CS-19 Afghanistan
Midterm Evaluation Report

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

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Attachments

Glossary of Acronyms and Terms

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival (USAID-supported Project)
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin/Tuberculosis Vaccine
BHC	Basic Health Center
BPHS	Basic Package of Health Service
CAAC	Catchment Area Annual Census
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CHC	Comprehensive Health Center
CHC	Community Health Council
CHS	Community Health Supervisor
CHW	Community Health Worker
CME	Community Midwife Education
CS	Child Survival
CS-19	The program, *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,* funded in large part through the 19th 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
daya	Traditional Birth Attendant
DIP	Detailed Implementation Plan
DPT	Diptheria-Pertussis-Tetanus Immunization
EPHS	Expanded Package of Health Services
EPI	Expanded Program on Immunization
FFSD	Fully Functional Service Delivery Point (a quality improvement tool for facilities)
FGD	Focus Group Discussion
FP	Child Spacing/Family Planning ("FP" is used in order to not confuse "CS" with "child survival.")
FSR	Facility Status Report
GMP	Growth Monitoring and Promotion

HFA	Health Facility Assessment
HMIS	Health Management Information System
HP	Health Post
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Result
IUD	Intra-Uterine Device
KPC	Knowledge, Practices, and Coverage (CSHGP-related survey tool)
LQAS	Lot Quality Assessment Survey
MAR	Monthly Activity Report
MAAR	Monthly Aggregated Activity Report
MCH	Maternal and Child Health
MIAR	Monthly Integrated Activity Report
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MTE	Midterm Evaluation
mullah	Religious Leader
NDF	Notifiable Disease Form
NGO	Non-Governmental Organization
NID	National Immunization Day
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PDME	Program Design, Monitoring and Evaluation
PDQ	Partnership Defined Quality
PHCC	Provincial Health Coordinating Committee
PHO	Provincial Health Office
PLG	Program Learning Group of Save the Children

PPH	Postpartum Hemorrhage
REACH	Rural Expansion of Afghanistan's Community Based Healthcare
RH	Reproductive Health
SA	Situation Analysis
SC/US	Save the Children (US)
shura	Community Health Council
SO	Strategic Objective
SSP	Support to Service Provision and Quality Improvement
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid Vaccine
UNICEF	United Nation's Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHZ	Weight for Height Z-score
WRA	Women of Reproductive Age

A. Summary

Description: Save the Children (SC/US) has now completed the third year of implementation of its Child Survival 19 (CS-19) project in northwestern Afghanistan. The project serves approximately 280,000 potential beneficiaries, including 124,200 children under age five and 155,800 women aged 15-49 years. Its goal is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan province and the Andkhoy Cluster (North Faryab province). Its Strategic Objective (SO) is to improve health practices at the household level, and increase use of essential MCH services.

Accomplishments: Observations of sick child management by health workers and exit interviews with mothers of sick children reveal that the skills of health workers have improved significantly on nearly every indicator since the baseline. CS-19 has initiated pilot tests of innovative approaches such as PD/Hearth. The project has assisted with the integration of birth preparedness education in facilities and communities**.** Technical point people in the Provincial Health Office (PHO) of the Ministry of Public Health (MOPH) report that their skills and capacities have improved through participation with CS-19 counterparts in training, joint monitoring, supervisory and planning activities. CS-19 has trained Community Health Workers (CHWs) to implement community case management (CCM), focusing on assessing and treating pneumonia and diarrhea in two pilot villages. Community Health Councils (CHC) (male and female) have been organized and trained in all clinic catchment areas to promote healthy practices in their communities. Comparisons of baseline results with results of HMIS data and a 2006 MOPH LQAS survey indicate progress was made toward many project objectives: e.g. gains in immunization coverage for TT2 and DPT3; and improvements in the capacities of skilled birth attendants due to CS-19's hands-on supervision of new midwives and community education regarding the importance of midwife's assistance in deliveries. In addition, exit interviews with mothers revealed an increase in the percent who offer more food and fluids during children's illness; and community testing of salt available at shops and kitchens showed that the use and availability of iodized salt had increased.

Constraints: The project's most significant constraints have been restrictions on project staff's ability to reach some target areas due to: 1) armed conflict and insecurity; and 2) extreme remoteness of some areas of Jawzjan province. A pipeline analysis is planned to ensure that funding is sufficient to improve community-level services to the two most remote districts, and recommendations are offered in this body of the report for doing so. In addition, project staff has been unable to meet the ambitious plan for initiating PD/Hearth in four villages (two villages have PD/Hearth pilots at mid term).

Capacity Building: The project builds the capabilities of several categories of workers: PHO technical point staff (for IMCI, EPI, Nutrition and Reproductive Health), CS-19 Maternal and Child Health (MCH) Promoters, community midwives, CHWs, facility-based health workers and CHCs. There is evidence of improved practice in all categories. In particular, classification and treatment of illness by health workers, as well as client counseling, appears to have improved, as evidenced by comparisons of 2006 exit interviews and checklist observation with baseline levels. In interviews and discussions carried out by the project, CHC members and CHWs displayed

good knowledge of CS-19's health messages, and indicated that the project had given them new communication skills for promoting these messages.

Sustainability: As part of its strategy for achieving sustainability, the project aims to institutionalize these new skills and abilities, including standard case management and optimal supervision and monitoring skills, within the partner organizations at all levels. Phase-out of some project activities has already begun, with a hand-over of support to six MOPH teams working in six health facilities not supported under the Basic Package of Health Services (BPHS) of Shiberghan district to local NGO partners STEP and MOVE (which began implementation of BPHS in these clinics July 1, 2006); and a joint workplan that will spell out the roles and responsibilities of CS-19 and its partners, and the final hand-over schedule which was developed.

Recommendations: The full list of recommendations is found in section B.1.a below, "Project Overview." Highlights are: CS-19 should offer lessons learned and successful methodologies to the MOPH for training CHWs in CCM; and it should advocate for a scale-up of PD/Hearth. Project resources should be re-allocated to provide adequate support to the remote Darzab/Qush Tepa districts. The project management team should review the DIP workplan quarterly to see that all activities are on schedule. A MOU should be developed specifying that all new doctors should be trained by the MOPH, CS-19 and NGO partners. The project should adopt a comprehensive behavior change strategy framework to guide the development of its BCC activities, and any new pictorial materials should be systematically pre-tested. Before the end of the project, all CHCs should independently develop a post-project Community Health Action Plan with clearly defined activities, responsibilities and a workplan, and they should consider possible means of providing incentives for CHWs. A workshop should be scheduled with MOPH HMIS staff to identify ways to strengthen and standardize data collection.

Response to MTE Recommendations: The CS-19 team and partners met during the final days of the MTE review to discuss MTE key findings and potential synergies for the next two project years. The timing of the MTE coincided with the initial start-up of Round 2 of the BPHS and the Service Support Project under ACCESS, offering a unique opportunity to review CS-19 work with a particular focus on adapting to the new policy structure for health services in the country. Staff and partners are in agreement with the MTE evaluator's recommendations, and many of the action items suggested are already in process. The comprehensive response to the MTE recommendations is located in Section G.

Revised Work Plan: As indicated above, the revised work plan for years 4 and 5 are tailored to meet the gaps and opportunities within the new BPHS system. CS-19 staff met in Kabul with senior representatives from the key delivery mechanisms of BPHS to ensure that CS-19 offers maximum support to the BPHS without duplication of services. CS-19 held initial planning meetings with partners under the new system to define and allocate roles and activities. A draft MOU from this meeting is found in **Attachment I.** Additionally, the revised CS-19 work plan in Section G. reflects the collaborative activities with new BPHS partners.

B. Assessment of the Progress Made Toward Achievement of Project Objectives

1. Technical Approach

a. Project Overview

In September 2003, Save the Children /US began implementing the CS-19 project in northern Afghanistan's Jawzjan province and in the Andkhoy Cluster of the adjacent Faryab province . The project builds upon earlier achievements in Jawzjan province, and it supports and complements the Basic Package of Health Services (BPHS) for Afghanistan that is being implemented in all health care facilities operated by the Ministry of Public Health (MOPH). The project will reach an estimated 280,000 potential beneficiaries, including 124,200 children under age five and 155,800 women of reproductive age (WRA), who are 15-49 years old. Its goal, strategic objective and intermediate results are:

Goal: To achieve a sustained reduction in under-five and maternal mortality in Jawzjan province and the Andkhoy Cluster (North Faryab province).

Strategic Objective: Improved health practices at the household level, and increased use of essential MCH services.

Intermediate Results:
IR1: Increased household-level knowledge of essential MCH practices in Jawzjan province and the Andkhoy Cluster of Faryab province.
IR2: Increased access to essential MCH services in Jawzjan province and the Andkhoy Cluster.
IR3: Increased quality of essential MCH services in Jawzjan province and the Andkhoy Cluster.
IR4: Established social network to support key behaviors.

The key intervention areas for CS-19, and the levels of effort devoted to each, are as follows:

1. Immunization (EPI) 20%;
2. Nutrition (Nut)15%;
3. Control of Diarrheal Diseases (CDD) 15%;
4. Pneumonia Case Management (ARI) 20%; and
5. Maternal and Newborn Care (MNC) 30%.

The project's goal and objectives will be achieved through a set of five mutually supportive strategies:

1. Supporting the implementation of the BPHS by strengthening the provincial-level MOPH through training, capacity building, supervision, and joint monitoring and evaluation.
2. Promoting behavior change in both communities and health care facilities by training and working closely with the PHO, health facility staff, women of child-bearing age, caregivers, pregnant women and their families, CHWs, community groups and leaders, *mullahs*, teachers, midwives, mothers-in-law and local radio.

3. Engaging health sector partners to leverage resources in support of essential MCH activities in the project area.
4. Mobilizing communities by organizing proactive community health councils to support CS-19's behavior change strategy and to provide an effective link between communities and project staff, CHWs and health care facilities.
5. Testing innovative approaches to improving access, quality and use of essential MCH services; documentation and dissemination of feasibility and results, and scaling-up of successful approaches such as:
    - 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 diagnosis and treatment in areas with poor access; and
    - Partnership Defined Quality (PDQ); Working with community members and health staff to improve mutual understanding and to improve the quality of services from the community perspective; and to increase the use of essential health services by community members.

Between the submission of the application and the preparation of the DIP, the MOPH adopted the Basic Package of Health Services (BPHS), with technical assistance from MSH/REACH. This was a change in policy that required a revision of the CS-19 strategy and workplan. During DIP preparation, therefore, project staff worked with MSH/REACH to develop a clear division of labor between the two organizations (see Attachment I.). Since REACH is tasked with building capabilities at the district and community levels, CS-19's capacity building activities have been focused upon strengthening the capacities of the PHO. During its first two-and-a-half years of implementation, CS-19 had also provided support to six MOPH teams to provide health services in six villages of Shiberghan districts that were not covered by REACH. In addition to strengthening and supporting the PHO, CS-19 implements a wide array of activities at the community level, such as training and supervision of CHWs, organization of community groups, and BCC/IEC activities.

In May 2006, the BPHS initiative entered its second round. The REACH program came to an end and was replaced by four technical support programs: Support to Service Provision and Quality Improvement (SSP), COMPRI-A (social marketing of health projects, TECH-SERVE (MOPH capacity building, primarily in management and administration) and GCMS, a grants management program. SC/US is partnering with JHPIEGO under the ACCESS program and with Constella Futures to implement the SSP program. The six MOPH teams supported by CS-19 in direct service implementation during the first half of the project have now passed to the management of two local NGO partners, STEP and MOVE (a grantee to STEP). The new arrangement of technical assistance programs may require some adjustments in CS-19's plans and activities during the second half of the granting period, and the mid-term evaluation has been conducted with this issue in mind.

b. Progress report by intervention area

The CS-19 project has achieved significant gains in each of its intervention areas. Activities for each intervention are consistent with those proposed in the DIP. The major activities and

progress to date in achieving relevant objectives in each intervention area may be summarized as follows:

Immunizations (EPI)

Major Activities:

At the time of DIP preparation, CS-19 was facing a situation in which approximately 50% of all vaccinators in health facilities required refresher training courses[1]. In addition, there was evidence that some women were failing to seek vaccinations (particularly TT immunizations) because of traditional cultural barriers, including the fact that the existing vaccinators were predominantly male. Contact between women and unrelated men is culturally unacceptable in the conservative rural areas of Afghanistan. In response to these challenges, CS-19 prioritized the *recruitment of female vaccinators and the training of vaccinators, both female and male, in correct immunization methods and procedures.* Thus far, 60 vaccinators (32 women, 28 men) have been trained.

Components of the training for vaccinators included the following:

- EPI schedule
- Cold chain maintenance at fixed centers
- Registration and reporting
- BCC messages supporting full immunization
- Community mobilization
- Caregiver counseling at facilities
- Monitoring and supervision of immunization services
- Calculating targets and coverage rates
- Creating graphic displays
- Microplan development

Expanded Program of Immunization (EPI) is a component of the national Basic Package of Health Services (BPHS). Two vaccinators in each clinic hold immunization sessions six days a week at fixed centers as well as outreach services. To further support the MOPH's implementation of EPI services, CS-19 has provided technical training and support to the Provincial Health Office (PHO) and HMIS staff at the provincial level in both Jawzjan and Faryab provinces. CS-19 provides support and capacity building to the PHO primarily through joint supervisory visits by the EPI point people in both the PHO and CS-19, to health care workers in fixed-site facilities, and to mobile teams. A total of 179 supervisory visits were made to facilities or outreach teams. MOPH supervisory instruments are used to assess performance, and low-coverage facilities are prioritized for supervisory visits. One purpose of the visit is to identify weak points and, together with the health care worker, to develop micro-plans that will address and resolve these weaknesses. Vaccinators use the micro-plans to develop their own monthly action plans and targets. CS-19 has provided training for the PHO, and for the partner NGO Save the Children (UK) during the past two years, on the development of EPI microplans.

[1] Communication from the Provincial Health Director

CS-19 provided support to the PHO for implementation of National Immunization Days (NIDS) campaigns. Five rounds of NIDS had been supported by the end of year 2. During the NIDs, vaccinators visit communities to provide polio drops plus one dose of vitamin A to all children under five. CS-19 helped the PHO develop micro-plans for NIDS and trained NIDS volunteers. The project's Maternal and Child Health (MCH) Promoters conducted monitoring and supervisory visits to all community sites during implementation of NIDS. In addition, during 2006 the CS-19 EPI Officer helped with the implementation of a TT vaccination campaign and a measles campaign in Andkhoy cluster.

The CS-19 EPI Officer has also worked with the PHO EPI Officer to revise and standardize reporting forms, map community access (near facility, moderate distance, far) to facilities, and to schedule mobile outreach teams for EPI based on these assessments. CS-19's EPI Officer has guided the revision of MOPH forms to calculate needed supplies for vaccinators. If there are unanticipated vaccine or cold chain supply needs, he works with MOPH to ensure that supplies are delivered in time. He also calculates the extra supply of vaccines needed for remote areas so that facilities can stock-up for the winter months when roads are impassable

CS-19 has also given technical support to the PHO for development of messages and pictorial materials to promote community awareness of the EPI schedule and the importance of childhood immunization and TT vaccination for women. Messages and materials were also created to alert communities to upcoming NIDs and to urge mothers to bring their children to the NID sites.

Progress toward benchmarks

As Table 1 demonstrates, the EPI intervention is on schedule with reference to the DIP work-plan for year 3.

Effectiveness of the intervention

The project's indicators of effectiveness for its EPI component are:

- Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age;
- Percent of children aged 12-23 months who received BCG, DPT3, OPV3 and measles vaccines before the first birthday (by card);
- Percent of infants who received DPT3; and
- Percent of children aged 12-23 months who received measles vaccine (by recall).

As the table below demonstrates, significant progress has been made toward the program objectives, particularly in the Jawzjan province. EPI indicators for Andkhoy Cluster at the time of the baseline varied widely. The fact that the Andkhoy Cluster's baseline indicators were better than those of Jawzjan may be a result of SC/US's of work in Andkhoy since 1995. Since 1995, SC/US had been implementing a primary health care project in the Andkhoy Cluster and therefore women of childbearing age (CBA) coverage rates for TT vaccine was relatively high at 79% even at the baseline, while the percent of infants who received DPT3 was only 24. Results

of the LQAS survey conducted by REACH/BPHS indicate that, by the time of the MTE evaluation, TT coverage among pregnant women has risen to 99% in the Andkhoy Cluster, and that 62% of infants had received DPT3. The BPHS and Provincial MOPH's HMIS figures estimate the DPT3 coverage at 84%; and the rate of fully immunized (BCG, DPT3, OPV3 and measles) children aged 12-23 months is estimated at 83% by the HMIS. While the results of the LQAS and HMIS vary widely, nevertheless both indicate significant improvement since the baseline KPC.

In contrast with Andkhoy, the indicators for Jawzjan province were uniformly poor at the time of the baseline. At that time only 4% of children were found to have received BCG, DPT3, OPV3 and measles vaccination by their first birthday. Eleven percent of children were found to have received DPT3. Only 15% of mothers were found to have received at least two TT vaccinations. These figures, however, may be artificially low because they were based on card-confirmed cases, and 77% of children had no cards. By the time of the mid-term evaluation, the HMIS reported that 71% of children aged 12-23 months were fully immunized. According to the LQAS results, only 33% had received DPT3. Even the LQAS estimate, however, indicates a significant improvement over the baseline. The survey results also indicate that TT2 coverage for mothers had risen to 57%; again an impressive gain.

The improvements in EPI indicators have been achieved through the joint efforts of BPHS/REACH, CS-19 and other partners. Nevertheless these improvements offer evidence that CS-19 and its partners have functioned effectively as a team, and that the EPI intervention has had success. There is every reason to believe, therefore, that the project's objectives for EPI will be reached by the end of the project.

Table 1. Improvements in EPI Indicators

Comparative coverage routine EPI children <1year Jawzjan province and Andkhoy Cluster 2003, 2004, 2005, 2006 years[2]																
Province	**BCG**				**Measles**				**DPT1**				**DPT3**			
	2003	**2004**	**2005**	**2006**	**2003**	**2004**	**2005**	**2006**	**2003**	**2004**	**2005**	**2006**	**2003**	**2004**	**2005**	**2006**
Andkhoy cluster	**77%**	**80%**	**83%**	**85%**	**73%**	**67%**	**84%**	**70%**	**77%**	**70%**	**86%**	**73%**	**71%**	**63%**	**84%**	**73%**
Jawzjan	**60%**	**63%**	**79%**	**82%**	**44%**	**48%**	**71%**	**62%**	**59%**	**60%**	**79%**	**78%**	**49%**	**57%**	**71%**	**77%**

[2] 2006 data covers months January to September 2006 – the yearly targets will be calculated in December 2006

Changes since the DIP

At the time the DIP was prepared, the government schedule for EPI included only the classic antigens: BCG, DPT 1-3, OPV 1-3, and measles. Since then, the Hepatitis B vaccine has been added to the schedule. CS-19 responded to this addition by assisting with the integration of Hepatitis B vaccine into the supply system and procedures for vaccinators. CS-19's EPI Officer and the MOPH Provincial EPI Management Team coordinator had provided training to all vaccinators on the inclusion of Hepatitis B in the immunization schedule.

Nutrition

Although the rate of acute malnutrition (defined as -2 WHZ and below) at 14.5% is not as high as might be expected for a country such as Afghanistan, nevertheless SC/US surveys have found chronic malnutrition to be as high as 50%, and feeding practices were found to be poor. Focus group discussions (FGDs) revealed that many mothers believe colostrum is harmful and discard it. Exclusive breastfeeding is therefore rare (though improvements have been documented), and weaning foods are low in nutritional value. *To identify and promote the behaviors and practices that can lead to good nutrition in this context, CS-19 has implemented a modified Positive Deviance/ Hearth approach (PD/Hearth) in two pilot villages*.

CS-19 staffs were trained on PD/Hearth during an eight-day Training of Trainers (TOT) on PD/Hearth. The CS-19 BCC/Nutrition, IMCI, MNC Officers and MCH promoters weighed 100% children between the ages of 6 to 36 months using Salter's scale and all children were classified according to their nutrition status as: normal, moderate or acute malnutrition. The staff then conducted a positive deviance inquiry to learn about existing feeding, child caring and health seeking behaviors and to identify positive deviant foods and behaviors. Information was used to develop health messages and four menus. CHCs or *shuras* (both the men's and women's) were provided with a one-day orientation on the PD/Hearth concept, and on approaches to recruiting volunteers and gaining support for community-based PD/hearth. The first PD/Hearth session was led by MCH Promoters. At that time, volunteers were trained to lead PD/Hearth sessions independently with minimum support.

A typical PD/Hearth session includes: preparatory hand washing; education on health-related topics (one topic a day: breastfeeding, weaning and feeding, pneumonia, diarrhea, immunization), food preparation with the involvement mothers/caregivers, child care, cooking the meal, feeding the children, and clean-up. Every child is weighed on the first and last day of the Hearth session. CS-19 MCH promoters weigh each child, record the weight in the PD/hearth register book, and plot the weight on the child's Road to Health Card. Caregivers are informed about the child's weight, growth and his/her malnutrition status.

Although CS-19's PD/Hearth approach includes most elements of the classic approach (including the Positive Deviance Inquiry and Menu Workshop), modifications were introduced into the group feeding and demonstration period. Because mothers travel from some distance to the PD sessions they cannot stay away from home for the entire two-week period recommended by the PD/Hearth model. They therefore, in alternate two-day periods, spend a total of 7 days in group feeding sessions and five days in their homes, where their home practice of the skills and

menus learned in group feeding are observed by a CHW. When the mothers are in the group feeding venue, they discuss their experiences and receive feedback and advice from the CHWs who observed them at home. Although concern has been expressed that these modifications might compromise the approach's ability to fully rehabilitate children identified as malnourished, 90% of children enrolled in the program have demonstrated significant weight gain. The justification for the modifications is that the primary goal of PD/Hearth in CS-19 is not rehabilitative feeding (since the acute malnutrition rate is only half of the 30% specified for the program) but rather the demonstration of good practice (in terms of appropriate feeding, child care and health-seeking behavior) and its benefits. CS-19's PD/Hearth activity, therefore, is primarily a behavior change strategy. During the mid-term evaluation, mothers' groups and CHCs in the PD/Hearth pilot villages spontaneously drew the evaluation team's attention to visually obvious weight gains among children participating in the program. The fact that male CHCs had noted and praised these improvements suggests that there was broad community impact.

While nutrition and growth monitoring are included in the BPHS guidelines, it should be noted that growth monitoring and promotion (GMP) is not yet integrated within BPHS everywhere, but only in those areas wherein NGOs are implementing the program and are able to support all three components of GMP (contact, measurement and counseling). The MOPH is still revising its nutrition policy and exploring the feasibility of including GMP within the IMCI strategy, both in the clinics and within community-based programs. This period therefore provides an opportunity for the project to explore the potential of community-based nutrition activities such as PD/Hearth, with the goal of advocating for their inclusion in government policy if they are successful. CS-19 is using weight for age measurement and the Road-to-Health card during PD/Hearth sessions and this experience could provide useful information when the MOPH's GMP program is rolled out.

Optimal breastfeeding practices are promoted through a variety of channels. MCH promoters, BPHS CHSs and CHWs have all conducted health education on breastfeeding (including exclusive breastfeeding) as part of the IMCI initiative, and also in MNC health education sessions. PD/Hearth sessions cover some aspect of breastfeeding every day.

