

Midterm Evaluation

Improving Maternal and Child Health in Northern  
Tajikistan: Sughd Child Survival Project  
Sughd Oblast, Tajikistan

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Finally, the evaluators would like to thank the many Community Health Educators and Village Development Committee members who have, in the last two years, significantly changed the health status of their communities. They are true life savers.

## GLOSSARY OF TERMS AND ACRONYMS

AAH	Action Against Hunger
ACNM	American College of Nurse Midwives
CHE	Community Health Educator
CNE	Community Nutrition Educator
C-IMCI	Community Integrated Management of Childhood Illness
CS/CSP	Child Survival/Child Survival Project
CSSA	Child Survival Sustainability Assessment
DOH	Department of Health – Sughd Oblast level
FAP	Traditionally the lowest level facility staffed by a medic – also called medpoint
Feldsher	Lowest level of health worker, a medic
GMP	Growth Monitoring and Promotion
IMCI	Integrated Management of Childhood Illness
LSS	Life Saving Skills- training program for maternal and neonatal care of ACNM
MCH	Maternal Child Health
MICS	Multiple Index Cluster Survey of UNICEF
MOH	Ministry of Health of Tajikistan – national level
MSF	Mediciens sans Frontiers
NNS	National Nutrition Surveys
PHAST	Participatory Hygiene and Sanitation Transformation
PCI	Peaceful Communities Initiative
SES	Sanitary and Epidemiological Service
SIDA	Swedish International Development Agency
SOMONI	Health Reform Program of the MOH
SUB	Rural hospital with limited in-patient care and physicians, midwives
SVA	Lower level health facility staffed by physician, midwife and feldsher
SVP	Reform mandated lowest level of facility staffed by physician, midwives
TIPs	Trials for Improved Practices
TOT	Training of Trainers
UNDP	United Nations Development Program
UNICEF	United Nations Children’s Fund
USDA	United States Department of Agriculture
VDC	Village Development Committee
WHO	World Health Organization

Oblast = region or province; Rayon = district; Jamoat = sub-division of a district

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## **A. SUMMARY**

This four year child survival grant is being implemented in Sughd Oblast (region), located in northeastern Tajikistan. Within Sughd, the project has focused on the districts of Asht, Zafarabad and Shahrستان. The project provides support to three district hospitals, 10 rural hospitals (SUBS), 76 village health facilities and 88 communities with a total population of 209,250. The target population includes 46,479 women of reproductive age and 23,645 children under the age of five.

The goal of the Sughd Child Survival Project is to improve the health of women of reproductive age and of children under five in the districts of Asht, Zafarabad, and Shahrستان through use of key maternal and child health and nutrition interventions. Mercy Corps has defined three objectives for the Sughd Child Survival Project (SCSP): **1)** Increase the percentage of mothers of children under two who practice improved feeding, care during illness and health-seeking practices; **2)** Increase the percentage of women who receive adequate maternal and health care (including four prenatal visits, iron-folate supplementation (IFA), improved nutrition, birth attended by health personnel, appropriate referral as needed, and post-partum/newborn care within two days); and **3)** Increase the capacity of Ministry of Health (MOH) health facilities to deliver quality maternal-child health services.

These objectives are to be achieved by building MOH capacity to address the challenges of sustainable, quality service delivery – principally via the Integrated Management of Childhood Illnesses (IMCI) and Live Saving Skills (LSS) training and supervision, and promoting behavior change and community mobilization in order to promote healthy lifestyles and better care of mothers and children.

Overall, the project has been well designed and executed as evidenced by the mid-term evaluation (MTE) assessment as well as the Knowledge Practice Coverage (KPC) survey results. The Sughd Department of Health, Mercy Corps' principal partner, expressed a high regard for the working relationship established with the cooperating sponsor and attribute a dramatic reduction in child mortality (41-55%) in all three districts to the interventions and assistance provided by Mercy Corps. The main accomplishments of the project, thus far has been:

1. Improved skills (LSS) of more than 70 midwives and ob/gyns which has resulted in fewer delivery-related traumas, less drug use for delivery and infant resuscitation, and better delivery outcomes for mother and child.
2. Improved skills (IMCI) of more than 80 physicians, nurses and feldshers which has resulted in a more complete assessment of the sick child and decreased use of antibiotics.
3. Increased knowledge and improved health behaviors of target population – all 31 project knowledge and behavior indicators have improved over baseline with several LOP targets already met.

The project's main constraint relates to the Sughd Department of Health's (DOH) capacity to support key interventions once the project finishes in two years. Currently, the funding required for behavior change materials/activities development, transportation and continued training of DOH staff is severely restrained. Mercy Corps, the DOH and Tajik Government have an opportunity over the next two years to plan for the eventual transition of support currently provided by Mercy Corps to the indigenous institutions. Additional constraints or areas of attention are clarified in the key recommendations below.

**1. Project Focus:** Thus far all levels within the Sughd Department of Health structure (Region, District, Sub-district and Community) have benefited from training activities and project support.

However, it is clear that further improvements in health outcomes will likely be best achieved in the following two years by primarily focusing on activities at the sub-district and community levels. While the project continues coordination and encouragement of active management at the regional and district levels, we recommend that training and health care improvement efforts be focused at the sub-district (SUB) and community (medpoint) levels, with particular emphasis in the areas of post-natal care, nutrition and ARI. In addition, the project will need to continue assisting the Centers for Healthy Lifestyles (CHL) to increase their capacity and support at the community level. It has been the intent of the project to initiate *community* IMCI activities in the coming year. Therefore, we urge the project to take a close look at the various C-IMCI tools available and determine which best fits their needs and will help further the goals of the project.

**Summary Response:** Mercy Corps has recently completed training staff for rural out-patient clinics and med-point in facility based IMCI. Training in Community IMCI will be introduced early in 2007. Training for 80 additional staff from maternity home and SUBs (rural hospitals) in Basic Life Saving Skills still needs to be provided during 2007 and possibly into 2008. During 2005, the Sughd DoH requested that women's consultation, med-point staff and SVA staff be trained in provision of pre-natal and postnatal care. During November 2006 a consultant from the American College of Nurse Midwives will train LSS trainers as trainers in pre-natal and post-natal care and assist the Project to develop a plan to cascade the training to the sub-district and community level.

**2. Ownership and Sustainability:** While the Ministry of Health at the regional and district levels are clearly impressed with the results of the project thus far, they have yet to invest the resources that will be necessary to sustain the results once the project finishes. We recommend that the project immediately begin working with the Sughd Department of Health and local government to plan for future commitments of resources for these basic activities. At the same time Mercy Corps should prepare the DOH for the eventual transfer of responsibility. We recommend that the actual process of transition begin well before the end of the project.

**Summary Response:** A CSSA is planned during February 2007 as a means to develop a vision for what sustainability looks like, and what activities are essential for each stakeholder to take on in order to ensure sustainability.

**3. Target groups:** This principle target group for behavioral change activities has been women of reproductive age. Given the seasonal migration of men to Russia, the evaluators feel that discussions with this target group should focus on HIV/AIDS/STDs prior to departure to Russia and family planning soon after their return. Given both the culture and migration of men, mothers-in-law play a significant role in the care and well being of both mother and child. We therefore recommend that the project devise a strategy to more actively engage and influence the direction and decision-making of mothers-in-law. School children, particularly girl children, are an important target group. We recommend that the project explore assisting the CHLs in developing a school campaign for health promotion based on the child-to-child approach that has proven successful in other countries.

**Summary Response:** Mercy Corps plans to include Mothers-in-law as a formal target group and will develop a strategy for doing so. This would entail expanding the role of the community health promoters to include mothers-in-law in the monthly health sessions they provide. It is critical to continue to involve men (husbands, fathers-in-law, religious leaders, etc.) in Project activities to the maximum extent possible. Mercy Corps, together with the Departments of Health and Education, will develop a strategy for implementing a child to child school health program. A cross visit will be

arranged for key DoH, DoE and Mercy Corps staff to learn from the Child to Child activities of the Save the Children Child Survival Project in Panjikent.

**4. Maternal Nutrition:** Health personnel interviewed expressed a high degree of confidence in the availability and accessibility of ferrous sulfate to pregnant women, yet anemia amongst pregnant women continues to be a serious problem. We therefore recommend that the project clearly determine if iron supplementation is a problem and if so, where the problem lies (access, distribution, use, etc.) including working with the DOH in the three districts to determine what levels and concentrations of anemia exist in order to better understand the problem. Finally, we recommend that the project conduct a small informal study on timing and volume of tea consumption among pregnant women and relate that information to current research on tea's impact on iron absorption.

**Summary Response:** Mercy Corps suggests advocating with the DoH to consider piloting different strategies for distributing iron supplements for women of reproductive age and pregnant women. The Project plans to work with the Centers for Healthy Lifestyle and community health educators to conduct qualitative research on tea drinking behavior and acceptable strategies to modify the behavior.

**5. Childhood Illnesses:** With regard to childhood illness prevention and treatment, the project has elected to emphasize diarrheal disease control with good result. However, in all the districts, acute respiratory infection (ARI) is equally problematic and typically more persistent throughout the year. We therefore recommend that the project increase its efforts to improve knowledge, care and health-seeking behaviors related to ARI. Also, while appropriate application of most of the IMCI procedures by health workers appear to be good, counseling skills was mentioned as a weakness among some providers. We therefore recommend that the project reinforce training in this area.

**Summary Response:** During December of 2006 (flu and cold season), Mercy Corps will provide refresher training on ARI for community health educators. The Project IMCI Coordinator presently conducts joint monitoring with the DOH IMCI coordinators both at the oblast and district level. The Project plans to include training for DoH staff on behavior change in the workplan for 2007.

**6. Delivery and postnatal care:** The LSS training provided to ob/gyns and midwives has been a critical and effective intervention for improving the quality of delivery care. In a number of cases, midwives must also work with neonatologists once the delivery has occurred. This has caused some problems between midwives who have been trained in natural resuscitation methods and the neonatologists who continue to use drug-managed resuscitation. We recommend that neonatologists be incorporated into the latter part of the LSS training provided to the midwives such that they can benefit from the same "bonding" experience which has obviously benefited the midwife-ob/gyn relationship.

Further, post-natal follow-up generally falls upon the shoulders of SUB and medpoint staff which must visit the mother and newborn at their household. Given that most health staff interviewed identified postnatal complications as the principle cause of maternal and neonatal mortality, we recommend that the project ensure that the principle post-natal follow-up agent(s), be they midwives, nurses or doctors from the SUBs or medpoints, are adequately trained, supervised and supported in conducting follow-up for both mother and child.

**Summary Response:** Both the Sughd DoH and Mercy Corps support the recommendation to incorporate the neonatologists into the present LSS training and plan to arrange for them to attend the sessions on post-natal care and resuscitation. The Project Safe Motherhood Coordinator

presently conducts joint monitoring with her DoH counterparts. During the joint monitoring she will have the opportunity to work with health staff to ensure that appropriate and timely post natal follow-up for both mother and child is provided.

**7. Training:** The training provided by this project has been strategic, well implemented and highly valued. We recommend that the VDCs receive training and support in setting measurable goals, resource mapping and establishing work plans. As mentioned, DOH staff at medpoints and SUBs could benefit from training in interactive communication and postnatal care. There is also a strong need for training in IEC materials development and dissemination. Finally, we would recommend that the project work with the CHLs to establish an annual “cycle” of training and health promotion that coincides with the seasonal onset of cause-specific morbidity as well as the health outcomes associated with seasonal social and economic activities.

**Summary Response:** The Project plans to incorporate the following trainings into the workplan for 2007: Training for VDCs and CHEs on Technology of Participation; training on behavior change for medpoint and SVA staff; training on pre-natal and post-natal care for medpoint and SVA staff; training on development of IEC materials for the Center for Healthy Lifestyle and DoH staff. The Project will work with the DoH to establish an annual health promotion plan that addresses the seasonal onset of ARI and diarrhea. The plan also needs to reach men who migrate before they leave for Russia with messages on HIV/AIDS and when they return with message on family spacing.

**8. Information management:** Mercy Corps has significantly invested in the collection of project data through KPCs, supervisory checklists and other information management tools. However, the evaluators felt that these tools could be better analyzed and utilized within the project. We recommend that efforts be made to regularly review, analyze and understanding the KPC data and other information. We would also recommend that the Ministry of Health be encouraged to participate in these activities as they have very limited practice in the analysis and use of data. A dissemination plan should be devised such that districts, sub-districts and communities can have a clearer understanding of their own conditions as conveyed by the data. Data produced by the DOH should also be included in the analysis.

**Summary Response:** Monitoring and survey data are discussed during quarterly and monthly meetings. The more important issue is helping both Project staff and the DoH staff better understands the data and use it for program planning. Data concerning indicators has not been discussed at the community level. Project staff will select key indicators which they feel are the most important for the VDCs and CHEs to understand and track.

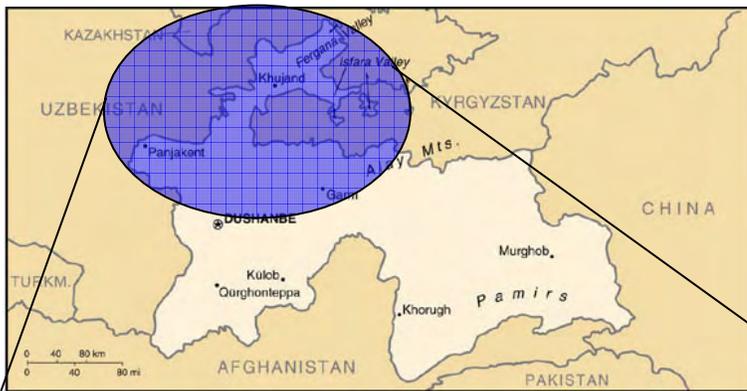
**9. Sanitation:** Many of the communities, and even health facilities, visited suffered from extremely inadequate and un-hygienic sanitation facilities. Ultimately, this will limit the potential impact the project could have. At a minimum, we would recommend that USDA staff provide technical assistance to the SCSP in order to construct latrine facilities at each of the Mercy Corps/DOH district office locations. These could then serve as models for staff, partners and community members. We would also urge the project to facilitate cross visits by VDCs to communities where the sanitation program has been implemented so that they can visually see the benefit of properly built and maintained latrines. We would also recommend that the project advocate for and encourage organizations and funders to support water and sanitation activities in the project districts.

## B. ASSESSMENT OF PROGRESS MADE TOWARD ACHIEVEMENT OF PROGRAM OBJECTIVES

### 1. TECHNICAL APPROACH

#### a. Brief Overview

This four year child survival grant is being implemented in Sughd Oblast (region), located in northeastern Tajikistan. The target region is approximately 200 miles and eight hours by road from the capital, Dushanbe. The regional capital, where the main CS project office is located, is Khujand. Within Sughd, the project has focused on the districts of Asht, Zafarabad and Shahrison. The



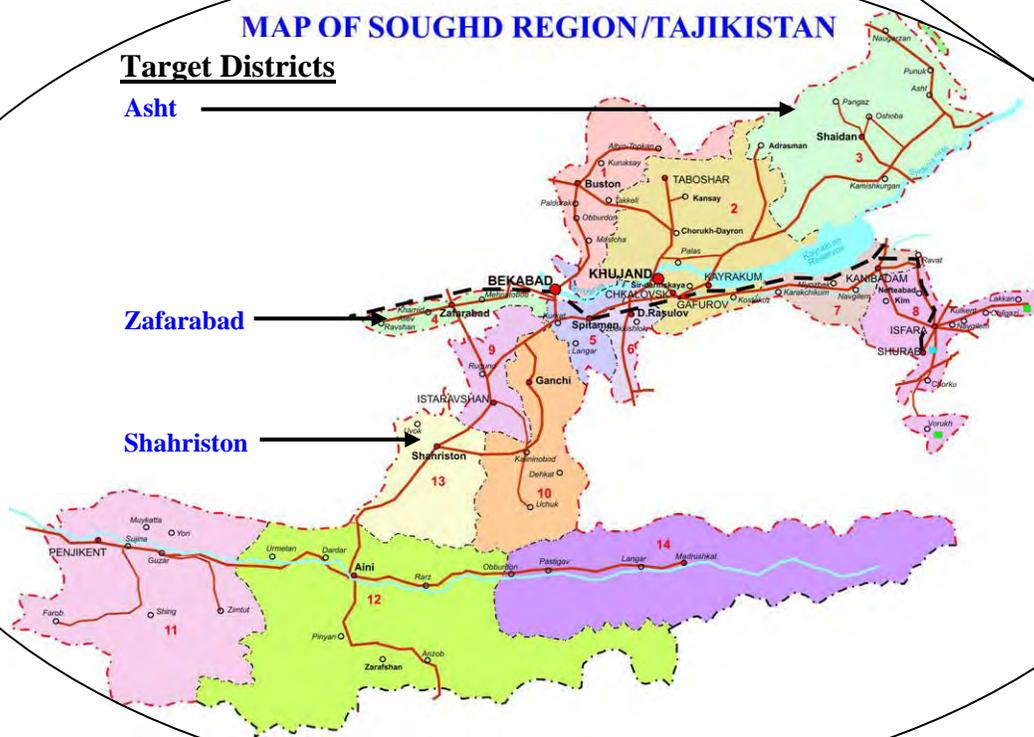
#### MAP OF SOUGHD REGION/TAJIKISTAN

##### Target Districts

Asht

Zafarabad

Shahrison



project provides support to three district hospitals, 10 rural hospitals (SUBS), 76 village health

facilities and 88 communities with a total population of 209,250. The target population includes 46,479 women of reproductive age and 23,645 children under the age of five.

Even though Tajikistan was one of the poorest Soviet republics, it benefited from the Soviet emphasis on health. Before independence in 1991, under-five mortality was at 78/1000 (UNICEF, State of the World's Children) and virtually all births occurred in hospitals. Health personnel say malnutrition was an anomaly associated with endocrine disorders. As of 2004, under-five mortality was reported to be 118 and infant mortality was 91 for every 1,000 live births.<sup>1</sup> Maternal mortality is estimated at 100/100,000.<sup>2</sup> In 2002 the National Nutrition Surveys (NNS) conducted by a consortium of Action Against Hunger, Mercy Corps, CARE, Save the Children, AKF, other NGOs and the MOH nutrition center, found nearly 38% of children under five were found to be chronically malnourished, with 12% severely malnourished (wasted), rates high enough to raise international alarm and qualify as a national disaster by Sphere's standards.<sup>3</sup>

According to the National Nutrition Survey (NNS), Sughd *Oblast* had the highest rates of chronic malnutrition in the country, with the spring 2002 survey showing that 44% of children between six and 59 months are more than two standard deviations below the international standard of height for age. The NNS included an in depth causal analysis, intended to define food security issues, which revealed that recent episodes of illness including diarrhea, lack of exclusive breastfeeding, and delayed introduction of complementary foods all contribute significantly to these high rates of chronic malnutrition. The June 2006 NNS found that 14.5% of children in Sughd Oblast were underweight.

Yet, in the Sughd Oblast target districts the high number of doctors, nurses and medical facilities is enviable for the population of its size, and virtually all women deliver at health facilities. Ironically, these attributes have not helped to improve the health of the population and, in some ways, have actually hindered progress. Resources are spread too thin, salaries consume budgets, continuing education needs remain unmet and infrastructure and equipment have fallen into decay and disrepair. Under such conditions, the quality of care has deteriorated significantly as evidenced by the statistics. Moreover, and perhaps most importantly, the Tajikistan health system has traditionally been one oriented to treating illness rather than preventing it.

The goal of the Sughd Child Survival Project is to improve the health of women of reproductive age and of children under five in the districts of Asht, Zafarabad, and Shahrستان through use of key maternal and child health and nutrition interventions. Mercy Corps has defined three objectives for the Sughd Child Survival Project (SCSP):

- 1. Increase the percentage of women who receive adequate maternal and health*
- 2. Increase the percentage of mothers of children under two who practice improved feeding, care during illness and health-seeking practices; care (including four prenatal visits, iron-folate supplementation (IFA), improved nutrition, birth attended by health personnel, appropriate referral as needed, and post-partum/newborn care within two days);*
- 3. Increase the capacity of MOH health facilities to deliver quality maternal-child health services.*

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<sup>1</sup> WHO estimate 2004

<sup>2</sup> WHO estimate 2000

<sup>3</sup> Sphere Project: Humanitarian Charter of Minimum Standards in Disaster Response, 2000

These goals are to be achieved by building MOH capacity to address the challenges of sustainable, quality service delivery, and promoting behavior change and community mobilization in order to promote healthy lifestyles and better care of mothers and children.

Specific technical strategies include:

- Training and implementation of Integrated Management of Childhood Illnesses (IMCI) at district health facilities;
- Training and implementation of Community IMCI;
- Training and support to the Department of Health (DOH) for certification as Baby Friendly Hospitals;
- Training and implementation of lactation management at facility and community levels;
- Training and implementation of safe motherhood activities with health facility staff;
- Training and implementation of safe motherhood activities with communities;
- Training community health educators and health facility staff on behavior change and community mobilization.

The Sughd Child Survival Project includes four interventions areas; diarrhea disease control (20%), nutrition (30%), breastfeeding (20%), and maternal-newborn care (30%).

Mercy Corps has partnered with the Sughd Department of Health, the Centers for Healthy Lifestyles, and local communities to apply a dual strategy of strengthening quality service delivery and promoting family behavior changes related to maternal-child health and nutrition. The Center for Healthy Lifestyle, established in 1994, is a unit within the Department of Health. Their mandate is to promote healthy changes in lifestyle through information, communication, and education activities and advocacy. SCSP is structured to provide training and supervision to improve health systems and staff skills and will complement this with a community education strategy, which will promote behavior change and encourage families to take more responsibility for their health.

The project is directly managed out of Khujand by a Project Manager, Deputy Project Manager and three technical coordinators - for training, communications and safe motherhood. There are three district coordinators, six facility monitors, six community mobilizers and 82 volunteer community health educators. Project support and oversight is provided by Mercy Corps' Health Program Manager in Dushanbe and additional technical support provided through Mercy Corps' Headquarters (*see Annex G for Organizational Chart*).

This project began on September 30, 2004 and continues through September 29, 2008. It is funded under the Standard Category of the CSHGP, with \$1.5 million from USAID, and a cost share of \$500,000, resulting in a Total budget of \$2,000,000.

## ***b. Progress Report by Intervention Area***

### **Diarrheal Disease Control**

Diarrheal Disease Control accounts for 20% of the project effort. In accordance with the DIP, project activities are to center on education and behavior change within communities and training of Department of Health staff on WHO protocols. Specifically, the activities under this area include the following:

- Train 60 DOH pediatricians and feldshers (medics positioned at community health posts called medpoints) in IMCI.
- Provide support for trained staff and ensure training *cascades* to other levels within the system.
- Train MC staff, feldshers, CHEs and community leaders (including 60 village development committees) in C-IMCI.
- Train and support CHEs in disseminating key messages on hygiene practices, appropriate food storage, recognition of signs of severe diarrhea and dehydration and appropriate home management of diarrhea and dehydration.
- Implement PHAST (Participatory Hygiene and Sanitation Transformation) training for project staff designed to provide strong guidance for sensitization and mobilization of communities for water, sanitation and hygiene.
- Provide complimentary support in Shahrستان to improve water and sanitation and seek support for similar projects in Asht and Zafarabad.

### **Progress**

As of the midterm, over 130 Department of Health staff members from 80 health facilities have received the nine-day IMCI training. In addition, eight MOH staff members have been trained as IMCI trainers. In 2006 the Sughd Oblast DOH eliminated its diarrheal disease control and pneumonia centers and replaced them with IMCI centers. Mercy Corps has supported this effort at



*Medpoint staff in front of IMCI protocol: Khushkurgan Village, Shahrستان*

both the oblast and district levels through financial, logistical and material support for the training, which was led by the DOH, as well as financing the costs of office furniture, equipment and materials for the IMCI Centers. Mercy Corps also conducts joint supervision visits with DOH staff. The key informant interviews conducted for the midterm found that the training was well received and readily put into practice. All facilities visited had the IMCI protocols posted on the walls of their examining rooms and IMCI manuals were readily accessible. Training was initiated in the spring of 2005 and was completed early this year. At least 70% of facilities have received one or more follow-up

(supervision) visits by Mercy Corps and DOH District IMCI Coordinators. During these visits, staff members were monitored as they applied their new skills and evaluated through the use of a checklist. Based on our interviews, the protocols seemed to be well understood. The one weakness

identified by supervisors was the neglect or poor use of counseling. This should be reinforced and special training provided on effective methods of counseling and education.

Staff interviewed by the evaluation team felt that the training had an important impact on their work as well as health outcomes within the population. When asked what was different in the way they treated a sick child, we repeatedly heard, *“Before I just used to ask what the problem was and provide medication. Now, I find out about all problems. I prescribe antibiotics less frequently as well.”* [paraphrased]

Community IMCI has yet to be initiated. The Ministry of Health has requested that NGOs complete facility based training in IMCI as well as initial monitoring before beginning C-IMCI. C-IMCI training is scheduled to begin during the first quarter of 2007. The lead evaluator found that project staff and DOH personnel had only a superficial understanding of what is C-IMCI and the MOH has yet to clearly define the parameters or a rollout strategy for it. Prior to initiating C-IMCI activities it would be helpful for SCSP staff to review the various approaches to this community level strategy as well as available C-IMCI tools and conceptual frameworks. Work conducted by the CORE Group and WHO would be starting points. With a clearer understanding of C-IMCI, Mercy Corps could build upon the existing successes and perhaps help guide policy as the MOH deliberates on an action plan for C-IMCI.

Mercy Corps has helped to establish or strengthen 66 Village Development Committees (VDCs) and has trained 82 Community Health Educators (CHEs). In practice we found that the VDCs and CHEs work hand in hand on community health promotion. The VDC members and CHEs have received training on community mobilization, behavior change, interactive methods of communication and the PHAST methodology. They have also received specific technical training in the following areas:

• What a community needs to be healthy	• Breastfeeding
• Causes and prevention of illnesses	• Complementary feeding
• ARI	• HIV/AIDS
• Nutrition for Good Health	• Bird flu
• Under-nutrition	

On a monthly basis health messages are disseminated to community members through interactive discussions led by the VDC and CHEs, as well as through the distribution of pamphlets. A particularly effective means of education is the use of *maballabs*, or neighborhood committees (*see Community Mobilization*). In addition CHEs conduct regular home visits to educate and to check up on the health status of household members. In cases of serious illness they’ll refer that patient to a health facility. On average, education sessions reach 6,568 beneficiaries each month. Collectively, CHEs provide 2,671 home visits and make 64 referrals each month.

In December of 2003 Mercy Corps initiated a water project through the use of complimentary funds that benefited selected communities in Shahrستان District. The aim was to improve quality, quantity and availability of drinking water as well as address hygiene practices, especially as they relate to the spread of water-borne diseases. As a part of the project Mercy Corps trained Water and Health

Committees charged with collecting user fees and managing the systems. Two of the communities where the project was implemented were in the SCSP district of Shahrستان. In addition, 200 family latrines were constructed in Shahrستان under a separate USDA funded project.

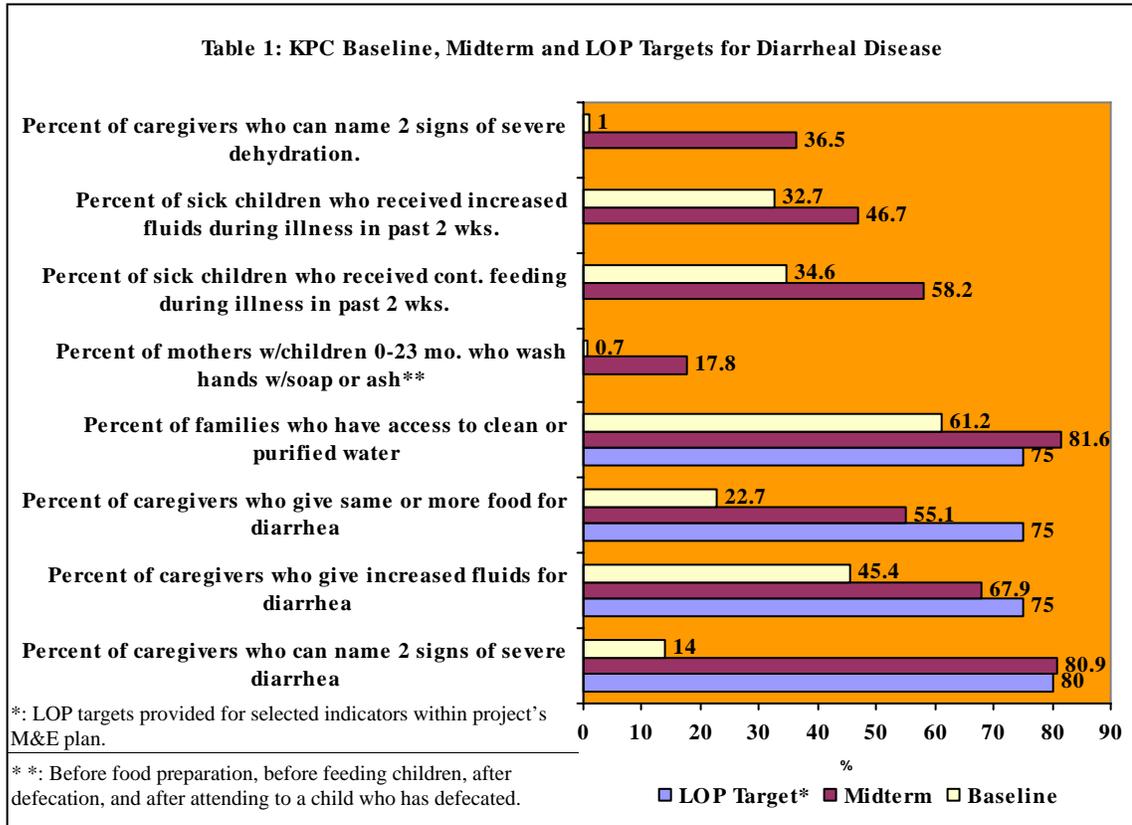
### **Outcomes and Impacts**

Overall, the project appears to have had a significant impact on the frequency and severity of diarrheal disease, as well as other childhood illnesses. In each of the target districts the Ministry of Health has reported a 41-55% reduction in child mortality<sup>4</sup> compared to the previous year. This coincides with the onset of training and community activities undertaken by the project. These data appear to be fairly reliable given the extensive coverage and high usage of DOH services (i.e., the DOH feels they are capturing most if not all mortality). In two of the districts the mortality data included children up to 14 years of age while in Zafarabad it was reported just for infants. Most of the reductions were in diarrhea and pneumonia cases. The District Chiefs and other health staff assert that the reductions are due to the work that Mercy Corps has done – particularly in changing behaviors in the communities. They did convey that peri-natal infection, ARI, poor nutrition and poor sanitation continue to be serious challenges to child health.

