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MIDTERM PERFORMANCE EVALUATION HEALTHY MOTHER, HEALTHY BABY ACTIVITY

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MIDTERM PERFORMANCE EVALUATION

HEALTHY MOTHER, HEALTHY BABY (HMBH) ACTIVITY

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ACRONYMS

Acronym	Definition
ADB	Asian Development Bank
AMEE	Abt (Associates)'s Monitoring and Evaluation Ecosystem
ANC	Antenatal Care
BFHI	Baby Friendly Hospital Initiative
BTN	Beyond the Numbers
CA	Central Asia
CBE	Community-Based Event
CDH	Central District Hospital
CHT	Community Health Team
CME	Continuing Medical Education
CPG	Clinical Protocols and Guidelines
CU2	Children Under 2 (years)
CU5	Children Under 5 (years)
DCC	Donor Coordination Council
DHIS2	District Health Information Software 2
DHS	Demographic Health Survey
DNT	District Nutrition Trainer
DO	Development Objective
DOE	Department of Education
DOH	Department of Health
EBF	Exclusive Breastfeeding
ENAP	Every Newborn Action Plan
EPC	Effective Perinatal Care
EmONC	Emergency Obstetric and Neonatal Care
EQ	Evaluation Question
ET	Evaluation Team
FF	Food Fortification
FGD	Focus Group Discussion
FTF	Feed the Future
GDP	Gross Domestic Product
GFSS	Global Food Security Strategy
GIZ	Deutsche Gesellschaft für International Zusammenarbeit
GMP	Growth Monitoring and Performance
GOT	Government of Tajikistan
GPCHI	Guideline on the Partnership with Communities on Health Issues
HCW	Healthcare Worker
HF	Health Facility
HLSC	Healthy Lifestyle Center
HMHB	Healthy Mother, Healthy Baby
IADB	Inter-American Development Bank
IC	Infection Control
IMCI	Integrated Management of Childhood Illness

Acronym	Definition
IP	Implementing Partner
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
JAP	Joint Action Plan
JDM	Joint Decision-Making
KAP	Knowledge, Attitudes, and Practices
KH	Knowledge Hub
KII	Key Informant Interview
LAF	Locally Available Food
LBW	Low Birth Weight
LHSS	Local Health System Sustainability
M&E	Monitoring and Evaluation
MCH	Maternal-Child Health
MERL	Monitoring, Evaluation, Research and Learning
MiL	Mother-in-Law
MMN	Multiple-Micronutrient (supplements)
MNCH	Maternal, Newborn, and Child Health
MNCH&N	Maternal, Newborn, Child Health, and Nutrition
MSCC	Multi-Sectoral Coordination Council
MTE	Midterm Evaluation
MOE	Ministry of Education
MOHSPP	Ministry of Health and Social Protection of the Population
NRC	Nutrition Resource Center
OB/GYN	Obstetrics and Gynecology
ORS	Oral Rehydration Solution
PA	Perinatal Audit
PHC	Primary Health Center
PNC	Postnatal Care
PPS	Probability Proportionate to Size
PSU	Primary Sampling Unit
QI	Quality Improvement
QIT	Quality Improvement Team
RCFM	Republican Center for Family Medicine
RCMSI	Republican Center for Medical Statistics and Information
RFTOP	Request for Task Order Proposal
RHFA	Rapid Health Facility Assessment
RHLSC	Republican Healthy Lifestyle Center
RT	Republic of Tajikistan
SAM	Severe Acute Malnutrition
SBC	Social Behavior Change
SBCC	Social Behavior Change Communication
SDG	Sustainable Development Goals
SOW	Scope of Work

Acronym	Definition
SPSS	IBM SPSS Statistics
SS	Supportive Supervision
SUN	Scaling Up Nutrition
THNA	Tajikistan Health and Nutrition Activity
TJS	Tajik Somoni
TOC	Theory of Change
TOT	Training of Trainers
TSMU	Tajik State Medical University
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WRA	Women of Reproductive Age
ZOI	Zone of Influence

ABSTRACT

The United States Agency for International Development Central Asia (USAID/CA)-funded Healthy Mother, Healthy Baby (HMHB) Activity is a five-year project designed to improve the quality of healthcare, increase access to health services, and help meet the increasing demand for health services in the 12 southwestern districts of the Khatlon region of Tajikistan (Balkhi, Dusti, Jaihun, Jomi, Khuroson, Kushoniyon, Levakant, Nosiri Khisrav, Qubodiyon, Shahritus, Vakhsh, and Yovon). Healthy Mother, Healthy Baby is seeking to achieve this goal by implementing a range of interventions and strategies that focus on the 1,000-day window of opportunity between conception and a child's second birthday—to make a lasting impact on the child's growth, learning, and future productivity. This midterm performance evaluation was commissioned to assess the continued relevance of the interventions and the progress made toward achieving its planned objectives. The Evaluation Team (ET) conducted desk review of materials; Key Informant Interviews (KIs) with key stakeholders; Focus Group Discussions (FGDs) with direct beneficiaries; beneficiary surveys with health workers and community members; and Knowledge, Attitudes, and Practices (KAP) surveys with mothers with Children Under [age] 2 [CU2] in selected HMHB target districts. The ET found that HMHB's interventions have been achieving results in improving access to and quality of Maternal, Newborn, and Child Health (MNCH) services in target districts—including increasing the early registration of pregnant women and the quality of first Antenatal Care (ANC) and Emergency Obstetric and Neonatal Care (EmONC), improving Postnatal Care (PNC) services, decreasing home deliveries, increasing the identification of malnourished children, improving the management and effective treatment of primary children's infections, and promoting the accreditation of hospitals. In the remaining two years of implementation, the ET recommends prioritizing the focus on building local ownership for all its key interventions, and institutionalizing Quality Improvement (QI) processes and the Social Behavior Change (SBC) program.

EXECUTIVE SUMMARY

EVALUATION PURPOSE

The purpose of the performance evaluation of the United States Agency for International Development (USAID) Healthy Mother, Healthy Baby (HMHB) Activity is: 1) to assess the continued relevance of the interventions and the progress made toward achieving its planned objectives; and 2) to identify which of the Activity's interventions are working well and which are not—and what has been accomplished against the intended results. USAID will share results within the USAID mission, Implementing Partners (IPs), the Government of Tajikistan (GOT) Ministry of Health and Social Protection (MOHSPP), and different stakeholders.

ACTIVITY BACKGROUND

HMHB is a Maternal, Newborn, Child Health, and Nutrition (MNCH&N) project implemented in the Feed the Future (FTF) Zone of Influence (ZOI) in the Khatlon region by Abt Associates in collaboration with MOHSPP. The HMHB Activity builds on USAID's prior work—including the Tajikistan Health and Nutrition Activity (THNA), whose goal was to improve the health status and nutrition of the women and children who live in the 12 southwestern districts of the Khatlon Region. HMHB aims to improve the quality of healthcare, increase access to health services, and help meet the increasing demand for health services in the 12 districts. It builds the capacity of health providers through in-service training and ongoing continuing education; integrates person-centered care across hospitals, Primary Health Care (PHC), and Healthy Lifestyle Centers (HLSCs); and supports an enabling environment for skilled, motivated providers by expanding Quality Improvement (QI) efforts and availability of infrastructure and equipment.

EVALUATION METHODOLOGY

The ET conducted the evaluation between November 2022 and February 2023 and used a mixed-methods approach that included: 1) key documents and available data review; 2) Key Informant Interviews (KIs) with the funder, MOHSPP officials, IP and HMHB partner staff, and district Health Facility (HF) managers and staff, medical education institutions staff, and others (50 KIs); Focus Group Discussions (FGDs) with beneficiaries (14 FGDs and 158 participants); beneficiary surveys with 113 Health Workers (HWs) and community members; and a Knowledge, Attitudes, and Practices (KAP) survey with 302 mothers with Children Under 2 (CU2) in selected HMHB target districts.

MAIN FINDINGS AND CONCLUSIONS

Findings

EQ1: To what extent has the activity met the needs of target beneficiaries and increased access to and improved the quality of the MNCH&N services?

The design of HMHB is highly relevant to the needs of target populations and is related to national policies and the Sustainable Development Goals (SDGs). The QI Committees are gradually functioning better and, overall, are better established in the HMHB districts when compared to other districts of the Khatlon region. In-service training and continuing education, supportive supervision, and mentoring programs supported by HMHB strengthen healthcare workers' capacity and improve the quality of medical care at the hospital and PHC levels. Digitalization is an innovative component of HMHB—which not only helps build a digital health ecosystem but also strengthens healthcare workers' skills. HMHB also has helped to increase the rate of women who made four or more antenatal visits during their last pregnancy in target areas.

At the same time, the prevalence of mothers making decisions about their own health and the health of their children remains low, due to the significant role that parents-in-law—especially Mothers-in-Law (MiLs)—play in decision-making. There has been an improvement in the number of pregnant women who receive adequate rest (from 86 percent at baseline to 93 percent at the midterm), particularly during the last trimester of pregnancy, as well as the increased practice of skin-to-skin contact after birth (from 82 percent to 87 percent). There also is progress with Post-Natal Care (PNC) services in HMHB target districts and an increase in the number of health workers who carry

out three or more postpartum visits at home. An improvement in managing and effectively treating main infections could be observed in HMHB districts due to the effective implementation of Integrated Management of Childhood Illness (IMCI) at the PHC level. The improvement could be also seen with handwashing practices as well as water treatment knowledge and practices at the community level (from 88 percent to 97 percent).

EQ2: To what extent has the activity improved the diets of pregnant and lactating women, and CU2 years of age, throughout the year—and why or why not?

Addressing the key determinants of malnutrition and improving health and nutrition outcomes requires a multisectoral response. HMHB collaborates with nutrition stakeholders to strengthen the coordination of various government sectors in addressing nutrition challenges. However, the tangible results of mobilizing resources to expand priority MNCH and nutrition interventions and launch the fortification of wheat flour in Tajikistan are still to be implemented.

Overall, HMHB applies a comprehensive approach toward Social Behavior Change Communication (SBCC) by engaging at the local, national, and media levels—which has not been done before. As a result, knowledge of the need to consume adequate nutrition during pregnancy and breastfeeding, and awareness about anemia and Exclusive Breastfeeding (EBF), are improving among mothers in HMHB districts. There also has been an increase in the number of children ages six to eight months who are supplemented with complementary foods in HMHB districts. Meanwhile, there was a decrease in the number of pregnant women who take iron and folic acid during pregnancy due to the stoppage of free-of-charge supply of iron and folic acid supplements to Health Facilities (HFs) since 2020. Breastfeeding in the first hour after birth did not improve, and anemia still prevails among caregivers and children.

#	Indicators	Baseline	Midterm	% Change from Baseline
		%	%	
1	Pregnant women visit a medical facility for prenatal care at least eight times during the pregnancy	14%	31%	↑ 17%
2	Every pregnant woman takes supplements during pregnancy			
	Iron supplements	42%	24%	↓ 18%
	Folic acid supplements	43%	47%	↑ 4%
	Combined iron and folic acid	16%	23%	↑ 7%
	<i>Note: Although HMHB advocates, educates and motivates on importance of iron tablets; UNICEF is no longer providing FE supplementation. Though it is available in the pharmacy, there is now a financial barrier to using it vs. receiving it for free</i>			
3	Pregnant women receive adequate rest, particularly during the last trimester of pregnancy	86%	93%	↑ 7%
4	Newborn receives skin-to-skin contact immediately after birth	82%	87%	↑ 5%
5	Timely initiation of breastfeeding (within 1 hr. after birth)	86%	76%	↓ 10%
	<i>Note: HMHB is fighting against (i) doctor turnover which is impacting consistency on EBF practice and (ii) the formula companies who are paying doctors bonuses for women to use formula. In Year 3, HMHB is planning to launch an aggressive SBCC campaign on EBF</i>			
6	Health workers carry out 3 postpartum visits at home	75%	86%	↑ 11%
7	EBF under 6 months	67%	69%	↑ 2%
8	Handwashing with soap at critical times (i.e., after defecation, before, during and after preparing food; and after caring for a child)	86%	85%	↓ 1%
9	Better water consumption (i.e., drink boiled or treated water, use appropriate water for cooking, and practice recommended water storage techniques)	88%	97%	↑ 9%

Figure 1. Summary of desired behaviors for the first 1,000 days which HMHB intends to improve.¹

EQ3: To what extent are the implemented activities sustainable beyond the activity timeline? Were (activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in the FTF ZOI? And were there barriers?

Work on the quality improvement process at the hospital and PHC levels will continue after the end of HMHB as it is embedded within the national healthcare system. However, further support is needed to strengthen the capacities of QI Committees, and collaborative approaches are needed to make them more sustainable. The pre-service educational programs for medical doctors and pre- and post-service training for family doctors and nurses have been already institutionalized by the medical educational institutions—which will further strengthen the capacity of future HCWs. Nutrition

¹ Note: Adapted based on the HMHB Community Nutrition Roadmap, May 2021.

Resource Centers (NRCs) and the Resource Center for Nutrition and Evidence-Based Medicine have a high degree of sustainability as both were established either within the healthcare system or within academia.

Meanwhile, the Continuing Medical Education (CME) coverage needs to be strengthened—especially among HCWs from hospitals—and institutionalization of the SBC curriculum for schools should be further promoted. The selected SBCC approach by HMHB has high prospects of sustainability as build-up under the government framework of community involvement in health issues. The area which requires further strengthening is the capacity of the Healthy Lifestyle Centers at the district and regional levels to take full ownership of the SBCC results. HMHB applies a multi-faceted approach for ensuring sustainability of its interventions focused on digitalization.

The Activity progressed in promoting the replication/scale-up of its digital tools among the donor community; however, ownership is limited at the national and community levels due to low digital literacy and lack of resources for continuing the use of developed digital tools and applications. During the first two years of implementation, HMHB was more focused on supporting the implementation of previously endorsed Clinical Protocols and Guidelines (CPGs) by MOHSPP at the hospital and PHC levels rather than supporting the revision/development of new CPGs.

Conclusions

EQ1: To what extent has the activity met the needs of target beneficiaries and increased access to and improved the quality of the MNCH&N services?

HMHB is well aligned with government priorities and local needs. It evolved to better target key gaps identified in the 2019 THNA final performance evaluation. HMHB is also relevant to the international MNCH&N goals. The evaluation found that HMHB has also been improving access and quality of MNCH services in target districts—including an increase in the early registration of pregnant women and quality of the first ANC and EmONC, improvement in PNC services, a decrease in home deliveries, an increase in identifying malnourished children, improvement in managing and effectively treating main childhood infections, and promoting the accreditation of hospitals.

Overall, USAID MNCH programming has contributed to improvements in child mortality (infant and children under age five)—although maternal, neonatal, and perinatal mortality remains a challenge in the Feed the Future (FTF) Zone of Influence (ZOI).

EQ2: To what extent has the activity improved the diets of pregnant and lactating women, and CU2 years of age, throughout the year—and why or why not?

Thus far, HMHB contributes to changing knowledge of maternal and child nutrition, while change in most behaviors is still to be achieved. HMHB just started its SBCC activities in early 2022, and more time is needed to see the results at the beneficiary and household levels. Moreover, access to nutritious food is not yet available in the country because the fortification of wheat flour has not yet started.

EQ3: To what extent are the implemented activities sustainable beyond the activity timeline? Were (activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in the FTF ZOI? And were there barriers?

HMHB incorporates measures to support sustainable results of its interventions. The Activity works through the health system to ensure sustainability and collaborates with a variety of stakeholders (health authorities at the national, regional, and local levels; and relevant state authorities, academia, development partners, and other USAID-funded projects) on digitalization, fortification, and MNCH&N activities to ensure synergies and avoid duplications. Levels of sustainability of HMHB interventions varies and more work is needed in strengthening the local ownership. However, many HMHB results could be at risk without ongoing donor support (e.g., digitalization, social behavior change, quality improvement, and CME). This is in part due to challenges at the country level such as the limited government commitment to fund health budgets, difficulties maintaining a trained health workforce within the country, and low technical and human resource capacities.

Key Recommendations

- It is recommended that USAID and HMHB, jointly with other donors and development partners, continue the advocacy at the national level for sustainable health financing in Tajikistan, to ensure the long run sustainability of the MNCH&N interventions in the FTF ZOI.
- Recognizing how closely intertwined nutrition, family planning, and reproductive health are, it is recommended that USAID consider bringing together its portfolios on MNCH&N and family planning and reproductive health.
- Accounting for the importance of the QI process, it is recommended that HMHB and USAID advocate for pushing QI into pre-service and continuing professional development for broad access.
- Continued advocacy and support in further developing and/or revising national guidelines, protocols, and standards—in line with the latest World Health Organization (WHO) recommendations and regulations, as well as monitoring results, is recommended.
- To ensure better local ownership, focus more on work with key decision-makers (health managers) at the national, regional and district levels by strengthening their Maternal-Child Health (MCH) analytical capacity, managerial and decision-making capacity, and digital skills; and set up managerial courses in coordination with the Postgraduate Training Institute.
- It is recommended that HMHB consider piloting different non-monetary incentive schemes in target districts and documenting success stories that may be considered for further scale-up by future USAID projects.
- Advocate for institutionalization of SBC on healthy lifestyle choices; nutrition; Water, Sanitation, and Hygiene (WASH); and gender equality in school curricula—jointly with the United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) along with advocacy on CME initialization and continuation of the PHC strengthening and reform.

I EVALUATION PURPOSE AND EVALUATION QUESTIONS

I.1 EVALUATION PURPOSE

The purpose of the HMHB Activity midterm performance evaluation is to: 1) assess the continued relevance of the interventions and the progress made toward achieving its planned objectives; and 2) identify which of the Activity's interventions are working well, which are not, and what has been accomplished against the intended results.

Results from this evaluation are intended to be used by USAID/Tajikistan. Evaluation results will further be shared with different stakeholders—including the MOHSPP, USAID mission, the HMHB Implementing Partners.

I.2 EVALUATION QUESTIONS

The HMHB midterm performance evaluation provides answers to the following four Evaluation Questions (EQs):

1. To what extent has the activity met the needs of target beneficiaries (mothers, household members, health providers, etc.) and increased access to and improved the quality of the Maternal, Newborn, & Child Health and Nutrition (MNCH&N) services—including nutrition, sanitation, and hygiene services in the Zone of Influence (ZOI), particularly in the first 1,000 days?
2. To what extent has the activity improved the diets of pregnant and lactating women, and Children Under Two (CU2) years of age, throughout the year—and why or why not?
3. To what extent are implemented activities sustainable beyond the activity timeline? a) Were (activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in the FTF ZOI? B) And were there barriers?
4. Going forward, is there anything else the Activity can prioritize in the remaining two years within its Statement of Work (SOW) to improve the health and nutrition status of mothers and children in FTF ZOI?

2 ACTIVITY BACKGROUND

In Tajikistan, women and children have benefited from the country's commitment and strengthened capacity to improve MNCH. However, the country continues to have the highest rates of maternal and child mortality and stunted, wasted, and underweight children in Central Asia.

Tajikistan struggles to provide timely and quality health care services for mothers and children. Registries on health service provision and data management are primarily paper based, which delays service and impacts the quality of care. Digitizing health information is an effective way to improve coordination and expedite decision-making. To address MNCH and nutrition issues, USAID awarded Abt Associates the five-year (October 2020–September 2025) \$17.3 million HMHB Activity.

The HMHB Activity builds on USAID's prior work, including the Tajikistan Health and Nutrition Activity (THNA)—whose goal was to improve the health status and nutrition of women and children in the 12 southwestern districts of Khatlon Region. HMHB pursues its goal of improving nutritional status and preventing the morbidity and mortality of mothers, and CU2, as well as improving the quality and availability of lifesaving evidence-based health interventions for women and children in FTF ZOI in Khatlon Region, as identified by USAID. The implementation districts are Balkhi, Dusti, Jaihun, Jomi, Khuroson, Kushoniyon, Levakant, Nosiri Khisrav, Qubodiyon, Shahritus, Vakhsh, and Yovon.

HMHB's overall Theory of Change (TOC) states that **IF** HMHB improves GOT's capacity and commitment to deliver quality healthcare services, increases the use of these improved services, and improves access to and consumption of diverse diets, **THEN** health and nutrition status will improve, particularly for women and children. To accomplish HMHB's goals, the TOC interconnects with the three objectives—which are:

Objective 1: **IF** health providers are skilled at and use evidence-based practices at all levels of the health system, **IF** they have the necessary supplies to carry out these practices, and **IF** ongoing supervision and quality improvement is institutionalized, **THEN** they will deliver better-quality services—and maternal and infant morbidity and mortality will decline.

Objective 2: **IF** GOT has the capacity and commitment to implement national strategies reflecting evidence-based guidelines and standards at all levels of the health system, **THEN** the quality of healthcare and health and nutrition outcomes will continue to improve over the long term toward sustainable self-reliance.

Objective 3: **IF** women, family decision-makers, and community members recognize the danger signs in pregnancy, delivery, and post-delivery—and the danger signs of child illnesses; and **IF** communities and families value and prioritize good nutrition during the first “1,000 days” window and good water/hygiene/sanitation behaviors, **THEN** they will practice healthy behaviors and seek healthcare when needed—and maternal-infant morbidity and mortality will decline.

HMHB works to close the knowledge-to-action gap and accelerate impactful shifts in social norms by expanding and innovating evidence-based global best practices that catalyze change at the community and facility level in the 12 districts of the Khatlon region. This approach will enable HMHB to achieve the Activity’s three objectives: (i) Scaling up and institutionalizing quality health and nutrition services to mothers, newborns, and children; (ii) Supporting the Scaling Up Nutrition (SUN) Movement and national strategies; and (iii) Instigating social and behavior change to improve nutrition and maternal and child health.

The anticipated end results include: (a) an improved quality of health and nutrition services for mothers and CU2; (b) an improved water/hygiene/sanitation behaviors during the first “1,000 days” to improve maternal and child health and nutrition practices; (c) a strengthened health system through coordinating the SUN Movement and leading food fortification efforts, plus other maternal-, child health-, and nutrition-related multi-sectoral activities.

As a result, the HMHB’s Activity contributes to USAID’s Global Food Security Strategy (GFSS) Objective 3: “Well-nourished children, especially among women and children”; USAID Tajikistan Country Strategy Result Framework Development Objective (DO) 3; and Intermediate Result (IR) 2.2: Use of health and nutrition services increased.

3 EVALUATION METHODS AND LIMITATIONS

3.1 EVALUATION METHODS

The midterm performance evaluation of HMHB was conducted by an Evaluation Team (ET) that consisted of an international team leader and two local technical specialists/team members. A local firm, Z-Analytics, assisted the ET in conducting the KAP survey. The evaluation involved a mix of qualitative and quantitative methods to collect and analyze both primary and secondary data. Data triangulation was accomplished within the research tools themselves (similar questions asked in different ways), between respondent types (HMHB stakeholders and beneficiaries), and between data sources (secondary to corroborate primary).

Primary data sources included KIIs with HMHB stakeholders and partners in the MNCH&N sector, FGDs and beneficiary surveys among health providers and community members, and the KAP survey among mothers with CU2. See Annex III.

Secondary data sources included HMHB contractual, Monitoring and Evaluation (M&E), technical documents, assessments, policy documents, official statistics, and donor reports. See Annex IV.

Data collection methods and tools were selected to ensure sufficient variation to reach the geographically dispersed populations of HMHB beneficiaries.

Qualitative Research and Analysis

The qualitative research comprised the following:

- **KIIs for stakeholders and partners** with a mix of open- and closed-ended questions. Interviews were conducted in person, virtually (Zoom and WhatsApp), or by phone.
- In total, 66 respondents (55 percent male, 45 percent female) were interviewed through 40 individual KIIs and 10 group KIIs (Figure 2).

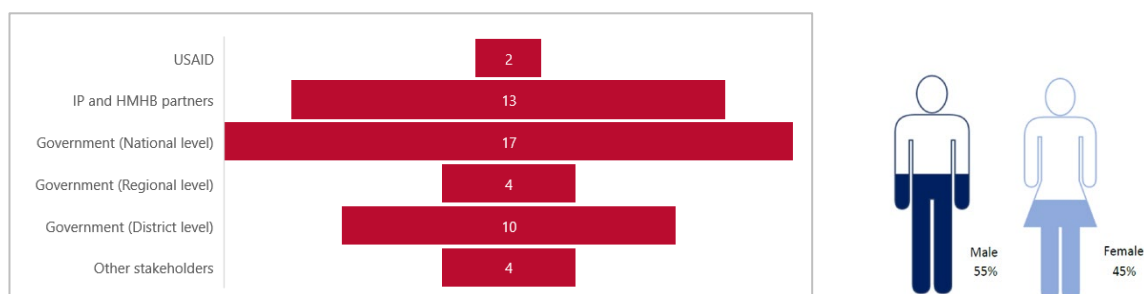


Figure 2. Number of KIIs conducted during HMHB MTE (N=50)

- **FGDs with beneficiaries:** The ET met with project beneficiaries in six out of 12 target districts to learn about their perception of the project's performance and achievements. In total, 14 FGDs (6 FGDs with Quality Improvement Teams [QITs], two FGDs with District Nutrition Trainers [DNTs], two FGDs with Community Health Teams [CHTs], two FGDs with mothers with CU2, and two FGDs with Mothers-in-Law (MiLs) with 158 HMHB beneficiaries (33 percent male, 67 percent female) were conducted (Figure 3).

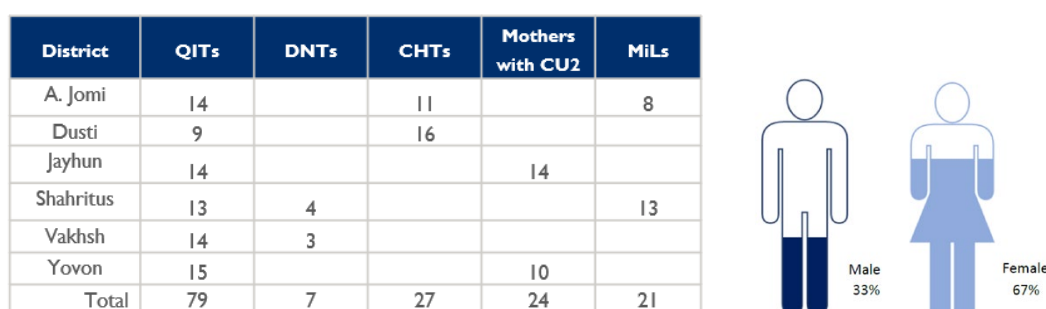


Figure 3. Number of FGD participants during HMHB MTE (N=158)

Quantitative Research and Analysis

- **KAP Survey:** It measured the outcomes related to knowledge and practice, such as the household food intake of mothers and CU2, household member knowledge and nutrition, and Water², Sanitation, and Hygiene (WASH) practices. It allowed the team to supplement data from KIIs and FGDs and gauge whether the health and nutrition services were effective and contributed to improved health and nutrition outcomes in comparison with the baseline. In total, 302 mothers with CU2 from Jomi, Jayhun, Dusti, Shahrutus, Vakhsh and Yovon participated in the KAP survey. The KAP survey used a two-stage cluster sampling approach with probability proportionate to size (PPS).³ The survey sample size was estimated applying a sample size formula designed to work with a large beneficiary population, i.e., $n = p(1-p)$

² Safe drinking water.

³ In the first stage, villages/communities were selected; and in the second stage, a systematic selection was conducted of mothers with CU2 from the communities in selected target districts.

(Z/E)⁴. The formula yielded a sample size of 270, which was adjusted upward to 300, considering expected non-responses. Further, a sample of 20 villages/communities using PPS sampling was prepared and an equal number of mothers (15) from each 20-sample villages/communities were selected.

- **Beneficiary Survey.** To augment its findings, the ET implemented a beneficiary survey at the end of each FGD with health providers and community members to obtain feedback from a sample population of HMHB beneficiaries (Quality Improvement Teams [QITs], District Nutrition Trainers [DNTs], and Community Health Teams [CHTs]) regarding their satisfaction with HMHB's capacity-building activities. This survey was anonymous and was distributed to participants in the local Tajik language. In total, 113 respondents (46 percent male, 54 percent female) took part in the beneficiary survey.

Sampling Methodology: The ET used a purposeful sampling methodology to select respondents for KIs (donor, IP, HMHB partners, and stakeholders). For the FGDs and KAP Survey, the sample of HMHB districts were selected based on four criteria: (i) share of Women of Reproductive Age (WRA) in the district, (ii) average score of the hospital and primary healthcare facilities as per the Rapid Health Facility Assessment (RHFA), (iii) progress in implementing the QI process, and (iv) geographic location of the district. The FGDs and KAP survey were conducted in six out of 12 target districts in the Khatlon Region (Jomi, Jayhun, Dusti, Shahritus, Vakhsh and Yovon). The KAP survey used a two-stage cluster sampling approach with Probability Proportionate to Size (PPS). In this design, Primary Sampling Units (PSUs) were selected by PPS in the first stage. Households within each selected PSU were selected randomly from a list of households in the second stage.

Data Analysis: Qualitative data analysis involved thorough content analysis by a multidisciplinary and experienced team working in Atlas.ti software. This enabled the ET to identify contradictory evidence and determine whether these differences related to project approaches, geographic location, gender, or some other characteristic of the respondents or data source. Quantitative data analysis involved analyzing IP M&E data plus responses from the KAP survey and mini-survey questionnaires using frequency distributions (how many answered "a" or "b"), cross-tabulation (types of answers by respondent category), and tables/graphs generated through IBM SPSS Statistics (SPSS) and Excel.

3.2 EVALUATION LIMITATIONS

The evaluation's main limitations included the possibility of social desirability bias, data contamination, subjectivity from the semi-structured interviews, and recall bias.

- **Time and resource limitations:** The rigor of the data-gathering analysis was constrained to some degree by the time availability. The ET was not able to meet with all key stakeholders, particularly for follow-up meetings and discussions. However, the ET worked closely with Abt Associates to identify and select key stakeholders to meet with during the field mission.
- **Subjectivity and semi-structured interviews:** The semi-structured approach to the KIs created the opportunity to explore specific issues and themes in more depth. This increased flexibility but may also have introduced more interviewer subjectivity. The ET sought to mitigate this problem by carefully evaluating the available data through triangulation.
- **Health Statistics:** At the time of HMHB's midterm evaluation, the official health statistics on maternal and children mortality were not available for 2022. Also, the last Demographic Health Survey (DHS) was conducted in Tajikistan in 2017, while the next DHS is planned for later in 2023. Therefore, the ET was not able to triangulate the data on some health outcomes with these sources.

⁴ Where: n= sample size; E= margin of error; Z= standard score; and p= estimated prevalence of a variable of interest in proportion.

4 Findings, Conclusions, and Recommendations

4.1 FINDINGS

4.1.1 EVALUATION QUESTION I

To what extent has the activity met the needs of target beneficiaries (mothers, household members, health providers, etc.) and increased access to and improved the quality of the maternal, newborn, and child health-and-nutrition services—including nutrition, sanitation, and hygiene services in the ZOI, particularly in the first 1,000 days?

The first HMHB objective aims to support the MOHSPP in scaling up and institutionalizing quality health and nutrition services to mothers, newborns, and children. The following section examines the relevance of HMHB interventions for target beneficiaries; scrutinizes the relevance of HMHB interventions focusing on improvement of access to and quality of MNCH; and provides an assessment of the level of improvement in access to and quality of MNCH in FTF ZOI for mothers' antenatal and postnatal health (attendance at eight ANC visits, getting adequate rest, skin-to-skin contact and Kangaroo Care, and PNC visits), childhood illness (WASH and management and effective treatment of main childhood illnesses), and the overall impact of USAID interventions (both THNA and HMHB) on in-home deliveries and maternal and child mortality rates.

RELEVANCE OF HMHB FOR TARGET GROUPS

The design of the HMHB is highly relevant to the needs of target populations, related national policies, and SDGs.

HMHB is well aligned to GOT's needs and priorities, specifically those reflected in the National Development Strategy of the Republic of Tajikistan (RT) for the period up to 2030, the Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030, the National Plan for PHC Development in Tajikistan for 2021–2025, and the National 1,000 Golden Days Communication Strategy and Plan. Interviews with health providers at the national, regional and district levels (KIIs=17) revealed that the HMHB is in line with national health strategies and policies—both for improving access to and quality of health services to mothers and children and supporting behavioral change for MCH and nutrition practices.

“Tajikistan still has relatively high mortality among children. Also maternal mortality is alarming. Improvement of the quality-of-service delivery particularly at rural areas is highly important for the country and HMHB supports us a lot with that.” – KII with Government at the national level

“Much depends on behavioral practices ... Changing behavior of the population through awareness raising affects the improvement of medical services. It is important that HMHB is focusing more on raising public awareness.” – KII with Government at the regional level

The GOT has identified food security and nutrition as one of the four strategic goals of the country in the National Development Strategy 2030. In the National Health Strategy, strengthening PHC systems is one of the goals—along with health systems management, health delivery systems, health financing, health human resources, and health information systems development. In addition, the PHC System Development Plan based on Principles of Family Medicine for 2021–2025 calls for (i) improving access to and quality of services at the PHC level, (ii) modernizing information systems to improve management at the PHC level, (iii) improving the integration and development of basic services in PHC facilities; and (iv) community involvement in health issues.

