



Save the Children®

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

Cost Extension of
Cooperative Agreement No.: FAO-A-00-98-00022-00
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Panjikent and Aini Districts of Sugdh Region

**CS-18 Tajikistan
Fourth Year Annual Report**

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ACRONYMS AND TERMS

ACNM	American College of Nurse-Midwives
A/N	Antenatal
ANC	Antenatal Care
APO	Assistant Project Officer
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
CAFO	Central Asian Field Office of Save the Children/US
CDD	Control of Diarrheal Diseases
C-IMCI	Community-Integrated Management of Childhood Illness
CS	Child Survival
CS-14	“Panjikent Partners,” the previous CS project in Tajikistan, which ended in September 2002, of which CS-18 is a cost extension.
CS-18	The cost extension of CS-14, funded in large part through the 18 th cycle of the PVO CSH Grants Program, which began in October 2002, is referred to as “CS-18” throughout this document to distinguish it from the previous “CS-14” grant, and for the sake of brevity.
CTC	Child-to-Child (health education)
DD	Diarrheal Disease
CPD	Country Program Director
CDH	Central District Hospital (of the MOH)
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization (MOH program and/or CS-14/-18 intervention supporting MOH immunization activities)
ETF	Emergency Transport Fund
<i>Feldsher</i>	MOH Health technicians with approximately four years of medical training
FFW	Food-for-Work
CD	Country Director
GMP	Growth Monitoring Promotion
HE	Health Education
HF	Health Facility

HFF	Health Facility Farm
HIS	Health Information System
HM	Health Monitor
<i>Hukumat</i>	District Level Government
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
<i>Jamoats</i>	Government authorities
KPC	Knowledge, Practices, and Coverage (survey)
LOP	Life of the Project
LSS	Life-Saving Skills (for maternal and newborn care)
MCH	Maternal and Child Health
MIL	Mothers-in-Law
MIS	Management Information System
MNC	Maternal and Newborn Care (CS-18 intervention)
MOH	Ministry of Health
NERS	Nutrition Education and Rehabilitation Sessions
NIDS	National Immunization Days
OH	Office of Health of Save the Children
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
Pactors	VHF communication and mailing system
PD	Positive Deviance
PD/H	Positive Deviance/Hearth
PDI	Positive Deviance Inquiry
PLG	Program Learning Group (of SC's Office of Health)
PM	Program Manager
PNC	Prenatal Care
PO	Project Officer
<i>Prikaz</i>	An official order issued within the government system.

PVO	Private Voluntary Organization
RDF	Revolving Drug Fund
RH	Reproductive Health
RHA	Regional Health Advisor (of Save the Children)
SC	Save the Children Federation/USA
SHM	Senior Health Monitor
SMT	Senior Management Team
SUB	MOH Rural Hospital (with 40 to 80 beds, staffed with pediatricians, gynecologists, and other specialists)
TA	Technical Assistance
TOT	Training-of-Trainers
TTBA	Trained Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
VDC	Village Development Committee (called Village Health Committee in CS-14)
VHF	Village Health Facility
VP	Village Pharmacy
WHO	World Health Organization
WRA	Women of Reproductive Age

A. ACCOMPLISHMENTS OF THE PROGRAM

Many significant events took place in Year 4 of the Child Survival 18 Project. Activities were started in Panjikent and Aini districts, which are geographically isolated and difficult to access. Many villages in these districts lack a health facility or trained health workers.

Districts	# Villages	CS-14 villages	CS-18 villages	1 st year, # (villages with project activities)	2- 3 rd year, # of CS-18	4 th year, CS-18	Remaining
Panjikent	143	73	70	16	20	34	0
Aini	61	0	61	0	45	16	0
Total	204*	73	131	16	65	50	0

* Total number of villages served is more than the original target of 201 villages mentioned in the project proposal

By the end of the reporting year, project activities were underway in all remaining (50 villages) throughout Panjikent and Aini, with the project achieving 100% coverage in target villages.

The on-site, full time Project Management position, based in Panjikent, has been shifted from an expatriate position to a national position as per project design. Dr. Gulchehra Boboeva was promoted from Project Officer to Project Manager.

Based on the recommendations of the mid-term evaluation (MTE) report, management of 73 program villages from the CS-14 program was transferred in a phased manner to the Ministry of Health (MOH) for continuation of project activities. A phase-out plan was developed and implemented jointly with representatives of district MOH to include trainings, monitoring, supervision and documentation. Project staff assisted MOH in assuming the new role and responsibilities associated with program management. An official prikaz was issued by the district MOH to health staff making them aware of their new responsibilities for the project activities in the phased-out villages. The info in the following table is from MOH sources.

MOH Activities in the Phased-out Villages (CS-14 villages)

According to the monitoring formats, in 73 villages MOH conducted the following activities:

- ARI/CDD/EPI - Number of health education sessions conducted by MOH staff
- Health education sessions of ARI to 3270 WRA, CDD for 3640 WRA, Immunization for 4517 WRA, MNC for 4422 WRA, BP for 1970 pregnant women and 581 family members, Exclusive breastfeeding for 2303 WRA, importance of iodated salt for 824 community members.
- BLSS
- MOH (Zonal gynecologists) visited 31 villages of CS-14 program for monitoring purposes to check activities of 31 BLSS-trained midwives. Results:
 - ANC - 790 visits
 - PNC - 399 visits
 - Newborn care - 392 cases
 - Delivery by BLSS-trained birth attendant - 373 cases
- Also monitoring re BP conducted with women of postnatal period and results achieved as follows:
 - Women during pregnancy received ANC=100%
 - Home deliveries =59% (from this 80% of deliveries taken by BLSS-trained staff)
 - Delivery at HF=40%
 - Women taken iron tablets during pregnancy=97%
 - Women during their pregnancy made birth plans jointly with family members=84%

VDC members jointly with health workers carried out tests in 47 villages (CS-14) for availability of iodine in salt samples. Results of tests are: VDC collected 499 samples from HH in the community; according to on spot test results,
27% - samples are non-iodized salt
73% - samples are iodized salt

Salt samples tested in 29 shops located in 21 villages. Results:

6% - selling non-iodized salt
94% - selling iodized salt

GMP

In 7 villages (CS-14) weight of 326 children under 2 years was checked and it was identified that 37% of children are malnourished.

