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Final Evaluation report . Varzob Reproductive Health Improvement Project

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Final evaluation of the Varzob Reproductive Health (VRH) Project, implemented in Tajikistan between April 2001 and January 2003. This effort was funded by the USAID/CAR through the NGO Networks for Health Project. The evaluation assesses the impact of IEC campaigns and the performance of midwives trained to manage normal deliveries as well as obstetric complications.

The **overall goal** of the VRH Project was to increase the access of women of reproductive age in Varzob District to quality reproductive health services through improved reproductive in applying basic primary care measures and seeking reproductive health services when required.

The **major strategies** employed by the project to reach its goal included: **Training and ongoing supportive supervision** of all midwives in the district in counseling, management of normal pregnancies and deliveries, and identification and management of obstetric emergencies (Basic Life Saving Skills) and **Community level health education for women of reproductive age** to improve awareness and knowledge on basic sexual and reproductive health issues and promote health care seeking behaviors.

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CARE International in Tajikistan

Final Evaluation Report

Varzob Reproductive Health Improvement Project

Funded by USAID

Prepared with assistance from:
NGO Networks for Health
CARE USA

I. INTRODUCTION

CARE International began implementing the Varzob Reproductive Health (VRH) Project in Tajikistan in April 2001. This effort was funded by the USAID regional office in Almaty, through the NGO Networks for Health Project. Project activities were completed in January 2003.

The **overall goal** of the VRH Project was for women of reproductive age in Varzob District to have increased access to quality reproductive health services and adequate knowledge of reproduction to apply basic primary care measures and seek RH services when required.

The **major strategies** employed by the project to reach this goal included:

- **Training and ongoing supervision** of all midwives in the district in counseling, management of normal pregnancies and deliveries, and identification and management of obstetric emergencies (Basic Life Saving Skills).
- **Community level health education with women of reproductive age** to improve awareness and knowledge on basic sexual and reproductive health issues and promote healthy preventive and care seeking behaviors.

The VRH Project was designed to complement the hospital-based strategy employed by CARE's Foundations for Enhancing Management of Maternal Emergencies (FEMME) Project. By implementing the two projects in overlapping geographic areas in close collaboration with the Ministry of Health, CARE Tajikistan has been able to take a comprehensive approach to maternal health interventions, and to the problems of pregnancy-related morbidity and mortality in particular. CARE has implemented both projects in partnership with the American College of Nurse Midwives (ACNM). ACNM training materials on both Advanced and Basic Obstetric Life Saving Skills have been translated into Russian for local use, and capacity building of both hospital level staff and community-based midwives to manage deliveries and obstetric emergencies has been led by consultants from ACNM.

As the NGO Networks funded component of CARE's program came to a close, CARE conducted an internal evaluation to assess the effectiveness of both the community-level IEC interventions and the training to enhance the capacity of midwives to manage normal deliveries and take appropriate life-saving action in the event of complications. This internal evaluation was conducted with assistance from Theresa Shaver, Child Survival/Safe Motherhood Advisor for the NGO Networks for Health Project and Ellen Pierce, CARE's Technical Advisor for Reproductive Health for the Asia region.

The final evaluation of the VRH project assessed the extent to which the following specific objectives were achieved:

Objective 1: By December 2002, 100 percent (N=24) of midwives in Varzob District will be skilled in proper counseling approaches, management of normal pregnancy and delivery, identification and management of obstetric complications

The extent to which Objective One has been achieved was assessed through evaluation of the clinical skills and case management practices of midwives trained through the project.

Objective 2: By December 2002, 80 percent of all women of reproductive age will have the knowledge required to take basic preventive measures to enhance and maintain their sexual and reproductive health.

The extent to which Objective Two has been achieved was assessed through comparison of the baseline survey with the results of the quantitative endline KAP survey, conducted in project communities.

Objective 3: By December 2002, 80 percent of all women of reproductive age will have the knowledge required to identify danger signs of pregnancy and seek medical help when required.

The extent to which Objective Two has been achieved was assessed through comparison of the baseline survey with the results of the quantitative endline KAP survey, conducted in project communities.

II. BACKGROUND AND PROJECT DESCRIPTION

Since the dissolution of the Soviet Union, the Republic of Tajikistan has experienced economic collapse and civil war. The impact of these events on the population has been wide spread under- and unemployment, continuing violence and a drastic cut in social service provisions. Entire segments of the population are now living below the poverty line, and the country has seen severe deterioration in the health status of the population. Major factors contributing to the decline include malnutrition, deteriorated living conditions, a reduction in government expenditure on health, migration of health workers, lower levels of immunization, destruction of hospitals during the civil war and lack of safe drinking water. Incidence of infectious and poverty-related diseases such as typhoid, diarrhea, and tuberculosis has increased.

In addition to the significant deterioration of the general health status of the population, the reproductive health status[1] of women has been affected in particular. Average family size is 6.1 in urban areas and 7.1 in the rural sections of the country. WHO lists the Maternal Mortality Ratio (MMR) in Tajikistan as 64.6/100,000 live births. Given the abrupt rise in the number of home births, however, in isolated conditions, with no skilled providers in attendance, this may be an underestimation of the numbers of women who are actually dying of pregnancy related causes. The major causes of maternal death recorded in Tajikistan, similar to those of the rest of the world, are hemorrhage (37.5%), toxemia (26.7%), abortion and its complications (12.2%), and sepsis (11.4%).[2]

Prior to the break up of the Soviet Union it was estimated that 90-95 percent of women gave birth in hospitals, with most births attended by an obstetrician/gynecologist. Even in the cities, this situation has changed. Compared to rural districts, the capital, Dushanbe, has the best facilities and choice of functional equipment, the most extensive access to supplies, and highest ratio of health care providers per patient. It is estimated that in areas surrounding the capital, however, hospital deliveries have dropped to about 40%. The result is a shift to predominately home births, which are not attended by skilled personnel.[3] The

[1] Reproductive Health is the state of physical, mental and social prosperity, the capacity of the people to have responsibility for safe sex which gives satisfaction, reproductive opportunity and the freedom of making decisions on the number of children in the family, when and how often they may have children.
[2] The findings of The Survey on the Reproductive Health of Women in some towns and rayons of Khatlon Oblast, UNFPA Division for Arab States and Europe, WHO Regional Office for Europe, Women's and Reproductive Health Programme, Feb. 2000.
[3] Trip Report 22 October – 8 December 2001, Life Saving Skills Training-Clinical 1st Training of Varzob District Midwives, Varzob Reproductive Health Improvement Project, Consultant P. Annie Clark, CNM, MPH.

baseline KAP survey conducted by CARE in Varzob District revealed that only 45% of women delivered with the help of a skilled provider (hospital and home delivery) with an increased shift towards home births assisted by local midwives and traditional birth attendants (TBAs or *Mama Doyas*).

The project location, Varzob District, is a mountainous rural area, located just north of Dushanbe in Region of Republican Subordination (RRS). Varzob District is divided into seven Jamoats, each of which consists of five to 17 villages. Over half of the district is inaccessible during the winter months. The total population of Varzob is approximately 56,000, with an estimated 12,000 women of reproductive age (15 – 45 years). During the project baseline survey, 71 percent of women responded that they gave birth in their homes. All but two percent of those who gave birth in facilities went to one of the Dushanbe Maternity Hospitals. An earlier survey showed that only 4% of babies in this district were born in the Varzob Central District Hospital.[4] The high number of referrals of women to Dushanbe for maternity services is a reflection of the poor conditions in the district hospital. Only 75 percent of the staff physician positions are filled, basic equipment is not available, and there is no blood bank. Cesarean sections are only available two days a week, and only during the day, when an anesthesiologist can come from Dushanbe to provide anesthesia services.[5]

In addition to the Central District Hospital – which, as has been illustrated, is characterized by poor quality and availability of services -- the healthcare needs of women and families in Varzob District are met by a network of rural facilities and providers. There are 9 Health Centers (some with in-patient facilities) and 24 Health Posts or "medical houses" with minimal out-patient facilities. Almost all of these facilities have staffing vacancies; none of them are fully staffed with the four to eight medical and paramedical personnel who are supposed to be providing services. Many of the medical houses are in such poor repair that the community-based service providers – midwives, nurses and *feldshers*[6] -- are seeing clients and providing services from their homes. Lack of supplies and equipment constitutes a major barrier to quality care. Please see Attachment A for a schematic diagram of the health service delivery system in Varzob District, listing number and type of facilities, filled and vacant posts and the service providers who received training in Basic Life Saving Skills through the project.

Skill levels among the community-based providers – many of whom received training 10 – 15 years ago, with no refresher or in-service training since – were minimal. Midwives and nurses, who were regularly attending home births, lacked the skills to manage a normal delivery correctly, much less to recognize and deal with a complication in a timely, appropriate manner. Although they were providing a much needed and highly valued service to their communities and doing so with enthusiasm and dedication, it was found, at the outset of the project, that midwives, nurses and *feldshers* required solid training and subsequent monitoring and coaching to bring their skills in maternity care up to acceptable standards.

