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

Cooperative Agreement No. FAO-A-00-98-00022-00
September 30, 2002 - September 30, 2007, in
Panjikent and Aini Districts of Sugdh Region

CS-18 Tajikistan
Report of the Midterm Evaluation

Submitted to USAID/BGH/HIDN
October 31, 2005

ACKNOWLEDGEMENTS

Sincere thanks and best wishes go to the following individuals for their participation in the Midterm Evaluation:

Pervez Shaukat, MBBS, MPH, Impact Area Manager, SC/Tajikistan
Eric Starbuck, DrPH, MPH, Child Survival Specialist, SC/HQ
Tedbabe Degefie, MD, Health and Nutrition Specialist, SC/Ethiopia Field Office
Mohammad Honey Mukhtar, Health Coordinator, SC/Afghanistan
Boboeva Gulchera, MD, Project Officer Health, SC/Tajikistan
Rahimova Mubina, Assistant Project Officer/Aini
Kodirova Nazokat, Senior Health Monitor and LSS Trainer/Panjikent
Mavlonova Mutriba, Health Monitor/Panjikent
Kholmahmadova Gulchehra, Health Monitor/Panjikent
Gafurova Zarina, Health Monitor/Panjikent
Temirova Umiya, Health Monitor/Panjikent
Ashurova Hilola, Health Monitor/Panjikent
Bahrieva Shahlo, Health Monitor/Panjikent
Muminova Bozorgul, Health Monitor/Aini
Alamova Gulbegim, LSS Trainer/Aini
Mahmudov Sharofidin, Senior MIS Assistant
Sharipova Munira, RDF Supervisor

In addition, thanks go to the many community members, volunteers, health workers and staff who responded to our many questions with candor and creativity!

Garth Osborn
Midterm Evaluation Team Leader

TABLE OF CONTENTS

I. KPC Survey Questionnaire
J. Results of the Tajikistan CS-18 MTE KPC Survey Using LQAS

List of Figures

ACRONYMS

ACNM	American College of Nurse Midwives
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival (USAID Project)
BF	Breastfeeding
BHR/PVC	Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation of USAID
BLSS	Basic Life Saving Skills
CAFO	Central Asian Field Office (SC)
CDD	Control of Diarrheal Disease
CMO	Chief Medical Officer
CS	Child Survival
CS-18	Child Survival 18 (The child survival program in Panjikent and Aini Districts, Tajikistan, funded in part through the 18th cycle of the BHR/PVC program.)
CTC	Child to Child
DD	Diarrheal Disease
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertusis and Tetanus Vaccine
EOP	End of Project
EPI	Expanded Program on Immunization
FACT	Food Aid Consortium of Tajikistan
FGD	Focus Group Discussion
FOD	Field Office Director (SC)
GH/HIDN	Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition of USAID
GOT	Government of Tajikistan
HFA	Health Facility Assessment
HFF	Health Facility Farm
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HQ	Headquarters of Save the Children in Westport, Connecticut
IDD	Iodine Deficiency Disorders
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
IR	Intermediate Result
KPC	Knowledge, Practice, and Coverage (survey)
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MIL	Mothers-in-Law
MNC	Maternal and Newborn Care
MOE	Ministry of Education
MOH	Ministry of Health

MOU	Memorandum of Understanding
MTE	Midterm Evaluation
NGO	Non-Governmental Organization
NIDS	National Immunization Days
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PDI	Positive Deviance Inquiry
PLG	Program Learning Group (of Save the Children)
PPH	Postpartum Hemorrhage
PRA	Participatory Rapid Appraisal
PSF	Pharmaciens Sans Frontiers
R	Result
RDF	Revolving Drug Fund
SC	Save the Children Federation, Inc. (US)
STI	Sexually Transmitted Infections
SUB	MOH Rural Hospital (with 40 – 80 beds, staffed with physicians and specialists)
TA	Technical Assistance
TFO	Tajikistan Field Office (SC)
TOT	Training of Trainers
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
VDC	Village Development Committee
VP	Village Pharmacy
WHO	World Health Organization
WRA	Women of Reproductive Age

I. Summary

Save the Children/US (SC) is now entering the eighth year of USAID-funded child survival programming in Tajikistan. The goal of this CS-18 project is "a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini Districts, and innovative CS-18 strategies contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan." The CS-18 project's original 31 objectives directly support achievement of the following results (R) and intermediate results (IR):

- **R-1:** Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent & Aini districts.
- **R-2: Sustained** investments in key MCH services by communities & rural health facilities in Panjikent & Aini districts
- **IR-1:** Increased household level **knowledge** of selected MCH issues in rural Panjikent & Aini districts.
- **IR-2:** Improved **capacity of communities** to address priority health needs of mothers & children under 5.
- **IR-3:** Improved **capacity of rural health facilities** to provide quality MCH services & support community health activities.
- **IR-4**: Improved **SC/Tajikistan Field Office capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajikistan.

The beneficiary population includes an estimated 60,000 women of reproductive age (WRA) and 36,000 infants and children under age five living in all 201 rural communities in Panjikent and neighboring Aini Districts, and focuses on the CS interventions of acute respiratory illness (ARI), control of diarrheal disease (CDD), maternal newborn care (MNC), immunization (EPI), and nutrition and micronutrients. The project's cross-cutting approaches are:

- Revolving Drug Funds for Village Pharmacies
- Health Facility Farms for continuing investments in improving maternal and child health services
- Joint training and supervision of rural health facility staff
- Community mobilization through Village Development Committees
- Interactive engagement of local health workers with community groups to promote improved MCH practices
- Child-to-Child health education

CS-18 has achieved several accomplishments, most notably:

- Met or exceeded six of the eight end of project (EOP) objectives relating to improved household practices and increased use of key MCH services.
- Met or exceeded three of the four EOP targets relating to mothers' knowledge of selected MCH issues.
- The project's promotion of home-based EPI cards has contributed to the Tajikistan Ministry of Health's (MOH) adoption of home-based cards throughout the country.

- Increased quality of antenatal, delivery, and postpartum maternal and newborn care as a result of BLSS training of health workers.
- The adoption of CS-18 strategies and approaches (BLSS training, Child-to-Child, birth plans, emergency transportation and village development committees) by Save the Children's Healthy Family Project in Khatlon District, Tajikistan.

CS-18 has responded to and faces some constraints and challenges that will require further attention:

- Difficulties in communication and physical access will continue to be major constraints, both between the SC offices in Dushanbe and the project site, as well as between the district centers and the more isolated villages that will be targeted during the remainder of CS-18.
- Turnover in the senior CS-18 management position has slowed progress on the development of the project sustainability plans and delayed the start of CS-18 activities in Aini District.
- The project will continue to need both administrative and technical support from Dushanbe, the Health Advisor for Asia, and HQ, as it develops and implements its phase over plans.
- Low morale and the limited number of MOH workers continues to be a challenge for this project as its primary focus is capacity building of health workers.

The project has been highly successful in building the technical capacity of health workers who are working at MOH facilities throughout both Panjikent and Aini Districts, particularly as a result of the joint training and supervision with SC staff. At the community level, the VDCs and the CTC participants are well organized, understand their roles, and appear to be highly committed to continuing to play an important role in project activities and building civil society. The challenge the project faces from this point on is to work with the district officials of the MOH and Ministry of Education (MOE) to help ensure that these improved services and strategies will receive the support necessary to continue.

Recommendations:

Immunization (EPI):

1. Project staff need to review national protocols for immunization contraindications with the Chief Doctors on Immunization in both Aini and Panjikent Districts to ensure compliance and consistency. This needs to be addressed in the proposed, up-coming MOH training on EPI.
2. The project needs to incorporate training and supervision of health facility staff on the proper use of vaccine vial monitors to ensure the quality of the vaccines.
3. The project needs to work with the district MOH and local Jamoats (government authorities) in both Panjikent and Aini to find sustainable solutions for ensuring the proper transport of vaccines into and throughout both project districts.

Maternal and Newborn Care (MNC):

4. The project should monitor the percentage of deliveries done at MOH facilities as a measure of the effectiveness of the birth plans and emergency transportation funds. [Fortunately, the

related question was asked in the KPC survey as part of the CS-18 baseline assessment (Question #10) and midterm evaluation (Question #5).]

5. To the extent possible, the project should support additional VDCs to develop their own emergency transportation funds, giving preference to VDCs that express an interest and are located in the more isolated rural communities that are becoming involved in CS-18 later during the life of the project.

Nutrition and Micronutrients:

6. The project should work with the VDCs to educate them on the value and importance of exclusive breastfeeding, so the VDCs can identify ways the community can provide a supportive environment for mothers of children under-six months of age to breastfeed exclusively.
7. The project should consider scaling up the PD/Hearth strategy to involve additional communities that are experiencing higher rates of childhood malnutrition. (SC has received a grant in support of the RDF strategy, which with donor approval could be transferred over to support scaling up PD/Hearth.)
8. Proper counseling on side effects of iron supplementation needs to be stressed in the MOH health worker training curriculum and supervisory checklists.
9. CS-18 is recommending two tablets a day and retesting once a month to treat anemia, while the MOH recommends two tablets per week. This has been discussed with MOH and still some differences exist. The national treatment guidelines and international standards need to be reviewed together with the MOH district offices and the MOH training curriculum and supervisory checklist need to be adapted as needed.

Child-to-Child:

10. Additional staff time will need to be directed to CTC if the project hopes to reach all 201 villages. Otherwise, a reasonable target needs to be set and criteria for selecting these communities needs to be developed for the remainder of CS-18.
11. The project should identify and support a "CTC Champion" in each District MOE who is committed to providing the ongoing support necessary to help design and implement the CS-18 CTC phase–out strategy and to support annual recruitment drives for the long-run.

Revolving Drug Fund/Village Pharmacies:

12. Recognizing the commitments made to the communities, the very real need for a safe/affordable source of drugs and the successes achieved to date, as well as the challenges at hand, the MTE Team recommends a responsible transition to the private sector of the VPs established to date. This process should also include an accounting for and dispensation of the remaining funds and stocks of medicines.

Interactive Engagement of Local Health Workers with Community Groups to Promote Improved MCH Practices:

13. Strategies for educating and promoting behavior change in mothers in law, other caregivers and decision-makers need to be developed and implemented as the project expands into the more isolated and remote areas.

Sustainability:

14. The CS-18 project should withdrawal from the original 75 CS-14 villages and monitor their ability to sustain the benefits of the CS project on their own. LQAS results can be used to inform any necessary changes to the project's exit strategies.
15. A formal Phase-Out Plan needs to be developed and implemented jointly with the MOH for each project activity that is to continue beyond CS-18.
16. A Phase-Out Plan needs to be developed and implemented for the VDCs that will help them solidify their roles and responsibilities within the community.

Supervision and Support of Program Staff:

17. CS-18 will require increased administrative supervision and support from the CAFO as it develops and implements its phase-out plans over the remaining years of CS-18 and turns over leadership to a local hire.
18. SC should seek to identify viable options for expanding and continuing the work of the CS-18 staff, particularly the scale-up of the project's PD Hearth strategy and starting to address HIV/AIDS/STIs, which appear to be an unmet need.

Information Management:

19. Some additional project indicators could be monitored by incorporating a few additional questions into the current supervisory checklists, such as indicators 21-22 that are to be evaluated based on the results of HFA.
20. It is suggested that the project review the data that is being collected and tie it to a use (i.e., monitoring progress on the project objectives, expanding the data collection/use capacity of the MOH, etc.) or stop collecting it.

LQAS Methodology:

21. It is suggested that in future, the project obtain at least 19 valid responses for each indicator in each lot, and a total of at least 95 valid responses combined for all lots. This can be done by seeking an interview for only the missing indicator information (and household identifiers) at the next closest household from the initial interview, and continuing this process until information is collected for each of the indicators (a process which is easier to do in surveys covering a small number of indicators or few different sub-populations, such as children ill in the last two weeks, or under six months of age, or 12-23 months old, than in surveys with long questionnaires or those covering several sub-populations).

Other Issues Identified by the MTE Team:

22. SC/Tajikistan should consider developing an emergency preparedness plan based on SC models from other countries and the recent experience with the floods in Panjikent District.
23. SC/Tajikistan needs to ensure that CS-18 is registered with the GOT.
24. SC together with the MOH should consider exploring programmatic and funding opportunities to assess and implement a response to the potential threat of HIV/AIDS/STIs during the remainder of CS-18 and beyond.

Save the Children's Response to the MTE Recommendations:

Save the Children staff from both HQ and the field were directly involved in the entire MTE process including the development of the MTE recommendations.

Action Plan:

The completed Action Plan is included in Section X of this report. It covers the remaining 26 months of CS-18 and responds to each of the MTE recommendations.

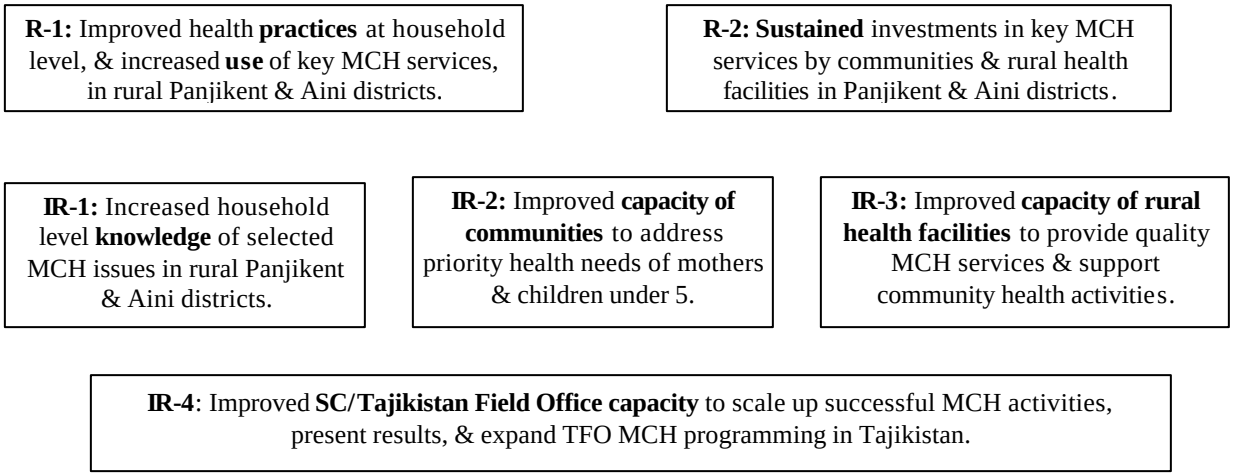
II. Technical Approach
II. A. Project Overview

Save the Children/US (SC) has been implementing a USAID-funded Child Survival (CS) Project in Panjikent District, Tajikistan since October 1998. Initially as CS-14, the project goal was "to sustainably reduce maternal and child morbidity and mortality through improved caretaker practices and increased access to high quality care." The beneficiary population included an estimated 26,400 women of reproductive age (WRA) and 20,640 infants and children under five living in 75 villages in Panjikent District. Selection of the project's CS interventions was based on the leading causes of maternal and child morbidity and mortality – acute respiratory illness (ARI), control of diarrheal disease (CDD), immunization (EPI), and maternal and newborn care (MNC).

The follow-on CS-18 project (September 30, 2002 – September 30, 2007) expanded the beneficiary population, the project site, and the number of CS interventions and cross-cutting approaches from CS-14. CS-18 is serving all the estimated 60,000 WRA and 36,000 infants and children under age of five living in all 201 rural communities in both Panjikent and neighboring Aini Districts. Panjikent and Aini are both located in the Zarafshon Valley, formerly part of the historic silk road. Aini is a five-hour drive from Dushanbe, over the 11,000-foot Anzob Pass, and Panjikent is an additional two-hour drive from Aini. The Anzob Pass is closed every year from October to May due to the snows and the poor roads, and is considered to be one of the most difficult areas in Tajikistan. During these winter months overland travel between Dushanbe and the project site is only possible through Uzbekistan, which requires two border crossings that can add several hours to the seven-hour drive. SC has phased in CS project activities, starting in the most accessible villages and expanding out into those that are more isolated. The last two years of CS-18 will focus on the remaining villages that are the most difficult to reach, due to their distance from the district centers and the damage done by the June 2005 floods to roads, bridges, health facilities, schools and homes. These are the communities where the most disadvantaged live.

The two-part goal of CS-18 is "a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini Districts, and innovative CS-18 strategies contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan." The CS-18 project originally included 31 quantifiable objectives that directly support the following results and intermediate results. (See Attachment F.):

Figure 1. CS-18 Results and Intermediate Results



CS-18 also added nutrition and micronutrients to the four CS-14 CS interventions. The project's cross-cutting strategies, most of which were initiated in CS-14, include:

- Revolving Drug Funds for Village Pharmacies
- Health Facility Farms for continuing investments in improving maternal and child health (MCH) services
- Joint training and supervision of rural health facility staff
- Community mobilization through Village Development Committees
- Interactive engagement of local health workers with community groups to promote improved MCH practices
- Child-to-Child health education

II. B. Progress by Intervention
Control of Diarrheal Disease (CDD):

No significant changes were made in the project's approach to CDD, as outlined in the DIP:

- Education of caregivers on preventing diarrhea, (including promotion of hand washing, boiling drinking water, and improved personal hygiene);
- Improved early recognition and home care of DD (including ORT, continued feeding and breastfeeding, and increased feeding after the episode);
- Improved recognition of DD-associated danger signs (dehydration, blood and persistence beyond two weeks) and prompt care seeking; and,
- Improved case management by MOH providers, monitored through joint training and supervisory visits.

The percentage of mothers who reported washing their hands before preparation of meals and feeding, as well as after defecating and cleaning the child after s/he defecated, increased from 19% at baseline to 65% at the midterm, surpassing the end-of-project (EOP) target by 25 percentage points.[1] Through its implementation of PDI/Hearth, the project has also sought to dispel some of the common misperceptions about diarrhea and food, such as the belief that fruits cause diarrhea and that oil-rich foods should be avoided when the child has diarrhea. Proper feeding of the sick child also improved markedly from the baseline to the midterm, having increased from 30% to 100%, surpassing the EOP target by 40 percentage points. ORS is being distributed quarterly to both districts by PSF and UNICEF, but some stock outs have occurred. Health workers then carry the ORS back with them to their health facilities after attending the monthly meetings at the district MOH offices. Posters and flip charts on ORS preparation were available at the health facilities and health workers said they are increasingly using the Child-to-Child students and VDC members to educate caregivers on how to prepare and administer ORS. When ORS is not available, health workers and community members are promoting rice water, an effective locally available substitute.

While the 60% EOP target for mothers' knowledge of the two most common DD-associated danger signs ('diarrhea and blood' and 'diarrhea lasting more than 14 days') was not achieved, there was an increase from 15% at baseline to 26% at midterm. A review of the possible answers to the related question in the KPC questionnaire, found other responses that would also suggest the need for medical care (including responses B, C, G and H, in addition to the commonly recognized and promoted DD danger signs: D and E, as noted below):

Figure 2. KPC Questionnaire Responses to DD Danger Signs Question.

DIARRHEA …….... A
DIARRHEA AND VOMITING…… B
DIARRHEA AND FEVER…….. C
DIARRHEA WITH BLOOD…….. D
DIARRHEA LASTING MORE THAN 14 DAYS .. E
LETHARGY……..…. F
UNABLE TO DRINK……..…G
UNCONSCIOUSNESS…….. H

When all of the potentially correct answers were included as correct responses, it was found that the 100% (95/95) of mothers listed two or more correct responses, which was consistent with the responses mothers made in focus group discussions (FGD) during the MTE. (This change has already been made and incorporated into the project's revised indicator table. See Attachment F.)

Anecdotal reports from MOH health workers and caregivers noted that children with diarrhea were being brought to health facilities sooner, upon recognition of symptoms, so the severity and duration of the disease is being mitigated. The MTE did not directly measure changes in the quality or consistency of diarrheal disease case management provided by MOH workers through

[1] NOTE: The MTE's KPC results, discussed throughout this report, only measured the communities that have been served by the project to date and not the entire CS-18 project area. It should be noted as well that many of the communities that remain to be served are some of the most is olated and remote. Therefore, the KPC results included in this report are more a measure of what has been accomplished to date than an accurate estimate of what remains to be done.

a formal health facility assessment since it is not required in the MTE guidelines. Results of trainee testing, however, found that MOH staff scores ranged between 59% and 69% on pre-tests prior to receiving the project's DD training. This range increased to between 94% and 99% directly after the training. Later training provided on counseling skills for health providers to support ARI and CDD case management increased from an average score of 38% (range of 8% to 85%) for the pre-test to 79% (range 23% to 100%) at the post-test. This improved knowledge about DD case management is consistent with what MOH staff at the district and peripheral levels reported in FGDs and interviews about their improved practices. Both health workers and MOH district officials said that they were cutting back on their use of antibiotics for diarrhea-related illnesses, limiting their use to dysentery rather than giving it for simple watery diarrhea, which had been common practice. They also said that they felt more comfortable using the WHO guidelines for DD case management.

The primary challenge in addressing both DD and ARI remains the general lack of access to safe, affordable and appropriate medicines for treating both diseases. (Reference the section below on the RDF/Village Pharmacies.)

Acute Respiratory Illnesses (ARI):

The project's approach to addressing ARI remained unchanged from the DIP, focusing on educating mothers about proper home-based care of the sick child and the ARI-related danger signs that signal the need for prompt medical care; the training of MOH health workers on WHO ARI case management guidelines; and the joint supervision of health workers by district MOH and SC staff to ensure quality case management. In addition, the project's revolving drug fund/village pharmacies were to expand access to safe and affordable drugs necessary for treating ARI.

As noted above in the section on CDD, proper feeding of the sick child improved markedly from the baseline to the midterm, having increased from 30% to 100%, surpassing the EOP target by 40 percentage points. While not reaching the EOP target, knowledge of the two danger signs associated with ARI and the need for prompt medical care (chest indrawing and/or rapid breathing) increased from 27% at baseline to 57% at the MTE, falling short of the 60% EOP target by only three percentage points. As noted with DD, health workers in FGDs said that children experiencing the danger signs were being brought to a health facility earlier in the course of the illness and they felt better equipped to provide quality case management. They also felt more comfortable in using the WHO chart for ARI case management.

With regard to IMCI, the original plan was for the project to provide ARI and CDD training to health workers using the standard WHO and MOH guidelines, which it has done. Once IMCI was ready to be rolled out in the project area, CS-18 would assist. In Panjikent District, the Chief Medical Officer reported that the National IMCI Director gave an overview on IMCI to district staff. Health workers were also shown the IMCI protocols during their recent training on ARI/DD-related counseling skills. The date when IMCI will be rolled out in Aini and Panjikent remains unclear, so it is now recognized that it might not be happening in the project area before the conclusion of CS-18.

Immunization (EPI):

Per the DIP, CS-18 focuses on supporting MOH childhood immunization coverage through:

- Health education of caregivers and community members on the importance of childhood immunization.
- Use of health facility farm profits to purchase and maintain cold-chain equipment.
- Use of ANC registries to record births and plan immunization outreach.
- Use of home-based EPI cards.
- Joint training and supervision of health workers.
- Involvement of VDC members and CTC participants in following up with defaulters and mobilizing communities for immunization outreach.

EPI coverage has improved in the project area. Completed childhood immunization coverage per card increased from 71% at baseline to 88% at midterm, exceeding the EOP target of 70% by 18 percentage points. Measles coverage increased from 67% to 94%, per mother's recall, having surpassed the EOP target of 80% by 14 percentage points. This is consistent with the 95%+ rates for completed childhood immunization coverage District MOH officials were reporting in both Aini and Panjikent.

Some questions surfaced during the MTE with regard to immunization, particularly at the district level MOH. The Aini District Chief Doctor on Immunization said that they do not vaccinate children during "certain illnesses such as blood illnesses, epilepsy, convulsions, or high temperature," which might not be consistent with national or international standards of EPI contraindications. The project's Immunization Supervisory Checklist results found that 40% (31/78) health facilities reported denying one or more children immunizations due to a contraindication.

RECOMMENDATION 1: Project staff need to review national protocols for immunization contraindications with the Chief Doctors on Immunization in both Aini and Panjikent Districts to ensure compliance and consistency. This needs to be addressed in the proposed, up-coming MOH training on EPI.

The district MOH staff responsible for immunization did not mention the VDCs or CTC participants as resources for supporting immunization outreach. This might not have been a critical issue to date, since the coordination between the health facilities, CTC trainers and VDC members appears to be strong at the community level, especially for immunizations. (Nearly all of the health facilities reviewed during supervisory visits reported that they coordinate closely with the VDCs and CTC participants on following up with defaulters, recording births and working together on planning immunization sessions.) When developing and implementing the sustainability plans for CS-18, it is important that the district MOH staff recognize the value of these community resources to achieving their goals and targets.

One of the major project accomplishments has been the establishment and promotion of home-based EPI cards, first in Panjikent, and then throughout the project area. The project's Immunization Supervisory Checklists showed that nearly all (99% or 77/78) of the health

facilities now have a sufficient supply of EPI cards in stock for distribution to caregivers. FGDs with mothers found that the cards not only remind them when to bring their child in for vaccinations, but also give them greater responsibility over their child's health. In part due to their success in Panjikent and Aini Districts, the national MOH has committed to the use of home-based EPI cards throughout Tajikistan.

While the high rates of EPI coverage and the lack of recent outbreaks of vaccine preventable diseases over the last few years implies that an effective cold chain system is in place, the difficulty of transporting vaccines into the districts and to the peripheral facilities (especially during the long winters) as well as the lack of a consistent power source and a limited number of refrigerators means that the efficacy of the cold chain remains in question. Vaccines are flown from Dushanbe to Khojand, where they are then driven to the Aini and Panjikent towns, often relying on the use of hired ordinary trucks, which raises questions about sustainability and maintenance of cold chain. From the district centers the vaccines are driven to the SUBs, where they are kept in UNCIEF-donated refrigerators and then transported via cold boxes to the peripheral health facilities. Access to many of these health facilities is limited due to the weather, poor roads and lack of transportation. In addition, a review of the summary results from the project's Immunization Supervisory Checklist done jointly with MOH staff in 2005 found that 15% (12/78) had had DPT frozen and only 31% (24/78) of vaccines were being consistently maintained within an acceptable temperature range (between 0 and 8 degrees Celsius.)