The document review reveals that overall, HMHB supports the implementation of 11 national strategies and policies.⁵ The Activity is operational in all 813 villages of the 12 FTF ZOI districts, which

⁵ Background information: HMHB supports implementation of such strategic documents as the National Development Strategy of the Republic of Tajikistan for the Period up to 2030, Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030, National Plan for PHC Development in Tajikistan for 2021–2025, National Communication Program for the “First 1,000 days of a Child's Life in the RT for the Period 2020–2024,” National 1,000 Golden Days Communication Strategy and Plan, “Government Program on Reproductive Health for the Period 2019–2022,” National Program on Healthy Lifestyle 2022–2026, MOHSPP's Guideline on the Partnership with Communities on Health Issues (GPCHI), state program for the Development of Health Care and Social Protection of the Population of the Khatlon region

are the poorest in Tajikistan and where there is the greatest need for maternal child health and nutrition. An analysis of the country context also makes the objectives of the Activity highly relevant. The intervention contributes to the attainment of MCH-related Sustainable Development Goal 3 (SDG3) (good health and well-being) targets for maternal and children mortality (neonatal, infant, perinatal, and children under age five) and SDG2 targets for food security and nutrition.

Maternal, newborn, and child mortality and morbidity are driven by multiple factors. Most drivers of mortality and morbidity can be attributed to the following “three delays”: i) delays in the decision to seek care, ii) delays in reaching health facilities, and iii) delays in receiving effective and appropriate care once the mother/child contact with service delivery site or provider. The first delay is based mainly on community and individual factors and determined by sociodemographic characteristics (poverty, support of husband and family⁶) and health-seeking behavior (knowledge and attitude toward accessing health care). The second delay is caused by accessibility factors (travel time, distance, infrastructure in remote areas, and road and weather conditions). The third delay relates to quality of care and other factors (lack of staff and availability of supplies and equipment) in HFs. HMHB is intended to help address the first and third delays.

Regarding responding to the needs of the targeted population, respondents (FGDs=8, KIIs=14) overwhelmingly agreed that HMHB interventions are highly important. Men and women in FTF ZOI lack adequate information about the overall importance of health and are not aware of dangerous symptoms during pregnancy, the risks of becoming malnourished during pregnancy, or the importance of nutrition for pregnant women. A coherent and culturally sensitive strategy to change the health-seeking behavior of rural families does not exist, and rural health workers also lack the skills to communicate effectively with communities in HMHB target districts.

The poor qualifications of healthcare workers, especially with maternity care issues, are another constraint which the HMHB is trying to address. This is done by the Activity through professional and institutional capacity building of health providers at primary health centers and hospitals; regular external and internal supportive supervision and mentoring visits. Continuous medical education is regulated by a special decree. Publicly financed slots are scarce, and neither health facilities nor physicians can afford to pay for training.

RELEVANCE OF HMHB MNCH&N INTERVENTIONS

Quality Improvement (QI)

QI Committees are gradually functioning better and, overall, are better established in HMHB districts when compared to other districts of the Khatlon region. At the same time, QI processes are still more advanced at the hospital level than at the PHC level.

Quality of care has long been recognized as a means for achieving universal health coverage. Therefore, like THNA, HMHB continued to strengthen the QI process in all 12 HMHB target districts in planning and improving MNCH&N outcomes. Gleaned from the interviews (KIIs=12), the operationalization of QI Committees in HMHB districts is better established in comparison with other districts of the Khatlon region. Key informants at the national level (KII=3) highlighted that HMHB-supported efforts on QI were very timely and helpful in improving overall healthcare services, including health institution infrastructure in HMHB target districts. Review of projects documents indicate that for QI committees, HMHB provides technical assistance, training, procurement of essential equipment, and digitalization of assessment tools—and supports the National Center for Medical Accreditation to monitor implementation of QI plans and assess facility readiness for accreditation.

for 2021–2025, Strategic Plan for Digital Health Development in the RT for 2021–2025, Multisectoral Plan of Action for Nutrition RT for 2021–2025, National Program for the Prevention of Micronutrient Deficiency and Related Diseases among the Population of the Republic of Tajikistan and Food Fortification Action Plan for 2022–2027.

⁶ Source: HMHB Gender Gaps Assessment, July 2021.

As a result, two out of six planned Central District Hospitals (CDHs) in the HMHB target districts have already passed accreditation⁷ (Yovon and Khuroson) in 2022,⁸ and one more CDH is forthcoming (Jayhun) in 2023.⁹ As evident from National Center for Medical Accreditation data, these are the first CDHs in the country to receive accreditation.¹⁰ To receive the Accreditation Certificate, the HF needs to meet standards in such areas as management and administration, infrastructure and equipment, infection control, and clinical safety. Yovon and Khuroson experienced the most significant improvements in their readiness for accreditation (90 percent and 70 percent, respectively). Both CDHs are now recognized as hospitals providing high-quality medical services.

“The accreditation gives a good opportunity for improvement of all aspects of the health system ... this also motivates staff to deliver quality services.” – KII with Government at the national level

“Cooperation and support from HMHB [is] very timely and useful as many health institutions are willing to be certified. However, they do not have resources for improvement and responding to accreditation criteria.” – KII with Government at the national level

Overall, the hospitals’ average readiness for accreditation improved 14 percentage points—from 38 percent in 2021 to 52 percent in 2022 (Figure 4).¹¹

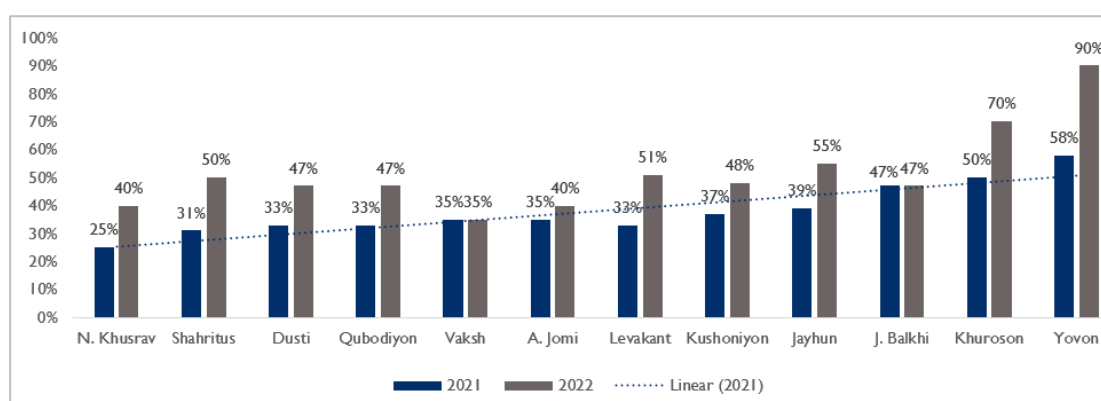


Figure 4. Readiness for accreditation of hospitals based on national standards in HMHB districts

Source: HMHB Annual Progress Report for Year 2

According to interviews with key project informants (KIIs=3), the Accreditation Certificate provides tangible benefits for the HF. Within two years after achieving accreditation, these HFs do not need to be checked by any inspection bodies, as they have already been assessed according to QI standards. Also, those HFs receive additional quantities of equipment and disposals from the MOHSPP. Moreover, the active work of the QI Committees resulted in CDH renovations in seven HMHB districts (N. Khusrav, Jayhun, Khuroson, Dusti, A. Jomi, Levakant, Qubodoyon)¹²—which contributes to improving quality of and access to healthcare for mothers and newborns.

⁷ Background information: All regulatory documents, including accreditation guidelines, have been developed and endorsed by MOHSPP in 2015, and HMHB supports implementation of this regulation.

⁸ Background information: To achieve accreditation, HMHB supported the facilities’ QI Committees to conduct self-assessments in all hospital sections (management, clinical safety, quality of medical care, and infrastructure), regular supportive supervision of QI teams by the National Accreditation Committee to improve QI skills of QI teams and prepare facilities for accreditation, facilitated the development of QI action plans based on the national accreditation standard, procured essential equipment based on RHFA results, and improved WASH and IC in the Khuroson CDH by reconstructing the water supply system.

⁹ Background information: Accreditation is through the self-assessment and external peer review process used by healthcare organizations to accurately assess their level of performance in relation to established National standards and implement ways to improve the healthcare system continuously.

¹⁰ Background information: For last few years, 105 health institutions in Tajikistan passed the accreditation process and got their certificates.

¹¹ Source: HMHB Annual Progress Report, p. 25.

¹² Background information: The major cosmetic repairs were completed in seven CDHs: N.Khusrav—the children’s department, internal diseases, infectious disease department; Levakant—admissions department; Qubodoyon—urology and children’s department; Khuroson—surgical department; Dusti—reception department, dentistry; and Jayhun—reanimation department and internal disease.

As evident from min-Rapid Health Facility Assessments (RHFA) results (Figure 5), there were improvements across all indicators. Most significant changes can be seen in availability of statistical data and recordkeeping, which increased from 1.5 to 2.2. There also have been improvements in the organization and provision of antepartum and postpartum care (from 2.0 to 2.6). The score for the quality of first ANC visits increased as well (average score 2.2) by working in partnership with PHC HLSCs under GPCHI, which involved sessions with facilitators at the rural level. At the same time, QI processes currently are more advanced at the hospital level and less at the PHC level. Significant improvements at PHC facilities are still needed with routine maternal ANC and PNC, as evident from the RHFA results.

Area	Feb-21	Sep-22
1.1 Availability of statistical data and record keeping	1.5	2.2
1.2 Drug availability and use for outpatient antepartum and postpartum care for women and infants	1.4	1.8
1.3 Available functional equipment and supplies for antepartum and postpartum care	2.0	2.5
2.1. Organization and provision of antepartum and postpartum care	2.0	2.6
2.2. Principles of privacy and confidentiality for antepartum and postpartum care	1.9	2.4
2.3. Principles of education and communication for antepartum and postpartum care	1.9	2.3
2.4 First antepartum visit	1.7	2.2
2.5 Routine follow up antepartum visits, considerations for select infectious and non-infectious conditions	2.2	2.4
2.6 Checking and managing particular non-infectious conditions	2.2	2.6
2.7 Antepartum counselling	2.3	2.4
2.8 Routine postpartum maternal care	1.8	2.2
2.9 Postpartum newborn care	1.4	2.3
3.1 Assessment and management of gestational hypertension, pre-eclampsia and eclampsia	2.0	2.7
3.2 Assessment and management of antepartum hemorrhage	2.1	2.8
4. Rapid assessment, management and referral of newborn baby with complications	1.5	2.5
5. Universal Precautions and Cleanliness	1.8	2.8
6. Regionalization and referral to hospital care for women	1.9	2.8
7. Regionalization and referral to hospital care for newborns	1.3	2.4

Figure 5. Self-assessment scores at the PHC level¹³

Source: HMHB Annual Progress Report for Year 2

The health officials interviewed (KIs=7) also demonstrated appreciation for support of the Activity in reviving the MNCH Coordination Council at the national level and initiating a multi-sectoral coordinating council on MNCH, nutrition, and gender in the Khatlon region.¹⁴ Tajikistan adopted Every Newborn Action Plan (ENAP) in early 2019. One of its objectives is to count every newborn through measurement, program tracking, and accountability. Key informants (KIs=4) highlighted the importance of the work for auditing perinatal mortality and an important role that HMHB can play—together with other key players such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and Deutsche Gesellschaft für International Zusammenarbeit (GIZ).

The other area where HMHB just started its activities is institutionalizing the Baby-Friendly Hospital Initiative (BFHI) to ensure that all infants begin breastfeeding within the first hour of birth. Interviews (KIs=6) showed that this work is needed as this initiative must be scaled up to the PHC and community levels, as stated by the new guidelines¹⁵ on breastfeeding protection, facilitation, and assistance in HFs.

As evident from document review and interviews with the project team (KI=5), HMHB focused on training and educating healthcare workers (obstetrician/gynecologists and midwives) from around the HMHB target districts to respond to the medical emergencies in their own HFs and communities. The Activity provided capacity-building on key Emergency Obstetric and Neonatal Care (EmONC) topics including postpartum bleedings, active management of the third stage of labor, blood lost

¹³ According to the WHO scorecard, each item is evaluated with information gathered by different sources to reach an overall score, ranging from 0 to 3: 0 = need for substantial improvements (totally inadequate care and/or harmful practices, with severe hazards to the health of mothers and/or newborns); 1 = need for substantial improvement to reach standard care (suboptimal care with significant health hazards); 2 = need for some improvement to reach standard care (suboptimal care but no significant hazards to health or basic principles of quality care); 3 = good or standard care.

¹⁴ Background information: Representatives from different ministries (such as education, agriculture, and economy) and representatives from committees on women and religion formed the council, which is led by the MOHSPP.

¹⁵ Revised WHO guidelines from 2018 to support and protect BF, adapted by MOHSPP.

measurement, newborn resuscitation, hypertensive cases, and emergency care. In addition, HMHB conducted online sessions for Beyond the Numbers (BTN) teams from target hospitals to enable them to audit critical cases for improving quality of care.

As a result, the interviewed HCWs (FGDs=6) stated that HFs improved care for normal labor and management of preterm labor, postpartum bleeding, and preeclampsia. The project monitoring data also suggest that there was an increase in the number of women giving birth who received uterotonics in the third stage of labor (i.e., 47,328 against a targeted 47,000 in Year 1 and 53,025 against a targeted 48,500 in Year 2).

Skills development

In-service training and ongoing continuing education, supportive supervision, and mentoring programs supported by HMHB strengthen healthcare workers' capacity and improve the quality of medical care at the hospital and PHC levels.

Findings from the document review and qualitative data (KIs=37, FGDs=8), the professional and institutional capacity-building of HCWs is one of the core components of the Activity. HMHB has continued to enhance the capacity of doctors, nurses, midwives, and sanitary staff through face-to-face and online trainings/sessions, Training of Trainers (TOTs), on-the-job trainings, mentoring, supervising, and revising training programs.

One of the areas where HMHB was especially successful and was able to achieve substantial results was updating the educational programs for HCWs. With the support of HMHB, Tajik State Medical University (TSMU) updated five pre-service education programs by including topics on healthy nutrition, nutrition for pregnant women, nutrition for young children, dietetics, and diabetes mellitus in pre-service curricula for general medical doctors; while the Republican Medical College updated the curriculum for family doctors and family nurses by including such nutrition-related topics as nutrition for pregnant women, anemia, Infant and Young Child Feeding (IYCF), breastfeeding, nutrition for underweight children, WASH, nutrition community guidelines, and COVID-19. As evident from interviews (KIs=3), this was the second time in the last 15 to 20 years when the USAID health interventions in Tajikistan were able to introduce some changes into the medical university curriculum.

"It is very difficult to introduce any changes in the curriculum ... introduction of several modules on nutrition into the curricula of five TSMU departments is a big step forward." – KI with the USAID staff

HMHB has also developed the training package based on the revised national guidelines on IYCF. This training package includes all components of IYCF (EBF, complementary feeding, treatment of Severe Acute Malnutrition (SAM), and Growth Monitoring and Performance [GMP]), which are in line with MOHSPP Order 873 on the child patronage system of children from 0 to 24 months, including PNC.

Also, HMHB has continued the support of 24 NRCs at the hospital and PHC levels, most of which were established and equipped within the predecessor THNA project. Respondents in 15 KIs and 8 FGDs—including at the national, regional, and district levels—stated that NRCs play a very important role in regular training of staff and improving the access to training materials and equipment.

"NRCs created at hospital and PHC levels are very useful, as key staff is gathered and have chance to participate in discussions, exchange of the knowledge and practical problems and solutions." – KI with the Government at the national level

"All trainings are very important as PHC staff have less chance to participate in post graduate trainings compared to doctors at hospital level. NRC on-[the-]job trainings is a good opportunity for them to strengthen their knowledge and skills." – KI with the Government at the regional level

"NRCs are fully equipped, have well-developed training materials, and give the opportunity for HCWs to be trained on key issues of mothers and child health." – KI with the Government at the district level

Information gleaned from the Desk Review revealed that HMHB trained over 5,900 healthcare workers during the first two years of implementation on a range of maternal and child health and nutrition issues to improve the quality of and access to maternal and child health services. In a review of the desk material and interviews with the HCWs (KIs=20, FGDs=8), it was generally agreed that the training provided was relevant and efficiently delivered. This was reconfirmed by the results of the survey conducted by the ET among the FGDs participants during the midterm evaluation.

Eighty-six (86) out of 113 HCWs surveyed (or 76 percent) mentioned that HMHB trainings were relevant for their daily work, had good balance between theoretical and practical work, had good trainers, useful and appropriate training materials, and improved their knowledge and practical skills.

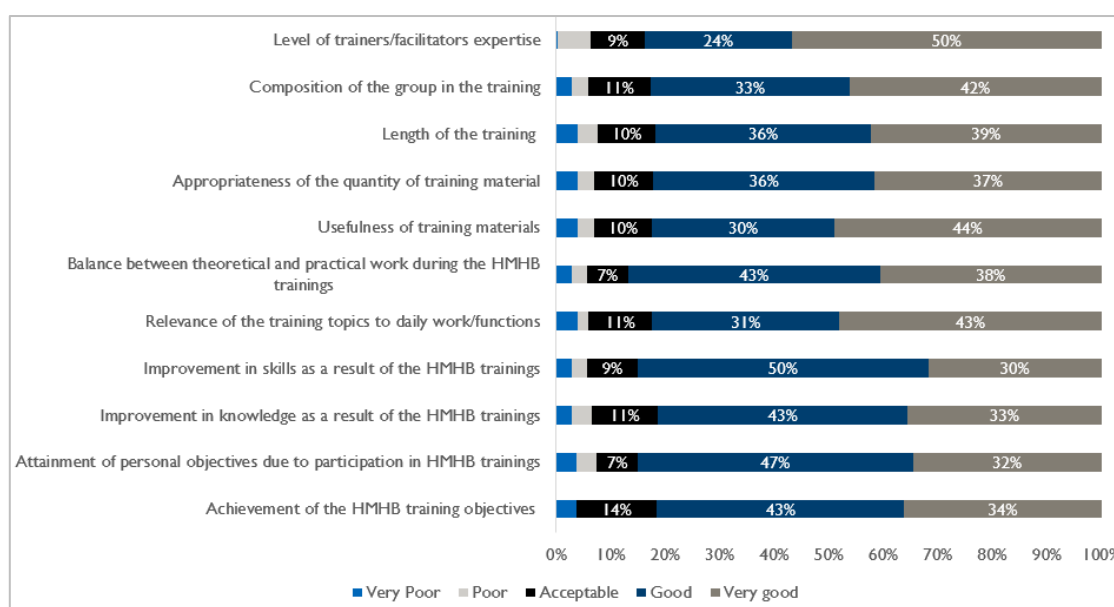


Figure 6. Assessment of the quality of HMHB trainings (N=113, Quality Improvement Team (QIT)=83; District Nutrition Trainers (DNTs)=3; Community Health Teams (CHTs)=24)

Source: Self-administrated surveys during FGDs, HMHB MTE, December 2022.

The strong elements of the HMHB capacity-building strategy that were identified by key informants (KIs=17) include: (a) adapting all training materials to local needs, together with local partners, before being used; (b) having almost all trainings facilitated by local partners to maximize sustainability and ownership and build local capacity; and (c) doing this in cascade when large numbers of people are being trained. As a result, as can be seen from the survey among trained HCWs, there is a high level of satisfaction with HMHB trainings. Ninety (90) percent of 113 respondents perceived the HMHB trainings to be “very useful” or “useful.”

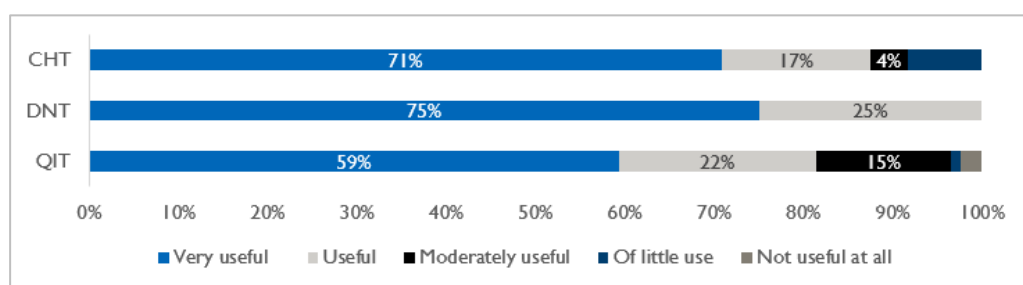


Figure 7. Overall satisfaction with HMHB trainings (N=113, QIT=83; DNTs=3; CHTs=24)

Source: Self-administrated surveys during FGDs, HMHB MTE, December 2022.

Most respondents (KIs=6; FGDs=6) from target districts appreciated training offered at the central, regional, and local levels. Key topics which were most valuable and highlighted during the FGDs with HCWs in six visited HMHB districts (FGDs=8) included: Managing pregnant women in critical conditions (bleeding, eclampsia/preeclampsia); hypertensive conditions and emergency care and

Partogram; antepartum counseling and routine postpartum maternal care; nutrition of pregnant and lactating women; IMCI; and clinical safety and infection prevention (Order 1119). According to interviewed CHTs (FGDs=2), the most useful topics were EBF and breastfeeding techniques; cooking demonstrations and locally available food; safe water; and the nutrition of pregnant and lactating women.

Among key suggestions mentioned for improving HMHB trainings were increasing the duration of the trainings (76 percent of survey respondents) and conducting trainings repeatedly on a regular basis (57 percent of survey respondents). One more area which requires strengthening in view of the ET is introducing the systemic pre- and post-knowledge tests in all CME trainings provided by the HMHB. The document review indicates that, currently, it is done systematically during TOTs but not for all on-the-job trainings delivered by NRCs.

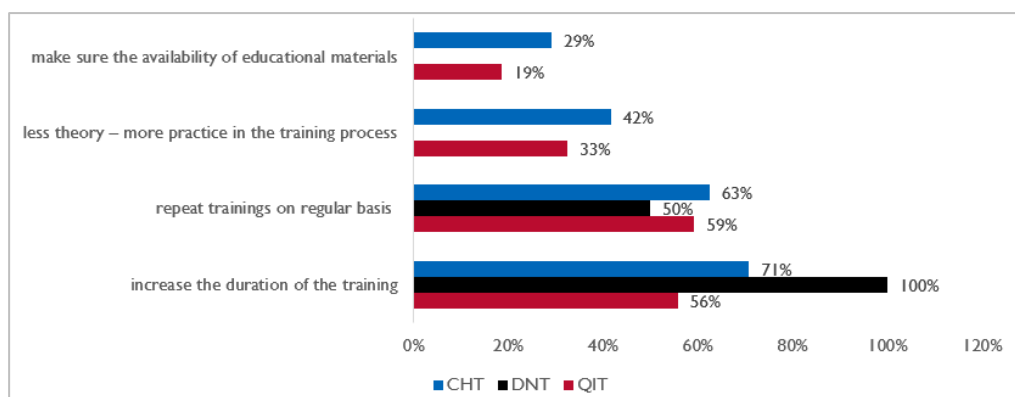


Figure 8. Suggestions for improving HMHB trainings (N=113, QIT=83; DNTs= 3; CHTs =24)

Source: Self-administrated surveys during FGDs, HMHB MTE, December 2022.

Key informants also reported that HMHB, in collaboration with the MCH Research Institute, established regular weekly online training sessions and mentorship in all target districts. These sessions were perceived as useful by HCWs interviewed (FGDs=8), although the MCH Research Institute's district supervisors are not fully involved in online training sessions and mentorship.

“Online sessions are a good support for district specialists, as they make an audit of critical cases once a week; however, there is no close working relationship with district supervisors.”

– KII with the Government at the national level

Digitalization

Digitalization is an innovative component of HMHB which not only helps to build a digital health ecosystem but also strengthens the skills of healthcare workers.

The Document Review and interviews (KIIs=16) demonstrate that digitalization is a completely new component of HMHB which was not implemented under THNA. This component is fully in line with the GOT strategy for digitizing the healthcare system.¹⁶ Currently, Tajikistan struggles to provide timely and quality healthcare services for mothers and children. Registries on health service provision and data management are primarily paper based, which delays services and impacts the quality of care. Therefore, HMHB was strategic and selected Dimagi's CommCare Platform—a digital platform which

¹⁶ Background information: The Concept for the Formation of Electronic Government in the Republic of Tajikistan for 2012–2020 is based on the National Development Strategy of the Republic of Tajikistan until 2030 and represents a general vision of using modern digital technologies to achieve the highest goal of Tajikistan's long-term development. In particular, it aims to improve the quality and availability of public services provided to citizens and organizations through the process of improvements in Information and Communication Technologies—and outlines the need to create a patient management system comprising a clinical management system and a patient record system.

can be integrated with the District Health Information Software 2 (DHIS2) system used by the MOHSPP.¹⁷

The uniqueness of the approach applied by the Activity to digitalize the health information system is that HMHB sets a standard by developing not only the professional digital applications but also improving digital literacy to help HCWs and community leaders increase the quality of services they deliver. In addition, HMHB uses Abt's Monitoring and Evaluation Ecosystem (AMEE) to capture, manage, and analyze routine data for the Activity. As evident from interviews with other development partners (KIs=4), this is a completely new approach for health projects in Tajikistan. Also, AMEE is built on DHIS2 and is compatible with Dimagi's CommCare.

An analysis of the AMEE system and interviews with key informants (KIs=5) reflected that during the first two years of implementation, Abt Associates—with the support of Dimagi—has developed a total of 11 digital applications, of which nine are apps¹⁸ for HMHB and two are apps¹⁹ for a sister project, the Local Health System Sustainability Project (LHSS).²⁰ Eight out of nine digital applications have already been launched—with the exception of MNCH version 3 (child growth monitoring), which is expected to be launched in early 2023. Key informants (KIs=8) confirmed that there are no duplications in developing digital applications and tools among the HMHB and other development partners (e.g., UNICEF, WHO, Asian Development Bank [ADB], Inter-American Development Bank [IDB], and World Bank [WB]).

IMPACT OF USAID INTERVENTIONS ON ACCESS TO AND QUALITY OF MNCH

While it is difficult to attribute success solely to USAID assistance,²¹ MNCH interventions funded by the USAID in FTF ZOI contributed to a decrease in home deliveries and child mortality (infants and children under age five). Limited progress can be seen in decreasing maternal, neonatal, and perinatal mortality rates in target districts of the Khatlon region.

Influence on public health outcomes

As evident from a document review of official statistics, USAID interventions in southern Tajikistan (THNA and HMHB) reduced in-home deliveries across the target districts from 4.8 percent in 2016 to 1.6 percent in 2021—giving women and their children better access to healthcare when they need it most. This can be attributed partly to USAID's comprehensive maternal and child health education activities delivered by THNA and HMHB between 2016 and 2022²²—which reached 459,254 pregnant women versus 289,000 planned, and 830,725 children younger than five years old versus 884,000

¹⁷ Background information: CommCare is an open-source mobile application platform and supports frontline workers across 200+ projects in over 80 countries. Both CommCare and DHIS2 are open-source software systems known as Global Goods. In addition, DHIS2's dynamic dashboards allow health workers to track indicator trends with heat maps, charts, and pivot tables.

¹⁸ Background information: The following digital apps were developed by HMHB: MNCH app v1 (CBE app), MNCH app v2 (ANC and PNC), MNCH v3 (child growth monitoring), CME, the RHFA tool, mini-RHFA tool, the KAP tool, Midwife Survey tool, and School Children Survey tool.

¹⁹ Background information: The Vaccine Form and Medical Waste Management Survey tools were developed for the Local Health System Sustainability Project (LHSS).

²⁰ Background information: LHSS is USAID's flagship initiative in integrated health systems strengthening, implemented by Abt Associates during 2020–2024 with an overall budget of \$13.9 million.

²¹ Background information: USAID is not the only donor in some of HMHB target districts. The WB is implementing the program (2021–2026) on increasing the use of basic healthcare and early childhood education for children aged 0–6 in Jomi, Jayhun, Dusti, Koshniyon, and Qubodoyon. UNICEF has a nationwide program (2016–2022) for treating malnutrition at the level of PHC and CDHs; providing technical and financial assistance to improve the population's access to iodized salt, vaccination, and newborn care; and revising clinical protocols, providing equipment, and building capacity. The Aga Khan Foundation supports partnership for social and economic development and community health funding, sanitation, and hygiene in Jayhun, N.Khusrav, Shahritus, and Qubodoyon (2018–2023). JICA supports the improvement of the healthcare system in the field of MCH (equipment, trainings, strengthening the referral system between PHCs and CDHs, and increasing the capacity of national supervisors) in Koshniyon and Levekant (2017–2022). WFP has a School Feeding Programme in Balkhi, Shahritus, and Dusti (2017–2021). Good Neighbors implemented a MCH project (providing PHC equipment, trainings for medical workers, and organization of CHTs) in Shahritus (Kholmatov jamoat) and N.Khusrav (Firuz and Navruz jamoats) in 2021.

²² Sources: THNA Annual Progress Reports for Y1–Y5, THNA MERL Plans, HMHB Quarterly Progress reports for Y1 and Y2, and MERL Plans.

planned.²³ Also, USAID trained over 23,662 healthcare workers during 2016–2022 versus 13,500 planned on a range of maternal and child health and nutrition issues to improve the quality and access to maternal and child health services.

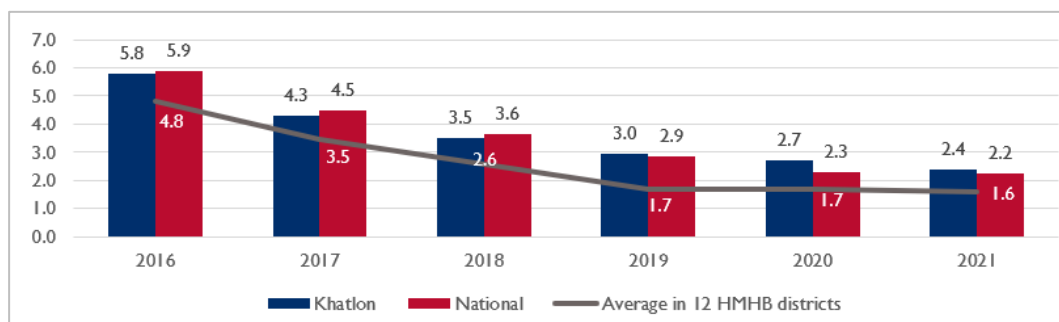


Figure 9. Home birth rates (in percent)

Source: MOHSPP

Further, USAID helped to make many improvements in the mortality rates for children from 2016–2021 in target areas of the Khatlon region through THNA and HMHB, including infant mortality rates changing from 16.2 to 14 deaths per 1,000 births (Figure 11); and the mortality rate for children under five years which also decreased from 21.1 to 17.7 deaths per 1,000 live births, as is evident from MOHSPP data (Figure 12).

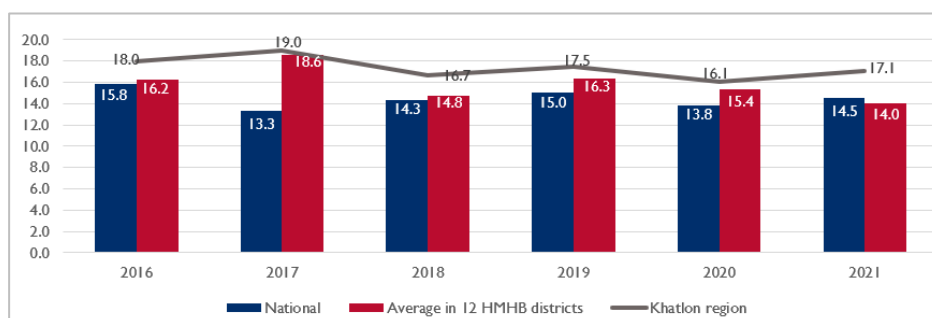


Figure 10. Infant mortality rate (death per 1,000 live births)

Source: MOHSPP

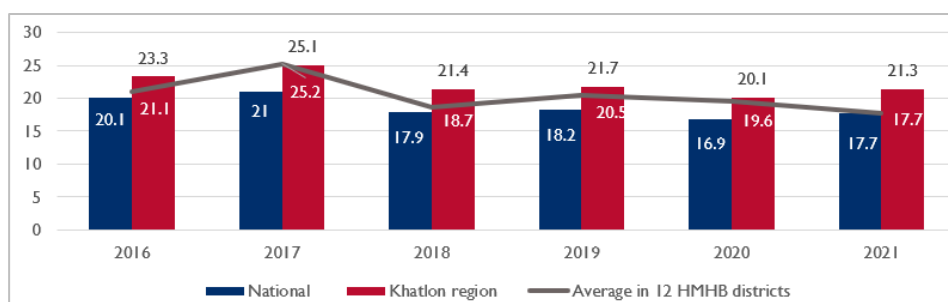


Figure 11. Mortality rate for children under 5 years of age (death per 1,000 live births)

Source: MOHSPP

At the same time, both neonatal and perinatal mortality rates remain high throughout the country and even increased between 2016 and 2021 from 7.5 to 8.6 deaths per 1,000 births and 16.8 to 17.2 death per 1,000 births, respectively, in HMHB districts. However, it is important to mention that neonatal and perinatal mortality rates in Bokhtar districts (i.e., in FTF ZOI) are lower as compared to Kulyab districts of the Khatlon region. The main causes of neonatal mortality are Low Birth Weight (LBW) (53 percent) and infections (20 percent), as is evident from MOHSPP data.

