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FAMILY EDUCATION PROJECT EVALUATION UZBEKISTAN

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FAMILY EDUCATION PROJECT
EVALUATION

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Acronyms

ADB	Asian Development Bank
CCA	Common Country Assessment
CIS	Commonwealth of Independent States
CPAP	Country Program Action Plan
CPC	Country Program of Cooperation
CPMP	Country Program Management Plan
CRC	Convention of the Rights of the Child
FEP	Family Education Program
FGD	Focus Group Discussion
FFL	Facts for Life
GIS	Geographical Information System
HRBAP	Human rights based approach to programming
IDD	Iodine deficiency disorder
IECD	Integrated Early Childhood Development
IMCI	Integrated Management of childhood illnesses
IMR	Infant Mortality Rate
INGO	International Non-Government Organization
MCH	Mother and child health
SVP	Rural medical points
MDG	Millennium Development Goals
MIS	Management Information Systems
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoPE	Ministry of Public Education
MTR	Mid Term Review
MTSP	Mid term Strategic Plan
NGO	Non-governmental Organization
PRS	Poverty Reduction Strategy
PTA	Parent Teacher Association
RC	Resource Corner
TOR	Terms of reference
TOT	Training of Trainers
USAID	US Agency for International Development
WHO	World Health Organization

Some Local Terms

Makhalla	Community or neighborhood
Methodist	Trained kindergarten teacher
Patronage nurses	Home visiting nurses providing antenatal care
Rayons	Districts
Regions	Larger administrative units with districts
Hokims	Governors or administrators

Executive Summary

The Family Education Project (FEP) with its vision of integrated Early Childhood Development (IECD) was initiated in May 2003 by the Government of Uzbekistan with technical support from UNICEF Uzbekistan. The broad aim was that of “*family empowerment and increasing families’ knowledge on child rearing practices through community volunteers*” particularly in the age group of 0-6 years (the latter phases of FEP were to address age groups 7-13 and 14-18). High MMR, IMR, anemia, IDD, almost no early learning interventions for the under-threes and low preschool coverage at 20% had indicated the need for FEP. UNICEF’s role was to assist the Government of Uzbekistan through providing technical expertise on integrated ECD, training of trainers and volunteers, developing materials and advocating for ECD at different levels. FEP resonated with UNICEF’s commitment to CRC, CEDAW and HRBAP.

FEP was piloted in 13 makhallas (communities) of 6 districts (rayons) in 3 regions – a) Fergana Region: Kuva District (Rasta and Tashkent Makhallas), Uchkuprik District (Yangabad, Gul, Bekmurod makhallas) b) Tashkent Region: Zangiata District (Nazarbek, Katartal Makhallas), Yangiyul District (Gulbakhor, Eski Kovunchi Makhallas) c) Republic of Karakalpakstan: Ellikala District (Abai, Ibn-Sino Makhallas), Nukus District (Akmagyt, Arbashi Makhallas). Volunteers from the community (such as doctors, nurses, retired professionals, makhalla advisors and others) were trained to implement FEP.

The rationale of the evaluation was that 2005 being the first year of UNICEF’s new program cycle, there was need for reliable, accurate and comprehensive data on the impact of FEP. Although the evaluation primarily focused on the achievements and gaps of FEP, it also identified lessons learned and recommendations for UNICEF’s new program cycle in Uzbekistan. The review was conducted in all three FEP regions of Karakalpakstan, Fergana and Tashkent and included a sample of all stakeholders involved in FEP such as volunteers, families, trainers, managing partners, implementing partners, donors, NGOs, related government officials and UNICEF. Data were collected from 80 interviews, 13 FGDs, observation of one training program and two FEP community events; visits to one State KG, 6 Resource Centers, 6 Resource corners, one Makhalla KG, one Family KG and three volunteer KGs in Fergana, Karakalpakstan and Tashkent regions. A *qualitative* evaluation framework was developed addressing key results areas related to inputs, process and outputs and evaluation findings assessed (in the absence of a baseline values for benchmark indicators) against project objectives and available *quantitative* district level data to identify program components that worked and those that did not.

FEP was implemented through existing governance structures – at national level, the Pediatrics Institute took overall responsibility for FEP training, monitoring, management as well as coordination with the Women’s Committee (who appoint the Makhalla Advisor), Ministry of Health, Ministry of Education, local Hokimyats and with UNICEF; at rayon level the Deputy Governors and Inter-sectoral committees took the lead and at makhalla level it was the makhalla committees and makhalla advisors.

The review assessed progress against plans. A number of events during implementation changed the design of FEP: support to Makhalla KG (community based full day KGs which were seen as an unnecessary competition to underutilized State KGs) was discontinued by UNICEF and government; volunteer dropout was high in FEP requiring new trainings; materials developed for ECD were very few compared to the large scale dissemination of Facts for Life (FFL) books and calendar posters; central coordination in the government changed a number of times; a new position of a Makhalla Advisor was created in the makhalla; and, clusters for parent group

learning were not formed. FEP truly began to be implemented only from August 2004. In 2005, local agencies were appointed to manage small grants of \$3000 given to rayons to implement FEP.

Evaluation findings indicate that *in the pilot makhallas, FEP had good coverage but overall in the rayon, it was very low*. During 2003-05, through family visits, FEP directly covered 10,498 families or 54% of total number of 19911 families and 7972 children aged 0-6 or 75% of total number of 10,834 children in the pilot makhallas. The total number of children 0-18 in the pilot makhallas was 31,298 of which 70% were indirect beneficiaries of FEP. However, in the 6 pilot rayons, FEP covered *only 6%* of total number of families. It is estimated that FEP reached 59% of total SVP (rural medical points) and 48% of total KG in the rayon.¹ Pilot makhallas also took the initiative to expand the program to 44 neighboring makhallas, or 15% of total number of 280 makhallas, which was 3.5 times more than originally planned.

Findings indicated that although families and communities clearly *understood the concept of FEP's integrated approach to ECD and its emphasis on the psychosocial development of children*, there were a number of gaps. FEP messages were simple – exclusive breastfeeding for six months, safe motherhood, ECD and the psycho-social development of children, prevention of and symptoms of communicable diseases, use of safe water by boiling, immunization, disability and gender. In content, FEP messages were more likely to be identified with the *FFL ten key messages*. The FFL has a health bias and slants towards the early years of childhood i.e. 0-3 years, whereas the FEP modules (although based on FFL) included both ECD (need for early stimulation, good parenting and ECD needs of older children) and health components.

In terms of its *strategy*, FEP is the *only program that works with families and communities*. Although there was no baseline, it may be stated with reasonable confidence that simple messages which demystified health knowledge; placed children's educational and psycho-social needs at the heart of the program; addressed complex family relationships and family gatekeepers (such as in-laws and husbands); universalized the messages to address whole communities; and, used community volunteers as educators, contributed to FEP's easy acceptance and visibility.

Dissemination of FEP was primarily through *community volunteers*. *Training* of volunteers was one time, of high quality, used participatory and interactive methods, but had no refresher training. The number and type of volunteers trained differed in Phase I (May2003-June2005) and Phase II (from July 2005), with a higher training load in Phase I. In Phase 1, a total of 48 multidisciplinary professionals from two makhallas in each rayon were trained - doctors, teachers, Methodists (preschool/KG teachers) but as *volunteers*. In Phase II (June 2005 onwards with a push for expansion), 50 volunteers were trained in the *whole* rayon and included one Makhalla Advisor from each Makhalla (about 30) and about 20 multidisciplinary professionals. At the Makhalla level therefore, FEP implementation was dependent on one person, the Makhalla Advisor (a 40+ woman appointed by the government in 2004 in response to emerging religious extremism primarily to liaise and counsel families). Lessons learned indicate that *adequate numbers of multi-disciplinary volunteers* are required for maximum and sustained outreach.

Volunteers *disseminated* FEP messages to families through home visits, formal and informal (weddings, 'gaps' or traditional gatherings of people) community events, meetings at FRC or corners, polyclinics and health services, KG, and others. Local media were used but not extensively. While family visits, though human resource intensive, were useful providing one on one live interaction, community events using role play and competitions were immensely popular

¹ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

and reached out to large numbers in the community. Volunteers also “trained” other volunteers in the community but were not monitored against any set standard. Use of volunteers was cost effective, created ownership but *volunteer interest* was not consistently high and differed across regions affecting program delivery. In Phase I, the small grants program to rayons to implement FEP community programs also included small amounts for facilitation which were given to volunteers as incentives.

All *FEP materials* were very useful in the field and in great demand. The FEP materials include a children’s kit, a trainers’ manual and a Family Activity Booklet in the new Latin script. The limited number of materials, only about 150 sets for each rayon, affected the reach of FEP although Uzbekistan has the natural advantage of a highly literate population. As over 50,000 FFL books and calendars were distributed through FEP, FFL (and not FEP IECD messages) were widely remembered across communities.

Six Family Resource Centers (one for each rayon) were established with a TV/video, IECD related books, FEP materials and toys and were useful for volunteers but use by parents and children could be optimized. Similarly, numerous small Resource Corners in different parts of the community such as polyclinics, makhalla committee offices and others, need to be reviewed regarding their usage to justify the cost.

Volunteers and families reported *changes in behavior* related to all the health, cognitive and psychosocial messages but it is difficult to confirm with certainty, as there was no baseline. An informal formative study by UNICEF in July 2005 indicated that breastfeeding went up to 94.6% in 2005 from 74% in 2003, 84% families practised safe motherhood compared to 60% in 2003 and 84% families practised prevention/management of childhood illness compared to 64% in 2003. The proportion of families using iodized salt was 90%, that using proper sanitation and hygiene was 90% and that using pure drinking water was 70%. Changes are probably due to a number of programs including FEP.

Children grow up in large extended Uzbek families and by educating *all the members of the Uzbek family*, FEP targeted underlying family relationships and norms. It addressed traditional gatekeepers such as mothers-in-law, included men (fathers and grandfathers) in child rearing, involved mothers in decision making, encouraged mothers and children to access available health and education services thus changing attitudes and influencing behavior. In two regions, Fergana and Tashkent, a grandfathers’ group and a fathers’ group advocated about FEP to men in the community. *FEP has been able to place early childhood needs center stage in communities and is unique because it worked not just to increase knowledge but also to develop a culturally appropriate enabling environment for integrated ECD.*

FEP was expected to create a demand for *ECD services* (currently only 20% children are enrolled) such as increase in enrollment for formal state KG as well as non-formal makhalla or family KG. In Karakalpakstan, many families wrote to government officials demanding more (and got) KG services. Although in FEP pilot rayons, enrollment in state KG increased, the demand is yet unmet as families are unable to meet the high cost of KG (which are full day and include meals). To ensure some degree of school preparedness, a few state KG started weekend schools and parents reported enrolling their children for just a year before primary school say at age 5 or 6 rather than at age 3 or 4. A study² indicated that the number of informal preschools increased from 5 to 21 and number of children from 94 to 581. However, non-formal KGs and Makhalla KGs were very few, served small numbers of children and were largely volunteer based

² FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

since the state regulates the establishment of KGs and taxes income. In terms of *health services*, FEP had sensitized care providers and decision makers such as mothers in law on the need for mothers and children to access available health services at health points and polyclinics.

Several *key recommendations* have emerged from the review: a) *Project redesign* must address service delivery needs such as the promotion and availability of *realistic and flexible ECD facilities* (such as Family KGs, part-time State and Makhalla KGs and others). A HRBAP approach demands that duty bearers respond to emerging needs of communities to fulfill children's rights to participate in early childhood programs b) *An IECD strategy* is needed to address the *differing* health and educational needs of 0-3 and 3-6 children in an integrated holistic manner (with emphasis on health in 0-3 years and education in 3-6). This strategy should provide for synergy with available and proposed programs of Government, donors and UNICEF and *integrate* FEP training into relevant ongoing training, maximizing coverage at minimal cost. By doing so, it will practically translate and integrate the CRC into available and potential programs. As needs of 0-6 year olds are largely unmet, expanding FEP to address older age groups is unrealistic. c) *Materials* need to be interactive, challenging, address universal and culturally specific IECD concerns and exploit the natural advantage of Uzbekistan's highly literate population for maximum outreach. The FEP children's materials are in the new Latin script and in great demand but parents educated in the Cyrillic script need to be supported to maximize their involvement with children. Most important *sufficient* quantities of materials are needed with a clear *dissemination plan* that first benefits the most vulnerable, that is children with little or no access to early childhood services. d) *Resource Centers and Corners* need to be easily accessible, rationalized and popularized to justify establishment costs. e) *Adequate numbers* of motivated, well-selected *volunteers* with multidisciplinary expertise in ECD and health are critical. Volunteer time can be optimally used through the critical and selective use of delivery mechanisms, such as family visits and community events and by targeting families most in need of FEP intervention. In its expansion phase, a minimum of three persons – the Makhalla Advisor, a Methodist and Health personnel need to be trained. *Cascade* training is possible provided *quality control* issues are addressed. FEP can be naturally extended into the job description of patronage nurses and Makhalla Advisors. *Monetary incentives* through community small grants may be continued but *non-monetary incentives* of recognition should be explored especially as community ownership is so high. An HRBAP approach recommends that volunteers and families be provided advocacy skills for addressing government and donors for a variety of IECD services. f) *A cadre of regional trainers/organisations* as managing partners to support cascade training, supported by national trainers for quality control would decentralize and localize training, enable rapid expansion and provide ongoing technical expertise to volunteers and communities. g) *Monitoring and Evaluation* needs to be strengthened with a baseline to develop tailor-made results and a rights-based M&E framework. Because FEP is volunteer and makhalla based, RBM skills training at the community level would ensure that communities are involved in goal setting, participatory monitoring thus enhancing ownership and sustainability. h) *External expertise* in dialogue with local experts should support the next design phase, baseline, an IECD strategy and action plan with input, output and outcome indicators. i) *Rapid, cost effective scaling up* requires that UNICEF advocates and shares its approach and strategy with other donors and government departments. A number of donors such as WHO, World Bank and ADB, have or plan to incorporate family and community mobilization and ECD into their activities.

In the post Soviet era, FEP is an excellent example of how families and communities when empowered can respond to the needs and rights of young children.

Uzbekistan: a country in transition

After the break-up of the Soviet Union in 1991, 15 new states emerged. Uzbekistan is the third most populous state in the CIS and the fourth largest in land area. It is a double land-locked country, bordered by five countries and lies across two major rivers, the Amu-Darya and the Syr-Darya. Exploitation of the river systems for cotton irrigation has resulted in the drying up of the Aral Sea, a major ecological disaster. The country is largely dry and arid. It has 14 administrative units consisting of 12 oblasts (regions), Tashkent city and the Autonomous Republic of Karakalpakstan. The Regions together include a total of 163 rayons or districts and 121 cities (including Tashkent city). The municipal unit at the community level is known as the "makhalla."

The country's population is 25.5 million and 63% live in the rural areas. Uzbekistan has a high natural growth rate because of a high birth rate - 22.3 per 1000 in 1999 and a low death rate - 5.3 per 1000. As a result, 41% of the total population are children under 15 and 12% of the population are children under 5. The official life expectancy is high at 71.3 years.

Agriculture, mainly cotton production is the primary industry and accounts for 43.4% of all employment. Uzbekistan is the world's second biggest exporter of cotton. Today, as earlier, manual cotton picking continues with labour contributions from the population during the season. Unsustainable agricultural production processes have caused irreversible ecological damage. Increased desertification has caused changes in air and water quality levels. This has affected the health status of the population which has a complex pattern lying between developing and industrialized countries – diseases ranging from cardiovascular problems to parasitic and digestive tract diseases, respiratory illnesses and high iodine deficiency because of the lack of marine products in the diet (due to its double landlocked geography).

Under the Soviet era, economic and social systems provided the population with a great deal of basic human security. Education and health care were free and although income levels were not high, all were assured employment. The Gini coefficient of income inequality was 0.26 in 1991, considerably lower than the US (0.43) or UK (0.35). The state also provided women with significant benefits such as maternity leave, encouraged the higher education of women and employment (women constituted 46.5% of the labour force in 1989). Because of the egalitarian philosophy of the Soviet era, literacy was universal. The transition shock resulted in declining incomes, reappearance of forgotten diseases and growing poverty and inequalities leading to a great deal of stress in the population.

The country promotes a liberal social state policy with 40% of government revenues devoted to the social sector – education, health and the social sector. Whereas access to basic services like water, basic sanitation and natural gas for heating is a problem, access to health and education services decreased as they became unaffordable to many. The poor in Uzbekistan, unlike other countries, are *human capital rich* as they have at least 9 years of schooling and *asset rich* as most own their land and house. However, these gains accumulated during the Soviet era can eventually deteriorate. The CCA analysis by the UN argues that economic growth can reduce poverty only when accompanied by social development such as a) promoting labour intensive growth and employment in the agricultural sector with attention to regional, gender and ethnic inequalities b) investing in and protect human capital through affordable access to health and education services and social protection and c) strengthening 'social capital' by involving citizens in governance through existing social structures and community networks.

Source: CCA, Uzbekistan, UN 2003; Study on the Restructuring of Health and Medical System in the Republic of Uzbekistan, Japan International Cooperation Agency (JICA), MoH, Dec. 2003

1. BACKGROUND

The Family Education Project (FEP) with its vision of Integrated Early Childhood Development (IECD) was initiated in May 2003 by the Government of Uzbekistan with technical support from UNICEF Uzbekistan in response to the country's need to empower families to address problems that affected children's health, growth and development particularly in the ages of 0-6 (the latter phases of FEP were to address age groups 7-13 and 14-18). The Project completed its first phase in July 2005 but as the evaluation took place in October 2005, it also reviewed programmatic developments from July to October. Expectations from the evaluation were multiple – to evaluate the project; to input into the five year strategy plan (2006-2009); to critique demands for geographical scale up, content expansion and increasing coverage to include all children between 0-18 years; and to assess the potential synergy with other donor and government programs for long-term sustainability. In this sense, although the evaluation primarily focused on the achievements and gaps of FEP, it also used the opportunity to analyze lessons learned and recommend a way forward.

The report is divided into six sections:

Section One Background discusses the aims, goals and objectives of FEP-IECD, need and design of FEP and the purpose of the evaluation.

Section Two Methodology describes the conceptual framework of the evaluation including key questions, tools used, methods of data collection, as well as the sampling plan and concludes with the limitations of the study.

Section Three Findings begins with an analysis of the extent to which plans were followed, deviations made and how the program was affected. The section then presents findings related to the Key Result Areas, reviewing inputs and process (training, materials, manpower and activities), advocacy and outputs and outcomes. The management, monitoring and evaluation of the project are also critiqued.

Section Four and Five analyse FEP's synergy with and contribution to other related programs, international conventions, instruments and global UNICEF priorities.

Section Six Way Forward describes conclusions, provides recommendations and outlines lessons learned.

An external consultant conducted the evaluation using a **participatory reflective** approach. A *participatory* approach ensured that the evaluation plan and tools for data collection were developed in partnership with the UNICEF team, FEP coordinator and suggestions incorporated. In using the *reflective* approach, beneficiaries at all levels while providing data also contributed to its critical analysis. In practice this meant that during the FGDs and interviews, **all stakeholders** – families, managers, implementers, decision makers had the opportunity to reflect on lessons learned and suggest a way forward. Perceptions of stakeholders were **shared across groups** periodically during the data collection, helping to refine results but most importantly building **greater ownership** for the findings and future actions. To complete the process, it is suggested that the evaluation report too be shared with all those who contributed to the findings.

1.1 Aims, Goals and Objectives of FEP

FEP evolved from the Government of Uzbekistan and UNICEF's continuous attempt to develop and improve their joint response to persistent problems affecting children's healthy growth and development.

UNICEF's role was to assist Government of Uzbekistan through:

- Providing technical expertise on IECD,
- Training of trainers and volunteers,
- Developing of materials and
- Advocating for ECD at different levels.

Total budget spent for FEP/IECD in 2003-2004 was 311,768 USD, and planned budget for 2005 was 285,300 USD, including set-aside funds in the amount of 115,000USD

The broad **aim** of the FEP is

“Family empowerment and increasing the families knowledge on child rearing practices through community volunteers”.

The overall **goal** of FEP is

“ To empower families and communities with knowledge and skills to ensure that children of all age groups grow up healthy, well-nourished, and benefiting from quality learning programs, and developing into well-adjusted young citizens in safe, hygienic, environmentally friendly and non-discriminating communities.”

The specific **objectives** of FEP for 2003-2005 were:

- To increase knowledge and skills of families and communities on childcare
- To improve childcare practices of families and communities
- To increase the % of children participating in IECD and other programs for older children

Three key program strategies were planned:

- a) Capacity Building through trainings of frontline workers and volunteers and development of materials
- b) Advocacy campaigns through mass media channels and ECD materials
- c) Support of local initiatives in communities

FEP's achievements were to be assessed using the following **indicators**:

- % of families where the behavioural changes occurred and were observed as a result of intervention of FEP (e.g. home health care, hygiene, psychological care, breastfeeding and feeding including use of iodised salt, care by both parents, care for pregnant women, etc.)

- % of families where CRC articles are being effectively applied into everyday life (e.g. explicit evidence of non-discrimination against girls, children attending schools, children are being protected from abuse, etc)
- % of children who participate in different types of ECD programs/preschools

FEP implementation was as follows:³

FEP was piloted in the following 13 makhallas of 6 districts in 3 regions – a) Fergana Region: Kuva District (Rasta and Tashkent Makhallas), Uchkuprik District (Yangabad, Gul, Bekmurod makhallas) b) Tashkent Region: Zangiata District (Nazarbek, Katartal Makhallas), Yangiyul District (Gulbakhor, Eski Kovunchi Makhallas) c) Republic of Karakalpakstan: Ellikala District (Abai, Ibn-Sino Makhallas), Nukus District (Akmagyt, Arbashi Makhallas).

Officially launched in May 2003, FEP was coordinated and managed by an Intersectoral Coordination Committee established under the Social Complex of Cabinet of Ministers at national, regional, and district levels which included Ministry of Education, Ministry of Health, Interior, Social Protection, local NGOs (e.g. Kamolot, Soglom Avlod Uchun), and local government offices. However, the Social Complex was abolished. As a result, FEP management was moved to the Tashkent Medical Pediatric Institute (TashPMI) under the Ministry of Health.

A multi-disciplinary Technical Working Group (TWG) prepared FEP-IECD materials such as the FEP-IECD Trainer’s Manual and the Family Home Activity Booklet; the Trainer’s Manual consists of 23 session guides organized under 5 modules on health and nutrition, early learning, family relations and child protection. The sessions reflect the key messages of the UN’s Facts for Life, which has been translated into Uzbek for distribution as well.

A Training of Trainers for 14 national and 12 regional trainers developed capacity for FEP implementation who in turn trained 280 Frontline Workers (48 volunteers from each rayon). These trainings have been further followed up by (a) home visits /one-on-one sharing by medical personnel (doctors and nurses) with mothers and mothers-in-law; (b) formal sessions organized by groups of trained workers and volunteers for various family members, including young men, besides mothers and mothers-in-law; and (c) non-formal sessions done during traditional gatherings of women (“gap”).

FEP Learning Resource Centers were set up in each of the 6 Districts (Rayons) in the 3 pilot Regions on the premises of a Pre-school or KG for two reasons - the focus on IECD and the active involvement of the Pre-school Department of the Ministry of Public Education (prior to the dismantling of the Social Complex). The FEP-Learning Resource Center was meant to function as a resource center for Makhalla Kindergarten, as well as for trainings and materials development and distribution.

1.2 Need for FEP

a) Both - the priorities of the government and numerous studies – indicated the need for FEP. Health and educational services for children and women are not new to Uzbekistan and have been implemented from the Soviet era. Characterized by a young population, the need to address

³ Integrated ECD- FEP 2003-2005: Informal Formative Evaluation Report by APO Family and Community Empowerment, Shakhlo Ashrafkhanova, July 2005

children has always been a priority. Various Government decrees recognize this⁴ – Decree #30 of the Cabinet of Ministers “Year of Health” as of January 25, 2005, which outlines cooperation with UNICEF in several areas. Others, directly related to FEP include “Healthy Family” and “Healthy Lifestyle” through mass media and work with makhallas as well as protection of women and children through provision of quality health services, improvement of maternal health and reduction of child mortality rate; Decree # 242 on Measures of Implementation of Priority Actions Aimed at Raising Medical Culture in the Family, Strengthening the Health of Women and Delivery and Upbringing of Healthy Generation” as of July 5 2002 as well as previous decrees of the Cabinet of Ministers such as “Year of Makhalla”, “Healthy Generation”, Resolution #68 of 5 February 2001 on “State program of Mother and Child,” and others.

However, transition changes and persistent problems in the situation of women and children indicated by the Multiple Indicator Cluster Survey, the UNICEF Midterm Review, Study on Child Rearing Practices in Nukus and Amudarya and Assessing Parents Needs in Medical, Psychological and Pedagogical Knowledge in the Framework of Mother and Child Survival, Development and Protection Program⁵ suggested the need for FEP. In addition, these studies indicated that families did not have modern information regarding appropriate childcare, which could prevent the causes of child illnesses, deaths and poor cognitive development among young children.

b) Although there were many achievements in addressing children’s needs in the areas of health and education, there were major gaps as well.