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<sup>4</sup> Asht District – 69 deaths to 39 deaths for children under 14 years for comparable months in 05 and 06; Zafarabad District – 11 deaths to 5 deaths for children under 1 year for comparable months in 05 and 06; Shahrستان District – 28 deaths to 13 deaths for children under 14 years for comparable months in 05 and 06.

Between the 18<sup>th</sup> of September and the 5<sup>th</sup> of October 2006, Mercy Corps conducted its midterm KPC survey. The results from that survey seem to support the outcomes witnessed by the DOH. Of the 8 knowledge and care behaviors related to diarrheal disease and childhood illnesses, all reflected significant improvements from the baseline. Four of these indicators were assigned LOP targets under Mercy Corps’ M&E plan, of which two have already been met or exceeded.



**Additional Observations on Diarrheal Disease Control**

Tajikistan has no national de-worming program. In some of the areas interviewed, hookworm infection was considered to be a significant problem affecting both mother and child. This is especially the case in the summer and fall when virtually everyone in the region is required to leave their homes for 10 days or more to pick cotton on one of the state-owned collective farms (a remnant of the Soviet system). Living conditions on the farms are rudimentary and sanitation is poor. Mercy Corps should consider assisting the DOH in piloting an anthelmintic chemotherapy program during the cotton harvesting season in the target districts. This may help to reduce hookworm as well as improving nutrition status of mothers and children. (see *Nutrition*).



*Obligatory labor during harvest season.*

Moreover, the conditions of latrines at the district hospitals are dangerously unhygienic and reflect the general conditions of most household latrines – shallow pits, open, un-maintained, feces visible throughout. When we asked about latrine hygiene in one of the communities they affirmed that while public latrines were poor, household latrines were well maintained. When visiting some of those latrines however (one of which was at the home of the chief medpost staff person) we noticed the same un-hygienic conditions. At minimum, Mercy Corps should construct a model latrine at their offices (on the premises of the district hospitals) as a means to demonstrate to medical staff and community members what a latrine should look like. Mercy Corps has the in-house capacity to do so having just completed their USDA sanitation program, and has constructed 200 family latrines in five different villages in Shahrison. They should also try to pursue additional funding or collaborators to improve sanitation in the project areas.

While diarrheal disease will continue to require support, equally important is early identification and care of ARI. As a percentage, pneumonia-related mortality is higher than diarrhea and is persistent for more months of the year due to cold weather and lack of reliable indoor heat. The head of the pediatric hospital in Khujand, where 50% of clients are referred to from the districts, stated that 35% of the patients were there due to ARI, more than any other cause. In working with communities and medpoints, Mercy Corps should increase efforts to improve prevention, early identification and care-seeking for ARI.

### ***Nutrition***

Nutrition accounts for 30% of the project effort covering both maternal nutrition and child nutrition. In accordance with the DIP, project activities are to include growth monitoring promotion, supporting behavioral change in complementary feeding techniques, appropriate nourishment for pregnant and lactating women and household education – including husbands and mothers-in-law. Specifically, the activities under this area include the following:

- Provide IMCI training that includes components on assessment and treatment of malnutrition, complementary feeding and preventing anemia in women.
- Provide support for trained staff and ensure training *cascades* to other levels within the system related to the above topics.
- Train MC staff, feldshers, CHEs and community leaders (including 60 village development committees) in C-IMCI.
- Implement a community-based growth monitoring program (GMP) including the printing and distribution of growth monitoring cards.
- Select, train and support Community Nutrition Educators (CNEs) in assisting GMPs and counseling mothers.
- Establish a PD/Hearth program in communities where malnutrition rates are over 30%.
- Initiate behavior change activities which focus on clarifying misconceptions about iron supplements, helping women deal with common side effects of taking ferrous sulfate supplements and encouraging women to attend prenatal care to obtain a supply of iron tablets.

### **Progress**

Progress towards implementation of IMCI and C-IMCI has already been discussed under Diarrheal Disease Control. The project work plan proposed initiating pilot community-based Growth Monitoring and Promotion programs in two communities during FY06. This has been delayed due to pending work being conducted by UNICEF and the MOH on the design of the growth monitoring cards. Currently, sixty rural health facilities that have been trained in IMCI regularly weigh and measure children during clinic visits. However, as Mercy Corps clarifies in their DIP, the emphasis of the GMP program should be *promotion*. This is the primary reason for proposing a community-based program as opposed to a clinic-based program. It is anticipated that the growth monitoring cards will be finalized before the end of the calendar year. Given the continued concern regarding nutrition, we recommend beginning pilot programmes as quickly as possible and then transitioning to district-wide programmes soon after.

The program has proposed selecting and training Community Nutrition Educators (CNEs) to support its nutritional initiatives. However, staff has concluded that this was unnecessary as the current cadre of trained CHEs and VDCs should be capable and willing to fulfill this role. In practice, they are already doing nutrition promotion based on training already received. Also, if the KPC survey results prove to be accurate, the project is not likely to find communities with malnutrition rates greater than 30%, thus disqualifying these districts from PD/Hearth which generally requires malnutrition rates of 30% or higher.

The evaluators found a lack of clarity regarding the underlying problems of iron deficiency or a defined strategy on improving iron levels (beyond general health promotion activities). Anemia continues to be a serious problem within the target districts and was identified by health staff as one of their biggest problems. Under the existing system, all women who are pregnant are tested for hemoglobin levels. Based on these results, district DOH staff indicate that anemia amongst pregnant women is between 80-90%. Childhood anemia is also believed to be high. The main causes attributed to this problem are poor economic conditions, poor knowledge about nutrition and high levels of tea consumption with meals.

It remains unclear what the true impediments are to improving iron levels within the community. The evaluation team extensively probed this subject in order to ascertain the level and quality of supplementation. While iron tablets appear to be readily available and distributed, the methods varied. Some physicians prescribed a course of 60 tablets taken two times a day for one month (each tablet containing 65mg of iron) and then further courses based on follow-up Hb tests. Others prescribed 30 tablets to be taken three times a day for ten days followed by tests and more supplementation. Based on international standards for iron supplementation<sup>5</sup> dosage for even severely anemic women under clinical care need not exceed 120mg a day indicating that in some of the facilities, ferrous sulfate may actually be *over-prescribed*. Not only is the additional supplementation unnecessary as the body can only absorb finite quantities of iron within a given timeframe, but it may actually increase the side effects causing women to stop taking the tablets all together.

The project should try to clarify through clinical records what true distribution practices are, and work with the DOH to ensure that dosage is within appropriate limits. Additionally, there appears to be growing evidence that shows weekly or twice weekly dosage of iron supplementation is equally

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<sup>5</sup> Guidelines for the Use of Iron Supplements to Prevent and Treat Iron Deficiency Anemia. Rebecca J. Stoltzfus and Michele L. Dreyfuss; International Nutritional Anemia Consultative Group (INACG).

or more effective than daily dosage.<sup>6,7,8</sup> We therefore recommend that project staff further research this issue and determine whether or not a pilot program testing weekly dosage would be helpful. Given that Hb is regularly tested at various intervals of pregnancy, the efficacy of such an effort could be reasonably evaluated without great effort or expense. During the evaluation team's debrief with the regional DOH, they expressed an openness to pilot such an approach.

Finally, there is a strong suspicion that high levels of tea consumption are affecting iron absorption. Tajiks, including children, are regular tea drinkers and consume tea throughout the day. During one of the community visits we asked women present how many cups of tea they consumed the day prior. All seven reported consuming three or more cups and three reported having nine cups of tea. Studies have shown that the tannic acid in tea can reduce iron absorption by as much as 60%.<sup>9</sup> We therefore recommend further research on tea drinking habits in the pilot communities as well as clarifying the parameters which determine tea's affect on iron absorption (types, amounts, timing, etc.). If tea consumption is considered to play a major role in the high levels of anemia within the project districts, we would then recommend developing and implementing a behavioral change strategy to specifically target tea consumption behaviors.

### **Outcomes and Impacts**

In spite of the continued problem with anemia, the midterm KPC results indicate that the health promotion activities are having a positive impact on nutritional behaviors. Four out of the five nutrition behavior indicators have shown significant positive trends.

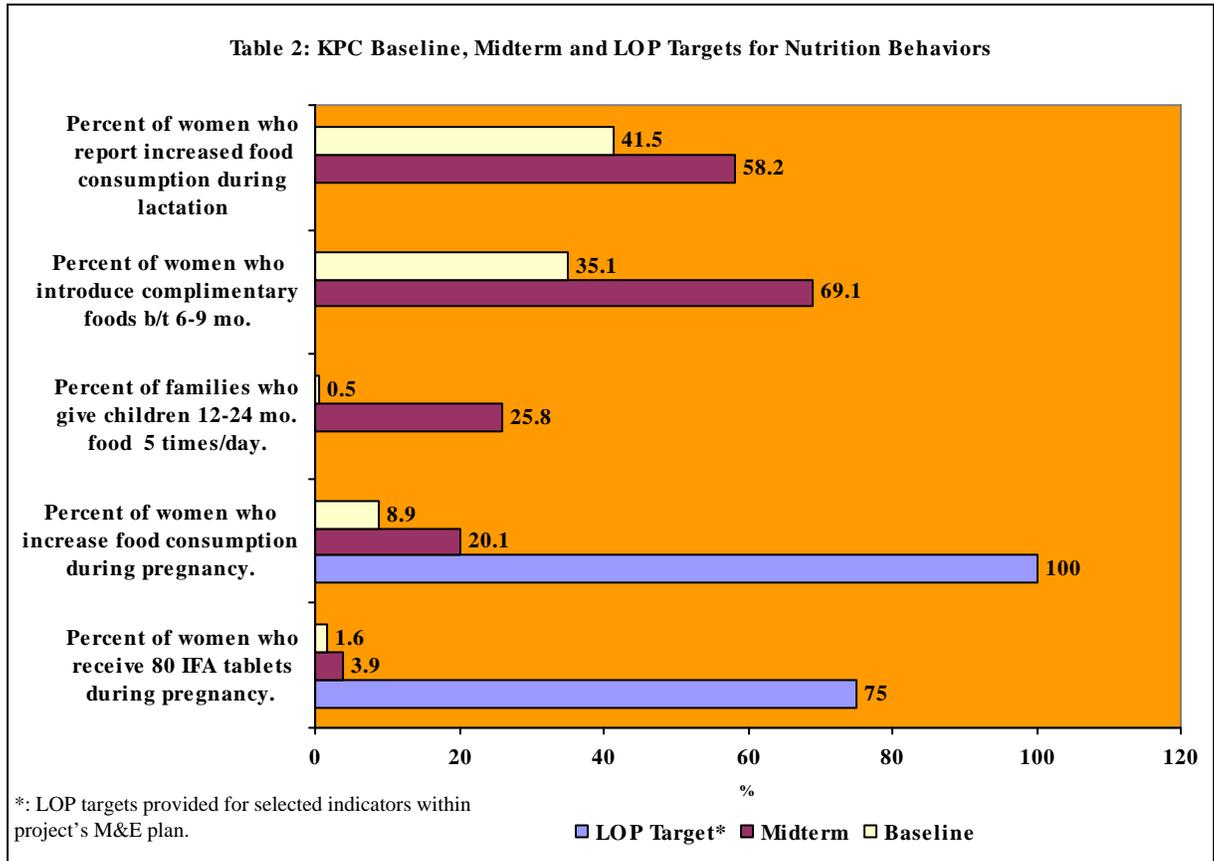
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<sup>6</sup> Fernando E. Viteri, Farah Ali and Jennifer Tujague. Long-Term Weekly Iron Supplementation Improves and Sustains Nonpregnant Women's Iron Status as Well or Better than Currently Recommended Short-Term Daily Supplementation *J. Nutr.*, January 1, 2001; 131(1): 85 - 90.

<sup>7</sup> J. P. Pena-Rosas, M. C. Nesheim, M. N. Garcia-Casal, D. W. T. Crompton, D. Sanjur, F. E. Viteri, E. A. Frongillo, and P. Lorenzana Intermittent Iron Supplementation Regimens Are Able to Maintain Safe Maternal Hemoglobin Concentrations during Pregnancy in Venezuela *J. Nutr.*, May 1, 2004; 134(5): 1099 - 1104.

<sup>8</sup> S. Muslimatun. Weekly Supplementation with Iron and Vitamin A during Pregnancy Increases Hemoglobin Concentration but Decreases Serum Ferritin Concentration in Indonesian Pregnant Women. *J. Nutr.*, January 1, 2001; 131(1): 85 - 90.

<sup>9</sup> J. Anderson. Iron: An Essential Nutrient; Colorado State University Agricultural Extension – Issue Paper No. 9.356.

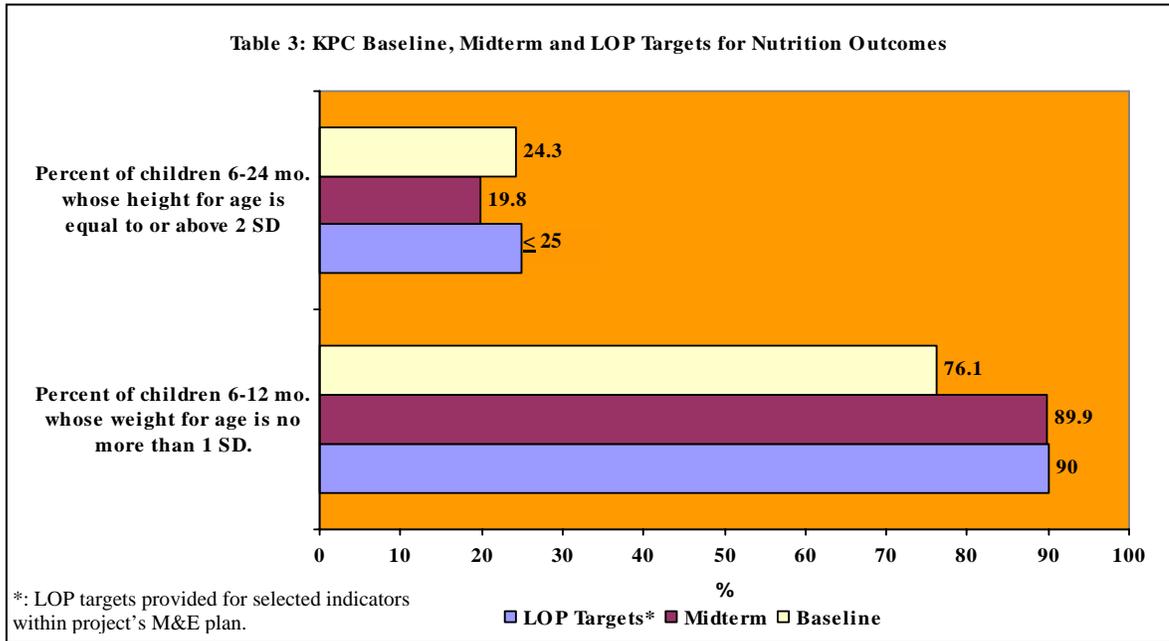


The evaluators found that the question on iron tablets was problematic and likely an inaccurate indication of iron supplementation. The first problem was in the translation. In Tajik, the word ‘received’ was changed to ‘taken’. Second, almost all women reported receiving some iron tablets but may have only reported what was given in one course (DOH staff were found to provide 10 days to one month’s worth of tablets and then ask women to return for a second or third course if needed). All districts reported that they usually have sufficient supplies of iron tablets and that they readily prescribed the tablets to both anemic and non-anemic pregnant women. As already mentioned, we would recommend that the project staff research DOH records to more accurately ascertain the level and completeness of supplementation rather than rely on the KPC questionnaire responses.

While there have been improvements in the responses for both food consumption during pregnancy and feeding frequency of children, they are still relatively low. Both may indicate the economic barriers implied by health staff. Also, feeding children five times a day may prove to be logistically challenging – especially when women are working in the cotton fields during harvest season (survey was undertaken during this time).

The KPC results also indicate some anthropometric improvements in children. During the evaluation, the lead evaluator recommended that Mercy Corps review the baseline and midterm anthropometric data for accuracy. This review took place, and revised baseline and final mid-term anthropometric data are shown in the table below. While both indicators have exceeded the LOP targets, the height for age target was inappropriately low as the baseline was nearly already at the

LOP goal ( $\leq 25\%$ ). The LOP goal for improvements in height for age should be adjusted. Note: Mercy Corps has adjusted the LOP target for percentage of children aged six to 24 months old whose height for age is equal to or above two SD to 15%.



### Additional Observations on Nutrition

Currently, there is no national zinc supplementation program within Tajikistan. Various studies however have shown the benefits of zinc supplementation in both the prevention as well as treatment of illnesses within young children.<sup>10,11,12</sup> In particular, zinc supplementation appears to reduce the incidence as well as severity of pneumonia and diarrheal disease. Mercy Corps should therefore consider piloting a zinc supplementation program within the target districts to compliment existing strategies.

We have also suggested an anthelmintic chemotherapy program under the *Diarrheal Disease Control* section which would help to reduce incidence of illness as well as eliminate another inhibitor to iron absorption.

### Breastfeeding

Breastfeeding accounts for 20% of the project effort. Capacity-building efforts in this area focus on training community members, CHEs and community-based DOH staff. Additionally, the DIP proposed establishing breastfeeding support groups as well as supporting baby-friendly certification and refresher training for district hospitals. Specific activities include the following:

<sup>10</sup> Brooks WA, Santosham M, Naheed A, et.al. Effect of weekly zinc supplementation on incidence of pneumonia and diarrhea in children younger than 2 year in an urban, low-income population of Bangladesh: randomized controlled trial. *Lancet*. 2005:366-999-1004.

<sup>11</sup> Hambidge, Michael K. Zinc and pneumonia: Article in the University of Colorado Health Sciences Center, Denver, CO summarizing studies on zinc.

<sup>12</sup> Norra MacReady. Zinc Reduces Pneumonia, Diarrhea in Children in Developing Countries. *WebMD Medical News*, 1999 – reporting on study in *Journal of Pediatrics*.

- Provide training to CS staff, medpoint staff and CHEs on breastfeeding promotion and counseling.
- Involve mothers-in-law and husbands in counseling sessions and discuss ways they can support mothers while breastfeeding.
- Initiate breastfeeding support groups within a limited number of communities and scale up based on effectiveness and appropriateness.
- Support DoH request to provide training to certify district maternity homes in Zafarabod and Shahrison and recertify the maternity home in Asht.

### **Progress**

To date, medical staff from 67 rural facilities has been provided with training on breastfeeding promotion and counseling. Additionally, all CHEs were provided with a TOT on both breastfeeding promotion and complimentary feeding. CHEs were provided with a manual adapted from Aga Khan's "Recommended Infant Feeding Practices and Counseling Guide. In turn the CHEs have provided training to VDC members as well as community groups and households.

While mothers-in-law and husbands are included in the general education sessions given to mahallahs and households, there has been no specific or defined strategy to target these groups (see *Communication for Behavioral Change* for further discussion on this topic.).

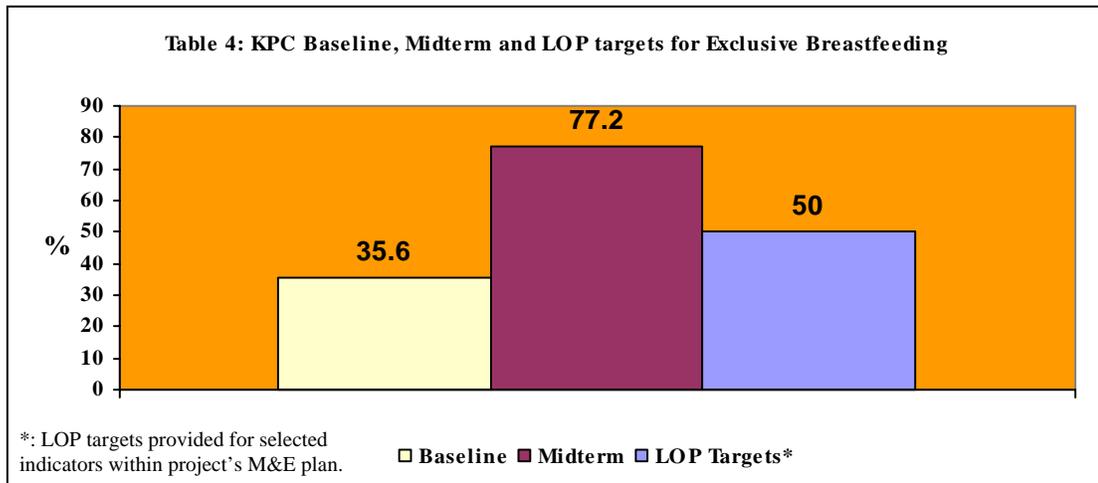
The breastfeeding support group is an initiative being led by the DOH and began in August/September of this year. Mercy Corps' Safe Motherhood Coordinator will jointly assess the effectiveness of this approach with the DOH before the end of the year.

Seventeen staff from maternity wards in Shahrison has been provided with TOT in BFHI and have begun to work towards certification however the Zafarabad training has yet to begin. It is anticipated that training in this district will start in November. In spite of the absence of certification, the evaluators found a high level of awareness about the importance of breastfeeding and hospital initiatives to support breastfeeding. In all three districts, babies were placed with their mothers (rooming-in) soon after delivery and breastfeeding encouraged. The 10 principles of successful breastfeeding were visible within the maternity wards. In Asht, Mercy Corps will begin refresher training in November and will work with DOH to incorporate this into its district support procedures.

### **Outcomes and Impacts**

Overall, the evaluators found breastfeeding awareness to be high. The larger issue appeared to be the timing of introduction of complimentary foods and types of complimentary foods. In Bahmal village where we interviewed a group of women they acknowledged the importance of exclusive breastfeeding for six months but said that they are sometimes overruled by their mothers-in-law who insist they introduce foods earlier. Dr. Davron, Director of the Oblast Center for Healthy Lifestyles also mentioned that one of the more difficult traditions to change is the habit of feeding infants the same food that is prepared for adults without sufficient modification. For example if the mother is preparing soup, take the meat and vegetables and puree them for the baby.

In spite of these challenges, the KPC survey indicate a marked increase in exclusive breastfeeding with more than twice the number of women indicating that they exclusively breastfed at midterm compared to baseline responses. This result well surpasses the LOP target for the project.



**Additional Observations on Breastfeeding**

All three district hospitals seem to be conscientious about promoting breastfeeding. While the project should continue to support Zafarabad and Shahrستان hospitals in their BFHI certification, focus should increase at the community level as part of an overall nutritional improvement strategy for mother and child.

***Maternal and Newborn Care***

Maternal and Newborn Care accounts for 30% of the project effort. At the clinical level, Mercy Corps efforts are to improve skills of DOH staff involved in delivery and post-partum care. At the community level, Mercy Corps' focus is to promote prenatal and post-natal care, recognition of danger signs, and support to families and communities for emergency transport to hospital for pregnant women experiencing a delivery emergency. Specific activities include:

- Provide Life Saving Skills (LSS) training to ob/gyn and midwife staff of district hospitals and SUBS (rural hospitals) through a contract with the American College of Nurse Midwives (ACNM).
- Train CHEs and feldchers to improve community awareness of the danger signs during pregnancy, delivery, and postpartum period for women as well as danger signs for newborns.
- Educate the community on the importance of post-partum visits within 48 hours and appropriate care of newborns.
- Mobilize VDCs to create emergency transport plans and promote family birth plans and savings for medical emergencies.

**Progress**

The LSS/Safe Motherhood Coordinator was hired and began work in July of 2005. Initially the project had proposed sending regional, district and SUB staff to Maternity House Three in Dushanbe to attend trainings but later determined that the City Center Maternity House in Khujand would be adequate for supporting the training. A mix of 10 midwives and ob/gyns were selected and trained as trainers by ACNM in September of 2005. ACNM supervised the first training

conducted by the new LSS trainers and Mercy Corps continued to supervise all subsequent training. To date 70 ob/gyns and midwives from district, city, and oblast maternity homes, as well as staff from SUBS, have been trained in LSS methods. ACNM is scheduled for a follow-up visit in November of this year to initiate TOT for prenatal/postnatal care within the districts.



*New mother with newborn at Shahrstan Maternity House*

The trainings were very well received and, like the IMCI training, staff has readily and enthusiastically put their new skills into practice. When queried about what they did differently than they had done before, the answers were similar to this one provided by the Chief Doctor at the Asht Maternity House, *“Before we used to use medication (oxytocin) to force labor – now we just wait. We also use the partograph which helps us to determine what assistance is needed. We knew about the partograph before but with LSS we were trained specifically how to use it.”* Staff at both oblast and districts levels has reported fewer traumas and reduced need to perform episiotomies.

They attribute these outcomes to better management of the third stage of delivery, supporting mothers in finding the most comfortable birth position and allowing births to occur naturally – all skills learned during the LSS training.

The one oversight in the LSS training has been the absence of neonatologists in the trainings. In Sughd, neonatologists are present at the oblast level as well as in all three district facilities. Once the child is born, any complications are handled jointly by the midwife and neonatologist. During the LSS training midwives were instructed on natural methods of infant resuscitation for breathing complications while neonatologists have been trained to induce breathing through medication. The consequence has been that midwives have been overruled by the neonatologists and the traditional drug-induced method applied. Mercy Corps and ACNM have attempted to correct this problem by providing a separate training for neonatologists. However the evaluators feel it would be better to include the neonatologist in the latter part of the training provided to ob/gyns and midwives in order to support the “team” approach that has work so well with the existing training participants. Oblast and district maternity staff also preferred this approach when presented with the two options. Therefore, we recommend that neonatologists be included in the latter part of the upcoming LSS trainings (80 more staff members are scheduled to be trained).

To date, no rural health facility staff or CHEs have been trained in prenatal/postnatal care or on helping communities identify danger signs during pregnancy, delivery, and postpartum period for women as well as danger signs for newborns. The evaluators found that prenatal check-ups were commonplace. In fact, Ministry of Health policy has been for women to receive six to eight prenatal check-ups during pregnancy and data shows high compliance. From our questioning it appeared that the midwives who perform prenatal check-ups understood at least the basic prenatal procedures however ACNM would be in a better position to evaluate this. Delivery was also not an issue as virtually every woman delivers in a hospital. Within the districts rural women will go to the district hospital for their first pregnancy or if there are any complications. Other deliveries are performed at the SUB level. Issues still exists on identification of prenatal danger signs and reaching facilities in a timely manner.

