FINAL EVALUATION REPORT

Zarafshan Partnerships
For Scaling-Up Innovative Approaches for Rural Tajikistan
To Building Community and Health Facility Capacity
To Sustain Key Investments in Essential Maternal and Child Health Services

Cost Extension of
Cooperative Agreement No.: FAO-A-00-98-00022-00
September 30, 2002 – September 30, 2007, in
Panjikent and Aini Districts of Sughd Region, Tajikistan

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Glossary of Acronyms and Terms

ACNM	American College of Nurse-Midwives
ANC	Antenatal Care
ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Diseases
CMO	Chief Medical Officer
CS	Child Survival
CS-14	"Panjikent Partners," the previous CS project, which ended in September 2002, of which CS-18 is a cost extension.
CS-18	The cost extension of CS-14, which began in October 2002
CtC	Child-to-Child (health education)
DD	Diarrheal Disease
DFID	Department for International Development
DHO	District Health Office (of the MOH)
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization (MOH program and/or CS-14/-18 intervention supporting MOH immunization activities)
feldsher	MOH health technicians with approximately four years of medical training
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GMP	Growth Monitoring and Promotion
HF	Healthy Family Project
HFA	Health Facility Assessment
HFF	Health Facility Farm
HIV/AIDS	Human Immune-Deficiency Virus/Acquired Immune Deficiency Syndrome
IDA	Iron Deficiency Anemia
IMCI	Integrated Management of Childhood Illness
JST	Joint Supervisory Team
KPC	Knowledge, Practices, and Coverage (survey)
LQAS	Lot Quality Assurance Sampling
LSS	Life-Saving Skills (for maternal and newborn care)
M&E	Monitoring and Evaluation
MC	Mercy Corps
MCH	Maternal and Child Health
MNC	Maternal and Newborn Care (CS-18 intervention)
MOE	Ministry of Education
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-Governmental Organization
OH	Office of Health of Save the Children
ORS	Oral Rehydration Solution
PD	Positive Deviance
PD/H	PD/Hearth
PDI	Positive Deviance Inquiry

PDQ	Partner Defined Quality
PLG	Program Learning Group (of SC's Office of Health)
PRA/PLA	Participatory Rapid Assessment/Participatory Learning and Action
PVO	Private Voluntary Organization
SC	Save the Children Federation/USA
SC/HO	Save the Children's Home Office
TFO	Tajikistan Field Office of Save the Children/US
TOT	Training-of-Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
VDC	Village Development Committee (called Village Health Committee in CS-14)
VP	Village Pharmacy
WFA	Weight-For-Age
WHO	World Health Organization
UNAIDS	The Joint United Nations Programme on HIV/AIDS

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A. Executive Summary

Save the Children (SC) implemented the CS-18 project as a follow-on or cost-extension of the CS-14 project in northwestern Tajikistan. The original CS-14 project targeted 73 communities in Penjikent District. The CS-18 project added the remaining 70 more remote communities in that district and also all 61 communities in neighboring Aini District. The project has now covered the entire rural Zarafshan Valley and surrounding mountains with interventions in maternal-newborn care (MNC) pneumonia case management (PCM), diarrhea, breastfeeding and nutrition. The project included improving health worker skills and performance, community education and mobilization, and some policy work. The project was implemented in partnership with the district health offices (DHO) of the Ministry of Health (MOH).

Project goals: (1) A sustained reduction in under-five and maternal mortality in rural Panjikent and Aini districts; (2) Innovative CS-18 strategies to contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan.

Results: (1) Improved health practices at the household level, and increased use of key maternal child health (MCH) services, and; (2) Sustained investments in key MCH services by communities and rural health facilities in Panjikent and Aini districts.

Intermediate Results: (1) Increased household level knowledge of selected MCH issues; (2) Improved capacity of communities to address priority health needs of mothers and children under five; (3) Improved capacity of rural health facilities in Panjikent and Aini districts to provide quality MCH services and support community health activities, and; (4) Improved SC/Tajikistan Field Office (TFO) capacity to scale up successful MCH activities, present results, and expand MCH programming in Tajikistan.

The final evaluation was conducted in August, 2007. SC's CS-18 project is exceptional in the level of behavior change achieved, the improved skills and attitudes of health professionals, and successful empowerment of Village Development Committees (VDCs). Success may be only partially attributed to the high level of education among the target population and their hunger for learning, and to relatively good access to health services. The well-designed project benefited from the solid technical expertise of the project managers, the SC regional health advisor, and the stability of project staff, many of whom were with the project in the CS-14 phase as well. The project investment in contracting the American College of Nurse Midwives (ACNM) paid off in that their training not only transmitted technical skills, but was also very motivational, increasing self-confidence and morale among all MOH staff who received the initial training or the refresher trainings.

Having two consecutive projects enabled SC/Tajikistan (TFO) to implement models with which to influence policy with the necessary time to produce visible results and engage in advocacy. One striking example of this is the introduction of child health cards, not previously used in former Soviet countries. After seeing SC's example, and with support from UNICEF, the MOH adopted child health cards as part of national strategy. Due to the influence of the SC child survival project, routine growth monitoring and promotion is being adopted as a standard in the target districts and, the MNC training resulted in Penjikent District adopting WHO norms for iron supplementation during pregnancy.

Available data show that the project reduced mortality in children under five from pneumonia in both districts and from diarrhea in Penjikent. MOH data also show dramatic increases in care-seeking for pneumonia and diarrhea. (Please see Figure 1. on page 8.) The following table shows the behavior changes between the baseline and final surveys.

Table 1. Changes in Key Behaviors

Indicator	Baseline 2002	Final 2007
% of births attended by a skilled birth attendant	85	95
% of children under 6 mos. exclusively breastfed in the past 24 hours	12	93
% of children 12 to 23 months with measles immunization	67	82
% of women who had 3 or more prenatal visits in last pregnancy	53	92
% of children 12 to 23 months with cards fully immunized	71	82
% of mothers reporting hand washing at necessary times	19	93
% of households with only iodized salt at the time of survey	10	92
% of children with ARI or DD in the past 2 weeks receiving continued feeding and more fluids	30	100

Conclusions:

- This exemplary child survival project changed family behaviors and community norms, empowered village development committees and youth, improved skills, motivation and morale of MOH health staff at all levels, and influenced MOH policy at the district and national levels.

- The highly successful experiences in achieving impressive levels of participation in growth monitoring and promotion (GMP) without incentives, and in mobilizing communities to reject non-iodized salt deserve documentation and further study by SC as models for other GMP and community mobilization efforts.

- The project's achievement of significant change in a cultural behavior like breastfeeding practices in just two years shows what is possible with sound behavior change strategy and dedication.

- The technical and leadership skills of the CS-18 project's expatriate staff and the SC regional technical advisor have produced highly competent local staff who will continue to be an asset to Tajikistan and the Zarafshan Valley.

- While project activities were phased over to the MOH and there is commitment and motivation on their part to continue, there is still the issue of lack of transportation, particularly in Aini. Due to this, it is doubtful that current supervision and community visit levels will be maintained.

- An income-generation scheme for the health facilities that had to be dropped in 2003 due to disappearance of complementary funding, continued in many places without SC support, as did many village pharmacies which SC also dropped due to new restrictive government regulations.

- Forming the Village Development Committees with a broader scope than just health, and providing them with appropriate organizational skills, enabled them to assume a true leadership

role in the community and evolve to pursue major community development projects with outside donors or internal fund-raising.

- The project significantly exceeded all targets for changes in household practices and knowledge on pertinent MCH issues. The project also exceeded all targets for results in improved capacity of communities and health facilities and for the sustainability objectives.

- There is the need for further intervention in the target area focusing on water and sanitation, de-worming, and HIV/AIDS.

B. Assessment of Results and Impact of the Project

1. Results Summary Chart

Result/Inter-mediate Result	#	Indicator	Method	Baseline Value	EOP Target	Final
R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent & Aini districts.	1	% of mothers who report having made 3 or more ANC visits to a health facility while pregnant with youngest child.[1,(3)]	KPC Survey	53%	80%	**92%**
	2	% of 0-23 month olds whose birth was attended by skilled health personnel.[1,3]	KPC Survey	85%	90%	**95%**
	3	% of 0–5 month olds exclusively breastfed during the last 24 hours.[3]	KPC Survey	12%	50%	**93%**
	4	% of 12-23 month olds who received a measles vaccine (by maternal history).[(1),3]	KPC Survey	67%	80%	**82%**
	5	% of 12-23 month olds with cards, fully immunized.[(3)]	KPC Survey	71%	70%	**82%**
	6	% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.[(3)]	KPC Survey	30%	60%	**100%**
	7	% of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.[3]	KPC Survey	19%	40%	**93%**
	8	% of households with children <2 which have only iodized salt for cooking.	KPC Survey	10%	50%	**92%**
R-2A: Key CS-18 benefits & activities **sustained** in Panjikent villages following SC phase-out	9 A	Final lot-specific achievements in phase-out villages for 6 of the 8 R-1 indicators sustained at no more than 10% below midterm coverage (for all 5 lots).	KPC Survey	See R-1	See R-1	**100%**
	10 A	Final lot-specific achievements in phase-out villages for 3 of the 4 IR-1 indicators sustained at no more than 10% below midterm coverage (for all 5 lots).	KPC Survey	See IR-1	See IR-1	**100%**
IR-1: Increased household level **knowledge** of selected MCH issue	13	% of mothers who know 2+ postpartum danger signs.[3]	KPC Survey	53%	70%	**95%**
	14	% of mothers who know 2+ newborn danger signs.[3]	KPC Survey	51%	70%	**98%**
	15	% of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.[(1)]	KPC Survey	27%	60%	**89%**
	16 A	% of mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.[(1)]	KPC Survey	15%	100%	**100%**
IR-2: Improved **capacity of communities** to address priority health needs of	17 A	% of children 6-23 months old with severe (< -3Z WFA) malnutrition in PD/H communities Unable to calculate	GMP reports	NA	<1%	**7%**
	17 B	% of children 6-23 months old with normal nutrition (> -2 Z WFA) in PD/H communities	GMP reports	61.5%	60%	**93%**

Result/Inter-mediate Result	#	Indicator	Method	Baseline Value	EOP Target	Final
mothers & children <5.	17 C	% of Hearth children who "graduated" from Hearth (rehabilitated [200g] or gained more than 400 grams within 1 cycle)	PD/H reports	NA	80%	**200g: 93%** **400g: 44%**
	18	% of villages with a health facility, having a Village Development Committee which organized 1+ health education session in past month, or had a VDC meeting addressing 1+ health topic in past 2 mos.(1)	CS-18 Records	estimate = 50%	90%	**95%**
IR-3: Improved **capacity of rural health facilities** in Panjikent & Aini districts to provide quality MCH services & support community health activities.	19	% of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.1,(2)	HFA	41% ***	70%	**73%**
	20	% of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.(1),(2)	HFA	48% ***	70%	**65 %**
	21	% of children <2 who have their weight plotted on growth chart.2	HFA	11% ***	60%	**85%**
	22	% of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.2	HFA	78% ***	90%	**95%**
	23	% of ANC clinic attendees who report having received iron supplements.	HFA and LSS	42% ***	70%	**95%**
	24	% of LSS-trained midwives who correctly manage normal pregnancies, deliveries, & obstetric complications. ****	ACNM LSS Forms	34%	70%	**Preg: 72%** **Del: 89%** **Com: 97%**
	25	% of rural health facilities which have staff trained in LSS.	"	37%	90%	**84% of villages**
	26	% of VDC meetings which have MOH staff participating.1	VDC Records	50%	90%	******-**
	27	% of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.	HF Records	0%	50%	**95%**
IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajik.	28	Number of CS-18 strategies successfully scaled up in new CS-18 areas.	Final Eval.	None	4	**4**
	29	Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.	Final Eval.	None	4	**4**
	30	Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.	PLG Report	No	Yes	**Yes**
	31	TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.	TFO Reports	No	Yes	**Yes**

*** Indicator source**: **1**: CS-14; **2**: BASICS HFA; **3**: KPC 2000 / 2000+ / CATCH; ( ) = indicator revised.
**** EOP target** set the same or lower than baseline because baseline value refers only to the smaller CS-14 site, and the target applies to the substantially larger CS-18 site/population with implementation through partners with less intensive SC involvement than was the case in CS-14.
***** Baseline HFA estimates** are weighted to reflect the distribution of population between old (CS-14) and new CS-18 areas, as the distribution of facilities in the HFA did not reflect this distribution of the population.
******** This indicator was added at mid-term then subsequently eliminated because it could not be readily measured.

2. Results: Technical Approach

a. Project Overview

SC implemented the CS-18 project as a follow-on or cost-extension of a CS-14 project in northwestern Tajikistan. The original CS-14 project targeted 73 communities in Penjikent District. The CS-18 project added the remaining 70 more remote communities in that district and also all 61 communities in neighboring Aini District. The project has now covered the 204 rural communities of the entire remote Zarafshan Valley and surrounding mountains with interventions in maternal-newborn care, pneumonia case management, diarrhea, immunization, nutrition, breastfeeding and micronutrients. The project included improving health worker skills and performance, community education and mobilization, and some policy work. The project was implemented in direct partnership with the district health offices of the Ministry of Health (MOH.)

CS-18 goals are: (1) A sustained reduction in under-five and maternal mortality in rural Panjikent and Aini districts, and; (2) Innovative CS-18 strategies that contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan. These goals were to be achieved through CS-18 results of: (1) Improved health practices at the household level, and increased use of key MCH services, and; (2) Sustained investments in key MCH services by communities and rural health facilities in Panjikent and Aini districts. These results were to be achieved through CS-18 intermediate results of: (1) Increased household level knowledge of selected MCH issues; (2) Improved capacity of communities to address priority health needs of mothers and children under five; (3) Improved capacity of rural health facilities in Panjikent and Aini districts to provide quality MCH services and support community health activities, and; (4) Improved SC/TFO capacity to scale up successful MCH activities, present results, and expand TFO MCH programming in Tajikistan.

Key elements of SC's CS-18 project included formation and support of Village Development Committees (VDCs) in 131 communities, introduction of the Child-to-Child (CtC) program into the schools, expansion of the Life Saving Skills (LSS) training from ACNM to all midwives plus introduction of community revolving loan funds and birth planning to address obstetric emergencies, funding training of Master Trainers for Integrated Management of Childhood Illness (IMCI), and targeting husbands and mothers-in-law with key messages. The project initiated child health cards, routine growth monitoring with counseling (GMP), and Positive Deviance Hearth (PD/Hearth), all of which were new to the MOH. SC staff, who are all physicians or professional midwives, implemented activities in partnership with local MOH personnel in each health facility, performed joint supervision visits with MOH supervisors, and phased over all project activities to the MOH, schools and communities through a clearly articulated sustainability strategy.

The project covered 131 communities and 74 health facilities in the CS-18 target area, while providing some continued support for the first two years to the 70 communities and health facilities of the CS-14 project. The project faced constraints of serious flooding in Year 3, delayed MOH acceptance of IMCI, and turnover of the project manager twice, but was able to go beyond proposed activities in the Detailed Implementation Plan (DIP) and to supersede all project targets.

b. Progress Report by Intervention Area

The CS-18 project included eight interventions as follows: Immunization (15%), Nutrition (15%), Vitamin A (1 %), Micronutrients (4%), Pneumonia Case Management (15%), Control of Diarrheal

Diseases (15%), Maternal and Newborn Care (30%), and Breastfeeding (5%). The levels of effort as planned in the DIP, had little bearing on needs or eventual levels of effort expended by the project. To their credit, project staff allocated their time and energy as they perceived was truly needed to bring about essential behavior changes in each intervention. For example, much more effort was needed to gain community acceptance of iodized salt than to increase care-seeking when children show signs of pneumonia.

Note: In the following section, findings and elements that indicate good potential for sustainability are identified with small capital letters.

Pneumonia and Diarrhea

Table 2. Control of Diarrheal Disease (CDD)

Indicators of results and other outcomes	Baseline	Final
% of mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.	none	**100**
% of mothers who report hand washing before food prep. & child feeding, & after defecation.	19	**93**
% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.	30	**100**

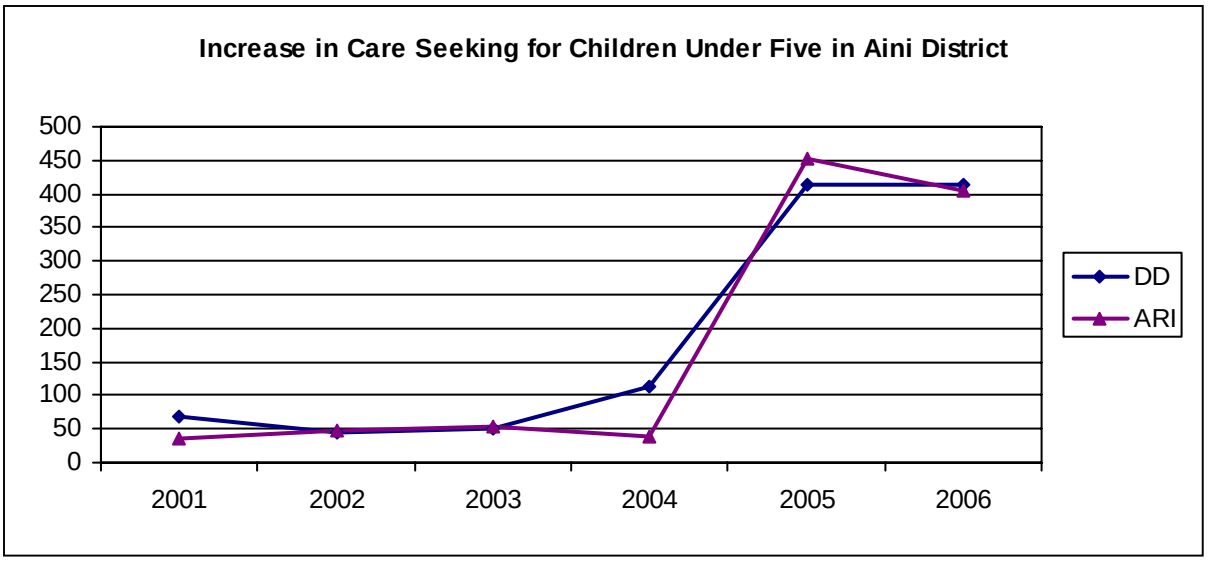
Table 3. Pneumonia/ARI

Indicators of results and other outcomes	Baseline	Final
% of mothers citing both rapid breathing & chest in-drawing as signs of respiratory infection which should lead them to take their child to a health provider.	27	**89**

The pneumonia and diarrhea interventions achieved a good balance of educating families and improving health worker skills. As can be seen in the baseline data presented above, mothers did not know any danger signs for diarrhea and only 27% could name the signs of pneumonia. The Chief Doctor for Maternal and Child Health in Penjikent stated that improving mothers' knowledge related to care-seeking for pneumonia and diarrhea is the project activity that has had the most direct impact on reducing child mortality in the district. In the final survey, mothers of all children with signs of pneumonia sought medical care.

The chart below illustrates the dramatic increase in care-seeking due to the intervention of the CS-18 project. The data from the MOH information system shows the number of cases of diarrhea or ARI diagnosed at health facilities. Project reports show that in 2003, mothers in Aini District began to receive the messages on signs of ARI and diarrhea and the need for medical care. Messages were conveyed through group education sessions organized by the VDCs and conducted by MOH staff, the CtC program, PD/Hearth, and through counseling from health staff.

Figure 1. Increase in Care Seeking for Children Under Five in Aini District



The CtC student-trainers taught younger students in middle school about the dangers signs of both diarrhea and pneumonia, how to prepare ORS, and the relationship of diarrhea to hygiene. Mothers told the final evaluation team heard from mothers of occasions when mothers asked and received assistance from their school-aged children on how to count respiration or to prepare ORS, which is distributed free from the health facilities to all families with children. CtC students and VDC members also encouraged neighbor families to take sick children for care at the health facility.

