Provision of Life Saving Humanitarian Health and Nutrition Services in Kandahar Province, Implemented by Save the Children Japan

SUMMATIVE EVALUATION REPORT

August 11th 2021

1. Acknowledgements

The HPRO Program Team would like to acknowledge the responsiveness, and constructive engagement of the key informants consulted during this evaluation. Their insights have been valuable in shaping this report.

Above all, we acknowledge the informants and participants from the health department, SCI-AF project manager, PPHD M&E manager, Directorate of public health (DPHO) MHT focal point, district, and community level participants who provided insights during the interviews, and accommodated the research team's many questions with candidness and patience and opened up about issues regarding implementation of the project in both the districts. This study is with regards to the Japan Platform (JPF) who in partnership with SC Japan project has the ultimate purpose to uplift the lives of Afghans and strengthen the existing systems. JPF funded the evaluation of Humanitarian Health and Nutrition Services in Kandahar Province and we are thankful for the opportunity to generate knowledge and evidence on the project to support the improvement of health system and health outcomes.

The findings within this document, however, are entirely the responsibility of the technical team of HPRO

August, 2021

Disclaimer

2. Executive Summary

Background:

The project "Humanitarian Health and Nutrition Services in Kandahar" in Afghanistan was started on 31 March 2020, ended on 30th March 2021 and was implemented by SCJ in partnership with SC Afghanistan by the funding support from JPF. HPRO was contracted as a third-party research and M&E entity by the JPF in order to conduct a summative evaluation of the project.

Methodology:

A mixed design approach using both qualitative (KII) and quantitative (Household survey and MIS data) methods was adopted for the evaluation in Zherai and Panjwayee districts. Multi-stage sampling was conducted and in each randomly selected HH Pregnant and Lactating women (PLW), mothers/care takers of children under five including those with Sever Acute Malnutrition (SAM) were selected for survey interview using structured questionnaire. Participants for KIIs were purposively selected and includes key stakeholders involved in the project.

Findings

Achievement of project outputs: The project was able to accomplish access to gender-sensitive primary health services to 29,578 IDPs, returnees, and residents in the host communities but slightly fall short on provisioning of psychosocial services due to several uncontrollable environmental factors. The project also achieved/exceeded planned targets for screening and treatment of acute malnutrition among PLW and children under five years of age, in addition to IYCF counselling. During the project life, a total of 44,367 OPD consultations including 9,419 children under five and 3,233 PLW screened for acute malnutrition, 447 children treated by SAM by the SC Mobile Health Team (MHT). Comparing the data captured by SCJ with HMIS data recorded at MoPH, slight variation in data was observed which could be attributed to the way the data is reported by the two mechanisms.

Demographic profile of the survey respondents: A total of 99 PLW or mother/care takers of children under five including those with SAM were randomly selected and enrolled in the survey. Of these 66% were in Panjwayee and 34% in Zharay district. Almost all the women in the study were illiterate (96%) and housewives (99%).

Service Provision: overall 46% of the study participants reported to have received at least one service from the SC MHT. Table 1 below provide a snapshot of the different MCH and nutrition services received from the SC MHT. In the following sections we present in details the services that were utilized by the study participants from SC MHT and other sources.

Maternal and new born Health: Overall, 88% of the study participant women reported to have received ANC services and 5% received from SC MHT. One quarter received PNC of which one reported to have received care from SC midwife. The low utilization of ANC and PNC provided by SC MHT can be attributed to the short time exposure of communities to MHT services in selected villages. The SCI-AF HMTs used to cover other villages for about 6-7 months but then due to active fight the MHT coverage areas had to be changed to new villages in December 2020. Data collection for summative evaluation took place in the newly selected villages. 85/94 (90%) respondents cited feeding colostrum to their new born babies and (98%) claimed exclusive breastfeeding practices. The key source of information was SC MHT staff (27%) followed by health facility staff (26%).

Health seeking for diarrhoea: half of the care takers for children with diarrhoea in the past two weeks, sought care from private health facility while 38% sought from the SC MHT.

Nutrition: In this study, 54 case or (55%) of the sample were children with Sever Acute Malnutrition (SAM). Of these 16 reported to have sought care from the SC MHT. Household visits were performed for 17/54 (31%) of cases; close to half (8/17) by SC MHT. However, Ready to Use Therapeutic Food (RUTF), Vitamin A and deworming were supplied to less than half of SAM cases by SC MHT and overall.

Complaint Management and Beneficiary Satisfaction: While 77% of the study participants did not know about where and whom to complain if they had any, 61% of beneficiary who received at least one service from SC MHT said no. 22% overall and 37% of those who used SC MHT services said they never complained and one person said yes and cited SC MHT staff as the focal point for complaint raising. On average the overall satisfaction was higher (91%) for those who did utilize SC MHT services than those who did not (44%).

CHS1: Communities and people affected by crisis receive assistance appropriate and relevant to their needs: Kandahar is struggling on several grounds such as conflict, refugees, IDPs, and others with a high rate of poverty among them. The emergency health and nutrition services provided coverage for basic health services in white areas of two districts of Kandahar to some extent.

CHS2: Communities and people affected by crisis have access to the humanitarian assistance they need at the right time: In the wake of the high demand for basic health and nutritional services, the presence of MHT was timely. While the service provision was not consistent and the target areas for MHT had shifted once due to conflict, the project was able to reach/exceed all planned targets excluding provisioning of psychosocial services. Additionally, the demand for malnutrition screening, referral and treatment was high, which SC was able to address, however, treatment was found partial.

CHS3: Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action: The awareness session on nutrition and counselling on IYCF within the community, generated awareness and presumably improved health seeking behaviour. This also generated awareness on SC MHT services.

