Case Study on Narrowing the Gaps for Equity

Uzbekistan
Toward equitable health care for children affected by the Aral Sea disaster
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ABSTRACT

The country of Uzbekistan and its Autonomous Republic of Karakalpakstan (RoK) are facing a monumental environmental disaster caused by the shrinking of the Aral Sea due to a series of water diversion projects implemented over the past 50 years. Increasing desertification of the area and contamination of the remaining lake water has contributed to dire health and economic consequences affecting millions of people, nearly half of them children. UNICEF Uzbekistan, in partnership with the Ministry of Health (MoH) and other stakeholders, has produced a Regional Plan of Action (RPA) for Child Wellbeing to address equity issues related to accessibility and quality of healthcare for children in the region. The innovative plan integrates a cross-sector approach, which involves UNICEF’s Health, Communications for Development (C4D) and Social Policy sections, with UNICEF’s global equity refocus strategy.

BACKGROUND

The Aral Sea, located on Uzbekistan’s northwest border with Kazakhstan, was once the fourth-largest lake in the world. Since 1960, it has shrunk to a fraction of its original size as farmers and state offices in Uzbekistan and other Central Asian states diverted the flow of many rivers that supply water to the lake, thus siphoning off millions of gallons to irrigate cotton fields and rice paddies. The resulting shrinkage has had disastrous impacts on the Aral Sea basin, including increased desertification and significant contamination of the remaining water and surrounding land by agricultural chemicals. The widespread pollution has led to the economic collapse of local communities and to grave health problems affecting about 3.5 million people, including nearly 1.5 million children. Of primary concern is the deterioration of children’s health due to the high rate of illness from pneumonia, diarrhoea and tuberculosis, malnutrition, water-borne diseases and retarded mental and physical development.

The Republic of Karakalpakstan (RoK), on the Southern border of the Aral Sea, is one of the country’s most deprived geographical areas and the region most affected by the Aral Sea disaster. According to Multi-Indicator Cluster Survey 3 (MICS 3) data generated in 2006, the mortality rate of children under five years old in RoK is more than double (65 per 1000 live births) that in the capital region of Tashkent (31 per 1000 live births) and 14 per cent higher than the national average (57 per 1000 live births). In addition to the high rate of mortality and level of environmental pollution, poverty causes significant additional hazardous impacts to children in the region, largely as a result of food and nutrition insecurity. According to the Study on Child Poverty conducted by the government and UNICEF in 2009, 50 per cent of children in RoK live below the poverty line (less than 1 USD per day).
The study also demonstrated that nutrition deprivation is tightly connected with the poverty level. Furthermore, 33 per cent of all households cannot afford daily intake of proteins, and nine per cent cannot provide children with three meals a day. The chronic malnutrition rate among children living in RoK (18 per cent, and double that of children living in Tashkent City) causes one in six children to suffer from stunting, which compromises physical growth, decelerates mental and cognitive development and leads to intergenerational poverty.

STRATEGY & IMPLEMENTATION

In April 2010, United Nations Secretary General Ban Ki-moon visited the Aral Sea region and noted the devastation. Subsequently, the UN reaffirmed its commitment to support the efforts of the Government of Uzbekistan to reduce the impact of the Aral Sea Disaster on the population. UNICEF Uzbekistan has also taken decisive steps to accelerate its engagement and actions in the region with the goal of improving the welfare and boosting the participation of the most deprived children and families. To address these challenges, UNICEF, in partnership with national and local authorities, developed a Regional Plan of Action (RPA) for Child Wellbeing in RoK for the period 2011-2012, which forms a critical component of UNICEF’s long-term commitment to the region. The main focus of the plan is to confront equity issues with respect to the provision of and access to quality healthcare for children through an integrated cross-sector approach which will involve UNICEF’s Health, Communications for Development (C4D) and Social Policy sections.

Defining approaches to address inequities. Based on research evidence, three approaches have been defined to confront existing inequities by addressing health system barriers, improving service delivery by health workers and caregivers and enhancing access through community empowerment and demand creation initiatives:

1. **Capacity development**: Supporting the Ministry of Health of the RoK to build the capabilities and governance skills of health managers for improved supervision, informed decision-making and equity-driven resource allocation through training and participation;

2. **Integrated child health services**: Implementing child survival interventions such as Integrated Management of Childhood Illnesses (IMCI) protocols for comprehensive child healthcare through technical and interpersonal communication training, post-training supervision and introduction of a pre-service IMCI training component in the Medical Institute; and

3. **Accelerated child survival package**: Expanding multi-micronutrient supplementation and immunization coverage, vitamin A supplementation, de-worming and hygiene promotion. This component of the plan will help reach underprivileged children living in the most rural and deprived areas of RoK. Targeted C4D interventions to develop interpersonal skills of health service providers will contribute to build trust and enhance demand for services. C4D interventions will be enacted in line with improvements in service quality and motivate disadvantaged families to access essential healthcare services.