²³ Data on the total number of children younger than five years old reached by HMHB in Y2 were not available at the time of MTE.

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

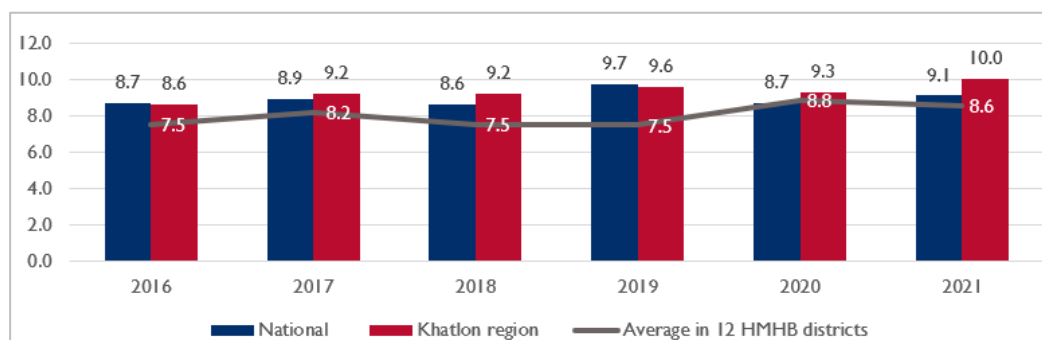


Figure 12. Neonatal mortality rate (death per 1,000 live births)

Source: MOHSPP

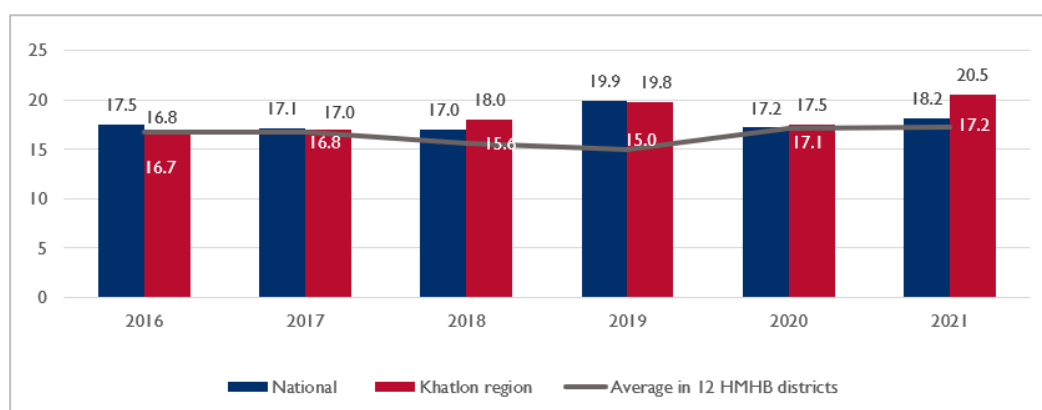


Figure 13. Perinatal mortality rate (death per 1,000 live births)

Source: MOHSPP

In addition, maternal mortality remains high not only in target districts but also nationwide. Maternal mortality increased on average from 12.4 to 30 deaths per 100,000 live births between 2016 and 2021 in FTF ZOI (see Figure 14). Information gleaned from the MOHSPP data illustrates that main causes for high maternal mortality include indirect causes, bleeding, sepsis, amniotic fluid embolism, and preeclampsia (see Figure 15).

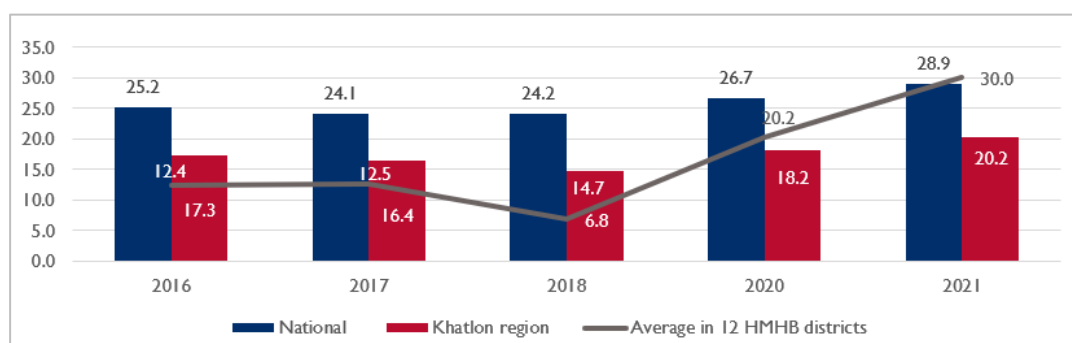


Figure 14. Maternal mortality ratio (number of maternal deaths per 100,000 live births)

Source: MOHSPP

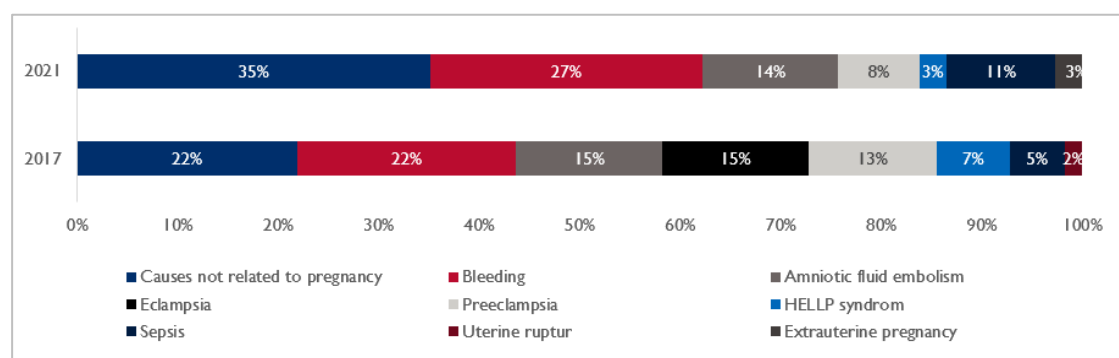


Figure 15. Maternal causes of death

Source: MOHSPP

The MOSPP data (Figure 16) further suggests that the causes of maternal mortality in 2021 in FTF ZOI districts (67 percent) were related to pregnancy—including bleeding, preeclampsia, and eclampsia—and less to non-related pregnancy causes (33 percent); while in nearby districts there was equal distribution of causes of maternal mortality (50 percent related to pregnancy and 50 percent to non-related pregnancy causes).

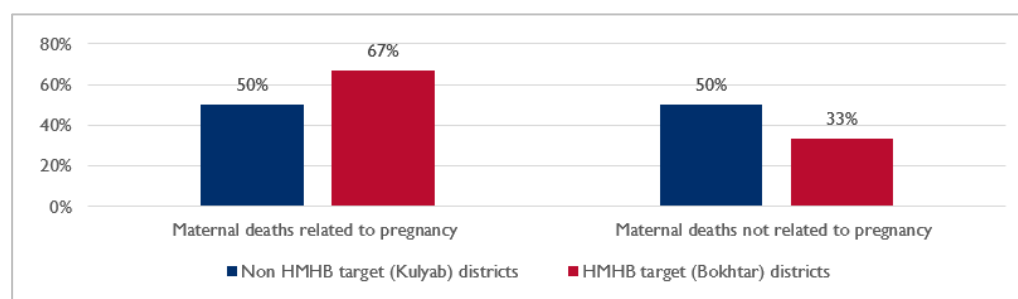


Figure 16. Comparison of maternal mortality causes in 2021 in HMHB target and non-HMHB target districts of Khatlon region

Source: MOHSPP

HMHB helped to increase the rate of women who made four or more antenatal visits during their last pregnancy in target areas. At the same time, the prevalence of mothers making decisions about their own health and the health of their children remains low.

Antenatal Care (ANC)

Antenatal care means care of the woman during pregnancy. The primary aim of ANC is to promote and protect the health of women and their unborn babies during pregnancy to achieve a healthy mother and a healthy baby at the end of pregnancy. A key function of ANC is to offer health information and services that can significantly improve the health of women and their infants. Moreover, ANC usage has a positive impact on the uptake of postnatal services.

Quantitative data (KAP Survey) demonstrate that the level of awareness about the importance of ANC among surveyed mothers increased from 88 percent (baseline) to 98 percent (midterm), indicating very high levels of awareness. Focus group discussions with MiLs (FGDs=2) also indicate that their understanding about ANC has improved, and they became more supportive.

“Pregnant women should make regular ANC visits during pregnancy, because this period is very danger[ous] with various complications and women should be well prepared for giving birth.” – FGD with MiLs

Reported attendance for ANC visits also increased from 74 percent who reported attending four or more ANC visits during baseline to 82 percent during midterm. This is significantly higher than the 2016 THNA household survey, which reported that 53 percent of women attended four or more ANC visits. In the KAP Survey, approximately 14 percent reported attending eight or more ANC

visits during baseline versus 31 percent during midterm. The MOHSPP recommends attending eight ANC visits.

“Now pregnant women have start to come to health facilities more often.... Previously, it was impossible to persuade them to come and being registered.” – KII with Government at the regional level

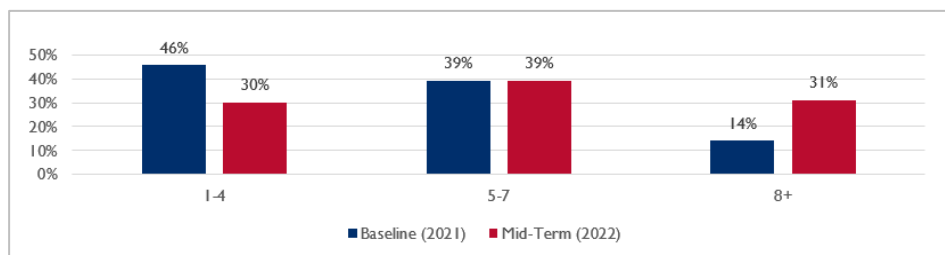


Figure 17. Number of ANC visits attended during last pregnancy (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

The KAP Survey results indicate a difference between practices and knowledge about the recommended number of ANC visits. Although 100 percent of women surveyed reported attending at least one ANC visit during both baseline and midterm surveys, the number of women who know how many visits a woman should attend during pregnancy was higher during baseline than during midterm. Of surveyed mothers who reported knowing the number of ANC visits, 45 percent answered that it is necessary to attend eight visits during baseline versus 34 percent during the midterm. This may be explained by the fact that HMHB launched SBCC in cohorts, and several districts that participated in the midterm KAP Survey (2 out of 6) were from Cohort 3—where SBCC activities just started in early 2022.

During ANC, the surveyed women reported that they received counseling on several relevant topics to support a healthy pregnancy. The most common topics included counseling on nutrition during pregnancy (71 percent baseline and 72 percent midterm), dangerous symptoms during pregnancy (53 percent baseline and 35 percent midterm), rest and daily routines during pregnancy (38 percent baseline and 32 percent midterm), caring for yourself during pregnancy (22 percent baseline and 36 percent midterm), and preparation for childbirth (24 percent baseline and 19 percent midterm). This was reconfirmed by the ET during FGDs with health providers at the hospital and PHC levels (FGDs=6) as well as CHTs (FGDs=2).

Over 60 percent of surveyed mothers (68 percent baseline and 64 percent midterm) indicated that MiLs made the decision about the number of ANC visits a woman attended during pregnancy. This confirms the prominent role that MiLs have as the main household decision-maker when it comes to health topics. There also was an increase in the involvement of husbands. Seventeen (17) percent of the women surveyed stated that the decision was made by the husband during the baseline versus 24 percent during the midterm. At the same time, there was a decrease in the number of women who made the decision on their own—from 11 percent during baseline to 6 percent during the midterm, as well as in the number when the decision was made jointly between spouses (4 percent baseline vs. 2 percent midterm).

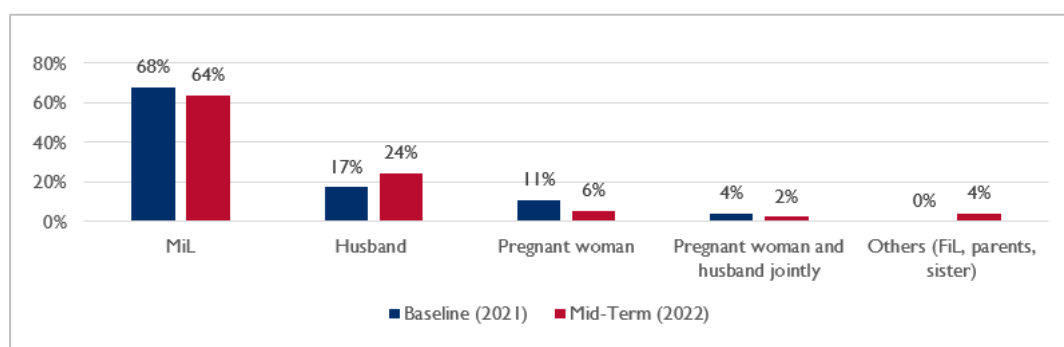


Figure 18. ANC access primary decision-maker (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

The review of official statistics also confirms that antenatal coverage is relatively high for the first 12 weeks of pregnancy in all HMHB target districts, although a bit decreased in comparison with 2020.

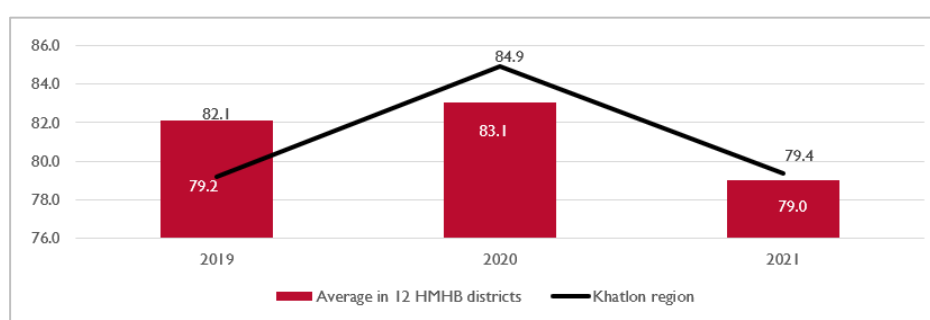


Figure 19. Antenatal checkup during first 12 weeks of pregnancy

Source: MOHSPP

Focus groups and interviews with health providers and mothers with CU2 (FGDs=8; KILs=7) demonstrate that a number of factors influence the frequency of ANC visits by pregnant women—including an increase in transportation costs from village to district health center, the need to pay for each lab examination (i.e., no exclusion for pregnant women as there was until 2020, as per MOHSPP Order 600), and the difficult financial situation of the population.

“Pregnant women come on average 3-5 times for ANC visits, but this depends on where women live.”
– FGD with QI Committees at the hospital and PHC levels

“Currently we are facing some additional payment for laboratory analysis or examination, which is a barrier for us to obtain health care services ... as at each visit to the gynecologist, tests are prescribed.”
– FGD with mothers of CU2

“The cost of all lab examinations has increased. A blood test costs TJS 20, hepatitis – TJS 75, Wasserman test – TJS 25, HIV – TJS 24.” – FGD with QI Committees at the hospital and PHC levels

“Due to limited family budget[s], sometimes the mothers-in-law or husbands do not allow the pregnant women to go to the doctor, as they need to take tests, make electrocardiogram, etc. ... all of that are [sic] not free of charge.” – FGD with QI Committees at the hospital and PHC levels

Some key informants (KILs=4) noted that resolving the issue of paid lab examinations can be achieved by introducing a health insurance system, which is not currently in existence in Tajikistan.²⁴ Also, it was mentioned that it is important to raise public awareness of the need to take proper care of health and allocate some financial resources when a family plans a child.

“Now everywhere in Tajikistan there are restrictions on expenses during a wedding or other events (e.g., farewell from maternity hospital, meeting a newborn at home), [so] why not spend money on your

²⁴ Background information: Although Law #408 on health insurance in the Republic of Tajikistan (RT) was endorsed by the GOT on June 18, 2008, its implementation has been postponed until 2025 due to the lack of state funding.

health? Patients are passing tests for themselves not for health care workers.... It is necessary to raise awareness of the population; if they have planned a child, then they need to assume the corresponding costs.” – KII with Government at the national level

There is an improvement in the number of pregnant women who receive adequate rest, particularly during the last trimester of pregnancy, as well as an increase in the practice of skin-to-skin contact after birth.

Adequate rest

According to KAP Survey results, mothers demonstrated high levels of knowledge about the optimal amount of sleep per night when pregnant (6 or more hours)—an increase from 86 percent at baseline to 93 percent at the midterm.

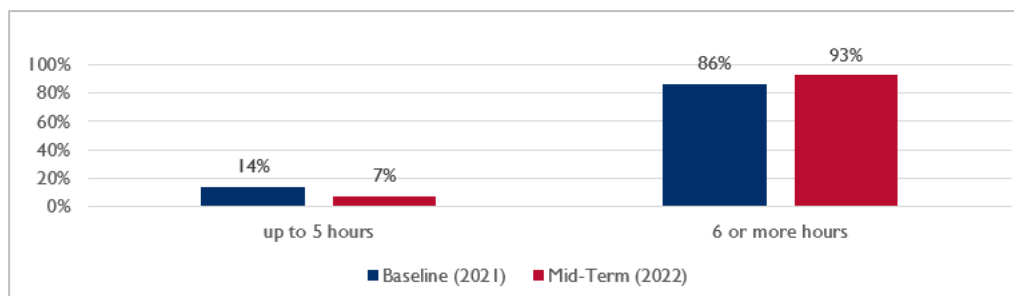


Figure 20. Mothers' knowledge of the ideal number of hours of sleep a pregnant woman requires per night (Baseline N= 228 Mothers; Mid-Term N=302 Mothers)

Source: KAP Survey

There also was an improvement in awareness among mothers of the risks of not getting enough sleep (68 percent baseline vs. 87 percent midterm)—and that complications during pregnancy may be related to lack of sleep and rest.

During the FGDs (FGDs=4), mothers of CU2 and MiLs mentioned some of the messages about behaviors during pregnancy. Some mothers mentioned that there was growing acceptance of pregnant women reducing their workload, asking for help, and eating healthy.

Skin-to-skin contact and Kangaroo Care

As evident from the KAP Survey, the practice of post-birth skin-to-skin contact and Kangaroo Mother Care was high and has increased 5 percent since the baseline. Eighty-two (82) percent baseline versus 87 percent midterm of mothers confirmed they had skin-to-skin contact with their newborn within two hours of birth. According to the Department of Health Services (DHS) in 2017, 86.8 percent of women confirmed skin-to-skin contact right after birth.

There was an improvement in PNC services in HMHB target districts and an increase in the number of health workers who carry out three or more postpartum follow-up visits at home.

Postnatal Care (PNC)

Postnatal Care (PNC) is one of the healthcare packages in the continuum of care for mothers and children that needs to be in place to reduce maternal and perinatal mortality and morbidity.

The document review indicates an improvement in PNC services in HMHB target districts according to MOHSPP Order 836. The project monitoring data shows an increase of 10 percent in the number of newborns who received postnatal care within two days of childbirth, i.e., from 47,557 in 2021 to 52,417 in 2022 in the HMHB districts. The KAP Survey also demonstrates an increase in the number of women who reported being visited at home by a HCW after giving birth—from 75 percent at baseline to 86 percent at midterm.

Of the women surveyed who received PNC, an increase also was observed in the number of visits at home by HCWs. Eighty-five (85) percent stated that the HCWs visited them three or more times

during midterm versus 60 percent during baseline. According to national standards, in the postpartum period, women and newborns must be visited at home three times for PNC. The first time should be within three days after discharge from the hospital, and the following visits should be during the second and fourth weeks after childbirth.

Of the women surveyed who did not receive postpartum care, 79 percent responded they did not know the reasons why they should receive care during the baseline, while during the midterm this number decreased to 49 percent. At the same time, a much larger number of women surveyed during midterm responded that they were not registered for pregnancy in a medical institution (22 percent midterm vs. 2 percent baseline) or that the health worker was not informed (17 percent midterm vs. 7 percent baseline).

When asked whether women in their community do not attend postpartum care because their husbands or MiLs refuse them the option, more than half (63 percent at midterm vs. 51 percent at baseline) of women disagreed or completely disagreed, indicating that the other half of women may feel unsupported. Mothers generally disagreed (77 percent midterm vs. 66 percent baseline) with the statement that they did not attend PNC due to quality of care (e.g., rude providers and/or long lines).

The responses to the Likert Scale questions did not overwhelmingly confirm a mother's barriers to receiving PNC. The most strongly agreed-upon statement was that the need for transport (38 percent at midterm vs. 21 percent baseline), followed by the need for support from their husband or MiL (33 percent at midterm vs. 25 percent baseline), the fear of being charged money (31 percent at midterm vs. 24 percent baseline), and the amount of housework (29 percent at midterm vs. 39 percent baseline) was a barrier to receiving PNC. For quality of care as a barrier for receiving PNC, 22 percent of mothers during midterm versus 8 percent during baseline mentioned it as a reason.

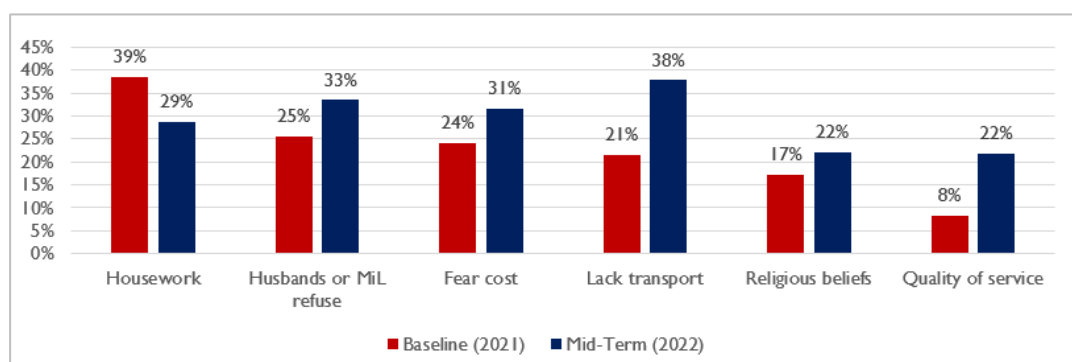


Figure 21. Barriers for not receiving PNC (Baseline N= 228 Mothers; Mid-Term N=302 Mothers)

Source: KAP Survey

During the KAP Survey, mothers indicated they have numerous childcare information sources, most of which are person-based versus technology or paper-based sources. Most (88 percent) mothers receive information from their MiL during the baseline, while 91 percent receive information from a doctor or medical facility during the midterm.

Response	Baseline (2021)	Midterm (2022)
Mother-in-law	88	45
Doctor at HF	44	91
Relative	19	18
Friends/peers, neighbors	21	9
Home visit by a community health worker	10	2
TV	6	9
Spouse/partner	5	5
Other	5	13

Figure 22. Where did you receive information about how to care for your child after birth? (in percent) (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

An improvement in managing and effectively treating main infections could be observed in HMHB districts due to the effective implementation of IMCI at the PHC level. The improvement could be also seen with handwashing practices as well as knowledge and practices on water treatment at the community level.

Management and effective treatment of main childhood illnesses (diarrhea, fever, malnutrition, and helminths)

Diarrhea and pneumonia are leading infectious causes of childhood morbidity and mortality. Knowledge of the epidemiology of childhood diarrhea and pneumonia is essential for planning and implementing comprehensive control programs for both diseases.

The project monitoring data shows a decrease of 6 percent in the number of cases of diarrhea treated in HFs of HMHB districts, i.e., from 15,290 in 2021 to 14,420 in 2022. The KAP Survey confirmed that knowledge of diarrheal prevention was high during both the baseline and midterm, as more than 85 percent of respondents were able to list at least two ways to prevent diarrhea in children. Respondents know to drink clean and safe water (52 percent at baseline and 17 percent at midterm), wash their hands with soap before eating and after using the toilet (51 percent at baseline and 57 percent at midterm), eat with clean hands (43 percent at baseline), and vaccinate for rotavirus (32 percent).

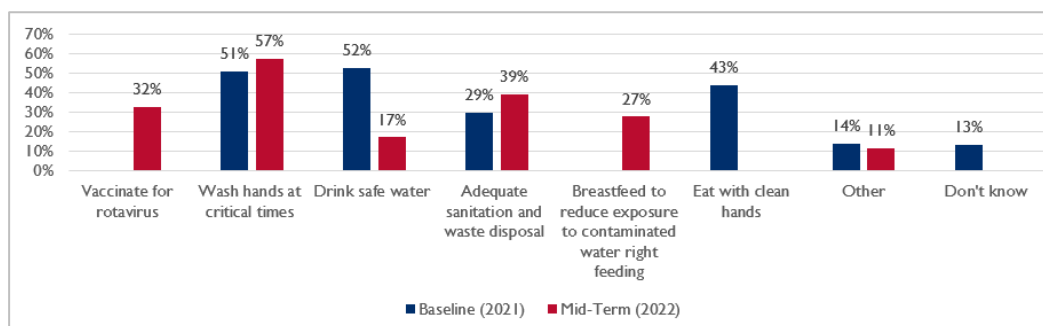


Figure 23. Diarrhea prevention (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Of the mothers interviewed who indicated that their children had diarrhea during the last month, there were mixed diarrheal treatment practices. The data indicate improvement in managing diarrhea at the community level. Fifty-three (53) percent said they received Oral Rehydration Solution (ORS) during midterm versus 44 percent during baseline; and 33 percent received zinc during the midterm versus 6 percent during baseline. The number of cases of diarrhea among children has decreased in Tajikistan. Medical workers, along with one-third of interviewed mothers of CU2 during the midterm KAP Survey, associate this with the vaccination of children against rotavirus infection.

The number of reported cases of fever of CU2 years of age reduced from 55 percent (baseline) to 35 percent (midterm) according to mothers interviewed during the KAP Survey. In case the fever lasted three or more days, most of the children were taken to the physician for treatment (91 percent at midterm and 76 percent baseline). On average, fevers lasted one to four days (94 percent at midterm and 96 percent baseline).

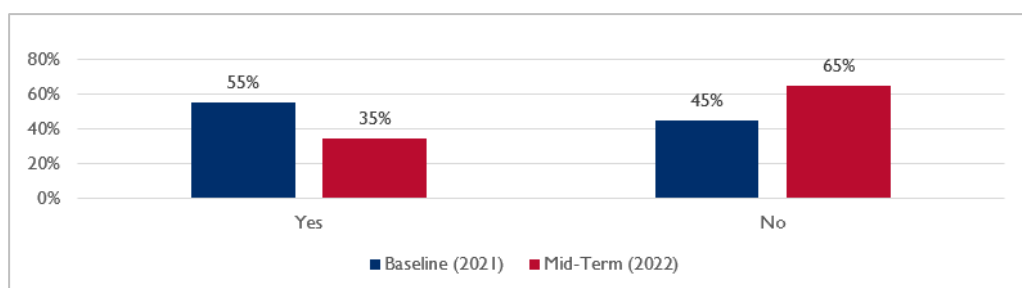


Figure 24. Reported cases of fever in the last month by mothers of CU2 (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Background documents²⁵ demonstrate that HMHB support resulted in an increase in identifying Children Under 5 (CU5) from 2,742 (2021) to 18,502 (2022)—and their better treatment at the hospital level in HMHB target districts (from 74 percent successfully treated in 2021 to 90 percent in 2022). This is perceived by interviewed stakeholders (KIs=7) as a very important achievement. Quantitative data (KAP Survey) further illustrate that there is a good level of knowledge among mothers about the common signs of malnutrition. Mothers are aware that the main signs of malnutrition are loss of weight (63 percent at baseline vs. 44 percent at midterm), lack of energy (48 percent at baseline vs. 38 percent at midterm), and suppression of appetite (43 percent at baseline vs. 38 percent at midterm).

Response	Baseline (2021)	Midterm (2022)
Loss of weight/thinness	63	44
Lack of energy/weakness: cannot work, survey, or play as normal (disability)	48	38
Children do not grow as they should (growth faltering)	43	38
Weakness of the immune system (becomes ill easily or becomes seriously ill)	0	16
Other	4	13
Don't know	14	14

Figure 25. Signs of child malnutrition (in percent) (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

There was a decrease in the number of women who reported that they do not know how to prevent a child from becoming malnourished (27 percent at baseline vs. zero percent at midterm). During baseline, three main measures were cited by women for prevention of malnutrition among CU2 years: timely and correct start of complementary feeding, practicing EBF, and preventing infectious diseases. Meanwhile, practicing EBF, preventing infectious diseases, and regular growth monitoring was mentioned during the midterm.

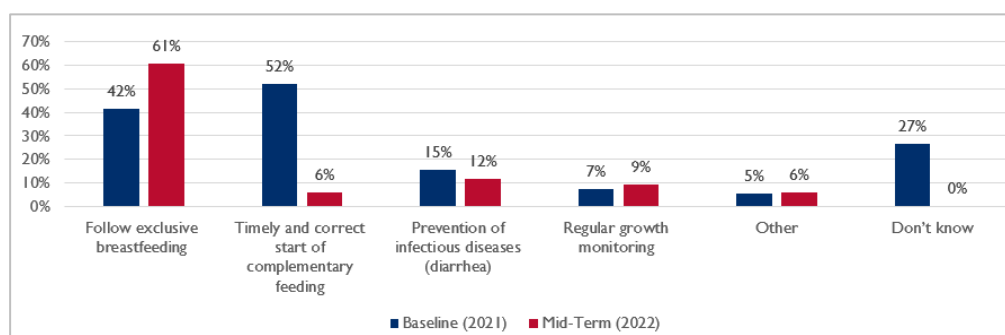


Figure 26. Prevention of malnutrition among CU2 (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Helminths are another cause of child illness and can stem from poor WASH practices. The awareness about helminths or parasitic worms improved from 66 percent at baseline to 78 percent at midterm (KAP Survey), but the children themselves are not examined and the mothers do not accept treatment for helminths. To combat this, MOHSPP conducts campaigns for deworming children and adolescents.

The main ways to prevent helminths are clean water for personal and domestic uses and improved access to sanitation, which includes the use of properly functioning and clean toilets by all community members. Most interviewed mothers (66 percent at baseline and 71 percent at midterm) correctly identified at least one behavior to prevent helminths.

²⁵ HMHB Annual Progress Report for Year 2, p.27.

Responses	Baseline (2021)	Midterm (2022)
Wash hands	46	62
Use a latrine	16	9
Wash fruit and vegetables before eating or cooking	38	36
Avoid food and water contamination	25	23
Keep animals outdoors or further away from family members	10	8
Other	7	18
Don't know	11	17

Figure 27. What can you do to prevent helminth infection? (in percent)

(baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Quantitative data (KAP Survey) suggest that most mothers during baseline and midterm surveys were able to identify the critical times for washing their hands. Most respondents (86 percent at baseline and 85 percent at midterm) mentioned having a place to wash hands with water and soap by their household members, demonstrating high coverage.

Response	Baseline (2021)	Midterm (2022)
After using the toilet/latrine	86	76
Before feeding children	79	35
While preparing/serving/eating meals	72	48
After disposal of feces, including children's nappies	45	21
After handling garbage	37	31
After handling raw food	16	24
After taking care of a sick individual	16	1
All the above	0	17
Other	4	6
Don't know	1	2

Figure 28. The most critical moments to wash hands with soap (in percent) (baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

All surveyed mothers (100 percent) were able to list at least one method of water purification—both during baseline and midterm surveys. The most common method was boiling water for at least three minutes (88 percent at baseline and 97 percent at midterm).

4.1.2 EVALUATION QUESTION II

To what extent has the Activity improved the diets of pregnant and/or lactating women and CU2 throughout the year—and why or why not?

The second and third HMHB objectives aim to support the SUN movement and the RT's national strategies—as well as social and behavior change to improve nutrition and maternal and child health.