CHS4: Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them: Information provided during awareness session in the community was about when to seek treatment for ailment and beneficiaries thus become aware about their entitlement for health services.

CHS5: Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints: The two layered complaint redress system was implemented as per discussion with SCI-AF and PPHD M&E officer. The two mechanisms included SCI-AF and PPHD/ DPHO, which is a walk-in complaint system through community elder (malik). However, community awareness about existence of the mechanism was low. Among the 46 participants who had used SC MHT services, one person said he

knew and cited SC MHT staff as the focal point for complaint raising. The rest 61% of the 46 did not know about the mechanism and 37% said they never complained. Conversely, the awareness was higher among community leaders who are the gate keepers for facilitating access to services by the communities. The complaints were resolved locally with facilitation from community leaders. This ensured trust building among all the stakeholders and the project was implemented with relative success. This informal structure functions well in a traditional system like Afghanistan.

CHS6: Communities and people affected by crisis receive coordinated, complementary assistance: The documentary assessment and interview with provincial health department highlight that government functionaries had been made aware of and approval sought for the project activities on a timely basis.

CHS7: Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection: The PPHD interview acknowledged they monitored the activities of the MHTs and any shortcoming they identified were communicated to SCI-AF in Kandahar who immediately addressed those.

Value assessment of program intervention: Assessing project intervention using JPF evaluation framework, it can be attested that emergency health and nutrition services to IDPs, returnees, conflict-affected people, including children was highly relevant to community needs (CHS1), such intervention was timely and almost all planned outputs achieved thus effective (CHS2), exhibited impact on vulnerable population malnutrition health status (CHS3) and was implemented through coordinated efforts of stakeholders (CHS6). Henceforth, the project was well worthy of implementation.

Recommendations

- There has been wide spread awareness on EBF, continued breastfeeding (CBF) among women many of whom SCI-AF MHT beneficiaries which fulfils the project outcome of better access to information on nutrition and infant and young child feeding (IYCF) counselling. Future programs to continue to focus on promotion of these cost effective and evidence based best practices.
- Afghanistan has a large problem of chronic nutritional deficiency which stems from acute malnutrition, inadequate dietary diversity, insufficient amounts of food, coupled with poor hygiene conditions. Incorporation of counselling on WASH, dietary diversity, food security targeted to women in the reproductive age group will be helpful in presenting a holistic program approach. Community outreach for identifying SAM cases to be strengthened to improve the provision of nutritional services to SAM cases.
- Providing services in conflict and volatile settings can be disrupted anytime by active fight and this is more so for fixed medical facilities than mobile health service provisions. No immediate prospect on stability requires innovative approaches such as mobile health services provided by this project for addressing the health and nutrition needs of the population affected by the conflict. It is essential for mobile health provision to liaise closely with host community that can generate a sense of ownership on projects and enable for the projects to secure safe space on service provision and access to timely security information.
- While it was evident in the study that sample population used the SC MHT service at least once were satisfied with all indicators including the gender sensitiveness of MHT staff,

WHO gender sensitive health facilities and services guidelines for Afghanistan can strengthen the future SC's interventions further in emergency health and nutrition sector.

3. Table of content

4. List of Tables

5. List of Figures

6. Abbreviations

BHC	Basic health centres
BPHS	Basic Package of Health Services
CBHC	Community-based health care
CBF	continued breastfeeding
CHC	comprehensive health centres
CDC	Community Development Council
CHS	Core Humanitarian Standard (CHS) Framework
COVID	Corona Virus Infectious Disease
DATC	Drug Abuse Treatment Center
DH	District hospital
DHS	Demographic Health Survey
DoPH	Department of Public Health
EBF	Exclusive Breast feeding
EIBF	Early initiation of breast feeding
EPHS	Essential Package of Health Services
FAO	Food and Agriculture Organization of the United Nations
GAM	Global acute malnutrition
GBV	Gender Based Violence
GoA	Government of Afghanistan
GBV	Gender-based Violence
GPS	Global Positioning System
HSC	Health sub-centres
HPRO	Health Protection and Research Organisation
IDP	Internally Displaced Population
IS	Islamic State
IYCF	infant and young child feeding practices
JPF	The Japan Platform
JPF	Joint Peace Fund
KII	Key Informant Interview
LFA	Log Framework
MHT	Mobile Health Team
MOU	Memorandum of Understanding
NGO	Non-Government Organization
NNS	National Nutrition Survey
OCHA	The United Nations Office for the Coordination of Humanitarian Affairs
ODK	Open Data Kit
PBF	Predominant breastfeeding
PDC	Provincial Development Council
PHCC	Provincial Health Coordination Committee
PHD	Provincial Health Department
PPHD	Provincial Public Health Department
PLW	Pregnant and lactating women
SAM	Severe acute malnutrition
SCI-AF	Save the Children International Afghanistan
SCI	Save the Children International
SCJ	Save the Children Japan
ToR	Terms of Reference
USDA	United States Department of Agriculture

UNDP	The United Nations Development Programme
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UN	United Nation
WFP	World Food Programme

1. Introduction

1.1. Overview

Kandahar is the second largest of the thirty-four provinces of Afghanistan, located in the southern part of the country bordering Pakistan. It is surrounded by Helmand in the west, Uruzgan in the north and Zabul Province in the east. Kandahar city is the capital of the province, located on the Arghandab River. The greater region surrounding the province is called Loy Kandahar. The province contains 18 districts: Arghandab, Arghistan, Daman, Ghorak, Khakrez, Maruf, Maiwand, Myanashin, Nesh, Panjwayee, Reg, Shahwali Kot, Shorabak, Spin Boladak, Zherai, Shaga, Dand and Kandahar city (capital).