PROGRESS & RESULTS

**Advocacy and consensus building.** Sustained advocacy has enabled UNICEF to obtain the endorsement of its partners for a strategic refocus on equity through a targeted project. A consensus-building meeting was held on February 8, 2011 in Nukus, the capital of RoK. Participants included UNICEF’s technical team, the First Deputy Chair of the Supreme Council of Ministers, the Women’s Committee Chair, the Minister of Health of RoK, and 35 district-level Ministry of Health (MoH) public health specialists.

The Director of the Maternal & Child Health (MCH) Department of the MoH highlighted the importance of the role of health care providers in achieving Millennium Development Goals (MDGs) 1 (end poverty and
hunger), 4 (child health) and 5 (maternal health). During the meeting, UNICEF and local partner the World Health Organization (WHO), presented a jointly developed project plan and reviewed internationally acknowledged methodologies, techniques and tools to improve and measure child wellbeing with a deliberate focus on the most disadvantaged and underserved.

For the first time, formative research was conducted in the ethnic Karakalpak minority community to gain deeper insights needed to identify the social and cultural determinants of their behavior related to infant and young child feeding. This KAP (Knowledge, Attitudes and Practices) study helped identify and analyze the traditional beliefs, spheres of influence and deep-rooted practices that pose barriers to positive change. In fact, the study challenged some of the prevalent assumptions about power relations within the family and indicated the need for a review of strategies to influence feeding practices of newborns and infants. The Minister of Health of RoK took full ownership of the initiative and selected the project districts based on evidence of child morbidity, mortality and stunting prevalence as well as the social data from the KAP study. He emphasized the service providers’ obligation to serve the Karakalpak and Uzbek populations equally. Focal persons were appointed and assigned to collect information about children according to age, anaemia level and language preference in each of the selected districts.

**Development of training materials.** The MoH and UNICEF jointly developed a behavior change communication strategic plan based on the KAP (Knowledge, Attitudes and Practices) study findings and designed communication materials for medical personnel and caregivers addressing barriers to knowledge, attitudes and practices around proper Infant and Young Child Feeding (IYCF). In partnership with WHO, UNICEF and the MoH jointly produced a guidance manual for primary healthcare providers called “Improvement of Infant and Young Child Feeding (IYCF) and Home-based Meal Fortification”. The manual focuses on inclusion and exclusion criteria to identify eligible children for a home-based food fortification programme. Additionally, an IMCI training package was developed to accelerate newborn and infant child survival at the community, primary and tertiary (hospital) levels, while taking into account the strategic capacity-building component of the equity refocus strategy.

**Health providers’ skills development.** The original plan anticipated using a training of trainers (ToT) model to build P-IMCI (Primary Integrated Management of Childhood Illness) capacity among a local pool of trainers. However, it was discovered that since the last IMCI training in RoK in 2006, most of the trained service providers were no longer working in the health system. Therefore, a new H-IMCI training program was initiated in February 2011, for 30 hospital-based, primary health care professionals from three pilot districts. National-level trainers conducted the sessions and administered pre- and post-session tests for all participants, who were ultimately certified in March 2011.

Sixty additional general practitioners and 90 patronage (home visitation) nurses attended the IMCI training in May and June 2011. The C-IMCI module for patronage nurses was enriched with a strong C4D component to enhance their counselling skills. Starting in May 2011, follow-up trainings and monitoring was performed, during which process a group of ToT participants was identified.

UNICEF also supported growth monitoring and breast feeding (BF) trainings for the first cohort of health workers and provided health managers and patronage nurses with the “Improvement of Infant and Young Child Feeding and Home-based Meal Fortification” training manual to enhance their IMCI and newborn survival capabilities.

Prior to the training roll-out, UNICEF collected baseline data in the three pilot districts using the WHO integrated monitoring tool, which consisted of a questionnaire and a record of observations. Once the trainings were completed, a follow-up assessment was performed using the same integrated monitoring tool. The monitoring results showed solid improvement in the use of skills obtained during the trainings. For example, proper application of primary IMCI methods improved from 25 per cent to 81 per cent, and Hospital IMCI methods application rose from 8.5 per cent to 70 per cent.

**Improvements in health system management.** In Uzbekistan’s centralized budget system all budgetary expenditures are overseen by the central ministries and directly controlled by the Ministry of Finance, a fact which creates barriers to long-term planning and reduces the flexibility of resource allocation. As a result,
and in order to address complexities in the allocation and monitoring of resources, the MoH incorporated results-based management (RBM) processes into training approaches, as follows:

- Health managers and decision makers in RoK were trained to review budgets and perform comparative budget analyses based on the findings of The Global Study on Child Poverty and Disparities in Uzbekistan (UNICEF Uzbekistan, 2009). This training enabled them to identify gaps in allocations to the poorest and the most disadvantaged sections of society and provided them with equity-based budget analysis techniques to address gaps.