Director EPI Center visited 25 villages (CS-14) for monitoring activities of 24 health workers.

The project has established a good rapport with both district and central Ministry of Health. As a result of the recommendation from the MTE team last year, a memorandum of understanding (MOU) was signed with Save the Children for the implementation of CS-18. There is considerable ownership of CS-18 by the district level ministry of health staff. The chief doctors of Panjikent and Aini keep their regional and central MOH supervisors informed about the benefits of the project and the assistance they are receiving.

Community involvement

Village development committees (VDC) were selected in 50 new villages and received training in community mobilization and on other health topics related to mother and child healthcare. VDC members are now actively involved in supporting community based project activities. In order to gain a better understanding of the CS-18 program, 9 VDC members and 5 MOH staff from 5 of the new CS-18 villages visited several established CS-18 villages.

Follow up on the Recommendations of the MTE

EPI

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

Actions Taken

All recommendations from the MTE have been fulfilled regarding EPI. Vaccines are transported within the districts via the district MOH vehicle equipped with cold boxes, although occasionally funds for fuel are limited. The larger concern is the vaccine transfer from the regional warehouse in Khujand to the program districts. Khujand is approximately an 8 hour drive on mountainous track over the 9000 feet high Shahrstan pass and may be snow-bound during winter for a period of days or weeks.

MNC

4. The project should monitor the percentage of deliveries to MOH facilities as a measure of the effectiveness of the birth plans and emergency transportation funds.
5. To the extent possible, the project should support additional VDCs to develop their own emergency transportation funds, giving preference to VDCs that express an interest and are located in the more isolated rural communities that are becoming involved in CS-18 later during the life of the project.

Project Actions

Data collected from exit interviews with postnatal women suggest that a higher proportion of deliveries still take place in the home, although they are now more often attended by a BLSS trained MOH staff. The figures from hospital sources are not reliable, since even home deliveries have to be recorded as hospital deliveries, because of official *prikaż* that stipulates that a delivery should only take place in a health facility.

During the reporting period, Emergency Transport Fund (ETF) was established in 42 villages. Sessions on birth planning were conducted with 2691 pregnant women and 2080 of their family members in 70 villages of Panjikent and 61 villages of Aini districts.

Nutrition and Micronutrients

6. The project should work with the VDCs to educate them on the value and importance of exclusive breastfeeding, so the VDCs can identify ways the community can provide a supportive environment for mothers of children under-six months of age to breastfeed exclusively.
7. The project should consider scaling up the PD/Hearth strategy to involve additional communities that are experiencing higher rates of childhood malnutrition.

Project Actions – Exclusive Breastfeeding

In spite of an apparently high awareness level of mothers and the community on the importance of exclusive breast-feeding (EBF), the MTE LQAS survey showed the under achievement of the EBF indicator. The most plausible reason identified during a focus group discussion was that mothers often must leave their babies at home when they go to work in the fields, a common activity among the area population. The project attempted to address the problem by adopting a multi-pronged approach. The VDC received additional training on the importance of EBF. They were then assigned to track children less than six months of age by listing all children under 6 months in their respective communities and conducting follow-up visits to see how BF was done.

In recognition of the role that mothers-in-law (MIL) traditionally play in the care of children, MOH staff now counsel MILs to support lactating mothers by advising them to breastfeed their babies before leaving for the fields and to return early to feed the child again. Mothers were also encouraged to express their milk in a clean vessel that is kept in a cool place at home. The MIL or caregiver can re-warm the expressed milk by placing the vessel in a bowl of hot water and feeding the child with a spoon. Household members were also advised to take the child to the mother working in the field for breast-feeding whenever possible.

Growth Monitoring Program, PD/Hearth and Malnutrition

GM coverage was increased to include 57 new villages of Panjikent and 48 villages of Aini district. In Panjikent, during the first GMP cycle in 57 villages, 89% (n=1927) of children under 2 years of age were weighed (out of 2170 total) and the malnutrition rate observed was 27% (n=517). 483 children (25%) suffered mild malnutrition while 2% were moderate/severely malnourished. Similarly

in Aini, 93% children (out of total 2805 children less than 2 years age) in 48 villages were enrolled in the GM program. 750 (29%) of the children were found to be malnourished (684 children (26%) suffered mild malnutrition and 3% were moderate/severely malnourished). VDC members, health workers and volunteers were trained to weigh children using Salter's scales and to plot the weight on a growth-monitoring card. In addition, health staff and VDC members were trained to analyze findings and counsel mothers/care givers on nutrition management of malnourished children. The CS-18 project has successfully piloted the Positive Deviance Hearth (PDI/Hearth) approach to rehabilitate malnourish children through nutritional education and rehabilitation sessions (NERS) in the pilot villages. With an expanded GMP, the hearth model is now replicated in 6 new villages of Panjikent and 6 new villages of Aini (total villages with PD/Hearth experience about 16 in both districts). During PD/Hearth NERS sessions, mothers of malnourished children received training on how to prepare nutritious food from locally available food edible items. Also, mothers received trainings ARI, CDD and Immunization. PD/Hearth activities are done jointly with VDC members, health workers and volunteers. Save the Children provided 210 scales from the USDA project to 143 villages of Panjikent district and 61 villages of Aini district .