In recognition of the fact that iodine deficiency is a serious health problem for Afghanistan's children and mothers, the program supported MOPH and UNICEF's efforts to promote the use of iodized salt both in village shops and in households. UNICEF's IEC materials on this topic were distributed to all REACH-supported facilities, and CS-19 in collaboration with UNICEF and MOPH organized two campaigns encouraging the use of iodized salt. Messages on the importance of iodized salt (especially for pregnant women and children under age 15) were disseminated in training sessions for health workers on topics such as ARI, CDD and MNC; and Reproductive Health (RH) Assistants in clinics were trained to urge antenatal and post-partum mothers to use only iodized salt. Iodized salt was also endorsed and promoted at village shops. Once monthly, the CS-19 IEC/BCC Officer and MOPH Nutrition Officer visit a sample of shops to test the salt in stock there for iodine.

Progress toward benchmarks

The nutrition intervention is on schedule for activities other than PD/Hearth. According to the DIP workplan, PD/Hearth would be pilot tested in four villages. To date, it had been initiated in only two. The MTE team feels the DIP plan for PD/Hearth may have been over-ambitious, since the approach was new to all staff members, and they have been unable to move ahead as quickly as anticipated. Nevertheless, it is important that the project management team work together to identify areas in which benchmarks are not being met, and to either develop a more realistic and feasible plan or take steps to accelerate implementation:

Recommendation: The project management team should review the DIP workplan on a quarterly basis to ensure that activities and inputs are implemented as planned.

In the first PD/Hearth pilot village, on-site training was carried out in each month of the year. Activities have now begun in a second pilot village. The benchmark that two new pilot areas would be established was not fully met, however, since resources were sufficient for the establishment of only one new pilot area. PD/Hearth monitoring and documentation were carried out more often than scheduled (every other month instead of quarterly). However, only two monitoring reports in *Dari* were produced instead of the five planned reports. During year 3, the project staff carried out additional activities that were not in the DIP workplan. For example, 20 CHCs were trained on the importance of iodized salt, and the local iodized salt factory was visited monthly (as were a sample of shops) to test the quality and presence of iodization.

Effectiveness of the intervention

The indicators of success identified at the time of the DIP for nutrition are:

- Percent of infants aged 0-5 months that were fed breast milk only in the last 24 hours.
- Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours.

In the Jawzjan province, 68% of infants aged 0-5 months were reported to have been fed only breast milk in the past 24 hours (see Attachment A.2.). In May, 2006, the LQAS survey reported that 80.5% of Jawzjan children in this age group were fed only breast milk. This represents a significant improvement. In Andkhoy, by contrast, 66% of infants 0-5 months old were fed only breast milk in the past 24 hours, while 58% received only breast milk according to the May 2006 survey. This suggests a decline in optimal breastfeeding practice in the Andkhoy Cluster. It is possible that the phrasing of the question influenced the results. Project staff members feel that exclusive breastfeeding rates are not as high as reported in the survey results.

In the PD/Hearth villages, evidence was found that CS-19's activities there are an effective strategy for improving feeding practices. FGDs were held with mothers, CHWs and CHCs in the PD/Hearth pilot villages to assess local perceptions of the effectiveness of the approach. Feedback was highly positive. In particular, PD/Hearth is credited with having introduced inexpensive protein sources (egg and beans) into the diets of children between the ages of six months and two years. Feeding eggs and beans was identified as a positively deviant behavior in

the PD Inquiry. In this region, however, these foods are generally withheld from pre-verbal children due to a traditional belief that eating eggs and beans would prevent the child from learning to speak. The CHWs trained to implement PD/Hearth were able to convince mothers participating in the program to feed their children eggs and beans. When other community members saw that these children gained weight and suffered no ill effects, they too began to incorporate eggs and beans into their children's diets. CHC members assured the evaluation team that mothers participating in the program had advocated good feeding practices (including exclusive breastfeeding) to their neighbors, and that as a result of their influence combined with the visible improvements in the nutritional status of their children, the PD feeding practices had therefore generalized to the community at large. As a result, the evaluation team believes that PD/Hearth has a positive potential for generating nutritional improvements among infants and small children throughout Afghanistan.

SC/US's PD/Hearth activities have generated wide interest in the province. Both STEP (a local NGO implementing BPHS) and the provincial MOPH have asked CS-19 to document its results and procedures for a possible scale-up. Since the MOPH is still in the process of developing its strategy for GMP, the project is now in a good position to advocate for broader adoption of PD/Hearth (or at least its most successful elements). A senior PHO official expressed interest in PD/Hearth as a means of reducing the rate of severe malnutrition – by identifying malnourished children and preventing them from progressing from moderate to severe malnourishment. The Provincial Nutrition Officer has suggested the possibility that PD/Hearth might be incorporated into the BPHS at the national level. This could be most effectively advocated through the sectoral Task Forces that meet in Kabul. The team recommends the following:

Recommendation: Project staff should analyze results and document the experience of PD/Hearth, including lessons learned and successful strategies – to share with SSP and MOPH's IMCI Task Force and Nutrition Task Force for scale-up.

The iodized salt promotion activities too have shown effectiveness, at least in terms of improving the availability of iodized salt in the target villages (Yang-i Aregh and Afghan Tepa) in Jawzjan Province. In April 2005, 10 shops from each area were sampled, and iodized salt was found in 3 of 10 in Yang-i Aregh and 4 of 10 in Afghan Tepa. A subsequent visit a year later (after CS-19's iodized salt campaign) revealed that iodized salt was available in all 20 shops, and some shopkeepers said they intend to carry only iodized salt in the future.

Changes since the DIP

Since UNICEF and MOPH developed IEC materials for the promotion of iodized salt, CS-19 has adapted its strategy and focused more on assisting the MOPH and UNICEF in community mobilization, distribution of MOPH IEC materials, and quality checks of iodized salt in the factory in Shiberghan and in shops in many villages.

Integrated Management of Childhood Illness

Consistent with MOPH policy, the MOPH approaches ARI and CDD through the IMCI framework and protocol. This report will do the same but will report findings separately under the ARI and CDD headings below.

a) Control of Diarrheal Diseases (CDD)

Diarrheal diseases are one of the primary causes of mortality among children in Afghanistan, and during FGDs held in connection with this evaluation, community members named diarrhea as one of the two (with ARI) most important health problems affecting their children. CS-19 is addressing the problem of diarrheal diseases by supporting and supplementing the IMCI program being carried out by the BPHS. To supplement the IMCI training provided through REACH, CS-19 conducted a TOT in 2005 for 11 PHO staff members on CDD. In addition, three CDD training sessions, and one refresher training session, were held for health care workers since the start of CS-19. The diagnosis and treatment protocol taught during these sessions was fully consistent with the national IMCI training guidelines being promoted by government. In each training session, health workers were introduced to the need for oral rehydration therapy (ORT) corners, and trained in how to implement them. Supervisory visits include assessment of the ORT corners, to ensure their existence and that essential items are there.

In addition, two groups of CHWs were trained by CS-19 in community case management (CCM) of diarrhea. CS-19's training of CHWS in CCM aims to bring quality treatment and care of the sick child closer to communities and households. CCM-trained CHWs distribute oral rehydration solution (ORS) packets, and diagnose and treat diarrhea cases based on their training. They utilize flipcharts for non-literates that were provided to support their knowledge and recall. They also advise caregivers on home care, follow-up care and danger signs of dehydration. A new checklist has been designed to test the knowledge/recall of the CCM CHWs.

Although CS-19 is treating its CCM initiative as a pilot test of the concept, the MOPH has now decided to roll out CCM more broadly as a strategy of the second phase of BPHS. To support the quality of care in the CCM program that will be established by the BPHS, it is suggested that SC/US document lessons learned and share its best practices with the MOPH.

Recommendation: Based on results of its CCM pilot study, CS-19 should offer lessons learned, successful methodologies and instruments to the BPHS for training CHWs in CCM. Results should also be shared with SSP to ensure the uptake of quality CCM through CHWs.

As in the other major CS-19 interventions, the CS-19 IMCI Officer and the PHO IMCI Point Person conduct joint supervision and monitoring visits to health care providers. On some occasions in Jawzjan province, the pair of IMCI Officers is joined by a counterpart from STEP. Each facility is visited quarterly. The team conducts exit interviews with caregivers to assess the quality of counseling, and utilizes observation checklists to assess the quality of case management of diarrhea.

CS-19's IEC/BCC strategy includes dissemination of messages and materials on CDD through health facilities, CHWs, CHCs, and community leaders such as *mullahs*. During the evaluation, CS-19's posters on CDD and ARI were found to be displayed in all the clinics visited by the evaluation team. A highly intensive IEC/BCC initiative was launched during the 2005 cholera outbreak. CS-19 staff and REACH/BPHS staff, with the help of CHCs and CS-19's MCH promoters, raised community awareness of cholera and its prevention and treatment at the community and household levels. Homes and communities were visited on a daily basis for this purpose. Health education messages (emphasizing danger signs; importance of timely care from health workers; importance of ORS use; hand washing with soap and water, drinking boiled/chlorinated water, food hygiene) were delivered during clinic hours to all caregivers and patients, at the mosque before offering prayers, at community gatherings, on bazaar days using microphones, and through CHWs during home visits and during client visits to health posts. SC/US also assisted with the chlorination of 60 wells in the program area.

Progress toward benchmarks

All CDD activities scheduled for year 3 were completed on schedule. Some recurrent tasks were carried out more often than scheduled – the progress of CCM was documented during routine monthly visits, instead of every quarter. Implementation of the CDD checklist during supervisory visits took place every second month instead of once a quarter. Several activities were carried out that were not in the DIP workplan. Six CHCs were trained on prevention, danger signs, and home care of diarrhea in children, and IMCI refresher/orientation courses were provided to 25 health workers in 7 districts. In addition, CS-19 staff distributed the MOPH's IMCI reporting forms to all BPHS clinics in its project area.

Effectiveness of the intervention

The project indicators that are pertinent to CDD are:

- Percent of children aged 0-23 months with illness in the last two weeks who were offered more fluids during the illness;
- Percent of children aged 0-23 months with illness in the past two weeks who were offered the same or more food during the illness;
- Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated;
- Percent of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment;
- Percent of MOH facilities with one or more stock-outs of ORS or essential drugs last month;
- Percent of caretakers of children under five who know at least two aspects of home care;
- Percent of caretakers of children under five who know at least 2 signs of when to return if child gets worse; and
- Percent of severely ill children under five who are classified correctly in MOPH facilities.

Data is not available to assess progress on some of these indicators, since a mid-term KPC was not implemented. There is no current data on the percent of mothers who wash their hands appropriately. However, mothers' exit interviews were conducted in MOPH health facilities in August 2006. These interviews revealed that, in Jawzjan province, the percent of mother offering more fluids had risen from 20% at baseline to 40% in 2006; and that mothers offering the same or more food had risen from 27% to 69%. In the Andkhoy Cluster, the figures increased from 20% at baseline to 49% in 2006 for fluids and from 27% to 67% for food. In FGDs held during the MTE, mothers indicated that they feed the child smaller portions but offer food more often during illness.

At the time of the baseline, 69% of Andkhoy mothers knew at least two signs of illness that require treatment; while the exit interviews found only 62% could name two or more signs. The percent of Andkhoy caregivers who knew when to return if a child gets worse was 96% at the baseline, but only 77.5% according to exit interviews. These comparisons suggest a decline, but the KPC and exit interview figures are not strictly comparable since the populations of the two studies differ in ways that might bias the result. Nevertheless, project staff should review CS-19's messages and materials on the danger signs of diarrhea to ensure that they are well understood and reaching the correct audience.

Recommendation: CS-19's IMCI Officer should review the client counseling component of CDD training for health workers to clarify and strengthen communication on the danger signs of diarrhea.

Jawzjan comparisons on the same variables show improvement (only 14% Jawzjan mothers knew two signs of illness requiring treatment at the time of the baseline KPC, while 68.3% of exit interview mothers knew two or more signs).

Results for the indicator on the percent of caregivers who know how to administer medicines at home were more encouraging, since the percentage in Andkhoy was only 67% at baseline and was 89.5% according to the 2006 interviews. For Jawzjan province the figures were 26% and 49% respectively. Gains in the percent of severely ill children who were classified correctly by health workers were also impressive. At the time of the baseline health facility assessment, only 50% were classified correctly in the Andkhoy Cluster, while in 2006, 92.5% were classified correctly. In Jawzjan, none were classified correctly at the time of the baseline HFA, while 2006 observations found 18% classified correctly. This is still far below par, but nevertheless suggests there has been some progress.

To summarize, the baseline KPC and HFA results for key CDD indicators were compared with exit interview data from 2006 to obtain a rough estimate of progress on achieving these indicators. The two sources of data were not strictly comparable but the comparisons do suggest that progress has been made, particularly with respect to the correct classification of children by health workers. This indicates that the training of health workers, including both BPHS/REACH's IMCI training and CS-19's training sessions on CDD, have been effective in raising health workers' skills. The Andkhoy Cluster's failure to demonstrate gains in caregiver knowledge of danger signs and of when to return to the clinic suggest that client counseling skills may lag behind diagnosis and treatment skills. CS-19 has already scheduled a three day TOT on

Basic Caregiver's Counseling Techniques for October 2006 (See Attachment J. for the training schedule).

Recommendation: CS-19's IMCI Officer should review the client counseling component of IMCI training for health workers to clarify and strengthen communication on danger signs, home care and when to return to the health center for follow-up.

The evaluation team noted that CS-19 was able to respond quickly and effectively to an unexpected health crisis in the form of the cholera outbreak of summer, 2005. At the end of the epidemic, the HMIS showed that only two people had died of cholera in the SC/US supported BPHS project area. In 2006, there was no cholera epidemic during the expected season. There has been speculation within the health team that last year's health education campaign, together with the chlorination of wells and this year's advance health education and community awareness initiative, may have prevented a 2006 epidemic.

Changes since the DIP

There have been no significant changes in this intervention since the DIP.

b) Pneumonia Care (ARI)

As with CDD, CS-19's approach to ARI/pneumonia care emphasizes the support and reinforcement of the MOPHs implementation of IMCI as a component of the BPHS. According to BPHS policy, ARI is managed at various levels of the referral system depending on its severity. Cough or cold without pneumonia and non-severe pneumonia is treated by doctors and nurses in BHCs and CHWs and at health posts. Severe pneumonia is referred to the CHCs and the District Hospital. Cotrimoxazole is available from trained CHWs (at health posts) and a wider range of antibiotics, as well as nebulizers and oxygen, are available at higher levels of care.

CS-19 has implemented a two-day IMCI orientation training as a stop-gap measure until all health workers can undergo the 11-day IMCI training course that was being implemented by a local NGO, CHA in Faryab Province during the previous round of REACH/BPHS. CS-19 has also provided supplemental pneumonia case management training to doctors at CHCs and at Shiberghan and Andkhoy Hospitals, and to a BPHS/REACH Senior Health Officer, to reinforce their ARI knowledge and skills. Included in these training sessions were a MOPH trainer and two of CS-19's own health Officers. The CS-19 ARI training protocols were consistent with those of the BPHS IMCI training course.

Although CS-19's relationship with the BPHS has been generally collaborative and supportive, CS-19 program staff have complained that BPHS/REACH training sessions rarely include staff members from NGO partners. SC/US has used opportunities within its other health programs to address some of these gaps. For example, in September 2005, the former CS-19 IMCI Officer (now the CS-19 Coordinator) attended an MOPH-led one-day IMCI training course in Mazar-i Sharif which was funded under SC/US's Community-IMCI project. He has recently been replaced, however, by a new IMCI Officer. The new IMCI Officer was formerly working for

SC/US on implementing the BPHS, but he has not yet received the IMCI TOT training. Now that the REACH project has ended and been replaced by a new array of technical assistance projects, this may be a good time for CS-19 to negotiate a place for its staff in BPHS training courses.

Recommendation: To ensure a consistent approach, SC/US should advocate strongly for inclusion of its CS-19 staff in BPHS training sessions relevant to their areas of specialization.

A centerpiece of CS-19's approach to expanding access to correct pneumonia case management is its support for Community Case Management (CCM). CS-19 is pilot testing CCM in two remote villages of Qargin and Qaramqol districts. SC's MCH Promoters have been trained to train and supervise CHWs in the diagnosis and treatment of ARI and CDD in these villages. During the training for CCM, CHWs transmits skills such as the following for management of ARI: counting breathrates, looking for chest-indrawing, administring a full 5-day course of cotrimoxalzole for pneumonia, preparing ORS, referrals (when and where), advising caregivers on home care, and danger signs of severe disease including severe pneumonia. The CHWs are assisted with diagnosis by a flipchart for people who are non-literate that illustrates the recommended procedure. This chart was adapted for Afghanistan from a successful pictorial tool used in an SC child survival program in Nepal. The CCM CHWs are supervised monthly by the MCH Promoters.

Progress toward benchmarks

According to the DIP workplan, the ARI intervention is on schedule for year 3. The only exception is the implementation of the ARI checklist – this has been replaced by an IMCI checklist, which was distributed by CS-19 to all health care facilities in its project area. As noted above (CDD) some activities were carried out more often than scheduled. This included CCM documentation and on-the-spot technical support to PHO technical Officers, both of which took place once a month instead of quarterly as planned in the DIP.

Effectiveness of the intervention

The following indicators were chosen by CS-19 to measure progress toward its objectives:

- Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness;
- Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness;
- Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source;
- Percent of others of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment;
- CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented;

- Percent of caretakers of children under five receiving oral drugs know how to administer all essential drugs at home;
- Percent of caretakers of children under five know at least two aspects of home care;
- Percent of caretakers of children under five know at least two signs of when to return if child gets worse; and
- Percent of severely ill children under five classified correctly in MOH facilities.

Progress on most of these indicators are discussed in greater detail in the section on CDD, above. It is notable, however, that in both the Andkhoy Cluster and Jawzjan provinces, the percent of mothers who gave more fluids and the same or more foods was significantly higher in the 2006 LQAS survey than in the baseline survey. While the Jawzjan percentages suggested improvement for caregivers who know at least two signs of illness that requires treatment and who know at least two signs of when to return, the Andkhoy comparisons for these variables suggested no improvement or even a decline. A comparison of caregivers' knowledge of how to administer medicines at home in 2004 and 2006 was more encouraging. In the Andkhoy Cluster, exit interviews indicated that 89.5% of mothers knew how to administer oral drugs at home (up from 67% in the baseline survey), while in Jawzjan these percentages were 49% in 2006 and 26% at the baseline. These comparisons would suggest a strong improvement. For all these comparisons, however, results are ambiguous because KPC results are not strictly comparable with those of the LQAS survey or exit interviews.

The percent of caregivers of children with cough and fast/difficult breathing who sought treatment was found to be high in Andkhoy by the baseline survey, at 84%, while it was only 39% in Jawzjan province. Unfortunately, no data was collected on this behavior in either the LQAS survey or exit interviews, and so there is no comparison possible. The indicator for CCM demonstrates that this activity is on track, since this initiative is underway in two pilot villages, CHWs have been trained and are being supervised, and all results are being documented. It is premature to measure the effectiveness of this activity, however, since it was initiated only in May/June 2005. One cause for concern emerged during the MTE, however, when it was learned that BPHS CHWs (not CS-19 trained) do not have any device (whether stop-watch or clock) to time children's breathing. This is a significant problem, since rapid breathing is a key diagnostic symptom of pneumonia. The CS-19 trained CCM CHWs observed by the evaluation team knew how to time breaths using a watch with a second hand, even though they are illiterate. Their training on this diagnostic procedure would appear to be adequate; but they could also use a timer for more exact diagnosis. The CS-19 IMCI Officer is currently investigating options for purchasing ARI timers.

Recommendation: CS-19 should work with BPHS and STEP/MOVE to advocate that all CHWs have training and access to either a stop watch or wall clock for timing breaths of children with ARI.

To summarize, there is some indication that IEC/BCC messages on feeding during illness have been effective in bringing about change. The results of FGDs held with community mothers during the MTE suggested that, although mothers offer foods and liquids more often during illness, they offer smaller amounts each time. Based on the results of exit interviews, it may be assumed that the total amounts given are actually more than usual.

One of the most positive signs of effectiveness in this intervention is the high percentage of health care workers who correctly classified childhood illness in the Andkhoy Cluster. In Andkhoy Cluster facilities, 92.5% classified children correctly in 2006 exit interviews. In Jawzjan the percentage was only 18%, but this was an improvement over 0% at the time of the baseline health facility assessment. A similar improvement is suggested for the percent of mothers who knew how to administer oral drugs at home. Thus, health workers' skills in diagnosing children with severe illness and counseling caregivers on home medication appear to have strengthened significantly since the baseline. It is likely that these improvements are attributable to the combined efforts of BPHS/REACH and CS-19, both of which provided training in IMCI and ARI to facility-based health workers during the past 3 years.

Changes since the DIP

MOPH guidelines for implementation of the BPHS had not been released at the time of the DIP. The current BPHS guidelines allow CHWs to treat pneumonia with a complete course of cotrimxazole (severe pneumonia is referred to doctors/nurses at BHCs, CHCs and hospitals) and therefore this drug is included in the CHW kits. CS-19's protocol for CCM has changed to remain consistent with government policy. The fact that government is rolling out CCM to all CHW areas gives some cause for concern, however, since the training received by BPHS CHWs on some key topics is less intensive than that received by CS-19 CHWs. The BPHS provides only a one-day training for CHWs on IMCI (including treatment of diarrhea an ARI), while CS-19 provides six day CCM training (three on ARI and three on CDD) for CHWs, along with IEC materials and tools. CS-19 also conducts close and supportive supervision. Lessons learned from this intensive training and supervision approach will be useful in the review of the section on IMCI in the CHW training curriculum

Maternal and Newborn Care (MNC)

Afghanistan suffers from one of the highest maternal mortality ratios – estimated at 1,600/100,000 in a recent UNICEF/CDC survey – of any country outside sub-Saharan Africa. Few women give birth with the assistance of a trained attendant, and post-partum care is a rarity. MNC is therefore a priority intervention for CS-19. The project places trained MCH Promoters in clinics to build the capacity of facility-based midwives/RH Assistants and CHWs working from health posts, and to assist with the integration of the birth preparedness concept and approach. CS-19 MNC Officers and MCH promoters have conducted birth preparedness education at the community level for pregnant women and their family members. Male family members were educated in separate groups by the CS-19 BCC Officer and Community Health Supervisors (CHSs).

Each year since the project's inception, CS-19's MNC Officer has implemented training and refresher training programs in maternal and newborn care for midwives, physicians and MCH Promoters. Training methods include simulations, role plays, demonstrations and, for female trainees, practical sessions in which normal deliveries and IUD insertions are observed.

CS-19 also provides technical assistance to the Community Midwife Education (CME) program when requested, especially in the areas of family planning and birth preparedness concepts and

approaches. The CME school was established by SC/US with USAID/JHPIEGO funding. Its purpose is to train women who had completed 9 years of schooling and who were either resident in the catchment area of the clinic in which they would practice, or who were willing to relocate as assigned. The CME school is now fully functional, has graduated its first group of 23 midwives, and has begun to train a second group of 26. CS-19's MNC Officer and the MOPH RH Officer assisted the CME to design an appropriate supervisory checklist and plan for the post-training support and supervision of the newly graduated midwives. This checklist is used during monthly joint CS-19 MNC and MOPH RH Officers' supervisory visits to the facilities where new midwives have been recruited.