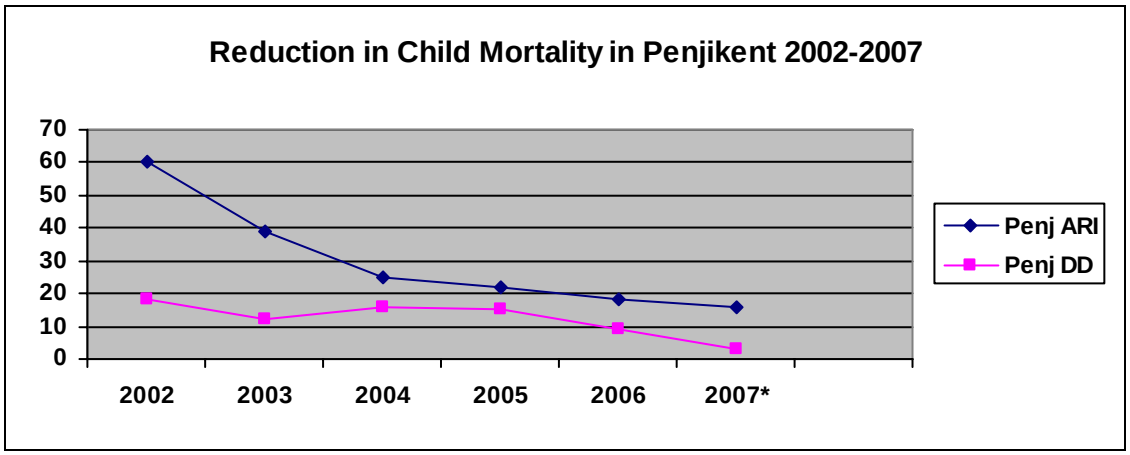
When SC wrote their proposal and DIP for this project, the potential for introduction of IMCI in Tajikistan was still uncertain, therefore, SC proposed continuing training the health professionals in the separate case management protocols, with particular emphasis on improving their skills to counsel mothers of sick children.

Following the MTE, the government did officially adopt IMCI. The CS-18 project covered the costs of sending five MOH staff from Penjikent to the UNICEF training of trainers for IMCI and a second training on monitoring and supervision of IMCI, in order for them to be qualified as Master Trainers. These Master trainers then proceeded to train all pediatricians and some other health personnel in their districts. In Penjikent District, a total of 126 persons were trained and are being supervised by the MOH district training team. THE SUPERVISORS ARE ALWAYS LOOKING FOR ANYONE NEEDING REFRESHER TRAINING AND HAVE A PLAN IN PLACE TO TRAIN NEW HIRES.

SAVE THE CHILDREN MADE A GOOD STRATEGIC CHOICE IN ASSURING THAT THE CHIEF DOCTORS FOR MATERNAL AND CHILD HEALTH IN EACH DISTRICT AND A FACULTY MEMBER OF THE PENJIKENT MEDICAL COLLEGE WERE AMONG THOSE TRAINED AS MASTER TRAINERS. THESE INDIVIDUALS ARE FULLY CONVINCED ABOUT IMCI. ONE CHIEF DOCTOR STATED THAT ALTHOUGH MORE TIME IS SPENT ATTENDING EACH CHILD, THE CHILD RECEIVES ALL THE TREATMENT NEEDED, INSTEAD OF TREATING JUST ONE SYMPTOM. THE OTHER CHIEF DOCTOR COMMENTED THAT APPLICATION OF IMCI IS REDUCING OVER-USE OF ANTIBIOTICS. THE FACULTY MEMBER IS NOW INCORPORATING IMCI INTO THE TRAINING OF MID-LEVEL HEALTH WORKERS.

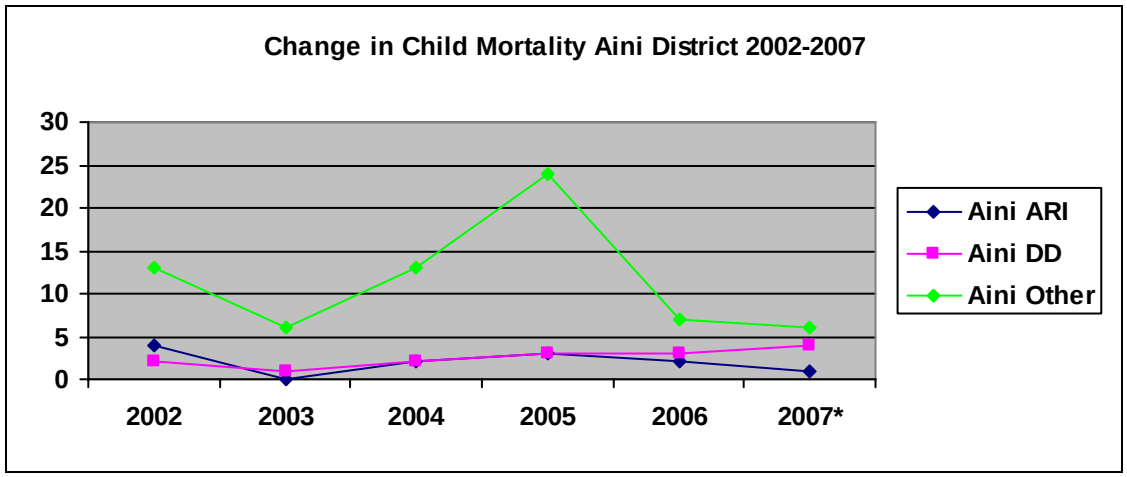
The following graphs show the changes in mortality due to ARI and CDD in the districts, according to the MOH, since 2002, the time period that corresponds to this project.

Figure 2. Reduction in Child Mortality in Penjikent



*2007 data for first six months.

Figure 3. Change in Child Mortality-Aini District



*2007 data for first six months. ** The spike in 2005 mortality is due to deaths related to floods.

Challenges:
The prevalence of diarrhea is related both to inadequate and insufficient potable water in the rural communities and to poor sanitation. Over half of villages still have to rely on collecting rain and snow for water, or getting water from irrigation ditches, streams, or the river. The scarcity of water particularly in the summer also impacts personal hygiene. Sanitation in rural communities is very poor. Even the families who have latrines do not use them properly or care for them. The project did put emphasis on hand-washing, but not particularly on sanitation. Water and sanitation is such an issue that a specific follow-on project would be merited.

Immunization

Table 4. Immunization Results

Indicators of results and other outcomes	Baseline	Final
% of 12-23 month olds who received a measles vaccine	67	**82**
% of 12-23 months olds with cards, fully immunized	71	**82**

During Soviet times, families did not seek immunizations; rather, health authorities sought out families on schedule to immunize the children. There was no decision left to the families and they were not given an explanation as to why children should be immunized. Records for immunizations were kept only within the health facilities. With the demise of the Soviet system, not only was the enforcement gone, but there were also acute shortages of vaccine for approximately 10 years. Immunization rates plummeted, particularly in remote areas, which were no longer visited by the mobile teams. Outbreaks occurred, although many were never reported.

With the support of UNICEF and other international organizations, vaccine supplies have been stabilized and cold chains rehabilitated. SC invested in the cold chain during CS-14. The challenge remaining was to help families understand why and when their children should be immunized. SC has successfully met this challenge by introducing child health cards and effective education programs in the communities. As reported in the final evaluation of CS-14, child health cards had never been used in Tajikistan before and SC faced an uphill battle in getting approval to introduce them. The DHO was not particularly interested until they began to see the results. Armed with knowledge about protecting their child's health and the card with the schedule, parents showed up at health facilities asking for immunizations! UNICEF subsequently joined the advocacy for child health cards in 2004, using Penjikent as an example, and they are now part of the national policy, with UNICEF paying the printing costs for the cards. Cards are given to mothers after delivery and are required to show complete immunization when a child enters school. Hospitals and clinics also ask to see the card before admitting any child. In the final survey, ninety-five percent of mothers could produce the card, three percent reported losing the card, and two who had never had a card were recent immigrants.

To improve immunization skills, the CS-18 project in collaboration with the District Centers for Immunizations provided three days of training to 224 MOH health staff. This was followed by joint supervision of the health workers, using a supervision check-list developed by the project. The training clarified the national protocols, including those on contraindications, which had caused confusion among health professionals and was identified in the MTE.

While transportation of vaccine from the Regional Center for immunization was detected as a problem at the time of the MTE, this seems to have been resolved according to the Directors of the District Immunization Centers. They also report having the capacity to store a two-month supply of vaccine, which would get them through the months when the 9,000 foot high mountain pass is closed due to snow.

In Kazdon, a remote Aini village, on immunization day, a mother felt her child was too sick with a cold to go out into the weather so she did not take him to be immunized even though she had been advised of the date by the VDC. Two weeks later, she went on her own to the health facility, which is in another village, to ask for the missing immunization.

To promote understanding of why children must be immunized and to alert families of immunization dates, SC linked the health facility to the Child-to-child (CtC) program. The CtC student-trainers not only spread the word among younger school children to send the message home, but also take the list of families whose children are due for immunizations and visit each at home. THIS IS ANOTHER EXAMPLE OF HOW CTC EFFECTS SUSTAINABILITY BECAUSE THE STUDENTS, WHO WILL ONE DAY BECOME PARENTS, HAVE BEEN PART OF PROMOTING, AND THUS, INTERNALIZING A NEW COMMUNITY NORM.

Challenges:
When the project started in Aini District, in some of the remote communities, children had not been immunized for years. The District Director of the Immunization Center is thrilled that SC has enabled him it raise coverage to 95% in many of these places. He admits that the transportation provided by SC was a big factor in reaching the far mountain villages and does not know how he is going to maintain the coverage rates without transportation. He says, "When I was young, I could walk 45 km in a day, but I can't do that now." UNICEF has donated a car to the Penjikent Immunization Center, but not to Aini.

An on-going challenge to immunizations in the mountain communities is that the families move even higher into the mountains in summer to pasture their livestock in areas inaccessible by road. With the cards and knowledge of the immunization schedule, when they return in the autumn, more and more of these families are visiting the nearest health facility to ask for the immunizations their children have missed.

The cost of printing the child health cards is being covered by UNICEF and supplies of the cards are given to the Regional Immunization Center, which is six hours from Penjikent. The District Immunization Center must bear the cost of transport from there to Penjikent, and tried to pass along these transportation charges to the mothers. After SC objected, this was stopped, but may become an issue again in the future.

Maternal and Newborn Care (MNC)

Table 5. Maternal and Newborn Care

Indicators of results and other outcomes	Baseline	Final
% of mothers who report having made 3 or more ANC visits to a health facility while pregnant with youngest child	53	**92**
% of 0-23 month olds whose birth was attended by skilled health personnel.	85	**95**
% of mothers who know 2+ postpartum danger signs.	53	**95**
% mothers who know 2+ newborn danger sings.	51	**98**

During post-Soviet years, the number of hospital births dropped dramatically. Women refused to deliver in hospitals which lacked heat, bedding, and food, preferring to deliver at home. Most births, however, continued to be attended by professional midwives or other health personnel. The

midwives are from the local towns and villages and have received three years of post-secondary training at a medical college, usually the one in Penjikent. Because they do not have much practice during their training and attend a limited number of deliveries per year, they often lack confidence in their abilities, particularly in dealing with obstetric or newborn complications. During CS-14, SC took advantage of a CARE project which brought trainers from ACNM to Dushanbe to train trainers for LSS, the emergency obstetric and newborn care package of ACNM. SC sent three women from the MOH and one of their own staff to be trained as trainers. This training team subsequently trained 280 midwives and OB/GYNS during the CS-18 project. (See more on LSS training in Section 3c. below.)

During the final evaluation, everyone who was interviewed from the head OB/GYN to midwives in the health posts, expressed their since appreciation for this training and many cited examples of having saved newborns or their mothers as a result of this training. The midwives all told how much it improved their self-confidence in attending deliveries and making referrals. Due to the increased number of referrals, however, there have been more maternal deaths at the hospitals because of severe complications. In the past, these women would have died, unreported, in their communities, hence, it appears that maternal deaths have increased both in SC project areas and those of CARE. This has led the MOH at the national level to question the value of LSS training, leading to discarding LSS as the national in-service training program (the policy that was adopted in 2002 as a result of the CARE project) and substitute the less comprehensive WHO training program. Nevertheless, the LSS training has instilled the needed skills in virtually all of the current midwives and these will be observed and shared with new hires who join them. MOREOVER, ONE OF THE ORIGINAL LSS TRAINING TEAM RETIRED FROM HER MOH POSITION AND HAS BECOME A FACULTY MEMBER AT THE PENJIKENT MEDICAL COLLEGE, WHERE SHE IS INCORPORATING THE CONCEPTS AND SKILLS FROM LSS INTO THE CURRICULUM FOR ALL MIDWIFERY STUDENTS.

The LSS training also served to improved supervision since the package comes with a program for monthly supervision and supervision tools. Both the midwives and their supervisor commented that this has changed the dynamic of supervision from something to be feared to a supportive relationship between supervisor and supervisee. From the supervisors' perspective, one of the most useful components of the training was the partograph, but the midwives are more apt to mention newborn resuscitation, manual extraction of the placenta and that no longer using IVs or drugs speeds up the delivery. Midwives now allow relatives to be present during the delivery. The final survey found that whereas 63% of deliveries occurred at home in the baseline, now 72% took place in health facilities.

In one of the remote villages in Aini, a mother told us that she had been pregnant six times, but lost the baby during first five deliveries, which were in the village. For the sixth, she accepted the advice of the midwife to go deliver in the district hospital and that baby survived and is now a healthy one-year-old.

SC also provided each midwife who was trained in LSS with a midwife kit. THE MIDWIVES ARE VERY GRATEFUL FOR THESE, AND BECAUSE THEY UNDERSTAND THE CRITICAL IMPORTANCE OF EACH COMPONENT, REPORT THAT THEY ARE WILLING TO PAY OUT OF THEIR OWN POCKETS TO REPLACE SMALL ITEMS. THE HEAD OB/GYN IN PENJIKENT ADDED A LINE ITEM TO THE BUDGET AND HAS BEGUN TO REPLACE LARGER ITEMS FOR THE STAFF, AS NEEDED.

Most of the CS-18 villages are anywhere from one to five hours' drive from the referral hospitals. Because there are costs associated with the travel and medical care, each VDC has a revolving loan fund for medical expenses. Women who lack the needed cash, may borrow from the loan fund to go to the hospital or clinic, and should repay the loan within one month. To create the funds, the VDCs collected a certain amount from each household. In most cases, the funds are working very well. There have been some instances of women not repaying the loan, or at least not repaying within the month. The VDCs may want to consider allowing more time for repayment.

Messages about the recognition of danger signs, the value of prenatal care, and care of the newborn were transmitted by the midwives during educational sessions organized by the VDCs. Age-appropriate content was also disseminated to secondary students through CtC. At baseline, 27% of women didn't know any postpartum danger signs and 32% didn't know any newborn danger signs. At the final survey, all women could correctly name some danger signs and 95% stated two or more for postpartum and 98% could describe two or more for newborns.

The project introduced the concept of birth planning to the MOH midwives and OB/GYNS, who then promoted birth planning with each pregnant woman who presented for prenatal care. The midwives collaborated with the VDCs to organize educational sessions on obstetric and newborn danger signs and birth planning for all community members. Sessions were organized for men during the season when most are home and for mothers-in-law. (After marriage, Tajik couples generally live with the man's parents. In the absence of the husband, the mother-in-law often makes decisions for the household.) The concept of birth planning was very well-received, judged by the favorable responses of the women and mothers-in-law who were interviewed during the final evaluation. The evaluation team repeatedly heard from women how grateful they were that the information on danger signs and birth planning had gotten to their husbands, as well, because the men now support them in making key decisions.

A phenomenon is occurring in rural Tajikistan, where large numbers of men are migrating abroad, mostly to Russia, in search of employment. In the villages of the CS-18 target area, from 50% to more than 70% of all men between ages 18 and 60 are gone, for at least much of the year. Many return from seasonal construction work to be at home from December through March. This limits the months in which their wives become pregnant, leading to large numbers of deliveries occurring from September to November. Both the OB/GYNS and personnel from the immunization centers commented that this is making it easier to plan their work for the year since they know when most babies will be born.

Nutrition, Breastfeeding, and Micronutrients

Table 6. Nutrition, Breastfeeding, and Micronutrients

Indicators of results and other outcomes	Baseline	Final
% of 0-5 month olds exclusively breastfed during the last 24 hours	12	**93**
% of household with children <2 which have only iodized salt for cooking.	10	**92**
% of children <2 who have their weight plotted on growth chart.	11	**85**

The nutrition component of the project encompassed activities in breastfeeding, complementary feeding, micronutrients and maternal nutrition; addressing all the components of the Essential Nutrition Actions. As is usually appropriate, the CS-18 project used a variety of approaches

including growth monitoring and promotion (GMP), counseling by health staff during visits to the health facilities, MOH-led community education sessions targeting not only women, but also men and mothers-in-law, PD/Hearth, counseling and print materials to promote micronutrients, and a community mobilization campaign directed at iodized salt.

Nutrition

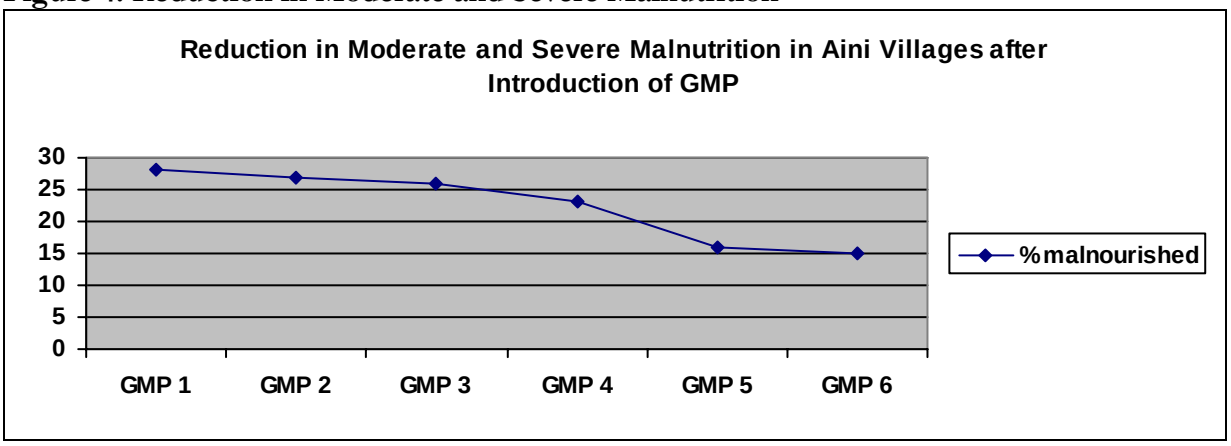
There was no growth monitoring program in the MOH prior to the CS-18 project. SC introduced the concept to the DHOs and trained health personnel in each health facility to weigh children, providing the Saltar scales. Children are now weighed one day every two months. VDC members have been trained to weigh the children in communities where there is no health facility and the health staff members may not come on schedule. Growth monitoring has been implemented in a total of 67 health facilities. Families from villages with no health facility attend at the nearest one. There is minimal counseling on the day of the weighing, but the health worker subsequently contacts each family with a malnourished child either to attend a small group session, or for individual counseling.

> In one of the most remote Aini villages, the mothers told the evaluation team that it is worth walking two hours each way to the next village to participate in GMP because they learn so much about feeding and caring for their children.

VDC members and CtC students remind the mothers of the date, but, when asked during the final evaluation, mothers said they would go even if no one reminded them because they like the activity, particularly seeing how well their child is growing. They also like learning what and how to feed their child. On average, 92% of eligible caregivers (those with children under 24 months) are attending each growth monitoring session without incentives. This is impressive, considering that SC and the many other PVOs implementing Title II programs consistently struggle with getting mothers interested in growth monitoring; most attending only because it is a requisite to receiving food rations. SC may want to document what motivates the women of the CS-18 project area in order to strengthen GMP in other programs.

The chart below shows the average rate of low weight for age (WAZ) in Aini for the first twelve months after GMP started. From the first session, fifteen villages were identified with rates of >30%. By the sixth session, one village remained with 30% and another with 33%, with the average down to 15%. The dramatic reduction from 23 to 16 % in the two months between the fourth and fifth sessions can be attributed to the initiation of PD/Hearth in the villages with more than 30% low weight for age.

Figure 4. Reduction in Moderate and Severe Malnutrition



When growth monitoring started, 14 villages in Aini and 12 in Penjikent were found to have moderate and severe malnutrition rates above 30% (weight for age). Children with severe malnutrition were referred to the district hospitals. PD/Hearth was implemented in 26 of the villages with the highest rates of malnutrition. SC, together with the local MOH staff, organized the PD/Hearth program with the support of the VDCs. Families contributed all of the food. When asked during the final evaluation, volunteers and MOH staff said they feel confident that they could organize and conduct a Hearth session on their own, if the need should arise again.

CS-18 made some modifications to the PD/Hearth protocol. The most significant was in having the mothers come for two days then, prepare one of the menus at home for the third day to feed the child an extra meal. This was deemed necessary because the mothers said they could not be away from home so many days in a row. It may have also helped with the fact that the mothers had no difficulty in bringing food contributions the other days. The second modification was to conduct a Positive Deviance Inquiry (PDI) in only two of the villages, then extrapolate the results to the others for menus and for PD practices taught. While this was effective in improving nutritional status, it deprived the volunteers, VDC and MOH members of the learning opportunity that conducting their own PDI and designing their own menus would have provided.

