Ministry of Health and Social Development of the Republic of Kazakhstan

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ASSESSMENT OF THE PATRONAGE NURSING SYSTEM WITH EQUITY ANALYSIS IN KAZAKHSTAN

FINAL REPORT

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ACRONYMS

BBP	Basic Benefit Package
CIS	Commonwealth of Independent States
EPI	Expanded program of immunization
FGD	Focus Group Discussions
GP	General Practitioner
HV	home visit
IGME	Inter-Agency Group for Child Mortality Estimation
IMR	Infant Mortality Rate
LBW	low birth weight
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoH	Ministry of Health and Social Development of the Republic of Kazakhstan
PHC	Primary Health Care
PMPHC	Pedagogical, Medical and Psychological Committee
PN	Patronage Nurse
PNS	Patronage Nursing System
PNSA	Patronage Nursing System Assessment
RK	Republic of Kazakhstan
SSI	Semi-structured interviews
SW	Social Worker
U5MR	Under-five mortality
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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PART 1:

INTRODUCTION

1.1. STRUCTURE OF THE REPORT

This report provides findings of the Patronage Nursing System assessment in Kazakhstan.

THE REPORT IS STRUCTURED AS FOLLOWS:

Part 1. Provides an introduction to the assessment by setting out the rationale and benefits expected from the assessment, and describes the approach and methodology used to carry out the assessment.

Part 2. Presents the country context, explains the organization of the health care system, and provides analysis of maternal and child health.

Part 3. Details the findings of the assessment.

Part 4. This section reflects the attempts of the assessment team to formulate conclusions that can shape the interventions for the introduction of a reformed Home Visiting/Patronage Nursing System in Kazakhstan.

1.2. ASSESSMENT RATIONALE AND OBJECTIVES

The overall purpose of the consultancy was to provide technical assistance to the MoH and UNICEF Country Office (CO) in conducting an assessment of the Patronage Nursing System (PNS), which included the Healthy Baby Rooms system and antenatal/postnatal visiting with social workers at Primary Health Care (PHC) level. The main strengths and weaknesses of the Patronage Nursing System were identified to inform concrete actions and changes to strengthen the system's quality and coverage, in order to address disparities and inequities in basic mother and child health services. The assessment took place in the wider context of the implementation of a State Program on Health System Development Salamatty Kazakhstan, which includes the establishment of a blended model of medico-social services at PHC level using the Patronage Nursing System.

In partnership with the MoH of the Republic of Kazakhstan and the Republican Centre on Health System Development, UNICEF intended to facilitate the PNS assessment with an equity analysis, and sought an international and national consultancy to support implementation.

The proposed assessment was carried out to achieve the following objectives:

- Review background information on the Mother and Child Health outcomes of Kazakhstan, National Statistics, on-going healthcare & social programs and policy documents, etc.
- Develop the methodology for the field data collection by research subjects, including sampling, research techniques, and budget estimation.
- Undertake a Patronage Nursing System Assessment(PNSA), including an analysis of the equity in utilization and quality of these services, which will include the following components:
- Based on the assessment findings, set out recommendations for the improvement of the existing services, assess the feasibility of implementing a "Blended Home Visiting" model, and provide recommendations for implementing such a model.
- Present the draft assessment to major in-country stakeholders through a consultative process, in close consultation and coordination with UNICEF CO.

1.3. BENEFITS OF ASSESSMENT

The assessment findings and recommendations are expected to generate the following benefits:

- The assessment will contribute to the global knowledge evidence base on child mortality and morbidity reduction.
- The findings and recommendations will primarily be addressed with policy makers and programme managers, both internally in UNICEF and externally in government institutions, partner and development organizations, and academia.
- The assessment will serve as a regional contribution to the global platform of learning and applying most feasible, effective and efficient approaches towards equity-based and evidence-informed planning for maternal and child health.
- Better documentation of the cost benefit of a blended home visiting system and identification of the most effective strategies for the introduction of such a model, alongside required interventions (road map), should also contribute to mobilizing additional funding for achieving further improvement of child health and development.
- The results of the consultancy will further inform policy makers and development partners and influence the development of a joint supported programme of cooperation.
- The assessment will also document lessons learned from the existing Patronage Nursing System, and will contribute to formulating country policies to support further progress in reducing infant and child mortality and morbidity, thus contributing to the "A Promise Renewed Initiative".

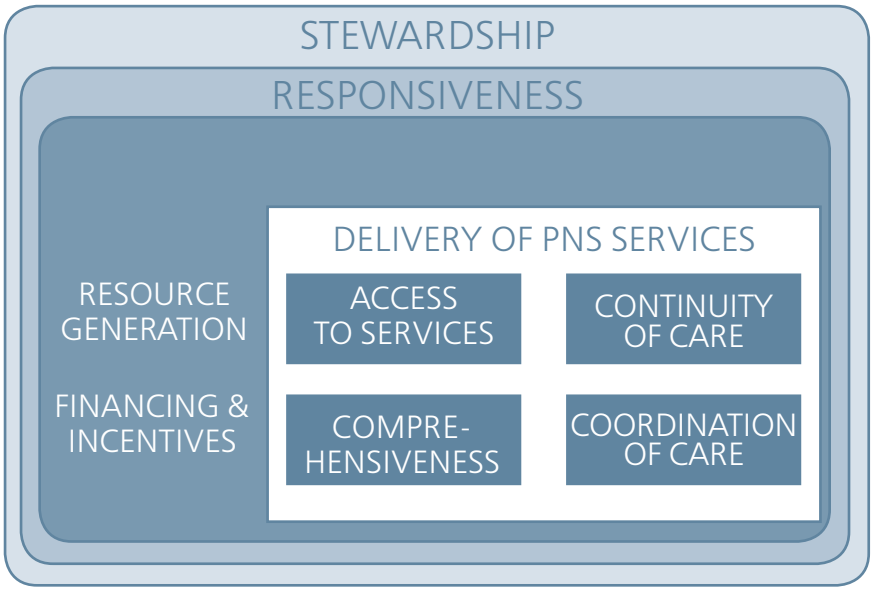
1.4. ASSESSMENT DESIGN AND IMPLEMENTATION PHASES

A mixed methods approach was used to inform different areas of the assessment. The quantitative methods were applied to the part of the assessment on resource generation, financing and incentives, and were used to characterize service delivery. The qualitative methods were used to further explore, understand, and inform underlying causes of the quantitatively measured indicators, to identify needs and problems, and to explore the potential for improvement. Considering the diversity of the methods and thematic areas (research objectives), a modular approach was employed to design the research instruments.

ASSESSMENT FRAMEWORK

The PNS assessment framework, from which the Patronage Nursing System Assessment (PNSA) tool has been developed, encompasses the four health care system functions and four characteristics of effective PNS service provision (Figure 1).

Figure 1: Patronage Nursing System Assessment (PNSA) Framework



ASSESSMENT SCHEME

Taking the Patronage Nursing System Assessment Framework[1] as its basis, the PNSA scheme provides further details by focusing on specific measurable topics and items relating to essential features and national priorities for change in primary care and the facilitating conditions. The PNSA scheme includes a number of key dimensions that have been identified for PNS function. Each dimension has in turn been translated into one or more information items or proxy indicators for the dimension (see Table 1).

Table 1: The Patronage Nursing System Assessment Scheme

FUNCTION	SUB FUNCTION	DIMENSION	SELECTED ITEMS/PROXIES
STEWARDSHIP		Policy development	Primary Health Care policy priorities
		Professional development	(Re) accreditation system for PHC
		Conditions for the care process	Laws and regulations
			Human resource planning
RESOURCE		Workforce volume	Numbers and density
		Professional development	Role and organization of professionals
			Education of patronage nurses and social workers
		Professional morale	Job satisfaction
		Facilities and equipment	Medical equipment
			Other equipment
FINANCING AND INCENTIVES		Primary Health care/PNS financing	PNS funding
		Incentives for professionals	Mode of remuneration
		Financial access for patients	Cost sharing/co-payments for PNS
DELIVERY OF CARE	Access to services	Geographical access	Distance for home visiting
		Organizational access	Patient list size
			PNS provider workload
			Home visits
			Electronic access
			Planning of home visits
		Responsiveness	Timeliness of care
			Service aspects
	Continuity	Informational continuity	Computerization of the practice
		Longitudinal continuity	Patient lists
			Longevity of patient–provider relationship
		Interpersonal continuity	Patient–provider relationship
	Coordination	Cohesion within PHC	PNS practice management
			Collaboration among general practitioners/family doctors and SWs
			Collaboration of PHC physicians with other PHC workers
		Coordination with other care levels	Referral system/gatekeeping
			Shared care arrangements

1. The world health report 2000 – Health systems: improving performance. Geneva, WHO, 2000, at http://www.who.int/whr/2000/en/whr00_en.pdf.

DELIVERY OF CARE	Comprehen-siveness	Practice conditions	Premises, equipment
		Service delivery	Procedures during home visiting
			Preventive, rehabilitative and educational activities
			Disease/case management
		Community orientation	Practice procedures and policies that help ensure comprehensive care
			Monitoring and evaluation
			Community links
		Professional skills	Technical skills

Table 2: Key Data, PNS Assessment in Kazakhstan

Target Groups	PHC Facility Managers
	Patronage Nurses
	Social Workers
	Households
	National Health Care Experts
Type of data collection	PHC Facility Manager: survey using structured questionnaire disseminated by field-workers and regional health officials to facility managers
	Patronage Nurses and Social Workers: Data collected by field workers using structured questionnaire
	Households: survey using structured questionnaire
	Health Care Experts: in-depth interviews
	Site visits
Recruitment of respondents	PHC Facility Manager: facility manager in each sampled facility
	Patronage Nurses and Social Workers: all PNs and SWs in the sampled facility
	Households: randomly sampled patients/households from home visiting register
	Health Care Experts: identified by Ministry of Health
Instructions provided to contributors	Local Coordinator: methodology of sampling and recruitment, identification of study facilities in predefined regions, lists of respondents and survey logistics
	Regional Health Authorities: aim and approach of the study
	Field Workers: explanation of questions, approaching and assisting respondents, quality considerations
	Respondents: written introduction and instructions in the questionnaires; verbal introduction and support from field workers
Coordination of fieldwork	Local Coordinator: overall responsibility
	Field Workers: information on respondents, correct administration of data collection on site
	CIF: general supervision during and after field visits
Data entry	Local Research Company
Analysis & reporting	CIF

As a first step, a directed literature study was conducted, based on the WHO performance framework, to gather information on possible ways to measure key PNS system functions. Particular attention was paid to PNS indicators and existing PNS performance measurements in the design of evaluation tools and questionnaires.

Draft versions of the questionnaires were developed on the basis of the information from the literature review, tested and revised based on the testing results. The final versions were translated into Russian and Kazakh with input from a primary health care expert, back translated into English, and compared to the original version.

QUALITATIVE DATA COLLECTION AND ANALYSIS

The qualitative data gathering and analysis took place after completion of the quantitative data collection.

Semi–structured interviews (SSI) – for SSI three categories of respondents were selected: a) Managers of the PHC facilities; b) Academic staff and experts in health and related fields; and c) Officials from the state institutions that work in the field of health and fields that have cross-cutting areas with health services in the community.

Focus Group Discussions (FGD) – Another method of qualitative data collection used was focus group discussions. These were conducted to further analyze the findings and to obtain in-depth and rich data on the reasons and consequences for the current situation, the practices and attitudes of the Patronage Nursing System, and the demand and needs of the community with regard to this service. For this purpose, three types of respondents were recruited for FGDs: a) Patronage nurses; b) Social workers; and c) Physicians in primary health care facilities.

DATA ANALYSIS AND TRIANGULATION

After the qualitative data was collected, it was processed using a thematic analysis aproach. Triangulation of qualitative and quantitative data was conducted, and the relevant literature and reports from domestic and international sources were simultaneously consulted. The results of the analysis and triangulation are presented further in this report under the main findings of the assesment.

PART 2:

COUNTRY CONTEXT

2.1. COUNTRY BACKGROUND

The Republic of Kazakhstan is one of the former Soviet republics that are now part of the Commonwealth of Independent States (CIS). It has one of the largest and fastest expanding economies in Central Asia, growing an estimated 9% between 2000 and 2007. In 2011, Kazakhstan marked the 20th anniversary of post-Soviet independence by introducing new health and social policies designed to strengthen its domestic socio-economic standing and political position in the international community. In addition, the central government of Kazakhstan has prioritized several goals aimed at diversifying the economy beyond its reliance on oil, natural gas, and other extractive industries, decreasing dependence on the government sector, and increasing competitiveness of the state as a whole. One of the key areas of interest to the central government is the improvement of population health.

Despite strong macroeconomic indicators, considerable progress in building civil society, efforts to democratize its system of higher education and related institutions and to modernize infrastructure to support population health, numerous challenges remain in delivering public health services to a population of over 16 million people, 59% of whom now live in the two largest urban centres: Almaty and the capital city of Astana. Although many health status measures show Kazakhstan to be ahead of most nations in the region, Kazakhstan continues to lag behind nations with the same size economy on several important health and environmental indicators[2].

Kazakhstan's population is currently estimated (as of 2012) to be 17.5 million, with a growth rate of 1.24%[3]. The World Bank has estimated the Gross National Product to be $149.06 billion in 2010, with a per capita gross national income of $6.280, which is below the average for other European Region states.

The World Health Organization (WHO) health profile for Kazakhstan estimates the average overall life expectancy at birth to be 64 years (59 years for males and 70 years for females), which falls behind the regional average of 75 for both genders[4]. The trend in life expectancy in Kazakhstan is similar to that observed in the other CIS, with female life expectancy at birth exceeding that for males by 11 years.

2.2. HEALTH CARE SYSTEM IN KAZAKHSTAN

When it gained its independence in 1991, Kazakhstan inherited a health care system in poor shape. The system suffered from underfunding, obsolete practices, outdated facilities, inefficiency and few incentives to provide quality services. The system was unable to effectively respond to the steep downward trend in population health during the 1990s. As health care reforms started relatively late and took effect slowly, system performance continues to be suboptimal. However, with the rapid growth of the economy in the last decade, boosted by growing revenues from oil and other natural resources, the tide is changing. Public expenditure per capita on health doubled between 2000 and 2005 (although as a percentage of the corresponding EU figure the growth was modest).

Kazakhstan's ambition for reform has been demonstrated through the 2005–2010 State Health Care Reform and Development Programme. The Programme aims not only to invest in buildings and equipment, but also to improve the technical and managerial expertise of the health care workforce in order to increase the efficiency and quality of services. In the second half of its implementation, the Programme has sought to reorganize and strengthen inpatient and emergency care, improve continuity of service delivery, and introduce competition among providers. Its other priorities have been to modernize medical education and training and to focus more on prevention and health education. Strengthening PHC services has been one of the Programme's chief overall aims.

Although privatization has been significant in dental care and dispensing of pharmaceuticals, it has not been well established in other parts of the health care sector.

2. Health Profile. World Health Organization, 2012. Available from: http://www.who.int/gho/countries/kaz.pdf.

3. World Fact Book. Central Intelligence Agency.

4. Ibid 1.

In a similar way to other government sectors, policy-making in health care is strongly centralized and the President plays a key role. Governance and management of the health care system is hierarchical, with the Ministry of Health at the top. The Minister of Health is appointed by presidential decree. In contrast to the situation in other CIS countries, however, the regional authorities in Kazakhstan, particularly the regional health departments, run their health services with relative autonomy, sometimes overstepping their authority and at other times simply deviating from national policy due to a lack of information.

However, the regional variation in the development of PHC does not appear to be simply a result of this autonomy; other factors include differences in economic development. The 14 regions and 3 independent cities own the government health facilities in their jurisdictions and employ the government health workers. Their health departments also play a key role in managing the hospitals and most polyclinics. The akim of each region or independent city appoints the director of these departments. The district authorities, subordinate to the regional authorities, are responsible for managing smaller secondary care and most PHC facilities. The chief physicians of the central hospital in each district manage the local PHC practices.

The Kazakh health care system is publicly funded through taxation. The state guarantees a basic benefit package of health care services intended to be free to the entire population. However, significant out-of-pocket payments are now required for many services that once were free.

Under the State Programme on Health Care Reform and Development, PHC reforms began in 2005. One element in the Programme consists of developing the specialty of family medicine, through initiatives that include a retraining programme for district therapists to become family doctors and improved continuing medical education. It should lead to an expansion in clinical responsibilities at the primary level and better services there, particularly in the areas of maternal and child health, reproductive health and cardiovascular screening. The quality of services provided by feldsher-midwife posts, which act as the point of entry to the health system in remote areas, also improved after the GPs from the nearest ambulatory started managing them. The Programme also upgraded PHC premises, equipment and transport facilities, especially in rural areas. In addition, GPs will receive a mix of capitation and performance-based payments, which should improve the accessibility and quality of services and improve GP motivation. Moreover, the Programme improved the way drugs are dispensed by introducing drug benefits for specific categories of patients. It also considered measures to make rural practice more attractive to staff.

Although the PHC reform began by focusing on rural areas, the intention is to gradually introduce GPs to urban facilities as well. As a first step, age- and sex-specific polyclinics were replaced with polyclinics for children and adults. Family group practices were also established independent from polyclinics, and they refer patients to polyclinic specialists as needed. In addition, independent PHC centres have been established, which are contracted by the state on a capitation and partial fundholding basis.

PHC in Kazakhstan is in a state of transition at present, with characteristics of both its former and its projected state. In towns and cities the old model of PHC organization still dominates, with polyclinics offering both primary and secondary care services to children, adults or women with gynecological issues. Family group practices and integrated polyclinics (those that serve all age groups and both sexes) are emerging only reluctantly. In the countryside, the quality of many feldsher-midwife posts and ambulatories still leaves much to be desired, but starting in 2006 feldsher-midwife posts have been reconfigured as medical posts offering a broader range of services. In rural ambulatories, the combination of therapist and pediatrician is increasingly being replaced by retrained GPs.

Nevertheless, the provision of high quality services in rural areas continues to be a challenge. Rural Kazakhs still have insufficient access to pharmaceutical services. The lack of public and private transport among widely dispersed villages and district towns is still an obstacle to accessing medical services, as is the continuing shortage of physicians in rural facilities.

A more general problem, which applies to other sectors besides health, is the inability of regional and district authorities to fully implement new policies and standards. It can lead to situations in which the Ministry of Health or other central authorities develop beneficial laws and regulations that are rarely properly realized. However, improving the capacity of regional and district policy-makers and managers is time-consuming and requires much greater financial resources than are currently available. Recognizing this, donors and international organizations have been actively supporting the capacity building process in the Kazakh health sector.

2.3. CHILDREN IN KAZAKHSTAN

2.3.1. POVERTY

In parallel with economic growth, standards of living in Kazakhstan have risen significantly over the last decade. Poverty estimates from 2010 show that poverty headcount, depth and severity rates fell sharply from 2001 to 2009, despite a blip following the international economic crisis in 2008-2009[5]. Nevertheless, children in Kazakhstan have a high risk of living in households where average consumption is below the minimum subsistence level. Based on the analysis of the 2009 Household Budget survey, 45 per cent of all children below the age of 18 are living in poverty compared to the average of 33 per cent for the total population. Seven per cent of children are living in households with consumption below 60 per cent of the minimum subsistence level. Across all regions, poverty rates are slightly higher for children aged five or under than for older children, and significantly higher than for adults[6].

Poverty is concentrated heavily among large households with small children, young families with children, and single parent families. Recent research has also indicated that households where the main income-earning adult is female are particularly vulnerable to poverty[7]. Divorced mothers, in particular, are facing increasing problems securing alimony from their former husbands, with a more than 50 per cent rise in court orders for alimony between 2008 (101.050) and 2011 (156.426), but only a 15 per cent success rate of these orders[8].

Almost half of all households (49 per cent) with three or more children under the age of six were poor in 2008, compared to 11 per cent of households without children. Poverty rates have also fallen less for households with three or more children below the age of six than for households with no children or one child[9]. This quantitative data indicates that poverty is a significant issue influencing the vulnerability of families and children[10].

Living standards in rural areas remain much lower than in urban areas. For instance, in Pavlodar and North Kazakhstan the rural population is three times more likely to be living in poverty than the urban population. The differences between urban and rural areas are even more pronounced for extreme poverty . There is also seasonal variation in poverty rates, particularly in rural areas and medium-sized towns. While 25 per cent of the population (including 60 per cent of people who were considered poor) lived in poverty for all four quarters, 16 per cent of those considered poor only experienced poverty for one quarter.

The extent to which poverty experiences are persistent or fluctuate across the year differs considerably across regions. In South Kazakhstan, for example, almost 25 per cent of the population experience poverty in one, two or three quarters of the year. Both chronic poverty and seasonal variation can have far reaching effects on children[12].

Along with urban-rural variations, there is considerable regional variation in poverty affecting children. Paradoxically, poverty rates are highest in Mangystau, despite the province's high economic output as a result of the oil industry. This output masks the sheer poverty of the rural population: 35 per cent of the rural population

5. United Nations Kazakhstan and Government of Kazakhstan, Millennium Development Goals in Kazakhstan, 2010, Astana; Gavrilovic, M., Harper, C., Jones, N., Marcus, R., and P. Pereznieto, Impact of the Economic Crisis and Food and Fuel Price Volatility on Children and Women in Kazakhstan, 2009, Overseas Development Institute, London.

6. Keetie Roelen and Franziska Gassmann, Child Wellbeing in Kazakhstan, UNICEF, July 2012.

7. Gavrilovic, M., Harper, C., Jones, N., Marcus, R., and P. Pereznieto, Impact of the Economic Crisis and Food and Fuel Price Volatility on Children and Women in Kazakhstan, 2009, Overseas Development Institute, London; World Bank, Targeting Performance and Poverty Impact of Social Benefits in Kazakhstan: Evidence from the 2007 Household Budget Survey, 2009.

8. Kazakhstan Ombudsman Annual report for 2011, http://www.ombudsman.kz/publish/docs/doklad_zhyl/detail.php?ID=2023.

9. Kazakhstan and the United Nations Country Team for Kazakhstan, MDGs in Kazakhstan – 2010.

10. Kazakhstan and the United Nations Country Team for Kazakhstan, MDGs in Kazakhstan – 2010.

11. Kazakhstan and the United Nations Country Team for Kazakhstan, MDGs in Kazakhstan – 2010.

12. Kazakhstan and the United Nations Country Team for Kazakhstan, MDGs in Kazakhstan – 2010.

in Mangystau lives in extreme poverty, and almost 90 per cent of all children are considered to be poor. In South Kazakhstan, the region with the second highest poverty rate, 58 per cent of children live in poverty, followed by Atyrau (45 per cent) and Almaty province (43 per cent). The lowest child poverty rates are observed in the two large cities, Almaty (18 per cent) and Astana (22 per cent)[13]. However, it should be noted that poverty is traditionally higher in rural areas, and, despite the urban-rural discrepancy, there has been a significant reduction in urban poverty from 3.000.000 people living below the subsistence minimum in 2005 to 700.000 in 2011[14].

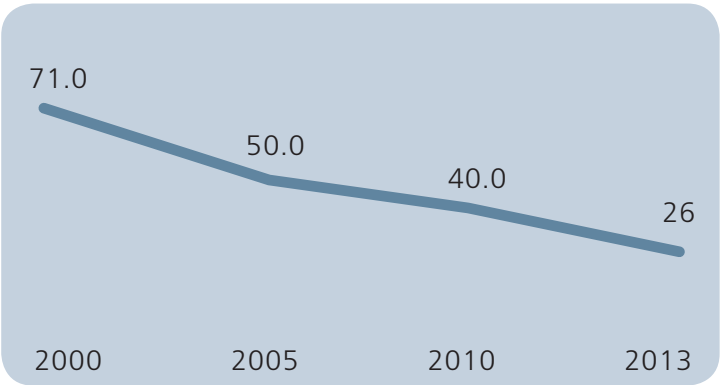
Social exclusion affecting certain groups also shapes child poverty in Kazakhstan. In particular, children living in households where one or more adults are disabled and migrant households, either internal migrants or those who have migrated from neighboring countries, are at considerable risk of poverty. Migrants, including children in migrant families, are also often unable to register in their new places of residence, meaning that they cannot access health and social services and benefits that could help to mitigate the impacts of poverty[15].

2.3.2. MORBIDITY AND MORTALITY INDICATORS

The CEE/CIS region has experienced its own unique historical development since the dissolution of the Soviet Union and the fall of the Berlin wall. Specifically, the transition from a centrally planned to a market economy caused major shifts in the socio-economic conditions of the societies, which negatively affected many aspects of societal life, including children's health.

During the early years of transition, the RK faced many challenges including deterioration of child health outcomes, although slow recovery occurred thereafter.

Figure 2: Maternal Mortality Ratio (per 100, 000 live births)



Source: UN data

The maternal mortality ratio shows a significant decline (63%) from 71 per 100.000 live births in 2000 to 26.0 in 2013 (Figure 2). The leading causes of maternal mortality continue to be hemorrhage, preeclampsia and abortion. In other words, Kazakhstan continues to lose mothers when maternal deaths could be avoided. Considering that almost 100% of deliveries take place in the presence or under the supervision of medical personnel, the main causes of maternal death result from the poor quality of health care for pregnant women. Despite the high rate of pregnant women enrolled in antenatal surveillance, the use of outdated and inefficient approaches impedes the achievement of expected results and continues to be a formality. The above-mentioned problems are the result of limited access to international practice for a long period of time[16].

Under-five mortality (U5MR) declined and indicates good prospects for reaching the MDG targets by 2015 (Figure 3). Although figures for U5MR and IMR differ slightly between the sources of the Inter-Agency Group for Child Mortality Estimation (IGME) and MICS surveys, it is notable that both sources report a decline of subject indicators.

13. Kazakhstan and the United Nations Country Team for Kazakhstan, MDGs in Kazakhstan – 2010.

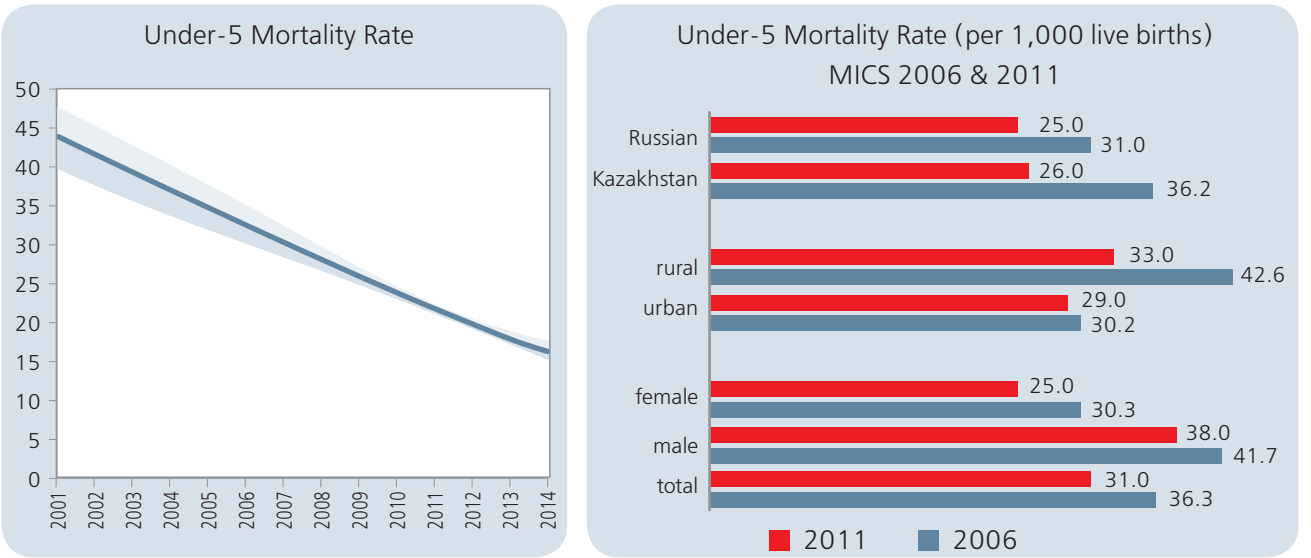
14. Analysis of the Situation of Mother and Children in Kazakhstan, UNICEF, 2012.

15. Gavrilovic, M., Harper, C., Jones, N., Marcus, R., and P. Pereznieto, Impact of the Economic Crisis and Food and Fuel Price Volatility on Children and Women in Kazakhstan, 2009, Overseas Development Institute, London.

16. Government Resolution on Programme to reduce maternal and infant mortality in the Republic of Kazakhstan 2008 – 2010, 2007.

While progress is evident, the RK fails to ensure equality. MICS data for the years 2006 and 2011 reveals a decrease in the U5MR in females by 5.3 points and by 3.7 points in the male population. A tangible decrease is observed in the decrease of U5MR in the rural population and in Russian and Kazakh ethnic groups. Less positive trends are observed in IMR rates in relation to urban/rural and ethnic inequalities. Specifically, no changes have been observed for these groups of the child population between 2005 and 2011.

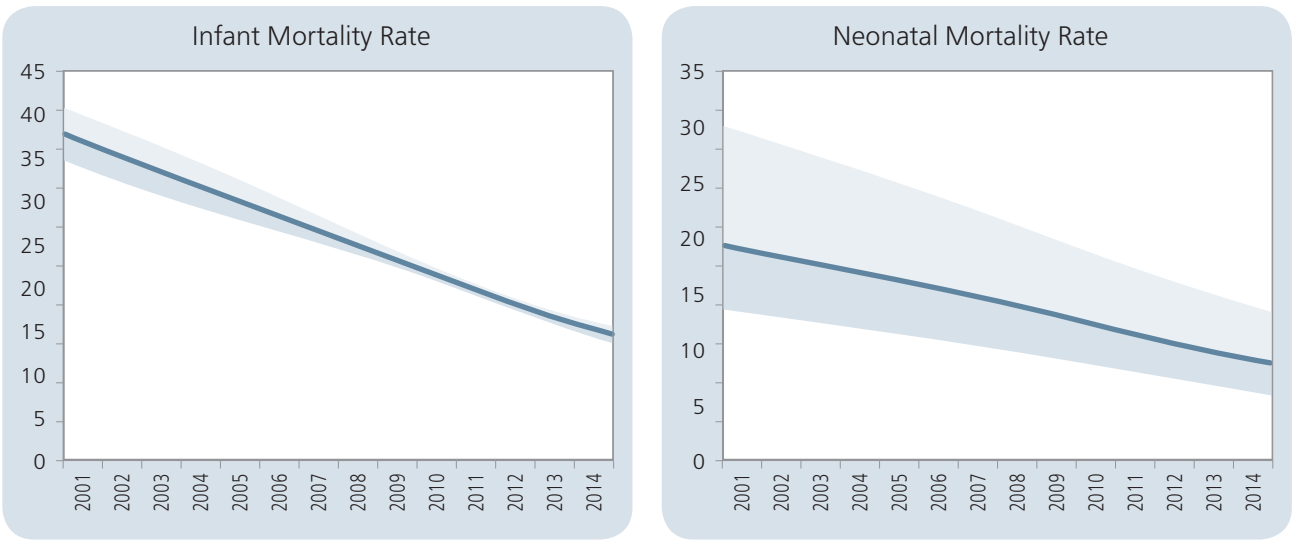
Figure 3: U5 Mortality rates (per 1,000 live births) with equality focus



Source: www.childmortality.org

Alongside the declining U5MR, Kazakhstan also progressed in reducing infant and neonatal mortality rates (IMR and NMR respectively) (Figure 4).

