



CS-19 Afghanistan Fourth Year Annual Report

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

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GLOSSARY OF ACRONYMS AND TERMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (USAID Global Health project implemented by JHPIEGO in partnership with Save the Children, Futures Group, the Academy for Educational Development, the American College of Nurse-Midwives and Interchurch medical Assistance)
ACCESS/HSSP	ACCESS/Health Service Support Project
AFP	Acute Flaccid Paralysis
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin/Tuberculosis Vaccine
BEHAVE	The BEHAVE Framework is a strategic planning tool for managers of programs that have major behavior change components.
BEOC	Basic Emergency Obstetric Care
BHC	Basic Health Center
BPHS	Basic Package of Health Services (of the Afghanistan Minister of Public Health)
CBA	Child Bearing Age (Women)
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CHC	Community Health Committee
CHS	Community Health Supervisors
CHV	Community Health Volunteer
CHW	Community Health Worker
CM	Community Mobilization
CME	Community Midwifery Education
CS	Child Survival
CSO	Central Statistics Office
DCOF	Disabled Children’s and Orphans’ Fund (USAID)
DH	District Hospital
DIP	Detailed Implementation Plan
DME	Design, Monitoring and Evaluation
DPT3	Diphtheria-Pertussis-Tetanus Vaccine, Third Dose

EPI	Expanded Program on Immunization
GMP	Growth Monitoring and Promotion
HF	Health Facility
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
JHPIEGO	Reproductive Health Program affiliated with Johns Hopkins University
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNC	Maternal and Newborn Care (CS-18 intervention)
MoPH	Ministry of Public Health
MOU	Memorandum of Understanding
MOVE	A local (Afghan) NGO
MVA	Manual Vacuum Aspiration
NERS	Nutrition Education and Rehabilitation Session
NGO	Non-governmental Organization
NID	National Immunization Day
NIH	National Institute of Health
OPV/OPV3	Oral Polio Vaccine/Oral Polio Vaccine Third Dose
ORS/ORT	Oral Rehydration Solution/Oral Rehydration Therapy
PD/PDI	Positive Deviance/Positive Deviance Inquiry
PDQ	Partnership Defined Quality
PHCC	Provincial Health Coordinating Committee
PHD	Provincial Health Director
PHO	Provincial Health Office of the MoPH
PPG	Partnership Performance Grant
PPPH	Prevention of Postpartum Hemorrhage
QIT	Quality Improvement Team
REACH	Rural Expansion of Afghanistan's Community-based Healthcare Program

RH	Reproductive Health
SC/US	Save the Children Federation, Inc.
SC/UK	Save the Children United Kingdom
SSP	Service Support Project
STEP	A local (Afghan) NGO
TB	Tuberculosis
TOT	Training-of-Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID REACH	USAID-funded Rural Expansion of Afghanistan's Community-based Healthcare
WHO	World Health Organization

Year 4 of the Save the Children Federation, Inc. (SC/US) CS-19 project in Afghanistan has progressed according to the work plan, with ongoing successes in building relationships with provincial partners, programmatic innovations, and synergies with existing and emerging USAID-funded government programs.

A. PROGRAM ACCOMPLISHMENTS

1. Immunization

Immunization sessions are carried out six days a week through 27¹ USAID partnership performance grant (PPG) supported health facilities (HF) located in four districts in Andkhoy cluster (Faryab Province) and 10 districts in Jawzjan Province. Each HF in the project impact area has two vaccinators; one who conducts immunization sessions at the clinic while the other provides outreach. During this reporting period, CS-19's Senior Officer/Health (EPI), MoPH provincial EPI officers in Faryab and Jawzjan provinces and EPI officers working with local NGOs, STEP and MOVE, supported EPI program in these health facilities, including the provincial hospital (not funded by USAID) in Shiberghan town (Jawzjan's capitol). In this year, CS-19 also provided particularly strong support to the EPI program in the remote Darzab and Qoushtepa districts of Jawzjan.

1.1. Immunization coverage data collection support to the Provincial Health Office (PHO)

The CS-19 Senior Officer, Expanded Program on Immunization (EPI) and Ministry of Public Health (MoPH) provincial EPI officers in Faryab and Jawzjan provinces reviewed EPI reports submitted by HFs each month, calculated coverage of each antigen and drop-out rates between DPT 1 and DPT 3, and overall drop-out rates between BCG vaccine and measles vaccine. The following table shows progress made in childhood immunization and TT vaccination of pregnant women between 2004 and 2007:

Antigen	2004	2005	2006	2007²
BCG	49%	51%	87%	99%
DPT3	54%	68%	75%	92%
Polio3	57%	68%	81%	88%
Measles	49%	54%	68%	84%
TT pregnant	44%	62%	69%	68%

1.2. Monitoring and supervision

During the reporting period, the CS-19 Senior Officer (EPI) and MoPH provincial EPI officers in Faryab and Jawzjan provinces conducted 62 monitoring visits to 27 HFs in all Jawzjan districts and in the Andkhoy cluster of four districts; they used a standard EPI checklist, and checklist results show that the quality of EPI activities remain very good. However, non-functional refrigerators in two HFs; resignations of vaccinators in three HFs; refusal of three Community Health Workers (CHW) to continue volunteer work; and inadequate BPHS budgets affected cold chain maintenance, plus caregiver's counseling and outreach. A summary of 62 checklists is compared with summary of 2003-2004 results:

¹ In Jawzjan: MOVE supports four BHCs, three CHCs; STEP supports 11 BHCs, two CHCs and two DH; In Andkhoy cluster SC/US supports three BHCs, one CHC and one DH.

² Data for each year is for 12 months. Data for 2007 is for nine months.

Monitoring and Supervision area	2003-2004	2005-2007
Clinics that have good quality cold chain maintenance	100%	93%
Clinics with immunization sessions	100%	99%
Clinics which conduct outreach sessions as per schedule	90%	85%
Clinics that have drop-out rates less than 10%	60%	51%
Clinics that use community maps for EPI	100%	100%
Clinics with immunization work-plans posted	80%	100%
Clinics with adequate supplies of vaccines (no stock-out reported)	100%	100%
Clinics that use CHWs to follow up defaulter children/refer to vaccination sessions	100%	70%
Vaccinators who joined a three-day EPI update training course	90%	95%
Vaccinators with correct knowledge of EPI registration and reporting	80%	80%
Vaccinators who can calculate targets and coverage rates correctly	80%	90%
Vaccinators who conduct counseling of caregivers before and after vaccinating children	95%	75%

Disease surveillance (e.g., polio, measles) remained an important role of vaccinators, medical officers, Community Health Supervisors (CHS) and CHWs. Every month CHSs collect disease surveillance forms/reports from CHWs and submit compiled reports to clinic heads and vaccinators. The medical officer then reviews, signs and submits to provincial EPI officers. The CS-19 Senior Officer/Health (EPI), Faryab and Jawzjan MoPH provincial EPI officers and WHO's EPI point person then review these surveillance forms and compile them for the respective provinces. They continue to strengthen surveillance during their monitoring visits. For example, in Mingajik District, when seven suspected cases of measles were reported in September 2007, the team visited the children in question, confirmed the diagnoses and then organized a measles vaccination campaign in the surrounding areas, vaccinating 133 children.

Disease surveillance activities also located seven cases of AFP during this reporting period. Samples of their stools were sent to WHO/Kabul for onward confirmation of suspected polio cases at the National Institute of Health Pakistan. Fortunately, results showed that these were negative cases.

Every month, during Provincial Health Coordinating Committee (PHCC) meetings, the results of monitoring and supervision visits are discussed with all stakeholders: MoPH, WHO, UNICEF, STEP and MOVE and plans developed to further strengthen EPI activities.

1.3. EPI microplan meetings

CS-19's Senior Officer/Health (EPI), MoPH provincial EPI officers and STEP/MOVE EPI officers review and update microplans every month further to improve strategies to increase coverage, including strategies for community mobilization and project resources/supplies management to implement the microplans in all 14 districts in the Andkhoy cluster and Jawzjan Province. In November 2006, a three-day workshop was held for STEP and MoPH staff to develop a microplan for the remotest districts of Jawzjan: Darzab and Qoustepa. (Annex 1 includes an example of an updated microplan.)

1.4. Training and capacity building

Between October and November 2006, the CS-19 Senior Officer (EPI), MoPH provincial EPI officers and STEP/MOVE EPI officers led an eight-day Routine EPI training for three medical officers and 17 vaccinators from STEP and MOVE; and the topics covered in the training included:

six preventable diseases and their signs and symptoms; vaccination techniques; cold chain maintenance; caregiver's counseling; community mobilization; Community Health Council (CHC) meeting facilitation; routine EPI at fixed centers and outreach; calculating targets, coverage and drop-out rates; calculating doses and wastage; disease surveillance; TT and measles campaigns. In June 2007 a similar four-day EPI refresher training was held for 37 vaccinators.

In January 2007, based on training needs assessments, CS-19's Senior Officer/Health (EPI), MoPH provincial EPI officers and STEP/MOVE EPI officers led a two-day refresher EPI course for six medical officers; 10 vaccinators and two EPI technicians. The topics were HMIS; EPI registration and recording; how to make daily tally sheets; use of EPI checklists; how to make and use an EPI monitoring chart; calculating targets, coverage and drop-out rates.

1.5. Support for National Immunization Days (NIDs)

In this reporting time, the CS-19 Senior Officer (EPI), MoPH provincial EPI officers and STEP/MOVE EPI officers supported four rounds of National Immunization Days (NIDs) that focused on giving oral polio vaccine (OPV) drops and one high dose of Vitamin A (100,000 i.u.). CS-19 support included development of microplans for NIDs; making monitoring and supervisory visits to all sites; and providing support to transport polio vaccine, vitamin A, carrier boxes and other supplies. The following table summarizes coverage of the November 2006 round of NIDs³:

Districts	Number of teams	OPV and Vitamin A Coverage				
		Target	Girls	Boys	Total	Coverage %
Jawzjan						
Shiberghan	101	46036	22686	21441	44127	96%
Khoja du Koh	20	5231	2682	2701	5383	103%
Aqcha	62	22039	10783	10419	21202	96%
Murdian	30	9594	4870	4900	9770	102%
Faizabad	36	11849	6235	6208	12443	105%
Khanqah	39	11625	5977	5939	11916	103%
Qarqin	28	6841	3432	2953	6385	94%
Khamyab	17	3264	1620	1645	3265	100%
Mingajik	40	10512	4897	4926	9823	94%
Darzab	35	12816	6438	6163	12601	99%
Qoushtepa	30	8991	4450	4007	8457	94%
Total	438	148798	74070	71302	145372	98%
Andkhoy						
Andkhoy	33	15601	8174	7792	15966	102%
Khancharbagh	15	5326	2180	2012	4192	79%
Qurghan	22	5638	3035	2970	6005	107%
Qaramqol	15	4494	2404	2046	4450	99%
Total	85	31059	15793	14820	30613	97%

³ The denominator is based on CSO conducted in 2004-2005, it is possible that in the recent years, population has changed with returnees – it is therefore some results are over 100%.

1.6. Support to Measles and TT campaigns:

In May 2007, the CS-19 Senior Officer/Health (EPI), MoPH provincial EPI officers and EPI Officers from STEP and MOVE, along with WHO and UNICEF EPI point persons, led the second measles and TT campaigns in Jawzjan Province and the Andkhoy cluster districts. The campaigns were implemented with help of 432 campaign teams, which each included two vaccinators, one registrar and one community mobilizer. Twenty-eight coordinators and 108 supervisors led these teams, and CS-19 support included two two-day trainings: one for the campaign coordinators and supervisors and another for the teams. Topics included measles and tetanus, their signs and symptoms; how to give measles and TT vaccines; side effects of vaccines; and infection prevention. The training also covered the roles of vaccination teams; of supervisors and coordinators; of community mobilizers and CHC members; registration and recording; and logistics.

District	Coordinators	Supervisors	Teams
Andkhoy cluster	4	15	60
Jawzjan Province	24	93	372
Total	28	108	432

TT and measles campaigns were held at the same time. A total of 83% of women of child bearing age (CBA) and 99% of children 6 months to 9 years of age were vaccinated. In Jawzjan, 99% CBA women received TT vaccines and 94% children received measles vaccine, as summarized here:

District	TT vaccine (CBA women)	Measles (6 months to 9 yrs)
Andkhoy cluster	24,315 (83%)	24,653 (99%)
Jawzjan Province	89,082 (99%)	103,207 (94%)

1.7. Development of health education materials and messages

During this reporting period, CS-19's Senior Officer/Health (EPI) and MoPH provincial EPI officers, together with the CS-19 Senior Officer/Health (BCC), produced Information, Education, Communication (IEC) posters adapted from USAID's REACH program. Twenty-two posters were developed and given/explained to HF staff for use in facilities. CS-19's Senior Officer/Health (EPI) and MoPH provincial EPI officers also introduced EPI IEC materials to 44 vaccinators in the HF's during their visits. (Please see Annex 2, EPI Poster.)

CS-19 MCH promoters, with guidance from the Senior Health Officer/Health (BCC) led a one-day training for 80 CHWs in Faizabad and Murdian districts of Jawzjan Province. Doctors from MOVE attended most of these trainings, too. In addition CS-19's Senior Officer/Health (EPI) and Senior Officer/Health, Basic Package of Health Services (BPHS) introduced 24 CHC members in Qorghan and Qaramqol districts to these EPI IEC materials and messages.

The EPI IEC messages are these:

- Vaccines protect your child from diseases (tuberculosis (TB), polio, measles, diphtheria, pertussis and tetanus).
- Make sure your child receives five vaccinations before s/he is one year old.
- Your child's vaccination card is her/his access to good health – keep it safe.

- It is normal for child who receives a vaccine to develop a fever, and pain at the injection site. This shows that vaccines are working, so you should not worry.
- Protect yourself from tetanus; get at least two tetanus vaccinations.
- Pregnant women must get at least two doses of TT vaccine.

New materials using photos of actual vaccination sessions; infection control; vaccination techniques; cold chain and caregivers counseling were also developed during the past year, and they are being field-tested in Andkhoy cluster.

2. Nutrition and Micronutrients

2.1. Nutrition Education and Rehabilitation (NERS)

In January 2007, an intern and CS-19's Senior Officers/Health, Behavior Change Communication (BCC) and Maternal and Newborn Care (MNC) finalized documentation of the Nutrition Education and Rehabilitation Service (NERS) pilot in Afghan Tapa and Chighchi villages (Jawzjan Province; May 2005 to May 2006) based on the PD/Hearth model. Results show an adequate weight gain (defined as a gain of more than 400 grams gained in a two week time period) occurred in 95% of children attending 12-day NERS. Further, 81 children (55%) had a weight gain of at least one kilogram; nearly all children showed progress toward achieving normal nutritional status.

