



Final Evaluation

***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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Glossary of Acronyms and Terms

ANC	Antenatal Care
ARI	Acute Respiratory Infections
BC	Behavior Change
BCC	Behavior Change Communication
BHC	Basic Health Center
BPHS	Basic Package of Health Service
CAF	Care for Afghan Families
CBO	Community Based Organization
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CFHE	Child Focused Health Education Program
CHC	Community Health Committee
CHS	Community Health Supervisor
CHV	Community Health Volunteer
CHW	Community Health Worker
CME	Community Midwife Education
CS	Child Survival
CS-19	The program, <i>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</i> , funded in large part through the 19 th cycle of the PVO CSH Grants Program which began in October 2003, is referred to as “CS-19”.
CSHGP	Child Survival and Health Grants Program of USAID
DD	Diarrheal Diseases
DIP	Detailed Implementation Plan
EOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
FP	Child Spacing/Family Planning (“FP” is used in order to not confuse “CS” with “child survival.”)
HFA	Health Facility Assessment (interchangeable with IHFA)
HIS	Health Information System
HMIS	Health Management Information System
HSSP	Health Services Support Project (USAID-funded continuation of support for BPHS implementation, 2007-2010)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IPC/C	Interpersonal Communication and Counseling
IR	Intermediate Result
KPC	Knowledge, Practices, and Coverage (CSHGP-related survey tool)
LNGO	Local Non-Governmental Organization
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MOPH	Ministry of Public Health
MOVE	Local NGO
MSH	Management Sciences for Health

MTE	Mid-term Evaluation
NGO	Non-Governmental Organization
NID	National Immunization Day
OCA	Organizational Capacity Assessment
ORS	Oral Rehydration Solution
PD	Positive Deviance
PDQ	Partnership Defined Quality
PHCC	Provincial Health Coordination Committee
PHO	Provincial Health Officer / Office
PPC	Postpartum Consultation
QIT	Quality Improvement Team
REACH	Rural Expansion of Afghanistan's Community Based Healthcare (USAID-funded BPHS project, 2004-2007)
RH	Reproductive Health
SC	Save the Children (US)
SC/UK	Save the Children Fund (UK)
SO	Strategic Objective
STEP	Local NGO
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid Vaccine
U2	Under 2 years old
UNICEF	United Nation's Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
Vit A	Vitamin A

A. Executive Summary

Save the Children's (SC) five-year child survival project CS-19, *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*, achieved the following accomplishments:

1. CS-19 filled the gaps in the REACH project by providing funds for training, transportation and community education in some areas.
2. CS-19 helped increase access to gender appropriate vaccination services by advocating for an increase in the hiring of additional female vaccinators and by supporting 11 female vaccinators for two years. By project's end, 26 out of 27 clinics had female vaccinators.
3. CS-19 helped increase the capacity of the Provincial Health Officers (PHO) and local NGO (LNGO) staff through training, mentoring, and on-the-job training. Through this, the PHO was also strengthened as an entity.
4. Through the introduction of PD/Hearth, CS-19 provided a model to the Ministry of Health (MOPH) and LNGOs for community-based nutrition activities.
5. By training PHO and LNGO staff in Partnership Defined Quality (PDQ), CS-19 provided a model for obtaining community input into quality assurance issues. Quality Assurance Teams have been established and the PDQ process has been replicated by LNGOs in all 22 clinics in Jawzjan Province. Evidence exists of Quality Assurance measures being taken as a result of the PDQ process.
6. CS-19 helped increase access to health information at the clinics and communities through the development, reproduction and distribution of appropriate IEC materials; also through the training of 600+ community volunteers.
7. CS-19 helped increase gender equity through the creation of female Shuras (one for each clinic); this model was replicated by LNGOs under the Basic Package of Health Services (BPHS) such that 100% of clinics now have women *Shuras*.

Summary of Impact Model Element for Project

Table 1. Impact

Inputs	Activities	Outputs	Outcome/Obj/ Intervention	Goal
<ul style="list-style-type: none"> ■ Qualified Staff ■ Training Curricula ■ Logistics ■ Funds 	a) Mentoring, formal/ refresher training and on the job training for EPI PHO, clinic and LNGO staff b) Joint supervision of EPI staff (including logistical support; vehicles/per diem) c) Advocacy of MOPH to hire more female vaccinators; d) Transport for female vaccinators to do outreach (2 years) e) Development, reproduction and distribution of EPI IEC materials at clinic and community levels f) Helped to plan and provided logistical support for the	a) Increased access to gender appropriate EPI services b) Improved quality of EPI services c) Increased access to EPI information d) Strengthened PHO in EPI e) Strengthened PHO and LNGOs in EPI	Improved Immunization Coverage (20%) See Table 2 for indicators	To achieve a sustained reduction in U5 and maternal mortality in Jawzjan province and the Andkhoy cluster.

Inputs	Activities	Outputs	Outcome/Obj/ Intervention	Goal
	National Immunization Days; Helped EPI PHO analyze data; g) During a measles outbreak, helped PHO learn to handle epidemic h) Trained CHCs (male and female) CHWs and Com. Health Volunteers in EPI i) Participation in PHCC meetings j) Introduced PDQ			
<ul style="list-style-type: none"> ■ Qualified Staff ■ Training Curricula ■ Logistics ■ Funds 	Same as a, b, e, h, i and j from above focused on reproductive health a) Conducted Campaigns for facility deliveries b) Took CHC members to clinics to see the birth room and MNC services c) Supported the PPH study d) Trained CHWs in birth preparedness (BP) education and conducted BP trainings for women in 10 out of 14 districts.	a) Increased access to RH/MNC svcs. b) Increased quality of RH/MNC svcs. c) Increased access to RH/MNC info. d) Strengthened PHO in RH.MNC and LNGOs in RH/MNC	Improved RH/ Maternal and Neonatal Care and Practices <u>(30%)</u> See Table 2 for indicators	
See above	Same as a, b, e, h, i and j from EPI section focused on CDD (later this became part of the IMCI training) a) Trained children in CDD (child focused health education) b) Conducted hand washing campaigns c) Assistance during cholera outbreak	a) Increased access to CDD services b) Improved quality of CDD services c) Increased access to CDD information Strengthened PHO in IMCI d) Strengthened LNGOs in IMCI	<u>Improved CDD Practices (15%)</u> See Table 2 for indicators	
See above	Same as a, b, e, h, i and j from EPI section focused on ARI (later this became part of the IMCI training) a) Trained children in ARI as part of child focused health education b) Pilot tested improved way of training (for pre-literates) CHWs in CCM	a) Increased access to gender appropriate ARI services b) Improved quality of ARI case management svcs. c) Increased access to ARI	Improved ARI Practices/ <u>PCM</u> (20%) See Table 2 for indicators	

Inputs	Activities	Outputs	Outcome/Obj/ Intervention	Goal
		information d) Strengthened PHO in IMCI e) Strengthened PHO and LNGOs in IMCI		
See above	Same as a, b, e, h, i and j from EPI section focused on ARI (later this became part of the IMCI training) a) Trained children in ARI as part of child focused health education b) Pilot tested improved way of training (for pre-literates) CHWs in CCM	a) Increased access to gender appropriate ARI services b) Improved quality of ARI case management svcs. c) Increased access to ARI information d) Strengthened PHO in IMCI e) Strengthened PHO and LNGOs in IMCI	Improved Acute Respiratory Infection practices (Pneumonia Case Management - 20%) See Table 2 for indicators	

B. Assessment of Results and Impact of Project

1. Results: Technical Approach

Save the Children's (SC) CS-19 project was implemented from October 2003 to September 2008 in Jawzjan Province and five districts in Faryab Province called the Andkhoy cluster. Jawzjan Province has a total population of approximately 707,510 inhabitants, including 280,000 potential beneficiaries, of which 124,800 are children under five and 155,800 are women 15 to 49 years of age.

According to its detailed implementation plan (DIP), the goal of CS-19 was to achieve a sustained reduction in under-five and maternal mortality in Jawzjan Province, which was met through the achievement of the following strategic objective and intermediate results:

- SO: Improved health practices at the household level, and increased use of essential MCH services;
 - IR-1: Increased household-level knowledge of essential MCH practices in Jawzjan Province;
 - IR-2: Increased access to essential MCH services in Jawzjan Province;
 - IR-3: Increased quality of essential MCH services in Jawzjan Province; and
 - IR-4: Established social network to support key behaviors.

To achieve these results, SC worked with the MOPH in Jawzjan in the following key intervention areas:

1. Immunization (20%);
2. Nutrition (15%);
3. Control of Diarrheal Diseases (15%);
4. Acute Respiratory Infection (20%); and
5. Maternal and Newborn Care (30%).

These interventions were implemented through the following four major cross-cutting strategies:

1. Provincial-level strengthening of the MOPH in Jawzjan through training, capacity-building of the PHOs, and supervision to effectively support the BPHS program;
2. Health behavior change (BC) activities through health facility staff, community health workers (CHWs), volunteers, mullahs, teachers, midwives, mothers-in-law, and local radio;
3. CS-19 engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and
4. Testing innovative approaches for improving access, quality, and use of essential MCH services, documentation and dissemination of feasibility and results, and scaling-up of successful approaches:
 - Community Defined Quality (CDQ or Partnership Defined Quality: PDQ): Working with community members and health staff to understand and improve the quality of MCH services from the community perspective, and to increase use of essential health services by community members; and
 - Community Case Management (CCM): Increasing community access to and prompt use of life-saving treatment for childhood diarrhea and pneumonia by training and supporting CHWs to provide this service in areas with poor access.

It is important to note that between the submission of the proposal (12/2002), the start of the project (9/2003) and the writing the DIP (2/2004), USAID/Afghanistan funded an initiative called REACH led by Management Sciences for Health (MSH) with SC as one of many implementing partners. The REACH project, which was national in scope and included Jawzjan Province, proposed to do much of the same work that the CS-19 project intended and therefore SC was obliged to modify its original proposed project. Instead of working at the community level, which would have been a duplication of the REACH activities, SC, in consultation with various stakeholders, decided to complement the REACH project by strengthening the Ministry of Public Health (MOPH) at the provincial level working with Provincial Health Offices (PHO), and to provide additional training to clinic and health post staff. SC's direct interventions at the community level in Jawzjan Province consisted of implementing pilot activities in 10 of 14 districts, and providing support¹ to CHWs, especially in the initial two years of the REACH project. Given the limited number and scope of CS-19's community-based interventions, and the significant input of REACH, SC/UK, and local NGOs (LNGO), the KPC survey results reflect the joint efforts of all of USAID's implementing partners and not specifically those of CS-19. While credit for KPC results are often shared, this is particularly the case in Afghanistan since the project had only two activities, joint supervision with the PHOs, and birth preparedness training, which covered the entire intervention area. (Please refer to the Activities Location Table in Annex 1.)

Summary M&E Table

As explained above, due to changes in the project, which prevented CS-19 from being a direct implementer at the community level (or even from directly supervising the community-based activities of other implementers), and because so many other actors worked at the district and community levels between 2003 – 2008, the results shown in Table 2 most accurately reflect the implementation efforts of all of USAID's implementing partners working in Jawzjan Province.

¹ Conducting initial CHW training in three phases as well as refresher courses.

Table 2. KPC Survey Results (Jawzjan Province only)

Objectives	Indicators	Baseline Est. %	Final Est. %	Final Target %	Explanation or Reference
Improved vaccination coverage	1. 20% increase in mothers of children U2 receiving 2 or more TT before birth of youngest child	15	68.4	35	Female vaccinators and outreach efforts. More clinics in remote area; better supply CS-19 support to supervision and monitoring and training CHWs in birth preparedness
	2. 60% of 12-23 month olds fully immunized by age 12 months	4	60.1	60	Female vaccinators may have influenced this since some mothers still prefer to go to women; constant supervision; IEC materials; training of vaccinators. Otherwise, work of other partners on supply and management, and cold chain also influences this. Better follow-up by CHW of drop-outs.
Nutrition	75% of 12-23 month olds received Vit. A in last 6 months	69	96	75	Helped by NID, micro-planning for NID done 2x year and trained volunteers
CDD	25% increase in mothers reporting hand washing before food prep, and child feeding and after defecation and child defecation (diaper change)	17	56	42	MCH Promoters in 10 districts conducted health education for caregivers. MCH Promoters also trained CHWs in messages related to diarrhea and hand washing
ARI (and CDD)	25% increase in ill children receiving increased fluids and continued feeding during illness in past 2 weeks	7	49.5	32	CHW refresher courses; network health education, MCH Promoters as system was being put into place, IEC materials;
	60% of mothers know 2 or more signs of child illness needing treatment	14	86 (2 or more signs)	60	See CDD comment: CS-19 support to CHW IEC materials

Objectives	Indicators	Baseline Est. %	Final Est. %	Final Target %	Explanation or Reference
MNC/RH	15% increase in % of children U2 whose birth was attended by a skilled health personnel	28	38	43	Still difficulties with distance, CM still newish; still trust the TBAs more; MOPH policy does not promote home deliveries by clinic staff. There are some health facilities with non local Community Midwives. In these facilities after hours and weekend maternity services not available.
	25% increase in mothers with 1 or more postpartum ² check	29	45	54	MOPH does not allow midwives to provide care at home; local tradition does not permit women to leave home before 40 days postpartum.
	20% increase in mother with knowledge of at least 2 maternal danger signs during the pp period	29	75.7	49	CS-19 support to CHW in birth preparedness IEC materials
	5% increase in non-pregnant mothers who desire no more children in next 2 years or are unsure, who are using a modern method of child spacing	17	42	22	

Immunization

Indicators	Baseline Est. %	Final Est. %	Final Target %
1. 20% increase in mothers of children U2 receiving 2 or more TT before birth of youngest child	15	68.4	35
2. 60% of 12-23 month olds fully immunized by age 12 months	4	60.1	60

CS-19 contributed significantly to strengthening the MOPH at the provincial level. As a result of these efforts and the work by other stakeholders on the supply-side, immunization coverage in the province improved dramatically.

The CS-19 project staff included an EPI Specialist who worked together with his counterpart in the PHO to strengthen the MOPH's support and implementation of immunization services throughout the province. Capacity building activities organized and supported by CS-19 included training for the PHO in charge of EPI, clinic staff (vaccinators) and staff of LNGOs who were also charged with strengthening basic health services, EPI among them. The project also

² A postpartum check was considered acceptable when one visit was done after 24 hours and within 28 days of the delivery.

provided refresher training on immunizations to *Shura* members³, community volunteers, and community health workers (CHW). The provision of this training is a major achievement for this project not only because it strengthened the capacity of the MOPH, PHO, and BPHS implementing partners, but because it filled a gap in the REACH project.

Since male vaccinators can not vaccinate all women without another woman present, immunization coverage was significantly hindered by the lack of female vaccinators. To address this, CS-19 management strongly advocated for the recruitment of additional female vaccinators. This effort succeeded and eleven new vaccinators were hired by the MOPH and their outreach activities were supported by CS-19 for two years. At the end of the project, all 27 clinics in the project area (Jawzjan and Andkhoy cluster) had female vaccinators. While this helped facilitate access to women for TT vaccinations at the clinic, the final evaluation team found that female vaccinators are much less active in outreach activities (community-based vaccination services) than their male counterparts. This is primarily due to continued gender inequities in the culture which prohibit women from traveling on their own or without a male relative, or riding a motorcycle.

At the provincial level, the CS-19 EPI Specialist worked closely with the PHO/EPI mentoring him during monthly joint supervision visits to district clinics. Through this mentoring process the PHO/EPI learned how to calculate the drop-out rate, how to anticipate vaccine needs, to assess the proper functioning of the cold chain and to effectively use the different EPI checklists for program monitoring. The CS-19 EPI Specialist also helped the PHO/EPI to plan and organize the National Immunization Days (NID), and to analyze data from those events. CS-19 provided logistical support for NID. During the final evaluation, the PHO/EPI reported having benefited considerably from the support provided by CS-19. While all of the PHOs who partnered with the project report having benefited considerably, the actual effects of this partnership could have been reflected in more concrete and objective ways had an Organizational Capacity Assessment (OCA) been conducted at the outset of the project, or as new PHOs were employed.⁴

In addition to the mentoring provided by project staff, CS-19 also developed, reproduced and distributed visual aids on EPI (and other topics) for display in clinics and health posts, and for use by volunteers and CHWs.

Control of Diarrheal Disease (CDD)

Indicators	Baseline Est. %	Final Est. %	Final Target %
25% increase in mothers reporting hand washing before food preparation and child feeding, and after defecation and child defecation (diaper change)	17	56	42
25% increase in ill children receiving increased fluids and continued feeding during illness in past 2 weeks	7	49.5	32
60% of mothers know 2 or more signs of child illness needing treatment	14	86	60

³ The *Shura* is a traditional leadership council made up of one representative from each community within the service area of a health center. Although the DIP refers to this group as a community health council, since their mandate is not limited to health, in this report it will be referred to by its traditional name, *Shura*.

⁴ When CS-19 began, there was only one PHO. During the life of the project other PHOs were employed by the MOPH and were mentored by project staff.

The indicators related to CDD are household-based behaviors that do not require support from the provincial level or clinic staff, which is where the CS-19 project was most influential. They are promoted primarily through community-based BC strategies. Because CS-19's presence and authority at the community level was limited – especially in Jawzjan Province – these KPC results reflect both the work of CS-19 and USAID's other implementing partners. Achievement of these objectives can be largely attributed to the recruitment, training and support of CHWs by both CS-19, the REACH project and subsequently by LNGOs, who are BPHS grantees.

Before the PHO recruited an IMCI officer, CS-19's CDD activities were implemented as a vertical program and activities focused on training community volunteers in danger sign identification, diarrheal disease (DD) prevention, and ORS use. Once a PHO/IMCI was named, the CDD program was integrated into the IMCI project and CS-19 efforts focused on strengthening the PHO/IMCI as described above for EPI, and supplemented the training provided under the REACH and subsequent USAID/Afghanistan-funded projects. Joint supervision with the PHO/IMCI was conducted with support from CS-19 staff and through this support, the PHO/IMCI learned how to assess and improve the management of a sick child suffering from diarrhea, through the use of the MOPH checklists and BASICS tools (observation and exit interviews). Likewise, CS-19 Promoters supervised the volunteers and CHWs in their areas of intervention (before Community Health Supervisors were hired). As with EPI, male and female *Shura* members were also trained in CDD.

In addition, CS-19 conducted a hand-washing campaign in response to a cholera outbreak, distributed chlorine to villages in the cholera-affected areas, and trained 1,600 children ages 10 to 16 in topics related to diarrhea prevention through the Child Focused Health Education (CFHE) Program. The CFHE program was first implemented in the Andkhoy cluster with funds generated by a micro-credit program and then extended into the Jawzjan Province where it was implemented in six communities in Shiberghan District under CS-19. Through the CFHE program, 102 child facilitators were trained by CS-19 MCH Promoters. The three modules – on diarrhea, nutrition and cough and cold – lasted four hours over a period of 4 – 6 week. Each child facilitator then trained a group of 12 other children who were in turn expected to promote BC within their families. While this approach was deemed successful in other parts of Afghanistan where SC has implemented previously it, no system was put in place in Andkhoy to objectively assess its effectiveness in that region. Since this approach was not included in the MOPH's BPHS program chances for scale up are limited.

While the original CS-19 proposal did not anticipate conducting hand washing campaigns, SC staff and the PHO deemed it necessary when a cholera outbreak occurred in Jawzjan between August and September 2005. The four-week campaign was conducted in four districts in Faryab Province (the Andkhoy cluster) and eight out of ten districts in Jawzjan Province (cholera affected areas). All of the CS-19 staff was involved, as well as staff from the PHO, and representatives from the LNGOs, STEP and MOVE who are grantees under the BPHS program. During this month, training on hand washing was conducted for the campaign managers, clinic staff, and *Shura* members. At the community level, health education sessions on hand washing were also organized and leaflets on hand washing were distributed. Large banners were hung at each of the district clinics. Since then, hand washing campaigns have been repeated annually in

these districts as a preventive measure with support from CS-19 and PHCC and other stakeholders.

As with EPI, the CS-19 project developed, reproduced and distributed visual aids on CDD topics for display in clinics and health posts, and for promotional use by volunteers and CHWs.

Acute Respiratory Infection (ARI)

Indicators	Baseline Est. %	Final Est. %	Final Target %
25% increase in ill children receiving increased fluids and continued feeding during illness in past 2 weeks	7	49.5	32
60% of mothers know 2 or more signs of child illness needing treatment	14	86	60

The activities related to ARI were very similar to those for CDD since both were eventually included under the MOPH's IMCI program. The CS-19 staff helped to improve the quality of care by mentoring the PHO/IMCI. Together they conducted monthly joint supervisory visits to the clinics in Jawzjan Province using the MOPH checklists and reviewing the results together. In addition, twice annually (and sometimes more frequently) CS-19 staff and MOPH IMCI staff used BASICS' tools (observation and exit) to monitor the quality of sick child management at the clinics. The project provided refresher courses to clinic staff and CHWs on ARI and PCM and provided visual aids to the clinics and health posts to increase awareness and promote BC.

In the Andkhoy cluster, SC through its BPHS grant developed a pictorial method for training the CHWs in community case management (CCM) of pneumonia. Since most of the CHWs have limited literacy levels, this training approach proved to be very effective. As part of the final evaluation a limited comparison of Jawzjan CHWs knowledge of pneumonia diagnosis and Andkhoy CHWs' knowledge, suggest that the pictorial training method was more effective.

As with CDD, the increases in the above indicators are impressive and both surpassed their targets. The training and support of the CHWs provided by both CS-19 and USAID/Afghanistan implementing partners are responsible for these results.

Nutrition

Indicators	Baseline Est. %	Final Est. %	Final Target %
75% of 12-23 month olds received Vit A in last 6 months	69	98	75

Between the submission of the proposal and the writing of the DIP, emphasis on nutrition was increased from 5% to 15%. Despite this, nutrition activities consisted of mentoring the PHO/IMCI and EPI as described previously, promoting the use of iodized salt through the distribution of IEC materials and some training, and piloting the Positive Deviance/ Hearth (PD/Hearth) approach to community management of moderate malnutrition. Given the focus on iodized salt consumption, it is surprising that no indicator to measure this was developed. The project's support to the PHO/EPI and the NIDs, during which Vitamin A was distributed, was the main effort for the Vitamin A objective. The EPI activities helped CS-19 to exceed its final target, with assistance from the other BPHS implementing partners.

In 2005, CS-19 piloted the PD/Hearth approach to address moderate malnutrition. Although the national rate of malnutrition is only 14%, there are communities where the rate exceeds 30% and therefore the PD/Hearth approach is appropriate. CS-19 first piloted the initiative in one village and later expanded it to four additional villages. During this expansion period, CS-19 trained PHOs and BPHS staff (Community Health Supervisors / CHS) in the approach and modified the implementation strategy to conform to the local context and constraints. Over the life of the project, 1,128 children participated in the PD/Hearth program in five villages in three districts in both the Faryab and Jawzjan Province. The activity showed a 30% total recuperation rate (and 95% of children gained 400 gr. during the initial feeding period), confirming the approach as a promising practice for the country, and potential inclusion in the BPHS. CS-19 staff shared these results at the national level at three different events. While this is important on its own, because the nutrition component of the BPHS is weak (no regular growth monitoring and promotion is conducted in Jawzjan Province), the introduction of PD/Hearth as a community approach to nutritional recuperation is all the more significant.

Maternal, Newborn and Child/Reproductive Health

Indicators	Baseline Est. %	Final Est. %	Final Target %
15% increase in % of children U2 whose birth was attended by a skilled health personnel	28	38	43
25% increase in mothers with 1/more postpartum ⁵ check	29	45	54
20% increase in mother with knowledge of at least 2 maternal danger signs during the postpartum period	29	75.7	49
5% increase in non-pregnant mothers who desire no more children in next 2 years or are unsure, who are using a modern method of child spacing	17	42.8	22

Progress toward the first indicator – births attended by skilled health personnel – was facilitated most concretely by SC's Community Midwife Education (CME) initiative that recruited and educated local women as midwives. Following graduation from the CME school in May 2006 (23 midwives) and March 2008 (23 midwives), the midwives were then deployed to work in the 22 clinics in Jawzjan achieving 100% coverage by May 2008.

The CME project, which was funded from another source, did not include supervision and support to the new midwives once they were placed in the clinics, however; and this is where the CS-19 project became instrumental in ensuring the smooth transition from school to health facility. After being posted in the clinics, CS-19 supported campaigns led by volunteers, CHWs and community *Shura* members to raise awareness regarding the role of community midwives and the importance of seeking antenatal care (ANC) and birthing assistance from them. Several community elders/leaders were invited to visit clinics to learn about safe motherhood services.

Similar to the other components, the CS-19 staff member in charge of Maternal and Reproductive Health mentored the PHO/RH and together they provided monthly joint supervision to the trained midwives working in the project area. The PHO/RH reports that this mentorship benefited her considerably and through this close supervision and the use of the MOPH checklists the quality of maternal, newborn and reproductive health services improved.

⁵ A postpartum check was considered acceptable when a visit was done after 24 hours but within 28 days of the delivery

Despite the placement of these midwives in district clinics, major barriers to facility births still persist. Chief among these is the fact that only a few midwives are available to attend deliveries outside regular working hours (nights and weekends). Distance to the clinic and discomfort with facilities are also constraints. BPHS implementing partners in Jawzjan are trying to address these and other issues and the introduction of the Partnership Defined Quality (PDQ) approach to quality assurance introduced by CS-19 has facilitated this process and resulted in some changes being made to improve access to facility deliveries as described in the next section and in the Results Highlights in Annex 2.

Although positive steps are being taken to increase facility deliveries, the vast majority of births take place at home and many are attended by traditional birth attendants (TBAs). While CS-19 had planned to work with TBAs to improve their understanding of a clean delivery, this was not done due to the MOPH policy not to train TBAs. While working to improve conditions that will favor facility deliveries, women and newborns are still at very high risk of morbidity and mortality. For this reason it is recommended that the MOPH consider working with TBAs to inform them about clean deliveries and especially the signs of danger that merit a facility birth. The BPHS should consider providing an appropriate incentive to TBAs who accompany laboring women to the health facility for delivery. Trained TBAs (as documented in many countries) could play a key role in saving the lives of many newborns too.

In 2004, CS-19 started birth preparedness education in Andkhoy cluster as part of SC's BPHS implementation. This program was later extended by CS-19 to Shiberghan District, which was not covered by REACH and then by BPHS implementers to eight of the ten districts of Jawzjan. As part of this program, health care providers, volunteers, CHWs, and *Shura* members were trained in the nine aspects of birth preparedness (deciding who will attend the delivery, where it will occur, transportation plan, plan for blood donors, nutrition and rest, decision maker identified, clean birth kit, saving money, danger signs known). This training was more comprehensive than the birth preparedness included in the CHW training course developed by REACH, which only covered five components of birth preparedness.

Related to birth preparedness, CHWs are expected to identify pregnant women in their community and make sure they each have a birth plan. Since birthing at the health facility is part of the plan, this approach also contributes to facility-based deliveries. The BPHS monitoring system in place and used by CS-19, identifies how many pregnant women are in the community, but does not track how many have birthing plans in place. The checklists used by the MOPH, BPHS NGOs and CS-19 staff focus primarily on the knowledge of the CHW regarding maternal health and not on the number of pregnant women with birth plans.

Achievement of the postpartum consultation (PPC) indicator is linked to facility deliveries since it is much easier to ensure a PPC in a timely manner if the woman is already in the facility. As in many Muslim countries, the custom of staying at home during the first 40 days postpartum, creates a major barrier to PPC coverage. While working to increase facility deliveries, alternative solutions need to be considered to prevent both maternal and neonatal morbidity and mortality among women who deliver at home.

Although the project maintained the family planning (FP) indicator, when the DIP was written the child spacing component was omitted as a separate component and FP was incorporated into the maternal and newborn care (MNC) component. In order to support and promote FP, CS-19 conducted several training courses on family planning for health care providers and also volunteers. In addition to this, the CS-19 RH Specialist supported the PHO/RH in the supervision of clinic staff and CHWs regarding their RH activities and she serves on the RH sub committee of the Provincial Health Coordinating Committee. Given the limited focus on FP and the fact that the project did not control or influence the availability of contraceptives, the appropriateness of a FP indicator is questionable.

New and Innovative Tools or Approaches

When the project was designed, SC decided to introduce the PDQ approach to quality assurance. This approach brings community members (including clients and *Shura* members in this case) and clinic staff together to assess the quality of health services provided by the clinic, and identify ways they could be improved. A Quality Improvement Team (QIT) is formed and an action plan developed to address the quality issues identified.