Decades of war and violent conflict compounded by economic problems and natural disasters have made millions of Afghans refugees. While some fled the country, others became refugees within their own borders. In addition, many of those forced to leave their homes due to economic factors or flee from natural disasters are now returning. Displacement has become a familiar survival strategy for many Afghans and in some cases, an inevitable part of life for two generations. The situation is further complicated by widespread unemployment, poverty, landlessness and a lack of basic services. As a result, an even more severe strain has been put on the country's already overstretched health system. A large portion of the Afghan population has been affected by chronic food insecurity and transitory food insecurity. This condition (chronic food insecurity) is becoming severe (World Bank, 2019) noted that 54.5% of the population lives below the poverty line in Afghanistan and above 53.2% of the total population is undernourished (USDA, 2019; FAO, 2019).[1],[2],[3] Thus, this country was categorized as the 169th food security country in the world in 2020, according to UNDP's Human Development Index.

1.2. Afghanistan Health Services and Nutrition

1.2.1. Humanitarian assistance and Health services

Ten national and international organizations (BARAN, INTERSOS, SCI and MEDAIR, AHDS, ACTD, ARCS, HNTPO, ICRC, Mercy Malaysia, Wadan, Handicap and MOPH) for Health services and four national and international NGOs (BARAN, MEDAIR, SCI and INTERSOUS) are working for health and nutrition services across 15 areas in the province. BARAN and MOPH are providing health services as BPHS and EPHS implementer in the province. In Kandahar province, there are a total of 84 health facilities, including 1 Regional Hospital, 1 district hospitals (DHs), 27 comprehensive health centres (CHCs), 16 basic health centres (BHCs), 1 BHC+, 8 health sub-centres (HSCs), 2 Drug Abuse Treatment Centers (DATC), and 1 Trauma Center. It is notable that 17 other health facilities and 10 health mobile teams

[1] World Bank. (2019) 'Food insecurity in Afghanistan, Five key policy-relevant findings of food insecurity', Washington, Rome World Bank.

[2] USDA. (2019) 'International Food Security Assessment from 2018-2028', Department of Agriculture, Economic Research Service, June 2018.

[3] FAO. (2019) 'The state of food insecurity in the world, Safeguarding against economic slowdowns and downturns. Rome Food and Agriculture Organization of the United Nations

providing health services are managed by different organizations outside of the BPHS/EPHS framework. Among these, Kandahar provincial hospital is providing the essential package of health services (EPHS), which is implemented by ICRC under the MoPH. The basic package of health services (BPHS) is implemented by BARAN.

According to "Integrated Nutrition, Mortality, WASH, and Food Security SMART Survey Final Report (2018)", a prevalence of 8.7%(GAM), which means 94 children were malnourished out of 1082 and 1.1% of (SAM); and 12 children were severely malnourished out of 1082 per WHZ. This level of severity was classified as a poor nutrition situation in the province according to UNICEF WINS Issue 24, 13 December 2018.

1.2.2. Micronutrient deficiencies and malnutrition

In 2018, Afghanistan experienced high rates of under-nutrition. The prevalence of stunting in children under 5 was almost 41 percent at the national level, with 42.3 percent for boys and 39.4 percent for girls, which is classified as very high according to the World Health Organization (WHO) thresholds. UNICEF, WHO and World Bank Joint Malnutrition estimates indicate that the prevalence of the wasting was 9.5.

Under-nutrition is of particular concern in women, children, displaced people, returnees, households headed by women, people with disabilities and the poor. Despite progress in recent years, under-nutrition rates are now increasing and the prevalence of stunting in children under 5 remains high at 41 percent at the national level, with peaks of 60 to 70 percent in some provinces[4]. In the first six months of 2019, WFP reached 162,800 girls and boys under 5 and mothers with treatment of moderate acute malnutrition.

Micronutrient deficiency rates are very high amongst both children and women, based on current data available NNS 2004 anaemia among under 5 are 38% with 72% of iodine deficiency; 50% of under 5 children having zinc deficiencies; Vitamin deficiencies, such as A and C, are also widespread[5].

Maternal under-nutrition is also a significant challenge. The 2004 National Nutrition Survey (NNS) found 20.9% of non-pregnant women of reproductive age with chronic energy deficiency (Body Mass Index <18.5). This is considered a problem of "high prevalence" according to WHO standards. The prevalence of iodine deficiency in pregnant and non-pregnant women was at least 75%, iron deficiency (48.4% non-pregnant) and anaemia 25% (non-pregnant). Women who were literate or had access to at least primary education were less likely to be undernourished and have micronutrient deficiencies. High incidence of birth defects in Kabul hospitals also suggests folate deficiency in the population, particularly among women.

1.2.3. Health status in Kandahar

In Kandahar Province, the infant mortality rate was 64 deaths per 1,000 live births, which was the fifth highest rate in Afghanistan's 34 provinces, and the under-five mortality rate was 84

[4] WFP, (2019). AN EVALUATION OF WFP'S COUNTRY STRATEGIC PLAN (2018-2022) (P 3), Retrieved from https://docs.wfp.org/api/documents/WFP-0000121509/download/

[5] UNICEF, (2021). Humanitarian Action for Children (P 2). Retrieved from https://www.unicef.org/media/87886/file/2021-HAC-Afghanistan.pdf

deaths per 1,000 live births, which was the sixth highest rate.[6] These rates were the highest rates in eight provinces where Save the Children has field offices.[7] The national average mortality rates for infants and children under the age of five were 55 deaths and 45 deaths, respectively. A survey conducted by the Nutrition Cluster in all provinces in 2018 revealed that Kandahar Province had the highest acute malnutrition rate of 15.7% among children aged six to 59 months.[8] A survey conducted only in Kandahar Province revealed emergency level acute malnutrition among children. The global acute malnutrition (GAM) rate and the severe acute malnutrition (SAM) rate were 13.6% and 3.4%, respectively, suggesting greater health service needs in the province. 49% of the infants included in the survey were breastfed within one hour of birth and the proportion of infants aged less than six months who were exclusively breastfed was low at 51%.[9] The survey also showed that the proportion of children who had received all the required vaccinations was only 61.8% and that diarrhoea was prevalent among 37.2% of children under the age of five.[10]

The number of IDPs is the highest among other districts of Kandahar in areas of Zherai (103,693 IDPs) and Panjwayi Districts (70,247 IDPs). The health and nutrition situations in these areas is very serious and urgent support is needed to maintain and improve health and nutrition services in the communities.