In February 2007, CS-19 shared the results of the pilot project with MoPH and STEP/MOVE colleagues, and led a discussion of how to expand this initiative. It was decided to integrate PD/Hearth initiative within the Basic Package of Health Services (BPHS) using CHSs and CHWs. Two villages, one in Khancharbagh in the Andkhoy cluster and another in Misrabad in Jawzjan Province, were selected to expand this initiative. In June 2007 the CS-19 Senior Officer/Health (BCC), the MoPH nutrition officer and four CS-19 MCH promoters trained BPHS staff (doctor and CHSs) and one STEP IMCI officer. In addition, in July 2007, two orientation sessions were held for 20 CHC members in the two villages; topics were malnutrition, weaning practices and the Positive Deviance Inquiry (PDI) approach with the goal of increasing their understanding of the concept and to enlist their support for the initiative.

Between June and July 2007, CS-19's Senior Officer/Health (BCC) and the MoPH's nutrition officer, with help from STEP's IMCI officer, conducted nutrition baseline surveys in the two villages. In Khancharbagh, Andkhoy cluster, 430 children (6 to 36 months of age) were weighed (weight for age), and results showed that 71% were malnourished (mild or SD-1 133 or 31%, moderate or SD-2 132 or 31% and severe or SD-3 41 or 9.5%). In Misrabad, 394 children were weighed and 68% were malnourished (mild or SD-1 138 or 35%; moderate or SD-2 100 or 25%; and severe or SD-3 31 or 7.8%).

Between June and July 2007, CS-19 Maternal and Child Health (MCH) promoters, under the guidance of CS-19's Senior Officer/Health (BCC) conducted a positive deviance inquiry with families of six well-nourished children and interviewed families of six malnourished children to identify positive deviant foods, child caring practices and health care seeking behaviors to use in developing BCC messages to include in NERS and community education.

In July 2007, CS-19 Senior Officers/Health (BCC, MNC) and CS-19 MCH promoters held four-day training for two BPHS CHWs; and six female volunteers⁴ in Misrabad and four BPHS CHWs and eight female volunteers in Khancharbagh. Topics for NERS included personal hygiene and hand-washing; nutrition; breastfeeding and weaning; ARI and diarrhea; immunization and how to organize NERS and home visits. The main reason to involve community volunteers in the initiative was to ensure peer motivation for the mothers/caregivers with malnourished children who attended Hearth sessions. The volunteers gave guidance to mothers/caregivers in meal preparation and feeding their children, and also maintained pictorial records and reports – according to their roles, which were explained during volunteer trainings and were reinforced during all PD/Hearth sessions.

For Misrabad 23 sessions were planned and, to date, 20 sessions have been completed. In Khancharbagh 33 were planned; to date 16 sessions have been completed. Of the total in Misrabad 65% (144/220) of participating children showed weight gain between 400gms and 700gms after 12 days of the first NERS cycle. In addition to NERS, CS-19 MCH promoters conducted a total of 283 home visits targeting mothers who continued to face problems feeding their malnourished child.

2.2. Promotion of household use of iodized salt

To promote the use of iodized salt, CS-19 staff used UNICEF IEC/health education materials and distributed 54 posters to all 27 USAID PPG supported facilities and one for each of the 80 CHWs in Jawzjan Province.

Between October and November 2006, the CS-19 Senior Officer/Health (BCC) and MoPH's nutrition officer visited factories (Shiberghan and Aqcha) and bazaars (Aqcha) to test salt for iodine; there were repeat visits in January 2007. In total 100 shops were visited and 100 salt samples tested. Three types of packaged iodized salt were found: Almas Zindagee produced (35 samples tested) and packaged in Shiberghan town; Alten Tuz (35 samples tested) from Mazar-i Sharif town and a third variety (no name; 30 samples tested) produced by a private mill in Shiberghan. Results showed the following: Almas Zindagi – 100% samples contain iodine at 30 p.p.m; Alten Tuz 100% at 15 p.p.m or less and no name sample 100% negative for iodine. These results were shared with CHC members, shopkeepers and MoPH staff.

With help from UNICEF and the MoPH, CS-19 staff helped in one iodized salt campaign. Additionally, messages about the importance of iodized salt were integrated in acute respiratory infections (ARI), control of diarrheal disease (CDD), MNC and EPI trainings and community health education activities like birth planning education sessions, CHW trainings and PD/Hearth sessions. Midwives were educated to give these messages during antenatal care and postpartum visits. In this reporting period, 500 UNICEF flyers were distributed to 213 shop keepers, 20 CHCs; 240 CHWs and 27 HFs.

2.3. Breastfeeding

The CS-19 Senior Officer/Health (BCC) collected and disseminated UNICEF breastfeeding education materials (posters; brochures) and developed additional messages. Breastfeeding education was incorporated in MNC, ARI, CDD, birth planning trainings and NERS, and included these messages:

⁴ The following criteria were used to select volunteers: female, married, mothers preferred; accepted by community members; may or may not be a government employee; may or may not be literate, but must be highly motivated, i.e., eager to learn and open to new ideas; willing to work as a volunteer.

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

In August 2007, linked to the PD/Hearth model, CS-19 piloted breastfeeding mothers' groups to promote exclusive breastfeeding. In November 2007, exit interview will be done with mothers attending clinics with children younger than six months of age to identify mothers who are exclusively breastfeeding and those who are not. Six mothers in each category will be visited with PDI to identify positive deviant practices that promote exclusive breastfeeding. These exit interviews will be held at four HFs in Afghan Tapa, Chighchi and Misrabad in Jawzjan and Khancharbagh in Andkhoy, where pilot PD/breastfeeding education and promotion sessions will be initiated.

3. Maternal and Newborn Care (MNC)

The MNC component of the CS-19 initiative supports BPHS interventions in maternal and newborn health, i.e., delivery, postpartum and newborn care. Trainings are conducted for facility-based Community Midwives; medical officers; female nurses and CS-19 MCH promoters. Outside the clinics, i.e., in villages' home-based Health Posts, female CHWs and CHC members (both men and women) are taught about these interventions. In this reporting period CS-19 also guided the implementation of a Prevention of Postpartum Hemorrhage (PPH) initiative, a highly successful demonstration project in Andkhoy cluster.

3.1. MNC trainings

In December 2006, CS-19's Senior Officer/Health (MNC) helped the MoPH provincial Reproductive Health (RH) officer and RH officers from STEP and MOVE lead a 5-day refresher RH training for 23 Community Midwives (CM). Topics included definition of reproductive health; the four delays in accessing emergency obstetric care; birth preparedness; antenatal care (TT vaccine, iron and folic acid tablets); childbirth; use of partograph; postnatal care (including vitamin A); newborn care; infection control; health management information system (HMIS) and registration and recording and child-spacing methods and counseling. Additional topics were Misoprostol tablets and their role in preventing PPH. In July 2007 training on how to use partograph was repeated for 16 women doctors; four CMs; and seven female nurses.

In December 2006, CS-19 Senior Officer/Health (MNC) and Community Midwife Education (CME) program Coordinator (senior-most leader, who is a doctor herself) led a two-day training on infection control for three medical officers; six CMs and two nurses in the Andkhoy District Hospital. Topics included use of self-protection materials and equipment; chlorine preparation and use; methods of sterilization of equipment and towels; standards for cleaning floors, furniture and delivery tables.

In February 2007, CS-19's Senior Officer Health (MNC) and the MoPH RH officer led a five-day MNC training that included Basic Emergency Obstetric Care (BEOC) for two MOVE/STEP RH officers; 11 female medical officers; and three midwives from the provincial hospital in Shiberghan. Topics included birth preparedness; use of IEC materials to promote birth preparedness; antenatal

care; ante partum hemorrhage and its management; pre-eclampsia and eclampsia and their management; normal delivery; use of partograph; breech delivery; use of vacuum extraction; placenta retention and bi-manual removal of placenta; postpartum care; postpartum hemorrhage and its management; newborn care including APGAR scoring and use of manual vacuum aspiration (MVA).

In May 2007, the CS-19 Senior Officer/Health (MNC) and MoPH's RH officer led a two-day workshop to introduce BEOC standards to STEP's RH officer, 16 female doctors and four CMs from HF's and district hospitals (DHs). The training was both theoretical and practical; topics were standards for normal delivery; for breech delivery; for episiotomy; and, for doctors, standards for MVA were introduced and posted on the wall in each HF for reference.

Four CS-19 MCH promoters trained 40 CHWs in Faizabad; 40 in Murdian and 59 in Shiberghan (all districts in Jawzjan Province) about MNC, highlighting the importance of clean delivery and the role of midwives. Four MCH promoters trained 32 CHWs in the Andkhoy cluster on the topic, and two newly appointed MCH promoters trained 10 CHWs in Darzab and Qoushtepa.

3.2 MNC health education materials

During this reporting period, CS-19 Senior Officers/Health (MNC; BCC), developed IEC posters and flip charts on child-spacing and family planning methods using MoPH IEC materials. Twenty-seven posters were developed and introduced to HF staff for posting in facilities; 10 posters were also given to CS-19 MCH promoter to use during their education activities in the communities.

3.3. Monitoring and supervision

During the reporting period, the CS-19 Senior Officer/Health (MNC); MoPH RH officer; and STEP and MOVE RH officers made 59 monitoring visits to 27⁵ HF's in Jawzjan Province and the Andkhoy cluster using the standard RH and birth planning checklist. Of these, 49 were joint visits and 10 were individual monitoring by CS-19 Senior Officer/Health (MNC). The main purpose of these monitoring visits was to support newly graduated community midwives; female doctors and nurses and to ensure good quality MNC services.

The summary of 2007 monitoring checklist shows that the quality of MNC services has significantly improved since 2006. This is due to a) presence of CMs in facilities, including those that are remote, and b) extensive, regular CS-19 staff technical support. Results of these monitoring and supervision visits are shared with all stakeholders: MoPH, STEP and MOVE and discussions are held to plan to further strengthen MNC services. The table below summarizes the results of these monitoring:

⁵ In Jawzjan: MOVE supports 4 BHCs, 3 CHCs; STEP supports 11 BHCs, 2 CHCs and 2 DH; In Andkhoy cluster SC/US supports 3 BHCs, 1CHC and 1 DH.

Assessment area	2006	2007
Pregnancy		
Does female HW communicate with clients (pregnant women)	70%	80%
Does female HW conduct physical examination in stages ⁶	65%	85%
Does female HW refer pregnant women for lab-exam (BPHS standards)?	20%	50%
Does female HW counsel regarding birth preparedness and danger signs?	50%	90%
Does mother get 'TT' vaccines according to schedule?	70%	100%
Does pregnant woman get iron and folic acid?	90%	100%
Childbirth		
Does female HW take history about pregnancy?	60%	70%
Does female HW carry out exam (determine stage and danger sign in the labor)?	55%	75%
Does female HW use partograph during delivery?	60%	100%
Does HF have medicines, equipment for emergencies (bleeding, eclampsia)?	40%	100%
Postnatal care		
Does female HW check for post partum hemorrhage (tears, uterus contraction and placenta atony) during after delivery?	30%	60%
Does female HW check for infection during after delivery?	20%	80%
Does female HW check breasts?	30%	70%
Does female HW educate (breast feeding, nutrition, hygiene)?	30%	60%
Do women get Iron and ferrous sulphate and Vitamin A?	60%	100%
Does female HW ask mothers about exclusive breast feeding?	50%	80%
Does female HW examine newborns for an infection?	60%	100%
Does newborn get polio and BCG in the facility?	80%	100%
Does female HW have correct knowledge/skills for new born resuscitation?	70%	90%
Does health facility have equipment for resuscitation?	60%	100%
Does female HW conduct education about family planning for mothers?	50%	60%
Does female HW counsel husband and mother?	0	10%
Does female HW refer mothers with complications (postpartum) to hospital?	0	100%

3.4. Health education by CS-19 MCH promoters

CS-19 MNC officers work closely with BPHS staff in the HFs and with CHWs. They support and train CHWs about maternal and newborn care; birth preparedness; and child-spacing and provide support during health education sessions. In this reporting period, the following health education sessions were held:

- 14,133 CBA women attended health education on safe motherhood in Jawzjan and in the Andkhoy cluster of districts.
- 3,600 pregnant women and their family members (7,300) living in two districts of Andkhoy and two districts of Jawzjan received information on birth preparedness and complication readiness.
- 36,000 women of CBA attended 600 sessions led by CS-19 MCH promoters and 36 CHWs in both the Andkhoy cluster and in Jawzjan Province.

⁶ (checking BP, BT, weight, height, edema, conjunctivitis, abdomen and fetal heart beat) according to national guidelines.

In this reporting period, the CS-19 Senior Officer/Health (MNC) visited 66 times to monitor CS-19 MCH promoters in the field. She visits most MCH promoters at the end of a health education session to assess the knowledge gained by mothers/women. The analysis of their knowledge in 2006 and 2007 show that MCH promoters education sessions are useful and have significant impact on women's knowledge (and their family members' too) – as shown here:

MNC performance areas	2006	2007
Mothers who know the importance of antenatal care	80%	90%
Mothers who knew all key danger signs in pregnant women	65%	80%
Mothers who knew the importance of saving money in advance	85%	85%
Mothers who knew the importance of arranging transportation in advance	75%	95%
Mothers who knew that it is important to identify blood donors	50%	60%
Mothers who knew the importance of rest during pregnancy (day time)	90%	90%
Mothers who knew that it is important to deliver in a health facility	66%	90%
Women who knew the importance of booking a skilled birth attendant in advance	80%	80%
Mothers with correct knowledge of nutrition during pregnancy and lactation	90%	90%
Women who knew the importance of postnatal care for mothers and newborns	40%	60%
Women who knew that breastfeeding must be initiated within 1 hour after delivery	80%	90%

3.5. Safe Motherhood campaign

During this reporting period, the CS-19 Senior Officer/Health (MNC) and MoPH RH officers, trained 10 CS-19 MCH promoters; 60 female nurses; 14 CMs; two women from Ministry of Labor and Social Affairs; and four women from the Ministry of Women's Affairs on the concept and strategy of a Safe Motherhood Campaign. (Inaugurated by the MoPH on October 8, 2006, the campaign is still to be an annual event and was scheduled for 2007). Training topics were these: danger signs of pregnancy, child birth and postpartum period; birth preparedness; and role of midwives in saving lives of women with obstetric complications. CS-19 supported the Safe Motherhood campaign in all the districts of Jawzjan and in the Andkhoy cluster.

Four CS-19 MCH promoters went to eight schools and trained 136 female teachers; and to areas covered by 89 mosques and trained 36 CHWs. In addition, 150 posters (developed by MoPH IEC department) were put on the walls in different locations.

3.6. Support to ACCESS/PPPH project

Save the Children implemented this demonstration project in Qurghan and Qaramqol districts in northern Faryab Province (intervention area) and Qarqin and Khamyab districts in Jawzjan Province (control area). In both areas, the focus of the program was to educate women and their family members about postpartum hemorrhage and its prevention, and about birth preparedness, generally, and complication readiness. In the intervention area, CHWs distributed misoprostol tablets to pregnant women in the third trimester of pregnancy with instructions to take the drug after delivery, but before expulsion of the placenta. The Prevention of Postpartum Hemorrhage (PPPH) demonstration project ended May 31, 2007. CS-19 staff took the lead to support the project technically; the CS-19 Senior Officer/Health (MNC) attended all required technical workshops and trainings led by ACCESS/JHPIEGO for the project, and led several orientation sessions for

provincial and district MoPH staff, community members and CHWs. She also led qualitative research in Faryab, Jawzjan and Kabul provinces to 1) understand existing household practices related to birth preparedness and complication readiness and 2) ensure that information and counseling used in community-based approaches to the reduction of postpartum hemorrhage (including misoprostol use) was culturally appropriate and acceptable to the community.