While PDQ had been introduced by SC in other countries with positive results, in the initial discussions with MSH/REACH, CS-19 was discouraged from implementing the PDQ process in the districts funded by REACH Program because another process of quality assurance (FFSDP) was being implemented. CS-19 staff first attended a course on PDQ led by SC in Kabul for its community-IMCI project, to learn the PDQ process themselves. It then piloted PDQ in Shiberghan District in 2005. In 2006, when the BPHS program was extended through the USAID/HSSP program (to which SC is a partner focusing on community mobilization, BCC and IPC/C), PDQ was included as one of the quality assurance tools. Because HSSP trainers were not familiar with PDQ, CS-19 led the first PDQ training in Jawzjan for HSSP trainers. The PDQ was subsequently expanded to five other provinces.

Preliminary results include these: re-arranging clinic rooms to provide maternal and newborn care services in a more private environment enhances care; and health committee members, *mullahs* and CHWs rigorously involved in community awareness and education leads to an increase in the attendance at the vaccination and postnatal care sessions. Seeing the benefits of the approach the LNGOs, grantees under the BPHS program, replicated the approach in all 22 clinics in Jawzjan Province. The introduction of PDQ is one of the most significant achievements of this project. However, it is important that LNGOs encourage and support the QIT meetings so they can continue to improve the quality of services being provided.

Technical Results - Recommendations

1. Assigning Attribution

Finding: The CS-19 project was originally designed to work at the community level. When USAID/Afghanistan funded the REACH project, CS-19 was obliged to change its approach from a community focus to strengthening the PHO and to filling training gaps of that and subsequent projects.

Conclusion: CS-19 was not a direct implementer of activities in Jawzjan Province. This hindered SC from more effectively using its vast experience in community health and limited

their impact. It pushed them into ‘pilot testing’ innovative initiatives in only a limited number of villages rather than allowing them to have a wider impact.

Lesson Learned: In the future, USAID/Afghanistan should try to develop programs that take CSHGP-funded health programs into account. They should consider the expertise of the responsible organizations when assigning responsibility for project implementation.

2. Increasing Vaccination Coverage

Finding: The total number of female vaccinators has increased and now 26 of 27 health facilities have female vaccinators. Despite being present in the clinics, the female vaccinators still do much less outreach than the male vaccinators. Medical Officers prefer that female vaccinators stay in the clinic to serve the many women and children who come to the clinic. Continued gender inequities (male accompanier, vehicle) prevent female vaccinators from going to communities on a regular basis.

Conclusion: As a result, the MOPH’s efforts to reach full vaccination coverage - TT and child immunizations - are hampered.

Recommendation: The MOPH and local implementing partners should look for ways to ensure that female vaccinators can conduct outreach activities at least ten days of every month. They should consider hiring additional female vaccinators (to replace the male vaccinators) so one can stay at the clinic while another goes on outreach. They could also hire couples to be vaccinators so they can go out together.

3. Measuring Capacity of PHO

Finding: CS-19 did not conduct an Organizational or Individual Capacity Assessment of the PHOs (or MOPH). The project did not have a strategic plan to guide its capacity building efforts of the PHOs.

Conclusion: As a result, it is difficult to measure the impact of the project’s efforts to build the capacity of the MOPH staff.

Lesson Learned: When a project seeks to increase the capacity of an organization/set of individuals, it is important to collect baseline data and to develop monitoring tools that will allow the project to track progress toward specific capacity building objectives. It is also important to develop a strategic plan for capacity building.

4. Behavior Change Strategy

Finding: The MTE recommended that the CS-19 BCC strategy be strengthened as did the REACH MTE team. In 2007, CS-19 staff was trained to use the BEHAVE Framework and this training was replicated for some project staff. Another type of BCC training, one that is more theoretical, was provided to REACH and LNGO staff. Despite this, there is little evidence that the BCC training was used to strengthen the CS-19 BCC strategy. The current strategy focuses uniquely on improving access and knowledge and does not address other determinants of BC.

Conclusion: The BC strategy of CS-19 (and the LNGOs) is not as strong as it could be. Not all behaviors are changing as quickly as they could.

Lesson Learned: When a project invests in training for its staff, especially to resolve a problem identified during the MTE, it is important for that trained staff to have the opportunity to use the new skills and information to improve that aspect of the project. Project backstop officers in Kabul and Headquarters, should follow up to make sure that the training is put to good use.

Recommendation The LNGOs should learn how to develop BEHAVE Frameworks in order to conduct barrier analysis or doer/non-doer surveys for difficult-to-change behaviors, and use this tool to develop activities at the community level which will promote the desired behaviors.

5. PD/Hearth Introduction

Finding: CS-19 staff piloted the PD/Hearth approach in five villages with a total recuperation rate of 30% and 95% of children gaining at least 400 grams during the two-week intensive care period. The BPHS program does not include community-based growth monitoring and promotion or a means to address malnutrition at the community level.

Conclusion: The BPHS program is not as strong on community-based nutrition activities as it could be. Given the presence of CHWs and trained *Shura* members and volunteers at the community level, and the high prevalence of malnutrition in some villages, the PD/Hearth approach offers an appropriate methodology for addressing malnutrition in children.

Recommendation: The MOPH/Afghanistan and USAID/Afghanistan's implementing partners should consider including the PD/Hearth approach into the BPHS program.

6. Maternal Health

Finding: Despite increasing the number of clinics with trained midwives and other changes made at the clinic level, the vast majority of births still take place at home where women are attended by untrained TBAs. Because of cultural constraints on the movement of women and low literacy levels (which makes it difficult to recruit and train women who live in the community where the clinic is located, as midwives) it is very difficult to ensure 24/7 availability of midwifery services. The MOPH/Afghanistan has a policy to not train traditional birth attendants.

Conclusion: Too many women are still not receiving adequate care during labor and delivery. Efforts to reduce maternal mortality are falling short.

Recommendation: While continuing to improve access to professional maternal/reproductive health care and promote facility deliveries, the MOPH/Afghanistan and the PHO should consider providing training to TBAs on the recognition of danger signs during pregnancy, clean deliveries, recognition of danger signs during labor and delivery, newborn care and postpartum care.

7. Postpartum Consultations

Finding: While the rate of PPC has increased, it is still less than 50%. The majority of women still give birth at home, and local custom prohibits new mothers from traveling outside the home for 40 days after birth.

Conclusion: Getting mothers to travel to the health facility for a PPC during the first week after their delivery will be exceedingly difficult. PPC that are done after the 40 day waiting period will not contribute significantly to the reduction of maternal or newborn morbidity or mortality. Other solutions are required.

Recommendation: The MOPH/A and USAID/A should consider training CHWs and TBAs to identify the postpartum/postnatal danger signs and should be required (CHWs)/encouraged (TBAs) to visit new mothers/newborns a couple of times during the week following the delivery to perform a simple PPC check-up. When signs of infection/ill health appear, the mother should be evacuated to the clinic or the midwife called to see the mother at home.

8. Partnership Defined Quality

Finding: The CS-19 Project introduced the PDQ approach which was subsequently replicated by LNGOs in all of the clinics in Jawzjan Province. Issues affecting the quality of care and influencing achievement of the project's objectives (and those of the BPHS Project) are being addressed as a result. The potential to further improve the quality of care and coverage depends on the QITs meeting on a regular basis.

Conclusion: While the PDQ approach has been shown to be effective, unless the QITs meet regularly, the potential impact on quality improvement will not be fulfilled.

Recommendation: LNGOs should support the continued meeting of QITs.

9. Working with TBAs

Finding: While much work is being done to increase the number of facility deliveries, there remains some major and insurmountable barriers (including midwives not available 24/7) to this objective. The vast majority of deliveries take place at home attended by untrained TBAs and family members.

Conclusion: Efforts to reduce maternal and neonatal morbidity and mortality are being thwarted by the MOPH policy not to train TBAs.

Recommendation: It is recommended that the PHO consider training TBAs regarding clean deliveries and especially danger signs that necessitate a facility birth. The BPHS should consider providing an appropriate incentive to TBAs who accompany laboring women to the health facility for delivery.

2. Results: Cross-cutting Approaches

Community Mobilization

Community Mobilization is defined as: "A capacity building process through which community individuals, groups and organizations plan, carry out and evaluate activities on a participatory and sustained basis to achieve an agreed upon goal either on their own initiative or stimulated by others"⁶. Using this definition, the one activity implemented by the CS-19 project that conforms to this definition is the PDQ Initiative. The QIT made up of *Shura* members and clinic staff was trained by CS-19 staff and worked together to analyze the quality of care provided by the clinic and then identified ways quality could be improved. They then worked together to implement those improvements. Examples of activities include the reorientation of the birthing room in some clinics, moving the door to the birthing room to ensure more privacy and building a wall around the clinic to increase security. In this example, the term 'community', refers more to the community of QIT members. It is not clear how QIT members received input about the quality of care from their constituents (men and women who live in the villages surrounding the clinic). Had this been clear, then the 'community' in community mobilization could have been defined as village members.

At the village level, little community mobilization was conducted since the CS-19 project's efforts were focused on increasing the capacity of the PHO and through them, health care providers at clinics and health posts. While the CS-19 MCH Promoters did help to train and support the CHWs during the first years of the project when the REACH project was just getting started, these efforts did not result in 'community mobilization' as defined above.

⁶ ACCESS Project definition.

Communication for Behavior Change (BCC)

When the CS-19 project was redesigned to take into account (and avoid duplication of effort) the REACH project and subsequent initiatives to support the BPHS, opportunities to promote BC *directly at the community level* were limited to Shiberghan District and the Andkhoy cluster where the REACH project was not active. Despite this constraint, the project used various means to promote BC, focusing primarily on the supply-side of health care.

The strongest aspect of the BCC strategy focused on increasing attendance at the clinics and health posts by improving the quality of care. This was done through monthly joint supervision and refresher courses for health care providers (clinic and health post-based). The PDQ approach can also be considered a BCC strategy since by eliminating some barriers to health center attendance, some behaviors, such as clinic deliveries, were facilitated.

Focusing on the provision of health services however, does not usually have a significant impact on those health behaviors that are conducted only at home and do not require any outside resources. In the case of CS-19, these included hand washing and child feeding behaviors related to diarrheal disease control and feeding a sick child. To promote hand washing CS-19 supported an awareness raising campaign (initially in response to a cholera outbreak) which later became an annual event supported by many stakeholders. Although not strictly geared to these behaviors, the introduction of the PD/Hearth included messages on hand washing and feeding during illness, as well as messages about feeding a malnourished child. This strategy was introduced in five (vs. four planned) villages however, so its impact as a BCC approach was limited. Nevertheless, scale-up opportunities exist if LNGOs and other BPHS implementing partners adopt the PD/Hearth approach.

The project also promoted BC by making various visual aids available to the clinics and health posts and assisting the PHO to conduct hand washing and birth preparedness campaigns. Rather than developing all new visual aids, the project staff collected materials already in existence and in some cases modified these to make them appropriate for the cultural context. The effectiveness of some of these materials (especially the banners used for the campaigns) was reduced through the over utilization of the written word to communicate with a largely pre-literate population.

The DIP proposed to use the radio as a means of communicating with the public. This idea was dropped after the cost of radio messages proved prohibitively expensive and since other stakeholders were already broadcasting health messages by radio.

The creation and training of the women's *Shura* groups and the recruitment and training of 600+ volunteers also increased access to health information at the community level.

During the second half of the project, two CS-19 staff members attended a training organized by Mercy Corps on the BEHAVE [Designing for Behavior Change (DBC)] Framework⁷ which was co-facilitated by SC/Afghanistan's Health Program Advisor. Through this training the CS-19 staff was taught how to design a BCC strategy based on qualitative data collected through a Barrier Analysis or Doer/Non-doer Survey and through the use of the BEHAVE Framework.

⁷ Based on the BEHAVE Framework developed by AED and the CORE Group

Unfortunately it does not appear that the CS-19 participants applied what they learned (or perhaps they did not effectively learn to use the tools) as no BEHAVE Framework was completed following the training. Rather, a different approach, one promoted by ACCESS/HSSP was used to improve the activities related to RH. The approach used is much more theoretical in nature than the BEHAVE Framework, however, making it difficult to translate into a concrete BC strategy. As a result, the CS-19 project continued to focus most of its efforts on increasing knowledge and awareness and access to quality health services.

Capacity Building Approach

Strengthening LNGOs

During Round 2 of the BPHS (starting in March 2006) two LNGOs, STEP and MOVE were selected to implement the BPHS in all of the districts of Jawzjan Province. This meant that all of the clinic staff and CHWs were ‘employed’ by these LNGOs supported through the grant. Though it was not planned as such, CS-19 helped strengthen the capacity of these LNGOs. The project filled training gaps in the grants to these organizations which did not cover the roll-out training for LNGO staff. CS-19 also provided training (see the Training Table in the next section) to LNGO staff in topics such as PDQ which were supplemental to the courses provided through BPHS. Had CS-19 not supported the roll-out of training for LNGO staff, it is safe to conclude, that the quality of care at the clinics and in the communities would not have reached the quality revealed by the CS-19 KPC survey.

In addition to the formal training provided to LNGOs by CS-19, LNGO staff (clinic doctors, nurses, midwives, vaccinators, community health supervisors) also benefited from the on-the-job training and regular supervision provided by project staff – technical advisors and Promoters included – and supported logistically by the project.

Because LNGO strengthening was not an anticipated outcome of the project, no assessment of the LNGOs’ capacities was conducted when Round 2 of the BPHS program got underway. Furthermore, it would not likely have appeared appropriate to do so, since SC was also a BPHS grantee, putting the organizations on the same level vis-à-vis USAID/Afghanistan. However, interviews with LNGO technical, management and clinical staff conducted as part of the final evaluation revealed that capacity was increased both individually and organizationally, as a result of the support of the project. LNGO staff uniformly expressed their appreciation for the support of the CS-19 project.

Training

The BCC plan contained in the DIP calls for a substantial amount of training for PHOs and health workers (including CHWs) in all of the five intervention areas. As Table 3 shows, a significant number of courses were conducted with support from the CS-19 project with most every health care provider in the province having likely attended at least one course (if not several) supported by CS-19. In addition to health care providers, CS-19 has also trained hundreds of community volunteers and *Shura* members.

A close look at the training topics cited in the Training Table below shows a few courses that seem outside the scope of the CS-19 project; notably VCT and Infection Prevention. These

courses may have been added at the request of the PHO members, since all training activities were discussed in this forum and CS-19's ability to respond to requests was much appreciated and helped build the capacity of the province's health care providers.

As mentioned previously, the BPHS program's support for training was limited to a series of TOT courses on different topics; courses were held in Kabul for key people who were expected to replicate the course upon return to the province. Lack of funds in the implementing partners' budgets prevented this and so CS-19 stepped in and covered the cost of the roll-out training in the province.

It is not easy to determine the effectiveness of the CS-19 trainings since many were refresher courses, and because the training reports available to the evaluator did not include a comparison of pre- and post-test scores. Follow-up supervision also supported by the project does suggest, however, that performance improved as a result of the training and close follow-up by project staff and PHOs was made possible by the project.

One of the special efforts that SC/Afghanistan made to improve the quality of training was to adapt a section of the CHW curriculum on pneumonia and diarrhea case management. The changes made the curriculum more appropriate for pre- and semi-literate populations. This training course was used in the Andkhoy cluster to train SC's CHWs under their BPHS Project funded by USAID/Afghanistan. An informal assessment of the CHWs' knowledge of pneumonia diagnosis revealed an apparent higher knowledge of diagnostic and treatment skills among the Andkhoy CHWs than the Jawzjan CHWs who were trained using a less pictorial-based curriculum.

Training for health workers in the province is financially supported through grants from USAID/Afghanistan to BPHS project implementers. Over the years, USAID/Afghanistan has learned that money needs to be provided in the grants to LNGOs so they can fully train the health care providers themselves.

Table 3. Training Table

Training Topic	LOP # Courses	LOP # Participants	Type of Participant	# Days per Course
CDD/ARI/IMCI				
CDD Training	9	1, 105	Doctors, Nurses, Midwives MCH Promoters, CHWs Volunteers, <i>Shura</i> members	3
Child Friendly Health Services Training (CDD/ARI/Nut)	2	30	Students	2
Acute Respiratory Infections	9		Doctors	3
IMCI Refresher	5	56	Doctors, Nurses, Midwives	3
Caregiver Counseling	1	17	Doctors 11 Nurses 6	3
Interpersonal Communication and Counseling	1	25	MOPH, STEP, MOVE 4 and CAF	4
CCM/ARI	1	11	CHW	3
CCM CDD	1	11	CHW	3

Training Topic	LOP # Courses	LOP # Participants	Type of Participant	# Days per Course
Maternal and Neonatal Care				
MNC	3	31	Doctors, Midwives, RH Assist. MCH Promoters	9
Reproductive Health Concepts + 5 elements	2	15	Doctors, Midwives	
Family Planning	2	48	Doctors, Midwives, RH Assist. MCH Promoters	5
Postpartum Hemorrhage	3	167	Doctors Midwives PPH staff Pharmacists MCH Promoters CHS CHWs <i>Shura</i> members	4
Safe Motherhood training and implement standard of EOC	2	28	15 Doctors , 13 Midwives	5
MNC Refresher Training	2	18	Doctors, Midwives	5
Family Planning Refresher Training	2	18	Doctors, Midwives	5
Use of Partograph	2	30	Doctors, Midwives	4
VCT	2	32	Doctors, Midwives Nurses	4
Birth Preparedness	10	395	Doctors, Midwives <i>Shura</i> members, CHS CHWs	4
Infection Prevention	2	33	Doctors, Midwives	4
Initial CHW Training	3	110	CHWs	18
Community Mobilization	4	52	Female <i>Shura</i> members	1
Message and Methods Family Planning	14	110	Volunteers	3
NUTRITION				
PD/Hearth TOT Training	1	16	Doctors, MCH Promoters	14
PD/Hearth Orientation Training	3	71	Nutrition Officers Doctors, Midwives Comm. Health Supervisor <i>Shura</i> members	2
PD/Hearth Training	1	36	6 CHWs, 6 CHS 22 Volunteers	4
PD/Hearth Refresher Training	2	78	CHWs, Volunteers, <i>Shura</i> members	1
Breastfeeding Orientation Training	3	388	Doctors, Midwives, MCH Promoters, CHS, CHWs, <i>Shura</i> members	1
Micronutrients Orientation Training (Iodine, Vit. A and FF)	10	538	Doctors, Midwives, MCH Promoters, CHS, CHWs, <i>Shura</i> members	1
Iodized Salt Orientation Training	20	910	Shopkeepers, CHC members, CHW, MCH Promoters	1
IMMUNIZATION				
EPI TOT	1	14		5
Essential EPI + Refresher	5	96		12,8,5,2
HMIS + Refresher	2	42		2 and 3
Micro-planning	2	31		2

Training Topic	LOP # Courses	LOP # Participants	Type of Participant	# Days per Course
CHWs Training	3	56	CHWs	18
<i>Shura</i> Training	17	250 @15	<i>Shura</i> members	1
Leadership Training	3	64	<i>Shura</i> members	2

Health Systems Strengthening (HSS)

When considering HSS, it should be noted here that when SC first designed the CS-19 project, it intended to work at the community level to support the BPHS. When USAID/Afghanistan funded MSH to implement the REACH project in Jawzjan and elsewhere, SC was obliged to change its approach and to focus on strengthening the PHO and to fill the gaps of the REACH project (as described in the training section and elsewhere). SC should be commended for its flexibility in redesigning the project to make sure that project funds helped support the efforts of the MOPH/Afghanistan and USAID/Afghanistan while avoiding duplicating the efforts of other projects being implemented at the same time and place. Readjustments were required not only once, but again when the REACH project ended in 2006 and another set of implementing partners came on board. Once again the CS-19 project sought ways to fill gaps and strengthen the LNGOs as they implemented the BPHS.

While both the PHO and the BPHS implementing partners clearly benefited from CS-19 support, it is fair to question whether the significantly altered focus away from the community and onto the provincial level took the project so far away from its original design that it merited being reconsidered for continued funding by CSHGP; particularly as the area of intervention where CS-19 was working directly at the community level with CSHGP funds was reduced from 22 districts to only one district and in as much as SC received funding from USAID/Afghanistan to implement the BPHS in the Andkhoy District. In an effort to clarify who was working where and when, Table 4 identifies the projects operating in the Jawzjan Province and Andkhoy cluster during the life of CS-19, and the duration of their activities. The table highlights how intertwined the health activities were in Jawzjan Province.

In today's Afghanistan, health care providers at the district level are employed by the implementing partners of the BPHS program (LNGOs) and implement health activities at the district and community levels. MOPH policies govern the actions of the LNGOs and the PHOs supervise activities at the district level, but the LNGO implementing partners represent the health system from the district level down. As a result, HSSP and LNGO (BPHS implementing partner) strengthening are closely intertwined.

Afghanistan is at a stage of development where the government, through grants from donors, is trying to build the capacity of the MOPH and the CS-19 Project helped to do this at the provincial level in Jawzjan. To strengthen the PHO, CS-19 staff mentored each of the PHOs as they came on board, and supported the Provincial Health Director's efforts to guide and support the work of the LNGOs at the district and community levels. CS-19 staff also sat on the Provincial Health Coordinating Committee (PHCC), which met each month to discuss progress and make plans. CS-19 staff also used this forum to introduce new ideas such as PD/Hearth and PDQ and to advocate to certain activities, such as the creation of female *Shuras*. Each of the PHOs was mentored by a CS-19 staff member with technical expertise. They conducted

monthly joint supervision, designed and conducted training courses together, planned activities such as NIDs, safe motherhood and hand washing campaigns, and reviewed progress made in their individual technical areas. The approach to strengthening the Provincial MOPH was very practical and influenced to a great extent the quality of care provided by clinic and health post staff at the district and community levels. This was evidenced by the various checklists completed each month. CS-19 also assisted the PHO logistically by providing vehicles for NIDs, covering transportation costs and other logistical needs.

Although each of the PHOs attests to the benefit of the support provided to them by project staff, because the project did not conduct either an organizational or individual capacity assessment it is very difficult to concretely ascertain in what ways and to what degree the efforts of the CS-19 team resulted in a stronger PHO with more capable staff. Furthermore, because an assessment was not conducted, the CS-19 team could not develop a plan (or individual plans) to address the capacity gaps among the health officers individually or in the PH Office as an entity. As a result, their capacity building approach was somewhat haphazard.

In addition to strengthening the capacity of the PHO as a whole, at the request of the Provincial Health Director, CS-19 agreed to directly assist the six clinics in the urban district of Shiberghan that were not covered by REACH during Round 1 of the BPHS. Thus from 2003 to 2006 CS -19 trained health care providers on EPI, MNC and IMCI in line with what REACH was doing in the rest of the Province. CS-19 provided rented vehicles to these clinics so they could provide outreach services, and CS-19 Promoters provided health education in communities and trained and supported community volunteers to do the same. CHWs were later recruited from among these volunteers during BPHS Round 2, when LNGO, MOVE, assumed responsibility for Shiberghan District. These efforts helped Shiberghan District stay on par with the rest of the province until the district was included in Round 2 of the BPHS.

Table 4. CS-19 and Concurrent Health Projects/Activities

Event	2003 -2004				2004-2005				2005 - 2006				2006 -2007				2007- 2008			
❖ Save the Children's CS-19 Project																				
○ CS-19 DIP submitted																				
○ SC Child Focused Health Ed. Project (CS-19)																				
○ Birth preparedness activities																				
○ Health education (EPI, ARI, CDD, nutrition)																				
○ CS-19 Mid Term Evaluation																				
❖ <u>BPHS Round 1</u> : REACH (MSH) funded by USAID/Afghanistan																				
▪ SC implements BPHS in 3 districts in Jawzjan funded by USAID/Afghanistan																				
▪ SC implements BPHS in 4 districts in Andkhoy funded by USAID/Afghanistan																				
▪ SC contracts LNGO, CAF, to implement BPHS in Andkhoy																				
▪ SC/UK implements BPHS in 6 districts in Jawzjan																				
▪ SC Community Midwife Education Project – USAID/Afghanistan funded (ACCESS) X = midwives deployed											X	X	X	X	X	X	X	X	X	X
▪ SC Prevention of Postpartum Hem. Project																				
❖ <u>BPHS Round 2</u> : HSSP, Tech Serve etc; Shiberghan District turned over to MOVE																				
▪ LNGOs - STEPand MOVE - start implementing BPHS																				

Policy and Advocacy

CS-19 staff has used their position on the PHCC to influence policies and to advocate for change within the PHO and amongst BPHS implementing partners. Examples of issues they advocated for include the creation of female *Shuras* so that women community members have a voice in health care services and can influence the quality of care. SC advocated for the extension of CHW training to three days and the use of pictorial job aids to strengthen their CCM skills. They advocated for the recruitment of female vaccinators and the training of midwives, which resulted in a very strong local support for the Community Midwife Education project once it was funded. CS-19 used the PHCC to share information about their special initiatives such as the PD/Hearth, the PDQ and the results of their Prevention of Postpartum Hemorrhage study (conducted as part of the BPHS project once it was led by JHPIEGO). As a result of these efforts, the PDQ was adopted by the BPHS implementing partners and was replicated throughout the province.

Additionally, SC has shared some of the results of the CCM and PD/Hearth at national fora such as MOPH-led round table discussions and at HSSP NGO/stakeholders meetings. BASICS, a USAID/Afghanistan-funded implementing partner, is considering incorporating this approach into their programs.

Contribution to Scale/Scaling Up

CS-19 supported scale-up by strengthening the PHO and staff capacities, and through SC staff work on the PHCC as described previously. As a result of the mentoring provided by CS-19 staff, all of the PHOs are better able to manage and supervise the activities at the district level. CS-19 pilot tested several initiatives, the results of which were shared with PHCC members and some of which (PDQ) were eventually replicated throughout the province by other implementing partners. Other initiatives such as the creation of female *Shuras* were also replicated throughout the province and into the neighboring province through SC's work in the Andkhoy cluster. The tools developed by CS-19 staff to train CHWs in CCM have also been adopted by the MOPH and BASICS, and are being used to re-train more than 10,000 CHWs.

SC partnered with other USAID/Afghanistan implementing partners to train midwives from the local area so that each clinic would have a trained midwife.

CS-19 staff also tested the use of misoprostol for the prevention of postpartum hemorrhage. While these activities were funded by other sources, CS-19's presence on the PHCC informed the implementing partners' operations in Jawzjan Province.

Equity

Gender inequity is the most pervasive and difficult problem facing everyone in Afghanistan trying to improve health care, especially for women. Women's movements are extremely restricted, though improvements are being made, and health care for women almost always needs to be provided by women. SC has made a significant effort to address gender inequities inherent to the Afghan culture. For example, CS-19's advocacy for the recruitment of female vaccinators ensured that women have access to female vaccinators at all but a few clinics. SC's education of midwives through the CME project increased the number of trained midwives so that each clinic has one, which begins to address a serious access problem. Though the education and support of

midwives was funded by another project, CS-19 supported the supervision of these midwives and helped improve the quality of care.

Further, CS-19 was the first implementing partner in the province to recruit and train female *Shuras* (one for each clinic), a practice that was later replicated by the other implementing partners. These groups' voices became even stronger as they participated in the PDQ approach and were able to represent the needs and desires of women with regard to health care issues. Many of the quality improvements that were made related to gender issues (providing better privacy during labor and delivery, for example) came about as a result of the PDQ process.

Despite these efforts, there remain many gender inequities for which easy solutions are not apparent. The current implementing partners are aware of these and are jointly searching for ways and means to ensure access to services for women within the cultural context of Afghanistan.

Sustainability Strategy

The question of sustainability in Afghanistan is a bit unique as the country is still in a state of war, and health services at the district and community levels are almost completely in the hands of LNGOs who are supported by donors such as USAID. The provision of health services, including the payment of providers' salaries, at the district and community levels depends entirely on those donor funds. Therefore, as long as donor funds are being provided, health services will also continue.

CS-19 has directly contributed to sustainability in two significant ways: 1) through its support to the PHO and strengthening of the PHOs (most of who are still there); and 2) by building the capacity (through trainings and joint supervision) at the district level of BPHS implementing NGOs and health workers. All of the PHOs have received support to increase their capacity and improve various aspects of their own performance. As long as these PHO employees stay in their current positions, their improved capacity will continue to benefit the provincial health system.