RECOMMENDATON 2: The project needs to incorporate training and supervision of health facility staff on the proper use of vaccine vial monitors to ensure the quality of the vaccines.

RECOMMENDATION 3: The project needs to work with the district MOH and local Jamoats (government authorities) in both Panjikent and Aini to find sustainable strategies for ensuring the proper transport of vaccines into and throughout both project districts.

Maternal and Newborn Care (MNC):

As noted in the CS-18 DIP, the project's MNC intervention activities focused on improving the quality of and access to antenatal care, safe delivery, and postpartum and newborn care at rural health facilities.

Antenatal Care: ANC attendance improved significantly, with 95% of mothers attending three or more sessions – up from 53% at the baseline and surpassing the EOP target by 15 percentage points. When asked in FGDs what they learned during their ANC sessions, mothers listed an extensive and comprehensive list of topics. This was consistent with the KPC results that found that 100% (95/95) of mothers knew two or more postpartum danger signs and 100% (95/95) knew two or more newborn danger signs, and in ANC observation and exit interview checklist results. While this is an impressive achievement, promotion of ANC needs to remain a project priority as CS-18 expands into the more isolated and remote communities during the remaining two years.

Birth Planning: A total of 3,015 women attended ANC sessions provided by a BLSS-trained health worker by the end of year two, where they were educated on the need for and the steps involved in developing a safe birth plan. In addition, VDC and health worker training on development of birth plans has been completed in 99 of the project's 201 communities. Developing the birth plans leads family and VDC members through a series of decisions that explain what is involved and helps to clarify roles and responsibilities. The idea of involving the wider community in this process was first considered novel or odd since these issues had been dealt with by the pregnant women, her parents, her in-laws, or not at all.

In FGDs it was found that the existence of a health facility and a trained health worker in a community was related to who had the authority to decide whether the pregnant woman could seek ANC and have a facility-based delivery. In communities where there is a health facility, mothers tend to have more authority in determining when and where they will seek medical care. In communities that lack a health facility and health worker, this authority tends to rest with the father or the mother-in-law, due in large part to the high cost of transport. In FGDs health workers reported that many husbands and family elders still do not support ANC or facility-based deliveries. Even though many communities have vehicles, it is taboo for women to drive and since many of their husbands are away, this is not a viable option, even if a family vehicle might be available. The project has reached its objectives for improved access to ANC and birth planning in the currently served communities, and nearly reached its target for the use of skilled attendants at deliveries. However, as it expands into the more remote isolated villages that lack health facilities, the project will need to educate and work with MILs, husbands, and other decision-makers as well, so they understand the importance of MNC services and will support mothers in seeking them.

Access to appropriate care during the delivery is not just tied to limited knowledge, but is also related to a lack of access to transport. In response, the project has promoted the development of emergency transportation funds by the village development committees (VDCs). The project has trained members from 17 VDCs on how to establish these funds using money collected from within their communities and on how they are to be managed. All 17 trained VDCs have established their own funds, twice the initial target of eight, and report that the loans are being appropriately used and consistently repaid. FGDs with other VDCs found many more VDCs interested in developing their own emergency transportation funds.

RECOMMENDATION 4: The project should monitor the percentage of deliveries done at MOH facilities as a measure of the effectiveness of the birth plans and emergency transportation funds. [Fortunately, the related question was asked in the KPC survey as part of the CS-18 baseline assessment (Question #10) and midterm evaluation (Question #5).]

RECOMMENDATION 5: To the extent possible, the project should support additional VDCs to develop their own emergency transportation funds, giving preference to VDCs that express an interest and are located in the more isolated rural communities that are becoming involved in CS-18 later during the life of the project.

Basic Life Saving Skills (BLSS): The midterm KPC found no significant change from the baseline in the percentage of mothers of children under two years of age whose births were attended by a skilled attendant, remaining at 85% (81/95), which is already high when compared with other CS projects worldwide. Now, 73% (147/201) of the project villages are served by a health worker trained by the project in BLSS, and the project is committed to expanding this coverage to all 201 villages. The project's focus on providing BLSS training to such a large number of health workers is an excellent opportunity to help ensure the widest possible access to quality care during delivery.

FGDs with midwives and interviews with the BLSS trainers and gynecologists in both districts found that the BLSS-trained health workers have greater confidence in their ability to assist in deliveries and to recognize and respond to complications. After having taken the BLSS training, they know how to conduct newborn resuscitation, do active management of third stage of labor without drugs, and counsel pregnant women more effectively. Anecdotal reports are that they are no longer delaying the removal of the placenta, which was common practice previously. Midwives can also now do episiotomies when they have the necessary equipment and are using the partographs. Observation of ANC sessions and exit interviews with pregnant women found that the vast majority (90%+) of BLSS trained health workers were completing all the necessary examination tasks, conveying the appropriate heath education messages, and promoting birth planning. The project has provided the health facilities with forms that are being used to monitor referrals. UNICEF provided seventy-five midwife kits that were provided to health facilities that sent health workers to the CS-18 BLSS training. The remainder of the 170 midwife kits have been ordered and are now on the way, using funds from SC's USDA grant.

In addition to the data collected by the project, MOH data also suggests improvement of midwife skills, particularly in the active management of the third stage of labor. As noted in the following tables, the number of cases of postpartum hemorrhage (PPH) reported in Panjikent District dropped from 118 in 2000 to 33 in 2004 and there have been no cases of postpartum sepsis since 2002. In Aini the number of PPH cases dropped from 17 in 2003 to seven in 2004.

Figure 3. MNC Data Panjikent District

	2000	2001	2002	2003	2004[2]	2005 (1/1-7/31/05)
Maternal Mortality	0	1	1	1	5	0
Neonatal Mortality	27	10	17	15	35	13
Postpartum Hemorrhage	118	74	58	18	33	11
Postpartum Infection	3	1	2	0	0	0

Per MOH/Panjikent (8/05)

[2] The increase in PPH, neonatal mortality, and maternal mortality that occurred from 2003 to 2004 in Panjikent is thought to be the result in part of improved reporting that is starting to happen in Tajikistan rather than a change in the number of cases. During the Soviet period health workers were directed to meet targets that were set by central authorities and penalized severely when they were not met, regardless of mitigating factors. Therefore, there were significant disincentives against recording or reporting any unfavorable statistics. The GOT has begun to try to turn this around.

Figure 4. MNC Data Aini District

	2002	2003	2004	2005 (1/1-7/31/05)
Maternal Mortality	0	0	0	1
Neonatal Mortality	47	36	36	24
Postpartum Hemorrhage	15	17	7	5
Postpartum Infection	0	0	0	0

Per MOH/Aini (9/05)

Nutrition and Micronutrients:

CS-18 added nutrition and micronutrients to the CS-14 intervention mix, focuses on:

- Promotion of breastfeeding.
- Promotion and sale of iron supplements through village pharmacies.
- Promotion of increased use of iodized salt in households.
- Support of the MOH and UNICEF introduction of vitamin A supplementation.
- Training and supervision of health facility staff in child growth monitoring, nutrition counseling, and management of childhood malnutrition.
- Use of United States Department of Agriculture (USDA) resources to support the development of kitchen gardens.
- Growth monitoring of infants and children between six and 23 months of age.
- Piloting and scaling up PDI/Hearth.

Breastfeeding: The project tripled the rate of exclusive breastfeeding from 12% at baseline to 37% at the midterm, which is thirteen percentage points short of the EOP target of 50%. FGDs with mothers found that they appear to understand the definition and importance of exclusive breastfeeding. This was corroborated during the most recent birth planning supervision which found that 97% (147/152) of mothers reported being counseled on the importance of exclusive breastfeeding during ANC visits. One of the reasons mothers are not exclusively breastfeeding their infants for the first six months, as found during the MTE FGDs, is due to their need to return to work shortly after the delivery. Mothers report having to work away from the home between three and twelve hours per day, leaving their children with older siblings, their mother-in-law (MIL), or other relatives, which not only impacts exclusive breastfeeding but also access to health education sessions. FGDs with MILs found several misconceptions about exclusive breastfeeding: that anemic or malnourished mothers do not produce sufficient quantity or quality of breast milk; that breast milk alone is not a sufficient diet for an infant under six months of age; and, that it was okay to give a little water to calm a crying infant when the mother is away. This is compounded by the fact that FGDs with mothers found that their in-laws exert a lot of authority in the household.

The need is not only to educate mothers further on the importance of exclusive breastfeeding but also, and more importantly, to provide a supportive environment that enables mothers to exclusively breastfeed, recognizing their need to be away from the home to work and to be respectful of their in-laws' authority. The project is highly adept at educating communities on

why exclusive breastfeeding is important and suggesting ways to support it. The project needs to put the onus on the communities to come up with solutions to this challenge that will work for them rather than attempt to impose a solution. This will not only help build problem-solving skills but will also make communities more responsible and accountable for health. Some viable solutions are already being done. In one of the MTE FGDs, a mother said that she was expressing and leaving her own breast milk at home with the caregiver when she went to work.

RECOMMENDATION 6: The project should work with the VDCs to educate them on the value and importance of exclusive breastfeeding, so the VDCs can identify ways the community can provide a supportive environment for mothers of children under-six months of age to breastfeed exclusively.

Growth Monitoring and Positive Deviance Inquiry (PDI)/Hearth: The project provided training and support to MOH staff to weigh and plot the weight of 3,863 children between six and 23 months of age living in 15 Panjikent villages and 923 children in the same age range living in five Aini villages. Of these, 23% (877/3863) in Panjikent and 36% (333/923) in Aini were found to be suffering from mild or moderate to severe malnutrition.[3] (SC/Tajikistan has ordered 210 salter scales through its USAID grant, which will be provided to each health facility in both districts in support of the growth monitoring.)

"Hearth is not just for the food, but also for the opportunity to learn."

A mother participating in Hearth

From this initial assessment the project selected four communities to pilot PDI/Hearth – two in Aini and two in Panjikent. The percentage of children found to be malnourished in these four pilot villages ranged between 36% and 58% prior to starting the hearth sessions. This range decreased to 8% to 16% after the conclusion of the fifth and final hearth session. FGDs with PDI/Hearth participants found that the PDI/Hearth approach was very popular, more so than just growth monitoring and nutritional counseling, since the mothers see quicker results – increased appetite, weight gain and a higher level of physical activity. Mothers also said they feel that they are better able to adopt the new cooking and feeding practices since the Hearth approach relies entirely on the use of locally available foods.

FGDs with PDI/Hearth participants also identified improved household practices as a result of PDI/Hearth, such as feeding the child from its own pot rather than the communal family pot; monitoring the child while eating rather than leaving her alone; not just providing soup broth, but also the vegetables; and, washing hands more frequently. FGD respondents noted several misconceptions about nutrition that were corrected during PDI/Hearth sessions, such as avoiding giving fatty foods during diarrhea and feeding children eggs and beans, as well as the mistaken belief that fruits cause diarrhea. As a result of this initial success in the four pilot villages, CS-18 has selected two new villages to implement PD/Hearth.

RECOMMENDATION 7: The project should consider scaling up the PD/Hearth strategy to

[3] A comparison done by members of the MTE Team found several discrepancies between the weight table used by the project to determine the degree of malnutrition in infants/children and the tables provided on pages 82 and 83 of the PD Hearth Manual. The project should use the later table.

involve additional communities that are experiencing higher rates of childhood malnutrition. (SC has received a grant in support of the RDF strategy, which with donor approval could be transferred over to support scaling up PDI/Hearth.)

Anemia: Anemia in women of reproductive age to considered to be a major public health challenge both in Tajikistan, where the MOH estimated the rate to have been 95% in 1999, and in the project area, as noted by health workers, community members and the Chief Medical Officers for both Panjikent and Aini. In response, the project has incorporated promotion of iron supplements, (which are reportedly available at MOH facilities), into its health worker training and community health education campaigns. Anecdotal reports from health workers noted that women are now taking their iron tablets with water rather than tea, which improves absorption. Some issues were identified during the MTE which warrant followup, including counseling clients on the side effects of iron supplementation and discrepancies between national and international standards on the proper dose of iron to treat anemia.

RECOMMENDATION 8: Proper counseling on side effects of iron supplementation needs to be stressed in the MOH health worker training curriculum and supervisory checklists.

RECOMMENDATION 9: CS-18 is recommending two tablets a day and retesting once a month to treat anemia, while the MOH recommends two tablets per week. This has been discussed with MOH and still some differences exist. The national treatment guidelines and international standards need to be reviewed together with the MOH district offices and the MOH training curriculum and supervisory checklist need to be adapted as needed.

Iodine Deficiency: Iodine deficiency and goiter continue to be considered major health problems as well by the community and the Panjikent District MOH. With the breakup of the Soviet Union, manufactures stopped iodization of salt and the government lacked the resources to test and enforce the laws. As a result vendors and consumers did not know whether the salt they were selling and buying was iodized, even though the labeling might say so. The project has provided 100 iodine test kits to local MOH facilities and VDCs, which they have used to test salt in the stores and households. Some VDCs have taken the results from these tests to local vendors to pressure them to only sell iodized salt and one VDC has written a letter to the MOH requesting them to test and enforce the iodization of salt. The results have been significant. The percentage of households that are now using iodized salt has increased from 10% (per label) at baseline to 74% (per test) at the midterm, exceeding the EOP target by 24 percentage points.

Other: The project continues to support vitamin A distribution as part of its EPI outreach and its general health education. The promotion of kitchen gardens (using USDA resources) was not introduced as part of the CS-18 nutrition intervention, but was instead implemented as part of the USDA project.

II.C. New Tools and Approaches

The project has incorporated numerous new tools and approaches in the context of Tajikistan (village development committees, Child-to-Child health education, revolving drug funds/village pharmacies, emergency transportation funds, and birth plans) and beyond (Health Facility Farms). These are discussed in detail in the following section.

III. Cross-Cutting Approaches

Community Mobilization through Village Development Committees (VDCs): VDCs are the backbone of all the project's community activities and provide a platform for launching civil society initiatives in health and other sectors of development. All VDCs have a core set of activities and responsibilities that are largely consistent from VDC to VDC – health education and promotion, community mobilization, coordination with health facilities, monitoring health needs, coordination with and support of Child-to-Child participants, assisting with birth plans, and responding to emergencies such as the recent floods. In addition, selected VDCs are participating in PD/Hearth, emergency transportation funds and village pharmacies, and some have taken the initiative to advocate for increased government support in the form of a new health facility and staff, requesting GOT oversight on salt iodization and requesting land for use as health facility farms. While other VDCs still look to SC to advocate for them or solve problems.

Membership on the VDCs includes women, teachers and elders. There appears to be good coordination at the community level with local health facilities as each of the ten VDCs visited during the MTE could document that MOH staff had attended their most recent meeting as per their written meeting minutes (Indicator #26). They were also able to show that each VDC had organized a health activity within the previous month (Indicator #18). The midterm KPC found that 65% (62/95) of mothers reported receiving health information from their VDC. Mothers, health workers and others who participated in the MTE FGDs appeared to have a clear understanding of the roles and responsibilities of their VDC members, implying that they are an effective body for leadership and community mobilization.

Seventy-five VDCs were formed during CS-14 and an additional 79 have been formed to date during CS-18, leaving an additional 47 to be formed by the end of the project. They are increasingly being viewed by community members and other development agencies (i.e., German Agro Action) as the one-stop-shop center for defining and addressing community challenges and goals. FGDs with members from ten VDCs found a commitment to continue their work beyond CS-18, that they have identified other needs they wish to address, and have begun to identify solutions, most importantly, recognizing that they will need to commit their own local resources. (The future of the VDCs is discussed in Section IV. Sustainability.)

Child-to-Child (CTC) Health Education: The focus of CTC is to improve the care students in grades eight through ten provide their younger siblings, to help prepare them for their future role as parents, and to utilize them in support of project-related initiatives, such as following up with EPI defaulters and identifying pregnant women. One of the key long-term benefits of youth involvement in CTC is that it teaches them about and connects them with public institutions in their communities such as their VDC and local health facility. To date, 2,175 students and trainers (teachers) have been trained in 129 communities, leaving 72 communities potentially yet to serve.

> ***"We have developed public speaking skills and are now more respected by the other children."***
>
> A CTC Participant

FGDs during the MTE found that CTC participants not only feel that they have learned important lessons about health but have also developed their communication skills; mothers, VDC members, and other community members are aware of who the CTC participants are in their village and what they do; and that, as a result of the training they have received, the CTC trainers approach teaching overall in a more participatory, interactive manner than before. The KPC found that nearly half of mothers (42% or 40/95) reported receiving health education messages from CTC participants in the previous month.

The CTC project faces two challenges in meeting its full potential. First, only one CS staff person is dedicated to implementing CTC in both districts and is having to do this in the context of a shortened year, since students are not in school and away in the mountains tending livestock herds during the summer months. This does not leave enough time to recruit and train trainers in one community while trying to support and monitor the on-going CTC efforts in the communities that have already begun. This will be even more difficult as the project starts to focus on the more isolated, hard to reach communities during the remainder of CS-18.

RECOMMENDATION 10: Additional staff time will need to be directed to CTC if the project hopes to reach all 201 villages. Otherwise, a reasonable target needs to be set and criteria for selecting these communities needs to be developed for the remainder of CS-18.

The other challenge relates to the sustainability of the CTC approach. District level administrators in the Ministry of Education (MOE), MOH health workers, trainers and students have all voiced their commitment to continue to support CTC into the future. Teachers have committed to developing their own education materials and to continuing to dedicate their time and classroom space to CTC. However, as a youth program the turn over of participants is ongoing and therefore significantly greater than other community-based strategies that rely on volunteers. To sustain itself, the CTC project will need to recruit new participants every year, as the older participants graduate or leave school. Schools can and should have a significant role in seeing that this happens and the CTC teachers will need ongoing support in this.

RECOMMENDATION 11: The project should identify and support a "CTC Champion" in each District MOE who is committed to providing the ongoing support necessary to help design and implement the CS-18 CTC phase–out strategy and to support annual recruitment drives for the long-run.

Revolving Drug Funds (RDFs) for Village Pharmacies (VPs): One of the critical needs in the project area has been access to safe and affordable drugs. In response, the project supported the establishment of village pharmacies in all 75 of the CS-14 project communities. They were supported and overseen by a revolving drug fund committee that included project staff, VPs and the Panjikent District MOH Pharmacist. The RDF committee was charged with overseeing the revolving fund, troubleshooting, and wholesale purchasing and distribution of drugs to the VPs for retail sale. These VPs were the only source of safe drugs in many of the project communities. Based on the results of the CS-14 final evaluation, it was decided to scale up this intervention to cover all of the CS-18 project communities. An additional seven VPs were formed in CS-18 and four of these had to be closed because the pharmacists moved away – leaving a total of 78 VPs at the time of the MTE.

In 2004 it became apparent that the RDF structure was not sustainable due to an increasingly restrictive legal environment, compounded by inadequate RDF inventory and accounting systems, and difficulties encountered in disposing of outdated drugs. The government was starting to enforce registration requirements and began to impose a 40% subsidization requirement. This meant that 40% of the costs of the drugs would have to be covered either by the community, in the form of significantly inflated prices, or through ongoing outside funding. In addition, some of the VPs went into debt due to the need to provide drugs for free or below cost when their neighbors could not afford to pay. This, along with the complexity inherent in managing the RDFs (See Attachment E.), has made the current approach untenable, especially within the limited amount of time remaining in the project. The possibility of turning the administrative coordination and oversight responsibilities over to another international organization has been explored, but neither of the two international organizations currently doing revolving drug funds and/or villages pharmacies in Tajikistan are equipped sufficiently to undertake that responsibility. Pharmacists sans Frontierres, is now completing their current projects in Tajikistan and will be leaving shortly thereafter. German Agro Action, which set up seven VPs in Aini has asked SC to take them over, since it will be departing as well.

Even with these challenges, the VPs can be considered a success to some extent, as 78 communities have had greater access to safe drugs provided by a trained health worker, even if only for a limited time. This represents a significant improvement over what was there in the past, when untrained drug vendors were selling medicines of questionable quality with little or no understanding of their proper use. Members of the MTE team met with four VPs who were still continuing to function and the continuing need for drugs was raised in FGDs. Despite the challenges inherent in this approach, all were committed to seeing the VPs continue. The four VPs interviewed said that they had already started to purchase wholesale supplies from other sources and planned to continue on in the future, with or without the support of the RDFs.

CS-18 currently has approximately $14,000 remaining in the RDF bank account, which includes advanced payments from VPs for future shipments that they have not yet received and CS-18 has some remaining stock in its warehouse and some VPs still owe payments back to the RDF fund. The process of concluding SC's direct involvement in the RDFs and VPs is going to require much time and attention. A full accounting and inventory of funds and stocks will need to be

done and a fair and fully transparent process for privatizing the RDF function of the VPs will need to be defined and implemented.

RECOMMENDATION 12: Recognizing the commitments made to the communities, the very real need for a safe/affordable source of drugs and the successes achieved to date, as well as the challenges at hand, the MTE Team recommends a responsible transition to the private sector of the VPs established to date. This process should also include an accounting for and dispensation of the remaining funds and stocks of medicines.

Joint Training and Supervision of Rural Health Facility Staff: This is the project's primary approach to building the capacity of MOH staff in the technical and administrative aspects of CS-18's CS interventions. SC staff has worked with district level MOH in designing and translating training curricula, planning the trainings, and scheduling and participating on the supervisory visits. Much of the training of rural health facility staff has been done on two separate tracks – one that is tied to the monthly MOH meetings held at the district centers and organized by the Chief Medical Officers (CMO), and the other that is provided by SC and MOH staff and held throughout the districts. While the trainings provided jointly by SC and MOH are more structured, include both theoretical and practical training methods, and the results are monitored through the use of pre/post tests and checklists, the training approach used by the district is probably more sustainable as it is tied to a regular on-going activity and therefore requires fewer resources to continue. In FGDs, health workers report that they feel more confident in planning the training and education sessions, and using adult participatory training techniques.

Figure 5. CS-18 MOH Training Topics

Training Topics	Health Workers Trained To Date	Health Workers To Be Trained
BLSS	147	50
Counseling Skills for health providers to support ARI/CDD case management	201	0
Immunization	0	172
IMCI	0	201
Growth Monitoring, Nutrition and PD/Hearth	26	75
TOT	4	15

Together with the MOH, the project has developed several supervisory checklists covering ANC, BLSS, ARI, CDD, EPI, PD/Hearth, birth planning, and Child-to-Child. The checklists are used every four to six months and verbal feedback is provided during subsequent followup visits. The supervisory visits are scheduled and done jointly by district MOH and SC staff, with SC frequently providing the transportation.

There are two challenges associated with sustaining the improved training and supervision resulting from CS-18. First, there are not sufficient resources to cover the costs of doing regular

supervisory visits to all of the health facilities within the districts due to the lack of transport. Second, despite a recent raise in health worker salaries, lack of resources and the incentives that continue to draw men to migrate to Russia for better paying jobs, low morale in the MOH work force continues to be a major impediment to building their capacity.

Health Facility Farms (HFF) for Continuing Investments in Improving MCH Services: This strategy was developed during CS-14 and expanded in CS-18. Locally available resources (donated land) were pared with USDA donated commodities that were used as payment to local community members for working the health facility farms. The proceeds from the HFFs were then used to support the repair of health facilities, cover the costs of in-service health worker training, and purchase medical supplies and equipment. It was envisioned that each participating VDC and health facility would receive three years of project support, which would gradually decrease each year. By the fourth year the HFF would function on its own without further outside assistance. A total of 31 HFFs were established in Aini and Panjikent Districts and over half (55% or 17/31) completed a fourth cycle on their own, without outside support. This exceeded the target of 20% (Indicator #9). The revenues generated by the health facility farms were used to refurbish health facilities and purchase medical supplies and drugs, as well as pay the HFF workers. In 2003 the Project Manager presented a paper at Save the Children's Program Learning Group (PLG) on the Health Facility Farm approach in Tajikistan (Indicator #30). SC had to end its support of the HFFs in October 2004 due to the conclusion of USDA support in the form of food commodities. The main challenge with regard to the future of the health facility farms appears to be the continued access to the land. In some communities the government has taken the land back after the conclusion of SC support and in at least one of these communities the health workers have started to lobby for its return.

Interactive Engagement of Local Health Workers With Community Groups to Promote Improved MCH Practices: This approach relates to and supports each of the project's other cross-cutting approaches in that each approach strengthens the links between the communities and their health care facilities in some way, helping to establish and strengthen civil society. The connections between the local health facilities and the VDC, CTC, Hearth Volunteers and the communities at-large appear to be strong, as there is ample evidence that they work closely together and understand each other's roles and responsibilities. VDC members report that they coordinate with health facilities on immunization outreach, identifying pregnant women for ANC, birth planning, IDD and emergency transportation funds. In addition, health workers report that they provide monthly lectures on health topics to mothers who are coming to the health facilities, and as a result feel that they are paying more attention to prevention and health promotion than before. CTC participants are doing community mobilization in support of EPI, health education, promotion of iodized salt, client referral to health facilities, and distribution of ORS – teaching caregivers how to prepare and administer it. VDC members have attended CTC health education sessions and MOH staff are regularly attending VDC meetings.

The MTE found that 92% of villages with health facilities had had one or more health education sessions conducted by health facility staff in the past month, exceeding the EOP target of 50% by 42 percentage points (Indicator #27). The percentage of mothers who reported that they received information on health from doctors increased from 62% (185/300) at the baseline to 76% (72/95) at the midterm and for nurses and midwives it increased from 44% (131/300) to 74% (70/95). In

FGDs it was apparent that communities appreciate the use of interactive education methods (role plays, stories, etc.) and visual media (flip charts, videos, puppets, etc.) and want more. In sum, both MCH knowledge and practices improved significantly as measured by the midterm KPC survey results – exceeding or nearly reaching the EOP targets for all four of the knowledge-related objectives, and exceeding six of the eight practice-related objectives and nearly achieving the remaining two.

