-specific mortality, where close to 50% of deaths in the neonatal period are attributed to preterm birth complications and intrapartum related events, have important implications for intervention selection and service delivery. For example, neonatal intensive care and hospital-based paediatric care are becoming more affordable in these countries as their economies progress. The highest priority is delivering interventions at scale that address the leading neonatal disorders. In particular, improving the quality of care at birth will contribute to neonatal survival if specific interventions are implemented, such as neonatal resuscitation and antenatal corticosteroids for preterm labour, etc.[109] The largest share of neonatal deaths occur among babies born small, two-thirds of whom are preterm. UNICEF should consider targeting simple and complex interventions to improve care for this population. However, delivering these strategies in settings similar to the evaluation countries would also require greater clarity on the roles and responsibilities of the clinical cadre involved in care provision to neonates (e.g. assessing all newborn babies, managing small and ill

[109] Bhutta ZA, Das JK, Bahl R, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? Lancet 2014; 384: 347–70.

babies, and counselling the mother and family)[110] and greater engagement with more highly qualified clinical staff (i.e. doctors vs. nurses).

As for 1-59 month old children, further advancements in case management of pneumonia and diarrhoea will be needed, while retaining a focus on the integrated management of childhood illness and assuring free and easy access to care, especially outpatient drugs. Attention should also be paid assure that national immunization schedules universally throughout the region include new vaccines, such as pneumococcus and rotavirus vaccines, which hold promise for further reducing deaths from pneumonia and diarrhoea[111]. Finally, unpacking unknown causes of death will become important if the lives of 1-59 month old children are to be saved and appropriate interventions for UNICEF support selected.

Finally, further promotion of improved maternal and child nutrition practices will be required to reduce foetal growth restriction, preterm births, and eventually neonatal mortality. Improved breastfeeding practices, such as achieving higher levels of exclusive breastfeeding, and nutrition interventions in early childhood would also contribute to a reduction of deaths from infections and will help to improve child survival[112,113]. Therefore, UNICEF needs to:

- Help countries to further improve quality of neonatal care on all levels through better care coordination;
- Help countries advance child health, development and well being, and, where possible, the identified women and maternal health issues through whole family approach;
- Help countries to develop and implement comprehensive national nutrition policies;
- Help countries to assure sustainability of national immunization programmes and assure universal inclusion of pneumococcus and rotavirus vaccines in national immunization schedules;
- Help Countries to develop context-specific multi-sectoral program for child injury prevention.

3. Where possible, consider not sufficiently addressed underlying causes of child mortality and morbidity

Partnerships across the MNCH continuum of care are fragmented and oriented toward single-issue advocacy and funding, and newborn survival has not been among the main issues. Consequently, it seems important to retain focus on MNCH continuum of care when developing UNICEF support programmes and/or when coordinating with partners involved in single-issue advocacy and funding. Focusing on preconception health and its links with maternal health, family planning, child health, and nutrition are particularly crucial for reducing neonatal mortality. Countries with greater success in this area have had alliances between the specialties involved in different stages of the care continuum, especially those involved in maternal health[114]. Thus, it is recommended that UNICEF should:

- Advocate for a greater attention to preconception and antenatal health of women, through:
    - ⇒ Advocating governments to improve ANC/reproductive health through enhanced and well coordinated joint programming, implementation and evaluation with UNFPA and WHO, where appropriate;
- Advocating for development and delivery of greater benefits to marginalized pregnant women through integrated social and health programming, including nutrition sensitive and specific interventions.

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[110] Darmstadt GL, Kinney MV, Chopra M, et al. The Lancet Every Newborn Study Group. Who has been caring for the baby? Lancet 2014; 384: 174–88

[111] Bhutta ZA, Das JK, Walker N, et al. Interventions to address deaths from childhood pneumonia and diarrhoea equitably: what works and at what cost? Lancet 2013; 381: 1417–29.

[112] Bhutta ZA, Das JK, Rizvi A, et al. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet 2013; 382: 452–77.

[113] Debes AK, Kohli A, Walker N, Edmond K, Mullany LC. Time to initiation of breastfeeding and neonatal mortality and morbidity: a systematic review. BMC Public Health 2013; 13 (suppl 3): S19.

[114] Darmstadt GL, Kinney MV, Chopra M, et al. The Lancet Every Newborn Study Group. Who has been caring for the baby? Lancet 2014; 384: 174–88

4. Address persisting bottlenecks at health system and community levels

Further work is required to eliminate the remaining bottlenecks under the MoRES determinants of the effective budgeting and financing, the management and service organisation and the quality of services. The extent of barriers across these determinants varies form country to country in the region. Countries from CEE and the European Part of CIS have mostly resolved financial access issues to the basic MNCHS services; yet, gaps remain, particularly for marginalised. Common approaches effective in reducing the bottlenecks in most country settings can be elaborated. For example, most regional countries, particularly in Central Asia still have to achieve free and uninhibited access to care with the help of BBP, which provides a significant depth of coverage, including higher financing of the necessary inputs for inpatient and outpatient care provision and outpatient drugs. Early experience in Kazakhstan [115] and other countries [116] suggests that innovative mechanisms in health financing – such as results based budgeting and pay for performance focused on MNCH – may be viable instruments in addressing the challenging bottlenecks pervasive in quality of care and health workforce motivation in many CEE/CIS countries. Institutionalising capacity building for health managers remains high on the health reform agendas in many countries. The quality of care issues are pervasive across the region.

To address these bottlenecks UNICEF needs to consistently apply those core roles in which it demonstrated maximum effectiveness and efficiency. Namely, initiating and maintaining the national dialogue to promote child friendly norms, and influence national policy and strategy setting in MNCH area; facilitating knowledge exchange and building national ownership of system change required for tackling remaining and emerging issues in MNCH, Intensifying partnerships with development agencies that provide substantial amount of funding in support of wider health system and inter-sectoral reforms to amplify the results achieved.

Finally, on the one hand, delivering interventions focused on priority causes of child death and on the needs of marginalised and hard to reach populations requires a good, research-based understanding of underlying causes and needs. On the other hand, delivering priority interventions and services through an integrated social protection system demands setting and monitoring explicit targets for interventions and for vulnerable groups, enhancing stewardship and management capabilities of the national and sub-national government and better functioning national systems. Thus UNICEF should:

- Help countries to enhance national/sub-national monitoring systems through:
  - ⇒ Improving vital registration and analysis, with emphasis on cause of child death analysis;
  - ⇒ Monitoring health related inequities, especially among marginalized/vulnerable groups;
  - ⇒ Monitoring service quality across continuum of MNCH care;
  - ⇒ Assessment of health system performance
- Help countries to put in place quality improvement systems for MNCH services
- Strengthen referrals between levels of care for high-risk pregnant women, newborns and children with emphasis on marginalized/vulnerable groups
- Help countries to enhance in-country management capacity through sustainable approaches to support national and sub-national implementation of necessary laws, policies and standards
- Help countries to continue work on family and community targeted C4D to address critical gaps identified by the evaluation.

5. General Recommendations

The final block of recommendations is derived from the evaluation experience and is pointed to the UNICEF RO and the UNICEF Headquarters.

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[115] Zoidze, A, Obermann, K. The assessment of comprehensive per capita payment/partial fund holding mechanisms for purchasing outpatient services, including recommendations on refining the methodology. *Oxford Policy Management*. Astana 2014. Unpublished technical report.

[116] OECD/WHO (2014), *Paying for Performance in Health Care: Implications for Health System Performance and Accountability*, Open University Press - McGraw-Hil, Buckingham.DOI: http://dx.doi.org/10.1787/9789264224568-en

- Revise and adjust regional ToC for RKLA 6 in light of the findings of this evaluation;
- Elaborate guidance for COs to facilitate operationalization of the MoRES framework with a clear methodology for classifying and attributing programme interventions across the core roles and the MoRES determinants. Also consider modifying the MoRES determinants framework and core roles. Namely:
    - ⇒ Eliminate "Timely and continuous utilization" and merge "social norms" with "cultural practices and believes" and
    - ⇒ Better define "capacity development" within the core roles (suggested to add to "knowledge exchange") and where it belongs.
- Enhance UNICEF's planning and financial accounting/management systems to allow for close linkages between the MoRES determinants, core roles and the programme expenditure for adequately tracking programme implementation across these dimensions.
- Improve utility of MICS/DHS surveys on a country level by developing user-friendly and web-based analytical tools, consider the possibility of establishing linkages with databases such as WHO EURO Health For All.

ANNEXES

ANNEX 1: DESCRIPTION OF UNICEF "INTERVENTION PACKAGES"

Global evidence over the past decade has become richer in examples of public health interventions with proven impact on child health outcomes. Table 16, sourced from Lancet, provides details about the strength of this scientific evidence. The evidence shows that development agencies, including UNICEF, are actively supporting this set of interventions in their programmes to help achieve the MDG4 and reduce child mortality.

Table 16 Child survival interventions with sufficient or limited evidence of impact for reducing mortality from the major causes of under-five deaths

	Diarrhea	Pneumonia	Measles	HIV/AIDS	Birth Asphyxia	Preterm Delivery	Neonatal Tetanus	Neonatal Sepsis
Preventive interventions								
Breastfeeding *	1	1						1
Complimentary feeding	1	1	1					
Water, sanitation and hygiene	1							
HIB Vaccine		1						
Zinc	1	1						
Vitamin A	1		2					
Antenatal steroids						1		
Newborn temperature management						2		
Tetanus toxoid							1	
Nevirapine & replacement feeding				1				
Antibiotic for premature rupture of membranes						2		2
Clean delivery							1	1
Measles vaccine			2					
Treatment interventions								
Oral rehydration therapy	1							
Antibiotics for pneumonia		1						
Antibiotics for sepsis								1
Antibiotics for dysentery	1							
Zinc	1							
Vitamin A			1					
Level 1 (sufficient) evidence	1							
Level 2 (limited) evidence	2							

* Exclusive breastfeeding in the first 6 months of life and continued breastfeeding during 6-11 month

Source:G. Jones; R.W. Steketee; R.E. Black; Z.A. Bhutta; S.S. Morris
How many child deaths can we prevent this year? Lancet 2003.362:65-71

The recent Lancet series has dealt with lifecycle periods along the continuum of care, including maternal,[117] neonatal[118] and child survival[119], and nutrition,[120] and has provided valuable evidence for global policymaking and for informing interventions at the country level. In respective subsections below, we describe each of these key "intervention packages". These are further mapped along the "continuum of care" presented in

Figure 40 (for description and presentational purposes only) and are thereafter used to explain their application to UNICEF's regional Theory of Change approach.

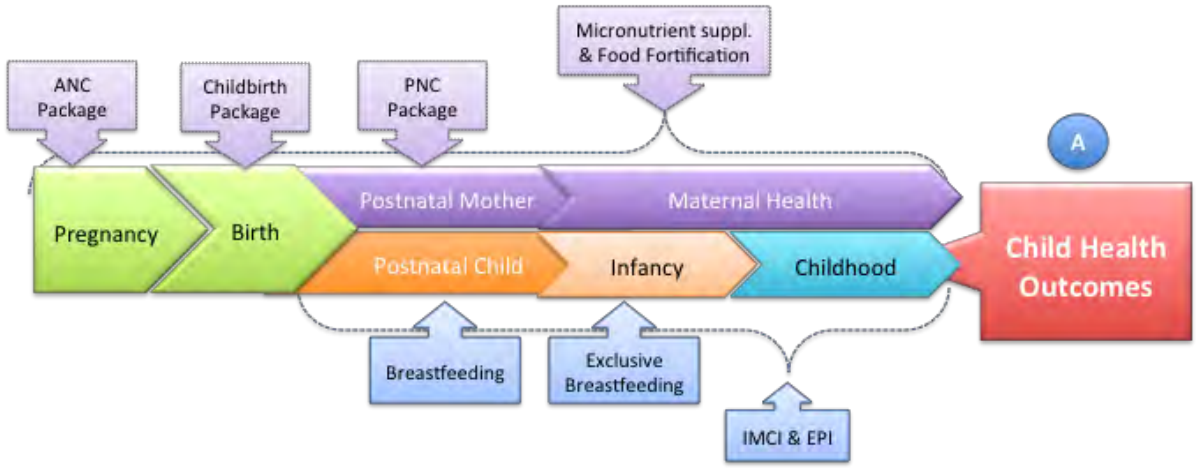
117 Ronsmans C, Graham WJ. Maternal mortality: who, when, where, and why. Lancet 2006; 368: 1189-1200.

118 Lawn JE, Cousens S, ZupanJLancet Neonatal Survival Steering Team. 4 million neonatal deaths: when? Where? Why?. Lancet 2005; 365: 891-900.

119 Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year?. Lancet 2003; 361: 2226-2234.

120 Black RE, Allen LH, Bhutta ZA, Caulfield LE, de Onis M, Ezzati M, Mathers C, Rivera J. Lancet Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. Lancet 2008; 371; 243-260.

Figure 40 The continuum of care: connecting care during the lifecycle (A) and intervention packages



Modified from Kerber et all. 2007

Antenatal and Postnatal Care Package

Antenatal care package: For antenatal care to be effective, all pregnant women need a minimum of four visits, at specific times and with evidence-based content.[121] Care for women during pregnancy improves health by preventive measures, and by prompt detection and management of complications. Essential components of a focused antenatal-care packages include screening for and treatment of disorders (such as anaemia, abnormal lie, hypertension, diabetes, syphilis, tuberculosis, and malaria); providing preventive interventions; and counselling about diet, hygiene, HIV status, birth, emergency preparedness, and care and feeding of babies.[122,123,124] At the same time, ANC provides an opportunity to promote healthy behaviours such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing. Therefore effective integration of different intervention packages during ANC offers an important potential for improving pregnancy outcomes for mothers and newborns.[125]

Childbirth clinical care package: This package consists of skilled attendance for normal childbirth and the availability of emergency obstetric care. Skilled care at birth and immediately afterwards can determine the survival and health of both mother and baby. Women with complications during childbirth need access to facilities that provide instrument delivery and caesarean sections. Clinical care should be made more accessible and culturally appropriate; necessary human resources and supplies for 24-hour care should be made available; quality should be improved; emergency transport schemes should be promoted; and financial barriers for the poor should be removed.[126]

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121 Villar J, Ba'aqeel H, Piaggio G, et al. WHO antenatal care randomised trial for the evaluation of a new model of routine antenatal care. Lancet 2001; 357: 1551-1564.

122 Campbell O, Graham WJ Lancet Maternal Survival Series steering group. Strategies for reducing maternal mortality: getting on with what works. Lancet 2006; 368: 1284-1299.

123 Lawn JE, Zupan J, Begkoyian G, Knippenberg R. Newborn Survival. In: Jamison D, Measham A, eds. Disease Control Priorities. Washington, DC, USA: Oxford University Press and The World Bank, 2006: 531-five49. www.dcp2.org.

124 Lawn JE, Cousens S, Darmstadt GL. Lancet Neonatal Survival Series Team. Executive Summary of the Lancet Neonatal Survival Series, 2005. http://www.who.int/child-adolescent-health/New_Publications/NEONATAL/The_Lancet/Executive_Summary.pdf.

125 WHO 2009. Integrated Management of Pregnancy and Childbirth (IMPAC): Recommended Interventions for Improving Maternal and Newborn Health. WHO/MPS/07.05.

126 Kerber KJ, de Graft-Johnson JE, Bhutta ZA, Okong P, Starrs A, Lawn JE. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet 2007; 370: 1358-1369.

Postnatal Care package: Postnatal care reduces the number of deaths of mothers and neonates, and supports the adoption of healthy behaviours. Compared to the large trials and detailed guides to implement antenatal care, postnatal care was neglected or divided into postpartum care for the mother and newborn care for the baby. However, new evidence is shaping the development of the postnatal package.[127,128] The postnatal package for mothers and babies should include routine visits in the first days after birth, when risk is high, to promote healthy behaviours and identify complications, and to facilitate referral. Some mothers or babies will need extra support, especially for preterm babies or HIV-positive mothers.[129] Postnatal care and intra partum care both have the potential to save 20 to 40% of newborn lives, and postnatal care costs only about half the amount of skilled care during childbirth.[130]

Integrated Management of Childhood Illness (IMCI)

The Integrated Management of Childhood Illness (IMCI) strategy, developed in 1996 by the World Health Organisation (WHO) and UNICEF is advocated globally, especially in developing countries, to improve the health of children and reduce under-five mortality.[131] IMCI focuses on the well being of the whole child and aims to reduce death, illness and disability, and to promote improved growth and development for children under five. IMCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities. Consequently the strategy includes three main components: a) Improving case management skills of health-care staff; b) improving overall health systems and c) improving family and community health practices.

In health facilities, the IMCI strategy promotes accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment of all major illnesses, strengthens the counselling of caretakers, and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care giving, improved nutrition and preventive care, and the correct implementation of prescribed care.[132] Due to its effectiveness IMCI is now implemented in over 113 countries and 5000 districts (>38% districts) across all six WHO regions.[133] Since IMCI introduction, many disease-specific interventions like diarrhoeal diseases (DD) and acute respiratory infections (ARI) have been included in this approach.

Expanded Programme on Immunization

Vaccination against childhood communicable diseases through the Expanded Programme on Immunization (EPI) is one of the most cost-effective public health interventions.[134] By reducing mortality and morbidity, vaccination can substantially contribute to achieving the Millennium Development Goal of reducing under-five mortality among children by two-thirds between 1990 and 2015.[135] WHO initiated EPI in 1974 with the objective to vaccinate children throughout the world. Ten years later, in 1984, they established a standardized vaccination schedule for the original EPI vaccines.[136] In 1999, the Global Alliance for Vaccines and Immunization (GAVI) was created with the sole purpose of improving child health in the poorest countries by extending the reach of the EPI. GAVI brought together a grand coalition, including the UN agencies and

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127 Haws RA, Thomas AL, Bhutta ZA, Darmstadt GL. Impact of packaged interventions on neonatal health: a review of the evidence. Health Policy Plan 2007; 22: 193-215.

128 Bang AT, Bang RA, Reddy HM. Home-based neonatal care: summary and applications of the field trial in rural Gadchiroli, India (1993 to 2003). J Perinatol 2005; 25: 108-122.

129 Kerber KJ, de Graft-Johnson JE, Bhutta ZA, Okong P, Starrs A, Lawn JE. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet 2007; 370: 1358-1369.

130 Horton R. The Executive Summary of The Lancet Neonatal Survival Series. Lancet. 2005; 365:977-88

131 WHO: Division of Child Health and Development. Integrated management of childhood illness: Conclusions. Bulletin of the World Health Organization 1997, 75(1):119-28.

132 http://www.who.int/maternal_child_adolescent/topics/child/imci/en/ (Last accessed June 3, 2014)

133 El Arifeen S, Blum L, Hoque D, Chowdhury E, Khan R, Black R, Victora CG, Bryce J: Integrated Management of Childhood Illness (IMCI) in Bangladesh: early findings from a cluster-randomised study. Lancet. 2004, 364(9445):1595-1602.

134 World Development Report 1993: Investing in health. http://files.dcp2.org/pdf/WorldDevelopmentReport1993.pdf

135 Brenzel L., Wolfson LJ., Fox-Rushby J., Miller M., Halsey N; in Disease Control Priorities in Developing Countries 2nd edition. Washington (DC): World Bank; 2006. Chapter 20. Vaccine Preventable Diseases.

136 Jamison D, Breman J, Measham A, Alleyne G, Claeson M, Evans D, Jha P, Mills A, Musgrove P. Disease Control Priorities in Developing Countries, Second Edition. 2006, The World Bank Group

institutions (WHO, UNICEF) as well as the World Bank, public health institutes, donor and implementing countries, the Bill and Melinda Gates Foundation, The Rockefeller Foundation, the vaccine industry, non-governmental organizations (NGOs) and many more. The creation of GAVI has helped to renew interest and maintain the importance of immunizations in battling the world's large burden of infectious diseases.[137]

Nutrition package

Adequate nutrients, beginning in early stages of life, are crucial to ensure good physical and mental development and long-term health. Iron-deficiency anaemia affects 42% of pregnant women (56 million), and maternal anaemia is associated with reduced birth weight for newborns, and an increased risk of maternal mortality. However, anaemia rates have not improved appreciably over the past two decades,[138] and every year an estimated 13 million children are born with intrauterine growth restriction[139] and about 20 million with low birth weight.[140] A child born with low birth weight has a greater risk of morbidity and mortality and is also more likely to develop non-communicable diseases, such as diabetes and hypertension later in life. In 2010 about 115 million children worldwide were underweight, 55 million had low weight for their height and 171 million under five had stunted growth.[141] Poor nutrition is an important determinant of mortality in the CEE/CIS region as well. Stunting remains high, affecting 20-30% of children in some countries. CEE/CIS has one of the lowest exclusive breastfeeding rates in the world (20% exclusive breastfeeding rate up to 6 months compared to the world average rate of 38%). To tackle nutrition-related problems and child mortality numerous interventions were evaluated[142] and the following were suggested as having the greatest public health impact:[143]

- **Early Initiation of Breastfeeding,** which is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. Numerous activities were implemented with WHO and UNICEF support including the Baby-friendly Hospital Initiative; promotion of International Code of Marketing of Breast-Milk Substitutes; etc.
- **Exclusive breastfeeding for up to six months**. Evidence shows that exclusive breastfeeding for six months is the optimal way to feed infants. Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond.**Error! Bookmark not defined.** This intervention alone has the potential to reduce neonatal and infant mortality by 55-87%.[144]
- **Micronutrient supplementation,** with an emphasis on Iron, Vitamin A, Iodine deficiency and zinc supplementation;
- **Food fortification** aimed at delivering micronutrients through fortified food.

To better visualise nutrition interventions we have mapped them along the child's life cycle in Figure 41. These interventions aim to improve nutrition and to prevent nutrition-related disease. They could reduce stunting at 36 months of age by 36%, and mortality between birth and 36 months by about 25%.[139]

137 The GAVI Alliance www.gavi.org

138 United Nations System Standing Committee on Nutrition. Progress in nutrition: Sixth report on the world nutrition situation. Geneva, United Nations System Standing Committee on Nutrition Secretariat, 2010.

139 de Onis M, Blössner M, Villar J. Levels and patterns of intrauterine growth retardation in developing countries. European Journal of Clinical Nutrition, 1998; 52(Suppl.1):S5-S15.

140 United Nations Children's Fund and World Health Organization, Low birthweight: country, regional and global estimates. New York, United Nations Children's Fund, 2004.

141 Underweight and stunting, in: World health statistics 2010, Geneva, World Health Organization, 2010.

142 Bhutta ZA, Ahmed T, Black RE, Cousens S, Dewey K, Giugliani E, Haider BA, Kirkwood B, Morris SS, Sachdev HPS, Shekar M., What works? Interventions for maternal and child undernutrition and survival. Lancet 2008; 371:417-440

143 Essential nutrition actions. Improving maternal-newborn-infant and young child health and nutrition. Geneva, World Health Organization, 2012.

144 Darmstadt GL, Bhutta ZA, Cousens S, Adam T, Walker N, de Bernis L. Evidence-based, cost-effective interventions: how many newborn babies can we save? Lancet. 2005; 365:977-88

Figure 41 Essential Nutrition Interventions During the Life Cycle

ANNEX 2: UNICEF SUPPORTED PPROGRAMMES THEIR RELEVANCE TO MAIN CAUSES OF CHILD MORTALITY AND MORBIDITY

"Intervention Packages"	UNICEF supported projects and program interventions in the evaluated period in Kazakhstan, Kyrgyzstan, Moldova, Serbia and Uzbekistan
ANC & PNC	• Antenatal Care • PMTCT • Effective Perinatal Care (EPC) • Emergency Obstetric Care (EmOC) • Neonatal and infant intensive care • Regionalization of perinatal care and delivery services • Postnatal visit for mother and child • Home Visiting Nurses • Demand creation activities
Nutrition	• Baby Friendly Hospital Initiative (promotion of International Code of Marketing of Breast-Milk Substitutes) • Early initiation of breast feeding • Exclusive breastfeeding • Food supplementation • Growth monitoring • Vitamin A supplementation • Anaemia Prevention and Control • Iodine deficiency • Food (salt, flour) fortification • Demand creation activities
EPI Strategy	• Traditional vaccine support • Underused vaccine support • New vaccine introduction • Vaccine Independent Initiative • Quality of Immunization services • Cold chain strengthening • Injection Safety • Surveillance system strengthening • Information, Education Communication (IEC)

"Intervention Packages"	UNICEF supported projects and program interventions in the evaluated period in Kazakhstan, Kyrgyzstan, Moldova, Serbia and Uzbekistan
IMCI Strategy	• ARI Support • Diarrheal diseases • Community and home based approach for better parenting • Information, Education Communication (IEC)

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
Perinatal causes of IMR	**ANC/PNC package** - interventions under this package mainly address perinatal conditions of infant mortality, such as prematurity, asphyxia, trauma and partially address the congenital anomalies		
	KAZAKHSTAN		
	Promoted development and supported implementation of the National Perinatal Action Plan directed towards improvement of the antenatal, delivery and postnatal care	Continued support for implementation of the National Perinatal Action Plan directed towards improvement of the antenatal, delivery and postnatal care. Furthermore, jointly with WHO UNICEF took initial steps for introduction of ILBD and BABIES. UNICEF independently supported further nationwide expansion of ILBD and BABIES matrix in all maternities.	Assisted the government in the development of a strategy and action plan on combating IMR and improving care for young children; Strengthened national capacities on international standards and practice on Effective Perinatal Care, Care for Development and promotion of vitamin and micronutrient supplementation; Performed equity and service efficiency focused cost–benefit analysis of the Basic Benefit Package; continued building health workforce capacity, provided support to MOH in the development of enabling legal environment and achieved national scale up of training programmes.
	Supported capacity building of the health professionals in safe motherhood, BF, integrated management of childhood illnesses, nutrition, better parenting, early childhood development	Supported the capacity building of the health HR in newborn resuscitation and ILBD, BEBEIS, quality of perinatal services, introduction of perinatal audit, as well as situation analysis of the MCH	
	By introduction of Family Education program helped to improve mother/caretakers knowledge about issues related to child development, nutrition, danger signs for child health etc.	By supporting patronage system reform, helped to build the country's antenatal care health workforce capacity in ANC new approaches aimed at promotion of early registration of pregnant women, risk identification and management.	
	In order to improve access to pre and postnatal services, UNICEF promoted changes into the BBP for effective delivery of perinatal services in the country.	UNICEF was instrumental in providing assistance to the MoH in regionalization of the perinatal services, development of national MCH package and standards and capacity building of health	

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
		Professionals and managers in perinatal care; monitoring of maternities in registration of low birth weight newborns, national certification of ENC and NR guidelines and monitoring in maternities, supported number of national consensus building activities as well as ensured integration of neonatal and child survival policies into the undergraduate and postgraduate education system.	
	KYRGYZSTAN		
	UNICEF supported introduction of neonatal part of EPC (Essential Newborn Care, Neonatal resuscitation) and EMoC through: protocols development, ToT and trainings, provided integration in in-service education system, Newbornlife saving equipment provision. Promoted introduction of the BABIES matrix and piloting and nationwide introduction of ILBD.	Expansion of EPC trainings, monitoring and supervision; continued provision of Newbornlife saving equipment. Supported the development and implementation of the National Perinatal Program; implementation of the regionalization and the PC quality assurance studies. Promoted the introduction of PMTCT. Supported Newborn e-registration system scale-up.	Expansion of EPC trainings, upgrading the maternity infrastructure and equipment in the south through the Equity Project. Perinatal quality care studies and the development of quality indicators and supporting the managerial capacity building. Update of PMTCT guidelines, integration of PMTCT in the EPC and at PHC level; Strengthening of perinatal infection control system (guidelines, SOP development; trainings)
		Supported implementation EPC trainings, upgrading the maternity infrastructure and equipment, quality of care in the south KYZ - most disadvantaged areas (in the frame of One UN Program)	
	MOLDOVA		
	UNICEF supported the development of the National Perinatal Program; perinatal system set-up/regionalization; within PHC piloting of antenatal care; Perinatal organizational and clinical guidelines protocols development, integration in the pre and in-service education system; UNICEF also supported perinatal surveillance system design and the introduction of the BABIES matrix	BBP package development, PHC reform scale-up; Revision of the Perinatal guidelines, protocols; supported a second wave of the National roll-out of trainings, supervision with monitoring, supervision; Evaluation and costing of the perinatal program; Community and social mobilization; introduction of PMTCT that included the development of national PMTCT guidelines; trainings and supervision	Supporting the scale-up of perinatal programmes by SDC (trainings, supervision, equipment provision). Further support to PMTCT, including the development of the updated PMTCT guideline
	SERBIA[145]		
	In 1999 UNICEF provided basic equipment, bed linen, matrasses, fuel for heating and emergency supplies to all	Continued to promote pregnant women and population education. Particular emphasis was placed on identification	UNICEF continued to promote pregnant women education through pregnant women schools; introduced new guidelines

[145]Serbia had 4 programme cycles. First – emergency response 1999-2001 and second 2002-2004. Thus we provide information for both cycles in the CPAP 1 column.

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	maternity wards in the country.	most marginalized group of the society, such as Roma IDPs and Roma ethnic groups in Roma settlements through introduction of Roma mediators and their integration into the PHC system.	for management of disabled and vulnerable children at PHC, opened Cabinets for management of disable children and promoted education and linking of Roma population to the PHC services and health system in general.
	Starting from 2000 UNICEF promoted Integrated Maternal and Child Health (IMCH) Program directed towards improvement of the antenatal, and postnatal care through capacity building of PHC health personnel with particular emphasis on patronage nurses. In parallel introduced Newborn Resuscitation guideline and ensured training of all neonatologists in the country.		
	UNICEF also promoted population education at community level. Carried out Research on Family Care Practices, promoted establishment of community education centres,translated and printed UNICEF's brochure on Fact for Life delivering of health education messages. Furthermore developed guidelines on child rights and introduced phone counselling services.	Continued training of patronage nurses with the focus on antenatal and postnatal care of women and children. Carried out Research on Family Care Practices, promoted establishment of community education centres.	
	UZBEKISTAN		
	Starting from 2000 UNICEF promoted safe motherhood program directed towards improvement of the antenatal, delivery and postnatal care. Furthermore, in order to improve reporting system, UNICEF jointly with WHO took initial steps for introduction of ILBD and BABIES. Provided technical support for the development of the national strategy and policy on PNC as well as for the national "Infant and child mortality reduction plan". Jointly with WHO provided technical assistance for the development of the Perinatal Service Regionalization Plan.	One of the key partners - UNFPA started to build the country's antenatal case health workforce capacity in ANC new approaches aimed at promotion of early registration of pregnant women, risk identification and management. Using UNFPA built national training capacity UNICEF supported training of human resources at PHC level in 6 regions of the country.	In the third phase of UNICEF programmes continued to support building health workforce capacity, provided support to MOH in the development of enabling legal environment (assisted the MoH in the development of ANC standards and referral guidelines) and achieved national scale up of training programmes, incorporation of ENC/PNC approaches in the medical education programmes country wide (undergraduate, postgraduate) as well as national introduction of ILBD as a single source of reporting.
		UNICEF was instrumental in providing assistance to the MoH in regionalization of the perinatal services, development of national MCH package and standards and capacity building of health professionals in EPC and NR and managers in perinatal care provision, birth and death registration; continued work on introduction of ILBD nation wide, , national certification of ENC and NR guidelines and monitoring in maternities, supported number of national	

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
		consensus building activities as well as ensured integration of neonatal and child survival modern approaches into the undergraduate and postgraduate education curricula.	
		UNICEF also helped the government in introduction of BABIES matrix in maternity homes (though not covering other facilities beyond maternities) for informed decision-making and policy development at national, local and facility levels.	
	Nutrition package - Some of the interventions included in the Nutrition package, such as prevention of micronutrient deficiencies in mothers target the perinatal conditions of infant mortality		
	KAZAKHSTAN		
	First steps were initiated to introduce salt iodization, flour fortification and introduction of vitamin A supplementation. Initiating the support in the development of the law on flour fortification,	In cooperation with the Ministry of Health, UN and national partners, a program on reducing maternal and child mortality incorporating best MCH practices was developed and approved which addresses control of micronutrient deficiencies, Promoted expansion of BFHI practices to additional health facilities and supported certification process. Provided substantial support to establish legislative base for USI and flour fortification through extensive advocacy and capacity building of key players in the field, which resulted in leveraging resources from policy makers, legislators, private producers, and civil society thus ensuring access to iodized salt and fortified flour. Contributed to the introduction of the Vitamin A supplementation nationwide by institutionalization of annual National VAD prevention weeks	Assisted the Government in strengthening the national monitoring and quality control system on the implementation of the flour fortification to further reduce anaemia level among women of reproductive age through building capacity of Kazakh Academy of Nutrition and SES.
	UNICEF also promoted population education at community level through its family education activities. Specifically piloted new community approaches and delivery of health education messages, particularly targeted at parents and pregnant women and covering breastfeeding, IDD, iron and Vitamin A deficiency	In partnership with Kazakh Academy of Nutrition and PR companies developed a logo for fortified food products, which was widely advertised countrywide. UNICEF continued to raise population knowledge on micronutrient deficiencies through its family education activities mass communication campaigns.	Continued to promote pregnant women and population education to improve utilization of iodized salt and fortified flour as well as communicated importance of iron deficiency anaemia prevention.

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	KYRGYZSTAN		
	UNICEF supported the prevention of IDD and USI through supporting the development of the legislative documents Presidential Decree, National Program on IDD), proposal for ADB to raise more funds, public and private sector capacity building, establishment of Salt Producers Association, organization of regional conferences, study tours; communication campaign and piloting salt iodization promotion by VHCs in pilot oblast.	UNICEF supported IDD, FF and USI through the scale-up and funds leveraging for the home fortification program (Gulazyk), development of the National Plan 2008-2012 for IDD control; National Program and plan of action for VMD elimination; Nutrition program expansion on the community level (VHC)s; Establishment of the revolving fund with "Premix Fund"; Vitamine A nationwide supplementation to women and children, leveraging of funds (inclusion in the SWAp); Micronutrient supply to south oblasts, staff training of severe malnutrition and feeding practices	UNICEF continued support to the prevention of IDD, FF and USI through supporting the development of the law on flour fortification, multi-sectoral cooperation on the development of National Food Security and Nutrition Program (Nutrition Strategy) for 2014-2017), leveraging funds from GAFSP, public and private sector capacity building,
	UNICEF supported BF and BFHI through ToT, training material and protocol development, eventually approved by MoH, training of health workers, integration of training modules in pre and post-diploma curriculum, monitoring, refresh trainings, IEC materials development	UNICEF continued support to BF and BFHI through the assistance in the development of the Code on Breast milk substitutes, in BFHI certification/recertification, trainings and monitoring.	UNICEF continued support to BF and BFHI through the assistance in BFHI certification/recertification, trainings and monitoring.
	UNICEF supported the prevention of IDA by developing protocol, conducting study on anaemia prevention and control piloting iron supplementation in 5 pilot districts, advocating for inclusion of iron and folic acid in BBP for antenatal care		
	UNICEF supported the prevention of VAD through Vitamin A supplementation pilot, trainings and community mobilisation		
	MOLDOVA		
	UNICEF supported the prevention of IDD and USI through conduct of nutrition studies, policy dialogue to rise awareness on magnitude of micronutrient deficiency burden, supported organization of first nutritional conference, IEC and social mobilisation.	UNICEF continued support to the prevention of IDD and USI through assistance in the Food Law development, support in the, development of the IDD National Program, organization of second nutritional conference, capacity development of the private sector in iodization and changing misconceptions regarding iodization affecting food quality.	Through multi-sectoral cooperation created enabling environment of National IDD elimination Program adoption. Private sector capacity development, Cooperation with industry and integration of FF and salt iodization in largest bakery of the country. UNICEF supported the development of the national program on reducing iron and folic acid deficiencies approved in 2012.
	UNICEF supported BF and BFHI through - ToT, training modules development, protocols development approved by MoH, training of health workers, integration of modules in pre and post-diploma curriculum, monitoring, refresh trainings, IEC materials development and BHFI certification	UNICEF continued support to BF and BFHI through the assistance in the development of the Concept on Child and Mother Friendly Maternity Houses and BFHI certification/recertification, trainings and monitoring.	Continued support to World Breastfeeding Weeks, breastfeeding and child feeding topics integrated into Perinatal and IMCI training modules, therefore no separate training activities.

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	SERBIA		
	Through itsproject on Breastfeeding and BFHI promotion along with introduction of early Childhood Growth and Development UNICEF and support for IDD quality monitoring addressed malnutrition as a cause of mortality. UNICEF together with WHO initiated BF and BFHI activities back in 1995. In order to identify underlying problems UNICEF financed analysis of BF&BFHI implementation and Public Opinion Poll on breastfeeding, assisted the government in the development of the BF & BFHI Action Plan,BF policy and training course, BF promotional materials, built capacity of the health professionals at PHC and maternity hospitals, supported operation of the National BF committee, BF Hot-line operations and continued certification, re-certification of maternities. Furthermore supported the government in celebration of Breastfeeding Weeks UNICEF strengthened national IDD laboratory capacity through provision of required equipment, supported IDD seminars for building IDD/USI monitoring capacity. Assisted the government in the development of the new standards on the levels of iodine in salt and the rulebook. Supported communication sessions for salt producers and media, as well as development of communication material for the pregnant women.	UNICEF's active involvement in BF&BFHI ended in the previous program cycle. UNICEF contributed to the inclusion of the articles of International Code of Marketing of Breast Milk Substitutes in the key laws of Serbia being approved in 2005. In support of USI financed survey on biological impact of USI, built national staff capacity on applying modern IDD standards. Assisted the country for the preparation for IDD elimination certification.	Facilitated inclusion of BFHI in the National Program on "Health care of women and children and young people", supported the National Breastfeeding, Infant and Young Child Feeding Committee established by the Government of the Republic of Serbia, assisted in the development of BF promotion action plan and attempted to integrate BFHI into the accreditation system. UNICEF's contribution towards IDD and USI was limited to the support for incorporation of IDD training module into the CME program.
	UZBEKISTAN		
	UNICEF addressed micronutrient deficiencies during pregnancy. First steps were initiated to introduce salt iodization, flour fortification and introduction of vitamin A supplementation. A mass iodization campaign held with UNICEF's financial and technical support aimed to increase the awareness of school children on the importance of consuming iodized salt to combat IDD. Promoted Breastfeeding through capacity building of health professionals in BF&BFHI, citification of maternities as BFHs and assisted the Government in annual celebration of the world breastfeeding week.	UNICEF continued support to the ensured access of pregnant women to iodized salt, and fortified flour through assisting the government in the development and implementation of strategic communication plan for flour fortification, development and approval of the relevant legislation in support of FF.	UNICEF through its advocacy efforts ensured provision of anaemia prevention for rural pregnant women fully supported and financed by the state. Technical assistance has been provided for the development of new nutrition standards for fortified products and for the development of outreach activities. Assisted the government in drafting a law on "Preventive measures for micronutrient deficiencies" and in preparation of plan of action for implementation of law. Jointly with other UN agencies helped the government in adoption of the National Strategy on sustainable agriculture, food security and nutrition being approved w/t support. Jointly with WHO continued training of national lab specialists for monitoring

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	Advocated for adoption of International Code of Marketing of Breast milk substitutes through organization of roundtables, workshops and seminars with policy makers and national stakeholders and provision of technical assistance for drafting the law on marketing of breast milk substitutes. Promoted capacity building of health professionals and other specialists on the Code and supported community based breastfeeding promotion activities in pilot regions.		micronutrient deficiencies thus supporting institutionalization of monitoring of micronutrient deficiencies at a national level.
	UNICEF also promoted population education at community level through its family education activities. Specifically piloted new community approaches and delivery of health education messages, particularly targeted at parents and pregnant women on nutrition during the pregnancy, danger signs, etc.	UNICEF continued support to BF and BFHI through the assistance in the adoption of the Code on Breast milk substitutes, in BFHI certification/recertification, trainings and monitoring.	UNICEF continued support to BF and BFHI through the assistance in BFHI certification/recertification, trainings and monitoring.
ARI/DD, respiratory and other infectious disease, as causes of IMR, U5MR and morbidity	**EPI intervention package** - interventions target leading causes of child mortality and morbidity, namely vaccine preventable infectious diseases		
	KAZAKHSTAN		
	UNICEF supported introduction of new vaccines through enhancement of the cold chain by provision of the cold chain equipment and supported the government in implementation of the National immunization campaigns. In order to address public concern regarding the overall benefits of immunisation practices in general, activities mainly focused on media sensitivity and mobilisation for two national immunisation campaigns	UNICEF continued support for national immunization campaigns for measles and rubella, cold chain management assessment	Supported supplementary immunization activities to respond Polio outbreak in CAR, conducted at the national and sub-national levels, assisted in the development of effective national and local strategies to 'reach the unreached' as a part of the Routine Immunization Programme and advocate for the integration of new strategies in the multi-year immunization plan with sustainable funding; Support was made available for continuous monitoring of the immunization coverage among marginalized groups.
	KYRGYZSTAN		

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	UNICEF supported the establishment of vaccine Independence Initiative and advocated for national budget allocations; immunization campaigns on Measles/Rubella and Hepatitis B with social mobilization components; Establishment of ICC, Support in the proposal development to GAVI and development of FSP; trainings on Immunization practice, Injection safety for PHC and maternity staff; development of the protocols on safe injection, AEFI; Cold chain upgrade, training of cold chain managers, cold chain assessment; Immunization MIS strengthening, knowledge exchange study, computer training for EPI managers	UNICEF provided advocacy work on new vaccine introduction, continued trainings on Immunization practice, cold chain upgrade, training of cold chain managers; promotion of injection safety for PHC and maternity staff; polio campaign support (two rounds); cold chain monitoring and assessment; EPI monitoring; strengthening MoH capacity in vaccine procurement, cost analyses,	UNICEF continued community mobilization, support in multi-year planning, advocacy work on new vaccine introduction, trainings on Immunization practice, cold chain upgrade, promotion of injection safety for PHC and maternity staff; cold chain monitoring and assessment; and EPI reviews
	MOLDOVA		
	UNICEF supported the cold chain upgrade, training of cold chain managers, cold chain assessment; Immunization MIS strengthening, computer training for EPI managers; development of the training modules for nurses and trainings on Immunization practice, Injection safety for PHC and maternity staff; EPI monitoring; advocacy for financial sustainability	UNICEF supported the development of the FSP, continued cold chain upgrade, training of cold chain managers; cold chain monitoring and assessment and EPI monitoring, supported communication for immunization campaigns.	UNICEF continued to support training of cold chain managers, cold chain assessment and upgrade; trainings on immunization practice, Injection safety for PHC and maternity staff; EPI monitoring; Supported research to identify perceptions, concerns and roots of resistance to vaccination. Developed evidence-based communication strategy that supported new Rotavirus vaccine introduction and development of crisis communication strategy.
	SERBIA		
	To improve the quality of EPI services UNICEF carried out cold chain management assessment and supported the government to update cold chain equipment. In response to MICS 2 findings assisted the government in the development of reaching unreached strategy for Roma and initiated Immunization Plus program for improvement of immunization coverage amongst Roma children;	UNICEF supported NGOs for immunization of vulnerable groups and advocated the government for the inclusion of marginalized groups in the health system. Continued the upgrade of the cold chain	UNICEF continued enhancement of cold chain management capacity and capacity building of EPI managers in cold chain management, building capacity of Roma health mediators to promote timely immunization and linking Roma children to PHC. No particular activities were carried out in response to anti immunization movement.
	UZBEKISTAN		
	UNICEF supported EPI program interventions before the evaluation period and achieved strengthening of national immunization program and introduced Vaccine Independent Initiative. Since 2000 the Government of Uzbekistan fully financed vaccine for routine immunization. In 2000 UNICEF	UNICEF supported vaccination campaigns for measles, cold chain management assessment, Built capacity of all nurses, EPI managers and vaccine store keepers at national and local levels in cold chain management; Continued staff raining in waste management. Contributed to the	UNICEF continued staff raining in waste management. Updated comprehensive multi-year immunization plan adopted and supported the government in supplementary immunization campaigns on sustainable polio eradication.

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	assisted the government to introduce new vaccines through GAVI and provided technical assistance together with WHO in preparation of the GAVI proposal; CmYP, development of MoH decree on introduction of new vaccines and training of health professionals. Furthermore UNICEF initiated development of the AEFI and Safe Immunization Practice guidelines and standards, assisted the government in strengthening the monitoring system and in the development of the regulatory framework for waste management and initiated training of health professionals in waste management.	development of MOH Decree on Standard Operation Procedures of vaccines storages and Vaccines Management and capacity building of EPI professionals Helped the government to develop SIP/AEFI guidelines and protocols, national standards and regulation documents, training curricula for inclusion of SIP/AEFI issues in the undergraduate and postgraduate education programmes, modified EPI monitoring system, piloted SIP in selected geographical locations, trained health personnel and contributed to the national scale up.	
	IMCI Package - interventions included in these package target all the leading causes of child mortality and morbidity		
	KAZAKHSTAN		
	Introduction of IMCI started back in 1999 with support of WHO. UNICEF through its IMCI package of interventions promoted international knowledge exchange of national partners, building national IMCI training capacity, supported establishment of national IMCI Centre and integration of IMCI related issues in the National Program through UNICEF's better parenting initiative the communication materials developed for parent education included IMCI related issues and piloted. Training of trainers and primary health care workers organized; Parenting Education Programme developed and basic health services package was designed	Activities directed towards implementation of IMCI were stopped based on the guidance from UNICEF RO. Therefore the focus was mainly on further strengthening of the better parenting initiative, parent education and promoting new model of the patronage system.	UNICEF supported training of health staff on IMCI hospital module and development of MOH Decree on nationwide introduction of IMCI Hospital standards. Continued parent education on antenatal and postnatal care, management of childhood illnesses, HIV/AIDS etc. in 6 oblasts of the country, though starting from 2012 the given program was closed due to the shortage of funding.
			UNICEF assisted the Government of Kazakhstan in the design of the models for Kazakhstan on strengthening the Family/Community component of Primary Health Care and Enhanced Home Visiting Systems; Conducted a public communication campaign to promote critical child-care practices and protective environment within families and communities and modelled multidisciplinary social services for children at Primary Health Care to address needs of most disadvantaged at community level.
	KYRGYZSTAN		

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	UNICEF supported the IMCI piloting in 5 districts; ToT and IMCI coordinators training, training module development, training of PHC personnel, protocol development and approval by MoH, integration of the module in the post-diploma curriculum; Establishment of the IMCI coordination centre and advocacy for inclusion of IMCI drugs in the list of essential drugs.	UNICEF supported the development of IMCI modules for nurses. However, suspended IMCI activities at PHC level, leaving to other donors (USAID, ADB) the scale-up efforts. Fudging was provided from National Den-Soluuk Program as well. UNICEF continued supporting CCD integration with the nutrition components and expansion to the communities through VHC	In collaboration with WHO, UNICEF supported training of health staff on IMCI hospital module in the pilot oblasts; continued support to CCD for parent education on antenatal and postnatal care, management of childhood illnesses and nutrition through VHC.
	MOLDOVA		
	UNICEF supported the IMCI piloting; ToT and IMCI coordinators training, training module development, training of PHC personnel, protocol development and approval by MoH, integration of the module in the pre and post-diploma curriculum and advocacy for inclusion of IMCI drugs in the list of compensated drugs; development of child and mothers cards.	UNICEF supported policy dialogue on ECCD; the development of new model of child and family community centres and a new ECD training module for nurses. UNICEF's support was picked by SDC and rolled out nation wide	UNICEF supported evaluation of IMCI program, results of which informed further programming (e.g. revision of the national monitoring system, strengthening nurse training) Supported revision of the child development card UNICEF supported the expansion of IMCI in Transdnestria, while IMCI trainings were scaled-up by SDC, integration in the local pre and in-service training programmes.
	SERBIA		
	Introduction of IMCI started back in 1999. In 2000 UNICEF through its IMCI package of interventions promoted training of PHC health workers on Integrated MCH (IMCH) program that targeted topics related to immunization, pneumonia, diarrheal diseases, breastfeeding and nutrition.	UNICEF continued training of health personnel in IMCH. Trainings in Emergency paediatrics has been discontinued due to the lack of funding.	
	UNICEF supported the development of Emergency Paediatrics training curriculum with major focus on PHC. UNICEF also provided Paediatric Emergency Training Equipment (training and demonstrational models). Through enhancement of patronage nursing system and population education activities targeted issues related to infectious diseases.	UNICEF continued support to the patronage nursing system, established phone counselling services along with community education centres	UNICEF assisted the government in the development of Standard guidelines of parenting schools, promoted capacity building of Roma health mediators and linking Roma children to patronage services.
	UZBEKISTAN		
	Introduction of IMCI in Uzbekistan started back in 1999 with support of WHO. UNICEF supporting IMCI promoted international knowledge exchange of national partners, building national IMCI training capacity, supported establishment of national IMCI Centre and integration of IMCI related issues in the National Program on Onava Bola" and	In the second CPAP period UNICEF UZ CO was instructed to stop activities directed towards IMCI, nevertheless starting from 2006 UNICEF supported capacity building of Health Managers in organization and management of MCH services including IMCI issues, development of ARI and DD guidelines and protocols and building health human resource capacity.	Supported the MoH in the assessment of IMCI implementation jointly with WHO and through organization of National conferences and workshops promoted development and adaptation of IMCI hospital guidelines, training materials. UNICEF supported training of health staff on IMCI hospital module in 6 regions and development of MOH Decree on

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	"SoglomAvlod", provided technical assistance to the MoH in development of national IMCI action plan, piloted in Fergana oblast and made first attempts to integrated IMCI approach into the undergraduate and postgraduate medical education system. Furthermore UNICEF provided IMCI basic supplies to health facilities in the pilot oblast.	Helped with integration of IMCI in health manager's continuous professional development, training of MCH Managers, assessment of IMCI action plan implementation together with WHO, and development of MOH decree in integration of IMCI in medical education system.	nationwide introduction of IMCI Hospital standards.
	Through Better Parenting Initiative supported development of the communication materials and promoted parent education on IMCI related issues.	Continued parent education on management of childhood illnesses, HIV/AIDS etc. in 6 oblasts of the country	Continued parent education on management of childhood illnesses, HIV/AIDS etc. in 6 oblasts of the country, though starting from 2012 the given program was closed due to the shortage of funding.
Malnutrition as a U5 child morbidity cause	**Nutrition Package -** specific interventions from these package target malnutrition as a leading cause of child morbidity		
	KAZAKHSTAN		
	Through its project on Micronutrients (IDD, FF VAD), Breastfeeding and BFHI promotion along with development of an effective USI monitoring system and communication strategy and campaign addressed malnutrition cause of morbidity and mortality of children U5	UNICEF continued to work on the control of micronutrient deficiencies, promoted USI and flour fortification, supported development of conducive legal environment, assisted the government in policy development, and developed government capacity in M&E and quality control issues.	UNICEF assisted the Government in strengthening the national monitoring system on the implementation of the flour fortification; provided technical assistance for the development of the National Program on Vitamin A supplementation and designed training module; carried out national wide social mobilization campaign for promotion of flour fortification
	KYRGYZSTAN		
	UNICEF initiated support to malnutrition prevention through the prevention of IDD, IDA; BF and BFHI and VAD promotion along with introduction of the early child feeding, child growth and monitoring in the PHC practice	UNICEF continued support to malnutrition prevention through the prevention of IDD, IDA; BF and BFHI and VAD promotion along with introduction of the child growth and monitoring in the PHC practice and community mobilisation initiatives. Integrated nutrition topics were incorporated into VHC communication package.	UNICEF continued support to the prevention of IDD, FF and USI through supporting the development of the law on flour fortification, National Program Strategy for 2014-2017); leveraging funds from GAFSP, public and private sector capacity building; continued support to BF and BFHI through the assistance in BFHI certification/recertification, trainings and monitoring.
	MOLDOVA		
	UNICEF supported the prevention of IDD and USI through conduct of nutrition studies, policy dialogue and IEC and social mobilisation.	UNICEF continued support to the prevention of IDD and USI through the support in the development of the IDD National Program, organization of second nutritional conference, capacity development of the private sector	UNICEF continued support in the development of the national IDD elimination program, continue monitoring on IDD prevalence. Capacity development of private sector on flour fortification

Causes	Programmatic support across interventions packages and countries		
	CPAP 1	CPAP2	CPAP3
	UNICEF supported BF and BFHI through - ToT, training modules development, protocols development approved by MoH, training of health workers, integration of modules in pre and post-diploma curriculum, monitoring, refresh trainings, IEC materials development and BHFI certification	UNICEF continued support to BF and BFHI through the assistance in the development of the Concept on Child and Mother Friendly Maternity Houses and BFHI certification/recertification, trainings and monitoring.	Capacity development on Breastfeeding and child feeding through perinatal and IMCI modules.
	SERBIA		
	Through itsproject on Breastfeeding and BFHI promotion along with introduction of early Childhood Growth and Development UNICEF and support for IDD quality monitoring addressed malnutrition as a cause of child morbidity. UNICEF together with WHO initiated BF and BFHI activities back in 1995. In order to identify underlying problems UNICEF financed analysis of BF&BFHI implementation and Public Opinion Poll on breastfeeding, assisted the government in the development of the BF & BFHI Action Plan,BF policy and training course, BF promotional materials, built capacity of the health professionals at PHC and maternity hospitals, supported operation of the National BF committee, BF Hot- line operations and continued certification, re-certification of maternities. Furthermore supported the government in celebration of Breastfeeding Weeks UNICEF strengthened national IDD laboratory capacity through provision of required equipment, supported IDD seminars for building IDD/USI monitoring capacity. Assisted the government in the development of the new standards on the levels of iodine in salt and the rulebook. Supported communication sessions for salt producers and media, as well as development of communication material for the pregnant women.	UNICEF's active involvement in BF&BFHI ended in the previous program cycle. UNICEF contributed to the inclusion of the articles of International Code of Marketing of Breast Milk Substitutes in the key laws of Serbia being approved in 2005. In support of USI financed survey on biological impact of USI, built national staff capacity on applying modern IDD standards. Assisted the country for the preparation for IDD elimination certification.	Facilitated inclusion of BFHI in the National Program on "Health care of women and children and young people", supported the National Breastfeeding, Infant and Young Child Feeding Committee established by the Government of the Republic of Serbia, assisted in the development of BF promotion action plan and attempted to integrate BFHI into the accreditation system. UNICEF's contribution towards IDD and USI was limited to the support for incorporation of IDD training module into the CME program.
	UZBEKISTAN		
	Through its project on Micronutrients (IDD, IDA, VAD), Breastfeeding and BFHI promotion along with introduction of early Childhood Growth and Development UNICEF addressed malnutrition as a cause of child mortality and morbidity.	UNICEF continues work on the control of micronutrient deficiencies, promotes USI and flour fortification, builds conducive legal environment, assists the government in policy development, and builds government capacity in M&E and quality control issues.	UNICEF assists the government in implementation of nutrition national policy and investment plan as well as through its national and community level activities promotes change of social norms and believes as well as timely utilization of iodized salt and fortified flour along with Vitamin A and iron supplementation. Support for certification and recertification of BFHI hospitals continued.

ANNEX 3: KEY PARTNERS ROLES AND CONTRIBUTIONS TO UNICEF SUPPORTED PROGRAMMES

DEVELOPMENT PARTNER	INTERVENTION PACKAGES				
	ANC/PNC	NUTRITION	IMCI	EPI	OTHER
KYRGYZSTAN					
	UNICEF leads SWAp MCH group since 2007				
Government		- National Nutritional Strategy development - Home fortification included in the national programming - Introduction of iron and folic acid supplements for pregnant women in the benefit package	- Introduction of IMCI drugs in the benefit package - Integration of ECD into communication materials of VHC	- Co-financing under of the Vaccine Independence Initiative	- MICS 3, 5
Academia	- EPC Curricula included in postgraduate education	- BF curricula included in postgraduate education	- IMCI curricula is included in postgraduate education		
GAIN		- Revolving funding was established to support potassium iodate supply;			
World Bank	- Defining RBF indicators for the WB project	- Support of micronutrient powder program - Generation of evidence on economic loss of under nutrition and possible growth after nutrition improvement			
ADB	Support in ILBD scale-up	- Supported FF and salt iodization program - Joint ministerial round-table in Almaty on food fortification - Advocated for reduction of taxes for fortificants / fortification equipment	- Supported IMCI in three oblasts		
WHO	- Joint initiation of PEPC - Development of first	- Advocacy and training on breast feeding and BFHI	- Joint initiation of ARI/DD and IMCI	- Development of national standards on Safe	

DEVELOPMENT PARTNER	INTERVENTION PACKAGES				
	ANC/PNC	NUTRITION	IMCI	EPI	OTHER
KYRGYZSTAN					
	cohort of national trainers - Joint UN Program (DaO) - Joint Equity Project - Adaption of the EPC, PMTCT guidelines	-	- Adaptation of IMCI materials - Hospital level IMCI	immunization, AEFI - National Immunization Campaigns - Cold chain assessment - Introduction of new vaccines	
UNFPA	- Joint UN Program (DaO) - Joint Equity Project - Scale-up of EPC program - Scale-up of PMTCT program				- DHS
USAID	- Jointly with CDC-Atlanta advocated for introduction of ILBD - Supported scale-up - Establishment of partners network to provide access to marginalized HIV positive women, development of training modules	-	Supported IMCI in two regions	-	DHS
SRC	- Infection control in maternity houses	- Training of VHC, development of communication materials for them - Training of VHC on salt iodization monitoring and equipping with test kits		-	
SOROS Foundation	- Establishment of partners network to provide access to marginalized HIV positive women, development of training modules	-		-	
JAPAN GOVERNMENT		-		Cold chain supplies	
GIZ	- Strengthening of M&E unit at the National MCH				

DEVELOPMENT PARTNER	INTERVENTION PACKAGES				
	ANC/PNC	NUTRITION	IMCI	EPI	OTHER
KYRGYZSTAN					
	center - Scale-up of EPC program - Scale-up of PMTCT program - Support in ILBD scale-up				
Private Sector		- Flour miller's association supported FF process - Salt manufacturers association supported salt iodization process - Support of local production of MNP (micronutrient powder)	-		
NGOs/CSOs	- Associations of ob/gyn; midwifes, family doctors involved in standards development, trainings, monitoring, coaching	- Monitoring of violation of Code of Breastmilk substitutes - Monitoring of salt iodization			

DEVELOPMENT PARTNER	INTERVENTION PACKAGES				
	ANC/PNC	NUTRITION	IMCI	EPI	OTHER
MOLDOVA					
Government	- Regionalized Perinatal care fully institutionalized	- Introduction of iron and folic acid supplements for pregnant women in the benefit package	- Introduction of IMCI drugs in the benefit package - Institutionalization of IMCI care	- Co-financing under of the Vaccine Independence Initiative	- MICS 3, 4 - DHS
Academia	- EPC Curricula included in pre and postgraduate education	- BF curricula included in pre and postgraduate education	- IMCI curricula is included in pre and postgraduate education		
World Bank			- Supported scale-up of IMCI		Cooperation on PHC reform piloting, BBP development
WHO	- Joint initiation of EPC - Adaptation of the EPC, PMTCT guidelines	- Advocacy and training on breast feeding and BFHI	- Joint initiation of ARI/DD and IMCI - Adaptation of IMCI guidelines	- Development of national standards on Safe immunization, AEFI - National Immunization Campaigns - Cold chain assessment - Introduction of new vaccines	Cooperation on PHC reform piloting, BBP development; MICS-4
UNFPA					- DHS
USAID	- Advocacy for and introduction of ILBD - Establishment of perinatal surveillance system - Provision of vaccines for immunization campaign				DHS
SDC	- Continued Perinatal Care		Continued IMCI program		MICS-4
JAPAN GOVERNMENT	- Supply of perinatal centres with life saving equipment			Vaccines and Cold chain supplies	
Private Sector		- Flour miller's association supported FF process - Support of local production of fortified bread	-		
NGOs/CSOs	- Perinatal association				LUMOS supported

	involved in capacity development, monitoring, training activities				Government in establishment of the multidisciplinary teams (social assistance and health worker) in order to address risky situation of children under five and avoid under five mortality at home
DEVELOPMENT PARTNER	**INTERVENTION PACKAGES**				
	ANC/PNC	**NUTRITION**	**IMCI**	**EPI**	**OTHER**
KAZAKHSTAN					
Government		- UNICEF initiated Iron Supplementation has been co-financed by JICA and later fully funded by the Government			- MICS 4 - Joint UN Program on the "raising competitiveness of the East Kazakhstan region, Kyzilorda and Mangistau through innovative approaches to regional planning and social services for 2011-2015.
GAIN		- Funding was made available for Flour fortification and communication related activities for control of micronutrient deficiencies			
World Bank		- Flour fortification			Revision of BBP based on the findings of UNICEF financed "Cost Benefit Analysis of BBP"
ADB		- Advocacy and communication for FF legislation - Supported implementation of national VAD survey within MICS framework procured the HPLC for KAN - National workshop for ISS communication strategy development			
UNDP	- Joint UN Program in SKO - GFATM funded PMTCT component of the National HIV Program				- MICS 3 - Joint UN Program on the "raising competitiveness of the East Kazakhstan region, Kyzulorda and Mangistau through innovative approaches to regional planning and social services for 2011-2015.
WHO	- Joint UN Program in SKO - Study tour to Ukraine, Odessa	- Advocacy and area wide training on breast feeding	- Advocacy - Adaptation of IMCI materials	- National Immunization Campaigns	- MICS 3, - Joint UN Program on the

	for the policy makers responsible for policy development in MCH, obstetrics, gynaecology, neonatology, paediatrics, and infectious diseases. - Supported development of PMTCT protocols - Workshop on strengthening perinatal care by appropriate technologies - IMR policy meeting - Adaptation and development of the clinical guidelines for effective perinatal care - PMTCT TOT	- IDD elimination certification	- IMCI Care for Development ToT course - A joint orientation meeting on the IMCI 3rd component development - Joint UN Program – strengthening of PHC home visiting scheme for families with young children under three - National orientation meeting for the development of the Better Parenting initiative -	- Cold chain assessment - Introduction of new vaccines	"raising competitiveness of the East Kazakhstan region, Kyzulorda and Mangistau through innovative approaches to regional planning and social services for 2011-2015.
UNFPA	- Joint UN Program in SKO - Capacity building of health professionals on Safe Motherhood policy, developed by the MoH with UNICEF support, has been adopted by UNFPA and Project "HOPE" (funded by USAID) and replicated across the whole country - Distribution of manuals on WHO Life Birth Definition and Essential Newborn Care and Breastfeeding		Joint UN Program – strengthening of PHC home visiting scheme for families with young children under three, Better Parenting Initiative		- MICS 3, - MICS 4 - Joint UN Program on the "raising competitiveness of the East Kazakhstan region, Kyzulorda and Mangistau through innovative approaches to regional planning and social services for 2011-2015.
ILO					MICS 3
USAID	- AIHA supported a Study tour to Ukraine, Odessa for the policy makers responsible for policy development in MCH, obstetrics, gynaecology, neonatology, paediatrics, and infectious diseases.	- Support to the IDD/USI and financed UNICEF's proposal - Supported participation of national partners in IRLI conference in Cape Town, South Africa	Co-financed Family Education and the printing of Facts for Life	-	MICS 3
JAPAN GOVERNMENT		- Co-financed Iron Supplementation	IMCI guidelines	Cold chain supplies	
CDC Atlanta	- Joined UN agencies in programming of MCH interventions within the frames of UN joint program in SKO - Training protocol on Infection Control - IMR policy meeting – demonstration of BEBIS	- Development of IDA Plan of Action and the communication strategy - National workshop for ISS communication strategy and implementation plan development - Supported participation of national partners in IRLI	- Better Parenting Communication workshop -		

	methodology - Study tour to CDC Atlanta and training in BABEIS methodology - Printing of manuals on WHO Life Birth Definition and Essential Newborn Care and Breastfeeding	conference in Cape Town, South Africa - Supported participation of public and private sector representatives in Area workshop on micronutrient deficiencies			
GIZ	Infection control in maternities and child hospitals				
National media network	Public awareness on issues of child protection, HIV, nutrition and the child-friendly city concept, CRC related issues, dissemination of better parenting messages, development of a logo for fortified food products, supported IDD communication campaign				
Private Sector	Kazkommenttsbank focused to combat infant mortality in East Kazakhstan region	Flour miller's association supported FF process and contributed to the development of a logo for fortified food products	- Bakyrchik Company fosters ECD programmes in rural areas - In partnership with Earnst&Young, new approaches to inclusive ECD were introduced		
NGOs/CSOs		Confederation of NGOs of Kazakhstan supported IDD communication campaign			

ANNEX 4: OVERVIEW OF THE SOCIOECONOMIC SITUATION AND HEALTH SYSTEMS OF THE EVALUATED COUNTRIES

KAZAKHSTAN

The Republic of Kazakhstan, which has a population of 17.16 million, is a former Soviet republic, which is now part of the Commonwealth of Independent States (CIS). It had one of the largest and fastest expanding economies in Central Asia, growing an estimated 9% between 2000 and 2007. In 2011, Kazakhstan marked the 20th anniversary of post-Soviet independence by introducing new health and social policies designed to strengthen its domestic socioeconomic standing and political position in the international community.

Kazakhstan is an upper-middle-income country with a per capita GDP of nearly US$13,000 in 2013. Kazakhstan's real GDP growth slowed from 6 percent in 2013 to 3.9 percent during the first half of 2014, due to internal capacity constraints in the oil industry, less favourable terms of trade, and an economic slowdown in Russia. The contribution of net exports to GDP growth improved materially following a sharp devaluation of the Kazakhstan Tenge in February 2014, leading to a strong drop in imports of goods that became more costly. As a result of the devaluation, domestic inflation, as measured by the consumer price index (CPI), increased from 4.8 percent year-on-year in December 2013 to 6.9 percent in August 2014, due to higher imported input prices.

Agriculture accounts for only 4.5 percent of GDP, but the sector continues to employ almost one-fourth of the working population and is critical to addressing poverty and food security, as well as providing an important avenue for diversification of the economy.

Income growth in the country had a positive impact on poverty indicators, with prosperity shared broadly. The share of the Kazakhstan population living in poverty went down from 47 percent in 2001 to about 3 percent in 2013, as measured by the national poverty line.

Similarly, at the international poverty line, as measured by the purchasing power parity (PPP)-corrected US$2.50 per capita per day, poverty in Kazakhstan fell from 41 percent in 2001 to 4 percent in 2009. However, against a benchmark of a higher poverty line at the PPP-corrected US$5 per capita per day (which is more appropriate for countries with a higher level of income per capita), some 42 percent of Kazakhstan's population were still living in poverty in 2009, though down from 79 percent in 2001. Kazakhstan's performance in the World Bank's indicator of shared prosperity also shows progress, with a growth rate of consumption per capita of the bottom 40 percent of households of about 6 percent, while the average consumption growth for all households was about 5 percent during 2006-2010.

In addition, the central government of Kazakhstan has prioritized several goals aimed at diversifying the economy beyond its reliance on oil, natural gas, and other extractive industries, decreasing dependence on the government sector, and increasing the competitiveness of the state as a whole. A key area of the central government's interest is the improvement of public health.

Despite strong macroeconomic indicators and considerable progress in building civil society, efforts to democratize the system of higher education and related institutions and modernize infrastructure to support public health, numerous challenges remain in delivering public health services to a population of over 16 million people, 59% of whom now live in the two largest urban centers: Almaty and the capital city of Astana. Although many health status measures show Kazakhstan to be ahead of most nations in the region, Kazakhstan continues to lag behind nations with an economy of a similar size on several important health and environmental indicators[146].

The population of Kazakhstan is currently estimated (as of 2011) to be 16.5 million, with a growth rate of 1.235%[147]. The World Bank estimated the Gross National Product to be $149.06 billion in 2010, with a per capita gross national income of $6,280, which is below the average of the World Health Organization's European Region.

[146]Health Profile. World Health Organization; 2012; available from: http://www.who.int/gho/countries/kaz.pdf

[147]World Fact Book. *Central Intelligence Agency*

The World Health Organization (WHO) health profile for Kazakhstan, which is located within the WHO European Region, estimates the average overall life expectancy at birth to be 64 years (59 years for males and 70 years for females), which lags behind the regional average of 75 for both genders[148]. The trend in life expectancy in Kazakhstan is similar to that observed in the other CIS. Similar to other nations, female life expectancy at birth exceeds that for males by 11 years.

KYRGYZSTAN

Kygyzstan is a landlocked country in Central Asia with population of roughly 2.15 million. Since 1996, Kygyzstan's macroeconomic indicators have demonstrated positive trends, yet Kygyzstan remains one of the poorest countries in the CEE/CIS region, with a Gross National Income of $1210 per capita in 2013[149]. It is among the medium human development category countries for 2012, with an index of 0.622 (125th in the world).

The period 2000 – 2008 was characterized by a sustainable trend in poverty reduction in the country. The trend of a decline in general and extreme poverty continued until 2010. The growth in remittances from labour migrants and increased pensions played a significant role in poverty reduction[150]. However, the political events of 2010 reversed this positive trend, and since 2010 a rise in poverty rates was observed. By 2012, 38% of the population was living below the poverty line, with 4.4% being extremely poor[151].

World Bank estimates[152] show similar levels and trends: a decline in 2008 and 2009 and increase thereafter. According to the estimates, the poverty headcount ratio at national poverty lines (% of population) was 38% in 2012, while the rural poverty headcount ratio was slightly higher than the national level and amounted to 39.6%.

The majority of poor people (nearly 70%) live in rural areas. There is a large difference between Bishkek and other areas in terms of general poverty levels: 21.4% of the population was below the poverty line in Bishkek in 2012, compared to 35.4% in urban areas and 39.6% in rural areas. In rural areas, access to services such as water supply, collection of solid waste and sewerage is limited for all the population, due to difficulties of service provision in mountainous regions. In urban areas, the poor population enjoy lower levels of access to services such as central heating, hot and cold water supplies, bathrooms/ showers, sewerage systems, central gas supplies and telephone lines than the better-off population. However, one-third of the non-poor urban population has no access to at least one of the services listed above[153].

The child poverty rate is a serious social concern. According to the survey of the National Statistics Committee in 2011, 44.6 % of children under 17 years of age live in poverty and 5.6% are classified as extremely poor. A study conducted in 2009[154] showed that three out of four poor children (77.6%) live in rural areas. Moreover, poverty in rural areas is more profound – among children living in rural areas extreme poverty is more prevalent (9.6 per cent) than among children in urban settlements (5.1 per cent). The study also revealed regional disparities of child poverty, with higher rates in Jalal-Abad and Osh provinces.

Among the determinants of child poverty thee main factors were identified: large families in the country, in particular those with three and more children; parental unemployment; and mother's education level. The risk of poverty among children living in such households is three times higher than among children living in families where at least one woman of working age has higher education.

Unemployment in Kyrgyzstan is widespread, especially among women. According to ILO estimates, the total unemployment rate ranges between 7.5% (2000) to 8.0% (2012)[155]. The unemployment rate among women is 10%.

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148 Ibid 1

149 Atlas method (current US$). The WB estimates accessed at http://data.worldbank.org/

150 Kyrgystan Second MDG progress report, Government of Kyrgystan, 2010

151 National Statistical Committee of the Kyrgyz Republic, 2011

152 http://data.worldbank.org/

153 Kyrgystan MDG progress report, 2013

154 National Study on Child Poverty and Inequalities in the Kyrgyz Republic, 2009. UNICEF

155 http://data.worldbank.org/

The state budget of Kyrgystan remains very socially oriented. In 2011, the government adopted the Strategy for Social Protection of population in Kyrgystan for 2012-2014, which recognized the social protection of vulnerable groups as a main priority of the state. It also included an increase in the minimum guaranteed income and in the average monthly benefit for low-income families. However, this benefit fails to provide adequate support for low-income families.

Kyrgystan has been hit by several major shocks during the last decade. Unstable economic growth, persistently high poverty rates, the lack of a tangible impact from economic reforms and high levels of corruption contributed to general public dissatisfaction, which led in turn to the "Tulip Revolution" in March 2005 and subsequent change of government. From 2007, Kyrgyzstan experienced a convergence of food and energy insecurity that has had serious long-term effects on the livelihoods of vulnerable groups in the country. The effects of the economic burden on society, coupled with the perception of high levels of corruption and nepotism under President Bakiev's government, led to violent protests against the government in April 2007. These resulted in at least 84 deaths and hundreds of people injured, and extensive damage to state and private buildings. In 2009 Bakiev won new presidential elections, although there were concerns about whether the official results reflected what the population had voted for. Following further unrest in 2009, the President was forced to flee the country. An interim Government made up of opposition political and civic leaders took power. Meanwhile, partially fuelled by the instability, interethnic tension grew in both the north and in the south where large ethnic Kyrgyz and Uzbek communities live side by side. In June 2010 violence erupted among ethnic groups that led to 415 death and more than 4600 injured people[156].The conflict negatively affected access to health services, leading to an increase in home deliveries, deliveries in rural hospitals, pre-term deliveries and late admissions to hospitals. An estimated 400,000 children were directly or indirectly affected by the 2010 inter-ethnic conflict[157].

MOLDOVA

Moldova is among the medium human development category countries for 2013, with a human development index of 0.663 (114 in the world). Gross National Income grew since 2000 and reached $1210 per capita in 2013.[158]

Since independence, the Republic of Moldova has faced serious economic challenges that have impacted on the funding available for health and other social welfare activities. Agriculture and food processing are core aspects of the Moldovan economy, but large-scale labour emigration and the associated remittance flows increasingly shape the economic and social landscape. Economic growth and the poverty reduction trend are closely correlated with the flow of remittances and the consumption it generates.

Although GDP grew on average by 5.1% annually during 2000-2010, the growth was volatile and jobless, reflecting the vulnerability of the economy to external factors.

Domestic unemployment remains high, which is one of the main reasons why 40% of the Moldovan workforce lives and works abroad. The total unemployment rate, according to the national estimates, ranges between 2.1% (2000) and 2.8% (2012). ILO estimates are rather higher, and range between 8.5% (2010) to 5.1% (2013).[159] There is a strong rural-urban gap in terms of unemployment: in this period, the share of urban employed population decreased by 4%, while the rural employed population decreased by 37%, with no signs of recovery.[160]

The incidence of poverty according to the international threshold of 4.3 dollars per day decreased from 34.5% in 2006 to 20.8% in 2012 (the MDG target – 23.0%). The share of the population living under the absolute poverty line decreased from 30.2% to 16.6% (the final target: 20.0%), while the share of population suffering from hunger shrank from 4.5% to 0.6% (the MDG target: 3.5%). The main factors which favour progress include: economic growth, the increase of revenues remitted by the emigrants and the social assistance

[156] Situation Assessment of Children in the Kyrgyz Republic, UNICEF 2011**Error! Bookmark not defined.**

[157] UNICEF, Humanitarian Action Update: Kyrgyz Republic, 3 November 2010

[158] Atlas method (current US$). The WB estimates accessed at http://data.worldbank.org/

[159] http://data.worldbank.org/

[160] The Third Millennium Development Goals Report of Republic of Moldova. Government of Moldova, UN agencies, 2013

provided by the Government according to a specific formula, which allows for better targeting of resources to assist the poorest families.[161]

The rural population is 3 times more exposed to the risk of poverty than urban populations, and one in four villagers lives under the national poverty line. Children, in general, continue to be more vulnerable to poverty: the rate of poverty registered in 2011 among children accounted for 19.6%, which exceeds the national average by 2.1 percentage points. Although it is declining, malnutrition still affects one in ten under-5 children.

After a decade of negative natural population growth, in 2011-2012 the Republic of Moldova registered zero natural population growth, which reflected an increased birth rate and decreased death rate. The disaggregated indicator reflects a worsening situation in the rural areas in comparison with urban areas: in the rural areas, a higher birth rate was accompanied by a higher death rate. The difference in attitudes towards health, lifestyle and food, as well as the unequal access to health care services are the main causes of an increasing rural-urban gap.

There are several groups that are particularly vulnerable to poverty and poor health: single mothers or families with many children, large families, unemployed parents, young parents, detainees, patients with TB and PTH, high risk behaviour groups, Roma people, and some religious groups (because of their reticence to access medical services and decline medical interventions). Emigrant mothers and mobile populations represent a recent and popular trend.[162]

The political context in the country is not stable. The unsettled Transnistrian conflict is an essential factor hindering the development on the right and the left sides of the River Nistru. The conflict impedes human and economic contacts, magnifies country risks and external financings costs, reduces Moldova's attractiveness as a destination for investment and as a place to live place for people from other countries, and creates a background of permanent stress, which impedes the ability of the authorities to focus on a long-term development agenda.

SERBIA

Serbia (The Republic of Serbia) is a parliamentary democracy with a population of 7.12 million, according to the recent Census in 2011. Serbs represent 83.3% of the population; Hungarians are the second largest ethnic group (3.5%), followed by Roma 2% and Bosniaks 1.8%.

Since the 1990's, Serbia has been coping with socio-economic and political problems due to a rapidly changing political and economic environment, which remains a serious challenge. As of today, Serbia is an upper-middle income economy, according to the World Bank and International Monetary Fund, in which the service sector dominates the country's economy, followed by the industrial sector and agriculture. The economy has an unfavorable trade deficit. According to World Bank data, real gross domestic product (GDP) growth in 2012 was negative at -1.7 %. The total unemployment rate (15-64 years) in 2012 was very high at 26.1% (Serbian Statistical Office 2012), while the youth unemployment rate in the same year was 50.9% (National action plan of employment 2012). Economic and other structures are prone to corruption due to the lack of regulatory authorities and control mechanisms.

Most of the former socially owned companies are privatized and social welfare programmes are restricted. Such a situation produced more people living in poverty. According to official statistics, 9.2% of the population are below the poverty line; those mostly affected include the unemployed, children, single mothers, refugees, internally displaced persons and ethnic minorities, in particular the Roma population (UNDP, 2012). One in ten citizens in Serbia lived on less than 8,544 dinars per month in 2011 (approx. 70-75 euro).

The demographic trends in the country are consistent with overall demographic profile for CEE countries, with an increasing share of the elderly population and a decreasing share of child population, which fell from 16.5% of the total population in 2000 to 15% in 2012 (UNICEF TransMonEE 2014).

UZBEKISTAN

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161 Ibid 160

162 PAS Centre, "Analysis on equity in mother and child health area", ordered by UNICEF, 2009

Uzbekistanis a landlocked Central Asian state with population of 30.18 million. The country obtained independence after the breakup of the Soviet Union and, along with other CIS countries, underwent a difficult transition period after 1991. According to national statistics, Uzbekistan's economy has grown steadily in recent years, with annual GDP growth rates exceeding 8 per cent. According to the World Bank, Uzbekistan entered the group of lower middle-income countries in 2010. This is an important step for the country's prosperity, but it can also have a number of implications, some of which involve children and women, as often observed in countries acquiring middle-income status.

One of these implications relates to the risk of increasing social inequities. This is typical for the CEE/CIS region due to the nature of economic growth and ineffective mechanisms for wealth re-distribution.

According to the latest official data, poverty in Uzbekistan (measured by daily consumption of less than 2,100 kilocalories per person) stood at 22 per cent in 2008[163]. At present, the reported rate is 16 per cent for 2011, with urban poverty at 11.6 per cent and rural at 18.5 per cent. The rural population is 64 per cent of the total population. Besides children from low-income families and from rural areas, vulnerable groups include children with disabilities, those from minority ethnic groups, children without parental care, those at risk of abuse and children from environmentally hazardous areas such as the Aral Sea basin.

The understanding of the particular vulnerabilities that these groups of children face needs to be broadened. Promoting tailored data collection, further enhancing disaggregation of key statistics and systematic data analysis are all crucial to assess inequities better and inform the development of interventions to further improve living standards of the population and ensure equal access to social services for all groups of children and women. Efforts in this direction could allow Uzbekistan to avoid mistakes sometimes made in fast-growing economies.

Mechanisms such as the recently established Social Protection Inter-Agency Group (SPIG) are important first steps along these lines, as they facilitate the coordination of efforts and refining of policies to protect the most vulnerable through a systemic approach. This mechanism is expected to ensure an integrated and evidence-based approach to the review of the social protection system, leading to an efficient use of resources whilst effectively reaching the most vulnerable social groups.

Newly graduated middle-income countries that need to review their budget priorities may also face reductions in incoming official development assistance. Uzbekistan has demonstrated that it is capable of using the fiscal space generated by economic growth. It is commendable that half of the country's state expenditure is for social purposes. Education financing has been considerably high at around 8 per cent of GDP[164], and a similar investment in the health sector would be desirable. Recently the Ministries of Health and Finance committed to fully self-financing the Expanded Programme of Immunization and to progressively achieving self-financing for antiretroviral drugs starting from 2014. Such policy decisions are promising steps towards a more systematic review of social budgeting and expenditure, balancing efficiency and the needs of the population with special attention to the best interests of the child.

Parliamentary elections in 2010 saw an increase in the proportion of women in the lower house from 17.5 to 22 per cent[165]. Meanwhile, the country has retained high levels of gender parity in primary and secondary education enrolment, although female participation falls from the age of 15 due to several factors.

Between 2005 and 2010 the number of girls in Uzbekistan who married under the age of 18 doubled[166]. The Government is seeking to reduce the prevalence of early marriages through improving the legislative and normative base, including making changes to the Family Code

[163] In 2001, the World Bank developed a methodology for measuring poverty in Uzbekistan. It is based on establishing the food poverty line, which is set at the level of spending to consume 2,100 calories.

[164] The mobilisation of financial non-capital expenditure in the education sector in 2011 was 8.1 per cent. [Institute of Forecasting and Macroeconomic Research under the Cabinet of Ministers of the Republic of Uzbekistan, Welfare Improvement Strategy of Uzbekistan 2012-2015 – Final Draft].

[165] Parliament Lower Chamber (OliyMajlis) website: http://www.parliament.gov.uz/en/events/international/2814

According to the Ministry of Justice, as of January 2013 there are more than 6,000 registered civil society organizations functioning in the country, including local branches of national organizations. Currently the government is focusing on strengthening the legislation on civil society, and has initiated a process for enhancing its capacity. This should facilitate the participation of a cross-section of society, including children and young people. In this context, a number of adult-led youth participation initiatives with few consultative elements are observed.

HEALTH AND HEALTH SYSTEMS IN CEE/CIS AND THE EVALUATED COUNTRIES

An inability to adequately accommodate increasing health needs due to the dual epidemiologic burden throughout the region in the conditions of underperforming and, in certain CIS countries (Central Asia and Caucasus), still severely underfinanced health systems, have negatively affected the population's health, including the health of the children. During the early years of transition, the region faced many challenges, including the deterioration of child health outcomes, although a slow recovery occurred thereafter. The general health status of the population residing in CEE/CIS region has changed unevenly across countries.

Most of these countries have faced significant problems of equity and access to quality essential health services, increasing official and informal user charges for health services, rising poverty and livelihood related diseases. As a result, policy makers in these countries devoted special attention to health sector reforms.

KAZAKHSTAN

The initial health system transition in Kazakhstan originated from the fact that the Semashko model -based on centralized planning and administration, government financing and provision of services through publicly owned health care providers (which were universally accessible and free at the point of delivery)[167] - was no longer able to respond to the emergence of chronic illness and the health needs of the population in the late 1980s[168]. The economic collapse and social dislocation that resulted from the breakdown of the Soviet Union made it harder to manage health services but, at the same time, have stimulated the reform process[169].

The newly independent states in general have experienced a decrease in funding and "a breakdown in the health infrastructure" caused by a collapse of public funding and the elimination of subsidies[170]. A rapid economic decline led to even greater underinvestment in the health sector, creating a substantial funding gap between the levels of financing required by the health system and the resources available. All of these economic constraints have caused an inability to pay for salaries and cover the cost of drugs, supplies and capital investment[171].

Organization of Care **-** The organization of care derived from the Semashko model up until the late 2000s. Various problems in the privatization process have emerged, and were related to the lack of national control over licensing and professional standards, the illegal privatization of some health care facilities, unlawful profit making and the misuse of privatized facilities[172]. Nevertheless, as mentioned before, the pharmaceuticals and medical supplies sub-sector, most dental care facilities and some general health facilities were successfully privatized[173]. The focus of the health delivery system reform, which was highly promoted by the international

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166 State Statistical Committee, Zhenshchiny i MuzhchinyUzbekistana, 2012

167 Borowitz, M., Atun, R. (2006). The unfinished journey from Semashko to Bismarck: health reform in Central Asia from 1991 to
2006. Central Asian Survey, 25(4), December, 421

168 Ibid 4

169 Parfitt, B. (2008). Health reform: the human resource challenges for Central Asian Commonwealth of Independence States (CIS)countries. Collegian, 16(1), 36

170 Borowitz, M., Atun, R. (2006). The unfinished journey from Semashko to Bismarck: health reform in Central Asia from 1991 to
2006. Central Asian Survey, 25(4), December, 423

171 Ibid 7

172 Kulzhanov, M., Rechel, B. (2007). Kazakhstan: health system review. Health systems in transition, 9(7), 33

173 Ibragimov, A., Meimanaliev, A., &Veen, J. (2007). Policy assessment report: Kazakhstan (for the Central Asian TB control
partnership). Project HOPE Central Asia &Campis International & USAID, 46

donors, was on a family model of primary health care with family doctors supported by family health nurses. The objective was to reverse the lack of trust by the population in the PHC and provide new services that enhanced both the skills and the knowledge of doctors and nurses towards generalist provision. It was also aimed to provide effective primary health care services to the population through improved facilities and infrastructure[174].

Health Financing - In the second half of the 1990s, Kazakhstan underwent a series of health reform experiments in health financing (introduction of health insurance in 1996-98 aimed to transform the health system through strategic purchasing and raise extra-budgetary funding for health[175], and revoking health insurance and program budgeting in 1999 due to declined health spending and numerous cases of corruption), optimization of health facilities network (mainly downsizing), and introduction of primary health care (PHC) (family medicine/general practice)[176].

Throughout this period, Kazakhstan moved back and forth on health reforms without a somewhat clear direction and lacked continuity in leadership and implementation, as well as the necessary political, financial and information support. At the same time, the health community perceived these endeavours ambivalently. They ended up unsuccessful or were suspended. There was a need, therefore, for a unifying comprehensive program at the national level, to combine a complex vision of the health system and strategic priority areas for its development.

In 1998, following a Decree of the President "On priority measures to improve health status of the citizens of Kazakhstan", the government developed a state program entitled "Health of the Nation" which defined the main health reform areas for 1998-2008. Although not fully implemented, this program, together with the Concept of Further Health Care Development in Kazakhstan in 2000-2005, established a direction and conceptual framework for further health sector reform and development. Between 2001 and 2004, the environment was not supportive of further health reform. The rolled-back PHC reform and decentralization of funding to the regional (oblast) level seriously challenged health reform implementation. The Government of Kazakhstan and the newly established Ministry of Economy and Budget Planning that initiated a new phase of health reform from 2005. The Government planned to substantially increase the health budget and pressured the health sector to reform itself in order to invest the increased budget more efficiently.

A review and analysis of the health reform experiences of the 1990s led to the development of the National Program of Health Sector Reform and Development in the Republic of Kazakhstan for 2005-2010 that broke a new era of health sector development. The National Program has among its main goals the introduction of an "effective health care delivery system based on the principles of joint responsibility of the state and the population, creation of a new health management model supported by an integrated health information system, as well as priority development of PHC aimed at improving the health status of the population"[177].

The desire to move away from the communist past and a wish to converge with western health care models, which were promoted by international donors, have led to the implementation of numerous reforms in the health care sector of Kazakhstan. This wish to reform the health sector suggests the presence of a greater idea, which is to develop and make functional all necessary prerequisites/conditions for a desired transition to a stable market. In other words, the intention to reform the current health care system to a more cost-effective and responsive market-oriented health care system has also presumably a bigger objective, which is to transition to a well-developed and stable market economy.

Other reforms aim to improve working conditions of health professionals through initiatives to increase their salaries and increase their competence through professional development training. However, these reforms

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[174] Parfitt, B. (2008). Health reform: the human resource challenges for Central Asian Commonwealth of Independence States (CIS)countries. Collegian, 16(1), 36

[175] Borowitz, M., Atun, R. (2006). The unfinished journey from Semashko to Bismarck: health reform in Central Asia from 1991 to
2006. Central Asian Survey, 25(4), December, 431

[176] Ibragimov, A., Meimanaliev, A., &Veen, J. (2007). Policy assessment report: Kazakhstan (for the Central Asian TB control
partnership). Project HOPE Central Asia &Campis International & USAID, 46

[177] Ibragimov, A., Meimanaliev, A., &Veen, J. (2007). Policy assessment report: Kazakhstan (for the Central Asian TB control partnership). Project HOPE Central Asia &Campis International & USAID, p. 46

are less successful in reducing the number of health personnel who leave the health sector altogether or retaining health care professionals in the national system, due to various factors discussed below.

The economic collapse that followed the disintegration of the Soviet Union resulted in a dramatic decrease of Kazakhstan's GDP. The health system was particularly hard hit, with health care expenditures dropping from 6% in 1991 to 1.9% of GDP in 1996. The health authorities looked for cost effective models, and international experts have proposed new approaches and health care reforms. The reduction of hospital and specialty care, and the simultaneous development of primary care became a cornerstone of health care development in all national programmes, concepts, and government decrees in the country.

In addition, the idea of social health insurance became highly promoted in political circles, leading to the creation of a special insurance fund in early 90s. For the first time in the country's history, the health service provider was independent from the health services' purchaser. A Mandatory Health Insurance Fund (MHIF) has collected taxes (up to 3%) from employers, where local government execution entities (akimats) had to pay to MHIF for children, pensioners, unemployed citizens, and other nonworking populations.

The MHIF has played a very positive role in health care reforms' implementation in Kazakhstan. Provider/payer relations became clearer, and more services were provided since there were greater financial allocations received by health facilities. Many hospitals reduced the number of beds and gave up extra buildings voluntarily. Health financing became more transparent and predictable than ever before. Terms such as business plan, health provider and purchaser, as well as service cost, cost effectiveness, per capita payment in primary health care (PHC), and clinical-statistical groups for hospitals were introduced and used in the health system. Health managers became more market and client oriented.

The MHIF rapidly became a strong political player in the country, which also led to tensions with the Ministry of Health. At the same time, local governments did not follow the rules and did not provide the necessary resources or allocated the amount they were supposed to cover health care costs for non-working population through the MHIF. The working population, at the same time, has mostly covered health sector expenditures, and health under-financing has continued.

In late 1998, after 1 year of piloting and 2 years of existence, MHIF was transferred to the Health Control Committee, while health financing returned to the local (region/city) governments. Local governments decided to keep the old infrastructure, which was only enough to cover salaries. The Ministry of Health ensured that the federal budget was allocated to medical education, research, and republican hospitals/centers.

In 2005-2010 the federal part of health financing was increased. The Ministry of Health started to build new hospitals (cardiology, emergency care, and National Centers in the new capital Astana) and outpatient facilities. Some money was allocated for the retraining of public health care providers. Equipment and medications were purchased centrally and distributed by the Ministry of Health.

In 2009-2011 the Ministry of Health persuaded the federal government to increase the centralization of the health care budget. The so-called Unified National System was implemented rapidly. In 2009 the hospital sector budget started to be collected at the federal level, and in 2010 the primary care budget was concentrated in one place.

A new Health Information System (HIS) was introduced in January 2010 without piloting. All hospitals including rural ones had to report each hospitalization case to the HIS. Doctors had to calculate each half of prescribed tablet given to a patient and report on it to the system. Old health protocols and standards that were developed in 2002-2003 were returned to use.

In January 2011, the Ministry of Health forced public health care workers to record data of all enrolled populations into the national electronic database in only 3 months. HIS was not capable of responding to requests by health professionals from all over the country trying to enter data to the system. Physicians ended up working over time (at night mainly) in order to get access to the HIS database when it was accessible.

All health facilities are financially covered from the federal budget now. One of the positive innovations in health funding was the introduction of a new two-component per capita payment system. Public health care doctors and nurses have received a stimulating component as an additional salary for first time in the history. However, this salary increase also produced more control from monitoring organizations/agencies.

Health workers in each health facility are being reviewed and evaluated by numerous control agencies such as the Health Control Committee, Health Departments, public procurator's offices, Chamber of Accounts, Tax

Committee, etc. Prosecutors look through patient charts to find mistakes and deviations made by physicians from existing standards and protocols.

As a result, the recent developments with financing of the health care sector suggest that unless the situation with wage arrears to health personnel is resolved in the nearest future (along with other cases of inadequate funding and underinvestment in the health sector) as well prevented from occurring again, the national health system will not be protected from losing its health professionals to the private or non-profit health sectors.

Moreover, all of these factors - rapid and unpiloted reforms, weak health information systems, poor management, increasing penalty system and external control – have resulted in the growth of a human resources crisis or physicians switching from the national health care system to the private one or to other employment opportunities.

KYRGYZSTAN

Following independence in 1991, Kyrgyzstan was quicker than its neighbouring countries to develop its own heath policy. The "Manas" health care reform programme was set up in 1994 as a joint programme between the Ministry of Health of the Kyrgyz Republic and the WHO Regional Office for Europe, which aimed to develop health care reform policies and implement the resulting plans. The objectives were to improve the health status of the population, to improve quality and equity, and to make more effective use of health resources. The Government adopted this health care reform plan in 1996, based on the results of the health reform model implemented in Issyk-Kul Oblast with USAID support. The World Bank was another important international player. The Ministry of Health supported by the WB and USAID rolled-out of the health reforms nationwide.[178,179]

The "ManasTaalimi" National Health Reform Programme, which was implemented from 2006 to 2010, played a crucial role in the health system of the Kyrgyzstan. The goal of the programme was to improve the health status of the population through the creation of an effective system of health care delivery that would provide better access to high-quality care while reducing the financial burden. The programme strategically focused on the completion and institutionalization of already initiated reforms.

The "ManasTaalimi" National Programme was implemented in the framework of the mid-term budget forecast. One distinctive characteristic was the introduction of the Sector Wide Approach (SWAp) - a new form of cooperation between the Government and donors, under which donor funds are allocated to support the state health budget according to standard budget procedures. In addition, considerable assistance is provided by donors such as KfW, Global Fund, GAVI, UNFPA, USAID, HOPE, ADB, and IAEA through parallel financing of certain projects. Within the SWAp, health funds are accumulated at the national level with division of authority for financing healthcare between the Ministry of Health and the Mandatory Health Insurance Fund (MHIF).

The MHIF is in charge of financing of The State Guarantee Basic Package Programme (SGBP) and The Additional Medical Provision Programme.

The SGBP has established a predictable and transparent system of entitlements. It guarantees to all citizens access to free primary care, as well as emergency care services. In order to receive primary care, patients must enrol with a Family Group Practice. Care is provided in the place of enrolment. Inpatient and specialized outpatient care services are provided through co-payments. Initially the services were provided for infants, pregnant women and for childbirth. However, since 2007 children under 5 are automatically enrolled in the program and are exempted from co-payments. Other privileged social categories include pregnant women, pensioners aged 70 or older, victims of the events of 2010 and their families, the disabled regardless of their income, 2nd World War veterans and citizens with defined priority medical conditions. Without a proper referral, the full cost of services must be paid regardless of the patient's insurance status. Patients from low-income groups have, theoretically, the right to co-payment exemption, but mechanisms for this exemption are not well defined. There are no clear rules governing such exemptions. Thus, while there is a national poverty threshold, there is no comprehensive, up-to-date national registry for people who are qualified for social

[178] Ibraimova A, Akkazieva B, Ibraimov A, et al. (2011). Kyrgyz Republic: Health System Review. Health Systems in Transition

[179] Kyrgyz Republic Health Reform Overview. ZdravReform (1999)

assistance programmes based on their income level, which makes it difficult to have a well-targeted co-payment policy.[180]

Den Solluk is the successor to the ManasTaalimi and ManasProgrammes. The programme design is based on the continuity of reform outcomes achieved throughout the previous years of reforms as well as on consideration of the country's current socio-political context. Den Solluk covers the period 2012-2016. Infant and maternal mortality reduction is one of the priorities of the Program. The key focus is on improving the quality of health care provided by health facilities at all levels of care.

Organization of care **-** Primary care services in Kyrgyzstan are provided by feldsher-midwifery posts (FAPs), Family Group Practices (FGPs) and Family Medicine Centers (FMCs). FAPs are the first point of contact with the health system for patients in rural areas. FAPs were formerly subordinate to central rayon hospitals, but at present they report to either FGPs or FMCs in their rayon.

FGPs were formed in recent years on the basis of pre-existing health facilities (FAPs, rural doctor ambulatories, polyclinics and rural district hospitals). FGPs are staffed by at least one physician, in addition to nurses and midwives, and serve villages with a population of more than 2000 inhabitants. The number of staff members depends on the size of the village. In cities, FGPs mainly exist as part of FMCs. The main principle of FGPs is that patients have a free choice of family doctors. Prior to changes in 2013, FAPs and FGPs provided delivery services. However, in response to low quality and unsafe care, the MoH and MHIF issued a joint decree[181] according to which maternity beds have been closed or reallocated to district maternity hospitals and FAPs and FGPs no longer provide delivery services.

FMCs are the largest outpatient health facilities in the country, formed in each rayon and oblast, and replace the former polyclinics. They combine outpatient care services, ranging from general medical care to specialized care and diagnostics, including radiology and ultrasound. FMCs provide care for children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, prescriptions, certifications, home visits and preventive and health promotion services. There are usually 10–20 specialists in each FMC.

Health Care financing **-** The MHIF is the "single payer" in the health sector, with responsibility for pooling health funds and purchasing health services under the SGBP. Using a programme budgeting approach, the MHIF administers two of the five Ministry of Health programmes: the SGBP and the Additional Drug Package. The Ministry of Health administers the other programmes: public health, the High Tech Fund and areas such as the vertical systems, education, science and administration. The MHIF is responsible for quality management of health services and the development of health information systems. The MHIF operates through its territorial departments.

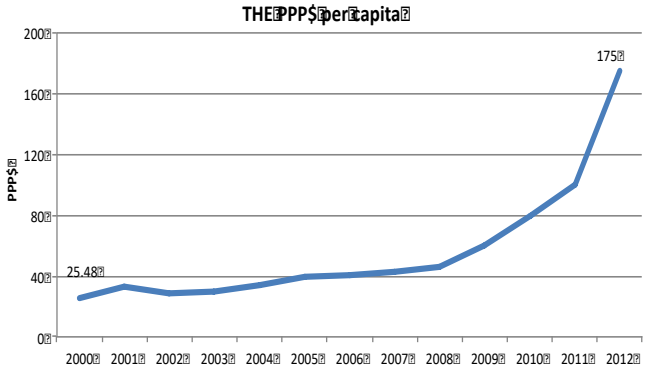
Local state administrations are in charge of health care within their respective territories. The Ministry of Health coordinates and controls them through coordination commissions on health management. These commissions are responsible for implementing national health policies and programmes and for developing and implementing territorial health programmes. Private health insurance has not yet been developed in the country.

The financing of the Kyrgyz health system comes from three principal sources: a) Public sector funds, including the state budget funds (based on general tax revenues) and mandatory health insurance funds (based on payroll-tax revenues); b) Private funds, including private out-of-pocket payments; and c) External funds, comprised of funds from international organizations and donors. rom the republican budget, funds flow to the Ministry of Health, the MHIF and other ministries and agencies. The Ministry of Health finances tertiary care facilities and the SSES services and institutions. The MHIF accumulates funds at the republican level, including revenues from the mandatory health insurance system and the Social Fund, and distributes them to the regions to finance provision of SGBP in health facilities at the primary and secondary level. Since 2006, some of the funds from international development agencies for the Kyrgyz health system have been allocated within the framework of a SWAp. These funds are integrated into the general state budget of the country.

