PROGRESS IN REDUCING HEALTH SYSTEM BOTTLENECKS TOWARDS ACHIEVING THE MDG 4: EVALUATION OF UNICEF’S CONTRIBUTION IN FIVE CEE/CIS COUNTRIES

KYRGYZSTAN COUNTRY SUMMARY

REGIONAL KNOWLEDGE AND LEADERSHIP AREA 6
RFP Health-2013-01 RKLA 6
ABBREVIATIONS

ANC  Antenatal Care
ARI  Acute Respiratory Infections
ARR  Annual Rates Of Reduction
AWP  Annual Work Plans
BABIES  Birth Weight Group and Age-At-Death Boxes for an Intervention Evaluation System
BF  Breast Feeding
BFHI  Baby Friendly Hospital Initiative
CEE  Central and Eastern Europe
CIF  Curatio International Foundation
CIS  Commonwealth of Independent States
CMD  Control of Micronutrient Deficiencies
CO  Country Offices
CPAP  Country Programme Action Plans
DD  Diarrheal Diseases
DHS  Demographic Health Survey
DPT3  Diphtheria, Pertussis, Tetanus the Third Dose
ECD  Early Childhood Development
EmOC  Emergency Obstetric Care
ENC  Essential Newborn Care
EPC  Effective Perinatal Care
EPI  Expanded Programme On Immunization
ET  Evaluation Team
FF  Flour Fortification
GAVI  Global Alliance for Vaccines and Immunization
GDP  Gross Domestic Product
HIV  Human Immunodeficiency Virus
IDD  Iodine Deficiency Disorders
ILBD  International Live Birth Definition
IMCI  Integrated Management Of Childhood Illness
IMR  Infant Mortality Rate
M&E  Monitoring and Evaluation
MCE  Multi-Country Evaluation
MCH  Maternal Child Health
MDG  Millennium Development Goal
MICS  Multiple Indicator Cluster Survey
MNCH  Maternal, Newborn and Child Health
MoH  Ministry of Health
MoRES  Monitoring Results for Equity Systems
MTR  Mid-Term Review
NMR  Neonatal Mortality Rate
OOP  Out-of-pocket Payment
ORS packet  Oral Rehydration Salt packet
Introduction

UNICEF commissioned this Multi-Country Evaluation (MCE) with the purpose to “show evidence to what extent UNICEF has been effective and efficient in pursuing those strategies and drawing from lessons learned of the past, how UNICEF should do programming further”1. The evaluation looked at both national and sub-national system level changes to a) document progress in reducing under 5 and infant mortality and morbidity, and generating lessons on how this was accomplished; b) inform programs aimed at scaling-up evidence-based and equity focused interventions; and c) enable better partnering with national governments to advance the child health and rights agenda. The evaluation objectives were formulated as follows:

1) To document results in terms of changes in access to MNCH services (enhanced coverage of children with proven health services packages and interventions) and reduction of equity gaps;
2) To assess how system level changes (enabling environment, supply and demand, and quality of MNCH services) led to these results; and
3) To document the contribution of UNICEF to addressing health system level bottlenecks.

The detailed description of the evaluation methodology is presented in the MCE Final Evaluation Report (Chapter 3). The Kyrgyz Republic was among the five evaluated countries.

During the evaluated period (2000-2012), Kyrgyzstan’s macroeconomic indicators were gradually improving. However, the positive trends were slowed down by several major shocks during the last decade. As a result, Kyrgyzstan remains one of the poorest countries in the CEE/CIS region, with a Gross National Income (GNI) of $1,210 per capita in 20132. It is among the medium human development category countries for 2012, with an index of 0.622 (125th in the world). After a decade of decline, since 2010, due to the political events and civil unrest that led to the humanitarian emergency, a rise in poverty rates was observed. By 2012, 38% of the population was living below the poverty line, with 4.4% being extremely poor3. The majority of poor people (nearly 70%) live in rural areas. In rural areas, access to services such as water supply, collection of solid waste and sewerage is limited for all the population, due to difficulties of service provision in mountainous regions.

The child poverty rate is a serious social concern. According to the survey of the National Statistics Committee in 2011, 44.6 % of children under 17 years of age live in poverty and 5.6% are classified as extremely poor. A study conducted in 20094 identified three main determinants of child poverty: living in large families, in particular those with three and more children; parental unemployment; and mother’s education level. The risk of poverty among children living in such households is three times higher than among children living in families where at least one woman of working age has higher education. Kyrgyzstan was among the first CEE/CIS countries to embark on comprehensive health system reforms that contributed to the improvements in health status of the population. Life expectancy at birth increased by 3 years (from 66 to 69 years) over the period of 2000-2012. However, the life expectancy was still well below the WHO European Region average at 76 years (2012)5.