Iron Tablets

8. Proper counseling on side effects of iron supplementation needs to be stressed in the MOH health worker training curriculum and supervisory checklists.
9. The national treatment guidelines and international standards regarding Iron supplementation need to be reviewed together with the MOH district offices and the MOH training curriculum and supervisory checklist need to be adapted as needed.

Project Actions

Counseling of women on iron supplementation was reemphasized in BLSS training, with special attention to the side effects and ways to minimize side effects. Though the national level protocol on iron supplementation still remains only for prophylaxis of anemia (2 tablets/week), the chief gynecologist of Panjikent revised the protocol for the district to the BLSS advocated regimen (2 tablets/day) after her BLSS training. Aini has had the new regimen in place since the beginning of the project.

CTC

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

Project Actions

Child-to-Child Education program was successfully expanded to 11 new schools in Panjikent district and 9 schools of Aini. 305 new students from higher grade levels were trained as the CTC trainers. The CTC Health Monitor made follow-up visits to 68 schools to conduct health education sessions. Students trained in these sessions are expected to disseminate health messages to the members of their own families, community and other children.

After meeting with the District Chiefs of Education, CTC champions were identified in each district as per recommendations of the MTE. The deputy of the chief of education in both districts will ensure sustainability of CTC program. They are already involved in the development of CTC phase-out strategy for the project.

RDF

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

Realizing the gravity of operating RDF in an increasingly restrictive legal/political environment, SC developed an exit strategy with key stakeholders, MOH, village pharmacists and VDC members. SC phased-out all village pharmacies by withdrawing drugs from those pharmacies. The medicine stock was handed over to the MOH for free of cost dispensing. Village pharmacists, who have the requisite qualification and can obtain a license, were encouraged to start their own private businesses. SC will determine the best use of the RDF funds in the project account.

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

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

Reviewed and refined health education strategies for MILs and other caregivers and developed interactive HE strategies. Incorporated interactive sessions within caregiver's counseling training. Incorporated interactive sessions with MIL and other caregivers on health education/BCC strategies (including those for promoting birth planning). The interactive engagement of community groups, especially mothers, mothers-in-law and husbands, on health topics exceeded the target by almost twice. Counseling is now an integral part of health workers' consultation with patients, which is also monitored by monitoring formats.

Joint monitoring visits of Save the Children staff and MOH staff were conducted on a regular basis and CS-18 activities were reviewed during these visits.

Factors that contributed to program accomplishments:

- Trained dedicated and experienced staff. The majority of CS-18 staff have work experience that dates back to CS-14 (1998-2002).
- A strong working relationship between the district level government (*bukumat*) and both district and central levels of MOH. After a long review process, an MOU was signed between Ministry of Health and Save the Children.
- A strong relationship between the VDCs and the communities based on mutual trust and goodwill.

- A fraternal relationship with other NGOs, including the other Child Survival project, also in Sugdh, implemented by Mercy Corps.
- Clear shared program plans developed through consultation with the community and MOH, who see themselves as part of the planning and implementation process.

B. FACTORS WHICH HAVE IMPEDED PROGRESS

- 1. During Year 4 of the CS-18 Project, the most distant and difficult to access villages were covered by the project. These villages are often inaccessible during the rainy season and winter, when roads are either blocked or too dangerous.**

Measures taken by the project: During the winter, only more accessible villages were targeted for project activities. From April onwards, project staff made visits to the remote villages. Some site visits required an overnight stay if a vehicle could not pass through the mountains and further travel was possible only on foot or donkeys/horses. Such villages were visited by a team of staff from SC and MOH, including the district health management, with a plan to complete all CS interventions (vaccination, ARI/CDD/M&NC etc.) at one time.

- 2. Villages included in Year 4 of the program often do not have health facilities and any health services are provided by a health worker who lives in nearby village and makes infrequent visits.**

Measures taken by the project: Health workers with low motivation have little incentive to serve people in distant and remote villages which may require hours of walking or use of limited transportation at a cost. With a joint MOH/SC visit, the MOH staff receives needed logistical and moral support to visit far flung villages, which they find difficult to travel to on their own.

- 3. High turnover of MOH staff due to seasonal or permanent migration to Russia affects the staffing in health facilities and the achievement of targets.**

Measures taken by the project: Low paid MOH workers choose to work as emigrant workers to support their families, rather to work with MOH. The majority of responsibilities for project implementation fall on project staff with assistance from VDCs. Project staff, jointly with MOH (CDH) and VDCs, work as organized teams to provide child vaccination in villages. Similar teams, in conjunction with the zonal gynecologist, carried out antenatal and postnatal care, conducted BP and MNC, and general HE sessions for WRA in rural areas.

- 4. As project expanded to cover all Aini district villages, staff in Aini were not sufficient to implement the project (only Asst PO and 2 Health Monitors for 61 villages).**

Measures taken by the project: During the planning workshop at the beginning of the year, the relative need for personnel was assessed against the planned target. Each district gets support whenever required. In the reporting period, one health monitor was shifted on a permanent basis to Aini to supplement that team.