[180] Kyrgyz Republic Public Expenditure Review Policy Notes, The WB, 2014

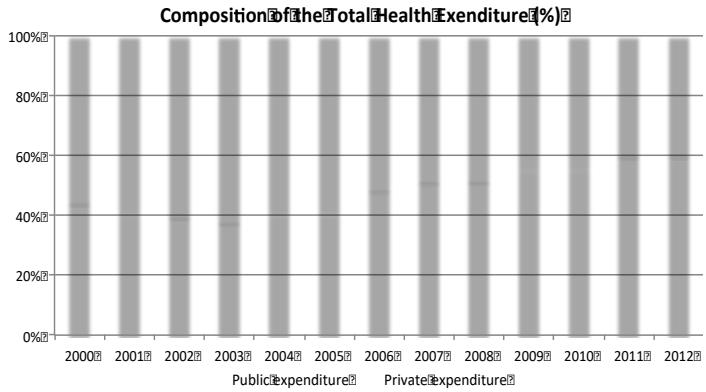
[181] Joint Decree of the MoH and MHIF #505 and #183, dated 28.08.2013

Figure 42: Total Health Expenditure per capita in PPP$, Kyrgyzstan



There was decline in government spending in general in 1990s that influenced state expenditures on health greatly. State health expenditure began to increase after 2000, in line with reforms to the health financing system. Total expenditure on health increased from 4.4% of GDP in 2000 to 6.4% in 2009. Public sector expenditure on heath as % of GDP increased from 2.1% in 2000 to 4.28% in 2012[182].When seen in the context of the WHO European Region, as well as trends in CIS and CARK, Kyrgyz Republic is spending a higher share of GDP on health than many other countries of the former USSR. However, considering that GDP per capita in Kyrgyz Republic is among the lowest in the WHO European Region, total health expenditure per capita is still very low compared with other countries of the WHO European Region[183]. Total health expenditure per capita increased 7-fold since 2000 with more steady growth from 2009.

Figure 43: Total Health Expenditure per capita in PPP$, Kyrgyz Republic, 2000-2012



Private sources accounted for more than half of Total Health Expenditure (THE) up until 2006. By 2012, private expenditures formed 40% of THE. This decline was determined by a number of factors. On one hand, other sources of financing increased, including external health financing which reached about 13% of THE in 2010 (under public expenditure in the graph). On the other hand, since 2004 the growth rate of public health expenditure was higher than that of private expenditure, on average 7.9% per annum compared to about 0% growth in average of private expenditures).

The share of PHC expenditure in total public health spending has increased since the start of health care reforms in the mid-90s. In 1994, only 7% of total public health expenditure was allocated to PHC, increasing to 25% by 2003. In 2011 the share of PHC expenditure in total public health spending reached almost 30%[184].

MOLDOVA

An economic downturn in the first decade following independence caused a disintegration in the health system of the Republic of Moldova. This led to significant catastrophic costs and left a large proportion of the general population with little or no access to health care and health services. In 1996, the government initiated an important reform, reorganizing service delivery by introducing the family medicine model for primary health-care delivery.

In 1999, the Law on the Minimum Package of Free-of-Charge Health Care Guaranteed by the State was approved. This regulatory act introduced a minimum package of services to be provided free of charge to the entire population, with the government and local public authorities responsible for its financing. Nevertheless,

182 Source: HFA-DBA
183 Ibid 178
184 Ibid 180

the capacity of medical facilities to provide services in line with the new legal provisions was limited through inequities in financing that resulted from the varying capacities of local public authorities to collect funds.

Increasing government allocations for the health sector were registered during the 2000s. In 2001, the National Heath Insurance Company (CNAM) was created, and in 2003 the new financing mechanism was piloted in the Hincesti rayon. Since 2004, the Mandatory Health Insurance (MHI) system has been implemented nationwide[185], leading to significant increases in the financial resources allocated to the health sector.

The government plays the role of insurer for 14 categories of non-working people, including children and pregnant women. These categories are automatically covered by transfers from the national budget without the individuals in question having to make formal contributions. Although the exclusion of certain groups from the MHI system is eliminated, some categories (such as unemployed or disabled people) need to register as such in order to benefit under the scheme. Undocumented migrants can access health services at a special Centre of Temporary Placement of Foreigners, and if necessary they can be hospitalized in a public medical institution. The benefits package under the MHI is described in the Unified Programme, which comprises a list of diseases and conditions requiring health care to be covered from MHI funds. The Unified Programme also includes a separate, limited list of compensated medicines. The services covered include emergency care, primary care, secondary and tertiary care (including rehabilitation services), termination of pregnancy, emergency and prophylactic dental care, and auxiliary services such as medical transportation, laboratory and instrumental investigations, and home and palliative care. Inpatient services are available without co-insurance, deductible or co-payment. Inpatients are also entitled to free medicines; outpatient medicines are covered at different levels depending on the drug: 50%, 70%, 90% and 100%. (Drugs for children are covered fully according to an established list that is renewed annually).

The CNAM offers certain incentives to providers who work with special groups of people, particularly at the primary care level. For example, bonuses are offered to family doctors for monitoring pregnant women from the gestation age of three weeks and for providing health checks for children in the first year of life. However, the share of resources allocated to these incentives represents just 4% of all per capita allocations for primary care.

Organization of care - The network of primary care facilities is quite extensive. The services provided are divided into basic primary care services (medical emergencies; prevention services including immunizations, health promotion and health education; management of chronic diseases; consultative services for pregnant and postpartum women, childrenetc.) and additional medical services, which are beyond the traditional scope of primary care and may be provided only when staff have additional qualifications and the necessary equipment is available. These additional services include diagnostic, rehabilitation and pharmaceutical services. The key actors in the provision of primary care are family doctors and family medicine nurses. Family medicine centres (FMCs)[186] in urban/district areas and territorial medical associations in the capital city play the central role in primary care provision all over the country. FMCs are located in district towns and serve a population ranging from 40 000 to 80 000, including the population served by health centres, family doctor offices and health offices in their catchment area. A health centre (HC) should serve at least 4500 inhabitants and have at least three family doctors. The health centres can be organized as subdivisions of the FMC or as autonomous entities (public or private).

The autonomous health centres are contracted directly by the CNAM for the provision of basic services in their catchment area. Family doctor offices and health offices (HO) are subdivisions of family medicine centres and health centres. A family doctor office serves a population of 900–3000 inhabitants and can have one or two family doctors. Health offices are organized in communities with fewer than 900 inhabitants and are only staffed with family medicine nurses. Secondary care at the district level is provided by district hospitals and specialized ambulatory services. Specialized ambulatory services are often physically located in the same premises as the FMC but are legally and financially subordinated to the district hospital. In the capital city, municipal hospitals and territorial medical associations provide secondary care. The territorial medical

[185] Turcanu G, Domente S, Buga M, Richardson E. Republic of Moldova: health system review. Health Systems in Transition, 2012, 14(7):1–151.

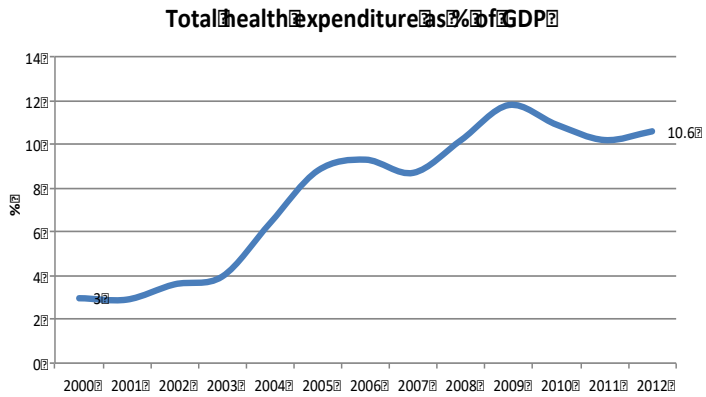
[186] As of the year 2015, the Family Medicine Centers were reformed into independent health centers

associations are independent entities contracted directly by the CNAM. They consist of family medicine centres and consultative and diagnostic centres providing specialized ambulatory care.

The organization of perinatal care services is structured in three levels. 26 district perinatal centres and 1 municipal perinatal centre in Chisinau represent the first level. The second level comprises 10 more advanced perinatal centres, which serve as regional referral centres for the first level: 8 are located in district towns, and 1 each in the municipalities of Balti and Chisinau. The third level is the Institute of Scientific Research in the Field of Mother and Child Health Care, which is a tertiary care institution in the capital city. The first level deals mainly with the management of physiological, uncomplicated pregnancies and births, while the second and tertiary levels accept more complicated cases and the associated pathologies in need of a higher level of specialized care[187].

Health Care Financing- There was dramatic decrease in public heath expenditure after the 1998 ruble crisis, and the post-crisis recovery was slow before 2004. However, following the introduction of MHI, there was a constant and continuous increase in both total health expenditure and public expenditure until the global economic downturn in 2008.

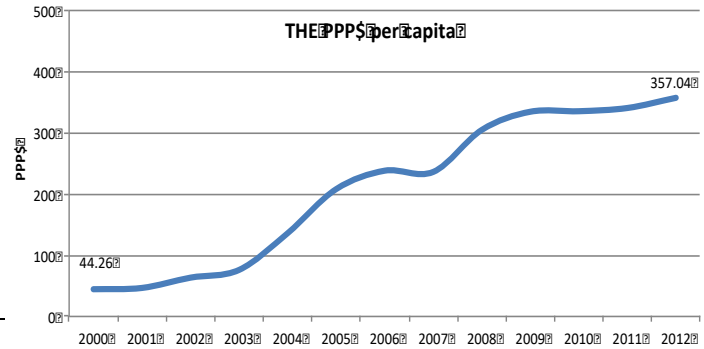
Figure 5.Total Health Expenditure as % of GDP, Moldova 2000-2012



The increase in public expenditure on health in 2009 (after the economic crisis) compared with 2008 was mainly the result of additional resources being allocated from the national budget for specific health programmes (immunization, paediatric care, diabetes, mental health etc.). The Republic of Moldova spends one of the highest shares of gross domestic product (GDP) on health care, yet, according to WHO, only an estimated 53% of the population was covered by the public sector in 2009. In 2009, total health expenditure as a proportion of GDP in the Republic of Moldova was the highest (11.8%) in the WHO European Region; by comparison, the EU average is 9.93%.

Although the share of government allocations to health are high, absolute spending is only $341 PPP per capita, which is one tenth of the European Union (EU) average of PPP$ 3152[188]. It should be noted that according to the CNAM data, the share of publicly covered population has increased to 80.8%[189].

Figure 6. Total Health Expenditures per capita in PPP$, Moldova, 2000-2012



According to WHO regional office for Europe (HFA-DB), private health expenditures comprise 54.4% of THE, and OOP payments comprise the largest share of private expenditure (83.2%) for 2012. This includes both formal payments and informal payments. OOP are mainly driven by drugs; according to the National

[187] Ibid 185

[188] WHO Regional Office for Europe, 2014

[189] Source: CNAM annual report, 2013 page 13, http://www.cnam.md/editorDir/file/Rapoarte_activitate/raport-activitate-2013_rus.pdf

Bureau of Statistics, drugs comprise between 79% (2007) to 73% (2010) of the OOP structure[190].

Table 17: Trends in health expenditure in Republic of Moldova, 2000–2012

	2000	2005	2006	2007	2008	2009	2010	2011	2012
THE as % of GDP	3	8.8	9.3	8.7	10.2	11.8	10.9	10.2	10.6
Private expenditure as % of THE	51.46	54.38	55.6	54.8	52.78	51.48	54.22	54.46	54.46
Private households' OOP on health as % of private health expenditure	83.34	82.12	82.94	83.32	85.42	84.82	82.8	82.82	83.24

Evidence suggests that reforms have increased the use of health services and improved financial protection. The number of outpatient contacts per person per year was below the EU average in 2007. By 2010, Moldovans had 6.5 outpatient contacts per person per year, which exceeds the EU average of 6.3 contacts[191].

In 2010, a nationally representative survey found that 70% saw a doctor when they felt they needed to. The main reason for not consulting a health professional amongst those who had not sought care in the past four weeks when they felt it was justified was unaffordability of medical services or drugs or both (63.9%) and self-treatment (30.4%). Based on affordability, this places the Republic of Moldova fourth after Georgia, Azerbaijan and Armenia[192].

According to the Household Budget Surveys, the proportion of people who said that they did not seek care when they needed it due to financial reasons fell by half: from 29.2% in 2008 to 14.8% in 2012. Access is still a problem for very poor people, although there is some improvement. The proportion of extremely poor people who said they did not seek care because of financial reasons fell by a third between 2008 and 2012: from 43.6% to 29[193]. Larger households also appear to be less likely to seek care. A 2010 survey by UNDP revealed that more than half (53.3%) of households with three or more children said that they do not approach health-care providers because of their difficult financial situation[194].

A study conducted among 2102 PHC patients in 2012 identified financial access barriers to primary health care. Three out of ten respondents reported that they had to pay for a visit to a medical specialist after referral by their FD. One fifth indicated that they had to pay for a home visit by the FD, and one sixth (16.7%) had to pay for a regular check-up of a baby or young child. Payment for drugs is a major obstacle to their utilization. 30% of patients reported that, in the past, private payment for medicines had made them decide not to visit or to delay a visit to their FD. The proportion was slightly higher among urban (31%) than rural residents (27.8%)[195].

SERBIA

After the break-up of former Yugoslavia, Republic of Serbia, as well as other ex-Yugoslav countries, inherited a Bismarck healthcare system model. The health care system in Serbia is based on universal health coverage. In 2011, 6,786,333 people had compulsory health insurance. The insured can be divided into two groups. The first group comprises those citizens who have an income and a legal obligation to pay a contribution; 69.5% of the funds are "collected" in this way. The second group Is made up of people who do not have an income, or their income is less than the established threshold; their insurance is funded from the budget of the Republic of Serbia out of employees' contributions.

190 Ibid 185

191 Vian T. et al. Framework for addressing out-of-pocket and informal payments for health services in the Republic of Moldova. WHO, Health policy paper series #16. 2014

192 Balabanova D. et al Health Care Reform in the Former Soviet Union: Beyond the Transition. Health Service Research. DOI: 10.1111/j.1475-6773.2011.01323.x

193 Ibid 191

194 UNDP Regional Bureau for Europe & CIS, 2011

195 Evaluation of the Structure and Provision of Primary Heath Care in the Republic of Moldova, Health Policy Paper Series #5.WHO, 2012.

Organization of Care - Health services are provided through a wide network of public health care institutions, organized at the primary, secondary and tertiary levels and overseen by the Ministry of Health. As of late 2011, this network was comprised of 344 health institutions with a total of 113,384 employees[196].

Health care at the primary level is provided by 157 state-owned primary health centers, which have a well-developed network of outpatient facilities and offices, covering the territory of one or more municipalities or towns, in accordance with the Health Institutions Network Plan[197]. A doctor, who is either a general practitioner (intern) or a paediatrician, provides primary care, while a gynaecologist provides antenatal and postnatal care to pregnant women[198].

If the primary health centre is unable to provide adequate health care, the general practitioner will refer the patient to the specialist and secondary health care (hospitals). Each patient can get needed treatment in one of 77 general or special hospitals in Serbia. It might be outpatient treatment (medical check-up in the clinic) or inpatient treatment.

The tertiary level of health care has the highest specialization in terms of personnel and technological equipment, and provides quality diagnostics and treatment. The tertiary level cooperates closely with the secondary level by providing technical assistance and support. It also engages in research and medical education activities, through the Clinic Research Institute, the Clinical Hospital Centre and the Clinical Centre). There are 40 general hospitals, 37 special hospitals for acute and chronic conditions and rehabilitation, 6 teaching hospitals, 16 institutes, 4 clinical-hospital centers at the metropolitan level, which were founded by the City of Belgrade, 4 clinical centers at the national level, which were founded by the State, and 23 public health institutes.

National legislation also allows private health care providers to operate, but their services are covered through out-of pocket payments. At the same time, Serbia does not have a developed system of additional private health insurance. This inevitably leads to a power imbalance, where private health providers negotiate prices directly with individual users (patients), instead of institutions with more leverage[199]. The provision of private health care services is still limited but is on the increase, especially as regards dental services. The private sector is also poorly regulated and has evolved largely without oversight and or the support of the state. Private clinics mainly employ medical professionals from the public sector who work on a temporary, consultancy basis. As per the records of the SORS, the private sector includes 1,220 outpatient medical offices and clinics, 1,663 dental clinics, 1,835 pharmacies and 149 laboratories. There are also 81 private hospitals and 58 policlinics providing secondary level health services[200].

Since 2000, significant progress has been made in developing overall health policy in Serbia. The aim of an ambitious reform program that was undertaken from 2004 to 2010 was to strengthen preventive health care and services, with a view to decreasing rates of preventable diseases and total health care costs. The reform also included the restructuring of hospitals to respond to patient needs more effectively, and the development of a new basic package of health care services aligned with existing resources. Changes to financing of the health system aimed to ensure that resources would be allocated based on patient needs and not on staff structures. The payment system for primary health care was made dependent on capitation, while a model of diagnostic related groups was introduced as the framework for payments in the secondary health care.

The aim of the present health care management system is to work towards greater decentralization, and the delegation of powers and responsibilities to the local government level. This objective has also been

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196 Institute of Pulic Health of Serbia „Dr Milan Jovanović Batut". Health Statistical Yearbook of Republic of Seria 2011. Belgrade: Institute of Public Health of Serbia 2012. p. 65

197 Official Gazette of RS 42/2006, 119/2007, 84/2008, 71/2009, 85/2009, 24/2010

198 Law on Health Care, Article 98. Official Gazette of RS, 107/2005, 72/2009, 88/2010, 99/2010, 57/2011, 119/2012 and 45/2013.

199 Gajic-Stevanovic M, Dimitrijevic S. Health Care System and Expenditures in Serbia from 2004 to 2010. Belgrade: Institute of Public Health of Serbia 2011. p. 21. http://www.batut.org.rs/index.php?category_id=50 (accessed July 15, 2013)

200 Gajic-Stevanovic M, Dimitrijevic S. Health System and Expenditures in Serbia 2004-2010. Belgrade: Institute of Public Health of Serbia 2012. p. 23. http://www.batut.org.rs/index.php?category_id=50 (accessed July 15, 2013)

emphasized in recent Government documents and strategies[201] that call for uniform development of the health sector with a view to reducing regional differences in health. The Government's health policy aims to improve public health and increase efficiency through an optimized network of health institutions.

Health Financing - The Health Insurance Fund (HIF) operates across the health service in Serbia. The aim of the organization is to make the health system equal for every citizen, regardless of his or her status. The state fund covers most medical services including treatment by specialists, hospitalization, prescriptions, pregnancy, childbirth and rehabilitation through health centers and smaller health stations. However, with 260 euro per person, Serbia is at the bottom of the European's countries hierarchy. The main goal for the government is to increase this number in the future, in accordance with EU recommendations.

The Bismarck healthcare system model consists of a publicly provided healthcare system financed through social healthcare insurance. The National Health Insurance Fund (RZZO) of Serbia covers recurrent expenditure through input-based provider payments. In 2010, the majority of RZZO funding (income) originated from two major sources: 69.48% came from employment contributions, and 29.01% came from pension plan contributions[202]. The health contribution in Serbia is 12.3% of the salary. Although there are no precise data on the share of "out of pocket" payments in the total health expenditure, estimates suggest that private health spending exceeds 30%[203]. Private health insurance exists in a supplementary form, covering faster access and enhanced consumer choice.

The financing of hospitals in Serbia is based on a DRG system, while primary health care is based on capitation. In some special fields, such as dialysis, in vitro fertilization and hyperbaric chamber, private hospitals are contracted by the National Health Insurance Fund to provide medical services to the patient. This is seen as a good example of involving the private sector in the reduction of long waiting lists in Serbia.

UZBEKISTAN

The Uzbek health system has evolved from the Soviet Semashko model of health care, although the public sector continues to constitute its core. The Cabinet of Ministers, which is accountable to the President and the Parliament, is at the top of the hierarchy of the health system both in terms of regulation and financing. It develops strategies, approves the health budget and holds other governmental agencies accountable for the implementation of health policies.

Organization of Care - At lower hierarchical levels, implementing agencies represent the Government. The Ministry of Health and the oblast (region) or rayon (district) health authorities assume administrative responsibilities, while the Ministry of Finance and its oblast branches (the oblast and rayon finance departments) are responsible for the implementation of financing directives. Although the administrative functions of the Ministry of Health and the oblast and rayon health authorities are tailored primarily towards the public sector, some of their functions extend to some degree to the private sector, such as the licensing of health care providers. The Ministry of Finance and its oblast and rayon branches, on the other hand, only deal with the disbursement and control of public funding to public providers of health care.

The lowest layer in the hierarchy of the Uzbek health system comprises a mixture of public and private health care providers. Public providers are tasked with the delivery of health care within a centrally set framework, and can be divided into three categories, depending on their accountability and source of funding.

Primary health care providers are administratively accountable to the rayon or urban health authorities and draw on public and private financing. Public financing to health facilities at the rayon level comes from the rayon or urban finance departments. The exception is primary care units in the oblasts covered by the World Bank-financed "Health" project, which are financed by oblast finance departments. Private funding is obtained through the delivery of services outside the state-guaranteed basic benefits package of medical services.

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[201] Government of RS. Fiscal Strategy for 2013 with projections for 2014 and 2015. http://mfp.gov.rs/UserFiles/File/dokumenti/2012/Nacrt%20fiskalne%20strategije%20za%202013_%20godinu%20sa%20projekcijama%20za%202014_%20i%202015.pdf. (accessed July 15, 2013)

[202] Zah V.(2011) The Role of Health Technology Assessment in Reimbursement Policy – Experiences from the Republic of Serbia, IME X. ÉVFOLYAM 9. SZÁM 2011. NOVEMBER

[203] Radivojevic, B. (08.05.2013) Nedostaje 450 lekara, Vecernjenovosti, available from: http://www.novosti.rs/vesti/naslovna/drustvo/aktuelno.290.html:432926-Nedostaje-450-lekara

The next category of public health care providers is located at the oblast level. These are administratively accountable to the oblast health authorities and are financed through the oblast finance departments. These oblast health care providers include general or specialized hospitals and specialized outpatient clinics.

The final category of public health care providers is located at the national (republican) level. A number of health facilities receive public funding directly from the Ministry of Health and are also administratively accountable directly to the Ministry of Health.

Private providers, which are still small in number, are subject to the regulations of "for-profit" (profit-making) entities. Administratively, they are accountable to local government, while financial accountability lies with the local tax departments, to which private providers are required to submit regular financial reports.

In addition to the statutory health system outlined above, some government agencies, such as the Ministry of Internal Affairs and national security services, and major industrial companies maintain their own health facilities. These parallel health care providers are directly accountable to, and receive funding from, the respective state agency or company. They primarily serve their respective employees, with little or no access for the general population. Public institutions exclusively provide medical education in Uzbekistan. They are administratively accountable directly to the Ministry of Health and local and central government, and are obliged to comply with the regulations of the Ministry of Higher and Specialized Education. Either the national or the local government provides public financing to these institutions.

Health Care Financing - The allocation of resources for health care in Uzbekistan depends on the financing sources and the ownership of health care providers. There are three principal mechanisms. In the first, public funding originates from the state budget and strictly follows the expenditure protocols developed by central government. Most of this funding flows into public health facilities, while a small share is directed towards the private sector, such as through the reimbursement for outpatient pharmaceuticals.

In the second allocation mechanism, public health facilities draw on external funding. Public health facilities have been permitted to charge fees for services provided outside the state-guaranteed package of services. This funding might flow from a variety of sources, including out-of-pocket payments, employer contributions or voluntary health insurance, and funding follows the protocols set by the central Government in a more flexible manner. In the third allocation mechanism, financing flows from external sources to the private sector, for which no protocols on expenditure and use of health resources exist.

ANNEX 5: DETAILED EVALUATION METHODOLOGY

The ET used a mixed-method approach to ensure the validity of findings through data analysis and triangulation, based on the systematic cross-comparison of findings by data sources and by data collection methods. The methods included a mix of site visits, face-to-face interviews, group discussions and desk-based research, including review of existing reports and available data. Qualitative data was complemented by secondary analysis of quantitative data, where relevant and appropriate. A short description of each method is provided in this section.

DOCUMENT REVIEW (DR)

Reviewing documents was a major part of this assignment. The Evaluation Team (ET) consulted and obtained a significant body of documents from UNICEF RO and CO. Up to 700 country and region-specific documents produced by UNICEF (CPAPs, AWPs, MTRs, surveys and program evaluations, etc.) were reviewed during this evaluation. UNICEF provided some of these documents, while the ET obtained the remainder from public sources and through its contacts in the relevant countries. These documents were complemented by scientific papers and international reports, which were published in peer-reviewed journals and by different donor organizations, and are referenced throughout this document. Furthermore, the evaluation library has been enriched with the documents produced by other donors that also worked on MNCH and health sector issues in the evaluated countries during 2000-2012. These documents formed the basis for the desk review, and provided qualitative and quantitative information for the evaluation (see ANNEX 7).

IN-DEPTH INTERVIEWS (IDI)

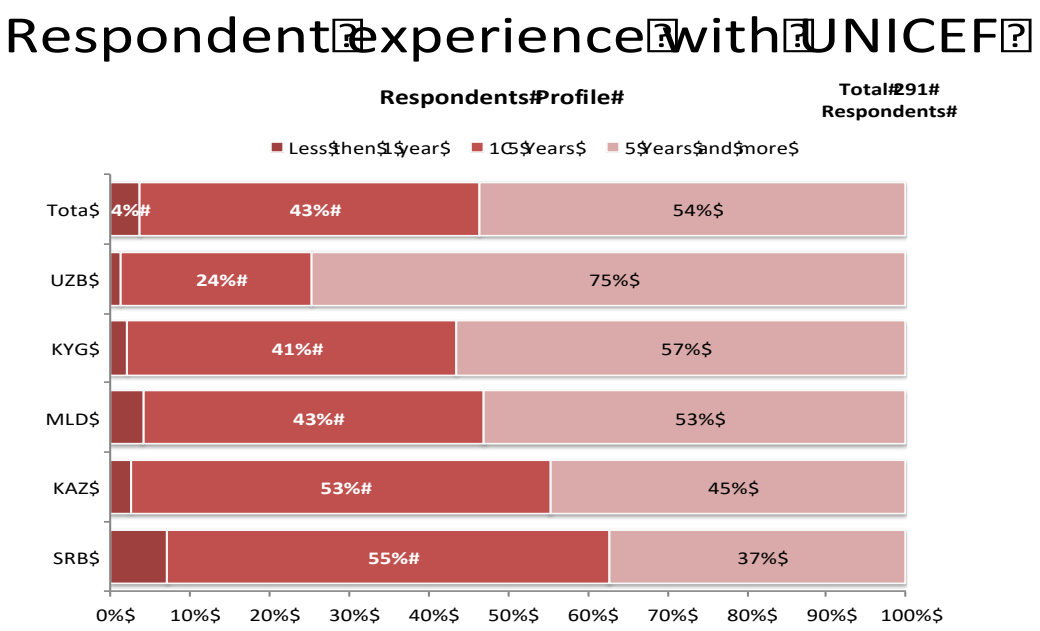
The Face-to-Face interview methodology was used to collect topic-specific qualitative information per each evaluation criteria where applicable. These interviews were conducted with key national, regional and international stakeholders including UNICEF Regional and Country Offices, Development Partners (DPs), and national and local level policy makers (see the list of interviewed stakeholders in ANNEX 8. Some IDIs with key informants who were not present in the respective countries were conducted over the phone or through Skype.

GROUP INTERVIEWS (GI)

GIs were conducted in each country for representatives of NGOs/community organizations, interest groups and selected stakeholders to acquire a more in-depth perspective on specific evaluation questions (see Evaluation Matrix) Separate GIs were organized in each site visit targeted at service providers.

Total of 291 respondents with knowledge and experience of UNICEF programmes were interviewed through the in-depth and group interviews. Figure 44 presents the experience of respondents with UNICEF Programmes in the five evaluated countries.

Figure 44: Respondent profiles by years of experience with, knowledge of, or exposure to UNICEF programmes in the five evaluated countries



SITE VISITS

Field visits to health care facilities were organized in purposefully-sampled/selected districts (two per country) to validate the evaluation findings that arose from the document review and in-depth interviews. The approach to the sampling, in terms of selecting the district and facility, was determined based on the desk-review and initial interviews. In each evaluated country, the ET visited one district / location where MNCH outcomes over the past decade were significantly improved, and a second district where progress was relatively marginal or non-existent. In each district, the maternity and outpatient facilities for pregnant and children were visited, and in-depth interviews with facility staff were conducted. Facility and community visits were complemented by in-depth interviews with district health authorities.

QUANTITATIVE ANALYSIS

Quantitative analysis formed a critical part of this evaluation, and was used for epidemiological as well as for financial analysis. Quantitative data was derived from various sources (including population and facility based surveys, MICS, DHS, Risk Factor Surveys, other Behavioural Surveillance Surveys, etc.) and from routine statistics (health and administrative-financial statistics). This data was used to evaluate the outcomes and impacts observed in these countries. During this analysis, the data was disaggregated (where possible) to look at outcomes and impact **through human rights, gender equality and equity lenses**. Earlier surveys conducted at the beginning of the evaluation period (1997-2000), where available, formed the baseline against which the outcome and impact achieved towards 2012 were assessed. Conclusions arising from different data sources were cross-compared to assure their external validity, quality and reliability.

Financial data from UNICEF's system about UNICEF supported interventions was complemented by the OECD/DAC and governmental databases to account for other donor assistance, and with financial information from the governments, where available. This database was used to measure the relative contribution of UNICEF in monetary terms.

Quantitative analysis mostly entailed **trend analysis**, in which comparable epidemiological data has been pulled together from public databases and reports, triangulated and analysed.

We also contemplated using **regression analysis** to evaluate the relationships between health system changes (measured with effective coverage indicators) and UNICEF's contribution to various interventions. However, such analysis proved impossible due to the limited comparable time series data available for all potential explanatory variables.

QUALITATIVE ANALYSIS

Based on the conclusions of the desk review, the ET used qualitative data analysis with a deductive approach. However, inductive approaches were also used for evaluation questions related to social determinants of health (EQ.5), human rights and gender equality. Each country review collected qualitative information arising from documents and interviews/discussions. The information was organized around the evaluation questions, as described in ANNEX 6.

For qualitative data analysis, the ET has structured the evaluation questions in a way that permitted qualitative data gathering using a standard coding frame e.g. for EQ.9 "Was the UNICEF supported programme(s) aligned with the national development and sectoral priorities?" or for EQ.15 where qualitative assessment was carried if the bottleneck reduction(s) contributed to disease-specific mortality reductions with: 0=No contribution; 1=Likely contribution.

Where necessary to enhance qualitative judgment, the ET triangulated quantitative and some qualitative data. This approach was used for the EQ.7, EQ.8 and EQ.13. For example, effective implementation of IMCI activities positively affected supply and demand side bottlenecks, and this translated into timely and adequate use of ORS and/or pneumonia treatment. We could therefore assume that reductions seen in ARI-specific mortality could be due to reduced bottlenecks.

The ET team validated all qualitative findings (a) collectively, through group discussion to assure consistency of qualitative judgements/findings across the countries; and (b) two ET members independently reviewed and validated the qualitative judgment scores assigned by the ET member responsible for the specific country report. More details on data triangulation are provided below.

DATA TRIANGULATION AND ANALYSIS

The data from the above sources was triangulated and analysed to arrive at conclusions and formulate evaluation recommendations. During triangulation, we used the "robustness scoring" approach for each finding to account for the quality of data obtained and assess the strength of our conclusions. Consequently, four scores (A to D) were used in this process. The specific score assigned was based on the following two criteria: a) the extent to which qualitative and/or quantitative evidence generated from different sources point to the same conclusion; and b) the quality of the individual data and/or source of evidence. Table 18 shows a detailed description of the "robustness score" assignment.

Table 18 Robustness Ranking for Evaluation Findings[204]

Ranking	Description
A	The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (*i.e.*, there is very good triangulation); and/ or the evidence source(s) is/are of relatively high quality and reliable to draw a conclusion (*e.g.,* there are no major data quality or reliability issues).
B	There is a good degree of triangulation across evidence, but there is less or 'less good' quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence are present.
C	Limited triangulation, and/ or only one evidence source that is not regarded as being of a good quality.
D	There is no triangulation and/ or evidence is limited to a single source and is relatively weak; or the quality of supporting data/ information for that evidence source is incomplete or unreliable.

During qualitative data analysis, specific attention was devoted to human rights, equity and gender issues in order to identify whether and how equity gaps were reduced, and if they still remain or if progress was not obvious, why this may have happened. Specific attention was also placed on triangulating feedback from male and female respondents to capture any gender diversity in emerging views.

Most of the analysis described earlier was carried out on a country level that informed the final MCE report. Preparation of the final report was an iterative process during which the Evaluation Team held numerous discussions on emerging conclusions, lessons learned and draft recommendations. The Evaluation Team's

[204] GAVI Second Evaluation Report; CEPA LLP. 2010; p.27

views and understandings derived from the application of this methodology are expected to be validated through a video-conference with the RO and COs that are planned for early 2015, and prior to delivery of the final evaluation report to UNICEF.

QUALITY ASSURANCE

The ET used number of techniques to ensure the quality of evaluation findings. These techniques included:

A. Elements of multiple coding, with regular crosschecks of coding strategies and interpretation of data between experts participating in the study. This represented one of the core activities of the weekly meetings and online conferences during the implementation phase;

B. Triangulation from different sources of data collected during the evaluation. In certain cases, this helped to address issues of internal validity by using more than one source of data to answer the proposed evaluation question(s);

C. Stakeholder validation, which involved crosschecking of evaluation findings with key informants. This has contributed to the rigor of the proposed evaluation and the evaluation results;

D. Finally, the Evaluation Team has appointed two members of the evaluation team Mr. Tito Armando Velasco and Dr. Gelmius Šiupšinskas as peer reviewers of the final report, which is also expected to add value to the quality of the evaluation outcomes. Both experts were involved at the initial stages of the evaluation, but had minimal input in the process of data collection and analysis. Therefore they have been able to provide an objective and, to a degree, external view on the evaluation findings.

DATA SOURCES

The ET primarily relied on following data sources to inform the evaluation findings:

PUBLIC DATABASES:	TransMonEE (Transformative Monitoring for Enhanced Equity) www.transmonee.org, OECD/DAC, Health For All Database, www.childinfo.org, www.dhsprogram.com, etc.
NATIONAL SOURCES:	Health care and administrative statistics, public finance databases (e.g. BOOST database in Moldova, Statistics Agency of the Republic of Kazakhstan, etc.)
DOCUMENTS:	All intervention/program and thematic area related documents (primary and secondary data sources) have been reviewed. A detailed list of UNICEF produced documents is available in the Evaluation Library and could be shared upon request. Available documents about other donor-funded projects also compiled.
PEOPLE:	Individuals (described earlier in the report and also listed in the stakeholder list) were consulted through individual in-depth-interviews and focus groups (for more details please see Annex 8).
SITE VISITS:	Data collected during the site visits to the sampled districts/facilities.

EVALUATION TOOLS

In-depth-interview and Group Interview Guides - The In-depth Interview guide supplied in the ANNEX 9 was used to interview the key policy makers/stakeholders, the partners, health care providers, community members, etc. Prior to visiting key informants, interview topics were tailored based on the Evaluation Framework to help ensure systematic coverage of questions and issues. The interview topics were selected around the evaluation questions, but grouped and targeted according to the organization and/or individual that was interviewed.

EVALUATION LIMITATIONS

The evaluation faced several limitations, as follows:

a. It was impossible to establish a rigorous counterfactual due to the length of the evaluation period, the complexity of public health interventions undertaken by the countries and the multiplicity of players involved in the health sector reforms.

b. Preliminary data analysis and the initial desk review pointed to the fact that most equity and gender based analysis could primarily be carried out with help of MICS and DHS surveys. While routine national statistics are only available in urban-rural, gender and regional breakdowns, the quantitative indicators that could fully reveal the equity impact of this evaluation are not included in the national statistical reports, and only limited information was sourced from population survey data (MICS and DHS primarily, thus offering only limiting comparability for certain indicators).

Table 19: Available MICS and DHS datasets

Country	MICS Round
UZB	DHS 1996 MICS 2 2000 MICS 3 2007
KAZ	DHS 1999 MICS 3 2003 MICS 4 2006
KGZ	DHS 1997 MICS 3 2005 DHS 2012
MDA	MICS 2 2000 (with Transnistria) DHS 2005 (without Transnistria) MICS 4 2012 (without Transnistria)
SRB	MICS 2 2000 MICS 3 2005 with Roma subpopulation MICS 4 2010 with Roma subpopulation MICS 5 2012 with Roma subpopulation

During preparation of this inception report, the ET obtained the MICS micro datasets listed in Table 19and carried out an initial crude analysis to identify the feasibility of using micro-datasets for the quantitative analysis. This initial work rendered the following findings:

a) MICS databases are prepared as separate data files for each round of a MICS (four data files per round) and for each country. However, UNICEF did not merge this data either for MICS rounds and/or for a given country, which imposes the need for significant data management to prepare MICS files for the analysis. This task is further compounded by the need to merge MICS and DHS datasets, which add additional complexity and demands more time;

b) data management aspects are further complicated by the fact that key variables used by countries in their respective MICS reports (e.g. DPT3 coverage rates, share of fully immunized child, etc.) are not readily available in the datasets, but have to be generated with the help of **generic syntaxes**[205] (SPSS program files). These do not work well on country-specific datasets without significant modification, which requires extensive reworking of SPSS syntaxes;

c) In most instances (and especially for ARI and DD cases), the number of cases captured in MICS do not render statistically significant differences between urban and rural residents (e.g. even for indicators with a large number of cases like breastfeeding). This limits the possibility for the evaluation team to note statistically significant changes in the indicators of concern that are necessary for equity analysis;

d) As shown on Table 19 three countries out of five only implemented two MICS rounds. Moldova implemented the 5th round of MICS (only in Transnitrian region), but the dataset was not available when this report was being written. The Kyrgyz Republic only implemented one MICS round, which was complemented by DHS. In Serbia, analysis of the Roma is important for an equity perspective; however, only MICS 4 had a separate sample for the Roma population. All of this indicates that the

[205] Syntax files for indicator generation/calculation are generic for a given MICS round and not country specific. Without significant modification in of syntaxes it is impossible to generate necessary indicator variables in the country datasets.

richness of micro data analysis could be significantly constrained unless different rounds of MICS and DHS datasets are compiled into one and analysed as a pooled dataset.

Due to these findings the ET adopted a two-pronged approach:

a) The ET team relied on general trend analysis and **triangulation** instead of micro dataset analysis. Arguments in support of this approach were manifold: i) detailed statistical analysis of the micro datasets was not explicitly requested in the ToR, and consequently were not budgeted in the original proposal; ii) initial analysis of the datasets revealed the need for extensive data management prior to analysis, which would be extremely labour intensive due to the structure and content of the available databases and would require significant additional resources from UNICEF; iii) even if additional resources were to be provided, the odds are high that this analysis may not render statistically significant results on many indicators necessary for this evaluation. Therefore, alternative solutions, like trend analysis, were necessary; iv) trend analysis were produced rather using MICS published reports and v) for robustness purposes they were validated with alternative data sources (where possible) in order to be conclusive on certain findings.

b) The ET developed terms of reference to contract a separate entity to undertake quantitative data analysis using the MICS and DHS datasets and deriving results that could contribute to UNICEF learning in addition to this evaluation.

c. UNICEF RKLA developed special guidance for country offices to retrofit UNICEF supported programmes/interventions to "core roles" and "determinants". This guidance requires COs to relate their programmes in the Annual Work Plans (AWP) and/or Rolling Work Plans (RWP) with the core roles and determinants. CO coded AWPs/RWPs were shared with the ET, and an initial review of submitted documents[206] revealed the following: a) **approaches to coding** of program/interventions and rules are not rigorous, which causes variability in coding similar interventions across countries; b) **conventions used to allocate the financial resources** of a program/intervention between different roles and determinants were lacking, which resulted in varying classification of the financial information. Some countries reported lump sums without further subdivision by core roles and/or determinants, while others reported separate amounts, although the logic behind how funds were split was not always clear; c) the **completeness of coding** also revealed some omissions that imposes limitations on the analysis. In light of this, the ET cannot assure the quality of the analysis in line with RKLA established procedures. Instead, alternative approaches to data coding have been proposed in the inception report, which offered more systematic coding of activities to core roles and across the five countries, and will enhance the rigor of the analysis. However, if an activity will contribute to two or more core roles, splitting the financial information between core roles was done using a convention and not the actual recorded data on a role assignment, which is not available in UNICEF's system.

d. The unavailability and/or poor quality of the data, in particular for public financing, further limited our analysis by not being able to relate UNICEF and donor investments directly to public spending. Some countries in our sample have well-developed systems that track public spending, while others do not; others still are even unwilling to share any information related to public expenditure. Furthermore, public health spending in most of the targeted countries (e.g. Kazakhstan, Moldova, Uzbekistan, Kirgiz Republic) is accounted for by institutions and by economic categories and not by service types, which made it impossible to relate government spending to UNICEF supported interventions. Consequently, rendering robust conclusions on leveraging resources from domestic sources was challenging, and the ET only made qualitative judgments on this topic.

STAKEHOLDER INVOLVEMENT AND PARTICIPATION

Based on the desk review (CPAP, program related reports and secondary data) and the pilot results, the evaluation team developed a Stakeholder List that grouped them in the categories of Public Sector (legislative and executive branches), Education institutions and Think tank research institutes, NGOs and Civil society, development partners/donors and implementing agencies and mass media. It also grouped them according to

[206] Only three countries out of five supplied their AWPs/RWPs at the time of this report production

their relation to health system strengthening, categorizing them as internal or external players, and by their actual or potential stake in efforts to strengthen MNCH related health systems.

The range of stakeholders relevant to each country context varied; therefore a country specific stakeholder matrix was elaborated for each country in close consultation with UNICEF country office staff, who have extensive local knowledge and provided a critical first hand understanding of which stakeholders (current and past) are/were relevant to the subject evaluation, according to their interests, level of influence and power in support of strengthening the health system.

Given the wide range of stakeholders and the time span (14 years) of the evaluation, in addition to the resource and time constraints, each prioritized, country specific stakeholder identified the names of key stakeholders (current and past), the contact information of individuals for each stakeholder, their potential role/stake/influence, and interview methods. The ET used face-to-face interviews, Skype/telephone interviews, and group interviewing practices where applicable.

ETHICAL CONSIDERATIONS

While designing the evaluation, the evaluation team consulted UNEG ethical norms and standard for evaluation as well as UNEG ethical guidelines[207], and applied following principles:

Impartiality of evaluators

a. The ET applied all efforts to operate in an impartial and unbiased manner at all stages of the evaluation.

b. The ET collected diverse perspectives on the subject under evaluation.

c. The ET attempted to guard against distortion in their reporting caused by their personal views and feelings.

Credibility

The ET produced reports that, from our perspective, show evidence of consistency and dependability in data, findings, judgements and lessons learned. The reports appropriately reflected the quality of the methodology, procedures and analysis used to collect and interpret data.

Selection of participants

Recruitment of key informants - All stakeholder groups and key informants/participants were selected fairly in relation to the aims of evaluation and actively included in research. The efforts were made to include the most relevant participants with knowledge on and/or experience with the issues explored, and not just those individuals that were available, or convenient to engage. All possible attempts were made to avoid marginalization, discrimination and/or exclusion of under-represented stakeholder groups and respondents. No children, or persons with disabilities were included as participants of in-depth and group interviews, as this was not deemed necessary for the current evaluation. Approval of local Bioethics Commissions was not required and has not been sought by the ET, considering the nature and form of the inquiry (e.g. no focus group discussions were conducted) performed for the evaluation.

Respect for Dignity and Diversity

The ET made every effort to: a) respect differences in culture, local customs, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity, and be mindful of the potential implications of these differences when planning, carrying out and reporting on evaluations, while using evaluation instruments appropriate to the cultural setting; and to b) keep disruption to a minimum while needed information is obtained, providing the maximum notice to individuals or institutions that they wished to engage in the evaluation, optimizing demands on their time, and respecting people's right to privacy and well as being gender sensitive when conducting interviews and selecting the interviewer.

Assure Confidentiality

To ensure that potential participants could make an informed decision, the evaluators informed all interviewees and participants about the purpose of the evaluation and the final outcome, and explained the process and duration of interview and/or FGD.

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[207] UN Evaluation Group Ethical Guidelines for evaluation, March 2008 http://www.unevaluation.org/ethicalguidelines

The evaluation team provided assurances for respondents' confidentiality when applicable and allowed respondents to refrain from answering the questions posed in case they feel uncomfortable to answer. Furthermore, key informants were interviewed face to face without the presence of other individuals. Their identities will not be revealed and their statements will not be attributed to any source to the extent possible. All information collected was kept secured, and the findings were reported accurately and impartially.

ANNEX 6: EVALUATION MATRIX

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
Impact:				
EQ.1. Has there been positive change in reduction of infant and under 5 mortality and morbidity over the period 2000 to 2012;	**Mortality** 1.1. U5 mortality per 1,000 live births by year 1.2. Infant mortality per 1,000 live births by year 1.3. Neonatal mortality per 1,000 live births by year 1.4. Cause-specific mortality (perinatal, respiratory, Infectious diseases, external causes and congenital malformation) among children 0-1 and 0-4 year old; 1.5. Birth weight and time specific foetal and infant mortality analysis (where BABIES has been implemented)	Trend analysis with triangulation of the reported data	Available but complete disaggregation was not possible for all countries For stunting and underweight MICS and DHS do not provide data for all countries, especially with the disaggregation needed for equity and gender focused analysis	- UN Inter-Agency Estimates - TransMonee database - National statistical yearbooks - BABIES[209] Matrixes (Kazakhstan, Kyrgyzstan, Moldova. Uzbekistan data was not used due to data quality and completeness concerns)
	Morbidity: 1.3 Underweight prevalence by MICS/DHS year 1.4 Rates of stunting by MICS/DHS year			- Country specific MICS and DHS reports - UNICEF Situation Analysis documents - Country specific surveys

[208] Country specific surveys, evaluations are given in a table attached to the evaluation matrix

[209] Birth weight group and Age-at-death Boxes for an Intervention and Evaluation System US CDC proposed methodology

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.2. What is the trend in these key child health indicators across geographical; ethnical; gender and other socio-economic stratifies;	2. Indicators 1.1 through 1.7 disaggregated by a) by gender; b) urban rural and c) rich and poor d) ethnical background and e) level of mother's education	Where possible the data was disaggregated by gender, urban-rural, region, etc. to unveil any equity related issues. Trend analysis with triangulation was used	Initial analysis showed unavailability of comparable disaggregated regional/ethnic/wealth quintiles data from MICS/DHS **for all countries**	- Country specific MICS and DHS reports - UNICEF Situation Analysis documents
EQ.3. What is the trend in reducing mortality and morbidity specific causes, also disaggregated by other socio-economic stratifies;	3.1. Cause-specific (infectious and parasitic diseases, respiratory, congenital malformations, diseases of perinatal period) death rate among under 1 year old 3.2. Cause-specific (infectious and parasitic diseases, respiratory, congenital malformations, diseases of perinatal period) death rate among 0-4 year old	Trend analysis of the reported data was used to arrive at conclusions **Data analysis disaggregated by other socio-economic stratifies, was not possible.**	Cause-specific data disaggregated by other socio-economic stratifies was not available in publicly available datasets	- TransMonee - National statistics
EQ.4. Who are the remaining outliers in terms of key child health indicators, disaggregated by geographical; ethnical and other socio-economic stratifiers;	4. This question is answered based on the analysis of the indicators under EQ 1-3	Secondary data analysis	There were concerns regarding the data availability comparability on disaggregated indicators	- See above sources for EQ.1-3
EQ.5. What other factors, for example, social determinants on health (education, unemployment, poverty etc.), contributed to change infant and U5 mortality and morbidity?	5. This analysis is primarily qualitative and based on the data obtained from review of country specific studies, reports and surveys.	multivariate regression for the contribution analysis was considered	Data availability did not allow multivariate regression analysis	- Country specific surveys, studies and reports
Relevance:				
EQ.6. Has UNICEF supported programme(s) addressed the most important causes of infant and under 5 morbidity and mortality?	6. Number of leading causes of under five morbidity and mortality targeted by UNICEF supported programmes over the time (by CPAP cycles). 6.1 Percent of deaths the targeted leading causes account for over the time (by CPAP cycles)	Data analysis of the indicators obtained for EQs 1 through 5 triangulated with UNICEF program analysis	Available with limitations noted earlier	- Sources for EQs 1 through 5 - UNICEF CPAPs, AWPs/RWPs, SITANs and annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable)

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.7. Were the most important bottlenecks in effective coverage with MNCH services identified and addressed with UNICEF's supported programme?	7. Number and share of the most important bottlenecks identified (implicitly and/or explicitly) in SITANs and CPAPs as validated by global and country specific evidence arising from reports supported by other donors	List of identified bottlenecks in effective coverage by UNICEF (by CPAP periods) is created based on the document review and compared with the global and country evidence	Available	- SITANs - CPAPs, AWPs/RWPs - Annual and MTR reports - Global Evidence sources around effective interventions - Other donor supported studies - Interviews (IDI & GIs where applicable)
EQ.8. Were the right and appropriate interventions identified, prioritized and applied by UNICEF supported programme (s), including for scope, target groups and scale to address health system bottlenecks;	8. Percent of identified bottlenecks (implicitly or explicitly) partially or fully addressed by UNICEF programmes. This is country specific list of bottlenecks to account for a country context and not a universal across countries.	Judgment score is assigned (2- fully addressed when scope, scale and targets is appropriate, 1- partially addressed when scope and target groups are appropriate while scale may be limited to pilot and/or subnational level, and 0- not addressed - any other cases.) The scope is defined as appropriate content of the intervention, scale is considered national or sub-national scale up and target group is defined as appropriate group of stakeholders and/or providers/individuals been targeted by the intervention. When rendering this judgment the ET also looked at why were not or why were partially addressed, as other donors may have addressed this bottleneck and there was no need for UNICEF to engage.	Available	
EQ.9. Was the UNICEF supported programme(s) aligned with the national development and sectoral priorities?	9. Qualitative judgment aligned (1) or not aligned (0)	Judgment is based on the ET review of comparative review of national development documents and UNICEF programmes.	Available	- CPAPs, AWPs/RWPs - Annual and MTR reports - Country Strategy and Policy documents (PRSP, National Development Strategies, Health Policies and Strategies) - Interviews (IDI & GIs where applicable)

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.10. Were relevant partners involved in the programme design, implementation and evaluation, including beneficiaries?	10. Share of relevant partners actually involved in a) programme design, b) implementation, c) evaluation from the total number of relevant partners identified (including beneficiaries) through the document review	List of relevant partners includes (Legislative branch of the government, MoH and local health authorities, Implementing partners, UNICEF and UN family, IFI/Bilateral donors, Service providers, Academia/Research Institutions, NGOs and Private sector). List of in-country relevant partners was developed based on document review and related to the "intervention package" Involvement of partners was evaluated using document review and interviews	Data availability was established during the pilot phase Length of recall period as well as unavailability of relevant experts /fluctuation of the staff affected evaluation of early years.	- SITANs - CPAPs, AWPs/RWPs - Annual and MTR reports - Monitoring and Evaluation reports - Interviews (IDI & GIs where applicable)
Effectiveness:				
EQ.11. Has the UNICEF supported programme (s) contributed to achieving required changes as per the Health System blocks/the Enabling Environment?	11. Answer to this question links with the EQ.7, EQ.8 and contribution score for Core Roles assigned according to Table 2 per each Intervention Package and sub-interventions.	Analysis triangulates Core role contribution and Bottlenecks addressed. For all EQ under this criteria triangulation from multiple sources: • Document review • Key informant Interviews with partners and policy makers, experts	Available	- Answers to EQ.7 and EQ8 UNICEF Country Annual Reports - Monitoring and Evaluation and MTR reports - Interviews (IDI & GIs where applicable)
EQ.12. Was UNICEF able to ensure that all relevant determinants at health system level (policy; legislation; financing; management) were tackled both through its direct intervention and by convening and advocating with partners?	12. Answer to this questions links with the EQ.7 and EQ.8 (because health system bottlenecks are mapped on MoRES determinants in our framework). Therefore the ET looked if interventions not supported by UNICEF (look at EQ.8) were advocated by UNICEF and/or independently supported by other donors.		Available	

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.13. Has the UNICEF supported programme (s) contributed to eliminating bottlenecks in ensuring effective coverage of priority MNCH interventions along the continuum, in particular those most relevant to the CEE/CIS region:	**Outcome measures:** a) exclusive breastfeeding; b) DPT3 coverage; c) percent of children immunized against specific antigens (measles, BCG); d) Vitamin A supplementation; e) low-birth weight infants; f) - Child with suspected pneumonia in the last two weeks taken to a health provider by type of provider; g) Use of oral rehydration therapy (ORT) h) use of or availability of adequately iodized salt in the households; i) Use of modern contraceptives; j) - Use of improved drinking water sources and improved sanitation facilities **Adequate coverage –** a) 4 antenatal visits; b) Share of pregnant women receiving basic services as part of the antenatal care (blood test; blood pressure, urine specimen; weight measurement) c) Share of women who were offered HIV testing and counselling with their antenatal care. **Initial Utilization** – a) Share of women conducting the 1 or more antenatal visit; b) children taken to provider for antibiotic treatment **Accessibility coverage-** (a) share of population having access to the nearest facility with qualified physician able to deliver essential MNCH services; b) any urban/rural difference and any differences by income group; **Availability coverage** - a) Share of pregnant women receiving antenatal care from doctor and nurse/midwife; b) Share of pregnant women receiving delivery care from doctor and nurse/midwife; c) physician to population ratio; d) nurse to population ratios at all levels)	These indicators help measure whether bottlenecks in a country have been reduced. However, to evaluate what was UNICEF's contribution the ET used contribution score (described in the methodology chapter) per each intervention to establish plausible contribution. Furthermore, depending on a data availability indicators are presented by a country data trend and are triangulated The ET provided long list of indicators to find at least two data points to present emerging trend and render conclusion. Tracer interventions are used to assess the effective coverage indicators	Review of MICS and DHS data showed that answering these questions for all countries present challenge due to unavailability of two data points.	- MICS and DHS reports - Routine national statistics - WHO Health for all database - Country surveys and reports
EQ.13.1. Increasing availability of essential supplies and qualified human resources;	13.1.1 Physician population ratios at PHC level 13.1.2 Availability of MCNH skilled personnel measured by type of provider for antenatal and delivery care provision	Data trend analysis	Data availability is limited in some countries	- Facility surveys - DHS/MICS reports - Routine national statistics - WHO Health for all database

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
				- MTR and evaluation reports - UNICEF Annual reports
EQ.13.2. Ensuring financial accessibility;	13.2.1 Shares of households reporting been sick and not able to obtain health services 13.2.2 Other financial protection qualitative indicators across three dimensions of Universal Health Coverage (who is covered, what services are covered, to what extent services are covered?)	Data trend analysis	Data availability is limited in some countries data is available (Kazakhstan, Kyrgyzstan, Moldova) and in others it presents challenge	- Country surveys and reports - Government documents describing BBP - Routine national statistics
EQ.13.3. Changing knowledge, attitudes and practices on MCH and raising awareness about and demand for services;	13.3.1 Level of parental knowledge on danger signs of pneumonia; 13.3.2 knowledge of types of symptoms for taking a child immediately to a health facility; 13.3.3.Knowledge of danger signs during pregnancy; 13.3.4 Knowledge of danger signs for diarrhea; 13.3.5 Percentage of women aged 15-49 years who know the main ways of preventing HIV transmission	Data trend analysis	Data availability is limited in some countries	- MICS and DHS reports - KAP Surveys, where available
EQ.13.4. Ensuring quality of services;	13.4.1 Share of children with suspected pneumonia who received antibiotic treatment 13.4.2 Share of pregnant women receiving basic services as part of the antenatal care (blood test; blood pressure, urine specimen; weight measurement); 13.4.3 Share of women who were offered HIV testing and counselling with their antenatal care.	Data trend analysis The indicators captured by effective coverage (EQ.13)		
EQ.14. Was the equity gap in coverage with MNCH services reduced? What groups of the society remain unreached disaggregated by place of residence, wealth, gender and ethnicity?	14. Depending on data availability indicators for EQ.13, stratified by gender, rural/urban, ethnic, wealth quintiles, where possible.	Data trend analysis and qualitative information	Not available for all countries	- MICS and DHS reports - Routine national statistics - Other surveys, MTRs and evaluation reports - Annual reports
EQ.15. Has the reduction in bottlenecks contributed to disease specific mortality reduction (mortality caused by ARI, DD, asphyxia,	15. Qualitative assessment if the bottleneck reduction(s) contributed to disease-specific mortality reductions with: 0=No contribution; 1=Likely contribution.	Quantitative and qualitative data triangulation allowed arriving at judgment. Namely, if appropriate bottlenecks were identified and addressed by UNICEF (EQ.7 and EQ.8)	Available	- All sources for EQ.11 through EQ.14 - Interviews (IDI & GIs where applicable)

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
prematurity, etc.) And if it could be positively associated with overall reduction in ENMR, PNMR, IMR, and U5MR?		if the intervention specific bottlenecks were reduced (EQ.13) and how possibly changes in disease-specific mortality could be associated with the changes in the bottleneck. E.g. effective implementation of IMCI activities positively affected supply and demand side bottlenecks and this translated into timely and adequate use of ORS and/or pneumonia treatment we could assume that reductions seen in ARI-specific mortality is likely to be due to reduced bottlenecks. Furthermore, if the ET saw reductions in ARI-specific mortality correlates with reduction in NMR, IMR and U5MR it is concluded that it is likely there is association between these two.		
Efficiency:				
EQ.16. Has allocation of resources for UNICEF supported programmes been done in the most cost-benefit manner?	16. Relative comparison of resource allocation by bottlenecks	Tracking resource allocation by bottlenecks and by years in each country and comparing across	The data is available from AWP/RWPs, however comparison in the pilot country did not lead to any conclusions, but showed that cost depends on the intervention and varies by implementation phase. The ET cautiously expects that increasing sample size, when all other countries are evaluated, my allow for better analysis	- AWPs/RWPs - UNICEF Annual, MTR and evaluation reports
EQ.17. Have UNICEF budgets and resources been adequately used on addressing priority bottlenecks? In other words, could we have the same programme results with less - resources (economic and technical efficiency)?	We will not be able to track resource allocation by bottleneck, because establishing linkages between a bottleneck and FTE allocated is impossible, while establishment of the reference point for comparison is not feasible.	NOT FEASIBLE		-

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.18. Was programme implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?	While answering this question might be simple for an activity planned in the AWP, this will not lead to any conclusion about timeliness of implementation across activities, interventions and CPAPs. The ET also questions the value of this question for this evaluation.	NOT FEASIBLE	Data is not available, as annul reports and MTR do not systematically reflect these data, only sporadic notions are made on timeliness of selective activities. Existing data storage systems within the data storage systems do not permit capturing the data with available resources of UNICEF staff and consultant's for this evaluation. Sheer number of interventions. complexity of interventions supported by UNICEF have faced diverse challenges, from conflicts and security disruptions to imposition of presidential veto on laws promoted by UNICEF. These factors were so much country specific that systematizing those and detecting the overall trend that may inform the learning seemed not possible. The value of this questions becomes questionable in relation to the objectives of the evaluation. Therefore, this indicator was dropped.	-
EQ.19. Was programme implementation appropriately monitored and evaluated? How were the results used?	19.2 The qualitative judgment about the adequacy of the M&E used by UNICEF to fully monitor implementation progress as well as critical outcomes per intervention package supported	Tracking M&E and MTR recommendations and how many of those were addressed in CPAPs and UNICEF country programmes Evaluating the set of indicators allowing measurement of	Available	- AWPs/RWPs - UNICEF Annual, MTR and evaluation reports - SITANs and CPAPs - Country data systems – annual statistical

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
	19.3 Where equity based indicators monitored by UNICEF (Yes or No) and used in analysis and/or planning?	achievement for a given intervention package. Availability of equity measuring indicators in UNICEF programmes?		yearbooks - Interviews (IDI & GIs where applicable)
Sustainability				
EQ.20. Are UNICEF supported programmes integrated into national policies and budgets?	20. Share of UNICEF supported interventions packages and sub-interventions integrated into (a) national policies; (b) into national budgets by country by year	Through document review identify the number of UNICEF supported programmes that were eventually reflected in national politics and/or budgets and compare with the total number of programmes supported	Available	- AWPs/RWPs - UNICEF annual, MTR and evaluation reports - Government documents and budgets - Interviews (IDI & GIs where applicable)
EQ.21. Have UNICEF developed models/pilots scaled-up, incorporated into national policies and/or systems?	21. Share of pilots scaled up (a) at regional level (b) at national level by country by year	Counting pilots that went to scale and that did not		
EQ.22. Have UNICEF assisted programme(s) been successful in leveraging resources and partnerships?	22. Share of intervention packages or sub-interventions (a) not successful; (b) partially successful (partnerships created but not sustainable, no funds leveraged; (c) successful (sustainable partnerships created, funds leveraged)	Share of intervention packages or sub-interventions(a) not successful; (b) partially successful (partnerships created but not sustainable, no funds leveraged; (c) successful (sustainable partnerships created, funds leveraged)		
EQ.23. What was the return on the investment ratio? What additional funding to MCH focused interventions was promoted through the UNICEF programme(s)?	23. Qualitative judgment	For this indicators no quantitative measurement is offered but more qualitative information is provided that allows presenting what was the leverage that UNICEF achieved through its own investments	Qualitative data available in the annual reports and MTRs validated through interviews	- UNICEF annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable)
EQ.24. Do programmes continue after the conclusion of UNICEF support?	24. Three categories 1=No, 2=Partially (with limited components); 3=Yes (full sustainability with potential further development)	Qualitative assessment of three categories 1=No, 2=Partially (with limited components); 3=Yes (full sustainability with potential further development)	Available	- Government documents - Interviews (IDI & GIs where applicable)
EQ.25. What were the critical elements, which made the programme sustainable (or which did not make it sustainable)?	25. Description of key elements of sustainability/non sustainability	Qualitative evaluation/identification of critical elements and validation with the help of stakeholders	Qualitative data available in the annual reports and MTRs validated through interviews	- UNICEF annual, MTR and evaluation reports - Government documents - Interviews (IDI & GIs where applicable)

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.26. Are other partners supporting MNCH programmes initiated with support from UNICEF?	26. Number of partners supporting MNCH programmes initiated with support from UNICEF	Key informant interviews (UNICEF staff, governmental partners, key development partners, key private sector and civil society partners)	Available	- UNICEF annual, MTR and evaluation reports - Government documents - Partner documents - Interviews (IDI & GIs where applicable)
Rights Approach and Gender Equality				
EQ.27. Were the Human Rights Based Approach to programming and Gender Equality aspects incorporated into programme(s) planning, implementation and evaluation?	27. Qualitative judgment score 0=no, 1= partial and 2 = yes.	Qualitative evaluation/identification and score assignment relative to bottleneck identified and necessity of human rights based approach to programming and gender equality to be present. Furthermore, Gender and other equity differentials are captured under EQ.1, EQ.2, and EQ.14 that in addition to these questions also help the ET understand how equity issues were considered and addressed by UNICEF. Furthermore, indicator 19.3 also contributes to answering this question. If some critical aspects of gender and equity were present but not completely captured to inform programming the ET assigned **partial score**.	Available	- CPAPs - AWPs/RWPs - UNICEF annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable)
EQ.28. Were planning, implementation and monitoring of evaluated programmes performed in a participatory and ethical manner with full respect to human rights and gender specific and sensitive issues?	28. Qualitative judgment score 1=yes, 0= no.	Reviewing evaluation reports and determining the share	Available	- CPAPs - AWPs/RWPs - UNICEF annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable)
EQ.29. Whether the programme being evaluated paid attention to effects on marginalized, vulnerable and hard-to-reach groups;	Share of evaluations paying attention to effects on marginalized, vulnerable and hard-to-reach groups	Reviewing evaluation reports and determining the share	Available	- MTRs and program evaluation reports

EVALUATION CRITRIA & QUESTIONS	Indicators	Methodology	Data Availability	Sources [208]
EQ.30. How gender issues were implemented as a crosscutting theme in programming, and if the programme being evaluated gave sufficient attention to promote gender equality and gender-sensitivity.	Share of UNICEF supported programmes/interventions where gender issues have been advocated (sensitized) and/or have been monitored and reported	Document review helped count those programmes/interventions that advocated and/or monitored gender related issues.	Available	- CPAPs, AWPs, Annual and MTR reports - Program evaluation reports

ANNEX 7: LIST OF DOCUMENTS CONSULTED

DOCUMENT TYPE DEFINITION

Code for Document Type	Code Definition
MTR	Medium Terms Review
PER	Program Evaluation Report
RPE	Regional Program Evaluation
MICS	Country Specific MICS Report
CPAP	Country Programme Action Plan
AR	Annual Country Program reports
MDGR	MDG Report
CSRF	Country Specific Results Framework
QMR	Quarterly Monitoring Report
PD	Policy Document
CS	Country Study
CAPE	Country Assistance Program Evaluation
CPD	Country Programme Document
CSR	Case study Report
CR	Country report
PRSP	Poverty Reduction Strategy Paper
AMR	Annual Monitoring Report
DAO	Delivery As One (Joint UN document)
ComR	Completion Report
HSR	Health Systems review
OTH	Other types not captured by above coding
KAP	Knowledge, Attitude, Practice

KAZAKHSTAN

Documents		Document Type	Producer	YY
1.	Minutes of the Annual Review meeting 2010 Child and Adolescent Health and Development	AMR	UNICEF	2010
2.	Протокол работы группы – «Укрепление систем направленных на защиту ребенка. Охрана здоровья и развития детей и подростков», Развитие потенциала молодежи»	AMR	UNICEF	2012
3.	Actions taken in 2013 and Plans for 2014 to scale up national action and joint initiatives as a follow-up to the A Promise Renewed and/or the SG Strategy on Women and Children's Health	AMR	UNICEF	2013
4.	Annual Report	AR	UNICEF	2002
5.	Annual Report	AR	UNICEF	2003
6.	Annual Report	AR	UNICEF	2004
7.	Annual Report 2005	AR	UNICEF	2005
8.	Annual report 2006	AR	UNICEF	2006
9.	Annual Report 2007	AR	UNICEF	2007
10.	Annual Report 2008	AR	UNICEF	2008
11.	Country Office Annual Report for 2009	AR	UNICEF	2009
12.	UNICEF Annual Report for Kazakhstan	AR	UNICEF	2010
13.	Country Office Annual Report for: Kazakhstan, CEE/CIS	AR	UNICEF	2011
14.	Cumulative Analysis of Progress in Implementation of the UNFPA Strategic Plan 2008-2013	AR	UNFPA	2011

Documents		Document Type	Producer	YY
15.	Kazakhstan Country Office Portal (CoP) 2012 – Template	AR	UNICEF	2012
16.	UNICEF Annual Report 2012 for Kazakhstan	AR	UNICEF	2012
17.	Kazakhstan Country Office Portal (CoP) 2012 – Template	AR	UNICEF	2013
18.	Consolidated Annual Report on Activities Implemented under the Joint Programme	AR	UNDP	2013
19.	Annual Work Plan: Better Parenting Project	AWP	UNICEF	2005
20.	Annual Work Plan for Quality MCH/PHC Sub-project	AWP	UNICEF	2005
21.	Annual Work Plan: Control of Micronutrients Deficiency Project	AWP	UNICEF	2005
22.	Annual Work Plan for Quality Youth Friendly Services Sub-Project	AWP	UNICEF	2006
23.	Annual Work Plan for Project Better Parenting Initiative	AWP	UNICEF	2006
24.	Annual Work Plan for Control of Micronutrients Deficiency Project	AWP	UNICEF	2006
25.	Annual Work Plan: Communication Strategy on Avian Influenza Prevention	AWP	UNICEF	2007
26.	Annual Work Plan: HIV/AIDS Prevention, Quality YFS and LSBE	AWP	UNICEF	2007
27.	Improvement of quality MCH/PHC and Better Parenting	AWP	UNICEF	2008
28.	Annual Work Plan: Prevention of Micronutrient Deficiencies	AWP	UNICEF	2008
29.	Improvement of quality MCH/PHC and Better Parenting	AWP	UNICEF	2009
30.	Annual Work Plan: Prevention of Micronutrient Deficiencies	AWP	UNICEF	2009
31.	Country Programme of Cooperation	CPAP	UNICEF	2000
32.	Стратегическийпланразвитияминистерство здравоохранения республика Казахстан на 2009-2011 Годы	CPAP	GoKaz	2008
33.	Country Programme Action Plan	CPAP	UNICEF	2005-2009
34.	Country Programme Action Plan	CPAP	UNICEF	2010-2015
35.	Draft Country Programme Document**	CPD	UNICEF	2004
36.	Комплексная программа «Здоровый образ жизни»	CPD	GoKaz	2007
37.	Country programme document 2010-2015	CPD	UNICEF	2009
38.	Причины смертности детей в Казахстане	CR	UNICEF	2002
39.	Inception report. Support for Maternal and Child Health in Kazakhstan	CR	WHO	2009
40.	Country Programme Performance Summary	CR	UNFPA	2009
41.	Impact of Economic Crisis and Oil and Fuel Price Volatility on Children and Women in Kazakhstan	CR	UNICEF	2009
42.	Assessing and Improving the Safety and Quality of Hospital Care for Children in Kazakhstan	CR	WHO	2010
43.	Nutrition Profile	CR	UNICEF	2010
44.	Effectiveness of Care for Development in Kazakhstan: A Quantitative and Qualitative Assessment	CR	UNICEF	2010
45.	Support for Maternal and Child Health in Kazakhstan	CR	WHO	2011
46.	Implementation of the Low of the Republic of Kazakhstan “On Special Social Services” in Relation to Children and Their Families: Assessment of the Situation	CR	UNICEF	2012
47.	Joint UNICEF/WHO Report on a Mission to Kazakhstan	CR	WHO	2013
48.	Analysis of the Situation of Children and Women in Kazakhstan	CR	UNICEF	2008-20013
49.	“Healthy Mother, Healthy Child” – Improving the Nutritional and Health Status of Women and Children in Kazakhstan	CSR	Red Cross Society	2012
50.	United Nations Development Assistance Framework	CSRF	UN	2000
51.	United Nations Development Assistance Framework for the Republic of Kazakhstan	CSRF	UNDP	2004
52.	Expected UNDAF Outcome II: Improved Access to Quality Basic Social Services	CSRF	UN	2005
53.	Results and Resources Framework	CSRF	UN	2005

Documents	Document Type	Producer	YY
54. United Nations Development Assistance Framework (UNDAF) for the republic of Kazakhstan	CSRF	UN	2009
55. Expected UNDAF outcome II: Improved Access to quality basic social services	CSRF	UNICEF	2005-2009
56. Evaluation Plan of the CPAP in the Republic of Kazakhstan, Country Programme 2010-2015	CSRF	UNICEF	2010-2015
57. Annex 2a: Results and Resources Framework – Kazakhstan – With introduced MTR adjustments	CSRF	UNICEF	2010-2015
58. Public Health Challenges and Priorities for Kazakhstan. Reviews the current public health challenges and describes five priorities for building public health capacity that are now being developed and undertaken at the Kazakhstan School of Public Health to strengthen population health in the country and the Central Asian Region	HSR	GAJGH	2012
59. Country Cooperation Strategy	HSR	WHO	2013
60. Study on Knowledge, Attitudes Behaviors and Practices on anemia prevention trough consumption of wheat fortified flour in the framework of Project of Social Mobilization on Flour Fortification with Iron and Vitamins to Improve Mother and Child's Health and Conducted Measures Efficiency for Prevention Of Iron Deficiency Anemia Prevalence among the Vulnerable Population Groups	KAP	UNICEF	2009
61. KAP Study	KAP	UNICEF	2001-2002
62. Evaluation of UNICEF's Early Childhood Development Programme with Focus on Government of Netherlands Funding (2008-2010)	MDGR	GoKaz, UN	2002
63. Millennium Development Goals in Kazakhstan	MDGR	GoKaz, UN	2005
64. Millennium Development Goals in Kazakhstan	MDGR	GoKaz, UN	2007
65. Millennium Development Goals in Kazakhstan	MDGR	GoKaz, UN	2010
66. Progress Toward the Millennium Development Goals and Other Measures of the Well-Being of Children and Women	MDGR	UNICEF	2013
67. Multiple Indicator Cluster Survey, (MICS3) 2006	MICS	UNICEF	2007
68. Multiple Indicator Cluster Survey in the Republic of Kazakhstan, (MICS4) 2010-2011	MICS	UNICEF	2012
69. MICS 2003-2006	MICS	UNICEF	2003-2006
70. Specific Objectives of the MTR	MTR	UNICEF	2002
71. Medium-term Review of the Country Program of Cooperation between UNICEF and the Government of the Republic of Kazakhstan	MTR	UNICEF	2007
72. Report on the Mid-term Review of the 2010-2015 Programme of Cooperation Between the Government of the Republic of Kazakhstan and the UN Children's Fund (UNICEF)	MTR	UNICEF	2013
73. Demographic and Health Survey	OTH	GoKaz	2000
74. Work and Financial Planning – Kazakhstan – 2002	OTH	GoKaz	2002
75. Реформа Системы Здравоохранения В Казахстане Варианты Для Рассмотрения	OTH	UNICEF	2004
76. Household Access to Iodize Salt and Iodine Nutrition Status	OTH	USAID	2004
77. Analysis of infant and U5 mortality in the Republic of Kazakhstan: challenges and solutions	OTH	WHO	2005
78. Доступность И Качество Медицинских Услуг В КазахстанеИсследование	OTH	UNICEF	2005
79. Comparative Study of Parenting Programmes: Belarus, Bosnia/Herzegovina, Georgia and Kazakhstan	OTH	UNICEF	2005
80. Analysis of accessibility and quality of public health care on the basis of 2003 study and MICS 2006.	OTH	UNICEF	2006
81. Improvement of Maternal and Child health in Kazakhstan	OTH	UNFPA	2007

Documents		Document Type	Producer	YY
82.	Policy Assessment Report Kazakhstan for the Central Asian TB Control Partnership	OTH	USAID	2007
83.	Comparative Analysis of Infant Mortality Rates in the United States and in Kazakhstan: Differences in Causes and Proposed Courses of Action	OTH	SPEA	2008
84.	Training on Effective Perinatal Care in East Kazakhstan Oblast	OTH	UNICEF	2008
85.	Внедрение технологий эффективного перинатального ухода, включая вмешательства при ВИЧ/СПИД и ИППП	OTH	UNICEF	2009
86.	Polio Communication and Social Mobilization in Kazakhstan	OTH	Gates Foundation	2010
87.	Polio Communication and Social Mobilization in Kazakhstan	OTH	UNICEF	2010
88.	Maternal, Newborn& Child Survival, country profile	OTH	UNICEF	2012
89.	Table: Обучение медицинских работников ПМСП и детских стационаров на курсах ИВБДВ по областям на 1 января 2012г.	OTH		2012
90.	Immunization Summary	OTH	UNICEF	2012
91.	Kazakhstan: WHO and UNICEF estimates of immunization coverage: 2012 revision	OTH	UNICEF	2012
92.	Empowering Health workers and Caregivers	OTH	UNICEF	2012
93.	Сравнительный анализ показателей педиатрической службы и внедрения индикаторов ИВ БДВ в РК за 2011 - 2012г.г.	OTH	UNICEF	2012
94.	Уход За Детьми Раннего Возраста В Семье	OTH	UNICEF	2012
95.	Совещания с участием Заместителя Премьер-Министра Республики Казахстан Орынбаева Е.Т.	OTH	GoKaz	2013
96.	Мониторинг областей по основным индикаторам ЭПУ	OTH	UNICEF	2013
97.	Goal1: Eradicate Extreme Poverty and Hunger; Goal 4: Reduce Child Mortality	OTH	UNICEF	2014
98.	Improvement of Maternal, Newborn and Child Health for Further Decreasing of IMR/U5MR	OTH	UNICEF	2014
99.	Improvement of Maternal and Child Health Services in the Republic of Kazakhstan: An Assessment of Equity and Socio- Economic Determinants of Health	OTH	UNICEF	2014
100.	Result of the Quality Assessment of Institutional Medical Care For Mothers and Children in East Kazakhstan Oblast and General Recommendations for Improving the Quality of Perinatal Care	OTH	GoKaz	2008-2004
101.	Расходы по Плану мероприятий по снижению материнской и младенческой смертности на 2014 – 2016 годы	OTH	GoKaz	2014-2016
102.	Уход За Детьми Раннего Возраста В Семье	OTH	UNICEF	N/A
103.	Обучающий курс «Уход за детьми раннего возраста в семье»	OTH	UNICEF	N/A
104.	Strategic Plan of Development of the Republic of Kazakhstan up to 2010	PD	GoKaz	2001
105.	Минздрав рапортует об успехах в реформировании системы здравоохранения	PD	GoKaz	2006
106.	Рабочий план по реализации постановления Правительства Республики Казахстан от 28 декабря 2007 года № 1325 «Об утверждении Программы по снижению материнской и детской смертности в Республике Казахстан на 2008 – 2010 годы» на 2008 год	PD	GoKaz	2008
107.	Salamatty Kazakhstan – State Health Care Development Program for 2011-2015	PD	GoKaz	2010
108.	«Саламатты Қазақстан»- Об утверждении Государственной программы развития здравоохранения Республики Казахстан на 2011-2015 годы	PD	GoKaz	2010
109.	Order on Special Needs (Приказы)	PD	GoKaz	2011

Documents		Document Type	Producer	YY
110.	Реализация Закона Республики Казахстан «О специальных социальных услугах» в отношении детей и членов их семей: оценка положения	PD	UNICEF	2012
111.	State Program on Improvement Mother and Child Health in Kazakhstan	PD	GoKaz	2013
112.	Мероприятия, направленные на охрану здоровья матери и ребенка в Республике Казахстан	PD	GoKaz	2013
113.	Includes Decree on BBP on 2008-2009. Приказы	PD	GoKaz	2007-2012
114.	Приказы	PD	GoKaz	2006-2012
115.	Результаты Оценки Качества Стационарной Медицинской Помощи Матерям И Детям В Восточно-Казахстанской Области И Общие Рекомендации По Улучшению КачестваПеринатальнойПомощи	PER	State Medical University	2009
116.	Empowering Health workers and caregivers. Evolution of patronage system in Kazakhstan 2003-2012	PER	UNICEF	2012
117.	Results of the Quality Assessment of Institutional medical Care for Mothers and Children in East Kazakhstan Oblast and General recommendations for Improving the Quality of Perinatal Care	PER	State Medical University	2010
118.	Project Plan Of Action for YH301-H16/02-Early Childhood Survival, Growth, Development and Protection Project	PPA	UNICEF	2004
119.	Project Plan Of Action for: YE302-H06/01Maternal and Neonatal Care	PPA	UNICEF	2004
120.	Mainstreaming Statistics in the Poverty Reduction Strategy Approach to Provide for More Effective Technical Assistance: Some Experience at the IMF	PRSP	IMF	2007
121.	Regional Monitoring of Child and Family Well-Being: UNICEF's MONEE Project in CEE and the CIS in a Comparative Perspective	RPE	UNICEF	2000
122.	Anaemia Prevention and control: Mid-term Evaluation for UNICEF-CARK Regional Office Central Asia Republics and Kazakhstan	RPE	UNICEF	2002
123.	A Specialist for the Left Kidney and a Specialist for the Right Kidney: A Preliminary Assessment of Health Promotion and Communication Capacity in Eight CEE/CIS Countries	RPE	UNICEF	2008
124.	Improving Maternal and Child Health Well Being in CEE/CIS through Strengthened Home Visiting and Outreach	RPE	CPHA ACSP	2011
125.	System Strengthening for a Protective Environment for Children Programme; Two Year Rolling Work Plan (RWP) for Child and Adolescent Health and Development Programme	RWP	UNICEF	2010-2011
126.	2012 – 2013 Rolling Work Plan (RWP) for System Strengthening for a Protective Environment for Children Programme Child and Adolescent Health and Development	RWP	UNICEF	2012-2013
127.	Improvement of quality MCH/PHC and Better Parenting	AWP	UNICEF	2008
128.	Annual Work Plan: Prevention of Micronutrient Deficiencies	AWP	UNICEF	2008
129.	Improvement of quality MCH/PHC and Better Parenting	AWP	UNICEF	2009
130.	Annual Work Plan: Prevention of Micronutrient Deficiencies	AWP	UNICEF	2009
131.	Annual Work Plan: Better Parenting Project	AWP	UNICEF	2005
132.	Annual Work Plan for Quality MCH/PHC Sub-project	AWP	UNICEF	2005
133.	Annual Work Plan: Control of Micronutrients Deficiency Project	AWP	UNICEF	2005
134.	System Strengthening for a Protective Environment for Children Programme; Two Year Rolling Work Plan (RWP) for Child and Adolescent Health and Development Programme	RWP	UNICEF	2010-2011

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Kyrgyzstan Documents	Document Type	Producer	YY
1. LQAS National Monitoring Survey of Gulazyk Program	AMR	UNICEF	2012
2. Kyrgyz Republic 2001 Annual Report	AR	UNICEF	2001
3. Kyrgyz Republic 2002 Annual Report	AR	UNICEF	2002
4. Kyrgyz Republic 2003 Annual Report	AR	UNICEF	2003
5. Kyrgyz Republic 2004 Annual Report	AR	UNICEF	2004
6. Kyrgyz Republic 2005 Annual Report	AR	UNICEF	2005
7. UNICEF Annual Report 2006	AR	UNICEF	2006
8. UNICEF Kyrgyz Republic 2007 Annual Report	AR	UNICEF	2007
9. UNICEF Kyrgyz Republic 2008 Annual Report	AR	UNICEF	2008
10. UNICEF Kyrgyz Republic 2009 Annual Report	AR	UNICEF	2009
11. UNICEF Kyrgyz Republic 2010 Annual Report	AR	UNICEF	2010
12. UNICEF Annual Report 2011 for Kyrgyzstan, CEE/CIS	AR	UNICEF	2011
13. UNICEF Annual Report 2012 for Kyrgyzstan, CEE/CIS	AR	UNICEF	2012
14. Access to Social Services Programme, Adolescent Development and Participation Project	AWP	UNICEF	2005
15. Programme: Access to Social Services Project: Mother and Child Health and Nutrition	AWP	UNICEF	2008
16. Program: Access to Social Services Project: Mother and Child Health and Nutrition	AWP	UNICEF	2009
17. Work Plan for Emergency Health and Nutrition Programme	AWP	UNICEF	2011
18. Правительство Кыргызской Республики И Юнисеф Программа Сотрудничества На 2000-2004 Годы ПрограммныйПланОпераций	CPAP	UNICEF	2000
19. Country Programme Action Plan for 2005-2010	CPAP	UNDP	2004
20. Country Programme Management Plan	CPAP	UNICEF	2004
21. Government of the Kyrgyz Republic and UNICEF. Program of Cooperation 2005-2010. Action Plan	CPAP	UNICEF	2005
22. Country Programme Action Plan between The Government of the Kyrgyz Republic and The United Nations Development Programme 2012-2016	CPAP	UNDP	2012
23. Country Programme Action Plan Between The Government of the Kyrgyz Republic and UNICEF (2012-2016)	CPAP	UNICEF	2012
24. Kyrgyzstan Country Program Document	CPD	UNICEF	2011
25. Work Plan for Emergency Health and Nutrition Programme	CPD	GoKyrg, UNICEF	2011
26. UNICEF Programme of Cooperation; 2 Year Rolling Work Plan for 2012-2013 Health and Nutrition Programme	CPD	UNICEF	2012
27. Follow-up survey of nutritional status in children 6-24 months of age	CR	GoKyrg, UNICEF	2010
28. Kyrgyz Republic: Medium-Term Development Program— Poverty Reduction Strategy Paper	CR	IMF	2012
29. Addressing Consequences of the Economic Crisis in the Kyrgyz Republic: Scaling-up Home Fortification of Complementary Food with Micronutrient Powder (Gulazyk) to Mitigate Nutritional Vulnerabilities Among Young Children	CR	UNICEF	2012
30. Rapid Assessment in FGPs and FAPs with maternity beds in target oblasts	CR	GoKyrg, UNICEF	2013
31. Программы по Улучшению Перинатальной Помощи в Кыргызской Республике на 2008-2017 годы	CR	UNICEF	2008-2017
32. Maternal and Newborn Health in Chui Province & Kyrgyzstan: Assessment and Implications for Interventions	CS	UNICEF	2009

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33. Базовая оценка оказания перинатальной помощи в родовспомогательных организациях Баткенской области	CS	UNICEF	2010
34. Reforming the Perinatal Care System in Kyrgyzstan	CS	UNICEF	2010
35. Assessing Development Strategies to Achieve the MDGs in The Kyrgyz Republic	CS	CASE	2011
36. Improving Quality of Care for Mothers and Newborn Babies in the Republic of Kyrgyzstan	CS	UNFPA, WHO	2012
37. Delivering As One Annual Programme Narrative Progress Report	DAO	UN	2010
38. Health and Nutrition	DAO	UNICEF	2011
39. One UN Programme in Kyrgyzstan 2012	DAO	UN	2012
40. Delivering As One MPTF Office GENERIC ANNUAL programme NARRATIVE progress report	DAO	UN	2012
41. DAO proposal: Ensuring access to affordable health services in the targeted areas of the country for women of reproductive age and children	DAO	UNICEF	2013
42. Den Sooluk Health Reform Programmes Joint Review Summary Note	HSR	GoKyrg	2012
43. Joint Assessment of the Kyrgyz Republic National Health Reform Program-Den Sooluk 2012-2016	OTH	GoKyrg	2011
44. Den Sooluk Health Reform Programmes Joint Review Summary Note November 11-16, 2013	HSR	GoKyrg	2013
45. Millennium Development Goals Progress Report	MDGR	UNDP	2003
46. The second periodic progress report on the Millennium Development Goals in the Kyrgyz Republic	MDGR	UNDP	2009
47. The second progress report on the Millennium Development Goals	MDGR	UNDP	2010
48. MDG Acceleration Framework	MDGR	UN	2013
49. Third Report on Progress Towards Achieving the Millennium Development Goals	MDGR	UNDP	2013
50. Monitoring the situation of Children and Women	MICS	GoKyrg, UNICEF	2006
51. Anaemia Prevention and control: mid-term evaluation for UNICEF-CARK Regional Office Central Asia Republics and Kazakhstan	MTR	UNICEF	2002
52. Mid-term review report of the UNFPA Country Programme Kyrgyzstan	MTR	UNFPA	2002
53. Mid-Term Review; Country Programme of Cooperation	MTR	UNICEF	2002
54. Страновая программа ЮНИСЕФ на 2005-2010 г.г. Среднесрочныйобзор	MTR	UNICEF	2008
55. Mother & Child Survival, Development and Protection Programme	OTH	UNICEF	2000
56. Coverage of Countdown indicators on MICS 2005	OTH	Count down to 2015	2005
57. The Health SWAp in the Kyrgyz Republic	OTH	SCO	2007
58. Assessment of the Nutritional Status of Children 6-24 Months of Age and their Mothers, Rural Talas Oblast, Kyrgyzstan, 2008	OTH	UNICEF	2008
59. National Survey of the Nutritional Status of Children 6-59 Month of Age and their Mothers, Kyrgyzstan, 2009	OTH	UNICEF	2009
60. Care for Development in Three Central Asian Countries	OTH	UNICEF	2011
61. One Programme Kyrgyzstan 2011	OTH	UN	2011

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62. United Nations Development Assistance Framework (UNDAF) for the Kyrgyz Republic 2012-2016	OTH	UN	2011
63. Situation Assessment of Children in the Kyrgyz Republic	OTH	UNICEF	2011
64. Situation Analysis: Improving Economic Outcomes by Expanding Nutrition Programming in the Kyrgyz Republic	OTH	UNICEF	2011
65. Improving Economic Outcomes by Expanding Nutrition Programming in the Kyrgyz Republic	OTH	UNICEF	2011
66. Lessons from the JANS on the Kyrgyz Republic National Health Reform Program	OTH	GoKyrg	2012
67. Maternal, Newborn& Child Survival	OTH	Countdown to 2015	2012
68. National Nutrition Quality Improvement for the Kyrgyz Republic Population	OTH	UNICEF	2012
69. Country Cooperation Strategy at a Glance	OTH	WHO	2013
70. Accountability for Maternal, Newborn& Child Survival	OTH	UNICEF	2013
71. Maternal, Newborn& Child Survival	OTH	Countdown to 2015	2013
72. Demographic and Health Survey (DHS), Kyrgyzstan, 1997	OTH	GovKurg	1998
73. Demographic and Health Survey (DHS), Kyrgyzstan, 2012	OTH	USAID	2013
74. Программа по улучшению перинатальной помощи в Кыргызской Республике на 2008-2017 годы	PD	GoKyrg	2008
75. Den Sooluk National Health Reform Program 2012-2016	PD	GoKyrg	2011
76. Country Development Strategy 2007-2010	PD	GoKyrg	2007-2010
77. Assessment of Implementation of Prevention of Mother-to-child HIV Transmission Activities in Health Care Facilities in the Kyrgyz Republic	PER	UNICEF	2013
78. Evaluation Of UNICEF Program on Perinatal Care for the period 2010 – 2013. Project Evaluation Report	PER	UNICEF	2014
79. Mother & Child Survival, Development and Protection Programme	PPA	UNICEF	2000
80. Programme Plan of Actions and Project Budget Allocation, 2003	PPA	UNICEF	2003
81. Early Childhood Survival, Growth, Development and Protection, EPI/IMCI Sub-Project	PPA	UNICEF	2004
82. Maternal and Neonatal Care, Micronutrients Sub-Project, IDA	PPA	UNICEF	2004
83. Mother and Child Survival, Development and Protection; Early Childhood Survival, Growth, Development and Protection	PPA	UNICEF	2004
84. Mother and Child Survival, Development and Protection; Early Childhood Survival, Growth, Development and Protection	PPA	UNICEF	2004
85. Mother and Child Survival, Development and Protection; Maternal and Neonatal Care	PPA	UNICEF	2004
86. Access to Social Services; Mother and Child Health and Nutrition	PPA	UNICEF	2005
87. Project Plan of Action for: Nutrition Sub-Project	PPA	UNICEF	2005
88. Access to Social Services; Mother and Child Health and Nutrition	PPA	UNICEF	2006
89. Mother & Child Survival, Development and Protection Programme	PPA	UNICEF	2006
90. Kyrgyz Republic: Poverty Reduction Strategy Paper— Country Development Strategy (2007–2010)	PRSP	IMF	2007
91. Package of Indicators for Monitoringof the National Health Care Reform Program “Den Sooluk”	QMR	GoKyrg	2011

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92. 2008 CEE/CIS: Regional Thematic Evaluation of UNICEF Contribution to Child Care System Reform in Central Asia. Executive Summary	RPE	UNICEF	2008
93. Two Year Rolling Work Plan (RWP) for Health and Nutrition	RWP	UNICEF	2010
94. UNICEF Rolling Working Plan on Program Cooperation	RWP	UNICEF	2012
95. UNICEF Annual Report 2013 for Kyrgyzstan, CEE/CIS	AR	UNICEF	2013
96. Kyrgyz Republic Public Expenditure Review Policy Notes, the WB 2014	OTH	WB	2014
97. Implementation Status & Results, Kyrgyz Health Results Based Financing (P120435), the WB 2014	OTH	WB	2014
98. Оценка прогресса в улучшении качества ухода за матерями и новорожденными в организациях здравоохранения Кыргызской Республики UNICEF 2014	OTH	UNICEF	2014
99. Socio-medical causes of mortality of children under 2 years of age at home and in the first 24 hours of hospitalization UNICEF 2010	OTH	UNICEF	2010
100. Public Expenditure Review Kyrgyz Republic 2007-2010	OTH	UNICEF	2010
101. Global Study On Child Poverty And Disparities, UNICEF	OTH	UNICEF	2009
102. The current salt iodization strategy in Kyrgyzstan ensures sufficient iodine nutrition among school-age children but not pregnant women.	OTH	Sultanalieva et al.	2009
103. Gulazyk for health and mind of your child, UNICEF, SDC, Sida	OTH	UNICEF	2009
104. Kyrgyz Republic Proposal for Funding for Agriculture Productivity and Nutrition Improvements under the Global Agriculture and Food Security Program (GAFSP).MOH, MoAg	OTH	MoH	2012
105. Achievements in implementation of VI MCH CARK Forum recommendations. November 5-7, 2003, Almaty, Kazakhstan	OTH	MoH	2003
106. Оценка реализации Национальной программы реформы здравоохранения Кыргызской Республики «Манас таалими» Апрель 2011 г.	OTH	MoH	2012
107. Good Health at Low Cost. KYRGYZSTAN: A REGIONAL LEADER IN HEALTH SYSTEM REFORM. 2011	OTH	Ibraimova et al.	2011
108. Formalizing informal payments: the progress of health reform in Kyrgyzstan.	OTH	ANGELA BASCHIERI et al.	2006
109. Trends in out-of-pocket payments for health care in Kyrgyzstan, 2001–2007. Jane Falkingham, BaktygulAkkazieva, Angela Baschieri	OTH	Jane Falkingham et al.	2010

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Moldova Documents	Document Type	Producer	YY
1. Monitoring Official Development Assistance to the Health Sector in the Republic of Moldova	AMR	WHO	2011
2. Monitoring Official Development Assistance to the Health Sector in the Republic of Moldova	AMR	WHO	2012
3. UNICEF Moldova Country Office Annual Report 2000	AR	UNICEF	2000
4. UNICEF Moldova Country Office Annual Report 2001	AR	UNICEF	2001
5. UNICEF Moldova Country Office Annual Report 2002	AR	UNICEF	2002
6. UNICEF Moldova Annual Report 2003	AR	UNICEF	2003
7. UNICEF Moldova Country Office Annual Report 2004	AR	UNICEF	2004

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8.	UNICEF Moldova Country Office Annual Report 2005	AR	UNICEF	2005
9.	UNICEF Moldova Country Office Annual Report 2007	AR	UNICEF	2007
10.	UNICEF Moldova Country Office Annual Report 2008	AR	UNICEF	2008
11.	UNICEF Moldova Country Office Annual Report 2009	AR	UNICEF	2009
12.	UNICEF Annual Report for Moldova	AR	UNICEF	2010
13.	Annual Report 2011 for Moldova, CEE/CIS	AR	UNICEF	2011
14.	Annual Report 2011 for Moldova, CEE/CIS	AR	UNICEF	2011
15.	UNICEF Annual Report 2012 for Moldova, CEE/CIS	AR	UNICEF	2012
16.	UNICEF Annual Progress Report 2012	AR	UNICEF	2012
17.	Country Office Annual Report 2013 for Moldova	AR	UNICEF	2013
18.	Republic of Moldova Country Programme Evaluation Approach Paper	CAPE	IFAD	2013
19.	Country Programme Action Plan 2007-2011	CPAP	UNDP	2007-2011
20.	Country Programme of Cooperation UNICEF – Government of the Republic of Moldova	CPD	UNICEF	2002-2006
21.	Drought After-Effects Upon Population of Republic of Moldova	CR	UNICEF	2007
22.	Health Communication and Promotion in Moldova	CR	UNICEF	2010
23.	Outcome Evaluation of the UNFPA Moldova extended Country Programme	CR	UNFPA	2011
24.	Republic of Moldova EVM Assessment	CR	UNICEF	2011
25.	View of Experience of Family Medicine in Eastern Europe and Central Asia	CS	UNICEF	2004
26.	Towards An AIDS-free Generation	CSR	UNICEF	2013
27.	United Nations Development Assistance Framework 2007 – 2011	CSRF	UNDP	2005
28.	Programme Component: Social Inclusion and protection of children	CSRF	UNICEF	2013
29.	Health Care Systems in Transition	HSR	WHO	2002
30.	Highlights on Health in the Republic of Moldova 2005	HSR	WHO	2005
31.	Health Systems in Transition	HSR	WHO	2008
32.	Health Systems in Transition	HSR	WHO	2012
33.	Millennium Development Goals in the Republic of Moldova	MDGR	GoM	2005
34.	The Second Millennium Development Goals Report	MDGR	GoM	2010
35.	The Third Millennium Development Goals Report	MDGR	GoM	2013
36.	Multiple Indicator Cluster Survey Republic of Moldova – 2000	MICS	UNICEF	2000
37.	Mid-decade assessment – Assessing the need for Multiple Indicator Cluster Surveys	MICS	UNICEF	2004
38.	Standard Tables MICS 2000	MICS	UNICEF	2004
39.	Report of the Work Group for the Assessment of the Program: "Youth Health, Development and Participation"	MTR	UNICEF	2004
40.	Summary of Midterm Reviews of Country Programmes Central and Eastern Europe and the Commonwealth of Independent States region	MTR	UNICEF	2007
41.	Government of Moldova and UNICEF Country Programme (2007-2011) Mid-Term Review	MTR	UNICEF	2009
42.	Summary of Midterm Reviews of Country Programmes Central and Eastern Europe and the Commonwealth of Independent States region	MTR	UNICEF	2010
43.	Mid-term Review Child Protection Programme	MTR	UNICEF	2002-2006
44.	The Situation of Children and Women in the Republic of Moldova	OTH	UNICEF	2000
45.	Country Strategy Paper 2002-2006; National Indicative Programme 2002-2003	OTH	EU	2001
46.	Report on the Preparation and Implementation of a National Communication Campaign to Promote the Exclusive Use Iodized Salt	OTH	UNICEF	2004
47.	Demographic and Health Survey 2005	OTH	UNICEF	2005

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48.	Children and Disability in Transition in CEE/CIS and Baltic States	OTH	UNICEF	2005
49.	Country Cooperation Strategy at a Glance Health and Development	OTH	WHO	2006
50.	Situation Analysis on Aspects of Child (under 5) Nutrition	OTH	UNICEF	2006
51.	National Communication Campaign on Antenatal Care (COMBI Antenatal)	OTH	GoM	2006
52.	Going Beyond the "Health Only" Approach	OTH	UNICEF	2006
53.	National Progress Report Review of the Implementation of the World Fit for Children Plan of Action	OTH	UN	2007
54.	A Specialist for the Left Kidney and a specialist for the Right Kidney: A Preliminary Assessment of Health Promotion and Communication Capacity in Eight CEE/CIS Countries	OTH	UNICEF	2008
55.	Evaluation of Prevention of HIV Mother to Child Transmission Services in the Republic of Moldova Report 2009	OTH	GoM	2009
56.	Tracking Progress on Child and Maternal Nutrition; A survival and development priority	OTH	UNICEF	2009
57.	Impact of the Economic Crisis on Poverty and Social Exclusion in the Republic of Moldova	OTH	UN	2009
58.	Quality of Care Study	OTH	UNICEF	2010
59.	Health Strategy in Republic of Moldova	OTH	GoM	2011
60.	Evaluation Report United Nations Development Assistance Framework – Moldova	OTH	UNDP	2011
61.	EVM Improvement Plan	OTH	UNICEF	2011
62.	Maternal, Newborn& Child Survival	OTH	UNICEF	2012
63.	Country Strategy 2011–2015	OTH	ADA	2012
64.	Evaluation of the Structure and Provision of Primary Care in the Republic of Moldova	OTH	WHO	2012
65.	Regional Analysis Report 2012	OTH	UNICEF	2012
66.	Деятельность Национальной Медицинской Страховой Компании В 2012 Году	OTH	NHIC	2012
67.	Towards Unity in Action	OTH	UN	2012
68.	Country Cooperation Strategy at a Glance: Health and Development	OTH	WHO	2013
69.	Ex-Ante Evaluation (for Japanese ODA Loan)	OTH	GoM	2013
70.	Impact of Maternal and Child Health on Economic Growth: New Evidence Based Granger Causality and DEA Analysis	OTH	PMNCH	2013
71.	Strengthening of Perinatal Health Care Moldova	OTH	UNICEF	1998-2002
72.	National Program Promoting Quality Perinatal Care in Republic of Moldova	OTH	UNICEF	2003-2007
73.	Summary of the Antenatal Communication Campaign (2005-2006) Communication for Behaviour Change (Antenatal COMBI)	OTH	GoM	2005-2006
74.	Cooperation Strategy; Special Program Republic of Moldova	OTH	WHO	2007-2009
75.	Summary Results Matrix: Government of Moldova – UNICEF Country Programme, 2007-2011	OTH	UNICEF	2007-2011
76.	National Health Policy 2007-2021	OTH	GoM	2007-2021
77.	SDC Mother and Child Health Programme in Moldova	OTH	SDC	2008-2009
78.	Healthcare System Development Strategy for the Period 2008-2017	OTH	GoM	2008-2017
79.	Swiss Cooperation Strategy 2010-2013 Special Program Republic of Moldova	OTH	SDC	2010-2013
80.	Cross-Sectoral Cooperation Mechanism	OTH	GoM	2011-2012
81.	Country Development Cooperation Strategy 2013 – 2017	OTH	USAID	2013-2017
82.	ПОСТАНОВЛЕНИЕ об утверждении Единой программы обязательного медицинского страхования на 2005 год	PD	GoM	2005
83.	ПОСТАНОВЛЕНИЕ об утверждении Единой программы обязательного медицинского страхования на 2007 год	PD	GoM	2007