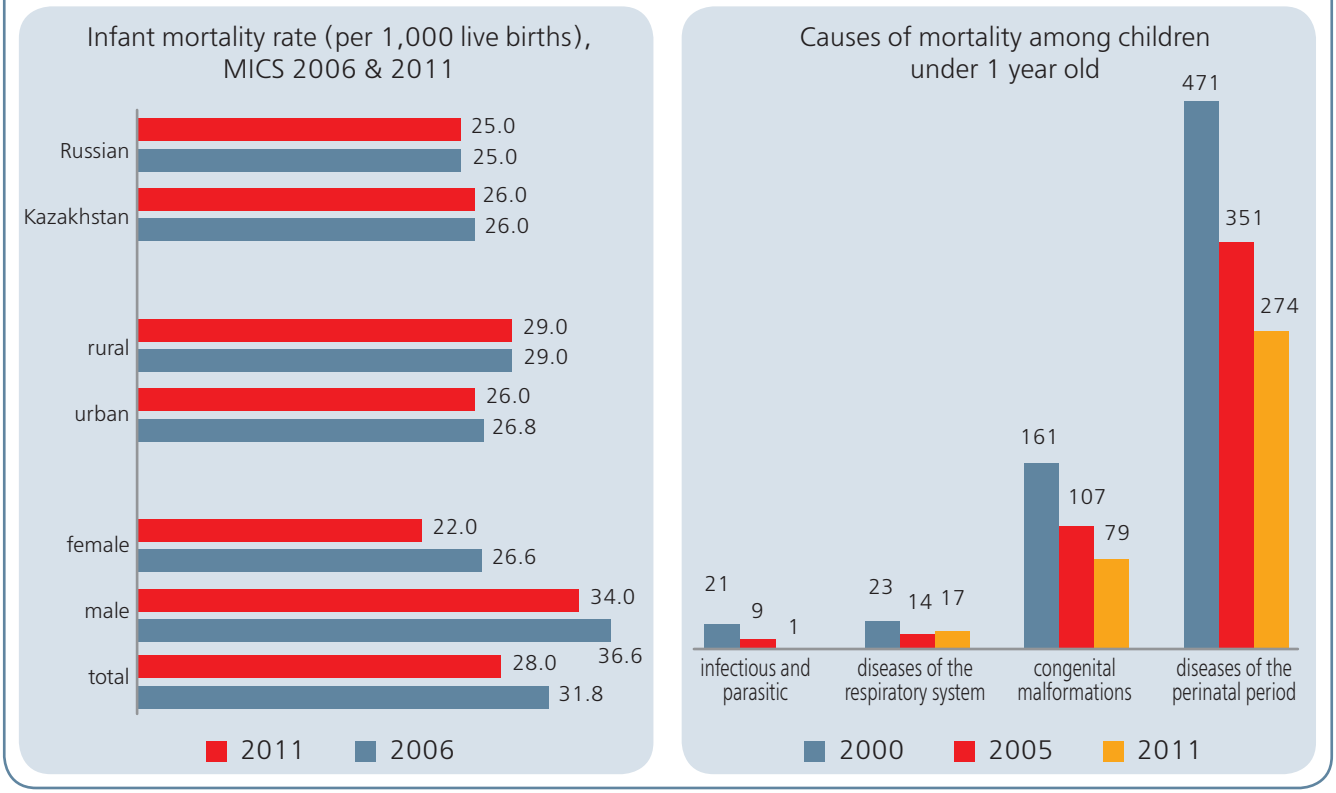
Figure 4: Infant and Neonatal Mortality



Despite progress in reducing the infant mortality rate, inequalities still persist. IMR remained largely unchanged in rural areas, though a decrease in mortality rates is observed in both male and female infants (Figure 5).

In 2000, diseases of the perinatal period contributed to approximately 70% of IMR. Due to the progress made in reducing mortality after the neonatal period, its share in IMR increased to 74% in 2011.

Figure 5: Infant mortality rate and mortality causes in children under one year old



Children who survive their first year of life are much more likely to survive into adulthood. The mortality rate for all children under the age of five in the country is 17.5, meaning that 85 per cent of under-five mortality occurs among infants. Again, this figure varies greatly between regions, from 26.5 per 1000 live births in Kyzylorda to 9.8 in Aktobe. South Kazakhstan, which has the highest number of births per year, has the second highest rate of child mortality at 23.5 per 1000 live births[17].

The key causes of death among children aged one to four years include diseases such as pneumonia and diarrhea that are preventable using known, affordable, low-technology interventions. The understanding of caregivers on when to seek medical care is an important factor contributing to morbidity and mortality rates in children. A key issue revealed in the 2010-11 MICS is the fact that parents appear more reluctant than in 2006 to take children to a health facility immediately when children develop signs of dangerous illness. The MICS data also shows clear inequity in that poorer families are less likely to take their children straight to a health facility when faced with danger signs (Table 3).

In addition, the number of mothers and caregivers who recognize two danger signs of pneumonia has decreased by 10 percentage points since 2006. According to the MICS, only 22.2 per cent of women knew the two danger signs of pneumonia (fast and difficult breathing). The figure falls to 15.7 and 15.8 per cent for the two poorest quintiles. This reflects a need for national educational campaigns to explain the signs, risks, and consequences of untreated diseases such as pneumonia[18].

17. Medinfo, 2010.

18. Agency of Statistics, UNICEF and UNFPA, MICS 2006 and 2011.

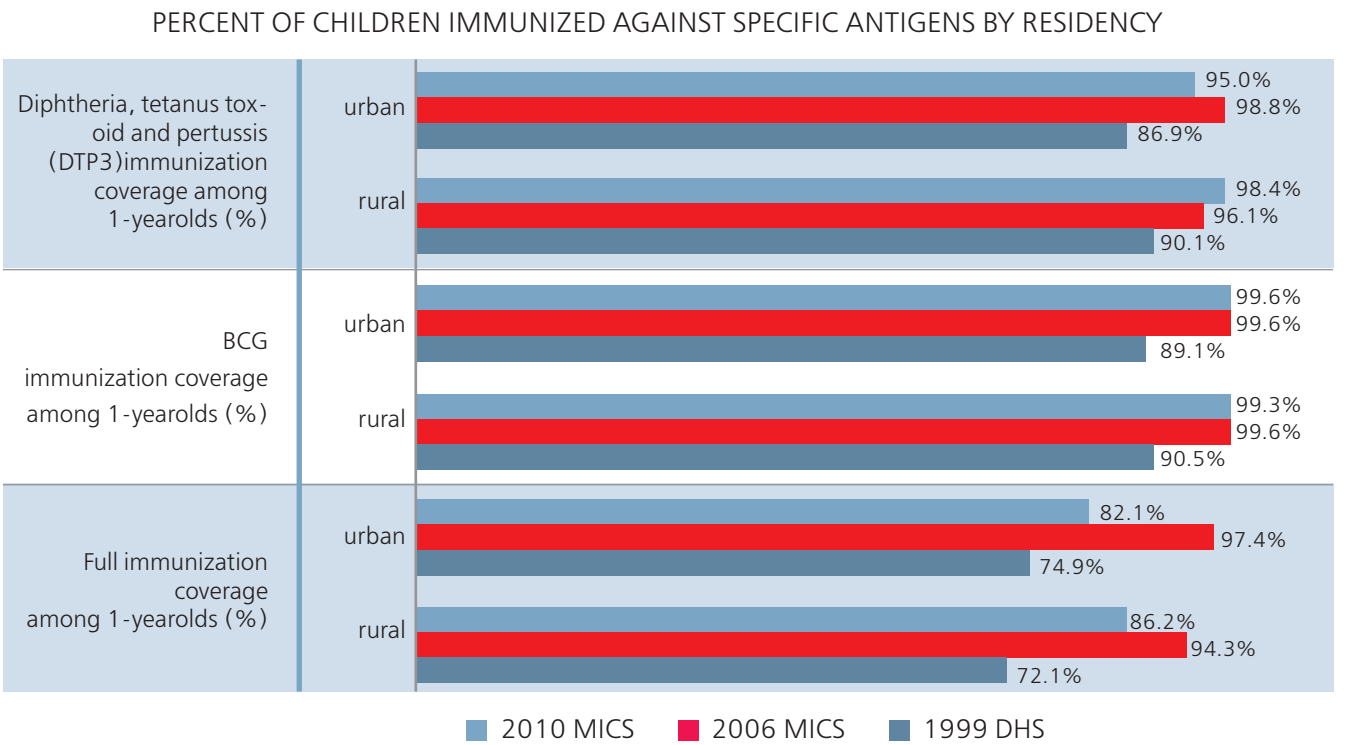
Table 3: Symptoms that would cause caregivers to take the child to a health facility right away

	Poorest	Second	Middle	Fourth	Richest	Total
Child not able to drink or breastfeed	14 %	20 %	25 %	29 %	26 %	23 %
Child becomes sicker	35 %	37 %	46 %	51 %	54 %	44 %
Child develops a fever	76 %	87 %	90 %	95 %	94 %	88 %
Child has fast breathing	26 %	27 %	37 %	41 %	44 %	35 %
Child has difficulty breathing	29 %	34 %	45 %	54 %	59 %	44 %
Child has blood in stool	16 %	19 %	26 %	34 %	37 %	26 %
Child is drinking poorly	9 %	11 %	15 %	20 %	21 %	15 %
Source: Sanigest Internacional based on MICS 2010-11						

As children grow up in Kazakhstan they face a wide range of safety issues. WHO's 2008 European Report on Child Injury Prevention indicated that Kazakhstan had the second highest child mortality rate (after the Russian Federation) from unintentional injury for any country in the WHO Europe region between 2003 and 2005, at 32 deaths per 100.000 population[19]. The highest rates of death by "trauma" are found in Pavlodar province (45 per 1000 children under five); Almaty city (33.9); North Kazakhstan province (29.0); and Almaty province (25.1).

Immunization achievements in the RK are impressive (Figure 6), though the share of fully immunized children less than one year old demonstrates a decrease since 2006 both in rural and urban areas. Challenges still persist especially in achieving regional disease elimination/eradication goals. These challenges are manifold: a) Poorly performing immunization programs in neighboring countries affecting diseases across the borders; b) The

Figure 6: Immunization Coverage Rates 2005-2011, MICS



19. Dinesh Sethi, European Report on Child Injury Prevention, WHO, 2008, at http://www.euro.who.int/__data/assets/pdf_file/0003/83757/E92049.pdf, p26.

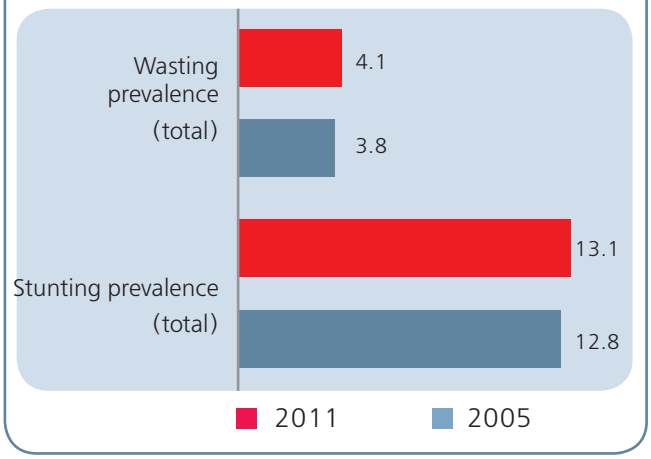
growing power of the anti-immunization movement[20] pushing down demand for immunization services; c) Weak governments failing to adequately communicate with the public and explain the value of immunization, etc. While progress in the EPI is obvious, a more granular analysis looking at various factors and/or population sub-groups seems to be necessary to unpack any underlying causes that may impede immunization program performance and consequently child health.

2.3.3. NUTRITION

In Kazakhstan in 2010-11, 3.7 per cent of children under five were underweight, including 1.2 per cent who were severely underweight. At the same time, 13.1 per cent were stunted, including 5.4 per cent who were severely stunted (Figure 8). Meanwhile, 4.1 per cent of children were wasted (i.e., low weight for their height) and 1.7 per cent of children were severely wasted. When using directly comparable figures, these remain substantially unchanged since the 2006 MICS[21].

Of all children under 18 years old, 4 per cent were moderately underweight and 1.5 percent severely underweight according to MICS 2011 (Figure 7). Stunting is a clear indication of chronic malnutrition or repeated food deprivations and is specifically related to poor infant and young child feeding practices in the first two years of life.

Figure 7: Change in stunting and wasting prevalence in the period of 2005-2011, MICS data



Malnutrition remains an important determinant of infant and under-5 morbidity and mortality, and also causes poor development of children. Persisting malnutrition is usually reflected in high rates of stunting and micronutrient deficiencies. UNICEF, in collaboration with its partners, was an active player in the region trying to address child nutrition issues through numerous nutritional interventions over the life cycle of a child's weight. Children in Aktobe province were most likely to be underweight for their age (11.9 per cent) and stunted (36.2 per cent). Meanwhile, the highest proportion of children moderately underweight for their height (wasting) was found in Aktobe province (8.6 per cent) and East Kazakhstan province (8.1 per cent). There were proportionately more moderately underweight and wasted children in urban areas, while there were more stunted children in rural areas. Those children whose mothers cent) or wasted (4 per cent) does not have a sense. Should be checked than children whose mothers had not completed school had completed higher education were less likely to be underweight (3.4 per cent), stunted (11.5 per)[22].

Like other middle-income countries, nutritional indicators in Kazakhstan show a dual pattern characterized by an increasing problem of overweight children under five, especially one to two year olds, as well as problems of under-nutrition among some sectors of society and in some regions[23]. About 13.3 per cent of the children surveyed for MICS were overweight, with boys more likely than girls to have this problem (14.8 per cent of boys compared to 11.8 per cent of girls). The highest proportions of overweight children were found in Aktobe province (33.5 per cent), Astana city (22.1 per cent) and Zhambyl province (21.3 per cent). Babies aged 6 to 11 months were most likely to be overweight (19 per cent)[24].

20.UNICEF 2013. Tracking anti vaccination sentiment in Eastern European social media networks, UNICEF Regional office for CEE & CIS.

21. Agency of Statistics, UNICEF and UNFPA, MICS 2006, Table NU.1 Nutrition, 2007.

22. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, Table NU.1 Nutrition, 2012.

23. Gavrilovic, M., Harper, C., Jones, N., Marcus, R., and P. Pereznieto, Impact of the Economic Crisis and Food and Fuel Price Volatility on Children and Women in Kazakhstan, 2009, Overseas Development Institute, London; Keetie Roelen and Franziska Gassmann, Child Wellbeing in Kazakhstan, UNICEF, July 2012.

24. Ibid 11.

Anemia prevalence among women of reproductive age fell from 44.7 per cent in 2008 to 38.9 per cent in 2011, while among children under five it fell from 47.4 per cent in 2008 to 35.2 percent in 2011[25]. Iron deficiency anemia is particularly prevalent in Aktobe and Kyzylorda provinces[26].

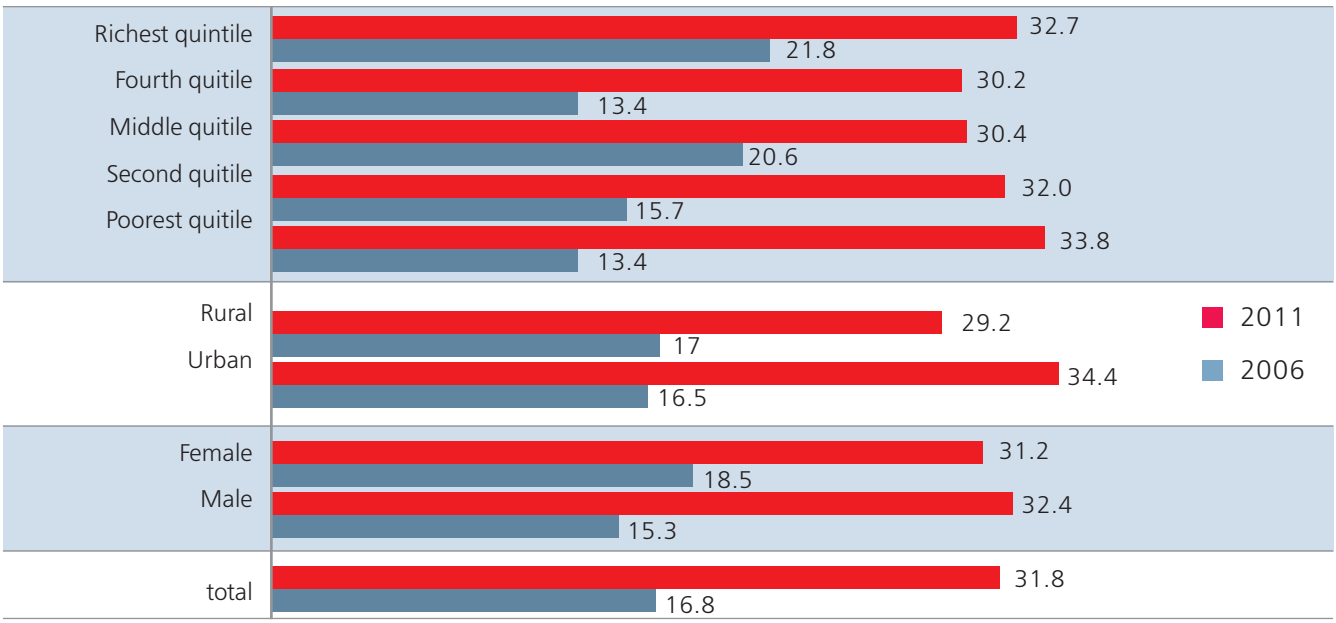
Available data reveals that some interventions did render results, although marginal. For example, exclusive breastfeeding rates have increased, albeit minimally, up to 32% in Kazakhstan, which is low compared to globally reported rates. Additionally, although early initiation of breastfeeding, which has a high impact on neonatal morbidity and mortality, is currently at an increased rate of 67.8% in Kazakhstan, this seems relatively low given the very high incidence of hospital delivery.

A major sign of progress is that by 2011 folic acid deficiency among 6-59 month old children, at 12 per cent, had fallen more than four times from the 2008 level (57.7 per cent). Of this, 11.4 per cent was mild deficiency and 0.6 per cent was severe. Folic acid deficiency among pregnant women was 8 per cent, almost half that for non-pregnant 15-49 year old women (15.3 per cent). However, significant numbers of children 6-59 months old (42.3 per cent), pregnant women (31.8 per cent), and non-pregnant women (39.7 per cent) had borderline levels, meaning that only 45.7 per cent of children, 60.2 per cent of pregnant women, and 45.0 per cent of non-pregnant women had safe levels of folic acid in their blood[27].

The prevalence of vitamin A deficiency among children aged 6-59 months was 23.2 per cent. This was less than half the figure of 2006, for both mild and severe vitamin A deficiency. A further 35.4 per breastfeeding remains so low in Kazakhstan, and what can be done to rectify this. Analysis by quintiles reveals that the poorest 20 per cent of children are significantly more under nourished than the richest 20 per cent. The most vulnerable children are almost five times as likely to be underweight than the richest 20 per cent, while in the height for age test, the ratio is 4:1[28].

The figures for exclusive breastfeeding up to six months in Kazakhstan remain a cause for concern. While exclusive breastfeeding rates increased from 16.8 per cent in 2006 to 31.8 per cent in 2010-2011, the lack of early

Figure 8: Exclusive breastfeeding rates



25. Kazakh Academy of Nutrition and UNICEF, National Nutrition Survey, 2008 and 2011.

26. UNICEF, The best beginning of life for every child, Date unknown, at http://www.unicef.kz/en/services/health_development/?sid=cds68hfr0vha06ug3fb04te4b4.

27. Ibid 14.

28. UNICEF, Analysis of Equity in Mother and Child Health in the Republic of Kazakhstan, 15 June 2012.

onset breastfeeding still leads to problems with respiratory diseases, hypothermia, diarrhea and infectious diseases among young children in the country[29]. Exclusive breastfeeding is found in urban areas more often than in rural areas (34.4 and 29.2 per cent respectively). In older age groups, urban children continue receiving breast milk more often than rural children.

Children of mothers who have a university education are more likely to be exclusively breastfed than children of women with lower education levels (34.8 per cent compared to 30.1 per cent)[30]. Analysis by quintiles reveals that the poorest 20 per cent of children are significantly more under nourished than the richest 20 per cent. The most vulnerable children are almost five times as likely to be underweight than the richest 20 per cent, while in the height for age test, the ratio is 4:1[31]

Recent surveys show that stunting rates remain high in Kazakhstan (17% in 2006) . Stunting is a clear indication of chronic malnutrition or repeated food deprivations and is specifically related to poor infant and young child feeding practices in the first two years of life. Similarly, iron deficiency anemia remains a public health problem, although measurement and monitoring challenges also persist. Additionally, recent data from MICS and other national surveys show a decline or no improvement in Universal Salt Iodization (USI) status after initial progress. All of this suggests that although there has been progress in nutrition, there continue to be challenges and these require thorough evaluation.

Advancing health gains and reducing child mortality in CEE/CIS countries requires better functioning health systems capable of delivering equitable and quality health services for mothers and children. Identification of barriers and bottlenecks arising, from the supply and/or demand side, and timely removal/reduction is a pre-requisite for implementing any effective public heath intervention and assuring effective coverage with Maternal, Newborn and Child Health (MNCH) services. Equitable and effective coverage means that all groups of the target population have access to quality services according to their needs and regardless of their capacity to pay. If, through this access, the population is offered quality health services matching their needs then access translates into improvement of population health and consequently helps reduce morbidity and mortality. Therefore, understanding the gaps between physical availability of services and effective coverage, and differences in coverage and bottlenecks for different groups and geographic areas is a critical element for equity-focused programming.

2.3.4. EARLY CHILDHOOD DEVELOPMENT

In Kazakhstan, only 47.8 per cent of children under five live in households where at least three children's books are present. The share of children with access to 10 or more books is only 26 per cent. While no significant gender differences are observed, urban children appear to have better access to children's books than those living in rural households. There is also a significant discrepancy between regions: while 72-80 per cent of families in Astana and Almaty cities have 10 or more children's books, in Kyzylorda, Mangystau, South Kazakhstan and Zhambyl provinces the figures range from 2.4 to 6 per cent of households. In rural areas only 13.9 per cent of families meet this indicator, compared to 38.9 per cent in urban areas. Other typical characteristics of families with fewer books are poverty, low educational attainment of the mother, and Kazakh ethnicity[33].

In 2011, 91.5 per cent of children under-5 years old had been engaged in more than four early learning activities with adult household members in the three days before being surveyed[34]. However, fewer than half (49.1 per cent) of fathers had been involved in any activities at all[35]. Meanwhile, 44.8 per cent of children

29. UNICEF Kazakhstan, Make Breastfeeding Easier for Mothers, 1 August 2012, at http://www.unicef.kz/en/news/item/425/?sid=cds68hfr0vha06ug3fb04te4b4.

30. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, Table NU.3 Breastfeeding, 2012.

31. UNICEF, Analysis of Equity in Mother and Child Health in the Republic of Kazakhstan, 15 June 2012.

32. www.childinfo.org (Last accessed 1 July, 2014).

33. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, 2012.

34. The figures in this section are taken from the Multiple Indicator Cluster Survey (MICS) carried out by the Agency of Statistics and UNICEF in 2010-11, Table CD.2, Astana, 2012.

35. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, 2012.

under five had two or more different types of playthings to play with in their homes. A total of 94.6 per cent of children play with toys bought from shops, and 41.7 per cent of children play with household objects. There is little gender or rural/urban difference for this indicator. However, children of mothers with poor educational attainment, children living in poor households, and children from South Kazakhstan and Atyrau provinces are significantly less likely to have two or more different types of plaything[36].

A total of 3.4 per cent of children under-five were left in the care of other children in the week before the survey, while two per cent were left alone in the week before the survey. A total of 4.4 per cent of children were left on their own or in the care of other children during the period. Inadequate care was more prevalent among children whose mothers had poorer educational attainment (10.2 per cent), as opposed to children whose mothers had degrees (3.3 per cent). Children aged 2-4 years were left with inadequate care more often (6.2 per cent) than younger children (1.7 per cent)[37].

2.3.5. CHILD ABUSE, VIOLENCE AND NEGLECT

There is little data on the scale or nature of childhood abuse, neglect and violence in the family and community in Kazakhstan. The 2011 MICS indicates that just under half of 2-14 year old children had experienced psychological or physical punishment from their parents, a slight fall from the 52 per cent reported in the 2006 MICS. The 2011 MICS figures are lowest in Almaty city (27.3 per cent), Astana city (38.6 per cent) and South Kazakhstan province (38.9 per cent); and highest in Kostanai province (72.6 per cent) and Mangystau province (65.3 per cent). Girls, children in the richest families, and children in families where the head of the household has a university degree are slightly less likely to receive such punishment, and there is virtually no rural/urban divide[38]. However it is unclear if this survey data reflects the full scale of the problem as there is no central database of cases where children have been referred following suspected abuse, and records are also not kept at the local level[39].

In general, little information is shared about children at risk of abuse, neglect and exploitation between hospitals, doctors, schools and pre-school providers and the Guardianship Authority when abuse is suspected. This is partly due to gaps in the referral systems in most areas. Even where referrals are made, several factors – including lack of training, low expectations that children should be protected from harm, a lack of mechanisms to deal with abuse, and the low level of local capacity- can in many cases mean that follow up is inadequate. Consequently, while a relatively high number of children currently live in state institutions, it is not clear whether these are the children who are most at risk of abuse, exploitation or neglect. It is likely that many children at risk of abuse, neglect and violence currently remain unidentified.[40]

The role of the Guardianship Authority under the Departments of Education is to determine whether to leave children with their families or take them into state care. However, a lack of training, capacity and resources, combined with weak coordination, an inadequate legal framework, and lack of clear guidelines in child protection referrals mean that, together, neither the local Children's Rights Protection Departments[41] nor the Education and Guardianship Authority are able to offer effective child protection services. As a result referrals are too often left to Police Departments of Minors, who have been trained to investigate crimes, not to assess the needs of children or to provide social work services to children[42].

36. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, 2012.

37. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, 2012.

38. Agency of Statistics, UNICEF and UNFPA, MICS 2010-11, and Agency of Statistics, UNICEF and UNFPA, MICS 2006, Table CP.4 Child Punishment, 2012 and 2007.

39. Children's Legal Centre, University of Essex, Child protection system in Kazakhstan: Draft Initial Report, 2010.

40. Children's Legal Centre, University of Essex, Child protection system in Kazakhstan: Draft Initial Report, 2010.

41. In 2013 the territorial Children's Rights Protection Departments of the Children's Rights Protection Committee under the Ministry of Education and Science of the Republic of Kazakhstan were abolished with the establishment of Children's Rights Protection Units subordinate to Akimats (local authorities). Their functions are being revised.

42. Children's Legal Centre, University of Essex, Child protection system in Kazakhstan: Draft Initial Report, 2010.

The Law on Domestic Violence outlines the specialized social services to be provided to victims of domestic violence, including children. According to the law, the police are responsible for identifying "parents or individuals caring for a child who fail to perform their parental rights and commit illegal acts."[43] The police also prepare cases to justify the need for protection and make suggestions in court regarding the type of punishment for individuals found guilty of domestic violence[44]. According to statistics from the General Prosecutor's Office for 2011, law enforcement officers recorded four cases of violence against children for that year[45].

In response to these concerns, a social work system has been introduced in Kazakhstan through the Law on Specialized Social Services, which was enacted to regulate provision of specialized social support to persons and families in particular need[46]. Specific authorities responsible for social protection, education, and healthcare are mandated to implement this under articles 8 to 10 of the Law. The Law includes the requirements for the qualifications and certification of social workers, though it does not set out explicitly the role of social workers. While this is an important development, social work functions have been assigned in the Law to three central-level bodies (in practice the Ministries of Social Protection, Education and Health), as well as local government. All three Ministries have issued secondary legislation to regulate the development of social work service provision in their areas of competence[47].

Under this secondary legislation, the Ministry of Health is responsible for "individuals recognized as being in difficult situations"; the Ministry of Education for orphans and children left without parental care, children with disabilities, children in street situations, children with behavioral problems, and families at social risk; and the Ministry of Social Protection inter alia for children with neuropsychiatric abnormalities, children with disabilities of the musculoskeletal system, and persons of no fixed abode[48]. Despite these developments, it appears that there is currently no central-level authority that has actively taken on the role of ensuring early identification and prevention of child abuse[49].

In this context, and as part of testing the Law on Specialized Social Services, two Family Support Centres were opened in East Kazakhstan province; one in the Oskemen area and the other in Semey. East Kazakhstan province and Semey Akimats have since scaled up this process and opened up six more centres around the region[50]. These centres are intended to provide valuable support to families in challenging situations, who may otherwise find it difficult to retain care of their children. In effect, these services work to keep children within their birth families, and prevent them from being placed in state institutions. Reportedly, the centres largely live up to international standards[51].

The Family Support Centres in East Kazakhstan report to the provincial education department, and provide free social, psychological and legal support to families and children. Families are referred to the centres because of reported neglect of the children, or because the parents asked for the children to be taken into state care. Usually the neglect results from neglect experienced by mothers in their own childhood, and consequent difficulties in bonding with their children. Material poverty can also be a factor in neglect. However, child abuse affects children from all strata of society[52].

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43. Law on Domestic Violence, Article 10(4).

44. Law on Domestic Violence, Article 10(4).

45. Analysis of situation of women and children in Kazakhstan, UNICEF, 2012.

46. Law 114-IV ZRK on Specialized Social Services, 13 February 2009, available online (in Russian) at http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/83933/93012/F1119530410/KAZ83933.pdf.

47. Ministry of Health Order 630 of 30 October 2009 "On approval of standards for provision of social services in the field of health."; Ministry of Education Order 526 of 18 November 2009 "On approval of standards for provision of social services in the field of education"; and Government Decision 1222 of 28 October 2011 "On approval of standards for social services in the field of social protection".

48. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

49. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

50. Oskemen Education Department Family Support Centre with UNICEF, Mapping of specialized social services in EKO, 2012.

51. Children's Legal Centre, University of Essex, Child protection system in Kazakhstan: Draft Initial Report, 2010.

52. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

2.3.6. CHILDREN WITH DISABILITIES

As of 1 January 2013 there were 65,844 children with disabilities in the country, of whom 57,627 were under 16 (1.2 per cent of all children under 16 in the country)[53]. However, this is much lower than the normal rate of disability in childhood in industrialized countries, which has been determined to be at least 2.5 per cent (with 1 per cent having serious conditions)[54]. In contrast, the Ministry of Education and Science reports that 151,216 children in the country have special needs[55]. Even when bearing in mind that this includes children up to 18 years, it is still a much higher proportion of children.

These different figures arise because the various Ministries assess children's conditions in diverse ways. The Ministry of Education and Science figures include the hearing impaired, the visually impaired, those with speech disorders, those with disorders of the musculoskeletal system, those with mental retardation and intellectual disabilities, those with emotional and behavioral disorders and those with multiple disabilities. Meanwhile, the Ministry of Labor and Social Protection includes those children with persistent disorders of body functions, caused by disease, injury, and their consequences, and defects, which lead to restrictions in their lives and the need for social protection[56]. While children assessed as having disabilities by the Ministry of Labor and Social Protection are entitled to certain benefits and some equipment, this does not apply to more than half the children registered with special educational needs by the Ministry of Education and Science. This means that there is no comprehensive interagency approach to addressing the needs of all children with disabilities. This report uses the term "children with disabilities" to refer to all children with disabilities in the country, whether or not they have been registered as such.

Despite efforts made by the State to facilitate life for children with disabilities, there are still barriers to their leading full lives in the community. For instance, public transportation, residential buildings, office blocks, pavements, subways and public toilets are not adapted for the needs of persons with disabilities, and there are not enough traffic lights emitting sounds to indicate when it is safe to cross[57]. Social programs for children with disabilities are inadequate: the Ministry of Labor and Social Protection began to introduce day care services in 2009 in connection with reform of the social care system and closure of some residential institutions[58].

While the Ministry of Labor and Social Protection reportedly has employed 12,101 social workers for children with disabilities[59] and a system has been developed by the Ministries of Health, Education and Science, and Labor and Social Protection to perform a multidisciplinary assessment of children's needs and draw up individual care plans[60], problems remain regarding strategic planning, contracting and managing the expansion of social services due to the fact that the management system for social work has not been defined. Meanwhile, children with disabilities are not generally integrated into mainstream schools[61] and not enough supplies for persons with disabilities are produced in the country. In addition, there are not enough civil society

53. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

54. See European Academy for Childhood Disability, Provision of Services for Children with Disabilities in Central and Eastern Europe and the Commonwealth of Independent States, UNICEF, December 2003.

55. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

56. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

57. S. Bulekbayeva, Problems of disabled children, Scientific Practical Journal of Medicine, "Vestnik KazNMU", Sep. 2011.

58. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

59. Ministry of Labour and Social Protection, State Social Assistance on 1 November, December 2012, at http://kontrast.enbek.gov.kz/en/node/267821.

60. Ministry of Health Order 186 of 18 March, 2010; Ministry of Education and Science Order 125 of 18 March, 2010; Ministry of Labour and Social Protection Order 89-p of 17 March, 2010.

61. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

organizations working at policy level to support persons with disabilities[62] and not enough supplies for persons with disabilities are produced in the country.

Many children with special needs remain at home with their families and may receive no education at all. Public attitudes remain extremely negative and discrimination frequently leads to social and economic exclusion both for the child and his or her family. Female relatives of people living with disabilities in particular may suffer from reduced marriage prospects[63].

In the early 2000s, several new laws were adopted affecting children with disabilities and their carers: the Law on Social, Medical and Educational Support for Children with Disabilities, the Law on Social Protection of Persons with Disabilities in the Republic of Kazakhstan, the Law on Special Allowances in the Republic of Kazakhstan, and the Law on State Social Benefits for Disability, Loss of Breadwinner and Age in the Republic of Kazakhstan. These laws constituted an important step in the development of social protection for children with special needs in the country[64].

Of particular relevance is the 2008 Law on Specialized Social Services, which provides for interagency coordination in the delivery of social services, especially between education, health and social protection authorities[65]. The implementation of the Law has reportedly led to changes in the attitudes of parents, who are now less likely to abandon children with disabilities, and instead keep their children and seek assistance from health and social professionals to assist the children's development[66].

A 2012 assessment of the implementation of the Law on Specialized Social Services reveals that not all children with the right to receive such services under the Law can in fact access them. While under the Law children with disabilities are entitled to access day-care facilities, the analysis shows that they are faced with waiting lists for these facilities, although they can still easily be admitted to residential care. Children with disabilities in some rural areas that have neither state-run day care centres nor NGO service providers have no access to day care services at all[67].

The analysis also shows that there are significant variations in the cost of specialized social services between regions. In Atyrau province the average cost of home-based care for a child with a disability is 80,000 Tenge ($530) per year, while in Almaty city it is 218,000 Tenge ($1440). Significant regional differences also exist in the residential and semi- residential care facilities for children with disabilities, meaning that children in different regions may receive different qualities of services. However, the Ministry of Labor and Social Protection is currently working to define a common approach to funding social services and regulatory requirements for organizations providing social services, taking into account regional issues, and thereby establishing a common mechanism in calculating the cost of social services per person per day[68].

62. S. Bulekbayeva. Problems of disabled children. Scientific-Practical Journal of Medicine, "Vestnik KazNMU". Sep. 2011. It should be noted, however, that at the level of provision of services to children with disabilities, civil society organizations have begun playing a much larger role: the number of NGOs involved in such services under the state social order process increased from 4 in 2007 to 47 in 2012 [information provided by Ministry of Labour and Social Protection].

63. OSI, Children with Special Education Needs in Kazakhstan, Kyrgyzstan and Tajikistan, 2009, at http://www.opensocietyfoundations.org/sites/default/files/special-education-en-20091207.pdf, p. 9.

64. Aleksandr Kovalevskiy, Evaluation of Implementation of the Law on Specialized Social Services in the Republic of Kazakhstan with regard to children and members of their families, UNICEF, December 2012.

65. Law No.114-IV 3 of 29 December 2008.

66. Aleksandr Kovalevskiy, Evaluation of Implementation of the Law on Specialized Social Services in the Republic of Kazakhstan with regard to children and members of their families, UNICEF, December 2012.

67. Aleksandr Kovalevskiy, Evaluation of Implementation of the Law on Specialized Social Services in the Republic of Kazakhstan with regard to children and members of their families, UNICEF, December 2012.

68. Analysis of the situation of women and children in Kazakhstan, UNICEF, 2012.

The 2012 assessment also shows that monitoring of the specialized social services is focused on quantity (types of services, number of services, number of visits, demographics of the client) rather than quality of services. Specific indicators measuring the quality of specialized social services and the progress of the beneficiary should be introduced to better monitor the results and impact. Meanwhile, the assessment for supporting children with special needs remains focused on the medical categorization of the child's disability rather than determining the needs of the individual child. This assessment is undertaken by the Pedagogical, Medical and Psychological Committee (PMPHC), a group of professionals from different disciplines who describe and define the additional needs children may have, so that the children can be allocated an appropriate level or type of education.

The PMPC can recommend to the Guardianship Authority that a child should be placed away from the family home or sent to a special school. Experts suggest that the PMPC needs to move away from isolating children with additional needs by limiting educational and social opportunities and become an organization facilitating the educational and social integration of children[69]. Another recent study notes that even with a reduction in the number of children with special needs who are institutionalized, it is rare to see children with special needs in the community. A lack of infrastructure makes it difficult for children with mobility limitations to move around. Furthermore, there has been a lack of ongoing support to parents of disabled children for respite care, financial support, and appropriate educational facilities[70].

69. Children's Legal Centre, University of Essex, Child protection system in Kazakhstan: Draft Initial Report, 2010.

70. Karen Malone with Marion Sturges, 'Child Friendly Kazakhstan: Background Paper', Research on the Child Friendly Cities initiatives and development of Child Friendly Cities certification standards and an accreditation scheme for Kazakhstan, UNICEF Kazakhstan, 2011, p.4.

PART 3:

DESCRIPTION OF THE CURRENT PATRONAGE NURSING SYSTEM

This chapter addresses key national aspects of PHC in Kazakhstan, and the Patronage Nursing System (PNS) in particular, including policy and legislation, financial arrangements, workforce, provider education, quality assurance and patient role. The chapter is organized according to health system function and the dimensions used in the PNS Scheme. It provides the general context for the results of the quantitative and qualitative data collection described in the previous chapter.

3.1. STEWARDSHIP AND GOVERNANCE

With the rapid economic growth after the turn of the century, the government undertook several policy initiatives to reform the health care sector, including Primary health Care (PHC). One major step forward was Presidential Decree No. 1438, which was issued on 13 September 2004 and called the State Programme for Health Care Reform and Development in the Republic of Kazakhstan for 2005–2010. The named Programme has aimed to prioritize the development of PHC and prevention in Kazakhstan in line with international principles, and to increase PHC financing to 4% of the total state budget for a guaranteed package of health services. The Programme period was divided into two implementation phases, 2005–2007 and 2008–2010. The second phase has been designed to reform PHC in conformity with general practice principles, notably by having the medical universities retrain therapists as GPs, the core PHC providers, and changing the financing scheme for PHC organizations to one based on capitation and partial fundholding. The Programme has also overseen a gradual introduction of GPs in urban areas. As a first step, several age- and sex-specific urban polyclinics have been merged into facilities that serve all ages and both sexes.

By the end of 2005, the Government published Resolution No. 1304, about measures to improve primary care for the population of the Republic of Kazakhstan. Resolution No. 1304 set formal standards for the network of PHC organizations and facilities in the country, based on the size of the population served and the distance of PHC clients from the facilities. It proclaimed the stepwise introduction of a GP-based PHC system by training GPs and retraining district therapists. By the end of 2009, 30% of physicians in PHC were to be retrained GPs. Furthermore, the Resolution announced that PHC services would be provided in the following types of facilities: polyclinics (multi-specialist facilities that would include general practice departments) in settlements with populations of at least 30 000, as well as district capitals; PHC centres in settlements with a population between 5000 and 30 000; ambulatories in settlements with a population between 2000 and 5000, as well as in rural areas with populations between 1000 and 5000; and medical points in settlements that have between 50 and 1000 people and are situated at least 5 km from the nearest PHC facility.

A third policy document relevant to the development of PHC in the country is Decree No.124 issued by the Ministry of Health in March 2006, which focused on the functioning of medical organizations providing PHC services. This decree included: a description of the structure of PHC organizations, functions, regulations regarding the functioning of PHC organizations, specification of PHC providers, approval of staffing norms and a definition of minimal norms for the medical services PHC organizations have to provide.

To support the reform programme, a health code was instituted in September 2009. The Health Code aimed to harmonize existing legislation on public health and bring it more in line with international standards. Specifically, the code addressed: quality improvement in health care services; accreditation of health care facilities; a supply of high-quality medical products; establishing standards for medical equipment; prioritization of PHC funding the professional autonomy of health care providers and reform of continuing medical education.

In response, the State guaranteed Basic Benefit Package (BBP) was formed covering primary health care and in-patient care. The primary health care component of the state guaranteed BBP covers prevention, diagnosis, treatment of acute and chronic patients in outpatient settings, medical rehabilitation and referral of patients for special care (Figure 9).

In support of the PHC sector reforms the Ministry of Health issued a number of regulatory documents. One such document was the MoH Decree No. 164, March 2011, on measures to improve medical care in the field of maternal and child health. The given decree establishes an enabling environment for the operation of the

Figure 9: State guaranteed Basic Benefit Package

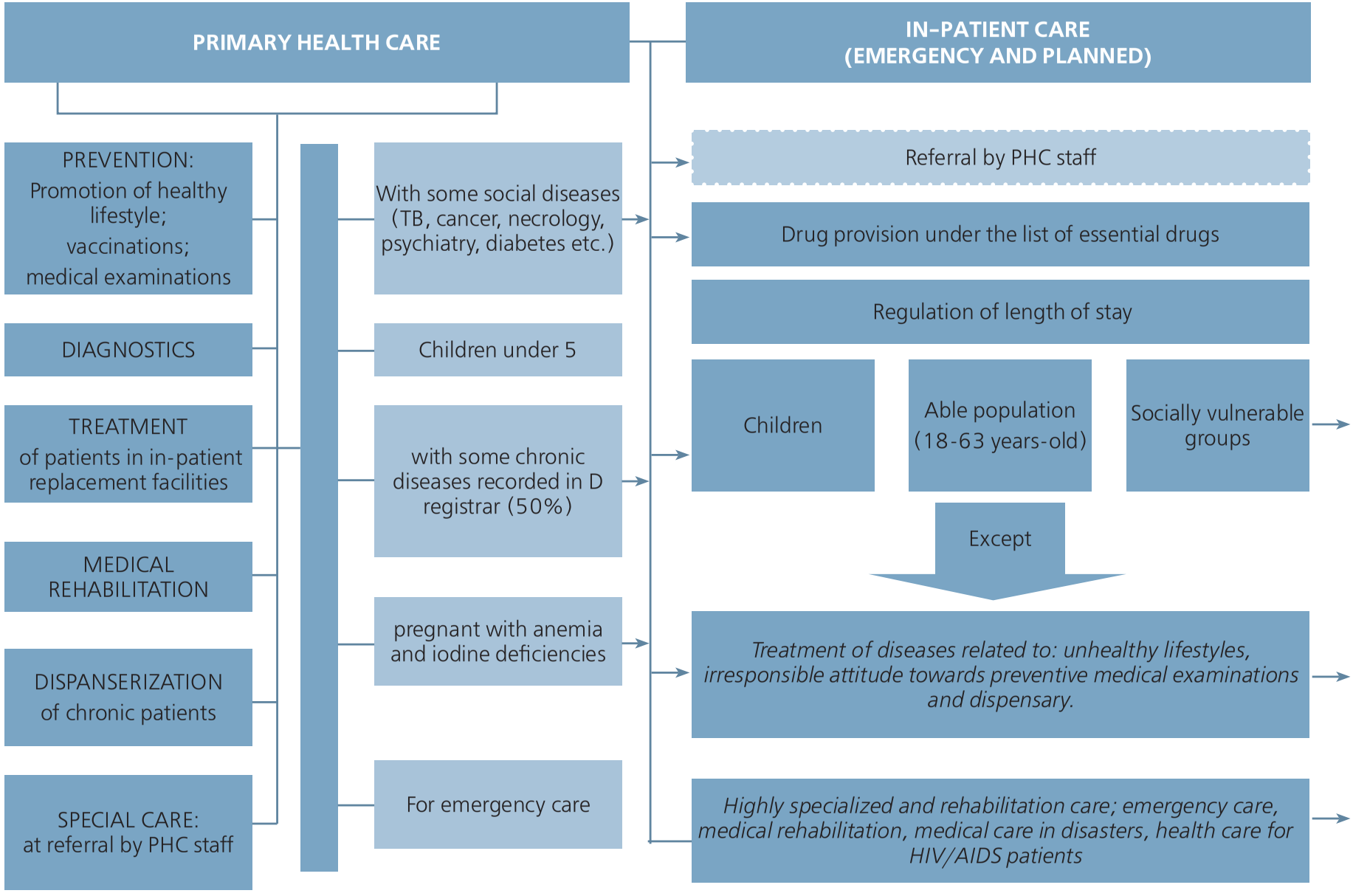
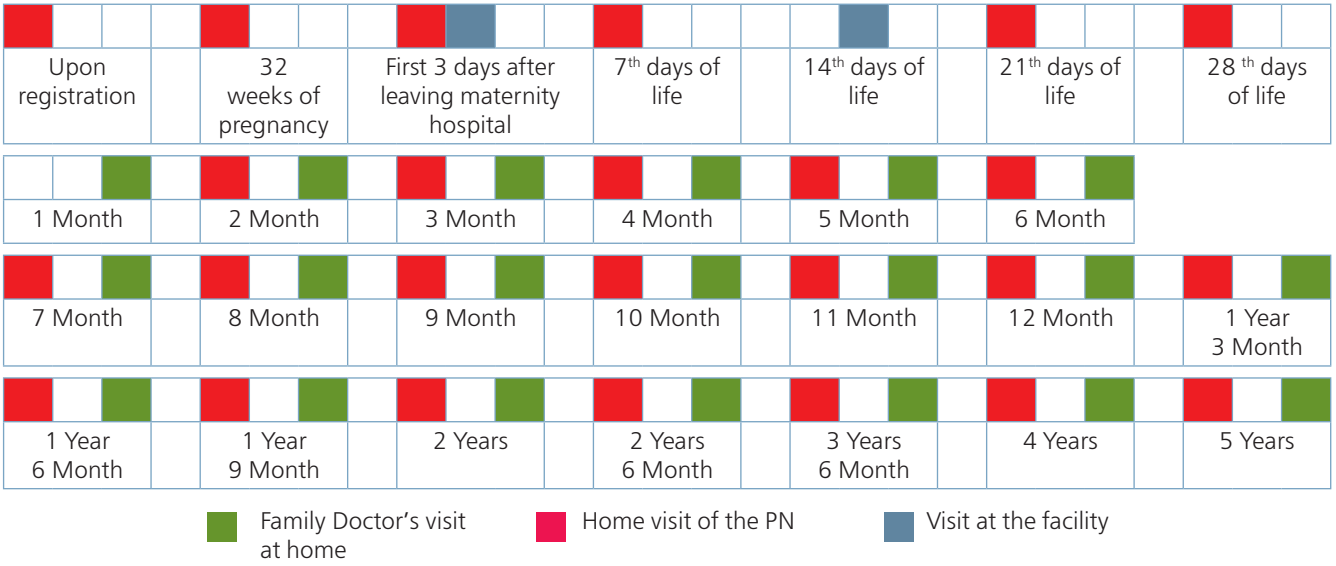


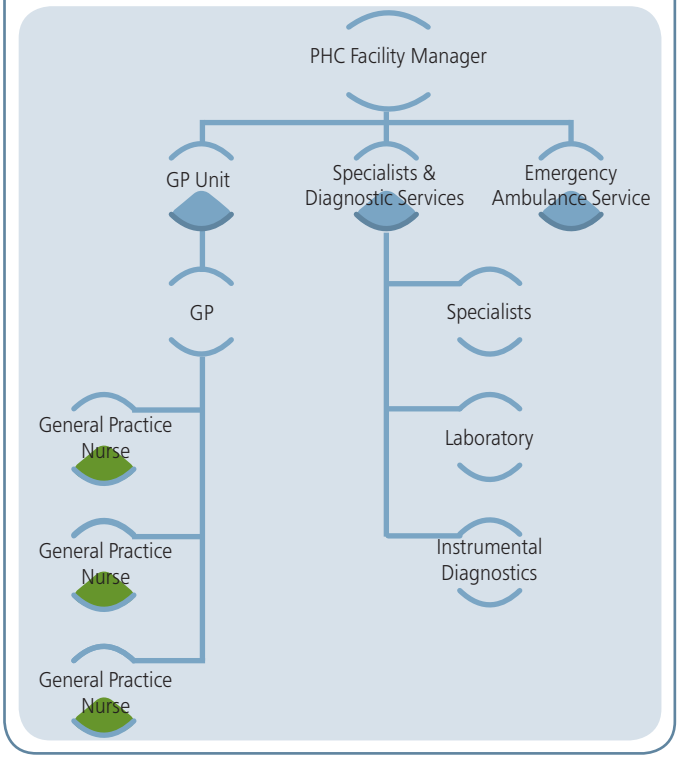
Figure 10: Number and timing of home and office visits for children U5 and pregnant women



"Health Child Cabinet" in all PHC facilities, as an organization sub-division responsible for continuous education of medical personnel in health promotion and prevention related counselling of caregivers and children.

The same decree defines the roles and responsibilities of the PHC preventative function and regulates the system of Patronage Nursing. The decree defines the target population (pregnant women, postpartum women, children 0-5 years) as well as the number and timing of home and PHC office visits alongside a basic set of activities/services/procedures to be provided by the patronage nurse to the target individual. Schematically, the number, timing and type of consultancy are provided in Figure 10.

Figure 11: Organization and Management of Patronage Nursing System



Patronage nurses are responsible for visiting pregnant women during the antenatal period twice and provide services described in Figure 10 above. The organization of the patronage services differs depending on the type of PHC facility (Figure 11). In the case of General Practice based PHC facilities, a team, represented by one GP and three General Practice nurses, is solely responsible for coordination of activities in order to provide effective prevention, promotion and care services to the population under their list. In a given model home visiting (HV)/patronage is proposed as a function of General Practice nurses in GP teams. The target population is equally distributed to each nurse for HV/Patronage services and nurses provide HV services every working day.

In the case of the old style specialized PHC facilities, pregnant women are the responsibility of the Gynecologist, whilst children are taken care of by the District Pediatricians and District Nurse.

In 2008 the Republic of Kazakhstan adopted a Law on "Specialized Social Services". According to the provisions of the law, the Ministry of Health

adopted Decree No. 630 and 907 in 2009 and 2011, which regulates recruitment of the social workers in health facilities, their functions and reporting forms. According to the decree, the social workers deployed at the PHC facility are responsible for provision of socio medical, psychological, legal, vocational, employment and other services. Special social health services are provided to a person (family) in difficult life situations and include a complex of available, special social services provided at the level of individual, family and society by: Counselling (individual or group); Active attendance, surveillance and home care (nursing and social support); Assistance (counselling) for "helpline"; Creation of support groups, trainings, works with initiative groups and self-help groups.

In order to enhance preventive activities of the health care system, another important regulation issued by the Ministry is Decree No. 685 of 2009 on screening programs for the children and adult population, its frequency and organizations responsible for implementation of screening programs. The schedule of screening programs for children is provided in Table 4 below. According to the decree, the PN is responsible for notification and ensuring that a child receives the assigned screening as per the schedule by contacting the caregiver either by phone or through a home visit.

Table 4: Screening of health status of children

	Pediatrician/GP	Surgeon	ORL	Neurologist	Dentist	Ophthalmologist	Endocrinologist	Gynecologist	Blood test	Urine Test	Test on Helmint	ECG
1 Year	+	+	+	+		+			+	+	+	
2 Year	+				+	+					+	
3 Year	+	+			+	+					+	
4 Year	+				+						+	
5 Year	+				+						+	
6 Year	+	+	+	+	+	+			+	+	+	
7 Year	+				+						+	
8 Year	+				+						+	
9 Year	+	+	+		+	+					+	
10 Year	+				+		+				+	
11 Year	+	+	+	+	+	+			+	+		
12 Year	+				+							
13 Year	+				+							
14 Year	+	+	+	+	+	+			+	+	+	
15-17 years girls	+				+			+				+
15-17 years boys	+	+	+	+	+	+			+	+	+	+

3.2. RESOURCE GENERATION

3.2.1. WORKFORCE

Table 5 lists the national norms for the number of people that GPs, district therapists and district pediatricians should serve. Although GPs have a much more comprehensive range of tasks, their normative practice population is only 200 less than district therapists. Moreover, in international comparisons, 2000 patients for GPs and 2200 adults for district therapists are considered large practice populations. The national norm for district pediatricians is 900 children age 18 and younger. Each GP and pediatrician has two nurses in the team responsible for patronage services.

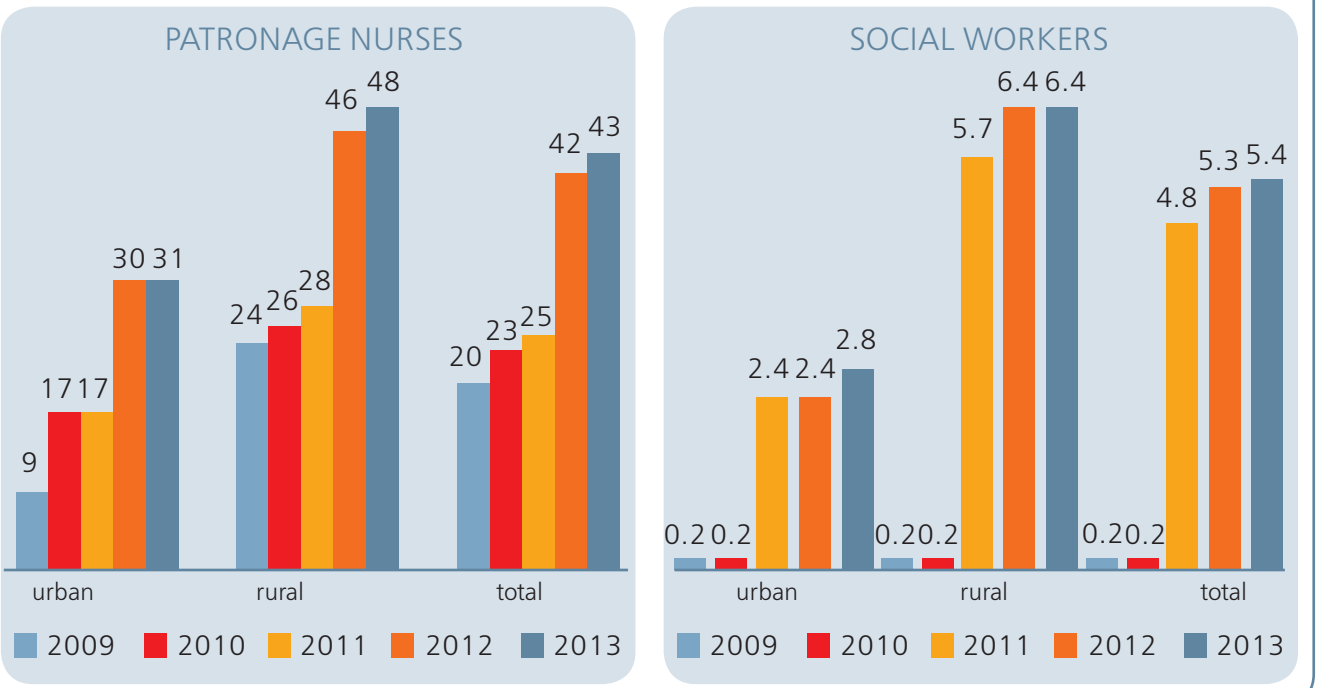
Table 5: Population served by full-time PHC workforce (official norms)

TYPE OF PHC PHYSICIAN	POPULATION SERVED
GP	2 000[a]
District therapist	2 200[b]
District pediatrician	900[c]
Patronage Nurse	Per physician
Social Worker	10 000

a- All age groups, b-older than 18, c-18 and younger.

According to the WHO PHC system evaluation report in 2009, the PHC system faced staff shortages. In particular, severe shortages have been reported among GPs all over the country. For PHC nurses, midwives, feldshers

Figure 12: Average number of Patronage Nurses and Social Workers per facility by the type of catchment area (2009-2010)

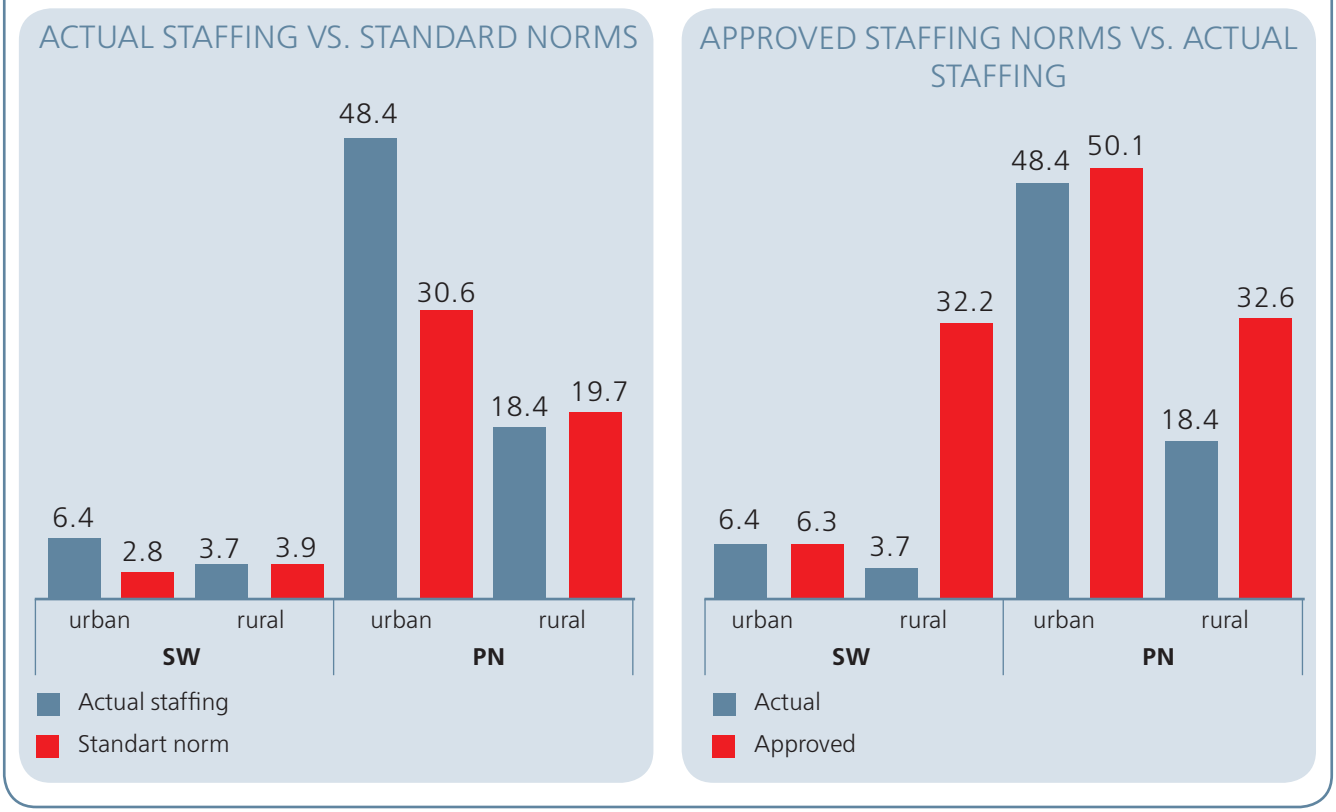


and gynecologists, national shortages also existed, albeit to a lesser extent. In general, shortages observed were much more acute in sparsely populated regions than in the more urbanized ones.

The PNSA shows a gradual increase of PNs and SWs in the system as exhibited in Figure 12 below.

However, the actual number of PNs and SWs deployed in PHC facilities of urban and rural areas demonstrates imbalances in staff distribution. PN actual staffing is much higher than the standard norm defined by the regulation in rural areas, whereas in urban areas it falls slightly short (Figure 13). SWs are in access in rural areas, whilst in urban areas the number is close to the established norm.

Figure 13: Comparative analysis of PN and SW staffing

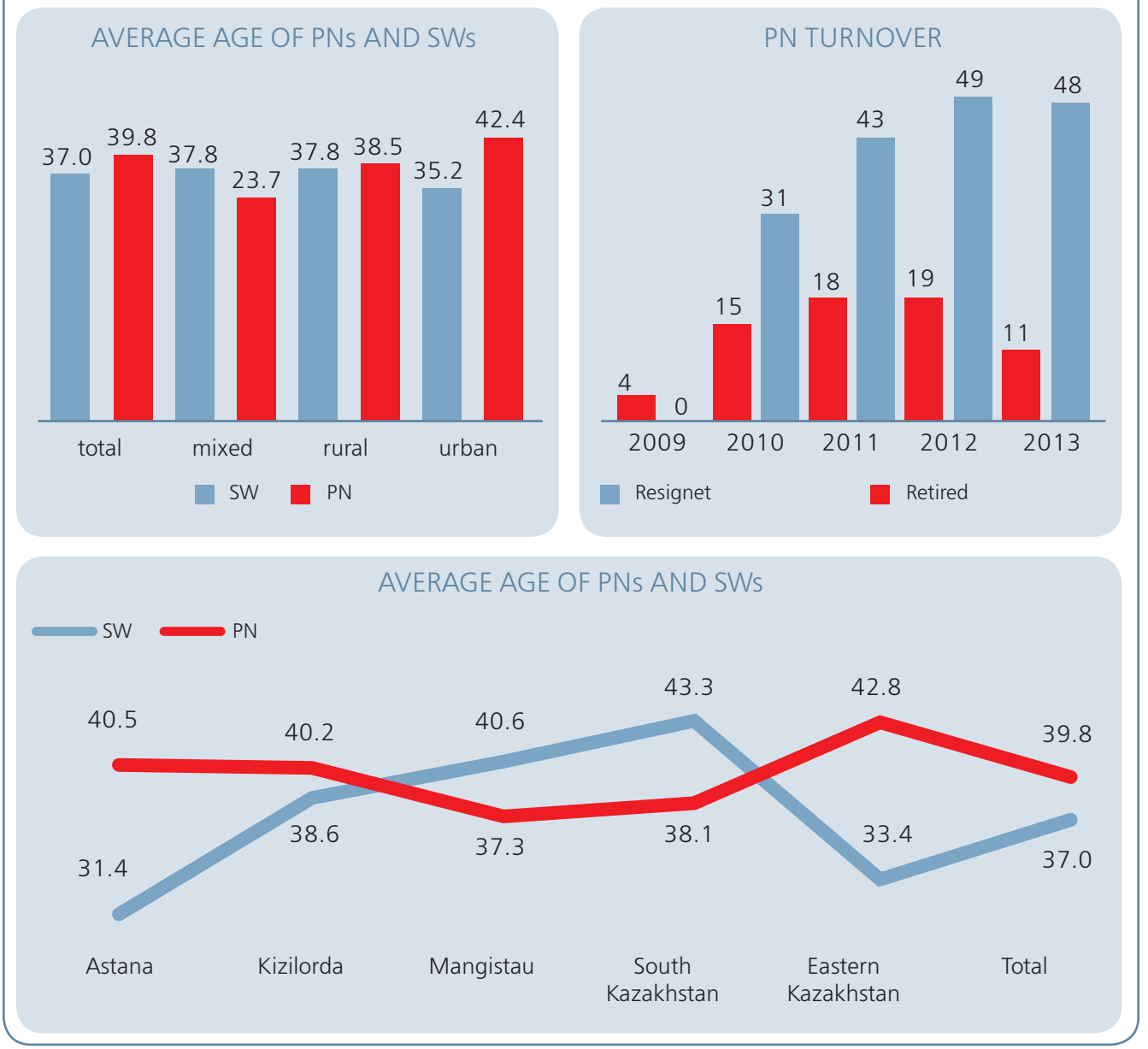


If the actual number of staffing is compared to national standards and approved staffing norms of facilities in 2013, it becomes obvious that staffing norms approved by local governments and standard norms regulated by the government differ. According to key informants, norms are defined according to the needs of a particular geographical location and the needs of the local community. Furthermore, imbalances revealed in staffing, especially in rural areas, can be explained by the fact that most of the staff occupies less than the full staffing norm in some cases due to the workload and long distances for patronage home visits.

