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Evaluation of Primary Health Care (PHC) Impact on
Infant and Child Mortality Reduction 2000 – 2017
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KAZAKHSTAN MAP

Image 1: Kazakhstan Map
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Executive Summary

Background

After years under the “Semashko” health care system of the Soviet Union, Kazakhstan has initiated a number of important reforms that aimed to improve the population’s health and the rationalize the healthcare system. In 2010, the government introduced the Universal Health System, which aims to give greater choice to citizens and provide integrated coverage for a basic package of health care service.

Comparisons of data from the current MICS with previous rounds conducted in 2005-2006 and in 2010-2011 demonstrate the notable progress Kazakhstan has made in mother and child health, improvements for families in their living conditions, in access to water and sanitation, literacy and education, increasing use of information and communication technology and significant level of life satisfaction among women. At the same time, MICS reveals emerging challenges in early child development, reproductive and sexual health of women, in women’ perception of domestic violence and in the level of such violence against children, decreasing knowledge about HIV/AIDS among young women.

In 2015 the Universal Progressive Home Visiting model has been introduced in Kyzylorda Region as a pilot intervention. Home visiting services, or patronage nursing system, are visits by primary health specialists to families expecting children and/or already having small children. The goal of such visits is to provide these families with necessary skills to raise their children physically, socially and emotionally healthy and developed: patronage nurses provide parents with child health check-ups, information and advice on general care, health, nutrition, and parenting skills. Currently, the model is in its final piloting stage in Kyzylorda region and is expected to expand to other regions. It is planned that eventually the model will be replicated in all the regions of Kazakhstan.

Evaluation objectives and intended audience

The UNICEF office in Kazakhstan was commissioned this evaluation to provide lessons and recommendations on the UPHV model developed in Kyzylorda Region. This report is part of the Consultancy Services for the Evaluation of Primary Health Care (PHC) Impact on Infant and Child Mortality Reduction in Kazakhstan.

The added value of the evaluation will be in the use of its findings and recommendations for: (a) evaluation of both PHC system’s and the home-visiting model’s impact on infant and child mortality and support government in the scaling up of the UPHV model; and (b) documentation of Kazakhstani experience with possible use by other countries confronting similar issues in primary health care provision.

The intended users of the Evaluation will be the Ministry of Health, local governments, line ministries that will use the results of the Evaluation as the main developers and implementers of the national programmes who need to monitor the progress based of effectiveness and efficiency criteria, to introduce corrective actions if needed, to use the best available practices, to engage trained/informed HR, to bridge the inequality gaps and to allocate sufficient funds. UNICEF as one of the main knowledge brokers in MCH practices providing technical assistance for effective implementation of MCH interventions worldwide.

Methodology

The methodological framework for conducting this Evaluation of the pilot UPHV model was based on the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation and the
The project evaluation questions were formulated as per OECD-DAC evaluation criteria: relevance, efficiency, effectiveness, sustainability and impact. The MoRES determinant analysis framework was used explicitly to identify which bottlenecks were removed and how change was achieved, under the Theory of Change approach. To carry out the effectiveness and impact analysis of the UPHV model, the Theory of Change approach has been applied. Both chapters should be understood together to interpret the results chain.

The evaluation methodology was developed as a process involving the systematic collection of information about the activities, outputs and outcomes of the model to determine its merit or worth. The methodology incorporated the use of qualitative and quantitative techniques. The identification of evidence led to the formulation of conclusions and recommendations and, to avoid the error of causal interpretations, a triangulation system of the information was applied.

Main findings and conclusions

Relevance

- The implementation of UPHV model has been a political priority for the Ministry of Health of the Republic of Kazakhstan. Since 2015 the government has achieved important milestones: the Pilot project in Kyzylorda (2016-2017) and the beginning of the scaling-up process (2018) are among the most remarkable.

- This political priority is fully embedded in the long-term healthcare policy framework that has in the Primary Healthcare one of its main strategies. In this sense the development of the UPHV model in the country will has a major impact in the PHC reform that goes back to the beginning of the present century.

- Although the consistency with governmental policies has been proved it has to be remarked that the UPHVM is not explicitly mentioned in the main healthcare planning document of the country (Densaulyk 2016-2019) nor in the Strategy Plan of the MoH (2014-18).

- UNICEF has been beside this UPHV model deployment process. The model of home visiting was adapted to the Kazakh health system context as a result of a regional initiative of Europe and Central Asia Regional Office (ECARO) launched in 2012. The role of UNICEF Country Office has been mainly focussed in the field of advocacy and technical assistance and has been highly evaluated by all stakeholders of the process.

- This sponsorship has guaranteed that the design of the care model has been grounded on the latest scientific evidence and respond to an evidence-based problem analysis and needs of the target groups as well to lessons learned from other regional an international experiences. Nowadays the UPHV experiences in Central Asia and East Europe that were born thanks to this regional initiative are arriving to a different degree of maturity and their results will enrich the following steps of the national processes.

Effectiveness

- The theoretical hypothesis of the model definition about the relevance and efficacy of the UPHV model addressing comprehensively biopsychosocial aspects of children’s development has been verified. The traditional patronage is more medicalized assessing and addressing only medical aspects of child development, but not focussing on preventive or social issues. Substantial differences were found regarding the traditional patronage system. Positive contributions from the UPHV model
were found in the PHC attributes: Comprehensive care, Family approach care and community orientation. On the other hand, the primary care system does not lose effectiveness under the UPHV model in the characteristics of “First-contact” care, continuous care and coordination; with no substantial differences in those features of PHC between the UPHV model and the traditional patronage model.

- Under the new UPHV model implemented in Kyzylorda, home visitors identify every single child in their attachment area, assess the risks and potential risks that could be socio economical, derived from poverty, environment, etc and then an individual plan of action is prepared, not limited to the health issues, distributing roles and responsibilities.

- It has been found differences between the UPHV model and the traditional patronage model, since under the UPHV model some services are best ranked by families: counselling for mental health problems, support on searching social assistance, treatment for harmful drug use, support dealing with the child’s behaviour problems or preventive recommendations to avoid injuries to children. There are no significant differences in child health interventions, such as identification of visual problems, nutritional supplementation programme, immunizations, counselling on first child health symptoms or promotion of child health.

- Important challenges remain for integration of social services and HV system, diminishing the effectiveness of both systems. The problems, such as child or caregiver’s disabilities, development difficulties or negative social-economic environment are difficult to solve without a best level of coordination.

- The continuity of care is, in general, well perceived by the families surveyed: the doctors / nurses and families build a long-term relationship in order to foster mutual understanding and knowledge of each other’s expectations and needs. This important element is limited and put in risk in some places by the high turnover of doctors and, to a lesser extent, of nurses. Besides the existing quality initiatives such as the use of clinical guidelines, accreditation processes, and care pathways, new quality improvement measures could enable frequent monitoring of health outcomes.

- Respondents from families to the survey affirm a good level of accessibility to the UPHV services, measured as the reception of regular visits. But this statement must be questioned since there are significant differences between families to the question whether children with chronic diseases receive regular visits or should call the medical center. In some cases, a practice of regular visits to families is identified, in other cases that evidence is not found.

- More and more, the possibilities of new technologies for information and communication are being exploited. The use of social networks and messaging platforms suppose a very great potential. But at the same time, it is a challenge on how to regulate its use and procedures.

Impact

- The universal progressive home visiting system is an effective solution to improve child’s lives in the country. Breastfeeding and parents’ awareness of the prevention of infectious diseases has experienced a positive evolution in the areas of pilot implementation.

- Infant mortality has shown a positive trend in parallel as has happened throughout the country. There is no evidence that the UPHV model has
made a significant contribution to the general reduction of mortality. However, if the causes of death are analyzed, a contribution is identified in the reduction of deaths caused by congenital malformations, highly significant reduction in rural areas where the UPHV has more incidence.

- A monitoring system focused on activities and outputs limits the capability to measure the results of the UPHV model at the outcome - impact level.

Efficiency

- The UPHV model has been efficient in achieving certain outcome results and in overcoming some bottlenecks of the system. This has been largely thanks to the substantial contribution of the home visitors staff. This contribution significantly exceeds the level of planned effort. The hours of dedication are greater, due to the fact that work hours generally cover the hours of visits to families and part of the paperwork is taken home and assumed during non-working hours. This puts stress on the model sustainability and generates situations of overcrowded, which is added to the high level of professional rotation.

- Decades of child development research and evidence from studies on child deprivation, resilience, early intervention and brain development clearly demonstrate that the early years - starting at conception- provide a highly cost-effective window of opportunity to enhance lifelong wellbeing and productivity. No costing assessment of the model has been performed in Kyzylorda, but performance data, the assessment on used resources and research evidence allow sustaining a high cost-effectiveness relationship. A costing assessment would improve the capability to make evidence-based decisions of the programme. This input would be one of the bases for an expansion of the programme to the country.

- Human Resources reports a demand for more physical space for home visitors and better setting for work. At this stage no HR planning for UPHV scaling-up and institutionalization of training modules have been identified.

- One of the main concerns of home visitors is to move between health centers and households. An important margin of efficiency gains is identified if logistical support for transport is increased. This is mainly important in rural areas with great geographical dispersion.

Sustainability

- The UPHV model is legally integrated in the in the health care delivery services funded by the state. Through the decree #1027 (December 2017) the Minster of Health approved the Paediatric Care Standard in the Republic of Kazakhstan. This decree explicitly includes the UPHVM as it was implemented in the Kyzylorda Pilot

- This decree signified the starting point of the scaling-up process of the model to the national state funded healthcare system.

- The process of extension of the UPHVM has been done much more faster than it was planned in 2015: the initial conceptualization of the scaling-up included a preparation phase and a second pilot of the model that has not been implemented.

- This acceleration is putting pressure on the sustainability of the UPHVM and at the same time justifies the need of continuity of the Technical Assistance of UNICEF.

- The supporting supervision of the UPHV teams is a key task for maintaining the
quality of services. The quantity of supervision (number of days) is not enough to provide quality supervision; and the function is not institutionalized into the system.

Cross cutting

- The intervention theory has clearly considered Human Rights and Gender issues since the definition of the UPHV model incorporates it as a core fundamental of the definition. The families experiencing socio-economic difficulties, psychosocial stress, and other unfavourable circumstances receive increased support. Intensive support is provided to families where children are highly vulnerable and in cases when cross-disciplinary support and cooperation between health, social and educational services is needed to reduce the risk. Disaggregated health and mortality data by sex, place of residence (urban / rural) and age is available.

- Five main risks associated with pregnant women are monitored by the UPHV model: nutrition, depression, medical risks, bad habits and social risks affecting the provision of the needs of the child.

- Considerable contributions are identified addressing inequalities and discrimination under the Leaving No One Behind model.

Main recommendations

R #1: The UPHV model should be included in the new health policy planning cycle. A document should describe the new PHC model including the UPHV. All this will allow to institutionalize the UPHV model to ensure, at least:

- integrate the UPHV system into the calculation of the per capita financing of the PHC,
- supporting supervision to the HV teams for maintaining the quality of services,
- development of the monitoring system to track the performance of the UPHV
- integrate the training modules into the continuous professional development of the Kazakh Health System

R #2: Define a strategy to foster the coordination and integration of social services and HV system. Promote inter-ministerial coordination, especially concerning multisectoral issues such as health, education, social and WASH, as required or permitted by the projects. The coordination and participation should be also improved at the governance and community local level.

R #3: Once the monitoring system is in place, an incentive system for home visitors should be developed. The differences in performance must also be analyzed to reduce the asymmetries that have been identified.

R#4: Guide and regulate the use of new technologies for information and communication, paying special attention to the use of social networks and messaging platforms.

R#5: Explore the possibilities to improve the efficiency of home visits, through logistical means that allow having more hours of attention to families.

R#6: Develop a costing assessment of the UPHV model in Kyzylorda and scenarios for the scaling-up. The absence of this study limits the capability to make evidence-based decisions to improve the cost-effectiveness of the program.

R#7: Develop in the short-medium term all key elements that needs to be supported to ensure a successful scaling-up process:

- Human Resources planning at national level to decrease high turnovers in rural regions and nurse shortage in the main cities.
- Human resource workload study to mitigate work overload
- Elaborate a new capitation funding modality including the UPHVM package of services.
- Improve the M&E system at national level
- Design a continuous and in-depth supervision system for the staff recently involved in HPHVM reinforcing their capabilities an assessing them on the field.
- Implement a residency program for PHC doctors at national level to increase this specialty knowledge in the country.

R #8: Actively engage a large number of professionals/officers to ensure that reforms are viable, legitimate, relevant and feasible and not limited to a few external experts promoting top-down diffusion of innovation.
1 INTRODUCTION

1. The Evaluation Report is the last deliverable of the Consultancy Services for the Evaluation of Primary Health Care (PHC) Impact on Infant and Child Mortality Reduction in Kazakhstan. Two-fold evaluation have been done: 1) Assessment of the universal progressive home visiting model in Kyzylorda region; and 2) the PHC impact on Child and Infant Mortality. This document presents the methodology applied, the findings, conclusions and recommendations of the first folder.

2. There was a commitment from the consultant team responsible for the evaluation to design and implement a unique methodology, specifically conceived to meet Unicef requirements and consistent with country’s characteristics and information availability. In addition, it has sought to integrate some tools and approaches used by the Multi-Country Evaluation of the Universal Progressive Home Visiting for Young Children Well-being and Development in the Europe and Central Asia Region, that is being done at the same time.

3. The main stakeholders of the evaluation will be MoHSD of RoK, MoES of RoK as the main policy developers and monitors; home visitors, staff of policlinics, pre-schools as the main implementers of the ECE/ECD programmes and primary source of information; families, with specific attention to vulnerable groups among families as the target/beneficiary group of the ECD/ECE programme with satisfaction/or not satisfaction assessment of the programmes. UNICEF will have two roles: (i) as one of the main knowledge brokers in MCH practices providing technical assistance for effective implementation of MCH interventions worldwide; and (ii) as evaluation manager will be the counterpart of the project implementation.

4. The 2030 Agenda commits to “realize the human rights of all and…gender equality and the empowerment of all women and girls”. The impact evaluation of primary healthcare system on infant and child mortality in Kazakhstan will consider human rights, gender and equity, focusing on:
   - Explicit alignment of Kazakhstan health system development efforts with international standards on human rights and gender equality;
   - A focus on addressing inequalities and discrimination towards leaving no one behind;
   - The identification of gaps to reduction of gender inequalities and empowerment of all women and girls and through attention to gender equality in primary health care reform policies.

5. The added value of the evaluation will be in the use of its findings and recommendations for: (a) evaluation of both PHC system’s and the home-visiting model’s impact on infant and child mortality; and (b) documentation of Kazakhstani experience with possible use by other countries confronting similar issues in primary health care provision. The period covered was 2000 – 2017 and the geographical coverage: city of Nur-Sultan; Kyzylorda and Karaganda oblasts, although the analysis takes the whole country.

2 CONTEXT OF THE INTERVENTION

6. After the breakup of the Soviet Union and the collapse of socialism in Central and Eastern Europe, most of the countries experienced a decline in economic wellbeing at both macro and micro level, with many countries in the CEE/CIS not recovering their former economic position a decade later (CPC, 2012). In this context, there is a diverse mix of old and new
policy challenges to improving child well-being and realizing children’s rights, and a divergence of child well-being priorities for the different countries.

7. After years under the “Semashko” health care system of the Soviet Union, Kazakhstan has initiated a number of important reforms that aimed to improve the population’s health and the rationalize the healthcare system. Despite significant progress, analyses done in 2008 and 2009 by the World Health Organization (WHO), Ministry of Health (MOH) and United Nations Children’s Fund (UNICEF) on clinical and operational issues facing paediatric and maternal care highlighted a number of areas of where improvements are needed. Some of the challenges outlined were (WHO and the Ministry of Health of Kazakhstan, 2008; Braveman and Barclay, 2009):

- Insufficient use of evidence-based diagnostic and therapeutic protocols and algorithms in clinical practice.
- Limited knowledge of safe labour practices and gaps in antenatal care.
- Lack of a precise definition of roles and responsibilities and of integration of case management protocols across the different levels of care.
- Lack of integrated teamwork among different specialists taking care for children to ensure consistency and continuity of care.

8. In 2010, the government introduced the Universal Health System, which aims to give greater choice to citizens and provide integrated coverage for a basic package of health care service. The new system has produced a doubling of health care expenditure per capita and improvements in coverage for a number of areas; yet, the impact on actual health outcomes seems to be lagging behind. Kazakhstan’s maternal and child health network is highly fragmented due to low overall population density, poor coordination of care, a rigid administrative system, and overcapacity in the hospital sector, amongst other issues.

9. The Kazakhstan Multiple Indicator Cluster Survey (MICS5) is a key source of information on the health policies that are being implemented in Kazakhstan and on the main health and development indicators. Surveys have been conducted in 2005, 2010 and 2015.

10. The last survey was conducted in 2015 by the Statistics Committee of the Ministry of National Economy of the Republic of Kazakhstan in collaboration with the Republican State Enterprise “Information and Computing Centre” as part of the Global MICS Programme.

11. Comparisons of data from the current MICS with previous rounds conducted in 2005-2006 and in 2010-2011 demonstrate the notable progress Kazakhstan has made in mother and child health, improvements for families in their living conditions, in access to water and sanitation, literacy and education, increasing use of information and communication technology and significant level of life satisfaction among women. A share of pregnant women that visited a medical services provider at least four times has increased from 87.

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1 The Union of Soviet Socialist Republics (USSR, founded in 1922) developed a totally state-run health-care model — the Semashko system — centralized, integrated, and hierarchically organised with the government providing state-funded health care to all citizens. All health personnel were state employees.


per cent in 2010 to 95.3 per cent in 2015. Maternal mortality has fallen dramatically from 92 deaths per 100,000 live births in 1995 to 12 deaths per 100,000 live births in 2015. The under-five mortality rate was reduced from 53 in 1990 to 11 per 1,000 live births in 2016. At the same time, MICS reveals emerging challenges in early child development, reproductive and sexual health of women, in women’s perception of domestic violence and in the level of such violence against children, decreasing knowledge about HIV/AIDS among young women (MICS Kazakhstan 2015).

12. Despite these improvements, inequalities persist. Shortages of medical personnel in rural areas, a high turnover of staff and difficulties in retaining qualified staff in remote areas, poor transportation services, and lengthy travel times to health care facilities are likely to undermine access to services in remote areas across the country.

Water and Sanitation

13. Unsafe drinking water can be the main determinant of diseases such as cholera, typhoid, and schistosomiasis. Drinking water can also be contaminated with chemical and physical contaminants with harmful effects on human health.

14. According to WHO, providing people with safer water can annually prevent: 1.4 million child deaths from diarrhoea; 500 thousand deaths from malaria; 860 thousand child deaths from malnutrition.

15. In addition to preventing disease, improved access to drinking water may be particularly important for women and children, especially in rural areas, who bear the primary responsibility for collecting and delivering water, often for long distances.

16. The survey (MICS Kazakhstan 2015) findings revealed that in Kazakhstan the majority, or 97.3 percent of the population, use improved drinking water sources: 99.7 percent in urban and 94.6 percent in rural areas.

17. The situation in the West Kazakhstan region is slightly worse than in other regions; only 80.1 percent of the population in the region have access to improved drinking water sources, and 18.6 percent of the population use the water from the tanker trucks. More favorable situation with access to improved drinking water sources is in the Aktobe and Mangistau regions and in Astana city.

18. Overall, 99.9 percent of Kazakhstan’s population lives in households using improved sanitation facilities, while with no notable differences by background characteristics.

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6 UN, World Population Prospects, 2017 Revision.

19. Water and sanitation are very relevant for UPHV model. Every year, mainly in the summertime, patronage nurses are doing activities in the prevention of infectious diseases, conduct seminars with parents, give information to families about drinking water and use of boiled water. Also, nurses distribute rehydron to every family. All these activities are preventing the infection of children.

Child mortality

20. Child mortality reflects social, economic and environmental conditions in which children live. It also reflects the quality, performance and equity of national health systems. To date, the overall situation in the Kazakhstan healthcare sector has improved with both infant and child mortality rates significantly reduced as can be viewed in figures below.

21. Specifically, the under-5 mortality rate is a central indicator for assessing the situation of young children and has experienced in the last decades an important decrease (figures 1 and 2).

22. Figure 1 shows the series of under-5 mortality rate estimates of the survey, based on responses of women in different age groups, and referring to various points in time, thus showing the estimated trend in USMR based on three surveys, DHS-1995, MICS-2006 and MICS-2010/11 as well as the country’s official statistics.

23. Discrepancies between data until mid-2008 from different sources can be explained in part by different approaches to live birth definitions and child mortality estimation techniques beginning from 2008 when Kazakhstan started using new criteria on live and still births recommended by WHO.

24. In 2010 the MICS-2010/11 survey indicates that mortality has been declining for the past 15 years (figure 1).

*Figure 1: Under -5 mortality trends, Kazakhstan 2010/2011*

*Figure 2: Mortality rate, under-5 (per 1,000 live births)*


https://data.worldbank.org/indicator/SH.DYN.MORT?locations=KZ
25. Finally, it is important to note that in Kazakhstan; most of the deaths of children can be prevented by the implementation of life-saving preventive and therapeutic measures in time. In fact, the factors known as “three delays” are: 1) the delay in recognizing the illness and complications among parents and appeal to a medical care, 2) the delay in admission to the medical organization (PHC facility or children's hospital) and 3) the delay in receiving proper assistance within the medical organization - are the main factors not allowing to increase the chances of survival.

Nutrition

26. Children’s nutritional status is a reflection of their overall health. When children have access to food that is adequate in quantity and balanced in composition, they are not exposed to chronic illness, and if they are well cared for, children reach their growth potential and are considered well-nourished and fully developed.

27. Undernutrition is associated with more than half of all child deaths worldwide. Undernourished children are more likely to die at an early age from common childhood ailments, and for those who survive, it is common to have chronic illness and faltering growth. Three-quarters of the children who die from causes related to malnutrition were only mildly or moderately malnourished – showing no outward sign of their vulnerability.

28. In Kazakhstan, 2.0 percent of children under age five are underweight. However, 8.0 percent of children are stunted and 3.1 percent of children are wasted for their height. In addition, 9.3 percent of children are overweight. (MICS Kazakhstan 2015).

29. The age pattern shows that the youngest, namely those <6 months of age, have the highest rates of underweight and wasting, however this might in part be due to larger proportion of children excluded from the analysis due to missing weights (Figure 1). The prevalence of overweight is higher among children aged 12-17 months (MICS Kazakhstan 2015).

Figure 3: Underweight, stunted, wasted and overweight children under age 5 (moderate and severe), Kazakhstan, 2015

30. In country, stunting of children is more prevalent than underweight. The indicator range by region varies from 2.3 percent in the North Kazakhstan region to 11.8 percent in the Atyrau region.

31. Those children whose mothers have higher education face the least likely to be underweight and stunted, and at the same time, the highest probability to be overweight compared to children of mothers with lower education levels. In urban areas, children are more likely to be overweight than in rural areas.

32. The age pattern shows that the youngest, namely those <6 months of age, have the highest rates of underweight and wasting, however this might in part be due to larger proportion of
children excluded from the analysis due to missing weights. The prevalence of overweight is higher among children aged 12-17 months (MICS Kazakhstan 2015).

33. From one hand 30 and over 40% of under-5 and women at reproductive age are affected by Anaemia (50% of this might be due to Iron deficiency). From the other the prevalence of child obesity is rapidly raising. Iron-deficiency anaemia, particularly in children under 2 years of age, can result in irreversible learning problems even if the iron deficiency and anaemia are corrected, this depicts the importance of early and timely prevention. Obesity is affecting over 13% of under-5 children and this figure increases during the school year to over 20%, only by adopting a multi-system approach involving health, food, education and social protection, the double burden can be addressed.

34. The Double-burden of malnutrition is originated from and affects several delivery systems and hence the solution demands to follow a multi-system approach, to understand this better, take the example of Iron deficiency and/ or Iron Deficiency Anemia, the problem is resulted from a nutritional deficiency which is caused by either poor dietary diversity and lack of fortified products (food systems) and or due to poor hygiene (WASH system), it affects the health of the child (poor immune system and hence a burden to health system) and it affects the cognitive development of the child (education system results hampered). So, to address or by addressing this a number of delivery systems are required or affected.

**Low Birth Weight**

35. Weight at birth is a good indicator not only of a mother's health and nutritional status but also the newborn's chances for survival, growth, long-term health and psychosocial development. Low birth weight (defined as less than 2,500 grams) carries a range of grave health risks for children. Babies who were undernourished in the womb face a greatly increased risk of dying during their early days, months and years. The children who survive with low birth weight may face problems with immune system function and increased risk of disease; they are likely to remain undernourished, with reduced muscle strength, to the end of their lives, such children suffer a higher incidence of diabetes and heart disease in later life. Children born with low birth weight also risk a lower IQ and cognitive abilities, affecting their performance in school and their job opportunities as adults.

36. In the developing world, low birth weight stems primarily from the mother's poor health and nutrition. Three factors have most impact: the mother's poor nutritional status before conception, short stature (due mostly to undernutrition and infections during her childhood), and poor nutrition during pregnancy. Inadequate weight gain during pregnancy is particularly important since it accounts for a large proportion of foetal growth retardation. Moreover, diseases such as diarrhea and malaria, which are common in many developing countries, can significantly impair foetal growth if the mother becomes infected while pregnant.

37. In the industrialized areas, cigarette smoking during pregnancy is the leading cause of low birth weight. In developed and developing countries alike, children born to teenagers who give birth when their own physical development is not yet completed, run a higher risk of bearing low birth weight babies.

38. There is a notable decline of underweight and stunting prevalence rates among children under five. Eight per cent of children are stunted or too short for their age and 3.1 percent

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8 Баттакова Ж.Е., Мукашева С.Б., Спажнева Т.И., Абдрахманова Ш.З., Буонкрисиано М., Адаева А.А., Акимбаяева А.А. ЭПИДЕМИОЛОГИЧЕСКИЙ МОНИТОРИНГ ДЕТСКОГО ОЖИРЕНИЯ И ФАКТОРОВ, ЕГО ФОРМИРУЮЩИХ, В РЕСПУБЛИКЕ КАЗАХСТАН, 2015-2016 гг. НАЦИОНАЛЬНЫЙ ОТЧЕТ. Алматы, 2017
are wasted or too thin for their height. Stunting varies significantly by region, with 11.8 per cent for Atyrau region and 2.3 per cent for North Kazakhstan.

39. Almost 20 per cent of children aged 6 to 9 years suffer from excessive weight or obesity that is mostly a result of unhealthy eating habits and insufficient physical activity. Obesity is most common in children from high-income families or with relatively few children and is often linked to excessive consumption of sugar, sweets, and commercial sweet drinks. Children in Kazakhstan are exposed to a high volume of marketing of high in saturated fats, trans fats, free sugars and/or salt foods.

40. The level of salt consumption in Kazakhstan is approximately 17 g per day, which nearly four times the World Health Organization (WHO) recommended rate and is the highest recorded rate in the world. Most of the traditional homemade dishes have high sodium content, indicating that excess salt is added.