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84.	Evaluation of Moldova's 2004 Health Financing Reform	PD	WHO	2008
85.	ПОСТАНОВЛЕНИЕоб утверждении Положения о механизме межотраслевого сотрудничества в медико-социальной области в целях предупреждения и снижения уровня детской смертности и смертности среди детей в возрасте до 5 лет на дому	PD	GoM	2010
86.	Improving the Hospital System in the Republic of Moldova	PD	WHO	2011
87.	Medicine Prices, Availability, Affordability and Price Components in the Republic of Moldova	PD	WHO	2011
88.	Analysis of the Key Achievements and Challenges in the Implementation of the National MDGs Agenda	PD	UNDP	2012
89.	Barriers and Facilitating Factors in Access to Health Services in the Republic of Moldova	PD	WHO	2012
90.	Analysis of Public Health Operations, Services and Activities in the Republic of Moldova	PD	WHO	2012
91.	Evaluation Report to UNICEF Hincesti PHC Rehabilitation Project	PER	UNICEF	2001
92.	Perinatal Care Evaluation/ Evaluation Of Access and Quality of Basic Primary Health Care to Early Childhood	PER	UNICEF	2004
93.	Final Evaluation Report on UNICEF 's National Communications Campaign "For a Healthy Prince Charming"	PER	UNICEF	2006
94.	Assessment of Development Results; Evaluation of UNDP Contribution	PER	UNDP	2012
95.	Evaluation of Integrated Management of Childhood Illnesses Initiative in the Republic of Moldova Years 2000-2010	PER	UNICEF	2012
96.	Evaluation of Implementation of the National Strategy & Action Plan for the Reform of the Residential Childcare System in Moldova 2007-2012	PER	UNICEF	2013
97.	Evaluation of Integrated Management of Childhood Illnesses Initiative in the Republic of Moldova Years 2000-2010	PER	UNICEF	2000-2010
98.	Interim Poverty Reduction Strategy Paper	PRSP	GoM	2000
99.	Republic of Moldova: Poverty Reduction Strategy Paper	PRSP	IMF	2004
100.	Republic of Moldova: Poverty Reduction Strategy Paper – National Development Strategy Report for 2008-2011	PRSP	IMF	2008
101.	Republic of Moldova: Poverty Reduction Strategy Paper – Progress Report	PRSP	IMF	2011
102.	Poverty Reduction Strategy Paper	PRSP	IMF	2013
103.	Making Pregnancy Safer Review of the early implementation phase - 2002-2003. Bacci	OTH	WHO	2004
104.	Quality of perinatal services in Moldova	OTH	MoH	2009
105.	The experience of the implementation of perinatal audit in Moldova. BJOG. 2014; 121 (Suppl. 4): 165–169.	OTH	Stratulat et al.	2014
106.	Maternal And Child Health Equity Analysis Study Report	OTH	UNICEF	2011
107.	Health Policy Paper Series No.7. Child and adolescent health services in the Republic of Moldova	OTH	WHO	2012
108.	Framework to address OOP in Moldova	OTH	WHO	2014
109.	VPD damage assessment and protection report on Iodine, iron deficiency and flour fortification_Dec2006	OTH	UNICEF	2006
110.	VPD damage assessment and protection report on Iodine, iron deficiency and VitA_Dec2006	OTH	UNICEF	2006
111.	IDD situation overview	OTH		2010
112.	The Situation Of Roma Children In Moldova	OTH	UNICEF	2010

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113. Maternal and newborn care in Moldova: achievements, challenges, lessons learned, ways forward. Presentation, Curteanu 2014	OTH	MoH	2014
114. Health Care Reform in the Former Soviet Union: Beyond the Transition. Dina Balabanova, Bayard Roberts, Erica Richardson, Christian Haerpfer, and Martin McKee_2011	OTH	Balabanova et al.	2011
115. Multiple Indicator Cluster Survey. Republic of Moldova - 2012	MICS	UNICEF	2014

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Serbia Documents	Document Type	Producer	YY
1. UNICEF Annual Report 2001	AR	UNICEF	2001
2. UNICEF Annual Report 2002	AR	UNICEF	2002
3. UNICEF Annual Report 2003	AR	UNICEF	2003
4. UNICEF Annual Report 2004	AR	UNICEF	2004
5. UNICEF Annual Report 2005	AR	UNICEF	2005
6. UNICEF Annual Report 2006	AR	UNICEF	2006
7. UNICEF Annual Report 2007	AR	UNICEF	2007
8. UNICEF Annual Report 2008	AR	UNICEF	2008
9. UNICEF Annual Report 2009	AR	UNICEF	2009
10. UNICEF Annual Report 2010	AR	UNICEF	2010
11. UNICEF Annual Report 2011	AR	UNICEF	2011
12. UNICEF Annual Report 2012	AR	UNICEF	2012
13. Country Office Annual Report for Serbia	AR	UNICEF	2013
14. Assessment of Development Results	CAPE	UNDP	2006
15. Evaluation of effectiveness and efficiency of development assistance to the Republic of Serbia per sector	CAPE	SIDA	2007-2010
16. CPAP	CPAP	UNICEF	2005-2009
17. Country Programme Action Plan	CPAP	UNICEF	2005-2009
18. Country Programme Action Plan 2011-2015 between The Government of the Republic of Serbia and UNICEF	CPAP	UNICEF	2011-2015
19. Revised country programme document Serbia and Montenegro	CPD	UNICEF	2004
20. Health Insurance System in Serbia – Quality, Reform, Financial Sustainability	CPD	AUTHOR	2013
21. Yugoslav Program for Protection and Support of Breastfeeding and BFI	CR	UNICEF	2000
22. Report on implementation of the Yugoslav program on protection and promotion of breast feeding in 2001	CR	GoS	2001
23. The program of promotion, support and protection of breastfeeding and the baby friendly hospital initiative in 2003	CR	GOS	2003
24. Comprehensive report on realization of the 21 educational courses for community home visiting nurses of Serbia "Life Messages – Family Health"	CR	UNICEF	2003
25. Evaluation of the Baby-Friendly Hospital Initiative in Serbia for the Period 1995-2008	CR	UNICEF	2009
26. Maternal, Newborn& Child Survival	CR	UNICEF	2012
27. Economic Sanctions, Health, and Welfare in the Federal Republic of Yugoslavia 1990 – 2000	CR	UNICEF	1990-2000
28. Former Initiatives for the adoption of good practice in view of the human rights protection in the process of prevention/ elimination of mortality and diseases of mothers	CS	GoS	2011
29. United Nations Development Assistance Framework (UNDAF)	CSRF	UNDP	2010

Serbia Documents		Document Type	Producer	YY
30.	United Nations Development Assistance Framework (UNDAF) for the Republic of Serbia, 2011-2015	CSRF	GoS	2010
31.	Adolescents affected by armed conflict. A review of programmes and policies	HSR	Women's Commission for Refugee Women and Children	2000
32.	EU support to health care in Serbia	HSR	EU	2007
33.	A Review of Progress in Maternal Health in Eastern Europe and Central Asia	HSR	UNFPA	2009
34.	Strategic orientation of public health in transition: challenges in Serbia	HSR	JPH	2009
35.	Official Development Assistance (ODA) for Health to Serbia	HSR	WHO	2001-2011
36.	Early Childhood Development UNICEF- Republic of Serbia 2002-2004	HSR	UNICEF	2002-2004
37.	Health care system and spending in Serbia	HSR	UN	2003-2006
38.	Health care system and spending in Serbia from 2004 to 2008	HSR	GoS	2004-2008
39.	Millennium Development Goals in the Republic of Serbia Monitoring Framework	MDGR	GoS	2006
40.	Progress of the Realization of Millennium Development Goals in the Republic of Serbia	MDGR	UN, Gos	2009
41.	Millennium Development Goals Barometer – Serbia 2013	MDGR	UN	2013
42.	The review of the Implementation the Millennium Development Goals in Serbia	MDGR	UN	2004-2005
43.	Multiple Indicator Cluster Survey II The Report for The Federal Republic of Yugoslavia	MICS	UNICEF	2000
44.	Serbia Multiple Indicator Cluster Survey 2005 Monitoring the Situation of Children and women	MICS	UNICEF	2005
45.	Serbia Multiple Indicator Cluster Survey 2010 Monitoring the Situation of children and women	MICS	UNICEF	2010
46.	MICS in Serbia Key Highlights	MICS	UNICEF	2012
47.	Master Plan of Operations	MPO	UNICEF	2002
48.	Annual report of the Executive Director: progress and achievements against the medium-term strategic plan	MTR	UNICEF	2007
49.	Mid-term Review Report of 2005-2009 Country Programme of Cooperation Between the Government of the Republic of Serbia and UNICEF	MTR	UNICEF	2008
50.	Annual report of the Executive Director: progress and achievements against the medium-term strategic plan	MTR	EU	2008
51.	Mid-term Review Report of 2011-2015 Country Programme of Cooperation Between the Government of the Republic of Serbia and UNICEF	MTR	UNICEF	2013
52.	Telephone Counseling for a Healthy Child	OTH	UNICEF	2002
53.	Early Childhood Development	OTH	UNICEF	2003
54.	Serbia Plan of Action for Children	OTH	GoS	2004
55.	Early Childhood Development	OTH	UNICEF	2004
56.	First Progress Report on the Implementation of the Poverty Reduction Strategy in Serbia	OTH	GoS	2005
57.	How to Make a Local Plan of Action for Children	OTH	GoS	2005
58.	Serbia and Montenegro: Poverty Reduction Strategy Paper—Progress Reports	OTH	IMF	2006
59.	The state of children in Serbia 2006 With focus on poor and excluded children	OTH	UNICEF	2006
60.	Strategy for Youth Development and Health in the Republic of Serbia	OTH	UNICEF	2006
61.	State of Children in Serbia 2006	OTH	UNICEF	2006

Serbia Documents		Document Type	Producer	YY
62.	Second Progress Report on the Implementation of the Poverty Reduction Strategy in Serbia	OTH	GoS	2007
63.	National Sustainable Development Strategy	OTH	UN	2007
64.	National Survey of the Biological Impact of Universal Salt Iodization in the Population of Serbia	OTH	UNICEF	2007
65.	Health care system and spending in Serbia	OTH	EU	2007
66.	Maternal IQ and child mortality in 222 Serbian Roma (Gypsy) women	OTH	ELSEVIER	2008
67.	Country Profile	OTH	GoS	2009
68.	Strategy for development cooperation with Serbia	OTH	SIDA	2009
69.	The State of the World's Children 2009	OTH	UNICEF	2009
70.	The abortion issue in Serbia	OTH	EJCRHC	2009
71.	The Risk of Harm to Young Children in Institutional Care	OTH	SC	2009
72.	UNICEF Global Evaluation Report Oversight System (GEROS) Review Template	OTH	UNICEF	2009
73.	Advancing the Rights of Children With Disabilities	OTH	UNICEF	2011
74.	Juvenile Marriages, Child-Brides and Infant Mortality Among Serbian Gypsies	OTH	GoS	2011
75.	Special Delivery: An Analysis of Health in Maternal and Newborn Health Programmes and Their Outcomes Around the World	OTH	JOURNAL	2011
76.	Women Motherhood Early Childhood Development	OTH	UNICEF	2011
77.	The Researchers Report 2012 Country Profile: Serbia	OTH	Delloite	2011
78.	UNICEF Global Evaluation Report Oversight System (GEROS) Review Template	OTH	UNICEF	2011
79.	Changing Levels and Trends in Mortality: the role of patterns of death by cause	OTH	UN	2012
80.	Country Profile Serbia Maternal, Newborn& Child Survival	OTH	UNICEF	2012
81.	Roma Early Childhood Inclusion Overview Report	OTH	UNICEF	2012
82.	The Socio-Economic Impact of Mobile Health	OTH	THE BOSTON CONSULTING GROUP	2012
83.	Country Cooperation Strategy at a Glance Health and Development Republic of Moldova	OTH	WHO	2013
84.	Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition?	OTH	LANCET	2013
85.	Immunization Summary: A statistical reference containing data through 2010	OTH	UNICEF	2014
86.	Maternal and Child Health and Health System in the republic of Serbia	OTH	WHO	2000-2005
87.	Rapid review of actions that can be taken during 2004-2005 on MTSP priorities under the framework of the Country Programme	OTH	UNICEF	2004-2005
88.	Health equity and Financial Protection data Sheet Serbia	OTH	WB	2005-2006
89.	Poverty and child health in the European Region	OTH	OTHER	2011
90.	Update on WHO activities for improving the health status of Roma in Europe	OTH	WHO	2013
91.	World We Want	OTH	WHO	2013
92.	Evaluation of the Integrated Maternal and Childhood Health Program in Serbia	PER	UNICEF	2003
93.	Breaking the cycle of exclusion ROMA children in South East Europe	PER	UNICEF	2007
94.	Blame and Banishment The underground HIV epidemic affecting children in Eastern Europe and Central Asia	PER	UNICEF	2010

Serbia Documents	Document Type	Producer	YY
95. Evaluation of the organization and provision of primary care in Serbia	PER	WHO	2010
96. First National Report on Social Inclusion and Poverty Reduction in the Republic of Serbia	PER	GoS	2010
97. ”Access for Women and Children to Services in the Rural Areas of Serbia and Proposed Measures to Improve the Situation	PER	UNICEF	2011
98. Programme Plan of Operations	PPO	UNICEF	1999-2001
99. Poverty Reduction Strategy Paper for Serbia	PRSP	IMF, GoS	2002
100. Poverty Reduction Strategy Paper for Serbia	PRSP	GoS	2003
101. Serbia and Montenegro: Poverty Reduction Strategy Paper	PRSP	IMF	2004
102. Cross-cutting Issues in the Poverty Reduction Strategy	PRSP	GoS	N/A
103. Monitoring the Growth and Development of Children in Serbia	QMR	UNICEF	N/A
104. Welfare in the Mediterranean Countries	RPE	CAIMED, Formez	2010
105. Improving the health of Roma in the WHO European region	RPE	WHO	2011
106. Improving Maternal and Child Health and Well Being in CEECIS	RPE	UNICEF	2012
107. core roles and Determinants	OTH	UNICEF	2003-2013

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Uzbekistan Documents		Document Type	Producer	YY
1.	UNICEF Uzbekistan: CEE/CIS and the Baltic States Region 2004 Annual Report	AR	UNICEF	2004
2.	UNICEF Uzbekistan: CEE/CIS Region 2005 Annual Report	AR	UNICEF	2005
3.	UNICEF Uzbekistan: CEE/CIS Region 2006 Annual Report	AR	UNICEF	2006
4.	UNICEF Uzbekistan: CEE/CIS Region 2007 Annual Report	AR	UNICEF	2007
5.	UNICEF Uzbekistan: CEE/CIS Region 2008 Annual Report	AR	UNICEF	2008
6.	UNICEF Uzbekistan: CEE/CIS Region 2009 Annual Report	AR	UNICEF	2009
7.	UNICEF Annual Report for Uzbekistan	AR	UNICEF	2010
8.	Country Office Annual Report for: Uzbekistan, CEE/CIS	AR	UNICEF	2011
9.	Country Office Annual Report 2011 for: Uzbekistan, CEE/CIS	AR	UNICEF	2011
10.	UNICEF Annual Report 2012 for Uzbekistan, CEE/CIS	AR	UNICEF	2012
11.	Country Office Annual Report 2012 for: Uzbekistan, CEE/CIS	AR	UNICEF	2012
12.	Report 2010-2011 Uzbekistan Improvement of Safe Water Access, Sanitation Facilities and Hygienic Behavior Through PH Interventions	AR	UNICEF	2010-2011
13.	Mother and Child Survival, Development and Protection Programme	AWP	UNICEF	2000
14.	Mother and Child Survival, Development and Protection Programme	AWP	UNICEF	2001
15.	Mother and Child Survival, Development and Protection Programme	AWP	UNICEF	2002
16.	Mother and Child Survival, Development and Protection Programme	AWP	UNICEF	2003
17.	Mother and Child Survival, Development and Protection Program	AWP	UNICEF	2004
18.	Maternal and Child Health and Nutrition	AWP	UNICEF	2005
19.	Annual Work Plan for Maternal and Child Health and Nutrition Project	AWP	UNICEF	2006
20.	Annual Work Plan for Maternal and Child Health and Nutrition Project	AWP	UNICEF	2007
21.	Annual Work Plan for Maternal and Child Health and Nutrition Project	AWP	UNICEF	2008
22.	Annual Work Plan for Maternal and Child Health and Nutrition Project	AWP	UNICEF	2009
23.	Multiyear Work Plan 2012-2013 for Health, Nutrition, HIV	AWP	UNICEF	2012-2013
24.	Vaccine Management Assessment in Uzbekistan	CAPE	UNICEF	2005
25.	Country Assistance Evaluation of Uzbekistan and Kazakhstan	CAPE	MOFA	2005
26.	Assessment of Development Results Evaluation of UNDP Contribution in Uzbekistan	CAPE	UNDP	2009
27.	Uzbekistan: Woman and Child Health Development Project	ComR	ADB	2012
28.	UNICEF Uzbekistan – Multi-year Integrated Monitoring and Evaluation Plan	CPAP	UNICEF	2010-2015
29.	План Действий по Страновой Программе на 2005-2009 гг.	CPAP	UNICEF	2005-2009
30.	Uzbekistan CPAP Results and resources Framework	CPAP	UNICEF	2005-2009
31.	Country Programme Action Plan 2010-2015	CPAP	UNFPA	2010-2015

Uzbekistan Documents		Document Type	Producer	YY
32.	Country Programme Action Plan (CPAP) 2010 – 2015	CPAP	GoU	2010-2015
33.	Annex 1 – CPAP Results and Resources Framework	CPAP	GoU	2010-2015
34.	Revised country programme document Uzbekistan	CPD	UN	2004
35.	Country Program of Cooperation	CPD	UNICEF	2000-2004
36.	Country Programme of Cooperation (CPC)	CPD	UNICEF	2000-2004
37.	Uzbekistan Country programme document	CPD	UNICEF	2010-2015
38.	UNICEF Uzbekistan Country Programme Programme 2: Social Policy Development and Implementation (Social Policy and Decentralized Planning for Children)	CPD	UNICEF	2010-2015
39.	Summary Results Matrix: Government of Uzbekistan – UNICEF Country Programme, 2010-2015	CPD	UNICEF	2010-2015
40.	Country Gender Assessment	CR	ADB	2005
41.	Convention On the Rights of the Child	CR	UN	2005
42.	Salt Situation Analysis in Uzbekistan	CR	EKSPERT-FIKRI	2005
43.	Sida Country Report 2006. Kyrgyzstan, Kazakhstan and Uzbekistan	CR	Sida	2006
44.	Committee on the rights of the Child Forty-second sessionConsideration of Reports Submitted by states parties under article 44 of the convention	CR	UN	2006
45.	Situation Analysis of Women and Children in Uzbekistan	CR	UNICEF	2006
46.	Country Report for Uzbekistan	CR	IDF	2007
47.	Primary care quality management in Uzbekistan	CR	WHO	2008
48.	Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women	CR	UN	2008
49.	Review and Assistance in Strategic Development of the Education Programme (2010-2015)	CR	UNICEF	2009
50.	Comprehensive Assessment (2005-2009) and planning (2010-2015) of Uzbekistan's National Immunization Program	CR	UNICEF	2010
51.	Внедрение методологии «Аудит критических состояний» в Республике Узбекистан. Приобретённыйопыт, полученныеуроки	CR	WHO	2010
52.	Assessment of the safety and quality of hospital care for mothers and newborn babies in Uzbekistan	CR	UNICEF	2010
53.	Formative Evaluation of Improvement of Mother and Child Health Services in Uzbekistan	CR	UNICEF	2011
54.	CQI in MNC care in Uzbekistan Report of reassessment of 4 Regional Maternity Centers	CR	UNICEF	2011
55.	Report on the Work Conducted by a Consultant DilraboUranova for UNICEF Representation in Uzbekistan	CR	UNICEF	2011
56.	Uzbekistan: Woman and Child Health Development Project	CR	ADB	2012
57.	Consultancy on WASH for the CEE/CIS region - Report from visit to Uzbekistan	CR	UNICEF	2012
58.	Ситуационный анализ рынка соли (САРС) по данным предприятий, производящих йодированную соль в Узбекистане.	CR	UNICEF	2012
59.	Joint UNICEF/WHO Report on a Mission to Uzbekistan	CR	UNICEF	2013

Uzbekistan Documents		Document Type	Producer	YY
60.	Отчёт О Результатах Базисной Оценки Качества Медицинских Услуг, Оказываемых Женщинам И Детям На Амбулаторном И стационарном Уровнях В Республике Узбекистан	CR	UNICEF	2013
61.	Integrating Nutrition in the IMCHS Phase II Project	CR	UNICEF	2014
62.	Infant and Young Child Feeding Programme Review; Case Study: Uzbekistan	CS	UNICEF	2009
63.	Assessing Development Strategies to Achieve the MDGs in The Republic of Uzbekistan	CS	UNDP	2011
64.	United Nations Development Assistance Framework (UNDAF) for the Republic of Uzbekistan 2005-2009	CSRF	UNDP	2005-2009
65.	Uzbekistan United Nations Development Assistance Framework 2010–2015	CSRF	UN, GoU	2010-2015
66.	Highlights on health in Uzbekistan	HSR	WHO	2005
67.	HIV and drug situation and response analysis in Uzbekistan Desk Review	HSR	CARHAP	2006
68.	Health systems in transition	HSR	WHO	2007
69.	Women and Child Health Development Project—Uzbekistan Consultancy Report Assessment and analysis of the current status of the health services in pediatrics	HSR	ADB	2007
70.	Отчет По Исследованию Барьеров Системы Здравоохранения В Внедрение Стратегии Интегрированного Ведения Болезней Детского Возраста В Республике Узбекистан	HSR	WHO	2009
71.	Improving Hospital Care for Children	HSR	WHO	2010
72.	Making Pregnancy Safer Multi-Country review meeting on maternal mortality and morbidity audit “Beyond the Numbers”	HSR	WHO	2010
73.	Public health risk assessment and interventions	HSR	WHO	2010
74.	Оценка Интеграции Пакетов По Обеспечению Выживания Новорожденных И Детей, А Также По Охране Материнского Здоровья В До- И Последипломное Профессиональное Образование	HSR	UNICEF	2012
75.	Health care and training Improvement of mother and child care health services in Uzbekistan	HSR	UNICEF	2008-2010
76.	Report Baseline Study of Knowledge, Attitude and Practices of Infant and Young Child Feeding in the Republic Karakalpakstan	KAP	UNICEF	2001
77.	Knowledge, Attitudes and Practices of Most at Risk Adolescents Relating to HIV/AIDS	KAP	UNICEF	2006
78.	Baseline study of knowledge, attitudes and practices (KAP) with a view to inform communication campaign for A/H1N1 influenza prevention and care in Uzbekistan	KAP	UNICEF	2010
79.	Report on the Survey of the Helminthiasis Epidemiologic Situation and Hygiene Knowledge, Attitude and Practice (LQAS) in Fergana valley the Republic of Uzbekistan	KAP	UNICEF	2011
80.	2009 Integrated Monitoring and Evaluation Plan – UNICEF Uzbekistan	M&E	UNICEF	2009
81.	Millennium Development Goals in Uzbekistan	MDGR	ADB	2004
82.	Millennium Development Goals Report	MDGR	UN	2006
83.	Progress Toward the Millennium Development Goals and Other Measures of the well-being of Children and women	MDGR	UNICEF	2012
84.	Multiple Indicator Cluster Survey Republic of Uzbekistan 2000	MICS	UNICEF	2000
85.	Multiple Indicator Cluster Survey	MICS	UNICEF	2000
86.	Monitoring the Situation of Children and Women	MICS	UNICEF	2006

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87.	Multiple Indicator Cluster Survey 2006	MICS	UNICEF	2007
88.	The Situation of Children and Women	MTR	UNICEF	2002
89.	Mid-Term Review (MTR) country report	MTR	UNICEF	2007
90.	Mid-Term Review Report UNICEF Uzbekistan	MTR	UNICEF	2013
91.	Information on the Situation of salt production in the Republic of Uzbekistan	OTH	UNICEF	2001
92.	Uzbekistan Health Examination Survey	OTH	GoU	2002
93.	Children at Risk: Infant and Child Health in Central Asia	OTH	WDI	2003
94.	Five barriers to physician workforce development in Uzbekistan	OTH	Health Policy	2005
95.	Make Every Child Count; Impact of introduction of Live Birth Definition to different sectors of State	OTH	UNICEF	2005
96.	Determinants of neonatal and under-three mortality in Central Asian countries: Kyrgyzstan, Kazakhstan and Uzbekistan	OTH	GMS MedizinischeInformatik	2006
97.	Concluding comments of the Committee on the Elimination of Discrimination against Women: Uzbekistan	OTH	UN	2006
98.	Uzbekistan Family Education Project Evaluation	OTH	UNICEF	2006
99.	Hospital Sector reform in Uzbekistan – A Policy Note1	OTH	NA	2007
100.	MTSP Specific Monitoring Questions	OTH	UNICEF	2008
101.	Tracking Progress towards sustainable Iodine Deficiency Disorders Elimination Program in Uzbekistan	OTH	ICCID	2009
102.	Economic Transition and Health Care Reform: The Experience of Europe and Central Asia	OTH	IMF	2009
103.	Uzbekistan profile of the Sexual and Reproductive Health (SRH) services available at PC level	OTH	UNICEF	2009
104.	Assessment of determinants of unreached children in immunization Analyses of surveys data	OTH	WHO	2009
105.	Immunization Summary	OTH	UNICEF	2010
106.	Multi-Country review meeting on maternal mortality and morbidity audit “Beyond the Numbers”	OTH	WHO	2010
107.	Public health risk assessment and interventions	OTH	WHO	2010
108.	Situational Analysis Improving Economic Outcomes by Expanding Nutrition Programming in Kyrgyzstan, Tajikistan, and Uzbekistan	OTH	UNICEF	2010
109.	ОТЧЕТ о работе консультанта по обучению персонала, работающего в Центрах дневного пребывания для детей и семей, затронутых ВИЧ г. Ташкент, Андижан, Наманган и Фергана	OTH	UNICEF	2010
110.	Continuous quality improvement in maternal and newborn care in Uzbekistan Report of the work carried out by Giorgio Tamburlini, MD PhD, UNICEF international consultant	OTH	UNICEF	2010
111.	Comprehensive multi-Year Plan for Immunization 2011-2015	OTH	GoU	2010
112.	WASH Strategy on Maternal and Child Health Care	OTH	UNICEF	2010
113.	Lessons from two decades of health reform in Central Asia	OTH	Health Policy and Planning/ Oxford University Press	2011
114.	Self-assessment of Public Health Services in the Republic of Uzbekistan	OTH	WHO	2011
115.	О проделанной работе по анализу, вводу и статистической обработке первичного материала проведенного исследования в Ферганской долине по изучению распространенности гельминтов среди организованных детей дошкольного и школьного возраста	OTH	GOU	2011

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116.	Equity of Access to WASH in Schools	OTH	UNICEF	2011
117.	Immunization Summary	OTH	UNICEF	2012
118.	Global Evaluation of the Application of the Human Rights-Based Approach to UNICEF Programming	OTH	UNICEF	2012
119.	СИТУАЦИОННЫЙ АНАЛИЗ "ВОДОСНАБЖЕНИЕ, САНИТАРИЯ И ГИГИЕНА В ШКОЛАХ РЕСПУБЛИКИ УЗБЕКИСТАН"	OTH	UNICEF	2012
120.	Making Pregnancy Safer/Promoting Effective Perinatal Care/Essential Obstetric and Neonatal Care Training Course	OTH	UNICEF	2013
121.	Regional Analysis Report 2012	OTH	UNICEF	2013
122.	UNAIDS report on the global AIDS epidemic 2013	OTH	UNAIDS	2013
123.	World Report	OTH	Human Rights Watch	2013
124.	Maternal, Newborn& Child Survival	OTH	Countdown to 2015	2013
125.	Assessment of the Quality of Hospital Care for Mothers and Newborns in Three Tashkent City Maternities Using WHO Standardized Tool	OTH	UNICEF	2014
126.	Health reform in central and eastern Europe and the former Soviet Union	OTH	LANCET	1995-2009
127.	Nursing Education Improvement Project	OTH	GoU	2005-2009
128.	Uzbekistan National indicators	OTH	WHO	2006-2013
129.	Summary Table of the Informal Review with Partners on Health Section RWP 2010 – 2011	OTH	UNICEF	2010-2011
130.	Quality MNCH Services	OTH	UNICEF	2010-2011
131.	БАЗИСНАЯ ОЦЕНКА ПИЛОТНЫХ ШКОЛ (WASH) "Инициатива чемпионста в гигиене"	OTH	UNICEF	2011-2012
132.	Multiyear Work Plan 2012-2013 for Health, Nutrition, HIV	OTH	UNICEF	2012-2013
133.	Review of implementation of the "World fit for children" Declaration and Action Plan in the Republic of Uzbekistan	OTH	GoU	N/A
134.	Success stories: improvement of maternal and child health in Uzbekistan	OTH	Vitaminangels.org	2011
135.	The roles and influence of grandmothers and men	OTH	USAID	2012
136.	Review of Situation of Disabled People in Uzbekistan	PD	JICA	2004
137.	Anaemia Prevention and Control Programme Evaluation in Uzbekistan	PER	UNICEF	2005
138.	Comparative Evaluation of "Family and Child Support Services" project in Uzbekistan (from October 2007 until present)	PER	UNICEF	2007
139.	Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan; Final Evaluation Report	PER	USAID	2007
140.	Evaluation of the Safe Motherhood Project (SMP) in Uzbekistan, 2003-2006	PER	UNICEF	2007
141.	Evaluation of the Regional Programme for Europe and the Commonwealth of Independent States 2006-2010	PER	UNDP	2007
142.	Evaluation of the Newborn Survival Training Program in Fergana Oblast, Uzbekistan	PER	UNICEF	2008
143.	External summative evaluation of the Family Education Project for the period January 2005 – July 2009	PER	UNICEF	2009
144.	Summative Evaluation of the Child-Friendly Schools Project (2006-2008)	PER	UNICEF	2009

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145.	Formative Evaluation of Improvement of Mother and Child Health Services in Uzbekistan	PER	UNICEF	2011
146.	Formative Evaluation of Improvement of Mother and Child Health Services in Uzbekistan; Inception Report	PER	UNICEF	2011
147.	Republic of Uzbekistan: Interim Poverty Reduction Strategy Paper	PRSP	IMF	2005
148.	Republic of Uzbekistan: Poverty Reduction Strategy Paper	PRSP	IMF	2008
149.	IOD PARC Support to UNICEF CEE/CIS Regional Evaluation QAS Formative Evaluation of Improvement of Mother and Child Health Services (Phase 1) in Uzbekistan for the period of July 2008 – May 2011	RPE	UNICEF	2008-2011
150.	Two Year Rolling Work Plan (RWP) for Health Section	RWP	UNICEF	2010-2011
151.	Uzbekistan Demographic and Health Survey	OTH	MoH of Uzbekistan	1996

REGIONAL DOCUMENTS

Regional Documents		Document Type	Producer	YY
1.	Strategic Directions in Health and Nutrition Aiming at Accelerating Achievement of MDG 4 and Related Objectives in the Countries of Central and Eastern Europe and Commonwealth of Independent States	MDGR	UNICEF	2007
2.	Inequalities in child and maternal health outcomes in CEE and the CIS	MICS	ESRC	2012
3.	Country Note	OTH	UNICEF	1998
4.	Mid-Term Reviews and Major Evaluations of Country Programmes	OTH	UNICEF	2001
5.	Regional Health and Nutrition Cluster Meeting	OTH	UNICEF	2004
6.	UNICEF Joint Health and Nutrition Strategy for 2006-2015	OTH	UNICEF	2006
7.	Immunization Costing and Financing: A Tool and User Guide for Comprehensive Multi-Year Planning (cMYP)	OTH	WHO	2006
8.	Assessment of the Capacity of Central and Eastern European / Commonwealth of Independent States (CEE/CIS) Countries to Deliver Pandemic Influenza Vaccine	OTH	UNICEF	2006
9.	CEE & CIS Regional Health and Nutrition Meeting; Recommendations and Follow-up Actions	OTH	UNICEF	2006
10.	The MDG the way ahead. The Pan-European Perspective	OTH	UN	2006
11.	UNICEF CEE-CIS Guidelines for Developing an Operational Plan on Pandemic Influenza Vaccination	OTH	UNICEF	2008
12.	Improvement of National Immunization Programme Capacities in CEE/CIS; Lessons Learned from Pandemic Vaccination Preparedness	OTH	UNICEF	2008
13.	Maternal and Newborn Health/The State of the World's Children 2009	OTH	UNICEF	2009
14.	Tracking Progress on Child and Maternal Nutrition; A Survival and Development Priority	OTH	UNICEF	2009
15.	CEE/CIS Regional Health Communication Capacity Development Initiative	OTH	UNICEF	2010
16.	UNICEF CEE/CIS Health & Nutrition Network Meeting Report	OTH	UNICEF	2010
17.	Situational Analysis	OTH	UNICEF	2010
18.	Communication Framework for New Vaccines and Child Survival	OTH	UNICEF	2011
19.	Towards Mother and Child Friendly Health Systems	OTH	UNICEF	2011
20.	Quality Management Systems in the CEE/CIS Region. Cross-Cutting Strategic Issues	OTH	UNICEF	2011
21.	UNICEF's Proposed Contribution to Immunization, 2011-2015 Strategy for Supporting Governments to Achieve Immunization for All	OTH	UNICEF	2011

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22.	Budgeting for Equitable Health Systems for Children	OTH	UNICEF	2011
23.	Evaluation on UNICEF's Early Childhood Development Programme with Focus on Government of Netherland's Funding (2008-2010)	OTH	UNICEF	2011
24.	The U.S. Global Health Initiative: A Country Analysis	OTH	KFF	2011
25.	Monitoring Maternal, Newborn and Child Health: Understanding Key Progress Indicators	OTH	UN	2011
26.	Regional Conference Supporting Families for Young Child Wellbeing; The Role of Community Nursing, Home Visiting and Outreach Services	OTH	UNICEF	2012
27.	Immunization Summary. A Statistical Reference Containing Data Through 2010	OTH	UNICEF	2012
28.	Committing to Child Survival: A Promise Renewed	OTH	UNICEF	2012
29.	UNICEF annual report 2011	OTH	UNICEF	2012
30.	WHO-UNICEF Guidelines for Comprehensive Multi-Year Planning for Immunization	OTH	UNICEF	2013
31.	Improving Maternal and Child Health and Well being in CEECIS	OTH	UNICEF	2013
32.	Joint Action Framework	OTH	UNICEF	2013
33.	UNICEF CEECIS Regional Knowledge and Leadership Agenda	OTH	UNICEF	2013
34.	Regional Training Course on Management for Equitable and Quality Health Services in Maternal, Newborn and Child Health	OTH	UNICEF	2013
35.	International Technical Advisory Group Meeting on Home Visiting	OTH	UNICEF	2013
36.	Regional Analysis Report 2012	OTH	UNICEF	2013
37.	Improving Child Nutrition. The Achievable Imperative for Global Progress	OTH	UNICEF	2013
38.	Levels & Trends in Child Mortality	OTH	UNICEF	2013
39.	UNICEF CEECIS Regional Knowledge and Leadership Agenda	OTH	UNICEF	2014
40.	Health Sector Reform	OTH	UNICEF	2007
41.	Health Sector Reform in Eastern Europe and Commonwealth of Independent States and its Effects on Immunization as a Basic Primary Health Care Intervention: Lessons Learned and Recommendations for Action	OTH	UNICEF	2011
42.	Regional Analysis Report 2002	RAR	UNICEF	2002
43.	Regional Analysis Report 2003	RAR	UNICEF	2003
44.	Regional Analysis Report 2004	RAR	UNICEF	2004
45.	Regional Analysis Report 2005	RAR	UNICEF	2005
46.	Regional Analysis Report 2006	RAR	UNICEF	2006
47.	Regional Analysis Report 2007	RAR	UNICEF	2007
48.	Regional Analysis Report 2009	RAR	UNICEF	2009
49.	Regional Analysis Report 2010	RAR	UNICEF	2010
50.	Regional Analysis Report 2011	RAR	UNICEF	2011
51.	Regional Analysis Report 2012	RAR	UNICEF	2012

ANNEX 8: LIST OF PERSONS INTERVIEWED AND SITES VISITED IN EACH COUNTRY

KAZAKHSTAN

#	NAME	INSTITUTION	POSITION
1.	Shamil Tazhibayev	Kazakh Academy of Nutrition	Vice president of KAN
2.	Aliya Zhalmagambetova	GIZ	Project Coordinator
3.	Aikan Akanov	Kazakh National Medical University	Rector
4.	Raimbek Sissemaliev	UNFPA	Assistant, Former WHO Health Officer
5.	Sairankul Kassymbekova	National AIDS Center	Ex-Head of MCH department
6.	Tokmurzaeva Gulnar	National Center for Healthy lifestyle (NHLSC)	Deputy Director General
7.	Sholpan Karzhaubaeva	Research Institute of Oncology	Head of Post Diploma Education; Ex Deputy Director for National Center for Healthy lifestyle NHLSC (2008-2012)
8.	Larissa Kokovinec	Kazkommertzbank	Head of PR
9.	SaltanatDzabagieva	South Kazakhstan Children's Hospital	Chief medical officer
10.	Bayan Babayeva	IMCI Center and National trainer on IMCI	Coordinator
11.	NailyaKarsybekova	ADB project	Ex- staff
12.	Aigul Nurgabilova	UNICEF	Coordinator of Health Programmes and Nutrition
13.	Tamara Chuvakova	Astana Medical Academy	Ex-Chief Neonatologist
14.	EvgeniyGan	National Millers Association	President
15.	MelitaVujnivich	WHO country office	Representative
16.	Baktybek Zhumadil	WB	Health Officer
17.	RozaAbzalova	Health Center "Demeu"	Chief medical officer
18.	Tatyana Voshenkova	National MCH Center	Director
19.	KanatSukhanberdiyev	Republican Center for Coordination of Implementation of Effective Perinatal Care	National Coordinator
20.	Aigul Kuanysheva	Polyclinic #7	Chief medical officer
21.	Sholpan Kozhahmetova	Perinatal centre	Deputy Chief medical officer
22.	Svetlana Dzhalamgabetova	Parliament	Senator
23.	Jun Kukita	UNICEF	The Chief representative of UNICEF in RK
24.	MagripaEmbergenova	MCH Department	Deputy director
25.	Elmira Akhmetova ,	Child and mother welfare division	Head
26.	NygmanovaNagima	Health fees committee	Head of division
27.	Aliya Kaidarova	Quality Control Department	Head
28.	ZhandarbekBekshin	Consumer right protection committee of the Ministry of National Economy	Deputy Chairman
29.	AizhanEsmagambetova	Consumer right protection committee of the Ministry of National Economy	Department Director
30.	Boyan Babaeva	Health Administration, SKO	MCH Department Head
31.	SairakulKasimbekova	GFATM project Implementation Unit	M&E Specialists
32.	Aigul Segizbaeva	Astana city Health Department	Head of Department
33.	Saule Nurasheva	Astana city Health Department	Head of MCH Unit
34.	Aigul Zhunussova	Semey State Medical University	Vice-rector for academic and educational work

#	NAME	INSTITUTION	POSITION
35.	Alatay Dyussupov	Semey State Medical University	Vice -rector on scientific and clinical work
36.	Clara Baidjalova	Semey State Medical University	Vice -rector on education quality and continuous education
37.	Vadim Ovsyannikov	Health Department, Ust Kamenagorsk	Head
38.	Jumagali Ismailov	Health Department, Shimkent	Head

KYRGYZSTAN

#	NAME	INSTITUTION	POSITION
1.	Boobekova Aigul	Ministry of Health of the Kyrgyz Republic	Senior specialist, Department of medical care and drug policy
2.	Artykbaeva J.K.	National MCH center	Senior specialist, former head of the IMCI center
3.	Mamyrbaeva T.T.	National MCH center	Deputy Director
4.	Abdraeva B.R.	Osh Oblast AIDS center	Head of the Department
5.	Akmatov B.A., Abduvalieva J.U.	Osh interprovincial children's hospital	Deputy Director
6.	Abjalov K.M.	Osh city territorial hospital	Head of the infectious diseases department
7.	Kenjebaeva G.K.	Osh interprovincial merged clinical hospital	Head of the maternity department
8.	Tursunbekova D.	Osh oblast mandatory health insurance funds department	Deputy director
9.	Hudoyarov D.	Osh Tuzu salt producer	Director
10.	Janybekov A.A.	KyzylKiya territorial hospital	Director
11.	Joroeva S.J.	Aravan territorial hospital Too Moyun department	Director
12.	Babaeva Abiba	AkShaar village health committee	Member
13.	Stanbekov M.S.	Osh city territorial hospital	Head of the maternity department
14.	Aitiev T.T.	Osh municipality	Head of the social unit
15.	Muratova G.M.	Kara Suu territorial hospital	Head of the maternity department
16.	Asel Sargaldakova	World Bank	Health Specialist
17.	Toktalieva N.	Naryn oblast center of family medicine	Director
18.	Atbaev M.A.	Naryn oblast hospital	Director
19.	Esengulov Z.	Family group medicine in Ottuk village	Clinical head
20.	Baybosunova Zaryl	Ottuk village health committee	Chief
21.	Kadyrkulova R.	Kochkor territorial hospital	Head of the Maternity Department
22.	Sydykanov A.S.	Health Promotion Department and SES	Deputy Director
23.	Murzakarimova L.K.,	Republic medical information center	Director
24.	Kindyakova O.N.	Republic medical information center	Deputy Director
25.	StakeevaCh.A.	Kyrgyz state medical institute for post-graduation education	Assistant, obstetrics-gynecologists department
26.	Omukeeva G.K.	Kyrgyz state medical institute for post-graduation education	Head of the training course
27.	Aytmurzaeva G.T.	Republic health promotion center	Director
28.	Djumalieva G.T.	Center for infection control	Head of the Center
29.	Djanabilova G.A.	Bishkek city emergence care hospital for children	Deputy Director

#	NAME	INSTITUTION	POSITION
30.	Djangazieva B.A.	Kyrgyz salt producers association	President
31.	Amanova K.	NGO Progress through education,	Director
32.	Djemuratov K.A.	Hospital association KR	Executive director
33.	Mukeeva S.T.	Family group practice	Executive director
34.	Orozalieva A.	Kyrgyz association for midwives	Executive director
35.	Kalilov D.S.	Republic immunoprevention center	Director
36.	Askerov A.	Kyrgyz association for obstetrics-gynecologists	Chief
37.	Imanalieva D.J.	Social committee of Parliament of the Kyrgyz Republic	Committee member
38.	Gelmius Shupshinkas	Swiss Health project	Coordinator of Swiss-Kyrgyz health project, Former international expert in neonatal care
39.	Toktobaev N.	Swiss Health project	Project Coordinator
40.	Kaliev M.T.	Ministry of Health of the Kyrgyz Republic	Deputy minister
41.	Smankulova N.	UNFPA	National Programme Analyst on Reproductive Health
42.	Monolbaev K.	WHO	Liaison officer
43.	Ibraimova A.S.	Independent expert	Former Deputy Minister of Health
44.	Asambaeva Ch.	GIZ	Health specialist
45.	Cholpon Imanalieva	UNICEF CO	Health and Nutrition Specialist
46.	Damira Abakirova	UNICEF CO	Health and Nutrition Officer
47.	EdilTilekov	UNICEF CO	Health and Nutrition Officer

MOLDOVA

#	NAME	INSTITUTION	POSITION
1.	Cornel Riscanu	UNICEF CO	Chief of Health and Education
2.	Nune Mangasaryan	UNICEF CO	Representative since 2013, with UNICEF since late 1990s
3.	Svetlana Stefanet	UNICEF CO	Chief, Equitable Access to Quality Services Program
4.	Viorica Berdaga	UNICEF CO	Programme Officer, Health Systems
5.	ȘtefanGațcan	National MCH Research Institute	General Director
6.	Petru Stratulat	National MCH Research Institute	Vice Director
7.	Ala Curteanu	National MCH Research Institute	Association of Perinatal Medicine
8.	Mihail Stratilă	National MCH Research Institute	Director
9.	Petru Crudu	National MCH Research Institute	Vice Director
10.	Nelly Revenco	National MCH Research Institute	Head of Pediatric Department
11.	Svetlana Cotelea	Ministry of Health	Vice minister, Chief Sanitary physician;
12.	Rodica Scutelinic	Ministry of Health	Chief of Department, Emergency and hospital medical assistance
13.	Carolina Cerniciuc	Ministry of Health	Chief of Department Public Health
14.	Mihai Pîslă	National Centre of Public Health (CNSP)	General director
15.	Ion Bahnarel	National Centre of Public Health (CNSP)	Deputy Director
16.	StelaGheorghița	National Centre of Public Health (CNSP)	Deputy Director
17.	Ion Șalaru	National Centre of Public Health (CNSP)	Deputy Director

#	NAME	INSTITUTION	POSITION
18.	AnatolMelnic	National Centre of Public Health (CNSP)	Chief of centre for Immunoprophylaxis
19.	Olga Cernețchi	State Medical and Pharmaceutical University ”Nicolae Testemiţanu”	Deputy Director
20.	EcaterinaStasii	State Medical and Pharmaceutical University ”Nicolae Testemiţanu”	Clinic director
21.	Prof. Oleg Lozan	School of Public Health Management	Director
22.	Galina Obreja	School of Public Health Management	Deputy Director
23.	ValentinaPîslaru	Territorial Medical Association sector Rîșcani, mun. Chișinău	Director
24.	Tatiana Cleșcovschi	Territorial Medical Association sector Rîșcani, mun. Chișinău	Deputy Director
25.	ȘtefanCalancea	Municipal Hospital for Children nr.1	Director
26.	Ala Holban	Municipal Hospital for Children nr.1	Head of pediatric clinic
27.	Dr. Svetlana Plămadeală	UNAIDS	National Coordinator
28.	Dr.Valeriu Sava	SDC	National Professional Officer
29.	Dr. Victor Savin	Municipal Hospital for adults nr.1	Director
30.	Dr. Iurie Dondiuc	Municipal Hospital for adults nr.1	Vice Director
31.	Dr. Victor Volovei	UCIMP	Executive Director
32.	Larisa Zaporojan	Bread factory “Franzeluta”	Head Engineer
33.	Lucia Pirtina	Dermato-venerolgical and communicable diseases hospital	vice director
34.	Dr.Mircea Buga	National Health Insurance Company (CNAM)	General director, Former deputy minister
35.	Dr. Boris Gîlca	UNFPA	Assistant Representative UNFPA
36.	Dr.IarnoHabicht	WHO	Representative OMS
37.	Dr. Angela Ciobanu	WHO	Coordinator programme, Former UNICEF health and nutrition officer
38.	Dr.Ghenadie Țurcanu	PAS Centre	Program Coordinator, former MoH official
39.	Dr.Stela Bivol	PAS Centre	Program, Policy and Research director
40.	Iuri Banal	Chisinau Bakery	Director
41.	Mihai Ciocanu	Ministry of Health	Deputy Minister
42.	Rodica Scutelinic	Ministry of Health	Chief of Department, Urgent and hospital medical assistance
43.	MaritaTarus	Ministy of Health	Head of MCH department
44.	Gheorghe Țurcanu	Ministry of Labor, Social and Family Protection	Deputy minister, former deputy minister of health
45.	Dr. Petru Cebotari	Rayonal Hospital Hîncești	Director
46.	Dr. Lilia Tanusi	Rayon Hospital of Hîncești	Chief MCH specialist
47.	Dr. Nicolae Ursu	Rayonal Centre for Family Doctors Rîșcani	Director
48.	Dr. Virgil Manole	Public Health Centre Rîșcani	Director
49.	Dr. Gheorghe Roșu	Rayonal Hospital Rîșcani	Director

SERBIA

#	NAME	INSTITUTION	POSITION
1.	Jelena Zajeganovic	UNICEF, Belgrade, Serbia	Early Childhood Development Specialist, Former YP/HIV/AIDS
2.	SnezanaSimic	Medical Faculty, University of Belgrade	Professor of public health/social medicine, Former assistant minister
3.	DanijelaSimic	Institute for public health of the Republic of Serbia "Batut"	Chief of national HIV office, Former member of the working group for PMTCT

#	NAME	INSTITUTION	POSITION
4.	VladislavVukomanovic	Institute for mother and child health care	Deputy director of the Institute, Head of the Pediatric Clinic
5.	Nina Kuburovic	Institute for mother and child health care	Chief of Service for planning and evaluation of health care and medical informatics
6.	Vesna Stefanovic	Institute for mother and child health care	Social worker
7.	PredragMinic	Institute for mother and child health care	Professor of Pediatrics, Chief of department for treatment respiratory diseases, Former coordinator of emergency paediatrics project
8.	VickoFerenc	Ministry of Health of the Republic of Serbia	State secretary, focal point for UNICEF
9.	Ivan Ivanovic	Institute for public health of the Republic of Serbia "Batut"	Head of Informatics and biostatistics department
10.	MajaKrstic	Institute for public health of the Republic of Serbia "Batut"	Social medicine specialist in Informatics and biostatistics department
11.	DraganaSocanin	NGO Parent	President
12.	DraganIlic	Institute for public health of the Republic of Serbia "Batut"	Director
13.	Jelena Gudelj Rakic	Institute for public health of the Republic of Serbia "Batut"	Chief of health promotion unit
14.	Biljana Klibarda	Institute for public health of the Republic of Serbia "Batut"	Chief of national tobacco control office, Former collaborate of coordinator of the BFHI
15.	Dragan Antic	Clinical hospital center "Dr DragisaMisovic", Belgrade	Head of the maternity ward
16.	SnezanaJankovic	Dom zdravlja Savskivenac, Belgrade	Chief of the service for women`s health care
17.	Vida Parezanovic	Federal institute for health protection	Collaborate of coordinator of the BFHI
18.	LjiljaSavic	Institute for mother and child health care	Collaborate of coordinator of the BFHI
19.	Olga Stanojlovic	Clinical hospital center "Zvezdara", Belgrade	Head doctor of the neonatology ward
20.	Ruzica Nikolic	Clinical hospital center "Zvezdara", Belgrade	Head nurse of the neonatology ward
21.	Slobodan Kostic	Clinical hospital center "Dr DragisaMisovic", Belgrade	Head doctor of the neonatology ward
22.	Djurdjica Ergic	NGO Bibija, Roma women`s center	President
23.	SlavicaDjukicDejanovic	Parliament, Committee for health and for child rights	President and member, Former minister
24.	GorankaLoncarevic	Institute for public health of the Republic of Serbia "Batut"	Chief of the immunization unit
25.	Milena Kanazir	Institute for public health of the Republic of Serbia "Batut"	Epidemiologist in the immunization unit
26.	PredragKon	Belgrade City Institute for public health	Chief of the immunization unit, Former coordinator of project Immunization of marginalized population groups
27.	Dragana Jovic	Institute for public health of the Republic of Serbia "Batut"	Specialist of hygiene, coordinator IDD
28.	ZoricaJovanovski	Institute for public health of the Republic of Serbia "Batut"	Chief of the hygiene - food safety department
29.	Vesna Bjegovic	Medical Faculty, School of public health	Professor of social medicine, director
30.	MiljanaGrbic	WHO Country Office Srbija	WHO office representative, Former UNAIDS
31.	AleksandarBojovic	WHO Country Office Srbija	WHO office staff, Former GF, CIDA, WB, MoH
32.	Ivan Zivanovic	WHO Country Office Srbija	Project coordinator
33.	DavorRako	UNHCR	Associate Protection Officer
34.	IvankaKostic	NGO Praxis	Executive Director
35.	Svetlana Jankovic	Belgrade City Institute for public health	Assistant director, public health specialist
36.	Ljiljana SokalJovanovic	Belgrade City Institute for public health	Social medicine specialist, former chief of the centre for planning of health care

#	NAME	INSTITUTION	POSITION
37.	AndjelkaKotevic	Belgrade City Institute for public health	Patronage nurse, chief of `Halo baby` phone counseling
38.	Aleksandra Jovic	UNICEF, Belgrade, Serbia	Child rights monitoring specialist, Former head of Government team for social inclusion
39.	Tanja Rankovic	UNICEF, Belgrade, Serbia	Education specialist, Former education and health in Government team for social inclusion
40.	NenadMladenovic	Dom zdravlja Vranje	Director
41.	Goran Stankovic	Dom zdravlja Vranje	Assistant director, emergency medicine specialist
42.	Jadranka Janic	Dom zdravlja Vranje	Chief of child development counseling service
43.	VojkaStojiljkovic	Dom zdravlja Vranje	Pediatrician in child development counseling service
44.	MiljanaMitrovic	Dom zdravlja Vranje	Head of service for health care of women
45.	Ivana Ilic	Dom zdravlja Vranje	Head nurse of Dom zdravlja
46.	TerezaSainovic	Dom zdravlja Vranje	Roma health mediator
47.	GabrijelaBajramovic	Dom zdravlja Vranje	Roma health mediator
48.	Karolina Popovic	Dom zdravlja Vranje	Patronage nurse, chief of service
49.	BrankaDodic	Dom zdravlja Vranje	Patronage nurse
50.	Svetlana Stojanovic	Instutute for public health Vranje	Social medicine specialist
51.	Milena Misic	Instutute for public health Vranje	Microbiologist
52.	Goran Radojcic	General hospital Vranje, maternity ward	Head of maternity ward
53.	ZoricaParezanovic	General hospital Vranje, maternity ward	Pediatrician, neonatologist
54.	Vesna Janic	General hospital Vranje, maternity ward	Head nurse in maternity ward
55.	MajaVuckovic-Krcmar	Delegation of the EU to the Republic of Serbia	Programme Manager EU Policies and Horizontal Coordination
56.	DraganaDjokovicPapic	Statistical Office of the Republic of Serbia	Head of Division for Social Indicators, Justice and Gender statistics
57.	VladicaJankovic	Statistical Office of the Republic of Serbia	Dev Info Administrator
58.	Radovan Bogdanovic	Retired	President of the Association of paediatricians, Former coordinator of the growth monitoring project
59.	MiodragIgnjatovic	Retired	Pediatrician, coordinator of the projects for pediatric primary care
60.	BorisavJankovic	Retired	Professor of pediatrics, neonatologist, Former coordinator of the project for regionalization of neonatal health care
61.	DraganaLozanovic	Institute for mother and child health care	Social medicine specialist, coordinator of ECD project, Former coordinator of the IMCI project for pediatricians in PHC
62.	DraganVukanic	Ministry of Health of the Republic of Serbia	Assistant minister in the Sector for public health, Child surgeon
63.	DraganDjordjevic	Ministry of Health of the Republic of Serbia	Advisor in the Sector for Public Health
64.	Vladimir Cakarevic	Ministry of Health of the Republic of Serbia	Advisor in the Sector for Public Health
65.	Mirjana Maksimovic	Government of the Republic of Serbia, Social Inclusion and Poverty Reduction Unit	Deputy manager
66.	Slobodan Ovuka	Dom zdravlja Pancevo	Director
67.	Jelena Kurucev	Dom zdravlja Pancevo	Head nurse
68.	AndrijanaRatkov	Dom zdravlja Pancevo	Patronage nurse
69.	Danijela Mani	Dom zdravlja Pancevo	Roma health mediator
70.	StojanVisekruna	Dom zdravlja Pancevo	Head of the Service for women`s health care
71.	Ljiljana Tomic	Dom zdravlja Pancevo	Head of Service for health care of children
72.	VioletaJockov	Dom zdravlja Pancevo	Head nurse of the Service for health care of children
73.	DraganaKrstevski	General hospital Pancevo, maternity ward	Head nurse of the maternity ward

#	NAME	INSTITUTION	POSITION
74.	DraganaJovanovic	General hospital Pancevo, maternity ward	Nurse in the maternity ward
75.	AndjelkaZubovic	General hospital Pancevo, maternity ward	Nurse in the maternity ward
76.	RastkoVasic	General hospital Pancevo, maternity ward	Chief of Gynecology and Obstetrics department
77.	VeronikaIspanovic	Retired	Psychiatrist, coordinator of the Child rights project, Protocol for protection from Child Abuse and Neglect
78.	MilicaPejovic	Institute for mental health	Psychiatrist
79.	Mirjana Sulovic	Institute for public health of the Republic of Serbia "Batut"	Social medicine specialist, data collection for child abuse and neglect
80.	TatjanaBajic	DILS (Delivery of Improved Local Services), Project funded from the World Bank	Project Administrator
81.	PredragDjukic	DILS (Delivery of Improved Local Services), Project funded from the World Bank	Specialist
82.	MelitaVujnovic	WHO	Head of WHO Country Office Kazakhstan Former Representative of WHO Country Office Serbia
83.	Michel Saint Lot	UNICEF Country office in Serbia	Representative (since end 2013)

UZBEKISTAN

#	NAME	INSTITUTION	POSITION
1.	Tuychiev Laziz Nadirovich	MOH	Head of Main Department of Sanitary-Epidemiology Surveillance
2.	Prof. Kamilov Asomiddin Ishakovich	MOH	Deputy Minister, responsible for MCH during 2000-20013
3.	Sidikov Abdunugmon	MOH	Head of Health Reform implementation and International Relations Department
4.	Mr Dominique Wauters	EU	Head of Cooperation Section, Delegation of the European Union to the Republic of Uzbekistan
5.	Nigora Karabaeva	KfW bank	ADB Banks Health I and II project
6.	Lyubchich Adelina	National Perinatal Centre	Director
7.	Prof. Dilorom Akhmedova	National Pediatric Institute	Director of Centre of Pediatrics currently and former head of MoH's MCH department. National Coordinator on IMCI and Nutrition
8.	Zukhra Sultanovna Umarova	National Pediatric Institute	BABIES National Coordinator
9.	Malika Usmanova	Tashkent Perinatal Center	National Coordinator on Newborn Resuscitation
10.	Prof. Dilbar Makhmudova	Consultant	Director of Centre of pediatrics, National Coordinator on IMCI
11.	Mr.Shikano Masao	JICA	Chief Representative of JICA Uzbekistan Office
12.	Prof. DaminAsadov	Institute for Postgraduate Education	Director of Centre of Health Management and former deputy minister of health
13.	AlisherIshanov	USAID	Former Officer
14.	IqbolAhajonov	WB	Specialist in Social Sphere
15.	Tatyana Shin	WB	Health Specialist
16.	Sidikov Abdunugmon	MOH	Head of Health Reform implementation and International Relations Department
17.	Islamova Nadira	MOH	Dep. Head of Delivery Unit
18.	RakhimovaDilfuza	MOH	Dep. Head of MCH
19.	Karabaeva Nigora	KfW bank	ADB Banks Health I and II project
20.	Umarova Zukhra	National Pediatric Institute	BABIES National Coordinator
21.	Lubchich Adelina	National Perinatal Centre	Director

#	NAME	INSTITUTION	POSITION
22.	BabadjanovaShakhira	National Perinatal Centre	Deputy Director Obstetric Services
23.	KhasanovaSaida	National Perinatal Centre	Deputy Director for Clinical Services
24.	Akhmedova Dilarom	National Pediatric Institute	Director of Centre of Pediatrics
25.	Salikhova Kamola	National Pediatric Institute	Deputy Head, Science
26.	AsadovDamin	Institute of Professional Development	Director of Center of Health Management
27.	MukhamadiarovaRoza	WB PIU	Project Manager of WB 1, 2, 3 Health Projects
28.	NarmukhamedovaNazira	WB PIU	Coordinator of Training Component
29.	Makhmudova Dilbar	Center of Pediatrics	Director of Centre of pediatrics, National Coordinator on IMCI (former)
30.	KuchimovAbulnabi	Project HOPE	Director
31.	Daisuke Fukumori	JICA	Representative
32.	Mukhidinov Malik	JICA	Project Coordinator
33.	Usmanova Malika	Tashkent Perinatal Center	Deputy Director, National Coordinator on Newborn Resuscitation
34.	Zohrabyan Lev	UNAIDS	Country director
35.	KazimovaNazokat	UNODC	National Coordinator
36.	Sobirov Jurobai	Tashkent Institute of Professional Development	Dean and Head of FMTC
37.	Isamukhamedova Mukharam	Tashkent Institute of Professional Development	Dean for international Relations
38.	Asmus Hammerich	WHO	WHO Representative and Head of Country Office
39.	Atadjanova Zulfia	WHO	MCH Officer
40.	Khodjaev Zakir	WHO	Officer
41.	Babamuradova Mavjuda	WHO	Officer
42.	TursunovaDillarom	MOH, SES	MoH National EPI coordinator
43.	LhoshimovBakhtier	MoH	Head of Department of Economics and Finance
44.	KuchkarovShakhobiddin	Fergana Oblast Health Authority	Deputy head of oblast health department
45.	Ermatova Muazam	Fergana Perinatal Center	Director
46.	Toichobaevashoirakhon	Fergana Perinatal Center	Chief Ob/Gyn
47.	Eshankulov Erkin	Fergana Perinatal Center	Chief Anesthesiologist
48.	Abdulaeva Kamola	Fergana Perinatal Center	Chief Neonatologist
49.	Mirzaev Bakhtior	Fergana, District Pediatric Hospital	Chief Doctor
50.	Buriboev Sirodjedin	Fergana, District Pediatric Hospital	Deputy Chief Doctor
51.	Tadjibaev Akhmadjon	Fergana, District Pediatric Hospital	Health Statistics Officer
52.	Mirzalieva Mukhabat	Fergana, Birlik PHC	Head of PHC Facility
53.	Karimov Khasanboy	Fergana, Birlik PHC	Coordinator
54.	Safaeva Sayara	Khorezm Oblast Women Committee	Chairman
55.	Djumaniazov Kudrat	Khorezm Oblast Health Authority	Deputy head of oblast health department, MCH
56.	Satimov Shavkat	Khorezm Oblast Health Authority	Chief Pediatrician
57.	Rakhimov Murat	Khorezm Oblast Health Authority	Finance Specialist
58.	NazarovKoshnazar	Khorezm Branch of Institute of Public Health and Health Statistics	Director
59.	UlukbekMatnazarov	Khorezm Oblast Perinatal Center	Deputy Head
60.	KhodjaevaDilfuza	Khorezm Oblast Perinatal Center	Deputy Head

#	NAME	INSTITUTION	POSITION
61.	SulatanovMinavar	Khorezm Oblast Perinatal Center	Chief Nurse
62.	Fuzailova Nargiza	Consultant	Former UNICEF staff
63.	SalikhodjaevaRiksi	Nurse Association,	MOH Chief Nurse
64.	MutalovaZulkhumor	State Medical Statistics Agency/department	Head
65.	Alimovna Matliuba	Centre of Medical Education	Director of Centre of Medical Education, Former staff of MoH's department of science and education
66.	Andreas Brunder	MSF	Head
67.	Karl Kulessa	UNFPA	Representative
68.	Fuad Aliev	UNFPA	Assistant Representative
69.	Ataniazova Raushan	GIZ	Health Officer
70.	Utunova Gulzoda	MOH	National IMCI Coordinator, Master Trainer
71.	Ubdalaeva Sevara	MOH	National Coordinator GM, Responsible for integration of MNCH packages into education system
72.	Zakirova Nadira	MOH	National GM Master Trainer
73.	Ismailova Muazim	MOH	National Trainer on NR
74.	Kim Lutsia	MOH	Republican SES, National EPI Master Trainer
75.	Arifjanova Diora	MOH	National Coordinator Safe Motherhood, former staff of MoH MCH Department

ANNEX 9: EVALUATION TOOLS: IN-DEPTH INTERVIEW GUIDES BY TYPE OF RESPONDENT

In depth interview guides were developed for each respondent type according to the stakeholder matrix of each evaluated country.

EVALUATION CRITRIA & QUESTIONS	SUB QUESTIONS	UNICEF	LEGISLATIVE AUTHORITIES	MOH	OTHER PUBLIC	SERVICE PROVIDERS	LOCAL GOVERNMENT/ HEALTH AUTHORITIES	PARTNERS/ DONORS/ IMPL. AGENCIES	CIVIL SOCIETY
RELEVANCE:									
EQ.9. Was the UNICEF supported programme(s) aligned with the national development and sectoral priorities?	EQ.9.1 Do you think UNICEF addressed all national development and sectoral priorities within its mandate? If not could you please name which priorities could have been addressed by UNICEF?	X	X	X				X	X
EQ.10. Were relevant partners involved in the programme design, implementation and evaluation, including beneficiaries?	EQ.10.1 Were you involved in each stage of UNICEF programme design, implementation and evaluation?		X	X	X	X	X	X	X
	EQ.10.2 Who else participated in the programme design, implementation and evaluation?		X	X	X	X	X	X	X
	EQ.10.3 Were the beneficiaries consulted and or participated in the programme design, implementation and evaluation?	X	X	X	X	X	X	X	X
Effectiveness:									
EQ.11. Has the UNICEF supported programme (s) contributed to achieving required changes as per the Health System blocks/the Enabling Environment?	EQ.11.1 Please explain whether UNICEF supported programme (s) of the last decade contributed to the achievement of required changes as per the Health System block (governance, financing, workforce, supply) /the Enabling Environment (such as laws, policies, standards; organization of services)	X		X		X	X	X	X
	EQ.11.2 Please provide examples for success of UNICEF supported programmes	X		X		X	X	X	X
	EQ.11.3 Who else contributed to the success of achieving required changes as per the Health System blocks/the Enabling Environment?	X		X		X	X	X	X
	EQ.11.4 Please name key factors that played a role in achieving required changes?	X		X		X	X	X	X
	EQ.11.5 Please define degree of UNICEF's contribution in achieving changes compared to other partners on the scale of 1 to 3 where 1 - marginal, 2 - significant, 3 - critical.	X		X		X	X	X	X
	EQ.11.6 Please explain whether UNICEF supported programme (s) of the last decade failed to the achieve required changes as per the Health System block (governance, financing, workforce, supply) /the Enabling Environment (such as laws, policies, standards; organization of services)	X		X		X	X	X	X
	EQ.11.7 Please provide examples of such failure of UNICEF supported programmes	X		X		X	X	X	X
	EQ.11.8 What were the key factors that caused failure of UNICEF supported programmes?	X		X		X	X	X	X

EVALUATION CRITRIA & QUESTIONS	SUB QUESTIONS	UNICEF	LEGISLATIVE AUTHORITIES	MOH	OTHER PUBLIC	SERVICE PROVIDERS	LOCAL GOVERNMENT/ HEALTH AUTHORITIES	PARTNERS/ DONORS/ IMPL. AGENCIES	CIVIL SOCIETY
EQ.12. Was UNICEF able to ensure that all relevant determinants at health system level (policy; legislation; financing; management) were tackled both through its direct intervention and by convening and advocating with partners?	EQ.12.1 What was UNICEF's contribution towards advocating for policy revision/development? Please provide an example	X	X	X	X		X	X	X
	EQ.12.2 What was UNICEF's contribution other than advocacy towards policy revision/development? Please provide an example	X	X	X	X		X	X	X
	EQ.12.3 What was UNICEF's contribution towards advocating for enabling legislation? Please provide an example	X	X	X	X		X	X	X
	EQ.12.4 What was UNICEF's contribution other than advocacy towards enabling legislation? Please provide an example.	X	X	X	X		X	X	X
EQ.14. Was the equity gap in coverage with MNCH services reduced? What groups of the society remain unreached disaggregated by place of residence, wealth, gender and ethnicity?	EQ.14.1 Are there remaining equity gaps in MNCH service provision? If yes please specify	X	X	X		X	X	X	X
	EQ.14.2 Which are the most underserved groups of population and or regions?	X	X	X		X	X	X	X
EQ.15. Has the reduction in bottlenecks contributed to disease specific mortality (mortality caused by ARI, DD, asphyxia, prematurity, etc.) and if it could be positively associated with overall reduction in ENMR, PNMR, IMR, and U5MR?	EQ.15.1 We observed that UNICEF's supported programmes' contributed to the reduction of bottlenecks, such as *(….specify).* In your opinion has this reduction affected disease specific mortality? Give an example	X		X				X	X
	EQ.15.2 Can reduction of disease specific mortality rates be positively associated with overall reduction in ENMR, PNMR, IMR, and U5MR?	X		X				X	X
Efficiency:									
EQ.18. Was programme implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?	EQ.18.1 *(If delays found)* We found that there were delays in certain program(s) implementation according to initial timeline (*specify*), can you please explain reasons for delays?	X		X	X		X	X	X
	EQ.18.2 How delays in program implementation effected achievement of stated program objectives?	X		X	X		X	X	X
EQ.19. Was programme implementation appropriately monitored and evaluated? How were the results used?	EQ.19.1 in general what was the practice applied for monitoring of UNICEF program(s) implementation? Where programmes monitored and evaluated in a participatory manner (joint monitoring, beneficiary and civil society participation)?	X		X		X	X	X	X
	EQ.19.2 Can you recall any recently completed program (please indicate), which was monitored and evaluated in a participatory manner? How results were used	X		X		X	X	X	X
	EQ.19.3 Please give us examples of the monitoring findings and explain what was the follow-up?	X		X		X	X	X	X
Sustainability:									
EQ.20. Are UNICEF supported programmes integrated into national policies and budgets?	EQ.20.1 Are UNICEF supported programmes integrated into national policies and budgets?	X		X	X		X	X	X

EVALUATION CRITRIA & QUESTIONS	SUB QUESTIONS	UNICEF	LEGISLATIVE AUTHORITIES	MOH	OTHER PUBLIC	SERVICE PROVIDERS	LOCAL GOVERNMENT/ HEALTH AUTHORITIES	PARTNERS/ DONORS/ IMPL. AGENCIES	CIVIL SOCIETY
	EQ.20.2 If UNICEF programmes are not integrated please explain reasons	X		X	X		X	X	X
	EQ.20.3 Please list all relevant examples when UNICEF supported programmes were and were not integrated into national policies and budgets.	X		X	X		X	X	X
	EQ.20.4 For those programmes, which were successfully integrated into national policies and budgets what has been done differently? Which strategies have been applied?	X		X	X		X	X	X
EQ.21. Have UNICEF developed models/pilots scaled-up, incorporated into national policies and/or systems?	EQ.21.1 Are UNICEF developed models/pilots scaled up and integrated into national policies and budgets?	X		X	X		X	X	X
	EQ.21.2 If UNICEF developed models/pilots are not integrated please explain reasons. Please list all relevant examples	X		X	X		X	X	X
EQ.22. Have UNICEF assisted programme(s) been successful in leveraging resources and partnerships?	EQ.22.1 Was UNICEF able to leverage public resources for UNICEF assisted programmes? Give examples and provide explanations.	X		X	X		X	X	
	EQ.22.2 Please provide examples when UNICEF failed to leverage public resources for UNICEF assisted programmes? Give examples and provide explanations.	X		X	X		X	X	
	EQ.22.3 Was UNICEF able to leverage partner resources for UNICEF assisted programmes? Please name partners that implemented UNICEF developed/assisted programmes	X			X		X	X	
	EQ.22.4 Please provide examples when UNICEF failed to leverage partner resources for UNICEF assisted programmes? Give examples and provide explanations	X			X		X	X	
EQ.24. Do programmes continue after the conclusion of UNICEF support?	EQ.24.1 Do programmes continue after the conclusion of UNICEF support? Please give examples	X		X		X	X	X	X
	EQ.24.2 If programmes continue please describe each program, whether it continued partially (with limited components) or fully (with potential further development)?	X		X		X	X	X	X
EQ.25. What were the critical elements, which made the programme sustainable (or which did not make it sustainable)?	EQ.25.1 In your opinion what was done by UNICEF to ensure program sustainability? What were the critical elements?	X		X		X	X	X	X
	EQ.25.2 If UNICEF supported programmes were not sustained what were the main reasons and what could have been done differently to ensure that programmes continue after UNICEF funding?	X		X		X	X	X	X
EQ.26. Are other partners supporting MNCH programmes initiated with support from UNICEF?	EQ.26.1 Which UNICEF initiated MNCH programmes are/were supported by other partners?	X		X			X	X	X
	EQ.26.2 Please name programmes and partners	X		X			X	X	X
Rights Approach and Gender Equality:									
EQ.27. Were the Human Rights Based	EQ.27.1 Were the Human Rights Based Approach to	X	X	X		X	X	X	X

EVALUATION CRITRIA & QUESTIONS	SUB QUESTIONS	UNICEF	LEGISLATIVE AUTHORITIES	MOH	OTHER PUBLIC	SERVICE PROVIDERS	LOCAL GOVERNMENT/ HEALTH AUTHORITIES	PARTNERS/ DONORS/ IMPL. AGENCIES	CIVIL SOCIETY
Approach to programming and Gender Equality aspects incorporated into programme(s) planning, implementation and evaluation?	programming and Gender Equality aspects incorporated into programme(s) planning, implementation, monitoring and evaluation? Please give examples								
	EQ.27.2 If not, in your opinion what was the reason?	X	X	X		X	X	X	X
EQ.28. Were planning, implementation and monitoring of evaluated programmes performed in a participatory and ethical manner with full respect to human rights and gender specific and sensitive issues?	EQ.28.1 In general was program planning, implementation, monitoring and evaluation performed in a participatory and ethical manner, with full respect of Human Rights and sensitive issues?	X	X	X		X	X	X	X
	EQ.28.2 Can you recall the last closed program, which was planned, implemented, monitored and evaluated in a participatory and ethical manner? If not please provide explanations	X	X	X		X	X	X	X
EQ 29. Whether the programme being evaluated paid attention to effects on marginalized, vulnerable and hard-to-reach groups	EQ.29.1 Please list the programmes for which the evaluations paid attention to effects on marginalized, vulnerable and hard-to-reach groups	X		X	X		X	X	X
EQ 30. How gender issues were implemented as a crosscutting theme in programming, and if the programme being evaluated gave sufficient attention to promote gender equality and gender-sensitivity.	EQ.30.1 Please explain how gender issues were reflected/taken into account during the program implementation and provide particular examples	X		X	X		X	X	X
	EQ.30.2 Please list the programmes for which the gender issues have been taken into account during the evaluation	X		X	X		X	X	X

ANNEX 10: THE MOST COMMON BOTTLENECKS MAPPED ACROSS HEALTH SYSTEM BUILDING BLOCKS, MORES DETERMINANTS, UNICEF SUPPORTED INTERVENTION PACKAGES IN THE EVALUATED COUNTRIES.

Health System Building Blocks and Thematic Areas	MoRES Determinants	Common Bottlenecks	Priority interventions of UNICEF programming	Intervention Packages and Countries
Leadership and governance				
Policy and legal framework development	Conducive laws, policies, standards and social norms	Lack or outdated national policies, standards and restrictive social norms	• **Laws**: Children rights, Social Services for Children, Flour Fortification, Iodized salt • **Policies:** MCH; Essential Drugs, Nutrition, IDD/USI, EPI • **Decrees:** BBP, BFHI, BABIES, IMCI, MMR Audit, ILBD • **Voice for Children** - facilitating national dialogue to promote child-friendly social norms	ANC/PNC - All countries; EPI - KYG, SRB, UZB; NT - All countries; IMCI - All countries
Policy implementation		Lack of ownership or mechanism for policy/strategy implementation	• **Advocacy and communication** targeting the policy makers and • **Capacity building** for policy makers	ANC/PNC - KYG, SRB, UZB; EPI - KYG; NT - All countries; IMCI -SRB
Administration and coordination	Management and services organization	Weak managerial capacity to translate policies into actions	• **Capacity building** for health managers in QI, Management of MNCH services, epidemiology, perinatal surveillance, RBB	All packages and all countries
		Improper/punitive administrative practices		ANC/PNC - UZB; EPI - UZB
		Ineffective coordination systems between the different levels of government, other partners and stakeholders	• **Advocacy** for the establishment of mechanisms for inter-sectoral coordination (Working Groups, Standing Commissions, SWAPs, etc.)	ANC/PNC - KYG, SRB, UZB; NT – KYR, MLD, UZB; IMCI - UZB
Health information system				
Data collection and reporting		Lack of indicators and appropriate tools for reporting	• **Technical assistance** adopting new indicators and reporting systems • **Capacity building** for MICS and BABIES	ANC/PNC - All countries; EPI - KYG, UZB; NT - All countries; IMCI - KAZ, SRB, MLD;
		Poor quality of data reported		
Data monitoring and use		Weak staff capacity for data management and use	• **Capacity building** for statistical agencies and health managers epidemiology, perinatal and disease surveillance, etc.	ANC/PNC - All Countries; EPI – KYR, UZB; NT - All countries; IMCI - KAZ, MLD, SRB

Health System Building Blocks and Thematic Areas	MoRES Determinants	Common Bottlenecks	Priority interventions of UNICEF programming	Intervention Packages and Countries
Health system financing				
Effective budgeting	Effective budgeting and financing/ financial access	Low priority and/or inadequate funds allocated for MNCH interventions, including commodities	• **CostingCostingof**of MNCH services in the BBP • **Advocacy** to promote adequate funding for MNCH services • **Cost-effectiveness analysis** for Flour Fortification; • **Financial sustainability plans** and multi-year budgeting for EPI • **Financing transportation** system • **Reducing financial access bottlenecks** by conducting studies on accessibility to health services (either stand alone or integrated into child poverty studies) to undertake policy advocacy.	ANC/PNC -All countries; EPI – KYR, UZB; IMCI- All countries; NT - KYG; UZB
		Inequitable financing of MNCH facilities and/or population groups		ANC/PNC – MLD, KAZ; EPI - SRB; IMCI – SRB, KAZ
Financial Access		High out-of-pocket payments and other financial barriers (cost of transportation, etc.)		ANC/PNC - All countries; EPI - KYG; MLD; IMCI - KYG, MLD, SRB, UZB; NT - KYG
Health workforce				
Human resource planning	Skilled and motivated human resources	Shortages of staff, poor deployment, and misdistribution between urban and rural areas and regions	• **Master planning** of human resources	All packages - KAZ;
Motivation of staff		Lack of motivation of staff due to poor remuneration or absence of incentives to work in rural areas.	• **Advocacy** for increased funding for MNCH services and salary increase for frontline providers	ANC/PNC - KAZ, KYG; SRB, EPI - KAZ; IMCI - KAZ; NT - KAZ; KYG
Staff Competency		Poor skills and low competency of service providers	• **Capacity building** in ANC, EPC, IMCI, NR through trainings	ANC/PNC - All countries; EPI - KYG, MLD, SRB, UZB; IMCI - All countries; NT - All countries
		Lack of competency-based training including pre-service and in-service training	• **Technical assistance** in the revision of undergraduate and postgraduate education curricula	ANC/PNC - KAZ, KYG, MLD; EPI - KYG, SRB, UZB; IMCI - KAZ; KYG, MLD, UZB; NT - KAZ, KYG, MLD
Essential medical products and technologies				
Availability of medicines, medical supplies and equipment	Necessary drugs, supplies and equipment	Absent or obsolete equipment	• **Provision of essential equipment** for maternities and/or PHC facilities and for cold chain	All packages and all countries

Health System Building Blocks and Thematic Areas	MoRES Determinants	Common Bottlenecks	Priority interventions of UNICEF programming	Intervention Packages and Countries
		Shortage of essential drugs, supplies and vaccines	• **Provision of essential drugs and supplies** to maternities and/or PHC facilities • **Provision of vaccines** and vaccination material for immunization campaigns • **Advocacy** for inclusion of essential drugs and supplies in BBP • **Advocacy** for vaccine independence initiative	ANC/PNC - All countries; EPI – KAZ, KYG, MLD, SRB, UZB; IMCI - KAZ, KYG, UZB; NT - KYG, MLD, SRB, UZB;
Inefficient use of resources		Improper/inefficient use of drugs and equipment	• **Capacity building** of the MNCH staff in the use of equipment and drugs	ANC/PNC - KYG, UZB;
Logistics chain, procurement and supply		Inefficient and unsustainable forecasting and procurement system for drugs and vaccines	• **Technical assistance** in the development of FSPs and cMYPs • **Provision** of UNICEF's vaccine procurement facility	ANC/PNC - All countries; EPI - KYG, MLD, SRB, UZB;
		Lack of safe disposal practices for syringes and other medical waste	• **Technical assistance** in elaboration and implementation of the safe syringe disposal policies	EPI - KYG, MLD, SRB, UZB;
Health service delivery				
Service availability	Geographical Access to Services	Poor availability of services due to lack of infrastructure of health facilities	• **Master planning** for MNCH services	ANC/PNC - KAZ; IMCI - KAZ
		Poor distribution of services with rural areas being underserved		All packages - KAZ, KYG;
	Management and Service Organization	Weak referral systems and linkages between levels for services	• **Technical assistance** in the implementation of the regionalization and referral system • **Modelling and scale up** for Healthy Child Rooms, Parenting Schools	ANC/PNC- All countries; IMCI - UZB, MLD
Service quality	Quality of Services	Poor quality of services due to absence of standards, guidelines, and job aids	• **Guidelines/Protocols/job aids:** ANC, EPC, ENC, NR. IMCI, PMTCT	All packages and all countries
		Absence of or weak supervisory, mentoring, and monitoring systems in MNCH health facilities	• **Technical assistance** in the development and implementation of the quality assurance systems for MNCH services (e.g. guidelines, protocols, perinatal audits, etc.)	ANC/PNC - KAZ, KYG; EPI - KYG, MLD, SRB, UZB; IMCI - KAZ; KYG, MLD, UZB; NT - KAZ, KYG,MLD
		Absence of quality improvement mechanisms including audits and regular review of performance in MNCH health facilities		ANC/PNC - All countries; EPI - MLD, KYG, SRB, UZB; IMCI - KYG, MLD, UZB;
Community ownership and partnership				
Demand for care and community engagement	Social and cultural practices and believes	Local conservative traditions/practices and believes	• **C4D** for improved family and community practices in child care: integrated	ANC/PNC - KYG, MLD, SRB, UZB; EPI - SRB; NT - All countries

Health System Building Blocks and Thematic Areas	MoRES Determinants	Common Bottlenecks	Priority interventions of UNICEF programming	Intervention Packages and Countries
		Stigma and discrimination associated with certain diseases (HIV. TB)	childhood care and development • **Capacity building** of health providers in interpersonal counselling	ANC/PNC –KYG, UZB, KAZ;
		Low knowledge and health awareness		ANC/PNC - KYG, MLD, SRB, UZB; EPI - All countries; IMCI - All countries, NT - All countries

ANNEX 11: LEVERAGING RESOURCES

Intervention package	KAZ	KRG	MLD	SRB	UZB
PNC	- UNICEF supported the government in leveraging resources from WHO, CDC, UN, agencies	- UNICEF led SWAp MCH group helped to formulate priorities for the following programmes and leverage resources. - World Bank (WB) support to results based financing in perinatal care and child health - German Development Bank (KFW) support to improvement of quality of medical services for newborns; - German Development Agency (GTZ) support to improvement of quality of medical services based in maternal hospitals and UNICEF leveraged significant resources to address MCH issues in South regions after 2010 conflict.	- UNICEF leveraged funds from Japanese Government that resulted in equipping of perinatal centers - UNICEF in the frame of the PHC reform developed BBP including essential drugs for antenatal care, which is funded by the government and ensures free supplements (iron, folic acid) for pregnant women. - UNICEF supported costing exercise for evidence based package and provided policy advice to the Heath Insurance Company to increase allocations to perinatal program. - UNICEF was instrumental is leveraging fund from SDC, during 2005-2006 SDC co-shared perinatal care program and from 2007 continues significant support.	No leverage	- UNICEF supported the government in leveraging resources from WHO, GIZ, WB, ADB, KFW, USAID, UNFPA, HealthProm (a UK based NGO) - UNICEF managed to obtain financial support from EU for the period of 200 -2015.
PMTCT	- UNICEF supported the government in leveraging resources from GFATM, through inclusion of PMTCT as a strategic direction into the National AIDS program. - Leveraged resources from GIZ and CDC for the development of a training protocol on infection control in pediatric hospitals	- UNICEF supported the government in leveraging resources from GFATM, through inclusion of PMTCT as a strategic direction into the National AIDS program.	- UNICEF supported the government in leveraging resources from GFATM, through inclusion of PMTCT as a strategic direction into the National AIDS program.	- UNICEF supported the government in leveraging resources from GFATM, through inclusion of PMTCT as a strategic direction into the National AIDS program.	- UNICEF supported the government in leveraging resources from GFATM, through inclusion of PMTCT as a strategic direction into the National AIDS program.
EPI	No leverage	- Assisted the MoH in preparation of the proposal for GAVI funding. - Through successful advocacy work achieved to secure 87% of Government funding for vaccine procurement by 2003 and 100% by 2004. - Assisted the MoH to leverage resources from JICA for upgrade of cold chain equipment.	- Assisted the MoH in preparation of the proposal for GAVI funding. - Through successful advocacy increased Government funding for vaccine procurement.	- Assisted the MoH in preparation of the proposal for GAVI funding. - Assisted the MoH to leverage resources from JICA for upgrade of cold chain equipment	- Assisted the MoH in preparation of the proposal for GAVI funding. - Assisted the MoH to leverage resources from JICA for upgrade of cold chain equipment. - Jointly with WHO assisted the government in the development of AEFI guidelines and procedures - Leveraged resources from the government to finance EPI.

Intervention package	KAZ	KRG	MLD	SRB	UZB
IMCI	- In support of IMCI implementation UNICEF leveraged resources from CDC, WHO, UN Agencies, especially at early stages of the evaluation period. - Later on was successful in leveraging national and subnational government resources in support of IMCI implementation	- Advocated for and succeeded in inclusion of IMCI drugs into additional list of drugs funded within the Benefit Package	- Advocated for and succeeded in inclusion of IMCI drug package in the Benefit Package funded by the national insurance company. - Leveraged USAID resources in support of the protocol development for management of most common childhood conditions at secondary care. - Leveraged SDC funds to expand geographical coverage of IMCI	- UNICEF was successful in leveraging resources in support of IMCI package implementation, from EC for the national scale up of IMCI and the private sector especially from Telenor for Roma Mediators	- UNICEF was successful in leveraging resources in support of IMCI package implementation from WHO, EU, WB, UNFPA, USAID etc.
CCD		- Advocated for integration of CCD messages into *Heath Promotion Center* communication strategy and thus ensured leveraging of state resources.	- UNICEF engaged in fundraising and fund leveraging to expand the CCD geographically as part of IMCI. SCD funds were leveraged to support and scaleup the initiative.	- UNICEF supported further enhancement of the patronage nursing system in Serbia, mainly financed through UNICEF mobilized resources; - Was successful in mobilizing resources in support of Roma mediators from the private sector especially from Telenor and local NGOs dealing with legal issues of Roma registration	- UNICEF's advocacy of FEP created interest amongst international organizations, such as USAID, to support the Family Education project through additional trainings. - An additional copies of FFL were printed through leveraged resources from UNFPA
Nutrition	- Leveraged resources through legislative and executive branches of the government, mass media, and private salt producers, and from international partners such as USAID, ADB, Kiwanis International, US CDC, GAIN etc.;	- With UNICEF support, the government committed to Scaling Up Nutrition (SUN) (2001), which resulted in funding for the National Nutrition strategy development, which was used to rise funding from the Global Agricultural Food Security Program (GAFSP).	- Leveraged resources in support of FF and Universal Salt Iodization through legislative and executive branches of the government, to name the largest state owned bakery in the country covering 80% of the capital needs ensures fortification and use of iodized salt in its production	- Not Applicable	- UNICEF's contribution to combating micronutrient deficiency disorders has been acknowledged by the government and donors, resulting in UNICEF receiving a portion of the GAIN grant, to lead the communication component.
Food Fortification	- Leveraged resources in support of FF through legislative and executive branches of the government, mass media; private sector; ADB, CDC, GAIN etc.	- Leveraged resources in support of FF through legislative and executive branches of the government and ADB. - Success of the Talas Gulazyk (micronutrient powder) project helped leverage resources from Soros Foundation and WB, and leveraged additional resources from the donors when sustainability of the Gulazyk funding threatened.	- UNICEF was less successful in leveraging resources from development partners, rather managed to fund rise for UNICEF core program	- Not Applicable	- UNICEF was successful in leveraging resources in support of FF through legislative and executive branches of the government, mass media; private sector; - UNICEF leveraged financial resources through GAIN and became an implementer of WB national flour fortification program - Leveraged resources from GRZ for oil fortification pilot
Iron supplementation	- Leveraged resources through GAIN and became an implementer of ADB financed project as well as leveraged US CDC support	- UNICEF provided technical assistance for the revision of the National Program for IDA and VAD prevention 20032007 and development of the 5year	- UNICEF ensured inclusion of iron and folic acid supplements in the state funded benefit package	- Not Applicable	- UNICEF was successful in leveraging resources in support of IDA and CMPD through legislative and executive branches of the government, mass media; private

Intervention package	KAZ	KRG	MLD	SRB	UZB
		(20052010) National Plan of Action for Elimination of Vitamin & Mineral Deficiency in Kyrgyz Republic. These programmes helped leverage donor support. - In addition, iron and vitamin A supplementation for children is ensured with Gulazyk for which significant funds were leveraged.			sector; - UNICEF leveraged financial resources through GAIN and became an implementer of WB, ADB and USAID funded programmes supporting CMD
Vitamin A supplementation	- Leveraged resources through legislative and executive branches of the government, mass media; private sector; GAIN, ADB and USAID funded programmes supporting CMD		- VAD was not a national priority based on the DHS 2005 findings	- Not Applicable	- Leveraged resources through legislative and executive branches of the government, mass media; private sector; GAIN, ADB and USAID funded programmes supporting CMD
BF&BFHI	No leverage	- No targeted leveraging of funds for the given sub-package, however child feeding falls under the National Nutrition Strategy, for which significant funds were leveraged.	No leverage	- To support the BF&BFHI hot line service introduction UNICEF fully financed the pilot. However later the hotline services in Belgrade was fully financed by the local municipality and private pharmaceutical companies	- UNICEF was less successful in leveraging resources from development partners, rather managed to fund rise for UNICEF led program
IDD	- Leveraged resources in support of IDD elimination and USI through legislative and executive branches of the government, mass media, and private salt producers, and from international partners such as USAID, ADB, Kiwanis International, US CDC, GAIN	- UNICEF support helped to secure $700,000 ADB grant funding for the MoH for salt iodization and flour fortification activities. - The MCH Working Group under the SWAP headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition (2011).	- UNICEF played a key role in development of a Food Law (2004) and three National IDD Elimination programmes, which helped leverage national resources.	- UNICEF was successful in leveraging resources in support of IDD elimination and USI through legislative and executive branches of the government, mass media, and private salt producers -	- UNICEF leveraged resources from USAID and GAIN; - UNICEF was successful in leveraging resources in support of IDD elimination and USI through legislative and executive branches of the government. - Signed the MOU with MoH on sustainable procurement of potassium iodate for salt producers from the state budget through UNICEF Supply Division; - Together with the WB supported development of "Nutrition Investment Plan"

KAZAKHSTAN

The proactive fundraising approach was a vital part of programming. The CO Fund Raising Task Force led by the UNICEF Representative conducted donor profile analysis periodically and facilitated development of program portfolio, proposals for all programmatic areas, that show a mixture of different types of project status, i.e. whether these are at the piloting, institutionalizing, or scaling up stages, so that these proposals are appropriately pitched according to donors' interests and expertise. The CO demonstrates satisfactory performance in leveraging funds from bilateral, multilateral, public and private sectors. To name the few:

- UNICEF's advocacy efforts have led to mobilizing donor's assistance to achieve USI and decrease IDA rates. A 900,000 USD project on food fortification was supported by ADB and UNICEF was a key partner in implementing it.
- UNICEF was successful to introduce the equity agenda into MNCH in close collaboration with the Embassy of Norway (donation of $600,000 for equity focused child protection system strengthening) and with USAID (50,000 USD for joint study on the situation of the most vulnerable children in the urban area).
- Within the framework of the International Programmes to Prevent and Control Micronutrient Malnutrition the UNICEF leveraged $87,259 for establishment of the system for monitoring of IDD elimination in CEE/CIS.
- As regards to leveraging private sectors resources for children in 2011, the Bakyrchik Mining Venture contributed $64,860 to support the development of youth friendly services in rural areas of East Kazakhstan; Ernst and Young ($16,000) and Eventica ($20,000) continued to support UNICEF in developing models for inclusive pre-schooling and fighting stigma towards children with disabilities.
- The MICS 4 for the first time was conducted with significant co-financing from the Government ($288,000) and with UNICEF's ($347,000) and UNFPA ($95,000) contributions.
- The major inter-agency and crosscutting program of UNICEF Kazakhstan is the Joint UN Program on the "Enhancing Human Security in the Former Nuclear Test Site of Semipalatinsk" for 2011-2015. This $11 million program, with UNICEF $4.1 million component, is a joint initiative of the Government of Kazakhstan, local authorities of East Kazakhstan Oblast, UNDP, UNFPA, UNV and UNICEF aimed to improve the quality of life of the population living in the area devastated by almost 500 nuclear tests conducted during the Soviet era as well as advance progress towards Millennium Development Goals at the local level. The main financial contributor of this UN Trust Fund managed programme is the Government of Kazakhstan ($9 million).
- In the funding pipeline 900,000 USD under the potential UN Joint Program for Kyzylorda Region from the HSTF, and 315,600 USD from private sector for child health program.

SERBIA

- UNICEF's successful negotiations with ECHO for an extension of the on-going Emergency Paediatric services' project in 2002 led to an increased US $480,000 for training, equipment and supplies.
- Funds from the Irish government in an amount of US $230,000 was mobilized to contribute only to established ECD projects targeting immunization of hard-to-reach populations, breast-feeding promotion and IMCI.
- UNICEF CO became an implementing partner of the GFATM for AIDS (US$ 45,000) via the Economic Institute. Furthermore. Canadian Public Health Association, who provided technical expertise in HIV/AIDS, separately funded by CIDA, also supported UNICEF's work in the area of HIV/AIDS.
- UNICEF also established an agreement with the two most important TV stations, RTS and Channel B-92, on systematic broadcasting on children's issues, where UNICEF served as the key technical assistance agent in production of 26-episode documentary TV serial, broadcasted every week – on "Serbia Fit for Children". This program influenced the EBRD, who financed broadcasting of series of round table discussions with key policy makers and experts being organized around most important aspects of childhood, concerns and to suggest the ways to address them.
- UNICEF CO advocacy for improved access to quality health services for Roma, resulted in budget increase of Health Insurance Fund by 1 million USD for targeting about 800,000 Roma without health insurance coverage.

UZBEKISTAN

As Uzbekistan is not a signatory to the Paris Declaration, none of the bi-lateral bilateral donors present in the country has made Uzbekistan a priority country. Despite a very active partnership with all missions, UNICEF CO was not very successful in leveraging funds. However there are some good examples such as:

- Over 10,000,000 EURO was leveraged from various donors for implementation of integrated MNCH packages
- By strengthening advocacy and communications, the CO has been able to attract donor funds. UNICEF's contribution to combating micronutrient deficiency disorders has been acknowledged by the government and donors, resulting in UNICEF receiving a portion of the GAIN grant, totalling US$570,000 USD to lead the communication component. USAID continued its support to the USI and accepted UNICEF's proposal for almost US$300,000.
- Broader advocacy of FEP created interest amongst international organizations, such as USAID, to support the project through additional trainings. An additional 20,000 copies of FFL were printed in close partnership with UNFPA.
- Communication support to activities under the CP has provided opportunities for expanded partnership and the leveraging of resources to scale up activities that were limited by shortages of funds to certain regions. For example, the introduction and capacity building of health professionals on Safe Motherhood policy, developed by the Ministry of Health with UNICEF support, has been adopted by UNFPA and Project "HOPE" (funded by USAID) and replicated across the whole country. USAID and UNFPA have also joined their efforts with UNICEF in printing 'Facts for Life'.
- The GAIN through the WB had allocated about 600,000 USD to UNICEF for three years to carry out the communication component of the national flour fortification programme.

Kyrgyzstan

UNICEF CO succeeded in leveraging resources from bilateral / multilateral donors and the Government to narrow the gaps in MCH financing. Significant resources were mobilized for the nutrition program. Below are some profound examples.

- UNICEF supported establishment of the Vaccine Independence Initiative and through successful advocacy work achieved to secure 87% of Government share by 2003 and 100% 2004.
- In 2011 UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition program.
- Success of the home fortification (Gulazyk) program in pilot region resulted in the leverage of resources for its countrywide implementation. The Soros Foundation provided US$1.3 million for scaling up home fortification three other provinces (2010). Later in 2012-2014 Soros Foundation released 1,4 mln for Nutrition (Gulazyk) and Early Childhood Development) in the south regions.
- The political resistance towards Gulazyk threatened sustainability of its' financing. For almost one-year Gulazyk program was not financed. However through UNICEF successful advocacy work a funding sources from the WB project was identified and since mid 2014 sprinkles are provided to children nationwide.
- Through UNICEF successful advocacy work the Government signed international commitment to Scaling Up Nutrition (SUN) through developing a nutrition strategy (2011). UNICEF promoted a multi-sectoral approach in the SUN movement by partnering with governmental organizations, donors, civil society, academic institutions, media and the private sector. This resulted in a US $235,000 grant from the SUN Committee to support the finalization and implementation of the National Nutrition

Strategy (2014-2017) so called Food Security and Nutrition Program. The Nutrition Strategy has been submitted to the government for approval. In 2013 UNICEF initiated the process of fund rising from the Global Agricultural Food Security Program (GAFSP). UNICEF developed a proposal with active involvement of different sectors that resulted in the 5 million USD project for the country that will be allocated for the National Nutrition Strategy needs.

Moldova

UNICEF CO demonstrated successful examples of leveraging resources for Perinatal and IMCI programmes that are given below:

- In the initial stage of Perinatal Program Implementation UNICEF leveraged funds from Japanese Government that resulted in supplying of perinatal centres with equipment to the tune of more than 6,000,000 USD (2001)
- UNICEF was instrumental is leveraging funds from SDC. During 2005-2006 SDC co-shared perinatal care program and from 2007 continues significant support to the program National Perinatal Program implementation.
- UNICEF engaged in fund-raising and fund leveraging to expand the IMCI geographically. SCD funds were leveraged to support and scale-up the initiative countrywide.