In 2005, the MNC Officer trained nine physicians and 23 midwives in family planning methods. In the Andkhoy Cluster, a demonstration project funded by USAID under ACCESS is being implemented to test whether CHWs can provide correct information on the use of misoprostol (i.e. take all three tablets soon after the birth of the baby and before the placenta is delivered). If the approach is successful, it will become MOPH policy. CS-19 MNC Officer and the MCH promoters assigned to this project carried out training for CHSs and CHWs on birth preparedness, danger signs, importance of skilled birth attendants during delivery, and correct use of misoprostol to prevent post-partum hemorrhage (PPH).

To follow-up on its classroom training, CS-19 has provided on-the-job training to midwives and RH Assistants during a two-year initiative to build capacity through supervision and coaching. Each health care facility in the program area is visited monthly by the MNC Officer, PHO RH Officer, and/or MCH Promoters, who assess midwives' performance levels and demonstrate good clinical practices when necessary. The MNC Officer has assisted clinic midwives to record patient information and to complete monthly reports that are consistent with HMIS requirements. Many midwives had initial difficulties understanding and filling out required forms, but CS-19 personnel worked with them until they were able to complete all data collection requirements independently.

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

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

The vast majority of women in Afghanistan give birth at home rather than in health facilities. The baseline KPC found that, in Jawzjan, 89% of children had delivered at home and only 28% were attended by a skilled professional. In the Andkhoy Cluster, 98% had delivered at home and 21.7% were assisted by a skilled birth attendant. Some women are assisted by an untrained traditional birth attendant, or *daya*, but the majority are attended by a mother-in-law or other relative. Currently, MOPH policy forbids any training of TBAs as such, since the goal of government is that all women will give birth with the assistance of skilled professionals (community midwives or doctors). It is unlikely that this will become a feasible reality in the near future. It will be important, therefore, to promote safe birth practices (including clean delivery techniques, clean cord care, and drying and warming the newborn) within the community setting.

Recommendation: Since most women are attended during childbirth by relatives, CHWs should be trained to educate the community at large on clean delivery and basic newborn care.

In a setting wherein home birth without skilled assistance is currently the norm, CS-19 faces a considerable challenge in its effort to reduce mortality from unexpected complications of labor and delivery. Its response to this challenge has been to institute a birth planning initiative in which pregnant women and their families are alerted to the possibility of obstetric emergencies, and encouraged to plan for such a contingency. CS-19's MCH Promoters, under supervision of the MNC Officer, train CHWs to organize groups of pregnant women who will make plans for emergency transportation, collect money and identify the nearest facility that offers emergency obstetrical care. These groups are organized with the help of the Women's CHCs in the target villages.

Since the spring of 2006, the above activities, plus the MNC activities of partner organizations, have been coordinated through monthly meetings of a Reproductive Health Committee that was organized by the CS 15 MNC Officer and the MOPH's RH Officer. The committee has five members: the CS-19 MNC Officer, the MOPH RH Officer, the RH/MNC point people from STEP and MOVE, and a physician from the CME school. The Committee makes a joint action plan for the coming month after discussing the previous month's challenges and reviewing the workplans of each of the member organizations. Several challenges have been identified and solved by the Committee. For example, when it was noted that clinic obstetric registers were not being properly filled out, the MNC Officer and RH Officer were delegated to visit facilities with poor record keeping procedures and to help health workers better understand and utilize the forms.

Progress toward benchmarks

For MNC, all activities scheduled in the DIP workplan for year 3 were completed on schedule. As was found for ARI and CDD, some activities were carried out more often than scheduled in the workplan. Examples include the implementation of bi-monthly supervision of health facilities, and participation in coordination meetings with BPHS/REACH staff. Both these activities took place every month. A number of activities not included in the DIP workplan were implemented. In connection with the addition of the ACCESS project for Prevention of PPH,

(ACCESS/PPH), 36 CHWs, four CHSs and four CHCs (male) were trained in the prevention of PPH approaches, including use of misoprostol for those mothers who cannot deliver at the facilities or by a skilled birth attendant.

Additional RH training activities were carried out at the community level. Eight Women's CHCs were established, and 50 female members received training in RH. Program staff also supported the supervision of newly trained midwives with site visits, observations, demonstrations and coaching as needed.

Effectiveness of the intervention

The project's indicators of progress in its MNC intervention are:

- Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age;
- Percent of children aged 0-23 months whose delivery was attended by skilled health personnel; and
- Percent of mother who had at least one post-partum check.

As noted in the EPI section above, there is evidence of good progress on TT2 coverage in both Jawzjan and the Andkhoy Cluster. Progress on the percent of children delivered with assistance of a trained attendant was less encouraging in Jawzjan, where it was 28% in the baseline results and 31% according to the 2006 LQAS survey. In Andkhoy, on the other hand, only 13% of baseline survey mothers gave birth with a skilled attendant while 59% of LQAS survey mothers said they had done so in 2006. If the LQAS report is accurate, a very dramatic improvement has been made on this indicator since 2004. Since midwives have only recently been recruited in some facilities, however, CS-19 project staff members feel that this increase is artificial and may be related to the way LQAS was conducted.

Data on post-partum care are ambiguous. While the Jawzjan comparison suggests a possible gain (28% of baseline mothers had a post-partum check-up, and 36% of 2006 LQAS mothers had done so), the Andkhoy Cluster data suggests the opposite. At the time of the baseline, 82% of mothers reported having had at least one post-partum check-up, while the 2006 LQAS survey found only 48% had done so. However, the baseline definition of a skilled birth attendant differed from that used in the LQAS (which excluded unskilled birth attendants such as trained CHWs and RH Assistants), so the findings are not comparable.

To summarize, the project and the health sector more generally face a considerable challenge in achieving the MOPH goal that all women will give birth with the assistance of a skilled birth attendant, but progress appears to have been made nevertheless in the Andkhoy Cluster. CS-19 is likely to show greater achievement in the percentage of women attended by a skilled attendant and receiving postnatal care by the end of project (EOP) as a result of the project's collaboration with the MOPH on the establishment of a CME training program, and the increase in the number of rural midwives. Moreover, CS-19's RH and MNC trainings for health facility staff and support for newly graduated midwives has broadened their knowledge base and sharpened their

skills. This intervention appears to be on track, and has good potential for demonstrating success.

Changes since the DIP

CS-19's support to ACCESS's Prevention of PPH project was added after the DIP was submitted. The addition of these activities reflects the project staff's post-DIP learning about the problems underlying the country's high maternal mortality rate, and their commitment to finding and testing feasible solutions to these problems.

2. Cross-Cutting Approaches

a. Community Mobilization

CS-19 has promoted the organization of several types of village groups as platforms for project and community outreach activities. They include the following:

- Community Health Councils (CHCs) have been organized in all communities served by CS-19. They have served in the effective dissemination of health messages and interfacing between communities and project staff. They also serve as a communication link between health facilities' staff and community members. Since cross-gender mixing is unacceptable in rural Afghanistan, separate mens' and women's CHCs have been organized.
- In PD/Hearth pilot villages, PD/Hearth Groups include the mothers and grandmothers of malnourished children. They participate in nutritional rehabilitation activities including menu workshops, hands-on preparation of nutritionally rich foods, and growth monitoring and tracking. The participants are encouraged to spread messages about child feeding practices to their neighbors, families and friends.
- Birth Preparedness Groups are organized in all districts in Andkhoy cluster and nine districts of Jawzjan. They include pregnant women and, in some cases, members of their families. The purpose of the groups is to encourage women and community members to acknowledge the possibility of an obstetric emergency and to develop a plan for their birth that includes a contingency plan for unexpected complications. The Groups are supported by the CHCs, who assist in the organization of transportation and, when needed, cash loans.

CS-19 also carries out community mobilization and organization activities in connection with the promotion of National Immunization Days (NIDs) and for the promotion of iodized salt. In preparation for each NID, Community Point People are trained by CS-19 in collaboration with the MOPH to facilitate NIDs in their village. They inform their communities of the upcoming NID and urge them to come to the vaccination site, facilitating travel whenever possible. To promote the household use of iodized salt, groups of school children were organized and trained to raise awareness of goiter and iodine deficiency in their homes and among their neighbors, and to encourage adults to only buy and use iodized salt.

FGDs carried out by the MTE evaluation team indicated that the community response to CS-19's community mobilization activities has been strongly positive. Because the CHCs include influential members of the community (elders, mullas, schoolmasters and local headmen), they

are able to provide convincing testimony in support of project goals. For example, village households were initially reluctant to allow their daughters to volunteer for training as CHWs and community midwives, since the free movement of young women outside the home was of questionable social acceptability. The CHCs were able to convince community members that the trainees would be safe and well-supervised, and so a number of volunteers came forward. Today, in many districts, there is no community resistance to these initiatives, and there is a plethora of volunteers.

During the MTE, discussions were held with five male CHCs and one female CHC to solicit feedback on CS-19. It was learned that there is a risk that prominent individuals may dominate some CHCs, and so broad participation should be encouraged by all CHWs who are working with and supervising CHCs. Nevertheless the CHCs visited report that they are meeting regularly, making decisions independently and are well-received by the community. Their replies to simple knowledge questions revealed that members have generally good recall of key CS-19 messages. The CHCs operating in the PD/Hearth pilot villages were particularly motivated and positive in their discussion of project activities.

The CHCs appear to have developed a positive synergy with the Birth Preparedness Groups. Of the CHCs interviewed, four out of five reported that they were now prepared to respond to obstetric emergencies – that they had identified and approached individuals with vehicles or arranged to send bicyclists to taxi stands if necessary. Most had secured agreement from the community that funds would be collected for an emergency loan if needed. Pregnant women and their families are urged to save money themselves in case of unexpected emergencies, but CHCs are being asked to assist in cases where the family's savings are insufficient.

A particularly strong community response was observed in discussions held in the PD/Hearth villages. The PD/Hearth mothers themselves, the CHWs serving the villages, and the CHCs all reported that the PD/Hearth mothers had been successful in persuading other mothers to adopt the improved feeding practices identified and promoted through the program. In particular, mothers have now begun to incorporate inexpensive protein sources such as eggs and beans into the diets of children between the age of 6 months and 2 years. Prior to PD/Hearth, mothers generally withheld these foods due to traditional beliefs. The visible improvement in the nutritional status of the PD/Hearth children, combined with the advocacy efforts of their mothers and grandmothers, have been an effective counter to this belief.

Few barriers to the project's community mobilization activities or community factors affecting its implementation were identified during the MTE. Although many of the target communities are ethnically mixed (Turkmen, Uzbek and some Dari), ethnic differences do not appear to limit open participation in community groups and activities. Gender differences however, do restrict full participation in community functions. Women in most communities are at least partially secluded, and mixing between unrelated males and females is unacceptable. To address this constraint, CS-19 organizes a separate women's CHC in every community where a men's CHC is organized. The Birth Preparedness and PD/Hearth groups have mostly focused on female members and CHC members, and to a lesser extent on male family members.

Other factors that have impeded CS-19's plans for community mobilization include geographical isolation, difficult terrain and transportation difficulties. Two of the areas served by CS-19 (Darzab and Qush Tepa) are extremely remote, and project staff find it administratively difficult to reach these areas from the project office in Shiberghan. Some portions of these are inaccessible by road, and some are cut off by snow during the winter months. Although strengthening of health facility services has been carried out as planned in these areas, community work is lagging because staff time and budgetary constraints (especially salaries for two additional MCH promoters) have limited the frequency of visits to Darzab and Qush Tepa. These areas have exceptionally poor health indicators, even for Afghanistan, and communities have had little or no exposure to health messages and information. They are therefore even more under-served and in need of outreach than those communities served by CS-19 where health indicators have improved.

Recommendation: To maximize service delivery to the Darzab/Qush Tepa districts of southern Jawzjan province, project resources should be re-allocated to provide adequate support. This may require placing two MCH Promoters hired in Darzab to reside there year-round. These new MCH Promoters should work jointly with two community midwives who recently graduated from the CME program and are now working in Darzab. CS-19 should support this team by developing a micro-plan for their training and supervision.

b. Communication for Behavior Change

The project has not followed a comprehensive behavior change strategy or approach that guides BCC development for all interventions. Nevertheless, CS-19 has implemented some appropriate and effective BCC activities that have shown evidence of achieving behavior change. For example, since traditional norms and beliefs often constitute constraints to behavior change in this conservative society, the project has made efforts to influence social norms and beliefs by organizing community groups to support project goals. These associations either serve as a reference group for members, offering mutual support and reinforcing new and improved health practices, or they may influence the behavior of non-members through example, persuasion or leadership. An example of the latter is the CHC, an association of community leaders organized by CS-19 to promote CS-19's key messages and improved practices in their communities. Examples of support groups for behavior change are the PD/Hearth mothers/grandmothers' groups and the Birth Preparedness Groups.

While the mobilization of community groups in support of behavior change is a strategy with a strong potential for positive impact, not all of CS-19's interventions have utilized this approach. Although health workers and CHWs are trained to be effective in interpersonal counseling of patients and clients, BCC/IEC activities for IMCI (CDD and ARI), as well as for EPI, tend otherwise to be limited to disseminating messages, raising awareness and providing information at the community and health facility levels.

As experience has shown, message dissemination may not be effective in changing behavior if the factors influencing behavior change are not systematically identified and addressed. CS-19 did implement FGDs with mothers to clarify puzzling and unclear findings from the KPC survey,

as well as a GAP analysis to identify delay factors impeding the household-to-hospital care path for obstetric emergencies. In many areas, however, the FGDs did not probe for factors influencing behavior in enough depth or detail to inform subsequent programming. The project would benefit from adoption of a comprehensive behavior change approach that examines both constraints to behavior change and existing incentives for change, in order to tailor all BCC messages and other activities to the social setting and existing conditions. A number of standardized tools and frameworks have been developed to guide users through a step-by-step process of developing effective BCC activities:

Recommendation: The project should adopt a comprehensive behavior change strategy framework, such as BEHAVE, to guide the development of its BCC activities; and it should seek technical assistance from within SC/US to train staff and partners in implementation of the approach.

The messages that are now being disseminated by the project are technically appropriate and up-to-date. The project's priority messages, based on its IRs and indicators, are found in the table below.

Table 2. Priority Project Messages

Issue (Intervention)	KPC results 03	Constraints	Target Group	Method	Message
1. Feeding while child is sick (CDD, ARI)	23% percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness	Traditional beliefs	Mothers, Caregivers	Home visits – materials available	When your child is sick your child needs more food and fluids, especially breast milk. This makes your child get better.
2. Feeding while child is sick (ARI)	26% percent of children aged 0- 23 months with illness in the last two weeks were offered the same or more food during the illness.	Traditional beliefs	Mothers, Caregivers	Home visits – materials available	When your child is sick your child needs more food and fluids, especially breast milk. This makes your child get better.
3. TT coverage in women (MNC)	15% percent of mothers who received at least two injections (card confirmed) before the birth of the youngest child less than 24 months of age	Mothers and families don't know about the benefits of TT vaccine	Mothers and families	Home visits and health education during NIDs campaign and tell benefit of TT vaccine during routine vaccination by vaccinator and CHWs	TT vaccine protects you and your child from tetanus.
4. MNC post partum check (MNC)	29% percent of mothers who had at least one post-partum check-up	Mothers and mother-in-law don't know about danger signs after delivery	Mothers, grandmother, and mother-in-law	Home visits and HE by CHWs	Every mother should check her health at least three times after delivery.
5. EPI General	4% percent of children aged 12-23	Community unaware of	Mothers, fathers,	Home visits Vaccinators describe benefits of	1. Vaccines protect your child from disease

Issue (Intervention)	KPC results 03	Constraints	Target Group	Method	Message
vaccination card (EPI)	months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card)	recommended EPI schedule. Fathers often take child for first vaccination, so mothers do not receive EPI info.	mothers in law	vaccine and when to return, CHWs, and volunteers raise awareness during NIDS.	2. Make sure that your child receives five vaccinations before its first birthday. 3. Your child's vaccination card is its card to good health – keep it safe.
6. EPI DPT3 in infants and drop out (EPI)	11% of infants who received DPT3.	Mothers and families fear that the side effects of DPT vaccine are harmful	Mothers, mothers in law, Other family members	Vaccinators and CHWs make home visits, describing benefits of vaccines and giving reassurance about side effects of DPT.	1. Vaccines protect your child from disease 2. Make sure that your child receives five times vaccinations before its first birth day. 3. Your child's vaccination card is its card to good health – keep it safe.
7. Safe birth practices (MNC)	28% of children aged 0-23 months whose delivery was attended by skilled health personal.	People are unfamiliar with location of facilities, lack of birth planning skills	Mothers, fathers, mothers in law	Organize open days for the facilities – show mothers the birth room	1. Give your baby a good start; Deliver your baby with skilled help
8. EPI measles vaccine by recall (EPI)	12% of children aged 12-23 months who received measles vaccine (by recall)	People not aware of recommended EPI schedule	Mothers, fathers, mothers in law	Home visits by CHWs describing benefits vaccination. Vaccinators, CHWs, and volunteers during NIDS raise awareness of recommended EPI schedule	Make sure that your child receives its measles end of second year.
9. Hygiene (CDD)	17% of mothers who usually wash their	Community unaware of the	All community	Health education during the home visits by CHWs and during clinic	Wash your hands before food preparation, before feeding

Issue (Intervention)	KPC results 03	Constraints	Target Group	Method	Message
	hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	need for personal hygiene and sanitation; scarcity of water in some communities.	groups	visits by health workers; shuras promote hand-washing	children, after defecation, and after attending to a child who has defecated.
10. Treatment during child illness (CDD, ARI)	14% of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	Mothers and grandmothers unaware of the danger signs of child illness	Mothers, fathers, mothers in law	Home visits , HE by all clinic staff, and CHWs and CHCs	When your child can not eat and drink, and very lethargic, take her/ him to health facility as soon as possible.
11. Child feeding (Nut)	33% of infants aged 6-9 months who received breast milk and solid foods in last 24 hours	Traditional beliefs	Mother Caregivers	Home visits – materials available	After 6 months children need more food and energy.
12. Care-seeking for Children during illness (ARI)	39% of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	Families not aware of the danger signs of pneumonia.	Mothers, fathers, and mother-in-law	Home visits, HE by all clinic staff, and by CHWs and CHCs.	When your child has cough and fast /difficult breathing, take her / him to health facility as soon as possible.

Issue (Intervention)	KPC results 03	Constraints	Target Group	Method	Message
13. MNC danger signs during post-partum (MNC)	29% of mothers able to report at least two known maternal danger signs during the post-partum period	Mothers and mother-in-law don't know about danger signs after delivery	Mothers, grandmother, and mother-in-law	Home visits and HE by CHWs	When a woman hemorrhages, has fever, headache and unconscious after delivery take her to health facility as soon as possible.

Throughout the life of the project, messages and information have been disseminated through a wide range of channels, including health workers, CHWs, CHCs, mosques, radio, and in the case of the iodized salt activity, school children. CS-19 has also developed a series of wall charts, posters and flipcharts with pictorial representations of key messages for people who are non-literate. All health facilities visited by the evaluation team were found to have mounted the posters on their walls. Health care staff explained that they use the posters and any flipcharts that accompany them to explain health messages to patients and in counseling sessions. This usage would seem appropriate. The posters, if viewed independently by a patient without explanation from a health worker, might not be self-explanatory, particularly since some of the images may be too small and crowded to be perceived from any distance. Although some pre-testing had been done, not all the pictorial materials had been pre-tested before distribution to health facilities.

Recommendation: The BCC/IEC Officer should promote use of IEC/BCC materials developed by REACH/BPHS (SSP in future). If additional materials need to be developed, the BCC/IEC Officer should follow a standard procedure for pre-testing of visual and pictorial materials, and ensure that all materials are pre-tested before broad distribution.

The effects of many of the project's behavior change activities are measured on a monthly basis through the review of HMIS data by the Nutrition/BCC/IEC, IMCI, MNC and EPI Officers together with their PHO counterparts. HMIS information is reviewed quarterly by the CS-19 staff in order to identify areas of weakness and develop plans to close gaps and improve any poor performance indicators. The project has also examined the results of the MOPH's Household LQAS survey (executed most recently in May, 2006) for evidence that CS-19's BCC activities are having a positive effect. Not all of CS-19's behavior change indicators are represented in the HMIS or LQAS survey, however, and so the project collects its own information to supplement these sources. This includes exit interviews with mothers who have visited clinics with their sick children, and observations of health worker management of childhood illness. Results of these monitoring activities were aggregated and analyzed in preparation for the MTE.

CS-19 can point to evidence in a number of areas that its BCC activities have been among the agents that were effective in changing behavior. These include:

- The LQAS-documented improvement in tetanus toxoid (TT) vaccination coverage the Andkhoy Cluster, and to a lesser extent in Jawzjan, is likely to be at least in part a result of CS-19's identification of the shortage of female vaccinators as a constraint to behavior change, and its subsequent recruitment and training of new female vaccinators.

- The relatively low death rate (two deaths) from cholera in the project area during the 2005 cholera epidemic, plus the absence of any cholera outbreak during the cholera season of 2006, suggest that CS-19's intensive BCC campaign aimed at cholera prevention and management may have been effective in limiting mortality and forestalling recurrence of the epidemic.

- In both PD/Hearth villages, mothers, CHCs and CHWs all commented that the positive deviance behavior identified during PDI – the feeding of eggs and beans to children

between the ages of 6 months and 2 years – had been adopted not only by the households that participated in the program, but by community households more generally. The PD/Hearth team had employed a variety of approaches to overcome the traditional belief that these foods are harmful to children under two. These included organizing a group of mothers to implement the improved diet and demonstrate its visible effects, tapping the authority of the CHC members to provide community leadership, interpersonal counseling, and broad message dissemination within the community.

These and other successful experiences have provided guidance to the CS-19 team in identifying effective approaches to BCC in the specific setting of northwest Afghanistan, so it is suggested that these approaches be applied more broadly to the program's other interventions.

CS-19 is planning to implement an innovative approach to behavior change in the form of a Partnership Defined Quality (PDQ) Initiative. The PDQ exercise described in the DIP was not carried out during the first half of the project because it appeared to conflict with a similar activity (FFSDP) being planned by BPHS. Now, the SSP and MOPH are encouraging CS-19 to pilot test PDQ, and so this will take place in the second half of the project. The purpose of PDQ is to improve the quality of care at health facilities, but one of its subgoals is to shape the behavior of health care workers in the direction of greater courtesy, attention and responsiveness to community and patient needs. During the PDQ exercise, community perceptions of quality of care are compared with health workers' perceptions. The goal of this comparison is to discuss differences and ultimately bring the views and understandings of the two groups into greater congruence. In fact, the behavior of health care workers in their dealings with patients often improves as a result of increased understanding of the clinic experience from the community and patients' points of view. The pilot test will test the hypothesis that PDQ will improve community satisfaction with health care facilities and promote better utilization of services.

c. Capacity Building Approach

Strengthening the Grantee Organization

Building the capacity of CS-19 staff has remained one of the important endeavors of SC/US.