1.2.4. Mobile Health Service delivery model in Afghanistan

The MoPH Basic Package of Health Services (BPHS) policy was envisioned to provide the entire population of Afghanistan equitable access to a bare minimum of essential primary health services, focused on rural areas of the country. However, accessibility has been a challenge to reaching the desired BPHS goal. BPHS has made improvements in primary health care services coverage, as well as secondary health care services through its network of district hospitals (DH), comprehensive health centers (CHC), basic health centers (BHC) and health posts using the wheel and spoke model. Though BPHS model has proven effective in establishing minimum standards of care, and it is also well known that topographical challenges and scattered pockets of population compounded by segregated development with a lack of infrastructure such as roads and bridges has raised concerns about actual coverage and accessibility. Additionally, providing basic care to internally displaced populations, vulnerable groups and to the population of Afghanistan has been a challenge. Considering the fact that basic health centers (BHC) are under-utilized, the rationale behind inclusion of Mobile Health Teams (MHTs) in the MOPH policy was that establishing more BHCs in remote areas would result in the creation of more underutilized health facilities. A better alternative is to create mobile health teams which are considered to be more effective in terms of increasing access to health services and are more feasible.

The introduction of mobile health teams is promising. It is a positive step towards bringing healthcare to remote communities, but does little to alleviate poverty and provide general infrastructure which make those communities inaccessible in the first place. An understanding

[6] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. 2017. "Afghanistan Demographic and Health Survey 2015," Kabul, Afghanistan: Central Statistics Organization.

[7] Save the Children has province offices in Kabul, Faryab, Jowzjan, Sar-e Pol, Balkh, Kunduz, Nangarhar, and Kandahar.

[8] "Severity of Acute Malnutrition in Afghanistan December 2018," Nutrition Cluster Afghanistan, OCHA

[9] P37 & P42, "Integrated Nutrition, Mortality, WASH, and Food Security SMART Survey Final Report Kandahar Province, Afghanistan, 21st November to 2nd December 2018" Action Against Hunger

[10] P22, "Rapid SMART Assessment Final Report Panjwayi and Zhari Districts of Kandahar Province, 25th June to 3rd July, 2018" Action Against Hunger

of the barriers to access and the policies that have been implemented to address them, is critical for Afghanistan to achieve Universal Health Coverage (UHC). Mobile health teams (MHTs) provide a vehicle to bring care closer to the homes of underserved populations living far from fixed health facilities and sensitise communities to health and nutrition services. These health include one female health provider, one male health provider, a driver and a vaccinator, together ensuring that underserved areas will achieve better access to care. In an effort to address outstanding challenges and to scale up the provision of the BPHS, an integrated model of mobile teams (health and nutrition) has been set up in Afghanistan. These mobile teams provide a range of services, including reproductive health care, gender-based violence prevention and response, as well as psychosocial services. The principal idea of mobile health services is to establish a limited number of mobile health teams in each province by dividing the province into clusters of districts for the following purposes:

1) To ensure the provision of essential and basic health services in remote villages located in geographically hard to access areas;
2) To expand and strengthen community-based health care (CBHC) through the identification of additional Community Health Workers in hard to access areas and to link community level interventions with BPHS facility-based services;
3) To encourage greater community participation and community ownership of health services.

Although the mobile teams will not be able to fulfil all of the same tasks as a BPHS clinic, they will be able to provide essential drugs and encourage care seeking behaviour. However, considerable challenges remain in the use of this model, including high costs, impediments to physical access to certain pockets of the population, supply chain issues and as experienced by this project, not entirely immune to prevailing insecurity in the country.

1.3. Overview of Humanitarian Health and Nutrition Services in Kandahar

1.3.1. The Health and Nutrition Services

The project Humanitarian Health and Nutrition Services in Kandahar was started on 31 March 2020 and ended on 30 March 2021. The project had two key objectives: firstly, to establish three emergency mobile health and nutrition teams and provide gender-sensitive primary health services, including vaccination and reproductive health services, and psychosocial support. The second objective was to conduct nutrition screening lead by emergency mobile health and nutrition teams especially for children under the age of five and pregnant and lactating women (PLW) and provide appropriate support for children with severe acute malnutrition (SAM), including referral to other facilities. Educate PLW and caregivers about infant and young child feeding (IYCF) practices. The project received funding of JPY 46,386,517 from JPF which was supplemented by JPY 4,028,407 from the SCJ which altogether is totalling to JPY 50,414,924. Three emergency mobile health and nutrition teams in two districts of Kandahar Province (Zherai and Panjwayi) were established, one in Zherai District and the other two in Panjwayi District. Each team was in charge of approximately 9,000 people in five areas. The teams worked five days a week, 20 days a month, and spent one to two weeks traveling to all areas. In total 15 areas were served but due to conflict the initial areas were replaced by new ones that were accessible. In November 2020 the number of areas were reduced to three and later in December 2020, 12 were resumed.

