



CS-19 Afghanistan Second Year Annual Report

*Provincial Strengthening in Northern Afghanistan:
Capacity Building and Innovation to Support the Basic Package of Health
Services and Sustainably Improve Access, Quality and Use of Essential MCH
Services throughout Jawzjan Province*

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Prepared and Edited by:

Dr. Mohammad Honey, CS-19 Coordinator, SC/US, Afghanistan
Dr. Aftab Tariq Ihsan, Health Advisor, SC/US, Afghanistan
Lynn Robson, Program Manager, Balkh and Jawzjan, SC/US, Afghanistan
Leslie F. Wilson, Field Office Director, SC/US, Afghanistan
Kathryn Bolles, Child Survival Specialist, SC/US, Westport
Sharon Lake-Post, Information and Documentation Specialist, SC/US, Westport

Submitted by:

Save the Children Federation, Inc.
54 Wilton Road
Westport, CT 06880
Telephone: (203) 221-4000
Fax: (203) 221-4059

Contact Person:

Kathryn Bolles, MPH, Child Survival Specialist

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GLOSSARY OF ACRONYMS AND TERMS

ANC	Antenatal Care
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin/Tuberculosis Vaccine
BPHS	Basic Package of Health Services (of the Afghanistan Minister of Public Health)
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CHC	Community Health Committee
CHW	Community Health Worker
CME	Community Midwifery Education
CS	Child Survival
DIP	Detailed Implementation Plan
DPT3	Diphtheria-Pertussis-Tetanus Vaccine
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
FOD	Field Office Director
GMP	Growth Monitoring and Promotion
HF	Health Facility
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNC	Maternal and Newborn Care (CS-18 intervention)
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NERS	Nutrition Education and Rehabilitation Session
NGO	Non-governmental Organization

NID	National Immunization Day
OPD	Out-patient Department
ORS/ORT	Oral Rehydration Solution/Oral Rehydration Therapy
PD/PDI	Positive Deviance/Positive Deviance Inquiry
PDQ	Partnership Defined Quality
PEMT	Provincial EPI Management Team
PHC	Provincial Health Council
PHCC	Provincial Health Coordinating Committee
PHO	Provincial health Office of the MoPH
PRR	Provincial Rehabilitation Reform
REACH	Rural Expansion of Afghanistan's Community-based Healthcare Program
RH	Reproductive Health
SC/US	Save the Children Federation, Inc.
SC/UK	Save the Children United Kingdom
TA	Technical Assistance
TOT	Training-of-Trainers
TT	Tetanus Toxoid
UNICEF	United nations Children's Fund
USAID	United States Agency for International Development
USAID REACH	USAID-funded Rural Expansion of Afghanistan's Community-based Healthcare
WHO	World Health Organization

Year 2 of the Save the Children Federation, Inc. (SC/US) CS-19 project in Afghanistan has progressed according to the work plan, with ongoing successes in building relationships with provincial partners, programmatic innovations, and synergies with existing and emerging USAID-funded government programs.

A. PROGRAM ACCOMPLISHMENTS

1. Immunization

Immunization sessions are carried out six days a week through USAID REACH supported health facilities (HFs). Each of the 20¹ clinics in the project impact area has two or three vaccinators; one who conducts immunization sessions at the clinic while others conduct outreach. During this reporting period, CS-19 staff and the Ministry of Public Health (MoPH) Provincial Health Office (PHO) team worked together to strengthen the capacity of staff working at 15² HFs supported by the USAID REACH program.

1.1. Immunization coverage data collection support to PHO

Each facility submits EPI reports to the Provincial EPI Management Team (PEMT) monthly. Subsequently, the CS-19 EPI officer, Dr. Rehmatullah, and the MoPH's Provincial EPI Management team (PEMT) manager, Dr. Yasin, review the reports, analyze the data and prepare feedback, which includes coverage rates for each antigen, drop-out rates between DPT 1 and DPT 3 and overall drop-out rates between BCG vaccine and measles vaccine. The following table shows progress made in childhood immunization and TT vaccination of pregnant women:

Years³	BCG	DPT3	Polio3	Measles	TT2 pregnant
2004	49%	54%	57%	49%	44%
2005	51%	68%	68%	54%	62%

1.2. Monitoring and supervision

During the reporting period, the CS-19 EPI officer and the PEMT manager conducted 140 monitoring visits to 20 HFs in Jawzjan Province and the Andkhy cluster of districts in nearby Faryab Province (14 USAID REACH supported and 6 MoPH supported HFs). Monitoring was conducted with the help of the EPI checklist, and a summary of 40 checklists showed the following about the clinics:

- 100% have good quality cold chain maintenance;
- 100% conduct immunization sessions;
- 90% conduct outreach sessions as per schedule;
- 60% have drop-out rates less than 10%;
- 100% have community maps;
- 80% have immunization work-plans posted;
- 100% have adequate supplies of vaccines (no stock-out reported); and
- 100% encourage Community Health Workers (CHW) to follow up with defaulter children and refer them to the clinics or outreach.

¹ Seven managed by Save the Children USA, seven by Save the Children UK, six by the Ministry of Public Health.

² Seven clinics and one district hospital by SC/US and seven clinics by SC/UK.

³ 2004 data is for 12 months and 2005 data is for 9 months.

Regarding vaccinators:

- 90% had joined a three-day EPI update training course;
- 80% have good knowledge of EPI registration and reporting;
- 80% know how to calculate their targets and coverage rates; and
- 95% conduct counseling sessions for caregivers before and after vaccinating children.

Disease surveillance (e.g., polio, measles) continues to be the crucial part of the EPI program. Every month the USAID REACH supported clinics collect disease surveillance reports from CHWs and submit compiled reports to WHO and MoPH. The CS-19 EPI officer and PEMT manager continue to strengthen this surveillance during their monitoring and supervision visits. No outbreak of measles was reported during this reporting period.

Every month, during a one-day meeting, the results of the monitoring and supervision visits are shared with all the stakeholders (SC/US, SC/UK, MoPH) and used to develop plans to further strengthen EPI activities.

1.3. EPI microplan meetings

In December 2004 and April 2005, the CS-19 EPI officer together with UNICEF, SC/UK and MoPH staff conducted two, three-day workshops to develop microplans for seven districts covered by SC/US BPHS management through USAID REACH. The PEMT manager, vaccinators, the heads of clinics and the USAID REACH coordinator attended these workshops, which resulted in microplans for 1) strategies to improve immunization coverage; 2) projecting resources/supplies required to implement the microplan and 3) community mobilization. Please see Annex 1 for April 2005 microplans.

1.4. Training and capacity building

In addition to regular capacity building that is part of monitoring and supervision, during this reporting period, the CS-19 EPI officer, in December 2004, conducted one 10-day training session for 15 vaccinators working in the USAID REACH supported clinics, two USAID REACH senior officers, and three PEMT cold chain technicians. The training course focused on: EPI target diseases; vaccines and administration techniques; cold chain maintenance; EPI registration and reporting; EPI targets, coverage, drop-out calculation and their application and EPI target disease surveillance.

Women continue to face problems accessing Maternal Newborn Care (MNC) services; especially receiving the Tetanus-Toxoid (TT) vaccine. One reason for low female and child vaccination rates is the lack of female vaccinators. SC/US's previous experience (from Andkhoy PHC program) shows that the presence of female vaccinators can improve TT coverage to as high as 69%. Experience also shows that women with basic literacy skills can be qualified as vaccinators. As a result CS-19, USAID REACH and MoPH staff held meetings with community leaders to identify female vaccinator candidates, which led to 12 women being recruited for an 11-day EPI training course tailored to train them using pictorial training, reference and reporting materials, and related, relevant practical sessions.

1.5. Support for National Immunization Days (NIDs)

Since October 2004, CS-19 has supported the PEMT in five rounds of NIDs that focused on providing polio drops to all <5 children, and complementing the drops with one high dose of vitamin A. CS-19 staff helped the PEMT train NID volunteers by supporting them in developing microplans for the days, conducting monitoring and supervisory visits to all community sites (through CS-19 MCH promoters) during NIDs and providing logistic support to transport polio vaccine, vitamin A, carrier boxes and other supplies.

1.6. Development of health education materials and messages

The CS-19 BCC officer working with the PEMT and CS-19 EPI officer developed EPI messages and pictorial materials to create community awareness and knowledge regarding the importance of childhood immunization and TT vaccination. Messages and supporting materials have been shared with staff at the 14 HF's supported by USAID REACH. The messages are:

- Vaccines protect your child from diseases (TB, polio, measles, diphtheria, pertussis and tetanus).
- Make sure your child receives five vaccinations before s/he is one year old.
- Your child's vaccination card is her/his access to good health – keep it safe.
- It is normal for child who receives a vaccine to develop fever and pain at the injection site. This shows that vaccines are working, so you should not worry.
- Protect yourself from tetanus; get at least two tetanus vaccinations.
- Pregnant women must get at least two doses of TT vaccine.

Messages and materials were also developed for NIDs to promote community awareness and understanding regarding the importance of polio vaccination. Handouts with key messages were distributed at public places such as bazaars, mosques and to Community Health Council (CHC) members.

2. Nutrition and Micronutrients

2.1. Nutrition Education and Rehabilitation (NERS)

Between May and June 2005, CS-19 staff began a pilot of the Hearth model using the Positive Deviance Inquire (PDI) approach to identify and share local positive weaning and nutrition practices that contribute to child health⁴. PD/Hearth was piloted in one village, Afghan Tapa, in rural Shiberghan District, which was selected through village level discussions with the MoPH based on the following criteria:

- Supportive CHC members in the village;
- MoPH staff were willing to support PD/Hearth activities in the facility catchment area by providing treatment and referral services to children referred from PD/Hearth sessions
- MoPH offers immunization and other child focused health services in the community (ARI, CDD, micronutrients), which will maintain sustained follow-up with PD/Hearth-attending children;

⁴ Lessons learned from this initiative will inform national Growth Monitoring and Promotion (GMP) strategy, especially those lessons that involve community-based programs. At a GMP national strategy meeting held in Kabul in March 2005 decided GMP will not be implemented as a national program at this time due to inadequate capacity at the peripheral health facility level to support monthly contact, measurement and counseling. Instead the long-term strategy is to explore the feasibility of expanding IMCI, once established, to include GMP in clinics and community-based programs.

- Out-patient department (OPD) records show a significant number of malnourished <5 children registered; and
- Village residents were mostly poor.

Following the selection of the pilot area, MoPH staff and CHC members were orientated to the importance of (1) a nutritional survey alongside the PDI, (2) the PD/Hearth model, (3) selection of volunteers, and (4) CHC members' role in this initiative. With the help of CHC members and MoPH staff, the CS-19 behavior change communication (BCC) officer selected eight health volunteers⁵ for a two-day training about malnutrition, weaning practices and the PDI approach with the goal of increasing their understanding of the concept and to enlist their support for the initiative.

The main reason to involve community volunteers in the initiative was to ensure peer motivation for the mothers/caregivers with malnourished children who attended Hearth sessions. The volunteers provided guidance to mothers/caregivers in meal preparation and feeding their children, and also maintained pictorial records and reports. (These roles were explained during volunteer trainings and were reinforced during all PD/Hearth sessions.)