Breastfeeding and Infant and Young Child Feeding

41. Proper feeding of infants and young children can increase their chances of survival; it can also promote optimal growth and development, especially in the critical period from birth to 2 years of age. Breastfeeding in the first days of life protects children from infection, provides an ideal source of nutrients, and breastfeeding as well as being an economical and safe method of the feeding.

42. Studies have shown that, continued breastfeeding along with complementary feeding to the child from 6 months with age-appropriate nutritious and safe solid, semi-solid and soft foods, are the key to a better health and proper development of the child, and makes it possible to eliminate or reduce stunting during the first two years of life. Starting at 6 months, breastfeeding can be combined with safe, age-appropriate feeding of solid, semi-solid and soft foods.

43. According to the Kazakhstan MICS 2015 survey, 38 percent of children aged 0-5 months are exclusively breastfed, and more than 70 percent of children are predominantly breastfed, indicating the prevalence of practice of giving non-milk liquids to infants in addition to breastmilk. By age 12-15 months, almost 60 percent of children are breastfed.


10 WHO, Улучшение питания в Казахстане: ключ к достижению целей в области устойчивого развития, 2019

11 Баттакова Ж.Е., Мукашева С.Б., Слажнева Т.И., Абдрахманова Ш.З., Буонкристиано М., Адаева А.А., Акимбаева А.А., Эпидемиологический мониторинг детского ожирения и факторов, его формирующих, в Республике Казахстан, 2015-2016 гг. Национальный отчет

12 WHO, Monitoring food and beverage marketing to children via television in the Republic of Kazakhstan National Center of Public Health of the Republic of Kazakhstan (Republic of Kazakhstan), 2019

13 WHO, Улучшение питания в Казахстане: ключ к достижению целей в области устойчивого развития, 2019

14 WHO, FEED cities project, The food environment in cities in eastern Europe and Central Asia – Kazakhstan, February 2019


and by age 20-23 months, 21.1 percent of children are breastfed; 22.3 percent of boys and 19.7 percent of girls aged 20-23 months continue to be breastfed.

44. Exclusive breastfeeding and predominant breastfeeding are more common in rural areas (42.1 and 77.9 percent, respectively) than in urban areas (33.7 and 68.8 percent, respectively); while the proportion of children aged 20-23 months who continue to be breastfed in urban and rural areas was 22.7 and 19.9 percent, respectively (MICS Kazakhstan 2015).

45. Figure 4 shows the detailed pattern of breastfeeding by the child’s age in months. Even at the earliest ages, in addition to breast milk, the majority of children are receiving plain water and vitamins, even in the first 4 weeks of life. Moreover, almost 70 percent of infants aged 0-1 months are exclusively breastfed; at 2-3 months, the proportion is more than halved reduced (31.4 percent), and by the age of 4-5 months, it is almost 3 times lower at 23.5 percent. By the age of 2 years, more than 80 percent of children are weaned off the breast (MICS Kazakhstan 2015).

**Figure 4:** Infant feeding patterns by age, Kazakhstan, 2015

![Infant feeding patterns by age, Kazakhstan, 2015](source: MICS Kazakhstan 2015)

**Figure 5:** Infant feeding patterns by age, Kazakhstan, 2010/2011

![Infant feeding patterns by age, Kazakhstan, 2010/2011](source: MICS Kazakhstan 2010/2011)

**Vaccinations**

46. The Millennium Development Goal (MDG) 4 aimed to reduce child mortality by two thirds between 1990 and 2015. Target 3.2 of the third goal of the Sustainable Development Goals (SDG) adopted in 2015 aims to end preventable deaths of newborns and children under 5 years of age by 2030. Immunization plays a key role in the attainment of this goal. In addition, the Global Vaccine Action Plan (GVAP) was endorsed by the 194 Member States
of the World Health Assembly in May 2012 to achieve the Decade of Vaccines vision by delivering universal access to immunization. Immunization has saved the lives of millions of children in the four decades since the launch of the Expanded Programme on Immunization (EPI) in 1974. However, there are still millions of children worldwide not reached by routine immunization and as a result, vaccine-preventable diseases cause more than 2 million deaths every year.

47. In Kazakhstan, the percentage of children who received all the recommended vaccinations by two years of age (by 24 months) is 84.1 percent. 1.1 percent of children aged 24-35 months received none of the recommended vaccinations. (MICS Kazakhstan 2015)

48. The country has introduced new vaccines including PcV and HiB, but not the Rotavirus Vaccine yet, this vaccine is a vaccine used to protect against rotavirus infections, which are the leading cause of severe diarrhea among young children. Figure 6 below shows the schedule for immunization in the Republic of Kazakhstan, as amended and approved in 2013.

**Figure 6:** Immunization Schedule in the Republic of Kazakhstan, approved in 2013

![Immunization Schedule in the Republic of Kazakhstan, approved in 2013](source: MICS Kazakhstan 2015)

**Maternal and newborn health**

**Antenatal Care Coverage**

49. Coverage of pregnant women during the antenatal period with medical and preventive activities is very important and vital to their health and well-being, as well as for the health and well-being of their children.

   - WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of antenatal care. WHO guidelines are specific on the content on antenatal care visits, which include: Blood pressure measurement
   - Urine testing for bacteriuria and proteinuria
   - Blood testing to detect syphilis and severe anaemia
   - Weight/height measurement (optional).

50. It is of crucial importance for pregnant women to start attending antenatal care visits as early in pregnancy as possible in order to prevent and detect pregnancy conditions that could affect both the woman and her baby. Antenatal care should continue throughout the entire pregnancy.

51. In Kazakhstan coverage of antenatal care by skilled health personnel, health care providers, is very high and amounted to 99.3 percent (MICS Kazakhstan 2015).
52. Thus, antenatal care for pregnant women was predominantly provided by:

- Qualified doctors (92.2 percent), for 6.6 percent of pregnant women
- Nurses or midwives, for 0.5 percent – by feldshers, these two categories of mid-level medical personnel are mostly typical for rural areas (10.8 and 1.0 percent respectively).

53. Among the regions, it can be noted that in the Zhambyl region every third pregnant woman was followed up by nurses/midwives (32.6 percent). Although across the country, access to antenatal care from any qualified medical personnel is very high; and it does not depend on the type of area of residence of pregnant women or their level of education and women’s household wealth or ethnicity; pregnant women living in urban areas (96.9 percent), or in the richest households (98.8 percent), or having higher education (95.8 percent) are more likely to receive antenatal care from doctors than their counterparts (MICS Kazakhstan 2015).

54. It is worth to note that antenatal and post-natal health care is state guaranteed in Kazakhstan (Code of the Republic of Kazakhstan "On People’s Health and Health Care System" Article 97 Protection of women’s health during pregnancy, childbirth and after childbirth). Similar to other countries, by significant reduction of under-5 mortality, the last mile to further close the gaps, is to focus on the narrow window around the time of birth, as over 50% of under-5 deaths are happening during the first 4 weeks of life. Investment on this period (and more specifically on the week before and after birth), has triple returns reduction of neonatal mortality, reduction of still birth and reduction of maternal mortality. Introduction of developmental care must be also started as early as possible for the premature newborns who are at higher risk of developmental delays.

Assistance at Delivery

55. About three quarters of all maternal deaths occur due to direct obstetric causes. The single most critical intervention for safe motherhood is to ensure that a competent health worker with midwifery skills is present at every birth, and in case of emergency that transportation is available to a referral facility for obstetric care. The skilled attendant at delivery indicator is used to track progress toward the Millennium Development Goal 5 of improving maternal health, as well as for recently adopted Sustainable Development Goals.

56. More than 90 percent of births in Kazakhstan were delivered with the assistance of doctors, and 9.1 percent of births with the assistance of nurses and midwives (Figure 7).

![Figure 7: Person assisting at delivery, Kazakhstan, 2015](image)

Nursing staff, i.e., nurses and midwives assisted at delivery more frequently in the West Kazakhstan, Zhambyl and Kyzylorda regions and Almaty oblast (28.1, 24.9, 21.9 and 19.5 percent, respectively) (MICS Kazakhstan 2015).

Place of Delivery

57. Increasing the proportion of births that are delivered in health facilities is an important factor in reducing the health risks to both the mother and the baby. Proper medical attention and care by health personnel and hygienic conditions during delivery can reduce the risks of
complications and infection that can cause morbidity and mortality to either the mother or the baby.

58. In Kazakhstan, 99.3 percent of births are delivered in health facilities: 98.9 percent predominantly occur in public sector facilities. Only a small proportion of births – 0.4 percent – are delivered in private sector health facilities, and 0.1 percent at home. There are no differences in the place of delivery by background characteristics of women. 3.2 percent of women from the Pavlodar region, as well as less than 2 percent of women from the Almaty city and Almaty oblast deliver in private sector health facilities. (*MICS Kazakhstan 2015*)

**Post-natal Health Checks**

59. The time of birth and immediately after is a critical window of opportunity to deliver lifesaving interventions for both the mother and newborn. Across the world, approximately 3 million newborns annually die in the first month of life¹⁷ and most of these deaths occur within a day or two of birth¹⁸, which is also the time when the majority of maternal deaths occur¹⁹.

60. Overall, 99.4 percent of newborns in Kazakhstan receive a health check following birth while in a facility or at home. With regards to PNC visits, these predominantly occur either on the first day following discharge (30.7 percent) or 3-6 days (30.5 percent) following discharge. Approximately every fourth PNC visit for newborns (23.5 percent) was carried out 2 days following discharge, and 10.2 percent after the first week following discharge. In general, almost every newborn child (with some exceptions) in the country received PNC visits following discharge from health facility, while 1.7 percent of children received no PNC visit following discharge from the medical facility (*MICS Kazakhstan 2015*).

61. The inefficiency and incompleteness of the services provided by PM and SR for target groups of the population is confirmed by data from a household survey conducted as part of a basic assessment of foster care services. Overall satisfaction with services received from PNS is 42% in rural areas and 56% in cities.

62. An analysis of household data shows that only 39% receive sufficient information about child care, more than half of the respondents believe that they could discuss issues related to domestic violence, child abuse and developmental issues. However, postpartum patronage services are less available to women and children in rural areas compared to urban areas (2015 baseline assessment).

63. Social norms and in particular traditional gender roles of men and women negatively affect opportunities for Early childhood development expansion. Whilst mothers are supported by the primary health care system to acquire knowledge and develop childcare skills, fathers are often not seen as important partners. Interventions raising awareness of importance of fathers in Early childhood development are mostly implemented ad hoc, with no systemic strategy and dedicated funding.²⁰

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²⁰ ЮНИСЕФ *Позаботьтесь о развитии вашего малыша*, a parents-focused booklet supported by UNICEF promotes more active involvement of fathers in ECD
64. Regarding early childhood education in Kazakhstan, pre-school organizations vary by the following types: 1) nursery; 2) kindergarten; 3) family nursery; 4) sanatorium nursery; 5) school-kindergarten combination facility; 6) pre-school mini-center. Pre-school organizations by type of ownership are divided into state and private. Educational process in pre-school organization is carried out in accordance with programmes and education plans developed on the basis of the state compulsory standard of pre-school education and training (Box CD.1), as well as determined by the preschool organization’s charter.

65. More than half (55.3 percent) of children aged 36-59 months are attending an organised early childhood education programme (Table CD.1). Urban-rural and regional differentials are notable – facilities with such programmes are attended by 62.2 percent of children from urban areas compared to 48.9 percent from rural areas. Among children aged 36-59 months, attendance to early childhood education programmes ranges from 31.7 percent in the Almaty oblast to 81.9 percent in the Western Kazakhstan region (MICS Kazakhstan 2015).

3 OBJECT OF THE EVALUATION: UNIVERSAL PROGRESSIVE HOME VISITING MODEL

66. Universal-progressive model is an advanced system for conducting “home visits” by a patronage nurse to young children, including in the prenatal period. Meeting with a family in its own environment gives the professional a unique opportunity to understand issues and make the right decision. There are 3 main patronage models, each of which has its advantages and disadvantages: A universal model is the coverage with patronage supervision of all young children with the mandatory attendance of each child in certain age periods. A progressive model is the coverage with patronage supervision of only those at high risk having special needs due to health or psychosocial risks. A universal progressive model of home-visiting patronage is a blended model that combines the advantages of the universal and targeted models through overcoming their limitations and ensuring peak efficiency. Under the universal progressive model, universal (mandatory) home-visiting services are available for all families while progressive (reinforced + intensive) visiting services are provided to a limited number of families based on risk and needs assessment. Those families experiencing socio-economic difficulties, psychosocial stress, and other unfavorable circumstances (for example, difficulties in child nutrition, issues with development, ensuring a safe

<table>
<thead>
<tr>
<th>Expected outcomes of the UPHV model</th>
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<tbody>
<tr>
<td>With the successful implementation of the universal progressive model positive outcomes on the part of children, family, parents and community can be envisaged in the short and long term.</td>
</tr>
<tr>
<td><strong>On the part of children</strong>: Improved neonatal indicators, such as low birth weight, premature birth, congenital malformations, improved nutrition and growth, reduced morbidity and mortality, improved immunization rates, improved cognitive and social development, reduced injuries, reduced disability and abandonment, reduced abuse and violence against children.</td>
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<tr>
<td><strong>On the part of family and parents</strong>: Improved prenatal care and prevention of obstetric complications, improved parental knowledge and skills in infant feeding (breastfeeding and complementary feeding), improved indicators for seeking medical help, improved parents’ awareness of the prevention of infectious diseases, improved attachment and parental knowledge about child development practices, safe home environment, improved support for families having children with disabilities, reduced levels of parental stress, maternal depression and anxiety.</td>
</tr>
<tr>
<td><strong>On the part of community</strong>: Reduced health protection costs, improved school readiness, academic performance and development indicators, reduced treatment costs of vaccine-preventable diseases, reduced health care costs associated with hospitalization, reduced costs of caring for children left without parental care, children affected by abuse, costs associated with combating crime and drug addiction, reduced suicide rate.</td>
</tr>
</tbody>
</table>
environment etc.) receive increased support so that they can take care of themselves and their children to secure their optimal growth and development. Intensive support is provided to families where children are highly vulnerable and in cases when cross-disciplinary support and cooperation between health, social and educational services is needed to reduce the risk21.

67. Home visiting services, or patronage nursing system, are visits by primary health specialists to families expecting children and/or already having small children. The goal of such visits is to provide these families with necessary skills to raise their children physically, socially and emotionally healthy and developed: patronage nurses provide parents with child health check-ups, information and advice on general care, health, nutrition, and parenting skills.

Figure 8: Person assisting at delivery, Kazakhstan, 2015


68. In 2015, UNICEF kicked off a blended model of home-visiting services in Kyzylorda region to introduce the Government to higher quality home-based services and encourage better coordination among the health, education and social protection systems. The model was a

response to the assessment findings which revealed that the existing system of home visits in Kazakhstan had several issues: the system significantly lacked funding to provide supplies for effective home visits; limited time that a home visitor spends in one household – ranging from 14 minutes in urban setting to 5 minutes in rural areas; and no system of quality assurance for home visits leaving in doubt the quality of effective engagement with families. The new model, adapted from the United Kingdom, combines two approaches to home visiting: the universal model and the targeted model. Under the universal model, home visits are paid to all families: ideally, during the pregnancy and until preschool/kindergarten age. The typical home visit will be based on the counselling approach (listen, observe, ask, assess, praise, advise, show) and include, depending on the timing, issues ranging from mother health and wellbeing to child health and development and the overall family situation.

69. However, the disadvantage of the model stems from its core feature: provided to all rights holders, it has no particular focus on at-risk families and children. The targeted model, on the other hand, is based on the evidence that targeting families and children that are at higher risk or who have special needs due to medical and/or psychosocial circumstances, is more effective. At the same time, while at-risk families and children are targeted, needs of other pregnant women, parents and children are left unaddressed. The universal-progressive model builds on the strengths of the two models. While essential home visiting services are provided to all families, at-risk families receive intense services based on their needs, for example, when they are undergoing socioeconomic difficulties, psychosocial stress and other adverse circumstances.

70. UNICEF’s budget shows an investment of US$993,033 in the development of the PNS in two provinces. Staff costs were high at 17% for the budget for 2016-2017, but within expected range for a pilot, which often requires substantial investment in technical inputs, training and the development of core materials. However, this is an under-estimate, as the programme relied on substantial monitoring and evaluation inputs to persuade and influence take up which are not reflected in this budget.

71. Currently, the model is in its final piloting stage in Kyzylorda region and is expected to expand to other regions. It is planned that eventually the model will be replicated in all the regions of Kazakhstan.

72. At present, in-service training of health workers continues in all regions and is fully funded from the public budget. Financing of these initiatives was confirmed in the new cycle of the National Healthcare Development Program for 2016-2020. In Kazakhstan, PHC pediatricians, general practitioners, medical assistants and nurses, as well as pediatricians and nurses from hospitals and ambulance service are subject to IMCI training. Accelerating the reduction in child mortality is possible by expanding effective preventive and curative interventions that target the main causes of child deaths and the most vulnerable newborns and children. With this in mind, PHC with the focus on the partner-work with parents and local communities plays the key role in prevention of mortality cases among infants and children.

4 EVALUATION PURPOSE, OBJECTIVES AND SCOPE

73. The UNICEF office in Kazakhstan is commissioning this evaluation to:

According to the Terms of Reference (ToR), the purpose of this evaluation is to assess the impact of primary healthcare system on infant and child mortality in Kazakhstan in light of past and present PHC reforms, policy changes, and approaches to family services provision, including through the home-visiting system.
74. The evaluation is summative. The evaluation questions are formulated as per OECD-DAC evaluation criteria: relevance, efficiency, effectiveness, sustainability and impact. Additional criteria such as coverage, coordination and coherence should also be used in the evaluation. The MoRES determinant analysis framework will be used explicitly to identify which bottlenecks were removed and how change was achieved.

75. To carry out the effectiveness and impact analysis of the UPHV model, the Theory of Change approach has been applied. Both chapters should be understood together to interpret the results chain. The contribution of the Pilot Project in Kyzylorda in reducing health system level bottlenecks (MoRES level 2) based on the TOC of the regional strategy towards "Young Child Health and Well-Being" (being used by the UPHV MCE) is analysed. This study analyzes the extent to which bottlenecks are overcome in the implementation of the UPHV mode:

<table>
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<th>Table 1: MoRES determinants</th>
<th>MoRES Determinants</th>
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<tr>
<td>Supply</td>
<td>HV is both universal and progressive and responsive to needs</td>
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<tr>
<td></td>
<td>Child developmental services are integrated into health and all relevant sectors</td>
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<td></td>
<td>Essential commodities, supplies and professional human resources are available</td>
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<tr>
<td>Quality</td>
<td>Quality practices institutionalized at all levels of service provision</td>
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<tr>
<td></td>
<td>Access to UPHV services is ensured</td>
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<tr>
<td></td>
<td>Culturally sensitive UPHV service standards are institutionalized &amp; practiced</td>
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<tr>
<td>Demand</td>
<td>Caregivers being supplied with knowledge and guidance on positive childcare and development practices</td>
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</table>

76. The impact chapter analyzes the performance of the UPHV results indicators, trying to identify the contribution made by the pilot model in the Kyzylorda region.

77. The intended users of the Evaluation will be the Ministry of Health, local governments, line ministries that will use the results of the Evaluation as the main developers and implementers of the national programmes who need to monitor the progress based of effectiveness and efficiency criteria, to introduce corrective actions if needed, to use the best available practices, to engage trained/informed HR, to bridge the inequality gaps and to allocate sufficient funds. UNICEF as one of the main knowledge brokers in MCH practices providing technical assistance for effective implementation of MCH interventions worldwide. Also MPs need to be informed in order to introduce necessary legislative changes. International, academic, private and civil society organisations including UN agencies and educators should use the results of the Evaluation in order to gain more knowledge and to improve their advocacy and practical actions in introduction and implementation of the PHC/MCH programmes.

78. The added value of the evaluation will be in the use of its findings and recommendations for: (a) evaluation of both PHC system’s and the home-visiting model's impact on infant and child mortality and support government in the scaling up of the UPHV model; and (b) documentation of Kazakhstani experience with possible use by other countries confronting similar issues in primary health care provision. Below are the objectives of the UPHV model evaluation:

- To analyze the influence of improved quality of PHC services, including based on the universal-progressive model of home visiting system, on families with children under 5 and pregnant women in reducing rate of infant and child mortality.
- To assess the cost-effectiveness of the universal-progressive home visiting model piloted in Kyzylorda oblast.
• To provide lessons learned and recommendations to the Government, UNICEF and other stakeholders on the further development of PHC with the focus on community-based services, and to identify weaknesses in the organization of medical care.

5 METHODOLOGY

79. The complexity of the evaluation, which has two objects of analysis, required the proper selection of the best instruments without falling into duplication of effort. Therefore, the qualitative instruments that were common to the two areas of evaluation were identified. These will be, mainly, desk review, interviews to key informants, focus group and meta-evaluation. Once the project started, there was a request from the evaluation manager to incorporate some of the instruments that are being used in the Multi-Country Evaluation of the Universal Progressive Home Visiting for Young Children Well-being and Development in the Europe and Central Asia Region. An effort was made to obtain findings that could feed that evaluation.

80. Specific quantitative tools were applied for each of the two main areas of evaluation: the Lives Saved Tool (LiST) and the Primary Care Assessment Tool (PCATool) survey were used. The main secondary sources of information were provided by the National Statistics Committee and the Department of Health of Kyzylorda Oblast to the Ministry of Health; in addition to key information provided by other stakeholders. The national data received were analyzed. Quantitatively work focused on the analysis of data provided by the stakeholders, especially through the document review, and took place in different process phases:

✓ Verification of data and preparation for analysis.
✓ Initial analysis based on the reference documentation.
✓ Additional analysis based on data collection in the field.
✓ Integration and synthesis of findings.

81. The initial analysis was done in order to generate information to document the issues raised in the evaluation and for accountability purposes. When the data analysis was completed, the next step was to select and integrate information and data obtained from the findings, which provided the basis for the evaluation report. This method was used to guide the selection process and display all the information needed to support each conclusion. Three features were searched that should always be addressed because of their impact on the credibility of the findings: validity, reliability and bias.

✓ Validity: The extent to which a measurement or test accurately measures what is intended to be measured.

✓ Reliability: The consistency of the data when collected repeatedly using the same procedures and under the same conditions.

✓ Bias: Any effect during the collection or interpretation of information that leads to a systematic error in one direction.

82. The described approach and previous instruments also apply for the UPHV model evaluation. However, given the specificity of the object of analysis, a detailed description of the work in this field is included. Several focus group were held with:

- Families with children under 5 of Department of Health of Kyzylorda oblast.

- Employees of the PHC facilities (PHC No 8 in Astana; PHC No1 in Kyzylorda city, PHC No6 in Kyzylorda city, PHC of Zhanakorgan village in Kyzylorda oblast).

83. In-depth interviews with:
- Households with children under 5, affixed to the pilot sites of the three polyclinics: CP No1 in Kyzylorda, CP No. 6 in Kyzylorda, CP Zhanakorgan; health visitors, social workers, psychologists, chief doctors of pilot organizations, employees of the Health Department of Kyzylorda oblast,

- Akimat of Kyzylorda oblast, district akimat of Zhanakorgan village, IMCI coordinator of Kyzylorda oblast centre, National Association “Primary health care” led by Roza Abzalova, NGO “Union of Medical Colleges of Kazakhstan”, master coaches, partners of the Republican Center for Health Development, IMCI Coordinators.

- Staff of NGO in Kyzylorda city involved in provision of progressive package services, employees of kindergartens, where the children of families from the pilot polyclinics were enrolled.

84. To carry out the field work a sample of households to pass the questionnaire was made. The choice of the sample is made in a random and representative manner. The simplest probabilistic sampling that meets these characteristics is simple random sampling, which gives the same probability of selection to all units in the universe. For sample size selection, it was received from the Department of Health of Kyzylorda Oblast to the Ministry of Health the list of homes and clinical records.

85. Once the list of households with children under 5 (affixed to the pilot sites of the three polyclinics: CP No1 in Kyzylorda, CP No. 6 in Kyzylorda and CP Zhanakorgan) has been received, then a random selection of households was made.

86. The Primary Care Assessment Tool - (PCATool) was used in this stage. Starfield and Shi, of the Johns Hopkins University, in the United States, have designed a set of tools to evaluate PHC, PCAT (Primary Care Assessment Tools).

87. This questionnaire allowed consultants to collect information on the experience of home visiting users as regards each of the characteristics of PHC. The dimensions that were assessed are:

- “First-contact” care: that care is first sought from the primary care provider when a new health or medical need arises.

- Continuous care: longitudinal use of a regular source of care over time, regardless of the presence or absence of disease or injury.

- Coordinated care: the linking of health care visits and services so that patients receive appropriate care for all of their health problems, physical as well as mental.

- Comprehensive care: the availability of a wide range of services in primary care and their appropriate provision across the entire spectrum of types of needs for all but the most uncommon problems in the population by a primary care provider.

88. At the time of passing the questionnaire where there are children, it was be done:

1 - Check availability of the person who cares for at home or family / caregiver of the child in the Polyclinics to follow through with the interview;

2 - Identify, in accordance with the research / evaluation objectives, whether the child in question is eligible for the study / evaluation (application of the inclusion and exclusion

22 The sample included 129 households surveyed
criteria of their study / evaluation). Identify the child's name and, thereafter, always use the name as reference;

3 - Identify the person responsible for the child (caregiver) who must respond to questionnaire. Use, for example, the question, "Who is the person most able to talk about the child's health care? ", identifying the child's relationship;

4 - Apply the Free and Informed Consent Form;

5 - Continue with the interview.

5.1 Data collection and analysis tools

Methodological tools

89. A non-experimental design methodology that combines qualitative and quantitative techniques has been applied, including surveys, key individual interviews, focus groups, documentary review and field visits. The scripts of the tools can be found in the Annexes.

5.2 Stakeholders' Participation in Evaluation

90. Key stakeholders engaged in this evaluation. The stakeholders mapping table presents a full inventory of the implementing partners, other partners and beneficiaries. A selection of stakeholders has been made to be interviewed during the field. The prioritization of the key actors has been made together with the UNICEF country office.

5.3 Ethics, norms and standards

91. This evaluation was conducted in accordance with the United Nations Evaluation Group (UNEG) evaluation principles (openness, transparency, participation, etc.) and standards using the Evaluation criteria (relevance, efficiency, effectiveness, impact, sustainability) as well as the UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis.

92. The consultant worked closely with UNICEF staff at key phases of the evaluation process to ensure that equity focus and Ethical requirements are fully met in the final Evaluation Report.

93. According to UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis, the Ethical Review Board of the methodology was required and approved, as well as continuous adherence to the ethical standards throughout the evaluation. Find in the annexes the Research Ethics Approval letter.

94. The evaluation design and implementation considered ethical safeguards where appropriate, including protection of confidentiality, dignity, rights and welfare of human subjects particularly children, and respect of the values of the local community. Mainly this applies for evaluating the PHC home-visiting interventions. Data collection and analysis followed the UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis, which outlines the ethical principles in part of evaluation intentionality, obligations of evaluators, obligations to participants and evaluation process and product. The common guiding principles were used to ensure ethical safety during the evaluation: (i) privacy and confidentiality, (ii) Informed consent, (iii) Harm and benefits, and (iv) Conflict of interest

95. The evaluators explained to the participants the purpose and use of the evaluation; the evaluators also made it explicitly clear to the participants that their participation was voluntary, and they can withdraw at any moment. The survey, interviews and all data
collected were anonymous and confidential and the findings were analyzed in an aggregated level.