Overview of UNICEF-supported programmes in Kyrgyzstan

The current evaluation captured three programme cycles (CPAP) for Kyrgyzstan covering the CPAP periods 2000-2004, 2005-2011 and 2012-2016 (only the first year 2012). The CPAPs’ content and the structure greatly varied during the evaluation period. Main strategies applied by UNICEF in the CPAP 2000-2004 were advocacy for policy development, creating models of excellence, providing technical assistance and M&E. Following the 2007 MTR recommendations and rethinking the UNICEF role in the country’s social reformation process, in

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1 Progress in Reducing Health System Bottlenecks towards Achieving the MDG 4 Goal: Evaluation of UNICEF’s Contribution in 5 CEE/CIS Countries. Terms of Reference. 2013
3 National Statistical Committee of the Kyrgyz Republic, 2011
4 National Study on Child Poverty and Inequalities in the Kyrgyz Republic, 2009. UNICEF
5 WHO Country Health Profile. http://www.who.int/gho/countries/kgz.pdf?ua=1
2008, the main programme strategies were refocused at institutional capacity building of local Governments and line ministries, sharing knowledge and provision of expertise in the revision and improvement of legal and regulatory frameworks, development of policies and standards. In 2009-2010, the UNICEF role temporarily shifted to the provision of emergency assistance before returning to more traditional core roles in the following years. Throughout the evaluated period UNICEF-supported country programmes in health sector aimed at strengthening health systems and addressing bottlenecks in effective coverage by MNCH services. In pursuing this goal, UNICEF programmes targeted a range of evidence-based interventions across the continuum of care and various delivery platforms, most of which can be grouped across several key “intervention packages” presented in Figure 1.

Figure 1: Continuum of MNCH care and the key “intervention packages”

Source: Modified from Kerber et al. 2007

Annex 1 of the Final MCE Evaluation Report provide detailed description of the intervention packages, while annexes 2 and 12 present the inventory of UNICEF projects/subproject activities grouped according to these packages by the CPAP periods in each evaluated countries including Kyrgyzstan.

Key evaluation findings and conclusions

Results: impact and changes in access to MNCH services and reduction of equity gaps

Key child health indicators

According to the UN Inter-agency Group for Child Mortality Estimation (IGME) estimates, during 2000-2013 in Kyrgyzstan under-5 mortality declined from 49.2 to 24.2 per 1,000 live births with an average Annual Rate of Reduction (ARR) of 3.9%, which exceeds the global and CEE/CIS regional averages of ARR at 3% and 3.7% respectively.

Figure 2: Under-5 mortality rate and the ARRs in the evaluated countries and the CEE/CIS, 2000-2013

Source: Authors estimates based on the UN Interagency Group Mortality Estimates 2014
It is notable, that these estimates are very close to the mortality figures reported through the national statistical system. Mortality reduction occurred throughout the continuum from birth up to fifth birthday, however the highest reduction 64% was achieved among 1 to 4 year-old children, followed by infant mortality reduction by 49% and the lowest reduction, although significant in its size, was noted among neonates – 42% (see Figure 2).

Figure 3: Under-5 Mortality rate and reduction in neonatal, infant and children aged 1-59 months mortality rates, Kyrgyzstan 2000-2013

![Graph showing under-5 mortality rate and reduction]

Source: UN Interagency Group Mortality Estimates 2014

In 2013, up to 3,950 children aged under-5 years were saved annually compared to the year 2000. Yet, estimated 3,824 child deaths were still occurring. Out of which, preterm birth complications, intrapartum related events and congenital abnormalities are claiming most of the lives of children during their first month of life and pneumonia, injuries, diarrhoea and meningitis being a leading causes of death of children under-5 (Figure 3).