- 5. Only one CTC Health Monitor for implementing the program in both districts until June 2006.**

Measures taken by the project: Recruitment of staff is a challenge in Panjikent but is especially challenging in Aini, where the remote and mountainous location and limited resources reduce the availability of qualified staff. One new health monitor has been recruited for CTC program in Aini.

C. TECHNICAL ASSISTANCE

The program received technical assistance (TA) from Save the Children country, regional and Home Office, when required. In the reporting period, Sr. Program Manager (Operations) backstopped this project from the Country Office. Technical, Administrative/Finance assistance from CACO/Dushanbe was received during visits of Sr. Program Manager (Operations), Central Asia Country Director, Country Program Director and Finance Director. No specific TA requirements foreseen in the last year of the project.

D. SUBSTANTIAL CHANGES FROM PROJECT DESCRIPTION

As part of the recommendations from the MTE, the following changes have been made in the program that may not require modification of the project agreement.

1. RDF activity phased-out because of new laws that would require all staff involved in the project, including Save the Children staff, to have a license for handling medicines.
2. Health facility farms strategy phased-out, as USDA commodities used in FFW activities were no longer part of the USDA project.

E. MONITORING PLAN

An activity work plan developed for the year is used to monitor progress against assigned tasks and quarterly reviews are conducted. In addition, project staff are in the process of reviewing monitoring formats, to make them more user friendly. (Please see the CS-18 work plan for years 4 and 5 following the narrative section of this report.)

F. SUSTAINABILITY

Project activities have strong sustainability since implementation is closely coordinated with the district MOH. Both MOH and the community regard project activities as highly beneficial for the health of mothers and children. The phasing-out of 73 villages to MOH and community management was a successful experience thus far. Almost all major activities continued, some with minor variations, but most importantly, MOH was able to receive timely activity reports from the health facilities. In the coming year, more villages are scheduled to be transferred to MOH management, and SC's role will be primarily to monitor program quality and coverage.

G. SPECIFIC INFORMATION REQUESTED

On the MTE report, the following remarks were received from Namita Agravat, Child Survival and Health Grants Programs Advisor, based in Washington DC, listed below with explanations from project staff.

1. ***Identify targets as EOP targets already achieved;*** The targets table remains largely unchanged as the project is undergoing a crucial phase. The most difficult to access villages, with little or no health services, will be covered by the project activities next year; however, the project villages will be progressively handed over to MOH for implementation of the program activities. We believe, the combined effect of these key factors, will bring down the seemingly overachieved indicators to within the target range set in the beginning of the project.

2. ***MOH permission to be taken for the implementation;*** MOU has been signed with MOH for the implementation of CS-18.
3. ***Support from the USAID Mission;*** In Tajikistan, the USAID Mission is aware of the CS-18 project. Dr Aziza Hamidova visited Panjikent during 2003 and is appreciative of the work done by Save the Children. During the MTE presentation in August 2005, Benjamin Mills, CTO of the USAID Regional Mission, made encouraging remarks after hearing the results and achievements of the project. Although much interaction with the local Mission revolves around the Healthy Family Project of Khatlon, because it is convenient for visitors, CS-18 is always mentioned during discussions. Verbal invitations to visit CS-18 project sites are usually extended and accepted, though at present there are no planned Mission visits to project sites of CS-18.
4. ***Update on IMCI training;*** IMCI training has been planned for Panjikent through a long, consultative process with UNICEF, Directorate of IMCI/MOH and Save the Children. Though not in the work plan of the MOH, project management was able to convince UNICEF and MOH that initial phase training for the health workers should be started this year, at least in Panjikent. The first IMCI training took place starting the second week of September, in which the PM CS also participated. The CS project will support Training of Trainers (ToT) since only limited funds are available in the budget.
5. ***CTC Champion and update on phase-out;*** CTC champions identified in both Panjikent and Aini, from within the Ministry of Education. The CTC champion is working closely with the project CTC trainer, and will work on the development of a plan to phase-in MOE.

I. PHASE-OUT

The project has already had a series of consultation meetings and workshops with MOH and VDCs to discuss and agree on phase-in and phase-out from the project to MOH/VDC. According to MTE recommendations, the oldest project villages were handed over to MOH/VDC this year. In the coming year, all other villages, except the newly started villages, will be handed over in phases. To date, the results from the hand-over villages are encouraging and hopefully MOH/VDC will be able to maintain the benefits of the project for a long time. Although this project was not designed to inform the health sector reform process, a future cycle of CS projects in the same geographic location could demonstrate impact at regional or sub-national scale to inform MOH programming.

L. PROGRAM MANAGEMENT SYSTEM

Describe the program's management system and discuss any factors that have positively or negatively impacted the overall management of the program since inception.

➤ Financial Management System

For CS-18, all financial and administrative procedures are compatible with SC's standard operating procedures and comply with USAID regulations. The Panjikent-based staff, including the Finance Officer and the Health PM, liaise with SC Country Office staff based in Dushanbe, including Finance and Operations Support staff and the Senior Program Manager Operations, on a regular basis to discuss current project requirements and program direction in budgeting and financing. Quarterly and annual budgets are developed in Panjikent, and submitted to the Finance Department in Dushanbe for approval.

Expenditures are recorded at the time of the expenditure and monthly finance reports are prepared by Panjikent staff. These reports are submitted to SC's Dushanbe Finance Department on a monthly basis, and are incorporated into the Field Office's monthly report to SC home office in Westport.

➤ **Human Resources**

SC staff based in Dushanbe:

Country Director, Director for Finance, Sr. Program Manager Operations (SC match for the Sr. Operations Manager only): Provide overall guidance and relations with MOH, USAID Mission, and other organizations.