The primary challenge the project faces on this approach for the remaining two years is to expand the focus of its IEC strategies to target decision makers in the families, through the health facility-community linkages it is establishing. This is especially critical as the project starts to work in the more isolated communities where MILs and husbands tend to exert more authority over decisions about home-based care practices and care seeking.

13. RECOMMENDATION: Strategies for educating and promoting behavior change in MILs, other caregivers and decision-makers need to be developed and implemented as the project expands into the more isolated and remote areas.

IV. Contributions to Scale-Up

CS-18's IR-4 focuses on "improved capacity to scale up successful MCH activities, present results, and expand TFO MCH programming in Tajikistan." This IR has been approached through joint programming, training, and capacity building strategies between CS-18 and the Healthy Family Project – a USAID-funded maternal, child and reproductive health project Save the Children has been implementing in Khatlon District in southern Tajikistan in partnership with Project HOPE (prime), American Red Cross, Red Crescent of Tajikistan, the American College of Nurse Midwives (ACNM), JHPIEGO, and Futures Group since October 2002. CS-14/18 staff assisted the Healthy Family staff in the design, implementation and analysis of their baseline KPC, Integrated Health Facility Assessment, and Safe Motherhood Needs Assessment surveys. CS-18 also hosted senior Healthy Family staff to attend training on the development of birth plans presented by Save the Children's Asia Area Health Advisor. Finally and most importantly, several of the CS-18 cross-cutting approaches have been adapted and scaled up for use in the Healthy Family site, including village development committees (VDC), BLSS training, Child-to-Child, safe birthing plans, and emergency transportation funds. (See Indicator 29 – number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.)

V. Sustainability

The project's sustainability indicators focused on achieving "Result 2 — Sustained investments in key MCH services by communities and rural health facilities in Panjikent and Aini Districts" and dealt directly with the establishment and continuation beyond CS-18 of the health facility farms and village pharmacies. Progress was to be monitored and evaluated based on measurement of four objectives, discussed above in Section III. Cross-cutting Approaches and noted in the attached revised Indicator Table (See Attachment F.) With the termination of direct CS-18 support of these two strategies, the project lacks a sustainable programmatic response to

address the need for ongoing financial support of health facilities and a safe source for drugs in the villages, even though some aspects of these two approaches might continue on their own.

Since CS-18 will no longer be focusing on village pharmacies or health facility farms as part of its overall sustainability strategy, the MTE team proposes a change to the project's sustainability IR to, "Result 2A – Key CS-18 benefits and activities sustained in Panjikent villages following - CS-18 phase-out." This IR focuses on the continuation of key aspects of community level knowledge, practice and use of health care services at the levels achieved by CS-18, essentially focusing on the project strategies that require little or no additional on-going financial support from the local partners. By cutting back its direct presence in the 75 CS-14 villages where it has been working since 1998, SC can monitor to what extent project-related achievements are maintained without its support over the remaining two years of CS-18. Using LQAS the project can continue to regularly monitor community level practices and use of key MCH services (Indicators 1-8) and household level knowledge of selected MCH issues (Indicators 13-16) in these 75 communities. (See Indicators 9A and 10A.) This not only gives CS-18 the opportunity to refocus its attention more directly on the remaining villages it needs to serve and a method for 'testing' sustainability, but also provides it with sufficient time to respond to any ebbs in performance and to bring any lessons learned from this experience to inform the phase-out strategies for the remainder of the communities.

RECOMMENDATION 14: The CS-18 project should withdrawal from the original 75 CS-14 villages and monitor their ability to sustain the benefits of the CS project on their own. LQAS results can be used to inform any necessary changes to the project's phase out plans.

MTE interviews with MOH and MOE district staff found an overwhelming appreciation for what the project has achieved, evidence that project staff have kept local partners informed of their activities, and a commitment to their continued support of CS-18 activities after the conclusion of this project. The transition has already begun to occur with the transfer of some responsibilities for implementing the project trainings over to the local MOH. When asked what their responsibilities will be once CS-18 has ended, however, the district MOH and MOE were unable to articulate a clear plan for this transition or beyond and what it will entail. This along with the tendency for local partners to assume that the international support will continue forever, means that this transfer needs to be formalized across all project activities that are to continue beyond CS-18, so the MOH (and MOE for CTC) are fully prepared to administer project activities at the level established by CS-18 after its conclusion.

This transition process is especially important in a project where so much of the focus is on increasing the ability of MOH staff to implement their regular responsibilities more effectively. Both Aini and Panjikent Districts are operating on very limited budgets with minimal staffing. When international NGOs focus on capacity building there is a natural tendency for districts to divert their attention and limited resources into areas that are not being supported by international projects. Without a well thought out, jointly developed phase-out strategy in place, the very health services that the project has helped to develop can suffer from under budgeting and lack of attention when the international NGO pulls out. For instance, CS-18 has helped transport MOH staff and vaccines, which has been a key factor contributing to the increased number of supervisory visits to the peripheral health facilities and possibly the increased EPI

coverage. Without joint planning for the phase-out strategy, it is feared that the amount of supervision could even possibly slip back to levels below what they had been before the project started.

RECOMMENDATION 15: A formal Phase-Out Plan needs to be developed and implemented jointly with the MOH for each project activity that is to continue beyond CS-18.

The VDCs and their connection with their local health facilities are key factors in sustaining project benefits and activities at the community level. The MTE found that several VDCs wish to continue their work and have already begun to focus on new challenges in health and other sectors of development. A primary focus of the remainder of CS-18 needs to be on ensuring that the VDCs are 'institutionalized' in their communities. This could entail providing them with training and working with them on developing strategic plans that will help them solidify their standing and responsibilities within the community and in their relationship with the health facility. Priority could initially be given to the original 75 CS-14 communities and then the lessons learned from their experience could be used to hone this process for the remaining 126 VDCs. The effectiveness of this strategy can already be monitored through objectives 18 and 26.

RECOMMENDATION 16: A Phase-Out Plan needs to be developed and implemented for the VDCs that will help them solidify their roles and responsibilities within the community.

VI. Program Management

VI. A. Planning

Most of the CS-18 program approaches and strategies were carried over from CS-14 and were based on the joint experiences of SC, the MOH, and the communities themselves. In addition, two assessment visits were made to Aini District, first to meet with community members and local officials to broach the possibility of expanding the CS project into their district, and then later, to solicit their input on program design for the project DIP. No formal changes were made to the program plan between the development of the DIP in early 2002 and implementation of the MTE in the summer of 2005. This was due in part to changes in the senior project management position and the ability of the other CS-18 staff to continue to work as a team and implement their regular day-to-day activities without much direct supervision from Panjikent or Dushanbe, as well as other factors discussed throughout the remainder of this report.

The project has not been able to fully utilize the increasing amount of data that it is collecting, (listed in the section below on Information Management). Some of it is being used for reporting, supervision and revising work schedules, however, it is not being used to its full potential for informing decisions about program design or developing phase out plans.

The CS-18 DIP work plan covers the first 24 months of the project, through September 2004. Per the Second Annual Report, project activities were on schedule except for those related to the health facility farms and revolving drug fund/village pharmacies for the reasons noted previously in this report. In addition, the following activities are behind schedule:

- Training of MOH staff on immunization, growth monitoring/nutrition, and training of trainers (TOT) teaching methodologies needs to be initiated.
- CTC training is supposed to be provided in 100 schools by the end of year two but was only being done in 55 by the time of the MTE. This is largely due to the limited staffing, where only one person is responsible for implementing CTC in both Aini and Panjikent Districts.
- The cross visits between Healthy Family and CS-18 have had to be cut after year one of CS-18 largely due to budget cuts in the Health Family project.

From interviews with program staff and MOH representatives, as well as FGDs with community members and volunteers, it appears that the project objectives, except for those directly related to sustainability, are well understood throughout the project area. Staff and partners have translated copies of the DIP and were well informed on what the project has achieved. The MOH staff and VDC members appear to be interested and motivated to start the discussions and planning for the project's phase out.

VI. B. Staff Training

Most of the current CS-18 staff have been working with SC in the project area since the start of CS-14 and as a result have developed a strong grounding in the technical aspects of each of the project's CS interventions and cross-cutting strategies. They have also developed practical skills in training, supervision and other aspects of capacity building of local partners. SC has provided them with English language classes and training on computers, and proposal writing. Staff have had training and practical on-the-job experience in monitoring & evaluation [KPC surveys using both LQAS and 30 cluster sampling, the BASICS Integrated Health Facility Assessment (IHFA), WHO/UNICEF Safe Motherhood Needs Assessment, FGDs, and participatory rapid appraisal (PRA)]; program management; administration; logistics; planning; and, each of the project's CS interventions and cross-cutting strategies. Staff performance is monitored primarily through annual personnel reviews. Staff expressed appreciation for the training they received and an interested in receiving more training, particularly in the use of computers and project data for monitoring and evaluation.

VI. C. Supervision and Support of Program Staff

Staff reporting and supervision is strong within the project area. All of the Health Monitors and other project staff meet daily as groups with their supervisors in Panjikent and Aini, where they report on their work, discuss challenges, and coordinate upcoming activities. There are also monthly staff meetings that include all Save the Children staff from both Panjikent and Aini, both for CS-18 and the USDA-funded FACT program, where project reports are reviewed, feedback provided, and future directions discussed. The supervisors in Panjikent and Aini were both promoted from within SC, where they had been Health Monitors previously, so each has a solid relationship with her staff and first hand understanding of their roles and responsibilities. While daily staff meetings might appear excessive, it is probably one of the reasons the project has been able to stay relatively on track despite numerous changes in the senior level management positions. It also affords a good opportunity to provide direct and timely feedback.

The senior staff person responsible for CS-18 who is officed in the project area is the Impact Area Manager. This position has been held by two individuals since the start of CS-18, with a six month gap in between that was covered by acting Impact Area Managers. The current Impact Area Manager has been in this position since May 2004. He is required to attend the SC country meetings that are held in Dushanbe monthly and involve all the senior level SC management staff in Tajikistan. A primary challenge for CS-18 continues to be the difficulty inherent in supervising and supporting the Impact Area Manager, primarily due to the isolation of the project site and the many winter months when it is cut off each year from the capital city, Dushanbe. Complicating this situation, the current Impact Area Manager was provided with only a minimal orientation to CS-18, which involved being given project documents and a half-day orientation at the project site by his supervisor, the SC Tajikistan Field Office Director. There was only a limited overlap period at the project site with his immediate predecessor, even though all three of his predecessors remained in country and one was still a SC employee for the first three months of the current Impact Area Manager's tenure and had held this position for over five years. (See detailed chronology in the next section.) The FOD made only one other visit to the CS-18 project between May 2004 and July 2005, when he was transferred to work in another country, which focused primarily on budget preparation. From September 2004 to February 2005, the Impact Area Manager's family, including four minors, was left in Panjikent without Uzbek visas, which would have been necessary if they had to be evacuated for any reason.

The challenges of providing the necessary support and supervision from SC's Central Asia Field Office (CAFO) in Dushanbe to the CS-18 project are going to be a critical factor for the remainder of the project, requiring more attention and involvement of the CAFO. The project budget assumes that the senior CS-18 management position will transition from an international to a local hire employee in year five. While this is fully consistent with the focus of the CSHGP of building local capacity, it is very important that whoever takes on this role has significant experience working within the administrative structure of an international NGO such as SC, including meeting reporting requirements, financial management/budgeting, strategic planning, etc. The current Impact Area Manager, who is an international hire, does have this experience, but the other local hire staff do not. If one or more of the local staff were to be elevated into this role, substantial training and coaching would be required.

RECOMMENDATION 17: CS-18 will require increased administrative supervision and support from the CAFO as it develops and implements its phase-out plans over the remaining years of CS-18 and turns over leadership to a local hire.

VI. D. Human Resources and Staff Management

The staffing structure has remained essentially the same throughout the last half of CS-14 and all of CS-18 to date. However, the number of Health Monitors has been cut back as more of the responsibility for project implementation is to move onto the shoulders of MOH staff.

All positions are currently filled. However, there were significant changes made in senior level project personnel between October 2003 and May 2004. The original Impact Area Manager, who had been in that position since the start of CS-14 was transferred to Dushanbe in November 2003 to support the SC Healthy Family Project in Khatlon. He was subsequently asked to resign by SC

in September 2004. His assistant in Panjikent, the Health Project Officer in November 2003, was promoted into the role of Acting Impact Area Manager and served in that role from November 2003 to February 2004, when she resigned for health reasons. The Senior Health Monitor who had been with the project since the start of CS-14 was promoted to take her role as Health Project Officer in October 2004, which she still holds. Between March and August 2004 a newly recruited Project Officer held this position for about 6 months before resigning in August. The current Impact Area Manager came on staff at the end of May 2004. To their credit, the rest of the project staff continued on with their regular responsibilities during this transition period.

While there probably was some degree of apprehension and stress in all staff due to the changes in senior management, staff morale appears to be strong now with little or no apparent evidence of the past difficulties. Staff reported that they feel comfortable communicating problems or other issues to the Impact Area Manager. In fact, staff appears to be much more animated and participate more fully in staff meetings and discussions, feeling that their comments and perspectives are taken more seriously than before. All staff has copies of their position descriptions and have been briefed on and have access to a translated version of Save the Children's personnel policies. Annual staff reviews are currently on schedule. Despite some difficult staffing changes in CS-18 and the challenges inherent in backstopping/overseeing this project from Dushanbe, the CS-18 field staff has done an excellent job in continuing to move the project forward.

RECOMMENDATION 18: SC should seek to identify viable options for expanding and continuing the work of the CS-18 staff, particularly the scale-up of the project's PD Hearth strategy and starting to address HIV/AIDS/STIs, which appear to be an unmet need.

VI. E. Financial Management

A July 31, 2005 pipeline report shows that the project's burn rate is on track with 25% of the combined CS-14 and CS-18 budgets remaining for the remaining 24% (26/108 months) of the project. The Impact Area Manager is the primary person at the project site responsible for management of the CS-18 project budget. As noted above, significant training and coaching in financial management and budgeting will be required when and if these responsibilities are turned over to others.

VI. F. Logistics

Logistics have always been a major challenge for this project, impacting access to wholesale drugs for the village pharmacies; transport of vaccines to and inside the Aini and Panjikent Districts; equipment purchased through project and health facility farms; and the purchase and distribution of midwife kits for the health facilities as part of the BLSS training. Logistics will become even more of a challenge as the project starts working in the more isolated and remote villages in Panjikent and Aini Districts, where there are few roads or bridges. This might require new implementation strategies where the Health Monitors might need to spend several days in project communities rather than traveling back and forth every day.

VI. G. Information Management

The project is collecting a lot of data, some of which is related to project inputs and some is tied to the project's results-based indicators. A hard copy filing system has been established and is updated daily to track project inputs per community, including VDC, CTC, RDF/VP, health facility farm, health education, community mobilization and project intervention-related activities, as well as project training. A set of monitoring checklists have been developed jointly with the MOH on BLSS, ARI, CDD, ANC exit interviews, EPI, PDI/Hearth, birth planning and CTC. Results of these checklists are entered into the project's computer system and summary reports are prepared quarterly or semiannually on ANC exit interviews, birth planning, CTC, PDI/Hearth, CDD, ARI and EPI. These reports are discussed at the monthly staff meetings that include all the CS-18 and FACT staff from Panjikent and Aini. In addition, the project is committed to monitoring some of its KPC-measured objectives through the use of regular surveys using LQAS through the remainder of CS-18.

One major focus of the project and an area where SC has worked to support the MOH HMIS, has been in the promotion of home-based cards for EPI, growth monitoring and antenatal care. The old Soviet system used an exclusively facility-based record keeping system that did not involve the clients. In an effort to improve EPI coverage and to increase client responsibility for the health of their families, SC initiated a system of home-based EPI cards in Panjikent CS-14 and now throughout the entire CS-18 project area. This system is now being implemented nationally throughout Tajikistan by the MOH.

Use of the data collected by the project appears to be limited to monitoring and reporting within Save the Children staff meetings. Other potential uses of this data have not yet been fully exploited, such as using the reports as part of supervisory visits to the peripheral health facilities and to inform the phase-out planning meetings SC needs to initiate with the MOH staff.

RECOMMENDATION 19: Some additional project indicators could be monitored by incorporating a few additional questions into the current supervisory checklists, such as indicators 21-22 that are to be evaluated based on the results of HFA.

RECOMMENDATION 20: It is suggested that the project review the data that is being collected and tie it to a use (i.e., monitoring progress on the project objectives, expanding the data collection/use capacity of the MOH, etc.) or stop collecting it.

VI. H. Technical and Administrative Support

CS-18 has received technical assistance from outside and within Save the Children. The American College of Nurse Midwives (ACNM) was instrumental in the design and initial training for BLSS. External consultants have trained project staff in proposal development, monitoring & evaluation, and presentation skills. The Child Survival Specialist officed at SC headquarters participated in the development of the CS-18 application and DIP; participated in this MTE; and has provided technical support throughout as needed. The Asia Area Health Advisor has visited the C-18 project site five times, when he has done progress assessments and provided training on the development of birth plans and PDI/Hearth. The technical and

administrative support received from SC's offices in Dushanbe was limited to two site visits made by the Field Office Director over the previous 15 months.

The project will continue to require both technical assistance and administrative support through its conclusion and beyond in the following areas:

- Identifying viable donors and preparing proposals in support of rolling out the project's PDI/Hearth strategy to more communities, exploring opportunities to address the growing concerns about HIV/AIDS/STIs, and the continuation of select CS-18 project activities beyond 2007.
- Developing and implementing phase-out plans together with the VDCs, MOH, and MOE.
- Completing a detailed review of current data collection needs and use.
- Developing the amended Action Plan. (See Section VIII below.)
- Administrative support and training of senior project staff, particularly if the senior project management position is turned over to a local hire in year five. If that is the case, then training or coaching will be necessary to make sure this person is able to fill the administrative responsibilities of the position, including financial management, budgeting, organizational reporting, etc.

VI.I. Mission Collaboration

The "increased emphasis on coordination with USAID Missions and their bilateral programs for improved in-country complementarily of programming," as noted in the updated MTE Guidelines was not a focus of the CSHGP when the CS-18 application guidelines or DIP directions were prepared and was therefore, not a focus of this project. However, the USAID/Tajikistan representative Aziza Khamidova, Health Specialist, USAID/CAR/Tajikistan, made a site visit to the CS-18, where she reviewed project RDF, birth planning and health education activities and met with the MOH partners. She also attended the debriefing in Dushanbe in August 2005 for this MTE.

VI. J. Other Issues Identified by the Team

In early June 2005 floods took the lives of six individuals in Panjikent District, including four children. In addition to this tragic loss of life, an estimated 400 households were destroyed and many bridges, wells, schools and health facilities were either damaged or completely lost – further isolating many of the most remote communities that had only had limited infrastructure, means of transportation, communication or access to public services to begin with. As the largest and longest serving international NGO in Panjikent, SC was called upon by district authorities to respond. SC/Tajikistan was able to use the emergency resources available through SC's Halaby Murphy Fund[4] to purchase and distribute household packs to the affected families and communities.

[4] This fund is accessible to SC projects around the world, affording them with immediate access to cash to respond to unforeseen natural and man-made disasters. It operates as a loan fund so SC/Tajikistan will have to pay the fund back with resources raised from other sources.

Discussions during the MTE found that although the June 2005 floods were particularly severe, the area has faced flooding on almost an annual basis. The "Report on the April 2002 Quality Management Review – November 2003," noted a related challenge. "Tajikistan is in a period of relative calm and quiet, but natural disasters have happened with frequency – and unpredictably. The lack of an emergency response plan means that the TFO will be caught flat-footed if a crisis strikes." Later the report suggests development of an emergency preparedness plan for SC/Tajikistan based on a review of similar plans developed by other SC country programs around the world. While this technically goes beyond the scope of CS-18, the development of such a plan for Tajikistan can only help to contribute to the sustainability and success of CS goals and objectives.

RECOMMENDATION 21: SC/Tajikistan should consider developing an emergency preparedness plan based on SC models from other countries and the recent experience with the floods in Panjikent District.

Another issue surfaced during the MTE that needs to be resolved. Discussions between SC and the MOH in Dushanbe in 2004 found that the MOH does not have documentation of permission granted to SC to implement its CS-18 project.

RECOMMENDATION 23: SC/Tajikistan needs to ensure that CS-18 is registered with the GOT.

Several factors suggest that HIV/AIDS and STIs might be growing yet hidden problems in the CS-18 project area, despite the low rates assumed by the GOT. Results from the CS-18 MTE KPC and the CS-14 Final Evaluation KPC surveys found that knowledge about HIV/AIDS and STIs and their transmission was very low in mothers. This is of concern due to the number of husbands going back and forth to Russia in search of employment, the amount of traffic through the project area, and the growing levels of poverty and unemployment.

RECOMMENDATION 24: SC together with the MOH should consider exploring programmatic and funding opportunities to assess and implement a response to the potential threat of HIV/AIDS/STIs during the remainder of CS-18 and beyond.

VII. Conclusions and Recommendations

The conclusions and recommendations are listed in the Executive Summary.

VIII. Results Highlight

Save the Children/US (SC) has completed seven years of USAID-funded child survival programming in northwestern Tajikistan. Since 2002 the goal of this program has been, "a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini Districts, and innovative project strategies contributing to improved maternal and/or child health policy or programming in other areas of rural Tajikistan."

SC and CARE initially worked with the American College of Nurse Midwives (ACNM) and the Ministry of Health (MOH) to adapt ACNM materials on Life Saving Skills (LSS) for maternal and newborn care for Tajikistan, and to gain government approval for training MOH staff in LSS. ACNM assisted with adapting the manual, completion of a health facility assessment, and the design of a system for supportive supervision of trained health workers. Extensive participatory training of the LSS training team, including four MOH and SC staff from Panjikent, was completed in November 2001 by ACNM at the Dushanbe Maternity Hospital III. This four-member MOH/SC LSS Training Team is now training all midwives who serve all 201 villages of Panjikent and Aini, along with other selected health staff. In addition, each health facility with a trained health worker is receiving a delivery kit for use in health facilities and home deliveries.

The Life Saving Skills and Birth Planning course includes four days of theoretical and eight days of practical training on: working with communities; birth planning (including the need for antenatal care, delivery by a skilled provider, recognition of danger signs, and contingency plans for emergency transport); infection prevention; antenatal care; care in the first, second, and third stages of labor; postpartum and newborn care; and clinical checklists.

Focus group discussions with midwives and interviews with the LSS trainers and gynecologists in both districts during the project's recent midterm evaluation found that LSS-trained health workers now have greater confidence in their ability to assist in deliveries and to recognize and respond to complications. LSS-trained staff now know how to conduct newborn resuscitation, do active management of third stage of labor, and counsel pregnant women more effectively. This is consistent with LSS monitoring data. Based on results from checklists completed by midwives after they see a client, 75% of LSS-trained midwives are managing normal pregnancies according to LSS protocols, 66% are correctly managing deliveries, and 93% of those who had to respond to obstetric complications managed them correctly.

A total of 3,015 women have attended antenatal care sessions provided by an LSS-trained health worker, where they were educated on developing a safe birth plan. The midterm survey found that 95% of mothers are attending three or more ANC sessions, and that 100% of mothers now know two or more postpartum danger signs and two or more newborn danger signs.

According to the midterm KPC survey, 86% of deliveries are attended by skilled health personnel (physicians, nurses, midwives, and feldshers) and 73% of deliveries are attended by an LSS-trained health worker. LSS training and follow-up for a large number of health workers thus has excellent potential for substantially improving the quality and use of antenatal, delivery, and postpartum care in this setting, and contributing to reducing maternal and newborn mortality. The approach is currently being scaled up in other parts of Tajikistan.

Tajikistan CS-18 Action Plan to Address MTE Recommendations

MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
1. Project staff need to review national protocols for immunization contraindications with the Chief Doctors on Immunization in both Aini and Panjikent Districts to ensure compliance and consistency. This needs to be addressed in the proposed, up-coming MOH training on EPI.	1. CS18 staff will attend EPI TOT arranged by MoPH (DR. Dostmatov, Chief of Immunization) in September 2005. The TOT will focus on: EPI schedule; Immunization techniques for each antigen; Data analysis including learning skills to calculate coverage and drop-out rates; how to conduct meaningful EPI feedback sessions where data is seriously discussed and planned; and how to conduct joint meaningful monitoring and supervision with a focus on ensuring quality of Cold Chain maintenance (especially on proper use of vaccine vial monitors), providing on-spot technical assistance re immunization techniques, infection control procedures and new monitoring formats received from Regional MOH by District MOH quality data collection and use. **The TOT workshop will also introduce national protocols for immunization contraindications** and will develop plans to incorporate this information within health worker's training plans. Information regarding side effects (fever, pain, swelling, etc) will also be introduced and information included within caregiver's counseling sessions in order to remove fears of side effects. This will be reinforced through regular supervision and monitoring.	September last week/Oct done 2005 Aini/November 05	Dr. Dostmatov MOH. Dr. Gulchera SC/US	Already done in Penjikent and Dr Dostmatov will be requested to do the same in Aini.
2. The project needs to incorporate training and supervision of health facility staff on the proper use of vaccine vial monitors to ensure the quality of the vaccines.		January 2006 onwards	MPH Chief of Immunization SC/US project office (Dr. Gulchera and Dr. Mobina	
3. The project needs to work with the district MOH and local Jamoats (government authorities) in both Panjikent and Aini to find sustainable solutions for ensuring the proper transport of vaccines into and throughout both project districts.	• Meeting of SC with District MOH Chief Doctor and Chief Doctor for Immunization, to exactly identify the gaps in transportation • Request assistance from local District Hukumats and Jamoats to help in vaccine transportation.	February'06	PM/PO Health/Chief Doctor/Hukumat representative	Will be done both for Aini and Penjikent
MNC				
4.The project should monitor the percentage of deliveries done at MOH facilities as a measure of the effectiveness of the birth plans and emergency transportation funds.	The existing MNC reporting forms already collect information on this. In addition data regarding birth plans is also collected during an interview with post delivered women. Data will continue to be analyzed and used to inform MNC monitoring, supervision and progress.	November 2005 onwards (continues)	Dr. Nazakat, Dr. GulBegum and MOH.	