Prior to participation in the Hearth, the families of malnourished children were primarily feeding them sugared tea and cookies or bread. The PD families were feeding their children eggs, beans, rice and potatoes. The PD families were found to practice better hygiene, spend more time caring for their children, and to feed the child off a separate plate.

Perhaps because of the intermittent schedule, half the children had to attend two cycles to achieve catch-up growth. Ultimately, 93% of the children graduated with a 200g weight gain, and 44% with a 400g weight gain. None of the children relapsed during the remainder of the project. Those few (six children) who did not gain weight were referred to the hospital with underlying medical problems. Participating mothers and MOH staff were equally thrilled with the results. The following are comments heard during the final evaluation interviews about the PD/Hearth.

"My child wasn't in the Hearth, but my neighbor went and she taught me the menus she had learned to prepare. My child likes the foods and they are easy to prepare." - Neighbor of a participating mother.

"We learned so much, I was sorry to see the Hearth end." – Participating mother.

"I learned so much from Save the Children's project, but best of all was the PD/Hearth. It is the first time we've had such success with teaching mothers so much in a short time and we saw how quickly their children improved." - Director of Women's and Children's Health for Aini District.

"Before Hearth, we gave our children only biscuits and sweet tea. Now, we give them eggs, beans, and potatoes. We never thought small children could eat beans." - Participating mother.

"My daughter-in law has to work in the fields so I took her son to PD/Hearth. I learned so many new ideas to teach her and my daughter about caring for their children. I wish there had been a program like this when my children were small." – Participating mother-in-law

"Right before our eyes we saw our children begin to walk better, speak better and become healthier." – Participating mother

The following charts show the impact of the initiation of PD/Hearth combined with GMP in the target districts which was achieved in a relatively short period of time. While the activities commenced in summer when food is quite available, the nutrition rates continued to drop through the winter when food is scarce and expensive and Hearth sessions had to be suspended due to weather. In some communities, the malnutrition rate dropped to less than five percent after just one Hearth session; in others Hearth was repeated up to five times. Some of these communities started with exceedingly high rates of malnutrition and had to conduct multiple cycles simply to be able to reach all the malnourished children and their caregivers.

Figure 5. % of Malnutrition (WAZ) in Penjikent Communities with both PD/Hearth and GMP between July, 2006 and March, 2007

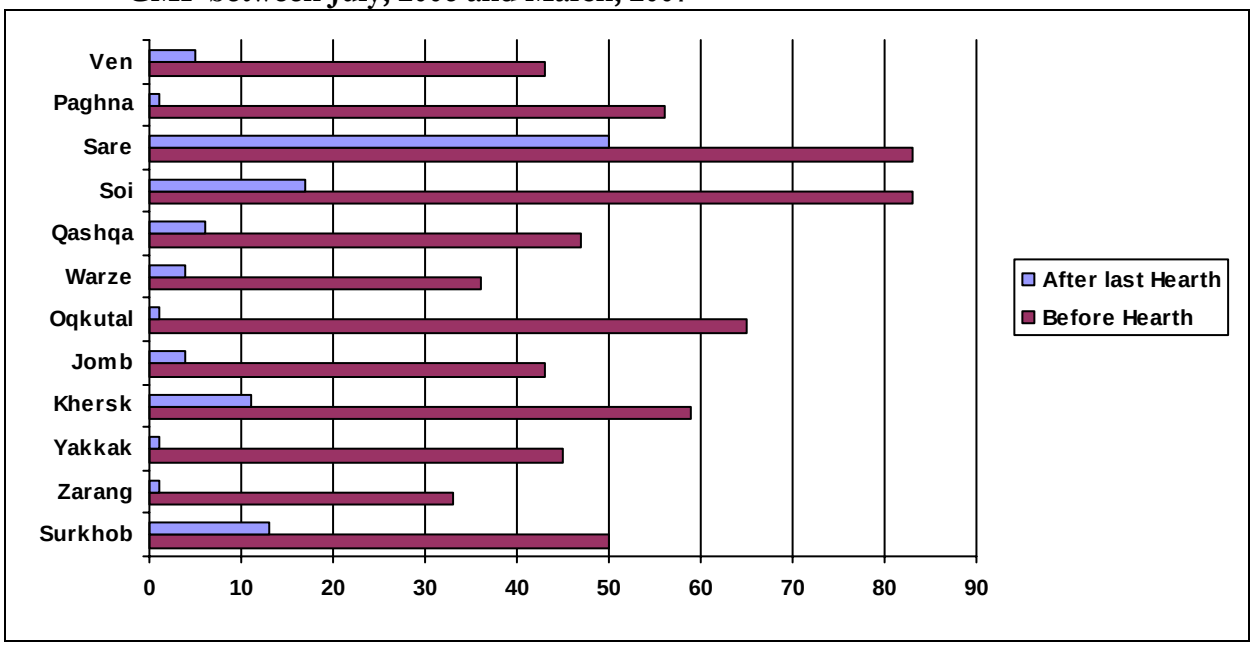
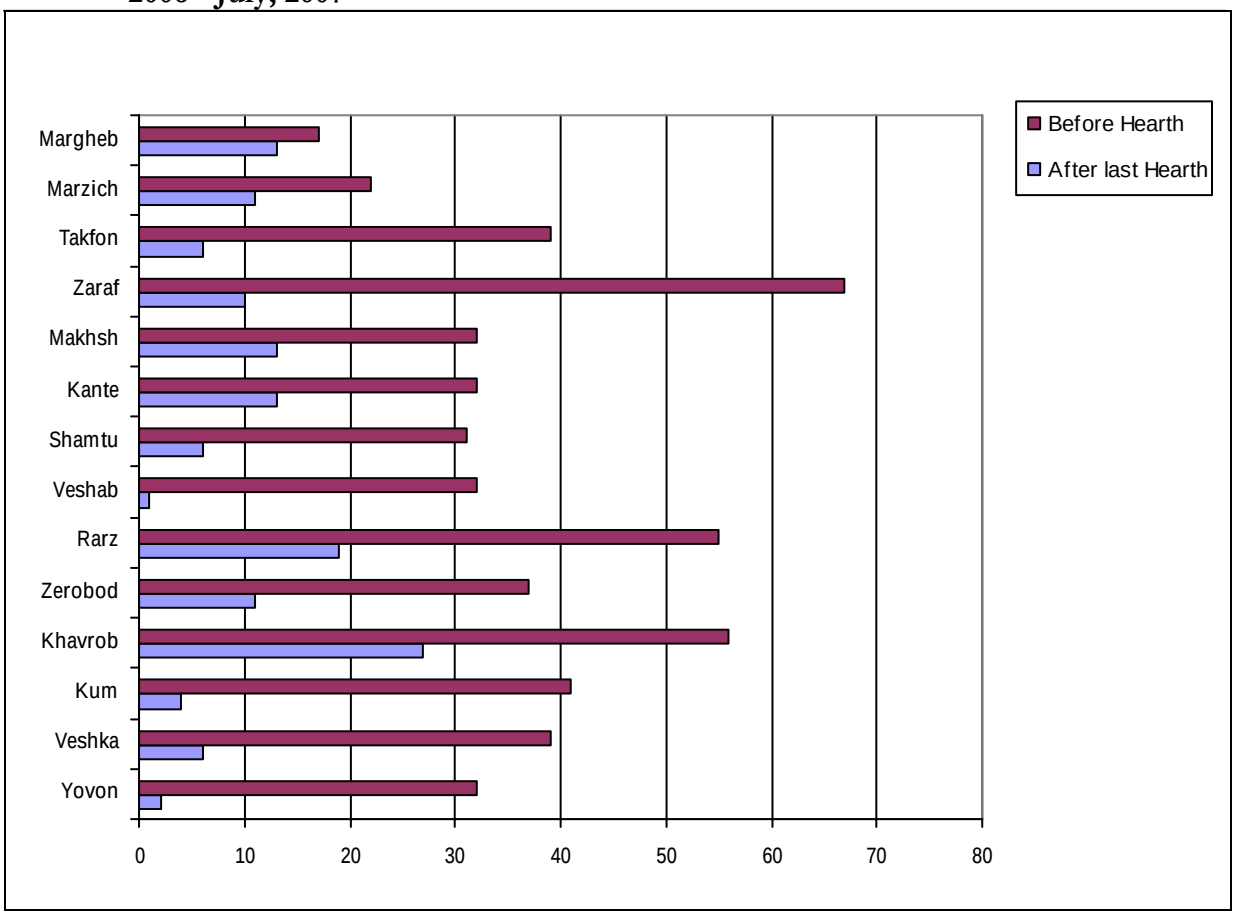


Figure 6. % of Malnutrition (WAZ) in Aini communities with PD/Hearth and GMP Aug., 2006 - July, 2007



Breastfeeding

Little progress had been made on promoting exclusive breastfeeding prior to the time of the MTE. Seeing the lack of improvement on this indicator, the project took seriously the recommendation to design a specific behavior change strategy for this aspect of the nutrition intervention. Project staff conducted focus groups to better understand the perceived barriers and benefits of exclusive breastfeeding and identified the husbands and mothers-in-law as key supporting groups. They organized a central group in each village and at the district level to assist with promotion efforts. The local imams were recruited to help tie in the Q'uran writings that support the idea of exclusive breastfeeding. In each village, the project also enlisted the support of the most influential woman. MOH staff conducted educational sessions for husbands and mothers-in-law, eventually reaching 15,000 of them. As can be seen from the KPC results, this well-designed, focused behavior change strategy paid off.

> A mother-in-law in an Aini village told the final evaluation team that she felt vindicated by the exclusive breastfeeding promotion. "It's like returning to old times. Our mothers gave only breast milk whenever the baby was hungry. The doctors told us [our generation] that we should only feed the baby breast milk on a schedule. When the baby cried and it wasn't feeding time, we gave something else – tea or water. Now, you've come and told us that the old way was correct after all."

At baseline, 91% of mothers said they had breastfed their child and this rose to 100% in the final survey. Also at baseline, only 54% of mothers initiated breastfeeding within an hour of birth and this rose to 94% in the final survey; evidence of the effect of the LSS training for midwives and OB/GYNS. The use of pre-lacteals was not investigated in the KPC surveys. Ninety-three percent of mothers of children under six months of age had given nothing but breast milk during the 24 hours prior to the survey and, when directly asked if they are always giving only breast milk, 87% said they were.

While all mothers interviewed during the final evaluation clearly got the message about exclusive breastfeeding, some still expressed concern about "women who have insufficient milk." Further probing revealed that not all the medical staff is clear in telling the women how they can increase milk production. On the other hand, mothers and mothers-in-law clearly understood, and put into practice, the messages for overcoming the barrier of mothers being gone to the fields or to work during the day (leaving expressed milk, or returning to feed the child, or having someone bring the child to the mother for breastfeeding).

Micronutrients

The micronutrients of chief concern in the target area are iron and iodine. Vitamin A is now being distributed through the immunization program and SC has reinforced that through the immunization trainings, particularly during CS-14, when this was a new protocol for the country.

Iron deficiency anemia (IDA) is extremely prevalent in the country, especially among pregnant women. The primary approach used by the project was to have the LSS-trained MOH staff counsel women during prenatal visits. While the government's protocol is to prevent anemia with distribution of just two iron tablets per week, the Chief Gynecologist of Penjikent changed the district protocol to the standard 2 tablets per day after having taken the LSS training. Since the MTE, the LSS training and supervision have reinforced information on coping with side effects.

Ninety-five percent of mothers surveyed in the final KPC reported receiving iron during prenatal care, but the survey did not ask how much or whether the supplements were all taken.

Through their participation in the Tajikistan coalition of PVOs implementing the USDA-supported FACT program in 2002, SC was able to acquire enough of the IDA prevention materials and posters developed by CARE to provide a set to every health facility in the target area. The materials are used by health staff to counsel pregnant women and the posters are prominently displayed. Health workers told the final evaluator that women sometimes come just to read the bright-colored posters, or, after counseling, return with a friend to show her the posters.

District health officers voiced concerns during the final evaluation about IDA among other groups, including children. They would very much like to start de-worming programs for school-aged children where IDA rates reach 80%. Mothers also said they are concerned about worms in their children and would like to learn more about prevention and treatment. This issue links back to the need for further work in sanitation as discussed in the section above on diarrhea.

When the project realized that initial educational efforts to promote use of iodized salt were having little impact, SC staff shifted the strategy to community mobilization. Capitalizing on the fact that goiter is common, as are the effects of iodine deficiency on mothers and their children, SC and the MOH incited the VDCs to conduct mass awareness activities in 141 communities. Imams joined the effort in spreading awareness. Shop keepers were targeted individually with information on the seriousness of iodine deficiency and, the VDCs persuaded them to sell only iodized salt, even though other salt is slightly cheaper and mined not far away. The project supplied CtC students with kits to test salt at home and in the shops and markets. CtC student-trainers taught the younger students about the issue and encouraged them to ask their parents to buy only iodized salt.

The mobilization effort was hugely successful as evidenced by the fact that the final KPC showed that 92% of households had only iodized salt, a finding corroborated by direct observation. The shops visited by the final evaluation team found only iodized salt for sale, although in the main market in Penjikent some vendors still have non-iodized salt. The mothers interviewed for the final evaluation all had a clear understanding of the relationship of iodized salt to goiter prevention and said they are willing to pay the extra few pennies for the iodized salt. There are, however, many women and adolescent girls who already have evidence of iodine deficiency and treatment in the form of oil capsules in not available in the area.

When the final evaluation team visited a shop in a small town near Penjikent, a 10-year-old boy was tending the shop alone. We asked him to show us the salt for sale and found it to be iodized. We then asked him why it was important to sell iodized salt, he responded without hesitation, "To prevent goiter."

Mothers in an Aini village told the evaluation team that a peddler had come to their village recently with a small truck loaded with salt direct from the mine that was not iodized. VDC members and other leaders went to him and asked him to leave because they did not want any salt sold that was not iodized.

Lesson Learned:
As many PVOs do with child survival projects, SC chose to focus project activities on rural areas, leaving out the urban centers of Penjikent and Aini. In both these small cities, uniodized salt is still available and mothers are not practicing exclusive breastfeeding or other key behaviors. Since rural

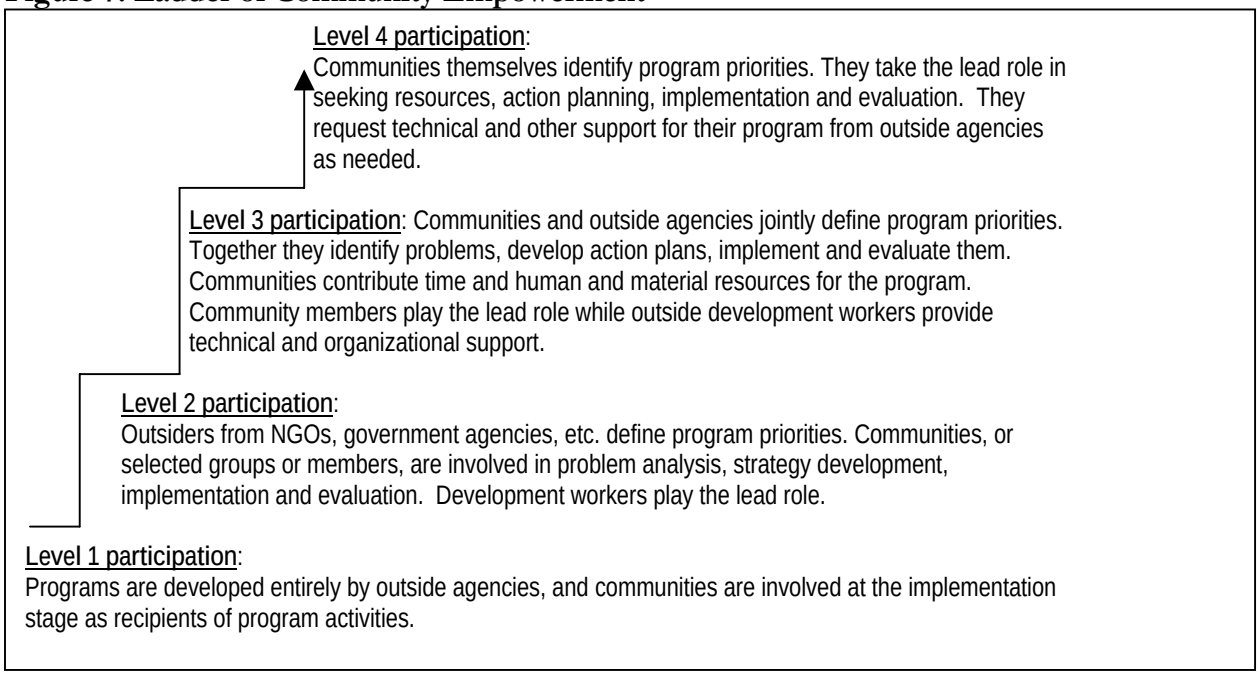
families often emulate behaviors they see in urban areas, or go there for shopping, omitting urban areas when disseminating key messages, is a missed opportunity.

3. Results: Cross-cutting Approaches

a. Community Mobilization

A hierarchy has been created by those who have led the development world in promoting community participation and empowerment. The term "mobilization" usually means that a community is galvanized to take action on a specific theme, for example, organizing an emergency transport system for injuries or obstetric complications. A higher level outcome is community empowerment, which means the community becomes organized, motivated, and skilled at pursuing initiatives of priority importance to the well-being of the majority of the community. The following graphic illustrates the hierarchical classification of empowerment, with Level 4 being the goal of community participation endeavors[1].

Figure 7. Ladder of Community Empowerment



SC's CS project in Tajikistan has achieved Level 4 participation in many of the target communities. During the final evaluation, the VDCs were found to be pursing major activities beyond the scope of the project, such as the construction of water systems, sewer systems, improving roads, and renovating schools or health facilities. Many had already sought and acquired funds for such projects from other international NGOs or from municipal government. Others are implementing internal fund drives or income generation schemes to support worthwhile projects. ALL VDCS INTERVIEWED HAVE GOALS AND LONG RANGE PLANS, WHICH THEY ARE PURSUING, INDEPENDENT OF THEIR WORK WITH THE SAVE THE CHILDREN PROJECT. Potential for sustainability of these groups is excellent.

[1] CARE, *Participation for Empowerment*, 2001

SC Tajikistan initiated the VDCs in the original target area as an activity of the companion USDA food project. While the first activity of the VDCs was to identify food recipients and manage distribution of the commodities at the local level, from the beginning SC advised them that they could do much more for their community and encouraged them to identify priorities using PLA/PRA methods. Over the life of CS-14 and CS-18, SC formed or strengthened 204 VDCs.

The child survival project worked with the VDCs to establish a revolving loan fund for medical expenses, described earlier under the maternal-newborn intervention, and VDCs received the training and responsibility for supervising the Village Pharmacies until that activity was dropped by SC. The VDCs were also engaged in the very successful iodized salt campaign and in supporting PD/Hearth as was described above in the nutrition intervention section. The VDCs continue to be a point of contact for the health facilities when there is the need to communicate with the community at large or organize an activity. The minutes of VDC meetings are often stored in the health facility, enabling health staff to keep abreast of VDC decisions and activities. VDC members refer patients and promote care-seeking, and sometimes conduct GMP in the absence of the health staff.

VDC membership is very stable, with good gender balance, and in 40% of the communities, one of the health professionals regularly participates as a member because they were elected by their neighbors. Each *mahalla*, which is the smallest political unit within a town, elects a representative to the VDC. Therefore, size of the VDC varies with the size of the town or village. Other international NGOs, government bureaus, and agencies are seeking out the VDCs as an entré into communities either for projects or for studies. For example, UNDP worked through the VDCs to start disaster-preparedness planning.

Under the Soviet system, Tajiks seem to have lost any traditional local councils such as those which exist in neighboring Uzbekistan and Afghanistan. The VDCs, established during this project, appear to be filling an unmet need, for local social leadership. Not only are the VDCs working on community improvements, many are also filling the role of planning events such as funerals and weddings, and mediating family disputes.

SC may wish to invest in identifying and documenting the specific motivating and organizing activities which have led to such strong, empowered groups. This documentation would be a good contribution to other projects and agencies which want to initiate community organization with a goal of long-term empowerment.

b. Communication for Behavior Change

As measured by the significant changes in the project indicators 1-8 as shown on page 2, the project's behavior change approaches were quite successful. The behavior change objectives were more than met in each instance.

For this project, SC had the most-formalized behavior change strategies for the exclusive breastfeeding and iodine behaviors. The effort put into identifying and addressing the determinants and secondary audiences, in both cases, paid off substantially. For the other behaviors, while no specific strategy development took place, the assumptions that the determinants were lack of knowledge, lack of risk perception, and/or lack of access happened to be correct in this context, hence, messages and activities addressing those key factors had the desired impact.