FEP identified achievements as well as areas that needed to be addressed. Some of the major achievements in the area of **health** included the following: 95% of qualified children had been immunized and 76% mothers breastfed their children till the first birthday (but not exclusively). Water and sanitation with access to safe water was available to 94% urban and 79% of rural population. 97% urban and 85% of rural population had access to toilets although pit latrines were predominantly found in the rural area. In terms of services, Mother and Child Centers had been established in 7 regions, 13 hospitals had been certified as baby friendly, IMCI was well under way and messages on better parenting (predominantly health) had been broadcast on mass media. FEP also identified areas of concern:

- High infant mortality rate at 52/1000 live births
- High under five mortality rate of 69 per 1000
- High and increasing MMR 34.1/1000 live births
- 52% of women of child-bearing age are afflicted with iron deficiency anemia with almost 100% in the poorest provinces in the north-western regions of the country
- Up to 60% of the population suffer from iodine deficiency disorders yet only 19% of 5 million households use iodized salt.
- High prevalence of Vitamin A deficiency

The egalitarian approach to **education** in the Soviet era had resulted in impressive educational gains. Literacy rates were 97% and ninety-one percent of children between 8-10 years were in primary school, with no differences in the enrollment of girls and boys⁶. During the Soviet era, comprehensive care for children 0-6 was provided through state funding or through farming

⁴ Integrated ECD- FEP 2003-2005: Informal Formative Evaluation Report by APO Family and Community Empowerment, Shakhlo Ashrafkhanova, July 2005

⁵ Strategy Paper FEP in Uzbekistan; FEP –IECD: The Process in Uzbekistan; Assessment of FEP-IECD October 2004 (all papers prepared by FEP design consultant Mercedes Chavez); Child Rearing Study in 3 pilot regions highlights concerns: swaddling, ‘beshik’ (a traditional cradle in which babies are strapped tightly), anemia, iodine deficiency; misconceptions about early learning

⁶ Multiple Indicator Cluster Survey 2000

cooperatives and other commercial enterprises (as childcare support provided to working mothers). Reform in the agriculture sector ended the Soviet style cooperatives and led to the closure of many pre-schools.⁷ State KG provided services to 0-6 years, children of 1-2 years could avail of nursery facilities and 3-5 years could attend KG in the same premises. State KG facilities were usually full day and provided mid-day meal and post Independence, charged between 5000 to 7000 sum a month. While the government encouraged various approaches to care, most children under 3 years were mainly cared for at home. Enrolment in pre-schools 3-6 declined drastically from 1,349,400 in 1991 to 681,200 in 1998.⁸ The FEP therefore also addressed concerns related to **education**:⁹

- Early learning interventions for under threes were almost nil
- Formal pre-school coverage for 3-5 years old was low at 20%.
- Enrollment increased but slowly primarily as there was little appreciation by government and parents for early learning.
- Government efforts encouraging traditional and non-traditional (makhalla and private KG) increased pre-school coverage to only 27% in 2002.¹⁰

1.3 Design of FEP

The design of FEP¹¹ was based on a number of considerations:

- a) Services for children and parents had been developed and delivered as individual packages and there was a need to package them in a **comprehensive** program
- b) While breastfeeding, immunization, nutrition and hygiene had intensified their program, opportunities for **integration of psycho-stimulation and early learning** in regular programs for children under three were left out
- c) **Front line workers** also were not adequately trained in child development and often used didactic child-unfriendly techniques thus defeating the aims of ECD
- d) Threat of **closure of Makhalla KG**, a neighborhood KG concept which was supervised by local administration, but had the same costing as the state KG. They were viewed as an unneeded competitor especially when the KG themselves were not using their full capacity.
- e) The UNICEF Midterm Review cited the need for a Family Empowerment strategy to address the critical information requirements of families with children of various ages. In this way, the MTR suggested a broadening of the Better Parenting initiative into the Family Empowerment Program – targeting the whole family rather than parents alone. This approach promoted ‘**whole family wellness**’ rather than just parent responsibilities

For these reasons, it was proposed that FEP would help to intensify the impact of regular programs on the status of children by actively pursuing a more systematic and integrated delivery of child care messages particularly ECD to families and communities. The FEP strategy paper (August 2003) provided a short-term vision (working with 0-6 years in the first phase) for the years of May 2003 to June 2005 and was known as the FEP-IECD. In the short term, the government agreed to focus on IECD for the remaining year of the Country Program of Cooperation and expansion to other years would continue in the next CPC 2005-2009. The FEP Strategy also provided a long-term vision to gradually increase the coverage to 7-13 years and

⁷ Assessment of FEP-IECD, Oct. 2004 by M.Chavez, Consultant

⁸Pg. 21, CCA, UNICEF 2003

⁹ Assessment of FEP-IECD, Strategy FEP and FEP- the Process by M. Chavez

¹⁰ Ministry of Education 2002, as quoted in “Project Proposal for Gulf Funds - Integrated ECD through community based family education program”

¹¹ “Project Proposal for Gulf Funds - Integrated ECD through community based family education program”; Family Empowerment Program- Integrated ECD- The Process in Uzbekistan (by M. Chavez)

then 14-18 years¹². The FEP would unify the child-focused messages for all programs expanding program scope to cover not only IECD but also other programs with capacity building components for families and communities.

The Facts for Life (FFL) would be used as the foundation block for the first phase of the program. FFL along with the IMCI Module would promote IECD and be a basis to develop FEP Training Modules. With so much information on childcare, parents and family members needed assistance in putting these bits of information systematically into a more action-oriented framework.¹³ Such an approach would enable caregivers to ‘think and do’ in an integrated way e.g. breastfeeding with psycho-social stimulation; diarrhea prevention with learning of hygiene (washing hands), using boiled water; nutrition and young child feeding with learning of colours, shapes, etc. In this way, a **bottom-up demand** for knowledge, childcare and services would be created.¹⁴ FEP was to be the standard bearer for capacity building of frontline workers and community volunteers in the propagation of **rights based family and community initiatives for children**¹⁵. These frontline workers and community volunteers would implement the project using a variety of advocacy and communication tools and media.

FEP assumed that government and communities would support child and family focused programs particularly ECD and Makhalla KG. With increased knowledge and skills, there would be a demand for IECD services. The proposal expected the *organization of clusters of family learners in the community and through the Makhalla KG*. The strategy clearly indicated that “whatever the delivery mode¹⁶, it is important to enroll parent/family learners and organize them into clusters in order for them to have a support group”. *Model Makhalla KG* would demonstrate innovative ECD practices¹⁷.

1.4 Purpose of Evaluation¹⁸

The rationale of the evaluation was that 2005 being the first year of UNICEF’s new program cycle in Uzbekistan, there was need for reliable, accurate and comprehensive data on the impact of the FEP. The audience for the evaluation would be various FEP partners – Ministry of Health, Ministry of Public Education, implementers at regional and district level, frontline workers and UNICEF (for preparation of its strategy paper 2005-2009).

The evaluation was to determine a) achievements b) constraints c) inform future program design based on findings of impact and behavioural change d) provide recommendations for scaling up, using the most effective and efficient channels for communication and leveraging of funds and address e) sustainability issues.

¹² This would include motivating children to follow good study habits, providing them time for study and leisure, developing a love for reading, maintaining open communication to lead them away from drugs, gambling, substance use and others, life skills and HIV information, along with sexuality and reproductive health information. Parents would also participate in monitoring how child friendly teaching norms were and to help children with learning problems.

¹³ Different documents talk of Family Empowerment or Family Education. This refers to objective one: to increase knowledge and skills of families and communities on childcare.

¹⁴ This refers to objective two: to improve childcare practices of families and communities

¹⁵ Assessment of FEP-IECD, Oct. 2004 by M.Chavez

¹⁶ Such as parent learners form a weekly listening class and learn via radio or tapes; or weekly caregiver discussions on self instructional home activity flyers coordinated by class coordinator; Structured home visit program with plan followed by home visitor and caregiver, learning groups of Makhalla KG parents; ECD sessions for caregivers in State KG

¹⁷ In May 2003, a Participatory training needs assessment workshop for Makhalla KG teachers and supervisors was conducted in Fergana.

¹⁸ From the evaluation TOR

2. METHODOLOGY

2.1 Conceptual Framework for the Evaluation

The evaluation framework particularly addressed relevance, efficiency, effectiveness, impact and sustainability¹⁹ as well as issues related to a) Coverage b) Coordination c) Coherence and d) Protection. The following three steps describe how the conceptual framework for the evaluation was systematically developed:

Step One: A **matrix** was developed to understand how key strategies are related to core objectives²⁰. Although all key strategies are relevant to objectives of the FEP, the matrix provides a conceptual understanding of key areas of intersection. This matrix was then used to develop the evaluation framework.

	Key Strategies			
	Capacity Building of frontline workers and volunteers	Development of materials	Advocacy campaigns using mass media and ECD materials	Support Local community initiative
Objectives of FEP				
To increase knowledge and skills of families and communities on childcare	X	X		
To improve childcare practices of families and communities	X	X		
To increase the % of children participating in IECD and other programs for older children			X	X

N.B. The evaluation additionally included issues such as the working structures, coordinating mechanisms, technical support groups that provide technical and management support to the program.

Step Two: This matrix formed the basis to develop a **results framework**²¹ for the evaluation.²² UNICEF currently uses the Results Framework for the strategic planning for its projects and the evaluation responds to this effort.

¹⁹ Definitions from UNICEF Evaluation Report Standards; *Relevance* is defined as “The extent to which the objectives of a development intervention are consistent with duty bearers and rights holders requirements, country needs, global priorities and partners’ and donors’ policies. Retrospectively, the question of relevance often becomes a question as to whether the objectives of an intervention or its design are still appropriate given changed circumstances. ; *sustainability* as “The continuation of benefits from a development intervention after major development assistance has been completed”; *efficiency* as “An economic term referring to the measure of the relative cost of resources used in a programme to achieve its objectives”; *effectiveness* as “A measure of the extent to which an aid programme attains its objectives or produces its desired results”; *impact* as “Positive and negative long-term effects on identifiable population groups produced by a development intervention, directly or indirectly, intended or unintended. These effects can be economic, socio-cultural, institutional, environmental, technological or of other types”;

²⁰ Developed by consultant.

²¹ Definition from UNICEF Evaluation Standards “The causal sequence for a development intervention that stipulates the necessary sequence to achieve desired objectives beginning with inputs, moving through activities and outputs, and culminating in outcomes, impacts and feedback. It is based on a theory of change, including underlying assumptions”.

²² See Annex Six for Evaluation Framework

FEP's three Key Strategies were rephrased as 'key results' and described in terms of:

- **Expected specific results** which outlined a **logical plan** of inputs, activities and outputs ending in probable impact. The underlying assumption is that planned inputs and activities must be in place to evaluate outputs and outcomes.
- Areas of study, **Indicators** or Information to obtain data regarding these expected specific results were defined.
- Finally, probable **sources** of data and a tentative analysis plan was developed

Step Three: Key questions were developed on FEP's Key Result Areas and included Lessons Learned for each of these areas, *reflecting needs of relevance, efficiency, effectiveness, impact and sustainability.*

The **participatory reflective** nature of the evaluation ensured that stakeholders' experience, concerns and perceptions were elicited, sampling frame discussed, indicators clarified and tools of data collection shared. The evaluation questions were piloted and revisions made based on feedback. On the basis of this, interview and FGD schedules were later developed for different stakeholders, to form the **qualitative** assessment. Multiple sources of data were identified to ensure triangulation and increase the reliability and validity of the data collected. **Quantitative** assessment available with UNICEF with district level data was used for analysis.²³ Reports, documents and internal trip reports were also studied to corroborate evidence collected through interviews and focused group discussions. To ensure that the evaluation of the program was not viewed as a threat but rather as a useful process to strengthen the program, UNICEF staff, FEP coordinators and beneficiaries contributed to data collection and in the critical analysis of findings, increasing ownership of findings.

This **multi-layered research design** contributed to the validity of the findings and compensated for the lack of a baseline and the essentially qualitative nature of the study.

The reviewer spent a week developing the evaluation framework, followed by a two day discussion with UNICEF staff and four weeks of data collection and a final day for sharing lessons learnt, reviewing challenges and chalking out future plans. The reviewer also gave a brief debrief of the initial findings.

2.1.1. Evaluation Questions

a) The evaluation addressed key questions related to **inputs, process and outputs**. In the absence of baseline values for benchmark indicators, the results of the evaluation could not be compared with any data. Thus, the evaluation results were compared with the program objectives to identify the components that were working and those that were not. This would allow corrections in the strategy to improve the program or to replicate it in other areas. A **time trend method** of analysis was used for the review as impact data would not be available as there was only two years of program implementation.

Evaluation questions were triangulated across **stakeholders** (see Annex Seven – Data Collection Instruments) – relevant government representatives at national, regional and makhalla level, UNICEF, donors, volunteers (including Makhalla Advisors) families, trainers, managing partners (NGOs and others) and corroborated with available secondary evidence from reports, documents, trip reports and studies.

²³ IECD-FEP, 2003-05 Uzbekistan, Informal Formative Evaluation Report, by APO Shakhlo Ashrafkhanova, July 2005

b) **Material Review:** The following materials were developed by FEP-IECD:
For Service Workers/Volunteers - Facts for Life

FEP-IECD Trainer's Manual
Posters and other visual aids
Family Home Activity Booklet

For Parents/Family Learners - Facts for Life

Posters
Family Home Activity Booklet

For Children (through parents) - Children's Storybooks

Book of Poems
Book of Songs
Book of Riddles & Games
Educational Toy, Shapes (25pieces)

Some of the **key questions** related to materials were: Did all families receive materials? Were families, volunteers oriented in use of them? How did families/volunteers use materials? How was use monitored? What impact did it create? Which ones were most useful? .

c) **Training Review** included key questions related to structure and management of training plan, quality of training, topics covered and participation of trainees.

All these questions were incorporated into the tools for data collection as were questions related to efficiency, relevance, effectiveness, sustainability and impact. (See Annex Seven)

2.1.2 Methods of Data Collection

Both primary and secondary data was used for the review.

Primary Data: Tools used

- a) Interview guides were developed for families, volunteers, deputy governors, donors, government departments, UNICEF and trainers.
- b) Focus group discussions were held with trainers, deputy governors, volunteers
- c) Observation of Family Resource Center, Makhalla KG, Family KG, training program
- d) Review of Materials

Secondary data such as studies, reports and trip reports for the period 2003-05, relevant documents were reviewed (see Annex Five, List of Documents and Reports Reviewed).

Limitations of the methodology were as follows:

- 1) There is no baseline data and hence, any improvement on indicators cannot be categorically reported as impact of FEP. However, trends have been indicated, the validity of the trends supported by the multi-layered research design and the participatory reflective approach of the evaluation.
- 2) About 23 families were interviewed and although consistent responses were received, a larger survey is suggested during the baseline study. For the purpose of the review, the family interviews gave an overview of the issues that need to be explored. It was agreed during planning for the review that it would not serve any purpose to interview control families, as there had been no baseline in the pilot rays, and therefore no point of comparison.

- 3) A decision not to include a control group was made after discussions with UNICEF management and FEP team²⁴ for several reasons – **one**, only one consultant was involved for the review with only four weeks of data collection and therefore time needed to be judiciously spent on the actual program; **second**, there was no baseline and using a classical control group would have no point of comparison; **third**, a control group needs to be matched family by family with the experimental group on various criteria. Because of the time and human resources available, the lack of baseline information and ethical questions raised, (Also see Ethical Guidelines) a control group methodology was considered but not adopted. Instead, to ensure validity, rigour was laid on triangulation of data and methods, involving a wide range of stakeholders at national, regional and makhalla levels, and inclusion of all FEP implementation regions for the field visits.
- 4) Reliability of statistical data from the rayon had to be assumed. An information sheet had been developed by the reviewer and shared with the deputy hokims, however the information received was erratic and lacked any internal validity. Although sent back for revision and followed up by the UNICEF staff, the discrepancies continued. This information sheet was therefore considered irrelevant and not included. Available quantitative data from UNICEF records and district level data were used for analysis.
- 5) A costing analysis requires a detailed enquiry into the project and due to limitations of time and human resources was not attempted. The review however does provide broad information regarding cost efficiency. (See Understanding FEP Costs)

In spite of these limitations, the review has very definite and clear findings, which were consistent across regions and corroborated by various stakeholders, families, trainers, volunteers, deputy governors and observations of UNICEF team and past records. Hence findings reported and recommendations may be used for future programming.

2.2 Sampling Plan

FEP has been pilot tested in 3 pilot regions, 6 districts and 12 makhallas. The review was conducted in all 3 **regions**, Fergana, Tashkent and Karakalpakstan.

The sample plan for the review ensured that all relevant **stakeholders** were represented. The sample included representatives of FEP Technical Working Group (most of the national trainers), the District Inter-sectoral Committees, district deputy governors, UNICEF (previous and current FEP team, departments working with FEP and management), national implementing organization (Paediatrics Institute), families (mothers, fathers and caregivers), volunteers (directors of Family Resource Centers, journalists, regional trainers, directors of State KG, doctors, heads of education and other related departments at rayon level, teachers, local volunteer groups such as grandfathers group, makhalla foundation members), donors (WHO, World Bank, ADB, AED, USAID), other UN organizations (UNFPA, UNDP), NGOs (Soglom Avlod Achum, Oila Center) and the government (Ministries of Health, Public Education, Institute of Health, Women’s Committee and Makhalla Foundation) .

²⁴ Discussions on October 17 and 18, 2005

Data was collected from 80 interviews, 13 FGDs, observation of one training program and two FEP community events; visit to one State KG, 6 Resource Centers in Fergana, Karakalpakstan and Tashkent regions, 6 Resource corners, one Makhalla KG, one Family KG, three volunteer KG. Details regarding sample, interviews and FGD are provided in Annex Eight.

2.3 Ethical Guidelines

There were rigorous ethical safeguards for those interviewed. Strict confidentiality was maintained. Names of beneficiaries do not appear in the report. Children have not been interviewed. Beneficiaries consent to be interviewed was verbally obtained by FEP volunteers, corroborated by accompanying UNICEF staff and the choice to decline information at any point in the interview indicated by the reviewer. Community volunteers and UNICEF staff were always present during interviews and FGDs to ensure ethical guidelines were maintained. Necessary government (at local and national levels as the case may be) permissions were sought in visiting services, meeting government officials and communities.

The FEP program though a pilot one provided benefits to communities in terms of information, materials, resource centers, and community grants. It was therefore considered unethical to gather information from those communities (over 80% of children are in need of FEP or similar such IECD interventions) that did not receive FEP benefits to gauge the potential ‘reach’ and ‘impact’ of the program. Such a methodology would have either raised expectations or highlighted that these communities were ‘left out’ from a highly valued service. No baseline had been collected from beneficiaries in communities not included in FEP in the beginning of the project and hence there was no justification to randomly select such beneficiaries many years later, at the time of the review.

3. FINDINGS

3.1 Progress against plans: Implementation changes

This section discusses how the design of FEP changed as a result of implementation and influenced outcomes.

In **2003**, FEP implementation was more or less as planned and included development of a strategy paper, establishment of TWG, capacity building of national trainers and development of materials. What was a significant change was that by June UNICEF (and government) did not continue support to Makhalla KG for various reasons including the reluctance of the government to promote a service that competed with the available state KG services. As a result, at the community level, besides the state KG, there were no other services for ECD. Although part of FEP design, clusters of caregivers were not formed in the community for a structured, regular ECD program.²⁵ **FEP sensitization, home visits and community events became the only source for ECD programming. FEP coordination and management at the central level was changed** because of a government reshuffle.

In 2004, implementation of FEP began but there were changes in coordination at the government once again, which were resolved only in the beginning of 2005. Although coordination structures were set up at the rayon and oblast level, it soon became apparent that the oblast level did not

²⁵ Refers to objective three: to increase the % of children participating in IECD and other programs for older children. Also see, Assessment of FEP-IECD, Oct 2004 by M. Chavez

contribute to the project and this level was discontinued. Volunteer dropout was high and FEP learned to select volunteers against criteria and a new training was planned midyear, reinforced with training in adult learning methods and toy making. Although manuals and kits were developed for FEP, the **quantity was limited (only 150 FEP sets per rayon) but FFL was widely distributed in large numbers** (50,000 printed and translated in Uzbek) as part of FEP material. Family Resource Centers were set up only in September 2004 (originally Makhalla KG were supposed to be demonstration sites). Newly government appointed Makhalla Advisors (middle aged women who had to keep personal contact with families to counteract religious extremism in the communities) were now available at the makhalla level and were included in FEP training. FEP truly began to be implemented only from August 2004. **Lack of monitoring and evaluation tools as well as an absence of structured parent learning groups were major gaps in implementation.**

In 2005, **small grants** were given to rayons to implement FEP and provided incentives to volunteers for FEP event facilitation. Implementing agencies were appointed to manage the grants. More material in the form of FFL calendars, brochures were made available. Modification of FEP manuals and materials and addition of new material have been postponed till the evaluation findings are received. Hence, **paucity of FEP-IECD materials continued.** To increase coverage, training moved to the rayon level, and only Makhalla Advisors were trained along with *some* doctors and Methodists. This resulted in a **rapid expansion but with minimal availability of trained multi-disciplinary personnel.** Using a timeline, a detailed explanation of how changes in implementation altered FEP is described in Annex Nine.²⁶

3.2 Key Findings Related to Inputs and Process of Implementation

3.2.1 Understanding the concept

a) Families, volunteers, trainers and deputy Governors (of both new and old rayons) had a clear understanding of the FEP and its emphasis on an integrated approach to early childhood education. They understood that FEP was different in both strategy and content.

In its **content, FEP integrated many program messages** – such as exclusive breastfeeding, safe motherhood, ECD and the psycho-social care of children, prevention of and symptoms of communicable diseases, use of safe water by boiling, immunization, disability and gender. All stated that health and education information was provided in simple language and for the first time, messages started early, even before the birth of the child. Deputy Governors stated they were typically involved in implementing government directives related to the health, education and well being of children and mothers but unlike FEP, government programs were vertical, used lecture methods and jargon to disseminate information and generally addressed just one issue or problem.

In terms of **strategy**, volunteers, families, trainers and deputy governors felt that FEP was also the **only program that directly worked with families and communities.** Other programs for children and mothers' health and education usually targeted specialists such as teachers, doctors and nurses. In FEP, doctors, Methodists, teachers and other interested community members were involved but as *volunteers*. Information was perceived as being provided by community members (though they were specialists) and in their own language. Because FEP addressed all members of the family including traditional decision makers, such as mothers and fathers in law, husbands

²⁶ Assessment of FEP-IECD; FEP-IECD The Process in Uzbekistan; Interviews with Shakhlo (current Asst. Program Officer) and Rustom (former FEP program assistant)

and educated them on various health and education issues using interactive methods such as role plays, social gatherings and home visits (which **addressed all members of the family**), they felt that FEP influenced **attitudes and behaviour**. This approach ensured that not only was health and educational knowledge brought into the family arena but family decision makers were also encouraged to access health and educational services.

All knew that FEP was aligned with **government priorities** such as the Year of Health (2005), Government Resolution 242 and had official administrative sanction. In this way, FEP reinforced other government and related donor programs²⁷ such as encouraging the use of iodized salt, exclusive breastfeeding, prevention and treatment of diarrhoea. The Women's Committee directed Deputy Governors (all women, who are appointed by and report to the Women's Committee at the central level but work locally with the rayon administration) to coordinate and support FEP work at the Makhalla level. In the new Makhalla structure instituted in September 2004, Makhalla Advisors (also women appointed by and with line reporting to the Women's Committee) are expected to be involved in the FEP. The distinct advantage to FEP is that the government pays both Deputy Governors and Makhalla Advisors.

In Soviet time, families thought schools will take care of children. I never paid attention to my children. With this program we can talk of both health and education and although we have all this in the state document, it does not reach the family. The program looks at the culture that the mother-in-law is strict and daughter-in-law has to do certain things. This UNICEF program is different – it expanded to the grandfather and grandmother of children and their father. UNICEF gave this design and the government supports it through the Women's Committee and Makhalla Advisors and because it knows the population needs to know about health and education.

- Interview with Regional Trainer, FEP

In the absence of a baseline, it would be difficult to verify these perceptions but as families, volunteers, trainers and deputy governors expressed the same opinion, it may be stated with reasonable confidence that the simple messages which demystified health knowledge, placed children's educational and psycho-social needs at the heart of the program, addressed the complex family relationships and family gatekeepers (such as in-laws and husbands), universalized the messages to address whole communities and used community volunteers as educators contributed to FEP's easy acceptance and visibility.

²⁷ Deputy Governors mentioned they complemented the FEP written materials with the health videos from the Zrdaf Plus, USAID funded program during community events.

Voices from the field

"FEP is the only program which uses a volunteer system".

"FEP is different from other programs, it encourages the child to go to Kindergarten and promotes health.....it addresses the child even before he enters school and looks at establishing early on fundamental child development concerns."

"Diarrhoea and pneumonia are major causes of infant mortality. We have Global Education and Water and Sanitation projects in our area but the FEP increases knowledge in the family, everything really starts in the family. Role plays are interactive and help a great deal."

"FEP mobilizes communities – it involves everyone – families, nurses, doctors, Methodists." "FEP volunteers without any medical background can deliver health messages."

"Makhalla Advisors know how and what to communicate to families now."

b) In content, FEP messages were more likely to be identified with the FFL ten key messages rather than the information from the FEP modules, which had a more comprehensive ECD component.

Volunteers and Deputy Governors used information from and disseminated the FFL book and calendars in all 3 regions. In 2 out of 3 pilot regions, Tashkent and Fergana Regions, **FEP has become synonymous with FFL**. In Karakalpakstan, as the FFL is yet to be translated in Karkal, volunteers still use the FEP Modules as a resource. However, FFL calendars were distributed to all families. Families identified the ten key FFL messages as FEP in all three regions.

FEP used FFL as a reference book for the development of the Manual.²⁸ FEP developed a Trainers Manual with 23 modules addressing **both** FFL and ECD priorities. The FFL was subsequently distributed in large numbers across rayons; the FEP Trainers manual had limited copies and enjoyed a sparing distribution. The FFL has a health bias and slants towards the early years of childhood i.e. 0-3 years, whereas the FEP modules (although based on FFL) included both ECD (needs for early stimulation, good parenting and ECD needs of older children) and health components. In this sense, the concept of FEP-IECD as a truly **integrated early child development for ages 0-6** is yet to be strengthened. This has been recognized in the trip reports of UNICEF staff as well.²⁹ The section on Materials (see 3.2.4) and Changes in knowledge (see 3.4.1) explores this issue in more detail.

3.2.2 Training

a) Training of volunteers was one time, of high quality, used participatory and interactive methods, but had a lot of content to cover.

Observation of the training, discussions with volunteers and trainers indicated that the five day training of FEP by national trainers for volunteers was of high quality. National Trainers were equally divided among health and education sectors and this is one reason why FEP training was so well integrated. A one day sensitization for representatives from health, education sectors and other influential leaders in the rayon was also conducted.

²⁸ See annex three for chapter plan of modules

²⁹ Mission Report, Implementation of FEP June 15-18 2004 by Rustam Haydarov, Project Assistant, Child Enrichment FEP

Training³⁰ consisted of **only five days** in which volunteers and deputy governors learned about the 23 modules using participatory methods. The participants are given home reading, as there is insufficient time to complete all the 23 modules. In the training, the 23 modules are ‘compressed’, as a result they resonate with the FFL messages and lose some of the details available in the original FEP modules. This is particularly true for the ECD component. Participants receive a copy of the FFL, the 23 modules and a book, which talks of the different stages of development of children. Since these materials are in short supply, participants use these materials for their own reference and not for dissemination in the community.

The training on FEP modules in 2003 was inadequate and **additional trainings for use of adult learning methods (2 days) and toy making (2 days)** were added in 2004. FEP training in interactive methods helped volunteers to communicate better with families. Teachers and Methodists were familiar with interactive methods and many of the ECD concepts but lacked health knowledge. Similarly health personnel were familiar with health information but needed training on interactive methods. Volunteers like the Makhalla Advisors however needed much more inputs and a five day training was not enough according to the trainers. There is **no refresher training available** currently.

“Earlier we used to just go and give advice but now FEP involves interactive methods – now we don’t tell and leave.”

“Doctors give messages at meetings but the method of FEP is such that it goes into your mind – with the use of role plays, games, exercises. It is practical and visual and so more effective.” (*At a Round Table meeting in Fergana Valley*)

b) Cascade model of training was used by and large, but national trainers were involved at makhalla level and further training by volunteers in the community differed in both time spent and content

In the TOT, 14 national and 12 regional (two from six rayons) were trained. National trainers were made responsible for all training at all levels. National trainers, assisted by regional trainers (who generally managed the logistics) trained all volunteers. When regional trainers trained at the rayon or makhalla level, they were generally assisted and supervised by the national trainer – they did not train independently. Regional trainers were expected to organize events at the rayon and makhalla level, and report to the national trainer. An example of their involvement can be seen in the Nukus FEP Plan, in section 3.2.5 on Activities (see box).