KAZAKHSTAN

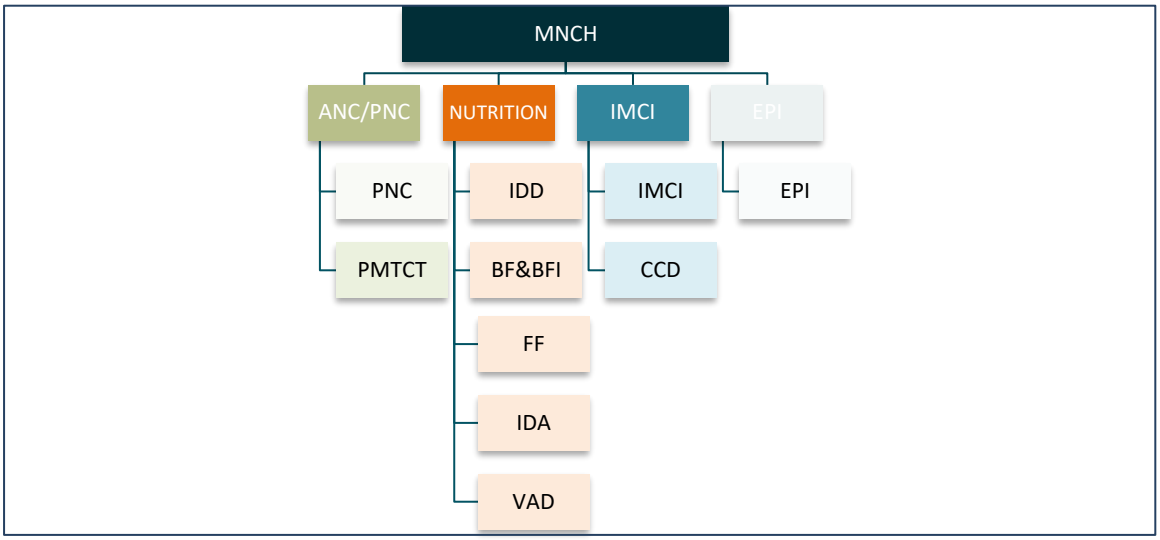
UNICEF PROGRAMME OVERVIEW IN THE COUNTRY

The UNICEF Programme in Kazakhstan was planned and implemented in three main cycles. Until 2005, UNICEF Kazakhstan CO was part of the CARK area office and managed from Almaty, Kazakhstan. The CARCK office was mainly responsible for leading programming in the period 2000-2004, while the UNICEF CO has developed country programmes since 2005. The current evaluation reviews three CPAP periods 2000-2004, 2005-2009 and 2010-2015.

CPAP content and structure varied greatly during the evaluation period. Based on a thorough analysis of AWP/RWPs and Annual Progress Reports (APR), UNICEF activities implemented under UNICEF projects and sub-projects during the evaluation period have been grouped under four main Evaluation "Intervention Packages", as shown on Figure 1 below:

- **ANC/PNC package** includes two sub-interventions such as "perinatal and neonatal care" (PNC) and PMTCT.
- **Nutrition package** includes Iodine deficiency disorders, Iron deficiency anaemia, Vitamin A deficiency disorders, food fortification (flour and salt), BF& BFHI, Growth monitoring and feeding and cross cutting nutritional issues
- **IMCI package** includes interventions directed towards the introduction of IMCI at PHC and hospital levels and third, community component of the package covering Better parenting initiative, family education ECD, patronage nursing etc.
- **EPI package** includes all activities related to EPI (campaigns, new vaccine introduction, etc.)

Figure 45: Key Intervention Packages



The main strategies applied by UNICEF in the CPAP 2000-2004 were advocacy for policy development, creating models of excellence, technical assistance especially for social sector development and M&E. Following the 2007 MTR recommendations and rethinking UNICEF's role in the country's social reform process, in 2008 the main programme strategies aimed at

institutional capacity building of local Governments and line ministries, sharing knowledge and provision of expertise in the revision and improvement of legal and regulatory frameworks, and the development of policies and standards.

ANC/PNC INTERVENTION PACKAGE

PERINATAL AND NEONATAL CARE SUB-PACKAGE

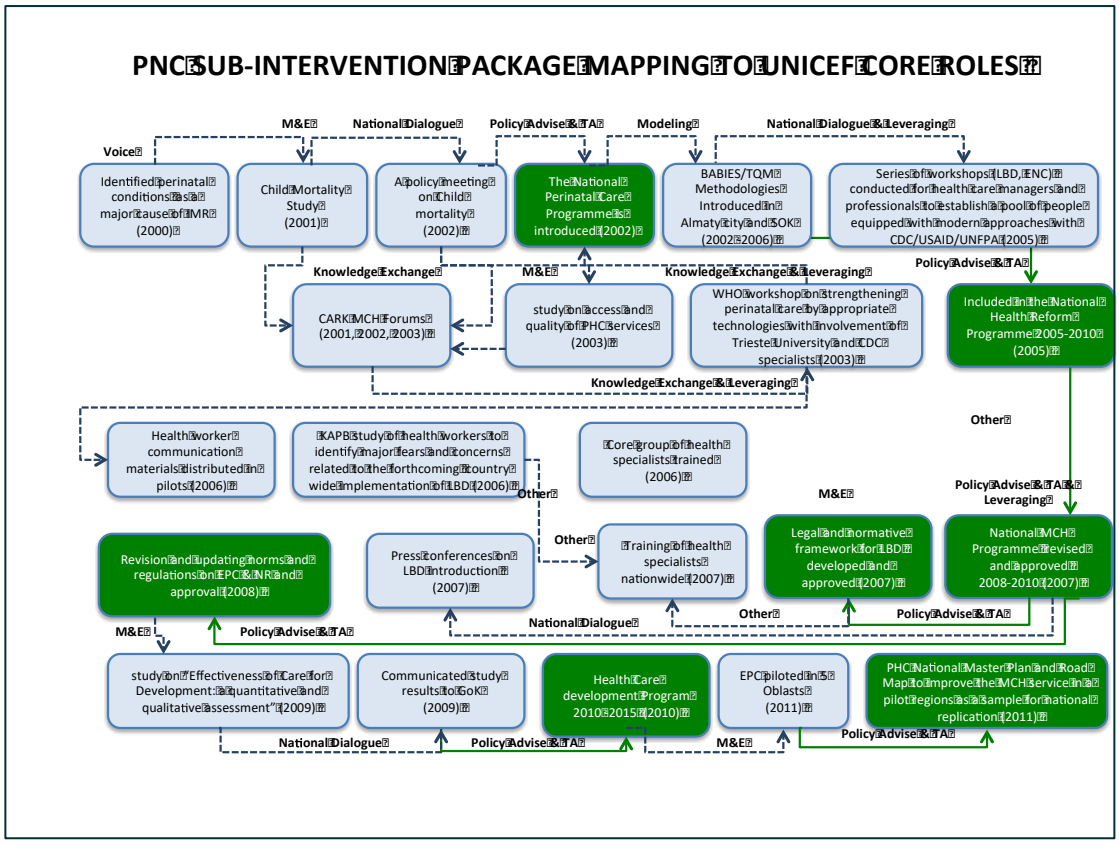
In 2002 UNICEF carried out an infant and child mortality survey **(Monitoring & Evaluation).** The survey provided a comprehensive picture of the pattern of infant and child mortality in the country, including causes and the timing of deaths. The results of the survey have been presented to the Government as grounds for the development of policies and strategies to improve children's health and the funding of mother and child health care initiatives (**Voice)**.

The issues of effective perinatal care revision received special attention and priority in 2003. A workshop on strengthening perinatal care by appropriate technologies, which was organised by UNICEF and WHO, allowed the development of new strategies (**National dialogue**). The workshop, which gathered representatives from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, aimed to provide a good basis and guidance for appropriate planning, taking into account study findings and using the best methodologies, tools, and approaches applicable world-wide, which were adjusted to each country situation. UNICEF was able to ensure the collaborative efforts of several agencies and institutions to facilitate and provide technical support at the workshop (**Leveraging)**. In addition to UNICEF and WHO staff, the workshop involved technical assistance from two institutions: the WHO Collaborating Centre at the Burlo Garofolo Institute in Trieste, and the WHO Collaborating Centre at CDC Atlanta (**Leveraging)**.

At the IMR policy meeting led by the Senator of the Parliament of the Republic of Kazakhstan (RK), specialists from the Centre for the Disease Control and Prevention (CDC) demonstrated the BABEIS methodology. The meeting brought together representatives from the MoH, Republican MCH Centre, perinatal centres, medical universities and academia, as well as international agencies and donors (**National dialogue)**. This meeting laid the grounds to develop an integrated policy and action plan aimed at reducing child deaths. Following the workshop, UNICEF facilitated sessions of the national working group to develop the national perinatal care program and implementation plan **(Policy advice and TA)**. In addition, UNICEF provided technical assistance together with WHO to adapt and develop clinical guidelines for effective perinatal care **(Policy advice and TA)**.

Representatives of the MoH and its structural units took a study tour to CDC Atlanta and received training in BABEIS methodology (**Knowledge sharing)**. Upon return, they became resource persons, and promoted the introduction of the BABEIS methodology in Almaty city and Almaty Oblast, which were selected by the MoH as pilot areas for the introduction of ILBD, as recommended by WHO and UNICEF (**Modelling)**. UNICEF was also instrumental in providing assistance to the government for the introduction of the BABEIS methodology country wide, through training staff from local MCH departments, perinatal centres, and maternity houses **(Knowledge exchange)**. The training materials were developed with the participation of the Association of Neonatologists of Kazakhstan.

Figure 46: PNC sub-package intervention flow chart & UNICEF Core Roles



UNICEF financed an international consultant to conduct a study on Access to and Quality of PHC services **(Monitoring & Evaluation),** and organized a dissemination workshop on the results of the study (**National Dialogue**). The study revealed that financial access to services was one of the reasons for high mortality and morbidity among children. Using the study results, UNICEF actively advocated the government to design a basic health care package that includes all aspects of MCH services **(Voice).** For this purpose, UNICEF organised and supported a study tour for high policy makers and technical experts, and provided technical expertise for the development of the BBP **(Knowledge exchange)**.

2005 was the first year of implementation of the National Programme of Health Reform and Development for 2005 – 2010, which is the first comprehensive national plan. The Programme promoted the joint responsibility of both the state and citizens for health, and provides general strategies of global reform of PHC with a special focus on rural areas, improved sanitation and care during epidemics, promotion of health, disease prevention, improved management, quality assurance and an inter-sectoral approach. Maternal and child health has been identified as a priority area and implemented according to the adopted strategy by declaring free access to a comprehensive package of health care services and drugs for children under five and pregnant women.

During 2005 UNICEF continued its support for development of the National Perinatal Programme **(Policy advice & TA)**. One of the major needs identified by a preliminary assessment of perinatal care conducted by UNFPA in SKO was the lack of knowledge of health personnel and poor equipment in health facilities. UNICEF addressed these gaps through a series of workshops conducted for health care managers and professionals to establish a pool of people equipped with modern approaches **(Knowledge exchange)**. The workshops' themes were: introduction of the WHO Life Birth Definition, and Essential

Newborn Care and Breastfeeding. Respective manuals were printed in close collaboration with CDC/USAID and distributed among health workers in collaboration with UNFPA **(Leveraging)**.

An analysis of IMR and U5MR conducted with the support of UNICEF in 2006, complemented by an analysis of maternal mortality **(Monitoring & Evaluation)**, made it possible to draw the attention of healthcare decision-makers to the urgent need either to reinforce the MCH component of the National Programme on Health Reforms and Development for 2005-2010, or to design a stand alone comprehensive national MCH programme with adequate funding for such purposes (**Voice)**. The analysis revealed poor skills, outdated knowledge and practices employed at maternity hospitals, a very formal approach in the provision of care for newborns and women, and unclear tools for tracking the real causes of deaths and thus addressing them in the most efficient manner. To address the identified bottlenecks, a core group of health specialists was trained and reinforced to provide adequate essential care for newborns and resuscitation of infants in critical conditions in accordance with WHO recommendations **(Knowledge exchange)**.

A KAPB study was initiated to identify the major fears and concerns among health workers related to the forthcoming implementation of ILBD in the country, as finally approved by the GoK (to be implemented in January 2008 according the Prime Minister's decree) as well as to help in designing communication materials for the groups of people affected and to ensure the appropriate introduction of criteria **(Monitoring & Evaluation)**.

Assistance was rendered to the development of a required normative framework **(Policy advice & TA)** and training of specialists nationwide (**Knowledge exchange)**. In addition, a communication strategy on ILBD introduction was developed and IEC materials were printed and distributed countrywide for targeted groups (health workers, representative of local authorities and mass media). UNICEF, in cooperation with CDC/USAID, organised a series of press conferences where the issue of the introduction of the ILBD was questioned and challenged **(Leveraging and National dialogue)**.

In cooperation with the Ministry of Health, UN and national partners **(Policy advice & TA, Leveraging)**, a program on reducing maternal and child mortality incorporating best MCH practices was developed and approved in 2007 and became effective in 2008, after the approval of other concerned ministries (Ministries of Finance, Economy and Budget Planning) with the allocation of funds on different levels, from central to local. This programme enabled the continuation of regular human resource capacity building at local levels fully financed by local governments, the allocation of health infrastructure and equipment investment budgets and the assurance of adequate staffing of health facilities with particular emphasis on ANC and delivery services.

In support of this programme, UNICEF aided local governments to establish local training centres in perinatal centres, train local master trainers and equip training centres with the required training materials **(Knowledge exchange)**. At present, 10% of the annual local health budget is allocated for continuous human resource development, while each LSG develops an annual health investment plan, which is approved by the central government.

Expectations of further growth of IMR and U5MR due to the adoption of ILBDs, which required substantial revision of services provided for newborns and preterm babies at maternities and further close follow up at homes and policlinics, created a niche for further policy development work for UNICEF in 2008 and directed UNICEF's efforts towards elaboration of a comprehensive package of child survival and development practices **(Policy advice & TA)**. In this regard, UNICEF in collaboration with MOH convened a technical working group to review current documents that regulated care for newborns, which helped to indicate the substantial gaps that needed to be addressed and rectified. The group's work

resulted in the revision and updating of norms and regulations on effective perinatal care and resuscitation of newborns **(Policy advice & TA)**. UNICEF advocacy and knowledge sharing led to the adoption and routine use of BABIES monitoring tools by MOH and health care facilities.

Findings and recommendations on infant's congenital malformations, trauma and injuries as well as an assessment of the management of quality of care in MCH **(Monitoring & Evaluation)** contributed to the development of national plans to reduce under 5 child mortality and disability (**Policy advice & TA**).

In 2012 UNICEF supported an inventory and assessment of maternities in four target regions, which was conducted in the context of improving perinatal / neonatal care and quality of care, A cost–benefit analysis of the Basic Benefit Package for children aimed at enhancing low-cost and high-effective interventions at the PHC level **(Monitoring & Evaluation)**. The findings of these studies will be used for further enhancement of the national program.

Table 20: Core Role Contribution to the implementation of PNC sub-package of interventions

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF together with WHO and CDC contributed to the PNC program initiation in the country by communicating the problem to the government and provision of advocacy. - Remained active throughout the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- UNICEF role in M&E was substantial. A number of studies was carried out to better inform the advocacy function of UNICEF CO along with programming. - UNICEF supported MICS 3 and MICS 4 in the country, and the results along with other researches were used for advocacy purposes. - UNICEF also provided assistance in strengthening the country's monitoring system through institutionalisation of BABEIS as an analytical tool to improve PNC, and through institutionalisation of ILBD reporting as a single reporting system. - UNICEF remained active during the entire evaluation period. Thus UNICEF's contribution through this core role is considered to be "Major/Critical".
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government throughout the evaluation period, together with other partners, and remained the leading player in the field of PNC. - UNICEF made available technical expertise to the government for the development of the policy and regulatory framework. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF supported the government in leveraging resources from WHO, CDC, UN agencies, Government and private sector. - Thus, its contribution through this core role is rated as "Major/Critical".
5. Facilitating national dialogue towards child friendly social norms	3	- During the evaluation period UNICEF demonstrated facilitation of national dialogue throughout UNICEF program implementation - Therefore its contribution through this core role is rated as "Major/Critical".
6. Enabling knowledge exchange	3	- UNICEF was the key development partner assisting the government in the development of human resource capacity at national and local levels through the creation of a pool of

		master trainers, and supported cascade training throughout the country along with other development partners. - UNICEF managed to include human resource capacity building in the State MCH program which guarantees local funding of these activities. It also assisted the government in creating training centres and supplying these centres with required hardware and software. - In summary, UNICEF's contribution through this core role is considered to be "Major/Critical".
7.Modeling/piloting	3	- UNICEF piloted the introduction of ILBD, BABEIS and ENC/NR packages in pilot districts with further national scale up. - Thus UNICEF's contribution through this core role is considered to be "Major/Critical".

PMTCT SUB-PACKAGE

The rise in cases of mother to child transmission of HIV was reported in 2002. UNICEF initiated a **national dialogue** on the need for the development of PMTCT policy and organized a study tour to Odessa, Ukraine for the policy makers responsible for policy development in MCH, obstetrics, gynaecology, neonatology, paediatrics, and infectious diseases **(Knowledge exchange)**. The workshop was an "eye opener" and triggered the PMTCT programming process in Kazakhstan. The work on national PMTCT policy **(Policy advice & TA)** started after return from study tour and later was presented at the VII CARK MCH Forum **(National dialogue)**.

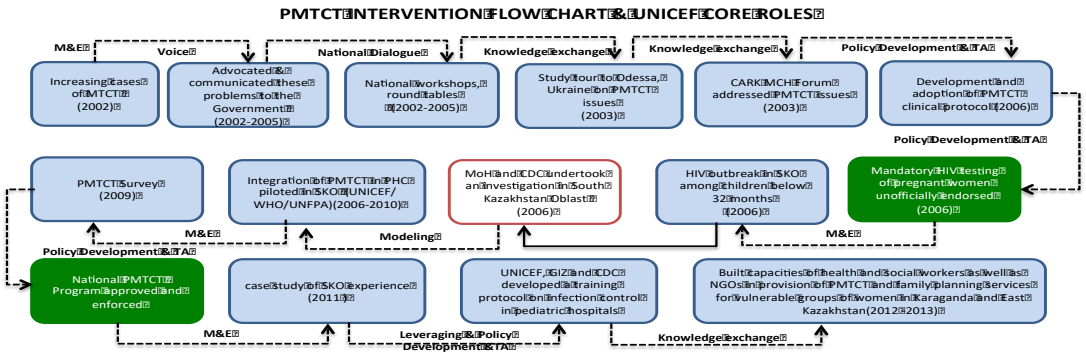
In 2005 Kazakhstan submitted a successful Round 2 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria, which integrated PMTCT component **(Leveraging)**. UNICEF provided technical expertise to the MoH for the development of the PMTCT clinical protocols **(Policy advice & TA)**, and created national training capacity by training national master trainers **(Knowledge exchange)**.

In 2006, a rapid growth of HIV-infected children under the age of 36 months was registered in South Kazakhstan Oblast (SKO), where births account for every fourth birth in the country. The Ministry of Health in collaboration with CDC undertook an investigation. The following risk factors were assessed: mothers' HIV status, breastfeeding practices, medical procedures in children's hospitals and out-patient facilities, blood and blood transfusion, availability of appropriate equipment and consumables, management of infectious waste, and related knowledge of healthcare personnel (adherence to the existing regulations, knowledge and application of quality and safety standards). In response to the assessment results, the MoH took the decision to start implementing PMTCT initially in SKO with UNICEF's assistance **(Policy advice & TA)**. UNICEF CO provided TA and initiated the training of health professionals in VCT and PMTCT management **(Knowledge exchange).**

One of the tragedies that occurred at this early stage of outbreak was the violation of infected patients' right to confidentiality. These breaches of confidentiality led to the stigmatization and discrimination of the affected families by their local communities. There have been reports of panic among the population in the affected oblast, including fears among parents of referring their children to healthcare facilities. Consequently UNICEF, together with a WHO-recommended ARV specialist from Ukraine, provided individual ARV counselling to all children in the region **(Policy advice & TA)**. In parallel, psychosocial counselling was provided to all children and the families of the HIV-infected children through a second Russian specialist. UNICEF also conducted local and national workshops for journalists, with a special session on sensitive issues such as journalistic ethics to protect the rights of infected children **(Voice).** Following these immediate activities, UNICEF examined

some of the longer-term issues and developed a strategy to address the serious problem of stigma and discrimination **(Policy advice & TA)**. To tackle the underlying fear that was in part fuelling the prejudice, UNICEF has initiated the

Figure 47: PMTCT Sub-Package Flow Chart mapped to UNICEF Core Roles



development of a regional communication campaign that aimed to: prevent further discrimination; educate the general population, including medical staff, on HIV/AIDS; dispel myths and disseminate accurate, accessible information (**Voice, Knowledge exchange)**. Since such an intervention had not been planned in 2006 AWPs, UNICEF had to re-allocate resources from regular programmes and request additional funding from RO.

UNICEF also initiated an analysis of PMTCT implementation in SKO **(Monitoring & Evaluation)**. The findings and recommendations were used to review and strengthen national PMTCT program approved by the government **(Policy advice & TA)**. After adoption of the national program, PMTCT was scaled up nationwide. The results of the pilot evaluation informed the government's decision to elaborate a National PMTCT program and include its financing in the government's budget. At present ART is fully covered by public funding for HIV positive mothers and their children, while PMTCT is operational countrywide.

Through its work in SKO, UNICEF managed to leverage resources from GIZ and CDC **(Leveraging)** to develop a training protocol on infection control in paediatric hospitals and expand activities to Karaganda and East Kazakhstan through capacity building of health and social workers and NGOs in the provision of PMTCT and family planning services for vulnerable groups of women (**Knowledge exchange)**.

Table 21: UNICEF Core Role Contribution to the implementation of PMTCT intervention sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF contributed to the critical phase of PMTCT initiation in the country by communicating the problem to the government and provision of advocacy. - Therefore UNICEF's contribution through this core role is considered as " Significant"
2. Monitoring & evaluation	2	- UNICEF role in M&E was limited to PMTCT cost-benefit analysis and evaluation of the pilot. Both researches guided and informed national decision-making on PMTCT strategy. UNICEF

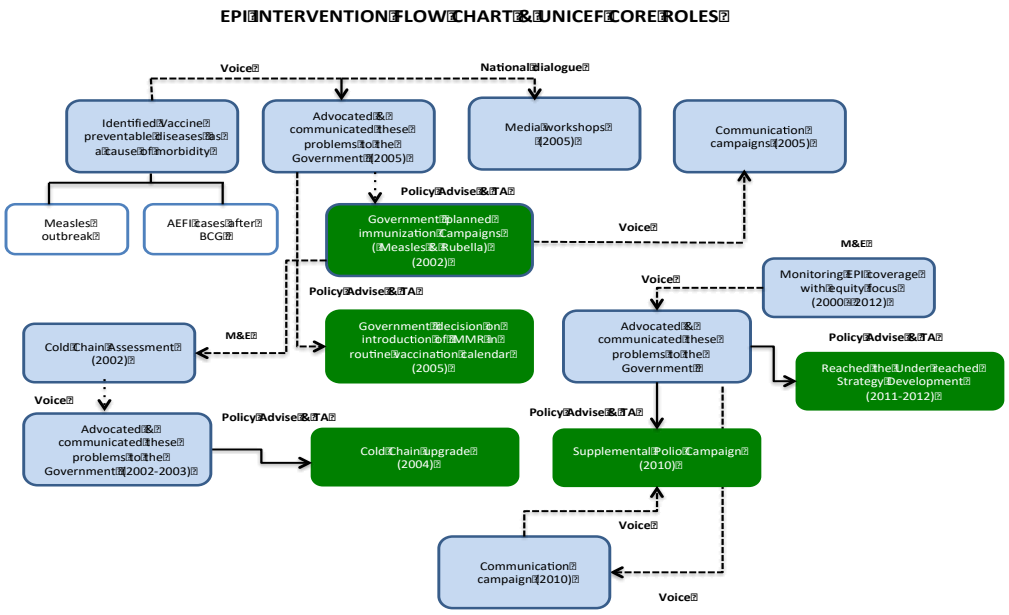
		was not involved in development of national M&E capacity, reporting etc. - Therefore UNICEF's contribution through this role was considered as " Significant"
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government throughout the evaluation period and remained active during the evaluation period. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
4. Leveraging resources	3	- UNICEF supported the government in leveraging resources from GFATM, through the inclusion of PMTCT as a strategic direction into the National AIDS programs. - UNICEF Leveraged resources from GIZ and CDC for the development of a training protocol on infection control in paediatric hospitals - Thus, UNICEF's contribution through this core role is rated as "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period UNICEF demonstrated facilitation of national dialogue in a very critical phase of PMTCT introduction in the country, - Therefore UNICEF's contribution through this core role is rated as " Significant"
6.Enabling knowledge exchange	2	- UNICEF supported the government in the development of human resource capacity at the national level through the creation of a pool of master trainers. The training of health professionals was mainly covered through the GFATM-funded AIDS Project. - In summary, UNICEF's contribution through this core role is rated as " Significant"
7.Modeling/piloting	3	- UNICEF piloted PMTCT implementation in SKO before its national scale up. - Thus contribution through this core role is considered to be "Major/Critical".

EPI INTERVENTION PACKAGE

Kazakhstan maintained a high level of child immunization and has successfully pursued a policy of vaccine independence, meeting all its needs for the expanded programme of immunization. In 2002 the country was certified as Polio Free and initiated a measles immunization program. UNICEF together with WHO advocated **(Voice & Leveraging)** for the introduction of MMR, and MOH took the decision to elaborate a strategy for the introduction of MMR vaccines.

To support the introduction of a new vaccine, UNICEF aided the MoH in implementing a cold chain assessment **(Monitoring & Evaluation)**, which provided useful information about how to strengthen the system in general and vaccine distribution capacity in particular. UNICEF procured and financed the installation of a cold chain in 7 regions of the country **(Other)**. Technical assistance was rendered to MoH for the development of the strategic plan for MMR introduction **(Policy advice & TA)**. Furthermore, support was also made available for the establishment of a National Regulatory Authority and the introduction of a safe sharp disposal system **(Policy advice & TA)**.

Figure 48: EPI Intervention Package Flow Chart mapped to UNICEF Core Roles



In 2004 a total of 1,063 AEFI cases were registered in the country following the BCG vaccination, which led to serious debate among the general population and in the mass media about the use of immunization. In order to address public concerns about the overall benefits of immunization practices in general, UNICEF mainly focused on media sensitivity and mobilization for two national immunization campaigns conducted in Kazakhstan **(Voice & National dialogue)**. UNICEF initiated and successfully developed a good relationship with the media, which was strengthened by the organization of two media workshops with the active involvement of regional office staff and a communication officer from Georgia CO **(Knowledge exchange)**. That helped to "neutralize" and even reverse negative public opinion resulting from numerous adverse effects of the BCG vaccination in 2004. A series of workshops with the media were conducted in Almaty and Shymkent to promote the benefits of immunization and to mobilize media support for the National Measles and Rubella Campaigns **(Knowledge exchange & Leveraging)**.

In 2005, two national immunization campaigns were supported by UNICEF: in February and March an immunization campaign against measles was carried out among the population aged 15 – 25 aged (with 99.3% of that population covered), and a campaign against rubella among women aged 26 – 35 was conducted between September and November (with coverage of over 95%). Both campaigns were successful and established a background for the introduction of the MMR (Measles, Mumps, rubella) vaccine into the routine vaccination of children and youth **(Voice)**.

UNICEF also supplied BCG AD syringes at the request of the MoH (**Other)**. In addition, leaflets and posters were developed, printed and distributed during the Immunization Campaign against Measles and Rubella among young people aged 15-25. Leaflets, a video spot and and an audio jingle were also developed for the Campaign against Rubella in childbearing-age women **(Voice)**. All these activities contributed to the country's immunization efforts and resulted in more than 96% coverage of target population.

The results of MICS 2010 **(Monitoring & Evaluation)** were presented to a wide group of national stakeholders, and the decision was made to elaborate a "reach unreached" strategy **(National Dialogue)**. UNICEF helped the MoH to identify the groups, barriers and root causes of exclusion from immunization programmes within the regions with low levels of polio immunization coverage **(Policy advice & TA)**.

UNICEF also successfully supported polio response activities in two rounds of the supplementary immunization activities both at national and sub-national levels in 2010 through funding a communication campaign **(Voice)**. UNICEF advocated for the integration of new strategies in the multi-year immunization plan **(Policy advice & TA)** with sustainable funding, and supported the continuous monitoring of the immunization coverage among marginalized groups **(Monitoring & Evaluation)**.

Table 22: EPI Intervention Package contribution to UNICEF Core Roles

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF, in a joint process with WHO, advocated for the introduction of new vaccines, the enhancement of vaccine and cold chain management and for unreached and marginalized groups of population to be reached by immunization services. - Remained active through the evaluation period, - Therefore UNICEF's contribution through the given core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- UNICEF's contribution through the given rore role is considered to be "Major/Critical", as it remained actively involved in monitoring immunization coverage and advising the government to target the most disadvantaged and marginalized population. UNICEF used cold chain assessment and MICS results for advocacy purposes.
3. Policy advice and technical assistance	3	- UNICEF was instrumental in supporting the MoH in policy development through the provision of the required technical assistance for the development of a strategic plan to introduce MMR, a plan to enhance cold chain capacity, and to establish the regulatory authority - As UNICEF remained active during the evaluation period, its contribution through this core role is considered as "Major/Critical"
4.Leveraging resources	0	- The immunization program is fully financed by the state; therefore UNICEF played no role in mobilization and leveraging resources.
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period, UNICEF supported a number of events (conferences, workshops) and facilitated national dialogue at critical stages. - Therefore UNICEF's contribution through this core role is considered as "Significant"
6.Enabling knowledge exchange	2	- UNICEF contributed to knowledge exchange by training EPI managers in the introduction of MMR, and carried out workshops for mass media in support of the national immunization campaigns. Also UNICEF contributed to the critical stages of the EPI program - Therefore UNICEF's contribution through this core role should be considered as "Significant"
7.Modeling/piloting	0	No piloting

IMCI SUB-INTERVENTION PACKAGE

The UNICEF-supported infant and child mortality study **(Monitoring & Evaluation)** revealed ARI and DD to be leading causes of morbidity and mortality. The results of the study were presented at a national roundtable, leading to a decision to establish the Republican IMCI centre (RIMCI) **(National dialogue)**. UNICEF assisted the MoH in building RIMCI capacity by providing technical assistance for the adaptation, translation and approval of the IMCI guidelines and protocols and training a pool of national trainers **(Policy advice & TA, Knowledge exchange)**.

In 2003 an IMCI Care for Development ToT course was organized for Kyrgyzstan, which was an important addition to the on-going IMCI Project activities in CARK countries. UNICEF held the workshop in collaboration with WHO (**Knowledge exchange and Leveraging)**. It was mainly designed for training facilitators and the trainers in Kyrgyzstan. However, IMCI National Coordinators of Tajikistan, Kazakhstan, and Uzbekistan also participated in the first three days of the workshop to learn about the content and processes. The training was an important addition to the IMCI Training Modules of the Paediatricians.

Building human resource capacity to apply IMCI approaches was first introduced in Kyzyl Orda Oblast (**Knowledge exchange and Modelling)**. To support the pilot, the MoH and local health authorities issued a Decree. Using the national IMCI trainer capacity, UNICEF supported first IMCI training courses in the pilot. After piloting the trainings in Kyzyl Orda Oblast, the trainings were expanded to Almaty, Karaganda and East Kazakhstan oblasts (**Knowledge exchange)**. To ensure effective implementation of IMCI principles, UNICEF managed to leverage resources from the Government of Japan **(Leveraging)**. As a result, IMCI drugs were supplied to all four oblasts of the country where IMCI guidelines were introduced under the Government of Japan-Government of Kazakhstan–UNICEF "Multi-bi" cooperation agreement **(Other)**.

In parallel to the introduction of IMCI in four regions of the country, UNICEF supported the RIMCI Centre to include IMCI principles in the curriculum of medical universities and provide training to medical university teachers **(Knowledge exchange)**. Regional training centres were established with UNICEF's support and human resource training was financed until 2005 **(Knowledge exchange)**. Since then IMCI on-job trainings have been fully funded by the government. Each oblast develops annual training plans and targets health staff from hospitals and PHC centres. The IMCI module is included as one of the mandatory modules in the continuous medical education and is counted for certification/recertification of medical personnel.

With UNICEF support, IMCI was fully integrated in postgraduate education (CME). These packages were also included in the undergraduate medical education curriculum, and faculty members were trained. UNICEF also supported the establishment of evidence based medicine (EBM) centres in scientific-research organizations. In order to improve postgraduate and continuous medical education, UNICEF supported the government in institutionalising the IMCI/ICAT training course, which is currently utilized by all Oblast Education Centres **(Knowledge exchange)**.

While UNICEF mostly concentrated on training courses and the supply of drugs, little attention was paid to the third, community IMCI component, which is essential for child survival and for the improvement of child rearing practices in the family and community. The need for the introduction of the IMCI community component was confirmed by a UNICEF-supported needs assessments of child development and better parenting (Monitoring **& Evaluation)**, which revealed the lack of knowledge regarding health, prevention and child

development stimulation among parents and family members. To obtain the government's buy-in, the results of the study were presented at a national orientation meeting conducted jointly with WHO **(National dialogue and Leveraging)**. This meeting stimulated the further development of the integrated Better Parenting strategy (BPI) with UNICEF's technical support **(Policy advice & TA).** To support strategy implementation, UNICEF introduced a massive campaign to properly disseminate Facts For Life to millions of families as a first step to raise awareness and demand better services to the beneficiaries **(Voice)**. In parallel, a study on KAPB of parents and families in respect to child rearing was carried out with UNICEF's support that guided the design of the BP strategy and information materials for children **(Monitoring & Evaluation)**.

The main obstacle acknowledged by all major partners was the lack of expertise on ECD in the country. Despite the substantial efforts put into developing BPI materials by key national partners such as National Centre for Healthy Lifestyle, SATR centre and the Kazakh Academy of Nutrition, it became apparent that technical assistance and advocacy was necessary to elaborate an integrated inter-sectoral approach to ECD programming. The findings from the pilot study on BPI **(Monitoring & Evaluation)** supported by UNICEF once again showed a lack of practical, parental knowledge with respect to the developmental needs of a child. A national dialogue facilitated **(National dialogue)** by UNICEF around these issues led to the Government's decision to pilot the survival, development and protection needs of children 0-3 years through a comprehensive communication strategy on Better Parenting **(Modelling)**, alongside the adoption of the Better Parenting model at the national level.

For this purpose an ECD TWG was established with UNICEF's technical support **(Policy advice & TA)**. A number of national and international consultants assisted the TWG in finalizing the ECD study in Almaty Oblasts, reviewing the materials on BP and holding periodic meetings to review each step. The good cooperation established with CDC **(Leveraging)** enabled the organization of a BP Communication workshop, which was facilitated by a CDC expert and two other experts contracted by UNICEF. Technical support was also provided to the TWG in the development of comprehensive implementation for BP communication in Kazakhstan **(Policy advice & TA)**.

Furthermore, technical assistance was provided to the MoH for the development of the BP training and communication materials **(Policy advice & TA)** for PHC staff, and a national training capacity in BPI was created that facilitated the training of PHC personnel in four targeted regions of the country **(Knowledge exchange)**. Since PHC workers, particularly nurses, were recognized as a major resource for building the competence of parents, and for providing key inputs in the design and implementation of IECD programs, the 3rd component of IMCI was seen as crucial to community ECD. Therefore UNICEF aided the MoH to integrate community IMCI and BP, thereby creating the conditions necessary for the improvement of child rearing practices in the family and community **(Policy advice & TA)**.

With UNICEF's support, issues related to IMCI, Perinatal care, Nutrition, pregnancy and newborn care along with ECD related communication, counselLing and parent education were integrated in the functions of patronage nurses and GPs **(Policy advice & TA)**. UNICEF assisted the Republican Healthy Lifestyle Centre in producing leaflets, brochures, posters, videos and other communication materials to improve parent/caretaker knowledge **(Policy advice & TA)**.

In 2006, attempts were undertaken within the Better Parenting Initiative to shift focus from sectoral-medical approaches towards integrating social and educational components. The combined challenge was to revise the care system as a whole, define a rationale for the work of nurses, consolidate child development issues at all levels and integrate some psychosocial and physical screening mechanisms into the routine work of social workers and

pre-school education facilities. To do so, the first conference on ECD issues was conducted in Semipalatinsk (**National dialogue)** gathering a mix of healthcare, education and social protection specialists and NGOs. As a result, priority needs were identified to provide a better start for children such as: inter-sectoral coordination, the inclusion of the most vulnerable within the scope of ECD, the provision of continuing care for children and the development of a family-centred approach.

The new proposed integrated approach was first piloted in South Kazakhstan **(Modelling)**. In support of the pilot three UN agencies (UNICEF, UNFPA and UNDP) joined forces and resources **(Leveraging)**. Based on an assessment of the Better Parenting project in pilot and lessons learned **(Monitoring & Evaluation)**, an improved PHC home visiting concept for families with young children under three was approved by the Ministry of Health **(Policy advice & TA)**. In 2008, a regulatory framework was elaborated and a package of protocols and guidelines were developed and approved with UNICEF's assistance **(Policy advice & TA)**. Furthermore, UNICEF assisted the MoH in revising the outreach system for parents with children under three and initiating the revision and development of standards for home visiting nurses, including the revision of the education system, staffing, methodological support, etc., as well as the establishment of the Healthy Child Rooms at PHC centres. All of these were integrated into the National Program on Health Reforms and Development for 2005-10. Under the National Programme of Health Reforms for 2005–2010, children under five and pregnant women have free access to essential drugs at PHC and hospital levels **(Policy advise & TA)**. Experience and lessons gained in the pilot phase **(Monitoring & Evaluation)** were used while advocating and developing new standards of home visiting services and helping to design an effective service delivery model. Above all, elements of child protection such as identification and response to child violence and abuse were incorporated into new standards **(Policy advise & TA)**.

To improve the continuum of care for children under three years of age, UNICEF in partnership with the Ministry of Health convened a multi-disciplinary working group comprising representatives from health, education and social protection to review the existing normative framework that guides the delivery of health services. This work resulted in the incorporation of IMCI, Better Parenting, early detection and intervention into the practice norms and guidelines of primary health care facilities **(Policy advice & TA)**. A model that demonstrated a continuum of care for young children with focus on children with special needs was tried out as part of a joint, three-year UN project in Semipalatinsk **(Modelling)**. During the first year of the project's implementation, a local knowledge body was created and two resource centres were established to provide in-service trainings for health workers; a critical mass of PHC workers was trained; and informational materials on the issues of ECD/BP became available to raise awareness of health workers and general population **(Knowledge exchange)**. Bearing in mind lessons learnt from the previous JP in South Kazakhstan **(Monitoring & Evaluation)**, UNICEF ensured the active involvement of local authorities and academia **(Leveraging),** which helped to update the curricula of Semipalatinsk Medical University and Medical College, and in-service training programmes for PHC workers **(Knowledge exchange)**.

Analysis of access to and quality of PHC services carried out in 2004 and MICS 2006 **(Monitoring & Evaluation)** was used for advocacy on improving the financing of health services with particular emphasis on MNCH **(Policy advice & TA)**.

In 2007 UNICEF conducted a BBP effectiveness survey **(Monitoring & Evaluation)**. A Cost Benefit Analysis of BBP findings was discussed with national and international partners and stakeholders and was taken into account by the government in financing **(National dialogue)**. As a result, BBP was revised, a special budget factor was elaborated and introduced for central government to allocate additional funds for socially vulnerable

population, and a decree on social vulnerability indicators was developed and adopted. Decree #691 on the establishment of Healthy Child rooms and patronage system ensured the allocation of additional funding (through Health Life Style Program) for ECD/BPI services.

The MoF was supported with technical assistance in reviewing the effectiveness and efficiency of public expenditures in the social sectors, including health. System gaps were identified and further policy recommendations were developed **(Policy advice & TA)**. A contribution was made to the institutionalization of social budgeting in 21 municipalities and the development of social budget evaluation methodology enforced at the end of 2010 **(Policy advise & TA)**. Since 2014, PHC facilities have become partial fund holders and obtained the freedom to manage their budgets in line with the needs of individual facilities.

Table 23: UNICEF Core Roles Contribution to the implementation of IMCI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1.The 'Voice' for children	3	- The results of UNICEF-supported MICS surveys together with other studies on child rearing practices and the effectiveness of BBP have been used for raising child health related issues - UNICEF was active during the evaluation period - Therefore contribution through this core role is considered to be "Major/Critical"
2.Monitoring & evaluation	3	- During the evaluation period UNICEF carried out a series of researches and studies to inform its programming as well as to advocate for child health rights - UNICEF introduced the MICS methodology in Kazakhstan to assist the Government of Kazakhstan in obtaining reliable data about the situation of children and women - UNICEF supported the institutionalization of DevInfo as a database for the Government to monitor progress towards MDGs and as a tool that could be used by the stakeholders to monitor the progress of mid-term and long-term national programmes - Therefore the contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF provided continuous policy advice and technical assistance to the government (IMCI guidelines and protocols; integration of IMCI medicines into the EDL and BBP; IMCI reflected in the National program on Health Reforms and Development and into undergraduate and postgraduate education systems in selected universities; revision of legal and regulatory frameworks with the focus on IMCI, etc.) - Therefore the contribution through this core role is considered to be "Major/Critical"
4.Leveraging resources	3	- In support of IMCI sub-package implementation UNICEF managed to leverage resources from partners (CDC, WHO, UN Agencies) especially at early stages of the evaluation period. Later in order to achieve sustainability, UNICEF was successful in leveraging national and sub-national government resources in support and continuous implementation of the IMCI strategy - Therefore the contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF supported the organization of national dialogue around the issues such as Better Parenting strategy, BBP study results, ECD, etc. and remained active thought the evaluation period - Therefore the contribution through this core role is considered to be "Major/Critical"
6.Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local health professionals till 2005 and ensured full integration of on-job training into the annual budgets of

		the national and local governments - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
7.Modeling/piloting	3	- UNICEF implemented a number of pilots (IMCI, Better Parenting, ECD, etc.) which have been scaled up nationally. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"

NUTRITION INTERVENTION PACKAGE

IDD SUB- INTERVENTION PACKAGE

The IDD KAP survey **(Monitoring & Evaluation)** clearly highlighted the need to develop an IDD communication strategy. Therefore in 2002 UNICEF, together with CDC and ADB, jointly supported a national workshop on developing such a strategy **(National dialogue and Leveraging)**. To facilitate the workshop, two international consultants were identified to carry out training on the CDC approach and to develop a plan of action for preparing the IDD prevention communication campaign. Funding for the workshop was received from CDC at the global level and allocated through UNICEF HQs **(Policy advice & TA)**.

To facilitate the campaign and provide necessary expertise, the GoK, following UNICEF's advocacy, agreed to establish a Technical Assistance and Implementation Group (TAIG) **(Policy advice & TA)**. This group included representatives from KAN, MoH, Ministry of Culture, Information and Public Accord, and the Confederation of NGOs of Kazakhstan, as well as representatives of PR companies involved in the project. The experts under the TAIG developed and printed communication material. With the support of UNICEF, KAN and PR companies developed a logo for fortified food products. This logo was initially developed for iodized salt, but it was then agreed that it could also be used for fortified flour **(Policy advice & TA)**.

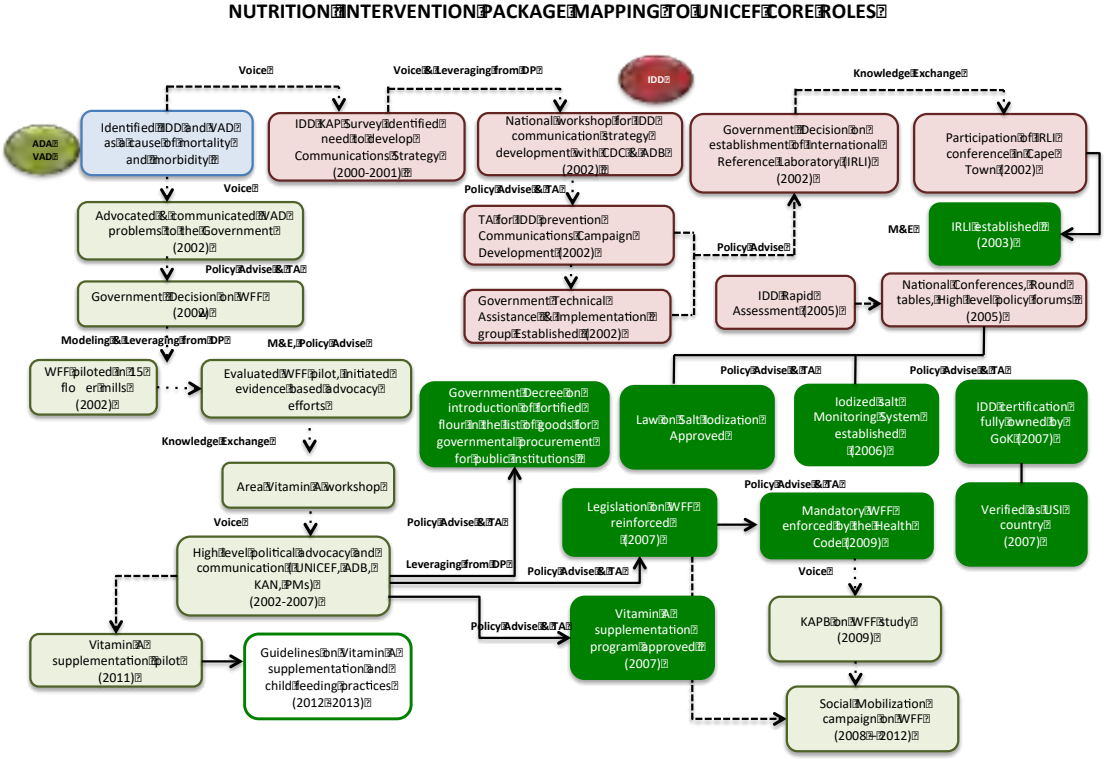
In support of the IDD Prevention Communication Campaign, UNICEF financed the Kazakhstan Press Club to conduct workshops for local mass media, hold press conferences and conduct media monitoring **(Knowledge exchange, Voice)**. A workshop for mass media on the IDD Prevention Communication Campaign was also carried out with support of KAN. Furthermore support was also made available for Training of Trainers for local NGOs on the promotion of IDD/IDA prevention materials to the general population **(Knowledge exchange)**.

To strengthen the monitoring capacity of KAN, UNICEF purchased an Atomic Absorption Spectrometer and promoted the inclusion of KAN in the register of international Reference Laboratories (IRLI) (**Other)**. In this regard UNICEF supported the participation of Kazakh representatives in an IRLI conference in Cape Town, South Africa **(Knowledge exchange)**. All these activities were finance by Kiwanis International, USAID and CDC funds **(Leveraging)**.

In 2003 UNICEF organized an area workshop on strengthening strategies for the elimination of micronutrient deficiencies in CARK **(Knowledge exchange and voice)**. The continued collaboration between ADB, KAN, Emory University, and UNICEF along with the new partnership with the US Centres for Disease Control and Prevention made this workshop possible **(Leveraging)**. The aim of the workshop was to strengthen the capacity of participants to support national efforts to eliminate micronutrient malnutrition, with a particular focus on iodine, iron, folic acid and vitamin A deficiencies. The Workshop concentrated on fortification, with due reference to other interventions as relevant. Participants from the government, food industry and UNICEF Kazakhstan, Uzbekistan, Kyrgyz Republic, Tajikistan and Turkmenistan attended this training workshop. Facilitation was organised by joint efforts of UNICEF CARK, UNICEF RO, UNICEF HQ, and CDC/Atlanta

(Leveraging). Furthermore UNICEF supported the participation of a Kazakh national delegation in the International Meeting for the Sustained Elimination of Iodine Deficiency Disorders, Beijing, 15-17 October 2003 **(Knowledge exchange)**. UNICEF, as the Chair of the Global Network for Sustained Iodine Elimination, and the Government of the People's Republic of China were organizers of this high level meeting.

Figure 49: IDD sub- Intervention Package Flow Chart



Due to the joint efforts and high-level political advocacy of UNICEF, ADB and KAN, and the mobilization of MPs and other national key players, in 2006 – 8 Government Decrees were issued on the introduction of premium and 1st grade flour fortification and on the introduction of fortified flour into the list of goods for governmental procurement for public institutions **(Policy advice & TA and Leveraging)**.

The IDD Rapid Assessment undertaken by UNICEF in 2005 **(Monitoring & Evaluation)** revealed that 86% of households consume adequately iodized salt. This indicated impressive progress compared with only 29% in 1999, which *inter alia* can be attributed to a nationwide ongoing information campaign led by UNICEF **(Voice)**. The results of the IDD Rapid Assessment were publically presented during the National Conference organized by UNICEF and the Kazakh Academy of Nutrition (KAN) in September with the participation of Anatoly Karpov, World Chess Champion and UNICEF Regional Goodwill Ambassador advocating for USI **(National dialogue)**. His participation in the national information campaign made it possible to attract the attention of policy makers, government officials, NGOs and the media to the problem of elimination of iodine deficiency disorders, as well as to the fight against anaemia through flour fortification.

The achievement of USI in Kazakhstan and the consolidation of efforts by all respective ministries and institutions were on the agenda at a special round table conducted by UNICEF for parliamentarians and top-ranking government officials **(National dialogue)**. The Resolution adopted by the participants highlighted the need for improved monitoring of iodized salt and the mobilization of stakeholders to withstand attempts to recall flour fortification legislation, thus ensuring further progress in this area. The Kazakhstan National Association of Salt Producers (**Leveraging)** was officially launched in Almaty; the organization lobbied USI not only in Kazakhstan, but also in the Central Asian region as a whole.

With UNICEF's support a sustainable surveillance and quality assurance system on iodized salt was established in 2006 **(Policy Advice & TA)**. Considerable progress achieved during the previous years in the area of IDD elimination in the country was supported by data obtained from the MICS **(Monitoring & Evaluation)**. Overall, about 91.4% of households in Kazakhstan consumed adequately iodized salt, and the median level of urinary iodine excretion among women of child-bearing age was 235.9 mkg/l. Such success was documented and published in the New York Times, citing the example of Kazakhstan's experience in overcoming IDD.

Moreover, standards and quality assurance procedures for importing and producing salt were drawn up, and a monitoring plan and regulatory framework were agreed by several involved agencies with UNICEF technical assistance **(Policy advice & TA)**. Based on the outcomes of this work, Vitamin A pills containing iodine and iron were included into the basic benefit package for pregnant women and children under two years old.

GoK was assisted in training the SES workers and Customs Committee and Standardization & Metrology Committee representatives on the surveillance system's strengthening and assuring compliance with standards **(Policy advice & TA)**. In addition, the required equipment was purchased for SES departments and private salt producers in order to ensure effective control over iodized salt **(Other)**.

UNICEF hired an International Consultant to support the preparation of the country for USI certification **(Policy advice & TA)**. In 2007 Kazakhstan made a final step towards the achievement of universal consumption of iodized salt by the Kazakh population. The UNICEF country office provided the required support to Government institutions and officials in conducting the final stage of verification of Kazakhstan as a USI country **(Policy advise & TA)**. Thus, according the MICS (2006) **(Monitoring & Evaluation)**, 92 percent of households consume adequately iodized salt, and the median level of iodine excretion with urine among childbearing women is 235.9 mkg/l. In addition, an international consultant reviewed the sustainability of the USI achievement. That enabled Kazakhstan to submit an application to UNICEF, WHO and the Board of the Network for Sustained Elimination of Iodine Deficiency and IDD ICC to be verified as a country that has achieved USI. In order to ensure a sustainable process of IDD elimination in the country, UNICEF supported the development of a regulatory framework to monitor IDD prevention activities. The Republican Sanitation and Epidemiological Service was identified as a responsible body for these activities **(Policy advice & TA)**.

In 2010 the IRLI resource laboratory in the Kazakh Academy of Nutrition prepared a system to monitor and evaluate the impact of IDD elimination programs and track iodine elimination status in Kazakhstan. UNICEF also assisted the IRLI resource laboratory to become a Centre for the IRLI Network for CEE/CIS Region, and ensured the financial sustainability of the national system on monitoring of elimination of iodine deficiency disorders **(Policy advise & TA)**.

Table 24: UNICEF Core Role contribution to the implementation of IDD Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated advocacy on IDD and USI - UNICEF remained active until Kazakhstan was granted a certificate on IDD elimination in 2007 - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- UNICEF supported the government in the design and institutionalisation of the USI quality monitoring system, carried out trainings for IDD M&E capacity building, and supported establishment of the IRLI at KAN which become a Centre for the IRLI Network for CEE/CIS Region - UNICEF's contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF assisted the government in the development and adoption of standards on IDD level in salt and the National IDD plan. It also institutionalised monitoring and quality assurance of Universal Salt Iodization nationwide. Furthermore UNICEF assisted the government in preparing for International IDD elimination certification through the provision of international expertise. - UNICEF remained active until Kazakhstan was granted a certificate on IDD elimination in 2007 - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IDD elimination and USI through legislative and executive branches of the government, mass media, private salt producers, and international partners such as USAID, ADB, Kiwanis International, US CDC, GAIN etc. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF facilitated a national dialogue by assisting National TAIG in National IDD Action Plan development and supporting TAIG's regular meetings - UNICEF was instrumental in facilitation of the national dialogue on number of occasions - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local governments, policy makers, of Salt producers and supported number of knowledge sharing events - UNICEF remained a key supporter of human resource capacity building in the country in the area of IDD and USI. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
7.Modeling/piloting	0	

FOOD FORTIFICATION INTERVENTION PACKAGE

After the approval of the USI law, UNICEF supported GoK in the development of legislation on mandatory flour fortification by iron and folic acid **(Policy advice & TA)**. In order to promote the development and adoption of the FF law, UNICEF financed cost benefit and cost-efficiency analyses of food fortification **(Monitoring & Evaluation)** and used the findings for advocacy purposes **(Voice)**. As a result, the Government began to prepare the relevant legislation. UNICEF advocated the GoK to establish a secretariat that would be responsible for the development of mandatory wheat flour fortification by iron and folic acid, and supported meetings of the secretariat. UNICEF provided technical assistance to MoH for the development of law enforcement mechanisms to ensure quality flour fortification, and for the revision of the technical requirements of fortified bread production in line with the new Law on Technical Standards & Procedures. UNICEF finalised the M&E plan on FF quality assurance and control, and submitted it to MoH for approval **(Policy advice & TA)**. In addition, UNICEF conducted inter-agency meetings with Technical Assistance and Implementation Group (TAIG) and National Fortification Alliance (NFA) to discuss the implementation of the FF communication campaign **(Policy advice & TA)**. With the support of UNICEF, KAN and PR companies **(Leveraging)** developed a logo for fortified food products. This logo was initially developed for iodized salt, but it was then agreed that it could also be used for fortified flour. UNICEF supported a national training workshop for the regional flour mills marketing departments **(Knowledge exchange and Leveraging)**, health workers and local authorities to develop a strategy to introduce the "Healthy Food" logo in sales and fortified wheat flour networks.

In 2006,UNICEF, in collaboration with KAN and ADB, restarted advocacy (**Leveraging)** and communication to counteract attempts to reverse progress on mandatory FF through the exclusion of such clauses from the law on quality and safety of food products. It did so through meetings with stakeholders (Parliamentarians, Ministries of Health and Agriculture, the Committee on Family and Gender policy), interviews, press conferences and preparation and dissemination of information kits on the impact of FF on the health of pregnant women and young children **(Voice and National dialogue)**.

In cooperation with the Ministry of Health, UN and national partners, a program on reducing maternal and child mortality incorporating best MCH practices was developed and approved which addresses control of micronutrient deficiencies, including FF. The key audiences were Senators, the Government, heads of state agencies, leaders of NGOs and the media editors and journalists. Messages were delivered at special events, including high-profile conferences in the Senate, and involving UNICEF's goodwill ambassador on nutrition **(National dialogue)**.

In spite of all the efforts made by UNICEF, the President vetoed the mandatory flour fortification that was included into a new law of 'Food Safety' passed in May 2007. Undoubtedly, this hampered implementation of some relevant activities planned for the year. In 2008 UNICEF continued evidence-based advocacy **(Voice)** for the inclusion of the article on mandatory wheat floor fortification in the Health Code, and assisted the Government in strengthening the national monitoring system on the implementation of flour fortification to further reduce anaemia levels among women of reproductive age. Assistance was also made available for the development of a WFF communication campaign **(Policy advice)** aiming at creating a sustainable demand for FF among consumers and generating support for flour fortification among producers and policy makers with funds available from GAIN **(Leveraging)**.

Table 25: UNICEF Core Role contribution to the implementation of FF Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on FF jointly with UN agencies and other development partners. UNICEF was instrumental in using M&E results for evidence-based advocacy of the government, and supported activities directed at awareness raising and demand creation for fortified flour etc. - UNICEF remained active throughout the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions as well as informed advocacy events - UNICEF also supported the enhancement of national lab capacity for institutionalisation of monitoring micronutrient deficiencies in the country - UNICEF's contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of the FF quality standards and ensured inclusion of FF in the national MCH program. It also supported the development of the legislation on FF by revising the law on quality and safety of food products and included FF into the Health Code, and assisted the GoK in the development of the national monitoring and evaluation plan for flour fortification - UNICEF remained active throughout the evaluation period - Therefore its contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of FF through the legislative and executive branches of the government, mass media, the private sector, ADB, CDC, GAIN etc. - Therefore its contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF facilitated a national dialogue on the control of micronutrient deficiencies and FF related issues by organising workshops, round tables, and sessions to promote adoption of the FF legislation, and remained active during the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local governments and policy makers, private millers and national laboratory staff - On a number of occasions UNICEF ensured national representation in international knowledge sharing events such as Regional Conference on FF, Area Conference on CMD, etc. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"

7.Modeling/piloting	0	No piloting

IRON DEFICIENCY ANEMIA - INTERVENTION PACKAGE

Starting from 2000, UNICEF continued advocacy efforts to promote the control of micronutrient deficiencies in the country, including anaemia prevention **(Voice)**. Within the framework of a Review of Anaemia Prevention Programme and Control programmes (APC) in CARK, organised by the Area office **(Monitoring & Evaluation),** the activities and strategies of APC implementation in Kyzyl Orda Oblast in 1998-2002 **(Modeling and Monitoring & Evaluation)** were evaluated and adjustments proposed for further programme planning and implementation **(Policy advice & TA)**. The review conclusions and recommendations emphasized a need for flour fortification with iron.

UNICEF's multiple advocacy events **(Voice)** led to the development of an ADB-funded project on "Improving poor mother and child nutrition in Asian countries in transition" which supported private millers with equipment, communication related activities as well as formulation of legislation **(Leveraging)**.

A country micronutrient workshop (**National dialogue), which** was held with support from UNICEF and CDC **(Leveraging)**, enabled the development of a detailed IDA plan of action and communication campaign implementation in 2003 **(Policy advice & TA).**

In 2007, UNICEF actively promoted and succeeded in introducing a section on Prevention of Iron Deficiency Anaemia into the Health Code **(Policy advice & TA)** based on the data from the MICS survey **(Monitoring & Evaluation), which** showed an alarming level of IDA among women of reproductive age exceeding 46 percent. The Health Code was adopted in 2008.

In order to reduce the prevalence of anaemia among mothers and children, UNICEF supported the capacity building **(Knowledge exchange)** of government regulatory bodies and flour millers to operationalise the legislation on mandatory FF. FF was supported by a strong public-private alliance and a nation wide advocacy and communication campaign **(Voice and Leveraging)**.

Table 26: UNICEF Core Role contribution to implementation of IDA Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on CMD and IDA in particular, and was instrumental in using M&E results for evidence-based advocacy. It also supported activities directed to awareness raising - UNICEF remained active through out the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions and informed advocacy events - UNICEF also supported the enhancement of national lab capacity to institutionalise the monitoring of micronutrient deficiencies in the country - UNICEF's contribution towards through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development of the IDA plan of action and communication campaign, and promoted and succeeded in introducing a section on Prevention of Iron Deficiency Anaemia into the

		Health Code - UNICEF remained active throughout the evaluation period - Therefore its contribution through this core role is considered to be ”Major/Critical”
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IDA - UNICEF leveraged financial resources through GAIN and became an implementer of an ADB-financed project, as well as benefitting from US CDC supported activities - Therefore its contribution through this core role is considered to be ”Major/Critical”
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF facilitated national dialogue on control of micronutrient deficiencies and FF related issues by organization of workshops, round tables, sessions during the evaluation period (MICS 3, 4, other IDA related studies) - Therefore UNICEF’s contribution through this core role is considered to be ”Major/Critical”
6. Enabling knowledge exchange	3	- UNICEF remained as active player in the capacity building of national and local governments and policy makers throughout the evaluation period - Therefore UNICEF’s contribution through this core role is considered to be ”Major/Critical”
7.Modeling/piloting	0	- Although UNICEF supported the piloting of the APC program in the period of 1998-2002, activities carried out during evaluation period were only limited to the assessment of the pilot during the evaluation period. Therefore it is considered that UNICEF did not use the modelling core role.

VITAMIN A DEFICIENCY ANEMIA - INTERVENTION PACKAGE

The results of the survey on Vitamin A among children U5 in two oblasts of Kazakhstan **(Monitoring & Evaluation)**, conducted by KAN under the initiative and with support of UNICEF, revealed a problem of Vitamin A deficiency (VAD) in Kazakhstan. Following a CARK Workshop **(Knowledge exchange)** on strengthening strategies to eliminate micronutrient deficiencies, which was organized by UNICEF and CDC in 2002 **(Leveraging)**, UNICEF advocated through national round table discussions for the establishment of a working group to develop a national policy and action plan for VAD prevention **(National dialogue)**. As a result of UNICEF’s continuous advocacy efforts for support of vitamin A supplementation among children from 6 month to 59 month, the MoH decided to introduce a National VAD prevention week. National surveillance system data **(Monitoring & Evaluation)** informed the decision to pilot vitamin A supplementation in two regions **(Modeling)**. UNICEF assisted the MOH in implementing the VAD prevention week in pilot oblasts through the provision of communication and information materials, training of local health and facility authorities, and round tables and workshops for all stakeholders and mass media to promote and launch the national VAD prevention week **(Modelling)**. Mass communication campaigns were carried out annually in support of national VAD prevention weeks with financial support from GAIN **(Voice and Leveraging)**.

The piloting outcomes **(Monitoring & Evaluation)** contributed to the introduction of the supplementation nationwide during the national VAD prevention weeks with appropriate funding from the State Health System Development Program **(Leveraging)**.

KAN hired a national consultant from their own resources to finalise and approve the National Programme on Vitamin A supplementation and the Plan of Action, as well as

development of procedures for Vitamin A capsule registration in the country **(Leveraging)**. Technical expertise was provided to the MoH for the development of the Vitamin A supplementation guidelines as well as for printing the National Programme on Vitamin A supplementation and Plan of Action **(Policy advice & TA)**.

Technical assistance was provided to the working group, and guidelines for health workers on VAD prevention through the Vitamin A supplementation programme were developed and approved by the government **(Policy advice & TA)**. UNICEF printed and distributed guidelines to health workers. As a result a training module to implement the National Program on Vitamin A supplementation was developed and incorporated in the undergraduate and postgraduate education programs **(Policy advice & TA)**.

In order to allow effective implementation of the national VAD survey within MICS framework, UNICEF and ADB procured the HPLC for KAN and trained staff in effective use of the equipment and collection of blood samples in the field, thus building national M&E capacity in the country **(Policy advice & TA and Knowledge exchange)**.

Table 27: UNICEF Core Role contribution to the implementation of VAD Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on CMD and VAD in particular, and was instrumental in using M&E results for evidence-based advocacy. It also supported activities directed to awareness raising among public and mass media etc. - UNICEF remained active throughout the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions and informed advocacy events - UNICEF also supported the enhancement of national lab capacity to institutionalise monitoring micronutrient deficiencies in the country and VAD monitoring and assessment system - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of a VAD prevention week, VAD national program and implementation plan, and Vitamin A supplementation guidelines and training material. It also ensured integration of VAD training into undergraduate and postgraduate education programs. - UNICEF remained active throughout the evaluation period - Therefore its contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of VAD and CMD through the legislative and executive branches of the government, mass media, and the private sector - UNICEF leveraged financial resources through GAIN and ADB and USAID funded programs supporting CMD - Therefore its contribution through this core role is considered to be "Major/Critical"

5. Facilitating national dialogue towards child friendly social norms	2	- UNICEF facilitated national dialogue on control of micronutrient deficiencies and VAD related issues by organising workshops and round tables throughout the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	1	- UNICEF's role in local capacity building was limited to training KAN staff to use new lab equipment and collect of blood samples and analysis for VAD - Therefore UNICEF's contribution through this core role is considered to be "Marginal".
7.Modeling/piloting	3	- UNICEF supported the piloting of VAD supplementation in two regions of the country, which was eventually scaled up to the national level. - UNICEF's contribution through this core role is considered to be "Major/Critical"

BF&BFHI SUB- INTERVENTION PACKAGE

UNICEF first initiated a breastfeeding-related intervention prior to the evaluation period and its activities under the BF&BFHI sub-package were limited during the evaluation period. Starting from 2000, together with WHO, UNICEF supported Area-wide training on breast feeding **(Leveraging and Knowledge exchange)**. Each year, UNICEF also printed and distributed information materials and organised different events to support orld breastfeeding week **(Voice)**. A book on "breastfeeding promotion for mothers" was translated into Kazakh language and distributed, and BF related issues were included in the national population education program "Kuancabi" **(Voice)**.

UNICEF supported in institutionalization (**Leveraging and Knowledge exchange and TA**) at national level the 10 steps of the BFHI within framework of the ANC/EPC technologies introduction over the 2005- 2010. UNICEF also supported promotion of BF and parents' education on feeding of young child as part of Better parenting initiative, IMCI and Care for Development package.

UNICEF supported monitoring **(Monitoring & Evaluation)** of Maternity houses all over the country using the Self Assessment Algorithm, data collection, data entry and analysis as well as certification and re-certification of maternities.

In order to promote adoption of the International Code of Marketing of Breast Milk Substitutes (ICBMS), UNICEF financed participation of policy makers in International Conference on ICBMS **(Knowledge exchange)**. It also carried out a survey **(Monitoring & Evaluation)** on violation of the Code and presented the results at a national workshop, as well as organising and facilitating various round table discussions **(National dialogue)**. An interagency working group consisting of the relevant ministries was established to coordinate activities aimed at promoting the enabling legislation. UNICEF also supported NGO 'Zhan Sabi' to implement promotion activities for the International Code on Marketing of Breast Milk Substitutes. All of these efforts resulted in adoption of the Code.

In addition, technical support was provided to MoH for the development and introduction of effective young children feeding practices **(Policy advice & TA)**.

Table 28: UNICEF Core Role contribution to the implementation of BF&BFHI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF initiated and continued advocacy on BF&BFHI, and was instrumental in using M&E results for evidence-based advocacy. It also supported activities directed at awareness raising among public and mass media etc. - UNICEF was not active throughout the evaluation period and only contributed to the critical phases - Therefore UNICEF's contribution through this core role is considered to be "Significant"
2. Monitoring & evaluation	1	- During the evaluation period UNICEF supported a survey on violation of the code that informed advocacy events. Furthermore it supported certification and recertification of BFHI facilities as well as monitoring. However, UNICEF was not active during the entire evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Marginal"
3. Policy advice and technical assistance	1	- UNICEF initiated and assisted the government in the adoption of the International Code on Marketing Breast Milk Substitutes - UNICEF did not remain active throughout the evaluation period - Therefore its contribution through this core role is considered to be "Marginal/Minimal"
4. Leveraging resources	0	- UNICEF was not successful in leveraging resources in support of BF&BFHI - Therefore its contribution through this core role is considered to be largely absent
5. Facilitating national dialogue towards child friendly social norms	0	- UNICEF was not successful in facilitating national dialogue around issues related to BF&BFHI - Therefore UNICEF's contribution through this core role is considered to be "none"
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of health professionals at national and local levels, however capacity building activities stopped in 2002 - Therefore UNICEF's contribution through this core role is considered to be "Significant".
7.Modeling/piloting	0	- None

UZBEKISTAN

ANC/PNC INTERVENTION PACKAGE

PERINATAL AND NEONATAL CARE SUB-PACKAGE

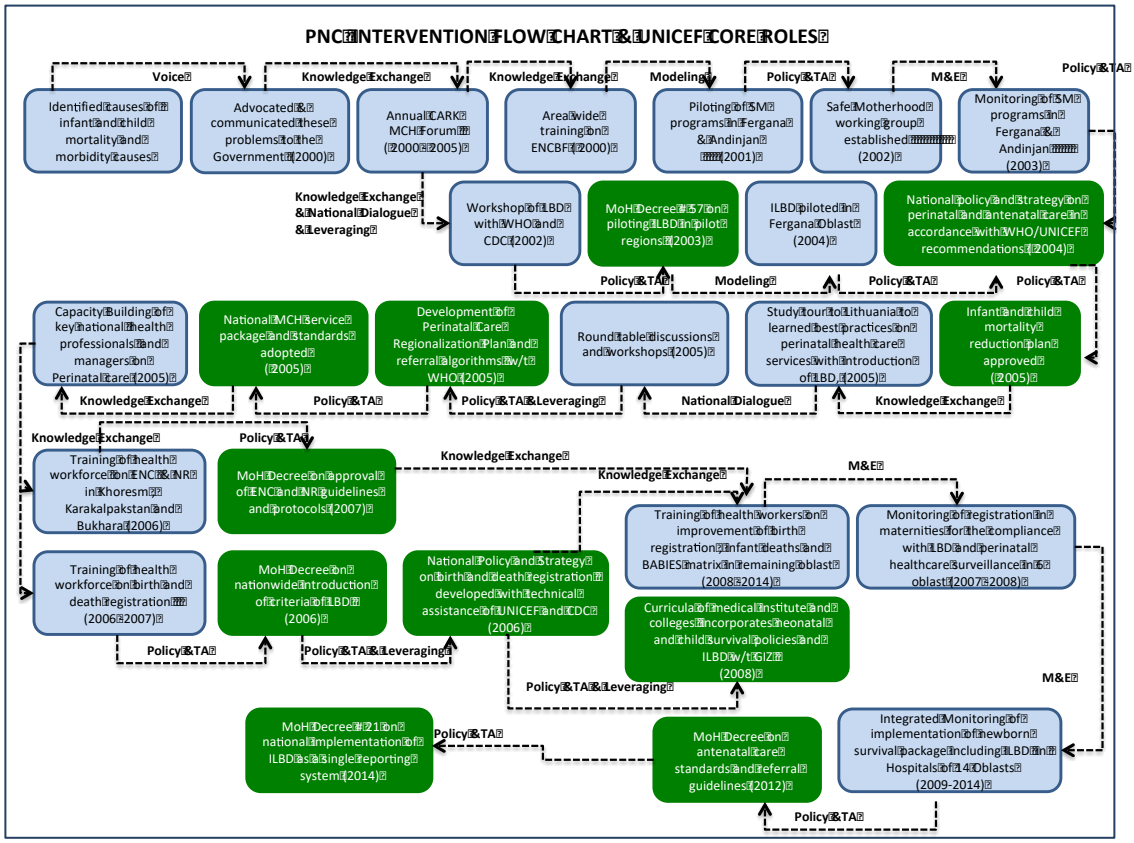
IMR, U5MR and morbidity causes were acknowledged before 2000. These problems were communicated to the government **(Voice)** and addressed during the Regional CARLMCH forums held annually for central Asian countries in the period of 2000-2005, which were supported and organized by UNICEF with wide participation from national policy makers from all CA countries and the involvement of international experts **(Voice & Knowledge exchange)**. The MNCH forums served as an excellent avenue for knowledge sharing, updates on maternal and child health gains achieved in the region, best practices observed etc. Following the first forum in 2000:

- UNICEF organised the first regional training on Early Neonatal care and Breastfeeding where international practices on ENC and BF were shared with participants and a small cohort of champions was developed in each country **(Knowledge exchange)**. This event led to the piloting of the ENC package in the Fergana region of Uzbekistan in 2001 with UNICEF's financial and technical support **(Modelling)**. In parallel, the National Safe Motherhood Working Group was established in 2002, which took part in monitoring of the Fergana pilot implementation (2003) **(Policy advice & TA)**.
- As a follow up to the MNCH Forum in 2002, UNICEF together with WHO and CDC organised the first workshop on the introduction of ILBD (**National dialogue and Leveraging)**, which was followed by the issuance of MOH Decree on piloting ILBD in the Fergana region **(Modelling)**. In response to the MOH decree UNICEF started a pilot in the Fergana region (2004).
- The results of the Fergana pilot assessment **(Monitoring & Evaluation)** largely informed the development of national policy and strategy on perinatal and antenatal care, in accordance with WHO/UNICEF recommendations in 2004 **(Policy advice & TA)**. UNICEF provided technical support to the development of the national strategy and policy on PNC as well as to the national "Infant and child mortality reduction plan", which was approved in 2005. In response to the plan, UNICEF organized a study tour to Lithuania to learn best practices on perinatal health care services with introduction of ILBD (2005) (**Knowledge exchange),** and hosted a number of roundtables, workshops and seminars where the problems of inefficient and non-effective perinatal service organization was addressed and it was agreed that a perinatal regionalization plan should be developed **(National dialogue)**. To support the government, UNICEF together with WHO mobilized technical expertise and assisted the MoH in developing the perinatal regionalization plan, referral algorithms and a National MNCH package of services for public funding **(Policy advice & TA and Leveraging)**.
- Realising the regionalisation plan and introducing other perinatal health packages required building the capacity of the MNCH key national health professionals and managers on Perinatal care. For this purpose, UNICEF began to train the health workforce on ENC & NR and on birth and death registration in Khoresm, Karakalpakstan and Bukhara (2006) **(Knowledge exchange)**. Lessons learned in these sites **(Monitoring & Evaluation)** informed the development of the legislation on nationwide introduction of criteria of ILBD (2006) and the approval of ENC and NR guidelines and protocols (2007). National Policy and Strategy on birth and death registration was developed with technical assistance of UNICEF and CDC (2006) **(Policy advice & TA and Leveraging)**.
- Training of health personnel **(Knowledge exchange)** and monitoring and evaluation **(Monitoring & Evaluation)** of the results in the period 2007-2014 mainly supported

UNICEF's assistance to the government in implementing these pieces of legislation **(Policy advice & TA)**.

- Although a decree on nationwide introduction of ILBD was issued in 2006, the country operated a dual reporting system until 2014. This comprised both official former statistical reporting and reporting according ILBD. In 2014, with UNICEF's technical assistance, the MoH Decree # 21 on national implementation of ILBD as a single reporting system was approved **(Policy advice & TA)**.

Figure 50: PNC sub-package intervention flow chart & UNICEF Core Roles



- Simultaneously support was provided for the introduction of these packages in the undergraduate and postgraduate education programs **(Policy advise & TA)**.
- Antenatal Care guidelines were mostly developed by UNFPA based on WHO guidelines and a national training capacity was built. Responsibility for further scale up of ANC trainings was initiated by UNICEF through an EU funded IMCH project in 2011 **(Knowledge exchange and Leveraging)**. Since then, UNICEF assisted the MOH in the development of an MoH Decree on antenatal care standards and referral guidelines (2012) **(Policy advisc & TA)**.
- The introduction of new approaches for perinatal care was jointly supported by WB, ADB, KFW, USAID and GIZ at different stages of programme implementation **(Leveraging)**. The clear division of labour and tasks was addressed, although according to key informants coordination improved during CPAP2, when the MoH, based on the advice of UNICEF and other partners, assumed a coordinating role. These partners mainly supported investment in perinatal care, alongside relatively small-scale activities on human resource development in the field of PNC.

Table 29: PNC contribution to UNICEF Core Roles

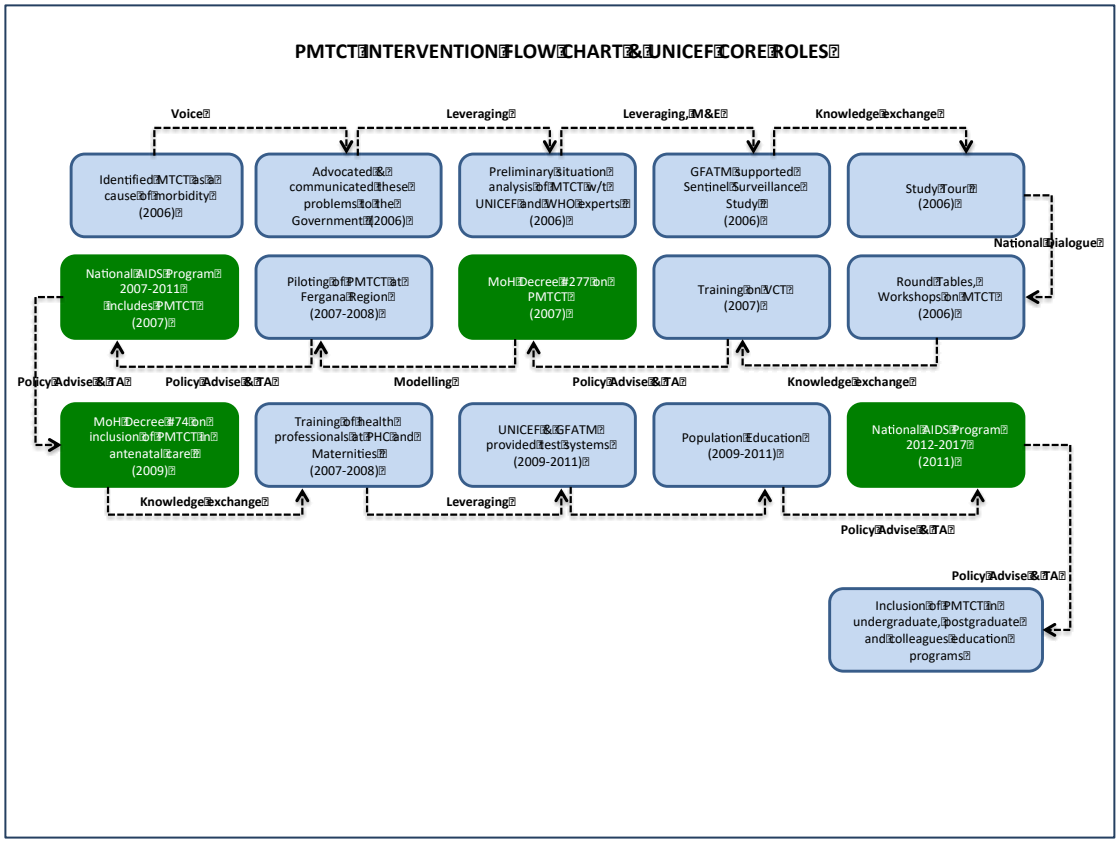
CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF together with WHO contributed to the PNC program initiation in the country by communicating the problem to the government and provision of advocacy. - As voice has been used only at the beginning of the evaluation period, UNICEF's contribution through this core role is considered to be "Significant"
2. Monitoring & evaluation	3	- UNICEF's role in M&E was substantial. New PNC packages along with ILBD and BABEIS were first piloted and monitored. The results informed the development of the enabling policy and legal environment. - UNICEF supported MICS 3 and MICS 4 in the country, although the international community did not officially accept the results of MICS 4. - UNICEF also provided assistance in strengthening countries' monitoring systems by introducing BABEIS as an analytical tool for improving PNC and by institutionalising ILBD reporting as a single reporting system. - UNICEF remained active during the entire evaluation period. Thus UNICEF's contribution through this core role is considered to be "Major/Critical".
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government throughout the evaluation period, together with other partners, and has remained the leading player in the field of PNC since 2008. - UNICEF made available technical expertise to the government for the development of the policy and regulatory framework. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF supported the government in leveraging resources from WHO, GIZ, WB, ADB, KFW. - UNICEF managed to obtain financial support from EU for the period of 2009-2015. - Thus, its contribution through this core role is considered to be "Major/Critical".
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period UNICEF demonstrated facilitation of national dialogue periodically at critical points of UNICEF program implementation - Therefore its contribution through this core role is considered to be "Significant"
6. Enabling knowledge exchange	3	- UNICEF was the key development partner assisting the government in the development of human resource capacity at national and local levels, through the creation of a pool of master trainers and supporting cascade training throughout the country, along with other development partners. - Since 2009, UNICEF has remained the main supporter of human resource capacity building activities in the country. - Furthermore UNICEF also ensured integration of PNC into undergraduate and postgraduate education programs. - In summary, UNICEF's contribution through this core role is considered to be "Major/Critical"
7.Modeling/piloting	3	- UNICEF piloted the introduction of ILBD, BABEIS and ENC/NR packages in pilot districts with further sub-national expansion

		before national scale up. - Thus UNICEF's contribution through this core role is considered to be "Major/Critical".

PMTCT SUB-PACKAGE

MTCT was first detected in the country in 2003. UNICEF together with WHO advocated and communicated the problem to the government **(Voice and Leveraging)** and, with MOH consent, initiated a preliminary situation analysis by involving UNICEF and WHO experts in 2006 **(Monitoring & Evaluation and Leveraging)**. Based on the preliminary assessment, a Sentinel Surveillance Study was carried out with financial support from GFATM AIDS project **(Leveraging)** and technical support of UNICEF and WHO **(Monitoring & Evaluation and Leveraging)**. In order to highlight the importance of the MTCT in HIV epidemics and learn about approaches used by other countries, a study tour **(Knowledge exchange)** was organised and financed by UNICEF for key policy makers followed by series of round table discussions and workshops dedicated to the issues of PMTCT introduction in the country. The first VCT training for PHC and maternity health professionals was organized in Tashkent **(Knowledge exchange)**. In 2007, the MoH issued a decree on piloting the introduction of PMTCT at maternity homes and departments.

Figure 51: PMTCT Sub-Package Flow Chart mapped to UNICEF Core Roles



In 2007, PMTCT was included as a strategic direction in the National AIDS program 2007-2011, followed by a MoH decree on the inclusion of PMTCT in antenatal care **(Policy advice & TA)**. The

decree instructed health providers to initiate counselling and testing of pregnant women twice (before 12 weeks and close to delivery) during the antenatal period.

To support implementation of the MoH decree, UNICEF supported the development of a national and sub-national master trainer capacity and performed cascade training of all health personnel at PHC and maternities in the country in the period 2007-2008, with funding from the GFATM AIDS Project **(Knowledge exchange and Leveraging)**. PMTCT has been nationally scaled up. In the period 2009-2011, UNICEF supported the education of the population in HIV related issues with a particular focus on MTCT **(Voice)**. It also leveraged resources from GFATM financed AIDS program for the provision of test systems (**Leveraging**).

In 2011 UNICEF assisted the government in the development and inclusion of PMTCT as a strategic direction of the National AIDS program 2012-2017 **(Policy advice & TA)**. UNICEF assisted the government in including PMTCT into undergraduate and postgraduate education programs **(Policy advice & TA)**.

Table 30: PMTCT Sub-Package contribution to UNICEF Core Roles

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF contributed to the critical phase of PMTCT initiation in the country by communicating the problem to the government and provision of advocacy. - Therefore UNICEF's contribution through this core role is considered to be " Significant"
2. Monitoring & evaluation	0	- UNICEF's role in M&E, other than supporting one consultant for the Sentinel Surveillance Study, was not reported. - Therefore UNICEF's contribution through this core role was considered to be largely absent.
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government through the evaluation period and remained the only player in the field of PMTCT. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF supported the government in leveraging resources from GFATM, through the inclusion of PMTCT as a strategic direction into the National AIDS programs. - Thus its contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period UNICEF only once demonstrated facilitation of national dialogue in a very critical phase of PMTCT introduction in the country. - Therefore UNICEF's contribution through this core role is considered to be " Significant"
6. Enabling knowledge exchange	3	- UNICEF was the only development partner assisting the government in the development of human resource capacity at national and local levels through creation of a pool of master trainers and supporting the cascade training throughout the country. - Furthermore UNICEF also ensured integration of PMTCT into undergraduate and postgraduate education programs. - In summary, UNICEF's contribution through this core role is considered to be "Major/Critical"

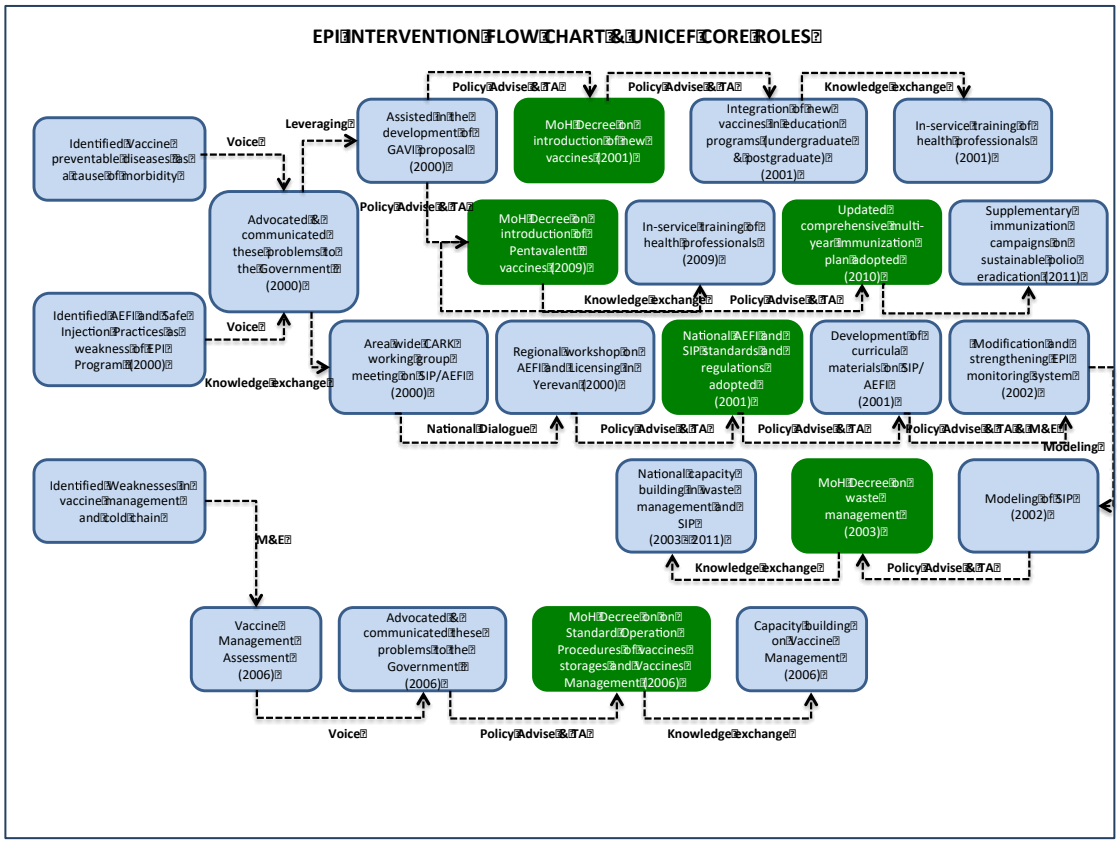
7.Modeling/piloting	3	- UNICEF piloted PMTCT implementation in Fergana region before its national scale up. - Thus its contribution through this core role is considered to be "Major/Critical".

EPI INTERVENTION PACKAGE

Vaccine preventable diseases were identified as key contributors to child mortality back in 1995. WHO and UNICEF supported the government in restoring EPI services. Through a vaccine independent initiative, it achieved full funding of vaccine procurement by the government through UNICEF SD.

In 2000 UNICEF advocated for introduction of new vaccines **(Voice)** into the national immunisation calendar. UNICEF assisted the government in developing a GAVI proposal and adopting legislation for the introduction of new vaccines in the country **(Policy advice & TA and Leveraging)**. Furthermore UNICEF initiated and contributed to the inclusion of EPI related issues in the undergraduate and postgraduate education system **(Policy advice & TA)**, and financed in-service training of health professionals involved in immunization with new vaccines **(Knowledge exchange)**. In addition, UNICEF supported supplementary immunization campaigns on sustainable polio eradication **(Voice)**.

Figure 52: EPI Intervention Package Flow Chart mapped to UNICEF Core Roles



In 2000, UNICEF was also instrumental in supporting the government in the revision of legislation and regulations for safe immunization practices and AEFI **(Policy advice & TA)**. Through national dialogue UNICEF helped the government to develop SIP/AEFI guidelines and protocols, national standards, regulation documents and training curricula for inclusion of SIP/AEFI issues in the undergraduate and postgraduate education programs It also modified the EPI monitoring system, piloted SIP in selected geographical locations, trained health personnel and contributed to the national scale up **(Policy advice & TA)**. Furthermore

within the EPI intervention package UNICEF also supported the MoH in building national capacity in waste management **(Knowledge exchange)**.

As part of the global measles eradication initiative, MOH with UNICEF and USAID supported the implementation of a Measles-Rubella eradication campaign in Tashkent city in December 2006 **(Voice and Leveraging)**. USAID provided assistance through a grant for MR vaccines and supplies to Tashkent City Health Department. UNICEF utilised existing communication strategies and packages to ensure that this campaign was widely publicised throughout Tashkent through posters, mass media announcements, coordination with educational institutions, etc. **(Voice).** UNICEF also provided refresher trainings for approximately 1000 health workers on correct vaccination **(Knowledge exchange)**.

Under the EPI intervention package, UNICEF also supported the strengthening of vaccine and cold chain management informed by a Vaccine Management Assessment (**Monitoring & Evaluation and Policy advice & TA)**. UNICEF contributed to the development of an MOH Decree on Standard Operation Procedures of Vaccines Storages and Vaccines Management (2006) (**Policy advise & TA),** and built the capacity of EPI professionals (2006) **(Knowledge exchange)**. UNICEF also assisted the MoH in leveraging resources from JAICA to upgrade the cold chain equipment **(Leveraging).**

Table 31: UNICEF Core Role contribution to the implementation of EPI Intervention Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- In a joint process with WHO, UNICEF advocated for the introduction of new vaccines and enhancement of vaccine and cold chain management - UNICEF made instrumental contributions to the critical phases - Therefore UNICEF's contribution through the given Core Role is considered to be "Significant"
2. Monitoring & evaluation	3	- UNICEF contributed to the institutionalisation of the AEFI surveillance system at the national level - UNICEF's contribution through the given Core Role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF was instrumental in supporting the MoH in policy development through the provision of required technical assistance for development of SIP/AEFI and waste management standards, and an enabling legal environment - UNICEF assured inclusion of these issues in undergraduate and postgraduate education programmes and regulatory documents for vaccine and cold chain management - As UNICEF remained active during the evaluation period, its contribution through this core role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF assisted the MoH in preparation of the proposal for GAVI funding - Furthermore UNICEF continues to assist state procurement of vaccines through UNICEF SD by transferring public funding through UNICEF CO to UNICEF SD - UNICEF assisted the MoH in leveraging resources from JAICA for upgrade of cold chain equipment - Based on the above, UNICEF was successful in leveraging resources for EPI services from partner organization as well as state. Its contribution through this core role is considered as "Major/Critical"

5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period, UNICEF supported a number of events (conferences, workshops) and facilitated to national dialogue at critical stages - Therefore UNICEF's contribution through this core role is considered to be "Significant"
6.Enabling knowledge exchange	2	- UNICEF contributed to knowledge exchange through regional workshops/conferences and in-service training courses at critical moments of the evaluation period, as well as by integrating EPI related issues in the undergraduate and postgraduate education system - Thus UNICEF's contribution through this core role is considered to be "Significant"
7.Modeling/piloting	3	- UNICEF's pilot for introduction of SIP was successfully scaled up and institutionalised - Thus UNICEF's contribution through this core role is considered to be "Major/Critical".

IMCI INTERVENTION PACKAGE

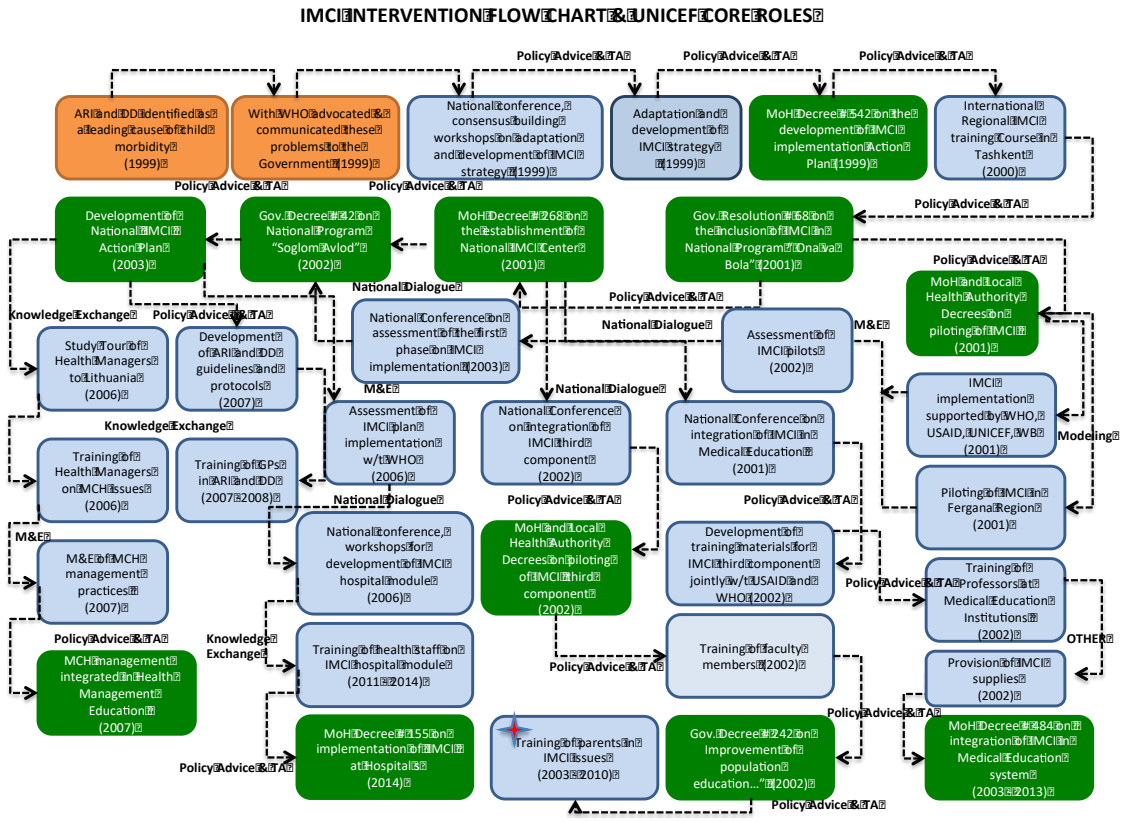
Conducted in 1996, an analysis of the global burden of diseases indicated that diseases such as pneumonia, acute respiratory infections and diarrhoea would remain the main causes of infant mortality if no remedial measures were taken. The fact that the majority of child morbidity and mortality in Uzbekistan was caused by these diseases served as a reason for implementation of the IMCI strategy starting from 1999.

WHO Euro advocated the Government of Uzbekistan to address these issues and, jointly with UNICEF, organized a national conference on IMCI, as well as workshops and round table discussions with key national and international stakeholders (**National dialogue)**. Consensus building and technical assistance efforts supported by UNICEF resulted in the adaptation and development of the IMCI strategy followed by the MoH Decree on IMCI implementation plan (**National dialogue and Policy Advice &TA)**.

In 2000 UNICEF jointly with WHO supported an International Regional IMCI training course in Tashkent (**Leveraging and Knowledge exchange),** and supported the integration of IMCI into the national programme "Ona va Bola", which was approved by Government resolution #68 in 2001 **(Policy advice & TA)**. To implement that resolution, the MoH and Local Health Authorities, with UNICEF's technical assistance, issued decrees for pilot implementation of IMCI in selected regions **(Policy advice & TA)**.

USAID Zdrav Reform and Project Hope, WB, UNICEF and WHO joined the Piloting/Modelling initiative of IMCI **(Modelling and Leveraging)**. With WHO technical support, UNICEF piloted the initiative in Fergana oblast **(Modeling**), while USAID supported programs piloted it in other geographical locations in the period of 2001-2002. In parallel UNICEF supported the MOH in the establishing a National IMCI Centre to oversee the implementation of IMCI related activities **(Policy advise & TA)**.

Figure 53: IMCI intervention package flow chart



Following Government Resolution #68 and the establishment of National IMCI Centre in 2001, UNICEF continues to support MOH activities in two directions:

1. Integration of IMCI in undergraduate and postgraduate medical education programs **(Policy advice & TA)**
    a. National Conference for integration of IMCI in undergraduate and postgraduate medical education programs (**National dialogue)**;
    b. Development of training materials for IMCI third component, jointly with USAID and WHO **(Policy advise & TA and Leveraging)**;
    c. Training of faculty members and professors on IMCI **(Knowledge exchange)**
2. Introduction of third component of IMCI at community level
    a. National Conference on integration of IMCI third component (2001) (**National dialogue)**;
    b. MoH and Local Health Authority Decrees on piloting of IMCI third component (2002) **(Policy advice & TA)**
    c. Inclusion of IMCI into the National Program on "improvement of medical culture of the family, women's health and on measures to develop healthy generation" **(Policy advice & TA)**.
    d. Training of parents through UNICEF supported Better Parenting and Family Education programmes in 6 regions (2003-2010) **(Knowledge exchange)**

UNICEF continued to promote Early Childhood Care and Development (EECD) from the very beginning of the evaluation period. UNICEF organised a study tour of government representatives to Turkey **(Knowledge exchange)**, assisted government representatives to participate in the area conference on ECCD **(Knowledge exchange),** and supported the government in establishing and operating a consultative group on ECCD **(Policy advice &**

TA). A series of round table discussions, workshops and TV programs have been organised to develop and promote a national ECCD concept (**Voice and National dialogue)**. The concept has been piloted in 2000 based on a special decree issued by the local government of Fergana **(Modelling)**. In the pilot region UNICEF supported the training of front line health professionals to orientate health workers to problem solving in the community. UNICEF supported the MoH to design and produce a "Health for All and Everyone" book, to develop ECD indicators and M&E framework, and to establish a Mother and Child Community-learning Centre. It also supported training for parents, relatives, teachers, school principals and community members on ECCD, and helped to develop methodological & instructive materials for teachers and children. The initial results and lessons learned from the pilot were presented at an area workshop on ECD in 2001. **(Policy advice & TA, Voice, Knowledge exchange).**

In 2002 UNICEF together with WHO supported an assessment of the IMCI pilot implementation **(Monitoring & Evaluation and Leveraging),** and organised a National conference on the results of the assessment **(National dialogue)**. It also supported inclusion of IMCI into the National Programme "Soglom Avlod", and in 2003 it supported development of the National IMCI Action Plan (**Policy advice & TA)**.

In 2003 UNICEF carried out an evaluation of the pilot and used the findings to further promote the scale up of the model through various advocacy events **(Voice).** As a result, MoH took the decision to scale up the ECCD/FEP model on a national level. In 2004 ECCD/FEP was integrated in the 'State Programme of Healthy Generation' and 'State Programme of Mother and Child' **(Policy advice & TA)**. Inter-sectoral Coordination Committees were established at national and local levels for overall project coordination and monitoring, and an ECCD/FEP advocacy/communication strategy was developed **(Policy advice & TA)**.