CS-19's Senior Officer/Health helped JHPIEGO adapt the CHW training course, led CHW training successfully in Faryab and Jawzjan provinces and visited the project site 26 times to ensure continued monitoring and supervision of CHWs by CHSs and SC/US senior health staff to strengthen CHW performance in implementing PPPH project activities.

CHWs enrolled several hundred pregnant women, and provided quality education. In the intervention sites, they successfully provided correct information on the use of misoprostol and distributed the drug to many women. Results show that most women who received misoprostol used it correctly; and, of those who did not use these tablets, many delivered at the facility or at home with midwives. Table below summarizes the results.

Demonstration Sites	# of Pregnant Women Counseled (Phase I)	# of Pregnant Women who Received 3 Misoprostol Tablets	#of Enrolled Women who Delivered	# of Delivered Women who used Misoprostol Tablets Correctly	Total Misoprostol Returned	Total Misoprostol Lost
Intervention area	2,054	1,912	1,150	1,080	266	0
Control area	1,382		1,231	1,180		
Total	3,436	1,912	2,381	2,260	266	0

4. Integrated Management of Childhood Illness (IMCI)

ARI and CDD are components of the MoPH's BPHS integrated management of childhood illness (IMCI) intervention, and CS-19's Senior Officer/Health (IMCI), the MoPH's IMCI officer and IMCI officers from STEP and MOVE, supported IMCI activities in 27 HFs through trainings; joint monitoring and supervision, including assessment of health worker's performance (sick child management) and exit interviews of caregivers to assess the quality of counseling provided at each health facility. In Addition, CS-19 continued to implement and document community case management (CCM) with seven BPHS CHWs in two villages in Andkhoy cluster of districts and in Jawzjan province.

4.1. IMCI trainings

In April 2007, the CS-19 Senior Officer/Health (IMCI), MoPH's IMCI officer and STEP/MOVE IMCI officers led a three-day IMCI training for 19 medical officers working in the HFs in Jawzjan Province. Topics included the IMCI concept; IMCI algorithm and its use; assessment and classification of illnesses in sick children under five years of age; diagnosis; treatment; caregiver counseling – especially the importance of patients/caregivers returning to HFs for follow-up. The training included two-day theory and one-day practice. Each participant received a booklet

containing IMCI algorithm. Each medical officer attending this training further gave orientation sessions to BPHS staff working in the HFs: midwives, nurses and pharmacists.

Four CS-19 MCH promoters trained 40 CHWs in Faizabad; 40 in Murdian and 59 CHWs in Shiberghan districts of Jawzjan province. Four MCH promoters trained 32 CHWs in the Andkhy cluster and two newly appointed MCH promoters trained ten CHWs in Darzab and Qoushtepa. Topics included key ARI and diarrhea assessment, examination and classification tasks, counting breath rates using a stop watch (ARI cases), measuring the correct dose of Cotrimoxazole and Paracetamol (for ARI cases), caregiver's counseling, health education and counseling messages, and the use of pictorial referral and reporting forms.

4.2. Monitoring and supervision

In this reporting period, the Coordinator/Health (CS-19), the MoPH provincial director and managers of STEP and MOVE conducted 11 joint supervisions to assess integration of IMCI and other health components within BPHS. CS-19's Senior Officer/Health (IMCI), MoPH's IMCI officer and STEP/MOVE IMCI officers jointly visited HFs 10 times to monitor implementation of IMCI activities. Between September and October 2007, they conducted IMCI assessment using observation checklists to assess the quality of ARI, diarrhea and fever case management and exit interviews to assess the quality of caregiver's counseling. The following table summarizes the results of Observation and exit interviews:

Assessment Areas	Baseline	2005	2006	2007
Observation of Sick Child Management				
% of children's caregivers asked for signs of severe disease	6%	78%	94%	98%
% of children with diarrhea correctly examined (6 key exam. tasks)	1%	90%	80%	91%
% of children with ARI correctly examines (4 key exam. tasks)	4%	37%	96%	96%
% children with diarrhea correctly assessed (degree of dehydration)	30%	88%	98%	99%
% of children with diarrhea who received correct treatment	35%	75%	98%	98%
% of children with ARI who received correct treatment	47%	55%	94%	97%
% of caregivers taught how to prepare ORS	35%	88%	91%	95%
% of caregivers taught how to give drugs at home (for ARI)	35%	43%	66%	77%
% caregivers able to demonstrate how ORS is prepared	14%	63%	75%	83%
% of caregivers taught danger signs of diarrhea and when to return	8%	74%	74%	88%
% of caregivers advised when to return for follow-up (for ARI)	8%	43%	45%	65%
% of caregivers counseled to give more fluids (for diarrhea case)	10%	75%	75%	92%
% of caregivers counseled to give more fluids (for ARI)	10%	64%	50%	76%
% caregivers counseled to breastfeed (for diarrhea)	13%	75%	75%	85%
% of caregivers counseled to breastfeed (for ARI)	13%	73%	83%	84%
Exit Interview				
% caregivers know how to give ORS at home	65%	87%	75%	90%
% caregivers knew how to give medicines to a child with ARI	56%	54%	83%	89%
% caregivers knew when to return for follow-up (for diarrhea)	35%	43%	33%	68%
% caregivers knew when to return for a follow-up (ARI)	-	31%	28%	73%
% caregivers knew signs indicating that a child's health is	35%	43%	33%	66%

Assessment Areas	Baseline	2005	2006	2007
declining at home (for diarrhea case)				
% caregivers knew signs of child's health declining at home (ARI)	-	16%	28%	70%
% caregiver knew hand washing after defecating prevents diarrhea	71%	94%	96%	99%
% caregivers knew hand washing before cooking prevents diarrhea	60%	60%	80%	92%

Results of these monitoring and supervision visits were shared during PHCC meetings; during individual meetings with STEP and MOVE and during IMCI committee meetings and used to develop plans to further strengthen activities for IMCI.

4.3. Community Case Management (CCM)

Community Case Management (CCM) through CHWs has been piloted in the two remote villages of Qarqin and Qaramqol districts since 2004. The main aim of this initiative is to diagnose and treat common causes of childhood illness and death, by enhancing the knowledge and skills of CHWs in sick child management, especially in treating children suffering from diarrhea with ORS and from pneumonia⁷ with a complete course of Cotrimoxazole. More specifically, the initiative aims to demonstrate the usefulness of a three-day IMCI training (versus only one-day: BPHS/PPG leads a one-day training); of pictorial illness classification and counseling tools; of a pictorial algorithm on how to use pediatric Cotrimoxazole. CS-19 MCH promoters continue to use hand-drawn tools and materials to enhance CHWs' knowledge and skills. (An artist will be hired to review and finalize these materials which will be printed in November 2007 after a series of field tests.)

Between April and May 2007, the CS-19 Senior Officer/Health (IMCI), the MoPH IMCI officer and four MCH promoters conducted a knowledge and skills assessments of CHWs in both the intervention area and control area. The following table summarizes and compares these results for both BPHS/PPG trained CHWs and CS-19 Trained BPSH CHWs.

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

Key Assessment Areas	REACH Trained	CS-19 Trained
What are key questions to ask if a mother brings a sick child?		
Age of the child?	67%	86%
Not able to drink or breastfeed?	33%	86%
Vomits everything?	33%	71%
Convulsions?	50%	57%
Change in consciousness/lethargic/Sleepy	17%	86%
Looked for consciousness/lethargic/Sleepy	0%	43%
If child is suffering from ARI, what will you look for? what will you check?		
Observe whether the sick child can drink/or breastfeed	0%	86%
Ask for how long the child is suffering from cough/cold?	67%	71%
Count the breath rates using stop watch	33%	43%
Can CHW count the breath rates correctly?	0%	57%
Look for Chest In-drawing?	0%	43%
If child is suffering from diarrhea, what you look for? what will you check?		
Ask for how long the child is suffering from diarrhea?	67%	71%
Observe whether the sick child can drink/or breastfeed	0%	43%
Ask, if the child has blood in the stool?	0%	71%
Look for sunken eyes?	67%	71%
Pinch the skin on the abdomen?	50%	71%
If a child has fever, what will you look for ? what will you Check?		
Ask for how long the child had fever?	0%	43%
Did the CHW check the child's body temperature correctly?	0%	43%
Look for rashes on trunk, arms and legs	0%	0%
Look for Watery Eyes	0%	0%
Knowledge of Illness Classification		
If a one month old child has cough, fever and fast breathing (60 per minute), what is the child suffering from?	67%	43%
If a 12 month old child has cough, fever and fast breathing (50 per minute), what is the child suffering from?	67%	71%
If a 15 month old child cough, fever and chest in-drawing, what is the child suffering from?	33%	43%
Knowledge of Treatment Pneumonia and Diarrhea		
Treatment of pneumonia in a child who is 6 months old	17%	57%
Can CHW demonstrate ORS preparation correctly	100%	100%
When should a child with pneumonia return for a follow-up session?	67%	71%
Knowledge of caregivers counseling		
Provide increased amount of liquid at home	83%	85%
The need to continue feeding or breast-feeding	67%	86%
The need to return if the child develops signs?	17%	43%
Child is not able to drink or drinking poorly	33%	57%
Child is not able to breast-feed/eat	83%	85%
Child develops a fever	33%	43%
Child develops fast or difficult breathing	17%	57%
Child develops blood in the stool	33%	86%
Change in consciousness/lethargic	33%	57%

Overall the results indicate that with three-day training (both theoretical and practical) and use of pictorial guide for counseling; illness classification and referral, performance of CHWs can enhance CHWs performance more than those trained over only one-day training with limited or no pictorial tools. BPHS CHWs trained by CS-19 can better describe the referral criteria for sick children; can better perform tasks related to illness classification and identify pneumonia or severe pneumonia or very severe disease. Overall CS-19 trained BPHS CHWs' knowledge and skills for caregiver's counseling is also good. This assessment has also identified weaknesses in the knowledge of CHWs where more CS-19 technical support is needed. In December 2007, after the pictorial illness classification, counseling tools; and pictorial algorithm on how to use pediatric co-trimoxazole are finalized, the results will be shared with MoPH, ACCESS/HSSP, UNICEF and other stakeholders at a roundtable discussion forum.

Between November 2006 and August 2007, CCM trained CHWs treated and referred the following number of children:

- CHWs in Kawk village treated 211 children with diarrhea. Of these, 49 children with severe dehydration and 12 children with bloody diarrhea were referred to the HF. A total of 225 children with cough and fast breathing were treated for pneumonia and of these 201 were referred to the HF.
- CHWs in Yousafi village treated 254 children with diarrhea. Of these, 36 children with severe dehydration and 7 children with bloody were referred to HF. A total of 222 children with cough and fast breathing were treated for pneumonia and of these 199 were referred to the HF.

5. Enhancing BCC and CM capacity

In August 2007, CS-19 and ACCESS/HSSP collaborated to conduct a one-week partnership defined quality (PDQ) workshop in Jawzjan for 17 participants from STEP, MOVE, SC/US and MoPH. The workshop was led by CS-19 Coordinator and SC/US CM Officer on ACCESS/HSSP project under the overall technical support of SC/US Senior Program Manager/Health. The overall aim was to improve quality of services by enhancing meaningful participation of community members, especially women (clients) and the community health shuras. Topics included were: PDQ concept; four PDQ phases; conducting quality inquiry from community/client's and health worker's perspective; analysis of information; preparing feedback for communities and health workers; establishing Quality Improvement Team (QIT); preparing for bridging the gap workshop at the community level; conducting the workshop and developing quality improvement plans. The workshop included theoretical and daily community practice. Two districts, Yangaregh and Baba Ali, in Jawzjan province were identified where participants practiced daily what they learned and assisted QIT to develop an action plan. Please see Annex 3, PDQ training schedule.

ACCESS/HSSP plans to replicate PDQ workshop in five USAID/PPG supported provinces in selected districts. In March and April 2008, PDQ pilot in the two districts in Jawzjan will be evaluated.

In March, SC/US coordinated with Mercy Corps to send three CS-19 and one BPHS participants to the BEHAVE workshop facilitated by Judiann McNulty (consultant) and Dr. Tariq SC/US Deputy Director/Program for 21 participants. The main purpose of this workshop was to introduce the behavior change model and BEHAVE framework to develop programs with effective BCC

approaches. The facilitators led participants step by step to complete the BEHAVE framework for their programs. In this workshop participants also learned how to analyze data to identify a problem requiring change; how to establish priority and secondary audiences; how to identify enabling and hindering factors; develop feasible strategies and activities; and how to establish indicators. Please see Annex 4, BEHAVE Training of Trainers (TOT) Training schedule.

6. Coordination

SC/US' Coordinator/Health (CS-19) continues as secretary for the MoPH Provincial PHCC, which is chaired by Provincial Health Director (PHD), and has attended 11 meetings this reporting period along with other SC/US staff and with STEP, MOVE, WHO and UNICEF colleagues, who are regular attendees. The meeting focuses on progress made by CS-19, BPHS and CME programs; identifying problems and their solutions; and planning joint supervision and monitoring visits. During this reporting period, CS-19 also attended one PHCC meeting which focused on developing emergency preparedness and response plan for natural disaster (disease outbreak; earth quake; floods, etc).

CS-19 staff collaborates closely with NGOs implementing BPHS in Jawzjan, STEP and MOVE, to enhance both programs' achievements through offering trainings and joint monitoring and supervision. For example, as described earlier in this report, CS-19 MCH promoters trained all CHWs in birth preparedness and complication readiness in Faizabad, Aqcha, Darzab and Qoushtepa. To complement monitoring and supervision efforts, CS-19 officers conducted supervision and monitoring both jointly as well individually to help improve the quality of some BPHS interventions.

CS-19's Senior Officer/Health (IMCI), the MoPH's IMCI officer; IMCI officers from STEP and MOVE; and the MoPH's HMIS officer form an IMCI committee that meets every six months to discuss problems in implementing sick child management based on the MoPH-approved IMCI approach; and develop strategies to further strengthen its integration. The committee reviews and refines the joint monitoring and supervision plan to make it more appropriate and effective. In this reporting period, the committee met two times to review national IMCI standards; develop IMCI training plans; plan dates for joint monitoring and supervision; identify and make a plan to develop training materials. The committee also decides when to conduct facility-based assessments for observation of health worker's management of sick children; and exit interview of caregivers.

The CS-19 Senior Health/Officer (MNC); MoPH RH officers; STEP and MOVE RH officers and SC/US' Coordinator/Health, Community Midwifery Education (CME) form a RH Committee that regularly meets to discuss problems in the implementation of Maternal and Newborn Care and family planning services and develop strategies to further strengthen these interventions at the facility level. The committee develops plans for joint monitoring to support community midwives in each HF and CHWs. The committee also decides when to conduct facility assessments using MoPH RH checklist. Since February 2007, the RH committee held seven meetings, one every month.