The project's use of multiple channels was undoubtedly helpful. Rather than relying on group sessions, as so many CS projects tend to do, SC and the MOH provided many opportunities for one-on-one interaction with a variety of individuals, through which women could get feedback on their questions and concerns and could analyze their own situation, often coming up with their own solutions to barriers which were not being addressed by the general education sessions. These same multiple channels also provided reinforcement as families were hearing the same messages from so many sources. As villages became saturated with the messages, families could process the concepts within the family or with neighbors and friends.

Table 7. Summary of Behavior Change Promotion Channels

Groups	One-on-one
VDCs organized regular educational sessions in the community led by an MOH staff person or a VDC member. Group sessions were held for mothers, men, and for mothers-in-law.	VDC members passed information and advice to members of their extended families and to neighbors at home, in the street, or during social events.
CtC Student Trainers conveyed information to middle-school aged students in classroom settings using methods such as songs, puppets, skits, and stories.	CtC Student Trainers and the younger students they taught took information they learned home to share with family and neighbors.
PD/Hearth sessions included information dissemination, demonstrations, and actual practice of a variety of behaviors besides child feeding. These sessions were led by the volunteer, under the guidance of SC or MOH staff	Influential women spread messages through their social networks and at social events.
	MOH staff counseled women during consultations and home visits.
	MOH staff members shared new ideas with their extended families and neighbors.
	Religious leaders spread messages tied to the Q'uran for selected behaviors.

It is true that there is an advantage in doing health education in Tajikistan because nearly all village women are not only literate, but also have a secondary education. Essentially, this means that fairly complex print materials are an option and that the women are accustomed to formal learning, i.e., sitting to listen to new information and concepts. Another advantage for behavior change promotion that is found in Tajikistan is that the health care professionals are generally from the communities in which they work and there is not the class difference between them and the average community member, such as exists in some cultures.

Child-to-Child

The Child-to-Child approach has been around for decades and this is certainly not the first time that SC has used it, but it is, perhaps, the first time that it's been taken to such scale in Central Asia. Through CS-18, mostly with match funding, CtC was introduced into 179 schools in the target communities. In each school, 15 secondary students between the ages of 15 and 17 years old were selected to become CtC Student-Trainers. One teacher assumed the responsibility for the CtC program in each school and prepared the Student-Trainers after being trained by SC staff. These teachers are very committed and enthusiastic, and during the final evaluation, other teachers stated they are "standing in line" to replace the CtC teacher, should there be a need. Following the recommendation of the MTE, SC sought a "CtC champion" in the district office of the Ministry of

Education (MOE). These individual are also very enthusiastic about CtC and have influenced the decision of the District MOE in both Penjikent and Aini to set aside an hour each week in the schools for the CtC sessions conducted by the Student-Trainers.

The CtC Student-Trainers teach the children just younger than them; those in grades six to nine. The advantage of engaging secondary students and middle school-aged students in CtC is that these young people may well become parents within eight to ten years or less. Thus, THEIR INTERNALIZATION OF GOOD HEALTH BEHAVIORS, IS A MEANS OF SUSTAINING THE CHANGES IN COMMUNITY NORMS THAT THE CS PROJECT HAS BROUGHT ABOUT AMONG ADULTS. While the CtC Student-Trainers told the evaluation team that they had changed some behaviors themselves because they now know they are role models, it seems that it would be more productive for the CtC Student-Trainers to emphasize certain topics such as hand washing and appropriate latrine use with very young children such as first graders, who are still forming habits.

In Vashkand, an Aini town, a CtC Student – Trainer named Oibek saw a young neighbor child get bitten by a dog. Oibek took the child to the mother and encouraged her to take the child to the clinic, but she didn't think it was necessary. Oibek went to the clinic to explain the situation to the doctor, who made a house call and began presumptive treatment for rabies. The dog died as did 4 others in the village so Oibek and the doctor worked with the state veterinarian to initiate a campaign to vaccinate all dogs against rabies. The CtC Student Trainers convinced all dog owners to bring their dogs for vaccination.

There is a close link between health facility staff, who provide some orientation, and the CtC Student-Trainers, who help the health facility staff by notifying families about immunizations and notifying health personnel when there someone who is ill but has not come to the health facility. CtC Student-Trainers feel comfortable coming to the health facility anytime. This relationship between these secondary students and the health personnel has led to an unexpected result.

The final evaluation team found that about half of the CtC Student-Trainers have a desire to enter a medical profession, with some having already having passed entrance exams. Some previous CtC Student-Trainers, who graduated have already entered medical college or university. This is good news in a country which is facing a pending health personnel shortage due to out-migration and the lost schooling of part of a generation during and immediately after the civil war. Sadly, lack of family funds and limited quotas will mean that not all the young people will pursue their dream.

In the baseline KPC survey, the women interviewed were asked where they seek information on health and nutrition. At that time, only 12%, probably from villages targeted by CS-14, mentioned the VDC members as sources of information. No one mentioned the CtC students. In the final survey, 77% of women mentioned VDC members and 45% mentioned CtC students. When probed about from whom they had received health information during the past month, 78% mentioned CtC students. In the baseline, 62% mentioned doctors as a source of

information and 44% mentioned nurses and midwives. This increased to 95% and 83% respectively in the final evaluation, possible reflecting increased contact with health professionals who are now out in the community more, and/or increased confidence in seeking information from them at the health facilities due to increased familiarity and to sensing greater confidence on the part of health professionals.

Table 8. Sources of Health Information

Channel	Function in Behavior Change Communication	Reach
VDCs	The VDC members received an orientation to all key project messages in order to reinforce them during their contacts with neighbors and other community members. VDC members visit pregnant women and families of small children to encourage use of health services. The VDCs are responsible for organizing educational sessions for their community, with the MOH staff member conveying the messages during the sessions.	A total of 6,888 health education sessions were held in the villages added through CS-18 and 4,380 were convened in the CS-14 villages which received project support until mid-term. In sum, under the CS-18 grant, 11,268 health education sessions were organized by the VDCs.
CtC	Students 15 to 17 years of age were selected and trained to convey information in classrooms of younger children ages 11 to 14 and to their own families and neighbors.	A total of 2,685 students were prepared as CtC trainers. They reached approximately 29,535 other children and family members.
MOH staff	MOH staff promote behavior change through counseling anyone who comes for services, counseling with growth monitoring, making home visits to pregnant women, and leading educational sessions in the communities, which are organized by the VDCs.	813 MOH staff in the target health facilities are providing counseling and community education.
PD/Hearth	Feeding sessions were accompanied by health lessons on diarrhea, ARI, breastfeeding and micronutrients. In the small group setting, mothers experienced more interactive and hands-on learning.	Participants included 242 mothers or other caregivers whose children were particularly at risk because of poor nutritional status.
Print Materials	Brochures were prepared in both Tajik and Uzbek on key topics and disseminated through VDCs and health facilities. The project created some posters and also obtained some from the previous CARE Tajikistan projects on IDA, breastfeeding and maternal danger signs. These were distributed to all health facilities and posted in the waiting areas or where the midwife could use them for counseling.	Brochures on ARI, diarrhea, and birth planning were distributed to every household. Every health facility received the posters which were used for counseling or patient education while waiting

c. Capacity Building Approach

i. Strengthening the Grantee Organization

In Tajikistan, through the CS-14 and CS-18 grants, SC applied best practices and approaches gleaned from their own work in other countries as well as from the child survival field at large. In designing and implementing this project, they learned to build on lessons learned from other experiences. In turn, SC was able to apply the learning and experiences from this project directly to their USAID mission-funded project Healthy Family (HF) which covers the large southern province of Khatlon. Thus, the CS-14 and 18 projects were building the capacity of Save Tajikistan to immediately replicate successful interventions and take them to regional scale. Virtually all CS project activities were also implemented in Khatlon including LSS training, VDCs, Village Pharmacies (VPs), Health Facility Farms (HFFs), CtC, PD/Hearth, GMP, child health cards, joint supervision, and birth planning. CS staff made several trips to Khatlon to provide training and orientation to the Healthy Family staff and HF staff have visited the CS sites to learn approaches and interventions first-hand. Most recently, CS-18 staff assisted the HF project with data analysis for the final evaluation of HF. (HF has recently received a one-year no-cost extension.)

For the MTE of CS-18, SC brought Dr. Tedbabe Degefie, the SC Health and Nutrition Specialist for the Ethiopia Field Office, to participate on the evaluation team. She took many ideas and lessons learned back to her country to improve CS and other programming there.

SC used the Zarafshan CS experience as the basis of their design for the CSHGP-funded child survival project in Afghanistan. The SC Afghanistan Health Coordinator Mukhtar Mohammad participated in the MTE of CS-18. The SC Asia Area Health Advisor has also continued to assist the Afghanistan project staff to benefit from the lessons learned from the CS-14 and CS-18 projects.

ii. Strengthening the Local Partner – MOH

The predecessor project put considerable focus on strengthening the health facilities which were in disrepair and underequipped following the economic collapse in the 1990s. The Health Facility Farms begun as an income generation mechanism for the health facilities under CS-14 and continued during the first year of this project, were seen as a mechanism for sustainable financing to maintain the physical structure and equipment including the cold chain. (Please see Section D at the end of this report for more details on how this is working out.)

The emphasis of CS-18 has been on building the capacity of health personnel, either through training as described below, or through participation in joint implementation. On the district level, the primary approach to capacity building was through the joint training and supervision of the staff of all rural health facilities. This has built the capacity of the district-level personnel, particularly the department heads, as noted in interviews with each of them during the final evaluation. In Penjikent, they fully assumed all organizing and funding for training since the MTE, with no lessening of quality according to post-test scores or supervision reports.

> The Penjikent District Director of Women's and Children's Health says that through the CS project he has learned much during the nine years of the CS projects. He mentioned examples of learning to manage, plan and supervise, as well as learning technical advances.

iii. Training for MOH staff

Joint Training and Supervision of Rural Health Facility Staff

This is the project's primary approach to building the capacity of MOH staff in the technical and administrative aspects of CS interventions. SC staff has worked with the district level MOH in designing and translating training curricula, planning the trainings, and scheduling and participating in the supervisory visits. Much of the training of rural health facility staff has been done on two separate tracks – one that is tied to the monthly MOH meetings held at the district centers and organized by the Chief Medical Officers (CMO), and the other that is provided by SC and MOH staff and held throughout the districts. While the trainings provided jointly by SC and MOH are more structured, include both theoretical and practical training methods, and the results are monitored through the use of pre/post tests and checklists, the training approach used by the district is probably more sustainable as it is tied to a regular on-going activity and therefore requires fewer resources to continue. In interviews during the final evaluation, district staff reported that they feel confident in planning the training and education sessions, and are using adult participatory educational methods.

Table 9. CS-18 MOH Training Topics

Training Topics	Length of Training	MOH Staff Trained
LSS	12 days	280
Counseling Skills for health providers to support ARI/CDD case management	2 days	201
Immunization	3 days	224
IMCI*	9 days	20
Nutrition and PD/Hearth	5 days	75
Growth Monitoring (practical training in the field)	2 days	125
TOT and monitoring for IMCI	9 days	4**

*IMCI training paid for by the project. Many more were trained with MOH and UNICEF funds. **Plus one SC staff member.

Together with the MOH, the project has developed several supervisory checklists covering antenatal care (ANC), LSS, ARI, CDD, EPI, PD/Hearth, birth planning, and Child-to-Child. The checklists are being used every four to six months and verbal feedback is provided during subsequent follow-up visits. The supervisory visits were scheduled and done jointly by district MOH and SC staff, with SC frequently providing the transportation, until completely handing over this activity to the MOH recently. Accustomed to punitive supervision, all levels of MOH staff mentioned the positive change in the style of supportive supervision introduced through the project.

Evidence of the effectiveness of the training and improved supervision appeared in the final KPC. Whereas in the baseline, 68% of mothers taking children for care of diarrhea reported receiving anti-diarrheal drugs or antibiotics, only one reported such treatment in the final survey. In the baseline 24% of the mothers were told to restrict the child's diet, but in the final survey only one reported receiving this instruction from the health provider. In the baseline, 68% of the mothers who sought care for diarrhea reported receiving treatment with ORS, whereas, in the final KPC, 100% of the diarrhea cases treated by health professionals were treated with ORS.

In the final KPC, many changes are evident in the practices of midwives and OB/GYNS due to the LSS training. For example, in the baseline, 25% of the newborns were immediately bathed and 19% were put on the floor. These practices had completely disappeared in the final survey. In the

baseline, only 29% of newborns were immediately put with the mother, but this increased to 97% in the final survey. Not only did 89% of mothers report receiving a postpartum/newborn check within a day in the final survey compared to 63% in the baseline, they also said they received more information, as follows:

Table 10. Percent of Mothers Reporting Receiving Counseling During Postpartum Visit

Topic	Baseline KPC %	Final KPC %
Family Planning	57	98
Infant nutrition and breastfeeding	67	98
Immunizations	53	98
Danger signs of diarrhea	48	98
Danger signs of pneumonia	48	98

Prior to the project, *feldshers* or nurses did not normally provide prenatal care, in spite of the fact that many small health facilities do not also have a doctor or midwife. The baseline survey found that only 4% of women reported receiving prenatal care from *feldshers* or nurses. Seeking prenatal care from a midwife or doctor means traveling to a larger health facility with the implications of transportation cost and obtaining family permission to make the trip. The project expanded access to prenatal care by training the *feldshers* and nurses who work in health facilities without a midwife, in LSS. In the final evaluation, 76% of women said they had received prenatal care from either *feldshers* or nurses, which may account, in part, for the significant increase in women having more than 3 prenatal visits (34% at baseline to 92% final).

Challenges:
There are two challenges associated with sustaining the improved training and supervision resulting from CS-18. First, there are insufficient resources to cover the costs of doing regular supervisory visits to all of the health facilities within the districts due to the lack of transportation. This is of particular concern in Aini where health facilities are very dispersed in a large geographic area, with many roads closed for several months in the winter.

Secondly, during the final evaluation, it became evident that, while the district health officials are very committed to continuing project activities such as growth monitoring, birth planning, etc., there was no plan for orienting new hires to these activities which they would not have learned about in medical college. This was discussed at length with project staff during the final evaluation debriefing and the evaluator recommended that during the remaining month of the project, staff members should work with the director of each health sub-district to come up with feasible plans for orienting new hires in the future.

iv. Building capacity beyond SC and the target area

The CS-18 project has had an impact on other child survival projects in the region. In 2002, three staff from Mercy Corps' newly initiated CSHGP-funded project in Azerbaijan visited Penjikent for their first exposure to another child survival program. The visit greatly enhanced their capacity to successfully implement activities such as the VDCs, immunization cards, birth plans and community education in a very similar cultural context.

When Mercy Corps (MC) received a CSHGP grant in 2004 for three districts of Tajikistan that are farther north than the SC target area, not only did MC staff visit the CS-18 site, but SC seconded the

staff member who is an LSS trainer to MC for their LSS training. Mercy Corps has also benefited from being able to hire as project manager, a former CS-14 staff member, who had left Penjikent to return to his home which is in the MC target area.

Save the Children Tajikistan participated in a consortium of NGOs implementing the USDA food program through 2002 and currently participates in a similar consortium of NGOs implementing a Title II food program. From their CS experience, SC contributed significantly to the design of the maternal-child health and nutrition components of these projects, including development of indicators and M&E plans.

d. Sustainability Strategy

The sustainability strategy underwent significant revision half-way through CS-18. The Village Pharmacies and Health Facility Farms were key components of the original strategy; the former intended to assure access to essential medicines and the latter to generate funds to support the health facilities and cover recurring costs for the project activities they were to assume. When these activities had to be dropped (see Section D), new sustainability indicators were written at the time of the mid-term and the strategy refocused. The post-MTE sustainability strategy focused on phasing over all activities either to the MOH, the schools, or the VDCs. The new sustainability indicators were achieved and, by the time of the final evaluation approximately six weeks before the end of the project, all but 20 communities in each of the two districts were phased over to the MOH, with the remainder scheduled to be fully phased over by the end of September.

The MOH was fully engaged in planning the phase-over strategy. The District Head Doctor issued an order for health facilities to fully assume activities and provide reports on them at specified times. The division heads interviewed during the final evaluation said that having seen the value of specific activities, they are willing to adjust their budgets to cover essential costs. There are other costs, however, such as transportation, replacement of scales, and others for which they do not yet have a solution.

Although the project has generated greatly increased demand for services, health personnel say that because the VDCs and CtC students are doing much of the legwork that health professionals used to do to contact families to come for services, follow-up with patients who need return visits, this has freed up their time not only to see patients, but to do more work in the communities such as health education sessions and coordination, and to spend more time counseling patients. When interviewed in the final evaluation, all health personnel were quite confident about continuing the new activities such as GMP, health education, supporting CtC, and counseling that have resulted from this project.

The VDCs will reinforce this because they now have clear expectations about the kinds and quality of activities that the health personnel should continue. Their relationship with the health facility staff members is such that they will go to discuss unmet expectations with the health facility. Some of the VDCs are also playing a role in the financial sustainability in that they are raising funds within the community to cover some former project activities and some have taken the lead in renovating the local health facility.

C. Project Management

1. Planning

Throughout most of CS-18, there was very close collaboration with the MOH at the district levels and in the health facilities. The latter was essential since the project was implemented through them on a daily basis. By the time the CS-18 project was designed, the Penjikent District officials had seen the benefits of CS-14 and were eager to continue with the follow-on. The process of planning and building relations with Aini District took some time after this project began, but this start-up phase was programmed into the work plan.

Within the project, all staff members were involved in planning implementation on an almost daily basis which gave them insight into the vision for the project and the rationale behind decisions. This was very significant in empowering them to do their jobs well, even in the absence of senior management. This is a lesson learned for other projects to follow.

The DIP work plan, constructed as it was around each result, gave a very "big picture" overview of the work to be done. Project staff report that they were not able to use it as an operational plan, rather, they had to take the time periodically to make detailed plans from which they planned and monitored their work. These plans included such details as when preparation should start for a training event, new educational materials to be developed, and each step for the expansion into new communities or for phasing out of older communities.

The DIP itself did not mention how the HFFs were to be monitored, but this became a moot point when the strategy had to be abandoned. There was also insufficient information in the DIP on the mechanics of how the Village Pharmacies would operate or be sustained so the new project manager wrote out this plan. These details were not caught in the DIP review process.

2. Staff Training

The training the staff received during CS-18 was planned primarily to complement the technical training in each intervention they had received during CS-14. This opportunity to enhance implementation skills was an advantage of having so little staff turnover. In addition to the specific trainings planned for them shown in the chart below, staff also participated in trainings they arranged for MOH staff such as the one on immunizations.

Table 11. Training for SC staff during CS-18

Topic	Name of Trainers	No. of Staff Trained	Dates	Length
TOT	Dr.Yousaf Hayat, Program Manager CS-18	11	Aug. 2000	3 days
	National Consultant from Dushanbe	11	Sept. 2005	5 days
Birth Planning	Dr. Tariq Ihsan, SC Asia Area Health Advisor	10	July 2003	3 days
Positive Deviance/ Hearth	Dr. Yousaf, Program Manager CS-18	9	Jan.2003	3 days
	Dr. Tariq Ihsan, SC Asia Area Health Advisor	9	July 2004	3 days
Community Mobilization	Dr.Yousaf Hayat, Program Manager CS-18	11	July 2003	3 days
	Marcela-Sr. Community Mobilization specialist, Gulchehra, Nasokat, and Dilshoda-SC staff	11	April 2007	10 days
Community Based Monitoring	Michael Mc Grath, SC Field Office Director and Lesley Dove, Consultant	2	Nov. 2004	5 days
LSS training	Qodirova Nasokat., LSS Trainer from CS staff	11	2005-2006	12 days
Basics of Counseling Skills	Dr. Tariq Ihsan, SC Asia Area Health Advisor	10	May 2005	5 days
PDQ Training	Adelaida Gallardo-DeGregorio SC Sr. Community Participation Advisor	1*	June 2006	3 days
IMCI	Lola Sadriddinovna, Director of national MOH IMCI Center-Tajikistan	1	Sept. 2006	9 days
Immunization	Dr. Tariq Ihsan, SC Asia Area Health Advisor	11	post MTE	3 days

*Only the project manager received this training during SC's annual Program Learning Group meeting in the U.S.

The excellent outcomes of the project attest to the ability of SC staff to apply the training. For example, the training in community mobilization led to the highly successful community mobilization to promote the use of iodized salt and the careful application of PD/Hearth training led to the high graduation rates and lack of recidivism. Adequate resources were available for training and were invested in key topics for which other SC staff could not provide the training. The evaluator has previously conducted training with both the Asia Area Health Advisor and the former program manager and can confirm their excellent training abilities.