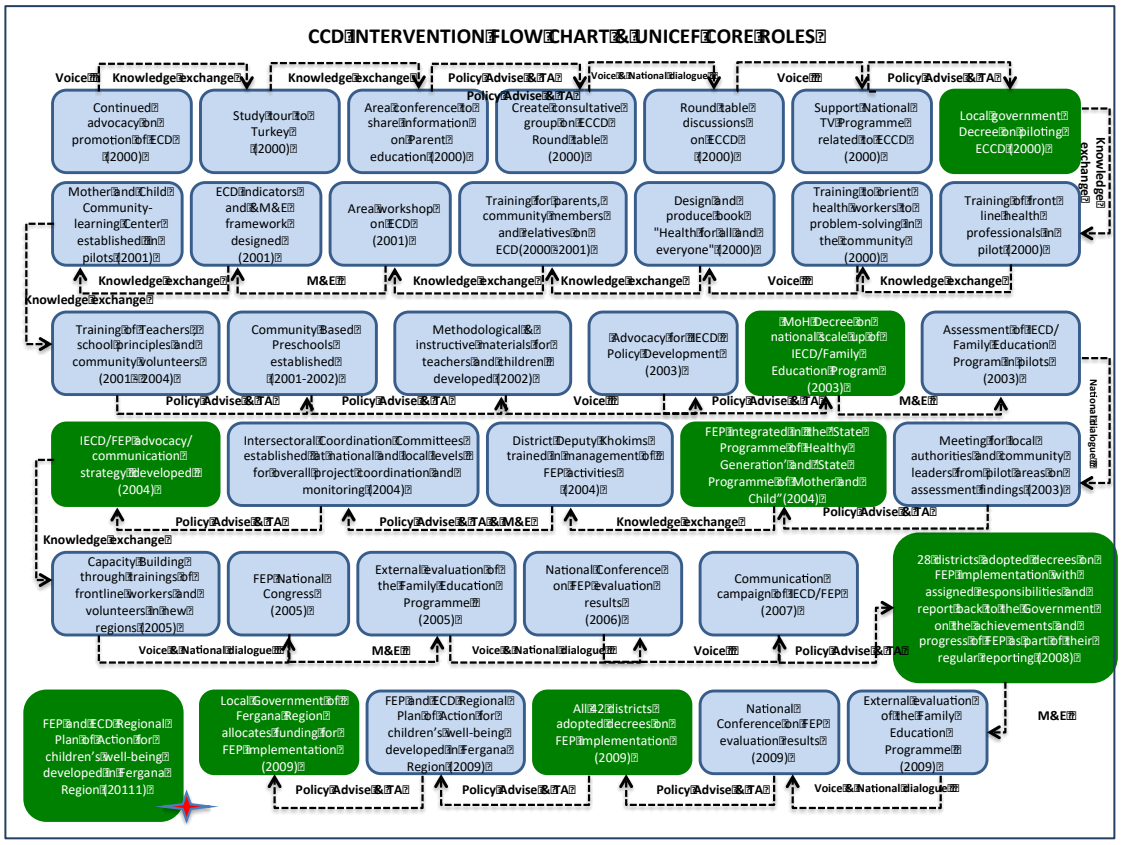
In the second CPAP period, UNICEF UZ CO was instructed to stop activities directed towards IMCI. Nevertheless, starting from 2006 UNICEF initiated support of MoH in the following directions:

1. Training of Health Managers in organization and management of MNCH services including IMCI issues.
    a. Study Tour of Health Managers to Lithuania (2006) **(Knowledge exchange)**
    b. Development of training materials for Health Managers on MNCH issues (2006) **(Policy advice & TA)**
    c. Training of Health Managers on MNCH issues (2006) **(Knowledge exchange)**
    d. Monitoring and evaluation of health manager MNCH practices (2007) **(Monitoring & Evaluation)**
    e. MNCH management was integrated in Health Management Education (2007) **(Policy advice & TA)**

2. Development of ARI and DD guidelines and protocols and building human resource capacity
    a. Development of ARI and DD guidelines and protocols (2006) **(Policy advice & TA)**
    b. Pre-tested clinical standards/guidelines on case management of ARI, Diarrheal Diseases (2006) **(Policy advice & TA and Monitoring & Evaluation)**
    c. Orientation workshops for deputy khokims (2007) **(Knowledge exchange)**
    d. TOT of GP trainers (2007) **(Knowledge exchange)**
    e. Supply of Zink and new ORS for enforcing of implementation of clinical guideline on diarrhoea diseases (2007) **(Other)**
    f. Printing of clinical guidelines on DD (2007) **(Policy advice & TA)**

g. Training on clinical guidelines on DD and ARI management in Ferghana oblast (2008) **(Modeling and Knowledge exchange)**
h. Monitoring of application of clinical guidelines in Ferghana oblast (2008) **(Monitoring & Evaluation)**

Figure 54: CCD sub- Intervention Package Flow Chart



In 2006 UNICEF supported the MoH in assessing IMCI implementation jointly with WHO **(monitoring & Evaluation and Leveraging)**. National conferences and workshops for the development of IMCI hospital module were supported (2006) **(National dialogue and Policy advice & TA)**. UNICEF assisted the MoH together with WHO and USAID in the development of training materials for hospital IMCI module (**Policy advice & TA and Leveraging)** and trained hospital staff (2011-2014) **(Knowledge exchange)**. UNICEF, jointly with the WB supported "Health 3" project, continued extensive training of medical staff **(Knowledge exchange and Leveraging)**. UNICEF assisted trainings in 6 regions, while the remaining regions are targeted by the WB "Health 3" Project. In addition UNICEF supported the MoH in developing a Decree on the institutionalisation of IMCI at hospitals in 2014 **(Policy advice & TA)**.

UNICEF continued implementation of the Family Education Program (FEP) **(Voice)**. Through a joint project, UNFPA and UNDP strengthened the capacity of Makhala advisors and women's committees **(Leveraging and Knowledge exchange)**. The advisors, together with volunteers, visited families, conducted community meeting and disseminated FEP messages. UNICEF operated in 6, high population density regions, and reached about 50% of the population. The FEP was designed alongside the third component of IMCI in partnership with USAID and WHO **(Leveraging)**: WHO provided technical support, USAID promoted community education program, while UNFPA and UNICEF divided the regions for joint programme targeting. To support national scale up, UNICEF provided FEP training to district Deputy

Khokims, front line workers and volunteers in the new regions **(Knowledge exchange)**. 28 districts adopted decrees on FEP implementation that assigned them clear responsibilities. They report back to the Government on the achievements and progress of FEP as part of their regular reporting.

A national congress on FEP was held in 2005 with wide participation from national, subnational and community representatives, legislative and executive bodies, NGOs and mass media **(National dialogue)**. Furthermore, the FEP programme was evaluated **(Monitoring & Evaluation)** and the results were presented at the FEP national conference (**National dialogue)**. One of the recommendations of the conference was to commission an external evaluation of the FEP programme for further improvement of programme design and effectiveness. The results of external evaluation **(Monitoring & Evaluation)** were also presented and discussed at the national conference **(National dialogue),** which led to the further extension of the program to all 42 districts in 2009. The Fergana local government allocated funds to ensure effective implementation of the programme **(Leveraging)**. In 2011 a FEP and ECD Regional Plan of Action for children's well being was developed **(Policy advice & TA)**. However, UNICEF stopped funding the programme at the end of 2011.

The capacity building of local authorities in monitoring the well-being of women and children was designed to help local decision-makers to understand and assume their responsibility as duty bearers for improved social service delivery at the local level **(Knowledge exchange)**. Weak managerial capacity was identified as a problem by the survey carried out in Khorezm region **(Monitoring & Evaluation)**. UNICEF communicated the need for strengthening MCH Management to the government **(Voice),** and organised a series of **knowledge exchange** study tours for government delegations to Lithuania and Iran.

In terms of local capacity building **(Knowledge exchange)**, UNICEF conducted a survey to identify priority needs of training among mid- and low-level state authorities **(Monitoring & Evaluation)**. Based on the findings of the survey, the State Academy, with the support of an international consultant, developed a special curriculum and trained 150 deputy governors on the Human Rights Based Approach to Programming and Result Based Management **(Policy advice & TA)**. These training modules became an integral part of the State Academy training programme and are fully financed by the government budget. The Health Management (HM) training course is included in the system of continuous professional development **(Policy advice & TA)**. The Medical Academy delivers HM courses annually and covers all managers from Oblast and district Health Departments and in-patient and outpatient facilities.

Improving the capacity of health managers at the field level has also been the focus of joint MOH and UNICEF activities **(Knowledge exchange and Leveraging)**. UNICEF supported MOH to develop a monitoring checklist with MNCH specific indicators, according to which managers may track progress, find problems related to MNCH services and solve them at the local level **(Policy advice & TA)**. Health care managers are trained on Maternal and Child Health (MNCH) and apply basic indicators to monitor MNCH services in 6 oblasts **(Knowledge exchange)**.

The HM course was initially piloted in 6 regions of the country and performance was subsequently monitored **(Modeling)**. The monitoring results were presented and discussed at a national conference **(National dialogue)**. Following the conference, a MoH Decree approved the state programme on training managers in Health Management and the integration of the HM training module into post diploma education programme **(Policy advice & TA)**.

After national scale up of the managers' training programme, UNICEF supported trainings in 6 regions of the country with a new training module on supportive supervision and quality improvement systems along with special training on the effective operationalisation of MNCH norms and standards.

Figure 55: MCHMNG sub- Intervention Package Flow Chart

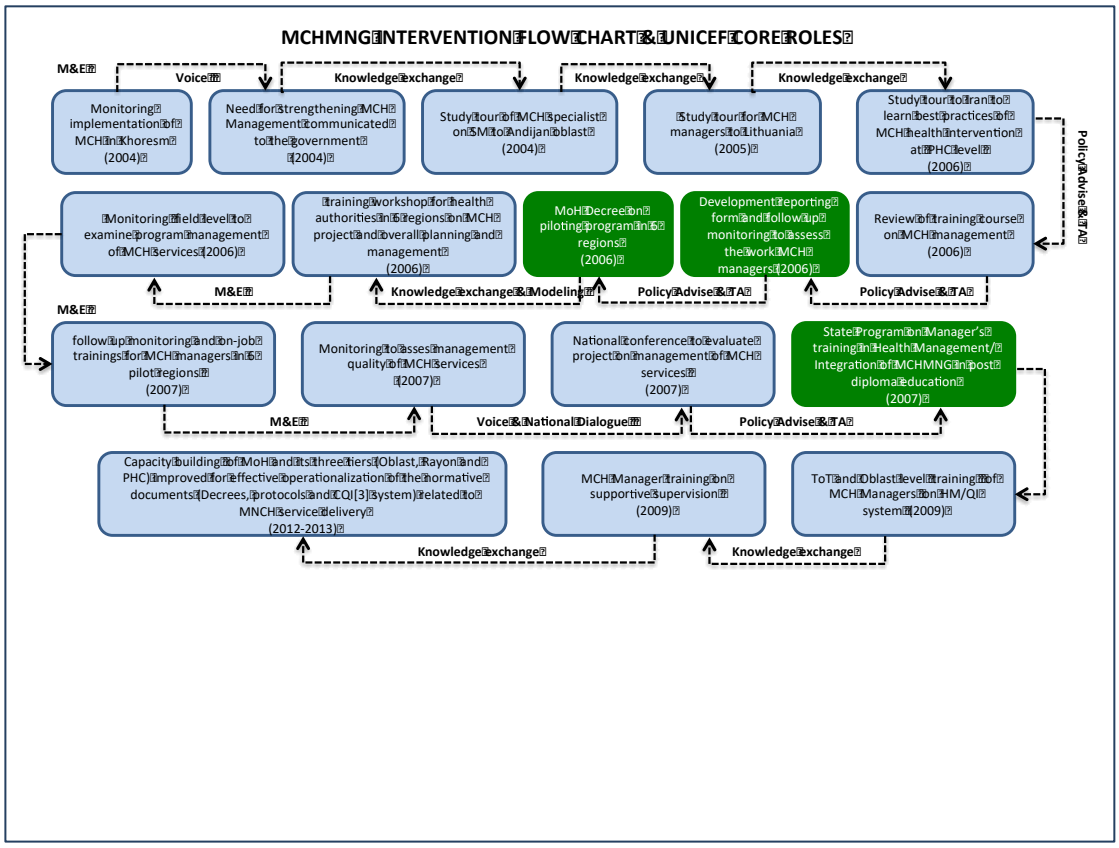


Table 32: UNICEF Core Role Contribution to the implementation of IMCI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on IMCI and ECCD related issues; was instrumental in using M&E results for evidence based advocacy; supported activities directed to awareness raising among national stakeholders; etc. - UNICEF remained active throughout the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through the core role is considered to be "Major/Critical"
2. Monitoring & evaluation	2	- UNICEF supported the MoH in assessing: IMCI pilot implementation, IMCI Implementation plan, and health manager practices in MCH and IMCI in particular. It also helped to assess the ECCD/FEP programme (third component of IMCI), which informed the design of UNICEF supported activities/interventions and ensured national and sub-national governments' commitment to employing the IMCI and ECCD/FEP model. - UNICEF also supported MOH in developing the MoH decree on institutionalising IMCI at the hospital level, which includes monitoring and reporting forms - As UNICEF joined the M&E processes led by WHO and

		contributed to critical phases, UNICEF's contribution through the core role is considered to be "Significant"
3. Policy advice and technical assistance	3	- UNICEF, jointly with WHO and USAID supported projects, provided policy advice and technical assistance to MoH, specifically in the adaptation of guidelines and protocols, development of strategies and legal and regulatory documents, national programmes, training materials and integration of IMCI in the education system, etc. - UNICEF remained active throughout the evaluation period and therefore its contribution through the core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IMCI package implementation from WHO, WB, UNFPA, USAID etc. - Thus its contribution through the core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF joined WHO in facilitating national dialogue on IMCI introduction. - UNICEF facilitated national dialogue for promotion of ECCD/FEP model in the country by organising workshops, round tables, sessions - UNICEF remained active throughout the evaluation period and supported a number of national conferences, workshops and round tables at different stages. - Therefore UNICEF's contribution through the core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of national and local health professionals, policy makers, MNCH health managers, deputy khokims, PHC front line staff and community volunteers in 6 UNICEF targeted districts, while UNFPA supported the remaining ones - UNICEF supported a number of knowledge sharing events, although in the period of 2004-2007 UNICEF stopped promoting IMCI at the request of UNICEF RO and instead supported capacity building of GPs at PHC level in ARI and DD - UNICEF remained an active player in building the capacity of national and local governments and policy makers - Since 2009, UNICEF has remained the only supporter of the human resource capacity building in the country. Therefore UNICEF's contribution through the core role is considered to be "Significant".
7.Modelling/piloting	2	- UNICEF supported the piloting of IMCI in Fergana oblast and further extended it to another 6 regions, while the remaining part of the country was covered by USAID projects - UNICEF also supported the institutionalisation of IMCI at the hospital level in selected regions, which eventually resulted in national scale up - Furthermore, UNICEF supported integration of IMCI in undergraduate and postgraduate education programmes and training of professors and lecturers in pilot oblasts and supported national scale up. - UNICEF supported piloting of ECCD/FEP program in Fergana region, which was eventually scaled up to the national level with joint support from a UNDP, UNICEF and UNFPA project. - The pilot was operation till 2011, but discontinued afterwards. Nevertheless, UNICEF's contribution through the core role is considered to be "Significant".

NUTRITION INTERVENTION PACKAGE

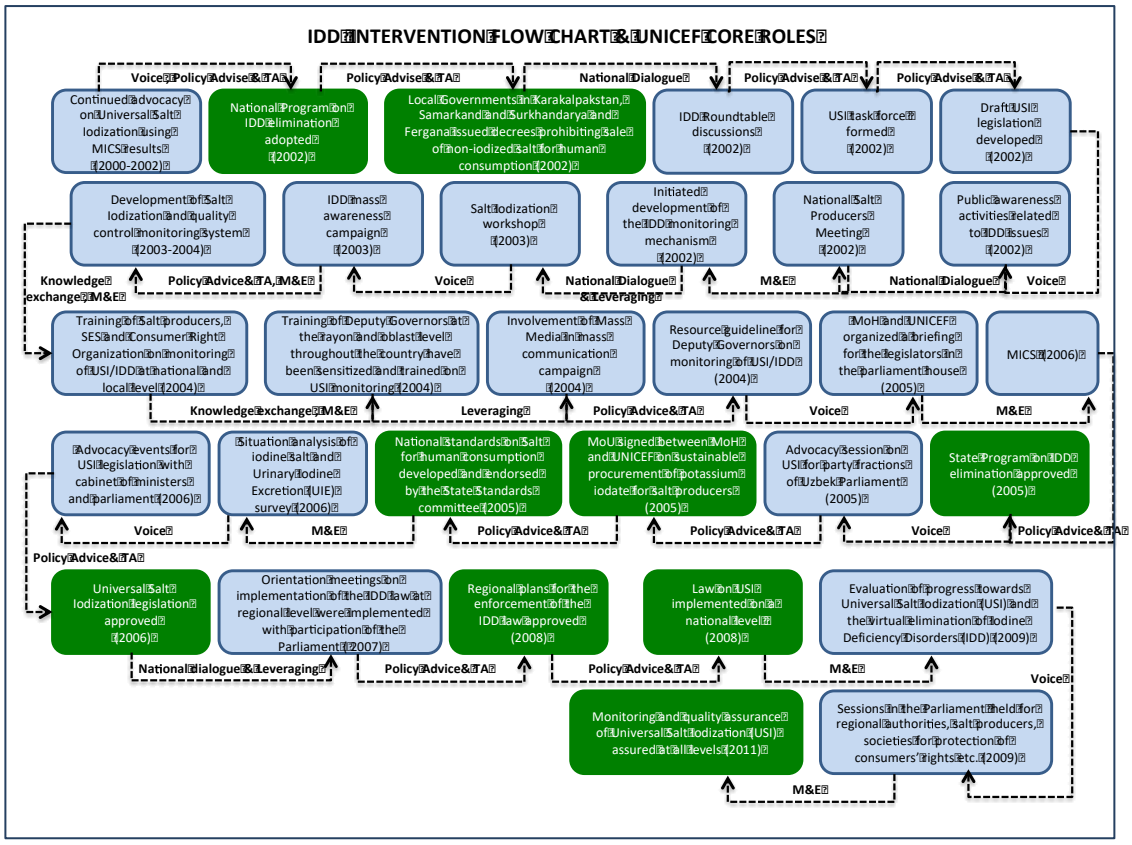
IODINE DEFICIENCY DISORDERS (IDD) SUB- INTERVENTION PACKAGE

Starting from 2000, UNICEF continued advocacy on IDD as one of the key issues of child morbidity **(Voice)**. Using MICS 2000 results **(Monitoring & Evaluation)**, UNICEF organised a number of advocacy related meetings, workshops **(National dialogue)**, and advised and assisted the government in the development of the first National IDD Elimination programme **(Policy advice & TA)**. In the absence of national legislation on salt iodization, the local governments of Karkalpakstan, Samarkand and Surkhandaria responded to UNICEF's advice by adopting local legislation on salt iodization. This initiative was followed by a number of round table discussions and meetings with various national and subnational, public and private stakeholders **(National dialogue)**. A national Universal Salt Iodization (USI) task force was formed that facilitated the development of USI draft legislation with UNICEF's technical support **(Policy advice & TA)**. In addition, UNICEF assisted the Task Force in the development of a salt iodization and quality monitoring system **(Policy advice & TA),** and implemented a number of public awareness activities related to IDD issues **(Voice)**.

In 2002, with UNICEF's support, a National Salt Producers meeting was held, followed by salt iodization workshops and training of salt producers, SES and Consumer Right Organizations on monitoring USI/IDD at national and local level. UNICEF also trained deputy Governors at the rayon and oblast level throughout the country and sensitised them on USI monitoring **(Voice and National dialogue)**. A resource guideline for Deputy Governors on monitoring of USI/IDD were developed and distributed during the training **(Policy advice & TA)**.

One of the key achievements was a mass iodization campaign, which was held in 2004 with UNICEF's financial and technical support **(Voice and Leveraging)**. The campaign aimed to increase school children's awareness of the importance of consuming iodized salt to combat IDD. More than 6 million school children from 9,600 schools tested salt samples from their homes for iodine content. This exercise was supported by a lesson on IDD. In 2004, under the leadership of the Youth Parliament, school children collected signatures to support the campaign on elimination of IDD through the use of iodized salt. The Presidential Institute on Strategic Studies prepared an analytical report to reinforce the legislation. UNICEF was also instrumental in involving the mass media in communication campaigns.

Figure 56: IDD sub- Intervention Package Flow Chart



In order to promote timely approval of the draft legislation, MoH and UNICEF organised a briefing for the legislators in the parliament house using preliminary data from MICS 3, which led to the development and approval of the National Programme on IDD Elimination in 2005 **(Voice)**. UNICEF actively promoted advocacy sessions on USI for different party factions of Uzbek Parliament; signed an MoU with MoH on sustainable procurement of potassium iodate for salt producers; assisted the MoH in the development of national standards on salt for human consumption and endorsement by the State Standards Committee; conducted a situation analysis of iodine salt and Urinary Iodine Excretion (UIE) survey **(Monitoring & Evaluation)**, and used the results for advocacy on USI legislation with the cabinet of ministers and parliament, which resulted in the adoption of USI legislation in 2006.

To facilitate timely and effective implementation of USI legislation, UNICEF, together with national partners and the Uzbek Parliament, organized orientation meetings on implementation of the IDD law at regional level **(Voice)**; provided technical assistance for the development of regional plans for the enforcement of IDD; and facilitated national implementation of the law **(Policy advise & TA)**. Later in 2009, UNICEF provided technical assistance to the government to evaluate progress towards USI **(Monitoring and Evaluation)** and the virtual elimination of IDD. The findings of the evaluation were presented at a parliamentary session held for regional authorities, salt producers, societies for protection of consumers' rights etc. **(National dialogue)**. By 2011 monitoring and quality assurance of USI was assured at all levels.

Table 33: IDD Intervention Sub-Package contribution to UNICEF Core Role

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated advocacy on IDD and USI - UNICEF remained active through out the evaluation period and organized a number of advocacy events to facilitate and promote adoption and implementation of USI legislation - Therefore UNICEF's contribution through the core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- UNICEF supported the government in the design and institutionalisation of USI quality monitoring system; trained salt producers, SES and Consumer Right Organization on monitoring of USI/IDD at national and local level; trained Deputy Governors at the rayon and oblast level throughout the country on USI monitoring; and developed resource guidelines for Deputy Governors on monitoring of USI/IDD; - UNICEF assured monitoring and quality assurance of USI at all levels - UNICEF's contribution through the core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of National Programme on IDD elimination; National standards on Salt for human consumption; USI legislation; Regional plans for the enforcement of the IDD law. UNICEF also institutionalised monitoring and quality assurance of USI nationwide; - UNICEF remained active throughout the evaluation period and - Therefore its contribution through the core role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IDD elimination and USI through legislative and executive branches of the government, mass media, and mobilised schools to raise awareness on salt iodization and IDD related issues; - UNICEF signed an MOU with MoH on sustainable procurement of potassium iodate for salt producers from the state budget through UNICEF's Supply Division; - UNICEF, together with the WB, supported development of "Nutrition Investment Plan" - Therefore its contribution through the core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF facilitated a national dialogue on IDD and USI related issues by organising salt iodization workshops, round tables, sessions at the parliament and in the Cabinet of Ministers. - UNICEF held orientation meetings for local governments for effective implementation of USI legislation - UNICEF remained active through out the evaluation period - Therefore UNICEF's contribution through the core role has been considered to be "Major/Critical"
6. Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local governments, policy makers, salt producers, SES and Consumer Rights Organisations, and supported a number of knowledge sharing events - UNICEF remained a key supporter of the human resource capacity building in the country in the area of IDD and USI - Therefore UNICEF's contribution through the core role is

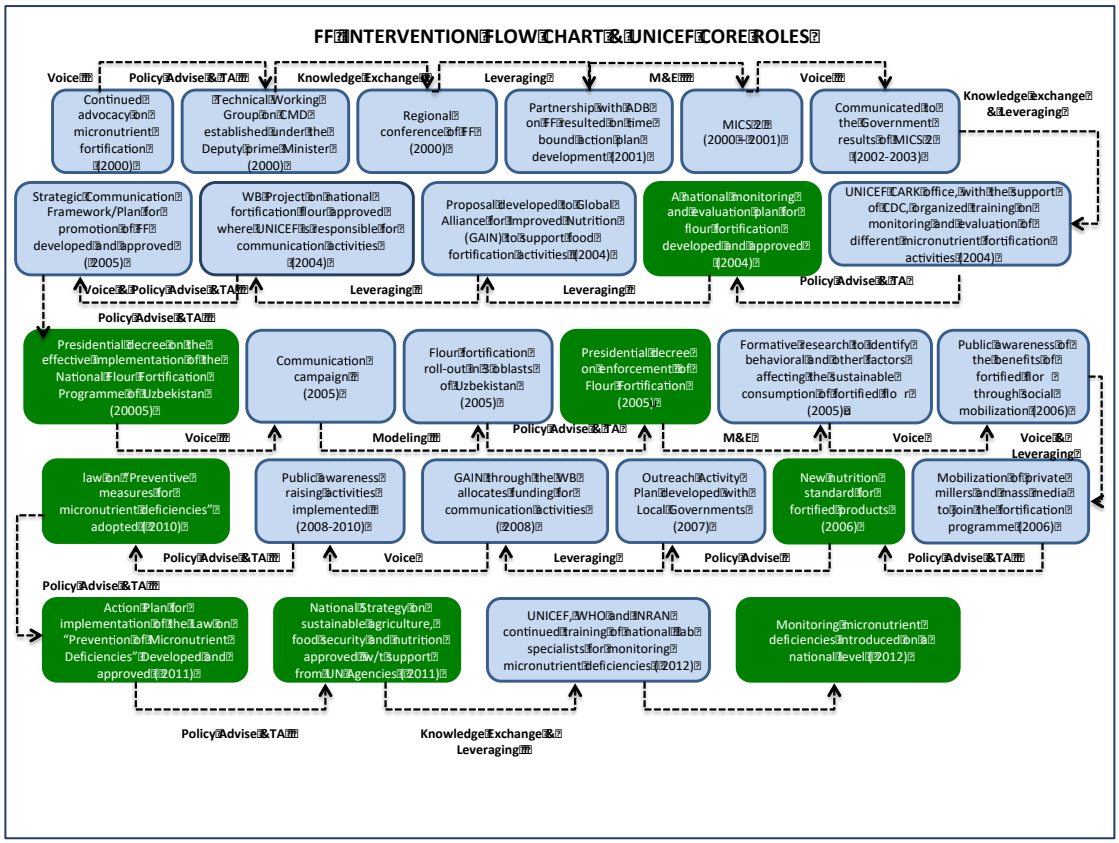
		considered to be “Major/Critical”
7.Modelling/piloting	3	- UNICEF supported local governments in Karakalpakstan, Samarkand and Surkhandarya and Fergana in issuing and implementing decrees prohibiting the sale of non-iodised salt for human consumption as well as monitoring the quality of salt iodisation - Later in 2006 with the adoption of USI legislation, salt iodisation and quality monitoring was scaled up nationally - Therefore, UNICEF’s contribution through the core role is considered to be “Major/Critical”

FLOUR FORTIFICATION SUB- INTERVENTION PACKAGE

UNICEF continues to advocate the government on micronutrient fortification issues **(Voice)**. In response, the government established a Technical Working Group on control of micronutrient deficiencies under the Deputy Prime Minister. National stakeholders have been supported to participate in a regional conference on food/Flour Fortification (FF) **(Knowledge exchange)**. UNICEF’s advocacy efforts resulted in leveraging resources from ADB and the establishment of partnership **(Leveraging)**. UNICEF jointly with the government and ADB developed a time bound action plan **(Policy advice & TA)**.

UNICEF has used the results of MICS 2 **(Monitoring & Evaluation)** for continuing advocacy of the government in support of FF in the country. National stakeholders participated in the training on monitoring and evaluation of different micronutrient fortification activities, which was supported by UNICEF CARK office and CDC **(Knowledge exchange and Leveraging)**. Following awareness raising and capacity building of national stakeholders, and technical support made available by UNICEF, a National FF Monitoring plan was developed and adopted by the government **(Policy advice & TA)**.

Figure 57: FF sub- Intervention Package Flow Chart



A successful proposal was made to the Global Alliance for Improved Nutrition (GAIN) to support food fortification activities **(Leveraging).** Funding was made available by GAIN through the World Bank, with UNICEF identified as the implementing partner for the communication component of the national FF programme. Within the frame of the given project UNICEF supported the development of a strategic communication framework/plan for promotion of FF **(Policy advice & TA)** and implemented extensive communication activities to raise the awareness of the population, and to increase demand for and consumption of FF **(Voice)**.

Resources made available through the WB project allowed UNICEF to support the government in the development and adoption of a Presidential decree on the effective implementation of the National Flour Fortification Programme of Uzbekistan **(Policy advice & TA)**. Once the Presidential decree was issued, flour fortification was rolled-out in 3 oblasts of Uzbekistan with UNICEF's assistance. In order to accelerate FF in the country, a second presidential decree was issued.

UNICEF also supported formative research **(Monitoring & Evaluation)** to identify behavioural and other factors affecting the sustainable consumption of fortified flour. The findings eventually informed UNICEF's communication activities and informed public awareness raising on the benefits of fortified flour. UNICEF was instrumental in leveraging private sector resources by mobilising private millers and mass media to join the fortification programme **(Leveraging)**.

Technical assistance was made available to the government for the development of new nutrition standards for fortified products as well as for the development of outreach activities **(Policy advice & TA)**.

Support was also made available to the government to development the law on "Preventive measures for micronutrient deficiencies". Subsequently, the National Strategy on

sustainable agriculture, food security and nutrition was approved with support from UNICEF and other UN Agencies in 2011 **(Policy advice & TA and Leveraging)**. Furthermore UNICEF, jointly with WHO, continued to train national lab specialists to monitor micronutrient deficiencies, thus supporting the institutionalisation of monitoring of micronutrient deficiencies at a national level **(Knowledge exchange and Leveraging)**.

Table 34: FF Intervention Sub-Package contribution to UNICEF Core Role

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on FF; was instrumental in using M&E results for evidence based advocacy of the government; supported activities directed to awareness raising and demand creation for fortified flour; etc. - UNICEF remained active through out the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions as well as informed advocacy events; - UNICEF also supported the enhancement of national lab capacity for institutionalisation of monitoring micronutrient deficiencies in the country - UNICEF's contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of a national monitoring and evaluation plan for flour fortification; a Presidential decree on the effective implementation of the National Flour Fortification Programme of Uzbekistan; a law on "Preventive measures for micronutrient deficiencies"; new nutrition standard for fortified products and a National Strategy on sustainable agriculture, food security and nutrition - UNICEF remained active throughout the evaluation period - Therefore its contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of FF through legislative and executive branches of the government, mass media and private sector; - UNICEF leveraged financial resources through GAIN and became an implementer of the WB national flour fortification programme - Therefore its contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- UNICEF facilitated national dialogue on the control of micronutrient deficiencies and FF related issues by organising workshops, round tables, sessions at critical points of the program - Therefore UNICEF's contribution through this core role is considered to be "Significant"
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of national and local governments and policy makers, private millers and national laboratory staff; - On a number of occasions UNICEF ensured national

		representation in international knowledge sharing events such as Regional Conference on FF, Area Conference on CMD, etc. - UNICEF only supported national capacity building on a limited scale - Therefore UNICEF's contribution through this core role is considered to be "Significant".
7.Modelling/piloting	3	- UNICEF supported piloting of FF in the Oblasts of the country, which was eventually scaled up at national level; - UNICEF's contribution to through this core role is considered to be "Major/Critical"

IDA SUB- INTERVENTION PACKAGES

Starting from 2000, UNICEF continued advocacy efforts to promote issues of the control, micronutrient deficiencies in the country and anaemia prevention among other micronutrient deficiencies **(Voice)**. A rapid nutrition assessment and evaluation of anaemia prevention and control programmes (APC), coupled with an assessment and monitoring of progress of CMD implementation **(Monitoring & Evaluation),** largely informed UNICEF's advocacy agenda and programming. As a result of UNICEF's advocacy issues, CMD was put on the top of the government agenda, and a CMD Technical Working Group established in the prime minister's office **(Voice)**.

In 2001 the Government took the decision to pilot CMD related activities in Fergana region **(Modelling)**, including the APC interventions for which the local government issued a decree.

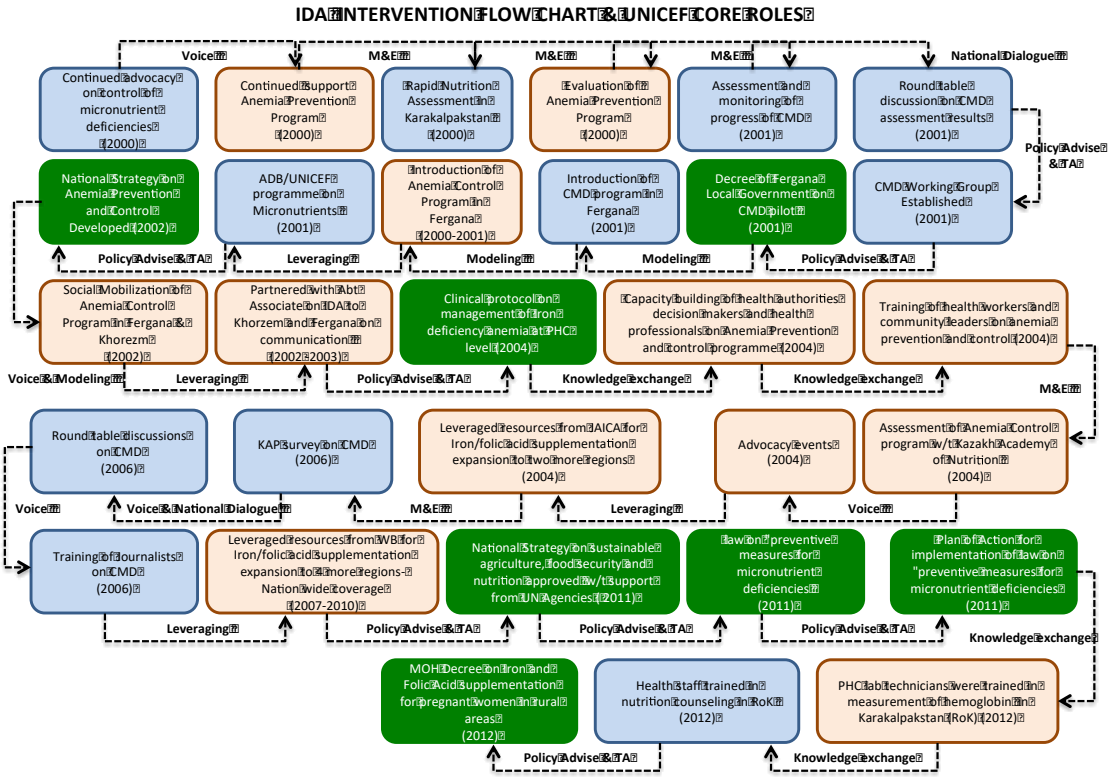
To support the government's efforts in CMD, UNICEF leveraged funding from ADB **(Leveraging)** and, among other activities, assisted the government in the development of National Strategy on Anaemia Prevention and Control **(Policy advice & TA)** and implemented the social mobilisation of Anaemia Control Programme in Fergana & Khorezm, in partnership with a USAID funded project **(Voice and Leveraging)**.

A clinical protocol on the management of iron deficiency anaemia at the PHC level was developed **(Policy advice & TA)** and implemented in Ferghana Oblast in cooperation with Zdrav Plus, a USAID supported project **(Modelling and Leveraging)**. Extensive training aas provided to health workers and community leaders on anaemia prevention and control **(Knowledge exchange)**.

In 2004, UNICEF supported the government in the assessment of the Anaemia Control program with the Kazakh Academy of Nutrition **(Monitoring & Evaluation)**. The findings were communicated to the wider group of national stakeholders and international partners through round table discussions organised by UNICEF **(National dialogue)**, which resulted in leveraging resources from JAICA for Iron/folic acid supplementation expansion to two more regions of the country **(Leveraging)**. Furthermore leveraged resources from WB enabled iron/folic acid supplementation to be expanded to 4 more regions, thus achieving nationwide coverage **(Leveraging)**.

With the support of UNICEF and other UN Agencies, the Government developed and adopted a national strategy on sustainable agriculture, food security and nutrition **(Policy advice & TA and Leveraging)**.

Figure 58: IDA sub- Intervention Package Flow Chart



Moreover, a law on "preventive measures for micronutrient deficiencies" was approved in 2011, and UNICEF assisted the government in preparing a plan of action for the implementation of a law on "preventive measures for micronutrient deficiencies **(Policy advice & TA)**.

UNICEF also aided the government to train PHC lab technicians in measurement of haemoglobin and health staff in nutrition counselling in the Republic of Karakalpakstan **(Knowledge exchange)**. In 2012, the MoH introduced a iron and folic acid supplementation programme for pregnant women in rural areas of Uzbekistan and ensures state funding for the procurement of iron and folic acid **(Leveraging)**.

Table 35: IDA Intervention Sub-Package contribution to UNICEF Core Role

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on CMD and IDA in particular; was instrumental in using M&E results for evidence based advocacy; supported activities directed to awareness raising among public and mass media; etc. - UNICEF remained active through out the evaluation period and organized a number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions and informed advocacy events; - UNICEF also supported the enhancement of national lab capacity for institutionalisation of monitoring micronutrient deficiencies in the country - UNICEF's contribution through this core role is considered to

		be ”Major/Critical”
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of a National Strategy on Anaemia Prevention and Control; a Clinical protocol on management of iron deficiency anaemia at PHC; a National Strategy on sustainable agriculture, food security and nutrition; a law on "preventive measures for micronutrient deficiencies”; a Plan of Action for implementation of the law on "preventive measures for micronutrient deficiencies”; and an MOH Decree on Iron and Folic Acid supplementation for pregnant women in rural areas - UNICEF remained active throughout the evaluation period - Therefore its contribution through this core role is considered to be ”Major/Critical”
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IDA and CMPD through legislative and executive branches of the government, mass media and private sector; - UNICEF leveraged financial resources through GAIN and became an implementer of WB, ADB and USAID funded programs supporting CMD - Therefore its contribution through this core role is considered to be ”Major/Critical”
5. Facilitating national dialogue towards child friendly social norms	2	- UNICEF facilitated national dialogue on the control of micronutrient deficiencies and FF related issues by organising workshops, round tables, sessions at critical points of the programme - Therefore UNICEF’s contribution through this core role is considered to be “Significant”
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of national and local governments, policy makers and PHC staff; - UNICEF support for national capacity building only on a limited scale - Therefore UNICEF’s contribution through this core role is considered to be “Significant”
7.Modelling/piloting	3	- UNICEF supported piloting of APC programs in the Oblasts of the country which were eventually scaled up at national level with support from WB and ADB; - UNICEF’s contribution through this core role is considered to be ”Major/Critical”

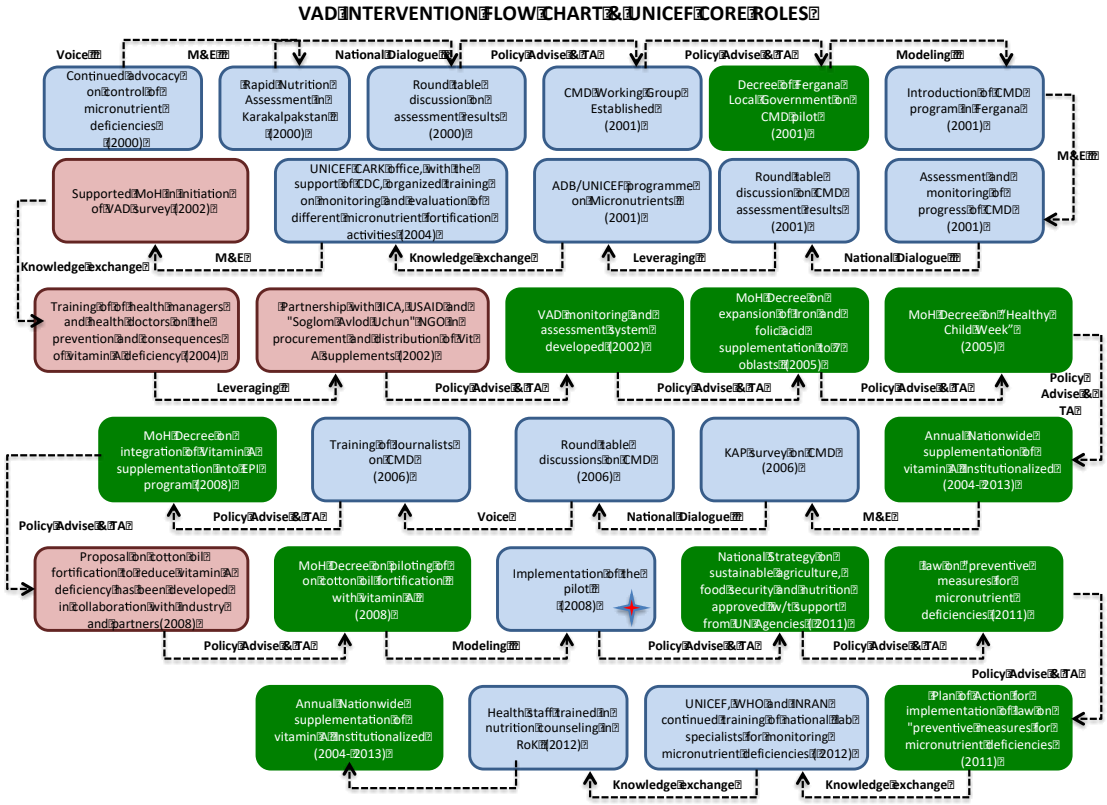
VAD SUB- INTERVENTION PACKAGES

Control of Vitamin A Deficiency has been acknowledged as one of the key contributors to improved child morbidity in Uzbekistan. The results of a rapid nutrition assessment in the Republic of Karakalpakstan **(Monitoring & Evaluation)** have been used to advocate for vitamin A supplementation as part of the larger package of control of micronutrient deficiencies through organisation of round table discussions with wide participation of national stakeholders **(Voice and National dialogue)**. As a result of UNICEF’s advocacy, issues of CMD including VAD were put on the top government agenda, and a CMD Technical Working Group established at the prime minister’s office.

In 2001 the Government took the decision to pilot CMD related activities in Fergana region **(Modeling)**, including VAD interventions for which the local government issued a decree.

To support the government's efforts in CMD and VAD in particular, UNICEF leveraged funding from ADB **(Leveraging)** and among other activities assisted the government in initiation of VAD survey **(Monitoring & Evaluation)** and establishment of VAD monitoring system **(Policy advice & TA)**, although this system is no longer operation.

Figure 59: VAD sub- Intervention Package Flow Chart



In partnership with JICA, USAID and "Soglom Avlod Uchun" NGO, UNICEF continued the procurement and distribution of Vitamin A supplements to pilot oblasts in the country **(Leveraging and Other)**. In 2005 the MoH issued decrees to expand further the pilots to another 7 regions and to introduce an annual "Healthy Child Week", which implied organising a health child week twice per year and providing Vitamin A supplementation to children. Monitoring visits prior to the organization of "Healthy Child Week" stipulated training health managers and health doctors on the prevention and consequences of vitamin A deficiency **(Knowledge exchange)**. Paediatricians and medical nurses carried out nationwide supplementation of vitamin A, with training provided by the MoH.

A UNICEF supported KAP survey on CMD **(Monitoring & Evaluation)** informed the government's decision to integrate vitamin A supplementation into the EPI program, for which UNICEF made technical assistance available **(Policy advice & TA)**. Furthermore, the government endorsed the piloting of cotton oil fortification to reduce vitamin A deficiency **(Modelling)**, although this project was not continued further after the pilot ended.

With support of UNICEF and other UN Agencies the Government developed and adopted a national strategy on sustainable agriculture, food security and nutrition **(Policy advice & TA and Leveraging)**.

Moreover, following the approval of the law on "preventive measures for micronutrient deficiencies" in 2011, UNICEF assisted the government in preparing a plan of action for implementation of the law **(Policy advice & TA)**.

Table 36: UNICEF Core Role contribution to the implementation of VAD Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on CMD and VAD in particular; was instrumental in using M&E results for evidence based advocacy; supported activities directed to awareness raising among public and mass media; etc. - UNICEF remained active through out the evaluation period and organized number of advocacy events - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	2	- During the evaluation period UNICEF supported a number of researches and studies that informed design of UNICEF supported activities/interventions as well as informed advocacy events; - UNICEF also supported enhancement of national lab capacity for institutionalization of monitoring micronutrient deficiencies in the country and VAD monitoring and assessment system, however the latter has been discontinued by the Government - Therefore UNICEF's contribution through this core role is considered to be "Significant"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of a MoH Decree on "Healthy Child Week" supporting annual nationwide supplementation of vitamin A institutionalization; integration of Vitamin A supplementation into EPI program; a MoH Decree on piloting of on cotton oil fortification with vitamin A; National Strategy on sustainable agriculture, food security and nutrition and law on "preventive measures for micronutrient deficiencies" - UNICEF remained active throughout the evaluation period and - Therefore its contribution through this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of VAD and CMD through legislative and executive branches of the government, mass media and private sector; - UNICEF leveraged financial resources through GAIN and became an implementer of WB, ADB and USAID funded programs supporting CMD - Therefore its contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- UNICEF facilitated national dialogue on control of micronutrient deficiencies and VAD related issues by organising workshops, round tables, sessions at critical points of the programme - Therefore UNICEF's contribution through this core role is considered to be "Significant"
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of national and local governments, policy makers and PHC staff; - UNICEF only supported national capacity building on a limited scale - Therefore UNICEF's contribution through this core role is considered to be "Significant".
7.Modeling/piloting	3	- UNICEF supported piloting of VAD programmes in regions of

		the country, which were eventually scaled up at national level with support from WB and ADB; - UNICEF's contribution through this core role is considered to be "Major/Critical"

BF & BFHI SUB- INTERVENTION PACKAGE

UNICEF first initiated breastfeeding related intervention prior to the evaluation period. In 1993, the MoH created a centre for breastfeeding support and promotion, and approved a National Policy on Protection, Support and Encouragement of Breastfeeding Practice. The policy instructed health care settings to apply principles of BFHI and promote exclusive breastfeeding up to 4 months. Following the policy the Breastfeeding Working Group was established, which developed guidelines and training modules for health care providers, based on the WHO/UNICEF 40 hour and 18 hour training courses on breastfeeding counselling for lactation managers and BFHI workers respectively. In 1999 the Government. with the support of UNICEF, adopted the "National Policy on Breastfeeding Promotion and Support in Uzbekistan" **(Policy advice & TA)**. This policy promoted exclusive breastfeeding up to 6 months and outlines education measures to improve BF practices, training of health personnel at maternities and strengthening of BFHI in 6 pilot regions.

Starting from 2000, the composition of the BF working group was reviewed, and UNICEF made available support to draft legislation and set up an inter-agency group to coordinate promotion of the legislation **(Policy advice & TA)**. Together with WHO, UNICEF supported area wide training on breastfeeding **(Knowledge exchange and Leveraging)**. Support was also rendered for annual celebration of the world breastfeeding week through printing and distributing information materials and organising different events **(Voice)**. In order to promote adoption of International Code of Marketing of Breast Milk Substitutes (ICBMS), UNICEF financed participation of policy makers in an International Conference on ICBMS **(Knowledge exchange)**.

In order to further promote breastfeeding, UNICEF continued provision of trainings in candidate BFHI hospitals and BFHI certification process. Training PHC/community health personnel was another important area that UNICEF supported **(Knowledge exchange)**.

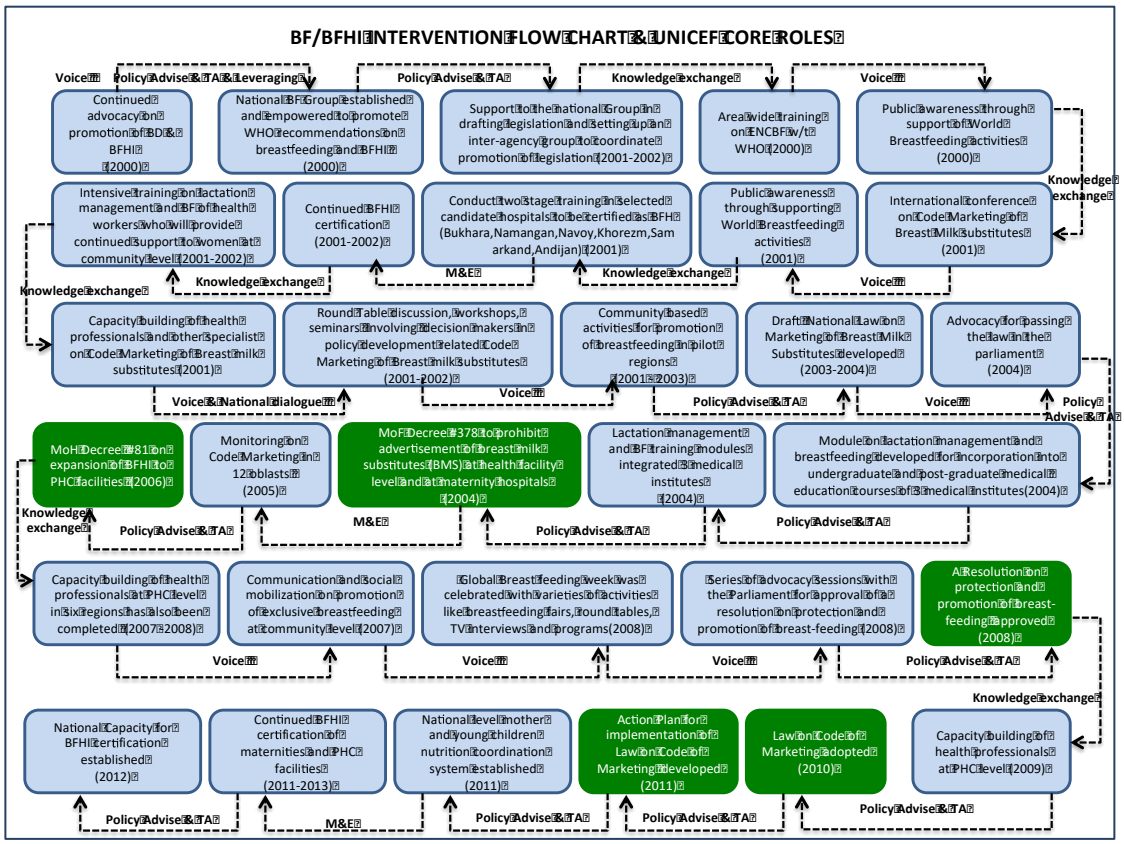
UNICEF advocacy efforts for adoption of ICBMS law were strengthened by building the capacity of health professionals and other specialists on the Code **(Knowledge exchange)**; organising roundtables, workshops and seminars with policy makers and national stakeholders **(National dialogue)**; community based breastfeeding promotion activities in pilot regions; and the provision of technical assistance to the BF working group to draft a law on marketing breast milk substitutes **(Policy advice & TA)**. As a result of these advocacy efforts, the MoH issued Decree #378 to prohibit advertisement of breast milk substitutes (BMS) at health facility level and at maternity hospitals.

In order to ensure the sustainability of BF&BFHI trainings in the country, a module on lactation management and breastfeeding was developed and incorporated into undergraduate and post-graduate medical education courses in 3 medical institutes **(Policy advice & TA)**.

UNICEF also supported the monitoring of Code Marketing in 12 oblasts of the country **(Monitoring & Evaluation)**. Based on the results of these activities, the MoH issued Decree #81 on expansion of BFHI to PHC facilities with UNICEF's support **(Policy advice & TA)**. UNICEF has ensured continuous support for BFHI certification up to now. UNICEF also

continues to support trainings for health professionals and community education activities through cascade training **(Knowledge exchange)**.

Figure 60: BF&BFHI sub- Intervention Package Flow Chart



UNICEF's advocacy efforts with parliamentarians **(Voice)** finally resulted in the issuance of a Resolution on protecting and promoting breast-feeding in 2008, and the approval of the ICMBS law in 2010. In order to make the law operational, UNICEF supported the government in the development of an action plan for implementation of the Law on Code of Marketing **(Policy advise & TA)** as well as establishing the national capacity for BFHI certification, although UNICEF still continues to finance the certification process up to now.

Table 37: UNICEF Core Role contribution to the implementation of BF&BFHI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF initiated and continued advocacy on BF&BFHI; was instrumental in using M&E results for evidence based advocacy; supported activities directed to awareness raising among public and mass media; etc. - UNICEF remained active throughout the evaluation period and organized number of advocacy events - Therefore UNICEF's contribution through the core role is considered to be "Major/Critical"
2. Monitoring & evaluation	2	- During the evaluation period UNICEF supported a number of M&E activities directed towards BFHI certification and monitoring Code of marketing amongst other things, which informed the design of UNICEF supported activities/interventions and advocacy events; - UNICEF also supported inclusion of BF indicators into routine

		statistics, but the system fails to report on exclusive breastfeeding at the age of 6 months - Therefore UNICEF's contribution through the core role is considered to be "Significant"
3. Policy advice and technical assistance	3	- UNICEF initiated and assisted the government in the development and adoption of MoH decrees in support of BFHI and marketing of breast milk substitutes. - UNICEF remained active throughout the evaluation period - Therefore its contribution to Core role is considered to be "Major/Critical"
4. Leveraging resources	1	- UNICEF was less successful in leveraging resources from development partners, and rather managed to fundraise for UNICEF led programmes; - Therefore its contribution through the core role is considered to be "Significant"
5. Facilitating national dialogue towards child friendly social norms	2	- UNICEF facilitated national dialogue on BF&BFHI, ICMBS related issues by organising workshops, round tables, sessions at critical points of the programme - Therefore UNICEF's contribution through the core role is considered to be "Significant"
6. Enabling knowledge exchange	2	- UNICEF remained as active player in capacity building of national and local governments, policy makers and health staff; - UNICEF initiated integration of BF related issues into undergraduate and postgraduate education system, although this remains a work in progress - Therefore UNICEF's contribution through the core role is considered to be "Significant".
7.Modeling/piloting	3	- UNICEF supported the piloting of BF& BFHI in 6 regions of the country, which have eventually been scaled up at national level; - UNICEF's contribution through the core role is considered to be "Major/Critical"

SERBIA

ANC/PNC INTERVENTION PACKAGE

PERINATAL AND NEONATAL CARE SUB-PACKAGE

UNICEF's involvement in perinatal care activities started much earlier than the beginning of the evaluation period. By the year 2000, safe motherhood and newborn care related guidelines had been developed and included in the IMCH education curricula (See under IMCI sub-package of interventions).

Right after the bombing of Serbia in 1999, UNICEF supported the MoH in a situation analysis of women and children **(Monitoring & Evaluation)**, which revealed shortages in basic medical equipment, supplies and deteriorating heating systems. The results were presented to national and international partners **(Voice and National dialogue),** and in response UNICEF leveraged donor resources **(Leveraging)** and provided humanitarian assistance to maternities through the provision of basic equipment, bed linen, matresses and fuel for heating **(Other)**. As a result, mother and child health service delivery was preserved as a result of dedicated humanitarian assistance efforts.

The situation analysis of women and children also revealed a need for capacity building of paediatricians, gynaecologists and patronage nurses, which was carried out within the frames of the Integrated Maternal and Child Health Care training courses (discussed in details in the section IMCI) developed by national experts from the Institute of Maternal and Child Health Care of Serbia **(Knowledge exchange)**.

Comprehensive training seminars commenced in 1999 for doctors throughout Serbia, and continued with UNICEF's funding until the end of 2003 **(Knowledge exchange)**. In parallel, a training course for nurses covering antenatal and postnatal care related issues were developed **(Policy advise & TA)**. The nurses' seminars were reasonably similar in content, teachers and teaching methods but separated by location. The differences were due to the perceived needs and activities of nurses compared with doctors. Nurse training commenced in late 1999, and ran until 2003. 48% of PHC doctors and 88% of patronage nurses in the country were covered by IMCH trainings.

An external evaluation of IMCH training programme, which was carried out in 2003 **(Monitoring & Evaluation),** recommended revisions to the training curricula and guidelines. The results of the evaluation were discussed at a round table with wide participation of the authors, MoH, professionals and partners **(National dialogue)**.

A new IMCH training curriculum was developed **(Policy advice & TA)** in 2006 (available only in Serbian) based on the MICS 2000 and MICS 2005 findings and recommendations derived from the external evaluation of IMCH training curricula **(Monitoring & Evaluation)**. New IMCH guidelines were used as a rulebook for all health care facilities, approved by MoH, printed and disseminated with UNICEF's assistance **(Policy advice & TA)**.

UNICEF also assisted the MoH in the development of Newborn Resuscitation guidelines **(Policy advice & TA)**. Professors from IMCHC and Perinatal centres were involved in the development of these guidelines, and a critical mass of health professionals at all levels of the perinatal care provision were trained **(Leveraging)**.

Neither IMCH not NR curricula were officially integrated into the undergraduate, postgraduate and CME education system. CME has only been introduced in Serbia late in 2009, when UNICEF's programmatic focus and funds were not available to support this development.

A National Health Care Programme for Women, Children and Youth was adopted in April 2009 **(Policy advice & TA)**. UNICEF provided critical support for the preparation of professional methodological guidelines that translate the documents into procedures and working principles for health professionals working with children and women in primary and secondary health care **(Policy advice & TA)**. The MoH and the National Health Council prepared a Health Care Development Plan 2010-2015, which represents a strategic umbrella and outlines priorities in the area of health. UNICEF participated in discussions of the draft document, ensuring the interests of children and particularly vulnerable groups **(Policy advice & TA)**.

Table 38: PNC contribution to UNICEF Core Roles

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF was active in communicating to the government the needs of children, especially of the most disadvantaged and vulnerable. The results of the situation analysis and MICS surveys were used to raise awareness on the needs to meet child rights. - UNICEF remained active during the evaluation period (as per annual reports), although no particular interventions were planned under the AWPs. UNICEF's active role in bringing challenges to the attention of the government was confirmed by majority of key informants interviewed. - UNICEF's contribution through this core role is considered to be "Major/Critical".
2. Monitoring & evaluation	3	- UNICEF's role in M&E was critical, as it carried out MNCH assessment and prepared child situation analysis; - UNICEF supported MICS 2, MICS 3, MICS 4 and MICS 5 in the country. MICS is the only source of information for Roma population (women and children) morbidity and mortality - UNICEF also provided assistance in strengthening countries monitoring system by introducing DevInfo, which was used as an analytical tool for evidence based planning for poverty reduction in general and maternal and child health in particular. - UNICEF remained active during the entire evaluation period. - Thus UNICEF's contribution through this core role is considered to be "Major/Critical".
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government throughout the evaluation period, together with other partners, and remained the leading player in the field of PNC - UNICEF made available technical expertise to the government for the development of the policy and regulatory framework. - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
4.Leveraging resources	1	- UNICEF was not successful in leveraging resources for this sub-package through national institutes and stakeholders - Therefore UNICEF's contribution through this core role is considered to be "Minor"
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period, UNICEF demonstrated periodic facilitation of national dialogue at critical points of UNICEF programme implementation - Therefore its contribution through this core role is considered

		to be "Significant"
6. Enabling knowledge exchange	2	- UNICEF was the key development partner assisting the government in the development of human resource capacity at national and local levels through the creation of a pool of master trainers and supporting training throughout the country. - UNICEF supported training in IMCH commenced in 1999 and ended in 2003, while later trainings were mostly targeted to Roma mediators in support of antenatal and postnatal care of Roma mothers and their children. - As there was a break in support of trainings, UNICEF's contribution through this core role is considered to be "Significant"
7.Modeling/piloting	0	- No modelling

Note: In the AWP base supplies provided during emergency to maternities is considered as core role 8 "OTHER" and has a substantial resources allocation.

PMTCT SUB-PACKAGE

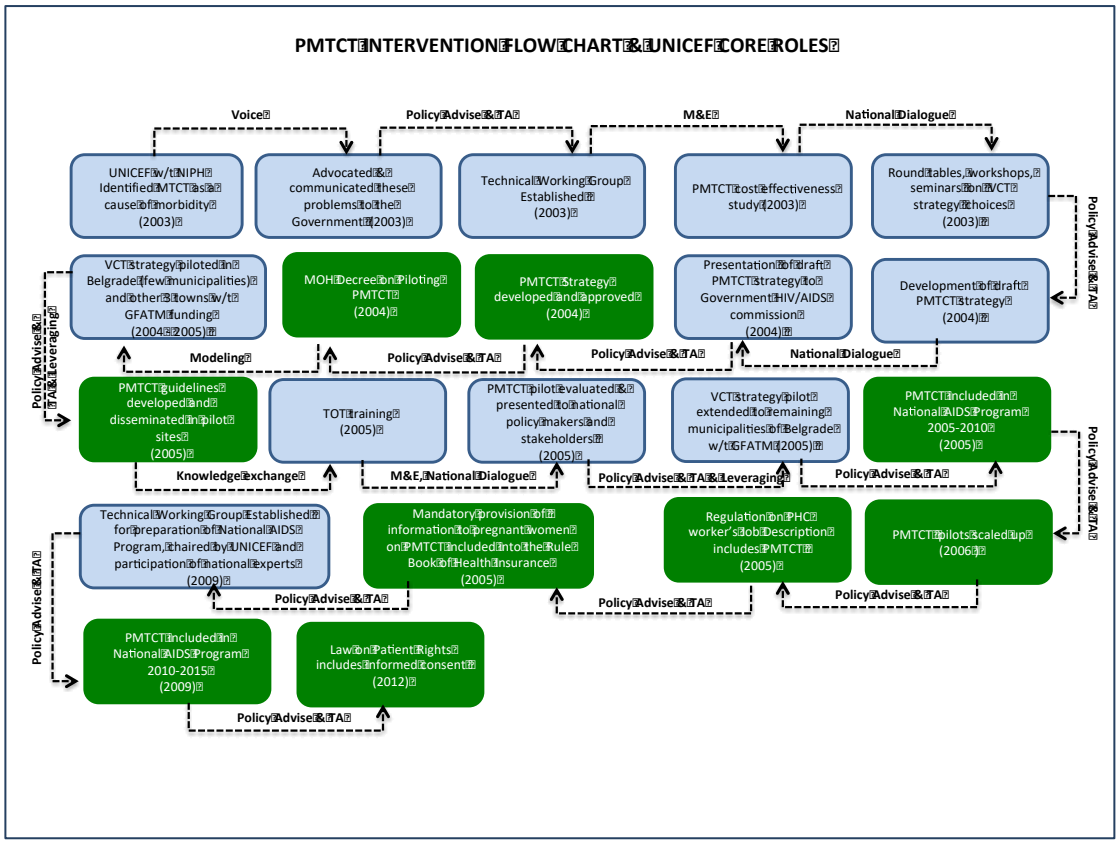
The first three cases of MTCT were detected in the country in 1989. UNICEF, together with Republican Institute of Public Health (RIPH), raised the issue of PMTCT importance and advocated and communicated the problem to the government **(Voice)**. In response the Technical Working Group (TWG) on PMTCT was formed at RIPH with financial support from UNCEF **(Policy advise & TA)**. As Serbia was a low prevalence country, policy makers debated the cost effectiveness of a massive VCT of pregnant women, so a PMTCT cost benefit analysis was carried out with UNICEF's support **(Monitoring & Evaluation)**.

The results of the study were presented to different policy makers and national stakeholders through workshops and round tables, and a decision was made to introduce an "opt out option" of HIV testing as part of antenatal care **(National dialogue)**.

The TWG, with UNICEF's technical assistance, developed a draft PMTCT strategy and presented it to policy makers for approval **(Policy advice & TA)**. The strategy was adopted and piloted in selected municipalities in the three cities of Serbia with the highest prevalence rates of HIV (Belgrade, Novisad and Graguevac) in 2004-2005 **(Modelling)**.

The pilot PMTCT was implemented with UNICEF's technical support from UNICEF **(Policy advice & TA)** and financial support made available through the GFATM funded HIV Project **(Leveraging)**. UNICEF assisted the MoH and NIPH in translating and adapting international PMTCT guidelines, and printing and disseminating them to health professionals **(Policy advice & TA)**. Furthermore UNICEF financed Training of Trainers (TOT), whereas GFATM supported training of medical personnel in pilot cities **(Knowledge exchange)**.

Figure 61: PMTCT Sub-Package Flow Chart mapped to UNICEF Core Roles



The pilot was evaluated in late 2005 looking at the barriers to HIV testing from the demand and supply sides **(Monitoring & Evaluation)**. The results were presented to the National AIDS Committee, and a decision was made to expand the pilot to the remaining municipalities in Belgrade **(National dialogue)**. In 2005 PMTCT was included in the National AIDS Programme 2005-2010. PMTCT was scaled up at national level starting from 2006. The MoH revisited and approved the job descriptions for PHC staff by inserting the provision of information about PMTCT and testing in the third trimester of pregnancy as mandatory functions of professionals carrying out antenatal care **(Policy advice & TA)**. The mandatory provision of information on PMTCT and testing with the consent of pregnant women has also been included in the Health Insurance "Rule Book" (BBP), thus ensuring that IPHs are reimbursed for tests provided to pregnant women. Late in 2009 the new TWG was formed for the preparation of the new National AIDS Program 2010-2015, which UNICEF chaired and provided with technical inputs **(Policy advice & TA)**. The new National AIDS Program, which had a component dedicated to PMTCT, was approved. Finally, in 2012 the Law on "Patients' rights" was amended to include mandatory requirement for patient's consent on HIV testing. UNICEF's financial support for PMTCT sub-package of interventions ended in 2005.

Table 39: UNICEF Core Role contribution to the implementation of PMTCT Sub-Package

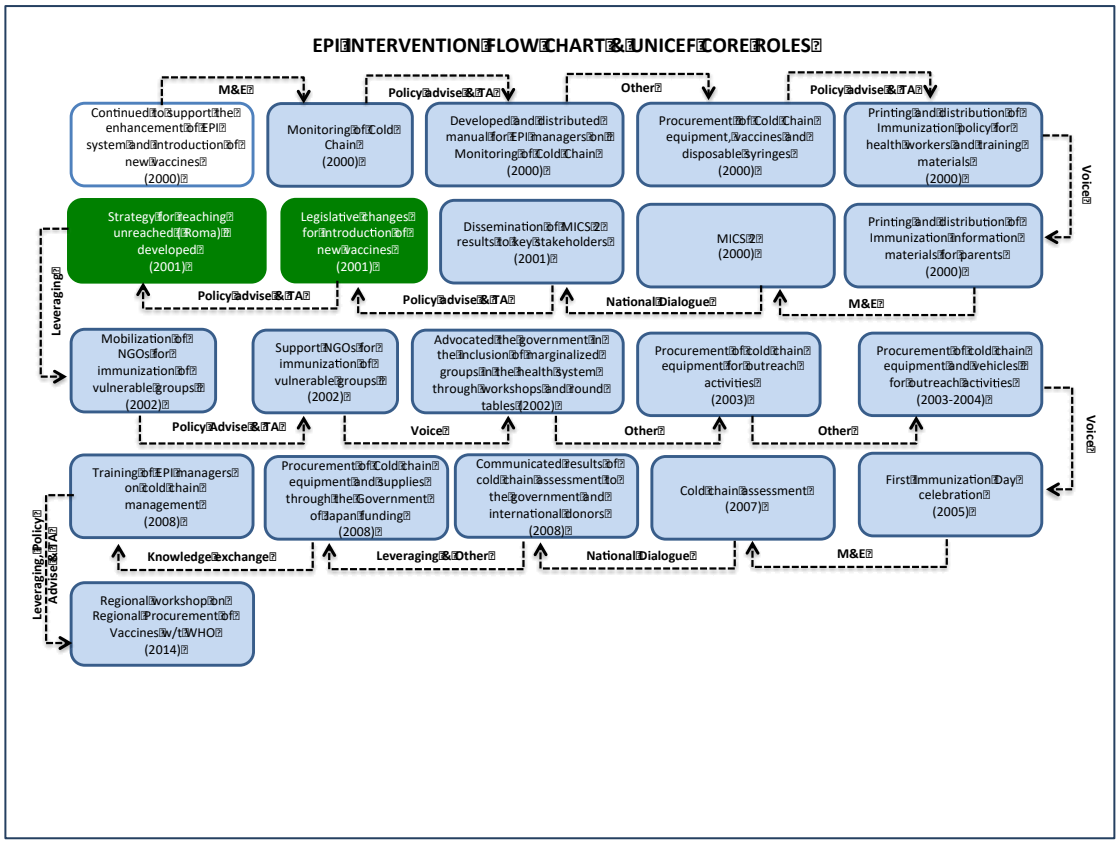
CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF contributed to the critical phase of PMTCT initiation in the country by communicating the problem to the government and provision of advocacy - Therefore UNICEF's contribution through this core role is considered to be "Significant"

2. Monitoring & evaluation	2	- UNICEF's role in M&E was limited to PMTCT cost-benefit analysis and evaluation of the pilot. Both researches guided and informed national decision-making on PMTCT strategy. UNICEF was not involved in the development of national M&E capacity, reporting etc. - Therefore UNICEF's contribution through this core role was considered to be " Significant"
3. Policy advice and technical assistance	3	- UNICEF was instrumental in providing policy advice and technical assistance to the government throughout the evaluation period and remained the only technical partner in the field of PMTCT - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
4. Leveraging resources	3	- UNICEF supported the government in leveraging resources from GFATM through the inclusion of PMTCT as a strategic direction into the National AIDS programs. - Thus, UNICEF's contribution through this core role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period UNICEF demonstrated facilitation of national dialogue in a very critical phase of PMTCT introduction in the country - Therefore UNICEF's contribution through this core role is considered to be "Significant"
6. Enabling knowledge exchange	2	- UNICEF supported the government in the development of human resource capacity at national level through creation of a pool of master trainers. Training of health professionals was mainly covered through GFATM funded AIDS Project - In summary, UNICEF's contribution through this core role is considered to be " Significant"
7.Modeling/piloting	3	- UNICEF piloted PMTCT implementation in four cities of Serbia before its national scale up - Thus UNICEF's contribution through this core role is considered to be "Major/Critical".

EPI INTERVENTION PACKAGE

UNICEF has supported the enhancement of the EPI system and the introduction of new vaccines in Serbia since 2000. UNICEF also supported monitoring of the cold chain system **(Monitoring & Evaluation)**, and the findings have been discussed with the government, resulting in the identification of system enhancement needs **(National dialogue)**. Thereafter UNICEF provided support to the MoH and IPH in developing and distributing a cold chain monitoring manual for EPI managers (**Policy advice & TA),** procuring a cold chain equipment, vaccines and disposable syringes **(Other),** and distributing an immunization policy manual for health workers and training **(Knowledge exchange)**.

Figure 62: EPI Intervention Package Flow Chart mapped to UNICEF Core Roles



MICS 2 identified a low level of immunisation coverage among Roma population **(Monitoring & Evaluation).** Moreover, quantitative research on the knowledge, attitudes and practices of parents and health workers towards immunisation was conducted in Serbia **(Monitoring & Evaluation)**. The results served as the basis for subsequent qualitative research to identify root causes (e.g. why marginalised people have lower access to services) and solutions to this problem **(Monitoring & Evaluation)**. The results were discussed among all national stakeholders **(National dialogue),** and technical support was provided to elaborate a Strategy to reach unreached populations **(Policy advice & TA).** For effective implementation of the strategy, UNICEF led NGO mobilisation activities (**Leveraging)** to ensure immunisation of vulnerable population groups. It also advocated the MoH to includ of Roma and marginalised groups in the state health programme by organising round tables and workshops (**National dialogue).** Cold chain equipment and vehicles **(Other)** were procured in support of outreach activities, and EPI managers were trained in cold chain management **(Knowledge exchange).**

Later in 2007, UNICEF carried out the next round of cold chain assessment **(Monitoring & Evaluation),** leveraged resources from the Japanese government **(Leveraging)** and assisted the government in procuring cold chain equipment **(Other).** In collaboration with WHO, UNICEF supported an area workshop on regional procurement of vaccines in 2014 **(Leveraging and Policy advice & TA).**

Table 40: EPI Intervention Package contribution to UNICEF Core Roles

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF, in a joint process with WHO, advocated for the introduction of new vaccines and the enhancement of vaccine and cold chain management

		- UNICEF was instrumental in contributing to the critical phases, - Therefore UNICEF's contribution through the given Core Role is considered to be "Significant"
2. Monitoring & evaluation	3	- UNICEF's contribution through the given Core Role is considered to be "Major/Critical" as it contributed to the institutionalisation of AEFI surveillance system at the national level
3. Policy advice and technical assistance	3	- UNICEF was instrumental in supporting the MoH in policy development by providing the required technical assistance for the development of SIP/AEFI and waste management standards and enabling legal environment - These issues were included in the undergraduate and postgraduate education programmes and regulatory documents for vaccine and cold chain management - As UNICEF remained active during the evaluation period, its contribution through the given Core Role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF assisted the MoH in preparation of the proposal for GAVI funding - UNICEF continues to assist state procurement of vaccines through UNICEF SD by transferring public funding through UNICEF CO to UNICEF SD - UNICEF assisted the MoH to leverage resources from JAICA for upgrade of cold chain equipment - UNICEF was successful in leveraging resources for EPI services from partner organisations and the state, and its contribution through the given Core Role is considered to be "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	2	- During the evaluation period, UNICEF supported a number of events (conferences, workshops) and facilitated national dialogue at critical stages - Therefore UNICEF's contribution through the given Core Role is considered to be "Significant"
6.Enabling knowledge exchange	2	- UNICEF provided training to EPI managers on cold chain management and EPI workers on cold chain monitoring country wide - The core role was used only once therefore the contribution score is considered to be "Significant"
7.Modeling/piloting	0	- No modelling

IMCI INTERVENTION PACKAGE

IMCI SUB-INTERVENTION PACKAGE

In Serbia, the Integrated Maternal and Child Health (IMCH) programme incorporated the IMCI concept and adapted the generic guidelines to both Serbian child and maternal health needs **(Policy advice & TA)**. The modifications in Serbian IMCI strategy led to the terminology of IMCH. A focus on key areas of child and maternal mortality and morbidity has been delivered from baseline statistics as found in the Statistical yearbook and MICS 1 and MICS 2, which were undertaken and published by UNICEF in 1996 and 2000 **(Monitoring & Evaluation)**. The training curriculum was decided by National consensus **(National dialogue)** and the health care of mother and child was considered as a whole.

The IMCH programme in Serbia followed the 1990 World Summit for Children Declaration, to which the Socialist Federal Republic of Yugoslavia was a signatory. As such, it committed itself to setting child welfare goals for the year 2000, mobilising the necessary resources to achieve these goals and monitoring progress towards these goals throughout the decade.

When SFRY disintegrated in 1990, the Federal Republic of Yugoslavia initiated the underlying legislation in 1996 contained in the Decree on Mother and Child Health care, with the aim of integrating mother and childcare into teaching and practice in the PHC system.

Following the legislation, UNICEF initiated partnerships and funding for the development of core manuals and a training package for PHC doctors and nurses **(Leveraging and Policy advise & TA)**, incorporating the IMCI strategy. The teaching methods incorporated "active learning" as opposed to "passive learning" for the first time in Serbia.

UNICEF, in partnership with the MoH, engaged two institutions to implement the IMCH program **(Leveraging)**, namely:

- Serbian Institute for Mother and Child Health Care (IMCHC) whose paediatricians and Ob/Gyn were responsible for teaching doctors (paediatricians, GPs and Gynaecologists) at PHC;
- Institute of Public Health, Belgrade was responsible for the teaching of patronage nurses.

National experts developed the IMCH curriculum though a multidisciplinary team comprised of two professors from the University of Serbia and two doctors from IMCHC and IPH Belgrade. The training materials were considered to be a clinical practice guideline and approved by the MoH.

The first training of trainers commenced in 1997 and a second training began in 1999. To date, there are about 60 doctors and nurses who have been trained as trainers, about 15 of whom are nurses **(Knowledge exchange)**. Each trainer is considered an expert. Two trainers are assigned to each module or topic, usually one older professor and one younger assistant from the Serbian Institute of Mother and Child Health Care or from the Institute of Public Health, Belgrade.

The courses covered all topics listed in the manual for health care professional and parents entitled **"Life messages on health of mother and child"**, which was published by UNICEF, and some other topics that were found to be useful for home visiting nurses. Accordingly, the following topics were covered:

Topics	**Curriculum for Doctors**	**Curriculum for Nurses**	**WHO IMCI curriculum**
Organisation of Healthcare	√		
Basic principles of education in health	√		
Medical records and documentation	√		
Immunisation	√	√	√
Basic principles of organisation of antenatal and postnatal care	√		
Family Planning	√	√	
STDs	√		

Acute Respiratory Infections	√	√	√
Diarrheal diseases	√	√	√
Principles of adequate nutrition and breastfeeding	√	√	√
Anaemia	√	√	√
Physical growth and development	√	√	√
Psychomotor development	√	√	
Clinical examination of newborn	√		
Acute urinary tract infection	√		
Acute neurological disorders	√		
Hygiene		√	
Communication skills		√	√ [210]
Care of newborn child		√	
AIDS and sexually transmitted diseases		√	√ [211]
Prevention of child injuries		√	
Right of the child to health focusing protection from abuse and neglect		√	
Stress and psychomotor development of the child		√	

Comprehensive training seminars commenced in 1999 for doctors throughout Serbia and continued with UNICEF funding until the end of 2003 **(Knowledge exchange)**. The nurses' seminars are reasonably similar in content, teachers and teaching methods, but separated in location. The differences are due to the perceived needs and activities of nurses compared with doctors. Nurse training ran from late 1999 to 2003. 48% of PHC doctors and 88% of patronage nurses have been trained by IMCH trainings.

An external evaluation of IMCH programme carried out in 2003 **(Monitoring & Evaluation)**, revealed the following weaknesses of the training programme: i) limited interactive techniques; ii) a need for higher problem solving and skill development; iii) IMCH curriculum is traditional disease oriented programme; iv) some chapters are outdated; v) no multidisciplinary approach; vi) nutritional issues, although addressed, need further specific priority, with both a preventive and treatment focus. The evaluation recommends: development of evidence based guidelines for both manuals (doctors and nurses) or preferably a common manual; an update of a significant part of the information using an evidence based approach; common problems using scenarios in keeping with a problem based approach; multidisciplinary representation by the team who uses it, etc.

[210] Added to IMCI module later in 2009
[211] Added to IMCI module later in 2009

An external evaluation of IMCH training program was carried out in 2003, and recommended revisions to the training curricula and guidelines. The new training curriculum, which is only available in Serbian, was developed in 2006 **(Policy advice & TA).**

As part of the IMCI intervention package, UNICEF spent a lot of effort in improving the monitoring of child growth and development in the country **(Monitoring & Evaluation)**. In response to MICS 2000 results on child growth and development, in 2010 national experts **(**the association of Paediatricians) from IPH Belgrade developed new standards of Growth and Nutrition for children and adolescents and a manual for their implementation **(Policy advice & TA)**. These standards were approved by the MoH Decree, and were included in the IMCH training curricula for patronage nurses **(Policy advice & TA)**. The trainings were carried out by trainers from IPH Belgrade **(Knowledge exchange)**. A critical mass of health professionals working in paediatric units in the hospitals and health centres were trained and materials distributed to all paediatric units in Serbia. Growth monitoring according to the new standards became an integral part of the new professional-methodological guidelines for paediatricians and practitioners working in primary health care **(Policy advice & TA)**. While GM issues were addressed through the training of health providers, no mechanism was available to track progress. Therefore, UNICEF supported the government in the development and institutionalisation of GM software at RIPH **(Monitoring & Evaluation)**, which involved training health personnel to use the software and recording the GM parameters for each child in the catchment area.

As part of the third IMCI component, UNICEF continued strengthening the patronage system **(Policy advice & TA)**. IMCH training guidelines and procedures were also developed for nurses and patronage nurses, who were initially trained in the pilot region **(Modelling)** and then scaled up nationwide.

Issues related to early learning and development (ELD) were addressed in 2012, when UNICEF carried out research on investing in ECD **(Monitoring & Evaluation)**. The results were presented to the government, and a national dialogue was initiated that resulted in the formation of ECD TWG and the preparation of a draft national ECD/ELD program **(Voice and National dialogue)**. Technical meetings accelerated the development of ECD standards with representatives of MoE, MoH, the Council of Child Rights, and national ECD/ELD experts. This process was closely coordinated and supervised by the MoH State Secretary and supported by UNICEF. The draft ECD/ELD program is currently presented to the government for approval and is expected to be approved in 2015 **(Policy advice & TA)**.

As a result of UNICEF advocacy in 2012 **(Voice)**, the MoH recognized ECD as a priority and allocated additional budget to build the capacity of all relevant PHC professionals until 2015 **(Leveraging)**. This commitment builds on ECD training in 13 PHC centers (8%) in the most deprived municipalities, which was carried out in 2012 using ECD training modules and tools developed with UNICEF technical support **(Leveraging)**.

Support to primary caregivers and families in acquiring new knowledge on child rights and ECD was provided through the development and dissemination of information and communication materials for parents with young children **(Voice)**. Parenting materials were developed – a manual for parents, calendar and posters – based on research findings, building on identified strength and addressing significant gaps in parents' knowledge and existing care practices **(Policy advice & TA)**.

In 2004 UNICEF conducted participatory research on poverty with excluded people **(Monitoring & Evaluation)**, which revealed that Roma women and children face access barriers to the required health services. Following this research, UNICEF financed a detailed assessment of the systematic and administrative obstacles that prevent Roma from accessing education and health services **(Monitoring & Evaluation)**. The results of this

research were presented to national stakeholders, and discussions promoted the elaboration of an action plan to improve Roma access to health services **(National dialogue)**. In order to enable excluded children to enter the health system and consequently reduce the U5 MR among Roma, UNICEF advocated for the missing link between health services providers and Roma communities to be filled **(Voice).**

Based on the national discussions **(National dialogue), a** decision was made by the government to introduce Roma Mediators into the health care system who would educate and raise the awareness of the Roma population link them to the health care system. To enable the implementation of this decision, UNICEF assisted the government in developing a special training package for Roma educators **(Policy advice & TA)**, carrying out Roma Mediators trainings in 21 municipalities of the country **(Knowledge exchange)**. It also supported the development of a Roma data base **(Monitoring & Evaluation)** and leveraged resources from National Mobile Company "Telenor" to equip Roma Mediators with PCs and mobile phones **(Leveraging)**. The teaming–up of Roma representatives and health professionals proved to be a winning combination when the team worked together on the identification and inclusion of excluded families with young children, delivering preventive and treatment intervention when needed. At present, following scale up, there are 350 Roma mediators deployed in all municipalities with substantial Roma settlements, although the remaining municipalities have yet to be targeted.

Since 2009, a UNICEF-Telenor supported database has enabled better monitoring of Roma health, providing the basis for the development of indicators in 2012 that will enable more analytical reporting **(Policy advice & TA)**.

Another challenge identified by the study on systematic and administrative obstacles to Roma access to education and health services and MICS 3, was related to difficulties in birth registration, especially for Roma IDPs from Kosovo who had no documents or place of registration. To resolve this issue UNICEF pared up with UNHCR **(Leveraging)** and carried out an awareness raising campaign on non-universal registration of children **(Voice)**. Furthermore UNICEF and UNHCR provided free legal assistance to ensure subsequent registration and allow receipt of the Health Card to access to health services freely. In this UNICEF leveraged resources from the local NGO **(Leveraging)**.

Although the Roma Mediators system is functions well, and salaries and operational costs are fully financed by the MoH, national regulations that govern the official integration of Roma mediators into the health system require both upgrading the Roma mediator education level and revising the legislation. These issues were brought to the attention of the new management of MoH by UNICEF and **(Policy advice & TA)**. A TWG, led by UNICEF and Secretary General of the MoH, has been established to elaborate a strategy and strategy implementation plan.

Table 41: UNICEF Core Role Contribution to the implementation of IMCI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	- UNICEF regularly raised issue regarding challenges of child health with particular emphasis on most disadvantaged and vulnerable children - UNICEF used the results of all four MICS and other research and surveys for advocacy purposes - UNICEF remained active during the evaluation period, therefore its contribution through this core role is considered to be "Major/Critical"

2. Monitoring & evaluation	3	- UNICEF supported the MoH in an external evaluation of IMCH training program, and some of the recommendations were updated to reflect IMCH training materials in 2006. During the evaluation period no further evaluation/assessment of IMCH related activities was carried out. The indicators related to ARI and DD were and continue to be routinely collected through statutory statistical reporting. - UNICEF also carried out research on family care practices, the results of which largely informed communication materials developed for population education. Moreover UNICEF analysed beneficiary satisfaction with the services received at community health centres; - UNICEF actively supported building MICS capacity at State Statistics Agency and supported implementation of MICS 2, MICS 3, MICS 4 and MICS 5. It also periodically provided technical assistance to the MoH in preparation of Situation Analysis of children in Serbia; - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
3. Policy advice and technical assistance	3	- UNICEF assisted the government in the update of IMCH guidelines and training material; development and approval of a decree on introduction of Roma Mediators into the health care system; development of the ECD and Growth Monitoring guidelines and standards, etc. - UNICEF provided continuous supports to the MoH during the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
4. Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IMCI package implementation from the private sector, especially from Telenor for Roma Mediators, UNHCR and Local NGOs - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
5. Facilitating national dialogue towards child friendly social norms	3	- UNICEF organised and facilitated national dialogue on a number of occasions around issues related to child rights, ECD, GM, Roma Mediators and remained active during the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
6.Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local health professionals throughout the evaluation period - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical".
7.Modelling/piloting	2	- Roma mediators were piloted in 15 municipalities and scaled up to all municipalities with large Roma Settlements; however the model lacks formal integration into the health system yet. - Therefore UNICEF's contribution through this core role is considered to be "Significant"

EMERGENCY PAEDIATRICS SUB-INTERVENTION PACKAGE

The Institute of Maternal and Child Health Care (IMCHC) initiated an emergency paediatrics sub-intervention in 2000. Based on an analysis of the admissions to the clinic, IMCHC raised the issue of necessary capacity building of paediatricians at PHC level in emergency paediatrics with the MoH. A decision was made to develop the training curricula, which will provide treatment protocols for selected emergency paediatric services such as: diarrhoea, acute respiratory diseases, convulsions, fever, etc.

In 2001, lead specialists from IMCHC developed training materials based on European treatment protocols and leveraged funding from UNICEF. UNICEF supported this initiative by providing training equipment such as demonstration models, trained the trainers at the national level in 2001, and financed training of PHC paediatricians in Sendazak Region (2002) **(Knowledge exchange)**. In parallel, in 2002, UNICEF assisted the MoH and IMCHC in the development and establishment of an emergency paediatric referral system **(Policy advice & TA)**. It also provided basic life saving equipment for emergency services at PHC level **(Other)**. In 2002-2003 trainings were extended to other regions of Serbia and post-evaluation of trainings performed **(Monitoring & Evaluation)** to demonstrate the results and leverage government funding. However the project was closed in 2004 due to the end of UNICEF funding and the government's reluctance to support emergency paediatrics.

Figure 63: IMCI Intervention Package Flow Chart mapped to UNICEF Core Roles

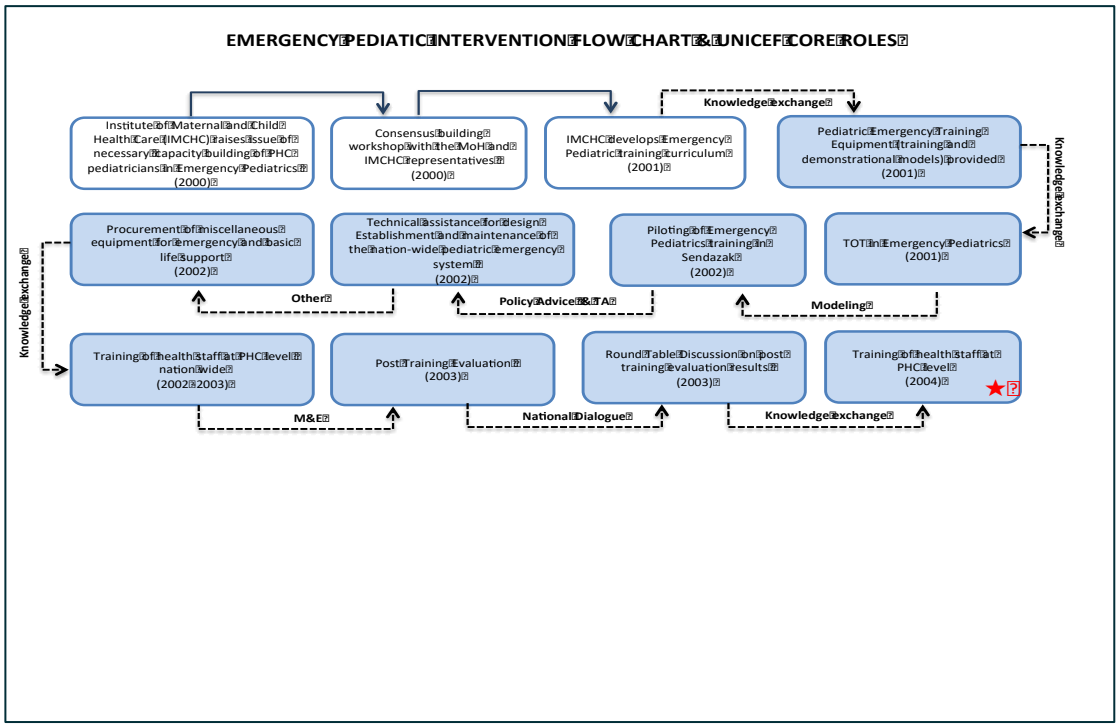


Table 42: UNICEF Core Role contribution to the implementation of Emergency Paediatrics intervention sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	0	- The necessity of introducing EP training for PHC level paediatricians were first raised by IMCHC - Therefore UNICEF's contribution through the given core role was largely absent.
2. Monitoring &	1	- UNICEF supported the MoH and IMCHC in post-training

evaluation		assessments only once and did not work for introduction and institutionalisation of revised M&E system. - Therefore UNICEF's contribution through the given core role is considered to be "Marginal"
3. Policy advice and technical assistance	1	- UNICEF only provided technical assistance to the design and introduction of national emergency paediatric system, which did not result in integration of the proposed system into the national strategies and budget. - Therefore UNICEF's contribution through the given role is considered to be "Marginal"
4. Leveraging resources	0	- UNICEF was the only partner supporting this initiative and failed to leverage funding from the government and/or from any other partner - Therefore UNICEF's contribution through the given core role is considered to be largely absent.
5. Facilitating national dialogue towards child friendly social norms	1	- UNICEF only facilitated national dialogue on further support of EP project in 2003. No attempts were made to integrate EP into undergraduate or postgraduate education system. - Therefore UNICEF's contribution through the given role is considered to be "Marginal".
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of PHC paediatricians in EP. Although the project lasted only for 4 years training was scaled-up to the national level with UNICEF's support. As UNICEF did not follow up on the project after funding ended, the project was closed end of 2004. - Thus UNICEF's contribution through the given role is considered to be "Significant".
7.Modelling/piloting	3	- UNICEF supported piloting of EP trainings in Sendazak, which were subsequently extended to the rest of the country. - UNICEF's contribution through the given role is considered as "Major/Critical"

NUTRITION INTERVENTION PACKAGE

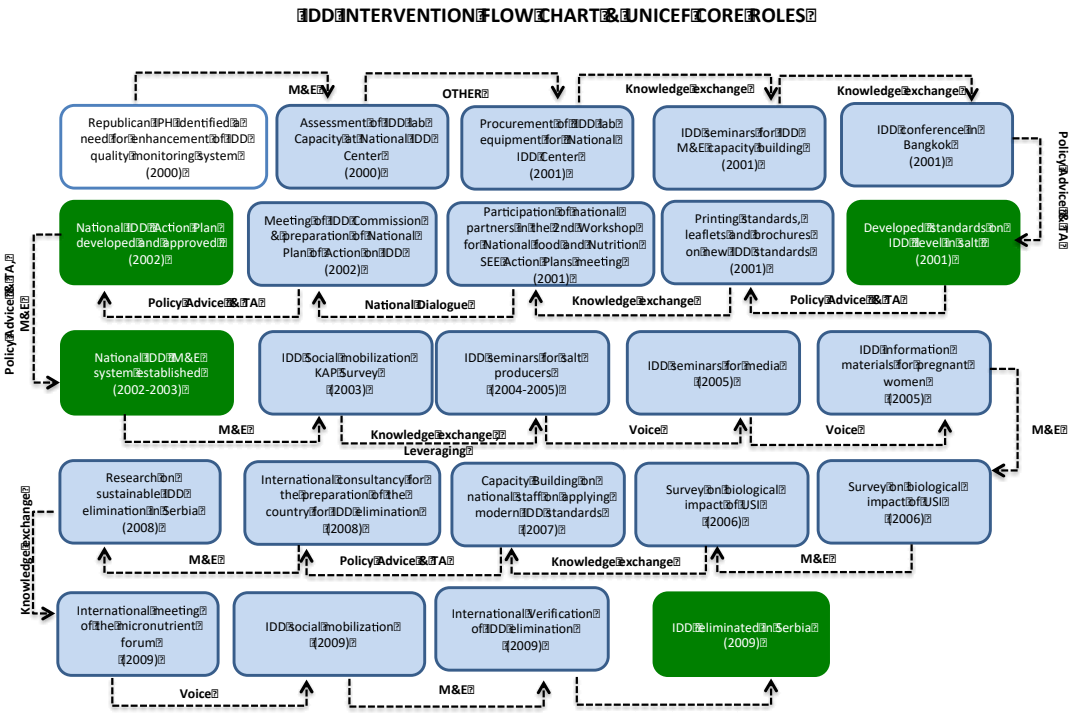
IDD SUB- INTERVENTION PACKAGE

USI has been practiced in Serbia since 1930. During last 60 years great improvements were achieved in IDD, however after the dissolution of the FYR the quality monitoring system deteriorated. The RIPH raised an issue of weak capacity for monitoring iodine in salt due to outdated laboratory equipment. In response, UNICEF carried out a laboratory capacity assessment at the National IDD center in RIPH **(Monitoring & Evaluation)** and procured required lab equipment **(Other)**. UNICEF also supported IDD seminars for building IDD/USI monitoring capacity and supported national experts' participation in an International Conference on IDD in Bangkok **(Knowledge exchange)**.

Technical support was also made available to the MoH and RIPH for the development of new standards on the levels of iodine in salt and the rulebook **(Policy advice & TA)**. UNICEF was actively involved in the TWG working sessions for the development of new standards. The rulebook was approved by a governmental decree, printed with UNICEF's support and disseminated. UNICEF also assisted the RIPH in the design, printing and dissemination of communication materials on the new standards of iodized salt **(Policy advice & TA)**.

Support was also made available for national partners to participate in the 2nd Workshop for National Food and Nutrition SEE Action Plans meeting, and meetings of IDD Commission & preparation of National Plan of Action on IDD **(Knowledge exchange)**. As a result, the National IDD Action Plan was developed and approved by the government in 2002 **(Policy advice & TA)**.

Figure 64: IDD sub- Intervention Package Flow Chart



An IDD Social mobilization KAP Survey **(Monitoring & Evaluation)**, which was carried out in 2003 by RIPH with technical assistance from UNICEF, identified the key information needs. The results of this survey largely informed the communication sessions carried out with UNICEF's support for salt producers and media, as well as the development of communication material for the pregnant women **(Policy advice & TA)**.

Later in 2006, UNICEF financed a survey on the biological impact of USI which was carried out by RIPH to assist the country to prepare for IDD certification **(Monitoring & Evaluation)**. UNICEF provided an international consultant to prepare the country for IDD elimination **(Policy advice & TA).** It also built national staff capacity to apply modern IDD standards **(Knowledge exchange)**. The MoH used the survey on the Impact of USI, which showed that according to physiological criteria, Serbia has eliminated IDD. In 2008, the new government confirmed its commitment to IDD, and UNICEF supported the development of a USI monitoring system and public reporting as two critical components of sustainability **(Policy advice & TA)**.

In 2009 UNICEF supported research on sustainable IDD elimination in Serbia **(Monitoring & Evaluation)** and an international meeting of the micronutrient forum **(National dialogue and Knowledge exchange)**. UNICEF also provided substantial support to IDD social mobilisation **(Voice)** and International Verification of IDD elimination in Serbia. The external evaluation carried out in 2009 recommended a change of iodine concentration levels in salt. To reflect this requirement in food safety laws, a special Task Force was established at the MoH with

wide participation of experts, salt producers, media, legislators, UNICEF etc. **(Policy advice & TA)**. UNICEF made an international expert available to the Task Force. Despite these efforts, the revision of the law is on hold due to the recent change of the government. With UNICEF's support, the RIPH organized dissemination of the IDD results **(National dialogue)**, accredited the IDD course in CME and trained more than two hundred participants from PHC, epidemiologists and pharmacists in 2012 **(Knowledge exchange)**.