Volunteers ‘trained’ further at the community level and many of these ‘trainings’ were for one day³¹. Although the number of those ‘trained’ further at the community level was large, how and what was taught at the makhalla level was not monitored against any set standard. **Cascade training had no systematic and rigorous follow-up** to assess the content and quality of training offered down the line.

³⁰ Observation of training and FGD with trainers and volunteers.

³¹ 131 trainings in 44 makhallas were reported in the study - IECD-FEP 2003-05 Uzbekistan: Informal Formative Evaluation Report, July 2005 by Shakhlo Ashrafkhanova, APO Family and Community Empowerment UNICEF Uzbekistan.

3.2.3 Volunteers as implementers

a) Although training load and cost is high, adequate number of multi-disciplinary volunteers are required to ensure integrated messages are disseminated, for maximum outreach, to safeguard against drop-outs and to form teams for peer learning.

In Phase I, training load and cost was high. Trainings had to be organized twice because of high dropouts and only 13 makhallas were reached although 300 volunteers were trained. Additional two trainings were held – one for toy making and the other for adult learning methods. According to the Deputy Governors and volunteers, the involvement of volunteers with different backgrounds and skills was helpful and **enabled an integrated intersectoral delivery at the makhalla level.** A study³² indicated that 311 volunteers had been trained of which 49 were male volunteers. Volunteers being multidisciplinary included 61 doctors/nurses, 52 preschool teachers, 77 schools teachers, 49 makhalla advisors, 72 others.

In Phase I, for example in Rasta Makhalla 25 volunteers were trained and of these 10 were school teachers, 9 were KG teachers and 6 were home nurses. For each street, there were two volunteers, one from the medical sector and one from the educational sector. Although each Makhalla had 24 trained volunteers, the **large number of volunteers was necessary to ensure maximum family coverage.** In rural areas such as Karakalpakstan or in highly dense areas such as the Tashkent region, a critical mass of volunteers or activists is necessary to reach out comfortably to families. For example, in Zangiata, volunteers said that families lived at great distances and a volunteer was responsible for as many as 600 families, consequently repeat visits to the same family was possible only after a couple of months.

Learning lessons from high volunteer dropout, in the second round of training, **more care was taken in selection of volunteers** and both Deputy Governors and Makhalla Advisors (newly appointed) were included to institutionalize FEP. The selection process helped to ensure better performance and additional trainings in adult learning methods and toy making led to better program delivery.

In FEP Phase II, training load (and cost) was decreased but availability of trained personnel at makhalla level also decreased. The five-day training included FEP, toy making and adult learning as well. To ensure rapid scale up, all makhallas were included at the rayon level and 50 volunteers were trained in each rayon – one Makhalla Advisor from each Makhalla (about 30) and about 20 doctors and Methodists from different makhallas so that if need be Makhalla Advisors could call on them for health and educational information. Therefore, with the inclusion of Makhalla Advisors the **profile** of the volunteers was dramatically different from Phase I. Typically, the MA are 40+, often retired professionals and their primary duty is to have close contact with families to ensure that religious extremism does not take root.³³ The Makhalla Advisors have little knowledge regarding health, education and development issues. The FEP program was **now dependent on primarily one person, the Makhalla Advisor** without any other person to support or provide a check and balance. The FEP National Coordinator especially had **concerns of quality** and had observed that at family level, some Makhalla Advisors were disseminating their own views as UNICEF's views. As there were no other trained volunteers and from other disciplines, there was no one who could challenge these messages. In practice, only

³² FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

³³ Makhalla Advisors position was created for women as one of the suicide bombers in Andijan was a woman. The intention was to address concerns of women and families and to ensure harmony in communities.

some of the Makhalla Advisors utilized the help of doctors and Methodists for more specialized information. For these reasons, all stakeholders felt that more volunteers were needed.

b) Quality of work by volunteers differed and was dependent on individual efforts and support received from the administration. Sustaining interest of volunteers was a challenge and many strategies were tried out.

Use of volunteers creates ownership and is cost-effective but volunteer interest was not consistently high across regions. Because volunteers are not paid, it is difficult to state for how long the enthusiasm will be sustained. The first phase saw more than 30% dropout.

Experience in Phase I had indicated that volunteers who had to meet families **as part of their job description were more likely to do so for FEP as well**, such as patronage nurses (they conduct home visits for the new born) and Makhalla Advisors. As the government pays them, there is greater accountability and sustainability. In some rayons, like Ellikala there is great hope that commitment will continue. The deputy governor³⁴ believes that 10-15 activists are needed to sustain the program. Patronage nurses used to go to families and check the newborn but those who are trained in FEP, now also talk to mothers in law about looking after their daughters-in-law³⁵. The Deputy Hokim plans to involve patronage nurses and tap other volunteer groups in the community such as high school students. Makhalla Advisors stated that FEP was useful for them when they visited families as it provided them concrete information to share with families.

Experience in Phase I indicated that, volunteers preferred working in **teams** to do home visits or conduct events.

Another strategy that helped sustain interest was the **small grants program** (started in January 2005) in which each rayon (includes the two makhallas implementing the FEP) received \$3000 to implement at least four FEP community programs with FEP-IECD issues as the main theme. Volunteers received small amounts for facilitation of these events and these have worked as **incentives** for implementing FEP. Volunteers are expected to rotate facilitation of events to ensure everyone is benefited.

³⁴ Interview with Deputy Governor

³⁵ FGD with Deputy Governor and volunteers Angrian City

Volunteers are not always well educated and may not be educators. Some of them are very active and because they are not paid, depend on the moral support they get. The Deputy Governor's involvement with them makes a great difference. A doctor who is a volunteer has more access to the medical points and can spread a lot of messages and collect data. Now that Makhalla Advisors are included in Phase II, it helps because they are elected by the Makhalla, paid by the administration, have more authority and are more interested. But in the old model, we were able to do 80-100% coverage with the large number of volunteers. It's hard to say how it will work out now, we suggest to the Advisors not to work alone and to form teams and include doctors and Methodists from other makhallas. One trained person per makhalla is insufficient and we must have more doctors and Methodists trained. *(Interview with FEP Coordinator)*

We should also involve the Education Department in the Rayon. There are a lot of education specialists in makhalla and region and we must train teachers in FEP so that they can assist Makhalla Advisors. Also the teachers and Methodists live in the community and they can share with neighbors. Similarly, Health Center staff should be used, as they have to promote health information in each rayon and city. *(Interview with Deputy Governor, Fergana, Ms. Khodjaeva)*

d) Volunteers used varied and different activities to reach out to families, some were planned and others were spontaneous but in the absence of minimum standards or monitoring formats it is difficult to assess both the extent and quality of reach.

Volunteers used different activities – **home visits, community events, formal trainings and 'gaps'** (informal community gatherings). All rayons planned their work systematically.

For **home visits**, volunteers were allotted streets and households. In some rayons, the information was used to **selectively target** family visits, in others **100% coverage** of families through home

visits was sought. This affected the **length of each visit and the number of times families received inputs** from volunteers. For example, in Nukus volunteers identified families in the

Example of a Work Plan 2005 – Nukus

1. To organize meetings of activists – April June Sept Dec
2. To conduct training workshops for young mothers with regional trainers and volunteers - April, May, June, July, Aug
3. To organize Resource Corners in schools, KG, library, cultural center, polyclinic, labor office, passport office. April – Dec
4. To conduct steering committee meetings with *national trainers*, deputy governors and volunteers – May, Aug, Nov
5. Volunteers bring weekly report of families they couldn't cover in makhalla – May
6. Event Children's Day – June 1st
7. Event – young couples getting married – July
8. Exchange of experiences among Makhallas, volunteers and *national trainers*, also included new Makhallas who wanted to join – Aug
9. Healthy Mother, Healthy Child Event on Independence Day – *national trainers* and volunteers – September
10. Information to Pregnant women – *national trainers* and volunteers – Oct
11. Monitoring twice a year
12. Printing of Newsletter
13. Women's Sports activity – contest among volunteers – Nov
14. Training of volunteers – Jan
15. Every Saturday evening give information to Makhalla Advisors and Women's Committee about FEP

(Role of national trainers in italics)

lanes allotted to them, which had children below 6 years of age. Family visits were made only to these families, the first visit was introductory to meet the family and children, followed by another one to see if suggestions had been incorporated. Most volunteers stated that they could visit these families twice a month. The volunteers with jobs were allotted fewer families.

I have two streets with 49 families of which 26 have children from 0-6 but only 9 families have children 3-6 who do not go to KG. I work with these families and help them send children to pre-school. I was able to get 6 children to KG and helped them prepare for it. I would give messages and leaflets on ARI, breastfeeding. I also use this opportunity to talk to the mother who is pregnant about going for check-ups. With the mothers-in-law I talk about how they should treat their daughters-in-law, give them nutritious food and rest. We tell the fathers to treat the mothers well and to encourage them to breast-feed. We spend time with children and work with books and helped children prepare for KG by talking about simple colors, numbers, how to make toys, and draw. Sometimes I have to spend one to one and a half hours with the family as I work with the children. Parents can't do much so it helps if we come.

Volunteer in Nukus during FGD

Volunteers filled in the **Family Profile Sheet** and knew how many children of what ages, pregnant women and other family details. Some volunteers were able to organize this data to target their messages. For example, a group of pregnant mothers were given information regarding safe motherhood, breastfeeding and stimulation. Children who do not go to KG were followed up to see if parents could send them to KG, attend informal classes or do various activities at home. Once again, some volunteers did this better than others. However, as there were **no monitoring formats** available it is difficult to state which makhallas did better in outreach.

Visits to families by volunteers in Khonqa region (Phase II, new region) were quite **short** say, 15 minutes as each Makhalla Advisor was expected to meet 200 families. According to the Deputy Governors and volunteers, it was **difficult to mobilize caregivers/parents for group learning** according to schedule because of their agricultural commitments and volunteer time available.

Many activities were also done **spontaneously**, using the natural opportunities they provide. Many volunteers showed great enthusiasm and spread messages to other professionals and makhallas. For example, a doctor in Nukus shared that while the mothers waited for their immunization, he educated them on hygiene, diarrhoea, ARI, iodine deficiency and other messages. A Director of a local KG talked to parents and encouraged them to come to the KG with their children on holidays or after school hours and use the materials available. Doctors spread messages to nurses in polyclinics, a state KG Administrator had trained other state KG heads in FEP and neighboring makhallas had invited FEP volunteers to address the community. None of these have been recorded and it is difficult to ascertain the outreach of FEP³⁶.

I have opened a file for each family. I have printed a book based on FEP and when I have time I collect children who do not go to KG and teach them. (*Volunteer, Hamida in Uchkuprik*)

³⁶ FGD with volunteers in all 3 regions

In the new rayons (Urgench, Khonqa)³⁷, although family visits were yet to be done, **events** had been organized such as meeting of young mothers and fathers, competition for children not attending KG.

The UNICEF consultant had suggested that **communication maps** be made to track volunteers' dissemination of information.³⁸ These and other monitoring efforts should be part of a larger M&E strategy. (Also see Section 3.6 on M&E)

3.2.4 Materials

1. All FEP materials were very useful in the field but because numbers were limited were in great demand.

The FEP materials include a children's kit, trainers' manual and Family Activity Booklet. The number of materials distributed was only about 150 sets in each rayon, and hence materials have been separately rotated, shared, preserved for events, impacting the reach of the FEP. Printed materials are particularly important and advantageous for FEP dissemination as the population is **literate**. Small colorful brochures have been developed and photocopied from the reference material in order to disseminate information widely and compensate for the limited quantity of materials available. The Children's kit uses the newly promoted (by government) Latin script for the Uzbek language (which used to use Cyrillic script, similar to what is used for the Russian language) and are very much in demand by families. Being **few in number**, they were 'rationed' in many ways, such as providing part of the kit, circulating it among families, giving it as a gift during competitions and using it for volunteer demonstrations and talks with parents and caregivers.

b) A clear relation between what families and communities learned and what materials were available and used could be seen.

All volunteers received the FEP Trainer's Manuals (modules) during training but when they in turn trained others in the community, they distributed FFL books (>50,000 distributed through Women's Committees and FEP) and calendars (FFL posters with yearly calendar and ten key messages) as these were readily available in large quantities. Messages from FFL were therefore widely remembered across communities.

c) The ECD component in the materials needs strengthening.

Consultant's interviews with families and discussions with volunteers in the field during the review supported the finding. Previous UNICEF trip reports have also commented on this phenomenon³⁹, the need to strengthen the ECD component and revise materials. The full version of the Trainers' Manual (a compressed version is available and used for training) and the Family Activity Booklet are detailed with a great deal of ECD information such as early stimulation of children as well as concrete ECD activities for children 3-6 years. In the design of the FEP (see 3.1.2 Design of project), it was envisaged that volunteers would be able to guide **groups of parents** through weekly skill building sessions to implement a structured ECD home program (essential because only 20% children are enrolled in KG). Plans to structure weekly sessions with parents groups were developed by the UNICEF FEP consultant during the design and training phase. An assessment by the UNICEF consultant (who designed FEP) a year later, in 2004, indicated that such groups had not been formed, suggestions and changes to develop such groups

³⁷ FGD with volunteers in the two rayons

³⁸ Pg. 14, Assessment of FEP-IECD, October 2004 by M. Chavez

³⁹ Mission Report, Implementation of FEP June 15-18 2004 by Rustam Haydarov, Project Assistant, Child Enrichment FEP

using ECD tapes, media and older children were included. However, at the time of the review, no change in implementation was visible.⁴⁰

The FEP-IECD was an ambitious program, requiring a skillful, trained Methodist with specialized knowledge in ECD and families to spare time on a regular basis to attend these group learning sessions. In reality, families did not have time, many Methodists were working and had limited time for FEP, sometimes volunteers were not Methodists but educated families on concepts of ECD and so by the time FEP reached families, the messages and materials used became simpler. The **health** component became FFL key messages and for the **educational** component, children were encouraged to draw and sing, some mothers educated children on the colours and shapes of vegetables while cooking. Some volunteer Methodists conducted a few hours' informal KG classes in the Makhallas or during weekends in the State KG and used all UNICEF materials to the fullest. However it was finally the **simplest** materials such as the adapted FFL and the compressed version of the FEP (which was also based on FFL), which were widely disseminated among families.

d) Children's kit needs to be revised addressing both quality and cost-effectiveness based on feedback from the field.

Because books of good quality in Latin script are not easily available for children, the UNICEF children's kits were in huge demand. Feedback had been received from the field and UNICEF was reviewing the materials, to both reduce costs and introduce creative thinking.⁴¹ The materials need a better design (such as using both sides of the page, using questions rather than passive statements). Some of the materials content and design do not relate to the specified age group of the children. For example, younger children would require more pictures, larger fonts, simpler language. The 'Apple Book' is too descriptive and needs to be written in a way that challenges children to think. A new book, the FFL Baby Book containing stories and poems with FFL messages colorfully packaged is under development.

3.2.5 Family Resource Center

The Family Resource Center is shared between two Makhallas in a rayon and there are 6 FRCs in the FEP. Each FRC was selected considering ease of access by caregivers and situated in the KG. They were equipped with a TV/video, audiotape recorder, books, brochures and toys. In addition, numerous Resource Corners were set up in the Makhallas, making it convenient to access and use FEP printed material and encouraged caregivers to meet. About 136 such corners were formed and the total number of materials distributed by them were 9970 of which, FFL was 2157, posters were 4300 and others 3513 which included children's books, training modules (reprinted in booklet form).⁴²

a) FRC was useful for volunteers but use by parents could be optimized; similarly although there were a number of Resource Corners, they need to be reviewed regarding their usage.

Volunteers used the FRC for meetings every month and to plan their work and maintain records. Attendance at FRC was dependent on a number of factors, such as the timings (some FRC are not open on weekends), proximity of the FRC to places of stay and the events scheduled there. In some rayons, FRC were better utilized by parents than others and number of parents visiting the FRC varied from 7 or 8 a week to more than 20. Sometimes caregivers meetings were held and about 15-30 would attend each of these meetings. In some FRC, children who did not attend KG,

⁴⁰ Implementing Strategy for Group Learning in the Community/Neighborhood Activities by M.Chavez, October 2004.

⁴¹ Interview with Shakhlo Ashrafkhanova and Yulia Narolskaya, UNICEF

⁴² FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

came on the weekend for ECD classes. Another study⁴³ corroborated the same, on average 135 visitors monthly or 34 visitors per FRC per week.

Many rayons preferred to use corners for meetings. For example, Zangiata rayon in Tashkent Region had over 96 corners. Interviews with families confirmed that either corners or/and FRC were visited, some visited them every month and some for events or group meetings and others only very occasionally. There is no record of actual number of people who visit the center and corner and for what purpose. Without any record of utilization it is difficult to ascertain which corners or Center should be continued and which need to be popularized or discontinued. In general, it may be said that utilization of FRC and corners could be strengthened.

b) New rayons (in Phase II) did not have Resource Centers but had set up Resource Corners Even in the new rayons⁴⁴ where Makhalla Advisors primarily had been trained Family Resource Corners had been established in different places such as KG, where young mothers received subsidies and Makhalla Committees.

3.3 Advocacy and Communication

a) Different strategies adopted by FEP has led to extensive advocacy and communication but their contribution to change in behavior needs to be assessed.

FEP is disseminated through home visits, formal and informal (weddings, ‘gaps’ or traditional gatherings of people) community events, meetings at FRC or corners, polyclinics and health services, KG, places where target population may be available such as when lactating mothers come to collect their social allowance. FEP is also disseminated through local media – TV and newspaper. The FEP Congress was useful to stimulate discussion, disseminate and promote FEP work to policy makers, donors and enabled sharing of field experience⁴⁵. The FEP Congress served as an important advocacy tool for government, other UN agencies and donors. Not only did FEP volunteers and population share their experience, they also got the benefit of expertise from regional advisors of UNICEF.

By linking with other NGOs, sectors, peer sharing the FEP has spread very fast⁴⁶. A great deal of advocacy is also done informally and spontaneously and needs to be mapped (also recommended by FEP consultant M. Chavez). For example, in Khonqa (a new rayon), and in Zangiata, doctors had on their own printed the ten FFL messages and distributed it to the community. It would be difficult to ascertain to what extent such advocacy and communication strategies influenced behavior change without a baseline and monitoring and evaluation tools. (Also see 3.2.3 d)

b) Family visits though human resource intensive were useful for targeting families and worked best when supported with community events.

According to Deputy Governors, interviews with families and FGD with volunteers, there were several advantages in working with families as it was ‘live’, ‘interactive’, providing opportunities to clarify and explain as per need. A modification of approaching families was to work with communities using natural social gatherings to educate on FEP using interactive methods such as role plays. In practice, this approach was very popular for several reasons. It enabled reaching out to large numbers, used the natural makhalla community and social gatherings to mobilize people, used indirect methods such as role plays, competitions to convey messages, and in this way

⁴³ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁴⁴ FGD with volunteers in Urgench Rayon and Khonqa Rayon.

⁴⁵ Interview with FEP coordinator, Ismailova Muazam, Pediatrician, Paediatric Medical Institute

⁴⁶ FGD with volunteers Kuva, Fergana

sensitively manage the attitudes of traditional gatekeepers and decision makers such as fathers and mothers –in-laws and husbands. Although events mobilized large groups of people, it was also more likely that the more active and aware community members would come. To reach the vulnerable group, family visits would therefore be essential.⁴⁷

Although family visits are important, community events provide an opportunity to share. It is easy to talk about roles of men and women. Men are more open and can talk freely about contraception, breastfeeding and birth spacing. (*Doctor volunteer during FGD, Ellikala*)

In the skit, there was a role reversal with an older woman played the young daughter-in-law and the daughter-in-law playing the difficult mother-in-law who refuses to give rest to the young daughter in law although she is anemic and pregnant. The nurse explains that she needs to go to the clinic but in vain. The reviewer saw young women weep openly as the role play was enacted. It seemed to have illustrated daily life vividly. (*Observation by reviewer in Feraana. Uchkuprik*)

c) FEP advocacy was unique because it worked not just at knowledge increase but also at developing a culturally appropriate enabling environment.

In its present form, one of the critical contributions of FEP strategies of family and community mobilization has been to target underlying family relationships and norms and in this way helped communities to **accept** the numerous messages, often radical (such as the need to look after daughters-in-law, husbands to contribute to child rearing, mothers-in-law to actively participate in IECD, modify food practices) and constitutes the first step towards changing attitudes and later behavior. The FEP had been able to target mothers-in-law and men (fathers and grandfathers) as per the Advocacy plan.

d) Local media was mainly used to report events and sometimes, educate. Its full potential to mobilize communities, though planned, was not implemented.

FEP had been advocated through local TV and newspaper channels, usually describing FEP events. National TV and other mass media have not been used so far. Overall, media coverage was poor, only 28 TV shows, 5 radio broadcasts and 19 articles in newspapers.⁴⁸ Although an elaborate Advocacy and Communication Plan had been developed for the strategic use of mass media, it had never been implemented.⁴⁹ The advocacy plan intended to gather data on children and families and various child-care practices to inform media messages. These were not implemented though planned in 2005.

I cover all the FEP community events in the Rayon Central newspaper and opened a section in the newspaper where I contribute articles on FEP twice a month. I have written on the modules and invite questions and answers. (*Volunteer journalist, Hilola Yunusova, Uchpukrik Rayon*)

Use of mass media, especially national, required large resources that included a rigorous needs assessments, baseline data, development of a strategy to disseminate messages to change behavior and constant monitoring for change and if necessary, course correction. Adequate resources for a full fledged media campaign were not available. Some other problems in using television was

⁴⁷ Interview with Regional Trainer, Zangiata

⁴⁸ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁴⁹ Advocacy and Communication Plan, developed by M.Chavez, FEP consultant

pointed out by deputy governors, such as irregular supply of electricity, lack of time for women to see TV as well as the ease with which viewers change channels and therefore miss FEP messages. They suggested that FEP messages be couched into popular TV soap operas or programs to ensure that messages actually reach the intended population.

3.4 Outputs and Outcomes

3.4.1 Changes in families

In the absence of a baseline and monitoring tools, it is difficult to state with certainty the contribution of FEP to knowledge and behavior change. However, certain trends were clearly indicative of changes in families. For the review, 23⁵⁰ families in Fergana, Tashkent region and Karakalpakstan were interviewed using open-ended questions⁵¹. Although the FEP was meant for all families, for the purpose of understanding how FEP impacted those most in need, families were selected purposively for the review – those having at least one child below 6 years of age as well as those who did not send their children to KG or those whose socio-economic situation was vulnerable. Volunteers were asked to select these families randomly on any street. The findings from these interviews were corroborated with FGD with volunteers and trainers.

a) Profile of families: 52% of the children in the families were below 6 years of age. Of these, half (21 children) were in the age group 3-6 years but only 28% (6 children) were in KG. These findings are slightly higher than the national average of 21% attendance in KG and are indicative of some impact of FEP. This finding is corroborated by evidence of increasing enrollment in state KG (see Changes in services 3.4.3). A few families mentioned that they were sending their children to KG because of FEP although the infrastructure was not up to the standard and it was expensive. To manage the expenses, children were enrolled in the last year of KG to make sure that they were ready for primary school.

b) Changes in knowledge: *a) All families stated FEP had given them simple health information regarding the need for iodized salt, exclusive breastfeeding, prevention of anemia by avoiding tea with meals and eating green vegetables, rest for pregnant and lactating mothers, need to drink clean boiled water to avoid diarrhoea and personal hygiene.*

Many families mentioned that they had heard about these messages from TV or from the health personnel or read about it. According to them FEP helped to reinforce these messages and ensure that they were followed. The follow-up by volunteers encouraged families to change behavior. Families also mentioned that many messages provided **specific information** that they did not know well e.g. breastfeeding should be exclusive for 6 months and its advantages; how to check the label for iodized salt, store it properly and use iodine testing kits (from volunteers) to check the level of iodine; to ensure that children washed their hands *every* time they ate or went to the toilet; that tea could be drunk 2 hours after food and that it should be avoided as far as possible with children and to substitute it with compote or juice. Volunteers corroborated the above. Volunteers stated that government programs were usually directives *and not aimed at families* but at specialists (such as doctors and nurses). That is why the health messages were demystified and easily understood.

⁵⁰ The Evaluation TOR expected 20 families to be interviewed

⁵¹ See 2.1 Conceptual Framework

FFL – Ten messages – a field translation

1. You have to provide pregnant women food rich with iron and iodine and you have to let them have rest.
2. Baby should be breastfed only with mother's milk for first six months. Baby does not need any other liquid, food or water
3. Boys and girls need food rich with iron and iodine for their physical, intellectual development. Use only iodized salt for cooking.
4. When you are breastfeeding your baby, show affection and sing songs
5. While educating your children use different games
6. Parents and other members in the family please find time to talk, play and tell stories to children
7. Tell your child that you love him and tell him often that he is dear to you
8. Please keep in mind that if birth intervals is more than two years, mother and child will be healthier
9. Always try to understand your child and be just to your child (do not punish unnecessarily)
10. Disabled children have a right to love and affection just like other children. Take care of them at home, provide all necessary conditions for the development. The affection and attention you give to the child in the family will strengthen the self-confidence of the child.

*b) All families particularly mentioned that they had learned for the first time, the **overall and broad need for psycho-social stimulation of children during pregnancy, and after they were born till they were six.***

The ECD messages recalled by families, that stressed cognitive development, care for and stimulation of children was in the form of key messages – see FFL messages 4,5,6,7,9,10. While such general messages were appropriate for 0-3, for the 3-6 year olds (and especially those who did not go to KG) far more rigorous, detailed and systematic ECD inputs were required. According to volunteers, FEP - ECD component for children especially for 3-6 was difficult to disseminate and volunteers felt that Methodist volunteers would be needed, as well as more follow-up with parents (as they lacked time) and more materials for children and parents responding to different age groups. Since about 80% children aged 3-6 did not go to preschool, the ECD component for children had become critical. About 75% of families interviewed reported that they had used the FEP children's materials or made toys and over 90% had read the FFL manual although all had received FFL calendars and were familiar with the messages.

c) More information was needed that targeted needs of older children, behavior of children at different ages and addressed fathers and older members of the family.