Levels of knowledge among women and their family members about basic reproductive care were extremely limited at the time of the baseline survey. Fewer than ten percent of respondents were able to provide correct answers to basic questions on reproductive physiology, contraception, antenatal and delivery care and danger signs, and transmission and prevention of STIs. This lack of knowledge regarding basic care, the

[4] Gafarova, D. Knowledge, Practice, and Coverage Baseline Survey in Varzob District. June 2001. CARE Tajikistan, VARZOB Reproductive Health Improvement Project.
[5] P. Annie Clark, 2001, *Ibid*
[6] *Feldshers* are male, community-based paramedical staff who receive four years of training; they are higher in the health service delivery structure than nurses and midwives, but often do not have skills in reproductive or women's health issues, as they are traditionally not consulted for what are considered female problems.

importance of having a skilled provider present at delivery and when to seek medical attention in the event of complications is compounded by the lack of resources to pay for such care. Poverty and poor infrastructure – roads, transportation and local health facilities – exacerbated women's inability to take appropriate steps to manage their own healthcare.

It is within this setting that CARE responded in partnership with the Tajikistan Ministry of Health to educate communities, train primary care providers, and equip peripheral health facilities in order to reach the women of Varzob District with skilled providers for antenatal, delivery, and postpartum care.

Community Education

CARE took a cascade approach to information, education and communication on basic reproductive health care issues. After assessing levels of knowledge and skill among women and determining what the major RH issues were for these women, CARE developed a series of messages on safe pregnancy and delivery, contraception and protection against STIs, including HIV. Please see Attachment B for a summary of these messages. The project developed colorful IEC materials, in the form of brochures, posters and flip books, for use in training with educators, display in health facilities and communities, in education sessions with groups and for distribution to individuals.

Eight "Responsible Persons" from the Ministry of Health were trained in delivery of the health messages. In turn, these Responsible Persons trained all health personnel in Varzob District (n=76), as well as 113 community volunteers. Volunteers, leader womens, were selected per one or two from each villages according number of households , and used the opportunity of another CARE project supplemental food distribution to hold group education sessions. They also held impromptu sessions in their communities and used social gatherings as an opportunity to talk about RH issues and communicate information on self-care and appropriate health seeking behaviors. Health service providers used the opportunity of interactions with clients, particularly during antenatal visits, to reinforce the health messages and distribute individual brochures.

Basic Life Saving Skills

During the life of the project, 30 community-based service providers in Varzob District – midwives, nurses and *feldshers* – received training in Basic Life Saving Skills (BLSS) for obstetrics The Basic LSS course was adapted from the internationally recognized clinical course developed by the American College of Nurse Midwives, and includes the first half of Module 6 (Infant Resuscitation) and the rest of Life Saving Skills modules 1 - 8; and the *Healthy Mother, Healthy Newborn Manual's* topic numbers two and six (antenatal and postpartum care). Basic Life Saving Skills modules 1-8 include:

1. Maternal mortality
2. Antenatal complications (e.g., pregnancy induced hypertension, anemia)
3. Use of the partograph to manage labor, progress in labor, normal labor and delivery
4. Prevention, use and repair of episiotomy, infiltration, hand and instrument ties, repair of lacerations, cervical inspection and laceration repair
5. Antenatal and postpartum hemorrhage including the active management of third stage, manual removal of the placenta, external and internal bimanual compression, digital removal of clots
6. Adult and infant resuscitation, use of the Heimlich maneuver
7. Infection prevention, common causes of sepsis; prevention and management
8. Hydration and rehydration[7]

[7] Marshall M. & Buffington S. Life-Saving Skills Manual for Midwives. 1998. ACNM.

A major accomplishment of the project was translating these training manuals into Russian, obtaining approval for the translation from the Ministry of Health and producing them for local use. The manuals are being used to train 120 midwives in a follow-on project implemented by CARE with another source of funding and will be used by Save the Children in a USAID-funded safe motherhood program in another region of the country.

Consultants from ACNM trained groups of senior midwives in Dushanbe to serve as the Safe Motherhood Training Team (SMTT) for the project, and CARE renovated and equipped a maternity facility in Dushanbe to serve as a training site. The SMTT went on to conduct several rounds of training for community-based providers, as well as to provide continued supportive supervision of the trainees to help them gain competence and confidence in their new skills.

Training methods included multiple learning modalities appropriate for adult learners. When trainees were in the hospital to perform clinical skills, consultants observed clinical care and gave coaching and feedback. The participants' performance was monitored and evaluated using a pre and post-tests, individual conferences, self and peer evaluation of performance of skills with models and clients, and a skill checkout. Post-test scores improved dramatically in comparison with pre-test scores.

One departure from the original strategy of the project was the inclusion of nurses and *feldshers* in the Basic Lifesaving Skills training, along with midwives. On detailed assessment of the project area, it was discovered that there were only seven actual midwives present in their posts in Varzob District. The rural health facilities in Varzob are staffed by a combination of the three types of providers, all of whom had roughly similar levels of skill in maternity care at the start of the project. Since coverage with health services is very sparse at community level, and people sought services from whoever was in place, it was decided to equip all rural service providers with Basic Life Saving Skills, for appropriate management of normal deliveries, as well as common complications of pregnancy and delivery. Hence, the final list of providers who received training through the project (in contrast with the original plan of 24 midwives) consists of seven midwives, fifteen nurses and eight *feldshers*.
All BLSS trained staff were provided with Delivery kits.

Following is a brief timeline of the clinical training activities undertaken by the project:

Time Line

April 2001: the project team and ACNM consultant, Annie Clark presented the training modules and curriculum to the MOH for endorsement and approval. The materials were adapted to MOH guidelines and the two training resources (LSS Manual and the *Healthy Mother, Healthy Newborn* package) were combined to create the Basic Life Saving Skills training (BLSS) curriculum. Translation of materials began, and the team conducted an assessment of the health facilities and based on this review established an equipment/supplies list to procure in order to conduct the first Training of Trainers Teaching (TOTT).

July/August 2001: First Training of Trainers (Theory) – Safe Motherhood Training Team began the TOTT, which consist of a 12 day course on teaching methodology.

October/November 2001: Four trainers from Panjikent (Save the Children), four trainers from Maternity House Three in Dushanbe, and two trainers from Varzob participated in a basic Life Saving Skills Training of Trainers Teaching (TOTT), which was conducted by the ACNM consultant, Annie Clark. The new Safe Motherhood Training Team then undertook training of the first group of midwives from Varzob (n=12), with support from the ACNM consultant.

February 2002: Monitoring of the clinical skills of trained providers began, with the monitoring system, including tools for record keeping, tracking and skills assessment being adopted in all health facility sites in Varzob.

March 2002: Additional 11 midwives trained in Basic Life Saving Skills.

June 2002: Refresher training conducted for the Safe Motherhood training team for a total of 3 weeks.

Summer 2002: Seven additional providers received BLSS training.

February – December 2002: Monitoring and supportive supervision of BLSS trainees continues to help them consolidate and continue to improve their skills

III. EVALUATION APPROACH

The project final evaluation was conducted in March 2003, with assistance from CARE and NGO Networks headquarters advisory staff. As noted in the introduction to this document, achievement of Objective # 1, enhanced midwifery skills among providers in Varzob District, was measured through an assessment of clinical skills among the trainees. Achievement of Objectives 2 & 3, enhanced knowledge of basic reproductive health care, with an emphasis on danger signs of pregnancy and delivery, was measured through comparison of the results of a KAP survey with the baseline. Brief descriptions of the methodology used for each component of the evaluation follow:

Clinical Assessment

All 29 Varzob District health service providers who had been trained in BLSS, and were still present in their posts (one had emigrated to Russia), were invited to participate in the assessment of clinical skills. A total of eighteen actually attended the assessment. Assessment of each trainee took a full day and consisted of two written exams (a general knowledge test, very similar to the pre- and post-tests used during the training and a case study on use of the partograph) and demonstration of three critical life-saving skills, using anatomical models. Please refer to Attachment C for a full list and description of each of the tools used by the evaluators for the clinical assessment.

This component of the evaluation was organized and overseen by Theresa Shaver, who trained two project staff and two senior midwives from the Safe Motherhood Training Team to use the evaluation tools and administer the exams to trainees. The results of the written exams and demonstrations were supplemented by observation of two deliveries, as well as a day spent observing antenatal visits in the field and interviewing trained midwives on protocols for antenatal care. Finally, some case records of women with complications who had been referred to the hospital were also reviewed.

KAP Survey

A 51-question Knowledge, Attitudes and Practices survey was administered in Varzob District to measure changes in levels of knowledge on reproductive health issues and practices related to care during pregnancy and delivery. The questionnaire that was used for baseline was reviewed and the questions sharpened somewhat, to get the most accurate information possible from the respondents. The revised 51-item questionnaire was translated into Tajik and then back-translated to ensure that the English and Tajik versions were comparable. The survey contained questions on knowledge and behaviors related to pregnancy and delivery, with a short section on contraception and STIs, including HIV. Please see Attachment D for a copy of the survey instrument in English.