In June 2005 the SC/US health advisor and CS-19 coordinator facilitated a ten-day training on the PD/Hearth approach for CS-19 staff including BCC, MNC, IMCI officers, the MoPH nutrition officer and six CS-19 MCH promoters. Please see Annex 2 for the PD/Hearth training outline. The objectives of this training were to (1) enhance participants' understanding of the PD approach, its terminology and ways it can be used to create behavior change; (2) develop plans to introduce the concept to communities and explain how PD might improve the nutritional status/weaning practices of mothers; (3) enhance skills of MCH promoters to conduct nutritional surveys using Salter's Scale; (4) enhance knowledge and skills regarding PDI; and (5) develop the ability to use PDI data to compare practices (child nutrition, child care and health care seeking behavior) among participating families and select PD food and practices. The training also aimed to enhance knowledge and skills of participants on how to conduct Hearth sessions. Participants also learned how to develop energy-dense menus and monitoring and evaluation (M&E) plans for PD/Hearth activities. The following activities were carried out after the training:

- 100% of children (270) 6-36 months of age were weighed using weight-for-age measurements: 37% of the children were moderately malnourished (-2 SD) and 6% were severely malnourished (<-3 SD).
- PDI was conducted with four PD families and two non-PD families.
- Data tabulation and analysis was conducted, and PD foods and behaviors were identified.
- Four energy-dense menus were developed and used during Hearth sessions.
- Health education topics including nutrition and weaning, breastfeeding, personal hygiene, ARI, diarrhea and immunization were selected, and lessons planned for NERS
- Eleven, 11-day PD/Hearth sessions were held between July and September 2005 for a total of 99 children.

⁵ The following criteria were used to select volunteers: female, married, mothers preferred; accepted by community members; may or may not be a government employee; may or may not be literate, but must be highly motivated, i.e., eager to learn and open to new ideas; willing to work as a volunteer.

- 90% of participating children showed weight gain between 400gms and 700gms after 12 days of the first Hearth cycle. See Annex 3 for combined results of 11 PD/Hearth sessions.
- Health volunteers made home visits to all children enrolled in the Hearth program to support their mothers to continue the practice of giving PD foods/menus.
- CS-19 maternal and child health (MCH) promoters conducted a total of 120 home visits targeting mothers who continued to face problems feeding their malnourished child.

2.2. Promotion of household use of iodized salt

To promote the use of iodized salt, CS-19 staff used UNICEF IEC/health education materials, which were distributed to all USAID REACH supported facilities. With help from UNICEF and the MoPH, CS-19 staff helped develop two campaigns on iodized salt. Additionally, messages about the importance of iodized salt were integrated in ARI, CDD, MNC and EPI trainings and community health education activities like birth planning education sessions, CHW trainings and PD/Hearth sessions. Clinic-based reproductive health (RH) assistants were trained to give these messages during antenatal care and postpartum visits. CS-19 staff encouraged MoPH staff to disseminate messages through health talks on TV; and 400 flyers were distributed through 18 of 22 HFs. Further, the CS-19 BCC officer attended 13 meetings with CHC members to disseminate messages.

2.3. Breastfeeding

The CS-19 BCC officer collected and disseminated UNICEF breastfeeding health education materials (posters and handouts) and developed additional messages. Breastfeeding education was incorporated within MNC, ARI, CDD, birth planning trainings and NERS. Breastfeeding messages included in the promotion were these:

- Exclusive breastfeeding up to six months;
- Breastfeeding on baby's demand and adequate maternal nutrition and fluid intake increase breast milk production;
- Breastfeeding initiated within one hour after delivery; and
- Breastfeeding should be continued for two years, with appropriate introduction of complementary foods.

3. Control of Diarrheal Diseases (CDD)

Control of diarrheal disease (CDD) is a component of the MoPH's Basic Package of Health Services (BPHS) integrated management of childhood illness (IMCI) intervention, CS-19 and MoPH PHO teams support CDD by training USAID REACH supported clinic staff and CHWs, developing health education materials, setting up oral rehydration therapy (ORT) corners in clinics and strengthening healthcare workers' CDD activities through joint monitoring and supervision. CDD activities were also conducted in the six MoPH supported villages (non-REACH areas) in Shiberghan district.

3.1. CDD trainings

In April 2005, the CS-19 IMCI officer and an MoPH pediatrician conducted a three-day training of trainers (TOT) CDD training course for 11 participants: nine MoPH pediatricians from the

Shiberghan Provincial Hospital; four MoPH doctors working in rural Shiberghan District villages; and one training officer from SC/UK. The topics of the CDD training were diarrhea prevention with emphasis on hand washing and home care (including ORT, continued feeding and breastfeeding, and increased feeding), assessment and classification of levels of dehydration, recognition of danger signs (dehydration, bloody diarrhea, persistent diarrhea), recommended management protocols, importance of effective caregiver's counseling, community education including campaigns/messages, management of oral rehydration solution (ORS) supplies and other essential drugs, monitoring and supervision (use of checklists⁶) and health management information system (HMIS). See Annex 4 for an outline of CDD training.

3.2. Monitoring and supervision

The CS-19 IMCI officer and MoPH pediatrician conducted quarterly joint monitoring and supervision to ensure that CDD program is being implemented effectively. They used observation checklists to assess the quality of diarrhea case management and exit interviews to assess the quality of caregiver's counseling. Results of combined observation of sick child management showed that for children with diarrhea:

- 78% of trained health workers asked for signs that indicate severe disease (versus 6% at baseline);
- 90% of health workers performed all six examination tasks (versus 1% at baseline);
- 88% were correctly assessed (degree of dehydration) (versus 30% at baseline); and
- 75% received appropriate treatment (versus 35% at baseline).

For caregivers:

- For 88% of caregivers, health workers explained how to prepare ORS (versus 35% at baseline);
- 63% were able to demonstrate how ORS is prepared (versus 14% at baseline);
- For 74% of caregivers, health workers described danger signs and advised when to return to the clinic if they appear – 8% at baseline;
- 75% received advice to give more liquid at home (versus 10% at baseline); and
- 75% received advice to continue to breastfeed (versus 13% at baseline).

Results of combined exit interviews show that, for caregivers:

- 87% know how to give ORS at home (versus 65% at baseline);
- 43% know when to return for follow-up (versus 35% at baseline);
- 43% know signs indicating that a child's health is declining at home (versus 35% at baseline);
- 94% knew that hand washing after defecating prevents diarrhea (versus 71% at baseline); and
- 60% knew that hand washing before preparing food for children prevents diarrhea (versus 60% at baseline).

⁶ Once every three months, BASICS checklists (observation and exit) will be used to monitor provider skill and quality of care. CS-19 works with the PHO counterparts in joint supervision and monitoring, with feedback to USAID REACH managers.

Results of these monitoring and supervision visits are shared with all the stakeholders (SC/US, SC/UK, MoPH) and used to develop plans to further strengthen activities for the integrated management of childhood illness (IMCI) activities.

3.3. CDD health education materials

The CS-19 IMCI officer, and REACH and MoPH staff developed BCC messages for caretakers regarding danger signs, home care, including ORS preparation, and prevention including hygiene. All training materials were translated into Dari and distributed to all trainees. Pictorial messages (posters) were developed and distributed to all HFs, and handouts and banners were developed and distributed during CDD and cholera campaigns.

4. Pneumonia Case Management

Management of acute respiratory infections (ARI) is a component of BPHS IMCI intervention, which CS-19 and MoPH PHO teams support through (1) ARI trainings to the USAID REACH supported clinic staff and CHWs, (2) development of health education materials, and (3) strengthening health workers' response to ARI through joint monitoring and supervision. ARI management was also supported in the six MoPH supported villages (non-REACH areas) in Shiberghan District.

4.1. ARI trainings

In November 2004, the CS-19 IMCI officer and a MoPH pediatrician conducted a three-day ARI training course for 16 participants: five pediatricians at Shiberghan and Andkhoy hospitals, seven MoPH doctors from peripheral facilities, one USAID REACH senior health officer, one MoPH trainer and two CS-19 health officers. Training topics included types of ARI, complications of ARI/pneumonia, ARI assessment and classification, ARI management, caregiver counseling, practicing counting breath rates in an OPD setting, home care, follow-up and M&E. See Annex 5 for training outline.

In December 2004, a three-day TOT ARI course was held for seven CS-19 MCH promoters. The training topics included common cold and pneumonia, counting breath rates and looking for chest indrawing, caregiver counseling, home care, follow-up and referral, community education campaigns (incorporating traditional beliefs about ARI) and CHW trainings. Following this TOT, MCH promoters conducted two trainings for 28 CHWs.

4.2. Monitoring and supervision

The CS-19 IMCI officer and MoPH pediatrician conducted quarterly joint monitoring and supervision in SC/US and SC/UK USAID REACH supported HFs to ensure that ARI intervention is being implemented effectively. They used observation checklists to assess the quality of ARI case management and conducted exit interviews to assess the quality of caregiver counseling. The combined results of these checklists revealed the following about children suffering from ARIs:

- in 64% of cases, health workers asked for signs indicating severe disease (versus 6% at baseline);
- in 37%, health workers carried out all four examination tasks (versus 4% at baseline); and
- in 55%, correct medication for diagnosis was provided (versus 47% at baseline).

Regarding caregivers:

- For 43% of caregivers, health workers explained how to administer medication at home (versus 35% at baseline);
- For 43% of caregivers, health workers explained when to return for follow-up (versus 8% at baseline);
- 64% of caregivers received advice regarding increased fluid intake (versus 10% at baseline); and
- 73% of caregivers with children under two years old received advice to continue breastfeeding children with ARI (versus 13% at baseline).

Exit interviews of caregivers:

- 54% caregivers knew how to give medicines to a child with ARI at home (versus 56% at baseline);
- 31% caregivers knew when to return for a follow-up (not measured separately for ARI at baseline);
- 16% knew what signs to look for to note a decline in a child's condition at home (not measured separately for ARI at baseline); and
- 55% knew that a child with ARI (6 months and above) needs extra fluids at home (versus 45% at baseline).

CS-19 would like to see significant improvement in several of these indicators. Results of these monitoring and supervision visits are shared with all the stakeholders (SC/US, SC/UK, MoPH) and used to develop a work plan to strengthen health worker capacity to recognize, diagnose and effectively treat ARI, and to increase caregivers' capacity to recognize danger signs in children.

4.3. ARI health education materials

The CS-19 IMCI officer, USAID REACH and MoPH staff reviewed and developed BCC messages for caretakers regarding ARI danger signs, home care including how to give medicines at home as per doctor's advice and when to return to the health provider. Training materials were translated into Dari and distributed to all trainees. Pictorial messages were developed into posters, and handouts and banners were developed as well, and all were distributed to HFs.

4.4. Community Case Management (CCM)

Since one key CHW role is to treat children suffering from respiratory infections, and to refer those suffering from pneumonia to HFs, SC/US deployed CS-19 MCH promoters to conduct ARI/CDD trainings for all CHWs in Jawzjan Province and the Andkhoy cluster. As per MoPH policy, these CHWs are supplied with pediatric Cotrimoxazole and Paracetamol to provide only the first dose to children suffering from pneumonia and refer those identified as suffering from pneumonia/severe pneumonia. Community Case Management (CCM) through CHWs is an intervention of CS-19 which is being piloted in the two remote villages of Qarqin and Qaramqol districts. The main aim of this research is to enhance the knowledge and skills of CHWs in sick child management, especially increase their skills to treat children suffering from pneumonia⁷

⁷ CHWs will not treat children suffering from severe pneumonia. For such children they will give first dose of Cotrimoxazole and refer them to the nearest health facility.

with a complete course of Cotrimoxazole. The research will document the results of CHW training, their skills in sick child management, supervision and monitoring, and use of pictorial reporting and referral forms.