The average age of PNs is about 40 years and 37 years for SWs (Figure 14). Average age differences are not significant between rural and urban settings and between regions, except in Astana and East Kazakhstan where the average age of SWs is 31.4 and 33.4 years respectively.

The relatively young age of PNs can be explained by an increase in retirement and replacement with younger PNs, as well as increasing resignation of PNs from their positions. Anecdotal evidence suggests that the health workforce resigns and migrates to other countries, mostly Russia, for better payisn't this a generalisation? Does it happen in particular regions or nation-wide?

Figure 14: Average Age of PNs and SWs and staff turnover tendency



3.2.2. EDUCATION & REMAINING TRAINING NEEDS

91 percent of all practicing PNs and 97.3 percent of SWs have specialized education.

PNs and SWs deployed in the PHC system demonstrate extensive work experience in the medical sphere in general and on the given position in particular (Figure 15). PNs exhibit longer work experience in the field (almost 19 years) and as patronage nurses (12 years), whilst SWs on average have worked about 9.5 years in the health care system and a SW in PHC only 3.5 years. The fact that the deployment of SWs in the health sector is a relatively new strategy, introduced only in 2009, explains these differences between PNs and SWs.

Before recruitment the majority of PNs and SWs received orientation training at the health facility (Figure 16), including classroom training on practice guidelines and documentation, and attained practical experience in home visiting with senior, experienced staff.

Figure 15: Average work experience in medical sphere in years

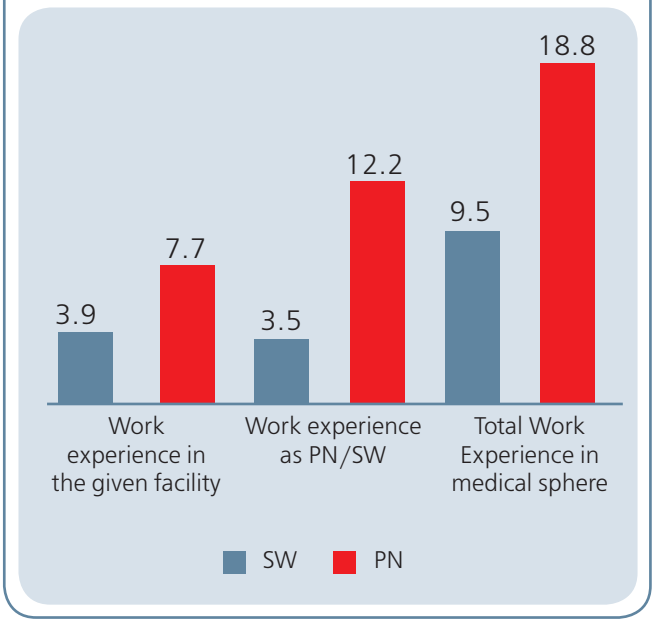
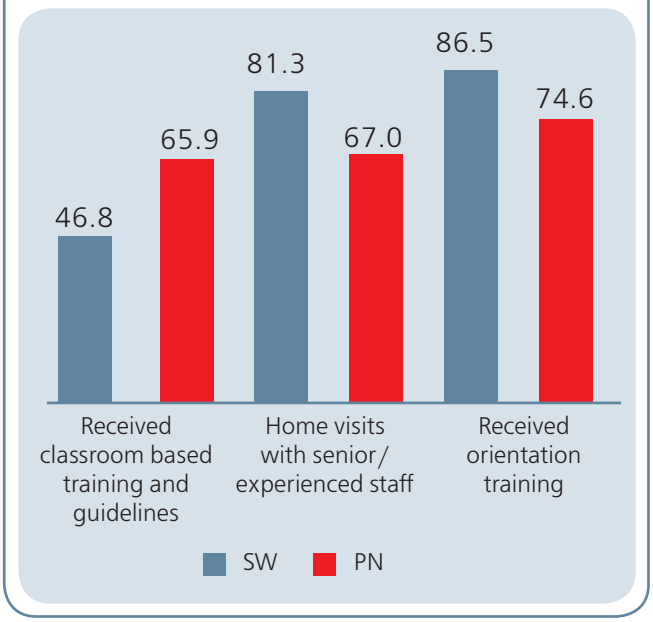
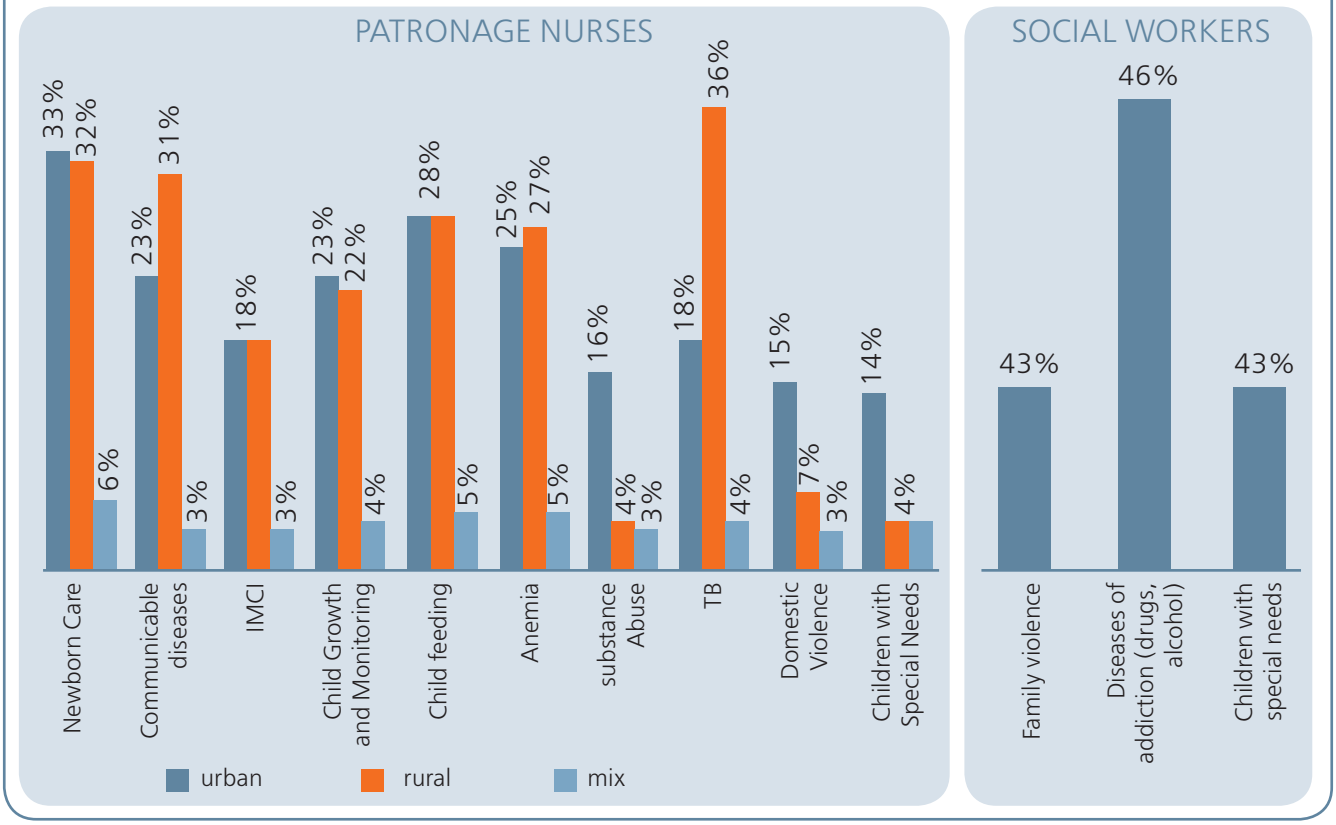


Figure 16: Share (%) of PNs & SWs who received orientation training



Although on-the-job training as part of the continuous professional education program is given due attention in Kazakhstan, it seems to be less oriented towards the actual needs of the health and social professionals. According to PNSA findings, the majority of PNs and SWs received some kind of modular trainings (Figure 17), though coverage with these training modules differs significantly between the workers by geographical location.

Figure 17: Key Training Courses attended by the majority of PNs and SWs in the last three years



With the rapid expansion of functional responsibilities during the last couple of years, assessment results speak about the absence of a standard package of training courses that every PN and/or SW has to be trained in as part of their continuous professional development. At the same time, it is commendable that due attention has been paid to issues such as domestic violence, substance abuse, management of individuals with special needs, child nutrition, communicable diseases, newborn care etc.

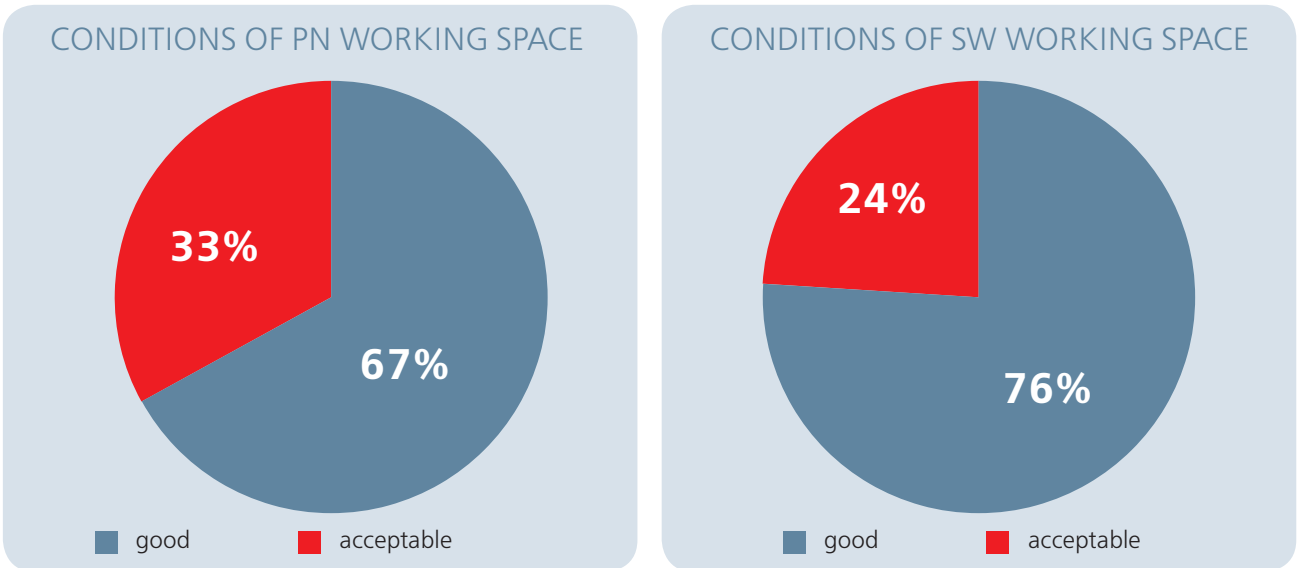
Nevertheless, PNs and SWs surveyed by the PNSA revealed unmet training needs, defined by lack of knowledge and/or practical skills, as well as by the services not covered by their functionality but required by the community.

3.2.3. FACILITIES AND EQUIPMENT

The technical means, as a quality precondition for patronage nursing services, have been examined through the spatial and infrastructural conditions, as well as in terms of equipment necessary for performing the services in the field. The absolute majority (94%) of PNs and SWs surveyed find access to the PHC facility easy; only 6% experience difficulties getting to the facility due to the long travel distance from their residency.

About three quarters of surveyed PNs share the office with physicians (GP/Pediatrician/Internist), whereas the majority of SWs have their own office space. Both PNs and SWs find the conditions of their offices acceptable (Figure 18).

Figure 18: Working space conditions



Notably, two thirds of PNs and SWs reported having all required equipment and material supplies available for work, however based on the analysis of the data collected during the PNSA, the standard list of equipment, supplies, and job aids have not been defined by the MoH. The list of available items differs from facility to facility. PNs often request a standard set of job aids packed in a "Patronage Bag". The most frequently requested missing items and/or items in short supply at facilities are as follows:

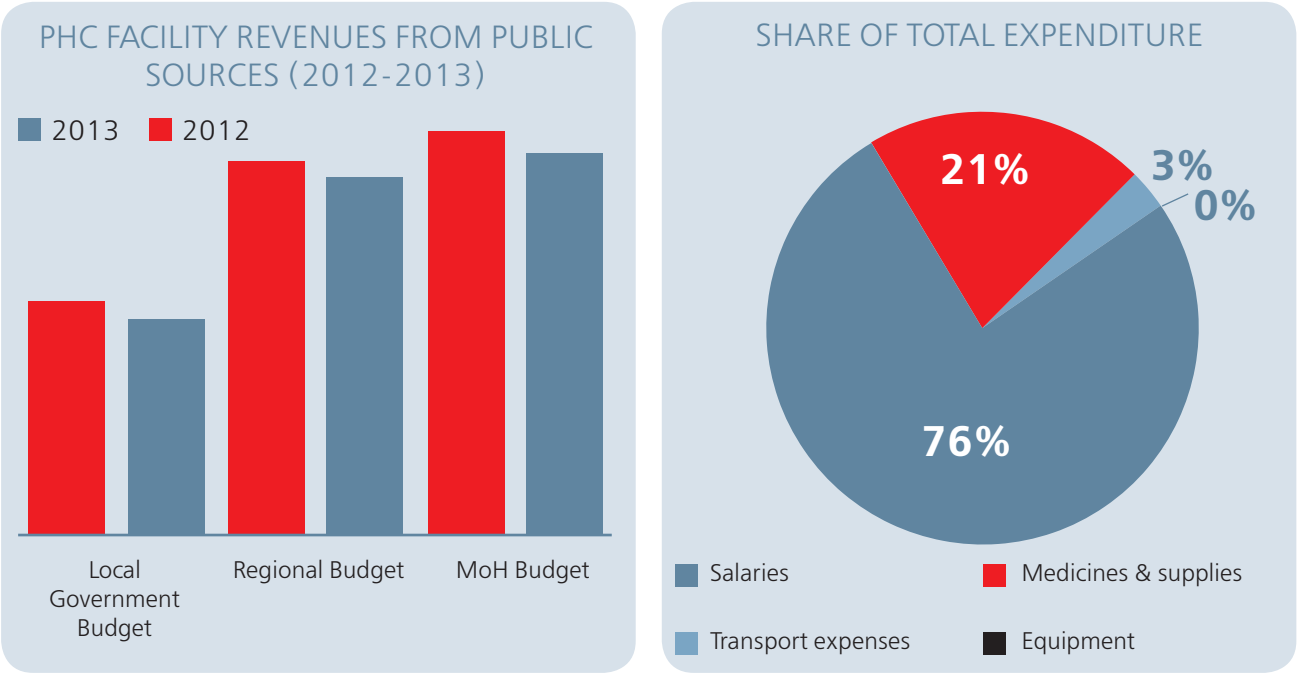
- **Office equipment** – computer, printer, stationery
- **Office furniture** – table, chair, examination couch
- **Patronage bag** – content to be defined
- **Information materials** – leaflets for parents, caregivers, family members, children with disabilities etc.
- **Transportation means** – vehicle and/or bicycle, payment for transportation
- **Communications** – monthly payment for mobile communication costs.

3.3. FINANCING & INCENTIVES

3.3.1. FINANCING

The PHC system is mainly publicly funded, although for some selected services (not covered under the BBP) PHC facilities are allowed to generate private revenues. The share of private revenues differs between facilities from 20% (urban) to 50% in urban areas. The main public sources for PHC funding are local government budgets for urban PHC facilities, whereas rural facilities may be eligible for funding from central, oblast and local government budgets. A funding increase is revealed between 2012 and 2013 in almost all PHC facilities surveyed. Facilities that were eligible for receiving a portion of funding from central and oblast governments demonstrate a 9% and 4% increase respectively. A 4% increase is observed in funding of PHC facilities by local government over the same time period (Figure 19).

Figure 19: Annual facility revenues from public sources and expenditures



Primary health care is financed based on the capitation principle and recently PHC facilities received a fund-holding function. Only a few of the facilities surveyed (2-3%) had a separate budget line dedicated to a home visiting system, whereas others find it difficult to separately analyze expenses incurred for provision of home visiting services. Therefore, the analysis is limited to examining the overall expenditures for four key expenditure categories (Figure 19). 76% of the PHC facility budget is spent on payroll, 21% on medicines and consumables, and only 3% on transportation, which covers emergency ambulance services as well as transportation expenses for home visits by patronage nurses and social workers. Based on the findings regarding the availability of all necessary medical and office equipment for the patronage system, it becomes obvious that current expenditures are not sufficient to provide adequate supplies and means for an effective home visiting function.

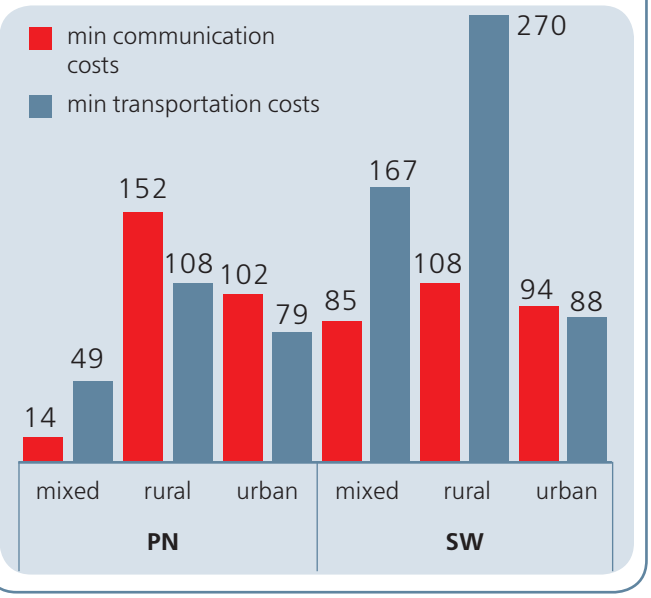
3.3.2. REMUNERATION & INCENTIVES

Salaries of patronage nurses vary between facilities depending on the professional category and shifts. The average salary of PNs is 40,297 Tenge per month. For SWs, the average salary is 28,068 Tenge.

Financial incentives are not practiced in the PHC system; rather, assessment results revealed that PNs and SWs often have to cover transportation and communication expenses themselves in order to fulfill their duties. This potentially serves as a perverse incentive for effective service provision.

Only 48% of PNs and 42% of SWs reported the facility covering transportation and communication expenses. The minimum and maximum monthly expenditure for transportation and communication differ between PNs and SWs, as well as according to the geographical location of the facility (Figure 20).

Figure 20: Personal Expenses for Transportation and Communication



3.4. SERVICE DELIVERY

Regulation requires PNs and SWs to work eight hours per day. According to PNSA respondents around 95% of SWs work eight hours, whereas only 42% of PNs work eight hours per day (Figure 21), out of which four hours are dedicated to home visits.

The patronage nurse spends the first half of the working day (four hours) in the office. During this time the PN: assists the GP or pediatricians in patient visits; deals with administrative work; prepares reports, lists of people eligible for different screening programs, a list of children to be immunized, and a list of home visits; invites people for regular screening programs either by phone call or includes them into the list of home visits; and performs other administrative work as prescribed by the GP and/or department head. The remaining four hours are used for home visits (planned and emergency). In contrary to PNs, SWs are more flexible to plan their working day.

Planning of daily home visits by PNs and SWs is schematically provided on Figure 22 below. Every morning the PN receives information from the facility registration office about requests for emergency home visits and names of newborns and children discharged from the maternity hospital. Based on the consultation with the GP, the patronage nurse defines the lists of newborns and discharged patients to be visited on that day. Based on this information and planned visits to children for regular follow-up and/or screening programs, the PN develops a list of home visits to be performed on that day and leaves for the home visits in the second half of the working day. The next morning the PN briefs the GP about performed home visits and, when applicable, alerts the GP to findings that require involvement of the social worker and/or doctor or other specialists.

Figure 21: Working shifts

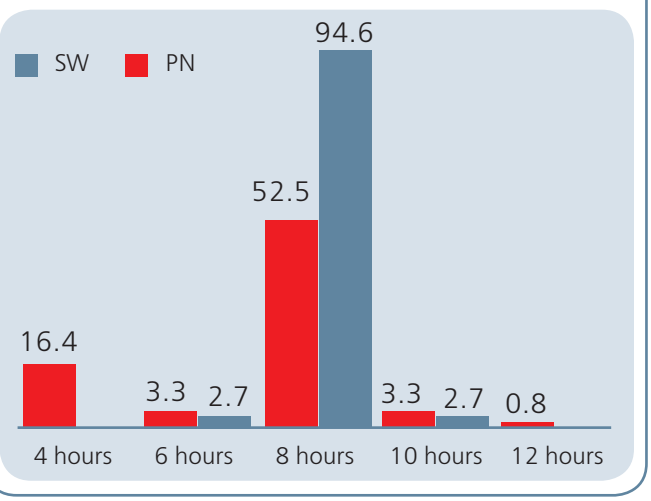
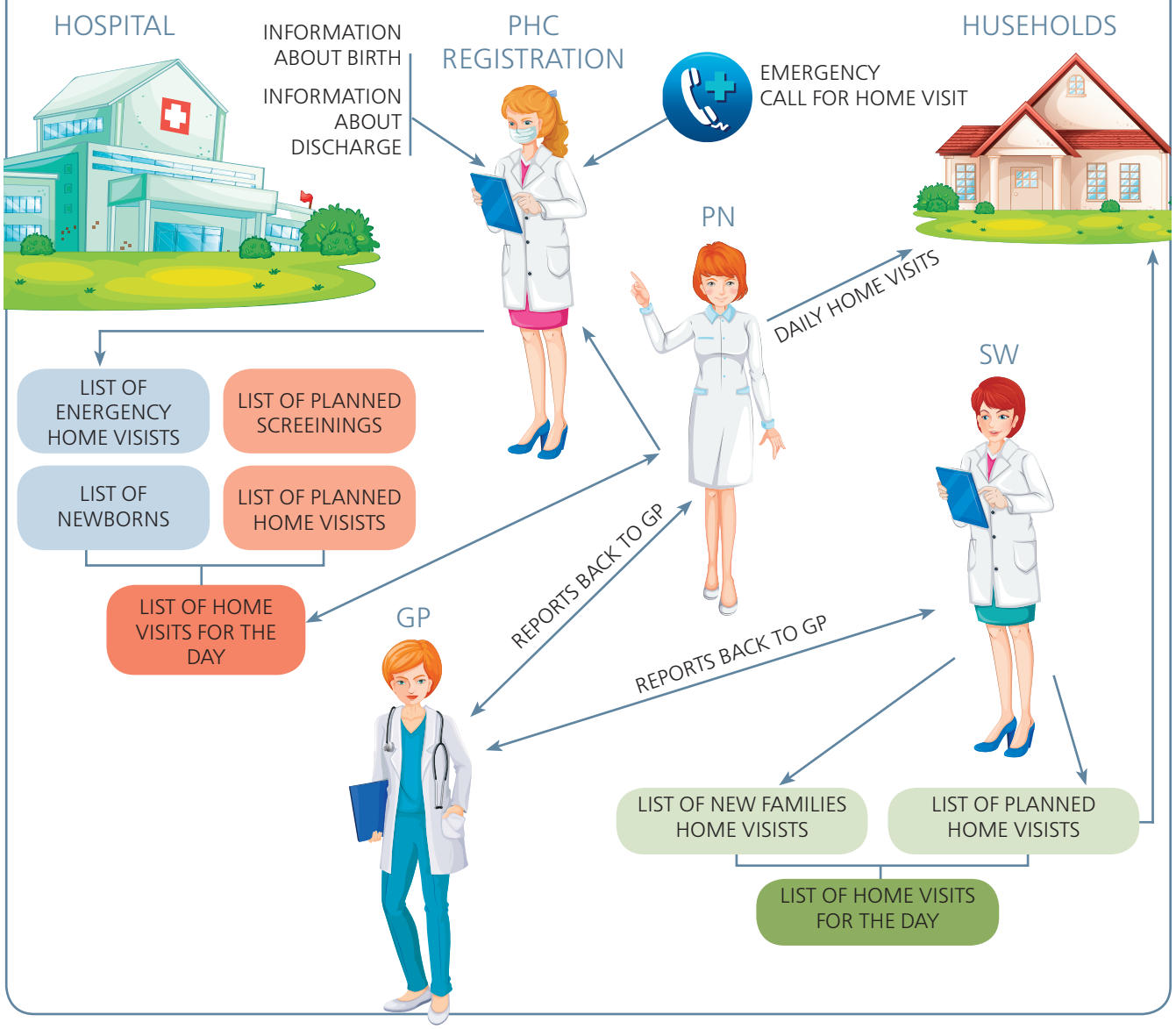


Figure 22: Planning algorithm of daily home visiting

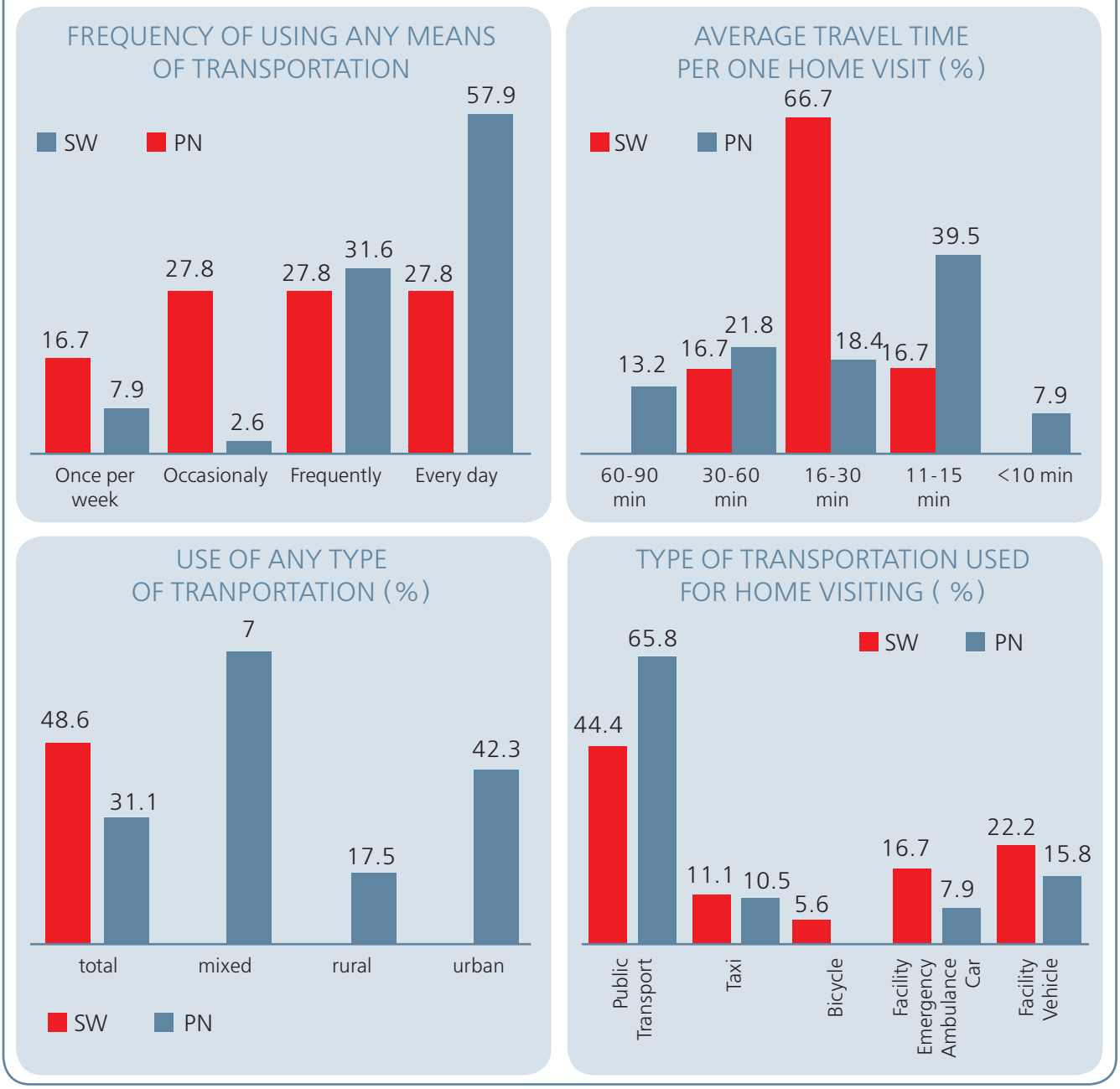


The social worker starts the morning acquiring information from the GP on new families/individuals identified either by the PN or the GP during office visits, consolidates the obtained information with the planned home visiting list, finalizes a home visiting plan for the day and then carries out the visits. The next morning the SW briefs the GP on the work conducted and additional findings. Notably, little to no coordination/planning of services for a particular individual/family has been observed during site visits and from the focus group discussions with SWs and PNs.

For home visits, only 58% of PNs and 28% of SWs use any means of transport. Use of health facility transport for home visits is very low and varies from 22% to 15% for SWs and PNs respectively (Figure 23). In the absence of facility transport, home visitors use public transport and, rarely, a taxi. As the transportation costs financed by the facility are less than required and home visitors have to pay transportation expenses out of their pocket, the majority prefer to walk to the household instead of using any transport.

On average 67% of SWs and 18% of PNs spent approximately 25-30 minutes for travel per visit. In urban areas, travel time is less and on average accounts for 15-20 minutes.

Figure 23: Average travel time for home visiting and Use of transportation means



Time spent to get to the household for home visiting leaves limited time to spend at the household. The PNSA analyzed the average number of home visits per day that a PN and SW performs based on the reported number of visits per year. On average PNs perform six to seven visits per day depending on the catchment area and SWs perform five visits.

The average duration of the home visit has been calculated, based on the required average travel time per home visit and the number of visits performed by the PN and SW. The analysis revealed that in urban locations the PN spends 14 minutes, in rural settings 5 minutes and in mixed, urban/rural settings 19 minutes for home visiting (Table 6). It is obvious that with the given visit duration PNs cannot perform standard tasks prescribed by the regulations. The latter raises issues about the efficiency and effectiveness of such visits. The situation is much better in the case of SWs, as they spend on average 30 minutes.

Table 6: Average number of visits per household visited & average length of each home visit

	PN			SW
	urban	rural	mixed	
Average number of households visited per month	82	95	94	24
Average total number of visits performed per month	120	114	165	45
Average number of visits per household per month	1.5	1.2	1.7	1.9
Average number of home visits per working day per month	7	6	7	5
Average length of home visit (minutes)	14.3	5.0	9.3	30.0
Average number of visits per child 0-5, per year	0.71	0.65	0.75	

Furthermore, the analysis of the facility data on planned and actual number of visits showed that on average the plan execution is not higher than 70%. This is confirmed by the average number of visits per child calculated in Table 6 above.