Women with children under one year of age were targeted for the survey (respondents for the baseline were women with children under two). This change in respondent characteristics was done in order to capture possible changes in behavior related to pregnancy and delivery, as well as knowledge and attitudes, among women who had exposure to the intervention during the eighteen-month life of the project. A random, thirty-cluster method was used to select villages (clusters), and five mothers of children under one year were identified in each cluster, using a uniform method for selecting women from the center of the village as well as in more remote corners.

The KAP survey was organized and led by the VRH Project Manager, Dilbar Gafarova, with assistance from Ellen Pierce. Six local physicians, who had worked with CARE previously on nutrition KAP surveys, conducted the actual interviews. One hundred and fifty-two women were administered the questionnaire, during four days of house-to-house interviews.

IV. MAJOR FINDINGS & CONCLUSIONS

Following are some of the general findings from both the clinical skills review and KAP survey.

Skills of Providers Trained in BLSS

As noted above, only 18 of the possible 29 trainees participated in the clinical skills assessment.

Tool 1: Knowledge Test & Partograph Case Study

In the introduction to this tool, participants were asked to estimate the number of deliveries attended since their BLSS training. For this group the reported range was from 1 to 68 deliveries since training; this range had a significant impact on trainees' performance in the evaluation, particularly in demonstration of skills.

All participants answered 100% of the questions out of a possible 34 in the knowledge test. The average score on the knowledge test was 83%. There was slight difference in scores between the three cadres of providers: midwives had an average score of 89.7%, nurses, an average score of 82%, and *feldshers* had an average score of 81.2%.

There was a possible score of 57 points on the partograph case study. The majority of participants answered all the questions. Although the participants had, for the most part, become comfortable with the partograph form and how to fill it, clinical interpretation of the data on the form was still a challenge for them. This became evident in verbal discussions on what action should be taken, as well as in the referral forms that were reviewed for the evaluation and in use of the partograph during the deliveries observed. There is no

significant difference between the midwives (average score of 81.1%), nurses (average score of 81.5%) and *feldshers* (average score of 85.6%).

Tool 2: Skills Demonstration

The type of clinical skills assessed by demonstration with models are discussed below and summarized in Table One, below.

Table One: Average scores out of 100% possible (n=18)

	BLSS Test	Partograph	External Bimanual Compression	Internal Bimanual Compression	Manual Removal of Placenta
Pre-Test	**26%**	**Out of 5 – 22%**			
Post-Test	**75%**				
Final Evaluation	**84%**	**83%**	**68%**	**60%**	**68%**

External Bimanual Compression

The average score of the 18 participants who demonstrated this skill was 68%. Comments from the evaluators indicated that there was some confusion about when to start intravenous fluids and understanding of the correct amount/rate of infusion was weak.

Internal Bimanual Compression

The average score for this skill was 60%. The evaluators noted that some participants were nervous demonstrating this skill. The external evaluator noted that participants were either over-confident or under-confident in demonstrating this skill. Many of the participants also experienced difficulty in maintaining sterility while putting on gloves. Other steps commonly omitted or demonstrated incorrectly during this procedure were massaging the uterus before the procedure, correct use/amount of oxytocin, amount and rate of intravenous infusion, client/provider interaction skills related to informing the mother about the procedure that was going to be done, and checking to see if the bladder was full before beginning internal bimanual compression. Counseling to the woman or her family members on what to observe and what steps to take in caring for the client after the procedure was often missed.

Manual Removal of the Placenta

The average score for this skill was 68%. The external evaluator and other evaluators had the same overall impression as with the description of internal bimanual compression. The official regulations of the MOH do not permit midwives, nurses and *feldshers* to do this procedure. However, community-based providers were, in fact, performing this procedure and it was included in the training – hence, CARE staff and the evaluation team felt it was important to evaluate this critical skill. In discussions with staff and trainees, it was also emphasized that in the more remote areas of Varzob that are cut off during the winter, correct performance of this procedure was essential to saving women's lives.

Overall summary findings with regard to assessment of clinical obstetric life-saving skills were as follows:

A. Providers have achieved a **good level of *knowledge*** in the training content, as evidenced by the good scores on the written exams; there seemed to be a good grasp of the training content overall.

B. ***Some* of the providers demonstrated confidence and skill** in emergency procedures; understandably, those who had attended the most deliveries since training tended to demonstrate the highest levels of confidence.
C. Areas related to clinical midwifery **skills requiring improvement include**:
   - ⇨ Correct performance of emergency procedures
   - ⇨ Client/provider interaction and counseling skills
   - ⇨ Use of equipment and supplies provided by the project
D. Providers were very honest with regard to areas where they lacked confidence and **required additional training and support** and requested that CARE and the MOH training team continue to provide assistance in this area
E. With time, providers are **losing confidence** in performing the new skills; this is reflected in the referral records; cases that should have been handled by the community-based providers were being unnecessarily referred to higher levels.
F. The **Safe Motherhood Training Team established through the project is very skilled and motivated** and can serve as an excellent resource for continued coaching and monitoring
G. **Men** who have received training have **not been accepted by the communities** to attend deliveries; only a few have been consulted in the event of complications.
H. The number of **deliveries attended by staff since training has varied widely** – from one to 68.

Knowledge, Attitudes and Behaviors Related to Reproductive Health & Maternal Care

Significant positive changes in levels of knowledge on RH issues were observed through comparison of baseline and endline KAP survey results, as illustrated in Table Two, below. Understandably, changes in actual behavior were less substantial; however, **positive trends were observed in relation to all health-seeking behaviors.**

Exposure to the IEC intervention was very high – 96 percent of respondents stated that they had received advice from a service provider or volunteer on how to care for themselves during pregnancy and delivery. The majority of these women reported receiving the advice from a health service provider, and relatively few remembered receiving information or advice from a volunteer in their community. It was hoped that diffusion of the IEC messages throughout the community would result in greater levels of support for health seeking behavior among women during pregnancy and delivery. Although there was no specific baseline information collected on family support, at the end of the project 99 percent of respondents stated that key family members (husbands and mothers-in-law) would be supportive of their desire to seek care from a skilled provider.

Fifty-six percent of respondents reported that they had given birth at home. Eleven percent delivered at the Varzob Central District Hospital and the remaining 33 percent delivered in facilities in Dushanbe (only 40 minutes away by car from the center of Varzob District). Despite the fact that CARE and the Ministry of Health have applied significant resources towards upgrading both staff skills and facilities at the Varzob Central District Hospital (CDH) – through the FEMME Project, funded by Columbia University – only 21% of respondents indicated that they would seek help in the event of an obstetric emergency at this facility. Lower level facilities and Dushanbe maternity homes all got higher response levels than the CDH on this question.

As illustrated in the following table, changes in knowledge related to reproductive health care were significant. This points to the effectiveness of CARE's approach of combining health messages delivered at community level with capacity building for service providers to enable them to respond to increased demands for service and to act as educators themselves. Widespread training with and use of CARE's IEC materials ensured that the same messages were being imparted during one-on-one counseling sessions with providers as were received during group sessions in the communities. These forms of verbal communication were reinforced by the visual aids created through the project, which were displayed prominently in all health facilities and at other venues in the District.

Table Two: Key Findings – KAP Survey

Indicator	Baseline	Endline
Women who received at least 4 antenatal check-ups	24%	28%
Women with knowledge of at least two danger signs of pregnancy	6.3%	82%
Women with knowledge of at least two danger signs during delivery	7.6%	76%
Women with knowledge of at least two post-partum danger signs	6%	78%
Women with knowledge of at least two danger signs for newborns	9.6%	97%
Women who delivered with the help of a skilled provider	45%	67%
Women who could correctly name at least 2 methods of contraception	11%	82%
Women who can correctly describe at least two methods for preventing transmission of STIs	2%	53%
Women who report that their communities have a plan for transporting obstetric emergency cases	21%	38%
Women with complications who actually sought care	58%	88%

Conclusions

Preliminary analysis of the data from both the KAP survey and clinical skills assessment resulted in the following summary conclusions being reached by the project team and the evaluators.

- The project **IEC strategy achieved significant penetration** with the messages contained in the communication materials, for reasons described above. Use of multiple channels for delivery of project IEC messages – health service providers, IEC volunteers, posters and brochures – as well as CARE's ability to combine educational sessions with distribution of supplemental nutrition (from a separate food assistance program), contributed to the success of the IEC efforts in raising knowledge and awareness of reproductive health issues in project communities.
- **Good synergy** was demonstrated between the behavior change and the service delivery improvement components of the project.
- Although stakeholders have embraced the new information and skills introduced through the project, there also appears to be **continued reliance on outdated RH protocols and information**. The service providers – both trainers and trainees, as well as CARE project staff – received their medical training under the Soviet Union. Many of the protocols that they are familiar with are not utilized in the West and do not adhere to WHO standards. Although they are enthusiastic about the new protocols

they are learning in connection with maternal care, there is a tendency to rely on older, more familiar practices in the process of embracing new ones. Pregnancy and delivery were very medicalized during Soviet times, and many practitioners still prescribe treatments that are not considered necessary or not indicated under current practice. Continued technical assistance and experience using the new protocols will be required to build confidence among providers, and to enable them to abandon outdated practices and beliefs at the same time that they are adopting new ones.