5.4 Limitations, risks and mitigation Measures

96. The main limitations for the Evaluation were that the disaggregated data on local level for some indicators were not available, or the quality of available data was not good.

97. The evaluation team proposed measures to mitigate some of the risks and limitations. Find below a table with some of the challenges and the solutions were proposed in order to avoid an impact on the results of the evaluation process.

Table 2: Risks and mitigation measures identified

<table>
<thead>
<tr>
<th>Risks</th>
<th>Measures</th>
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<tbody>
<tr>
<td>1. The intervention’s context is complex.</td>
<td>- Allocate enough time and resources to understand the context.</td>
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<tr>
<td></td>
<td>- Undertake a web search and/or a literature search.</td>
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<tr>
<td></td>
<td>- Plan to hire local experts who can bridge the contextual gaps.</td>
</tr>
<tr>
<td>2. The normative work is not reflected in a logic model, theory of change or country programme framework.</td>
<td>- Try to find out why the normative work was not reflected by contacting those responsible for the intervention's design and implementation.</td>
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<tr>
<td></td>
<td>- Constructed a retrospective theory of change to include the normative work and validate it with those responsible for the intervention.</td>
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<tr>
<td>3. The normative work is reflected in the logic model, theory of change or country programme framework, but these are seriously flawed.</td>
<td>- If the flaws are major, such that many of the outcomes, indicators and assumptions are unrealistic, where feasible, negotiate with the programme stakeholders and revise them.</td>
</tr>
<tr>
<td>4. Documents provide little information about the normative work and its outcomes.</td>
<td>- Contact those responsible for implementation to understand the nature of normative work. Look for information from other sources, such as national governments, reports of other UN bodies, development organizations and local NGOs.</td>
</tr>
<tr>
<td></td>
<td>- Focus on expected outcomes over which the implementing organization had control (rather than high-level impacts).</td>
</tr>
<tr>
<td>5. There is insufficient time or resources to thoroughly evaluate the normative work.</td>
<td>- Scale back the evaluation and focus it on short- and medium-term normative outcomes rather than normative impacts.</td>
</tr>
<tr>
<td></td>
<td>- Look for ways to save time and resources, such as a desk study, self-evaluation or 1-2 information-rich case studies.</td>
</tr>
</tbody>
</table>

98. Besides these general conditions, the evaluation team assessed in a preliminary manner that the conditions necessary for the evaluation of the PHC policy were given. In any case, the main limitations and risks are highlighted:

- The availability of information about processes, outputs and outcomes to carry out a deep analysis, as well as the basic information for the indicators: baselines and targets. Monitoring system were not fully developed for UPHV model. Therefore, in the methodology for the analysis of, qualitative methodological techniques are introduced that allow to know possible institutional weaknesses or other circumstances that limit the capacity to generate key information on the indicators.
- Quantitative information quality. To minimize this risk, information triangulation was applied. The triangulation of the information allowed to reduce the error of causal interpretations from the available data, identifying possible negative outputs to obtain the planned outcomes or, conversely, possible unidentified positive outputs in the PHC policy. On the other hand, the information triangulation system allowed reducing the bias of the interviewed participants or focus groups, allowing the comparison of data and information from different sources.
- Good execution of the methodological tools, so that the best strategy for each institutional environment was worked within the evaluation team. For this purpose, the evaluation team in Kyrgyzstan was reinforced with two consultants to fine-up the tools.
6 EVALUATION FINDINGS

6.1 Relevance

Evidence-based problem analysis
99. The Home Visiting Model deployed in Kazakhstan is rooted in a regional initiative boosted by UNICEF ECARO in 2012: “The Right of Every Young Child to Comprehensive Development and Wellbeing initiative”. The initiative addressed inequities in the health, development, care and protection of young children in the region and was informed by the findings of several evaluations in the region. These studies suggested that the health sector did provide some level of universal home visiting services to families of expectant mothers, newborns and young children in most countries in the region\textsuperscript{23, 24}. These services were often provided by a patronage nurses: this system came from the soviet times, was more medicalized, addressing only medical health aspects of child development. In addition the quality of home visiting services was reportedly low and too narrowly focused on medical and basic health conditions and providers lacked the knowledge, skills, and tools for early identification of risks and needs, including children with developmental difficulties, and children maltreated or exposed to violence, and for assisting families to secure early intervention and other needed social services\textsuperscript{25}.

Correspondence to the needs of the target groups
100. Universal patronage nurse during the visit do not assess social risks that threaten child’s health and well-being and does not focus on such important aspects as parents’ affection and attachment to the child, depression of mother or father, tension in family relationships, lack of positive parenting and other factors, which ultimately determine the health, resilience, development, and well-being of the child. Even if the patronage nurse through her experience sees such risks, she does not know what specific steps need to be taken to eliminate or reduce them\textsuperscript{26}.

101. The new Universal Home Visiting Model is grounded in a population targeting strategy. Assumes that all children receive a universal basic package of patronage services, some receive an extended package, and very few receive an intensive package.

102. In this sense Universal-progressive model of home-visiting services respond promptly to family needs in relation to the child, promotes child's rights to health and development. The professional qualities of the new patronage nurse in PHC, good communication skills, style of relationships with the family based on a tolerant, considerate and non-judgmental attitude allow building trusted partnerships with families. Supportive relationships of the patronage nurse help unveil family strengths enabling it to overcome life difficulties\textsuperscript{27}.

Consistency with Government health policy
103. There is evidence that Home Visiting model is consistent with governmental development priorities as well with the main health policy strategies. Although UPHV is not mentioned in the main health policy documents strong evidence have been found to prove


\textsuperscript{25} Regional Framework for Home Visiting, UNICEF, draft, 2016.

\textsuperscript{26} Idem.

its consistency with governmental development priorities and main healthcare strategies. In this sense the two current health planning documents “Densaulyk” (2016-2019) and “Strategic Plan 2014-2018” stressed the importance of the PHC and the needs of improvement in terms of human resources, quality and integration with social services among others..

State programme “Densaulyk” for health care system development in republic of Kazakhstan 2016 – 2019 (Decree #176 January 15, 2016)

104. Densaulyk has 7 major areas of interventions. The second of these areas is “the integration of all health services around the needs of the population on the basis of modernization and priority development of primary health care”. Although is not specifically mentioned in this State Program HMV’s principles are fully aligned with the government vision of the PHC:

- “Social orientation of primary care will be provided by integrating the work of primary health care, social protection and public health services, the active involvement of PHC professionals in the activities of the inter-sectoral cooperation on public health.”
- “Accordingly, primary care would be considered as a primary health and social care, including the provision of integrated health and social services with the involvement of psychologists, social workers, nurses, paramedics, midwives and support staff. In cooperation with the social security authorities a social and psychological support and multiprofile patronage will be provided.”
- “As a part of PHC development, some functions such patients monitoring, management of chronic diseases and patient care at home will be gradually transferred to specially trained general nurses-practitioners.”

105. The following table links the main objectives of the UPHVM with the areas and contents of the Desaulyk.

<table>
<thead>
<tr>
<th>Key objectives of the UPHVM</th>
<th>Densaulyk Main Areas</th>
<th>Densaulyk contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of the health, psycho-social functioning, living conditions and identification of risk factors to the health of the family</td>
<td>The development of inter-sectoral cooperation</td>
<td>In accordance with international standards, cross-sectoral cooperation of various state and public institutions should be aimed at reducing risk factors for infectious and non-communicable diseases, and provide comprehensive measures aimed at the formation of new behaviors that reduce the prevalence of risk factors (smoking, alcohol abuse, low physical activity)</td>
</tr>
<tr>
<td>Promotion of the health of the family and the local community and education about healthy lifestyles for all family members</td>
<td>Formation of the public health service (PHS)</td>
<td>The main activities of PHS will be the management of public health, changes in the direction of health and behavioral patterns of the population through education, counselling, advocacy, promotion of a healthy lifestyle based on interagency cooperation with Primary PHC</td>
</tr>
<tr>
<td>Identification of risk factors and needs during pregnancy and the early years</td>
<td>The development of inter-sectoral cooperation</td>
<td>Protecting and promoting human health will focus on preventive measures to reduce external and behavioral risk factors of diseases and their consequences, taking into account age and social characteristics of a person that will start from the</td>
</tr>
</tbody>
</table>

28 Densaulyk 2016-2020 pags. 13-14
| **Promotion of child health, growth, and development** | The development of inter-sectoral cooperation | Priority in inter-sectoral cooperation will be the realization of complex measures for maternal and child health, including reducing child injuries, strengthening the mental and reproductive health of children and youth. |
| **Linking of the family with health care, social protection and other services in the community in accordance with the needs of the family** | Modernization and priority development of PHC | Social orientation of primary care will be provided by integrating the work of primary health care, social protection and public health services, the active involvement of PHC professionals in the activities of the inter-sectoral cooperation on public health. |
| **Promotion of responsible parenthood and a positive relationship between parents and children even before the child is born to support healthy attachment** | | |
| **Health monitoring and adequate interventions for families with special health and social needs** | Modernization and priority development of PHC | The universality of primary health care will be provided through further transition to the family principle of service, which would include monitoring of human health throughout his life, taking into account the characteristics of the organism in each age period, with an emphasis on prevention. |
| **Nurturing relations of mutual respect and confidence between the home visitor and the family members.** | | |

Source: Author’s elaboration

**Strategic plan for 2014 - 2018 of Ministry of Healthcare and Social Development of the Republic of Kazakhstan**

106. This second main governmental policy strategy document also stresses the importance of PHC. In its first Strategic Area (Promotion of health of residents and decrease of mortality rate) the MoH acknowledges that “the majority of the health related problems can be resolved at the level of PHC. International practice demonstrates that PHC maximum coverage and effectiveness is achieved when volume of PHC financing is not less than 40% of healthcare expenditures. However, according to results of year 2013 Kazakhstan invests insufficient funds of guaranteed free medical care (hereafter to be referred to as GFMC) into PHC. There are still problems associated with insufficient focus of PHC on prevention measures that include the planned parenthood work, raising public awareness on healthy lifestyle formation.”

107. The Document also identifies the main internal factors affecting the PHC service provision in the county: “lack of efficient preventive examinations and early diagnostics; insufficient introduction of new evidence medicine-based methods and protocols for diagnostics, treatment and rehabilitation of diseases; no continuity between PHC and in-patient hospital; lacking role of primary sanitation service in public healthcare including prevention and reduction of incidence rate of non-contagious diseases”. Finally the Ministry

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calls for a “further improvement of PHC as well as medical and social development is expected to enhance availability, effectiveness, quality and development of PHC”. 30

Coherence and consistency with other agencies global strategies

108. The development of the UPHV model in Kazakhstan is fully consistent with the global UN policy frameworks to protect the maternal and child health. With no intention of being exhaustive some of this hallmark documents and events should be listed:
- Convention on the rights of the child (UNCRC 1989)
- Every Woman, Every Child (UN, Secretary General 2010)
- Health 2020 (WHO, Europe Regional office 2012)
- International meeting in child development (WHO, 2013)

109. Lastly is also relevant to mention the recent Global Conference on Primary Health Care held in Astana in October 2018. This international meeting organized by the Ministry of Health, UNICEF and WHO, was a global demonstration of the importance of the PHC as one of the main health strategies. The principles of the Astana declaration are also aligned with Universal-Progressive HVM.

110. World bank’s 80 USD million loan called “Social health insurance project: improving access, quality, efficiency, and financial protection” (P152625) has strong focus in the PHC service delivery in terms of strengthening of population services; primary and secondary prevention; development of the health facility network, including public-private partnerships; improving evidence-based health care delivery; implementation of HTA and effective tools for health services quality management; corporate governance / management in the health sector; development of human resources policy and medical education through strategic partnership with leading academic centres. It is also remarkable that although the WB Project was approved on 2016 – in that time the HVM was piloted and Kyzylorda– the HVM is not mentioned in the Project Appraisal Document.

111. Asian Development Bank has no current specific project on healthcare system development. In the Country Partnership Strategy 2017-21 this financial institution mentions the necessity of “knowledge support to enhance primary healthcare delivery and facilities through the development of public–private partnership (PPP) programs. KPSs are needed to analyze best international practices, design new primary healthcare projects, and rehabilitate existing ones. Knowledge support is also needed to assess the capacity for planning and implementing PPPs to provide primary health care support in oblasts.”

112. On November 2017, the ADB approved the provision of transaction technical assistance (TA) to the Government of Kazakhstan. The TA had two outputs: (i) detailed project design

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and costing prepared, and (ii) project due diligence undertaken. 2. The TA became effective on 30 December 2017, with an expected completion date of 31 December 2019. ADB requested the Ministry of Health (MOH) to decide on the oblast and confirm the use of public investment for a viable public–private partnership project. MOH was to organize a working group to decide on these two issues. However, due to a change of government priorities in the health sector, the government has decided not to pursue this TA. Accordingly, this TA was cancelled on August 2018.

**UNICEF Contribution to the development of the UPHV model in Kazakhstan**

Also following the proposed tool of the MCE, the UNICEF’s contribution to each bottleneck has been assessed (Table 3).

<table>
<thead>
<tr>
<th>MORES DETERMINANTS</th>
<th>ENVIRONMENT</th>
<th>SUPPLY ISSUES</th>
<th>DEMAND BARRIERS</th>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNICEF CORE ROLES</strong></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
</tr>
<tr>
<td></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
<td><strong>POLITICAL</strong></td>
</tr>
<tr>
<td>Advocacy</td>
<td>(independent voice)</td>
<td>3 3 3 3 3 3 3 3</td>
<td>3 3 3 3 3 3 3 3</td>
<td>3 3 3 3 3 3 3 3</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>3 1 2 2 2 3 1 1 1 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA &amp; Policy Development</td>
<td>3 2 3 3 3 3 3 3 3 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge Generation &amp; Child Rights Monitoring</td>
<td>3 3 2 3 2 3 3 2 3 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Converging dynamic partnerships and leveraging resources</td>
<td>3 3 2 2 2 2 2 2 3 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity development of government &amp; civil society</td>
<td>3 2 2 3 2 3 2 2 3 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modelling and testing innovations</td>
<td>3 1 2 2 2 2 1 2 3 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median UNICEF Contribution to bottleneck reduction</td>
<td>3 2,14 2,29 2,57 2,29 2,71 2,14 2,14 2,74 2,57</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Author’s elaboration


35 A contribution score ranging from 1 to 3 was assigned along each intersection of the Core Roles with a bottleneck, with 3 representing a “critical/major” contribution of UNICEF and 1 representing a “marginal/minimal” contribution.
114. The contribution of UNICEF for the development of the UPHV model and the elimination of bottlenecks has been identified as key by all stakeholders. UNICEF Kazakhstan participated in several regional meetings and did an assessment about the feasibility of implement the UPHV model, and how the model could be implemented in the Kazakh context and the existing patronage system. Based on this assessment recommendations were given to start with a pilot of model in Kyzylorda, not focus only service delivery but also in sustainability and scalability. The assessment was presented to Government and Kyzylorda authorities and they express their willingness to support and initiate, even with an official document.

115. The relevance of the support of UNICEF to the implementation of the UPHVM in Kazakhstan has been stressed by all the stakeholders interviewed in this evaluation. This support can be divided into the promotion of UPHV at regional level (Central Asia) and the specific support to the Kazakhstan development of a HV national model first with the support to the pilot and later to its expansion to national level.

Role of UNICEF promoting UPHV at a regional level

116. UNICEF UPHV activities and their implementation in the region have been summarized and reviewed in the recent Home Visiting Stocktaking Report 2018\(^{36}\). A non-exhaustive list of some of these interventions include:

- Assessing the situation and defining goals for the UPHV Services;
- Generating political commitment, advocacy, building public awareness and demand around the benefits of home visiting;
- Defining the service delivery models in different country contexts and supporting the development of institutional structures;
- Modelling of new types of services; - Strengthening human resources through the provisions of training materials and training;
- Facilitating international study visits, continuous education programs at in-service level, established pre-service curricular, internal supervision;
- Management costing and financing of new UPHV services;
- Supply, including patronage bags, equipment, smartphones;
- Optimizing the workload through IT solutions (mobile application);
- Strengthening multispectral approach by providing trainings to the staff of different agencies and NGOs and establishing the referral algorithms;
- Monitoring and documenting;
- Developing of data collection tool to monitor the quality of the services (Lot Quality Assurance Sampling); and
- Evaluation of UPHV models/services

Role of UNICEF promoting UPHV national level

117. The activities of advocacy and technical assistance supported by UNICEF have been intense and they are fully accredited by the internal and external reports issued by the Country Office. In this sense the 2015 Assessment\(^{37}\) is a very comprehensive evidence of the vision of UPHVM in Kazakhstan and envisages the fundamentals an operationalization of the model and also the whole deployment strategy from the pilot to the national scaling up. With no intention of being exhaustive the following hallmarks are very representative of the kind of technical and assistance provided by UNICEF through the 2015-2017 period.

\(^{36}\) Jon Kofmacher, Supporting Families for the Nurturing Care of Young Children, Taking Stock of ECA Home Visiting Systems Reforms and Charting the Way Forward, UNICEF, 2018

- The programme formally began in 2015, when the baseline assessment was conducted, the determinants of mother’s health in Kazakhstan were researched and the technical working groups was formed and visited the Republic of Serbia with a study-tour.
- In 2016, the piloting facilities were identified, nurse’s job duties revised and training for the health care staff were delivered. Moreover, UNICEF and the regional authorities managed to establish the resource center, a special office for continuous education and self-evaluation.
- In 2017 a special mobile technology for nurses and mothers had been started developing. Moreover, the Union of Medical Colleges adopted the updated curriculums, containing models of the new home visiting system, for medical colleges. The model became strategically sustainable.38

*International standards and good practices*

118. As it has been said UPHVM in Kazakhstan has been developed in a UNICEF conceptual framework designed for ECA Region. The universal-progressive approach is currently used by several countries in Europe, notably the UK. In extensive consultation with international experts and country representatives in the UNICEF Regional Conference on home visiting held in Ankara (2012), a consensus was reached to recommend this model in the CEE/CIS Region39.

119. HV system in Kazakhstan is attached to UNICEF supported model. Kazakhstan as other post-soviet countries in the region always had the patronage HV system and this was not an issue for the Government in those years; since they have other priorities in the health system reforms.

120. However, when UNICEF started preparing estimation of the results achieved for SDG in the region, they found out that more children are surviving (reducing mortality under 5), however no evidence about more children are developing according to the potential. Secondly not all children had equal and similar access to reformed services that were promoted by different countries. UNICEF understood that equity had to be a focus of the strategy support in the region. There were initiatives by the government to promote Child development, but it wasn’t a systematic approach. The initial foundation of the model was to ensure that government can outreach the most vulnerable (as migrants, minorities, social vulnerable, disabled, etc) and children with special needs.

121. UNICEF regional office started to explore different strategies. It was established the Technical Advisory Group with experts from several countries and based on the discussions, came up the idea that the health system is the best place that could provide a better outreach than any other. Only Health System has this patronage system which could be reformed and has a more frequent contact with the community. The reform of the patronage system was seen as the best strategy to reach out the most vulnerable and systematize the child development approaches. UNICEF elaborated the UPHV model and this is the system implemented as a pilot in Kyzylorda region.


6.2 Effectiveness

122. To carry out the effectiveness and impact analysis of the UPHV model, the Theory of Change approach has been applied. Both chapters should be understood together to interpret the results chain. The contribution of the Pilot Project in Kyzylorda in reducing health system level bottlenecks (MoRES level 2) based on the TOC of the regional strategy towards “Young Child Health and Well-Being” (being used by the UPHV MCE) is analyzed.

123. On the other hand, the contribution in terms of better outcome indicators was analyzed, according to those defined in the model in Kazakhstan.

Key interventions of the UPHV model

124. In order to achieve alignment with the UPHV model evaluations that are being carried out in other countries (MCE), the interventions covered by the model have been analyzed. This could assess effective implementation of the home visiting model in Kyzylorda, starting from map the set of interventions across the continuum of child-care that target MoRES determinants. Each UNICEF supported intervention in the UPHV model will therefore be mapped onto bottlenecks to identify which bottlenecks these interventions were trying to address and the outcome. In order to make a descriptive and comparative analysis of the UPHV service package regarding the needs of the young children and their families (main target groups) the evaluation team have followed the World Bank taxonomy for key interventions described on Figure 8, as proposed by the MCE.

Figure 9: Key interventions for Young children and their families

<table>
<thead>
<tr>
<th>NUTRITION</th>
<th>Health</th>
<th>Water &amp; Sanitation</th>
<th>Education</th>
<th>Social Protection</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling on adequate diet during pregnancy</td>
<td>Antenatal visits</td>
<td>Access to safe water</td>
<td>Maternal education</td>
<td>Birth registration</td>
<td>Resources and referral (beyond health)</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>Antenatal delivery</td>
<td>Adequate sanitation</td>
<td>Education about early stimulation, growth and development</td>
<td>Parental leave and adequate childcare</td>
<td>Home safety</td>
</tr>
<tr>
<td>Complementary feeding</td>
<td>Immunisation</td>
<td>Hygiene and hand washing</td>
<td>Early childhood &amp; preprimary programs</td>
<td>Child protection services</td>
<td></td>
</tr>
<tr>
<td>Adequate, nutritious, and safe diet</td>
<td>Deworming</td>
<td></td>
<td>Continue to quality primary education</td>
<td>Social Assistance transfer programs</td>
<td></td>
</tr>
<tr>
<td>Therapeutic QE supplementation for diarrhea</td>
<td>Planning for family size and spacing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention &amp; treatment for acute malnutrition (moderate and severe)</td>
<td>Access to health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micronutrient supplementation and fortification</td>
<td>Prevention and treatment of parental depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promotion of positive parental-child interaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family mental health issues beyond parent depression (e.g., trauma)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: World Bank 2014 for 26 Key interventions, with modification marked in yellow

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40 This taxonomy it has been proposed by technical team of the “Multi-Country Evaluation of the Universal Progressive Home Visiting for Young Children Well-being and Development in the Europe and Central Asia Region RFPS-ECARO-2018-181225.

125. Based on this taxonomy, the following health interventions has been identified in the UPHV model package.

<table>
<thead>
<tr>
<th>Intervention in WB taxonomy</th>
<th>Kazakhstan UPHVM Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUTRITION:</td>
<td></td>
</tr>
<tr>
<td>Counseling an adequate diet during pregnancy</td>
<td>Included</td>
</tr>
<tr>
<td>Iron-folic acid for pregnant</td>
<td>Included. If patronage nurses and doctors see signs of malnutrition, they recommend including that in their diet, but this depends on the social and financial status of the parents.</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>Included but presents some limitations. Sometimes women have difficulties to produce breast milk, sometimes it is easy to give infant formula if the mother have another problems. It also depends on local customs, which plays a major role: the grandmother takes care of the baby, and for her is easier to feed the baby with infant formula.</td>
</tr>
<tr>
<td>Prevention &amp; treatment for acute malnutrition</td>
<td>Included</td>
</tr>
<tr>
<td>Micronutrient supplementation and fortification</td>
<td>Included. If the patronage nurses and doctors see signs of malnutrition, they recommend including that in their diet, but this depends on the social and financial status of the parents.</td>
</tr>
<tr>
<td>HEALTH</td>
<td></td>
</tr>
<tr>
<td>Antenatal visits</td>
<td>Included</td>
</tr>
<tr>
<td>Attended delivery</td>
<td>Included</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Included</td>
</tr>
<tr>
<td>Planning for family size and spacing</td>
<td>Included. Few families are planning a pregnancy, but after giving birth, contraceptives are recommended to all women</td>
</tr>
<tr>
<td>Acces to health care</td>
<td>Included</td>
</tr>
<tr>
<td>Promotion of positive parents-child interaction</td>
<td>Included</td>
</tr>
<tr>
<td>Prevention and treatment of parental depression</td>
<td>Included. The quality of care depends on the experience of psychologists</td>
</tr>
<tr>
<td>WATER AND SATITATION</td>
<td></td>
</tr>
<tr>
<td>EDUCATION</td>
<td></td>
</tr>
<tr>
<td>Maternal education</td>
<td>Included</td>
</tr>
<tr>
<td>Education about early stimulation, growth and development</td>
<td>Included</td>
</tr>
</tbody>
</table>

Source: Author’s elaboration

General contribution in reducing health system level bottlenecks

126. Bottlenecks (MoRES 2) are identified in the regional strategy that is key for ToC analysis. The effectiveness study analyzes the extent to which bottlenecks are overcome in the implementation of the UPHV model. Find below the assessment by bottleneck:

<table>
<thead>
<tr>
<th>MoRE Determinants</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
<td>Universal home visiting services are made available to all families. Pogressive home visiting services are provided to a limited number of families based on an evaluation of risks and needs. The difference between the traditional model (patronage) and the one implemented in Kyzylorda has been verified. The patronage, that was well ruled in the soviet system, was more medicalized looking at assessing and addressing only medical aspects of child</td>
</tr>
</tbody>
</table>
development, but not social. Under the new HV model, nurses or health mediators – community health workers - reaches every single child in their attachment area, assess the risks – identify potential risks that could be socio economical, poverty, environment, etc and then an individual plan of action is prepared, not only limited to the health sector, distributing roles and responsibilities. And this is only focus on those who are subject to any of those risks – home visitors do more frequent visits and deliver more services than the traditional patronage system. There were initiatives by the government to promote child development but not in a integrative and systematic approach.

The first contact starts with a comprehensive assessment of the family’s health, psycho-social and economic situation. During the universal visit the patronage nurse conducts assessment on the following risk factors that could affect child outcomes:

1) exclusive breast feeding (according to data (2018-2019) collected by pilot PHC facilities, on average 25% of children from 0 to 6 months have this risk);
2) complementary feeding (15%);
3) attachment with care giver/parent (0.5%);
4) involvement of fathers (2.5%);
5) nurturing care (playing, reading, talking) (15% of children with defined risk on the nurturing care);
6) depression of parent (0.3%);
7) safe environment, prevention of injuries at home (1.3%);
8) protection from neglect, abuse and violence (0.7%);
9) medical risks (3%);
10) speech development (1.5%);
11) gross and fine motor skills (1%);
12) psycho-emotional development (2%);
13) low weight (0.5%);
14) overweight (0.5%);
15) social risks (2%);
16) other risks for early childhood development (35%).

When the patronage nurse visits pregnant woman, the following factors have to be assessed in line with the monitoring system of the universal progressive home-visiting model:

1) nutrition of pregnant woman (35%);
2) depression (1.5%);
3) medical issues (7%);
4) harmful habits (0%);
5) social issues (3.5%);
6) other social and medical risks (45%).

* Data are retrieved and combined based on the monitoring data
sets of the pilot PHC facilities within 2018 and 2019.

Based on this assessment, the home visitor assigns low (green), moderate (orange), or high (red) risk status to a family and leverages additional support. Data from pilot sites indicate that almost half of families need such additional support.