Figure 4: Causes of death in neonatal period and children under 5 years of age, Kyrgyzstan, 2013

![Graph showing causes of death in neonatal period and children under 5 years of age]


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6 This means that 7,246 children would have died if Under-5 mortality rate remained the same as in the year 2000.
The trend in one of the key child health indicators - underweight prevalence rate - for the evaluated period also appear positive, while stunting prevalence appears to have increased over the time. However, it was impossible to establish the statistical significance of the observed changes in both indicators (Table 1).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Endpoint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting prevalence %</td>
<td>13.7</td>
<td>12.9</td>
</tr>
<tr>
<td>Education (Lowest vs. Highest)*</td>
<td>2.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Wealth (poorest vs. richest)*</td>
<td>1.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Rural vs. Urban*</td>
<td>1.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Underweight prevalence %</td>
<td>3.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Education (Lowest vs. Highest)*</td>
<td>3.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Wealth (poorest vs. richest)*</td>
<td>1.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Rural vs. Urban*</td>
<td>1.0</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Compiled by the Evaluation Team from MICS 2006 (Baseline) and MICS 2014 (Endpoint) databases

Wealth, education and rural-urban related equity gaps have been reduced in Kyrgyzstan in the evaluated period (Table 1), but significant sub-national differences in child health status remain between the regions of the country (see Figure 4). Moreover, according to 2006 and 2014-MICS findings inequalities in IMR and U5MR between urban and rural residents are still observed, with rural and poor children and children born to less educated families having higher chances of dying.

Figure 5: Infant mortality rate, regions of Kyrgyzstan, 2000, 2012

Source: Ministry of Health 2014

The other remaining outliers in terms of key child health indicators in Kyrgyzstan, include:

- Children that are born in poor and less educated families, particularly those residing in the rural areas and less developed regions and cities that are experiencing social deprivations are still at a greater risk of dying;

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7 Although it should be noted that part of the observed increase in IMR for Osh city may be related to the implementation of the perinatal referral system resulting in more children referred from Osh and Batken Oblasts dying at Osh Perinatal Center. This issue requires further in-depth study.
• Stillborn babies, whose numbers increased from app. 6 to app. 10 per 1,000 live births in the period 2000-2013;
• Infants dying before their first birthday, particularly in neonatal period, who account for 45% of under-5 children deaths occurring in Kyrgyzstan and who are dying from preventable causes.
• Children leaving in up to 13% of families having limited access to the clean water and sanitation.

Effective coverage with MNCH services

In the evaluated period the indicators measuring various dimensions of effective coverage with MNCH services in Kyrgyzstan show mixed trends. Availability of human resources declined, while financial accessibility to and demand for MNCH have improved, along with moderate improvements in the quality coverage with MNCH services. Other indicators characterising effective coverage mostly show the positive developments. (see Table 2).

Table 2: Selected effective coverage indicators across the continuum of care (intervention packages), Kyrgyzstan

<table>
<thead>
<tr>
<th>Indicator</th>
<th>BL</th>
<th>MP</th>
<th>EP</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANC/PNC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person providing antenatal care - Doctor</td>
<td>71.1</td>
<td>85.8</td>
<td>82.1</td>
<td>11.0</td>
</tr>
<tr>
<td>No antenatal care received</td>
<td>2.1</td>
<td>2.9</td>
<td>2.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Person assisting at delivery - Doctor</td>
<td>65.1</td>
<td>77.9</td>
<td>79.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Current use of contraceptives (any method)</td>
<td>60.5</td>
<td>48.2</td>
<td>42.0</td>
<td>-18.5</td>
</tr>
<tr>
<td><strong>IMCI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child with suspected pneumonia taken to any appropriate HC Provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic treatment of suspected pneumonia</td>
<td>40.4</td>
<td>19.5</td>
<td>35.4</td>
<td>-5.0</td>
</tr>
<tr>
<td>Use of ORS packet</td>
<td>19.8</td>
<td>23.1</td>
<td>67.2</td>
<td>47.4</td>
</tr>
<tr>
<td>Oral rehydration therapy with continued feeding</td>
<td>61.7</td>
<td>47.0</td>
<td>22.7</td>
<td>-19.0</td>
</tr>
<tr>
<td>Knowledge of the danger signs of pneumonia (fast breathing)</td>
<td>47.0</td>
<td>47.0</td>
<td>47.0</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely initiation of breastfeeding with 1 hour of birth</td>
<td>45.0</td>
<td>65.0</td>
<td>82.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Exclusively breastfed 0-5 month old children</td>
<td>24.0</td>
<td>27.4</td>
<td>41.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Percentage of households consuming adequately iodized salt</td>
<td>27.0</td>
<td>77.8</td>
<td>92.8</td>
<td>65.8</td>
</tr>
<tr>
<td><strong>Environmental Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of improved drinking water</td>
<td>79.1</td>
<td>88.1</td>
<td>87.0</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Source: DHS 1997 (BL), MICS 2006 (MP) and DHS 2012 or MICS 2014 (EP), Kyrgyzstan

The remaining gaps in the effective coverage include:

- Exclusive breastfeeding rates gradually increased between 1999-2013, but still remains low at app. 41%;
- Immunization coverage remains above 90%, despite the temporary negative effects of the anti-vaccination campaign in 2010-2011. More prone to such campaigns, the urban and wealthier resident have lower vaccination coverage;
- More urban and male children are taken to the health facilities than rural and female children;
- 20% less parents/caretakers in general and fewer rural and poor parents/caretakers and with lower education recognize danger signs of pneumonia (fast breathing) in 2014 compared to 2005.