- Health staff trained through the project demonstrate enthusiasm and motivation for their new skills in BLSS; there was **strong agreement from the trainees on the usefulness and effectiveness of the training content and methodology.**
- **Continued support and supervision will be required for all trained staff** to demonstrate competency in management of normal deliveries, as well as obstetric emergencies
- Members of the **Safe Motherhood Training Team** who participated in the evaluation **demonstrated a high level of skill, dedication and commitment**. They represent an **important sustainable resource** established through the project.
- Close **contact and coordination** between the CARE team and the Safe Motherhood Training Team at Maternity House Three have contributed to the overall success of the initiative.

V. RECOMMENDATIONS & LESSONS LEARNED

Based on the preliminary findings from the evaluation exercise and review of the overall achievements of the project, the evaluation team developed the following summary recommendations for CARE Tajikistan:

1. Build on what has been established through the activities of this and other projects: CARE has established solid technical capacity for safe motherhood programming through implementation of the VRH and FEMME projects, as well as a strong relationship with the Ministry of Health and other members of the public health community in Tajikistan. The Ministry of Health training teams established and deployed through the project represent a tremendous asset and have the potential to build the skills of other midwives throughout the country, as well as to continue providing supportive supervision to those already trained. Finally, CARE is implementing a number of other projects and has established excellent working relationships with local government structures as well as civil society groups, such as women's unions and micro-credit groups. These groups and CARE's relationships could serve as an excellent platform for introducing health interventions in other geographic areas. With creative use of relationships and funding resources, there seem to be numerous opportunities for CARE and partners to build on what has been accomplished through the VRH project to benefit women's health in a more comprehensive way in Tajikistan.

2. Continue support, coaching and supervision of trained health staff. During the clinical skills assessment, it became clear that trained service providers require continued monitoring, coaching and supportive supervision for them to become completely competent and confident in implementing their new midwifery skills. It was suggested that trained staff could rotate through the Maternity Hospitals in Dushanbe on a regular basis to perform deliveries under supervision, gain more practice and have their skill levels monitored by senior midwives in these facilities.

3. Combine efforts to monitor and support both BLSS and ALSS trained staff: CARE and the Ministry of Health have trained both tertiary providers (obstetricians at district level hospitals in Advanced Life Saving Skills) and community level providers through the NGO Networks supported VRH project. There are extensive monitoring plans for both of these projects, and since resources for monitoring the

ALSS trainees will be in place for a longer period, it was suggested that some of these resources could be used to continue coaching and monitoring for the midwives as well. Continued support for the Safe Motherhood and Core Training Teams, as well as regular supportive supervision of trained staff should be an element of CARE's follow-on proposal to Columbia University at the end of this calendar year.

4. IEC/BCC activities and linkages with health services can be promoted through structures established by other projects, e.g. Women's Unions, partner NGOs: This point relates to the one above, encouraging CARE to build on existing activities and relationships to strengthen interventions related to women's health.

5. IEC materials and communication methodologies can be shared with other projects, MOH staff and NGOs in other operational areas, and with other agencies working on RH in the country. A great deal of time, effort and resources were devoted to developing IEC visual and written materials on topics in reproductive health that are appropriate to the local context in Tajikistan. They have been approved for use by the Tajik Ministry of Health and are the only comprehensive materials of their kind in the country. Along with the clinical training curricula, these represent a fantastic resource in the country, and CARE has already actively shared them with other international NGOs and the Ministry for widespread use.

6. The family planning and essential newborn care components of the IEC can and should be strengthened with very few additions – there seems to be high unmet need for family planning in the country and qualitative information suggests that women and their partners, as well as service providers, are extremely interested in having accurate information on contraception.

7. BLSS Training – Recommendations with regard to the clinical skills component of the project include:

- There should be **greater focus on practice of skills** and attainment of competence during training than on theory.
- Whenever possible, **more than one provider per community should be trained** as there is frequent absence and illness among service providers. In addition, newly trained providers should be able to consult and support one another in provision of clinical services, in the absence of a supervisor or more experienced provider.
- Through coordination with the MoH and other stakeholders, **make every attempt to stagger trainings so that communities are not left uncovered** by skilled providers. As a result of different and sometime conflicting training programs being undertaken by the Ministry and various donors, many providers had spent more time in training over the past year than in practicing in their communities. CARE should make every attempt to avoid exacerbating this situation when planning future training events and courses.

8. For those who have received training in Basic Life Saving Skills through the project, **additional support and continued training is required in**:

- ⇨ Use of equipment (midwifery kits) provided through the project
- ⇨ Clinical management of both normal and complicated deliveries
- ⇨ Correct use of the partograph
- ⇨ Immediate care of the newborn and assistance with breastfeeding
- ⇨ Counseling and client/provider interaction

9. SMTT members have **encouraged trained staff to accompany their referrals** to Maternity House Three in Dushanbe and continue to manage the case and assist the delivery under supervision. This system can be promoted by CARE and MoH partners in Varzob and other districts where staff are being trained.

10. CARE – ideally with support from the Maternity hospitals and other stakeholders – could encourage the MOH to **facilitate rotations for trained Midwives into the Maternity hospitals**

11. A mechanism for **continuing education** could be established during regular meetings of health staff (e.g., when they come to collect their salary or turn in reports).

12. CARE and the Ministry may want to revisit the **record-keeping and referral forms** introduced through both projects to identify ways that they can be more fully integrated into the existing health MIS. Although the records introduced during the project facilitated collection of monitoring information, their use is unlikely to be sustained after both projects are phased out – they're complicated, time consuming and providers are still keeping their regular records for the purpose of reporting to the Ministry. Recording and referral forms that can be easily used by the Ministry, while giving providers the information they need on individual cases and trends in caseloads, are more likely to be useful and sustainable.

Tajikistan Safe Motherhood Working Group

Finally, it was recommended to CARE staff and the Safe Motherhood Training Team that CARE and Ministry partners could spearhead the establishment of a Safe Motherhood Working Group in Tajikistan. Given that USAID, the World Bank, UNICEF and other significant players all have maternal health components to the programs they support, and the Ministry of Health is interesting in using international and local resources for safe motherhood in the most effective manner possible, there is great need for some sort of coordinating body in the country.

Theresa conducted an orientation session for CARE and other NGOs on the White Ribbon Alliance, encouraging them to form a chapter in Tajikistan. The WRA could possibly serve as a coordinating platform for maternal health activities in the country. Whether or not a WRA chapter is initiated in Tajikistan, a coordinating body for safe motherhood issues could serve the following purposes:

- Involve key national-level stakeholders in maternal and newborn health (national and international NGOs, UN organizations, the World Bank, the bilateral donors and the MOH) in collective action in support of safe motherhood initiatives in Tajikistan.
- Share experiences, methodologies and effective tools and guidelines among all actors in safe motherhood to promote use of best practices.
- To develop a uniform approach to maternal and newborn health protocols and messages, avoid duplication of effort and make the best use of donor and government resources.
- To serve as both an advisory group to the Ministry on key maternal health/RH issues and a forum for policy dialogue.

VI. SUSTAINABILITY AND FOLLOW-ON ACTIVITIES

CARE Tajikistan is following through with many of the recommendations made by the evaluation team to build on the systems and capacities established during the life of the project. Monitoring and support of

trained staff is continuing through the regular monitoring activities being undertaken through the Columbia University funded FEMME Project. As noted above, the Advanced and Basic Life Saving Skills training curricula and IEC materials developed through the project are now being used by other organizations – most notably Save the Children and the Aga Khan Foundation – in maternal health programs being implemented in other geographic areas of the country. CARE has had several very positive meetings with the new Minister of Health, who is eager to learn from successful interventions like the Varzob Reproductive Health Project, and is in a good position to influence policy with regard to provider training and follow-on support.