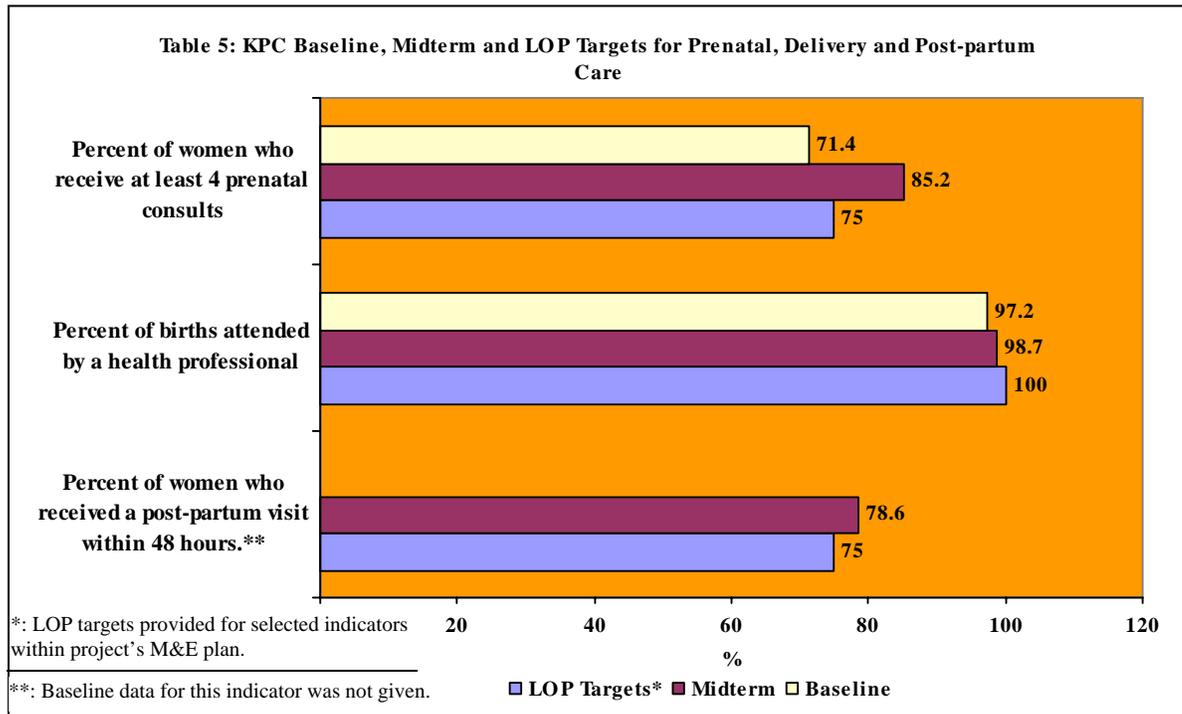
The larger problem however appears to be during the postnatal/neonatal period. If there are no complications women remain in the hospital for two or three days after delivery and then go home. Each district hospital has a women’s consultation center which then provides postnatal follow-up. However, after delivery, most women do not go to the consultation center as tradition requires that

women stay secluded in the home for 40 days. Hence, much of the postnatal follow-up falls upon the shoulders of rural facility staff that must do home visits in order to evaluate the mother and child. According to SUB and medpoint staff interviewed, the first visit is conducted within three days of returning home and then once a week for the next 40 days. However, depending on the profession of the individual conducting the visitation (midwife, nurse, pediatrician), either the mother or child may not be adequately evaluated. For example, in Kushkurgan village in Shahrستان District, Isoyeva Ijobat serves as a midwife but has been trained as a nurse. She felt she didn't have the skills to adequately provide follow-up with the mother. In many medpoints, there are trained midwives who lack the appropriate knowledge and skills to follow-up with newborns. In theory, pediatricians/feldshers/nurses should provide follow-up for the child while midwives should provide follow-up for the mother. This dissection of care is apparent throughout the system as women are required to go to maternity houses for care for themselves and regular hospitals or the pediatric hospital in Khujand for care of their children. In the rural areas however it is often the midwife who provides continuous follow-up at the household. The evaluators therefore recommend that the project provide special focus on community-based postnatal care interventions in the remaining two years of the project. SUB and medpoint staff, irrespective of their profession, should be adequately trained in providing follow-up to *both* mother and child.

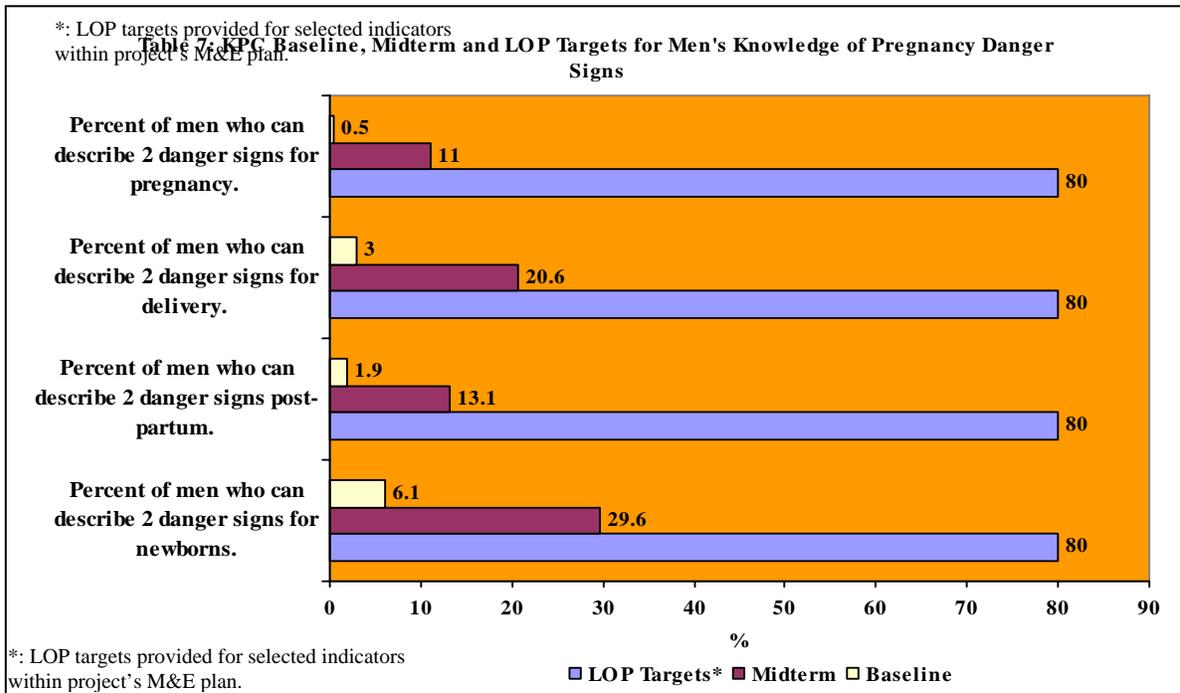
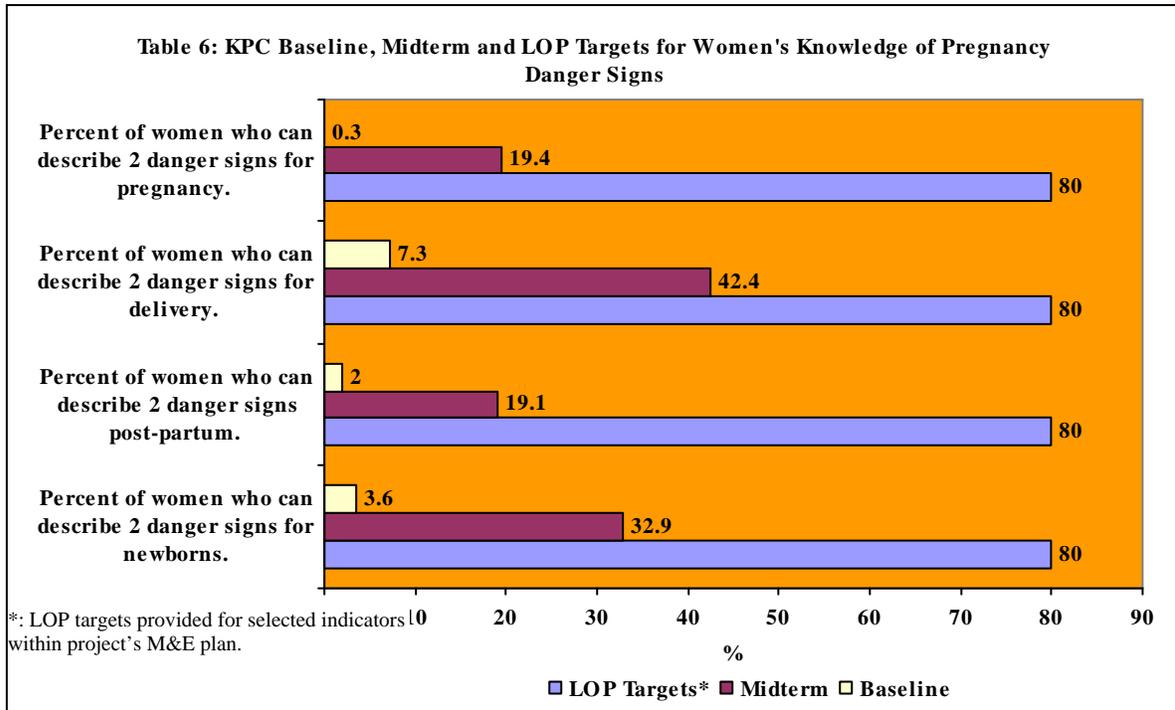
Village Development Committees (VDCs) have yet to be trained in establishing emergency transport plans and promoting family birth plans and savings for medical emergencies. However, some of the committees have already raised money and have applied that to assist in emergency transport. We would recommend that cross-training be supported whereby VDCs that have established emergency funds provide guidance and assistance to those who have yet to do so.

**Outcomes and Impacts**

As in the other intervention areas, the KPC midterm indicators for *Maternal and Newborn Care* have all shown improvement over baseline results. Two of the three indicators for prenatal, delivery and postnatal care have already exceeded LOP targets.



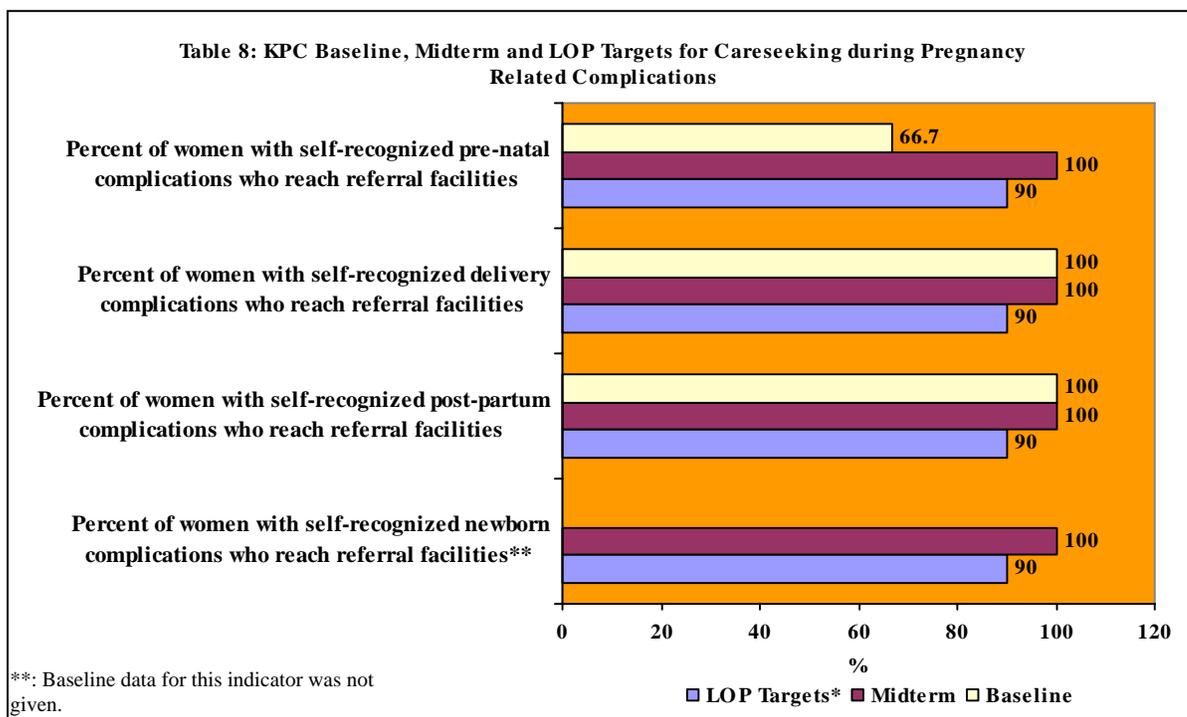
Knowledge of danger signs during the different stages of pregnancy were asked of both women and men and, in both cases, improved significantly. However, substantial progress needs to be made in the following two years if the project hopes to achieve its' LOP targets. This is particularly important for the postnatal period for the reasons already mentioned. Moreover, while awareness among males is important, many men (as much as 80 percent in Asht and Shahrstan) migrate to Russia for work for nine months or more in the year and therefore partake in few of the decisions regarding pregnancy – other than to take part in initiating it! In practice, it is the mother-in-law who makes decisions about care and care-seeking during pregnancy. As will be discussed later, the project would benefit from a more concerted focus on this group.



Finally, careseeking behaviors for women with recognized danger-signs seems to have improved, particularly those related to pre-natal danger signs. During the mid-term, some confusion arose around denominators used to calculate these indicators at the baseline and for the mid-term KPC surveys. These indicators have been recalculated to include only those danger signs recognized by the Project and WHO as the most frequent and serious complications, and the updated figures are presented above. As can be seen from Tables 6-8, recognition of danger signs seems to be the key determinate of care seeking behaviors, as once danger signs are recognized care is always sought.

**Additional Observations on Maternal and Newborn Care**

The



evaluators were told by several health staff that one of the biggest problems faced in the districts was high birth rates with most women having their first child at 18 or 19 years of age. Yet, family planning was not brought up as a major initiative and was only discussed when asked about it (with the exception of Shakristan). Birth control is available at rural health facilities and is provided free of charge.<sup>13</sup> However in Kushkurgan village the nurse/midwife informed us that only a small percentage of families take advantage of the services. We therefore recommend that the project consider how it could best support a more active family planning program in the district. This is obviously an area where men need to be the target of education and behavioral change.

**c. New Tools and Approaches**

Both the LSS and IMCI training were well suited for the environment and demonstrate that where there is good access to facilities and health personnel, a little training can go a long way. While IMCI has had problems in other countries where poor access and high staff-patient ratios make it more daunting, this program should demonstrate the effectiveness of IMCI within the Tajikistan context (especially in areas where there is good access to health facilities) and should be used to encourage further rollout of the program throughout the country. The LSS training has also proven to be very practical at the clinical level. In areas of the country where more births occur at home attended to by TBAs, it would be interesting to see if the home-based version (HBLSS) would also prove effective.

<sup>13</sup> While all health services are considered ‘free’, it is common and expected to pay for services given the low wages of health staff. As a point of reference, uncomplicated deliveries cost about \$100 including transportation, medications and services.

## **2. CROSS-CUTTING APPROACHES**

### **a. Community Mobilization**

The Sughd Child Survival program has used three principle vehicles to reach and mobilize targeted communities: (1) The Department of Health – via its Center for Healthy Lifestyles, SUBS and medpoints; (2) Community Health Educators; (3) Village Development Committees.

#### ***Department of Health***

The Center for Healthy Lifestyles is a unit within the MOH which was established in 1994. Its purpose is to increase level of knowledge, change health behaviors and promote healthy lifestyles. Within Sughd Oblast, a regional office was established in 1999. However, seven years after its inception, it is still sparsely furnished and with very limited equipment. The entire annual budget for the CHL in the region is \$15,000. There are also 18 district CHL offices which generally have only one staff person, one desk and one chair. We found that the CHLs in the target districts have no budget, no equipment, and no materials. In truth, Mercy Corps has been a vehicle for the CHL to reach and mobilize the communities rather than the other way around. Mercy Corps has provided the materials, helped to renovate office space, and provides transportation. They have also organized the CHEs and VDCs in the target districts. As Dr. Davron, the Regional Chief for the Center for Healthy Lifestyles put it, *“The work we’ve done with Mercy Corps in two to three years would take us 10 years if we had to do it alone.”* While this is admirable and the close collaboration with the CHL should continue, it is also an alarm bell that threatens the sustainability of community mobilization efforts once the project ends. This will be discussed further in the *Sustainability Strategy* section of the report.

Staff members from SUBs and medpoints are also active participants in the community mobilization efforts. In each of the communities we visited medpoint and SUB staff members were also members of the Village Development Committee and in some cases served as Community Health Educators. This was intended by Mercy Corps and has been a positive strategy ensuring close coordination between the village and the department of health.

#### ***Community Health Educators***

CHEs are the key contacts points in the community responsible for organizing meetings, conducting household visits and disseminating information. Two CHEs are selected in each community with an effort made to have one male and one female educator. At the onset of the project, Mercy Corps provide volunteers with a monthly stipend of \$25 (which is by the way the official salary of a physician within the districts) as well as in-kind incentives. In the DIP, Mercy Corps points out that *“A comprehensive incentive system including monetary and in-kind incentives...is needed to sustain a program of community volunteers.”* This was based on AED/BASICS document: Community Incentives and Disincentives: How They Affect Motivation. However, Mercy Corps has decided to phase out the monetary incentive program and the evaluators believe this was an appropriate step. In retrospect, they wished they would have started out without the monetary incentive in the first place. There are several drawbacks to the payments - one of which is that it is simply not sustainable once the program ends. Also, it appears that the training and non-monetary incentives have been sufficient motivation as retention has been high (approximately 70 percent of the original CHEs stayed on despite the monetary phase out). Volunteers are generally well educated but have little or no opportunities to further their education. Hence, the stimulus of learning, as well as other non-monetary incentives, appears to be sufficient reward at this time.

CHEs divide their time between disseminating information as members of the VDCs as well as doing home visits. They follow a regular routine of visiting households with children under two. As GMP begins, they will take part in organizing the communities for monthly weighing and measuring activities.

### ***Village Development Committees***

Mercy Corps has helped to establish or strengthen 66 VDCs throughout the three target districts. Each VDC is made up of 10-15 community members who are selected at public meetings to represent their community. The VDCs visited by the evaluators tended to have a large number of teachers as well as medpoint staff. VDCs meet on a routine basis and address a broad range of community problems that extend beyond health issues. One VDC visited was working with the village to organize volunteer labor to construct a community tea house. The other two VDCs identified water issues as a priority. In practice, the VDCs serve as an extension of the CHEs. In the three communities visited, each VDC member was responsible for a *maballah*. This is a block or neighborhood committee that convenes regularly to discuss issues associated with their particular section of the village. The VDCs use these meetings as opportunities to discuss health issues as well as to inform and seek feedback on other activities being undertaken by the VDCs. This is a particularly effective method of getting information out amongst the community and probably one of the reasons why the project has seen such good results on knowledge and behavior indicators. It's important to note that VDCs are not part of any formal community representation or liaison with the jamoat (sub-district government) however they de-facto serve such functions. In Bahmal village, one of the VDC members aptly noted, "*You can see this committee as the government of our community because we try to solve every problem of our community.*" They do appear to be tackling problems and providing leadership in the community. As such, they are a particularly effective mechanism for mobilizing and educating the community at-large.

### **b. Communication for Behavior Change**

For all four intervention areas Mercy Corps has identified target audiences, behaviors, key factors influencing behaviors and activities designed to change behavior. Behavior message and activity tables can be found in *Annex I*. The key factors influencing behaviors were primarily identified through a Doer/Non-doer survey conducted in January of 2005. Activities have principally focused on developing culturally appropriate materials for distributions as well as one-on-one counseling. Mercy Corps has also helped to develop radio and TV PSAs. A unique approach employed by Mercy Corps has been to distribute cassette tapes to bus drivers that have popular music interspersed with health messages (*see Results Highlight: Innovative ideas*). Mercy Corps has made full use of existing materials developed by other organizations such as Agha Khan and Save the Children and has adapted them to meet their needs. In some areas, materials must be translated into both Tajik and Uzbek languages given the proximity to the border and high percentage of Uzbek populations.

As the KPC results indicate, the behavioral change strategies employed by Mercy Corps have been extremely effective in targeting the right group with the right messages. When asked what they felt the most effective strategy was for changing behavior, Mercy Corps' community mobilizers indicated that the one-on-one approach used by CHEs and VDCs was best. Radio and TV PSAs were more complicated as some groups preferred Uzbek stations and channels over Tajik ones and some communities simply did not have radio reception. The Director for CHL in Shahrستان believed publishing articles in the local paper was also an effective tool as literacy is high and people regularly read the paper.

While the Doer/Non-Doer survey identified *individual* attitudes and knowledge affecting behavior it did not appear to bring out external social and economic factors. One of those factors, which became poignantly clear during our evaluation, is the mother-in-law. In fact, through informal chats with mothers in the maternity wards we discovered that most women had not given their child a name yet. This would be the privilege of the mother-in-law. In these communities the status of the mother-in-law is further elevated simply due to the fact that many husbands are absent for much of the year. Hence, the mothers-in-law become the surrogate father as well. She handles the money, she helps in childrearing and she decides what is best for the mother and child. While Mercy Corps has appropriately identified mothers-in-law as a target audience, there has been, to date, little effort to engage them as a unique group of decision-makers. The evaluation team therefore recommends that the project devise a strategy to more effectively target this group.

Men are also an important target group. The project has tried to reach them by engaging religious leaders to disseminate health messages in the mosques. Timing however is important. Most men leave for Russia in the early spring and don't return home until November/December. Moreover, while it is important that they understand the healthcare needs of the mother and child, it is most important that they understand the risks of HIV/AIDS prior to leaving for Russia and the importance of family planning upon return.

Evaluators heard from VDCs, CHLs and others a strong need to more effectively engage the school and school children as a communication and behavioral change strategy. In Zafarabad, the CHL works with school children in writing 'dictations' which they are then required to take home and read to family members. Family members must sign the dictation confirming that it had been read to them. It would seem that the project would benefit from a more dynamic school-based program modeled after the child-to-child approach whereby children are trained as junior CHEs and given the guidance and support using interactive and entertaining methods to educate and inform. Also mentioned was the need to provide special attention to girl children. As one of the VDC members from Baht village put it, "*You know girls are future moms, we should train school girls and not wait until they get married.*" We therefore recommend that the project consider review and assisting the CHL in adapting the child-to-child model to meet the needs of the target communities.

Finally, Mercy Corps should work with the Centers for Healthy Lifestyles to develop a health promotion schedule that coincides with the seasonal onset of various illnesses as well as the social patterns that evolve from male migration to and from Russia. Messages need to be reinforced and timed so that they are heard when they will be most useful. A sample of this scheduling is found in *Annex J*.

### **c. Capacity Building Approach**

#### ***Strengthening the Local Partner Organizations***

The Sughd Child Survival projects has employed a two-pronged approach to capacity building by strengthening the Department of Health as well as building or strengthening community entities to more effectively address their own health needs. Within the Department of Health, Mercy Corps works both vertically (regional-district-community) as well as horizontally (maternal care-pediatric care-health promotion). They have done an exceptionally good job at navigating the web of relationships and respecting the lines of authority. It was clear that the DOH at all levels identified Mercy Corps as a partner and valued the manner in which they've interacted with the Department of Health. Here is some of the feedback that reflects the opinions we heard:

*"Mercy Corps listens to our opinions and helps us solve our problems."*

*Dr. Soira, Deputy for Pediatrics – Regional DOH*

*“Mercy Corps doesn’t distance themselves but works with CHL. Other groups do it without the CHL. I like the fact that Mercy Corps works with populations, individuals and conduct meetings jointly. Working with the CHL supports the sustainability of the project.”*

*Dr. Davron, Director of CHL – Regional DOH*

*“Its great that Mercy Corps organizes such activities. They provide us with practical assistance, they are gentle with our staff and more than half of our work on prevention is done by MC staff. We would be grateful to you if you increase number of MC staff here.”*

*Dr. Samador Abdumalik, District Chief – DOH Zafarabad*

### **Regional DOH**

At the regional level, Mercy Corps has assisted the DOH in setting up the IMCI Center and supporting IMCI and LSS training at the regional hospitals which have benefited DOH staff throughout the oblast. Mercy Corps jointly plans its activities with the DOH at the regional level and encourages participation by regional staff in planning or reporting meetings. On October 19, the Regional Chief of the Department of Health, Deputy for Pediatrics, Deputy for Maternal Child Health as well as various district staff participated in a debrief provided by the evaluators on the assessment and KPC survey results. It was an interactive meeting that engaged them in commenting on and helping to interpret results. The regional DOH also approves any materials that are developed and distributed by Mercy Corps.

At the regional level, the evaluators felt that Mercy Corps could work more closely with the DOH in gathering and evaluating data as well as planning pilot interventions on micronutrient supplementation and de-worming which has already been discussed. Moreover, Mercy Corps needs to begin engage regional DOH on transfer of responsibilities and sustainability which will be discussed in the sustainability section of this report.

### **District DOH**

At the district level, Mercy Corps has supported specific technical trainings and has assisted in establishing district IMCI centers. All materials used within the various trainings and health promotion activities are financed and printed by the project. Capacity building has focused primarily on quality supervision and support. Mercy Corps staff accompanies DOH district staff on visits to SUBS and medpoints and assists them in providing supportive supervision and using checklists to evaluate performance. It was felt that the district could benefit from more focused training in materials development for health promotion. Because the districts have no budgets for health promotion, all materials are hand made. Most of the health promotion materials we saw in the hospitals and clinics were poorly placed, extremely wordy and used very small print.

It is the strong opinion of the evaluators that most of the capacity building and project support in the final two years of the project should focus on the community level. While the needs at the regional and district levels are evident, they will require policy changes, reprioritization of budgets and improvement of infrastructure and equipment – all of which are outside of the control or financial limits of the project. Further improvements in health outcomes will be best achieved by building the capacity of SUBS, medpoints and communities. Thus far, Mercy Corps has provided support to SUBS and medpoints through IMCI training support as well as LSS training for SUB-level midwives and pediatricians. Additional training and support are needed in adult learning, post-natal care for mother and child and materials development.

Other than the IMCI, iron tablets and family planning methods, the medpoints have no pharmacies. In the villages visited there were no private drug stores and the closest available drug store was located in the district capitals which in some cases are 60 kms away. Hence the evaluators felt that a *community* pharmacy managed by the VDC and administered by medpoint staff would help improve care, limit the need for referrals and decrease costs. There are various models of community pharmacies that have proven effective in communities where there no formally medical staff persons are present. We recommend that the project look into this approach and possibly pilot the program in selected communities.

### **VDCs**

The Village Development Committee has also received capacity building support from Mercy Corps. Each of the 66 VDCs has received training from Mercy Corps in community mobilization techniques and adult learning methods. They receive continuous topical trainings via information provided by the CHEs who receive regular trainings from Mercy Corps. They too have expressed their appreciation for the support provided by Mercy Corps. However, the VDCs interviewed lacked skills in strategic planning. When pressed about their objectives for the year they found it difficult to define what their priorities were. They had no written plan or measurable goals identified. Therefore, we recommend that Mercy Corps train VDCs in how to develop annual plans with objectives and activities as well conduct resource mapping. This will help to give the VDCs greater focus and also contribute to their sustainability. Also, since some VDCs have successfully raised funds to provide emergency transportation and support other activities it would be helpful if Mercy Corps could provide opportunities for cross-training and information sharing amongst the VDCs so that they can learn from each other.

### ***Health Facilities Strengthening***

A large focus of Mercy Corps' capacity building and training efforts have been at the health facility level which has already been adequately covered in other sections of this report. The core element of facility strengthening has been skills building in LSS and IMCI followed by supervision to ensure skills are appropriately and effectively applied.

### ***Training***

The core training activities for Mercy Corps has been LSS, IMCI and promotion of healthy behaviors at the community level. In addition, Mercy Corps will be assisting Zafarabad and Shahrstan Maternity Houses in obtaining BFHI certification. The project has, in some ways, benefited from the sheer paucity of continuing education opportunities available to medical staff. Since the collapse of the Soviet Union there have been very few training opportunities available – especially for SUB and medpoint staff. Of those individuals interviewed only one could recall receiving any training since 1991. Hence, not only were they very appreciative of the training, they were also eager to learn and apply their new skills. The trainings were appropriate, practical and well executed which also contributed to their successful application.

The LSS training has been implemented through a contract with the American College of Nurse Midwives. ACNM has made three trips to Tajikistan and is scheduled to make one final trip. The first two trips helped to identify appropriate facilities for training, orient Mercy Corps' LSS/Safe Motherhood Coordinator and provide the initial TOT on the Life Saving Skills program. The third trip was to support and assist the newly trained DOH LSS trainers as they conducted their first training. Since then, seven trainings have occurred with the support and coordination efforts of

Mercy Corps' LSS/Safe Motherhood Coordinator. ACNM will return in November of 2006 to conduct follow-up on the LSS trainings and initiate pre/post-natal care training.

The initial IMCI TOT training was given by DOH trainers from Dushanbe for selected DOH staff in Khujand in July of 2005. As a result of this training, 13 additional trainings at both the regional and district levels in selected districts (including SCSP districts) were conducted, and to date over 130 Department of Health staff from 80 health facilities has received the nine-day IMCI training. Mercy Corps has supported this effort by financing costs associated with the training, producing the manuals and posters for the health centers and supporting the establishment of the regional and district IMCI centers. All of the planned IMCI trainings have now been completed. Over the next two years, Mercy Corps and DOH will focus on conducting Community IMCI training. Discussion of C-IMCI has already been covered under *Diarrheal Disease Control*.

Training has also been provided to 82 Community Health Educators and 66 Village Development Committees. More than any other intervention, these trainings and the health promotion that has resulted from them have been cited as the key contributing factor to the positive changes in health behaviors and outcomes witnessed. The excellent training should continue. Moreover, specialized trainings should be developed for school children, mothers-in-law, and men. As we've already mentioned, in the final two years of the project, much of Mercy Corps' training and health promotion efforts should focus at the community level – including the SUBS and medpoints.