More detailed findings on effective coverage are presented in the MCE Final Evaluation Report (Chapter 4 and Annex 13)

System level changes and UNICEF contribution

The evaluation findings indicate that these developments in child health outcomes and in the effective coverage with MNCH services are most likely associated with system level changes that were triggered by targeting specific causes of child morality and morbidity and removing the critical health system bottlenecks preventing the achievement of the desired level of the effective coverage. UNICEF-supported intervention
packages in Kyrgyzstan have addressed main causes of child morbidity and mortality during the evaluation period. However, the mortality and morbidity causes originating in the preconception and antenatal periods were less addressed (see section 4.2.1 of the MCE Final Report).

The evaluation assessed UNICEF and its partners’ joint performance in inducing system change through addressing critical bottlenecks using “addressing scores” assigned to specific bottlenecks across the intervention packages. The evaluation findings show that UNICEF independently and/or in cooperation with its international and national partners managed to “fully address” 54 out of 89 identified bottlenecks (61%). This denotes that the right and appropriate scope, target groups and scale of programmes were used. In the case of 34 bottlenecks (38%), where the correct and appropriate scope and/or target groups were used but scale was limited to pilot and/or fragmented activities at subnational/national level, the bottlenecks were considered “partially addressed”. For 1 bottleneck (1%), considered “not addressed”, the interventions were isolated, with inappropriate scope and/or target groups and inadequate scale. Across MoRES determinants, UNICEF and its partners were most successful in addressing bottlenecks in enabling environment and supply for MNCH services and relatively less successful in addressing demand and quality dimensions (Figure 5), particularly for ANC/PNC intervention packages (Table 3). UNICEF also managed to involve relevant partners in the programme design, implementation and evaluation, however representation of beneficiaries in this process was relatively small.

Table 3: Bottlenecks average addressing score across MoRES determinants and the key intervention packages

<table>
<thead>
<tr>
<th>MoRES Determinants</th>
<th>ANC/PNC</th>
<th>EPI</th>
<th>IMCI</th>
<th>NUTRITION</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand</td>
<td>1.0</td>
<td>1.7</td>
<td>1.5</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Enabling Environment</td>
<td>1.7</td>
<td>1.7</td>
<td>1.5</td>
<td>2.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Quality</td>
<td>1.0</td>
<td>2.0</td>
<td>1.0</td>
<td>2.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Supply</td>
<td>1.1</td>
<td>2.0</td>
<td>1.6</td>
<td>1.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Average</td>
<td>1.4</td>
<td>1.8</td>
<td>1.5</td>
<td>1.9</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Most of the UNICEF supported programmes were integrated into national policies and the national budgets adopted during the evaluated period.

UNICEF also ensured the financial sustainability of the scaled models, which was attained through upfront and continuous engagement with the government officials and open and frank dialogue about the need to assume financial responsibilities, supported with the needed evidence and, where necessary, with strong advocacy. UNICEF assisted programmes were also mostly successful in leveraging resources and partnerships. As a result of these efforts 12 out of 15 programmes continue after the conclusion of UNICEF support (see Figure 6).
UNICEF identified and in cooperation with its partners has attempted to tackle all health system level determinants: conducive laws and policies, management and service organization, effective budgeting and financing, skilled and motivated human resources, necessary drugs, supplies and equipment, quality of services and social and cultural believes, however UNICEF was least successful in addressing quality of service and skilled and motivated human resources bottlenecks in the country. The bottlenecks remain that hamper further progress. These bottlenecks include low skilled and motivated primary, perinatal care and paediatric emergency health personnel, shortage of staff; low awareness of mothers/caretakers on danger signs child illness; inadequate feeding practices of pregnant women and mothers, poor access to care for certain vulnerable groups; poor infrastructure and obsolete equipment; and poor management capacity at local level.