5. To the extent possible, the project should support additional VDCs to develop their own emergency transportation funds, giving preference to VDCs that express an interest and are located in the more isolated rural communities that are becoming involved in CS-18 later during the life of the project.	• Birth Planning training will be conducted in the remaining 72 villages in the remaining part of the project, starting with BP orientation sessions for VDC members and MOH staff working in the nearest villages. • A one day training on birth planning will be conducted for VDC members in each selected villages, including the selection of cashier for the transportation fund • BP education for pregnant women will be conducted at the facilities (where trained BLSS midwives are) as well as at homes. • Family members (of pregnant women) and communities will also be educated.	January 2006 February 2006 onwards. ---do---- ---do-----	MOH facility staff including midwives) SC/US Health monitors.	
MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
Nutrition and Micronutrients:				
6. The project should work with the VDCs to educate them on the value and importance of exclusive breastfeeding, so the VDCs can identify ways the community can provide a supportive environment for mothers of children under-six months of age to breastfeed exclusively.	• Counseling training on BF will incorporate a component on developing support from VDC for exclusive BF • In monthly MOH/VDC meeting MOH staff conduct orientation sessions for VDC members on exclusively BF and make action plans to support mothers with children less than 6 months. • VDC to involve local Mullah to convince family members in continuation of exclusive breastfeeding by mothers. • Progress monitored jointly by SC and MOH.	Dec 2005 Jan 2006 Jan 2006 onwards	SC/US health monitors MOH staff with support from SC/US health monitors in the monthly coordination meetings	
7. The project should consider scaling up the PD/Hearth strategy to involve additional communities that are experiencing higher rates of childhood malnutrition.	• Conduct a one-day workshop on GMP/PD hearth for MOH staff in CS18 areas the remaining health facilities staff on GMP (total of three sessions) • MOH staff conduct GMP of 100% children in their impact areas and tabulate/analyze data. Together with SC/US staff identify communities with higher rates of malnutrition. Choose x number of communities for PD/Hearth activities. Start implementation of PD/hearth sessions.	December 2005 February 2006 February 2006 onwards	SC/US MOH facility staffs – facilitated by SC/US health monitors MOH staff and SC/US health monitors	

8. Proper counseling on side effects of iron supplementation needs to be stressed in the MOH health worker training curriculum and supervisory checklists.	This already is part of BLSS and MNC health education lesson plan. This will be specifically stressed in BLSS and MNC health education training by the midwife.	Oct 2005 onwards	MOH midwives	
MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
9. The national treatment guidelines and international standards regarding Iron supplementation need to be reviewed together with the MOH district offices and the MOH training curriculum and supervisory checklist need to be adapted as needed.	• The national treatment guidelines and international standards regarding Iron supplementation will be reviewed together with the MOH district offices. • Training and supervisory checklists revised according to the agreed protocols. Eric: this is changing national protocol, which is not a mandate for CS18 and even may not be rational to plan a revision of the protocol in the lifetime of the project. We can only engage in advocacy towards that end. If I understood correctly Garth's comment, that we need to remove to discrepancies with national protocols, which can mean that we change to the MOH one!!!!	Dec/2006	MOH staff and SC/US health monitors	
Child to Child (CTC)				
10. Additional staff will need to be directed to CTC if the project hopes to reach all 201 villages. Otherwise, a reasonable target needs to be set and criteria for selecting these communities needs to be developed for the remainder of CS-18.	A reasonable target will be set for expanding CTC activities in the selected communities. Especially those that have schools.	November 2005	CTC trainer/MOE VDC and MOH	

11. The project should identify and support a "CTC Champion" in each District MOE who is committed to providing the ongoing support necessary to help design and implement the CS-18 CTC phase–out strategy and to support annual recruitment drives for the long-run.	1. A champion (s) identified at MOE Penjikent and Aini. 2. Phase out plan for CTC developed with his assistance. 3. Phase out planned approved from the District Chief MOE. 4. Regular liaison kept by SC with MOE focal person. 5. Conduct Follow-up to ensure that MOE is supporting CTC in selected areas (once in two months)	January 2006 Jan-Feb 2006 February 2006 to end of project	PM/PO/Health/CTC Trainer PO/Health/CTC Trainer	
MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
RDF/VP:				
12. Recognizing the commitments made to the communities, the very real need for a safe/affordable source of drugs and the successes achieved to date, as well as the challenges at hand, the MTE Team recommends a responsible transition to the private sector of the VPs established to date. This process should also include an accounting for and dispensation of the remaining funds and stocks of medicines.	SC to develop RDF exit strategy with consultation of all stakeholders.	November 2005	PM, PO/Health, MOH, VDC,	
Interactive Engagement of Local Health Workers With Community Groups to Promote Improved MCH Practices:				

13. Strategies for educating and promoting behavior change in mothers in law, other caregivers and decision-makers need to be developed and implemented as the project expands into the more isolated and remote areas.	• Review and refine health education strategies for MILs and other caregivers and develop interactive HE strategies. • Incorporate interactive sessions within caregiver's counseling training • Incorporate interactive sessions with MIL and other caregivers health education/BCC strategies (including those for promoting birth planning).	December 2005	SC/US health staff	
Sustainability				
14. The CS-18 project should withdrawal from the original 75 CS-14 villages and monitor their ability to sustain the benefits of the CS project on their own. LQAS results can be used to inform any necessary changes to the project's exit strategies.	Starting in October 2005, CS18 will start developing plans to phase out of CS14 area. For this purpose SC/US will arrange a two-days workshop to discuss and develop phase-out plans. The workshop will endeavor to refresher all stakeholders regarding: Program implementation, trainings, BCC activities and materials, monitoring and supervision and documentation. Supervision checklists will be re-introduced and practiced (practice will include field work). During this workshop an action-plan for the phase-out will be developed and signed by all stakeholders.	November 2005 to Jan 2006	SC/US and MoPH	A period of at least 6 weeks required for a reasonable transition.
MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
15. A formal Phase-Out Plan needs to be developed and implemented jointly with the MOH for each project activity that is to continue beyond CS-18.	• CS14 Phase out: CS18 staff will monitor from distance (receive data and conduct data analysis and provide feedback; regular bimonthly meetings; occasional CS14 monitoring visits – once in three month in Year 4 and once in four months in Year 5. Awards (Year 5) will be provided to those CS14 area MoPH staff and VDC members who demonstrate successful EPI program. • CS18 Phase out: With MOH/VDC discuss and agree on a road map to transfer CS18 responsibilities progressively and in orderly fashionJointly with MOH	November 2005 through September 2007	SC/US and MOH	
16. A Phase-Out Plan needs to be developed and implemented for the VDCs that will help them solidify their roles and responsibilities within the community		December 2005 to end of the project	SC/US and MOH	
Supervision and Support of Program Staff				

17. CS-18 will require increased administrative supervision and support from the CAFO as it develops and implements its phase-out plans over the remaining years of CS-18 and turns over leadership to a local hire.	The expatriate PM position is anticipated to be based in Dushanbe beginning of November and the Project Officer will assume increased management responsibilities; however, She will be closely supervised and TA provided by the expat position, through frequent travel and stay in Penjikent. The expat position will assume greater responsibilities to help other health projects of CAFO and would assist in seeking more funding opportunities for CAFO, in line with recommendation # 18 and # 24.			
18.. SC should seek to identify viable options for expanding and continuing the work of the CS-18 staff, particularly the scale-up of the project's PD Hearth strategy and starting to address HIV/AIDS/STIs, which appear to be an unmet need.	CAFO is contemplating to make proposals on both themes, PD/Hearth scale-up and HIV/AIDS/STI, probably by the end of year 2005. Brain storming meeting of the senior program staff on thematic search already done as a starting point. CAFO is considering re-appropriating staff time for making new proposals including PD/Hearth scale-up and HIV/AIDS/STI.			
Information Management				
19. Some additional project indicators could be monitored by incorporating a few additional questions into the current supervisory checklists, such as indicators 21-22 that are to be evaluated based on the results of HFA.	During the workshop/training on GMP indicators will be incorporated within the existing reporting formats.	December 2005	SC/US and MoPH.	
MTE Recommendation	Planned Action	Planned Date(s)	Person(s) Responsible	Status
20. It is suggested that the project review the data that is being collected and tie it to a use (i.e., monitoring progress on the project objectives, expanding the data collection/use capacity of the MOH, etc.) or stop collecting it.	Conduct a three day PDME workshop to: review the existing HMIS and prioritize data that could best inform project design and progress; develop MoPH and SC/US's staff's capacity to start using data for monitoring progress and planning.	June 2006	Dr. Tariq Dr. Pervez Etc.	

21. It is suggested that in future, the project obtain at least 19 valid responses for each indicator in each lot, and a total of at least 95 valid responses combined for all lots. This can be done by seeking an interview for only the missing indicator information (and household identifiers) at the next closest household from the initial interview, and continuing this process until information is collected for each of the indicators (a process which is easier to do in surveys covering a small number of indicators or few different sub-populations, such as children ill in the last two weeks, or under six months of age, or 12-23 months old, than in surveys with long questionnaires or those covering several sub-populations).	This will be incorporated in future M&E and final evaluation surveys using LQAS methodology.	Periodic M&E And Final Evaluation		
22. SC/Tajikistan should consider developing an emergency preparedness plan based on SC models from other countries and the recent experience with the floods in Panjikent District.	Key staff of SC have received training on disaster preparedness; Emergency preparedness plans are being worked out for the Field Office and each Impact Area. Capacity of CAFO to deal with emergencies especially to access additional resources both human and financial will be built progressively??	January 2006 onwards		
23. SC/Tajikistan needs to ensure that CS-18 is registered with the GOT.	Draft of MOU submitted to MOH and response awaited from MOH.	Draft MOU submitted to MOH Dushanbe		
24. SC together with the MOH should consider exploring programmatic and funding opportunities to assess and implement a response to the potential threat of HIV/AIDS/STIs during	CAFO is seriously considering to draft a proposal on HIV/AIDS prevention program, keeping in mind the large migrant workers population of Tajikistan that goes seasonally to Russia, a known place with rising HIV infection.	Jan 2006		

the remainder of CS-18 and beyond.				

CS-18 Work Plan for Year 4 and 5

R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent and Aini districts.

Indicator 1. % of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.	KPC survey
Indicator 2. % of 0-23 month olds whose birth was attended by skilled health personnel.	KPC survey
Indicator 3. % of 0–5 month olds exclusively breastfed during the last 24 hours	KPC survey
Indicator 4. % of 12-23 month olds who received a measles vaccine (by maternal history).	KPC survey
Indicator 5. % of 12-23 month olds with cards, fully immunized (Measles vaccine is now given from age 12 months.)	KPC survey
Indicator 6. % of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.	KPC survey
Indicator 7. % of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.	KPC survey
Indicator 8. % of households with children <2 which have only iodized salt for cooking.	KPC survey

Major Activities	**October 2005 to September 2006**												**October 2006 to September 2007**												**Personnel**	**Benchmarks**	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 4**	**Year 5**
Household																											
Pregnant women make birth plans involving their husbands and other family members.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC staff will facilitate and MOH staff will implement	2500 pregnant women will have birth plans	2500 pregnant women will have birth plans
Mothers have and use immunization mother based cards for their children			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff. SC will provide cards	2500 mothers will have cards	2500 mothers will have cards
Postpartum mothers receive checkups by HF staff during home visits				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2000 post-partum mothers	2500 post-partum mothers

Newborns receive care from MOH health facility staff within first 8 hours of their birth.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2000 newborn receive care within 1st eight hours	2500 newborn receive care within 1st eight hours
Deliveries attended by BLSS trained birth attendant (MOH rural health facility staff)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2000 deliveries	2000 deliveries
Mothers have and use Road to Good Health cards for their children (0 to 24 months of age)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC staff	2500 mothers	4000 mothers
Husbands & MIL of antenatal women visit HFs at least once along with the A/N woman during her pregnancy				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	1000 husband & MILs	1000 husbands & MILs
Community																										
VDCs arrange health education sessions for WRA and men.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	128 VDCs arrange HE sessions	128 VDCs arrange HE sessions
MOH rural HF staff, with the assistance from VDCs, conduct BCC activities with WRA.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 reached by BCC activities	5000 WRA reached by BCC activities
VDCs mobilize communities for birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	VDCs with MOH staff	128 VDCs	128 VDCs
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	40VDCs	40 VDCs
VDCs collect and make available emergency transport funds					X	X			X	X			X	X			X	X			X	X			SC will facilitate	40 VDCs will have transpor-tation fund	40 VDC will have transpor-tation fund

Iodized salt made available in the villages by mobilizing business persons through VDCs						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 villages	128 villages
VDCs facilitate immunization sessions by gathering all children <2 for vaccination			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	128 villages	128 villages
VDCs make emergency transport plans					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 VDCs	128 VDCs
VDCs maintain emergency transport funds					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	40 VDC	40 VDC
VDCs organize Hearths in their villages				X	X				X	X	X				X	X	X			X	X	X				SC will facilitate	7 VDCs	7 VDCs
Phase Out Plan developed with the VDC		X	X	X												X	X	X	X	X	X	X	X	X	X	SC staff	73 CS 14 villages	77 CS18 villages
CTC health education for children conducted at schools				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	School teachers	10 schools	10 schools
Home work assignments for CTC trained students to review and report back on immunization cards of their younger siblings				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC CTC promoter	315 students	270 students
Health Facility																													
MOH rural HF staff conduct BCC activities with WRA attending HFs.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff		77 HFs)
HF staff conduct ANC & postpartum checkups				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 ANC 1500 PNC	2500 ANC 1500 PNC
HFs conduct at least one immunization session per month				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	77 HFs (same)
Pregnant women counseled on birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 pregnant women	2500 pregnant women
MOH rural HF staff counsel mothers on nutrition & exclusive BF				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	3000 Mothers	4000 mothers

MOH rural HF staff check immunization cards during visits of children & refer children for immunization	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	77 HFs
MOH rural HFs conduct planned immunization sessions	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	77 HFs
MOH rural HFs use facility-based immunization registers/log books	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HFs	77 HFs
MOH rural HF staff conduct GMP sessions. Each register child (0-24 months) is weighed & monitored once in 2 months					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	20 HF (CS14) 77 new HFs	77 HFs
MOH rural HFs use facility based growth monitoring registers/log books					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HFs	77 HFs
MOH rural HF staff maintain stocks of iron supplements for distribution to the antenatal mothers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HFs	77 HFs
Exit interviews with pregnant women & mothers of <5s to assess & improve quality of counseling					X			X			X		X		X		X		X		X		X		SC staff	250 exit interviews (should we also do it in CS14 areas??	250 exit interviews

R-2: Sustained investments in key MCH services by communities & rural health facilities in Panjikent and Aini districts.																											
Indicator 9. % of Health Facility Farms started before 10/04, producing crops without SC support. **Indicator 10.** % of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services. **Indicator 11.** % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month. **Indicator 12.** % of Village Pharmacies with at least 65% cost recovery.																										Final Eval. Final Eval. VP records RDF Reports	
Major Activities	**October 2005 to September 2006**												**October 2006 to September 2007**												**Personnel**	**Benchmarks**	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 4**	**Year 5**

Community																									
VDCs assist HF staff in the formation of FFW brigades																								Activity phased out	Activity phased out	Activity phased out
VDCs provide technical assistance (in agriculture) to HF staff																								Activity phased out	Activity phased out	Activity phased out
VDCs and HF staff renovate, equip, or supply facilities, or support MCH services, using revenues collected from selling harvested crops																								-do-	-do-	-do-
VDCs monitor village pharmacies.																								-do-	Phase out Nov onwards	-do-
VDCs ensure amount owed by patients is recovered in time by VPs																								-do-	-do-	-do-
VDCs ensure seed stocks in villages for HFFs																								-do-	-do-	-do-
Villages establish VPs																								-do-	-do-	-do-
Health Facility																									
HFs with farms make plans to utilize revenues and ensure supply of seeds for the next harvest																								-do-	-do-	-do-
HF staff participate in FFW brigade selection																								-do-	-do-	-do-
HF staff monitor and supervise HFF brigades																								-do-	-do-	-do-
MOH rural HF staff monitor and supervise village pharmacies																								-do-	-do-	-do-
District																									
Main pharmacy updates stock records																								Phase out	Phase out Nov onwards	Phase out Nov onwards
Main pharmacy distributes medicines at least once per month																								Phase out	Phase out Nov onwards	Phase out Nov onwards

Funds collected from village pharmacies once every two months																								Phase out	Phase out	Phase out
RDF committee ensures replenishment of medicines when main pharmacy stocks reach 30% balance																								Phase out	Phase out Nov onwards	Phase out Nov onwards
Main Pharmacy maintains all procurement records																								Phase out	Phase out Nov onwards	Phase out Nov onwards
Funds recovered deposited in local bank every month																								Phase out	Phase out Nov onwards	Phase out Nov onwards
Quarterly coordination meetings conducted between MOH officials and RDF committee members																								Phase out	Phase out Nov onwards	Phase out Nov onwards
Quarterly coordination meetings conducted between MOH district officials and Agriculture district department officials																								Phase out	Phase out Nov onwards	Phase out Nov onwards

IR-1: Increased household level **knowledge** of selected MCH issues.				
Indicator 13. % of mothers who know 2+ postpartum danger signs.				KPC survey
Indicator 14. % of mothers who know 2+ newborn danger signs.				KPC survey
Indicator 15. % of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.				KPC survey
Indicator 16. % of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.				KPC survey
Major Activities	**October 2006 to September 2007**	**October 2006 to September 2007**	**Personnel**	**Benchmarks**

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 4	Year 5
Household																											
Children attending CTC sessions disseminate EPI health messages to their mothers, fathers and other family members.					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	315 children trained 1000 children listen to messages	270 children trained 1000 children listen to messages
Children attending CTC sessions disseminate ARI health messages to their mothers, fathers and other family members.			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	435 children trained 1300 children listen to messages	540 children trained 1600 children listen to messages
Children attending CTC sessions disseminate CDD health messages to their mothers, fathers and other family members.	X	X	X				X	X	X	X	X							X	X	X	X	X	X	X	SC will facilitate	600 children trained 1800 children listen to messages	285 children trained 1000 children listen to messages
Children attending CTC sessions disseminate iodized salt health messages to their mothers, fathers and other family members.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	150 children trained 600 children listen to messages	150 children trained 600 children listen to messages
Community / Health Facility																											
VDCs facilitate BCC activities with WRA				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			VDCs	128 VDCs	128 VDCs

VDCs assist school children trained in CTC to disseminate key messages within their communities				X		X		X		X		X		X		X		X		X		X		X	SC will facilitate	18 new VDCs 56 old VDCs	18 new VDCs 74 old VDC
BCC activities conducted with WRA to improve knowledge, care, & care seeking for postpartum danger signs			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			MOH staff	5000 WRA	5000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for newborns			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	5000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for pneumonia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	5000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for diarrhea		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	5000 WRA
Husbands & MIL of antenatal women participate in HE sessions on A/N care & birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	1000	1500
VDCs and MOH have regular monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff SC will facilitate	77 VDCs & MOH	77 VDCs & MOH
CTC champion identified in each district				X																							
CTC Action Plan developed with CTC champion				X	X																						
Schools in each community conduct CTC re CDD health education sessions							X	X	X	X									X	X	X	X			SC will facilitate	40 new schools XXX CS14 schools	19 schools
Schools in each community conduct CTC re ARI health education sessions			X	X	X									X	X	X								X	SC will facilitate	29 schools	36 schools
Schools in each community conduct CTC re EPI health education sessions				X	X	X	X	X				X	X	X	X				X	X	X	X			SC will facilitate	21 schools	18 schools

Schools in each community conduct CTC re iodized salt health education sessions							X	X	X	X	X	X	X	X					X	X	X	X	X	X	SC will facilitate	10 schools	10 schools
Active counseling of pregnant women on birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 women	2500 women

IR-2: Improved **capacity of communities** to address priority health needs of mothers & children <5.																											
Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy which sold medicines in past month. CS-18 Records **Indicator 18.** % of villages with a health facility, having a Village Development Committee which organized 1+ health education Session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months. CS-18 Records																											
Major Activities	**October 2005 to September 2006**												**October 2006 to September 2007**												**Personnel**	**Benchmarks**	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 4**	**Year 5**
Community																											
VDCs established in new CS-18 villages		X	X	X	X					X	X	X	X	X	X			X	X	X	X				SC staff	47 new VDCs	-
VDCs trained in community mobilization methods			X	X	X	X						X	X	X	X	X				X	X	X	X		SC staff	128 VDCs	128 VDCs

VDCs monitor village pharmacies																								Phase out Nov onwards	Phase out	Phase out
VDCs assist VPs in cost recovery of funds owed by households																								Phase out Nov onwards	Phase out	Phase out
VDCs cross visits between old & new CS-18 sites					X	X								X	X	X						X	X		PO & APO	3 VDCs	3 VDCs
VPs cross visits between old and new CS-18 sites for practical training on RDF activities																								Phase out Nov onwards	Phase out	Phase out
VPs supplied with appropriate antibiotics and ORS																								Phase out Nov onwards	Phase out	Phase out
Health Facility																										
MOH rural HF staff support village pharmacies																								Phase out Nov onwards	Phase out	Phase out
MOH rural HF staff participate in VDC monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 HFs	128 HFs
District																										
Main pharmacy maintains stocks of appropriate antibiotics and ORS																								Phase out Nov onwards	Phase out	Phase out
RDF committee replenishes main pharmacy when stocks reach 30%																								Phase out Nov onwards	Phase out	Phase out

IR-3: Improved **capacity of rural health facilities** in Panjikent & Aini districts to provide quality MCH services & support community health activities.	
Indicator 19. % of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.	HFA
Indicator 20. % of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.	HFA
Indicator 21. % of children <5 who have their weight plotted on growth chart.	HFA
Indicator 22. % of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.	HFA
Indicator 23. % of ANC clinic attendees who report having received iron supplements.	HFA
Indicator 24. % of LSS-trained midwives who correctly manage normal pregnancies, deliveries, & obstetric complications.	ACNM LSS forms
Indicator 25. % of rural health facilities which have staff trained in LSS.	ACNM LSS forms
Indicator 26. % of VDC meetings which have MOH staff participating.	VDC Records
Indicator 27. % of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.	HF Records

Major Activities	**October 2005 to September 2006**												**October 2006 to September 2007**												**Personnel**	**Benchmarks**	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year4**	**Year5**
Health Facility																											
HF staff trained on WHO/ UNICEF ARI case management protocols			T	T							T	T		R	R							R	R		SC staff	10 HFs	10 HFs
HF staff trained on WHO/ UNICEF Diarrhea case management protocols								T	T											R	R				SC staff	10 HFs	10HFs
HF staff trained on new EPI protocols cold chain, and contraindications	X	X											X	X											MOH staff	MOH staff 120 in Penjikent 61 in Aini	New health workers + left over from previous year
MOH staff trained in counseling techniques and Exclusive breastfeeding			T								T														SC staff	10 MOH staff	-
PDM&E workshop for MOH staff to strengthen HMIS									X											X					Dr Tariq		
Joint SC/MOH district officials conduct bimonthly supervisory visits to rural HFs	X		X		X		X		X		X		X		X		X		X		X		X		SC/MOH staff	6 visits	6 visits

HFs equipped with basic essential instruments				X	X	X																			SC staff	77 HFs	-
MOH provides vaccines and supplies to rural health facilities at least once per month.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 new HFs CS14 areas	77 HFs
VP staff bring RDF drugs to HFs																									MOH staff	Phase out Nov onwards	Phase out Nov onwards
MOH rural HF staff receive regular bimonthly BLSS monitoring visits.		X		X		X		X		X		X		X		X		X		X		X		X	SC MNC monitor	77 HF staff CS14	77 HF staff
MOH staff given on-the-spot BLSS training during monitoring & supervision		X		X		X		X		X		X		X		X		X		X		X		X	SC MNC monitor	40 midwives	37 midwives
MOH rural HF staff given feedback reports on antenatal, delivery or postpartum referrals					X	X			X	X			X	X			X	X				X	X		SC MNC monitor	77 HF staff	77 HF staff
MOH rural HFs provided with IEC materials				X	X	X																			SC	77 HFs	-
District																												
TOTs on Nutrition/ Growth monitoring and management of childhood malnutrition conducted by PD/Hearth with MOH district and rural health facility staff			T	T	T													R	R						SC staff	75 MOH staff	
MOH district and rural health facility staff trained in BLSS				T	T				T	T						R	R					R	R		SC staff	40 MOH staff	37 MOH staff
Monthly reports submitted by rural HFs consolidated	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	77 HFs
MOH Staff cross visits between old and new CS-18 sites						X	X			X	X						X	X							PO & APO	5 MOH staff	10 MOH staff
Main Pharmacy established at Dis trict Hospital, Aini																									Phase out Nov onwards		
CS14 phase-out and documentation workshop & regular meetings		W				M			M			M			M			M			M				MOH, SC and VDCs	1 workshop 3 meeting	3 meetings

CS14 regular joint supervision/visits				X				X				X						X						X	MOH, SC and VDCs	2 visits	2 visits

IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajik.	
Indicator 28. Number of CS-18 strategies successfully scaled up in new CS-18 areas.	Final Evaluation
Indicator 29. Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.	Final Evaluation
Indicator 30. Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.	PLG Report
Indicator 31. TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.	TFO Reports

Major Activities	**2005**			**2006**												**2007**									**Personnel**	**Benchmarks**	
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year4**	**Year5**
District																											
CS-18 Program Manager participates in annual meetings of SC's OH Program Learning Group																									Done		
Technical backstopping through e-mail correspondence	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			
Program Manager participates in SC regional PD/H training, and trains TFO staff in PD/H																									Done		
TA visit from ACNM to follow-up training of MOH midwives in LSS																									Done		

Conduct a 3-day PDME Workshop to review the existing HMIS and prioritize data that could best inform project design and progress; develop MoPH and SC/US's staff's capacity to start using data for monitoring progress and planning.																										