- Its Senior Health Advisor provided workshops on MNC and PD/Hearth. He also trained CS-19 staff on how to conduct health facility assessments using BASICS tools, including observation of sick child management and exit interviews to assess the quality of client counseling. In April 2006, he also led a nine- day refresher workshop on IMCI tools, MNC, EPI and family planning.
- SC/US also funded the CS-19 Coordinator to attend several key child survival-related sessions during the Global Health Council meeting in 2005 and SC/US's global program learning group meetings (PLG) in Washington DC. The CS-19 Coordinator, Health Manager and Senior Health Manager also attended the SC Asia-area health conference in July, 2006. The Program Manager attended the SC Global PLG in 2006
- Two regional meetings were also attended by the CS-19 Coordinator, including a 5 day Program Design, Monitoring and Evaluation Workshop (PDME) (Egypt, 2004). The

CS-19 Coordinator and CS-19 IMCI Officer also attended a three-day workshop on Operation Research approaches.

- 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 PPH and Birth Preparedness initiatives (Jan 2006).
- HQ's child survival expert (Kathryn Bolles) also arranged a 3 day workshop on Partnership Defined Quality in Thailand (2005). This training was replicated in Afghanistan and attended by CS-19 staff.
- SC/US Afghanistan Country Office also exposed CS-19 staff to trainings within its other health programs. CS-19 coordinator attended an 11-day IMCI training under SC/US's community-IMCI project.

The implementation of the CS-19 project has provided valuable experience for local staff in designing and carrying out innovative activities aimed at increasing community access to health care, improving community understanding of childhood nutritional requirements, and the importance of birth planning.

Strengthening the Local Partners

The relationship of CS-19 to its partners is represented graphically in **Attachment I.** The DIP identified the PHO and its personnel as CS-19's most important partners. Although the PHO is staffed by capable and experienced individuals, they did not have familiarity with or experience in the full range of activities and skills required to meet BPHS and CS-19 objectives. CS-19 did not, however, undertake a formal institutional capacity assessment of the PHO (though it did carry out health facility assessments throughout the project area). The question of how CS-19 could help the PHO to build its capacity was addressed in some detail in the DIP workshop. PHO officials and technical specialists were active participants in these discussions, and their input is reflected in the DIP workplan. The absence of a formal baseline assessment of PHO capabilities, however, will limit the ability of the final evaluation team to measure improvements in the skills and capacities of the PHO staff.

PHO point people for each intervention area participate in training sessions and refresher trainings conducted for health facility workers and CHWs by their CS-19 counterparts. They participate in the planning of these training programs, and in the planning and implementation of meetings and review sessions. For example, the Provincial Health Coordinating Committee is a venue in which the PHO, CS-19, local NGOs, UNICEF and WHO meet monthly to coordinate and plan activities for the coming month. CS-19 was instrumental in supporting the PHCC to carry out its functions. The PHO's EPI, RH, Nutrition and IMCI point people have also learned about the development and evaluation of projects by participating in CS-19's own design, planning and evaluation process. They all participated actively in the DIP Preparation Workshop and as team members in this MTE.

The central and most important capacity building initiative aimed at the PHO, however, is the joint monitoring, supervision and planning process that is implemented continuously throughout the life of the project. Each month, the Nutrition/IEC/BCC, IMCI, MNC and EPI Officers visit health facilities and other field sites together with the PHO point people in each of these areas, in

order to assess the performance of health workers and of the health program more generally. Usually, these visits are targeted at sites identified as in need of attention during monthly joint reviews of HMIS data. While in the health facilities, the PHO point person completes the supervisory checklist developed by BPHS, while the CS-19 Officer carries out checklist observations of case management by health workers and exit interviews with mothers of sick children. Information from these exercises is then triangulated in order to identify any areas of sub-optimal performance, and the PHO and CS-19 point people work with the facility's health workers to develop a plan to resolve the problems.

The roles and responsibilities of the partner organizations have been in transition in the latter half of 2006, when the BPHS entered its second phase and the REACH support project was replaced by several new initiatives: TechServe (management support and capacity building), Support to Service Provision and Quality Improvement (SSP), Compri-A (social marketing of health products), and a BPHS/EPHS grants program. During the REACH period, CS-19's primary NGO partner was Save the Children/UK. SC/US and SC/UK were responsible for implementing BPHS in Jawzjan and northern Faryab during phase I of BPHS. CS-19 supported the PHO to provide technical assistance to these NGOs in implementing BPHS. Since June 2006, however, these responsibilities have been handed over to local NGOs STEP and MOVE in Jawzjan province. With support from SSP (in which SC/US is a participating partner), the staff of these NGOs will be trained to provide initial clinical training to health facilities staff. Although a formal joint workplan is now in process, it has been agreed that CS-19 will help meet STEP and MOVE's training targets by providing CS-19 staff as resources for initial training, and CS-19 will also continue to provide refresher training as the need arises.

Although, as noted above, no formal baseline assessment of PHO capabilities was carried out, the mid-term evaluation team conducted informal interviews with the PHO point people for EPI, MNC, IMCI and EPI, to discuss the value added by CS-19. All reported that learning had taken place during their joint activities with CS-19. The EPI Point Person, for example, noted that he and his technical staff had improved their information management, computer, and supervisory skills (including cold chain management) as a result of participating in CS-19. The IMCI Point Person reported that his ability to plan meetings, set agendas, etc., had improved as a result of participating with CS-19 in the implementation of the PHCC meetings. The MNC Point Person stated that she had improved her understanding and skills in the area of family planning as a result of CS-19's RH training and supervision, and that her own (and facility workers') ability to meet the requirements of the HMIS reporting system had been improved by the MNC Officer's on-the-job coaching.

The primary obstacle CS-19 has encountered in its initiative to build the capacity of its partners occurred in the hand-over of health care facilities to STEP and MOVE. When these organizations took control, they retrenched many of the doctors that had been trained during the first half of the project and replaced them with doctors who had no training. It is imperative that CS-19 now work closely with STEP and MOVE to ensure that these new doctors are trained in standard case management and other skills transmitted by the project.

Recommendation: CS-19 should develop a Memorandum of Understanding (MOU) with STEP, MOVE and the MOPH specifying that all new doctors will receive joint training from the MOPH, CS-19 and local NGO partners.

A secondary constraint on further strengthening the capacities of the partner organization is budgetary. Resources for additional training are limited. A pipeline analysis to examine the possible need for re-alignment of budgetary line items is being planned, but there are many competing priorities within CS-19 and so difficult decisions will have to be made.

Health Facilities Strengthening

The strengthening of health facilities in terms of physical infrastructure, equipment, supplies, drug management, etc., is the responsibility of the BPHS. CS-19's contribution to health facilities strengthening is to focus upon building the skills of health workers, particularly with regard to the classification and management of children's illness, reproductive health, and EPI. CS-19's capacity building activities for health workers, which are discussed in more detail in the next section, include initial training, refresher training, on-the-job support, coaching/mentoring, and technical assessments with feedback on results. To provide ongoing assistance and monitoring, CS-19 assigns one MCH Promoter to each health care facility in its project area. The MCH Promoters assist the clinic with the support, professional development and supervision of CHWs providing outreach to communities in the clinic catchment area.

The project carried out a comprehensive Health Facility Assessment (HFA) at the time of the baseline. The HFA used the four Integrated Health Facility Assessment (IHFA) questionnaires developed by USAID/BASICS (Observation Checklist – Sick Child, Exit Interview – Caregivers of Sick Child, Health Care Worker Interview, and Equipment and Supplies Checklist). Minor adjustments were made to these instruments to reflect local conditions.

The assessment team visited a total of 14 health facilities in the project area – all those that were providing services to children under five at that time -- including eight BHCs, two district hospitals, one CHC, one MCH clinic, one health post, and the pediatric department of the provincial hospital. In preparation for the final evaluation, the HFA will be repeated to allow progress toward objectives to be assessed.

Linkages between health care facilities and communities are provided through the mechanisms of CHWs and, in CS-19 areas, CHCs. The CHWs form the primary bridge between facilities and communities, since they carry a variety of outreach services to the community level. Each CHW serves approximately 150 -200 rural households. In addition, CS-19 has organized and built the capacities of one male and one female CHC (*shura*) in the catchment area of each clinic. The CHCs are a key bridge between facilities and communities, since they promote health messages and advocate for recommended behavior change. They also assist, along with NIDs Community Point People, in the organization of immunization campaigns, and they inform and persuade community members to come to vaccination sites (both fixed and mobile) and to NIDs sites. The CHCs are also trained to organize and facilitate emergency transportation to health care facilities, particularly for women with complications of labor and delivery.

Strengthening Health Worker Performance

The CS-19 MNC and EPI Officers support to health workers has been described in detail in the technical approach section above.

The appropriateness and effectiveness of the project's approach to strengthening the capabilities of health workers for sick child management (IMCI intervention) is measured in relation to the results of health facilities assessments that were executed at the time of the baseline (see above). The IHFA questionnaires adapted from the BASICS Project evaluated the following:

- The assessment, diagnosis, and treatment of children with diarrhea, fever and malaria, and acute respiratory infections (ARI);
- The screening and vaccination of women and children against common vaccine-preventable diseases;
- How well caretakers are able to provide home treatment for their children;
- How well health workers educate caretakers about preventive and curative care;
- The quality of training and supervision received by health workers; and
- Equipment, supplies and record keeping in health facilities.

As part of the MTE, the results of the baseline assessment of sick child management by health workers was compared to the aggregated results of observations of sick children in 2006. Dramatic improvements were seen in diagnosis and management of diarrheal diseases, and in the assessment of danger signs of childhood illness. At the baseline, only 6% asked about all danger signs; while in 2006, 65% did so. With regard to diagnosis of pneumonia, the percent of health workers who had counted breaths per minute rose from 13% to 30% at the MTE; and those who looked for chest indrawing rose from 17% to 31% – but this is still far below optimal:

Recommendation: CS-19's IMCI Officer and Health Officer should ensure that health workers receive refresher training that further strengthens their skills with regard to assessment and classification of pneumonia.

In addition to strengthening the clinical and counseling skills of doctors, nurses and vaccinators, the project also builds the capacities of midwives. During the interim before midwives could be trained by the CME and assigned to health facilities, CS-19 trained a cadre of RH Assistants to implement antenatal and postnatal care in these facilities. After newly trained midwives are assigned to clinics, they are visited monthly by CS-19's MNC Officer together with the PHO's RH Officer, for supervision and post-training support. With the assistance of a supervisory checklist designed for the purpose, the two Officers observe the new midwife on the job, give feedback on her performance, and (if necessary) demonstrate appropriate techniques and practices.

Training

A common weakness of training programs worldwide is the failure to ensure that newly learned skills will actually be reflected in changes in practice. CS-19's approach to training and capacity building is founded on the understanding that classroom training alone is seldom adequate to

establish and entrench improved clinical practices in health care facilities. The project's training strategy, therefore, includes practical hands-on training, demonstration, direct observation of service delivery (including routine labor and delivery) and substantial post-training follow-up. For example, intensive follow-up supervision is provided to new midwives who are beginning practice in rural clinics after completing their training in the CME 18-month residential program. CS-19's MNC Officer and the PHO Reproductive Health Officer make monthly visits to the health facilities where the new graduates are practicing. They observe the work of the new midwife, offer advice on any difficulties she has encountered, and coach her on any areas of weakness that have been observed. Similar post-training support is provided to health care workers by the IMCI, EPI and Nutrition/IEC/BCC Officers. In view of the MTE, this is a highly effective approach to ensuring that skills learned in training are actually applied in the health facility setting.

All training programs include pre- and post-test knowledge assessments to measure the effectiveness of the program in transferring knowledge and skills.

d. Sustainability Strategy

The project did not develop explicit sustainability objectives beyond its SO, IRs and key indicators. Instead, project managers believe that sustainability is built into the design of the project and into its capacity building program. By the close of CS-19, health facilities in Jawzjan province and the Andkhoy Cluster of Faryab are expected to have institutionalized an array of best practices promoted by the project. These include sick child management using the IMCI protocol; the integration of MNC within BPHS at all BHCs and CHCs, and regular and accurate recording and reporting of health information to higher levels of the MOPH.
By the end of CS-19, the PHO is expected to be implementing a well-established monitoring and evaluation system that is now being instituted through the joint supervisory activities they are carrying out each month with their CS-19 counterparts. Turnover of technical staff at the PHO has been low thus far (only the IMCI Point Person has been replaced of the four PHO intervention counterparts who are participating in joint supervision). There is reason to believe, therefore, that the health system at the provincial and facility levels will continue to practice the skills and capacities they have learned through participation in the CS-19 project.

At the community level, the sustainability and continued high activity levels of the CHCs depend upon the sense of ownership they have developed in CS-19's health promotion activities. By the end of the project, they should begin independently identifying, planning and implementing health-related activities they consider to be high priority – as some are now doing.

Recommendation: To foster the continued leadership of the CHCs after the project ends, CS-19 should oversee all CHCs in the independent development off a post-project Community Health Action Plan with clearly defined activities, responsibilities, and a workplan. CS-19 should advocate STEP and MOVE's continuing support of these workplans and activities.

CS-19 is cementing in place an interactive relationship between health care facilities and CHCs by means of the linkages provided by CHWs. The CHWs themselves, however, are unpaid

volunteers with no financial incentives or obvious career path. Thus far, there has been only a 2% turn-over rate among the CHWs trained by the project. Nevertheless, since considerable training and mentoring is built into CS-19's program for building the capacities of CHWs, it is important that they continue to perform their trained tasks for as long as possible. The project should consider the possibility of incentives (however small) for CHWs:

Recommendation: The project, together with STEP and MOVE, should discuss with CHC/*shuras* regarding how best to support CHWs and keep them motivated. This may include the possibility of small incentives for CHWs.

CS-19's phase-out strategy rests primarily on its relationship with local NGO partners (STEP and MOVE) and the PHO. CS-19 has already handed over to STEP and MOVE the technical support of the 6 clinics that were not covered by BPHS during its first phase. The project will now focus on transmitting skills, methods and best practices to STEP and MOVE so that they will be able to carry out their new responsibilities and guarantee high quality service delivery to mothers and children in Jawzjan province. In a joint planning meeting held during the MTE, it was determined that CS-19 will include STEP and MOVE in all its training activities. In particular, CS-19 will build STEP/MOVE's capacity to implement innovative strategies such as the PD/Hearth, PDQ, PPH and Birth Planning programs. CS-19's managers expect that, by the end of CS-19, the PHO in collaboration with STEP and MOVE will be fully able to assume responsibility for the planning, implementation and monitoring of these and the project's other key activities.

C. Project Management

1. Planning

As noted above, the project design described in the application was revised significantly during the DIP preparation period due to the MOPH's introduction of the BPHS as a new strategy for rebuilding the national health system and expanding the availability of health services. As part of the implementation of the new BPHS, the task of strengthening district level health systems and facilities was assigned to the REACH project. To ensure that all key stakeholders were involved in the revised design and planning of the CS-19 project, CS-19 and the MOPH worked together to plan and implement a DIP preparation workshop in March, 2004. The workshop was attended by 36 representatives of 10 organizations that were active in the implementation of REACH in the Jawzjan province. An initial draft of the DIP was prepared from the results of the workshop, and a subsequent meeting was held with the Provincial Health Director (PHD) to refine and finalize it. At that time, the PHD requested direct support from CS-19 to new health care facilities not included in REACH. An agreement was reached that CS-19 would support nine clinics.

Routine project planning takes place each month based on the results of joint supervisory and monitoring visits carried out by the CS-19 MNC, Nutrition, IMCI and EPI Officers together with the corresponding PHO Point People. In some cases, they are accompanied by a representative from the local NGO partners, STEP and MOVE. The supervisory team reviews HMIS data in

order to identify health care facilities and program components that are poor performers, and they develop a monthly plan to address these weaknesses.

As described in section B.1., the DIP workplan can be considered to be on schedule, with a few minor variations. In each intervention area, additional activities have been implemented beyond those planned in the DIP, and many routine activities have taken place with a greater frequency (e.g. monthly instead of quarterly) than specified in the DIP.

During the MTE, field staff demonstrated a good understanding of the project's objectives and indicators. To improve the partners' understanding of CS-19 and its objectives, a wall chart was developed that lists the project's objectives and cross-cutting strategies. This chart has been distributed to REACH staff and other partners. Community organizations do not necessarily have a comprehensive understanding and recall of all the project's objectives, since many of them are concerned with health worker performance rather than community and household factors.

Project monitoring activities and the information they generate are utilized to improve performance in the period following the assessment. The Nutrition/IEC/BCC, EPI, IMCI and MNC Officers all review HMIS data monthly for their intervention, as part of the joint supervision and monitoring they undertake with their PHO Point Person counterpart (and sometimes the NGO partner). For example, CS-19's EPI Officer and the PHO EPI Point Person analyze EPI data for the previous month, including drop-out rates at health facilities. They then visit the facilities with higher-than-normal drop-out rates to ascertain the cause of the problem, provide feedback to clinic staff, and work with them to develop a plan for improvement. The plan usually includes outreach activities for catch-up immunization of children who have failed to receive DPT2 or DPT3 on schedule.

2. Staff Training

As discussed in detail in section B.2.c., all intervention point people (the EPI, MNC, IMCI and Nutrition/BCC/IEC Officers) plus the CS-19 Coordinator and Health Officer received several initial trainings from the SC/US Senior Health Advisor in Afghanistan, on all technical areas covered by the project. Each of the intervention point people has designed and implemented a training course for MCH Promoters on their topic of specialization. The MCH Promoters, therefore, have received training in MCN, EPI, CDD, and ARI. They were also trained in TOT by BPHS/REACH to enable them to provide initial training to CHWs. Most CHWs receive initial training directly from BPHS, but in the areas BPHS does not cover, they were trained by CS-19's MCH Promoters. The MCH Promoters have also carried out several refresher training courses for CHWs in specific areas such as birth preparedness, CCM, PD/Hearth, etc.

Monitoring and supervision of staff is discussed in the section below.

In general, however, staff members indicated that the project had managed to find adequate resources for staff training when it was needed, but that resources for the training of partners and stakeholders were more difficult to access. Although the MTE team did not find notable gaps in the knowledge or understanding of CS-19 staff members on any technical area, resources for

staff training are limited and some staff members felt it would be beneficial if additional resources could be devoted to this component of the project. However, the cost of staff training was described as less of a problem than the limitations on staff time. Staff members say they are usually unable to leave their assigned duties for a long enough period to attend training or refresher training courses.

3. Supervision of the Project Staff

Supervision of staff performance is a multi-step process, in which SC strives for a participatory, give-and-take approach throughout. The supervisory relationships of CS-19 staff are as follows:

Staff Member	Supervisor
Community Health Worker (CHW)	Maternal/Child Health Promoter
Maternal/Child Health Promoter	MNC Officer
Intervention Point People (Officers)	CS-19 Coordinator and Health Officer
All technical staff	Program Manager Jawzjan with technical support from Senior Program Manager/Health for Afghanistan

In addition to the joint monitoring of health facilities with the PHO, joint supervision also takes place within the CS-19 team. The CS-19 Coordinator and Health Officer travel to project intervention sites to observe the performance of staff members when they are implementing training sessions, and supervisory visits in the field. Afterward, they provide feedback to the staff member and if necessary, work with them to address any performance weaknesses. In addition, each employee undergoes an annual performance evaluation that is consistent with SC/US guidelines. The annual reviews are supplemented by quarterly coaching sessions, during which staff members discuss their on-the-job problems and difficulties with their supervisors – in the case of the intervention point people, with the CS-19 Coordinator and/or Health Officer -- and identify ways to address and resolve these problems. The supervisors, in turn, share results of their observations with the staff member they are coaching.

The intervention point people and other technical staff are also supervised by the Senior Health Advisor. He visits the CS-19 sites quarterly to observe job performance, review technical reports, and assess CS-19's progress on key DIP indicators. Normally, he focuses upon one intervention area per visit. He then discusses his observations with the Officer responsible for that intervention, and assists him or her to make a plan to address any weaknesses or problems that have emerged.

The MCH Promoters are supervised primarily by the MNC Officer. She has developed a supervisory checklist to assess their performance, and does this on a monthly basis. The MCH Promoters are themselves responsible for the supervision and monitoring of CS-19's CHWs, particularly those implementing birth preparedness, CCM and PD/Hearth. The CHWs receive monthly supervision, using checklists developed for the purpose by CS-19.

To summarize, project staff are well supervised at all levels. They receive feedback on their performance on at least a quarterly basis, and in the case of the MCH Promoters and CHWs,

monthly. SC/US has sufficient technical expertise in country to oversee the execution of work activities in all intervention areas, and to ensure that the quality of employee performance is at or above expectation.

4. Human Resources and Staff Management

The project has adequate human resources to carry out its mandate and work plan. All positions were found to be filled at the time of the MTE, and this has been the case during the majority of the project's running time. Only one shift of personnel has occurred during the life of the project so far. In 2006, the project's former Coordinator was promoted to the position of Health Officer (with responsibilities both within and beyond CS-19). He was replaced by the former IMCI Officer after a lengthy national search failed to locate a better-qualified candidate. The IMCI Officer, in turn, was replaced by a physician who had been working with the BPHS in Jawzjan and hence was already familiar with CS-19. Since the expertise and institutional memory of the former Coordinator and the former IMCI Officer are still available when needed, this change in personnel and positions did little to impede the ongoing flow of activities. The only exception was that during the period in which recruitment for the Coordinator position was going on, the former Coordinator was attempting to fill two positions at once and was under some strain. This problem was resolved as soon as the decision was made to promote the IMCI Officer to the Coordinator position. The Health Officer (former Coordinator) had laid the foundations for CS-19 in a variety of areas, and has influenced the development of other projects in the area. His experience and guidance will continue to be available to CS-19 in his new role.

All staff members are in possession clear job descriptions, and there is an up-to-date organigram that reflects current functions and lines of responsibility. The partner organizations, however, do not have a copy of these job descriptions and so it is not certain that they are fully aware of all staff functions and chains of command within CS-19 and SC/US – particularly as these relate to shared operations and joint activities with the partners. This is an oversight that is in the process of being corrected, since CS-19 has begun to clarify its relationship to the new NGO partners, STEP and MOVE. Development of a joint work plan (CS-19, PHO, STEP and MOVE) is now being planned, and CS-19 will share its job descriptions and organigram with the participating partner organizations at that time.

Morale and cohesiveness among staff members appears to be high, as is evidenced by the lack of staff turn-over after three years of implementation. In interviews with the MTE team, no staff member raised significant problems and all expressed satisfaction with their positions as they are currently defined. CS-19 does not have any explicit plans to facilitate staff members' transition to other paying jobs. However, SC/US has several programs in Afghanistan (and operating out of Shiberghan). As a matter of policy, SC/US attempts to re-deploy retrenched staff members with good performance records in other SC programs. Most of CS-19's staff members are former MOPH personnel; and they would likely have the option of returning to the MOPH (with enhanced skills) if SC/US were unable to employ them after the EOP.

5. Financial Management

With 40% of its time left to run, the CS-19 has nearly 40% of its funding remaining. SC/US plans to raise some extra funds through private donations and other designated funding for the project. There is, therefore, every reason to believe that the project will have sufficient funds to complete its work plan. The project's match has been primarily in cash, although recently the time of the CHWs has begun to be tracked as an in-kind contribution.

The project's financial status is tracked primarily through the Life of Grant Report, which reports on spending to date from the inception of the project, and what funding is left until the end of the grant. Monthly reports are completed for each line item in the budget. Copies of the monthly reporting forms are sent to every program office.