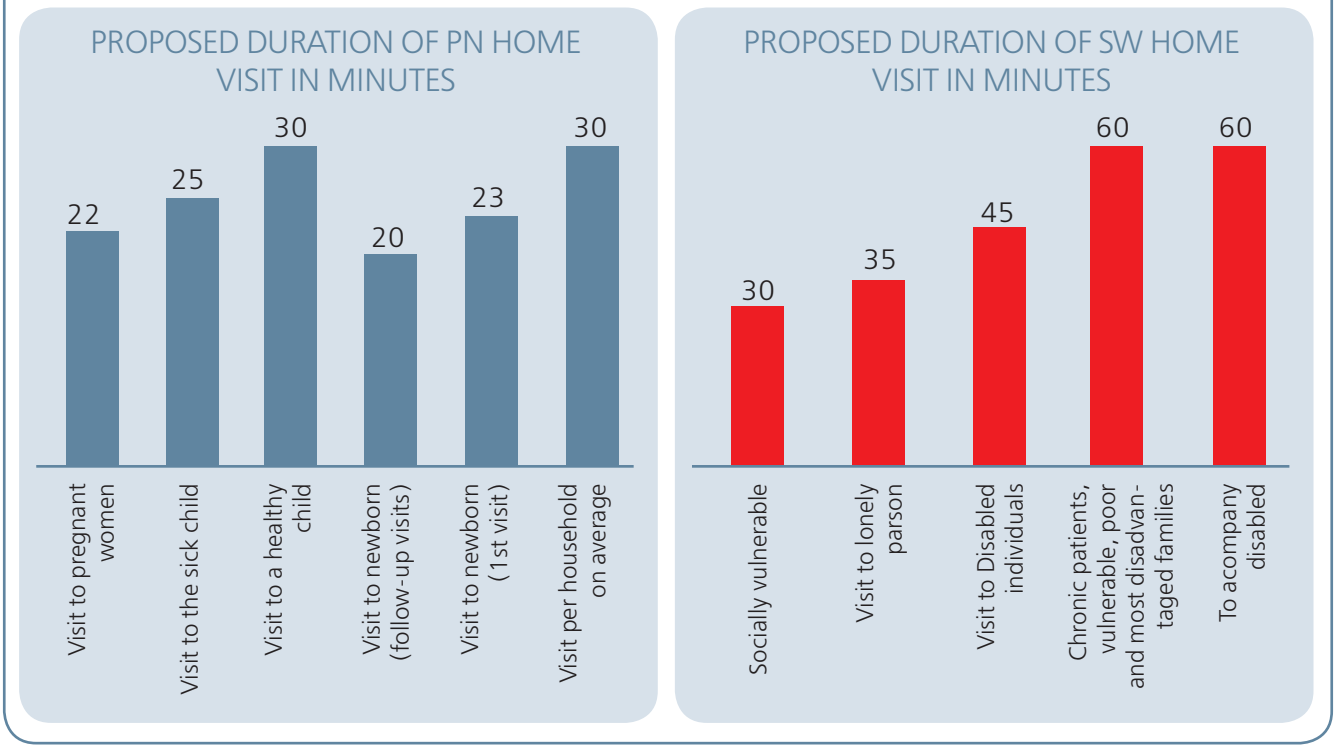
The ineffectiveness and incompleteness of the services provided by PNs and SWs to target groups of the population is corroborated by the data from the household survey carried out as part of PNSA. Overall satisfaction with services received from PNs is 42% in rural areas and 56% in urban areas, whereas satisfaction with SWs is high and varies between 82% in rural and 83% in urban areas (Table 7).

Table 7: Satisfaction with services provided by PN and SW

	PN		SW	
	RURAL	URBAN	RURAL	URBAN
Satisfied with the information received	46%	52%	93%	80%
When I have a question I ask	36%	62%	56%	71%
Helps to learn new things	39%	59%	53%	61%
Knows other services that will be useful for me and my family	39%	59%	62%	71%
Helps to access other services needed	41%	57%	62%	66%
Is available when needed	44%	54%	76%	71%
Asks about my opinions	42%	55%	75%	75%
Families that experience domestic violence could discuss this with their PN/SW	60%	38%	58%	28%
Families where a parent is mistreating a child can discuss with PN/SW	57%	42%	57%	32%
Families that have a child with development problems can discuss with PN/SW	50%	49%	64%	47%
Can help families to find solutions to family problems	56%	44%	63%	38%
Satisfied with the services received from my PN/SW	42%	56%	82%	83%

Analysis of household data shows variance in responses of rural and urban caregivers. In rural areas, possibly due to the lowest length of home visits, two thirds of caregivers are not given an opportunity to ask the PN questions (36%); six out of ten caregivers are not helped to learn how to take care of their child (39%); only 39% receive sufficient information about other services available for them; and only 42% are asked about their opinion by PNs. More than half of respondents felt that they could discuss issues related to domestic

Figure 24: Proposed duration of home visits



violence, child abuse and developmental problems with their PNs; although fewer respondents in urban areas felt that the PN was the right person with whom to discuss such issues. Notably these issues are not discussed with SWs either in urban settings.

The insufficient length of home visits has been acknowledged by PNs and SWs (Figure 24). The PNSA enquired about PN and SW opinion on the adequate duration of home visits for different groups of people they serve and learned that the PN visit on average should not be less than 30 minutes, whilst SWs indicated that the duration of home visits should range from 30 to 60 minutes, depending on the problem they have to deal with.

According to the personal accounts of PNs, SWs and health managers, there is a system of recording all visits performed by type and number on a daily basis, and all health facilities surveyed maintained such records. However, there is no system to track the accuracy of the data provided in the records, as well as no system for quality assurance of the services provided. Thus far, according to PNs and SWs the system self-controls based on the principles of their diligence and loyalty/devotedness to their profession. However, they also note that such a system is needed for reasons of fair and just valuation of the work and the efforts of each home visitor.

All health facility managers that the team has spoken to think that quality assurance is very important, but there have been no ideas yielded on how to establish this system. The only method of monitoring the working hours of the PNs and SWs established so far is the necessity to come to the facility when working hours begin and to come back before the end of the shift so that working time is recorded.

Information on the services provided during home visits was obtained from interviewed caregivers through the household survey. A few examples of services that pregnant women received from PNs in the first month after a child's birth are provided in Tables 8 and 9 below. The tables present selected services/counselling/screening services received by target beneficiaries as defined by the patronage standards.

In summary, PNs seem to provide services to more pregnant women in rural areas than in urban, while the services in the postpartum period are provided to less women and children in rural areas compared to urban settings.

Table 8: Main services/procedures provided by PN to pregnant women during the home visit

SERVICES/PROCEDURES	RURAL	URBAN
Checked if the house was clean	92%	85%
Interacted with you in a pleasant way	100%	97%
Measured blood pressure (e.g. someone wrapped a wide cloth around your arm, above the elbow; you felt a squeezing pressure in your arm; pressure was released after a couple of minutes)	66%	85%
Gave you enough opportunity to ask questions if you wanted to	60%	97%
Advised about nutrition and weight gain	64%	85%
Recommended and explained some of the medical tests and prevention measures	64%	88%
Discussed advantages of breast feeding and how to prepare for it	64%	70%
Explained how to plan and get ready for the baby	66%	76%
Discussed preparation for labour and birth, including information about coping with pain in labour and the birth plan	76%	79%
Explained how to recognize active labour	68%	76%
Discussed care of the new baby including breastfeeding		
Explained postnatal self-care	66%	70%
Informed about possibility of postnatal depression	62%	82%
Explained importance of regular antenatal visits	62%	82%
Made appointment for next antenatal visit	68%	76%
Notified about danger signs and where to seek care	80%	76%
Asked about domestic violence	80%	82%
Discussed other family needs and provided referrals to other services when needed	74%	58%
Spent enough time with you	66%	61%

Table 9: Main services/procedures provided by PN during home visit to mother and newborn after delivery

SCREENING	RURAL	URBAN
Checked if the house was clean	94 %	74 %
Checked whether your baby: Sleeps	82 %	82 %
Is fed	62 %	81 %
Is cleaned	66 %	72 %
Checked baby's weight	80 %	51 %
Asked about breastfeeding and provided additional information	94 %	77 %
Helped with correct positioning of the baby during breastfeeding	92 %	80 %
Answered your questions about infant care	80 %	97 %
Explained what your baby knows and your baby is learning during the first month of life	56 %	72 %
Showed how you can communicate and interact with your baby	68 %	78 %
Showed how to massage your baby	74 %	81 %
Explained importance of immunization and a vaccination calendar	84 %	84 %
Provided information about other available services	58 %	73 %
When needed provided support to access these services	52 %	64 %
Spent enough time with you	76 %	85 %
Interacted with you and your baby in a pleasant way	78 %	88 %
Gave you enough opportunity to ask questions you had	84 %	88 %
Asked whether you had any concerns with your baby	82 %	70 %
Checked on your health and recovery from delivery	82 %	70 %
Asked about your feelings and ability to cope with the baby	76 %	64 %
Asked about wellbeing of other family members	68 %	47 %
Discussed your plans about contraception	74 %	42 %

Table 10: Main services/procedures provided by SW during home visit

	RURAL	URBAN
Assessed your home and environment	96 %	81 %
Asked about your education and employment	93 %	100 %
Assessed your or any of your family member's consumption of Alcohol and Drugs	67 %	75 %
Asked about your relationship with husband/partner and other family members	39 %	75 %
Asked about whether you ever felt pressured or uncomfortable about having sex with your husband or partner? Whether you have ever been abused, or been forced into having sex?	50 %	75 %
Assessed how you cope with difficulties	67 %	75 %
Assessed how you and/or your immediate family members deal with anxiety	74 %	75 %
Assessed economic condition of the family	80 %	75 %
Assessed hygienic conditions of the house and child's room	83 %	75 %
Explained what your baby knows and your baby is learning during this stage of life	72 %	100 %
Showed how you can play with your baby	70 %	75 %
Showed how to use colorful objects for the baby to see and reach for	63 %	75 %
Showed how to respond to your baby's sounds and talk to your baby	87 %	75 %
Discussed how your baby is developing and explained how you and your family can help with it	41 %	75 %
Asked how you usually make your baby smile	48 %	75 %
Asked what you do when you are unhappy with your baby's behavior	63 %	75 %
In case of problems you faced did the social worker develop a plan of assistance?	65 %	100 %
Checked whether your baby: Sleeps	65 %	100 %
Is fed	52 %	100 %
Is cleaned	54 %	100 %
Plays	59 %	100 %
Spent enough time with you	80 %	100 %
Interacted with you and your baby in a pleasant way	85 %	100 %
Gave you enough opportunity to ask questions you had	65 %	100 %
Asked whether you had any concerns with your baby	65 %	100 %
Asked about your feelings and how you cope with the baby	57 %	100 %
Provided information about other services that are available	80 %	100 %
When needed provided support to access these services	89 %	100 %

PART 4:

DISCUSSIONS AND CONCLUSIONS

4.1. DISCUSSIONS

4.1.1. STEWARDSHIP AND GOVERNANCE

There is an overall regulatory framework available in Kazakhstan that sets formal standards for the network of PHC organizations and facilities in the country, based on the size of the population served and the distance of PHC clients from the facilities. Legislation also defines types of health facilities responsible for provision of PHC facilities as well as functional responsibilities. By-laws approved by the government outline the structure of PHC organizations, PHC functions, and staffing norms for PHC organizations, and provide a definition of minimal norms for the medical services PHC organizations provide. Furthermore, legislation also regulates the introduction of specialized social services at the primary health care level, staffing norms for social workers, and their functions. Moreover, the legislation also determines statutory reporting requirements for patronage nursing and social services.

Despite the fact that an overall regulatory framework is in place, it reveals certain shortcomings:

- It lacks clarity on the standard organization and governance of the home visiting system at the PHC level. The PHC system in Kazakhstan has not yet fully shifted to family medicine and represents a mixed system. The majority of the PHC facilities function according to the family medicine principles where GPs and nurses are responsible for caring for the population of all ages, whereas some PHC facilities still follow the old specialized, pediatrician and internist led system. Given these two different types of PHC settings, the organization of patronage nursing/home visiting systems differs. If in the case of GP health centres, nurses are responsible for home visiting of children and other categories of the elder population, in the old type of PHC facilities pediatric nurses are only involved in home visits to children. Given the different setting and service organization in these two types of PHC facilities, the legislation is silent about standard approaches for service organization in each type of PHC facility.
- Besides, standards for staffing do not take into account differences in the workload of nurses for each type of PHC facility, thus creating perverse incentives for attaining the planned number of visits at the expense of the quality of services provided.
- Although the legislation defines a standard set of services that the PN has to provide on every visit to a pregnant woman and a child at different stages of life, the standard procedures and job aids are largely lacking. Screening standards on household's economic, hygiene, violence, abuse, etc. is largely absent and left to the subjective judgment of the PN and or SW.
- Standard procedures/protocols for coordinated care and support of a family and/or individual in need are not yet clearly defined.
- Monitoring indicators stated by the legislation are more quantitative measures of the services provided and place less emphasis on the quality of home visiting services.

4.1.2. RESOURCE GENERATION

As mentioned above, the legislation defines staffing norms for PHC workers including the PNs and SWs. However the PNSA revealed unequal distribution of the workforce as well as high retirement and resignation rates for PNs. The actual number of PNs and SWs deployed in PHC facilities of urban and rural areas demonstrate imbalances in staff distribution. PN actual staffing is much higher than the standard norm defined by the regulation in rural areas, whereas in urban areas it falls slightly short. SWs are in access in rural areas, whilst in urban areas their numbers are close to the established norm. Staffing norms approved by local governments and standard norms regulated by the government differ.

Analysis of the PN work performance revealed that planned home visits are never 100% implemented and on average account for 70% of planned annual visits. Thus PNS fails to ensure full coverage of all target groups by the number of visits mandated by the regulation. PNS performance is largely influenced by long travel times and lack of transportation means, thus leaving insufficient time for performing all services as defined by the respective regulatory framework.

The government policy on human resource production and deployment is largely undefined, requiring urgent prioritization of human resource planning for PHC in general and the Patronage Nursing System in particular. Undergraduate and continuous education programs have to be standardized and renewed in light of the introduction of polyvalent home visiting at PHC level. On the job training provided to the PNs, demonstrated by the findings of PNSA, is not standardized. The standard set of basic packages of training modules required for capacity building of practicing PNs has yet to be defined and approved.

The PNSA reveals the absence of a standard set of medical equipment, consumables, and job aids required for the provision of effective home visits by PNs and SWs.

4.1.3. FINANCING & INCENTIVES

PHC facilities are financed on a capitation basis in Kazakhstan. It is largely unknown whether the capitation formula considers costs related to home visiting/patronage nursing by PNs and SWs. Thorough analysis of capitation formula on the costs of PHC services, including home visitation, has to be performed to ensure that PNS costs are adequately factored into the funding.

Budget planning and execution by facilities lacks clear allocation of funding for home visits. With the recently introduced fund holding mechanisms, the PHC facility managers can improve budgeting practices ensuring adequate financial support for home visits.

Lack of supplies, transportation, and communication means and/or required funding impedes the effectiveness of the home visits and affects staff motivation.

4.1.4. SERVICE DELIVERY

An assessment of service delivery organization reveals weaknesses and lack of coordination, and a collective approach to the family/individual in need of care and support. As described in Figure 21, there is clearly an absence of communication between the PN and SW; rather, both of them separately deliver information and receive guidance from the physician. Although it was reported that individual plans for care and support are defined for each risk group individual/family, no hard evidence has been obtained during the visits to PHC facilities.

Site visits to selected PHC facilities demonstrated inefficient use of PN time for services that can be easily performed by administrative and/or support staff. A good example is invitation of a target population for screening programs and immunization. PN participants of the FGDs reported that more than 50% of their time in the office is spent on record keeping, preparation of registries for immunization and for all screening programs mandated by the regulation, telephoning the target population and invitation for screening programs. The absence of an electronic information system results in increased administrative workload for PNs.

In the absence of well-functioning state social service offices the SWs deployed at PHC facilities often perform the tasks of the social service offices.

The assessment was not intended to look at the actual quality of the Patronage Nursing System, however the PNSA revealed indirectly quality related problems: i) High workload eventually requires quality of care to be sacrificed by reducing time spent on each home visit; ii) Although end users in general are satisfied with the services received from PNs, the study revealed that critical services/tasks are performed only in about 50% of home visits.

4.2. CONCLUSIONS

The assessment of the Patronage Nursing System in Kazakhstan was conducted with the intention to better understand how the patronage services are functioning and how to make the system better –more efficient, sustainable and equitable, respecting community traditions, building upon the best practices in the region, and at the same time responding to the challenges posed by recent reforms in the PHC sector.

The current state of the PNS, with a high degree of variation of resources and performance throughout the country, renders irrelevant any discussion about efficiency, quality or equity of the provision of PN services. At the same time, the very fact that PNS survives without a clear operational framework indicates that these services are demanded, valuable and represent a case of missed opportunity.

The findings of the assessment can be summarized in the SWOT table as follows:

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Services are demanded and valuable • Well-developed PHC network • Strong dedication among professionals • Introduction and institutionalization of social workers in the health care system	• Absence of professional standards • Absence of operation procedures and job aids • Absence of earmarked funding • Inadequate allocation of resources to cover non-labour costs • No incentives for quality and efficiency • Insufficient coverage • Inefficient work process organization • Lack of access to patient information system (electronic information system)	• Willingness of the government and partners to strengthen the PNS by gradually moving towards Universal-Progressive model of home visiting • Government's demonstrated interest in human resource capacity building	• Poorly developed social network • No formalized interaction between patronage nurses and other health professionals at primary health care • Fragmentation of service delivery and lack of coordination with other services

If the quality of home visits has to be improved, the desired progress in practice cannot be achieved unless the existing workload and performance related issues are revised adequately.

PART 5:

RATIONALE FOR UNIVERSAL-PROGRESSIVE MODEL OF HOME VISITING/PATRONAGE SYSTEM

5.1. WHY UNIVERSAL-PROGRESSIVE MODEL OF HOME VISITING/ PATRONAGE SYSTEM?

This section of the report describes the benefits of a Universal-Progressive model of home visiting as provided in UNICEF's Framework document on Home Visiting[71].

Home visiting programs for expecting mothers, parents and young children are based on a three-fold rationale:

- First, over the period from conception to the third year of life there are windows of vulnerability and opportunity that remain unparalleled over the entire life course and can be addressed with the maximum of return for;
- Second, over this period the family, starting from mothers and fathers, represent the primary social agency and the key mediators of child health and development outcomes, and home visitors meet the family in its own environment which provides a unique insight into the family's challenges and coping strategies;
- Third, pregnant mothers, parents and children who are most in need are those who most frequently fall through the cracks of the health, social (including child protection) and educational services. The following sections will further expand upon these concepts.

5.2. THE EARLIER, THE BETTER

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 change.

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 nutrition[72]. Early interactions with caregiver/s in a warm and predictable "serve and return" relationship enable children to develop a secure base of attachment from which they can explore and learn, and to which they can return in times of stress.

Research has also demonstrated that young children who are institutionalized before the age of six months suffer long term developmental delay, while young children who have experienced residential care after six months are more likely to recover from their deprived background and catch up on their physical and cognitive development once they have been placed in a caring family environment. Similarly, early exposure to a caring and stimulating family environment can effectively promote early literacy with improved cognitive outcomes which are detectable even 15 years later[73,74].

71. Home Visiting Policy Framework, UNICEF, 2014 (not published).

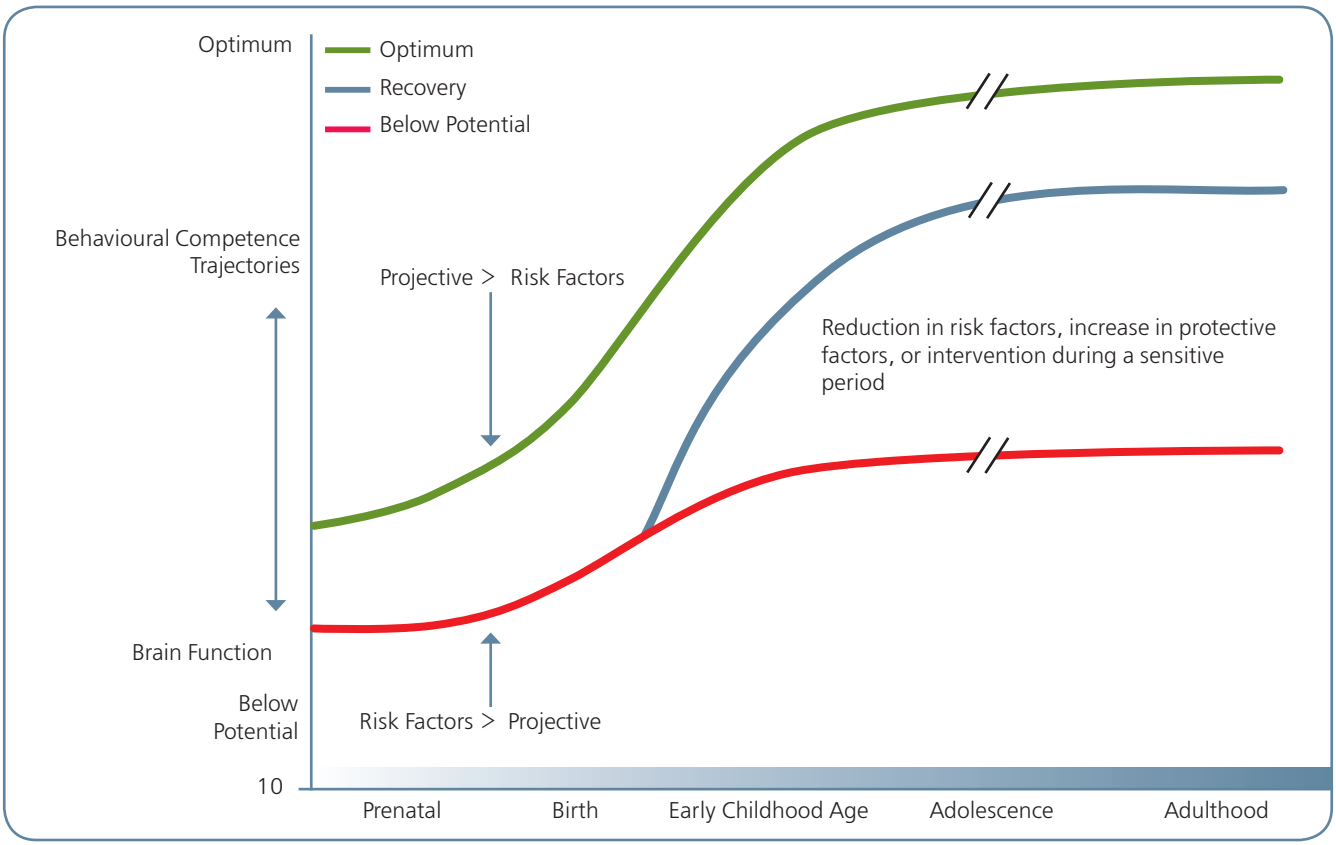
72. Walker, Wachs, TD, Grantham-McGregor, S, Black, MM, Nelson, CA, Huffman, SL, Baker-Henningham, H, Chang, SM, Hamadani, JD, Lozoff,B, Meeks Gardner, JM, Powell, CM, Rahman, A, & Richter, L. (2011). Inequality in early childhood: risk and protective factors for early child development. www.thelancet.com Published online 23 September, 2011 DOI:10.1016/S0140-6736(11)60555-2.

73. London School of Economics (2007). Cost Benefit Analysis of Interventions with Parents. Research Report DCSF-RW008. London, UK: Department for Children, Schools and Families. http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RW008.pdf.

74. Walker, Susan P., et al. "Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study." The Lancet 366.9499 (2005): 1804-1807.

The Center on the Developing Child at Harvard University (2007) proposed that children may encounter three broad categories of stress. Positive stress, related to everyday frustrations, contributes to normal growth and development in a supportive environment. Tolerable stress, may affect the brain architecture, but can be mediated by a positive and supportive environment. Toxic stress (e.g., related to poverty, maternal depression, abuse and neglect, institutional living), however, tends to be sufficiently severe and often cumulative, so that the developing brain architecture and the body's physiological response can be permanently affected, with negative outcomes observed into adulthood (Shonkoff, Boyce, & McEwen, 2009).

Figure 25: Developmental itineraries depend on the combination of risk and protective factors, which produce an early and frequently irreversible gap, which can be reduced by early interventions (Walker, 2011).



The way the child develops and the impacts on child and adult outcomes are mediated by the intricate interplay of biological, environmental and social risk and protective factors in the child, the family, community and the larger social and political context. What constitutes toxic stress for one child may remain moderate stress for another due to such factors as the child's own resilience, a caring adult, or supportive school environment. However, because risk factors (e.g., poverty, contaminated environment) and adversities (domestic violence, child abuse and neglect, maternal depression, parental mental illness, substance abuse, war, etc.) often occur in combination, children and families need comprehensive support early on, as later interventions may not be able to reverse the cumulative damage and come at a much higher cost.

The Lancet series estimates that more than 200 million children under the age of five in low and middle income countries are not developing their full potential due to one or more risk factors, and that early interventions and policies aimed at enhancing protective factors can significantly improve the development trajectory of children.

5.3. THE CRUCIAL ROLE OF THE FAMILY

The family is the primary agency of child health and development. One of the leading medical journals, The Lancet, in its Series on child survival, highlighted the key role of parents, their education, knowledge and skills in determining the ultimate outcome for their children[75]. In another Series in 2011, it highlighted the role of a further set of parental factors in determining child outcomes. For example, parental mental health pre- and post-birth (e.g., parental depression, particularly but not exclusively of the mother) is a key determinant of the ability to provide the optimal conditions for child development. Other risk factors that impact on the outcomes for the child include maternal stress during pregnancy, poor maternal nutrition, parental alcohol or drug mis-use and lack of parenting skills[76].

Figure 26: Risk and protective factors for optimal child development

DOMAIN	RISK FACTORS	PROTECTIVE FACTORS
Individual	Prematurity/Low birth weight. Congenital anomalies. Developmental disorders and disabilities.	No significant health problems. Adequate growth and development.
Family	Poverty. Low parental educational level. Parental stress, mental health problems/ substance abuse. Illness and physical disability. Family dysfunction. Domestic violence.	Adequate household income. Good educational level. Adequate family functioning, including support to mother from father and other family members. Caring family environment. Competent and caring parents. Exclusive and prolonged breastfeeding and appropriate complementary feeding.
Community/ Society	Social exclusion and stigma. Poor social capital. Conflict. Adverse or risky physical environment. Lack of social protection and of welfare policies.	Social cohesion. Social safety nets.

Most of the effects of poverty, lack of food security and a hazardous environment are mediated by the family and particularly the parents/caregivers, who may reduce or amplify risks and vulnerabilities by the way they care for their children. Well-supported, informed and caring parents may counteract the effects of poverty and disadvantaged environments. This is why working with parents to support their knowledge, practice and skills is fundamental to improve children's chances of developing optimally.

Within the role of the family, the role of both mother and father needs to be emphasized. Although the attitude is slowing changing, fathers are on average less involved in early child development, and nurturing the child is too often considered to be exclusively the mother's task. On the other hand, fathers can be dominant when deciding on child wellbeing/protection and seeking help outside the family. In addition, other caregivers may play an important role in the life of the child.

Although there are many useful ways to provide advice and support to parents even within health services, the most appropriate environment to talk to parents, assess the family environment and child development,

75. Walker, S.P., Warchs T.D., et al., Child Development: Risk Factors for adverse outcomes in developing countries, 2007, Lancet, 369, 145-147.

76. Walker, Wachs, TD, Grantham-McGregor, S, Black, MM, Nelson, CA, Huffman, SL, Baker-Henningham, H, Chang, SM, Hamadani, JD, Lozoff,B, Meeks Gardner, JM, Powell, CM, Rahman, A, & Richter, L. (2011). Inequality in early childhood: risk and protective factors for early child development. www.thelancet.com Published online September 23, 2011, DOI:10.1016/S0140-6736(11)60555-2.

provide advice about how to best care for themselves and the child, identify risk factors, and provide real-time support when needed is not the medical clinic, but the community and the home.

5.4. THE NEED TO REACH OUT TO THOSE MOST IN NEED

It is common knowledge and experience that the most disadvantaged families, the poorest, the least educated, those living in remote areas, those belonging to discriminated population groups, and those with one or more members suffering from severe disabilities or mental disorders, are the least covered by most health and education services. The inverse care law (i.e. those most in need receive the least services) has very few exceptions. And it has been shown that the uptake of all child health interventions is much slower and never reaches full coverage for the poor (Victora, 2007). Thus, from the prenatal period onward, the effects of risk factors combine with those of poor access to services to impact negatively on maternal health and as a consequence on neonatal outcomes and on cognitive development. Children who grow up in poor early environments are more likely to continue to experience challenges throughout their life course: health issues, lower educational achievement with poorer career prospects, and a range of psychosocial problems.

This is why it is crucial to reach out to those most in need, and to find ways to do this particularly for families that are planning to have and have just had a child, to support them in this very crucial period to do their best for their children.

In summary, home visiting programs, by providing an early intervention, supporting the parents and families, and reaching out to all, particularly to those most in need, are especially fitting to ensure the best start for all children. For these reasons, over the last decades, many countries have established community based services to provide parent and family information and support, thus increasing opportunities for children's health and cognitive and social development.

5.5. ECONOMIC BENEFITS OF HV SERVICES

Evaluating the economic impact of home visiting interventions is important to guide decision-making regarding distribution. Several studies and reviews provide information on the economic returns of home visiting. In general, it has been shown that the earlier the investments along the life course, the greater the benefits.

As far as home visiting programs are concerned, there have been a number of evaluations carried out in different countries and with different scope and methods, so that conclusions should not be considered as necessarily applicable in all countries, particularly in monetary terms. Rather, they should be seen only as an indication of the existence of good evidence supporting the view that home visiting programs are a sound economic investment.

A London School of Economics (2007) cost-benefit analysis of home visiting programs found that cost-effectiveness was higher when the program was targeted towards high-risk individuals, but the program would have been cost-effective even when targeting low-risk individuals. The findings led to the conclusion that, "the evidence provides support for the continuation of home visitation (and other) programs".

A cost-benefit analysis of a home visiting program for families at risk of child abuse and neglect in the UK found that costs, which included the cost for dealing with abuse cases, were much less in the intervention area than they were in the non-intervention area (£3874 versus £7120, respectively).

A small randomized controlled trial of a home visiting program for low-income mothers in an inner-city neighborhood in the US showed a lower rate of major illness and accidents requiring hospital admission amongst the treatment group, which led to saving US$27.31 per month for the medical care costs of children in the treatment group (US$55.60 per month) versus those in the comparison group (US$82.91 per month) (Hardy & Streett 1989).

Based on this evidence, home visiting is becoming a common component of interventions for expectant families and families with young children within developed nations. For example, in the US, new legislation provides

US$1.5 billion for the provision of home visiting services to new and expectant families (U.S. Congress, 2010). It should be emphasized that: "decision makers in children's services will have to make decisions about what is a reasonable cost to incur in return for a given likelihood of effect. These are social values, as much as social-scientific judgments" (Stevens et al, 2010).

5.6. INTERNATIONAL CONSENSUS AND COHERENCE WITH GLOBAL MCH POLICY FRAMEWORKS

The general principles and purposes of home visitation (investing over the life course, focusing on early prevention rather than on expensive and late remedial action, supporting parents, pursuing equity through reaching out to those most in need, empowering women and communities, strengthening the role of nursing) are fully coherent with all the existing policy frameworks developed at the global level over the last few years, starting from the UN Secretary General (SG) global strategy for women's and children's health, Every Woman Every Child, launched in 2010. They are also in line with the Convention on the Rights of the Child (UNCRC) (1989) and subsequent comments and developments.

States Parties to the UNCRC are required to render appropriate assistance to parents, legal guardians and extended families in performing their child-rearing responsibilities (arts. 18.2 and 18.3), including assisting parents in providing living conditions necessary for the child's development (art. 27.2) and ensuring that children receive necessary protection and care (art. 3.2). The Committee (on the Rights of the Child) is concerned that insufficient account is taken of the resources, skills and personal commitment required of parents and others responsible for young children, especially in societies where early marriage and parenthood is still sanctioned, as well as in societies with a high incidence of young, single parents. Early childhood is the period of most extensive (and intensive) parental responsibilities related to all aspects of children's well-being covered by the Convention: their survival, health, physical safety and emotional security, standards of living and care, opportunities for play and learning, and freedom of expression. Accordingly, realizing children's rights is in large measure dependent on the well-being and resources available to those with responsibility for their care. Recognizing these interdependencies is a sound starting point for planning assistance and services to parents, legal guardians and other caregivers. For example:

- An integrated approach would include interventions that impact indirectly on parents' ability to promote the best interests of children (e.g. taxation and benefits, adequate housing, working hours) as well as those that have more immediate consequences (e.g. perinatal health services for mother and baby, parent education, home visitors);
- Providing adequate assistance should take account of the new roles and skills required of parents, as well as the ways that demands and pressures shift during early childhood -for example, as children become more mobile, more verbally communicative, more socially competent, and as they begin to participate in programs of care and education;
- Assistance to parents will include provision of parenting education, parent counselling and other quality services for mothers, fathers, siblings, grandparents and others who from time to time may be responsible for promoting the child's best interests;
- Assistance also includes offering support to parents and other family members in ways that encourage positive and sensitive relationships.