2. Purpose of the study

2.1. Scope of the summative evaluation

To accurately capture information, monitor activities and analyse data on these project activities and to use the outcome of this evaluation for improving the current and future JPF projects and programme.
This evaluation covered the period (March 2020 – March 2021) of the project with implementation in two districts: Zherai and Panjwayee districts of Kandahar province

2.2. Objectives of the summative evaluation exercise are:

- To verify and measure actual outputs and if possible, outcomes of the project with the available data;
- To understand the beneficiary's level of satisfaction;
- To determine the value of the project's implementations with all of the above and identification of actual measurements of beneficiary's satisfaction;
- To verify that the humanitarian principles and standards including but not limited to CHS are respected;
- To document above achievements and challenges and reports to donors and the general public;
- To provide feedback for the future project and programme improvements for both JPF and member NGOs.

3. Methodology

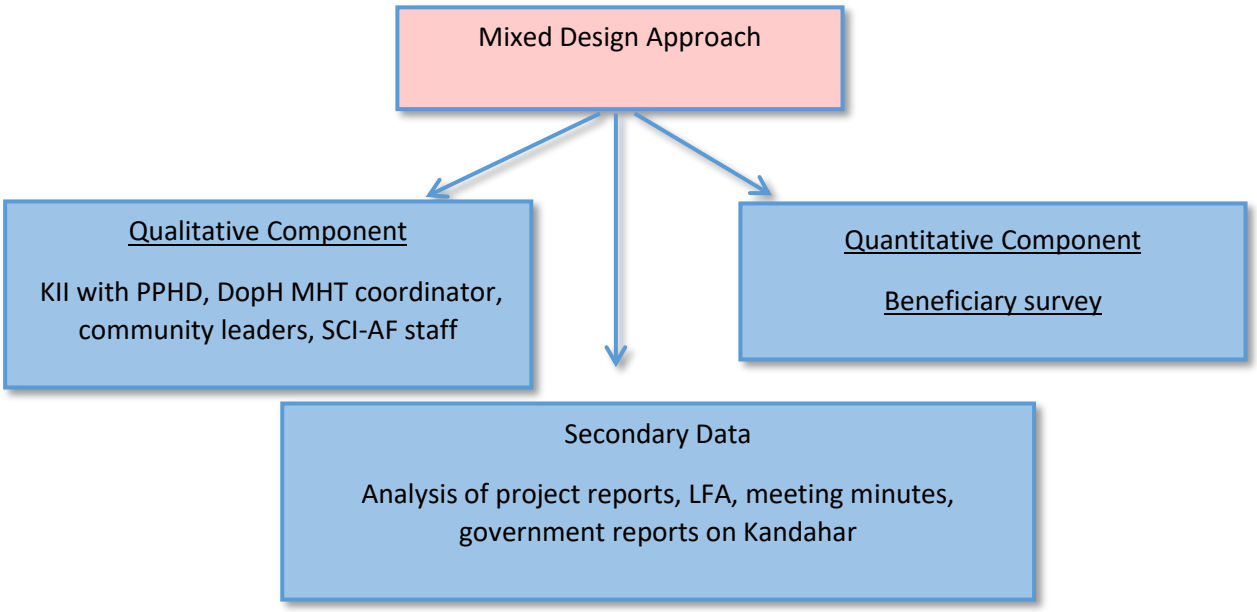
3.1. Study Design

Provision of life-saving humanitarian health and nutrition services in Kandahar province, made it imperative to use mix methods – quantitative and qualitative methods, and different streams of analysis- for the study. The design of the summative evaluation was informed by the overarching CHS standards and and conclusion was inferred based on JPF evaluation framework.

3.2. Methodology for data acquisition

In line with the above-mentioned objectives, a mixed design approach was adopted for the evaluation. As a method, this research design focused on collecting, analysing, and mixing both quantitative and qualitative data in order to provide a better understanding of study objectives. Evaluation design was based on triangulation of primary and secondary information collected during the study.

Figure 1: Summative evaluation data collection methodology



3.3. Sampling

All two districts are covered by the summative evaluation exercise. For quantitative data collection, multi-stage sampling was conducted in which first 6 villages were randomly selected from the list of accessible villages covered by SC MHT using probability proportionate to size and then large villages were segmented to about 100 HH in each segment and a segment was randomly selected using simple random sampling. In the selected segment HH were randomly selected using systematic random sampling. In each randomly selected HH Pregnant and Lactating women, mothers/care takers of children under five including those with Sever Acute Malnutrition (SAM) were selected for HH survey interview using structured questionnaire. Participants for KIIs were purposively selected and includes key stakeholders involved in the project such as PPHD M&E manager, DoPH MHT coordinator, SCI-AF health coordinator, community leaders and head of clinic (table 1).

Table 1: Interviews conducted during the summative evaluation

	Panjwayee	**Zherai**	**Total**
Total Operational MHT	2	1	3
Respondents			
Survey of PLW & care takers of children <5 years	65	34	99
Survey of Children with SAM	37	17	54
KII with Community leader	5	1	6
KII with Head of MHT	2	1	3
KII with SCI-AF health coordinator	1		1
KII with PPHD In-charge (M&E Manager))	1		1
KII with DoPH (MHT Coordinator)	1		1
			165

3.3.1. Secondary data collection

Desk Review: Prior to starting the field work, review of documents regarding the project, a introductory meetings were held with SCI-AF and SCJ team on the project. Post meeting, a comprehensive review of secondary documents related to the project and availed to HPRO was conducted. This involved:

- Monthly Reports August and Sep 2020
- Project Implementation Plan
- Monitoring report (provided by JPF)

Literature review was first conducted during the tool development. The documents received from the project such as applications and monthly reports were critical for understanding the context for provision of life-saving humanitarian health and nutritional services evaluation. The gathered information was used to inform our data collection tools. The evaluator also reviewed existing peer reviewed journals on the internet for developing the tools. We used the key words ("Mobile health team" or "Kandahar mobile health units" or "Kandahar health services") and ("tools" or "questionnaires") and ("Afghanistan", "Pakistan", "India", "Iran", "developing countries" or "low- and middle-income countries"). The documents were reviewed in detail and evidence on the evaluation objectives and CHS was extracted. Where possible, evidences were triangulated. However, analyses were at times constrained by the availability of secondary data.