#### **d. Sustainability Strategy**

The development and implementation of a sustainability strategy will be critical for ensuring that project achievements are sustained and further progress made once the project ends. The good news is that the trainings in LSS and IMCI are already proving to be sustainable in several ways. For one, there are now trainers staffed within facilities at both the regional and district levels who are capable and continue to provide both formal and informal training. Second, at the Regional Maternity House and City Center Maternity House, new staff members as well as student interns that circulate through these facilities, are being taught the new LSS skills. Hence, the benefits of these trainings are continuous and extend beyond the boundaries of the program and project districts.

However, skilled staff over time will require refresher training as well as ongoing supervision. Mercy Corps has been very good at incorporating joint supervision into the program in order to institutionalize and strengthen this aspect. However, without Mercy Corps vehicles, fuel and drivers it is likely that much of the supervision would not occur. The reality is that the region and district facilities are over-staffed yet have no money for transport, training, facility maintenance or equipment. In Asht for example, the District Chief stated that 90% of his budget is for salaries. For a population of 120,000 they have 340 beds in eight departments in addition to seven rural hospitals, five in-patient clinics and 42 medpoints – all of which are staffed with doctors, nurses, midwives and feldshers (medpoints may only have a midwife and feldsher). Yet the district hospital has latrines that are dangerously unhygienic, no running water, an incubator from 1954 that no longer works. Moreover, any travel by health staff to the villages must be paid for out of their own pockets.

The Centers for Healthy Lifestyles are even worse off. They simply have no budget. They literally have a desk and a chair and one individual assigned to manage the 'Center'. As the project has demonstrated, the role of the CHL will be crucial for providing the necessary support for the CHEs, VDCs which are the force behind the changes seen in the community. The CHL's role is to get information out into the community in timely, effective and appropriate ways. It is therefore essential that they have a budget to do this.

While the Ministry of Health has ambitious plans to reform the health system, progress has been slow. One of the initiatives mentioned includes allocation of 80 percent of district budgets to SUBS and medpoints. This would be wonderful once and if it occurs. While Mercy Corps cannot change health policy, it is now armed with some promising results that might help to encourage and motivate more support. Specifically, this project should develop a strategy that would work to ensure there is money budgeted for transportation, training and production of health promotion materials by the end of the project period. These are the basic requirements needed for the continuity of support and quality of service at the community level that Mercy Corps has provided.

The evaluators learned that health budgets are not exclusively the domain of the health department but also depend upon regional, district and sub-district government officials (outside of the Ministry). Mercy Corps should determine who the key points of contact are within the various levels of government, present them with the project findings and appropriately engage them with DOH partners in discussions budget needs by the district as the project phases out. This will be a long process involving relationship-building and good diplomacy skills. For that reason, we recommend that Mercy Corps develop a plan as quickly as possible so that it can work over the next two years to implement it.

In the DIP, Mercy Corps proposed using the CSTS+ Child Survival Sustainability Assessment (CSSA) beginning in the second year of the project, coincident with start up of the LSS cascaded training and the GMP start up. This has yet to be initiated. The evaluators would recommend beginning this process as soon as possible.

## **C. PROGRAM MANAGEMENT**

### **1. PLANNING**

DOH staff at the oblast and district levels were involved in the development of the DIP, and provided feedback on the draft report. Mercy Corps' Health Program Manager led the process in coordination with SCSP technical staff from Khujand. The qualitative research and KPC surveys provided opportunities for community input into the process. The DIP was reviewed by Mercy Corps headquarters and Mercy Corps' Health Director came to Tajikistan to assist in project start-up.

All Mercy Corps project staff and key DOH staff at the oblast and district levels have copies of the project's objectives as well as the M&E plan translated into Tajik. Based on the evaluation, field staff seemed to have a clear understanding of the general objectives and specific activities of the project as did the DOH. At the community level, CHEs and VDCs understood the project objectives as it related to their activities. However, when it came to the measurement indicators within the project monitoring and evaluation plan, responses were more mixed. While some staff had a relatively good handle on the indicators and baseline values, others did not. Mercy Corps should make sure that all staff have a copy of baseline-midterm and LOP targets within one table and provide orientation on the indicators and the potential interpretations of the values. This should then be shared with DOH staff at all levels as well as CHEs and VDCs.

A work plan is developed annually and progress towards that plan reviewed on a quarterly basis. A copy of the SCSP activity progress to date is submitted in *Annex H*. Of the 34 benchmarks established for FY05-06, 24 have been reached. Most of the benchmarks not achieved centered on C-IMCI and GMP activities. It's likely that the work plan was a little over-ambitious however activities were also delayed due to external factors. The DOH for example has requested that C-IMCI activities not begin until all the IMCI trainings have been completed and initial monitoring

conducted. Also, GMP activities have had to wait until MOH, WHO and UNICEF defined what the Tajikistan growth monitoring cards would look like. It is anticipated that this will be finalized before the end of the year.

## **2. STAFF TRAINING**

Mercy Corps seems to have done a very good job at selecting and training staff. Key management and technical staff have been involved in training on LQAS, behavior change, motivational interviewing, community mobilization, supervision, TOT training as well as all of the technical trainings (IMCI, LSS, etc.). Behavior change and TOT training was provided by Mercy Corps HQ. They've also participated in trainings hosted by other organizations and have conducted site visits to other non-Mercy Corps projects. For example, the project's Communications Coordinator recently participated in a 3 day workshop on materials and message development hosted by Project Hope. Staff also felt that their active participation in the baseline survey was practical hands-on training that provided them with important skills and helped them better understand community needs. They mentioned that they would like additional training on inter-personal skills and supportive supervision techniques.

One limitation discovered by the evaluators is that only the Project Manager and Deputy Manager have unlimited access to the internet. Mercy Corps may want to consider expanding access and providing guidance in search techniques for at least the three project coordinators. The training coordinator mentioned that one of her responsibilities is to look for training opportunities but she doesn't know where to look and has no access to information outside of Khujand.

## **3. SUPERVISION OF PROGRAM STAFF**

There is very good program oversight and supervision by Mercy Corps' Health Program Director, Mary Helen Carruth. Twice a month Ms. Carruth travels to Khujand to work with Saïidi Izatof, SCSP Manager, and other project staff. Dr. Izatof also travels to Dushanbe on occasion. These trips provide excellent opportunities for supervision and problem-solving.

Dr. Izatof is in day-to-day contact with his deputy project manager and three project coordinators whom he supervises. In Khujand they all share office space together. Dr. Izatof also spends roughly 50 percent of his time in the field reviewing project activities and providing support to field staff. The Deputy Project Manager supervises district coordinators who supervise project monitors and mobilizers.

Workload for some staff has been heavy but should be lightened as Mercy Corps' Swiss-funded project comes on-line in November. The SIDA program (Strengthening Tajikistan Primary Health Care Services and Outreach) targets the same districts as the SCSP and will provide complimentary funding which will enhance staff support and expand activities. This will include a Deputy Health Program Manager who will spend 50 percent of her time in Khujand as well as an additional Deputy Project Manager. Additionally, a Community Training Coordinator will be assigned to the project allowing the present Training Coordinator to focus on IMCI. Mercy Corps should also look at the workload in Asht District, which is considerably larger than the other two districts but without a proportionally larger staff.

## **4. HUMAN RESOURCES AND STAFF MANAGEMENT**

The program's personnel management structure seems effective and adequately layered to provide good oversight and support. Mercy Corps Tajikistan has established policies and procedures in place for expatriate and local staff. The policies and procedures manual has been translated into

Tajik and all local staff have copies and have received a policies and procedures orientation. Mercy Corps has a dedicated HR Manager in Dushanbe to handle human resource issues and everyone has written job descriptions. A memorandum of understanding has been signed with the Ministry of Health as well as Sughd Department of Health delineating roles and responsibilities of the MOH, Sughd DOH and Mercy Corps.

The evaluators met privately with the three technical coordinators and also held a special meeting with all of the district coordinators, monitors and community mobilizers to discuss program management and identify any problems that may exist. Staff has a high regard for their superiors and the monitors and mobilizers identified team cohesiveness as one of the principle strengths of the project. Under the SIDA project, funds have been allocated for team building activities.

There has been very low turnover in the project. Two mobilizers were let go for poor performance and another left for personal reasons. There has been no turnover in project management since the start of the SCSP. Approximately one third of CHEs left when Mercy Corps made the decision to phase-out its monetary incentives. All have since been replaced.

The SIDA project will allow selected project staff to continue their employment beyond the end of the child survival project. However, as with most projects, there are no guarantees of continued employment beyond the project period.

## **5. FINANCIAL MANAGEMENT**

SCSP budgets are developed and revised annually in Dushanbe by Mercy Corps' Health Program Manager who receives budget input from SCSP staff in Khujand. Final approval is provided by Mercy Corps HQ. Requests for funds are made by project staff on an activity-by-activity basis and submitted to Dushanbe. These requests are aggregated by Mercy Corps' Health Program Director who then seeks approval through the Dushanbe finance office. Each expense must receive signature approval prior to expenditure as well as on expenditure reports. A recent policy change allows anything expenditure under \$300 to be approved by the SCSP Manager and anything over that amount must receive approval by the Health Program Manager in Dushanbe.

Project pipelines are prepared monthly which includes both HQ and field expenses. This is submitted to the Health Program Manager who shares it with the Project Manager. Other than the pipeline, financial information flow tends to be unidirectional. Project coordinators have no access to the overall budget and there is little understanding of the budget process beyond the reports they are required to submit. Staff expressed that it would be helpful to have a better understanding of the process as well as more information on the budget itself.

## **6. LOGISTICS**

Most purchases can be made locally in Khujand which has a reasonable commercial market for items required by the project. The logistics process was quite poor the first year of the project due to ineffective administrative management in the Khujand office. It has improved significantly in 2006 with a new administrative manager and procurement officer. Mercy Corps Tajikistan has developed a procurement matrix identifying the average amount of time necessary to procure common items. This helps in planning and gives staff the right to follow-up with the procurement officer if items are not received in within the projected time required. Mercy Corps Tajikistan has a procurement manual in Russian language which was adapted from their international procurement manual. Assistance was provided by Mercy Corps Headquarters in developing that manual.

## **7. INFORMATION MANAGEMENT**

Every quarter, IMCI and LSS monitoring reports are developed based on an aggregation of data derived from monitoring site visits. These data are reviewed by project staff as well as regional and district health staff. This information has been helpful in identifying problems in CHE referrals and project activities have been revised based on the review of that data. Twice per year the project also conducts a mini-KPC with selected questions. This is also discussed amongst staff and with head doctors within the target districts.

While monitoring data is regularly used by DOH and Mercy Corps staff to determine project effectiveness, Mercy Corps's Health Program Manager feels there is a need for better understanding and more effective use of all information. The evaluators concur with this and witnessed instances where information could have been more effectively analyzed or used. For example, according to the KPC survey, immunization coverage at baseline was 5.2 percent and preliminary results from midterm put it at around 30 percent. Given that DOH has good coverage throughout the region and vaccinations were readily available, the evaluators felt these data required closer study. Through further analysis it was discovered that vitamin A supplementation had been erroneously included as a requisite for complete vaccination. Once removed the data more accurately reflected actual coverage (47.7% baseline; 69% midterm). Iron supplementation data, while correctly calculated in the KPC, also fails to provide a clear picture of distribution without further research. Most of the other data appear to be accurate based on the triangulation of information received from DOH and communities, however it would be worthwhile to provide a more critical review of all data and utilize it to better understand the barriers to health within the target communities.

Moreover, the Department of Health at the district and community level maintains data that could aid the project's understanding of community health which, heretofore, has gone unused. For example, all pregnant women are tested for hemoglobin levels and re-tested throughout their pregnancy while they receive iron tablets. Hence, it is possible for the project to gain a clear picture of the prevalence of anemia amongst pregnant women, as well as geographic concentrations and even severity levels. The districts also maintain fairly reliable records on mortality. The project could, for example compare mortality reductions in the target districts with trends in other districts to get a relative sense of the impact of the project. Likely, other data exist that would be of value to the project as well.

## **8. TECHNICAL AND ADMINISTRATIVE SUPPORT**

Technical assistance has been provided by Mercy Corps headquarters on TOT and behavior change. In addition, Mercy Corps' Health Director designed the original project and also came out to assist with start-up. Carlos Cardenas, Mercy Corps' current Health Director, also participated in the mid-term evaluation. The project receives primary technical support from Kati Moseley, Mercy Corps' Deputy Director for Health. External assistance has also been provided. Staff has received outside assistance on motivational interviewing, LQAS sampling methodology and facility assessment methodology. All of these trainings have been considered timely and useful.

In the remaining two years of the project staff anticipate needing support for any potential pilot micronutrient (iron, zinc) supplementation project or de-worming program. Training in interpersonal skills and supportive supervision have also been mentioned. Training is also slated to assist VDCs in technologies for participation and assistance will be provided in conducting community development assessments.

## **9. MISSION COLLABORATION**

Mission involvement in the project has been quite limited. Tajikistan does not have a full USAID Mission but provides some backstopping functions through a local office. General administrative support is provided through the regional USAID Mission in Kazakhstan. Mercy Corps has submitted its DIP and annual reports to the USAID Mission but has received no feedback. It regularly invites the local USAID health representative, Aziza Kahmidova, to important meetings or functions. In July of this year Ms. Kahmidova visited the project in Shahrستان and also met with the evaluators during our visit. She expressed that the work of Mercy Corps, and NGOs in general, is crucial to the MOH – especially in the areas of illness prevention/health promotion.

## **D. CONCLUSIONS AND RECOMMENDATIONS**

Overall, the lead evaluator found the project to be well managed, focused and with properly selected interventions that are effectively addressing the needs of the population. The program should be commended for its strong, respectful and productive relationship it has maintained with the Sughd Department of Health, the quality of its staff and the evident impact they are having on the health within the region. The project has an excellent chance of achieving most if not all LOP targets in the next two years. The evaluators feel that the following recommendations will help guide priorities for the remainder of the project and build upon the accomplishment made thus far.

### **KEY RECOMMENDATIONS**

These recommendations are considered by the evaluators to be important, strategic and feasible within the parameters of the project. None of the key recommendations requires substantial changes to the project description or DIP.

**1. Project Focus:** Thus far all levels within the Sughd Department of Health structure (Region, District, Sub-district and Community) have benefited from training activities and project support. This has been a successful strategy in building unity in vision and ownership of project activities among key staff within the DOH – Mercy Corps' principle partner. However, it is clear that further improvements in health outcomes will likely be best achieved in the following two years by primarily focusing on activities at the sub-district and community levels. This was the opinion of the evaluators and also shared by DOH officials. Therefore, while the project continues coordination and encouragement of active management at the regional and district levels, we recommend that training and health care improvement efforts be focused at the sub-district (SUB) and community (medpoint) levels, with particular emphasis in the areas of post-natal care, nutrition and ARI. This will result in earlier treatment, fewer complications and lower costs to the client as well as the health system. In addition, the project will need to continue assisting the CHL to increase their capacity and support at the community level.

It has been the intent of the project to initiate *community* IMCI activities in the coming year. This effort will help the project achieve the recommendations made above. However, globally C-IMCI has been described and defined in different ways. WHO, the CORE Group and selected PVOs have developed parameters, guidelines and tools for applying C-IMCI. Therefore, we urge the project to take a close look at the various C-IMCI tools available and determine which best fits their needs and will help further the goals of the project.

**2. Ownership and Sustainability:** While the Ministry of Health at the regional and district levels are clearly impressed with the results of the project thus far, they have yet to invest the resources that will be necessary to sustain the results once the project finishes. This is especially true in the area of health promotion which falls under the management of the Centers for Healthy Lifestyles.

In its most rudimentary form, the DOH, as well as local government needs to demonstrate their support by budgeting resources for transportation (for supervision), training and health promotion materials. Therefore, we recommend that the project immediately begin working with the Sughd Department of Health and local government to plan for future commitments of resources for these basic activities. At the same time Mercy Corps should prepare the DOH for the eventual transfer of responsibility. We recommend that the actual process of transition begin well before the end of the project.

**3. Target groups:** This principle target group for behavioral change activities has been women of reproductive age. It has also been the intention of the project to work with men and mothers-in-law as important change agents within the family and community. Given the seasonal migration of men to Russia (up to nine months of the year), the evaluators feel that discussions with this target group should focus on HIV/AIDS/STDs prior to departure to Russia and family planning soon after their return. Given both the culture and migration of men, mothers-in-law play a significant role in the care and well being of both mother and child. We therefore recommend that the project devise a strategy to more actively engage and influence the direction and decision-making of mothers-in-law.

Also, school children, particularly girl children, are an important target group that can help support promotion within the household while at the same time influence the attitude and behaviors of the next generation of families. We therefore recommend that the project explore assisting the CHLs in developing a school campaign for health promotion based on the child-to-child approach that has proven successful in other countries.

**4. Maternal Nutrition:** Health personnel interviewed expressed a high degree of confidence in the availability and accessibility of ferrous sulfate to pregnant women. Yet, anemia amongst pregnant women continues to be a serious problem in all the target districts. Analysis of the KPC survey indicates that almost 70% of women *did* receive iron tablets but most received fewer than the 80 tablets recommended by the MOH. We therefore recommend that the project clearly determine if iron supplementation is a problem and if so, where the problem lies (access, distribution, use, etc.). Also, given the high percentage of prenatal visits coupled with the fact that women are required to get their blood checked, a good opportunity exists to assess the levels of anemia within the target population. We therefore recommend that the project work with the DOH in the three districts to determine what levels and concentrations of anemia exist in order to better understand the problem. Health records could also confirm doses of ferrous sulfate actually received. Finally, considering the high consumption of tea and the effects it can have on the bio-absorption of iron, we recommend that the project conduct a small informal study on timing and volume of tea consumption among pregnant women and relate that information to current research on tea's impact on iron absorption. If tea is considered to be a relevant factor in maternal nutrition, we recommend that the project devise a campaign to modify tea drinking among pregnant women.

**5. Childhood Illnesses:** With regard to childhood illness prevention and treatment, the project has elected to emphasize diarrheal disease control. As a result, it appears that the SCSP has had a considerable impact on both knowledge and behavior associated with diarrheal disease. Consequently, health officials believe, diarrheal severity and mortality have significantly decreased. However, in all the districts, ARI is equally problematic and typically more persistent throughout the year. We therefore recommend that the project increase its efforts to improve knowledge, care and health-seeking behaviors related to ARI.

Also, while appropriate application of most of the IMCI procedures by health workers appear to be good, counseling skills was mentioned as a weakness among some providers. We therefore recommend that the project reinforce training in this area. It would seem that training provided to the CHEs and VDCs on behavior change and interactive methods of teaching would be valuable tools for health workers as well.

**6. Delivery and postnatal care:** The LSS training provided to ob/gyns and midwives has been a critical and effective intervention for improving the quality of delivery care. Health workers attribute their new skills with reducing drug use for labor inducement and resuscitation, reducing the need for episiotomies, and reducing risk to mother and child through active management of partograms. Part of the training approach has been to pair ob/gyns and midwives in order to strengthen the partnership and ensure common understanding and practice of skills. However, in a number of cases, midwives must also work with neonatologists once the delivery has occurred. This has caused some problems between midwives who have been trained in natural resuscitation methods and the neonatologists who continue to use drug-managed resuscitation. The project has attempted to correct this by providing a separate workshop for neonatologists. However, we recommend that neonatologists be incorporated into the latter part of the LSS training provided to the midwives such that they can benefit from the same “bonding” experience which has obviously benefited the midwife-ob/gyn relationship. Health personnel we spoke with also indicated that this would be the preferable approach.

Further, post-natal follow-up generally falls upon the shoulders of SUB and medpoint staff which must visit the mother and newborn at their household. Depending on their training (midwife, nurse or felcher) follow-up may not adequately focus on *both* mother and child. Given that most health staff interviewed identified postnatal complications as the principle cause of maternal and neonatal mortality, we recommend that the project ensure that the principle post-natal follow-up agent(s), be they midwives, nurses or doctors from the SUBs or medpoints, are adequately trained, supervised and supported in conducting follow-up for *both* mother and child.

**7. Training:** The training provided by this project has been strategic, well implemented and highly valued. Over the next two years additional training could further build capacity and improve project outcomes. Specifically, we recommend that the VDCs receive training and support in setting measurable goals, resource mapping and establishing work plans. As mentioned, DOH staff at medpoints and SUBs could benefit from training in interactive communication and postnatal care. There is also a strong need for training in IEC materials development and dissemination. Finally, we would recommend that the project work with the CHLs to establish an annual “cycle” of training and health promotion that coincides with the seasonal onset of cause-specific morbidity as well as the health outcomes associated with seasonal social and economic activities. An example of such a plan is provided in *Annex J*. As already mentioned under sustainability, advocacy for continued support of training by the MOH will be critical to ensuring the quality of service and health promotion continues beyond the project period.

**8. Information management:** Mercy Corps has significantly invested in the collection of project data through KPCs, supervisory checklists and other information management tools. However, the evaluators felt that these tools could be better analyzed and utilized within the project. We recommend that efforts be made to regularly review, analyze and understanding the KPC data and other information. We would also recommend that the Ministry of Health be encouraged to participate in these activities as they have very limited practice in the analysis and use of data. A dissemination plan should be devised such that districts, sub-districts and communities can have a clearer understanding of their own conditions as conveyed by the data. Data produced by the DOH

should also be included in the analysis. In order to assist with this effort, we suggest Mercy Corps review *Measures* new Data Demand and Information Use (DDIU) toolset as a potential vehicle to assist in this effort.

**9. Sanitation:** Many of the communities, and even health facilities, visited suffered from extremely inadequate and un-hygienic sanitation facilities. Ultimately, this will limit the potential impact the project could have. From our interviews and observations it is also clear that community and even medical staff members lack a clear understanding of what an adequate facility should look like. Through its USDA program, Mercy Corps Tajikistan has developed an excellent latrine construction and hygiene education program. At a minimum, we would recommend that USDA staff provide technical assistance to the SCSP in order to construct latrine facilities at each of the Mercy Corps/DOH district office locations. These could then serve as models for staff, partners and community members. We would also urge the project to facilitate cross visits by VDCs to communities where the sanitation program has been implemented so that they can visually see the benefit of properly built and maintained latrines. We would also recommend that the project advocate for and encourage organizations and funders to support water and sanitation activities in the project districts.

## **OTHER RECOMMENDATIONS**

These additional recommendations are provided for consideration by the project. It is understood however, that the project may decide that it cannot allocate time or resources to *all* of the recommendations and in some cases, the recommendations may go beyond the limits of the project. Nonetheless, the evaluators feel they merit consideration and would positively contribute to achieving the objectives of the project.

1. While health officials have indicated that hookworm is a significant problem the Ministry of Health has no official de-worming campaign. Such a campaign would have a positive impact on both mother and child. We recommend that the project consider discussing with Sughd DOH the possibility of piloting a de-worming program in one or more of the project which can later be scaled up by the MOH.
2. Recent research on zinc supplementation for children in developing countries has suggested that zinc has an important immune-building and therapeutic benefit resulting in reductions in incidence and severity of diarrheal disease and even greater reductions for pneumonia. Given the extensive health infrastructure yet high child mortality in Tajikistan, a zinc supplementation program may prove to be readily implement-able and highly valuable. We therefore recommend the project consider the feasibility of piloting a zinc supplementation program in the target districts in coordination with the Sughd Department of Health which can later be scaled up by the MOH.
3. The evaluators were told that one of the problems faced in the districts was high birth rates with most women having their first child at 18 or 19 years of age. Yet, family planning was not brought up as a major initiative and was only discussed when asked about it (with the exception of Shahrstan). We therefore recommend that the project consider how it could best support a more active family planning program in the district.
4. Medpoints maintain only a limited number of drugs associated with the IMCI program, some family planning methods and ferrous sulfate. Even at district hospitals clients are often required to purchase medicines through private pharmacies. Having a broader range of essential drugs available at the medpoints could help provide for earlier treatment and reduce the need for referral. We therefore recommend that the project consider piloting “community pharmacies” that would be

housed at the medpoints and distributed by medpoint staff with overall management provided by the Village Development Committees. Community members would pay for the drugs at reduced costs (since there is no profit margin)

## **E. RESULTS HIGHLIGHT**

### **1. INNOVATIVE IDEAS**

#### ***Public Transport Health Promotion***

Roughly 80 percent of all men from the target villages travel to Russia nine months out of the year for work. This creates a high-risk environment for the contraction and spread of HIV/AIDS within rural Tajikistan. The SCSP has developed an innovative approach for getting the word out on HIV/AIDS. Mercy Corps has developed an audio cassette with messages on transmission and prevention of HIV/AIDS which has been distributed them to drivers on 10 buses and 15 mini-buses providing transportation from the Project districts to Khujand town. The mini-buses in Asht also reach the sub districts. The messages are in the form of an audio drama. A man is telling his friend about his plans to migrate to Russia. His friend provides him with information on the risks of contracting HIV/AIDS in Russia and how he can protect himself. The cassette also contains popular music motivating the driver to play it and passengers to listen.

The messages have the potential to reach 864 passengers each day. Monitoring conducted at bus stations with disembarking passengers has suggested that 75% the passengers heard the message and could recall two to three modes of transmission and two to three modes of prevention. There was poorer recall or understanding of signs of AIDS, how the virus is not transmitted and where to go for testing. Most passengers interviewed during monitoring could name only one sign of AIDS and reported misconceptions about how HIV/AIDS virus is not transmitted. When asked where they could go to be tested for HIV/AIDS, they responded their village medpoint. Monitoring at the household level is planned during the first quarter of 2007.

### **2. PROMISING PRACTICES**

#### ***Life Saving Skills***

Virtually all women within the Sughd region deliver their babies at health facilities (rural, district or regional hospitals) staffed with ob/gyns, midwives and neonatologists. Yet the maternal mortality rate nationally is 100 for every 100,000 live births and neonatal mortality is 38 per 1,000 live births. This is in part due to the fact that women with complications don't reach facilities in adequate time but can also be attributed to the quality of care. While facilities and personnel exist, they are poorly equipped, hygiene standards are low and staff often apply techniques that are not conducive to healthy deliveries and in some cases can actually do significant harm. The goal of the LSS program is to reduce maternal and newborn mortality by applying delivery management techniques that facilitate healthy births and are not dependent on sophisticated equipment or technologies. During a 12 day training participants learn techniques in four areas: a) monitoring labor progress; 2) prevention and the treatment of hemorrhage; 3) infection prevention; and 4) infant resuscitation. In Mercy Corp's child survival project, trainings occurred in maternity houses where students had practicum opportunities during live deliveries. Seventy ob/gyns and nurse midwives have been trained to apply these new techniques on the more than 6,500 deliveries that occur annually at the regional level and within the three project districts. Routine monitoring as well as the mid-term evaluation found that LSS was easily understood and readily applied. Health workers attribute their

new skills with reducing drug use for labor inducement and resuscitation, reducing the need for episiotomies, and reducing risk to mother and child through active management of partograms.

### **3. BEST PRACTICES**

#### ***Integrated Management of Childhood Illnesses***

In Tajikistan, many illnesses go untreated not due to poor access to health facilities but as a result of incomplete assessment of the child. The Sughd region where Mercy Corps is implementing its child survival program is a case in point. In this region there are more facilities and qualified staff than most countries and exceeds ratios recommended by WHO. However, child mortality has remained high due to the poor quality of care received. Nationally, child mortality is 120 per 1,000 live births which is almost an anomaly given the extensive reach of the health system. Yet, children die due to poor care-seeking practices and inadequate diagnosis and treatment. Under this program Mercy Corps has supported the training of 130 physicians, nurses and medics in IMCI who serve a population of more than 200,000. Routine monitoring as well as the mid-term evaluation found that IMCI was easily understood and readily applied. Medical staff believes they are doing a better and more thorough job of diagnosing illnesses and using antibiotics much less frequently to treat. This program further demonstrates that under the right conditions (good access and usage) IMCI can be an important contribution to the health care system.

#### ***Community-based health promotion***

The Soviet system of healthcare in Tajikistan was squarely grounded in facility-based treatment. This system produced large numbers of facilities and as well as trained staff to operate them - all the way down to the village level. For many years this capital and labor intensive health system, along with a heavily subsidized economy, was able to mask the vulnerability of a population. These economic and health safety-nets have since eroded with the collapse of the Soviet Union. What limited health resources exists are being consumed to sustain an overbuilt, poor quality and cost-ineffective system. As a result, under-five mortality has increased from 79/1,000 births prior to independence to over 120 today.

While other parts of the world have recognized and well documented the benefits of community-based health promotion, it is a relatively new concept in Tajikistan. Through its research, Mercy Corps identified a number of household behaviors that, if modified, could result in decreased morbidity and mortality. Among them were exclusive breastfeeding, recognition and treatment of diarrhea in the home, as well as early care-seeking behaviors for children with diarrhea and ARI. A major barrier to behavioral change was simply lack of knowledge about danger signs and appropriate practices. In over 80 communities Mercy Corp organized and trained Village Development Committees (VDCs) and volunteer Community Health Educators (CHEs) to provide counseling and health education to their communities. In addition to home visits made by the CHEs, VDCs take advantage of regularly scheduled neighborhood committee meetings to present the latest information provided by Mercy Corps on a particular health topic. On average, education sessions reach 6,568 beneficiaries each month. Collectively, CHEs provide 2,671 home visits and make 64 referrals each month.