An issue revealed during the final evaluation related to sustainability but not directly linked to the CS-19 project bears mentioning here so that it can be addressed in the future. While there is a direct link between the PHO and the clinic-based health care providers, there is no direct link between the PHO and the CHW. Currently, the work of the CHWs is organized by the LNGOs, who also supervise them. This means that in the future, when the PHO assumes complete responsibility for running the health program in the province, there will be no direct link from the provincial to the community level. It also means that each time the implementing partners change – which can happen with each round of funding – that the continuity from one partner to another can be lost. This occurred when a new implementing partner fired many of the doctors previously trained by CS-19. Since ensuring the quality of the work of the CHWs is essential to achieving the coverage objectives, an effective link between the PHO and the CHWs needs to be established.

Findings, Conclusions and Recommendations: Cross Cutting Issues

1. Behavior Change Communication

Finding: CS-19 helped promote BC by developing, reproducing and distributing visual aids on various project messages. Some of these visual aids communicate primarily through the written word, even though the majority of the target audience is pre-literate.

Conclusion: Overdependence on communication through writing limits the effectiveness of the visual aids.

Recommendation/Lessons Learned: When working with a pre-literate audience, the use of writing to communicate a message should be limited. Culturally appropriate pictures should be used most often.

2. Behavior Change Communication

Finding: Despite being trained to use the BEHAVE framework, CS-19 staff chose to use another tool to design a BCC strategy related to RH (birth preparedness and FP). That strategy focused primarily on increasing knowledge and awareness.

Conclusion: CS-19's BC strategy and community level activities implemented by LNGOs are not as strong as they could be. Behaviors are not changing as quickly as they could.

Lessons Learned: When a project invests in training for its staff, especially to resolve a problem identified during the MTE, it is important for that staff to use the new skills and information to improve that aspect of the project (BC strategy). When training is provided, the people responsible for technical backstopping should follow-up to make sure that the training is put to good use.

Recommendation: The BPHS implementing partners should learn to use the DBC framework including the Barrier Analysis and Doer/Non-doer Survey as a way to improve their BCC strategies through the use of more creative activities that directly relate to key BC determinants.

3. Assessing Effectiveness of Training

Finding: The project did not systematically collect information on pre-training knowledge/skills and post-training knowledge/skills.

Conclusion: As a result it is difficult to ascertain the effectiveness of the training.

Lesson Learned: All training courses should include a pre- and post-test, based on the learning objectives of the course, in order to effectively measure the knowledge gained. The results could then be included in a training report.

4. Training Approach

Finding: SC used a more pictorial-based curriculum to train CHWs in Andkhoy cluster in its BPHS project funded by USAID/ Afghanistan.

Conclusion: An informal assessment of the CHWs' pneumonia diagnosis and treatment knowledge suggests that the pictorial approach was very effective.

Recommendation: LNGOs should consider using the pictorial-based curriculum when providing refresher courses to the CHWs in Jawzjan.

5. USAID/Afghanistan and CSHGP Coordination

Finding: The CS-19 project was originally designed to work at the community level. When USAID/Afghanistan funded the REACH project, CS-19 was obliged to change its approach from

a community focus to strengthening the PHO and covering related training gaps for this and subsequent projects.

Conclusion: CS-19 was not a direct implementer of activities in Jawzjan at the community level as defined in the original proposal. This hindered SC from using their vast experience in community development and health, and limited their impact.

Recommendation: In the future, USAID/Afghanistan should take into account CSHGP-funded programs when designing/funding/implementing mission funded initiatives with the same/similar objectives. Likewise, CSHGP should have a contingency plan for dealing with CS projects that need to be re-designed between the time of conception and the writing of the DIP.

6. Measuring the Capacity of the PHO

Finding: CS-19's focus was on strengthening the capacity of PHO staff. CS-19 did not conduct an Organizational or Individual Capacity Assessment of the PHOs or the PHO as an entity. The project did not have a strategic plan to guide its capacity building efforts of the PHOs.

Conclusion: As a result, the capacity building efforts were not as *strategic* as they could have been and it is difficult to measure the impact of the project's efforts to build the capacity of the PHO staff.

Lesson Learned: When a project seeks to increase the capacity of an organization/set of individuals, it is important to collect baseline data and to develop monitoring tools that will allow the project to track progress toward specific capacity building objectives. It is also important to develop a strategic plan for capacity building.

7. Sustainability

Finding: There is no supervisory link between a PHO and the CHWs, who are supervised by the LNGOs. With each round of BPHS funding, the implementing partner who plans and supervises the CHWs can change, leaving the PHO without oversight responsibility or continuity of quality assurance.

Conclusion: There is no direct means for information about the work of the CHWs to be shared at the provincial level and inform the planning process. The PHO does not guide the work of the CHWs, even though they play an essential role in the achievement of the PHO's objectives. When the BPHS ends, it is not clear who will support the CHWs.

Recommendation: The PHO of Jawzjan should consider creating a PHO position responsible for Community Health Promotion and Case Management.

8. Sustainability – Future use of Community Volunteers

Finding: CS-19 recruited, trained and supported over 600 community volunteers. Some of these became CHWs when the BPHS was initiated, but many did not. The LNGOs that are now operational in the areas where these volunteers exist do not currently work with them.

Conclusion: Precious human resources are being wasted.

Recommendation: Actions need to be taken to ensure that community health volunteers trained by CS-19 prior to the creation of CHWs are supported by the LNGOs under the BPHS. The first step would be to share the job description, names, locations and any phone numbers of the community health volunteers (CHVs) with the LNGOs. A copy of the curricula used to train the CHV should also be provided to the LNGOs along with any tools or IEC materials they were taught to use.

C. Mission Collaboration

The final evaluation team leader met twice with the Health, Population, and Nutrition Officer of USAID/Afghanistan, Randolph Augustin, MD, MPH and his Deputy, Dr. Faiz Mohammad. While Dr. Faiz Mohammad has been working for USAID for many years and is very familiar with SC's work in Jawzjan (he is a former SC employee and worked in the region previously), Dr. Augustin has only been with USAID/Afghanistan for 11 months and was less knowledgeable. Upon the arrival of Dr. Augustin in country, the SC Country Director, Leslie Wilson, and the Deputy Director of Programs, Dr. Tariq Ihsan, met with the USAID health team to brief them on the portfolio and provide them a copy of the Fourth Annual Report. Other key documents including, the proposal, the DIP, and each of the previous annual reports had already been sent to the USAID health team electronically.

USAID holds coordinating meetings with their implementing partners, including JPHIEGO and MSH, on a weekly basis, but does not invite SC. During our discussions each party agreed that communication could be improved and one way to do that would be for USAID to invite SC to these coordinating meetings. This would also help Dr. Augustin to understand the extensive role that SC has been playing in the province and especially the extent to which the CS-19 project was used to strengthen and fill the gaps of the USAID/Afghanistan-funded (BPHS and CME) projects. It would also help USAID to better understand and appreciate the close collaboration that CS-19 has enjoyed with the PHO.

At the time the CS-19 project proposal was written, the involvement of the USAID mission was not as substantial (or required) as it is now. This might explain how it came to pass that the mission planned and funded a project for Jawzjan Province (and many other provinces) when another project (CS-19) had already been funded (not to the same level) by CSHGP. When the REACH project was funded, to avoid duplication of effort, SC redesigned their CS project so that it filled the gaps of the REACH project. While this was done in consultation with MSH who implemented the REACH project, there was no involvement of either the mission or CSHGP (apart from the presentation of the DIP).

SC receives funding directly from USAID/Afghanistan as a member of the ACCESS HSSP consortium. Through these projects and also through CS-19, SC/Afghanistan supports the achievement of the Mission's health objectives.

D. Contextual Factors that Influenced Results

The most obvious contextual influences on this project are the fact that it was implemented in a country at war and in a state of reconstruction. These two factors limited movement within the project area throughout the life of the project, and meant that the MOPH at the provincial level (the PHO) required substantial capacity building and logistical support. The insecurity of the country as a whole limited the availability of technical assistance, as consultants were not always willing to take the risk involved with working in Afghanistan. The special context also meant that the provision of health care from the district to the community was the responsibility of different NGOs – international and then local – which complicated partnering options and limited SC's authority. Although it is rarely mentioned, the cost of operating in a location with such high security risks is also a factor that influenced the project.

The issues described above that prevented SC from working at the community level as they had originally planned, including USAID/Afghanistan's funding of a similar project, directly influenced project implementation. Rather than building on their area of strength, community health, SC was required to redesign the project to fill other gaps. Furthermore, it was unfortunate that SC was still obligated to use the KPC survey as its evaluation tool, when given the redesign, this tool was no longer the most appropriate.

SC/Afghanistan had been working in Andkhoy cluster (four districts) from 1995–2004 and as a result, it was determined that they needed to conduct a separate KPC survey in the Andkhoy cluster. While this did not influence program choices, it was an additional cost.

Finally, there was an abundance of organizations and projects which were ongoing in both Andkhoy and Jawzjan during the life of CS-19; all had similar objectives, making it difficult to determine which approaches or inputs were most responsible for the positive outcomes and therefore ought to be replicated. However, this level of collaboration is very positive.

E. Conclusions and Recommendations

1. Effectiveness in Reaching Objectives

Like all Child Survival projects funded through CSHGP, CS-19 conducted a baseline and final KPC survey. As Table 2 shows, 8 out of the 10 indicators were achieved. As previously discussed, it is important to note that the KPC survey was not the appropriate tool to measure project achievements (as refocused). Fortunately, a qualitative evaluation was conducted and includes both quantitative and qualitative data, revealing the following important achievements for CS-19.

2. Achievements

1. CS-19 filled the gaps in the REACH and subsequent USAID/Afghanistan-funded projects by working in geographical areas not covered (Shiberghan) and providing funds for training, transportation and supervision of district level health care providers.
2. CS-19 helped increase access to gender appropriate vaccination services by advocating that additional female vaccinators be hired and by supporting 11 female vaccinators for two years. By project's end, 26 out of 27 clinics had female vaccinators in both Andkhoy cluster and Jawzjan.
3. CS-19 helped increase the capacity of PHO and LNGO staff through training, mentoring and on-the-job training. Through this, the PHO was also strengthened as an entity.
4. Through the introduction of PD/Hearth, CS-19 provided a model to the MOPH and LNGOs for community-based nutrition activities, an area of the BPHS that needs to be strengthened.
5. By training PHO and LNGO staff in PDQ, CS-19 provided a model for obtaining community input into quality assurance issues. Quality Assurance Teams have been established and the PDQ process has been replicated by LNGOs in all 22 clinics in Jawzjan Province. Evidence exists of Quality Assurance measures being taken as a result of the PDQ process.
6. CS-19 helped increased access to health information at the clinics and communities through development, reproduction and distribution of appropriate IEC materials; also through the training of 600+ community volunteers.

7. CS-19 helped increase gender equity through the creation of female *Shuras* (one for each clinic); this model was replicated by LNGOs under the BPHS, and as a result, 100% of clinics now have women *Shuras*.

3. Recommendations and Lessons Learned

Technical Areas

- In the future, USAID/Afghanistan should try to develop programs that take CSHGP-funded health programs into account. They should consider the expertise of the implementing organizations when assigning responsibility for project implementation.
- MOPH and local implementing partners should look for ways to ensure that female vaccinators can conduct outreach activities at least ten days out of every month. They should consider hiring additional female vaccinators (replace the male vaccinators) so one can stay at the clinic while another goes on outreach. Another possibility would be to hire couples to be vaccinators so they can go out together.
- It is recommended that the PHO consider training TBAs regarding clean deliveries and especially danger signs that necessitate a facility birth. The BPHS should consider providing an appropriate incentive to TBAs who accompany laboring women to the health facility for delivery.
- When a project seeks to increase the capacity of an organization/set of individuals, it is important to collect baseline data and to develop monitoring tools that will allow the project to track progress toward specific capacity building objectives. It is also important to develop a realistic strategic plan for capacity building.
- When a project invests in training for its staff, especially to resolve a problem identified during the MTE, it is important for that trained staff to use the new skills and information to improve that aspect of the project. Project backstop officers in Kabul and Headquarters, should follow up to make sure that the training is put to good use.
- The LNGOs should develop BEHAVE Frameworks, conducting barrier analysis or doer/non-doer surveys for difficult-to-change behaviors, and use this tool to develop activities at the community level which will promote the desired behaviors.
- The MOPH/Afghanistan and USAID/Afghanistan's implementing partners should consider including the PD/Hearth into the BPHS program.
- While continuing to improve access to professional maternal/reproductive health care and promote facility deliveries, the MOPH/Afghanistan and the PHO should consider providing training to TBAs on the recognition of danger signs during pregnancy, clean deliveries, recognition of danger signs during labor and delivery, newborn care and postpartum care.
- The MOPH/A and USAID/A should consider training CHWs and TBAs to identify the postpartum/post natal danger signs and should be required (CHWs) /encouraged (TBAs) to visit new mothers/newborns a couple of times during the week following the delivery to perform a simple PPC check up. When signs of infection/ill health appear the mother should be evacuated to the clinic or the midwife called to see the mother at home.
- LNGOs should support the continued meeting of QITs.

Cross-Cutting Issues

- When working with a pre-literate audience, the use of writing to communicate a message should be limited. Culturally appropriate pictures should be used most often.

- When a project invests in training for its staff, especially to resolve a problem identified during the mid term evaluation, it is important for that trained staff to use the new skills and information to improve that aspect of the project (BC strategy). When training is provided the people responsible for technical backstopping should follow-up to make sure that the training is put to good use.
- The BPHS implementing partners should learn to use the DBC framework including the Barrier Analysis and Doer/Non-doer Survey as a way to improve their BCC strategies through the use of more creative activities that directly relate to key determinants of BC.
- As a part of all training courses a pre- and post-test, based on the learning objectives of the course should be administered and the results should be made available in a training report.
- LNGOs should consider using the pictorial-based curriculum when providing refresher courses to the CHWs in Jawzjan.
- In the future, USAID/Afghanistan should take into account CSHGP-funded programs when designing/funding/implementing mission funded initiatives with the same/similar objectives. Likewise, CSHGP should have a contingency plan for dealing with CS projects that need to be re-designed between the time of conception and the writing of the DIP.
- When a project seeks to increase the capacity of an organization/set of individuals, it is important to collect baseline data and to develop monitoring tools that will allow the project to track progress toward specific capacity building objectives. It is also important to develop a strategic plan for capacity building.
- The PHO of Jawzjan should consider creating a Provincial Health Officer position responsible for Community Health Promotion and Case Management.
- Steps should be taken to ensure that CHVs trained by CS-19 prior to the creation of CHWs are supported by the LNGOs under the BPHS. The first step would be to share the job description, names, locations and any phone numbers of the CHW with the LNGOs. A copy of the curricula used to train the CHVs should also be provided to the LNGOs, along with any tools or IEC materials they were taught to use.

4. Use of Best Practices and Lessons Learned

Training

As USAID-funded BPHS program did not include budget for training, therefore CS-19 used its resources to provide on the job training, TOT courses and refresher courses. Consistent demonstration of good knowledge and skills as noted during supervisory visits to health facilities or CHWs show that CS-19 trainings were of very good quality. Best practices included:

- Designing trainings for facility health workers based on needs assessments and keeping in mind national quality assurance performance standards; BPHS program; and using adult learning techniques that incorporated group learning; individual learning and structured on the job training and supporting visual aids including power point presentations, posters and flip charts.
- Competency based trainings that focused on clinical skills including methods that allowed participants to demonstrate competency in a simulation before working with clients and patients.
- Pre and post tests were used to assess the quality of trainings and intensive follow-up of trainees by CS-19 trainers, trained PHO and BPHS implementing NGO staff were carried out to ensure that knowledge and skills acquired are retained and used.

- For CHW training, different techniques of adult education including use of IEC materials and interactive teaching methods such as group discussions; questions and answers; demonstration; role plays; and story telling – and where feasible, videos and models were also used.
- Throughout the educational process, theoretical and clinical practice aspects were promoted to enhance CHWs' knowledge so they are able to decide how, why and when a skill should be used; practical skills so they are able to use the skills; decision making skills so they know what actions are needed for a particular client or a patient; and enhancing communication skills so they are able to counsel caregivers to ensure compliance of instructions on home care, follow-up and referral.

Monitoring & supervision – best practices

CS-19 four qualified and experienced professional staff (men and women) supported the PHO and BPHS implementing NGOs through regular monitoring and supervision of health facilities and CHWs to assess MNC, IMCI, Nutrition, EPI and BCC to ensure that the BPHS program was meeting the national quality assurance standards and that the PHO team was using QA methods and tools systematically, consistently and effectively. Best practices to promote good quality monitoring and supervision included:

- Familiarization with national Quality Assurance tools and methods. CS-19 staff first attended MoPH-led orientation sessions on FFSDP in 2006 and Standard Based Management and Recognition (SBM-R) methods and tools in 2007. SBM-R is now considered an approach for improving the performance and quality of health services based on operational performance standards for each component of BPHS program and rewarding compliance of these standards usually through a recognition mechanism.
- Discussing results of each joint monitoring and supervisions with PHO and BPHS implementing NGOs and developing and implementing plans to further improve the performance.
- Keeping themselves (CS-19 team) well informed of how the BPHS project was progressing at each health facility and its catchment area as, without this information, assessing improvements against findings from previous monitoring and supervision visits would have been difficult. Every three months CS-19 team and PHO staff reviewed information from previous supervisory visits; PHCC meetings; HMIS data; and meetings with *Shura-e-sahee* and CHWs. With this knowledge in mind, monthly supervisory schedules were developed and shared with PHO and BPHS implementing NGOs.
- Maintaining high level of morale and job satisfaction through promoting supportive supervision approach focused on cultivating an environment where colleagues can learn from each other; and where supervisors and supervisee jointly discuss problems related to performance; specific skills and health services and develop action plans for further improvement.

Mobilizing resources and collaborating with other health programs

CS-19 staff worked very closely with other SC health program teams as well as other NGOs' and the MOPH. This gave an opportunity to CS-19 to use its innovative ideas and approaches within its maternal and newborn care intervention as well as provided high quality technical support to these health programs that resulted in success of these projects.

CS-19 staff provided overall technical guidance and support to ACCESS/Prevention of Postpartum Hemorrhage project that demonstrated the successful use of misoprostol in reducing postpartum hemorrhage in home births. CS-19 birth preparedness and complication readiness education training materials, methods and tools were used in this project. Final evaluation of this project showed that a three-day CHW training (on birth preparedness education, prevention of postpartum hemorrhage and, in the intervention area, correct use of misoprostol) followed by rigorous supervision from Community Health Supervisors (CHS) has proven effective in the correct use of misoprostol. A total of 1,185 (82%) received misoprostol; 865 (73%) took it correctly; while the remaining used the services of midwives. The results further revealed that education on birth preparedness and prevention of postpartum hemorrhage has helped increase community awareness regarding the importance of midwives at deliveries.

CS-19 also worked closely with staff in the REACH and then ACCESS/HSSP Community Midwifery Education (CME) program that focuses on educating women who have completed at least nine years of schooling and are supported by their communities, to become successful community-based midwives. CS-19 staff facilitated meetings between communities, the PHO and BPHS implementing NGOs to recruit students for the Jawzjan Province CME School. In addition, CS-19 not only provided trainings on birth preparedness education and family planning to midwives, but helped them settle into their clinics once they graduated and returned to their villages, and also followed up with them.

CS-19 was also successful in mobilizing resources from the ACCESS/HSSP project to lead the first PDQ TOT in Jawzjan Province; and, as a result BPHS implementing NGOs successfully replicated PDQ in most districts of the province. Further ACCESS/HSSP training colleagues who attended the workshop successfully replicated it in five other provinces.

5. Scale Up Options

The current implementing partners should consider incorporating the PD/Hearth approach into their community nutrition activities and use this as a way to strengthen the nutrition component of the BPHS.

ANNEXES

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Annex 1
Activity Location Table

Province/ District	# Clinic	# villag es	# MCH Prom.	CFHE* (sep grant)	PPH (sep)	PD/H	CCM	Birth Prep. *	Vols/ CHW Trained	♀ Shura Formed	SC/ UK	LNGO STEP	LNG O/ CAF	MOVE	PDQ CS- 19	Joint Super vision
Faryah				# villages	District wide	# villages	# villages									
1. Andkhoy	1	33	1 H	8	-	-	-	30	100/ 75	X	-	-	X	-	-	X
2.Qarmaqul	1	7	1 M	2	X	1	1	13	23/ 26	X	-	-	X	-	-	X
3. Khancherbagh	1	8	1 Hn	4	-	1	-	10	30/ 30	X	-	-	X	-	X	X
4. Surkhi Baazar	1	6	1 H	4	X	-	-	6	9/ 12	X	-	-	X	-	-	X
5. Qurghan	1	10	1 H	4	X	-	-	10	30/ 28	X	-	-	X	-	-	X
Jawzjan																
1. Aqcha	1		-	-	-	-	-	-	0/0	-	X	X	-	-	X	X
2.Faiza Abad	2	55	1 ML	-	-	-	-	11	0/ 40	-	X	-	-	X	X	X
3.Murdyan	1	28	1ML	-	-	-	-	28	0/ 40	-	X	-	-	X	X	X
4. Mingajik	1	34	-	-	-	-	-	-	0/0	-	X	-	-	X	X	X
5. Qarquín	1	4	1Zul	-	X	-	1	5	5/ 24	X	-	-	-	X	X	X
6. Kahmyab	1	5	1Mast	-	X	-	-	5	12/ 12	X	-	-	-	X	X	X
7. Darzab	1	60	2 Hmd Sara	-	-	-	-	33	0/ 29	X	X	X	-	-	X	X
8. Khoja Du Koh	1	23	1 Saf	-	-	-	-	23	8/ 24	X	-	X	-	-	-	X
9. Khanqah	1	51	1 SHK	-	-	-	-	20	0/33	X	X	-	-	X	X	X
10. Shiberghan	7	49+81	4 (same as above)	6	-	2	1	72	50 fac 49 vol CHW	X	-	X	-	-	X	X
11. Qush Tepa	1		-	-	-	-	-	-	0/0	-	X	X	-	-	X	X
16 Districts	23		10 Prom	28	5	4	2		266/373	11		5	5	6		16

CFHE = Child Focused Health Education

Annex 2
Results Highlight
Partnership Defined Quality Application in Afghanistan: “Quality Improvement for Basic Package of Health Services”

With maternal mortality ratio (MMR) of 1600 per 100,000 live births and infant mortality rate of 129 per 1000 live births Afghanistan has one of the world’s poorest health indicators. More than one-third of the deaths are due to hemorrhage during or shortly after delivery. Since 2002, the Ministry of Public Health (MoPH) has focused on improving the health delivery system. Currently, it is reaching more than 80% of Afghanistan’s population with the Basic Package of Health Services (BPHS) through health facilities and Community Health Workers (CHWs). While access to BPHS has increased, quality of care remains a challenge in many parts of Afghanistan.

Partnership Defined Quality (PDQ) is an approach to improve the quality and accessibility of services with greater involvement of the community in defining, implementing, and monitoring the quality improvement process. This process involves identification of gaps in quality of services jointly by community representatives and health facility staff and take action to address them. In the CS-19 project, PDQ process was piloted in Jawzjan province. The overall aim was to improve quality of services by enhancing meaningful participation of community members, especially women (clients) and the community health Shuras (consultative body).

As a first step SC/US organized a workshop to train for staff from SC/US, MoPH and National NGOs, STEP and MOVE to facilitate the PDQ process in all the health facilities in the intervention areas. Topics included: PDQ concept; four PDQ phases - conducting quality inquiry from community/client’s and health worker’s perspective; analysis of information; preparing feedback for communities and health workers; establishing Quality Improvement Team (QIT); preparing for bridging the gap workshop at the community level; conducting the workshop and developing quality improvement plans. Two districts were identified where participants conducted field work and assisted QITs to develop an action plan.

Next, PDQ process was facilitated by MOVE and STEP in the health facilities. The clinic staff and male and female chairpersons from the catchment area village Shuras are members of the QIT. Both men and women members participated in the PDQ inquiry and bridging the gap exercise, discussed quality issues and developed consensus around priority issues. The QITs developed action plans which are displayed prominently at the health facility for all the clients to see. The QITs meet every month and discuss issues related to availability and quality of care for the health facility catchment population.

QITS have been formed in all the 22 health facilities in Jawzjan province by the BPHS implementing LNGOs. Major quality improvement activities carried out by the QITS are: rearranging of labor room entrance for privacy, transfer of non performing staff, filling vacant posts of CMWs, construction of health facility boundary walls and community awareness campaigns by health committee members leading to improved staff motivation, increased vaccination coverage and deliveries at health facilities. Following the successful implementation in Jawzjan, PDQ process is being considered by ACCESS/HSSP as a quality improvement approach for scaling up in 13 provinces. To-date, it has been replicated in five provinces.

Annex 3
Publications and/or Presentations

Not applicable.

Annex 4

Project Management Evaluation

Planning

In the case of CS-19 the DIP development process was essential because so much had changed between the time of writing the proposal, project start up and the second quarter of the project (Jan – March 2004). It provided CS-19 staff, the PH Office and the new implementing partners of USAID to essentially redesign the project to avoid duplication of the REACH project activities and to complement the REACH project. Thus for example, CS-19 agreed to work in the 6 urban clinics in Shiberghan District which were not covered under the REACH project. Because MSH and SC/UK representatives participated in the development of the DIP it allowed all of the implementing partners to discuss the role that CS-19 should play and how best to use the project funds to achieve the objectives of the BPHS.

Supervision of Project Staff

As SC is an experienced organization with standard human resources policies and procedures in place, the supervisory system for the CS project was adequate. The SC Health Sector Advisor based in Kabul, spent 50% of his time in the project area and was therefore able to oversee the work of the project staff. In addition to this oversight, there is also a Regional Health Advisor based in Shiberghan who supported the CS-19 Project Coordinator and supervised project staff.

As mentioned earlier, the CS-19 project mentored PHOs and helped strengthen their capacity to supervise district level health care providers. Through the development and monthly use of checklists the PH Officer's capacity to supervise their staff all improved and will be continued with support from the current implementing partners.

Human Resources and Staff Management

As with the supervision systems, given the experience of SC, all of the personnel policies that are needed are definitely in place. SC/Afghanistan also benefits from a very comprehensive security system which serves to protect the welfare of all of the staff.

Throughout the life of the project the morale and rapport between staff was quite high despite the constant threat of insecurity and violence. Only one staff member left the project prematurely but this gap was filled internally causing little disruption to project implementation.

Almost all of the staff had already found jobs by the time of the final evaluation and plans were underway to keep most of the remaining staff to work on current health projects in the province.

Financial Management

During the final evaluation there was little time to discuss the financial management of the project. To a large extent financial reports were compiled and submitted from Kabul after having received financial accounts of monthly expenditures from the field. Keeping track of the various projects that were intervening in the same geographical areas and using staff from other projects, must have been very difficult to track. When asked about this the CS-19 Project Manager explained that after requesting them, life-of-project expense reports were shared with the project manager so that he could better judge the rate of expenditures.

The CS-19 benefited financially from grants received from USAID/Afghanistan that supported BPHS activities implemented by SC in both Jawzjan (3 districts) from 2004-2006 and in Andkhoy from 2004 – 2008.

Future activities will be financially supported through the BPHS program which is funded by USAID and other donors.

Logistics

There appears not to have been any issues related to logistics. This said, it should be noted that the additional expenses required to adhere to SC's security policy – always traveling in convey within Kabul after sunset and between Kabul and the project area, having various means to communicate with individuals etc – is very expensive.

Information Management

The monitoring system is probably one of the weakest aspects of the CS-19 project. The project conducted a baseline data survey using the usual KPC questionnaire and then repeated this again at the end of the project. This tool was not appropriate for evaluating the project. This is because the project was redesigned at the time of the DIP and the project's focus shifted from the community level to strengthening the PHO. The fact that so many other groups were working at the community level means that the KPC survey more accurately assesses their work (which was in fact assessed by the REACH project) than the efforts and inputs of the CS-19.

CS-19 could have recreated a monitoring system to assess the growing capacity of the PH Office and the individual Officers. The fact that it was decided not to conduct an Organizational Capacity Assessment and that CS-19 could not therefore develop a strategic plan for building the PHO capacity – which they could then monitor – means that evaluators had to depend on anecdotal evidence to show progress rather than concrete evidence. Had the project employed an M&E specialist or if the backstop support from HQ had been stronger this may have been avoided.