Volunteers, mothers and mothers-in-law stated that there was need for messages exclusively for fathers and older members and that FFL appeared to be addressed to mothers. As the widely disseminated FFL health messages pertain to 0-3 years more, many families with older children found messages on breastfeeding and safe motherhood irrelevant. Parents wanted more user-friendly information such as information on growth and development of older children and year wise description of possible ECD activities to be used at home.

c) Changes in attitude and behavior: *a) FEP changed attitudes by creating an enabling environment in the family:* Family relationships were addressed and mothers and fathers in law, as well as fathers were aware of their role in ensuring the health and well being of the children. These are extremely important in the Uzbek cultural context where families live together, family ties are important and women are not decision makers. By educating the *whole* family, the FEP

content was widely disseminated and access to services encouraged. Families were more receptive to FEP because messages were conveyed by respected members of the community (volunteers) and in a simple language. (Also see 3.3 c Advocacy section)

b) Volunteers and families reported changes in behavior related to all the health, cognitive and psycho-social messages but it is difficult to confirm with certainty as there was no baseline. Some have reported that families made a special corner or room for the children in the home where their pictures, books and toys could be kept.⁵² Families and volunteers reported that utilization of health services - check ups and referrals to health centers, asking questions to doctors and patronage nurses - had improved. Caregivers and volunteers mentioned that children looked forward to volunteers home visits and that mothers, fathers, grand-parents were more sensitive to the needs of children – looked after their health, told stories, played with them. Disabled children's needs were better understood and there was greater acceptance of disability among family members.

Enrollment increase in state KG was one indication of changes in parents understanding of ECD for their children. One of the **problems** that emerged was that parents are sending their children in the last year of KG (because of the high cost) as a result of FEP or selecting one from many children to attend the three years. Although a good sign, it also defeats the very purpose of ECD in that ECD is not just school preparedness but is valuable in its own right.

A study⁵³ indicated that breastfeeding went up to 94.6% in 2005 from 74% in 2003, 84% families practiced safe motherhood compared to 60% in 2003 and 84% families practiced prevention/management of childhood illness compared to 64% in 2003. Families' using iodized salt was 90% and number of families using proper sanitation and hygiene was 90% and using pure drinking water was 70%. Changes are probably due to a number of programs including FEP and in the absence of a baseline, it is difficult to attribute the change to FEP.

c) Some cultural practices were also discussed but whether there was any change in behavior is difficult to say.

Volunteers mentioned that some cultural practices were difficult to change for example, a new daughter-in-law should not bow down to all the guests during Id and other festivals as this might lead to a miscarriage or that there should not be many visitors during the first 40 days after delivery to avoid infection to the newborn, spacing of children and delaying pregnancy. Families corroborated the above. Some unhealthy childcare behavior patterns mentioned in the child rearing study had **not** been addressed such as, bishek use.

d) Behavior change was attributed to constant interaction with volunteers at home, in communities and at the resource center and use of available FEP materials.

Families stated that the advantage of FEP was that it was interactive, questions could be resolved and was accessible through trusted members of the community. Volunteers said that follow-up, checking on progress was important to bring about change. As a result, there was greater motivation for knowledge, attitude and behaviour change. The strategies used by FEP such as community events and role plays made changes more *acceptable* in families and communities as it universalized the change expected thus not stigmatizing any family member. TV was useful but not all watched it and many could not remember the specific messages mentioned in the program. Health personnel such as doctors and nurses also talked about many of the health messages but these were just stated and the reasons for not following a suggested behavior were not discussed.

⁵² FGD with volunteers, Uchkuprik Rayon

⁵³ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

In the same way, government decrees on the same health issues were *lectured* about without trying to understand why such behavior was practiced. IMCI program also received support from FEP activities. For example, in one makhalla, volunteers reported that anemia tablets provided by the patronage nurses used to be discarded but now, they are used carefully as families understand the ill effects of anemia better. In this way, the patronage nurse's work has become easier.⁵⁴ Available FEP material determined which behavior would change – the FFL messages and behavior associated with it saw change.

*e) Overall, families and volunteers reported that **all family members attended to children's needs.***

Fathers, mothers, older siblings and grandparents were more responsive to children's needs such as reading and answering questions to encourage their curiosity, treating them with love and respect, not shouting at them, parents not fighting in front of the children, finding time to talk and play with children, making sure children who did not go to KG were not loitering about but engaged in some activity - thus promoting a *rights based approach and whole family wellness*⁵⁵.

⁵⁴ FGD with volunteers Nukus

⁵⁵ See strategy paper FEP.

Voices from families

We now make sure that children's hands are washed *every time* before eating or going to the toilet, boil our water, wash hands before cooking. At the hospital, the doctor had told me of this but I had forgotten it. I learned from the volunteer that I should not raise my voice and punish my child, I should show my love and talk while breastfeeding. With my older one, I talk about shapes and colors of vegetables. I never knew that this helps my child to grow better.

When I go to the doctor, he asks me if I breastfeed. With my child he measures height and weight. But in FEP, I know that I must exclusively breastfeed, feed whenever he asks for it and that I should sing and talk to my child.

My mother-in-law gives me more time to be with my child, I read to him. His father also plays with him. We bought some story books and ABC books for my older child, I think he is developing quicker.

On the TV, I saw a program called Mothers School – it also talks of safe motherhood and healthy children. The message is the same but FEP is interactive and has more impact because it is so simple and I can ask questions.

My younger girl is brought up differently – she studies well because I learned I must interact, tell stories, sing and though she does not go to KG, I think she has done better than her brothers. I did not know about all this when they were growing up.

After the volunteer came and talked to me, I give my daughter-in-law a lot of rest, proper food and we have the right food not to have anaemia and use iodized salt. (A mother-in-law's voice)
I have talked about FEP to a lot of other people, I am older and so people listen to me (A mother-in-law's voice)

There is a lot of change in family members, earlier they were not interested in children. We never used to ask them about school. My husband and the child's father now make toys for the children, tell stories. (A mother-in-law's voice)

Because of FEP, I did not give my child any additional fluids, I go regularly for checkups and know how to make toys. My child has not fallen sick because I have only breastfed him. My mother-in-law knows the importance of diet and iodine and to go for checkup.

We attend the role plays – FEP is very simple, it talks about our daily life and the message is very simple. It goes into our head.

We did not know when the child is inside, we should sing or put music. Men were shy doing this but after one of the children was born smiling, he goes around and tells everyone what to do. (volunteer)

I ask for the kit to find out if the salt is iodized even if there is a label. We then tell the shopkeeper that the label is there but salt does not have the right amount of iodine. He has asked the volunteer for the kit as well.

In our culture, we expect children to be obedient but now we know we must talk to them, dance, sing and the distance between the children and us is not there.

In Zangiata, a paralyzed child got a first prize and in this way was accepted by all and not as disabled. He felt more confident.

3.4.2 Changes in communities

a) *Because of FEP, IECD has become a community concern.*

FEP involves a variety of volunteers from both education and health, addresses all members of the family and uses community events to create awareness on many IECD issues including child rights, disability, gender which are attended in large numbers attracting over 100 persons in the audience. Traditional social gatherings such as gap, weddings and other meetings (outside the mosque after prayers) are also used to spread awareness. In this way, FEP has become a natural extension of community events. Initially it was very difficult to mobilize people for gatherings, and parents would not even listen to the FEP. Volunteers had to play with children and gradually the importance of FEP was understood. Doctors also reported that self referrals had gone up from say 25% to 75%.⁵⁶

I was trained in FEP and as chief of the Health Center, I expanded the program to the whole district. I trained doctors and nurses in Rural Medical Points and in Rural Ambulatorys. In 2004, I trained over one day more than 57 nurses and distributed FFL. We had questions and answers and I also monitor and follow up with families. Because we have little material, I have developed posters and made printouts on the messages and distributed it widely at my own expense. I also give articles in the newspaper and educate population on FEP. One of the biggest advantages of FEP is its effect on hygiene and sanitation, there is no trash in the streets and there is less diarrhoea and hepatitis. Children drink boiled water, FEP is about ECD too and that is also important. *(Interview with male volunteer, Dr. Erkin Joraboiv)*

b) *Community events illustrated the changes in attitude – there were competitions and events for the disabled and children who did not attend KG, for men and mothers-in-law thus encouraging them to participate.*

As community members saw the educational impact of FEP in the way the children participated, attendance at the community events improved tremendously. There were also programs for men suggesting a dramatic change in the traditional culture – for example, competitions for young fathers were arranged in one rayon. Men – fathers and grandfathers – talked of their role in IECD for children at various social gatherings. In two regions, Fergana and Tashkent, a grandfathers group and a fathers group have been formed that advocate about FEP to men. This is truly a major change in a traditional, patriarchal society where children's issues are considered to be a woman's domain. Competitions for children with disability were popular and many of the children not attending KG won over the children attending KG.

⁵⁶ FGD volunteers, Uchkuprik Rayon

We are all Makhalla leaders and we went through a training on FEP for 3 days. We do not go to houses but we hold meetings and we have developed a program for FEP. We hold meetings and about 20-30 people come, we talk about FEP and there are questions and answers – since January 2005 we have held ten meetings. Since we are men, everyone listens. It is a bit difficult to talk of breastfeeding to women of course. What we do is we first talk to mothers-in-laws and daughters-in-law and explain the messages. Then we hold a separate meeting with the men and tell them that they should give money for good food. We also tell them that we are old, grandparents and we must talk to the children and tell them our experiences and speak freely with them. We as Chairmen, also have lists of poor families and we help them out too. We make sure there is a good link between health center, school and family. We believe there is less hepatitis and diarrhoea but we don't have a monitoring tool to tell for sure. We must have a lot of messages on the TV as well, say in the soap operas. Materials should be easily available, the Resource Center is too far away and we don't go there. *(Meeting with Grandfathers Group, Tashkent Region)*

We have a school for fathers because we realized that we would sit in the café and drink and eat and didn't bother about our children. Most of us missed our children grow. We involve young fathers, old ones and older ones and we exchange experiences. I am a male teacher at school and teach sports. I work with mothers and mothers-in-law and men, after I learned about adult learning methods. *(Report of fathers group, Fergana)*

c) Changes in behavior can be seen in pilot communities and in others as well.

KG teachers reported that mothers who came to pick their children from the school now asked about their child's progress. Others would visit the FRC if located in the KG. Still others attended parents meetings in school in large numbers and wanted to know how to improve the children's performance.

Evidence of the spread of FEP is available from the many volunteer efforts to spread messages into other makhallas in rayons, other health and education personnel. For example, in Uchpukrik Rayon, the national trainers helped the community to draw up a plan to expand the FEP to more makhallas and now it includes 22 (out of 44) makhallas. In Zangiata, one of the KG heads trained 34 others from various KG in FEP. In Karakalpakstan, many families wrote to government officials demanding more (and got) KG services.

3.4.3 Changes in use of services

*a) It was envisioned that FEP would create a demand for **ECD services** such as increase in enrollment for formal state KG as well as non-formal makhalla or family KG. Data indicates that although in many rayons, enrollment in state KG has increased, the demand is yet unmet.*

- In Karakalpakstan, the increased demand for ECD generated by FEP has led the local government to renovate and reopen old KGs. For example in Ellikala⁵⁷, of the 15000 children between the ages of 3-6, only 1500 can be covered in the 15 KG. These KG have 92% enrollment. Two branches of the FRC manage to provide some ECD service to another 50, but of these only 17 come regularly. The rayon government however has responded positively to these urgent demands for KG. In 2003, there were 6 KG with enrollment of 700 children, whereas in 2005 there were 1500 children enrolled. The Deputy Governor seeing the increased demand renovated and opened KG, generating

⁵⁷ FGD with volunteers Ellikala

- money through sponsors. In some KG, parents are also permitted to pay in kind and bags of potatoes are accepted!
- In Zangiata Katartao, children in the state KG increased from 188 to 250; in Nazarbent, in State KG 2 enrollment increased from 167 to 190 and in State KG 5, enrollment went up from 75 to 100.⁵⁸
 - These findings corroborate with that of an informal evaluation conducted by UNICEF, where number of children attending KG increased from 1776 in 2003 to 2697 in 2005 in the pilot makhallas indicating a 52% increase.⁵⁹

In the Soviet era, ECD and KG was synonymous with *free* day care facilities for women workers who constituted over 40% of the labor force. During transition, economic changes resulted in a closure of employment and therefore daycare facilities creating a large vacuum. State KGs are not free and charge an average of 5000 sums a month, which though not large is often unaffordable to families with several children. Primary education is free and not a financial burden. To ensure school preparedness, some state KG have started weekend schools, in other communities because of FEP, parents now send their children for just a year before primary school say at age 5 or 6 rather than at age 3 or 4. In a sense, this defeats the purpose of ECD, which propagates that ECD should **not** be substituted with mere school preparedness. The high cost of the state KG is because they are full day and provide food as well. Data indicated that in 2000, there were 6742 KG with 608,500 children enrolled and by 2005 there were 6629 KG with 564129 children enrolled, indicating a drop in enrollment. A Pre-assessment in Sukhandariya Region by Ministry of Public Education 2005⁶⁰ indicated that parents did not send their children to preschool because of the cost (49%) and because the mother was at home and could look after the child (24%). Other reasons included the distance of the KG, ill health of the child, and poor quality of education. The government will plan what to do once the study is completed which will review the alternatives to state KG. One of the options being explored was making the last year of preschool (before entering Std. 1) compulsory and to regulate and develop standards for non-formal ECD.

b) Non-formal KG and Makhalla KG were very few and served small numbers of children.
The FEP has encouraged the growth of non-formal ECD such as family KG (where children come for a few hours two or three times a week) or weekend KG at the state KG (e.g. in Zangiata they charge 1000 Sums but catered to only 18 children). However, most non-formal efforts were on a volunteer basis since the state regulates the establishment of KG and taxes income. Retired Methodists provide volunteer time in Zangiata and state KG Methodists do so in Karakalpakstan, in makhallas once a week for several hours.

Some children in FEP rayons have gone to Makhalla KG (supported by UNICEF till 2003) but deputy governors were not in favour of these, as they require the same monitoring as State KG, teachers are paid by the state and are in fact a competition to State KG. Makhalla KG charge the same fees and the only advantage was that they are located near to where the families lived. The coverage of existing Makhalla KG was very low – about 8 to 10 children in each KG.

A study⁶¹ indicated that number of informal preschools increased from 5 to 21 and number of children from 94 to 581.

⁵⁸ FGD with volunteers in Zangiata

⁵⁹ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁶⁰ Draft report findings shared by Yulia Narolskaya, UNICEF

⁶¹ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

c) Need to access health services were better understood to obtain information on prevention and seek timely treatment.

In terms of **health services**, interviews with families and other stakeholders indicated that caregivers, including decision makers such as mothers in law were more amenable to accessing available health services at health points and polyclinics. Additionally, families and volunteers attributed FEP to creating greater awareness, increasing knowledge regarding health promotion, prevention and treatment. Most stated that health knowledge was simple, demystified and therefore easier to act on. Since FEP educated *families* on health in a simple, interactive way, they believed that changes in health status and access to services were due to FEP efforts. Since no baseline data is available, it is difficult to ascertain this finding. Data on illnesses, safe motherhood practices was collected over the years during the review and change is visible but as there are many government and donor programs on the same issues, it would be difficult to isolate the contribution of FEP. For example, the Head of the Children's Polyclinic in Ellikala⁶² claimed that health department had trained doctors and nurses on all 23 modules and that they accompanied Makhalla Advisors to families. He claimed that there was a reduction in anemia, iodine deficiency, increase in breast-feeding and better referrals for children.

3.5 Management of the Project

Coverage: During 2003-05, FEP directly through family visits covered 10,498 families or 54% of total number of 19911 families in pilot makhallas. FEP covered 7972 children aged 0-6 or 75% of total number of 10,834 children in the pilot makhallas. Total number of children 0-18 in the pilot makhallas was 31,298 of which 70% were indirect beneficiaries by FEP. Overall in the 6 pilot rayons, FEP covered only 6% of total number of families⁶³. The urgent need to expand expressed by the government is understandable considering this reach. It is estimated that FEP reached 59% of total SVP and 48% of total KG in the rayon.⁶⁴ Pilot makhallas also took the initiative to expand the program to 44 neighboring makhallas, or 15% of total number of 280 makhallas which was 3.5 times more than originally planned.⁶⁵

FEP intended to cover **all age groups** of children from 0-18 but in a **phased** manner. The first phase 2003-05 was intended to work with 0-6, and over the next two years extend the program to address needs of 7-13 and then later to 14-18. This approach meant that it would take six years to complete the program and would not address the needs of children as they grew. In itself, the 0-6 age group was very complex and diverse in its needs and needed to be split into 0-3 and 3-6 to adequately address the changing needs of children. One of the problems that deputy governors mentioned was that families had children of different age groups and needed to be addressed. Transition societies like Uzbekistan needed to address the growing needs of adolescents such as HIV, drug addiction, crime, suicide, school performance, friendships, early marriage and so on.

However coverage of 0-6 years is itself poor. It is estimated that about 60% families in any Makhalla would require FEP.⁶⁶ Besides, current volunteers were older and communication gaps between generations would be difficult to bridge if FEP were to extend to older children.

Coordination: At the national level, the Pediatrics Institute coordinates with Deputy Chairman of Women's Committee, Ministry of Health, Ministry of Education, local Hokimyats and with

⁶² Interview during discussions at FRC Ellikala

⁶³ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁶⁴ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁶⁵ FEP-IECD: Informal Formative Evaluation Report, by Shakhlo Ashrafkhanova, UNICEF Uzbekistan, July 2005

⁶⁶ Kakun City FGD

UNICEF. Deputy Governors⁶⁷ at rayon level coordinated the program with assistance from either NGOs, hokimiyat or government departments to manage the FEP small grants. The FEP is backed up with the local hokimiyat's special decree⁶⁸ that outlines job responsibilities, timeline and reporting procedures. Every Saturday, Deputy Governors hold coordination meetings for various government programs and FEP. FEP is coordinated with many government programs and decrees such as the Year of Health, MoH decrees, Healthy Generation, flour fortification, for anaemia and goiter among others as well as donor programs. For example, in Zangiata the FEP program was coordinated with a WHO program related to educating the population on mother and child issues.

Since most of the work is at the rayon and makhalla level, the coordination at regional level (available in the early stages of the program) was discontinued because it added no value to the program. In addition steering committee meetings (Intersectoral Committee) are held which enable an interdepartmental and intersectoral management of FEP as there is representation from different departments and NGOs. The Intersectoral Committee consists of persons from different fields including medicine, local active NGOs, makhalla activists and advisors, education and others.

Although a number of regional trainers have been trained, national trainers from Tashkent have been 'assigned' certain rayons for training and other technical support and work at the makhalla level as well. Such a centralized system is familiar to Uzbekistan (under the Soviet rule) but the cost and logistics of such coordination are high.

Managing Partners: In 2005, small grants of about \$3000⁶⁹ were provided to each rayon to conduct FEP activities. To manage these grants, different organizations/departments⁷⁰ (for example, local department of education, Soglog Avlod (an NGO)) were appointed after discussions with the Deputy Governors. The role of these partners evolved and some were more active than others – for example, Soglog Avlod in Zangiata trained volunteers at the regional level, adapted FEP to respond to local needs, worked with the Deputy Hokim to coordinate FEP programs, incorporated FEP activities into other programs funded by government, UNICEF and other donors – such as advocacy for fortified flour (UNICEF program), Healthy Generation (state program), sports program for State KG and children not going to any ECD. Also on Child Protection Day, 200 children from FEP makhallas and 200 from other Makhallas came together for a children's event. The Soglog Avlod representative in Zangiata managed to use the grant efficiently for all Makhallas in the Rayon and ensured good coverage from regional mass media, such as newspaper, radio and TV. This managing partner also monitors volunteer effort. In case of expansion to rayons, the role of managing partners can be critical – for organizing, coordinating, training and providing technical support to volunteers and communities.

Linkages: As FEP is an integrated program, linkages with patronage nurses, Methodists, local NGOs and health and educational department's local personnel was important. Many volunteers were either of these, and often worked in teams. For example, in Zangiata volunteers reported that patronage nurses prepared a list of pregnant women who were not coming regularly to the polyclinic and with the FEP volunteers did home visits. FEP volunteers were able to convince the mothers in law and women about the benefits of going for checkups.

⁶⁷ Role was mentioned in Annual Report 2004

⁶⁸ See annex four for sample decree

⁶⁹ Grants support steering committee meetings, coordination money to Deputy Hokim, at least three big community events in which children under 6 have to be the focus such as on Child Protection Day or others, other groups such as Fathers' Group or Grandfathers' Group.

⁷⁰ In Uckpukrik and Kuva, the Dept. of Education; In Zangiata and Yangiyul, Soglong Avlom; In Nukus and Ellikala, the Dept. of Education

Patronage nurses are expected to visit homes and doctors from the regional Institute of Health have to work with communities for a certain number of hours. Involving such personnel in FEP has brought value addition to their work as well. However, FEP is not part of the job description of patronage nurses and doctors.

Institutionalization: FEP has become institutionalized within the Makhalla Committee and community. The newly appointed (Sept. 2004) Makhalla Advisor has been trained in FEP and also promotes IECD. Makhalla Advisors were appointed and received brief training, hence the FEP training spread over five days using interactive methods and good material have been very well accepted. The Women's Committee which appoints the Advisors has requested the UN organizations to jointly develop a training package for Advisors related to current developmental issues concerning women and children. All chairpersons of Makhallas have been trained and every Saturday, Makhalla Advisors come to the Deputy Governors office to report and learn about new messages. By institutionalizing coordination with the Deputy Governor and the Inter-sectoral Committee, FEP has become part of the rayon's programs. FEP is sustainable since it works with Hokimyats and involves both Health and Education sectors.

UNICEF's Role: UNICEF provided technical input for the development and management of the program – appointing an international consultant to design the program with relevant stakeholders in Uzbekistan recognizing both national and international priorities, selection of an implementing coordinating agency (which changed several times but now resides with Pediatrics Institute), field monitoring visits to develop coordination mechanisms with hokimyats and provision of support at the field level. In addition at the central level, links with the Women's Committee and the Makhalla Foundation were developed as changes in the structure of the Makhalla occurred with the appointment of the Makhalla Advisors. Hence, UNICEF also seized opportunities arising in the field. UNICEF also participates in Joint programming efforts with other UN agencies and has a dialogue with other donors and government health and education departments. In terms of financial support, UNICEF developed and disseminated materials and contributed to setting up of the Family Resource Center (Government improved infrastructure and bore this expense), supported training and coordination efforts at central and hokimyat, and provided technical inputs through the international consultant and its own staff.

3.6 Understanding Program Costs

Although it was not possible to have a detailed cost analysis as the evaluation was conducted by one consultant over four weeks, it is possible to understand how cost implications affected the project. Based on these broad findings, a detailed cost analysis may be undertaken.

In the consultant's expert opinion, the fund utilization was efficient and available resources were used optimally. The Family Resource Centers were established on a cost sharing basis with UNICEF providing materials and the state KG providing space and appropriate infrastructure. The Centers received sanction from relevant Education authorities. FEP staff costs were minimal as volunteers implemented FEP and patronage nurses and makhalla advisors (who are paid by the government) also received FEP training. In future, an inclusion of FEP implementation in their job description would make FEP sustainable and cost effective. There were constraints in materials production and dissemination because of the cost. In the consultant's opinion, the materials budget if realistically increased would ensure that adequate numbers of the desired quality are available. Measures to reduce cost by changing the design, better use of paper, color and size would be useful. Similarly advocacy budgets need to be realistically planned for especially if mass media is to be used. Training loads will remain high and available funds need

to be increased, with cost efficiency being realized through local decentralized training. By mainstreaming FEP into relevant programs and with other donors the costs can be managed so that increased coverage is also possible.

3.7 Monitoring and Evaluation

Volunteers filled in the **Family Information Sheets**, one of the monitoring tools for each area of the makhalla. The form included information on number of lanes, population size, number of households, number of families, number of children 0-6, 7-13 and 15-18. However, observation in the FRC and discussions with volunteers indicated that they were being used to collect data and not to monitor and evaluate.

Volunteers kept **diaries** but there was no formal system across regions of how volunteers should plan their outreach to families and how to modify it based on progress. Through field visits, UNICEF and national trainers also monitored the program.

An ongoing M&E system provides evidence to plan for targeted FEP dissemination. For example, in Nukus a pretest of young mothers on breastfeeding indicated that 70% had accurate knowledge, which increased to 100% after the FEP session. Such information provides guidelines to volunteers on efficient dissemination of information. This baseline also provided evidence on the high level of knowledge that already existed among young mothers.

Deputy Governors felt the need for a **simple system** of monitoring across regions and rayons to ensure comparability of data and monitoring of the progress of the project. Currently, there was no system available and in the absence of a baseline, it was difficult to state with confidence the contribution of FEP towards educational and health indicators.

Because messages do reach families and volunteers are the channel, it is very important that a good monitoring system be in place. It is possible that volunteers who are trained only once, who work alone (as in Phase II) are likely to provide their personal opinions as expert opinions and in the absence of other trained volunteers, there is no check and balance.

4. INTERFACE WITH RELATED PROGRAMS

4.1 Within the UN Family

WHO provides technical support to Ministry of Health (MOH) and promotes the latest research findings in health programs. IMCI (addresses children between 0-3 years) is one of the core programs where support is being provided and is closely related to FEP⁷¹. Of its three components⁷², the most important one is regarding educating parents and caregivers on child health. This component was the third in priority but experience has indicated that it should be promoted as the most important component in IMCI. There is a great deal of overlap with FEP. IMCI is being implemented since four years (there has been a 50% reduction in the funding although it is to continue to 2009) and WHO has provided technical inputs to Zrdaf Plus (begun in June 2005), Healthy Family Project⁷³ (USAID funded having a community IMCI component) by training ten national trainers who in turn then train physicians and patronage nurses involved in these projects. Patronage nurses are being trained as they visit the families and the content is similar to FEP – breastfeeding, supplementary foods, immunization, when to visit the physician. The IMCI component has been updated to include messages related to the cognitive development of children as well and in this sense is *very similar to the integrated approach of FEP*. The IMCI modules developed by WHO have been enriched in August 2005, renamed IMCI Care for Development to include cognitive and social development of children – how to play and communicate with children, relationship of mothers and children, stages of children’s development. WHO and UNICEF can collaborate so that there is synergy in overlap, in the information provided and the training of patronage nurses and physicians and FEP materials can be utilized. Similarly, ADB and the World Bank also have a community IMCI component in their programs (see next section). The National IMCI Center and the coordinating committee with representation from MOH could review the inputs of the FEP in relation to the IMCI component. By itself, the reach of all these projects is very limited and in order to widen the reach of the program, community IMCI needs to be promoted nationwide.

UNFPA has also tried to spread community awareness through its Reproductive Health program regarding, problems of early marriage, participation of men in family planning, contraception. The strategy was to involve men and mothers in law and it was operationalized through their regional partner, the implementing agency of Uzbek Association of Reproductive Health, and coordinated by the Deputy Hokim. There are many similarities with the UNICEF program in terms of strategy and so synergy is possible and needs to be explored.

A Joint Program by UNDP, UNICEF and UNFPA, requested by the Women’s Committee, is underway to strengthen the capacity of the Makhalla Advisors⁷⁴. The FEP project trains Makhalla Advisors and volunteers who together visit families, conduct community meetings and disseminate FEP messages. The Joint program proposes a four day training for the Makhalla Advisors, giving a snapshot on each of the core areas of the UN agencies⁷⁵ so that while visiting families, the Makhalla Advisors disseminate development and rights based knowledge rather than stereotypes or personal value based information. Because the Makhalla Advisors are already being trained in FEP, care needs to be taken to synergize overlap and not to ‘overload’ the

⁷¹ Interview with Faizullo Abdulhaev, Program Officer MCH, WHO

⁷² The other two components are increase clinical competence of health providers and health reform.