Based on mid-term evaluation survey results, all indicators related to knowledge of warning signs and caretaking of sick children have improved substantial – many of them more than doubling baseline values. Perhaps most telling however is the fact that the Department of Health in all three target districts have reported a 41-55% decrease in child mortality (mostly diarrhea and pneumonia)

since the onset of health promotion activities which they strongly attribute to changes in community behavior.

## **G. ACTION PLAN**

### **KEY RECOMMENDATIONS**

These recommendations are considered by the evaluators to be important, strategic and feasible within the parameters of the project. None of the key recommendations requires substantial changes to the project description or DIP.

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**1. Project Focus:** Thus far all levels within the Sughd Department of Health structure (Region, District, Sub-district and Community) have benefited from training activities and project support. This has been a successful strategy in building unity in vision and ownership of project activities among key staff within the DOH – Mercy Corps' principle partner. However, it is clear that further improvements in health outcomes will likely be best achieved in the following two years by primarily focusing on activities at the sub-district and community levels. This was the opinion of the evaluators and also shared by DOH officials. Therefore, while the project continues coordination and encouragement of active management at the regional and district levels, we recommend that training and health care improvement efforts be focused at the sub-district (SUB) and community (medpoint) levels, with particular emphasis in the areas of post-natal care, nutrition and ARI. This will result in earlier treatment, fewer complications and lower costs to the client as well as the health system. In addition, the project will need to continue assisting the CHL to increase their capacity and support at the community level.

It has been the intent of the project to initiate *community* IMCI activities in the coming year. This effort will help the project achieve the recommendations made above. However, globally C-IMCI has been described and defined in different ways. WHO, the CORE Group and selected PVOs have developed parameters, guidelines and tools for applying C-IMCI. Therefore, we urge the project to take a close look at the various C-IMCI tools available and determine which best fits their needs and will help further the goals of the project.

Mercy Corps has recently completed training staff from SVAs (rural out-patient clinics) and med-point in facility based IMCI. Training in Community IMCI will be introduced early in 2007. The Project agrees with the suggestion to review the both MoH/WHO Tajikistan approach to C-IMCI and CORE resources on C-IMCI and to implement a version of C-IMCI that uses a multi-sectoral platform to support child health and nutrition.

Training for 80 additional staff from maternity home and SUBs (rural hospitals) in Basic Life Saving Skills still needs to be provided during 2007 and possibly into 2008.

During 2005, the Sughd DoH requested that women's consultation, med-point staff and SVA staff be trained in provision of pre-natal and postnatal care. During November 2006 a consultant from the American College of Nurse Midwives will train LSS trainers as trainers in pre-natal and post-natal care and assist the Project to develop a plan to cascade the training to the sub-district and community level.

**2. Ownership and Sustainability:** While the Ministry of Health at the regional and district levels are clearly impressed with the results of the project thus far, they have yet to invest the resources that will be necessary to sustain the results once the project finishes. This is especially true in the area of health promotion which falls under the management of the Centers for Healthy Lifestyles. In its most rudimentary form, the DOH, as well as local government needs to demonstrate their support by budgeting resources for transportation (for supervision), training and health promotion materials. Therefore, we recommend that the project immediately begin working with the Sughd Department of Health and local government to plan for future commitments of resources for these basic activities. At the same time Mercy Corps should prepare the DOH for the eventual transfer of responsibility. We recommend that the actual process of transition begin well before the end of the project.

During the first six months of 2007, the Project will work with the Department of Health to develop a phase-out or hand over strategy that includes resources for transportation, materials and training. The DoH will need to submit this plan to the government officials responsible for making budgetary decisions. It is equally important for Mercy Corps to assist the Center for Healthy Lifestyle to advocate on its own behalf for the resources it needs to carry out its mandate.

A CSSA is planned during February 2007 as a means to develop a vision for what sustainability looks like, and what activities are essential for each stakeholder to take on in order to ensure sustainability.

**3. Target groups:** This principle target group for behavioral change activities has been women of reproductive age. It has also been the intention of the project to work with men and mothers-in-law as important change agents within the family and community. Given the seasonal migration of men to Russia (up to nine months of the year), the evaluators feel that discussions with this target group should focus on HIV/AIDS/STDs prior to departure to Russia and family planning soon after their return. Given both the culture and migration of men, mothers-in-law play a significant role in the care and well being of both mother and child. We therefore recommend that the project devise a strategy to more actively engage and influence the direction and decision-making of mothers-in-law.

Also, school children, particularly girl children, are an important target group that can help support promotion within the household while at the same time influence the attitude and behaviors of the next generation of families. We therefore recommend that the project explore assisting the CHLs in developing a school campaign for health promotion based on the child-to-child approach that has proven successful in other countries.

Mercy Corps plans to include Mothers-in-law as a formal target group and will develop a strategy for doing so. This would entail expanding the role of the community health promoters to include mothers-in-law in the monthly health sessions they provide.

It is critical to continue to involve men (husbands, fathers-in-law, religious leaders, etc.) in Project activities to the maximum extent possible. During discussion with VDCs during this evaluation, it became clear that, even though young men migrate to Russia, fathers-in-law play an important role

in supporting their daughters-in-law while their husbands are away. While Mercy Corps has not yet conducted formal qualitative research on the role of grandfathers/fathers-in-law, it is looking into funding for this type of research. Focus Group information and anecdotal information from project staff indicate that fathers-in-law control money in households where husbands have migrated for work, making them a key decision maker in care seeking behaviors. Religious leaders have also shown to be important advocates for behavior change, in health as well as other sectors of interventions including agriculture, nutrition, conflict prevention and domestic violence. Mercy Corps has learned to work closely with religious leaders through programs funded by USDA and USAID targeting these non-health sectors. When involved in project activities, religious leaders have spoken to men in their communities when they meet to pray about health and social issues including hygiene, nutrition, HIV/AIDS and gender based violence.

Mercy Corps, together with the Departments of Health and Education, will develop a strategy for implementing a child to child school health program. A cross visit will be arranged for key DoH, DoE and Mercy Corps staff to learn from the Child to Child activities of the Save the Children Child Survival Project in Panjikent.

**4. Maternal Nutrition:** Health personnel interviewed expressed a high degree of confidence in the availability and accessibility of ferrous sulfate to pregnant women. Yet, anemia amongst pregnant women continues to be a serious problem in all the target districts. Analysis of the KPC survey indicates that almost 70% of women *did* receive iron tablets but most received fewer than the 80 tablets recommended by the MOH. We therefore recommend that the project clearly determine if iron supplementation is a problem and if so, where the problem lies (access, distribution, use, etc.). Also, given the high percentage of prenatal visits coupled with the fact that women are required to get their blood checked, a good opportunity exists to assess the levels of anemia within the target population. We therefore recommend that the project work with the DOH in the three districts to determine what levels and concentrations of anemia exist in order to better understand the problem. Health records could also confirm doses of ferrous sulfate actually received. Finally, considering the high consumption of tea and the effects it can have on the bio-absorption of iron, we recommend that the project conduct a small informal study on timing and volume of tea consumption among pregnant women and relate that information to current research on tea's impact on iron absorption. If tea is considered to be a relevant factor in maternal nutrition, we recommend that the project devise a campaign to modify tea drinking among pregnant women.

Mercy Corps suggests advocating with the DoH to consider piloting different strategies for distributing iron supplements for women of reproductive age and pregnant women. The DoH may want to consider following the WHO recommended protocol or the strategy of weekly supplementation that has recently been piloted by different NGOs. If the DoH shows substantial interest in considering a new strategy it may be helpful for Mercy Corps to contract a consultant to assist in testing, refining and evaluating the strategy and developing education materials with messages on iron supplementation targeted for women of reproductive age.

The Project plans to work with the Centers for Healthy Lifestyle and community health educators to conduct qualitative research on tea drinking behavior and acceptable strategies to modify the behavior.

**5. Childhood Illnesses:** With regard to childhood illness prevention and treatment, the project has elected to emphasize diarrheal disease control. As a result, it appears that the SCSP has had a considerable impact on both knowledge and behavior associated with diarrheal disease. Consequently, health officials believe, diarrheal severity and mortality have significantly decreased. However, in all the districts, ARI is equally problematic and typically more persistent throughout the year. We therefore recommend that the project increase its efforts to improve knowledge, care and health-seeking behaviors related to ARI.

Also, while appropriate application of most of the IMCI procedures by health workers appear to be good, counseling skills was mentioned as a weakness among some providers. We therefore recommend that the project reinforce training in this area. It would seem that training provided to the CHEs and VDCs on behavior change and interactive methods of teaching would be valuable tools for health workers as well.

During December of 2006 (flu and cold season), Mercy Corps will provide refresher training on ARI for community health educators. The health educators will cascade this training to the VDCs and families in their villages.

The Project IMCI Coordinator presently conducts joint monitoring with the DoH IMCI coordinators both at the oblast and district level. This is an opportunity to reinforce with health facility staff IMCI protocol on recognition and treatment of cases of ARI.

The Project plans to include training for DoH staff on behavior change in the workplan for 2007.

**6. Delivery and postnatal care:** The LSS training provided to ob/gyns and midwives has been a critical and effective intervention for improving the quality of delivery care. Health workers attribute their new skills with reducing drug use for labor inducement and resuscitation, reducing the need for episiotomies, and reducing risk to mother and child through active management of partograms. Part of the training approach has been to pair ob/gyns and midwives in order to strengthen the partnership and ensure common understanding and practice of skills. However, in a number of cases, midwives must also work with neonatologists once the delivery has occurred. This has caused some problems between midwives who have been trained in natural resuscitation methods and the neonatologists who continue to use drug-managed resuscitation. The project has attempted to correct this by providing a separate workshop for neonatologists. However, we recommend that neonatologists be incorporated into the latter part of the LSS training provided to the midwives such that they can benefit from the same “bonding” experience which has obviously benefited the midwife-ob/gyn relationship. Health personnel we spoke with also indicated that this would be the preferable approach.

Further, post-natal follow-up generally falls upon the shoulders of SUB and medpoint staff which must visit the mother and newborn at their household. Depending on their training (midwife, nurse or felcher) follow-up may not adequately focus on *both* mother and child. Given that most health staff interviewed identified postnatal complications as the principle cause of maternal and neonatal mortality, we recommend that the project ensure that the principle post-natal follow-up agent(s), be they midwives, nurses or doctors from the SUBs or medpoints, are adequately trained, supervised and supported in conducting follow-up for *both* mother and child.

Both the Sughd DoH and Mercy Corps support the recommendation to incorporate the neonatologists into the present LSS training and plan to arrange for them to attend the sessions on post-natal care and resuscitation.

As previously noted, the Project plans to provide training in pre-natal and post natal care for med-point and SVA staff.

The Project Safe Motherhood Coordinator presently conducts joint monitoring with her DoH counterparts. During the joint monitoring she will have the opportunity to work with health staff to ensure that appropriate and timely post natal follow-up for both mother and child is provided.

**7. Training:** The training provided by this project has been strategic, well implemented and highly valued. Over the next two years additional training could further build capacity and improve project outcomes. Specifically, we recommend that the VDCs receive training and support in setting measurable goals, resource mapping and establishing work plans. As mentioned, DOH staff at medpoints and SUBs could benefit from training in interactive communication and postnatal care. There is also a strong need for training in IEC materials development and dissemination. Finally, we would recommend that the project work with the CHLs to establish an annual “cycle” of training and health promotion that coincides with the seasonal onset of cause-specific morbidity as well as the health outcomes associated with seasonal social and economic activities. An example of such a plan is provided in *Annex J*. As already mentioned under sustainability, advocacy for continued support of training by the MOH will be critical to ensuring the quality of service and health promotion continues beyond the project period.

The Project plans to incorporate the following trainings into the workplan for 2007:

- a) Training for VDCs and CHEs on Technology of Participation. The national NGO ICA-EHIO will be contracted to facilitate this training.
- b) Training on behavior change for medpoint and SVA staff.
- c) Training on pre-natal and post-natal care for medpoint and SVA staff
- d) Training on development of IEC materials for the Center for Healthy Lifestyle and DoH staff.

The Project will work with the DoH to establish an annual health promotion plan that addresses the seasonal onset of ARI and diarrhea and which takes into consideration months when families are busy with harvest activities. The plan also needs to reach men who migrate before they leave for Russia with messages on HIV/AIDS and when they return with message on family spacing.

**8. Information management:** Mercy Corps has significantly invested in the collection of project data through KPCs, supervisory checklists and other information management tools. However, the evaluators felt that these tools could be better analyzed and utilized within the project. We recommend that efforts be made to regularly review, analyze and understanding the KPC data and other information. We would also recommend that the Ministry of Health be encouraged to participate in these activities as they have very limited practice in the analysis and use of data. A dissemination plan should be devised such that districts, sub-districts and communities can have a clearer understanding of their own conditions as conveyed by the data. Data produced by the DOH

should also be included in the analysis. In order to assist with this effort, we suggest Mercy Corps review *Measures* new Data Demand and Information Use (DDIU) toolset as a potential vehicle to assist in this effort.

Monitoring and survey data are discussed during quarterly and monthly meetings. The more important issue is helping both Project staff and the DoH staff better understands the data and use it for program planning. The evaluation consultant has recommended Measure's new Data Demand and Information Use. The Project will review these resources and to assess appropriateness.

Data concerning indicators has not been discussed at the community level. Project staff will select key indicators which they feel are the most important for the VDCs and CHEs to understand and track. Mobilizers will present this information at VDC meetings drawing on visual formats, and facilitating discussions using PLA techniques. Techniques drawn from community mobilization approaches used in PD/Hearth will also be drawn from.

### **OTHER RECOMMENDATIONS**

These additional recommendations are provided for consideration by the project. It is understood however, that the project may decide that it cannot allocate time or resources to *all* of the recommendations and in some cases, the recommendations may go beyond the limits of the project. Nonetheless, the evaluators feel they merit consideration and would positively contribute to achieving the objectives of the project.

1. While health officials have indicated that hookworm is a significant problem the Ministry of Health has no official de-worming campaign. Such a campaign would have a positive impact on both mother and child. We recommend that the project consider discussing with Sughd DOH the possibility of piloting a de-worming program in one or more of the project which can later be scaled up by the MOH.
2. Recent research on zinc supplementation for children in developing countries has suggested that zinc has an important immune-building and therapeutic benefit resulting in reductions in incidence and severity of diarrheal disease and even greater reductions for pneumonia. Given the extensive health infrastructure yet high child mortality in Tajikistan, a zinc supplementation program may prove to be readily implement-able and highly valuable. We therefore recommend the project consider the feasibility of piloting a zinc supplementation program in the target districts in coordination with the Sughd Department of Health which can later be scaled up by the MOH.
3. The evaluators were told that one of the problems faced in the districts was high birth rates with most women having their first child at 18 or 19 years of age. Yet, family planning was not brought up as a major initiative and was only discussed when asked about it (with the exception of Shahristan). We therefore recommend that the project consider how it could best support a more active family planning program in the district.
4. Medpoints maintain only a limited number of drugs associated with the IMCI program, some family planning methods and ferrous sulfate. Even at district hospitals clients are often required to purchase medicines through private pharmacies. Having a broader range of essential drugs available at the medpoints could help provide for earlier treatment and reduce the need for referral. We therefore recommend that the project consider piloting "community pharmacies" that would be housed at the medpoints and distributed by medpoint staff with overall management provided by

the Village Development Committees. Community members would pay for the drugs at reduced costs (since there is no profit margin)

Mercy Corps feels that it is most important to consider and discussions with the MoH suggest the most interest in addressing recommendations 1, 3 and 4.

During 2005, the WHO conducted a country wide survey which documented the prevalence of worms in each region of Tajikistan and recommended protocol for de-worming strategies. The Ministry Health recognizes the extent of the problem. A few NGOs such as the Aga Khan Foundation and CARE have supported de-worming campaigns but have not documented the impact. Mercy Corps suggests advocating with the DoH to pilot a de-worming program and document the impact on the prevalence of diarrhea.

Mercy Corps has experience and expertise in promoting and constructing family VIP latrines through the Taiwan government funded Community Health and Sanitation Program and the USDA Food for Progress Project. The latrines have been well received and well maintained. Mercy Corps suggests reviewing the Project budget to assess the possibility of constructing a model latrine in as many Project communities as possible.

UNDP supports the MoH in providing family spacing services. Counseling on family spacing and contraceptive supplies are available at MoH family planning centers. The Project feels integrating education sessions on family planning and encouraging health educators to make referrals to family planning facilities could increase demand for these services. The community health educators and VDCs are very appropriate channels through which to promote family spacing at the family and community level.

Mercy Corps has approached the Deputy Minister of Health for Maternal Child Health in Dushanbe and the Chief Doctor of Sughd oblast regarding a zinc intervention. Their response is that they would not support such an initiative. Tajikistan has very strict regulations on drugs imported into the country and the MoH is very wary of medications that are not on already within their protocol. The Project feels it would have more impact and would be a better investment of Project resources to try to interest the DoH in developing and piloting a strategy for de-worming and also supporting latrine construction.

The Aga Khan Foundation and Save the Children have both implemented revolving fund pharmacies in Tajikistan. Both organizations have utilized donor funding to provide initial stocks of drugs. With present resources, the Project does have the capacity to support a community pharmacy component. Mercy Corps, however, is interested to have Project staff visit both Save the Children and AKF projects to learn how the community pharmacies were established and sustained and assess possibilities for future programming.

## H. ATTACHMENTS

*Annex A: Baseline information from DIP*

*Annex B: MTE KPC report (including Rapid Catch Indicators)*

*Annex C: Evaluation team members and their titles*

*Annex D: Evaluation assessment methodology*

*Annex E: List of persons interviewed and contacted*

*Annex F: MTE Scope of work*

*Annex G: Organizational chart*

*Annex H: Workplan benchmarks and achievements FY05-06*

*Annex I: Behavior message and activity tables*

*Annex J: Sample health communication schedule*

*Annex K: Key informant and focus group questionnaire guide*

*Annex L: Project Data Sheet form*

## Project Indicators - Revised Baseline

Table 1: Project Indicators

Diarrheal Diseases (handwashing practices and water)	Numerator	Denominator	%	CI Upper	CI Lower
	Percent caregivers who can name 2 signs of severe diarrhea	45	304	14.8%	19.7%
Percent caregivers who can name 2 signs of severe dehydration	3	304	1.0%	8.0%	-6.1%
Percent of caregivers who give appropriate home treatment for diarrhea; - increased fluids	23	53	43.4%	53.8%	33.0%
Percent of caregivers who give appropriate home treatment for diarrhea; same or more food	12	53	22.6%	33.7%	11.5%
Percent of families who have access to clean or purified water.	185	302	61.3%	65.6%	56.9%
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	2	304	0.7%	5.0%	-3.6%
<b>Integrated Management of Childhood Illness</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
Percent of sick children who received continued feeding during an illness in the past 2 weeks	37	107	34.6%	43.5%	25.7%
Percent of sick children who received increased fluids during an illness in the past 2 weeks	35	107	32.7%	41.5%	23.9%
<b>Maternal and Child Nutrition</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
Percent women who report increased food consumption during pregnancy	27	304	8.9%	13.4%	4.4%

<b>Percent women who practice exclusive breastfeeding for the first 6 months</b>	36	101	<b>35.6%</b>	44.3%	27.0%
<b>Percent women who report increased food consumption during lactation</b>	137	304	<b>45.1%</b>	50.6%	39.5%
<b>Percent women who introduce complementary foods between 6-9 months; (or 80% of children six to nine months receive appropriate complementary foods)</b>	13	37	<b>35.1%</b>	47.5%	22.8%
<b>Percent families who offer their children ages 12-24 months something to eat 5 times a day</b>	1	190	<b>0.5%</b>	8.0%	-6.9%
<b>Maternal and Newborn Care</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
<b>Percent of women who receive at least 4 prenatal consults</b>	217	304	<b>71.4%</b>	75.4%	67.4%
<b>Percent of women who receive a post-partum visit within 48 hours.</b>	To be assessed during Lss assessment				
<b>Percent of women who receive 80 IFA tablets during pregnancy</b>	5	304	<b>1.6%</b>	3.8%	-0.5%
<b>Percent or births that are attended by a health professional</b>	296	304	<b>97.4%</b>	98.6%	96.1%
<b>Percent women who can describe 2 danger signs for pregnancy.</b>	1	304	<b>0.3%</b>	4.8%	-4.1%
<b>Percent women who can describe 2 danger signs each delivery.</b>	22	304	<b>7.2%</b>	12.8%	1.7%
<b>Percent women who can describe 2 danger signs for post-partum.</b>	6	304	<b>2.0%</b>	6.4%	-2.4%
<b>Percent women who can describe 2 danger signs for newborn.</b>	11	304	<b>3.6%</b>	8.9%	-1.7%
<b>Percent men who can describe 2 danger signs for pregnancy</b>	1	212	<b>0.5%</b>	4.1%	-3.1%
<b>Percent men who can describe 2 danger signs for delivery</b>	6	212	<b>2.8%</b>	7.5%	-1.8%

<b>Percent men who can describe 2 danger signs for post-partum</b>	4	212	<b>1.9%</b>	5.8%	-2.0%
<b>Percent men who can describe 2 danger signs for newborn.</b>	13	212	<b>6.1%</b>	11.4%	0.9%
<b>Percent women with self –recognized prenatal complications who reach referral facilities</b>	2	3	<b>66.7%</b>	73.2%	60.2%
<b>Percent women with self –recognized delivery who reach referral facilities</b>	11	11	<b>100.0%</b>	112.2%	87.8%
<b>Percent women with self –recognized post partum complications who reach referral facilities</b>	11	11	<b>100.0%</b>	112.2%	87.8%
<b>Percent women with self –recognized newborn complications who reach referral facilities</b>	0	0			
<b>Percent of infants 6-12 mos. of age no more than 1 SD below mean weight for age</b>	70	92	<b>76.1%</b>	81.8%	70.4%
<b>(By year four) &lt;25% of children ages 6 mos. 24 mos show low height for age (≥-2 standard deviation)</b>	51	210	<b>24.3%</b>	27.4%	21.2%

#### RAPID CATCH

<b>Description</b>	<b>Numerator</b>	<b>Denominator</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
<b>Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)</b>	57	298	<b>19.1%</b>	21.0%	17.2%
<b>Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child</b>	83	137	<b>60.6%</b>	69.4%	51.8%

<b>Percentage of children age 0-23 months whose births were attended by skilled health personnel</b>	296	304	<b>97.4%</b>	98.6%	96.1%
<b>Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child</b>	<b>The Tajikistan Ministry of Health protocol does not include TT immunizations for infants or pregnant mothers</b>				
<b>Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours</b>	36	101	<b>35.6%</b>	44.9%	26.4%
<b>Percentage of infants age 6-9 months receiving breastmilk and complementary foods</b>	13	37	<b>35.1%</b>	47.5%	22.8%
<b>Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday</b>	63	132	<b>47.7%</b>	55.7%	39.7%
<b>Percentage of children age 12-23 months who received a measles vaccine</b>	88	132	<b>66.7%</b>	74.6%	58.7%
<b>Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)</b>	<b>The Project coverage area is not at high risk for malaria</b>				
<b>Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment</b>	93	304	<b>30.6%</b>	<b>35.3%</b>	25.9%

<b>Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks</b>	3	53	5.7%	14.5%	-3.2%
<b>Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection</b>	16	304	5.3%	10.6%	0.0%
<b>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</b>	2	304	0.7%	5.0%	-3.6%



**Mid-Term Knowledge Practice Coverage Survey**

**Sughd Child Survival Project**

**Sughd Oblast, Tajikistan  
October 2006**

**Prepared by  
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Health Program Manager  
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**November 2006**

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## **A. Executive Summary**

During September and October of 2006, the Mercy Corps' Child Survival Project in Tajikistan conducted a mid-term Knowledge, Practice and Coverage survey for the four-year Sughd Child Survival Project (SCSP). The survey questionnaire was based on questions from the KPC technical modules. The SCSP used the Lot Quality Assurance Sampling (LQAS) as its sampling methodology.

The survey was undertaken to:

1. Evaluate the performance of Mercy Corps' Child Survival and Health Grant in Tajikistan against the expected project impact
2. Establish mid-term data on the health and nutritional status of the target population, especially children under-five years of age and women of reproductive age to compare with baseline survey
3. Identify maternal and child health and nutritional conditions and needs.
4. Inform SCSP interventions and workplan

## **B. Background**

### Project Location, Characteristics Of Target Beneficiary Population, Health, Social, Economic Conditions Within The Project Area

Tajikistan, a mountainous country, has only 7% arable land and most of that is dependent on irrigation. The Child Survival Project is implemented in Sughd oblast, located in the northwest of the country. Sughd is one of the four oblasts which make up Tajikistan and is located in the northwest of the country. The region shares a border with Uzbekistan and Kyrgyzstan. The Zaravshan and Syr Darya rivers flow through it. The capital and administrative center is the city of Khujand. Sughd Oblast is cut off from the rest of the country for 5 to 6 months of the year when heavy snows block the passes in the Mugh and Zaravshan mountain ranges. During winter, travel between the capital of Dushanbe and Sughd is possible only by air.

The population of Sughd Oblast is largely ethnic Tajik with Uzbek minorities. The two ethnic groups have been living side by side since the Middle Ages and, as a result, their ways of life are essentially identical. Each group, however, has retained its own language.

As a result of the Soviet emphasis on education, 96% of the adult population is literate with 93.5% of women in Sughd literate (estimates from UNICEF Tajikistan). Of the literate women, 96.6% have attended secondary school. Levels and quality of education are in serious decline, however, due to end of Soviet subsidies with young mothers tending to have less education than their own mothers.

Tajikistan, always the poorest region of the Soviet Union, has remained the poorest of the Newly Independent States due to unemployment, food shortages, frequent natural disasters, political and religious conflicts and corruption.

World Bank estimates that 44% of the population is unemployed. An independent commercial sector is beginning to emerge, but it is hampered by excessive government regulations, difficulties with customs officials of neighboring countries, and poor market

development. Families who formerly had salaried employment are surviving through small-scale farming on rented land, small businesses or migration. An estimated 600,000 people, mostly men, migrate from Tajikistan to Russia, Turkey, Dubai, or other Central Asian countries for temporary or long-term employment. The economies of Zafarabod and Asht are reliant on cotton cultivation.

In parallel with rising poverty, the health care infrastructure has been steadily deteriorating since the collapse of the Soviet Union. Government health care expenditures have dropped from 6,4% of GDP in 1994 to 1% in 2001. Low and late salaries, lack of adequate equipment, high cost and reduced availability of drugs, and infrequency or unavailability of training programs have caused a considerable number of qualified doctors, nurses and midwives to seek work in other countries or leave their profession. Those who remain in their profession augment their incomes through farming, small business activities and widespread collection of informal fees from patients, or the sale of drugs from hospitals.

Families use health services when they are sick and do not look to them for health information or prevention services. Women are most likely to use health services during their pregnancies and delivery, and when their children are ill or need to be immunized. Men use services much less often than women, primarily when they are very ill. Men see taking care of the health of the family as the responsibility of the wife. The wife takes care of her own health during pregnancy and also takes care of the health of the children.

#### National Standards/Policies Regarding MCH

USAID, World Bank, Asian Development Bank (ADB), WHO and UNICEF are all supporting initiatives in health system reform and/or the adoption of WHO standards for quality of care. Initially, these efforts were focused in southern Tajikistan, but the ADB project has started a family practice training center in Sughd to shift physicians from specialized tertiary care to primary care and is funding equipment and renovation for the health facilities, which are considerably deteriorated.

The government's key objectives in the health sector are based on the following long-term objectives of the National Development Strategy:

1. Reform Government policy on funding and administration in the health sector to allow increased role for the private sector
2. Improve medical services for mothers and children
3. Halt the expansion of HIV/AIDS, reduce the rates of infectious diseases, and eradicate vaccine-controlled diseases
4. Increase the access, quality and effectiveness of medical services to the population by improving the human capacity of medical staff, and provide better materials and equipment for medical institutions; ensure the availability of sufficient amounts of quality medicines

During the past four years, various NGOs have supported the Ministry of Health to implement IMCI and C-IMCI in Dushanbe and the Varzob and Khatlon regions. In addition to the three Child Survival Project target districts, the Sughd Department of Health, with support from UNICEF, is in the process of rolling out facility based IMCI in the districts of Isfara and Panjikent and C-IMCI in Babajon Gafurov.

UNICEF's Baby Friendly Hospital Initiative has made progress. Nine hospitals have been certified, including the regional hospital in Sughd. The regional hospital and maternity center, as well as the city maternity center in Khujand and the six district level hospitals in Isfara, Kanibodom, Istaravshan, Asht, Spitamen, and Macho, have been certified as Baby Friendly.

### Project Goals And Interventions

The goal of the Sughd Child Survival Project is to improve the health of women of reproductive age and of children under five in the districts of Shahkristan, Zafarobod, and Asht through use of key maternal and child health and nutrition interventions.