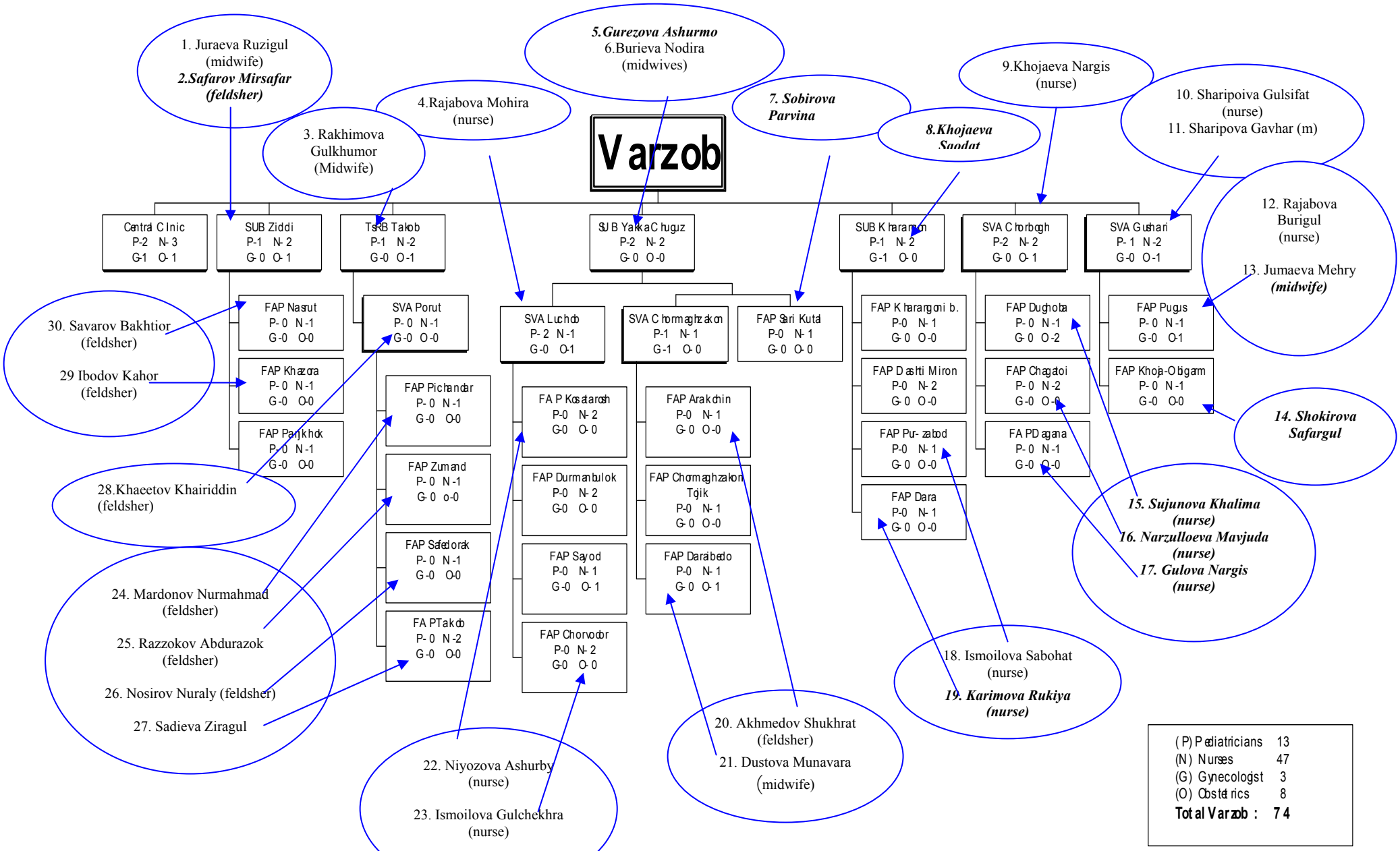
CARE is using the strategy developed through the VRH Project – a synergistic approach to community education and provider training – to undertake reproductive health activities in two additional districts, using funds obtained through monetization of US-donated commodities. Training has been implemented for approximately 120 additional midwives, and IEC activities are underway in Leninsky District, adjacent to Dushanbe. Using lessons learned through implementation of the Varzob RH project, CARE is adding a greater emphasis on male involvement in reproductive health and maternal care to the community education and communications campaigns being implemented in Leninsky.

USAID Almaty and the Ministry of Health in Tajikistan are extremely pleased with the results demonstrated by the Varzob Reproductive Health Project, and have expressed eagerness to support similar activities in the future.

ATTACHMENTS:

A. Health Service Delivery Structure – Varzob District
B. Basic Reproductive Health Messages – VRH Project
C. Assessment Tools – Clinical Skills
D. KAP Survey Questionnaire

Attachment A. Health Service Delivery Structure – Varzob District



Attachment B. Basic Reproductive Health Messages – VRH Project

REPRODUCTIVE HEALTH – BASIC MESSAGES FOR IEC

Promoting a Healthy Pregnancy - 1

Every woman should know that although pregnancy is a time for joy, there are risks associated with every pregnancy that can result in illness or life-threatening complications. Factors that may increase this risk include:

Becoming pregnant at a very young age can increase the health risks for both mother and child

Spacing between births of less than three years can increase the risk of malnutrition in the children and result in poor health for the mother

Having many children (more than four) can increase the risk of post-partum hemorrhage for some women.

Before a young woman has reached her full physical maturity, there is a greater risk that she will have difficulty giving birth. **Obstructed labor, low birth weight** and other risks to health of both the mother and her unborn child are more common in very young women.

Children born 3 – 5 years after a previous birth are about 1.5 times as likely to survive to age 5 than children born at 2 – 3 year intervals and **2.5 times as likely to survive as children born at intervals shorter than 2 years.** Infants born after longer intervals are also **less likely to be born premature, less likely to suffer from low birth weight and less likely to be malnourished**.

Mothers benefit from longer birth intervals too! Waiting three years or more between births can help women to avoid **anemia**, avoid **bleeding during the third trimester** of pregnancy and avoid the **risk of death during childbirth**.

Having many children at close intervals can have serious consequences for the health of a woman and even increase the risk of dying during pregnancy or childbirth. Women with a history of complications during pregnancy or delivery, particularly hemorrhage, are more likely to experience other complications with repeated pregnancies.

Promoting a Healthy Pregnancy – 2

Dear women -- Taking care of your health and making a plan for your expected childbirth will help you to become a happy mother of a healthy baby.

- Visit your midwife, nurse or doctor for regular prenatal check-ups; follow the advice of your medical provider during your pregnancy
- Ensure that you know your expected date of delivery
- Know the danger signs of pregnancy and seek medical help immediately in case you experience one of them
- You and your family should save an adequate amount of money for the delivery, and to cover extra expenses in case of an emergency
- Identify a trained, skilled provider (Midwife, Nurse, Feldsher or Doctor) to attend your delivery
- If you plan to deliver at home, you and your family need to know which facility you will go to in case you experience a complication
- Make arrangements ahead of time for transportation to the facility in the event of an emergency
- Make arrangements ahead of time for someone to care for your family during and after your delivery

There are simple things that a woman and her family can do to take extra care during pregnancy:

Make sure that your diet is as nutritious as possible – eat plenty of food that is rich in iron, protein and vitamins such as meat, organ meat, eggs, dried fruits, fresh fruits, vegetables and dairy products

Take all of the iron pills, supplied by your healthcare provider

Reduce your physical workload during pregnancy

Drink lots of fluids during pregnancy (but avoid having more than cups of tea each day; boiled water and juices are best!)

Each day try to get some exercise – walking is best – in the fresh air

Pregnant women should have at least four antenatal check-ups during each pregnancy.
Early and consistent prenatal care will help a mother to maintain her own health and the health of her unborn baby during pregnancy and prepare more effectively for birth.

Basic messages on DANGER SIGNS during pregnancy, delivery and postpartum period

During pregnancy and childbirth, there are certain SIGNS AND SYMPTOMS that warn a woman and her family that a complication is occurring that can result in illness or death of the mother or her baby.

To take **appropriate, life-saving action** during pregnancy and delivery, every woman and her family members should be aware of the following danger signs. **When these danger signs occur, it is very important to seek medical care from a trained provider immediately!**

These are signals your body is sending to tell you that something may be wrong:

Danger signs during PREGNANCY:

Vaginal bleeding
Severe abdominal pain
Headaches, blurred vision and/or dizziness (high blood pressure)
Swelling in your face, hands, feet
Pale, difficulty in breathing
Convulsions
High fever
No fetal movement
Premature rupture of membranes

Danger signs during CHILDBIRTH:

Heavy bleeding
Convulsions
Prolonged labor (more than 12 hours)
Swelling in your face, hands, feet
Fever, chills, discharge
Malpresentation of fetus
Placenta not delivered within 30 minutes

Danger signs for mother during the days and weeks after delivery (POSTPARTUM PERIOD):

Heavy vaginal bleeding
Convulsions
Fainting, cool, clammy skin (shock)
Headache, blurred vision
Sharp decrease in blood pressure
Fever, chills, discharge
Lower abdominal tenderness/pain

Danger signs for baby during the first 28 days after delivery (NEONATAL PERIOD):

Immediate (at birth) -

Not breathing
Skin color is yellow (jaundice)
Blue skin color - especially on palms and soles of feet (hypothermia)
Unable to suck

After first day -

Hypothermia/fever/chills
Skin color is yellow (jaundice)
Fast or labored breathing/difficulty in breathing
Convulsions
Unable to suck/poor ability to suck
Rigidity
Diarrhea/Constipation
Not active/sleeping all the time
Consistent, high-pitched crying
Red swollen eyes with discharge
Redness around the cord
No urination

PLEASE! Apply to your healthcare provider if you have any of the signals listed above.

Whether you choose to deliver at home or in a facility, EVERY woman should deliver in clean conditions and with attendance of a trained, skilled health provider (Midwife, Nurse, Feldsher or Doctor).