ATTACHMENTS

Attachment A. Baseline Information from the DIP

There have been two substantial changes in this CS-18 project that occurred between the approval of the DIP and the MTE:

1. Changes in the two lead project management positions as described in Section VI. D. Human Resources and Staff Management.

2. The end of Save the Children's support of the Health Facility Farms approach due to the conclusion of USDA funding that provided the necessary food for work inputs. This is discussed in Section III. Cross-Cutting Approaches.

In addition, if adopted by Save the Children, the MTE recommendation to conclude Save the Children involvement in the Revolving Drug Fund/Village Pharmacy approach will also constitute a substantial change in the remainder of CS-18. This is discussed in Section III. Cross-Cutting Approaches.

Attachment B. Evaluation Team Members and Titles

Tedbabe Degefie, MD, Health and Nutrition Specialist, SC/Ethiopia Field Office
Boboeva Gulchera, MD, Project Officer Health, SC/Tajikistan
Mohammad Honey Mukhtar, Health Coordinator, SC/Afghanistan
Garth Osborn, MPH, Consultant and MTE Team Leader
Pervez Shaukat, MBBS MPH, Impact Area Manager, SC/Tajikistan
Eric Starbuck, DrPH, MPH, Child Survival Specialist, SC/HQ

In addition, the following SC/Tajikistan staff participated in data collection during the KPC and FGDs:

Rahimova Mubina, Assistant Project Officer/Aini
Kodirova Nazokat, Senior Health Monitor and LSS Trainer/Panjikent
Mavlonova Mutriba, Health Monitor/Panjikent
Kholmahmadova Gulchehra, Health Monitor/Panjikent
Gafurova Zarina, Health Monitor/Panjikent
Temirova Umija, Health Monitor/Panjikent
Ashurova Hilola, Health Monitor/Panjikent
Bahrieva Shahlo, Health Monitor/Panjikent
Muminova Bozorgul, Health Monitor/Aini
Alamova Gulbegim, LSS Trainer/Aini
Mahmudov Sharofidin, Senior MIS Assistant
Sharipova Munira, RDF Supervisor

Attachment C. MTE Assessment Methodology

Figure 6. MTE Schedule

Action	Dates
Finalize KPC Questionnaire	July 2005
Select lots and respondents	
KPC data collection and tabulation	
MTE Team arrives in Dushanbe	PM Saturday (8/13)
MTE Team travels to Panjikent.	Sunday (8/14)
Introductory meeting with project staff.	Monday (8/15)
MTE Team meeting.	
LQAS Survey Results Analysis	
Finalize Field Questionnaires and Train Staff on FGDs.	Tuesday (8/16)
Finalize LQAS Results	
Community and Health Facility Data Collection (FGDs). Debrief in the evenings.	Wednesday (8/17) to Sunday (8/21)
MTE Team interviews Impact Area Manager.	Thursday (8/18)
MTE Team interviews Aini District Officials.	Friday (8/19)
MTE Team site visits at Heath Facility Farms and Village Pharmacies.	Saturday (8/20) and Sunday (8/21)
MTE Team interviews SC Field Staff.	Monday (8/22)
MTE Team interviews Panjikent District Officials.	Tuesday (8/23)
MTE Team prepares findings and recommendations.	Wednesday (8/24)
Presentation of Major Findings and Recommendations.	
Preparation of debriefing results for presentation in Dushanbe.	
Travel from Panjikent to Dushanbe.	Thursday (8/25)
Debriefing in Dushanbe.	Friday (8/26)
MTE Team departs Dushanbe.	Saturday (8/27)
Osborn submits draft MTE report to MTE Team.	Tuesday (9/27)
MTE Team provides comments to Osborn.	Saturday (10/15)
Osborn submits final draft MTE report to SC.	Thursday (10/20)
Final report due to USAID.	Monday (10/31)

To ensure that all of the key topics were covered during the MTE, the following data collection table was prepared that ties project-related topics to respondents, data collection methods, and MTE members:

Figure 7. MTE Data Collection Table

	RESPONDENTS																			
	Moms of <5's	Birth Plan Moms	Hearth Moms	Hearth Volunteers	VDCs	Village Pharmacists	CTC Teachers	CTC Students	MILs	CMOs	Director of Schools	Health Facility Staff	Midwives	Other Health Workers	Impact Area Mgr	Proj Health Ofrs.	Health Monitors	MIS Staff	SC/Dushanbe	SC/HQ
TOPICS:																				
ARI/CDD	X				X	X	X		X	X		X			X	X	X	X		
EPI	X				X		X	X		X		X			X	X	X	X		
Nutrition					X					X		X			X	X	X	X		
- Iodized salt	X				X		X	X		X		X			X	X	X	X		
-PD/Hearth/GM	X		X	X	X					X		X			X	X	X	X		
MNC	X				X					X		X	X	X	X	X	X	X		
- BLSS	X	X			X					X		X	X	X	X	X	X	X		
- Birth Planning/ Emergency Transport Funds	X	X			X				X	X		X	X	X	X	X	X	X		
VDCs	X	X	X	X	X	X	X	X	X	X		X	X	?	X	X	X			
RDF/VPs						X														
HFFs												X			X	X	X			
MOH Training/ Supervision						X				X		X	X	X	X	X	X	X	X	
MOH-Community Links/Health Education	X	X	X	X	X	X	X	X		X		X	X		X	X	X			
CTC	X	X			X		X	X		X	X	X			X	X	X			
TFO Capacity															X				X	X
Sustainability					X	X	X			X	X	X	X		X	X	X	X	X	X
MIS/Data use					X	X				X		X	X		X	X	X	X	X	X
Project Planning										X		X			X	X	X	X	X	X
Communication															X	X			X	X
Personnel															X	X			X	
Finances/Budget															X				X	X
Logistics															X	X			X	
TA.												X			X	X	X	X	X	X
DATA COLLECTION METHODS																				
KPC/LQAS	X																			
FGDs	X				X			X	X								X			
Interviews		X	X	X		X	X			X	X	X	X		X	X		X	X	X
Document Review	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HMIS Review		X	X	X	X	X	X	X					X	X						
MTE TEAM																				
Degefie						X				X	X			X	X	X	X		X	
Gulchera	X	X	X	X	X		X	X	X	X	X	X	X							
Mukhtar						X				X	X			X	X	X	X		X	
Osborn						X				X	X			X	X	X	X		X	X
Shaukat						X				X	X			X						
Starbuck						X				X	X			X	X	X	X	X	X	
SC Staff	X	X	X	X	X		X	X	X			X	X							

Five data collection methods were used during the MTE to collect both quantitative and qualitative information:

1. Review of Project Documents
2. Knowledge Practice Coverage (KPC) Survey
3. Focus Group Discussions (FGD)
4. Informational Interviews
5. Review of Health Management Information System (HMIS) Data

Review of Project Documents: CS-18 shared the following documents with members of the MTE team prior to the start of fieldwork:

- Midterm Evaluation Guidelines (August 2004)
- CS-18 Detailed Implementation Plan
- CS-18 First Annual Report (October 1, 2002 – September 30, 2003)
- CS-18 Second Annual Report (October 1, 2003 – September 30, 2004)
- Field Trip Reports for July 5-14, 2004 and September 9-20, 2004 by Dr. Aftab Tariq, SC Asia Health Advisor
- CS-18 Staff List

Knowledge Practice Coverage (KPC) Survey: The KPC survey was conducted by CS-18 staff in July 2005 following their training in LQAS survey sampling methods[1] and editing of the CS-18 baseline KPC survey questionnaire to reduce the number of questions. Villages covered to date through CS-18 were divided into five lots (excluding those villages yet to be covered by the project), with CS-14 early intervention villages in Panjikent assigned to Lot 1, villages in Panjikent in which CS-14 activities were phased-in at a somewhat later date in Lot 2, CS-14 late intervention villages in Lot 3, Panjikent villages in which activities were introduced after the start of CS-18 in Lot 4, and CS-18 villages in Aini in Lot 5. Nineteen villages were chosen in each of the five lots using systematic random sampling with probability of selection proportionate to population size (using the same methods used to select clusters in cluster sampling). One household was selected for interview in each of the 19 villages by dividing up the villages into sections, randomly choosing one section, and then randomly choosing one house in the selected part of the village.

Coverage was estimated using two methods for each of the eight CS-18 indicators related to practices at household level and use of key MCH services and the four household-level knowledge indicators. (See Attachment F.) An un-weighted coverage estimate was obtained by dividing the correct responses by the total number of valid responses for each of the indicators. As the lot-specific populations ranged from 34,000 to 54,000, population-weighted coverage estimates were obtained for each indicator using the following formula: [(Lot 1 number correct / Lot 1 total respondents) X (Lot 1 population

[1] JJ Valadez, W Weiss, C Leburg, R Davis. Assessing Community Health Programs: A Trainer's Guide. Using LQAS for Baseline Surveys and Regular Monitoring. Teaching-aids At Low Cost, 2003. (Available at www.coregroup.org and at www.childsurvival.com)

/ total population of all 5 lots)] + [(Lot 2 number correct / Lot 2 total respondents) X (Lot 2 population / total population of all 5 lots)] + …….
Weighted coverage estimates were within two percentage points of the un-weighted estimate for all but one indicator (#3).

Five lots of 19 respondents per lot yield coverage estimates with precision similar to that obtained from 30 clusters of seven respondents per cluster (95% confidence intervals of +/- 10% around a 50% point estimate). Four of the twelve indicators involved sub-sets of respondents, yielding substantially fewer than 95 respondents, and thus, result in very wide confidence intervals. Lot-specific achievements for each indicator were assessed by comparing the decision rule for the end-of-project site-wide target and number of respondents to the number of correct responses. Lot-specific achievements could not be assessed for the four indicators with small sample sizes.

Recommendation: It is suggested that in future, the project obtain at least 19 valid responses for each indicator in each lot, and a total of at least 95 valid responses combined for all lots. This can be done by seeking an interview for only the missing indicator information (and household identifiers) at the next closest household from the initial interview, and continuing this process until information is collected for each of the indicators (a process which is easier to do in surveys covering a small number of indicators or few different sub-populations, such as children ill in the last two weeks, or under six months of age, or 12-23 months old, than in surveys with long questionnaires or those covering several sub-populations).

Focus Group Discussions (FGD): A set of seven FGDs was completed in each of ten selected communities to collect qualitative information on attitudes about the project and to shed further light on the KPC results. The following respondents were selected from each community:

Health Workers	Mothers of Children Under Five
Mothers of Newborns	PD Hearth Participants
PD Hearth Volunteers	Child-to-Child Trainers/Teachers
Child-to-Child Students	

To gain as broad, representative, and unbiased a view as possible, a set of criteria were developed by the MTE team to select communities:

- Communities from the original CS-14 site in Panjikent (4), versus the new CS-18 site in Panjikent (3), versus the new CS-18 site in Aini (3).
- Communities with strong (5) vs. weak (5) village development committees.
- Communities with health facilities (6) vs. those without (4)
- Communities involved in PDI/Hearth (3) vs. those that are not (7)
- Accessible (5) vs. isolated communities (5).

Figure 8. Village Selection for FGDs

Name	PD Hearth?	District/ CS Cycle	Health Facility Present/ Type	Facility Type	Accessibility	VDC Strength (Strong/ Weak)	Population
Gharibak	Y	P/CS-14	Y	SVA	Y	S	2,297
Guliston	Y	P/CS-14	Y	FAP	Y	W	830
Veshkand	Y	A/CS-18	Y	SVA	Y	S	1976
Ghujtan	N	P/CS-18	N	-	N	W	477
Jombulog	N	P/CS-18	N	-	N	S	580
Vota	N	A/CS-18	N	-	Y	W	219
Pushti Qurghon	N	P/CS-18	Y	FAP	N	S	2,230
Teshiktosh	N	P/CS-14	N	-	Y	W	395
Pasrud	N	A/CS-18	N	-	N	S	789
Sor	N	P/CS-14	Y	SVA	N	W	3,656

FGD questionnaire guides were then developed for each of the respondent groups based on the questionnaires used in the CS-18 baseline and the preliminary results from the MTE KPC. CS-18 staff have extensive experience in doing FGDs, so after a brief refresher, the training focused on a review and translation of the questionnaires and the process for random selection of respondents. The CS-18 staff were then assigned roles, broken up into six teams of two members each (one facilitator and one recorder) and two groups of three teams each:

Figure 9. FGD Teams

	Team #'s	Facilitators	Recorders
Group One	1	Boboeva Gulchehra	Alamova Gulbegim
	2	Kholmahmadova Gulchehra	Ashurova Hilola
	3	Bahrieva Shahlo	Mominova Bozorgul
Group Two	4	Kodirova Nazokat	Temirova Umija
	5	Gafurova Zarina	Rahimova Mubina
	6	Mavlonova Mutriba	Sharipova Munira

Teams were then assigned to specific respondents:

Figure 10. FGD Respondents per MTE Teams

FGD Respondents	Teams
Mothers of Children <5	1 and 4
Birth Planning Mothers	
PD/Hearth Mothers	
VDC	2 and 5
Health Workers	
Hearth Volunteers	
CTC Students	3 and 6
Mothers-in-Law	
CTC Teachers	

Each group (made up of three teams) was then assigned to implement all seven FGDs in one village per day. To help limit the potential for bias, CS-18 staff were placed on teams whose focus was outside their area of expertise and assigned to villages where they were not currently working.

Figure 11: FGD Village Schedule

	Group One	Group Two
Wednesday, August 17	Gharibak (P)	Veshkand (A)
Thursday, August 18	Guliston (P)	Pasrud (A)
Friday, August 19	Pushti Qurghon (P)	Vota (A)
Saturday, August 20	Sor (P)	Teshiktosh (P)
Sunday, August 21	Jombuloq (P)	Ghujtan (P)

Staff then met each evening to debrief on their notes, the results of which are summarized in Attachment G.

Informational Interviews: MTE Team members met and discussed the project with each of the contacts listed in Attachment D.

Review of HMIS Data: MTE Team members reviewed data collection tools and reports as noted in Section VI. G. Information Management.

Attachment D. Persons Interviewed and Contacted

Aini District

District Officials

Dr. Okilov Mirzoali, Chief Doctor
Dr. Murodov Zuhur, Deputy Chief Doctor on Immunization
Dr. Ergasheva Sobira, Deputy Chief Doctor on ARI and CDD
Dr. Sanginov Alboi, Deputy in Charge for Gynecology
Mr. Zohidov Navurzboy, Chief of Education Department
Ms. Kholova Umrioy, BLSS Trainer

Health Facility Staff:

Midwives: 1
Felchers: 1
Doctors: 2

Panjikent District

District Officials:

Dr. Rotiera, Chief Doctor
Dr. Bahriyev, Deputy Chief Gynecologist
Dr. Nasriddinov, Deputy Chief Doctor on ARI and CDD
Mr. Salimboyev, Deputy Chief of Education
Ms. Musafora, BLSS Trainer
Ms. Rukiya, BLSS Trainer

Health Facility Staff:

Midwives: 3
Felchers: 3
Doctors: 1
Nurses: 4

Village Pharmacists: 4

Save the Children

Eric Starbuck, Child Survival Specialist, SC/HQ
Tom McCormick, Acting Regional Office Director, SC/Dushanbe
Pervez Shaukat, MD, Impact Area Manager, SC/Tajikistan
Boboeva Gulchera, MD, Project Officer Health, SC/Tajikistan
Rahimova Mubina, Assistant Project Officer/Aini
Kodirova Nazokat, Senior Health Monitor and LSS Trainer/Panjikent
Mavlonova Mutriba, Health Monitor/Panjikent
Kholmahmadova Gulchehra, Health Monitor/Panjikent
Gafurova Zarina, Health Monitor/Panjikent
Temirova Umija, Health Monitor/Panjikent
Ashurova Hilola, Health Monitor/Panjikent
Bahrieva Shahlo, Health Monitor/Panjikent
Muminova Bozorgul, Health monitor/Aini
Alamova Gulbegim, LSS Trainer/Aini
Mahmudov Sharofidin, Senior MIS Assistant
Sharipova Munira, RDF Supervisor

Attachment E. Revised Revolving Drug Fund Strategy For Tajikistan

Save the Children Inc. Penjikent Impact Area Office

79, Karl Marx Street
Penjikent
Republic of Tajikistan
Tel: (37775) 53301, 54395
Fax: (37775) 5-43-77
Email:panjakent@savechildren.tj

Revised Revolving Drug Fund Strategy For Tajikistan

(For SC/CAFO internal use only)

Prepared by

Dr Pervez Shaukat
Program Manager CS 18, Panjikent/Aini
Central Asia Field Office, Tajikistan

Dated February 2005

List of Words and Acronyms

CDH	Central district hospital
CS14	Child Survival Project 14
CS18	Child Survival Project 18
DIP	Detailed implementation plan
EDL	Essential drug list
IAM	Impact area manager
MoH	Ministry of Health
MOU	Memorandum of understanding
PMS	Pharmacy management system
PO	Project officer
PSF	Pharmacein Sans Frontier
QA	Quality assurance
Qarz	drugs taken on credit
RDF	Revolving drug fund
RDU	Rational drug use
SC	Save the Children
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
SUB	Secondary care health facility
ToRs	Terms of Reference
UNICEF	United Nations children Fund
VDC	Village development committee
VP	Village pharmacist
WHO	World Health Organization

Revised Plan for the improved RDF strategy in Tajikistan

1. Contextual History and Justification

SC/US has been running RDF in Tajikistan since seven years now with variable experience. In Vose project in the context of relief operations, village pharmacies were set up to provide essential drugs and get a niche in development of working relationship with Ministry of Health (MoH) (Narula et al 1998). The early RDFs setup through UNICEF drug donation in villages, were based on the concept of full cost recovery but emphasis was more on the provision of essential drugs rather than setting up a truly functioning RDF.

Narula and Swedberg in the final evaluation report of Vose project made a distinct recommendation that SC should phase-in MoH when starting up RDFs elsewhere. In Panjikent, it was an issue under discussion with UNICEF to phase-in MoH in CS14 from the start. However, this was not done at least in any formal way, till even this date in CS18. Both DIP and the proposal of CS18 only allude toward possible partnership of communities and MoH to operate RDF at the end of project life, though no road map with specific milestones to that effect is available, as how that will happen.

In the budget narrative of CS18, the position of pharmacist is not funded from year 4 of the project with an assumption that RDF should be able to pick up the cost of not only this position but also other RDF associated overheads; nowhere this financial workout can be found that gives clarity as how RDF will able to sustain financially.

Panjikent RDF strategy seems to lack all essential components of a workable RDF system e.g. clear vision, framework for operation, feasibility both technical and financial, operation manual to provide work guidelines and setting operating standards, formal agreements with counterparts vis-à-vis roles and responsibilities, etc.

In spite of all these deficiencies, CS18 has been able to setup about 90 VPs in Panjikent through exclusive project support. This strategy is however, experiencing inevitable situation where only a sustained or even enhanced project support could prevent failing VPs, now plagued by under recovery and burgeoning debts and loads of medicines getting expired.

To complicate things further, many spin offs of unregulated RDF are also rampant, such as irrational prescription, poly pharmacy, an extensive drug list with items whose selection is based on their reputation as "hot selling" then actual need, or private drugs of the village pharmacist usually low quality acquired from underground markets are sold side by side. Such practices defeat the very reason for the creation of RDF. It is redundant to add here that issues such as legal standing and taxation status threaten SC supported pharmacies and it is imperative for SC to phase-in MoH at this stage.

2. Road Map: MoH phase-in

RDF strategy should be handed over to MoH in about the rest of the three years project life in a phased manner. This handing over should be tailored with capacity building of MoH and incremental shift of responsibility tied with agreed milestones. This is however, only possible when the existing RDF system is fixed, formal framework for RDF developed, ToRs of the partnership defined, agreed and MoU signed to that effect. Hence, this handing over in the partnership should be recognized by all stakeholders and not perceived as merely passing on the buck.

2.1. Year 1

SC runs the system with the involvement of MoH, in planning and implementation. SC retains total control of finances and drug supplies including procurement and distribution to the VP. MoH/ community participate/facilitate.

Tasks for year 1 Panjikent

- Revision of EDL
- New RDF committee reconstituted and TORs of the committee developed and agreed
- First meeting of the RDF committee held to approve ToRs, code of conduct, schedule of meeting, approval of RDF proposal
- Proposed revised RDF document/proposal submitted to chief doctor (MoH) for approval
- Formal agreement signed for RDF operation by all partners
- Funds arranged for new drugs procurement; SC to raise 30,000$ initially for RDF drugs of Aini/Aini.
- Recruitment of fully qualified pharmacist for Aini/Aini and Khatloon
- New EDL drugs invoiced through PSF
- Drugs received and proper inspection done by RDF committee
- Drugs distributed based on the revised supply schedule
- Supervision and cost recovery continues on monthly basis

Aini

- Proposal presented and MoU signed with local Chief Doctor
- Space for main pharmacy located
- Assistant pharmacist recruited and trained
- First round of VP selected and trained in RDF
- Drugs supplied to main pharmacy
- VP supplied drugs from Aini's main pharmacy
- Joint monitoring with MoH/VDC

2.1.1. Milestones:

i. MoH Pharmacist assists SC pharmacist in receipt of new drugs consignment and management of the main pharmacy.
ii. MoU signed with MoH for the taking over of RDF in three years.
iii. Training received by MoH pharmacist/Deputy Chief Doctor on rational drug use, PMS for RDF.
iv. Joint supervision of VP with MoH/VDC members according to schedule.

2.2. Year 2

SC hands over the drugs supply to MoH/community, but retains finances in a SC maintained bank account. MoH uses its existing communication and supply lines, SC facilitates; though many of the tasks for the second year depend on progress made in the first year.

Tasks for both Panjikent and Aini

- SC pharmacist hands over drugs stocks in the main pharmacy and that in possession of the VPs, to the hospital pharmacist
- SC pharmacy team helps MoH in re-supply of VPs and monitoring in the field

- MoH pharmacist trains new VPs and provide refresher training to old ones
- Management core group receive orientation in RDF operation and international procurement
- Management core group manages second procurement, assisted by SC team
- Cost recovery and supervision handled by MoH staff and proceeds remitted to SC RDF account
- Financial working revised, in light of one year experience, and strategies identified for reduction in operating costs
- Finance team SC and MoH identifies and install new exclusive financial mechanism to handle RDF receipts and expanse
- New funds requisition for additional VPs and system improvement
-

2.2.1. Milestones

i. Stock taking by MoH pharmacist.
ii. Supervisory reports show rational drug use and best practices pharmacy management.
iii. 90% cost recovery from VPs
iv. Receipt of proceed remission to RDF account; reconciled by SC finance officer.
v. New financial working done incorporating operating costs.
vi. Permanent procurement wholesaler identified for future business.

2.3.Year 3

SC hands over the financial controls and supervises RDF operations. The RDF operates without project support by year 3.

- Chief Doctor opens a new ledger in the official MoH account in a bank, where all RDF funds are shifted. All financial transactions however, would require verification by SC
- RDF core group, manages subsequent procurement through usual wholesaler or look for alternative sources
- Financial audit done by SC internal auditor

2.3.1. Milestones

- Chief Doctors verifies receipt of funds in MoH government account
- Audit report of the Auditor

The RDF Committee will verify the progress of handover through these milestones.

3. Re-design of RDF

RDF is more than just passive selling of medicines and using proceeds to buy more. There are several things that need to be kept in mind while going into RDF, apart from the aims and objectives below are few important design elements that should be considered.

3.1. Preferred Cost Recovery Model for RDF

There are many variants of cost recovery in RDF system working in different settings according to local needs and evolving environment of health sector financing e.g. partial cost

recovery, where seed funds are maintained through continuous external financial support usually by public funds, full cost recovery where seed funds and operating costs are all factored in the cost of drugs, profit oriented cost recovery where marginal mark up from the sales of medicines is used to finance other health services. The preferred model for Panjikent RDF can be the full cost recovery model, which can be modified later based on the evolving local health sector environment.

3.2. Organizational Structure

Ultimate aim of the revision of RDF is to cede full control of the system to MoH with District Chief of Health as the responsible person to run the system after project life. Since RDF is a new setup for the public health sector, initially it can be a shared responsibility run by the following committees. However, in long term District Health Chief Doctor is expected to take over effective operational control assisted by the management core group, while RDF committee keeps an overall supervisory role.

3.2.1. Re-structured RDF Committee

MoH - District Chief of Health, Pharmacist, two SUB in-charge doctors
Hukumat - Deputy Chief Mayor for Health,
Save the Children - IAM, PO health, Pharmacist
Community - Two chiefs of VDC, two representative village pharmacists.
Co-opt members – Finance Officer SC and counterpart Finance Officer/Accountant MoH
The detailed ToRs of this committee needs to be developed, which will be mandated in general to supervise the affairs of RDF, including procurement, storage, supply, personnel etc.

3.2.2. RDF Management Core Group

MoH – Chief Doctor, Deputy Chief CDH, pharmacist CDH
Save the Children – Project officer health, SC Pharmacist and Assistant pharmacist

3.3. Community Participation

RDF Panjikent essentially should be an activity of the community, by the community and for the community. RDF broadly can be viewed as a trust operated for the benefit of project village communities, where community is not only end user of the services but actually playing a key role in village pharmacy operation at the village level. Two representatives of the village development committees shall represent community in the RDF Committee at the policy level. In the villages, VDC members will be entrusted the job to supervise the entire functions of the village pharmacy including maintenance of the value of seeds funds earmarked for that particular pharmacy. This role shall be clearly documented and agreed when establishing a village pharmacy. Some percentage of proceeds can be put at the disposal of the VDC to exempt deserving patients. This shall however, be first piloted before taken to scale in at least five or six communities of Panjikent.