Finance Manager (10%): Responsible for fiscal oversight and financial reporting in compliance with grant policies and procedures.

Admin. Manager and Admin. Assistant (10% each): Responsible for administrative oversight in compliance with grant policies and procedures.

SC Health Program Manager (25%): Responsible for technical content of training and services, and staff training.

SC staff based in Panjikent and Aini Districts:

SC Health Program Manager (95%): Responsible for technical content of training and services, staff training and supervision.

CS Project Officer (100%): Responsible for overall on-sight management, assisting the PM with the overall planning and implementation of CS-18 activities, including monitoring the development of community-based providers and ensuring productive collaboration with the DHOs and other local partners. The PO is responsible for the organization and implementation of training activities for all CS interventions, including materials development, and district health planning and management for SC and MOH staff. PO provides technical support for training organized by the DHOs and health education sessions conducted at the community level by the rural MOH health facility staff in Panjikent and Aini districts.

Assistant Project Officer (100%): The APO is responsible for assisting the Project Officer with the overall planning and implementation of CS-18 activities, particularly in Aini District, including monitoring the development of community-based providers, and ensuring productive collaboration with the DHOs and other local partners. The APO is responsible for facilitating the design/improvement of training materials, and providing technical assistance and monitoring of training courses conducted by SC and MOH staff. The APO is responsible for the overall performance of the Health Monitors, health education sessions conducted by MOH rural health facility staff, joint supervisory visits with the rural hospitals staff to health centers and health posts, and assisting the rural health facility staff with the HIS at Aini. The APO also provides technical support to MOH counterparts for establishing the mother-based immunization card system.

Senior Health Monitor (SHM) (100%): The role of the SHM is very similar to that of the APO, except that work will continue to be focused in Panjikent District.

Pharmacist now converted to HM (100%): This position has been converted to Health Monitor position to supplement the project staff in Panjikent. Due to this position, one extra HM has been assigned to support CS Aini team.

Maternal and Newborn Care Monitor (LSS trainer) (100%): The MNC Monitor assists the Project Officer with MNC activities, and is the focal person for expansion of LSS training in Panjikent and Aini, mobilizing the DHO, health facility staff, and VDCs for improved maternal and newborn care. Together with SC and MOH counterparts, the MNC Monitor's responsibilities include: (1) advocacy for maternal and child health from community to district levels; (2) mobilization of women at community level for family health, focusing on maternal and newborn care; (3) inputs for training MOH personnel, VDC members, and CS-18 partners; (4) assisting with development of messages and testing innovative delivery channels (drama, song, etc.); (5) motivating and planning with MOH counterparts, and; (6) working with Maternity Department Chief Doctors.

MIS Assistant (100%): Under the supervision of the Project Officer, the MIS Assistant is responsible for the design of health information systems, data collection forms, and computer programs; training others in computing; and collection of data from the health monitors, pharmacies and MOH staff. The MIS Assistant is also responsible for designing questionnaires, EPI Info programs, data entry, and analysis for surveys; performing and/or supervising accurate entry of all collected data; maintaining computers in working order; and submitting data and reports in a timely manner to the appropriate person.

Seven Health Monitors (100% each): Coordinates with MOH Master Trainers to facilitate training of rural health facility staff. HMs are responsible for mobilizing communities in new CS-18 villages, and establishing and training VDCs. After the VDCs are established, the HMs coordinate the activities of VDCs and MOH rural health facilities, focusing on maternal and child health issues, including referrals, birth plans, planning for emergency obstetric transportation, setting up the child registry system, etc. The HMs monitor health education sessions conducted by rural health staff, and maintain good relations with women's groups, school children who are CTC trainers, school staff, and community members. The HMs assist with rural health facility documentation and analysis of monthly reports, including those for immunization and MNC.

Finance Officer (50%): Responsible for keeping financial records and for financial reporting.

Petty Cashier (50%): Responsible for cash, radio equipment

Admin. Officer (50%): Responsible for all administrative issues including recruitment, procurement, transportation, security and general administration of the office.

Admin. Assistant (50%): Responsible for procurement, record keeping, stores and general administration of the office.

Translator (80%): Responsible for the translation of correspondence, workplans, reports, etc., from English to Russian, and Russian and Tajik to English.

Backstopping and Technical Assistance from SC's Headquarters and Regional Health Advisor: Regular technical and administrative assistance and monitoring of CS-18 from SC's home office include: provision of technical materials for baseline assessments; joint writing, review, and revision of the Detailed Implementation Plan, annual reports, and other technical documents; participation in mid-term and final evaluations; annual program review and technical assistance visits to the site; technical backstopping through frequent e-mail correspondence encouraging the Country Office to seek technical materials and guidance from the Home Office, and prompt responses to queries from Tajikistan; and regular internal and external auditing. Key SC Home Office staff supporting CS-18 include: Dr. Eric S. Starbuck, Child Survival Specialist, responsible for technical backstopping and guidance from Westport, Connecticut; and Ms. Carmen Weder, Associate Director for the Office of Health, based also in Westport. Dr. Tariq Ihsan, SC's RHA for Asia, based in Afghanistan, provides technical assistance and oversight, particularly with regard to planning, baseline and other assessments.