The project relied entirely on a series of checklists (few of which are available for review in English) to facilitate the work of the PHOs. These checklists are used on a monthly basis to supervise various aspects of district-level health care provided by clinicians who are employees of LNGOs funded through USAID/Afghanistan, and who have their own means of measuring progress. The supervision was done jointly between CS-19 staff and PHOs and the results were then discussed and feedback given the implementing partner (LNGOs) who would take steps to strengthen the clinic or the system in question.

Among the checklist used were, Observation checklists used by PHOs to assess performance of midwives and doctors in the area of MNC and IMCI. Other tools (that BPHS does not use in its system) included exit interviews of caregivers to assess the quality of caregiver's counseling (CS-19 used BASICS tools to do these two latter exercises). CS-19 also piloted CCM and PD/Hearth and used tools to assess CHWs and volunteers performances regarding CCM and PD hearth. CS-19 also documented its PD/Hearth initiative. Information gathered through these tools and methods were continuously used to improve interventions and share lessons learned with all

key stakeholders and policy makers. CS-19 played a key role in field-testing and finalizing MOPH IMCI and MNC checklists.

CS-19 did not create its own HMIS system – rather it helped PHO and BPHS implementers to effectively use one created by MOPH. HMIS data were reviewed every month by the RH, EPI and IMCI sub-committees and ways to address gaps were discussed. All of these checklists focus on the knowledge and performance of the clinic staff. Ways to monitor the work of the CHWs and progress toward project objectives were absent.

Technical and Administrative Support

External technical assistance was provided to CS-19 at the time of DIP development and at the time of the mid term evaluation. In early 2007 two CS-19 staff attended a workshop on the BEHAVE Framework, organized by Mercy Corps in Kabul. An outside consultant led the final evaluation. In addition to this some staff members attended a workshop in Thailand on the PDQ process.

The current technical backstop person has been in his position for only 2 months and prior to that there was a gap of about 8 months when backstopping was provided by the SC CS team. Prior to that, the SC Child Survival Advisor had visited the project twice; once at the time of the DIP and once during the mid term evaluation. This is less than the usual annual visits which are typical for CS projects, but within the expectations of SC. As mentioned under the M&E section, the project received some poor advice when it was not encouraged to conduct an Organizational Assessment of the PHO when the design of the project made the KPC much less appropriate as a measurement tool, and better follow up after the BEHAVE training would have been useful.

While support to the project from outside the country was not very strong, SC/Afghanistan supported the project very well. The Health Sector Advisor visited the project 2 weeks out of each month and assistance was also provided by the Regional Health Advisor based in Shiberghan.

Strengthening the Grantee Organization

The implementation of the CS-19 project has provided valuable experience for national staff especially for innovative approaches such as PD/Hearth, CCM, PDQ and birth preparedness and education. Their capacity was strengthened to the extent that other SC health projects (CME, ACCESS/PPPH and BPHS projects) also benefited from their technical expertise.

SC continued to build the capacity of CS-19 team throughout the life of the project. SC Deputy Director, who was senior health advisor in his previous position with SC/Afghanistan-Pakistan was key in providing essential trainings including TOT courses on Maternal and Newborn Care, birth preparedness, PD/Hearth, PDQ and IPC/C. He also arranged workshops on community IMCI, EPI, Family Planning and sessions on how to use health facility assessments using BASICS tools and played a key role in helping CS-19 team to field test CCM pictorial materials and in conducting CCM training CHW performance assessments.

The CS-19 team also benefited from other SC resources. For example SC funded the CS-19 Coordinator to attend Global Health Council meeting in 2005 and SC's global program learning

group (PLG) meetings in Washington, DC. The CS-19 Coordinator, Health Manager and Senior Health Manager also attended the SC Asia Area health conference in July 2006, and the Program Manager attended the SC Global PLG in 2006. In addition to these, in 2005, SC funded senior health advisor to attend 21-day PD/hearth TOT course in Vietnam. SC also sent the CS-19 Coordinator in 2006 to participate in the Final Evaluation of CS-18 in Tajikistan. And, in addition to these, two regional meetings were attended by the CS-19 Coordinator, including a five-day Program Design, Monitoring and Evaluation (PDME) workshop (Egypt, 2004). The CS-19 Coordinator and CS-19 IMCI Officer also attended a three-day Operation Research approaches workshop.

The CS-19 Coordinator and the CS-19 MNC and BCC Officers attended a JPHEIGO-led workshop on IEC materials development for the ACCESS Prevention of Postpartum Hemorrhage and Birth Preparedness initiatives (January 2006) this helped CS-19 MNC Officer to provide overall guidance and technical support to this important project that aimed to demonstrate that CHWs can be trained effectively to promote use of misoprostol tablets correctly.

SC HQ child survival expert also arranged a three-day workshop on Partnership Defined Quality in Thailand (2005). This training was replicated in Afghanistan and attended by CS-19 staff. Kathryn Bolles also arranged with another organization a 10-day workshop on BEHAVE. Lessons learned from this workshop helped CS-19 team streamline birth preparedness BCC strategy.

Management Lessons Learned

- When a project is redesigned such that the required means of measuring effectiveness or impact (the KPC survey) is no longer appropriate, both the donor and the implementing organization should question whether the redesigned project still meets the criteria for funding;
Or
- When redesigning a project the grantee should make sure that it can still legitimately be measured using the required tool (KPC survey).
Or
- If the required tool (KPC survey) is no longer appropriate for measuring the effectiveness of the redesigned project, then another more appropriate tool needs to be designed and used.
- All CS projects ought to employ an experienced M&E specialist.
- When budgeting for a project, the grantee ought to ensure that there are funds enough to visit each CS project annually. Supervisors of backstop people should make sure that these visits take place.

Annex 5
Full M&E Table

Objectives	Indicators	Baseline Est. %	Final Est. %	Final Target %	Explanation or Reference
Improved vaccination coverage	1. 20% increase in mothers of children U2 receiving 2 or more TT before birth of youngest child	15	68.4	35	Female Vaccinators and outreach efforts. More clinics in remote area; better supply
	2. 60% of 12-23 month olds fully immunized by age 12 months	4	60.1	60	Female vaccinators may have influenced this since some mothers still prefer to go to women; constant supervision; IEC materials; training of vaccinators. Otherwise, work of other partners on supply and management and cold chain also influences this. Better follow up by CHW of drop outs
	3. 80% of 12-23 month olds receive measles vaccine	12	60.1	80	Target was overly ambitious –This indicator was based on the assumption that UNICEF would do many measles campaigns. They only did 2. This is based on the vac. card and many cards were either not available or not completed well.
Nutrition	75% of 12-23 month olds received Vit. A in last 6 months	69	96	75	Helped by NID, micro-planning for NID done 2x year and trained volunteers
	25% increase in ill children receiving increased fluids and continued feeding during illness in past 2 weeks	7	49.5	32	CHW refresher course; network health education, MCH Promoters as system was being put into place, IEC materials;
	25% increase in mothers reporting hand washing before food prep, and child feeding and after defecation and child defecation (diaper change)	17	56	42	
	15% increase in % of children U2 whose birth was attended by a skilled health personnel	28	38	43	Still difficulties with distance, CM still newish; still trust the TBAs more; MOPH doesn't support clinic

Objectives	Indicators	Baseline Est. %	Final Est. %	Final Target %	Explanation or Reference
					staff going out to conduct deliveries in the community.
	25% increase in mothers with 1/more postpartum ⁸ check	29	45	54	Big disparity
	5% increase in non-pregnant mothers who desire no more children in next 2 years or are unsure, who are using a modern method of child spacing	17%	42.8	22%	
	60% of mothers know 2 or more signs of child illness needing treatment	14%	86	60%	CS-19 support to CHW IEC materials
	20% increase in mother with knowledge of at least 2 maternal danger signs during the pp period	29%	75.7	49%	CS-19 support to CHW IEC materials ARI Campaign

⁸ A postpartum check was considered acceptable when 1 visit was done after 24 hours but within 28 days of the delivery

Annex 6
Work Plan Table

Objectives/Activities	Objective Met	Activity Status*
<i>Increase Vaccination Coverage</i>	yes	
EPI Management Training for PHO (including sections on HMIS, M &E, keeping registers/log books, and community mobilization)	yes	completed
EPI refresher training	yes	completed
Support MOPH in NIDs	yes	completed
Development of IEC tools	yes	completed
Microplans for poor access areas	yes	completed
Immunization coverage data collection (support to PHO)	yes	completed
Feedback on immunization coverage to PHCC	yes	completed
“On the spot” technical support to PHO technical officers	yes	completed
<i>Control Diarrheal Disease</i>		completed
ARI/CDD case management training	yes	completed
ARI/CDD refresher training	yes	completed
Development and implementation of checklists	yes	completed
MCH Promoters work with CHWs	yes	completed
CCM Training	yes	CCM was already a function of the CHWs so this was not a special component
CCM start-up	yes	
CCM assessed and documented	no	
CCM refresher training	yes	
Development of CDD training modules	yes	
“On the spot” technical support to PHO technical officers	yes	
<i>Reduce ARI</i>		
ARI/CDD case management training	yes	completed
ARI/CDD refresher training	yes	completed
Development and implementation of checklists	yes	completed
Development of ARI training modules	yes	completed

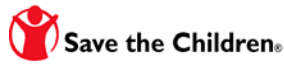
Objectives/Activities	Objective Met	Activity Status*
“On the spot” technical support to PHO technical officers	yes	completed
<i>Nutrition</i>	yes	completed
Development of IEC materials on nutrition and growth monitoring	yes	completed
GMP technical support	Yes, but just in Andkhoy	partially
Logistics support for iodized salt distribution	yes	completed
Development of BCC messages surrounding iodized salt, breastfeeding and weaning foods	Yes; just for Iodized Salt	partially
Community mobilization technical support	limited	completed
PD/Hearth training	yes	In 5 communities
PD/Hearth technical support, including M & E	Yes	completed
<i>Maternal and Newborn Care</i>		
MNC Training	yes	completed
MNC Refresher	yes	completed
Community Midwife Training	Yes (but through another project)	completed
Community Midwife Refresher	Yes	Completed
Development of BCC messages	yes	completed
Collaboration with REACH on recruiting female health workers	yes	completed
Technical support on community mobilization	limited	completed
Technical support on midwifery	yes	completed

* It should be noted that it may be more accurate to say that these activities were all partially completed since they were not always implemented throughout the anticipated project area – Jawzjan Province. CS-19 only worked directly at the community level in 3 districts in Jawzjan during 2 years and 4 districts in Andkhoy.

Annex 7
Rapid CATCH Table

#	Indicators	Baseline	End-line
1	Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	56.3% (45.6-67)	39.9 (32.4-47.4)
3	Percentage of children age 0–23 months whose births were attended by skilled health personnel	28% (20.1-35.9)	38% (30.8-45.2)
4	Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	14.7% (8.8-20.6)	68.4% (59-7.3)
5	Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	68.1% (46.2-90)	70.7% (51.9-89.5)
6	Percentage of children age 6–9 months who received breast milk and complementary foods during the last 24 hours	33.3% (15.3-51.3)	55.2% (37.3-73.1)
7	Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	4.2% (-.5-8.9)	60.1% (48.6-71.6)
8	Percentage of children age 12–23 months who received a measles vaccine	12% (4.2-19.8)	60.1% (48.6-71.6)
9	Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night.	43.7% (34.4-53)	64.9% (56.2-68.8)
10	Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.	0%	8.4% (4.7-12.1)
11	Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	16.7% (10.4-23)	56% (47.7-64.3)
12	Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment.	14.3% (8.5-20.1)	86% (76.9-95.1)
13	Percentage of sick children age 0–23 months that received increased fluids and continued feeding during an illness in the past two weeks.	6.8% (1.8-11.5)	49.5% (37.8-61.2)

Annex 8
Final KPC Report



**Partnership for Maternal and Child Survival in Northern Afghanistan:
Capacity Building and Innovation to Sustainably Improve Community
Access, Quality, and Use of Essential MCH Services throughout
Jawzjan Province**

Cooperative Agreement No. GHS-A-00-03-00011-00.
September 30, 2003 - September 30, 2008

Afghanistan CS-19
End-line KPC Report
Jawzjan, Afghanistan

Prepared by

Save the Children/US

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacille Calmette-Guerin (Vaccination for tuberculosis)
BHC	Basic Health Center
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DPT	Diphtheria Pertusis Tetanus Vaccine
EPI	Expanded Program of Immunizations
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment
IUD	Intrauterine Device
IV	Intravenous
KPC	Knowledge Practice and Coverage (Survey)
LAM	Lactational Amenorrhea Method
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non Governmental Organization
NID	National Immunization Day
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PPC	Postpartum Care
PNC	Prenatal Care
PRA	Participatory Rapid Appraisal
R	Recommendation
SC	Save the Children
SD	Standard Deviation
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid Vaccine
Vit A	Vitamin A

I. FINDINGS

A. PROJECT INDICATORS

The following table presents the baseline rates and the proposed targets for the project's eleven KPC-related indicators.

#	End of Project Targets/Indicators	Baseline	Target	Endline
1	20% increase in mothers of children under 2 receiving 2 or more TT before birth of youngest child.	15% (44/300)	35%	68.4% (308/450)
2	60% of 12-23 month olds fully immunized (against 6 diseases) by age 12 months.	4% (6/142)	60%	60.1% (146/243)
3	80% of 12-23 month olds receive measles vaccine.	12% (17/142)	80%	60.1% (146/243)
4	75% of 12-23 month olds received vitamin A in last 6 months.	69% (208/300)	75%	96.3% (234/243)
5	25% increase in ill children receiving increased fluids & continued feeding during illness in past 2 weeks.	7% (14/205)	32%	49.5% 103/208
6	25% increase in mothers reporting hand washing before food preparation & child feeding, & after defecation & child defecation.	17% (50/300)	42%	56% (252/450)
7	15% increase in % of children <2 whose birth were attended by skilled health personnel.	28% (84/300) ⁹	43%	38% (171/450)
8	25% increase in mothers with 1/more postpartum check.	29% (87/300)	54%	45.1% (203/450)
9	5% increase in non-pregnant mothers who desire no more children in next two years, or are unsure, who are using a modern method of child spacing.	17% (21/122)	22%	56% (177/316)
10	60% of mothers know 2 or more signs of child illness needing treatment.	14% (43/300)	60%	86% (387/450)
11	20% increase in mothers with knowledge of at least 2 maternal danger signs during the postpartum period.	29% (87/300)	49%	78.2% (352/450)

⁹ Included in this cohort were doctors (20), nurses (2), midwives (40) and trained traditional birth attendants (22).

B. DEMOGRAPHICS (KPC Questions 5 to 12)

Language: Four languages were represented in the communities surveyed, including the following:

Languages Spoken by the Mothers	Frequency (N=450)	Percent
Uzbaki	150	35.6%
Turkmani	188	41.8%
Pashto	54	12%
Dari	40	10.7%
Total		

Age: The average age of the mothers interviewed was 29 years and ranged from 17 to 47. Two percent (7/450) of the mothers were under the age of 20. Ninety-nine percent (448/450) had at least one biological child under the age of five living with them. On average each mother interviewed had 1.5 biological children under the age of five living with them. The age of the children aged 0-23 years is further classified as shown in the table below:

Child's Age	Frequency (N=450)	Percent
Infants under six months	99	22%
Infants under 11 months	207	53%
Children between 12 and 23 months	243	47%
Infants/children between birth and 23 months	450	100%

Education: Only 6% (27/450) of mothers had ever attended school. Four percent (20/450) attended primary school and 2% (7/450) had attended secondary school or higher. An increase in the proportion of pre-literate mothers (94% versus 87% at the baseline) is due to refugees and internally displaced people returning to their villages in Jawzjan.

Employment: The proportion of mothers who do not work outside home has decreased from 94% at baseline to 81% (364/450). Those who work outside home most work in carpet weaving and handicrafts. The majority of their spouses (92% or 415/450), are working in agriculture, while some also work as salaried workers, keep live stock or are shop keepers or street vendors. Eight percent (35/450) of spouses are reportedly unemployed.

Child Care: Most mothers (43% or 192/450) reported that they take their children with them when they leave the house (32% baseline). Of the others, 46% (208/450) reported they leave the child with a grandmother and 30% (134/450) said they leave the child with older children. Ten percent (47/450) said that their husbands take care of the child (baseline 2%). There is no appreciable difference in these rates when taking the gender of the youngest child into account.

C. MATERNAL NEWBORN CARE

Antenatal Care (KPC Questions 13 to 25)

Attendance at ANC: Most mothers (87% or 390/450) reported having seen someone for antenatal care (ANC) during their most recent pregnancy. This represents a 21% increase over the baseline (66% baseline). A total of 71% (321/450) mothers attended ANC sessions more than two times (44% baseline). Of these 82% (or 318/390) received care from MOPH skilled health care providers such as doctors, midwives and nurses (56% baseline) – this shows a significant increase (26%) in pregnant women accessing MOPH skilled health care providers.

Sources of ANC	Baseline (2004)		End-line (2008)	
	Frequency (N=199)	Percent	Frequency (N=390)	Percent
MoPH doctor	49	24%	170	44%
MoPH Nurses	64	32%	26	7%
MoPH Midwives	-	-	122	31%
Private doctor	73	37%	197	51%
Traditional Birth Attendant	6	3%	38	10%
Traditional Healer	7	4%	9	2%

Of mothers who said they saw someone for antenatal care, most (82% or 321/390) reported having visited for more than two times.

Reasons for not seeking ANC: Of the mothers who did not seek ANC, 38% (23/60) informed they were not aware of the need for care (baseline 39%); 52% (31/60) said that distance to health facility was a factor (39% baseline); 25% (15/60) said they were not permitted by their family to seek care (12% baseline); 22% said they didn't have a family member to accompany them; and 10% (6/60) said they did not have enough money (3% baseline).

Tetanus Toxoid (TT) Immunization: A majority of mothers (74% or 331/450) were able to produce a TT immunization card -- unlike during baseline survey when only 28% mothers had done so. Based on a review of these cards, 69% (308/450) mothers had received two or more doses of TT vaccine, representing an increase by 54% in coverage of two doses of TT vaccine (15% baseline). Each of the mothers was also asked whether she remembered having had a TT vaccination and 78% (352/450) reported having received two or more based on recall (24% baseline)

Diet and anemia: There is a significant improvement in maternal nutrition during pregnancy as indicated by 43% mothers (193/450) who reported they ate more than usual when they were pregnant with their last child(6% baseline). Thirty eight percent (169/450) reported eating the same amount as usual (31% baseline); and 22% (101/450) reported eating less than usual (63% baseline). There is also an impressive improvement in the mothers' knowledge of foods that can prevent anemia. Ninety percent mothers (405/450) could recognize protein rich foods that prevent anemia (63% baseline); and 84% (376/450) noted green leafy vegetables (27% baseline).

Most mothers who said they sought health care during pregnancy, 69% (270/390) reported they received iron tablets (32% baseline). The overall coverage for iron supplementation has increased from 21% at the baseline to 60% (270/450) at end-line.

Knowledge of and responding to pregnancy-related danger signs: Significant improvement is noted in the mother's knowledge regarding danger signs as symptoms that would lead them to seek emergency healthcare services during pregnancy. In sum, 69% (310/450) of mothers were able to identify two or more danger signs (42% baselines). The table below shows that more mothers could list danger signs compared with those at the baseline.

Prenatal Danger Signs	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Bleeding	154	51%	307	72%
Fever	79	26%	277	65%
Swelling/high BP	56	19%	148	35%
Breathlessness/Anemia	51	17%	189	44%

While many families continue to go to private practitioners to treat obstetric complication/s during pregnancy, access to MoPH's BHCs and CHCs has significantly improved. This is primarily due to the availability of Community Midwives at these local clinics. Table below shows different sources of emergency medical care:

ANC providers	Baseline (2004)		End-line (2008)	
	Frequency (N=255)	Percent	Frequency (N=426)	Percent
MoPH Hospital	133	52%	201	47%
BHC/CHC	5	2%	199	47%
Private Practitioner	74	29%	230	54%
Traditional Healer	14	6%	89	21%
TBAs	-	-	37	9%
NGO Clinic	10	4%	0	0%
MCH Clinic	9	3%	0	0%
Mulla	8	3%	5	1%
Mobile Clinic	2	1%	0	0%

Delivery and Immediate Newborn Care (KPC Questions 26 to 32)

Delivery: A total of 67% (300/450) of mothers delivered their last child at home (baseline 89%). Of the rest, 16% (71/450) delivered at MoPH hospitals; 6% (71/450) BHCs and CHCs; and 10% (45/450) private practitioners. In sum, deliveries at health facilities have significantly improved from 11% (baseline) to 32% (endline). Of those who delivered at the health facilities 3% (4/150) had a cesarean section.

Places where mothers delivered their last child	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Home	266	89%	300	67%
Hospital	14	5%	71	16%
BHC/CHC	0	0%	29	6%
PVT Practitioners	19	6%	45	10%
Others	0	0%	5	1%

Deliveries assisted by skilled birth attendants (SBA) have also increased by 10% over the baseline (38% versus 28%). The following table shows mothers reporting different types of birth attendants who assisted them at the birth of their last child.

Assistance at Deliveries	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Skilled Birth Attendants (SBA)				
Doctor at hospital	20	7%	67	15%
Doctor at BHC/CHC	-	-	22	5%
Midwife at Hospital	40	13%	27	6%
Midwife at BHC/CHC	-	-	55	12%
Trained TBA	22	7%	-	-
Doctor	-	-	-	-
Nurse	2	1%	-	-
Subtotal	84	28%	171	38%
Unskilled Birth Attendant				
Untrained TBA	114	38%	218	48%
Untrained Relative	71	24%	33	7%
Herself	10	3%	27	6%
Trained Relative	10	3%	-	-
Husband	10	3%	-	-
Don't know	1	1%	1	0.2%
Subtotal	216	72%	279	62%
Total	300	100%	450	100%

Preparing essential materials for Child Birth¹⁰:

All mothers were asked to report regarding essential materials that should be available to ensure clean delivery at home. Eighty-seven percent (392/450) reported arranging clean towel or a cloth; 68% (305/450) boiled thread; 52% (236/450) reported arranging a new blade for cutting the umbilical cord; and 37% (166/450) reported new and boiled blade. Soap was mentioned by only 15% (68/450) mothers.

Immediate Newborn Care (KPC questions 33 to 41)¹¹

Cutting Umbilical Cord: Eight-two percent (370/450) mothers reported that a razor was used to cut the umbilical cord (93% baseline). Only 42% (189/450) mothers reported that a clean and boiled instrument (razor or scissors) was used to cut the cord (no baseline).

¹⁰ This question was not added in the baseline, therefore no comparison is made

¹¹ Many of these questions were not included in the baseline, therefore no comparison is made

Instrument used to cut the umbilical cord	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
New Blade	-	-	223	50%
New, boiled blade	-	-	144	32%
Used & boiled blade	-	-	3	1%
New scissors	-	-	109	24%
Boiled scissors	-	-	34	8%
Used & boiled scissors	-	-	8	2%
Razor	280	75%	-	-
Others (knife)	76	25%	18	4%

Immediate Newborn Care: After birth, delayed bathing is one way to prevent development of hypothermia among newborns. Results of end-line survey shows that this practice has significantly improved. Thirty-six percent (162/450) of newborns were bathed after hour 8 of birth (16% baseline); and 9% (52/450) were bathed between one to eight hours after birth (85% baseline).

Postpartum Care (KPC Questions 42 to 49)

Mothers and newborns' access to postpartum care service continues to remain low, however compared with baseline data a significant improvement in PNC coverage is noted – as indicated by 45% (203/450) mothers who informed that their health was checked after their most recent delivery (29% baseline). Of these, 64% (129/203) of mothers received postpartum check from skilled health care providers (38% baseline).

Sources for PNC	Baseline (2004)		End-line (2008)	
	Frequency (N=87)	Percent	Frequency (N=203)	Percent
Doctor at BHC/CHC	-	-	16	8%
Doctor at Hospital	33	38%	72	36%
Midwife at BHC/CHC	-	-	28	14%
Midwife at hospital	-	-	13	6%
Kabla/any midwife ¹²	42	48%		
TBAs	3	4%	33	16%
Mother	1	1%		
Do not know	1	1%		
Others	-	-	37	18%

Health education during PNC visits: Mothers' access to essential health messages during postpartum period remains low. However, compared with baseline data, significant improvement is noted. Forty-seven percent (210/450) mothers reported receiving information on breastfeeding during postpartum period (7% baseline); 46% (206/450) mentioned receiving information related to childhood immunization (12% baseline); and 29% (129/450) reported receiving information about infant nutrition (5% baseline). Some also mentioned receiving information on family planning, and danger signs of pneumonia, diarrhea and newborn illnesses.

¹² Kabla is a local term communities use for women (doctors, nurses, midwives, TBAs) who have skills to assist in deliveries – does not necessarily mean skilled birth attendants.

PNC counseling topics	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Family planning	9	3%	69	15%
Infant nutrition	15	5%	129	29%
Breastfeeding	21	7%	210	47%
Childhood immunization	36	12%	206	46%
Danger signs of pneumonia	9	3%	78	17%
Infant diarrhea	8	3%	90	20%
Newborn danger signs	-	-	62	14%

Postpartum danger signs for mothers: Regarding danger signs during postpartum period, mothers' knowledge has significantly increased. Eighty-eight percent (397/450) of mothers reported excessive bleeding as a danger sign during postpartum period (71% baseline); 68% (306/450) cited severe abdominal pain (19% baseline); and 46% (206/450) mentioned fever (no baseline). A few also mentioned foul smelling vaginal discharge, convulsions, problem with breastfeeding, high blood pressure, and fainting. In sum, 67% (303/450) of mothers knew at least three danger signs during postpartum period (3% baseline).

Postpartum Danger Signs	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Excessive Bleeding	212	71%	397	88%
Fever	-	-	206	46%
Smelly vaginal discharge	21	7%	39	9%
Convulsions	-	-	73	16%
Severe abdominal pain	57	19%	306	68%
Problems breastfeeding	-	-	26	6%
Others	45	15%	55	12%

Postpartum danger signs for the newborn: During PPC visits 81% (164/203) of mothers reported that the health of their newborn child was checked as well (70% baseline). Fifty-six percent (254/450) of mothers knew three or more danger signs in newborn child (8% baseline). Mothers listed the following danger signs in newborn children for which they would seek healthcare.

Newborn Danger Signs	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Poor sucking of breasts	97	32%	227	50%
Baby very small	-	-	22	5%
Blue color of palm and sole	-	-	35	8%
Failure to cry	74	25%	154	34%
Convulsions	-	-	50	11%
Fever	-	-	245	55%
Redness/discharge (eyes)	74	25%	44	10%
Fast breathing (pneumonia)	164	55%	264	59%
Failure to pass urine	-	-	33	7%
Failure to pass stool	-	-	38	8%
Redness/discharge (cord)	81	27%	58	13%
Jaundice	-	-	281	62%

Baby cold (hypothermia)	-	-	65	14%
Others	-	-	34	8%

D. BREASTFEEDING AND CHILD NUTRITION (KPC Questions 50-55)

Breastfeeding: The vast majority of mothers (98% 441/450) reported having breastfed their youngest child at some point. Breastfeeding was initiated:

Initiating breastfeeding after delivery	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Within the first hour	180	61%	328	73%
Between hours 2 and 8	19	6%	18	4%
Between hours 9 and 24	8	3%	18	4%
After 24 hours	86	29%	86	19%
Do not remember	1	1%	0	0%
Total	294	100%		

Sixty three percent (65/99) of infants under six months of age were exclusively breastfed (61% baseline). Majority of mothers (89% or 290/326) with children between 6 and 23 months of age were continuing to breastfeed (90% baseline). Thirty-five percent (113/326) of these mothers were pregnant at the time of survey; and of these, 82% (93/113) were continuing to breastfeed (67% baseline). By contrast those who were not pregnant 95% (200/211) were still breastfeeding, which represents a difference of 13 % (baseline 21%)¹³.

Vitamin A: Seventy-eight percent (275/351) of mothers reported that their child (6 to 23 months of age) had received a dose of vitamin A (VitA) within the past six months (69% baseline). Vitamin A is given as part of the NIDS/polio campaigns and is not recorded on the cards, so the project showed mothers a VitA capsule to see if their child had received one at a national immunization day (NID).

Growth monitoring: Ninety-seven (437/450) of mothers consented to having their youngest child weighed – 209 girls and 227 boys. Twenty-one percent (44/209) of the girls and 16% (36/227) of the boys fell under the second standard deviation (SD) measured weight-for-age and 40% (174/436) fell under the first SD.