Financial issues include the share of salary for some staff members that is allocated to CS-19. The Shiberghan Program Manager, the Senior Program Manager/Health and the Country Director all devote more time to CS-19 than is now budgeted. In addition, project staff have called attention to the need for a line item re-alignment to meet transportation costs in the field. Afghanistan's high inflation rate plus the dramatic rise in the cost of fuel and air tickets have exerted a strain, but thus far SC financial Officers have been able to adjust for these added costs. SC/US is now planning a pipeline analysis in response to the recommendations from this evaluation. Projections will examine whether or not a budget re-alignment will be needed to support costs associated with these recommendations.

Financial sustainability is not a significant issue for CS-19 the project was never expected to cover supply, equipment and recurrent costs. CS-19's own contribution is primarily to capacity-building through training, supervision, BCC and community mobilization. The main recurrent costs covered by the project at this time are the salaries of CS-19 staff and the transportation expense for joint supervision of health facility workers by CS-19 and the PHO. Preliminary discussions with new NGO partners STEP and MOVE have indicated that these organizations will be able to pick up the transportation costs related to joint monitoring and supervision by the end of the project.

6. Logistics

Since the central focus on CS-19 has been on capacity building, there has been no need for major purchases of equipment, supplies or furniture. The primary logistical constraint has been in the area of transportation. Shiberghan is a hub for SC/US projects and programs, and the Shiberghan sub-office manages all SC/US transportation in NW Afghanistan. To maximize efficiency, vehicles are shared between projects, so that there are seven SC/US vehicles and seven drivers available to the projects operating out of Shiberghan. The administrative system in Shiberghan has been able to handle all transportation needs thus far, with the exception of travel to Darzab and Qush Tepa. These regions are extremely remote. Some villages are not reachable by road, and vehicle access to portions of these regions is cut off for five months of the year due to snow. The issue of providing services to Darzab and Qush Tepa is discussed in more detail above in section 2.a., Community Mobilization.

Although transportation needs have generally been met to date, this evaluation report includes a series of recommendations that, if followed, could increase transportation costs by as much as 20%. Some transportation-related line items have been fully expended, while related line items possess some flexibility. SC/US plans to execute a pipeline analysis that will determine whether or not a line item re-alignment would be required to meet these additional transportation costs.

It should also be noted that the conflict situation in Afghanistan has had a limiting effect on CS-19's logistics and transportation situation. Although in general the north-western part of Afghanistan has been less subject to conflict than the south and east, serious incidents occurred in 2006 (including the targeting and killing of NGO workers) that caused SC/US to temporarily classify certain CS-19 project villages as no-go areas. It is hoped that these incidents will not recur, but if the situation should worsen, CS-19 staff may be cut off from some portions of Jawzjan or Faryab provinces.

7. Information Management

The measurement of progress toward project objectives is achieved through periodic comparisons of current status with the following baseline data collection exercises:

- Baseline KPC survey;
- Baseline Health Facilities Assessment; and
- Focus Group Discussions and GAP Analysis.

Monthly monitoring of progress and performance takes place during supervisory visits performed by project staff, usually jointly with PHO point people, to health care facility workers and CHWs. During these visits, the PHO point person assesses performance using MOPH supervisory checklists. The accompanying CS-19 Officer records observations of health worker performance on checklists developed by CS-19, and conducts exit interviews with mothers to ascertain whether correct procedures were followed and client counseling was effective. CS-19 also tracks changes in key indicators by reviewing results of the HMIS on a quarterly basis. HMIS data is derived from a system of data collection and reporting that is implemented at each level of the referral system. Health workers in these facilities collect patient information on forms and checklists developed in connection with the BPHS, aggregate the results, and send periodic reports to the HMIS Officers. The forms used for these purposes are as follows:

Health Posts:

- Pictorial Talley Sheet (for non-literate people);
- Pictorial Patient Register;
- Monthly Activity Report (MAR); and
- Monthly Aggregated Activity Report (MAAR).

The last two forms are completed by Community Health Supervisors, while the first two are completed by CHWs. The MAAR is submitted to the PHO (through local NGOs providing technical support).

Forms, registers and reports that are in use at the BHCs and CHCs include:

- Patient Register;
- Outpatient Tally Sheet;
- Monthly Integrated Activity Report (MIAR);
- Facility Status Report (FSR) (supplies, equipment and human resources;)
- Notifiable Disease Form (NDF); and
- Catchment Area Annual Census (CAAC).

Of the above, the MIAR is submitted monthly to the HMIS, while the FSR is submitted once a quarter and the CAAC annually. After reports are received they are entered into the HMIS database for the province by the BPHS HMIS Officer. There is a BPHS HMIS Officer in Andkhoy, working with SC/US, and another in Jawzjan working with STEP. Copies of their reports are submitted to the Provincial HMIS Officer. A CD with updated information is sent to SC/US, as well as to BPHS and the national HMIS in Kabul. The national HMIS department sends feedback a month after the HMIS data is received to BPHS implementers and to the provincial HMIS Officer. Once this is received, the provincial HMIS Committee arranges a meeting with all partners (CS-19 staff also attend) and discusses gaps and solutions.

Project staff have found information on most of the project's key indicators in the results of LQAS household surveys that are carried out by BPHS/REACH every 2 ½ years, although a few of the home care indicators are not included in the LQAS. The project attempts to track behavior change relevant to these indicators through qualitative research (discussions with mothers, CHWs and CHCs). The most recent LQAS Household Survey was carried out in 2006. In addition to its review of the findings of the LQAS and the MOPH's HMIS, CS-19 has collected information independently in its effort to track progress towards benchmarks and objectives. For example, in preparation for the MTE, CS-19 aggregated and analyzed the results of its monthly caregiver exit interviews and observations of management of sick children by health workers. A comparison of these results with baseline findings has been used to report on progress toward objectives in this report.

CS-19 supports the MOPH data collection system in a number of ways. For example, facility records often do not capture data on immunizations provided by mobile services and NIDs. To ensure that this information is included in the HMIS, the CS-19 EPI Officer together with the MOPH EPI Point Person keep records of outreach EPI activities and enter them into the database. The MNC Officer and OPH Point Person also routinely share data from their joint supervision activities with the HMIS. When needed, CS-19 IMCI, MNC, EPI and Nutrition Officers have provided hands-on assistance to health workers who had difficulty completing forms and registers correctly. CS-19's senior health staff members have noted that some forms may be overly complex, as health workers are often unable to complete them without help. It is likely, therefore, that errors are common and that data collection and recording could benefit from additional standardization:

Recommendation: A workshop should be scheduled with MOPH HMIS staff to identify ways to strengthen and standardize data collection and to ensure accurate utilization and completion of all forms, registers and reporting instruments.

The PHO HMIS Officer has distributed the national HMIS guidelines to all doctors in charge of clinics and provided training for them in the use of data for decision making. Decision-making about modifications to the HMIS itself takes place in monthly meetings of the HMIS Committee (of which CS-19's Coordinator is a member), based on a review the previous month's data. During the REACH period, monthly joint HMIS reviews were attended by REACH staff, SC/US staff (including CS-19 project staff) and representatives of the MOPH. These meetings are expected to resume under the new system.

Planning and decision-making for the health sector overall takes place during monthly Provincial Health Coordinating Committee (PHCC) meetings. Participants in the PHCC include the PHO officials, CS-19 staff, representatives of NGO partners STEP and MOVE, and sometimes representatives of WHO and UNICEF. At these meetings HMIS data on the performance of facilities with respect to key indicators is reviewed. Participants take note of low-performing facilities and weak areas of service delivery based on these results, and identify problems that must be addressed through supervision, refresher training or other methods. During the first two years of the project, CS-19's Senior Health Officer served as secretary for the PHCC. His responsibilities included setting the agenda, recording results, and distributing minutes to members.

CS-19's MNC, Nutrition/BCC/IEC, IMCI and EPI Officers utilize HMIS data monthly, to spot clinics that are either performing poorly or failing to complete data reporting requirements. They then target these facilities for joint supervisory visits with PHO counterparts. Once a quarter, CS-19's full staff meets to review data from the HMIS on the project's key indicators, and to assess the degree to which the project's activities are contributing to achievement of its goals. This information review and planning exercise enables the staff to pinpoint weaknesses and gaps, and to place stronger emphasis on weak aspects of the program in planning for the next quarter.

8. Technical and Administrative Support

CS-19 has received technical and administrative support from both within and outside SC/US. Technical consultants from outside SC/US provided support to the baseline KPC survey, the GAP Analysis, and a one-day orientation for all staff on birth preparedness planning. From within SC/US, the Regional Health Advisor visited field staff monthly to provide any technical updates or other assistance that were required (including technical training, help with health facilities' assessments, research on birth preparedness and TOT on MNC and birth preparedness). CS-19 senior staff members also attended a workshop on Partnership Defined Quality (PDQ) in Bangkok that was facilitated by SC/US's Child Survival Specialist.

For the remainder of the project, technical assistance will be required in two areas. First, in order to respond to requests from partners and to ensure that insights and best practices are identified, CS-19 requires help with the documentation of results and lessons learned from its pilot projects on PD/Hearth and CCM. Second, the MTE evaluation team has recommended that CS-19 solicit assistance from within SC/US to train its staff in planning and implementation of a comprehensive behavior change strategy using an established framework such as BEHAVE. The project will also benefit from the planned situation analysis (SA) that will be implemented in

preparation for SC/US's Saving Newborn Lives Initiative. The results and analysis from the SA will enable CS-19 to fine tune its own newborn care program.

Project staff expressed that technical support from SC/US has been adequate to date. The SC/US Home Office Child Survival Specialist has made two visits thus far, once to participate in the DIP workshop and again to be part of the MTE team. Beyond this, CS-19 does not require a great deal of assistance from outside Afghanistan since it has a well-qualified Senior Manager/Health based in Kabul.

9. Mission Collaboration

SC/US recognizes the key role of the USAID Mission as one of the primary partners in the implementation of the MOPH's health program. The USAID Mission was consulted during the preparation of the DIP to ensure that its views and priorities were reflected in the design and workplan of the project. During the MTE, the team met with USAID's new HPN Officer to discuss the ways in which CS-19, USAID and the new technical assistance programs would work together in the future.

D. Other Issues Identified by the Team

N/A

E. Conclusions and Recommendations

The CS-19 project is largely on track with regard to its expected achievements by the project's mid-point. The activities specified in the DIP workplan for years 1-3 have been carried out with the exception of pilot testing PD/Hearth in four villages. Only two villages have PD/Hearth activities thus far. The MTE team believes that the DIP plan was over-ambitious in relation to staff capacities that had no prior experience with the approach. With respect to PD/Hearth, CS-19 staff has learned by doing and so their capabilities in implementing the approach are now strong. The review of the project's progress against benchmarks also revealed that many supervision and monitoring activities were carried out more often (monthly instead of quarterly) than called for in the DIP workplan. Further, additional activities that were not described in the DIP, but were deemed important to the successful implementation of the program, were carried out in all intervention areas.

There is solid evidence that the project has made progress toward the achievement of many of its IRs, as measured by the project's key indicators. Using structured observations of health worker performance and exit interviews with mothers, the project was able to demonstrate improvements in the case management and counseling skills of health workers that had been trained by CS-19 in collaboration with BPHS/REACH and other partners. Evidence provided by the HMIS and by REACH/BPHS LQAS survey results (2005) indicates that mothers' home care practices have also seen some improvement, particularly in the areas of child feeding during illness.

There are indications that CS-19 has helped to build the capacities of the PHO and health care workers. Immunization rates for TT2 and DPT3 have risen significantly in the project area. The number of skilled birth attendants serving project area health care facilities is growing as a result of continued support of the CME program. CS-19's contributions to the CME program and its supervision and coaching of new graduates have been a major factor in the success of the community midwife program. The project is reinforcing health workers' knowledge of CDD and ARI case management through refresher training for IMCI-trained doctors and nurses. There is reason to believe, therefore, that CS-19 will be successful in achieving its objectives by the end of the project.

The project continues to face constraints that result from the armed conflict situation in Afghanistan and from the remoteness and difficult terrain that characterize portions of Jawzjan province. Project staff recently carried out a brainstorming session to discuss ways of mitigating these constraints. In response to these discussions, this report includes a recommendation (below) for providing enhanced services at the community level to two of the most remote districts of Jawzjan.

Afghanistan's health sector is now in transition as BPHS implementation enters its second phase. The MSH/REACH technical support project has ended and been replaced by an array of USAID-supported technical assistance projects. SC/US is a partner in one of them, Support to Service Provision and Quality Improvement (SSP). Discussions were held with the head of SSP during the MTE, and it was established that CS-19 and SSP will work in close collaboration, and that CS-19 will share results, lessons learned, methods and materials from its innovative pilot studies with SSP. In Jawzjan province, direct technical support to health care facilities, which was provided by SC/US, REACH/BPHS staff and SC/UK in phase I of the BPHS implementation, has now been handed over to local NGO partners STEP and MOVE. CS-19 is now in the process of developing a joint workplan with STEP and MOVE that will outline the roles, responsibilities and relationships between the partners during the next two years. It is not anticipated, however, that CS-19's responsibilities or workplan related to support for BPHS will change significantly during its remaining two years. The complete list of recommendations for this period is as follows:

- To ensure a consistent approach, CS-19 should advocate strongly for inclusion of its staff in BPHS training sessions relevant to their areas of specialization.
- CS-19 should develop a Memorandum of Understanding (MOU) with STEP, MOVE and the MOPH specifying that all new doctors will receive joint training from the MOPH, CS-19 and local NGO partners.
- Based on results of its CCM pilot study, CS-19 should offer lessons learned, successful methodologies and instruments to the BPHS for training CHWs in CCM. Results should also be shared with SSP to ensure uptake of quality CCM through CHWs.
- To maximize service delivery to the Darzab/Qush Tepa districts of southern Jawzjan province, project resources should be re-allocated to provide adequate support. This may require placing two MCH Promoters hired in Darzab and living there year-round. These new MCH Promoters should work jointly with two community midwives who recently graduated from the CME program and are now working in Darzab. CS-19 should support this team by developing a micro-plan for their training and supervision.

- The project management team should review the DIP workplan quarterly to see that all activities are implemented on schedule.
- The project should adopt a comprehensive behavior change strategy framework, such as BEHAVE, to guide the development of its BCC activities; and it should seek technical assistance from within SC/US to train staff and partners in implementation of the approach.
- The BCC/IEC Officer should promote use of IEC/BCC materials developed by REACH/BPHS (SSP in future). If additional materials need to be developed, the BCC/IEC Officer should follow a standard procedure for pre-testing of visual and pictorial materials, and ensure that all materials are pre-tested before broad distribution.
- To foster the continued leadership of the CHCs after the project ends, CS-19 should oversee all CHCs in the independent development of a post-project Community Health Action Plan with clearly defined activities, responsibilities and a workplan. CS-19 should advocate STEP and MOVE's continuing support of these workplans and activities.
- The project, together with STEP and MOVE, should discuss with CHC/*shuras* how to best support CHWs and keep them motivated. This may include the possibility of small incentives for CHWs.
- A workshop should be scheduled with MOPH HMIS staff to identify ways to strengthen and standardize data collection and to ensure accurate utilization and completion of all forms, registers and reporting instruments.
- Project staff should analyze results and document the experience of PD/Hearth, including lessons learned and successful strategies – to share with SSP and MOPH's IMCI Task Force and Nutrition Task Force for scale-up.
- CS-19 's IMCI Officer should review the client counseling component of CDD training for health workers to clarify and strengthen communication on the danger signs of diarrhea.
- CS-19 should work with BPHS and STEP/MOVE to advocate that all CHWs implementing CCM have access to either a stop watch or wall clock for timing breaths of children with ARI.
- Since most women are attended during childbirth by relatives, CHWs should be trained to educate the community at large on clean delivery and basic newborn care.
- CS-19's IMCI Officer and Health Officer should ensure that health workers receive refresher training that further strengthens their skills with regard to assessment and classification of pneumonia.
- The project should work out with SSP and TechServe to ensure that CS-19's technical support to both PHO and health facility staff is appropriate and conducted in a well coordinated manner.

F. Results Highlight: Positive Deviance/Hearth

The Problem: SC/US's Child Survival 19 (CS-19) program pilot tested a program to address the problem of malnutrition among young children in Afghan Tepa, a village of 7000 people in Northern Afghanistan. Information gathered from health posts and clinics had shown high rates of malnutrition among young children and this was confirmed when a June 2005 survey conducted by SC/US revealed that 42% of children aged six months to three years were malnourished (malnutrition was defined as 2 standard deviations or below, using the Weight for Age index.).

Addressing the Problem: To attack the problem of high malnutrition rates, CS-19 designed and implemented a nutrition education and rehabilitation program based on the Positive Deviance/Hearth (PD/Hearth) model. The goal of the pilot test was to assess whether the PD/Hearth approach could be effective in finding solutions to the problem of childhood malnutrition that are feasible, affordable and already exist within these children's communities. PD/Hearth aims to identify and rehabilitate malnourished children in the community, while simultaneously teaching the children's caregivers how to sustain these nutritional improvements at home.

The first step was to weigh and measure village children. Since the children of some households were found to be better-nourished despite the fact that these households were no wealthier than their neighbors, SC/US began to examine the question of what practices led to good nutritional status among some low-income children. To identify the feeding, caregiving and health-seeking factors that contributed to good nutritional status, project staff conducted a Positive Deviance Inquiry (PDI). The results of the PDI indicated that child feeding practices were a key element; specifically, feeding the child between-meal snacks such as fruits and biscuits, and giving her an extra meal (in addition to family meals) once a day. The recipe for this meal, called Kitchri, included beans (an inexpensive local source of protein). To introduce inexpensive sources of protein, SC/US had to combat traditional taboos against feeding beans and eggs to small children.

The project team then organized a group of caregivers of malnourished children to participate in nutritional education and cooking demonstrations. The caregivers learned to carry out the improved feeding practices, including feeding their children Kitchri and giving between-meal snacks. During these sessions, they also learned about good nutrition, hygiene, sanitation, and appropriate use of clinics and health posts. They then practiced what they had learned in their own homes under the supervision of CS-19 staff. By the end of the two-week program, the caregivers could prepare the improved menus independently and had learned about how to protect their children against malnutrition in the future.

Proven results: The program identified 6 examples of positive deviance and 99 children that were malnourished. Of the 99 children enrolled in the program, only two dropped out. Of the remaining children, 90% showed weight gain (defined as a gain of over 400 grams) at a pace that promises full recovery. The program trained 13 volunteers who worked with the mothers and children. All continue to do so. The program did not rely on outside support, as the mothers offered their own homes for the meetings, and each mother brought her own food and her own fire wood. At the moment volunteers are continuing to follow up mothers of malnourished children and encourage the practicing of PD feeding behaviors. The community also responded positively to PD/Hearth. CHCs were organized by the project, and functioned effectively to promote the program within wider community. When a group of community leaders was asked to assess the success of Pd/H, they replied that the practice of feeding low-cost sources of protein (eggs and beans) had generalized to most households in their village. This indicates that the women who participated in the program had spread the program's messages and methods to their neighbors and friends, and that child feeding practices had improved as a result.

Opportunity for Scale-Up: During discussions held during the mid-term evaluation of CS-19, the Project Manager of the Social Support Project (SSP) expressed strong interest in the PD/Hearth methodology. SSP is a USID-funded program that is tasked with providing technical assistance to the Ministry of Public Health for strengthening health services delivery. In her remarks to CS-19 staff members, the Project Manager noted that the government is still in the process of developing its approach to improving the nutritional status of young children. This is therefore an excellent opportunity to introduce PD/Hearth as a possible model for scale-up to the national level. The staff of CS-19 is therefore beginning a careful documentation of its results and lessons learned in order to identify successful strategies that can be offered to SSP and the MOPH for wider replication and scale-up. In discussions held with local partners who have been tasked with providing technical assistance to the provincial Ministry of Public Health, local NGO representatives expressed interest in learning more about PD/Hearth in order to assess whether the approach should be applied more broadly within the province.

G. Action Plan: MTE Recommendations and CS-19 Response

MTE Recommendation	CS-19 Response	Action
1. To ensure a consistent approach, CS 19 should advocate strongly for inclusion of its staff in BPHS training sessions relevant to their areas of specialization	Agreed. USAID funded Service Support Project (SSP) provides technical training to staff of BPHS implementers only. Possible to include CS-19 staff during BPHS trainings at provincial level.	1. CS-19 will coordinate with SSP and BPHS implementing NGOs and include CS-19 staff in the BPHS provincial training calendar in both Jawzjan and Faryab (NOV'06).
2. CS 19 should develop a Memorandum of Understanding (MOU) with STEP, MOVE and the MOPH specifying that all new doctors will receive joint training from the MOPH, CS 19 and local NGO partners.	Agreed. MOU is absolutely necessary to ensure coordination between CS-19 and BPHS activities and to extend CS-19 IMCI, MNC, EPI and Nutrition trainings for all newly appointed BPHS clinical staff.	1. CS-19, STEP, MOVE and MOPH staff will finalize and sign MOU by OCT 10, 2006.
3. Based on results of its CCM pilot study, CS 19 should offer lessons learned, successful methodologies and instruments to the BPHS for training CHWs in CCM. Results should also be shared with SSP to ensure uptake of quality CCM through CHWs.	Agreed. CS-19 will document lessons learned, review and refine CCM tools and methods and share results with SSP and MOPH Child and Adolescent's Department.	1. CHW treatment of children with pneumonia will be assessed in non-CS-19 and CS-19 supported areas for comparison (January 2007). 2. CCM tools and methodologies will be reviewed, refined and finalized (JAN/FEB'07) 3. CS-19 will document CCM lesson learned (FEB'07) 4. CCM lesson learned shared with SSP and MOPH (SEPT'07)
To maximize service delivery to the Darzab/Qush Tepa districts of southern Jawzjan province, project resources should be re-allocated to provide adequate support. This may require placing two MCH Promoters hired in Darzab and resident there year-round. These new MCH Promoters should work jointly with two community midwives who recently graduated from the CME program and are now working in Darzab. CS 19 should support this team by developing a micro-plan for their training and supervision.	Agreed. CS-19 will recruit two local MCH promoters for Darzab and Qush Tepa districts. Before deployment MCH promoters will receive a 4-6 week long orientation and training. In addition, a micro-plan detailing support for BPHS staff including midwives will be developed and implemented.	1. Two MCH Promoters recruited (DEC'06) 2. Two MCH promoters Orientation and Training (DEC'06-JAN'07) 3. Micro-plan to support BPHS staff developed (DEC'06) 4. MCH promoters start CS-19 activities in Darzab and Qush Tepa (JAN'07)