Families supports the UPHV model and stated some important benefits of the Home Visitors work:
- Explained importance of personal and home hygiene
- Explained how to eat healthy
- Explained about the negative impact of smoking, alcohol and substance use on family and child health
- Other issues related to newborn care, breastfeeding, sleep, etc.
- Gave enough opportunity to ask questions about families concerns
- Spent enough time with families by standard 45 – 59 minutes; sometimes even 90 minutes
- Got to know “you as a person”
- Tried to engage other members of the family

Also some nurses do mailing in groups in Whatsapp about main topics. The use of social networks and messaging platforms suppose a very great potential. But at the same time it is a challenge on how to regulate its use and procedures.

Child developmental services are integrated into health and all relevant sectors

The introduction of UPHV allowed identifying vulnerable families and solving of social problems (helping parents organize children in kindergartens, solving social problems with coal, heating, financial support by volunteers etc.), conducting trainings with psychologists, identifying women in the early stages of depression during pregnancy and after childbirth and helping , etc.

In cases of maternal depression or anxiety, food insecurity, unsafe home environments, or the risk for violence, abuse or neglect, the home visitor develops an eco-map of the child’s relevant relationships. This assists in identifying where relationships need to be strengthened or can provide new perspectives on how to address the family’s unique needs. For families with complex health and/or psychosocial-economic vulnerabilities, the PHC teams can access the inter-sectoral municipal committee of the Akim (head of municipality or oblast). This committee, consisting of representatives from other sectors and services and local NGOs, considers the case and allocates resources to reduce a family’s vulnerability (see Box 3 for an example). Additionally, HVNs may also ask neighbours or the community where the family lives, to support the caregiver and the family.

Examples of assistance provided by the Akimat Committee of Zhanakorgan district to 57 families at the initiation of the PHC team (in 2018)
- Arranged a place in preschool - 35 children
<table>
<thead>
<tr>
<th>Essential commodities, supplies and professional human resources are available</th>
<th>This determinant is analysed in the efficiency chapter</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Families are first sought care from the primary care provider when a new health or medical need arises and the UPHV has been identified as very relevant in the pilot region. Few families say they take their children to an alternative private center, and the model is perceived as an absolutely positive added value. The primary care provider serves as the usual entry point into the health care system for each new need for health services, except in the case of serious emergencies. In order to be considered as providing first-contact care, the services must be accessible (a structural characteristic) and used by the population each time a new need or problem arises (a behavioral characteristic); both features were found in Kyzylorda Region.</td>
</tr>
</tbody>
</table>

- Provided food - 6 families
- Enrolled one caregiver in substance abuse programme
- Provided support to women via the Akim’s adviser on Gender Policy and Women’s Affairs - 16 families
- Provided school supplies - 1 family
- Assisted one mother in acquiring citizenship of the Republic of Kazakhstan and identity documents
- Financially supported a child’s special medical treatment - 1 family
- Assisted one mother to enroll in the College of Agriculture

The meetings of the intersectoral committees have been documented, the status of filed families cases have been reviewed on their dynamic.

At the same time, some benefits from the home visitros work are indicated by families:
- Helped to access social services in the community (including services for children with disabilities and developmental difficulties)
- Helped to get social benefits
- Helped the child to be admitted to a kindergarten or preschool program, or to child care
- Helped find services for family violence
- Helped the child / the mother get access to health care services, including mental health services

Challenges remain for integration of social services and UPHV system, diminishing the effectiveness of both systems. Informants stated that there is ample scope to improve the level of coordination, such as child or caregiver’s disabilities, development difficulties or negative social-economic environment.
region where families remain faithful to their reference health center.

Coordination within the health system is well established, and UPHV activities do not imply a loss of coordination, nor a negative perception of families about the continuity of care. The social workers of the PHC facilities have documented and collected data on referred cases to other services, including the social services. However, the quality of the services have not been assessed by the UPHV teams.

The continuity of care is, in general, well attended: the home visitors and families build a long-term relationship in order to foster mutual understanding and knowledge of each other's expectations and needs. It requires identification of the population for whom the home visitor is responsible, and it requires an ongoing person-focused (not disease-focused) relationship over time between home visitors and families. This important element is limited in some places by the high turnover of doctors and, to a lesser extent, of nurses.

Finally there is no system to track the accuracy of nurse's professionalism during home visits. This limits manager's capacity to evaluate and improve nurse’s professionalism.

| Demand | Access to UPHV services is ensured | Responses from families to the survey affirm a good level of accessibility to the UPHV services, measured as the reception of regular visits. But this statement must be questioned since there are significant differences between families to the question whether children with chronic diseases receive regular visits or should call the medical center. In some cases a practice of regular visits to families is identified, in other cases evidence is not found |
| Culturally sensitive UPHV service standards are institutionalized & practiced | The training received by health professionals incorporated the cultural perspective. In the absence of a monitoring system with indicators on cultural sensitivity, no evidence can be shown about the effective implementation of this approach. There are several cultural sensitive data that are collected by the patronage nurses on the constant basis: - sexual violence towards pregnant woman; - involvement of fathers; - placement of infant into the besik (traditional cradle with a very strong wrapping); - neglect and violence against child. |
| Caregivers being supplied with knowledge and guidance on positive childcare and development practices | During 2016 several trainings initiated the pilot implementation in Kyzylorda. The initial trainings were organized by UNICEF’s international consultants in about 3 weeks for each area. Studies included theoretical information, team building, and practical work on clinical cases. In recent times, trainings are not guided in the same way by UNICEF. The recipients of the training report a loss of effectiveness when not leaded by UNICEF. |
Contribution of the UPHV model in the PHC effectiveness

127. The definition of PHC services tends to vary across countries. Primary care includes a large range of curative as well as preventive and health promotion activities. The distinction between PHC and other outpatient services (e.g. consultative and diagnostic) is not clear-cut. Therefore, it is key to take a theoretical reference that allows measuring effectiveness based on real practice with the population of the PHC. Effectiveness analysis used the definition of PHC developed by scholar Barbara Starfield, as the theoretical approach of the Primary Health Care to contrast PHC performance in Kazakhstan. PHC must comply with some basic attributes. To assess the performance of UPHV model in each of the attributes, in addition to interviews with stakeholders and documental review, the PCAT survey (find sample in the annex) was conducted to 129 families with children under 5 years, 97 under UPHV model and 32 under the traditional patronage model.

Table 4: Characteristics of Primary Health Care

128. Considering the UHPV model definition and approach, there should be a substantial difference in the results for the attributes of cover, family approach and community orientation. The other attributes should not lose effectiveness or even improved under the UPHV model. This is the ToC hypothesis that has been tested in this evaluation.

First-contact care

129. With the economic growth, health has attained a higher priority on the policy agenda, with the result that Kazakhstan has increased its investment in health and launched several waves of health care reforms intended to improve the accessibility, equity, and efficiency of health services. In particular, the population is now entitled to access a basic package of benefits free-of-charge, primary health care has been expanded, and the hospital sector has been restructured to reduce on inpatient care.

130. Despite some extent of service delivery fragmentation, families surveyed state they first sought care from primary care provider when a new health or medical need arises (not urgent cases). Few families say they take their children to an alternative private center. The primary care provider serves as the usual entry point into the health care system for each new need for health services, except in the case of serious emergencies. This situation is different in the big cities, where a greater supply of private services and a greater capacity of families in health spending makes this situation vary.

131. Those families where the UPHV model is being implemented perceive a good accessibility to health services; but, in general, the differences between the two models are not significant.
Continuity of care

132. Continuous care, which is concerned with Primary Health Care professionals accompanying patients over time, is considered a central feature of this level of health care. The fulfillment of this attribute is related to positive health results due to longitudinal use of a regular source of care over time, regardless of the presence or absence of disease or injury.

133. The continuity of care is, in general, well perceived by the families surveyed: the doctors/nurses and families build a long-term relationship in order to foster mutual understanding and knowledge of each other’s expectations and needs. This important element is limited and put in risk in some places by the high turnover of doctors and, to a lesser extent, of nurses. Besides the existing quality initiatives such as the use of clinical guidelines, accreditation processes, and care pathways, new quality improvement measures could enable frequent monitoring of health outcomes.

134. From the responses on the attribute of continuity in the PHC, two main findings can be seen. In first place, the population is assigned to reference centers and there is little capacity to change the reference center. Second, there are responses with a lower score in the continuity of the same doctor who attends the child over time in places who UPHV model is being implemented. This may be an indicator of a fact already indicated previously expressed by the stakeholders: the high turnover of primary care doctors, mainly in remote areas.

135. Very positive is the perception of families that has to do with the reliability to talk about health problems, the knowledge that professionals have about the treatment of children or the access to talk to the doctor or nurse who has greater knowledge about the child. En general, no significant differences between the models.
Coordination

136. The essence of coordination is the availability of information about prior, and existing problems and services, and the recognition of that information as it bears on needs for current care.

137. As stated before according to national regulation, Primary care should be the point of entry to the health system and the place where most health needs are met, but when more specialised care is required, PHC providers should play a central role as co-ordinators of care. Effective care coordination requires, among other things, the integration of information systems between different levels of providers, alignment of financial incentives, a multi-professional working culture, accountability mechanisms and strong leadership and commitment, elements which are for the most part stakeholders still lacking in Kazakhstan. Nevertheless, the Ministry of Health reports that integrated models of medical care are being developed and implemented in some regions.

138. The families surveyed perceive a good level of coordination between PHC and referral to specialists when necessary. There were 22 cases of children with chronic diseases within the sample of families surveyed. Out of 22 with chronic diseases, 4 families claim the child didn’t consulted with any other specialist or specialized service during the period that he / she was being followed up by the health center.

139. Families under UPHV model perceive good coordination between primary care and specialized level when required. While there is no significant difference on access to information between the two patronage models.
The traditional patronage model seeks to evaluate and address the medical aspects of child development, but not social issues. The UPHV model definition states that nurses or health mediators – community health workers have to reach every single child in their attachment area, assess the risks – identify potential risks that could be socio economical, poverty or environment and develop an individual plan of action not only limited to the health sector. According to family answer this core feature of the UPHV model is observed in pilot programme. It can be found below important differences between the two models in services like counselling for mental health problems, support on searching social assistance, treatment for harmful drug use, support dealing with the child’s behaviour problems or preventive recommendations to avoid injuries to children. There are no differences in child health interventions, such as identification of visual problems, nutritional supplementation programme, immunizations, counselling on first child health symptoms or promotion of child health.
Families under the UPHV model appreciate a more family-centered care. This is reflected in a best understanding of the nature, role, and impact of family members’ health, illness, disability, or injury on the entire family and the impact of family structure, function, and dynamics. This is especially evident when asking about nurses’/doctor’s ways to approach to family’s opinions and concerns about child care or knowledge about most important problems for the family.
142. Families under the UPHV model also appreciate a more community-oriented care. Therefore, it is concerned with the characteristics of communities that influence the health care needs of everyone in the community. This is important because for the analysis of risks and vulnerabilities of the progressive component, it is key to analyze the community context in which the child lives and not just the family.

Source: Author’s elaboration from the surveys administered to families with children U-5

143. All this confirms the hypothesis about the relevance and efficacy of the UPHV model, addressing comprehensively biopsychosocial aspects of children’s development, with substantial differences from the traditional Patronage system. Substantial positive contributions from the UPHV model are found in the PHC attributes: Comprehensive care, Family approach care and community orientation. On the other hand, the primary care system does not lose effectiveness under the UPHV model in the characteristics of “First-contact” care, continuous care and coordination.
6.3 Impact

144. Under the Theory of Change approach and following the results chain, the next step was to analyze the performance of the outcome indicators. According to Regional Recommendations Package for Universal-Progressive Home visiting, the framework proposed in Volume IV for Monitoring, Evaluation and Research (MER) should guide the data gathering necessary for tracking the implementation of services as well as measuring the impacts of these services on child and family outcomes. This system has not been developed to the level of impact tracking. However, some information has been analyzed that may indicate positive contributions of the HV model towards the achievement of expected results.

145. The evaluation focused on the UPHV program outcomes. In line with MCE that is being implemented in parallel, the limited timespan of implementation, the lack of agreed impact indicators compounded by nascent and underdeveloped monitoring system for UPHV are significant limiting factors when looking at programme impact.

Child mortality, morbidity and prematurity

146. The reduction of mortality is one of the outcomes indicated in the HV model design. Although it should be noted that mortality is not the central objective in the HV model design (focus on child development), attention should be paid to under 5 mortality evolution.

147. Child mortality, like the whole country, has experienced a significant reduction in recent years. This has been an effort of the entire health system. The trend has remained stable so we can infer that there is no direct relationship between the reduction of mortality and the implementation of the HV model. A significant rebound in the last year is identified.

Table 5: Number deaths of under 5

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% Decrease by year

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Table 5: Number deaths of under 5 - Kyzylorda

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% Decrease by year

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Source: Author’s elaboration from the NSC data

148. Historically Kyzylorda had a mortality rate higher than the country’s average. However, in recent years this gap has been reduced. In the year 2018 there has been a stop of the trend at both, national and regional level. Below it can be found the series of under-5 mortality rate.
149. Regarding geographical gap in child mortality within the region, two levels were analyzed: rural / urban gap and rayon differences within the Kyzylorda region.

150. There is a convergence trend between rural and urban settings in reducing children mortality under 5. There is a trend that comes from the past and gets the balance from 2015

![Number of deaths rural-urban in Kyzylorda Oblast](image)

Own elaboration. Data from the National Statistics Committee (2018)

151. At the level of territorial distribution of mortality under 5, the regional capital has the highest number of dead children. It is obvious from the size of its population, but worrying the increase given in 2018, as previously stated. In general, in almost every rayon there has been a decrease in mortality, although there are sustancial differences in the level of this trend, as can be seen in the following figures.
152. Analyzing the cause of death, grouped by ICD, the following trend can be observed in the Kyzylorda region:
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**Table 6: Number of deaths by cause in Kyzylorda Oblast**

I Certain infectious and parasitic diseases

II Neoplasms

III Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism

IV Endocrine, nutritional and metabolic diseases

IX Diseases of the circulatory system

V Mental and behavioural disorders

VI Diseases of the nervous system

X Diseases of the respiratory system

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**XI Diseases of the digestive system**

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<td></td>
<td></td>
</tr>
</tbody>
</table>

**XII Diseases of the skin and subcutaneous tissue**

<table>
<thead>
<tr>
<th>GROUP XIII</th>
<th>1</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**XIII Diseases of the musculoskeletal system and connective tissue**

<table>
<thead>
<tr>
<th>GROUP XIV</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>3</th>
</tr>
</thead>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

**XIV Diseases of the genitourinary system**

<table>
<thead>
<tr>
<th>GROUP XVI</th>
<th>268</th>
<th>262</th>
<th>218</th>
<th>229</th>
<th>155</th>
<th>119</th>
<th>98</th>
<th>102</th>
<th>62</th>
<th>85</th>
<th>1598</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>112</td>
<td>119</td>
<td>96</td>
<td>97</td>
<td>71</td>
<td>62</td>
<td>63</td>
<td>69</td>
<td>35</td>
<td>52</td>
<td>776</td>
</tr>
<tr>
<td>2</td>
<td>156</td>
<td>143</td>
<td>122</td>
<td>132</td>
<td>84</td>
<td>57</td>
<td>35</td>
<td>33</td>
<td>27</td>
<td>33</td>
<td>822</td>
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</table>

**XVI Certain conditions originating in the perinatal period**

<table>
<thead>
<tr>
<th>GROUP XVII</th>
<th>87</th>
<th>86</th>
<th>64</th>
<th>82</th>
<th>67</th>
<th>61</th>
<th>56</th>
<th>60</th>
<th>65</th>
<th>47</th>
<th>675</th>
</tr>
</thead>
<tbody>
<tr>
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<td>39</td>
<td>39</td>
<td>28</td>
<td>42</td>
<td>29</td>
<td>26</td>
<td>34</td>
<td>30</td>
<td>27</td>
<td>26</td>
<td>320</td>
</tr>
<tr>
<td>2</td>
<td>48</td>
<td>47</td>
<td>36</td>
<td>40</td>
<td>38</td>
<td>35</td>
<td>26</td>
<td>26</td>
<td>38</td>
<td>21</td>
<td>355</td>
</tr>
</tbody>
</table>

**XVII Congenital malformations, deformations and chromosomal abnormalities**

<table>
<thead>
<tr>
<th>GROUP XVIII</th>
<th>44</th>
<th>44</th>
<th>49</th>
<th>26</th>
<th>24</th>
<th>35</th>
<th>20</th>
<th>20</th>
<th>23</th>
<th>23</th>
<th>308</th>
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<tr>
<td>1</td>
<td>21</td>
<td>19</td>
<td>23</td>
<td>8</td>
<td>6</td>
<td>16</td>
<td>9</td>
<td>4</td>
<td>12</td>
<td>17</td>
<td>135</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>25</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>11</td>
<td>16</td>
<td>11</td>
<td>6</td>
<td>173</td>
</tr>
</tbody>
</table>

**XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**

<table>
<thead>
<tr>
<th>GROUP XX</th>
<th>38</th>
<th>34</th>
<th>34</th>
<th>48</th>
<th>50</th>
<th>30</th>
<th>27</th>
<th>15</th>
<th>9</th>
<th>12</th>
<th>297</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>74</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>28</td>
<td>26</td>
<td>43</td>
<td>39</td>
<td>20</td>
<td>21</td>
<td>9</td>
<td>3</td>
<td>7</td>
<td>223</td>
</tr>
</tbody>
</table>

**XX External causes of morbidity and mortality**

| Total general  | 575 | 530 | 475 | 491 | 387 | 345 | 300 | 261 | 219 | 241 | 3824 |

*Source: Author’s elaboration from the NSC data*
153. According to data from the National Statistics Committee, Respiratory distress syndrome of newborns and Neonatal cerebral ischaemia are the main causes of death that have significantly increased in 2018. Although in general terms, before 2018, there had been a significant reduction in mortality due to these causes. These are diseases generally managed at the hospital level, so little impact can be attributed to primary health care performance.

154. In the other hand, also according to data from the National Statistics Committee a high positive trend is identified in the reduction of death related to respiratory problems and multiple congenital malformations. The latter seems important for the purpose of evaluation. Congenital malformations are highly related to the lifestyle of the parents, especially the mother. A good prevention and monitoring during pregnancy seem to be making positive effects. It is relevant that morbidity due to this cause has been increasing in the last years (see table below) in parallel. It can be a sign that newborns with this problem are being identified and treated with greater attention. The same can be said related to premature birth and low birth weight monitoring by the health system.

<table>
<thead>
<tr>
<th>Morbidity - Neonatal indicators</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nº premature birth (недоношенные новорожденные)</td>
<td>45</td>
<td>61</td>
<td>66</td>
<td>82</td>
</tr>
<tr>
<td>Nº congenital malformations (новорожденные с ВПР)</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Nº low birth weight (с низкой массой тела)</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019

**Outcomes of HVM for young children and families**

155. Home visiting services are expected to contribute to improvements in some others outcome indicators.

156. **Breastfeeding** initiation an exclusive breastfeeding during the first six months of life a breastfeeding on demand. A positive trend is identified in the area of UPHV pilot implementation. During the interviews with health personnel, it was proved that an important effort was being made in this area. Despite cultural barriers, important progress is identified. Trust of parents and relatives, especially grand-mothers, has been identified as key feature. Grandmothers play an important role in nurturing kids due to long traditions. Generally, one big family consists of three generations: grand-parents, children, and grandchildren. The evidence from field showed that when nurses gains trust from the older generation, then it will be easier to teach about breastfeeding and nursing.

<table>
<thead>
<tr>
<th>Only breastfeeding first 6 months (исключительно грудное вскармливание в первые 6 мес жизни)</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>82,5%</td>
<td>79%</td>
<td>81%</td>
<td>89%</td>
<td></td>
</tr>
</tbody>
</table>

---

42 It is a syndrome in premature infants caused by developmental insufficiency of pulmonary surfactant production and structural immaturity in the lungs

43 It is abnormal neurological function in the first few days of life in an infant born at term

157. Improvement in **health-related behaviors of adults**. An important effort was highlighted during the field work in Kyzylorda, mainly by the nurses, to increase the parent’s awareness of the prevention of infectious diseases. Data shows a good performance on this.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>157.</td>
<td>78.5%</td>
<td>87%</td>
<td>92%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019

158. Improvement in **health seeking behaviors** and reduction in unnecessary health services consultations. This indicator shows a good exercise in the empowerment of the population regarding the management of health problems. As in the other indicators, it has increased more than 10% in the last three years. The detail of the indicators has not been facilitated so this data should be analyzed in more detail in future research.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>158.</td>
<td>83%</td>
<td>80.5%</td>
<td>88%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019

159. **Immunization rates**

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>159.</td>
<td>69%</td>
<td>70%</td>
<td>69%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019

160. **Increased** identification of **children with disabilities** and developmental difficulties, and families receiving **rehabilitation** and other support services. Important contribution is identified, although there is ample scope to expand these figures.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>160.</td>
<td>3</td>
<td>13</td>
<td>14</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019

161. **Reduction of violence against children**, child abuse neglect and institutionalization of children under three. Monitoring coverage in contexts of vulnerability due to violence and abuse of children has been increased by more than 10% in the last three years.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>161.</td>
<td>61%</td>
<td>61%</td>
<td>71%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Source: Department of Health of Kyzylorda Oblast to the Ministry of Health. 2019
162. The universal progressive home visiting system is an effective solution for lowering maternal and child mortality rates and improve child’s lives in the country. According to data from the Department of Health of Kyzylorda oblast to the Ministry of Health, it increased the exclusive breastfeeding practices up to 80%, parent’s awareness of the development milestones up to 90%, and parent’s satisfaction with the HV system\(^\text{45}\). Evidences show that the universal progressive home visiting contributes for:

- Lowering infant mortality and morbidity rates through better monitoring, support and education of parents;
- Increasing the importance of exclusive breastfeeding among parents through regular visits and advocacy messages that nurses deliver;
- Active health-seeking behaviour by parents and their awareness of early signs of diseases;
- Increasing parenting skills and improving early childhood development through cross-sectoral collaboration and shift from punitive to supportive focus of the whole system;

163. The main bottlenecks stated by home visitors’ staff for a best performance of the UPHV are:

- Social customs: tight swaddling, early refusal of breastfeeding. Great influence of grandmothers: they often take children from their mothers and feed them themselves, interrupting breastfeeding. Low involvement of fathers.
- In local level lack of handouts and other materials. At the state and regional levels, lack of social advertising in mass-media, which would help to combat these problems.
- In the PHC children and adults are attended together. Nor the health workers or patients are comfortable with this setting.
- Some lack of coordination with the curators of the programme in the PHC. Often they does not understand the problems of nurses, as they were not trained in the program.
- Training of social workers is not enough and demands for special education in UPHV.

164. No reliable information was identified on other relevant indicators: Increased health literacy, School readiness, Improved parent-infant attachment, Increased awareness of community resources available to them, Increased engagement of vulnerable and marginalized families in health, social and other public services, Hospital admission rates caused by unintentional and deliberate injuries.

165. As previously noted, the absence of a continuous monitoring system that allows tracking the key indicators limits the impact analysis exercise in detail. It can be concluded that no impact can be identified in terms of attribution of the UPHV on outcomes indicators. However, there is substantial evidence on the positive contribution of the model HV implemented in Kyzylorda on the good performance identified for child wellbeing and development.

6.4 Efficiency

166. As already established by the defining documents of the UPHV model, research shows that the early years of a child’s life have impacts on healthy brain development, cognitive functioning and social and emotional functioning, therefore influencing a range of outcomes, from health to social adjustment and productivity, throughout the life course. Neurological maturation is highest in prenatal life and the first two to three years of life, establishing a foundation for future cognitive and social development. As time goes on, the plasticity of the brain decreases so that by the time children start school their developmental trajectory is well established and becomes increasingly difficult to change46.

167. Decades of child development research and evidence from studies on child deprivation, resilience, early intervention and brain development clearly demonstrate that the early years -starting at conception- provide a highly cost-effective window of opportunity to enhance lifelong wellbeing and productivity. For good development, young children need responsive and emotionally available caregivers, a predictable, stimulating, and safe environment, in addition to health and good nutrition47. No costing assessment of the model has been performed in Kyzylorda, but performance data, the assessment on used resources and research evidence allow sustaining a high cost effectiveness relationship. A costing assessment would improve the capability to make evidence-based decisions of the programme. This input would be one of the bases for an expansion of the programme to the country.

168. The number of families with young children receiving the new comprehensive universal and progressive visits has increased significantly from 5,877 in 2017 to 18,055 in 2018. Of these, 46% of families in 2017 and 67% in 2018 were identified with moderate or high risks and received additional visits as part of the progressive component. Thanks to the additional visits and support in 2018, risks were addressed in 95% (12,169) of families who were supported to provide optimal nurturing care to their children.

169. The pilot areas have reported some encouraging outcomes. These include a potential contribution of home visiting to the reduction in infant and child mortality rates as a result of increased utilization of health services. Notable improvements in the rates of breastfeeding (exclusive breastfeeding increased from 47% in 2016 to 66% in 2017) decreased the number of infants on baby formula, resulting in health and nutrition benefits to mother and babies and savings of about $250,000. (Baby formula is available by prescription with costs covered by the government.) Vaccination coverage also increased from 70% (2016) to 80% (2017).

170. The use of risk assessment tools has also made it possible to increase the number of identified young children at risk of developmental delays and disability. About 7% of children, i.e. those identified with developmental delays, are now receiving needed services every month.

171. Pilot PHCs report improvements in relation to skills and competencies of home visitors, team spirit and team work in the PHC, adoption of the whole family approach, identification of various family risks including maternal depression, decreased morbidity from preventable causes and much stronger focus on at-risk groups of the population.

Assessing the planned dedication versus the actual execution, it can be stated that these successes rest largely due to the effort that home visitors are making. This overstress limits the sustainability of the model due to quick burnout and high turnover of home visitors. For the efficiency analysis the workload of the home visitors to the different tasks, was studied. Below can be find a summary of times dedicated to different tasks:

<table>
<thead>
<tr>
<th>Home visitors’ tasks</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time dedicated to paperwork: bureaucracy (fill in clinical records for example) and identification of vulnerable people (planning of UPHVM activities)</td>
<td><em>Officially, patronage nurse should work 4 hours of visiting, 2 hours of documentaries. Nevertheless, in reality, they work more than 4 hours at the field with parents and children. As a result, they sometimes work at the evening and even at the weekends to fill all the necessary documentation. Usually HV nurses are always available for communication with families, with the phone connected the 24 hours.</em>&lt;br&gt;Home visitors claim to have a lot of paperwork compared to time dedicated to visits; and too large processes (the information about home visit is copied in 3 different papers and then in the electronic medical record).</td>
</tr>
<tr>
<td>Time spent traveling between homes and health center</td>
<td><em>30-45 minutes on average. It depends on weather and seasons. Very difficult to visit in summer and in winter. Travel times could be reduced with the availability of means for transportation.</em></td>
</tr>
<tr>
<td>Time dedicated to caring for patients in their homes</td>
<td><em>As explained before, the home visitor assigns low (green), moderate (orange), or high (red) risk status to a family and leverages additional support. Data from pilot sites indicate that almost half of families need such additional support. Data are automatically analysed on the accomplished cases and open cases with relevant status of risks, from low to high. This monitoring tool allowed to advocate for the performance of patronage nurse based on the quality of the services. As a result, the Ministry of Health applied this tool as solid evidence to increase the salary of the patronage nurses up to 25%. Moreover, patronage nurses are issued additional part of the salary on the monthly basis in case in the could define risks and refer to other sectors among 10% of pregnant women and children aged from 0 to 5.</em>&lt;br&gt;The duration of the visit depends on the risk zone of the family; red, yellow and green. In the red zone - the visiting nurse visits the family 3-4 times a week and the psychologist visits 2 times a week. Yellow zone – 2-3 times per week. The visit lasts about 45-59 minutes.</td>
</tr>
</tbody>
</table>
173. All members of the focus group participants agreed that in the home visiting model the health workers are more attentive to family problems of their patients and interested in the complex approach to resolve a problem, than former patronage model.