This section examines HMHB support to the SUN movement in Tajikistan—particularly on food fortification, HMHB SBC strategies and approaches focused on nutrition, and the influence of HMHB interventions on maternal and child nutrition for changing behaviors in: (a) intake of multiple-micronutrient supplementations, (b) breastfeeding and EBF, (c) feeding children according to WHO's recommendation for Minimum Dietary Diversity and Minimum Acceptable Diet, and (d) children's intake of Multiple-Micronutrient (MMN) supplements, including zinc, per WHO guidelines.

ACCESS TO NUTRITIOUS FOOD

Addressing the key determinants of malnutrition and improving health and nutrition outcomes require a multisectoral response. Healthy Mother, Healthy Baby collaborates

with nutrition stakeholders to strengthen coordination of various government sectors in addressing nutritional challenges. However, the tangible results of mobilizing resources to expand priority MNCH and nutrition interventions and launch the fortification of wheat flour in Tajikistan are still to be implemented.

Micronutrient deficiencies in Tajikistan remain a pressing public health concern with short-term and long-term effects, especially among women and children. Therefore, HMHB continued its commitment to the SUN movement.²⁶ Evaluation interviews (KIs=5) demonstrate that the SUN activities are strongly supported by UNICEF and USAID—which function as SUN donor co-conveners—and by GiZ, which provided technical assistance to the national SUN secretariat under the Multi-Sectoral Coordination Council (MSCC) and has dedicated a permanent staff to assist the MOHSPP with multi-sectoral coordination and communication.

Respondents (KIs=8) have indicated that HMHB actively participates in and helps to lead the work on SUN activities in Tajikistan—to ensure that mothers and children have greater access to nutritious food. As noted in the Desk Review documents, during the first two years of implementation, HMHB provided technical and consultative assistance to the national SUN secretariat on the implementation of the National Multisectoral Plan of Action for Nutrition for 2021–2025 and supported finalization of the Action Plan of the National Program for the Prevention of Micronutrient Deficiency and Diseases Associated with it in the RT for 2022–2027, which was approved by GOT in 2021.

Several stakeholders (KIs=6), although appreciative of HMHB and its support of the SUN movement, admitted that because the SUN Multi-Sectoral Coordination Council is placed within one line ministry (MOHSPP), its strength in convening meetings across sectors and mobilizing resources to expand priority MNCH and nutrition interventions is limited. Therefore, how this council could be empowered and whether it could be anchored at a higher level is being discussed. Several options currently under discussion include either raising the political profile of the SUN focal point from the MOHSPP to the presidential administration or the Ministry of Finance—or merging the SUN MSCC with the Food Security Council under the Prime Minister’s office.

When it comes to food fortification, GOT revised its law on food fortification in 2019. While, in the past, only salt had to be fortified with iodine, it is now mandatory to fortify wheat with iron, folic acid, zinc, and vitamin B12. Along with USAID, the World Food Programme (WFP) supports GOT in food fortification (a big player in wheat flour) and UNICEF (in iodized salt). Healthy Mother, Healthy Baby provides support for wheat flour fortification by conducting a feasibility assessment on wheat fortification in Tajikistan, making an inventory of legislative and regulatory frameworks on food fortification—together with revision of standards on wheat flour fortification, and working on raising awareness of fortified food (iodized salt and fortified flour).

Input from key informants (KIs=7) suggests that the overall food fortification process is slow and needs a certain amount of time to be implemented—primarily due to the absence of a centralized supply chain of premixes and Standard Operating Procedures (SOPs) for respective ministries and agencies to support wheat flour fortification. It is expected that flour fortification will start in 2023.²⁷ If this happens, it will be a real breakthrough as USAID has supported food fortification activities in Tajikistan since 2007.

²⁶ Background information: Tajikistan made a strong commitment to improving maternal and child health and nutrition by becoming a SUN Movement member in 2013. Since joining the SUN movement, a multi-sectoral platform has been established in the form of MSCC to work at the policy level for nutrition. This coordination body is anchored within the MOHSPP and is chaired by the SUN focal person, the First Deputy Minister of MOHSPP. Members of the MSCC are typically Deputy Ministers. The MSCC is supported by the technical working group, which meets more regularly and includes the Ministry of Education, Ministry of Economic Development and Trade, Ministry of Agriculture, Ministry of Finance, Ministry of Industry and New Technology, representatives of the President’s Office, development partners, and civil society. The Director of the Maternal and Child Health Department chairs this technical working group.

²⁷ Background information: Currently, the World Bank (WB) is considering the possibility of attracting its own finances to organize a revolving fund for purchasing premixes for flour mills following the successful example of Uzbekistan. The WB is awaiting approval of the proposal from their headquarters. If approved by the WB, this activity will be regulated by the Ministry of Industry. According to GOT estimates, it is necessary to fortify 1 million tons of wheat flour annually—and for that, around \$2 million is needed.

“We hope by the end of next year some of the mill factories will start producing fortified wheat flour. It will be a huge success if it starts in 2023. This will be the most important achievement for 15 years of U.S. and other donors’ investment.” – KII with IP

Good progress was observed in raising awareness of food fortification in the target districts. The midterm KAP Survey revealed significant improvement in awareness among mothers about food fortification since the baseline, i.e., an increase of 43 percentage points from 15 percent baseline to 58 percent midterm. Further, 96 percent of mothers at baseline and 99 percent at midterm stated that they use iodized salt—versus 92 percent of households as per the 2017 DHS, which shows a slight increase.

“We are consuming salt which has iodine as it prevents goiter. So, when we are buying salt, we always look [to see] whether it is iodized or not.” – FGD with MiLs

FGDs with health providers (FGDs=6) and interviews with health and state authorities at the regional and district levels (KIIs=10) showed that when asked about fortified food, they always referred to vitamin-rich foods (fruits and vegetables). Thus far, fortified foods—except iodized salt—are not available in FTF ZOI and in Tajikistan as a whole.²⁸

SOCIAL AND BEHAVIOR CHANGE COMMUNICATION (SBCC) ON NUTRITION

HMHB applies a comprehensive approach toward SBCC by engaging at the local, national, and media levels, which has not been done before.

Improving the health and nutrition of women and children in rural areas is dependent on two factors. The health system should be capable of delivering the health services adequately and timely, and it must be responsive to people’s needs. In this context, as was discussed in the previous section, the capacity-building of service providers is crucial. The other factor involves the demand by the people for health services. Building a community’s capacity to take responsibility for their health is essential. This includes increasing awareness about the services available, demand for the needed services, proper use of these services, and an adequate knowledge and practice of healthy behaviors.

Behavioral change communication underpins the ability to successfully address and change unhealthy practices known to be associated with poor health and nutrition outcomes. For that reason, HMHB has modified the approach toward SBCC compared to THNA.

First, the village-level PHC providers known as “Community Health Team (CHT) Facilitators” were selected as entry points at the community level, while in previous projects it was community volunteers. Second, the focus was switched to partnership and collaboration at multiple levels (Republican Healthy Lifestyle Center [RHLSC], PHC, and community) by developing the Joint Action Plans (JAPs) to increase responsibility for health and nutrition. Third, the HMHB SBC strategy was developed using MOHSPP’s five Key Life Moments (Pregnancy, First Week of Life [0-7 days], First 40 Days [8-40 days], First Five Months (1-5 months), and Six Months through Two Years [6-23 months]).²⁹ Fourth, HMHB put more focus on the involvement of influencers apart from mothers with CU2 in its SBCC activities from households (MiLs, husbands) and the community level (religious authorities). Fifth, HMHB promotes handwashing to address the “disease aspect” of undernutrition. Last, HMHB uses communication channels (radio, TV, and social media) to deliver messages on proper nutrition for children and pregnant women.

Most of the respondents (KIIs=20; FGDs=6) also noted that most of the projects and the system itself are pushing healthcare providers to go to the household level to improve access to healthcare services in the country. This leads to overburden of the healthcare workers and negatively influences their motivation to work in remote rural areas. In turn, HMHB is trying to slightly change the approach by

²⁸ Note: Through its School Feeding Programme, WFP remains the only agency in Tajikistan to bring fortified food, especially fortified wheat flour and vegetable oil, to the country and arrange hot meals for almost 440,000 primary grade schoolchildren in 2,000 schools across the country.

²⁹ As per First 1,000 Days of a Child’s Life in the RT for 2020–2024.

educating both HCWs and patients about their rights and strengthening the interactions between HCWs and their patients.

As a result, HMHB developed three SBC campaigns: 1) Joint Decision Making and Planning (JDM); 2) Locally Available Food (LAF) for moms and young children, and 3) Breastfeeding Beyond the First 40 Days. Two out of three SBC campaigns (JDM and LAF) were launched in 2022, while Breastfeeding Beyond the First 40 Days is expected to be launched in 2023.

Background documents indicated that HMHB supported formation of 845 CHTs with 13,256 members—which reached 202,759 community members with nutrition messages (maternal nutrition, breastfeeding, complementary feeding, WASH behaviors, and managing nutrition during illness) during the first two years of implementation. FGDs with beneficiaries (FGDs=4) showed that the most useful ways to receive SBC messages are through face-to-face meetings with HCWs or CHTs, cooking demonstrations, and small pamphlets in Tajik.

“HMHB revitalized the work at the community level as well as explanatory work on the healthy behaviors among the community members.” – KII with the Government at the national level

“What is important that HMHB has an impact on maternal health by raising awareness of the population, especially among women of reproductive age.” – KII with the Government at the district level

Also, HMHB works at the school level to increase schoolchildren's knowledge about healthy lifestyle choices, nutrition, WASH, gender equality, and COVID-19. As of September 2022, it reached 1,957 schoolchildren in grades 8–10 in eight targeted schools. Evaluation interviews (KIIs=8) indicated that although adolescents are not a part of HMHB target groups, they were included in the Activity's nutrition component based on the results of baseline study—which showed a lack of knowledge on gender issues and nutrition among this category of beneficiaries. They also are perceived as important behavioral change agents in their families.

One of the themes that emerged prominently during interviews and focus groups (KIIs=20, FGDs=8) was the opinion that planning of pregnancies and healthy spacing of deliveries have a significant impact on children's nutritional status. However, HMHB is addressing these topics to a limited extent only as it is out of scope of its mandate. Key informants (KIIs=3; FGDs=1) reported that there is a big problem in Tajikistan with the supply of contraceptives. It was stopped by the USAID in 2013, and the only donor (UNFPA)—which provided the contraceptives—will fully stop the supply in 2024. Many women in Tajikistan cannot afford the contraceptives on their own. The level of knowledge about reproductive health and family planning also is limited among adolescents—especially girls in remote areas. It was highlighted by key informants that it is important to mainstream the activities of reproductive health in the USAID-funded MCH and nutrition interventions.

IMPACT OF HMHB ON MATERNAL AND CHILD NUTRITION

Nutrition and multiple-micronutrient supplementation

Improvement in knowledge of the need to consume adequate nutrition during pregnancy and breastfeeding could be seen among mothers in HMHB districts. Meanwhile, there has been a decrease in the number of pregnant women who take iron and folic acid during pregnancy—due to stoppage of the free-of-charge supply of iron and folic acid supplements to the HFs since 2020.

The KAP Survey indicates that due to HMHB interventions, there is an increase in knowledge about the need to eat more food than usual while pregnant, between baseline and midterm—from 78 percent to 95 percent. Most of the women interviewed—91 percent at baseline and 100 percent at midterm—confirmed their awareness of the need for breastfeeding women to eat more food than usual.

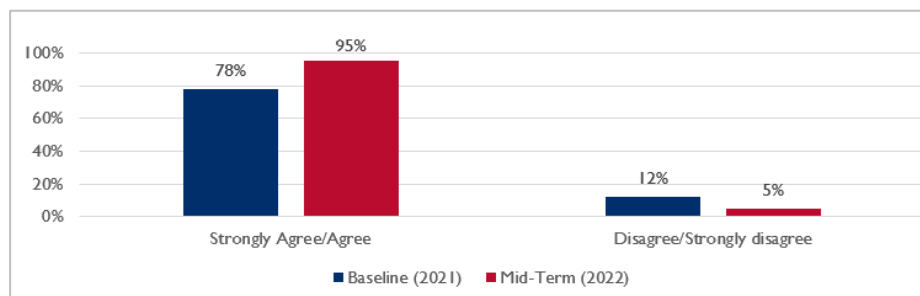


Figure 29. Perceptions of the quantity of food pregnant women need to eat

(baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Micronutrients such as iron and folic acid³⁰ are essential during the gestation period. A deficiency or an imbalance in intake during this moment negatively affects the growth and development of the fetus and the health of the mother. As evident from the KAP Survey data, awareness about the importance of taking folic acid supplements during pregnancy substantially improved among mothers in HMHB target districts. Eighty (80) percent of mothers (midterm) versus 46 percent (baseline) felt that taking folic acid during pregnancy is necessary for healthy intrauterine development.

There was also a decrease in the number of women who are unaware that folic acid is needed during pregnancy—38 percent baseline versus 23 percent midterm. In the meantime, a considerable decrease was observed in the number of women who reported taking iron supplements during their last pregnancy (42 percent at baseline vs. 24 percent at midterm).

According to 2017 DHS data, 49 percent of women took iron supplements during pregnancy. Qualitative data (KIs=5; FGDs=8) showed that this is due to discontinuation of the free-of-charge supply of iron and folic acid supplements to the HFs throughout the country since 2020. During focus groups with mothers of CU2 (FGDs=2), most of them confirmed that they purchased the iron pills on their own during their last pregnancy and took them mainly for a month. Also, most of the mothers interviewed mentioned that they took folic acid for at least three months.

“We advise and prescribe iron folic acid (IFA) for pregnant women, but they need to buy them on their own. As a result, only some pregnant women purchase IFA due to their expensiveness. For example, 25 iron pills of Russian production costs TJS 25. This is quite a significant amount for a family budget.” – FGD with QI Committees at the hospital and PHC levels

Breastfeeding and Exclusive Breastfeeding (EBF)

Breastfeeding in the first hour did not improve, while there was a slight increase in EBF in HMHB districts.

Two important components of infant health are the prompt initiation of breastfeeding and EBF until the infant reaches six months of age (WHO). This practice significantly reduces infections and malnutrition in infants. Colostrum—the yellowish, sticky breast milk produced at the end of pregnancy—is recommended by WHO as the perfect food for the newborn, and feeding should be initiated within the first hour after birth.

Data from the KAP Survey indicate that breastfeeding in the first hour did not improve but, to the contrary, showed some decline from baseline to midterm (85 percent to 76 percent). This may have been caused by a stricter definition of “first hour” by interviewers during the midterm survey compared to the baseline and the fact that baseline and midterm KAP Survey were done by different teams, although this could not be confirmed.

At the same time, there was an improvement in the level of knowledge on breastfeeding among mothers and MiLs as evident from FGDs (FGDs=6).

³⁰ Background information: Folate is a vitamin that is essential for development of the brain, spinal cord, and skull.

“We are feeding our children with breastmilk, only in [a] few cases if breastmilk [is] not enough we are giving cow[s] milk.” FGD with mothers of CU2

“Breastfeeding protects our children from loo[e]s stool (diarrhea) and makes them stronger.” – FGD with MiLs

“After our information sessions, we [did] observe that more mothers in our community started to breastfeed their children.” – FGD with CHTs

FGDs with health providers (FGDs=3) shows that the practice of using soothers (pacifiers) disappears due to better awareness among the population of the benefits of breastfeeding.

Also, the KAP survey data displays that there is a decrease in mentioning a lack of knowledge about breastfeeding as a common barrier in communities to breastfeeding of newborns (from 67 percent during baseline to 30 percent during midterm).

The WHO recommends that infants should be exclusively breastfed for the first six months of life. The 2017 DHS indicates relatively high rates of EBF, i.e., 70 percent of children under six months were exclusively breastfed. The KAP Survey revealed that there was a slight increase in knowledge on how long EBF should last in HMHB target districts—with 67 percent (baseline) and 69 percent (midterm) of mothers indicating that babies should be exclusively breastfed until six months. This could be explained by the fact that HMHB has not yet launched “Breastfeeding Beyond the First 40 Days Campaign” and plans to do it only from Year 3 onward, as is evident from the document review.

Responses	Baseline (2021)	Midterm (2022)
1-5 months	4	0
6 months	67	69
7-12 months	20	9
Until the baby starts wanting more food	7	15
Other	3	7

Figure 30. Mothers’ perceptions of ideal duration of EBF (no supplementary food or water) (in percent)

(Baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Feeding of children according to the WHO recommendation for Minimum Dietary Diversity and Minimum Acceptable Diet

There was an increase in the number of children ages six to eight months who are supplemented with complementary foods in HMHB districts.

WHO and UNICEF also recommend gradually introducing solid, semi-solid, or soft foods to infants at six months of age—and that the mothers continue breastfeeding until the infant is two or more years of age. The introduction of foods is an important step in infant growth, and it is important that mothers know how and when to introduce foods to their infants.

The 2017 DHS indicates that 63 percent of children aged six to eight months were supplemented with complementary foods in the form of soft and semi-solid foods. Results from the KAP Survey indicated an increase of 18 percentage in mothers who reported babies should be six months old when they begin receiving foods in addition to breastmilk—from 67 percent at baseline to 85 percent at midterm—in HMHB districts. Of mothers who indicated that secondary foods should be introduced when babies are seven or eight months old, there was a decrease of 11 percentage points—from 23 percent at baseline to 12 percent at midterm.

The surveyed mothers were able to list multiple ways to encourage a child to eat. The most common were to make funny faces/play/laugh with young children (49 percent at baseline and 43 percent at midterm), saying encouraging words to the child (40 percent at baseline and 49 percent at midterm), and giving them attention during meals (26 percent at baseline and 31 percent at midterm).

FGD respondents (FGDs=2) listed the following benefits of diverse diets for pregnant women:

“When they follow diverse diets, pregnant women stay healthy and strong during delivery. The baby is born with a very good weight, and this is a sign that the mother was eating well.” – FGD with mothers of CU2

“Diverse diets are important for the health. Diverse diets enable both mothers and children to grow well. When people have diverse diets, they rarely fall sick.” – FGD with mothers of CU2

“When a woman is expecting or pregnant, she should eat three meals in a day plus a snack. The other thing is that she needs to rest after eating. A woman is also supposed to eat three groups of food.” – FGD with mothers of CU2

The FGDs with district nutrition trainers (FGDs=2) revealed that, previously, children were not given complementary foods up to one year. After a series of trainings conducted with HMHB support, they observed some changes as more and more mothers started to introduce solid/semi-solid foods to infants starting at six months and going to two years.

When mothers were asked who makes decisions about when and how to start giving complementary foods to children, both during baseline and midterm, it becomes clear that a key role is played by MiLs (59 percent at midterm vs. 57 percent at baseline). Thirty-seven (37) percent at baseline and 27 percent at midterm answered that mothers decide for themselves; and in 5 percent (baseline) and 9 percent (midterm) of cases, they said that husbands decide.

“When [a] child reaches 6 months, we (MiLs) are advising to our daughters-in-law to start giving some foods in small amount. Mainly we start [with] mashed potatoes, carrot, rice porridge.” – FGD with MiLs

Knowledge of eggs as a complementary food by mothers has improved, but cultural prejudices about eggs still exist in the population.

Knowledge about when mothers should begin introducing eggs into a child’s diet varied, with 80 percent baseline and 57 percent midterm of respondents indicating they should be introduced when the child is younger than 12 months old. Specifically, 65 percent (baseline) and 33 percent (midterm) of respondents indicated they should be introduced when the child is between seven and 12 months old. Thirty-one percent baseline and 30 percent midterm indicated that they should be introduced when the child is 12 months old; 11 percent baseline and 4 percent midterm indicated they should be introduced between 13 and 18 months; and 8 percent (baseline and midterm) indicated that eggs should be introduced when the child is 24 months or older. This was also reconfirmed by the ET during the focus groups with mothers (FGDs=2).

“We start giving some additional food when [a] child reaches 6 months of age. We start from [a] very small number of mashed potatoes and carrot soup and gradually give meat and eggs at 9-10 months.” – FGD with mothers of CU2

Evaluation interviews with IP (KIs=3) demonstrated that HMHB worked closely with MOHSPP during the first two years of implementation to revise the national standards on complementary feeding—which was approved by the Ministry in early January 2023. As per the national standards, eggs should be given to children from seven months of age, with meat from eight months. Meanwhile, as per UNICEF³¹ and WHO’s³² global strategy on complementary foods, both eggs and meat should be introduced starting at six months.

“Because of the absence of the MOHSPP approval until December 2022, health workers were not able to advise families to introduce eggs and meat as per the global standards.” – KI with IP

Due to HMHB interventions, the improvement in knowledge among mothers on the benefits of giving eggs can be observed. Based on KAP data, mothers were able to list multiple benefits of serving children eggs: 55 percent midterm and 37 percent baseline reported that eggs are a complete protein

³¹ <https://www.unicef.org/media/93981/file/Complementary-Feeding-Guidance-2020.pdf>.

³² <https://www.who.int/data/nutrition/nlis/info/infant-and-young-child-feeding>.

food, and 25 percent midterm and 38 percent baseline of mothers reported that eggs are nutrient-rich.

Response	Baseline (2021)	Midterm (2022)
Eggs are a complete protein food	37	55
Eggs contain a large amount of nutrition	38	25
My child likes to eat eggs	2	1
Eggs are available and affordable for my family	2	1
Other	4	3
There is no benefit	1	1
Not sure	16	14

Figure 31. Mothers' perception of giving eggs to young children (in percent)

(baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

When asked why a mother does not give her young child eggs to eat, 56 percent baseline and 51 percent midterm said they feared it might delay speech; 44 percent baseline and 24 percent midterm said eggs might be difficult to digest. Twenty (20) percent baseline and 17 percent midterm said the children might be allergic to eggs; and 16 percent baseline and 4 percent midterm said it might slow child development.

"Before we were afraid to give eggs as there was a belief that eggs delays speech of the child. Now we do not have such prejudices [prejudices]." – FGD with MiLs

"We see some improvements ... More mothers started to give eggs to kids. They split the egg into four parts and add it as complementary food for better digesting." – FGD with DNTs

Children's intake of MMN supplements—including zinc—per WHO guidelines

Although awareness about anemia is improving among mothers in HMHB districts, anemia still prevails among caregivers and children.

According to the 2017 DHS, 42 percent of young children in Tajikistan are anemic (<11 g/dl). Increasing awareness of the symptoms and prevention of anemia among caregivers will reduce the number of children with anemia. As evident from the KAP Survey, the awareness about anemia has increased among mothers from 66 percent (baseline) to 78 percent (midterm) in HMHB districts. The main signs of anemia cited were low energy (67 percent at midterm and 86 percent at baseline), pale skin (55 percent at midterm and 59 percent at baseline), and poor feeding or getting tired while eating (24 percent at midterm and 40 percent at baseline).

Regarding knowledge of behaviors to prevent anemia in children, the KAP survey result indicates that 33 percent baseline and 35 percent midterm of mothers were able to list at least two preventative actions. The ways most cited by mothers surveyed for preventing anemia by mothers was to consume Vitamin C-rich foods (72 percent at midterm and 63 percent at baseline) and consume iron-rich foods (51 percent at midterm and 58 percent at baseline).

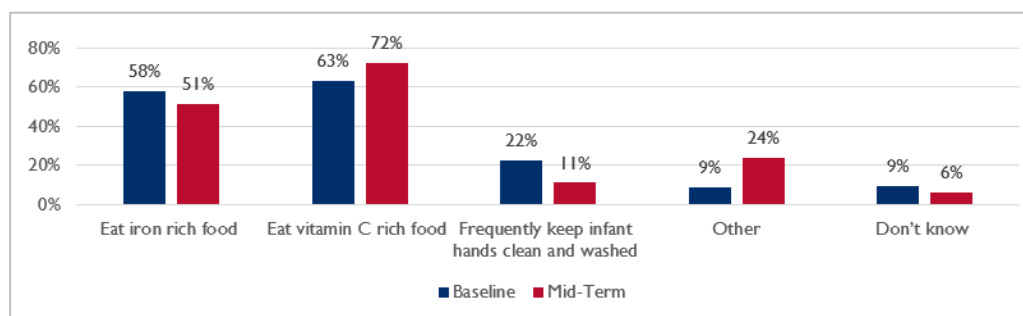


Figure 32. Mothers' perception of ways to prevent anemia among children

(Baseline N= 228 mothers; midterm N=302 mothers)

Source: KAP Survey

Further, interviews and FGDs with health providers at the PHC level (KII=5, FGDs=5) demonstrate that there has been an improvement with Vitamin A supplementation in all 12 HMHB target districts. The document review suggests that five target districts achieved 100 percent coverage of Vitamin A distribution among CU5 in Y2, five districts achieved 91–99 percent coverage, and the remaining two districts achieved 75–80 percent coverage.³³ This happened because of improved cooperation between HWs and the community with the Vitamin A distribution and GMP campaign, which was supported by HMHB. Good coverage with Vitamin A supplementation was possible due to the change in the approach, i.e., parents started to bring their children for Vitamin A supplementation and anthropometry to the HFs rather than HCWs making personal visits to each household for Vitamin A distribution.

"We started to come regularly to [the] health facility for immunization of children and receipt of Vitamin A." – FGD with mothers

At the same time, PHC QI Committees reported during FGDs (FGDs=5) that although zinc should be provided to children free of charge until five years of age, it is not done due to supply shortages.

Although HMHB is undertaking several activities focused on preventing anemia (e.g., updating the terms of reference for family nurses with expansion of their responsibilities for nutrition counseling of anemic pregnant women, integrating education sessions on anemia into school curricula, and printing and disseminating anemia brochures), anemia is still prevalent among pregnant women in Tajikistan. According to official data, every third pregnant woman in the Khatlon region suffers from anemia. In general, anemia among pregnant women in the HMHB target districts was higher than in the Khatlon region or at the national level between 2019–2021.

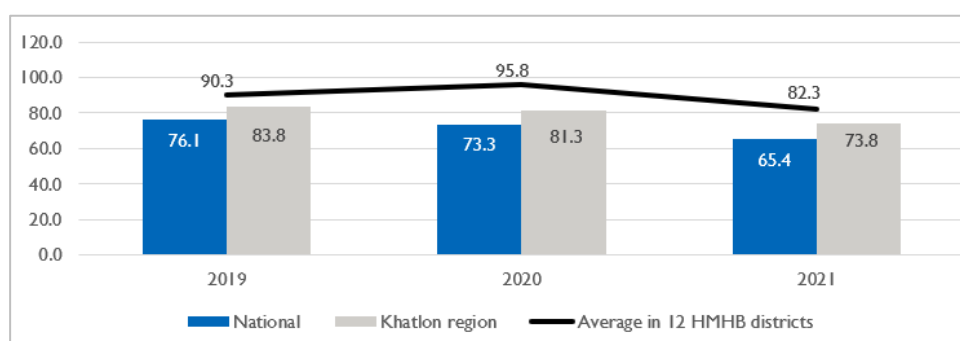


Figure 33. Anemia among pregnant women (per 1,000 pregnant women)

Source: MOHSPP

Interviews with MOHSPP (KII=5) showed that anemia among the population has various causes including iron/folic acid deficiency, vitamin deficiency, genetic problems, and other micronutrient deficiencies.

³³ Source: HMHB Annual Report for Year 2, p. 26

“Anemia is still high among pregnant and lactating women, but there [are] no clear data [as to] why it is too high in our country.” – KII with Government at the national level

“Anemia has multiple causes ... so far only iron deficiency is detected, although there are many other causes.” –KII with Government at the regional level

FGDs with health providers (FGDs=6) demonstrate that, in general, the level of anemia among pregnant women has not decreased in HMHB districts, but changes in the severity of cases have been observed by HWs. Previously, there were more severe cases; now they are more moderate or low in severity.

4.1.3 EVALUATION QUESTION III

To what extent are implemented activities sustainable beyond the Activity timeline? a) Were (Activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in FTF ZOI? b) Were there barriers?

In this section, an assessment of the level of sustainability of key HMHB interventions (QI, Skills Development, SBCC, Digitalization, and CPGs) is presented—followed by a discussion of the main barriers (external factors) which might influence the sustainability of the HMHB results long term.

SUSTAINABILITY OF HMHB INTERVENTIONS

Quality Improvement (QI)

The work on the QI process at the hospital and PHC levels will continue after the end of HMHB as it is embedded within the national healthcare system. However, further support is needed to strengthen the capacities of QI Committees and collaborative approaches and make them more sustainable.

Establishment of the QI Committees is regulated by MOHSPP Order 233 on Accreditation (2014) and the Health Code of Tajikistan endorsed in 2017 by GOT. Article 5 of this Code says that each HF should establish a committee on the quality and safety of healthcare services. The main tasks of this committee include regularly analyzing healthcare services in accordance with national regulations and identifying factors that violate the order of medical care and standards. MHB has supported the development of QI Plans in each target district for CDHs and PHCs. Review of 12 QI Plans (six for CDHs³⁴ and six for PHCs³⁵) of the Dusti, Vakhsh, Sharituz, Jomi, Yovon, Jayhun districts revealed that annual QI Plans are almost the same in all these districts. They include very general issues without accounting for the local problems—due to not having properly conducted a situation analysis. The Monitoring, Evaluation, Research and Learning (MERL) system for monitoring the implementation of QI plans (i.e., data collection tools, procedures for data collection, and reporting of achievements against anticipated indicators) is not yet in place—as is evident from meetings with health providers at the district level (KIIs=6, FGDs=6). Moreover, neither QI Committee members nor HF managers during focus groups or interviews mentioned the use of RHFA (self-assessment) results for planning and/or revising QI plans. However, RHFA and mini-RHFA are powerful tools for understanding the

³⁴ Background information: QI plans for CDH include the following six components: Quality of healthcare services: access to continuous services from PHC to hospital services; partogramme; management of bleeding; cesarian section; newborn care and management of newborn diseases; children's disease management; management of human resources (for each action for which they have indicators); safety of healthcare delivery (prevention of healthcare-associated infections—HAI indicators); safe management of medicine (drugs); safety of HCWs (PPE, PEP [post-exposure prophylaxis], safe working environment); environmental safety (safe use of medical equipment; safety measures electric supply; safe environment for patient); and patients' rights (access to healthcare services, assessment of patient satisfaction).

³⁵ Background information: QI plans for PHC include the following topics: ANC (indicators—share of women taking IFA; percentage of women referred to hospital; percentage of women with anemia, percentage of women receiving treatment for anemia); nutrition during pregnancy (indicator—percentage of women who participated in nutrition sessions); family planning (indicator—share of women using contraceptives); child (mal)nutrition (indicators—percentage of CU5 who undergo anthropometric measurements; percentage of underweight children); infection control at HF; increase in the number of HWs who got certification (indicator—number of trained HWs); increased knowledge of population on health and nutrition, JDM in HF catchment areas (indicators—number of sessions conveyed by CHT and HWs); increased knowledge of the population on patient's rights (indicator—number of submitted statements/applications about quality of healthcare services from patients).

current situation at the HF level, providing data for decision-making, and planning for future improvement of healthcare services.

“[The] QI Plan should be different in each district and based on [the] real situation at [the] district health facility, while QI meeting reports should be practical and track implementation. This is not the case right now.” – KII with the Government at the national level

Further, there are some districts where CDHs and PHCs are not coordinating at all. Therefore, HMHB just started the work of combining the QI Committees at the hospital and PHC levels into one QI Committee—to create a common approach to resolving MNCH problems. The results of this work are still to be realized.

Skills development

The pre-service educational programs for medical doctors and pre- and post-service training for family doctors and nurses already have been institutionalized by the medical educational institutions—which will further strengthen the capacity of future HCWs. NRCs and the Resource Center for Nutrition and Evidence-Based Medicine have a high degree of sustainability as they were established either within the healthcare system or academia. Meanwhile, the CME coverage needs to be strengthened—especially among HCWs from numeric hospitals and institutionalization of the SBC curriculum for schools should be further promoted.

Document review and interviews (KIIs=5) demonstrated that the updated pre-service educational programs for medical doctors were approved by the MOHSPP and the Ministry of Education (MOE) and were introduced to the curriculum of nutrition-related departments for post-graduate and PhD students at TSMU. Meanwhile, pre- and post-service training curriculums for family doctors and nurses were updated with inclusion of the nutrition-related topics (36 hours for the third course and 24 hours in the fourth course syllabus) and approved by the Republican Medical College.³⁶

Respondents noted (KIIs=4) that HMHB assisted the TSMU to establish the Resource Center for Nutrition and Evidence-Based Medicine. Thanks to this center, the university staff and students can access and search for evidence-based medicine information, materials, and training programs.

“TSMU staff and students can visit this center and learn about new curricul[a] [and] updated guidelines [that are] not only national but also from other countries ... We do see the high level of effectiveness of this center.” – KII with the Government at the national level

In interviews with key informants (KII=1), it was confirmed that the resource center will be an integral part of the university research library in the long run, and the cost of running of this center can be covered by TSMU.