In March 2005, five CHWs were trained in Qaramqol (Yousafi village) and five CHWs in Qarqin (Kawk village) on how to assess a child with diarrhea, classify dehydration and how to administer ORT. Between April and August 2005 CHW treated and referred the following number of children:

- CHWs in Kawk village treated 1,263 children with acute watery diarrhea at home and referred 306 children with severe dehydration and 165 children with bloody diarrhea to the HF.
- CHWs in Yousafi village treated 734 children with acute watery diarrhea at home and referred 76 children with severe dehydration and 49 children with bloody diarrhea to Qarqin basic health center.

In November 2005, CHWs will be trained on pneumonia case management. The training will focus on key ARI assessment, examination and classification tasks, counting breath rates using a stop watch, measuring the correct dose of Cotrimoxazole and Paracetamol, caregiver's counseling, health education and counseling messages, and the use of pictorial referral and reporting forms.

In September 2005, the CS-19 IMCI officer attended an 11-day IMCI course in Mazar-i Sharif arranged by the SC/US community IMCI project and MoPH. This will enhance the quality of ARI and CDD interventions through refresher courses based on the IMCI approach for provincial level MoPH and district level HF staff.

5. Maternal and Newborn Care (MNC)

The MNC component of the CS-19 initiative supports BPHS interventions in maternal and newborn health, i.e., delivery, postpartum and newborn care with (1) trainings for RH assistants, (2) placement of MCH promoters at clinics to build RH assistants' and CHWs' MNC capacity, (3) iron foliate supplementation, and (4) education on maternal nutrition and birth planning.

5.1. MNC trainings

In March 2005 CS-19 and MoPH RH officers trained 13 health care workers (eight midwives working in areas of Shiberghan District who are not supported directly by USAID REACH activities, and five CS-19 MCH promoters) during a three-day workshop about (1) safe motherhood, including birth planning and child spacing, (2) newborn care, (3) communication and counseling skills, and (4) teaching mothers about the importance of skilled birth attendance, and the importance of postpartum care, either at home or in a facility (including the need for a high dose of vitamin A after delivery, the value of exclusive breastfeeding, and the importance of increased maternal nutrition during lactation).

In August 2005, a family planning training was held for eight CHWs in Afghan Tapa, a village not supported by USAID REACH. In September 2005, the CS-19 RH officer, with the help of USAID REACH's Community Midwife Education master trainer and MoPH obstetricians and

gynecologists, led a three-day family planning TOT, which covered types of modern contraceptive methods and methods available locally, side effects, client counseling, and infection control, especially for inserting IUDs and injectible contraceptives.

5.2. MNC health education materials

CS-19 RH, BCC and MoPH RH officers reviewed existing MNC health education materials and messages and developed messages for topics that were not covered in existing materials, especially those related to birth planning. Next, sets of birth planning posters were developed and distributed to 20 HFs (including those not supported by USAID REACH). Each set of posters carries messages on the importance of the following:

- Antenatal care by a trained health worker;
- Maternal nutrition and rest during pregnancy;
- Danger signs (pregnancy, child birth and postpartum);
- Scheduling a skilled birth attendant for delivery;
- Saving money for transportation and emergency obstetric care;
- Identifying and “booking” blood donors;
- Booking transportation in advance;
- Newborn care; and
- Family planning.

5.3. Monitoring and supervision

During the past year, CS-19 RH and MoPH RH officers conducted bi-monthly joint monitoring and supervision in SC/US and SC/UK managed (USAID REACH supported) clinics to ensure that MNC interventions are being implemented effectively. They used observation checklists to assess the quality of antenatal care and conducted exit interviews with patients to assess the quality of counseling. See Annex 6 for results of these observations.

Results of these monitoring and supervision visits are shared with all of the stakeholders (SC/US, SC/UK, MoPH) and used to develop plans to further strengthen MNC activities.

6. Support to MoH staff working in six rural areas of Shiberghan district

As noted in earlier sections, the CS-19 project continues to allow for support to six MoPH teams (doctors, nurses, vaccinators) in remote Shiberghan villages: Afghan Tapa, Kauchin, Yangeargh, Cheghchi, Baba Ali and Jaghsai, through trainings and by supporting transportation for the health teams to these villages. CS-19 officers and MoPH counterparts continue to conduct joint supervision and support visits, and SC/US supports MoPH in its HMIS, i.e., data collection, analysis and feedback. CS-19 staff also continue to give technical assistance during national immunization days (NID), CDD and ARI campaigns; and community mobilization activities. SC will phase out and REACH will begin support in 2006.

7. Joint monitoring and supervision

CS-19 officers and their MoPH counterparts conducted several joint visits to support USAID REACH health activities in Jawzjan province and the Andkhoy cluster. The following table summarizes these monitoring and supervision activities:

Interventions	Reason for joint monitoring visits	# of joint visits	Achievements
EPI	To improve EPI coverage in Jawzjan Province and build MoPH capacity in supervision and monitoring	35	EPI coverage has improved significantly in most districts and the MoPH EPI manager has developed new monitoring and supervision skills.
MNC	To ensure quality integration of MNC interventions, especially birth planning strategies, into the BHPS	39	Birth planning has been integrated into BPHS services.
IMCI (ARI/CDD)	CS-19 is concentrating on provincial level capacity building, and joint monitoring allows SC/US to track the PHO's role in building capacity at the district and local levels.	46	ARI/CDD case management has improved and the MoPH ARI/CDD officer is trained on using supervisory checklists and doing on the job trainings.

8. Coordination

SC/US's CS-19 coordinator continues as secretary for the MoPH Provincial Health Coordinating Committee (PHCC). To date the CS-19 coordinator has attended 11 PHCC meetings to help maintain a focus on coordination, and joint supervision and monitoring, to report CS and USAID REACH program progress, and to document MoPH and NGO activity and service plans for the province.

CS-19 staff collaborate with REACH staff – both SC/US and SC/UK – to enhance both programs' achievements in Jawzjan and the Andkhoy cluster. For example, to help REACH teams meet community leadership training goals for CHCs, CS-19 MCH promoters trained 40 council members in three districts, and they also helped with Phase III training of 156 USAID REACH supported CHWs in seven districts. To complement USAID REACH monitoring and supervision efforts, CS-19 officers conducted supervision and monitoring visits to help improve the quality of some BPHS interventions.

Additionally, the CS-19 RH officer and coordinator supported USAID REACH's Community Midwifery Education (CME) program by orientating CME students on community mobilization, leading learning trips to rural HFs so students can improve their antenatal and postpartum care skills, and by helping the CME program coordinator with report writing, general communications, presentation preparation and in the use of assessment tools.

In September 2005, the CS-19 IMCI officer attended an 11-day IMCI course arranged through SC/US's UNICEF-funded and MoPH-supported community-based IMCI pilot project.

Finally, during the reporting period, the CS-19 coordinator participated in an ACCESS team's visit to CS-19 impact area in search of sites to conduct operations research on community-based approaches to reduce postpartum hemorrhage (by use of Misoprostol tablets). NOTE: CS-19 team members will play a key role in this operation research and demonstration project.

9. Reporting

Basic monthly tracking and planning reports are prepared by the CS-19 coordinator and reviewed by the health advisor and program manager for monitoring and progress tracking. These in turn, inform SC/US's annual report to USAID.

10. Progress against work plan (Achievements)

EPI (20%)			
Indicator 2	% of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before first birthday (by card)		
Indicator 3	% of infants who received DPT3		
Indicator 4	% of 12-23 month olds who received the measles vaccine (by recall)		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
EPI Refresher courses	To be completed by February 2005 (Year 2, Quarter 2)	Yes	10 day refresher courses for 15 REACH, SC/US, SC/UK and MoPH participants
Support MoPH in NIDs	To be completed by Quarters 3 and 4, Year 2 (May and June, August and September)	Yes	CS-19 supported MoPH on 5 NIDs and one sub-NID by conducting trainings for NID coordinators, supervisors and volunteers. CS-19 also helped NID microplanning, monitoring, social mobilization, supply management and report writing.
EPI micro plan meetings	To be completed by Year 2, Quarters 1 and 4	Yes	CS-19 staff developed two microplans for NIDs and one microplan for routine EPI.
Immunization coverage data collection (support to PHO)	Every month	Yes	CS-19 EPI officer conducts this activity on monthly basis
EPI IEC materials used in the HFs and communities	Every month	Yes	CS-19 EPI officer provided these materials in coordination with BCC officer and MoPH PEMT to HFs and communities. Their use is checked during monitoring visits.
EPI joint monitoring and supervision visits using EPI checklists	Every second month	Yes	CS-19 EPI officer has done these joint supervisions with MoPH EPI manager and SC/UK on a monthly basis. CS-19 has documented these activities in supervisory trip reports.
Monthly monitoring and supervision by PHO staff	Every month	Yes	See above.
Feedback on immunization coverage to PHCC	Every month	Yes	CS-19 coordinator gives feedback to PHCC on coverage and during meetings with SCF/UK and help develop action plans.

CDD (15%)			
Indicator 5	% of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness		
Indicator 6	% of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness		
Indicator 7	% of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated		
Indicator 14	% mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment		
Indicator 16	% of MoPH facilities with 1 or more stock-out of ORS or essential drugs last month		
Indicator 17	CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented		
Indicator 18	% of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home		
Indicator 19	% of caretakers of <5s know at least 2 aspects of home care		
Indicator 20	% of caretakers of <5s know at least 2 signs of when to return if child gets worse		
Indicator 21	% of severely ill <5s classified correctly in MoPH facilities		
Indicator 24	% of <5 diarrhea cases treated correctly in MoPH facilities		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
CDD refresher training	By Quarter 2	Yes	CDD refresher courses were held for 11 participants.
Implementation of CDD checklist (monitoring)	Once a quarter	Yes	CDD checklist used once in three months.
Observation of sick child management (Child with diarrhea, ARI and fever)	Once a quarter starting from Quarter 2, Year 2	Yes	Conducted observation of sick child management three times in Year 2.
Exit interviews with caregivers of child suffering from ARI/diarrhea/Fever	Once a quarter starting from Quarter 2, Year 2	Yes	Conducted caregiver interviews three times in Year 2.
MCH promoters work with CHWs	Every month	Yes	Six MCH promoters work with CHWs every month.
CCM Training	Quarter 3, Year 2	Yes	10 CHWs trained in Qarqin and Qaramqol trained in diarrhea management as part of CCM. ARI training will be conducted in November 2005.
CCM start up	Quarters 2, 3 and 4 (on-going)	Yes	Ongoing.
CCM documentation	Quarters 3 and 4	No	Currently CS-19 is using CCM checklists to document the work of CHWs re diarrhea management. CCM documentation will be initiated in December 2005.
On the spot technical support to PHO technical officers	Once a quarter	Yes	CS-19 IMCI officer provides on the spot TA to PHO staff during joint monitoring and supervision visits
IEC CDD materials used in the HFs and communities	Every month	Yes	CS-19 BCC officers provided these materials to the HFs and CHWs, and use is checked during monitoring visits.