As a result, the evaluation concludes that UNICEF supported programmes most likely contributed to achieving required changes as per the health system determinants in Kyrgyzstan. This was achieved by identifying the critical health system bottlenecks in effective coverage for the evidence-based MCHN interventions and addressing them with the help of core roles: the “voice” for children and adolescents; leveraging resources from public and private sectors; facilitating national dialogue concerning child-friendly social norms; monitoring and evaluation; policy advice and technical assistance; enabling knowledge exchange; and modelling. UNICEF contribution in addressing the bottlenecks in Kyrgyzstan was assessed by the evaluation team as “significant” (contribution score “2”) or “major/critical” (contribution score “3”) for most of the bottlenecks (see Table 4). Detailed description on how these core roles were applies in Kyrgyzstan see Annex 12 of the MCE Final Report.

Table 4: UNICEF contribution score by core roles in addressing system bottlenecks in Kyrgyzstan

<table>
<thead>
<tr>
<th>MoRES Determinants</th>
<th>Policy advice and technical assistance</th>
<th>Modeling/piloting</th>
<th>Enabling knowledge exchange</th>
<th>National Dialogue</th>
<th>Monitoring &amp; evaluation</th>
<th>The 'Voice' for children</th>
<th>Leveraging resources</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducive laws, policies &amp; Standards</td>
<td>2.9</td>
<td>3.0</td>
<td>2.8</td>
<td>2.7</td>
<td>2.8</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Effective budgeting &amp; financing</td>
<td>2.8</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Management &amp; Service Organization</td>
<td>2.9</td>
<td>2.8</td>
<td>2.8</td>
<td>2.4</td>
<td>2.8</td>
<td>2.7</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Necessary drugs, supplies &amp; equipment</td>
<td>3.0</td>
<td>2.9</td>
<td>2.4</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Quality of services</td>
<td>3.0</td>
<td>2.8</td>
<td>3.0</td>
<td>3.0</td>
<td>2.7</td>
<td>3.0</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Skilled &amp; motivated HR</td>
<td>2.3</td>
<td>2.6</td>
<td>2.9</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Social and cultural practices and beliefs</td>
<td>2.8</td>
<td>3.0</td>
<td>2.5</td>
<td>2.0</td>
<td>3.0</td>
<td>2.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.7</strong></td>
<td><strong>2.9</strong></td>
<td><strong>2.6</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.7</strong></td>
<td><strong>3.0</strong></td>
<td><strong>2.8</strong></td>
</tr>
</tbody>
</table>

There is a high likelihood that UNICEF supported programmes contributed to reducing bottlenecks in ensuring effective coverage of priority MNCH interventions along the continuum, considering the improved coverage indicators for availability of services, financial accessibility of MNCH services, and moderate improvements in the quality of services observed in Kyrgyzstan by the end of the evaluated period.

The results achieved in reduction of equity gap in coverage with MNCH services were mixed. While some gaps were reduced the other inequities widened. Yet, it is likely that the reduction in bottlenecks contributed to disease specific mortality reduction for perinatal conditions, ARI, DD, and meningitis and these reductions appear to be positively associated with overall reduction in NMR, IMR, and USMR in Kyrgyzstan. Bottlenecks’ reduction contribution to the reduction of deaths due to congenital conditions and injuries was impossible to establish.

Human rights approach and gender equality of UNICEF supported programs in Kyrgyzstan

Gender Equality was largely absent and the Human Rights Based Approach to programming was partially incorporated into UNICEF supported programmes planning, implementation and evaluation. Monitoring and evaluation of UNICEF supported programmes were mostly declared as performed in a participatory and ethnical manner with full respect to human rights and gender specific and sensitive issues, while evidence of such performance with regards to programme planning and implementation was impossible to obtain. MNCH programs supported by UNICEF in Kyrgyzstan, with few exemptions (e.g. recent collaborative projects under One UN programme and the “equity project”) did not define clearly the marginalized, vulnerable and hard-to-
reach groups for programmatic purposes and subsequently focused interventions on these groups. UNICEF has however monitored equity effects of its interventions. As a cross cutting theme, gender has been implemented in a significant proportion of the UNICEF country interventions but restricted to child protection activities and very little, if any, were found in the area of MNCH.

**Country Specific Recommendations**

Along with the recommendations presented in the MCE evaluation report that are relevant to Kyrgyzstan, the evaluation team also proposes to UNICEF CO in Kyrgyzstan following country specific recommendations for future programming:

- Focus on the most disadvantaged regions and populations groups, drawing on successful experience of One UN Programme, while closely monitor developments in better off parts of the country and maintain flexibility to intervene when necessary;
- Enhance Health management capabilities at central and local levels;
- Enhance health personnel counselling skills;
- Elaborate innovative approaches for continuous awareness raising and population education on women and child related issues;
- Closely monitor immunization coverage to avoid deterioration of achievements;
- Carry out external evaluation of government led continuous medical education program and elaborate recommendation for further improvement