The Ministry of Health is working to improve the **quality of healthcare services for woman and children** – by upgrading the facilities and providing in-service training in updated obstetric skills for providers.

CARE is working with the Ministry of Health to ensure that facilities and providers are provided with the **skills, equipment and supplies to manage a normal delivery and take appropriate measures in the event of a complication.**

The **Varzob, Leninski and Bokhtar District Hospitals** have been provided with modern medical equipment and Doctors, Midwives and Nurses have the skills required to give quality health care to women and newborns.

Basic Messages on CONTRACEPTION

Spacing pregnancies (at least 3 years) will result in a healthier mother and healthier babies.

The Koran states that babies should be breastfed for two years. Try to space your children at least three years apart. Exclusive breastfeeding (NO other liquids or solids, and breastfeeding on demand) for the first six months, warmth, cleanliness and loving care gives every baby the best start in life! Breast milk is the best and only food that a baby should have for the first six months – and exclusive breastfeeding helps women to delay return of their fertility and, along with adequate nutrition and fluids, helps to tone the uterus and regain pre-pregnancy strength and energy.

In the early days of breastfeeding, women and their partners should think about how they will delay the birth of their next child or take measures to stop having children if they have reached their desired family size.

There are many methods – temporary, long-term and permanent – to help you and your partner plan your family. These are:

Effective during the post partum period -

Exclusive breast feeding for the first 6 months (Lactational Amennhorea Method – LAM)
Intrauterine Device (IUD)
Condoms – **protect against BOTH pregnancy and sexually transmitted infections (STIs)**
Depo provera (injectable)

- Progestin only or "mini" pill
- Abstinence
- Sterilization – male or female

Effective any time during your reproductive years -

- Combined oral contraceptives
- Condoms – **protect against BOTH pregnancy and sexually transmitted infections (STIs)**
- Abstinence
- Intrauterine Device (IUD/"Copper T")
- Depo provera (injectable)
- Progestin only or "mini" pill
- Diaphragm
- Spermicides
- Calendar Method (Standard Days Method), only for women with a regular menstrual cycle between 26 and 32 days
- Sterilization – male or female

SEEK ADVICE FROM YOUR MIDWIFE OR OBSTETRIC GYNECOLOGIST TO CHOOSE A CONTRACEPTIVE THAT IS APPROPRIATE FOR YOU. WHEN USED CONSISTENTLY AND CORRECTLY, CONDOMS (BOTH MALE AND FEMALE) ARE AN EXCELLENT CONTRACEPTIVE METHOD AND ALSO PROTECT BOTH PARTNERS FROM STIS. THIS IS PARTICULARLY IMPORTANT IF ONE OR BOTH PARTNERS HAVE OTHER SEXUAL PARTNERS, OR IF YOU ARE UNDERGOING TREATMENT FOR AN STI.

Women and their partners should also know about Emergency Contraceptive Pills or "Postinor", which are available from health service providers and in pharmacies. When used correctly (within 72 hours), EC can prevent pregnancy after unprotected intercourse, method failure, or incorrect method use. Women who use EC should take immediate steps to begin a regular, effective method of contraception.

Health benefits of contraception:

Besides preventing unwanted pregnancies and helping women to protect their health by waiting three years or more between births, family planning has other benefits!

- *Family planning can help you and your partner enjoy sex more, and not to be afraid of unwanted pregnancy.*

- *Hormonal methods can help with irregular bleeding and pain during a woman's monthly bleeding. Reduced bleeding during menstruation can not only reduce discomfort during menstruation, but can be beneficial for women who suffer from anemia.*

- *Hormonal methods can also reduce the risk of certain reproductive cancers.*

- *As noted above, condoms protect both partners from sexually transmitted diseases (STDs), including HIV/AIDS.*

- *The risk of illness or death during pregnancy and childbirth are far greater than potential any health risks from side effects of modern contraceptives.*

Basic Messages on STIs AND HIV/AIDS

STIs, including HIV/AIDS, can be transmitted from one sexual partner to another by unprotected intercourse. STIs are harmful to the health of both you and your partner. If you are pregnant, there are also health risks for your unborn baby. STIs can lead to:

- ***Male and female infertility***
- ***Ectopic pregnancy***
- ***Stillbirth or miscarriage***
- ***Congenital syphilis or blindness***
- ***Cervical cancer***
- In the case of HIV/AIDS, illness and death of one or both parents and infants who contract HIV during pregnancy or delivery.

Many sexually transmitted diseases are curable and **ALL are preventable**. There is currently no cure for the virus called HIV, which leads to AID. Acquired Immune Deficiency Syndrome (AIDS) is a serious, incurable illness that leads to death in those affected. Hepatitus B is also a serious illness that can lead to death and is particularly dangerous in pregnant women.

Some of the most common STIs are:

- Gonorrhea
- Chlamydia
- Syphilis
- Herpes Simplex Virus (HSV)
- Human Papillomavirus (HPV)
- Hepatitis B
- Trichomoniasis
- Human Immunodeficiency Virus (HIV)

Many STIs do not exhibit any symptoms and people can be carriers or STIs without ever becoming symptomatic themselves. You cannot tell if a person has an STI by looking at him or her – the only sure way to know that there is no risk of infection is through testing or if both partners are uninfected and remain mutually monogamous.

Many STIs DO have signs and symptoms, however and the following are some of them:

- Foul smelling discharge from either the penis or vagina
- Burning during urination
- Sore/ulcer on the genitals
- Itching/redness/irritation of genitals
- Pain in the lower abdomen
- Pain during intercourse

HIV is characterized by a flu-like illness that goes away of its own accord. The majority of people who have the HIV virus do not know that they are infected. People can live for many years with HIV, and it is not until people develop "opportunistic" infections, for example TB, some types of pneumonia, some cancers and thrush, which is a sign that AIDS has developed, that they realize they are ill. Therefore, it is very important to know which behaviors can put an individual at risk of contracting HIV, and to make every effort to avoid these putting yourself or your partner at risk through engaging in these behaviors.

Having an STI is a risk factor for having HIV – this is because HIV is transmitted through the same route as other STIs (unprotected intercourse with an infected person) – and having a sore, ulcer or irritation on the genitals can make a person more vulnerable to the HIV virus if they come in contact with it.

HIV can also be transmitted through use of a needle that has been used by an infected person and then not been sterilized. Health workers and anyone who comes into contact with infected blood

are at greater risk of contracting HIV. The vast majority of HIV infections in the world have been transmitted through sexual intercourse, however.

Every sexually active adult is at risk of contracting an STI, including HIV! The following behaviors can put an individual at greater risk:

Having unprotected sex (without a condom) with a person whose STI status is unknown
Having multiple sexual partners
Having unprotected sex with a commercial sex worker
Intravenous drug use; sharing needles
Healthcare providers who have contact with blood without following the universal precautions for infection prevention

If you have a sign or a symptom of an STI, or think that you or your partner have engaged in behavior that puts you at risk, talk with your midwife or doctor, and she can refer you to a specialist.

When undergoing treatment for an STI, it is essential for your partner to also get treatment. If your partner is not treated, then you can easily become reinfected.

The best protection from STIs, including HIV, is for both partners to remain monogamous after they ensure that they are free from infection.

Condoms can also protect you from STIs -- only if used correctly. Condoms can be purchased at pharmacies.

HIV/AIDS

Can be transmitted in following ways:

- Through unprotected sexual intercourse with an infected person
- Through contact with infected blood
- From infected mother to her fetus/ newborn
- By means of injections with non-sterile infected syringes

Cannot be transmitted:

- ***Through touching, kissing or hugging***
- ***Through coughing, sneezing***
- ***By sharing food***
- ***By sharing a bed***
- ***By sharing or washing laundry or cleaning latrines or toilets***
- ***Through bathing and dancing***
- ***From insect and animal bites***
- ***By caring for someone with HIV/AIDS***

Attachment C: Assessment Tools – Clinical Skills

Clinical Assessment Tools used in Evaluation of the Varzob Reproductive Health Project

TOOL NUMBER	TOOL NAME
1.A	Test (multiple choice) AND Test Key
1.B	Partograph Case Study AND Partograph Case Study Key
2	Skills demonstration – External/Internal Bimanual Compression AND manual removal of the placenta
3	Level of Satisfaction with Training and Training Materials
4	Review of Normal Cases/Complicated Cases – From existing incidence reports and referral forms
5	Client interview forms – From checklist for New and Revists ANC visit. "Healthy Mother And Healthy Newborn Care"
6	Clinical Observation Summary – From checklist "Healthy Mother And Healthy Newborn Care"
7	Clinical Skills Checklist – Review of existing supervisory checklist

Tool 1.A: Knowledge Test

The test consisted of 34 questions, covering all the topics throughout the training to test retained knowledge. Multiple choice, true/false, and short written answer items make up the test. A total score of 34 points was possible on this test. The time allotted was one hour. It took participants from approximately 30 minutes to one hour to complete.

