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The U.S. Government's Global Hunger & Food Security Initiative

COMMUNITY-BASED APPROACHES TO IMPROVE MATERNAL AND CHILD HEALTH AND NUTRITION IN TAJIKISTAN

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Background

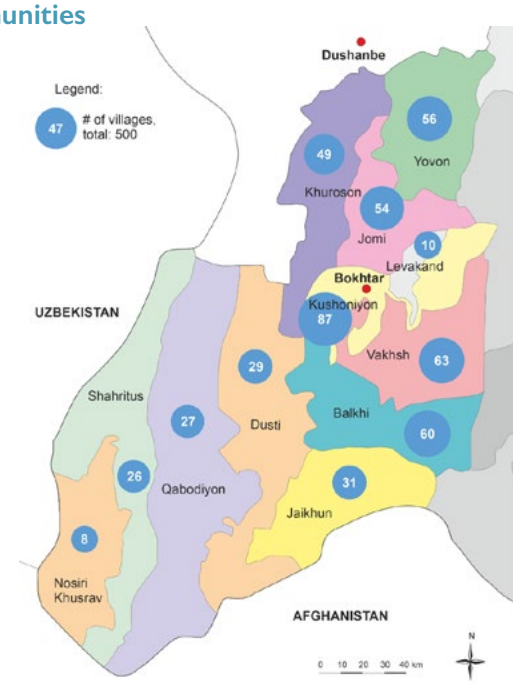
The Feed the Future Tajikistan Health and Nutrition Activity (THNA) is a five-year (2015-2020) project funded by USAID and led by IntraHealth International. With partner Abt Associates, IntraHealth is working with the Ministry of Health and Social Protection of the Population to improve the health and nutrition of women and children living in 12 of 24 districts of the Khatlon region.

A land-locked country with a population of nine million, three-quarters of whom live in rural areas, Tajikistan remains the poorest and among the least developed republics of the former Soviet Union. The 1992-1997 civil war, which took place mostly in Khatlon, threw the country even further behind and affected health care infrastructure and services, with over 60 primary and secondary care health facilities destroyed.

In the 12 districts where THNA implements its interventions, malnutrition is a major challenge, with stunting affecting 18% of children aged 6 to 59 months. More than 50% of married women of reproductive age and children under five are anemic. Anemia is further compounded by unspaced pregnancies and frequent diarrhea episodes among children. Exclusive breastfeeding up to six months is just 15% nationally, and only 10% of children under five and 9% of married women of reproductive age consume the desired variety of food to keep them healthy.[1] Many myths and misconceptions surround breastfeeding and newborn and child feeding practices, restricting the use of nutritious ingredients available even in the poorest households. Health-seeking behavior is poor for maternal, newborn, and child health (MNCH) preventive and curative care.

In the Feed the Future districts, infrastructure for water, sanitation, and hygiene (WASH) is lacking in households and facilities. Children drinking from open sources like canals is common, and improved latrines and soap are not widely available, contributing to diarrhea, malnutrition, and anemia. The districts are in an agricultural zone where vegetables and fruits are cultivated in abundance and communities raise livestock, mainly sheep, cows, goats, and chickens. However, crop rotation, fertilization, and animal feeding lack essential expertise, and seasonal changes affect stable food security throughout the year.

Figure 1. Feed the Future THNA districts and communities



Approaches

To address these challenges, THNA implements four integrated, cross-sectoral approaches:

1. Improve quality, accessibility, and utilization of MNCH services at the community, primary health center (PHC) and hospital levels
2. Increase availability and consumption of diverse nutrient-rich foods throughout the year
3. Drive behavior change related to MNCH, WASH, and nutrition for children and women
4. Conduct advocacy to support and institutionalize these interventions.

This technical brief covers community-level activities (Table 1) while a second technical brief covers clinical quality improvement interventions in hospitals and PHCs. Advocacy is addressed in both briefs.

Community-level Activities

Community volunteers: The cornerstone of the community interventions involved recruiting and training 1,300 health volunteers and 500 agriculture volunteers. Joint community work (khashar) on a one-off project for common good, such as mosque construction or cleaning an irrigation canal, has long cultural roots in Tajikistan. However, regular volunteer work is a relatively new concept introduced to Feed the Future districts by international projects shortly before THNA started. THNA has succeeded in engaging community members into long-term voluntary commitments.

THNA trained volunteers on behavior change interventions, tools, and measurement indicators. Volunteers are supervised and monitored by THNA district coordinators through regular monthly meetings where volunteers share challenges, best practices, and results of their work and THNA staff guide them in developing and improving their skills and plans. Since behavior change is affected positively by repeated messaging and multiple channels of delivery, THNA uses the following mixed approaches for interaction between the volunteers and the community:

Home visits: Health volunteers visit homes regularly to screen for new pregnancies and conduct growth monitoring for children under five. They counsel families on antenatal care (ANC), danger signs in pregnancy and child illness, exclusive breastfeeding, complementary feeding of children over six months of age, nutrition for pregnant and breastfeeding women, WASH, and other topics. Volunteers also refer malnourished children and mothers to PHCs and hospitals as needed. Each volunteer is responsible for 100 designated households.