174. Below are some challenges highlighted by the home visitor staff of different health facilities with UPHV model with potential impact on cost-effectiveness:

1. The high pressure and tension that HV nurses, psychologists, and social workers have.

2. Staff demands of a high salary.

3. Visit of children under 5 years old and adults happens at the same time. Asked for a better place for patronage work.

4. Regarding the cost of the UPHV, the possibility to calculate a differentiate coefficient of the salary of the home visitors and social workers based on the number of visits, specifically, number of progressive visits, since, this figure may vary every month. Having analysed the outputs of the home visitors’ workloads, their monthly performance depends on the progressive visits. One family may require more that one visit per month or per week, whereas another family needs only the universal visit.

5. Supervision (including clinical case studies, supportive supervision, peer-to-peer support, monitoring visits) of the home-visitors and social workers should be included (at least 1-3 hour per week).

6. Continuous educational training of the home visitors should be included into the cost of the UPHV model. The training package consists of the three 5-day courses (per each): 1) IMCI training, 2) Basic universal-progressive modules; 3) Advanced universal-progressive modules with case management and supervision.

7. The cost for the managers training on monitoring of the home-visiting services and data management has to be envisaged in the budget line of the UPHV model.

175. In general, informants reported not enough printed materials with colorful prints. In some areas often bags for home visitor nurses are not enough: not enough scales for kids, sometimes there are no bandages, cotton wool, tonometry, scissors or tweezers. In other facilities, this situation is much better. This information was gathered from FGD, since there is not an assessment on the supplies and commodities.

176. There are no specific vehicles for home visitors. Logistic depends on local conditions. In some places with a big territory and population dispersion, nurses must walk to reach patients. Especially, the work is hard to walk in winter (at the frosty time) and summer (the temperature raises up to 40 degrees Celsius). In that moment, nurses should use a taxi, not being financed for that.

177. Regarding the organization of work, when visiting families HV nurses takes notes about all information on paper notebook and when return back to the hospital they types the information into the computer base. The mobile application for patronage nurses has been already released in the testing mode under the funding and supervision of the Ministry of Health. This application will be mandatory for usage from January 2020.
6.5 Sustainability

178. Nowadays the UPHVM is legally integrated in the in the health care delivery services funded by the state. Through the decree #1027 (December 2017) the Ministry of Health approved the Paediatric Care Standard in the Republic of Kazakhstan. This order explicitly includes the UPHVM as it was implemented in the Kyzylorda Pilot:

“33. Patronage visits to pregnant women, new-borns and infants shall be organized as required by the universal progressive model, recommended by the United Nations International Children’s Emergency Fund (UNICEF) in order to identify and reduce medical or social risks that threaten life, health, child development, and also to reduce the number of mandatory visits to risk-free families. Along with mandatory scheduled visits (universal approach), the universal progressive patronage model shall introduce additional active visits according to an individual plan (progressive approach) for pregnant women, new-borns and children in need of special support due to medical or social risks to the life, health or development of a child.”

179. This fact is a major achievement in the sustainability of the UPHVM and is a cornerstone of the scaling up process to the whole primary health care model of the Republic. Along with this it is also important the economic incentive system for PHC professionals introduced in 2018 (20% increase of salary) and the increase of one nurse position in the PHC team. The Ministry also proposed workplan (2019–2021) focusing on: 1) strengthening the professional competencies and practical implementing a system for monitoring the quality of patronage services in selected regions; 3) establishing standards and norms for home visiting based on the pilot experience; and 4) implementing a new system on monitoring child injuries⁴⁸.

180. In the 2015 UNICEF Equity analysis included a scheme of proposed phases for introduction of the UPHVM:

| 2015-2016 | Phase 1: Preparation for reforming current universal home visiting/patronage nursing model. |
| 2017      | Phase 2: Piloting of the new universal home visiting/patronage nursing model |
|           | Phase 4: Preparation for introduction of universal progressive model |
|           | Phase 5: Piloting of Universal-Progressive model |
|           | Phase 6: National scale up of universal-progressive model |

181. Each phase had a detailed list of tasks and activities to be developed on the different building blocks of the health system as well as a list of outputs to be obtained. It should be observed that the initial conceptualization of the scaling-up included a preparation phase and a second pilot of the model that has not been implemented. Instead of that the Ministry has directly extended the UPHVM to the whole country.

182. This acceleration is putting pressure on the sustainability of the UPHVM. During our field work we have gathered opinions and evidences that shows us that although the scaling up process is being deployed at national level the process presents some bottlenecks that should be. Examples of the challenges found on the field are:

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⁴⁸ Nurturing Care. Case Study: Kazakhstan. Fostering cooperation between the health and social sectors to deliver better nurturing care services. Sukhanberdiyev K. and Tikhonova, UNICEF Kazakhstan
• Problems in recruiting 3rd Nurse: all the non-pilot PHC Centres visited in Nursultan and Zhanakorgan could not complete the basic PHC Team (family doctor plus three nurses). The reason argued is that they couldn’t find professionals in the labor marked. We also gathered evidence that this situation is similar for all Nursultan PHC Centers.
• The nurses on the field express a sense of overload, and professional stress. The Nurse must assume a lot of non-clinical work (paperwork, reporting to the data base, family selection, activity planning) and must combine the UPHVM intervention with the Chronic Patient Management Program (also being deployed at national level).
• The extension of the model to the whole health system has aroused problems in the area of monitoring and supervision from central level to regional and local levels.
• Lack of training for the GP on PHC and specific contents for the UPHVM. In Kyzylorda all the PHC Team was properly trained on the principles, methodologies and tools of the UPHVM (3 days training program) but this is not happening in the rest of the Oblasts. Without this background the GP in not embedded in the philosophy of the UPHVM and as a result the Nurse is feeling more professional loneliness regarding its duties and objectives with the new model.

183. All of these challenges justify the need of continuity of the Technical Assistance of UNICEF. According to findings some elements that needs to be supported to ensure a successful scaling-up process are:

– Human Resources planning at national and regional level
– New capitation funding modality including the UPHVM package of services.
– M&E system at national and regional level
– Continuous and in-depth supervision system for the staff recently involved in UPHVM model reinforcing their capabilities an assessing them on the field.
– Residency program for PHC doctors at national level to increase this specialty knowledge in the country.

6.6 Cross cutting

184. The intervention theory has clearly considered Human Rights and Gender issues since the definition of the UPHV model incorporates it as a core fundamental of the definition. The families experiencing socio-economic difficulties, psychosocial stress, and other unfavourable circumstances (for example, difficulties in child nutrition, issues with development, ensuring a safe environment etc.) receive increased support so that they can take care of themselves and their children to secure their optimal growth and development. Intensive support is provided to families where children are highly vulnerable and in cases when cross-disciplinary support and cooperation between health, social and educational services is needed to reduce the risk. Disaggregated health and mortality data by sex, place of residence (urban / rural) and age is available. The following matrix unveils the most relevant aspects of the gender-responsive approach. Substained by rubrics – one per traffic light, it gives a thorough visual assessment of the performance in terms of gender-responsiveness.

**Common transformative questions**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributes to social and economic change process?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyzes inequalities, discrimination practices and injustice power relations?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Principles**

- **Inclusion**
  - Groups disaggregated by relevant criteria?
  - Benefits and contributions fairly distributed?
  - Acknowledges stakeholders negatively affected?
  - Sheds light on how to minimize these negative effects?

- **Participation**
  - Stakeholders participate in design, implementation and monitoring?
  - Stakeholders consulted/participated in deciding what to evaluate and how to evaluate it?
  - Evaluation measures stakeholders group participation?

- **Fair power relations**
  - Seeks to balance power relations between groups?
  - Seeks to balance power relations within groups?
  - Supports the empowerment of disadvantaged groups?

**Gender analysis at initial and outcome level**

- Analysis of gender roles
- Analysis of changes identifies root causes of existing gender inequalities
- Analysis of fulfilment of priorities and needs

In green marked cells, the UPHV model follows thoroughly the gender-responsive motivation, purposes and means. It provides evidence to make it possible to highlight the issues the programme has to strengthen to improve gender equality.

In yellow marked cells, overall the UPHV model follows many of the gender-responsive approach, but they don’t really utterly guide the decisions and methodologies. Many areas could improve resulting in a more gender-sensitive programme.
185. Specifically, five main risks associated with pregnant women are monitored by the UPHV model:

✓ Risk 1: Number of pregnant women evaluated for nutrition
✓ Risk 2: Number of pregnant women evaluated for depression
✓ Risk 3: Number of pregnant women who have been tested for medical risks
✓ Risk 4: Number of pregnant women who have been tested for bad habits
✓ Risk 5: The number of pregnant women who have been assessed for social risks affecting the provision of the needs of the child

186. Regarding policies and programmes for addressing inequalities and discrimination the Leaving No One Behind model has been followed. The UN Chief Executives Board (CEB) for Coordination put forth its Shared UN System Framework for Action on Leaving No One Behind and set out the elements of a comprehensive and coherent package of policy and programme support areas to combat discrimination and inequalities within and among countries at the country, regional and global levels. Below it is pointed out those to whom the UPHV model contributes:

| Promote institutions, laws, policies and actions to combat discrimination on the basis of race, sex, language, ethnicity, religion, age, disability, caste, indigenous status, health status, migrant status, minority status or other grounds, and to advance equal access to justice | ✓ |
| Provide support for reducing spatial or geographical inequalities between rural and urban areas and/or between industrialized and non-industrialized or remote regions, including by promoting responsible and socially inclusive investments | ✓ |
| Promote gender equality and eliminate all forms of discrimination and violence against women, and promote investments to close the gender gap and strengthen support for institutions that promote gender equality and the empowerment of women | ✓ |
| Strengthen economic governance, regulation, accountability and the rule of law in the economic sphere | ✗ |
| Sustain full employment and inclusive economic policies, promoting decent work | ✗ |
| Support the elimination of employment discrimination and reinforce labour rights, including decent work, minimum wages (including for migrant workers), freedom of association and collective bargaining, and the eradication of forced and child labour | ✗ |
| Implement initiatives to combat all forms of age discrimination against older persons in employment and promote youth employment and socio-economic inclusion of all ages, and to address the vulnerability of young people to higher unemployment and lower quality of jobs and to longer and more insecure school-to-work transitions | ✗ |
| Social protection systems that reduce inequalities through safety nets that maintain the right to an adequate standard of living for all. Ensure support for | ✗ |
| **universal health coverage** and universal access to healthcare to prevent catastrophic out-of-pocket expenditures that result from health costs that produce poverty and inequality | ✓ |
| Establish programmes for universal access to **education, water, sanitation, healthcare** and other economic and social rights to promote greater equality in opportunities and outcomes | ✓ |
| Provide assistance in achieving universal **access to ICTs** and the narrowing of the digital divide | X |
| Set up programmes to support **redistributive fiscal policy and progressive taxation** in order to reverse extreme concentrations of wealth, and progressively achieve greater equality | X |
| Provide assistance for **tackling illicit outflows and tax evasion** | X |
| Strengthen the protection of freedom of expression, association, and assembly, insulate **democratic institutions and processes** from elite political capture, ensure equal political participation for all women and men, and to promote public access to information | ✓ |
| Create programmes to reinforce **private sector accountability**, including by implementing the *Guiding Principles on Business and Human Rights*, ensuring the effective regulation of businesses by governments, conducting **social, environmental and human rights impact assessments**, and implementing due diligence safeguards to prevent negative impacts | X |
| **Support measures to protect vulnerable, marginalized and excluded communities** in prevention and mitigation of the impacts of, and building resilience to, climate, natural disasters, desertification, land degradation and humanitarian crises | X |
7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

Relevance

187. The implementation of UPHVM has been a political priority for the Ministry of Health of the Republic of Kazakhstan. Since 2015 the government has achieved important milestones: the Pilot project in Kyzylorda (2016-2017) and the beginning of the scaling-up process (2018) are among the most remarkable.

188. This political priority is fully embedded in the long-term healthcare policy framework that has in the Primary Healthcare one of its main strategies. In this sense the development of the UPHVM in the country will has a major impact in the PHC reform that goes back to the beginning of the present century.

189. Although the consistency with governmental policies has been proved it has to be remarked that the UPHVM is not mentioned in the main healthcare planning document of the country (Densaulyk 2016-2019) nor in the Strategy Plan of the MoH (2014-18).

190. UNICEF has been beside this UPHVM deployment process. The model of home visiting was adapted to the Kazakh health system context as a result of a regional initiative of Europe and Central Asia Regional Office (ECARO) launched in 2012. The role of UNICEF Country Office has been mainly focussed in the field of advocacy and technical assistance and has been highly valuated by all stakeholders of the process.

191. This sponsorship has guaranteed that the design of the care model has been grounded on the latest scientific evidence and respond to an evidence-based problem analysis and needs of the target groups as well to lessons learned from other regional an international experience. Nowadays the UPHV experiences in Central Asia and East Europe that were born thanks to this regional initiative are arriving to a different degree of maturity and their results will enrich the following steps of the national processes.

Effectiveness

192. The theoretical hypothesis of the model definition about the relevance and efficacy of the UPHV model addressing comprehensively biopsychosocial aspects of children's development has been verified. The traditional patronage is more medicalized assessing and addressing only medical aspects of child development, but not focussing on preventive or social issues. Substantial differences were found regarding the traditional patronage system. Positive contributions from the UPHV model were found in the PHC attributes: Comprehensive care, Family approach care and community orientation. On the other hand, the primary care system does not lose effectiveness under the UPHV model in the characteristics of “First-contact” care, continuous care and coordination; with no substantial differences in those features of PHC between the UPHV model and the traditional patronage model.

193. Under the new UPHV model implemented in Kyzylorda, home visitors identify every single child in their attachment area, assess the risks and potential risks that could be socio economical, derived from poverty, environment, etc and then an individual plan of action is prepared, not limited to the health issues, distributing roles and responsibilities.

194. It has been found differences between the UPHV model and the traditional patronage model, since under the UPHV model some services are best ranked by families: counselling for mental health problems, support on searching social assistance, treatment for harmful drug use, support dealing with the child's behaviour problems or preventive recommendations to avoid injuries to children. There are no significant differences in child
health interventions, such as identification of visual problems, nutritional supplementation programme, immunizations, counselling on first child health symptoms or promotion of child health.

195. Important challenges remain for integration of social services and HV system, diminishing the effectiveness of both systems. The problems, such as child or caregiver’s disabilities, development difficulties or negative social-economic environment are difficult to solve without a best level of coordination.

196. The continuity of care is, in general, well perceived by the families surveyed: the doctors / nurses and families build a long-term relationship in order to foster mutual understanding and knowledge of each other’s expectations and needs. This important element is limited and put in risk in some places by the high turnover of doctors and, to a lesser extent, of nurses. Besides the existing quality initiatives such as the use of clinical guidelines, accreditation processes, and care pathways, new quality improvement measures could enable frequent monitoring of health outcomes.

197. Respondents from families to the survey affirm a good level of accessibility to the UPHV services, measured as the reception of regular visits. But this statement must be questioned since there are significant differences between families to the question whether children with chronic diseases receive regular visits or should call the medical center. In some cases, a practice of regular visits to families is identified, in other cases that evidence is not found.

198. More and more, the possibilities of new technologies for information and communication are being exploited. The use of social networks and messaging platforms suppose a very great potential. But at the same time, it is a challenge on how to regulate its use and procedures.

Impact

199. The universal progressive home visiting system is an effective solution to improve child’s lives in the country. Breastfeeding and parents’ awareness of the prevention of infectious diseases has experienced a positive evolution in the areas of pilot implementation.

200. Infant mortality has shown a positive trend in parallel as has happened throughout the country. There is no evidence that the UPHV model has made a significant contribution to the general reduction of mortality. However, if the causes of death are analyzed, a contribution is identified in the reduction of deaths caused by congenital malformations, highly significant reduction in rural areas where the UPHV has more incidence.

201. A monitoring system focused on activities and outputs limits the capability to measure the results of the UPHV model at the outcome - impact level

Efficiency

202. The UPHV model has been efficient in achieving certain outcome results and in overcoming some bottlenecks of the system. This has been largely thanks to the substantial contribution of the home visitors staff. This contribution significantly exceeds the level of planned effort. The hours of dedication are greater, due to the fact that work hours generally cover the hours of visits to families and part of the paperwork is taken home and assumed during non-working hours. This puts stress on the model sustainability and generates situations of overcrowded, which is added to the high level of professional rotation.

203. Decades of child development research and evidence from studies on child deprivation, resilience, early intervention and brain development clearly demonstrate that the early years
-starting at conception- provide a highly cost-effective window of opportunity to enhance lifelong wellbeing and productivity. No costing assessment of the model has been performed in Kyzylorda, but performance data, the assessment on used resources and research evidence allow sustaining a high cost effectiveness relationship. A costing assessment would improve the capability to make evidence-based decisions of the programme. This input would be one of the bases for an expansion of the programme to the country.

204. Human Resources reports a demand for more physical space for home visitors and better setting for work. At this stage no HR planning for UPHV scaling-up and institutionalization of training modules have been identified.

205. One of the main concerns of home visitors is to move between health centers and households. An important margin of efficiency gains is identified if logistical support for transport is increased. This is mainly important in rural areas with great geographical dispersion.

Sustainability

206. The UPHVM is legally integrated in the in the health care delivery services funded by the state. Through the decree #1027 (December 2017) the Minster of Health approved the Paediatric Care Standard in the Republic of Kazakhstan. This decree explicitly includes the UPHVM as it was implemented in the Kyzylorda Pilot

207. This decree signified the starting point of the scaling-up process of the model to the national state funded healthcare system.

208. The process of extension of the UPHVM has been done much more faster than it was planned in 2015: the initial conceptualization of the scaling-up included a preparation phase and a second pilot of the model that has not been implemented.

209. This acceleration is putting pressure on the sustainability of the UPHVM and at the same time justifies the need of continuity of the Technical Assistance of UNICEF.

210. The supporting supervision of the UPHV teams is a key task for maintaining the quality of services. The quantity of supervision (number of days) is not enough to provide quality supervision; and the function is not institutionalized into the system.

Cross cutting

211. The intervention theory has clearly considered Human Rights and Gender issues since the definition of the UPHV model incorporates it as a core fundamental of the definition. The families experiencing socio-economic difficulties, psychosocial stress, and other unfavourable circumstances receive increased support. Intensive support is provided to families where children are highly vulnerable and in cases when cross-disciplinary support and cooperation between health, social and educational services is needed to reduce the risk. Disaggregated health and mortality data by sex, place of residence (urban / rural) and age is available.

212. Five main risks associated with pregnant women are monitored by the UPHV model: nutrition, depression, medical risks, bad habits and social risks affecting the provision of the needs of the child.

213. Considerable contributions are identified addressing inequalities and discrimination under the Leaving No One Behind model.
7.2 Lessons Learned

214. UPHV model implemented in Kyzylorda Region allowed to confirm key functions the literature on development identifies as significant in helping to shape the way successful development policies can be designed and implemented:

I. **Policy Support**: projects are effective where able to identify policy innovations, especially at a local level as the case of UPHV model, and assist governments in devising ways to scale them up. UNICEF is viewed by stakeholders as positive and influential when it was able to provide sophisticated, quality policy advice (that is, advice that is sharp and well-contextualized, informed by detailed knowledge of past and current experiences as well as budgetary and political constraints) at different levels of government. UNICEF Kazakhstan has the capability and resources to identify and promote successful local efforts (even ones at small scale) to improve social outcomes like child nutrition or access to education and offer advice on how governments could extend those policies to other communities elsewhere in the country. Therefore, in this evaluation different stakeholders have claimed the continuity of UNICEF support for the implementation of the UPHV model throughout the country.

II. **Norms, Standards and Advocacy**: The programmes have been most successful where advocacy has been embedded into all activities, from policy support for UPHV to monitoring and evaluation or service provision. This required not only designing project or policy support initiatives, but also fostering an internal culture around those norms and standards within the implementing partners. Advocacy is successful when two types of effort were considered: high-level and secondary reach. High-level involved the ability to influence and have an impact on the decision-making of high ranking government officials to foster and scale-up the UPHV model, from brainstorming policy options to raising awareness of key challenges to disseminating the results of analyses. Secondary involves developing ways to partner with governments to make development-related information accessible and available to the widest possible audience using resources such as publications, social networks, and other means of communications. It has also meant undertaking multi-stakeholder partnerships with organized civil society entities, grassroots groups, and private sector actors.

III. **Strategic focus for Service Delivery**: As an evaluation by the Canadian International Development Agency (CIDA, 2012) noted, the programme's initiatives tended to be most successful where programming was not widely dispersed across a vast number of projects and/or a large geographic area and where there was effective investment in knowledge development. The UPHV model has been implemented as a pilot project. UNICEF played a leading role in the training of doctors and nurses to adapt their work to the needs of the UPHV model.

215. Many policy reform initiatives fail to achieve sustained improvements in performance because they are merely isomorphic mimicry or agenda conformity rather than enhanced functionality.

216. The emphasis on *form* (what reforms ‘look like’) over *function* (what they actually ‘do’) is a crucial characteristic of the capability trap facing many countries. UPHV model

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49 Isomorphic mimicry conflates form and function: “that is, governments and organizations pretend to reform by changing what policies or organizations look like rather than what they actually do.”
implementation focused more in function than in form. The challenge of escaping this trap involves focusing on improved functionality as the key to improved state capability. The basic message must be that interventions are successful if they empower a constant process through which agents make organizations better performers, regardless of the forms adopted to effect such change.

217. Given this basis, three domains has been influed the UPHV model implementation arising some lessons:

- The importance of the support needed for pilot implementation in different ways: political, legal, organizational, or personal. It was important to get authority at the top health system and regional level to foster the change.
- Also the acceptance by those who were affected by policy change (team of the PHC centres) accepted the new approach and the implications of change. Different types of change require different levels of acceptance (from narrow or broad groups and at different depths) and the key is to recognize what acceptance exists and what gaps need to be closed to foster change.
- And the need to focus on the practical side of the reform, and the need for time, money, skills and the like to even start any kind of intervention (ability). Training is a great component of the strategy.

218. These three elements, to a greater or lesser extent, were followed for the design of the pilot in Kyzylorda. It is critical for a successful expansion of the model, to review the capability gaps in these domains: authority, acceptance and ability.

7.3 Recommendations

219. The recommendations presented below were derived from the findings and conclusion of this evaluation. Besides, some of them were prompted by the interviewees and supported by other participants through surveys and consultations.

<table>
<thead>
<tr>
<th>RECOMMENDATIONS</th>
<th>Aligned with conclusion</th>
<th>Stakeholder responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R #1:</strong> The UPHV model should be included in the new health policy planning cycle. A document should describe the new PHC model including the UPHV. All this will allow to institutionalize the UPHV model to ensure, at less:</td>
<td>C#1,2, 3, 13, 14</td>
<td>Ministry of Health</td>
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<tr>
<td>- integrate the UPHV system into the calculation of the per capita financing of the PHC,</td>
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<td>- supporting supervision to the HV teams for maintaining the quality of services,</td>
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<tr>
<td>- development of the monitoring system to track the performance of the UPHV</td>
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<tr>
<td>- integrate the training modules into the continuous professional development of the Kazakh Health System</td>
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| **R #2:** Define a strategy to foster the coordination and integration of social services and HV system. Promote inter-ministerial coordination, especially concerning multisectoral issues such as health, education, social and WASH, as required | C#7 | Ministry of Health – Ministry of Labor and Social Protection – |
### RECOMMENDATIONS

<table>
<thead>
<tr>
<th>R #3:</th>
<th>Once the monitoring system is in place, an incentive system for home visitors should be developed. The differences in performance must also be analyzed to reduce the asymmetries that have been identified.</th>
</tr>
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<tbody>
<tr>
<td>C#9</td>
<td>Ministry of Health</td>
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<table>
<thead>
<tr>
<th>R#4:</th>
<th>Guide and regulate the use of new technologies for information and communication, paying special attention to the use of social networks and messaging platforms.</th>
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<tr>
<td>C#10</td>
<td>Ministry of Health</td>
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<tr>
<th>R#5:</th>
<th>Explore the possibilities to improve the efficiency of home visits, through logistical means that allow having more hours of attention to families.</th>
</tr>
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<tbody>
<tr>
<td>C#16</td>
<td>Ministry of Health</td>
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</table>

<table>
<thead>
<tr>
<th>R#6:</th>
<th>Develop a costing assessment of the UPHV model in Kyzylorda and scenarios for the scaling-up. The absence of this study limits the capability to make evidence-based decisions to improve the cost-effectiveness of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C#17</td>
<td>UNICEF – Ministry of Health</td>
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<table>
<thead>
<tr>
<th>R#7:</th>
<th>Develop in the short-medium term all key elements that needs to be supported to ensure a successful scaling-up process:</th>
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<tbody>
<tr>
<td></td>
<td>- Human Resources planning at national level to decrease high turnovers in rural regions and nurse shortage in the main cities.</td>
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<td></td>
<td>- Human resource workload study to mitigate work overload</td>
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<td>- Elaborate a new capitation funding modality including the UPHVM package of services.</td>
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<td>- Improve the M&amp;E system at national level</td>
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<td>- Design a continuous and in-depth supervision system for the staff recently involved in HPHVM reinforcing their capabilities an assessing them on the field.</td>
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<td>- Implement a residency program for PHC doctors at national level to increase this specialty knowledge in the country.</td>
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<tr>
<td>C#18 to 22</td>
<td>Ministry of Health and Development partners</td>
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</tbody>
</table>

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<tr>
<th>R #8:</th>
<th>Actively engage a large number of professionals/officers to ensure that reforms are viable, legitimate, relevant and feasible and not limited to a few external experts promoting top-down diffusion of innovation.</th>
</tr>
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<tbody>
<tr>
<td>C#18 to 22</td>
<td>Ministry of Health</td>
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</table>
ANNEXES