Tool 1.B: Partograph Case Study

Participants are asked to chart, on a blank partograph, the information provided from a printed case study. Points are allocated for correct charting of each item given and correct representation on the partograph, for a total of 57 possible points. In addition, a series of questions assessed the ability of providers to interpret the observations on the partograph and to suggest management based on the interpretation. This tool was allotted one hour. It took participants between 45 minutes to one hour to complete.

Tool 2: Skills demonstration – External/Internal Bimanual Compression & Manual

Removal of the Placenta. A checklist was developed for each of the three demonstration stations that was consistent with the Varzob training objectives and methods. A case scenario was explained to each participant verbally, including instructions to demonstrate each of the three critical life-saving skills on an anatomical model. The observer used a check (✔) if done correctly and zero (0) if done incorrectly to score each key step of the procedure, including clinical and interpersonal actions. Points were allocated for each correctly done step in the checklist. Total points possible: external bimanual compression – 47, internal bimanual compression – 32, and manual removal of the placenta – 44.

Tool 3: Level of Satisfaction with Training and Training Materials

This tool was created for the participants to rate: 1) the topics covered in the training program and their usefulness, 2) the training materials used and their usefulness, and 3) use of different teaching methodologies and their effectiveness. Open-ended questions asked the participants to articulate other thoughts and feelings related to the training. The results of this tool are mainly qualitative.

Tool 4: Review of Normal Cases/Complicated Cases

This review was taken from existing incidence reports and referral forms collected from participants and through a request made to Maternity House Three in Dushanbe. The evaluators also reviewed the hospital logbook at Varzob and Maternity 3. Unfortunately the information contained in case histories and referral forms is not as complete as anticipated, and the evaluators were not able to make conclusive remarks on overall trends in case management based on the small number of forms they were able to retrieve and two hospital logbooks.

Tool 5: Client Interview Forms

This form was adapted from a checklist for ANC New Visits and Revisits in the "Healthy Mother And Healthy Newborn Care" training manual. The evaluators used clinical skills checklists to evaluate clinical performance, marking each key step of the procedure with a check (✔) if done correctly and zero (0) if done incorrectly, including clinical and interpersonal actions. At the completion of the observation the assessment was shared with the participants and technical support was provided in the areas of skills observed that still required improvement.

Tool 6: Clinical Observation Summary

Adapted from the checklist in "Healthy Mother And Healthy Newborn Care". This was to be used for observation of a delivery at either the medial houses or at home. The evaluator was able to observe one delivery at the Varzob hospital.

Tool 7: Clinical Skills Checklist

Review of existing supervisory checklist. A clinical monitoring and supervision system was established in February 2002. The external evaluator reviewed these forms, process, and sustainability of the approach, and provided feedback accordingly to the project team.

ATTACHMENT D. KAP SURVEY QUESTIONNAIRE

CARE INTERNATIONAL IN TAJIKISTAN
Varzob Reproductive Health Project
Final Evaluation Survey Questionnaire

Jamoat: _____

Mahala/Street: _____

Name of Respondent: _____

Date of birth: _____

Date of birth of youngest child: _____

EXPOSURE TO INTERVENTION

1. Have you received information or advice from anyone about how to have a healthy pregnancy and/or delivery?

   1. yes ( )
   2. no ( ) → **GO TO # 6**
   3. don't remember ( ) → **GO TO # 6**
   4. don't know ( ) → **GO TO # 6**

2. Where/from whom did you receive this information/advice?

   1. Doctor ( )
   2. Midwife/Nurse/Feldsher ( )
   3. Women leaders/volunteers ( )
   4. TBA ( )
   5. Other (specify) _____ ( )
   6. Don't remember ( )

3. Did you find this information/advice useful?

   1. yes ( )
   2. no ( )
   3. don't remember ( )
   4. don't know ( )

1

4. Did you try to follow some of this advice during your pregnancy and/or delivery?

1. yes ( )
2. no ( )
3. Don't remember ( )
4. don't know ( )

5. Do you share this information/advice with friends or relatives who are pregnant?

1. yes ( )
2. no ( )
3. don't know ( )

MATERNAL HEALTH

6. When you were pregnant with (name of child), did you receive any prenatal care from medical staff?

1. yes ( )
2. no ( ) → **GO TO # 12**

7. Where did you receive these check-ups?

1. FAP ( )
2. SUB ( )
3. SVA ( )
4. Central District Hospital ( )
5. Home ( )
6. Other (specify) _____ ( )
7. Don't remember ( )

8. During this last pregnancy, how many prenatal checkups did you receive?

1. one ( )
2. two ( )
3. three ( )
4. four or more ( )
5. don't remember ( )

9. Who (what type of provider) gave you a medical check during your pregnancy?

1. Doctor ( ) → **GO TO 12**
2. Nurse ( )
3. Midwife ( )
4. Feldsher ( )
5. Other (specify) _____ ( ) → **GO TO 12**

6. Don't know ( ) → **GO TO 12**

10. If you can remember, please tell us the name of the provider.
    1. Name _____
    2. Don't remember ( )
    3. Don't know ( )

11. What did this provider do during your prenatal check-ups?

(you can mark more than one answer)

1.	Check blood pressure	( )
2.	Check for anemia	( )
3.	Measure abdomen (check the baby's growth)	( )
4.	Check the baby's heartbeat	( )
5.	Check the baby's position	( )
6.	Check for swelling	( )
7.	Check for tenderness in the back	( )
8.	Check reflexes	( )
9.	Provide iron tablets	( )
10.	Other (specify) _____	( )
11.	Don't remember	( )
12.	Don't know	( )

12. Did anyone provide you with advice regarding your pregnancy?

    1. Yes ( )
    2. No ( ) → **Go To # 14**
    3. Don't remember ( ) → **Go To # 14**

13. What kind of advice were you given?

1.	Avoid heavy physical work during pregnancy	( )
2.	Eat more nutritious food (meat, fruits and vegetables) every day	( )
3.	Advice on the danger signs of pregnancy	( )
4.	Advice on the danger signs around delivery	( )
5.	How to plan for the expected delivery	( )
6.	How to delay the birth of next child (birth spacing/family planning)	( )
7.	Other (specify) _____	( )
8.	Doesn't know, doesn't remember	( )

14. When you were pregnant, were you given iron supplements by health staff?

    1. yes ( )
    2. no ( ) → **GO TO # 16**
    3. don't know, Don't remember ( ) → **GO TO # 16**

15. Did you complete the course/take all of the tablets that your provider gave you?

1.	yes	( )
2.	no	( )
3.	don't know/Don't remember	( )

16. Do you know anything about "anemia"?

1.	Yes	( )
2.	No	( ) → **GO TO # 19**
3.	Don't know/Don't remember	( ) → **GO TO # 19**

17. What are some of the causes of anemia?

1. Poor diet	( )
2. Drinking tea/tea with meals	( )
3. Parasites	( )
4. Pregnancy	( )
5. Other (specify) _____	( )
6. Don't know	( )

18. What are some of the consequences of anemia?

1. Higher risk of death during delivery	( )
2. Premature delivery	( )
3. Low birth-weight baby	( )
4. Weakness/tiredness	( )
5. Unhealthy baby	( )
5. Other (specify) _____	( )
6. Don't know	( )

19. Where did you give birth to (name of child)?

1.	Central District Hospital	( )
2.	SVA	( )
3.	SUB	( )
4.	Home	( ) → **GO TO # 21**
5.	Other (specify) _____	( )

IF OTHER AND HEALTH ESTABLISHMENT, CONTINUE WITH # 20; IF OTHER AND NOT HEALTH ESTABLISHMENT, GO TO # 31

20. Why did you decide to give birth to (name of child) in a health establishment?

1.	had an obstetric complication	( )
2.	services have improved in the health establishment	( )
3.	they don't charge for childbirth	( )
4.	by recommendation of medical provider	( )
5.	by recommendation of the woman leader or midwife	( )
6.	family members decided to take me to facility	( )
7.	other (specify) _____	( )
8.	don't know	( )

<u>GO TO # 22</u>

21. Why did you decide to deliver at home?

1.	More comfortable at home	( )
2.	Food not available in health establishment	( )
3.	No need to go to facility for normal delivery	( )
4.	Provider available in village	( )
5.	Conditions in facility not good	( )
6.	Health provider not available in facility	( )
7.	Services in facility too expensive/providers charge money	( )
8.	Family members decided on home delivery	( )
9.	Other (specify) _____	( )
10.	Don't know	( )

22. Who attended your last delivery?

1.	Doctor	( )
2.	Midwife	( )
3.	Nurse	( )
4.	Feldsher	( )
5.	TBA	( )
6.	Family member	( )
7.	Other (specify) _____	( )
8.	Don't know	( )

23. How soon after your delivery did you begin breastfeeding your baby?

1.	Within one hour	( )
2.	Between one and 24 hours	( )
3.	Between 24 hours and 3 days	( )
4.	After 3 days	( )
5.	Don't remember	( )

24. Have you begun feeding other liquids or solids to your baby yet?

1. Yes ( )
2. No ( ) → **GO TO # 26**

25. At what age did you introduce other liquids or solids into your baby's diet?

1. Within the first month ( )
2. During the second month ( )
3. During the third month ( )
4. During the fourth month ( )
5. Between four & six months ( )
6. After six months ( )
7. Don't remember ( )

GO TO # 27

26. At what age do you plan to introduce other liquids or solids into your baby's diet?

1. Within the first month ( )
2. During the second month ( )
3. During the third month ( )
4. During the fourth month ( )
5. Between four & six months ( )
6. After six months ( )
7. Don't know ( )

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT *DANGER SIGNS* FOR THE MOTHER AND BABY DURING PREGNANCY AND DELIVERY AND AFTERWARDS.