Table 43: IDD Intervention Sub-Package contribution to UNICEF Core Role

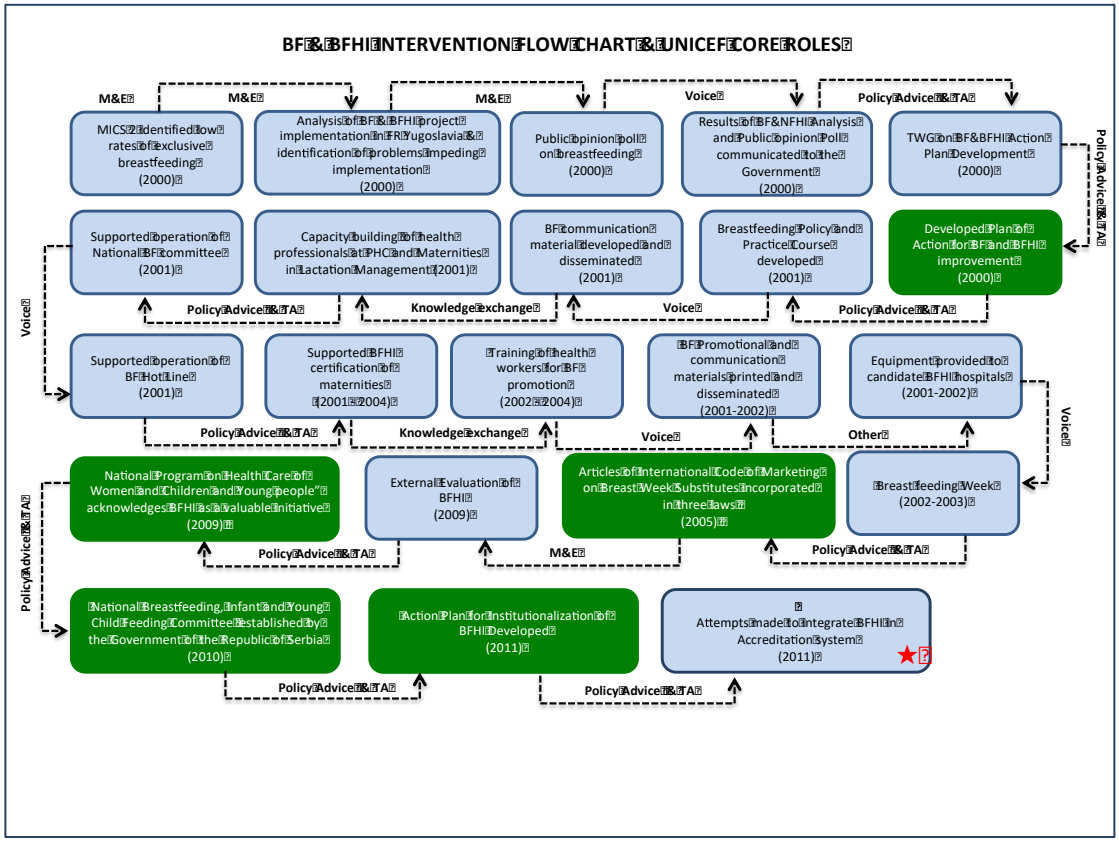
CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	– UNICEF initiated advocacy on IDD and USI after approval of new USI standards; - UNICEF remained active until Serbia was granted a certificate on IDD elimination in 2009 - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	- UNICEF supported the government in the design and institutionalisation of USI quality monitoring system, organised IDD seminars for IDD M&E capacity building, carried out IDD Social mobilization KAP Survey, Research on sustainable IDD elimination in Serbia and Survey on biological impact of USI - At present M&E capacity built at Republican Institute of Public health (RIPH) is capable of regular monitoring of iodine levels in salt - UNICEF's contribution through this core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF assisted the government in the development and adoption of standards on IDD level in salt, National IDD plan, and institutionalised Monitoring and quality assurance of Universal Salt Iodization nationwide. - UNICEF assisted the government in preparation of International IDD elimination certification through the provision of international expertise - UNICEF remained active until Serbia was granted a certificate on IDD elimination in 2009 (throughout 2000-2009) - Therefore its contribution through this role is considered to be "Major/Critical"
4.Leveraging resources	3	- UNICEF was successful in leveraging resources in support of IDD elimination and USI through legislative and executive branches of the government, mass media, and private salt producers - UNICEF was actively involved in the period of 2000-2009 - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	3	- UNICEF remained an active player in capacity building of national and local governments, policy makers, of Salt producers and supported number of knowledge sharing events - UNICEF remained a key supporter of the human resource capacity building in the country in the area of IDD and USI - Therefore UNICEF's contribution through this core role is considered to be "Major/Critical"

7.Modelling/piloting	0	- None

BF&BFHI SUB- INTERVENTION PACKAGE

UNICEF together with WHO initiated BF and BFHI activities back in 1995. Based on the preliminary results of MICS 2 in 2000 **(Monitoring & Evaluation)**, UNICEF informed the government of the unacceptably low levels of exclusive breastfeeding **(Voice)**. In order to identify the underlying problems, UNICEF financed analysis of BF&BFHI implementation and Public Opinion Poll on breastfeeding **(Monitoring & Evaluation)**. The results were communicated to the government with wide representation of national and local health authorities, research institutes and experts **(National dialogue)**. In response, a technical working group was established to develop a BF & BFHI Action Plan. As part of the Action Plan, UNICEF supported the government in developing a BF policy, a practice course and BF promotional materials **(Policy advice & TA)**. It also built the capacity of health professionals in PHC and Maternity hospitals **(Knowledge exchange)**, supported operation of the National BF committee (**Policy advise & TA**) and the BF Hotline **(Voice)**, and continued the certification/re-certification of maternities (**Policy advice & TA**).

Figure 65: BF&BFHI sub- Intervention Package Flow Chart



Furthermore UNICEF supported the government in celebrating Breastfeeding Weeks in the period 2002-2003 **(Voice)**. UNICEF's active involvement in BF & BFHI ended in the CPAP2. UNICEF contributed to the inclusion of articles from the International Code of Marketing of

Breast Milk Substitutes in the key laws[212] of Serbia that were approved in 2005 **(Policy advice & TA)**.

UNICEF resumed support for BFHI in 2009, after the external evaluation of the BFHI was carried out **(Monitoring & Evaluation)**. Based on the recommendations of external evaluation, UNICEF facilitated the inclusion of BFHI in the National Programme on "Health care of women and children and young people" adopted by the government of Serbia in 2009 **(Policy advice & TA)**. The Programme covers several activities proposed by UNICEF/WHO Strategy in the "Ten steps to successful breastfeeding", and also calls for implementation of BFHI in all health institutions dealing with pregnant women, birth and infants. Furthermore UNICEF supported the National Breastfeeding, Infant and Young Child Feeding Committee established by the Government of the Republic of Serbia, provided technical assistance for the development of action plan and attempted to integrate BFHI into the accreditation system. However no further developments had been observed by 2014 **(Policy advice & TA)**.

Table 44: UNICEF Core Role contribution to the implementation of BF&BFHI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	- UNICEF initiated and continued advocacy on BF&BFHI; was instrumental in using M&E results for evidence based advocacy; supported activities directed to awareness raising among public and mass media; etc. - UNICEF was not active through out the evaluation period and only contributed to the critical phases - Therefore UNICEF's contribution through this core role is considered to be "Significant"
2. Monitoring & evaluation	1	- During the evaluation period UNICEF supported a number of researches and studies that informed the design of UNICEF supported activities/interventions as well as informed advocacy events - UNICEF supported certification and recertification of BFHI facilities as well as monitoring. However, since UNICEF's active involvement and funding ended, compliance with BFHI has fallen and certification process ended as this function was not mainstreamed into the national system - Therefore UNICEF's contribution through this core role is considered to be "Marginal"
3. Policy advice and technical assistance	1	- UNICEF initiated and assisted the government in the integration of the Code marketing articles into three laws of Serbia; inclusion of BFHI into the National Program on MCH and development of an action plan; and made attempts to integrate BFHI into the accreditation system. However these efforts did not result in the resuscitation of BF&BFHI activities in the country at the time of evaluation. - UNICEF did not remain active throughout the evaluation period - Therefore its contribution through this core role is considered

[212] Rules on labelling packaged products intended for feeding infants and young children (Official Gazette of Serbia and Montenegro, # 4/2005, January 28, 2005); Consumer Protection Law (Official Gazette of Serbia and Montenegro, # 79/2005, September 16, 2005); Advertising Law Official (Gazette of Serbia and Montenegro, # 79/2005, September 16, 2005)

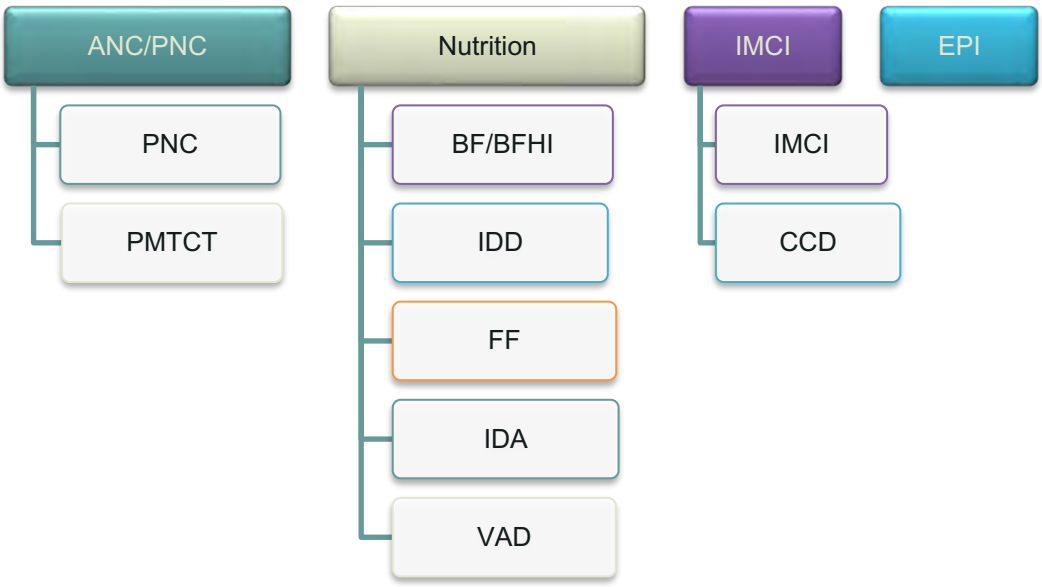
		to be ”Marginal/Minimal”
4. Leveraging resources	0	- UNICEF was not successful in leveraging resources in support of BF&BFHI - Therefore its contribution through this core role is considered to be largely absent
5. Facilitating national dialogue towards child friendly social norms	0	- UNICEF was not successful in facilitating national dialogue around issues related to BF&BFHI - Therefore UNICEF’s contribution through this core role has been considered to be “none”
6. Enabling knowledge exchange	2	- UNICEF remained an active player in capacity building of health professionals at national and local levels. However capacity building activities stopped in 2003 - Therefore UNICEF’s contribution through this core role is considered to be “Significant”.
7.Modelling/piloting	0	- None

Kyrgystan

UNICEF COUNTRY PROGRAMME OVERVIEW

The current evaluation covers three CPAP periods 2000-2004, 2005-2011 and 2012-2016. CPAP content and structure varied greatly during the evaluation period. Based on a thorough analysis of AWP/RWPs and Annual Progress Reports (APR), UNICEF activities implemented under UNICEF projects and sub-projects during the evaluation period have been grouped in four main "Intervention Packages" as shown in the figure below.

Figure 66: Key Intervention Packages



- **ANC/PNC package** includes two sub-interventions. Perinatal Care (PNC) incorporates interventions such as EPC, EmOc, Neonatal Care, Neonatal Resuscitation, International Live Birth Definition (ILBD) and Newborn registration. The second sub-package is PMTCT.
- **Nutrition packages** includes BF/BFHI, Iodine Deficiency Disorders (IDD), Food Fortification (flour, salt, home fortification) (FF), Iron Deficiency Anaemia (IDA), Vitamin A Deficiency Disorders (VAD).
- **IMCI package** is limited to interventions directed towards the introduction of IMCI at PHC and hospital level, and Child Care for Development (CCD).
- **EPI package** includes all activities related to EPI (vaccine supplies, immunization campaigns, cold chain support, New and underused vaccine introduction, Injection Safety, Financial Sustainability, Immunization Information System, AEFI and VPD surveillance, etc.)

Interventions that are cross cutting through all packages e.g. those related to SWAp, MCH forums, MICS studies are reflected in all packages. The actual composition of packages is slightly different and consists of EPI, Nutrition, IMCI and HIV packages, where EPI is part of IMCI package. However, for evaluation purposes, a standardised approach was applied across the countries.

UNICEF's programme design in the period 2000-2004 was informed by a "life cycle" approach. During this period UNICEF initiated or continued support of new effective

interventions to address the leading causes of Perinatal, Infant and Child mortality, although most of the projects were pilot or small-scale.

The programme for 2005-2011 was designed to support and achieve the outcomes identified by UNDAF in its three priority areas of poverty and social services and HIV/AIDS. It was framed to respond to national priorities articulated in the Comprehensive Development Framework and the NPRS. MNCH and Nutrition programmes focused on Mother and Child Health, Vitamin A, IDD, IDA, Flour Fortification. Since 2007 major shifts were noted in the Health and Nutrition Programme. Within the MNCH component, a shift was made from supporting many small projects to focusing on national level support and addressing systemic challenges in MCH.

For CPAP 2012-2016 the programme takes steps to ensure that more women and children from poor and vulnerable families have access to quality, priority lifesaving health services, including those for nutrition. The programme continues to support the government in sector reform within the SWAp and in coordinating with development partners, and advocates at the policy level to increase the focus on vulnerable and hard-to-reach people and to ensure that State guarantees are met fully and equitably. During CPAP-3 UNICEF focuses on under-nutrition as an important public health problem, and is taking active steps to address nutritional deficiencies.

PERINATAL AND NEONATAL CARE SUB-PACKAGE

Implementation of activities to improve mother and newborn health in Kyrgyz Republic began as part of the WHO Regional Office for Europe (WHO-Europe) CARK project (1995-2000). After a project evaluation in 2000, the second stage began with a Making Pregnancy Safer/Promoting Effective Perinatal Care (MPS/PEPC) review and planning meeting in June 2001. This meeting introduced the global WHO MPS initiative to the Kyrgyz Republic. In 2001 a PEPC workshop exposed senior managers at the MoH and oblast level to the modern approach of care during pregnancy, birth and postpartum period. The PEPC initiative was well accepted and in 2001 the MoH took a decision to promote PEPC at national level after piloting at selected oblasts **(Voice)**.

In 2001 UNICEF, in partnership with WHO, introduced the PEPC neonatal part (Neonatal Resuscitation and Essential Newborn Care) in two pilot areas (Chui and Issyk-Kul oblasts) **(Modelling).** In 2001-2002 a critical mass of professionals were trained on PEPC, specifically on Essential Newborn Care and Newborn Resuscitation, in all oblasts.

The first cohort of the national trainers on PEPC was developed in 2003 with technical assistance from UNICEF and WHO EURO. This continued in 2004 with ToT training on PEPC and NR. A national training capacity was developed in 2010 at the central and oblast level. Two oblast level training centres were established in Osh, at the Osh provincial maternity hospital, and in Bishkek, at the National MCH Centre. The centres were equipped with the necessary IT equipment, furniture, training materials, and manikins. Apart from trainings, the trainers are permanently involved in health personnel training, monitoring and on-site mentoring processes **(Policy advice &TA)**.

The training of heath personnel is one of the key activities that started after 2000 and is implemented up until the present in the frame of the DaO and Equity Projects (2010-2013) in southern regions. By 2012, 35% of all deliveries in the country were carried out with EPC services. By 2012, 95% of all maternities had medical workers trained on EPC, with technical support from UNICEF, UNFPA, USAID, GIZ and WHO. One of the effective approaches applied by UNICEF is on-the-job training provided by obstetricians / neonatologists from Baltic states to local counterparts **(Knowledge exchange).** According to key informants specialists (in teams composed of Ob/Gyn, Neonatologist and nurse) use to spend weeks with Kyrgyz medical staff and provide on-site support in maternity wards. Mentoring has been continuously provided by the national teams composed of ob/gyn, neonatologist, anesthesiologist, nurse from Bishkek in the pilot maternity sites. As reported by the trainers and health personnel in the maternities this approach was found to be the most efficient way of knowledge transfer and skill acquisition. Some recommendations to strengthen mentoring process was to develop a framework/strategy tailored to the local needs based on the monitoring results, make it more regular and select team members with more caution.

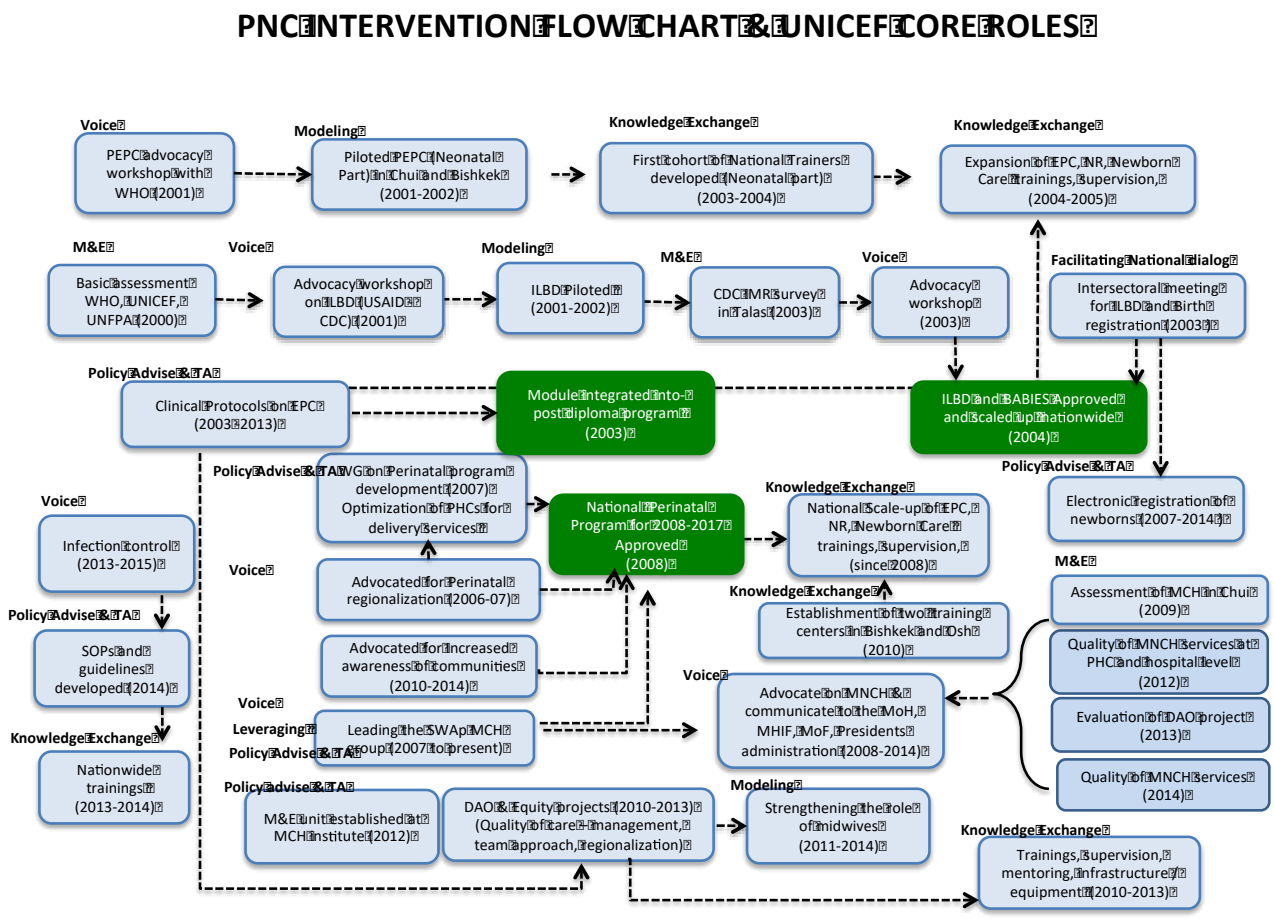
Other **knowledge exchange** activities included study tours of MoH officials and professionals, e.g. visit to Uzbekistan (2003) to learn positive experience from PEPC implementation, later on number of study tours of tertiary level professionals and MoH staff were organized to Lithuania and Estonia to learn best practices on obstetric care and perinatal system regionalization (2006,2009). UNICEF supported study tours of maternity facility managers between pilot regions to exchange views and experience of pilot sites (2012-2013).

UNICEF plays significant role in development and revision clinical protocols in Obstetrics and Neonatal care. The process was initiated in 2003 and continues up to present. The

developed protocols/standards are approved by the MoH. In 2013 based adapted WHO recommendations UNICEF developed guidelines for midwifes in FAPs on antenatal care, obstetric care and newborn resuscitation **(Policy advice &TA)**. Sustainability is ensured through integration of the modules in pre and post-service training curricula. According to the key informants at this stage pre-service curricula does not fully incorporate the modules, it is still in the transition process, while post-diploma training curricula fully integrates new approaches.

UNICEF in partnership with USAID (CDC-Atlanta) played a critical role in introduction of the International Life Birth Definitions (ILBD) in the country. Advocacy workshops, communication of the Talas IMR study findings (that uncovered infant mortality causes) triggered the Government decision to introduce the ILBD in the country since 2004. Kyrgyzstan was the first country in the region that moved away from the old soviet definitions and introduced the WHO recommendations on live birth definitions. Technical and financial assistance was provided by UNICEF and partners to support MoH activity to implement a Newborns Electronic Register. The staff was trained on how to use the new methodology and IT equipment was provided **(Policy advice &TA)**. An immediate outcome of this activity is a higher level of accuracy of birth registration and increased reliability in the statistics and monitoring processes. Initially activity was supported by Health Metrix Network, and USAID and was piloted in Chui and Bishkek. UNICEF advocated e-register to become a routine system of health care. UNICEF supported this activity in Talas and Naryn (2007-2008) and later in Batken, Osh, Jalalabad (2012-2013), GIZ supports e-registry in Issyk-kul and Chui.

Figure 67: PNC sub-package intervention flow chart mapped to UNICEF Core Roles



UNICEF as a leading partner of the SWAp MCH group since December 2007 and plays strategic role in coordination of the donors, planning and leveraging resources to fill existing gaps in MCH financing **(Voice & leveraging).**

UNICEF uses evidence-based advocacy and policy dialogue **(Voice)**. UNICEF played a critical role in development of the National Perinatal Program, 2008. UNICEF uses evidence-based advocacy to create enabling environment at the political level to facilitate implementation of the Perinatal Care Program. Evidence-based advocacy was used to raise awareness among policy and decision-makers in the MoH and MoF, the MHIF, the Prime Minister's Office and the Presidential Administration in order to exchange views on how the perinatal/neonatal care system functions and how to implement a model referral system in pilot regions. UNICEF CO was first in the CAR region that designed and proposed perinatal referral model with technical assistance from Baltic state experts **(Policy advice &TA)**.

During 2010-2013 UNICEF, UNFPA and WHO collaborated on the One UN Program (DaO). In the first year activities covered 6 maternities in Bishkek (UNFPA), Osh and Batken Provinces (UNICEF), which cover up to 15% of all deliveries in the country. In 2012, the project was expanded into another 14 maternity hospitals, covering in total 20 maternities, approximately 35% of total deliveries located in remote and rural areas of Osh and Batken Provinces **(Knowledge exchange)**. DAO project activities were integrated with Equity Project, funded by DFID, which is covering Osh, Batken and Jalal-Abad oblasts.

Focus of the both projects is on the quality of care through strengthening management capacity, team approach, regionalization. The Perinatal component under the both projects included ToT and extensive training activities on ANC, EPC, NR, regular monitoring and supervisory visits, supply with life saving equipment, improvement of infrastructure of maternity wards. As a result of the EPC programme implementation in deprived regions of southern Kyrgyzstan 40,224 women in labour (35% of deliveries nationwide) were provided EPC services by 2012 (MoH monitoring report 2012). UNICEF pilot districts in the DaO as well as in the "Equity project" are located in the most deprived areas **(Modeling)**. The project has equity based approach and targets districts with worst indicators on child poverty, geographical remoteness, maternal and child mortality rates, access to water and sanitation, etc. According to the key informant UNICEF CO approach is to select the most challenging sites to achieve a greatest impact of child /perinatal mortality reduction.

Throughout the evaluation period UNICEF has played a critical role in supplying maternity wards and neonatal units with life saving medical equipment for mothers and newborns (obstetric surgical kits, baby warmer mattresses, CPAPs for newborns, Vacuum extractors for newborns used with obstructive childbirth, Ambu bags, silicon face masks, nebulizers, infusion pumps, mannequins for training of personal maternity departments, as well as IT equipment (2003-2013). UNICEF equipped training centers in Osh oblast and Bishkek. UNICEF supported perinatal service providers and training centers with printed materials such as guidelines and protocols, training materials, job-aids, program implementation bulletins as well as awareness rising materials for beneficiaries (2004-2013). In number of district maternity houses in the south UNICEF provided maintenance work, such as repairing water supply, sewage systems, heating systems, changing windows, etc. (2010-2013) **(Policy advice &TA)**.

UNICEF in partnership with SRC addresses infection control problems at the facilities. As a part of implementation of Russian Federation grant on Strengthening the Infection control system in medical institutions, UNICEF is implementing activities on Strengthening infection control system in the MCH facilities. UNICEF activities focus is on the maternity departments, while SRC focuses on the hospitals. Activities include assessment of Infection control in MCH (2013), development of training module for trainers on Infection control in

MCH facilities (training module and DVD course) 2014, development of SOPs on Infection control during manipulations (22 standard operational procedures, 2014) and trainings for medical personal of MCH facilities on developed modules on IC (2014-2015) **(Policy advice &TA)**. Activities are newly initiated (since 2013) and has not scaled-up yet. Plan is to cover all maternities that are not captured by GF trainings.

Other donors that have contributed and still provide support to the Kyrgyz Perinatal care are with different volume of contribution at different stages. From end of 2007 UNICEF plays a key role in coordination of donor activity in the MCH as a leader of the SWAp MCH group. Key informants acknowledge strategic role of UNICEF in coordination, planning, prioritization, resource leveraging and turning maternal and child health as a key priority of the Kyrgyz health reform process.

Figure 68: UNICEF Core Roles contribution to the implementation of the PNC Intervention sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• Promotion of Effective Perinatal Care (PEPC) was introduced in Kyrgyzstan jointly with the WHO from late 1990s. Following a PEPC advocacy/orientation workshop in 2001 the initiative was well accepted and the MoH took a decision to introduce at national level after piloting at selected oblasts. (2001). • UNICEF in partnership with USAID (CDC-Atlanta) advocated for introduction of the International Life Birth Definitions. Through advocacy workshops, presenting evidences on infant mortality (Talas IMR study) the Gov made decision and ILBD was introduced in the country from 2004. • UNICEF role in communicating at a policy level intensified during 2005-2006 when the National Health Care Reform Program Document Manas Taalimi was under development. UNICEF played a strong role in the national MCH priority setting and Manas Taalimi development and was involved in the process from the very beginning. • UNICEF has been leading the MCH group in SWAp since December 2007 and contributed to make it most successful among other SWAp groups. • The SWAp 2010 JAR highlighted the strategic role of UNICEF in the process, especially through the integration of maternal and child health as a priority of health sector reform; • Based on above UNICEF contribution to this role is considered "Major/critical"

CORE ROLE	RATING	JUSTIFICATION
2. Monitoring & evaluation	3	• M&E component has been strongly emphasized in PNS sub-package. During evaluation period number of studies were initiated and funded by UNICEF that informed country's policy and strategies. Specifically, in 2003 UNICEF commissioned the IMR study in Talas oblast that uncovered causes of infant death and IMR data at facility and household level. This was the first hard evidence on infant mortality that was successfully used by UNICEF and partners in policy dialog. • M&E remained a key activity during the evaluation period. UNUCEF supported the following key studies: Quality of and Access to Primary Health Care Services with focus on Mother and Child Care, Rapid Appraisal (2003), MICS 3 (2006) and MICS 5 (2014), Assessment of MCH in Chui Province & Kyrgyzstan (2009), Assessment of risk factors of Ch. Death under two at home and first day of hospitalization (2010), Assessment of quality of MNCH at hospital and PHC levels (2012), Evaluation of perinatal program (2013), Assessment of Quality MNCH services (2014). Assessment of knowledge and awareness of pregnancy and childhood diseases in communities in Osh, Batken and Jalal-Abad provinces (2014). According to the key informants UNICEF has always being using evidence for prioritization and planning. There accomplishments are also measured by well-designed studies /evaluations. • All national studies and majority of evaluations/assessments commissioned by UNICEF were implemented using local resources. In order to strengthen local capacity UNICEF promoted the partnership arrangements with international and national consultants and institutes (e.g. national statistical committee). One of the integral parts of the EPC program is extensive monitoring and supervision activities in the pilot regions, where capacity of the national trainers is widely deployed. One of the shortcomings of the supervision process identified by the Perinatal System Assessment in 2012 was no use of measurable and time-bound indicators of change before and after the supervision/mentoring mission with the facility administration and health personnel. To monitor the quality of perinatal care, UNICEF has successfully advocated the MoH to establish an M&E unit for MCH programs under the National Center of Mother and Child Health (2012). The M&E unit has defined staff and functions, however it s not operational yet. There is discussion among the partners (GIZ, UNICEF) to delineate perinatal care M&E and Supervision/mentoring functions at the institutional level, with clear distribution of responsibilities and plans. • UNICEF supported Medical Information Center in implementation of the e-register of newborns, provided trainings for medical workers on system use and supported maternities with IT equipment. UNICEF advocated e-register to become a routine system of health care. UNICEF supports publishing on newborn statistics book annually that provides disaggregated information on newborn birth and death. • UNICEF contribution to this role is considered "major/critical".

CORE ROLE	RATING	JUSTIFICATION
3. Policy advice and technical assistance	3	• UNICEF leaded revision and development of clinical protocols in Neonatal care. The process was initiated in 2003 and continues up to 2014. The developed protocols/ standards were approved by the MoH. Other partners (e.g. UNFPA, GTZ) contribute to the development and national guidelines in maternal care. • To ensure sustainability of the modern approaches modules were incorporated into postgraduate curricula of the Kyrgyz State Medical Academy and the Kyrgyz State Medical Institute of Continuous Education of medical personnel (2003). • UNICEF was major contributor to the development of the key strategy document of the country - the National Perinatal Care Program for 2008-2017. UNICEF provided technical and financial support for its implementation. • UNICEF developed CD based training module, SOPs, and training material on Infection control in MCH • UNICEF uses international technical assistance for training capacity development as well for production of high quality surveys / assessments. • UNICEF contribution to this role is considered "Major/critical"
4. Leveraging resources	3	• The SWAp 2010 JAR highlighted the strategic role of UNICEF in the process, especially through the integration of maternal and child health as a priority of health sector reform; UNICEF succeeded in advocacy of allocation of funds to maternal and child health. • UNICEF led SWAp MCH group helped to formulate priorities for the following programs. - World Bank (WB) support to results-based financing in perinatal care and child health ($11 million); - German Development Bank (KFW) support to improvement of quality of medical services for newborns (4.6 million Euros); - German Development Agency (GTZ) support to improvement of quality of medical services based in maternal hospitals (a total of $2 million over 2 years); • UNICEF leveraged significant resources to address MCH issues in South regions after 2010 conflict. UNICEF contribution to this role is considered "Major/critical"
5. Facilitating national dialogue towards child friendly social norms	2	• ILBD was initiated by USAID. UNICEF promoted the initiative through inter-sectoral meetings to advocate for introduction of the ILBD and births registry. • UNICEF played significant role in advocating for and fostering of the national adoption process that was accomplished in 2004. • Electronic birth registration was initiated by the Medical Information Center with Health Metrics Network grant and supported by USAID to pilot in 2 oblasts. UNICEF joined the process since 2003 and played significant role in scaling up the process. Other donors included ADB and GIZ. Currently the coverage is 100%. UNICEF contribution to this role is considered "significant"

CORE ROLE	RATING	JUSTIFICATION
6. Enabling knowledge exchange	3	• UNICEF is a major player in health workers capacity development in perinatal care since 2000. • In the early years national policy makers and experts participated in number of CA Regional forums on maternal and perinatal mortality issues (2000-2006) that facilitated sensitization of the opinion leaders. • UNICEF contributed to the development of the local training capacity at national and oblast level. National trainers along with international experts permanently involved in the medical personnel training, monitoring and on-site mentoring processes. • Two oblast level training centers were established (in Osh at the Osh provincial maternity hospital and in Bishkek at the National MCH Center). The centers were equipped with the necessary IT equipment, furniture, training materials, and manikins. • Targeted capacity development activities were directed to the National MCH center in methodological issues, data analyses, monitoring, planning. • Training activities continue since 2000 to present. NR and Newborn care trainings were implemented countrywide early 2000s. By 2012 95% of all maternities have medical workers trained on EPC. UNICEF has played a critical role in supplying of maternity wards and neonatal units with life saving medical equipment for mothers and newborns . • Sustainability is ensured through integration of the modules into pre and post-service education. • Other donors contributing to strengthening health workers capacity in perinatal care is UNFPA and GIZ. • UNICEF contribution to this role is considered “major/critical”
7. Modeling/piloting	3	• UNICEF introduced Neonatal Component of Promotion of Effective Perinatal Care since 2001 in two pilot areas (Chui and Issyk-Kul oblasts). UNICEF supported Monitoring visits to see how PEPC initiative is being implemented in two pilot sites. After the piloting the PEPC initiative has been up scaled to national level. • During 2010-2013 UNICEF, UNFPA and WHO collaborated on the One UN Program (DaO). In the first year activities covered 6 maternities in Bishkek (UNFPA), Osh and Batken Provinces (UNICEF), which cover up to 15% of all deliveries in the country. In 2012, the project was expanded into another 14 maternity hospitals, covering in total 20 maternities, approximately 35% of total deliveries located in remote and rural areas of Osh and Batken Provinces. UNICEF pilot districts in the DaO as well as in the “Equity project” are located in the most deprived areas. • EPC program continues with the scale-up throughout the country in partnership with UNFPA and GIZ support. • UNICEF contribution to this role is considered as “major/critical”

PMTCT SUB-PACKAGE

PMTCT activities start in Kyrgyzstan from 2003 when UNICEF promoted need of integration of the PMTCT into the MCH services. By that time till 2005 all prevention and curative services were provided solely by the AIDS center in Bishkek and its oblast centers.

UNICEF organized study tours to Odessa, Ukraine, for health officials of the Central Asian Countries and Kazakhstan to facilitate knowledge sharing on PMTCT best practices. During the study tour participants get acquainted with the Ukraine experience on prevention of vertical transmission of HIV, in particular, essential elements of a comprehensive approach

to prevent HIV infection in infants; integration of services to prevent HIV in infants in MCH and other RH services **(Knowledge exchange)**.

UNICEF supported development of first national program on PMTCT and Pediatric AIDS **(Policy advice &TA)**. The program is based on a model that integrates PMTCT and Pediatric AIDS services into general medical services piloted in Osh and Batken. The intervention was assessed as very successful innovative approach and has being scaled up in the country (2010). Currently comprehensive MPTCT services are provided in Bishkek, Naryn, and Jalal-Abad Family Medicine Centers and maternity hospitals, UNICEF supported Osh and certain areas of Batken, UNFPA provided support in Talas oblast and GIZ in Chui and Issyk-kul.

With UNICEF technical assistance national protocols were developed on breastfeeding of child born to HIV infected mothers, on PMTCT (2004) **(Policy advice &TA)**. The modules were integrated into pre and post-service education system (2005). UNICEF provided technical assistance to revise the national standards on PMTCT, HIV treatment of children, Screening on drug use among pregnant women according to the latest WHO recommendations (2012-2014).

UNICEF contributed to the development of the national training capacity **(Policy advice &TA)**. Five master trainers and 18 national trainers were trained (2007). First trainings took place in 2007 for maternity staff and AIDS center in Bishkek and Oblasts **(Knowledge exchange & Modelling)**.

With UNICEF strong advocacy the PMTCT module was integrated into EPC module since 2012 **(Voice).** Approval from the WHO regional office was obtained through intensive policy dialogue with the MoH who justified the request for integration. Currently EPC module incorporates 3 days for PMTCT.

UNICEF advocated to provision of rapid tests and ARV drugs to the maternity houses in Osh oblast (2009**) (Voice).** Currently maternity houses are equipped with rapid tests and ARV drug for diagnosing those who missed HIV testing during pregnancy (mostly marginalized and most-at-risk population who drop out from ANC services).

UNICEF jointly with MoH provided technical support on Early Infant Diagnoses (EID) and trainings to health workers on EID provision (collection of blood samples, transportation, and testing) (2014). National and Regional AIDS Centers were supplied with test systems and kits for EID provision. Developed guideline on provision of EID and EID algorithms were included into clinical protocol on Pediatric AIDS **(Policy advice &TA)**.

Jointly with partners (Soros foundation, USAID) UNICEF provided support in establishment of partner network to provide access or marginalized women to health services, through development of clinical protocols (2014), advocacy in MoH Decree in Provision of services to IDU women (2014), Development of training module (DVD course on Pregnancy management of drug addicted women and treatment of withdrawal syndrome among newborns, 2014) SOROS and USAID **(Policy advice &TA).**

UNICEF is the sub-recipient of the Global Fund and help to MoH to scale up trainings on Integration of PMTCT into Safe motherhood in ANC level (2012-2014) and Health Specialist is the member of CCM (Country coordination mechanism)

In collaboration with parents of children affected with HIV, UNICEF organized training for medical workers of Osh AIDS center and social workers of NGOs on psychosocial support of children living with HIV **(Knowledge exchange).**

As a part of this initiative, UNICEF renovated child facilities in Osh AIDS center, to make them more friendly to children receiving HIV treatment and other services. (2013-2014)

In 2014 developed tool based on mobile phones, to increase adherence to ARV treatment among children and pregnant women. UNICEF supplied 200 mobile phones with installed applications, which will be provided to clients of ARV treatment.

Figure 69: PMTCT Sub-Package Flow Chart mapped to UNICEF Core Roles

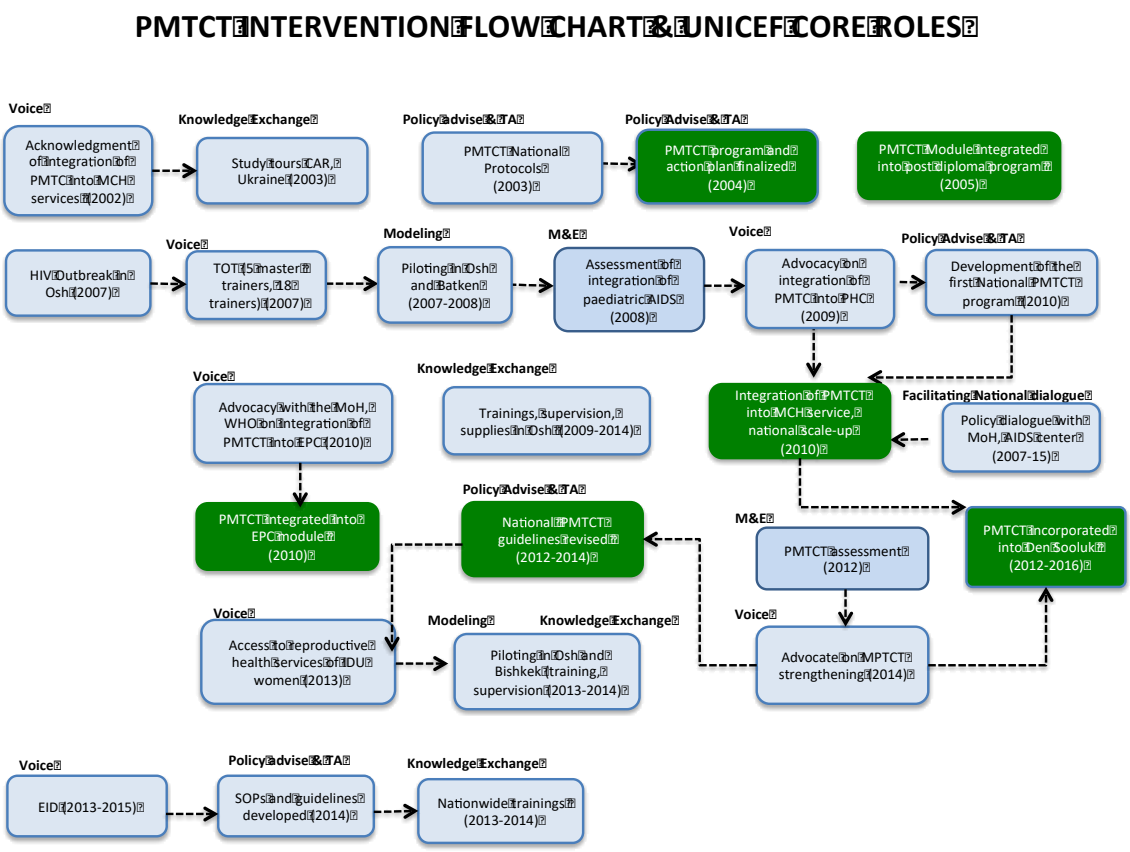


Figure 70: UNICEF Core Roles contribution to the implementation of the PMTCT sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF initiated the process by advocating for integration of PMTCT into MCH services. Through lengthy process of modeling, evaluating, policy dialogue the model was integrated into primary care and maternal care services since 2010 • UNICEF advocated for integration of the PMTCT into EPC module, which was approved in 2012 • UNICEF initiated project on adherence to ARV treatment through modern technologies (mobile based application for children and women on ARV treatment) • UNICEF advocated for empowerment of NGOs and Public Funds working with marginalized women (drug addicted women and their children) and parents of HIV affected children • Therefore UNICEF's contribution to this core role is considered as "Major/Critical"

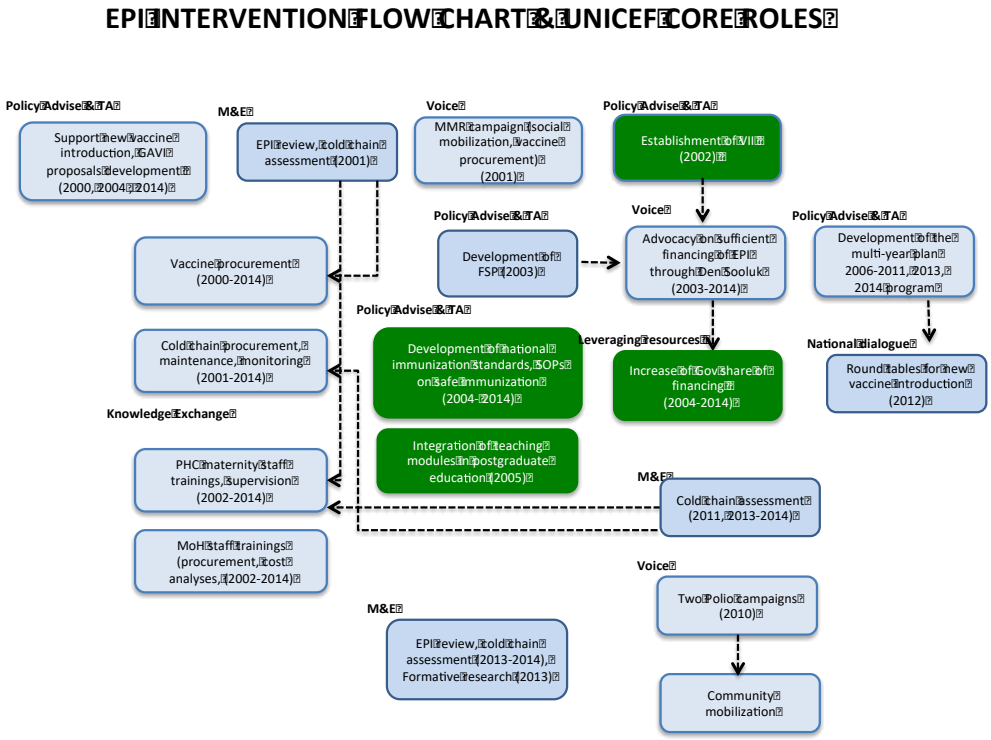
2. Monitoring & evaluation	3	• UNICEF carried out studies that informed policy dialogue with MoH and program design. Two major studies / assessments were Model of Integration of Pediatrics AIDS into general medical services (with consultant from Baylor Initiative, June 2008) and MPTCT assessment (2013), Situation assessment on provision of ARV services provided to children born from HIV positive mothers • Therefore contribution to this role was considered "Major/Critical"
3. Policy advice and technical assistance	3	• UNICEF was instrumental to provide policy advice and technical assistance to the government through the evaluation period and remained to be the only player in the field of PMTCT. • To respond to stigma against HIV infected mothers and children a strategy to address this problem is being developed. The strategy elements became part of the new national program on HIV/ AIDS for 2012-2016. • UNICEF provided policy advice for integration of PMTCT into EPC • Therefore UNICEF's contribution towards this core role is considered to be "Major/Critical"
4. Leveraging resources	3	• UNICEF supported integration of the PMTCT into the national system. • UNICEF leveraged funds from GF and Russian Federation • Thus, its contribution to this core role is rated as "Major/Critical"
5. Facilitating national dialogue towards child friendly social norms	3	- During the evaluation period UNICEF organized round tables on advocacy and integration of the MPTCT module into MCH services, that resulted in integration of the model - Due to UNICEF involvement communication strategy to reduce stigma and discrimination on children affected by HIV with was adopted by the Governor of Osh oblast - Therefore UNICEF's contribution towards this core role is considered to be "Major/Critical"
6. Enabling knowledge exchange	3	- UNICEF was the only development partner assisting the government in the development of human resource capacity at national and local levels through creation of a pool of master trainers and supporting the training throughout the country on PMTCT and Ped AIDS - UNICEF ensured integration of PMTCT into the EPC course. - UNICEF also ensured integration of PMTCT into undergraduate and postgraduate education programs. In summary, UNICEF's contribution towards the given role is rated as "Major/Critical"
7.Modeling/piloting	3	- UNICEF piloted integration of PMTCT into routine PHC and Perinatal system in Osh and Batken oblast. Piloting results were evaluated as successful model. Based on this model PMTCT was integrated in the national system. Thus contribution to this core role is considered to be "Major/Critical".

UNICEF advocated for introduction of new vaccines into the national immunization calendar, supported establishment of ICC and assisted the in the development of GAVI proposal to introduce the HepB vaccine (2000) and Injection Safety proposal in 2004 **(Policy advice &TA)**.

As part of measles eradication UNICEF supported MMR Immunization campaign in 2001 (vaccine procurement, cold chain equipment, social mobilization). In 2010 in response to polio outbreak in Tajikistan two Polio campaigns were supported by UNICEF **(Voice).**

With UNICEF support Vaccine Independence Initiative was established (2002). Government was not able to meet its obligations under Vaccine Independence Initiative to finance MMR vaccine procurement. Following advocacy activities Ministry of Finance disbursed 87% of the 2003 amount expected from the government in co-financing under the JICA grant **(Voice).** In the following year 100% commitment was reached from the Government owing to UNICEF advocacy work. UNICEF provided technical assistance in FSP development and revision (2002-2003). Special trainings were provided for procurement officers at MoH **(Knowledge exchange)**. For pentavaccine introduction facilitation UNICEF provided capacity building of MOH staff on new vaccine introduction cost analysis (2009) **(Policy advice &TA)**.

Figure 71: EPI Intervention Package Flow Chart mapped to UNICEF Core Roles



UNICEF was instrumental in revising protocols on Adverse Effect Following Immunization (2004), developing national immunization standards (2005), SOPs on safe immunization practice (2014) developing of training modules on EPI for medical teaching institutions (Medical Academy and Colleges for Nurses) (2005) **(Policy advice &TA)**.

Significant support was provided to equip, maintain and strengthen the cold chain management system at the national and subnational level. Several rounds of cold chain assessments were commissioned by UNICEF **(Monitoring & Evaluation)**. UNICEF provided support with vaccines during hepatitis B introduction and during immunization campaigns. National EPI procures vaccines from UNICEF supply division.

In 2013-2014 – UNICEF provided support to Center of immunization to conduct survey on assessment of cold chain in vaccination services, installation of computer based monitoring system for cold chain at central vaccine's warehouse in Bishkek **(Monitoring & Evaluation; Policy advice &TA)**.

Table 45: UNICEF Core Roles contribution to the implementing of EPI Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	• UNICEF advocated for introduction of underused and new vaccines together with the WHO through advocacy meetings, round tables. • UNICEF advocated at high levels for support to ensure uninterrupted procurement of vaccines and rationalization of the process of vaccine registration • UNICEF contributed to a critical phases of the processes. e.g. during measles eradication campaign and following polio outbreak in neighboring country UNICEF played major role in immunization campaigns including social mobilization and vaccine / cold chain supply. Therefore UNICEF's contribution to the given Core Role is considered to be "Significant"
2. Monitoring & evaluation	2	• UNICEF contributed to strengthening of monitoring capacity of national and oblast level EPI managers • UNICEF conducted EPI reviews, cold chain assessments, (2001, 2011). MICS studies (2006, 2014) provided information on vaccination coverage for decision-making. • Contribution to the given Core Role is considered to be "Significant"
3. Policy advice and technical assistance	3	• UNICEF assisted the Gov in the development of the Multi-Year Plan of Immunization for Kyrgyzstan and the National Programme on Immunization 2006-2010, provided assistance for developing and revising FSP (2002-03). • UNICEF was instrumental in developing national immunization standards, SOPs on safe immunization practice, AEFI. • Immunization module was integrated in the postgraduate education of doctors and college of nurses. • Significant support was provided to strengthen cold chain capacity of the country, through procurement of cold chain equipment for national and subnational level, strengthening cold chain maintenance and monitoring process. As UNICEF remained active during the evaluation period, its contribution to this core role is considered as "Major/Critical"

4.Leveraging resources	3	• UNICEF assisted the MoH in preparation of the proposal for GAVI funding. • UNICEF supported establishment of VII (2002) and through successful advocacy work achieved to secure 87% of Government share by 2003 and 100% 2004. • Based on UNICEF recommendations, the World Bank used government commitment in vaccine procurement as a major precondition for approval of its health sector loans. The first joint paper to position immunization within public health reform in the region was developed. (2004) • UNICEF assisted the MoH to leverage resources from Government of Japan/JICA for upgrade of cold chain equipment. • UNICEF provided support in procurement of vaccine through Vaccine SD. Based on above, UNICEF was successful in leveraging resources for EPI services from partner organization as well as state and its contribution is considered as "Major/Critical"
5. Facilitating national	2	• During the evaluation period, at critical stages UNICEF supported number of round tables to facilitate national dialogue on new vaccine introduction. Therefore UNICEF's contribution to this core role is considered as "Significant"
knowledge 6.Enabling exchange	3	• UNICEF conducted capacity building activities for health personnel on safe immunization practices, disease surveillance, congenital rubella syndrome, immunization MIS. Significant contribution was provided to strengthen cold chain capacity through training of health workers responsible for cold chain countrywide. Special trainings were provided for MoH staff on procurement, costing of new vaccine introduction • UNICEF contributed to knowledge exchange through study tours, regional workshop/conferences • Conducted formative research on refusals from vaccination • Thus UNICEF's contribution should be considered as "Major/critical"
7.Modelin g/piloting		• UNICEF did not use modeling for EPI activities

IMCI INTERVENTION PACKAGE

In the early 1990's, WHO and UNICEF introduced small-scale programs in Kyrgyzstan to educate health workers on the treatment of diarrheal diseases and, separately, on managing acute respiratory infections (ARIs). In the mid 1990's, as the IMCI approach began to be tested in countries around the world and the WHO Euro advocated the Government of Kyrgyzstan to introduce IMCI initiative. IMCI introduction was joint WHO /UNICEF initiative in the country. UNICEF initiated process in three pilot districts (Aravan, Jail, Jety-Oguz) and following pilot assessment activities were extended to Moskovskyi and Tyupskyi districts **(Modeling)**. USAID Zdravplus supported IMCI in Talas and Naryn oblasts.

Through UNICEF advocacy IMCI coordinators at district level were deployed who were trained through the country (2003-2004). UNICEF supported the MOH in the establishment of National IMCI Center at the National MCH center oversee the implementation of IMCI related activities that became fully operational in 2003-2004. With assistance of UNICEF, the Ministry of Health has issued several orders ("Prikaz") on IMCI strategy implementation (2004) **(Monitoring & Evaluation and Policy advice &TA).**

UNICEF provided IMCI drugs for to the pilot regions (2001-2003). Responding to the system level bottleneck of insufficient drugs at PHC level for management of childhood conditions UNICEF advocated for inclusion of IMCI drugs into essential list of drugs (2004) and into Additional List of drugs (2006) that ensured free drug supply to children under-5 **(Voice)**.

IMCI activities were extended through the country with partners contribution. E.g. IMCI Program was integrated in USAID/HOPE Project and implemented in Bazar-Korgon and Aksyi Rayons of Jalal-Abad oblast (by 2006). Through ADB support the trainings covered Osh, Jalal-Abad and Naryn Oblasts.

IMCI was fully integrated into post-service education system (Kyrgyz State Medical academy, Kyrgyz State Medical Institute for Retraining and Continuing Education). During 2000-2001, five-day IMCI course was part of the four-month FM retraining curriculum. From 2003 with support of UNICEF full duration 8-day IMCI course was integrated into the system **(Policy advice &TA)**. IMCI became a part of pre-service medical school training. In 2006 IMCI training module for nurses was developed.

In 2006, UNICEF and WHO agreed that WHO will undertake training for hospitals and UNICEF will focus on community level. However, there was no serious commitment to develop a national IMCI strategy from the MoH side. In 2006, UNICEF discontinued support for the implementation of this direction. Due to lack of political and financial support for the program IMCI was implemented only on primary care level by 2011 with funding through ministry of health's Den-Sooluk program . Den Soluuk identifies hospital level IMCI as a priority since 2011 . From 2011 the WHO took initiative to implement hospital level IMCI, that included development of the guideline (pocket book), ToT and training of health personnel in 11 pilot hospitals, other partners covered their respective pilot sites, e.g. USAID in Naryn oblast, UNICEF in Osh, Batken and Jalal-Abad oblasts. UNICEF reprinted the WHO guidelines and using the national trainers carried out training courses for hospital level personnel. Special trainings were provided for the MHIF staff in the pilot regions to educate them on requirements of the IMCI guidelines. Hospital level IMCI modules have been integrated into the pre and post-service education system since 2013.

The Care for Development Module of IMCI provides age-based recommendations for

parents in how to play (cognitive development) and communicate (language and social devel opment) with their children from birth through 2 years of age, as well as problems that care givers may bring up and possible solutions. It is designed to be integrated into IMCI,

and recommendations are on the Mother's Card along with recommendations for infant and young child feeding. The module should improve parents' ability to support their children's development and to link development with effective feeding practices, including responsive feeding. The Care for Development module was revised in 2008 and renamed as Care for Child Development.

IMCI module during 2001-2003 did not include care for development. The initial introduction of CCD in Kyrgyzstan was strongly supported by UNICEF. First ToT took place in 2003, followed by training of IMCI coordinators and trainings in five pilot districts. Adaption of materials and development of national standards and ECD policy took place in 2004-2005 **(Policy advice &TA)**. From 2005 UNICEF played a smaller role, and WHO

lead the adaptation of materials and introduction in 2005.

The focus was of the trainings was on pediatricians, family doctors, and medical assistants,

but few nurses were trained.

Evaluation of care for development module of IMCI was conducted in 2007 and 2009 that provided recommendations on strengthening of this component. UNICEF supported a

demonstration project of home fortification (sprinkels) and it was agreed to integrate ECD and nutrition components. With UNICEF support, the Republican Health Promotion Centre, UNICEF's main partner in communication and social mobilization further integrated ECD into communication materials and activities that are delivered to the population through Village Health Committees **(Policy advice &TA)**. Their communication strategy combines sprinkles, proper diet during pregnancy, exclusive breastfeeding, ECD messages that are scaled-up and currently cover more than 80% of rural areas.

In 2012 MoH revised order of the MOH on home visiting and applied approach when to mothers were give at each visit package of messages consisted of:

- Child health
- Child development
- Nutrition/feeding practices

Education/ECD section initiated development of standards of child development (0-3 years old) with interministerial group of experts with leading role of health sector. (2014)

In 2014 UNICEF commissioned an Assessment of knowledge and awareness of danger signs of pregnancy and childhood disease in communities of Osh, Batken and Jalal-Abad by using mobile technologies **(Monitoring & Evaluation)**. The study evaluated change in knowledge at baseline and follow-up after targeted capacity building activities with VHCs and action groups in the villages. It was found that consistent promotion of awareness on certain issues raises awareness of people. However this study was limited to pilot oblasts were very intensive capacity building activities and monitoring takes place, therefore the findings could not be generalized at the country level.

Table 46: UNICEF Core Roles contribution to the implementation of IMCI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	• IMCI was introduced in the country jointly with the WHO, USAID, GIZ. • UNICEF played significant role in IMCI institutionalization at PHC level, other active partner was USAID. • According the agreement between WHO and UNICEF WHO became responsible for hospital level IMCI, while UNICEF had to focus on community level. Hospital level IMCI was initiated by WHO (with delay) and UNICEF joined the process by introducing it at the pilot sites. • UNICEF contributed to critical phases of the project, e.g. advocated for inclusion of IMCI drugs into Additional List of Drugs. • CCD module of IMCI was introduced in the country by UNICEF. It was strong start, but UNICEF did not remain a lead of the process. WHO took over the process. • UNICEF advocated on revision of home visiting standards with development of package of messages: child health, development and feeding practices, which is active now. • Based on above UNICEF contribution to this role is considered "significant"

2. Monitoring & evaluation	2	• UNICEF supported the MoH in assessment of IMCI pilot implementation, training of district level IMCI coordinators to monitor and supervise IMCI implementation process. • UNICEF supported establishment of the IMCI coordination center and M&E unit at the National MCH Center, however the latter is not fully functional due to insufficient budgetary support. • Since 2012 UNICEF initiated monitoring and supervisory visits for primary health care facilities to monitor IMCI • As UNICEF contributed to critical phases, UNICEF's contribution towards M&E Core role is considered as "Significant"
3. Policy advice and technical assistance	2	• UNICEF supported WGs during IMCI guidelines adaptation, training material development, and integration of IMCI in education system, etc. • UNICEF developed package of messages: child health, development and feeding practices, which is active now. Several trainings were organized to implement it nationally wide. • CCD is part of pre and in-service education system as integral part of the IMCI. • In 2014 UNICEF initiated the process of development of standards of child development (0-3) • However UNICEF did not remain active player throughout the evaluation period therefore UNICEF contribution to this Core role is considered to be "significant"
4. Leveraging resources		• UNICEF advocated for and succeeded in inclusion of IMCI drugs into Additional List of drugs for Benefit Package. • UNICEF advocated for integration of CCD messages into Heath Promotion Center communication strategy and thus ensured leveraging of state resources. However extra funding was not ensured by the government meaning that existing funding might not be adequate for all activities the center is implementing. • Therefore UNICEF contribution to this Core role is considered to be "major/critical"
5. Facilitating national dialogue towards child friendly social norms	1	• UNICEF joined the process. UNICEF facilitated the national dialogue e.g. in 2006 when conducted joint meeting with Oblast and Rayon Family Medicine Centers Directors including IMCI coordinators on IMCI strategy implementation sustainability. • UNICEF initiated national dialogue on CCD introduction e.g. provided round tables with stakeholders and policy makers on Better Parenting Programmes, however did not remain active through out the evaluation period. • UNICEF's contribution to this role has been considered as "minimal"
6. Enabling knowledge exchange	2	• UNICEF remained as active player in capacity building of national and subnational health professionals during 2000-2006. After that period UNICEF stopped IMCI activities at PHC level. • UNICEF joined WHO in hospital level capacity building activities in the pilot sites. Therefore UNICEF's contribution towards this Core role is considered as "Significant".

7.Modeling/piloting	2	• UNICEF supported piloting of PHC level IMCI in three districts and further extended to other areas. National scale-up was assured by other partners contribution such as USAID, • UNICEF piloted CCD component of IMCI in five districts. Evaluation of CCD in three countries marked that training mainly targeted doctors and very few nurses were trained. Later on CCD messages were integrated with the nutrition component and scaled-up through village health committees. The study in the three pilot oblasts identified positive changes in awareness among community members, however this could not be generalized countrywide. • UNICEF's contribution to the given Core Role is considered as "Significant"

NUTRITION INTERVENTION PACKAGE

BF/BFHI SUB- INTERVENTION PACKAGE

In late 1990s joint WHO/UNICEF child mortality assessment identified major causes of child mortality that created ground for introduction of Breastfeeding and BFHI initiative in Kyrgyzstan. It was joint WHO/UNICEF initiative. UNICEF trained pool of national trainers and training activities started in pilot districts maternity houses. Training activities extended to other oblasts **(Knowledge exchange)**, and were supported by ongoing monitoring visits **(Monitoring & Evaluation)**. With UNICEF technical assistance National breastfeeding standards were approved by the MoH in 2004. From 2000 up to 2013 56 maternities were certified and recertified as Baby Friendly.

UNICEF supported communication campaign by developing IEC materials for World Breastfeeding Weeks (2003-2004) **(Voice)**.

UNICEF developed a new community health project in Talas province that promoted complementary feeding and other key family practices. A mini-KAP study was conducted to identify current knowledge, attitudes and feeding practices with regard to exclusive breast-feeding and complementary feeding of children of up to 2 years of age. The study identified need of involvement of community members in rising awareness among women on breastfeeding and feeding practices. The FGD among health personnel revealed low adherence to BF practices among health workers. MICS 2006 also identified low exclusive breastfeeding rate (32%) **(Monitoring & Evaluation)**. Based on this findings and lessons learned few major shifts were noted in the Health and Nutrition Programme during 2007. Within the MCH component, firstly, a shift was made from supporting many small projects to focusing on national level support and addressing systemic challenges in MCH. Within nutrition, a shift was made from only hospital-based promotion of breastfeeding to promoting all aspects of nutrition (breastfeeding, complementary feeding, feeding during illness and pregnancy and so on) through a community-based approach to empower families with nutritional skills and knowledge. This integrated approach implied training of Village Heath Committee members on delivering messages on breastfeeding, complementary feeding, feeding during pregnancy. Communication messages were developed by UNICEF technical assistance **(Policy advice &TA)**. Training and monitoring of VHC members was responsibility of Health Promotion Centers. At present VCH are functional in more than 85% rural areas.

UNICEF initiated and supported WGs on legislative work from 2005 **(Voice)**. Technical assistance and strong advocacy work (round tables, consultations) resulted in adoption of the Law on Breastfeeding and Marketing. Substitutes in in December 2008 **(Policy advice &TA)**. The law is based on the International Code of Breast Milk Substitutes and subsequent WHA resolutions.

UNICEF created capacity among civil society and governmental people in monitoring of violation of Code on Marketing of Breast milk Substitutes **(Policy advice &TA)**. Monitoring was provided continuously, after 2010 events serious violations of Code was detected **(Monitoring & Evaluation)**. This prompted revision of the Code (2010) development of the materials for breastfeeding during emergency

With UNICEF technical assistance accreditation criteria for maternity houses were revised to incorporate BFHI criteria into it.

UNICEF commissioned number of studies **(Monitoring & Evaluation)** and assessment that informed policy dialogue and UNICEF program design **(Voice; Policy advice &TA)**.

Figure 72: BF/BFHI sub- Intervention Package Flow Chart mapped to UNICEF Core Roles

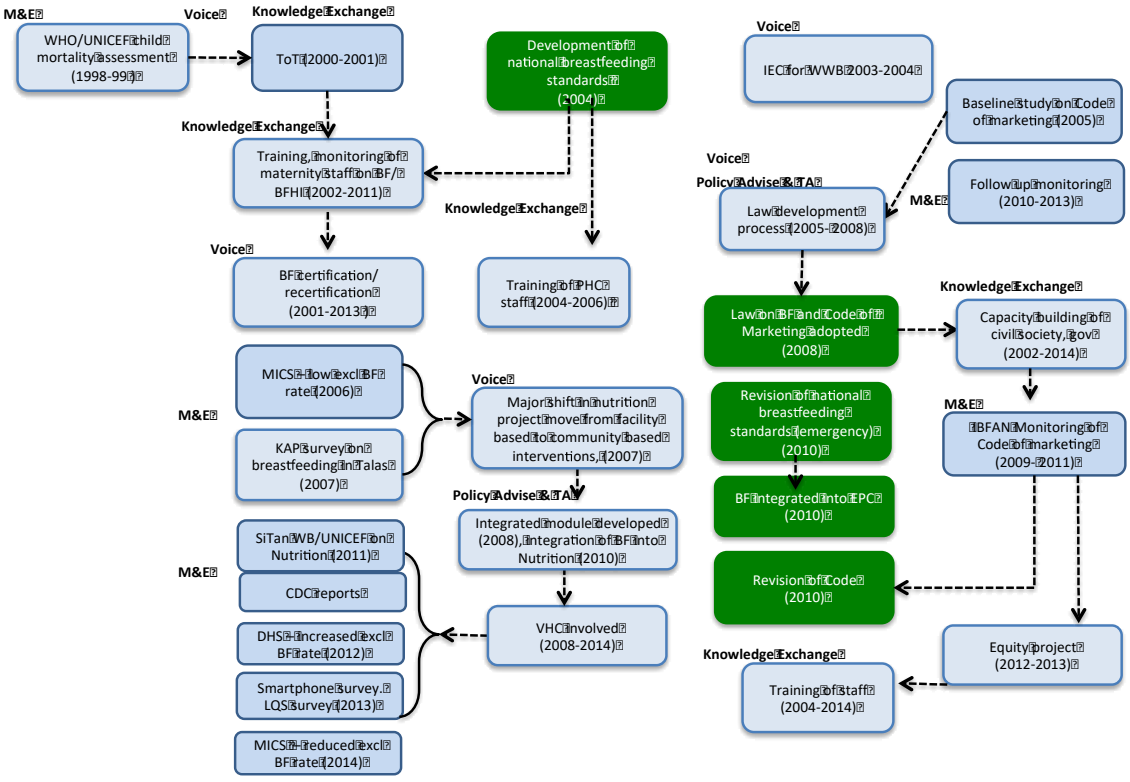


Table 47: UNICEF Core Roles contribution to the implementation of the BF&BFHI Intervention sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF initiated and continued advocacy on BF&BFHI; was instrumental in using M&E results for evidence based advocacy; advocated for integration of the BF into community education activities, EPC module. • UNICEF was active through out the evaluation period and organized number of advocacy events • Therefore UNICEF's contribution to Core role is considered to be "Major/Critical"
2. Monitoring & evaluation	3	• UNICEF supported number of M&E activities directed towards BFHI certification and monitoring Code of marketing as well as other that informed design of UNICEF supported activities/interventions as well as informed advocacy events; • UNICEF commissioned number of studies that vere critical in informing policy dialogue and program design. • Therefore UNICEF's contribution to Core role is considered to be "Major/Critical"
3. Policy advice and technical assistance	3	• UNICEF initiated and assisted the government in the development and adoption of MoH decrees in support of BF and BFHI. • UNICEF initiated and succeeded in adoption and subsequent revision of the Code on BF substitutes. • UNICEF remained active throughout the evaluation period and therefore its contribution to Core role is considered to be "Major/Critical"
4. Leveraging resources	3	• UNICEF was successful in leveraging government and other partner resources in support of BF by inclusion of BF into national nutrition policy. • Through UNICEF successful advocacy work the government signed international commitment to Scaling Up Nutrition (SUN) through developing a nutrition strategy (2011). UNICEF promoted a multi-sectoral approach in the SUN movement by partnering with governmental organizations, donors, civil society, academic institutions, media and the private sector. This resulted in a US $235,000 grant from the SUN Committee for a civil society coalition to support the finalization and implementation of the National Nutrition Strategy (2014-2017) so called Food Security and Nutrition Program. The Nutrition Strategy has been submitted to the government for approval. In 2013 UNICEF initiated the process of fund rising from the Global Agricultural Food Security Program (GAFSP). UNICEF developed a proposal with active involvement of different sectors that resulted in the 5 mln project for the country that will be allocated for the National Nutrition Strategy needs. UNICEF contribution to this role is considered "major/critical"
5. Facilitating national dialogue	3	• UNICEF initiated and facilitated national dialogue on BF&BFHI, ICMBS related issues by organization of workshops, round tables, sessions • UNICEF was active throughout the process and resumed national dialogue when violations of the Code was revealed and initiated Law revision process • Therefore UNICEF's contribution has been considered as "major/critical"

6. Enabling knowledge exchange	3	• UNICEF remained as active player in capacity building of national and local governments and policy makers, and health staff, civil society • UNICEF ensured integration of BF related issues into undergraduate and postgraduate education system • Therefore UNICEF's contribution towards this Core role is considered as ""major/critical"
7.Modeling/ piloting	3	• UNICEF supported piloting of BF& BFHI in 6 regions of the country which eventually has been scaled up at the national level; • UNICEF's contribution to the given Core Role is considered as "Major/Critical"

IDD and FF SUB- INTERVENTION PACKAGES

UNICEF made significant progress in reduction of micronutrient deficiency in Kyrgyzstan. Consumption of the iodized salt by the households has gradually increased from 27.2% (DHS 1997) to 75% (MICS 2006) and 92.8% (MICS 2014). Stunting prevalence among children has decreased from 13.7% (MICS 2006) to 12.9% (MICS 2014). In Talas oblast where community nutrition education and home fortification (Micronutrient Powder - MNP) programs was piloted baseline and follow-up surveys identified reduction of iron deficiency anemia by 27% among 6-24 month old children. Among the group of children who consumed MNP for one year the decrease in iron deficiency anemia was 40.2%.

Iodine deficiency disorders, iron deficiency anemia, vitA deficiency was recognized as an important public health problem in Kyrgyzstan leading to poor health outcomes (high stillbirth, low birth-weight, stunting, congenital anomalies) **(Voice).**

To address nutritional problems UNICEF established a collaborative project with ADB in 2001. UNICEF supported realization of ADB project in Kyrgyzstan during 2001-2004 and took over implementation of large-scale nutrition activities since 2005**(Policy advice &TA)**

Activities included supporting legislation, strengthening of private and public sectors capacity in local processing of salt iodization and wheat flour fortification, empowering of local manufacturers by creating associations of salt producers and millers, establishment of quality control system, providing incentives for fortification, and promoting civil society to monitor the quality of fortified food in the market. **(Voice; Policy advice &TA; Knowledge exchange; National Dialogue)**

UNICEF developed a systematic and comprehensive advocacy programme targeting not only policy makers but also communities, professionals and a broad range of other stakeholders **(Voice).**

Advocacy was complemented by demand creation activities, such as community education and monitoring of salt iodization through Village Health Committees (**Knowledge exchange**). UNICEF partnered successfully with the Swiss Red Cross (CRS) and the MoH on a community education program to raise awareness on importance of the iodized salt consumption among the community members.

In 2009 the MoH in close collaboration with UNICEF launched a pilot home fortification program in Talas oblast **(Modeling)**. The program aimed to improve the micronutrient status of 6-24 months children through "home fortification" using micronutrient powder (MNP), locally called "Gulazyk" containing iron, vitamin A and other micronutrients. The program was supplemented by education component implemented in collaboration with the Swiss Red Cross (CRS) that implied education of community members on importance and benefits of Gulazyk by Village Heath Committees (VHCs).

Based on the impact evaluation survey results **(Monitoring & Evaluation)** in Talas oblast the MoH made a decision to scale-up home fortification program nation-wide from 2010 **(Voice)**. Gulazyk composition was adapted to local needs. Financing of MNP was included in the national program, while UNICEF ensured its provision through the supply division. Gulazyk was distributed through primary heath care network and primary heath care workers were equipped with necessary knowledge to empower community members. However major driver to create demand on the MNP were VHCs. Through excellent coordination of UNICEF with the MoH and partner (CRS) the education campaign was rolled-out nationwide. Education messages on the benefits of Gulazyk and proper ways of its use were included in the education program of VHCs **(Policy advice &TA)**. The VHCs operating in 85% of rural areas provided awareness campaigns through door-to-door visits. By 2011 the Gulazyk programme reached 83.9% of 6-24 month old children countrywide.

One year after the scaled up, the home fortification program faced political resistance. Several members of the parliament attacked the programme by spreading misinformation about the MNP product in media and in parliamentary hearings. As a response, UNICEF developed an advocacy plan, which was implemented both at the national and grassroots levels **(Voice)**. Advocacy work was supported by evidence-based information. VHC and primary health care workers were mobilized to reinforce education activities with community members, while leading experts and CBOs targeted parliamentarians and other opinion leaders to increase their awareness, supply them with scientific justifications and thus change their views in support of MNP **(National Dialogue; Voice)**. The advocacy work was successful to refute the rumours about Gulazyk, however political resistance threatened financing of MNP for one year. UNICEF worked actively to leverage funds and in 2013 secured financing was ensured for MNP for the next three years from multi-sectoral Food Security and Nutrition Program. **(Leveraging)**

To ensure MNP sustainability UNICEF supported creation of the local capacity of Gulazyk production. Since 2013 Gulazyk is produced by the local manufacturer.

Success of the Talas Gulazyk project resulted in the leverage of resources for countrywide implementation. The Soros Foundation provided US$1.3 million for scaling up to other provinces **(Leveraging)**. The political resistance towards Gulazyk threatened sustainability of its' financing. For almost one-year Gulazyk program was not financed and children did not received the MNP. However through UNICEF successful advocacy work a funding sources were identified and since mid 2014 MNP program is provided to the children nationwide.

Figure 73: IDD sub- Intervention Package Flow Chart mapped for UNICEF Core Role

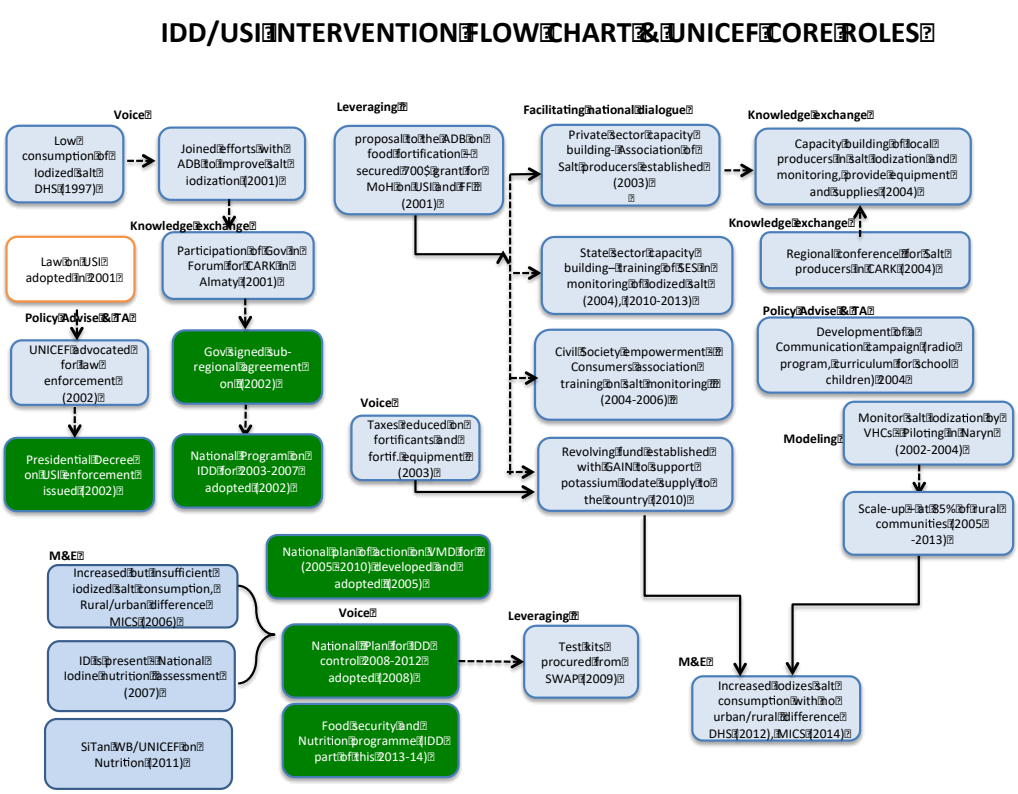


Table 48: UNCIF Core Roles contribution to the implementing of the IDD Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF played a key role advocating for and promoting policy changes in Universal Salt Iodization. The work stream was initiated in partnership with ADB under the ADB regional $6 mln grant to assist CAR countries in salt iodization and flour fortification. • In 2001 UNICEF supported the Kyrg Gov participation at the UNICEF/ADB Almaty forum of CA countries where the Kyrgyz Government signed sub-regional agreement to boost production, distribution, and consumption of iodized salt and iron-enriched wheat flour. UNICEF supported realization of ADB project in Kyrgyzstan during 2001-2004 and took over implementation of large-scale nutrition activities since 2005. Activities included strengthened private and public sectors capacity, including the quality control system, supporting legislation, providing incentives for fortification, and promoting an active civil society to monitor the quality of fortified food in the market. • UNICEF/ADB advocated for reduction of import taxes for fortificants and fortification equipment that was adopted by GoK in 2003. • UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach between all involved partners from different ministries, agencies, private sector, public sector. • UNICEF remained active player through the process. In 2013 UNICEF strong advocacy work, multi-sectoral approach and strategic partnership with other players resulted in the development of the Food Security and Nutrition Program for 2014-2017 • UNICEF contribution to this role is considered "major/critical"
2. Monitoring & evaluation	3	• M&E was integral part of the IDD/USI sub-package. Use of iodized salt in households was investigated by MICS studies (2006, 2014). Model calculations based on the results of the MICS in 2006 showed that by preventing stunting, Kyrgyzstan could save about 2,200 children each year from mortality. On the basis of this evidence, UNICEF developed a systematic and comprehensive advocacy programme targeting not only policy makers but also communities, professionals and a broad range of other stakeholders. • In 2007 UNICEF supported first national survey on Iodine Nutritional Status, findings of which provided bases for the development of the National Plan 2008-2012 for IDD control. • One of the key studies was conducted in collaboration with the WB. The study estimated economic losses due to under nutrition and potential economic gains from improvements in nutrition status of mothers and children through expanding nutrition programming;. • UNICEF created local manufacturers, state control institutions (SES) as well as civil society capacity in monitoring of iodized salt. • UNICEF contribution to this role is considered "major/critical"
3. Policy advice and technical assistance	3	• To address shortcomings of the law on Universal Salt Iodization (adopted by the parliament in 2001), UNICEF played a key role in development of a Presidential decree supporting the law enforcement (2002). • UNICEF supported National Nutritional Strategy development by involving different sectors. At present the draft national strategy for the period from 2013 to 2017 is submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"

4. Leveraging resources	3	• Extensive support was provided to the preparation of a draft proposal to the ADB on food fortification, as well as to a joint ADB/UNICEF round table on micronutrients in Almaty. UNICEF support helped to secure $700,000 of grant funding for the MoH for salt iodization and flour fortification activities. • The MCH Working Group under the SWAp headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition (2011). • UNICEF contribution to this role is considered "major/critical"
5. Facilitating national dialogue towards child friendly social norms	3	• UNICEF has consistently advocated on the priority for IDD elimination through USI with the Government and the national partners. The main partners were ADB, Swiss Red Cross (SRC), Ministry of Health, Kyrgyz Association of Salt Producers and consumer groups. • The Association of Salt Producers was established in 2003 with technical and financial assistance of UNICEF and ADB. Currently 16 salt producers countrywide are covered by UNICEF activities. • UNICEF supported establishment of a revolving fund with the "Premix Fund" in Geneva that ensures procurement of a high quality potassium iodate by the association. (2010) • To improve nutritional status of the population multi-sectoral approach is needed. UNICEF supported National Nutritional Strategy development by involving various sectors such as agricultural, education, health, private industry, and community. At present the draft national strategy for the period from 2014 to 2017 is submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
6. Enabling knowledge exchange	3	• UNICEF supported capacity building of salt producers in technology of salt production and iodization as well as monitoring of the quality of iodized salt (2003). • UNICEF supported procurement of spectrophotometers for salt producers, provided training for state and salt industry laboratory technicians on strengthening of internal quality control, provided appropriate reagents to determine content of iodate in salt samples for 54 SES throughout the country, and supported a competition on "Best manufacturing practices" in salt processing enterprises. Test kits for monitoring of salt iodization were provided to the salt industry, Consumer Association, and VHCs. (2004) • UNICEF ensured training of VHCs on monitoring of salt iodization and their supply with test-kits. • UNICEF contribution to this role is considered "major/critical"
7. Modeling/ piloting	3	• Pilot program of salt iodization monitoring involved children of 7th and 8th grades from 55 targeted schools who surveyed availability of salt iodization at retail outlets in each administrative unit of The Kyrgyz Republic. Pilot testing of the programme was completed in 2001. • In Naryn oblast UNICEF collaborated with the Swiss Red Cross (SRC) to pilot-test salt iodization testing by VHCs at household level and retail outlets. (2002-2004). Within three years iodated salt in households rised from 67% to 98% for the oblast. • The pilot program was scaled-up nation-wide. Through collaboration with the MoH and SRC all VHC operating in 85% of rural communities are trained on and equipped with special test systems to monitor salt iodization. • UNICEF contribution to this role is considered "major/critical"

Table 49: UNICEF Core Roles contribution to the implementing of FF sub- package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF plays a key role advocating for and promoting policy changes in Nutrition. To create enabling legal environment UNICEF strongly advocates for the revisions in the Law on Flower fortification (to ensure fortification of locally produced and imported flower). Various strategies have been applied to overcome resistance of certain groups of the parliamentarians such as: evidence based policy dialogue, inclusion of CBOs, VHC in communicating the messages. • To address micronutrient deficiency and high prevalence of anemia UNICEF initiated and successfully advocated for the national scale-up of the Gulazyk (micronutrient powder) Program countrywide. A year after it's scaled up in 2012 Gulazyk faced sudden political resistance. As a response, UNICEF in cooperation with the MoH developed an advocacy plan, which refuted the rumors about Gulazyk by means of evidence-based justification. The advocacy work, both at the national and grassroots levels, helped to mobilize village health committees (VHCs) and primary health care workers and it successfully resulted in rebuilding trust into Gulazyk MNP with coverage of over 70% of children nationwide. • UNICEF/ADB advocated for reduction of import taxes for fortificants and fortification equipment that was adopted by GoK in 2003. • UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach between all involved partners from different ministries, agencies, private sector, public sector. • UNICEF remained active player through the process. In 2013 UNICEF strong advocacy work, multi-sectoral approach and strategic partnership with other players resulted in the development of the Food Security and Nutrition Program for 2014-2017 • UNICEF contribution to this role is considered "major/critical"
2. Monitoring & evaluation	3	• M&E was integral part of the Nutrition component. Number of studies were provided during evaluation period that played a role in policy advocacy and policy changes. One of the key studies was conducted in collaboration with the WB. The study estimated economic losses due to under nutrition and potential economic gains from improvements in nutrition status of mothers and children through expanding nutrition programming; • Another key study documented effectiveness of Gulazyk in reducing iron deficient anemia among children: Follow-up survey of nutritional status in children 6-24 months of age. Talas Oblast (2010). • Other studies are (Anemia Prevention and Control, Mid-Term Evaluation for UNICEF-CARK Area, 2002, Study of anemia prevalence among women of Kara-Suu district, Osh oblast (2003); Baseline survey on nutritional status of children aged 6-24 months and their mothers, rural Talas oblast (2008); LQAS National Monitoring Survey of Gulazyk Program (2011). • UNICEF contribution to this role is considered "major/critical"

3. Policy advice and technical assistance	3	• UNICEF supported technical working groups on "Mandatory Law o Flour Fortification" development and later for the Law amendment (2013-2014). Currently the amended Law is ready for the second hearing at the Parliament. • Policy dialogue of UNICEF with the government on scale-up of Gulazyk project countrywide was based on the evidence from the follow-up Nutrition survey in Talas province showing decrease of almost 27 per cent in the level of iron-deficiency anemia among children 6-24 months old in one year. • UNICEF supported development of the flour fortification methodology (2008) • UNICEF supported National Nutritional Strategy development by involving different sectors. At present the draft national strategy for the period from 2013 to 2017 is submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
4. Leveraging resources	3	• Success of the Talas Gulazyk project resulted in the leverage of resources for countrywide implementation. The Soros Foundation provided US$1.3 million for scaling up to three other provinces (2010). • The MCH Working Group under the SWAp headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition (2011). • 2012-2014 Soros Foundation 1,4 mln for Nutrition (Gulazyk and ECD) in the south. The political resistance towards Gulazyk threatened sustainability of its' financing. For almost one-year Gulazyk program was not financed and children did not received the MNP. However through UNICEF successful advocacy work a funding sources from the WB project was identified and since mid 2014 sprinkles are provided to the target groups nationwide. • Through UNICEF successful advocacy work the government signed international commitment to Scaling Up Nutrition (SUN) through developing a nutrition strategy and revising a law on flour fortification (2011). UNICEF promoted a multi-sectoral approach in the SUN movement by partnering with governmental organizations, donors, civil society, academic institutions, media and the private sector. This resulted in a US $235,000 grant from the SUN Committee for a civil society coalition to support the finalization and implementation of the National Nutrition Strategy (2014-2017) so called Food Security and Nutrition Program. The Nutrition Strategy has been submitted to the government for approval. • In 2013 UNICEF initiated the process of fund rising from the Global Agricultural Food Security Program (GAFSP). UNICEF developed a proposal with active involvement of different sectors that resulted in the 5 mln project for the country that will be allocated for the National Nutrition Strategy needs. • UNICEF contribution to this role is considered "major/critical"

5. Facilitating national dialogue towards child friendly social norms	3	• To address resistance of the parliament members on the revision of the Law on Flower Fortification UNICEF through CBOs and VHCs carried out communication and advocacy campaign. This helps to sensitize parliament members and fosters Law adoption process. Currently the Law is ready for the second hearing at the Parliament. • Kyrgyzstan signed the pledge "A Promise Renewed" and continued the work within the SUN Movement (2012). Promoting a multi-sectoral approach, UNICEF has been partnering with national level stakeholders such as governmental organizations, donors, the private sector, and associations of producers, academic institutions and media as well as with local level authorities and community-based groups. • To ensure MNP sustainability UNICEF supported creation of the local capacity of Gulazyk production. With involvement of international partner Global Alliance of International Nutrition Feasibility study was provided to identify local producers. • To improve nutritional status of the population multi-sectoral approach is needed. UNICEF supported National Nutritional Strategy (so called Food Security and Nutrition Program) development by involving various sectors such as agricultural, education, health, private industry, and community. The Strategy is being developed under Prime Minister office and MoAg and MoH have prioritized nutrition in their policies and programs. At present the draft National Strategy for the period from 2014 to 2017 have been submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
6. Enabling knowledge	3	• Support to the National Association of Millers in flour fortification methodologies. • Kyrgyzstan acted as knowledge sharing resource for African region on fortification experience. Regional workshop was held in 2012 in Bishkek. • UNICEF supported capacity building of millers in technology of flour fortification (2003). • UNICEF contribution to this role is considered "major/critical"
7. Modeling/ piloting	3	• In Naryn oblast in the frame of the Anemia Prevention and control program flour fortification was piloted in 2001. • Jointly with Swiss red Cross (SRC), UNICEF implemented a home fortification programme "Gulazyk" (sprinkles) in Talas Province. (2009). The project included free provision of micronutrient powder to all children between. Gulazyk program was rolled out nationwide after proven of its effectiveness in reducing iron deficiency anemia (2012). • UNICEF contribution to this role is considered "major/critical"

IDA SUB- INTERVENTION PACKAGE

Anemia among children and pregnant women was identified as a major public health problem in Kyrgyzstan leading to poor health outcomes (high stillbirth, low birth-weight, stunting, congenital anomalies). An Anemia Prevention and Control pilot program was initiated in Karasu rayon of Naryn oblast in 2001 **(Modeling)**. The project had three major components: i) iron supplementation (daily for pregnant women and children 6- 24 months old and weekly for childbearing-age women); ii) flour fortification; and iii) nutrition counseling. Field monitoring of project performance indicated increase demand for low-cost iron supplements through improved social communication and excellent compliance with the supplementation.

UNICEF advocated for adaptation of the National Programme on IDA and VAD prevention in the Kyrgyz Republic for 2003-2007 **(Voice)**. The study was commissioned by UNICEF on Vitamin A deficiency and monitoring of anemia levels in women of childbearing age and children under 3 years old (2003) **(Monitoring & Evaluation)**. The results of the study were used for revision of the National Anemia and development of Vitamin A Prevention and Control Programme **(Policy advice &TA)**.

UNICEF provided iron and folic acid supplements women and children to five pilot districts (2004) and subsequently for pregnant women in pilot oblasts in the southern oblasts in the frame of the

Equity project (2012-2013). UNICEF responded to emergency after 2010 events in Osh and Jalal-Abad oblasts by providing supplements for women and children and staff training on severe nutrition and feeding practices (2010). UNICEF advocated for inclusion of iron and folic acid supplements among Additional List of drugs for Basic Guaranteed package **(Voice)**.

To address iron and other micronutrients deficiency among children UNICEF launched a pilot home fortification program in Talas oblast in 2009 **(Modeling)**. The program aimed to improve the micronutrient status of 6-24 months children through "home fortification" using micronutrient powder (MNP), locally called "Gulazyk" containing iron, vitamin A and other micronutrients (see details on FF sub-package). The program proved its effectiveness in reduction of child anemia and the program was scale-up nationwide.

Extensive training has been provided to health workers on anemia prevention and control, mainly as a part of integrated nutrition trainings. In close collaboration with the SRC and MoH the nutrition component was extended to the community level (from 2008) **(Leveraging)**. The community members (VHCs) have been trained through Health Promotion Center specialists how to deliver messages on proper nutrition during pregnancy, on food fortification with MNP, BF and complementary feeding. Communication messages and visual aids were developed by UNICEF. **(Policy advice &TA).**

In 2011 UNICEF in collaboration with the WB conducted one of the key studies that estimated economic losses due to under nutrition. The study identified child malnutrition and maternal anemia as high priorities that require urgent actions. The study identified potential economic gains from improvements in nutrition status of mothers and children through expanding nutrition programming; This study also informed further development and scaling up of policies and programs. **(Monitoring & Evaluation; Voice).**

Prevention and control of anemia is integral part of the national nutrition policy of the MoH and wider multi-sectoral Food Security and Nutrition Program for 2014-2017 (National Nutrition Strategy). UNICEF played a key role in developing this policy document that has been submitted to the government for resolution (2014) **(Policy advice &TA).**

To support its implementation UNICEF leveraged funding from SUN movement (2011), from additional sources for Gulazyk program, from GAFSP (2013) **(Leveraging)**.

Table 50: UNICEF Core Roles contribution to the implementation of IDA sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF plays a key role advocating for and promoting policy changes in Nutrition and specifically for IDA. E.g. to address micronutrient deficiency and high prevalence of anemia UNICEF initiated and successfully advocated for the national scale-up of the Gulazyk (micronutrient powder) Program countrywide. • UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach between all involved partners from different ministries, agencies, private sector, public sector. • UNICEF remained active player through the process. In 2013 UNICEF strong advocacy work, multi-sectoral approach and strategic partnership with other players resulted in the development of the Food Security and Nutrition Program for 2014-2017 • UNICEF contribution to this role is considered "major/critical"

2. Monitoring & evaluation	3	• M&E was integral part of the Nutrition component. Number of studies were provided during evaluation period that played a role in policy advocacy and policy changes. One of the key studies was conducted in collaboration with the WB. The study estimated economic losses due to under nutrition and potential economic gains from improvements in nutrition status of mothers and children through expanding nutrition programming; • Another key study documented effectiveness of Gulazyk in reducing iron deficient anemia among children: Follow-up survey of nutritional status in children 6-24 months of age. Talas Oblast (2010). • Other studies are (Anemia Prevention and Control, Mid-Term Evaluation for UNICEF-CARK Area, 2002; Micronutrients deficiencies; Study of anemia prevalence among women of Kara-Suu district, Osh oblast (2003); Baseline survey on nutritional status of children aged 6-24 months and their mothers, rural Talas oblast (2008); LQAS National Monitoring Survey of Gulazyk Program (2011). • UNICEF contribution to this role is considered "major/critical"
3. Policy advice and technical assistance	3	• UNICEF advocated for and provided technical assistance for the revision of the National Program on Anemia Prevention Control for 2003-2007. • UNICEF provided policy dialogue with the government on scale-up of Gulazyk project countrywide. • UNICEF supported National Nutritional Strategy development by involving different sectors. At present the draft national strategy for the period from 2013 to 2017 is submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
4. Leveraging resources	3	• Success of the Talas Gulazyk project resulted in the leverage of resources for countrywide implementation. The Soros Foundation provided US$1.3 million for scaling up to three other provinces (2010). • The MCH Working Group under the SWAp headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition (2011). • 2012-2014 Soros Foundation 1,4 mln for Nutrition (Gulazyk and ECD) in the south. The political resistance towards Gulazyk threatened sustainability of its' financing. For almost one-year Gulazyk program was not financed and children did not received the MNP. However through UNICEF successful advocacy work a funding sources were identified and since mid 2014 sprinkles are provided to the target groups nationwide. • Through UNICEF successful advocacy work the government signed international commitment to Scaling Up Nutrition (SUN). UNICEF promoted a multi-sectoral approach in the SUN movement by partnering with governmental organizations, donors, civil society, academic institutions, media and the private sector. This resulted in a US $235,000 grant from the SUN Committee for a civil society coalition to support the finalization and implementation of the National Nutrition Strategy (2014-2017) so called Food Security and Nutrition Program. The Nutrition Strategy has been submitted to the government for approval. • In 2013 UNICEF initiated the process of fund rising from the Global Agricultural Food Security Program (GAFSP). UNICEF developed a proposal with active involvement of different sectors that resulted in the 5 mln project for the country that will be allocated for the National Nutrition Strategy needs. • UNICEF contribution to this role is considered "major/critical"

5. Facilitating national dialogue towards child friendly social norms	3	• Kyrgyzstan signed the pledge "A Promise Renewed" and continued the work within the SUN Movement (2012). Promoting a multi-sectoral approach, UNICEF has been partnering with national level stakeholders such as governmental organizations, donors, the private sector, and associations of producers, academic institutions and media as well as with local level authorities and community-based groups. • To ensure MNP sustainability UNICEF supported creation of the local capacity of Gulazyk production. With involvement of international partner Global Alliance of International Nutrition Feasibility study was provided to identify local producers. • UNICEF supported development of the National Nutritional Strategy (so called Food Security and Nutrition Program). The Strategy is being developed under Prime Minister office and UNICEF played key role in collaborating with various sectors such as agricultural, education, health, private industry, and community. At present the draft National Strategy for 2014-2017 have been submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
6. Enabling knowledge	3	• Capacity building on IDA was achieved through primary health workers training on integrated nutrition topics, as well as VHC capacity building through Health Promotion Centers. UNICEF was active throughout the evaluation period, therefore UNICEF contribution to this role is considered "major/critical"
7. Modeling/ piloting	3	• UNICEF piloted anemia prevention project in Karasu rayon, Naryn 2001. Based on the pilot performance results National Anemia Prevention and Control program was revised. • Jointly with Swiss red Cross (SRC), UNICEF implemented a home fortification programme "Gulazyk" (sprinkles) in Talas Province. (2009). The project included free provision of micronutrient powder to all children between. Gulazyk program was rolled out nationwide after proven of its effectiveness in reducing iron deficiency anemia (2012). • UNICEF contribution to this role is considered "major/critical".

VAD SUB- INTERVENTION PACKAGE

UNICEF advocated for adaptation of the National Programme on IDA and VAD prevention in the Kyrgyz Republic for 2003-2007 **(Voice)**. The study was commissioned by UNICEF on Vitamin A deficiency and monitoring of anemia levels in women of childbearing age and children under 3 years old (2003) **(Monitoring & Evaluation)**. The results of the study were used for revision of the National Anemia and development of Vitamin A Prevention and Control Programme **(Policy advice &TA)**.

With UNICEF technical and financial assistance, the country VMD programme was reviewed. UNICEF was instrumental in the development of the 5-year National Plan of Action for Elimination of Vitamin & Mineral Deficiency in Kyrgyz Republic. The draft was presented to the members of the National Fortification Alliance **(Policy advice & TA)**. Key barriers/constraints in the progress to VMD elimination in the country were assessed and debated, clear and balanced roles for all partners in implementing VMD elimination programmes were formulated (2005) **(National Dialogue)**. In 2006 the Government adopted National Plan of Action for 2005-2010.

Through technical assistance UNICEF contributed to the development of the national guidelines of VAD in 2004 **(Policy advice & TA)**.

UNICEF provided rounds of nationwide vit A supplementation to children 6-59 month and mothers after delivery for 8 weeks through National Center for Immunoprophylaxis (2005, 2006, 2008). UNICEF responded to emergency after 2010 events in Osh and Jalal-Abad oblasts by providing Vit A supplements to children and staff training on severe nutrition and feeding practices (2010). UNICEF advocated for inclusion of vit A to pregnant women in the SWAp. MoH took responsibility and financed provision of vit A (2009) **(Voice)**. Trainings of family doctors on vit A supplementation were provided separately prior to supplementation campaigns and as a part of integrated nutrition

trainings. Vit A supplementation rounds were also complemented by IEC campaign. Targeted communication activities were carried out in south oblasts as a response to emergency.

In close collaboration with the SRC and MoH the nutrition component was extended to the community level. To address micronutrients deficiency among children UNICEF launched a pilot home fortification program in Talas oblast in 2009 **(Modeling)**. The program aimed to improve the micronutrient status of 6-24 months children through "home fortification" using micronutrient powder (MNP), locally called "Gulazyk" containing iron, vitamin A and other micronutrients (see details on FF sub-package). The program proved its effectiveness and the program was scale-up nationwide. The community members (VHCs) have been trained through Health Promotion Center specialists how to deliver messages on proper nutrition during pregnancy, on food fortification with MNP, BF and complementary feeding. Communication messages and visual aids are developed by UNICEF **(Policy advice & TA)**.

Since 2011, the MOH guidelines no longer support postpartum vitamin A supplementation during the first six to eight weeks after delivery.

Vitamin A prevention is integral part of the national nutrition policy of the MoH and wider multi-sectoral Food Security and Nutrition Program for 2014-2017 (National Nutrition Strategy). UNICEF played a key role in developing this policy document that has been submitted to the government for resolution (2014). To support its implementation UNICEF leveraged funding from SUN movement (2011), from additional sources for Gulazyk program, from GAFSP (2013) **(Leveraging)**.