3.4. Data collection

3.4.1. Selection and Training of Field staff

HPRO mobilized from its pool qualified field supervisor and data enumerators who have been trained on various occasions by HPRO for other studies. The supervisor is a Medical doctor and the three data enumerators are all women midwives or nurses. The training of provincial supervisor and enumerator for SCI-AF summative evaluation was conducted successfully from 18 to 20 February 2021 in Kandahar. The training facilitated by HPRO technical team. Four participants made up of one male and three females, participated in this training. The topics of evaluation approaches, orientation on SCI-AF project which was presented by the SCI-AF representative in Kandahar, role of HPRO as third party monitor, orientation on conducting a KII, household selection and survey of women and care takers of children including those with SAM, COVID-19 prevention and control measures, research ethics, ensuring confidentiality, role of consent, and data quality presentations were presented to the participants. In addition, the data collection tools were presented separately to the participants who practically worked with the tools on Smart Phones using ODK system. Different methods, such as presentation, group work, questions and answers and practical work were conducted. Finally, the feedback was given by the facilitators regarding filling out the questionnaires and using ODK properly.

3.4.2. Project Discussion meeting with SC staff

The meeting on 21st January was held through the virtual Zoom platform among SCJ, SCI-Af staff and HPRO. The discussion points were:

- Ground operations and areas currently served considering the Covid situation and insecurity of districts
- Selection criteria for districts
- Coordination and monitoring with PHD and district health department
- Information on community awareness campaigns,
- Issues around sustainability

3.4.3. Field data collection

Data collection was conducted from 21 February to 5 March 2021. The data collection team faced challenges in reaching to the villages that were covered during earlier months by SCI-AF due to the volatile insecurity situation and new villages in Zherai and Panjwayee districts that were exposed to SC MHC for only two to three months were subjected to data collection. An ODK based cloud mobile data collection platform "Kobotoolbox" was used for the data collection and storage. Digital data collection tools were designed in a manner that ensured receipt of quality data to the system. All possible validation measures were taken into account while designing the tool. Data collectors were sent pop-up alerts when submitting invalid data and they were prevented from submitting incomplete or invalid data. To analyze and visualize the data, a dashboard was designed which also pointed out errors in the data.

The key challenge faced by the data collection team was identifying SCI-AF project beneficiaries such as SAM cases due to inconsistent coverage of MHT services and growing insecurity within districts of Kandahar. These were overcome by supervisor and field coordinator coordination with the SCI-AF project coordinator. The supervisor in coordination with SCI-AF field team included SAM cases that had received treatment from other health facilities in the area and accomplished the sampling frame for that area.

3.4.4. Monitoring and Supervision for quality assurance

A monitoring team from the HPRO Kabul office met with the data collection teams at the end of the training. The mock work of the data collectors was reviewed and many spot corrections were initiated. The study supervisor also conducted monitoring of the data collection process through on-site visits. In addition to taking such quality control measures in the data collection application, a data quality assurance officer was assigned to regularly check the data for invalidity and communicated the data related issues with the data collectors. Incorrect records were rectified or eliminated from the database. To ensure respondents' personal information confidentiality, instead of collecting their names, the application generated an auto number for each respondent formatted as (Province Code, District Code, First three letters of village name, 4-digit random number). To ensure that data collected is spatially scattered a geospatial analysis on the collected GPS point was recorded. The data that was spatially converged was scrutinized by monitors. All qualitative data collection events were audio recorded.

3.5. Data management and analysis

3.5.1. Transcription and Translation

Transcription of field notes started as soon as the data arrived in the database. The quality assurance officer reviewed field notes for completeness and made additions to the notes after

listening to the audio-recorded interviews. To get an accurate account of data from the interviews, the quality assurance officer, data manager and field supervisor had to review notes and make additions to the field notes. One translator was solely responsible for translating transcripts from Pashto to English. The quality assurance officer translated quantitative information. Verbatim transcripts were created from the recordings using a standardized transcription protocol. Transcripts were translated into English, and used for analysis.

3.5.2. Coding of data

The questionnaires were coded with information such as: district name, village name etc. The study team developed coding rules for all the situations and applied them consistently. The coding issues were pertaining to missing information, ambiguous information and details of responses disconnected from choices selected by respondents. The data files were cleaned for errors. The data manager checked thoroughly the data file to ensure that all responses are within the valid range. Invalid entries were rechecked with the electronic database and based on consensus within the team, observations were replaced with valid numbers. Once questionnaire data was coded, the data was entered into an electronic file of access spreadsheet so that this file that can be easily imported into a data analysis software program.

3.5.2.1. Qualitative

Some identifiers such as KII interview name used in the study were put in hidden folders since we no longer need this information as we wanted to eliminate the possibility of linking responses on the electronic file to individuals. During the study respondents were given opportunity to provide written comments at the end of the questionnaire. The responses were coded according to the type of comment that was made. The open-ended comments were coded and the data was entered electronically in the access program.