- Awareness-raising activities were conducted among health policy makers and resource managers about factors affecting child deprivation and vulnerabilities. UNICEF advocated for prioritizing resources for the most vulnerable children and trained health managers to use evidence-based tools and techniques in budget planning and allocation.

- Health policy makers received training in situational analysis for strategic planning, indicator-based monitoring and evaluation in order to improve health care quality and accessibility for the most disadvantaged.

Furthermore, to ensure the sustainability of strategy’s equity-related considerations, a UNICEF-supported consultant with expertise in results-based management and health finance continues to collaborate with the Tashkent Institute of Post-Graduate Medical Education and the Training Centre of the Ministry of Finance to integrate RBM processes into the training curriculum of post-graduate medical studies.

In addition to these systemic improvements, a pilot test of the ICATT (IMCI Computerized Adaptation and Training Tool) is in progress at the Institute of Pediatrics, through an initiative supported by WHO and UNICEF. This cost-saving training software will reduce spending on face-to-face workshops and support the scale-up of the IMCI programme throughout the country.

**CHALLENGES**

Increased poverty and isolation resulting from the Aral Sea Disaster have compounded inequities faced by the people of RoK, namely:

- Insufficiency and unavailability of medical literature or other training materials in the minority Karakalpak language for health personnel and service providers creates inequitable barriers to needed health interventions for this population.

- There are very few Karakalpak-speaking resource persons and trainers. Community interventions and C4D initiatives in RoK must address a variety of cultural specificities and vast differences in living conditions and lifestyles among the region’s people. Therefore, communication strategies developed for other parts of Uzbekistan are not transferable. For example, the IYCF KAP study revealed that mothers of children in the 0-5 age group have strong opinions and play an assertive role in the family, independent of the influence of their mothers-in-law in household decision-making processes, unlike in the rest of Uzbekistan. Consequently, communications must directly target Karakalpak mothers to be successful.

**LESSONS LEARNED**

To achieve sustainable improvements in health and nutrition practices and outcomes for infants and young children in RoK, closer connections need to be established among health facilities, service providers and communities, especially between patronage nurses and communities in remote areas.

Critical gaps need to be closed in the continuum of care for newborns and children discharged from hospitals. Opportunities must be created for community members to improve child care practices at home, to be able to recognize danger signs early and to seek timely medical aid. Positive behaviors can be developed at the family and community level through enabling caregivers to take greater responsibility for the health and well-being of their children.
Health-related materials must be developed and field tested in the Karakalpak language and disseminated to the most deprived communities in remote areas of RoK. Knowledge-sharing activities should not be limited to dissemination of materials. Positive attitudes and good health and nutrition practices can be promoted through participatory learning and action in these communities using culturally appropriate materials and tools.

Access barriers to quality health services can be significantly reduced by addressing systemic bottlenecks at all levels through results-based management, equity-focused targeting of resources and skill-building (both technical and interpersonal) of service providers.

INNOVATION

The approaches identified for addressing existing inequities in RoK are expected to be integrated into an innovative Accelerated Child Survival and Development (ACSD) package and complemented by behavioral change interventions with regard to hand-washing practices and hygiene promotion. They are also intended to stimulate interest in further policy dialogue on more efficient health sector budgeting with a focus on equitable use of financial resources to provide sustainable access to quality health care, nutrition and hygiene services for the most excluded population groups in RoK.

NEXT STEPS

- Continue evidence-based advocacy for implementing an equity focus in health planning, resource allocation and management.
- Undertake further capacity-building activities for health providers on growth development and monitoring and breast feeding practices, and develop more Baby-friendly Hospital Initiative (BFHI)-certified health facilities in RoK.
- Strengthen positive household childcare practices through community participatory learning and action.
- Develop training materials for health providers in the Karakalpak language to expand the intervention beyond the three pilot districts.
- Promote adoption of the UNICEF community IYCF manual in Karakalpak into the health system, and its wider dissemination.
- Disseminate the model for improvement of IYCF and micro-nutrient powder supplementation across RoK.
- Package and implement basic health interventions such as Vitamin A supplementation and de-worming activities.
- Develop a pool of Karakalpak-speaking health trainers.

RELATED LINKS*


UNICEF Infant & Young Child Feeding (website). UNICEF (2011)


Cover photo: A patronage nurse attends to a baby as mother and grandmother look on during a home visit in a traditional yurt tent in the remote Khujayli district of the Republic of Karakalpakstan in western Uzbekistan.

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