⁷³ Zrdaf Plus works in 9 districts of Fergana Region and Healthy Family works in two regions and in each region, two pilot rayons

⁷⁴ Interview with Dilafuz Heydarova, Program Specialist Gender, UNDP

⁷⁵ UNDP core areas are Gender, Domestic violence, Millennium Development Goals; UNICEF core areas are Child Protection and Well Being; UNFPA core areas are Reproductive Health and Population

capacity of the Makhalla Advisors. The four day training is expected to influence knowledge and attitudes of Makhalla Advisors, critical as they will be the frontline workers in the community. For these reasons a careful monitoring and support plan needs to be in place. The joint program training will be developed systematically with the piloting of the new manual, training of national trainers and a cascade training to follow. Each agency will monitor change in the knowledge, attitude and behavior of the community in its core areas and funds will be pooled for community events. Initially, the training will work with the regions in which the UN agencies are currently working in and will eventually train all 8000 Makhalla Advisors.

UNDP works closely with UNICEF in the implementation of the MDG. A close collaboration exists with the Improving Living Standards program in which UNDP works with two of the poorest regions. It helps the communities to develop local and regional plans based on the MDG. Although the projects deal with for example, water and sanitation or installing water pumps, the area where UNDP needs the expertise of UNICEF is in community mobilization. The project will continue its work in the Fergana region (also where FEP works), however the intersection with FEP would be in the health messages rather than the ECD ones. As a strategy, the community mobilization component is similar to what FEP believes in and has expertise about. UNDP would like to work closely with FEP on areas of involving community on water and health issues.⁷⁶

Within UNICEF, FEP can collaborate with ongoing programs of departments that also work with the age group 0-6. A good FEP- IECD program indirectly promotes issues related to children's health, ECD and child protection. Specific child protection issues such as child abuse and child trafficking have been addressed in UNICEF through the Child Protection Department. FEP currently reaches out to all families in the Makhalla and can identify those families most at risk, children who do not go to school and are labourers, disabled children and children who are abused and neglected. By identifying and working with such vulnerable families, FEP has the potential of addressing child protection issues and mainstreaming them within the makhalla. Available resources such as the Women's Resource Centers could be utilized and double up for FEP Resource Centers as well if the location and other logistic issues work out. Such use of available infrastructure could cut costs and enable future expansion of the FEP. UNICEF's Child Protection Department also supports the government in developing curricula for social work at the university. Once the first batches of social workers roll out in a couple of years, development expertise will be available locally for FEP. Under the Soviets, social work was synonymous with geriatric care, but not with development. A modified version of development curricula used for social workers could be utilized to strengthen the technical resource base of management organizations such as Kamolot, Soglom Avlom, Oyla involved in FEP's training and community event management and other development programs.

4.2 Other Donors

International donors providing support to various educational and health programs for infrastructure, supplies and training to health and educational specialists have expressed interest in mobilizing communities to create awareness and a bottom up demand for services. Some of these donors have worked with FEP on a small scale but collaborations so far have been for specific tasks such as a training program rather than joint programming.

⁷⁶ Interview with UNDP

The **AED**⁷⁷ implements a Regional Training Project for Uzbekistan for various USAID projects, such as Zrdaf Plus, in four strategic areas: Democracy and media; Health education; Energy and water management; and Enterprise and finance. FEP would fall into the strategic area, Health Education. AED collaborated with FEP national trainers to train teachers and nurses at a regional level. The training however covered only 24 persons. Like FEP, AED has also trained SVP nurses on adult communication skills and with Zrdaf Plus, implemented health lessons in schools. AED and other USAID projects could utilize FEP materials and training curriculum in the designated geographical areas (for example, both FEP and Zrdaf Plus work in the Fergana region), provided USAID norms and procedures are followed to procure funding.

Zrdaf Plus is implemented in Fergana region and will cover all rayons by 2009 in that region. It trains doctors and communities on IMCI components (such as diarrhoea, breast feeding, immunization, clean water, anemia and nutrition). Zrdaf Plus includes health campaigns through mass media (messages in soap operas, organized through the Institute of Health) and booklets containing IMCI messages. In addition, grants are given for Makhalla Initiative Groups, represented by influential leaders, doctors, etc) which is linked with SVP, to promote community events to popularize IMCI messages. It is this component which is the same as FEP. Health corners have been developed in the Central Rayon hospital, however only those who actually have reason to visit the hospital use the corner. Zrdaf Plus can train Makhalla Advisors and help in the organization of community events.

One of the largest donors in Uzbekistan is the World Bank and ADB. They fund both health and education sectors (with the World Bank primarily focusing on health and ADB on education) and since FEP is an integrated approach that straddles health and educational components, there is room for synergy and collaboration.

The **World Bank** initiated the 40 million Health II project as a follow on to the 25 million dollar Health I project which intended to improve rural health care services through improved infrastructure, retraining of specialist Doctors in family medicine and curriculum change in medical curriculum. The project however was limited to only 3 oblasts. The Health II project building on lessons learned would continue the work of the Health I project as well as collaborate with the ADB's MCH⁷⁸ program through a joint implementation body. Significantly, this new project will work on public health issues, which among others, includes addressing children's needs under 5 years as they are frequent visitors to the rural health points. Since much of the work in PHCs are related to women and children, this area will be the focus of support from ADB.⁷⁹ Although a large component of the ADB MCH program (begun in March 2005) will strengthen the infrastructure at SVP and central rayon hospitals related to maternal and child health, it will also strengthen the capacity of the Institute of Health to deliver health education. The training of patronage nurses, midwives, paediatricians would build on other trainings on IMCI, breastfeeding and other neonatal issues and collaborate with Zrdaf Plus, UNICEF and CDC.⁸⁰ In the project, patronage nurses are considered a vital link as they visit families. Most patronage nurses, unlike the nurses at the SVP are new graduates, usually under 20 years and with little experience. Over a period of five years, using a cascade approach, all patronage nurses will be trained in monitoring the health status of 0-6 children and educating the families on various health issues of mothers and children. Leaflets, videos, kits for patronage nurses will be developed. In the last mission, it was agreed that information would be IECD, jointly developed

⁷⁷ Interview with Shakroza and Borikhari, AED.

⁷⁸ Has four components a) Improving system of MCH protection b) Finance and health sector reform c) safe use of blood and d) management, monitoring and evaluation and the use of MIS

⁷⁹ Interview with World Bank

⁸⁰ Interview with ADB...; Nigora Karabayeva (ADB)and Shukrat (with regards the Public Health component) Health II World Bank

with Ministry of Health and Ministry of Public Education. The government will contribute and provide teaching rooms at rayon level and thus make the training and retraining a sustainable process. The content of training, use of interactive methods and other matters related to training will be finalized following a formal needs assessment study. UNICEF's FEP program because it trains patronage nurses on IECD and has materials available should be in a position to dialogue with ADB and World Bank regarding technical support to patronage nurse training. The biggest advantage for FEP is of the large scale – all patronage nurses will be trained in this project.

The project also plans to develop Health Committees at Makhalla level consisting of community leaders and activists who will also receive training to ensure families avail of health services. As one of the major components in the ADB and World Bank is community mobilization to address health problems such as high IMR, lack of exclusive breastfeeding and others, collaboration of UNICEF can be explored. The ADB project also plans to have \$100,000 funds for small grants to makhallas to improve health (currently under negotiation with Counterpart, an INGO and USAID). The grant will be awarded on competitive bids to tackle problems related to children such as, prevention of infectious diseases such as through a campaign for washing hands or changing old water pipes or training on hygiene. A collaborative attempt with Zrdaf Plus, UNICEF and ADB would enable a synergy and pooling of resources – materials, approach and trainers.

The **World Bank** will also provide a *Basic Education* package for 1500 schools and 692 KG, covering children in the age group 3-11, managed directly by the government (through the appointment of coordinators and not an Implementing Agency). Schools and KGs were selected on criteria so that the most remote and poor schools were included from seven regions – Samarkand, Bukhara, Navoi, Kashkadariya, Sukhadariya, Khorezm and Sirdaria. Of the five components⁸¹ of this project, two are relevant to the FEP – strengthening of School Boards promoting the involvement of parents, school and community and the provision of learning materials. Since FEP works directly with families and communities and uses learning materials developed for IECD, both may be shared with the World Bank project in order to avoid duplication and better utilization of resources. FEP has expanded the project since June 2005 to some of the regions covered by the Health II and Basic Education Projects. Like the FEP, the Basic Education project wants to create a demand for KG services, encourage parents to send their children and learn about ECD concepts and materials. Further, it believes in providing small grants to communities to manage some of the awareness building activities required for parents to access services. Like FEP, the World Bank project will also train Methodists and other teachers to communicate with parents and communities on age related educational issues. UNICEF's experience with families and communities in FEP would help in the implementation of these World Bank and ADB projects.

In 2006, **ADB** plans to commission a needs assessment study for ECD to design ECD programs in 2007. It will review and explore initiatives like the FEP towards program design.

⁸¹ The five components are a) Provision of learning material through government and ADB support which will include visual aids, textbooks and other materials. Approximately 30-35 million dollars out of 40 million are earmarked for this. b) Redesign training of teachers so that teachers can acquire skills to teach other subjects than the ones they currently teach + use interactive methods. Methodists will also receive training. c) strengthen school boards to involve parents through establishment of parents committee and community committee. Parents will review the teaching quality in school and receive help in reading the new Latin script so that they can contribute to the education of their children. It is proposed (not yet approved by government at the time of the review) to provide small grants of \$2000 to schools at Makhalla level for improvement of school services based on competitive bids. d) Finance and management – to empower schools and Headmasters regarding fund management and transparency in transactions. Schools will be encouraged to innovate, improve services and attract more students and therefore greater funds for school management. e) monitoring and evaluation of the project.

4.3 Government

To educate the population on health knowledge is a priority of the government. In each region, there is a local Commission in Charge of programs that reports quarterly about health information dissemination and involves education, health and civil society sectors. For example, even soldiers and children are given information on reproductive health.⁸²

Ministry of Health: MCH is a government priority⁸³ and a number of decrees have been declared. Over the ten years of independence, the reproductive statistics have also improved especially in the high birth rate and maternal mortality rate. Earlier the only regulation of birth was through abortion but advocacy regarding oral contraceptives had helped. Decree 242 in 2002 supports the healthy growth of children and the important role of mothers and the FEP supports these initiatives. Other projects in rayons such as the Healthy Family Project, World Bank Health II (in 8 oblasts) and the ADB MCH (in 6 oblasts) were other initiatives supported by the government and coordinated by the Deputy Hokim at the rayon level. All these programs have a community component and at the end of the project would have trained over 12000 patronage nurses on community health. The Ministry of Health believes that FEP can play an important role (with the FEP national trainers and available resources such as modules) in these health initiatives of other donors because it has an integrated approach and has expertise in reaching communities and families. MoH and Ministry of Public Education have already approved FEP and FEP's impact on communities was evident at the National Conference held this year. MoH would like a wider reach geographically and in content to include adolescent needs as well. Mass media should be utilized to advocate for FEP and to advocate some recent health messages of MoH (2003) such as avoiding tight swaddling, partner delivery (relative should be present and support the mother during delivery), use of bisheks, exclusive breastfeeding. By involving MoH, there would be a planned overlap with other programs such as Zrdaf Plus. For sustainability, MoH believed that FEP should continue to train Makhalla Advisors and have a strong monitoring system in place.

Women's Committee: Chairpersons of Women's Committees are the Deputy Governors at Rayon and Region and coordinate FEP programs (and other development programs) in the field. The Makhalla Advisors are being trained in each Makhalla instead of a number of volunteers as was in the first phase to reduce the training load and expand the program. Although a good step, it would be necessary to identify committed activists to assist the Advisor. FEP training had been very useful for the Advisors and the Women's Committee had further asked the Joint UN program to strengthen their capacity and orient them on various developmental issues. Makhalla Advisors can visit a maximum of 5 or 10 families a day. If FEP is to scale up, it must train doctors, nurses, Methodists, school teachers and members of Women's Committees (found in each Makhalla) to spread FEP messages. Women's Committee at the Makhalla level has a Chairperson and street leaders who also need to be trained. Although FEP has worked with 0-6 age group and much needs to be done, the Women's Committee expressed the need to expand to up to 14 years, over 38% of Uzbekistan's population. Geographical expansion was also a demand considering the size of the country and the enormity of the problems. Women's Committee also suggested that men be involved by ensuring that all Chairpersons of Makhalla Committee undergo training.

*Institute of Health:*⁸⁴ Established in 2001, it was merged with Information and Analytical Department of MoH. It implements a project called Healthy Family, which promotes healthy

⁸² Interview with Deputy Governor, Fergana, Ms. Mavlyuda Khodjaeva

⁸³ Interview at MoH

⁸⁴ Interview with first Deputy Directors Magdalev Olimjon and Gorbunova Irina and Methodologist Isakjanova Aidm

lifestyles. It has 14 regional branches and 157 health centers in rayons and cities and works with Oila Center, Soglom Avlod, Komolot, Salomaklit and others, including Makhalla Advisors to spread health messages similar to FEP. The Institute uses mass media free of charge once a month for say 15 –30 minutes to air health messages usually through interviews regarding anemia, diarrhoea, safe motherhood. It could collaborate at the regional level with FEP and use mass media and their staff in rayon level could be trained on FEP. Doctors in regions and rayons have a responsibility to visit families and communities and schools and according to their job description, are to spend 4 hours a month working with communities. During cotton picking season they talk to people in the field. They also train patronage nurses and staff at SVP. They worked with Komolot in schools to deliver the Lessons for Health in primary and Healthy Lifestyles for older children.

*Department. of Preschool, Ministry of Public Education*⁸⁵: FEP is useful as it helps parents to understand the importance of early socialization and preschool and work at home with them. It also influenced attitudes towards disability. In this way it supports government priorities of ECD. The World Bank loan is going to support 560 KG in both materials and teacher training, in which FEP can play a role. Although FEP trains Makhalla Advisors and a few doctors and teachers, it is important to involve more with an educational background and those who are trained need to work together as a team. FEP is the only program to reach parents and MoPE recognizes this. In-service training should also include FEP. A study is under way with UNICEF to understand why parents are not sending their children to KG. One of the major reasons is financial and decisions have to be made how to help families if preschool is made compulsory. Because FEP changed attitudes, it could be extended to work with young people's issues such as — early marriage, conflict with parents, religious fanaticism.

4.4 Local Organisations

Uzbekistan has a variety of organizations that can assist in the implementation of FEP. In the pilot phase, UNICEF managed implementation by coordinating training and supporting activities at the makhalla level. This human resource intensive pilot phase would require support from local organizations if consolidation and expansion are the next step. These local organizations are recognized and supported by the government and thus have credibility in the regions, rayons and makhallas. Profiles of some of these organizations are provided below – further institutional appraisal would be required to understand how they could technically contribute towards the implementation of the FEP.

Oila Foundation established in 1998 with regional offices called Family Centers, has expertise in pedagogy and economics and works on issues related to families – medical and biological, economic, rights, psychological and spiritual and demographic changes. Oila works closely with the Ministry of Public Education, Women's Committee and other donors⁸⁶ and has gained experience in training, research and program implementation. Based on a study on disability, it initiated (with UNICEF and government support) a home-based education program using part-time home teachers for children with disabilities. Lessons learned indicated that parents often need professional support to provide for the educational needs of disabled children, sharing experiences through parents groups helped to address stigma and that progress of children has to be carefully monitored against indicators.

⁸⁵ Interview with Feroza Vakhobova, Head of Preschool Dept., M of Public Education

⁸⁶ Disability Study with UNICEF; Micronutrient Study and training with ADB; HIV program with Global Fund; Study of Tobacco smoking among Young people are some of its past works.

The Makhalla Foundation: It builds on the natural community or the Makhalla. Sometimes, several Makhallas may also come together to form a Makhalla Union. It is responsible for ensuring all the members of the Makhalla Committee are in place. Each Committee has a Chairperson, Secretary, Internal Security Officer and a Makhalla Adviser, which was a new position, introduced last year. All these are paid positions. The Makhalla Advisor is part of the Makhalla Committee but appointed through the Women's Committee. Makhalla Foundation has branch offices at oblast and rayon.

*Soglom Avlod Foundation:*⁸⁷ A 12 year old organization, it focuses on the medical and social needs of families. With 14 branch offices and mobile clinics, it maintains social and demographic data and can reach out to families. Its staff also has a combination of medical and education expertise. It works closely with MoH, MoPE and Ministry of Social Protection (which works with disability). One of the regional offices in Zangiata is closely involved in managing the FEP program. The organization currently trains volunteers and feels that the 5-day training is barely sufficient for 23 modules and although for scale up, cascade training is inevitable, it is necessary to monitor quality.

Currently there is no follow up and in expanding; there will be need for more national trainers who will have to supervise regional trainers well. The volunteer training load will always be high because about 30% turnover is to be expected. Any involvement of local NGOs would require a systematic plan to build capacities so that technical support can be provided at grassroots and not be directly provided by national level organizations or donors such as UNICEF.⁸⁸

5. INTERFACE WITH INTERNATIONAL INSTRUMENTS AND STRATEGIES

5.1 MDGs⁸⁹ and PRS

The eight MDG are a global project and adapted in each country so that its priorities and targets may be set. During the Soviet era, Uzbekistan had high levels of human development and scored high on the MDG on most categories. However a transition to the market economy has resulted in tightening of public resources, closure of factories and decline in real income requiring a review of Uzbekistan's achievements and future plans for the MDG. The closure of factories and cooperative farming where a large number of women were employed also meant the closure of day care and ECD services provided by the employer for children under 6 years.

The Living Standards Assessment 2002 (World Bank,) estimated that 27% of the population in Uzbekistan lives below the poverty line and does not have the means to ensure a daily minimum calorie intake of 2100 calories. The MDG is relevant to FEP both directly and indirectly. Five out of the eight goals are related to the well being of women and children and relevant to FEP as it promotes an *integrated* approach to ECD and addresses the whole family, including mothers and caregivers. Further, an improvement in living standards (MDG goal 1) will indirectly affect enrollment to KG. Poor families with many children were unable to access available KG because of the 'high' fees, thus depriving children of ECD services although approximately 7.4% of GDP is allocated to education and government spending per student at the pre-primary, vocational and higher levels is above international standards. MDG Goal 2 is achievable if children have access

⁸⁷ Interview with Alimodjanova Dilbar Director and D. Shazipova (national FEP trainer);

⁸⁸ Because of the shortage of time other NGOs could not be interviewed such Kamolot. However suggestions regarding local NGOs pertain to all.

⁸⁹ MDG Development Goals in Uzbekistan, UN Country Team and ADB, Tashkent 2004

to and are enrolled in a good ECD program prior to entering primary school. MDG 4 and 5 is committed to increase the level of health knowledge of the family and resonates with objectives of the FEP.

It is hoped that baseline studies will be conducted for MDG advocacy as the UN system intends to increase its support to the government to monitor MDG.⁹⁰

Related to PRS (also see above, Living Standards Assessment)

Uzbekistan enjoys a 99.3% literacy rate (2003), however in conformity with ensuring quality education, it recommends increased enrolment rates for state preschool institutions and suggests non-state and home-based services as well with shorter hours to make pre-school more affordable⁹¹. It overall also recommends the strengthening of quality of teachers and children's materials. All of these have been addressed in FEP and the need for services has been highlighted. It also recognizes that with the improvement in living standards, children's well being will improve. Although a number of institutions and organizations are involved in the well being of children, it also recognizes the need to streamline, rationalize and have appropriate indicators. In this sense it resonates with the recommendation that FEP needs to establish a baseline, clear objectives and indicators so that progress can be monitored.

MDG Goals and Targets for Uzbekistan (in italics)

- Improve living conditions and reduce malnutrition: *By 2015, halve the proportion of people living in poverty*
- Improve the quality of education in primary and secondary schools: *By 2015, improve the quality of primary and secondary education while maintaining universal access*
- Promote gender equality and empower women: *By 2005, achieve gender equality in primary and general basic secondary and vocational education; by 2015, improve gender balance in higher education.*
- 4/5.Reduce child mortality and improve maternal health: *By 2015, a) reduce by two-thirds the mortality rates among children aged between*
- *0-5 years, b) reduce maternal mortality by one third. Undertake measures to adopt internationally accepted WHO live birth definition.*
- Combat HIV/AIDS and Tuberculosis: *By 2015 a) make sure that country's policies and programs protect the environment for today's and tomorrow's generations and reverse the loss of environmental resources. b) increase the share of rural and urban population with access to an improved water source and sanitation.*
- Ensure environmental sustainability: *By2015, make sure that the country's policies and programs protect the environment for today's and tomorrow's generations and reverse the loss of environmental resources b) increase the share of rural and urban population with access to an improved water source and sanitation.*
- Strengthen Uzbek's global partnership: *Tentative targets are: a) to ensure partnership with regional neighbors and other countries by joining efforts to promote regional peace and stability b) expand trade including regional and cross border trade and transport c) attract foreign direct investment and d) rationalize water and energy management*

⁹⁰ CPMP, UNICEF Uzbekistan, May 13,2004 Pg. 3

⁹¹ Based on the Welfare Improvement Strategy Paper of the Republic of Uzbekistan for 2005-10, Interim Document

5.2 CRC, CEDAW and HRBAP

In 2002, to monitor the progress of the country towards implementation of the CRC, UNICEF and the Cabinet of Ministers agreed to monitor the achievement of 33 basic mother and child development indicators reflecting quality of life and living standards⁹².

Uzbekistan ratified the **CRC** in 1992 and **CEDAW** in 1995. In 2001, it submitted its first national report on CRC implementation. Concerns of the committee related to the need to have disaggregated data from 0-18 and that data needed to be systematically collected and used to assess progress. The committee also pointed out serious policy gaps in ECD and low awareness of families (in spite of high literacy) regarding well being of women and children. It also commented that family education was based on traditional stereotypes and did not empower families and communities.⁹³

FEP addressed several CRC articles of rights to survival, development and protection – care, nutrition and education. Some of the articles that relate to FEP are – increase social responsibility towards children’s education; (Articles, 2, 28, 29); children have a right to play, leisure and participation (Articles 31 and 12); joint parental responsibility to raise the child (article 18); child has right to highest level of health and health services (Article 24)

FEP is directly related to the **Country Program’s** goal under CRC and CEDAW which is to strengthen the ability of the state to meet its obligations towards improving children’s, young people and women’s rights to live, grow up and develop in a nurturing, caring and protective environment.⁹⁴ This will mean that using a Human Rights Based Approach and Results based Management, decision makers need to be oriented on using monitoring tools that provide age and gender specific data and therefore better targeting of *integrated* efforts. This will influence decisions regarding the geographical expansion of FEP and how to monitor efforts.

FEP’s HRBAP approach ensures that the **vulnerable**, children who do not go to preschool are addressed and ensures that the disabled and girls are equally addressed (also see Annex six and seven for questions related to this as part of the review). As the FEP follows the HRBAP approach to programming, it has trained available volunteers in the community thus creating ownership and building sustainable pools of expertise at grassroots. These **rights holders** are now in a position to understand the critical IECD needs of young children. This approach however also highlights the need for **duty bearers** such as government, national and local, to provide affordable, accessible and responsive services for IECD, which have emerged as major gaps in FEP. There are also no dialogue mechanisms in place that can ensure that rights holders and duty bearers can together work on policy change nor are there any **advocacy skills training** for rights holders to lobby for services.

⁹² MDG Development Goals in Uzbekistan, UN Country Team and ADB, Tashkent 2004

⁹³ CPAP, Draft 26 Jan 2005 Pg. 6

⁹⁴ Country Program Management Plan (2005-09), May 13 2004

5.3 UNDAF and RBM

The FEP program is in accordance with the Uzbekistan CPAP Results and Resources Framework (2005-2009) under the *program Good governance achieving women's and children's rights*.

FEP falls under the UNDAF expected *outcome #2* which by 2009, will achieve universal access to quality basic education and *outcome 2.3*, families child rearing practices for child survival, development and protection are improved in priority areas. Without baselines or monitoring tools, it will be difficult to reach the targets outlined in the UNDAF.

Within this outcome, **baselines** were not available to assess families and communities' childcare practices (2.3.3), skills of frontline worker to deliver ECD information in priority geographical areas to parents and communities (2.3.2). For these reasons, targets for 2.3.2 and 2.3.3 would be difficult to achieve. The knowledge of families in childcare practices according to the Child Rearing Study 2003 was 35%, but it is difficult to assess if by 2009, 80% families would have acquired knowledge (2.3.1), if this were not being monitored.

FEP also partially contributes to *outcome #5*, by 2009, strengthened government and civil society capacity and partnership towards more effective governance and *outcome 5.1*, enabling environment for civil society to participate actively in the development process. This outcome will be achieved if institutionalization of FEP, already begun with the involvement of makhallas, rayons and local NGOs, in coordination is strengthened further with capacity building. These administrative units and NGOs would then need to support communities in local decision making by providing necessary training and inputs.⁹⁵

To achieve these results the CPMP has outlined the need to increase the coverage to 80% in the selected areas and to ensure there is policy support for expansion of the project as past lessons have indicated that pilot projects remained just at that level.⁹⁶

The Uzbekistan UNICEF team using a **results based approach** managed the implementation of FEP. A number of the changes that occurred (See section 3.1 Progress against plans) were based on responses to changing environments and lessons learned in the field through a large number of field visits, FEP design consultant's visit and feedback from deputy governors, volunteers, trainers and community. UNICEF's critiques on IECD internationally and regionally (applicable to the uniqueness of the Central Asian needs) also helped to refine the approach. In fact, the need for an evaluation is a direct response to this approach – the need to know what FEP has achieved and what its coverage and scope is. However, to ensure that FEP fulfills in its entirety the requirements of a results based approach, clear objectives and indicators need to be designed, followed by a baseline. In the absence of these, it would be difficult to develop a best practice results based management (RBM) for FEP. The current program has emphasized process (over results) as it was still in its initial phase but needs to refocus in the light of these requirements.

5.4 MTSP (2006-09)⁹⁷

The new MTSP does not include ECD as a term although essential concepts have remained. The Focus Area 1 (FA1) has four result areas of which one is “improve family and community care

⁹⁵ See UNDAF sections pertinent to UNICEF

⁹⁶ CPMP, May 13, 2004 Pg. 9.

⁹⁷ ECD Communication Workshop, 2005 by Deepa Grover, UNICEF RO CEE/CIS

practices that impact on child survival, growth and development in all countries”. Within that it relates to Key Result Area “improve family and community care practices that impact on child survival, growth and development”. This in turn has three targets a) increase by 50% the number of families using appropriate care and feeding practices for child survival, growth and development b) increase by 50% families with access to services and resources to promote child survival, growth and development c) all program countries have an enabling policy environment for improved family and community practices.