7.4 Evaluation Matrix

Below it can be found the matrix for the two-fold evaluation: 1) Assessment of the universal progressive home visiting model in Kyzylorda region; and 2) the PHC impact on Child and Infant Mortality in Kazakhstan.
<table>
<thead>
<tr>
<th>Relevant evaluation criteria</th>
<th>Key Question</th>
<th>Specific Sub-Questions</th>
<th>Data Sources</th>
<th>Data collection Methods/Tools</th>
<th>Indicators/ Success Standard</th>
<th>Methods for Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>- To what extent are the objectives of the PHC policy consistent with country development priorities and policies, and were they aligned throughout the period with government priorities and with agencies global policies and strategies?</td>
<td>- To what extent has the need for reform been grounded in evidence-based problem analysis and to what extent does it correspond to the needs of the target groups? &lt;br&gt;- How relevant were the government’s PHC reforms and policies to national goals and achievements in respect to reduced infant and child mortality rates (ICMR)? &lt;br&gt;- To what extent was UNICEF’s support relevant to the country’s PHC reforms that led to reduced infant and child mortality? How relevant was the home-visiting model for PHC reform aimed at ICMR reduction? &lt;br&gt;- To what extent have the reforms and UNICEF interventions taken into account international standards and good practices? &lt;br&gt;- To what extent have national authorities in charge of implementing the reform been involved in its design (through all the process)? &lt;br&gt;- To what extent has the reform and the home visiting model integrated gender equality and equity into its design?</td>
<td>- Government strategies, programmes and policies. &lt;br&gt;- UNICEF analysis on MDGs and the needed reforms &lt;br&gt;- Sectoral regulations, guidelines. &lt;br&gt;- UNICEF technical level recommendations &lt;br&gt;- Country Program Document for Kazakhstan &lt;br&gt;- Kazakhstan CPD Result Matrix &lt;br&gt;- Situation Analysis for Children and Women &lt;br&gt;- UNICEF Strategic documents &lt;br&gt;- ODS Reports</td>
<td>- Documentary review &lt;br&gt;- Key Individual interviews &lt;br&gt;- Focus groups &lt;br&gt;- Microsurveys</td>
<td>- To what extent are the outputs of the PHC policy definition linked to the national priority and/or needs &lt;br&gt;- To what extent are the objectives and strategies of the PHC Policy consistent with the priorities of the the national development strategies and policies &lt;br&gt;- Capacity of response to changing scenarios, failed assumptions and to requests made by national stakeholders. &lt;br&gt;- Degree of flexibility in redirecting funds and the adaptation of the objectives and interventions in light of changes in national priorities. &lt;br&gt;- To what extend has UNICEF adapted regional and international frameworks to national plans and strategies</td>
<td>Qualitative analysis &lt;br&gt;Triangulation &lt;br&gt;Expert and desk research</td>
</tr>
<tr>
<td>Relevant evaluation criteria</td>
<td>Key Question</td>
<td>Specific Sub-Questions</td>
<td>Data Sources</td>
<td>Data collection Methods/Tools</td>
<td>Indicators/Success Standard</td>
<td>Methods for Data Analysis</td>
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</table>
| **Effectiveness**           | To what extent the PHC outputs have been achieved so far, and to what extent the outputs have contributed to the achievement of the infant and child health outcomes | - To what extent have state reforms and interventions contributed to **improving PHC system**, its institutions and achievement of MDG 4?  
- What **interventions** within the framework of PHC system for mother and child care were the **most and least effective**? Were these interventions sufficient to achieve the goal to reduce ICMR?  
- What were the **key factors** that influenced or hindered the achievement of the reduced ICMR?  
- To what extent has the **home visiting model** achieved planned outputs and outcomes?  
- Was the **model effective** in reducing infant and child mortality and improved parenting practices since 2015?  
- Were the established partnerships effective in achieving the current results of the model?  
- How effective were the **home visiting model implementation mechanisms** (coordination, management, etc.) in achieving the current results/outputs of the project? | Government strategies, programmes and policies.  
- UNICEF analysis on MDGs and the needed reforms  
- Sectoral regulations, guidelines.  
- UNICEF technical level recommendations  
- Country Programm Document for Kazakhstan  
- Kazakhstan CPD Result Matrix  
- Situation Analysis for Children and Women  
- UNICEF Strategic documents  
- ODS Reports  
- Health Evaluation Reports  
- Project documents  
- Primary data from institutional sources | - Documentary review  
- Key Individual interviews  
- Focus groups  
- Primary data from field visits  
- Surveys  
- Statistical Data | Degree of achievement of the MDG 4  
To what extent changes in the MoRES determinants are identified  
Degree of achievement of the outcome indicators specified in the PHC policy, meeting the indicators defined for each of them and checking the satisfaction of partners.  
To what extent the output impacted on outcomes according to assumptions stated in policy formulation and ToC | Theory of change  
Quantitative and qualitative analysis  
LiST  
PCATool  
Triangulation  
Expert and desk research |
### Efficiency

To what extent the PHC policy was implemented regarding a good relationship between outputs and inputs, identifying that the most efficient management system has been adopted.

<table>
<thead>
<tr>
<th>Question</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What strategies of the government, partners and actors were the most efficient in improving PHC and achieving lower ICMR?</td>
<td>- Government strategies, programmes and policies.</td>
</tr>
<tr>
<td>- What interventions were the most cost effective in providing PHC services to pregnant women and families with children under 5?</td>
<td>- Sectoral regulations, guidelines.</td>
</tr>
<tr>
<td>- Have the resources at the national and regional levels been used in the most economical way to achieve the expected results in PHC reforms?</td>
<td>- UNICEF technical level recommendatio ns</td>
</tr>
<tr>
<td>- To what extent the approaches at PHC level related to MCH services were cost-effective to reach the most vulnerable families with children U5? What measures were most cost effective in providing PHC services to pregnant women and families with children under 5?</td>
<td>- Health Evaluation Reports</td>
</tr>
<tr>
<td>- How efficiently were used the human resources allocated by the Government and partners/actors?</td>
<td>- Project documents</td>
</tr>
<tr>
<td>- Did the reform system include a coordination system to encourage synergy and avoid overlaps?</td>
<td>- Primary data from institutional sources</td>
</tr>
<tr>
<td>- To what extent the universal-progressive model of home visiting is more efficient than traditional approaches at PHC level?</td>
<td>- Budgetary data and documentation</td>
</tr>
<tr>
<td>- How well have the financial resources been used for the model implementation? Were funds managed in cost-effective manner? Could the same results have been achieved with fewer resources?</td>
<td>- HR management data</td>
</tr>
<tr>
<td>- Documentary review</td>
<td>- Focus groups</td>
</tr>
<tr>
<td>- Key Individual interviews</td>
<td>- Primary data from field visits</td>
</tr>
<tr>
<td>- Surveys</td>
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</table>

To what extent the approaches, resources and models are relevant to achieve the planned outcome.

Relationship cost effectiveness

To what extent the monitoring and evaluation systems has been implemented.
**Impact**

- To what extent over the period 2000-2017 the reformed PHC structure and care support, including the antenatal, prenatal and home-visiting services, *influenced* the level and trends of infant and child mortality in Kazakhstan and which internal and external factors positively or negatively contributed to this result?
- To what extent the PHC reforms and interventions by the government of Kazakhstan and with support of partners *affected* a) boys and girls; and b) the most vulnerable groups of children and families including those with lower income, living in rural area, single parent, etc.?
- To what extent have different *stakeholders, and particularly UNICEF*, contributed to those results?
- Has the *inequality* between the most affluent and the most vulnerable groups increased, remained unchanged or declined after the implementation of the MCH services at PHC level?
- Were there any *unforeseen* (positive and/or negative) results due to interventions?
- What is the *evidence* of the contribution of the piloted universal-progressive model of home visiting to PHC in the region?
- In what ways, if any, do mothers and children under 5 *benefit* from the piloted model? Are there any differences related to gender, socio-economic status and rural-urban location?
- Government strategies, programmes and policies.
- UNICEF analysis on MDGs and the needed reforms
- Sectoral regulations, guidelines.
- UNICEF technical level recommendations
- Country Programm Document for Kazakhstan
- Kazakhstan CPD Result Matrix
- Situation Analysis for Children and Women
- UNICEF Strategic documents
- ODS Reports
- Health Evaluation Reports
- Project documents
- Primary data from institutional sources
- Government review
- Key Individual interviews
- Focus groups
- Surveys
- Statistical Data
- Data on child health status

| To what extend the the PHC reform and the UPHV model contributed to the infant and child mortality reduction
| PHC approaches / interventions focused to reduce bottlenecks of the health system in the care of pregnant women, infants and children
| To what extend the decrease in health inequities for children could be attributed to reforms

- **Theory of change**
- Quantitative and qualitative analysis
- LIST
- PCATool
- Triangulation
- Expert and desk research
## Relevant evaluation criteria

### Sustainability

**To what extent the benefits from the PHC are guaranteed, linked, in particular, to their continued resilience to risks?**

- What are the **factors contributing** to sustainability of the PHC system towards reducing the ICMR?
- To what extent the **Government owned** the PHC reform process and is committed to sustain it, including through an evolution of budget allocations for PHC and MCH?
- What should be the **next steps** for the Government of Kazakhstan to sustain the achieved results?
- Will **UNICEF’s contribution** to system level changes continue to impact families with children U5 and pregnant women after its support is withdrawn?
- Is the universal-progressive model of home visiting ready for **national scale-up**? What kind of systems and instruments have been setup to facilitate the rollout of the new home visiting model for a national replication?
- To what extent **national and local authorities** involved in the model piloting have the capacity to sustain the model?

**To what extend the strategies and mechanisms for appropriation by national counterparts are in place**

- **Government strategies, programmes and policies.**
- UNICEF analysis on MDGs and the needed reforms
- Sectoral regulations, guidelines.
- UNICEF technical level recommendations
- Country Programm Document for Kazakhstan
- Kazakhstan CPD Result Matrix
- Situation Analysis for Children and Women
- UNICEF Strategic documents
- ODS Reports
- Health Evaluation Reports
- Project documents
- Primary data from institutional sources

- **Documentary review**
- Key Individual interviews
- Focus groups
- Field visits
- Surveys
- Statistical Data

- Identification of conditions for sustainability of the PHC results
- Existence of formal political and financial commitments to give sustainability to the products and results
- Identification of instruments and methods for national scale-up the universal-progressive model of home visiting

**Theory of change**

- Quantitative and qualitative analysis
- Triangulation
- LiST
- PCATool
- Expert and desk research

---

For all this criteria, the evaluation team will apply crosscutting dimensions/questions:
## Cross-cutting

<table>
<thead>
<tr>
<th>Relevant evaluation criteria</th>
<th>Key Question</th>
<th>Data Sources</th>
<th>Data collection Methods/Tools</th>
<th>Indicators/Success Standard</th>
<th>Methods for Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent are sex and age disaggregated data collected and monitored?</td>
<td>- Government strategies, programmes and policies.</td>
<td>- Government strategies, programmes and policies.</td>
<td>- Documentary review</td>
<td>Disaggregated data by sex and age available</td>
<td>Theory of change</td>
</tr>
<tr>
<td></td>
<td>- UNICEF analysis on MDGs and the needed reforms</td>
<td>- UNICEF technical level recommendations</td>
<td>- Key Individual interviews</td>
<td>Equity based approach used in PHC reform and UNICEF piloted model</td>
<td>Quantitative and qualitative analysis</td>
</tr>
<tr>
<td></td>
<td>- Sectoral regulations, guidelines.</td>
<td>- Country Programm Document for Kazakhstan</td>
<td>- Focus groups</td>
<td>To what extend the interventions for the promotion of child and women rights, non-discrimination and equity focus were used</td>
<td>LiST</td>
</tr>
<tr>
<td></td>
<td>- UNICEF technical level recommendations</td>
<td>- Country Programm Document for Kazakhstan</td>
<td>- Primary data from field visits</td>
<td></td>
<td>Triangulation</td>
</tr>
<tr>
<td></td>
<td>- Sectoral regulations, guidelines.</td>
<td>- Situation Analysis for Children and Women</td>
<td>- Surveys</td>
<td></td>
<td>Expert and desk research</td>
</tr>
<tr>
<td></td>
<td>- UNICEF technical level recommendations</td>
<td>- UNICEF Strategic documents</td>
<td>- Statistical Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sectoral regulations, guidelines.</td>
<td>- ODS Reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- UNICEF technical level recommendations</td>
<td>- Health Evaluation Reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Project documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Primary data from institutional sources</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- UNICEF piloted model integrated an equity based approach into the design and implementation of its interventions.
- Do the PHC reform and UNICEF piloted model actively contribute to the promotion of child and women rights, especially the most vulnerable?
- To what extent and how do the PHC reform and UNICEF piloted model ensure a non-discrimination and equity focus?
<table>
<thead>
<tr>
<th>Relevant evaluation criteria</th>
<th>Key Question</th>
<th>Data Sources</th>
<th>Data collection Methods/Tools</th>
<th>Indicators/Success Standard</th>
<th>Methods for Data Analysis</th>
</tr>
</thead>
</table>
| **Coverage**                | - Was representativeness of coverage ensured by PHC reform and UNICEF piloted model activities? | - Government strategies, programmes and policies.  
- UNICEF analysis on MDGs and the needed reforms  
- Sectoral regulations, guidelines.  
- UNICEF technical level recommendations  
- Country Program Document for Kazakhstan  
- Kazakhstan CPD Result Matrix  
- Situation Analysis for Children and Women  
- UNICEF Strategic documents  
- ODS Reports  
- Health Evaluation Reports  
- Project documents  
- Primary data from institutional sources | - Documentary review  
- Key Individual interviews  
- Focus groups  
- Primary data from field visits  
- Surveys  
- Statistical Data | Groups reached by PHC reform and UNICEF pilot model  
To what extend the vulnerable children has been reached, including children with disabilities | Theory of change  
Quantitative and qualitative analysis  
LiST  
PCATool  
Triangulation  
Expert and desk research |
### Coordination

**Key Question**
- What was the role of the MoH, local government, NGOs, UN agencies, community and other key actors in the design, coordination and implementation of PHC reform and UNICEF piloted model?

**Data Sources**
- Government strategies, programmes and policies.
- UNICEF analysis on MDGs and the needed reforms.
- Sectoral regulations, guidelines.
- UNICEF technical level recommendations.
- Country Programm Document for Kazakhstan.
- Kazakhstan CPD Result Matrix.
- Situation Analysis for Children and Women.
- UNICEF Strategic documents.
- ODS Reports.
- Health Evaluation Reports.
- Project documents.
- Primary data from institutional sources.

**Data collection Methods/Tools**
- Documentary review.
- Key Individual interviews.
- Focus groups.
- Primary data from field visits.
- Surveys.
- Statistical Data.

**Indicators/Success Standard**
To what extent stakeholders participated in design, coordination and implementation phases of the PHC reform and UNICEF pilot model.

**Methods for Data Analysis**
- Theory of change.
- Quantitative and qualitative analysis.
- LiST.
- PCA Tool.
- Triangulation.
- Expert and desk research.
<table>
<thead>
<tr>
<th>Relevant evaluation criteria</th>
<th>Key Question</th>
<th>Data Sources</th>
<th>Data collection Methods/Tools</th>
<th>Indicators/Success Standard</th>
<th>Methods for Data Analysis</th>
</tr>
</thead>
</table>
| Coherence                    | - What were the areas and ways of cooperation with other UN and donor agencies’ in regard to development of services for vulnerable children? | - Government strategies, programmes and policies.  
- UNICEF analysis on MDGs and the needed reforms  
- Sectoral regulations, guidelines.  
- UNICEF technical level recommendations  
- Country Programm Document for Kazakhstan  
- Kazakhstan CPD Result Matrix  
- Situation Analysis for Children and Women  
- UNICEF Strategic documents  
- ODS Reports  
- Health Evaluation Reports  
- Project documents  
- Primary data from institutional sources | - Documentary review  
- Key Individual interviews  
- Focus groups  
- Primary data from field visits  
- Surveys  
- Statistical Data | Cooperation mechanisms with other UN identified UNDAF Kazakhstan M&E data | Theory of change  
Quantitative and qualitative analysis  
LiST  
PCATool  
Triangulation  
Expert and desk research |
7.5 Research Ethics Approval letter

UNICEF | for every child

Research Ethics Approval

11 February 2019

Alberto Nunez, Team Leader
United Nations Children’s Fund
10A Beibitshilik st., Astana, Kazakhstan


Dear Mr. Nunez,

Protocols for the protection of human subjects in the above study were assessed through an ethics review by HML Institutional Review Board on 28 January – 11 February 2019.

This study’s human subjects’ protection protocols, as stated in the materials submitted, received IRB approval. Please notify this IRB of any changes in this study’s design, risks, consent, or other human subject protection protocols.

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Zhanar Sagimbayeva, Damir Kozhanbayev, Kanat Sukhanberdiyev, Penelope Lantz, JD

HML Institutional Review Board
1101 Connecticut Avenue, NW Suite 450
Washington, DC 20036 USA
+1.202.752.5040
unticef@hmlirb.com www.hmlirb.com

US Department of Health & Human Services, Office of Human Research Protections IRB #00001211
# 7.6 Interviews samples

<table>
<thead>
<tr>
<th>Script for the staff of the UNICEF Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information: internal organization, country program outputs of its responsibility, main implementing partners</td>
</tr>
<tr>
<td>To what extent has the need for reform been grounded in evidence-based problem analysis and to what extent does it correspond to the needs of the target groups? <strong>RELEVANCE</strong></td>
</tr>
<tr>
<td>To what extent the results achieved through the implementation of the PHC Policy Reform impacted in the child mortality reduction? <strong>RELEVANCE – EFFECTIVENESS</strong></td>
</tr>
<tr>
<td>How relevant were the government’s PHC reforms and policies to national goals and achievements in respect to reduced infant and child mortality rates (ICMR)? <strong>RELEVANCE</strong></td>
</tr>
<tr>
<td>To what extent have the reforms and UNICEF interventions taken into account international standards and good practices? <strong>RELEVANCE</strong></td>
</tr>
<tr>
<td>What interventions within the framework of PHC system for mother and child care were the most and least effective? Were these interventions sufficient to achieve the goal to reduce ICMR? <strong>EFFECTIVENESS</strong></td>
</tr>
<tr>
<td>How effective were the home visiting model implementation mechanisms (coordination, management, etc.) in achieving the current results/outputs of the project? <strong>EFFECTIVENESS</strong></td>
</tr>
<tr>
<td>How effective was the implementation process of the PHC Policy? (Effectiveness) (identify internal or external limiting factors / challenges that hinder the achievement of the expected health results), What resources were used, were these enough? <strong>EFFICIENCY</strong></td>
</tr>
<tr>
<td>What strategies of the government, partners and actors were the most efficient in improving PHC and achieving lower ICMR? What interventions were the most cost effective in providing PHC services to pregnant women and families with children under 5? <strong>EFFICIENCY</strong></td>
</tr>
<tr>
<td>To what extent the universal-progressive model of home visiting is more efficient than traditional approaches at PHC level? <strong>EFFICIENCY</strong></td>
</tr>
<tr>
<td>Do you think that the country will be able to sustain the outputs and outcomes produced so far in the long term? Why/ Why not? What do you perceive as internal or external factors that limit the sustainability of the results? <strong>SUSTAINABILITY</strong></td>
</tr>
<tr>
<td>Is the universal-progressive model of home visiting ready for national scale-up? What kind of systems and instruments have been setup to facilitate the rollout of the new home visiting model for a national replication? <strong>SUSTAINABILITY</strong></td>
</tr>
</tbody>
</table>
How were cross cutting issues integrated: gender, human rights, humanitarian response, capacity building? **STRATEGIC ALIGNMENT**

Request information on outputs achievements so far, unexpected results; with detail of the sources of information on output and outcome indicators

---

### Script for government stakeholders

- **In what policy area have you participated in the PHC policy reform?**

- **How effective was the process of reform implementation? Did you find any obstacles that hinder an effective collaboration and implementation? **RELEVANCE – STRATEGIC ALIGNMENT**

- **To what extent has the need for reform been grounded in evidence-based problem analysis and to what extent does it correspond to the needs of the target groups? **RELEVANCE**

- **To what extent the results achieved through the implementation of the PHC Policy Reform impacted in the child mortality reduction? **RELEVANCE – EFFECTIVENESS**

- **How relevant were the government’s PHC reforms and policies to national goals and achievements in respect to reduced infant and child mortality rates (ICMR)? **RELEVANCE**

- **To what extent have the reforms and UNICEF interventions taken into account international standards and good practices? **RELEVANCE**

- **What interventions within the framework of PHC system for mother and child care were the most and least effective? Were these interventions sufficient to achieve the goal to reduce ICMR? **EFFECTIVENESS**

- **How effective were the home visiting model implementation mechanisms (coordination, management, etc.) in achieving the current results/outputs of the project? **EFFECTIVENESS**

- **How effective was the implementation process of the PHC Policy? (Effectiveness) (identify internal or external limiting factors / challenges that hinder the achievement of the expected health results), What resources were used, were these enough? **EFFICIENCY**

- **What strategies of the government, partners and actors were the most efficient in improving PHC and achieving lower ICMR? What interventions were the most cost effective in providing PHC services to pregnant women and families with children under 5? **EFFICIENCY**

- **To what extent the universal-progressive model of home visiting is more efficient than traditional approaches at PHC level? **EFFICIENCY**
Do you think that the country will be able to sustain the outputs and outcomes produced so far in the long term? Why/ Why not? What do you perceive as internal or external factors that limit the sustainability of the results? **SUSTAINABILITY**

Is the universal-progressive model of home visiting ready for national scale-up? What kind of systems and instruments have been setup to facilitate the rollout of the new home visiting model for a national replication? **SUSTAINABILITY**

How were cross cutting issues integrated: gender, human rights, humanitarian response, capacity building? **STRATEGIC ALIGNMENT**

What aspects would you like to highlight about the partnership with UNICEF Country Office? Both positive and those which need to be improved. Also about some important cross cutting issues: capacity building, humanitarian response and ability to establish effective partnerships. **EFFICIENCY - ADDED VALUE**

Request information on outputs achievements so far, unexpected results; with detail of the sources of information on output and outcome indicators

---

**Script for local stakeholders**

Presentation of the evaluation project and request for general information: internal organization, review the country program outputs of its responsibility, main implementing partners at local level

How effective has been the process of implementing the PHC policy? (From planning, goal setting, implementation, resources, management, results and sustainability). What degree of autonomy have you had to adapt the policy to the local reality? What is the type of relationship with central MOH officials, technical support, project control or other?

To what extent does UNICEF contribute to your organization’s effective programme delivery/mandate and achievement of results? **EFFICIENCY - EFFECTIVENESS**

How effective were the home visiting model implementation mechanisms (coordination, management, etc.) in achieving the current results/outputs of the project? **EFFECTIVENESS**

To what extent the universal-progressive model of home visiting is more efficient than traditional approaches at PHC level? **EFFICIENCY**

To what extent are the regional priorities aligned to PHC policy at country level? **RELEVANCE - SUSTAINABILITY**

Is the universal-progressive model of home visiting ready for national scale-up? What kind of systems and instruments have been setup to facilitate the rollout of the new home visiting model for a national replication? **SUSTAINABILITY**

Do you believe that the project carried out locally can be extended to the whole country? What do you think is the
<table>
<thead>
<tr>
<th><strong>best strategy to make this expansion</strong></th>
<th><strong>SUSTAINABILITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What were the main barriers at the local level for PHC policy design and implementation?</td>
<td><strong>EFFECTIVENESS</strong></td>
</tr>
<tr>
<td>What were the main benefits to the local population of the Home visiting model?</td>
<td><strong>EFFECTIVENESS</strong></td>
</tr>
</tbody>
</table>
7.7 Surveys Sample: PCATool – Child version

Description of the tool

It consists of 55 items divided into 10 related components as follows to PHC attributes:

1. Degree of Affiliation with Health Service (A). Consisting of 3 items (A1, A2 and A3)
2. First Contact Access - Usage (B). Consisting of 3 items (B1, B2 and B3).
3. First Contact Access - Accessibility (C). Consisting of 6 items (C1, C2, C3, C4, C5 and C6).
4. Longitudinality (D). It consists of 11 items (D1, D2, D3, D4, D5, D6, D7, D8, D9, D10 and D11).
5. Coordination - Integration of Care (E). Consisting of 5 items (E2, E3, E4, E5 and E6).
6. Coordination - Information System (F). Consisting of 3 items (F1, F2 and F3).
7. Integrality - Available Services (G). It consists of 9 items (G1, G2, G3, G4, G5, G6, G7, G8 and G9).
8. Integrality - Services Provided (H). Consisting of 5 items (H1, H2, H3, H4 and H5).