3. Supervision of Project Staff

The supervision of project field staff was adequate and supportive. Separate teams worked in each district, meeting several times a week with their respective supervisor to discuss plans, challenges, and coordination. These frequent meetings were essential for building a team and for keeping the project on schedule, particularly when there were gaps without an on-site project manager and turnover of project managers twice. The meetings also allowed for direct and timely feedback. There were also monthly staff meetings for all project staff and those working on the companion FACT and CtC programs. The supervisors were promoted from within the staff, as was the person who ultimately became project manager. The last ex-pat project manager was an especially good model and mentor for these individuals.

There were more challenges in supervision and support of the expatriate project managers, who found themselves very isolated from the Dushanbe office, unable to travel there for long periods

during the winter. Both were ultimately moved to Dushanbe to assume additional responsibilities and had to continue providing long distance support to CS-18 for a time. During the life of the project, the SC Field Office Directors made five visits to the project site.

No one from SC/HO, or the SC Central Asia Regional Field Office[2] in Dushanbe participated in the final evaluation, nor did the Asia Area Health Advisor. While it is understandable that the timing coincided with a major staff transition and competing priorities, staff must have sensed a lack of affirmation for a job well-done.

4. Human Resources and Staff Management

The project team in place at the end of the project appeared to not only work well together, but to enjoy working together. There was evidence of good team work with everyone knowledgeable about the work of the others and of respect for and good relationships with their MOH counterparts. These characteristics facilitated project implementation as did the continuity of the staff. Two of the staff completed all nine years (CS-14 and CS-18), two seven years and most others were with CS-18 from the beginning.

The turnovers occurred at the project manager and project officer levels. This was fully explained in the MTE report, and appears to have had minimal impact on the field staff members, who were so clear on their job descriptions and the project work plan, that they did not lose pace. When one of the staff was promoted to Project Officer, then to Project Manager, she continued to receive significant support from her predecessor who moved to Dushanbe. The one way identified during the final evaluation in which turnover of the project managers had an impact concerns evaluation data. The current project manager no longer has the data set from the KPC baseline, which eliminated the possibility of doing any additional analysis to make further comparisons to final KPC results. There was also a very complete Health Facility Assessment conducted in 2002, but the current staff did not have the leadership to repeat this during the final evaluation period.

Project staff will be retained by SC only if funding becomes available for other projects in the target area. There are very few opportunities for them in the target area, even though they now also have some English and computer skills, due to the lack of other development agencies, but the Director of Women and Children's Health in Penjikent told the evaluator that he would like to hire them (back) to the MOH because of all their skills gained through the project.

5. Financial Management

The project is ending without being either under or over spent, which indicated good budget management overall. The project managers and Dushanbe finance officers have provided budget oversight and made the decisions about adjustments. When the village pharmacy component, which included pharmaceuticals as match, had to be dropped, SC was successful in finding other sources of match. Financial management has been totally in line with USAID regulations.

6. Logistics

Supplies for the village pharmacies and equipment for the health facility farms presented real challenges due to transportation problems during the first half of the project, but this became a non-

[2] The name of this office changed from SC/TFO to Central Asia Regional Field Office during the life of the project. The names are used interchangeably in this report and previous project documents.

issue when these activities were dropped. The purchase of all the materials for the midwife kits was challenging due to lack of local sources and the need to order items from other countries. In the end, all of this was worked out and the kits were distributed and there was no impact on timing of project activities.

7. Information Management

The project not only collected a lot of their own data to monitor project processes and intermediate results, they also utilized MOH data for monitoring and decision-making. Examples of this were shown in the graphs on pages 8 and 9. Project staff members tracked inputs for each community on a daily basis including such things as CtC, VDC meetings, and health education sessions. By the end of the project, for example, they could say with confidence that there had been 49,947 contacts through group education sessions on MNC. As noted in the MTE, not all data collected was useful, hence, following the MTE recommendation to tie data to a specific use, data collection was somewhat reduced. Project staff members have gained a good understanding of collecting and using data for decision-making, skills which will serve them in new jobs.

The project staff and MOH used a set of checklists for the joint monitoring visits, the results of which were entered into the computer, with reports generated quarterly. These reports were discussed at monthly meetings and decisions made on support needed in particular areas.

Besides introducing the child health cards and cards for prenatal care, SC developed other forms to improve data collection and use at the health facility level. These included a patient registration journal, a journal to register prenatal care, delivery and postpartum checks, a form for monthly report of immunizations, and another form for recording births and deaths. The information thus collected is meant for use within the health facility, but also makes it easier for staff to prepare the required reports for the District Health Office. The health facility staff state that these registers and forms are all useful and are providing them with information from which to make plans. Reproduction of these forms in the future will be the responsibility of the District Health Offices.

One way this information has been used beyond the impact area is related to IDA. The former MOH policy called for hospitalizing any woman with a hemoglobin reading of 9 or less. Once health facilities began recording all hemoglobin results for pregnant women and compiled the data, it was shown that 95% of the pregnant village women have such low hemoglobin readings. When this data was presented to the Regional Head Doctor, he agreed to drop the policy of hospitalization for treatment due to the impracticality of hospitalizing so many women.

8. Technical and Administrative Support

The project received very good administrative support from the SC Field Office in Dushanbe. Coordination became even easier when Penjikent and Aini gained cell phone coverage, eliminating the need for inefficient radio communication.

For technical support, the CS-18 project was able to obtain the needed assistance from within SC. The two expatriate project managers brought excellent skills from their previous work with SC and, the Asia Area Technical Advisor complemented those. He made five visits to the project from Pakistan or Afghanistan before the MTE, and provided critical staff training, as shown in the training chart above. The HO backstop was in Tajikistan to prepare the DIP and to participate in

the MTE and has provided long distance support, as needed. Between them, the Area Technical Advisor and HO Child Survival Specialist have devoted 25% of their time to supporting this project.

9. Management Lessons Learned

The SC/TFO was stretched to provide adequate support to a project and supervision of project managers, in a site so remote from Dushanbe and the rest of their programming in the south of the country. They learned that more supervision was needed for even very senior personnel posted in such a place with little possibility of frequent contact. During the last 3 years of the project, TFO directors made more frequent visits to provide some oversight and the field office invested in cell phones for Penjikent and better e-mail access, as soon as that became a possibility, to improve frequency of communication. When a national staff member was promoted to the role of project manager, she was in almost daily contact with her supervisor in the Dushanbe office thanks to the cell phones.

10. USAID Mission Collaboration

The USAID mission, that only recently opened an office in Tajikistan, has been very aware of the CS-18 project, often using it as a showcase of their development efforts for visitors. USAID health staff members have visited the project three times. It was their familiarity with the CS-14 project that led them to award a large bi-lateral maternal-child health project in the south of the country to SC and their partners.

The Director of the USAID mission in Dushanbe and the health officer were invited to participate in the final evaluation, but were unable to make the nine-hour trip due to other commitments. They both attended a de-briefing on the evaluation at the SC Tajikistan office on August 22, 2007.

D. Other Findings

During the final evaluation other findings worth noting included the continuation of two strategies completely without SC support. There is also an emerging health issue of concern to the population that merits follow-up.

i. Self-sustaining strategies

Two of the strategies which SC began in CS-14 and intended to continue in CS-18 were meant to foster sustainability. Both were subsequently dropped from the SC work plan for a variety of reasons, but the initial effort and investment has born fruit anyway.

One of these strategies was the establishment of village pharmacies (VPs) or revolving drug funds in the communities. At the time, the MOH had virtually no supply of essential medicines and families had to travel long distances to the district capitals to buy medicines. The project started 90 village pharmacies, providing training in management, inventory control, and pricing. By 2005, the Tajik government had passed a series of regulations restricting acquisition and resale of pharmaceutical and limiting who could sell them. There was also question at the time of the MTE about the lack of involvement of the MOH, since VPs were being supervised by the VDCs and the sustainability potential considering the replacement cost of drugs and lack of a long-term plan for operational costs. For all these reasons, SC decided to drop the VPs in 2005.

At the time of this final evaluation, 65 of the 90 village pharmacies were found to be still functioning, even without any support from SC or the MOH. They are being operated as private enterprises mostly by the individuals SC had trained or another health worker who assumed the responsibility. Those running the pharmacies credit SC with giving them the idea, skills, and vision to conduct the business.

The Health Facility Farms (HFF) were meant to generate income for the health facilities to make physical improvements and to eventually cover recurring costs for project activities which were to be sustained. The HFFs were started with technical assistance, funds, and materials of SC's companion USDA-supported project. There was not clear articulation either in the DIP or the USDA proposal about monitoring and supervision of this activity, but farms were established by 36 health facilities. These "farms" consisted of a plot of land that was borrowed from the government. Health facility staff planted, tended, and harvested the crop in their off hours. The crop was sold and the profits used primarily for physical improvements to the health facility. During the first years, when the HFF were being established, the health facility staff received food for work from the USDA project as an incentive. After 2003, the USDA project was not extended in Tajikistan. Due to lack of food for work, technical assistance or funds in the CS project budget for the farms, SC had to stop supporting the HFF in any way.

The final evaluation found that 19 of the 36 HFF are still functioning. The doctors, midwives, and other staff who are working them are quite enthused as they have seen direct benefits to the health facility which make their work easier. It is probable that they are also using the income to top off their very low salaries, but this was not investigated. Staff members from other health facilities are so interested they have come to visit the HFF. For most, the only limiting factor in replicating the HFF is the lack of land. In fact, more of the HFFs might have continued had the government collective farms not taken back the land that was loaned to them.

At the left, the director of a health facility stands by the HFF corn field. From their corn crop, the HF netted nearly $2000 in 2006.

The money was used to re-wire the rural hospital and to renovate an outlying health post. In previous years, the extra income was spent on rehabilitating and equipping the maternity ward, replenishing midwife kits (originally supplied by CS-14), painting the facility and purchasing linens.

ii. HIV/AIDS

When the CS-14 project began, HIV/AIDS was new to Tajikistan. Due to dramatic social changes since 2000 which include escalation in the use of IV drugs and massive migration of men to work seasonally in Russia and other countries with high HIV prevalence, HIV/AIDS has become a serious issue in Tajikistan. The CS-18 baseline showed that only 29% of women interviewed had ever heard of HIV/AIDS. In the final survey, awareness had increased to 48%. Major projects funded by the Department for International Development (DFID), The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and UNAIDS are using media to raise awareness and are targeting high risk groups.

During the final evaluation, in focus groups with VDCs, CtC trainers and health staff, and in individual interviews with mothers, mothers-in-law, teachers, and health workers, many men, women and youth expressed a desire for more understanding of HIV/AIDS and how to protect themselves and their families. With such high rates of migration from the project area to Russia, families feel threatened, myths abound, and community members are expressing strong feelings which will lead to stigmatizing those infected.

During the final weeks, the project staff hoped to acquire and distribute the brochure that has been prepared with GFATM funds which specifically addresses HIV and migration. Due to the level of anxiety among the target population, the risk of increasing prevalence including mother-to-child transmission, and potential for stigmatization, SC should consider building on the CS project base to implement an intensive HIV/AIDS project in the same target area.

E. Conclusions and Recommendations

Conclusions:

- This exemplary child survival project changed family behaviors and community norms, empowered village development committees and youth, improved skills, motivation and morale of MOH health staff at all levels, and influenced MOH policy at the district and national levels.

- The project significantly exceeded all targets for changes in household practices and knowledge on pertinent MCH issues. The project also exceeded all targets for results in improved capacity of communities and health facilities and for the sustainability objectives.

- The project's achievement of significant change in a cultural behavior like breastfeeding practices in just two years shows what is possible with sound behavior change strategy and dedication.

- The technical and leadership skills of the CS-18 project's expatriate staff and the SC Area Technical Advisor have produced highly competent local staff who will continue to be an asset to Tajikistan and the Zarafshan Valley.

- While project activities were phased over to the MOH and there is commitment and motivation on their part to continue, there is still the issue of lack of transportation, particularly in Aini. Due to this, it is doubtful that current supervision and community visit levels will be maintained.

- An income-generation scheme for the health facilities that had to be dropped in 2003 due to disappearance of complementary funding, continued in many places without SC support, as did village pharmacies which were dropped due to new restrictive government regulations.

- Forming the Village Development Committees with a broader scope than just health and providing them with appropriate organizational skills enabled them to assume a true leadership role in the community and evolve to pursing major community development projects with outside donors or internal fund-raising.

- Having two consecutive projects enabled SC Tajikistan to implement models with which to influence policy with the necessary time to produce visible results and engage in advocacy.

Recommendations

☐ The highly successful experiences in achieving impressive levels of participation in growth monitoring and promotion (GMP) without incentives, and in mobilizing communities to reject non-iodized salt deserve documentation and further study by SC as models for other GMP and community mobilization efforts.

☐ In implementing future CtC programs, SC may want to consider having the secondary school students who are CtC trainers convey certain messages to much younger students. For example, messages on hand washing, latrine use, and dental care are much more likely to result in behavior change among first graders, who are open to new habits, than among junior high students.

☐ There is need for further intervention in the target area focusing on water and sanitation, de-worming, and HIV/AIDS. The latter is of particular concern considering the high rates of male migration to Russian and elsewhere.

☐ There are currently no iodine oil capsules available in the districts or the region for treating clinical iodine deficiency. SC could advocate with donor agencies in Dushanbe such as UNICEF to get supplies for the MOH and provide training to health staff in the districts on this form of treatment.

☐ There is another remote district east of Aini which currently has only four physicians and would benefit greatly from child survival interventions.

F. Results Highlight – Contribution to Scaling Up

Introduction of Child Health Cards in Tajikistan

While the Soviet health system kept meticulous records at the health facility level and made home visits to follow-up on children who did not come for scheduled immunization appointments, families were given no record of their child's immunizations and little information on the reasons for immunizing their children. The responsibility for immunization coverage fell completely on the health workers.

During the CS-14 phase of the project in Penjikent, Save the Children proposed the idea of child health cards to the District Department of Health (DHO). It took approximately two years to persuade the DHO, who did not perceive how the cards would improve coverage and felt that giving families the cards would lessen the authority of the health workers. In 1999, SC received permission to pilot child health cards in the target areas of Penjikent District. This was the final component of a large effort by the project to rehabilitate the cold chain, stabilize vaccine supply, and educate families about the importance of and schedule for immunizations. SC subsequently produced child health cards for the health facilities in the project area and trained health staff to use them.

Armed with knowledge about protecting their child's health and the card with the schedule, parents showed up at health facilities asking for immunizations, something that had never occurred before. This quickly removed any lingering doubts of the DHO, who reported on the innovation at a national meeting sponsored by WHO in 2001. Further reports were shared with the central MOH officials and representatives of the National and Regional Centers for Immunization visited Penjikent in 2001 and 2002.

UNICEF subsequently joined the advocacy for child health cards in 2004, using Penjikent as an example. UNICEF wanted to see the child health cards become national policy and enlisted the support of SC to share their experiences with introduction of the cards in Penjikent and, starting in 2003, in Khatlon Region through the bi-lateral USAID funded Healthy Family project.

Child health cards are now national policy, with UNICEF paying the printing costs. Cards are given to all mothers after delivery. Families are required to show them to prove complete immunization when a child enters school. Hospitals and clinics also ask to see the card before admitting any child.

While UNICEF pressure on the central MOH to adopt child health cards would likely have eventually occurred, they did not have their own pilot to show the effectiveness of the cards in Tajikistan. The Tajik government has consistently found it difficult to adopt policies and strategies from other countries without first having evidence of their benefit and feasibility in the Tajikistan context. Save the Children's role in creating effective models at the district level was key in the development of the new national policy of family-held child health cards.

Annex A: Evaluation Team Members

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Annex B: Final KPC Survey Report

Report on Final Evaluation KPC Survey And Health Worker Performance Assessment Child Survival-18 Project Save the Children

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Pervez Shaukat– Sr. Program Manager Operations

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August 2007

SECTION I.

1. Introduction

The Child Survival project conducted a final evaluation KPC survey to compare final results against project indicators in August 2007, using Lot Quality Assurance Sampling (LQAS) methodology. The goal of this assessment was twofold:

1) To measure final results toward the achievement of project targets for each indicator
2) To compare the performance of individual project districts against the overall achievement of project as a whole for each indicator. This is the average project coverage for each indicator;

2. Methodology

In July 2005, Dr. Pervez Shaukat, Senior Program Manager Operations conducted training on survey methodology for LQAS that was then used during the Mid-term Evaluation (MTE) of CS-18. For the final survey, project staff with the program manager CS-18 reviewed existing questionnaires and decided to add 2 questions required by indicator, but otherwise followed the same protocols as for the MTE survey.

The two project districts, Penjikent and Ayni were considered as separate supervisory areas (SA). Fieldwork was conducted between August 1, 2007 and August 9, 2007. Five survey teams were organized for conducting the survey. Each group consisted of 1 person from Ayni staff and the other person from Penjikent staff and a supervisor who was responsible for monitoring proper marking of each of the questionnaires and submission for data entry. Data entry and analysis was carried out by Sharofiddin Mahmudov, MIS Assistant from Save the Children Penjikent Office.

2.1. Assessment Tools

The instrument used to assess progress on the indicators was the same as that used to establish the values of the indicators at the baseline and mid-term evaluation survey. For the final survey, the project added two questions in an effort to validate the responses to existing questions on exclusive breastfeeding and on knowledge of danger signs during illness. A copy of the survey instrument, which was based on the standardized KPC questionnaire in use in 2000, is included at the end of this report.

3. Community Indicators assessed

The following indicators were assessed in this final KPC survey. The survey also collected data for relevant Rapid Catch indicators, which were measured at baseline. The Rapid Catch indicators are given in the final attachment to this report.

Ind. # in DIP	Inter-vention	Indicator
1	MNC	% of mothers who report having made 3+ANC visits to a health facility while pregnant with youngest child
2	MNC	% of 0-23 month olds whose birth was attended by skilled health personnel.
3	Nutr	% of 0-5 month olds exclusively breastfed during the last 24 hours
4	EPI	% of 12-23 month olds who received a measles vaccine
5	EPI	% of 12-23 months olds with cards, fully immunized. (Measles vaccine is now gives from age 12 month.)
6	ARI CDD	% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.
7	CDD	% of mothers who report hand washing before food prep. & child feeding, & after defecation.
8	Nutr	% of household with children <2 which have only iodized salt for cooking.
13	MNC	% of mothers who know 2+ postpartum danger signs.
14	MNC	% mothers who know 2+ newborn danger sings.
15	ARI	% of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.
16	CDD	% of mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.
21	Nutr	% of children <2 who have their weight plotted on growth chart.

4. Selection of villages

All 204 villages were separated into 5 lots:

1. Lot-CS-14 villages of Penjikent
2. Lot-old CS-18 villages in Penjikent
3. Lot-new CS-18 villages in Penjikent
4. Lot –old CS-18 villages in Aini
5. Lot - new CS-18 villages in Aini

From each lot 19 villages were selected for survey giving a total of 95villages selected for the final KPC survey. One household was selected in each village.

4.1. Selection of caregivers of children under 24 months of age:

A household was randomly selected for interview as suggested by LQAS training manual.
The interviewer would go to the center of the village, divide the village in 2 or 4 parts and choose randomly one street or collection of households. If the street had houses more than 30, it was again divided into two or more sections and then one section selected randomly usually writing it on pieces of papers and selecting one. If the houses were thirty or less, all households were numbered, written on pieces of papers and one household randomly chosen. If that household had no woman with child less than two years of age the interviewer would move to the next household till they found one with mother of child less than 2 years.