UN General Assembly Resolution 65/197 on the Rights of the Child (UN General Assembly, 30 March 2011), which:

"Recognizing also that the family has the primary responsibility for the nurturing and protection of children and that children, for the full and harmonious development of their personality, should grow up in a family environment and in an atmosphere of happiness, love and understanding..." ..."Calls upon all States to include, within the overall context of policies and programs for all children within their jurisdiction, appropriate provisions for

the realization of the rights of children in early childhood, in particular: (a) To ensure that the rights of the child are fully respected, especially in early childhood, without discrimination on any grounds, including by adopting and/or continuing to implement regulations and measures that ensure the full realization of all their rights; (b) To provide special support and assistance to children in early childhood who are suffering from discrimination or living under especially difficult circumstances, in order to ensure their physical and psychological recovery and social integration and the full realization of their rights within an environment that encourages dignity and self-respect." (Convention on the Rights of the Child. CRC/C/GC/7/Rev.1)

The importance of early child development, which is one of the core contents of modern home visiting programs, and the role of parents in promoting it, has been reemphasized recently by Margaret Chan, WHO Director-General, who highlighted the links between child survival and early child development as mutually reinforcing goals:

"A stable and engaged family environment in which parents show interest and encourage their child's development and learning is the most important of the foundations of child health and wellbeing"..."The reason we have to ensure that child development stays on a healthy track is because we now know much more about the consequences of it being off course. Adverse early experiences—e.g., unstable caregiving, deprivation of love or nutrition, and stresses associated with neglect and maltreatment—greatly increase the likelihood of poor health across the entire life course. The more numerous these experiences, the greater is the health risk. Adverse experiences in early childhood increase poor social and health outcomes: low educational attainment, economic dependency, increased violence, crime, substance misuse, and depression, and a greater risk of non-communicable diseases, such as obesity, cardiovascular disease, and diabetes."

"In 2008, when WHO's Commission on the Social Determinants of Health envisioned a new era of global health equity, one of the key factors identified was support for children's early development. In recognition of the need to establish a strong early foundation for health, sustainable development, and equity —and in an effort to spark a global action agenda— WHO hosted an international meeting on early child development in January, 2013. The meeting focused on factors that influence early child development, evidence of effective interventions to promote development in early childhood with a life course approach, and experiences of taking interventions to scale and delivering integrated services at high levels of coverage. Participants concluded that the time is right to scale up investment in early child development as a way to optimize health outcomes along the life course. Many of the interventions that support child development are the same as those that reduce mortality, so helping children to thrive is complementary to ensuring they survive".

A Promise Renewed provides the framework for such an integrated push on child survival. It is time to translate talk, data, and science related to equity in child survival, health, and nutrition into action to give the world's most vulnerable children a fair chance to survive and develop.

In Europe, the WHO Regional Office developed its new region-specific health policy – Health 2020 – which emphasizes, based on a social determinants approach, a shift to the whole-of-government and the whole-of-society approach to governance. This involves all sectors of society, all parts of government and, most importantly, people themselves. Additionally, the European Commission issued a recommendation (2013) on "Investing in children: breaking the cycle of disadvantage":

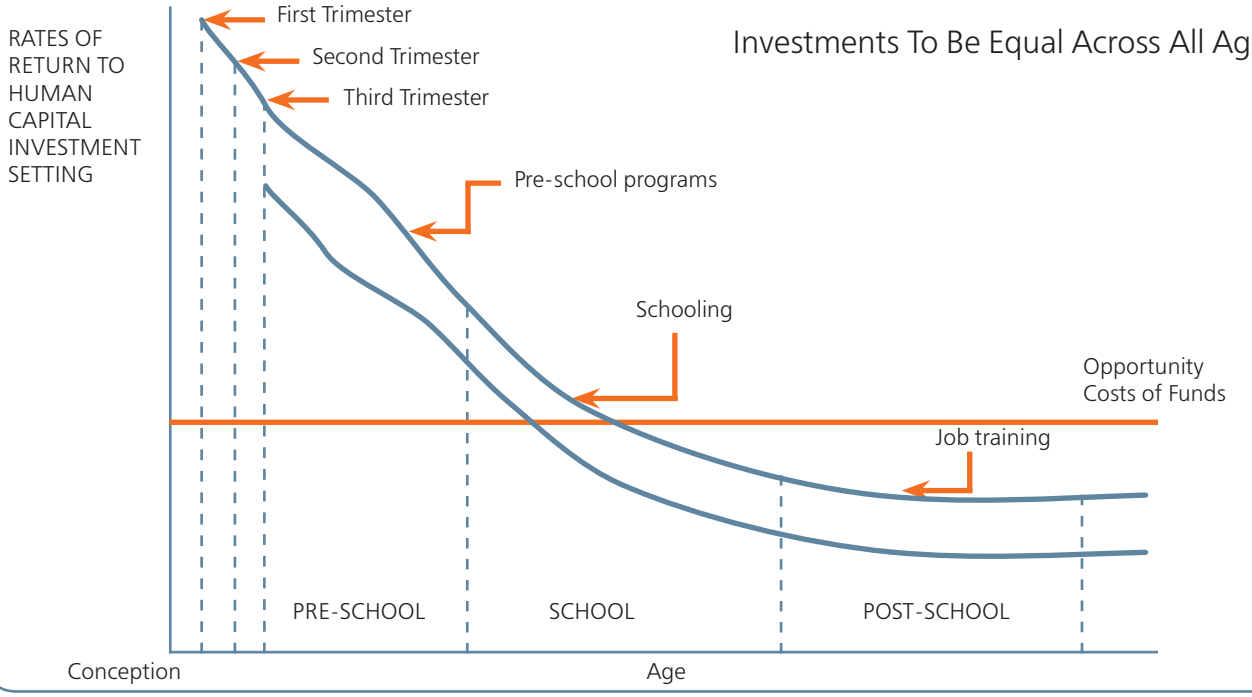
> *Tackling disadvantage in early years is an important means of stepping up efforts to address poverty and social exclusion in general. Prevention is most effectively achieved through integrated strategies that combine support to parents to access the labor market with adequate income support and access to services that are essential to children's outcomes, such as quality (pre-school) education, health, housing and social services, as well as opportunities to participate and use their rights, which help children live up to their full potential and contribute to their resilience.*

In the post 2015 development agenda, many agencies and lead global experts recommend that child development should have a prominent role. The evidence is compelling to expand the child survival agenda to encompass child development. Promoting healthy child development is an investment in a country's future workforce and capacity to thrive economically and as a society. By ensuring that all children have the best first chance in life, we can help individuals and their communities to realize their maximum potential, thereby expanding equality and opportunity for all.

5.7. RETURNS ON INVESTMENTS

Evaluation of the economic impact of home visiting interventions is important to guide decision-making regarding the distribution of services and allocation of resources. Several studies and reviews provide information on the economic returns of home visiting. In general, it has been shown that the earlier the investments along the life course, the greater the benefits (Figure 27).

Figure 27: The rates of return of investments are higher in the first periods from conception to school age (Heckman, 2007).



As far as home visiting programs are concerned, there have been a number of evaluations carried out in different countries and with different scope and methods, so that conclusions should not be considered as necessarily applicable in all countries, particularly in monetary terms, but only as an indication of the existence of good evidence supporting the view that home visiting programs are a good economic investment.

In 2007, a London School of Economics research report on the cost-benefit analysis of home visiting programs found that cost-effectiveness was higher when the program was targeted towards high-risk individuals, but that the program would have been cost-effective even when targeted towards low-risk individuals. It concluded, "the evidence provides support for the continuation of home visitation (and other) programs" . A cost-benefit analysis of a home visiting program for families at risk of child abuse and neglect in the UK found that in the group that received home visitors, costs, which included the cost for dealing with abuse cases, were almost half of the costs incurred in the group that did not receive home visits (£3874 versus £7120, respectively) . A small randomized controlled trial of a home visiting program for low-income mothers in an inner-city neighborhood in the US showed a lower rate of major illness and accidents requiring hospital admission amongst the treatment group, which led to saving US$27.31 per month for the medical care costs for children in the treatment group (US$55.60 per month) versus those in the comparison group ($US82.91 per month)[77].

As the provision of appropriate and needed services is also a child rights and ethical issue, "decision makers in children's services will have to make decisions about what is a reasonable cost to incur in return for a given likelihood of effect. These are social values, as much as social-scientific judgments" (Stevens et al, 2010))[78].

77. Hardy, J. B., & Streett, R. (1989). Family support and parenting education in the home: An effective extension of clinic-based preventive health care services for poor children. The Journal of Pediatrics, 115(6), 927-931.

78. Stevens, M., Roberts, H., & Shiell, A. (2010). Research Review: Economic evidence for interventions in children's social care: revisiting the What Works for Children project. Child & Family Social Work, 15, 145-154.

5.8. CONCEPTUAL FRAMEWORK FOR THE UNIVERSAL-PROGRESSIVE MODEL

There are three different models of home visiting that draw from experiences and evidence in many countries:

- Universal
- Targeted
- Mixed (Universal and Progressive)

These models are described here to reveal their scope and limitations so as to enable an informed decision on the model/combination of approaches deriving from these models, to be adopted given the different contexts and needs of countries.

Different approaches to home visiting have been used by different countries, reflecting diverse goals, intensity of services, staffing, target populations and delivery methods in light of the differing policy contexts (Gomby,2005; Sweet and Appelbaum, 2004; Bennett et al, 2007). Taking this difference of contexts and approaches into consideration, it is hard to identify universally applicable factors that contribute to efficiency. There is however some consensus amongst experts that antenatal (as opposed to postnatal) recruitment produces best results. Most of the preconditions for achieving the desired outcomes, including health development and wellbeing, are best addressed during pregnancy and starting from conception, and even when a couple is planning to have a baby.

THE UNIVERSAL MODEL

The Universal home visiting model provides home visiting to all families to complement child health services based on family doctors or pediatricians. Its goal is to assist all families in providing the most appropriate resources to their children in terms of general care, health, nutrition, attachment and stimulation, to ensure optimal growth and development, and to prevent the consequences of socially adverse circumstances. The Universal model of home visiting covers the prenatal period -ideally when a pregnancy is planned, to 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.

Figure 28: Benefits and Key Features

BENEFITS	KEY FEATURES
• Medical professionals usually do not have the time or the communication skills to provide this kind of parent focused care or may have to pay attention to other immediate medical concerns and needs • Parents feel increasingly in need of information and advice • Risk factors are not confined to poor families or disadvantaged communities • A Universal service or one that targets disadvantaged communities as a whole is not seen as stigmatizing, and therefore is more easily accepted by families who are in fact at higher risk	• Limited number of home visits – from 12 to 15 • Commencement in early pregnancy until the third birthday – with options to limit to first or second year or extending to six years depending on the context • Specific contents for each visit depending on age and developmental stage of the child, with a focus on child development and wellbeing combined with more traditional areas of focus on health and nutrition • Contents include information and advice on health and development issues for both mother and child, risk assessment and early identification of health, developmental and social problems • Service provided by skilled professionals within the health sector, as part of primary health care services, and in close collaboration with other services

THE TARGETED MODEL

While the evidence for Universal models is good, there is also 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. Olds (2007b) states that "There is consistent evidence that programme effects on care-giving and children are more pronounced among disadvantaged families where mothers have low psychological resources".

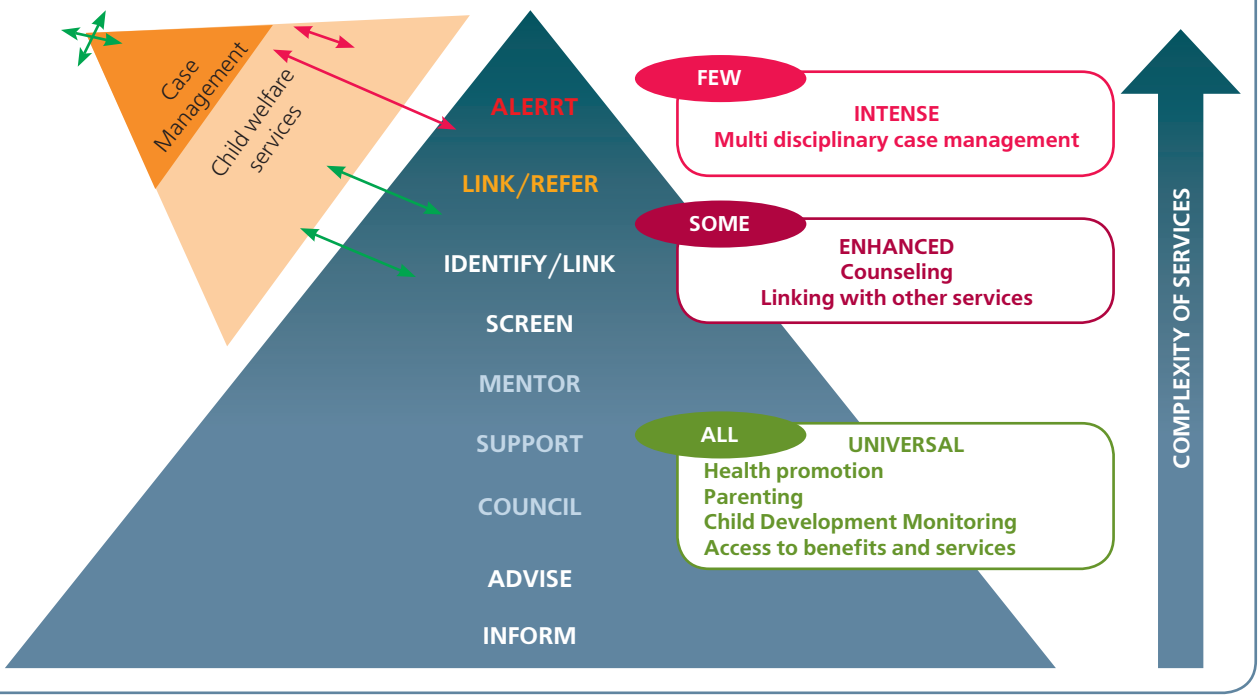
However it must be emphasized that risks are not confined to specific families and population groups, but are distributed, although unevenly, across all population groups, particularly those risks that have psychosocial rather that socio-economic dimensions. While the choice to invest in targeted programs may be driven by financial concerns, it leaves unaddressed the vast majority of pregnant women, parents and children in society.

THE MIXED "UNIVERSAL–PROGRESSIVE" MODEL

The Universal-Progressive model of home visiting overcomes the limitations of both the Universal and the Targeted models by combining them to ensure maximum benefits. In this model, Universal (essential) home visiting services are made available to all families, and Progressive (enhanced and intense) home visiting services are provided to a limited number of families based on an evaluation of risks and needs.

This enables the provision of enhanced home visiting interventions to those caregivers undergoing socioeconomic difficulties, psychosocial stress and other adverse circumstances, providing the additional support they need to take care of themselves and their children to ensure optimal growth and development. In cases of high vulnerability more intense interventions requiring multidisciplinary support may be provided through collaborations with health, social and educational services.

Figure 29: Conceptual framework for the Universal-Progressive model, including scope and intensity of its activities, links with other health services or other child educational and welfare services for full assessment and case management



This model implies (Figure 29):

1. An adequate number of home visits (which is significantly less than in currently existing HV services in most CEE/CIS countries, but consistent with existing services in western Europe) offered to all families to provide the essential preventive and promotive interventions – Universal package; and
2. Greater resources focused on families and children for whom specific risks and vulnerabilities are detected, to whom additional interventions are provided based on specific needs – Progressive (enhanced + intense) package.

The Universal-Progressive approach (also called the blended model) is currently used by a number of 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, a consensus has been reached to recommend the Tiered Universal -Progressive model in the CEE/CIS Region.

PART 6:

AIM AND OBJECTIVES OF A NEW EFFECTIVE HOME VISITING /PATRONAGE SYSTEM FOR KAZAKHSTAN

Improving the health and welfare of parents and their children is the surest way to a healthier nation. Experience before birth and in early life has a crucial impact on the life chances of each individual, not just through their childhood but also during their adult life. Healthy children start with healthy mothers, so we have looked back to before birth to include maternity services, as well as reaching forward across the transition into adult life.

Therefore the aim should be to set national standards for the first time for children's health and social care, which promote high quality women and child centered services and personalized care that meets the needs of parents, children, and their families.

EVERY CHILD MATTERS

We must maximize opportunities and minimize risks for all children and support them to:

- Be healthy;
- Stay safe;
- Enjoy and achieve;
- Make a positive contribution; and
- Achieve economic well-being.

6.1. AIM

The overarching aim of the service is to protect and promote the health and wellbeing of children in the early years. Given that the health and wellbeing of infants and young children is closely linked to the wellbeing of their caregivers and family, home visiting also addresses the wellbeing of caregivers and other primary family members.

The following elements of effective service delivery have been identified in a comprehensive review:[79]

- "Relationship-based;
- Involve partnerships between professionals and parents;
- Target goals that parents see as important;
- Provide parents with choices regarding strategies;
- Build parental competencies;
- Are non-stigmatizing;
- Demonstrate cultural awareness and sensitivity; and
- Maintain continuity of care" (p. 3).

In addition, the following principles underlie effective service delivery:

- Human rights
- Rights of the child
- Non-discriminatory practices
- Respect for the family and its cultural identity
- Transparency in decision-making
- Equitable access
- Flexible approach
- Safety of the child

79. Moore, T.G., McDonald, M., Sanjeevan, S. and Price, A. (2012). Sustained home visiting for vulnerable families and children: A literature review of effective processes and strategies. Prepared for Australian Research Alliance for Children and Youth. Parkville, Victoria: Murdoch Children Research Institute and The Royal Children's Hospital Centre for Community Child Health.

6.2. OBJECTIVES

Key objectives of the Universal–Progressive home visiting service are:

- Improvement of the health, psycho-social functioning, living conditions and identification of risk factors to the health of the family
- Promotion of the health of the family and the local community and education about healthy lifestyles for all family members
- Identification of risk factors and needs during pregnancy and the early years
- Promotion of child health, growth, and development
- Promotion of responsible parenthood and a positive relationship between parents and children even before the child is born to support healthy attachment
- Linking of the family with health care, social protection and other services in the community in accordance with the needs of the family
- Health monitoring and adequate interventions for families with special health and social needs
- Nurturing relations of mutual respect and confidence between the home visitor and the family members.

Families can expect the following from Universal services:

- Delivery of a core program of visits starting during the antenatal period. Universal services will include:
  - A continuum of care from the antenatal period through the early years
  - Identifying risk factors and needs during pregnancy
  - Preparing mothers and fathers for parenthood
  - Health promotion and advising on healthy lifestyles and uptake of immunizations
  - Undertaking health and development reviews
  - Teaching in child development and early stimulation
  - Working with families on responsive parenting and supporting behavior change
  - Developing ongoing relationships, support and advice where there are complex needs, e.g., a child with special education needs or a disability, or where there are child protection issues
  - Supporting parents to know what to do when their child is ill
  - Making referrals where additional specialist skills are needed (e.g., severe post-natal depression, domestic violence, substance misuse, developmental delay, etc.)
- Home visiting nurses will make sure families know about a range of community services and resources
- Provide advocacy for families and their needs with health and other services
- A rapid response from the home visiting nurse for specific needs, e.g., postnatal depression, weaning, sleeping problem, discipline
- Ongoing support from the home visiting nurse team, plus provision of a range of local services working together and with families, to deal with more complex issues over a period of time.

Families with additional needs can expect the following Progressive services:

- Additional support visits according to the needs of the family
- Assist families to engage with support services
- Assist with social inclusion of families
- Assist families to deal with the emotional impact of raising a child with a disability or developmental difficulties
- Help families to adapt environment, care, and activities to meet the needs of a child with a disability and/or developmental difficulties
- Referral to appropriate services
- Coordination of care and case management
- Advocacy.

Based on a comprehensive review of international evidence, with a focus on low resource settings, WHO and UNICEF issued a joint statement[80] promoting the use of home visitation during an infant's first week of life (i.e., first and third day) as effective in improving neonatal outcomes. Therefore, HV is particularly appropriate for remote and disadvantaged areas and population groups where infant and child outcomes may be worse or much worse than average.[81]

6.3. EXPECTED HEALTH AND WELLBEING OUTCOMES FOR YOUNG CHILDREN AND FAMILIES

Home visiting services are expected to contribute to improvements in:

- Infant mortality, morbidity rates, and prematurity
- Breastfeeding initiation and exclusive breastfeeding during the first six months of life, and breastfeeding on demand
- Comprehensive child development
- Increased health literacy
- Improved health-related behaviors of adults
- Improvement in health seeking behaviors and reduction in unnecessary health services consultations
- Hospital admission rates caused by unintentional and deliberate injuries
- Population vaccination coverage
- School readiness
- Increased number of infants and young children growing up in a responsive and safe family environment ("good enough parenting")
- Improved parent-infant attachment

80. WHO and UNICEF, 2009.

81. UK Department of Education and Wave Trust, 2012, Cowley, 2013, Moore, 2012.

- Increased family awareness of community resources available to them
- Increased engagement of vulnerable and marginalized families in health, social, and other public services
- Increased identification of children with disabilities and developmental difficulties and increased numbers of children and families receiving rehabilitation and other support services
- Reduction in violence against children, child abuse, neglect and institutionalization of children under three.

Follow-up studies have shown the long term effects on children, in terms of cognitive development, productivity and social adjustment. Research by Izzo et al (2005) documents an increased ability to cope with stressful life events 15 years later when visited by a nurse during the postpartum period. Effects on society are also persistent and include improved school readiness, reduced costs for health care, reduced welfare costs, and improved overall social cohesion and productivity. Well designed and quality home visitation programs are able to produce a variety of positive effects, both short term and long term, on children, families, and society (Table 11).

Table 11: Short and Long term results of home visiting for children, families and society

CHILDREN	PARENTS AND FAMILIES	SOCIETY
Improved neonatal outcomes (LBW, preterm delivery, congenital malformations)	Improved antenatal care and prevention of obstetric complications, identification of appropriate place of birth	Reduced costs for health care (both for acute and long term care)
Improved nutrition and growth	Improved parental knowledge and skills on child nutrition (breastfeeding and complementary feeding)	Improved school readiness and human capital
Reduced morbidity and mortality	Improved care seeking	Reduced costs for health care (both for acute and long term care)
Improved immunization rates	Improved parental awareness about prevention of infectious diseases	Reduced hospital cost for preventable disease vaccine
Improved cognitive and social development	Improved attachment and parental knowledge and skills on development-focused practices	Improved school readiness Reduced costs for school drop outs and juvenile delinquency Improved human capital
Reduced injuries	Safer home environment	Reduced costs for health care (hospital admissions)
Reduced burden from disabilities	Improved support for families with children with disabilities	Reduced financial costs for assistance to children with disabilities*
Reduced abandonment and child maltreatment	Reduced parental stress, maternal depression and anxiety	Reduced costs for care for abandoned and maltreated children and to control juvenile delinquency and substance abuse

6.3. THEORY OF CHANGE FOR THE NEW, UNIVERSAL-PROGRESSIVE MODEL OF HOME VISITING/PATRONAGE SYSTEM

Figure 30: Theory of change for the new model of Home Visiting/Patronage System

IMPACT

FAMILIES ARE SUPPORTED TO RAISE CHILDREN WHO ARE HEALTHY, HAPPY AND SUCCESSFUL

LONG TERM OUTCOMES

- **Babies are born healthy**
- **Children are nurtured by their parents & caregivers**
- **Children are physically & mentally healthy & ready for school**
- **Children & families are safe**
- **Families are connected to formal & informal supports in their communities**

SHORT TERM OUTCOMES

- Women are healthier throughout their pregnancies and babies experience improved birth outcomes
- Mothers who experience postpartum depression (PPD) receive appropriate treatment
- Parents have the knowledge and skills needed to nurture their child's development so that each child is ready for school
- Parents provide appropriate health and safety monitoring, supervision and practices according to the developmental needs/stages of their children
- Health and safety issues and possible developmental delays are identified early
- Families are more connected to health care and needed social supports

OUTPUTS

- Increased use of prenatal care & early registration of pregnant women
- Increased numbers of babies born – (знак больше) 37 weeks gestation
- Mothers with possible symptoms of PPD are identified
- Mothers who screen positive for PPD demonstrate knowledge of how to access services to help them with this condition
- Parents demonstrate knowledge of their children's developmental abilities and emerging skills and stages
- Parents routinely spend time interacting in a nurturing and positive manner with their children
- Parents demonstrate knowledge of which developmental milestones their children have achieved
- Parents demonstrate awareness of health, nutritional and physical safety needs appropriate for child's age and stage of development
- Parents demonstrate knowledge of how to access community resources available to them to help address identified areas of need (including domestic violence, substance abuse, physical, dental and mental health needs and developmental services)
- Parents demonstrate knowledge of how to access needed services available to them in the community
- Parents demonstrate knowledge of how reliable, safe and appropriate friends, family members and neighbors can provide their families with support when they need it

INPUT

UNIVERSAL PROGRESSIVE MODEL OF HOME VISITING/ PATRONAGE SYSTEM
that provides a coordinated continuum of high quality, community-driven culturally and linguistically appropriate home visiting services that promotes maternal, infant and early childhood health, safety, development and strong parent-child relationships

6.4. PROPOSED MODEL OF HOME VISITING/PATRONAGE SYSTEM

6.4.1. RECOMMENDED MODEL OF HOME VISITING

It is recommended that Kazakhstan adopts the proposed home visiting model:

PROPOSED MODEL: Universal & Progressive home visiting model

TYPE OF HV SERVICE PACKAGES: Universal package and Progressive (targeted) package

TARGET BENEFICIARIES:

UNIVERSAL PACKAGE
- All pregnant women
- All newborns and children under 3 years

TARGETED PACKAGE
- Risk group pregnant women
- Risk group newborns and children up to 3 years

NUMBER OF VISITS:
- 2 visits for pregnant women
- 9 visits for newborns and children up to 3 years old
- Visits to risk group pregnant women, newborns and children up to 3 years as per individual needs and individual plans.

6.4.2. RECOMMENDED HOME VISITING SCHEDULE AND SERVICES PER VISIT

Table 12, below, illustrates type of home visits, timing of visits and type of health professional responsible for the home visit.

Table 12: Proposed Patronage service packages, targeting and timing of home visits

TYPE OF PACKAGE	TARGET BENEFICIARIES	TIMING	TYPE OF HOME VISITOR
UNIVERSAL PACKAGE	All Pregnant women	1. By 12 weeks of gestation 2. 32 weeks of pregnancy	PN
	All Newborns and children up to 3 years	1. First 3 days after leaving maternity hospital 2. 7 days of life 3. 1 to 2 months 4. 3 months 5. 6 months 6. 12 months 7. 18 months 8. 24 months 9. 36 months	PN
PROGRESSIVE PACKAGE	Risk group pregnant women	As per individual plan	PN, SW
	Newborns and children up to 3 years	As per individual plan	PN, SW, GP – as defined by individual need of a sick child

A detailed Recommended Visiting Schedule and services to be provided per visit is set out in ANNEX B: RECOMMENDED VISITING SCHEDULE.

6.4.3. ROLES AND RESPONSIBILITIES OF PHC STAFF FOR HOME VISITS

In many CEE/CIS countries, family and village doctors are still required to provide home visiting services, usually together with nurses and/or midwives. International experience shows that appropriately trained home visitors/community nurses can effectively deliver all the interventions included in the Universal package, and are perfectly able to use all the communication skills that are needed and which doctors may not be very familiar with. The current shift from doctors to nursing in home visiting is therefore not driven by financial concerns, but primarily by the awareness that nurses (which may include midwives and nurse/midwives as some countries do, provided that a public health and child approach is ensured throughout the education process) are the most appropriate to provide the holistic approach that HV requires.

The role for doctors in home visiting is best limited to specific medical needs that may be better addressed at home, due to specific circumstances that make referral to the clinic difficult or hazardous for the patient, for example when the baby has been discharged with indications for medical follow-up. The contribution of doctors to HV services should therefore be viewed as necessary only as a transition phase until a sufficient number of properly trained HV personnel are available.

Key activities to be performed during home visiting are as follows:

ASSESSMENT & SCREENING	FOLLOW-UP ACTIVITIES
• Clinical Monitoring • Assessment • Examination • Questioning	• Counselling, teaching and practice • Advice • Planning • Referral • Linking

Home visits should last approximately 30-60 minutes and have both a predictable structure to ensure that families receive content and quality services, as well as sufficient flexibility to adapt to family priority concerns and needs. The home visit structure could be (broadly) as follows:

Table 13: Home visit structure

COMPONENT	ACTIONS
1. Maternal wellbeing	PN monitors clinical status, asks (including standard questions on maternal depression), listens, observes, explores issues, advises, counsels
2. Infant/child wellbeing	PN asks, listens, observes, explores issues, advises, counsels
3. Wellbeing of other family members	PN asks, listens, observes, explores issues, advises, counsels
4. Activities discussed during last visit and tried preceding current visit	PN asks caregiver if she/he was able to try activities as discussed during last visit, how it went, whether there are questions, ...
5. Planned check-ups, screens, etc.	PN explains activities to be completed to caregiver and completes them with his/her active involvement
6. Standard questions on domestic violence	PN asks standard questions, listens, discusses, advises, refers
7. Flexible activity	PN and caregiver select activity from list of developmentally relevant topics for this visit, explains, models, has caregiver try with child
8. Review and agree	Review what was covered, probe for understanding, and agree on what will be tried until the next visit

9. Provide educational materials	Select from relevant parents factsheets or tips
10. Provide referral if needed	Agree on referral and address barriers that might affect uptake of referral
11. Thank caregiver and agree on next visit date	
Throughout visit, uses all opportunities to praise the caregiver, points out strengths, and supports competencies	

6.4.4. CORE HOME VISITING PRACTICE REQUIREMENTS

The home visiting service should be provided by trained nurses with skills in working with families and children in the first years of life. The competency profile defines the skills, knowledge, and experience required to carry out the job and will also be used in the selection process (Table 15).

Table 14: Overall Competency Profile

REQUIREMENTS		
EDUCATION AND EXPERIENCE		
D1	Educated to specified degree level for this position	A
KNOWLEDGE, SKILLS AND ABILITIES		
E1	Excellent communication skills, IT, written and oral	A/I
E2	High level of clinical skills relating to maternal, child, and family health, with the ability to identify, respond to and evaluate health needs, including the delivery of public health programs.	A/I
E3	Good knowledge of the importance of the early years (general child development, cognitive, social-emotional, behavior development, speech and language development)	A/I
E4	Willingness to support management of change	A/I
E5	Knowledge of current legislation and national guidance relating to children	A/I
E6	Ability to apply research to practice	A/I
E7	Understanding of the safeguarding process and child protection procedures, clinical governance and the ability to make decisions in this area (reporting, documenting, referring) in collaboration with agencies involved in child protection	A/I
E8	Ability to model and teach good parenting practices (including responsive and nurturing caregiving and stimulation)	A/I
E9	Ability to map and build community resources to meet the needs of families and young children	A/I
E10	Ability to apply standardized monitoring and basic assessment tools	A/I
E11	Ability to collect, analyze and use public health and family information for programme planning, assessment of results and advocacy	A/I
E12	Ability to coordinate services within the health sector and with other sectors	A/I
E13	Ability to set personal objectives, and manage time, priorities, and stressful situations	A/I
E14	Ability to delegate work appropriately and safely	A/I
E15	Ability to work as part of a team	A/I
E16	Evidence of continuing professional development	A/I
E17	Commitment to the development of excellent services, which focus on improved outcomes for children and families	A/I
E18	Valuing diversity	A/I
E19	Knowledge of home safety and infection control procedures	A/I
E=Essential, D=Desirable, Assessed by: A=Application I=Interview		

6.4.5. SERVICE STANDARDS

The home visiting nurse will work in a range of settings to meet the service need. The home visiting nurse will be trained and expected to show competence across a range of family and child related topics. They will be able to engage families, including those that are vulnerable or at risk and enable parents to use their strengths and support their children's overall development and social skills. The home visiting nurse will promote and demonstrate responsive parenting either with individual parents in the home or as part of a group in a community setting. See standard job description in ANNEX A. JOB DESCRIPTION FOR HOME VISITOR.