The Senior Officer/Health (MNC) coordinates and collaborates with the CME program regularly. She provides feedback on the performance of the newly graduated Community Midwives and gets advice on how to further support them. The Senior Officer/Health (MNC) also led a one-day workshop for CME faculty members on *Women in Leadership Roles in Health* in which the participants explored leadership: competencies required for effective leadership; types of activities led by a

leader; and using the heart, emotional and intelligence inventory that helps a leader. (This was done following a Save the Children regional workshop for women health sector leaders from throughout Asia: the Philippines, VietNam, Nepal, Bangladesh and Pakistan as well as Afghanistan, which had three participants in the privately-funded workshop.)

Finally, in this reporting period, CS-19 Senior Officer/Health (MNC) and four CS-19 MCH promoters continued to participate in ACCESS/JHPIEGO's visits to support the Prevention of Postpartum Hemorrhage Project in Faryab and Jawzjan.

7. Reporting

Basic monthly tracking and planning reports are prepared by the CS-19 coordinator and reviewed by the his supervisor (Manager/Health) and the Deputy Director/Program for monitoring and progress tracking. These in turn, inform SC/US' annual report to USAID.

8. Progress against work plan (Achievements)

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	Year 4 benchmarks	Bench Marks Achieved	Comments
EPI Refresher Management Training for PHO (including sections on HMIS, M &E, keeping registers/log books, and community mobilization)	To be completed within the 2 nd quarter of Year 4	Yes – Completed in 1st quarter	Provincial EPI and HMIS staff were included in an 8-day training on Routine EPI that included topics on HMIS, registration and community mobilization
EPI refresher training	To be completed within the 3 rd quarter of Year 4	Yes – Completed in 1st and 2 nd quarters	Refresher trainings were conducted for medical officers, vaccinators and EPI supervisors.
Support MOH in NIDs	To be completed in 1st quarter of Year 4 (one NID)	Yes – completed	Three rounds of NIDs were supported in this reporting period.
Refine and finalize IEC tools	To be completed in quarter 4 of Year 4	Yes – completed	MoPH/PPG materials were reviewed and finalized based on ACCESS/HSSP list of IEC materials
Microplans for poor access areas	To be completed in quarter 1 of Year 4	Yes-completed	One microplan was developed in November 2006. This was updated every month.
Immunization coverage data collection (support to PHO)	To be completed each month of Year 4	Yes – completed	Every month EPI data is collected, compiled, analyzed and feedback is prepared.
Feedback on immunization coverage to PHCC	To be completed each month of Year 4	Yes – completed	Every month EPI data is collected, compiled, analyzed and feedback is prepared.
“On the spot” technical support to PHO technical officers	To be completed each month of Year 4	Yes – completed	62 monitoring visits were conducted to 27 Health Facilities.

CDD (15%)			
<p>Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.</p> <p>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.</p> <p>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.</p> <p>Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.</p> <p>Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.</p> <p>Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.</p> <p>Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.</p> <p>Indicator 19. % of caretakers of <5s know at least 2 aspects of home care.</p> <p>Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse.</p> <p>Indicator 21. % of severely ill <5s classified correctly in MOH facilities.</p> <p>Indicator 24. % of <5 diarrhea cases treated correctly in MOH facilities.</p>			
Major Activities	Year 4 benchmarks	Bench Marks Achieved	Comments
TOT on Caregiver's Counseling Techniques	To be completed in 4 th quarter of Year 4	Yes – completed	A three day TOT on basic counseling technique was conducted in September 2007
IMCI refresher courses for new NGO BPHS staff	To be completed in 2 nd quarter of Year 4	Yes – completed	A 3-day IMCI refresher course was held for doctors, nurses and pharmacists.
Observation of sick child management using IMCI checklist	To be completed 1 st and 3 rd quarters of Year 4	Yes – completed	A summary of results is included in this report in the IMCI section.
MCH promoters support CHWs	To be conducted every month in Year 4	Yes – completed	This is an on-going activity each month.
CCM tools, materials and methods refined and finalized	To be initiated from the 1 st quarter of Year 4	Yes – on-going	Tools and materials will be finalized in the 1 st quarter of Year 5
Assessment of CHW's performance in CCM in CS-19 and non-CS-19 supported CHWs for comparison	To be completed in the 1 st and 2 nd quarters of Year 4	Yes – completed	A summary of results is included in this report in the CCM section of this report.
CCM refresher training	To be completed in 1 st and 2 nd quarters of Year 5	Not applicable for Year 4	-
CCM assessed and documented	To be completed in 1 st and 2 nd quarters of Year 5	Not applicable for Year 4	-
“On the spot” technical support to PHO technical officers	To be completed every month of Year 4	Yes – completed	Technical support is provided on each monitoring and supervision visit to HFs

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	Year 4 benchmarks	Bench Marks Achieved	Comments
TOT on Caregiver's Counseling Techniques	To be completed in 2 nd quarter of Year 4	Yes – completed	A three day TOT on basic counseling technique was conducted in September 2007
IMCI refresher courses for new NGO BPHS staff	To be completed in 2 nd quarter of Year 4	Yes – completed	A 3-day IMCI refresher course was held for doctors, nurses and pharmacists.
MCH promoters work with CHWs	To be completed every month of Year 4	Yes – completed	This is an on-going activity each month.
CCM tools, materials and methods refined and finalized	To be initiated from the 1 st quarter of Year 4	Yes – on-going	Tools and materials will be finalized in the 1 st quarter of Year 5
Assessment of CHW's performance in CCM in CS-19 and non-CS-19 supported CHWs for comparison	To be completed in the 1 st and 2 nd quarters of Year 4	Yes – completed	A summary of results is included in this report in the CCM section of this report.
CCM refresher training	To be completed in 1 st and 2 nd quarters of Year 5	Not applicable for Year 4	-
CCM assessed and documented	To be completed in 1 st and 2 nd quarters of Year 5	Not applicable for Year 4	-
CCM lesson learned shared with SSP and MOPH	To be completed in the 4 th quarter of Year 4	Yes – completed	Preliminary results shared with MOVE, STEP and MoPH.
“On the spot” technical support to PHO technical officers	To be completed every month of Year 4	Yes – completed	Technical support is provided on each monitoring and supervision visit to HFs

Nutrition (15%)			
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours.			
Indicator 12. % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.			
Major Activities	Year 4 benchmarks	Bench Marks Achieved	Comments
Refresher Training on Growth Monitoring and Promotion in Andkhoy Cluster	To be completed in the 2 nd quarter of Year 2	Yes – completed	A refresher Tot on growth monitoring was conducted in Andkhoy cluster.
Community mobilization to promote use of iodized salt (MOPH and UNICEF plan)	To be completed every month of Year 4	Yes – completed	Visited bazaar and salt factories and discussions were held with CHC members in all the districts
Assessment of availability (home and shops) and use of iodized salt at homes.	To be completed in the 1 st quarter of Year 4	Yes – completed	100 Salt samples were tested in various villages, bazaar and factories. A short summary of results is in the section of nutrition in this report.
PD/Hearth replicated in two other villages	To be completed in the 2 nd and 3 rd quarter of Year 4	Yes – completed	PD/Hearth extended to two new villages: Khancharbagh in Andkhoy cluster and Misrabad in Jawzjan.
PD/Hearth tools, materials and methods refined and finalized	To be initiated in the 2 nd quarter of Year 4	Yes – on-going	Materials are being reviewed and refined by an artist.
PD/Hearth documented	To be completed in the 2 nd quarter of Year 2	Yes-completed	PD/Hearth in Afghan Tapa and Chighchi villages has been documented.

MNC (30%)			
<p>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.</p> <p>Indicator 9. % of 0-23 month olds whose delivery was attended by skilled health personnel.</p> <p>Indicator 10. % of mothers who had at least one postpartum check.</p> <p>Indicator 13. % of mothers able to report at least two known maternal danger signs during the postpartum period.</p> <p>Indicator 15. % of MOH facilities with female health workers.</p>			
Major Activities	Year 4 benchmarks	Bench Marks Achieved	Comments
Workshop on community education on clean delivery and role of community midwives in selected areas.	To be started in the 2 nd quarter of Year 4	Yes – ongoing	40 CHWs in Faizabad; and 40 in Murdian trained. Training of 59 CHWs in Shiberghan is on-going.
MNC Training for new NGO BPHS staff in Jawzjan	To be completed in 1 st quarter of Year 4	Yes- Completed	Based on training needs assessment a 5-day MNC/RH course for community midwives was conducted
MNC Refresher	To be completed in the 2 nd quarter of Year 4	Not applicable	Not applicable for this reporting period.
Technical support to CME graduate midwives	To be conducted every month of Year 4	Yes – on-going	CS-19 Senior Officer Health (MNC) and MoPH RH Officer provide technical support during regular monitoring and supervision to HF's
Technical support to CHWs involved in the Prevention of Postpartum Hemorrhage demonstration project	To be completed in the 1 st quarter of Year 4	Yes – completed	CS-19 MCH officers supported PPPH project in the demonstration project areas – 4 districts in Andkhoy cluster and Jawzjan province.
Technical support on community mobilization	To be completed in the 1 st quarter of Year 4	Yes – on-going	CS-19 MCH promoters train women health council members in 5 districts of Jawzjan; 3 districts in Andkhoy.
Collaboration as needed on FP activities in BPHS	To be initiated in the 1 st quarter of Year 4	Yes – on-going	CS-19 Senior Officer Health (MNC) and MoPH RH Officer provide technical support during regular monitoring and supervision to HF's
Implementing supervisory checklists and quarterly monitoring	To be conducted every month of Year 4	Yes – on-going	A summary of results is included in this report in the MNC section of this report.
Appoint and train 2 MCH promoters for Darzab and Qush Tapa districts	To be completed in the 2 nd quarter of Year 4	Yes – completed	Two MCH promoters have been appointed and trained in Darzab and Qush Tapa districts of Jawzjan
Support 2 MCH promoters in Darzab and Kush Tapa districts	To be initiated in from the 3 rd quarter of Year 4	Yes – on-going	

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	Year 4 benchmarks	Bench Marks Achieved	Comments
Attend PHCC monthly meetings	To be conducted every month	Yes – on-going	
Attend PHO's technical committee meetings	To be conducted every month	Yes – on-going	CS-19 staff attend RH and IMCI technical committee meeting every month
PDQ (Partnership Defined Quality) implementation in two selected districts	To be completed in the 2 nd and 3 rd quarter of Year 4	Yes – completed	PDQ activities initiated in Baba Ali and Yangaregh in Jawzjan
Equity task force established and action plan development	To be completed in every quarter in Year 4	Yes – on-going	CS-19 represent and participate in IMCI and MNC committee meetings and develop action plans to improve health activities.
CS-19 staff attends provincial BPHS related trainings.	To start in the 2 nd quarter of Year 4	Yes – on-going	CS-19 Senior Officer Health attended a 21 day ACCESS/HSSP led BEOC training.
CS-19, STEP, MOVE and MOPH staff will finalize and sign MOU	To be completed in 1 st quarter of Year 4	Yes – completed	MOUs were completed in the 2 nd quarter of Year 4
A 5-day BCC workshop conducted on BEHAVE concept	To be completed in the 2 nd quarter of Year 4	Yes – completed	CS-19 attended a 10 day workshop on BCC using BEHAVE framework approach.
Collect REACH/BPHS and SSP IEC materials	To be completed in 3 rd and 4 th quarter of Year 4	Yes – completed	CS-19 staff collected all the MoPH IEC materials.
Review DIP/Action plan	To review every month in Year 4	Yes – on-going	CS-19 review DIP/action plan each month
Discussions held with CHC/ <i>shura</i> and plan to support for CHW in all locations developed and implemented through partners.	To initiate in 2 nd and 3 rd quarter of Year 4	Yes – initiated in selected districts	
MOPH Led HMIS workshop facilitated	To be completed in 2 nd quarter of Year 4	Yes – completed	CS-19 supported one HMIS workshops in Andkhoy cluster and Jawzjan province
Coordinate PHO capacity building needs of Jawzjan and northern Faryab, with SSP and TechServe on quarterly basis.	Conduct every month in Year 4	Yes – on-going	As TechServe representative is appointed in Jawzjan – this discussion is held regularly.
Annual Reports	To be completed in quarter 4 of Year 4	Yes – completed	
Final Evaluation	To be completed in 4 th quarter of Year 5	Not applicable for this reporting period	

B. FACTORS WHICH HAVE IMPEDED PROGRESS TOWARDS ACHIEVEMENT

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

In April 2006, when SC/US and SC/UK handed over BPHS program in Jawzjan Province to local NGOs, STEP and MOVE, a high staff turnover and loss of many trained medical officers occurred, affecting IMCI activities. So, in this reporting period, CS-19 staff trained the newly hired doctors and nurses, thus putting IMCI back on track in the project area. Coordination with STEP and MOVE was a challenge in the beginning of this reporting period. With hard work putting partnering practices and Memorandum of Understanding (MOUs) in place between SC/US, STEP and MOVE, coordination and working relationships have improved for the good of impact area communities, especially.

The Provincial Health Director (PHD) of Jawzjan Province changed three times in this reporting period. This was a challenge, but not an impediment to project progress. The current PHD is Dr. Kemia Azizi who has clear understanding of and support for CS-19 activities.

C. TECHNICAL ASSISTANCE REVIEW

The SC/US Coordinator/Health (CS-19) provided overall guidance for the implementation of Year 4 activities. In March 2007, Dr. Hadi Athar, was promoted to Manager/Health for Jawzjan and north Faryab. Previously he was Coordinator/Health (BPHS) and, in that role, who worked closely with CS-19, so he brought tremendous knowledge of BPHS to the project. In this reporting period, he supported CS-19 staff in their field activities and attended regular technical meetings. He also played a key role in bringing CS-19 support closer to health facilities and improved working relationship between CS-19 and STEP/MOVE. SC/US' Senior Program Manager/Health (previously health advisor; now Deputy Director/Program) continued to provide technical support. In this reporting period, he assisted CS-19 staff replicate PD/Hearth; and assess a Community Case Management (CCM) initiative and trained CS-19 staff on PDQ concepts and approaches.

The CS-19 coordinator helped the Senior Officer/Health (IMCI) lead the assessment of CCM; and assisted Senior Officer/Health (BCC) replicate PD/Hearth in two new villages. After attending the initial training on PDQ, the Coordinator, works with STEP and MOVE to guide the integration of PDQ activities within BPHS in their target areas. The CS-19 Senior Officer Health (MNC) plays a key role in building the capacity of RH officers of MoPH, STEP and MOVE. She is a key trainer for MNC, conducts regular training needs assessment and develops plans for capacity building for midwives, nurses and female doctors. She attended a USAID/PPG led 21-day training on BEOC and uses this knowledge to continuously improve MNC services.

In April 2007, SC/US CS Advisor Kathryn Bolles coordinated with Mercy Corps and helped arranged a 10-day TOT for Behavior Change and Communication, using the BEHAVE framework. Ms. Judiann McNulty, consultant for Mercy Corps and Dr. Tariq Ihsan, SC/US Deputy Director/Program, co-facilitated this workshop in Kabul, Afghanistan.

D. CHANGES FROM PROGRAM DESCRIPTION AND DIP

No major changes occurred in the program design as described in the DIP. SC/US as a partner in ACCESS/HSSP has advocated for PDQ inclusion in the National Quality Improvement Standards.

