Delivering As One

MPTF OFFICE GENERIC FINAL PROGRAMME NARRATIVE REPORT

REPORTING PERIOD: FROM 1 JANUARY 2010 TO 31 DECEMBER 2013

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MPTF OFFICE GENERIC FINALPROGRAMME[1] NARRATIVE REPORT
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Programme Title & Project Number

- Programme Title: Ensuring Access to Affordable Health Services in the Targeted Areas of the Country for Women of Reproductive Age and Children
- Programme Number: 00074587
- MPTF Office Project Reference Number:[3]
  SC100158-UNICEF

Country, Locality(s), Priority Area(s) / Strategic Results[2]

Kyrgyzstan/Osh and Batken Provinces

Priority area/ strategic results
UNDAF outcome: The poor and vulnerable groups have equitable access to social services and benefits, in a strengthened pro-poor environment.

Achieving MDG 4 and MDG 5 through institutionalizing the continuous quality improvement of medical services for women and children

Participating Organization(s)

- UNICEF, UNFPA 2010-2013
- WHO 2010

Implementing Partners

Governmental partners: Ministry of Health (Mother and Child Health Department, National Center of Mother and Child Health, National Health Promotion Center, Kyrgyz Medical Academy, Postgraduate University).

International organizations: UNFPA, UNICEF, WHO, GIZ, USAID, University Murcia in Spain.

Local NGOs: Association of Obstetric-Gynecologists, Association of Perinatologists, Association of Midwifes, Hospital Association in KR.

Programme/Project Cost (US$)

Total approved budget as per project document:
MPTF /JP Contribution[4]:
UNICEF: 1,307,653
UNFPA: 305,903
WHO 105,930 (only in 2010

Agency Contribution
UNICEF: 468,710.00USD
UNFPA: 20,000.00 USD

Government Contribution
(if applicable)

Other Contributions (donors)
(if applicable)

TOTAL: 2,208,196.00 USD

Programme Duration

Overall Duration 48 months
Start Date[5] 01.03.2010

Original End Date[6] 31.12.2013

Actual End date[7]31.12.2013

Have agency(ies) operationally closed the Programme in its(their) system?	Yes	No
	☐	x

Expected Financial Closure date[8]:
31.04.2014

Programme Assessment/Review/Mid-Term Eval.

Evaluation Completed
X Yes ☐ No Date: 15.03.2014
Evaluation Report - Attached
X Yes ☐ No Date: *dd.mm.yyyy*

Report Submitted By

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[1] The term "programme" is used for programmes, joint programmes and projects.
[2] Strategic Results, as formulated in the Strategic UN Planning Framework (e.g. UNDAF) or project document;
[3] The MPTF Office Project Reference Number is the same number as the one on the Notification message. It is also referred to as "Project ID" on the project's factsheet page on the MPTF Office GATEWAY.
[4] The MPTF/JP Contribution is the amount transferred to the Participating UN Organizations – see MPTF Office GATEWAY
[5] The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the MPTF Office GATEWAY
[6] As per approval of the original project document by the relevant decision-making body/Steering Committee.
[7] If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the original end date. The end date is the same as the operational closure date which is when all activities for which a Participating Organization is responsible under an approved MPTF / JP have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities. Please see MPTF Office Closure Guidelines.
[8] Financial Closure requires the return of unspent balances and submission of the Certified Final Financial Statement and Report.

List of abbreviations and acronyms

ALOS	Average Length of Stay
ANC	Antenatal Care
AWP	Annual Work Plan
BFHI	Baby-Friendly Hospital Initiative
CO	Country Office
CPAP	Continuous positive airway pressure
DAO	Delivering As One
DFID	Department for International Development of the United Kingdom
ENC	Effective Neonatal Care
EPC	Effective Perinatal Care
FAP	Feldsher-Midwife Point
FGP	Family Group Practitioners
FMC	Family Medicine Centres
GIZ	German Society for International Co-operation (German acronym)
ICU	Intensive Care Unit
MAF	MDG Acceleration Framework
MCH	Maternal and child health
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NRT	Neonatal Resuscitation
OECD	Organisation for Economic Cooperation and Development
OECD/DAC	OECD Development Assistance Committee
PHCC	Primary Health Care Centres
QoC	Quality of Care
SWAp	Sector-wide approach to programming or planning
ToT	Training for Trainers
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WB	The World Bank
WHO	World Health Organisation