Girls Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
0	3	0.5			1	2				0.4
1	12	0.6	1	1	2	8				0.5
2	9	0.7		1	1	6	1			0.7
3	11	0.7	1	2	3	4	1			0.8
4	9	0.8		2	2	4	1			0.8
5	12	0.8	1	1	2	8				0.9
6	13	0.9	1	2	3	6	1			0.9

¹³ Breastfeeding is promoted through the Qur'aan, which states that a girl must be breastfed for two and a half years and a boy for two years. However, commonly held beliefs that a mother's milk goes bad during pregnancy could explain the difference in the breastfeeding rates between non-pregnant and pregnant mothers. Breastfeeding Research, Andkhoy, Afghanistan, SC/US, 2002

Girls Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
7	12	0.9		1	2	9				0.9
8	6	0.9		1	1	4				1.0
9	13	1.0	2	2	3	5	1			1.0
10	3	1.0		1	1	1				1.0
11	12	1.0	1	2	3	5	1			1.0
12	9	1.0		2	2	5				1.0
13	6	1.1		1	2	3				1.1
14	11	1.1		1	2	7	1			1.1
15	10	1.1	1	1	2	6				1.1
16	2	1.1			1	1				1.1
17	7	1.2	1	1	1	3	1			1.1
18	16	1.2		3	3	9	1			1.1
19	8	1.2		2	2	3	1			1.2
20	3	1.2	1	1	1	0				1.2
21	1	1.2		1		0				1.2
22	8	1.2		2	3	3				1.2
23	13	1.2	1	2	2	7	1			1.3
TOTAL	209	N/A	11	33	45	109	11			N/A
	100%		5%	16%	22%	52%	5%			

Boys Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
0	3	0.4			1	2				0.5
1	7	0.7			2	5				0.7
2	9	0.9			1	7	1			0.8
3	9	1.0		1	4	4				0.9
4	5	1.0		1	1	3				0.9
5	12	1.0	1	2	4	5				0.9
6	13	1.0	1	2	3	6	1			1.0
7	9	1.0	1	1	2	4	1			1.0
8	15	1.0	1	2	4	7	1			1.0
9	9	1.0	1	1	1	5	1			1.0
10	15	1.0		2	4	9				1.1
11	9	1.0		1	2	6				1.1
12	10	1.0		1	2	6	1			1.1
13	11	1.0		2	2	7				1.1
14	7	1.1	1	1	1	4				1.2
15	14	1.1	1	4	2	5	2			1.2
16	10	1.1	1	1	2	6				1.2
17	10	1.1			1	5	1			1.2
18	7	1.2		1	2	4				1.2
19	6	1.2		2	2	2				1.2
20	7	1.2		1	2	4				1.3
21	9	1.3		1	1	5	2			1.3
22	18	1.3			2	13	3			1.3
23	3	1.3		1	1	1				1.3
TOTAL	227	N/A	8	28	49	125	14			N/A
	100%		4%	12%	22%	55%	6%			

E. IMMUNIZATION (KPC Questions 56-58)

The coverage of fully immunization status among children 12 to 23 months has significantly improved. Sixty-six percent (297/450) of mothers had an EPI card available for review (23% baseline). Of the children between the ages of 12 and 23 months, 60% were fully immunized per card (4% baseline); and 60% had their measles vaccination per card (12% baseline). Also per card, 90% (241/243) had BCG; 60% (146/243) DPT3; and 60% measles. DPT dropout rate is 39%. Only 1% (2/243) of mothers reported they did not have their child's EPI card (77% baseline).

F. CARE FOR THE SICK CHILD (KPC Questions 59-62)

Danger signs: Majority of mothers could list several signs of illness that would indicate that a child needed care or treatment. Eighty-six percent (387/450) of mothers knew three or more danger signs. Common signs cited include: Fast or difficult breathing, lethargy or difficult to wake, high fever, bloody diarrhea and diarrhea for more than 2 weeks.

Signs of illness among children	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Not eating or drinking	58	19%	73	16%
Lethargic/difficult to wake	12	4%	205	46%
Fast/difficult breathing	174	58%	321	72%
High fever	222	74%	330	73%
Vomits everything	96	32%	70	16%
Convulsions	34	11%	149	33%
Bloody diarrhea	82	27%	213	47%
Diarrhea > 2weeks	67	22%	203	45%
Do not know	9	3%	2	0.4%

Care of sick children: Forty-six percent (208/450) mothers reported that their youngest child was sick in the past two weeks. Of these, 50% (103/208) of mothers reported that they had offered their sick child more to drink (23% baseline); and another 50% said they fed more to eat (26% baseline).

G. Control of Diarrhea (KPC Questions 63-71)

Prevention: All mothers were asked to list the times when they usually wash their hands. Fifty-two percent (238/450) of mothers knew at least important times to wash their hands with soap and water (17% baselines). Seventy-six percent (343/450) mothers reported they washed their hands before preparing meals and after using toilets; 82% (369/450) wash their hands after cleaning a child who has defecated; 67% (303/450) before feeding children; and 64% (290/450) before eating meals.

Hand washing practices	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Before preparing meals	181	60%	343	76%
Before eating	141	47%	290	64%
Before feeding children	95	32%	303	67%
After using a toilet	212	71%	341	76%
After cleaning a child who has defecated	170	57%	369	82%

Home management: Fifty-three percent (240/450) of mothers reported their child had experienced watery diarrhea and/or blood in the stool in the two weeks prior to the survey. The mothers had treated their children with the following:

Treatment for Diarrhea Provided by Mothers	Baseline (2004)		End-line (2008)	
	Frequency (N=132)	Percent	Frequency (N=240)	Percent
Nothing	11	8%	8	3%
Fluid from ORS packet	30	23%	143	60%
Home made fluids	26	20%	69	29%
Pills or syrup	89	67%	135	56%
Injection	36	27%	91	38%
(IV) intravenous	7	5%	31	13%
Home remedies/herbal	13	10%	37	15%
Medicine from bazaar	9	7%	39	16%
Others	-	-	7	3%

All 450 mothers interviewed were asked to demonstrate how to prepare ORS. Sixty-five percent (294/450) prepared it correctly (46% baseline).

Knowledge of danger signs: Mothers knowledge about danger signs of diarrhea has improved when compared with baseline data. Common danger signs reported by most mothers reported severe vomiting (92% or 413/450) and fever with diarrhea (75% or 338/450). In sum 46% (209/450) of mothers knew three or more danger signs (9% baseline).

Diarrhea related Danger signs	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Severe vomiting	129	43%	413	92%
Fever with diarrhea	188	63%	338	75%
Diarrhea > 14 days	120	40%	197	44%
Bloody diarrhea	18	6%	137	30%
Lethargy	-	-	7	2%

Care seeking: Medical treatment was sought for children with diarrhea from the providers listed in the table below.

Sources of health care for diarrhea	Baseline (2004)		End-line (2008)	
	Frequency (N=132)	Percent	Frequency (N=240)	Percent
MOPH BHC/CHC	28	21%	89	37%
MOPH Hospital			37	15%
CHWs	0	0%	87	36%
Private Practitioners	54	41%	60	25%
Pvt. Pharmacy			31	13%
Traditional healers	11	8%	31	13%
Neighbors	7	6%	48	20%
Self Treatment	20	15%	0	0%
Others	7	6%	1	0%

Comparison between baseline and endline data shows that access to MoPH health facilities to treat diarrhea has increased, as shown in the table above. Further analysis showed that 34% (43/126) of MoPH health facilities still provided antibiotics to treat diarrhea (86% baseline). In contrast 53% (32/60) of private practitioners treated diarrhea with antibiotics. Seventy-six percent (93/126) of MoPH health facility staff provided ORS to children with diarrhea compared with only 53% (32/60) by private practitioners.

H. ACUTE RESPIRATORY INFECTIONS (KPC Questions 72-76)

Care seeking: Twenty-five percent (114/450) of mothers reported their youngest child had cough or difficult breathing. Of these, 98% (112/114) said they sought treatment or advice. Regarding how long after they noticed cough and/or fast breathing did they seek treatment outside home, many mothers (51% or 58/113) reported seeking care on the same day. Among the rest, 23% (26/113) sought care the next day (34% baseline); 20% (26/113) after two days (21% baseline); and 6% (7/113) after three or more days (30% baseline).

There is a significant improvement in accessing care for children suffering cough and/or difficult breathing at the MOPH health facilities (65% or 73/112 versus only 32% at the baseline). Another important finding is seeking care from Community Health Workers (CHWs) as reported by 18% (20/112) of mothers. Mothers reported taking their children with cough and/or difficult breathing to the following:

Sources of health care for cough/difficult breathing	Baseline (2004)		End-line (2008)	
	Frequency (N=116) ¹⁴	Percent	Frequency (N=112)	Percent
MoPH hospitals	34	29%	34	30%
MoPH BHC/CHC	4	3%	39	35%
Private Practitioners	39	34%	63	56%
CHWs	-	-	20	18%
MCH Clinic	6	5%	-	-
NGO clinic	3	3%	-	-
Pharmacy/Bazaar	2	2%	1	1%

¹⁴ Multiple responses were allowed to this question.

Traditional Healers	23	20%	22	20%
Mullahs	1	1%	1	1%
TBAs	-	-	5	4%

I. CHILD SPACING (KPC Questions 78-80)

When asked to identify a place where family planning supplies could be obtained, 33% (143/450) of mothers said they did not know (61% baseline) – this represents the fact that many mothers now know where to get family planning supplies. The others listed the following:

Sources for Family Planning supplies	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
Do not know	0	0%	143	33%
MoPH hospitals	64	21%	144	32%
MoPH BHC/HC	7	2%	179	40%
Private practitioners	13	4%	91	20%
Pharmacy/bazaar	-	-	10	2%
CHWs	-	-	86	19%
MCH clinic	10	3%	-	-
Other health facility	24	8%	-	-
Traditional healers	7	2%	-	-
Others	-	-	2	0%

Of the 450 mothers interviewed, a total of 316 (70%) were not currently pregnant. Of these, 44% (138/316) wanted to have another child in the next two years. Of the remaining, who either did not want to become pregnant or were not sure, 9% (16/178) were not using family planning methods (39% baseline) representing a significant increase in the number of mothers using at least one method. Injections, pills and LAM were among the most commonly used.

Use of Family Planning Methods by Mothers Who Are Not Pregnant and Do Not Want Another Child or are Unsure	Baseline (2004)		End-line (2008)	
	Frequency (N=122)	Percent	Frequency (N=178)	Percent
No method	48	39%	16	9%
Injections	10	8%	46	26%
Pill	7	6%	48	27%
IUD	1	1%	2	1%
Condom	1	1%	9	5%
Vasectomy	-	-	1	1%
Lactational Amenorrhea	46	37%	41	23%
Abstinence	-	-	4	2%
Withdrawal	-	-	4	2%
Others	7	2%	7	4%

J. HIV/AIDS (KPC Questions 81-82)

Slightly more mothers (8% 38/450) have heard of AIDS (3% baseline). When asked how it could be prevented, following responses were recorded: by avoiding used razors (13); by avoiding injections with used syringes (11); by avoiding unscreened blood transfusion (7); by avoiding sex with persons who inject drugs (5); by using condom (3); avoiding sex with prostitutes (3); and avoiding sex with persons of the same sex (3)

K. MALARIA (KPC Questions 83-85)

Seventy-one percent (319/450) of mothers reported that they have at least one bednet (51% baseline). In 91% (292/321) of household the children slept under the net the previous night (44% baseline); and in 80% (257/321) the mother did as well (44% baseline).

L. Health Contacts and Sources of Information (KPC Questions 86-87)

Mothers reported receiving advice on health and nutrition from the following sources:

Sources of Advice on Health and Nutrition	Baseline (2004)		End-line (2008)	
	Frequency (N=300)	Percent	Frequency (N=450)	Percent
From no where	-	-	75	17%
Doctor at MoPH clinics	39	13%	145	32%
Nurses at MoPH clinics	11	4%	23	5%
Midwife at MoPH clinics			75	17%
Community Health Councils	3	1%	76	17%
CHWs	19	6%	267	59%
Radio	21	7%	20	4%
Television	22	7%	50	11%
Campaigns	8	3%	38	8%
Newspaper	8	3%	3	1%
Health Trainers	4	1%	-	-
Others	1	1%	-	-

KNOWLEDGE, PRACTICE AND COVERAGE (KPC) SURVEY.
AFGHANISTAN **JULY 2008**

Informed Consent

Hello. My name is _____, and I am working with Save the Children-US and the MOPH. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help Save the Children and the MOPH to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

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

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

Signature of Respondent: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED < END

CLUSTER NUMBER: _____ (1-30) ID NUMBER: _____ (001-450)

DISTRICT: _____ NAME OF THE VIALAGE: _____

LANGUAGE: _____ HOUSEHOLD HEAD'S NAME: _____

ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD 11 TO 23 MONTHS

1. INTERVIEW DATE: ____/____/____ (dd/ mm/ yy)

2. INTERVIEWER'S NAME: _____

3. NOTETAKER'S NAME: _____

QUESTIONS START HERE

4. What is your name? (RESPONDENT): _____

5. How old are you? (RESPONDENT) : ____ (RECORD AGE IN YEARS)

6. How many children living in this household are under age five? _____

7. How many of those children are your biological children? _____

8. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON THE MOTHER'S RESPONSE TO QUESTION NUMBER 7

ONLY 1 CHILD UNDER FIVE: "What is the name, sex and date of birth of that child?"

MORE THAN 1 CHILD UNDER FIVE: "What are the names, sex, and dates of birth of your two youngest children?"

	NAME	SEX	DATE OF BIRTH
1			__ / __ / __ DD MM YY
2			__ / __ / __ DD MM YY
3			__ / __ / __ DD MM YY
4			__ / __ / __ DD MM YY

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
9	Have you ever attended school? IF "NO": CIRCLE 1 [NONE] IF "YES": What is the highest level of school you have attended?	(Single response) NONE 1 PRIMARY 2 SECONDARY 3 HIGHER 4	
10	Do you work outside of the home to earn money? IF NO, CIRCLE "A" (NO OUTSIDE WORK) IF YES, What kind of work do you do?	(Multiple Response) NO OUTSIDE WORK A HANDICRAFTS B HARVESTING C SELLING FOODS D SHOPKEEPER/ST.VENDOR E SERVANT/ HOUSEHOLD WKR F SALARIED WORKER G LIVE STOCK H CARPET WEAVING I OTHER X _____ (Specify OTHERS)	
11	What is your husband's occupation?	(Multiple Response) DOES NOT WORK A AGRICULTURAL PRODUCTS B HARVESTING C SELLING FOODS D SHOPKEEPER/ STREET VENDOR E SERVANT/ HOUSEHOLD WKR F SALARIED WORKER G LIVE STOCK H CARPET MERCHANT I OTHERS X _____ X (Specify OTHERS)	

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD UNDER AGE TWO			
12	Who takes care of (NAME) when you are away from home?	<p>(Multiple Response)</p> <p>MOTHER (RESPONDENT) A</p> <p>HUSBAND B</p> <p>OLDER CHILDREN C</p> <p>GRANDMOTHER D</p> <p>AUNT E</p> <p>OTHER RELATIVES (OUTSIDE) F</p> <p>NEIGHBORS/ FRIENDS G</p> <p>MAID H</p> <p>NURSERY SCHOOL I</p> <p>OTHER X</p> <p>_____ X</p> <p>(Specify OTHERS)</p>	
A. MATERNAL HEALTH CARE:			
A.1. Pre-natal Care:			
13	<p>Do you have a TT card?</p> <p>IF YES, Can I please see it?</p> <p>RECORD THE NUMBER OF TT IMMUNIZATIONS RECEIVED ---- -----→</p>	<p>(Single response)</p> <p>YES, SEEN BY INTERVIEWER 1</p> <p>NOT AVAILABLE 2</p> <p>NEVER HAD A CARD 3</p> <p>DON'T KNOW 99</p> <p>TT1: YES [] NO [] TT2 YES [] NO []</p> <p>TT3: YES [] NO [] TT4 YES [] NO []</p> <p>TT5: YES [] NO []</p>	
14	Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus (local term)?	<p>(Single response)</p> <p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 99</p>	<p>> Q16</p> <p>> Q16</p>
15	How many times did you receive such an injection?	<p>(Single response)</p> <p>ONCE 1</p> <p>TWICE 2</p> <p>> THAN 2 TIMES 3</p> <p>DO NOT KNOW 99</p>	
16	<p>Did you see anyone for pregnancy care while you were pregnant with (NAME)?</p> <p>IF YES: Whom did you see? Anyone else?</p> <p>PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.</p>	<p>(Multiple Response)</p> <p>NO ONE Z</p> <p>MoPH DOCTOR A</p> <p>MoPH NURSE/ MIDWIFE B</p> <p>MoPH MIDWIFE C</p> <p>PVT.DOCTOR D</p> <p>TBA E</p> <p>TRADITIONAL HEALERS F</p> <p>OTHERS X</p> <p>OTHER: _____ X</p> <p>(Specify)</p>	<p>> Q21</p>
17	How many times did you go to seek care for pregnancy while	<p>(Multiple Response)</p> <p>ONCE DURING PREGNANCY A</p>	

	<p>pregnant with (NAME)?</p> <p>TAKE THE NAME OF THE PLACE SHE MENTIONED IN Q16</p>	<p>TWICE DURING PREGNANCY B</p> <p>THRICE DURING PREGNANCY C</p> <p>MORE THAN THRICE D</p> <p>DO NOT KNOW Z</p>	
18	<p>During the time you were pregnant with (Name), did you receive iron tablets?</p> <p>SHOW SAMPLE IRON/FOLATE TABLET.</p>	<p>(Single response)</p> <p>YES RECEIVED 1</p> <p>DID NOT RECEIVE ANY 2</p> <p>DO NOT REMEMBER 99</p>	
19	<p>During the time you were pregnant with (Name) for how long did take these iron tablet?</p>	<p>(Single response)</p> <p>DO NOT REMEMBER 99</p> <p>FOR WHOLE PREGNANCY PERIOD 1</p> <p>OTHERS 96</p> <p>OTHER: _____ X</p> <p>(Specify)</p>	
20	<p>Do you have a card for the pregnancy care?</p> <p>IF YES, Can I see it?</p> <p>RECORD THE NUMBER OF VISITS RECORDED AND THE NUMBER OF IRON TABLETS RECEIVED.</p>	<p>(Single response)</p> <p>YES, SEEN BY INTERVIEWER 1</p> <p>NOT AVAILABLE 2</p> <p>NEVER HAD A CARD 3</p> <p>NUMBER OF ANC VISITS RECORDED _____</p> <p>NUMBER OF IRON TABLETS RECEIVED _____</p>	> Q22
21	<p>Why did you not see someone for care during the pregnancy?</p> <p>RECORD ALL MENTIONED.</p>	<p>(Multiple Response)</p> <p>WAS NOT AWARE A</p> <p>LONG DISTANCE B</p> <p>NOT ALLOWED BY FAMILY C</p> <p>NO FAMILY MEMBERS TO GO D</p> <p>NO HEALTH FACILITY E</p> <p>NO HEALTH STAFF PRESENT F</p> <p>OTHERS X</p> <p>OTHER: _____ X</p> <p>(Specify)</p>	
22	<p>When you were pregnant with (NAME), how much did you eat?</p> <p>GIVE OPTIONS: more than usual, less than usual or same as usual?</p>	<p>(Single response)</p> <p>LESS THAN USUAL 1</p> <p>SAME AMOUNT 2</p> <p>MORE THAN USUAL 3</p> <p>DO NOT REMEMBER 99</p>	
23	<p>In your opinion which foods should a pregnant woman eat to prevent Kam Khuni (anemia)?</p>	<p>(Multiple Response)</p> <p>DO NOT KNOW Z</p> <p>PROTEINS RICH IN IRON A</p> <p>(EGGS, FISH, MEAT)</p> <p>LEAFY GREEN VEGETABLES B</p> <p>OTHER X</p> <p>OTHER (SPECIFY):</p>	

		OTHER (SPECIFY): _____ OTHER (SPECIFY): _____	
24	In your opinion, what signs/symptoms during pregnancy indicate the need to seek immediate health care outside home?	<div style="text-align: right;">(Multiple Response)</div> DO NOT KNOW Z FEVER A SHORTNESS OF BREATH B BLEEDING C SWELLING OF FACE/BODY/ HANDS D OTHERS X OTHER: _____ X (Specify) NUMBER OF CORRECT ANSWERS: _____	> Q26
25	Where would seek emergency care if a pregnant woman had these signs/symptoms?	<div style="text-align: right;">(Multiple Response)</div> NO WHERE Z HOSPITAL A BHC/CHC B PVT PRACTITIONERS C TRADITIONAL HEALERS D TBAS E OTHERS X OTHER: _____ X (Specify)	
A.2. Delivery/ Immediate Newborn Care:			
26	Where did you give birth to (Name)?	<div style="text-align: right;">(Single Response)</div> HOME 1 HOSPITAL 2 BHC/CHC 3 PVT PRACTITIONERS 4 OTHER 96 OTHER: _____ X (Specify)	> Q28
27	In the health facility (facility mentioned by respondent) how was (Name) delivered?	<div style="text-align: right;">(Single Response)</div> CESERIAN SECTION 1 VAGINAL DELIVERY 2	
28	At the time of delivery (Name), who assisted you with the delivery?	<div style="text-align: right;">(Single Response)</div> DOCTOR AT BHC/CHC 1 DOCTOR AT HOSPITAL 2 MIDWIFE AT BHC/CHC 3 MIDWIFE AT HOSPITAL 4 TBAs 5 DELIVERED ON MY OWN 6 RELATIVES 7 DON'T REMEMBER 99 OTHERS 96 OTHER: _____ X (Specify)	

29	In your opinion, what essential materials must be prepared for a clean delivery at home?	<div style="text-align: right;">(Multiple Response)</div> DO NOT KNOW Z NEW BLADE ONLY A NEW AND BOILED BLADE B USED AND BOILED BLADE C NEW SCISSORS D NEW AND BOILED SCISSORS E USED AND BOILED SCISSORS F THREAD/BOILED G CLEAN TOWEL/CLOTH H OTHERS X OTHER: _____ X (Specify)	
30	In your opinion, what are signs/symptoms during delivery that indicate the need to seek immediate health care outside home?	<div style="text-align: right;">(Multiple Response)</div> DO NOT KNOW Z LONG LABOR (> 12 HOURS) A EXCESSIVE BLEEDING B RETAINED PLACENTA C CONVULSIONS D BABY HANDS/FEET CAME FIRST E OTHERS X OTHER: _____ X (Specify) NUMBER OF CORRECT ANSWERS: _____	
31	What signs/symptoms during delivery did you develop that indicated the need to seek health care? RECORD ALL MENTIONED.	<div style="text-align: right;">(Multiple Response)</div> NONE A LONG LABOR (> 12 HOURS) B EXCESSIVE BLEEDING C RETAINED PLACENTA D CONVULSIONS E BABY HANDS/FEET CAME OUT FIRST F OTHERS X OTHER: _____ X (Specify)	> Q33
32	When you developed these signs/symptoms, where did you seek care outside home?	<div style="text-align: right;">(Single Response)</div> NO WHERE 1 HOSPITAL 2 BHC/CHC 3 PVT PRACTITIONERS 4 OTHER 96 OTHER: _____ X (Specify)	
33	After (Name) was delivered, what instrument was used to cut the cord?	<div style="text-align: right;">(Multiple Response)</div> DO NOT KNOW Z NEW BLADE ONLY A NEW AND BOILED BLADE B USED AND BOILED BLADE C NEW SCISSORS D NEW AND BOILED SCISSORS E	

		USED AND BOILED SCISSORS F OTHERS X OTHER: _____ X (Specify)	
34	After (Name) was delivered, what was applied to the cord after it was cut and tied? PROBE TO FIND OUT FROM OTHERS WHO WERE PRESENT AT THE DELIVERY	(Multiple Response) DO NOT KNOW Z NOTHING A ANTIBIOTICS (POWDER/OINMENT) B ANTISEPTIC/ SPIRIT/ALCOHOL C ANTIMONY D BABY POWDER E OTHERS X OTHER: _____ X (Specify)	
35	After (Name) was delivered, when was (Name) wiped or dried? How long after birth (NAME) was wiped/dried?	(Single Response) DO NOT KNOW 99 NOT WIPED AT ALL 1 WIPED AFTER PLACENTA WAS DELIVERED 2 WIPED IMMEDIATELY (DID NOT WAIT FOR PLACENTA) 3 TIME: _____ (IN MINUTES)	
36	How long after (NAME) was born, was the body wrapped? PROBE TO FIND OUT FROM OTHERS WHO WERE PRESENT AT THE DELIVERY	TIME: _____ (IN MINUTES)	
37	How long after delivery was (NAME) bathed for the first time?	(Single Response) DO NOT KNOW 99 WITHIN ONE HOUR 1 HOURS 2 THROUGH 8 2 AFTER HOUR 8 OF BIRTH 3 AFTER THE FIRST DAY (24 HRS) 4	
38	Did (NAME) cry immediately just after birth?	(Single response) YES, CRIED IMMEDIATELY 1 NO DID NOT CRY IMMEDIATELY 2	> Q40
39	What measures were taken to make (Name) cry/breathe?	(Single Response) NO MEASURES WERE TAKEN 99 SLAPPED THE BACK OF BABY 1 CLEANED NOSE/MOUTH 2 HELD BABY UPSIDE DOWN 3 OTHERS 96 OTHER: _____ X (Specify)	
40	Did you ever breastfeed (NAME)?	(Single Response) YES 1 NO 2	> Q42

41	How long after birth did you first put (NAME) to the breast?	(Single Response) DO NOT REMEMBER 99 WITHIN 1 HOUR 1 WITHIN FIRST 8 HOURS 2 AFTER 8 HRS, WITHIN 24 HRS 3 AFTER 24 HOURS 4	
Postpartum Period:			
42	After (NAME) was born, within the 1 st 24 hours, did anyone check on your health?	(Single Response) YES 1 NO 2 DO NOT REMEMBER 99	> Q46 > Q46
43	Who checked on your health at that time? PROBE FOR MOST QUALIFIED PERSON.	(Single Response) DOCTOR AT BHC/CHC 1 DOCTOR AT HOSPITAL 2 MIDWIFE AT BHC/CHC 3 MIDWIFE AT HOSPITAL 4 TBAs 5 DELIVERED ON MY OWN 6 RELATIVES 7 DON'T REMEMBER 99 OTHERS 96 OTHER: _____ X (Specify)	
44	How many days after (Name) was born, did the first check take place?	(Multiple Response) DO NOT REMEMBER Z WITHIN 24 HRS AFTER DELIVERY A BETWEEN 3 & 7 DAYS AFTER DELIVERY B BETWEEN 7 DAYS AND 28 DAYS OF DELIVERY C	
45	At that time, did the person check on (NAME)'s health as well?	(Single Response) YES 1 NO 2	
46	What are the signs of danger after giving birth that indicate the need to seek emergency care outside home?	(Multiple Response) DO NOT KNOW Z EXCESSIVE BLEEDING A FEVER B SMELLY VAGINAL DISCHARGE C CONVULSIONS D SEVERE ABDOMINAL PAIN E PROBLEMS BREASTFEEDING F OTHERS X OTHER: _____ X (Specify) NUMBER OF CORRECT ANSWERS:	
47	What are the signs that indicate that a newborn baby is sick?	(Multiple Response) DO NOT KNOW Z POOR SUCKING OF BREASTS A BABY VERY SMALL B BLUE COLOR OF PALM AND SOLE (cyanosis) C FAILURE TO CRY D	