Respondents (KIIs=6) have indicated that HMHB has developed a curriculum on nutrition, gender, hygiene, and COVID-19 prevention for schoolchildren in grades 8–10³⁷ which was approved by the working group of the DOE for the Khatlon region and currently has been piloted in eight targeted schools. There are plans to introduce the curriculum in another 16 schools in the HMHB districts.³⁸ If the pilot is successful, the DOE of the Khatlon region plans to replicate it in other schools of the region. Nevertheless, one of the interviewees mentioned that it is important to expand this initiative—not to the other schools but, rather, institutionalize it within the school curriculum at the national level to ensure the continuous learning by schoolchildren of the basic principles of proper nutrition, a healthy lifestyle, and gender equality.

³⁶ Background information: The pre- and-post service training programs are approved by MOHPSS and MOE once every three and five years, respectively. Therefore, the updated curricula were approved by the Republican Medical College as the educational plan is approved by them annually at the beginning of each academic year.

³⁷ Background information: The educational materials were developed based on a desk review of all existing materials for schoolchildren by the HMHB Nutrition and WASH specialists. Those materials that met the HMHB goals and objectives were collected into one curriculum.

³⁸ Note: In total, 24 schools are planned to be covered during HMHB (i.e., two schools in each HMHB pilot district).

As evident from interviews with stakeholders (N=7) the NRCs have been already institutionalized within the HFs—both at the hospital and PHC levels. As it was mentioned earlier, most of the NRCs were established either within THNA or even earlier; and although there was a gap between THNA and HMHB for a year, 90 percent of NRCs have maintained their staff and equipment. The other 10 percent of NRCs have missed the equipment, and HMHB had to replace it. The premises for the NRCs are provided by the HFs.

Regarding the trainers, they are appointed by the CDH or PHC managers and their salaries are covered by the HFs. They have a base salary plus 0.75 of the base salary as a trainer. Also, four out of 12 HMHB districts are paying the additional funds to the trainers from the hospital funds. Healthy Mother, Healthy Baby provides only small incentives to the trainers, i.e., a payment of TJS 500–600 per month for data collection and provision of CME data to the Activity. Moreover, during COVID times, all telemedicine appointments and conferences with MOHPSS were done by HCWs from NRCs. The NRCs were also used for the COVID-19 vaccination rollout by the sister LHSS project.

“NRCs are functioning from the previous project (THNA); some trainers are also from that project. They will continue to be sustainable if HFs managers are interested in it.” – KII with the Government at the national level

However, the NRCs’ capacity in delivering proper CME must be further strengthened—especially for the training process (approaches and teaching methods) and trainers’ skills. The results of the NRCs’ training quality assessment conducted by HMHB in Y1³⁹ shows that the quality of the training process was dissatisfactory (24 percent out of 100 percent), and trainers’ skills were only somewhat satisfactory (44 percent out of 100 percent)—while the training room equipment was satisfactory (75 percent out of 100 percent).

“In principle, NRCs’ trainers are competent, but in most cases, they do not have good facilitation skills.” – KII with IP

Although HMHB has increased the coverage of HCWs with CME to 79 percent (from 3,662 in Y1 to 6,006 in Y2), the coverage of HCWs by NRCs with on-the-job training on MNCH&N topics is 53 percent at the hospital level and 47 percent at the PHC level in 12 HMHB target districts as of 2022.⁴⁰

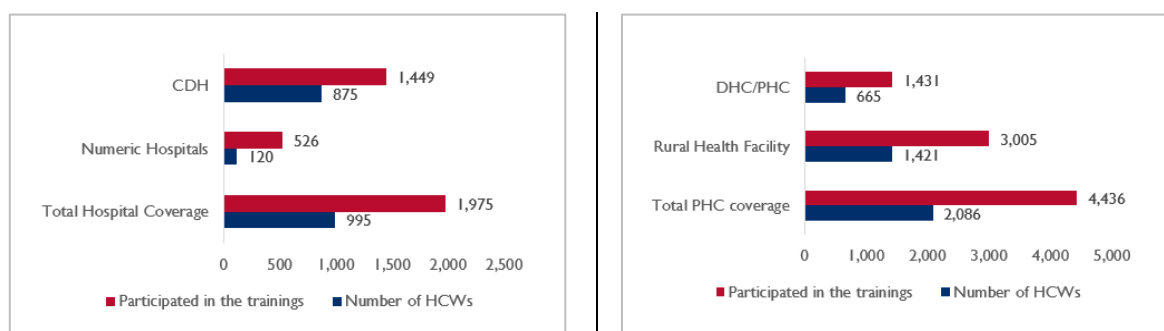


Figure 34. Coverage of HCWs through NRC trainings in 12 HMHB target districts

Source: HMHB Annual Report Y2

Information gleaned from the desk review reveals that there is still a low level of enrollment in CME by the HCWs of the numeric hospitals (i.e., 26 percent vs. 60 percent of HCWs from CDHs⁴¹). Key informants (KIIs=4) further noted that the Khatlon region remains the leader among other regions of Tajikistan in bleeding, severe preeclampsia, and eclampsia during pregnancy. Moreover, due to high turnover among trained staff, HCW capacity improvement requires continuous attention. Therefore, further work on increasing the CME coverage is still needed in HMHB target districts.

³⁹ Source: HMHB Annual Progress Report for Y1, p. 42

⁴⁰ Sources: AMEE Dashboard, CME coverage, HMHB Annual Progress Report for Y2, p. 67

⁴¹ Source: HMHB Annual Progress Report for Y2, p. 66.

“HMHB needs to pay more attention [to] training of HCWs from peripheral health facilities (nurses, feldshers), as they are contacting with [sic] families every day.” – KII with the Government at the national level

Supportive supervision (SS) and mentoring have a high degree of continuation after the end of HMHB as this is one of the MOHSPP's priorities.

“We are working on strengthening the work in the direction of supervision and mentoring, because due to staffing problems, this approach gives real results.” – KII with the Government at the national level

Social and Behavior Change Communication (SBCC)

The selected SBCC approach by HMHB has a high prospect of sustainability as build-up under the government framework of community involvement in health issues continues. The area which requires further strengthening is the capability of the Healthy Lifestyle Centers at the district and regional levels to take full ownership of the SBCC results.

As is evident from the document review and interviews with key informants (KIIs=8) on the stage of development of the project's SBCC model, HMHB agreed with all project stakeholders that it will be based on MOHSPP's Guideline on the Partnership with Communities on Health Issues (GPCHI).⁴² The Republican Healthy Lifestyle Center developed GPCHI in collaboration with development partners, and it is required to be implemented at the country level. The guidelines specify that the PHC and HLSC structures are the lead agencies in working with communities on health issues. The approach is based on integrating PHC with CHTs, building their capacity through training and mentoring, and providing informational and educational materials. Therefore, CHTs were formed by HMHB in its target districts in line with the GPCHI approach—based on close collaboration and interaction between PHCs (including family doctors), HLSCs (state institutions), and the community (CHTs)—which contributes to better local ownership.

“HMHB is trying to form CHTs, which will stand to advocate and educate both healthcare system providers and communities.” – KII with IP

“CHT members do not get any financial incentives from HMHB, but what is very important [is] that we receive knowledge which we can use and disseminate further.” – FGD with CHTs

However, the capabilities of HLSCs at the district and regional levels must be further enhanced due to staff turnover. It particularly relates to four of the 12 districts (Dusti, Jomi, N. Khusrav and Khuroson) as well as the regional HLSC—as is evident from evaluation interviews (KIIs=9).

Digitalization

HMHB applies a multi-faceted approach for ensuring sustainability of its interventions focused on digitalization. The Activity progressed a lot in promoting replication/scale-up of its digital tools among the donor community; however, ownership is limited at the national and community levels due to low digital literacy and lack of resources for continuing usage of developed digital tools and apps after the end of HMHB.

In a review of the desk material and interviews with the IP and key stakeholders (KIIs=6), it was generally agreed that HMHB is taking steps to ensure sustainability of its efforts on digitalization. At the national level, HMHB set up the server at the Republican Center for Medical Statistics and Information (RCMSI) so that all data coming to CommCare are located at MOHPSS and are under the DHIS2 platform.

Two RCMSI specialists were trained on database maintenance and information tracking. HMHB provided access to AMEE system for all managers at the district, regional, and national levels. Access to AMEE (DHIS2) dashboards should allow HF managers to conduct regular internal monitoring of indicators for QI Committees and to analyze changes and timely take any necessary corrective measures. Moreover, all applications were developed according to national guidelines and standards.

⁴² Background information: GPCHI was approved by Order 153 of MOHSPP on March 9, 2017.

For example, the MNCH v1 CBE application fully reflects the indicators of GPCHI, while the MNCH v2 (ANC and PNC) application displays all data according to the ANC standard. In the future, the plan is to include the data on perinatal and neonatal mortality in this application.

At the community level, HMHB distributed smartphones, together with SIM cards and internet access, to facilitators (PHC-level HCWs) to digitally gather data on community-level behavior change activities. It also conducted a series of training sessions for the HCWs on the developed digital applications and the AMEE system. During FGDs with trainers and facilitators (FGDs=8), they emphasized that digital apps simplify a lot of the reporting and allow for quickly obtaining the data on CME or CBE events. At the donor level, HMHB developed the digital tools which the donor community can use and scale up.

HMHB, together with USAID, is a part of the technical working group on the Digital Donor Coordination Council (DCC), which helps GOT to map how to implement the digital ecosystem in the health sector. The Activity gave access to the AMEE system to all members of the Digital DCC so the donors can see how the system works and how it could support the implementation of health interventions. Input from key informants (KIs=7) suggests that GiZ is interested in using the MNCH v2 (ANC and PNC) application and MNCH v3 (child growth monitoring) application. WHO plans to use the RHFA digital tool in other districts, and WB is considering usage of the CME application and MNCH v1-v3 apps. Moreover, UNICEF has included the HMHB concept in its Bepo app,⁴³ which now has been introduced worldwide.

“We are very interested in replication of digital apps and tools developed by HMHB ... We like a lot ... how AMEE works and allows [us] to quickly obtain the data online without any calls and requests to share the data.” – KI with development partner

Nevertheless, it is important to recognize that HMHB has quite ambitious goals for digitalization—as building a digital literacy mindset takes time. The Activity’s remaining time might not be sufficient for seeing a shift in the mindset of HCWs and managers because of very low digital literacy in Tajikistan.

“Digital technologies [and] the CommCare program are effective, as their implementation contributes to the rapid and reliable receipt of information. But it takes time for HCWs to learn how to professionally use smartphones and digital apps.” – KI with Government at the national level

The level of usage of AMEE and apps by HF management is still limited, as is evident from interviews with health providers and IPs (KIs=10). Further, it is challenging to ensure local ownership when all official reports in healthcare are paper-based and there is a need for HCWs to duplicate the data in paper forms and in digital format. Evaluation interviews (KIs=3) indicated that further usage of data by the RCMSI will depend on the availability of funding and IT staff for its further maintenance. In addition, GOT has a challenge relating to HIS. It has an older generation of DHIS and needs substantial investments to update it and extend it to the village level—as now it covers only the national, regional, and district levels.

Moreover, because HMHB covers only 12 districts in one of Tajikistan’s regions, ensuring usage—at the national level—of data collected from the developed apps by HMHB requires replication to the other districts and regions of the country. It will also take time and require considerable financial and human resources, which are not available from MOHSPP.

Clinical Protocols and Guidelines (CPGs)

During the first two years of implementation, HMHB was more focused on supporting implementation of previously endorsed CPGs by MOHSPP at the hospital and PHC levels rather than supporting the revision/development of new CPGs.

As is evident from the document review and interviews (KIs=5) in the first two years of implementation, HMHB has supported the revision and update of two guidelines and standards on

⁴³ Background information: This is a free app developed by UNICEF and national partners to lend a helping hand to parents—with easy parenting tips on topics like breast pumps, baby weaning, learning, toys, child protection, etc. The Bepo app is available across 12 countries in Europe and Central Asia.

MNCH&N at the national level based on MOHSPP's requests. These are: (i) the Terms of Reference (TOR) for Family Nurses⁴⁴ which expands the family nurses' responsibilities for nutrition counseling and care of malnourished children and anemic pregnant women, and (ii) the IYCF National Guidelines—including counseling for mothers during ANC, teaching them about complementary feeding, and introducing meat and eggs at six months to meet children's nutritional requirements.

Interviews with the government stakeholders (KII=3) indicate that TOR for Family Nurses was approved by MOHSPP in December 2021. Meanwhile, the revised IYCF National Guidelines successfully passed MOHSPP's approval process—and now this guideline, together with the developed training package,⁴⁵ is an official training tool to be used during trainings at all levels.

“HMHB revises the CPGs and the MOHPSS use[s] them for training of healthcare workers.... They do not sit on the shelves [sic].” – KII with the funder

According to interviews with key project informants (KII=14), HMHB supports implementation of 10 CPGs on MNCH&N—which were previously revised and approved by MOHSPP in the THNA framework. Key informants (KII=4) noted that HMHB thus far is not very active in revising CPGs, in comparison with THNA. This can be explained by the fact that the work on CPG development, revision, and/or updating is done by the Activity through the MNCH Council led by the Deputy Minister of MOHPSS—in line with the national timetable for CPG review.

Currently, there is an ongoing process of revitalizing the National Technical Working Group (NTWG). It is anticipated that the NTWG will be formed in 2023; and HMHB, together with WHO and GiZ, will support this NTWG for CPG revision. Also, the CPGs should be revised every five years according to WHO recommendations or initiation of new global protocols and/or standards. Because all 10 previously revised CPGs on MNCH&N are still active and the time for their revision has not yet come, HMHB supported revision of only two CPGs during 2021–2022. One of the interviewees noted that, overall, the situation with the CPGs (except HIV/TB) is better than in other sectors (e.g., traumatology, neurosurgery, and neurology), as the MNCH&N sector is donor driven.

At the same time, a few informants (KII=2) stated that there needs to be a thorough review of existing CPGs for two reasons: 1) a basic service package is not yet fully improved, and 2) unnecessary hospitalization⁴⁶ is still widespread—which leads to unnecessary out-of-pocket payments.

“Too many standards are not helpful [either] ... Taking into account the current situation in the health sector of Tajikistan with [the] basic healthcare package, maybe it would be better to create just a package of life-saving standards.” – KII with the development partner

Moreover, the interviewed health providers at district level (KII=6) mentioned that during the revision of clinical protocols and standards on MNCH&N, it is important to account for local conditions and possibility for their implementation.

“We cannot implement everything which is done in other developed or developing countries ... Each district should have flexibility to adapt the implementation of CPGs to the local situation.” – KII with health managers at the district level

During FGDs with health providers (FGDs=8), they highlighted that (a) there is a lack of printed standards on nutrition and breastfeeding as well as pocket guides (e.g., Standard 1104) for medical workers at the PHC level, and (b) there are several CPGs which either need to be developed (e.g., protocols of treatment of pregnant women with kidney problems, diabetes, endocrinological diseases, noncommunicable diseases, and pregnancy) or revised (e.g., standards on induction and preinduction of labor, and bleeding).

⁴⁴ Background information: The last update of the regulatory documents on family medicine that include Qualifications and Regulations on Family Physicians and Nurses was done in October 2005.

⁴⁵ Background information: The training package includes all components of IYCF (EBF, complementary feeding, treatment of SAM, and GMP—which are in line with MOHSPP Order 873 on child patronage system of children from 0 to 24 months, including PNC.

⁴⁶ Background information: Bed occupancy rates in Tajikistan are 66.4 percent, with an average length of stay of nine days; this points to significant scope for efficiency gains. Source: Health-related SDG targets in Tajikistan: implementation of policies and measures to achieve the SDG health-related targets. Copenhagen: WHO Regional Office for Europe; 2020.

To improve the accessibility of national standards and guidelines on MNCH&N, HMHB has created an online Knowledge Hub (KH) at the MOHSPP website, where 130 documents were uploaded—including all existing nationally approved MNCH and nutrition standards, clinical protocols, and guidelines.⁴⁷ Thanks to HMHB's interventions and promotion of the KH among HMHB stakeholders and beneficiaries, the number of visitors of the KH page has increased significantly—as is evident from traffic data, *i.e.*, from 25,732 unique visitors to the KH webpage as of the end of September 2022 to 82,295 unique visitors as of early January 2023.

At the same time, interviews and FGDs with health providers (FGDs=8; KIIs=9) indicated that the level of usage of KH is still limited by interviewed HCWs in HMHB target districts due to bad internet connectivity at the local level, problems with downloading data from KH, and difficulties in navigating KH—particularly in filtering down and finding the needed data. Moreover, HMHB provides monthly technical support for the MOHSPP website maintenance and KH—and from interviews with GOT (KIIs=2), it is unlikely that MOHSPP can cover KH maintenance costs on its own after the end of HMHB because of budget constraints.

BARRIERS TO SUSTAINABILITY

Main barriers that might hamper the sustainability of HMHB interventions are systemic health-sector issues—including limited health system financing, the shortage and migration of HCWs, and high out-of-pocket payments.

In addressing the issue of sustainability, several external factors come into play that impact whether the Activity can be sustained—and many stakeholders, including beneficiaries, were aware of these. Everyone interviewed across the board mentioned the following system-level problems existing in the national health system of Tajikistan which influence the sustainability of health interventions like HMHB:

- **Healthcare financing:** Public spending on healthcare has grown rapidly over the past decade in Tajikistan, but at \$18 per person per year, or 2.2 percent of Gross Domestic Product (GDP), health spending falls far short of the US \$40 to \$80 per capita needed to provide basic health coverage.⁴⁸ Moreover, public funding accounts for only one-quarter of total healthcare spending in the country. Consequently, Tajik households shoulder most of the healthcare costs. According to WHO data, there is still a markedly high rate of out-of-pocket payments, which accounted for 71.2 percent of health spending in Tajikistan in 2019. The Tajik health sector suffers from inequitable and inefficient financing practices. The current system remains biased toward hospital care, leaving PHCs underfunded and underdeveloped. The budget for PHC facilities in urban areas is calculated at TJS 67 per capita per year, and the budget for PHC facilities in the district areas is calculated at TJS 54 per capita per year, which is distributed to local governments. However, 95 percent of this budget is currently spent on the salaries of health personnel.
- **Human resources for health:** Despite the overall increase in the number of human resources for health, there are significant inequalities in geographical distribution within the country. The largest proportion is in Dushanbe, with 8.25 doctors per 1,000 population, while in Khatlon Oblast there are only 1.15 doctors per 1,000 population. Also, in the Khatlon region, the doctors work at 0.25 rates; and in rural areas, there is a shortage of personnel. Moreover, Tajikistan has a shortage of doctors in certain specialties like Obstetrics and Gynecology (OB/GYN), pediatrics, neonatology, and family medicine. Out-migration of healthcare professionals is one of the causes of the shortage of qualified human resources. According to

⁴⁷ Background information: In total, 12 CPGs on safe motherhood, infection prevention, clinical safety, emergency care for mothers and newborns, the management of physiological and complicated deliveries, antenatal care, and the management of obstetrics cases with COVID-19 complications, national guideline on treatment of children with moderate and acute malnutrition, and accreditation standards for hospitals and PHCs were placed on the KH.

⁴⁸ Source: Tajikistan Public Expenditure Review, "Strategic Issues for the Medium-Term Reform Agenda (PI72237)," World Bank, December 2021.

the Minister of MoHSPP, in the first six months of 2022 alone, 674 doctors and 1,350 nurses left Tajikistan for labor migration.⁴⁹

“At the moment, the issues with staffing and the capacity of health workers remain the most acute problems.... In [the] Khatlon region, the staffing policy as a whole suffers due to the shortage or uneven distribution of personnel.” – KII with the Government at the national level

4.1. CONCLUSIONS

EQ1: To what extent has the activity met the needs of target beneficiaries and increased access to and improved the quality of the MNCH&N services?

HMHB is well aligned with government priorities and local needs. It evolved to better target key gaps identified in the 2019 THNA final performance evaluation. HMHB is also relevant to international MNCH&N goals. The evaluation found that HMHB has been achieving results in improving access to and quality of MNCH services in target districts—including an increase in the early registration of pregnant women and quality of first ANC, improvement of PNC services, increase in identifying malnourished children, improving the management and effective treatment of main children's infections, and promoting accreditation of hospitals. Overall, USAID MNCH programming has contributed to improvements in child mortality (infant and children under five)—although maternal, neonatal, and perinatal mortality remains a challenge in FTF ZOI.

EQ2: To what extent has the activity improved the diets of pregnant and lactating women, and CU2 years of age, throughout the year—and why or why not?

So far, HMHB has contributed to improving knowledge of maternal and child nutrition, while change in behavior is still to be seen. HMHB started its SBCC activities just in early 2022, and more time is needed to see the results at the beneficiary and household levels. Moreover, access to nutritious food is not yet available in the country as food fortification of wheat flour has not yet started. Meanwhile, mobilization of resources to expand priority MNCH and nutrition interventions has not yet begun. Intake of multiple-micronutrient supplementation is still a challenge due to the stoppage of free-of-charge supply of iron and folic acid supplements for pregnant women. Anemia prevails among mothers and children, and the need was identified for more emphasis on an integrated, multi-sectoral approach to further address determinants of health.

EQ3: To what extent are the implemented activities sustainable beyond the activity timeline? Were (activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in the FTF ZOI? And were there barriers?

HMHB incorporates measures to support sustainable results of its interventions. The Activity works through the health system to ensure sustainability and collaborates with a variety of stakeholders (health authorities at the national, regional, and local levels; and relevant state authorities, academia, development partners, and other USAID-funded projects) on digitalization, fortification, and MNCH&N activities to ensure synergies and avoid duplications. However, many HMHB results could be at risk without ongoing donor support (e.g., digitalization, social behavior change, quality improvement, and CME). This is in part due to challenges at the country level, such as limited government commitment to fund health budgets and low technical and human-resource capabilities. It can take 10 years or more to see the results of health system strengthening efforts—thus highlighting the need for longer timelines for project implementation.

4.2. RECOMMENDATIONS

Based upon an analysis of the triangulated data, the ET provides the set of recommendations for the remaining timeframe of HMHB as well as beyond HMHB.

⁴⁹ <https://cabar.asia/en/tajikistan-migration-of-doctors-grows>

WITHIN HMHB

Quality Improvement (QI)

QI interventions cannot be time limited and donor driven. They must be institutionalized and sustained by national programs to strongly signal to providers that quality care is not optional. This can be done in multiple ways, some of which were introduced and piloted by HMHB. But these need to be scaled to national level through:

- Providing technical assistance to MOHSPP in the development of the QI package (policy, key implementing guidelines, assessment tools)
- Continuing advocacy and support in revitalizing the Perinatal Audit (PA) process (PA committee, developing PA audit tools, data analysis, and decision-making) together with WHO and UNICEF.

Despite the establishment of QI Committees, there is still a need to strengthen the capacity of district health authorities⁵⁰ to oversee the QI process and QI Committees—particularly in planning, developing M&E frameworks, monitoring their implementation, and using RHFA results for developing QI plans.

Accounting for the importance of the QI process, it is suggested that the HMHB and USAID advocate for pushing QI into pre-service and continuing professional development for broad access. Quality improvement training needs to be pushed into the pre-service curricula so that it becomes embedded in the HCWs' skill sets. Early training in HCW careers will reap dividends for patients and the workers themselves as they see their ability to bring needed changes enhanced.

To date, HMHB has focused on accrediting hospitals. It is recommended that providing technical support to the QI process and creating minimum conditions for accrediting selected PHC institutions in HMHB target districts be accelerated.

Staff turnover and retention are the biggest challenges to sustaining quality-of-care improvements generated by HMHB. Sustaining staff motivation can be facilitated by a non-monetary incentive system. The short-term incentives (e.g., recognition program, and inter-facility and departmental competition through NRC sessions) and longer-term incentives (e.g., continuous education certification; recognition letter linked to future promotion opportunities; small facility improvements based on assessed need, etc.) for facilities and individuals may better motivate staff and help with staff retention and turnover challenges. As HMHB already is conducting several activities on short-term incentives, the Activity should consider further emphasizing the piloting of longer-term incentives.

Clinical Protocols and Guidelines (CPGs)

Recommendation: Continue advocacy and support in the further development and/or revision of national guidelines, protocols, and standards—in line with the latest WHO recommendations—as well as monitor results:

- Provide technical assistance, in coordination with development partners, for effective operationalization of MNCH&N NTWG on revising existing national guidelines, protocols, and standards or develop a new set of protocols/standards (e.g., induction and preinduction of labor, Noncommunicable Diseases [NCD]-diabetes), and pregnancy, and newborn survival package [Effective Perinatal Care (EPC)/neonatal resuscitation/essential newborn care/live birth definition]).
- Provide support in monitoring and evaluating the CPGs' implementation through establishing an M&E team, developing monitoring tools, and providing training on monitoring and data analysis.

Recommendation: Update the National Supportive Supervision (SS) Guideline, including child health and nutrition, for quality of health care and training of key staff on SS at the national and regional levels:

⁵⁰ Background information: The role of district health managers (hospital and PHC) is to facilitate the adoption of QI principles at the district and HF levels and providing ownership and sustainability of the QI process.

- Support TWG in revising the existing National Supportive Supervision Guideline with an additional focus on nutrition, dietary diversity, and PNC in line with MOHSPP Order 873 on patronage of the CU2 years.
- Provide support in conducting SS and discuss the results for decision-making.

Skills Development

Continue implementing high-quality interventions that reflect the cross-sectoral strengths that HMHB brings. Training, materials, sensitization campaigns, and work addressing structural barriers have all won praise; and the focus on quality and the holistic approach should be maintained. However, if training remains a focus, an increase in monitoring training quality and outcomes should be included in HMHB's activities. Possible ways of doing this might include the following:

- Introducing pre- and post-knowledge tests in all in-service and CME trainings to ensure consistent measurement of the effectiveness of HMHB's capacity-building activities.
- Documenting the change in use of services after training HCWs in HFs through in-service and CME training. For example, describe how the training of X personnel to a Y skill level increased the level of care available at Z percent of facilities from a B care level (e.g., basic obstetric care) to an A care level (e.g., comprehensive obstetric care)—and, consequently, how the use of services increased the monitoring and implementation of updated curricula on nutrition in medical educational institutions.

Effective leadership and governance are essential to a robust health system. Strong commitment, capacity, and accountability at all levels of government are required to improve nutrition and health outcomes. Therefore, it is suggested to intensify the capacity-building of key decision makers and administrators (health managers) at the national, regional and district levels by (i) strengthening their managerial, decision-making and analytical capacity on MNCH and digital skills (short-term), and (ii) setting up managerial courses (evidence-based planning, budgeting, and monitoring) in coordination with the Postgraduate Training Institute (long term).

Involve all district supervisors assigned by MOHSPP in online and offline trainings, discussions, and training events on near-miss cases and clinical audits within WHO BTN, in cooperation with the HMHB facilitator.

Continue to provide technical assistance to medical educational institutions with timely integration of newly endorsed CPGs into in-service and post-graduate teaching curricula.

SBCC

Advocate for institutionalizing SBC on healthy lifestyle choices, nutrition, WASH, and gender equality in school curricula jointly with UNFPA and UNICEF.

BEYOND HMHB

Overall

Recognizing how closely intertwined nutrition and family planning and reproductive health are, it is recommended that USAID consider bringing together its portfolios on maternal, child, and newborn health; nutrition and family planning; and reproductive health. Also, the use of modern contraceptives among Tajik married women aged 15 to 49 years was reported as 29.3 percent in the 2017 Demographic and Health Survey, which is largely unchanged from the value of 27.1 percent reported in 2012. It is also relatively low compared to other Central Asian countries such as Kazakhstan, Kyrgyzstan, and Turkmenistan—where the use of contraceptives ranged from 40 to 50 percent. In addition, evidence suggests that spacing pregnancies (not births) three years apart is the fertility behavior associated with the greatest reduction of under-five mortality.⁵¹

⁵¹ Source: International Food Policy Research Institute. 2014. Global Nutrition Report 2014: Actions and Accountability to Accelerate the World's Progress on Nutrition. Washington, DC.

Therefore, integrating nutrition and family planning not only makes sense from a delivery efficiency perspective, but doing so may drive mutually reinforcing health outcomes as well. By integrating nutrition into family planning programs, healthier pregnancies and birth outcomes—and reduced rates of stunting, wasting, and infant/child/maternal mortality—can be achieved.

Quality Improvement (QI)

Taking into consideration systemic health issues that might influence the sustainability of HMHB results, USAID—jointly with other donors and development partners—should continue advocacy at the national level for sustainable health financing in Tajikistan. In particular, following the examples of other Central Asian countries (e.g., Kyrgyzstan, Kazakhstan), improving the distribution of resources and transitioning from an infrastructure based on centrally allocated funding to a per-capita and performance-based system, as well as scaling up the coverage of the Basic Benefit Package and the State Guaranteed Benefit Package, is likely to bring significant results.

USAID should facilitate joint advocacy with MOHSPP for budget allocation for procuring essential medicine for mothers and children at the hospital and PHC levels.

Access to nutritious food

USAID should consider enhancing advocacy for integrating SUN into the existing National Council on Food Safety and Security (chaired by the Prime Minister), which mobilizes domestic and external funds for implementing SUN activities and the food fortification initiative of the country—jointly with USAID and in coordination with development partners. This will improve the implementation of the National Multisectoral Plan of Action for Nutrition for 2021–2025 and the Action Plan of the National Program for the Prevention of Micronutrient Deficiency and Diseases (associated with it in the RT) for 2022–2027.

ANNEXES

ANNEX I. EVALUATION STATEMENT OF WORK

EVALUATION RATIONALE

Evaluation Purpose and Intended Uses

The purpose of this Task order is to procure a midterm project performance evaluation for the Healthy Mother, Healthy Baby Activity (HMHB), under the Feed the Future Zone of Influence (FtF ZOI) in Khatlon province.

The midterm performance evaluation aims to assess the continued relevance of an intervention and the progress made towards achieving its planned objectives. It will provide an opportunity to make modifications to ensure the achievement of these objectives within the life of the project. The evaluation also provides which of the project's interventions are working well and which are not and what has been accomplished against the intended results.

The outcomes of the performance evaluation, lessons learned and challenges will be shared with different stakeholders including the Ministry of Health and Social Protection of the Population (MOHSPP), USAID mission, the HMHB Implementing Partners, and will be posted on the DEC (Development Experience Clearinghouse) for public access within 90 days of report completion. The dataset of the evaluation will be uploaded into the USAID Development Data Library (DDL).

Evaluation Questions

Evaluators will review and finalize questions in collaboration with USAID prior to finalizing the evaluation design.

Activity *relevance*:

To what extent has the activity met the needs of target beneficiaries (mothers, household members, health providers, etc.) and increased access and improved the quality of the Maternal, Newborn, & Child Health and Nutrition services including nutrition, sanitation, and hygiene services in the Zone of Influence, particularly in the first 1000 days?

Activity *effectiveness*:

To what extent has the activity improved the diets of pregnant, lactating women and CU2 years of age throughout the year, and why or why not?

Activity *efficiency*:

To what extent implemented activities are sustainable beyond the activity timeline? a) were (activity-supported) evidence-based guidelines and procedures institutionalized by the health systems in the FtF ZOI? b) And were there barriers?

Going *forward*:

Is there anything else the activity can prioritize in the remaining two years within its SoW to improve the health and nutrition status of mothers and children in FTF ZOI.

EVALUATION DESIGN AND METHODOLOGY

The evaluation team, in collaboration with USAID, will finalize the evaluation methods before fieldwork begins. The data collection methodology will include a mix of tools appropriate to the evaluation questions and include a document review, in-depth interviews with the key stakeholders, surveys and focus group discussions with beneficiaries.

USAID expects that, at a minimum, the evaluation team will:

- Upon award, familiarize themselves with documentation about the project and USAID's current assistance in the health area in the region. USAID will ensure that this documentation is available to the team prior to their arrival in the region.
- Review and assess the existing performance and effectiveness information or data.

- Conduct site visits for field testing survey instruments (when applicable and feasible).
- Meet and interview USAID project beneficiaries, partners, and host government counterparts at appropriate levels (when applicable).
- Interview USAID staff and a representative number of experts working in the sector.
- Spend approximately 4 to 6 weeks in the region carrying out this SOW.

The desk review includes at a minimum:

- USAID activity SoW.
- Activity materials: Annual and Quarterly Reports, Annual Work Plan, MEL Plans, sector assessments, trip reports, performance reports, gender analyses, relevant sections of the Project Appraisal Document, and miscellaneous thematic reports from other sources.
- Tajikistan Country Strategic Framework
- Performance Management Plan

The contractor will submit the preliminary evaluation design in response to the Request for Task Order Proposal (RFTOP) for review by USAID. The Evaluation Task Order Contracting Officer's Representative (TOCOR) will approve the finalized evaluation design two weeks or more prior to the team's arrival in the country.

The evaluation design matrix should include a data analysis plan for each evaluation question. Requests of the offeror can include explicit description of major limitations in data collection and analysis.