3.4. Resource Requirement

Existing field staff of MoH and Save the Children. SC would hire one qualified pharmacist full time, in Panjikent, while one assistant pharmacist will be hired for Aini. All these positions will be supported by project funds till handover of RDF to MoH by end of year 3.

3.4.1. Financial Worksheet

RDF is foreseen to operate independently by the end of year 3.

This finance working is done for illustrative purposes and appropriate experts will do actual working later.

The whole concept for a revolving drug fund stands on the assumption that drugs are purchased at rock bottom prices and sold with a mark up big enough to cover the running costs and any wastage that might occur. The following working is based on the current market prices and with the assumption that at least 30% cushion will be available for the system to cover overheads. The estimation of mark up depends on ABC classification of drugs method where drugs are classified in to groups based on the turnover (consumption) and relative quantities in which RDF funds are invested in, so to say. In brief, drugs with greatest turnover and larger quantities for procurement, can cross subsidize other infrequent and expensive items of the drug list. Possible classification of drugs according ABC system can be seen in the actual consumption of drugs in one-year from all village pharmacies, shown in highlights for illustrative purposes in **Annex A**. It can be noted that not all drugs with higher consumption have been highlighted as A (consumption rates of 44% and above) for they are not part of the current proposed EDL.
The same principle can be applied to the proposed essential drug list, and quantities of drugs and the amount of funds required for purchase can be forecasted from **Annex B**.
This 30% may be distributed according to below scheme for illustrative purposes only and actual working may be different based on rigorous finance data:

No.		Flexibility	Remarks
1.	CDH Main store	5%	Top up for District hospital pharmacist/wastage/services
2.	Logistics for supply	5%	Transport, handling supervision
3.	Incentive for VP	10%	Incentive for VP
4.	Currency fluctuations/ non recovery/ training/ stationary/ advertisement/ other unforeseen	10%	

For RDF drugs in other settings, mark up is usually left as high as 65% and still drugs are cheaper from the market.
The initial working done on the quotation received from Missionpharma (a reputed organization known for the supply of cheap good quality generic drugs to international agencies) indicates a possible flexibility of about average 54% markup with the current market prices **(Annex D)**. This flexibility can be enhanced once Missionpharma give quotes for bulk purchases as currently planned for MCH/RH and CS18 project. This can increase significantly the ability of RDF to generate funds for operations and still remain competitive with retail drug market. Drug orders based on ABC classification, will not only ensure balanced procurement of items, those consumed quickly will be replaced quickly, while others with slower turnover will only need infrequent procurement. In quick succession of procurement cycles, class A drugs with healthy margin should be able to generate enough revenues to cover the operating cost even in tighter market situations.

3.4.2. Current RDF Position (as of December 2004)

RDF Component	Drugs worth (USD)	Cash in UNICEF account (USD)	Liabilities (qarz) (USD)	Expired drugs in main pharmacy
Main pharmacy	6,312 $	10,000 $ (approx)		- 305 $
Village pharmacies	13,000 $		2,300 $	
Total	19,312 $	10,000 $	2,300 $	- 305 $

3.4.3. Operating Costs

At the moment for one Assistant pharmacist and rented vehicle operating costs are 530$ per month. This does not include hidden costs e.g. time of other staff, rent, utilities or other indirect costs and hence may not represent a realistic picture.
For the proposed staffing and logistic support as in below table, a very high operating cost is contemplated and eventually, RDF Committee has to come with cheaper alternatives in the due course of time or seek cheaper sources of drugs to generate enough cushion to cover these operating costs.

Staff and logistics	Per month per person	Per year	Remarks
Pharmacist salary	300 $	3600 $	
Assistant pharmacist	200 $ X 2	4800 $	
Rented vehicle/fuel	330 X 2	7920 $	
Total		16320 $	This cost is prohibitingly expansive for RDF to sustain after project support

3.4.4. Pricing of Drugs

There are two ways to work out the pricing of drugs; all the operating direct and indirect costs are added into the selling prices of drugs. There will be uniform increase across the board in prices. Second mechanism is to cross subsidize some items by others; this is more proactive approach and requires some financial expertise.
But in all cases, the selling price of drugs should be cheaper than the retail outlet prices. Price review can be a periodic activity each quarter or on need basis; however, proactive approach will be needed to keep intact seed funds after each review.

3.5. Equity and Exemptions

According to international literature on affordability of drugs for all sections of the society, there are approximately 10-20% of patients who are not able to pay for the drugs needed. In a true RDF system this is either not considered or is factored in the operating costs of the drug. The catch is however, who should be exempted and by whom? Again experience shows abuse of this mechanism by either health workers or others responsible for handling exemptions. In Panjikent, inability to pay on time is the main reason for accumulation of

debts (qarz). At the moment village pharmacies across Panjikent have accumulated more than 2000 $ worth of qarz and recovery of qarz is a demanding job for the pharmacist. This issue can be addressed through bringing in greater role of VDC members, refer to community participation for details.

4. Threats and Constraints

4.1.1. Legal status

RDF operation is subject to approval by the government of Tajikistan. RDF in the present form contravenes the prevailing land laws of Tajikistan. Its existence is threatened by closure for not being compliant with laws related to licensing, authority and qualification to procure, store and dispense drugs. The laws related to patent, taxation etc. are some other requirements that RDF has to comply with. A MoU that could provide waiver for SC to operate RDF is immensely important; and inability to do so would be death knell for the whole strategy. In that case SC is better advised not to further invest in RDF strategy.

4.1.2. Spurious drugs and underground drug markets

Presence of unlicensed and often low quality cheap drugs can influence pricing of RDF drugs. This needs to be taken in consideration when revising prices.

4.1.3. Permanent supply system

RDF operation depends on steady supply of drugs; inability to identify secure sources of cheap good quality drugs, will ultimately lead to the failure of the system. SC needs to build sufficient capacities of the RDF Committee/Management Core Group to do this function with ease.

4.1.4. Currency fluctuation

Conversion loss of capital has to be built-in, even in the relatively stable environment of exchange rate at the moment; because fluctuations are unpredictable and devastating for an RDF system.

4.1.5. Local operational capacity

RDF system to run smoothly is quite challenging and demanding activity; if MoH and community fail to develop sufficient capacity, RDF can face failure after project support.

4.1.6. Lack of commitment

Lack of commitment within stakeholders would surely lead to failure and wastage of resources; this could be just general attitudinal problem leading to mismanagement, pilferage or even corruption.

5. Possible Results of RDF

It is difficult to predict future prospects for RDF now; but some possible scenarios can happen, listed below:

5.1. RDF becomes redundant as health facilities receive proper share of drugs/ or drug budget. This is bit speculative at the moment, for no major initiative for drug procurement/supply is planned in near future by the government.

5.2. RDF remains closely knit and efficiently operated by the MoH with assistance of the communities, then it can work for long time and even can be replicated elsewhere. This is also a very wishful situation, as the commitment required to operate RDF is much beyond informal support from the government, it has to have a bail out plan and commitment in writing.

5.3. RDF disintegrates; some communities take things in their own hands and start community level RDFs according to their needs.

5.4. RDF strategy brings in further competition from private sector and more private VPs are set up in different villages.

5.5. RDF simply fails, during the start up period; either wavering of support from stakeholders, government actions, inability of SC to allocate proper funds, RDF seed funds erosion due to mismanagement, theft, pilferage or losses etc. The same can happen soon after handover.

From SC point of view, all options should be considered acceptable but the last scenario that should be avoided; out of others listed above scenarios any one or mix of them can happen to RDF after cessation of project support.

6. General Guidelines For Operation

Following are general guidelines to operate an RDF system. These guidelines are merely suggestive based on the experience gained in the field and international experiences of RDF in other settings, but are not exhaustive in any way. These guidelines will be fine-tuned during course of time and would eventually lead to make standard operating procedures (SOP) for future such operations.

6.1. Procurement

Drug procurement will set the stage for the entire working of RDF, its immensely important to buy cheap generic but good quality drugs through non profit suppliers (PSF, UNICEF etc). In Tajikistan, initially PSF should be engaged to buy medicines for the RDF. Procurement process shall be strictly supervised by the RDF Committee, from the discussion on the EDL, quantities, tendering process, approval of procurement, inspection of the consignment received, Quality Assurance (QA), authorization of payment, price review, policy matters relating to taxation local laws etc.

6.3. Essential Drug List

Essential drug list is revised and only basic essential drugs/supplies are included to keep it in line with recommended treatment protocols of IMCI/WHO/UNICEF. The quantities of drugs per VP are re-worked based on disease patterns rather than prescription practices of the MoH staff at the moment. Both MoH staff and VPs will be trained on rational drug use and best practices in pharmacy management.

The revised list of drugs is annexed with the proposal. Some drugs for specific conditions such as malaria, typhoid, STIs/STDs can be worked out for selective availability at few SUB VPs.

6.4. Logistics

The existing storage facilities the main pharmacy at the Central District Hospital (CDH) will be utilized; improvement will be brought in the storage practices including special storage requirement if any for the procured drugs. Bin cards or tally system shall be used to maintain an updated stock status.

SC pharmacist will be the overall in charge of the main pharmacy, assisted by the assistant pharmacist and pharmacist from the CDH.

6.5. Establishment of new village pharmacies in Panjikent and Aini

All new VPs will be established using the seven criteria developed by SC consultant. Based on which the number of VPs in Panjikent shall be reduced to 74 in total, against 90 at present and planned 140; similarly in Aini, total 40 VPs will be established against 61 planned. For Panjikent, in CS14 villages non-performing VPs shall be closed down.

List of villages attached with criteria **Annex C.**

6.6. Minimizing Operating Costs

As is evident from the discussion above that for conservation of RDF funds, it is absolutely essential to keep operating costs at the minimum. For RDF operation, either the project support will be factored in inception in. This is expansive option, though it does provide the kind of staff commitment needed for such an operation. The less expansive option is to top-ups on the salaries of involved MoH staff and provide for the fuel etc. of the car and other consumables needed for logistic support. This however, can be determined after three years of experience.

6.7. System For New RDF

New procurement for the RDF shall be done by PSF initially. The RDF Management Committee will first inspect newly procured drugs. Details about licenses, expiry dates, batch numbers, physical condition shall be checked. Samples of drugs will be sent for quality assurance to appropriate government drug testing laboratory.

Main pharmacy will be reorganized with drugs stored on the principle of *first in first out.* Bin cards displayed clearly with updated stock status. Necessary environmental conditions will be ensured for storage as required by the laws of Tajikistan. The main pharmacy shall store one-year supply for all the operational VPs, plus buffer stocks for four months. Record keeping will be done both manual in registers and entered in a computer. Appropriate computer software shall be developed to keep inventory of drugs up-to-date and that is able to generate periodic reports, projections etc.

In the first year, supply for three months will be given to each VP and consumption rate closely monitored each month. Any unsold item with a reasonable length of shelf life will be with held from the next re-supply, while only items and quantities sold shall be replenished. Exceptions to this can occur after due approval from the PO health and program manager in circumstances of actual need e.g. increased disease load etc.

6.8. Supervision

Regular monthly schedule for joint supervision as a committee with MoH staff and VDC members will be developed by SC pharmacist/assistant pharmacist. A SUB in charge of the area will participate from the MoH side while one person can be nominated by the VDC to participate in the supervisory visit.

Each VP will be visited every month using a checklist that records information about the

i. Medicine stock position, including expiry date review
ii. Cost-recovery
iii. Records patients load, diseases patterns
iv. Prescription review for rational drug use

All expired/near expiry drugs will be collected and returned to the main pharmacy and necessary entry recorded in the VP stock register.

The supervisory committee will record its remarks at the end of the visit in a register maintained at the VP, duly signed by the members of the committee. The remarks should include observations about the performance of the VP and any suggested improvement to be brought in by a certain time line.

The SC pharmacist and assistant pharmacist will collect all new demands during supervisory visits and supply drugs after approval from the project officer health and program manager.

In the subsequent years, supervision and supply of medicine can continue as before provided cost of operation can be factored in the cost of the RDF. Otherwise, alternative mechanisms less costly shall be explored based on experience.

6.9. Training

Training of RDF operational staff and VP will be done on a regular basis. The following are the tentative training that will be provided to staff involved in RDF.

6.8.1. Orientation about RDF work

Community (VDC)/MoH/RDF Committee members

6.8.2. Supervisory training

VDC/MoH staff/pharmacists

6.8.3. Pharmacy management training

VP/MoH staff

ANNEX A
Estimation of Drug Consumption - ABC classification

Percentage of drug sales (from July 2003 to July 2004)

#	Name of drugs	Price	VP r?vd in a year	VP sold	% of sales	Balance	expired drugs
1	Alumi Hydro TAB 500 mg (1000)	4	5072	703	13.8	4283	86
2	Amox Powd Susp 125mg/ml	310	349	157	44.9	92	100
3	Amox TAB 250mg (1000)	10	65336	34926	53.4	24100	6310
4	B- Salicylic Acid Oint	880	48	9	18.7	19	20
5	Benzyl Benz Lot 25% (1000mg)	100	172	113	65.6	36	23
6	Cimitidine TAB 200mg (100)	7	34133	10474	30.6	13215	10444
7	Ferr + Fol AC TAB (1000)	5	32099	418	1.3	19721	11960
8	Folic Acid TAB (1000)	2	74579	8473	11.3	7636	58470
9	Ibuprofen TAB 200mg (100)	5	33361	14706	44	7976	10679
10	Mebendazole TAB 100 mg (100)	5	9241	5437	58.8	1465	2339
11	Metronidazole TAB 250mg(1000)	4	28118	9537	33.9	6558	12023
12	Nystatin Oint100,000/Gm (30 G)	190	223	125	56	54	44
13	Nystatin Pess 100,000IU(PK 15)	18	966	385	39.8	203	378
14	ORS	0	300	100	33.3	122	78
15	Paracetamol TAB 500mg (1000)	4	55391	35269	63.6	19586	5536
16	Paracetamol Tab 100mg (1000)	2	48715	19391	39.8	9961	19363
17	Para Elix 125mg/5ml BTL(60ml)	80	246	184	74.7	41	31
18	SNX+TMP TAB 100+20mg(100)	4	71641	21725	30.3	38079	11837
19	SNX+TMP TAB 400+80mg(500)	10	51582	23439	45.4	18164	9979
20	Tetrac HCL Oph Oint 1% (5 G)	74	629	328	52.1	130	171
21	H2O Inj 5ml (Box of 50 amp)	23	2778	735	26.4	183	1860
22	Benzyl Penicillin Inj	45	12953	6043	46.6	5562	1348
23	Zinci Oxidi 10% (500Gm)	940	99	28	28.2	46	25
24	Tetracycline CAP 250mg (1000)	7	44652	17173	38.4	8592	18887
25	Povidone Iodine 10% (500ml)	780	45	7	15.5	17	21
26	Ampicillin Powder for Inj 500mg	55	11906	5404	45.3	5881	621
27	Benzathine Benz-Penicillin Inj (3 G)	120	1424	363	25.4	206	855
28	Erythromycin Oral Susp 125mg/5ml	203	279	162	58	43	74
29	Furosemide TAB 40mg (100)	7	11659	1505	12.9	3016	7138
30	Methyldopa TAB 250mg (100)	11	19680	2810	14.2	2114	14756
31	Promethazine TAB 25mg (100)	8	0	0	0	0	0
32	Chloramphenicol CAP 250mg (1000)	10	28761	12409	43.1	9398	6954
33	Chlorpheramine TAB	2	7190	2886	40	1049	3262
34	Na Cl 0.9%	320	594	97	16.3	304	193
35	Chlorohexidine Conc. Sol 5%	1036	9	0	0	7	2
36	Needles 1.0x38mm/19G x 1.5"	7	1016	217	21.3	780	19
37	Needles 0.8x40mm/21G x 1.5"	7	9746	2475	25.3	2614	4657
38	Syringe 2ml	17	19470	7656	39.3	11574	120
39	Syringe 5ml	17	17545	7256	41.3	9777	512
40	Cotton Wool (500Gm)	550	127	36	28.3	82	9
41	Gauze bondage	52	1300	596	45.8	634	70

42	Gauze Pad 8Ply (100 x 100mm/100	546	4	0	0	4	0
43	Gauze Pad 12 Ply (76mm x76mm)	318	304	27	8.8	47	230
44	Glucose Isotonic Inj Sol 5% 500ml	320	673	307	45.6	324	42
45	?ipralyot tab.	35	2979	1201	40	659	1119
46	Noshpa tab.	12	4939	1509	30.5	3081	349
47	Demidrol tab.	1	9643	4940	51.2	4579	124
48	Diazipan tab.	77	2170	2150	99	0	20
49	Klofellin tab.	5	2436	1256	51.5	831	349
50	Delogel tab.	9	34545	6404	2.2	15367	12774
51	Primaquine tab.	8	34824	7359	21.1	22886	4579
52	Bromohexin tab.	3	17276	9548	55.2	7388	340
53	Furazolidine tab.	3	26527	10618	40	14993	916
54	Negram tab.	50	2857	578	20	1383	896
55	?erukal tab.	18	1897	426	22.4	1413	58
56	Salbutamol tab.	12	9405	982	10.4	7145	1228
57	Karsel #80 tab.	7	3452	1652	47.8	1760	40
58	Albucet kapl.	42	1193	406	34	263	524
59	Doctor Mom	730	244	97	39.7	144	3
60	Analginum inj. 2%	18	9702	7099	73.1	1518	1085
61	Calcium chlorine of 10 % inj.	28	4213	1747	41.4	2320	146
62	Novokain inj.	23	21405	10412	48.6	9258	1735
63	Noshpa inj.	91	1324	347	26.2	965	12
64	Demidrol inj.	10	5114	2579	50.4	2448	87
65	Iufellin(Aminophylline) inj.	28	963	388	40.2	235	340
66	Gentomicin inj. 40%	30	9627	4994	51.8	4259	374
67	Oxytocin inj.	35	2042	785	38.4	930	327
68	Declofenic inj.	23	4216	1701	40.3	1138	1377
69	Ledaza(Aloe) inj.	15	3675	1428	38.8	2247	0
70	Papaverin inj.	14	2133	885	41.4	1175	73
71	Sticking Plaster	80	985	413	4.9	548	24
72	Hemodez inj.	400	435	135	31	292	8
73	?intomycin ung.	175	914	430	47	381	103
74	Vishnevesky ung.	175	750	349	46.5	390	11
75	Indomethacin ung.	330	563	260	46.1	196	107
76	Flucinar ung.	700	248	53	21.3	188	7
77	Vipro?al ung.50gr	260	869	140	16.1	223	506
78	Sistem drops	70	1548	556	35.9	709	283
79	Dibazol 1% inj.	14	3189	1157	36.2	2002	30
80	Ascorb.	19	2780	1724	62	1046	10
81	Formatex	0					
82	Condons	0					

Class A B C

Drugs that can be introduced later

ANNEX B

Revised RDF EDL 2005

#	Type	Name of drug	Quantity caps/tab /bottles	Cost per unit (dirhams)	Cost per month	Cost per year
Antibiotics						
1		Susp Amoxil 125mg/5ml	15	280	4200	
2		Tab Amoxil 250 mg	60	10	600	
3		Syp Cotramaxzole	15	730	10950	
4		Tab Cotramaxzole forte	50	10	500	
5		Inj Benzyl Penicillin (500,000 IU)	40	33	1320	
6		Inj Procaine Penicillin	2	40	80	
7		Capsules Tetracycline 250 mg	10	7	70	
8		Tab Metronidazole 250 mg	20	3	60	
Analgesics/ antipyretics						
9		Tab Ibuprofen 200 mg	50	3	150	
10		Tab Paracetamol 500 mg	50	2	100	
11		Syp Paracetmol	10	100	1000	
Haematinics						
12		Tab Iron folate	Not required now			
Anti worms						
13		Tab Mebendazole	10	4	40	
14		Syp Mebendazole	10	?		
Diarrhea/ dysentery						
15		ORS	Not needed now			
16		Ringers lactate	3	250	750	
Eye Care						
17		Oint 1% tetracycline	3	30	90	
Antiseptics						
18		Gentian violet	1	?		
19		Methylated spirit	1	?		
RH drugs						
20		Inj Oxytocin	5	22	110	
21		Inj. Magnesium sulphate 50%	1	?		

Anti scabies						
22		Benzyl Benzoate lotion 25%	2	1000	2000	
23		Tab Chlorpheniramine maleate	?			
Other supplies						
24		Cotton wool	1			
25		Gauze bandage	5	5	25	
26		Disposable syringe	80	11	880	
27		Inj. Novocain	50	20	1000	
Total cost per month in dirhims					23925	
Total cost per year in dirhims						287100
Total cost per year in USD						957 $

1. Given the fact that not all drugs are listed or priced, e.g. IMCI, RH especially for STI/STDs and local endemic diseases such as typhoid and malaria, the total thus may cost around 1200 USD per VP per year.
2. The calculations are on current market rates taken in Panjikent that might be slightly variable in Khatlon.
3. Use of drugs like Nalidixic acid in dysentery has been questioned in WHO EDL latest edition and therefore not included here.

Class A

Class B

Class C

ANNEX C

Village Pharmacies For Panjikent

VP selection according to criteria in Panjikent

2/11/2005

#	Village name	VP proposal	NGOs	Comments
1	Abdusamad	yes		
2	Uti baland	no		VP should be closed - VP went to Russia. Drugs can be taken from Marghedar VP.
3	Chimkurgan	yes		
4	Chubot	yes		
5	Roj	yes		
6	Weshist	yes		
7	Qushteppa	yes		
8	Shurcha	yes		
9	Kosatarosh	yes		
10	Chorbog	yes		
11	Yamongiya	yes		
12	Guliston	yes		Should be selected new VP as pharmacist went to Russia.
13	Shurnova	yes		
14	Kattakishlok	yes		
15	Khujapang	yes		
16	Dashti Qozi	yes		
17	Kuktosh	yes		Should select new VP - due to death of previous pharmacist
18	Zebon	yes		
19	Khurmi	yes		
20	Bedak	yes		
21	Panjrud	yes		
22	Artuch	yes	ADB	
23	Devashtich	yes		
24	Bahor	yes		
25	Ghusar	yes		
26	Dasht	yes	ADB	
27	Teshiktosh	yes		
28	Filmandar	yes		
29	Ghijdarva	no		VP should be closed - as MOH lives in the other village. Drugs can be taken from Rovadin VP.
30	Padrud	yes	ADB	
31	Margedari Bolo	yes		
32	Madovra	yes		
33	Sujina	yes		
34	Masori Sharif	no		VP should be closed - VP went to Russia. Drugs can be taken from Bahor VP.
35	Boghcha	no	ADB	Already closed - No MOH staff.
36	Qumsoy	no		VP should be closed - VP went to Russia. Drugs can be taken from Teshiktosh VP.

37	Sovetobod	yes		Should be selected new VP - as VP is running his own pharmacy.
38	Ghezani bolo	no	ADB	VP should be closed - drugs can be taken from Ghezani Poyon VP.
39	Rovadin	yes		
40	Rashnai Poyon	yes		
41	Chorvodor	yes	ADB	
42	Tagobi Khalg	yes		
43	Zeri Hisor	yes		Should be selected new pharmacist - VP went to Russia.
44	Yori	yes		
45	Qumok	yes		
46	Maikatta	yes		
47	Shing	yes		
48	Mogiyon	yes	PSF	Pharmacien sans Frontier
49	Obe Borik	yes		
50	Sughdion	yes		
51	Wagashton	yes		
52	Sor	yes	ADB	
53	Khumgaron	no		VP should be closed - drugs can be taken from Bedak VP.
54	Margedari Poyon	yes		
55	Porven	yes	ADB	Should be selected new VP - as previous VP does not want to work.
56	Negnot	yes		
57	Zimtut	no		VP should be closed - drugs can be taken from Porven VP.
58	Ghezani Poyon	yes		
59	Shingak	yes		
60	Ravot	yes		
61	Amondara	yes	ADB	
62	Garibak	yes		
63	Mingdona	yes		
64	Qiziljar	no		Already closed - Drugs can be taken from Amondara VP.
65	Dashti Malla	yes		
66	Sufijon	yes		
67	Navobod	yes		Should selected new VP - VP running his own pharmacy.
68	Shashkat	no	ADB	VP should be closed - VP went to Russia.
69	Shashkatstroy	yes		Should be selected new VP - Previous VP refused to work.
70	Sohibnazar	yes		
71	Savr	no		Already closed - VP went to Russia. Drugs can be taken from Shurcha VP.
72	Avazali	yes		Should select ed new VP - went to Russia.
73	Qirg-Archa	yes		
74	Havzak	no		Already closed - No any MOH staff.
75	Badgah	yes		
76	Changal	no		VP should be closed - Drugs can be taken from Chubot VP.

77	Chinor	no		No VP activities. Drugs can be taken from city of VP Chorvodor.
78	Chuboti Chimkurgan	yes		
79	Farob	yes		
80	Jombulok	yes		
81	Kishtudak	yes		
82	Mogiyon(new)	yes	ADB	
83	Mughulon	yes	ADB	
84	Novi Chomog	no		VP should be closed - Drugs can be taken from Sugdiyon VP.
85	Pushti Qurghon	yes		
86	Qashka	yes		
87	Turki Roj	yes		
88	Voru	yes		
89	Yalokgar	no		VP should be closed - Drugs can be taken from Chorvodor VP.
90	Kamar	no		Drugs can be taken from Chimqurgon VP.
91	Urtakishlok	no		Drugs can be taken from Chimqurgon VP.
92	Sari Kamar	yes		
93	Surkhob	no		Drugs can be taken from Kattakishloq VP
94	Zarangbosh	no		Drugs can be taken from Kattakishloq VP
95	Khujagarib	yes		
96	Zavron	no		Drugs can be taken from Navobod VP
97	Kuloli	no		Drugs can be taken from Zeri Hisor VP
98	Ziddi	no		Drugs can be taken from Mingdona VP
99	Ghazza	no		Drugs can be taken from Voru VP
100	Majdone Mogiyon	no		Drugs can be taken from Mogiyoni Nav VP.
101	Qiyogli	no		Drugs can be taken from Padrud VP
102	Pani	no		Drugs can be taken from Padrud VP
103	Marghsor	no		Drugs can be taken from Padrud VP
104	Musobozor	no		Drugs can be taken from Farob VP
105	Havzak(khurmi)	no		Drugs can be taken from Chubot VP
106	Khonako	no		Drugs can be taken from Chubot VP
107	Tojik	no		Drugs can be taken from Sohibnazar VP
108	Rajabali	no		Drugs can be taken from Avazali VP
109	Foni	no		Drugs can be taken from Mogiyoni Nav and Moghiyon VP

Total selected 74 villages for RDFactivity.