FINAL PROGRAMME REPORT

EXECUTIVE SUMMARY

In 2010-2013 UNFPA, UNICEF and WHO implemented a project "*Ensuring access to affordable health services in targeted areas of the country for women of reproductive age and children*" in 20 maternity hospitals in Batken and Osh provinces and in one tertiary level referral hospital on the national level. In addition, 52 primary health care facilities were supported. The project aimed to strengthen the Government to realize the National Perinatal Care Programme for 2008-2017 by improving the quality of maternal and newborn services and thus to accelerate the progress towards achieving the MDG 4 and MDG 5 in Kyrgyzstan. As a result of the project, 35% of parturient women and newborns in the country have access to good quality, evidence-based effective perinatal care services.

The DAO project strengthened the nascent referral system within perinatal care with development of key regulations on antenatal, perinatal and neonatal care based on effective WHO-endorsed technologies and evidence-based medical principles. The quality of antenatal and perinatal care services for pregnant and parturient women and newborns was enhanced by improving professional knowledge and practical skills of health professionals. Eight birth preparedness schools for pregnant mothers and families were established. Furthermore, the project supported the establishment of monitoring and evaluation system in perinatal care including institutionalization of the Newborn Register that contributes to evidence-based decision making on the national and facility level. The project was implemented following the principle of continuum of care thus enhancing the quality of services from antenatal care to postpartum and neonatal care.

Evidence shows that due to the implementation of the effective perinatal technologies, severe complications during pregnancy and after delivery, such as hemorrhage (-26%) and asphyxia among newborns (-64%), have reduced and care practices have clearly improved. For example, unjustified Cesarean sections have reduced by 23% and the number of newborns in need of intensive care has halved thanks to reduction of hypothermia, asphyxia and birth trauma. In addition, newborns in need of resuscitation after birth reduced by one third. The number of maternal deaths has reduced by 46% during the project implementation period. The medical equipment procured within the project are contributing directly to newborn survival rate as currently 64% of premature and sick newborns are able to be rescued. As a result, early neonatal mortality has reduced in the target hospitals by 36,6% in 2009-2013. In regards to child mortality countrywide, reduction of neonatal deaths is crucial as 49% of all under-five deaths are due to neonatal causes. The good progress in newborn survival is reflected in the fact that currently Kyrgyzstan is on track to achieve the MDG 4 and will most likely meet the target by 2015.

I. Purpose

The UNFPA. WHO and UNICEF "Ensuring Access to Affordable Health Services in the Targeted Areas of the Country for Women of Reproductive Age and Children" joint programme, implemented from 2010 to 2013, aimed to improve maternal and newborn survival through enhancing the quality of maternal, newborn and child health care services. The project targeted 20 maternity hospitals and 52 Family Medicine Centers in two provinces and one tertiary level referral hospital on the national level. In addition to the highest rate of deliveries in the country, the target facilities were selected based on the weakest capacity of medical workers, infrastructure and compliance to standards.

The project contributed to the following objectives:

- Overall objective: Achieving MDG 4 and MDG 5 through institutionalizing the continuous quality improvement of medical services for women and children
- UNDAF outcome: The poor and vulnerable groups have equitable access to social services and benefits, in a strengthened pro-poor environment.
- Expected Programme outcomes:

i) Continuous Quality Improvement process demonstrated in maternity hospitals
ii) Medical experts on the national level with enhanced capacity on Quality Improvement
iii) Improved quality of antenatal and perinatal care through improved infrastructure and critical lifesaving equipment
iv) Medical workers in antenatal and perinatal care with good clinical skills to deliver health care services
v) Effective registration and monitoring system in place including analysis of critical cases (i.e. pregnancy registration, Newborn Register, The Near Miss Cases review)
vi) Adequate referral and remote consultation system in place
vii) Improved accessibility and utilization of maternal and newborn services especially in rural and remote areas through increased level of awareness of population.