ARI (20%)			
Indicator 5	% of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness		
Indicator 6	% of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness		
Indicator 8	% of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a HF or received antibiotics from an alternative source		
Indicator 14	% mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment		
Indicator 16	% of MoPH facilities with 1 or more stock-out of essential drugs last month		
Indicator 17	CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented		
Indicator 18	% of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home		
Indicator 19	% of caretakers of <5s know at least 2 aspects of home care		
Indicator 20	% of caretakers of <5s know at least 2 signs of when to return if child gets worse		
Indicator 21	% of severely ill <5s classified correctly in MoPH facilities		
Indicator 23	% of <5 ARI cases treated correctly in MoPH facilities		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
ARI case management training	Quarter 1, Year 2	Yes	16 doctors (MoPH, SC/US and SC/UK) trained. Separate ARI training held for 7 MCH promoters.
Observation of sick child management (Child with diarrhea, ARI and fever)	Once a quarter starting from Quarter 2, Year 2	Yes	Conducted observation of sick child management three times in Year 2.
Exit interviews with caregivers of child suffering from ARI/diarrhea/Fever	Once a quarter starting from Quarter 2, Year 2	Yes	Conducted caregiver's interviews three times in Year 2.
MCH promoters work with CHWs	Every month	Yes	Six MCH promoters work with CHWs every month.
CCM training	Quarter 2 (February 05)	No	Lack of ARI timers delayed the training in January/February 2005. Planned for November 2005.
CCM start-up	Quarters 2, 3 and 4	Yes	But lacks ARI component.
CCM documentation	Quarter 3 and 4	No	Currently CS-19 is using CCM checklists to document the work of CHW re:diarrhea management. CCM documentation will be initiated in December 2005.
On the spot technical support to PHO technical officers	Once a quarter	Yes	CS-19 IMCI officer provides on the spot TA to PHO staff during joint monitoring and supervision visits.
IEC ARI/fever materials used in the HFs and communities	Every month	Yes	CS-19 BCC officers provided these materials to the HFs and CHWs; use is checked during monitoring visits.

Nutrition (15%)			
Indicator 11	% of infants 0-5 months who were fed breast milk only in the last 24 hours.		
Indicator 12	% of infants 6-9 months who received breast milk and solid foods in the last 24 hours.		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
Development/or procurement of IEC materials on nutrition and growth.	Quarters 1 and 2, Year 2	Yes	±400 iodized salt posters distributed to 18 HF's.
GMP technical support	Once a quarter	No	Growth Monitoring and Promotion (GMP) national strategy meeting (Kabul, March 2005) decided GMP will not be implemented as a national program at this time due to inadequate capacity at district facilities. to support monthly contact, measurement and counseling. Instead, the long-term strategy is to explore the feasibility of expanding IMCI, once established, to include GMP in clinics and community-based programs.
Logistic support for iodized salt distribution	Quarters 2, 3 and 4 (four times)	Not needed	A Shiberghan factory is transporting iodized salt to districts bazaars. Awareness is enhanced and many people buy iodized salt.
Community mobilization technical support	No benchmark	Yes	CS-19 helped UNICEF and MoPH in two iodized salt campaigns. The CS-19 BCC officer attended 13 meetings with CHC members in different locations and disseminated messages.
PD/Hearth Training	Quarter 2, Year 2	Delay to Quarter 3	Delayed to third quarter due to non-availability of health advisor.
PD/Hearth Training in pilot area	Quarter 2, Year 2	Delay to Quarter 3	Selected one village. Conducted PD inquiry in this village. To date, conducted 9 PD/Hearth sessions providing benefits to 99 malnourished children. Eight CHWs were trained on PD/Hearth, monitoring and supervision.
PD Inquiry and establishment of Hearth	Quarter 2 onwards	Delay to Quarter 3	
PD/Hearth monitoring and documentation	Quarters 2, 3 and 4 (4 times)	Started in Quarter 3; ongoing	PD/Hearth activities and volunteer home visits are documented.

MNC (30%)			
Indicator 9	% of children aged 0-23 months whose delivery was attended by skilled health personnel		
Indicator 10	% of mothers who had at least one postpartum check-up		
Indicator 11	% of infants aged 0-5 months who were fed breast milk only in the last 24 hours		
Indicator 12	% of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
MNC refresher (focusing on birth planning)	Quarter 2, Year 2 (Feb05)	Yes	CS-19 and MoPH RH officers conducted this refresher for 7 MoPH midwives, 8 MCH promoters and 7 RH assistant..
Collaborate with SC Community Midwife Training	Once a quarter	Yes	Regular meetings re: ANC, PNC, BP and FP with teachers and students. CS-19 RH officer taking CME students to 6 rural clinics for practice work and community network. CS-19 BCC and RH officers highlight roles of community midwives during CHC meetings.
Assist MSH/USAID in the development of MNC/birth planning messages	Once a quarter (Quarter 1, 2 and 3)	Yes but only one meeting	Reviewed birth planning materials.
Procure MNC/birth planning BC materials	By Quarter 2, Year 2	Yes	CS-19 RH officer developed birth preparedness materials and distributed to all HFs.
Collaborate with USAID REACH staff	Once in two months	Yes	CS-19 assisted USAID REACH staff in identifying CHWs and choosing women's health committees (CHC). CS-19 trained midwives/RH assistants re: MNC, birth planning and HMIS. CS-19 staff helped established delivery rooms in 3 HFs. CS-19 MCH promoters help CHWs collect MNC data monthly.
Technical support on community mobilization (birth planning / community alarm and transportation)	By the end of Quarter 2, Year 2	Yes	MCH promoters and CHWs train communities re: birth planning. CS-19 helped establish women's CHCs in 4 Shiberghan District villages (non-USAID REACH) and pilot tested community alarm and transportation education materials.
FP TOT training for BPHS/REACH staff.	By the beginning of Quarter 2, Year 2.	Yes.	CS-19 staff, MoPH trainer and CME trainers conducted Family Planning TOT course for 7 midwives, 8 MCH promoters, 7 RH assistant 10 MoPH staff..
Implementation of bimonthly supervision	Every two months	Yes	Monthly joint supervisions are for MNC activities in HFs and communities.

All interventions			
Indicator 22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality.		
Indicator 25	% of mothers receiving general information or advice on health or nutrition from a member of the informal community network.		
Indicator 26	% of CDQ Quality Improvement Committees including at least one female participant.		
Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
Attend PHCC monthly meetings	Every month	Yes	
PDQ training			Cancelled as part of CS-19 activity because MSH recommended the FFSDP process.
PDQ implementation in two pilot areas			Cancelled as part of CS-19 activity because MSH recommended to stick to their FFSDP process.
CS-19 Intervention task forces monitoring meetings	Once in two months	Yes	Task force is composed of CS-19 officers, SC/UK and MoPH staffs. And meets every month after PHCC meetings.
Transportation provided for health staff at 6 MoPH clinics	Every day	Yes	
Annual reports		Yes	Year One provided.

B. FACTORS WHICH HAVE IMPEDED PROGRESS TOWARDS ACHIEVEMENT

Progress toward goals has not been impeded significantly, during the past year.

The leave of absence of SC/US's regional health advisor (while he finished an MPH degree) limited technical assistance in the first quarter, delaying some activities such as training on CCM and PD/Hearth, but this is not significantly detrimental to the project in the current context.

The arrival of a new provincial health director to Jawzjan Province in June 2005 during the national government Provincial Rehabilitation Reform (PRR) had led to the loss of the previous director's clear understanding of and support for CS-19 activities, and the need for the orientation and newly developed support of the new director, which seems to be slow in coming. This is a challenge, but not an impediment to project progress.

C. TECHNICAL ASSISTANCE REVIEW

The CS-19 coordinator provided overall guidance for the implementation of Year 2 CS-19 activities. SC/US's Afghanistan health advisor (previously regional health advisor), together with the CS-19 coordinator, trained CS-19 staff on the concept of PD and helped to implement PD/Hearth initiative in one pilot area, Afghan Tapa.

The CS-19 coordinator, in consultation with the health advisor, helped implement CCM in two pilot areas, Qarqin and Qaramqol. They reviewed the Year Two work plan and documentation process, and recommended checklists and forms to document CCM training, monitoring, supervision, community awareness and health education activities. The CS-19 coordinator gave

technical assistance to the CS-19 RH officer during development of birth planning education materials. Finally, CS-19 and USAID REACH staff initiated a number of joint, complementary processes between the projects.

D. CHANGES FROM PROGRAM DESCRIPTION AND DIP

No major changes occurred in the program design as described in the DIP except that the Partnership Defined Quality (PDQ) approach has been replaced by the USAID REACH-required Fully Functional Service Delivery Point (FFSDP) approach to quality assurance. While USAID REACH and the MoPH may be interested in the results of PDQ if implemented by SC/US elsewhere, SC/US was advised that USAID REACH-supported facilities/communities must employ the FFSDP approach to improve service quality. PDQ will, therefore, not be used in the CS-19 impact area.

E. SUSTAINABILITY

In June 2006, the contractor, Management Sciences for Health (MSH), will transfer oversight and management of USAID REACH to the MoPH, which will oversee/manage USAID REACH follow-on projects. The MoPH will do this through national and international NGOs, much like the current USAID REACH initiatives, which ends April 30, 2006. SC/US will apply to implement follow-on BPHS in all of Jawzjan Province (including the seven districts where SC/UK currently implements the BPHS (USAID REACH) project. SC/US will also apply to continue CME activities. SC/US, like USAID and the MoPH, does not expect a break in service or loss of momentum in this parallel project. CS-19 staff will continue their efforts to build the capacity of the Jawzjan PHO and to support USAID REACH-supported health workers (SC/US staff as well as MoPH (clinic and district hospital staff) and communities through the new USAID REACH system. CS-19 plans to develop a sustainability/phase-out plan in Year 3 along with the MoPH, including a timeline for MOPH uptake of activities such as supporting the Shibergan clinics.

F. RECOMMENDATIONS MADE IN THE DIP REVIEW

Responses to recommendations made in the DIP Review were submitted in the first Annual Report.

G. INDICATORS REPORTING TABLE

N/A

H. PROGRAM MANAGEMENT SYSTEM

SC/US' Afghanistan Field Office continues to ensure professional management (finance, personnel, program delivery) of the project and all related health projects/activities.

H.1. Financial management system

A system of documenting and accounting for required matching funds has been designed this year, and scheduled for collection and monitoring. We developed separate time sheets for CHWs and training participants. The time sheets will show CS-19 match during a month. As it is in starting stage it will need some modifications/changes. We will report on it October 2005 and onward.

H.2. Human resources

SC/US staff based in Kabul:

Field Office Director, Deputy Director Operations and health advisor: Provides overall guidance and relations with MoH, USAID Mission, and other organizations.

Manager Finance: Responsible for fiscal oversight and financial reporting in compliance with grant policies and procedures.

Manager Administration: Responsible for administration oversight in compliance with grant policies and procedures.

SC/US staff based in Balkh/Jawzjan:

Program manager, Balkh/Jawzjan: Responsible for oversight of management, administration/operations and of technical content of training and services, staff training and supervision.

CS coordinator: Responsible for day-to-day management, reporting to the program manager regarding activity planning and implementation, including monitoring the professional development of community-based care providers and ensuring productive collaboration with the PHO and other partners; responsible for organizing and overseeing implementation of training activities for all CS interventions, including materials development, and district health planning and management for SC/US and MoPH staff; provides technical support for training organized by the PHO and health education sessions conducted at the community level by rural MoPH HF staff in Jawzjan Province; responsible for writing and submitting monthly reports.