This has been accepted by the Ministry of Public Health, so PDQ, which was cancelled in the previous CS-19 years, has once again been scheduled. Currently CS-19 is assisting ACCESS/HSSP, STEP and MOVE to implement PDQ in two districts of Jawzjan.

E. SUSTAINABILITY

USAID continues to support BPHS implementation through a Partnership Performance Grant (PPG) through two national NGOs STEP and MOVE in Jawzjan Province and through SC/US in the Andkhoy cluster of districts. CS-19 continues its efforts to build the capacity of the Jawzjan Provincial Health Office (PHO) and of professional health staff in 27 health facilities and CHWs in their communities.

In May 2006, after two-days of CS-19 orientation, CS-19's support⁸ of the six health facilities and health staff working in Afghan Tapa, Kauchin, Yangeargh, Cheghchi, Baba Ali and Jaghsai, has been handed over to STEP and MOVE. CS-19 staff continues to integrate PD/Hearth; birth preparedness education; and EPI best practices within BPHS.

Beginning in November 2007, PHO staff and STEP and MOVE staff will conduct joint monitoring and supervision activities to health facilities without CS-19 staff. Once a month, CS-19 and PHO staff will meet and discuss the progress; identify problems; discuss and implement solutions. CS-19 will only participate in joint monitoring and supervision activities only once a quarter.

F. PROGRESS ON RECOMMENDATIONS MADE IN THE MTE

MTE Recommendation	CS-19 Response	Action	Progress
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.	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.	CS-19 coordinated with HSSP and to-date CS-19 Senior Officer Health (MNC) attended one 21-day Competency Based Training on BEOC
2. CS-19 should develop a 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.	CS-19, STEP, MOVE and MOPH staff will finalize and sign MOU by OCT 10, 2006	CS-19, STEP, MOVE and MOPH finalized a MOU in the first quarter of Year 4
3. Based on results of its CCM pilot study, CS-19 should offer lessons learned, successful methodologies and	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	1. CHW treatment of children with pneumonia will be assessed in non-CS-19 and CS-19 supported areas for	1. CHW treatment of children with pneumonia assessed in non-CS-19 and CS-19 supported areas for comparison 2. An artist will finalize the

⁸ CS-19 support included trainings and transportation for the health teams to these six villages.

MTE Recommendation	CS-19 Response	Action	Progress
<p>instruments to the BPHS for training CHWs in CCM. Results should also be shared with SSP to ensure uptake of quality CCM through CHWs.</p>	<p>Department.</p>	<p>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)</p>	<p>CCM tools in November 2007. 3. Initial documentation has started between March and April 2007. 4. Preliminary results shared with MoPH, STEP and MOVE (August 2007)</p>
<p>4. 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.</p>	<p>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.</p>	<p>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)</p>	<p>1. Two MCH promoters were recruited in January 2007 2. 2-week orientation in the first quarter of Year 4 3. Microplan for their work was developed (January 2007) 4. MCH promoters started their work in Darzab and Qush Tepa (February 2007)</p>
<p>5. 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.</p>	<p>Agreed.</p>	<p>1. Budget re-alignment (NOV'06)</p>	<p>1. Budget re-alignment was done between November 2006 and January 2007</p>
<p>6. The project management team should review the</p>	<p>Agreed. CS-19 coordinator and staff will review the CS-19 updated work-plan</p>	<p>CS-19 work-plan reviewed each quarter starting from October</p>	<p>CS-19 work-plan was reviewed each month in this reporting period and will continue as</p>

MTE Recommendation	CS-19 Response	Action	Progress
DIP work-plan quarterly to see that all activities are implemented on schedule.	quarterly to ensure that all activities are implemented on schedule	2006	such
7. 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/US resources. Kathryn Bolles from Home Office and Tariq Ihsan Afghanistan senior manager health will identify SC/US trainer.	SC/US BCC trainer identified (NOV'2006) A six-day BCC workshop conducted (JAN'2007)	SC/US coordinated with IMC to send three CS-19 and one BPHS participants to the BEHAVE workshop facilitated by Judiann McNulty (consultant) and Dr. Tariq SC/US Senior Program Manager/health
8. 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)	1. CS-19 staff collected all REACH/BPHS materials (DEC'06 to FEB'07) 2. CS-19 staff collected Posters for safe Motherhood campaign developed by HSSP 3. CCM IEC materials were reviewed and final selection of materials made – refined materials will be available in NOV'07
9. To foster the continued leadership of the Community Health Councils (CHC, also called <i>shuras</i>) after the project ends, CS-19 should oversee all Community Health Councils in the independent development off a post-project Community Health Action Plan with clearly defined	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)	1. This is on track – but integrated within PDQ approach now being piloted in two villages with help from ACCESS/HSSP and NGOs STEP and MOVE

MTE Recommendation	CS-19 Response	Action	Progress
activities, responsibilities and a workplan.			
10. The project, together with STEP and MOVE, should discuss with <i>shuras</i> regarding how best to support CHWs and keep them motivated. This may include the possibility of small incentives for CHWs	Agreed.	<ol style="list-style-type: none"> 1. An agenda to discuss support for CHW with CHC/<i>shura</i> jointly developed (CS-19 staff, MOVE, STEP and MOPH) – DEC'06 2. Discussions held with CHC/<i>shura</i> 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) 	<p>CS-19 staff with BPHS staff attend CHC meetings and discuss support for CHWs. The leadership training of CHCs has a section on CHW support. CS-19 uses this as an agenda to discuss with CHC members.</p> <p>Only in two selected districts of Jawzjan PDQ approach is being implemented. An action plan developed by QIT has incorporated support for CHWs.</p>
11. 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	<ol style="list-style-type: none"> 1. CS-19 facilitated two HMIS workshops conducted (MAR'07 and JAN'08) 	<ol style="list-style-type: none"> 1. One workshops on HIMS have been conducted in the 2nd quarter of Year 4
12. 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 advisor will help identify a summer intern to help in this regard.	<ol style="list-style-type: none"> 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) 	<ol style="list-style-type: none"> 1. PD/Hearth in pilot areas documented (Jan and FEB'07). 2. Preliminary results shared with MoPH, UNICEF, STEP and MOVE (FEB07) 3. Final results will be shared at National Level in the 1st quarter of Year 5
13. CS-19's IMCI Officer should review the client counseling component of CDD	Agreed. CS-19 has already planned to lead a three-day TOT on "Caregiver's Counselling", which will	Two three-day TOT on caregiver's counselling conducted for 20 doctors, 18 pharmacists	A 3-day TOT on Basic Caregiver's counselling technique conducted (SEPT'07)

MTE Recommendation	CS-19 Response	Action	Progress
training for health workers to clarify and strengthen communication on the danger signs of diarrhea.	highlight danger signs in a sick child as well as focus on home care.	and 12 MCH promoters. (JAN'07)	
14. 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	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 1. Provided 10 wall clocks to CCM trained CHWs (DEC'06) 2. UNICEF Afghanistan does not have stop watches.
15. 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	CS-19 will lead one TOT with partners on community education on clean delivery and role of community midwives.	A refresher TOT on MNC highlighting the importance of clean delivery and roles of midwives, conducted (DEC 2007)
16. 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	CS-19 IMCI certified trainer will conduct a refresher training focusing on assessment and classification of pneumonia.	A 3-day refresher on IMCI conducted (April 2007)
17. 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	CS-19 will coordinate PHO capacity building needs of Jawzjan and northern Faryab, with SSP and TechServe on quarterly basis, starting DEC'06	This is an on-going activity. After every PHCC meeting, PHD, CS-19 coordinator and TechServe discuss capacity building needs

G. INDICATORS REPORTING TABLE

N/A

H. PROGRAM MANAGEMENT SYSTEM

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

H.1. Financial management system

A system of documents and accounting for required matching funds is in place. Separate time sheets for community health volunteers (CHV) and training participants have been developed and used for capturing their foregone or opportunity costs while volunteering with the project. The time sheet is detailed and shows the number of days or hours worked/spent in the project by each CHV. The total hours spent by each CHV or other community member on the project is then multiplied by market rates to determine the value of their contributions to the project (the CS-19 match). For example, in the past 12 months, starting from October 2005, CHVs have contributed total 16,420 hours of work to the project, which is worth \$26,738. The value of the training participants' time is calculated at \$7,386.10. Similarly, in FY 2007 (from October 2006 to September 2007), CHV work time contribution to the project is calculated at 17,495 hours valued at \$25,543; training time is valued at \$7,533.

Cash Contribution

From October 2005 to September 2007, Save the Children has spent \$66,620 (cash contribution) from its private funding sources as match to the project. The match is mainly coming from the staff time (i.e., staff working for the project's success, but their salaries and benefits are not covered by the project). Particularly, part of the Country Director's and Deputy Director of Operations' time, which is paid from non-US Government sources is part of SC/US' cash contribution.

H.2. Human resources

SC/US staff based in Kabul:

Country Director, Deputy Director Operations and Deputy Director Program, Design, Monitoring and Evaluation (DME): Provide overall guidance and relations with MoPH, USAID Mission and other health organizations.

Contract and Grant Compliance Manager: Responsible for budget preparation, budget revisions and budget monitoring plus donor reporting (not paid by CS-19).

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

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

SC/US staff based in Balkh/Jawzjan:

Program Manager, Balkh/Jawzjan: The Program Manager left in July 2007, and this role has been assumed by the Manager/Health (Afghan), with support from the Deputy Director Program (DME) and Senior Program Manager (northern Afghanistan), both expatriates.

Coordinator/Health (CS-19): Responsible for day-to-day management, reporting to the Manager /Health regarding activity planning and implementation, including monitoring the professional development of community-based care providers and ensuring productive collaboration with the PHO and other partners; responsible for organizing and overseeing implementation of training activities for all CS interventions, including district health planning and management for SC/US and MoPH staff; provides technical support for training organized by the PHO and health education sessions conducted at the community level by rural MoPH HF staff in Jawzjan Province and Andkhoy cluster; responsible for writing and submitting monthly reports.

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

Senior Officer Health (IMCI): As of August 2007, this position was absorbed into the CS-19 coordinator's role. For IMCI CS-19 coordinator is responsible for planning, implementing and monitoring IMCI in USAID/PPG supported health facilities by ensuring that BPHS staff are well trained in managing sick children, following national IMCI guidelines; monitors and provides feedback to staff on appropriate case management of childhood illnesses in facilities; monitors and leads CCM trainings in two pilot areas with the help of the manager health and deputy director program (DME) (previously SC/US health advisor).

Senior Officer Health (MNC): Responsible for planning, implementing and monitoring RH and MNC programs in USAID/PPG supported health facilities and ensures that community midwives, female doctors and nurses are well trained in providing RH and MNC services; monitors and provides feedback to staff in facilities and communities; supervises and evaluates community midwives; ensures development and use of appropriate RH and MNC health education materials; coordinates MNC and RH training, provides technical support to MoPH, STEP and MOVE RH officers; provides statistical and narrative information on the RH and MNC program; works closely with other SC/US CS project staff, ensuring coordinated implementation of all project components; and represents CS-19 in RH committee.

Senior Health Officer (BCC): Responsible for planning, implementing, and monitoring behavior change related activities within the health program in targeted areas: uses baseline and monitoring data and other information to identify and document behavior change needs in both the target area

and in health programs nationwide; develops a plan to address the selected behavior change needs, identifying target groups, methodology and specific messages; reviews behavioral change materials available/in use; contributes to all trainings developed and implemented in the target areas to ensure inclusion of behavior change in the curriculum; implements training sessions as appropriate; contributes to the development of a M&E systems for impact of behavior change; works closely with other SC/US CS project staff, ensuring coordinated implementation of all project components. Works closely with MoPH Nutrition Officer and leads PD/Hearth initiative.

Health Officers (2): These posts have been abolished. Funding used to appoint two MCH promoters in the remote districts of Jawzjan Darzab and Qush Tepa.

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

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

SC/US' headquarters is responsible for regular technical assistance and monitoring of CS-19, including annual program reviews, site visits, and technical backstopping through e-mail correspondence and phone calls/conferences. Key SC/US home office staff supporting CS-19 include Kathryn Bolles, Child Survival Advisor responsible for technical backstopping of CS-19 and Carmen Weder, Office of Health Associate Director.

H.4. Communication system and team development

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

Data management occurs at the HF and community level, using national BPHS HMIS reporting instruments throughout Jawzjan Province and Andkhoy cluster of districts.

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

H.5. Local partner relationships

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

NGO coordination/collaboration in country

As already described in this report, SC/US coordinates all activities and planning with other NGOs and the MoPH. As already cited, this includes attending monthly Provincial Health Coordination Committee meetings, which are also attended by representatives of UNICEF, WHO, STEP and MOVE. Coordination and collaboration result in attendance, as needed, at other organizations' trainings, joint meetings and ongoing communication about program implementation.

Information management

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

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

Health worker practices in IMCI in 27 HF are monitored on a monthly basis by PHO and CS-19 staff using a checklist. They conducted two Observation exercises to assess health worker's performance during sick child management; and two exit interview exercises with mothers during this year's supervisory visits. BPHS staff submits childhood illness data/disease monthly reports, with total number of children treated by age and diagnosis, to the PHO on a monthly basis.

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

- MNC and child registry system

The CS-19 project has introduced registration books in all HFs to record antenatal care, births and postnatal care, and relevant health care workers are trained to record all relevant information/data. National HMIS forms are used to record MNC data such as visits to antenatal care; deliveries at the HFs/or at home by midwives; postnatal care; TT vaccination; iron and folic acid supplementation.

I. MISSION COLLABORATION

SC/US collaborates with the USAID Mission in Afghanistan on four health portfolio initiatives (CS, PPG/BPHS and CME, and a DCOF-funded child protection project). SC/US Afghanistan partners with ACCESS on its HSSP to enhance the MoPH IEC department's capacity in BCC and community mobilization. During this reporting period, SC/US, an ACCESS partner, implemented a demonstration project on the prevention of postpartum hemorrhage (see below). The Country Director has a positive relationship with members of the Mission's health team.

J. TIMELINE OF YEAR 4 ACTIVITIES

Please see below.

K. HIGHLIGHTS

The PD/Hearth model is proving to be an effective BCC approach to change poor child feeding and weaning practices. This initiative has been expanded to two new villages. Please see Annex 5, PD/Hearth Report).

CS-19 support to implement a USAID-funded demonstration project (via ACCESS) on the prevention of postpartum hemorrhage by use of misoprostol ended in May 2007 with very promising results. Preliminary evaluation results showed that 75% of women took the misoprostol tablets correctly. Of those who did not, almost all used a skilled birth attendant during delivery. The demonstration also proved, significantly for Afghanistan, that CHWs are acceptable and reliable sources of counseling and misoprostol distribution. Their three-day training, followed by periodic supervision by CHSs, promoted correct use of misoprostol tablets (take tablet soon after the baby is born and before placenta delivers) and prevented misuse. Training and information sharing also ensured that district leaders and local Shura members were fully supportive and found innovative means of motivating community volunteers.