II. Assessment of Programme Results

Outcomes

Between 2010-2013, UNICEF. WHO and UNFPA supported the Ministry of Health to implement the National Perinatal Care Programme for 2008-2017, that aims to reduce maternal, perinatal and infant mortality in the country in line with MDG targets and improve the quality of care by introducing a multilevel structure of referral in perinatal care. Based on the recommendations of WHO on regionalization, the programme defines the delivery of services in four stages: in addition to primary health care (FMCs, FGPs and FAPs) the system consists of three levels of hospital services: territorial and city hospitals (primary); provincial hospitals (secondary) and national centers in the two largest cities in the country (tertiary level).

In the first year of the project in 2010, the project supported six selected maternities on the secondary and tertiary hospital levels and 10 Family Medicine Centers (FMCs) with 40 Family Group Practitioners (FGPs) on the primary health care level in Osh and Batken Provinces and in Bishkek covering up to 15% of all deliveries in the country. In 2012, the project was expanded into another 14 maternity hospitals and 2 FMCs with 12 FGPs on the primary health care level increasing the targeted deliveries up to 35% of total deliveries in the country. The sites were selected based on the weak capacity of medical workers, poor quality of infrastructure and poor compliance to clinical standards. In addition, Osh and Batken provinces are in the region with the highest delivery rate in the country. It was also these provinces that were affected by interethnic violence in 2010 resulting in displacement of over 300,000 people at that time.

The project has supported three out of five key objectives set by the Government in the National Perinatal Care Programme. Firstly, through the DAO project, the nascent referral system within perinatal care was strengthened with development of key regulations on antenatal, perinatal and neonatal care based on effective WHO-endorsed technologies and evidence-based medical principles. Secondly, quality of perinatal care services for pregnant and parturient women and newborns was enhanced by improving professional knowledge and practical skills of health professionals. And thirdly, the project supported the establishment of monitoring and evaluation system (audit system) in perinatal care.

Two approaches to ensure the quality of the activities were deployed. Firstly, a system rather than activity-based approach demonstrated advantages and resulted in better outcomes, motivation of medical staff and participation of the management. A case in point, a project shifted from organization of separate trainings for different professionals to multi-professional team trainings that allowed doctors and midwives to be trained together as a team. This helped to better understand the roles and distribution of tasks and responsibilities during the service provision and built multi-disciplinary teamwork in facilities. Secondly, organizing capacity building activities for medical workers on-the-spot at the facility level rather than having mass trainings proved to be effective approach to enhance clinical skills, improve clinical practices and optimize the use and organization of the space at wards.

As a result of the project, the **newborn survival** in target maternities improved. According to the external evaluation[9], the implementation of the Effective Perinatal Care halved the amount of newborns in Intensive Care Unit due to reduction of hypothermia, asphyxia and birth trauma. The number of newborns that had to be resuscitated reduced by one third and birth asphyxia decreased by 64%. As a result, there has been a positive trend in mortality indicators in the target hospitals, for example early neonatal mortality (0-7 days after birth) dropped by 38,6% between 2009 and 2013. The project has contributed to the realization of the MDG 4 in Kyrgyzstan as the country is currently steadily on track to achieve the target of child mortality by 2015.

In terms of **maternal health**, the implementation of ANC and EPC contributed to decrease of hemorrhage (-26%) and other complications before and after delivery (-4%). In addition, the share of unjustified Cesarean sections significantly reduced by 23%. The number of maternal deaths in the region reduced by 46% during the project implementation. Furthermore, from the psychological point of view, the project supported parturient women through institutionalization of partner deliveries that were not practiced at all before 2010. Pain relief was also improved due to introduction of new equipment such as balls and ropes in the delivery rooms that encourage women to move during the first phase of delivery. Not to mention the importance of individual delivery rooms and beds supporting vertical deliveries that were introduced within the project. As a result of the project implementation on ANC 65% of the women were birth prepared and women's knowledge of obstetric complications and symptoms increased by 42% enabling them to seek emergency care in time. A birth-preparedness intervention in the south region substantially increased the use-rate of emergency obstetric services as well as increased utilization of antenatal and post-partum care. More than 84% of pregnant women covered fully by good quality antenatal services (at least 4 visits) and of them, 96.7% before 12 weeks of pregnancy.