EVALUATION MANAGEMENT

Logistics

The contractor will be responsible for all logistical support of the evaluation activities, including translation/interpretation, accommodation, meeting and site visit arrangements, office space, equipment, supplies, insurance and other contingency planning. The contractor must not expect any substantial involvement of the USAID staff in either planning or conducting the evaluation. Upon request, USAID/Tajikistan mission will provide the contractor with introductory letters to facilitate meeting arrangements. USAID/Tajikistan Mission requests that any forthcoming American and local Tajik holidays be considered in scheduling evaluation meetings, group discussions, surveys, and site visits in Tajikistan.

The evaluation TOCOR may observe some of the data collection efforts. USAID may also delegate one or more staff members to work full-time with the evaluation team or to participate in selected evaluation activities. The evaluation TOCOR will inform the contractor in writing about any full-time or part-time USAID delegates no later than 5 (five) working days after the submission of a draft evaluation work plan. USAID will pre-define any staff's level of involvement by indicating the purpose of their inclusion, their role on the team and in which components of the evaluation they will participate, their expertise in the topic or sector, and their expertise in evaluation design or implementation. USAID maintains primary responsibility for management of its own staff. USAID will outline collaboration, delivery, and performance expectations for its staff as well as reporting lines and how staff management roles and responsibilities will be coordinated between USAID, the contractor, and the evaluation team lead. This plan will be finalized in consultation with the contractor and the evaluation team lead, with final approval by the TOCOR to ensure it is feasible and appropriate to the evaluation objectives and Health unit of the Tajikistan Mission needs and that it addresses mitigation of risk of impeding evaluation implementation or biasing findings. All costs associated with the participation of full-time or part-time USAID delegates in the evaluation will be the responsibility of USAID.

ANNEX II. EVALUATION SCHEDULE

Evaluation Phases	Event/Deliverable	Date(s)	Notes
Inception Phase <i>(November 1-December 6, 2022)</i>	Kick-off meeting with USAID	8 November 2022	Virtual
	Kick-off meeting with IP	15 November 2022	Virtual
	Draft Evaluation Workplan	18 November 2022	-
	Final Evaluation Workplan	6 December 2022	-
Data Collection and Analysis Phase <i>(December 7, 2022-January 19, 2023)</i>	In-Brief with USAID	12 December 2022	Virtual
	Field mission in Tajikistan (KIs and FGDs)	12-27 December 2022	In-country
	Field mission in Tajikistan (KAP Survey)	12-23 December 2022	In-country
	Out-Brief with USAID	9 January 2023	Virtual
	Recommendations Workshop with Stakeholders	19 January 2023	Virtual
Reporting & Synthesis Phase <i>(January 20-March 3, 2023)</i>	Draft Evaluation Report	7 February 2023	-
	Final Evaluation Report and PPP	2 March 2023	-
	Presentation of final evaluation report to USAID	3 March 2023	Virtual

ANNEX III. DATA COLLECTION TOOLS**Key Informant Interviews****Interview Guide for USAID**

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of interview
-		-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time
-		-	-	-
#	Interview questions			Responses
Introduction				
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).				
-				
Questions related to EQ I				
Q1	In your view, does the HMHB allocate activities according to priority needs of target beneficiaries (mothers, household members, health providers, etc.)? Are there important factors outside of the project's control that are or will impact on the effectiveness of project efforts?			
A1	-			
-	As a result of work done by HMHB activities during Y1-Y2, have you noticed any improvements in improving access to and/or utilization of maternal, newborn, and child health (MNCH), and nutrition of mothers and children in HMHB target districts especially with regard to the "1,000 Days Strategy"? Please give examples.			
A2	-			
Q3	What are barriers to changing health provider practices? Has the activity done anything to address these barriers?			
A3	-			
Q4	Are there other donors or programs working with the same health providers in MNCH and nutrition? If yes, does HMHB coordinate activities for synergies and cost efficiencies?			
A4	-			
Q5	To what extent have women been empowered to act in support of health behaviors and interventions in HMHB target districts? Please give examples.			
A5	-			

Questions related to EQ3	
Q6	Did HMHB experience challenges working on national-level policy change while simultaneously working in remote rayons in Khatlon region?
A6	-
Q7	In overall, what do you think is the perception of GOT ministries responsible for services supported by HMHB and GOT counterparts to plan, design, implement, manage, monitor, and evaluate health programs at the national, regional, and district levels? (Please be specific.)
A7	-
Q8	For activities that have been established, how many do you think will be sustained after the HMHB project ends? Are there measures that HMHB can take to promote sustainability or scale-up of successful strategies?
A8	-
Recommendations	
Q9	What can be done to increase further the impact of activities of HMHB on nutritional outcomes, diet diversity, child health and feeding behaviors, and health care-seeking behaviors?
A9	-
Closing	
Is there anything else you would like to share that we did not discuss?	
-	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

Interview Guide for IP and HMHB Partners

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of the KII	Location
-		-	-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time	
-		-	-	-	
#	Interview questions			Responses	
Introduction					
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).					
-					
Questions related to EQ I					
Q1	As a result of work done by HMHB activities during Y1-Y2, have you noticed any improvements in improving access to and/or utilization of maternal, newborn, and child health (MNCH), and nutrition of mothers and children in HMHB target districts especially with regard to the “1,000 Days Strategy”? <i>Please give examples.</i>				
A1	-				
Q2	Have health care providers changed practices related to MNCH/nutrition High Impact Evidence-Based practices? If so, which of these practices are a result of technical assistance from HMHB?				
A2	-				
Q3	Which specific changes in health provider practices have been measured?				
A3	-				
Q4	What are barriers to changing health provider practices? Has the activity done anything to address these barriers?				
A4	-				
Q5	To what extent have women been empowered to act in support of health behaviors and interventions in HMHB target districts? <i>Please give examples.</i>				
A5	-				
Q6	Are there other donors or programs working with the same health providers in MNCH and nutrition? If yes, does HMHB coordinate activities for synergies and cost efficiencies?				
A6	-				

Q7	Are there client-related factors impacting access to MNCH and nutrition services? Has the project taken measures designed to reduce barriers to access and utilization of services?
A7	-
Questions related to EQ2	
Q8	What activities did the project select to enhance access to a diverse set of nutrient-rich foods? How were activities selected? Have they changed over the life of project? If yes, why?
A8	-
Q9	What specific collaborative activities did HMHB undertake to coordinate efforts to improve access to and consumption of nutrients at the beneficiary level? How were they measured?
A9	-
Q10	What specific collaborative activities did HMHB undertake to coordinate efforts to improve access to and consumption of nutrients at the beneficiary level? How were they measured?
A10	-
Q11	What tools did HMHB use to assess household dietary consumption of specific nutrients by pregnant and lactating women and/or children under 2? Is HMHB measuring changes in access and/or consumption patterns?
A11	-
Q12	What specific activities did HMHB do to promote immediate and exclusive breastfeeding in newborns and infants under the age of 6 months?
A12	-
Q13	Wasting of infants has reportedly increased in Tajikistan in recent years, with the highest rates in infants under 6 months of age? Was this trend noted in the HMHB catchment area? Did the project undertake specific measures to respond to this trend?
A13	-
Q14	How has the activity affected the dietary habits and health-related behaviors of families with young mothers, children, and adolescent girls?
A14	-
Q15	What were the barriers to increased consumption within households? Within communities? Did the project implement measures designed to overcome these barriers? Are there barriers that have not yet been overcome? If yes, what would be needed to overcome them?
A15	-
Q16	Are pregnant women provided with adequate supplies of iron/folate during pregnancy? If not, are they available for purchase in the private sector? Is there a way to determine if foods fortified (by other programs) are consumed by women and children in the HMHB beneficiary population?
A16	-

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

Q17	What additional measures could the project take to increase uptake of nutrition-related MNCH behaviors?
A17	-
Questions related to EQ3	
Q18	Has any program-supported evidence-based guidelines and procedures in MNCH, nutrition, or WASH been institutionalized since 2020? If yes, what were they? What role (if any) did HMHB play?
A18	-
Q19	Is there evidence-based partnership for maternal, newborn, and child health (PMNCH) practices that HMHB has not been able to promote? Why?
A19	-
Q20	Did HMHB experience challenges working on national-level policy change while simultaneously working in remote rayons in Khatlon region?
A20	-
Q21	In overall, what do you think is the perception of GOT ministries responsible for services supported by HMHB and GOT counterparts to plan, design, implement, manage, monitor, and evaluate health programs at the national, regional, and district levels? (Please be specific.)
A21	-
Q22	For activities that have been established, how many do you think will be sustained after the HMHB project ends? Are there measures that HMHB can take to promote sustainability or scale-up of successful strategies?
A22	-
Recommendations	
Q23	What can be done to increase further the impact of activities of HMHB on nutritional outcomes, diet diversity, child health and feeding behaviors, and health care-seeking behaviors?
A23	-
Q24	What lessons learned does the HMHB project have for reaching adolescent girls about nutrition? Are there strategies that are could to be successful that the project did not use yet?
A24	-
Closing	
Is there anything else you would like to share that we did not discuss?	
-	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

Interview Guide for National Government

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of interview	Location
-		-	-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time	
-		-	-	-	
#	Interview questions			Responses	
Introduction					
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).					
-					
Questions related to EQI (Relevance)					
Q1	HMHB project funded by USAID is focusing to contribute to solving Tajikistan health and nutrition challenges through three project objectives (1) scaling up and institutionalizing quality health and nutrition services to mothers, newborns, and children; (2) supporting the SUN and Republic of Tajikistan's national strategies and (3) Social and behavior change to improve nutrition, and maternal and child health practices. In your opinion, are these the right priorities and interventions to solve the health and nutrition problem? What challenges/problems in those areas are not being addressed, if any?				
A1	-				
Q2	Would you comment on specific training and capacity-building activities provided by HMHB? Is it relevant to the need of health workers and mothers and children? Probes: a. Care of the pregnancy process b. Nutrition during pregnancy c. Breastfeeding d. Care of healthy children 0-24 months e. IMCI f. Malnutrition g. Anemia h. Infection control i. Covid-19 (PHC) j. Guideline on Partnership with communities on health issues				
A2	-				
Q3	In your opinion, were the HMHB project activities aligned with national and regional priorities and strategies?				
A3	-				

Q4	Looking back over the past two years, what have been the most significant changes in access and quality health care and nutrition services for mothers, newborns, and children in HMHB districts?
A4	-
Q5	To what extent is the HMHB project facilitated synergies and avoided duplications with interventions and strategies promoted by other UN agencies and developing partners?
A5	-
Q6	How have the QI management and supportive supervision effectively reinforced skills application and tracking progress?
A6	-
Q7	In your opinion, was data collected during RHFA helpful in decision-making and prioritization of intervention by districts and type of health facilities.?
A7	-
Q8	How is the situation with Iron-folic acid supply? Do you have constant supply and has the supply changed since last year?
A8	-
Questions related to EQ2 (Effectiveness)	
Q9	What specific collaborative activities did HMHB undertake to improve access to and consumption of nutrients at the beneficiary level? How were they measured?
A9	-
Q10	What tools did HMHB use to assess household dietary consumption of specific nutrients by pregnant and lactating women and/or children under 2?
A10	
Q11	To what extent was the implementation modality of HMHB project were efficient in comparison to other agencies? Can you bring some examples? Probes: a. nutrition resource center, b. community health team, c. SBCC
A11	-
Q12	Could the intended results have been achieved at a higher level of quantity/quality by: a. improved monitoring of risks and internal factors b. targeting of health professionals during trainings c. shifting balance of responsibilities between the various stakeholders d. accompanying measures taken or to be taken by the government
A12	-

Q13	What key barriers were identified and how they were addressed? Probes: a. Governance & Leadership; b. Service delivery; c. Human Resources (sufficiency, turnover, aging, skills, workload); d. Supplies (lifesaving equipment (Ambu, baby warmer, etc.), medications; e. Information system; f. Financing (costing, OPP)
A13	-
Q14	One of the objectives of HMHB project was to support the Scaling Up Nutrition Movement and Republic of Tajikistan's national strategies. a. So far, what has been achieved? b. How HMHB contributed to food fortification initiative in Tajikistan?
A14	-
Questions related to EQ3	
Q15	Have health system managers' capacities been created and/or reinforced at regional /district levels? What opportunities can HMHB build on to support sustainability?
A15	-
Q16	Could you bring examples of policy, protocols, and training curriculum changes as a result of lessons learned from the HMHB project implementation? Are there those that are in-progress, but not yet implemented? Probes: a. Guidelines/Protocols b. Training curriculum c. QI management
A16	-
Q17	What type of policies, guidelines and protocols/standards are still required to enhance the functioning MNCHN services?
A17	-
Q18	Is supportive supervision efficiently and regularly operational in HMHB project districts?
A18	-
Q19	In your opinion, how can central or regional health authorities contribute to the sustainability of HMHB initiative when HMHB project ends? What are main barriers to sustain project success in HMHB districts or scaling up to other districts?
A19	-

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

Q20	Could you describe by each project activity (trainings, DHIS2, QI management, SBCC) which Governmental institution has ownership on its implementation?
A20	-
Q21	What could HMHB project do in the remaining project period to further strengthen QI, enhancing HR capacity and policy development: - At national level: - At regional level: - At district level:
A21	-
Q22	Is there any evidence in regard to integration of health and nutrition topics into pre-services training curriculum of university or medical college?
A22	-
Closing	
Is there anything else you would like to share that we did not discuss?	
Thank you very much for your time. Your knowledge and insights will be very helpful to us.	

Interview Guide for Local Government (Regional and District Health Authorities)

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of interview	Location
-		-	-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time	
-		-	-	-	
#	Interview questions			Responses	
Introduction					
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).					
-					
Questions related to EQI (Relevance)					
Q1	To what extent were the HMHB project activities responding to most important needs and problems in the field of MNCHN sector in your region?				
A1	-				
Q2	One of the objectives of HMHB project was to increase access and quality maternal, newborn and child health services. a. So far, what has been achieved? b. Do you have any evidence of increased access to services? c. How HMHB contributed to QI process in HFs?				
A2	-				
Q3	Based on your experience or observations, do you believe that access and quality of care at village level has improved? If so, what groups of village members have benefited most from HMHB activities? Are there still groups that are yet to be reached?				
A3	-				
Q4	Do you think there is any difference in improvement in MCH and nutrition between those parts of districts not served by HMHB project compared with those where HMHB has been working?				
A4	-				
Q5	In your opinion, which type of HMHB interventions was most efficient in changing health care knowledge, skills and practices?				
A5	-				
Q6	What are the most important issues related to attracting and retaining health workers in rural positions that need to be addressed in the next two years by HMHB and local government & HF?				
A6	-				

Q7	How have the QI management and supportive supervision effectively reinforced skills application and tracking progress?
A1	-
Questions related to EQ2 (Effectiveness)	
Q8	Did beneficiaries from the pilot districts improve their childcare and health-seeking practices as a consequence of community-based activities?
A8	-
Q9	What approaches have HMHB used to increase awareness and knowledge of mothers and HH members on nutrition, including dietary diversity, particularly by pregnant and lactating women and/or children under 2?
A9	-
Q10	What are the barriers to increasing the consumption of nutritious food within households? Within communities? Did the project implement measures designed to overcome these barriers? Are there barriers that have not yet been overcome? If yes, what would be needed to overcome them?
A10	-
Q11	In your view, how effective have HMHB capacity building activities been to improve community involvement in health/nutrition (demand for services, behavior, practices) in target districts? Pls., give some examples.
A11	-
Q12	In your opinion, was data collected during RHFA helpful in decision-making and prioritization of intervention by districts and type of health facilities.?
A12	-
Q13	Are any fortified foods being available in your region? If yes, what kind of food accessible to population?
A13	-
Questions related to EQ3(Sustainability)	
Q14	To what extent was this project designed, implemented and monitored jointly with central and local Government partners?
A14	In your view, has there been any progress in HMHB supported districts in the following areas: - Training - Developing training manuals/resources - Conducting Research and assessments
Q15	Is any coordination mechanism that exists and is operational for coordinating partners' interventions? If YES, how is organized? How often? Who are participants?
A15	-

Q16	To what extent do the health authorities at regional and district levels take ownership over the HMHB project packages to ensure the sustainability of the achieved results? Probes: a. How sustain DHIS 2 data collection and analysis for policy decisions? b. Nutrition resource centre and challenges to sustainability c. Continue supporting CHT at the village level d. Model of partnerships e. Types of services or service delivery aspects – including referral mechanisms f. Supervision mechanisms (supportive supervision) g. Resource management
A16	-
Q17	In your opinion, what are the key obstacles or difficulties to sustaining project success in target districts where HMHB is operational?
A17	-
Q18	In your view, have HMHB activities affected any changes in the following areas: a. Coordination of health/nutrition activities; b. Supportive supervision, c. Participation and provision of TA support to MHSPP at national, regional and district levels in planning, monitoring and data analysis?
A18	-
Q19	Is there any intention to scale up HMHB project initiatives to other districts health institutions of the region?
A19	-
Recommendations	
Q20	What can be done in addition to what HMHB is doing to increase the impact of activities on nutritional outcomes, diet diversity, child health and feeding behaviors, and health care-seeking behaviors?
A20	-
Closing	
Is there anything else you would like to share that we did not discuss?	
-	
Thank you very much for your time. Your knowledge and insights will be very helpful to us.	

Interview Guide for Local Government (Hukumats and DOE)

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of interview	Location
-		-	-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time	
-		-	-	-	
#	Interview questions			Responses	
Introduction					
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).					
-					
Questions related to EQ1 (Relevance)					
Q1	Are you familiar with USAID supported project, which is HMHB project? If yes, to what extent HMHB project activities responding to the most essential needs and demands of mother, newborn, and child health and nutrition in your region?				
A1	-				
Q2	In your opinion, are there any changes in provision of improved health- care services and nutrition counselling to mothers, newborns and children?				
A2	-				
Q3	Do you know any other agencies/donors supporting health sector in your region?				
A3	-				
Q4	Do you think there is any difference in improvement in MCH and nutrition between those parts of districts not served by HMHB project compared with those where HMHB has been working?				
A4	-				
Q5	Do you aware of WASH and nutrition interventions in targeted schools by HMHB project? Is there evidence in improving hygiene and nutrition practices among school children?				
A5	-				
Questions related to EQ2 (Effectiveness)					
Q6	What is basic tradition in nutrition and food preparation practices at the HH level?				
A6	-				
Q7	In your opinion, what problems related to the nutrition of mothers and children exist and remain in your region?				
A7	-				

Q8	What obstacles exist in implementing nutrition programs among the population, especially mothers and children? Can you list some of these problems?
A8	-
Q9	Did you hear about food fortification initiated by the Government of Tajikistan? Are fortified foods available in your region?
A9	-
Q10	In your opinion, what forms of communication are preferable among women to change nutrition and food intake behavior in your region?
A10	-
Questions related to EQ3(Sustainability)	
Q11	Is there any regional-level mechanisms/platforms exist that can support coordination? How have they functioned? How can they be made to function better?
A11	-
Q12	How is local hukumat planning to contribute to the improvement of nutrition status of population, particularly mothers and children? <i>Probes:</i> a. increase awareness of population of nutritious food, b. promotion of BF practices and timely complementary feeding of infants; c. ensuring availability of iron/folic acid pills, d. food fortification
A12	-
Q13	Do you have any guidelines, training and informational materials related to WASH and nutrition at school level developed and disseminated by HMHB project?
A13	-
Recommendations	
Q14	What can be done in addition to what HMHB is doing to increase the impact of activities on nutritional outcomes, diet diversity, child health and feeding behaviors, and health care-seeking behaviors?
A14	-
Closing	
Is there anything else you would like to share that we did not discuss?	
-	
Thank you very much for your time. Your knowledge and insights will be very helpful to us.	

Interview Guide for Other Stakeholders

Names and Designation of Interviewee		Name of Institution	Date of interview	Mode of interview	Location
-		-	-	-	-
Name of Interviewer		Name of Note Taker (if relevant)	Interview start time	Interview end time	
-		-	-	-	
#	Interview questions			Responses	
Introduction					
Please describe your role/involvement with the HMHB (length of time, responsibilities, nature of interactions, etc.).					
-					
Questions related to EQ1					
Q1	Please tell us about cooperation of your organization with HMHB project.				
A1	-				
Q2	In your view, are the key challenges for improving the health and nutrition and health status of mothers and children in target districts? 1. Improving communication for RMNACH and nutrition behavior change 2. Improving access to health services 3. Improving access to improved health security 4. Improving quality of health services				
A2	-				
Q3	In your opinion, HMHB project activities responding to most important needs and problems in the field of MNCHN services?				
A3	-				
Questions related to EQ2 (Effectiveness)					
Q4	Do you participate in partner's coordination meetings related to HMHB project activities?				
A4	-				
Q5	If your agency is collaborating with HMHB project, what is your agency role/function?				
A5	-				
Q6	In your opinion, in what extent HMHB project contributed to improvement of MNCHN services?				
A6	-				

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

Q7	In your view, have HMHB activities affected any changes in access and utilization of maternal, newborn, child health (including adolescent, or RMNACH), and nutrition behaviors in its target districts since the HMHB project began?
A7	-
Q8	What HMHB strategies or activities are you aware of that have helped to strengthen community participation in improving nutrition, sanitation, and hygiene services?
A8	-
Q9	Has HMHB contributed to improved health worker performance to provide quality services? In RMNACH and nutrition? If yes, please specify what services and what HMHB did to improve them?
A9	-
Questions related to EQ3 (Sustainability)	
Q10	Are you aware of any program-supported evidence-based guidelines and procedures in MNCH, nutrition, or WASH been institutionalized since 2020? If yes, what were they? What role (if any) did HMHB play?
A10	-
Q11	What helps/hampers to sustain project success in HMHB districts?
A11	-
Recommendations	
Q12	What can be done to increase further the impact of activities of HMHB on nutritional outcomes, diet diversity, child health and feeding behaviors, and health care-seeking behaviors?
A12	-
Closing	
Is there anything else you would like to share that we did not discuss?	
-	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

Focus Group Discussion Guidelines

FGD GUIDE FOR QUALITY IMPROVEMENT TEAMS			
Date of FGD:	-	Location:	-
District:		-	
Name of Facilitator:		-	
Name of Note Taker:		-	
Total Number of FGD participants:		-	
# of Males:	-	# of Females:	-
Ice Breaker			
1. Introduce yourself 2. Introduction to the objectives of the research 3. A brief introduction to the rules of focus groups a. Everything said and done is confidential and will not be used outside the room except for the purposes of this research; b. Every statement is right; c. Please do not hesitate to disagree with someone else; d. But do not all talk at once 4. Ask people to describe who they are and say few words about themselves 5. Introduce the topic under review - We are here to evaluate the HMHB Project implemented in your regions 6. Ask questions			
Questions for Discussion during FGD			
Questions related to EQI:			
Q1	In your opinion, how and in which way creation of QI team by the HMHB project was helpful for improving access and quality of healthcare services? Is QI team meets regularly? How often? What are key topics in the agenda of meetings?		
A1	-		
Q2	Have you participated in trainings provided by the HMHB project? Which trainings have been the most useful? Which aspects of health provider performance that still need to be improved?		
A2	-		

Questions related to EQ2	
Q3	HMHB project focuses on improving access to and quality of Mother, Newborn and Child health and nutrition care. In your opinion is there any improvements? Probes: - What changes do you observe in your facilities /in your region in terms of quality of MNCHN services? (Probes: RHFA, trainings, supply, WASH, resource center, infection control, etc) - What should be done to sustain the changes? - What changes in diet diversity among population? - What are challenges for further improving of providers knowledge and practices?
A3	-
Q4	Do you aware about food fortification initiative and regulation by the GoT? Any type of fortified food available in your region?
A4	-
Q5	What are hampering factors to accept new practices/procedures in nutrition (reluctant to change, lack of awareness, low motivation, socio-economic factors, etc.) by health workers and explain how?
A5	-
Q6	Do Health centers in your region/villages have adequate supplies of Iron/Folate tablets for pregnant women?
A6	-
Q7	In our opinion, is HMHB project equally covers all villages/ hard to reach families of your region?
A7	-
Q8	Please explain whether and how supportive supervision helps/limits you to improve service quality? - could you describe any changes or corrections done during project implementation based on supportive supervision results? - could you describe any managerial actions done based on reviewing facility/rayon child birth/mortality data?
A8	-
Q9	In your opinion to what extent project is efficiently using resources to tackle real problems? If no, can you suggest how it should be done
A9	-

Questions related to EQ3	
Q10	Are you aware about a recent guidelines and protocols endorsed by MHSP supported by HMHB project in the field of MNCHN services?
A10	-
Q11	Do you have hard copy of key clinical guidelines, protocols and standards in regard QI, MNCHN services, including infection control? Has a Quality Control Commission been established and how it functions?
A11	-
Q12	What kind of barriers exist for the effective implementation of protocols and standards approved by the Ministry of Health and supported by HMHB project? Probes: - Governance & Leadership; - Service delivery; - Human Resources (sufficiency, turnover, aging, skills, workload); - Supplies (lifesaving equipment (Ambu, CPAP, warmer, drugs, etc), medications), - OPP
A12	-
Q13	In your opinion, what may hinder the further continuation of activities after the completion of the HMHB project
A13	-
Q14	Did health facilities/authorities show technical capacity and leadership commitment to keep working with the project or to scale it up?
A14	-
Recommendations	
Q15	Do you have any additional suggestions on the training and/or support that you received from the HMHB project and recommendations for the future improvement of MCHN services within on going HMHB project's activities?
A15	-
Closing	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

SURVEY AMONG QUALITY IMPROVEMENT TEAMS

Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Age: ☐ Under 25 years ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and over

District: ☐ Jomi ☐ Jayhun ☐ Dusti ☐ Shahritus ☐ Vaksh ☐ Yovon

Occupation: ☐ Doctor ☐ Neonatologist ☐ Obstetricians/gynaecologist ☐ Nurse

Years spent in this profession: ____ years

Type of health facility: ☐ Hospital ☐ PHC

Years spent in this facility: ____ years

In which trainings/workshops organized by the HMHB project you took part between October 2020-October 2022? Please Check All That Apply.

HMHB Trainings for Hospitals	HMHB Trainings for PHC
☐ Organization and provision of antepartum and postpartum care ☐ Principles of privacy and confidentiality for antepartum and postpartum care ☐ Principles of education and communication for antepartum and postpartum care ☐ First antepartum visit ☐ Routine follow up antepartum visits, considerations for select infectious and non-infectious conditions ☐ Checking and managing particular non-infectious conditions ☐ Antepartum counselling ☐ Routine postpartum maternal care ☐ Postpartum new-born care ☐ Assessment of breastfeeding and management of common breastfeeding complications	☐ Anemia ☐ Breastfeeding ☐ COVID-19(Hospital) ☐ Clinical safety and infection prevention (Order 1119) ☐ Hypertensive conditions and emergency care ☐ Kangaroo Methods ☐ Management of bleedings ☐ Nutrition during pregnancy ☐ Nutrition for pregnant and lactating women ☐ Partogram ☐ Premature birth ☐ Resuscitation of new-borns ☐ Thromboembolism in obstetrics ☐ WHO Pocket Handbook ☐ Infection Control ☐ IMCI ☐ Malnutrition ☐ Guideline on Partnership with communities on health issues

ASSESSMENT OF THE QUALITY OF HMHB TRAININGS

-	On a scale of 0 to 5, with 0 being the worst and 5 being the highest, please provide your opinion of the quality of the trainings according to the question 1 to question 10 provided below:	Min	.	.	.	Max	N/A
		1	2	3	4	5	
1	To what extent have the objectives of the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
2	To what extent have your personal objectives for attending the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
3	To what extent has your understanding of the subject improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
4	To what extent have your skills in the subject of the training improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
5	Were the training topics relevant to your daily work or functions?	☐	☐	☐	☐	☐	☐
6	How do you rate the balance between theoretical and practical work during the HMHB training(s)?	☐	☐	☐	☐	☐	☐
7	Was the training material useful?	☐	☐	☐	☐	☐	☐
8	Was the quantity of training material appropriate?	☐	☐	☐	☐	☐	☐
9	Was the length of the training sufficient?	☐	☐	☐	☐	☐	☐
10	Did you find the composition of the group appropriate?	☐	☐	☐	☐	☐	☐
11	Are you satisfied with the level of trainers/facilitators expertise?	☐	☐	☐	☐	☐	☐
12	Were any pre and post knowledge tests conducted?	☐ Yes ☐ No					
13	How would you rate your overall satisfaction with the HMHB training(s)?	Very useful 5 4 3 2 1 Little use Very interesting 5 4 3 2 1 Of little interest					

14	Do you have any suggestions for improvement? <i>Please Check All That Apply.</i>	☐ increase the duration of the training ☐ repeat trainings on regular basis ☐ less theory – more practice in the training process ☐ make sure the availability of educational materials
15	Please give three knowledge that you received during the HMHB trainings:	1 2 3
16	Would you recommend the HMHB trainings to your colleagues?	☐ Yes ☐ No

Thank you for your feedback!

FGD GUIDE FOR DISTRICT NUTRITION TRAINERS					
Date of FGD:	-	Location:	-	District:	-
Name of Facilitator:			-		
Name of Note Taker:			-		
Total Number of FGD participants:			-		
# of Males:	-	# of Females:	-		
Ice Breaker					
1. Introduce yourself 2. Introduction to the objectives of the research 3. A brief introduction to the rules of focus groups a. Everything said and done is confidential and will not be used outside the room except for the purposes of this research; b. Every statement is right; c. Please do not hesitate to disagree with someone else; d. But do not all talk at once 4. Ask people to describe who they are and say few words about themselves 5. Introduce the topic under review - We are here to evaluate the HMHB Project activities implemented in your region 6. Ask questions					
Questions for Discussion during FGD					
Questions related to EQ1:					
Q1	Please list the nutrition or BCC trainings in which you participated?				
A1	-				
Q2	In your opinion, to what extent the HMHB trainings and disseminated educational and information materials focused on real needs/problems in your region?				
A2	-				
Q3	How many training sessions have you delivered thus far? Who are the main participants in your training sessions? Do you use the NRC training materials standardized and aligned with MoH protocols and guidelines during your training courses? Are you conducting follow up monitoring or evaluation of your trainings? How?				
A3	-				
Questions related to EQ2:					
Q4	Have your practices/attitudes related to nutrition counselling changed since participation in the HMHB trainings? How?				
A4	-				

Q5	Are you giving information on diet diversity, nutritious food, the food pyramid and locally available food stuff during your training sessions?
A5	-
Q6	In your opinion, what changes in mothers' or HH members behavior in relation to nutrition practices can be observed?
A6	-
Q7	Have you ever heard of the 1000 Days programme? Why is it called First 1000 Days?
A7	-
Q8	Are fortified food items available in your region? If yes, what type of food?
A8	-
Q9	In your region, there are various nutritious foods available, why mothers are not using widely these food stuffs for families?
A9	-
Questions related to EQ3:	
Q10	In your opinion, what are key obstacles/barriers at HH level to change nutrition, and child feeding practices?
A10	-
Q11	How the supportive supervision has been effective in reinforcing skills application and quality of services? - could you describe any changes or corrections done during project implementation based on supportive supervision results? - could you describe any managerial actions done based on reviewing facility/rayon child birth/mortality data?
A11	-
Q12	To what extent the government will continue the implementation of project activities with its own resource or find external funds for: training activities, supportive supervision, supplies, etc.?
A12	-
Q13	In your opinion, to what extent the Nutrition Resource Training Centre organized by HMHB project is effective and useful? Why or why not? Does Nutrition Training Resource Center have regular training sessions? What are the common agendas for trainings? Who are key participants?
A13	-

Q14	Are there any HMHB project activities which builds household members capacity in nutrition related issues, such as EBF/BF, complementary feeding, dietary diversity among women and adolescent girls?
A14	-
Recommendations	
Q15	What benefits have your community received from HMHB project? What needs to be done differently to achieve and maximize a positive impact from the HMHB project?
A15	-
Closing	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

SURVEY AMONG DISTRICT NUTRITION TRAINERS

Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Age: ☐ Under 25 years ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and over

District: ☐ Jomi ☐ Jayhun ☐ Dusti ☐ Shahritus ☐ Vaksh ☐ Yovon

Occupation: _____

Years spent in this profession: ____ years

In which trainings/workshops organized by the HMHB project you took part between October 2020-October 2022? Please Check All That Apply.