Table 51: UNICEF Core Roles contribution to the implementation of VAD sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF plays a key role advocating for and promoting policy changes in Nutrition. UNICEF advocated for the National Programme on IDA and VAD prevention in the Kyrgyz Republic for 2003-2007. and specifically for IDA. • UNICEF advocated for inclusion of vit A supplements for pregnant women in the SWAp. • To address micronutrient deficiency UNICEF initiated and successfully advocated for the national scale-up of the Gulazyk (micronutrient powder that includes Vit A) Program countrywide. • UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach between all involved partners from different ministries, agencies, private sector, public sector. • UNICEF remained active player through the process. In 2013 UNICEF strong advocacy work, multi-sectoral approach and strategic partnership with other players resulted in the development of the Food Security and Nutrition Program for 2014-2017 • UNICEF contribution to this role is considered "major/critical"
2. Monitoring & evaluation	3	• M&E was integral part of the Nutrition component. Number of studies were provided during evaluation period that played a role in policy advocacy and policy changes. One of the key studies was conducted in collaboration with the WB. The study estimated economic losses due to under nutrition and potential economic gains from improvements in nutrition status of mothers and children through expanding nutrition programming; • Other studies are Vitamin A deficiency prevalence (2003); (Baseline survey on nutritional status of children aged 6-24 months and their mothers, rural Talas oblast (2008); LQAS National Monitoring Survey of Gulazyk Program (2011). • UNICEF created monitoring capacity at the National Center for Immunoprophylaxis, which was main partner in nationwide Vit A supplementation rounds. • UNICEF contribution to this role is considered "major/critical"

3. Policy advice and technical assistance	3	• UNICEF provided technical assistance for the revision of the National Programme on IDA and VAD prevention in for 2003-2007 and development of the 5-year (2005-2010) National Plan of Action for Elimination of Vitamin & Mineral Deficiency in Kyrgyz Republic. • UNICEF provided policy dialogue with the government on scale-up of Gulazyk project countrywide. • UNICEF supported National Nutritional Strategy development by involving different sectors. At present the draft national strategy for the period from 2013 to 2017 is submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"
4. Leveraging resources	3	• Following UNICEF advocacy MoH took responsibility and financed provision of vit A from the budget (2009). From 2011 the MoH no longer provides financial support due to removal from the MOH guidelines postpartum vitamin A supplementation. This was justified by the national scale-up of the Gulazyk program that provides vit A to children from 6 to 24 months. • Success of the Talas Gulazyk project resulted in the leverage of resources for countrywide implementation. The Soros Foundation provided US$1.3 million for scaling up to three other provinces (2010). • The MCH Working Group under the SWAp headed by UNICEF negotiated financial support from DFID (£1 million) and the World Bank ($2.6 million) for child nutrition (2011). • 2012-2014 Soros Foundation 1,4 mln for Nutrition (Gulazyk and ECD) in the south. The political resistance towards Gulazyk threatened sustainability of its' financing. For almost one-year Gulazyk program was not financed and children did not received the MNP. However through UNICEF successful advocacy work a funding sources were identified and since mid 2014 sprinkles are provided to the target groups nationwide. • Through UNICEF successful advocacy work the government signed international commitment to Scaling Up Nutrition (SUN). UNICEF promoted a multi-sectoral approach in the SUN movement by partnering with governmental organizations, donors, civil society, academic institutions, media and the private sector. This resulted in a US $235,000 grant from the SUN Committee for a civil society coalition to support the finalization and implementation of the National Nutrition Strategy (2014-2017) so called Food Security and Nutrition Program. The Nutrition Strategy has been submitted to the government for approval. • In 2013 UNICEF initiated the process of fund rising from the Global Agricultural Food Security Program (GAFSP). UNICEF developed a proposal with active involvement of different sectors that resulted in the 5 mln project for the country that will be allocated for the National Nutrition Strategy needs. • UNICEF contribution to this role is considered "major/critical"
5. Facilitating national dialogue towards child friendly social norms	3	• Kyrgyzstan signed the pledge "A Promise Renewed" and continued the work within the SUN Movement (2012). Promoting a multi-sectoral approach, UNICEF has been partnering with national level stakeholders such as governmental organizations, donors, the private sector, and associations of producers, academic institutions and media as well as with local level authorities and community-based groups. • To ensure MNP sustainability UNICEF supported creation of the local capacity of Gulazyk production. With involvement of international partner Global Alliance of International Nutrition Feasibility study was provided to identify local producers. • UNICEF supported development of the National Nutritional Strategy (so called Food Security and Nutrition Program). The Strategy is being developed under Prime Minister office and UNICEF played key role in collaborating with various sectors such as agricultural, education, health, private industry, and community.. At present the draft National Strategy for 2014-2017 have been submitted to the government for approval. • UNICEF contribution to this role is considered "major/critical"

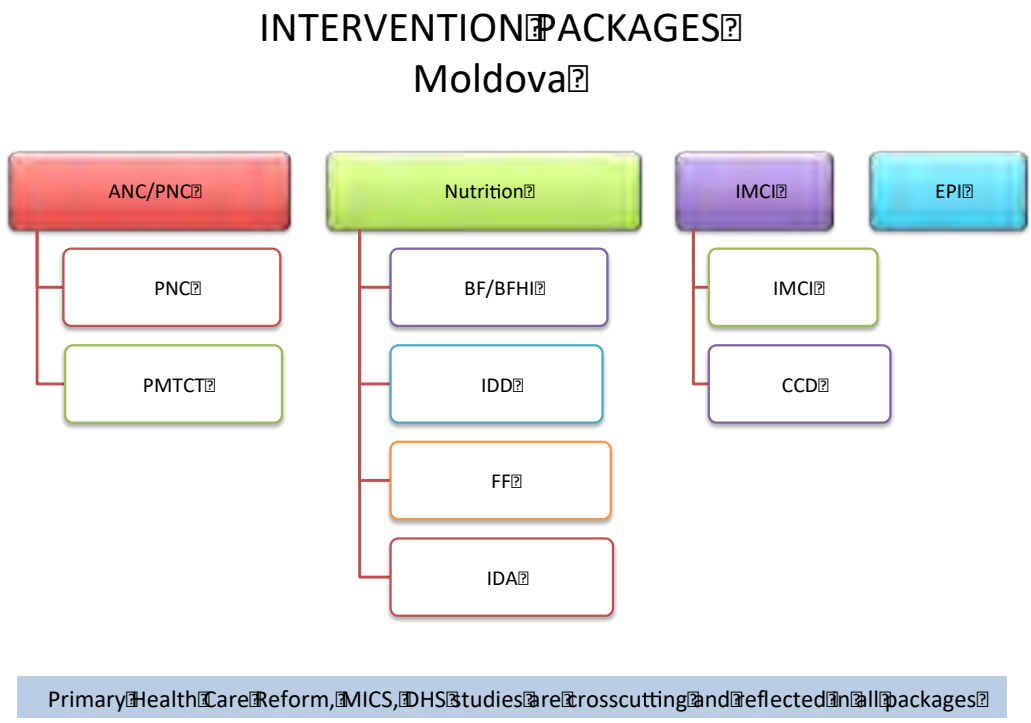
6. Enabling knowledge	3	• Capacity building on VAD was achieved through family doctors training on vit A supplementation, as well as VHC capacity building through Health Promotion Centers. UNICEF was active throughout the evaluation period, therefore UNICEF contribution to this role is considered "major/critical"
7. Modeling/ piloting	3	• UNICEF piloted vitamin A supplementation week in Bishkek that was scale-up in nationwide rounds. • Jointly with Swiss red Cross (SRC), UNICEF implemented a home fortification programme "Gulazyk" (sprinkles) in Talas Province. (2009). The project included free provision of micronutrient powder to all children between. Gulazyk program was rolled out nationwide after proven of its effectiveness in reducing iron deficiency anemia (2012). • UNICEF contribution to this role is considered "major/critical".

MOLDOVA

UNICEF COUNTRY PROGRAMME OVERVIEW

The current evaluation reviews three CPAP periods 1997-2001, 2002-2006 and 2007-2012. CPAP content and the structure greatly varied for the evaluation period. Based on the thorough analysis of the AWP/RWPs and the Annual Progress Reports (APR) UNICEF activities implemented under UNICEF projects and sub-projects during the evaluation period have been grouped into four main Evaluation "Intervention Packages" as shown on Figure 74 below.

Figure 74: Key Intervention Packages



ANC/PNC package includes two sub-interventions. Perinatal Care (PNC) incorporates interventions such as EPC, EmOc, Neonatal Care, Neonatal Resuscitation and International Live Birth Definition (ILBD). Second sub-package is PMTCT.

- **Nutrition packages** includes: BF/BFHI, Iodine deficiency disorders (IDD), Food (flour, salt) Fortification (FF), Iron deficiency anemia (IDA). Vitamin A deficiency disorders (VAD) was not prioritized by UNICEF CO based on evidence that Vitamin A is not a public health burden due to high consumption of Vitamin A rich vegetables.
- **IMCI package -** is limited to interventions directed towards introduction of the IMCI at PHC and hospital level, and Care for Development (CCD).
- **EPI package** - includes all activities related to EPI (vaccine supplies, immunization campaigns, cold chain support, New and underused vaccine introduction, Injection Safety, Financial Sustainability, Immunization Information System, AEFI and VPD surveillance, etc.).

Interventions that are cross cutting through all packages e.g. those related to primary health system reform, MCH forums, MICS studies are reflected in all packages.

UNICEF Country Programme for 1997-2002 was closely interlinked and guided by sound, joint strategies such as strong social mobilization and advocacy, institutional capacity building and service delivery. PHC reform project was not within a standard set-up of the UNICEF projects, however its design and implementation was driven by the UNICEF CO intention to address existing system bottlenecks. The project was unique in its design and attracted attention from the Government and donors. It formed a ground for further reform directions.

The Childhood Care and Development Programme for 2002-2006 was based on the MTSP priorities and applies a life-cycle/human-rights approach. The programme was shifting from a project approach based mainly on collaboration with NGOs and technical assistance provided through punctual external expertise to a broader national approach based on a greater ownership by the government and the local stakeholders. The programme for 2007-2012 took steps to ensure that more women and children from poor and vulnerable families have access to quality, priority lifesaving health services, including those for nutrition.

ANC/PNC INTERVENTION PACKAGE

PERINATAL AND NEONATAL CARE SUB-PACKAGE

Implementation of activities to improve mother and newborn health in Moldova was initiated in late 1990s by UNICEF. As a response to critical maternal and child health situation **(Voice)** UNICEF provided policy advice and technical support for the development of the 1st national programme "Strengthening Perinatal Care in Republic of Moldova for 1998-2002 **(Policy advice & TA)**. The programme was approved by the Government resolution no 1171 of December 18th 1997. Following the 1st National Conference of Perinatal Care in 1997 the national programme was launched. The programme provided provisions of the regionalized perinatal services. The Perinatal medical card was developed in 2001 and approved as a standard of care during pregnancy. The perinatal card includes information about each pregnancy and information on young child care. UNICEF was instrumental in developing Guidelines on major strategies, basic principles and more than 150 organizational standards for perinatal care facilities at different levels. The guidelines were approved with the ministerial decree. UNICEF supported an external consultant to work with the national working group to finalize the clinical protocols for care and treatment in perinatal care. Major principles promoted by the expert consultant included evidence-based medicine, the use of internationally agreed-upon standards and definitions, the cost-effectiveness of the interventions, and a step-by-step approach. National Working Group developed 38 standards of care and treatment for pregnant women and 36 standards of care and treatment for newborns. The standards address – among others – the management of normal pregnancies and deliveries, and the essential care of normal newborns, including breastfeeding. Curricula and training materials on perinatal care for medical students were developed and integrated into medical university training programmes (2001) **(Policy advice & TA)**.

Perinatal model was implemented in four pilot counties during 1998-2001 **(Modelling)**. Following its evaluation **(Monitoring & Evaluation)** the results were presented at the 2nd National Perinatal Conference (organized with UNICEF support in 2001) **(Voice)** and the perinatal programme was scaled-up.

Significant support was provided to improve technical base of the maternities of level III and II. In the initial stage UNICEF leveraged funds from Japanese Government **(Leveraging)**. With Japanese Government support 11 secondary perinatal centers were equipped with the equipment with the value of more than 6,000,000 USD (2001).

With the UNICEF support trainings for maternity staff on different aspects of ante-, intra- and postnatal care for pregnant women and newborns were provided FROM 1998. National scale-up of trainings took place in 2001-2003 **(Knowledge exchange)**. Primary health care staff was trained as well. UNICEF supported production of the perinatal bulletin to inform professionals on the latest achievements and modern technologies in perinatal care.

The development of the perinatal care surveillance system represented an important milestone (2001). In partnership with the CDC Atlanta professionals perinatal care surveillance system model and a work-plan for its implementation were developed **(Monitoring & Evaluation)**. Technical support to the national working group was provided: to develop indicators, define responsibilities for different levels, adjust documents, and estimate the necessary resources. In order to support the group, UNICEF in collaboration with the CDC Atlanta organized a one-week workshop on "Surveillance Systems for Maternal and Child Health". The workshop was followed by a series of important decisions at the national level for modifying data collection procedures for documenting births and deaths and for issuing primary documentation, including birth certificates. With

UNICEF advocacy Perinatal Surveillance system was integrated into the National System. (2001) **(Policy advice & TA).**

Moldova was also selected as the global MPS Initiative European pilot country that was introduced in January 2002.

Series of extensive monitoring and evaluations were performed to track progress, identify implementation problems and find out solutions in 2003-2007. The results of the evaluation were shared with the maternity managers, district and national level managers for analyses, planning and decision-making. As a response to poor managerial capacity special trainings were organized for district and national level managers to develop capacity in the area of problem definition, problem analysis, selection of appropriate solution, as well as monitoring and evaluation (2003) **(Knowledge exchange).**

UNICEF contributed to perinatal audit capacity development (2004-2005) **(Policy advice & TA)**. UNICEF used evidence-based advocacy to create enabling environment at the political level to facilitate implementation of the Perinatal Care Programme. UNICEF provided technical support in the development of the National Perinatal Programme "Promotion of quality perinatal care services" for 2003-2007 **(Policy advice & TA)**.

In 2004 costing of perinatal system was conducted. A set of recommendations on differentiated contracting/funding of maternity hospitals from the primary, secondary, and tertiary levels were developed **(Policy advice & TA)**.

Extensive training of medical staff from maternities and PHC facilities in cost-effective interventions in MNHC was conducted. Second wave of trainings took place in 2004-2005 **(Knowledge exchange)**.

Significant focus was on the community component, through awareness raising activities, developing educational materials for parents, support to the national communication (COMBI) plan on antenatal care (2006), setting up of community education units in maternity hospitals.

From 2005 Swiss Development and Cooperation Agency (SDC) was instrumental to expansion of in-service training and supervision activities on Perinatal Care (to 6 districts) **(Leveraging)**.

UNICEF in partnership with USAID (CDC-Atlanta) played a critical role in advocating for and introduction of the International Life Birth Definitions (ILBD) in the country **(Voice)**. Nevertheless, ILBD was introduced only in 2008 after international community strongly advised the Government to align with the WHO standards of Life Birth definition.

UNICEF heavily supported the MoH with technical, financial and supply assistance in implementing the international live birth definition (ILBD) and scaling up good practices of providing integrated services to children and their families in the health system. With UNICEF support, the capacity of the health system was strengthened to allow a smooth transition to the ILBD by providing medical equipment to all maternities where babies with low and very low birth weight are referred **(Knowledge exchange).** In addition, information materials on child care and development for parents with premature babies were developed and distributed through maternities. The Office ensured a close collaboration with the WHO. The fact that the IMR and U5MR barely increased after the adoption of the ILBD shows that the transition was well managed. As a part of the implementation of ILBD, UNICEF supported the MoH in the development communication materials for the parents on childcare and development of babies born with low and very low birth weight. (2009)

In 2013 UNICEF supported health professionals from the Transnistrian region in enhancing their capacities to provide obstetrical emergencies care and neonatal resuscitation using simulation trainings **(Knowledge exchange)**. This joint project was implemented together with the WHO and UNDP under the EU funded Confidence Building Measures Programme.

UNICEF was an active player up to 2005-2006. From 2007 SDC took over financial **(Leveraging)** and technical support of the Perinatal Care in Moldova and remains the major donor in this field. Other donors that have contributed and still provide support to the Perinatal care in Moldova are WHO and UNFPA, with the different volume of contribution at different stages. MoH, national experts and development partners acknowledge critical role of UNICEF in reforming the perinatal care system in Moldova.

Figure 75: PNC sub-package intervention flow chart mapped by UNICEF Core Roles

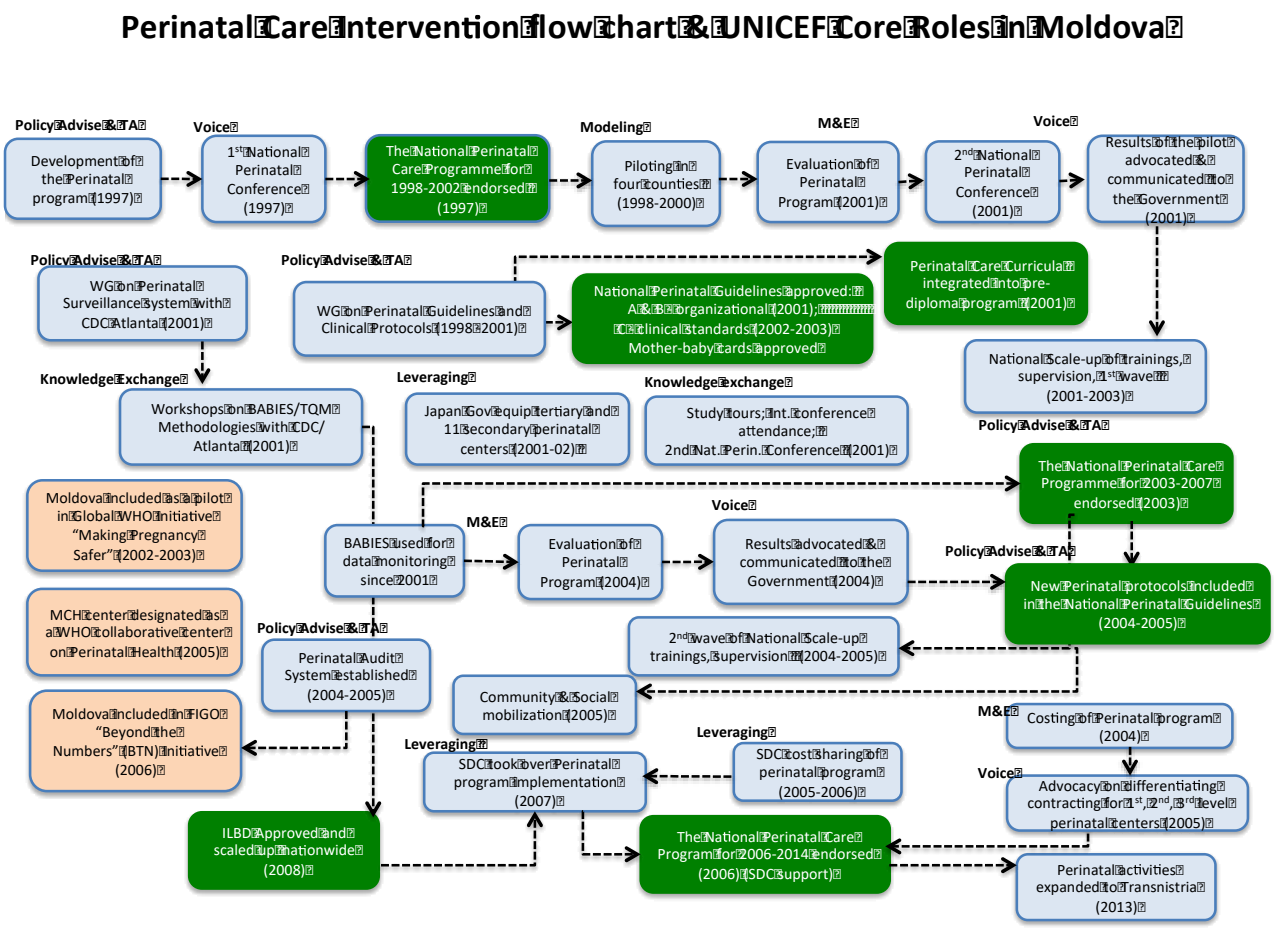


Table 52: UNICEF Core Roles contribution to implementation of PNC sub-package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF was a leading partner in advocating for and implementing regionalized perinatal care system in Moldova. Following the 1st Perinatal National Conference in 1997 the National programme on Strengthening of Perinatal Care in Republic of Moldova for 1998-2003 was launched (1997). The Perinatal Programme developed by UNICEF technical assistance introduced a regionalized model of care. • UNICEF in partnership with USAID (CDC-Atlanta) advocated for introduction of the perinatal surveillance system (2001) and International Life Birth Definitions. The latter was officially introduced in 2008 after international partners' strong advocacy work. • UNICEF advocated for differentiated contracting / funding maternity hospitals from the primary, secondary, and tertiary levels based on perinatal system costing analyses (2004). The results were used by Health Insurance Company to increase allocations. • UNICEF was an active player up to 2005-2006. From 2007 SDC took over financial and technical support of the Perinatal Care in Moldova. • Based on the above UNICEF's contribution to this role is considered "Major/critical"
2. Monitoring & evaluation	3	• M&E component has been strongly emphasized in PNC sub-package. Several evaluations of the perinatal programme were carried out, that represented hard evidence for programme performance, lessons learned and further programming. Evaluation results have been used to educate facility, district and national level managers in problem identification, planning and problem resolution. • M&E remained a key activity during the evaluation period. According to the key informants UNICEF has always used evidence for prioritization and planning. Their accomplishments are also measured by well-designed studies /evaluations. • UNICEF contributed to introduction of the perinatal surveillance system that was integrated into the national system. UNICEF contributed to perinatal audit capacity development. • Specific capacity development activities were directed to strengthen Perinatal Center in data analyses, monitoring and evaluation. UNICEF's contribution to this role is considered "Major/critical"
3. Policy advice and technical assistance	3	• UNICEF provided policy advice for and leaded development of the first and second National Perinatal Programmes. • Through UNICEF's technical assistance with active involvement of WHO experts from Italy, Canada and Scotland, perinatal guidelines on organization of care, regionalization and clinical protocols were developed and approved by the MoH decrees. • To ensure sustainability of the modern approaches modules were incorporated into the curricula of the pre and post-service education system (2003). • UNICEF uses international technical assistance for training capacity development as well for production of high quality surveys / assessments. • UNICEF's contribution to this role is considered "major/critical".

CORE ROLE	RATING	JUSTIFICATION
4. Leveraging resources	3	• In the initial stage UNICEF leveraged funds from Japanese and German Governments that resulted in equipping of perinatal centers with the equipment with the value of more than 6,000,000 USD (2001) • UNICEF in the frame of the PHC reform project developed BBP including essential drugs for antenatal care. After sustained advocacy BBP was scaled-up nationwide that ensured free supplements (iron, folic acid) for pregnant women. (2003) • UNICEF supported costing of evidence-based package and provided policy advice to the Health Insurance Company to increase allocations to perinatal programme (2004) • UNICEF was instrumental in leveraging funds from SDC, during 2005-2006 SDC co-shared perinatal care programme and from 2007 continues significant support to the National Perinatal Programme implementation. • UNICEF leveraged resources from UNDP for perinatal care equipment procurement for Transnistrian region in the framework of Confidence Building Measures project in 2010. • UNICEF's contribution to this role is considered "Major/critical"
5. Facilitating national dialogue towards child friendly social norms	2	• ILBD was initiated by USAID. UNICEF promoted the initiative through inter-sectoral meetings to advocate for introduction of the ILBD and births registry. • Although advocacy work of UNICEF and other partners was strong it did not succeed in early introduction of ILBD in the national system. Only following international communities strong pressure it was possible to introduce ILBD in 2008. • UNICEF's contribution to this role is considered "significant"
6. Enabling knowledge exchange	3	• UNICEF was a major player in health workers capacity development in perinatal care since 1998 up to 2004. • UNICEF contributed to the development of the local training capacity at national and subnational levels. Two waves of nationwide trainings were provided on – from 2000 up to 2004. • The centers were equipped with the necessary IT equipment, furniture, training materials, and manikins. Following capacity building and extensive trainings the Perinatal center experts initiated provision of the technical assistance perinatal systems of other countries. • With UNICEF support, the capacity of the health system was strengthened to allow for care of very low birth weight babies, all perinatal centers where babies with low and very low birth weight are referred were equipped with modern equipment. • Sustainability is ensured through integration of the modules into pre and post-service education. • Currently Moldavian National MCH center has been designated as the WHO collaborative center in perinatal care and its experts provide consultative services to other countries (e.g. CA countries). • The major donor contributing to strengthening health workers capacity in perinatal care in 2006-2014 was SDC. UNICEF's contribution to this role is considered "major/critical"
7. Modeling/piloting	3	• UNICEF introduced piloting of the model in four rayons during 1998-2001. Following evaluation of the pilot programme the national scale-up took place. UNICEF's contribution to this role is considered as "major/critical"

PMTCT SUB-PACKAGE

UNICEF supported PMTCT activities initiated in Moldova from 2002 when an interdisciplinary Working Group was established by the MCH Department to work on a national plan of action for PMTCT prevention, defining clear responsibilities for various health care services, as well as developing guidelines and standards for clinical practice. This was complemented by procurement of antiretroviral drugs for ten HIV infected pregnant women and their newborns – an initiative by the country office on behalf of the Government. Pharmaceuticals were purchased to cover the country's needs for preventing PMTCT in the next two years. (2002)

UNICEF played a leading role in advocating for PMTCT activities among development partners by organizing joint meetings and providing inputs to the National HIV/AIDS Strategy and PMTCT plan of action **(Voice)**. UNICEF facilitated the development of project proposals for the Global Fund on HIV/AIDS and the World Bank grant **(Policy advice & TA)**.

With UNICEF's technical assistance national PMTCT guidelines were developed (2003) that entered into force in 2004. With UNICEF's technical assistance training manuals were developed and 16 national trainers were trained **(Policy advice & TA)**.

Health personnel training activities initiated in 2004. Since 2004 UNICEF provided technical assistance to PMTCT trainings for the staff involved in PMTCT activities (obstetricians, gynecologists, neonatologists, infectionists, paediatricians, family doctors, midwives and nurses) categories of medical personnel as well as senior management of facilities responsible for PMTCT provision, with a significant scaling up in 2005, covering 500 persons (UNICEF and GF programmes). Initially PMCT trainings for the staff of the maternity houses were conducted only for 4 specialised institutions accepting HIV-positive women for delivery (2 in Chisinau, 1 in Balti and Tiraspol) **(Knowledge exchange)**.

UNICEF supported incorporation of PMTCT into the curricula of Medical University, colleges and Postgraduate Education Institution (2004). PMTCT related info has been included in the Home-Based Perinatal Care Record routinely used in antenatal care.

UNICEF supported modification of the PMTCT surveillance system (including new PMTCT data collection forms and reporting procedures). The new surveillance system was approved by the MoH and implemented nationwide **(Monitoring & Evaluation)**.

In 2007, based on the Order of the Ministry of Health Nr. 344 of 05.09.2007 a network of VCT centres were established which could ensure universal access of the general population to counselling and testing to HIV. PMTCT was identified as a government priority in Strategy of the current National Programme.

UNICEF supported the Ministry of Health to update and distribute the National PMTCT Guidelines in line with the latest WHO protocols. Multidisciplinary teams were trained on PMTCT in all districts nationwide (2008) **(Knowledge exchange).**

UNICEF piloted two projects in Balti and Tiraspol in 2007 **(Modeling)**. The project targeted HIV+ pregnant women and mothers, HIV+ children, children affected by HIV and their families covering at least 20% of the HIV/AIDS affected families in the two cities. The focus of the projects was creation of a "school of HIV+ mothers", building capacities of health workers from the perinatal center in Balti in dealing with HIV+ pregnant women and mothers and their newborns, provision of integrated counseling services to HIV+ mothers and their children, combating stigma and discrimination related to HIV, with focus on educational establishments (kindergarten and schools), development of relevant info-materials, etc.

In 2007-2009, UNICEF consolidated the previously initiated activities on PMTCT and together with the WHO supported the Ministry of Health in provision of significant advocacy and technical support to develop a policy and supportive legal and regulatory framework and to build capacities of the service providers at all levels **(Voice; Policy advice & TA**.

Starting from 2014 all pregnant women with HIV will receive ARV treatment that will continue throughout the life. Percentage of HIV positive women receiving ARV prophylaxis treatment to reduce HIV transmission from mother to child in the Republic of Moldova, (92.8%) 2012 and (95.4%) 2013.

Table 53: UNICEF Core Roles contribution to the implementation of PMTCT Sub-Package

CORE ROLE	RATING	JUSTIFICATION

1. The 'Voice' for children	3	• UNICEF initiated PMTCT activities in the country through advocating for PMTCT activities among development partners by organizing joint meetings and providing inputs to the National HIV/AIDS Strategy and PMTCT plan of action. • UNICEF Country office maintained leading role in PMTCT during 2004-2009. Currently PMTCT is fully integrated into the national system, by all maternities providing prevention services • Therefore UNICEF's contribution to this core role is considered as "Major/Critical"
2. Monitorin &	3	• UNICEF carried out number of evaluations, need assessment to guide interventions. • UNICEF contributed to development of the PMTCT surveillance system that was approved by the MoH. • Therefore contribution to this role was considered "Major/Critical"
3. Policy advice and technical assistance	3	- UNICEF was instrumental to provide policy advice and technical assistance to the government during 2004-2009. UNICEF partnered with the WHO in the development, revision of the national guidelines and clinical protocols that were incorporated into Curricula of Medical University, colleges and Continuous Education Institution. - Therefore UNICEF's contribution towards this core role is considered to be "Major/Critical"
4. Leveraging resources	3	- With UNICEF's technical assistance country proposals for GFATM were developed (2002, 2008). UNICEF leveraged funds from the WB and GF to support PMTCT. Number of critical issues in the area of PMTCT (i.e. training on VCT, procurement of HIV tests, ARV drugs and formula) were approved for funding by the Global Fund and the World Bank. • Thus, its contribution to this core role is rated as "Major/Critical"
5. Facilitating national	3	- During the evaluation period UNICEF carried out advocacy work to decentralize PMTCT, so that services are integrated into the PHC and Maternity facilities. Currently MPTCT in integrated into the MCH services UNICEF partnered with the WHO, and its role - is considered to be "major/critical;"
6. Enabling knowledge exchange	3	- UNICEF played significant role in developing the human resource capacity at the national and local levels through creation of a pool of master trainers and supporting the training of multidisciplinary teams (ob/gyn, neonatologist, family doctors, midwives, nurses) throughout the country. - With UNICEF support PMTCT training curricula & materials were included into the pre-service and continuous training programmes of health care workers, both doctors and nurses. (2004) - UNICEF ensured integration of PMTCT into the EPC course. - In summary, UNICEF's contribution towards the given role is rated as "Major/Critical"
7.Modeling/pilo ting	2	- Initially training activities were limited to four maternity facilities, where PMTCT services were provided; later on capacity building activities covered all district maternity houses. - In 2007 UNICEF piloted two projects in Balti and Tiraspol on MPTCT and Pediatric AIDS. The focus was creation of school of mothers, involvement of educational establishments, local authorities. No further scale-up in such as form took place. - Thus contribution to this core role is considered to be "Significant".

EPI INTERVENTION PACKAGE

As part of measles eradication UNICEF supported MMR Immunization campaign in 2002. By Memorandum of Understanding amongst key partners, UNICEF was appointed as a key coordinator of campaign. The campaign included a strong social mobilization component, procurement of 1,2 million doses of measles/rubella vaccine **(Voice)**. Partners were CDC-Atlanta, Red Cross/USA, Red Cross/Moldova

UNICEF procured vaccines for National EPI from JICA and GAVI funds and monitored the vaccine & supply arrival and distribution (2002).

In collaboration with the partners UNICEF advocated on increased allocations of the Government funds to the national EPI. As a result in 2002 93 percent of the Government committed funds were disbursed (compared with 63 percent in 2001) **(Leveraging)**.

UNICEF provided support to the external training on financial sustainability of immunization programme for a group of national experts. As a result of joint UNICEF-WB advocacy and technical assistance, the Financial Sustainability Plan on Immunization was endorsed by the Moldovan Government (2005) **(Voice)**.

To support the implementation of the nation-wide immunization campaign against Hepatitis B, UNICEF partnered with the World Bank.

Special trainings were provided for procurement officers at the MoH. For pentavaccine introduction facilitation UNICEF provided capacity building of MOH staff on new vaccine introduction cost analysis (2009) **(Knowledge exchange)**.

UNICEF was instrumental in revising protocols on Adverse Effect Following Immunization (2004), developing national immunization standards (2005), SOPs on safe immunization practice (2014) developing of training modules on EPI for medical teaching institutions (Medical Academy and Colleges for Nurses) (2005) **(Policy advice & TA).**

Significant support was provided to equip, maintain and strengthen the cold chain management system at the national and subnational levels. Several rounds of cold chain assessments were commissioned by UNICEF **(Monitoring & Evaluation)**. UNICEF provided support with vaccines during hepatitis B introduction and during immunization campaigns.

In response to resistance to Immunization with the UNICEF support, the National Public Health Centre conducted a formative assessment on immunization that allowed the identification and exploring of perceptions, concerns, and perspectives of key stakeholders (beneficiaries, service providers, opinion makers) on vaccination that may lie at the root of potential resistance to the new vaccines **(Monitoring & Evaluation)**. Research data supported the development of an evidence-based communication strategy that supported the introduction of the new Rotavirus vaccine and of a crisis communication strategy.

UNICEF continued to provide support related in customs clearing and logistics to assist with the Government procurement of GAVI supported vaccines. UNICEF supported the national center for Immunoprofilaxis in GAVI report, Joint reporting, etc. **(Policy advice & TA)**.

Among development partners the WHO remains the main player contributing to strengthening of the national EPI. UNICEF's role is significant in communication, vaccine procurement, cold chain strengthening. Good coordination among the partners ensures synergy of efforts and strengthening of the Programme.

Table 54: UNICEF Core Roles contribution to implementation of EPI Intervention Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF continuously advocated with the MoH and major donors for ensuring sustainability of the National Immunization Programme, financing of the health care sector based on priorities. • UNICEF advocated for introduction of underused and new vaccines together with the WHO through advocacy meetings, round tables. • During measles eradication campaign UNICEF played major role in immunization campaigns including social mobilization and vaccine / cold chain supply. • As a result of joint UNICEF-WB advocacy and technical assistance, the Financial Sustainability Plan on Immunizations was endorsed by the Moldovan Government. • UNICEF's role was significant in social mobilization during campaigns, during introduction of new vaccine and to support routine immunization. • UNICEF's contribution to the given Core Role is considered to be "Critical"
2. Monitoring & evaluation	2	• UNICEF contributed to strengthening of monitoring capacity of national and rayonal level EPI managers through training activities, equipping them with monitoring tools and job-aids. • MICS, DHS studies provided information on vaccination coverage for decision-making. • Contribution to the given Core Role is considered to be "Significant"
3. Policy advice and technical assistance	2	• UNICEF assisted the Government in the development and revising FSP, which was approved by the Government. • Major partner in developing national immunization standards is the WHO. • With UNICEF support Immunization module was integrated in the pre-service education of doctors and college of nurses. • As UNICEF remained active during the evaluation period, its contribution to this core role is considered as "significant"
4.Leveraging resources	2	• UNICEF assisted the MoH in preparation of the proposal for GAVI funding. • UNICEF in cooperation with the partners conducted high level advocacy meetings, aiming at increasing government supported financing of vaccine & supply procurement /Vaccine Independence Initiative to reach self-sustainability of the National Immunization Plan • UNICEF provided support to the external training on financial sustainability of immunization programme for a group of national experts • UNICEF provided support in procurement of vaccine through Vaccine SD. • Based on above, UNICEF's contribution to the given role is considered as "significant"
5. Facilitating	0	• Did no use this role for EPI activities
6.Enabling knowledge exchange	2	• UNICEF conducted capacity building activities for health personnel on safe immunization practices, disease surveillance, to strengthen cold chain capacity. • Thus UNICEF's contribution should be considered as "Significant"
7.Modeling/piloting		• UNICEF did not use modelling for EPI activities

IMCI INTERVENTION PACKAGE

Moldova was among the first countries in the WHO European Region to implement IMCI starting in 1998. IMCI had been recommended to Moldovan Government and Ministry of Health by the WHO, UNICEF, and the World Bank as the most cost-efficient strategies of improvement mother and child care with a considerable potential to accelerate the processes of social and economic development of the country.

After an adaptation and pilot phases until 2002, the years 2002-2007 were the years with the most intensive IMCI programme implementation for the Right Bank and 2008-2010 for the Left Bank. Since 2007 UNICEF and its implementing partners have gradually decreased their technical and financial support to IMCI activities. MCH Department of the Ministry of Health and the M&E Unit of the Mother and Child Institute have taken over full oversight and monitoring functions of the programme in 2008.

The initial two phases received technical and financial support of the WHO Office for Europe, WHO Moldova and UNICEF. Starting with year 2003 SDC co-financed UNICEF for support of scale-up programme phase **(Leveraging).** SDC contribution was instrumental in ensuring the implementation National IMCI Strategy. SDC assistance contributed to geographical expansion of the IMCI training to ensure nationwide coverage, thus complementing the work supported by the UNICEF and WHO in the area of Mother and Child Health. Additional partners in the initial phase included Health Investment Fund and non-profit organization Amici dei Bambini.

UNICEF ensured programmatic and financial management of all IMCI activities and ensured coordination of SDC support to the one provided by the UNICEF and the WHO in the area of Mother and Child Health. UNICEF staff undertook systematic field visits to project sites to monitor the implementation of SDC supported activities and made recommendations or suggested corrective actions to its main partners, prepared progress and financial implementation reports **(Monitoring & Evaluation)**.

The implementation of the programme has evolved in three phases:

Programme adaptation and introduction (1998-2000). During phase one UNICEF supported a national working group that oversaw and adapted IMCI training curriculum and training materials, developed job aids and mother's card. The adapted IMCI package was reviewed and received approval from the WHO **(Policy advice & TA)**. Training of Trainers (ToT) was provided and training center was established (2001) **(Knowledge exchange)**.

Programme piloting (2000-2002) IMCI was piloted in the same county of Lapusna/Hincesti, where the pilot PHC reform was conducted **(Modelling)**. The PHC reform project focused on provision of a basic package of services and emergency care. UNICEF provided basic equipment to health facilities, training on new heath management techniques and initial stocks of essential drugs including IMCI drugs. The availability of essential drugs in the county and better preparation of local health personnel in the health reforms process influenced the selection of this pilot region for IMCI. During piloting national supervisors were trained to supervise IMCI implementation, training curriculum was adapted to add the module Care for Development **(Policy advice & TA)**.

- UNICEF supported revision of the Child Development Card #112 (2001) and child card for Parents (2002).

UNICEF in partnership with other donors supported integration of IMCI training materials into the pre-service training of doctors and nurses. Two training manuals were developed and published, with UNICEF support, for the Medical University and College. IMCI training modules were included in in-service training of the primary health care staff as part of a joint project between UNICEF and the Health Investment Fund (World Bank project). (2002) **(Policy advice & TA).**

By 2002 (after 4 year), around 700 family doctors and 1,500 nurses in all the judets[213] benefited from IMCI training. National level orientation meeting with PHC facility managers was conducted **(Knowledge exchange)**.

*Programme scale-up (2003-2010)***.** As a result of the PHC reform UNICEF advocated for incorporation of evidence-based essential drug list into national policies and budgets such as IMCI drugs. After sustained advocacy, IMCI is now included in the national Basic Benefits Package and IMCI drugs are available for children

[213] Judets, same as counties were comprised of several districts. Judets were established in 1999 and were abolished in 2003.

under-5 without cost **(Voice)**. The list of drugs is renewed on annual bases and covers all needs for management of common childhood conditions at the PHC level.

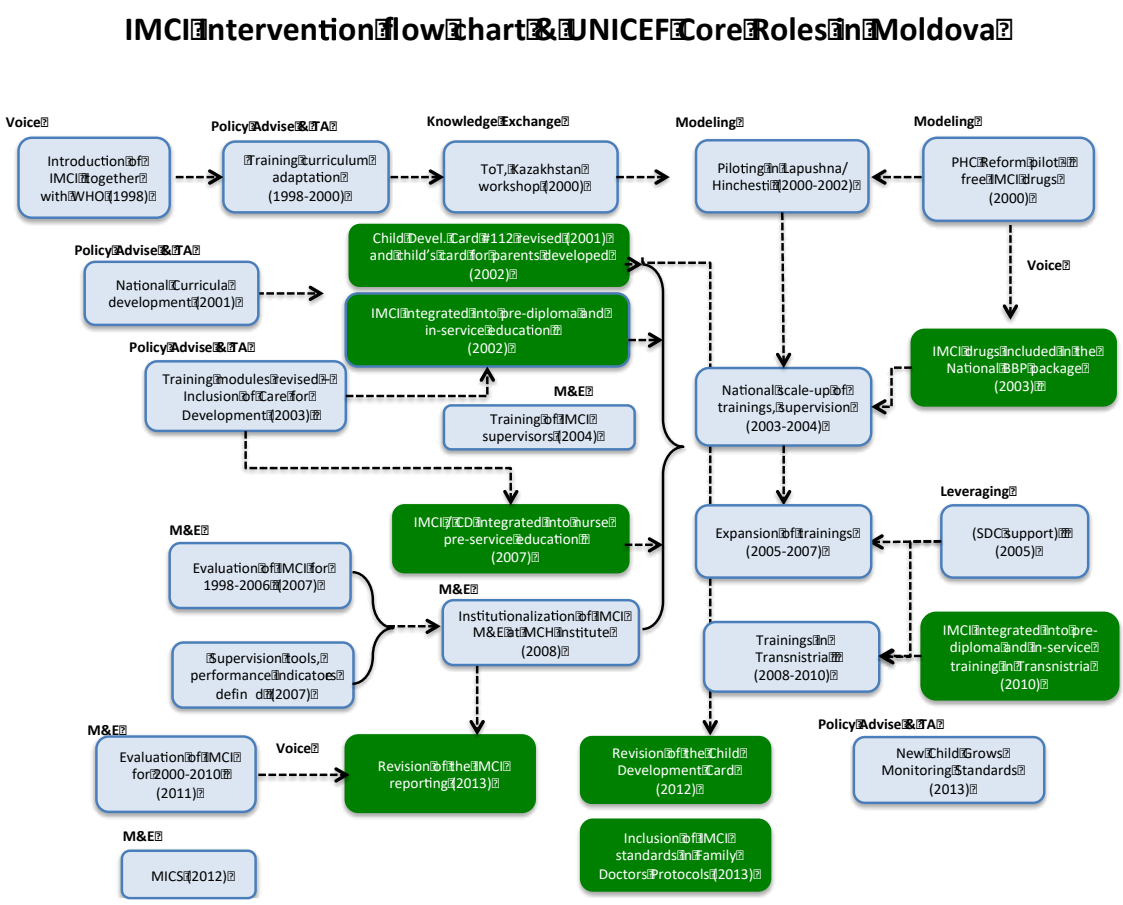
UNICEF was instrumental in strengthening of monitoring and supportive supervision in IMCI **(Monitoring & Evaluation)**. Supervision regulations, tools and performance indicators were developed and supervision activities were costed. UNICEF supported institutionalization through advocating for development of the IMCI supervision center within the M&E unit of the National MCH Centre. Local capacity was increased through training of district level managers. Evaluation in 2010 revealed that reporting system added a significant writing burden on health providers leading to increasing service provider resistance towards the whole IMCI strategy. Based on the recommendations by 2013 MOH order IMCI specific reporting systems were abolished.

During 2008-2010 UNICEF directed its effort to IMCI activities in Transnistria and other districts where training coverage was low.

Currently new protocols developed for the PHC workers incorporate IMCI principles. The protocols have been developed by the WB supported project since 2013.

Hospital level IMCI has not been introduced in Moldova. Since 2006 the USAID has supported development of the protocols for management of most common childhood conditions at the secondary care level. The protocols are approved by the MoH decree and is distributed countrywide. Nevertheless, as found by the site visits and key informant interviews old fashioned practice with over-medicalization and unjustified hospitalizations is still prevalent at the hospital level.

Figure 76: IMCI Intervention flow chart mapped by UNICEF Core Role



Care for Child Development (CCD). At the initial stages of IMCI implementation it was focused on health workers capacity strengthening with less attention paid to the community. Several studies indicated need of strengthening parent's awareness about child development issues. MICS 2000 revealed that parents did not know when a child's condition was critical enough to seek the help of a doctor. Perinatal evaluation in 2004

indicated that the weakest components of IMCI were family and community practices. To address this bottleneck Care for Development (CCD) sub-package was added to IMCI. The initiative focused on strengthening and enriching family education/counseling, going beyond health, nutrition, and immunization to include a broader understanding of child development. Since 2004 CCD became integral part of the IMCI. In the frame of the initiative the following activities were done:

  - Form #112/1/e for parents was developed and Form #112 child medical record was revised in line with desired goals in working with parents and families.
  - Form 112 - Child's medical record kept in PHC facility by the family doctor. The form, revised and enriched with reference growth charts, is structured to reflect the IMCI approach to physical examination, parent education and the planned follow-up. The form also features a matrix of what to look for/talk about during each visit to the family doctor or nurse. Medical staff has to check the box in the matrix for each topic
  - Form 112/1/e - Card for parents entitled Agenda for Family. It includes information on child development and on what family members can do to support the child's overall development. There is emphasis on: nutrition, feeding, immunization (immunization chart), care for Development (communication: talking to the child, reading to the child and playing with the child), danger signs in relation to the identification of illnesses for which medical services should be sought, safety, hygiene.
  - A series of 12 booklets for parents were developed and used in selected regions. The booklets were accompanied by a facilitator's manual on how to use these with parents. Some of the titles are Play: An adventure in learning, Fun with books, Keeping your child safe etc.;
  - In connection with promoting greater public awareness of the importance of the first three years of life, in 2005, a one- or two-day course was offered in each district to which key people within the district were invited (mayors, council leaders) in order to introduce them to early stimulation practices. The attendance rates at these workshops were high with many requests for more information and training. This awareness-raising process included teachers and other community members.
  - 41 teaching staff from the State University of Medicine and Medical Colleges acquired up-to-date knowledge and skills in the area of early childhood and parent education. PHC workers in pilot regions (Balti, Cahul, Orhei, Riscani district of Chisinau) acquired knowledge and skills in working with families on early childhood care and development practices. (2004).
- Evaluation of IMCI in 2010 identified that IMCI programme was effective in changing knowledge and practices of caregivers especially in the areas of child feeding and knowledge of danger signs. The overlooked area where little progress was achieved was counseling for early stimulation and development.

Below are given programme weaknesses as well as challenges during programme implementation, based on the review of IMCI evaluation report carried out in 2010 and key informants interviews during the evaluation.

- IMCI was met with significant initial resistance of health provider.
  - Resistance was mainly caused by shortage in PHC physicians and nurses that leads to work overload and does not allow sufficient time for data collection and reporting.
  - Those who had long working experience and pediatrician’s background, mainly those from urban areas resisted the programme. They considered the IMCI approach more relevant to less developed countries and not for physicians; Therapists who were retrained into family doctors, those with short working experience were more receptive and acknowledged the value of the programme.
  - Training coverage of nurses was lower than anticipated and the quality of training as integrated in the Medical College was lower than of the medical doctors training.

- Although acknowledged by everyone to be a tremendous help in informing and counseling mothers, reprinting of Mother's Agenda with help of local health authorities did not occur, with exception of single cases (e.g. Balti) and most PHC institutions faced stock-outs (2010). During site visits the facilities had stock of new cards reproduced by SDC programme.
- The hospital pediatric and emergency sectors have not been included in the IMCI training process and there is a discrepancy in practice between PHC sector and hospital sector.
- Noncompliance with the IMCI standards. Although IMCI standards do not require hospitalization of children under-1 with ARI if the condition does not qualify for it, there is an established practice of hospitalization of all infants with ARI regardless of severity. The practice is explained by minimizing chance of poor outcome if child deteriorates at home and the care-taker underestimates the severity of illness. This approach could have been justified taking into account decreasing trend of awareness among mothers on danger sign of child to seek care. Another example of noncompliance to standards is unjustified prescription of antibiotics. Although this practice varies from facility to facility, some facilities with strong monitoring system observe reduction in the expenditures on drugs, while others with weak monitoring system do not see reductions in cost expenditures as a result of IMCI implementation.

The evaluation found that IMCI programme in Moldova is a strong, well-designed, well-implemented high-quality programme. The IMCI programme has achieved and exceeded its outputs of coverage with training, IEC and supervision of health providers and coverage with the information materials of caregivers. The programme has also been effective in changing knowledge and practices of caregivers, especially in the area of child feeding and knowledge of danger signs. The overlooked area where little progress has been achieved is counseling for early stimulation and development.

Among the impacts of the programme is reduction of child mortality cases at home. As suggested by the qualitative data IMCI has helped to reduce hospitalization of severe and very severe cases overall and for diarrhea and pneumonia specifically. Fewer cases of meningitis have been observed during recent years.

The MoH identified that child mortality at home and mainly among vulnerable groups (single mothers, poor, drug and alcohol abused women) was one of the major contributors to poor health outcomes and acknowledged that the problem needed health and social sector collaboration. The MoH approached different partners including the UNICEF. LUMOS (UK)[214] responded to the problem with an initiative that implies close partnership of health and social workers and the local government. The specific aims of this initiative are to prevent and reduce child and under-five mortality at home and improve the quality of life of children and families (particularly those who are vulnerable) by ensuring equitable access to high-quality services. A high-level policy decision to establish closer links between health and social care, with a focus on disadvantaged families and young children, was taken in 2010. Currently the medico-social teams are functional at each municipality that takes responsibility to solve health and social problems with joint efforts.

Table 55: UNICEF Core Roles contribution to the implementation of the IMCI Intervention Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	• IMCI was introduced in the country by the WHO and UNICEF joint efforts. • UNICEF played significant role in IMCI institutionalization at PHC level; along with the WHO other active partner was the WB. • UNICEF contributed to critical phases of the project, e.g. advocated for inclusion of IMCI drugs into Essential List of Drugs and list of compensated drugs for children. • Based on the above UNICEF's contribution to this role is considered "significant"

[214] http://wearelumos.org/

2. Monitoring & evaluation	3	• UNICEF supported the MoH in assessment of IMCI pilot implementation, training of IMCI coordinators to monitor and supervise IMCI implementation process. • MCH Department of the MoH and the M&E Unit of the National MCH center took over full oversight and monitoring functions of the programme in 2008 with UNICEF and SDC support. • With UNICEF support reporting forms were developed and institutionalized. • UNICEF supported MICS and DHS studies that provided significant data on IMCI programme implementation. • In 2010 UNICEF commissioned evaluations of IMCI programme implementation for 1998-2006 and 2000-2010. The latest evaluation provided recommendations for further strengthening of the IMCI programme. Based on the evaluation report findings reporting procedures were revised and simplified by the MoH decree (2013). • UNICEF's contribution towards M&E Core role is considered as "significant/critical"
3. Policy advice and technical assistance	3	• UNICEF supported IMCI guidelines adaptation, training material development and integration of IMCI in education system, etc. • Since 2006 USAID has supported development of the protocols for management of most common childhood conditions at secondary care. The Protocols are approved by the MoH decree and is available countrywide. • Hospital level IMCI has not been introduced in Moldova. Currently work is underway to adapt the WHO manual, the process is supported by the partners. • UNICEF was instrumental in revising Child Development Card in 2001 and subsequent revision in 2012. With UNICEF's contribution child card for mother's was developed (2002) that has been used by the facilities till present. The Card reproduction was supported by SDC in later years. • In transnistria capacity development and sustainability were ensured through inclusion of IMCI in the curricula of local university and two nursing colleges. • In 2013 UNICEF contributed to Child Growth Monitoring charts development. • UNICEF's contribution to this Core role is considered to be "major/critical"
4. Leveraging resources	3	• UNICEF advocated for and succeeded in inclusion of the IMCI drugs into the Compensated List of drugs for Basic Benefit Package, therefore UNICEF's contribution to this Core role is considered to be "major/critical"
5. Facilitating national dialogue towards child friendly social norms	2	• At the initial stage of the PHC reform process UNICEF initiated the national dialogue with the local communities' health managers and health service providers to establish PHC Council. The Council mobilized resources, monitored the use of contributions and ensured access of the most vulnerable to the basic package of health services. The PHC reform led to defining the BBP in inclusion of the IMCI in the package. • UNICEF contributed to critical phases of the process. Later in 2010 to support care of most vulnerable children UNICEF responded to the MoH's request and supported development of cross-referral tools protocols between health and social sector. Major partner in this area is LUMOS (UK). • UNICEF's contribution to this role has been considered as "significant"
6. Enabling knowledge exchange	2	• UNICEF remained as active player in capacity building of the national and subnational health professionals during 2000-2004. SDC joined IMCI support from 2005. • UNICEF activated IMCI work in Transnistira during 2008-2009. • Therefore UNICEF's contribution towards this Core role is considered as "Significant".
7.Modeling/piloting	2	• UNICEF supported piloting of the PHC level IMCI in Lapusna Hinchesti (PHC reform site) during 2000-2002. After piloting the activities were extended to other areas. National scale-up was assured by SDC involvement since 2005. • Therefore UNICEF's contribution to the given Core Role is considered as "Significant"

NUTRITION INTERVENTION PACKAGE

BF/BFHI SUB- INTERVENTION PACKAGE

In late 1990s joint WHO/UNICEF Breastfeeding and BFHI initiative was introduced in Moldova.

UNICEF supported BFHI trainings and certification of maternity houses at the initial stage. By 2004 60% of maternity houses were designated the BFHI title. **(Policy advice & TA; Knowledge exchange)**. Since that period UNICEF discontinued BFHI activities and none of maternities received the status.

In 2009 UNICEF supported the MoH in World Breastfeeding Week. All maternities received communication materials, including in the Transnistria region **(Voice)**. In addition, special materials containing breastfeeding and young child feeding messages reached over 20,000 most vulnerable mothers

BF and child feeding topics are integrated into perinatal and IMCI modules, therefore no separate BF training activities are conducted.

UNICEF supports communication campaign by developing IEC materials for World Breastfeeding Weeks on annual bases **(Voice)**.

Figure 77: UNICEF Core Roles contribution to implementation of BF/BFHI Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	• UNICEF initiated advocacy on BF&BFHI. • Through UNICEF advocacy provisions of the International Code of Marketing for Breast-milk substitutes were partially approved by the Government through the Regulation on initiating and continuing baby formula s (2006). • UNICEF strongly supports BF; however no major advocacy works were done with the exception of supporting annual World Breastfeeding Weeks. • Therefore UNICEF's contribution to Core role is considered to be "Significant"
2. Monitoring & evaluation	2	• UNICEF supported studies of MICS, DHS to collect information on BF practices for decision making. • UNICEF supported number of M&E activities directed towards BFHI certification and recertification at the initial stage. By 2004 27 (60%) of maternity houses were designated the BFHI title. Since that period none of maternities received the title. • UNICEF's contribution to the given Core role is considered to be "significant"
3. Policy advice and technical assistance	2	• UNICEF contributed to critical phases of the process: provisions of the International Code of Marketing for Breastmilk substitutes were partially approved by the Government with UNICEF support.. • UNICEF initiated and assisted the government in the development and adoption of the MoH decrees in support of BF and BFHI. • Therefore its contribution to the given Core role is considered to be "Significant"
4. Leveraging resources	1	• UNICEF was less successful in leveraging resources from development partners, rather managed to fund raise for UNICEF core programme. • UNICEF's contribution to this role is considered "minimal"
5. Facilitating national dialogue towards child friendly social norms	1	• UNICEF initiated and facilitated national dialogue on BF&BFHI, ICMBS related issues by organization of workshops, round tables, sessions. However, this Core role was mainly used during development stage and less thereafter.

		• Therefore UNICEF's contribution has been considered as "minimal"
6. Enabling knowledge exchange	2	• UNICEF initiated capacity building activities for primary care and maternity staff. • Subsequently BF and child feeding topics were integrated into the Perinatal and IMCI modules, therefore no separate training courses were carried out. SDC continued training of heath personnel on perinatal care and IMCI including BF issues. • Therefore UNICEF's contribution towards this Core role is considered as "significant"
7.Modeling/piloting		• During evaluation period no modeling was used;

IDD SUB- INTERVENTION PACKAGE

- The first epidemiological survey carried out in children between 1996 and 1998 underlined high levels of iodine deficiency. Median urinary iodine level was found to be 78 mcg/l while according to the WHO the minimum standard is 100 mcg/l (Nutrition Survey Moldova 1996-2000. The Ministry of Health of Moldova/ UNICEF Moldova). The MICS-2000 results showed that only 35% of households interviewed had adequately iodized salt. A Damage Assessment Report for Moldova, developed by the Micronutrient Initiative estimated that 14-to-15,000 Moldovan babies are born each year with intellectual impairment caused by iodine deficiency during pregnancy.

UNICEF initiated communication campaign and continuous advocacy for developing a supportive legal framework for enabling the achievement of Universal Salt Iodization (USI) **(Voice)**. The IEC campaign consisted of editing posters and leaflets, and developing media spots of iodine-related issues. A National Nutrition Report, including one chapter on Iodine Deficiency Disorders was developed and presented at the National Nutrition Conference organized by UNICEF (2003). The Conference targeted high level decision-makers in order to raise their awareness on the magnitude of IDDs, to build commitments, and to create a national alliance to support Universal Salt Iodization **(National Dialogue)**.

UNICEF initiated large-scale activities on legislative level as well as knowledge sharing and communication activities. Technical assistance was provided to develop regulatory framework. Following awareness raising work and dialogue with the policy-makers, legislators and industry representatives the food Law was adopted in 2004 stipulating mandatory use of iodized salt for human and animal consumption **(Policy advice & TA)**. In 2007 Government approved the National Program on IDD elimination.

UNICEF strengthened monitoring system through revision of indicators, monitoring forms; laboratory capacity was strengthened – procurement of the laboratory equipment and reagents and technical assistance for the assessment of existing system of monitoring the quality of Iodized Salt **(Monitoring & Evaluation)**.

Huge communication campaign was initiated in 2004, complemented by knowledge sharing activities (study tours) for industry representatives **(Voice)**.

There was huge resistance from the industry due to strong perception in the society that iodized salt damages the quality of processed food (pickles, cheeses, salami) and existing regulations related to processed food precluded the endorsement by the Parliament of the legal provision (under the newly endorsed Food Law, April 2004) on the mandatory use of iodized salt. UNICEF commissioned Pickling Study. Based on the study results, it was recommended to initiate use of iodized salt in canning industry, conditional to availability of nationally approved quality standards on products **(Monitoring & Evaluation; Voice)**. (2005)

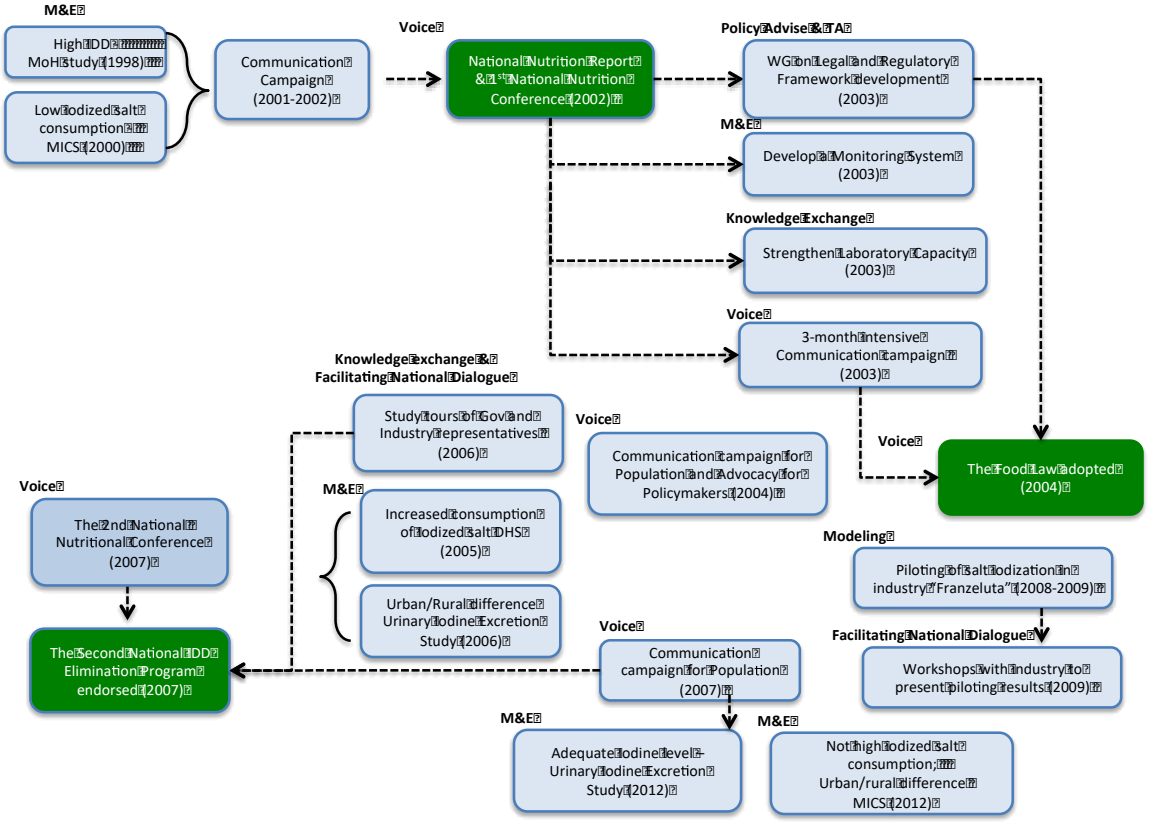
Meanwhile UNICEF continued monitoring of IDD. Urinary iodine excretion study (2006) found goiter prevalence rate was 27% in the South of the country and a 41% rate in the central zone of Moldova, indicating inadequate consumption of iodine **(Monitoring & Evaluation)**.

UNICEF worked actively on the National DD Elimination Programme and Plan of Action. Partnership was strengthened at the ministry level, including the Ministry of Health, Agriculture, Education, Economy, Moldova Standards, Customs Department, Trade Department, Salt Importers Association of Moldova and media **(Policy advice & TA; National Dialogue).** Employees of the Government, science and food industry visited Switzerland and Bulgaria to observe first-hand the practical use of iodized salt in the production of foods such as cheese, bread, meat and meat products, pickles, etc. **(Knowledge exchange).**

High-level advocacy material was disseminated among politicians and the press ('Damage Assessment Report', 'Leadership Briefing') that outlined the impacts on the economy and the human condition of continued deficiencies (2006). Advocacy in the area of micronutrient deficiencies (the 2nd National Nutrition Conference (2007), whereby over 100 national policy decision makers and media representatives were informed on micronutrient deficiencies) allowed for a breakthrough: **the** Government approved the Second National Programme for the Elimination of IDDs. **(Voice).**

Figure 78: IDD Intervention Sub-Package mapped by UNICEF Core Roles

IDD/USI Intervention flow chart & UNICEF Core Roles in Moldova



Trainings for 40 food inspectors were provided for monitoring the quality of iodized salt. Awareness raising strategies included education of children. As a pilot during a special hour at school, over 140,000 children in grades 1-4 nationwide learned about iodized salt. Since primary and secondary pupils were covered during a similar campaign in 2004, it is considered that a "generation" of pupils has been sensitized to this issue, forming a critical mass **(Knowledge exchange)**.

Piloting of salt iodization was done in the largest bakery "Franzeluta" that piloted use of iodized salt in its production **(Modelling)**. The company covers 60% of country needs. Five major food producers and several small food processing enterprises have accepted use of iodized salt in their production.

From 1998 up until 2010 use of iodized salt in domestic consumption and food industry was mandatory, however, after 12 marketing of non-iodized salt was authorized.

Table 56: IDD Intervention Sub-Package contribution to UNICEF Core Role

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF played a key role advocating for and promoting policy changes in Universal Salt Iodization. • UNICEF supported large-scale nutrition activities since 2000. Activities included developing legislation, national conferences to present evidences and promote policy changes, strengthened private and public sector capacity, including the quality control system. • UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach between all involved partners from the different ministries, agencies, private sector, public sector • UNICEF remained an active player through the process. In 2013 UNICEF's strong advocacy work, multi-sectoral approach and strategic partnership with the other players resulted in the development of three National IDD elimination Programmes. • UNICEF contribution to this role is considered "major/critical"
2. Monitoring & evaluation	3	• M&E was an integral part of the IDD/USI sub-package. Use of iodized salt in households was investigated by MICS studies (2000, 2012). • UNICEF supported development of the monitoring system. • UNICEF created local manufacturers, state control institutions (food inspector) capacity in monitoring of iodized salt. • UNICEF commissioned number of studies such as IDD burden study, pickling study (2005), Damage Assessment and Protection Audit (2006); iodine excretion studies (2006, 2012) to generate evidence for policy makers. • UNICEF's contribution to this role is considered "major/critical"
3. Policy advice and technical assistance	3	• UNICEF played a key role in development of a Food Law (2004) and development of three National IDD Elimination programmes: 1) eradication of IDD (1998-2004); 2) Eradication of IDD (2005-2010) and 3) Measures for Elimination of IDD (2011-2015) and implementation of two of them. • UNICEF's contribution to this role is considered "major/critical"
4. Leveraging resources	0	• UNICEF was less successful in leveraging resources from development partners, rather managed to fund raise for UNICEF core programme.

5. Facilitating national dialogue towards child friendly social	3	• UNICEF supported National IDD elimination programme development. Multispectral cooperation implemented by the UNICEF strengthened partnership between different ministries that resulted in final adoption of the Programme in 2007. • UNICEF's contribution to this role is considered "major/critical"
6. Enabling knowledge exchange	2	• UNICEF supported capacity building of salt producers in technology of salt production and iodization as well as monitoring of the quality of iodized salt. • UNICEF ensured training of food inspectors on monitoring of salt iodization and their supply with test-kits. • UNICEF's contribution to this role is considered "significant"
7. Modeling/ piloting	2	• Pilot programme of salt iodization education involved children of 1-4 grades. Pilot was not scaled-up thereafter. • UNICEF piloted salt iodization in one largest bakery "Franzeluta". Currently iodized salt should be used countrywide by all food producers. • UNICEF's contribution to this role is considered "significant"

FLOUR and FOOD FORTIFICATION SUB- INTERVENTION PACKAGE

This sub-package includes flour fortification activities.

A Damage Assessment Report for Moldova, developed by the Micronutrient Initiative, showed that approximately 30% of 6-to-24 month-old children are at risk of disrupted brain development because of iron deficiency. The lowered productivity of adult work-force because of iron and iodine deficiency causes loss to Moldova estimated at US$ 11.9million each year, or 0.6% of GDP. UNICEF initiated advocacy work with the policy makers on Flour Fortification **(Voice)**.

From 2005 UNICEF was forging alliances with private sector (millers) for Flour Fortification **(National Dialogue)**;

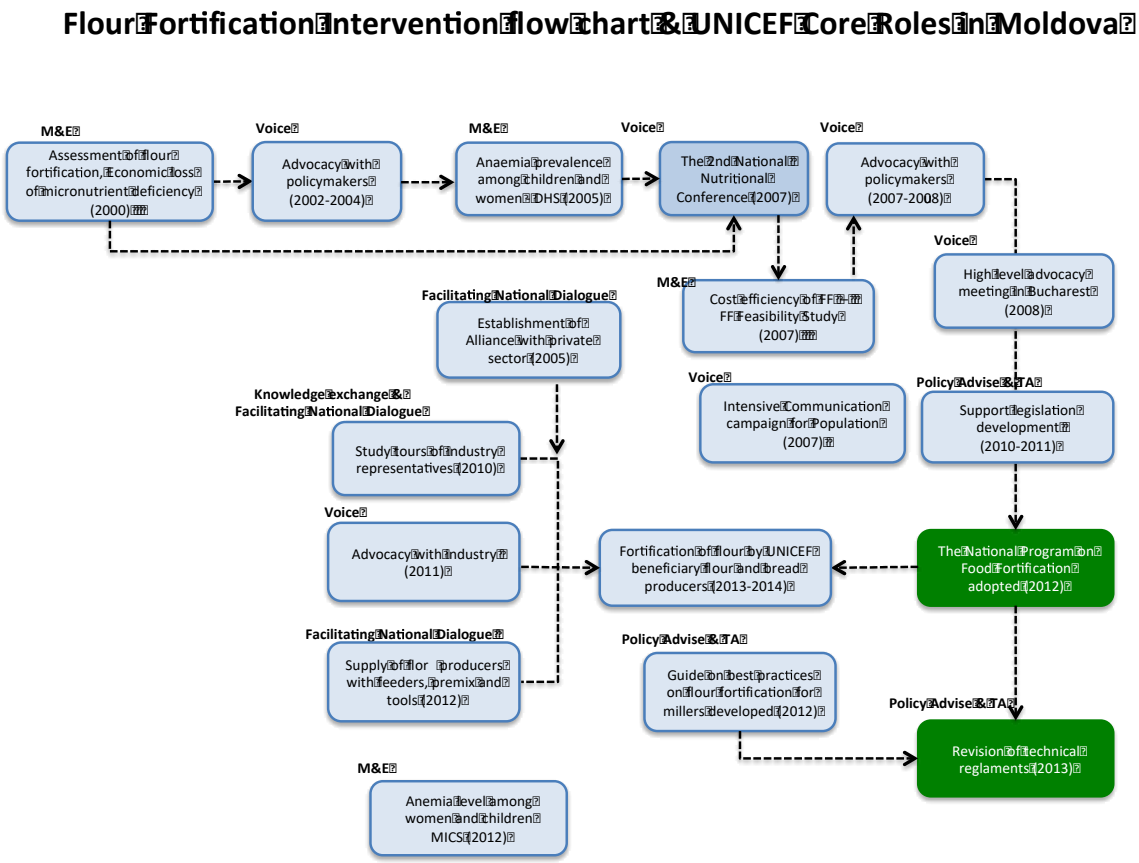
In 2007 UNICEF supported the 2nd National Nutrition Conference, whereby over 100 national policy decision makers and media representatives were informed on micronutrient deficiencies. Following the conference the Prime-minister personally expressed interest and requested renewed evidence. In response to the MoH request UNICEF carried out FF fortification study and cost efficiency of FF. It projected an insignificant increase of 1% in the cost of the final product. This is strong evidence in support of the cost-efficiency argumentation by the Ministry of Economy in favor of the flour fortification. Advocacy resulted in the approval in principle of the National Food Alliance **(Voice)**. Policy work was complemented by a media campaign: video spots promoting the use of iodized salt were broadcasted nationally for 12 weeks; a media campaign on micronutrient deficiencies was conducted for four months (2007).

The Office continued advocacy toward Flour Fortification, in 2008 a high-level advocacy meeting was held in Bucharest.

UNICEF provided support in the development of the National Programme on Iron and Folic Acid Deficiencies **(Policy advice & TA)**. In 2012 The Government adopted the programme. A guide on best practices on flour fortification was developed, six mills received feeders and premixes for flour fortification and technical regulations on flour, manna croup and cereal bran were modified.

The partnerships built around flour fortification agenda helped revising and approving the technical regulations. (2013).

Figure 79: FF sub- Intervention Package Flow Chart



To ensure the quality production of fortified products, cooperation was initiated with the line ministries, academia, Kazakh Associations of Grain Producers, and Flour Fortification Initiative to contribute to development of necessary by-laws, strengthen capacities of professionals, ensure knowledge transfer and exchange of best practices. However, to ensure the quality production of fortified products, partnerships need to be strengthened (2013). **(National Dialogue; Policy advice & TA)**

The dialogue started between Moldovan and Kazakh millers and flour producers to collaborate and exchange experience and technical expertise on flour fortification with iron and folic acid, in order to enable Moldovan producers to meet mandatory flour fortification gradually entering into force in 2014 and 2015 **(National Dialogue).**

UNICEF supported development of fortification technical guideline (2012) **(Policy advice & TA).** However the guidelines has not been reproduced and distributed yet due to budgetary constraints.

During 2013-2014 fortification of bread was done by "Franzeluta" bakery that cover 60% of bread production. Flour fortification process has not started yet in Moldova.

Since January 2015 the regulations on FF requires that all flour imported or locally produced should be fortified. According to the key informants the system is not ready to these changes. In addition the regulations lack information on monitoring responsibilities. In addition there are no mechanisms to carry out quality control of fortified flour.

Table 57: UNICEF Core Role contribution to the implementation of FF Intervention Sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	3	• UNICEF played a key role advocating for and promoting policy changes in Flour Fortification. • UNICEF supported large-scale nutrition activities since 2000. Activities included developing legislation, national conference to present evidences and promote policy changes, strengthened public and private sector capacity in fortification. • UNICEF Prioritized Nutrition in the agenda of Government with the coordinated approach among all involved partners from the different ministries, agencies, private sector, public sector. • UNICEF remained an active player through the process. In 2013 UNICEF's strong advocacy work, multi-sectoral approach and strategic partnership with the other players resulted in the adoption of the National programme on Food Fortification • UNICEF's contribution to this role is considered "major/critical"
2. Monitoring & evaluation	2	• M&E was an integral part of the FF sub-package. • UNICEF commissioned a number of studies such as Assessment of FF (2000), Economic loss study (2000), FF feasibility study (2007), to generate evidence for the policy makers. • UNICEF's contribution to this role is considered "major/critical"
3. Policy advice and technical assistance	3	• UNICEF played a key role in development of a Food Law (2004) and National FF Programme (2010). Development of the fortification technical guidelines (2012), Revision of technical regalements (2013). • UNICEF's contribution to this role is considered "major/critical"
4. Leveraging resources	2	• UNICEF was less successful in leveraging resources from the development partners, rather managed to fund raise for UNICEF core programme.
5. Facilitating national dialogue	3	• UNICEF supported National FF programme development. Multispectral cooperation implemented by the UNICEF strengthened partnership between different ministries that resulted in final adoption of the Programme in 2007. • UNICEF's contribution to this role is considered "major/critical"
6. Enabling knowledge exchange	3	• UNICEF supported capacity building of millers in technology of fortification. • UNICEF's contribution to this role is considered "significant"
7. M	0	• No piloting

IDA SUB- INTERVENTION PACKAGE

With the UNICEF support iron and folic acid supplements were included in the Basic Benefit Package (BBP) that ensured free access to these supplements since 2004. Iron supplements were included in the BBP IMCI drugs for children.

DHS 2005 identified that overall, about one-third (32.2%) of children of 6-59 months in Moldova have some level of anemia, including 22 percent of children who are mildly anemic (10.0-11.9 g/dl), 10 percent who are moderately anemic (7.0-9.9 g/dl), and no children with serious anemia. Twenty-eight percent (27.9) of women in Moldova have some level of anemia. The great majority of women with anemia have a mild form of anemia

(23 percent out of 28 percent), and the remainder have moderate anemia (4 percent) and severe anemia (less than 1 %)

Through UNICEF's advocacy The Government adopted the National Programme on Iron and Folic Acid Deficiencies (2012).

No specific activities were implemented to address iron deficiency among women and children

Table 58: UNICEF Core Role contribution to the implementation of IDA sub-Package

CORE ROLE	RATING	JUSTIFICATION
1. The 'Voice' for children	2	• UNICEF Prioritized Nutrition in the agenda of Government with coordinated approach among all involved partners from the different ministries, agencies, private sector, public sector. • UNICEF advocated for inclusion of iron and folic acid supplements in BBP and advocated for the national programme on Iron and Folic Acid Deficiencies • UNICEF's contribution to this role is considered "significant".
2. Monitoring & evaluation	2	• MICS, DHS measured Anemia prevalence among women and children. • UNICEF's contribution to this role is considered "significant".
3. Policy advice and technical assistance	3	• UNICEF played a key role in development of a national programme on Iron and Folic Acid Deficiencies (2012). • UNICEF's contribution to this role is considered "major/critical".
4. Leveraging resources	3	• UNICEF ensured inclusion of iron and folic acid supplements in the state funded BBP package.
5. Facilitating national dialogue towards child friendly social	0	• Did not use this role for IDA.
6. Enabling knowledge exchange	0	• Did not use this role for IDA.
7. Modeling/ piloting	0	• No piloting.

VAD SUB- INTERVENTION PACKAGE

The WHO recommends vitamin A supplementation starting at 9 months of age in the areas where infants and children are prone to deficiencies. In the areas where foods rich in vitamin A are not consumed regularly, deficiencies that pose serious health problems for young children can incur. DHS-2005 results reveal that most young children in Moldova have a diet in which fruits and vegetables rich in vitamin A are consumed regularly.

By DHS-2005 percentage of youngest children under age three living with the mother who consumed fruits and vegetables rich in vitamin A in the 24 hours preceding the survey was 73.4%. Based on the evidence vitamin A supplementation programme does not emerge as a priority in Moldova, therefore UNICEF did not focus on this direction.

PRIMARY HEALTH CATE INTERVENTION PACKAGE

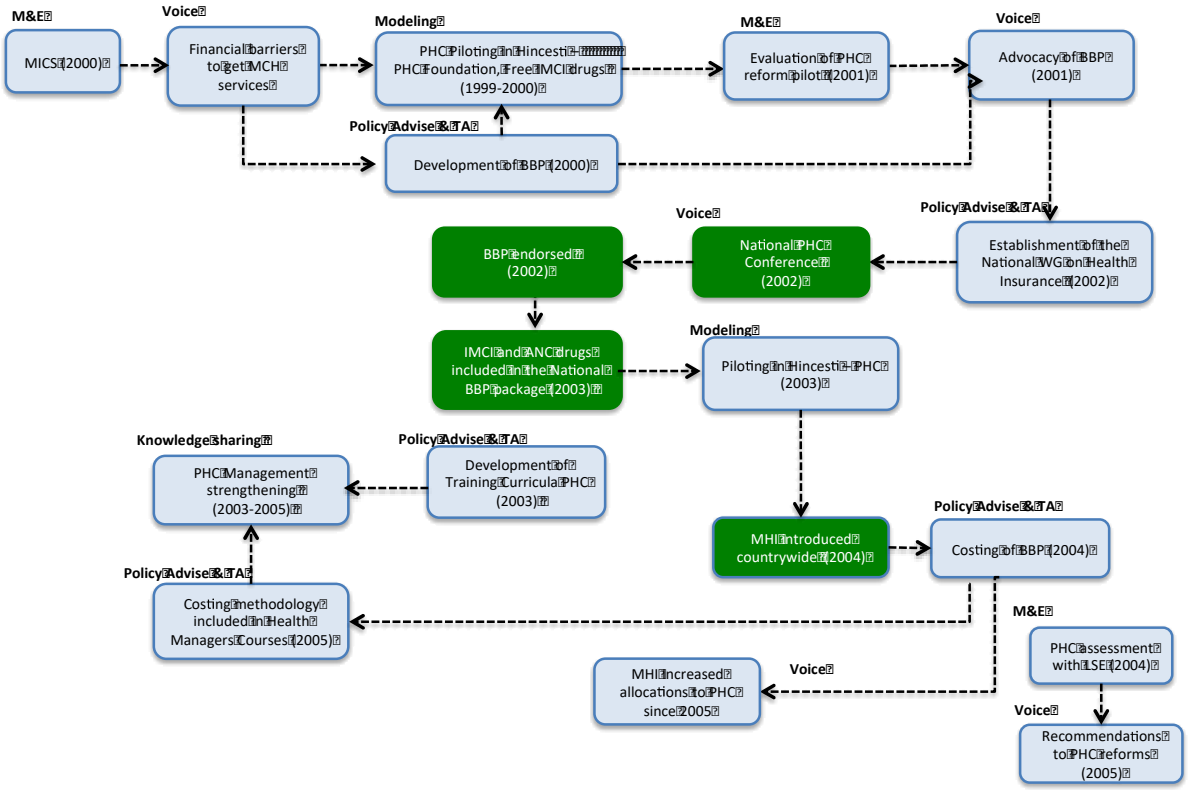
Primary Health Care reform was a separate work stream in UNICEF programming during CPAP-1 and CPAP-2. We do not describe this package separately as interventions undertaken under this package influence all packages.

Major activities under this work stream were the following:

UNICEF carried out first systematic assessment of financial access barriers **(Monitoring & Evaluation).** To address the bottleneck UNICEF piloted a PHC reform in Hincesti that included establishment of a local resource mobilization scheme, defining BBP, developing public health capacities in the county **(Modeling)**. Evaluation of the pilot project (2001) revealed improved access to health care services, increased service delivery better quality of care and improved satisfaction with the health care services. Based on the piloting results, UNICEF carried out extensive advocacy work to build political commitment **(Voice)**, UNICEF supported development of the BBP based on newly adopted standards of care that comprehensively covered maternal and child health needs including drugs for antenatal care and IMCI **(Policy advice & TA)**. BBP was piloted in 2003 and from 2004 BBP became integral part of the health care system. In 2004 UNICEF carried out costing exercise **(Policy advice & TA)**: Cost of the BBP of health care services was estimated. UNICEF succeeded in evidence based advocacy work with the MHI to increased allocations to PHC (increase from 80 lei to 137 lei per capita).

Below is given a flowchart of interventions for this work stream titled PHC REFORM. Figure 80: PHC reform flowchart mapped by UNICEF core roles

PHC REFORM Intervention flow chart & UNICEF Core Roles in Moldova



ANNEX 13: CHANGES IN INDICATORS OF EFFECTIVE COVERAGE WITH MNCH SERVICES IN THE EVALUATION PERIOD

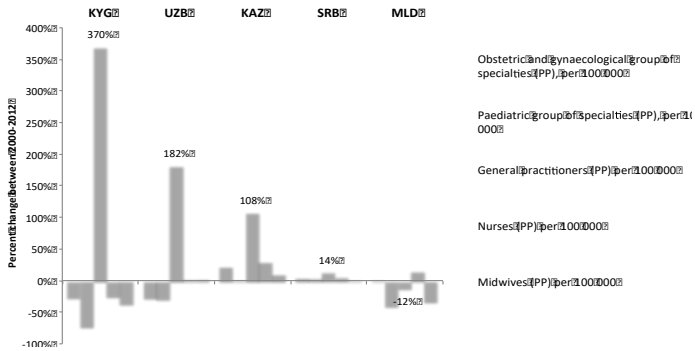
To assess the changes in the indicators characterising effective coverage with MNCH services over the evaluation period in the evaluation countries we used quantitative data obtained from publicly accessible databases, national statistics offices and from MICS/DHS surveys implemented in these countries. Qualitative information was collected from both published and grey literature sources. The domains of the Tanahashi framework (availability, accessibility, contact and adequate coverage) underpin the analysis in this section. This framework is particularly useful for ascertaining challenges in access to key preventive and curative interventions at an affordable cost, thereby achieving equity in access and service use. This annex looks in detail at how the population's coverage with MNCH services has been affected during 2000–2012 in the evaluation countries.

We start by looking at availability coverage, before moving onto describing accessibility coverage and contact or initial utilization, followed by effective or adequate coverage. We conclude by describing the quality dimension of the effective coverage.

4.3.2.1 AVAILABILITY OF SERVICES

The availability of services is suggested to measure a health system's capacity for delivering services in relation to the size of the population in need[215]. Therefore, we looked at the actual supply of necessary human resources, reported through administrative data, which presented a variable picture (see **Figure 81**).

Figure 81: Changes in human resources for health between 2000-2012



In all countries except Kazakhstan, the physician to population ratio for OB&Gyn and paediatric group of specialists declined. At the same time, the supply of general practitioners increased significantly, especially in Central Asian countries. This increase was most likely due to large-scale PHC reforms supported by the World Bank, Asian Development Bank and other donors. Donors supported similar reforms in Moldova, althoughthe supply of health human resources declined for all specialist groups with the exception of nurses, because Moldova faces the high out-migration of physicians and nurses[216,217]. Increased availability of general practitioners could have aided improvements in availability coverage with MNCH services.

[215] For the MNCH services being evaluated it is assumed that individuals are in need solely in virtue of being in a certain age group or of a certain sex, or have certain health condition (pregnancy and its complications, delivery, malnutrition, etc.) that makes them eligible to receive that intervention

[216] Extended migration profile of the republic of Moldova. IOM 2012. http://www.iom.md/attachments/110_emp_report.pdf

[217] Turcanu G, et al. (2012). Republic of Moldova: Health system review. Health Systems in Transition, 14(7):1–151.

Table 59 Availability coverage for antenatal and delivery services

Person providing antenatal care - Doctor	Badeline	Midpoint	Endpoint
KYG	65.4	85.3	79.4
KAZ	76.1	88.9	82.6
MD		97.3	97.7
SRB		98.1	98.9
UZB	91.4	96.4	
Person assisting at delivery - Doctor	75.2	86.2	86.9
KYG	60.8	76.3	77.4
KAZ	76.8	80.9	81.7
MD		90.7	95.3
SRB		87.8	93.1
UZB	87.9	95.1	
Person assisting at delivery - Nurse/Midwife	21.7	10.8	12.4
KYG	37.3	20.9	21.4
KAZ	20.7	18.2	17.8
MD		8.8	3.8
SRB		1.8	6.6
UZB	7.0	4.5	

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

The observed increases require cautious interpretation. General practice did not exist in the former Soviet states.Instead, paediatricians, internists, and Ob&Gyn delivered primary care to the public. GPs as a profession became frontline health care providers because of health sector reforms. Consequently, their ratio grew steadily from very low levels. For example, in Kazakhstan they increased from 15 per 100,000 population in 2000 to 31.2 by 2012. Kyrgyzstan achieved a similar GP to population ratio in 2012, but it started from significantly lower level in 2000 of 6.7 per 100,000 population. Both Serbia and Moldova had high number of GPs: 67.7 and 62.7 respectively per 100,000 populations in 2002, which is almost twice the ratio achieved by Central Asian Countries almost ten years later. In conclusion, the supply of GPs has certainly increased, but since they replaced old health care providers (paediatricians, internists, Ob&Gyn) we cannot be conclusive if availability coverage for MNCH services has improved because of increased GP supply.

Therefore we moved onto analysing data from MICS/DHS surveys that indicate improvements in availability coverage to deliver qualified antenatal and delivery care.Currently more women receive these services from doctors, while the share of those obtaining services from nurses-midwifes has declined. A similar decline in the use of feldshers and midwifes was noted by Balabanova et. al., which included two countries from our sample and eight countries from former Soviet block [218]. Improvements were more pronounced in Kyrgyzstan and Kazakhstan, where the lowest baseline availability coverage was 65% and 76% respectively, but improvements were visible in all countries. All of this indicates that services needed for pregnant women are currently more available than the levels observed in 2000.

Improvements in availability coverage for antenatal and delivery services were accompanied by inequity reductions (see**Table 60**). The poorest women started accessing more physicians for delivery services and fewer nurses/midwifes. Education and urban-rural inequities seems to have also declined. The only exception to this trend is antenatal care provision by doctors to the poor, where the gap between poorest and richest seems to have widened since midpoint. Notwithstanding these improvements, some income and education related inequities in availability coverage still remain and call for further attention.

Table 60: Equity ratios for availability coverage (five country average)

Antenatal and delivery services	Richest vs. Poorest		Highest education vs. Lowest			Urban vs. Rural Residence		
	MP	EP	BL	MP	EP	BL	MP	EP
Person providing antenatal care - Doctor	1.10	1.20	1.32	1.04	1.13	1.27	1.07	1.11
Person assisting during delivery - Doctor	1.19	1.10	1.26	1.09	1.00	1.20	1.13	1.05

[218] Balabanova D., Roberts B., Richardson E., Haerpfer C., McKee M. Health Care Reform in the Former Soviet Union: Beyond the Transition. 2012. Health Services Research 47:2

Person assisting during delivery - Nurse/Midwife	0.26	0.47	0.52	0.55	0.77	0.50	0.38	0.71

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

4.3.2.2 ACCESSIBILITY COVERAGE

According to Tanahashi's framework, even when a service is available, it must be accessible for the population to use these services. Consequently, accessibility can be defined in two dimensions: a) demand and b) supply. Supply side could be sub-divided into **physical (geographical) access** to facilities and **affordability** of the needed services. However, before discussing supply side aspects we concentrate on demand side, by looking at changes in population's knowledge using tracer indicators provided in**Table 61**[219], as they play an important role in translating health care needs into actual utilisation.

The data provided in **Table 61**reveals conflicting trends. It seems that the population's knowledge about two danger signs of pneumonia is declining, while comprehensive knowledge about HIV/AIDS transmission is improving. However, for both indicators we noted widening inequities indicating that poor, less educated and rural residents reveal lowest knowledge, which potentially could impede their timely access to the needed care and/or expose them to risky behaviour. Therefore, if accessibility coverage needs to be further improved, it becomes important to support community education and individual counselling programmes, especially focused on poor, rural, and disadvantaged populations.

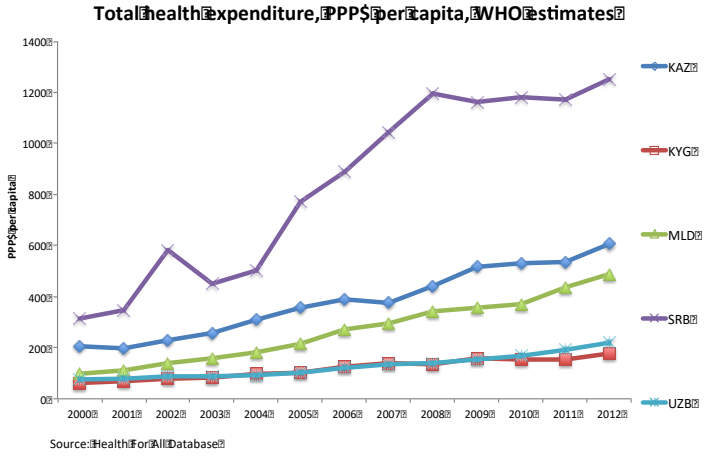
Table 61: Changes in population knowledge

Indicator/Country	Baseline	Midpoint	Endpoint
Knowledge of two danger signs of pneumonia			
KYG		41.8	
KAZ		31.7	22.2
MD	72.4		22.0
SRB	57.8	33.3	25.6
UZB	71.4	14.6	
5 Country average	**67.2**	**30.3**	**23.3**
Richest vs. poorest equity ratio	*1.03*	*1.76*	*1.99*
Highest educ. vs. lowest equity ratio	*1.16*	*1.41*	*2.29*
Urban vs. Rural equity ratio	*1.00*	*1.24*	*1.39*
Percentage of women aged 15-49 years who know the main ways of preventing HIV transmission[220]			
KYG		20.4	23.8
KAZ		22.3	38.0
MD			33.0
SRB		37.4	52.7
UZB		35.3	
5 Country average		**28.9**	**38.2**
Richest vs. poorest equity ratio		*1.8*	*2.1*
Highest educ. vs. lowest equity ratio		*1.9*	*3.1*
Urban vs. Rural equity ratio		*1.2*	*1.4*

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

Physical access may be hindered if the resources are available but located inconveniently e.g. the distance to reach a health care provider requires significant travel time, which could be also associated with transportation costs. The second main dimension of supply side factors is ***financial accessibility*** (affordability), when services are not affordable, especially for the poor and deters them from using services.

Figure 82: Trends in total health expenditure



In general, post Soviet and Eastern European countries, prior to transition, enjoyed well-developed health care provider network, which assured adequate geographic access

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to services. Although the transition negatively affected the quality of infrastructure, the overall network has largely been retained. The exception is rural hospitals,which were replaced by PHC facilities/providers, and eventually received investmentfrom the governments (with or without donor support). Consequently, the evaluation countries reported relatively adequate geographic access to outpatient services, although the available evidence is not rigorous and comparable across the countries (see**Table 62** on page 333). During the evaluation period, countries managed to reduce urban-rural differences in the supply of health care providers, where they existed, but still many rural areas face staff shortages, caused by migration and/or the lack of attractiveness of rural work places. As a result, there are remaining geographic pockets and sub-national differences that need further attention[221].

While geographic access does not seem to pose major challenges, financial access to care, including to MNCH services, emerged as a major challenge for these countries at the time of transition. However, gradual economic development and increased health spending by the governments helped to reduce financial access barriers and, based on the available regional evidence, utilisation of essential maternal health services is improving. Most likely, increased government participation in health care financing[222]facilitated access to MNCH services in the evaluation countries. Furthermore, Balabanova et al.[223] when evaluating 10 years of experience in eight former Soviet Union countries found that access to health care and within-country inequalities have improved over the past decade. However, considerable problems remain, including out-of-pocket payments and the unaffordability of outpatient drugs, despite efforts to increase public spending and consequently improve financial protection. Besides paying for health care services, which have declined in many countries, patients are required to pay for outpatient drugs, the amount of which varies significantly e.g. in Moldova OOP for drugs consume around 0.83% of GDP annually, while in Kazakhstan they consume only 0.15%[129]. Consequently drug expenditures still pose a challenge when accessing services.

Table 62: Selected geographical and financial accesses indicators

Country	KAZ	KYG	MLD	SRB	UZB*
Distance to out-patient facility	Lives more than 10km from hospital 23.7% (2001)[224] Less than 5 km from PHC 93.4% (2005)[225]	Lives more than 10km from hospital 12.1% (2001)[220]	Lives more than 10km from hospital 28% (2001)[220] Less than 5 km from PHC 97.1% (2000)[226]		Less than 5 km from PHC 91.3% (2007)[227]
Share of patients living within	20 minutes travel of GP or therapist 30% (2012)[228]	Less than 30 min to PHC facility 73% (2005)[229]	20 minutes travel of GP, paediatrician or FD 48% (2012)[230]	20 minutes travel of GP, paediatrician or FD[226] 73% (2010)[231]	
Travel time to nearest hospital	Less than 30 min 89.9% (2005)[224]		40 minutes 70% (2012)[226]	40 minutes 67% (2012)[227]	

221 Rechel B., Richardson E., McKee M. 2014. Trends in health systems in the former Soviet countries. Observatory studies series 35. The European Observatory on Health Systems and Policies.

222 Kruk M.E., Galea S., Prescott M., Freedman L.P. Health care financing and utilization of maternal health services in developing countries Health Policy Plan. (2007) 22 (5): 303-310

223 Balabanova D., Roberts B., Richardson E., Haerpfer C., McKee M. Health Care Reform in the Former Soviet Union: Beyond the Transition. 2012. Health Services Research 47:2

224 Suhrcke M., Walters S., Mazzuco S., Pomerleau J., McKee M., Haerpfer C.W. 2008. Socioeconomic differences in health, health behaviour and access to health care in Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation and Ukraine. WHO Regional Office for Europe.

225 Accessibility and quality of health care services in Kazakhstan. UNICEF, UNFPA, 2005.

226 Berdaga V, Stefanet S, Bivol O (2001). Access of the population of the Republic of Moldova to health services. Chisinau, Gunivas.

227 Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan. Final Evaluation Report. Project Hope. 2007

228 Evaluation of the organization and provision of primary care in Kazakhstan. World Health Organization 2011.

229 Meimanaliev A-S, Ibraimova A, Elebesov B, Rechel B. Health care systems in transition: Kyrgyzstan. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005

230 Evaluation of the structure and provision of primary care in the republic of Moldova. Republic of Moldova Health Policy Paper Series No. 5. WHO 2012. Chisinau.

231 Evaluation of the organization and provision of primary care in Serbia. Primary care in WHO European region. World Health Organization 2010

Country	KAZ	KYG	MLD	SRB	UZB*
Proportion of respondents having to make a payment for obtaining health care and (mean amount of payment US$) year	28.6% (10.75 US$)[232]	27% (0.94US$) (2004) 20% (1.61 US$) (2007)[233]	36.6% (12.06 US$)[226] (2010)		
Reasons for not seeking health care					
Share of population that could not afford services and drugs	28.4% (2001)[229] 4.1%%(2010)	The share of population has fallen significantly, from 11.2% in 2000 to 4.1% in 2009[234]	47.3% (2001)[226] 20.1%(2010)[226]		
Share of population that could not afford drugs	5.0% (2010)[225]		15.2% (2010)[226]		
Other			The major expense for Moldovan citizens is the cost of pharmaceuticals; spending on medicines accounted for 73.1% of all OOP expenditure in 2010[235]	Limited access to the primary health care system by ethnic minorities, IDPs, refugees and other marginalized groups	79% of the sampled population experienced financial hardship from the disease. A substantial part of this hardship (49%) was reportedly due to the cost of buying additional drugs[236]

* Uzbekistan data is subnational

Source: Compiled by the Evaluation Team from various sources

Obviously, the ability to pay for services and drugs depends on a country's economic wealth and therefore on per-capita spending on health. Consequently, Serbia has the greatest potential to finance service provision, followed by Kazakhstan and Moldova, which spend comparable amounts on health in per-capita PPP$ terms. The lowest amounts are spent in Kyrgyzstan and Uzbekistan (see

[232] Balabanova D., Roberts B., Richardson E., Haerpfer C., McKee M. Health Care Reform in the Former Soviet Union: Beyond the Transition. 2012. Health Services Research 47:2

[233] Falkingham, J., Akkazieva, B. and Baschieri, A., 2010. Trends in out - of - pocket payments for health care in Kyrgyzstan, 2001 - 2007. Health policy and planning, 25 (5), pp. 427 - 436.

[234] Ibraimova A, Akkazieva B, Ibraimov A, Manzhieva E, Rechel B. Kyrgyzstan: Health system review. Health Systems in Transition, 2011; 13(3):1–152.

[235] Turcanu G, Domente S, Buga M, Richardson E. Republic of Moldova: health system review. Health Systems in Transition, 2012, 14(7):1–151.

[236] Hasker, E., Khodjikhanov, M., Usarova, S., Asamidinov, U., Yuldashova, U., Van Der Werf, M.J., Uzakova, G. and Veen, J., 2009. Drug prescribing practices for tuberculosis in Uzbekistan. The international journal of tuberculosis and lung disease: the official journal of the International Union against Tuberculosis and Lung Disease, 13(11), pp. 1405-1410.

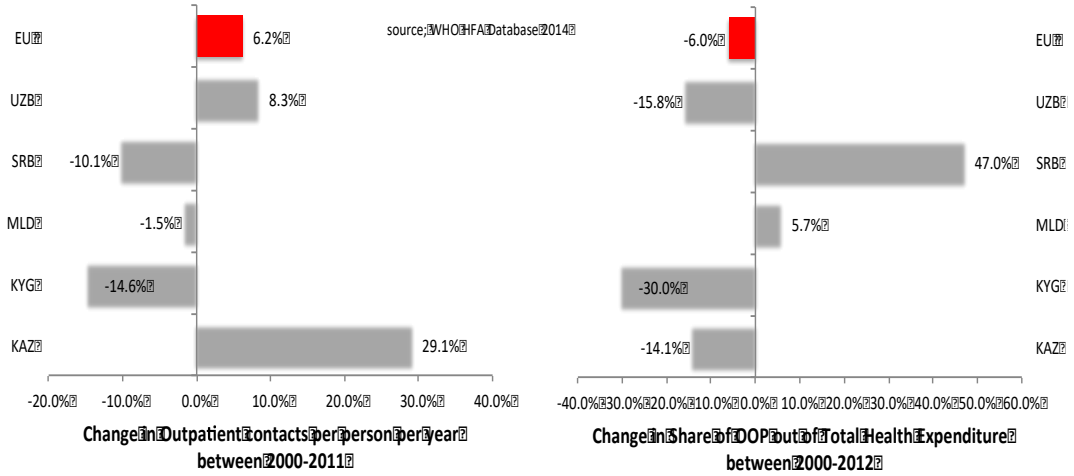
Figure 83).

Another important dimension is the share ofhouseholds' out-of-pocket spending on health out of total health expenditure, which is proxy for financial access to care. In the evaluation countries, the share of household OOP out of total health expenditure declined in the central Asian countries at a higher pace than the EU average, but increased in Moldova and Serbia. When these changes are compared to outpatient service utilisation, we note that an increasing share of OOP payments reduced per capita annual outpatient contacts and vice versa, with a correlation coefficient r = -0.41 and statistically significant ($p<0.001$)[237]. The only exception from this pattern is Kyrgyz republic, where the share of OOPs in total health expenditure declined by 30% in the period 2000-2012, and per capita outpatient service utilisation also reduced by 14.6% (see

[237] The correlation coefficient is derived for the 5 evaluation countries and for the evaluation period using data from WHO HFA database

Figure 83). As a consequence, the Kyrgyz republic reports the lowest per capita outpatient service utilisation i.e. 3.5 contacts per annum. With the exception of the Kyrgyz republic, outpatient service utilisation rates reported by the evaluation countries, are close to the EU average. This proves that countries achieved a level of access to outpatient services comparable to European countries, although this does not translate into comparable access to free or subsidized drugs, which still imposes a significant financial burden on households.

Figure 83: Changes in OOPs and per-capita annual utilization of outpatient services during 2000-2012



To conclude, geographic and financial access seem to have improved over 2000-2012, although urban-rural and wealth related disparities remain. Access to free drugs, including those needed for adequate ANC and IMCI, remains a particular challenge in some countries (e.g. in Kyrgyzstan and Uzbekistan access to ANC and IMCI drugs is a significant financial burden for households) as the poorest groups of society are not well protected[238,239,240].

4.3.2.3 INITIAL UTILISATION

To evaluate initial utilisation the ET used two tracer indicators: a) women who have not received any antenatal services during pregnancy; and b) early initiation of breastfeeding within the 1st hour of birth. **Table 63**describes trends over the evaluation period and provides equity analysis. It reveals that across the five countries, the number of those that opted for not using antenatal services was halved, althoughthe country specific trends are not well pronounced. Equity analysis proves that the poor, those with low educational attainment and those living in rural areas remain disadvantaged as they are more likely to opt not to use antenatal care. Instead of decreasing over the evaluation period, the equity gaps actually widened and further marginalised disadvantaged groups.

On the other hand, the rate of initiation of breastfeeding within one hour of birth, which was low at the baseline, shows significant improvement, and five-country average increased from 33% to 76% (see **Table 63**). Equity analysis for this indicator, although the data is not presented, shows that inequities were not present at baseline and did not emerge thereafter.

Table 63: Initial utilisation

Indicator/Country	Baseline	Midpoint	Endpoint
1. No antenatal care (percent)			
KYG	2.5	2.5	2.7
KAZ	5.2	0.1	0.8
MD		1.8	1.2
SRB		0.7	1.0
UZB	1.2	0.9	
5 Country average	**3.0**	**1.2**	**1.4**
Richest vs. poorest equity ratio		*0.3*	*0.2*

238 Barriers and facilitating factors in access to health services in the Republic of Moldova. Copenhagen, WHO Regional Office for Europe, 2012.