The **capacity building** activities improved clinical practices in the target maternities and Family Medicine Centres. As a result, the decrease of complications consequently shortened the average length of stay in hospitals form five to 3.3 days thus lowering expenditure on treatment and human resources. The project has improved the role of midwives and they have been delegated the management of normal deliveries without presence of a doctor. Also in the primary health care, midwives that used to be at the bottom of hierarchy, are now recognized as a valuable part of the new multidisciplinary teams. Currently Midwives' Association is a strong professional association in the country advocating for midwives' interests.

[9] Perinatal care component was evaluated by two external evaluators Dr. Tamar Gotsadze and Dr. Chiara Zanetti and the majority of the results described in this Narrative report are based on the evaluation report *Evaluation of UNICEF Programme on Perinatal Care for the Period 2010-2013* (in press).

Improved capacity of the management and institutionalization of the ANC and EPC resulted in a new approach to organization of services making it more effective. Rationalized use of medicines, teamwork and optimization of the space at wards are good examples of a **new mindset** deriving from effective perinatal technologies. As the EPC decreased expenditure on medicines and human resources, more funds are now allocated to infrastructure, medical equipment, consumables and supplies. Thanks to the saving made by the project, in Kyzyl Kya for example, the hospital was able to invest 20 times more in renovation and medical equipment in 2013 compared to 2010. In some hospitals, such as Karasuu, hospital managers are now applying the same approach to other departments, too.

Indicator	% of Change	Status
Complications	-4%	↓
Hemorrhage	-26%	↓
Birth asphyxia	-64%	↓
Newborn resuscitation	-27%	↓
Medically unjustified C-Sections	-23%	↓
ALOS	-34%	↓
Early neonatal mortality	-38,6%	↓
Neonatal mortality	-28,3%	↓
Maternal deaths	-46%	↓
Fines by MHIF	-70%	↓

Table 1. Change in selected indicators in the target hospitals between 2009-2013

As the quality and quantity of **medical equipment** in target maternities was poor and needs were more than allocated funds, it was inevitable to prioritize and select the most efficient investments. The priority was given to funding investments that maximized the impact on improvement of services for mothers and children. Furthermore, the procurement of equipment was mostly performed through UNICEF Supply Division at minimum possible cost and of high quality. The external evaluation showed that CPAPs donated by UNICEF helped the facilities to increase premature and sick newborn survival in Intensive Care Unit up to 64% during the project period. However, especially on the small maternity units on the primary health care level, more support is needed to fill the 20% of gap in basic medical equipment and supplies.

According to the external evaluation, the project supported the institutionalization of the Newborn register that is now practiced countrywide. The project improved the data collection and record keeping practices and since 2010, the statistics have been published on an annual basis within the framework of the DAO project. In addition, new individual pregnancy records were ensured using the existing Health Information System for all facilities providing antenatal care. This has enabled **evidence-based decision making** among policy makers and resulted in more effective and well-informed planning. However, on the facility level, there is room for improvement in terms of evidence-based decision making. Data collection in maternities is mainly used for administrative and statistical reports rather than with intention to analyze the situation. It is difficult for healthcare providers and managers to use and compare available data and to follow up trends, causes and correlations for informed decision making in care provision and organization. In any case, the project improved the record keeping practices also on the facility level and next step is to strengthen the management to analyze collected data.

One of the greatest achievements of the project was establishment of eight birth preparedness schools procurement of training equipment, furniture and supplies in Osh and Batken provinces. Training and

mentoring visits were organized to strengthening health provider's knowledge and skills on counseling and management of the school. National consultants during the mentoring conducted studies using various techniques in practice on various themes: choice of position during labour, vertical position, breastfeeding, non-pharmacological methods of pain relief - breathing, massage).

Ensuring the access of pregnant and parturient mothers to good quality perinatal care is inevitable for attaining the MDGs in the country. In 2013, the Ministry of Health established the Quality of Care and Pharmaceutical Policy Department at the MoH to ensure the continuous Quality Assurance on the national level. Apart from this, the Quality of Care (QoC) Committees are operational at the health facility level. Within the framework of the project, the national capacity was strengthened on Quality Improvement in health care and as a result, a draft concept and national assurance plan were developed. In addition, the training module on QoC for health managers was developed and next steps are to develop the QoC concept and action plan further as well as to integrate the training module into the curricula of post-graduate studies.