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	2007			2008									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
EPI Refresher Management Training for PHO					X								CS-19 EPI Sr. Health Officer, MOPH EPI Officer	27 doctors, 30 vaccinators (including HMIS, registration, and CM)
EPI refresher training			X			X				X			CS-19 EPI officer, MOH EPI Manager, WHO PPO	20 vaccinators and 20 doctors from BHCs, CHCs and DH
Support MOH in NIDs			X			X					X		CS-19 EPI Officer and PHCC NID Committee	Three Micro-planning sessions
Adapt and finalize HSSP IEC tools				X (if need be)									CS-19 BCC Officer with PHCC BCC staff	IEC materials developed and displayed in HF
Microplans for poor access areas	X		X		X		X			X		X	CS-19 EPI Officer, PHO staff	6 times microplans reviewed and refined for poor access areas
Immunization coverage data collection (support to PHO)		X		X		X		X		X		X	CS-19 EPI officer & MOH EPI manager	Six monitoring visits completing 20 facilities each time
Feedback on immunization coverage to PHCC	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 EPI Officer with PHO	12 feedback sessions
“On the spot” technical support to PHO	X		X		X		X			X		X	CS-19 EPI Officer with PHO	PHO EPI and HMIS officers (6 visits)

CDD (15%)														
<p>Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.</p> <p>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.</p> <p>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.</p> <p>Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.</p> <p>Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.</p> <p>Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.</p> <p>Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.</p> <p>Indicator 19. % of caretakers of <5s know at least 2 aspects of home care.</p> <p>Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse.</p> <p>Indicator 21. % of severely ill <5s classified correctly in MOH facilities.</p> <p>Indicator 24. % of <5 diarrhea cases treated correctly in MOH facilities.</p>														
Major Activities	2007			2008									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
TOT on Caregiver's Counseling Techniques (Refresher)					X								SC/US Senior Manager Health and CS-19 coordinator	27 doctors, 23 midwives and 23 pharmacists
IMCI refresher courses for new NGO BPHS staff								X					CS-19 Coordinator, MOPH IMCI officer	27 doctors and 23 pharmacists
Observation of sick child management using IMCI checklist			X			X			X			X	CS-19 and MOPH IMCI Officers	implemented at Health Facilities
MCH promoters support CHWs	X	X	X	X	X	X	X	X	X	X	X	X	MCH promoters	MOH-selected CHWs in Andkhoy cluster and selected Jawzjan province

CCM tools, materials and methods refined and finalized	X	X	X										CS-19 IMCI Officer and an artist.	15 CCM Training sets including tools, materials and methods
Assessment of CHW's performance in CCM in CS-19 and non-CS-19 supported CHWs for comparison			X										SC/US Senior Manager Health, CS-19 and MOPH IMCI Officer	7 CCM trained CHWs 7 BPHS trained CHWs
CCM refresher training			X										CS-19 IMCI and BCC officers	7 CHW in CCM pilot area
CCM assessed and documented			X	X	X								CS-19 staff, NGO partners	Finalized Report
"On the spot" technical support to PHO technical officers	X		X		X		X		X		X	X	CS-19 IMCI Officer	PHO, STEP and MOVE IMCI Officers

ARI (20%)														
<p>Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.</p> <p>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.</p> <p>Indicator 8. % of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a HF or received antibiotics from an alternative source.</p> <p>Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.</p> <p>Indicator 16. % of MOH facilities with 1 or more stock-out of essential drugs last month.</p> <p>Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.</p> <p>Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.</p> <p>Indicator 19. % of caretakers of <5s know at least 2 aspects of home care.</p> <p>Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse.</p> <p>Indicator 21. % of severely ill <5s classified correctly in MOH facilities.</p> <p>Indicator 23. % of <5 ARI cases treated correctly in MOH facilities.</p>														
Major Activities	2007			2007									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
TOT on Caregiver's Counseling Techniques					X								SC/US Senior Manager Health and CS-19 coordinator	27 doctors, 23 midwives and 23 pharmacists
IMCI refresher courses for new NGO BPHS staff								X					CS-19 Coordinator, MOPH IMCI officer	27 doctors and 23 pharmacists
MCH promoters work with CHWs	X	X	X	X	X	X	X	X	X	X	X	X	MCH promoters	MOH-selected CHWs in Andkhoy cluster and selected Jawzjan province
CCM tools, materials and methods refined and finalized	X	X	X										CS-19 IMCI Officer and an artist.	15 CCM Training sets including tools, materials & methods
Assessment of CHW's performance in CCM in CS-19 and non-CS-19 supported			X										SC/US Senior Manager	7 CCM trained CHWs 7 BPHS trained

CHWs for comparison													Health, CS-19 and MOPH IMCI Officer	CHWs
CCM refresher training			X										CS-19 IMCI and BCC officers	7 CHW in CCM pilot area
CCM assessed and documented			X	X	X								CS-19 staff, NGO partners	Finalized Report
CCM lesson learned shared with SSP and MOPH							X						CS-19 IMCI Officer	PHO, STEP and MOVE IMCI Officers
“On the spot” technical support to PHO technical officers	X		X		X		X		X		X	X	CS-19 IMCI Officer	PHO, STEP and MOVE IMCI Officers

Nutrition (15%)														
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours.														
Indicator 12. % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.														
Major Activities	2007			2008									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 3
Refresher Training on Growth Monitoring and Promotion in Andkhoy Cluster							X						CS-19 MNC and BCC officers	MOPH Nutrition Officer, 8 midwives (BHC and CHC) in Andkhoy cluster
Community mobilization to promote use of iodized salt (MOPH and UNICEF plan)	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 BCC Officer and MOPH Nutrition Officer	18 BPHS Community Health Supervisors (CHSs) trained xxx CHC/ <i>shuras</i> trained in Andkhoy cluster
Assessment of availability (home and shops) and use of iodized salt at homes.			X				X						CS-19 BCC and MOPH Nutrition Officers	Kitchen salt tested 200 baseline; 200 repeat - Shops 200 baseline and 200 repeat
PD/Hearth tools, materials and methods refined and finalized	X												CS-19 BCC, MNC and MOPH Nutrition Officers	Materials disseminated to partners and implementing NGOs
PD/Hearth documented	X	X											SC/US SPM/Health Health, CS-19 and MOPH IMCI Officer	Final document with methods, tools and IEC materials, impact and lesson learned

MNC (30%)														
Indicator 1. % of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months old. Indicator 9. % of 0-23 month olds whose delivery was attended by skilled health personnel. Indicator 10. % of mothers who had at least one postpartum check-up. Indicator 13. % of mothers able to report at least two known maternal danger signs during the postpartum period. Indicator 15. % of MOH facilities with female health workers.														
Major Activities	2007			2008									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
Refresher on community education on clean delivery and role of community midwives							X						CS-19 MNC Officer and MCH promoters	27 CHSs trained 80 CHW trained
MNC Refresher								X					CS-19 MNC Officer and MCH promoters	27 doctors, 15 nurses; 23 midwives
Technical support to CME graduate midwives	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 MNC and MOPH RH Officer	23 graduate midwives
Technical support on community mobilization			X					X					CS-19 MNC and MOPH RH Officer	PHO, STEP and MOVE
Collaboration as needed on FP activities in BPHS	X			X			X			X			CS-19 RH Officer, MOPH RH Officer	BPHS staff and CHWs
Implementing supervisory checklists and quarterly monitoring	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 RH Officer	Checklists in use in all districts
Support 2 MCH promoters in Darzab and Kush Tapa districts	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 MNC and MOPH RH Officers	Supervisory visit once a month for the remaining project period

All interventions														
Indicator 22. CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality. Indicator 25. % of mothers receiving general information or advice on health or nutrition from a member of the informal community network. Indicator 26. % of CDQ Quality Improvement Committees including at least one female participant.														
Major Activities	2007			2008									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
Attend PHCC monthly meetings	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 Coordinator.	CS-19 representation in each mtg
Attend PHO's technical committee meetings (RH, EPI, HMIS and IMCI committee)	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 staff	HMIS, EPI, RH and IMCI Committee monthly mtg.
PDQ (Partnership Define Quality) implementation in two selected districts	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 staff with BPHS NGO staff	Work plan in place with selected sites
Equity task force established and action plan development	X	X	X	X	X	X	X	X	X	X	X	X	PHCC	Action plan created
CS-19 staff attends provincial BPHS related trainings.			X				X						CS-19 staff	CS-19 staff attendance in BPHS trainings
Review DIP/Action plan	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 staff	Once quarterly
CHC/ <i>shura</i> to support for CHW in all locations (plan developed and implemented through partners.	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 staff, MOVE, STEP and MOPH	20-30 shura discussions, agenda and plans
MOPH Led HMIS workshop facilitated					X								MOPH HMIS officer and CS-19 staff	Two HMIS workshops conducted for BPHS staff
Coordinate PHO capacity building needs of lawzian and	X	X	X	X	X	X	X	X	X	X	X	X	Senior Manager	Regular meetings, joint

northern Faryab, with SSP and TechServe on quarterly basis.													Health and CS-19 Coordinator	planning
Final Evaluation												X	External Evaluator and CS Advisor	Final Report

Annexes

Annex 1: EPI Microplan

Annex 2: EPI Poster

Annex 3: PDQ Training Schedule

Annex 4: BEHAVE TOT Training Schedule

Annex 5: PD/Hearth Report

Annex 6: TOT on Basic Caregiver's Counseling Techniques

Annex 7: Updated CSGHP Data Form

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

Annex 1: Updated EPI Microplan for District Qush Tepa, Jawzjan Province

Demographic Information س و فن دروم رد تامول عم							Hours by vehicle	Planned dates of community contact			
R شماره R	R نام قریه R	R نفوس مورد هدف R									
SN		Name of village	R نفوس مجموعی قریه R	R نفوس زیریکسال R	R نفوس یک تا دو سال R	R زنان زمان باروری R					
Cluster/site	Total population of villages		Children under 1 year of age	Children 12 -23 months of age	CBA Women	1st contact		2nd contact	3rd contact	4th contact	
1	Cluster-1 Jarqudoq	Turman Qudok	2100	84	84	420	2	21/07/2007	22/08/2007	26/09/2007	28/11/2007
		Now Abad	840	34	34	168	2	21/07/2008	22/08/2008	26/09/2008	28/11/2008
		Aqsai	1400	56	56	280	3	21/07/2009	22/08/2009	26/09/2009	28/11/2009
Cluster total			4340	174	174	868					
2	Cluster-1 Qush Tepa	Sozma	175	7	7	35	3	21/07/2011	22/08/2011	26/09/2011	28/11/2011
		Qudoqcha	280	11	11	56	2	21/07/2012	22/08/2012	26/09/2012	28/11/2012
		Hous Baili Payan	210	8	8	42	1	21/07/2013	22/08/2013	26/09/2013	28/11/2013
		Hous Baili Bala	350	14	14	70	3	21/07/2014	22/08/2014	26/09/2014	28/11/2014
		Kochar Boi	490	20	20	98	3	21/07/2015	22/08/2015	26/09/2015	28/11/2015
Cluster total			1,505	60	60	301					
3	Cluster-2 Qushtepa	Tash Akhor	560	22	22	112	3	21/07/2015	22/08/2015	26/09/2015	28/11/2015
		Dara	105	4	4	21	2	21/07/2016	22/08/2016	26/09/2016	28/11/2016
		Aslam	140	6	6	28	2	21/07/2017	22/08/2017	26/09/2017	28/11/2017
		Aashor Qule	420	17	17	84	3	21/07/2018	22/08/2018	26/09/2018	28/11/2018
		Tash Sai	70	3	3	14	2	21/07/2019	22/08/2019	26/09/2019	28/11/2019
		Charsai	2,100	84	84	420	3	21/07/2020	22/08/2020	26/09/2020	28/11/2020
Cluster total			3,395	136	136	679					

Annex 2: EPI Poster



 Save the Children USA
 CS-19 Program

واکسین Vaccination



واکسین کردن ممکن است سبب مرده تب شود. این عکس العمل طبیعی بوده ولی اگر تب شدید شود و یا بیشتر از 3 روز دوام نماید، طفلتان را به مرکز صحن (کلینیک) ببرید.



مطلقاً تا ۲ روز بعد از ولادت اسی ۱۵ روز واکسین نمائید تا در مقابل امراض توبرکلوز و قحط اطفال و فایده شود.



دور چهارم واکسین را به طفلتان در سن ۱۴ هفتهگی تطبیق نمائید. واکسین ها هیچ نوع خطر ندارند، حتی اگر طفل تب، ریزش، سرخه یا اسهال هم داشته باشد باید واکسین ها تطبیق گردند.



اطفالتان را برای دور دوم واکسین به سن ۶ هفتهگی به مرکز صحن (کلینیک) بیاورید در مقابل امراض تیتانوس، دفتیری، سیاه سرفه و آبله و آبله شون. دوره های بعدی آن در ۱۰ هفتهگی و ۱۴ هفتهگی تطبیق میشوند.



تمام خانم های حامله برای حفظ خود و طفل آینده خود از امراض تیتانوس، باید حداقل ۲ بار قبل از ولادت واکسین ضدانیم بختبار را بگیرند. بار اول که برای گرفتن واکسین به مرکز صحن (کلینیک) میروید، برای آن یک کارت میگذرانید که در آن نوزاد های بعدی واکسین نوشته شده است. هر وقت که به مرکز صحن (کلینیک) میروید کارت را همراهتان ببرید.



بعد از واکسین درد، سرخی و پشه های گری در جای واکسین شاید پیدا شود. این عکس العمل طبیعی بوده و قابل تشویش نیستند. اما اگر از سه روز زیاد کرد طفل را به مرکز صحن (کلینیک) ببرید.



اطفالتان را برای دور پنجم واکسین برای سرخشان در ماه نهم به مرکز صحن (کلینیک) ببرید. اطفالتان را قبل از رسیدن به سن یکسالگی برای واکسین کردن، حداقل پنج مرتبه به مرکز صحن (کلینیک) ببرید تا تمام دوره های واکسین ها را تکمیل نمائید.



تمام خانم های ۱۵ تا ۴۹ ساله باید تمام دوره های واکسین ضد تیتانوس را تکمیل کنند تا خودشان و اطفال نوزادشان به مقابل امراض تیتانوس به صورت درست محافظه شوند.