The research objectives and research questions guided data coding for qualitative data. The key themes were developed based on the objectives of the evaluation. The sub-themes were generated using the relevant research questions. These were priori codes that guided the categorization of the data. As new sub-themes emerged, those were also coded as new codes. The quality assurance officer and data manager provided support to the team during transcription of field notes. After the transcription of field notes, a quality assurance officer worked on the organization of field notes. The field notes and transcribed interviews were organised by respondents and type of data collection method (KII). Data was organised by main folder and sub folders and then started coding of data. A deductive thematic analysis was conducted with the transcripts using the qualitative data analysis software. For the coding process, first priori codes were developed based on the existing themes. Priori codes provide a general framework for major themes and subthemes that were generated later through an iterative process. Then, the technical lead had to review transcribed notes multiple times so they could label or group certain areas in the dataset. The quality assurance officer and field coordinator team looked for similar views and opinions and group them together to support a particular theme.

3.6. Data analysis

3.6.1. Quantitative

For quantitative data analysis, data was first run for missing values, double entries in STATA 14. Data was recoded for certain values and new variables were generated. During data analysis of quantitative data, data issues of type I and type II errors were assessed. The

quantitative information was compiled to generate ratios and figures. In this study only univariate analysis was conducted, mainly in the form of frequencies and percentages.

3.6.2. Qualitative

For analysis of qualitative data, the technical lead used ATLAS.ti software version 1.0.50 (282). To ensure a link is established between major and sub themes, several analytic themes were grouped under one major theme. Grouping of sub themes took place by reviewing their meaning in relation to the major themes. The major themes were: 1. beneficiary Demographics, 2. Program functioning 3. Project Management, 4. Complaint management and Beneficiary satisfaction 5. CHS compliance. Sub themes were generated under each major theme based on the objectives stated in ToR. The purpose was to group themes in a hierarchical structure. Sub themes were placed under each major theme in a way that supports the major theme.

Eventually, a core set of codes was prepared and used to further support analysis and interpretation of data. After organization and transcription of data, systematic analysis and interpretation of qualitative data followed the analysis process. In addition, when reading text under the themes and adding thoughts and ideas about a particular theme, evaluator tried to identify and assess the relationship between different variables. Similarities and difference between the themes and determined how they interact with each other was assessed. In addition, while presenting views from different respondent groups, "Verbatim" quotes were added to further support a particular theme or argument.

4. Limitations

There were various limitations to this study, which are listed below.

Transcribing and Translation: In order to comply with quality assurance of data, some recorded interviews had to be discarded and repeated interview, transcription and translation again on the KII's. This delayed the overall analysis. In order to comply with quality assurance of data, the transcription and translation was discarded and interview repeated again on the KII's. This delayed the overall analysis.

Duration: This was short term study with overlapping evaluations of other JPF projects. This limited the in-depth data analysis, interpretation, desk review and triangulation of data.

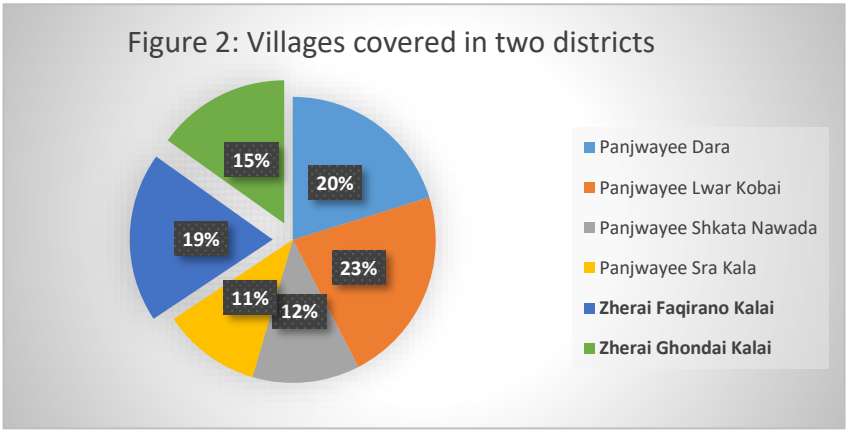
Short period of exposure of the communities to the SC MHT services: The villages that were targeted by the SC MHT services at the outset of the project had to be replaced, due to active fighting, by villages located in secure areas close to the Kandahar city. The MHT started its activities in these new villages in December 2020. Field data for this evaluation was collected from the villages that were recently targeted by the SC MHTs and by the time of the evaluation there was limited exposure of the communities to the MHT services. While the SC project serves both male and female but this evaluation especially the household survey only evaluated mothers' voices. The quantitative survey was planned in such a way that would ask a random sample of respondents in the coverage area of the SC MHT to recall services they received when they were pregnant for their youngest child. The age of the youngest child at the time of the survey as reported by the care taker was (Mean 14.7 SD 8.6) months. Therefore, only a very small proportion of the respondents in the sample were eligible for the ANC/PNC services provided by the MHT. So, the low coverage of services are due to the short period of exposure of the communities to the SC MHT services and the way the survey was planned and conducted. Our data collectors confirmed that many cases were new to the area and

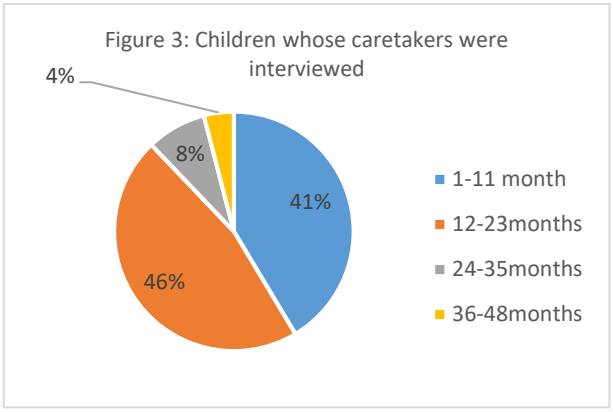
they had received cards for SAM when they were in initial places, but from the time they were displaced they had not received treatment/materials.