MTE Recommendation	CS-19 Response	Action
4. A budgetary re-alignment should be carried out in order to ensure that added transport costs, including those required to support community-level services in Darzab and Qush Tepa, can be met.	Agreed.	1. Budget re-alignment (NOV'06)
5. The project management team should review the DIP work-plan quarterly to see that all activities are implemented on schedule.	Agreed. CS-19 coordinator and staff will review the CS-19 updated work-plan quarterly to ensure that all activities are implemented on schedule	CS-19 work-plan reviewed each quarter starting from October 2006
6. The project should adopt a comprehensive behavior change strategy framework, such as BEHAVE, to guide the development of its BCC activities; and it should seek technical assistance from within SC/US to train staff and partners in implementation of the approach.	Agreed. Technical assistance will be sought from within the existing SC/USA resources. Kathryn Bolles from Home Office and Tariq Ihsan Afghanistan senior manager health will identify SC/USA trainer.	SC/USA BCC trainer identified (NOV'2006) A 5-day BCC workshop conducted (JAN'2007)
7. The BCC/IEC Officer should promote use of IEC/BCC materials developed by REACH/BPHS (SSP in future). If additional materials need to be developed, the BCC/IEC officer should follow a standard procedure for pre-testing of visual and pictorial materials, and ensure that all materials are pre-tested before broad distribution.	Agreed. No additional IEC materials will be developed. CS-19 staff will collect and promote use of IEC/BCC materials developed by REACH/BPHS and SSP. CCM materials will be refined based on the experience of their use since 2005.	1. CS-19 staff will collect REACH/BPHS materials (NOV'2006) 2. CS-19 staff will collect IEC/BCC materials developed by SSP (FEB'07) 3. CCM IEC materials will be refined and finalized (FEB'07)
8. To foster the continued leadership of the Community Health Councils (CHC, also called *shuras*) after the project ends, CS 19 should oversee all Community Health Councils in the independent development off a post-	Agreed. CS-19 train partners and provide community health council action plan and tool	1. CS-19 (one time) will train partners on community health council action plan and tool development (JUN'07)

MTE Recommendation	CS-19 Response	Action
project Community Health Action Plan with clearly defined activities, responsibilities and a workplan.		
9. The project, together with STEP and MOVE, should discuss with *shuras* regarding how best to support CHWs and keep them motivated. This may include the possibility of small incentives for CHWs	Agreed.	1. An agenda to discuss support for CHW with CHC/*shura* jointly developed (CS-19 staff, MOVE, STEP and MOPH) – DEC'06 2. Discussions held with CHC/*shura* and plan to support for CHW in all locations developed (FEB'07 to JULY'07) 3. Follow-up Implementation plan conducted by CS-19 staff. (JULY'07 onwards on quarterly basis)
10. A workshop should be scheduled with MOPH HMIS staff to identify ways to strengthen and standardize data collection and to ensure accurate utilization and completion of all forms, registers and reporting instruments.	Agreed	1. CS-19 facilitated two HMIS workshops conducted (MAR'07 and JAN'08)
11. Project staff should analyze results and document the experience of PD/Hearth, including lessons learned and successful strategies and share with MOPH's IMCI Task Force and Nutrition Task Force to influence national nutrition/GMP strategy.	Agreed. It is important to document lesson learned from PD/hearth and document effectiveness of its tools, methods and materials. Kathryn Bolles child survival expert will help identify a summer intern to help in this regard.	1. PD/Hearth in 4 locations documented (APR to MAY'07) 2. Share lesson learned and successful experience with MOPH IMCI and Nutrition task force (MAY/JUN'07)
12. CS 19's IMCI Officer should review the client counseling component of CDD training for health workers to clarify and strengthen communication on the danger signs of diarrhea.	Agreed. CS-19 has already planned to lead a three-day TOT on "Caregiver's Counselling", which will highlight danger signs in a sick child as well as focus on home care.	1. Two three-day TOT on caregiver's counselling conducted for 20 doctors, 18 pharmacists and 12 MCH promoters. (JAN'07)

MTE Recommendation	CS-19 Response	Action
13. CS 19 should work with BPHS and STEP/MOVE to ensure that all CHWs implementing CCM have access to either a stop watch or wall clock for timing breaths of children with ARI.	Agreed	1. CS-19 will provide stop watch to 10 CHWs in CCM two pilot areas (DEC'06) 2. CS-19 will discuss with STEP/MOVE to advocate with UNICEF to provide 2 stop watches for each HP in Jawzjan
14. Since most women are attended during childbirth by relatives, CHWs should be trained to educate the community at large on clean delivery and basic newborn care.	Agreed.	1. CS-19 will lead one TOT with partners on community education on clean delivery and role of community midwives.
15. CS 19's IMCI Officer and Health Officer should ensure that health workers receive refresher training that further strengthens their skills with regard to assessment and classification of pneumonia.	Agreed	1. CS-19 IMCI certified trainer will conduct a refresher training focusing on assessment and classification of pneumonia.
16. Work out with SSP and TechServe to ensure that CS-19's technical support to both PHO and health facility staff is appropriate and conducted in a well coordinated manner.	Agreed	1. CS-19 will coordinate PHO capacity building needs of Jawzjan and northern Faryab, with SSP and TechServe on quarterly basis, starting DEC'06

Revised Workplan (Based on MTE Findings and Recommendations)

EPI (20%)											
Indicator 2. % of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (card.) **Indicator 3.** % of infants who received DPT3. **Indicator 4.** % of 12-23 month olds who received the measles vaccine (recall.)											
Major Activities	**Y4 Q1**	**Y4 Q2**	**Y4 Q3**	**Y4 Q4**	**Y5 Q1**	**Y5 Q2**	**Y5 Q3**	**Y5 Q4**	**Personnel**	**Benchmark/ Target**	**Activity Focus***
EPI Refresher Management Training for PHO (including sections on HMIS, M &E, keeping registers/log books, and community mobilization)		X							CS19 EPI Sr. Health Officer, MOPH EPI Officer	15 participants, including MOPH HMIS, EPI and NGO technical staff	Quality Behavior Change Access
EPI refresher training			X						Same as above	20 vaccinators and 20 doctors from BHCs, CHCs and DH	Quality Behavior Change Access
Support MOH in NIDs	x				x				CS-19 EPI Officer	PHCC NID Committee	Quality, Access
Refine and finalize IEC tools				x					CS-19 BCC Officer with PHCC BCC staff	IEC materials developed and displayed in HF	Behavior Change
Microplans for poor access areas	x				x				CS-19 EPI Officer, PHCC	Microplans in place, sites selected	Quality, Access
Immunization coverage data collection (support to PHO)	x	x	x	x	x	x	x	x	CS-19 EPI Officer with PHO	BHCs, CHCs and DH	Quality, Access
Feedback on immunization coverage to PHCC		x		x		x		x	CS-19 staff, PHO EPI Officer	PHCC	Quality, Access
"On the spot" technical support to PHO technical officers	x	x	x	x	x	x	x	x	CS-19 EPI Officer	PHO EPI and HMIS officers	Quality

CDD (15%)

Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.
Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness.
Indicator 7. % of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.
Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.
Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.
Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.
Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.
Indicator 19. % of caretakers of <5s know at least 2 aspects of home care.
Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse.
Indicator 21. % of severely ill <5s classified correctly in MOH facilities.
Indicator 24. % of <5 diarrhea cases treated correctly in MOH facilities.

Major Activities	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
TOT on Caregiver's Counseling Techniques		X				X			SC/USA Senior Manager Health and CS19 coordinator	25 doctors and pharmacists from BHCs, CHCs and DH	Quality
IMCI refresher courses for new NGO BPHS staff		X							CS19 Coordinator, MOPH IMCI officer	18 doctors from NGO supported BHCs and CHCs	Quality
Observation of sick child management using IMCI checklist	X		X		X		X		CS19 and MOPH IMCI Officers	implemented at Health Facilities	Quality, Access
MCH promoters support CHWs	X	X	X	X	X	X	X	X	MCH promoters	MOH-selected CHWs in Andkhoy cluster and selected Jawzjan province	Quality, Access, Behavior Change

CCM tools, materials and methods refined and finalized	X	X	X						CS19 IMCI Officer and an artist.	15 CCM Training sets including tools, materials and methods	Quality
Assessment of CHW's performance in CCM in CS19 and non-CS19 supported CHWs for comparison		X	X						SC/USA Senior Manager Health, CS19 and MOPH IMCI Officer	10 CCM trained CHWs 10 BPHS trained CHWs	Quality
CCM refresher training			X						CS19 IMCI and BCC officers	10 CHW in CCM pilot area	Quality
CCM assessed and documented					X	X			CS-19 staff, NGO partners	Finalized Report	Quality
"On the spot" technical support to PHO technical officers	x	x	x	x	x	x	x	x	CS-19 IMCI Officer	PHO IMCI Officer	Quality

ARI (20%)

Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.
Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness.
Indicator 8. % of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source.
Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.
Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.
Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.
Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.
Indicator 19. % of caretakers of <5s know at least 2 aspects of home care.
Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse.
Indicator 21. % of severely ill <5s classified correctly in MOH facilities.
Indicator 23. % of <5 ARI cases treated correctly in MOH facilities.

Major Activities	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
TOT on Caregiver's Counseling Techniques		X				X			SC/USA Senior Manager Health and CS19 coordinator	One TOT will cover counseling areas on both diarrhea and ARI	Quality
IMCI refresher courses for new NGO BPHS staff		X							CS19 Coordinator, MOPH IMCI officer	Same as in the CDD section above (IMCI refresher will cover both CDD and ARI)	Quality
MCH promoters work with CHWs	X	X	X	X	X	X	X	X	CS19 MCH promoters	MOH-selected CHWs	Quality, Access, Behavior Change

CCM tools, materials and methods refined and finalized	X	X	X						CS19 IMCI Officer and an artist.	Same as in the CDD section above (15 CCM Training sets including tools, materials and methods)	Quality
Assessment of CHW's performance in CCM in CS19 and non-CS19 supported CHWs for comparison		X	X						SC/USA Senior Manager Health, CS19 and MOPH IMCI Officer	Same as in the CDD section above (10 CCM trained CHWs 10 BPHS trained CHWs)	Quality
CCM refresher training						X			CS19 IMCI and BCC officers	10 CHW in CCM pilot area	Quality
CCM assessed and documented				X					CS-19 staff, NGO partners	Same as in the CDD section (Finalized CCM Report)	Quality
CCM lesson learned shared with SSP and MOPH				X					SC/USA Senior Manager Health and CS19 coordinator	One presentation on CCM lessons learned with SSP, UNICEF, MOPH	Quality
"On the spot" technical support to PHO technical officers	x	x	x	x	x	x	x	x	CS-19 CDD/ARI Officer	PHO IMCI Officer	Quality

Nutrition (15%)											
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours. **Indicator 12.** % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.											
	Y4 Q1	**Y4 Q2**	**Y4 Q3**	**Y4 Q4**	**Y5 Q1**	**Y5 Q2**	**Y5 Q3**	**Y5 Q4**	**Personnel**	**Benchmark/ Target**	**Activity Focus**
Refresher Training on Growth Monitoring and Promotion in Andkhoy Cluster		X				X			CS19 MNC and BCC officers	MOPH Nutrition Officer, 8 midwives (BHC and CHC) in Andkhoy cluster	Quality, Access and Behavior Change
Community mobilization to promote use of iodized salt (MOPH and UNICEF plan)	X	X	X	X	X	X	X	X	CS19 BCC Officer and MOPH Nutrition Officer	18 BPHS Community Health Supervisors (CHSs) trained xxx CHC/*shuras* trained in Andkhoy cluster	Quality, Access and Behavior Change
Assessment of availability (home and shops) and use of iodized salt at homes.	X				X				CS19 BCC and MOPH Nutrition Officers and UNICEF	Salt tested twice in six selected districts (Demonstration sites) - 400 Kitchen salt tested (200 baseline and 200 repeat) - 400 samples at shops tested (200 baseline and 200 repeat)	Quality, Access, Behavior Change
PD/Hearth replicated in two other villages		X							CS19 BCC, MNC and MOPH Nutrition Officers	6 NGO staff trained on PD/hearth methods. 8 CHWs trained 8 volunteers trained	Quality, Access, Behavior Change

PD/Hearth tools, materials and methods refined and finalized	X								CS19 BCC, MNC and MOPH Nutrition Officers	Materials disseminated to partners and implementing NGOs	Quality, Access, Behavior Change
PD/Hearth documented		X			X				CS19 BCC, MNC and MOPH Nutrition Officers and a summer intern.	One document highlighting PD/Hearth methods, tools and IEC materials, impact and lesson learned	Quality

MNC (30%)											
Indicator 1. % of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months old. **Indicator 9.** % of 0-23 month olds whose delivery was attended by skilled health personnel. **Indicator 10.** % of mothers who had at least one postpartum check. **Indicator 13.** % of mothers able to report at least two known maternal danger signs during the postpartum period. **Indicator 15**. % of MOH facilities with female health workers.											
Major Activities	**Y4 Q1**	**Y4 Q2**	**Y4 Q3**	**Y4 Q4**	**Y5 Q1**	**Y5 Q2**	**Y5 Q3**	**Y5 Q4**	**Personnel**	**Benchmark/ Target**	**Activity Focus**
Workshop on community education on clean delivery and role of community midwives in selected areas.		X				X			CS19 MNC Officer and MCH promoters	15 CHSs trained 15 CHW trained	Quality, Access and Behavior Change
MNC Training for new NGO BPHS staff in Jawzjan	X								CS19 MNC and MOPH RH Officer	20 participants including doctors and nurses	Quality
MNC Refresher						X			Same	25 participants: PHO, NGOs, PHCC	Quality
Technical support to CME graduate midwives	X	X	X	X	X	X	X		CS19 MNC and MOPH RH Officer	23 graduate midwifes	Quality
Technical support to CHWs involved in the Prevention of Postpartum Hemorrhage demonstration project	X								CS19 MNC Officer and 4 CS19 MCH promoters	CHWs in Qurghan in Andkhoy cluster (number TBD) CHWs in Qaramqol in Andkhoy cluster (number TBD)	Quality, Access and Behavior Change
Technical support on community mobilization	X				X				SC staff	PHO, NGOs	Quality, Access and Behavior Change
Collaboration as needed on FP activities in BPHS	X				X				CS-19 RH Officer, REACH staff	FP providers	Quality, Access and Behavior Change
Implementing supervisory checklists and quarterly monitoring	X	X	X	X	X	X	X	X	CS-19 RH Officer	Checklists in use in all districts	Quality, Access

Appoint and train 2 MCH promoters for Darzab and Qush Tepa districts		X							Senior Management and CS19 staff	Two local MCH promoters appointed in Darzab and Qush Tepa	Quality, Access and Behavior Change
Support 2 MCH promoters in Darzab and Kush Tepa districts			X	X	X	X	X	X	CS19 MNC and MOPH RH Officers	Supervisory visit once a month for the remaining project period	Quality

All interventions											
Indicator 22. CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality. **Indicator 25**. % of mothers receiving general information or advice on health or nutrition from a member of the informal community network. **Indicator 26.** % of PDQ Quality Improvement Committees including at least one female participant.											
Major Activities	**Y4 Q1**	**Y4 Q2**	**Y4 Q3**	**Y4 Q4**	**Y5 Q1**	**Y5 Q2**	**Y5 Q3**	**Y5 Q4**	**Personnel**	**Benchmark/ Target**	**Activity Focus**
Attend PHCC monthly meetings	X	X	X	X	X	X	X	X	CS-19 Coordinator.	CS-19 representation in each mtg	Quality, Access
Attend PHO's technical committee meetings	X	X	X	X	X	X	X	X	CS19 staff	HMIS committee meetings RH monthly meetings EPI monthly meetings	Quality, Access
PDQ (Partnership Define Quality) implementation in two selected districts		X	X	X					CS-19 staff with BPHS NGO staff	Work plan in place with selected sites	Quality, Access
Equity task force established and action plan development	X		X		X		X		PHCC	Action plan created	Access
CS 19 staff attends provincial BPHS related trainings.		X		X		X			CS19 staff	CS19 staff attendance in BPHS trainings	Quality
CS19, STEP, MOVE and MOPH staff will finalize and sign MOU	X								Directors SC/USA, STEP and MOVE	MOU agreed and signed	Quality, Access, Behavior Change
A 5-day BCC workshop conducted on BEHAVE concept		X							SC/USA identified trainer	One TOT on BCC conducted for 5 CS19 staff, 6 partner NGOs and 4 MOPH PHO staff	Quality
Collect REACH/BPHS and SSP IEC materials		X	X						CS19 coordinator SSP BCC manager	Complete set of IEC materials available	Quality

Review DIP/Action plan	X	X	X	X	X	X	X	X	CS19 staff	Once quarterly	Quality
Discussions held with CHC/*shura* and plan to support for CHW in all locations developed and implemented through partners.		X	X						CS19 staff, MOVE, STEP and MOPH	An agenda to discuss support for CHW with CHC/*shura* 20-30 CHC/*shura* discussions held and action plan developed	Quality, Access, Behavior Change
MOPH Led HMIS workshop facilitated		X			X				MOPH HMIS officer and CS19 staff	Two HMIS workshops conducted for BPHS staff	Quality
Coordinate PHO capacity building needs of Jawzjan and northern Faryab, with SSP and TechServe on quarterly basis.	X	X	X	X	X	X	X	X	Senior Manager Health and CS19 Coordinator	Regular meetings, joint planning	Quality
Annual Reports				x					CS Specialist	1 Annual Report	Quality
Final Evaluation								x	External Evaluator and CS Specialist	Final Report	Quality

ATTACHMENTS

A. Baseline Information from the DIP
   1. **Andkhoy Data Comparison**
   2. **Jawzjan Data Comparison**

B. Reports/Surveys Findings
   1. **Summary of Baseline Results**
   2. **Observation of Sick Child Management**

C. Evaluation Team Members and Their Titles

D. Evaluation Assessment Methodology

E. List of Persons Interviewed and Contacted

F. CD with Electronic Copy of Report

G. Special Reports
   1. **Sample of Monthly Reporting Form**
   2. **Observations of RH/Assistants, Midwives**
   3. **MNC Trainings**

H. Updated Project Data Form

I. Memorandum of Understanding

J. Basic Counseling Skills Training of Trainers Agenda

Attachment A.1.
Andkhoy Data Comparison

Strategic Objective/ Intermediate Result	#	Indicator	Method	Baseline value	Interv	Comments
SO: Improved health **practices** at household level, & increased **use** of essential MCH services, in Jawzjan Province.	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	79%	MNC	Household survey May 2006: percentage of mothers receiving TT vaccination 99%
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	64%	EPI	HMIS (CS19) 2005: BCG 83%, DPT3 84%, OPV3 84%, Measles 84% **Fully immunized: 83%**
	3	Percent of infants who received DPT-3.	HIS	24%	EPI	HMIS (CS19) 2005: DPT3: 84% Household Survey May 2006: 62%
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	72%	EPI	HMIS August 2006: Measles 84% Household survey didn't assess this
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	20%	CDD ARI	Exit interviews May 2006 revealed that 49% mothers of under 5 children gave more fluids during an illness (No KPC survey was repeated)
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	27%	CDD ARI	Exit interviews May 2006 revealed that 69% mothers of under 5 children fed more frequent during an illness (No KPC survey was repeated)
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	69%	CDD	No data
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	84%	ARI	No data
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	13%	MNC	Household survey May 2006: 59% HMIS data:
	10	Percent of mothers who had at least one postpartum check.	KPC	82%	MNC	Household survey May 2006 48% This is for skilled birth attendants, which we had only in one facility. Baseline included PNC by trained birth attendants (CHWs and RH assistants)-these were not counted in the HH survey as skilled birth attendant.
	11	Percent of infants aged 0-5 months that were fed breast milk only in the last 24 hours.	KPC	66%	Nut	Household survey May 2006: 58%
	12	Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours.	KPC	N/A	Nut	No data Focus group discussion with mothers in two villages showed that they have learned about weaning and feeding practices.

Attachment A.1.
Andkhoy Data Comparison

IR-1: Increased household-level **knowledge** of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	70%	MNC	No data. Focus group discussions with women during MTE revealed that most mothers had good knowledge about danger signs.
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	69%	ARI CDD	No data; However the Exit interview August 2006: 62% but this does not represent overall situation (No KPA survey repeated).
IR-2: Increased **access** to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	75%	MNC	Indicator collected by BPHS and not uniquely CS-19. CS-19 will provide the information as available.
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv.	100%	CDD ARI	Indicator collected by BPHS and not uniquely CS-19. CS-19 will provide the information as available.
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	No	CDD ARI	PD/Hearth conducted in two villages. All Activities documented.
IR-3: Increased **quality** of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv.	67%	CDD ARI	Exit interviews August 2006 89.5% (segregated analysis for Andkhoy clusters (n=50)
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv.	87%	CDD ARI	Exit interviews August 2006 87.5% (segregated analysis for Andkhoy clusters (n=50)
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv.	96%	CDD ARI	Exit interviews August 2006 77.5% (segregated analysis for Andkhoy clusters (n=50)
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	50%	CDD ARI	Exit interviews August 2006 92.5% (segregated analysis for Andkhoy clusters (n=50)
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	No	All	Was removed from CS19
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	50%	ARI	Exit interviews August 2006 67% (segregated analysis for Andkhoy clusters (n=50)
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey).	HFA	60%	CDD	Exit interviews August 2006 81% (segregated analysis for Andkhoy clusters (n=50)

Attachment A.2.
Jawzjan Data Comparison

Strategic Objective/ Intermediate Result	#	Indicator	Method	Baseline value	Interv	Compare data from other sources
SO: Improved health **practices** at household level, & increased **use** of essential MCH services, in Jawzjan Province.	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	15%	MNC	Household survey May 2006: percentage of mothers receiving TT vaccination 57%
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	4%	EPI	HMIS (CS19) 2005: BCG 79%, DPT3 71%, OPV3 71%, Measles 71% **Fully immunized: 71%**
	3	Percent of infants who received DPT-3.	HIS	11%	EPI	HMIS (CS19) 2005: DPT3: 71% Household Survey May 2006: 33%
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	12%	EPI	HMIS August 2006: Measles 71% Household survey didn't assess this
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	23%	CDD ARI	Exit interviews May 2006 revealed that 55% mothers of under 5 children gave more fluids during an illness (No KPC survey was repeated)
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	26%	CDD ARI	Exit interviews May 2006 revealed that 75% mothers of under 5 children fed more frequent during an illness (No KPC survey was repeated)
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	17%	CDD	No data
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	39%	ARI	No data
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	28%	MNC	Household survey May 2006: 31% HMIS data:
	10	Percent of mothers who had at least one postpartum check.	KPC	29%	MNC	Household survey May 2006: 36% (skilled Birth attendants) HMIS data:
	11	Percent of infants aged 0-5 months that were fed breast milk only in the last 24 hours.	KPC	68%	Nut	Household survey May 2006: 80.5%
	12	Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours.	KPC	33%	Nut	No data FGDs with mothers in two villages showed that they have learned about weaning and feeding practices.

Attachment A.2.
Jawzjan Data Comparison

IR-1: Increased household-level **knowledge** of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	29%	MNC	No data. Focus group discussions with women during MTE revealed that most mothers had good knowledge about danger signs.
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	14%	ARI CDD	No data; However the Exit interview August 2006: 68.3% but this does not represent overall situation (No KPA survey repeated).
IR-2: Increased **access** to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	43%	MNC	Indicator collected by BPHS and not uniquely CS-19. CS-19 will provide the information as available.
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv.	Not available	CDD ARI	Indicator collected by BPHS and not uniquely CS-19. CS-19 will provide the information as available.
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	No	CDD ARI	PD/Hearth conducted in two villages. All Activities documented.
IR-3: Increased **quality** of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv.	26%	CDD ARI	Exit interviews August 2006 49%
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv.	59%	CDD ARI	Exit interviews August 2006 68.3%
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv.	66%	CDD ARI	Exit interviews August 2006 71.2%
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	0%	CDD ARI	Observation: 18%
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	No	All	Was removed from CS19
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	30%	ARI	Exit interviews August 2006 33.3%. STEP and MOVE have new untrained doctors
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey).	HFA	35%	CDD	Exit interviews August 2006 29.2%. STEP and MOVE have new untrained doctors

Attachment A.2.
Jawzjan Data Comparison

IR-4: Established **social network** to support key behaviors.	25	Percent of mothers receiving general information or advice on health or nutrition from a member of the informal community network.[1]	KPC	1%	ALL	No data
	26	Percent of CDQ Quality Improvement Committees including at least one female participant.	Final Eval.	N/A	All	Was removed

[1] From KPC+2000, the informal network consists of the following: husband/partner, mother/mother-in-law, sister, grandparent, aunt, friend/neighbor, traditional healer, village elder, or other.