Annex 3: PDQ Training Plan/Schedule, Day 1: 12 August 2007

Time	Modules	Contents of the session	Methodology	Facilitator/s
8:00 – 8:15 am	Introduction	<ul style="list-style-type: none"> - Registration - Recitation of holy Quran - Opening by PHD - Participants' introduction 	Pair-up with the participant seated next. Introduce each other.	Dr. Qemia Dr. Mansoor
8:15-8:45 am	Workshop objectives	<ul style="list-style-type: none"> - Share participants' expectations from the workshop - Presentation of objectives - Compare participants' expectations with workshop objectives. - Review of agenda 	Cards, flip charts and markers Write 1-2 expectations Paste expectations in broad categories Display objectives of the workshop and compare with participants/ expectations	Dr. Mansoor Dr. Sharifi
PDQ Session 1: Describing Community Consultation Process (Partnership Defined Quality Process or PDQ)				
8:45 – 9:10 am	Why PDQ?	<ul style="list-style-type: none"> - Rationale for implementing PDQ a community consultation process 	Presentation (Dari) Questions & answers	Dr. Mansoor Dr. Tariq
9:10-9:30am	Describe how perceptions of "quality" affects clients and vendors (service providers)	Participants will be asked to define quality of vegetables in a market place (negative/ positive) that influences whether or not to buy them.	1. Each participant will use two cards to write quality of onions or tomatoes they look when buying them 2. Each participant will be given two cards to jot down quality of vegetable vendor. 4. Conclude by asking question: <ul style="list-style-type: none"> - What is about vegetables you choose that makes you buy them? Are there those that you avoid to buy? Why? - If ten vendors are selling the same vegetables what makes you go to the one that you do? Are there those that you avoid? Why? What should the other nine vendors do to improve their business?	Dr. Sharifi Dr. Tariq
Time	Modules	Contents of the session	Methodology	Facilitator/s
PDQ Session 2: Four phases of PDQ implementation				
9:30 – 10:00 am	Steps involved in PDQ process	Presentation will highlight all phases of PDQ process:	Presentation Questions and Answers	* Dr. Mansoor Dr. Sharifi

Time	Modules	Contents of the session	Methodology	Facilitator/s
		<ul style="list-style-type: none"> - Building support - Exploring quality - Bridging the gap - Working in partnership 		
10:00-10:15am	TEA BREAK			
PDQ Session 3: In Preparation for PDQ				
10:15 – 10:30 am	Preparations to consider when planning for achieving a goal or a task.	Participants will mention steps involved in the preparation to improve quality issues	<u>Brain storming (refer to session 9:10-9:30am)</u> From the exercise on “quality” pick one negative quality issue and ask participants: <ul style="list-style-type: none"> - What would they improve? - Why would they improve? - How would they improve? - Who would they involve 	Dr. Sharifi Dr. Mansoor
10:30-11:00 am	PDQ process planning considerations	Presentation will elaborate on PDQ process planning consideration: setting goals & objectives; identifying level of services to focus PDQ efforts; identifying community most interested in PDQ process	<u>Presentation</u> Questions and answers Explain the matrix	Dr. Mansoor Dr. Tariq
11:00-12:00 noon	Identifying and prioritizing service quality issues in participants target areas.	<ul style="list-style-type: none"> * To identify services needing quality improvement most. * To identify levels to target * To identify factors affecting quality and needing improvement 	<u>Group work think about 3 clinics</u> <ol style="list-style-type: none"> 1. Group discussions (3)- using analysis matrix 2. Prioritize the most important aspect of the quality (Access, demand, service) 3. Prioritize the level of service to be targeted. 4. Prioritize factors that affecting quality and needing improvement 5. Presentations by each group. 	Dr. Mansoor Dr. Sharifi Dr. Tariq

Time	Modules	Contents of the session	Methodology	Facilitator
12:00-12:10 pm	Establishing Goals and Objectives	Presentation on example goals & objectives	<u>Presentation</u>	Dr. Sharifi Dr. Tariq
12:10-12:30 pm		Goals and objectives are established using the prioritized list of quality issues from above exercise	<u>Group work & presentations</u> Use each group's list (above) to facilitate this exercise. Help establish goals and objectives	Dr. Sharifi Dr. Mansoor Dr. Tariq
12:30 – 1:30 pm	LUNCH BREAK			
1:30-1:45 pm	Other considerations before PDQ implementation	- Planning for all phases of PDQ implementation	<u>Presentation</u> <u>This session is more a conclusion f session 10:30 – 11:00am)</u>	Dr. Mansoor Dr. Sharifi
1:45-2:00pm	What did we learn today?	Revision of main points learned so far Repeat steps of PDQ (four phases)	Questions and Answers Participants will recite all phases of PDQ and give one example of each phase.	Dr. Mansoor Dr. Tariq
PDQ Session 4: Phase I: Building support				
2:00-2:30pm	Presentation on Building support	Purpose of this phase; components of this phase; who to contact; how best to present PDQ concept; Reasons why partners might be interested in PDQ.	Presentation	Dr. Sharifi Dr. Mansoor Dr. Tariq
2:30-3:00pm	Building support (ideas)	Participants will discuss methods of presenting PDQ process to health workers and communities.	Group discussion (3) keep matrix in front of you 1. Who to contact? And why? 2. how will you present PDQ (methods) 3. What rationale will you use to highlight the importance of using PDQ process?	Dr. Sharifi Dr. Mansoor Dr. Tariq
3:00-3:30pm	Presentation by 3 groups			

Day 2: 13 August 2007

Time	Modules	Contents of the session	Methodology	Facilitator
8:00-8:15 am	Pearls of wisdom	Review of learning from the previous day	Questions and answers	Dr. Tariq/Dr. Sharifi Dr. Mansoor
8:15-8:30 am	PDQ – examples from other countries	Presentation contains examples from Nepal, Peru and other countries.	Presentation (purpose is to reinforce the idea of PDQ and its effectiveness)	Dr. Mansoor
Phase II: Exploring Quality (Health Workers' perspective on Quality of services)				
8:30-9:00 am	Participants describe quality of services from their projects (both negative and positive)	Participants will describe quality (good and bad) from their own perspectives. These may be: Access; Availability; Client-provider relations: Communication/information; Safety; Facility ; Equipment & supplies; systems & policies; cultural issues	Group discussions (three) Each group gets pieces of paper. 4 for each participant. Facilitators: paste slips under broad categories (Access; availability; demand; equipment; etc) after reading and discussing with participants where to place them. Conclude: review all responses under each broad category.	Dr. Sharifi Dr. Mansoor
9:00-10:00	Participants describe quality of services from Technical Standard point of view.	Participants review minimum standards they should follow as professionals	Group discussions (three) 1. EPI standards 2. Maternal and newborn care standards 3. TB Control standards Each group will prepare a feedback for not more than 10 minutes.	Dr. Tariq/Dr. Sharifi Dr. Mansoor
10:00-10:15 am	TEA BREAK			
10:15-10:30am	Differences between minimum standards and practice	Participants will compare the standards with the practice (session 8:30-9:00) and assess discrepancies.	Questions and answer session Post flip charts from sessions 8:30-9:00 and 9:00 -10:00 Ask questions: 1. Are these standards available to everyone? 2. Are these standards widely used? 3. What are the discrepancies between these standards and the practice and how they impact work?	Dr. Mansoor Dr. Sharifi
Time	Modules	Contents of the session	Methodology	Facilitator
10:30-11:15am	Problem analysis	The participants will analyze the quality issues from their	Participants will identify 2-3 main problems related to the quality (standards versus practice)	Dr. Tariq/Dr. Sharifi Dr. Mansoor

Time	Modules	Contents of the session	Methodology	Facilitator
		services is – they can contribute meaningfully to the quality improvement process.		
2:00 – 3:00 pm	Preparing for quality exploring exercise (field work)	Participants will choose three sites in Shiberghan districts. Review the analysis matrix developed on the first day. Choose 1-2 quality problems; revise goals and objects; revise list of people to meet; and develop quality exploring checklist for health workers and potential clients	Going back to session 11:00-12:00 Day 1. Use the analysis matrix. Three groups: Presentation of the plan Presentation of the checklist	Dr. Tariq/Dr. Sharifi Dr. Mansoor
3:00-3:30 pm	Preparing for the field trip	Developing plans for introducing PDQ Logistics; group leader; etc		Dr. Mansoor Dr. Sharifi

Day 3: 14 August 2007

Time	Modules	Contents of the session	Methodology	Facilitator
Field-test quality exploration tools in three locations of Shiberghan				
8:00 - 11:00am	Field-test	Participants will build support by introducing PDQ concept to communities and Health Workers. Participants will explore perception of quality from Community and Health Worker's perceptions.	All participants will divide into three teams. Each team will have two sub-teams (6) - Three teams will first introduce PDQ concept to health workers and then explore quality issues around selected health service - Three teams will first introduce PDQ concept to community members (men, women) and then explore quality issues around selected health service (these three teams may need to be further split to discuss issues with men and women separately). <i>They will inform key representatives to attend a meeting on August 15, 2007 at the BHC/health centre</i>	Dr. Mansoor Dr. Sharifi Dr. Tariq
11:00 – 11:15 am	TEA BREAK			

Time	Modules	Contents of the session	Methodology	Facilitator
Phase III: Preparing for the Bridging the Gap phase				
11:15 -12:30 pm	Categorize Information	Participants will learn how to conduct analysis and how to categorize information. They will also learn that categorizing information" is one step to prepare for bridging the gap".	Participants will use information gathered during the field-test The first step is categorizing information The 2 nd step is analysis using Venn Diagram Three groups	Dr. Mansoor Dr. Sharifi Dr. Tariq
12:30-1:30pm	LUNCH BREAK			
1:30 – 2:00 pm	Presentations	Presentations will include categorized information followed by presentation on Venn Diagram (or analysis)	Three groups	Dr. Mansoor Dr. Sharifi Dr. Tariq
2:00-2:30 pm	Preparing for bridging the gap workshop	Participants plan how to conduct bridging the gap workshop. Plan has a session on sharing information; developing common vision; and selecting members for QI team.	Same three teams - Use PDQ manual for guidance - how will categorized information shared - how will the analysis be shared - community member confirm - method for selecting community reps for QI team	
2:30-3:30 pm	Presentations			

Day 4: 15 August 2007

Time	Modules	Contents of the session	Methodology	Facilitator
Field Trip: Bridging the gap workshop in three designated places				
8:30-11:00 am	Bridging the gap workshop at 3 locations (health facilities)	Participants conduct bridging the gap workshop. They share information; develop a common vision; and selecting members for QI team.	Same three teams - categorized information is shared - Venn Diagram/analysis is shared - community member confirm - select community reps for QI team - developing a shared vision Teams inform selected members to attend QI team on August 16, 2007 at the health facility	Dr. Mansoor Dr. Sharifi Dr. Tariq
11:00-11:15 am	TEA BREAK			
Phase IV: Working in Partnership				
11:15-12:15 pm	Introduction to Action Planning Matrix	Participants will use a matrix which includes: Problem; factors; solutions; desired action; action taken by whom; resources required; time action is taken. They will analyze discussions	Presentation on the matrix (introduction) Group discussions (3). Matrix is provided. Practice using matrix	Dr. Mansoor Dr. Sharifi Dr. Tariq

Time	Modules	Contents of the session	Methodology	Facilitator
		with HWs and communities and further discuss root problems using tools (problem analysis tree or Fish bone analysis)	Facilitators will teach participants how use problem analysis tree or fish bone analysis tool.	
12:30-1:30 pm	LUNCH BREAK			
1:30-3:00 pm	Introduction to Tracking Table For QI Team	Participants will use a matrix that will help QIT track progress. This includes key problems; desired level of change; proof of change; methods of measuring change; and bench marks.	Presentation on the matrix (introduction) Group discussions (3). Matrix is provided. Practice using matrix	Dr. Mansoor Dr. Sharifi Dr. Tariq
3:00-3:30 pm	Presentations	Participants will show how they have used the two matrixes and how they will use these with QIT		Dr. Mansoor Dr. Sharifi Dr. Tariq

Day 5: 16 August 2007

Time	Modules	Contents of the session	Methodology	Facilitator
Field-trip: working with Quality Improvement team in the three designated locations				
8:30-10:30 am	Developing quality improvement action plan	Participants will use a matrix which includes: Problem; factors; solutions; desired action; action taken by whom; resources required; time action is taken. They will also use analysis of discussions with HWs and communities. They will further discuss root problems using tools (problem analysis tree or Fish bone analysis)	Three teams in three locations. QIT meets at the BHC First the community members go on a round to see BHC activities. Health facility staff introduces them as members of QIT. Facilitators use matrix to complete the action plan. Roles of QIT (health workers and community reps) are highlighted; dates are finalized;	
10:30-12:00pm	Developing QIT action plan tracking plan.	Participants will use a matrix that will help QIT track progress. This includes key problems; desired level of change; proof of change; methods of measuring change; and bench marks.	Facilitators introduce the matrix that would help track the action plan. Roles of QIT (health workers and community reps) are highlighted; dates are finalized; bench marks are identified/ finalized Date for the next meeting is identified and agreed.	

Time	Modules	Contents of the session	Methodology	Facilitator
12:30-1:30pm	LUNCH BREAK			
1:30-2:00 pm	National Quality Assurance process and PDQ in it.	National Quality Assurance standards review. Discussions on how to integrate PDQ.		
2:00-3:00 pm	How to integrate PDQ within the role of Health facility staff	Discuss types of orientation and training required for HWs.		
3:00	Closing	MoPH Provincial Health Director (PHD) closing remarks and certification		

Annex 4: BEHAVE TOT Training Schedule

Mercy Corps and Save the Children-USA, Kabul, Afghanistan, March 5-10, 2007

March 5, Monday

Time	Topic	Duration
8:00 – 8:30	Registration	.5 hour
8:30 – 9:00	Welcome and introductions, presentation of participants, logistics announcement	.5 hour
9:00 – 10:30	Workshop goals & objectives, agenda review, participant expectations	1.5 hours
10:30 – 10:45	BREAK	
10:45 – 12:00	Introduction to behavior change, role of change agent, vocabulary	1 hr 15 min
12:00 – 13:00	LUNCH	
13:00 – 15:00	Overview of the Behavior Change Matrix	2 hours
15:00 – 15:15	BREAK	
15:15 – 17:15	Defining the behavior	2 hours
17:15 – 17:30	Evaluation of the day	15 min.

March 6, Tuesday

Time	Topic	Duration
8:30 – 8:45	Energizer - Review of previous day	25 min
8:45 – 10:30	Identifying the priority group and secondary group	1 hr 35 min
10:30 – 10:45	BREAK	
10:45 - 12:00	Priority group + behavior	1 hr.15 min
12:00 – 13:00	LUNCH	
13:00 – 15:30	Identifying motivators, deterrents, and facilitating factors	2.5 hours
15:30 – 15:45	BREAK	
15:45 – 16:45	Identifying motivators, deterrents, and facilitating factors, continued	1 hour
16:45 – 17:30	Review and evaluation of the day	45 min.

March 7, Wednesday

Time	Topic	Duration
8:30 – 8:45	Energizer (review of previous day)	15 min
8:45 – 10:30	Using qualitative research to identify key factors (includes doer/non-doer)	1 hr 45 min
10:30 – 10:45	BREAK	
10:45 – 12:00	Conducting qualitative research and developing questions for qualitative research	1 hr 15 min
12:00 – 13:00	LUNCH	
13:00 – 15:30	Identifying Key Factors from our research	2.5 hours
15:30 – 15:45	BREAK	
15:45 – 16:45	Prioritizing key factors	1 hour
16:45 – 17:00	Evaluation of the day	15 min.

March 8, Thursday

Time	Topic	Duration
8:30 – 8:45	Review of previous day energizer	15 min
8:45 – 9:45	Cluster Critique of each group's work	1 hour
9:45 – 10:30	Revision of behavior change framework	45 min.
10:30 – 10:45	BREAK	
10:45 – 12:00	Selecting activities and messages to address the key factors	1 hr. 15 min.
12:00 – 13:00	LUNCH	
13:00 – 15:30	Group work to select activities and messages	2.5 hours
15:30 – 15:45	BREAK	
15:45 – 16:45	Cluster critique of group work and revision of work	1 hour
16:45 – 17:00	Review and evaluation of the day	15 min.