6.4.6. TRAINING AND COMPETENCE STANDARDS FOR HOME VISITING NURSES

Home visiting nurses require a multitude of skills and knowledge, relating to work with individuals, families, communities, and general public health. All home visiting nurses will have training in the following areas:

Table 15: Required knowledge and skills

KNOWLEDGE	SKILLS
• Healthy Child Programme basics • Conception and the antenatal period • Care of infant/child • Child health and development • Play • Speech and language • Attachment and bonding • Responsive parenting and parenting issues • Family health • Health and health promotion • Nutrition/infant feeding/diet, responsive feeding • Oral health • Minor ailments • Infection control, hygiene and safety • Safety and accident prevention • Child and maternal mental health • Behavior management • Prevention of neglect and abuse	• Communication • Record keeping and documentation • Translating evidence into practice • Public health skills, intervention skills • Basic data analysis of service data • Development assessment • Adult learning methodologies • Working with parents • Behavior change technique (including motivational interviewing) • Use of screening and assessment tools • Advocacy • Leadership skills

6.4.7. TOOLS

The Recommended Visiting Schedule (See ANNEX B: RECOMMENDED VISITING SCHEDULE) includes tools that should be used as part of regular development reviews and other tools that are useful for developmental monitoring, monitoring of parent wellbeing, assessment of the parent-young child relationship, and assessment of the home environment.

6.4.8. SUPERVISION AND SERVICE QUALITY AUDIT

Home visiting nurses will be supported through clinical supervision. Good supervision is characterized by:

- Matching the supervisor and supervisee carefully with understanding of the issues and expectations of the role and home visiting principles and techniques
- Creating an environment which feels safe, where the person being supervised can disclose their concerns, without fear of reprisals
- Having regular protected time
- A relationship of trust
- A chance for reflection and restoration.

Regular supervision of the home visitor is essential for quality and improving outcomes for young children and families. It should encompass systems that address service and professional development, as well as support for the workforce. The types of supervision are described below:

RESTORATIVE SUPERVISION

Restorative supervision should take place between the home visitor and a senior nurse supervisor, trained in restorative supervision techniques, at least monthly, using principles of reflection, coaching, and problem solving to strengthen the resilience of the HVs and their abilities to gain a different perspective.

CLINICAL SUPERVISION

Clinical supervision should take place between the HV and the senior nurse supervisor (either in the field or in separate meetings) at least every two months. It should be used to validate good practices and promote improvement in skills, knowledge, and attitudes.

PRACTICE OBSERVATION – MONITORING THE RELATIONSHIP QUALITY

As it is recognized that the quality of the relationship between the home visitor and family contributes to the success of home visiting, tools have been developed to assess the interaction between the home visitor and the family, the quality of the strategies used, and the level of engagement of parent and child in the activities. In addition, there are inventories for home visitors and for parents to rate the level of satisfaction, shared goals and objectives, level of collaboration, etc.

REGULAR CASE DISCUSSIONS

Regular case discussions will be scheduled twice monthly with the HV team to discuss difficult cases, share information and joint problem solving, and provide mutual support.

MANAGEMENT SUPERVISION

Management supervision (audit) can be undertaken by a non-clinical manager or supervisor quarterly as part of an internal review of quality and performance against service standards. This may include reports, data collection, and assessment of client satisfaction. Some supervision can also be provided through peer support mechanisms.

6.4.9. RECORD KEEPING AND INFORMATION SHARING

Good record keeping is an important part of home visiting practice and is essential to the provision of safe and effective care. Good record keeping, whether at an individual, team or organizational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- Helping to improve accountability
- Showing how decisions related to the services provided to the family were made
- Supporting the delivery of services
- Supporting effective clinical judgements and decisions
- Supporting child and family care and communications
- Making continuity of care easier
- Providing documentary evidence of services delivered
- Promoting better communication and sharing of information between members of the multi-professional healthcare team and professionals from other sectors
- Helping to identify risks, and enabling early detection of complications
- Supporting clinical audit, research, allocation of resources and performance planning.

Confidentiality is an important factor in home visiting. It is important that home visitors are aware of legal requirements and guidance regarding confidentiality, and ensure their practice is in line with national policies. They should not discuss the people in their care in places where they might be overheard, nor should they leave records, either on paper or on computer screens, where unauthorized personnel might see them. The exception is situations where there is a serious threat or safeguarding concern related to the child or family. In such cases, the home visitor must follow the local referral procedures to notify child protection services and, in the most serious cases, the police must also be notified.

Information sharing protocols should be in place to facilitate within and across-sector coordination and referral, and to clarify what information can be exchanged and when this would be appropriate between agencies.

Transparency between PNs and those in their care is paramount in building and maintaining a positive relationship. PNs will be expected to listen to families and respond to their concerns and preferences, helping them build capacities and resilience in caring for themselves and their children. The contribution that people make to their own care and well-being should be respected and information shared in a way families can understand.

Clear transparent communications between home visitors and others providing care to the family is also important to ensure continuity of care and appropriate coordination of services. As such, clear referral pathways and counter-referral processes need to be established. All referrals should be followed up by information containing action taken and further action planned.

Parent held records can be an effective way of information sharing between professionals and also act as a communication aid and reference point for the families about what to expect from home visitors at different stages of development, information about typical child development, services or screenings the child has received (immunization, hearing, etc.), and practical tips for self- and child-care.

PART 7:

ROADMAP FOR INTRODUCTION OF UNIVERSAL-PROGRESSIVE MODEL OF HOME VISITING/ PATRONAGE SYSTEM

7.1. PREREQUISITES FOR INTRODUCTION OF A UNIVERSAL – PROGRESSIVE MODEL

In order for a Universal-Progressive model of home visiting to work and achieve its objectives, some fundamental requisites must be met:

- The development of a risk-based assessment approach
- The existence of intra-sectorial pathways
- The establishment of strong inter-sector collaborations and case-management
- The development of professional competence
- An equity-focused approach
- Adequate service management

The assessment of the current PNS against the prerequisites outlined above for the introduction of a Universal-Progressive model shows:

RISK–BASED ASSESSMENT – MoH Decree № 164 on " Improvement of maternal and child Health"[82] defines the need for risk assessment of pregnant women, newborns and children during the patronage visits. However, neither the given decree nor any other legal/regulatory document provides detailed guidance/standards on the medical risk assessment and follow-up actions. Thus there is the need to move away from a mechanical, detect-and-refer model towards a more interactive flexible and needs based approach. While in the traditional approach the home visitor is viewed as someone that detects and highlights anomalies to refer to specialized services, in the new model the home visitor is called to identify risk factors, if any, during the periodical visits included in the universal package, to support the family to identify and develop the necessary resources to cope with such risk factors, to build on existing protective factors, and involve other services when necessary to provide extra social, psychosocial or medical services. Risk assessment is thus immediately combined with the initiation of action to reduce risk, promote resilience and address any risky situation or overt vulnerability. Of course, in order to do so, home visitors need to have the ability, capacity, and decision-making autonomy for the complex assessment and case management tasks that enhanced and intensive interventions require. A risk/protective assessment approach means that the approach needs to be highly individualized, and at the same time participatory. Far from being merely prescriptive or controlling, home visitation builds on a dialogue with family members. This approach is especially critical in managing the delivery of Universal-Progressive services.

INTRA–SECTORAL PATHWAYS – In many cases, home visiting will deal with medical needs, either of the baby or the mother, which require referral to health facilities. This could either be a new problem, identified during the visit, such as failure to thrive or post-partum depression, or a condition that is already known and needs further care and follow-up, such as prematurity. It is very important that home visitors know where to refer and how to support the family in the referral process, including the necessary administrative steps where needed, to ensure that specialist care and advice is given promptly and effectively. Mother's and baby's medical records can help greatly in ensuring continuity of care and information through the process, and mechanisms for referral and feedback should be identified and agreed upon within the different levels of the health system. Home visitors should be recognized by the health system at all levels as an important component of service delivery.

INTER–SECTOR COLLABORATIONS AND CASE–MANAGEMENT- A Universal-Progressive model of HV/PNS that aims not only to identify problems and to help find solutions in a variety of dimensions, even beyond the purely medical one, needs to be closely linked to all community services and resources, including public, private, non-profit, community-based etc. This is important so that the model can ensure continuity of care and specific responses to emerging needs, whether financial, psychosocial or medical, or various combinations of these. Collaboration is particularly important with the social sector, the education sector, and with all kinds of

82. MoH Decree № 164 on " Improvement of maternal and Child Health", 31 March, 2011.

health. Unfortunately, there is often fragmentation among these community services, with different government departments, health, education and social welfare setting up separate services and programs with little or no coordination between them. For example, the social sector may be weak or non-existent, which would hamper many of the actions of the intensive option.

In addition to providing direct support for parents and families, giving advice regarding parenting, and identifying new or emerging health and development problems, home visiting is an effective way of linking young children and parents to existing education and social services. Parents can be encouraged to enroll children in regular child care or preschool, early intervention programs where they exist and if the child is eligible, or be referred to specialized agencies or programs as appropriate.

For all these reasons, a clear distribution of tasks needs to be made and agreed upon among different services, so that home visiting services are not overloaded with requests that should be addressed by other services. Inter-sector agreements at the local (municipal, provincial, or other) level should be made so as to set clear collaboration and information mechanisms and responsibilities.

A well-functioning social sector with clearly defined tasks for child protection represents a necessary building block of any comprehensive family and child policy, and a necessary complement to an effective health visiting service. Cooperation with the social sector is crucial. The social (and child protection services where they exist as a separate service) sector may contribute to the identification of risks and barriers. Home visiting may be combined with social work outreach services, and some of the potential beneficiaries identified through family assistance schemes (e.g. cash transfers).

In this way, comprehensive home visiting programs can begin to address the great disparity in outcomes that exist between advantaged and disadvantaged communities. While the overriding causes of the social gradient may remain, and can only be addressed over time by national and local government policies and actions that are much broader in nature, home visiting programs can represent the important first steps in supporting parents to create an optimal environment for the child throughout the important early years.

PROFESSIONAL COMPETENCE – As the required skills become more complex, both the curricular training and professional profile of PNs need to reach a higher level. As Gomby[83] writes, "home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the visiting program whilst still responding to family crises that may arise ... and the cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if programs are to be successful.' Other authors suggest that the personal qualities that are required include respect, genuineness, humility, empathy, personal integrity, quiet enthusiasm, technical qualities and expertise, communication skills and commitment.

The training program needs to be both broad enough to cover the range of issues, emerging problems and risk factors that families face, and at the same time deep enough to provide the PN with the skills that are needed to address these issues and to know when and to whom to refer. The PN will thus need to feel confident in assessing the various risk factors and situations in terms of the impact they may have on the mother, the family and the child, as well as some skills in child surveillance and the use of screening instruments.

EQUITY–FOCUSED APPROACH – Just because services are available does not mean that all families use them. Indeed, there is abundant evidence that the most vulnerable and at-risk families who would benefit most from health services are often those least likely to use them. Numerous barriers to accessibility have been identified (cost, transport, cultural and interpersonal). For all these reasons, it is necessary to adopt a proactive approach where health services, knowing that opportunities and obstacles vary, do not limit themselves to offering the same service to all, waiting for patients to show up, but instead reach out to those who otherwise would not have access to the services. This approach is typical of a well-designed HV/PNS service and represents one of its key added values. In a given context, it will be necessary to redistribute or increase human resources in order to be in a position to provide equal opportunities to all. It is often the case that in remote areas there is a lack of personnel, and that health workers need to use their limited time to reach out to remote villages.

83. Gomby, D.S. (2005). Home Visitation in 2005: Outcomes for Children and Parents. Invest in Kids Working Paper No. 7. Committee for Economic Sustained home visiting for vulnerable families and children: A review of effective programs Page 66 of 80 Development Invest in Kids Working Group. http://www.ced.org/docs/report/report_ivk_gomby_2005.pdf.

SERVICE MANAGEMENT- As with any other service, the effectiveness of HV/PN services requires good management capacity at all levels. At country level, there should be a well identified department or unit in charge of home visiting, which could be ideally set within the MoH primary health care or health services department. This ensures oversight on human resources planning, recruitment deployment and training, updating technical guidelines and job aids, professional development and guidance, and leadership in promoting intra and inter-sector collaboration, or collaboration through appropriate normative frameworks and legislation when necessary.

In the UK, even greater autonomy is allocated to home visiting through the establishment of a HV Institute within the National Health Service. At local level, a clear line of management of a HV service should ensure coordination of activities, collaboration with other services and sectors, monitoring and evaluation, and periodical meetings for professional development and quality improvement. At all levels, the best managers of home services would be professionals who have been health visitors themselves, and who have been selected for their outstanding capacities and further trained in managerial skills. Ideally, there should be a master/specialization course in the management of home visiting and community services, financing and status.

In Kazakhstan, poor salaries, poor recognition and poor social status, and the consequent high turnover, jeopardize the kind of continuous and trusting relationship between families, communities and PNs, which is needed to achieve the desired outcomes. How to address this and other key challenges will be discussed in the following section of this document.

7.2. READINESS FOR INTRODUCTION OF UNIVERSAL-PROGRESSIVE MODEL

In order to examine system readiness for the introduction of a new Universal-Progressive model of HV/PNS, the health system thinking -a holistic understanding of health system building blocks[84] (Figure 31)- has been used, which identifies where the system succeeds, where it breaks down, and what kinds of integrated approaches will strengthen the overall system[85]. This orientation towards designing, implementing and evaluating interventions that strengthen systems[86] is directly relevant to a home visiting/patronage nursing system. The highly complex, system-level issue must be addressed across the system rather than in isolation from it[87].

By coordinating actions across different blocks of the health system, a HV/PNS program can increase coverage and reduce barriers to the use of services. Effective programs assemble packages of appropriate reforms in each of the six main building blocks of the health system (Figure 31): governance of the health sector (to provide sectorial policy and regulatory mechanisms, and partnerships with the private sector); infrastructure and technologies (to provide emergency referral centres linked to primary care providers); human resources (to scale up the availability of skilled personnel); financing (to reduce financial barriers for patients and incentivize providers), and services (to ensure quality and an appropriate configuration of HV/PN services).

Based on the international evidence of using the proposed approach, the action plan for modernization of HV/PNS in Kazakhstan is built across all six system building blocks and has six main (building block) components, with one component oriented towards engagement of patients. In addition, establishing rigorous monitoring and evaluation of the new HV/PN system will enable decision makers and implementers to take evidence based decisions and actions for the introduction of an effective and sustainable Universal-Progressive model of HV/PNS in Kazakhstan.

84. Everybody's business – strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007.

85. Atun R, de Jongh TE, Secci FV, Ohiri K, Adeyi O. Integration of targeted health interventions into health systems: a conceptual framework for analysis. Health Policy Plan, 2010.

86. Atun R, Menabde N, "Health systems and systems thinking". In: Coker R, Atun R, McKee M, editors. Health systems and the challenge of communicable diseases: experiences from Europe and Latin America. Maidenhead: McGraw Hill & Open University Press; 2008.

87. Knippenberg R, Lawn JE, Darmstadt GL, Begkoyian G, Fogstad H, Walelign N, et al., et al. Systematic scaling up of neonatal care in countries. Lancet 2005; 365: 1087-98 pmid: 15781104.

Figure 31: Modified WHO Health System Framework

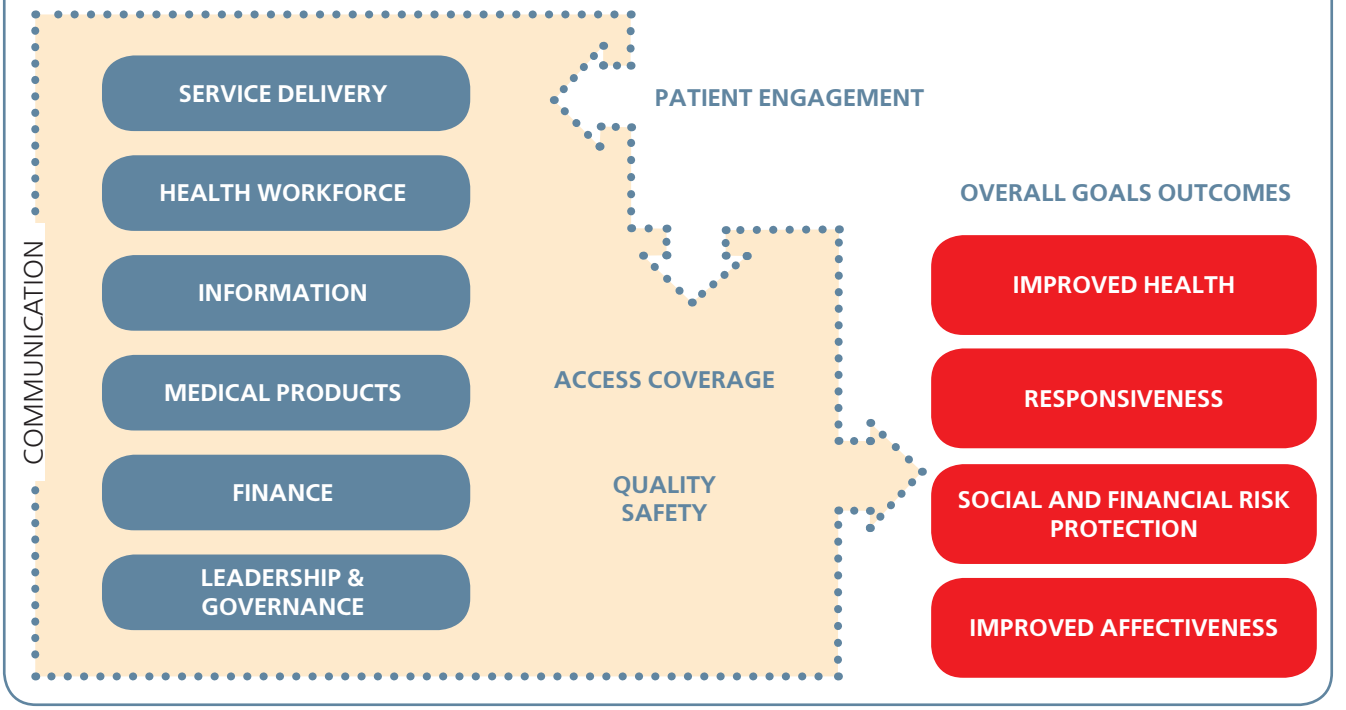


Table 16, below, presents the readiness of the system for introducing the Universal–Progressive HV/PN system in Kazakhstan by assessing the status of the current PNS–Universal model and the remaining challenges, as well as proposing strategies for gradually moving towards a Universal-Progressive HV/PNS.

Table 16: List of key challenges for the introduction of Universal-Progressive Home Visiting/ Patronage system

Health System Building Block	Status and remaining challenges of current Universal HV/PNS model		Strategies for reaching desired state of Universal-Progressive HV/PNS model	
Leadership and stewardship	Availability of political commitment to enhance patronage nursing system	⊙	Achieve continuous political commitment to invest in/maintain /support MCH home visiting/patronage program through the development of enabling legal and policy environment	Ⓟ
	Current universal HV/PNS standards, under development	□	A need to define the new Universal-Progressive MCH HV/PNS standards	Ⓟ
	Competencies of the implementing professionals yet to be defined	○	A need to define the expected competencies of the Universal-Progressive MCH HV/PNS implementing professionals	Ⓟ
	National legislation in place	⊙	A need for the development of national and local legislation, regulations and agreements regarding inter-sectorial coordination and collaboration	Ⓟ

Service Delivery	PNS governance structure defined	⊙	A need for the development of a HV/PNS governance structure at national, local and facility levels	Ⓟ
	Two types of PNS: at GP centres and Specialized PHC centres	□	Development of unique organization structure of the HV/PNS that can operate in both settings during the transition period of PHC reform.	Ⓟ
	Low status and autonomy of home visiting personnel, who attend office as well as perform home visits, resulting in increased workload and low quality home HV/patronage services	○	Development of the autonomous unit at PHC tasked with only home visiting	Ⓟ
	Absence of the mapping of social and community based services and referral links	○	Mapping of social and community based services and development of clear referral pathways and communication procedures within health system and between sectors	Ⓟ
	Lack of experience and readiness for inter-sectorial collaboration	○	Development of capacities for inter-sectorial collaboration	Ⓟ
	Poor Case Management function, processes and responsibilities	□	Design of Case Management function, operational procedures and identify responsible professional	Ⓟ
	Weak team collaboration and coordination	□	Build team collaboration and coordination skills	Ⓟ
Financing	Insufficient capitation funding allocation to cover new patronage nursing system operation	□	Revision of capitation funding allocation to ensure effective operation of Universal-Progressive model of HV/PNS	Ⓟ
	Absence of separate funding envelope for home visiting/patronage services	○	Earmark funding for Universal-Progressive model HV/PNS	Ⓟ
	No incentives to reward quality rather than quantity of home visits	○	Introduce performance based incentive scheme for PNs	Ⓟ
	Lack of funding for job aids and transport	○	Incorporate funding for job aids, communication and transport into the revised capitation funding	Ⓟ
Skills and motivate human resources	Availability of required numbers of adequately trained personnel	□	Development of the human resource plan (required numbers)	Ⓟ
			Elaboration of the human resource development plan promoting required knowledge and skills for the new HV/PN functions	Ⓟ
	Lack of capacity and approaches for service management and coordination and for supportive supervision	○	Development of management and supervision functions of respective administrative staff	Ⓟ
	Lack of undergraduate and on the job training programs for patronage nurses	○	Development of PN training curricula and integration into undergraduate and continuous education programs	Ⓟ
	Inertia in training institutions and shortage of faculty members with the needed knowledge and training skills	○	Development of the faculty capacities in education institutions with needed knowledge and training skills	Ⓟ

Infrastructure, medical supplies & technology	HV recording forms developed	⊙	Revision of Individual Medical Card to reflect all required information/data about the HVs	Ⓟ
	Lack of materials and job aids, information material	O	Develop home visitor job aids (including e-health tools for reporting, parent education materials, and family-held baby book)	Ⓟ
	Absence of access to E-health tools for reporting and education activities	O	Development of E-health tools for reporting and education activities	Ⓟ
	Shortage of communication and transportation means	□	Development of Investment plan for procurement of communication and transportation means	Ⓟ
	Office space for PNs ensured	⊙	Ensure allocation of adequate office space for PNs	Ⓟ
nformation system	Monitoring indicators developed though do not adequately track services processes and outcomes	□	Introduce enhanced data gathering systems and tools and define an indicator system that measures process and outcomes of HV/PNS	Ⓟ
	Information system based on paperwork	□	Design and institutionalize software enabling planning of HVs, data entering, tracking progress and outcomes	Ⓟ
			Ensure availability of required information technologies and equipment	Ⓟ
			Build human resource capacity in use of the information technology	Ⓟ
	Lack of skills in data collection and analysis at all levels	O	Build human resource capacity in data analysis and reporting at all levels	Ⓟ
Community Demand	Poor awareness of the rationale for the home visiting service and its content	□	Public awareness campaign through community women's groups	Ⓟ
	Perception of home visiting – currently community nurses are not perceived as the essential support system to pregnant women and families of young children	□		

⊙ AVAILABLE

O NOT AVAILABLE

□ AVAILABLE BUT NEEDS REVISIONS

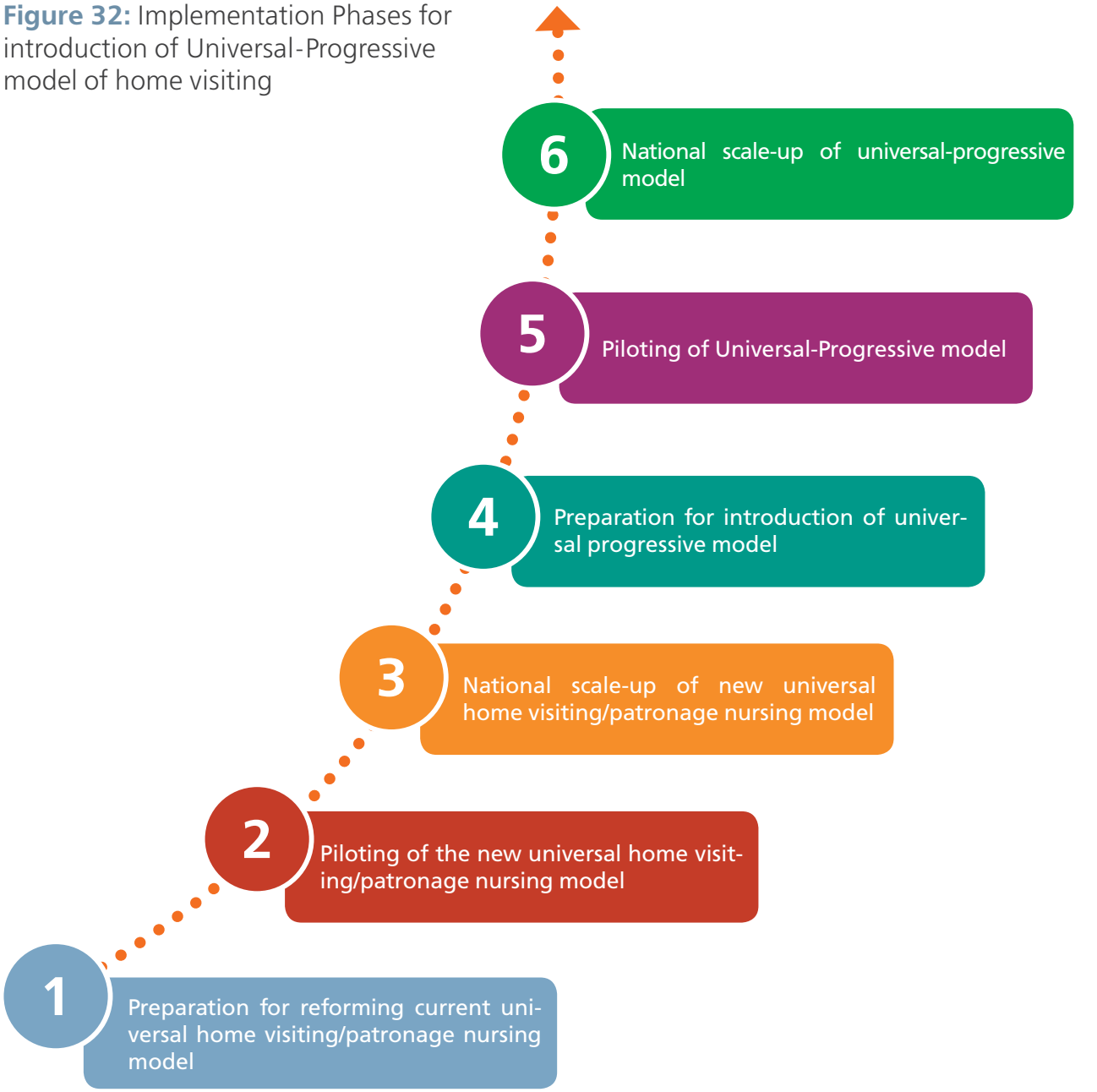
Ⓟ PLANNED-TO BE DEVELOPED

Based on this analysis it becomes obvious that the system is not yet ready to introduce a new, Universal-Progressive model of HV/PNS, albeit demonstrating prospects for a phased introduction.

7.3. PROPOSED PHASES FOR INTRODUCTION OF UNIVERSAL-PROGRESSIVE MODEL OF HOME VISITING/PATRONAGE SYSTEM AND ACTIVITIES PER IMPLEMENTATION PHASE

Given the system readiness, it is recommended to apply a phased approach to the introduction of a Universal-Progressive model of HV/PNS. Specifically, it is proposed to have six phases as schematically presented in Figure 32, below.

Figure 32: Implementation Phases for introduction of Universal-Progressive model of home visiting



PHASE 1: PREPARATION FOR REFORMING CURRENT UNIVERSAL PATRONAGE NURSING SYSTEM

Rationale: A Universal-Progressive model of the home visiting/patronage system is based on a strong universal home visiting service package, separate from a targeted/progressive package. As such, the system readiness findings suggest the need to establish an enhanced and streamlined universal PNS system. The first phase should therefore predominantly focus on establishing an enabling environment for the institutionalization of streamlined home visiting/patronage services.

Activities: Tasks and activities to be accomplished during the first phase are listed according to the health system building blocks in Table 17 below.

Table 17: Phase 1 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Adopt the new, Universal-Prospective Home visiting Road Map
		1.2	Revise/develop and approve PN standards and norms (visiting schedule, service package, number of visits, target beneficiaries, staffing, etc.)
		1.3	Development and adoption of the new organization structure of HV/PNS at national, oblast and facility levels
		1.4	Revise and adopt Job Descriptions (PNS manager, PN, GP, SW, etc.)
		1.5	Develop PNS Operational Manual (procedures)
		1.7	Design and adopt job aids, guidelines, referral algorithms
		1.8	Design and approval of revised recording and reporting forms
		1.9	Design of the PNS performance evaluation system (system design, indicators, responsibilities, procedures)
		1.10	Development and approval of the basic training courses for PNS capacity building
		1.11	Development of required legislation/bylaw/decree
		1.12	Development of the pilot site selection criteria for effective implementation of Phase 2
2	Service Delivery	2.1	Development of the PHC reorganization plan which intends to introduce an autonomous PNS unit
3	Financing	3.1	Introduction of the earmarked funding for PNS
		3.2	Development and approval of earmarked funding modality for piloting enhanced universal home visiting/patronage nursing system
		3.3	Initiation of recalculation of capitation funding which will reflect new HV/PNS model

4	Infrastructure, Medicines and Supplies	4.1	Development of the standard list of required equipment, medicines, supplies, office furniture and standards for office space allocation
		4.2	Development and approval of the procurement budget and plan for piloting enhanced universal home visiting/patronage nursing system
		4.3	Procurement of required goods
		4.3	Development of the facility based plan for allocation of office space for new PNS unit
		4.4	Printing of job aids, guidelines, etc.
		4.5	Printing of the population information materials
5	Skilled and motivated human resources	5.1	Development and approval of the facility based staffing plan
		5.2	Recruitment of PN where needed
		5.3	Development and approval of the PN training plan
		5.4	Build National and Local on-the-job training capacity in modern home visiting
		5.5	Training of PN of the pilot sites
6	Information System	6.1	Development of the PNS information management software
		6.2	Procurement of required information technology
		6.3	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Development and printing of the population information material about PNS
		7.2	Mobilization of community women's groups, volunteers for population awareness raising

PHASE 2: PILOTING NEW UNIVERSAL HOME VISITING /PATRONAGE NURSING MODEL

Rationale: Upon completion of Phase 1: Preparatory phase, pilot the enhanced universal HV/PNS model in selected sites. Piloting will allow for fine tuning standards, procedures, job aids, MIS, etc. and getting ready for national scale-up.

Activities:

Table 18: Phase 2 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Development and approval of MOHSP Decree on piloting enhanced universal patronage system model in selected sites
		1.2	Development of local health authority decrees for piloting
		1.3	Introduction of the new organization structure of HV/PNS at pilot sites
		1.4	Development of capacity and implementation of supportive supervision of PNS
		1.5	Baseline and follow-up evaluation of the pilot
2	Service Delivery	2.1	Implementation of the facility reorganization plan
3	Financing	3.1	Implementation of the earmarked funding for PNS at facility level
4	Infrastructure, Medicines and Supplies	4.1	Ensure availability of office space, materials and job aids for PNS
5	Skilled and motivated human resources	5.1	Recruitment of PN as needed according to facility based staffing plan
		5.2	Development, approval and implementation of the facility based PN training plan
6	Information System	6.1	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Implementation of population awareness rising activities

PHASE 3: NATIONAL SCALE UP OF NEW UNIVERSAL HOME VISITING/ PATRONAGE NURSING MODEL

Rationale: Upon completion of Phase 2: Pilot phase, and based on the pilot evaluation results, finalize all aspects of the enhanced universal HV/PNS model and roll out nationwide.