- ☐ Exclusive breastfeeding
- ☐ Immunization
- ☐ Anemia (iron rich food)
- ☐ Breastfeeding support group activities
- ☐ Breastfeeding technique
- ☐ Complementary feeding of a child from 6 to 23 months and continuous BF
- ☐ Cooking demonstration
- ☐ Covid-19
- ☐ Diarrhea (causes, prevention)
- ☐ Environmental hygiene
- ☐ Folic acid
- ☐ Food containing vitamin A
- ☐ Fortified Foods (Iodized Salt)
- ☐ Goiter
- ☐ Hygiene: hand washing and nutrition hygiene
- ☐ Iodized salt
- ☐ Locally available food
- ☐ Nutrition for adolescents and women of reproductive age
- ☐ Safe toilets
- ☐ Nutrition of pregnant and lactating women
- ☐ Regular monitoring of the physical development of the child
- ☐ Safe water

ASSESSMENT OF THE QUALITY OF HMHB TRAININGS

-	On a scale of 0 to 5, with 0 being the worst and 5 being the highest, please provide your opinion of the quality of the trainings according to the question 1 to question 10 provided below:	Min	.	.	.	Max	N/A
		1	2	3	4	5	
1	To what extent have the objectives of the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
2	To what extent have your personal objectives for attending the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
3	To what extent has your understanding of the subject improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
4	To what extent have your skills in the subject of the training improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
5	Were the training topics relevant to your daily work or functions?	☐	☐	☐	☐	☐	☐
6	How do you rate the balance between theoretical and practical work during the HMHB training(s)?	☐	☐	☐	☐	☐	☐
7	Was the training material useful?	☐	☐	☐	☐	☐	☐
8	Was the quantity of training material appropriate?	☐	☐	☐	☐	☐	☐
9	Was the length of the training sufficient?	☐	☐	☐	☐	☐	☐
10	Did you find the composition of the group appropriate?	☐	☐	☐	☐	☐	☐
11	Are you satisfied with the level of trainers/facilitators expertise?	☐	☐	☐	☐	☐	☐
12	Were any pre and post knowledge tests conducted?	☐ Yes ☐ No					
13	How would you rate your overall satisfaction with the HMHB training(s)?	Very useful 5 4 3 2 1 Little use Very interesting 5 4 3 2 1 Of little interest					

14	Do you have any suggestions for improvement? <i>Please Check All That Apply.</i>	☐ increase the duration of the training ☐ repeat trainings on regular basis ☐ less theory – more practice in the training process ☐ make sure the availability of educational materials
15	Please give three knowledge that you received during the HMHB trainings:	1 2 3
16	Would you recommend the HMHB trainings to your colleagues?	☐ Yes ☐ No

Thank you for your feedback!

FGD GUIDE FOR COMMUNITY HEALTH TEAMS					
Date of FGD:	-	Location:	-	District:	-
Name of Facilitator:			-		
Name of Note Taker:			-		
Total Number of FGD participants:			-		
# of Males:	-	# of Females:	-		
Ice Breaker					
1. Introduce yourself 2. Introduction to the objectives of the research 3. A brief introduction to the rules of focus groups a. Everything said and done is confidential and will not be used outside the room except for the purposes of this research; b. Every statement is right; c. Please do not hesitate to disagree with someone else; d. But do not all talk at once 4. Ask people to describe who they are and say few words about themselves- Could you please go around the circle and share your name and village you come from? How long have you been a CHW in this community? 5. Introduce the topic under review - We are here to evaluate the HMHB Project activities implemented in your region 6. Ask questions					
Questions for Discussion during FGD					
Questions related to EQ1:					
Q1	What kinds of activities/services do you offer to community members? Probes: - Breastfeeding - Child Care, - Hygiene, - Growth Monitoring, - Nutrition During Pregnancy and Lactation, - Nutrition Of Adolescents Do you have any guidelines and or protocols for services you provide?				
A1	-				
Q2	Whom do you reach most often in the community with information and services? Probe on target groups - women, men, youth, couples. Who is the target priority groups? Why? Do you also reach young mothers? Why or why not?				
A2	-				

Q3	Do you refer mothers for ANC, PNC, and FP services? How do they react?
A3	-
Q4	In your opinion, is the communication (education/information) package you offer relevant to the real demands of community members? Why or why not?
A4	-
Q5	What kind of services and information need and want to receive community members, specifically mothers and children under two years of age?
A5	-
Q6	Have you participated in any trainings organized by the HMHB project? Can you name of them?
A6	-
Q7	In your opinion, are there any changes for the last two years in delivering health care services and nutrition for mothers and children in your community/region? Provide examples
A7	-
Q8	Not all mothers seek health services (antenatal care services). What barriers prevent them from going during pregnancy, births and for FP services? Probes: family opposition, financial, religious doctrine, stigma of early pregnancy, distance, cost.
A8	-
Questions related to EQ2:	
Q9	Did you hear about fortified foodstuffs in Tajikistan? Is fortified food available in your region? If Yes, what kind of food items?
A9	-
Q10	Have you ever heard of the 1000 Days program? Why is it called First 1000 Days?
A10	-
Q11	Have you received any training or information on the importance of a diverse diet? Where did you receive this? Can you share your knowledge on why diverse diets are important?
A11	-
Q12	In your opinion, what are the main obstacles and difficulties for HH members, and mothers to change nutrition habits and culture? Probes: availability of food; financial; cultural; awareness, skills.
A12	-

Q13	From your experience, can you tell us what is the primary form of communication that affects for action? Probes: Face to face communication in the health facility and/or at home, Flip chart on key child feeding, videos on child care; Mother card; Posters; Examples; other.
A13	-
Q14	From your observation and communication with pregnant mothers, do they take iron pills regularly? If No, why?
A14	-
Questions related to EQ3:	
Q15	Are you getting any incentives from HMHB project? Is Yes, please list them
A15	-
Q16	What do you think, when HMHB project ends, will you continue your activities as you offer them now?
A16	-
Q17	In addition to CHT and services at health facilities, are there other ways and places that mother's, men, and couples can get health information and services? On nutrition? On parenting? Probes: for radio, internet, NGOs, others.
A17	-
Q18	Are you coordinating your activities with jamoat committee and getting any support from them?
A18	-
Q19	What is your relation/ cooperation with the village health facility? Probes: on supervision support, materials supply, making referrals, organizing outreach activities with the health facility.
A19	-
Recommendations	
Q20	What benefits have your community received from HMHB project? What needs to be done differently to achieve and maximize a positive impact from the HMHB project?
A20	-
Closing	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

SURVEY AMONG COMMUNITY HEALTH TEAMS

Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Age: ☐ Under 25 years ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and over

District: ☐ Jomi ☐ Jayhun ☐ Dusti ☐ Shahritus ☐ Vaksh ☐ Yovon

Occupation: _____

Years spent in this profession: ____ years

In which trainings/workshops organized by the HMHB project you took part between October 2020–October 2022? Please Check All That Apply.

- ☐ Exclusive breastfeeding
- ☐ Immunization
- ☐ Anemia (iron rich food)
- ☐ Breastfeeding support group activities
- ☐ Breastfeeding technique
- ☐ Complementary feeding of a child from 6 to 23 months and continuous BF
- ☐ Cooking demonstration
- ☐ Covid-19
- ☐ Diarrhea (causes, prevention)
- ☐ Environmental hygiene
- ☐ Folic acid
- ☐ Food containing vitamin A
- ☐ Fortified Foods (Iodized Salt)
- ☐ Goiter
- ☐ Hygiene: hand washing and nutrition hygiene
- ☐ Iodized salt
- ☐ Locally available food
- ☐ Nutrition for adolescents and women of reproductive age
- ☐ Safe toilets
- ☐ Nutrition of pregnant and lactating women
- ☐ Regular monitoring of the physical development of the child
- ☐ Safe water

ASSESSMENT OF THE QUALITY OF HMHB TRAININGS

-	On a scale of 0 to 5, with 0 being the worst and 5 being the highest, please provide your opinion of the quality of the trainings according to the question 1 to question 10 provided below:	Min	.	.	.	Max	N/A
		1	2	3	4	5	
1	To what extent have the objectives of the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
2	To what extent have your personal objectives for attending the HMHB training(s) been achieved?	☐	☐	☐	☐	☐	☐
3	To what extent has your understanding of the subject improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
4	To what extent have your skills in the subject of the training improved or increased as a result of the HMHB training(s)?	☐	☐	☐	☐	☐	☐
5	Were the training topics relevant to your daily work or functions?	☐	☐	☐	☐	☐	☐
6	How do you rate the balance between theoretical and practical work during the HMHB training(s)?	☐	☐	☐	☐	☐	☐
7	Was the training material useful?	☐	☐	☐	☐	☐	☐
8	Was the quantity of training material appropriate?	☐	☐	☐	☐	☐	☐
9	Was the length of the training sufficient?	☐	☐	☐	☐	☐	☐
10	Did you find the composition of the group appropriate?	☐	☐	☐	☐	☐	☐
11	Are you satisfied with the level of trainers/facilitators expertise?	☐	☐	☐	☐	☐	☐
12	Were any pre and post knowledge tests conducted?	☐ Yes ☐ No					
13	How would you rate your overall satisfaction with the HMHB training(s)?	Very useful 5 4 3 2 1 Little use Very interesting 5 4 3 2 1 Of little interest					

14	Do you have any suggestions for improvement? <i>Please Check All That Apply.</i>	☐ increase the duration of the training ☐ repeat trainings on regular basis ☐ less theory – more practice in the training process ☐ make sure the availability of educational materials
15	Please give three knowledge that you received during the HMHB trainings:	1 2 3
16	Would you recommend the HMHB trainings to your colleagues?	☐ Yes ☐ No

Thank you for your feedback!

FGD GUIDE FOR MOTHERS WITH CHILDREN UNDER TWO YEARS OF AGE			
Date of FGD:	-	Location:	-
District:	-		
Name of Facilitator:	-		
Name of Note Taker:	-		
Total Number of FGD participants:	-		
# of Males:	-	# of Females:	-
Ice Breaker			
1. Introduce yourself 2. Introduction to the objectives of the research 3. A brief introduction to the rules of focus groups a. Everything said and done is confidential and will not be used outside the room except for the purposes of this research; b. Every statement is right; c. Please do not hesitate to disagree with someone else; d. But do not all talk at once 4. Ask people to describe who they are and say few words about themselves 5. Introduce the topic under review - We are here to evaluate the HMHB Project implemented in your regions 6. Ask questions			
Questions for Discussion during FGD			
Q1	Can you list the most common diseases observed among mothers and children in your community? If high prevalent why?		
A1	-		
Q2	Which clinic/health facilities do you prefer to attend for seeking health care services for yourself and your child (a. HH, b. RHC, c. RHC, d. DHC, e. Private clinic)?		
A2	-		
Q3	Do you see any obstacles in obtaining health care services? Probes: unofficial payment, lack of health cards, or availability of essential drugs.		
A3	-		
Q4	What kind of services and information do you want or need to receive from health center for yourself and/or your child? Probes: Antenatal care visits/ Deworming/ Growth monitoring/ Vitamin A/ IMAM/ Zinc?		
A4	-		

Q5	Can you point to anything noteworthy that has changed for your family? What kind of assistance do you receive from health workers and CHT?
A5	-
Q6	In your opinion, are there any changes for last two years in terms of accessibility, quality of health services in your health facilities (including capacity of health workers)?
A6	-
Q7	From whom and what sources do you get information about nutrition, health, pregnancy or child feeding? What kind of information do you receive? What have you learned?
A7	-
Q8	Did you take or are you taking Iron-folic acid during pregnancy? Please tell us about your experience receiving iron and folic acid (IFA) during pregnancy. Did you take all the IFA you were given? Please explain why if you did not.
A8	-
Q9	In your opinion, what do women in your community usually feed their new baby, right after birth?
A9	-
Q10	When is the most important time for mothers and children to receive the right kind and amount of nutrition?
A10	-
Q11	Who is doing nutrition consultation in your community? Can you describe any nutrition work done in this community? Probes: home visits, promotion of BF; cooking demonstration, food pyramid, sensitizations.
A11	-
Q12	Please tell us about any difficulties you might have putting into practice the things you have learned about diverse diets.
A12	-
Q13	Are information and education messages disseminated by your HW or community health team relevant to your needs and demands and clear for you?
A13	-
Q14	What kind of communication do you need or prefer which helps to change your practices in nutrition, child feeding, hygiene etc.? Probes: Face-to-face communication, posters, videos, examples, etc.
A14	-

Q15	Have you heard of some initiatives in your village to help children less than two years old? Probes: VA supplementation, creation CHT, training of health staff etc.
A15	-
Q16	In your opinion when do women in your community usually start giving other foods than breast milk? Probes: What types of foods do they give? What is the timing? What are the reasons for giving other foods?
A16	-
Q17	What is stunting? Do you think stunting is a big problem in your community? If yes, what kinds of things are being done to reduce or prevent it?
A17	-
Q18	How often is your youngest child weighed, either in the village or in the clinic? When was this done the last time? Did you get any feedback information/advice from health workers following measurement?
A18	-
Q19	Are mothers and children in your community receiving health care and nutrition counselling support from other agencies or from private clinics? If yes, which one?
A19	-
Recommendations	
Q20	Do you have any additional suggestions in improvement of health care and nutrition services to mothers and children in your community?
A20	-
Closing	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

FOCUS GROUP GUIDE FOR MOTHERS-IN-LAW (MILs)					
Date of FGD:	-	Location:	-	District:	-
Name of Facilitator:			-		
Name of Note Taker:			-		
Total Number of FGD participants:			-		
# of Males:	-	# of Females:	-		
Ice Breaker					
1. Introduce yourself 2. Introduction to the objectives of the research 3. A brief introduction to the rules of focus groups a. Everything said and done is confidential and will not be used outside the room except for the purposes of this research; b. Every statement is right; c. Please do not hesitate to disagree with someone else; d. But do not all talk at once 4. Ask people to describe who they are and say few words about themselves 5. Introduce the topic under review - We are here to evaluate the HMHB Project implemented in your regions 6. Ask questions					
Questions for Discussion during FGD					
Q1	Can you list the most common diseases observed among mothers and children in your community? If high prevalent why?				
A1	-				
Q2	Where did you get this information in regard nutrition or other health related information?				
A2	-				
Q3	Which clinic/health facilities attends your family members for seeking health care services (a. HH, b. RHC c. RHC, d. DHC, e. Private clinic for antenatal visits/Deworming/Growth monitoring/Vitamin A/IMAM/Zinc)? Do you see any obstacles in obtaining health care services, such as unofficial payment, lack of health cards, or availability of essential drugs?)				
A3	-				
Q4	Can you point to anything noteworthy that has changed for your family? What kind of assistance do you receive from health workers and CHT?				
A4	-				

Q5	In your opinion, are there any changes for last two years in terms of accessibility, quality of health services in your health facilities (including capacity of health workers)?
A5	-
Q6	In your opinion, what do women in your community usually feed their new baby, right after birth?
A6	-
Q7	When is the most important time for mothers and children to receive the right kind and amount of nutrition?
A7	-
Q8	Who is doing nutrition consultation in your community? Can you describe any nutrition work done in this community (<i>please prompt for home visits, promotion of BF; cooking demonstration, food pyramid, sensitizations</i>)
A8	-
Q9	Here you are the mother-in-law, the head of the family. If family members, particularly daughter in law, children need to go to hospital, they ask permission from you. Right?
A9	-
Q10	What kind of communication do you need or prefer which helps to change your practices in nutrition, child feeding, hygiene etc. {Probe: Face-to-face communication, posters, videos, examples etc}
A10	-
Q11	Are mothers and children in your community receiving health care and nutrition counselling support from other agencies or from private clinics?
A11	-
Q12	In your opinion when do women in your community usually start giving other foods than breast milk? {Probe: What types of foods do they give? What is the timing? What are the reasons for giving other foods?}
A12	-
Q13	Did you hear about diet diversity, what is it? Tell us about the pregnant diet? What can they eat?
A13	-
Q14	In our opinion why visit of pregnant women to health institution is important?
A14	-
Recommendations: Do you have any additional suggestions in improvement of health care and nutrition services to mothers and children in your community?	
	-
Closing	
Thank you very much for taking the time to talk with us today. We appreciate your time.	

KAP Survey Questionnaire

I. BACKGROUND INFORMATION

Data validation rules:

- Answers should be programmed so that if “Don’t Know” is selected other responses cannot be selected
- If “Other” is selected as a response, respondent must list or specify what “other” includes

II. INTERVIEW INFORMATION

Name of the locality (Neighborhood/Village)	.
Name of jamoat	.
Name of district	Drop down list with 6 Khatlon Region districts targeted by KAP
Geolocation:	.
Name of nearest health facility	Drop down list with health facility names, can type into quickly narrow search
Interviewer’s name	Drop down list, can type into quickly narrow search
Date of interview	Calendar pop-up to facilitate date selection
Language of questionnaire	Tajik Other

As part of this survey, we would like to ask you questions about your household, Maternal and Child Health and Water, Hygiene and Sanitation. We will be focusing on your experience with your child between 06 and 24 months old. We would very much appreciate your participation in this survey so we can improve our program for mothers and children. Your participation in the survey is voluntary. You have no direct benefit to participate in the survey. Refusing to participate in the survey will not affect your access to health services. The survey interview will take about 35-40 min to complete.

Everything we discuss will remain confidential and we will not collect your name or place of residence. The information you provide will not be linked to you in the reports. Information you provide anonymously will be shared as a summary or aggregated data between Ministry officials and health stakeholders to improve program performance. We will share the aggregated and unidentified data set with program partners such as USAID. In accordance with USAID requirements, anonymized data sets developed using this information will be uploaded to the USAID data warehouse for use by authorized researchers.

Your participation in this survey involves very few risks. Some of the discussions that we may have a little sensitivity. We assure you that your participation is voluntary, and if you feel uncomfortable about what we are discussing, you can ask to skip the question or stop the interview completely. You are free to withdraw from the survey at any time and you will not be obliged to answer questions that you consider to be personal or for any other reason.

If you have any questions or concerns about your participation in this survey, you may call the Z-Analytics, Abduaziz Kasymov. I will give you his phone number to note at the end of the interview, in case you have questions.

Do you want to ask me something about this survey? _____ Yes _____ No

Do you agree to participate? _____ Yes (Continue with the questionnaire and proceed to question I)
_____ No (thank them for their time, indicate the result in the spreadsheet)

III. BACKGROUND

1. What is your date of birth?

Fill in age

Don't know (if don't know, enter the year or approximate year of birth)

Data validation (DV) for calendar dates

2. Please list the number of household members who currently live in your household

Household members	Resides at the household? Yes, No	If person doesn't reside in the household, why not? (1 = Lives elsewhere, 2 = Located internationally, 3 = Deceased, 4 = Other, specify)	Sex Male, Female	Age for children under 24 months: show in months and include birthdate	Indication of which child data will be collected on Data collector: Select which child for whom the mother will be asked about. This should be the oldest child who is between 6 and 24 months. Indicate child you will be collecting data on
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Respondent (mother of child under two or primary care giver) *DV: Default to female*

Mother-in-Law *DV: Default to female*

Father-in-Law

Husband or partner

Child 1 (lastborn child)

Child 2

Child 3

Child 4

Child 5

Child 6

Other

Other

Data Collector: For the purpose of this survey, we would like to focus on Child #____. This is the oldest child in your house who is between the ages of 6 months and 24 months old. I will not record his/her name, but I will use his/her name in my questions so that we can easily refer to the baby. For the rest of the questions today, we'll talk about (child's name).

3. Are you the biological mother to [name]?
a. Mother
b. Primary caregiver
4. Has [name] received Vitamin A supplementation in past six months?
a. Yes
b. No
c. Don't know

Data collector: Now, I'm going to ask some general questions about you and your household.

5. Are you currently pregnant?
a. Yes
b. No
6. What is the highest level of education you (respondent) have reached? *Select one*
a. None
b. Primary school (1-4 grade)
c. Secondary school (5-11 grades)
d. Professional middle (attestat)
e. Higher education
7. When you get sick, who decides when you go to see a doctor? *Select one*
a. Myself
b. Parents, in-laws
c. Husband
d. Myself and my husband together
f. Other Specify
8. When your child gets sick, who decides when s/he should see a doctor? *Select one*
a. Myself
b. Spouse
c. Mother-in-law
d. My community healthcare worker or health practitioner
e. Traditional healer
f Other/Someone else (If selected, specify who:____)
9. How often do you use the internet? *Select one*
a. Daily
b. Weekly
c. Monthly or less
d. Never *Skip to Q11*
e. Don't know

10. If yes, for what purpose do you use internet? *Select all that apply*
- a. For messaging (WhatsApp, Viber, etc.)
 - b. Social media sites *Skip to Q14*
 - c. Watch video (YouTube, Netflix, etc.)
 - d. News
 - e. Other: specify
11. Do you have a smart phone?
- a. Yes
 - b. No *Skip to Q14*
12. *If not*, Is there a smart phone in your household that is available to you?
- a. Yes
 - b. No
13. What is your primary source of information? *Select all that apply*
- a. Friends/ neighbors
 - b. Family
 - c. Radio
 - d. Television
 - e. Social media (Facebook etc)
 - g. Booklets, brochure, posters
 - h. Other *Specify*

IV. MODULE 1: MOTHER'S HEALTH ANC & PNC

Data collector: Now, I'm going to ask questions about your pregnancy with [name].

Behavior: Attend eight (8) ANC visits

14. Antenatal care are medical check-ups while you are pregnant. During your pregnancy with **[child's name]**, did you receive information about the importance of antenatal care?
- a. Yes
 - b. No *Skip to Q16*
 - c. Not sure *Skip to Q16*

15. If yes, where did you receive information on antenatal care? Do not read answers out loud, select all that apply
- a. Mother-in-Law (MiL)
 - b. Spouse
 - c. Friends, peers, or Neighbors
 - d. Relative
 - e. Flyer/leaflet/brochure
 - f. Poster
 - g. Radio
 - h. Television
 - i. SMS
 - j. Community events
 - k. Home visit by a community health worker
 - l. Community Agent
 - m. NGO (specify)
 - n. Doctor at health facility
 - o. Traditional Healer
 - p. Mosque
 - q. Other (Specify)
16. During your pregnancy with **[child's name]**, how many antenatal care visits did you attend?
- Number _____ Numerical range from 0, no limit
17. If you were not able to attend one or more of your antenatal care visits, why were you not able to go? Select all that apply
- a. The medical facility was too far away
 - b. Didn't have the financial resources
 - c. I was too busy
 - d. I didn't think it was necessary to attend all 8 visits
 - e. My Mother-in-Law didn't think it was necessary to attend all 8 visits
 - f. My Husband or partner didn't think it was necessary to attend all 8 visits
 - g. Other: Specify
18. If you received 1 or more ANC visit: During your ANC counseling, what messages were shared? Do not read answers out loud, select all that apply
- a. Danger signs during pregnancy
 - b. Nutrition during pregnancy
 - c. Rest during pregnancy
 - d. Self-care during pregnancy
 - e. Birth preparedness
 - f. Danger signs during delivery
 - g. Postpartum danger signs for the mother
 - h. Danger signs for the newborn
 - i. Pregnancy

19. Do you know how many times should a pregnant woman receive ANC? _____ *Numerical range from 0, no limit*
Don't know
20. Who from your family members decides your visit for ANC or who usually makes decision on your health and nutrition?
a. Myself
b. Mother-in-law
c. Husband
d. Myself and my husband jointly
e. Myself and my Mother-in-law
f. Other
21. Do you receive consultations on nutrition during your ANC visits?
a. Yes
b. No

Behavior: Get adequate rest

22. How many hours of sleep should a pregnant woman sleep every night? _____ *Number of hours (number parameters: 0 to 24)*
- 22a. If a pregnant woman doesn't get enough sleep, do you think that pregnancy complications can occur?
a. Yes
b. No
c. Not sure

Behavior: Skin-to-skin contact and Kangaroo Care

23. When [Name] was born, did you have skin to skin contact with your newborn within 2 hours of birth?
Skin to skin contact means your newborn baby is placed belly-down, directly on your chest, right after birth
a. Yes
b. No
c. Not sure
25. Can you name one benefit of skin-to-skin contact (kangaroo care)?
Do not read answers out loud
a. No/Don't know
b. More successful breastfeeding
c. Decreased crying
d. More rapid weight gain
e. Gaining sleep time
f. Improving baby's health

Behavior: Attend Post-Natal Care (PNC)

28. Did a health worker visit your home soon after your baby was born?
a. Yes
b. No
- 28a. If Yes, how many times? *Number* _____

- 28b If did not visit at all, then, Why not?
- a. The mother was not registered for pregnancy in a medical institution
 - b. The health worker did not know about the birth of the child
 - c. The distance between the institution and the home is far
 - d. Don't know
 - e. Other *Specify*: _____
29. And can you tell us how many and at what time should you and your child receive postnatal care (PNC)?
- a. One day after a child is discharged from the hospital.
 - b. On sixth day after a child is discharged from the hospital.
 - c. One month later after a child is born
 - d. Don't know

Data collector: Please answer the following questions with Strongly agree, Agree, Don't agree, or strongly don't agree. Or you can say that you don't know:

30. Women in my community sometimes don't attend Post Natal Care (PNC) because their husbands or mother in laws refuse to let them.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
31. Women in my community don't attend PNC because they fear they will be charged money.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
32. Women in my community don't attend PNC because they lack transport.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree

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33. Women in my community don't attend PNC because there are more important priorities for their time.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
34. Women in my community sometimes don't attend PNC because of religious beliefs.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
35. Women in my community sometimes don't attend PNC because of quality of services (the provider is rude, there are long lines, etc.).
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
36. Are you satisfied with access and quality of provided services?
- a. Yes
 - b. No
- 36a *If No, Can you list of problems?*
- a. Lack of trained health staff
 - b. Financial constraints (no money for transport, unofficial payment, Treatment etc.)
 - c. HF is far from my house
 - d. Other specify_____

V. MODULE 2: MATERNAL AND CHILD NUTRITION

Behavior: Take Multiple-Micronutrient Supplementations

37. Pregnant women need to eat more food than usual
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
38. Breastfeeding women need to eat more food than usual
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree

39. Did you take any nutritional supplements during your pregnancy with [name]?
a. Yes
b. No *Skip to 41*
40. If Yes, What types of supplements or tablets did you take during your last pregnancy? *Read out all options and select all that apply*
a. Iron supplements
b. Folic acid supplements
c. Combined iron and folic acid
d. A multi-vitamin
e. Other *Specify*
- 40a If YES, how long you took iron/folic acid
1 month
2-3 months
> 3 months
- 40b Who provided the iron pills?
a. health facility
b. myself
41. Why it is important to take folic acid supplements during pregnancy? *Select all that apply*
a. For healthy development of the of the unborn baby (brain, spine and skull)
b. To prevent birth defects/abnormalities the nervous system of the unborn baby (brain, spine and skull)
c. Other *Specify*
d. Don't know

Data collector to read: Now, I am going to ask you some questions about breastfeeding and infant nutrition. Please let me know if you need me to clarify any of my questions.

42. After giving birth to **[child's name]**, did you initiate breastfeeding immediately (within 1 hour of birth)?
a. Yes
b. No
c. Don't know
43. Have you heard about exclusive breastfeeding?
a. Yes
b. No
- 43a What does exclusive breastfeeding mean?
a. Exclusive breastfeeding means that the infant gets only breastmilk and no other liquids or foods
b. Other
c. Don't know

Data collector: Next, I would like to ask you about some liquids that your baby may have had yesterday during the day or at night.

Data collector: Did (name of baby) have any of the following liquids during the day or night:

- | | | |
|-----|---|----------------------------------|
| 44. | Breastmilk | a. Yes
b. No
c. Don't know |
| 45. | Plain water | a. Yes
b. No
c. Don't know |
| 46. | Infant formula (examples: Nan, Nestogen, Nutrilon, Nutrilak, Малыш) | a. Yes
b. No
c. Don't know |
| 47. | Milk, such as tinned, powered or fresh animal Milk | a. Yes
b. No
c. Don't know |
| 48. | Juice or juice drinks | a. Yes
b. No
c. Don't know |
| 49. | Clear broth | a. Yes
b. No
c. Don't know |
| 50. | Yogurt | a. Yes
b. No
c. Don't know |
| 51. | Thin Porridge | a. Yes
b. No
c. Don't know |
| 52. | Tea | a. Yes
b. No
c. Don't know |
| 53. | Any other liquids | a. Yes
b. No
c. Don't know |

Behavior: Exclusive Breastfeeding

54. For how long should a baby be exclusively breastfed, that is to say, receiving no food or water except breastmilk?
- a. 1-5 months
 - b. 6 months
 - c. 7-12 months
 - d. Until the baby starts wanting more food
 - e. Other *Specify*
55. What are the benefits for a baby if he or she receives only Breast Milk during the first months of life? *Select all that apply*
- a. The baby grows healthy
 - b. Protection from diarrhea and other infections
 - c. Protection against obesity and chronic diseases in adulthood
 - d. Other *Specify*
 - e. Don't know
56. What are the physical or health benefits for a mother if she exclusively breastfeeds her baby? *Select all that apply*
- a. Delays fertility naturally
 - a. Helps her lose the weight she gained during pregnancy
 - b. Lowers risk of cancer (breast and ovarian)
 - c. Lowers risk of losing blood after giving birth (less risk of post-partum hemorrhage)
 - d. Improves the relationship between the mother and the baby
 - e. Other *Specify*
 - f. Don't know
57. Many times, mothers complain about not having enough breastmilk to feed their babies. Please tell me different ways a mother can keep up her milk supply. *Select all that apply*
- a. Breastfeeding exclusively on demand
 - b. Manually expressing breast Milk
 - c. Having a good nutrition/ eating well
 - d. Having a healthy or diversified diet
 - e. Drink enough liquids during the day
 - f. Other *Specify*
 - g. Don't know
58. Have you stopped breastfeeding your baby?
- a. Yes Ask Q58a and 58b
 - b. No Ask Q59
- 58a If yes, how many months old was your baby when you stopped breastfeeding? _____*Enter number of months*

- 58b *If respondent responds yes to having stopped breastfeeding of a child under two, then ask Why did you stop breastfeeding your last-born baby?*
- a. It was too difficult or painful
 - b. My baby became sick and could not breastfeed
 - c. My baby began to bite
 - d. My baby lost interest in nursing or began to wean him or herself
 - e. Breast Milk alone did not satisfy my baby
 - f. I thought my baby was not gaining enough weight
 - g. A health professional said my baby was not gaining enough weight
 - h. I didn't have enough Milk
 - i. I was sick or had to take medicine
 - j. Breastfeeding was too inconvenient
 - k. I wanted to be able to leave my baby for several hours at a time
 - l. I had too many household duties
 - m. I became pregnant or wanted to become pregnant again
59. What are common barriers in your community to breastfeeding a newborn? *Probe ("anything else?") and select all that apply*
- a. Lack of knowledge about breastfeeding
 - b. Misconception that formula is equivalent
 - c. Poor family and social support
 - d. Lactation problems
 - e. Other: *Specify*

Behavior: Children take MMN supplements including Zinc per WHO guidelines

60. Do you know what anemia is?
- a. Yes
 - b. No *Skip to Q64*
61. What are the symptoms of anemia in infants?
- a. Having pale skin
 - b. Having low energy
 - c. Poor feeding or getting tired while eating
 - d. Having fast heart rate and rapid breathing when resting
 - e. Other: *specify*
 - f. Don't know

62. What can happen to an infant when he/she has anemia?
- a. Can get chronic disease
 - b. Slow physical and mental development
 - c. Can lead to stroke
 - d. Other: *Specify*
 - e. Don't know
63. What can mothers and caregivers do to prevent anemia among children?
- a. Eat iron rich food
 - b. Eat vitamin C rich food
 - c. Frequently keep infant hands clean and washed
 - d. Other: *Specify*
 - e. Don't know

Behavior: Children fed according to WHO recommendation for Minimum Dietary Diversity and Minimum Acceptable Diet

64. How old (months) should babies start eating foods in addition to breastmilk? *Number of months* _____
65. Do you know any ways to encourage young children to eat?
- a. Giving them attention during meals (ex: talk to them, make mealtime happy)
 - b. Clap hands
 - c. Make funny faces/play/laugh
 - d. Demonstrate opening your own mouth very wide and showing how to eat
 - e. Say encouraging words
 - f. Other *Specify*
 - g. Don't know
66. Which family member decides what, when and how complementary food should be given to the child?
- a. Myself
 - b. Mother-in-law
 - c. Husband
 - d. Other
67. Have you heard about food fortification?
- a. Yes
 - b. No
 - c. Not sure

68. If yes, where did you hear or learn about food fortification?
- a. Radio,
 - b. On TV,
 - c. In the training session,
 - d. Health provider
 - e. CHT/Volunteer
 - f. Others ____
69. Have you and your family used/eaten fortified food?
- a. Yes
 - b. No
 - c. Don't know
70. If Yes, what kind of fortified food items have you or your family consumed?
- a. Milk
 - b. Yoghurt
 - c. Cereal
 - d. Bread
 - e. Salt
 - f. Juice
 - g. Other: _____
71. In your understanding, why are the food items fortified?
- a. Enhances food usefulness
 - b. Helps human body to get necessary vitamins and minerals
 - c. Improves health status
 - d. Other
 - e. Not sure
72. Do you use iodized salt?
- a. Yes
 - b. No
 - c. Not sure
73. At what age do you think you can start feeding your child eggs?
- Number of months* ____
74. What are the primary benefits of giving eggs to young children?
- a. Eggs are a complete protein food
 - b. Eggs contain a large amount of nutrition
 - c. My child likes to eat eggs
 - d. Eggs are available and affordable for my family
 - e. Other
 - f. There is no benefit
 - g. Not sure

75. Why would a mother not give her young child eggs to eat?
- a. It's feared that it may slow development
 - b. It's feared that it may delay speech
 - c. Eggs may cause allergy
 - d. Eggs may be hard to digest
 - e. Eggs are not available all year round
 - f. Eggs are expensive
 - g. Only adults eat eggs
 - h. Other

VI. MODULE 3: CHILDHOOD ILLNESSES

Data collector: Now I'm going to ask about childhood illnesses.