Cooking demonstrations: Health volunteers conduct at least one cooking demonstration per village each month, focused on supplementary food for children of different age groups, nutrition for pregnant and breastfeeding women, and diversifying diets using nutritious local produce like pumpkin, sweet potato, and bok choy. These gatherings also emphasize WASH principles and the need to diversify agricultural crops to realize food security. THNA produced a recipe book that volunteers reference during the demonstrations.

Figure 2. THNA's book of nutritious recipes for women and children

Community support groups: THNA established, for the first time, four types of peer-support groups, at least one in each of 500 communities:

- *Mothers-in-law support groups:* Mothers-in-law wield enormous power in running households, including nutrition, WASH, and health-seeking behaviors for mothers and children. The support groups have succeeded in channeling their power positively to affect behavior change in households and communities.
- *Younger mothers' support groups* focus on antenatal and postnatal care and mother and child nutrition.
- *Men's support groups:* Men possess the decision-making power in most households, which has a major effect on MNCH. These groups educate men on MNCH and nutrition for women and children, but have also proved very helpful in THNA's agriculture and latrines interventions.
- *School peer educators:* THNA trains students to coach their peers and younger students on life skills, agriculture, nutrition, food security and diversity, and WASH. THNA supports 12 schools in training students in cultivation practices for school gardens, which has increased yields and contributed to feeding schoolchildren better food. Students also pass on agriculture advice to their parents and help improve home gardens.

Community behavior in WASH practices: THNA uses multiple channels to improve WASH including health volunteers' home visits, sharing messages at community fairs, and establishing village WASH committees supported by the heads of village development committees. WASH messages cover such topics as proper garbage disposal, disease prevention through handwashing with soap, the importance of hygiene and sanitation in child development and prevention of enteropathies, and communal hygiene and the need for ventilated improved pit latrines. THNA also engages village masons and trains them to build concrete latrines for the community at affordable prices.

Food security: Agriculture volunteers train household members in home garden management, household budgeting and entrepreneurship, winter food storage, postharvest technologies, cheese-making, and poultry farming.

Health-seeking behavior: THNA introduced a system for referrals between community health volunteers and PHCs or hospitals. The volunteers encourage referred families to utilize the facilities and make follow-up visits to mothers

and children after a facility visit. Health volunteers also communicate with the health facility providers to keep them informed on progress.

Planning and advocacy: THNA organizes and facilitates quarterly meetings to discuss achievements and challenges in implementing the joint action plans among the Khatlon Department of Health, district PHC and hospital managers, and community volunteers. THNA presents data that these stakeholders use in decision-making to strengthen the continuum of care and better link facilities and communities. Using project results, THNA has advocated for linking community volunteers with Centers for Healthy Lifestyles, government-led public health and health promotion centers for community outreach, to become part of the formal health system. **The World Health Organization (WHO)'s Guideline on Health Policy and System Support to Optimize Community Health Worker Programs** was also used in this advocacy.

Table 1. Data on THNA community-based interventions

Intervention	Result	Denominator
Health		
Health volunteers trained in behavior change communication	**1,389**	Total number of THNA target communities: **500**
PHC providers trained in anemia management for mothers and children (Years 4-5)	**823**	Total number of PHC providers in FTF districts (2018): **2,400**
Underweight children under five referred by health volunteers (Years 3-5)	**4,634**	Estimated number of underweight children under five in THNA target communities: **8,180**
Children under five with diarrhea referred to PHCs (Years 4-5)	**3,944**	Total number of children under five with diarrhea registered in FTF districts (2018): **23,205**
Home visits conducted (Years 2-5)	**765,577**	Total households in THNA target communities: **135,252**
Pregnant women, not registered for ANC, identified and referred for ANC (Years 4-5)	**9,416**	Total number of pregnant women registered in FTF districts (2018): **52,162**
Food Security and Nutrition		
Agriculture volunteers trained in behavior change communication	**500**	Total number of THNA target communities: **500**
Individuals reached with agriculture and food security programs, allowing for double counting (Years 2-5)	**1,183,311**	Total population in THNA target communities: **930,700**
Cooking demonstrations conducted (Years 4-5)	**7,344**	Total number of THNA target communities: **500**
Recipe books to address malnutrition distributed (Years 4-5)	**6,000**	Total number of volunteer and PHC providers: **4,200**
Cross-cutting Interventions		
School students educated on nutrition, agriculture, and WASH (Years 3-5)	**11,284**	Total number of school students in FTF districts: **371,600**
Peer support groups established (Years 4-5)	**693**	Total number of THNA target communities: **500**
Individuals reached with peer support groups (Years 4-5)	**6,670**	Total population in THNA target communities: **930,700**
Community members reached with messages on WASH and MNCH, allowing for double counting (Years 3-5)	**432,799**	Total population in THNA target communities: **930,700**
Latrines installed (Years 3-5)	**1,905**	n/a
Schools	**6**	Total number of schools in FTF districts: **650**
Health facilities	**271**	Total number of health facilities in FTF districts: **541**
Households	**1,628**	Total number of households in THNA target communities: **135,252**