ANNEX C – Cont'd Possible Village Selection in Aini For RDF Activity Using Criteria

VP selection according to criteria in Aini

2/11/2005

#	Village name	VP proposal	NGOs	Comments
1	Vota	no	GAA	GAA
2	Yovon	no	GAA	GAA
3	Revad	no	GAA	GAA
4	Urmetan	yes		
5	Langar	yes		
6	Vashan	yes		
7	Madm	no	GAA	GAA
8	Veshkand	no	GAA	GAA
9	Dar-Dar	yes		
10	Kum	yes		
11	Khairobod	yes		
12	Novdonak	yes		
13	Zerobod	yes		
14	Iskodar	no	GAA	GAA
15	Fatmev	no	GAA	GAA
16	Guzari bod	yes		
17	Ispagn	yes		
18	Rarz	yes		
19	Pokhut	yes		
20	Sayron	yes		
21	Fatmovud	yes		
22	Shivaki Poyon	no	GAA	GAA
23	Shivaki Bolo	yes		
24	Margsor	yes		
25	Pasrud	no		No MOH staff in the village.
26	Shurmashq	yes		
27	Pinyon	no	GAA	GAA
28	Kante	yes		
29	Pete	no		No MOH staff in the village.
30	Haironbed	yes		
31	Makhshevad	yes		
32	Djik	yes		
33	Norvad	no		No MOH staff in the village.
34	Saratogh	no		No MOH staff in the village.
35	Tuda	no		Distance to the nearest VP is 2km.
36	Khushekat	yes		
37	Kurut	yes		
38	Zindakon	yes		
39	Sangiston	yes		
40	Zoosun	yes		
41	Tomin	yes		

42	Putkhin	yes		
43	Gabirud	yes		
44	Anzob	yes		
45	Takfon	yes		
46	Kumargh	yes		
47	Poimasor	yes		
48	Veshab	no	GAA	GAA
49	Utoghar	yes		
50	Shamtuch	yes		
51	Dargh	yes		
52	Pishanza	yes		
53	Remon	yes		
54	Marzich	yes		
55	Chore	no		No MOH staff in the village.
56	Kazdon	no		No MOH staff in the village.
57	Ravot	no		No MOH staff in the village.
58	Margeb	yes		
59	Zarafshon-1	no		No MOH staff in the village.
60	Zarafshon-2	no		No MOH staff in the village.
61	Yaghnob	no		No MOH staff in the village.

Total selected 40 villages for RDF activity.

A. ANNEX D

Quote for Drug supply from Missionpharma with price for Dushanbe

#	Item required			Supplier # 1		Supplier # 2			Supplier # 3						
				Retail Pharmacy		Retail Pharmacy			Name: Missionpharma Address:			Difference from lowest		Difference from lowest	
	Item description	Qty required		Unit price (Smn/$)	Total price ($)		Unit price (Smn/$)	Total price ($)	Total price ($)	Total price ($)	Total price ($)	USD		%	
		Unit	Nos.			Nos.									
1	Amox Powd Susp 125mg/ml				0.82			0.98			0.37	0.45		54.88	
2	Amox TAB 250mg (1000)				42.55			49.09			15	27.55		64.75	
3	Ferr + Fol AC TAB (1000)				0			0			1.4	1.4		0.00	
4	Ibuprofen TAB 200mg (100)				0.98			0.98			0.36	0.62		63.27	
5	Mebendazole TAB 100 mg (100)				0.98			1.31			0.31	0.67		68.37	
6	Metronidazole TAB 250mg(1000)				8.18			9.81			3.67	4.51		55.13	
7	ORS				0.13			0			0.058	0.072		55.38	
8	Paracetamol TAB 500mg (1000)				5.89			6.55			3.09	2.8		47.54	
9	Paracetamol Tab 100mg (1000)				3.93			4.91			3.47	0.46		11.70	
10	Para Elix 125mg/5ml BTL(60ml)				0.44			0.65			0.2	0.24		54.55	
11	SNX+TMP TAB 400+80mg(500)				20.45			16.37			3.93	16.52		80.78	
12	Tetrac HCL Oph Oint 1% (5 G)				0.98			0.98			0.098	0.882		90.00	
13	Benzyl Penicillin Inj				1.05			1.08			0.056	0.994		94.67	
14	Tetracycline CAP 250mg (1000)				8.18			8.18			6.87	1.31		16.01	
14	Chlorpheramine TAB				0			0			0.99	0.99		0.00	
15	Na Cl 0.9%				0.78			0.82			0.1	0.68		87.18	
16	Syringe 2ml				0.04			0.03			0.035	0.005		12.50	
17	Syringe 5ml				0.04			0.03			0.04	0		0.00	
18	Cotton Wool (500Gm)				1.8			3.93			1.37	0.43		23.89	
19	Gauze bondage				0.11			0.13			0.065	0.045		40.91	
20	Sistem drops				0.14			0.2			0.11	0.03		21.43	
21	Syp,Cotramaxzole				2.39			0			0.31	2.08		87.03	
	Net %age													* 54%	

- This flexibility further increases by investing more in high turnover drugs.

ANNEX E

Revised RDF Timeline

Year 1													
Tasks	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Remarks
Revised RDF doc prepared	X												
Revised RDF doc internally reviewed		X											
Adoption of Revised scheme		X											
Revision of EDL	X												
Proposal submitted for MoU and MoU signed		X											Milestone
New RDF Committee			X										
First Meeting of RDF Com.			X										
Funds for procurement arranged			X										
Recruitment of Pharmacist			X										
Drugs invoiced through PSF		X											
MoH pharmacist assist in Drugs receipt					X								Milestone
Drugs distributed					X	X							
Aini MoH MoU signed					X								Milestone
Pharmacist						X							

recruited for Aini													
Main pharmacy space identified in Aini					X								
Assistant pharmacist recruited and trained					X								
New village pharmacies setup in Aini Panjikent				X	X	X							
Re supply to VPs					X	X	X	X	X	X	X	X	
Training of VPs					X	X							
Monitoring visits with MoH/VDC			X	X	X	X	X	X	X	X	X	X	Milestone
Training of MoH staff/pharmacist on RDF/PMS/RDU													Milestone
Year 2													
Drugs in stock handed over to MoH	X												Milestone
Refresher Trg.	X	X			X	X			X	X			
Management core group receive training in procurement													
Second procurement ordered	X												
Drugs received				X									
Joint supervision re-supply continues	X	X	X	X	X	X	X	X	X	X	X	X	Milestone
Recalculation of					X								Milestone

RDF fund													
Receipts handled by MoH	X	X	X	X	X	X	X	X	X	X	X	X	Milestone
Third procurement invoiced										X			Milestone
Year 3													
MoH handles RDF AC	X												Milestone
Procured drugs taken on stock	X												
Financial Audit					X							X	Milestone

Attachment F. Revised CS-18 Results and Indicator Table

Revised CS-18 Results, Indicators, Measurement Methods, Baseline & Midterm Values, & Targets

Result/Inter-mediate Result	#	Indicator [indicator source *]	Method	Baseline Value	Midterm Value	EOP Target	Interv.
R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent & Aini districts.	1	% of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.[1,(3)]	KPC Survey	53% (1+ = 92%)	94%	80%	MNC
	2	% of 0-23 month olds whose birth was attended by skilled health personnel.[1,3]	KPC Survey	85%	86%	90%	MNC
	3	% of 0–5 month olds exclusively breastfed during the last 24 hours.[3]	KPC Survey	12%	46%	50%	Nutr.
	4	% of 12-23 month olds who received a measles vaccine (by maternal history).[(1),3]	KPC Survey	67%	94%	80%	EPI
	5	% of 12-23 month olds with cards, fully immunized.[(3)] (Measles vaccine is now given from age 12 months.)	KPC Survey	71%	89%	70% **	EPI
	6	% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.[(3)]	KPC Survey	30%	100%	60%	ARI CDD
	7	% of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.[3]	KPC Survey	19%	64%	40%	CDD
	8	% of households with children <2 which have only iodized salt for cooking.	KPC Survey	10%	72%	50%	Nutr.
R-2A: Key CS-18 benefits & activities **sustained** in Panjikent villages following SC phase-out	9A	Final lot-specific achievements in phase-out villages for 6 of the 8 R-1 indicators sustained at no more than 10% below midterm coverage (for all 5 lots).	KPC Survey	See R-1	See R-1	See R-1	All
	10 A	Final lot-specific achievements in phase-out villages for 3 of the 4 IR-1 indicators sustained at no more than 10% below midterm coverage (for all 5 lots).	KPC Survey	See IR-1	See IR-1	See IR-1	MNC ARI CDD
R-2: Sustained investments in key MCH services by communities & rural health facilities in Panjikent & Aini districts. **(REPLACED BY R-2A & INDICATORS ABOVE)**	9	% of Health Facility Farms started before 10/04, producing crops without SC support.	Final Eval.	6%		20%	All
	10	% of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services.	Final Eval.	22%		32%	All
	11	% of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month.	VP Records	94%		90% **	All
	12	% of Village Pharmacies with at least 65% cost recovery.	RDF Reports	89%		65% **	All

IR-1: Increased household level **knowledge** of selected MCH issue	*13*	% of mothers who know 2+ postpartum danger signs.[3]	KPC Survey	53%	100%	70%	MNC
	14	% of mothers who know 2+ newborn danger signs.[3]	KPC Survey	51%	100%	70%	MNC
	15	% of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.(1)	KPC Survey	27%	56%	60%	ARI
	16 A	% of mothers citing 2+ signs in children with diarrhea which should lead them to seek treatment or advice for their child.(1)	KPC Survey		100%	100%	CDD
	16	% of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.(1)	KPC Survey	15%	**RE-PLACED BY 16A**	60%	CDD
IR-2: Improved **capacity of communities** to address priority health needs of mothers & children <5.	17 A	% of children 6-23 months old with severe (< -3Z WFA) malnutrition in PD/H communities	GMP reports	TBD after baseline	NA	<1%	Nutr.
	17 B	% of children 6-23 months old with normal nutrition (> -2 Z WFA) in PD/H communities	GMP reports	TBD after baseline	NA	60%	Nutr.
	17 C	% of Hearth children who "graduated" from Hearth (rehabilitated or gained more than 400 grams within 2 months)	PD/H reports	TBD after baseline	NA	80%	Nutr.
	17	% of villages with resident rural health facility staff, having a Village Pharmacy which sold medicines in past month.	CS-18 Records	100% (in CS-14 site)	**RE-PLACED 17A-C**	80% **	All
	18	% of villages with a health facility, having a Village Development Committee which organized 1+ health education session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months.(1)	CS-18 Records	estimate = 50%	100% (MTE FGDs with 10 VDCs)	90%	All

IR-3: Improved **capacity of rural health facilities** in Panjikent & Aini districts to provide quality MCH services & support community health activities.	19	% of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.[1,(2)]	HFA	41% ***	NA	70%	CDD
	20	% of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.[(1),(2)]	HFA	48% ***	NA	70%	ARI
	21	% of children <5 who have their weight plotted on growth chart.[2]	HFA	11% ***	NA	60%	Nutr.
	22	% of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.[2]	HFA	78% ***	NA	90%	Nutr. CDD
	23	% of ANC clinic attendees who report having received iron supplements.	HFA	42% ***	93%	70%	Nutr. MNC
	24	% of LSS-trained midwives who correctly manage normal pregnancies, deliveries, & obstetric complications.	ACNM LSS Forms	34%	Preg: 75% Del: 66% Com: 93%	70%	MNC
	25	% of rural health facilities which have staff trained in LSS.	"	37%	64% of villages	90%	MNC
	26	% of VDC meetings which have MOH staff participating.[1]	VDC Records	50%	70% (MTE FGDs)	90%	All
	27	% of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.	HF Records	0%	92%	50%	All
IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajik.	*28*	Number of CS-18 strategies successfully scaled up in new CS-18 areas.	Final Eval.	None	3	4	All
	29	Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.	Final Eval.	None	3	4	All
	30	Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.	PLG Report	No	Yes 2003 PLG	Yes	All
	31	TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.	TFO Reports	No	Yes	Yes	All

*** Indicator source**: **1**: CS-14; **2**: BASICS HFA; **3**: KPC 2000 / 2000+ / CATCH; ( ) = indicator revised

**** EOP target** set the same or lower than baseline because baseline value refers only to the smaller CS-14 site, and the target applies to the substantially larger CS-18 site/population with implementation through partners with less intensive SC involvement than was the case in CS-14.

*** Baseline HFA estimates **are weighted to reflect the distribution of population between old (CS-14) and new CS-18 areas, as the distribution of facilities in the HFA did not reflect this distribution of the population.**

Attachment G. Focus Group Discussion Summary Results

Questionnaires and Summary Results from Focus Group Discussions

Save the Children
CS-18 Midterm Evaluation
Panjikent and Aini Districts
Tajikistan

August 2005

Health Workers
(Including Midwives)

1. What are your responsibilities as a health worker?

The health workers are doing case management, referral and going out into the communities to provide health education, organize EPI outreach, assist with birth planning, find/register newborns, and do home visits. Coordination with VDCs or CTC participants is not listed here as a responsibility, but is discussed later in this FGD.

2. What training have you received from the project?

They mentioned training in CDD, ARI, maternal danger signs, LSS, counseling, birth planning, RDF/VPs, MNC and EPI.

3. What support have you received from the project?

Learned how to coordinate with VDC and MOH. "Training was very good and we learned a lot from it. Shared what we learned with VDC members and the community." Received forms, registration books, midwife kits, and EPI cards,

4. What do you do differently now after receiving training and support from the project?

- *Do more deliveries in the clinic.*
- *Plan training and education sessions.*
- *Use the midwifery kits during the home visits.*
- *Focus more on preventive health than before.*
- *Know how to conduct newborn resuscitation.*
- *Use WHO charts for assisting children with DD/ARI.*
- *Give better advice to clients after having taken the LSS training.*
- *Proper use of antibiotics for diarrhea – for dysentery as opposed before when they were using antibiotics for simple diarrhea.*
- *Women used to take the iron tablets with tea, but have switched to boiled water.*
- *They have started to use the CTC students for ORS distribution, EPI followup, help with health education, and sanitation and hygiene.*
- *Communicating with patients in a very polite manner.*
- *Manage third stage of labor.*
- *Skin to skin and immediate/exclusive breastfeeding.*

5. How do you interact with the VDC?

Coordination on immunizations, health education, identifying pregnant women for ANC, birth planning, and emergency transportation funds.

6. How do you interact with the CTC participants?

- *Promote immunizations, distribute ORS, and educate on ARI/CDD.*
- *MOH staff have visited the CTC sessions.*

7. What health services do you provide outside the health facility? (Indicator 27)

- *Provide health education at the mosques, weddings and parties.*
- *Every month we provide a lecture on a health topic to the mothers who attend the clinic.*
- *Home visits for pregnant and postpartum women.*
- *Identify malnourished children through the VDC and SC staff, and organized the Hearth.*
- *Organize transport to the referral hospital and, if the pregnant woman is having complications they will accompany her to the SUB in the nearby village.*

8. What have been the most effective ways to communicate health education messages to caregivers?

Health workers appear to have a better understanding of adult education techniques:
- *Want to see more interactive training techniques, flip charts, role-plays, and stories used.*
- *Use simple language.*
- *Educate husbands too.*
- *Use smaller groups.*

9. What are the most common messages you tell new mothers? (Indicator 22)

Responses were consistent with the project's health education messages.

10. Did your village have a health facility farm? IF YES, what did they use the funds for? IF NO, why? (Indicator 9)

The main reason for not having a health facility farm was due to a lack of arable land.

11. How has this project helped you improve the health of women and children?

Improved behaviors/coverage consistent with KPC and related to project indicators.

12. How has the supervision you receive changed over the past two years?

- *The quantity of supervision has increased and is appreciated, due in part to availability of free rides in project vehicles.*
- *Appreciate the additional forms provided by the project.*
- *It was not clear from the FGDs what improvements have been made in terms of the quality or content of the supervision as a result of the project.*

13. What difficulties do you face in performing your duties and responsibilities?

- *Lack of health facility, transport, consistent electricity, medicines, and communication system.*
- *Not all communities have a midwife – has to come from a nearby village.*
- *Not all health facilities have received a midwife kit.*
- *Some MILs and husbands still don't support facility-based deliveries.*
- *Some stock out of forms.*

Note: The VDC in one community wrote a letter and to the SUB chief doctor asking for help in reestablishing a health facility in their village.

14. How will your role and responsibilities change after the conclusion of the child survival project?

They will continue to do their jobs, including support of the new project initiatives such as CTC. No mention of the potential difficulties they might face as a result of the end of CS-18, like difficulty in doing supervision in the more remote villages or transporting vaccines from Khojohn to district MOH offices.

Village Development Committees

1. Who are the members of your VDC?

There is a good representation of women and teachers, but only two of the ten VDCs visited had a health worker as a member.

CODE	Health Workers	Teachers	Women	Elders	TOTAL
A	1	2	8	2	10
B	0	4	4	0	8
C	0	2	5	1	9
D	0	3	3	1	7
E	0	2	3	0	6
F	0	2	3	1	6
G	1	1	2	0	8
H	0	1	4	1	8
I	0	2	2	0	6
J	0	1	3	0	5

2. What activities does your VDC do?

VDCs have a core set of activities and responsibilities that are largely consistent from VDC to VDC – health education/promotion, community mobilization, coordination, monitoring health in the community and selected ones are participating in PD Hearth and emergency transportation funds. Some have also gotten involved in advocacy – requesting government support (new health facility/worker, requesting GOT oversight on salt iodization and requesting land for a FAP Farm).

3. What health education activities has your VDC done in the past month (Indicator #18)?

Each VDC interviewed reported having done a health activity in the previous month.

4. What did your VDC discuss in meetings over the past two months (Indicator #18)?

Each VDC discussed health or a health related topic within the previous two months.

5. What support has your VDC received from this project?

Very appreciative of the support they have received. There appears to be some confusion distinguishing between CS-18 and the FACT project inputs, which is probably not of concern at this level.

- *Midwife kits.*
- *Health education on CDD/ARI/pregnancy/birth planning*
- *Health Facility Farm support.*
- *A latrine, hand washing station and soap for the school and soap for every household.*
- *Farm tools, seedlings, and beehives from the FACT program and CS -14.*
- *Drugs for their VP.*

6. Who does your VDC coordinate and work with?

The VDCs appear to be well connected within their communities, working with MOH staff, community, Brigadiers (head of the working brigades), informal women groups, SC staff, leaders of labor groups, village activists, VDC members, village elders, CTC students, and village chiefs.

7. Does your VDC keep a record of its meetings and if so, did an MOH employee participate in your most recent meeting (Indicator #26)?

All VDCs visited are keeping records and per those records 7/10 had a MOH employee participate in its most recent meeting. (See question 1 above that found that only 2/10 had an MOH employee on staff.)

8. What types of information do you collect and report on? How is that information used?

Identify pregnant women and coordinate on general health activities, for instance EPI outreach. No mention of sharing other health related data.

9. What activities does your VDC plan to do in the future?

Challenges (Solutions):
- *They do not have a midwife. (They want more girls from their village to study midwifery.)*
- *Women are too busy with fieldwork to attend health education sessions. (Organize the health education sessions around the women's schedules/needs) NOTE: See how this relates to exclusive breastfeeding.*
- *Need a health facility. (Seeking SC assistance to advocate with MOH).*
- *Lack of a health worker in the village. (Seeking SC assistance to advocate with MOH)*

Mothers of Children <5 Years of Age

1. Did you attend antenatal care? IF YES – What did you learn or do in the care of your pregnancy as a result of those visits? IF NO – Why? (Indicator #1)

- *ANC attendance appears to be high, which is consistent with the LQAS results on this indicator (3+ ANC visits = 94%). The main reason for not attending ANC appears to be due to the lack of a health worker and health facility in a community.*
- *Long and comprehensive list of topics covered in ANC.*

2. Who decides when you or your child needs to go to a health facility?

In communities without health facilities, MILs and husbands appear to exert more authority over care seeking behavior due to the high cost of transport. In those villages with health facilities, the mother still seeks approval and advice from spouse and elders, but she has a greater say in making the decision. This could imply the need for focusing BCC more on MILs and husbands as the project expands its focus to those communities that lack health facilities in the remainder of CS-18.

3. What are the best foods to feed a child during its first six months? (Indicator 3)

Most said exclusive breastfeeding, but then they listed many reasons for why women do not breastfeed exclusively, such as the need to respond to a crying child (implying that breast milk by itself is insufficient) and the need for the mother to return to work as soon as possible after the delivery. (Other reasons are listed below in response to question 4.)

4. Why do some mothers decide to add foods and liquids other than breast milk to their child's diet before six months? (Indicator 3)

- *"Some mothers do not have sufficient milk due to infection, illness, or emotional disturbance."*
- *"They believe the milk is not enough because when the mother is out in the field from 5 am to 7 pm, she is not breastfeeding so it dries up."*
- *"When the mother has to work in the fields she does not have enough time."*
- *"They all know that exclusive breastfeeding is important, but they don't do it anyway."*
- *"Some thought the milk was too rich."*
- *"When the mother has anemia, liver/kidney problems, or loses her appetite she might not have sufficient milk."*
- *"If the mother's milk is not adequate we consult the health worker and if advised to do so, we give other foods."*
- *"Some are giving water."*

5 How long do you have to leave the house during the day?

3-12 hours a day.

6. Who is taking care of the child when the mother is away at work?

MILs and older siblings.

7. What is the child fed while you are away? What if the child is under six months?

For children under six months, working moms are trying to return home to breastfeed every two to three hours, but for many this is not possible. Other moms leave pre-prepared foods with the caregivers. One mother was expressing and leaving her breast milk with the caregiver.

8. Where and from whom do you learn about health?

VDC members, TV, MILs, elders, CTC participants, and health workers.

9. What is the best way to educate and reach out to MILs about health?

The most common channels for conveying health information to MILs is through VDC members and TV.

10. When your child has **diarrhea** what would lead you to take him or her to a health facility? (Indicator 16)

Many were saying to take the child into a health facility immediately when it has diarrhea, without drawing a distinction between simple diarrhea and dysentery/persistent diarrhea. In addition, mothers listed many systems related to or in addition to diarrhea that would cause them to seek medical care, in addition to the standard two DD-associated danger signs. (This is similar to what the experience with the KPC survey questionnaire responses tied to indicator #16.)

11. When your child has a **cough** what would lead you to take him or her to a health facility? (Indicator 17)

Most of the groups knew the two main ARI danger signs, but also listed other related symptoms, which could require medical care, such as high fever, noisy breathing, and loss of appetite.

12. What activities does your Village Development Committee do? (Indicator 18)

Mothers appear to have a good understanding of what their local VDC does.

13. What activities do the CTC Students do?

Mothers knew the roles of CTC participants.

14. What do you use the EPI cards for?

Moms recognize the value and use of EPI cards: know the timing of vaccines and report that they feel more responsible for the health of their children,

15. What challenges do you still face and how do you plan to address them yourselves?

Challenges similar to those listed by the VDC members. Solutions don't generally mention the VDCs.

Birth Plan Mothers

1. Where did you deliver your baby?

Many deliver at health facilities, but some continue to deliver at home.

2. Who decided where you would deliver your child?

MILs and husbands are deciding where the delivery will occur in communities that lack a health facility. Conversely, the pregnant woman will decide where to deliver in communities where they have ready access to a health facility.

3. Who decided who would be with you during your delivery? (Indicator 2)

Same as 2 above.

1. Who helped you develop a safe birth plan and how did they help?

SC trained the VDC members, who helped develop the plans and raise emergency transport funds.

5. How did your family and community help you during your pregnancy and the birth of your child?

Development of birth plans increased family and community awareness of what needs to happen around the birth and to help ensure as safe a delivery as possible.

PD/Hearth Mothers

1. How did you get involved in Hearth?

They were invited or referred to the growth monitoring session by VDC members and MILs.

2. What training and support have you received from Hearth and who provided it?

Training was given on proper hand washing, food options, the need for snacks, ARI/CDD, breastfeeding, EPI, and child care/feeding. This training was provided by the PD Volunteer, the VDC and the SC Supervisor. The participants are very appreciative. (Even though the roads were cut off the SC Supervisor was visiting.) Nutritious, locally available foods were identified: smashed beans (which they did not provide previously), ground meat, eggs (used to believe it was bad to give eggs to the child – that it would lead to deafness and dumbness), oil-rich food because it has vitamin A (Used to avoid giving any fatty foods during diarrhea, but now are providing.)

3. What does your Hearth Volunteer do when she visits you?

Consistent understanding of Hearth Volunteer roles.

4. What do you do differently since participating in PD/Hearth?

- *Washing my hands and my child's.*
- *Feeding my child with a spoon.*
- *I know how to prepare nutritious/fresh foods: fruits, yogurt, whole milk, cheese, and a locally available fruit juice. (Used to think fruits caused diarrhea.) NOTE: Add to diarrhea section.*

2. How will you share what you have learned with others?

Sharing news about hearth with other mothers. Tell about hearth at community events (weddings, etc.)

3. How has your child's health changed as a result of participating in Hearth?

Mothers see for themselves the changes in their child's appetite, weight and level of activity.