The main beneficiaries of the project are mothers and children in Osh and Batken provinces (up to 48,000 mothers with newborns each year) and in some extend, in countrywide as the tertiary level hospital is located in the capital. In addition to improved health status of the beneficiaries, the project has changed the atmosphere of medical institutions and the external evaluation showed that women are satisfied with improved conditions at the target maternities. From the perspective of lay service users, mainly mothers and their close relatives, the most significant improvement has been changed attitude of health workers as midwives, nurses and doctors are considered to be more friendly and caring than before the project implementation. Compared to the previous experiences, women valued the benefits of partner and vertical deliveries as well as having their babies next to them at the wards.

Outputs

The strategies used to ensure the achievement of the project were advocacy on Quality Improvement, capacity building of medical workers and national level stakeholders through trainings and clinical conferences, roundtables and Training for Trainers (ToT), quality improvement on the facility level through regular monitoring and supervision, supporting national and local data collection, particularly the Newborn Registration System and improving the infrastructure and equipment through installation of water and sanitation systems, temperature management and procurement.

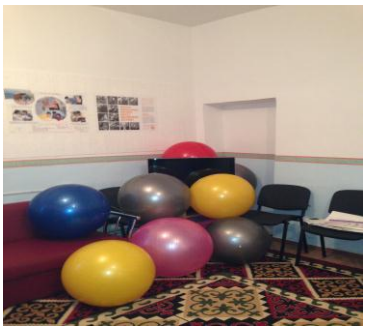
Evidence-based national clinical guidelines and protocols on management of obstetrical hemorrhages and severe preeclampsia/eclampsia, the main causes of maternal mortality and near misses, on other complications of pregnancy, as well on antepartum care and management of normal labor and delivery were developed and endorsed by Ministry of Health with WHO technical assistance. National experts, continue to elaborate other clinical protocols for obstetrical emergencies (abruptio placentae, placenta previa) and complications of pregnancy to implement evidence-based practices into maternity care.

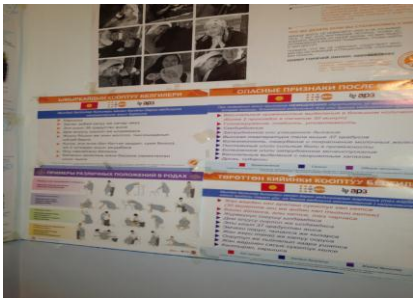
Within the project, four main training courses, based on WHO standards, were adapted and used for capacity building purposes: Antenatal Care (ANC), Effective Perinatal Care (EPC), Neonatal Resuscitation (NRT) and Effective Neonatal Care (ENC). Over the course of the project, total 43 trainings were organized in Osh and Batken Provinces. As a result, 430 health care providers have knowledge and skills on Antenatal

Care, 561 medical workers (75% of all doctors, midwives and nurses in target facilities) have clinical skills on provision of Effective Perinatal Care services, 604 (88%) have neonatal resuscitation skills and 95 neonatologists and nurses in Neonatal Intensive Care Unit are equipped with good clinical skills on intensive care. From the beneficiaries' point of view, each year approximately 48,000 mothers and newborns, respectively, benefit from enhanced quality of perinatal care services.

Near Miss Cases Review (NMCR) – guidelines have been developed with WHO technical assistance, staff (240 people) of pilot facilities trained, tools are used by teams; local standards on EOC were improved, staff schedule of auxiliary services was reviewed, hospital management improved procurement of the essential drugs, blood banks were created (4 pilot facilities), more active participation of mid-level staff and representatives of other services was discussed. WHO assessment visits included observing Near Miss Case Review audit sessions in pilot maternities selected by the Ministry of Health of Kyrgyzstan, providing feedback and recommendations to local team of professionals on the process of Near Miss Case Review. Field visits included meetings with members of national working group and key stakeholders, sharing recommendations and support for NMCR implementation. In addition to this, each hospital general and delivery wards, pathological pregnancy and post partum wards, as well as Intensive Care Units have been visited and recommendations provided. Organizational workshop on Confidential Enquiry into Maternal Deaths (CEMD took place at the national level with a specific target audience (leading specialists and stakeholders, local health care facilities' heads, who were appointed to the position of Field Coordinators following Recommendations, people in charge of data collection/receipt for the enquiry). People in charge of Confidential Enquiries into Maternal Deaths (CEMD) were assigned and approved at the state and local levels. Field Coordinators were introduced to the principles of CEMD organization (67). Professional obstetrician/gynecologists, pathology-anatomical doctors, specialists on infectious diseases, family physician, Intensive care doctors, midwifes – became members of the National CEMD Committee.