5. Summary Results of Survey for Indicators Result/Inter-mediate Result	Ind. # in DIP	Interv.	Indicator	Site-wide Baseline %	Site-wide EOP Target %	Midterm Evaluation %	Final Evaluation %	Total Sample Size	Total Correct response
R-l: Improved health practices at household level, & increased use of key MCH services, in rural Panjikent &Aini districts	1	MNC	% of mothers who report having made 3+ANC visits to a health facility while pregnant with youngest child	53	80	94	**92**	95	**87**
	2	MNC	% of 0-23 month olds whose birth was attended by skilled health personnel.	85	90	86	**95**	95	**90**
	3	Nutr	% of 0-5 month olds exclusively breastfed during the last 24 hours	12	50	46	**93**	31	**29**
	4	EPI	% of 12-23 month olds who received a measles vaccine	67	80	94	**82**	39	**32**
	5	EPI	% of 12-23 months olds with cards, fully immunized. (Measles vaccine is now given from age 12 mos.)	71	70	89	**82**	39	**32**
	6	ARI CDD	% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.	30	60	100	**96**	32	**31**
	7	CDD	% of mothers who report hand washing before food prep. & child feeding, & after defecation.	19	40	64	**93**	95	**88**
	8	Nutr	% of household with children <2 which have only iodized salt for cooking.	10	50	72	**92**	95	**87**
IR-1: Increased household level knowledge of selected MCH issues	13	MNC	% of mothers who know 2 or more postpartum danger signs.	53	70	100	**95**	95	**90**
	14	MNC	% mothers who know 2 or more newborn danger sings.	51	70	100	**98**	95	**93**
	15	ARI	% of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.	27	60	56	**89**	95	**85**
	16	CDD	% of mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.		100	100	**100**	95	**95**
	21	Nutr	% of children <2 who have their weight plotted on growth chart.		60		**85**	95	**81**

RESULTS FOR ALL KPC SURVEY QUESTIONS

			Yes	
#	Questions	Options of response (answers)	Number	%
1.1	Did you see anyone for pre-natal care while you were pregnant with (NAME)?	DOCTOR	1	1
1.2		NURSE	72	76
1.3		MIDWIFE	54	57
1.4		TBA		
1.5		TRADITIONAL HEALERS	0	0
1.6		OTHER:	1	1
1.7		DO NOT KNOW		
2.1	How often did you go to receive antenatal care? PROBE FOR FREQUENCY	ONCE DURING PREGNANCY…….. A	1	1
		TWICE DURING PREGNANCY…… B	1	0
		THRICE DURING PREGNANCY….. C	6	6
		MORE THAN THRICE…… D	87	92
		DO NOT KNOW…….. E	0	0
3.1	Do you remember receiving iron supplements during your ANC visit(s)?	1	90	95
4.1	What are the symptoms during pregnancy indicating the need to seek health care?	DO NOT KNOW	0	0
4.2		HEADACHE	94	99
4.3		DARKENING OF VISION	77	81
4.4		SWELLING OF FACE/BODY/HANDS	84	88
4.5		PAIN ABDOMEN	90	95
4.6		BLEEDING	95	100
4.7		SLOW FETAL MOVEMENTS	74	78
4.8		OTHER	90	95
5.1	Where did you give birth?	YOUR HOME…….. 11	25	26
5.2		OTHER HOME…… 12	0	0
5.3		DISTRICT HOSPITAL…….. 21	25	26
5.4		RURAL HOSPITAL (SUB)…..... 22	41	43
5.5		HEALTH CENTER (SVA)…… 23	3	3
5.6		HEALTH POST (FAP)…….. 24	0	0
5.7		OTHER HEALTH FACILITY….. 26	0	0
5.8		OTHER:_____ 96	1	1
6.1	Who assisted you with the delivery?	DON'T KNOW	0	0
6.2		DOCTOR	45	47
6.3		NURSE		
6.4		MIDWIFE	43	45
6.5		FELDSHER	3	3
6.6		TBA	0	0
6.7		TBA UNTRAINED	2	2
6.8		HUSBAND	0	0
6.9		FAMILY MEMBER TRAINED	1	1
6.10		FAMILY MEMBER UNTRAINED	2	2
6.11		MYSELF	0	0
6.11,1		0-23 month olds whose birth was attended by skilled health personnel	90	95
6.12		OTHER		

			Yes	
#	Questions	Options of response (answers)	Number	%
7.1	Where was (NAME) put immediately after birth?	WITH MOTHER…… 1	92	97
7.2		IN COT…….... 2	2	2
7.3		ON FLOOR……..…. 3	0	0
7.4		BATHED…… 4	0	0
7.5		OTHER: _____ 6	1	1
7.6		DON'T KNOW……..…… 8	0	0
8.1	How many days or weeks after the delivery did the first check take place?	HOURS AFTER DELIVERY_____	3	3
8.2		WITHIN ONE DAY AFTER DELIVERY	89	94
8.3		ONE WEEK AFTER DELIVERY	3	3
8.4		NEVER ---------- 996	0	0
8.5		DON'T KNOW _____ 998		
9.1	During your postpartum check, were you counseled on the following:	Family planning 1	93	98
9.2		Infant nutrition 1	93	98
9.3		Breastfeeding 1	93	98
9.4		Child Immunization 1	93	98
9.5		Danger signs of diarrhea 1	93	98
9.6		Danger signs of pneumonia 1	93	98
10.1	What are the signs of danger after giving birth indicating the need for you to seek health care?	DON'T KNOW		
10.2		FEVER	91	96
10.3		EXCESSIVE BLEEDING	95	100
10.4		SMELLY VAGINAL DISCHARGE	75	79
10.5		CONVULSIONS/FITS	67	71
10a.1		Mothers who know 2+ postpartum danger signs	90	95
11.1	At that time, did the person check on (NAME)'s health as well?	YES 1	95	100
12.1	What are the signs to watch for that may indicate that a newborn baby is ill?	DON'T KNOW		
12.2		POOR FEEDING	95	100
12.3		FAST BREATHING	73	77
12.4		NOT ACTIVE	93	98
12.5		REDNESS AROUND THE CORD	87	92
12.6		RED/DISCHARGING EYE	47	49
12.6a		Mothers who know 2+ newborn danger sings.	93	98
12.7		OTHER	42	44
13.1	Did you ever breastfeed (NAME)?	YES 1	95	100
14.1	How long after birth did you first put (NAME) to the breast?	WITHIN FIRST HOUR…….. 1	89	94
14.2		WITHIN FIRST 8 HOURS…… 2	4	4
14.3		AFTER FIRST 8 HOURS…….. 3	2	2
15.1	Are you breastfeeding (NAME) now?	YES 1	79	83

			Yes	
#	Questions	Options of response (answers)	Number	%
16.1	Now I would like to ask you about the types of liquids (NAME) consumed yesterday during the day or at night. Did (NAME) have……ASK THE LIST BELOW.	A. Plain water?	66	69
16.2		B. Commercially produced infant formula?	3	3
16.3		C. Any other milk such as tinned, powdered, or fresh animal milk?	35	37
16.4		D. Fruit juice?	29	31
16.5		E. Any other liquids such as sugar water, flavored water, tea, carbonated drinks, infusion, soup broth?	53	56
17.1	Now I would like to ask you about the types of foods (NAME) consumed yesterday during the day or at night. Did (NAME) have ASK THE LIST BELOW	F. Any food made from grains [maize, rice, wheat, porridge, or other local grains]?	51	54
17.2		G. Pumpkin, carrots, or red sweet potatoes?	52	55
17.3		H. Any other food made from roots or tubers [e.g. white potatoes, white yams, cassava, or other local roots/tubers]?	27	28
17.4		I. Any green leafy vegetables?	15	16
17.5		J. Local Vitamin A rich fruits?	15	16
17.6		K. Any other fruits and vegetables [e.g. melon, apple, pears, tomatoes, pomegranates]	39	41
17.7		L. Meat, poultry, fish or eggs?	38	40
17.8		M. Any food made from legumes [e.g. lentils, beans, soybeans, pulses, or peanuts]?	21	22
17.9		N. Cheese or yoghurt?	34	36
17.10		O. Any food made with oil, fat or butter?	18	19
17b.1	Do you only breastfeed your <6-months child?		27	87
18a.1		Household with children <2 which have only iodized salt for cooking.	88	93
19.1	Do you have a card where (NAME's) vaccinations are written down?	YES, SEEN…… 1	90	95
19.2		YES, LOST IT..…….. 2	3	3
19.3		NEVER HAD A CARD..…..…….. 5	2	2
21.1	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?	YES…… 1	93	98
21.2		NO…….. 2	0	0
21.3		DON'T KNOW…….. 8	2	2
22.7,1		Children of 12-23 month olds	56	59
22.7,1,1		Children of 12-23 month olds who received a measles vaccine	32	82
22.7,1,2		Children of 12-23 months olds with cards fully immunized. (Measles vaccine is now gives from age 12 month.)	32	82
23.1	Has (NAME) had diarrhea in the last 2 weeks?	YES……..… 1	29	31
23.2		NO…….. 2	66	69
23.3		DON'T KNOW…….. 8	0	0

#	Questions	Options of response (answers)	Yes	
			Number	%
24.1	When (Name 0 suffered from diarrhea, from who did you seek advice or treatment?	Government health facility staff ----------A	26	89
24.2		Private practitioners ----------B	0	0
24.3		Private practitioners(non –qualified) ----------C	0	0
24.4		Traditional Healers ----------D	0	0
24.5		Self ----------E	3	3
24.6		Don't know ----------F	0	0
25.1	What type of treatment was provided to your child, by the (above mentioned) health care provider?	ORS	29	100
25.2		(I.V) INTRAVENOUS FLUIDS		
25.3		ANTI-DIARRHEAL DRUGS	1	1
25.4		RESTRICTED DIET	1	1
25.5		OTHER:	4	4
26.1	When (NAME) had diarrhea, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS…… 1	0	0
26.2		SAME…….. 2	0	0
26.3		MORE……..3	29	31
26.4		NOTHING TO DRINK…….....4	0	0
26.5		DON'T KNOW..……..……..... 5	0	0
27.1	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS…… 1	1	1
27.2		SAME…….. 2	0	0
27.3		MORE…….…… 3	28	29
27.4		NOTHING TO EAT…..…….. 4	0	0
27.5		DON'T KNOW..……..…….…... 5	0	0
28.1	If your child suffers from diarrhea, which danger signs will prompt you to seek treatment or advice?	DIARRHEA	93	98
28.2		DIARRHEA AND VOMITING	93	98
28.3		DIARRHEA AND FEVER	93	98
28.4		DIARRHEA WITH BLOOD	92	97
28.5		DIARRHEA LASTING MORE THAN 14 DAYS	56	59
28.6		LETHARGY	58	61
28.7		UNABLE TO DRINK	80	84
28.8		UNCONSCIOUSNESS	21	22
28.8a		Mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.	95	100
28.9		OTHER:	90	95
29.1	Does your household have a special place for hand washing?	YES	88	93
30.1	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF EACH OF THE FOLLOWING ITEMS ARE PRESENT	(I) WATER/TAP 1	83	87

			Yes	
#	Questions	Options of response (answers)	Number	%
30.2		(II) SOAP, ASH OR OTHER CLEANSING AGENT 1	87	99
30.3		(III) BASIN 1	36	41
31.1	When do you usually wash your hands with soap or ash?	NEVER	1	1
31.2		BEFORE FOOD PREPARATION	92	97
31.3		BEFORE EATING	93	98
31.4		BEFORE FEEDING CHILDREN	90	95
31.5		AFTER DEFECATION	95	100
31.6		AFTER ATTENDING TO A CHILD WHO HAS DEFECATED	93	98
31.6,1		Mothers who report hand washing before food prep. & child feeding, & after defecation.	88	93
31.7		OTHER:	95	100
32.1	Has (NAME) had an illness with a cough at any time in the last two weeks?	YES……..… 1	8	8
32.2		NO……..… 2	87	92
32.3		DON'T KNOW…….. 8	0	0
33.1	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, fast breaths?	YES……..… 1	5	5
33.2		NO……..… 2	2	2
33.3		DON'T KNOW…….. 8	1	1
34.1		Did you seek advice or treatment for the cough/fast breathing?	5	100%
35.1	Sometimes children get sick and need to receive care or treatment for illness. What are the signs of illness that would indicate your child needs treatment?	DON'T KNOW	1	1
35.2		COUGH WITH FEVER	95	100
35.3		FAST BREATHING	95	100
35.4		DIFFICULT BREATHING	76	80
35.5		CHEST INDRAWING	85	89
35.6		WHEEZE	83	87
35.7		CHRONIC COUGH	57	60
35.8		MEASLES	3	3
35.9		WHOOPING COUGH	2	2
35.10		LETHARGIC OR DIFFICULT TO WAKE	19	20
35.11		NOT EATING OR DRINKING	68	72
35.12		LOOKS UNWELL OR NOT PLAYING NORMALLY	67	71
35.13		CONVULSIONS	16	17
35.13a		Mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider	85	89
35.14		OTHER	94	99
36.1	When (NAME) was sick, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS……..…… 1	0	0
36.2		SAME…….. 2	0	0
36.3		MORE……..…. 3	95	100

			Yes	
#	Questions	Options of response (answers)	Number	%
37a.1		Children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.	31	100
38.1		Have you ever heard of an illness called HIV/AIDS?	46	48
39.1	(Apart from AIDS), have you heard about (other) infections that can be transmitted through sexual contact?	YES	37	39
40.1	In a man, what signs and symptoms would lead you to think that he has such an infection?	DON'T KNOW	16	43
40.2		ABDOMINAL PAIN	1	3
40.3		GENITAL DISCHARGE/ DRIPPING	8	22
40.4		FOUL SMELLING DISCHARGE	7	19
40.5		BURNING PAIN ON URINATION	17	46
40.6		REDNESS/ INFLAMATION IN GENITAL AREA	5	14
40.7		SWELLING IN GENITAL AREA	3	8
40.8		GENITAL SORES/ ULCERS	4	11
40.9		GENITAL WARTS	1	3
40.10		BLOOD IN URINE		
40.11		LOSS OF WEIGHT	1	3
40.12		IMPOTENCE		
40.13		NO SYMPTOMS		
40.14		OTHER:	37	100
41.1	In a woman, what signs and symptoms would lead you to think that he has such an infection?	DON'T KNOW	15	41
41.2		ABDOMINAL PAIN	4	11
41.3		GENITAL DISCHARGE	4	11
41.4		FOUL SMELLING DISCHARGE	10	27
41.5		BURNING PAIN ON URINATION	19	51
41.6		REDNESS/ INFLAMATION AND ITICHING GENITAL AREA	5	14
41.7		SWELLING IN GENITAL AREA	3	8
41.8		GENITAL SORES/ ULCERS	4	11
41.9		GENITAL WARTS	2	5
41.10		BLOOD IN URINE		
41.11		LOSS OF WEIGHT	3	8
41.12		INABILITY TO GIVE BIRTH		
41.13		NO SYMPTOMS		
41.14		OTHER:	37	100
42.1	During the last 12 months, have you had a sexually-transmitted disease?	YES…….… 1	0	0
42.2		NO…….. 2	37	100
42.3		DON'T KNOW…….. 8	0	0
43.1	Where do you get general information or advice on health or nutrition?	DOCTOR	90	95
43.2		NURSE/ MIDWIFE	79	83
43.3		TRADITIONAL BIRTH ATTENDANT	5	5
43.4		VDC MEMBER	73	77
43.5		CS-18 STAFF HEALTH MONITOR	87	92

			Yes	
#	Questions	Options of response (answers)	Number	%
43.6		HEARTH VOLUNTEER	18	19
43.7		CTC TRAINED CHILD	43	45
43.8		CTC TRAINED TEACHER	61	64
43.9		FELDSHER	29	31
43.10		HUSBAND/ PARTNER	22	23
43.11		MOTHER/ MOTHER-IN-LAW	71	75
43.12		SISTER	13	14
43.13		GRAND PARENT	26	27
43.14		AUNT	10	11
43.15		FRIEND/ NEIGHBOR	18	19
43.16		TRADITIONAL HEALER	2	2
43.17		VILLAGE ELDER	28	29
43.18		OTHER:	94	99
44.1	In the past month, have you received any health messages from the following?	RADIO	21	22
44.2		NEWSPAPER	32	34
44.3		TELEVISION	76	80
44.4		HEALTH MONITOR	63	66
44.5		VDC MEMBER	74	78
44.6		CTC TRAINED STUDENT	71	75
44.7		MOH WORKER	92	97
44.8		VOLUNTEER	11	12
44.9		TEACHERS	14	15
45.1	Is activity weighing program in your village?	YES……..… 1	82	86
45.2		NO…….. 2	13	14
45.3		DON'T KNOW…….. 8	0	0
46.1	If Yes, how many times your baby is weighed? (card)	Two month 2	81	85

SECTION II.

5. Health Worker Performance Assessment

As a part of the final quantitative evaluation, the CS-18 project conducted an assessment of the performance of the staff in the MOH health facilities who had received training from the project. The results were used to measure progress against three of the indicators for IR. 3.

5.1. Assessment Tools

The tool used to assess progress on the indicators was the same observation checklists as those used to establish the values of the indicators at the baseline survey. The assessment also employed an exit interview tool with the care-giver of the sick child. Both tools are found at the end of this report.

#	Indicator	Assessment tools
19	% of children<5 with diarrhea for whom all 6 diarrhea assessment tasks are completed by health worker	Health facility's assessment sick Child Observation Checklist
20	% of children<5 with ARI for whom all 4 ARI assessment tasks are completed by health worker	Health facility's assessment Sick Child Observation Checklist
22	% of children's care takers counseled on important of continued breastfeeding or feeding food at home.	Health facility's assessment Sick Child Observation Checklist

5.2 Selection of villages

The performance assessment was conducted in the health facility in the 95 selected villages for the KPC or the nearest health facility. The survey team observed the pediatrician or other staff member who is responsible for attending children at that health facility.

6. Sick child

Sick children for observation were selected by random draw of names. If the team did not find sufficient numbers of CDD or ARI cases, VDC members in the community of each selected village identified and sent 4-5 cases of CDD/ARI to the health facility for assessment.

6.1. Data collection, Tabulation and analysis

The coding formats were jointly developed by CS-18 management team (Program Manager, Assistant Project Officer and Senior Health Monitor). In the questionnaire the schedule of vaccination was amended. Data was manually tabulated.

6.2. Findings

The CS-18 project exceeded target for all of the 3 quality of care indicators measured:

#	Indicator	EOP target	Final
19	% of children<5 with diarrhea for whom all 6 diarrhea assessment tasks are completed by health worker	70%	73%
20	% of children<5 with ARI for whom all 4 ARI assessment tasks are completed by health worker	70%	65%
22	% of children's care takers counseled on important of continued breastfeeding or feeding food at home.	90%	95%

6.3. Management of the Sick Child

The IMCI trained project staff used observation checklist of Heath Facility Assessment (HFA) to assess health worker's management skills. Sick children presenting at the health facility were randomly selected for assessment. During the survey team visit, if not many children present in the health facility, VDC went to homes and sent sick children to the health facility for examination by the health worker. Only IMCI-trained project staff were asked to use the observation checklist.

According to the results of the observation checklist the health workers:

- children were weighed-96%(79/76)
- identified the general dangerous signs- 97%(79/77)

- classified the sick child correctly -96%(79/76)
- prescribed appropriate treatment and counseled mother/care-giver on medication - 86%(79/68)
- advised mothers when to bring the child back -83% (79/66)
- child was correctly managed and treated -87%(79/69)
- appropriate treatment prescribed for diarrhea -97% (45/44)
- appropriate treatment prescribed for pneumonia -80%(20/16)
- advices given for nutritious food for child- 95%(79/760

The majority of the health workers (90%) who performed all tasks listed in the checklist were recorded as correctly managing sick children. This may be considered as proxy for the project indicator, which is about correct treatment of ARI/pneumonia and diarrhea cases in children.

KNOWLEDGE, PRACTICE AND COVERAGE (KPC) SURVEY.

FINAL EVALUTION CS-18 **AUGUST 2007**

Informed Consent

Hello. My name is _____, and I am working with Save the Children-US. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help Save the Children to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes 30 minutes or less to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 〈 END

LOT NUMBER: _____ (1-5)
RECORD NUMBER: _____ (01-19)

ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 24 MONTHS OF AGE.