The PCATool-Child version should be applied to the parents of the children or they caregivers (such as grandparents, uncles or legal caregivers), identifying the family / caregiver who is most responsible for the child's health care. The following question can be used to identify this caregiver: "Who is the person most able to talk about the health care of .......... (child's name)?"
Primary Care Assessment Tool

PCATool - Child version

**Initiation:** Presentation of the interviewer and the objectives of the study / evaluation.

**Introductory Items**

In this section, you must:

1. Check availability of the person who does not have a household or family member / caregiver of the health unit then with an interview;
2. Identify, according to the research / evaluation objectives, whether the child in question is eligible for the study / evaluation (application of the inclusion / exclusion criteria of your study / evaluation). Identify the child's name and, from then on, always use his name as a reference.
3. Identify the person responsible for the child (caregiver) who should respond to PCATool. Use, for example, the question, "Who is the person most able to talk about the child's health care?", Identifying the relationship with the child;
4. Apply the Informed Consent Form;
5. Continue with the interview.
### PRIMARY CARE ASSESSMENT TOOL

**PCATool – Child Version**

#### A - AFFILIATION LEVEL

<table>
<thead>
<tr>
<th>Age of the child</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do he/she have a chronic disease?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A1 - Is there a doctor/nurse or healthcare service where you usually go with your child when he/she gets sick and need a advice about her/his health??</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>A2 - Is there a doctor/ nurse / health service who knows best (name of the child) As a person? (Do not read the alternatives)</th>
<th>Yes, same doctor / nurse / health service as above</th>
<th>Yes, different doctor / nurse / health service (Please provide name and address)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>A3 - Is there a doctor or healthcare service who is more responsible for the health care of the (name of the child)? (Do not read the alternatives)</th>
<th>No</th>
<th>Yes, same as A1 and A1</th>
<th>Yes, same as A1</th>
<th>Yes, same as A1</th>
<th>Yes, different than A1 &amp; A2 (Please provide name and address)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>A4 - Whos visited most your child: a doctor or a nurse?</th>
<th>Doctor</th>
<th>Nurse</th>
<th>Not answer</th>
</tr>
</thead>
</table>

<p>| A5 - What is the procedure to receive a doctor home visit (call, go to the center, etc.)? | | | |</p>
<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B1</strong> - When your child <strong>needs a check-up visit</strong> (&quot;routine consultation&quot;), do you receive a visit of a doctor from &quot;name of healthcare service / or doctor / nurse&quot; before going to another health facility?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>B2</strong> - When your child <strong>needs a check-up visit</strong> (&quot;routine consultation&quot;) and nobody visits you, do you go to your &quot;name of healthcare service / or doctor / nurse&quot; before going to another health facility?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>B3</strong> - When your child has a <strong>new health problem</strong>, do you receive a visit of a doctor from your &quot;name of healthcare service / or doctor / nurse&quot; before going to another health service?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>B4</strong> - When your child has a <strong>new health problem</strong>, do you go to your &quot;name of healthcare service / or doctor / nurse&quot; before going to another health service?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>B5</strong> - Do your child receive doctor visits in home regularly or do you have to call for visits?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>B6</strong> - When your child has to consult a specialist doctor, does your &quot;name of healthcare service / or doctor / nurse&quot; have to refer you to it?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
### PRIMARY CARE ASSESSMENT TOOL

**PCATool - Child Version**

**C - FIRST CONTACT - UTILIZATION - ACCESSIBILITY**

*Interviewer - for all upcoming questions use the Answers Card.*

<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 - When the &quot;name of healthcare service / or doctor / nurse&quot; is open and your child becomes ill, does someone from this health service see you on the same day?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C2 - Do you have to wait a long time or talk to many people to set the time for &quot;name of healthcare service / or doctor / nurse&quot;?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C3 - Is it easy to set a time for a CRITICAL REVIEW (&quot;routine consultation&quot;) query in &quot;name of healthcare service / or doctor / nurse&quot;?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C4 - Do you have to wait more than 30 minutes for your child to see the doctor / nurse (not counting screening or care) when you arrive at the &quot;name of healthcare service / or doctor / nurse&quot;?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C5 - Is it difficult for you to get medical care for your child in the &quot;name of healthcare service / or doctor / nurse&quot; when you think it is necessary?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C6 - When the &quot;name of healthcare service or doctor / nurse&quot; is open, can you get quick advice on the phone if you need to?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

C7 - What is the procedure to receive a doctor home visit (call, go to the center, etc.?)?
<table>
<thead>
<tr>
<th>PRIMARY CARE ASSESSMENT TOOL</th>
<th>PCATool - Child Version</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D - LONGITUDINALITY</strong></td>
<td></td>
</tr>
<tr>
<td>Interviewer - for all upcoming questions use the Answers Card.</td>
<td></td>
</tr>
<tr>
<td>Please, select the best option</td>
<td>Absolutely, yes</td>
</tr>
<tr>
<td>D1 - When you go to &quot;name of healthcare service / or doctor / nurse&quot;, is it the same doctor or nurse who attends your child every time? &quot;</td>
<td>4</td>
</tr>
<tr>
<td>D2 - If you have a question about your child’s health, can you call and talk to the &quot;doctor / nurse&quot; that best knows your child?</td>
<td>4</td>
</tr>
<tr>
<td>D3 - Do you believe your child’s &quot;doctor / nurse&quot; understands what you say or ask?</td>
<td>4</td>
</tr>
<tr>
<td>D4 - Does the &quot;doctor / nurse&quot; answer your questions in a way that you understand?</td>
<td>4</td>
</tr>
<tr>
<td>D5 - Does &quot;doctor / nurse&quot; give you enough time to talk about your concerns or problems?</td>
<td>4</td>
</tr>
<tr>
<td>D6 - Do you feel comfortable telling the worries or problems related to your child to the &quot;doctor / nurse&quot;?</td>
<td>4</td>
</tr>
<tr>
<td>D7 - Does the &quot;doctor / nurse&quot; know your child more as a person than only as someone with a health problem?</td>
<td>4</td>
</tr>
<tr>
<td>D8 - Does the &quot;doctor / nurse&quot; know the complete medical history of your child?</td>
<td>4</td>
</tr>
<tr>
<td>Please, select the best option</td>
<td>Absolutely, yes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>D9 - Does the &quot;doctor / nurse&quot; know about all medications your child is taking?</td>
<td>4</td>
</tr>
<tr>
<td>D10 - Would the &quot;doctor / nurse&quot; meet with family members if you felt it necessary for your child?</td>
<td>4</td>
</tr>
<tr>
<td>D11 - Would you change the &quot;name of healthcare service / or doctor / nurse&quot; to another healthcare service if this was very easy to do?</td>
<td>4</td>
</tr>
</tbody>
</table>
## PRIMARY CARE ASSESSMENT TOOL
PCATool - Child Version

### E - COORDINATION - INTEGRATION OF CARE

E1 - Has your child consulted with any other specialist or specialized service during the period that he / she is being followed up on the "name of healthcare service / or doctor / nurse"?

- Yes
- No (Skip to question F1)
- Not sure / do not remember (Skip to question F1)

*Interviewer - for all upcoming questions use the Answers Card.*

<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2 - Did the &quot;name of the healthcare service / or doctor / nurse&quot; suggest / advise your child to consult with this specialist or specialist service?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>E3 - Does your child's &quot;doctor / nurse&quot; know that she has had this consultation with this specialist or specialist service?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>E4 - Did your child's &quot;doctor / nurse&quot; know the results of this consultation?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>E5 - After this consultation with the specialist or specialist service, did your &quot;doctor / nurse&quot; talk to you about what happened during this consultation?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>E6 - Did your &quot;doctor / nurse&quot; seem interested in the quality of care your child received at the specialist or specialist service?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>F1. When you take your child to the &quot;name of healthcare service / or doctor / nurse&quot; do you bring any of the healthcare records or service bulletins the child has received in the past? (as: emergency medical records, vaccination card)?</td>
<td></td>
<td></td>
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<tr>
<td>------------------</td>
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<td></td>
</tr>
<tr>
<td>Absolutely, yes</td>
<td>Probably, yes</td>
<td>Probably, not</td>
<td>Absolutely, not</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

| F2. When you take your child to the "name of health care / or doctor / nurse", is his medical record always available at the clinic? |
|------------------|------------------|------------------|------------------|------------------|
| Absolutely, yes  | Probably, yes    | Probably, not    | Absolutely, not  | Not sure         |
| 4                | 3                | 2                | 1                | 9                |

| F3. Could you read (see) the chart of your child if you wanted in the "name of the health service / or doctor / nurse"? |
|------------------|------------------|------------------|------------------|------------------|
| Absolutely, yes  | Probably, yes    | Probably, not    | Absolutely, not  | Not sure         |
| 4                | 3                | 2                | 1                | 9                |
### PRIMARY CARE ASSESSMENT TOOL
**PCATool - Child Version**

#### G - INTEGRALITY - AVAILABLE SERVICES

*Interviewer - for all upcoming questions use the Answers Card.*

The following information is a list of services/guidelines that you and your family or people using this service may need at some point.

Please indicate if these services or guidelines are available in the "name of the health service / or doctor / nurse".

(Repeat every 3-4 items: “It is available at "name of the health service / or doctor / nurse". ...”)

<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1 - Vaccines (immunizations).</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G2 - Verify if your family can participate in any social assistance program or social benefits.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G3 - Family Planning or Contraceptive Methods.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G4 - Nutritional supplementation program (eg. milk and food).</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G5 - Counseling or treatment for the harmful use of drugs. Licit or illicit (eg. alcohol, cocaine, sleeping pills).</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G6 - Counseling for mental health problems.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G7 - Suture a cut that needs stitches.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G8 - Counseling and requesting HIV testing.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>G9 - Identification (some type of evaluation) of visual problems (to see).</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
**PRIMARY CARE ASSESSMENT TOOL**  
**PCATool - Child Version**

**H - INTEGRALITY - SERVICES PROVIDED**

"I will tell you about several important issues for your child's health. I want you to tell me whether in the consultations with your "doctor / nurse", any of these matters were discussed with you?  
"Inquires at "name of the health service / or doctor / nurse", have any of the following questions about your child already been discussed with you? (Repeat every 3-4 items)

<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1 - Guidelines to keep your child healthy, eating healthy, good hygiene or adequate sleep.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>H2 - Home safety: how to store medicines safely.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>H3 - Child growth and developmental changes, that is, what things you should expect from each age. For example, when the child is going to walk, control the pee ...</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>H4 - Ways to deal with your child's behavior problems.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>H5 - Ways to keep your child safe, such as: Avoid falling over or keeping children away from the stove.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>H6 - Have you been given information or advice on how to identify and act with the first warning signs of your child's health problems, such as fever, diarrhea, etc.?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
## PRIMARY CARE ASSESSMENT TOOL
**PCATool - Child Version**

### I - FAMILY COUNSELING

*Interviewer - for all upcoming questions use the Answers Card.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1 - Do you think &quot;doctor / nurse&quot; knows your family well enough?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>I2 - Does the &quot;doctor / nurse&quot; know what are the most important problems for you and your family?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>I3 - Does the &quot;doctor / nurse&quot; know about the work or employment of your child's family members?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>I4 - Would the &quot;doctor / nurse&quot; know in any way if you had problems getting or paying for medications your child needs?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>I5 - Does your &quot;doctor / nurse&quot; ask about your ideas and opinions about the treatment and care of your child?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>I6 Has your &quot;doctor / nurse&quot; ever asked you about diseases or problems that exist in your child's family (cancer, alcoholism, depression)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
### PRIMARY CARE ASSESSMENT TOOL
**PCATool - Child Version**

#### J - COMMUNITY APPROACH

*Interviewer - for all upcoming questions use the Answers Card.*

<table>
<thead>
<tr>
<th>Please, select the best option</th>
<th>Absolutely, yes</th>
<th>Probably, yes</th>
<th>Probably, not</th>
<th>Absolutely, not</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1 - Does anyone from &quot;name of healthcare service/ or doctor / nurse&quot; make home visits?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>J2 - Does the &quot;name of healthcare service/ or doctor / nurse&quot; know about the important health problems in your neighborhood?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

Below are listed different ways to evaluate the quality of health services. Does "name of health service / or doctor / nurse" do any of these?

| J3 - Do community research to identify health problems that he or she should know about? | 4 | 3 | 2 | 1 | 9 |
| J4 - Invites family members to participate in Local Health Council (Managing Council / User Council)? | 4 | 3 | 2 | 1 | 9 |
7.8 FGD Sample:

Focus Group Discussion with home visitors

Introduce yourself: My name is …..representing Gesaworld and UNICEF.

Introduction to the objectives of the research: UNICEF has contracted us to evaluate the demonstration home visiting services in the region, including in your country. The findings of the given evaluation will help to identify both the positive outcomes and the remaining challenges and inform future actions to streamline the HV service package in a way to better meet your needs.

A brief introduction to the rules of focus groups:

- The FGD will last for 60-90 minutes

- Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no negative consequences on you.

- Your names will not be asked and recoded. Names will not be associated with responses. Everything said and done is confidential and will not be used outside the room except for the purposes of this research. We will not tell your home visitor anything about what you say;

- FGDs will be tape-recorded to allow us to have a complete notes. Records will be transcribed later and together with records will be kept in a secure place with limited access to non-authorized individuals for another 12 months.

- You are also requested to keep the information you get from other participants during the discussion in confidence.

- You do not have to talk about anything you do not want to, and you may end your participation in discussion at any time

- Every statement is right;

- Please do not hesitate to disagree with someone else, but we ask that any disagreements be respectful and civil;

- But do not all talk at once Ask questions I would like to begin our discussion with some general questions about home visiting services

Ask questions

I would like to begin our discussion with some general questions about home visiting services

1. What do you personally see as the most important aspect of your work? What do you feel proud of in your work?

2. In your opinion to what extent the home visiting services are important for and relevant to the needs of the most vulnerable children and families?

3. To what extent have you been equipped with necessary knowledge and practical skills to do your job?

Probe for:
How did you learn to do your job?

Did you receive formal training?

Did this happen before or after you were hired in your current position?

How effective were these trainings?

What do you feel you still need training in?

4. Could you please explain to what extent you have all supplies required for the delivery of quality home visiting services?

Probe for:
- Transport or transportation costs
- Home visitors “BAG” with all necessary equipment and materials
- Identification card
- Medical forms for recording home visit results
- Cell-phone or tablet for communication and data entry
- Information materials - Etc.

5. How much supervision do you get and how useful supervision is? Who can they go to for help if they have a very challenging family?

Probe for:
- Which entities from which level
- Frequency of supervision visits
- Administrative or clinical supervision (paper work, caseload, etc. or difficult cases, case management, observation)
- Average duration of supervision mission
- Provision of feedback by supervisors
- Supervision performed on an individual or group bases
- Time for reflection and problem solving allowed by supervision
- Usefulness of supervisory visits

6. Who do you see as the most vulnerable groups of children, their families and pregnant women? Have you been able to reach out to these groups? What are the barriers for this happening (or happening more)? What strategies have worked or been more successful?

7. What are key factors that impede provision of effective home visiting services? What makes it more challenging to do your job well? Please give examples.
8. In your opinion, would it be possible to achieve the same results with less resources? If yes, please give examples. If no, explain why.

9. Please explain how the quality of your services are monitored. How do you keep track of what you do? How do you or your supervisor know that you are doing a good job and providing services as expected? Where does this information go? What are the follow-up actions, if any? Please give concrete examples.

10. How would you assess your workload? On average how many home visits do you undertake per day? What is the share of the working time you spend on paper work vs. home visits? Please explain and give examples.

11. Are you satisfied with your work?
   Probes:
   What do you like best about your job?
   What could you change, if possible?
   What more do you need to do your job well and feel satisfied with your work?
   Do you see your work as stressful?
      IF YES, What makes is stressful
      IF YES: How do you cope with the stress?
   Who can you go to for help?
   Do you think most home visitors feel the same way as you?
   Is there a lot of turn-over in this position?
      IF YES: What makes people leave?
      IF NO: What keeps people working in this role?

12. What are your further needs?

13. Is there anything I haven’t asked about that you would like to tell me related to the topics we have discussed?

   Bring the discussion to the closure
7.9 Terms of Reference

ANNEX I – STATEMENT OF WORK AND TERMS OF REFERENCE

I. Introduction

UNICEF Kazakhstan Country Programme aims to continue supporting the efforts of Kazakhstan to further advance its progress towards the sustained realization of children’s rights, with particular attention to the rights of the most vulnerable children and their families. These include children living under or close to the national poverty line, children with disabilities, children without parental care, children victims of violence, abuse and neglect, children in contact with the justice system, as well as marginalized, stigmatized, and socially excluded children and adolescents.

II. Background:

Guided by the Convention on the Rights of the Child, UNICEF strives to establish children’s rights as international standards of behaviour towards children. The Convention on the Rights of the Child, adopted by the General Assembly of the United Nations in 1989 and subsequently ratified by all but a small number of countries, explicitly recognizes a child’s right to health and health services. Article 24 of the convention obligates all ratifying parties to “pursue full implementation of this right and, in particular, [to] take appropriate measures...to diminish infant and child mortality.”

Healthcare system in the Republic of Kazakhstan.

After gaining independence in 1991, Kazakhstan faced many problems that were typical for other countries of the former USSR. The country had a cumbersome and inefficient network of medical institutions which focused mainly on inpatient treatment. In the early years of the transition period, the volume of the state health financing sharply reduced. In the second half of the 1990s, the government started implementing several important health reforms, although these reforms lacked strategic leadership, and often were inconsistent. The situation, both economic and social, started to improve in the 2000s as Kazakhstan began to undertake major efforts in reforming its post-Soviet health system aimed at universal coverage of population via strengthened primary health care system.

To date, the overall situation in the healthcare sector has improved with both infant and child mortality rates significantly reduced: from 26.4 and 34.8 per 1,000 live births in 1991 to 8.6 and 10.9 in 2016, respectively (Figure 1). Other improvements in healthcare were achieved as well: reduction of post neonatal mortality rate from 8.3 in 2000 to 5.5 in 2005 with reduction of cause specific rates: pneumonia (from 140 per 100,000 in 2000 to 32 per 100,000 in 2010) and diarrhea (from 24.4 to 3.3). Early neonatal mortality rate has been stable around 7 per 1,000 (increasing share in the structure of IMR around 60%). (WHO DB Health for All)

The significant drop in both infant and child mortality rates, clearly seen in the graph, has been a result of numerous policies and actions taken by the government of Kazakhstan. A number of comprehensive healthcare reforms and policy documents have been developed: the National Programme for Health Care Reform and Development 2005-2010; the Code on Health of the Population and the Healthcare
System; the Concept on the Unified National Healthcare System; the State Health Care Development Programme “Salamatty Kazakhstan” for 2011-2015; the State Healthcare Development Programme “Densaulyk” for 2016-2019, and other policies.

**Figure 1 Infant and Child Mortality rates in Kazakhstan, 1991-2016**

![Graph showing Infant and Child Mortality rates in Kazakhstan, 1991-2016](image)

- **Under-5 mortality rate**\(^1\);
- **Infant mortality rate**\(^2\).

The first state programme “*On the Health of the Nation*”, elaborated as far back as **1998**, is still being implemented within the framework of the country Development Strategy “Kazakhstan-2030”. The programme targeted the following elements: (1) undertaking complex measures aimed at the development of the system of health care services, as well as adapting the health care system towards open market mechanisms; (2) ensuring economic and legal guarantees for the creation of the inner market of medical services; (3) enhancing the efficiency of the medical institutions and optimizing the quality of health care services; and (4) accountability of the state as well as participation of the citizenry and employers in the process to strengthen health.

In **2004**, with the onset of economic recovery, mainly due to rising oil prices, Kazakhstan embarked on the implementation of the comprehensive **State Program for Health Care Reform and Development for 2005-2010**. The program provided for a gradual by 2010 increase of budgetary allocations for health care to 4% of GDP. But in addition to increasing financial allocations, the country's health sector also needed significant changes in the organization, management and provision of health care services, as well as in strengthening the PHC sector and strengthening the integration of health services. One of the program components was the development of the "family medicine" specialisation in the framework of a program of advanced training of district therapists and pediatricians as family

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\(^1\) [www.childmortality.org](http://www.childmortality.org)
\(^2\) [www.medinfo.kz](http://www.medinfo.kz)
doctors (GP) and advanced continuous medical education. In addition, under the programme, the Government introduced a targeted programme for the Maternal and Child Mortality reduction for 2008-2010 which among other initiatives entailed introduction of the international Live Birth Definition, nationwide implementation of the integrated management of childhood illnesses/ early age child development (IMCI/ECD) and effective perinatal technologies.

It is also without a doubt that the decline in mortality in the last decade was due to the improved welfare of people (poverty reduction from 35% in 1996 to 4% in 2012) and increased health expenditure per capita from US$ 50.9 in 2000 to US$ 393.1 in 2013). Along with the regionalization of perinatal care in progress from 2007, this enabled supply of necessary medical equipment, medicines, vehicles to obstetric facilities in each oblast, and improvement in outpatient and inpatient facilities with a focus on rural regions).

But significant challenges remained. Before 2005 the health care system was lacking the strategic vision of the system development. In addition, unclear delegation of authority within vertically centralized system and an existing at the time controversial legislation hindered integration of services and maintained poor capacity of health care managers and fragmented Primary Health Care as well as affected the access and quality of the primary health care services available to mothers and children at early stage of identification of the needs.

In this challenging time, in 2008 the government of Kazakhstan introduced WHO live birth criteria, resulting in increase of infant mortality rate from 15.1 per 1,000 live births (2005) to 20.7 in 2008s (Figure 1). Despite the understanding that the mortality rate would increase with the introduction of new criteria, the Ministry of Health had a clear understanding the new criteria would improve the identification of causes of death in newborns and infants leading to more adequate prevention measures in the future. Upon its introduction, the new criteria of newborn and infant registration enabled to strengthen the interventions in MCH at the PHC level and to plan programs aimed at reduction of risks of infant and child mortality.

There also was an understanding that more data and evidence on primary healthcare trends were needed. Starting from 2005, UNICEF has provided an extensive support to the Government in data generation including through Multiple Indicators Cluster Surveys. The results of the 2005 nationwide survey showed that the half of child deaths occurred in the first week of life due to the lack of proper and up-to-date training on antenatal, perinatal and pediatric practices as well as the low level of parental knowledge.

The legislation on healthcare underwent significant changes with development and adoption of the 2009 Code of the Republic of Kazakhstan “On People’s Health and Healthcare System”. This enabled the legal regulation of social relations in the field of healthcare ensuring realization of the constitutional right of Kazakhstani citizens to health care. The act enabled regulations in the full range of healthcare organization issues in the country and established the instruments of state control in the

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5 State Health Program 2011-2015: http://adilet.zan.kz/rus/docs/U1000001113
field. Evidently, the Code created the legal platform on implementation of innovative medical technologies in the health organizations and health education institutions of the Republic of Kazakhstan.

From 2011 the Integrated Management of Childhood Illnesses (IMCI) and Making Pregnancy Safer (MPS) strategies that include effective perinatal technologies, confidential enquiry “Beyond the Numbers” (confidential enquiries into maternal deaths at national level and near miss cases review in all perinatal centers of the country) and regionalization of perinatal care were scaled up across the country in the framework of the National Healthcare Development Program for 2010-2015. According to the Ministry of Health, the improvements in referral and re-referral system with the use of specialized vehicles enabled concentration of up to 70-80% pregnant women and newborns with a high risk of obstetric/neonatal complications and premature births at level III perinatal facilities. At present, there are 25 perinatal centers and 6 obstetric facilities of level III in 14 oblasts and 2 main cities of Kazakhstan. From this time on, an essential decline of early neonatal and post-neonatal mortality (mainly caused by pneumonia) has been observed, primarily due to improved emergency care for newborns and young children.

In 2012, UNICEF embarked on another study conducting a comprehensive assessment on socio-economic determinants of health. The study revealed that the infant and U5 mortality rates, though declining, had significant variation by oblast and rayon with health specialists overstaffing in some regions and a lack of qualified specialists in other. The assessment also found unnecessary hospitalization and extended length of stay leading to a waste of resources and, in fact, to worsening life conditions for women and children. As such, the study recommended improving primary care and aggressive interventions in lifestyle changes to reduce the need for hospitalization and to improve overall child health.

With the end of the era of the Millennium Development Goals, the international community agreed on a new framework – the Sustainable Development Goals (SDG). The SDG target for child mortality represents a renewed commitment to the world’s children: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-five mortality to at least as low as 25 deaths per 1,000 live births. To reach the SDG target, the Ministry of Health of Kazakhstan is now establishing an integrated model on medical and social service at Primary Health Care level, where social workers were introduced officially as additional staff members to cover the needs of about 200,000 vulnerable families with children at the community level.

As for ongoing national efforts, under the 2016-2020 State Program of Public Health Reforming and Development, Kazakhstan continues to demonstrate its adherence to implementing the reforms. Improving PHC services via integrating medical and social determinants of child’s wellbeing has become one of the main overall objectives of the Program. To improve the social sector in service provision, the structural reorganization was enabled by introduction of the social workers as the staff workforce at PHC level. Kazakhstan is considered the first country in Central Asia to support the

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6 An Assessment of Equity and Socio-Economic Determinants of Health, UNICEF 2012
strengthening cooperation between health and social services to move towards a blended model of home-visiting (patronage) system.

Home visiting

Home visiting services, or patronage nursing system, are visits by primary health specialists to families expecting children and/or already having small children. The goal of such visits is to provide these families with necessary skills to raise their children physically, socially and emotionally healthy and developed: patronage nurses provide parents with child health check-ups, information and advice on general care, health, nutrition, and parenting skills.

In 2015, UNICEF kicked off a blended model of home-visiting services in Kyzylorda region to introduce the Government to higher quality home-based services and encourage better coordination among the health, education and social protection systems. The model was a response to the assessment findings which revealed that the existing system of home visits in Kazakhstan had a number of issues: the system significantly lacked funding to provide supplies for effective home visits; limited time that a home visitor spends in one household – ranging from 14 minutes in urban setting to 5 minutes in rural areas; and no system of quality assurance for home visits leaving in doubt the quality of effective engagement with families. The new model, adapted from the United Kingdom, combines two approaches to home visiting: the universal model and the targeted model. Under the universal model, home visits are paid to all families: ideally, during the pregnancy and until preschool/kindergarten age. The typical home visit will be based on the counselling approach (listen, observe, ask, assess, praise, advise, show) and include, depending on the timing, issues ranging from mother health and wellbeing to child health and development and the overall family situation. However, the disadvantage of the model stems from its core feature: provided to all rights holders, it has no particular focus on at-risk families and children. The targeted model, on the other hand, is based on the evidence that targeting families and children that are at higher risk or who have special needs due to medical and/or psychosocial circumstances, is more effective. At the same time, while at-risk families and children are targeted, needs of other pregnant women, parents and children are left unaddressed. The universal-progressive model builds on the strengths of the two models. While essential home visiting services are provided to all families, at-risk families receive intense services based on their needs, for example, when they are undergoing socioeconomic difficulties, psychosocial stress and other adverse circumstances.

Currently, the model is in its final piloting stage in Kyzylorda region and is expected to expand to other regions. It is planned that eventually the model will be replicated in all the regions of Kazakhstan.

At present, in-service training of health workers continues in all regions and is fully funded from the public budget. Full financing of these initiatives was confirmed in the new cycle of the National Healthcare Development Program for 2016-2020. In Kazakhstan, PHC pediatricians, general practitioners, medical assistants and nurses, as well as pediatricians and nurses from hospitals and ambulance service are subject to IMCI training.

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Accelerating the reduction in child mortality is possible by expanding effective preventive and curative interventions that target the main causes of child deaths and the most vulnerable newborns and children. With this in mind, PHC with the focus on the partner-work with parents and local communities plays the key role in prevention of mortality cases among infants and children.

III. Purpose of the evaluation:

UNICEF, in partnerships with the Ministry of Health of Kazakhstan, is seeking an institutional consultancy to conduct the summative evaluation.

The purpose of this evaluation is to assess the impact of primary healthcare care system on infant and child mortality in Kazakhstan in light of past and present PHC reforms, policy changes, and approaches to family services provision, including through the home-visiting system.

Stakeholders: MoHSD of RoK, MoES of RoK as the main policy developers and monitors; home visitors, staff of policlinics, pre-schools as the main implementers of the ECE/ECD programmes and primary source of information; families, with specific attention to vulnerable groups among families as the target/beneficiary group of the ECD/ECE programme with satisfaction/or not satisfaction assessment of the programmes.

Intended users of the Evaluation:

Primary: Ministry of Health, local governments, line ministries should use the results of the Evaluation as the main developers and implementers of the national programmes who need to monitor the progress based of effectiveness and efficiency criteria, to introduce corrective actions if needed, to use the best available practices, to engage trained/informed HR, to bridge the inequality gaps and to allocate sufficient funds. UNICEF as one of the main knowledge brokers in MCH practices providing technical assistance for effective implementation of MCH interventions worldwide.

Secondary: MPs need to be informed in order to introduce necessary legislative changes. International, academic, private and civil society organisations including UN agencies and educators should use the results of the Evaluation in order to gain more knowledge and to improve their advocacy and practical actions in introduction and implementation of the PHC/MCH programmes.

IV. Specific objectives of the Evaluation:

To determine the impact of PHC policies and services at reduction of infant and child mortality in Kazakhstan since the start of the country’s economic growth, particularly from 2000 and till 2017.

To identify inequalities in access of vulnerable families with pregnant women and children under 5 to PHC services.

To analyze the influence of improved quality of PHC services, including based on the universal-progressive model of home visiting system, on families with children under 5 and pregnant women in reducing rate of infant and child mortality.
To assess the cost-effectiveness of the universal-progressive home visiting model piloted in Kyzylorda oblast.

To provide lessons learned and recommendations to the Government, UNICEF and other stakeholders on the further development of PHC with the focus on community-based services.

V. Scope of evaluation and questions:

The evaluation will be summative. The project evaluation questions are formulated as per OECD-DAC evaluation criteria: relevance, efficiency, effectiveness, sustainability and impact. Additional criteria such as coverage, coordination and coherence should also be used in the evaluation. The MoRES determinant analysis framework will be used explicitly to identify which bottlenecks were removed and how change was achieved.

The added value of the evaluation will be in the use of its findings and recommendations for: (a) evaluation of both PHC system’s and the home-visiting model’s impact on infant and child mortality; and (b) documentation of Kazakhstani experience with possible use by other countries confronting similar issues in primary health care provision.