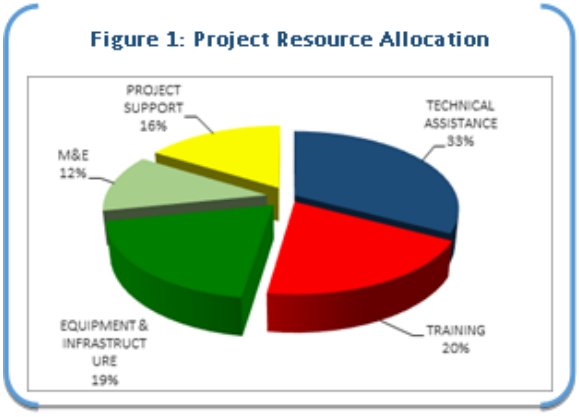
To ensure that the new skills are deployed, the maternities themselves are currently organizing regular trainings for their staff. The project procured 63 neonatal mannequins for practicing resuscitation and care on the maternity level so as to increase the sustainability of the obtained skills. Since the high turnover over medical workers poses a risk for the sustainable results, it is particularly important that the health facilities themselves are maintaining good level of the capacity. Another important factor to intensify the impact of the trainings was conduction of supervisory and monitoring visits twice a year that were powerful tools to trace the changes on the facility level and immediately enhance the conditions in case some issues were found. 15 largest hospitals were equipped with laptops and projectors to support in organization of trainings and seminars. Supportive supervision to reinforcing antenatal and effective perinatal skills was undertaken following ANC and EPC training in the south region comprising of 80% of the health facilities in which health care workers had been trained. The focus of the supportive supervision was to identify any gaps and to reinforce knowledge on focused antenatal and perinatal care and danger signs of pregnancy and newborns. The national supervisors on ANC and EPC identified gaps in the collection and collating of health information pertaining to maternal and neonatal health.





In addition, the project supported the establishment of eight birth preparedness schools on the primary health care level to increase the knowledge of expecting mothers of issue related pregnancy and delivery, such as non-pharmacological methods of pain, position during labour, breastfeeding, nutrition and child care. Through training and mentoring visits health providers' knowledge and skills on counseling and management of the schools was developed and material support was given through procurement of training equipment and materials, furniture and supplies. Additionally, the population has been encouraged to get involved. Through awareness raising and inviting partner or the mother/mother in law to clinical visits, women were supported to follow medical recommendations, encouraged to decision making and supported psychologically. During the monitoring visits 40% of community had knowledge of 2 or more key danger signs during the three periods. More women attend postpartum care especially if a skilled health care provider assisted them at birth. Women are now more likely to have their blood pressure measured and physical examination on the primary health care level. Of the all birth preparedness practices, some of family had saved money using the prepared birth plan and about 90% community had received information materials.

As mentioned already above, procured CPAPs have a significant impact on sick newborn survival. Within the project, 17 CPAPs, 616 sets of Ambu bags with masks, mucus suctions and stethoscopes were procured to the target facilities to ensure good quality care for newborn in need for intensive care. To reduce hypothermia among newborn, 22 baby warmers and heaters were purchased and temperature management was strengthened by installing new windows are door to the maternities (replacement of old windows were supported also by Equity funds from DFID). As a result, hypothermia among newborns is currently less than 0,5%. In Perinatal Centre in Osh, serving approximately 7,000 mothers with newborns, a central oxygen system was installed and a washing machine and a refrigerator for blood storage were procured for the Batken maternity. To ensure good hygiene in the health facilities, water and sewage systems were improved in eight maternities. Figure 1 shows the resource allocation within the project.