The FEP also falls into Focus Area 2 (FA2) – Basic Education and Gender Equality in which it relates to the Key Result Area “Children’s developmental readiness to start primary school on time improved, especially marginalized children”. Here two targets are relevant a) Increase proportion of children starting school at the prescribed age by at least 40% of the gap to achieve 100% by 2015. Increase from 6 to 40 the number of countries that have developed nationwide standards for monitoring developmental readiness. Therefore in the new MTSP, FEP-IECD is also integrated with the FA1 falling in the health sector and FA2 falling in the education sector.

In this way, **FEP is based on HRBAP**, ensuring that rights of children in both CRC and CEDAW are addressed. **Gaps** exist, as there is lack of understanding by partners of the holistic view of ECD, the need to have extensive resources (financial and human), how to ensure behaviour change in families and how to sustain activities, and how to measure impact on children. Therefore, it has been recommended that UNICEF involve government and other stakeholders in developing and signing on to an IECD Strategy that is more in alignment with the new MTSP.

6. WAY FORWARD

6.1 FEP according to the OECD-DAC evaluation criteria

The following analysis is possible as the conceptual framework of the review ensured that evaluation questions supported the OECD-DAC criteria. (See Section 2.1 Evaluation Framework and Annex Six and Seven). The matrix below is a succinct synthesis from findings reported using the Key Result Areas framework. (See Section 3.2 Inputs and Process and Section 3.4 Outputs and Outcomes) citing specific evidence with special focus on issues relevant to the OECD criteria.

<p>Relevance: What is the value of intervention in relation to 1) the national and international partners’ policies and priorities (including MDG, UNDAF, PRS); 2) the global references such as the CRC and CEDAW; 3) the MTSP, the CCC, HRBAP and RBM? Do final beneficiaries-families and communities regard IECD-FEP top priority compared to other immediate issues and MDGs?</p>	<p>FEP is closely aligned to national priorities as it is based on development indicators and a child rearing study that indicated the need to address children and family well being and childcare practices. Section 4 describes in detail the alignment of FEP with international priorities MDG, UNDAF, PRS, CRC, CEDAW, MTSP, CCC, and HRBAP. The FEP review has been developed using the RBM (see Section 2 Methodology, 2.1 Conceptual Framework. Evidence from the review indicates that IECD-FEP is top priority as there is a great deal of community mobilisation towards FEP events and numerous preschool efforts – both formal and informal. (Also see Section 3.4.3 Changes in use of services and 3.3 Advocacy and Communication</p>
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<p>Efficiency: Does FEP use the resources in the most economical manner to achieve its objectives? How many materials have been developed/published? How many trainings have been held? How often are FEP Resource Centers (RC) being used? Was the cost spent for 6 FEP RC worth doing it against expected/achieved outputs? Should this practice be continued? Is it worth continuing trainings on community level in pilot communities?</p>	<p>FEP is truly a volunteer effort and if the cost contribution of these volunteers were estimated, FEP would be extremely cost efficient in the use of human resource. FEP also dovetails into the work of Makhalla Advisors and patronage nurses. A Trainers' Manual, Stages of Development of children – A Family Activity Booklet, Children's Kit and Poster calendars were developed. FEP materials were in short supply (1100 FEP sets for 6 rayons and 40,000 FFL copies) and they were rotated and shared. In addition, small booklets were prepared and distributed. Many volunteers printed materials on their own. Volunteer trainings were held and they in turn 'trained' a large number of people in the community (over 150 trainings) although some criteria needs to developed regarding what is training and what is sensitisation. The use of FRC (currently about 135 persons use 6 FRC monthly) needs to be encouraged to justify the expense. If expansion were to take place, regional trainers would need to take more responsibility at rayon and makhalla level than the national trainers.</p>
<p>Effectiveness: FEP phases/modules were structured as follows: 2003-2004 - development of materials and conducting trainings in selected pilot areas for children ages 0-6, 2005-2007 – for children ages 7-13, 2007-2009 –for children ages 14-18, whereas family education is to be intended for children of all age groups. This is both neither effective nor efficient in terms of timing, efforts, expected results against set overall goal and specific objectives for FEP. Therefore, the following questions should be considered: What is the quality/appropriateness of programme design? Are FEP's activities achieving satisfactory results in relation to stated objectives short and long term? What is the quality/sufficiency of FEP trainings/training materials? What is the quality and sufficiency of volunteers' contacts with families? Is list of indicators and internal monitoring scheme by volunteers' sufficient/relevant to achieve stated results? What is the communication/advocacy strategy for FEP? Is it effective?</p>	<p>There is a large unmet need for 0-6 and the review indicated that although needs for 0-3 were met to some extent, the ECD needs of 3-6 were only generally addressed and there was a paucity of services. Firstly, this age group needs to be split into 0-3 and 3-6. Although families have children of different ages and there is need for family education, the delivery of FEP currently is with Makhalla Advisors (40+ years) and family visits. To expand the program to other ages, families may be targeted using the school as the venue for FEP. Therefore in the short term, FEP has achieved its objectives but in the long term, a number of issues would need to be addressed to make it more effective including expanding the volunteer base by piggybacking on other donor programs to reduce training load, involving managing partners at the rayon level to take more responsibility for training and technical support (instead of relying on UNICEF and national trainers). Similarly the different strategies of FEP – family visits, community events need to be judiciously planned and clear objectives with indicators and a baseline needs to be in place. Long-term objectives of behaviour change are difficult to ascertain with certainty, as there is no baseline. The community advocacy strategy is an effective means of mobilisation and is explored</p>

	in detail in Section 3.3 Advocacy and Communication.
Impact: What are the results of intervention in terms of behavioural changes on individuals, communities, institutions (e.g. preschools, local medical points) against set indicators?	Section 3.4 details changes in families, communities and services, which denote impact. Without baseline, impact cannot be stated quantitatively but trends indicate that access to health and educational services has increased but demand outstrips supply. Health indicators such as reduction in anaemia, IDD, increase in exclusive breastfeeding, better nutrition is reported as also the increase in enrolment in state KG and the opening of non-formal voluntary schools.
Sustainability: What is needed for FEP to be adapted/replicated nationwide? What are people's resources, motivation and ability to continue advocacy/communication campaigns on delivering messages of FFL and FEP in the future? What are other resources (both human and financial) to be used to sustain the program?	Deputy hokims, makhalla advisors, patronage nurses are involved and in this way FEP is institutionalised through decrees and because FEP work coincides with their assigned job of home visits. Small community grants provide motivation to volunteers and are essential to sustain the program. Mass media has not been exploited fully. Materials availability needs to be increased.
Coverage: Which groups have been reached by FEP and what is the different impact on those groups?	Total coverage is still low and only 6% population of the rayon reached, in pilot makhallas 80% families with children 0-6 have been reached. Although all families need FEP, it needs to also target those families 0-6 and those who are vulnerable or do not send children to KG.
Coordination: What are the effects of coordination at district level and lack of coordination on National level?	Coordination at makhalla and rayon level function smoothly with involvement of makhalla advisors, committee and deputy hokims and intersectoral committee. There have been a lot of changes at the national level and there is need to rope in other departments and get a buy in to make it truly multi-sectoral; coordination with other donor and government programs will rationalize and coordinate efforts. An IECD strategy is one way to coordinate efforts.
Coherence: What are areas and ways of cooperation with other UN and donor agencies' in regard to FEP goals and objectives? What is the existing national policy on ECD? Is there coherence across policies of different donor agencies and national stakeholders? (This criteria should be assessed to the extent possible)	A joint program with other UN agencies to train Makhalla advisors is under development. ECD needs are recognized by government and a study is under way to inform of services and options. However, IECD needs to be promoted vigorously. A number of donor agencies and national stakeholders have recognized the need for ECD and some programs already address or will address this and community mobilisation component. However, at present there is no synergy among them. See Section 4 Interface with Related Programs
Protection: Is the response adequate in terms of protection of children of different groups? (Internal rapid assessment by APO didn't	FEP has helped communities recognize the rights and needs of children with disabilities and to avoid stigma. Services and inclusion

reveal significant achievements in this area; yet these criteria should be assessed in regards to what measures/actions need to be taken to provide, for example, support systems for children with disabilities?)	however needs to be promoted, but these were beyond the purview of FEP.
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6.2 Conclusions and⁹⁸ Recommendations

Six major areas have been analysed based on findings and **specific** as well as **key recommendations** provided. These relate to:

- Design of FEP – strategy and content
- Materials
- Resource Centers
- Service Delivery
- Training
- Use of volunteers

1. The program design of FEP is unique for two reasons - as a strategy and for its content of IECD. As a *strategy*, UNICEF’s FEP program is one of the few that targets and works directly with families and communities. It is a bottom up approach meant to create demand and awareness. In terms of its *content*, IECD is an integrated holistic approach to ECD and clearly reflects the nation’s priorities, supported by data from the Child Rearing Study, health indicators and a very low 20% ECD enrollment. The following section discusses conclusions drawn from the review findings related to strategy and content.

a) *Strategy*: FEP addresses the whole **family** (which consists of grandparents, parents, and children) creates an enabling environment and therefore influences attitudes. The design responds to the existing strengths of family and community structures and relationships. Most Uzbek children grow up in extended and joint families; hence, by its very design the FEP has enabled parents and grandparents to be involved in the integrated development of the child. In terms of its metamorphosis from a Better Parenting initiative, the FEP strategy was far more rooted in the Uzbek context. Knowledge and awareness of IECD messages are expected to change attitudes and influence behaviour. Although, the biggest drawback of the program is the lack of a baseline, it is evident in the field observations, interviews and focused discussions over all three implementing sites, that FEP addresses various cultural ‘**gatekeepers**’ that impede the utilization of IECD knowledge, such as the mothers-in-law. Hence, **male involvement** is another critical

Specific Recommendation

It is recommended therefore that if the FEP moves into Phase II, the baselines study include the role of different family members in childcare practices and explore how relationships influence the **enabling environment necessary for the operationalization of FEP-IECD.**

area that FEP targets because of its wide scope. It does all this in the **makhalla** (community) context and thus makes it easier for acceptance of messages. In this sense, FEP has been able to influence larger community attitudes.

⁹⁸ Many of the lessons learned were also mentioned as Future Plans in Annual Report of 2004 (Annual Report of 2005 was not available at the time of review) – strengthen M&E; maximize use of FRC and organize neighborhood learning and play groups for children 3-6 years; promote non-formal preschools; radio and TV to carry FEP messages; formulate appropriate policy for increase access and quality of preschool and train national and local teams on management of ECD services.

The CPMP (2004-09) has also indicated the need for evidence-based advocacy to leverage resources for expansion of successful pilot projects. One of the three main objectives of the CPMP is local institutional capacity development and community/family empowerment.⁹⁹

b) *Strategy*: In its design, FEP-IECD had planned to develop formal ECD parent (and older children) learning groups with 3-6 year olds since a large number of children were not enrolled into KG. This plan was not implemented. Some reasons were that mothers were busy with household chores and could not spare the time for regular, structured activities; not all FEP volunteers were Methodists and a five day FEP training was not sufficient to build competence in delivery of ECD programs; and volunteers were not paid to conduct these weekly activities. In practice, the ECD component for older children (3-6) in the FEP meant distribution of UNICEF FEP materials, occasional visits by volunteers to educate children, social gatherings which advocated for ECD and in its best case scenario a volunteer led few hours a week program in ECD for non KG attending children.

Specific Recommendations

If FEP intends to address the many children out of KG and provide the benefit of a high quality informal ECD program,

It is recommended that for community initiatives like FEP, a feasibility study assess time availability of caregivers, availability of Methodists, incentives as well as quality assurance standards.

It is recommended that realistic options be explored with government for more and flexible ECD facilities within the state services such as few hours of KG, Makhalla KG and others. FEP-IECD can then supplement and support children in families *even in the absence of a full day KG program*

Discussions in the field indicated that children were not sent to KG because they could not afford the fees or facilities were too far or not available. A study is under way by UNICEF and the government to understand the reasons why children are not enrolled in KG and the availability (or lack of) of formal and non-formal ECD services. The findings should provide input into the FEP-IECD.

c) *Strategy*: FEP delivers messages through family visits, FEP community gatherings and informal social gatherings. The local media is occasionally used. Of these delivery modes, family visits remains the most personal, intensive and targets specific needs. In some rayons, volunteers aim at 100% coverage, as they believe FEP is every family's right. However, family visits are also time consuming. In practice, some families need more follow-up and support.

⁹⁹ CPMP, UNICEF Uzbekistan, May 13, 2004 Pg.4

d) *Strategy*: Delivery and coordination of the project is local and multisectoral. Ownership is high as community level volunteers are trained to deliver the program. Although initially a high turnover, appropriate selection the next time around led to better volunteer commitment. Including doctors, nurses, Methodists and other interested individuals in the training fulfills intersectoral needs in FEP thus making it a true IECD project. It also ensures that all sectors are **together** responsible for children's development. Although FEP delivery is based on volunteer efforts, community small grants (started in 2004, the second year of FEP) gave small incentives for facilitation and did motivate volunteers.

Specific Recommendation

It is recommended that a judicious mix of delivery mechanisms be planned and be incorporated in the IECD strategy using mass media, large gatherings and more targeted family visits. Criteria will have to be developed to identify vulnerable families most in need of volunteer family visits.

d) *Strategy*: Delivery and coordination of the project is local and multisectoral. Ownership is high as community level volunteers are trained to deliver the program. Although initially a high turnover, appropriate selection the next time around led to better volunteer commitment. Including doctors, nurses, Methodists and other interested individuals in the training fulfills intersectoral needs in FEP thus making it a true IECD project. It also ensures that all sectors are **together** responsible for children's development. Although FEP delivery is based on volunteer efforts, community small grants (started in 2004, the second year of FEP) gave small incentives for facilitation and did motivate volunteers.

Specific Recommendation

It is recommended that coordination responsibility, at the makhalla committee level and at the rayon level by involving the Women's Committee and Deputy Governors, thus institutionalizing the program, be strengthened.

e) *Content*: FEP promotes an **integrated approach** to ECD or IECD, but in practice there was more emphasis on *specific* health issues rather than ECD. It did however create an *overall general* awareness of and importance of ECD. This has happened for several reasons. The basis of the FEP program was the adapted version of the FFL, which though it promotes an integrated approach, has more concrete recommendations for health issues and especially for 0-3 years. FEP also developed a set of 23 Modules that laid out the content of IECD. Volunteers were trained in FEP and received both the Modules and the FFL. A number of events however led to the emphasis of FFL over the FEP modules.

First, the FFL was disseminated in very large numbers and through various channels – through the government - the Women's Committee, Deputy Governors at the rayon level - and through the FEP program. Hence it became the most visible resource. Calendar Posters with the ten key FFL messages introduced in 2004 reinforced the reach of the FFL messages.

Second, the FEP training was for only 5 days and needed to cover 23 modules and therefore, the sessions were ‘compressed’, a study of these sessions indicates that ‘priority messages’ emerged which were essentially related to FFL.

Third, not all volunteers were Methodists and familiar with ECD concepts available in the FEP modules. Fourthly, the FFL is very simple, brief and easily understandable by anyone. It was also widely read because of the high literacy of the population. Hence, at the field level, FEP became associated with FFL.

The FEP modules are based on various IECD themes. The **health** component was supported by the simple messages of FEP but for the ECD component, volunteers and caregivers had to rely on the FEP modules. *This theme approach in the FEP Modules was most appropriate for an ECD specialist to conduct Parent ECD learning groups.* Parents however preferred receiving information about their children in a convenient **age wise** manner. The FEP modules were accompanied by another book, which denotes development changes in children, which was well received where available. Feedback from all three regions to trainers, deputy governors and UNICEF indicate the need to strengthen the ECD component in FEP.

This may be supplemented by **Home Activity Booklets**, which provides guidance for each age to supplement the modules and development stages book. The Home Activity Booklet may be developed as a series, so that when the parent finishes one set, h/she is eligible to get the second set. Great care must be taken not to overload the revised books with too much information or activities for caregivers. For this reason, the content revision should be dependent on strategy revision.

FEP Modules were used the most in Karakalpakstan, as FFL was under translation into the Karkal language. Here too, the *quantity* of both the modules and the development stages book were too few for dissemination and could not create impact.

MA who are 40+, not necessarily Methodists, or volunteers with a medical background found it difficult to provide details of ECD messages except in its most general form, which also were available in FFL messages. Similarly, FFL knowledge available to Methodists and Makhalla Advisors had to be supplemented by volunteers with a medical background. The FEP advantage in using FFL was to demystify health information. On the other hand, the ECD messages while being disseminated became too general, such as you must sing to, play, draw and read to your child. Yet some frontline workers assumed that these limited, less structured, general ECD messages, could provide an IECD experience (in the absence of enrollment in a state KG) to children at home.

Specific Recommendations

It is recommended that both FEP modules and FEP development stages book be reviewed, link ECD activities to each age and make it more user friendly for caregivers.

It is recommended that content revision consider who will use the resources. The review has indicated that the specialized, detailed FEP Modules though a valuable resource were fully used and appreciated by those with an ECD background such as Methodists.

It is recommended that ‘assessment’ of the children in such a ‘home ECD’ be undertaken to monitor progress. Again, ECD content of FEP would need to be strengthened. (See Strategy above)

The FEP covers age group 0-6, which has very diverse, extensive needs. The content therefore becomes too voluminous. Needs for 0-3 are very different from 3-6 and in the absence of this clarification, most FEP messages that were disseminated related to breastfeeding, safe motherhood, immunization, anaemia, use of iodine salt and prevention of illnesses. The messages for ECD were general for all ages for example to sing, play and talk to the child. To illustrate, a good baseline would provide information on say how many hours a baby spends in the bishek (a traditional cradle in which children are strapped and so cannot move. It is customary to leave children in them for hours as children are safe, remain dry and enable caregivers to complete household and other chores). If bishek hours are too long, FEP could work on reducing the number of hours in the bishek along with the more general message of singing, playing with children. Similarly, for health messages, information is needed whether breastfeeding is exclusive for six months or if tea is being drunk with or after the meal, and if so, what is the time gap. If specific information is available, behavior change will be better targeted.

There is a demand to address FEP to **older children** as well. If FEP is considered a strategy, the same approach may be used but in available settings such as schools through PTAs, curriculum change and NGOs that work with adolescents such as Komolot could be involved. With older children, there would be need of a different type of volunteers (perhaps not Makhalla Advisors) but teachers, doctors and nurses, peers and a different type of training and materials for both adolescents and parents. The *strategy* of FEP could be used effectively such as mobilizing families and communities using interactive methods to change attitudes.

Specific Recommendations

It is recommended that FEP-IECD address the differing needs of 0-3 and 3-6 using baseline data that identifies specific child rearing practices that need to be targeted for behavior change and in this way help volunteers and caregivers to understand the specific interventions required.

It is recommended that expansion to other age groups be left to other agencies as FEP-IECD is in its initial phase and has yet to adequately cover the needs of 0-6. The volunteer expertise available (such as older Makhalla Advisors) does not support program delivery for adolescents.

It is recommended that other avenues such as school based programs be utilized for program delivery and involvement of family using the strategy of FEP, which is interactive and promotes family and community mobilization.

Overall Key Recommendations for the design of FEP in terms of its strategy and design are as follows:

Key Recommendations

All the above recommendations indicate the need for UNICEF to promote the development of an **IECD strategy** with the government to address the needs of 0-6 children in an integrated holistic manner, rather than as piecemeal separate programs by different donors and government departments. This umbrella strategy will enable a systematic integrated development of future family education which addresses children's needs in the context of family and community mobilization, targets specific IECD indicators, identifies delivery mechanisms (family visits, social gatherings, use of mass media) and promotes health and ECD services for children. The current FEP strategy paper is only related to the program and the IECD strategy recommended would be comprehensive and respond to current and future needs of 0-3 and 3-6 years children in Uzbekistan.

It is recommended that UNICEF share its approach and strategy with other donors and government departments as it has effectively demonstrated how programs can reach and mobilize families and communities.

2. A variety of FEP related materials were developed. These included materials for trainers (see above) and a children's kit. Materials were in great demand but the quantity available was very limited constrained by available budgets. This resulted in a 'rationing' of materials at field level. Materials however need to be available in an optimum quantity and variety for reach and impact. FFL was available in large quantities but FEP-IECD materials were very few. The scope of FEP was ages 0-6 but the variety of learning materials were not realistically tailored to meet needs of different age groups. Font size, age-appropriate quantity and level of content, pictures used will need to be reviewed. As very few materials are available for this age group in the new Latin script, the FEP materials for children were in great demand. The toy-making workshop was useful but it would also be useful to educate caregivers and volunteers on the many creative ways to use the environment to help children learn.

Key Recommendations

It is recommended that if FEP is to cater to IECD needs of 0-3 and 3-6, new materials be developed and existing ones modified. Resources from other ECD and health programs should also be reviewed for inclusion. One of the biggest advantages in Uzbekistan is the high literacy of the population and this should be exploited in the development of materials. Parents, caregivers and volunteers however will need to be educated on how to use the materials.

It is recommended that sufficient quantities of materials be available. As indicated above, to manage costs, cost reduction options may be explored in designing, printing and in disseminating. A plan is needed to ensure that all those who need materials especially the vulnerable, that is children with little or no access to IECD benefit first.

It is recommended that communities be involved in managing costs through various options such as developing a mobile or circulating resource library with a revolving fund built in to replenish materials.

3. FEP established Resource Centers to enable caregivers and volunteers extensive access to a variety of materials and media. Although the government provides the space for the Resource Center, a TV and other equipment are provided which has budgetary implications for future expansion. Resource Corners (corners in different locations, stocked with some FEP print materials) were also set up in places such as KG, polyclinics and medical points, where caregivers tended to naturally gather. Some resource corners were set up at unique places such as offices where lactating mothers received allowances for their young children. In general, resource corners were used more widely than resource centers. Utilization of most Resource Centers (with reference to its investment and materials) was low with an average of 10-15 parents visiting the center every week. Meetings for parents attracted about the same number. Some Resource Centers and Corners were used more than others. Resource Centers however need to be a hub for activities and resources.

If the program is to be extended to other rayons and regions, some Resource Centers would be required as a 'holding' place for materials in circulation, as training center, for PTA meetings and for events. The Resource Center provides an identity to the program and for volunteers to gather and share. Other NGOs and community members could also use the Resource Center if it is adequately 'marketed'. The Resource Center should therefore be in a place that is easily accessible both in terms of location and timings. If community members find it convenient to come in during weekends or in the evening, such adjustments should be made. As many resources as possible, outsourced from other programs should be available and volunteers should be encouraged to use Resource Center resources in the Corners for their community training. Resource corners should be reviewed regarding location, use and child-friendliness – for example, are children's materials, products prominently displayed? Are Corners in the Makhalla Office accessible to children? A few master copies of materials in both Cyrillic and Latin scripts may be kept as reference material so parents can decipher what children are reading.

Key Recommendation

It is recommended that location of Resource Centers and Corners be carefully chosen and their use popularized. A plan needs to be in place for collection of available relevant and useful resources (from other donor and government programs) and for their utilization by volunteers, children and caregivers. Unless Resource Centers and corners are utilized well, there is little justification for setting them up.

4. The FEP was intended to increase access and demand for health and ECD services.

Interviews and discussions indicated that FEP had created awareness regarding the importance of early referral. Data was not available at Makhalla level to verify this finding. Health services are available in communities and patronage nurses make home visits for newborn children. This remains an untapped resource. Some patronage nurses have been trained under the FEP but a concerted attempt to include them would be useful as their job description includes home visits. Patronage nurses are being trained in IMCI and other health related programs by other donors.

Key Recommendation

It is recommended that UNICEF dialogue with these programs to include the FEP-IECD component in their training. Data on use of health services would provide information on impact of FEP.

In terms of **increased utilization** of ECD services, one of the indicators for the FEP-IECD program, the only services available are the state KG. Because of their fees, they are underutilized. Support for Makhalla KG (promoted by UNICEF) was discontinued in 2003. Therefore, although a demand is being generated, there is a vacuum at the moment as alternative means that are less costly are not available. The UNICEF – Government ECD Services study should throw light on these issues. At the moment because of increased awareness, there is evidence that children are being sent in the last year of preschool or to weekend classes, making it a school readiness activity defeating in many ways, what UNICEF has promoted – that psychosocial stimulation is a child’s right from birth and has value in **itself**. A better understanding of these changes in enrollment hopefully will be possible from the ECD Services Study.

Key Recommendation

Advocacy skill training will need to be provided to rights holders to influence duty bearers to respond. The FEP program, which currently works independently, will have to work in synergy with service delivery programs, health and ECD, to be effective.

5. The FEP program delivery is dependent on the number, expertise and commitment of its volunteer workers. In year one, most of the volunteers who had been trained dropped out or were ineffective. Better selection criteria led to more stability later on. FEP programs vary in quality across rayons, in some rayons FEP has encouraged governments to restart KG programs and there is clear evidence of volunteer efforts in the dissemination of information to families and communities on various health and ECD issues. In Phase I, FEP trained 24 workers in each Makhalla but in the new expansion into additional rayons since June 2005, only one Makhalla Advisor is trained in each Makhalla. Because FEP-IECD is multisectoral, it requires volunteers who are Methodists *and* with a medical background. Because work is intensive and coverage is wide, more volunteers are needed.

Key Recommendations

It is **recommended** that volunteers be selected carefully, be in adequate numbers and some need to have expertise in ECD and health. In its expansion phase, a minimum of three persons – the Makhalla Advisor, a Methodist and Health personnel needs to be trained. This team can then train further at the Makhalla level. An optimum number of properly trained persons needs to be defined depending on the population strength, geographical distribution and the numbers of families that require IECD support in the makhalla.

To maintain the motivation of volunteers, it is **recommended** that the community small grants be continued as they have a small facilitation fee for volunteers organizing the events. In the absence of paid grassroots workers, this is a cost effective and sustainable way to ensure program delivery. Both **monetary** and **non-monetary incentives**, such as recognition and awards, can be used especially as community ownership is so high.

6. FEP training is of a high order and uses national level trainers to train grassroots volunteers at makhalla level. Designated national trainers to maintain quality also supervise subsequent trainings at rayon and makhalla level. This creates a very centralized top down structure and inhibits local capacity development besides being high cost. To manage the community small grants, partners – NGOs, departments or other such institutions have been appointed with concurrence from the Deputy Governor to coordinate and manage FEP activities. The scope of work of appropriate implementing partners may be increased to include training, technical support and monitoring and evaluation at makhalla and rayon level.

Key Recommendations

It is recommended that quality training be continued but national trainers focus more on training at the regional level and provide initial support for cascade training by regional trainers. Appointing implementing partners may institutionalize the requirements for regional and rayon level training and technical expertise.

It is also recommended that national trainers develop quality assurance procedures and formats for periodically monitoring the rayon/ makhalla training and implementation. Regional trainers or implementing agencies may initially share responsibility with national trainers and then be empowered to independently manage for their own and neighboring rayons.

7. FEP activities have not been monitored and evaluated regularly. In the absence of a baseline, an action plan based on its findings and indicators it is difficult to ascertain any change in knowledge, attitude and behavior and attribute it to FEP. Current indicators of FEP are outcome level indicators and in the short time of two years of implementation it would not be possible to reach them.