Period to be covered: 2000 - 2017

Geographical coverage: cities of Astana, Almaty; Kyzylorda and Karaganda oblasts.

Proposed evaluation questions:

Below are a set of guiding questions that should be responded to by the evaluation. However, it is expected that the international consultants may suggest additional questions or sub-questions, and during the evaluation additional information that adds substance to the key questions will be collected and included in the final evaluation report.

Evaluation Questions for the PHC system and Universal-Progressive Model of home visiting in Kazakhstan

1. Relevance

1.1 To what extent has the need for reform been grounded in evidence-based problem analysis and to what extent does it correspond to the needs of the target groups?

1.2 How relevant were the government’s PHC reforms and policies to national goals and achievements in respect to reduced infant and child mortality rates (ICMR)?

1.3 To what extent was UNICEF’s support relevant to the country’s PHC reforms that led to reduced infant and child mortality? How relevant was the home-visiting model for PHC reform aimed at ICMR reduction?
1.4 To what extent have the reforms and UNICEF interventions taken into account international standards and good practices?

1.5 To what extent has the home visiting model contributed to improved MCH services for mothers and children under 5?

1.6 To what extent have national authorities in charge of implementing the reform been involved in its design (through all the process)?

1.7 To what extent has the reform and the home visiting model integrated gender equality and equity into its design?

2. Effectiveness

2.1 To what extent have state reforms and interventions contributed to improving PHC system, its institutions and achievement of MDG 4?

2.2 What interventions within the framework of PHC system for mother and child care were the most and least effective? Were these interventions sufficient to achieve the goal to reduce ICMR?

2.3 What were the key factors that influenced or hindered the achievement of the reduced ICMR?

2.4 To what extent various stakeholders were effective in ensuring the achievement of MDG4?

2.5 To what extent has the home visiting model achieved planned outputs and outcomes?

2.6 Was the model effective in reducing infant and child mortality and improved parenting practices since 2015?

2.7 Were the activities, planned under the model, necessary and sufficient (in quantity and quality) to achieve the outputs?

2.8 Were the established partnerships effective in achieving the current results of the model?

2.9 How effective were the home visiting model implementation mechanisms (coordination, management, etc.) in achieving the current results/outputs of the project?

2.10 What are the strengths and weaknesses in design, coordination, management and monitoring of the model?

2.11 To what extent has the reform and the home visiting model integrated gender equality and equity?

3. Efficiency

3.1. What strategies of the government, partners and actors were the most efficient in improving PHC and achieving lower ICMR?

3.2 What interventions were the most cost effective in providing PHC services to pregnant women and families with children under 5?
3.3. Have the resources at the national and regional levels been used in the most economical way to achieve the expected results in PHC reforms?

3.4. To what extent the approaches at PHC level related to MCH services were cost-effective to reach the most vulnerable families with children U5? What measures were most cost-effective in providing PHC services to pregnant women and families with children under 5?

3.5. How efficiently were used the human resources allocated by the Government and partners/actors?

3.6. Did the reform system include a coordination system to encourage synergy and avoid overlaps?

3.7. To what extent the universal-progressive model of home visiting is more efficient than traditional approaches at PHC level?

3.8. How well have the financial resources been used for the model implementation? Were funds managed in cost-effective manner? Could the same results have been achieved with fewer resources?

3.9. Were the indicators SMART enough to determine the outputs and outcomes of the universal-progressive model of home visiting?

4. Impact

4.1. To what extent over the period 2000-2017 the reformed PHC structure and care support, including the antenatal, prenatal and home-visiting services, influenced the level and trends of infant and child mortality in Kazakhstan and which internal and external factors positively or negatively contributed to this result?

4.2. To what extent the PHC reforms and interventions by the government of Kazakhstan and with support of partners affected a) boys and girls; and b) the most vulnerable groups of children and families including those with lower income, living in rural area, single parent, etc.?

4.3. To what extent have different stakeholders, and particularly UNICEF, contributed to those results?

4.4. Has the inequality between the most affluent and the most vulnerable groups increased, remained unchanged or declined after the implementation of the MCH services at PHC level?

4.5. Were there any unforeseen (positive and/or negative) results due to interventions? What strategies of stakeholders had the most important impact in influencing reduction of the ICMR?

4.6. What is the evidence of the contribution of the piloted universal-progressive model of home visiting to PHC in the region?

4.7. In what ways, if any, do mothers and children under 5 benefit from the piloted model? Are there any differences related to gender, socio-economic status and rural-urban location?

4.8. How do the stakeholders (both duty-bearers and right-holders) perceive the results of the model?

5. Sustainability

5.1. What are the factors contributing to sustainability of the PHC system towards reducing the ICMR?
5.2 To what extent the Government owned the PHC reform process and is committed to sustain it, including through an evolution of budget allocations for PHC and MCH?

5.3 What should be the next steps for the Government of Kazakhstan to sustain the achieved results?

5.4 Will UNICEF’s contribution to system level changes continue to impact families with children U5 and pregnant women after its support is withdrawn?

5.5 Is the universal-progressive model of home visiting ready for national scale-up? What kind of systems and instruments have been setup to facilitate the rollout of the new home visiting model for a national replication?

5.6 To what extent national and local authorities involved in the model piloting have the capacity to sustain the model?

**Cross-cutting:** To what extent are sex and age disaggregated data collected and monitored? In what ways and to what extent has the PHC reform and UNICEF piloted model integrated an equity based approach into the design and implementation of its interventions? Do the PHC reform and UNICEF piloted model actively contribute to the promotion of child and women rights, especially the most vulnerable? To what extent and how do the PHC reform and UNICEF piloted model ensure a non-discrimination and equity focus?

**Coverage:** Was representativeness of coverage ensured by PHC reform and UNICEF piloted model activities? Which groups have been reached by the PHC reform and UNICEF piloted model and what is the different impact on those groups? Have vulnerable children been reached, including children with disabilities?

**Coordination:** What was the role of the MoH, local government, NGOs, UN agencies community and other key actors in the design, coordination and implementation of PHC reform and UNICEF piloted model?

**Coherence:** What were the areas and ways of cooperation with other UN and donor agencies’ in regard to development of services for vulnerable children? How does the PHC reform and UNICEF piloted model relate to the existing national and/or local policy on children under five? Was there coherence across interventions supported by different agencies?

The following 10 determinants, or “conditions”, will help categorise critical bottlenecks and barriers:

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Norms</td>
<td>Widely followed social rules of behaviour that are followed within a society</td>
</tr>
<tr>
<td>Legislation/Policy</td>
<td>Adequacy of laws and policies to reduce/avoid barriers</td>
</tr>
<tr>
<td>Budget / expenditure</td>
<td>Allocation &amp; disbursement of required resources that constrain effective coverage</td>
</tr>
</tbody>
</table>
Management / Coordination | Bottlenecks that obstruct accountability and transparency, as well the impediments to coordination and partnership
---|---
Availability of essential commodities / inputs | Essential commodities/ inputs required to deliver a service
Access to adequately staffed services, facilities and information | Target population’s physical access to the relevant services, facilities and information
Financial access | Direct and indirect costs that prevent target group from utilizing available services or adopting certain practices
Social and cultural practices and beliefs | Individual/community beliefs, behaviours, practices, attitudes
Timing and Continuity of use | Completion/ continuity in service, practice that undermine the effectiveness of such service, practice, or other intervention
Quality of care | Adherence to quality standards (national or international)

VI. Evaluation methodology:

In order to deliver this assignment, the international experts/or institution will have to make and arrangement for contracting the national consultant(s) to assist in evaluation design, to undertake the field data collection and data entry, and to provide raw data for analysis and interpretation under guidance of the UNICEF CO and in close cooperation with Ministries and other partners.

The international consultant will be requested to propose a detailed methodology as part of the inception report, which should be guided by the UNICEF’s new Evaluation Policy9, the Evaluation Norms and Standards of the United Nations Evaluation Group (UNEG)10, UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis 11 and UNICEF’s reporting standards.

In addition, the team will retroactively reconstruct a Theory of Change for the primary health care with a chain of indicators arranged hierarchically from the output to long-term impact indicators.

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11 [https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF](https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF)
It is expected that in the end the evaluation will reach six inter-related and coherent outcomes, which should be the main building blocks for achieving the goal of the consultancy. Achievement of those six outcomes will be measured with set of indicators to be provided to international consultant after the contractual arrangements.

The Evaluation team is expected to submit a work plan within the first 10 days of assignment and to confirm the evaluation methodology, tools and sample size with the UNICEF. The Ethical Review will be conducted through either Ethical Review Board (ERB) of the EVT company or ERB at Nazarbayev University via UNICEF-Nazarbayev University MOU. If neither of these options will be available then the regional LTA holder will be used for the ERB. The Evaluation team will have the sole responsibility for the hiring, training, supervision and payment of the national consultants needed for this evaluation. Upon request, UNICEF may recommend people who were engaged in similar research previously, but it will be the responsibility of the evaluator to select and manage these consultants. Logistical support such as transport and office use will need to be agreed upon before the evaluation is initiated.

**Limitations to the evaluation**

There are several imitations to the evaluation which can hinder the process.

- Disaggregated data on local level might not be available, or the quality of available data may not be good.
  - Interviewing government counterparts for the evaluation may depend on their availability. The applicants should discuss the above or other potential limitations in their proposal.

The evaluation team is expected:

- to elaborate the methodology for the field data collection by the set of evaluated components and questions, including sampling, research techniques, and budget estimation.
- are encouraged to propose own solutions ensuring reliability of collected data and cost-effectiveness of research approaches. In any case, the field research should provide findings to answer research questions as outlined above.
- is required to conduct a desk-research primarily of official documents and secondary data which are not available in English and extract information if need.
- will be responsible to design the evaluation tools and to conduct survey/interviews s in accordance with the methodology proposed in response to this Request for Proposals.

Subject to discussion with the contractor of choice, it is proposed that a mix of the following methodologies could be adopted (but not necessarily limited to):

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Data sources</th>
</tr>
</thead>
</table>
| 1. *Analysis of secondary data:*  
1.1. Desk review of key documents and reports on reforms of the PHC sector of health care | Evaluating the system:  
system in the Republic of Kazakhstan;

1.2. Review of the studies and reports of WHO, World Bank, UNICEF on situation of children Under 5, the MCH program interventions at PHC level.

<table>
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<tbody>
<tr>
<td>Evaluating the PHC home-visiting interventions:</td>
<td>Evaluation system:</td>
</tr>
<tr>
<td>- UNICEF staff and consultants;</td>
<td>- Policy/decision makers and experts at Ministry of Health of the RoK;</td>
</tr>
<tr>
<td>- Heads of Department of health of Astana, Almaty, Kyzylorda and Karaganda oblasts;</td>
<td>- Heads of the PHC facilities in Astana, Almaty, Kyzylorda and Karaganda oblast;</td>
</tr>
<tr>
<td>- Academic professionals of the Kazakh Medical University of Continuing Education, IMCI Coordinators, independent expert in ECD, MCH, IMCI.</td>
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</tr>
<tr>
<td>Evaluating the PHC home-visiting interventions:</td>
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</tr>
<tr>
<td>- Households with children under 5, affixed to the pilot sites of the three polyclinics: CP No1 in Kyzylorda, CP No. 6 in Kyzylorda; health visitors, social workers, psychologists, chief doctors of pilot organizations, employees of the Health Department of Kyzylorda oblast,</td>
<td>- Households with children under 5, affixed to the pilot sites of the three polyclinics: CP No1 in Kyzylorda, CP No. 6 in Kyzylorda; health visitors, social workers, psychologists, chief doctors of pilot organizations, employees of the Health Department of Kyzylorda oblast,</td>
</tr>
<tr>
<td>- Akimats of Kyzylorda oblast, district akimats of Zhanakorgan village, IMCI coordinator of Kyzylorda oblast centre, specialists of &quot;Demeu&quot; centre, NGO &quot;Union of Medical Colleges of Kazakhstan&quot;, master coaches, partners of the Republican Center for Health Development, IMCI Coordinators.</td>
<td>- Akimats of Kyzylorda oblast, district akimats of Zhanakorgan village, IMCI coordinator of Kyzylorda oblast centre, specialists of &quot;Demeu&quot; centre, NGO &quot;Union of Medical Colleges of Kazakhstan&quot;, master coaches, partners of the Republican Center for Health Development, IMCI Coordinators.</td>
</tr>
<tr>
<td>- Staff of NGO in Kyzylorda city involved in provision of progressive package services, employees of kindergartens, where the children of families from the pilot polyclinics were enrolled.</td>
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</table>

2. In-depth interviews with key informants (right-holders and duty-bearers)

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>- Policy/decision makers and experts at Ministry of Health of the RoK;</td>
<td>- Policymakers at national level (experts and heads of departments on MCH at Ministry of Health, Republican Center for the Health Development; experts of the National Pediatric institute and surgery, IMCI Coordinators of 14 oblasts and two cities of Almaty and Astana);</td>
</tr>
<tr>
<td>- Heads of the PHC facilities in Astana, Almaty, Kyzylorda and Karaganda oblast;</td>
<td>- Decision makers at subnational level (heads of Department of Health, heads of the MCH departments at DOH in Astana, Almaty, Kyzylorda, Mangystau)</td>
</tr>
<tr>
<td>- Heads of the PHC facilities in Astana, Almaty, Kyzylorda and Karaganda oblast;</td>
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3. Focus groups

<table>
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<tr>
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<td>- Policymakers at national level (experts and heads of departments on MCH at Ministry of Health, Republican Center for the Health Development; experts of the National Pediatric institute and surgery, IMCI Coordinators of 14 oblasts and two cities of Almaty and Astana);</td>
<td>- Policymakers at national level (experts and heads of departments on MCH at Ministry of Health, Republican Center for the Health Development; experts of the National Pediatric institute and surgery, IMCI Coordinators of 14 oblasts and two cities of Almaty and Astana);</td>
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<td>- Decision makers at subnational level (heads of Department of Health, heads of the MCH departments at DOH in Astana, Almaty, Kyzylorda, Mangystau)</td>
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</tr>
</tbody>
</table>
- Professionals at academia level (Kazakh University of Continuous studies, Union of the Medical Colleges of Kazakhstan);

**Evaluating the PHC home-visiting interventions:**

- Families with children under 5; PHC partners (NGOs, the Department of Social Protection, pre-school institutions, employment centers), decision makers of Department of Health of Kyzylorda oblast.
- Employees of the PHC facilities (PHC No 8 in Astana; PHC No1 in Kyzylorda city, PHC No6 in Kyzylorda city, PHC of Zhanakorgan village in Kyzylorda oblast).

4. **Sample surveys of households covered with home-visiting services at PHC level in Kyzylorda oblast**


5. **Cost-estimation of home-visiting system.**

Documents on model piloting, including work plans, monitoring reports, financial reports, financial and political documents of the national/local authorities.

In gathering data and views from stakeholders, the evaluation team will ensure that it considers a cross-section of stakeholders (decision makers, programme personnel, beneficiaries, etc.) with potentially diverse views to ensure the evaluation findings are as impartial and representative as possible. The approach followed from the outset of the evaluation will be as participative as possible. Stakeholders will participate in the evaluation through interviews, discussions, consultations, providing comments on draft documents and making management responses to the recommendations of the evaluation.

During the **inception phase**, the evaluation team will design the evaluation methodology to be present in an inception report. The methodology should:

- be built on the theory of change (retroactively reconstructed) in the Europe and Central Asia (ECA) and common objectives arising across interventions to develop an evaluation matrix be geared towards addressing the evaluation questions. A model looking at groups of “main activities” across a number of interventions rather than at individual actions should be adopted. These could be organised around 10 determinants mentioned above.
- take into account the limitations to evaluability described below as well as budget and timing constraints.

To the extent possible, secondary data will be assessed during the Inception phase to start addressing evaluation issues and identifying the information gaps prior to the in country mission.
The selected team of international experts / institutions and national experts / institutions will:

Work together to conduct interviews with relevant national and local partners;

Develop research tools (including the data entry tool) and their field visits prior to the assessment;

Organize data collection and field work with a local team of experts

Discuss comments / feedback on fieldwork results and provide explanations;

Submit a draft evaluation report with the organization of the consultative process, led by the Deputy Representative of UNICEF CO and Health and Nutrition Program officer with key stakeholders in the country, and assist in the preparation of the evaluation report;

Provide a summary report and recommendations to the Government with the organization of the consultative process, led by the Deputy Representative of CO UNICEF and the Health and Nutrition Program officer.

**Ethical considerations:**

The Evaluation will be conducted in accordance with the UNEG evaluation principles (openness, transparency, participation, etc.) and standards using the Evaluation criteria (relevance, efficiency, effectiveness, impact, sustainability) as well as the UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis.

The consultant will work closely with UNICEF staff at key phases of the evaluation process to ensure that equity focus and Ethical requirements are fully met in the final Evaluation Report.

According to UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis, the approval by the Ethical Review Board of the methodology is required as well as continuous adherence to the ethical standards throughout the evaluation. Consequently, the contractor should allocate additional resources (Human and Financial) to ensure compliance with the ethical requirements.

The evaluation design and implementation should consider ethical safeguards where appropriate, including protection of confidentiality, dignity, rights and welfare of human subjects particularly children, and respect of the values of the local community. Please refer to UNICEF Procedure for Ethical Standards in Research, Evaluations and Data Collection and Analysis, which outlines the ethical principles in part of evaluation intentionality, obligations of evaluators, obligations to participants and evaluation process and product. Based on UNICEF Procedure For Quality Assurance In Research the evaluation should undergo independent External reviews for each required stage (Inception Report, Research design, Final Report).

**VII. Existing Information Sources:**

Consultants should develop a specific indicative list of information sources, taking into account the following categories of information materials:

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12 http://www.uneval.org/search/index.jsp?q=ETHICAL+GUIDELINES

13 https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF
National and local planning strategies and documents
- Sectoral plans and document concepts;
- UNICEF global and country publications and reports;
- Reports of national and international UNICEF consultants;
- Reports of monitoring visits of supporting mentors;
- Internal orders of pilot organizations;
- Records of case workers on family management, results of families evaluation;
- Minutes of meetings of interdepartmental commissions;
- Publications of materials about the pilot in the media;
- Census data, administrative data, household survey data, for example, MICS.

VIII. Indicative List of Deliverables:
The Table below provides the list of expected deliverables and preliminary terms of assignments completion.

The evaluation should include the following steps:

Step 1: Desk review of relevant project documents
The group of international consultants/or institute/organization will review key documents to understand the reform approaches, process and activities since 2000 to date. The documents could include the relevant national policies and programmes, other study reports, CPDs/CPAPs, progress and monitoring reports; review meeting documentation, TOC.

Step 2: Preparation of Inception Report that includes evaluation methodology and tools
The methodology should be prepared to cover all the intended objectives of the evaluation. The evaluation methodology design will be finalized in agreement with the reference group (with UNICEF, MOH, academia, NGOs) and inception report should be prepared based on the Evaluation Norms and Standards of the United Nations Evaluation Group and submitted to reference group.

Step 3: Data collection
The application of both qualitative and quantitative data collection methods is expected, which should be human rights based, including child rights based and gender sensitive. The data collected should be disaggregated by sex, age, disability, economic status and location. Field visits should employ methods ranging from document review, interviews, focus group discussions, surveys, observation depending on the final methodology.

Step 4: Data analysis
Collected data should be analysed by using relevant analysis method that should be clearly described in the report.

Step 5: Sharing preliminary findings and recommendations
The group of international consultants/or institute/organization will share preliminary findings and recommendations with the reference group. While feedback will be taken into consideration and incorporated into the draft report, the international consultant is encouraged to guard against validity threats, such as personal bias.
**Step 6: Draft report**
The group of international consultants/or institute/organization prepares a draft report, with conclusions and recommendations drawn from the data. The report structure should follow UNICEF’s evaluation report guidance.\(^{14}\)

**Step 7: Finalization of the evaluation report**
The group of international consultants/or institute/organization will present the final draft evaluation report to the reference group with a power point presentation. Recommendations of the evaluation report should also be presented. Comments and feedback on the findings and recommendations should be incorporated to finalize the report.

<table>
<thead>
<tr>
<th>Description of Deliverables</th>
<th>Time estimate</th>
<th>Assessment criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk-review &amp; Inception report</td>
<td>20 days</td>
<td>All relevant documents are reviewed and inception report submitted that includes result of desk review, consultation meetings and detailed evaluation methodology that is compliant with UNICEF requirements. Inception report will be assessed based on Global Evaluation Report Oversight System (GEROS) review criteria. Among others, the inception report should include following components: 1. Evaluation plan including timelines and activities 2. Methodology with a reconstructed Theory of Change for PHC; 3. Data collection instruments (quantitative &amp; qualitative) 4. Ethical protocols (if relevant) 5. Quality control procedures</td>
</tr>
</tbody>
</table>

\(^{14}\) UNICEF-Adapted UNEG Evaluation Reports Standards, July 2010
<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration (including travels)</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Training plan</td>
<td></td>
<td>Field work plan including team composition, logistics, field monitoring, etc.</td>
</tr>
<tr>
<td>7. Field work plan including team composition, logistics, field monitoring, etc.</td>
<td></td>
<td></td>
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<tr>
<td>8. Plans for data analysis (quantitative and qualitative), report preparation and dissemination</td>
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<td></td>
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<tr>
<td>The approximate length of the inception report is 20 pages.</td>
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<td>As per UNICEF Procedures the Inception report must be submitted for External Evaluation Review.</td>
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<tr>
<td>Data collection</td>
<td>14 days</td>
<td>Primary data is collected from target groups and partners based on the methodology described in inception report.</td>
</tr>
<tr>
<td>Data analysis and first draft report</td>
<td>20 days</td>
<td>Relevant analysis methods applied to analyse primary and secondary data and draft report is prepared in accordance with UNICEF-Adapted UNEG Evaluation Reports Standards (see section 12 and document attached).</td>
</tr>
<tr>
<td>Presentation of final report and recommendations to UNICEF and the Government of Kazakhstan. Production of the Evaluation brief.</td>
<td>10 days</td>
<td>Final report should be between 30-50 pages and structured as per the UNICEF-Adapted UNEG Evaluation Reports Standards</td>
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<td></td>
<td>1. Executive summary</td>
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<td>2. Object of evaluation</td>
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<td>3. Evaluation purpose, objectives and scope</td>
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4. Evaluation methodology
5. Findings
6. Conclusions and lessons learned
7. Recommendations
8. Gender and human rights including child rights issues to be consolidated and clearly articulated from all report sections.
9. Annexes

PowerPoint presentation of findings including practical recommendations is presented to reference group and project partners feedbacks recorded to be considered in the final report.

More detailed information of the UNICEF-Adapted UNEG Evaluation Reports standard is provided in the UNICEF Global Evaluation Report Oversight System (GEROS) Review Template, which will be shared at the start of the consultancy. Evaluation report should be finalized based on the feedback of the external quality assurance entity and UNICEF CO/RO and national partners.

All submissions should be electronic (Word and Power Point).

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meet the quality standards of both UNICEF and the Government of Kazakhstan, not delivered or for failure to meet deadlines (fees reduced due to late submission: 20 days - 10%; 1 month-20%; 2 months-50%; more 2 months – payment withhold).

### IX. Supervision and reporting:

The evaluation team will be supervised by and report to UNICEF Health and Nutrition officer in Kazakhstan with a regular de-briefing on the progress of the assignment to the UNICEF Deputy Representative and will work on a regular basis with all involved staff of UNICEF CO: Child protection /Education, Child Rights Monitoring and Social Policy and with identified national and sub-national stakeholders/partners.

For quality assurance purposes, a reference group consisting UNICEF staff, staff of the Ministry of Health, Labour and Social Protection of Population, the health related academic institutions, and NGO partners will be established.

### X. Qualification requirements:

The Evaluation is expected to be undertaken by the team of international evaluators with sub-contracting of national consultants to produce the expected results. Experts undertaking this Evaluation should either individually or as a team have the following qualifications:

- University degree in public health, public policy, social sciences.
- Minimum 5 years of working experience in public health, healthcare and healthcare system strengthening.
- General knowledge of UN evaluation policy, norms and standards, including human rights-based approach to programming and results-based management, including gender equality and child rights;
- Demonstrated expertise in data collection, analysis and reporting of quantitative and qualitative data.
- Demonstrated capacity and partnership building skills with local partners
- Good communication and advocacy skills
- Work experience and/or knowledge of social-economic surveys in ECA region. Field experience in Europe and Central Asia countries is an asset.
- Proven record of research experience and/or written publications at the regional level.
- Experience in designing and implementing evaluation and surveys.
- Excellent written English language skills, demonstrable with samples of publications. Knowledge of Russian is a strong asset.
- Excellent drafting skills and ability to synthesise complex information and issues. Ability to organise and plan complex work following the established timeframes.

The international consultant must remain in strict adherence with UNEG ethical guidelines and code of conduct. International consultant should clearly identify any potential ethical issues and approaches, as well as the processes for ethical review and oversight of the evaluation process in his/her proposal.
XI. Structure of Evaluation Report:

The evaluation report structure must be compliant with the UNICEF-Adapted UNEG Evaluation Reports Standards, 2010 (see the attached files) and include:

a. The title page and opening pages
b. Executive summary (2-3 pages)
c. Annexes
d. Object of Evaluation
e. Evaluation Purpose, Objective(s) and Scope
f. Evaluation Methodology
g. Findings
h. Conclusions and Lessons Learned
i. Recommendations
j. Gender and Human Rights, including child rights

UNICEF will keep the right to share the shorter (external) version of the report with the Government and make it public. The report will be disseminated to the reference group including government, donor and implementing partners in hard and soft copies.

XII. Duration:

The consultancy is expected to take not more than 6 months to complete from the date of contract signing (August 2018-January 2019), comprising less than 64 working days of work in total. At the same time, the exact schedule of activities will be agreed with the selected institution based on the proposal and implementation work plan.

The country visits schedule will be included into the implementation work plan.

XIII. Procedures and logistics:

Travel arrangements including purchase of the air tickets is the responsibility of the selected company/institution and estimated cost of travel should be clearly indicated in the financial proposal. Calculations of travel costs should be based on economy class travel regardless of the length of the travel. Cost estimates should be exclusive of all taxes as UNICEF is exempted from all taxes. UNICEF does not provide or arrange health insurance coverage for contractors.

Laptops or computers will not be provided.

XIV. Payment modality

Applicants should submit a financial proposal for their services based on the schedule of deliverables. Payments will be made upon successful completion of deliverables.
7.10 Acronyms

CP           Country Programme
CPAP         Country Programme Action Plan
CMT          Country Management Team
COPC         Community-oriented primary care
DAC          Development Assistance Committee (OECD)
EC           European Commission
DP           Development Partner
HR           Human Resources
MDG          Millennium Development Goals
MTR          Mid term Review
PCATool      Primary Care Assessment Tool
PHC          Primary Health Care
OECD         Organization for Economic Cooperation and Development
ProMS        Programme Management System
RBM          Results Based Management
RC           Resident Coordinator
ToC          Theory of Chance
ToR          Terms of Reference
UN           United Nations
UNCT         United Nations Country Team
UNPFD        Partnership Framework for Development between Government of Kazakhstan and the UN System
UNDP         United Nations Development Programme
UNICEF       United Nations Children’s Fund
UPHV         Universal Progressive Home Visiting
WHO          World Health Organization
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