Senior health officer EPI: Responsible for planning, monitoring and evaluating EPI activities within all SC/US health activities, including trainings for MoPH staff; supports MoPH district and provincial management teams with (1) planning and organizing supplies and communication of routine EPI programs with the aim of improved coverage and quality of programming; (2) planning, implementing and evaluating EPI awareness-raising programs (advocacy) in communities with the aim of increased demand for immunization services; (3) support for campaigns (NIDs, TT and measles) through planning, supervision and monitoring, as appropriate, in target areas; provides statistical and narrative reports for donor reporting on EPI programming in the target areas; coordinates with MoPH, UNICEF and WHO in EPI-related activities; works closely with other SC/US CS project staff, ensuring coordinated implementation of all the components of the project; coordinates with MoPH and UNICEF to provide updated micro plans for routine EPI and NIDs.

Senior health officer CDD/ARI: Responsible for planning, implementing and monitoring CDD/ARI programs in target areas; ensures that MoPH facility staff in the target areas are well trained in providing CDD/ARI services following WHO guidelines; monitors and provides feedback to staff on appropriate case management of childhood illnesses in facilities; monitors

and supports community health staff on community-based childhood illness prevention and treatment programs; coordinates CDD/ARI training activities, including logistics; provides technical support to provincial and district MoPH service providers to ensure implementation of appropriate case management of childhood illnesses and appropriate organization of child health services; provides statistical and narrative information on diarrhea control (CDD) and acute respiratory infections (ARI); works closely with other SC/US CS project staff, ensuring coordinated implementation of all project components ; leads CCM trainings in two pilot areas with the help of the coordinator and health advisor.

Senior RH health officer: Responsible for planning, implementing and monitoring RH programs in target areas: ensures the appropriate MoPH facility staff are well trained in providing RH services; monitors and provides feedback to staff on providing RH services in facilities and communities; helps identify district-based MCH promoters for community based RH programs, and supervises and evaluates them; ensures development and use of appropriate health education materials to promote good RH; coordinates RH training, including logistics; provides technical support to provincial and district government health service providers to ensure coordination and implementation of appropriate RH services; provides statistical and narrative information on the RH program; works closely with other SC/US CS project staff, ensuring coordinated implementation of all project components.

Senior BC health officer: Responsible for planning, implementing, and monitoring behavior change related activities within the health program in targeted areas: uses baseline and monitoring data and other information to identify and document behavior change needs in both the target area and in health programs nationwide; develops a plan to address the selected behavior change needs, identifying target groups, methodology and specific messages; reviews behavioral change materials available/in use; identifies and procures appropriate (existing) materials, if any; coordinates the development of new materials; contributes to all trainings developed and implemented in the target areas to ensure inclusion of behavior change in the curriculum; implements training sessions as appropriate; contributes to the development of a M&E systems for impact of behavior change; works closely with other SC/US CS project staff, ensuring coordinated implementation of all project components.

Health officers (2): Responsible for monitoring and helping to integrate the USAID REACH-supported Community Health Workers (CHW) program into the basic package of health services (BPHS) program throughout the province: ensures strong links between the CHWs and HFs; ensures regular monitoring and support of CHWs; identifies training needs and organizes trainings accordingly; organizes the work schedule of CHWs to ensure geographical coverage; participates in meetings with community representative and volunteers

MCH promoters (10): Responsible for helping to implement BPHS services: trains and provides refresher courses for CHWs; implements BCC activities; takes part in community mobilization; supports caretakers through counseling; liaises with local leaders, arranges committee meetings; submits monthly reports and conduct birth planning sessions for pregnant women.

Senior finance officer, finance officer (2): Responsible for keeping financial records and for financial reporting.

Senior administration officer, logistics administration officer, officer of administrative support (2): Responsible for procurement, record keeping, stores and general administration of the office.

H.3. Backstopping and technical assistance from SC/US Headquarters

SC/US's headquarters Office of Health is responsible for regular technical assistance and monitoring of CS-19, including annual program review, site visits, and technical backstopping through email correspondence. Key SC/US home office staff supporting CS-19 include Kathryn Bolles, Child Survival Specialist and responsible for technical backstopping of CS-19 and Carmen Weder, Office of Health Manager.

H.4. Communication system and team development

Collection and use of health data for CS-19 project management is integrated with MoPH systems. SC/US, through CS-19, USAID REACH and other health projects works diligently with MoPH counterparts *to strengthen care delivery and management teams* for BPHS, CME, IMCI and specialized health activities like post-partum hemorrhage prevention and PD/Hearth.

Data management occurs at the HF and community level, focusing on the use of uniform reporting instruments throughout Jawzjan Province. USAID REACH monthly and quarterly reporting formats for BPHS are used unaltered in Jawzjan and the Andkhoy Cluster of districts.

MoPH and SC/US joint supervisory teams, include both CS-19 and USAID REACH staff, provide supervisory support to HF staff on a monthly basis, then review and analyze data and actions that affect health taken by facilities and communities. CS-19 officers and MoPH counterparts consolidate data from HFs and communities, calculate key indicators, identify problems, take action at the appropriate level, and report on problems identified, actions taken, and requests for assistance.

H.5. Local partner relationships

CS-19 staff, with USAID REACH staff, have developed relationships with Community Health Councils, provincial and district governors, and local leaders in all communities. USAID REACH and CS-19 staff attend the monthly Community Health Council meetings, which provide a forum to review successes and challenges/shortcomings, and to problem-solve, plan and share information. In preparation for and during meetings, partners receive training on meeting facilitation, priority setting, problem-solving, organizational structure, team building and partnering as well as education information and basic training about specific health issues.

NGO coordination/collaboration in country

As already described in this report, SC/US coordinates all activities and planning with other NGOs and the MoPH. As already cited, this includes attending monthly Provincial Health Coordination Committee meetings, which are also attended by representatives of SC/UK, Cross Link Development International, UNICEF, WHO and USAID REACH. Coordination and collaboration result in attendance, as needed, at other organizations' trainings, joint meetings and ongoing communication about program implementation to ensure no duplication of efforts and to respond to emergencies like the cholera outbreaks of 2005 (see I, Additional Information, below, for a full report).

Information management

Process to Gather, Analyze, and Use Data in Project Management in Relation to MoPH HMIS

- Nutrition and management of childhood malnutrition, ARI, and diarrhea

Health worker practices in ARI case management and ORT Corners in every MoPH HF are monitored on a bi-monthly basis by MoPH and SC/US supervisors using a checklist. CS-19 and MoPH staff conducted three exit interview exercises with mothers during this year's supervisory visits. MoPH staff submits ARI and CDD patient/disease monthly reports, with total number of children treated by age and diagnosis, to the PHO on a monthly basis.

Health workers responsible for immunization report the total number of children immunized by antigen and dose, and track and report on the DPT dropout rate for their area. Home-based immunization cards have been introduced in all districts. When the cards are handed over to the mothers, duplicate records (immunization registers; daily and permanent) are kept at the HF. By referring to the permanent register, a health worker is able to determine the number and names of the children due for vaccination. The permanent register is used to identify dropouts. After compiling the monthly report, facilities prepare a list of all defaulters and dropouts and provide this data to the EPI contact persons (community members), which trace the defaulters for participation in the next immunization session. Immunization schedules are planned with the vaccinators.

- MNC and child registry system

The CS-19 project has introduced registration books in all HFs to record ante-natal care, births and post-natal care, and relevant health care workers are trained to record all relevant information/data.

I. MISSION COLLABORATION

SC/US collaborates with the USAID Mission in Afghanistan on four health portfolio initiatives (CS, REACH BPHS and REACH CME, and a DCOF-funded child protection project). Soon, the SC/US Afghanistan health team will partner with an ACCESS initiative to address post-partum hemorrhage as well. The Field Office Director has excellent relationship with members of the Mission's health team.

J. TIMELINE OF YEAR 3 ACTIVITIES

Please see below.

K. HIGHLIGHTS

In the Nutrition section (above) and Annex 2, good results from PD/Hearth activities in Afghan Tapa village are reported. Also CS-19 had during the past year, a very important role in coordinating with other USAID-funded programs (e.g. REACH/BPHS, REACH/CME and ACCESS) through joint supervisions, trainings and orientations, and in PHCC meetings.. Additionally, the CS-19 team played a key role in activities to control disease outbreaks, e.g., cholera outbreaks in Qarqin and Khamyab districts and a whooping cough outbreak in Sheberghan district.

L. ADDITIONAL INFORMATION

Cholera Outbreak

In July 2005, an outbreak of Cholera occurred in Jawzjan province affecting Qarqin (SC/US supported area) and Aqcha (SC/UK area). In response to this outbreak, the CS-19 IMCI officer with help from USAID REACH senior health officers, conducted a two-day training on “cholera control” for staff working in the HFs in Qarqin and Khamyab districts. The trained HF, CS-19 and REACH staff conducted similar trainings for 30 CHWs working in these areas. Topics for cholera control training included:

1. Cholera and its prevention – emphasis on hand-washing and drinking boiled water.
2. Management of cholera cases.
3. Maintenance of buffer stocks of ORS and intravenous fluids at clinics
4. Cholera daily surveillance and reporting by both HF staff and CHWs.
5. Community awareness campaigns.
6. Role of task force – importance of coordination

CS-19 and REACH staffs also conducted cholera control trainings for CHC members and implemented daily community awareness and health education campaigns and chlorination of 300 wells in district communities. An area taskforce was established in the Qarqin district with facility staff, local government representatives and SC/US staff. In addition, a 24 hour emergency service in Qarqin HF was established with adequate buffer stocks of Ringers Lactate and ORS.

A total of 168 cases (52 <5 years of age and 116 >5 years of age) were treated by clinic staff and CHWs between July 28 and August 19, 2005 with only 2 deaths (adults) reported in the communities.

To prevent cholera from spreading in other districts of Jawzjan, the CS-19 IMCI officer and MCH promoters conducted cholera control trainings for CHWs in Kwaja du Koh, Qaramqul, Qurghan, Khane Chahar Bagh and Andkhoy districts.