Qualitative assessment

Based on the discussions with implementing partners and partner health organizations, including the Ministry of Health, and supported by the findings of the external evaluation, the project has been able to address the key barriers and bottlenecks hindering the access to good quality maternal and newborn health services. The project has been efficient as the government and management system set up proved to work well. Efficiency has been ensured by adequate resource allocation, selection of the most efficient funding modalities especially for trainings and monitoring and supervision components, timely implementation of the planned activities and budget adjustments for meeting additional training, equipment and monitoring needs. No major changes were conducted to the workplan. Furthermore, in terms of effectiveness, the project ensured reaching the both output and outcome level changes. The project emphasized the continuum of care from antenatal to postpartum/postnatal period and the project, by and large, achieved its purpose to increase access to and utilization of good quality maternal and newborn services in the target area including strengthening the referral system between primary and secondary levels, enhancing skilled attendance at birth and improving the health management system.

Planning of the project was implemented jointly between UNFPA, WHO and UNICEF agencies and governmental partners and the activities supported the national priorities outlined in the Den Sooluk National Health Care Reform Programme. All implementing agencies, UNFPA and WHO as members and UNICEF as a leading agency of MCH group are active participants in the Sector-Wide Approach (SWAp) which ensures good donor coordination between the Government and the Development Partners in the health sector. The quality of the project was ensured by regular monitoring visits and data collection. In the end of the project, UNICEF[10], WHO and UNFPA commissioned external evaluations for the antenatal and perinatal care components.

Starting from 2012, activities within the DAO project were strengthened by the Equity project, funded by DFID for 2012-2015, that operates mainly on the primary health care level thus enhancing the continuity of care in the target region. In addition, within the Equity project, some investments in infrastructure, such as improvement of the temperature management in maternities add up directly to outcomes of the DAO project.

The DAO project contributed to increasing the United Nations (UN) impact, effectiveness and efficiency by delivering in a coordinated and coherent way while at the same time reducing transaction costs for the Government and the UN by taking advantage of the strength and comparative advantages of the different UN agencies (UNICEF, UNFPA,WHO) funds and programmes. The Government supports and values the DAO initiative within this project framework as it improved the coordination and consolidation of the National Perinatal Care Programme. The DAO project has built a solid ground for further collaboration between several UN agencies, namely between WHO, UNFPA and UNICEF giving good basis for further collaboration within the MDG Acceleration Framework (MAF) that is being applied to MDG5 in Kyrgyzstan since 2013.

[10] Perinatal care component was evaluated by using OECD/DAC criteria on relevance, efficiency, effectiveness and sustainability. The evaluation report *Evaluation of UNICEF Programme on Perinatal Care for the Period 2010-2013*, prepared by two international evaluators Dr. Tamar Gotsadze and Dr. Chiara Zanetti will be published in 2014.

ii) Indicator Based Performance Assessment:

Using the **Programme Results Framework from the Project Document / AWPs** - provide details of the achievement of indicators at both the output and outcome level in the table below. Where it has not been possible to collect data on indicators, clear explanation should be given explaining why.

	Achieved Indicator Targets	**Reasons for Variance with Planned Target (if any)**	**Source of Verification**
Outcome 1[11] To contribute to the increased utilization of high-quality reproductive health services and information in meeting the needs of poor and vulnerable persons **Indicator:** % of children and women from poor families having access to quality priority life-saving health services **Baseline:** 20% **Planned Target:** 10% increase	Fully achieved target. In 2013, 63% health facilities have an adequate level of equipment and trained staff so as to provide evidence-based life-saving health services.		MoH statistics
Outcome 2[12] Access and utilization of quality maternal health services increased in order to reduce maternal mortality and morbidity **Indicator:** % newborns with asphyxia **Baseline:** 7,6% **Planned Target:** 0-5% of newborns	Fully achieved target. Asphyxia in newborns reduced by 64% (in 2013 2,7% of newborns with asphyxia)		MoH statistics
Output 1.1 Capacity of health workers to provide antenatal care services in selected PHC facilities of Osh and Batken oblasts is strengthened **Indicator 1.1.1** Percentage of the health providers trained on ANC **Baseline: 0** **Planned Target:44%**	Fully achieved targets. More than 84% of pregnant women covered by ANC (at least 4 visits) and increased in the coverage of a first trimester ANC visit. For instance, on average, 96.7% of women were registered before 12 weeks of pregnancy (in the first trimester) and averaged 5-6 (82%) visits during antenatal care.		MoH statistics, UNFPA evaluation report

[11] Note: Outcomes, outputs, indicators and targets should be **as outlines in the Project Document** so that you report on your **actual achievements against planned targets**. Add rows as required for Outcome 2, 3 etc.