INTERVIEW DATE: _____/_____/_____ RESCHEDULE INTERVIEW: _____/_____/_____
(dd/ mm/ yy) (dd/ mm/ yy)

INTERVIEWER'S NAME: _____

SUPERVISOR'S NAME: _____

LOCATION (CIRCLE ONE ONLY): CS-14/PENJIKENT CS-18/PENJIKENT CS-18/AINI

VILLAGE: _____ ETHINIC GROUP: _____

NAME OF THE HEAD OF THE HOUSEHOLD: _____

NAME OF THE MOTHER	NAME OF THE YOUNGEST CHILD LESS THAN 24 MONTHS
AGE OF THE MOTHER (In Years)---------- _____	SEX OF CHILD (1=Male, 2=Female) _____ DATE OF BIRTH: _____/_____/_____ (dd/mm/yy) AGE OF THE CHILD (In months) _____

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	Go To
A-	**MATERNAL HEALTH CARE:**		
A1-	**Pre-natal Care:**		
1	Did you see anyone for pre-natal care while you were pregnant with (NAME)? IF YES: Whom did you see? Anyone else? **PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.**	**HEALTH PROFESSIONAL** DOCTOR……. A NURSE……. B MIDWIFE…… C **OTHER PERSON** TBA…….... D TRADITIONAL HEALERS…….... E OTHER: _____ X (Specify) NO ONE…… Z	⟨ 4
2	How often did you go to receive antenatal care? PROBE FOR FREQUENCY	ONCE DURING PREGNANCY…….. A TWICE DURING PREGNANCY…… B THRICE DURING PREGNANCY….. C MORE THAN THRICE…… D DO NOT KNOW…….. E	
3	Do you remember receiving iron supplements during your ANC visit(s)?	YES ……..…….…… 1 NO……..…….... 2	
4	What are the symptoms during pregnancy indicating the need to seek health care? RECORD ALL MENTIONED.	HEAD ACHE …… A DARKENING OF VISION……... B SWELLING OF FACE/BODY/HANDS …..C PAIN ABDOMEN ……..…D BLEEDING ……..……..E SLOW FETAL MOVEMENTS...……....F OTHER: _____ H` (Specify) DO NOT KNOW……..…. Z	
A2-	**Delivery/ Immediate Newborn Care:**		
5	Where did you give birth? IF THE SOURCE IS HOSPITAL, HEALTH CENTER, HEALTH POST, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	HOME YOUR HOME…….…….. 11 OTHER HOME…… 12 HEALTH FACILITY DISTRICT HOSPITAL……..….. 21 RURAL HOSPITAL (SUB)……..... 22 HEALTH CENTER (SVA)……..… 23 HEALTH POST (FAP)……..….. 24 OTHER HEALTH FACILITY…... 26 OTHER:_____ 96 (Specify)	

6	Who assisted you with the delivery?	**HEALTH PROFESSIONAL** DOCTOR……. A NURSE ..……..……. B MIDWIFE…… C FELDSHER……. D **OTHER PERSON** TBA…….…..... …..E TBA UNTRAINED……...…… F HUSBAND …….. G FAMILY MEMBER UNTRAINED …. H FAMILY MEMBER TRAINED…….I MYSELF…….……..... J DON'T KNOW……..… Z OTHER: _____ X (Specify)	
7	Where was (NAME) put immediately after birth?	WITH MOTHER…… 1 IN COT……... 2 ON FLOOR……...…. 3 BATHED…… 4 OTHER: _____ 6 (Specify) DON'T KNOW……..…… 8	
A3-	**Postpartum Period:**		
8	How many days or weeks after the delivery did the first check take place? RECORD '00' DAYS WITHIN 8 HRS.	HOURS AFTER DELIVERY_____ DAYS AFTER DELIVERY_____ WEEKS AFTER DEL._____ NEVER ---------- 996 DON'T KNOW _____ 998	< 10 < 10
9	During your postpartum check, were you counseled on the following: Family planning? Infant nutrition? Breastfeeding? Child Immunization? Infant diarrhea? Early signs of pneumonia?	**YES NO** Family planning 1 2 Infant nutrition 1 2 Breastfeeding 1 2 Child Immunization 1 2 Danger signs of diarrhea 1 2 Danger signs of pneumonia 1 2	
10	What are the signs of danger after giving birth indicating the need for you to seek health care?	FEVER……...…. A EXCESSIVE BLEEDING……..… B SMELLY VAGINAL DISCHARGE…...C CONVULSIONS/FITS……..D DON'T KNOW…….. Z	
11	At that time, did the person check on (NAME)'s health as well?	YES……. 1 NO……...… 2	
12	What are the signs to watch for that may indicate that a newborn baby is ill? RECORD ALL MENTIONED	POOR FEEDING…….. A FAST BREATHING……..…. B NOT ACTIVE……C REDNESS AROUND THE CORD….. D RED/DISCHARGING EYE……..E OTHER: _____ X (Specify) DON'T KNOW……..…… Z	

B-	**Breastfeeding & Infant/Child Nutrition:**		
13	Did you ever breastfeed (NAME)?	YES…… 1 NO…….. 2	⟨ **16**
14	How long after birth did you first put (NAME) to the breast?	WITHIN FIRST HOUR……. 1 WITHIN FIRST 8 HOURS…… 2 AFTER FIRST 8 HOURS……..... 3	
15	Are you breastfeeding (NAME) now?	YES……..…… 1 NO…….. 2	
16	*Now I would like to ask you about the types of liquids (NAME) consumed yesterday during the day or at night. Did (NAME) have……ASK THE LIST BELOW* A. Plain water? B. Commercially produced infant formula? C. Any other milk such as tinned, powdered, or fresh animal milk? D. Fruit juice? E. Any other liquids such as sugar water, flavored water, tea, carbonated drinks, infusion, soup broth?	**CONSUMED IN LAST 24 HOURS** A. _____ B. _____ C. _____ D. _____ E. _____	
17	*Now I would like to ask you about the types of foods (NAME) consumed yesterday during the day or at night. Did (NAME) have……. ASK THE LIST BELOW* F. Any food made from grains [maize, rice, wheat, porridge, or other local grains]? G. Pumpkin, carrots, or red sweet potatoes? H. Any other food made from roots or tubers [e.g. white potatoes, white yams, cassava, or other local roots/tubers]? I. Any green leafy vegetables? J. Local Vitamin A rich fruits? K. Any other fruits and vegetables [e.g. melon, apple, pears, tomatoes, pomegranates] L. Meat, poultry, fish or eggs? M. Any food made from legumes [e.g. lentils, beans, soybeans, pulses, or peanuts]? N. Cheese or yoghurt? O. Any food made with oil, fat or butter?	**CONSUMED IN LAST 24 HOURS** F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ M. _____ N. _____ O. _____	
17a	How many months did you exclusively breastfeed or will you breastfeed?	Months _____	
18	May I see the salt that is used for cooking? ASK FOR THE PACKET AND SEE THE LABEL OF IODIZED SALT. Spot test with a testing kit Record color change: encircle one	**YES NO Don't Know** Sample 1: Iodized (from Label) 1 2 3 Color Change: 0% ---7%---15%----30% or more Sample 2: Iodized (from Label) 1 2 3	

		Color Change: 0% ---7%---15%----30% or more Sample 3: Iodized (from Label) 1 2 3 Color Change: 0% ---7%---15%----30% or more	
C-	**Immunization:**		
19	Do you have a card where (NAME's) vaccinations are written down? IF YES: May I see it please?	YES, SEEN…… 1 YES, LOST IT..…….. 2 NEVER HAD A CARD..…..…….. 5	**⟨ 21** **⟨ 21**
20	(1) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD. HEPATITT B1 POLIO 0 (Polio given at birth) BCG HEPATITT B2 HEPATITT B3 POLIO 1 POLIO 2 POLIO 3 DPT 1 DPT 2 DPT 3 MEASLES	**DAY MONTH YEAR** _____/_____/_____Hepatit B1 _____/_____/_____Polio 0 _____/_____/_____BCG _____/_____/_____Hepatit B2 _____/_____/_____Hepatit B3 _____/_____/_____Polio 0 _____/_____/_____Polio 1 _____/_____/_____Polio 2 _____/_____/_____Polio 3 _____/_____/_____DPT 1 _____/_____/_____DPT 2 _____/_____/_____DPT 3 _____/_____/_____Measles	
21	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?	YES…… 1 NO…….. 2 DON'T KNOW…….. 8	**⟨ 23** **⟨ 23**
22	Please tell me if (NAME) received any of the following vaccinations. 22.0- Hepatitis vaccination against jaundices, that is, an injection in the leg 22.1-If yes how many times? 22A- A BCG vaccination against tuberculosis that is, an injection in the arm or shoulder that usually causes a scar? 22B- Polio vaccine, that is, drops in the mouth? 22C- When was the first polio vaccine received, just after birth or later? 22D- How many times was the polio vaccine received? 22E- DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops? 22F- If yes how many times?	 YES…… 1 NO……...……... 2 DON'T KNOW…….. 8 NUMBER OF TIMES _____ YES…… 1 NO……...……... 2 DON'T KNOW…….. 8 YES…… 1 NO……. 2 DON'T KNOW…….. 8 JUST AFTER BIRTH……..…….. 1 LATER…….. 2 NUMBER OF TIMES _____ YES……..…… 1 NO…….. 2 DON'T KNOW…….. 8 NUMBER OF TIMES _____	 **⟨22E** **⟨22E** **⟨22G** **⟨22G**

	22G- An injection to prevent measles?	YES……..… 1 NO…….. 2 DON'T KNOW…….. 8	
D-	**Diarrhea:**		
23	Has (NAME) had diarrhea in the last 2 weeks?	YES……..… 1 NO…….. 2 DON'T KNOW…….. 8	⟨ 28 ⟨ 28
24	When (NAME) suffered from diarrhea, from whom did you seek advice or treatment? **SELECT ONE OF THE RESPONSES**	GOVT. HEALTH FACILITY STAFF……. A PRIVATE PRACTITIONERS (qualified)……..B PRIVATE PRACTITIONERS (non-qualified).. C TRADITIONAL HEALERS…….....D SELF……..E DON'T KNOW…… F	
25	What type of treatment was provided to your child, by the (above mentioned) health care provider? **RECORD ALL MENTIONED**	ORS ……..……... A (I.V) INTRAVENOUS FLUIDS……. B ANTI-DIARRHEAL DRUGS…… C RESTRICTED DIET…….. D OTHER:_____ X (Specify)	
26	When (NAME) had diarrhea, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS…… 1 SAME…….. 2 MORE……..…. 3 NOTHING TO DRINK……... 4 DON'T KNOW..……..……... 5	
27	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS…… 1 SAME…….. 2 MORE……..…. 3 NOTHING TO EAT….…….. 4 DON'T KNOW..……..……... 5	
28	If your child suffers from diarrhea, which danger signs will prompt you to seek treatment or advice? **RECORD ALL MENTIONED**	DIARRHEA ……... A DIARRHEA AND VOMITING…… B DIARRHEA AND FEVER……. C DIARRHEA WITH BLOOD…….. D DIARRHEA LASTING MORE THAN 14 DAYS. E LETHARGY……. F UNABLE TO DRINK……..… G UNCONSCIOUSNESS…….. H OTHER:_____ X (Specify)	
29	Does your household have a special place for hand washing?	YES……..…. 1 NO……. 2	⟨ 31
30	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF EACH OF THE FOLLOWING ITEMS ARE PRESENT.	**YES NO** (I) WATER/TAP 1 2 (II) SOAP, ASH OR OTHER CLEANSING AGENT 1 2 (III) BASIN 1 2	
31	When do you usually wash your hands with soap or ash? **RECORD ALL MENTIONED**	BEFORE FOOD PREPARATION……..… A BEFORE EATING…… B BEFORE FEEDING CHILDREN…… C AFTER DEFECATION…… D AFTER ATTENDING TO A CHILD WHO HAS DEFECATED…… E NEVER…….. F OTHER:_____ X (Specify)	

E-	**Acute Respiratory Infections (ARI):**		
32	Has (NAME) had an illness with a cough at any time in the last two weeks?	YES……..… 1 NO……..… 2 DON'T KNOW…….. 8	⟨ 35 ⟨ 35
33	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, fast breaths?	YES……..…… 1 NO…….. 2 DON'T KNOW…….. 8	⟨ 35 ⟨ 35
34	Did you seek advice or treatment for the cough/ fast breathing?	YES……..…. 1 NO……. 2	
35	Sometimes children get sick and need to receive care or treatment for illness. What are the signs of illness that would indicate your child needs treatment? **DO NOT PROMPT. CIRCLE ALL MENTIONED** **CHECK WITH TRANSLATION**	COUGH WITH FEVER……... A FAST BREATHING……. B DIFFICULT BREATHING……..… C CHEST INDRAWING..……D WHEEZE…….. E CHRONIC COUGH……. F MEASLES……. G WHOOPING COUGH…….H LETHARGIC OR DIFFICULT TO WAKE……... I NOT EATING OR DRINKING …….....J LOOKS UNWELL OR NOT PLAYING NORMALLY ……K CONVULSIONS…….. L DON'T KNOW……M OTHER:_____ X (Specify	
36	When (NAME) was sick, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS……..…… 1 SAME……..…….. 2 MORE……..…… 3	
37	Was (NAME) was sick, offered less than usual to eat, about the same amount, or more than usual to eat?	LESS……..…… 1 SAME……..……..…. 2 MORE……..…..…..…. 3	
F-	**HIV & Other STDs:**		
38	Have you ever heard of an illness called AIDS?	YES……..……..…. 1 NO……..……... 2	
39	(Apart from AIDS), have you heard about (other) infections that can be transmitted through sexual contact?	YES……..……..…. 1 NO……..……... 2	⟨ 43
40	In a man, what signs and symptoms would lead you to think that he has such an infection? Any others? **RECORD ALL MENTIONED**	ABDOMINAL PAIN……..…….. A GENITAL DISCHARGE/ DRIPPING……. B FOUL SMELLING DISCHARGE……..…. C BURNING PAIN ON URINATION……. D REDNESS/ INFLAMATION IN GENITAL AREA……..…... E SWELLING IN GENITAL AREA…….. F GENITAL SORES/ ULCERS……..…… G GENITAL WARTS…….. H BLOOD IN URINE……. I LOSS OF WEIGHT……J IMPOTENCE……. K NO SYMPTOMS……. L OTHER:_____ W (Specify) DON'T KNOW……..…. Z	
41	In a woman, what signs and symptoms would lead you to think that he has such an infection?	ABDOMINAL PAIN……..…….. A GENITAL DISCHARGE……B FOUL SMELLING DISCHARGE……..…. C	

	Any others? **RECORD ALL MENTIONED**	BURNING PAIN ON URINATION……. D REDNESS/ INFLAMATION AND ITICHING GENITAL AREA……. E SWELLING IN GENITAL AREA…….…….. F GENITAL SORES/ ULCERS……..…… G GENITAL WARTS……..…. H BLOOD IN URINE……..…… I LOSS OF WEIGHT……..…….. J INABILITY TO GIVE BIRTH…..……..…….. K NO SYMPTOMS……..…… L OTHER:_____ W (Specify) DON'T KNOW……. Z	
42	During the last 12 months, have you had a sexually-transmitted disease?	YES……..…. 1 NO…….. 2 DON'T KNOW…….. 8	
G-	**Health Contacts and Sources of Information:**		
43	Where do you get general information or advice on health or nutrition? **RECORD ALL MENTIONED**	FORMAL NETWORK DOCTOR……. A NURSE/ MIDWIFE……. B TRAINED BIRTH ATTENDANT ….…….. C VDC MEMBER……..…….... D HEALTH MONITOR……E HEALTH VOLUNTEER……. F CTC TRAINED TEACHER…….G CTC TRAINED CHILD …….H FELDSHER……...I INFORMAL NETWORK HUSBAND/ PARTNER…….. J MOTHER/ MOTHER-IN-LAW……..K SISTER……. L GRAND PARENT……M AUNT……N FRIEND/ NEIGHBOR……O TRADITIONAL HEALER……P VILLAGE ELDER…….……...R OTHER:_____ X (Specify)	
44	In the past month, have you received any health messages from the following?	**YES** / **NO**	
	RADIO	1 / 2	
	NEWSPAPER	1 / 2	
	TELEVISION	1 / 2	
	HEALTH MONITOR	1 / 2	
	VDC MEMBER	1 / 2	
	CTC TRAINED STUDENT	1 / 2	
	MOH WORKER	1 / 2	
	VOLUNTEER	1 / 2	
	TEACHERS	1 / 2	

H-	Weighing:		
45	Is activity weighing program in your village?	YES……..… 1 NO…….. 2 DON'T KNOW…….. 8	
46	If Yes, how many times your baby is weighted?	Two month 2 Other _____	

1. EXIT INTERVIEW -SICK CHILD

Exit interviewer ID number:_____
Date:_____ Facility Name:_____
Facility Type:_____

Child's age:_____ in months

1. Did the health worker give you any oral medicines at the clinic today? [YES] [NO],
   If NO, go to question 3

   If Yes, compare care takers medications with samples for identification of the oral medication.

   (Instructions to fill the table. Enter as required=AR, Until complete=UC and I don't know=DNK)

Medicine	How much each time?	How many times/day?	How many days?	All correct Yes/No
Antibiotic Tabs/syp Name:_____ Dose/tab:_____				
Aspirin tabs/syp Or paracetamol Dose/tab:_____				
ORS				
Other:_____ Dose/tab				

A. Caretaker knows how to give ALL essential medications correctly? [YES][NO]

2. What will you do for your child when you return home? (code 1)
   - Doesn't know ..... [ ]
   - Continue feeding or breastfeeding the child [ ]
   - Give same quantity/more fluids to the child [ ]
   - Complete course of medications/ORS/RHF ..... [ ]
   - Bring the child back if he/she doesn't
   - get better or gets worse ..... [ ]
   - Other [ ] Specify _____

B. Caretaker knows at least 2 aspects of home case-management? Y/N

3. How will you know if the child becomes worse at home?
   (Code 1 all ticked responses)
   - Doesn't know ..... [ ]
   - Fever begins or doesn't go away .. [ ]
   - Child unable to eat ..... [ ]
   - Diarrhea continues ..... [ ]

- Child has chest indrawing ..... [ ]
- Vomiting begins or continues ..... [ ]
- Child unable to drink ..... [ ]
- Child has convulsions ..... [ ]
- Child has difficulty breathing ... [ ]
- Blood in stool..... [ ]
- Other [ ] Specify _____

C. Caretaker knows at least 2 signs of child getting worse at home? [YES] [NO]

4. Which diseases will be prevented by the immunizations your child has received? (Code 1 all ticked responses)

- Don't know [ ]
- Diphtheria [ ]
- Tetanus [ ]
- Whooping cough [ ]
- Measles [ ]
- Tuberculosis [ ]
- Polio [ ]
- Other [ ] Specify _____

5.a Do you know what might happen as a side effect after the immunization? [YES][NO] If NO, go to question 7

B. If YES, what were you told? (Code 1 all ticked responses)

- Fever .....[ ]
- Irritability.....[ ]
- Pain at injection site.....[ ]
- Swelling.....[ ]
- Other [ ] Specify _____

6. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations?:_____ (1=Correct, 2=Incorrect, 9=Doesn't know)

7.a Did your child receive an immunization today? [YES] [NO]
.b If No, Why:_____ (1=Referred for vaccination another day,2=Was not given or referred for vaccination,3=Up to date)

8.a Were you or your child prescribed any oral medication at your last visit?:_____ (1=YES,2=NO,9=N/A)

.b Were you able to get your medication? [YES] [NO]
.c If YES, where did you get your medication?
(Code 1 all ticked responses)

- This health facility ..... [ ]
- Private pharmacy ..... [ ]
- Another HF/hospital ..... [ ]
- Drug vendor ..... [ ]
- Other [ ] Specify _____

d. If NO, why not? (Code 1 all ticked responses)

- No drugs available ..... [ ]
- No money/could not afford . [ ]
- Other ..... [ ]

9. Do you have your child's vaccination card?:_____(1=Yes, 2=Lost, 3=Never Received, 4=Left at home)(If the caretaker has the card, record the dates of ALL VACCINES GIVEN, both today and in the past, and the child's birth date and age.)

Immunization	Received (Yes) (NO)
HEPATITT B1	
POLIO 0 (Polio given at birth)	
BCG	
HEPATITT B2	
HEPATITT B3	
POLIO 1	
POLIO 2	
POLIO 3	
DPT 1	
DPT 2	
DPT 3	
MEASLES	

D. Child is up to date? ..... [YES] [NO]

END OF INTERVIEW

==========

2. OBSERVATION CHECKLIST - SICK CHILD

Observation ID number:_____
Dates:_____ Facility Name:_____
Facility Type: _____
HW Category:_____ (1=Physician, 2=MCH assistant, 3=MORW, 4=FORW)

Child's age:_____ (months)

1. What reason does the caretaker give for bringing the child to the health facility? (CODE 1 ALL RESPONSE TICKED)
   - Diarrhea/vomiting…… [ ]
   - Fever/malaria…… [ ]
   - Difficulty breathing/cough/pneumonia…… [ ]

2. Does the health worker ask of the age of the child or have the age available? [YES] [NO]

3. a. Is the child weighed? [YES] [NO]
   b. Is the degree of malnutrition calculated? [YES] [NO]

4. Is the child's temperature checked? [YES] [NO]

Does the health worker ASK about (or does the caretaker REPORT):

Danger signs: 1=YES, 2=NO)
5. Able to drink or breastfeed?……[YES] [NO]
6. Vomits everything?……[YES] [NO]
7. Convulsions? …… [YES] [NO]
8. Change in consciousness/lethargic……[YES] [NO]

9.a Diarrhea?…… [YES] [NO]
  .b For how long?……[YES] [NO]
  .c Is there blood in the stool?……[YES] [NO]

10.a Cough or difficult breathing?…… [YES] [NO]
  .b For how long?……[YES] [NO]

11.a Fever? ……[YES] [NO]
  .b For how long?……[YES] [NO]

12.a Ear problems?……[YES] [NO]
  .b Ear pain?……[YES] [NO]
  .c Ear discharge?……[YES] [NO]
  .d IF YES, for how long?…… [YES] [NO]

13. History of home treatment with:……[YES] [NO]

Does the health worker perform these EXAMINATION tasks:

(1=YES, 2=NO)
14. Look for lethargy or unconsciousness?…… [YES] [NO]

15. Observe drinking or breastfeeding?……[YES] [NO]

16. Pinch the skin of abdomen?……[YES] [NO]

17. Look for sunken eyes?……[YES] [NO]

18. Raise the shirt?…… [YES] [NO]

19. Count breaths/minute?……[YES] [NO]

20. Look for chest indrawing?……[YES] [NO]

21. Look or feel for stiff neck?……[YES] [NO]

22. Look for generalized rash?……[YES] [NO]

23. Look for cough, runny nose or red eyes?……[YES] [NO]

24. Look for pus from ear?……[YES] [NO]

25. Feel for swelling behind ear?……[YES] [NO]

Malnutrition:

26. Undress and look for wasting?…… [YES] [NO]

27. Look for pallor or conjunctive pallor?……[YES] [NO]

28. Look for edema of both feet?……[YES] [NO]
29. Was the child referred for vaccination……N/A [YES] [NO]

A. All danger signs (Q.6 to Q.9 [or Q.15]) assessed? [YES] [NO]
B. All main symptoms (Q.10 to Q.13) assessed? ..... [YES] [NO]
C. Number of diarrhea assessment tasks completed?:_____(0 to 5)
D. Number of ARI assessment tasks completed? :_____(0 to 4)
E. Number of fever assessment tasks completed?:_____(0 to 5)
F. Nutritional status correctly assessed? ..... [YES] [NO]

Diagnosis:

How does the health worker classify the child?