Mercy Corps has defined four key interventions for the SCSP:

- Diarrheal disease control
- Maternal Nutrition and Child Nutrition
- Breastfeeding
- Maternal and Newborn Care

### Project and Survey Objectives

*The objectives of the Sughd Child Survival Project are to:*

- 1) Increase the percentage of mothers of children under two who practice improved feeding, care during illness and health-seeking practices
- 2) Increase the percentage of women who receive adequate maternal and health care (including four prenatal visits, iron-folate supplementation (IFA), improved nutrition, birth attended by health personnel, appropriate referral as needed, and post-partum/newborn care within two days)
- 3) Increase the capacity of MOH health facilities to deliver quality maternal-child health services

*The mid-term KPC survey was undertaken to:*

1. Evaluate the performance of Mercy Corps' Child Survival and Health Grant in Tajikistan against the expected project impact
2. Establish mid-term data on the health and nutritional status of the target population, especially children under-five years of age and women of reproductive age to compare with baseline survey
3. Identify maternal and child health and nutritional conditions and needs.
4. Inform SCSP interventions and workplan

### **C. Process and Partnership Building**

The Project attempted to engage the Department of Health in the data entry and analysis but the Health Statistics Center requested unreasonable compensation.

As an alternative, Mercy Corps contracted the national NGO ICA: EHIO to conduct the KPC interviews and enter the data into the survey database. ICA-EHIO (Empowerment for Human Involvement Organization), is an affiliate of the Institute for Cultural Affairs. ICA-EHIO's mission is:

1. To promote the philosophy of participation.
2. To give people participation tools.
3. To incorporate participation in development work.
4. To promote youth as a valuable resource and active participant in community life.

The NGO has provided training in the Technology of Participation and Participatory Rural Appraisal for local communities through the Mercy Corps Community Fund financed Community Empowerment for Health & Water and USAID Peaceful Initiatives Project. ICA-EHIO also conducted both qualitative and quantitative research to evaluate the Community Fund Project.

#### **D. Methodology**

##### Questionnaire

The survey questionnaire used during the Project baseline was revised to improve the flow of the questions. Additional questions were added about post-natal care and HIV/AIDS. Questions that were not included in the KPC modules, for example the questions on increased food consumption during pregnancy and breastfeeding, were developed by the team and pre-tested.

The baseline questionnaire consisted of 48 questions on anthropometry, maternal/newborn care, breast feeding and child nutrition, IMCI, care and feeding during diarrhea, HIV/AIDS, hand washing and immunization status of the child. The instrument was translated from English into Russian, Tajik, and Uzbek.

##### Study Indicators

Indicators are listed and defined in Table 1, below.

##### Sampling Framework:

As with the November 2004 baseline KPC, the implementation of the survey was based on the LQAS methodology. The three Child Survival Project districts were considered the coverage area. The jamoat was again considered the supervision area. The table below shows the number of supervision areas in each catchments area. Nineteen homes were sampled within each supervision area to give a total of 304 questionnaires.

<b>District</b>	<b>No. of jamoats</b>	<b>Total population</b>	<b>Number of households to be sampled</b>
<b>Zafarabod</b>	5	54,861	95
<b>Asht</b>	9	122,785	171
<b>Shahriston</b>	2	31,604	38
<b>TOTAL</b>	16	209,250	304

Villages within the supervision area and the number of homes sampled were selected using the LQAS methodology. Upon arrival to the designated village the interview teams randomly selected the households. Help was sought in each village from someone who knows the village lay out in order to fulfill the LQAS selection criteria.

If it was established that there was a child 0-24 months old living within the household, permission was sought to interview the mother or main caretaker of the child. The woman

was required to be alone while interviewed with no mother-in-law or husband present. If the mother or caretaker was not present in the house or refused to take part in the survey, the nearest house that fell under the survey criteria was selected.

It was then asked if the woman’s husband was present to be interviewed. If the husband was not present, another male over the age of 17 years from the same family was interviewed.

KPC interviewers were organized into four teams of three persons. One team member administered the questionnaire, the second recorded the answers, and at the end of the interview the child was weighed and measured. The third member supervised, and had the responsibility to review the questionnaire for accuracy and manage any difficulties that arose during the interview. To ensure that surveyed families were comfortable, at least one man and one woman were included in each team.

### Training

During January 2006 an independent consultant provided a 3 day training on LQAS methodology for the Child Survival team.

During the week before the midterm KPC survey was conducted, September 13 - 15, a three-day training was provided for survey interviewers. The training was facilitated by the Child Survival Project Manager and Assistant Program Manager. The training agenda included proper interviewing techniques, interacting with the interviewee and family, role plays, and practice interviewing families in their homes.

### Data collection

Each interview lasted about 30 minutes. The data collection took 17 days. There were no unforeseen constraints in the field.

### Data analysis

At the end of data collection, all hard copies of the survey were given to ICA-EHIO for data entry. The Child Survival Project data base manager provided training and supervision. Data analysis was carried out by the Project data base manager and Health Program Manager using Microsoft Access.

## **E. Project Indicators and Results**

Table 1: **Project Indicators**

Diarrheal Diseases	Numerator	Denominator	%	CI	
				Upper	Lower
Percent caregivers who can name 2 signs of severe diarrhea	246	304	80.9%	85.9%	76.0%

Percent caregivers who can name 2 signs of severe dehydration	65	304	21.4%	28.4%	14.3%
Percent of caregivers who give appropriate home treatment for diarrhea; - increased fluids	53	78	67.9%	78.4%	57.5%
Percent of caregivers who give appropriate home treatment for diarrhea; same or more food	43	78	55.1%	66.2%	44.0%
Percent of families who have access to clean or purified water.	248	304	81.6%	85.9%	77.2%
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	54	304	17.8%	22.1%	13.5%
<b>Integrated Management of Childhood Illness</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
Percent of sick children who received continued feeding during an illness in the past 2 weeks	57	122	46.7%	55.6%	37.8%
Percent of sick children who received increased fluids during an illness in the past 2 weeks	71	122	58.2%	67.0%	49.4%
<b>Maternal and Child Nutrition</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
Percent women who report increased food consumption during pregnancy	61	304	20.1%	24.6%	15.6%
Percent women who practice exclusive breastfeeding for the first 6 months	71	92	77.2%	85.8%	68.6%
Percent women who report increased food consumption during lactation	177	304	58.2%	63.8%	52.7%
Percent women who introduce complementary foods between 6-9 months; (or 80% of children six to nine months receive appropriate complementary foods)	38	55	69.1%	81.4%	56.8%
Percent families who offer their children ages 12-24 months something to eat 5 times a day	34	132	25.8%	33.2%	18.3%
<b>Maternal and Newborn Care</b>	<b>N</b>	<b>D</b>	<b>%</b>	<b>CI U</b>	<b>CI L</b>
Percent of women who receive at least 4 prenatal consults	259	304	85.2%	89.2%	81.2%
Percent of women who receive a post-partum visit within 48 hours.	239	304	78.6%	83.2%	74.0%
Percent of women who receive 80 IFA tablets during pregnancy	12	304	3.9%	6.1%	1.8%
Percent or births that are attended by a health professional	300	304	98.7%	100.0%	97.4%
Percent women who can describe 2 danger signs for pregnancy.	59	304	19.4%	23.9%	15.0%
Percent women who can describe 2 danger signs each delivery.	129	304	42.4%	48.0%	36.9%
Percent women who can describe 2 danger signs for post-partum.	58	304	19.1%	23.5%	14.7%
Percent women who can describe 2 danger signs for newborn.	100	304	32.9%	38.2%	27.6%

Percent men who can describe 2 danger signs for pregnancy	32	291	11.0%	14.6%	7.4%
Percent men who can describe 2 danger signs for delivery	60	291	20.6%	25.3%	16.0%
Percent men who can describe 2 danger signs for post-partum	38	291	13.1%	16.9%	9.2%
Percent men who can describe 2 danger signs for newborn.	86	291	29.6%	34.8%	24.3%
Percent women with self-recognized prenatal complications who reach referral facilities	14	14	100.0%	106.5%	93.5%
Percent women with self-recognized delivery who reach referral facilities	15	15	100.0%	112.2%	87.8%
Percent women with self-recognized post partum complications who reach referral facilities	4	4	100.0%	112.2%	87.8%
Percent women with self-recognized new born complications who reach referral facilities	4	4	100.0%	127.9%	72.1%
Percent of infants 6-12 mos. of age no more than 1 SD below mean weight for age	98	109	89.9%	95.6%	84.2%
(By year four) <25% of children ages 6 mos. 24 mos show low height for age ( $\geq$ 2 standard deviation)	44	222	19.8%	22.9%	16.7%

#### RAPID CATCH

Description	Numerator	Denominator	%	CI U	CI L
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	38	304	12.5%	14.4%	10.6%
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	74	114	64.9%	73.7%	56.1%
Percentage of children age 0-23 months whose births were attended by skilled health personnel	300	304	98.7%	100.0%	97.4%
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	<b>The Tajikistan Ministry of Health protocol does not include TT immunizations for infants or pregnant mothers</b>				
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	71	92	77.2%	86.4%	67.9%
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38	55	69.1%	81.4%	56.8%
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	89	132	67.4%	75.4%	59.4%
Percentage of children age 12-23 months who received a measles vaccine	90	132	68.2%	76.1%	60.2%

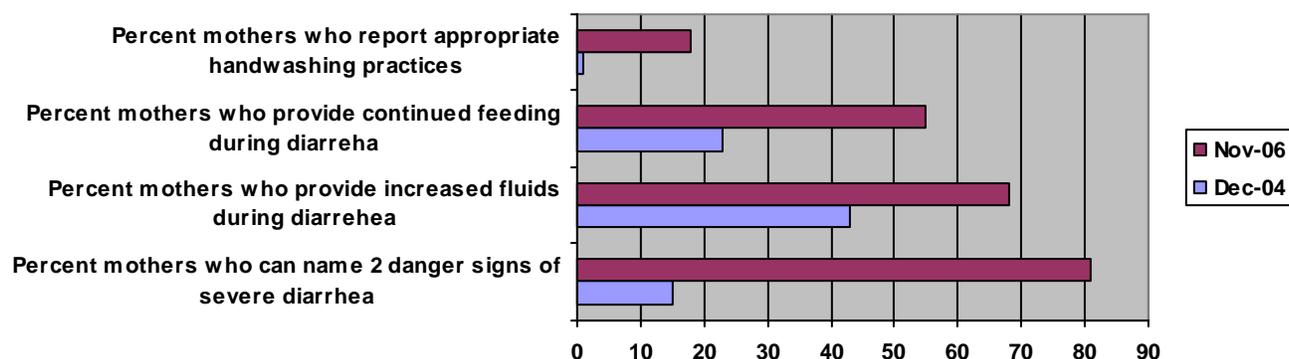
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	The Project coverage area is not at high risk for malaria				
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	237	304	78.0%	82.6%	73.3%
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	57	122	46.7%	55.6%	37.8%
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	102	304	33.6%	38.9%	28.2%
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	54	304	17.8%	22.1%	13.5%

## Discussion

### Diarrheal Disease

The survey findings show that mothers' knowledge of danger signs of diarrhea improved from 15% to 81%, reaching the Project target of 80%. Improvements in home care for children with diarrhea improved more moderately. Sixty eight (68%) of mothers reported giving increased fluids during diarrhea as compared with 43% at baseline. Continued feeding improved from 23% to 55%. Hand washing is more a more difficult behavior to change with 18 % of mother reporting appropriate hand washing practices during the midterm survey compared to 1% at baseline.

**Table 3: Comparison of baseline and midterm indicators for diarrhea**

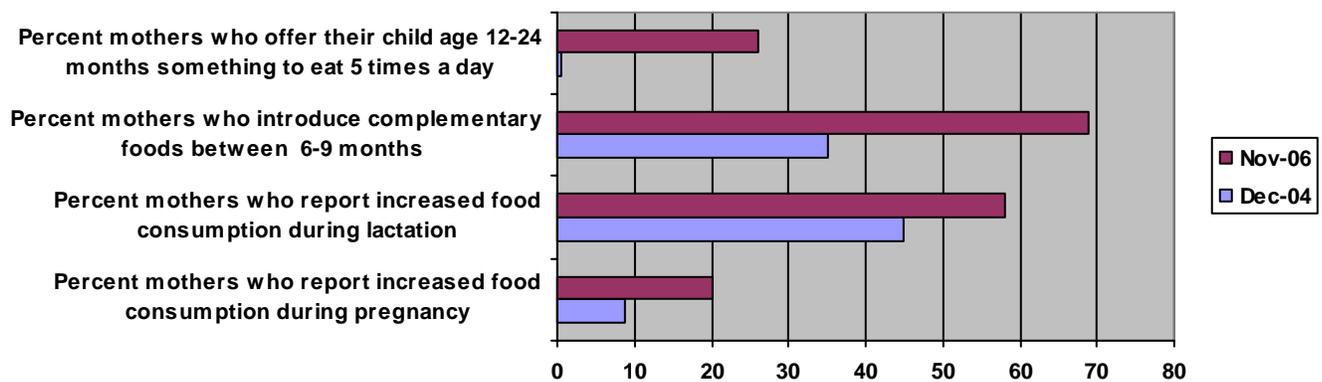


### Maternal and Child Nutrition

Improvements in food consumption during pregnancy and breastfeeding were moderate. The percent of mothers who reported increased food consumption during pregnancy improved from 9% to 20% and reported increased consumption during breastfeeding improved from 45% to 58%. The evaluation report discusses important issues regarding iron supplementation.

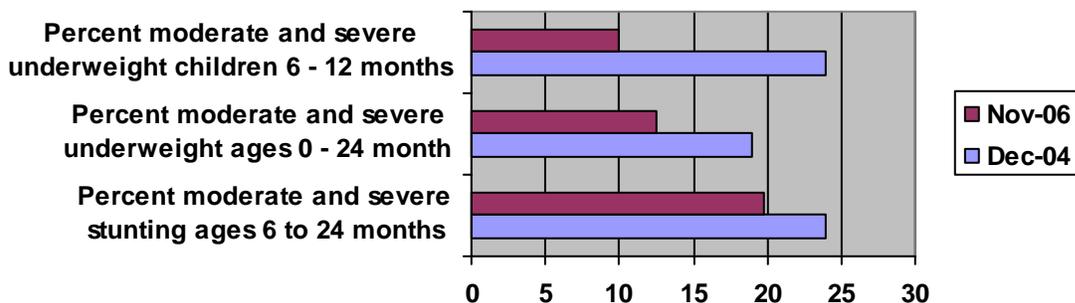
Important concerns about complementary feeding identified during baseline assessments were the serving size and frequency of complementary feeding and diversity of foods provided. Survey results suggest that mothers seem are waiting until 6 months to introduce complementary foods and are providing a greater variety of foods. The number of mothers who introduce appropriate complementary foods between 6 and 9 months improved from 35% to 69%. The number of mothers reporting giving their child complementary foods 5 times a day showed a more moderate increase from 0.5% to 26%.

**Table 4: Comparison of baseline and midterm indicators for maternal and child nutrition behaviors**



Anthropometric indicators show that the rates of underweight and stunting have decreased since 2004. During the baseline survey 76% of children 6 to 12 months were found to be of normal weight for age or mildly underweight. This increased at midterm to 90%. The significant decrease in underweight for children of this age suggests improvements in breastfeeding and complementary feeding practices. Rates of underweight for children under two years of age decreased from 19% to 12.5%. Rates of stunting decreased from 24% to 20%.

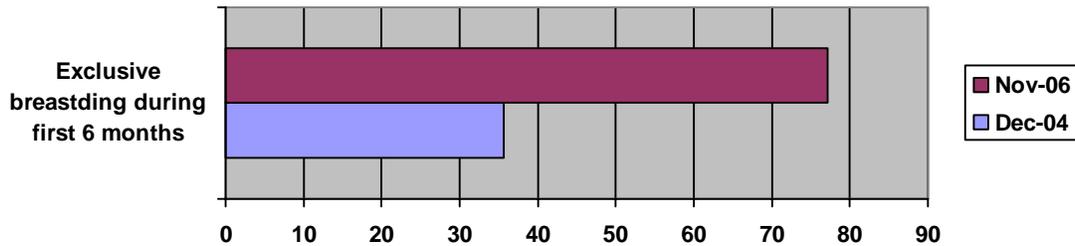
**Table 5: Comparison of baseline and midterm anthropometric indicators**



### Breastfeeding

Rates of exclusive breastfeeding improved by two-fold during the past two years, from 36% at baseline to 77% at midterm. The Project target for exclusive breastfeeding is 50%.

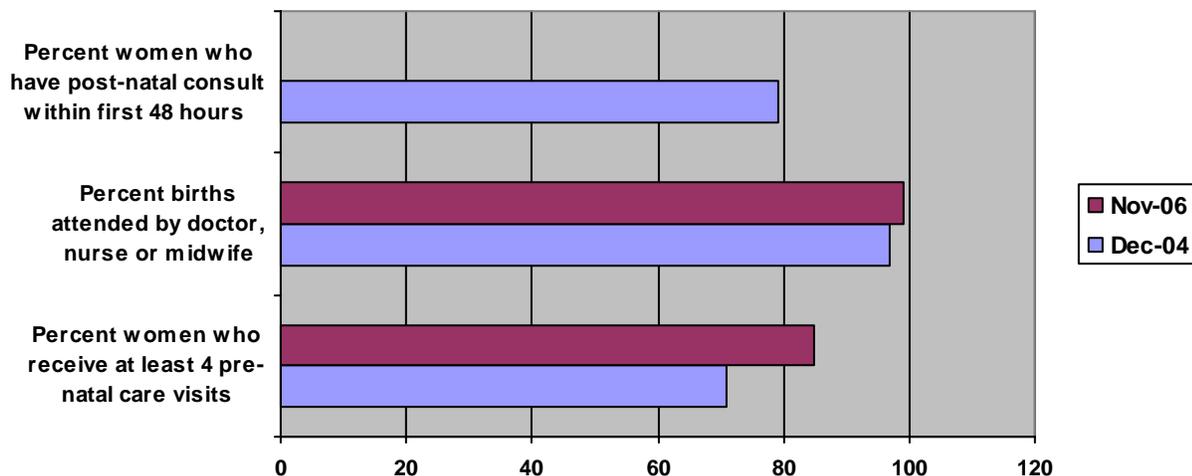
**Table 6: Comparison of baseline and midterm exclusive breastfeeding rates**



### Maternal and Newborn Care

Indicators for prenatal care and medically assisted birth were quite high at baseline and both improved slightly at midterm. The number of women receiving 4 prenatal visits improved from 71% to 85%. The Project target is 75%. Rates of facility attended births increased from 97% to 99%. The Project target is 100%. The number of mothers receiving post-natal visits was not measured during the baseline and was estimated at 77% during the midterm, exceeding the Project target of 75%.

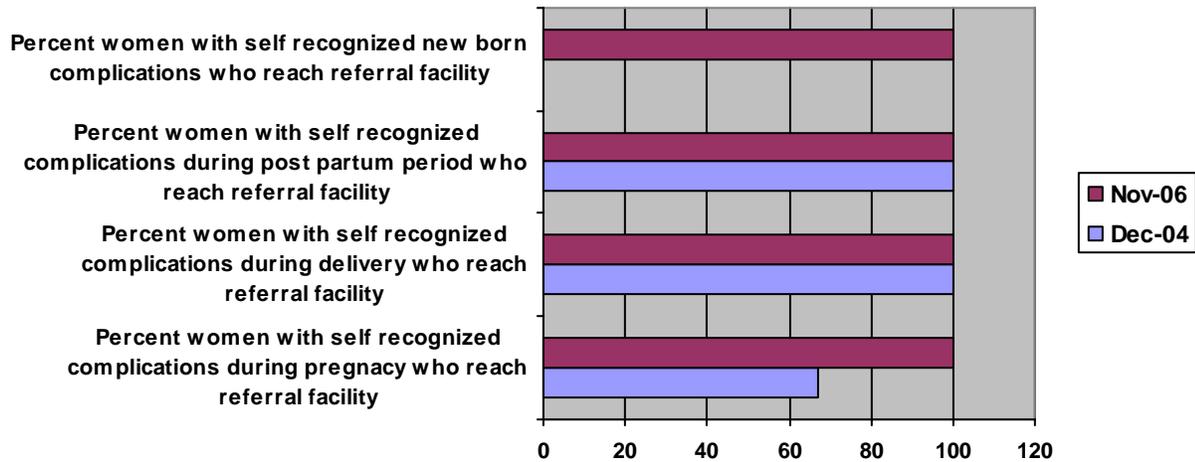
**Table 7: Comparison of baseline and midterm indicators for utilization of prenatal, postnatal, delivery and post-partum services**



The midterm surveys results show that when women recognize a danger sign during pregnancy, delivery or post partum, or in their newborn, they seek help. All mothers who recognized danger signs reported doing so. Looking at the raw data suggests that, at midterm, more mothers are able to recognize danger signs. During the baseline survey, only 3 mothers reported experiencing complications during pregnancy compared with 14 during

the midterm. In 2004, none of the mothers interviewed reported complications in their newborn while 4 mothers did during the midterm.

**Table 8: Comparison of baseline and midterm indicators for careseeking behaviors for pregnancy, delivery, delivery, postpartum and newborn complications**

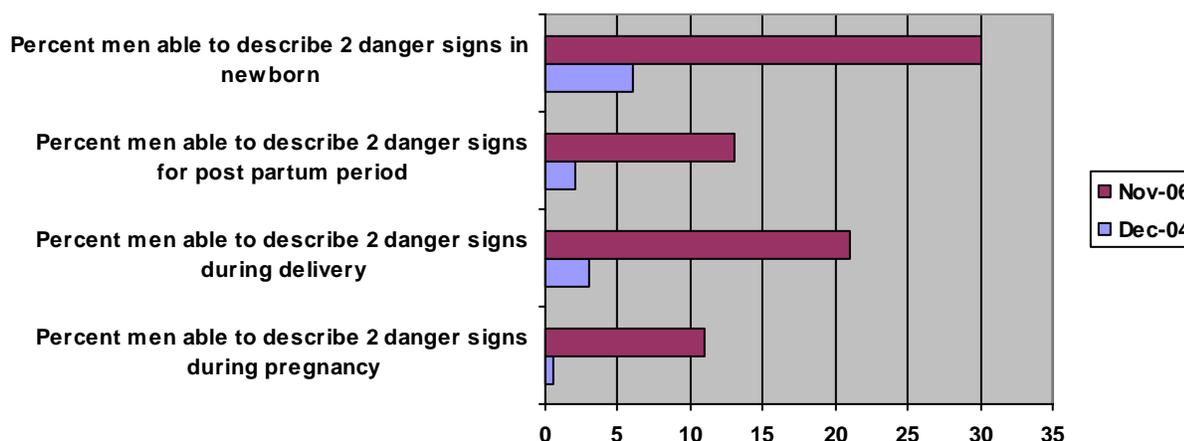


Knowledge about danger signs during different stages of pregnancy improved significantly for both men and women though is still well below the Project target of 80%. For both men and women, knowledge of danger signs during pregnancy and the post partum period were the lowest. Promotion of birth planning will be provided during the last quarter of 2006 and will focus on helping families and communities plan so they are able to support women during and after their pregnancy. Training will include information on danger signs and preparation for emergencies. The approach is similar to that promoted by the USAID CHANGE Project utilized by the Save the Children Child Survival Project in Panjikent and Aini, Tajikistan.

**Table 9: Comparison of baseline and midterm indicators for knowledge of prenatal, delivery, postnatal and newborn danger signs (Women)**



**Table 10: Comparison of knowledge of pregnancy, delivery, postnatal and newborn danger signs (Men)**



**Non Project Indicators of special interest:**

Birth Spacing: Rates of birth spacing showed only a small increase. The percentage of children born at least two years after the previous child increased from 60% in 2004 to 65% in 2006. Focus group discussions during the MTE revealed an interest in learning more about family spacing.

Vaccination: Rates in full vaccination coverage increased from 48% at baseline to 67% at midterm. Rates of measles immunization coverage stayed about the same, 67% during the 2004 survey and 68% during the 2006 KPC. The Ministry of Health conducted national measles campaigns during 2004 and 2005.

Knowledge of HIV/AIDS: The number of women who could describe two ways to prevent transmission of HIV/AIDS increased from 5% to 34% during the first two years of the Project. This indicates moderate progress and indicates the need to focus more attention and resources on HIV/AIDS awareness. Tajikistan is a point where they can still prevent an AIDS epidemic like those happening in other Central Asian countries and Russia.

**Program Implications:**

Diarrheal Diseases:

Indicators for recognition of danger signs, home care and care seeking practices for children with diarrhea have improved significantly since 2004. Rates of diarrhea cases, however, are not likely to significantly decrease further without provision of clean water and latrines and addressing the high rates of intestinal parasites.

Maternal and Child Nutrition:

The survey results reveal that mothers are waiting until 6 months to introduce complementary foods and are providing a greater variety of foods. The most important concern regarding complementary feeding is the serving size and number of times a day the child is fed.

Midterm improvements in diet during pregnancy and breastfeeding were moderate. Community education sessions during 2005 and 2006 did not include nutrition during pregnancy or breastfeeding and anemia. These topics will be included in the work plan for 2007.

An important concern to address is iron supplementation. Initial discussions with the DoH indicate an interest in piloting different strategies for distributing iron supplements. Qualitative research needs to be conducted on tea drinking behavior and acceptable strategies to modify the behavior.

#### Breastfeeding:

Rates of reported exclusive breastfeeding have doubled during the past two years. Supporting the DoH breastfeeding support group initiative and involving mothers in law in exclusive breast feeding promotion activities will help facilitate even further increases.

#### Maternal and Newborn Care:

Knowledge of danger signs during pregnancy, delivery, postpartum and newborn improved during the first two years of Project implementation though are still below the Project targets. Knowledge of danger signs during pregnancy and post partum are of particular concern. Community education sessions have not yet included maternal and newborn care. Sessions on birth-planning which includes recognition of danger signs will be provided during the last quarter of 2006. During 2007, the Project has planned to work with the village development committees to organize resources for women needing emergency transport during pregnancy or delivery.

#### **Information Dissemination**

The results of this survey were shared with Child Survival and Department of Health staff at a meeting on October 19, 2007. The agenda for the meeting was to present recommendations that came from the MTE, compare baseline and midterm KPC results and discuss implications for programming during the next two years. A summary of the MTE report will be translated and provided to Child survival and DoH staff.

#### Limitations/Lessons Learned

In general the midterm survey went much more smoothly than the baseline. The staff felt that the revised questionnaire was easier to use and more complete than the baseline questionnaire. Experience gained during the baseline survey and additional training on LQAS sampling methodology during January of 2006 gave the staff more confidence in their ability to conduct surveys. The staff was able to work more independently in conducting the midterm survey and there were fewer errors made during data collection. The NGO ICA-EHIO proved to be a very competent partner in data collection and data entry.

Data analysis was easier during the midterm KPC than during the baseline but was still a struggle. The Project database manager has requested additional training on Microsoft Access. Project staff have requested training in using survey and monitoring data for program planning.

Initial comparison of midterm results with data from the baseline raised many questions and as a result, the Project data base manager and Child Survival Project Manager went back to the baseline data base and original questionnaires to recheck. Their review revealed inaccuracies in the anthropometric data and also in indicators on care seeking during complications during different stages of pregnancy. As discussed in the MTE report, it also revealed that vitamin A supplementation affected the rates of full vaccination.

As also discussed in the MTE narrative report, the question to assess iron supplementation needs to be revised for the final survey. A review of health facility data will probably give a clearer picture of the present status.

**Evaluation Team**

**Christopher Bessenecker**, Team Leader (External Evaluator)

**Carlos Cardenas**, Director of Health Programs, Mercy Corps, US

**Mary Helen Carruth**, Health Program Manager, Mercy Corps, Tajikistan

**Saadi Izatov**, Program Manager, Soughd Child Survival Project, Mercy Corps

**Zamira Karimova**, Asst. Program Manager, Soughd Child Survival Project, Mercy Corps

**Janatoy Nabieva**, Training Coordinator, Soughd Child Survival Project, Mercy Corps

**Fatima Khujaneva**, Communications Coordinator, Soughd Child Survival Project, Mercy Corps

**Jabarova Tahmina**, Safe Motherhood Coordinator, Soughd Child Survival Project, Mercy Corps

## **EVALUATION ASSESSMENT METHODOLOGY**

The evaluation methodology included document review, in depth interviews with Mercy Corps staff and partners in the field, focus group discussions, KPC data collection and analysis and a meeting with USAID-Tajikistan's Project Manager for Health. In addition, the team members drew on their own prior experience and expertise in public health – which was substantial.

In accordance with USAID's guidelines, the assessment methodology was designed to achieve the following objectives:

1. Assess progress implementing the DIP;
2. Assess progress towards achievement of the objectives or yearly benchmarks;
3. Assess if interventions are sufficient to reach desired outcomes;
4. Identify barriers to achievement of objectives; and
5. Provide recommended actions to guide the project staff through the last half of the project.

Prior to the field work, the evaluation Team Leader carefully reviewed the following documents:

- USAID's guidelines for MTE Evaluation
- Tajikistan general background information (CIA Factbook, WHO health statistics, etc.)
- Mercy Corps' CS Detailed Implementation Plan
- CS Annual report FY04-05.