Attachment B.1.
Summary of Baseline Results

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
1. What reason does the caretaker give for bringing the child to the health facility?			These represent that most children suffered from more than one disease/sign
- Diarrhea/vomiting	32% (35/109)	62% (62/100)	
- Fever/malaria	55% (60/109)	58% (58/100)	
- Cough/difficult breathing pneumonia	78% (85/109)	45% (45/100)	
2. Does the health worker ask of the age of the child or have child's age available?	51% (55/109)	96% (96/100)	100% children's age must be asked. However shows significant progress.
3 a. Is the child weighted? Is the child's weight plotted on a growth?	2% (2/109)	76% (76/100)	Child must be weighed and his/her weight plotted on the card. Shows progress especially in Andkhoy cluster where GMP is strongly integrated.
4. Is the child's temperature checked?	13% (14/109)	62% (62/100)	Shows progress, but 100% sick children's body temperature must be measured
Does the health worker ASK about (or does the caretaker REPORT):Danger signs:			
5. Able to drink or breastfeed?	22% (24/109)	70% (70/100)	Sick children with **signs and symptoms showing severity of illness** are at an increased risk of death, therefore, it is important to screen them for these signs (or sign 13). The results above show that a majority of sick children were screened for danger signs. This is true for Andkhoy cluster where the doctors continued to work. This was poor in Jawzjan, where STEP and MOVE hired new doctors who lacked training. Individual screening tasks need to be targeted through training and reinforced through supervision in Jawzjan area
6. Vomits everything?	28% (30/109)	72% (72/100)	
7. Convulsions?	15% (16/109)	54% (54/100)	
8. Change in consciousness/lethargic	8% (9/109)	55% (55/100)	
9. The child has Diarrhea?	63% (69/109)	91% (91/100)	Many children suffer from more than one disease. It is therefore very important that 100% caregivers of sick children attending OPD are asked Q9, 10 & 11, in order to screen and exclude other diseases. The results here show that for more than half the sick children doctors asked the caregivers questions related to other diseases. This **is true for Andkhoy cluster where the doctors continued to work and perform on IMCI standards.** Results were poor in Jawzjan, where STEP and MOVE hired new doctors who lack IMCI training and where even when caregivers reported presence of other signs and symptoms (other than those reported as chief complaints) None asked follow-up
For how long?	32% (22/69)	68% (62/91)	
Is there blood in the stool?	15% (10/69)	55% (50/91)	
10.a Cough or difficult breathing?	67% (83/109)	85% (85/100)	
.b For how long?	54% (45/83)	61% (52/85)	
11.a Fever?	66% (72/109)	79% (79/100)	
.b For how long?	44% (32/72)	75% (59/79)	
12. a. The child Ear problems?	-	57% (57/100)	
.b Ear pain?	-	88% (50/57)	

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
.c Ear discharge?	-	65% (37/57)	questions. Individual screening tasks need to be targeted through training and reinforced through supervision in Jawzjan.
.d for how long?	-	33% (19/57	
Does the health worker perform these EXAMINATION tasks:			
13. Look for lethargy or unconsciousness?			See above
Diarrhea/dehydration related			To assess dehydration, apart from history questions (9b and 9c), for all children with diarrhea these examination tasks must performed. Results here show that for most children these examination tasks were performed.
14. Observe drinking or breastfeeding?	7% (8/109)	53% (53/100)	
15. Pinch the skin of abdomen?	3% (3/109)	75% (75/100)	
16. Look for sunken eyes?	7% (8/109)	72% (72/100)	
ARI/Cough/Difficult breathing related - the following analysis for the repeat is for 45 children who had cough/cold			
17. Raise the shirt?	51% (56/109)	100% (100/100)	Children with cough or difficult breathing must be classified into those suffering from common cold, pneumonia or severe pneumonia in order to establish a correct line of management. To this along with history questions 10b, these examination tasks must be performed. Results show that the doctors did not perform these tasks for most children suffering from cough and/or difficult breathing. However, counting breath rates and looking for chest in-drawing has comparatively increased.
18. Count breaths/minute?	13% (14/109)	30% (30/100)	
19. Look for chest indrawing?	17% (19/109)	31% (31/100)	
Fever related			
20. Look or feel for stiff neck?	25% (27/109)	33% (33/100)	Many caregivers give only a history of fever for sick children, especially in cases where the main illness is not easily recognized. These illnesses may be meningitis, malaria, cerebral malaria, measles, etc. It is therefore important to carry out all these three examination tasks (along with history questions) for the correct assessment/classification and treatment. Results here show for some children doctors have carried out these tasks, especially in Andkhoy cluster.
21. Look for generalized rash?	19% (21/109)	46% (46/100)	
22. Look for cough, runny nose or red eyes?	3% (3/109)	57% (57/100)	
24. Feel for swelling behind ear?		34% (34/100)	
Nutrition related:			Correct assessment of nutritional status is required for all sick children regardless of any chief complaints caregivers present. While improving, the assessment for nutritional status is
25. Undress and look for wasting?	6% (6/109)	37% (37/100)	
26. Look for palmar or conjunctive pallor?	6% (7/109)	39% (39/100)	

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
27. Look for edema of both feet?	5% (5/109)	37% (37/100)	generally not carried out. Where implementation of IMCI program is intended, it is useful at the beginning to look at how well health workers perform each of these tasks so that those that are weak could be targeted through trainings and supervision. If doctors are not required to do the job of weighing sick children, doctors must ensure that this information is present at a sick child's visit. Note: GMP is integrated in Andkhoy cluster only.
Overall scores for assessment and classification			
A. All danger signs (Q.5 to Q.8 [or Q.13]) assessed?	6% (6/109)	65% (65/100)	Sick children with **signs and symptoms showing severity of illness** are at an increased risk of death, therefore, it is important to screen them for these signs (or sign 13). The results above show that a majority of sick children were screened for danger signs. In sum for 65% children all danger signs were assessed and this is a significant increase over baseline.
B. All main symptoms (Q.9 to Q.12) assessed?		51% (51/100)	
C. Number of diarrhea assessment tasks completed? (0 to 5)			If the caretakers of children give a history of diarrhea, the assessment involves asking key history questions and conducting key examination tasks for 100% children. These are as follows: 1) Ask about duration of diarrhea; 2) Ask about a history of bloody diarrhea; 3) Look at the skin turgor on the abdomen; 4) Look for sunken eyes; 5) Assess how the child is drinking; and 6) Assess the child's general condition (lethargic or unconsciousness; restless/irritable. While results show improvement, there is still a great need to progressively increase the proportion of essential tasks that need to be completed.
✓ 0 tasks (all 6 tasks not preformed)	68% (74/109)	9% (9/100)	
✓ 1 task	22% (24/109)	12% (12/100)	
✓ 2 tasks	7% (8/109)	10% (10/100)	
✓ 3 tasks	1% (1/109)	14% (14/100)	
✓ 4 tasks	1% (1/109)	25% (25/100)	
✓ 5 tasks	1% (1/109)	30% (30/100)	
D. Number of ARI assessment tasks completed? (0 to 4)			
✓ 0 tasks (all 4 tasks not preformed)	32% (35/109)	22% (22/100)	If a caretaker of a sick child gives a history of ARI, the assessment involves asking a key history question and conducting key examination tasks. These are as follows: 1) Ask about the duration of cough; 2) Raise the shirt; 3) Count breath
✓ 1 task	35% (38/109)	15% (15/100)	
✓ 2 tasks	14% (15/109)	14% (14/100)	
✓ 3 tasks	15% (17/109)	22% (22/100)	

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
✓ 4 tasks	4% (4/109)	27% (27/100)	rates in one minute; 3) Look for chest in-drawing. Correct assessment is required in order to classify and treat all children suffering from ARI, it is therefore important to note which tasks are completed for ARI and which one needs to be addressed through training and supervision. While results show some (more 4 or 5 tasks being performed) improvement, there is still a great need to progressively increase the proportion of essential tasks that need to be completed.
E. Number of fever assessment tasks completed? (0 to 4)			
1. 0 tasks	53% (58/109)	27% (27/100)	If the caretakers of sick children give a history of fever, the assessment involves asking key history question and conducting key examination tasks. This involves: 1) Asking about duration of fever; 2) Looking for runny nose (minimum examination requirement); 3) Looking for stiff neck (meningitis, cerebral malaria); 4) Looking for generalized rash, cough or red eyes (measles). Fever may also be due to meningitis, malaria, cerebral malaria, measles, etc. It is therefore important to carry out all four tasks (along with history questions) for the correct assessment/classification and treatment. While results show some (more 4 or 5 tasks being performed) improvement, there is still a great need to progressively increase the proportion of essential tasks that need to be completed
✓ 1 task	24% (26/109)	12% (12/100)	
✓ 2 tasks	16% (18/109)	21% (21/100)	
✓ 3 tasks	6% (6/109)	18% (18/100)	
✓ 4 tasks	1% (1/109)	22% (22/100)	
F. Nutritional status correctly assessed?	0% (0/109)	30% (30/100)	See notes above on page 3, *Nutrition related*. GMP is integrated in Andkhoy Cluster only.
Immunization and Screening- (67 children were between 0-23 months old)			In order to avoid 'missed opportunity' to vaccinate a child, WHO recommends active screening of the immunization status of all children (belonging to target age for childhood immunization), in the clinics and during home visits. There is no contraindication to childhood immunization, except when the child is very sick. Results indicate that doctors asked for most children's EPI cards and assessed what actions to take. This shows that if screening of immunization cards at sick child's visit is institutionalized, there is a great chance to reduce missed opportunities. Practice needs to be institutionalized in Andkhoy cluster and Jawzjan
28. a. Does the HW ask for the child's immunization card?		66% (44/67)	
b. If YES, does the child have the card?	1% (1/109)	59% (26/44)	
c. After looking at the card, is the child referred for vaccination			
1. Today?	0	25% (11/44)	
2. Another day?	0	43% (19/44)	
3. Not referred,	0	16% (7/44)	
4. Up to date?	0	16% (7/44)	
29. a . Does the HW ask for the caretaker's immunization card?	-	41% (41/99)	Sick children are usually brought by their mothers, or older female siblings or aunts (child bearing women). Sick child visit

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
b. If YES, does the caretaker (mother/older sister) have the card?	-	24% (10/41)	is a great opportunity for doctors to screen caregiver's TT vaccination status. Results show that most doctors asked some caregiver's for TT cards, and when they did, only some mothers produced the cards. This shows that caregivers (CBA women) TT immunization status is not assessed during a sick child's visit and hence loose the chance of addressing missed opportunities. Practice needs to be institutionalized in Andkhoy cluster and Jawzjan.
d. Is the caretaker referred for TT vaccination 1. Today?	-	5% (2/41)	
2. Another day?	-	20% (8/41)	
3. Not referred,	-	17% (7/41)	
4. Up to date?	-	59% (24/44)	
Overall results for diagnosis and treatment			WHO/IMCI guidelines recommend ORS and home based fluids for children suffering from simple diarrhea. ORS was given to nearly all children suffering from diarrhea, which is very encouraging. But the use of antibiotic and other drugs for some children with watery diarrhea clearly points towards poor understanding of CDD guidelines. WHO/IMCI guidelines recommend that for children suffering from common cold home care should be adopted and if required antipyretic be prescribed. The use of antibiotics in common cold cases is not recommended. Most cases diagnosed as 'common cold were prescribed an antibiotic. There has been a significant improvement overall, however there is a great need to supervise and support HWs to adopt IMCI guidelines religiously .
G. is the treatment appropriate for the diagnosis?	27% (29/108)	62% (62/100)	
I.a Diarrhea case received appropriate medication?	35% (8/23)	75% (47/62)	
I.b Cough/common cold received appropriate medication?	47% (39/83)	47% (21/45)	
i.c Dysentery received appropriate treatment	25% (1/4)	50% (4/8)	
Interpersonal communication			
For all oral medication			
65a. Does the health worker explain how to administer medications/ORS?	35% (38/108)	78% (78/100)	Generally, the health worker's role is to classify an illness, make a diagnosis and write a prescription and dispense medicines. Giving correct treatment at home is the sole responsibility of the caregivers. Therefore it is important to counsel caretakers effectively to ensure that they are able to carry out these tasks without difficulty. From the program planning point of view, it is important to see which of these tasks health workers perform well and which ones need a focus through trainings and supervision. Results here show that usually doctors explain how to give oral medication, but rarely demonstrate or ask open-ended questions to verify if caregivers have understood correctly.
.b Does the health worker demonstrate how to administer oral medications/ORS?	14% (15/108)	42% (42/100)	
.c Does the health worker ask an open-ended question to verify the comprehension	10% (11/108)	28% (28/100)	
Follow-up and home care advice			In order to avoid dehydration all caretakers must give increased amount of fluids to their sick children. Similarly, for all sick children food intake should also be increased during and after the illness in order to avoid under nutrition. This is particularly true for diarrheal diseases but also for other illnesses that cause children to drink and eat less.
66. Does the health worker explain when to return for follow-up?	15% (16/108)	56% (56/100)	
67. Does the health worker explain the need to give the same quantity/more liquid at home?	10% (11/108)	65% (65/100)	
68. Does the health worker explain the need to continue feeding or breast-feeding at home?	13% (14/109)	55% (55/100)	

Observations of sick child management (doctors)	Baseline (Jan 2004)	MTE (2006)	Comments
69. Does the health worker tell the caretaker to bring the child back for the following signs?			Many children die unnecessarily because the caretakers are unable to recognize danger signs and take actions (seek health care outside home) on time. The health workers need to educate caretakers regarding danger signs and when to return to health facility. Returning to health facility is important as this may require a change in the therapy or referral to a next level health facility. Results indicate that while counseling has generally improving, many caregivers are still not counseled regarding home care, danger signs and when to return for re-assessment.
✓ Child is not able to drink or drinking poorly	5% (5/109)	50% (50/100)	
✓ Child is not able to breast-feed/eat	4% (4/109)	37% (37/100)	
✓ Child becomes sicker	11% (12/109)	49% (49/100)	
✓ Child develops a fever	6% (7/109)	35% (35/100)	
✓ Child in unconsciousness/lethargic	1% (1/109)	29% (29/100)	
L. Are at least 3 of the Q.69 messages circled?	8% (9/109)	44% (44/100)	
70. Does the health worker give the caretaker any advice on nutrition			

Attachment B.2.
Observation of Sick Child Management (2006 MTE CS-19)

Results of caregiver's exit interviews	Results baseline (109)	Final 2006	Comments
About Oral Medication			
1. Did the health worker give you any oral medicines for your child at the BHU today?	79% (86/109)	90% (90/100)	
Caretaker knows how to give ALL essential medications correctly?	57% (62/109)	72% (66/92)	Caretaker's knowledge of how to give treatment appropriately is an essential requirement for the correct treatment at home. So it is important that the health workers explain how to give drugs, show the caretakers how to calculate a dose, make them understand how many times each dose will be given in a day and explain to them for how many days the treatment should be continued. The most important aspect of this is to ask questions to assess whether caregivers have understood - and to demonstrate to ensure that they do understand correctly. The results above indicate that more caregivers understand how to give medicines at home. Further analysis showed for some medicines their knowledge was better than the others, for example, their relatively high knowledge regarding antibiotics and ORS, both of which require demonstration on how to prepare them on a mandatory basis. Knowledge of caretakers regarding antipyretic was very poor and their response was quite consistent throughout, which may reflect poor knowledge of pharmacists themselves. Antipyretics are given only when there is fever and not "three time a day for 3-5 days", which is both harmful to the health of a child and a waste of money.
Home Care			This assessment marks it adequate if a care taker knows at least two home care rules. The results above indicate that a large proportion of caretakers knew at least two aspects: continuing feeding or breastfeeding and giving adequate amounts of fluids. Nearly half knew the importance of completing the medication. These findings are consistent with those from the "observation of sick child management" assessment, in which a significant proportion of caretakers did
2. What will you do for your child when you return home?			
Doesn't know	6% (6/109)	7% (7/100)	
Continue feeding or breastfeeding the child	74% (81/109)	73% (72/99)	
Give same quantity/more fluids to the child	45% (49/109)	53% (53/100)	
Complete course of medications/ORS/RHF	25% (27/109)	52% (52/100)	
Bring the child back if it doesn't get better	35% (38/109)	39% (39/100)	
Others	6% (6/109)	4% (4/100)	

Results of caregiver's exit interviews	Results baseline (109)	Final 2006	Comments
Caretaker's know at least two home care measures	59% (64/109)	64% (64/100)	assessment, in which a significant proportion of caretakers did not receive any such information. Although improving (since the baseline), there is a need that caregiver's counseling must emphasize all these important aspect of home care - and from the program planning point of view, the aim should be that caretakers should know at least three home care rules.
Knowledge of danger signs (reflects counseling)			Children demonstrating the signs of severe illness in the home are at increased risk of dying and should be taken to (trained) health worker immediately. In the absence of effective treatment, mortality from pneumonia, malaria and diarrheal diseases could be high. The results show that there was no significant change except for some danger signs (inability to drink, eat, vomiting, convulsions). A large proportion of caretakers did not cite fast breathing or chest indrawing as danger signs. This maybe due to the fact that many children had diarrhea during this sick child visit and probably these are the easy signs t note and report. Areas where caretaker's knowledge is weak should be emphasized through trainings of health workers and during home visits.
3. How will you know if the child becomes worse at home?			
Doesn't know	9% (10/109)	18% (18/100)	
Develops fever or fever continues	68% (73/109)	51% (51/100)	
Child unable to drink	15% (16/109)	33% (33/100)	
Diarrhea continues	37% (40/109)	29% (29/100)	
Child cannot eat	7% (8/109)	22% (22/100)	
Vomiting begins	27% (29/109)	50% (50/100)	
Blood in stool	7% (8/109)	5% (5/100)	
Convulsions	5% (5/109)	28% (28/100)	
Fast breathings	27% (29/109)	4% (4/100)	
Chest in-drawing	8% (9/109)	7% (7/100)	
C. Caretaker knows at least 2 signs of child getting worse at home?	66% (71/109)	62% (62/100)	
About child hood vaccines and TT vaccine			
4. Which diseases will be prevented by the immunization you or your child have received? Check all that applies.			All caretakers of children including those who are sick must know names of all the six diseases that are prevented by childhood immunization. Results show that knowledge has comparatively increased for measles, polio, tetanus and whooping cough. Generally the results are not very encouraging. There are local names for some of these diseases and it is important to learn these from the community members, so that they are incorporated with health education/counseling sessions
• Does not know	29% (31/108)	15% (15/100)	
• Measles	61% (66/108)	74% (74/100)	
• Tuberculosis	44% (47/108)	37% (37/100)	
• Polio	42% (45/108)	47% (47/100)	
• Diphtheria	21% (23/108)	28% (28/100)	
• Tetanus	19% (21/108)	34% (34/100)	
• Whooping cough	31% (33/108)	49% (49/100)	
5. Do you know what might happen as a side effect after the immunization?			Many people decide not to take their child back for immunization because of the fear from the side effects. These are common side effects that usually occur after a child
• Fever	59% (64/108)	83% (83/100)	
• Pain at injection site	15% (16/108)	54% (54/100)	

Results of caregiver's exit interviews	Results baseline (109)	Final 2006	Comments
• Irritability/crying	45% (49/108)	25% (25/100)	receives a vaccine shot and include pain at the site of injection, swelling, fever, irritability, etc. All caregivers must understand that these are usual side effects and there is nothing to worry about. Information regarding types of vaccines and their possible side effects must be provided in advance before a child is vaccinated. Feedback from caretakers on what they have understood is important to remove their fear or misinformation
• Swelling	31% (33/108)	33% (33/100)	
6. How many vaccination visits does a child need in the first year of life to complete the series of vaccination?			In order for a child to complete the series of vaccination in the first year of his/her life, caregivers must take them to the immunization clinics at least five times. The first visit when the child gets BCG vaccine (at birth), second time for polio1 and DPT1 (1½ months later), third time for polio2 and DPT2 (four weeks after), fourth time for polio3 and DPT3 (four weeks after) and the fifth time for measles vaccine (at nine months of age). Caretakers who know number of times a child has to attend an immunization clinic are more likely to bring them on time and have their child's immunization series completed. Results show some improvement in caregiver's knowledge.
• Correct answer	26% (28/108)	58% (58/100)	
12. Did the health worker speak about family planning with you today	14% (15/109)	32% (32/100)	Counseling on child spacing could occur any day. This includes visits to antenatal care clinics, immunization sessions and sick child visit. It is encouraging to see that counseling has started to occur in this regard.
13. Are you pregnant now?	14% (15/108)	9% (9/100)	
14. Do you want to have another child in the next 2 years (NO)	61% (57/108)	68% (68/100)	
15. Are you using FP methods now? (YES)	12% (7/57)	18% (18/100)	

Attachment C.
Evaluation Team Members and Their Titles

1. Barbara Parker, Independent consultant, PhD
2. Tariq Ihsan, Senior Program Manager/Health, MD, MPH
3. Kathryn Bolles, Child Survival Specialist, MPH
4. Lynn Robson, Program Manager
5. Honey Mukhtar, Health Manager, MD
6. Abdul Sartar Sharifi, Child Survival Coordinator, MD
7. Rahmatullah Kolal, EPI Senior Officer, MD
8. Mina Niazi, Reproductive Health Senior Officer, OB/GYN
9. Mohammed Latif Olugh Zada, Behavior Change Senior Officer, MD
10. Abdul Nasir Azizi, Provincial Office of Health, IMCI Officer, MD
11. Abdulla Ghafoor Ahadi, Provincial Office of Health, Control of Communicable Diseases Officer, MD
12. Mohammed Yasin Hamrah, Provincial Office of Health, EPI Officer, MD
13. Noosheen Shahab, Provincial Office of Health, Reproductive Health Officer, OB/GYN
14. Mohammed Anwar Rasoli, Provincial Office of Health, HMIS Officer, MD

Attachment D.
Evaluation Assessment Methodology

The Team: The MTE team consisted of 14 persons: an independent consultant team leader, the Senior Health Advisor from SC/US in Kabul, a Child Survival Specialist based at SC/US headquarters, the Shiberghan Program Manager, the CS 19 Coordinator, the SC Health Officer (Shiberghan), the CS 19 EPI, IMCI, MNC and Nutrition/BCC Officers, the PHO point persons for EPI, IMCI, RH and HMIS. For some activities, they were joined by a representative of NGO partners STEP and/or MOVE. Some of the team members were committed full-time to the evaluation for a 15-day period (the core team), while others participated as needed.

Data Collection Methods: In preparation for the MTE, project staff carried out a structured observation of health workers' management of childhood illness, and analyzed the results of routine exit interviews with mothers leaving health facilities with sick children. This information was supplemented by the HMIS and by results of a 2005 LQAS survey that had been carried out by REACH/BPHS. The findings from these exercises were compared to baseline percentages derived from the KPC and Health Facilities Assessments, in order to develop a quantitative assessment of changes and improvements that have been made during the life of the project. The MTE team was able to utilize these comparisons to assess and report on progress towards objectives at the project's mid-point.