Results

- Volunteers and support groups have earned community trust and introduced multiple healthy behaviors. Table 2 shows marked improvements in most indicators in THNA intervention communities as compared with 2017 Demographic and Health Survey (DHS) data and control communities.
- Volunteers and support groups have improved health-seeking behavior and access to PHCs and hospitals through counseling and referrals. This has resulted in improved utilization of services for ANC, postnatal care, and malnutrition. Early registration for ANC rose from 62% to 78% between Year 2 and Year 4 of THNA interventions.
- The cross-sectoral approach helped in reaching different community members with the same messages, creating a pivot for behavior change among mothers-in-law, men, schoolteachers, students, and village masons.

Table 2. Select indicators from THNA's 2016 and 2019 Recurrent Household Surveys and the 2017 Tajikistan Demographic and Health Survey (DHS)

		THNA Recurrent Household Survey, Oct. 2016	THNA Recurrent Household Survey, June 2019		DHS national results, 2017
			THNA communities	Control communities	
Exclusive breastfeeding 0-5 months, %		91	72	50	36
Continuous breastfeeding, %		68	71	78	50
Minimum acceptable diet in children 6-23 months, %	Breastfed	20	37	18	9
	Non-breastfed	16*	53	3*	10
Child feeding practices during diarrhea, %	More fluids	33*	80	63	27
	More food	10	55	21	10
Households with soap present at handwashing station, %		48	70	68	76
Women achieving minimum dietary diversity, %		84 †	90	71	80
Number of ANC visits for previous pregnancy		3.6	5.7	4.0	-
Women who had 4+ ANC visits, %		57*	86	48	64
Women participating in their health care decision-making, %		4	11	4	-

* Difference statistically significant at $p<0.05$ compared to THNA communities in June 2019
† May 2017 data

Challenges

- FTF communities have adopted volunteers as a new concept. Volunteer activities, however, are not likely to be sustained unless the government offers volunteers with some incentives as official community health providers. THNA advocates for this to the government's Centers for Healthy Lifestyles, which are charged with coordinating community volunteers.
- Essential inputs for WASH such as drinking water, sewage systems, toilets, and soap are still lacking in communities, schools, and some facilities. THNA continues its work with village masons and its advocacy efforts in this area.
- Family planning and contraceptive use are still very low in the 12 districts because of the lack of social behavior change programs regarding family planning. Unfortunately, family planning activities are not funded as part of THNA.
- Many women continue to delay or avoid seeking ANC, postnatal, or child care for preventive or curative services. Certain lab tests for ANC and pediatric services cost money, in addition to transport costs, which collectively are major deterrents to seeking services.
- Regular deworming programs are not in place, although deworming medicine is available at PHCs. School deworming programs are offered for school-age children but not to those less than 5 years.
- Behavior change often takes longer than the life of a five-year project given that some of the changes require functional infrastructure that communities cannot achieve without outside support from the government or private entities.

Recommendations

- ***Align government and donor approaches to supporting community volunteers.*** Include regular material incentives in government-run community health volunteer programs.
- ***Support sustainability:*** Given the success of the community volunteers in behavior change, the Ministry of Health and Social Protection of the Population is advised to establish a formal status for their work such as linking them to Centers for Healthy Lifestyles.
- ***Attend to missing inputs:*** WASH infrastructure needs to be addressed by the government, private entities, local communities, and donors.
- ***Expand counseling and services for family planning:*** MNCH and nutrition gains through behavior change and improved quality of services will not sustain their intended outcomes without addressing family planning seriously in future programs.
- ***Partner with income-generation entities:*** Future programs should incorporate income-generation components—e.g., marketing of fresh produce or preservation and marketing of different agricultural products—as improved economic status will contribute to further advancing household nutrition, WASH, and health-seeking behaviors. THNA includes a number of family income-generating activities, from poultry production and cheese-making to household budgeting and modern agricultural technologies.
- ***Introduce and expand deworming programs:*** This can contribute to reducing malnutrition in mothers and children.
- ***Scale up and continue implementing the program:*** The tools and approaches have proven to be successful in behavior change if challenges are addressed.

[1]Statistics referenced in the Background section are from the 2017 Tajikistan Demographic and Health Survey.
Photos by Khosiyatkhon Komilova for IntraHealth International

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