		CONVULSIONS E FEVER F REDNESS/DISCHARGE IN EYES G FAST BREATHING OR PNEUMONIA H FAILURE TO PASS URINE I FAILURE TO PASS STOOL J REDNESS/DISCHARGE AROUND CORD K YELLOW COLOR (JAUNDICE) M WHEN BABY FEELS COLD N RIGIDTY O OTHERS X OTHER: _____ X (Specify) NUMBER OF CORRECT ANSWERS: _____																												
48	In your opinion when a newborn has these danger signs, where should the treatment be sought?	(Multiple Response) DO NOT KNOW Z GOVT. HEALTH FACILITY (BHC/CHC) A GOVT. HOSPITAL B PRIVATE PRACTITIONERS C MULLAHS/TRADITIONAL HEALERS D TBAS E OTHERS X OTHER: _____ X (Specify)																												
49	After (Name) was born and during your first check (postpartum check), were you counseled on the following:	(Multiple Response) <table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th></tr> <tr> <th></th><th>S</th><th></th></tr> </thead> <tbody> <tr> <td>FAMILY PLANNING</td><td></td><td></td></tr> <tr> <td>INFANT NUTRITION</td><td></td><td></td></tr> <tr> <td>BREASTFEEDING</td><td></td><td></td></tr> <tr> <td>CHILD IMMUNIZATION</td><td></td><td></td></tr> <tr> <td>DANGER SIGNS OF NEWBORN ILLNESSES</td><td></td><td></td></tr> <tr> <td>DANGER SIGNS OF DIARRHEA</td><td></td><td></td></tr> <tr> <td>DANGER SIGNS OF PNEUMONIA</td><td></td><td></td></tr> </tbody> </table>		YES	NO		S		FAMILY PLANNING			INFANT NUTRITION			BREASTFEEDING			CHILD IMMUNIZATION			DANGER SIGNS OF NEWBORN ILLNESSES			DANGER SIGNS OF DIARRHEA			DANGER SIGNS OF PNEUMONIA			
	YES	NO																												
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DANGER SIGNS OF PNEUMONIA																														
Child Nutrition:																														
50	Did you ever breastfeed (NAME)?	YES..... 1 NO..... 2	> Q52																											
51	How long after birth did you first put (NAME) to the breast?	(Single Response) WITHIN FIRST HOUR 1 WITHIN FIRST EIGHT HOURS 2 AFTER EIGHT HOURS, WITHIN 24 HOURS 3 AFTER THE FIRST DAY 4 DO NOT REMEMBER 96																												

52	Now I would like to ask you about the types of liquids and foods (NAME) consumed yesterday during the day or at night. Did (NAME) have.....	<p align="center">CONSUMED IN LAST 24 HOURS</p> <p align="right">(Single Response)</p> <table> <tr><td>BREAST MILK</td><td>1</td></tr> <tr><td>PLAIN WATER</td><td>2</td></tr> <tr><td>OTHER LIQUIDS</td><td>3</td></tr> <tr><td>SOLID/SEMI SOLID FOODS</td><td>4</td></tr> <tr><td>OTHERS</td><td>96</td></tr> </table> <p>OTHER: _____ (Specify)</p> <p>OTHER: _____ (Specify)</p> <p>OTHER: _____ (Specify)</p>	BREAST MILK	1	PLAIN WATER	2	OTHER LIQUIDS	3	SOLID/SEMI SOLID FOODS	4	OTHERS	96	
BREAST MILK	1												
PLAIN WATER	2												
OTHER LIQUIDS	3												
SOLID/SEMI SOLID FOODS	4												
OTHERS	96												
53	Did (NAME) receive a vitamin A dose like this during the last 6 months? SHOW THE AMPULE/CAPSULE/SYRUP.	<p align="right">(Single Response)</p> <table> <tr><td>YES</td><td>1</td></tr> <tr><td>NO</td><td>2</td></tr> <tr><td>DON'T KNOW</td><td>99</td></tr> </table>	YES	1	NO	2	DON'T KNOW	99					
YES	1												
NO	2												
DON'T KNOW	99												
54	May I weigh (NAME)?	<p align="right">(Single Response)</p> <table> <tr><td>YES</td><td>1</td></tr> <tr><td>NO</td><td>2</td></tr> </table>	YES	1	NO	2	> Q56						
YES	1												
NO	2												
55	Weigh (Name) and record weight to the nearest tenth	____ . ____ KILOGRAMS											
Immunization:													
56	Do you have a card where (NAME's) vaccinations are written down? IF YES: May I see it please?	<p align="right">(Single Response)</p> <table> <tr><td>YES (SEEN BY INTERVIEWER)</td><td>1</td></tr> <tr><td>NOT AVAILABLE</td><td>2</td></tr> <tr><td>NEVER HAD A CARD</td><td>3</td></tr> <tr><td>DON'T KNOW</td><td>99</td></tr> </table>	YES (SEEN BY INTERVIEWER)	1	NOT AVAILABLE	2	NEVER HAD A CARD	3	DON'T KNOW	99	If 2, 3 or 99 go to Q58		
YES (SEEN BY INTERVIEWER)	1												
NOT AVAILABLE	2												
NEVER HAD A CARD	3												
DON'T KNOW	99												
57	COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD.	<p><u>DAY</u> <u>MONTH</u> <u>YEAR</u></p> <p>____/____/____ BCG</p> <p>____/____/____ Polio 0</p> <p>____/____/____ Polio 1</p> <p>____/____/____ Polio 2</p> <p>____/____/____ Polio 3</p> <p>____/____/____ DPT 1</p> <p>____/____/____ DPT 2</p> <p>____/____/____ DPT 3</p> <p>____/____/____ Measles</p>											
58	Did (NAME) ever receive vaccinations during a national immunization day campaign?	<p align="right">(Single Response)</p> <table> <tr><td>YES</td><td>1</td></tr> <tr><td>NO</td><td>2</td></tr> <tr><td>DO NOT KNOW</td><td>99</td></tr> </table>	YES	1	NO	2	DO NOT KNOW	99					
YES	1												
NO	2												
DO NOT KNOW	99												
Care of the Sick Child													
59	In your opinion what are the signs of an illness that would indicate your child needs treatment?	<p align="right">(Multiple Response)</p> <table> <tr><td>DO NOT KNOW</td><td>Z</td></tr> <tr><td>LOOKS UNWELL OR NOT PLAYING NORMALLY</td><td>A</td></tr> </table>	DO NOT KNOW	Z	LOOKS UNWELL OR NOT PLAYING NORMALLY	A							
DO NOT KNOW	Z												
LOOKS UNWELL OR NOT PLAYING NORMALLY	A												

		NOT EATING OR DRINKING LETHARGIC OR DIFFICULT TO WAKE HAS FAST OR DIFFICULT BREATHING HAS HIGH FEVER VOMITS EVERYTHING HAS CONVULSIONS HAS BLOODY DIARRHEA DIARRHEA LASTING > 2 WKS OTHERS OTHER _____ (SPECIFY) NUMBER OF CORRECT ANSWERS: _____	B C D E F G H I X	
60	In the past two weeks, did (Name) face any illness?	YES NO DO NOT KNOW	(Single Response) 1 2 99	>Q63 >Q63
61	When (NAME) was sick, was s/he offered less than usual to <u>drink</u> , about the same amount, or more than usual to drink?	LESS THAN USUAL SAME AMOUNT MORE THAN USUAL NOT AT ALL	(Single Response) 1 2 3 4	
62	When (NAME) was sick, was s/he offered less than usual to <u>eat</u> , about the same amount, or more than usual to eat?	LESS THAN USUAL SAME AMOUNT MORE THAN USUAL NOT AT ALL	(Single Response) 1 2 3 4	
Diarrhea:				
63	In the past two weeks, did (Name) suffer from Diarrhea?	YES NO DO NOT KNOW	(Single Response) 1 2 99	> Q67 > Q67
64	What did you provide to (NAME) to treat the diarrhea? Anything else? RECORD ALL MENTIONED.	NOTHING FLUID FROM ORS PACKET HOME MADE FLUID PILL OR SYRUP INJECTION (IV) INTRAVENOUS HOME REMEDIES/HERBAL MEDICINES MEDICINE FROM SHOP OTHERS OTHER _____ (SPECIFY)	(Multiple Response) A B C D E F G H X	
65	When (NAME) suffered from diarrhea, from whom did you seek advice or treatment FIRST? SELECT ONLY ONE RESPONSE.	DO NOT KNOW NO WHERE MOPH BHC/CHC MOPH HOSPITAL CHWs PRIVATE PRACTITIONERS PHARMACY (SELF) TRADITIONAL HEALERS	(Single Response) Z A B C D E F G	

		NEIGHBORS H OTHERS X OTHER _____ (SPECIFY)	
66	What type of treatment was provided to (Name) by (above mentioned) health care provider? RECORD ALL MENTIONED	(Multiple Response) DO NOT KNOW Z ORS A (I.V) INTRAVENOUS FLUIDS B ANTI-DIARRHEAL DRUGS C ANTIBIOTIC D RESTRICTED DIET E OTHERS X G OTHER: _____ X (Specify)	
67	What signs and symptoms would cause you to seek advice or treatment for (Name)'s diarrhea?	(Multiple Response) DO NOT KNOW Z SEVERE VOMITING A FEVER WITH DIARRHEA B DIARRHEA > 14 DAYS C BLOODY DIARRHEA D OTHERS E X OTHER: _____E (SPECIFY) NUMBER OF CORRECT RESPONSES:	
68	Do you have any ORS packets in the house? If No give her an ORS sachet to use for Demonstration ONCE MOTHER HAS COMPLETED PREPARATION, RECORD WHETHER PREPARED CORRECTLY OR NOT • USED 1 LITER OF CLEAN WATER • USED THE ENTIRE PACKET • DISSOLVED THE POWDER FULLY Once demonstration is over – provide one sachet of ORS to mother	(Single Response) YES PREPARED CORRECTLY 1 NO DID NOT PREPARE CORRECTLY 2	
69	Does your household have a special place for hand washing?	(Single Response) YES 1 NO 2	>Q71
70	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF EACH OF THE FOLLOWING ITEMS ARE PRESENT.	(Multiple Response) WATER/TAP YES [] NO [] SOAP YES [] NO [] ASH YES [] NO [] OTHER CLEASING AGENT YES [] NO []	

71	When do you usually wash your hands with soap or ash? RECORD ALL MENTIONED.	<div>(Multiple Response)</div> <div> NEVER Z BEFORE FOOD PREPARATION A BEFORE EATING B BEFORE FEEDING CHILDREN C AFTER DEFECATION D AFTER CLEANING CHILD WHO HAS DEFECATED E OTHERS X OTHER: _____ X (Specify) </div>	
Acute Respiratory Infections (ARI):			
72	In the past two weeks, did (Name) suffer from cough/difficult breathing (seen wa baghal)?	<div>(Single Response)</div> <div> YES 1 NO 2 DO NOT KNOW 99 </div>	> Q77 > Q77
73	When (NAME) had cough - did he/she breathe faster than usual with short, fast breaths?	<div>(Single Response)</div> <div> YES 1 NO 2 DO NOT KNOW 99 </div>	
74	Did you seek advice or treatment for the cough/ fast-breathing?	<div>(Single Response)</div> <div> YES 1 NO 2 DO NOT KNOW 99 </div>	
75	How long after you noticed (NAME'S) cough and fast breathing did you seek treatment?	<div>(Single Response)</div> <div> SAME DAY 1 NEXT DAY 2 TWO DAYS AFTER 3 THREE OR MORE DAYS 4 </div>	
76	Where did you seek advice or treatment? Anywhere else? RECORD ALL MENTIONED.	<div>(Multiple Response)</div> <div> NO WHERE Z HOSPITAL A BHC/CHC B PVT PRACTITIONERS C TRADITIONAL HEALERS D TBAS E OTHERS X OTHER: _____ X (Specify) </div>	
Child Spacing:			
77	Do you know of a place where you could obtain a method of family planning? If yes, from where you can get FP methods?	<div>(Multiple Response)</div> <div> DO NOT KNOW Z HOSPITAL A BHC/CHC B PVT PRACTITIONERS C PHARMACY/SHOPKEEPERS D CHWS E OTHERS X OTHER: _____ X (Specify) </div>	
78	Are you currently pregnant?	<div>(Single Response)</div>	

		YES 1 NO 2 UNSURE 3	> Q81
79	Do you want to have another child in the next 2 years?	(Single Response) YES 1 NO 2 UNSURE 99	> Q81
80	Are you currently doing something or using any method to delay or avoid getting pregnant? IF YES, ASK "What is the main method you or your husband/partner are using now to AVIOD getting pregnant?"	(Single Response) NO METHOD 1 INJECTIONS 2 PILL 3 IUD 4 CONDOM 5 FOAM/GEL 6 TUBAL LIGATION 7 VASECTOMY 8 BARRIER METHOD/DIAPHRAM 9 LACTATIONAL AMENORRHOEA 10 ABSTINENCE 11 WITHDRAWAL 12 OTHERS 96 OTHER: _____ (Specify)	
HIV & Other STDs:			
81	Have you ever heard of an illness called AIDS?	(Single Response) YES 1 NO 2	> Q83
82	What can a person do to avoid getting AIDS or the virus that causes AIDS? Anything else? RECORD ALL MENTIONED.	(Multiple response) DO NOT KNOW Z ABSTAIN FROM SEX A USE CONDOMS B LIMIT SEX TO ONE PARTNER C AVOID SEX WITH PROSTITUTES D AVOID SEX WITH PERSONS WITH MANY PARTNERS E AVOID SEX WITH PERONS OF THE SAME SEX F AVOID SEX WITH PERSONS WHO INJECT DRUGS (IV) G AVOID UNSCREENED BLOOD TRANSFUSIONS H AVOID USED INJECTIONS I AVOID KISSING J AVOID SHARING RAZORS, BLADES K OTHERS X OTHER: _____ W (Specify)	
Malaria Prevention			
83	Do you have any bednets in your house?	(Single Response) YES 1 NO 2 DO NOT KNOW 99	> Q86 > Q86
84	Who slept under a bednet last night? CIRCLE ALL THE APPLY.	(Multiple Response) CHILD (NAME) 1 RESPONDENT 2 OTHERS 96	
85	Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or bugs?	(Single Response) YES 1	

		NO	2	
		DO NOT KNOW	99	
Health Contacts and Sources of Information:				
86	Where do you get general information or advice on health or nutrition? RECORD ALL MENTIONED.	(Multiple response) NO WHERE Z DOCTOR A NURSE B MIDWIFE C CHC MEMBER D CHWS E RADIO F TELEVISION G CAMPAIGNS H NEWSPAPER I OTHERS X OTHER: _____ (Specify)		
87	In the past month, have you received any health messages from the following?	(Multiple response) NO WHERE Z DOCTOR A NURSE B MIDWIFE C CHC MEMBER D CHWS E RADIO F TELEVISION G CAMPAIGNS H NEWSPAPER I		
Thank you for taking the time to meet with me and answer these questions. The information you provided will be kept strictly confidential and will not be shared with any other person.				

Annex 9
Evaluation Team Members and Their Titles

Bonnie Kittle – Evaluation Facilitator – Independent Consultant
Salim Sadruddin – SC Technical Backstop Officer
Tariq Ihsan – Senior Program Manager
Mina Niazi – Reproductive Health Senior Officer – CS-19
Mohammed Latif Olugh Zada – BCC Senior Officer – CS-19
Abdul Nazir Azizi – Provincial Office of Health IMCI Officer, MOPH
Mohammed Yassin Hamrah – Provincial Office of Health, EPI Officer, MOPH
Nosheen Shahab, Provincial Office of Health, RH Officer, MOPH
Dr. Laila - STEP
Dr. Razia – MOVE
Hafiza Oyghun– CS-19 Promoter
Shookria Akhtari– CS-19 Promoter
Maliha Ghafoori – CS-19 Promoter

Annex 10

Evaluation Assessment Methodology

The final evaluation was conducted over a period of 24 days as shown below.

# of days	Total # days	Date/Days	Task Description	Location of work
2	2	Prior to Sept 13	Review project documents	US
1.5	3.5	Sept. 13 and 15 Sat - Monday	Arrive in Kabul via Dubai at 14:15pm via Kam Air on Monday Sept. 15 th Meeting USAID	US-Afghan.
4	7	Sept. 16 – 19 Tues - Fri.	Fly to North and drive to Shiberghan arriving @ 2:00 pm Team Planning Meeting, Development of Tools, field schedule, some staff interviews as possible	Shiberghan
3	10	Sept. 20 – 22 Sat – Monday	Field Data Collection – 2 teams working simultaneously in 2 different locations	Field Sites
2	12	Sept.23-24 Tues - Wed.	Data analysis as an entire evaluation team together – any final staff interviews If time allows start preparations for presentation	Shiberghan
1	13	Sept. 25 Thursday	Plan presentation Make presentation in Shiberghan	Shiberghan
1	14	Sept. 26 Friday	Option 1 - Drive back to Kabul - Option 2 - Do presentation in the morning and finalize all interviews	en route
1	15	Saturday, Sept 27	Alternative 2 – fly back to Kabul	en route
1.5	16.5	Sept 28 Sunday (arrive home Sept. 30)	Debriefing in Kabul with USAID, SAVE and other stakeholders at 9:00 BK departs at 14:00 via Kam Air	en route
5	21	Sept. 30 – Oct. 10	Report Writing	US
2	22	Oct. 16 - Thurs.	Final Edits	US

The in-country portion of the evaluation was divided into four components: Team planning meeting (3 days); key informant interviews/field work (3 days), data analysis (2 days) and presentation preparation and facilitation (1 day). For the key informant interviews, the larger evaluation team was divided into 3 sub groups as shown below and each group conducted

interviews in each of the two target Provinces/areas. Care was taken to avoid the appearance of conflict of interest by assigning team members to area where they hadn't worked or to avoid interviewing people they knew.

Field Team Groups

Team 1	Team 2	Team 3
Bonnie - Indp	Salim – CS	Tariq - CS
Dr. Noshim - MOPH	Dr Yassim - MOPH	Dr. Nasir - MPOH
Dr. Laila - LNGO	Dr. Mina - CS	Dr. Razia LNGO
Dr. Latif - CS	Shukria - Promoter	Hafiza - Promoter
Interpreter	Interpreter	

Field Work Schedule

	Team 1	Team 2	Team 3
Saturday Andkhoy			
District	Khancharbagh	Corghon District 2 clinics	Qaram Qol
village	Khanqah	Kohna Qorgham (clinic 1)	Yousaf Marzai (CCM)
village	Surkhi	Lafi (clinic 2)	Altibolar
village	Khancharbagh	Choqa	Markazi
Sunday Jawzjan			
District	Jaghsai	Misrabad	Afghar Tepa (<i>Shura</i>)
village	Pirmasjid	Qazi Zabi	Kabuli
village	Yaka Pata	Worta Masjid	Se Shamba
village	Labi- I jar	Tokhta Bai	Turkmania
Monday Jawzjan			
District	Khajakoh	Aakcha (no Promoters)	Yangaregh (<i>Shura</i>)
village	Chobash	Komak Omar	Kanjogha
village	Salteq	Laghmani	Yangaregh
village	Nazar Abab	Naya Yak	Bala Masjid

Annex 11

List of Persons Interviewed and Contacted

USAID/Afghanistan

Dr. R. Augustin – Chief of Health Unit

Dr. Mohammed Faiz, Population, Health and Nutrition Advisor

MOPH

Dr. Abdul Nazir Azizi – Provincial Office of Health IMCI Officer, MOPH

Dr. Mohammed Yassin Hamrah – Provincial Office of Health, EPI Officer, MOPH

Dr. Nosheen Shahab, Provincial Office of Health, RH Officer, MOPH

CS-19 Staff

Dr. Tariq Ihsan – Senior Program Manager

Dr. Mina Niazi – Reproductive Health Senior Officer – CS-19

Mr. Mohammed Latif Olugh Zada – BCC Senior Officer – CS-19

Hafiza – CS-19 Promoter

Shukria – CS-19 Promoter

Maliha – CS-19 Promoter

LNGOs

Dr. Laila - STEP

Dr. Razia – MOVE

USAID Implementing Partners

Tech Serve

JPHIEGO - Access Project

District and Community Level Interviews

Type of Questions	Team 1	Team 2	Team 3	Total
Med Director	3	4	3	10
Mid wife	3	4	3	10
Vaccinator	3	4	3	10
Community Health Supervisor	3	4	3	10
Community Health Worker	12	12	12	36

Annex 12
Report on PD/Hearth

See attached report on PD/Hearth.



Annex 12
Report on PD/Hearth

A Pilot Program in Afghan Tapa and Chighchi Villages
In Jawzjan Province, Afghanistan



Save the Children, USA
Child Survival Program (CS-19)

Prepared By:

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Dr. M. Latif, Senior Officer Health (BCC)
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Roberta Horth, Intern

February 2006

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Glossary of Acronyms and Terms

BPHS	Basic Package of Health Services
CHC	Community Health Council
CHW	Community Health Worker
CS	Child Survival
CS-19	The program, <i>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</i> , funded in part through the 19 th cycle of the PVO CSH Grants Program which began in October 2003.
CSHGP	Child Survival Grant Program of USAID
FGD	Focus Group Discussion
GMP	Growth Monitoring and Promotion
IMCI	Integrated Management of Childhood Illnesses
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOH	Ministry of Health (Afghanistan)
MOPH	Ministry of Public Health (Afghanistan)
ORS	Oral Rehydration Solution
NGO	Non-Governmental Organization
PD	Positive Deviant
PD/Hearth	Positive Deviance and Hearth Approach
PDI	Positive Deviance Inquiry
SC/USA	Save the Children, US
SSP	Social Support Project
USAID	United States Agency for International Development

1 Summary

Description

Save the Children US (SC)'s Child Survival 19 (CS19) team decided to undertake a Positive Deviance (PD)¹/Hearth² pilot program to address malnutrition among young children in two villages of Jawzjan Province. PD/Hearth is an empirically proven community-based approach to successful and sustainable reduction of malnutrition in resource-poor settings. The PD/Hearth approach identifies and taps into local, culturally appropriate solutions (to malnutrition) already present in a community and shares this local knowledge and practice with all community members, most importantly to those whose children are malnourished.

Objectives

- ◆ raise awareness of good child feeding and weaning practices in the community
- ◆ promote healthy feeding, cooking, caring and hygiene practices
- ◆ educate women on breastfeeding, diarrhea, acute respiratory infection, and vaccinations
- ◆ empower caregivers and families to take responsibility for the health of their children at home on their own
- ◆ rehabilitate malnourished children
- ◆ sustainably prevent malnutrition and common disease in children in the community in the future.

Activities

The PD/Hearth program began by mobilizing the Afghan Tapa and Chighchi villages to educate them on the potential value of the PD/Hearth approach to their children. One-hundred and forty-seven (147) children and their families enrolled in PD/Hearth: 98 in Afghan Tapa and 49 Chighchi. About half of the children were girls and half were boys. The next step was to weigh and measure all children in those villages between ages 6 and 36 months to identify those who were malnourished. After this a Positive Deviant Inquiry (PDI) was conducted to discover feeding, care-giving and (health) care-seeking practices that contributed to normal nutrition status in the well-nourished children. From the inquiry's results, PD/Hearth sessions were developed in partnership with study participants (mothers/caregivers). Next, the SC CS19 team organized groups of mothers/caregivers and their malnourished children to participate in PD/Hearth groups, who received lessons on feeding, cooking, hygiene, sanitation and other key health practices that affected the nutritional status of their children. All lessons were taught using basic health/nutrition education materials from existing programs and local foods; and, by the end of the 12-day learning program, caregivers knew how to prepare nutritional calorie-dense meals for their children and how to maintain correct child feeding practice including and food hygiene in order to keep their children well-nourished and prevent future malnutrition.

Results

When defining "weight gain" as gain of more than 400 grams (to account for normal weight gain that might occur in a two week time period), 95% of children experienced weight gain. In total 81 children, or 55%, experienced a weight gain of at least one kilogram. So, after the PD/Hearth sessions ended, 44 children, or 30%, were rehabilitated to normal nutrition status. Further, nearly all children showed progress and were steadily making headway towards achieving normal nutritional status.

¹ Right here, first thing, we need to cite the origin / basic point of PD/PDI, no? An article or something? Name Jerry and Monique Sternin? I know we explain it at the start of section 2, but that explanation is weak, too.

² Ditto Hearth; what is it and where did it originate?

Recommendations

After successful implementation of PD/Hearth in these two villages of Jawzjan Province, it is evident from both quantitative and qualitative analysis that the approach is an exceptional, sustainable method of improving the nutritional status of Afghan children – particularly those in resource-poor rural areas of low socioeconomic status. Because the Afghan government, particularly the Ministry of Public Health (MoPH) is in the process of developing approaches to improve the nutritional status of young children, the success of the Afghan Tapa and Chighchi pilot project studies gives Save the Children and USAID an excellent opportunity to introduce PD/Hearth as a model for additional testing and, potentially, for national scale-up within the Basic Package of Health Services (BPHS) or other Ministry protocol.

For additional study, in Jawzjan Province alone, SC can work with two Afghan NGOs, STEP and MOVE, which are overseeing implementation of the BPHS currently, to expand the PD/Hearth program. In addition, the Growth Monitoring and Promotion (GMP) program already in place in Andkhoy District (Faryab Provinces) gives an ideal setting from which to test the effectiveness of PD/Hearth intervention in a village already part of the GMP program versus a control village (one that is socioeconomically similar where only GMP is conducted). Additional study sites are no doubt identifiable – in SC project impact areas and others’.

2 Background on Positive Deviance and Hearth Approach

2.1 What is PD/Hearth?

PD/Hearth is an empirically proven community-based approach to successful and sustainable reduction of malnutrition in resource-poor settings. PD is based on the theory that certain individuals in a community, who have the same resources and face the same risks as all others, have practices/behaviors that help them avoid malnutrition, particularly in their children. These individuals are termed *positive deviant*. And the PD approach isolates their different (deviant) positive, nutritional behaviors/practices and shares the information about this with other community members, most importantly primary and secondary caregivers with malnourished children.

The second part of this approach is Hearth, a participative method to share this positive deviant knowledge. In a Hearth group, caregivers of malnourished children and volunteer leaders meet to learn and practice new techniques for cooking, feeding, maintaining hygiene and caring for malnourished children.

This aid, it is important to note that the PD/Hearth approach is not fixed; rather, it is a flexible method that relies on local, culturally-accepted practices/behaviors and on resources available in a community.



2.2 Why does PD/Hearth work?

Most traditional approaches to nutrition intervention tend to look for problems to solve. On the contrary, the PD/Hearth approach looks for solutions: positive behaviors and strengths that exist in the community and can be built upon. The PD/Hearth approach identifies assets within the community: behaviors that already work, e.g., to have healthy, well-nourished children, using available resources. The PD/Hearth approach works because it is quick, affordable, participatory, sustainable, reliant on indigenous knowledge, culturally acceptable, and based on achievable behavior change.

PD/Hearth also works because the approach not only teaches nutrition, but also educates primary and secondary caregivers about other relevant health topics, such as weaning, vaccine, (health) care-seeking behaviors, and nurturing practices. Together these topics help mitigate preventable diseases and health problems, both for current community members and for future generations.

3 Objective of PD Hearth in Jawzjan Province

3.1 *Individual and Community Outcomes*

The PD/Hearth pilot program implemented by SC in Afghanistan was developed and implemented to meet multiple objectives at the individual and the community levels. These objectives aimed to address the immediate nutritional needs of malnourished children in the target communities, as well as to alter negative health behaviors of caregivers, in order to have an impact on the entire communities' nutritional status for long-term sustainable results. Six key objectives of the PD/Hearth pilot in Jawzjan Province were these:

PD/HEARTH OBJECTIVES IN JAWZJAN PROVINCE

1. Raise awareness of good child feeding and weaning practices in the community
2. Promote healthy feeding, cooking, nurturing, health-seeking and hygiene practices
3. Educate communities on breastfeeding, diarrhea, acute respiratory illness, and vaccinations
4. Empower caregivers and families to take responsibility for the health of their children at home on their own
5. Rehabilitate malnourished children
6. Sustainably prevent malnutrition and common diseases in children in the community

3.2 *Direct and Indirect Target Population*

The PD/Hearth intervention was designed to have an impact on the entire population in Afghan Tapa and Chighchi. Although the main target population was malnourished children between the ages of 6-36 months and their immediate caregivers, other people were first targeted and educated to help identify children and caregivers for PD/Hearth sessions. In addition, there was another large cohort expected to be reached by association with the direct target population, i.e., other siblings, extended family members and neighbors.

DIRECT TARGET POPULATION

- Malnourished children ages 6-36 months
- Mothers of malnourished children
- Other caregivers (sisters, grandmothers, and other wives in the same household) of malnourished children
- Community Health Workers (CHW = volunteer workers in the MoPH BPHS system)
- Maternal and Child Health (MCH) promoters (SC CS19 staff)

INDIRECT TARGET POPULATION

- Members of the Community Health Committees
- Siblings of malnourished children
- Community leaders
- All children in the community
- All women in the community
- All community members
- Neighboring communities
- Children born in the community in the future

4 Overview of the PD/Hearth Pilot

4.1 *Rational for using the PD/Hearth Approach*

SC nutritional surveys in 2000 and 2002 (Annex 1) revealed that the highest acute malnutrition in this geographic area was in the weaning age group, and so PD/Hearth approach was used to address acute malnutrition. SC has a long history of successfully implementing PD/Hearth programs in other places worldwide, many of which have socioeconomic conditions and high malnutrition rates similar to those found in Afghanistan.