Work plan for Year 3

EPI (20%)														
Indicator 2. % of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (card.)														
Indicator 3. % of infants who received DPT3.														
Indicator 4. % of 12-23 month olds who received the measles vaccine (recall.)														
Major Activities	2005			2006									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
EPI Refresher			X					X					MOH EPI and CS-19 EPI officer	20 doctors, 20 vaccinators and 15 MCH promoters
Support MOH in NIDs			X			X			X		X		CS-19 EPI officer, MOH EPI Manager, WHO PPO	-- 20 doctors, 100 vaccinators (including volunteers) -- 4 NIDS sessions
EPI micro plan meetings			X			X				X			CS-19 EPI officer, MOH EPI Manager, WHO & UNICEF PPOs	Two microplanning sessions
Immunization coverage data collection (support to PHO)	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 EPI officer & MOH EPI manager	12 consolidated reports from 20 HF's with feedback
EPI IEC materials used in the HF's and communities	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 MCH promoters, vaccinators	IEC materials developed and displayed in HF; use assessed during supervisory visit (4 reports)
EPI joint monitoring and supervision visits using EPI checklists		X		X		X		X		X		X	CS-19 EPI officer & MOH EPI manager	Six monitoring visits completing 20 facilities each time
Monthly monitoring and supervision by PHO staff	X	X	X	X	X	X	X	X	X	X	X	X	MOH EPI manager	Each visit targeting four clinics
Feedback on immunization coverage to PHCC	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 coordinator, EPI officer & MOH EPI manager	PHCC and NGOs

CDD (15%)														
<p>Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness. Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness. Indicator 7. % of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment. Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month. Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented. Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home. Indicator 19. % of caretakers of <5s know at least 2 aspects of home care. Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse. Indicator 21. % of severely ill <5s classified correctly in MOH facilities. Indicator 24. % of <5 diarrhea cases treated correctly in MOH facilities.</p>														
Major Activities	2005			2006									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
CDD refresher training								X					MOH ARI / CDD officer and CS-19 ARI / CDD officer	30 doctors and 10 MCH promoters
Implementation of CDD checklist (monitoring)		X			X			X			X		MOH ARI/CDD officer and CS-19 ARI/CDD officer	Checklist used in 20 HFs. Two compiled reports.
Observation of sick child management (Child with diarrhea, ARI and fever)			X			X			X			X	ARI/CDD CS-19 officer & MOH pediatrician	300 observations
Exit interviews with caregivers of child suffering from ARI/diarrhea/Fever			X			X			X			X	MCH promoters	300 caregivers

MCH promoters work with CHWs	X	X	X	X	X	X	X	X	X	X	X	X	MCH promoters	10 MCH promoters will cover with at least 60 health posts
CCM Training		X						X CDD refresher					CS-19 ARI/CDD officer	5 CHWs Qarqin 5 CHWs Khamyab
CCM continues	X	X	X	X	X	X	X	X	X	X	X	X	CHWs	10 CHWs in Qarqin and Khamyab
CCM CHW supervision	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 ARI/CDD officer	4 supervision reports.
CCM documentation			X			X			X				CS-19 ARI/CDD officer, MCH promoter in Qarqin and Khamyab	Knowledge assessments (two) Client interview reports (two)
On the spot technical support to PHO technical officers		X			X			X			X		CS-19 ARI/CDD officer	4 CDD monitoring & supervision with on spot TA.
IEC CDD materials used in the HFs and communities	X	X	X	X	X	X	X	X	X	X	X	X	MOH HF staff, CHWs & MCH promoters	28,000 WRA (10 promoters x 12 days x 20WRAx 12 months)

ARI (20%)														
<p>Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness. Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness. Indicator 8. % of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a HF or received antibiotics from an alternative source. Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment. Indicator 16. % of MOH facilities with 1 or more stock-out of essential drugs last month. Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented. Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home. Indicator 19. % of caretakers of <5s know at least 2 aspects of home care. Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse. Indicator 21. % of severely ill <5s classified correctly in MOH facilities. Indicator 23. % of <5 ARI cases treated correctly in MOH facilities.</p>														
Major Activities	2005			2006									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
ARI case management training (Refresher)			X										CS-19 ARI/CDD officers and MOH pediatrician	20 doctors and 10 MCH promoters
Implementation of ARI checklist		X			X			X			X		CS-19 ARI/CDD officer	Please refer to observation and exit interviews in CDD section
MCH promoters work with CHWs			X			X			X			X	MCH promoters	10 MCH promoters will cover with at least 60 health posts
CCM Training					X (ARI)								CS-19 ARI/CDD officer	8 MOH staff 5 CHWs Qarqin 5 CHWs Khamyab
CCM continues						X	X	X	X	X	X	X	CHWs	10 CHWs in Qarqin and Khamyab

CCM documentation			X			X			X				CS-19 ARI/CDD officer, MCH promoter in Qarqin and Khamyab	3 monitoring and supervision visits.
On the spot technical support to PHO technical officers			X			X			X			X	CS-19 ARI/CDD officer	4 CDD monitoring & supervision with on spot TA.
IEC ARI/fever materials used in the HFs and communities	X	X	X	X	X	X	X	X	X	X	X	X	MOH HF staff, CHWs & MCH promoters	28,000 WRA (10 promoters x 12 days x 20WRAs x 12 months)

Nutrition (15%)														
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours.														
Indicator 12. % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.														
Major Activities	2005			2006									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
Community mobilization technical support		X		X		X		X		X		X		
PD/Hearth Training in pilot area continues	X	X	X	X	X	X	X	X	X	X	X	X	Advisor, CS-19 coordinator	HF staff, CHWs and CHC members, MCH promoters in pilot areas
PD Inquiry and establishment of Hearth in other two new					X	X	X	X	X	X	X	X	Advisor CS-19 coordinator MCH promoters CHWs	Two pilot areas
PD/Hearth monitoring and documentation			X			X		X		X		X	CS-19 MNC officer, PHC nutrition officer	5 monitoring reports

MNC (30%)														
Indicator 1. % of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months old.														
Indicator 9. % of 0-23 month olds whose delivery was attended by skilled health personnel.														
Indicator 10. % of mothers who had at least one postpartum check-up.														
Indicator 13. % of mothers able to report at least two known maternal danger signs during the postpartum period.														
Indicator 15. % of MOH facilities with female health workers.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
MNC refresher (focusing on birth planning)						X							CS-19 MNC officer	40 BHC and CHC staff and 10 MCH promoters
Collaborate with SC Community Midwife Training		X			X			X			X		CS-19 MNC officer	Four meetings
Collaborate with REACH/BPHS staff	X		X		X		X		X		X		CS-19 coordinator and REACH coordinator	Six coordination meetings
Technical support on community mobilization (birth planning/community alarm and transportation)					X				X				CS-19 MNC and CS-19 coordinator	PHO staff and NGO staff
FP refresher courses for BPHS/REACH staff							X						CS-19 MNC officer	20 MOH staff and 10 MCH promoters
Implementation of bimonthly supervision	X		X		X		X		X		X		CS-19 MNC officer and MOH MCH manager	Six joint monitoring visits covering 20 HFs

All interventions														
Indicator 22. CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality.														
Indicator 25. % of mothers receiving general information or advice on health or nutrition from a member of the informal community network.														
Indicator 26. % of CDQ Quality Improvement Committees including at least one female participant.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
Attend PHCC monthly meetings	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 coordinator	Monthly attendance and representation
Equity task force established and action plan development		X		X		X		X		X		X		
CS-19 Intervention task forces monitoring meetings		X		X		X		X		X		X		
Transportation provided for health staff at 6 MOH clinics	X	X	X	X	X	X	X	X	X	X	X	X		
Mid term Evaluation							X							MTE report
Post MTE planning								X						Post MTE planning report.
Annual reports														None for this year – Only MTE report

ANNEX1. Annual Action Plan - Year 2005

Province: Jawzjan

S/N	Milestone	Priority Activities	Steps to be followed or Implementation Method	Support Required			Budget source			
				Human Resources	Materials	Funds				
1	Increase access	Establishment of 2 new fix centers	Micro planning/justification of needs	PICC	Stationery	100	GAVI			
			Coordinate with partners	PEMT	Refreshment	10	GAVI			
			Selection of sites	PICC	Transport	-	SC US/			
			Hire interim vaccinators	SCUS/PEMT	Incentive	3,840	GAVI			
			Provide equipment / supply	PEMT	All Equipment	2,000	GAVI			
			Training of new vaccinators	SCUS/PEMT/SCUK	Stationery	400	GAVI			
						6,350				
		Conduct Pulse Imm. In 2 districts (khawja Do kou & Qaramqul)	Develop Microplan	SCUS/PEMT	Computer, Stationery	2,000	GAVI			
			Forcast of vaccines and supply in routine request	PEMT	Stationery	-	0			
			Include other interventions such as Bed Net, ORS distribution	MoPH	ORS	-				
						2,000				
		District micro planning and rescheduling for EPI	Develop Plan and Schedule for microplaning	PICC	Stationery	10				
			Assigne provincial facilitator	PEMT Manager		80				
			Orientation for facilitators	Dr Yasin, & Dr Rahmatullah		-				
			Provision of logistic/trasportation	PEMT Driver, Rented vehicle		200	GAVI			
			Collection of village information and community mapping	District officers		-	SC US			
			Scheduling out-reach sessions in all EPI centers	District officers		-	SC US			
							290			
		Decrease missed opportunities	Asses extend of the problem in all health facilities	PICC	Checklist	-				
			Relocation of (X) EPI centers within the h. facility	Facility staff		-				
			Assignment of health facility staff to screen immunization of cleints and refering eligible children and women	Facility staff	Orientation	-				
			Distribution of Immunization schedule (poster)	District officers	Poster	-				
			On job training of staff on screening	District officers	Guide line	-				
			Train (1/Facility) health non EPI staff on immunization as back up	Vaccinator	Guile line	-				
			Improve/establish patient follow system based on priliminary screening by registere or health educator	District officers	0	-				
			Regular supervision	PEMT/WHO/UNICEF/ SC US	Checklist	800	GAVI			
							800			
2	Increase utilization of services	Decrease drop out rate	Improve communication skills of vaccinators to properly communicate vaccine reaction & time of next viwsites	PICC	Stationery	200\$	GAVI/SCUS			
			Ensuring regular supply	PEMT/SC/US		3000\$	GAVI?SC/US			
			Establishment of defaulter tracing system	PEMT/SC/US			SC/US			
			Proper and regular scheduling of out reach sessions	PEMT/SC/US			SC/US			
			Regular supervision and monitoring at the district level	PEMT/SC/US			SC/US			
3	IEC	Increase community awarness and Creat demond	Develop communication plan for EPI	PICC	Stationery		GAVI/SCUS			
			Distribut leaflets for school	PICC	Stationery		GAVI/SCUS			
			Broadcast EPI messages through local Radio	PICC	Stationery		GAVI/SCUS			
			Conduct meetings withn community leaders	PICC	Stationery		GAVI/SCUS			
			Conduct orientation for school teachers	PICC	Stationery		GAVI/SCUS			
			Conduct awarness meeting with Mullas	PICC	Stationery		GAVI/SCUS			
			Distribution of posters and leflets	PICC	Stationery		GAVI/SCUS			
		EPI promotion weeks	Provision of one megaphon for each district	PICC	Stationery		GAVI/SCUS			
			Select target districts/cities	PICC	Stationery		GAVI/SCUS			
			Plan in advance	PICC	Stationery		GAVI/SCUS			
			Involve all partners and concerned government departments	PICC	Stationery		GAVI/SCUS			
			4	Improving quality of supervision	Establishment of supervisory system	Involve at least one supervisors from each partner agency	PEMT/SC/US	Cheek list/transport	500\$	GAVI/SCUS
						Plan supervision visits on quarterly basis	PEMT/SC/US	Cheek list/transport	500\$	GAVI/SCUS