(1=YES, 2=NO)

30. Simple diarrhea……[YES] [NO]
    a. No dehydration……[YES] [NO]
    b. Some dehydration……[YES] [NO]
    c. Severe dehydration……[YES] [NO]

31. Dysentery……[YES] [NO]
32. Persistent diarrhea……[YES] [NO]
33. Severe persistent diarrhea……[YES] [NO]
34. Severe pneumonia……[YES] [NO]
35. Pneumonia……[YES] [NO]
36. Upper respiratory inf.(cough/cold) [YES] [NO]
37. Severe malnutrition…… [YES] [NO]
38. Moderate malnutrition or anemia [YES] [NO]
39. Very severe febrile disease…… [YES] [NO]
40. Severe complicated measles…… [YES] [NO]
41. Complicated measles…… [YES] [NO]
42. Measles…… [YES] [NO]
43. Fever, other cause…… [YES] [NO] Specify_____
44. Mastoiditis…… [YES] [NO]
45. Acute ear infection……[YES] [NO]
46. Chronic ear infection……[YES] [NO]
47. No diagnosis…… [YES] [NO]
48. Other [ ] Specify _____

Ga. Health workers classification is correct [YES] [NO]
G.b Severely ill children classified correctly [YES] [NO]

Treatment

What does the health worker administer or prescribe for the child?

(1=YES, 2=NO)

49. Immediate referral? ..... [YES] [NO]
50. Paracetamol/Aspirin ..... [YES] [NO]
51. Tepid bath ..... [YES] [NO]
52. Antibiotic injection ..... [YES] [NO]
53. Antibiotic tablets/syrup ..... [YES] [NO]
54. Vitamin A or vitamins ..... [YES] [NO]
55. ORS/Atmit ..... [YES] [NO]

56. Antidiarrheal/antimotility ..... [YES] [NO]
57. Metronidazole tablet or syrup ... [YES] [NO]
58. Tablet or syrup, unknown type ... [YES] [NO]
59. Injection, unknown type ..... [YES] [NO]
60. None ..... [YES] [NO]
61. Other ..... [YES] [NO]
(Specify) _____

(1=YES, 2=NO

H.	**Is the medication appropriate for the diagnosis? .....**	**[YES]**	**[NO]**
I.a	**Diarrhea case received appropriate medication? .....**	**[YES]**	**[NO]**
I.b	**Pneumonia case received appropriate medication? .....**	**[YES]**	**[NO]**
I.c	**Dysentery case received appropriate medication? .....**	**[YES]**	**[NO]**

If validation performed:

J.a	**Is the child treated correctly?**		**[YES]**	**[NO]**
J.b	**Severe classification correctly referred?**	**N/A**	**[YES]**	**[NO]**
J.c	**Pneumonia case correctly treated?**	**N/A**	**[YES]**	**[NO]**
J.d	**Diarrhea case correctly treated?**	**N/A**	**[YES]**	**[NO]**
J.e	**Dysentery case correctly treated?**	**N/A**	**[YES]**	**[NO]**

Interpersonal communication:
For all oral medication:

(1=YES, 2=NO, 9=N/A))

62 a. Does the health worker explain how to administer medications/ORS? … [YES] [NO]
b. Does the health worker demonstrate? N/A [YES] [NO]
c. Does the health worker ask open ended questions. [YES] [NO]

K. Number of treatment tasks performed?:_____(0 to 3)

(1=YES, 2=NO)

63. Does the health worker explain when to return for follow-up?…… [YES] [NO]
64. Does the health worker explain the need to give the same quantity/more liquid at home? ……[YES] [NO]
65. Does the health worker explain the need to continue feeding or breast-feeding at home? ……[YES] [NO]
66. Does the health worker tell the caretaker to bring the child back for the following signs?

- Child is not able to drink or drinking poorly .... #
- Child is not able to breast-feed/eat ..... #
- Child becomes sicker ..... #
- Child develops a fever ..... #
- Child develops fast or difficult breathing ..... #
- Child develops blood in the stool ..... #
- Change in consciousness/lethargic ..... #

L. Are at least 3 of the Q.73 messages circled? [YES] [NO]

67. Does the health worker give the caretaker any advice on nutrition? [YES] [NO]

Duration of observation:_____ (minutes)

Attachment: CS-18 Baseline KPC Survey Findings for CATCH Indicators Compared to Final Survey

KPC 2000+ CATCH Indicator (* = CS-18 Indicator)	%	Num. Den.	Comments re. CS-18 KPC	Final Survey (LQAS)	Num. Den.
1. % of children 0–23 months underweight (< -2 SD of median weight-for-age of WHO/ NCHS reference population)	-	-	-	-	
2. % of children 0–23 months born at least 24 months after the previous surviving child	-	-	-	-	
3. * % of children 0–23 months whose births were attended by skilled health personnel	85%	255 300	-	95%	90 95
4. % of mothers with children 0–23 months who received at least two TT injections before the birth of their youngest child	-	-	Not applicable - TT not given in Tajikistan	-	
5. * % of children 0–5 months who were exclusively breastfed during the last 24 hours	12%	8 64	-	93%	29 31
6. % of children 6–9 months who received breast milk & complementary foods during last 24 hours	68%	56 82	-	90%	19 21
7. % of children 12–23 months (with cards) fully vaccinated (against the five vaccine-preventable diseases) ~~before the first birthday~~	-	-	Not applicable - measles given from 12 months	82%	32 39
8. * % of children 12–23 months who received measles vaccine (by maternal history)	67%	83 124	-	82% card	32 39
9. % of children 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	-	-	Not applicable to site: cases of malaria are rare	-	
10. % of mothers with children 0–23 months who cite at least two known ways of reducing the risk of HIV infection	5%	16 300	-	28%	27 95
11. * % of mothers with children 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defection, & after attending child who has defecated	19%	58 300	-	93%	88 95
12. % of mothers of children 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	-	-	-	ARI 89% DD 100%	ARI-85/95 CDD-95/95
13. * % of sick children 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	30%	28 92	Asked for any ARI or diarrhea in last 2 weeks	100%	ARI-5/5 CDD-28/28

Annex C: Evaluation Assessment Methodology

The quantitative part of the evaluation, a KPC survey using LQAS sampling, was conducted during July of 2007. The analysis of key indicators was done before the arrival of the evaluation consultant with further analysis conducted subsequently.

The qualitative evaluation was conducted between August 13 and 23. Of this time, two days were spent in Dushanbe and the rest in the field sites. The evaluation was designed to fully engage SC CS-18 staff in participating in evaluating the results of their work. The first day in Penjikent with the full team was devoted to listening to their successes, reviewing the data, and having them identify lessons learned and challenges. The second day was spent in further discussion, design of the interview guides and interviews with key MOH officials.

Staff then divided into three teams to conduct the community visits, during which they interviewed people and made guided observations. The teams visited a total of 24 communities as shown in the schedule on the following page. Every effort was made to choose a wide representation of communities based on level of response to the project, length of project intervention, remote vs. accessible, and the variety of on-going activities.

Separate interview guides for group interviews were developed in Tajik for each of the following:

- Women with children under age five
- Mothers-in-law
- Health facility staff
- PD/Hearth participants
- Village Development Committees
- CtC students

Individual interview and observation guides were developed for:

- CtC teachers
- PD/Hearth volunteers
- Shopkeepers
- Recently-delivered women on birth planning
- LSS-trained midwives

Teams conducted some de-briefing every day and triangulated information. An in-depth de-briefing, with the presence of a translator, was held in Penjikent on Sunday and in Aini on Tuesday. During these sessions, conclusions and recommendations were discussed, including recommendations for the final month of project implementation.

To prepare for the evaluation, the evaluation team leader read the DIP, MTE report, and the most recent annual report. Many detailed reports from the management information system (MIS) were also reviewed and were discussed with staff. Some additional reports have been generated from MIS data to be included in this report.

A list of persons interviewed during the evaluation is found in Annex D.

List of Communities Visited and Characteristics of Each

Names of Villages	Project	Years of Project Intervention	Phased Out	GMP	PD/ Hearth	CtC	Health Facility Present	Health Worker	LSS Trained	HFF	VP
Friday-Penjikent											
Chorvodor	CS-14	7 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Chimkurgan	SC-14	9 years	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Tojik	SC-18	3 years	Yes	Yes	No	No	No	Yes	Yes	No	No
Sarazmi Nav	CS-18	3 years	Yes	Yes	No	Yes	Yes	Yes	No	No	No
Turki Roj	CS-18	4 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Ven	CS-18	3 years	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No
Gutan	CS-18	4 years	Yes	Yes	No	Yes	No	Yes	Yes	No	No
Kamar	CS-18	3 years	Yes	Yes	No	Yes	No	Yes	Yes	No	No
Saturday- Aini											
Urmetan	CS-18	4 years	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No
Langar	CS-18	4 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
Veshkand	CS-18	4 years	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Madm	CS-18	4 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
Zerobod	CS-18	4 years	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Khairobod	CS-18	4 years	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Zoosun	CS-18	4 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
Putchin	CS-18	3 years	No	Yes	No	Yes	Yes	Yes	Yes	No	No
Monday- Penjikent											
Soi Margsor	CS-18	2 years	Yes	Yes	No	Yes	No	No	No	No	No
Badgah	CS-18	5 years	Yes	Yes	No	Yes	Yes	Yes	No	No	No
PushtiQutgon	CS-18	5 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Mogiyangusar	CS-18	5 years	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Monday- Aini											
Veshab	CS-18	2 years	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Shamtuch	CS-18	2 years	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Darg	CS-18	2 years	No	Yes	No	Yes	Yes	Yes	Yes	No	No
Kasdon	CS-18	2 years	No	No	No	No	No	No	No	No	No

CtC	Child-to-Child program in the school(s)
GMP	Growth Monitoring and Promotion
Health Worker	Some villages have a government health worker although there is no health facility, as such.
HFF	Health Facility Farm (all started under CS-14 or in 2002)
LSS	One or more of health staff trained in Life Saving Skills
VP	Village Pharmacy (strategy dropped after MTE due to government restrictions.

Annex D: List of Persons Interviewed and Contacted

Penjikent District Health Officials:

1) Nasriddinov Murodullo - Assistant Chief Doctor Maternal Child Health, Chief Pediatrician
2) Dusmatov Muhsiddin - Director of Immunization Center
3) Mirsoolimova Tojiniso - Chief Gynecologist
4) Asisov Abdurasok - Director IMCI Center

Aini District Health Officials:

1) Khodjaev Fusail - Director of Immunization Center
2) Sanginov Elboy - Chief Gynecologist
3) Ergasheva Sobira - Director of Maternal Child Health
4) Asisov Abdurasok - Director IMCI Center, Deputy Chief Doctor

Community members and MOH personnel:

Mothers of children < 5 years	72 (includes PD/Hearth participants)
Mothers-in-law	41
CtC students	42
VDCs	20 committees with 81 members present
Health facility staff/health staff	36
Shopkeepers	11
CtC teachers	19
PD/Hearth volunteers	8

CS-18 Project Staff:

Boboeva Gulchehra, Program Manager CS-18
Rahimova Mubina, Assistant Project Officer - Aini
Kodirova Nazokat, Senior Health Monitor, LSS trainer-Penjikent
Kholmahmadova Gulchehra, Health monitor-Penjikent
Gafurova Zarina, Health monitor-Penjikent
Temirova Umija, Health monitor-Penjikent
Ashurova Hilola, Health monitor-Penjikent
Bahrieva Shahlo, Health monitor-Penjikent
Mahmudov Sharofidin, IT officer Penjikent
Sharipova Munira, Health monitor-Penjikent
Alamova Gulbegim, LSS trainer-Aini
Ashurova Gulbahor, PD Health monitor Aini
Shonazarova Muhabbat, CtC Health monitor Aini
Muminova Bozorjon, Health monitor-Aini

Save the Children Central Asia Field Office Staff:

Dr. Pervez Shaukat, Acting Country Director, former CS-18 Program Manager

Annex E: Positive Deviance/Hearth Report

The activities of PD/Hearth started on September 2004, in four pilot villages, where the level of malnourished children reached 58%. The program was supported by members of the VDC, MOH and other volunteers, and the rate of malnutrition was reduced to 12% in the pilot villages. After achieving our goals, we have expanded the PD/Hearth program to 26 other villages of Ayni and Penjikent districts.

Currently, the program is being successfully implemented in 12 remote villages of Penjikent, including Ven, Paghna, Yakkahona, Khirshona, and in 14 remote villages of Ayni district including Veshab, Makhshevad, Kante and Yovon villages, which do not a have health facility or MOH staff, and where malnutrition is as high as 83%. A total of 338 (35%) malnourished children attended the Hearth and after 1-3 cycles of Hearth, the weight of over 148 (44%) children was normal. Moreover, 191 malnourished children increased their weight over 400gr, and will attend the Hearth with other malnourished children in future Hearth cycles. The project plans to expand this program to another 17 new villages in both districts in 2007.

GM coverage was increased to include 67 new villages of Penjikent and 58 villages of Ayni districts. In both districts, first cycle GMP was implemented in 105 villages, 90% (n=4,732) of children under two years old were weighed (of 4,975 total) and the malnourished rate was 28% ; 1,233 children (26%) suffered mild malnutrition and 3% out of them were moderately/severely malnourished. VDC members, health workers and volunteers were trained to weigh children using Salter's scales and to plot the weight on growth monitoring cards.

Picture #1. Children are being weighed by VDC members, volunteers and health workers. Now they can independently weigh children and register their weight in the register book and on the children's GM cards.

Picture #2. Malnourished children are being fed in PD/Hearth.

Picture #3. During the PD/Hearth NERS session, mothers of malnourished children receive training on how to prepare nutritious food from local available edible items.

Success story from the Chief of Pediatrician CDH of Penjikent district-Dr. Nasriddinov

As I know, the PD/Hearth program is running from 2004 within the Penjikent district. As a Chief of Pediatrics of CDH of Penjikent I support and assist this program very well, because the level of malnourished children is very high and over of all patients addressing to us are malnourished of various levels. In addition over 70% of children who died had malnutrition as their additional disease. I am introduced with the plan and activities of this program and due to joint monitoring and analysis of PD/Hearth it was obvious that in pilot villages, that the number of malnourished children is declining. The main goal is to ensure that the community understands the mission of the program and supports it very well. I suggest and support this program to be replicated in other villages and districts because it positively contributes towards reducing children mortality and their diseases.

Success story from a mother of Varsi Kanda village

I am mother of Dilkusho, from Varzi Kanda village. Due to my child's malnutrition, I attended the Hearth. The Hearth was very useful for my child. At the beginning of the Hearth my child was very poor and did not have an appetite, above all she had restless sleep. I fed my child only with manufactured milk, which is very expensive. Attending the Hearth I learned very useful things like: preparing separate food for child, spending significant time with my child, include beans, eggs, yogurt, vegetables for my every food menu which we grow on our household land. I was really observing improvement of my child's health, she gained weight, she learnt to go, her appetite got better, she is silent now and doesn't get ill very often any more. I am very happy that we attended the Hearth and improved my child's health.

Success story from volunteer Marjona Boboeva

The PD/Hearth program was created in our village and I was selected as a volunteer. Before I did not know my duties and responsibilities, after Save the Children explained to us the importance of the Hearth and charged me with this activity, I agreed to collaborate with them. I felt responsible for improving the health of malnourished children, and running of the Hearth. Mothers of our village did not prepare separate food for their children, and fed their children from common food of the family. Now, after the Hearth, mothers understood for children's growth, additional food is very necessary. As well as mothers realized that for preparing separate food additional money is not needed, because they can prepare food from vegetables, bean, greens and other vitamins growing on their household land. In the Hearth I trained mothers how to cook food, conducted health education for mothers, as well as visited their houses and monitored them to see if they applied their skills at home. I observed mothers results and saw how children gained weight, how children smile and are kept clean. Child health is the health of the community!

Annex F: Updated CSHGP Project Data Form

Child Survival and Health Grants Program Project Summary
Dec-04-2007
Save the Children - Tajikistan

General Project Information:

Cooperative Agreement Number:	FOA-A-00-98-00022-00
Project Grant Cycle:	18
Project Dates:	(9/30/2002 - 9/29/2007)
Project Type:	Cost XT
SC Headquarters Technical Backstop:	Eric Starbuck
Field Program Manager:	Gulchehra Boboeva
Midterm Evaluator:	
Final Evaluator:	Judiann McNulty
USAID Mission Contact:	Aziza Khamidova

Field Program Manager Information:

Name:	Gulchehra Boboeva
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Alternate Field Contact:

Name:	Pervez Shaukat
Address:	Dushanbe
Phone:	
Fax:	
E-mail:	drpervez@savechildren.tj

Funding Information:
USAID Funding:(US $): $1,250,000 **PVO match:(US $)** $333,300

Project Information:
Description:
This is a cost extension for the Scaling-up Innovative Approaches for Rural Tajikistan To Building Community and Health Facility Capacity To Sustain Key Investments in Essential Maternal and Child Health Services program. The goals are a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini districts, and; (2) Innovative CS-18 strategies contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan Project Description. The interventions include acute respiratory infections; control of diarrheal disease; immunization; maternal and newborn care; and nutrition and micronutrients.

The project will implement these five interventions through six strategies:
1. Revolving Drug Funds for Village Pharmacies;
2. Health Facility Farms for continuing investments in improving MCH services;
3. Joint training and supervision of rural health facility staff;
4. Community mobilization through Village Development Committees;
5. Interactive engagement of local health workers with community groups to promote improved MCH practices, and;
6. Child-to-child health education. CS-18 will also introduce the Positive Deviance approach.

Location:
All 202 villages in and above the Zarafshon Valley of Panjikent District and neighboring Aini District of Sugdh (formerly Leninabad) Region in northwestern Tajikistan.

Project Partners	Partner Type	Subgrant Amount
MOH (at district & facility levels)	Collaborating Partner	

General Strategies Planned:
(None Selected)

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Lot Quality Assurance Sampling

Behavior Change & Communication (BCC) Strategies:
Interpersonal Communication

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
(None Selected)	(None Selected)	Pharmacists	Health Facility Staff	Health CBOs

Interventions/Program Components:

Immunizations (15 %)
- Mobilization

Nutrition (15 %)
(CHW Training)
- Hearth

Vitamin A (1 %)

Micronutrients (4 %)
- Iodized Salt
- Iron Folate in Pregnancy

Pneumonia Case Management (15 %)
(HF Training)
- Pneum. Case Mngmnt.
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (15 %)
(HF Training)
- ORS/Home Fluids

Maternal & Newborn Care (30 %)
(HF Training)
- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Normal Delivery Care
- Birth Plans
- Emergency Transport

Breastfeeding (5 %)
- Promote Excl. BF to 6 Months

Target Beneficiaries:

Infants < 12 months:	7,500
Children 0-59 months:	36,000
Women 15-49 years:	60,000
Population of Target Area:	251,000

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population	0	0	0.0%	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0%	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	90	95	94.7%	4.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0%	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	29	31	93.5%	8.6
Percentage of infants age 6-9 months receiving complementary foods breast milk and	19	21	90.5%	12.6
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	32	39	82.1%	12.0
Percentage of children age 12-23 months who received a measles vaccine	32	39	82.1%	12.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0%	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	0	0	0.0%	0.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	36	37	97.3%	5.2
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	27	95	28.4%	9.1

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who had defecated	88	95	92.6%	5.3

Comments for Rapid Catch Indicators

Used weighted averages for the percentage estimates, something which this data entry system does not allow.

Measles given from age 12 months, so "before the first birthday" does not apply.