Health facility staff and community elder's knowledge of malnutrition issues in Afghan Tapa and Chighchi villages, as well as CS19 staff's good community relations, made these villages excellent choices to pilot this approach. The size of villages and their geographic isolation as well as the lack of infrastructure were also important factors in deciding which village to choose. Villagers' limited access to bazaars that sell diverse types of foods coupled with the economic inability to pay for such foods made the PD/Hearth approach an ideal one for improving children's nutritional status using only locally available foods.

Since SC knew, also, that taboos about certain foods and feeding practices also contributed to the malnourishment of children in the area, PD/Hearth was a good tool to help educate mothers/caregivers about these unhealthy beliefs and practices related mostly to weaning and feeding.

Lastly, as suggested, widespread poverty in the region was also has an impact of SC's decision to test the PD/Hearth approach in these villages. Specific poverty measurements are constrained by lack of data, but it is estimated that most rural Afghans are living under the international poverty line of a \$1 a day, including those in Afghan Tapa and Chighchi, where income is very low and most villagers subsist on farming and low-paid agricultural labor. Related to this, however, is an important positive factor for selecting these particular villages: there were no shortages of foods and local foods were grown at home and/or affordable. The reason this matters is because it is not recommended to conduct PD/Hearth in villages with prolonged food insecurity or where relief-feeding programs are the main source of food.

4.2 *Additional Information: Geographical Location*

Afghan Tapa, where the pilot program was first conducted, has a population of approximately 7,000; while Chighchi's population is 4,252. The villages are further divided and named for their mosques, and PD/Hearth participants came from the following areas: Harab Mosque, Jami Mosque, Kokhdan Mosque, Mulaneze Mosque, Kabuli Mosque, Qulbandi Mosque, Haji Taj Mosque, A Rahim Mosque, Mulanaze Mosque, Toor Khil Mosque, Shirkhil, Gunash, and Erekli.



In addition to being representative of the socioeconomic and nutritional status conditions that might be addressed by a PD/Hearth approach, Afghan Tapa and Chighchi were chosen for their proximity to one another and their closeness to (about 25-30 km) Shiberghan, where SC staff are based. Selecting

pilot sites that were accessible was important because of the need for daily visits for PD/Hearth group and home sessions, which take place during a 12-day period. The proximity also made it easier for volunteers to visit participating families' homes frequently. PD/Hearth has also been shown to work best when houses are relatively close together because caregivers are able to join daily sessions without too much travel (walking) time. And, in rural Afghanistan SC was particularly concerned with this issue because it is especially difficult for women to walk long distances alone with their children.

4.3 Resources

Pilot Implementation Cost

Costs included salary and transportation for the SC team members leading the project; training materials for CHWs, plus their transportation and food / refreshments at the training; and materials for PD/Hearth education sessions themselves (paper, markers, etc.). CHW work as volunteers in the MoPH BPHS, and MCH Promoters are paid SC/CS19 employees. Otherwise, supplies (fuel, utensils) and food/water were provided by participants – a key to the projects sustainability!

Personnel

Twenty people were involved in implementing the pilot project: SC employees (three CS19 senior staff and four MCH Promoters) and BPHS volunteers, i.e., 13 CHWs. The MCH Promoters were led everyday implementation of the PC/Hearth sessions, while more senior health colleagues planned, coordinated and monitored the entire process. CHWs mobilized villagers, and helped implement sessions – both group and in- home one-on-one. They were also charged with the formidable and essential task of helping insure the sustainability of PD/Hearth because they live in the communities.

Materials

As noted, a key aspect of the PD/Hearth approach is that it is designed to be used in resource-poor environments using locally available materials/foods, all of which participants provide. Further, SC's PD/Hearth team developed low or no cost, locally appropriate teaching aids – or used ones that were already available from other MoPH and/o SC projects, including the BPHS.

Because of low literacy in the target villages (typical of all Afghan villages) most teaching aids were pictorial. Other teaching methods requiring no materials, such as role playing, were also used to eliminate any learning barrier from illiteracy.

For training of SC staff, such as the MCH promoters, more advanced materials were used, including PowerPoint presentations, white boards/markers, and hard and soft copies of PD/Hearth published materials, which were translated from English to Dari and from Dari to English.

Partners: SC/USA partnered with CHWs and Community Health Committee members – all community members who know the mothers/caregivers. There was also a great deal of support from other community leaders. Other partners were the MoPH nutrition officer and Integrated Management of Childhood Illness (IMCI) officer.³

³ Since the goal of PD/Hearth is to increase the possibility for Afghanistan to support its families' health and nutrition in the long term, when international NGOs are gone, SC is now increasing cooperation with STEP and MOVE, Afghan NGOs, to ensure future PD/Hearth initiatives.

4.4 Timeline

The time it takes to implement PD/Hearth in a community depends on the size (population) of the community and the number and degree of malnourished children. The time needed to mobilize a village, identify and train volunteers, and take children's baseline and end line weights. In Afghan Tapa, the project took just over a year with the core of the initiative – 11 PD/Hearth sessions – taking about two weeks each. In Chighchi, only 6 sessions were needed; so, the pilot took only eight months.

Aghan Tapa Timeline

May 17, 2005:	Meeting the male CHC to train about PD/Hearth method
June 06, 2005:	Date of obtaining baseline weights
June 16, 2005:	Began training of CHW
June 27, 2005:	Began PD/Hearth Sessions
Oct. 09, 2005:	End of PD/Hearth Sessions (total 11 sessions)
June 11, 2006:	End-line measurements (re-weigh all children in the village)

Chighchi Timeline

June 13, 2006:	Date of obtaining baseline weights
June 27, 2006:	Meeting the male CHC to train about PD/Hearth method
June 27, 2006:	Began training of CHW
July 02, 2006:	Began PD/Hearth Sessions
Aug. 08, 2006:	End of PD/Hearth Sessions (total 6 sessions)
Feb. 17, 2007:	End-line measurements (re-weigh all children in the village)

5 Implementation Process

Many of the implementation procedures followed for the PD/Hearth Pilot in Jawzjan Province were taken directly from the manual, *A Resource Guide for Sustainably Rehabilitating Malnourished Children*, by the Nutrition Working Group of the Child Survival Collaborations and Resources Group (CORE) in February 2003. The guide gives specific examples and detailed methods to identify nutritionally at-risk children, conduct a Positive Deviance Inquiry to identify positive practices, develop and implement Hearth sessions, and set up a monitoring and evaluation system. There are many important steps involved in properly implementing a PD/Hearth program from beginning to end. SC's PD/Hearth Afghanistan pilot used seven key steps to complete the project successfully.

PD/HEARTH STEPS

1. Select and mobilize community
2. Identify and train local personnel
3. Carry out a Positive Deviance Inquiry
4. Design PD/Hearth sessions
5. Conduct PD/Hearth sessions
6. Follow-up of PD/Hearth sessions
7. Collect end-line results and evaluation

5.1 Details of Selecting and Mobilizing the Afghan Tapa and Chighchi Communities

The main reasons for selecting Afghan Tapa and Chighchi for the PD/Hearth pilot were cited in section 4.X and 4.3, plus the fact that SC had been working in these villages through other CS19 interventions since 2003 – and BPHS since 2004. As a result of CS19 and BPHS activities, these communities were already mobilized to support the introduction of the PD/Hearth initiative – one of the main methods for mobilization being Community Health Councils comprised of men and women with an interest in their community's health and the knowledge/ability to help make positive changes in their communities.

The first step in preparing the communities for PD/Hearth was to fully inform both men's and women's health Councils about the initiative to help them understand its potential importance for their communities. Of particular importance was the need, in the Afghanistan context, to include men in community mobilization for projects, like PD/Hearth, that involve their wives, daughters and sisters. In all, 25 men (13 in Afghan Tapa and 12 in Chighchi) joined in the PD/Hearth information sessions. All participants, as it turned out, were elderly men and all but one of were illiterate. But, the training results showed that men's support for PD/Hearth was possible – even enthusiastic; they were very open to learning about this new approach to improving their children's health and felt it was very important for the women to participate.

5.2 Identifying and Training of Local Personnel (Volunteers)

Gender roles also were considered when selecting local volunteer session facilitators. Custom dictates that women not be in the presence of men who are not their relatives, making it inappropriate to have men lead PD/Hearth sessions. This known, female volunteer identification was facilitated by previous CS19 activities in the villages. SC's MCH Promoters, who had worked in other village-based activities with women in these villages, were ideal for organizing PD/Hearth sessions with mothers/caregivers and for supporting female volunteers, who would lead them. Much of the previous CS-19 work in the villages had also been facilitated by the support and involvement of female volunteers. These women lived in the village and their homes were often used to hold other group training for women of the community.

5.3 Carrying out a Positive Deviance Inquiry (PDI)

Village-wide Weighing

The first step of the PDI was to weigh all children in each village to find normal weight children and malnourished ones. Those identified as extremely malnourished were immediately referred to the local clinic for further assessment and management, including referral to provincial hospital. In Afghan Tapa there was one weighing site to which mothers or other caregivers brought children for weighing. Since this proved to be very difficult for women who lived some distance from the one location, in Chighchi, two weighing sites made it easier for all families to participate.

Home visits and interviews

After weighing all the children, the next step was to select some children and their families as either positive deviant (PD) or negative deviant (ND).

A PD child was defined as a well-nourished child belonging to a poor family; and a PD family was a poor family with a well-nourished child. A ND child was one who was malnourished in a



poor family living under similar socioeconomic conditions as PD child; and a ND family was one that was poor and has a malnourished child.

Some of the selection criteria used for determining whether a child or its family could be considered PD were these: the child must have

- ◆ belonged to the target age group (6 months–3 years)
- ◆ belonged to a family with a minimum of two children (which in rural Afghanistan is not difficult as it is very uncommon for families to have only one child)
- ◆ been well (not ill) at the time of the visit
- ◆ not been a very big baby that was losing weight, nor a very small baby who is growing well at the time.

In addition, the family must have been representative of the community. In other words, family members must have had occupations, ethnicities, socioeconomic status, etc., similar to most villagers. Nearly all families in the chosen villages were poor and worked in farming related jobs. Diversity was also not an issue, especially in Chighchi, where everyone was of Turkmen ethnicity. In Afghan Tapa there was a little more diversity, including mostly ethnic Arab and Pashtun families, with a few Uzbek and Turkmen families, too

After careful consideration, the PD/Hearth team selected three families and their children as PD and another three families and their children as ND for participation in the PDI. Next, two- to three-hour visits were made to these families' homes to determine diets and habits that contributed to the well-being or ill-being of these children, with a checklist used as the key tool to record relevant observations. (See Appendix I for the complete checklist)

During home visits, individual in-depth interviews were also held with PD and ND children's primary caregivers. In all pilot project cases, it was the mother who was asked questions about specific health-related practices and foods that her child was fed. (See Appendix II.) Similar interviews were held with other (secondary) caregivers such as older siblings, fathers, sisters, grandmothers and second wives living in the same home. (See Appendix III.)

5.4 Designing PD/Hearth Sessions

Analysis of PDI

The first step in analyzing the PDI was to distinguish between the behaviors and practices of PD and ND children and families. PD behavior was defined as behavior that was unique or not normally practiced by the majority, but contributed to the physical health and nutrition of the child of a child. The second step in the analysis was to determine which were the PD foods used by the PD families to feed their children that kept them at normal (high) nutritional levels. PD foods were defined as nutritious foods fed to a child by a poor or very poor family. These were foods normally available in the community, but not fed to children by the majority of families.

The PDI was conducted by using charts, such as the one shown in Appendix IV, listing different nutrition and health-related practices that could, potentially, be PD practices. The number of PD and ND families that followed each practice was also charted. The practices that had many more PD families listed as using them than ND families were considered PD practices. Interestingly, analysis showed that PD children were often fed by grandmothers when mothers were unable to feed, but ND children were fed by older siblings. Therefore, feeding by older siblings had a negative impact on the nutritional status of a child. Another practice identified as

important was that of using clean utensils or clean hands to feed a child rather than unwashed hands or unwashed utensils.

PD/Hearth Menus

After conducting the PDI in Afghan Tapa, the PD/Hearth team identified four calorie-dense menus that proved helpful in reducing malnutrition for some families. The identification of these meals was carried out in the homes of PD families through in-depth interviews, after which the families taught the PD/Hearth team how to prepare the meals, citing key ingredients for each recipe. The PD/Hearth team then added some other PD foods to the menus: eggs and beans. Eggs were not fed to children in these villages because of the belief that eggs made children mute. Beans were not fed because it was believed that infants would choke on the thin skins/hulls.

The selected menus were (by their local names) *kitchiree*, *shola*, *peeyawa*, and *mash awaa*. (See Appendix IV for the recipes.) Menus used only foods produced and available locally. They did not include foods that must be purchased at the market. The calories in these meals ranged from 593 to 625, and the cost per meal range from 5 to 8 Afghanis (10 to 16 US cents).

Some foods are only available during certain times of the year, so mothers were also educated about substitute foods, e.g., pumpkin can be substituted for carrots.



The preferred meal of infants and adults was *kitchiree*.

5.5 Conducting PD/Hearth Sessions

PD/Hearth Health Sessions

Upon completing the PDI and the design of the menus and PD/Health education sessions, caregivers of identified malnourished children in the villages were invited to participate in the PD/Hearth sessions, which incorporated nutrition and health education with nutrition rehabilitation, and were led by MCH Promoters with help from female volunteers. Sessions were kept purposefully small with only about 10 children in each group to help keep lessons participatory, and also allow MCH Promoters and CHW give individualized attention to each caregiver. In all 27 PD/Hearth sessions were held: in Chighchi there were 6 sessions with 7-10 children in each session, totaling 49 children; in Afghan Tapa there were 11 sessions with 7-10 children, totaling 98 children. Secondary caregivers, primarily grandmothers, also participated in the sessions. In some instances when mothers were busy and could not bring children to a session, they would send grandmothers with their child (until the time they could arrive themselves). Secondary caregivers participating totaled 71: 15 in Chighchi and 56 in Afghan Tapa.

PD/Hearth sessions took place during 12 consecutive work days, Sundays through Thursdays. Appendix V shows the 12-day plan, outlining two types of sessions: group and one-to-one (home). The group sessions usually took place at the home of a female volunteer, where MCH Promoters and the CHW would teach caretakers about important health topics while guiding them in the preparation and cooking of energy-rich, calorie-dense meals, which they would then feed to their malnourished children during the session. As the *price of admission*, so to say, and to

support the key strategy to teach and support practice of new, improved feeding habits, caretakers were required to make a daily contribution of the specific positive deviant food identified in their community through the PDI.

Home sessions were individual at caregivers' and children's homes. The purpose of these sessions was to help women practice independently what they had learned in the previous group session. MCH Promoters and female volunteers visited all participants' homes to observe their use of newly learned practices and give one-on-one advice on how to improve their practices and behaviors.



Some of the health topics taught during these sessions were hand washing, breastfeeding, nutrition, vaccination, home care of acute respiratory infection, control of diarrheal diseases, danger signs of diarrhea, oral rehydration and sanitation. Weaning was also an important topic. Caregivers were

taught when children should begin receiving solid foods. They were also taught the importance of feeding and breastfeeding regardless of whether the mother or child is sick. Further, while prevention and home care of acute respiratory infections and diarrheal diseases were taught, teachers also made sure to distinguish what could be treated at home and what – and when – a child should be taken to a clinic for skilled attention and care. Diets for pregnant women and breastfeeding practice were also discussed as the health of the baby is dependent upon the mother's health.

In addition to teaching about health and nutrition, MCH Promoters and female volunteers also promoted the idea that women should go to clinics to support their own and their children's health – particularly children's need for vitamin supplements and basic vaccinations (BCG, DPT, OPV and measles). The importance of immunization was reinforced by MCH Promoters checking all children's vaccine cards during home visits and, if a child had not received his or her vaccines, referring them to the clinic or, at least, to take advantage of clinic vaccinators; outreach. Also, if needed, children were referred to clinics to be treated for worms or other acute diseases that were contributing to the child's malnutrition status.



One challenge in teaching Afghan Tapa and Chighchi women was that almost none of them had any formal education and were illiterate. Additionally, it was hard to have women pay attention to lessons taught in a lecture style. MCH promoters quickly discovered that if they tried to teach

using lectures (just speaking to them), the women would not pay attention and soon enter into their own personal discussions with their friends and ignore the topic at hand.

Because of this, MCH Promoters learned to use participatory teaching to involve PD/Hearth participants in their own learning. So, for example, when teaching the importance of always washing hands with soap and clean water when preparing meals, before feeding their children, and after defecation/urination, instead of simply telling group members how to wash their hands, the MCH Promoters demonstrated how hands should be washed, and then participants took turns practicing washing their own hands and the hands of their children.

Another successful teaching activity involved the use of flip charts with pictures of different nutritious foods available in the community that should be included in children's diets. When these were shown, participants discussed the foods and then practiced hygienic ways of preparing these foods and cooking the different PD recipes that contained the foods.

Monitoring of Health Sessions

Ongoing monitoring of all sessions helped PD/Hearth team members understand exactly what took place during each session. Checklists, listed in Appendix VI and VII, were completed by MCH Promoters at each session to track attendance, materials/food brought, topic(s) covered, and problems faced. Checklists then helped the PD/Hearth team make improvements in the PD/Hearth sessions, where needed.

5.6 Following Up after PD/Hearth Sessions

Once a PD/Hearth session ended, MCH Promoters and female volunteers conducted follow-up visits, especially with women and children who did not experience significant improvement during PD/Hearth, to ensure that the practices learned during the program continue in the long-run. During such visits, problems related to feeding and child care were identified and mothers were counseled.

5.7 Collecting End-line Data and Evaluation after PD/Hearth Sessions

Approximately six months after completing the PD/Hearth sessions, re-surveys were conducted to re-weigh all the children of the village between the ages of six months and three years – in order to see whether the PD/Hearth program had an impact on the community. The new data collected was compared with the original data (the baseline), to assess whether there have been significant changes in the weight of all children in the villages. This re-survey also served as a tool to discover which children that might still be having problems and who continue to be malnourished. In Afghan Tapa and Chighchi villages the re-survey demonstrated decreased percentages of malnourished children, indicating that weaning practices may have improved in these villages.

Also, in addition to collecting quantitative data on changes, the CS19 MNC Officer and an intern met with Community Health Council members, MCH Promoters, female volunteers, and caregivers to speak to them on how they perceived the PD/Hearth program. Everyone who participated unanimously agreed that the PD/Hearth method was a successful approach to reducing malnutrition in their village; and the participatory group evaluation proved most valuable because it elicited important feedback, both positive and negative, on the experience of everyone involved in PD/Hearth pilot, which can be used to make changes to the program for future implementation.

6 Results of PD/Hearth

6.1 Baseline Results

Baseline data was obtained by weighing all the children in the villages where PD/Hearth was conducted for two purposes (as earlier noted): (1) decide if the villages were suitable to benefit from a PD/Hearth intervention⁴ and (2) to have a standard against which to measure the long-term impact of PD/Hearth.

In Afghan Tapa and Chighchi weight-for-age measurements were used to assess malnutrition. Child growth cards with the MoPH-developed national standard for determining the nutritional level of an Afghan child were used to measure the nutritional status of children in the PD/Hearth pilot. The standard was plotted in an easy to read age chart with different colors representing different nutritional strata. (See Appendix VI): normal, mild, moderate, and severe (from best to worst). *It is important to note that, in using this national standard for Afghanistan in place of the international standards for measuring nutritional status, the rates of malnutrition were much lower.*

In Afghan Tapa, 253 children's weights were taken during the baseline data collection. The results proved that Afghan Tapa would be an ideal village to conduct PD/Hearth because, of all children 126, or 42%, were identified as being malnourished. In Chighchi village, 124 children were weighed during baseline measurements. Of these 56, or 45%, were found to be malnourished. Therefore, this village was also an ideal location to carry out the PD/Hearth program.

Process Results

Results reported here are the immediate results obtained in the short-term time period between the first and last (12th) day of the PD/Hearth sessions; measurements show the weight gain of participants during this time. Of the 147 enrolled children (98 in Afghan Tapa; 49 in Chighchi), the number of boy and girl children was similar: 71 boys and 76 girl children. (See Table 1)

Table 1. PD/Hearth Participants

	Male	Female	Total
Afghan Tapa	46	52	98
Chighchi	25	24	49
Total	71	76	147

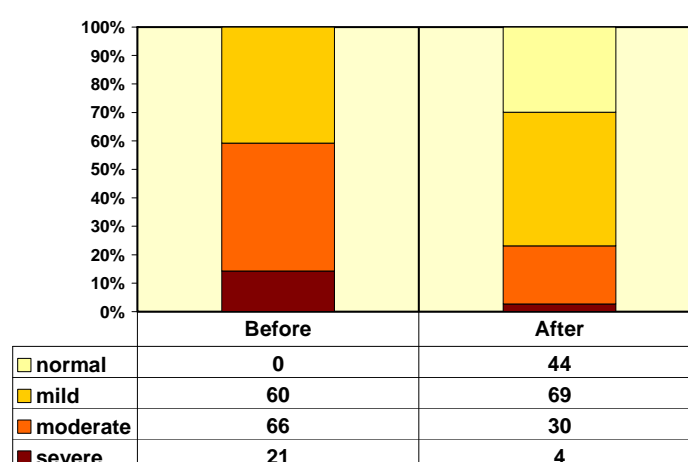


Figure 1. Nutritional Status Before vs. After PD/Hearth

⁴ If baseline results show the number of malnourished children to be more than 30% of all children, PD/Hearth should be conducted. If the baseline was lower than this, PD/Hearth would not be conducted (because evidence suggests that the intervention is optimally successful when 30%-plus children/families participate) but SC would continue with other CS19 initiatives.

The mean age of participating children was 23.1 months, with the youngest being six months old and the oldest being 36 months (three years) old.

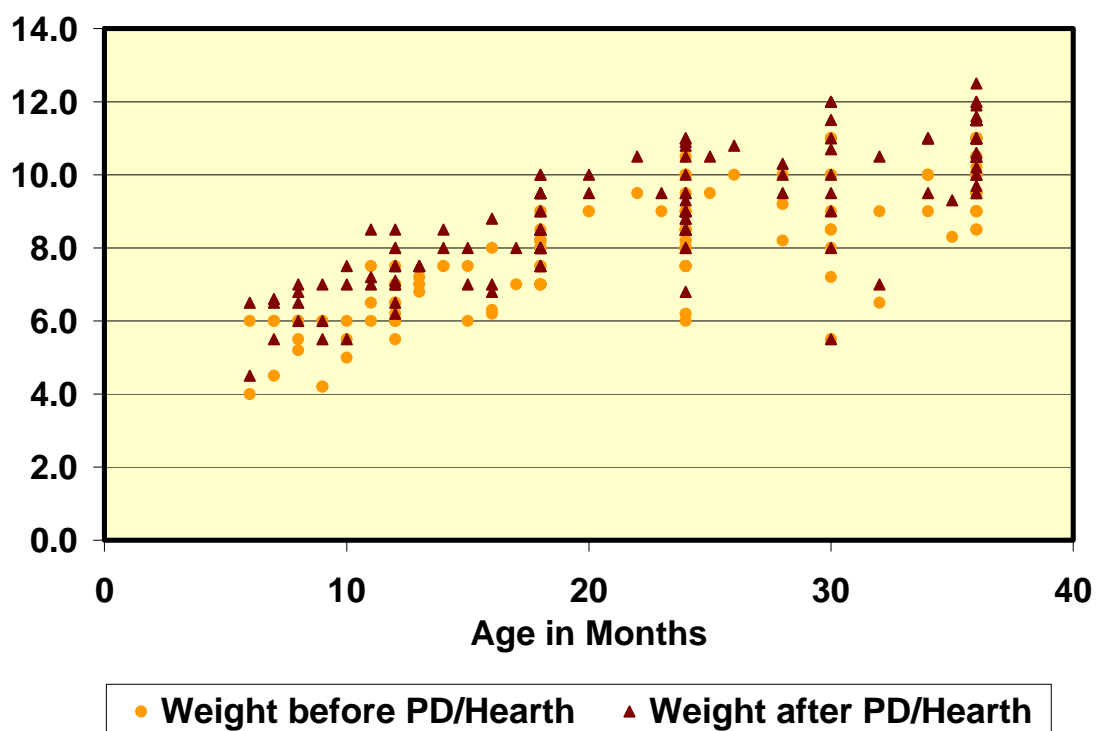
Nearly all children who participated in the PD/Hearth pilot gained weight; only two did not. The mean weight of participants before PD/Hearth was 8.20 kg and the mean weight after PD/Hearth was 9.07 kg.

A paired sample t-test was used to test the difference between weights of children taken in the beginning and the end of the PD/Hearth initiative, and results showed that the difference was significant at the 99% confidence level ($p > 0.001$). Figure 1. below plots the initial and final weights in kilograms of each child according to age in months. The orange dots represent the initial weights and the red dots represent the final weights. It is evident from looking at this graph that most children experienced some weight gain and that there is a trend towards weight gain among participants regardless of age.

The mean weight gain for the entire sample was 0.88 kg, with a range between 0 kg and 2.00 kg. There was no statistically significant difference in weight gain by gender with girls gaining on average 0.88 kg and boys gaining on average 0.89 kg. It is important to note that there was a slight difference in weight gain by village, with children in Afghan Tapa having on average gained more weight than children in Chighchi: 0.98 kg vs. 0.68 kg, respectively. However this difference was not statistically significant at the 95% confidence level. The difference here is largely attributed to the fact that Afghan Tapa had more children who were severely malnourished at the beginning of PD/Hearth than Chighchi did.

Figure 2. Weights of children before vs. after PD/Hearth participation

Weight in Kg



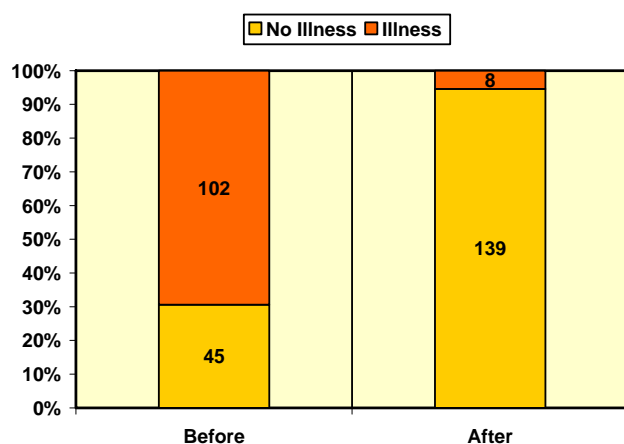
Of all children involved only two did not gain any weight, mostly due to illnesses that needed clinical attention. When defining weight gain as gain of over 400 grams (to account for normal weight gain that might occur in a two week time period), 95% of children experienced gain. In total 81 children, or 55%, experienced notable weight gain of one kilogram or more.

Besides the overall weight gain for participants, there was also significant improvement in their nutritional status (normal, mild, moderate, and severe) as defined by the Afghan MoPH. Project data show that, before the PD/Hearth initiative began, 60 children, or 41%, were mildly malnourished; another 66, or 45%, were moderately malnourished, and 21 children, or 14%, were severely malnourished. (See Figure 2) Although these statistics are combined data for both Afghan Tapa and Chighchi village there were some notable differences in the nutritional status of children by village. In Afghan Tapa 20% of children were severely malnourished, but in Chighchi only 2% of children were severely malnourished.

After the PD/Hearth sessions, 44 children, or 30%, were rehabilitated to normal nutrition status. Because the time period for the intervention was only 12 days, it could not be expected that all children would return to normal nutrition standard during this short time. But it is significant that the majority of children did demonstrate progress, and were steadily making headway towards achieving normal nutritional status. Also, only four children, or 3%, were still severely malnourished. This is approximately an 80% decline in the prevalence of severe malnutrition in these children. Figure 2 illustrates the significant shifts that occurred in the short time between day one and day 12 of the PD/Hearth pilot project. It is clearly shown in the graph that the percentage of moderate and severely malnourished children made up the majority of children at the beginning of initiative; but, at the end, the number of children in these two categories had dropped to approximately 20%.