After a review of project documents and initial briefings with representatives of USAID, Tech-Serve and SSP (2 days), the core team traveled to the SC/US sub-office in Shiberghan. From Shiberghan, visits were made to 4 villages in Jawzjan province and 2 villages in the Andkhoy Cluster. The villages were selected so as to include the test sites for pilot activities such as PD/Hearth, CCM and support to Birth Preparedness Planning. In each village, team members visited health care facilities (BHCs and CHCs) to assess staffing levels, infrastructure, the drug supply, and cold chain maintenance; and to talk with doctors, nurses, vaccinators and midwives about any access, utilization or other problems the clinic might be facing. In the villages, team members conducted discussions with members of Community Health Councils (or Shuras), Community Health Workers, and groups of mothers/grandmothers who had benefited from the program. The goal of these discussions was to obtain community-level views of the effectiveness of the program, to carry out informal tests of beneficiaries' knowledge of key messages transmitted by CS 19, to identify any issues and constraints, and to elicit suggestions for strengthening and improving the project during its final two years. The team spent a total of 15 days in Shiberghan, then returned to Kabul for preparation of the report and de-briefing to USAID and key partners from Tech-Serve and SSP.

Attachment E.
List of Persons Contacted

USAID

Douglas Palmer, Senior Health Advisor
Dr. Mohammed Faiz, Population, Health and Nutrition Advisor

Service Support Project (SSP)

Hannah Gibson, Chief of Party

Tech-Serve

Dr. Mubrak Shah, Chief of Party
Dr. Mohammed Rashidi, Senior Technical Manager
William Newbrinder, Technical Director

Provincial Office of Health

Dr. Khemiya Azizi, Acting Provincial Health Director
Dr. Hassan Naseem Hajeer, Deputy Director PHO
Dr. Abdu Nasir Azizi, IMCI Officer
Dr. Abdulla Gafu Ahadi, Community and District Officer
Dr. Mohammed Yasin Hamrah, EPI Officer
Dr. Noosheen Shahab, Reproductive Health Officer
Dr. Mohammed Anwar Rasoli, HMIS Officer

NGO Partners: STEP and MOVE (sub-grantee to STEP)

Community Development Officer, STEP
Project Manager, MOVE
Reproductive Health Officer, STEP
Dr. Fahim, Provincial Project Manager for Health, MOVE
Dr. Hossain, STEP

Community-level Key Informant Interviews, Focus Group Discussions, and Clinic (BHC, CHC) Staff Interviews

Doctors, Nurses, Midwives and Vaccinators from BHCs and CHCs in Jawzjan province and the Andkhoy Cluster
Community Health Council Focus Groups (male and female)
Community Health Workers, and CHW supervisors
Community Midwife Education staff and PPH program staff (to discuss synergies with CS-19)

Attachment F.
CD with Electronic Copy

Attachment G.1. Sample of Monthly Reporting Form, Balkh/Jawzjan Program

Month: February 2006 **First Week**
From: 1st - 7th **Date Submitted: February 06**

Activities	Objective	Expected Output	Achievements
Cooperation with other Maternal and Child health programs	Increased access to essential MCH services in Jawzjan	Reduced maternity death due to Post Partum Hemorrhage (PPH) in targeted areas	Health Manager along with CS-19 MNC and BCC Sr. Officers attended a 3-day CHW TOT workshop in Kabul which was conducted by ACCESS for PPH program.
Support to REACH/BPHS	Increased quality of essential MCH services	All health centers will manage childhood illnesses through IMCI program	CS-19 IMCI Senior Officer developed IMCI IEC materials for Qarqin and Khamyab health centers.
Joint monitoring and distribution of EPI graphs	Increased quality and use of essential MCH services in Jawzjan	35% of children aged 12-23 months will receive BCG, DPT3, OPV3, and Measles vaccines before first birthday	CS-19 EPI Officer carried out a joint monitoring to Jangal Aregh and Murdian EPI centers and provided them the EPI new IEC materials and graphs.
Security: The over all security situation was good.			
Issues/Obstacles (and how they will be handled):			

Save the Children (USA), Balkh/Jawzjan Program

Month: February 2006 **Second Week**
From: 8th-14th **Date Submitted: February 06**

Activities	Objective	Expected Output	Achievements
Support to NIDs	Increased access to essential MCH services in Jawzjan	All children under 5 will receive polio vaccine during NIDs	CS-19 EPI Senior Officer attended the NIDs TOT workshop in Mazar for two days. Then he trained NIDs coordinators and supervisors for Khwaja du Koh, Aqcha and Shiberghan districts.
Support to REACH/BPHS	Increased quality of essential MCH services	All health centers will manage childhood illnesses through IMCI program	CS-19 IMCI Senior Officer provided IMCI orientation for Qarqin and Khamyab health facility staff and MCH promoters.
Monitoring and supervision of Andkhoy and Khwaja du koh health facilities.	Increased quality of essential MCH services and increased access to essential MCH services in Jawzjan	MCH promoters supervise CHWs and are conducting birth planning sessions with pregnant mothers	CS19 MNC officer supervised the midwives and RH assistants in Andkhoy and Khwaja du Koh health facilities and provided them on the job training on birth planning counseling.
Security: The over all security situation was good.			
Issues/Obstacles (and how they will be handled):			

[

Save the Children (USA), Balkh/Jawzjan Program

Month: February 2006 **Third Week**
From: 15th - 21st **Date Submitted: February 06**

Activities	Objective	Expected Output	Achievements
Joint monitoring to Qarqin and Khamyab EPI centers.	Increased quality and use of essential MCH services in Jawzjan	35% of children aged 12-23 months will receive BCG, DPT3, OPV3, and Measles vaccines before first birthday	CS-19 EPI Senior Officer carried out these supervisions/monitorings along with MoPH staff. He trained NIDs coordinators and supervisors for Qarqin and Khamyab districts. The officer also provided the developed EPI IEC materials and EPI graphs to the health facilities.
Support to NIDs	Increased access to essential MCH services in Jawzjan	All children under 5 will receive polio vaccine during NIDs	CS-19 EPI Senior Officer trained NIDs coordinators and supervisors for Mengajik, Murdyan, Bala Murdyan, Faizabad and Khan Aqa districts.
Birth planning training	Increased quality and use of essential MCH services in Jawzjan	Most deliveries will take place in health centers, pregnant women will know danger signs of pregnancy and preparedness plan for delivery	CS-19 MNC Senior. Officer and four MCH Promoters conducted birth planning training for 11 CHWs in Afghan Tapa and Cheghchi villages for 5 days.
Issues/Obstacles (and how they will be handled):			

Save the Children (USA), Balkh / Jawzjan Program

Month: February 2006 **Fourth Week**

From: 22nd - 31st **Date Submitted: February 06**

Activities	Objective	Expected Output	Achievements
Support to REACH/BPHS	Increased quality of essential MCH services	All health centers will manage childhood illnesses through IMCI program	CS-19 IMCI Senior Officer provided IMCI orientation for Andkhoy district hospital staff.
Support to NIDs	Increased access to essential MCH services in Jawzjan	All children under 5 will receive polio vaccine during NIDs	CS-19 EPI Senior Officer trained NIDs coordinators and supervisors for Andkhoy and monitored the training process in Qaramqol and Qurghan districts.
Security: The over all security situation was good.			
Issues/Obstacles (and how they will be handled):			

Save the Children (USA), Balkh/Jawzjan Program

PLANNED ACTIVITIES: March 06

1	Joint Monitoring and supervision with MoPH
2	Preparing for and attending PHCC meeting
3	Coordinate with and support MoPH on emergency outbreaks
4	Conduct CHW TOT training for new PPH staff
5	Preparation for MTE
6	Expand IMCI training to three more health facilities

Attachment G.2.
Observations of RH/Assistants/Midwives Performance 2004 to 2006

Observation[1]	Percentage		
	AUG 2004 (n=22)	AUG 2005 (n=20)	MAY 2006 (n=20)
Antenatal Care			
1- Two-way communication with pregnant women	60 %	80%	100%
2- Ask about family history and previous deliveries?	66 %	74%	83%
3- Check blood pressure correctly	60%	74%	90%
4- Take weight of pregnant women correctly	80%	83%	100%
5- Looking for edema and anemia	76%	82%	86%
6- Provide iron and folic acid	60%	93%	100%
7- Health education about following things:			
➢ Importance of antenatal care ……...	60%	73%	77%
➢ Nutrition …….	85%	71%	85%
➢ Danger signs (pregnancy, delivery and postpartum)	50%	56%	69%
➢ TT vaccine…….	70%	90%	90%
➢ Saving money for emergency obstetric care……	60%	78%	85%
➢ Importance of booking skilled birth attendant…..	14%	43%	66%
➢ Post partum care. …….	60%	60%	63%
➢ Danger signs after delivery……	70%	63%	90%
➢ Vitamin A and folic acid ……	85%	90%	100%
➢ Educate about newborn care…….	57%	56%	67%
Newborn Care			
1- Give BCG to newborn babies	32%	65%	75%
2- Register newborns for GMP	55%	55%	63%
3- Danger signs among newborns (educate)	55%	66%	76%
8-Familiy planning ;			
➢ Take family history……..	70%	83%	90%
➢ Educate about methods of contraceptive …	10%	30%	73%

[1] Observations carried out jointly by CS19 MNC Officer and MOPH RH Officer in 2004, 2005 and 2006

Attachment G.3.
Maternal & Newborn Care Trainings, 2004-2006

No	Date	Type of training	Participants	Name of trainers
1	August 2004	10-day Orientation to Maternal & Newborn Care	7 RH Assistants (BPHS) 5 CS19 MCH Promoter 2 CS19 Midwives	CS19 MNC Officer
2	September 2005	10-day Orientation to Maternal & Newborn Care	3 Doctors (BPHS) 6 Midwifes (BPHS) 5MCH Promoter (BPHS) 1 RH assistants (BPHS)	CS19 MNC Officer CS19 BCC Officer MOPH RH Officer
3	September 2005	5-day Family planning Methods and Client Counseling	8 Doctors (BPHS) 1 Midwife (BPHS)	CS19 MNC Officer MOPH Obstetrician CME Instructor
4	May 2005	3-day Safe motherhood concept - MNC	6 Doctors 6 Midwives	CS19 MNC Officer CME Instructor
5	May 2005	3-day orientation to Birth preparedness	22 CME Students	CS19 MNC Officer CME Instructor
6	July 2005	3-day orientation to Birth preparedness and Community mobilization	10 Female CHC/Shura members	CS19 MNC Officer BPHS Trainer
7	July 2005	3-day orientation to Birth preparedness and Community mobilization	8 Female CHC/Shura members	CS19 MNC Officer BPHS Trainer
8	July 2005	3-day orientation to Birth preparedness and Community mobilization	11 Female CHC/Shura members	CS19 MNC Officer BPHS Trainer
9	September 2005	3-day orientation to Birth preparedness and Community mobilization	12 Female CHC/Shura members	CS19 MNC Officer BPHS Trainer
10	March 2005	3-day refresher on MNC	1 Doctors (BPHS) 8 Midwifes (BPHS) 5 CS19 MCH promoters	CS19 MNC Officer MOPH RH Officer
11	March 2005	3-day refresher on MNC	4 CS19 MCH promoters 5 RH assistants (BPHS)	CS19 MNC Officer
12	March 2005	3-day Family planning Methods and Client Counseling refresher	1 Doctors (BPHS) 8 Midwifes (BPHS) 5 CS19 MCH promoters	CS19 MNC Officer MOPH RH Officer

No	Date	Type of training	Participants	Name of trainers
13	March 2005	3-day Family planning Methods and Client Counseling refresher	4 CS19 MCH promoters 5 RH assistants (BPHS)	CS19 MNC Officer
14	May 2006	3-day Orientation on Reproductive Health (National Guidelines)	8 Doctors (BPHS) 7 Midwifes (BPHS)	CS19 MNC Officer MOPH RH Officer
15	March 2006	3-day Orientation to Prevention of Postpartum Hemorrhage (ACCESS/PPPH project)	6 PPPH staff 3 Doctors (BPHS) 2 Midwifes (BPHS) 2 pharmacists (BPHS) 4 CS19 MCH Promoters	CS19 MNC Officer Program Manager Health
16	March 2006	3-day Orientation to Prevention of Postpartum Hemorrhage (ACCESS/PPPH project)	6 PPPH staff 4 CS19 MCH Promoters	CS19 MNC Officer Program Manager Health
17	May 2006	3-day Orientation to Prevention of Postpartum Hemorrhage (ACCESS/PPPH project)	22 Community Health Workers	CS19 MNC Officer PPPH Trainer
18	April 2006	3-day Orientation to Prevention of Postpartum Hemorrhage (ACCESS/PPPH project)	12 Community Health Workers	CS19 MNC Officer PPPH Trainer
19	February 2006	2-day orientation to Birth preparedness and Community mobilization	7 Community Health Workers	CS19 MNC Officer CS19 MCH Promoter
20	February 2006	2-day orientation to Birth preparedness and Community mobilization	4 Community Health Workers	CS19 MNC Officer CS19 MCH Promoter
21	June 2006	1-day Orientation to BPHS	22 Newly graduated Midwives	CS19 MNC Officer

Attachment H.
Updated Child Survival and Health Grants Program Project Summary
Oct-11-2006

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:	James L. Griffin

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. Honey Mukhtar
Address:	Shibergan
Phone:	009379370891
E-mail:	HMukhtar@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 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 (Int'l./US)
Local NGO
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 Management/Counseling

Maternal & Newborn Care (30%)
(IMCI Integration)
(CHW Training)
(HF Training)
- Emergency Obstetric Care
- Neonatal Tetanus
- Recognition 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)

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

Rapid Catch Indicators:

Indicator	**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)	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months that 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
0 0 0.0% 0.0

Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child
0 0 0.0% 0.0

Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours
0 0 0.0% 0.0

Percentage of infants age 6-9 months receiving breast milk and complementary foods
0 0 0.0% 0.0

Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday
0 0 0.0% 0.0

Percentage of children age 12-23 months who received a measles vaccine
0 0 0.0% 0.0

Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)
0 0 0.0% 0.0

Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment
0 0 0.0% 0.0

Percentage of sick children age 0-23 months that received increased fluids and continued feeding during an illness in the past two weeks
0 0 0.0% 0.0

Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection
0 0 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
0 0 0.0% 0.0

Comments for Rapid Catch Indicators
We have used the following formula to calculate the Confidence Limits: P = p + Z x 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%.”

Attachment I.

MEMORANDUM OF UNDERSTANDING

"DRAFT"
Between

Jawzjan Provincial Public Health Office

STEP and MOVE
and
Save the Children Federation, Inc. (SC/USA)

Purpose:
This memorandum of understanding (MoU) outlines the coordination of program activities between the Jawzjan Province Public Health Office (PHO), STEP and MOVE, and Save the Children Federation, Inc. (SC/USA), both working in Jawzjan Province to ensure the service delivery and quality of the Basic Package of Health Services (BPHS). The parties to this MoU agree to seek to improve health services in the province through the goals of BPHS.

Project Collaboration:
Projects implemented by the PHO, STEP and MOVE, and SC/USA each have several components, in the same geographical areas. In signing this MoU, all three entities seek to improve their coordination of these activities. The three parties agree to ensure that project activities promote the quality of the BPHS in Jawzjan province. The parties acknowledge the role of the community councils supporting Health Posts (HP) and Health Facilities (HF).

The MOU goes into effect upon its signing and is valid until either party indicates in writing that it is no longer so.

For Jawzjan Provincial Public Health Office	**For *STEP and MOVE***	**For Save the Children Federation, Inc. (SC/USA)**
_____	_____	_____
Dr Abdul Ali Halim, Jawzjan Provincial Public Health Minister	Dr. Abdul Latif Rashed, Programme Coordinator	Leslie F. Wilson, Country Director
DATE: _____	DATE: _____	DATE: _____

Terms of Reference for the MOU between STEP and MOVE and SC/USA:

HMIS			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Lead	Provide logistics	Provide trainer and training materials	Location: 8 new health facilities Shiberghan District
RH(ANC, PNC, Birth preparedness, infection prevention and Family Planning)			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Lead	Identify potential participants and logistics	Technical support by providing trainer, and training materials	TOT for MoPH, STEP/Move key staff
IMCI(General child assessment, GMP, ARI)			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Lead	Identify potential participants and logistics	Technical support by providing trainer, and training materials	Heads of Jawzjan province health facilities (23)
EPI (New Vaccinators and refresher)			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Lead	Identify potential participants and logistics	Technical support by providing trainer, and training materials	Heads of Jawzjan province health facilities (23)
BCC and IPCC Trainings			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Identify potential participants	Identify potential participants	Lead	TOT for MoPH, STEP and Move key staff
Involve CHWs in Community Health Activities			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Support/facilitate CHWs involvement in new programs	Support/facilitate CHWs involvement in new programs	Support and involve CHWs in PD-Hearth districts	
Support NIDs/ Campaigns			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Lead	Identify NID Volunteers, Supervisors and Coordinators with MoPH, participate in micro plan development	Develop micro plan with partners, train NID Coordinators and Supervisors, take part in monitoring	
Joint Supervision with MoPH, STEP and MOVE (on-the-job trainings)			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Coordination with partners	Lead	Coordinate with MoPH and STEP/Move	
Innovations: PD/Hearth, PDQ, CCM, PPPH (STEP, MOVE and MoPH to observe and provide input)			
MoPH	**STEP/Move**	**SC-USA**	**Remarks**
Coordinate with all partners and take responsibilities	Coordinate with SC-USA to better use opportunities	1- Plan partner involvement at the provincial level, community and health facility staff in pilot area demonstrations, field supervision, data management	1-Partnership Development Quality (PDQ)

		and analysis 2- Lead national advocacy with provincial partners	2- Develop documentation of innovations and review and refine tools: PD Hearth, Community Case Management and PPPH

Attachment J.
Basic Counseling Skills, Training of Trainers Agenda
Save the Children/US, CS-19, Jawzjan, Afghanistan

Day 1:

Time	Module/Lesson	Methodology/comments
8:30-8:40am	Introduction	Matching pairs and introducing each other
8:40-9:00am	***Warming up-Session. Difference between counseling and health education.*** What is the difference between health education and counseling	Role plays Brain storming/jot it on flip chart Summarize (use flipchart)
9 – 9:10am	***Objectives of this workshop*** • 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	***Five rules of an effective communication*** Activity 1: 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	What are 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	TEA BREAK	
11:00-11:30am	Activity 2: 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	Activity 3: • 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	Activity 4: 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" • Comfortable setting-no distraction • Focus on listener's needs or interests • Be brief – do not give too much information • Use words that are familiar to listener • Use two way communication	Use flip chart/or multimedia Ask questions: • In the health facilities does counseling usually take place in a comfortable setting? • Do Health workers usually use simple language? • Is communication between a doctor and a patient or caretaker really a two-way?

Time	Module/Lesson	Methodology/comments
1:30-2:15pm	***Overcoming barriers to Communication during counseling*** Activity 1: Similarities often help in effective communication What are the differences and similarities between caretakers and health providers? Activity 2: - 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?	Two group discussions (not more than 10 minutes) Group1: Think of words and phrases that best describe the caretakers who come to their health facilities. Group2: Think of words and phrases that best describe the health workers such as the participants in this training. -Use flip charts and list all differences -Use flip chart and list all similarities -Give examples of how similarities could be used to influence an effective counseling. (roles plays)
2:15-2:30pm	Pearls of Wisdom (what have we learned new since morning) Quiz!!!	Prepare quiz (not more than 5 minutes) Conduct quiz (not more than 10 minutes)
2:30-4:00pm	***Reinforcing positive beliefs and practices to influence counseling*** Activity 1: Discuss traditional beliefs and practices regarding pneumonia that are common in your communities/target areas. Identifying beliefs and practices that are helpful, harmful and neutral Feedback by each group (5 minute each)	Two group discussions (not more than 10 minutes). Group 1: lists all harmful practices related with pneumonia Group2: lists all useful practices related with pneumonia Group 3: lists all 'neutral' practices related with pneumonia.
4:00-4:30pm	- Ask "How can we reinforce helpful beliefs and practices in our work and during counseling? - How can we help to change the harmful ones? - What should we do for the neutral ones? - Are there any medical beliefs or practices that go against local traditions – how can these be changed to be more acceptable to people?	Take feedback on the flip charts Summary
4:30-5:00pm	***Reinforcing positive beliefs and attitudes to influence counseling*** Statements of beliefs and attitudes of health workers (Key questions – after gallery walk) - Did everyone in the group have the same beliefs and attitudes? Why some had different beliefs and attitudes than others? - 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? 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)?	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. Brainstorm Use news print – summarize with written news print

Day 2

Time	Module	Method
9:00-9:15am	***Warm up session.***	
9:15-9:25am	***Use of appropriate emotions, tone of voice and the art of praising & encouragement*** *Activity 1 (tone of voice)* Guessing emotions (Tone of voice) What tone of voice would you prefer when you go somewhere for help? What tones of voice do you hear most often in health facilities? What messages do they convey to patients?	Five volunteers expressing emotions written on the slips they take out of the box Feedback on the News Print
9:25-10:00am 10:00-10:10am	*Activity 2: (Use of appropriate body language)* • What body language did people note in the role plays? • Which ones were appropriate and which ones inappropriate? • How does this influence counseling sessions? List culturally appropriate and inappropriate body language (local)	Two Role plays (appropriate and inappropriate body language List feedback on the flipcharts
10:10-10:30am	*TEA BREAK*	
10:30-10:15am 10:15-10:45am	*Activity 3 (praise and encouragement)* * What is the meaning of praise? What does praise mean when working with clients or patients in health facilities? * What is the meaning of encouragement? What does encouragement mean when working with clients or patients in the health Facilities? Practice praising and encouraging initial responses. Ask: Was it difficult to find something nice to say? How do you think this will make patients feel? ***How would this influence your communications and counseling?***	Brain storm and take feedback on the flip-chart. Read out the statements and ask participants to respond.
10:45-11:00am	***Asking The Right Questions during counseling*** Activity 1: Types of questions: - Closed ended - Open ended - Paraphrasing questions - Reflecting questions	Brain storm/news print Jot down new questions on fresh news print.

Time	Module	Method
	- Probing questions	
11:00-12:00Nn	Activity 2: "What are some of the questions that you ask a caretaker who brings a sick child into your health center or clinic? Presentation by groups (not more than 5 minutes) 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? Summarize	Two group discussions: (10 minutes) Group 1: ARI case and role play questions Group2 : Breastfeeding problems and role play questions Presentation by groups
12:00-12:30pm	***Visual aids and other methods that can make counseling effective*** Activity 1: Group discussions & presentations: 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	Group 1: Role Play using an ARI home care flip chart. Group 2: Role play using demonstration as a 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.
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 2:45-3:15pm 3:15-3:45pm	Develop the "counselor contract" Developing the checklist for assessing counseling areas. Presentation on the "counselor contract and discussions" Presentation on the "counseling checklist"	Two groups

Day 3

Time	Module	Method
9:00-9:15am	Feedback	
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	Review ARI and CDD guidelines Presentation on ARI guidelines Presentation on CDD guidelines	
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	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).	Presentation
2:15-3:00am	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	Zarmeenas' case scenario. Focusing feeding problems.	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