➤ **Communication System and Team Development**

CS-18 management relies on established lines of communication. The Panjikent-based team arranges monthly staff meetings when all the Panjikent staff is available to participate. Weekly health staff meetings provide forums for the exchange of ideas and discussions on key program issues. There is further coordination with the Agriculture project staff on overlapping areas such as CTC, school health, CDD, ARI, hygiene, water and sanitation. Routine communication between the Panjikent and the Central Asian Country Office (CACO) is through monthly country management team (CMT) meetings in which the PM participates. In SMT meetings, major policy decisions about program and overall management are made. The land telephone line and e-mail system has improved over time though still can be painfully slow. The use of cell phones for immediate contact with higher management has helped to somewhat address this challenge. VHF communication and *Pactors* system (a VHF communication and mailing system) is also available as a backup.

➤ **Local Partner Relationships**

Project staff work in close collaboration with MOH staff and village communities. For example, CS staff participates in all MOH sponsored activities such as NIDs. The project was able to provide logistical support to NID for Measles held earlier this year. Through the established channels of VDC networks and CTC, awareness activities were undertaken to assist the MOH. Transportation was provided for vaccines and staff delivery. The education department is supported by USDA grant activities, including feeding and infrastructure support. SC assistance is acknowledged both by the government and the communities in which SC works.

Local MOE staff acknowledge SC support through its USDA grant, and has initiated a school health and sanitation program which has components of health and hygiene education through CTC, latrine construction, and installation of hand washing stations etc.

➤ **PVO coordination/collaboration in country**

The new PM held introductory meetings with key staff of various international agencies involved in the health and agriculture sector in Tajikistan; UNICEF, German Agro Action, and Deputy Minister Health MOH. This coordination is further supported from the country office. Senior SC Management attend partner meetings, especially health coordination meetings, and liaise with all partner agencies through an NGO coordination meeting held monthly and which is chaired by SC on a rotating basis.

M. MISSION COLLABORATION

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

USAID Country Representative Peter Argo and Project Specialist Abdurahmon Mohidov visited Panjikent after flash floods destroyed many villages. The visiting mission saw the relief work done by Save the Children which included provision of tents, non-food items (NFIs), construction of latrines, bathing rooms, a small bridge, and a two and half kilometer long emergency water supply scheme for the internally displaced people (IDP). The CS project immediately dispatched essential medicines/supplies to the affected villages. CS staff worked closely with MOH and setup an emergency ORT center in the IDP relief camp at Sarazam.

O. RESULTS HIGHLIGHT

A Promising Practice from the MTE Report

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

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

The Life Saving Skills and Birth Planning course includes four days of theoretical and eight days of practical training on: working with communities; birth planning (including the need for

antenatal care, delivery by a skilled provider, recognition of danger signs, and contingency plans for emergency transport); infection prevention; antenatal care; care in the first, second, and third stages of labor; postpartum and newborn care; and clinical checklists.

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

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

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

Mothers have and use Road to Good Health cards for their children (0 to 24 months of age)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC staff	2500 mothers	4000 mothers	
Husbands & MIL of antenatal women visit HF's at least once along with the A/N woman during her pregnancy				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	1000 husband & MILs	1000 husbands & MILs	
Community																											
VDCs arrange health education sessions for WRA and men.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	128 VDCs arrange HE sessions	131 VDCs	
MOH rural HF staff, with the assistance from VDCs, conduct BCC activities with WRA.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 reached by BCC activities	8000 WRA reached by BCC activities	
VDCs mobilize communities for birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	VDCs with MOH staff	128 VDCs	131 VDCs	
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	40VDCs	131 VDCs	
VDCs collect and make available emergency transport funds					X	X			X	X			X	X			X	X			X	X		SC will facilitate	40 VDCs will have transportation fund	40 VDC will have transportation fund	
Iodized salt made available in the villages by mobilizing business persons through VDCs						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 villages	131 villages	
VDCs facilitate immunization sessions by gathering all children <2 for vaccination			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	128 villages	131 villages	
VDCs make emergency transport plans					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 VDCs	131 VDCs	
VDCs maintain emergency transport funds					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	40 VDC	40 VDC	
VDCs organize Hearths in their villages				X	X				X	X	X				X	X	X			X	X	X		SC will facilitate	7 VDCs	20 VDCs	
Phase Out Plan developed with the VDC		X	X	X											X	X	X	X	X	X	X	X	X	SC staff	73 CS 14 villages	131 CS18 villages	
Home work assignments for CTC trained students to review and report back on immunization cards of their younger siblings				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC CTC promoter	315 students	405 students	

Health Facility																												
MOH rural HF staff conduct BCC activities with WRA attending HFs.					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 new HFs 73 old CS14	154 HFs (77 HFsCS-14 and 77HFsCS-18 areas)
HF staff conduct ANC & postpartum checkups					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 ANC 1500 PNC	2500 ANC 1500 PNC
HFs conduct at least one immunization session per month					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	154 HFs (77 HFsCS-14 and 77HFsCS-18 areas)
Pregnant women counseled on birth planning					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 pregnant women	2500 pregnant women
MOH rural HF staff counsel mothers on nutrition & exclusive BF					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	3000 Mothers	4000 mothers
MOH rural HF staff check immunization cards during visits of children & refer children for immunization	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	154 HFs (77 HFsCS-14 and 77HFsCS-18 areas)
MOH rural HFs conduct planned immunization sessions	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	77 HFs	154 HFs (77 HFsCS-14 and 77HFsCS-18 areas)
MOH rural HFs use facility-based immunization registers/log books	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HFs	154 HFs(77 HFsCS-14 and 77HFsCS-18 areas)
MOH rural HF staff conduct GMP sessions. Each register child (0-24 months) is weighed & monitored once in 2 months					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	20 HF (CS14) 77 new HFs	125 villages