			Monthly supervisory meeting	PEMT/SC/US	Guide line	400\$	GAVI/SCUS
			Distribut supervisory documents/checklist to all partners	PICC	Cheek list	300\$	GAVI
			Analyse and document result of supervisory visites	PEMT/SC/US	Stationery		SC/US
		Conduct supportive supervision	Use standard supervisory tools	PICC	Guide line		
			Train supervisors (MLM)	PEMT/SCUS	Guide line		
5	Monitoring & data management	Timely reporting	Collect EPI coverage Data on monthly basis	PEMT/SCUS	Guide line		
			Collect data on EPI target diseases (Measles, NNT, AFP and others) on monthly basis	PEMT/SCUS			
			Submission of the data on 5th of the next month to national Epi office through REMT	PEMT/SCUS			
			Monitoring of timeliness and completeness of the reports	PEMT/SCUS			
			Investigate and find reason of reported negative drop out rate in year 2004 and provide information for national EPI office	PEMT/SCUS			
		Improve quality of EPI data	Conduct small scal data quality audit during supervisory visits	PEMT/SCUS			
			Analyse data on monthly basis and provid feedback	PEMT/SCUS			
			Distribut monitoring chart to all Epi center and enssure properly used	PEMT/SCUS			
			Define Target DPT-3 Coverage for each EPI center	EP center/scus/pemt			
			Conduct on job training on data management for vaccinators	PEMT/SCUS			
			Provide all EPI centers with needy documents such as tally sheet, registration books, monthly reporting forms and immunization cards	PEMT/SCUS			
6	Training	MLM training	Conduct training for () Mid-Level-managers	PEMT/SCUS/who unicef			
			Conduct Training for () District Health Coordinators	PEMT/SCUS/who unicef			
		Refresher training for vaccinators	Conduct refresher training for vaccinators	PEMT/SCUS/who unicef			
7	Review and Coordination	Provincial Inter Agency Coordination Committee Reviews	Involve BPHS implementers in PICC	PICC			
			Conduct PICC meeting on monthly basis	PEMT SCUS			
			Conduct EPI review at provincial level	PICC			
8	Improve safe injection practices and safe wast disposal	Apply Standard Operation Procedure (SOP) for Safety	Distribut SOP	PICC			
		Provision of bandle supply to FCs	Monthly stock report to PEMT	EP center/scus			
			Monthly stock report to REMT	PEMT			
			Monthly stock report to national EPI	REMT			
		Safe disposal practices	Selection of proper place for waste disposal	PEMT SCUS			
			Provision of incenerator to each district	WHO SCUS			
			Regular supervision	SCUS			
		Report AEFI	Train EPI staff on AEFI				
Reporting AEFI to PEMT							
Reporting AEFI to REMT/national EPI							
9	SIAs For Polio Eradication	Suppliomintary Immunization Activities (SIAs)	Plan in advance for NIDs and others SIAs				
			Improve selection and quality ofr training				
			Conduct post SIAs Coverage survey				
			Develop supervision and monitoring plans				
		AFP Surviellance	Assigne all health staff to detect and repourt AFP Cases				
			Assigne all EPI workers to search and repourt AFP cases duringg outreach				
			Conduct coordination meetings for preparation and review of SIAs				

Annex 2. PD/Hearth Workshop Training Agenda

Day 1 - Thursday June 16, 2005

Time	Module/Topic	Methods	Remarks
8:30-8:45am	Introduction Objectives/expectations		
8:45 to 9:30am	<u>Building the concept of PD approach</u> Step1: Discussing why children suffer from malnutrition?	Introduce PD community: <ul style="list-style-type: none"> - boundary wall – chart paper - Bricks represent houses - White paper slips with pictures of malnourished children - Same socio-economical conditions (Yellow slips) - Pick up white slips first and then yellow. - Discuss why some children well nourished and others are not despite similar socio-economical conditions. - What can families do to keep their children healthy? (good feeding, caring and health seeking practices) 	Dr. Sharifee
9:30 to 10:00am	Summarizing why children become malnourished and what can families do to keep children healthy	Presentation on Key Community IMCI family Practices.	Dr. Honey
10:00 to 10:15am	TEA BREAK		
10:15 to 11:30Nn	<u>Building the concept of PD approach.</u> Step 2: Learning from communities what they do to keep their families healthy	Go back to PD community model. <ul style="list-style-type: none"> ▪ Ask the same question: why some children well nourished and others are not despite similar socio-economical conditions. ▪ Lets see what families have done: <ul style="list-style-type: none"> - vaccine or no vaccine (green slips) - good feeding or no good feeding (pink slips) - good caring or no good caring (blue slips) - good health seeking or no good health seeking (brown slips) 	Dr. Sharifee
11:30-12:15pm	Comparing good feeding practices, foods, child care and health care practices and finding PD behavior	Use of matrix on the flip chart <ul style="list-style-type: none"> ▪ Ask the same question: why some children are well nourished and others are not despite similar socio-economical conditions. ▪ What are similar behaviors ▪ What are dissimilar behaviors (both good and bad) ▪ Which ones are common and which ones are not. ▪ Which ones are PD behaviors? ▪ Define a PD person or a behavior ▪ What did we learn from these exercises? 	Dr. Tariq and Dr. Latif

Annex 2. PD/Hearth Workshop Training Agenda

12:15 – 1:00pm	LUNCH BREAK		
1:00-1:30pm	Summarizing PD approach and concepts	Presentation	Dr. Honey
1:30-2:00pm	What is PD/Hearth Approach?	Presentation	Dr. Honey
2:00-3:00pm	Develop a community orientation plan	<p>One group develops a community orientation plan</p> <ul style="list-style-type: none"> - Select a community - Discuss with communities why small children suffer from malnutrition - How to orientate communities about what is PD approach - Getting their support - Use of innovative ways to make an orientation plan - Arrange with community to gather all 6-36 months old to gather for GMP on 19th of June, 2005. - Explain to community about the importance of 100% GMP 	Dr. Honey and all the groups.
3:00-3:30pm	Presentations on the community orientation plan (one hour)	Presentations by participants	Dr. Tariq and all group

Day 2 - Saturday, June 18, 2005

Time	Module/Topic	Methods	Remarks
8:00-10:00pm	Going to villages for community Orientation.	Two Female Orientation sessions (community) One male Orientation session. (community)	
10:00-10:30am	TEA BREAK		
10:30-11:00am	Feedback from community orientation sessions	Feedback by all groups	Dr. Tariq
11:00-11:15am	Advantages of PD/Hearth	Questions and Answers / Presentation	Dr. Tariq/Dr. Honey
11:15-11:30am	Getting familiar with PD language	Presentation	Dr. Tariq/Dr. Honey
11:30-12:00Nn	Steps in PD approach	Presentation with highlight on step-2	Dr. Tariq/Dr. Honey
12:00-1:00pm	LUNCH BREAK		
Prepare for a Positive Deviance Inquiry			
1:00-1:35pm	How to do GMP; introduce GMP Data form	Presentation	Dr. Tariq/Honey

Annex 2. PD/Hearth Workshop Training Agenda

1:35-2:00pm	Conduct a Nutrition Baseline Assessment and wealth ranking	Practice Growth Monitoring: How to use Salter's scale; How to use adult scale; Target children	Dr. Meena and Dr. Tariq
2:00-2:30pm	Practice GMP and use of data forms	In the training center. Feedback	Dr. Meena and Dr. Tariq
2:30-3:30pm	Practice GMP in the neighborhood		Dr. Meena
3:30-4:30pm	Plan for GMP in 1 village (children 6-36 months)		

Day 3 – Sunday, June 19, 2005

Time	Module/Topic	Methods	Remarks
8:00-8:30am	Feedback on PD terminology	Presentation - What is a PD child?	Dr. Tariq and Dr. Honey
8:30-8:45am	Selection of PD families and NPD families (Criteria)	- What is a PD family?	Dr. Honey and Tariq
		- What is a non-PD child?	
		- What is a non-PD family?	
8:45-9:00am	Selection of volunteers and the process of PDI	Presentation on Common Criteria PD and NPD families	Dr. Tariq
9:00-10:00am	Introduce PDI tools - Observation - SSI tools	Presentations.	Dr. Tariq
10:00-10:30am	TEA BREAK		
10:30-11:30am	Practicing PDI tools	In pairs	Dr. Tariq, Dr. Honey
11:30-12:30pm	Field-test PDI (Neighborhood).	In the neighborhood	Dr. Meena
12:30-1:30pm	LUNCH BREAK		
1:30-2:00pm	Feedback and more training		Dr. Tariq, Dr. Meena, Dr. Honey
2:00-3:00pm	Preparing Community feedback Preparing for conducting PDI in the community	Prepare feedback on nutritional status/data Prepare "how to have a dialogue with community"	Dr. Tariq

Annex 2. PD/Hearth Workshop Training Agenda

Day 4 – Monday, June 20, 2005)

Time	Module/Topic	Methods	Remarks
8:00-1:00am	Conduct GMP in the villages	5 trained MCH promoters weigh 100% of children ages 6 to 23 months	
12:00-1:00pm	LUNCH BREAK		
1:00-2:30pm	Data analysis (hand tabulation); Putting nutrition data in the matrix; Identify % malnutrition Yellow; Identify % malnutrition red; Presentations	Use data tabulation forms Use of Summary Forms	Dr. Tariq
2:30-3:00pm	Feedback sessions on tabulated data		Dr. Tariq
3:00-4:00pm	Identifying PD and NPD Children Plan for community meeting - feedback on malnutrition - going for PDI		Dr. Tariq

Day 5 – Tuesday, June 21, 2005

Time	Module/Topic	Methods	Remarks
8:00-10:30am	Conduct PDI		Dr. Meena and 5 MCH promoters
10:30-11:00am	TEA BREAK		
11:00-12:00N	Identifying good foods, caring and health seeking practices.	Use the table to do this exercise: one table for each PD and non-PD child.	Dr. Tariq
12:00-1:00pm	LUNCH BREAK		
1:00-1:30pm	Continue		
1:30-2:30pm	Consolidating individual teams findings.	Two summary flipcharts with four columns. While each team presents findings on PD child and families record on the summary chart for PD children. Do the same for the non-PD child.	Dr. Honey and Dr. Sharifee
2:30-3:15pm	Selecting key practices	Use the two summary tables and do this exercise.	Dr. Tariq

Annex 2. PD/Hearth Workshop Training Agenda

	from the PD and Non-PD families.	Use good practices tables Use bad practices tables	
3:15-4:00pm	Identifying PD foods and PD caring and health seeking behaviors.	Use the summary tables above	Dr. Tariq

Day 6 – Wednesday, 22, 2005

Time	Module/Topic	Methods	Remarks
Step 6: Design Hearth Sessions			
8:00-9:00pm	What is Hearth and its activities	- Presentation	
9:00-10:00am	Developing NRES Menus.	<ul style="list-style-type: none"> - Discuss which staple foods are usually used to make weaning foods. - Assess if the food has proteins, carbohydrates, fats and vitamins - Discuss how much to prepare for these 10 children belonging to different ages. - Discuss to make at least at least four menus to be used on 4 different hearth days. 	Dr. Tariq and Dr. Honey
10:00-10:30am	TEA BREAK		
10:30-11:15am	Presentations on menus		
11:15-12:00N then	Developing NERS education components	<ul style="list-style-type: none"> - Choose NERS education messages for at least seven days. - Develop messages for feeding/foods, child caring and health seeking. - Develop messages regarding continuing hearth feeding at home. - Make daily health education schedule 	Three groups Foods/feeding Child care Health seeking (curative and preventive) Include messages on vitamin A, iodized salt.
12:00-1:00pm	LUNCH BREAK		
1:00-2:00pm	Continue		
2:00-3:00pm	Hearth Messages	Presentation	
3:00-5:00pm	NERS/Hearth activities	<ul style="list-style-type: none"> - Discuss elements of hearth activities. - Develop daily hearth activities - Discuss requirements for hearth (materials) - Discuss roles of volunteers (at homes and at Hearth) - Discuss roles of CS19 MCH promoters - Discuss roles of MOH staffs/identify who will participate - Discuss referral linkages for the Hearth activities with existing health providers. 	Dr. Tariq

Annex 2. PD/Hearth Workshop Training Agenda

Day 7 – Thursday June 23, 2005

Time	Tasks to do	What	Remarks
8:00-9:00am	Develop first GMP training for health volunteers.	<ul style="list-style-type: none"> - Steps for the trainings - Salter's scales & GMP cards for the volunteers - First venue would be the 1st day at the hearth session - Plan for refresher trainings/further support 	Dr. Meena, Dr. Sharifee, Dr. Latif
9:30am to 10:00am	Introduce Hearth activities related registration and other recording systems.	Introduce a hearth register. Introduce a daily observation checklist Introduce GMP session registers/form/checklist Introduce home visiting observation checklist Introduce vital events recording form (by volunteers and VDCs) Introduce GMP cards that also records Vitamin A, de-worming and use of iodized salt.	Dr. Tariq
10:00-10:30am	BREAKFAST		
10:30-11:30am	Making plans to meet VDC and health volunteers to inform about the first Hearth model and their roles.	Making plans to discuss with VDC members Making plans for meeting volunteers Making plans to inform mothers of 10 children for the first Hearth session.	Three groups <ul style="list-style-type: none"> - VDC - Mothers - Volunteers
11:30-12:30pm	LUNCH BREAK		
12:30-3:30	Going out to meet CHC members and volunteers who are booked for next day's hearth session		
3:30-4:00	Reporting back		
One hour	Making plans for the first Hearth session	<ul style="list-style-type: none"> - Prepare Materials (GMP cards and Salter's Scales) - Make copies of checklists - Registers for the hearth - Pens and copies/diaries 	

Day 8 – Sunday, June 27, 2005 (Dr. Honey)

Time	What	Remarks
8:00-12:00	Wrap-up discussion and closure.	
12:00-4:00pm	Discussions and preparation for the second day of Hearth.	