[12] Note: Outcomes, outputs, indicators and targets should be **as outlines in the Project Document** so that you report on your **actual achievements against planned targets**. Add rows as required for Outcome 2, 3 etc.

Indicator 1.1.2 Number of established birth preparedness schools in primary health care facilities **Baseline:** 2 (Osh maternity and Batken oblast FMC) **Planned Target:** 4 (Karasuu, Kizil-Kia, Kadamjai and Isfana FMCs)	Eight birth preparedness schools are established: overall 65% of pregnant women were prepared for child birth and involved their husbands/partners in birth preparedness classes on maternal health practices; women's knowledge of obstetric complications, risk and dangerous symptoms increased by 42% enabling them to seek emergency care in time.		MoH statistics, UNFPA evaluation report
Output 1.2 A process for continuous quality improvement of the medical services for women and newborns demonstrated and institutionalized in target maternity hospitals	Fully achieved targets.		
Indicator 1.2.1 Percentage of the hospitals trained on resuscitation of the newborns and equipped with Ambu bags and mannequins for training **Baseline:** 25 % **Planned Target:** 100%	Achieved, 100% of hospitals with capacity on neonatal resuscitation (88% of all medical workers trained)		Evaluation of the UNICEF Perinatal Care Programme 2010-2013.
Indicator 1.2.2 At least 60% of maternities were certified within Baby Friendly Hospital Initiative (BFHI) according to the WHO/UNICEF criteria **Baseline:** 45% **Planned Target:** 60%	Achieved, 70% of maternities certified as Baby Friendly in the end of the project.		MoH statistics
Indicator 1.2.3 Percentage of the medical staff trained as per Effective Perinatal Care technologies. **Baseline: 10%** **Planned Target: 75%**	Achieved, 75% trained.		Evaluation of the UNICEF Perinatal Care Programme 2010-2013.

iii) Evaluation, Best Practices and Lessons Learned

The perinatal care component of the project was evaluated by using OECD/DAC criteria on relevance, efficiency, effectiveness and sustainability by two international evaluators Dr. Tamar Gotsadze and Dr. Chiara Zanetti. The evaluation report *Evaluation of UNICEF Programme on Perinatal Care for the Period 2010-2013* will be published in 2014 simultaneously with an evaluation UNFPA report on Antenatal Care component. The key finding of the evaluations are that the project was able to improve the health status of parturient mothers and newborns through continuity of care between primary and secondary health care levels in the target region as described in detail above in the outcome section. The project supported the national priorities and thus was rated as highly relevant and efficient. In terms of effectiveness, the project did well in strengthening the national and sub-national capacities, enhanced medical practices along with service delivery and rationalized use of resources at the facility level. According to the evaluation, *UNICEF planted seeds for Perinatal Care sustainability in Kyrgyzstan* and by strengthening the national capacity including the MoH on QoC and Quality Assurance, the sustainability of the project has been increased.

In addition to the team approach described already on page 6, one of the most important lessons learnt during the project implementation was the changing of the funding mechanism. As in the early years of the project, UNICEF contracted professional associations to deliver trainings, however while this was beneficial for the empowerment of the professional associations, there was a lack of ownership of the health facility management. Thus starting from 2013, entire responsibility for training organization and logistics was delegated to the hospitals. The change in funding modality resulted in decrease of training costs per person per day by 54% as well as raising ownership, commitment and interest of hospital management in trainings of the personnel and implementation of evidence-based approaches.

Moreover, lessons learnt from the project point to the fact that realizing improvements requires a systems approach and the strategic interventions identified above need to work in a synergistic manner to increase utilization of maternal services at the primary and secondary health care level and increase the obstetric need in order to improve maternal health. As a whole, UNFPA, WHO and UNICEF were working well together and thus able to support the Ministry of Health in realization of national priorities in mother and child survival.