MOH rural HF's use facility based growth monitoring registers/log books					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HF's	125 villages (The GMP session basically is conducted during the immunization session, however, GMP is conducted once in two months)
MOH rural HF staff maintain stocks of iron supplements for distribution to the antenatal mothers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	77 HF's	CDH has no Iron tablet for distribution.
Exit interviews with pregnant women & mothers of <5s to assess & improve quality of counseling					X			X			X		X		X		X		X		X		SC staff	250 exit interviews (should we also do it in CS14 areas??)	250 exit interviews in CS-18 areas and 100 exit interviews in CS-14 areas Total= 350	

R-2: Sustained investments in key MCH services by communities & rural health facilities in Panjikent and Aini districts.																												
Indicator 9. % of Health Facility Farms started before 10/04, producing crops without SC support.																							Final Eval. Final Eval. VP records RDF Reports					
Indicator 10. % of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services.																												
Indicator 11. % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month.																												
Indicator 12. % of Village Pharmacies with at least 65% cost recovery.																												
Major Activities	October 2005 to September 2006											October 2006 to September 2007											Personnel	Benchmarks				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul		Aug	Sep	Year 4	Year 5	
Community																												
VDCs assist HF staff in the formation of FFW brigades																										Activity phased out	Activity phased out	Activity phased out
VDCs provide technical assistance (in agriculture) to HF staff																										Activity phased out	Activity phased out	Activity phased out
VDCs and HF staff renovate, equip, or supply facilities, or support MCH services, using revenues collected from selling harvested crops																										Activity phased out	Activity phased out	Activity phased out
VDCs monitor village pharmacies.																										Activity phased out	Activity phased out	Activity phased out
VDCs ensure amount owed by patients is recovered in time by VPs																										Activity phased out	Activity phased out	Activity phased out
VDCs ensure seed stocks in villages for HFFs																										Activity phased out	Activity phased out	Activity phased out
Villages establish VPs																										Activity phased out	Activity phased out	Activity phased out
Health Facility																												
HF with farms make plans to utilize revenues and ensure supply of seeds for the next harvest																										Activity phased out	Activity phased out	Activity phased out
HF staff participate in FFW brigade selection																										Activity phased out	Activity phased out	Activity phased out

IR-1: Increased household level knowledge of selected MCH issues.																											
Indicator 13. % of mothers who know 2+ postpartum danger signs. Indicator 14. % of mothers who know 2+ newborn danger signs. Indicator 15. % of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider. Indicator 16. % of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.																							KPC survey				
																							KPC survey				
																							KPC survey				
Major Activities	October 2005 to September 2006											October 2006 to September 2007											Personnel	Benchmarks			
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul		Aug	Sep	Year 4	Year 5
Household																											
Children attending CTC sessions disseminate EPI health messages to their mothers, fathers and other family members.					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	315 children trained 1000 children listen to messages	405 children trained 1300 children listen to messages
Children attending CTC sessions disseminate ARI health messages to their mothers, fathers and other family members.			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	435 children trained 1300 children listen to messages	705 children trained 2200 children listen to messages
Children attending CTC sessions disseminate CDD health messages to their mothers, fathers and other family members.	X	X	X				X	X	X	X	X						X	X	X	X	X	X	X	X	SC will facilitate	600 children trained 1800 children listen to messages	480 children trained 1500 children listen to messages
Children attending CTC sessions disseminate iodized salt health messages to their mothers, fathers and other family members.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	150 children trained 600 children listen to messages	1200 children trained 3600 children listen to messages
Community / Health Facility																											
VDCs facilitate BCC activities with WRA				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	128 VDCs	131 VDCs

VDCs assist school children trained in CTC to disseminate key messages within their communities				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	18 new VDCs 56 old VDCs	25 new VDCs 76 old VDC
BCC activities conducted with WRA to improve knowledge, care, & care seeking for postpartum danger signs			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	8000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for newborns			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	8000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for pneumonia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	8000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for diarrhea		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	5000 WRA	8000 WRA
Husbands & MIL of antenatal women participate in HE sessions on A/N care & birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	1000	2500
VDCs and MOH have regular monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff SC will facilitate	77 VDCs & MOH	131VDCs and MOH
CTC champion identified in each district				X																					completed
CTC Action Plan developed with CTC champion				X	X																				8 meetings
Joint monitoring visit with CTC champion												X	X	X	X	X	X	X	X	X	X	X			50 visits
Schools in each community conduct CTC re CDD health education sessions							X	X	X	X							X	X	X	X			SC will facilitate	40 new schools	32 new schools
Schools in each community conduct CTC re ARI health education sessions			X	X	X								X	X	X							X	SC will facilitate	29 schools	47 schools
Schools in each community conduct CTC re EPI health education sessions				X	X	X	X				X	X	X	X			X	X	X	X			SC will facilitate	21 schools	27 schools
Schools in each community conduct CTC re iodized salt health education sessions							X	X	X	X	X	X					X	X	X	X	X	X	SC will facilitate	10 schools	80 schools
Active counseling of pregnant women on birth planning				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 women	2500 women