Hearth Volunteers

1. Why did you become a Hearth Volunteer?

They were recruited by the VDC and they wanted to help the malnourished children.

2. What are your responsibilities as a Hearth Volunteer?

To explain PD Hearth, promote hand washing, prepare menus, organize the mothers to bring food to the sessions, do home visits, provide health education, and answer mothers' questions to make sure they understand.

3. How can the training you received as a Hearth Volunteer be improved?

- *Do more role-plays.*
- *Bring toys so mothers can focus on learning without being interrupted by their children.*

4. What support have you received as a Hearth Volunteer and who provided it?

- *Invited to the health facility and trained on the related health topics (CDD, ARI, nutritious foods, breastfeeding), and how to educate mothers.*
- *Received flip charts and health education materials.*
- *When one mother can't bring enough foods, then the volunteers figure out a way to make up the difference by providing it themselves or asking others.*

5. What challenges do you face as a Hearth Volunteer?

- *At the beginning there was no electricity to cook food, so some mothers had to bring firewood.*
- *Some mothers are too poor to bring food to the PD Hearth sessions.*
- *It was hard to get some of the shy mothers to attend at first.*
- *When mothers couldn't attend, the food was brought to them at their houses.*
- *"Hearth is not just for the food but also for the opportunity to learn."*

6. What do you hope to achieve in the future as a Hearth Volunteer?

- *Want to prevent malnutrition, which will mean no further need for PD Hearth.*
- *Want to see the children's weight increased, their health improved, and their hygiene improved.*

7. What benefits did you see from your work? How did these benefits occur?

- *Used to feed the child from the same family pot and now they feed the child from his/her own separate pot.*
- *Used to leave the child by itself to eat and now watch the child.*
- *Used to only give the soup broth, but not the other ingredients (veggies and meat). Now they smash all the ingredients together and feed that to the child.*
- *They used to think the hands should only be washed when they looked dirty. They have now learned about the 'four times' for hand washing.*
- *Mothers feel more comfortable about showing the foods they cook to the monitors.*

Mothers-in-Law

1. From where and whom do you get information about health?

- *SC staff during health education*
- *MOH staff*
- *VDC members*
- *Radio*
- *TV (morning program on the Tajik channel)*
- *Newspapers from Panjikent and several from Dushanbe (one of which has a page on health issues)*
- *CTC participants*
- *Village elders. Chairman of the Collective Farms.*

2. When should your daughter-in-law go to the health facility?

All of the responses were related to pregnancy, delivery, or the postpartum period, and were consistent with the project's health education messages.

3. When should children be brought to a health facility?

For vaccinations, when sick or malnourished, and for growth monitoring.

4. What kinds of foods and liquids should be provided to a newborn child and why?

Support of exclusive breastfeeding by MILs is mixed. Some talked about the importance of exclusive breastfeeding, but several also talked about the need to give supplemental foods or liquids (cow's milk, water, tea or formula) when 'the breast milk is not enough' or 'when the mother needs to be away for an hour or more.'

5. Who decides when someone in the family needs to go to a health facility?

The decision is usually made as a group, which includes the mother, father, grandparents and in-laws.

6. What health issues are you most interested in learning about and why?

Goiter (two participants complained of iodine deficiency), anemia, blood pressure, heart disease, rheumatism, cancer, diabetes, nutrition, breastfeeding, and one suggested family planning.

7. What difficulties do you face?

- *Lack of safe drinking water.*
- *Lack of electricity in the winter.*
- *Unemployment*
- *Lack of health facility, health worker, or transport.*

CTC Teachers

1.What are your responsibilities as a CTC Teacher?

CTC Teachers clearly understand their roles and responsibilities.

2. Why did you decide to participate in CTC?

- *Want to learn about health and disease prevention.*
- *Like to speak to the larger community.*
- *Want to contribute to the health of the community.*
- *Improves teaching skills.*

3. How can the CTC training be improved?

- *Encourage competition between classes.*
- *Use awards.*
- *Use visual aids like videos and puppets.*
- *Work with village activists.*
- *Use role-plays and the poetry game (Bai t barak) that requires inventing a 2-4 line poem that starts with the last letter of the previous poem. People memorize poems*

4. What support have you received as a CTC Teacher since your training and who provided it?

Training, supervision, and training materials (lesson plans, stationary, flip charts, and posters developed by the CTC participants)

5. What are the CTC students doing in your community?

CTC Teachers clearly understand the roles and responsibilities of the CTC students.

6. What are your plans for continuing to recruit and train new CTC participants at the end of the project? Who is supporting you to do this?

There is widespread interest in continuing to recruit and train CTC participants and for supporting CTC into the future. However, there is not a clear understanding of what assistance is needed and how it will work.

7. What is your plan to continue the CTC sessions and who will help you?

- *Increase the number of CTC participants.*
- *Organize new groups.*
- *"Recruit intelligent and active students and use them for the project activities."*
- *The teacher will seek support from the other CTC participants, school administrators, and VDC members.*
- *Identify which topics to focus on.*

8. What are the problems you are facing and what are the solutions?

- *Lack of space for CTC activities.*
- *Some parents don't allow their children to participate in CTC activities.*
- *Lack of contact with the CTC Project staff.*

CTC Students

1. Why did you decide to participate in CTC?

- *Want to learn about health and how to prevent disease.*
- *Like to train and educate.*
- *Like to participate in school activities.*
- *Want to improve the health of our community.*

2. What are your responsibilities as a CTC Student?

They understand their roles and responsibilities as CTC Students.

3. What has been your most important accomplishment as a CTC Student?

- *Received training/information on ARI, CDD, ORS preparation and EPI and provide education on these topics to others.*
- *We are going to the other kids' homes to see that they are adopting the project's health behaviors.*
- *Increased their skills in how to communicate and educate on health.*

4. How has your work improved the health of mothers and children?

All answers related to project health education messages and strategies.

5. How can the CTC training be improved?

- *More poetry, games, and role-plays.*
- *Would like to see competition between schools added to the project.*
- *We like to have more trainings and contact with SC CTC staff.*
- *Provide incentives to the more active CTC members.*
- *Video films.*

6. What other support have you received as a CTC participant and who provided it?

- *Received flip charts, posters, pins, and notebooks.*
- *Regular monitoring visits from SC staff.*
- *Increased knowledge.*

7. What do you do differently now after having participated in CTC?

- *Named Saturdays as a cleaning day when they clean their village.*
- *Monitor and advise households on sanitation, hygiene, and nutrition.*
- *Check the hands and clothes of school children every week for personal hygiene.*
- *Keep toilets clean.*
- *We are more respected and are listened to by the other children.*
- *Have developed communication and public speaking skills.*

8. What other topics would you like to have training on in the future?

Goiter, cholera, TB, typhoid, diabetes, anemia, hepatitis, and worms.

9. What are the problems you are facing and what are the solutions?

- *Want more frequent health education sessions from SC.*
- *During the summer when schools are closed, the women and children go to the fields to work and the mountains to tend their herds. This makes it more difficult to use CTC to reach them. (Solution: They will invite them after they return to the community in the fall.)*

H. Project Data Sheet Form

General Project Information:

Cooperative Agreement Number:	FOA-A-00-98-00022-00
Project Grant Cycle:	18
Project Dates:	9/30/02-9/29/07
Project Type:	Cost XT
SC HQ Backstop:	Eric Starbuck

Field Program Manager Information:

Name:	Pervez Shaukat
Address:	Save the Children Central Asia Field Office, Dushanbe
Phone:	011-992-372-210771 (Dushanbe) 011-992-3475-53301 /-545395 (Panjikent Project Site)
Fax:	011-992-372-510079 (Dushanbe)
E-mail:	pervezshaukat@hotmail.com

Funding Information:

USAID Funding: (US$) $1,250,000 PVO Match: (US$) $333,300

Project Information:

This is a cost extension for scaling up innovative approaches that will build community and health facility capacity in rural Tajikistan to sustain key investments in essential maternal and child health services. The goals are (1) a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini Districts, and (2) innovative CS-18 strategies contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan. The project interventions include acute respiratory infections, control of diarrheal disease, immunization, maternal and newborn care, and nutrition and micronutrients. The project is implementing these five interventions through the following strategies:

1. Revolving Drug Funds for Village Pharmacies;
2. Health Facility Farms for continuing investments in improving maternal and child health (MCH) services;
3. Joint training and supervision of rural health facility staff;
4. Community mobilization through Village Development Committees;
5. Interactive engagement of local health workers with community groups to promote improved MCH practices; and,
6. Child-to-Child health education.

CS-18 will also introduce the positive deviance approach.

Project Partners:

- MOH at the district and facility levels.

M&E Strategies Planned:

- KPC Survey
- Health Facility Assessment
- Lot Quality Assurance Sampling

Interventions:

Immunization (15%)
- Mobilization
Nutrition (15%)
- Hearth
Vitamin A (1%)
- Integrated with EPI
Other Micronutrients (4%)
- Iodized Salt
- Iron Folate in Pregnancy
Acute Respiratory Infection (15%)
- HF Training
- Pneumonia Case Management
- Recognition of ARI Danger Signs
Control of Diarrheal Diseases (15%)
- HF Training
- Hand Washing
- ORS/Home Fluids
Maternal & Newborn Care (30%)
- HF Training
- Emergency Obstetric Care
- Recognition of Danger Signs
- Newborn Care
- Postpartum Care
- Integration with Iron Folate

- Normal Delivery Care
- Birth Plans
- Emergency Transport
Breastfeeding (5%)
- Promote Exclusive Breastfeeding for the first six months

Target Beneficiaries:

Infants (0-11 months):	7,500
0-59 month old children:	36,000
Women 15-49:	60,000

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Estimated Percentage	95% CI
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age according to the WHO/NCHS reference population).	0	0	0.0%	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	0	0	0.0%	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	81	95	85.3%	7.1
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child.	0	0	0.0%	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	10	27	37%	18.2
Percentage of infants age 6-9 months receiving breast milk and complementary foods	0	0	0.0%	0.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday.	22	25	88%	12.7
Percentage of children age 12-23 months who received a measles vaccine	29	31	93.5%	8.6
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only).	N/A	N/A	N/A	N/A
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment.	0	0	0.0%	0.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	0	0	0.0%	0.0
Percentage of mothers of children 0-23 months who	0	0	0.0%	0.0

cite at least two known ways of reducing the risk of HIV infection.				
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	62	95	65.3%	9.6

Comments for Rapid Catch Indicators:

Weighted averages were used for the percentage estimates, something that this data entry system does not allow.

Attachment I. KPC Survey Questionnaire

KNOWLEDGE, PRACTICE AND COVERAGE (KPC) SURVEY.
MID TERM EVALUTION CS-18 JULY 2005

Informed Consent:

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

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

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

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED á END

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

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

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

INTERVIEWER'S NAME: _____

SUPERVISOR'S NAME: _____

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

VILLAGE: _____ ETHINIC GROUP: _____

NAME OF THE HEAD OF THE HOUSEHOLD: _____

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

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

		FAMILY MEMBER TRAINED ..…… G FAMILY MEMBER UNTRAINED ….H OTHER: _____ X (Specify) MYSELF…..…… Y DON'T KNOW…… Z	
7	Where was (NAME) put immediately after birth?	WITH MOTHER…… 1 IN COT……... 2 ON FLOOR……...…. 3 BATHED…… 4 OTHER: _____ 6 (Specify) DON'T KNOW……..…… 8	
A3-	**Postpartum Period:**		
8	How many days or weeks after the delivery did the first check take place? RECORD '00' DAYS WITHIN 8 HRS.	HOURS AFTER DELIVERY_____ DAYS AFTER DELIVERY_____ WEEKS AFTER DEL._____ NEVER ---------- 996 DON'T KNOW _____ 998	< 10 < 10
9	During your postpartum check, were you counseled on the following: Family planning? Infant nutrition? Breastfeeding? Child Immunization? Infant diarrhea? Early signs of pneumonia?	**YES NO** Family planning 1 2 Infant nutrition 1 2 Breastfeeding 1 2 Child Immunization 1 2 Danger signs of diarrhea 1 2 Danger signs of pneumonia 1 2	
10	What are the signs of danger after giving birth indicating the need for you to seek health care?	FEVER……...…. A EXCESSIVE BLEEDING……..…. B SMELLY VAGINAL DISCHARGE… C CONVULSIONS/FITS……..D DON'T KNOW…….. Z	
11	At that time, did the person check on (NAME)'s health as well?	YES……. 1 NO……...…. 2	
12	What are the signs to watch for that may indicate that a newborn baby is ill? RECORD ALL MENTIONED	POOR FEEDING…….. A FAST BREATHING……. B NOT ACTIVE……C REDNESS AROUND THE CORD….. D RED/DISCHARGING EYE……..E OTHER: _____ X (Specify) DON'T KNOW……..…… Z	
B	**Breastfeeding & Infant/ Child Nutrition:**		
13	Did you ever breastfeed (NAME)?	YES…… 1 NO…….. 2	á **16**
14	How long after birth did you first put (NAME) to the breast?	WITHIN FIRST HOUR……. 1 WITHIN FIRST 8 HOURS…… 2 AFTER FIRST 8 HOURS…….. 3	
15	Are you breastfeeding (NAME) now?	YES…… 1 NO…….. 2	

16	Now I would like to ask you about the types of liquids (NAME) consumed yesterday during the day or at night. Did (NAME) have……ASK THE LIST BELOW A. Plain water? B. Commercially produced infant formula? C. Any other milk such as tinned, powdered, or fresh animal milk? D. Fruit juice? E. Any other liquids such as sugar water, flavored water, tea, carbonated drinks, infusion, soup broth?	**CONSUMED IN LAST 24 HOURS** A. _____ B. _____ C. _____ D. _____ E. _____	
17	Now I would like to ask you about the types of foods (NAME) consumed yesterday during the day or at night. Did (NAME) have……. ASK THE LIST BELOW F. Any food made from grains [maize, rice, wheat, porridge, or other local grains]? G. Pumpkin, carrots, or red sweet potatoes? H. Any other food made from roots or tubers [e.g. white potatoes, white yams, cassava, or other local roots/tubers]? I. Any green leafy vegetables? J. Local Vitamin A rich fruits? K. Any other fruits and vegetables [e.g. melon, apple, pears, tomatoes, pomegranates] L. Meat, poultry, fish or eggs? M. Any food made from legumes [e.g. lentils, beans, soyabeans, pulses, or peanuts]? N. Cheese or yoghurt? O. Any food made with oil, fat or butter?	**CONSUMED IN LAST 24 HOURS** F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ M. _____ N. _____ O. _____	
18	May I see the salt that is used for cooking? ASK FOR THE PACKET AND SEE THE LABEL OF IODIZED SALT. Spot test with a testing kit Record color change: encircle one	**YES NO Don't Know** Sample 1: Iodized (from Label) 1 2 3 Color Change: 0% ---7%---15%----30% or more Sample 2: Iodized (from Label) 1 2 3 Color Change: 0% ---7%---15%----30% or more Sample 3: Iodized (from Label) 1 2 3 Color Change: 0% ---7%---15%----30% or more	
C	**Immunization:**		
19	Do you have a card where (NAME's) vaccinations are written down? IF YES: May I see it please?	YES, SEEN…… 1 YES, LOST IT..…….. 2 NEVER HAD A CARD..…….. 5	á **21** á **21**
20	(1) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD. BCG POLIO 0 (Polio given at birth) POLIO 1 POLIO 2	**DAY MONTH YEAR** _____/_____/_____BCG _____/_____/_____Polio 0 _____/_____/_____Polio 1 _____/_____/_____Polio 2	

	POLIO 3 DPT 1 DPT 2 DPT 3 MEASLES	_____/_____/_____Polio 3 _____/_____/_____DPT 1 _____/_____/_____DPT 2 _____/_____/_____DPT 3 _____/_____/_____Measles	
21	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?	YES…… 1 NO…….. 2 DON'T KNOW…….. 8	á **23** á **23**
22	Please tell me if (NAME) received any of the following vaccinations. 22A- A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar? 22B- Polio vaccine, that is, drops in the mouth? 22C- When was the first polio vaccine received, just after birth or later? 22D- How many times was the polio vaccine received? 22E- DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops? 22F- How many times? 22G- An injection to prevent measles?	YES…… 1 NO……...…….. 2 DON'T KNOW…….. 8 YES…… 1 NO…… 2 DON'T KNOW…….. 8 JUST AFTER BIRTH…….. 1 LATER…….. 2 NUMBER OF TIMES _____ YES……..…… 1 NO…….. 2 DON'T KNOW…….. 8 NUMBER OF TIMES _____ YES……..… 1 NO…….. 2 DON'T KNOW…….. 8	á **22E** á **22E** á **22G** á **22G**
D	**Diarrhea:**		
23	Has (NAME) had diarrhea in the last 2 weeks?	YES……..… 1 NO…….. 2 DON'T KNOW…….. 8	á **28** á **28**
24	When (NAME) suffered from diarrhea, from whom did you seek advice or treatment? **SELECT ONE OF THE RESPONSE:**	GOVT. HEALTH FACILITY STAFF…… A PRIVATE PRACTITIONERS (qualified)…….. B PRIVATE PRACTITIONERS (non-qualified)... C TRADITIONAL HEALERS…….... D SELF…….E DON'T KNOW…… F	
25	What type of treatment was provided to your child, by the (above mentioned) health care provider? **RECORD ALL MENTIONED.**	ORS ……..……... A (I.V) INTRAVENOUS FLUIDS…… B ANTI-DIARRHEAL DRUGS…… C RESTRICTED DIET…….. D OTHER:_____ X (Specify)	

26	When (NAME) had diarrhea, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS…… 1 SAME…….. 2 MORE……..…. 3 NOTHING TO DRINK…….... 4 DON'T KNOW..……..…….... 5	
27	Was (NAME) offered less than usual to eat, about the same amount, or more than usual to eat?	LESS…… 1 SAME…….. 2 MORE……..…. 3 NOTHING TO EAT….……... 4 DON'T KNOW..……..…….... 5	
28	If your child suffers from diarrhea, which danger signs will prompt you to seek treatment or advice? **RECORD ALL MENTIONED.**	DIARRHEA …….... A DIARRHEA AND VOMITING…… B DIARRHEA AND FEVER…….. C DIARRHEA WITH BLOOD…….. D DIARRHEA LASTING MORE THAN 14 DAYS .. E LETHARGY……...…. F UNABLE TO DRINK……..…G UNCONSCIOUSNESS…….. H OTHER:_____ X (Specify)	
29	Does your household have a special place for hand washing?	YES……...…. 1 NO…….. 2	á **31**
30	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF EACH OF THE FOLLOWING ITEMS ARE PRESENT.	**YES NO** (I) WATER/TAP 1 2 (II) SOAP, ASH OR OTHER CLEANSING AGENT 1 2 (III) BASIN 1 2	
31	When do you usually wash your hands with soap or ash? **RECORD ALL MENTIONED.**	BEFORE FOOD PREPARATION……...…. A BEFORE EATING…… B BEFORE FEEDING CHILDREN…… C AFTER DEFECATION…… D AFTER ATTENDING TO A CHILD WHO HAS DEFECATED…… E NEVER…….. F OTHER:_____ X (Specify)	
E	**Acute Respiratory Infections (ARI):**		
32	Has (NAME) had an illness with a cough at any time in the last two weeks?	YES……...…. 1 NO……..…. 2 DON'T KNOW……. 8	á **35** á **35**
33	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, fast breaths?	YES……...…..… 1 NO…….. 2 DON'T KNOW…….. 8	á **35** á **35**
34	Did you seek advice or treatment for the cough/ fast breathing?	YES……...…. 1 NO…….. 2	
35	Sometimes children get sick and need to receive care or treatment for illness. What are the signs of illness that would indicate your child needs treatment? **DO NOT PROMPT. CIRCLE ALL MENTIONED.**	COUGH WITH FEVER……... A FAST BREATHING……. B DIFFICULT BREATHING……..…. C CHEST INDRAWING..……D CONVULSIONS…….. E WHEEZE…….. F CHRONIC COUGH…… G MEASLES…… H	

	CHECK WITH TRANSLATION	WHOOPING COUGH…… I LOOKS UNWELL OR NOT PLAYING NORMALLY ……. J NOT EATING OR DRINKING ……..…K LETHARGIC OR DIFFICULT TO WAKE……... L DON'T KNOW……. M OTHER:_____ X (Specify) OTHER:_____ X (Specify) OTHER:_____ X (Specify)	
36	When (NAME) was sick, was he/she offered less than usual to drink, about same amount, or more than usual to drink?	LESS……..…… 1 SAME……..…….. 2 MORE……..……..…. 3	
37	Was (NAME) was sick, offered less than usual to eat, about the same amount, or more than usual to eat?	LESS……..…… 1 SAME……..…….. 2 MORE……..……..…. 3	
H	**HIV & Other STDs:**		
38	Have you ever heard of an illness called AIDS?	YES……..…. 1 NO…….. 2	
39	(Apart from AIDS), have you heard about (other) infections that can be transmitted through sexual contact?	YES……..…. 1 NO…….. 2	á **43**
40	In a man, what signs and symptoms would lead you to think that he has such an infection? Any others? **RECORD ALL MENTIONED.**	ABDOMINAL PAIN…… A GENITAL DISCHARGE/ DRIPPING…….. B FOUL SMELLING DISCHARGE…… C BURNING PAIN ON URINATION……. D REDNESS/ INFLAMATION IN GENITAL AREA……. E SWELLING IN GENITAL AREA…….. F GENITAL SORES/ ULCERS…… G GENITAL WARTS…… H BLOOD IN URINE…… I LOSS OF WEIGHT…… J IMPOTENCE……. K NO SYMPTOMS…… L OTHER:_____ W (Specify) OTHER:_____ X (Specify) DON'T KNOW……. Z	
41	In a woman, what signs and symptoms would lead you to think that he has such an infection? Any others? **RECORD ALL MENTIONED.**	ABDOMINAL PAIN…… A GENITAL DISCHARGE……B FOUL SMELLING DISCHARGE…… C BURNING PAIN ON URINATION……. D REDNESS/ INFLAMATION AND ITICHING GENITAL AREA…….. E SWELLING IN GENITAL AREA…….. F GENITAL SORES/ ULCERS…… G GENITAL WARTS…… H BLOOD IN URINE…… I LOSS OF WEIGHT…… J INABILITY TO GIVE BIRTH…..……. K	

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

Attachment J. Results of the Tajikistan CS-18 MTE KPC Survey Using LQAS

Coverage & Lot-Specific Results of the Tajikistan CS-18 Midterm KPC Survey Using Lot Quality Assurance Sampling (LQAS)

Result/Inter-mediate Result	Ind. # in DIP	Interv.	Indicator [indicator source **]	Site-wide Baseline Coverage	Site-wide EOP Target	MTE LQAS: Coverage, & Total Correct, Sample Size, & Decision Rule by Lot*					
						Coverage@	1	2	3	4	5
R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent & Aini districts.	1	MNC	% of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.[1,(3)]	53% (1+ = 92%)	80%	Un-Wtd.: 95% Weighted: 94%	19 19 13	17 19 13	19 19 13	18 19 13	17 19 13
	2	MNC	% of 0-23 month olds whose birth was attended by skilled health personnel.[1,3]	85%	90%	**85%** **86%**	17 19 15	17 19 15	**13** 19 15	17 19 15	17 19 15
	3	Nutr.	% of 0–5 month olds exclusively breastfed during the last 24 hours.[3]	12%	50%	**(37%)** **!! (46%)**	0 4 NA	3 7 NA	1 2 NA	2 10 NA	4 4 NA
	4	EPI	% of 12-23 month olds who received a measles vaccine (by maternal history. Measles vaccine is now given from age 12 months.) [(1),3]	67%	80%	(94%) (94%)	6 6 NA	5 5 NA	6 6 NA	5 6 NA	7 8 NA
	5	EPI	% of 12-23 month olds with cards, fully immunized.[(3)] (Measles vaccine is now given from age 12 months.)	71%	70% ***	(88%) (89%)	6 6 NA	4 4 NA	4 5 NA	4 5 NA	4 5 NA
	6	ARI CDD	% of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.[(3)]	30%	60%	(100%) (100%)	5 5 NA	9 9 NA	9 9 NA	5 5 NA	8 8 NA
	7	CDD	% of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.[3]	19%	40%	65% 64%	16 19 5	9 19 5	12 19 5	14 19 5	11 19 5
	8	Nutr.	% of households with children <2 which have only iodized salt for cooking.	10%	50%	74% 72%	16 19 7	14 19 7	17 19 7	13 19 7	10 19 7
IR-1: Increased household level **knowledge** of selected MCH issues.	*13*	MNC	% of mothers who know 2+ postpartum danger signs.[3]	53%	70%	100% 100%	19 19 11	19 19 11	19 19 11	19 19 11	19 19 11
	14	MNC	% of mothers who know 2+ newborn danger signs.[3]	51%	70%	100% 100%	19 19 11	19 19 11	19 19 11	19 19 11	19 19 11
	15	ARI	% of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.[(1)]	27%	60%	**58%** **56%**	13 19 9	**8** 19 9	12 19 9	14 19 9	**8** 19 9
	16	CDD	% of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.[(1)]	15%	60%	**26%** **25%**	**5** 19 9	**5** 19 9	**6** 19 9	**7** 19 9	**2** 19 9

* The LQAS survey was conducted in communities covered to date by CS-18. **Decision rule** for each lot is based on the end of project target set for each indicator.

@ **LQAS coverage:** Un-weighted mean over mean weighted by lot population size (1: 44,000; 2: 49,000; 3: 36,000; 4: 34,000; 5: 54,000). **Parentheses** indicate small sample size & wide confidence intervals.

** **Indicator source**: **1**: CS-14; **2**: BASICS HFA; **3**: KPC 2000 / 2000+ / CATCH; ( ) = indicator revised

***** EOP target** set the same or lower than baseline because baseline value refers only to the smaller CS-14 site (where EPI cards were available), and the target applies to the substantially larger CS-18 site/population, with implementation through the MOH, with less intensive SC involvement than was the case in CS-14.