Success was not only evident in the changes of children's nutritional status, but also in their overall health. This is evident from the number of children who were ill in the beginning of the SC PD/Hearth pilot and the number of children who were ill at the end. Illnesses reported by caregivers included diarrhea, fever, and pneumonia – the most frequent being diarrhea. Whereas, in the beginning of the intervention, 102, or 70%, of children were reported as ill, at the end of PD/Hearth, the number had dropped to only 8, or 5%. The drop in the number of ill children was likely the result of the health education, particularly that which covered the topics of diarrhea, oral dehydration solutions (ORS), and sanitation.

Figure 1. Illness Before vs. After PD/Hearth



6.2 End-line Results to follow

6.3 Strengths, Challenges, and Weaknesses

Strengths of the PD/Hearth Approach

Perhaps the greatest strength of the PD/Hearth pilot project was the willingness and cooperation of community members, especially men/leaders. The orientation sessions conducted with the Community Health Council to inform men about the PD/Hearth approach and its importance to their children helped mobilize both communities' men as well as

women. Men showed their support for women by transporting them on their motorcycles or donkeys, and many waited outside the PD/Hearth session site to take/escort their female

relatives home at sessions' end. Some also helped motivate other family members to attend sessions and some helped women practice what they learned in class at home.

Another strength of the PD/Hearth initiative was that it involved volunteers from the community. The PD/Hearth team also found that, besides the trained female volunteers, many people were willing to volunteer to help in any way they could. Many women came to the trainings and the PD/Hearth sessions, and non-target caregivers wanted to attend sessions. The community clearly enjoyed the sessions and, in some cases, even continued to hold them after the PD/Hearth sessions, truly reflecting the sustainability of the program. Other strengths include its affordability for very poor families, its near-term impact and its efficiency, i.e., participation does not take a lot of time away from the other activities that women need to be involved in within their homes, and it uses a participatory approach helps women actively learn to improve child health. This type of learning has been proven to be the most effective method of adult learning because it involves hearing, seeing, and doing.

Challenges of PD/Hearth

Some of the challenges encountered during the pilot program were easily solved, while others were not overcome. When the PD/Hearth approach was first taught to MCH Promoters, they were concerned there would be much difficulty in getting members of the community to become involved. They were especially concerned with the approach of having caregivers provide the materials/foods required to implement sessions. They also thought it would be difficult for women to have time to participate in the daily two- or three-hour sessions, which would take a lot of time away from their other work. Fortunately, once they started implementing the program, MCH Promoters and female volunteers were pleasantly surprised to learn that the opposite was true. Most women could bring materials/food, and women who were too busy to attend would send another caretaker. Nevertheless, these challenges should be noted, as they will likely be encountered in other places in Afghanistan.

Other challenges not easily overcome included the difficulty for women to meet at specified times; some tardiness, and over-crowded spaces. Some women were too poor to contribute food, fuel or utensils, but MCH Promoters were flexible and still allow them to participate. Also, the requirement of the contribution of fire wood for fuel was a big problem; wood was the most difficult resource for some women to bring. Although the PD/Hearth reference guide suggests not letting women participate if they do not contribute, the PD/Hearth team allowed some women to participate regardless of whether they could contribute, or not. Accordingly, future PD/Hearth project implementers, including SC, need to find ways to track separately failure to continue gains in child nutrition of families who cannot provide their own materials (fuel, utensils, all foods) for the initial project.

7 Recommendations for Scale-up

Since the 1960s, the PD/Hearth approach has repeatedly proven to be an effective method of malnutrition reduction in both rural and urban settings worldwide. Save the Children has much experience with PD/Hearth projects, and has witnessed positive results from the approach in other Asian countries besides Afghanistan: Vietnam, Nepal, Bangladesh and Indonesia.

SC's most notable success story comes from Vietnam where the PD/Hearth approach showed astonishing results and was, eventually, scaled up to a national program. The pilot project began in 1991 in four villages with a total population of 20,000. The initial implementation was associated with 40% reduction in moderate malnutrition and 68% reduction in severe malnutrition. (Sternan et al, 1998) In addition, caregivers were able to sustain enhanced nutrition

status beyond their participation in the program. Furthermore, siblings of the children who participated in PD/Hearth enjoyed the same enhanced nutritional status as their participating siblings. All of which data caused the program to be adopted by the Ministry of Health and, in 1998, it was reaching more than 256 villages with a total population of 1.2 million

In discussions held during the mid-term evaluation of the CS19 project, the leader of the Service Support Project (SSP) expressed strong interest in the PD/Hearth approach. SSP is a USAID-funded initiative tasked with providing technical assistance to the MoPH for continuing to strengthen health care service delivery. In her remarks to the CS19 team, leader noted that the government is still in the process of developing its approach to improve the nutritional status of young children. This is therefore an excellent opportunity to introduce PD/Hearth as a possible model for national scale-up. In discussions with local NGO partners tasked to provide technical assistance to the provincial MoPH in Jawzjan Province, representatives expressed interest in learning more about PD/Hearth approaches to assess whether the approach should be applied more broadly within the province. (Parker et al, 2006)

Currently, Afghanistan is involved in building up a national Growth Monitoring Program, which focuses on the routine weighing of children to categorize them by nutritional status and capture their growth process. According to the PD/Hearth resource guide, the existence of programs that identify and monitor childhood malnutrition rates characterizes an optimal situation for PD/Hearth implementation because Growth Monitoring Programs facilitate the detection of target communities with high malnutrition prevalence and also help identify malnourished children and their caregivers for participation in PD/Hearth programs.

There are numerous features in the PD/Hearth approach that makes it potentially relatively easy to expand in Afghanistan. One of the main features of the PD/Hearth approach is that it promotes long-term self-sustaining solutions to malnutrition, and demonstrated the potential for achieving results in a very short amount of time.

PD/Hearth sessions are not set up as permanent sessions that promote dependency on the program. Rather, the PD/Hearth approach is designed for quick behavior change by educating families – teaching them new practices that show results so they do not have to be dependent on anyone or any organization after the short (12-day) intervention has taken place. This is especially important in Afghanistan, where lack of infrastructure and geographical barriers make many villages difficult and time-consuming to reach. A well-trained group could easily help improve the nutritional status of Afghans living in these isolated communities in just a few weeks.

Another feature of the PD/Hearth that makes it extendible throughout other communities in Afghanistan is that it is low-cost and affordable to poor families. Participants are each responsible to provide the food / resources (fire wood) needed for the Hearth sessions, and all the resources are items that are already available within the community at large. (In Vietnam the cost was approximately \$2 per child for the entire program.) Also, when comparing the short-term cost of the approach to the long-term costs of mortality and morbidity that happen from untreated malnutrition, these few dollars (which likely would have been spent in much the same way, i.e., for food and fuel) prove to be a cost effective solution because PD/ Hearth focuses not only on the treatment of malnutrition, but also on its prevention.

The PD/Hearth approach can also be used for other purposes besides addressing malnutrition in children between the ages of 6 months and 3 years. Positive Deviance has been shown to be successful when used to improve outcomes for pregnant women. (Bhat, 2000) In Afghanistan,

where negative pregnancy outcomes remain high, the positive deviance approach could prove to be a successful approach in mitigating this problem.

Additionally, Positive Deviance Inquiry (PDI) is known to be a good stand-alone rapid assessment approach that can be done with minimal baseline malnutrition data. A study of Afghan refugee children living in Pakistan found that the PDI approach was an affordable, participatory and valid method to identify feeding behaviors and other factors associated with good nutrition. (Lapping et al, 2002)

Because there are hundreds of national and international NGOs now working throughout Afghanistan, developing partnerships with and training workshops for these NGOs to initiate PD/Hearth projects in the areas where they have existing community ties, could well be an efficient and effective way to spread the PD/Hearth approach to other areas of Afghanistan. Doing this in partnership with the Ministry of Public Health – perhaps in the context of the Basic Package of Health Services – would be ideal.

Annex 6: TOT on Basic Caregiver's Counseling Techniques

Day 1:

Time	Module/Lesson	Methodology/comments
8:30-8:40am	Introduction	Matching pairs and introducing each other
8:40-9:00am	<p><u>Warming up-Session. Difference between counseling and health education.</u></p> <p>What is the difference between health education and counseling</p>	<p>7.1.1.1 Role plays</p> <p>7.1.1.2 Brain storming/jot it on flip chart</p> <p>Summarize (use flipchart)</p>
9 – 9:10am	<p><u>Objectives of this workshop</u></p> <ul style="list-style-type: none"> • To get familiar with five rules for an effective communication • How similarities and differences between health workers and caretakers influence communication. What are some ways to use similarities to improve communication? • Local beliefs and practices - helpful, harmful or neutral. How can health workers integrate local beliefs and practices in their counseling sessions? • Learn about our own beliefs and practices and how this may affect or influence the quality of counseling. • How verbal and non-verbal communicating influence interaction between a health worker and a patient/caretakers. Identify the appropriate tone of voice for communicating with patients • Explain the importance of praise and encouragement for effective counseling skills. • The importance of asking the right questions to help determine a caretaker's needs and knowledge • Explain the basic guideline for effective use of visual aids. • The participants will understand the usefulness of two way communication using simple language during counseling sessions • The participants will be able to describe how paraphrasing, clarifying and probing questions are used to make a counseling session more effective and meaningful 	Use flip charts or multimedia.

Time	Module/Lesson	Methodology/comments
9:10-9:40am	<u><i>Five rules of an effective communication</i></u> <u>Activity 1:</u> What are some barriers in communication	Brain storming session. Take feedback on the flipchart List barriers (physical, environmental, cultural, gender, etc)
9:40-10:30am	Factors that 'help' or 'hinder' an effective communication.	Two role plays (one good and one bad) Two flip charts for brain storming re factors that 'helped' and factors that 'hindered'
10:30-11:00am	<u>TEA BREAK</u>	
11:00-11:30am	<u>Activity 2:</u> Short simple and appropriate messages	Four volunteers and Long Confused Message. (Embarrassment, confusion, distraction) Feedback from the four volunteers Feedback from observers Lessons learned (What hindered? What would help?)
11:30-12:00Nn	<u>Activity 3:</u> <ul style="list-style-type: none"> What some of the medical terms regarding disease, medical instruments and procedures they use in their work. What are some local words and phrases that best describe the medical terms SUMMARIZE – Keep It Simple and Sensible	Two group discussions (not more than 10 minutes) Feed back on the news prints in two columns – “medical” and “local terms”. (role plays) Explain how these can influence the interaction between a health worker and the caretakers/patients
12:00-12:30pm	<u>Activity 4:</u> Two way communication	Pasting pictures in two sessions – in one session the one who pastes the pictures does not have a right to speak and in the second session both can ask questions and give answers Feedback from the 4 participants Feedback from the observers
12:30-12:40pm	Summarize the session “five rules of an effective communication” <ul style="list-style-type: none"> Comfortable setting-no distraction Focus on listener’s needs or interests Be brief – do not give too much information 	Use flip chart/or multimedia Ask questions: <ul style="list-style-type: none"> In the health facilities does counseling usually take place in a comfortable setting?

Time	Module/Lesson	Methodology/comments
	<ul style="list-style-type: none"> Use words that are familiar to listener Use two way communication 	<ul style="list-style-type: none"> Do Health workers usually use simple language? Is communication between a doctor and a patient or caretaker really a two-way?
12:40-1:30pm	LUNCH BREAK	
1:30-2:15pm	<p><u>Overcoming barriers to Communication during counseling</u></p> <p><u>Activity 1:</u> Similarities often help in effective communication What are the differences and similarities between caretakers and health providers?</p> <p>7.1.1.2.1 <u>Activity 2:</u></p> <ul style="list-style-type: none"> Ask if the participants have further things to add to the two flip charts. What are the similarities in these two news prints? What are the differences? How might the differences create barriers in communication? How could similarities help in carrying out effective communication? 	<p>Two group discussions (not more than 10 minutes)</p> <p><u>Group1:</u> Think of words and phrases that best describe the caretakers who come to their health facilities.</p> <p><u>Group2:</u> Think of words and phrases that best describe the health workers such as the participants in this training.</p> <p>Use flip charts and list all differences Use flip chart and list all similarities</p> <p>Give examples of how similarities could be used to influence an effective counseling. (roles plays)</p>
2:15-2:30pm	<p>Pearls of Wisdom (what have we learned new since morning)</p> <p>Quiz!!!</p>	<p>Prepare quiz (not more than 5 minutes)</p> <p>Conduct quiz (not more than 10 minutes)</p>
2:30-4:00pm	<p><u>Reinforcing positive beliefs and practices to influence counseling</u></p> <p>Activity 1: Discuss traditional beliefs and practices regarding pneumonia that are common in your communities/target areas.</p> <p>Identifying beliefs and practices that are helpful, harmful and neutral</p> <p>Feedback by each group (5 minute each)</p>	<p>Two group discussions (not more than 10 minutes).</p> <p>Group 1: lists all harmful practices related with pneumonia</p> <p>Group2: lists all useful practices related with pneumonia</p> <p>Group 3: lists all 'neutral' practices related with pneumonia.</p>
4:30-5:00pm	<p><u>Reinforcing positive beliefs and attitudes to influence counseling</u></p> <p>Statements of beliefs and attitudes of health workers</p> <p>(Key questions – after gallery walk)</p> <ul style="list-style-type: none"> Did everyone in the group have the same beliefs and attitudes? Why 	<p>A Gallery walk and choosing a statement that fits close to one's own beliefs and attitude or statement that a participant wants to discuss.</p>

Time	Module/Lesson	Methodology/comments
	<p>some had different beliefs and attitudes than others?</p> <ul style="list-style-type: none"> - How did you feel when your beliefs and attitudes were different from the majority? - How if some of these beliefs and attitudes are expressed to the patients- how would patients feel? <p>How can health worker's different beliefs and attitude influence counseling? What should the health worker do to avoid his/her beliefs and attitudes influencing counseling (negatively)?</p>	<p>Brainstorm</p> <p>Use news print – summarize with written news print</p>

7.1.1.2.1.1 Day 2

Time	Module	Method
9:00-9:15am	<i>Warm up session.</i>	
9:15-9:25am	<p><i>Use of appropriate emotions, tone of voice and the art of praising & encouragement</i></p> <p><u>Activity 1 (tone of voice)</u></p> <p>Guessing emotions (Tone of voice)</p> <p>What tone of voice would you prefer when you go somewhere for help?</p> <p>What tones of voice do you hear most often in health facilities?</p> <p>What messages do they convey to patients?</p>	<p>Five volunteers expressing emotions written on the slips they take out of the box</p> <p>Feedback on the News Print</p> <p>7.1.1.3</p>
9:25-10:00am	<p><i>Activity 2: (Use of appropriate body language)</i></p> <ul style="list-style-type: none"> • What body language did people note in the role plays? • Which ones were appropriate and which ones inappropriate? • How does this influence counseling sessions? 	Two Role plays (appropriate and inappropriate body language)
10:00-10:10am	List culturally appropriate and inappropriate body language (local)	List feedback on the flipcharts
10:10-10:30am	<i>TEA BREAK</i>	
10:30-10:15am	<p>7.1.1.3.1 <u>Activity 3 (praise and encouragement)</u></p> <p>* What is the meaning of praise? What does praise mean when working with clients or patients in health facilities?</p> <p>* What is the meaning of encouragement? What does encouragement mean when working with clients or patients in the</p>	<p>7.1.1.4</p> <p>Brain storm and take feedback on the flip-chart.</p>

Time	Module	Method
	health Facilities?	
10:15-10:45am	<p>Practice praising and encouraging initial responses.</p> <p>Ask: Was it difficult to find something nice to say? How do you think this will make patients feel?</p> <p>7.1.1.3.2 <i>How would this influence your communications and counseling?</i></p>	Read out the statements and ask participants to respond.
Time	Module	Method
10:45-11:00am	<p><u>Asking The Right Questions during counseling</u></p> <p><u>Activity 1:</u> Types of questions:</p> <ul style="list-style-type: none"> - Closed ended - Open ended - Paraphrasing questions - Reflecting questions - Probing questions 	Brain storm/news print Jot down new questions on fresh news print.
11:00-12:00Nn	<p><u>Activity 2:</u> “What are some of the questions that you ask a caretaker who brings a sick child into your health center or clinic?”</p> <p>Presentation by groups (not more than 5 minutes)</p> <p>Do any of these questions tell you what services or information the caretakers need? What questions would really focus on finding out what this caretaker really needs and What he/she already knows? What are open ended questions?</p> <p>Summarize</p>	<p>Two group discussions: (10 minutes) Group 1: ARI case and role play questions Group2 : Breastfeeding problems and role play questions</p> <p>Presentation by groups</p>
12:00-12:30pm	<p><u>Visual aids and other methods that can make counseling effective</u></p> <p>Activity 1: Group discussions & presentations:</p>	<p>Group 1: Role Play using an ARI home care flip chart.</p> <p>Group 2: Role play using demonstration as a</p>

Time	Module	Method
	Feedback after presentations * What is the potential benefit of carrying out counseling with the help of visual aids, demonstrations, story telling and drawings? * What are some problems that health workers encounter in using visual aids? SUMMARIZE	tool in counseling. Group 3: Role play using drawing as a tool in counseling. Group4: Role play using story telling to counsel a client/caretaker Take feedback on each tool on separate flip-charts.

Time	Module	Method
12:30-1:30pm	LUNCH BREAK	
1:30-2:00pm	Presentation of the three groups on types of questions	
2:00-2:15pm	So what is the difference between health education & counseling	Feedback on the flip chart
2:15-2:45pm	Develop the “counselor contract” Developing the checklist for assessing counseling areas.	Two groups
2:45-3:15pm	Presentation on the “counselor contract and discussions”	
3:15-3:45pm	Presentation on the “counseling checklist”	

Day 3

Time	Module	Method
9:00-9:15am	Feedback	7.1.1.4.1.1.1
9:15-10:00am	ARI case management story. Assessing sick child management.	Read out the story step by step and ask questions.
10:00-10:15am	TEA BREAK	
10:15-10:45am 10:45-11:30am 11:30-12:15pm	<i>7.1.1.5 Review ARI and CDD guidelines</i> Presentation on ARI guidelines Presentation on CDD guidelines	7.1.1.5.1.1.1
12:15-12:45pm	Presentation on the checklist of sick child management (observation checklist)	Presentation
12:45-1:30pm	LUNCH BREAK	
1:30pm-2:15pm	<i>7.1.1.6 Introducing checklist (IMCI type), to identify areas for management and counseling. (identify treatment, counseling for medication, home care and when to return for follow-up).</i>	Presentation
2:15-3:00pm	Three scenarios (practicing the checklist) Focusing on sick child management and counseling needs for follow-up, medication and Immunization and GM Presentations	Three groups. Presentations
3:00-3:30pm	Feeding recommendations for a child less than 4 months Feeding recommendations for children 4-6 months	Presentation
3:30-4:30pm	<i>7.1.1.7 Zarmeenas' case scenario. Focusing feeding problems.</i>	Group discussions and using IMCI checklist to identify management and counseling areas/needs
4:30-5:00pm	Three scenarios on feeding problems and follow-up (Focusing on the feeding problems of children belonging to different age groups)	Questions and answers

Annex 7: Updated CSHGP Data Form

Child Survival and Health Grants Program Project Summary

Oct-25-2007

Save the Children
(Afghanistan)

General Project Information:

Cooperative Agreement Number:	GHS-A-00-03-00011-00
Project Grant Cycle:	19
Project Dates:	(9/30/2003 - 9/29/2008)
Project Type:	Standard
SC Headquarters Technical Backstop:	Kathryn Bolles
Field Program Manager:	Dr. Abdul Satar Sharifi
Midterm Evaluator:	Barbara Parker
Final Evaluator:	
USAID Mission Contact:	Dr. Kassahun Abate Belay

Field Program Manager Information:

Name:	Dr. Abdul Satar Sharifi
Address:	Darulaman Road -- Sherkat Bus Stop Kabul
Phone:	0093798183257
Fax:	
E-mail:	Ssharifi@savechildren.org

Alternate Field Contact:

Name:	Dr. Aftab Tariq Ihsan
Address:	Darulaman Road -- Sherkat Bus Stop Kabul
Phone:	009379370891
E-mail:	TIhsan@savechildren.org

Funding Information:

USAID Funding:(US \$): \$1,500,000	PVO match:(US \$) \$500,000
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Project Information:

Description:

The goal of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan. The following key intervention areas are; immunization; nutrition; control of diarrheal disease; pneumonia case management; and maternal and newborn care. These interventions will be implemented through the following four major cross-cutting strategies:

1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS through The

Rural Expansion of Afghanistan's Community Based Healthcare (REACH);

2. Health behavior change activities through health facility staff, CHWs, TBAs, mullahs, teachers, children, and local radio;

3. SC/MOH engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and

4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of two successful approaches (Community Case Management, and Community Defined Quality.)

Location:

Jawzjan Province, including the Andkhoy Cluster, in Northern Afghanistan.

Project Partners	Partner Type	Subgrant Amount
Ministry of Public Health and local NGOs	Collaborating Partner	

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey

Health Facility Assessment

Organizational Capacity Assessment with Local Partners

Participatory Rapid Appraisal

Lot Quality Assurance Sampling

Appreciative Inquiry-based Strategy

Community-based Monitoring Techniques

Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing

Mass Media

Interpersonal Communication

Peer Communication

Groups Targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	PVOs/NGOs (int'l/US) Local NGOs Networked Group	Pharmacists Traditional Healers	National MOH Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Immunizations (20%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Polio
- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Cold Chain Strengthening
- New Vaccines
- Injection Safety
- Mobilization
- Measles Campaigns
- Community Registers

Nutrition (15%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Comp. Feed. from 6 mos.
- Hearth
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition
- (IMCI Integration)
- (CHW Training)
- (CHW Training)
- (HF Training)

Pneumonia Case Management (20%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs
- Community based treatment with antibiotics

Control of Diarrheal Diseases (15%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding

- Care Seeking
- Case Mngmnt./Counseling

Maternal & Newborn Care (30%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- Home Based LSS
- Control of post-partum bleeding
- Emergency Transport

(IMCI Integration)

(CHW Training)

(HF Training)

(CHW Training)

(HF Training)

Target Beneficiaries:

Infants < 12 months:	24,840
Children 12-23 months:	17,610
Children 24-59 months:	81,750
Children 0-59 months:	124,200
Women 15-49 years:	155,800
Population of Target Area:	707,500

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2SD from the median weight-for-age, according to the WHO/NCHS reference population)	152	270	56.3%	10.7
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	38	81	46.9%	18.5
Percentage of children age 0-23 months whose births were attended by skilled health personnel	84	300	28.0%	7.9
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	44	300	14.7%	5.9
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	49	72	68.1%	21.9
Percentage of infants age 6-9 months receiving breast milk and complementary foods	22	66	33.3%	18.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	6	142	4.2%	4.7
Percentage of children age 12-23 months who received a measles vaccine	17	142	12.0%	7.8
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	131	300	43.7%	9.3
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	43	300	14.3%	5.8
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	14	205	6.8%	5.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	0	300	0.0%	0.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	50	300	16.7%	6.3

Comments for Rapid Catch Indicators

We have used the following formula to calculate the Confidence Limits: $P = p \pm Z \times \text{the square root of } (pq/n')$, where P = the true proportion of the population; Z = 95% confidence (1.96); p = the proportion found in the survey; $q = 1 - p$; and n' = the size of the sample divided by the design effect. As suggested on page 9 in “Writing the KPC Report” of the KPC 2000+ Manual, we have computed each indicator two ways: without the design effect and with a design effect of 2 to account for the potential bias resulting from the use of cluster sampling. Therefore, it can be said for the first indicator that “We are 95% confident that the true proportion of the population is between 48% and 64%. The best estimate for the true proportion of the population is 56%.”

Annex 8: Letter of Appreciation Public Health Director of Jawzjan Province



Annex 13
Updated CSHGP Project Data Form

Child Survival and Health Grants Program Project Summary
Jan-14-2009
Save the Children
(Afghanistan)

General Project Information:

Cooperative Agreement Number:	GHS-A-00-03-00011-00
Project Grant Cycle:	19
Project Dates:	(9/30/2003 - 9/29/2008)
Project Type:	Standard
SC Headquarters Technical Backstop:	Salim Sadruddin
Field Program Manager:	Dr. Abdul Satar Sharifi
Midterm Evaluator:	Barbara Parker
Final Evaluator:	Bonnie Kittle
USAID Mission Contact:	Randolph Augustin

Field Program Manager Information:

Name:	Dr. Abdul Satar Sharifi
Address:	Darulaman Road -- Sherkat Bus Stop Kabul
Phone:	0093798183257
Fax:	
E-mail:	Ssharifi@savechildren.org

Alternate Field Contact:

Name:	Dr. Aftab Tariq Ihsan Ihsan
Address:	Darulaman Road -- Sherkat Bus Stop Kabul
Phone:	009379370891
E-mail:	TIhsan@savechildren.org

Funding Information:

USAID Funding: (US \$): \$1,500,000 **PVO match:** (US \$) \$500,000

Project Information:

Description:

The goal of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan. The following key intervention areas are; immunization; nutrition; control of diarrheal

disease; pneumonia case management; and maternal and newborn care. These interventions will be implemented through the following four major cross-cutting strategies:

1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS through The Rural Expansion of Afghanistan's Community Based Healthcare (REACH).
2. Health behavior change activities through health facility staff, CHWs, TBAs, mullahs, teachers, children, and local radio;
3. SC/MOH engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and
4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of two successful approaches (Community Case Management, and Community Defined Quality.)

Location:

Jawzjan Province, including the Andkhoy Cluster, in Northern Afghanistan.

Project Partners	Partner Type	Subgrant Amount
Ministry of Public Health and local NGOs	Collaborating Partner	

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Organizational Capacity Assessment with Local Partners
 Participatory Rapid Appraisal
 Lot Quality Assurance Sampling
 Appreciative Inquiry-based Strategy
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
 Mass Media
 Interpersonal Communication
 Peer Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	PVOs/NGOs (Int'l/US) Local NGO Networked Group	Pharmacies Traditional Healers	National MOH Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions/Program Components:**Immunizations (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Polio
- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Cold Chain Strengthening
- New Vaccines
- Injection Safety
- Mobilization
- Measles Campaigns
- Community Registers

Nutrition (15 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Comp. Feed. from 6 mos.
- Hearth
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition
- (IMCI Integration)
- (CHW Training)
- (HF Training)
- (IMCI Integration)
- (CHW Training)
- (HF Training)

Pneumonia Case Management (20 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs
- Community based treatment with antibiotics

Control of Diarrheal Diseases (15 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

(IMCI Integration)

(CHW Training)

(HF Training)

Maternal & Newborn Care (30 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- Home Based LSS
- Control of post-partum bleeding
- Emergency Transport

(IMCI Integration)

(CHW Training)

(HF Training)

(IMCI Integration)

(CHW Training)

(HF Training)

(IMCI Integration)

(CHW Training)

(HF Training)

(IMCI Integration)

(CHW Training)

(HF Training)
 (IMCI Integration)
 (CHW Training)
 (HF Training)

Target Beneficiaries:

Infants < 12 months:	24,840
Children 12-23 months:	17,610
Children 24-59 months:	81,750
Children 0-59 months:	124,200
Women 15-49 years:	155,800
Population of Target Area:	707,500

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	174	436	39.9%	7.5
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0%	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	171	450	38.0%	7.2
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	308	450	68.4%	8.8
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	70	99	70.7%	18.8
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	53	96	55.2%	17.9
Percentage of children age 12-23 months who are fully vaccinated (against the five	146	243	60.1%	11.5

	Numerator	Denominator	Percentage	Confidence Interval
vaccine-preventable diseases) before the first birthday				
Percentage of children age 12-23 months who received a measles vaccine	146	243	60.1%	11.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	292	450	64.9%	8.7
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	387	450	86.0%	9.1
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	103	208	49.5%	11.7
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	38	450	8.4%	3.7
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	252	450	56.0%	8.3

Comments for Rapid Catch Indicators

We have used the following formula to calculate the Confidence Limits: $P = p \pm Z \times \text{the square root of } (pq/n')$, where P = the true proportion of the population; Z = 95% confidence (1.96); p = the proportion found in the survey; $q = 1 - p$; and n' = the size of the sample divided by the design effect. As suggested on page 9 in "Writing the KPC Report" of the KPC 2000+ Manual, we have computed each indicator two ways: without the design effect and with a design effect of 2 to account for the potential bias resulting from the use of cluster sampling. Therefore, it can be said for the first indicator that "We are 95% confident that the true proportion of the population is between 48% and 64%. The best estimate for the true proportion of the population is 56%."

Annex 14
Grantee Response to Final Evaluation Findings (optional)

Initial response is incorporated in the cover letter sent to USAID on December 31, 2008. Please see copy attached.