In the process of designing and implementing the evaluation, the team applied the following principles (a) participation; (b) triangulation; (c) contextualization.

**Participation:** It was important that project staff, partners and communities actively participate both as informers as well as self-evaluators. This encourages reflective and analytical thinking as well as ownership of the evaluation's conclusions. Therefore, all project management staff were interviewed and also participated (primarily as observers) during the interviews and group discussions with Department of Health staff and community members. In addition, evaluators provided monitors and mobilizers, Mercy Corps key interface with DOH staff and communities, a special half-day meeting to discuss their opinions and ideas. The evaluation team also met with Department of Health staff at all levels of project engagement – regional, district and community and encouraged them to share their assessment on the project, its accomplishments and its problems. Finally, communities were involved in two ways – both through discussions with VDCs and CHEs who regularly interact with project staff, and also with community members who are the ultimate beneficiaries of this project.

**Triangulation:** Information gathered and conclusions reached were based on a process of triangulation. Typically KPC results were checked against perceptions, opinions and data provided by the DOH which was checked against the same from community

members. Any inconsistencies would be further probed until a clearer and consistent picture emerged. Triangulation occurred on both a vertical axis (region, district, community) as well as a horizontal axis (different project districts, different DOH departments, different MC management and field-based staff). Key questions were asked multiple times in multiple ways to multiple persons in order to ensure a level of confidence in the findings.

**Contextualization:** It was not only important for the evaluators to understand *what* was happening but *why* it was happening. Hence, there was a persistent process of contextualizing the information received. So, for example, if the KPC results showed that women weren't receiving a full course of iron tablets the evaluators probed health staff, MC staff and the database itself to understand why this wasn't occurring. Simply stating that something was not happening would not be helpful and could lead to erroneous assumptions as to why. Therefore it was extremely important for the evaluation team, and the lead evaluator in particular, to have the fullest understanding possible in order to provide useful and accurate guidance.

The evaluation team members had scheduled meetings with project personnel and partners as well as conducted impromptu meetings. Project coordinators were interviewed in private outside the presence of their supervisors to provide them with an opportunity to share more freely any concerns regarding management. Monitors and mobilizers were taken through an exercise that prompted them to identify the top three strengths and top three weaknesses of the program. Finally, DOH staff were presented with the MTE findings and recommendations and then given a chance to respond.

The evaluation was designed to capture a representative cross-section of the communities and participants involved in the CS project. In total the evaluation team interviewed over 130 persons representing Mercy Corps staff, Department of Health staff, community volunteers and beneficiaries themselves. All three target districts were visited as well as communities within those districts.

*Annex – E: List of persons interviewed and contacted*

<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 6	Mercy Corps Office in Dushanbe	USAID	<ul style="list-style-type: none"> <li>• Aziza Kahmidova - Project Management Specialist in Health/USAID Tajikistan</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> </ul>
October 7	Mercy Corps Office in Khujand	Child Survival Technical and Managerial Staff	<ul style="list-style-type: none"> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Zamira Karimova – Deputy Project Mgr./MC CS Project</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 7	City Maternity House - Khujand	City Maternity Management	<ul style="list-style-type: none"> <li>• Dr. Saidulloeva Marhamat – Director/MOH City Center Maternity House</li> <li>• Dr. Natalie Samieva - Asst. Dir./MOH City Maternity House</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 9	Sughd Region Ministry of Health - Khujand	Chief Managers for District Health Services	<ul style="list-style-type: none"> <li>• Dr. Ochilava Sharofniso – Deputy for MCH &amp; Gynecology/Regional MOH</li> <li>• Dr. Shoira – Deputy for Pediatrics/Regional MOH</li> </ul>	Same as above
October 9	Sughd Region Center for Healthy Lifestyles - Khujand	Chief Managers for Regional Health Services	<ul style="list-style-type: none"> <li>• Dr. Davron – Dir. for CHL/Regional MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 9	Sughd Region Pediatric Hospital – Khujand	Chief of Pediatric Hospital	<ul style="list-style-type: none"> <li>• Dr. Abu Salom – Chief of Pediatric Hospital/Regional MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 9	Sughd Region Center for IMCI - Khujand	Director of Sughd Region IMCI Center	<ul style="list-style-type: none"> <li>• Dr. Musafar – Dir. of IMCI Center/Regional MOH</li> <li>• Azimova Jicoyat – IMCI Trainer/MOH</li> </ul>	Same as above

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<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 9	Sughd Region Maternity House - Khujand	Director of Sughd Region Maternity House	<ul style="list-style-type: none"> <li>• Dr. Nuria Dadoboeva – Dir. of Sughd Region Maternity House/Regional MOH</li> <li>• Dr. Wilnora – Asst. Dir. of Sughd Region Maternity House/Regional MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 10	Shaydan Town – Asht District Hospital	Director of Asht District Hospital	<ul style="list-style-type: none"> <li>• Dr. Gairat Khasanov – Head Doctor/Asht District MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Kabir – District Coord./MC Asht</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 10	Shaydan Town – Asht District Hospital: Center for Healthy Lifestyles	Director of CHL in Asht District	<ul style="list-style-type: none"> <li>• Dr. Zokirova Barohat – Dir. of CHL/Asht District MOH</li> </ul>	Same as above
October 10	Shaydan Town – Asht District Hospital: IMCI Center	Director of IMCI Center in Asht District	<ul style="list-style-type: none"> <li>• Dr. Ergasher Zokirjon – Dir. of IMCI Center/Asht District MOH</li> </ul>	Same as above
October 10	Shaydan Town – Asht Maternity House	Maternity House Mgrs. in Asht District	<ul style="list-style-type: none"> <li>• Dr. Numonova Tuhtajon – Dir. of Maternity House/Asht District MOH</li> <li>• Negmatzoda Volida – Neonatologist in Maternity House/Asht District MOH</li> <li>• Pulotora Mutabar – Midwife and LSS Trainer in Maternity House/Asht District MOH</li> <li>• Maidarova Marluda – Chief of newborn dept. in Maternity House/Asht District MOH</li> </ul>	Same as above

*Annex – E: List of persons interviewed and contacted*

<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 11	Bahmal Village Medpoint – Asht District	Medpoint Staff	<ul style="list-style-type: none"> <li>• Rahmatov Mahmeedaly – Felsher/Bachmon Village MOH</li> <li>• Mitzoahmedova Sayohat - Nurse/Bachmon Village MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Murodali Abdultoer – Monitor/MC Asht District</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Kabir Rasulov – District Coord./MC Asht</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 11	Bahmal Village School – Asht District	Village Development Committee	<ul style="list-style-type: none"> <li>• Rahmatov Mahmeedaly - VDC Member and CHE</li> <li>• Mitzoahmedova Sayohat - VDC Member</li> <li>• Niyozov A. - VDC Member</li> <li>• Beknazarov - VDC Member</li> <li>• Begmator - VDC Chief</li> <li>• Rajabor - VDC Member</li> <li>• Mamarajabova Hafiza - VDC Member and CHE</li> <li>• Saidmurodova - VDC Member</li> <li>• Jamoliddinova - VDC Member</li> <li>• Ishmatova - VDC Member</li> <li>• Solier - VDC Member</li> </ul>	Same as above
October 11	Bahmal Village Mahallah (Community Neighborhood)	Community members	<ul style="list-style-type: none"> <li>• 10 women</li> <li>• 5 men</li> </ul>	Same as above
October 12	Zafarabad Town – Zafarabad District Hospital	Director of Zafarabad District Hospital	<ul style="list-style-type: none"> <li>• Dr. Samador Abdulmalik – Head Doctor/Zafarabad District MOH</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Alijon – District Coord./MC Zafarabad</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 12	Zafarabad Town – Zafarabad District Hospital: Center for Healthy Lifestyles	Director of CHL in Zafarabad District	<ul style="list-style-type: none"> <li>• Dr. Mirdirov Pulat – Dir. of CHL/Zafarabad District MOH</li> </ul>	Same as above

*Annex – E: List of persons interviewed and contacted*

<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 12	Zafarabad Town – Zafarabad District Hospital: IMCI Center	Director of IMCI Center in Zafarabad District	<ul style="list-style-type: none"> <li>• Dr. Kayumova Dilshoda – Dir. of IMCI Center/Zafarabad District MOH</li> </ul>	Same as above
October 12	Zafarabad Town – Zafarabad District Maternity House	Maternity House Mgrs. in Zafarabad District	<ul style="list-style-type: none"> <li>• Dr. Azizova Mamura – Dir. of Maternity House/Zafarabad District MOH</li> <li>• Dr. Ernazarova Shahlo – LSS Trainer &amp; Ob-Gyn/ Zafarabad District MOH</li> <li>• Sherkuzier Kibiljon – Neonatologist/Zafarabad District MOH</li> </ul>	Same as above
October 13	Baht Village School – Zafarabad District	Village Development Committee	<ul style="list-style-type: none"> <li>• Sharipov Zokir - Chairman of VDC</li> <li>• Mukim Ashurov - VDC Member</li> <li>• Egamov Mulloakram -VDC Member</li> <li>• Juraeva Mahario - VDC Member &amp; CHE</li> <li>• Kodirov Abduralbrim - VDC Member &amp; CHE</li> <li>• Sharipov Mari - VDC Member</li> <li>• Mahkamboev Hisrav - VDC Member</li> <li>• Mirzoeva Mahfirat - VDC Member</li> <li>• Murodova Sanarbar - VDC Member</li> <li>• Egamova Rajabmoh - VDC Member</li> <li>• Holova Salomat - VDC Member</li> <li>• Sharipova Igboloi - VDC Member</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Alijon – District Coord./MC Zafarabad</li> <li>• Abdulloev Kudrathoja - Monitor/MC Zafarabad</li> <li>• Mahsumor Tumaboi - Mobilizer/MC Zafarabad</li> <li>• Mireva Dilorom - Mobilizer/MC Zafarabad</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 13	Baht Village Mahallah (Community Neighborhood)	Community members	<ul style="list-style-type: none"> <li>• 10 women</li> <li>• 6 men</li> </ul> <p>[interviewed separately]</p>	Same as above
October 13	Baht Village SUB (Rural Hospital)	Rural Hospital Staff	<ul style="list-style-type: none"> <li>• Dr. Mukim Ashurov – Chief Doctor of SUB/Baht Village MOH</li> <li>• Dr. Egamov Mulloakram – Pediatrician/Baht Village MOH</li> </ul>	Same as above
October 14	Mercy Corps Office in Khujand	Child Survival Technical and Managerial Staff [continued from Oct. 7]	<ul style="list-style-type: none"> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>

*Annex – E: List of persons interviewed and contacted*

<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 16	Mercy Corps Office in Khujand	Mercy Corps District Coordinators, Monitors and Mobilizers	Dilorom - Mobilizer/Zafarabad Foziljon - Mobilizer/Asht Khuzmat - Monitor/Shakristan Murotali - Monitor/Asht Maxsumov - Mobilizer/Zafarabad Gafazov Nozmahmat - Coord./Shakristan Nodisov Tyucht - Mobilizer/Shakristan Abdulloev Cudzatchdga- Monitor/Zafarabad Abdulloeva Tamara - Mobilizer/Asht Oripova Zarrina - Mobilizer/Asht Rubimatova Nafisa - Mobilizer/Asht Kabir Rasulov - Coordinator/Asht	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Zamira Karimova – Deputy Project Mgr./MC CS Project</li> <li>• Ayub Eghamov - Database operator/MC CS Project</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 17	Shahristan Town – Shahristan District Hospital: IMCI Center	Director of IMCI Center in Sharistan District	• Dr. Hasanov Sharif – Dir. of IMCI Center/Shahristan District MOH	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Mirsakiyeva Hurmatoy – Monitor/MC Shahristan</li> <li>• Gafforova Normahmad – Coordinator/MC Shahristan</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 17	Shahristan Town – Shahristan District Hospital: Center for Healthy Lifestyles	Director of CHL in Shahristan District	• Dr. Karimkulov Valamat – Dir. of IMCI Center/Shahristan District MOH	Same as above
October 17	Shahristan Town – Shahristan District Maternity House	Maternity House Mgrs. in Shahristan District	• Dr. Tatiana Delivron – Dir. of Maternity House/Shahristan District MOH	Same as above
October 18	Shahristan Town – Shahristan District Hospital	Director of Sharistan District Hospital	• Dr. Yussuf Niazmamadof – Head Doctor/Shahristan District MOH	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Mirsakiyeva Hurmatoy – Monitor/MC Shahristan</li> <li>• Gafforova Normahmad – Coordinator/MC Shahristan</li> <li>• Malika Mirzobahadurova - Translator</li> </ul>
October 18	Kayerma Village	Clinic and village beneficiaries of latrine project	<ul style="list-style-type: none"> <li>• Nasirjon – Coord./USDA MC Sanitation Project</li> <li>• Clinic mgr.</li> <li>• Head of household</li> </ul>	Same as above

*Annex – E: List of persons interviewed and contacted*

<b>Date</b>	<b>Location</b>	<b>Focus Group or Key Informants</b>	<b>Person(s) Interviewed</b>	<b>Evaluators and Participants</b>
October 18	Kushkurgan Village Medpoint	Medpoint staff	<ul style="list-style-type: none"> <li>• Dr. Galatove Ismoil – Chief of Medpoint</li> <li>• Rahimov Abdurahmon - Felcher</li> <li>• Isoyeva Ijobat - Nurse/Midwife</li> </ul>	Same as above
October 18	Kushkurgan Village Medpoint	Village Development Committee and community members	<ul style="list-style-type: none"> <li>• 7 men</li> <li>• 7 women</li> </ul>	Same as above
October 19	Restaurant in Khujand	Debrief and group analysis with Sughd Region and District MOH Staff	<ul style="list-style-type: none"> <li>• Dr. Rabijanov – Sughd Region Chief of MOH</li> <li>• Dr. Ochilava Sharofniso – Deputy for MCH &amp; Gynecology/Regional MOH</li> <li>• Dr. Shoirā – Deputy for Pediatrics/Regional MOH</li> <li>• Various District Chiefs and heads of District CHLs and IMCI Centers</li> </ul>	<ul style="list-style-type: none"> <li>• Chris Bessenecker – External Consultant</li> <li>• Carlos Cardenas - Health Director/MC International</li> <li>• Saiidi Izatof – Project Mgr./MC CS Project</li> <li>• Mary Helen Carruth - Health Program Manager/MC Tajikistan</li> <li>• Janatoy Nabieva - Training Coord./MC CS Project</li> <li>• Fatima Khujaneva – Comm. Coord./MC CS Project</li> <li>• Jabarova Tahmina – Safe Motherhood Coord/MC CS Project</li> <li>• Zamira Karimova – Deputy Project Mgr./MC CS Project</li> <li>• Ayub Eghamov - Database operator/MC CS Project</li> <li>• Malika Mirzobahadurova – Translator</li> <li>• All 3 MC District Coordinators</li> </ul>

**Scope of Work - Mid Term Evaluation**  
**Improving Maternal and Child Health in Northern Tajikistan:**  
**Sughd Child Survival Project**  
**Sughd Oblast, Tajikistan**  
**September 30, 2004 to September 29, 2008**

The Sughd Child Survival Project is a four-year project covering three districts in Sughd Oblast in the north of Tajikistan near the Uzbek border. The Project is a partnership between Mercy Corps and the Sughd Department of Health. The intent of the partnership is to help the Department of health shift to a primary-care focused delivery of maternal-child health services, improve quality of care, and introduce community outreach activities. In addition to the major partnership with the Department of Health, Mercy Corps works with the Centers for Promotion of Healthy Lifestyles, the branch of the Ministry of Health responsible for health promotion. The project started up on October 15th 2004 and has now completed two years of implementation.

The population of Sughd Oblast is largely ethnic Tajik (Indo-Europeans whose language is closely related to Persian) with Uzbek (Turkic speaking) minorities. Because these populations have been living side by side since the Middle Ages their ways of life are essentially identical. Each group, however, has retained its own language.

The goal of the Sughd Child Survival Project is to improve the health of women of reproductive age and of children under five in the districts of Shahrison, Zafarabod, and Asht through use of key maternal and child health and nutrition interventions. Mercy Corps has defined three objectives:

1. Increase the percentage of mothers of children under two who practice improved feeding, care during illness and health-seeking practices;
2. Increase the percentage of women who receive adequate maternal and health care
3. Increase the capacity of DoH health facilities to deliver quality maternal-child health services.

These goals are achieved by building DoH capacity to address the challenges of sustainable, quality service delivery, and promoting behavior change and community mobilization to take appropriate responsibility for health.

Specific technical strategies include:

1. Training and implementation of Integrated Management of Childhood Illnesses (IMCI) at district health facilities;
2. Training and implementation of Community IMCI;
3. Training and support to the Department of Health (DoH) for certification as Baby Friendly Hospitals;
4. Training and implementation of lactation management at facility and community levels;
5. Training and implementation of safe motherhood activities with health facility staff;
6. Training and implementation of safe motherhood activities with communities;
7. Training community health educators and health facility staff on behavior change and community mobilization.

The Sughd Child Survival Project includes four interventions; diarrhea disease control (20%), nutrition (30%), breastfeeding (20%), and maternal-newborn care (30%).

**Evaluation Audience:** The audience for the findings from the mid-term evaluation includes the Sughd Department Health, Sughd Centers for Promotion of Healthy Lifestyle, Mercy Corps HQ and field staff, and the USAID CSHGP and Tajikistan and Central Asia Missions.

**Objectives of the Evaluation:**

1. Evaluate the performance of Mercy Corps' Child Survival and Health Grant in Tajikistan against the expected project impact, using USAID's Mid - Term Evaluation Guidelines. Specifically, assess progress achieved by the project to meet project objectives articulated in the DIP.
2. Generate a "Results Highlight," capturing a topic identified by the Program and Project Manager as particularly successful.
3. To establish recommendations for technical support and workplan during the last two years of the project, focusing on sustainability and operational practicalities.

**Methodology** Mercy Corps will conduct a participatory evaluation involving community members from the Project area, Child Survival staff, and Sughd DoH and Centers for Promotion of Healthy Lifestyle and HQ Carlos. Overall leadership will be provided by an external evaluator. Data will be gathered using a variety of tools, both qualitative and quantitative.

1. *Quantitative data collection:* The Project will begin conducting a KPC survey during the week of September 18. The data will be available by October 31. The EE and HQ representative are asked to provide a list of "key indicators" for which they would like preliminary analysis to take place.
2. *Qualitative data collection:* The External Evaluator will work with project staff to define what qualitative information is sought, and develop a plan for gathering this information. Qualitative data will be collected through interviews and/or focus groups with beneficiaries and Department of Health staff and visits to health facilities. To ensure objectivity, the External Evaluator will work independently (with a translator) to facilitate to gather information.
3. *Data analysis:* Quantitative and qualitative findings will be analyzed jointly with community members, Project staff and DoH staff so that all stakeholders are involved in learning from the findings and understand the project's impact. Facilitation of these workshops will be shared by the EE and Project staff.
4. *Report writing:* An Evaluation report, following the USAID guidelines for Mid-Term Evaluations of USAID Child Survival grants, will be written by External Evaluator.

**Terms of Reference – External Evaluator:**

Consultant/External Evaluator: Christopher P. Bessenecker

Dates: Approximately October 03 – October 27, 2006, including 2 preparation days, 3 travel days, 11 days field work, 7 writing days for a total not to exceed 23 days. A sample calendar of dates and activities is below.

Dates	Oct. 03-04	Oct. 05-06	Oct. 09 - 19	Oct. 20 - 26	Oct. 27	Oct. 30 - Nov. 03	Nov. 06
Activities	Prepare	Travel to Tajikistan	Field Work	Report Writing Report sent to PM and HQ on Nov. 01.	Travel back to the US	PM and HQ Backstop review report draft	Report finalized based on PM and HQ feedback and sent to PM and HQ backstop

Rate: \$8,000 lump sum

**Tasks and Deliverables:**

**Before Arrival:**

1. Review project documents including proposal, DIP, Mid Term Evaluation report and first annual report. (Documents will be provided by HQ).
2. Review USAID’s MTE Evaluation guidelines (available at [http://www.childsurvival.com/documents/usaidd/fe\\_guidelines\\_10-21-05.doc](http://www.childsurvival.com/documents/usaidd/fe_guidelines_10-21-05.doc)), and develop an “action list” or “work plan” for the evaluation which ensures that the collection of all information needed to meet the expectations of these guidelines.
3. Work directly with the Program Manager, Project Manager and HQ representative to develop a list of key stakeholders with whom to meet during the term of the evaluation. The Project Manger is responsible for organizing a field schedule for the consultant, including meetings with individual and groups of key project stakeholders.

**In Country:**

1. Request and review current monitoring data and mid-term KPC survey results.
2. Lead the overall evaluation process, following the guidelines laid out by USAID in their 2006 MTE Guidelines (available at [www.childsurvival.com](http://www.childsurvival.com) <http://www.childsurvival.com/>) working directly with the Program Manager, Project Manager and HQ backstop.
3. Produce a Mid Term Evaluation Report, on the scheduled specified above, including all the sections described in the MTE Guidelines (except for the CSHGP data sheet), and other information that is relevant and pertinent to the project's progress. Overall, the evaluation and report must assess and communicate the following information:
  - a) Assess progress in implementing the DIP

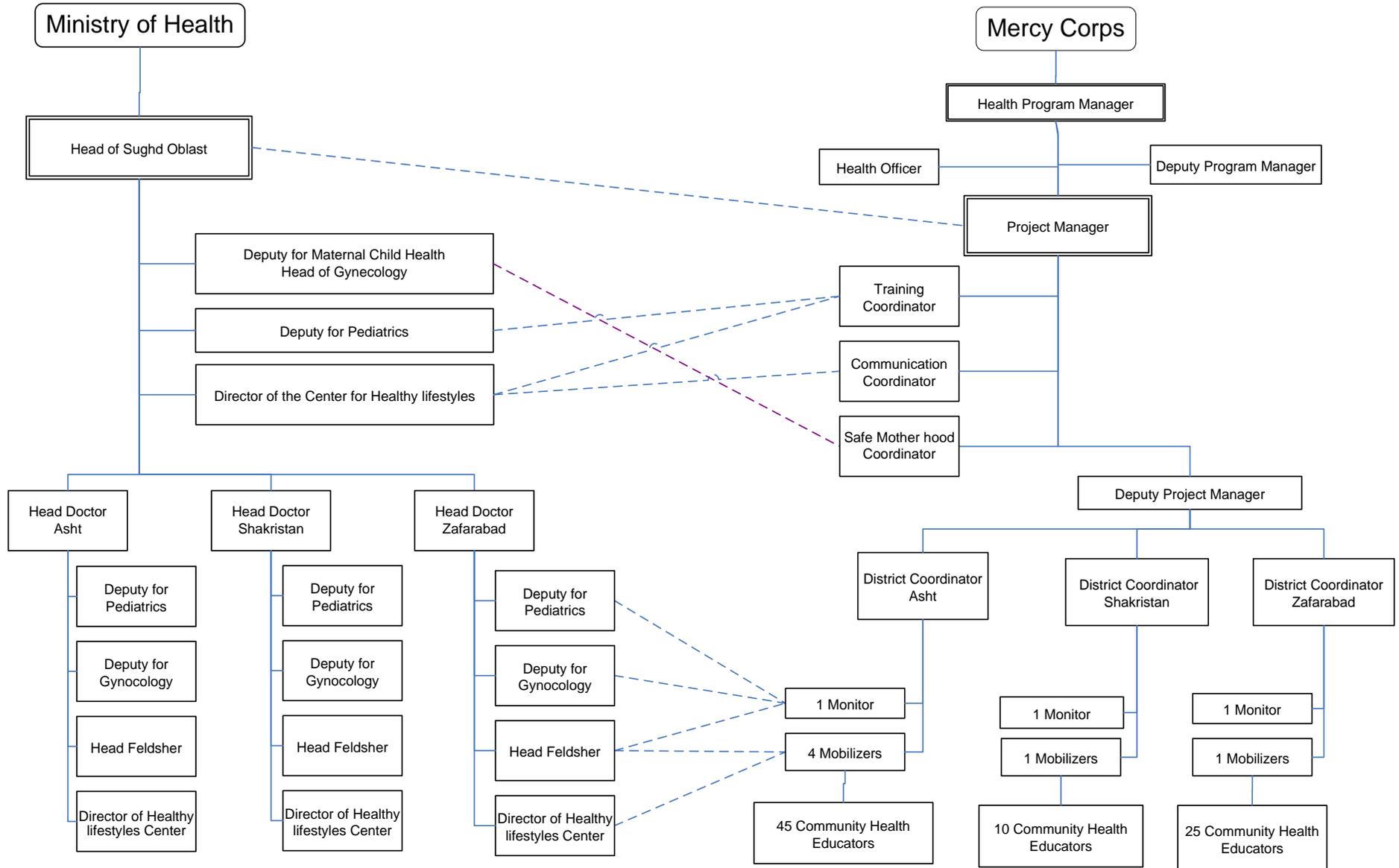
- b) Assess progress towards achievement of objectives and yearly benchmarks;
  - c) Assess if interventions are sufficient to reach desired outcomes;
  - d) Identify barriers to achievement of objectives; and
  - e) Provide recommended actions to guide the project staff through the last half of the project.
- 
- ❖ *The final report will be considered final once it has been thoroughly reviewed and is free of spelling or grammar errors, is stylistically consistent and polished to be clear and concise.*

Annex A: Report Writing Responsibilities

<u>REPORT SECTION</u>	<u>PARTIES RESPONSIBLE (INFORMATION SOURCE)</u>
A. Summary	External Evaluator
B. Assessment of the progress made toward achievement of program objectives	External Evaluator
C. Program Management	External Evaluator
D. Other Issues Identified by the Team	External Evaluator, Program/Project Manager
E. Conclusions and Recommendations	External Evaluator
F. Results Highlight (if an appropriate topic is identified)	Program Manager/External Evaluator
G. The action plan	Program and Project Managers; HQ Backstop
H. Project Data Sheet form	HQ Backstops

<u>ATTACHMENTS</u>	<u>RESPONSIBLE PARTY</u>
A. Baseline information from the DIP	A. External Evaluator
B. Mid-Term KPC Report	B. Program Manager
C. Evaluation Team Members and their titles	C. Program/Project Manager
D. Evaluation Assessment methodology (in brief)	D. External Evaluator
E. List of persons interviewed and contacted	E. Program/Project Manager
F. Diskette or CD with electronic copy of the report in MS WORD	F. HQ Backstop
G. Special reports	G. Program/Project Manager
G. CSHGP Data Sheet	H. Backstop

Annex G: Organizational Chart



<b>R-1: Increase the percentage of mothers of children under two years who practice improved feeding, caring and health-seeking practices</b>			
<b>Activities</b>	<b>Year 1 and 2 Benchmarks</b>	<b>Benchmark Achieved</b>	<b>Comments</b>
<b>Household</b>			
Community Health Educators provide education in their communities on maternal and child health topics	82 CHEs provide monthly community health education sessions	Yes	Education sessions reach an average of 6,568 beneficiaries each month (1,359 men and 5,209 women).
Community health educators make home visits and provide referrals to health facilities	82 Community Health Educators make home visits, especially to high risk families, and provide referrals to health facilities	Yes	The CHEs make an average of 2,671 home visits per month and refer an average of 64 persons per month to health facilities for vaccination, respiratory infections, postnatal and pre-natal care, burns or other injuries.
Community Health educators provided with training on behavior change	82 Community health educators able to apply behavior change concepts in education sessions	Yes	Eighty four (84) CHEs trained in BCC.
DoH and Child Survival staff provided with training of trainers on WHO Participatory Hygiene and Sanitation Transformation (PHAST) methodology	10 Child Survival and one Center for Healthy Lifestyle staff trained in PHAST methodology	Yes	10 Child Survival Project staff and 2 Center for Healthy Lifestyle staff and 84 CHEs trained in PHAST methodology.
<b>Community</b>			
Community Health Educators provided with training on community mobilization	84 CHEs trained in community mobilization.	Yes	84 CHEs trained in community mobilization.
Village development committees established and provided with training on community mobilization	60 Village Development Committees established and provided with training on community mobilization	Yes	Sixty six (66) VDCs provided with training on community mobilization.

*Annex H: Workplan benchmarks and achievements FY05-06*

Public Service announcements produced and broadcast	One public service announcement was produced and broadcast	Yes	Public serves announcements on breast feeding, diarrhea, under-nutrition and birth planning were produced and broadcast.
Representatives from village development committees provided with C-IMCI training	60 village development committees trained in C-IMCI	No	The Ministry of Health has requested that NGOs complete facility based training in IMCI and complete first monitoring before initiating C-IMCI.
Growth Monitoring and Promotion Program established and supported by village development committee	One pilot GMP program established in one village in each district	No	The MoH, UNICEF and WHO have not finalized the growth monitoring and promotion card.  20 breastfeeding support groups have been established in Shahrison and 10 in Asht.
<b>Health Faculty</b>			
Train rural health staff in adult learning and ToT	60 DoH staff trained in adult learning	Yes	77 DoH staff trained in adult learning
Rural health staff provide community education sessions on maternal and child health topics	60 health facilities provide health monthly education sessions	Yes	74 health facilities provide health monthly education sessions
District hospitals in Shahrison and Zafarabod provided with Baby Friendly Hospital training	Staff from maternity wards in Zafarabod and Shahrison provided with BFHI training and begin to work towards certification	No	17 Staff from maternity wards in Shahrison have been provided with Training of Trainers in BFHI and have begun to work towards certification.  The Maternity ward staff in Zafarabod will begin training in November.
District hospital in Asht provided with Baby Friendly Hospital refresher training	Staff from maternity ward in Asht provided with BFHI refresher training	Yes	Staff from maternity ward in Asht will be provided with BFHI refresher training in November.