27. During a **pregnancy**, what are the danger signs that indicate the necessity to look for medical attention?

(you can mark more than one answer)

1. fever ( )
2. vaginal bleeding ( )
3. lower abdominal pain ( )
4. swelling of the face, hands or feet ( )
5. blurred vision ( )
6. constant headaches ( )
7. no fetal movement ( )
8. convulsions ( )
9. other (specify) _____ ( )
10. don't know ( )

28. What are the danger signs during **childbirth** that indicate the necessity to seek medical attention?

(you can mark more than one answer)

1.	prolonged labor (over 12 hours)	( )
2.	heavy bleeding (hemorrhage)	( )
3.	convulsions	( )
4.	swelling in hand, face or feet	( )
5.	poor position of baby	( )
6.	other (specify) _____	( )
7.	don't know	( )

29. In the **hours and days after a birth,** what are the danger signs for a **mother** that indicate the need to seek medical attention?

(you can mark more than one answer)

1.	fever	( )
2.	excessive vaginal bleeding	( )
3.	foul-smelling discharge	( )
4.	lower abdominal pain	( )
5.	convulsions	( )
6.	headaches	( )
7.	blurred vision	( )
8.	Don't know	( )
9.	Other (specify) _____	( )

30. If you had a problem before, during or after delivery, where would you go to seek help?

1.	Central District Hospital	( )
2.	SVA	( )
3.	SUB	( )
4.	FAP	( )
5.	Pharmacy	( )
6.	Friends and relatives	( )
7.	Other (specify) _____	( )
8.	Don't know	( )

31. What are the danger signs **during the first week after delivery** that indicate that a **newborn** is not healthy and needs medical attention?

(you can mark more than one answer)

1.	fever	( )
2.	yellow skin color	( )
3.	heavy or very fast breathing	( )
4.	redness around the cord stump	( )
5.	convulsions	( )
6.	Inability/poor ability to suck	( )
7.	No activity/sleeping all the time	( )
8.	Incessant crying	( )
9.	No stool/swollen abdomen	( )
10.	Abnormal stool/blood or mucous	( )
11.	red, swollen eyes with discharge	( )
12.	Don't know	( )
13.	Other (specify) _____	( )

32. Where would you seek help if your baby was sick?

1.	Central District Hospital	( )
2.	SVA	( )
3.	SUB	( )
4.	FAP	( )
5.	Pharmacy	( )
6.	Friends and relatives	( )
7.	Other (specify) _____	( )
8.	Don't know	( )

33. If you decided to seek medical care for yourself or your baby, would your family members (husband, mother-in-law) agree with this decision and support you?

1.	Yes	( )
2.	No	( )
3.	Don't know	( )

34. When you were pregnant with (name of child) did you discuss in your family what you were going to do in case of an emergency during your pregnancy or delivery?

1.	Yes	( )
2.	No	( ) → **GO TO # 36**
3.	Don't remember	( ) → **GO TO # 36**

35. Did your family members (husband; mother-in-law) support your ideas for planning in case of an emergency?

1.	Yes	( )
2.	No	( )
3.	Don't remember	( )
4.	Don't know	( )

36. In your last pregnancy or childbirth, did you suffer any complication?

1.	Yes	( )
2.	No	( ) → **GO TO # 39**
3.	Don't know	( ) → **GO TO # 39**

37. What was the complication?

1.	heavy vaginal bleeding (hemorrhage)	( )
2.	infection/fever	( )
3.	obstruction/prolonged labor	( )
4.	swelling of hands, face or feet	( )
5.	convulsions	( )
6.	other (specify) _____	( )
7.	don't know	( )

38. Who helped you when you had this complication?

1.	Doctor	( )
2.	Midwife	( )
3.	Nurse	( )
4.	Feldsher	( )
5.	TBA	( )
6.	Family member	( )
7.	Other (specify) _____	( )
8.	Don't know/don't remember	( )

39. In the first two weeks following your delivery, did a health provider visit you to see your health status?

1.	Yes	( )
2.	No	( ) → **GO TO # 41**
3.	Don't remember	( ) → **GO TO # 41**

40. Who came?

1.	Doctor	( )
2.	Midwife	( )
3.	Nurse	( )
4.	Feldsher	( )
5.	TBA	( )
6.	other (specify) _____	( )

41. Do you know the closest health facility that handles obstetric emergency cases?

1.	yes	( ) If yes, specify name and place _____
2.	no	( )

42. Is your community organized to evacuate an expectant mother in case of an emergency?

1.	Yes	( )
2.	No	( ) → **GO TO # 44**
3.	Don't know	( ) → **GO TO # 44**

43. What kind of emergency arrangements have been made by the community?

1.	Funds collected	( )
2.	Buying and keeping gasoline	( )
3.	Identifying driver & vehicle	( )
4.	Other (specify) _____	
	_____	
	_____	
5.	Don't know	( )

44. Did you or your family put aside money (savings) for an emergency during pregnancy or delivery?

1.	Yes	( )
2.	No	( )
3.	Don't know	( )

THE QUESTIONS ARE ALMOST COMPLETED, BUT NOW I WOULD LIKE TO TALK A LITTLE BIT ABOUT SOME OTHER ASPECTS OF REPRODUCTIVE HEALTH, IF YOU DON'T MIND.

45. Are you interested in waiting two to three years or more between giving birth to your children?

1. Yes ( )
2. No ( )
3. Don't know ( )

46. What are some of the methods of contraception that you know about?

1. Condoms ( )
2. Oral Pills ( )
3. IUD ( )
4. Exclusive breast feeding for the first 6 months ( )
5. Calendar method ( )
6. Abstinence ( )
7. Injections (DMPA) ( )
8. Other (specify) _____ ( )
9. Don't know ( )

47. Where can you get contraceptives in Varzob District?

1. Doctor ( )
2. Nurse/Midwife/Feldsher ( )
3. Pharmacy ( )
4. Central District Hospital ( )
5. SUB/SVA/FAP ( )
6. Other (specify) _____ ( )
7. Don't know ( )

48. Which infections do you know of that can be transmitted through sex?

(you can mark more than one answer)

1. Gonorrhea ( )
2. Syphilis ( )
3. Trichamoniasis ( )
4. Chlamydia ( )
5. HIV/AIDS ( )
6. Other (specify) _____ ( )
7. Don't know ( )

49. What are the signs or symptoms of sexually transmitted infections for women and men?
(you can mark more than one answer)

1. Discharge (with foul odor) from genitals (male or female ( )
2. Burning during urination ( )
3. Sore/ulcer on the genitals ( )
4. Itching/redness/irritation of genitals ( )
5. Pain in the lower abdomen ( )
6. Pain during intercourse ( )
7. Other (specify) _____ ( )
8. Don't know ( )

50. What methods of protection from STIs do you know about?

(you can mark more than one answer)

1. Being mutually faithful (both partners having only one partner) ( )
2. Only having one partner ( )
2. Using a condom during intercourse ( )
3. Abstinence (no sex) ( )
4. Other (specify) _____ ( )
5. Doesn't know ( )

51. Has your husband migrated for employment within the past two years (left home for a period of more than one month)?

1. Yes ( )
2. No ( )
3. Don't know/can't remember ( )

**** **** ****

GO TO NEXT PAGE

CHECK THAT EVERYTHING IN THE SURVEY IS COMPLETED AND THAT YOU DID NOT SKIP ANYTHING BY ACCIDENT. FINISH THE INTERVIEW WITH THE MOTHER. THANK HER AND SAY GOODBYE COURTEOUSLY. ONCE OUTSIDE THE HOUSE, WRITE YOUR NAME IN BLOCK LETTERS AND SIGN WHERE IT IS INDICATED FOR THE INTERVIEWER.

THANK YOU!

I HAVE COMPLETED THE SURVEY UNDER THE APPROPRIATE PROCEDURES AND I HAVE CORRECTLY AND HONESTLY REGISTERED THE ANSWERS OF THE MOTHER IN THE BEST WAY POSSIBLE.

_____

NAME OF INTERVIEWER (BLOCK LETTERS)

_____ _____

SIGNATURE **DATE**

I HAVE CHECKED THE QUESTIONNAIRE FOR ERRORS. IF IT IS NECESSARY, I WILL RETURN TO THE HOUSE OF THE MOTHER TO CORRECT OR CLARIFY ANY DOUBT OR INCONSISTENCY.

_____

NAME OF SUPERVISOR (BLOCK LETTERS)

_____ _____

SIGNATURE **DATE**