IR-2: Improved capacity of communities to address priority health needs of mothers & children <5.																													
Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy which sold medicines in past month.																										CS-18 Records			
Indicator 18. % of villages with a health facility, having a Village Development Committee which organized 1+ health education Session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months.																										CS-18 Records			
Major Activities	October 2005 to September 2006													October 2006 to September 2007													Personnel	Benchmarks	
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Year 4	Year 5			
Community																													
VDCs established in new CS-18 villages		X	X	X	X					X	X	X	X	X	X			X	X	X	X					SC staff	47 new VDCs	Completed-	
VDCs trained in community mobilization methods			X	X	X	X						X	X	X	X					X	X	X	X			SC staff	128 VDCs	131 VDCs	
VDCs monitor village pharmacies																										Activity phased out	Activity phased out	Activity phased out	
VDCs assist VPs in cost recovery of funds owed by households																										Activity phased out	Activity phased out	Activity phased out	
VDCs cross visits between old & new CS-18 sites				X	X								X	X	X							X	X			PO & APO	3 VDCs	6 VDCs	
VPs cross visits between old and new CS-18 sites for practical training on RDF activities																										Activity phased out	Activity phased out	Activity phased out	
VPs supplied with appropriate antibiotics and ORS																										Activity phased out	Activity phased out	Activity phased out	
Health Facility																													
MOH rural HF staff support village pharmacies																										Activity phased out	Activity phased out	Activity phased out	
MOH rural HF staff participate in VDC monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	128 HF's	204 villages (73 CS-14 villages and 131 CS-18 villages)	

Annex 1

Updated Project Data Form

Child Survival and Health Grants Program Project Summary

Oct-25-2006

Save the Children (Tajikistan)

General Project Information:

Cooperative Agreement Number: FOA-A-00-98-00022-00
Project Grant Cycle: 18
Project Dates: (9/30/2002 - 9/29/2007)
Project Type: Cost XT

SC Headquarters Technical Backstop: Eric Starbuck
Field Program Manager: Gulchehra Boboeva
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: Aziza Khamidova

Field Program Manager Information:

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Alternate Field Contact:

Name: Pervez Shaukat
Address: Dushanbe
Phone:
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E-mail: drpervez@savechildren.tj

Funding Information:

USAID Funding:(US \$): \$1,250,000

PVO match:(US \$) \$333,300

Project Information:

Description:

This is a cost extension for the Scaling-up Innovative Approaches for Rural Tajikistan To Building Community and Health Facility Capacity To Sustain Key Investments in Essential Maternal and Child Health Services program.

The goals are a sustained reduction in under-five and maternal mortality in rural Panjikent and Aini districts, and; (2) Innovative CS-18 strategies contribute to improved maternal and/or child health policy or programming in other areas of rural Tajikistan Project Description.

The interventions include acute respiratory infections; control of diarrheal disease; immunization; maternal and newborn care; and nutrition and micronutrients.

The project will implement these five interventions through six strategies:

1. Revolving Drug Funds for Village Pharmacies;
2. Health Facility Farms for continuing investments in improving MCH services;
3. Joint training and supervision of rural health facility staff;
4. Community mobilization through Village Development Committees;
5. Interactive engagement of local health workers with community groups to promote improved MCH practices, and;
6. Child-to-child health education. CS-18 will also introduce the Positive Deviance approach.

Location:

All 202 villages in and above the Zarafshon Valley of Panjikent District and neighboring Aini District of Sugdh (formerly Leninabad) Region in northwestern Tajikistan.

Project Partners	Partner Type	Subgrant Amount
MOH (at district & facility levels)	Collaborating Partner	

Project Sub Areas:

General Strategies Planned:

(None Selected)

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Lot Quality Assurance Sampling

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
(None Selected)	(None Selected)	Pharmacists	Health Facility Staff	Health CBOs

Interventions/Program Components:

Immunizations (15 %)

- Mobilization

Nutrition (15 %)

(CHW Training)

- Hearth

Vitamin A (1 %)

Micronutrients (4 %)

- Iodized Salt
- Iron Folate in Pregnancy

Pneumonia Case Management (15 %)

(HF Training)

- Pneum. Case Mngmnt.
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (15 %)

(HF Training)

- ORS/Home Fluids

Maternal & Newborn Care (30 %)

(HF Training)

- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Normal Delivery Care
- Birth Plans
- Emergency Transport

Breastfeeding (5 %)

- Promote Excl. BF to 6 Months

Target Beneficiaries:

	Total Beneficiaries
Infants < 12 months:	
Children 12-23 months:	
Children 0-23 months:	
Children 24-59 months:	
Children 0-59 months:	
Women 15-49 years:	
Population of Target Area:	

Rapid Catch Indicators:

☐ LQAS sampling methodology was used for this survey				
UNDERWEIGHT CHILDREN				
Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)				
Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age				
Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0
BIRTH SPACING				
Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child				
Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth (Rapid CATCH Question				
Denominator: Number of children age 0-23 months in the survey who have an older sibling				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0
DELIVERY ASSISTANCE				
Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel				
Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D				
Denominator: Number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0
MATERNAL TT				
Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child				
Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9				
Denominator: Number of mothers of children age 0-23 months in the survey Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9 Denominator Numerator: Number of mothers of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

EXCLUSIVE BREASTFEEDING

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

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

COMPLEMENTARY FEEDING

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6-9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

FULL VACCINATION

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

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

MEASLES

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

BEDNETS

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

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

DANGER SIGNS

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

SICK CHILD

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

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

HIV/AIDS

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

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

HANDWASHING

Description -- 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

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
	0	0	0.0%	0.0
	0	0	0.0%	0.0

TB TREATMENT SUCCESS RATE

Description -- Percentage of new smear positive cases who were successfully treated

Numerator: Number of new smear positive cases who were cured plus the number of new smear positive cases who completed treatment

Denominator: Total number of new smear positive cases registered

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
			%	
			%	

Comments for Rapid Catch Indicators

used weighted averages for the percentage estimates, something which this data entry system does not allow. We