Behavior: Manage and effectively treat main childhood illnesses (ARI, Pneumonia, Diarrhea and helminths)

76. Where did you receive information from about how to care for your child after childbirth? *Don't read answers out loud. Select all that apply*
- a. Mother-in-Law (MiL)
 - b. Spouse/partner
 - c. Friends/peers
 - d. Neighbors
 - e. Relative
 - f. Flyer/leaflet/brochure
 - g. Poster
 - h. Radio
 - i. Television
 - j. SMS
 - k. Community events
 - l. Home visit by a community health worker
 - m. NGO (*specify*)
 - n. Doctor at health facility
 - o. Community Agent
 - p. Traditional Healer
 - q. Faith based group
 - r. Other (*Specify*)
77. Did [child's name] have any fever in the last month?
- a. Yes
 - b. No *Skip to Q78*

- 77a. If Yes, how long did the fever last? Fill in number of days_____
- If over 3 days, complete next question
- 77b. If the fever lasted three or more days, was [child's name] taken to the physician for treatment?
- Yes Skip to Q78
 - No
- 77c. If not, why?
- The medical facility was too far from my household
 - Transport is not available
 - No money to pay for transport and treatment/medicines
 - MiL or husband did not allow to take a child to physician
 - No confidence in doctor
 - other Specify_____
 - Don't know
78. What do you think are the symptoms of malnutrition in children?
- Lack of energy/weakness: cannot work, survey or play as normal (disability)
 - Weakness of the immune system (becomes ill easily or becomes seriously ill)
 - Loss of weight/thinness
 - Children do not grow as they should (growth faltering)
 - Other _____
 - Don't know
79. Why do you think children under two and a half years old can become malnourished?
- They eat less nutritious food
 - They are exposed to infectious diseases (like diarrhea)
 - Caretakers lack knowledge on how to prepare a proper meal for a child
 - Other: specify
 - Don't know

80. What do you think can help prevent a child from becoming malnourished? *Select all that apply*
- a. Follow exclusive breastfeeding
 - b. Timely and correct start of complementary feeding
 - c. Prevention of infectious diseases (diarrhea)
 - d. Regular growth monitoring
 - e. Other: Specify
 - f. Don't know
81. What can you do to prevent diarrhea in young children? *Probe, "anything else?" and select all responses that apply*
- a. Vaccinate for rotavirus
 - b. Wash hands at critical times
 - c. Drink safe water
 - d. Adequate sanitation and waste disposal
 - e. Breastfeed to reduce exposure to contaminated water
82. Has [name of child] had diarrhea in the last month?
- a. Yes
 - b. No *Skip to Q83*
 - c. Not sure *Skip to Q83*
- 82a. *If Yes, Was [name of child] given Oral Rehydration Solution (ORS) during diarrhea?*
- a. Yes
 - b. No
 - c. Not sure
- 82b. *If Yes, was [name of child] given a Zinc tablet or syrup during diarrhea?*
- a. Yes
 - b. No
 - c. Not sure
83. Have you ever heard about helminths or parasitic worms in children?
- a. Yes
 - b. No
- (if the respondent answers No, explain that helminths or worms are parasites that feed on the host organism and secrete toxins that affect internal organs and systems. The most common groups are oysters and roundworms, namely they are most often found in the bodies of small children, interacting with the external environment and not the most hygienic methods)*

84. What do you think are the signs and symptoms of helminth infections? *Select all that apply*
- a. Diarrhea
 - b. Stomach cramps
 - c. Swollen stomach
 - d. Vomiting/nausea
 - e. Loss of appetite
 - f. Weight loss
 - g. Blood in stool
 - h. Blood in urine
 - i. Worms in stool
 - j. Other
 - k. Don't know
85. What can you do to prevent helminth infections?
Select all that apply
- a. Wash hands
 - b. Use a latrine
 - c. Wash fruit and vegetables before eating or cooking
 - d. Avoid food and water contamination
 - e. Keep animals outdoors or further from the family members
 - f. Other
 - g. Don't know

Behavior: Wash hands with soap at critical times / Community level WASH behavior

86. What is the main source of water for drinking, cooking and hand washing in your HH? *Select one*
- a. canal water
 - b. piped water
 - c. public tap/standpipe
 - d. underground (borehole)
 - e. rain water
 - f. other _____

87. In general, what are the most critical moments to wash hands with soap? *Select all that apply*
- a. While preparing/serving/ eating meals
 - b. Before feeding children
 - c. After using the toilet/latrine
 - d. After disposal of feces, including children's nappies
 - e. After handling raw food
 - f. After handling garbage
 - g. After taking care of someone sick
 - h. All of the above
 - i. Other
 - j. Don't know
 - k. Other:
88. Do you do anything to the water to make it safer to drink?
- Disinfection may include: boiling, a point-of-use water treatment solution like chlorine or iodine, piped safe water,*
- a. Yes Ask Q88a
 - b. No
 - c. Sometimes
- 88a. What do you usually do to make your water healthier to drink?
- a. Boil for over 3 minutes
 - b. Add chlorine
 - c. Filter through a cloth
 - d. Use a water filter (ceramic, sand, composite)
 - e. Solar disinfection
 - f. Let water stand and settle
 - g. Other *Specify*
89. Could you please show me where you wash your hands?
- a. Yes, showed the handwashing facility
 - b. No, did not show the handwashing facility
90. Do you have soap, detergent, ash, or sand available at the handwashing site?
- a. Yes
 - b. No

ANNEX IV. SOURCES OF INFORMATION

Documents Reviewed

SOW

HMHB SOW

Workplans

HMHB Year 1 Work Plan

HMHB Year 2 Work Plan

HMHB Year 3 Work Plan

MEAL

HMHB Activity Monitoring, Evaluation and Learning Plan for Year 1

HMHB Activity Monitoring, Evaluation and Learning Plan for Year 2

Progress Reports

Quarterly

HMHB Q1 Report for Y1

HMHB Q3 Report for Y1

HMHB Q1 Report for Y2

HMHB Q3 Report for Y2

Annual

HMHB Annual Report for Y1

HMHB Annual Report for Y2

Baseline KAP Survey

Baseline Report 'Knowledge, Attitudes, and Practices Survey on Maternal Newborn and Child Health, Nutrition, Water Sanitation and Hygiene, and COVID-19 in Khatlon Region, Tajikistan Abt Associates, January 18, 2022

Briefers

Building a Knowledge Hub, HMHB, Abt Associates and Dimagi, March 2022

DHIS2 and COMM CARE Integration, HMHB, Abt Associates and Dimagi, March 2022

Knowledge, Attitudes, and Practices, HMHB, Abt Associates and Dimagi, March 2022

Continuous Medical Education, HMHB, Abt Associates and Dimagi, March 2022

Maternal, Newborn, and Child Health, HMHB, Abt Associates and Dimagi, March 2022

Rapid Health Facility Assessments, HMHB, Abt Associates and Dimagi, March 2022

Social Behavior Change Communication: Locally Available Foods, HMHB, Abt Associates, March 2022

Social Behavior Change Communication: Joint Decision Making, HMHB, Abt Associates, March 2022

Social Behavior Change Communication: Strategy and Concept, HMHB, Abt Associates, March 2022

Datasets

AMEE System (<https://amee.abtassociates.com/dhis-web-dashboard/#!/>)

USAID Previous Evaluations

Final Performance Evaluation of the Feed the Future Tajikistan Health and Nutrition Activity (2015-2020), ME&A, December 2019

Completed Studies

Rapid Health Facility Assessment (RHFA)

Gender Gaps Assessment

Digitalization Landscape

Financial Barriers Assessment

Assessment of 12 pilot CDHs by National Accreditation Committee

Rapid initial assessment of 12 District HLSCs

Self-assessment to track the improvements by the facility QI teams of maternity

Wheat flour mill assessment in Tajikistan

Developed strategies and roadmaps

Nutrition Strategy

Nutrition Roadmap

Water Sanitation and Hygiene (WASH) Roadmap

Social and Behavior Change Communication (SBCC) Stakeholder Collaboration Strategy

SBCC Action Plan

HMHB's Support MoHSPP's Guideline on the Partnership with Communities on Health Issues

SBCC Monitoring Guidelines

SBCC Materials Pre-test

Food Fortification Action Plan

Joint Action Plan to integrate hospital, PHC and community activities to improve MNCH

Facility plans on preparation for accreditation

Policy Documents

National Development Strategy of the Republic of Tajikistan for the Period up to 2030

Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030

National Communication Program for the "First 1,000 days of a Child's Life in the RT for the Period 2020-2024"

National 1,000 Golden Days Communication Strategy and Plan

Government Program on Reproductive Health for the Period 2019-2022

State program for the Development of Health Care and Social Protection of the Population of the Khatlon region for 2021-2025

QI Plans

2022 QI Plans for CDHs of Jayhun, Joami, Dusti, Shakhrituz, Vaksh, Yovon

2022 QI Plans for PHCs of Jayhun, Joami, Dusti, Shakhrituz, Vaksh, Yovon

Official Statistics

MoHPSS Data on Home Births for 2017-2021

MoHPSS Data on Maternal Mortality and Causes of Mothers Death for 2016-2021

MoHPSS Data on Perinatal Mortality for 2016-2021

MoHPSS Data on Mortality of Children Under-Five for 2016-2021

MoHPSS Data on Prevalence of Anemia among Pregnant Women for 2017-2021

MoHPSS Data on Antenatal check-up during first 12 weeks of pregnancy for 2017-2021

MoHPSS Data on HCW staffing in HMHB districts for 2017-2022

LIST OF STAKEHOLDERS INTERVIEWED

#	Name	Position	Organization
1	Christopher Barrett	Health and Education Office Director	USAID Tajikistan
2	Malika Makhkambaeva	Senior Public Health Project Management Specialist	USAID Tajikistan
3	Clifford Lubitz	HMHB COP	Abt
4	Gulnora Razykova	HMHB DCOP	Abt
5	Tahmina Jaborova	HMHB Technical Team Leader	Abt
6	Surayo Pulatova	HMHB QI Manager/ PHC level	Abt
7	Halima Boboeva	HMHB QI Manager/ Hospital level	Abt
8	Ranokhon Dododzhonova	HMHB SBCC/Gender Specialist	Abt
9	Ahmad Kayumov	MEL Manager	Abt
10	Yuliya Rakhimova	Digital Health Specialist	Abt
11	Mukhtor Khasanov	HMHB Operations Regional Manager	Abt
12	Kairinisso Akhmedova	HMHB Community Programme Manager	Abt
13	Khusanova Ranogul	HMHB Nutrition Specialist	Abt
14	Olim Abdulloev	HMHB WASH Specialist	Abt
15	Karima Hikmatulloeva	HMHB District Coordinator Jomi	Abt
16	Mehri Nasrulloeva	HMHB District Coordinator Dusti	Abt
17	Mustafo Huseynov	HMHB District Coordinator Shahritus	Abt
18	Saodatsho Ahmadov	HMHB District Coordinator Jayhun	Abt
19	Sharof Nazarkhudoev	Senior Technical Project Analyst	Dimagi Tajikistan
20	Dr. Rano Rahimova	Chief, International Relations Department	MoHSPP
21	Dr. Zoir Narzulloev	Head of MCH Department	MoHSPP
22	Dr. Rano Alieva	Chief Obstetrician/gynaecologist	MoHSPP
23	Dr. Yorakov Bakhtiyor	Director	National Centre for Medical Accreditation
24	Dr. Nodirshoeva Roza	OBGYN/EPC specialist	Scientific Research Institute Obstetrics, Gynaecology and Perinatology

#	Name	Position	Organization
25	Mavjuda Komilova	OBGYN/EPC specialist	Scientific Research Institute Obstetrics, Gynaecology and Perinatology
26	Shamsov Bakhtovar	Deputy Director	Republican Centre of Paediatrics and Child Surgery
27	Dr. Safarova Gulrukhsor	Director	Republican Center for Medical Information and Statistics of MOHSPP
28	Farmon Khakimov	DHIS2 Specialist	Republican Center for Medical Information and Statistics of MOHSPP
29	Vohidzoda Azalshoh	Head of the State Supervision Sector for Compliance with Regulatory and Technical Documents/ Member of NTWFG of Food Fortification	Tajikstandard
30	Saidov Maksumdzhon	Deputy Director/ Member of NTWFG of Food Fortification	State Unitary Enterprise "Khurokvori"
31	Mukhtorova Parvina	Director	Republican Healthy Life Style Center
32	Dr. Ibragimova Zarina	Director	National Midwife Association
33	Dr. Jonova Bunafsha	Head of the Department, Business planning and analysis of FM development	Republican Training and Clinical Family Medicine Center MoHSPP
34	Dr. Rahmonaliev Orzu	Deputy Director	Republican Nutrition Center
35	Dr. Davlatmurod Olimov	Deputy Director, Expert for quality of medical services	National Centre for Control and Quality of Medical and Pharmaceutical Services
36	Munira Rakhmatulloeva	HMHB District Coordinator Jovon	Abt
37	Dr. Rakhmatulloev Sherali	Previous SUN Coordinator and member of TWG on Food Fortification	MoHSPP
38	Dr. Shahlo Saidahmadova	Head of Obstetric, Gynaecology Department	Republican Medical college of RT
39	Rahimov Bekmurod	Deputy Director	Healthy Life Style Center Khatlon region
40	Dr. Saidov Jurabek	Deputy of Head of the Department	Khatlon Oblast Health Department
41	Dr. Qurbonzoda Hakim	DOH Programs Coordinator	Khatlon Oblast Health Department

#	Name	Position	Organization
42	Alimardonov Safarmahmad	Director, Education and Methodology Center	Khatlon Oblast Education Department
43	Saidova Malika	Family Nurse, Teacher of Khatlon Oblast Family Medicine Center	Khatlon Oblast Family Medicine Centre
44	Rasulova Tojinniso	Head of Women's Committee	Vaksh Hukumat
45	-	Head of Social Department	Dusti Hukumat
46	Saidzoda Gulrukhsor	Deputy of District Hukumat	Yovon Hukumat
47	Mastura Muminzoda	Deputy of District Hukumat	Jomi Hukumat
48	Kholov Mahmadzoir	Acting Director	Yovon Healthy Resource Lifestyle Center
49	Dr. Burhonidin Khalilov	Hospital Manager	Yovon Hospital
50	Dr. Nuralizoda Alikhon	Hospital Manager	Jomi Hospital
51	Soliev Amriddin	PHC Manager	Jomi PHC
52	Dr. Idibekov Musojon	Hospital Manager	Shahritus Hospital
53	Murodova Munira	PHC Manager	Shahritus PHC
54	Gulomov Toshmurod	HLRC Manager	Shahritus Healthy Lifestyle Resource Center
55	Dr. Mallazoda Saidullo	Hospital Manager	Dusti Hospital
56	Dr. Bozorboy Sharipov	PHC Manager	Dusti PHC
57	Raiimov Shuhrat	HLRC Manager	Dusti Healthy Lifestyle Resource Center
58	Dr. Abdulhamidzoda Homid	Hospital Manager	Jayhun Hospital
59	Dr. Muhamadi Yahyoev	Deputy Chief	Jayhun Hospital
60	Dr. Kholov Saidmurod	PHC Manager	Jayhun PHC
61	Mahmudov Jonibek	Deputy Director	Jayhun Healthy Lifestyle Resource Center
62	Savrinoz Mamadekubova	Building a System on Integrated Primary Health Care in Tajikistan (BaSIC)	GiZ
63	Shahlo Shakarova	Project Manager, ADB funded Maternal and Child Health Integrated Care Project	UNICEF
64	Shoira Yusupova	RMNCAH NPO	WHO

#	Name	Position	Organization
65	Masumi Maehara	Nutrition Specialist	UNICEF
66	Alizoda Sukhrob	Head of Center for Nutrition and evidence-based medicine	Tajik State Medical University

FGD Participants

FGDs with QI Committees

#	Name	Gender	Age	District
1	Mirzoeva	f	41	Dusti
2	Zokunova	f	29	Dusti
3	Mukhnis	m	40	Dusti
4	Kholtachev	m	52	Dusti
5	Bekmurodov	m	44	Dusti
6	Rozanov	m	44	Dusti
7	Gozeeva	f	27	Dusti
8	Saidova	f	42	Dusti
9	Shamsova	f	58	Dusti
10	Kholov	m	39	Jayhun
11	Abdulkhamizoda	m	34	Jayhun
12	Makmudov	m	49	Jayhun
13	Akheev	m	62	Jayhun
14	Kamarov	m	53	Jayhun
15	Shomatov	m	43	Jayhun
16	Nazarov	m	31	Jayhun
17	Gulmamadova	f	53	Jayhun
18	Shokirova	f	37	Jayhun
19	Giesova	f	30	Jayhun
20	Abdulakhatov	m	46	Jayhun
21	Makhmudov	m	67	Jayhun
22	Sharipova	f	32	Jayhun

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

#	Name	Gender	Age	District
23	Borunov	m	45	Jayhun
24	Kuziev	m	64	Yovon
25	Artikholov	m	35	Yovon
26	Khasanova	f	56	Yovon
27	Izzatuloeva	f	55	Yovon
28	Shukurova	f	32	Yovon
29	Kirkicheva	f	63	Yovon
30	Sharipov	m	33	Yovon
31	Khoshaev	m	55	Yovon
32	Dzuraeva	m	34	Yovon
33	Barotov	m	45	Yovon
34	Khollikov	m	40	Yovon
35	Guloev	m	43	Yovon
36	Rakhimov	m	50	Yovon
37	Rakhmonov	m	53	Yovon
38	Kamalov	m	62	Yovon
39	Valiev	m	28	Jomi
40	Valeiv	m	63	Jomi
41	Kodirov	m	52	Jomi
42	Safakhordzaev	m	46	Jomi
43	Khakimovich	f	46	Jomi
44	Kurbonov	m	30	Jomi
45	Davydov	m	64	Jomi
46	Bobomurodov	m	50	Jomi
47	Dyvyasimova	f	53	Jomi
48	Nozirova	f	62	Jomi
49	Suyashymova	f	58	Jomi

#	Name	Gender	Age	District
50	Kamoliddinov	m	30	Jomi
51	Sulaymanova	f	39	Jomi
52	Karimova	f	31	Jomi
53	Gandzalov	m	28	Vakhsh
54	Giafeeva	f	39	Vakhsh
55	Safarova	f	37	Vakhsh
56	Kurbonov	m	46	Vakhsh
57	Muminov	m	48	Vakhsh
58	Naimov	m	63	Vakhsh
59	Gandzalov	m	58	Vakhsh
60	Safarov	m	58	Vakhsh
61	Gadoev	m	42	Vakhsh
62	Sherali	m	47	Vakhsh
63	Dovudova	f	38	Vakhsh
64	Kholikova	f	47	Vakhsh
65	Ismailova	f	55	Vakhsh
66	Shamsuloeva	f	45	Vakhsh
67	Dodkudoeva	f	30	Shahritus
68	Shomatova	f	57	Shahritus
69	Sodridinova	f	29	Shahritus
70	Musshyzova	f	33	Shahritus
71	Shahkarova	f	63	Shahritus
72	Usmanova	f	49	Shahritus
73	Eltridinova	f	48	Shahritus
74	Izatov	m	60	Shahritus
75	Ramshidov	m	29	Shahritus
76	Sokitsov	m	51	Shahritus

#	Name	Gender	Age	District
77	Mirzoev	m	47	Shahritus
78	Gulomov	m	47	Shahritus
79	Guloniv	m	51	Shahritus

FGDs with District Nutrition Trainers

#	Name	Gender	Age	District
1	Kakhkarova	f	63	Shahritus
2	Dorkhudoeva	f	30	Shahritus
3	Gulamov	m	53	Shahritus
4	Khurshedzoda	f	26	Vakhsh
5	Allamurodov	m	28	Vakhsh
6	Abdukordir	m	30	Vakhsh
7	Gulmirzoev	m	35	Vakhsh

FGDs with Community Health Teams

#	Name	Gender	Age	District
1	Davlatmaeva	f	58	Dusti
2	Gustamova	f	60	Dusti
3	Khuseynova	f	43	Dusti
4	Klicheva	f	61	Dusti
5	Jamilova	f	52	Dusti
6	Mamarakhimova	f	37	Dusti
7	Sharipova	f	62	Dusti
8	Mubalieva	f	65	Dusti
9	Donaeva	f	51	Dusti
10	Khomatova	f	27	Dusti
11	Navruzshoeva	f	35	Dusti
12	Yusupova	f	36	Dusti
13	Khalalieva	f	42	Dusti

#	Name	Gender	Age	District
14	Kurbanova	f	48	Dusti
15	Goibova	f	23	Dusti
16	Khuseynova	f	51	Dusti
17	Makhmadalieva	f	60	Jomi
18	Karimova	f	48	Jomi
19	Khaitova	f	68	Jomi
20	Khaknazarova	f	54	Jomi
21	Dodova	f	54	Jomi
22	Dodova	f	60	Jomi
23	Saidova	f	43	Jomi
24	Odinaeva	f	54	Jomi
25	Khaknazarova	f	35	Jomi
26	Kholova	f	35	Jomi
27	Obidzoda	m	24	Jomi

FGDs with Mothers of CU2

#	Name	Gender	Age	District
1	Kurbonkuli	f	27	Yovon
2	Kabgova	f	45	Yovon
3	Khasanova	f	37	Yovon
4	Rakhmatulaeva	f	33	Yovon
5	Rakhmatulaeva	f	34	Yovon
6	Abdulova	f	48	Yovon
7	Kabirova	f	38	Yovon
8	Zaripova	f	35	Yovon
9	Palaeva	f	52	Yovon
10	Shodieva	f	25	Yovon
11	Jonieva	f	37	Jayhun

#	Name	Gender	Age	District
12	Maunsova	f	24	Jayhun
13	Rozikova	f	31	Jayhun
14	Zokirova	f	41	Jayhun
15	Bozorova	f	35	Jayhun
16	Mirzoeva	f	34	Jayhun
17	Kasirova	f	26	Jayhun
18	Mashrapova	f	28	Jayhun
19	Mirzoeva	f	23	Jayhun
20	Shoeva	f	34	Jayhun
21	Kasirova	f	23	Jayhun
22	Shoeva	f	27	Jayhun
23	Zokirova	f	30	Jayhun
24	Ashurova	f	23	Jayhun

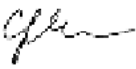
FGDs with MiLs

#	Name	Gender	Age	District
1	Oisha Zakirova 3	f	55	A. Jomi
2	Jonmakhmadova	f	68	A. Jomi
3	Sharipova	f	55	A. Jomi
4	Davlatova	f	50	A. Jomi
5	Dodova	f	62	A. Jomi
6	Kosimova	f	54	A. Jomi
7	Zaripova	f	52	A. Jomi
8	Abdukhodirova	f	57	A. Jomi
9	Yarmatova	f	50	Shahrirus
10	Khaitova	f	52	Shahrirus
11	Parotova	f	58	Shahrirus
12	Abdukhodirova	f	58	Shahrirus

Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity

#	Name	Gender	Age	District
13	Kholmatova	f	74	Shahritus
14	Kayumova	f	71	Shahritus
15	Kenzaeva	f	62	Shahritus
16	Dustova	f	60	Shahritus
17	Ogildieva	f	48	Shahritus
18	Kenzaeva	f	59	Shahritus
19	Saidileva	f	57	Shahritus
20	Rakhmonkulzoda	f	42	Shahritus
21	Safomudinova	f	44	Shahritus

ANNEX V. DISCLOSURE OF ANY CONFLICT OF INTEREST**CONFLICT OF INTEREST (COI)** (please fill/sign/date the form below)

Name	Kateryna Stolyarenko
Title	Consultant
Organization	ME&A, Inc.
Evaluation Position	Team Leader/Evaluation Specialist
Evaluation Award Number (or RFTOP or other appropriate instrument number)	RFTOP 72011922R00003
Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity
I have a real and/or potential conflict of interest to disclose.	☐ Yes ☒ No N/A
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> 1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	
Signature:	
Date:	09/12/2022

CONFLICT OF INTEREST (COI) (please fill/sign/date the form below)

Name	Dr. Sabir Kurbanov
Title	Consultant
Organization	ME&A, Inc.
Evaluation Position	Senior Technical Specialist (Maternal and Child Health (MCH) Evaluation
Evaluation Award Number (or RFTOP or other appropriate instrument number)	RFTOP 72011922R00003
Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity
I have a real and/or potential conflict of interest to disclose.	☐ Yes ☒ No N/A
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	
Signature:	<i>SKurbanov</i>
Date:	09/12/2022

CONFLICT OF INTEREST (COI) (please fill/sign/date the form below)

Name	Mirkhaidarova Shodiya
Title	Consultant
Organization	ME&A, Inc.
Evaluation Position	Technical Specialist (Nutrition Evaluation)
Evaluation Award Number (or RFP/OP or other appropriate instrument number)	RFP/OP 72011922R00003
Project(s) Evaluated (include project name(s), implementer name(s) and award number(s), if applicable)	Midterm Performance Evaluation for Healthy Mother, Healthy Baby (HMHB) Activity
I have a real and/or potential conflict of interest to disclose.	☐ Yes ☒ No ☐ N/A
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> 1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant through indirect, in the implementing organization(s) whose projects are being evaluated or in the outcomes of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	
Signature:	
Date:	09/09/2022

ANNEX VI. EVALUATION TEAM MEMBERS

Team Leader/Evaluation Specialist, Kateryna Stolyarenko: Ms. Stolyarenko is an evaluation expert with over 16 years of international experience in M&E in more than 25 countries in Europe, Asia, and Africa including many post-Soviet nations. She has worked for several bilateral and multilateral organizations, including USAID, European Commission, Council of Europe, Danish Ministry of Foreign Affairs, Polish Aid, United Nations (UN), International Labor Organization (ILO), and other private and public entities. Throughout her extensive career, Ms. Stolyarenko has evaluated projects in protection, health, shelter, food security, livelihoods, civil society strengthening, rule of law, human rights, gender and youth. She has conducted more than 50 humanitarian and development project/program evaluations, both as an evaluation expert and a team leader, using a variety of evaluation approaches such as theory-based, developmental, participatory, utilization-focused, mixed methods to determine the relevance, coherence, effectiveness, efficiency, and sustainability. Since 2014, Ms. Stolyarenko has served as senior evaluation expert/team leader for evaluations of large donor funded projects including baseline studies, mid-term, final, and impact evaluations in such thematic areas including youth, health, food security, livelihoods, civil society, SMEs, inclusive economic development, rule of law and migration. Selected evaluations she conducted include: a) evaluation of European Union (EU) humanitarian assistance in Ukraine (2014–2018) the EU humanitarian aid in eastern Ukraine (government-controlled areas and NGCA); b) mid-term review of Civil Society for Enhanced Democracy and Human Rights in Ukraine project; c) mid-term evaluation of USAID's Enhancing Governance, Accountability, and Engagement in Ukraine; d) country evaluation of the EU's cooperation with Armenia (2007–2017) with a focus on the rule of law, human rights, civil society, and gender; e) independent evaluation of the International Labor Organization's (ILO) Program of Work in Lebanon and Jordan in response to the Syrian refugee crisis; f) final evaluation of Youth for Development program in Ukraine; g) evaluation of UNHCR's Country Program in Ukraine (2014–2016) for legal and social assistance to refugees and asylum seekers through protection, food security, and shelter; h) evaluation of the Strengthening and Protection of Human Rights, Civil Society, and Democratization project in North Iraq; and i) final evaluation of Support to Fundamental Rights in Belarus project; and others. In 2019, as team leader of the USAID/Central Asia LEAD Economic and Social Connections- a Multi-Year Area Development Financing Facility for Tajikistan (ESCoMIAD)- she led the evaluation team assessing the effectiveness of interventions supporting economic/financial inclusion and civil society/community mobilization, including SME creation and competitiveness on the Tajik Afghan border. She holds a B.A. in International Relations from International University Concordia-Audentes in Tallinn, Estonia, and is earning a M.A. in Evaluation from The Melbourne University, Melbourne, Australia. Ms. Stolyarenko speaks fluent Ukrainian and Russian.

Senior Technical Specialist, Maternal and Child Health (MCH) Evaluation, Dr. Sabir Kurbanov: Dr. Kurbanov is a Tajik public health and nutrition expert with extensive experience in public health; health policy; maternal and child health and reproductive health; HIV/AIDS and PMTCT; nutrition; project and survey design and implementation; monitoring and evaluation; research; and teaching. As Health Specialist with UNICEF in Tajikistan, he was responsible for policy formulation and development; program design, management, implementation, monitoring, and evaluation of the health and nutrition projects (MCH, EPI, HIV, Nutrition) supported by UNICEF; strategic planning and program development; analysis of the country situation related to child health and nutrition; data gathering, analysis, and presentation for appropriate policy and strategy formulation; development of national laws and legislations related to child and newborn health/nutrition; and management of human and financial resources of over 2 million USD per year. Dr. Kurbanov practical experience designing and implementing surveys having worked on numerous surveys in Tajikistan including the USAID/Feed the Future Cost of the Diet (CotD) Survey in the Khatlon Region; Health Policy Unit of Ministry of Health household-based survey to assess access to ANC services; and MOH/World Bank Baseline Nutrition Survey in the Khatlon Region where he developed research modules and materials, trained interviewers, monitored data collection, analyzed data, and wrote the report. In addition, as the nutrition consultant for the joint FAO and Agency of Statistics (AOS) assessment of the Women's Dietary Diversity Score

Survey (WDDS), Dr. Kurbanov assessed the nutrition situation, analyzed the nutrition status of women and children, and performed data analysis and interpretation, working closely with AOS staff to develop proposals, implement training, and facilitate the process of integration of MDDW into household budget survey modules. As the Chief Pediatrician of the Ministry of Health in Tajikistan, he designed, implemented, and monitored MCH Programs/Projects, namely CDD/ARI, Breastfeeding, and EPI and conducted trainings and seminars related to child health and nutrition. As the Chief of the Infectious Department of the Mother and Child Health (MCH) Institute in Dushanbe, he designed and implemented MCH research studies and trained health workers. Dr. Kurbanov holds MD from Tajik Medical University and PhD from Institute of Pediatrics, Moscow, Russia. He speaks Tajik (fluent), Uzbek (fluent), Russian (fluent), English (fluent).

Technical Specialist (Nutrition Evaluation), Dr. Shodiya Mirkhaidarova: Dr. Shodiya Mirkhaidarova is a trained obstetrician/gynecologist with over 25 years of experience working directly with patients, advising national health authorities, as well as leading and supporting the implementation as well as monitoring and evaluation of numerous donor-funded projects in the health sector in Tajikistan. She has worked extensively with international donor organizations including USAID, UNICEF WHO and UNFPA, and International and Local non-governmental organizations (NGOs). In addition to her experience as a physician in local health centers, she has been an integral part of USAID-funded Activities, including USAID Central Asia HIV Flagship Activity, USAID Dialogue on HIV and TB project, USAID RH project on Social Marketing 'I KNOW', and USAID MCH/RH "Healthy Family" project. Dr. Mirkhaidarova has direct experience conducting baseline/end line assessments on child health and nutrition care practices at the family and community level, developing methodologies and questionnaires, ensuring quality control during project implementation, and presenting findings to donors and other stakeholders. She is also intricately familiar with USAID rules and regulations related to project management and implementation. Ms. Mirkhaidarova holds Postgraduate Certificate in Obstetrics & Gynecology from Postgraduate Medical Institute of Tajikistan, Dushanbe, Tajikistan, and MD from Tajik State Medical University, Dushanbe, Tajikistan. Ms. Mirkhaidarova is fluent in Tajik, Russian, and English.

Local Partner, Z-Analytics Group: Z-Analytics is a leading research group in Tajikistan providing professional research services, including carrying out both quantitative and qualitative data collection using computer-assisted personal interview (CAPI) methods. Z-Analytics actively works with local NGOs, businesses, governmental agencies, and international clients. It will conduct the KAP survey of mothers with CU2 years of age using six experienced and trained survey enumerators over the two-week period of field data collection. The enumerators will have a minimum of three years of experience implementing surveys with additional experience in health, nutrition, agriculture, or food security. Z-Analytics is supported by cutting-edge data collection, entry, and analysis using specialized statistical software for data processing, such as SPSS for Windows and CSPro 3.0. Its in-house capacity includes quantitative and qualitative technical specialists, monitoring and evaluation supervisors, managers, and data analysts.