Key Recommendations

It is **recommended** that a results based framework be developed and simple monitoring and evaluation formats that monitor key indicators be used. This is possible only if baseline data is available to guide implementation efforts. Such rigour is likely to demonstrate real change in knowledge, attitude and behavior.

It is **recommended** that UNDAF indicators be used as a reference to evaluate FEP progress. The impact on CRC, child protection and living standards programs can then be evaluated. It is **recommended** that external expertise be used to design the next phase of the FEP using the evaluation findings. External expertise would be needed to design a baseline, followed by the development of an IECD strategy and action plan with input, output and outcome indicators.

6.3 Lessons Learned

The FEP review outlines a number of lessons that may be used for future IECD programming in the CIS region.

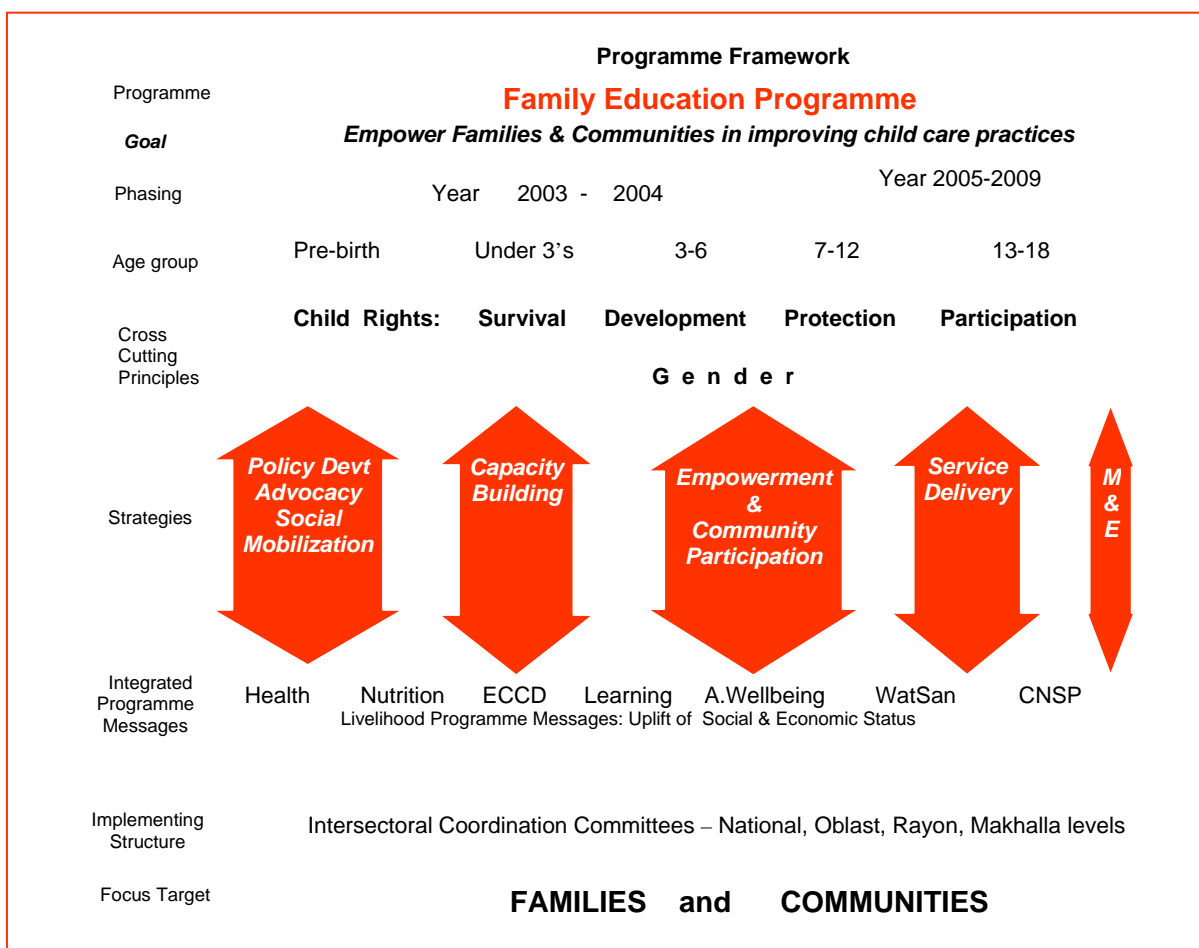
1. **Design** of IECD is most successful when it builds on existing strengths and invests in an enabling environment, which is culturally appropriate. Children as rights holders are dependent on parents and communities for the realization of their rights. IECD programs are most acceptable when they are contextual; address local needs and target decision makers within families. Available governance structures at national, district and local levels need to be oriented, sensitized and involved in the entire planning process with responsibility of implementation, monitoring and evaluation. IECD awareness creates huge demands for services and duty bearers must understand the need to respond to these services and explore innovative ways to fulfill them. Similarly rights holders need advocacy training to exercise their rights effectively.
2. **Materials** are vital and need to be developed locally, with high quality control but must address costs and have a clear dissemination plan. In highly literate societies, print materials are a cost effective way to reach large populations. Audio-visual materials and mass media are other ways that can reach out to large audiences but because of the cost involved need to be planned and budgeted for.
3. **Training** that is participative and of high quality positively impacts implementation. However, refresher trainings and small group trainings available at the local level is cost effective and easily deliverable. Although cascade training is inevitable when coverage is high, a rigorous quality control mechanism can reduce 'training loss'.
4. **Community empowerment** through the use of community volunteers for community empowerment is a powerful rights based model but requires careful selection and plan for incentives. **Non-monetary incentives can be very powerful** at the community level and should be explored. Such approaches must also recognize the continuous need for capacity building and creation of a large pool of volunteers.
5. **Strategy for IECD** is critical to synthesize various demands for awareness, community efforts and service delivery across sectors into a comprehensive framework. For countries

- in transition, this also provides a framework for donor interests to contribute to country programs rather than to sectoral donor driven needs. In the long run, it is a cost effective mechanism as it enables creative and efficient use of related services and synergizes overlapping of information needs, services and resources. Most important, it emphasizes the government's commitment to children and IECD needs.
6. **Coverage** demands though legitimate need to be reviewed in terms of quality control and available resources. Although maximum coverage is necessary, numbers cannot substitute for quality. However creative and rational use of materials and media, synergy across sectors and the involvement of communities can create an excellent impetus for expansion.
 7. **Sustainability** is possible only when existing resources for training, management and implementation are utilized. Available governance structures and staff when used institutionalize the program. By creating a synergy among available government and donor resources, sustainable structures can be put in place.
 8. **A participatory reflective evaluation methodology** that involves stakeholders not only in data collection but in planning, design and analysis of findings is critical for formative evaluations (such as FEP's) which aims to learn lessons for future programming. Such an approach creates wide ownership through debate and discussion based on findings and evidence.
 9. **Rights of children, especially IECD needs** require widespread sensitization and advocacy as children and especially those under six are dependent for the realization of their rights on adults. Because the 0-6 years represent a very broad age group with widely differing health and educational needs, dividing the age group into 0-3 to 3-6 age groups will enable a more relevant and effective program delivery.

A number of donors have incorporated family and community mobilization as an important component of various health and educational programs. Also there is a renewed interest in responding to urgent ECD needs in Uzbekistan (ADB plans to work in this area in the next two years). *UNICEF can provide value addition to government and other donors because of its field experience in implementing FEP and should seize this opportunity. It is only in this way that the program can be made sustainable.*

ANNEX ONE: FEP framework

The framework below reflects the main strategies of FEP, the cross cutting principles that will guide the program and the integration of program messages through a delivery process reaching families and communities.



Source: Project documents 2003-2005 prepared by Consultant Mercedes Chavez

ANNEX TWO: Terms of Reference for external evaluation

UNICEF UZBEKISTAN TERMS OF REFERENCE FOR CONSULTANTS AND CONTRACTORS FAMILY EDUCATION PROJECT

Title:

External Evaluation of the Family Education Project for the period of May 2003-July 2005.

Background:

Family Education Project (FEP) aims at family empowerment and increasing the families' knowledge on child rearing practices through community volunteers. In 2003 Government of Uzbekistan initiated Integrated Early Childhood Development through Family Education programme, which intends to improve child rearing practices among families in Uzbekistan. UNICEF assists Government of Uzbekistan through providing technical expertise on IECD, training of trainers and volunteers, developing of materials and advocating for ECD at different levels.

The Family Education Program- Integrated Early Childhood Development (FEP-IECD) evolved from the Government of Uzbekistan and UNICEF's continuous attempt to develop and improve their joint response to persistent problems affecting children's healthy growth and development. The Government agreed to focus FEP activities on IECD during 2003-2004, and to carry out family empowerment initiatives for other age groups through FEP in the next CPAP for 2005-2009. (More information can be found in the present Country Program of Cooperation, which lays out specific interventions for the survival, development, participation and protection of children of all age groups). Total budget spent for FEP/IECD in 2003-2004 was 311,768 USD, and planned budget for 2005 is 285,300 USD, including set-aside funds in the amount of 115,000USD.

In 2003, there was an Intersectoral Coordination Committee established under the Social Complex of Cabinet of Ministers at national, regional, and district levels which included Ministry of Education, Ministry of Health, Interior, Social Protection, local NGOs (e.g. Kamolot, Soglom Avlod Uchun), and local government offices. Since Social Complex was abolished, FEP is now being implemented by Tashkent Medical Paediatric Institute (TashPMI) under the Ministry of Health.

The overall goal of FEP is to empower families and communities with knowledge and skills to ensure that children of all age groups grow up healthy, well-nourished, and benefiting from quality learning programs, and developing into well-adjusted young citizens in safe, hygienic, environmentally friendly and non-discriminating communities.

The specific objectives of FEP for 2003-2005 are as follows:

- To increase knowledge and skills of families and communities on childcare
- To improve childcare practices of families and communities
- To increase the % of children participating in IECD and other programs for older children
- Indicators:

- % of families where the behavioural changes occurred and observed as a result of intervention of FEP (e.g. home health care, hygiene, psychological care, breastfeeding and feeding (including use of iodized salt), care by both parents, care for pregnant women, etc.)
- % of families where CRC articles are being effectively applied into everyday life, e.g. explicit evidence of non-discrimination against girls, children attending schools, children are being protected from abuse, etc.)
- % of children who participate in different types of ECD programs/preschools

Key program strategies:

- Capacity Building through trainings of frontline workers and volunteers and development of materials
- Advocacy campaigns through mass media channels and ECD materials
- Support of local initiatives in communities

FEP now had been pilot tested in 3 pilot regions and 6 districts. At this stage of programme implementation - it is critical to assess the impact of the programme and behavioural changes it brought to the household level - in order to identify further directions of the programme.

Purpose of the evaluation:

2005 – is the first year of UNICEF’s new programme cycle in Uzbekistan. It is therefore crucial to have reliable, accurate and comprehensive data on the FEP impact, achievements, and constraints and to generate relevant recommendations for scaling up, using the most effective and efficient channels for communication and leveraging of funds.

The baseline information on the impact and behavioural changes that programme brought will serve as a basis for further programme design. It will also provide information for leveraging of funds and reporting to donors.

The evaluation report shall reflect the status of the programme in terms of its relevance, efficiency, effectiveness, sustainability and impact.

The evaluation findings and recommendations will be addressed/followed in a strategy paper for years 2005-2009 and AWP’s by UNICEF programme staff

FEP partners from the Ministry of Health, Ministry of Public Education, implementers at regional and district levels will use the evaluation report. The major outcomes will also be shared with the frontline workers, for them to take into account successful strategies and further work on the weak points in work with the families.

Scope and focus:

In evaluating FEP, OECD-DAC evaluation criteria and evaluation questions should be considered as follows:

Relevance: What is the value of intervention in relation to 1) the national and international partners’ policies and priorities (including MDG, UNDAF, PRS); 2) the global references such as the CRC and CEDAW; 3) the MTSP, the CCC, HRBAP and RBM? Do final beneficiaries-families and communities regard IECD-FEP top priority compared to other immediate issues and MDGs?

Efficiency: Does FEP use the resources in the most economical manner to achieve its objectives? How many materials have been developed/published? How many trainings have been held? How often are FEP Resource Centers (RC) being used? Was the cost spent for 6 FEP RC worth doing

it against expected/achieved outputs? Should this practice be continued? Is it worth continuing trainings on community level in pilot communities?

Effectiveness: FEP phases/modules were structured as follows: 2003-2004 - development of materials and conducting trainings in selected pilot areas for children ages 0-6, 2005-2007 – for children ages 7-13, 2007-2009 –for children ages 14-18, whereas family education is to be intended for children of all age groups. This is both neither effective nor efficient in terms of timing, efforts, expected results against set overall goal and specific objectives for FEP.

Therefore, the following questions should be considered: What is the quality/appropriateness of programme design? Are FEP's activities achieving satisfactory results in relation to stated objectives short and long term? What is the quality/sufficiency of FEP trainings/training materials? What is the quality and sufficiency of volunteers' contacts with families? Is list of indicators and internal monitoring scheme by volunteers' sufficient/relevant to achieve stated results? What is the communication/advocacy strategy for FEP? Is it effective?

Impact: What are the results of intervention in terms of behavioural changes on individuals, communities, institutions (e.g. preschools, local medical points) against set indicators?

Sustainability: What is needed for FEP to be adapted/replicated nationwide? What are people's resources, motivation and ability to continue advocacy/communication campaigns on delivering messages of FFL and FEP in the future? What are other resources (both human and financial) to be used to sustain the program?

Coverage: Which groups FEP has reached and what is the different impact on those groups?

Coordination: What are the effects of coordination at district level and lack of coordination on National level?

Coherence: What are areas and ways of cooperation with other UN and donor agencies' in regard to FEP goals and objectives? What is the existing national policy on ECD? Is there coherence across policies of different donor agencies and national stakeholders? (this criteria should be assessed to the extend possible)

Protection: Is the response adequate in terms of protection of children of different groups? (internal rapid assessment by APO didn't reveal significant achievements in this area; yet these criteria should be assessed in regards to what measures/actions need to be taken to provide, for example, support systems for children with disabilities?)

Existing information sources:

- Project documents and reports for the period 2003-2005
- Trip reports of relevant UNICEF programme staff
- Project Assessment by Mercedes Chavez (Consultant on the FEP who developed the phase I of the programme). Since the consultant was in charge of developing the program, this assessment may not be considered as being objective. In accordance with comments of the Regional Adviser Deepa Grover in "Feedback on Uzbekistan Annual Report -2004," this assessment "is not recommended for inclusion in database. The AR doesn't say if the results described are based on evaluation. Results are mainly related to process. Other reported results, are impressionistic... An example of somewhat tenuous assumptions and sweeping generalizations can be found in the description of Family Education Resource Centers. Results must be more rigorously assessed and accurately reported."
- Meetings with Deputy of Deputy Prime Minister Ms. Tureeva and representatives of the National FEP Technical Working Group, some of the districts' deputy governors and members of District Intersectoral Coordination Committees

- Meetings with representatives of implementing partner/coordinator of the project Ms. Ismailova (TashPMI)
- Field visits to the regions, districts and communities
- Meetings with the FEP frontline workers/volunteers and representatives of families
- Rapid formative assessment and recommendations done by APO for FEP National Congress held on July 8-9, 2005
- Recommendations from FEP congress

** Additional data on attendance of the pre-school establishments of the districts/communities can be obtained from the local governor's offices.*

Evaluation process and recommended methodology

The proposed type of evaluation is formal, summative. The evaluation process will be based on:

- analysis of existing project related documents listed above
- analysis of existing training materials and modules
- analysis of existing national policies/priorities
- development and analysis of surveys/questionnaires with list of questions/indicators against set objectives

During at least 3 field-visits:

structured observations at the household level

- structured observations of trainings/ events within the project framework(depending on time and availability of evaluator)
- individual interviews with key stakeholders (e.g. national implementing partner/coordinator of FEP, some district deputy governors, some directors of FEP RC)
- focus groups with frontline workers and volunteers during site-visits

Suggested sampling will be a mixture of purposive sampling (where an evaluator is required to understand and explore the evidence of behavioural changes with a small group of people) and stratified random sampling (where the evaluator will examine differences among subgroups which had /didn't have program interventions to be able to draw generalizations). Sampling size should include at least 20 families/households; if needed to be discussed/ with evolution team. Analysis of both quantitative and qualitative data should be presented in evaluation report. Certain measures will be taken to ensure that evaluation process is ethical and interviewees are protected (e.g. reference to sources of data will remain anonymous and final Evaluation report will not contain names while referring to data, unless interviewees will give permission to provide the names if needed so).

Stakeholder participation

Stakeholders will be mainly involved into the evaluation process as sources for data collection and analysis and upon presentation of Evaluation Report for further follow up to address key findings and recommendations to take actions.

Accountabilities:

UNICEF programme staff will be accountable for coordination of stakeholders' involved, organizing field-visits, focus groups, providing translator/interpreter and other logistical issues. APO will be accountable for reviewing/approving of intermediate and final evaluation results. An evaluator shall be independent in evaluation exercise, however taking into account sensitive issues which may arise during the course of assessment. There are no specific concerns related to conflict of interest.

Mandatory Qualification or Specialized Knowledge/Experience and competencies required:

University degree in Social Sciences/Developmental Studies/Communication
At least 5 to 7 years of practical experience in the field of ECD, family education, communication and community development
Experience in monitoring and evaluation of ECD, Communication programmes

Good analytical and report writing skills
Proven skills to develop training and facilitation skills
Fluency in English.

Procedures and logistics:

An evaluator will be provided an office space, computer, a car for site visits and official meetings. A separate translator/interpreter will be hired to assist an evaluator in his/her work. Other logistical issues will be discussed with successful candidate.

End products:

The Evaluation Report, which should include findings, conclusions, recommendations, lessons learned. The report should be provided in both hard copy and electronic version.

Completed data sets (filled out questionnaires, records of individual interviews and focus group discussion, etc.)

Assessment of evaluation methodology, including limitations of objectives-oriented approach
The evaluation report will be rated in accordance with “UNICEF Evaluation Report Standards” and UNICEF Evaluation Technical Notes

Resource requirements:

One month consultancy fee – 6500 USD. The fee is inclusive of DSA for trips within Uzbekistan up to total 15 days in the field.

For the assignment the consultant will be provided with one return airfare ticket by the most direct flights in economy class.

The consultant will be paid one time setting in grant of \$124 per day for 7 days at Tashkent DSA rate. This rate is subject to change depending on the prevailing rate at the time of assuming duty.

Total 15 travel days are covered by consultant’s monthly fee. Should the assignment involve over 15 cumulative days of travel within Uzbekistan, then the Consultant will be entitled to additional DSA as to ICSC standards.

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, not delivered or for failure to meet deadlines.

All materials developed will remain the copyright of UNICEF and that UNICEF will be free to adapt and modify them in the future

Prepared by
APO
Shakhlo Ashrafkhanova

Reviewed and approved by
Programme Coordinator
Andro Shilakadze

ANNEX THREE: FEP Manual for Trainers - Modules

I. We Strive to Build Healthy Families

1. We pay special attention to the nutrition of our children during the most important years of their life
 - 1.1 Nutrition of pregnant and breastfeeding mothers
 - 1.2 Breastfeeding
 - 1.3 Nutrition and development
 - 1.4 Identifying anemia and iodine deficiency disease and preventing those
- 2 We Prevent Diseases
 - 2.1 Clean water, hygiene and sanitation
 - 2.2 Preventing Accidents
 - 2.3 Proper childcare leads to better health
- 3 We know how to identify and prevent children's diseases
 - 3.1 Diarrhoea
 - 3.2 ARI

II. We like to talk, read, to listen, to play and to set examples to our children

1. We assist the growth and development of our children
 - 1.1 Development of children
 - 1.2 Stages of development
 - 1.3 Intellectual development
2. We develop our children through games
 - 2.1 We create necessary conditions to tell tales to our children
 - 2.2. Games and events, in family and makhalla
 - 2.3 Music and role play
3. We are showing unconditional love and feelings to our children
 - 3.1 World through the eyes of children
 - 3.2 Importance of setting example in the family
 - 3.3 Role of father and other family members in child's education and development
4. We are supporting the comprehensive development of our children through daily activities
 - 4.1 Development of children through daily activities

III. We are improving the health of mothers for the benefit of family and particularly for the benefit of children

1. Safe Motherhood
2. Stress Management

IV. We Support children with special needs

1. Identify disabilities of children at early stage and prevent them

V. We protect our children from any kind of violence and punishment

1. What father and mother should know about children's rights.

ANNEX FOUR: Sample Decree of local Government on implementation of FEP

Unofficial translation

ELLIKALA RAYON KHOKIMIYAT

Decree #

Date:

About introduction of the Family Education programme in makhallas

In accordance with the letter # 11-8-54 from the Complex on social protection of families, mothers and children of the Cabinet of Ministers as of August 6, 2004 and with the purpose of implementation of the Family Education programme under the UNICEF and Government's initiative on delivering the most important information on children rearing to parents...

DECREE:

To consider the letter # 11-8-54 from the Complex on social protection of families, mothers and children of the Cabinet of Ministers as of August 6, 2004

To establish rayon coordination committee on introduction of the Family Education Programme in accordance with the attachment

For action of the coordination committee:

In order to deliver relevant information on child rearing in time and on systematic basis, Family Education center to be established under the kindergarten Shodlik

Makhallas Abay and Ibn Sino to be selected as pilots to introduce Family Education programme

To implement all the FEP activities accordingly, through effective utilization of funds

To monitor the implementation of the FEP and report to other relevant agencies on time

To the head of rayon education and health departments, to the chairpersons of Abay and Ibn Sino Makhalla committees: to involve all the necessary staff/persons in communities into the implementation of the FEP

Implementation of this decree should be monitored and supervised by the rayon deputy khokim on women's issues – Ibragimova Z.

Khokim of rayon:

Khudaybergenov

Attachments to the decree:

Members of the rayon coordination committee

Annual work plan for introduction of the FEP in rayon

ANNEX FIVE: List of documents and reports reviewed

Author	Title
Mercedes Chavez	<ol style="list-style-type: none"> 1. Implementation Strategy for Group Learning in the Community/Neighborhood Activities (11.10.04) 2. Assessment of FEP-IECD, Oct, 2004 3. Monitoring Checklist (undated) 4. M&E Scheme (undated) 5. Advocacy and Communication Strategy for FEP, 2004 6. Development of Key Messages, 20 June 2004 7. FEP-IECD the Process in Uzbekistan (undated) 8. Strategy Paper FEP- in Uzbekistan 9. TOR for important milestones of FEP-IECD 10. Project Proposal for Set Aside Funds Enhancing IECD by Popularizing FFL in Community based FEP 11. TOR for TWG for Materials Development and training of FEP-IECD, June 2003 12. Organisational Workshop for TWG, June 2003 (PowerPoint) 13. Suggested Format for Training Module, June 2003 14. Family Home Activity Booklet, 2003 15. Highlights of Workshop of TWG on Materials Development and training, June 2003
UNICEF Uzbekistan	<ol style="list-style-type: none"> 1. Country Program Management Plan (2005-09) May, 13, 2004 2. Annual Report.2003 3. Annual Report, 2004 4. Annual Work plans 2004.2005 5. Logical Framework 6. Orientation on FEP May 2003 (power point) 7. Intersectoral Coordination Committee Responsibilities 8. Project Proposal: Expanding the Family Empowerment Program focusing on IECD 9. Project proposal for Gulf Funds IECD through Community based FEP 10. Revised Country Program Document, 1 April, 2004 11. UNICEF PPP Guideline: Annex Uzbekistan CPAP, Results and Resources Framework 12. Trip Reports: March 9-10Sept 19-22 2005 (Family and Community Empowerment Team) 13. Welfare Improvement Strategy Paper of the Republic of Uzbekistan for 2005-10 Interim Document 14. Uzbekistan's Family Empowerment Program 15. Family Education Program Makhalla KG Uzbekistan, Oct 2002 16. Makhalla KG Project, Uzbekistan, Progress Report No 2 Oct. 2003 17. Dutch funded UNICEF IECD Project in Uzbekistan, Makhalla KG Uzbekistan 18. Annex A: Makhalla KG, Access to High quality ECD Programs for Disadvantaged Families in Uzbekistan 19. Mission Report, Implementation of FEP June 15-18 2004 by Rustam Haydarov, Project Assistant, Child Enrichment FEP
Center for Social and Marketing Research (for UNICEF)	Salt Situation Analysis in Uzbekistan
S. Pahrudinov, et al NAASB	Analysis of Government Structure in Uzbekistan, September 2005
System Science Consultants, Inc	Study on the Restructuring of Health and Medical System in the Republic of Uzbekistan, Dec. 2003

Government of the Republic of Uzbekistan and UNICEF Office in Uzbekistan	<ol style="list-style-type: none"> 1. Mid-term Review: Mother and Child Development and Protection Program, Integrated Early Childhood Care and Development Project, August 2002 2. Country Program Action Plan 2005-09 Draft 26 January 2004
Shakhlo Ashrafkhanova, APO Family and Community Empowerment UNICEF Uzbekistan	IECD-FEP 2003-05 Uzbekistan: Informal Formative Evaluation Report, July 2005
UNICEF	<ol style="list-style-type: none"> 1. Uzbekistan Common Country Assessment 2003 2. Status of Women and Children in Uzbekistan, Multiple Indicator Cluster Survey, 2000 3. Joint program Document, 2005
UNICEF Innocenti Research Center	Children and Disability in Transition in CEE/CIS and Baltic States 2005

ANNEX SIX: Evaluation Framework – Key Strategies and Result Areas

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
UNICEF has provided relevant, quality, timely technical expertise for training to implementing partner	What areas and how has UNICEF translated national and international priorities and policies; UNDAF, MDG, PRS, CRC, CEDAW, MTSP, CCC, HRBAP, RBM in providing technical expertise to FEP ¹⁰⁰ ?	A.1 Evidence of dissemination on information on emerging and sensitive issues A2 Perceptions of key stakeholders on the contribution of UNICEF to information about new realities	A1. Reports and documents; minutes of meetings A2 Current and past key informants – government, consultant, FEP in charge at UNICEF, implementing partner in charge of FEP, Frontline workers, Family Resource Centers;	Review of data (objectives of training, training schedule, materials used in training) in capacity building program Comparison of issues covered and informants view of coverage and gaps
Implementing partners have developed training modules and completed quality training to all frontline workers	Did training happen as planned? Selection of trainers? Did the training materials reflect the Uzbek priorities? Were trainers of the desired quality? Did training provide opportunity for hands on training? Was an evaluation of training done after training and in follow-up? Were findings used to refine further training?	A3 Range, type and relevance of capacity building activities held for frontline workers A4 perceptions of recipients of training A5 Evidence of responsiveness and quality/quantity of support provided by implementing partner A6 Access to support by frontline workers		
Frontline workers have accurate knowledge of childcare, are able to clear misconceptions, demonstrate skills and support families in the practice of new child-care practices	What knowledge was easier to retain, what was difficult? What childcare information and skills did most frontline workers give to families? How often was it given? How relevant and useful was it to them? What were lessons learned – what was easier to disseminate and bring change and what was difficult? Did frontline level workers target critical issues?	A7. Example of horizontal transfer of knowledge and skills to target population A8 Perceptions of recipients regarding front line workers quantity/ quality of information, skills A9 Perceptions of recipients regarding support by frontline workers towards change in child care skills and practice		