Activities:

Table 19: Phase 3 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Development and approval of MOHSP Decree on national scaling up of universal patronage system model
		1.2	Development of local health authority decrees
		1.3	Introduction of the new organization structure of HV/PNS at pilot sites
		1.4	Development of capacity and implementation of supportive supervision of PNS
		1.5	Baseline and follow-up evaluation of the scale-up
2	Service Delivery	2.1	Implementation of the facility reorganization plan
3	Financing	3.1	Implementation of the earmarked funding for PNS at facility level
4	Infrastructure, Medicines and Supplies	4.1	Ensure availability of office space, materials and job aids for PNS
5	Skilled and motivated human resources	5.1	Recruitment of PN as needed according to facility based staffing plan
		5.2	Development, approval and implementation of the facility based PN training plan
6	Information System	6.1	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Implementation of population awareness raising activities

PHASE 4: PREPARATION FOR INTRODUCTION OF UNIVERSAL-PROGRESSIVE HOME VISITING /PATRONAGE NURSING MODEL

Rationale: Phase 4: Preparation for the nation-wide introduction of a Universal-Progressive HV/PNS model starts in parallel with Phase 2 and continues until the end of Phase 3. Such timing will allow for the development of all necessary inputs for each health system building block, piloting them, fine-tuning and preparing for sub-national piloting.

Activities:

Table 20: Phase 4 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Adopt the new, Universal-Prospective Home Visiting Road Map
		1.2	Revise/develop and approve PN standards and norms (visiting schedule, service package, number of visits, target beneficiaries, staffing, etc.) for Universal-Prospective Home Visiting
		1.3	Adaptation and adoption of the new organization structure of Universal-Prospective HV/PNS at national, oblast and facility levels
		1.4	Adaptation and adoption of job descriptions (PNS manager, PN, GP, SW, etc.) if needed
		1.5	Revision and finalization of PNS operational manual (procedures)
		1.6	Mapping of community and other services (education, social, etc.)
		1.7	Adaptation and approval of job aids, guidelines, referral algorithms inside and outside the health system
		1.8	Approval of final version of recording and reporting forms
		1.9	Finalization and enforcement of the PNS performance evaluation system (system design, indicators, responsibilities, procedures)
		1.10	Development of the PNS human resource production, deployment and on-the-job capacity development plan
		1.11	Introduction of the basic and elective training courses for PNS capacity building
		1.12	Development of the PN certification program
		1.13	Development of required legislation/bylaw/decree
		1.14	Development of the pilot site selection criteria for effective implementation of Phase 5
2	Service Delivery	2.1	Development of the country wide PHC reorganization plan which intends to introduce an autonomous PNS unit
3	Financing	3.1	Finalization of the preparatory work for introduction of the earmarked funding for PNS
		3.2	Approval of earmarked funding modality for piloting Universal–Progressive home visiting/patronage nursing system
		3.3	Finalization of revised capitation funding which reflects new HV/PNS model
		3.4	Revision and approval of the public financial resource allocations for PHC and integration into the Mid Term Expenditure Framework
		3.5	Development and approval of PNS staff performance based motivation scheme

4	Infrastructure, Medicines and Supplies	4.1	Finalization of the standard list of required equipment, medicines, supplies, office furniture and standards for office space allocation
		4.2	Finalization and approval of the procurement budget and plan for piloting Universal-Progressive home visiting/patronage nursing system
		4.3	Procurement of required goods
		4.3	Development of the facility based plan for allocation of office space for new PNS units where applicable
		4.4	Printing of job aids, guidelines, etc.
		4.5	Printing of the population information materials
5	Skilled and motivated human resources	5.1	Development and approval of the facility based staffing plan
		5.2	Recruitment of PN where needed
		5.3	Development and approval of the PN training plan
		5.4	Build National and Local on-the-job training capacity in modern home visiting
		5.5	Training of PN of the pilot sites
6	Information System	6.1	Finalization of the PNS information management software
		6.2	Procurement of required information technology
		6.3	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Development and printing of the population information material about PNS
		7.2	Mobilization of community women's groups, volunteers for population awareness raising

PHASE 5: PILOTING OF UNIVERSAL-PROGRESSIVE HOME VISITING/ PATRONAGE NURSING MODEL

Rationale: Upon completion of Phase 4: Preparatory phase, pilot the enhanced Universal HV/PNS model in selected sites. Piloting will allow for fine tuning standards, procedures, job aids, MIS, etc. and getting ready for national scale-up.

Activities:

Table 21: Phase 5 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Development and approval of MOHSP Decree on piloting Universal-Progressive HV/patronage system model in selected sites
		1.2	Development of local health authority decrees for piloting
		1.3	Introduction of the new organization structure of HV/PNS at pilot sites
		1.4	Development of capacity and implementation of supportive supervision of PNS
		1.5	Baseline and follow-up evaluation of the pilot
2	Service Delivery	2.1	Implementation of the facility reorganization plan
3	Financing	3.1	Implementation of the earmarked funding for PNS at facility level
4	Infrastructure, Medicines and Supplies	4.1	Ensure availability of office space, materials and job aids for PNS
5	Skilled and motivated human resources	5.1	Recruitment of PN as needed according to facility based staffing plan
		5.2	Development, approval and implementation of the facility based PN training plan
6	Information System	6.1	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Implementation of population awareness raising activities

PHASE 6: NATIONAL SCALE UP OF UNIVERSAL-PROGRESSIVE HOME VISITING/ PATRONAGE NURSING MODEL

Rationale: Upon completion of Phase 5: Pilot phase, and based on the pilot evaluation results, finalize all aspects of the new Universal-Progressive HV/PNS model and roll out nationwide.

Activities:

Table 22: Phase 6 Tasks and activities

BUILDING BLOCK		ACTIVITY	
1	Leadership and Stewardship	1.1	Development and approval of MOHSP Decree on national scaling up of Universal-Progressive patronage system model
		1.2	Development of local health authority decrees
		1.3	Introduction of the new organization structure of HV/PNS at pilot sites
		1.4	Development of capacity and implementation of supportive supervision of PNS
		1.5	Baseline and follow-up evaluation of the scale-up
2	Service Delivery	2.1	Implementation of the facility reorganization plan
3	Financing	3.1	Implementation of the earmarked funding for PNS at facility level
4	Infrastructure, Medicines and Supplies	4.1	Ensure availability of office space, materials and job aids for PNS
5	Skilled and motivated human resources	5.1	Recruitment of PN as needed according to facility based staffing plan
		5.2	Development, approval and implementation of the facility based PN training plan
6	Information System	6.1	Training of PNs and other facility staff in utilization of the new PNS MIS, data entry and analysis and reporting
7	Demand Generation	7.1	Implementation of population awareness raising activities

7.4. TIMING OF IMPLEMENTATION PHASES AND KEY OUTPUTS

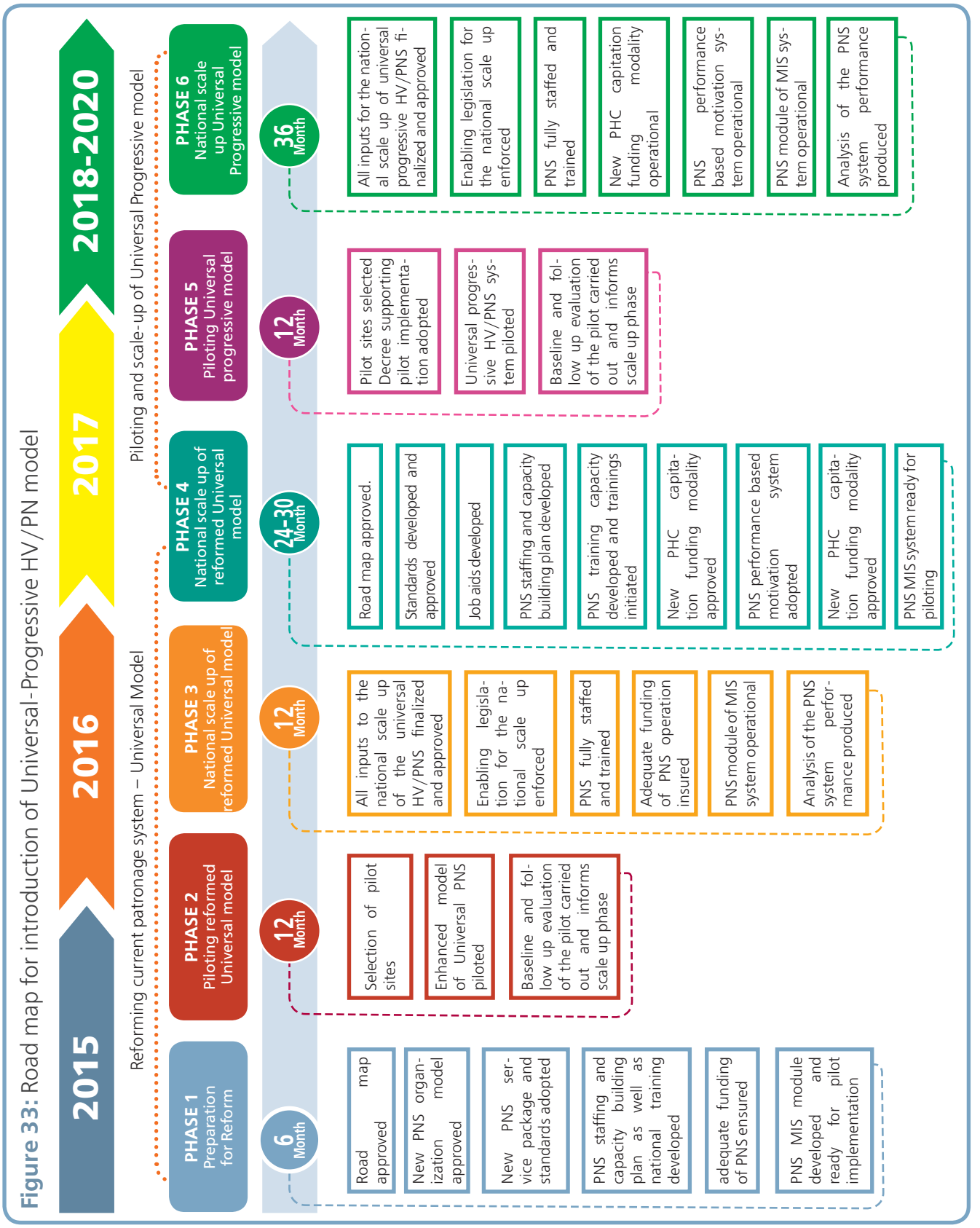


Figure 33: Road map for introduction of Universal-Progressive HV/PN model

This section of the report presents timing and duration of each implementation phase and outlines key outputs per phase as shown in Figure 33 below. Although, it should be noted that the timing and duration of each phase is subject to accomplishing key outputs required for moving towards the next phase. Furthermore, the timing, duration, and list of key outputs can be revised/ updated during implementation.

PHASE 1: Preparation for reforming the current Universal PN system

This phase will be initiated as soon as the given road map is approved by the government and will last no longer than six to eight months.

The key outputs of the phase will be:

- Roadmap for introduction of a Universal-Progressive HV/PNS model is approved by the MoHSP
- New PNS organizational and governance structure at national, oblast and facility level developed and approved
- New standards for reformed Universal PNS developed and approved including:
  - Home visiting schedule, timing, number of visits, services per visit, target beneficiaries
  - PNS staffing norms, functions and credentials
  - PNS operational manual
  - PNS job aids, guidelines and referral algorithms
  - Recording and reporting forms, as well as a set of process and quality indicators
  - Norms for office space, equipment, medicines and supplies
- PNS staffing and capacity development plan adopted
- PNS staff training capacity at national and local levels developed
- Adequate funding of PNS ensured
- PNS Management Information System module developed and ready for piloting
- PNS staff training in use of MIS and information/communication technologies initiated for pilot sites
- Legislation issued for piloting reformed Universal PNS model defining pilot sites.

PHASE 2: Piloting of reformed Universal PN system

This phase will be initiated upon completion of Phase 1 and will last for a full 12 months to allow generation of sufficient evidence on the model's performance. Before the second phase commences, a baseline assessment will be carried out, followed by an end-line evaluation of the pilot. This research will provide information about the effectiveness of the model, as well as highlighting weaknesses, and will inform the revision and finalization of all inputs required before the national scale-up of the Universal model.

The key outputs of Phase 2 will be:

- Availability of an enabling legal environment for piloting through the issuance of MoHSP and Local Health Authority Decrees on piloting
- Baseline assessment carried out
- Pilot Universal PNS model is fully implemented
  - PNS new organizational structure introduced
  - PNS fully staffed and PNs trained in basic training modules
  - PNS operation manual fully complied with by facility staff

- Adequate funding of the PNS made available
- New reporting and recording modalities applied
- PNS module of MIS fully operational

- End line evaluation of the pilot carried out and recommendations for further enhancement of the model clearly stipulated
- Budget for the national scale-up developed and adopted.

PHASE 3: National scale-up of reformed Universal PN system

This phase will begin immediately after the completion of Phase 2 and once the results of the pilot evaluation are available. The results of the pilot evaluation will inform final revisions to be made to the model design until it is scaled-up nationwide.

The key outputs of Phase 3 will be:

- Availability of an enabling legal environment for national scale-up
- All inputs for national scale-up are finalized and approved through issuance of respective legal and regulatory documents
- Budget for national scale-up is made available
- PNS fully staffed with skilled and well-trained professionals
- Supportive supervision of PNS functions
- PNS performance based system in place and fully functional
- PNS module of the MIS is operational and the capacity for data analysis and utilization built.

PHASE 4: Preparation for the introduction of Universal-Progressive model of PN system

Phase 4 starts at the beginning of the pilot phase of reforming the current Universal PNS, or even earlier, and will last for approximately 24 months. Early initiation of preparatory works for introducing a progressive package will enable forecasting the targeted/progressive package composition, scope, and target, and will allow for piloting some tools, guidelines, job aids, training materials, MIS, etc. before starting the national scale up.

The key outputs of Phase 4 will be:

- Revised road map for the introduction of the Universal-Progressive HV/PNS model approved
- Standards and norms of the Universal-Progressive HV/PNS model developed and approved
- Job aids, guidelines, referral algorithms developed and approved
- PNS staffing and capacity building plan developed
- PNS training capacity developed and trainings initiated
- New PHC capitation funding modality approved
- PNS performance based motivation system adopted
- Universal-Progressive HV/PNS MIS system ready for piloting
- Pilot sites selected and legislation adopted for piloting.

PHASE 5: Piloting of Universal-Progressive model of HV/PN system

This phase will begin upon completion of Phase 4 and will last for a full 12 months to allow sufficient evidence to be generated on the model's performance. Before the last phase begins a baseline assessment will be carried out, followed by an end-line evaluation of the pilot. This will provide information about the effectiveness of the model, as well as highlighting weaknesses, and will inform the revision and finalization of all inputs required before the national scale-up.

The key outputs of Phase 5 will be:

- Availability of an enabling legal environment for piloting through issuance of MoHSP and Local Health Authority Decrees on piloting
- Baseline assessment carried out
- Pilot Universal-Progressive HV/ PNS model is fully implemented
  - PNS fully staffed and PNs trained in basic and additional training modules
  - PNS operation manual fully complied with by facility staff
  - Adequate funding of the PNS made available
  - New reporting and recording modalities applied
  - Universal-Progressive HV/PNS module of MIS fully operational
- End line evaluation of the pilot carried out and recommendations for further enhancement of the model clearly stipulated
- Budget for the national scale-up developed and adopted.

PHASE 6: National scale-up of Universal-Progressive model of HV/PN system

This phase will commence right after the completion of Phase 5 and once the results of the pilot evaluation are available. These results will inform final revisions to be made to the model design before it is scaled-up nationwide.

The key outputs of Phase 6 will be:

- Availability of an enabling legal environment for national scale-up
- All inputs for national scale-up are finalized and approved through issuance of respective legal and regulatory documents
- Budget for national scale-up is made available
- PNS fully staffed with skilled and well-trained professionals
- Supportive supervision of PNS functions
- PNS performance based system in place and fully functional
- PNS module of the MIS is operational and the capacity for data analysis and utilization built.

ANNEXES

ANNEX A

JOB DESCRIPTION FOR HOME VISITOR

1. Duties and Responsibilities

1.1. Home Visiting

- Schedules and conducts home visits with parents and children in their homes in accordance with guidelines
- Assesses physical, emotional, social and environmental needs of children and their families
- Plans and develops with parents an individualized program based on their child's assessment and incorporating identified family's strengths and needs
- Provides health education activities to families
- Provides teaching for families in acquiring skills
- Provides families with developmentally appropriate activities and information designed to enhance the child's intellectual, social-emotional, motor, and language abilities
- Provides, models, and teaches positive child guidance, nurturing skills, and appropriate discipline methods and techniques to challenging behaviors of children
- Advises and assists families in establishing priority goals and outcomes
- Advises and assists families in the utilization of learning opportunities for their child
- Advises and assists families in the principles of child health and safety by reviewing health and safety conditions of their home and family on a regular basis
- Plans and implements all required screenings, assessments and control of mother/child health and child development
- Informs parents of the need to schedule and keep appointments for all screenings, evaluations, and follow up services for their children and encourages them to participate fully
- Provides education, support and referral resources in assisting families in attaining their targeted goals
- Provides management of crisis intervention
- Consults and collaborates with other professionals involved in providing services to families
- Links families to services in health care system and other sectors as well as other resources in the community, e.g., support groups, NGOs
- Implements community campaigns and community activities for health promotion and uses community resources to develop family support groups

1.2. Administrative

- Supports policies, procedures, guidelines and standards in HV
- Maintains individual records on family/children including screenings, assessments, referrals, progress reports, documentation of home visitation activities, etc.
- Maintains accurate, complete and timely documentation
- Submits reports according to guidelines, policy and administrative regulations
- Collects and analyses performance data related to child and family health and wellbeing outcomes

1.3. Communication

- Develops and maintains community relationships to support family referrals
- Maintains clear, effective, open, honest communication with both families and colleagues
- Maintains confidentiality
- Assists in creating a positive work environment that promotes productivity, mentoring, teamwork and cooperation
- Seeks and responds appropriately to feedback

1.4. Professional Development

- Accurately assesses own learning needs and develops strategies to meet them
- Stays informed of current knowledge based-developments within field of child health, early child development, public health, and home visitation

2. Qualifications

- Bachelors or Associates degree in nursing, child development, education, social sciences or related field
- At least 2 years experience working with children and families
- Capacity for outreach work, problem solving, handling crises, and work with families and children of various cultures
- Approach to working with families that is empathic, nonjudgmental, respectful, and professional
- Flexibility with respect to time and days able to work as well as to work tasks (Flexible work style and approach)
- Computer literacy
- Good communication skills and team work skills
- Good coordination/managerial skills
- Ability to work effectively with diverse groups and situations

ANNEX B

RECOMMENDED VISITING SCHEDULE

SUGGESTED ACTIVITIES		GUIDELINES & TOOLS
FIRST PRENATAL BY 12 WEEKS OF GESTATION		
CLINICAL MONITORING	Clinical monitoring Measurement of weight, blood pressure, anemia, folic acid	Clinical monitoring check-list
ASSESSMENT	Pregnancy risk factor screening Assessment of maternal mood Assessment of substance abuse Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Risk factor screening check-list Maternal mood screening check-list Substance abuse screening check-list Home environment screening check list
EXAMINATION	- Problems faced during pregnancy	Standard algorithms
QUESTIONING	On domestic violence and discussion around relationship issues	National guideline
COUNSELLING & TEACHING &PRACTICE	About physical and mental changes associated with pregnancy Healthy eating, weight, physical activity, oral health, harmful effects of stress in pregnancy, smoking and smoke-free environments, alcohol use, drugs and some medicines, and some infectious diseases For mild depression, provide structured listening support/counselling Smoking cessation advice Offer weight control strategies Danger signs of pregnancy	Job aids and guides Standard counselling messages
ADVICE		
PLANNING	Antenatal visit to GP/Gynecologist	Standard Individual planning checklist
REFERRAL	Where domestic violence is disclosed refer to respective institutions (follow local guidelines) Where alcohol or drug abuse is identified refer to specialist services	Referral algorithm for domestic violence Referral algorithm for special services
LINKING	Linking with social services and other community resources	Local map of available social and community services
SECOND PRENATAL AT 32 WEEKS OF PREGNANCY		
CLINICAL MONITORING	As above	Clinical monitoring check-list
ASSESSMENT	Assessment of maternal mood Parent views and feelings about pregnancy and parenthood	Maternal mood screening check-list
EXAMINATION	Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Home environment screening check list

QUESTIONING	On domestic violence and discussion around relationship issues	Domestic violence screening check-list
COUNSELLING & TEACHING &PRACTICE	Preparation for birth and parenting, including home and equipment Transition to parenthood Relationship issues Discussions about labor, birth, breastfeeding Counsel on healthy eating, weight, physical activity, oral health, harmful effects of stress in pregnancy, smoking and smoke-free environments, alcohol use, drugs and some medicines, and some infectious diseases For mild depression, provide structured listening support/counselling	Job aids and guides Standard counselling messages Information materials
ADVICE	What to pack for hospital delivery How to prepare room for a newborn Social welfare advice (maternity leave, benefits)	Standard list of items required for delivery Guideline for social benefits and list of nearest social welfare service offices
PLANNING	Antenatal visit to GP/Gynecologist	Reminder service algorithm Appointment service tools
REFERRAL	Pregnant woman in abusive relationship refer to respective institution(s) as per local guidelines	Referral algorithm for domestic violence
LINKING	When needed link with community support services	Map of the community support services and contact information
FIRST VISIT (FIRST 3 DAYS AFTER DISCHARGE FROM MATERNITY)		
CLINICAL MONITORING	Assessment of baby's weight and signs of jaundice, umbilical cord care	Clinical monitoring check-list
ASSESSMENT	Parent views and feelings about pregnancy and parenthood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Home environment screening check list
EXAMINATION	Height of uterine fundus (involution), state of lochia, and management of preexisting health conditions Assessment of maternal mood	Guideline Maternal mood screening check-list
QUESTIONING	Caretaker's knowledge on newborn care On domestic violence and discussion around relationship issues	Domestic violence screening check-list
COUNSELLING & TEACHING &PRACTICE	Importance of breastfeeding, position of the baby during breastfeeding, care of nipples, preparation of formula and feeding practices, hygiene issues Infant care, bathing, diapering, sleep position, room temperature, advice on reducing sudden infant death syndrome Danger signs of diarrhoea and acute respiratory diseases	Job aids and guides Standard counselling messages Information materials

ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Elaboration of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Standard for individual plan Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized care when needed	Guidelines for management of disability and specialized care
LINKING	To other service providers (social, police, etc.) when applicable	Referral algorithms Map of nearest social, education, police offices and contact numbers
SECOND VISIT (7 DAYS OF LIFE)		
CLINICAL MONITORING	Assessment of baby's weight and signs of jaundice, umbilical cord care	Clinical monitoring check-list
ASSESSMENT	Assessment of maternal mood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.) Check if baby listens attentively to sounds and voices	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Height of uterine fundus (involution), state of lochia, and management of preexisting health conditions	Guideline and check-list
QUESTIONING	Caretaker's knowledge on newborn care Concerns about baby and parenting issues On domestic violence and discussion around relationship issues	Check-list Domestic violence assessment check-list Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Importance of breastfeeding, position of the baby during breastfeeding, care of nipples, preparation of formula and feeding practices, hygiene issues Infant care, bathing, diapering, sleep position, room temperature, advice on reducing sudden infant death syndrome Danger signs of diarrhoea and acute respiratory diseases Educate on infant care as per family need Promoting sensitive parenting and bonding Involvement of father and other family members Support positive interactions with newborn and interpret baby's needs	Job aids and guides Standard counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence

LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information
THIRD VISIT (1 TO 2 MONTHS)		
CLINICAL MONITORING	Assessment of baby's weight, feeding and sleeping	Clinical monitoring check-list
ASSESSMENT	Assessment of maternal mood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Check if baby listens attentively to sounds and voices	Developmental assessment guideline and check-list
QUESTIONING	Concerns about baby and parenting issues	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Position of the baby during breastfeeding, care of nipples, preparation of formula and feeding practices, hygiene issues Infant care, bathing, diapering, sleep position, room temperature Danger signs of diarrhoea and acute respiratory diseases Educate on infant care as per family need Promoting sensitive parenting and bonding Involvement of father and other family members Support positive interactions with newborn and interpret baby's needs Activities with baby: go for walk, talk to baby and point out sights, smells and sounds, encourage eye contact with baby	Job aids and guides Standard counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community upport services and contact information
FOURTH VISIT (3 MONTHS)		
CLINICAL MONITORING	Assessment of baby's growth On-going review and monitoring of the baby's health	Clinical monitoring check-list
ASSESSMENT	Assessment of maternal mood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list

EXAMINATION	Check if baby listens attentively to sounds and voices Check development of baby (ability to control head, follow moving object with eyes, open hand to hold finger or rattle, show interest and excitement with facial expression, smile at people, look at who is talking, kicking legs)	Developmental assessment guideline and check-list
QUESTIONING	Concerns about baby and parenting issues	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Promoting infant development (cuddle baby while smiling, talking, and singing, give baby toys to explore, show books with black and white pictures and patterns) Follow natural routine for eating and sleeping Take baby outside, encourage physical activity through floor play, water play, develop reaching and grasping skills, loose clothes to develop kicking and rolling Provide safety advice on baby's sudden movements and grabbing small objects that can cause choking Oral hygiene advice	Job aids and guides Standard counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information
FIFTH VISIT (6 MONTHS)		
CLINICAL MONITORING	Assessment of baby's growth On-going review and monitoring of the baby's health	Clinical monitoring check-list
ASSESSMENT	Assessment of maternal mood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Check development of baby (turning head from side to side to look at who is talking, rolling from side to side, reaching for toys, showing understanding of mother's emotional state and react to tone of voice, sit up with support, push up on hands, coo, giggle and make lots of sounds, batter dangling objects, recognize familiar people, play with toes)	Developmental assessment guideline and check-list

QUESTIONING	Concerns about baby and parenting issues	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Promoting infant development (singing nursery rhymes, playing peek-a-boo, talking about what baby is doing and mother is doing, giving the baby time to explore on their own for short periods, dancing with baby in arms, bouncing baby gently, copying noises, helping sitting safely, copying baby's language, sharing books, finger rhymes, songs and games, responding to bubbling sounds and smiles, providing a basket of toys, tummy time, reflective mirrors, go outside every day, walks in pram) Oral hygiene advice Counsel on accident prevention Promoting infant development (talk and sing to baby, read book, nursery rhymes, body movement, imitate baby facial expressions and sounds...)	Job aids and guides Standrd counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information
SIXTH VISIT (12 MONTHS)		
CLINICAL MONITORING	Assessment of child's growth On-going review and monitoring of the child's health	Clinical monitoring check-list
ASSESSMENT	Assessment of the toddler's physical, emotional and social needs in the context of their family, including predictive risk factors (check development of toddler: able to get self into sitting position, watch a toy being hidden and know that it still exists, pulls self to stand and may crawl, may walk, babbles with expression, follows simple instructions, understands and anticipates routines) Check development of baby (protests if something is taken away, stands holding on to something, sits without help, picks up small objects with thumb and finger, and eats some foods with fingers, copies sounds and offers toys to others, makes sounds that sound like a real word, fearful of strangers, rolls and may crawl or move on floor, empties boxes)	Maternal mood assessment check-list Home environment screening check list

EXAMINATION	Assessment of maternal mood Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Developmental assessment guideline and check-list
QUESTIONING	Concerns about child and parenting issues	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Provide parents with information about attachment and the type of developmental issues that they may now encounter, health promotion, raise awareness of dental health and prevention, healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention Promoting toddler development (provide commentary of activities and use short simple sentences, give toddler time to make a sound in response, provide toys that can be pushed around, help toddler stand and walk, introduce rules, move baby away from things not to be touched and give baby something else to touch, acknowledge/encourage toddler's achievements, using gestures when talking, saying goodbye to pacifier) Promoting infant development (use box of different textured every-day objects, use baby's name and show affection, use toys that do things, give finger foods, respond to baby's attempts to communicate, help baby to stand, visit interesting places in the outdoor environment, look at and feel items in environment, have baby in garden/park to enjoy sights and smells) Advise on teething and tooth care Advise on baby socialization Accident prevention (use stair guards and electric plug guards, use straps on feeding chairs, do not leave unsupervised)	Job aids and guides Standard counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information
SEVENTH VISIT (18 MONTHS)		
CLINICAL MONITORING	Assessment of child's growth On-going review and monitoring of the child's health	Clinical monitoring check-list

ASSESSMENT	Review immunization status Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Check development of toddler (climbs up and down a step or low stair, uses a spoon to eat, begins to show temper, says a few words or gestures, stands and sits without help, walks holding a toy or walks, points to named objects, people and pictures)	Developmental assessment guideline and check-list
QUESTIONING	Concerns about child and parenting issues	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Promoting toddler development (naming everyday objects and pictures and repeating them, imitating and turn taking, looking at books, talking about pictures, giving choices (apple, ...), music, dancing, dress-up, make repeat visits to outside favorite places, play with nature, sand play, picnics in park... Advise on routines for sleeping and sleeping, managing behavior and tantrums, making nutritious meals... Encourage physical activity for three hours a day spread over the day Accident prevention	Job aids and guides Standard counselling messages Information materials
ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information
EIGHTH VISIT (24 MONTHS)		
CLINICAL MONITORING	Review with parents the child's social, emotional, behavioral and language development	Clinical monitoring check-list
ASSESSMENT	Review immunization status Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Check development of child (saying lots of words and some joined together, shows comfort when others unhappy, scribbles spontaneously, sorts shapes, feeds self and drinks from cup without a lid, takes off shoes, socks, hats, points to six body parts, runs but may not avoid obstacles, builds a tower of three or more blocks, follows simple instructions)	Developmental assessment guideline and check-list

QUESTIONING	Respond to any parental concerns about physical health, growth, development, hearing and vision	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Promoting child development (comfort child after tantrum, talk to child a lot and give time to respond, encourage outdoor play, encourage play with interesting textures (dough, cooking materials), looking at picture books and reading stories, look for simple shapes (squares, circle), coloring, painting, digging, imagination play...) Accident prevention (do not leave unattended) Advise parents that child may develop strong likes and dislikes, provide guidance on behavior Toilet training advice Give health information and guidance	Job aids and guides Standard counselling messages Information materials
ADVICE	Offer advice on nutrition and physical activity for the family, and sleep management	
PLANNING	Social welfare advice when applicable	Information on social benefits
REFERRAL	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
LINKING	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
NINTH VISIT (36 MONTHS)		
CLINICAL MONITORING	Review with parents the child's social, emotional, behavioral and language development	Clinical monitoring check-list
ASSESSMENT	Review immunization status Home environment safety screening (economic status, living conditions, hygiene, abuse, violence, etc.)	Maternal mood assessment check-list Home environment screening check list
EXAMINATION	Check development of child (balance on one foot, combine words to form short sentences, provide appropriate answers, comprehend size, match shape and colors, play cooperatively)	Developmental assessment guideline and check-list
QUESTIONING	Respond to any parental concerns about physical health, growth, development, hearing and vision	Parent-baby interaction assessment check list
COUNSELLING & TEACHING &PRACTICE	Promoting child development (engage in pretend play, show child how to dress, catch a ball, play counting game, go on adventure outside, get child to help in tidying up toys, read lots of stories, promote positive discipline with parents) Accident prevention (do not leave unattended) Give health information and guidance hygiene practice and prevention of communicable diseases Advise on preparation for kindergarten attendance	Job aids and guides Standard counselling messages Information materials

ADVICE	Social welfare advice when applicable	Information on social benefits
PLANNING	Monitoring/revision of individual plan (next home visit, visit to GP, visit for immunization, other etc.)	Reminder service algorithm Appointment service tools
REFERRAL	For additional support for newborns with disabilities For specialized health care when needed	Referral algorithm for domestic violence
LINKING	To other service providers (social, police, etc.) when applicable	Map of the community support services and contact information

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