Annex 3. Summary of 11 PD/Hearth Sessions in Afghan Tapa Village

(June 26th-October 9th, 2005)

S.No	Child's Name	Father's name	Sex	Age in months	Weight day 1 (in Kg)	weight day 12 (in Kg)	Total Wt. gained (Grams)
1	Bibi ma	Jabbar	F	18M	7	7.1	100
2	Halaviden	Rashid	M	35M	8.3	8.8	500
3	Gul ahmad	Samad	M	34M	10	10.2	200
4	Ghosidin	Malook	M	18M	7	7.5	500
5	Bahder jamal	Naser sha	F	24M	6	6.4	400
6	Nar khal	Bi naser	F	10M	5	5.4	400
7	Shfiqa	M. murad	F	30M	5.5	5.5	0
8	Fazel Amad	Surat	M	8M	5.5	6	500
9	Shakiba	Ab. Akim	F	12M	6	6.3	300
10	Gul Mohammad	Samad	M	8 M	5.2	5.5	300
11	Fahima	Asmahil	F	9 M	4.2	4.8	600
12	Shakiba	Gul Mamad	F	24 M	7.5	8.2	700
13	Sang ma	Surat	F	36 M	11	11.6	600
14	Rozima	Nuril ma	F	12 M	6	6.5	500
15	Freshta	Niyaz M	F	24 M	8.5	9.3	800
16	Naz bibi	Akhtar	F	16 M	6.3	6.5	200
17	Freshta	Mer amza	F	18 M	7	7.6	600
18	Rasuol	A Satar	M	30 M	9	9.3	300
19	Moner	A Satar	M	12M	6.5	6.8	300
20	Rawof	A Raziq	M	24 M	9	9	0
21	Batawer	Samad	F	30 M	11	11.3	300
22	Zazi	Samad	F	30 M	11	11.4	400
23	Zarwari	Amad khan	F	17 M	7	7.4	400
24	Wahidullah	M Omar	M	24 M	8	8.4	400
25	Dordana	Qamidin	F	18 M	7	7.4	400
26	Nasir Ahmad	Lil	M	30M	8	8.3	300
27	Fahima	A.B rasul	F	9M	7.5	7.7	200
28	Shokrullha	Golam sakhi	M	24 M	7.5	8	500
29	Gull buddin	Gafor	M	36 M	10	10.5	500
30	Razmohammad	Baz	M	11 M	6	6.3	300
31	Hamida	Noor	F	23 M	9.5	9.5	0
32	Wzer Gull	Mohmmad	M	8 M	6	6	0
33	Hason	Noor Den	M	36 M	10.5	10.5	0
34	Huseon	Noor Den	M	36M	10.5	10.5	0
35	Fahima	khalldar	F	18 M	8.5	8.8	300
36	Mslema	Feaz	F	18 M	7	7	0
37	Bodom Gull	ABdull	F	36 M	10	10	0
38	Naqebullha	Joma Nazer	M	32 M	6.5	6.5	0
39	Asmat llha	Qader	M	32 M	9	9.4	400
40	Masuma	Faez	F	36 M	10	10.4	400
41	Sallh Mohmmad	Nazer	M	34 M	9	9.5	500
42	Anorgull	Qayum	F	18M	7	7.4	400
43	Shah Mohmmad	Jan	M	12 M	6.5	6.8	300
44	Farshta	Mohmmad	M	12 M	7	7.5	500
45	Jamshid	Nasar	F	8 M	6	6.5	500
46	Shamil	Mohmmad	F	24 M	10	10.3	300
47	Asadullha	Mullah	M	13 M	7	7.5	500
48	Pari	Said Mohmmad	F	12 M	7	7.4	400

49	Qorbon Nazar	Mohammad Kreim	M	18 M	8.2	8.5	300
50	Homaira	Hkar Mohammad	F	12 M	7.5	7.7	200
51	Habibiullha	kharuden	F	25 M	9	9.4	400
52	zabihullah	Akhtar	M	24 M	7.5	7.7	200
53	Fahima	M. Rahim	f	36 M	9	9.9	900
54	Taj Mohammad	Said	M	24M	8	8.4	400
55	Marjan	Abdul Khaliq	F	36M	10	10.5	500
56	Abdul Hakim	Qurban	M	36M	11	11.8	800
57	Shamsudin	Ata Mohamm	M	36M	9.5	9.9	400
58	Habiba	Akhtar	F	36M	10	10.5	500
59	Naqibulla	Sabir	M	24M	7.5	7.8	300
60	Hassan	Khaldar	M	34 am	10	10.3	300
61	Hussian	Khaldar	M	34M	10	10.4	400
62	Shukrulla	Saber	M	36M	9.5	9.9	400
63	Gulshan	Ziaudine	F	36m	9	9.7	700
64	Farida	Ziaudine	F	7m	4.5	5.1	600
65	Noor Agha	Imam yar	M	10m	5.5	5.9	400
66	Fereshta	Imam yar	F	36m	9.5	9.9	400
67	Humirah	Nasrullah	F	15m	6	6.6	600
68	Bi Bi Gul	Said	F	36m	10	10.6	600
69	Zabeullah	Zafer	M	18m	7.5	7.7	200
70	Faizullah	Abdullah	M	9m	4.2	4.5	300
71	Alishah	Haq Nazar	F	10m	6	6.5	500
72	Belqis	Khair	F	24m	6.2	6.7	500
73	Najibulla	Abdul Wahid	M	36m	11	11.9	900
74	Jamila	Noroz	M	18 m	8.2	8.6	400
75	Nazreah	Akhtar M	M	36 m	9	9.8	800
76	Marzeah	Mirza	M	20 m	9	9.5	500
77	Naghma	M Rasoul	M	24 m	8	9	1000
78	Khiyal bi bi	Samad khan	M	18 m	7.5	8.5	1000
79	Sabera	Mollah dad	M	18 m	8.2	8.8	600
80	Naz bi bi	Abdul	M	12 m	6.2	7	800
81	Mohibulla	Sado khan	F	18 m	9	9.7	700
82	Lialoma	Razaq khan	F	36m	10.2	10.5	300
83	Tawab	Nowroz	M	36m	11	11.7	700
84	Yunis	Mohammad	M	24M	8	8.5	500
85	Assad	Ghafar	M	24M	8	9	1000
86	Aminah	Amanullah	F	36M	9	10	1000
87	Fatimah	Jabar	F	16M	6.2	7	800
88	Khan gul	M Azam	M	24M	8.5	9	500
89	Khan bi bi	Khan M	F	36M	8.5	8.8	300
90	Kimya	Ghafar	F	36M	9.5	10.2	700
91	Kamilah	Nahim Khan	F	18M	7.5	8	500
92	Jamilah	Sardar	F	12M	5.5	6.2	700
93	Assad	Afzal Khan	M	24M	8.5	9	500
94	Abdul Wali	Ibrahim	M	36M	8.5	8.8	300
95	Assaddullah	Abdul Wahid	M	12M	6	6.8	800
96	Assad	M Ismahil	M	30M	8.5	9	500
97	Amad Khan	Abdul Aziz	M	30M	8.5	8.9	400
98	Roqia	Ekhlas	F	28M	8.2	8.8	600

Average weight gain

445gms

**Annex 4. MNC Supervision and Monitoring Analysis
Combined Analysis of Eight Observation Checklists
(January to August 2005)**

Physical Examination and take care pregnant women and evaluation	Percentage
1- Communication with pregnant women	90%
2- Does midwife ask about family history and previous deliveries?	66%
3- Does midwife check the BP correctly?	72%
4- Does midwife weigh pregnant women correctly?	95%
5- Does midwife look for edema and anemia in pregnant women?	64%
6- Does midwife distribute folic acid for pregnant women?	70%
7- Does midwife give health education about following:	
Importance of prenatal care.....	90%
Nutrition of pregnant women.....	85%
Danger signs of pregnancy.....	50%
TT vaccine.....	90%
Re-attendance.....	85%
Breastfeeding:	80%
Post partum care.	50%
Danger signs after delivery.....	60%
Benefits of Vit A and folic acid	70%
8-Family planning:	
Midwife ask about family history.....	70%
Usage for method of contraceptive.....	10%
9- Care of the new born :	
Does midwife check the newborn correctly?	55%
Does midwife weigh newborn correctly?	60%
10- Does midwife give health education about following:	
Breastfeeding	60%
Vaccination.....	75%
Danger sign of newborn	30%
Does MCH promoter give health education about following:	
Antenatal care	90%
Danger sign pregnant women	70%
Method of save the money	75%
Arrange of vehicle.	90%
Blood donor.	60%
Reset of pregnancy women	80%
Place of delivery	66%
Nutrition of during delivery and after delivery	80%
Post natal care	70%
Breastfeeding	98%
Appoint the skilled birth attendant for delivery.....	60%
Physical Examination, care and evaluation of pregnant women	
1- Communication with pregnant women	70%
2- Does midwife ask about family history and previous deliveries?	66, 66%
3- Does midwife check the BP correctly?	72%
4- Does midwife weigh pregnant women correctly?	90%
5- Does midwife looking for edema and anemia in pregnant women?	80, 64%
6- Does midwife distribute folic acid for pregnant women	90%

**Annex 4. MNC Supervision and Monitoring Analysis
 Combined Analysis of Eight Observation Checklists
 (January to August 2005)**

7- Does midwife give health education about following things:	
Importance of prenatal.....	70%
Nutrition of pregnant women.....	55%
Danger signs of pregnancy.....	50%
TT vaccine.....	90%
Re-attendance.....	75%
Breastfeeding:	70%
Post partum care.	50%
Danger signs after delivery.....	80%
Benefits of Vit A and folic acid	90%
8-Family planning	
Midwife ask about family history.....	90%
Usage for method of contraceptive	40%
9- Care of the newborn :	
3- Does midwife cheek the newborn correctly?	55%
Does midwife weigh newborn correctly?	60%
10- Does midwife give health education about following:	
Breastfeeding	80%
Vaccination.....	75%
Danger sign of newborn	50%