¹⁰⁰ All the following documents and relation to FEP required

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
		A10 Evidence of change in childcare behaviour as a result of frontline worker intervention A11 Evidence of feedback from families to frontline workers		
UNICEF has provided expertise to develop materials that are of high quality, reflect local concerns, user-friendly and reflect best practice.	How did UNICEF's information activities improve the availability and quality of information resources pertaining to good child-care practices? Was information focused on priority concerns? How was adaptation to local context done?	A12 Method used to identify innovative policies, strategies and actions A13 Range of gaps identified by UNICEF A14 Perception of key informants of role of UNICEF in identifying the gaps A15 Perception of responsiveness to demand for UNICEF expertise and relevance to national partners	Document review and interviews of UNICEF, other partners in material development, government Document Interviews of government officials, NGOs others Interviews of government officials, implementing agency, NGOs, experts involved	
Frontline workers are familiar with, educate and use materials regularly with target population.	How adapting are frontline workers in use of knowledge and materials to specific child care needs of families and communities? Any baseline and monitoring done by UNICEF or implementing agency? What materials are used regularly? What are most useful? Problems and constraints in visiting and using materials? Achievements?	A16 Procedures established and actions taken to assist frontline workers to translate approaches to action A17 Evidence of good practice dissemination A18 Evidence of use of and satisfaction with relevant materials A19 Evidence of UNICEF action in establishing technical resource base A20 Perceptions of target population regarding knowledge, skills and materials used by frontline workers		
Families (includes all family members) and communities have increased knowledge, skills and practice better child care	To what extent have children benefited in health, psycho-social care, education as a result of better child care by families and communities? What knowledge, skills or behaviour have been acquired?	A 21 Perceptions of change in children as a result of increased knowledge, skills by families, educators, community members A22 Evidence of increased knowledge, skills and child care practices in families and communities	Monitoring and evaluation data of family change Health statistics Enrolment in ECD and other services	Review of health data along with perceptions of key stakeholders and change perceived in children; emerging issues addressed

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
	<p>What is the nature of participation of different family members and community?</p> <p>Known critical problem areas addressed and feedback loop addresses new ones – nutrition, anaemia, stimulation of children, others</p>	<p>A23 Nature of participation of different family members and communities</p> <p>A24 Impact of improved child care on critical problem areas such as nutrition, anaemia, iodine deficiency</p> <p>A25 Extent to which child protection issues are addressed such as children with disabilities, gender, abuse of children, minority groups</p>	<p>Perceptions of key informants – mothers, fathers, caregivers, educators, health personnel, key decision makers</p>	
Key Strategy: B. Advocacy campaigns through mass media and ECD materials				
Key Result: B. Advocacy campaigns result in support from key stakeholders for good ECD models that are indigenous and responsive to rights of children and promote demand for ECD and other related services				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
Advocacy by UNICEF has improved political commitment at national and local levels	To what extent has advocacy efforts influenced existing ECD national policies and resource allocations? Has the level of political commitment been adequate to address the emerging needs? What are the commonalities and differences between UNICEF with other donors and UN agencies regarding FEP goals and objectives? Any areas of mutual cooperation? In relation to national concerns?	<p>B.1 Extent and nature of coverage of ECD in health, development and other policy and strategy documents</p> <p>B2 Perceptions of key stakeholders on the contribution of UNICEF on changing awareness</p>	<p>B1. Policy and strategy documents before 2003 and after 2003-2005.</p> <p>A2 Current and past key informants – government, consultant, FEP in charge at UNICEF, implementing partner in charge of FEP, Frontline workers, Family Resource Centers; NGOs; other donors and target groups</p>	<p>Review of data (objectives of training, training schedule, materials used in training) in capacity building program</p> <p>Comparison of issues covered and informants view of coverage and gaps</p>
Advocacy has reached target populations	To what extent do advocacy issues resonate with concerns of target population	<p>B3 Evidence of disseminating of information on emerging and sensitive issues</p> <p>B4 Extent to which families and communities think that ECD is a priority issue</p>	<p>B3 Records of dissemination</p> <p>B4 Interviews of managers, target population and frontline workers</p>	
Advocacy has been enhanced by concise, critical statistical analysis	How has UNICEF used emerging data to lobby for unaddressed needs and critical issues in ECD?	<p>B5 Opinions of decision makers in the use of data and documents to support this commitment</p> <p>B6 Range, type and relevance of capacity building activities held for frontline workers</p> <p>B7 Evidence of responsiveness and</p>		

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
		quality/quantity of support provided by implementing partner B8 Access to support by frontline workers		
Media Advocacy has resulted in awareness of, commitment to by a wide range of national/local actors	What visible change has been created in different types of media regarding urgency, importance and approach to ECD issues? What are the issues that are widely disseminated? Have new efforts or commitment emerged because of advocacy efforts? How have materials contributed to creating awareness? What were lessons learned – what was easier to disseminate and bring change and what was difficult? Did media target critical issues? What structures and/or mechanisms were used by UNICEF to help increase advocacy efforts? What has been UNICEF’s experience vis a vis other advocacy efforts? What were reasons for failure or success?	B9 Evidence of change in media diversity, quantity (no. of publications, number of categories of analysis) content (range of topics, level of detail); timeliness (date of most recent data) and accuracy (declared levels of confidence in reported data) B10 Evidence of use of information in different settings B11 evidence of improvement in quantity and content of information about responses B12 Perceptions of recipients regarding improvement as a result of sharing information B13 number and type of specific partnerships that developed B14 Extent of coverage in sectoral documents B15 Perceptions of key stakeholders regarding adequacy of coverage		
Commitment is expressed in tangible terms such as forging new partnerships, increase in resources and personnel	Which particular channels worked well? Which new players were included? What was their contribution to advocacy? Did UNICEF’s efforts enhance or supplant local/national/regional energies to cope with ECD issues	B16 Extent (number and scale) of involvement of different groups (NGOs, marginalized groups, other sectors) B17 Perception of key informants of role of UNICEF in broad basing, expanding and supporting ECD and ECD related issues B18 Quantitative analysis of budgeted and actual commitments at local and national level	Records of partnerships (minutes, MOU) Interviews of government officials, NGOs others Donor and government records of resource allocation pre 2003 and 2003-2005	
Key Strategy: C. Support of local initiatives in communities				
Key Result: C. Support to local initiatives such as the Family Resource Centers and Makhallas increases ECD acceptance, ownership and is sustainable				

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
UNICEF support of local initiatives has helped to integrate and streamline efforts at national and local level	To what extent has UNICEF been able to drum up support for local initiatives with government and key stakeholders? Is there evidence that these local efforts have possibilities of going to scale quickly? What are the effects of coordination at the local level and absence at the national level?	C.1 Perceptions of key stakeholders regarding support for local initiatives by UNICEF and reasons thereof Analysis of national, regional and global policies Perceptions of key stakeholders regarding influence of UNICEF in promoting local initiatives	A1. Reports and documents; minutes of meetings A2 Current and past key informants – government, consultant, FEP in charge at UNICEF, implementing partner in charge of FEP, Frontline workers, Family Resource Centers;	Review of data (objectives of training, training schedule, materials used in training) in capacity building program Comparison of issues covered and informants view of coverage and gaps
Budget and work plans at local and national level reflect the new reality		Evidence of comprehensive plan with resource allocation for local initiatives. Evidence of other sectoral work plans supporting the FEP program and coordinating with it	Desk review and budget review of relevant sectors participating with FEP pre and post FEP	
FEP current vertical program design regarding materials, training and family education will achieve goal and objectives of FEP	To what extent will FEP phased development that addresses material development and training for only 0-6years children in 2003-4; 7-13 years in 2005-7 and 14-18 years in 2007-9 affect goals of FEP? Does program design need to be changed? Are FEP's activities achieving desired results? Are FEP trainings adequate in number and of good quality? Training Materials? How often and how well do volunteers contact families? Are volunteers able to monitor regularly and collect reliable data? Do they know what are the relevant indicators?	Perceptions of experts and implementers regarding appropriateness of program design, quality/quantity of training and training materials, use of volunteers Perceptions of target population, managers of programs, community regarding role and efficacy of using strategy of volunteers. Evidence regarding volunteer contact, use of materials and perceived change in child care knowledge, skills and practice Evidence of use of various child care services by target group	Interviews with key and primary stakeholders Review of training and materials according to checklist Review of volunteer contact data Observation of FRC Enrolment figures in ECD, primary schools	
Support for local initiatives (Makhalla and Family resource Center) is possible in the long run and sustainable	What resources will be needed to sustain the program at local level? How much can families and local governments contribute? How will it be managed and monitored? What are problems in replication and scaling up? What other models are available?	Evidence of available and future resources – skilled and trained human manpower, cost Case studies of replicable models Motivation of families and communities to take ownership and management	Interviews with key stakeholders Review of other ECD models Population evidence	Analysis of different available ECD models and comparative advantage

Key Strategy: A. Capacity building of frontline workers and volunteers and development of materials				
Key Results: A. Knowledgeable, trained, skilled grassroot workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices				
Expected specific results	Questions	Indicators/Information	Sources of data	Analysis
		Numbers of children to be reached; special needs of marginalized and vulnerable children		

ANNEX SEVEN: Data Collection Instruments

		Govt/U NICEF /Donor /Experts	Local: Region/ Rayon/ (D.Gov)	Volunteers (also Makhalla Advisor)	Families	Evidence Info. Sheet/ Documents
	Core Areas for evaluation					
1	Introductory: The FEP program caters to improving the health of children 0-6 through family visiting by trained volunteers to change knowledge, attitude and behaviour of family caregivers.					
1.1	Understanding the FEP in your area: Coverage					X
	a. How is FEP different from other programs? What is your role and responsibility in FEP? Explain how it has helped the FEP? Who do you report/coordinate with and what support do you get? (Q for UNICEF and Govt: will include support from each other and other donors) What support would you like?	X	X		X	
	b. What do you think was UNICEF's role? What was the role of the government?	X	X			X
2	Key Result Area A. Knowledgeable, trained, skilled grassroots workers, and the development and availability of relevant ECD materials will enable families and communities to acquire the knowledge, skills and practices to improve child care practices For each answer provide evidence					
2.1	What was the quality of training provided?					
	All deputy governors were sensitized and oriented. Were you satisfied with the training? What are your suggestions for future training of deputy governors e.g. a) Should anyone else be trained b) Should content be changed – any priorities? c) Length of training? d) Any other training required? e) Follow-up needed?	X	X			X
	All volunteers were trained. Were you satisfied with the training? Any suggestions?	X	X	X		X
	Quality of training provided by Implementing organization and national trainers:	X				
	Did training material clearly include all national priorities? Are FEP trainings adequate in number and follow on/support provided by trainers or implementing					

		Govt/U NICEF /Donor /Experts	Local: Region/ Rayon/ (D.Gov)	Volunteers (also Makhalla Advisor)	Families	Evidence Info. Sheet/ Documents
	Core Areas for evaluation					
	organisation? Quality of trainers and methodology used; Quality of technical assistance provided by UNICEF to implementing partner; Monitoring by UNICEF on quality of training;					
2.2	What did volunteers learn? What did they translate into practice?					
	a. What new knowledge and skills did volunteers learn? (probe: FFL, key messages, and especially FEP modules) Did frontline workers also identify local/family concerns and advise?		X	X		
	b. What strategies did frontline workers use to contact families? (e.g. Visiting, events, gatherings, providing materials, using local media, use of FRC?) Which strategy was most useful to change behaviour? Which strategy can reach the maximum families and still enable families to learn well?		X	X		X
2.3	How relevant and useful are the materials? The Training Manual, the Family Book, the Children's Kit? (show the full set during interview)					
	a. Which module do volunteers use more? Which is most relevant and useful?		X	X	X	X
	b. What modules do families use and translate into practice? Which materials are used the most?			X	X	
	c. How do volunteers monitor change in families?		X	X	X	X
2.4	How well have families learned?					
	a. The volunteer discussed many things with you. Please explain what you learned, what new things you do with the children. What changes do you see in children in health, psychosocial care, and education as a result of this? Probe (in how you speak with children, showing affection, reading, toy making, using everyday items to educate, gender, disability).			X	X	X Family booklet
	b. Did you learn about these messages in any other way? (Media, other programs)			X	X	
	c. How often does the front line worker visit you? How often do you go to meetings? How often do you visit the FRC? Are there any groups such as young fathers groups, grandmothers groups?				X	X
	d. Has involvement of father, grandmother increased? Other family members? Explain			X	X	
2.5	Lessons Learned Investment in training was high as was the development of materials. Training at the national level and local level were to increase skills of frontline workers so that key messages could be conveyed and used by families. Materials were to support this.					
	a. How will training be expanded to increase national coverage? How will it be sustained?	X	X	X		
	b. Materials: How do you ensure everyone gets to use materials – volunteers, activists, and families?	X	X	X		

		Govt/U NICEF /Donor /Experts	Local: Region/ Rayon/ (D.Gov)	Volunteers (also Makhalla Advisor)	Families	Evidence Info. Sheet/ Documents
	Core Areas for evaluation					
	c. This capacity building was limited to 0-6 needs, what would be required for older children?	X	X	X		
3.	Key Result: B. Advocacy campaigns result in support from key stakeholders for good ECD models that are indigenous and responsive to rights of children and promote demand for ECD and other related services					
3.1	With which other programs was FEP linked to centrally and locally and how? (Intersectoral committees, use of regional trainers, combining programs, meetings) How useful was this strategy to change behaviour of families in FEP?	X	X	X		
3.2	Has there been a change in the allocation of resources for ECD (0-3 and 3-6) and FEP – human and financial because of this advocacy e.g. change in budget, personnel? At local level and at the central level? Has lack of coordination at national level affected local level?	X	X			
3.3	What type of media advocacy was used? How has it helped? Did media target critical or local issues?	X	X			X
3.4	Lessons Learned: The advocacy process widened its stakeholder involvement and participation – in terms of variety of stakeholders, community involvement and the number of persons. It involved media at local and national level					
	a. For the future, which programs would you like to link up with? How? If you had to include older children concerns, what else would you link up with?	X	X	X		
	b. What lessons were learned in the use of mass media?	X	X			
4.	Key Result: C. Support to local initiatives by FEP increased ECD acceptance and services (such as enrolment in Makhalla KG or other KG), ownership and is sustainable					
4.1	Because of better ECD understanding, how has KG enrolment changed?	X	X	X	X	X
4.2	Lessons Learned					
	What new local initiatives e.g. Makhalla KG and others would be required for children 0-3 and 3-6? Up to 18 years? Who will support Makhalla KG and Family Resource Centers? Can local efforts be scaled up quickly and with desired quality?	X	X	X	X	
5.	Overall Questions: Lessons Learned					
5.1	What expertise did UNICEF provide in identifying national priorities in ECD? What and how were international priorities identified that were relevant to Uzbekistan? What was the quality of UNICEF assistance? How did UNICEF build consensus?	X				
5.2	The FEP process used over two years an elaborate planning process across national, district and local levels including various mechanisms such as TWG, material development workshops, coordinating meetings, trainings to develop, use the program. How feasible is it to use the same procedure to scale up geographically for ages 7-13 and 14- 18 every two years?	X	X			
5.3	How do you ensure that FEP reaches the most vulnerable families – those who do not send their children to ECD?	X	X			

		Govt/UNICEF/Donor/Experts	Local: Region/Rayon/(D.Gov)	Volunteers (also Makhalla Advisor)	Families	Evidence Info. Sheet/Documents
	Core Areas for evaluation					
5.4	How are goals and objectives of FEP-IECD same as or different from other donors and UN system? How are these efforts coordinated? With national policies and priorities? What and how has emerging data been used by UNICEF for continuing advocacy? What has been UNICEF's experience vis a vis other advocacy efforts?	X				
5.5	What was key in managing, coordinating this effort and worked out well? What did not work out so well? How was the monitoring? What could be done better?	X	X			
5.6	How do you scale up and make it sustainable? What new management, coordination efforts and monitoring will be needed? What will be UNICEF's role? Government's role? Other donors? What administrative mechanism is to be used?	X	X			

ANNEX EIGHT: FEP Sample Details

Stakeholder Group	Details	Sample size	Names of persons
1. UNICEF	Previous FEP team	8	Rustam Haydarov, Communication and Marketing Officer; Yulia Narolskaya, Assistant Project Officer, Child Development and Education
	Current FEP team		Shakhlo Ashrafkhanova, Assistant Project Officer, Community and Family Empowerment; Oyunsahan Dendevnorov, Project Officer
	Departments working with FEP		Shukhrat Rakhmojanov, Project Officer, Health and Nutrition; Siyma Barkin, Child Protection
	Management		Reza Hosseini, Country Representative; Andro Shilakadze Program Coordinator
2. Implementing Organization	Pediatric Medical Institute	1	Ismailova Muazem, Pediatrician and FEP Coordinator
3. Trainers	National Trainers	3	Gulyanova Muyassar; Raupora Achida; Usmanuva Mashkuva
	National Trainers	One FGD	12 attended
4. Deputy Hokims	Old and new rayons – interviews and FGD	15 FGD 6 interviews	Mavlyuda Khodjaeva, Fergana; Muhamedova Diloram, Margilan City; Manzura Yusupova, Quva; Makhfirat Omonova, Uchpukrik; Salomatkhon Abdullaeva, Kakun City; Nazarova Nargiza, Angrian Tashkent; Berdieva Khurliman, Nukus; Ibragimova Zulfia, Ellikala; Rano Kadirova, Urgench; Maryakuvor Behchambay; Zamira Begchanova, Khonqa; Roila Shamsieva, Gijduvan, Bukhara; Rano Rakhimova, Jondor Bukhara; Lazzet Eshbaeva, Kanlikul Karakalpakstan; Kodirova Ozoda, Yangiyul, Tashkent
5. Families	Mothers Fathers Caregivers	23 families	In Fergana, Karakalpakstan, Tashkent Regions
6. Volunteers	Director of FRC	2	Sarina, Quva; Nasiba, Begmurad;
	Journalist	1	Hilola Yunusova, Rayon Central newspaper, Uchpukrik;
	Male volunteer, Doctor	1	Dr. Erkin Joraboiv, Tashkent Region
	Volunteer, Center Bio Ecosan Karakalpakstan	1	Musava Zina
	Quva, Uchpukrik, Kakun, Margilan; Katartao; Nazarbete; Nukus; Ellikala; Urgench; Khonqa	10 groups FGD	At least 10 attended each session
	NGO Representative and Regional Trainer,	1	Shohira Otabekova, Soglog Avlod Uhchum Director Zangiata District Branch, Tashkent Region
	Volunteer, Doctor, Medical Sanitary Department Katartal	1	Mukhamedova Nodira
	Volunteer, chairman of Katartal WC	1	Juraboeva Nodira
	Advisor, Yangiabad makhalla (former teacher)	1	Tajihanova Mukkaram,
	Volunteer (nurse) Tashkent region	1	Inagamova Rakhima,

	Director State KG	2	Ashurmatova Khayot, Begmurad KG #16; Samamutova Bibisara, Nukus;
	Rayon Polyclinic Doctor Nukus	1	Dr. Roza Khaderaleeva
	Head of Rayon Education Department Ellikala	1	Ebadulev Farkhod
	Grandfathers Group/Makhalla Committee Chairmen Zangiata	1 FGD	1. Salimov Tulkin, (Navbakhor) 2. Odilov Erkin (Nazarbek) 3. Buronov Davron (Navrouz) 4. Zikirillaev Davlat (Kharakat) 5. Izamov Iskandar (Ahunbabaev) 6. Ishonkulov Muhamamad-sobir (Mehmondust) 7. Yuldashev Shavkat (Nazarbek Union)
	Volunteer, teacher, Zangiata	1	Nurmatova Kholida
	Chairwoman of Makhalla Foundation, Tashkent region	1	Dilorom Tashmedova
	Teacher, who organized makhalla kindergarten	1	Shonabieva Mukhabbat
7. Donors	World Bank/ADB	3	Flora Salikhova, World Bank, Human Development Operations Officer, Economist; Shukhrat Shukurov, Specialist in Public Health; Nigora A. Karabaeva, ADB Project Coordinator/Specialist on WCHD
	WHO	1	Faizullo Abdulhaev, program Officer, MCH
	ADB	1	Zulfia Karimova, ADB, Portfolio Management Officer, Uzbekistan Resident Mission
	AED	2	Borikhan Shaumarov, Program Manager, Central Asia Regional Training Program in Uzbekistan; Shahnoza Ikramova, Program Specialist
	USAID – ABT Zrdaf Plus	1	Dana Koneeva, Country Manager
8. NGO	Soglom Avlod Achum	2	Alimoyamova Dilbar, Director; D. Shazipova
	Oila Republican Scientific and Applied Center	1	Vasila M. Karimova, Director
9. Government	Ministry of Health	1	Klara T. Yadgarova, Chief of the MCH Department
	Ministry of Public Education	1	Feroza Vakhobova, Head of Preschool
	Women's Committee	1	Ms. Turaaeva
	Makhalla Foundation	2	Dhragimova Arafat; Shermatao, Markhabo, Head of HR Dept.
	Institute of Health	3	First Deputy Director, Magdalev Olimjon, First Deputy Director Gorbunova Irina; Methodologist Isakhanova Aidm
10. Other UN organizations	UNDP	2	Laura Rio, Program Coordinator Dilafruz Heydarova, UNDP Program Specialist Gender
	UNFPA	1	Feruza Fazilova, National Program Officer on Reproductive Health

ANNEX NINE: Year wise FEP implementation changes

Year	UNICEF related	Design	Materials	Training	Management
2003	<ul style="list-style-type: none"> • IECD is one of UNICEF's 5 global priorities; studies and MTR advocate need for FEP; • International consultant appointed and FEP strategy paper developed • Makhalla KG Manual developed in May but Makhalla KG initiative discontinued in June • Total budget for FEP in 2003-04 was 311,768\$ ad planned budget for 2005 was 285,300\$ including set aside funds of 115,000\$ • FFL translated into Uzbek • UNICEF supports FEP material development and production, training of volunteers 	<ul style="list-style-type: none"> • Government supports launch of FEP in Karakalpakstan, Fergana, Tashkent Regions - 13 Mohallas in 6 districts of 3 regions (May) • Volunteers selected with consultation at field level • Proposed dissemination through home visits, community events, informal social gatherings, media and clusters of parent learning groups 	<p>TWG develops FEP-IECD materials based on FFL a) Trainers Manual – 23 sessions in 5 modules Health & Nutrition; Early Learning, family relations, child protection; b) Family Home Activity Booklet (Sept)</p> <p>TWG head is Head of Preschool + Paediatric Dr from Dept. of Health (for integration of messages)</p>	<p>14 national and 12 regional trainers undergo TOT</p> <p>First batch 280 frontline workers trained – 48 from each rayon. Mahalla educator, KG teacher, Preschool teacher, Home visiting nurse, informal leaders and volunteers (Nov- Dec)</p>	<p>Intersectoral Coordination Committee established under Social Complex of Cabinet of Ministers at national, regional and district levels and included representation from Ministries of Education, Health, Interior, Social Protection; local NGOs (Kamolot, Soglom Avlod Uchun) and local govt. offices. Social Complex was however disbanded by government and so was the committee.</p>
2004	<p>Coordination at oblast proved difficult and slowed process, and so committees at oblast level discontinued in April. Coordination continued at rayon level</p> <p>FEP leadership crisis at center affects FEP progress</p> <p>Preschool identified in each of 6 Districts or Rayons for Family Resource Center; Delayed since 2003, implemented in Sept</p> <p>Visit by consultant indicates that parent learning groups not formed and develops new implementation strategy (Oct)</p> <p>Need to create a FEP brand image and FEP calendar posters developed with 10 key FFL messages (Nov)</p> <p>\$35,000 were spent for printing of Uzbek adapted FFL 2nd edition and 40,000 copies printed</p>	<p>High dropout results in need for new selection criteria for volunteers</p> <p>Government introduces paid position of Makhalla Advisor, necessarily a woman expected to address religious extremism. She is roped in for FEP as job description requires her to make family visits</p> <p>Revision of cluster group learning by caregivers and implementation of M&E plan proposed by international consultant</p>	<p>10,000 FFL printed for distribution in pilot rayons (June)</p> <p>FEP kits given to each rayon (Modules, Family Home Activity booklet, Stages of development of children, books for children in Uzbek) – only 150 kits for each of six Resource Center (Sept)</p> <p>Large numbers of Calendar and poster with 10 FFL key messages printed; 5000 Shapes Box (for children as part of their kit) available for distribution (Nov-Dec)</p>	<p>New Batch of 48 volunteers trained in each rayon, each receives FFL too. Makhalla Advisors included in training.</p> <p>2 day training on adult learning methods and 2 day toy workshop to strengthen ECD component (Oct/Nov)</p>	<p>Deputy Hokims take lead for coordination at rayon level</p> <p>FEP Coordinator at M of PE removed by government (Aug)</p> <p>New FEP Coordinator from M of PE appointed by govt. (Oct)</p>

Year	UNICEF related	Design	Materials	Training	Management
	Set aside funds for FEP \$217,000 received				
2005	<p>UNICEF restructuring - FEP is now part of Good Governance Dept. in UNICEF</p> <p>\$75000 available for printing material</p> <p>Joint UN capacity building program for Makhalla advisors</p> <p>External Evaluation (Oct, delayed from August)</p>	<p>Small grants for FEP - each rayon to receive \$3000- and grant managing partners appointed at rayon level. FEP incentives for facilitators/volunteers built into small grants</p> <p>Monitoring Plan – not implemented</p> <p>Cluster caregiver IECD learning not implemented</p> <p>New rayons introduced for expansion with different volunteer profile (from pilot makhalla) for training</p> <p>Baselines planned; school readiness program in old and new rayons. Delayed from Q1 and Q2; awaiting evaluation findings</p>	<p>FEP folders developed</p> <p>New FEP materials for children developed (printing delayed from Q1, awaiting evaluation findings)</p> <p>Modification of older children’s materials (printing delayed from Q1, awaiting evaluation findings)</p> <p>Plan to modify FEP modules – strengthen ECD component (international consultant to assist – delayed from Q1, awaiting evaluation findings)</p> <p>Translation of FFL in Karakal language</p> <p>Iodine kits for testing, (Delayed from Q1, Under process)</p>	<p>Training of new batch including Makhalla advisors on FEP and adult learning methods</p> <p>Expansion to rayons – 50 trained in each rayon, with one Makhalla Advisor from each makhalla + some doctors and Methodists from rayon (Q2)</p>	<p>Pediatric Institute in Ministry of Health appointed as FEP Coordinator</p>