239 Kassim. A. 2014. Health system financing reforms and its impact on access to health care in low and lower middle income countries of WHO European Region: A systematic review. Master's Thesis Public Health School of Medicine Faculty of Health Sciences University of Eastern Finland. http://epublications.uef.fi/pub/urn_nbn_fi_uef-20140858/urn_nbn_fi_uef-20140858.pdf

240 Evaluation of the organization and provision of primary care in Serbia. Primary care in WHO European region. World Health Organization 2010

Highest educ. vs. lowest equity ratio	*0.33*	*0.76*	*0.08*
Urban vs. Rural equity ratio	*1.35*	*0.64*	*0.54*
2. Timely initiation of breastfeeding with 1 hour of birth (percent)			
KYG	41.0	64.9	83.8
KAZ	27.0	64.2	67.8
MD		64.5	60.9
SRB	32.1	16.9	90.1
UZB		67.1	
5 Country average	**33.4**	**55.5**	**75.7**

Source: Compiled by the Evaluation Team from MICS and DHS (1999-2014) databases

4.3.2.4 ADEQUATE COVERAGE

To conclude the coverage assessment, we looked at the adequacy of coverage with MNCH services using tracer indicators, due to the lack of elaborate data from the available sources. These tracer indicators were available from MICS/DHS reports, which were mainly produced during or after 2005-2006. The only exception was Kazakhstan DHS-1999, which included only two out of three tracer indicators presented in **Table 64**. In general, a significant share of pregnant women had four or more antenatal visit in the evaluation countries. Moldova (95.4%) and Serbia (94.2%) reported the highest numbers, whilethe Kyrgyz Republic reported the lowest (83.6%). (Data from Uzbekistan was not available and cannot be provided). While the reported rates are high, Kazakhstan and Kyrgyzstan still have a fair share of pregnant women who did not make an adequate number of antenatal visits, which could have a potentially negative impact on their pregnancy outcome. Data limitations also meant that we were unable to conclude whether the reported levels are improvements from what was observed at the baseline.

Furthermore, countries not only reported adequate coverage with antenatal visits, but they also delivered antenatal care with adequate content e.g. blood pressure is measured, and urine and blood samples are drawn and tested (see **Table 64**indicator No.2). Although the reported rates at midpoint and endpoint are quite high and comparable, equity analysis reveals that the existing urban-rural and education related inequities declined during the period 2005-2012.

Finally, a significant share of pregnant women receive HIV counselling during antenatal visit, are offered an HIV test, are being tested and receive test results. However, country level progress on this indicator is variable (see **Table 64**indicator No.3). Serbia has very low testing rates (13.9%), while Moldova has the highest (82.8%). Furthermore, Moldova almost doubled this rate since 2005, while in Kazakhstan and the Kyrgyz Republicthe situation either deteriorated or remains unchanged[241]. Consequently, overall progress in increasing HIV testing rates among pregnant women across the five countries cannot be validated. However, equity analysis reveals that since 2005 wealth related and urban-rural inequities were reduced in these countries, but education related inequities widened and may need further attention.

Table 64: Adequate coverage indicators and equity ratios (where available)

Indicator/Country	Baseline	Midpoint	Endpoint
1. Women who had 4 and more antenatal visits (percent)			
KYG	81.1		83.6
KAZ	70.0	99.5	87.0
MD		88.8	95.4
SRB			94.2
2. Blood pressure measured, urine and blood sample taken during antenatal visit (percent)			
KYG		96.6	99.6
KAZ	72.1	99.5	98.9
MD		98.9	97.5
SRB		95.4	97.8
UZB		97.6	
Highest educ. vs. lowest equity ratio		*1.27*	*1.03*
Urban vs. Rural equity ratio		*1.14*	*1.01*
3. Were offered an HIV test and were tested for HIV during antenatal care, and received the results (percent)			
KYG		54.6	45.0
KAZ		78.8	71.5
MD		43.1	82.8
SRB		8.9	13.9
UZB		65.4	

[241] Due to lack of statistical tests, we cannot be conclusive if observed changes in these two countries reflect reality.

Richest vs. poorest equity ratio		*1.50*	*1.19*
Highest educ. vs. lowest equity ratio		*1.26*	*1.36*
Urban vs. Rural equity ratio		*1.24*	*1.12*

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

4.3.2.5 QUALITY

Quality, the final dimension of effective coverage, was assessed with proxy indicators measuring selected outcomes (for nutrition interventions) and measuring the content of care, with an implicit definition of quality that relates not to health gain or outcome, but to the main content of the intervention provided (this has been widely used elsewhere). While this approach has its limitations[242], no viable alternative was accessible due to the lack ofavailable data.

While looking at quality measures, we noted variable progress made by countries and in different areas. Namely:

- Immunization coverage rates in CEE/CIS regions were significantly higher compared to other developing parts of the world. Although transition years and conflicts negatively affected immunization coverage rates, from 2000 the evaluation countries began to report very high coverage rates for DPT3, Polio3 and HepB3, ranging between 96-99%. These countries also introduced HIb vaccine during the later years of the evaluation period.Since 2010 all countries have reported high post-introduction coverage rates that range between 89-99%. Consequently the ET did not feel it was necessary to fully unpack immunization related issues, as all the countries are achieving high coverage rates and no major progress was noted over the evaluation period.
- The share of live born babies weighting <2,500g was evaluated using national routine statistics triangulated with MICS findings. Both sources confirmed that no progress was made in reducing this indicator, which stood stable during 2000-2012 at around 5-6% of live births.
- Slight improvements were noted in population behaviour when treating suspected pneumonia and diarrhoea cases among children aged less than 5. Namely, 3 out of the 5 countries

[242] Ng et al. Effective Coverage: A Metric for Monitoring Universal Health Coverage. PLOS Medicine, September 2014, Volume 11 (9) DOI: 10.1371/journal.pmed.1001730.

- **Table** 65 show increasing use of a health care provider for suspected pneumonia cases. The two exceptionsare Serbia, where the trend was stable, and the Kyrgyz Republic, where a declining trend was noted. However, the reliability of the Kyrgyz Republic data for the endpoint is questionable, because the DHS-2012 survey was implemented during August-December while the midpoint MICS-2006 only took place during the winter months. Consequently, the overall number of suspected pneumonia cases (n=49) captured by the DHS-2012 was six times less, and data in

- **Table** 65could be misleading[243]. Furthermore, endpoint surveys, with the exception of the Kyrgyz Republic, show that the use of antibiotics to treat suspected pneumonia among children increased and reached higher levels compared to midpoint. This trend was well pronounced when looking at five-country averages.

Along with these changes, we have also noted equity improvements. Specifically, wealth related inequities that were significant during midpoint, particularly for taking child with suspected pneumonia to a health care provider, were eventually reduced. Also, education related inequities continuously declined from baseline to endpoint (see details in

[243] National Statistical Committee of the Kyrgyz Republic (NSC), Ministry of Health [Kyrgyz Republic], and ICF International. 2013. Kyrgyz Republic Demographic and Health Survey 2012. Bishkek, Kyrgyz Republic, and Calverton, Maryland, USA: NSC, MOH, and ICF International.

Table 65).

Table 65: Treatment practices for suspected pneumonia among children under five

Country	Baseline	Midpoint	Endpoint
Child with suspected pneumonia taken to any appropriate HC Provider			
KAZ	47.4	70.3	81.5
KYG		62.7	33.0
MD	80.9	54.5	79.2
SRB		92.8	90.2
UZB	55.1	68.6	
5 Country Average	**61.1**	**65.9**	**82.7**
Richest vs. poorest equity ratio	1.1	2.2	1.2
Highest vs. lowest education equity ratio	1.7	1.4	1.0
Antibiotic treatment of suspected pneumonia			
KAZ		31.7	86.6
KYG		44.5	41.0
MD			81.9
SRB		58.2	81.6
UZB		55.7	
Five Country Average		**47.5**	**72.8**

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

MICS/DHS data also reveal that population behaviour has improved when treating diarrhoea at home. The share of those using oral rehydration therapies with continued feeding increasedin every countriesexcept Serbia, where a decline in the endpoint survey was noted. However, the five-country average obviously reflects an increasing trend, and points towards improved behaviour (see details in**Table 66**).

Table 66: Oral rehydration therapies with continued feeding for diarrhoea cases

Country	Baseline	Midpoint	Endpoint
KYG		22.3	62.7
KAZ		48.0	54.0
MD	21.1		54.7
SRB		72.6	59.7
UZB	18.5	28.1	
Five Country Average	**19.8**	**42.8**	**57.8**

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

Table 67: Share of households with Improved drinking water supply

Country	Baseline	Midpoint	Endpoint
KYG	76.9	88.2	88.2
KAZ	77.7	93.7	93.9
MD	91.0	86.7	86.4
SRB	98.4	99.0	99.5
UZB	84.3	89.6	
5 Country average	**85.7**	**91.4**	**92.0**
Urban vs. Rural equity ratio	1.26	1.13	1.11

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

Along with improved behaviour when treating diarrhoea, data analysis for 2000-2012 revealed improvements in the quality of drinking water supplied to households, especially in those countries reporting the lowest levels at baseline (Kazakhstan and the Kyrgyz Republic). Major improvements were noted during the first half of the evaluation period (see **Table** 67), and almost 90% of households enjoyed improved water supply sources. These developments were accompanied by reductions in urban-rural inequity.

Some improvements were also noted in iodized salt availability and consumption in the surveyed households. **Table 68**provides more details drawn from MICS/DHS data, where available, and reveals that by 2012/2013 around 97% of households in Kyrgyz Republic and 85% in Kazakhstan were consuming iodized salt. However,

the levels reported in Moldova and Uzbekistan, while showing improvements compared to baseline, were still low because only about half of the households consumed iodized salt.

Table 68: Percentage of households consuming adequately iodized salt[244]

Country	Baseline	Midpoint	Endpoint
KYG	27.0	76.1	96.6
KAZ		92.0	85.4
MD	38.1	59.8	44.3
UZB	19.2	53.1	
4 Country average	**28.1**	**70.3**	**75.4**
Richest vs. poorest equity ratio	1.3	1.4	1.3
Urban vs. rural equity ratio	1.3	1.2	1.1

Equity analysis shows that poor households are still less likely to use iodized salt.Income related inequalities were not eliminated over the evaluation period, while urban-rural inequities seem to have been reduced.

Table 69: Exclusively breastfed 0-5 month old children

Country	Midpoint	Endpoint
KYG	31.5	56.1
KAZ	16.8	31.8
MD		36.4
SRB	14.9	13.7
UZB	26.4	
5 Country average	**22.4**	**34.5**

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

It is well known that the available evidence demonstrates that exclusive breastfeeding is a cost-effective intervention with a proven public health impact. However, the indicators from our analysis related to exclusively breastfed 0-5 months old children were inconclusive. Baseline data was not available from MICS/DHS reports, which imposed limitations on our trend analysis. Furthermore, two data points were only available for three countries out of five (see**Table 70**). Two of these three countries, the Kyrgyz Republic and Kazakhstan, revealed an increasing trend of exclusive breastfeeding, while in Serbia the indicator stood at around 14% for both periods. Nevertheless, the five-country average confirmed a slight increase in exclusive breastfeeding rates that reach around 34.5% towards the end of the evaluation period.

Table 70: Contraceptive use among currently married women aged 15–49 years (%), any method

Countries	Baseline	Midpoint	Endpoint
KYG	59.5	47.8	36.3
KAZ	66.1	50.7	51.0
MD	62.3	67.8	59.5
SRB	58.3	41.4	60.8
UZB	67.2	64.9	
5 Country average	**62.7**	**54.5**	**51.9**

Source: Compiled by the Evaluation Team from MICS and DHS (1996-2014) databases

Finally, MICS/DHS reports for the five countries under evaluation indicate declining rates of contraceptive use by 15-49 year old married women. The five-country average indicates that rates declined from around 63%in early 2000 to 52% in 2012/2013. While rates declined, education, wealth and urban-rural inequities seem to have stayed stable, fluctuating between 1-1.2 throughout the evaluation period.

[244] Serbia was not included in this analysis as only one data point at the baseline was available

ANNEX 14: ROBUSTNESS SCORE FOR FINDINGS SUPPORTING THE EVALUATION CONCLUSIONS

Evaluation Conclusions	Robustness Score	Justification	Sources
Impact:			
EQ1. There has been a positive change in the reduction of the infant and under-5 mortality and morbidity over the period 2000 to 2012	**A**	The findings leading to this conclusion are consistently supported from all sources: document review and secondary data analysis of the reliable and high quality data sets	- UN Inter-Agency Estimates - TransMonee database - National statistical yearbooks - BABIES[245] Matrixes (Kazakhstan, Kyrgyzstan, Moldova) - Country specific MICS and DHS reports - Country specific surveys
EQ2. The trends in these key child health indicators across geographical, ethnical, gender and other socio-economic stratifiers in CEE/CIS and the evaluated countries were uneven.	**A**	Though trend analysis was not conducted, presented findings for this conclusion are drawn based on secondary analysis of high quality data sets and documental sources	- UN Inter-Agency Estimates - Country specific MICS and DHS reports - UNICEF Situation Analysis documents
EQ3. The trend in reducing specific causes of child mortality in in the evaluated countries was generally positive, yet with significant variability of the pace of decline for different causes.	**A**	Though trend analysis was not conducted, presented findings for this conclusion are drawn based on secondary analysis of high quality data sets and documental sources	- Vital registration statistics - National Statistics - Vital registration data-based multicause model (Liu et al, 2014)
EQ4. The remaining outliers in terms of key child health indicators in the CEE/CIS and the evaluated countries, include: **5. Children that are born in poor and less educated families, particularly those residing in the rural areas and that are experiencing ethnic or social deprivations are still at a greater risk of dying;** **6. Stillborn babies, whose numbers remained almost unchanged for the last 15 years;**	**A**	To arrive to the findings for this conclusion, secondary data analysis and triangulation from multiple sources and documental review was used	- See above sources for EQ.1-3 conclusions - World Development Indicator Database (The World Bank)

[245]Birth weight group and Age-at-death Boxes for an Intervention and Evaluation System US CDC proposed methodology

7. **Infants dying before their first birthday, particularly neonates, who account for 88% under-5 children deaths occurring in the evaluated countries and that are dying from preventable causes;** 8. **Children that live in the countries that are lagging behind and/or sub-national entities that achieved least progress in the key child health indicators and have mortality rates that are 2 to 3 times higher than the CEE/CIS regional average;**			
EQ5. Along with health system related interventions and factors, numerous other factors, or socioeconomic determinants have most likely contributed to the change in infant and under -5 mortality and morbidity in CEE/CIS and the evaluated countries.	**B**	Presented findings for this conclusion are drawn based on secondary analysis of high quality data sets and documental sources, however limited triangulation is available	- International peer reviewed literature - National and Global Statistical Databases (WDD, TransMonee); - Country specific MICS and DHS reports and databases - Country specific surveys, studies and reports
Relevance:			
EQ6. The UNICEF supported programmes invariably addressed the most important causes of infant and under 5 morbidity and mortality in all the evaluated countries, with the exemption of causes related to the preconception period. **Also the mortality and morbidity causes originating in the antenatal period were less addressed.**	**A**	Findings are based on data analysis of the indicators obtained for EQs 1 through 5 were triangulated well with UNICEF programmes analysis conducted from multiple sources	- Sources for EQs 1 through 5 - UNICEF CPAPs, AWPs/RWPs, SITANs and annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable)
EQ7. UNICEF identified and attempted to address all the most important bottlenecks in effective coverage with MNCH services.	**A**	Findings for this conclusion are supported by the qualitative information gathered and well triangulated from the documental review and key informants.	- SITANs - CPAPs, AWPs/RWPs - Annual and MTR reports - Global Evidence sources around effective interventions - Other donor supported studies - Interviews (IDI & GIs where applicable)
EQ8. The UNICEF supported programmes were mostly successful in identifying and applying right and appropriate interventions (activities), including for scope, target groups and scale to address health system bottlenecks.	**A**	Findings for this conclusion are supported by the qualitative information gathered and well triangulated from the documental review and key informants. Two other researchers independently validated Qualitative judgment Scores assigned oby the principal investigators were independently verified by 2 other	

		researchers.	
EQ9. The UNICEF supported programmes were fully aligned with the national development and sectoral priorities in all evaluated countries	**A**	Findings for this conclusion are supported by the qualitative information gathered and well triangulated from the documental review and key informants.	- CPAPs, AWPs/RWPs - Annual and MTR reports - Country Strategy and Policy documents (PRSP, National Development Strategies, Health Policies and Strategies) - Interviews (IDI & GIs where applicable)
EQ10. UNICEF applied considerable efforts to involve relevant partners in the programme design, implementation and evaluation, however representation of beneficiaries in this process was relatively small.	**A**	Findings for this conclusion are supported by the qualitative information gathered and well triangulated from the documental review and key informants.	- SITANs; CPAPs, AWPs/RWPs - Annual and MTR reports - Monitoring and Evaluation reports - Interviews (IDI & GIs where applicable)
Effectiveness			
EQ11-12. UNICEF supported programmes most likely contributed to achieving required changes as per the health system block/enabling environment in the evaluated countries. This was achievedby identifying the critical health system bottlenecks in effective coverage for evidence-based MCHN interventions and addressing them with the help of core roles. UNICEF identified and in cooperation with its partners has attempted to tackle all health system level determinants: policy, legislation, management and financing, human resources, supplies, information system. However UNICEF was least successful in addressing health financing bottlenecks independently and in certain cases even in partnership with the development partners traditionally active (The World Bank, USAID, EU) in health financing reforms **EQ13. There is a high likelihood that UNICEF supported programmes contributed to eliminating bottlenecks in ensuring effective coverage of priority MNCH interventions along the continuum, in particular those most relevant to the CEE/CIS region, considering the improved coverage indicators in all the evaluated countries and aplausible probability established for UNICEF's contribution to the required system changes to ensure the improved coverage.**	**B**	Findings for these conclusionswere drawn through data and methodology triangulation: qualitative information was gathered and triangulated from the documental review and key informants. Two other researchers independently validated Qualitative judgment Scores assigned by the principal investigators were independently verified by 2 other researchers. However, triangulation results for findings for UNICEF contribution to several bottlenecks was not consistent across data sources	- Answers to EQ.7 and EQ8 UNICEF Country Annual Reports - Monitoring and Evaluation and MTR reports - Interviews (IDI & GIs where applicable)

EQ14.The results achieved in reduction of equity gap in coverage with MNCH services were mixed. While some gaps were reduced the other inequities widened. Subsequently, significant inter and intra country variations are observed and marginalized groups of population still remain deprived of effective coverage with critical MNCH interventions.	**A**	Findings for this conclusion are supported by the secondary data analysis of high quality data-seta	- MICS and DHS reports - Routine national statistics - WHO Health for all database - Country surveys and reports
EQ15. While establishing direct causal relation was not an objective of this evaluation, it is likely that the reduction in bottlenecks contributed to disease specific mortality reduction for perinatal conditions, ARI, DD, and meningitis and these reductions appear to be positively associated with overall reduction in NMR, PNMR, IMR, and U5MR in the evaluated countries. Bottlenecks' reduction contribution to the reduction of deaths due to congenital conditions and injuries was impossible to establish.	**B**	Quantitative and qualitative data source and methodology triangulation described was used to derive findings supporting these conclusion, however, there was a limited triangulation of sources for specific findings.	- All sources for EQ.11 through EQ.14 - Interviews
Efficiency:			
EQ16. Financial resources for UNICEF supported programmes were allocated in accordance with identified priorities and bottlenecks	**B**	Primary cost was gathered and analysed and well triangulated with other data sets compiled by the ET.	- AWPs/RWPs - UNICEF Annual, MTR and evaluation reports
EQ19. UNICEF closely monitored program implementation using different tools and approaches and acted upon the identified issues	**A**	Conclusion was cross-verified based on the qualitative and quantitative findings from multiple reliable sources.	- AWPs/RWPs - UNICEF Annual, MTR and evaluation reports - SITANs and CPAPs - Country data systems – annual statistical yearbooks - Interviews (IDI & GIs where applicable)
Sustainability			
EQ.20 Most of the UNICEF supported programmes were integrated into national policies and budgets. UNICEF was somewhat more successful in assuring integration in national policies than in the national budgets. **EQ21.Overall, UNICEF succeeded in assuring scale-up of pilots and their inclusion in national policies and/or systems.**	**A** **A**	Findings for this conclusion are supported by the qualitative information gathered and well triangulated from the documental review and key informants.	- AWPs/RWPs - UNICEF annual, MTR and evaluation reports - Government documents and budgets - Interviews (IDI & GIs

		Findings for these conclusions are supported by the qualitative information gathered and triangulated from the documental review and key informants. However, data quality on leveraged funds was not adequate	where applicable)
EQ22.UNICEF assisted programmes have been mostly successful in leveraging resources and partnerships.	**B**		
EQ24. Two out of every three programmes continue after the conclusion of UNICEF support.	**A**	Findings for these conclusions are supported by the qualitative information gathered and well triangulated from the documental review and key informants.	- UNICEF annual, MTR and evaluation reports - Interviews (IDI & GIs where applicable) - Government documents - Interviews (IDI & GIs where applicable) - UNICEF annual, MTR and evaluation reports - Government documents - Interviews (IDI & GIs where applicable)
EQ25. A combination of critical elements were identified that made UNICEF programmes sustainable	**A**		
EQ26. There were several other partners that were supporting MNCH programmes initiated with support from UNICEF.	**A**		
Rights Approach and Gender Equality			
EQ27.Gender Equality was largely absent and the Human Rights Based Approach to programming was partially incorporated into UNICEF supported programmes planning, implementation and evaluation.	**A**	Findings supporting this conclusion were obtained using comprehensive documental review and interviews with key informants	- CPAPs - AWPs/RWPs - UNICEF annual, MTR and evaluation reports - Key informant interviews
EQ28. Monitoring and evaluation of UNICEF supported programmes were mostly declared as performed in a participatory and ethnical manner with full respect to human rights and gender specific and sensitive issues, while evidence of such performance with regards to programme planning and implementation was impossible to obtain	**B**	Findings supporting this conclusion were obtained using comprehensive documental review however some information gaps were not addressed	- CPAPs - AWPs/RWPs - UNICEF annual, MTR and evaluation reports
EQ29. MNCH programmes supported by UNICEF, with few exemptions largely failed to clearly define the marginalized, vulnerable and hard-to-reach groups for programmatic purposes and subsequently focused interventions on these groups. UNICEF has however monitored equity effects of its interventions.	**A**	Findings supporting this conclusion were obtained using comprehensive documental review	- MTRs and program evaluation reports

ANNEX 15. Terms of Reference for the Evaluation

Regional Knowledge and Leadership Area 6

Progress in Reducing Health System Bottlenecks towards Achieving the MDG 4 Goal: Evaluation of UNICEF's Contribution in 5 CEE/CIS Countries

Terms of Reference

Final, September, 2013

1. Overview

This Terms of Reference is developed for the Multi-country Evaluation (MCE), which will look at the extent to which UNICEF supported programmes in 5 countries have contributed to addressing critical bottlenecks in delivering life-saving interventions to children. The evaluation will examine UNICEF's contribution to system level changes and transformation of community practices and norms (supply and demand driven), over the period 2000-2012. More specifically, how this has contributed to reduction of child mortality and morbidity, and narrowed down the equity gaps for these critical child health outcomes. The proposed time period is chosen for two reasons. First, it coincides with the major health reform processes that took place in the selected countries. Second, the duration of programme interventions allows sufficient time to measure their effectiveness (results for children) and efficiency (measures UNICEF's specific contribution).

The countries which will be covered by the MCE evaluation are: Kazakhstan, Kyrgyzstan, Moldova, Serbia, and Uzbekistan. Selection of these countries will not only document evidence of programme achievements and lessons learned, but will show feasibility of a range of interventions applied in different health, socio-economic and political context. The countries proposed for evaluations, although significantly different in terms of their baseline child health indicators and format of programmes applied, have been selected based on the scale of their programme's influence at system level changes. Therefore, the overall evaluation will bring richness and diversity of approaches in both middle-income and high-income countries.

The multi-country evaluation will include both summative and formative type of evaluation. The purpose of the summative evaluation will be to assess overall achievement of UNICEF supported country programmes i.e. contribution to health system strengthening and addressing bottlenecks (from demand and supply side) to facilitate effective coverage of services and interventions, and consequently, their potential contribution to reduce child specific causes of mortality and morbidity.

On the other side, the formative piece of evaluation will allow to gather information to understand strengths, weaknesses, opportunities and lessons learned (i.e. what could and what could have been done differently?) of the previous, as well as for the current health programme, in order to improve and sharpen further equity based programming, thus contributing to the recommendations for UNICEF's future engagement to accelerate the achievement of MDG4 with a focus on equity. Outcomes of the evaluation will be used to share knowledge and experience within the CEE/CIS and other regions with similar socio-economic context, initiate dialogue with partners and donors related to further programming of maternal and child health care, and most important, partnering with national governments to support and improve programming, which should result in improvement of child health indicators.

2. Background

In April 2012, the Regional Office initiated a participatory process involving all Country Offices in CEE/CIS to identify few strategic result areas where UNICEF has the capacity to deliver high-quality and relevant results that contribute to address child rights violations and close equity gaps. This process follows a decade of

UNICEF's upstream work i.e. system approach to programming in a significant number of countries, which yields tangible results not only in terms of system changes (outcome results), but also in terms of changes in the life of children (impact results).

Considering the aforementioned, UNICEF CEECIS Regional Management Team launched a Regional Knowledge and Leadership Agenda (RKLA) which aims at: documenting progress and trends in child rights indicators; generating knowledge, sharing experience and innovations concerning most feasible interventions to advance children's rights agenda; and bring recommendations for adjusted and equity-based programming primarily for national governments, developmental partners and across the region(s). The main purpose of the RKLA is to identify what works by documenting results for children in a large number of countries, with different context and level of development, and create an "innovation lab" by exploring, implementing and documenting new and emerging areas of engagement. A number of initiatives, the so called "mature areas", have already generated knowledge around good practices especially in public sector reform at the system level where large-scale, well-documented results can be directly associated with country programmes.

For each of the "mature areas", multi-country evaluations will be undertaken to demonstrate how reduction of equity gaps and impact results (in terms of changes in the life of children) were made possible through changes in the national (regional/local) systems and document UNICEF's contribution to these changes:

1. Children's right to be raised in a family environment (2012)
2. Juvenile Justice: Children's right to support to re-integration into society (2013)
3. Children's right to early learning / school readiness (2013)
4. Inclusion of all Out of School Children in Quality Learning (2012)
5. **Children's right to health: infant and under 5 and mortality (2013)**

Reference Groups (composed of representatives of the Regional Office and concerned Country Offices) were set up in order to identify common elements and differences in the country approaches and policy options that led to the achievement of various impact and outcome results.
In line with these criteria, Reduction of Infant and Under 5 Mortality has been selected as one of the Mature Areas, where results have been achieved in a number of countries. The scope of the evaluation is also aligned with the objectives of the global initiative "A Promise Renewed" launched in June 2012, aimed at enhancing commitment and efforts of governments and development partners to stop preventable child deaths. Therefore, assessing and documenting UNICEF's specific contribution to address critical bottlenecks in delivering life-saving interventions to children will boost the following objectives of "A Promise Renewed" global campaign:

- Mobilize and reinforce political leadership to end preventable child deaths;
- Achieve consensus on a global and regional roadmaps highlighting innovative and proven strategies to accelerate reductions in child mortality;
- Drive sustained collective action and mutual accountability;

3. Context

3.1 Maternal and Child Health: Analysis of the Situation in CEECIS

The Convention of the Rights of the Child stipulates that "State parties shall ensure to the maximum extent possible the survival and development of the child." (Article 6.2) and "State parties recognize the right of the child to the enjoyment of the highest attainable standards of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." (Article 24.1)

Furthermore, the Millennium Development Goals have established specific targets to reduce Under Five and Infant Mortality Rates by 2/3 between 1990 and 2015. UNICEF has further demonstrated that without an equity-focus to achieving MDGs, it will neither be possible to achieve the MDG target nor reduce the gap between the better-off and the most impoverished and vulnerable children. In Narrowing the Gap to Meet the Goals, UNICEF has argued that an equity-focused approach is both right in principle and right in practice, and this has become the basis for the organizational renewed focus on equity.

Overall the CEE/CIS is a region of comparatively low Under 5 Mortality, achieving a 56% reduction between 1990 and 2012. This progress was uneven, leaving several countries and population groups lagging behind. Most of Central Asia and Caucasus countries continue making slow progress in reducing the U5MR. Striking inequities persist in countries with low U5MR where children of some ethnic groups (primarily Roma) as well as in rural and remote communities are at substantively higher risks of dying before their fifth birthday. There are significant regional and within country disparities. Countries in Central Asia and Caucasus have mortality rates which are 2 to 3 times higher than the regional average.

Also, the U5MR is 50% to over 100% higher in families in the poorest wealth quintile compared to the richest. Similar inequalities occur by gender, level of maternal education, urban/rural residence, and ethnic or language group. Higher mortality rates in the poorest wealth quintile compared to the richest, rural areas and in socially excluded groups (i.e. Roma) are determined by unequal access to health services, lack of financial protection and other social determinants.

Neonatal causes contribute to over 60% of U5MR in all CEECIS countries (UNICEF SOWC 2010). Prematurity is the primary cause of neonatal death in the region, with asphyxia and infection as the second and third important cause in most of the countries. As reported by several assessments carried out at country level, the main causes of maternal mortality in CEECIS are haemorrhage, obstructed labour, sepsis and eclampsia, which mean that in most countries (primarily pertinent to Central Asia countries) the maternal mortality profile is still similar to that in developing countries. The rates and the distribution of the main causes of maternal and neonatal mortality, within an overall context of improved living conditions, decreasing fertility and very high coverage with antenatal care and institutional births, point to problems in the quality of care for pregnant women and newborns, and again to inequitable access by disadvantaged population groups[246].

Immunization coverage levels in six countries are below the regional target of 95% for DTP3. Even in countries of high national average, a more detailed analysis of MICS and administrative data reveals in-country inequalities in coverage by geographical area, wealth, settlement, gender and mother's education. Surveys show dramatic gaps in immunization of Roma and other vulnerable populations. Ukraine is the highest risk country for disease outbreaks like polio, measles and diphtheria with a 50% immunization coverage persisting over the last three years. Nine countries have challenges in achieving financial sustainability in immunization, thus continue to need varying degrees of donor support in procuring vaccines and covering programmatic expenditures.

Challenges persist in achieving regional disease elimination/eradication goals. Although the region maintained its polio-free status, the large polio outbreak that occurred in Tajikistan and neighbouring countries in 2010 revealed persistent immunization gaps in susceptible populations. Measles and rubella outbreaks are ongoing since 2009 particularly in the Western part of the region, Bulgaria and Ukraine bearing the highest disease toll.

Scepticism towards the continuing necessity of vaccination has started to grow among the public in the last decade. This worrying situation has also been exacerbated by organized anti-vaccine movements born of political motives, religious or ideological positions. As a result, several crisis situations were encountered following adverse events wrongly attributed to vaccination, and public trust has declined.

Malnutrition remains an important determinant of infant and under-5 mortality and poor development of children. Persisting malnutrition is reflected in high rates of stunting and micronutrient deficiencies and is often coupled with increasing rates of overweight and obesity. Recent surveys show that stunting rates remain high in a number of countries in the region with Tajikistan at 39%, Azerbaijan at 25%, Albania 19%, and Kyrgyzstan 18%, with significant regional and minority group disparities within some other countries. Stunting is a clear indication of chronic malnutrition or repeated food deprivations and is specifically related to poor infant and young child feeding practices in the first 2 years of life. Similarly, iron deficiency anaemia remains a public health problem in the majority of the countries in the region based on recent surveys conducted in Albania, Armenia, Georgia, Kosovo (under UNSCR 1244), Kyrgyzstan, tFYR Macedonia, Moldova, and Turkey, ranging from moderate to significant public health issue (> 40%).

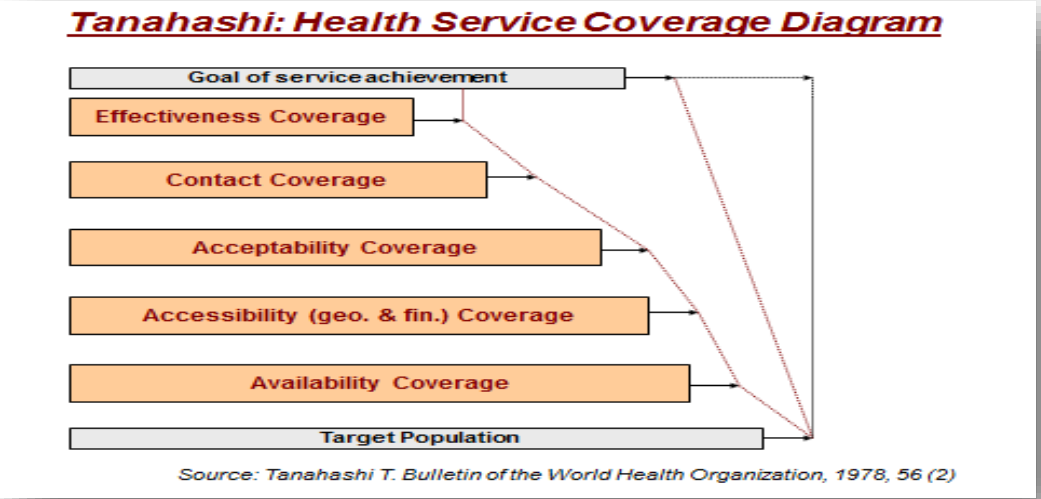
[246] Strategic directions in health and nutrition aiming at accelerating achievement of MDG 4 and related objectives in the countries of Central and Eastern Europe and Commonwealth of Independent State, Adriano Cattaneo, Ilkhom Gafurov, Tamara Bomestar, Marianna Bacci and Giorgio Tamburlini, WHO Collaborating Centre for Maternal and Child Health), Institute for Child Health IRCCS Burlo Garofolo, Trieste, Italy, 2008;

Additionally, recent data from MICS and other national surveys show decline or no improvement in USI status (percentage of households consuming iodized salt) in countries such as Kazakhstan, Kyrgyzstan and Tajikistan. This is mainly due to weak monitoring systems and lack of commitment on the part of the government. Regional exclusive breastfeeding rates have increased only minimally from 27% to 30%, among the lowest globally, and in some countries, like Serbia, it declined from 15% to 13&. Additionally, early initiation of breastfeeding which has a high impact on neonatal mortality is currently at 49%, which, despite high rates of hospital delivery, are only marginally above the World's rate of 43%.

3.2 Health Services Coverage Bottlenecks in CEECIS

The aim of the health systems is to provide equitable and quality health services. Identification of barriers and bottlenecks in effective coverage is a pre-requisite for implementing effective interventions. According to the **Tanahashi model** (Figure 1), there are five domains of coverage: availability coverage, accessibility coverage, acceptability coverage, contact coverage, effective coverage. An equitable and effective coverage means that the population has access to quality services according to the needs and regardless of capacity to pay. This access translates into improvement of population health and/or decrease in mortality. Therefore understanding the gaps between physical availability of services and the effective coverage and differences in coverage and bottlenecks by different groups and geographic areas is a critical element for equity-focused programming.

Figure 1 . Tanahashi Health Services Coverage Model



Availability of health services and geographic accessibility (first two domains of Tanahashi model) have not been a major problem in general in many CEECIS countries. The network of health facilities in Central and Eastern Europe and in Central Asia was often characterized by overcapacity and significant inefficiencies, particularly at hospital level. In terms of **acceptability coverage** (third domain of Tanahashi model), during the early transition of the 1990s the budget austerity led to the shift of a substantive financial burden from the state to the population as the lack of essential drugs, low salaries and other costs related to health care had to be increasingly covered out-of-pocket. The rise in out-of-pocket payments was coupled with a deteriorating infrastructure and outdated protocols of care that were not based on evidence nor were efficient in addressing MCH conditions. A review of inequities in MCH in CEECIS identified that high levels of income inequalities and out-of-pocket expenditures for health services are the major drivers of inequities in maternal and child health in the region. In most of the countries in the CEECIS region, out-of-pocket expenditures represent about 40-50% of total health expenditures, reaching 60-70% in a number of countries.

Inequities in accessing the continuum of care for women and children are important determinants of mortality and health status. Concerning **contact coverage** (fourth domain of Tanahashi model), CEECIS countries are generally reporting high initial utilisation of antenatal care (in particular first visit) and facility-based deliveries. The overall proportion of institutional deliveries is close to 100% in most countries, with the main exception being Tajikistan, where there are still about 12% of home deliveries reported. Under these circumstances,

continuum and quality of perinatal care (or **effective coverage** as the fifth domain of Tanahashi model) remains a significant problem.

An important factor in many CEECIS countries is the low prioritization and insufficient capacity related to public health interventions, particularly in the area of health promotion and health communication, both, for promoting health behaviours in nutrition, ECD, HIV prevention, etc. and for communicating risk. These gaps have resulted in insufficient knowledge and care-seeking behaviours among parents and care-givers. In addition, the 2006 country MICS have confirmed that many caregivers are not aware of the needs of young children for responsive parenting. Obvious gaps have been also revealed in relation to immunization programmes. UNICEF research has repeatedly shown that many families now hesitate to have their children vaccinated because of increased anti-immunization coverage in the traditional and new media.

The IMR and U5MR have increased in many countries in the region during the 1990s before substantive health sector reforms were initiated. The health reforms that were implemented in the 1990s focused primarily on making health services more efficient, thus reducing the burden on public expenditures. Consolidation of the hospital sector, introduction of new service delivery models (e.g. GPs, family doctors) and changing health system financing (switching to health insurance models) constituted major elements of these reforms.

4. UNICEF Programme Focus in CEE/CIS in the area of Health and Nutrition

Towards the end of the 1990s UNICEF programmes in CEECIS gradually shifted from a predominantly emergency, service delivery and project mode to a more up-stream health system approach, aligning itself to the overall efforts to modernize and improve quality of health service. UNICEF's focus was to protect access to the most effective MCH interventions (i.e. immunization, prevention and treatment of the most common childhood diseases, i.e. acute respiratory infections and diarrhoeal diseases) and the improvement of the quality of MCH services with particular focus on maternal and newborn care.

According to the Tanahashi model, UNICEF supported country programmes focused at health system strengthening and primarily aimed at addressing bottlenecks to ensure effectiveness in coverage (quality of care), financial accessibility (including access to essential drugs, vaccines and other commodities and evidence-based interventions), and allowing effective implementation of demand side interventions (increasing knowledge of families on case management and referral in the case of most common childhood illnesses). In addressing the bottlenecks identified, UNICEF programmes aimed at influencing health system blocks and creating an enabling environment, thus promoting system changes that would translate into sustainable elimination of bottlenecks in service coverage. Therefore, the purpose of the multi-country evaluation is to show evidence to what extent UNICEF has been effective and efficient in pursing those strategies and drawing from lessons learned of the past, how we should do programming further.

More specifically, UNICEF programmes of cooperation in CEECIS countries aimed at reduction of inequities in key child health indicators (mortality and morbidity) by supporting wide range of evidence-based interventions and at the same time with primary objectives to addressing the health system bottlenecks and social determinants of health to create enabling environment and bring positive outcomes in terms of maternal and child health, focusing its support in the following areas:

- **Improve the quality of services provided to women and children during antenatal, intra-partum, neonatal and post-neonatal periods**. In a number of countries, large-scale UNICEF supported programmes focusing on Strengthening Perinatal Care and implementing cost-effective Primary Health Care interventions using the Integrated Management of Childhood Illnesses (IMCI) and complementary Care for Development packages have been implemented;

- **Conduct research and provide policy advise and technical support in the formulation of Basic Benefit Packages** aimed at ensuring that evidence-based and cost-effective interventions, both preventive and curative, are available free-of-charge or partially subsidized to beneficiaries;

- **Enhance knowledge and skills of parents and caregivers** to provide appropriate care, home based case management and timely and appropriate referral in case of childhood illness through strengthening capacity of health systems to implement behaviour change communication, support strengthening of health promotion and communication for development (C4D) programmes;
- **Increase awareness of families about their entitlements and quality of care** through policy development and stimulating beneficiaries demand for services;

- **Maintain and increase access to and quality of immunization services** by assisting governments in making vaccines accessible through procurement services (and in some countries, provide vaccines and make them accessible through the Supply Division), improving EPI programme management skills, strengthening the cold chain capacity, improving communication on vaccine related issues and responding to outbreaks;

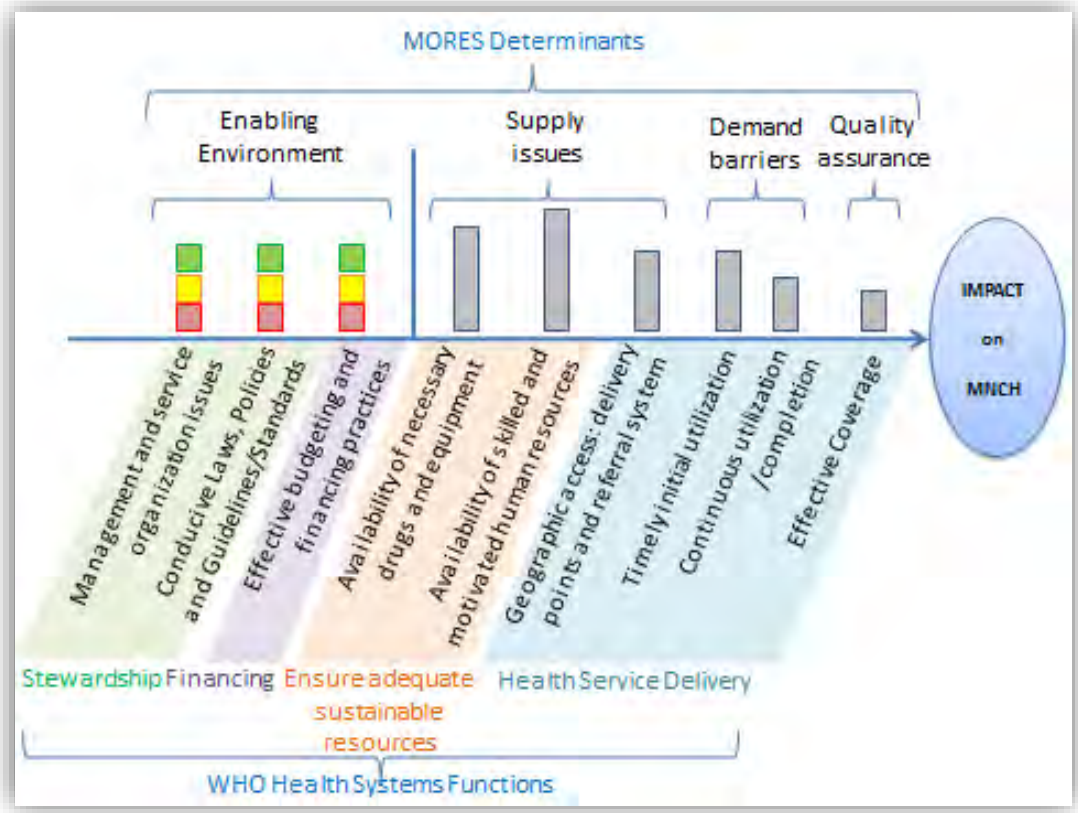
- **Improve nutrition**. UNICEF supported programmes aimed at providing women and children with micronutrient fortified products, i.e. iodized salt and fortified flour, promote exclusive breastfeeding until 6 months and timely and adequate complementary feeding.

The focus, scale and impact of UNICEF supported programmes and interventions vary among countries. This evaluation will therefore focus on five countries with the largest and most innovative health programmes supported by UNICEF, to examine whether they have contributed to system change, by addressing bottlenecks that constrained provision of effective coverage in evidence-based and continuous maternal and child health services, thus contributing to improvements in key maternal and child health outcomes. In addition, the evaluation (in particularly the formative piece of evaluation) will document whether programme implementation could have been differently targeted to yield better results and eventually improved health outcomes for women and children.

5. What do we want to evaluate? (Conceptual Framework/Theory of Change)

The subject for the multi-country evaluation is the regional approach of UNICEF to support health system strengthening and health system reforms to ensure equitable and quality delivery of maternal and child health services, implemented at country level and further detailed below in the "Theory of Change" **(Annex 1).** The evaluation is based on the conceptual framework that sustainable and progressive realization of children's rights and reduction in equity gaps could be achieved through changes at system level, which will translate into effective targeting of service coverage bottlenecks. For the purpose of this evaluation, the "Theory of Change" has been re-constructed to reflect the essential functions of a health system (approach applied for UNICEF programming before MORES framework) and it is aligned in a logical model with the MORES determinants framework, which includes the core health system building blocks. (Fig.2). The Conceptual Framework for the Multi-Country Evaluation further looks at UNICEF's Core Roles and programme approaches at sustained health system changes around addressing all four MORES determinant areas: enabling environment; supply issues; demand barriers and quality assurance (Fig.2).

Figure 2. Conceptual Framework for the Multi-Country Evaluation



The multi-country evaluation will aim at assessing and documenting whether UNICEF focus to ensure effective coverage of evidence-based maternal and child health interventions, following an upstream programme engagement at the level of health systems/enabling environment and addressing community practices and norms (both on the supply and demand side) has ultimately contributed to reducing morbidity, mortality and reducing the equity gap between population groups. Specific emphasis will be given at reviewing UNICEF's contribution along the MORES framework, e.g. creating enabling environment, starting from development and implementation of conducive policies and legal framework; allocation and utilisation of expenditures; as well as effective management and coordination at national and sub-national level, and identification, prioritization and overcoming bottlenecks hampering availability, affordability, adequacy and continuity in use of maternal and child health services, both from supply and demand driven determinants (Fig 2). The concepts of Enabling Environment and Coverage Bottlenecks are summarized within the Determinant Analytical Framework ("MoRES Framework") developed by UNICEF to strengthen equity focused programming **(see Annex 2).**

The multi-country evaluation will present a broader review of progress on reducing Infant and Under 5 Mortality Rates in the countries of the CEECIS region. The countries' evaluation will look at specific UNICEF's contribution to system level changes and addressing bottlenecks in effective delivery of MCH services into a wider context, looking at trends into determinants and contributing factors at the level of health systems and identifying significant changes in social determinants of child survival (e.g. economic situation, fertility, nutrition, housing and environment, WASH, etc).
UNICEF's work is guided by a set of **Core Roles** which are common to most country contexts in which UNICEF operates in the CEECIS region:

- **The 'Voice' for children and adolescents** -- advocating and communicating on key national policies, social issues, mindsets and attitudes;
- **Monitoring and evaluation** – assisting independent assessments of the functionality of the Child Rights guarantee systems, the progressive realisation of child rights and the reduction in equity gaps in child well-being;

- **Policy advice and technical assistance** – through well-designed UNICEF positions (based on local, regional, and international best practices) on key issues, supporting the development of the normative frameworks related to specific national legislation, policy or programme, as well as private sector standards that can improve equity;
- **Leveraging resources from the public and private sectors** – accompanying and redirecting reforms, including those supported by the EU, IFIs, bilaterals and national/multi-national corporations;
- **Facilitating national dialogue towards child friendly social norms** – bringing together government, private sector and civil society, as well as convening divergent forces to enhance public debate, participation and action around equity and child rights;
- **Enabling knowledge exchange** – fostering horizontal cooperation and exchange of experience among countries and regions on 'what works' for enhancing child well-being and equity.
- **Modelling/piloting** demonstrating how systems could meaningfully improve to reduce equity gaps and address child's rights violations

Last but not least, UNICEF contribution comes in the context of wider partnerships which are particularly rich and complex in the area of health. Understanding the potential added-value and strategic positioning of UNICEF supported programmes is of particular importance to the relevance, efficiency and effectiveness of organizational inputs. Therefore, the evaluation will also review synergies and complementarities of programme implementation and upstream technical support with all developmental partners, as well as country-led initiatives at the time period indicated for evaluation.

Within this generic approach UNICEF Country Offices have aimed at addressing different bottlenecks and prioritized strengthening of different Health System blocks, depending on country priorities, roles of other partners and resources available. There was however uniformity in the UNICEF upstream approach in working at the level of Health System/Enabling Environment. Details of country specific programme focus and results achieved are attached in **Annex 3 (Country Result Matrix)**.

Rationale for the evaluation

The multi-country evaluation is conducted in the context of the Regional Knowledge and Leadership Agenda aiming at documentation of progress in reduction of under 5/infant mortality and morbidity, generation of lessons learned how this was accomplished, in order to inform adjustments and scaling-up of evidence-based and equity focused programming to enable better partnering with national governments for advancing the child health rights agenda. While CEECIS countries made significant progress in reducing IMR and U5MR, there are still large disparities which have to be addressed and the evaluation will inform further efforts in this area. The evaluation will also contribute to the global knowledge evidence base on child mortality and morbidity reduction.

The findings and recommendations of this evaluation will primarily be addressed with policy makers and programme managers, both internally in UNICEF and externally in governments, partner organizations, and academia. The evaluation will serve as a regional contribution to the global platform of learning and applying most feasible, effective and efficient approaches towards equity-based and evidence-informed planning for maternal and child health. A better documentation of results achieved and identification of most effective strategies and interventions should also contribute to mobilizing additional funding for achieving further reduction of avoidable child deaths in the region and globally.

The results of the evaluation will further inform the MTRs and influence the development of UNICEF supported programme of cooperation. The evaluation will also document lessons learned from country specific programmes, which have contributed to formulating regional policies to support further progress in reducing infant and child mortality and morbidity, thus contribute to the A Promise Renewed Initiative.

Objectives of the evaluation

1. Evaluate UNICEF's specific contribution (along the core roles explained above) to addressing health system level bottlenecks and improving effective coverage with evidence-based Maternal, Newborn and Child Health interventions (as per TOC and MORES determinants).

2. Determine whether the system level changes generated through UNICEF support and improved effective coverage could be associated with reduction of morbidity and/or mortality in children under 5 (cause specific), while reflecting the contribution and technical support of other development and national partners.

3. The evaluation of UNICEF contributions as per Objectives 1 and 2 will be conducted in the context of assessing overall trends in under 5 and infant mortality and morbidity (2000-2012), including equity and gender based analysis, review of causes of specific U5 and Infant morbidity and mortality, and potential influence of external factors and social determinants (education; place of residence, wealth status, etc)

The logical model of connection among different objectives of the evaluation is presented in **Annex 3.**

Scope

The multi-country evaluation will cover the following countries: Kazakhstan, Kyrgyzstan, Moldova, Serbia, and Uzbekistan. The evaluation will primarily look into UNICEF assisted programmes, however, these will be analysed within the wider context of health partnerships in the selected countries. UNICEF's direct contribution, as well as its ability to leverage additional support and funding to MCH, will be part of the evaluation.
As the evaluation is looking at system level impact, it will go beyond one programme cycle (which is on average 5 years). Since it would look into the catalytic role of UNICEF programmes, it could cover at least two or even three programme cycles where appropriate (2000 – 2012). The proposed time period is chosen for two reasons. First, it coincides with the major health reform processes that took place in the selected countries. Second, the duration of programme interventions allows sufficient time to measure their effectiveness (results for children) and efficiency (measures UNICEF's specific contribution). Selection of these countries will not only document evidence of programme successes and lessons learned, but will show feasibility of a range of interventions applied in different health, socio-economic and political context. The countries proposed for evaluations, although significantly different in terms of their baseline child health indicators, format and scale of programmes applied, have been selected based on the scale of their programme's influence of the system level changes. Therefore, the evaluation will bring richness and diversity of approaches in both middle-income and high-income countries.

The evaluation will look both at national and sub-national system level changes. In collaboration with RO and CO teams, evaluators will review the country result matrix and select programmes for further evaluation. Criteria for doing so will be: **i)** availability and quality of data at impact and outcome level; **ii)** nationwide programmes with system level upstream work and impact; **iii)** documented pilot programmes , as well as **iv)** programmes targeting inequities and specific vulnerable groups.

The following limitations to the evaluation are anticipated: **i)** unavailability and poor quality of data, in particular for impact and outcome level; **ii)** there was no explicit theory of change aligned with the MORES framework, as a programming tool at the onset of the evaluated programmes. However, what has guided the work of UNICEF in this region over the past decade is a consensus that the progressive realization of child rights and reduction of equity gaps is best achieved through health system changes at all levels, and that sustained UNICEF engagement through its core roles contributes to these system changes. Therefore, the programme design in the countries selected for this evaluation used a health system change approach which is reconciled now with the MORES approach (as per fig.2). Therefore, the evaluation methodology and implementation plan will take into account the common health system strengthening approach in addressing a range of different bottlenecks depending on the specific country context.

Also to address some of these limitations, the evaluation will be conducted in a "step-by-step" manner, composed of three stages. The first one will assess availability, scope and quality of data and validate key

determinants of inequity and trends at impact and outcome level. The second stage will further narrow down the evaluation approach, examining all and country specific programme interventions and their impact, including UNICEF's specific role (for more details see full methodology and **Annex 3)**. Third stage will be implemented at country level and detailed evaluation framework will be developed based on the outcome of two previous stages. Detailed in-country evaluation framework should be developed to allow comparability of programme approaches across the countries.

Evaluation questions

The evaluation will respond to the following specific questions:

1. **Impact**

a) Has there been positive change in reduction of infant and under 5 mortality and morbidity over the period 2000 to 2012;
b) What is the trend in these key child health indicators across geographical; ethnical; gender and other socio-economic stratifiers;
c) What is the trend in reducing mortality and morbidity specific causes, also disaggregated by other socio-economic stratifiers;
d) Who are the remaining outliers in terms of key child health indicators, disaggregated by geographical; ethnical and other socio-economic stratifiers ;
e) What other factors, for example, social determinants on health (education, unemployment, poverty etc.), contributed to change infant and under 5 mortality and morbidity?

2. **Relevance**

a) Has UNICEF supported programme(s) addressed the most important causes of infant and under 5 morbidity and mortality?
b) Were the right and appropriate interventions identified, prioritized and applied by UNICEF supported programme (s), including for scope, target groups and scale to address health system bottlenecks;
c) Were the most important bottlenecks in effective coverage with MCH services identified and addressed with UNICEF's supported programme?
d) Was the UNICEF supported programme(s) aligned with the national development and sectoral priorities?
e) Were relevant partners involved in the programme design, implementation and evaluation, including beneficiaries?

3. **Effectiveness:**

a) Has the UNICEF supported programme(s) contributed to achieving required changes as per the Health System blocks/the Enabling Environment?
b) Was UNICEF able to ensure that all relevant determinants at health system level (policy; legislation; financing; management) were tackled both through its direct intervention and by convening and advocating with partners?
c) Has the UNICEF supported programme(s) contributed to eliminating bottlenecks in ensuring effective coverage of priority MCH interventions along the continuum, in particular those most relevant to the CEECIS region:
    i. Increasing availability of essential **supplies and qualified human resources**;
    ii. Ensuring **financial accessibility**;
    iii. Changing knowledge, attitudes and practices on MCH and raising awareness about and **demand for services**;
    iv. Ensuring **quality of services**;
d) Was the equity gap in coverage with MCH services reduced? What groups of the society remain unreached, disaggregated by place of residence, wealth, gender and ethnicity?
e) Has the reduction in bottlenecks contributed to disease specific mortality (mortality caused by ARI, DD, asphyxia, prematurity, etc) and if it could be positively associated with overall reduction in ENMR, PNMR, IMR, U5MR ?

4. **Efficiency:**

a) Has allocation of resources for UNICEF supported programmes been done in the most cost-benefit manner?

b) Have UNICEF budgets and resources been adequately used on addressing priority bottlenecks? In other words, could we have the same programme results will less resources? (economic and technical efficiency)
c) Was programme implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?
d) Was programme implementation appropriately monitored and evaluated? How were the results used?

5. Sustainability:

a) Are UNICEF supported programmes integrated into national policies and budgets?
b) Have UNICEF developed models/pilots scaled-up, incorporated into national policies and/or systems?
c) Have UNICEF assisted programme(s) been successful in leveraging resources and partnerships?
d) What was the return on the investment ratio? What additional funding channelled to MCH focused interventions was promoted through the UNICEF programme(s)?
e) Do programmes continue after the conclusion of UNICEF support?
f) What were the critical elements which made the programme sustainable (or which did not make it sustainable)?
g) Are other partners supporting MNCH programmes initiated with support from UNICEF?

6. Were the Human Rights Based Approach to programming and Gender Equality aspects incorporated into programme(s) planning, implementation and evaluation?

a) Were planning, implementation and monitoring of evaluated programmes performed in a participatory and ethnical manner with full respect to human rights and gender specific and sensitive issues?
b) Whether the programme being evaluated paid attention to effects on marginalized, vulnerable and hard-to-reach groups;
c) How gender issues were implemented as a cross-cutting theme in programming, and if the programme being evaluated gave sufficient attention to promote gender equality and gender-sensitivity;

Methodology Framework and Accountabilities

Description of methodology framework

The evaluation will consist of various methods clustered around **three stages:**

I. Analysis of the latest MICS 4, DHS and other population based studies and the evaluability assessment (15 Days).

This analysis will be done for all CEECIS countries for which data are available to validate the regional context and refine the scope of the evaluation. Also at this stage, baseline and target indicators for the five countries included in the evaluation will be defined, grouped under a logical framework of results based programing. Indicators and data will be derived from UNICEF Country Programme Action Plans; Annual work plans and Annual reports for the indicated time-frame of the evaluation. Reliability, level of disaggregation and quality of data will also be examined. This stage will be critical for the evaluability assessment and to continue with explorative and more formative research at country level, but also, to indicate approaches to address data gaps and use of proxy sources during the second stage analysis.

The initial analysis will produce a **draft inception report** that will look into the trends in the overall progress and reduction of equity gaps in IMR /U5MR and morbidity (including for causes) and effective coverage along the continuum of MCH services. Comparison (where possible) will be made with the previous rounds of population based surveys (ex. MICS and DHS comparable data-points over the last 10-15 years) and considerations about data availability and data quality will be determined, along with potential limitations of the final evaluation findings. This stage will determine initial evaluability of the assessment. The team of evaluators should then indicate approaches to address data gaps and use of proxy sources during the second stage analysis, and also to determine the options and feasibility of assessing impact with the available data in each country included in the evaluation. The analysis will validate the key determinants of inequities at impact and outcome level and system bottlenecks constraining further progress.

II. Desk review of secondary reports and data (15 Days)

This analysis will be done for the five countries included in the evaluation. The desk review will be informed by the inception report of the first stage and it will further narrow the objectives of the evaluation depending on the scale and focus of UNICEF programmes in each country. Issues around availability and quality of data, identification of additional data collection exercises (if required), including for project reports and grey literature will be addressed **(see: Annex 3 for country specific data sources and results).** Upon completion of this stage, **the methodology for the final in-country formative research will be defined and agreed upon** with all relevant stakeholders. At this stage, the team of evaluators should design an in-country evaluation methodology that will further allow comparability of approaches and data across the countries included in the evaluation.

The **final inception report** of the evaluation will build on the theory of change to:

- Develop an evaluation matrix and the detailed methodology of the evaluation;
- Refine evaluation questions by identifying common threads and approaches among countries;
- Propose an adjusted country plan and budget for the evaluation;
- Proposed Structure of the Final Evaluation Report;

III. Country visits, additional data collection and preparation of country reports (60 days)

Following the review and approval of the Inception Report by the Regional KLA 6 Reference Group, additional data collection will be conducted by the evaluation team with the support of the Country Offices. Video and teleconferences will be organized as required prior to the country missions.

A first pilot visit will be conducted in one country in order to refine the methodology. The evaluation team will then visit all countries, conduct key informant interviews, including key stakeholders and partners, finalize the

analysis of additional data collection exercises and draft the report which will be discussed and validated with the major stakeholders. The evaluators will then synthetize common features and major differences in approach, identify major achievements and lessons learned, and will formulate recommendations for further programming. In addition to the common patterns, approaches, achievements and lessons learned, country specific summaries (up to 5 pages) would be also provided to inform country specific decision-making.

A Draft Report will be disseminated to all stakeholders and will be reviewed during a validation meeting (15 days). The Final Report will be accompanied by a short Evaluation Brief (up to 3 pages) summarizing key findings and recommendations (15 days).

Accountability

The detailed evaluation design and methodology will be developed by the evaluation company or groups of experts contracted, under the methodology framework provided below. The methodology should demonstrate impartiality and lack of biases by relying on different and reliable information sources (e.g. stakeholder groups, including beneficiaries, etc.) and using a mixed methodology approaches (e.g. quantitative, qualitative, participatory) to ensure triangulation of information through a variety of means. The evaluation will be using primary and secondary data sources. The evaluation will be participative, including all stake-holders from the onset. The Multi-Country Evaluation is a regional undertaking led by the Regional Office for CEE/CIS. The regional reference group (at the regional level) and country stakeholder groups (at country level) will be involved in the selection of evaluation company and /or individual experts, consulted throughout the evaluation process through interviews, group discussions, review of draft documents and provision of feedback on conclusions and recommendations, and preparing the management response. The **Regional Office Management Committee** will ensure that the evaluation process is in line with the regional evaluation guidance. The evaluation team will apply UNEG evaluation norms, standards and ethical guidelines **(see: Annex 4)**

Work plan

Roles and responsibilities

A regional Reference Group was established to guide and oversee the implementation of the Multi-Country Evaluation **(see: Annex 5).** The Reference Group will be consulted throughout the process, will act as key informants of the evaluation and its Chair will approve the ToRs, Selection of the Evaluation Institution/Team, Inception report, Final methodology, Draft Report and Final Report.

At the UNICEF CEECIS Regional Office level, the Regional Advisor Health Systems and Policy and the Regional Advisor on Monitoring and Evaluation will be the key focal points for the Evaluation Institution/Team. At CO level, this role will be assumed by the Health Officer or other staff designated by the CO Representative.

Health and Nutrition Section of the Regional Office will act as the secretariat for the evaluation, conduct regular videoconferences for the Reference Group, liaise and consult with the stakeholders and facilitate access to background data and documents. M&E Section will review and comment on the ToR, liaise with the M&E facility and provide support to the evaluation throughout the process.

The HQ Programme Division /Health Section and Office of Evaluation will review and provide advisory support at various stages of the evaluation process (review the draft TOR, inception and evaluation reports).
The Evaluation Institution/Team is responsible for the successful implementation of the evaluation and timely submission of deliverables, as defined in the previous sections. The team will appoint a Team Leader who will be the focal point for the communication with UNICEF. The Evaluation Institution/Team will be independent in the evaluation exercise. Considering that UNICEF programme beneficiaries are among most vulnerable children and families, there are ethical dimensions to be taken into account by the evaluation team with regards to consulting them in the process. Ethical guidance for evaluations can be accessed through the link below:
http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=980

Evaluation team

The Evaluation Institution/Team will ideally consist of a multi-disciplinary, multicultural and international group of experts, including the following profiles:

- Evaluation specialists;
- Public health specialists, epidemiologists;
- MCH specialists;
- Health economists;
- Health system management specialists;
- Specialists in behaviour studies;

Previous experience in CEECIS and availability of Russian speaking experts (or other languages spoken in the five evaluation countries) on the team will be an asset. At least one team member is expected to have relevant expertise on gender equality and/or child rights, and gender balance within the team will be sought as possible.

One of the evaluators who has the most experience will be appointed as the Team Leader to manage the overall implementation of the evaluation. The Team Leader should be familiar with most of the countries, be available to lead at least three of the country evaluations missions, and be responsible for coordinating and summarizing the findings and recommendations of the evaluation team. National experts in the visited countries will also join the team to support country level work.

Deliverables

1. **Inception report:** detailing the evaluation methodology and evaluation plan.

2. **The Pilot, Draft and Final Evaluation Reports**, which should include an executive summary, description of the evaluation methodology, data collection instruments, types of data analysis, assessment of methodology (including limitations), findings, conclusions, recommendations, lessons learned, attachments with developed list of indicators and questionnaires. Based on the UNICEF report template (to be provided to the evaluators) the evaluation report should reflect the status of the programme in terms of its relevance, efficiency, effectiveness, sustainability and impact. The reports should be provided in electronic form in English in the required UNICEF format. The evaluation report will be required to follow and will be rated in accordance with the UNEG Norms, Standard, Ethics Guidelines for Evaluation in the UN system **(attached as Annex 4).**

3. **Power point presentations**

4. **Country Summaries** (up to 5 pages)

5. **Evaluation brief** (up to a maximum of 3 pages) on key evaluation findings and recommendations

Travel

- Travel and daily subsistence allowances will be as per the rules and regulations of the contracted evaluation company;
- UNICEF at country and regional levels will support travel facilitation (e.g. support for obtaining visas);
- Any additional specific information regarding the time schedule, procedures, benefits, travel arrangements and other logistical issues will be discussed with the successful candidate evaluation company.

Documents for submission and estimated cost of consultancy work

Together with the **technical proposal** in line with this Terms of Reference (which should also include Work Portfolio of the organization and CVs of recommended experts), the evaluation company will be required to submit **a financial proposal up to 200 000 USD.** For details on the submission of both technical and financial proposal, please refer in the RFP document (RFP Health-2013-01 RKLA 6).

ANNEXES *(Note: Annex 3 – Country Results Matrix is separate attachment to this Terms of Reference)*

Annex 1: Theory of Change

Regional Knowledge and Leadership Agenda
Generic Theory of Change underlying UNICEF's approach in CEE/CIS Region
January 2013

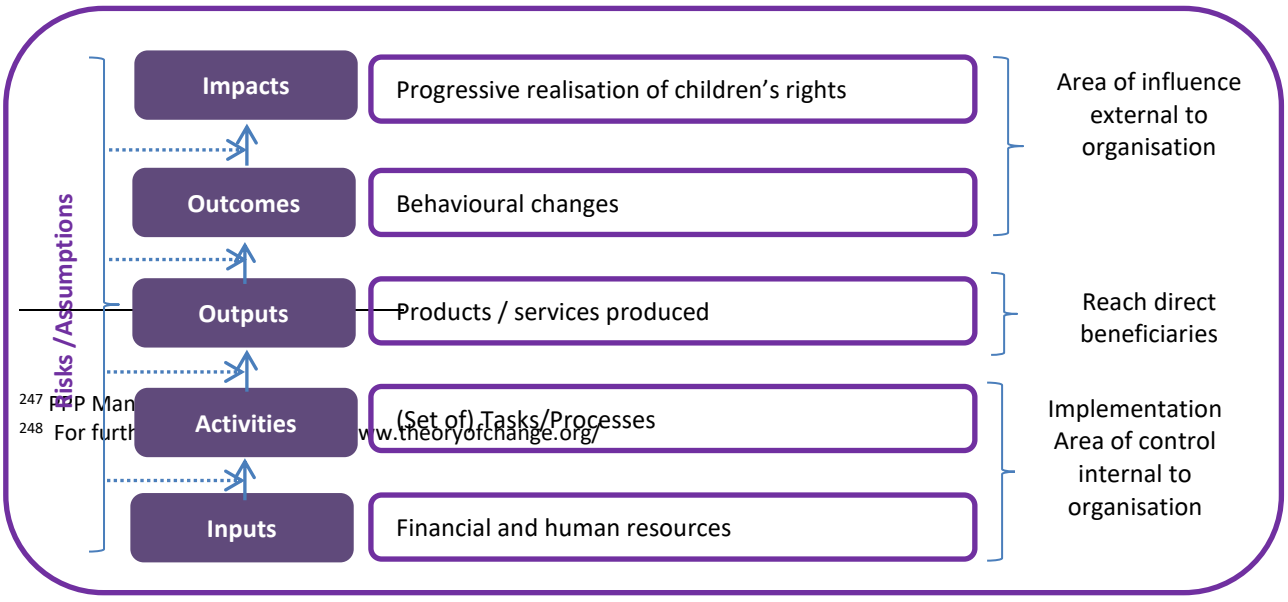
TO NOTE: The main objective of this note is to formulate in a simple manner the main theory of change framing most of UNICEF Engagement in the Region as reflected in the Regional Knowledge and Leadership Agenda. This generic theory of change is based on a consensus in the Region that the progressive realization of child rights and reduction of equity gaps is best achieved through changes in systems at national/regional/local levels and that sustained UNICEF engagement through its core roles contributes to these system changes. This theory of change can be adapted to each the Key Leadership Area to frame both their prospective and retrospective dimensions and to COs according to their realities and context.

Theory of change : what does that mean?

As per the Programme, Policy and Procedure Manual **"A Theory of Change (ToC) provides a blueprint of the building blocks needed to achieve long-term goals of a social change initiative. It can be viewed as a representation of how results will be achieved in a development undertaking and the markers that will permit measurement of whether or not it remains on track. At its core, a ToC identifies:**

a) the results a development effort seeks to achieve;
b) the actions necessary to produce the results –in terms of outputs, outcomes or impact of that effort;
c) the events and conditions likely to affect the achievement of results;
d) any assumptions about cause and effect linkages and
e) an understanding of the broader context in which the programme operates."[247].

As this short definition and corresponding summary graphic presentation below show clearly, theory of changes are very closely related to the logical framework approach and to result based management. It includes a set of connected blocks which together constitute the pathway to change. All theory of change development requires articulation and management of risks and assumptions underlying the process towards change at various levels. Assumptions explain both the connections between the various blocks and the expectations about how and why proposed interventions will bring them about. Often, assumptions are supported by research, strengthening the case to be made about the plausibility of theory and the likelihood that stated goals will be accomplished. Stakeholders value theories of change as part of program planning and evaluation because they create a commonly understood vision of the long-term goals, how they will be reached, and what will be used to measure progress along the way.[248]



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[248] For furth ww.theoryofchange.org/

Without going into too many details, the following questions show briefly what any theory of change need to address:

- The context for change
  - Who are we aiming to support and why?
  - Who are the groups and what are the structures and processes that influence changes in the target groups?
- Contribution to change
  - What are the long term changes that need to happen in target group's lives?
  - Who and what needs to change to achieve these long term changes?
  - What factors, relationships, approaches, pathways influence changes at each level?
  - What are the key factors to which it is possible to contribute, that will be vital to bring about change?
  - What are the other stakeholders key contributions to the expected changes?

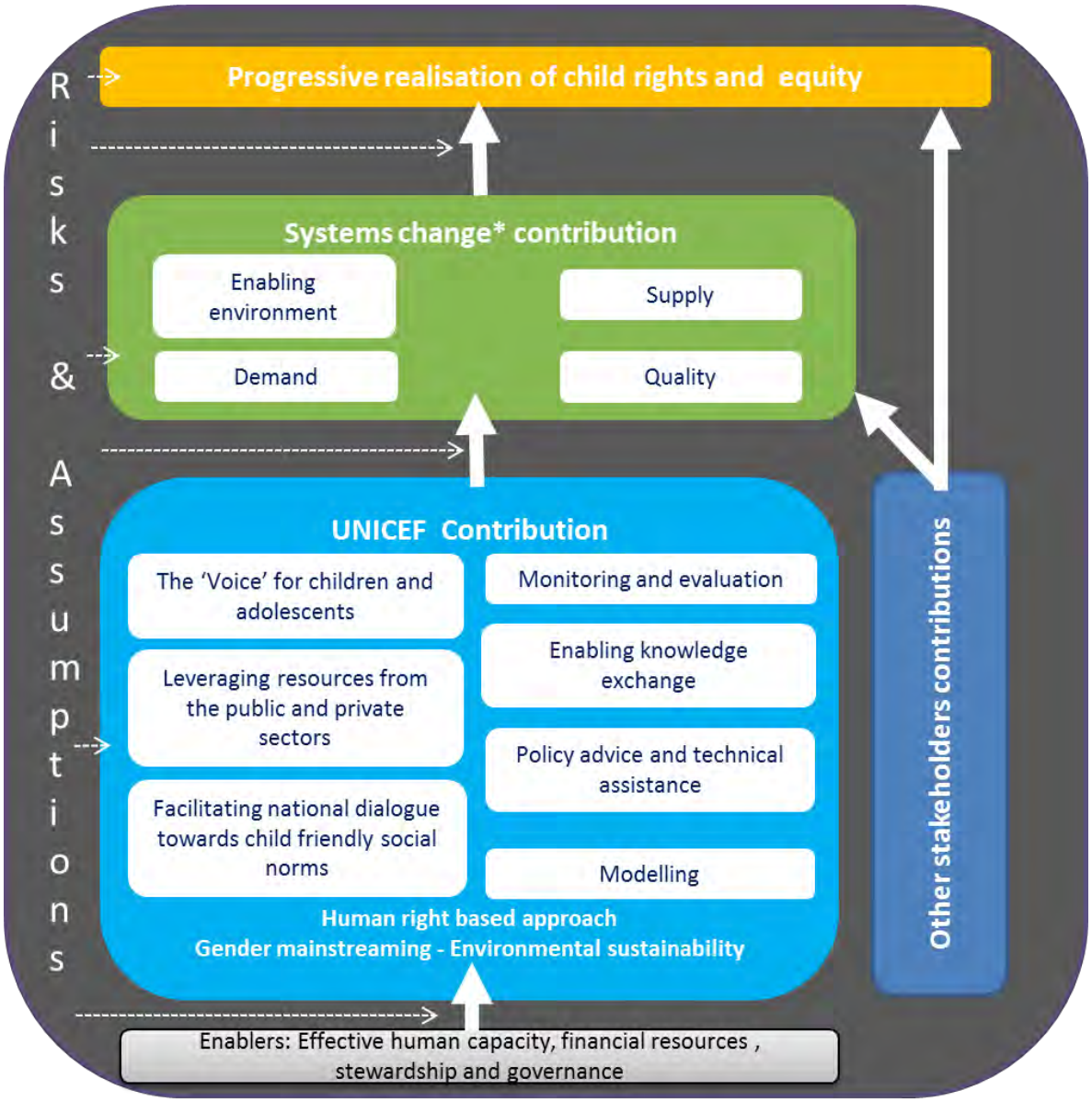
Generic theory of change of UNICEF Engagement in CEE/CIS[249]

As mentioned earlier this generic theory of change is based on a consensus in the Region that the progressive realization of child rights and reduction of equity gaps is best achieved through changes in systems at national/regional/local levels and that sustained UNICEF engagement through its core roles contributes to these system change. All building blocks of the theory of change have to be explicitly developed so that they benefit the most vulnerable.

Each KLA can adapt this generic theory of change to guide both their prospective and retrospective dimensions. Similarly each CO would align this generic theory of change with its strategic positioning to support changes in the system needed to improve the situation of most vulnerable children in their country.

Enablers: UNICEF contribution is only possible with timely adequate human capacities, financial resources and good governance and stewardship.

[249] This generic Theory of Change was presented for the first time during the RMT in April 2012.



UNICEF Contribution: Across the Region UNICEF fulfils core roles indispensable to contribute to changes in systems at national, regional or local levels with the strategic intent of ensuring the realization of the rights of children everywhere. These core roles reflect UNICEF foundational normative principles of Human Rights Based Approach to Development, Gender Mainstreaming and Environmental Sustainability. These core roles also translate in essential functions which are common to most context in which UNICEF operates such as advocacy and partnership, policy work, M&E, social change communication, Communication for development and operations management. UNICEF contribution comes along side contributions of other partners, civil society, etc.

Changes in the systems. In order to contribute to changes in the systems, UNICEF has a critical role to play in identifying and ensuring that key bottlenecks, hampering the progressive realization of children rights, are addressed. These bottlenecks can be grouped

* System changes to be analysed as per the 10 determinant analytical framework grouped in 4 main categories mentioned in the table, while making sure that the human right based approach is kept explicit.

around 4 main categories as per the determinant analytical framework developed under MoRES. Changes in the systems are the results of complex process and interactions between the various determinants. The understanding of these processes and interaction as well as the role of other partners is critical for an adequate prioritization of UNICEF contribution to focus on some bottlenecks rather than others.

Progressive realization of child rights and equity. This is the ultimate goal of all UNICEF engagement in the Region. Understanding the elements conducive of the flow from one level to another is of critical importance to ensure that changes actually taking place are those that are benefitting the most vulnerable.

Assumptions and risks. The assumptions are the necessary conditions for the achievement of results at different levels. These can refer to the commitment of the Government related to the programme, the expected contributions of other partners, etc. The risks refer to a potential event or occurrence beyond the control UNICEF but which could adversely affect its contribution, changes in the systems and impact negatively the most vulnerable children. Both assumptions and risks are critically important to articulate explicitly at each TOC level.

Linkages between the theory of change building blocks, MoRES levels and evaluation criteria

Theory of change elements	MoRES levels	Evaluation criteria
Progressive realization of children's rights and equity	Levels 1 & 4	Impact
Changes in system at national, (regional/ local) levels	Level 3	Effectiveness
Contribution of UNICEF to these changes	Level 2	Efficiency

In more details

Across each level risks and assumptions need to be carefully made explicit

Progressive realization of children's rights and equity

"*The Mandate of UNICEF is the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. UNICEF is committed to ensuring special protection for the most disadvantaged children*" (mission statement).

For each KLA it is necessary to identify the most vulnerable children as well as the main children's rights violations and equity gaps that UNICEF wants to see addressed. In depth situation analysis is required to understand the nature of these inequities and their causes. This analysis can be supported by various analytical tools and approaches (as per SITAN Guidance). The Reference Groups need to identify few key indicators related to children's situation that will be regularly monitored across countries. It is recognized that some indicators might be monitored only by a subset of the countries facing specific equity gaps.

Changes at system level (national, regional, local)

In order to reduce child rights violations and equity gaps, changes have to take place in systems at various levels (national, regional, local) to ensure that they are fully operational. Fully operational systems require:

- An enabling environment with
    1. Conducive social norms
    2. Adequate legislations in place
    3. Adapted budgets
    4. Operational coordination mechanisms
- Appropriate supply
    5. Availability of essential commodities
    6. Access to adequately staff services, facilities and information
- Ability to express demand
    7. Financial capacity to access the services
    8. Enabling social and cultural practices
    9. Continued ability to timely use the services
- Quality
    10. Adherence to required quality of services

For each KLA, in depth understanding of the systems and the way they operate is critical to develop the most relevant, effective and efficient intervention that can contribute to ensuring sustainable impact on children. Depending on child rights violations and equity gaps identified, some categories of determinants might play a more important role than others. The Reference Groups need to identify the key bottlenecks affecting operationalization of the systems, their interrelations as well as ways to prioritize them for en effective UNICEF contribution taking into consideration other stakeholders' contributions. They also need to identify the corresponding indicators that will be monitored to assess progress towards changes in those systems. It is recognized that some indicators might be country specific.

Contribution of UNICEF

UNICEF plays a key role supporting changes in the system conducive of reduction of equity gaps and child rights violations. There is consensus that the following Core Roles are indispensable for a sustainable UNICEF engagement and its universal presence in support of results and the realization of the rights of children everywhere:

- **The 'Voice' for children and adolescents** -- advocating and communicating around key national policies, social issues, mindsets and attitudes;

- **Monitoring and evaluation** – assisting independent assessments of the functioning of the Child Rights guarantee systems, the progressive realisation of child rights and the reduction in equity gaps in child well-being;
- **Policy advice and technical assistance** – through well-designed UNICEF positions (based on local, regional, international best practices) on key issues, supporting the development of the normative frameworks related to specific national legislation, policy or programme as well as private sector standards that can improve equity;
- **Leveraging resources from the public and private sectors** – accompanying and redirecting reforms, including those supported by the EU, IFIs, bilaterals and national/multi-national corporations;
- **Facilitating national dialogue towards child friendly social norms** – bringing together government, private sector and civil society, as well as convening divergent forces to enhance public debate, participation and action around equity and child rights;
- **Enabling knowledge exchange** – fostering horizontal cooperation and exchange of experience among countries and regions on 'what works' for enhancing child well-being and equity.
- **modeling/piloting** demonstrating how system could meaningfully evolve to reduce equity gaps and children's rights violations

For each KLA. UNICEF is one of the stakeholders in any given KLA. It is therefore important to conduct a stakeholder mapping to identify the other key actors in any given area and identify UNICEF specific roles within this map. The reference groups need to identify the key UNICEF core roles required to address the main determinants

Enablers/inputs

No contribution of UNICEF would be possible without the adequate human capacities, financial resources and stewardship and governance. The reference groups need to identify the relevant inputs required to bring the agenda forward.

Annex 2: UNICEF MORES programming approach[251]

Monitoring and the equity refocus

The refocus of UNICEF on equity, launched by the Executive Director in 2010, prioritized attention on results for the most disadvantaged children and highlighted the importance of data and monitoring across all programmes. Analysis of data across different country types and regions pointed to the cost-effectiveness of equity based strategies and advanced the case for investments giving priority to reaching the most disadvantaged as a critical step for MDG acceleration. In order to ensure that UNICEF's resources are being used where they can make the greatest difference and can lead to scaling up of responses for deprived groups, focus was placed on a set of common, critical intervention packages known to make a major difference for children.

The need became clear for fuller, more reliable and more frequent information on children and on the determinants of deprivation, disaggregated by different dimensions of disadvantage. Tools and methods were developed to systematically track progress against identified barriers and bottlenecks – in the enabling environment, in the availability or supply of services and support, in access to and use of services, and in the overall effectiveness or quality of interventions. Data collection methods, going beyond household surveys, were explored to assess progress in reaching the most disadvantaged.

During 2011 MoRES was developed to consolidate these developments and institute monitoring for equity on a sustained basis by building up the capacity to generate, analyze and make use of regularly collected disaggregated data at the subnational level. Consultations were held with governments, member states, UN and bilateral agencies, NGOs and other international partners on the equity agenda. Collaboration was strengthened with academic institutions and research centres in different regions to design and conduct in-depth analyses of deprivations and intervention strategies. Expanding the concept

[251] Monitoring Results for Equity System (MoRES) and Country Programming, UNICEF Intranet MORES resources

of intervention packages, seven Strategic Result Areas were identified as markers to focus and track organization-wide action, monitoring and learning. At the country level the SRAs are linked to Intermediate Results within the UNICEF country programme structure.

The system has four levels for monitoring:

(1) *Situation analysis and strategic planning:* the identification of disadvantaged groups and the causes of their deprivation including through the use of the determinant framework to identify key barriers and bottlenecks, initiating the process of programme development or review.

(2) *Monitoring of programme implementation,* with focus on UNICEF inputs and outputs to respond to child deprivations.

(3) *Programme monitoring at subnational and national levels* to assess and review progress in addressing the barriers and bottlenecks to reducing deprivation in representative areas and groups.

(4) *Monitoring trends in the situation of children,* to validate the achievement of outcomes and estimates progress towards reducing childhood deprivations such as through the sample household surveys (MICS) etc.

The four levels are closely interrelated. Outputs from each monitoring level support programming and hence establish the context and provide input for monitoring in the levels that follow. Feedback from each monitoring level in turn represents an assessment and validation of the levels that precede it and provide the basis for refinement and adjustment.

MoRES promotes innovative and adapted tools to collect data and evidence at local level, and structures the analysis and communication of evidence for course correction, planning and advocacy. The system is designed to be applicable to all countries – those where UNICEF has direct engagement and access to monitoring opportunities at subnational level, as well as in middle income countries where access to decentralized information is more limited, and emergency settings where subnational data collection is limited.

The monitoring system needs to fit with existing national and subnational systems for data collection and reporting, enhancing them where possible with new and innovative means to obtain relevant data. Advocacy about the value of monitoring is a key component of this strategy, to support understanding, buy-in and use of the system and evidence it generates by government and other partners.

A toolkit, focusing on Level 1 and Level 3 monitoring, is being field-tested in the first half of 2012, in 26 countries spanning all regions. The steps in this effort include review of the situation of children in selected result areas across all UNICEF programme countries, the launching of information systems to track the use of resources, and the initiation of monitoring process at national and subnational levels. Humanitarian specific monitoring approaches are being introduced in the Sahel countries and all major new emergencies in 2012. Based on the lessons learned from the field testing phase the framework will be further refined.

Implementing the four levels of monitoring

MoRES represents a significant enhancement of UNICEF's programming approach, designed to strengthen the evidence base on the determinants of deprivation in different sectors and programme areas. It promotes national and subnational systems to monitor progress in removing barriers and bottlenecks through the use of indicators defined at the country level.

Level 1 – Situation analysis and strategic planning

Action for equity rests on the foundation of knowledge about the children and population groups that are most deprived and the reasons underlying their exclusion. Situation analyses – focused studies, joint analyses with partners or contributions to common UN assessments – continue to be normally conducted every five years as a foundation for the development of country programmes of cooperation, with ongoing analyses and updates carried out to support mid-term reviews and national planning milestones.

Current analyses of the situation of children provide an overall understanding of the nature and extent of challenges faced by children and their priority needs. Common elements include a multidimensional perspective on children's situation and needs; rigorous use of data from multiple sources, and a causal analysis of the economic, social and institutional factors that make up the underlying and immediate causes of children's situation. Level 1 analysis is intended to verify the quality of situation analysis in relation to the determinants of deprivation and confirm that strategies to are appropriate to overcoming barriers and bottlenecks and thus achieving the intended results.

The guidance for situation analysis has been revised to heighten the focus on equity, to identify specific groups that are disadvantaged and excluded – including children and families in poverty, migrant children and those living on the streets, children with disabilities, ethnic and minority groups, and those vulnerable to impact of natural disasters and conflict. Special data collection efforts may be needed to develop evidence on the most disadvantaged children, who are often hidden from routine administrative systems and household surveys. Attention is given to understanding the impact of existing policies and programmes, and to determining the changes required to fill gaps and guide the prioritization of action by UNICEF and partners.

The determinants framework. Key to this process in MoRES has been the development of a framework of determinants of deprivation, identifying key barriers and bottlenecks to meeting children's needs with equity and realizing their rights. The four major areas, and specific categories of barriers and bottlenecks within them, are:

(A) **The *enabling environment*** – the social, political, budgetary and institutional factors that either promote or hinder the achievement of objectives related to children's well being and rights, including:

(1) *social norms*: the informal or formal rules of behaviour and social attitudes that are widely followed within a society;
(2) *legislation and policy*: the existence and implementation of appropriate and supportive laws and policies at different levels of society.
(3) *budgets and expenditures*: the presence of adequate and equitable budgets and expenditures by government (and other stakeholders) in favour of children.
(4) *institutional management and coordination mechanisms*: the existence, implementation and overall *effectiveness* of management structures and coordination mechanisms that promote collaboration and efficiency and reduce duplication of effort among govenrment, communities and development partners.

(B) ***Availability of services and support ('supply')*** – factors that affect the capacity and effective functioning of the systems required to deliver services or promote desired practices among priority populations, including:

(5) *availability of essential materials and inputs*: the regular supply and adequate quality of essential commodities and inputs to services and practices.
(6) *adequately staffed services, facilities and information:* the presence of appropriate infrastructure and qualified personnel of services and functioning information channels to promote change in practices.

(C) ***Access to and use of services ('demand')*** – the geographic, financial, social and cultural factors that encourage or discourage the use of existing services or the adoption of desirable practices among priority populations, including:

(7) *financial accessibility:* direct charges or indirect costs faced by families and communities to make use of *available* services or adopt desirable practices.
(8) *cultural practices and beliefs:* social and cultural practices prevalent in the community that mediate *individual* decisions to seek care or adopt desirable practices.
(9) *continuity of use:* factors affecting the continued use of a service or the sustainability of changes in practice *over* the medium to long term; and

(D) Quality - the *quality of the intervention* – a measure of the degree to which the actions to address barriers and bottlenecks adheres to national and international standards, and generates intermediate results that validate the analysis and the strategy that has been followed.

Completing Level 1 analysis. Level 1 analysis validates and, where necessary, supplements existing situation analysis. All *new* SitAns, following the new guidelines, will represent a full Level 1 exercise.

For the majority of countries with recent, valid SitAns, Level 1 analysis should consist of a review of the equity focus of the situation analysis, the quality of the analysis of the determinants of child deprivation, and the identification of strategies and interventions to address them. This will normally be carried out through a desk review that in particular aims to confirm that barriers and bottlenecks have been addressed in the identification of strategies and interventions, and that information on them is sufficient to provide baselines for data collection at subnational level and for subsequent follow-up assessment at national level. Where this is found not to be in place, an additional, usually 'light' analysis should be carried out to provide this foundation.

The review of barriers and bottlenecks should so far as possible draw from and support the existing framework of indicators, baselines and targets used by UNICEF to capture progress toward results – including UNDAF outcomes and outputs, indicators for Programme Component Results (presented in the strategic results matrix for the country programme) and the more specific indicators of Intermediate Results which guide the monitoring of CPAPs/Action Plans and annual workplans. On this basis, reviews of progress against these different indicators will represent an updated analysis of the barriers and bottlenecks to addressing deprivation. Level 1 analysis may suggest refinements to IR indicators, in particular, with this aim in mind.

The analysis may confirm existing programme strategies and call for current interventions to be further enhanced, or in other cases new approaches may be called for, entailing a refocusing of efforts by UNICEF and partners. While strategic planning is done mainly at the time of preparation of a new country programme, course corrections can be made and new actions instituted at mid-term or annual reviews, or in relation to milestone events in national planning for children.

Level 1 analysis in high emergency-risk contexts and ongoing humanitarian situations. *In countries with high to medium emergency-risk exposure*, bottleneck analysis must bring in an additional dimension, that of identifying where and how emergency risk exposure interacts with current equity gaps and key determinants. This entails understanding which emergency risks pose the biggest risk to children and women; where these risks manifest themselves, who is the most vulnerable and in what way; as well as what are the barriers and bottlenecks to reducing risks now as well as to responding in the event of an emergency.

In actual emergencies, the priority actions for the survival and protection of children and women are outlined in the Core Commitments for Children in Humanitarian Action (the CCCs). Rapid needs assessment, most often undertaken as an Inter-Agency exercise, will help refine UNICEF and partners response further in terms of defining the specific challenges and needs and relevant result areas. Needs assessment will certainly draw from any previous situation analysis, will take into consideration the enabling environment, will reassess availability of services and support as well as background on and changes to access to and use of services. In emergency contexts, immediate response will typically focus on the fastest changing determinants -- the availability of services and support (supply) and institutional management and coordination mechanisms in the form of cluster coordination – shifting to address slower changing determinants as the context allows.

Level 2 – Monitoring of programme implementation

Systems to monitor the use of resources by UNICEF focus primarily on budget allocations and expenditures and on the outputs that they generate towards Intermediate Results in the Country Programme Action Plans (CPAP). The systems serve their main purpose of supporting financial tracking and accountability of UNICEF resources. Supplementary analysis means are generally needed to understand the contribution and leveraging of UNICEF inputs in relation to partner resources for the achievement of larger results.

VISION has been designed to facilitate monitoring of the use of resources for achieving results, by tracking resources and actions along with measures of their effectiveness linked in particular to Intermediate

Results. Level 2 monitoring will focus on IRs that are linked to the strategic interventions to reach the disadvantaged, identified in Level 1. Monitoring will be mainly carried out using the VISION management dashboard that brings together and summarizes key quantitative and descriptive data from across the system.

Level 2 monitoring asks whether programme implementation by UNICEF is adequate to achieve the results intended. Focus is on the use of UNICEF's resources and the outputs produced, for ongoing management review and reporting to the Executive Board and donors.

The role and impact of UNICEF contributions to jointly produced results needs to be interpreted in relation to the actions taken and the resources provided by government and other partners. This information is crucial for assessing the contribution of UNICEF to the achievement of results, but it is also essential to develop an overall understanding of the shared contributions to a country's achievement of results for children. In the current version of VISION there might be provision to refer to the inputs of partners in a descriptive manner. It may be explored in future versions to build in more systematic recording of these complementary inputs for a fuller and more systematic picture of the collective contribution of all stakeholders towards the achievement of PCRs and IRs. An entry point here might be recording of partner inputs to joint programmes or SWApS. This further information will facilitate the focusing of UNICEF's limited resources in areas of comparative advantage and which have the greatest impact in reducing deprivations.

Applying Level 2 monitoring in ongoing humanitarian situations - VISION management reports are being developed to allow COs to track resources and outputs specifically related to an emergency response, based on CO selection of relevant IRs. Combined with the narrative analysis in the standard Situation Report (SitRep) template, these will provide CO management as well as RO and HQ with strong information on use of resources for humanitarian response. SitRep reporting and more critically the management review of this information is undertaken at the frequency established with the Regional Office, EMOPS and/or Global Emergency Coordinator as appropriate to the level and phase of emergency.

Level 3 – Programme monitoring at subnational and national levels

Situation analysis at Level 1 has identified the most disadvantaged children and why, establishing a change model based on the determinants of deprivation and guiding interventions that address the identified barriers and bottlenecks. Level 3 monitoring is aimed to monitor incremental progress in achieving results for children. Through regular review and analysis of frequently-collected, disaggregated information on these factors it supports ongoing refinement and strengthening of programme interventions.

Country-based indicators need to be developed for routine monitoring of progress related to the framework of determinants and the prioritized barriers and bottlenecks identified at Level 1. Indicators for Level 3 monitoring will normally be linked to the indicators that have been established as part of the country programming process, usually for intermediate results that can be reasonably achieved in 3-5 years. Current IR indicators will need to be reviewed to address gaps that may exist in the suitability and completeness of these indicators for country-level barrier and bottleneck analysis, with additional indicators developed as required.

A few principles apply – it should be possible to measure Level 3 indicators relatively frequently and in a consistent manner, and be simple to interpret and analyze. In terms of advocacy and partnership, indicators should ideally be already in use by partners, or be suitable for their use. For communication purposes they should be understandable to a wide audience. Data must be obtainable at reasonable cost and effort, reinforcing the importance of aligning indicators so far as possible with existing information systems. Baselines values need to be established and realistic targets set, related to the barrier or bottleneck being effectively addressed within the relevant timeframe.

Information to monitor barriers and bottlenecks will be collected at national and subnational levels. Indicators on legislation, policy, budgets and institutions in the enabling environment will be largely measured at the national level. Indicators of the supply and demand for services, of community practices

and of effective outcomes, need to be collected at subnational level, and disaggregated with respect to disadvantaged or marginalized segments of the population.

Level 3 analysis takes into account the varying time horizons typically needed to address different determinants of deprivation. Constraints in service delivery systems can often be addressed over relatively short period through improvements in supply and reduction of barriers to families' access. However, changes in underlying factors such as social norms and practices, or shifts in policies and budgets, normally only occur over longer periods. Yet even these longer term undertakings involve intermediate, concrete steps, and the aim in Level 3 monitoring is to track and take stock of incremental progress and to identify opportunities for course correction or new actions. To track progress in these cases, indicators should not be constructed as yes/no (e.g., 'a policy is in place'), but should be able to capture incremental change and improvements within longer-term processes.

To support indicator development at country level, comprehensive sets of illustrative indicators for monitoring progress in each determinant category have been developed for each organizational target of the MTSP related to the SRAs. This preparatory work includes examination of the linkages to indicators for humanitarian action in rapid onset emergencies as well as protracted humanitarian situations. (See also below for further guidance on indicator selection for humanitarian response.)

Within sectors, a wide range of multi-country indicator frameworks exist or are under testing, which should be further explored as a means of ensuring technical quality, leveraging strategic partnerships, promoting effective communication and avoiding unnecessary duplication.

It is expected that barriers and bottlenecks would be monitored on an approximately six-monthly basis. This does not mean that fresh, quantitative data needs to be collected twice a year, but rather that data from the systems of government and development partners (typically monthly or annual in cycle), supplemented by informal types of information, should be able to generate approximately six-monthly 'snapshots' to track changes across the range of priority determinants, and highlight the presence of any external constraints.

Where UNICEF and partners are engaged in support to services and capacity building at subnational level, monitoring can often be best done in locations where interventions are underway, and where partners and capacity exist to make monitoring feasible. Emphasis needs to be placed on the use of existing information and monitoring systems, rather than developing new or separate processes. However, where existing subnational monitoring systems are limited, data can be obtained through a variety of potential supplementary sources – rapid household surveys, provider assessments, field visit reports, focus group discussions and other qualitative methods, and population or facility-based use of mobile technologies (rapid sms etc). While continuing attention is needed to the quality of data, such mixed approaches are expected to provide information that is relevant, affordable, and offers a credible picture of progress and constraints. In all cases, priority needs to be given to developing national and sub-national capacity and encouraging partners' role in data collection and analysis.

Level 3 monitoring reflects progress in addressing barriers and bottlenecks by all partners, that will rarely be attributable to the efforts of individual interventions or partners. The review process at local level should collaboratively examine the extent, to which progress is on track, the constraints to progress if it is not on track, and the causes of remaining barriers and bottlenecks. On this basis decisions can be made on corrective actions as needed, through shifts in programme approach or the allocation of resources. Tools and formats may be needed to facilitate analysis of the information that will be generated and its effective communication to different audiences.

In summary, the key steps of Level 3 monitoring are to:

1. *Decide what to monitor* – focusing attention on specific barriers and bottlenecks, including the critical underlying determinants of deprivation
2. *Define specific indicators* for identified priority barriers and bottlenecks
3. *Identify information sources* and data collection methods, focusing particularly on deprived areas.
4. *Collect information and track changes* in relevant barriers and bottlenecks frequently as they can be acted upon with recoding and reporting (e.g. in VISION) at least once in six months.
5. *Regularly update analysis* of barriers and bottlenecks using disaggregated information.
6. Periodically *review programme approaches* and decide on corrective action

7. *Report on results*, especially on common or cross-cutting barriers and bottlenecks, at national, regional and global level

Level 4 – Monitoring trends in the situation of children

The fourth level of monitoring is intended to generate comprehensive knowledge of the longer-term impact of actions on children and their lives across all dimensions, to verify that changes are being made and how the removal of barriers and bottlenecks makes a difference in results for children. It is expected to be carried out mainly through major household surveys such as MICS and DHS in 2013-2014, with attention to equity and trends in disparities. Ad hoc or special surveys may also be conducted if the situation warrants it.

Level 4 monitoring is aimed to shift from focus on individual bottlenecks and barriers to assess overall system functioning, and deepen the understanding of how actions have addressed the multiple factors influencing outcomes for children's survival, growth, development and protection. The further elaboration of Level 4 analysis will therefore include links to the processes of evaluation and research, to strengthen the overall evidence-based narrative of the results that are being achieved for children, how barriers and bottlenecks have been addressed, how resources have been used, and the lessons that have been learned.

Annex 4: UNEG Norms, Standard, Ethics Guidelines for Evaluation in the UN system; and Human Rights and Gender Evaluation handbook

Annex 5: Terms of Reference Regional Knowledge Leadership Area (RKLA) No.6 - Reference Group

Country Offices participating in this Knowledge Leadership Area (KLA) aim at achieving shared results that will lead to more effective use of limited resources to generate innovations and strengthen the quality of programme interventions. The KLA 6 Reference Group will also contribute to a more strategic building of partnerships and leveraging resources, generating and sharing knowledge and influencing regional and national policies. Working in close coordination across border will also allow the RO (and HQ) to provide support to country offices in a coherent and predictable manner, as well as ensure that regional capacity building efforts are prioritized and focused.

KLA 6 Reference Group composition: Uzbekistan (Chair), Kazakhstan, Kosovo (under UNSCR 1244), Kyrgyzstan, Moldova, Serbia. KLA6 participating UNICEF Offices: Armenia, Bosnia and Herzegovina, Georgia, Kazakhstan, Kosovo (under UNSCR 1244), Kyrgyzstan, tFYR of Macedonia, Moldova, Romania, Serbia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

1. Participants in the Reference Group will agree on common shared results for a two-year period

2. Participants in the Reference Group will jointly conduct the evaluation of progress made in reducing infant and child mortality in selected countries to inform further programming.

3. The Regional Office will support the implementation of agreed upon actions by:
   - Planning and identifying technical support and securing long term arrangements with both individual and institutional experts in support of country and regional activities.
   - Planning multi-country evaluations, documentation and dissemination of programme results achieved.
   - Establishing a knowledge hub on the UNICEF regional intranet and systematically collecting and disseminating information on country specific results and up-to-date technical resources.
   - Planning and conducting regional/multi-country capacity building activities both for UNICEF staff and Government counterparts.
   - Organizing regional knowledge sharing and advocacy and policy setting events.
   - Supporting COs in fund mobilization by developing joint proposals for each priority area and actively looking for possible donors.

4. Country Offices will take the following steps in supporting the implementation of the agreed priorities:
   - Designing a country specific plan of action for the respective Key Strategic Results.

- Incorporating relevant activities and budgets in the A(R)WPs.
- Establishing indicators for monitoring progress (L2-L3) and participating at joint evaluations (L4)
- Prioritizing funding of activities contributed to the KLA 6 WG joint plan.