*Annex H: Workplan benchmarks and achievements FY05-06*

Trainers identified and trained as trainers for IMCI	8 DoH staff trained as trainers in IMCI	Yes	10 DoH staff trained as trainers in IMCI
Rural Health staff provided with IMCI training	Key health staff from 60 polyclinics, SVAs and FAPs are provided with IMCI training	Yes	130 Department of Health staff from 80 health facilities have provided with a nine day training workshop in IMCI.
Rural health staff provide appropriate counseling on breastfeeding	Health staff at 60 polyclinics, SVAs and FAPs provide appropriate counseling on breastfeeding	Yes	Health staff at 67 polyclinics, SVAs and FAPs provide appropriate counseling on breastfeeding
Rural health staff provide appropriate counseling on care of sick children	Health staff at 60 polyclinics, SVAs and FAPs provide appropriate counseling on care of sick children	Yes	One hundred and eighty (180) health staff from 80 polyclinics, SVAs and FAPs provide appropriate counseling on care of sick children
Rural health staff at pilot facilities conduct monthly growth monitoring sessions	One health facility in each district conducts monthly growth monitoring	No	The MoH, UNICEF and WHO have not finalized the growth monitoring and promotion card.  Sixty (60) rural health facilities regularly weigh and measure children during clinic visits.
Monitoring and supervision system established to track IMCI activities	60 polyclinics, SVAs and FAPS receive regular monitoring and supervision visits	Yes	10 Department of Health staff have been trained in monitoring. Monitoring is conducted every six months
IMCI resource room established in Khujand	IMCI resource room established and functioning according to ToR developed with DoH	Yes	An IMCI resource room has been established in Sughd Oblast Pediatric Hospital and provided with a computer, technical manuals, tables, desk, bookshelf and whiteboards.

*Annex H: Workplan benchmarks and achievements FY05-06*

Rural Health staff provided with Community IMCI training	Rural Health staff from 60 facilities provided with Community IMCI training	No	The Ministry of Health has requested that NGOs complete facility based training in IMCI and complete first monitoring before initiating C-IMCI. C-IMCI training will begin during first quarter 2007.
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<b>R-2: Increase the percentage of women who receive adequate maternal health care and newborn care.</b>			
<b>Activities</b>	<b>Year 1 and 2 Benchmarks</b>	<b>Benchmark Achieved</b>	<b>Comments</b>
<b>Household</b>			
Community health educators provide community sessions on safe motherhood (including birth planning)	82 community health educators provide training on safe motherhood and birth planning in their communities	No	82 CHEs provided with ToT on birth planning during October and will provide education sessions on birth planning during November.
Families make birth plans for pregnant women	100 families will make birth plans for pregnant women	No	CHEs will provide education sessions on birth planning during October
Post partum mothers and newborn receive check up within in 48 hours after birth	75% postpartum mothers receive post partum check up within 48 hours	Yes	70% postpartum mothers and newborns receive post partum check up within 48 hours after birth.
<b>Community</b>			
Community health educators and village development committees provided with training on safe motherhood, including birth planning	82 community health educators and representatives from 60 village development committees are provided with training on safe motherhood and birth planning	No	Eighty four (84) CHEs provided with training on birth planning during October. Village Development Committees will be trained during November.

*Annex H: Workplan benchmarks and achievements FY05-06*

Emergency transport system established by village development committees	60 village development committees establish emergency transport systems for deliveries	No	Village development committees will establish emergency transport systems for deliveries after training in October.
<b>Health Faculty</b>			
Rural Health staff provided with training on safe motherhood, including birth planning	Health staff at 60 facilities provided with training on safe motherhood	No	Village Development Committees will be trained on birth planning during November.
Rural health facilities work with village development committees to establish emergency transport system for deliveries	Staff at 60 rural health facilities work with village development committees to establish emergency transport system for deliveries	No	Village Development Committees will be trained on birth planning during November.

<b>R-3: Increased capacity of DoH facilities to deliver quality maternal-child health services</b>			
<b>Activities</b>	<b>Year 1 Benchmarks</b>	<b>Benchmark Achieved</b>	<b>Comments</b>
<b>Health Facility</b>			
Safe Motherhood Coordinator hired and starts preparations for LSS training	One national safe motherhood coordinator recruited and starts preparation for LSS training	Yes	LSS/Safe Motherhood Coordinator began work during July 2005.
Needs assessment conducted for LSS training facilities	Needs assessment conducted at oblast and city maternity homes to assess suitability for LSS training.	Yes	Both facilities are currently used as training centers
Core trainers for LSS provided with training of trainers	10 midwives or Ob/Gyns trained as trainers for LSS	Yes	10 midwives or Ob/Gyns trained as trainers for LSS
Midwives and OB/Gyns provided with LSS training	30 OB/Gyns and midwives from district, city, and oblast maternity homes and SUBS provided with LSS training	Yes	Seventy (70) ob/gyns and midwives from district, city, and oblast maternity homes and SUBS provided with LSS training
Referral system established for complications during pregnancy and delivery	Referral system established for complications during pregnancy and delivery	Yes	The Ministry of Health has a well established referral system for complications during pregnancy and delivery
Monitoring and supervision system established to track LSS activities	Maternity homes in Project districts receive regular monitoring and supervision visits	Yes	Maternity homes in Project districts receive quarterly monitoring and supervision visits

*Annex I: Behavior message and activity tables*

<b>Maternal and Child Nutrition Messages and Activities</b>			
Audience	Behavior	Key factors Influencing the Behavior	Planned Activities
<b>Individual</b>			
Mothers of children six to 24 months of age	Introduce quality, complementary foods at 6 - 7 months	<p>Maternal confidence that infant does not need complementary foods until s/he is about six months of age</p> <p>Knowledge of appropriate and varied complementary foods</p> <p>Knowledge of appropriate consistency and portion size for complementary foods</p> <p>Belief that semi-solid foods, especially protein legumes, eggs and milk are difficult for an infant to digest</p> <p>Mothers' attitudes towards active feeding practices</p>	<p>Individual counseling sessions on complementary feeding for mothers facilitated by CHEs and community-based health staff</p> <p>Print &amp; distribute brochures on complementary feeding</p> <p>Culturally appropriate community education sessions on complementary feeding provided by CHEs and community based health staff</p> <p>Positive Deviance/Hearth</p>
Pregnant women	Increase food consumption	<p>Knowledge of increased nutritional needs during pregnancy</p> <p>Skills to solve nutrition related problems during pregnancy such as anemia, heartburn, nausea and constipation during pregnancy</p> <p>Addressing fear of weight gain during pregnancy</p> <p>Addressing fear of increased pregnancy complications during delivery</p>	<p>Conduct TIPS research to identify appropriate dietary recommendations for women during pregnancy and breast-feeding.</p> <p>Individual counseling sessions on diet during pregnancy and breastfeeding for mothers facilitated by CHEs and community-based health staff</p> <p>Print &amp; distribute brochures on diet during pregnancy and breastfeeding</p> <p>Culturally appropriate community education sessions on diet during pregnancy and breastfeeding provided by CHEs and community based health staff</p>

*Annex I: Behavior message and activity tables*

Pregnant women	Take 80 iron/folate tablets at a rate of 2 per week of pregnancy, for the duration of the pregnancy	<p>Knowledge of increased requirements for iron during pregnancy</p> <p>Skills to avoid common side effects of taking ferrous sulfate supplements.</p> <p>Addressing common misconceptions about taking ferrous sulfate supplements</p> <p>Encourage attendance at prenatal consultations to receive ferrous sulfate supplements</p>	<p>Individual counseling sessions on taking ferrous sulfate supplements for mothers facilitated by CHEs and community-based health staff</p> <p>Develop brochure with information on taking ferrous sulfate supplements including facts about their importance, instructions on how to take and suggestions for avoiding side effects.</p> <p>Culturally appropriate community education sessions on taking ferrous sulfate supplements for mothers facilitated by CHEs and community-based health staff</p>
Lactating women	Increase food consumption	<p>Knowledge of increased nutritional needs during lactation</p> <p>Knowledge about how mother's diet can affect breastmilk production</p> <p>Addressing concern of weight gain with increased food consumption</p> <p>Skills to plan appropriate diet during lactation using locally available foods</p>	<p>Facilitation of discussions by breastfeeding support group leaders on diet during breastfeeding</p> <p>Conduct TIPS research to identify appropriate dietary recommendations for women during pregnancy and breast-feeding.</p> <p>Print &amp; distribute brochures on diet during pregnancy and breastfeeding</p> <p>Culturally appropriate community education sessions on diet during pregnancy and breastfeeding provided by CHEs and community based health staff</p> <p>Individual counseling sessions on breastfeeding for mothers facilitated by CHEs and community-based health staff</p>
<b>Family/ Household</b>			
Mothers-in-law, husbands and other family members	Support women to increase food consumption during pregnancy and lactation	Increasing families' knowledge of increased nutritional needs during pregnancy and lactation	Culturally appropriate community education sessions on diet during pregnancy and breastfeeding provided by CHEs and community based health staff
	Participate in feeding young children	Attitudes towards active feeding practices	<p>Print &amp; distribute brochures on complementary feeding</p> <p>Culturally appropriate community education sessions on complementary feeding provided by CHEs and community based health staff</p>

*Annex I: Behavior message and activity tables*

<b>Breastfeeding Messages and Activities</b>			
Audience	Behavior	Key Factors Influencing the Behavior	Activities
<b>Individual</b>			
Mothers with children 0 to 6 months of age	Exclusive breastfeeding during first 6 months	<p>Breastfeeding positioning and attachment</p> <p>Maternal confidence in quality and quantity of breastmilk they produce</p> <p>Knowledge of benefit of continued breastfeeding during illness</p> <p>Attitudes towards feeding on demand</p> <p>Perception of social support for EBF</p> <p>Sleep benefits to child and mother</p>	<p>Establishing breastfeeding support groups at the community level, tested for appropriateness and effectiveness, and scaled up based on test results</p> <p>Individual counseling sessions on breastfeeding for mothers facilitated by CHEs and community-based health staff</p> <p>Broadcast public service announcements on importance of exclusive breastfeeding</p> <p>Print &amp; distribute brochures on breastfeeding developed by CARE Tajikistan</p> <p>Culturally appropriate community education sessions on breast feeding provided by CHEs and community based health staff</p>
Mothers of children 6 to 24 months of age	Introduce appropriate complementary foods at 6 to 7 months of age	<p>Knowledge of appropriate complementary feeding</p> <p>Household support for active feeding of the child</p> <p>Knowledge of locally available, easy to digest foods</p>	<p>Individual counseling sessions on infant feeding for mothers facilitated by CHEs and community-based health staff</p> <p>Print &amp; distribute brochures on infant feeding</p> <p>Culturally appropriate community education sessions on infant feeding provided by CHEs and community based health staff</p> <p>Pilot Growth Monitoring and Promotion</p> <p>Establish Hearth Programs in indicated villages</p>
<b>Family/ Household</b>			

*Annex I: Behavior message and activity tables*

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Mothers in Law and husbands	Participate in feeding the child	Confidence in quality and quantity of breastmilk produced  Engage in child's meal preparation  Perceptions of breastfeeding or feeding on demand	Community education sessions on breastfeeding facilitated by CHEs and community-based health staff
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*Annex I: Behavior message and activity tables*

<b>Maternal and Newborn Care Messages and Activities</b>			
Audience	Behavior	Key Factors Influencing the Behavior	Activities
<b>Individual</b>			
Women of reproductive age	Receive four prenatal consults	<p>Importance of monitoring health of fetus</p> <p>Potential of pre-natal visits to prevent complications such as toxemia</p> <p>Potential of pre-natal visits to monitoring of mother's health</p>	<p>Culturally appropriate safe mother promotion provided by CHEs and community based health staff</p> <p>Print and distribute education materials on safe motherhood</p> <p>Broadcast public service announcements broadcast on safe motherhood</p>
	Women receive a post-partum visit within 48 hours.	Potential to prevent complications for mother and baby during pp period	<p>Culturally appropriate safe mother promotion provided by CHEs and community based health staff</p> <p>Print and distribute education materials on safe motherhood</p> <p>Broadcast public service announcements broadcast on safe motherhood</p>
	Births are attended by a health professional	Appreciation of the importance of having birth attended by a trained health professional	<p>Culturally appropriate safe mother promotion provided by CHEs and community based health staff</p> <p>Improving access to transport to delivery services</p> <p>Print and distribute education materials on safe motherhood</p> <p>Broadcast public service announcements broadcast on safe motherhood</p>

*Annex I: Behavior message and activity tables*

	Recognition of danger signs results in visit to health facility	Recognition of danger signs during pregnancy, delivery, post-partum and new born  Access to transport to prenatal, delivery and post-natal services	Culturally appropriate safe mother promotion provided by CHEs and community based health staff  Print and distribute education materials on safe motherhood  Broadcast public service announcements broadcast on safe motherhood
<b>Family/ Household</b>			
Mothers-in-law, husbands and other family members	Take pregnant women and new mothers to prenatal care, delivery, and post natal care services.	Appreciation of importance of receiving 4 prenatal care visits  Appreciation of the importance of having birth attended by a trained health professional  Knowledge of danger signs during pregnancy, delivery, post-partum and new born  Appreciation of importance of developing emergency transport plans	Culturally appropriate safe mother promotion provided by CHEs and community based health staff  Print and distribute education materials on safe motherhood  Broadcast public service announcements broadcast on safe motherhood  Emergency transport plan established

*Annex I: Behavior message and activity tables*

<b>Diarrheal Disease Control Messages and Activities</b>			
<b>Audience</b>	<b>Behavior</b>	<b>Key factor influencing the Behavior</b>	<b>Planned Activities</b>
<b>Individual</b>			
Mothers who have children less than 5 years of age	To wash hands with soap/ash before preparing food, eating or feeding child, after defecation or helping child to defecate	Knowledge on modes transmission and prevention of diarrhea	<p>Culturally appropriate community education sessions on transmission and prevention of diarrhea provided by CHEs and community based health staff</p> <p>Print &amp; distribute brochures developed by Mercy Corps on transmission and prevention of diarrhea</p> <p>Broadcast public service announcements on transmission and prevention of diarrhea</p>
	Respond to recognized danger signs for severe diarrhea and dehydration by giving ORS	Knowledge of danger signs for diarrhea and dehydration	<p>Culturally appropriate community education sessions on danger signs of diarrhea provided by CHEs and community based health staff</p> <p>Print &amp; distribute brochures danger signs of diarrhea</p> <p>Broadcast public service announcements on danger signs of diarrhea</p>
	Increase fluids and maintain/increase foods offered during an episode of diarrhea	<p>Knowledge appropriate home treatment of diarrhea</p> <p>Attitudes towards breastfeeding and feeding semi-solid foods during diarrhea</p>	<p>Culturally appropriate community education sessions on home treatment of diarrhea provided by CHEs and community based health staff</p> <p>Print &amp; distribute brochures on home treatment of diarrhea</p> <p>Broadcast public service announcements on home treatment of diarrhea</p>
<b>Family/ Household</b>			

*Annex I: Behavior message and activity tables*

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Mothers-in-law, husbands and other family members	Encourage mothers to provide appropriate treatment for diarrhea and dehydration	Increasing families' knowledge appropriate home treatment of diarrhea	Culturally appropriate community education sessions on home treatment of diarrhea provided by CHEs and community based health staff  Print & distribute brochures on home treatment of diarrhea  Broadcast public service announcements on home treatment of diarrhea
	Improve access to clean water	Implementing complementary water projects targeting communities where the need is greatest.	Install or repair community water points

**Illustrative Example of Cyclical Health Promotion**

Season	Activities/Conditions	Health issue/topic	Target Group
<b>Spring</b>	<ul style="list-style-type: none"> <li>• Men migrate to Russia</li> <li>• Planting begins</li> <li>• Onset of pregnancies</li> <li>• Cold weather</li> </ul>	<ul style="list-style-type: none"> <li>• HIV/AIDS/STDS</li> <li>• Hygiene</li> <li>• Pre-natal care</li> <li>• ARI</li> </ul>	<ul style="list-style-type: none"> <li>• Men</li> <li>• Mothers</li> <li>• Mothers-in-laws</li> </ul>
<b>Summer</b>	<ul style="list-style-type: none"> <li>• Women alone &amp; mothers-in-laws in charge</li> <li>• Mothers in first/second trimester</li> <li>• Children born in fall/winter pass 6 months</li> <li>• Warm weather</li> </ul>	<ul style="list-style-type: none"> <li>• Breastfeeding</li> <li>• Complimentary feeding</li> <li>• Nutrition</li> <li>• Illness prevention and treatment</li> <li>• Diarrhea</li> </ul>	<ul style="list-style-type: none"> <li>• Mothers</li> <li>• Mothers-in-laws</li> </ul>
<b>Fall</b>	<ul style="list-style-type: none"> <li>• Cotton harvesting</li> <li>• Women deliver</li> <li>• Neonatal/newborn period</li> <li>• Cold weather</li> </ul>	<ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Birth planning – emergency transport</li> <li>• Post-natal care</li> <li>• Diarrhea</li> <li>• ARI</li> </ul>	<ul style="list-style-type: none"> <li>• Mothers</li> <li>• Mothers-in-laws</li> </ul>
<b>Winter</b>	<ul style="list-style-type: none"> <li>• Men return from Russia</li> <li>• Newborns</li> <li>• Cold weather</li> </ul>	<ul style="list-style-type: none"> <li>• Family planning</li> <li>• Newborn care</li> </ul>	<ul style="list-style-type: none"> <li>• Men</li> <li>• Mothers</li> <li>• Mothers-in-laws</li> </ul>

**Key questions for DOH, Clinics and Medpoints, Center for Healthy Lifestyles:**

1. What are the main objectives (mission) of this institution? What is the main objective with respect to mother and child health?
2. What is the main health and nutrition problem with respect to mother and child health?
3. What activities are supported by the SCSP? How are those activities integrated with other program or other sectors?
4. What kind of partnership has been agreed to between MC and DHO? What are the roles of each party? (with respect to facilitation, human resources, budget, time, data sharing, etc).
5. What are other institutions, community groups, or individuals involved in the program? Which are the new ones (as a results of the program), which are the existing ones?
6. What do you consider to be the general strengths and weaknesses of the program?
7. Has there been anything especially innovative and/or successful about this program that you are excited about?
8. What do you've think are the reasons for the weakness and how could they best be overcome?
9. Who mostly benefits from the Program? What evidence shows that?
10. What specific activities have been initiated related to IMCI through this program and what has been your impression of the effectiveness of these activities thus far?
11. What specific activities have initiated related to breastfeeding promotion through this program what has been your impression of the effectiveness of these activities thus far?
12. **[Zafarabon and Shahkristan only]** At what point are the district hospitals in the Baby Friendly training/certification process? What barriers/constraints are faced in achieving certification?
13. What specific activities have initiated related to improving nutrition through this program and what has been your impression of the effectiveness of these activities thus far?

14. How is GMP being implemented and how does it differ from how it was implemented in the past?
15. What specific activities have initiated related to LSS through this program and what has been your impression of the effectiveness of these activities thus far?
16. What specific activities have initiated related to DDC through this program and what has been your impression of the effectiveness of these activities thus far?
17. At this point, how can MC/CS project best support you in achieving your objectives for these initiatives?
18. In your opinion, how can the program continue after MC/CS? How can additional resources be mobilized to ensure sustainability of the health improvements?

**Key questions for Village Development Committee/Community Health Educators:**

1. What are the main health and nutrition problems in the community? What is the main health and nutrition problem with respect to mother and child health?
2. Have you heard of MC/CS project? What have you heard? How are those activities integrated with other programs?
3. What has the VDC done to help in the implementation of the project?
4. What are the barriers to participating in the Village Health Committee? How do you manage your time?
5. What have the Community Health Educators done to help in the implementation of the project?
6. Have you received any training and if so, what have you learned?
7. How have you used what you learned in your community?
8. What are the barriers to participating as a Community Health Educator? How do you manage your time?
9. What other institutions, community groups, or individuals are involved in the program? Are you working together? How?
10. Who mostly has benefited from the MC/CS? What evidence do you have of that?
11. At this point, how can this project best support you in creating a healthier community – especially for mothers and children?

**Key questions for mothers/caretakers:**

1. How do you define health?
2. What do you do if your child gets sick? Who do you go to if you think your child needs help? Why do you go to that person?
3. Have you ever been visited by a CHE? Have you learned anything about health and nutrition from the CHE? Are you doing anything differently because of the CHE? What?
4. Do the health services in this community meet your needs? Why? Why not?
5. Where do mothers go to give birth? With whom did you give birth to your youngest child? Why did you ask help from him/her? Are you satisfied with their services? Why? Why not?
6. Do you know of any mothers in this community who have had trouble during delivery? What happened? How do you think it could have been prevented?
7. What are your neighbors doing to improve the health of their children?
8. In your opinion, what is the most important thing for your child future? What do you do in order to make your wish come true for your child?

**Key questions for males group :**

1. What is health? What is good health for you? For your wife? Your child?
2. What can you do to help your child be healthy?
3. What can you do to help your wife improve the families' health?
4. Where do you get information on health to support your family?
5. What are avenues for improving health?
6. Have you heard of the CHEs? Have you learned anything from them about the health of your children or spouses?
7. What should we do to get more men involved in supporting the health of their families? How can you and your friends be more supportive of your wives' involvement in health activities?

**Key questions for MC/CS Staff:**

**A. Community Mobilization**

1. What kinds of community mobilization activities have been undertaken by the project?
2. How has the community responded to these? Can you describe examples of how community capacity or cohesion has grown?
3. What challenges do you face in community mobilization and how have you addressed it thus far?

**B. Communication for Behavioral Change**

1. Do you have an overall behavioral change strategy (BEHAVE) and how has that been implemented?
2. Do you think the strategy is effective? If so why?
3. How are the BCC messages going beyond dissemination – teaching skills, negotiating changes, influencing norms?
4. How is BCC being measured/monitored?

**C. Capacity building – Mercy Corps**

1. What organizational capacity building activities have taken place at HQ and in the field?
2. How are you assessing your own organizational capacity?
3. What indications do you see that the project has increased organizational capacity?

**D. Capacity building – Partners**

1. Describe the capacity building that has been conducted with each partner since the onset of the program?
  - a. DOH
  - b. CHL
  - c. VDC
  - d. CHE
2. How has the organizational capacities of these local partners changed since the beginning of the project and what do you think has most contributed to this change?
  - a. DOH
  - b. CHL
  - c. VDC
  - d. CHE
3. What are the primary challenges in further building the capacity of partners?

4. How are you assessing the capacities of health facilities? Do you feel they adequately assess the need?
5. Is the VDC the primary linkage between the community and the health facility? Are there others? How effective has it been?
6. How effective has been the approach to building and improving CHEs
7. How is their performance being monitored? What tools are used?
8. How are you addressing gaps in performance and standards?
9. Describe your training strategy and its effectiveness.

**E. Sustainability**

1. What are your objectives for sustainability and what progress have you made to date on meeting those objectives?
2. Have you begun to lay the groundwork for a phase-out strategy with staff and local partners during the first two years of the project?
3. Is there a strategy for building financial sustainability (e.g. local level financing, cost recovery, diversification?)

**F. Project Planning**

1. To what degree have partners been involved in the planning of this project?
2. Do you think the project objectives are understood well at all levels (partners, community, etc.?)
3. Do all the partners have a copy of the projects objectives as well as M&E plan?
4. To what extent are project monitoring data used for planning and/or revising project implementation?

**G. Staff Training**

1. What has been the process for determining staff training needs?
2. How is skill performance in a new area monitored?
3. Given the limits of the budget, do you feel staff training is adequately addressed?

**H. Supervision**

1. How are staff supervised? How are they corrected or supported in improving performance?
2. What do you think has been the effectiveness of this project's supervision approach?
3. Are there sufficient resources (human, financial, time) for providing effective supervision?

**I. Human Resources and Personnel Management**

1. Have there been any major changes to MC's personnel management system since the DIP?

2. Are there key personnel policies and procedures in place and job descriptions for HQ, field staff and partners?
3. Describe the morale, cohesion and working relationship of project personnel and how it impacts the program?
4. Has staff turnover been an issue?

**J. Financial Management**

1. How is the project's finances managed within MC and with the local partners? What challenges, if any, has there been?

**K. Logistics**

1. What impact has logistics had on the implementation of the DIP?
2. What logistical challenges will the project face during the remainder of the project?

**L. Information Management**

1. Is there a systematic way of collecting, reporting and using data at all project levels?
2. What is the frequency and level of data analysis?
3. Does the project use/fuse its information with other data reporting systems (government?)
4. How does the data inform management decision-making? Can you give an example?

**M. Technical and Administrative Support**

1. Discuss the types and sources of external technical assistance the project has received to date and how timely/beneficial that support has been.
2. What are the anticipated technical needs of the project in the remaining period?
3. What has been the level of HQ support of the field project?

# Child Survival and Health Grants Program Project Summary

Nov-03-2006

## Mercy Corps (Tajikistan)

### General Project Information:

Cooperative Agreement Number: GHS-A-00-04-00019-00  
Project Grant Cycle: 20  
Project Dates: (9/30/2004 - 9/29/2008)  
Project Type: Standard

MC Headquarters Technical Backstop: Kati Moseley  
Field Program Manager: Saadi Izatov  
Midterm Evaluator: Chris Bessenecker  
Final Evaluator:  
USAID Mission Contact: Aziza Khamidova

### Field Program Manager Information:

Name: Saadi Izatov  
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Dushanbe  
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### Funding Information:

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

PVO match:(US \$) \$375,000

**Project Information:****Description:**

The project goal is to improve the health of women of reproductive age and children under five years old. The project will include four interventions: diarrhea disease control, nutrition, breastfeeding, and maternal-newborn care. Technical strategies will include; training and implementation of Integrated Management of Childhood Illnesses (IMCI) at district health facilities; training and implementation of Community IMCI; training and support to the Department of Health (DOH) for certification as Baby Friendly Hospitals; training and implementation of lactation management at facility and community levels; training and implementation of safe motherhood activities with health facility staff; training and implementation of safe motherhood activities with communities; and training community health educators and health facility staff on behavior change and community mobilization.

**Location:**

Three districts in northern Tajikistan: Shakristan, Zafarabad, and Asht.

<b>Project Partners</b>	<b>Partner Type</b>	<b>Subgrant Amount</b>
Tajikistan Ministry of Health	Collaborating Partner	

**General Strategies Planned:**

Strengthen Decentralized Health System

**M&E Assessment Strategies:**

KPC Survey  
Health Facility Assessment  
Lot Quality Assurance Sampling  
Community-based Monitoring Techniques

**Behavior Change & Communication (BCC) Strategies:**

Mass Media  
Interpersonal Communication  
Support Groups

**Groups targeted for Capacity Building:**

<b>PVO</b>	<b>Non-Govt Partners</b>	<b>Other Private Sector</b>	<b>Govt</b>	<b>Community</b>
US HQ (CS unit) CS Project Team	(None Selected)	(None Selected)	National MOH Dist. Health System Health Facility Staff	Health CBOs CHWs

## **Interventions/Program Components:**

### **Nutrition (30 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

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

### **Control of Diarrheal Diseases (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

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

### **Maternal & Newborn Care (30 %)**

(IMCI Integration)

(HF Training)

- Emerg. Obstet. Care
- Recog. of Danger signs
- Post partum Care
- Integr. with Iron & Folate
- Birth Plans
- Emergency Transport

### **Breastfeeding (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Promote Excl. BF to 6 Months
- Support baby friendly hospital

### Target Beneficiaries:

Infants < 12 months:	3,814
Children 12-23 months:	8,632
Children 0-23 months:	12,446
Children 24-59 months:	16,340
Children 0-59 Months	28,786
Women 15-49 years:	50,787
Population of Target Area:	204,448

### Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	38	304	12.5%	5.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	74	114	64.9%	17.2
Percentage of children age 0-23 months whose births were attended by skilled health personnel	300	304	98.7%	11.2
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0%	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	71	92	77.2%	19.9
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38	55	69.1%	25.1
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	89	132	67.4%	16.1
Percentage of children age 12-23 months who received a measles vaccine	90	132	68.2%	16.2
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0%	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	237	304	78.0%	11.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	57	122	46.7%	15.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	102	304	33.6%	8.4

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	54	304	17.8%	6.4
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#### Comments for Rapid Catch Indicators

The Tajikistan Ministry of Health protocol does not include TT immunization for infants or pregnant women.

The Project's coverage area is not at high risk for malaria.