March 9, Friday

Time	Topic	Duration
8:30 – 8:45	Energizer - Review of previous day	15 min
8:45 – 9:30	Determining effectiveness of the strategy	45 min.
9:30 – 10:30	BREAK	
10:30 – 12:00	Developing Measurable indicators for the framework	1.5 hours
12:00 – 13:00	LUNCH	
13:00 – 15:00	Final critique of group work and revisions	2 hours
15:00 – 15:15	BREAK	
15:15 – 16:00	From one BC framework to a BC Strategy	45 min.
16:00 – 16:15	Evaluation of the day	15 min.

March 10, Saturday

Time	Topic	Duration
8:30 – 8:45	Review of previous day	15 min
8:45 – 10:00	Wheel of Suggestions	1 hr. 15 min.
10:00 – 10:15	BREAK	
10:15 – 12:00	Planning to create a behavior change strategy	1 hr. 45 min.
12:00 – 1:00	LUNCH	
13:00 – 14:00	Presentation of plans	1 hour
14:00 – 15:00	Evaluation and Closing	1 hour



Annex 5: PD/Hearth Report

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



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

Prepared By:

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February 2006

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Glossary of Acronyms and Terms

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

1 Summary

Description

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

Objectives

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

Activities

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

Results

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

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

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

Recommendations

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

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

2 Background on Positive Deviance and Hearth Approach

2.1 What is PD/Hearth?

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

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

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



2.2 *Why does PD/Hearth work?*

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

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

3 Objective of PD Hearth in Jawzjan Province

3.1 Individual and Community Outcomes

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

PD/HEARTH OBJECTIVES IN JAWZJAN PROVINCE

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

3.2 Direct and Indirect Target Population

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

DIRECT TARGET POPULATION

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

INDIRECT TARGET POPULATION

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

4 Overview of the PD/Hearth Pilot

4.1 Rationale for using the PD/Hearth Approach

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

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

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

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

4.2 Additional Information: Geographical Location

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



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

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

4.3 Resources

Pilot Implementation Cost

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

Personnel

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

Materials

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

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

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

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

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

4.4 Timeline

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

Aghan Tapa Timeline

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

Chighchi Timeline

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

5 Implementation Process

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

PD/HEARTH STEPS

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

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

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

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

5.2 Identifying and Training of Local Personnel (Volunteers)

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

5.3 Carrying out a Positive Deviance Inquiry (PDI)

Village-wide Weighing

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



Home visits and interviews

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

A PD child was defined as a well-nourished child belonging to a poor family; and a PD family

was a poor family with a well-nourished child. A ND child was one who was malnourished in a poor family living under similar socioeconomic conditions as PD child; and a ND family was one that was poor and has a malnourished child.

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

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

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

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

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

5.4 Designing PD/Hearth Sessions

Analysis of PDI

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

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

siblings had a negative impact on the nutritional status of a child. Another practice identified as important was that of using clean utensils or clean hands to feed a child rather than unwashed hands or unwashed utensils.

PD/Hearth Menus

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

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



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

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

5.5 Conducting PD/Hearth Sessions

PD/Hearth Health Sessions

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

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

feed to their malnourished children during the session. As the *price of admission*, so to say, and to support the key strategy to teach and support practice of new, improved feeding habits, caretakers were required to make a daily contribution of the specific positive deviant food identified in their community through the PDI.

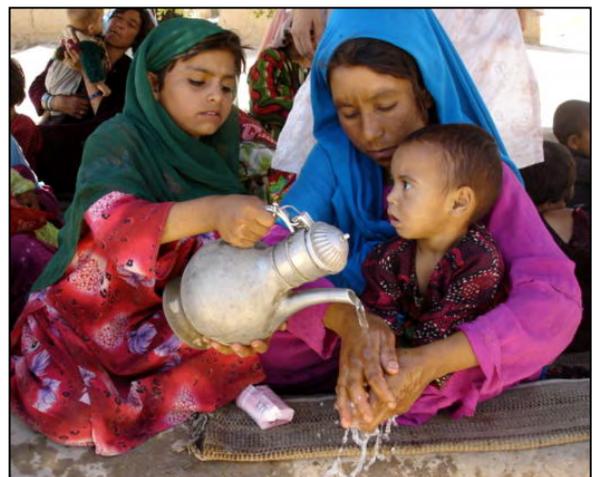
Home sessions were individual at caregivers' and children's homes. The purpose of these sessions was to help women practice independently what they had learned in the previous group session. MCH Promoters and female volunteers visited all participants' homes to observe their use of newly learned practices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



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

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

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



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

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

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

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

Monitoring of Health Sessions

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

5.6 Following Up after PD/Hearth Sessions

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

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

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

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

6 Results of PD/Hearth

6.1 Baseline Results

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

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

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

Process Results

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

Table 1. PD/Hearth Participants

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

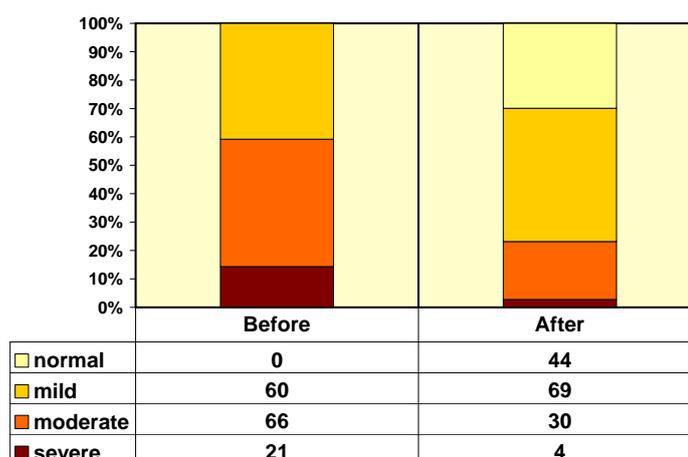


Figure 1. Nutritional Status Before vs. After PD/Hearth

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

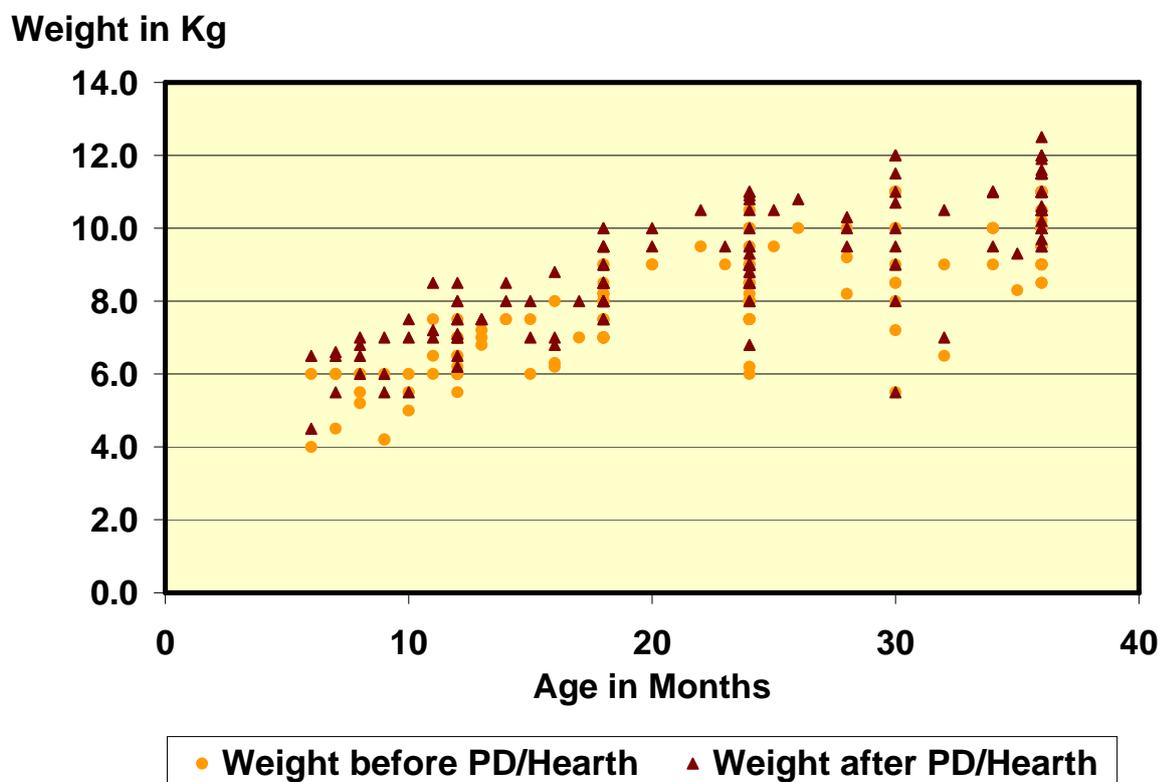
The mean age of participating children was 23.1 months, with the youngest being six months old and the oldest being 36 months (three years) old.

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

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

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

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



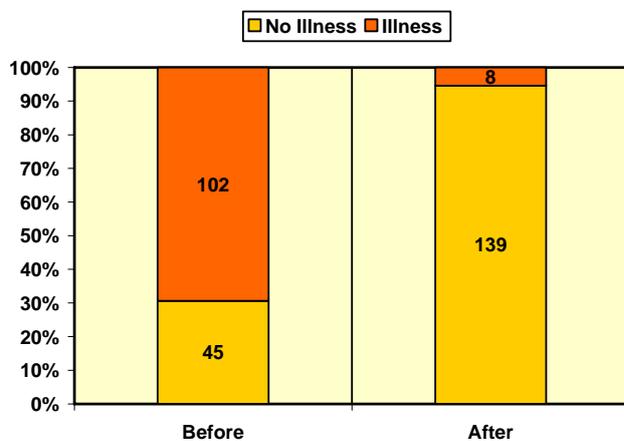
Of all children involved only two did not gain any weight, mostly due to illnesses that needed clinical attention. When defining weight gain as gain of over 400 grams (to account for normal weight gain that might occur in a two week time period), 95% of children experienced gain. In total 81 children,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

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

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

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

Figure 1. Illness Before vs. After PD/Hearth



6.2 End-line Results to follow

6.3 Strengths, Challenges, and Weaknesses

Strengths of the PD/Hearth Approach

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

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

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

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

Challenges of PD/Hearth

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

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

7 Recommendations for Scale-up

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

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

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

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

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

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

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

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

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

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

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

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

Annex 6: TOT on Basic Caregiver's Counseling Techniques

Day 1:

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

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

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

Time	Module/Lesson	Methodology/comments
	<ul style="list-style-type: none"> - 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? <p>How can health worker's different beliefs and attitude influence counseling? What should the health worker do to avoid his/her beliefs and attitudes influencing counseling (negatively)?</p>	<p>Brainstorm Use news print – summarize with written news print</p>

7.1.1.2.1.1 Day 2

Time	Module	Method
9:00-9:15am	<i>Warm up session.</i>	
9:15-9:25am	<p><i>Use of appropriate emotions, tone of voice and the art of praising & encouragement</i></p> <p><i>Activity 1 (tone of voice)</i></p> <p>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?</p>	<p>Five volunteers expressing emotions written on the slips they take out of the box</p> <p>Feedback on the News Print</p> <p>7.1.1.3</p>
9:25-10:00am	<p><i>Activity 2: (Use of appropriate body language)</i></p> <ul style="list-style-type: none"> • What body language did people note in the role plays? • Which ones were appropriate and which ones inappropriate? • How does this influence counseling sessions? 	Two Role plays (appropriate and inappropriate body language)
10:00-10:10am	List culturally appropriate and inappropriate body language (local)	List feedback on the flipcharts
10:10-10:30am	<i>TEA BREAK</i>	

Time	Module	Method
10:30-10:15am	<p><i>7.1.1.3.1 Activity 3 (praise and encouragement)</i></p> <p>* What is the meaning of praise? What does praise mean when working with clients or patients in health facilities?</p> <p>* What is the meaning of encouragement? What does encouragement mean when working with clients or patients in the health Facilities?</p>	<p>7.1.1.4</p> <p>Brain storm and take feedback on the flip-chart.</p>
10:15-10:45am	<p>Practice praising and encouraging initial responses.</p> <p>Ask: Was it difficult to find something nice to say? How do you think this will make patients feel?</p> <p><i>7.1.1.3.2 How would this influence your communications and counseling?</i></p>	<p>Read out the statements and ask participants to respond.</p>
Time	Module	Method
10:45-11:00am	<p><u><i>Asking The Right Questions during counseling</i></u></p> <p><u>Activity 1:</u> Types of questions:</p> <ul style="list-style-type: none"> - Closed ended - Open ended - Paraphrasing questions - Reflecting questions - Probing questions 	<p>Brain storm/news print Jot down new questions on fresh news print.</p>
11:00-12:00Nn	<p><u>Activity 2:</u> “What are some of the questions that you ask a caretaker who brings a sick child into your health center or clinic?”</p> <p>Presentation by groups (not more than 5 minutes)</p> <p>Do any of these questions tell you what services or information the caretakers need? What questions would really focus on finding out what this caretaker really needs and What he/she already knows?</p>	<p>Two group discussions: (10 minutes) Group 1: ARI case and role play questions Group2 : Breastfeeding problems and role play questions</p> <p>Presentation by groups</p>

Time	Module	Method
	What are open ended questions? Summarize	
12:00-12:30pm	<u>Visual aids and other methods that can make counseling effective</u> 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.

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

Day 3

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

Annex 7: Updated CSHGP Data Form

Child Survival and Health Grants Program Project Summary

Oct-25-2007

Save the Children

(Afghanistan)

General Project Information:

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

Field Program Manager Information:

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

Alternate Field Contact:

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

Funding Information:

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

Project Information:

Description:

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

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

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

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

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

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

Location:

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

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

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey

Health Facility Assessment

Organizational Capacity Assessment with Local Partners

Participatory Rapid Appraisal

Lot Quality Assurance Sampling

Appreciative Inquiry-based Strategy

Community-based Monitoring Techniques

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

Behavior Change & Communication (BCC) Strategies:

Social Marketing

Mass Media

Interpersonal Communication

Peer Communication

Groups Targeted for Capacity Building:

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

Interventions/Program Components:

Immunizations (20%)

(IMCI Integration)

(CHW Training)

(HF Training)

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

Nutrition (15%)

(IMCI Integration)

(CHW Training)

(HF Training)

- Comp. Feed. from 6 mos.
- Hearth
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition

(IMCI Integration)

(CHW Training)

(CHW Training)

(HF Training)

Pneumonia Case Management (20%)

(IMCI Integration)

(CHW Training)

(HF Training)

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

Control of Diarrheal Diseases (15%)

(IMCI Integration)

(CHW Training)

(HF Training)

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

- Care Seeking
- Case Mngmnt./Counseling

Maternal & Newborn Care (30%)

(IMCI Integration)

(CHW Training)

(HF Training)

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

(IMCI Integration)

(CHW Training)

(HF Training)

(CHW Training)

(HF Training)

Target Beneficiaries:

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

Rapid Catch Indicators:

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

Comments for Rapid Catch Indicators

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

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