5. Key Findings

Sections 3.1 to 3.5 present the findings of analysis against the key thematic areas presented in Chapter 2 (Methodology). Reference was also made to link the findings with the project's stated outcome and CHS framework. As discussed in Chapter 2 (Methodology), the findings draw primarily from the in-depth analysis performed through an extensive review of policies around BPHS/MHT, project documents and primary data generated from the field.

This section presents the findings under two large themes followed by sub thematic areas. Headline findings are presented as bold (and numbered) statements and the supporting findings are presented as sub sections with additional paragraphed text. Evidence sources are highlighted (mainly through footnotes)





5.1. Demographic Profile of Women

A total of 99 PLW and care takers of children under five, who were selected by rigorous stratified random selection in the catchment areas by SCJ MHT, were interviewed during the household survey. Of these 66% were interviewed in 4 villages in Pajwayee district and 34% in 2 villages in Zherai district. The women populations were disaggregated by three sub age categories by 10-year age groups. The large proportion of women beneficiaries in the study were in 25-34 age group (51%). The proportion of this age group was higher in Zherai district (56%). Almost of all the women in the study group were illiterate (96%) lacking any formal or religious education. Similarly, all beneficiaries were married and only 1% of the sample was widowed. None of the women were employed and hence all were housewives (99%).

Table 2: Demographic Characteristics of Study Women

Respondent Women Age	Overall N=99		Panjwayee (n=65)		Zherai (N=34)		Education		Marital status		Employment	
							Illiterate	Religious studies	Married	Widow	Housewife	Tailor
15-24	19	19%	14	22%	5	15%	100%		100%		100%	
25-34	51	52%	32	49%	19	56%	96%	4%	98%	2%	98%	2%
35-45	16	16%	10	15%	6	18%	94%	6%	100%		100%	
Don't know	13	13%	9	14%	4	12%	13%		100%		100%	

5.2. Service Provision and utilization

Review of the HMIS data revealed that between June 2020 and Feb 2021 a total of 22,787 consultations were provided to the target population by SC MHT. These services included ANC, PNC, Screening for acute malnutrition and general OPD (table 3).

Table 3: services provided by the three MHTs (source MoPH HMIS)

MHT	Period	ANC	PNC	Screening for acute malnutrition in < 5	< 5 female	< 5 male	> 5 female	>5 male	Total OPD
Panjwaye 1 MHT (10064)	1 June 2020- 28 Feb 2021	495	145	337	1210	1349	3808	1549	**7916**
Panjwaye 2 MHT (10065)	1 June 2020- 28 Feb 2021	824	198	536	1523	1666	2050	2205	**7444**
Zherai MHT (10063)	1 June 2020- 28 Feb 2021	599	136	397	753	885	4037	1752	**7427**
Grand total		**1918**	**479**	**1270**	**3486**	**3900**	**9895**	**5506**	**22787**

Table 4 presents number of and proportions of people in the survey sample who reported to have utilized one or more of the MHT services. Overall, 46% of the study participants reported to have received at least one service from the SC MHT (table 4).

Table 4: Proportion of participants who reported receiving services from SC MHT

Services	denominator	Numerator	%
ANC (mothers of under five children)	99	4	5%
PNC (mothers of under five children)	94	1	1%
BF Counseling	94	25	27%
Vaccination of children	87	8	9%
Caretaker sought treatment for diarrhea	19	6	32%
Caretaker visited MHT for SAM	54	16	30%
Beneficiary received at least one service from SC MHT	99	46	46%

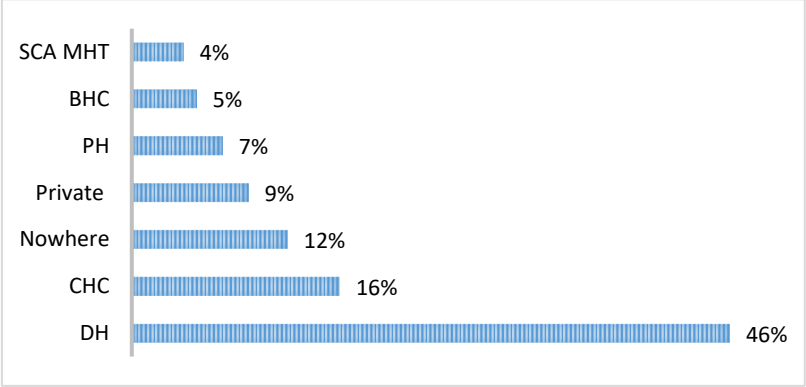
2.1.1 Maternal Health

The principal objective of assessing maternal health was to measure the beneficiary responses in light of SC project outcome for improving access to gender-sensitive primary health services and psychosocial support. Maternal health services were evaluated on two areas of ANC and PNC services.

2.1.2 ANC

The ANC services were availed at district centre health facility (47%) followed by CHC (17%) where a small percentage utilised SC MHT services (4%), and 12% of study participants did not seek ANC (figure 4). Further analysis of the ANC data showed that 10% of the participants in Panjwayee district received ANC services from the MHT while zero in Zharay district. ANC and PNC utilization from the MHT is very low in both districts because the service provision in the surveyed area had only started in December 2020 against the original plan of April 2020 due to conflict and the need to shift Service Delivery Points (SDP) and hence most of the mothers of children < 2 were not eligible for ANC and PNC services during the short period of exposure to the SC MHT services. The quantitative survey was planned in such a way that would ask a random sample of respondents to recall services they received when they were pregnant for their youngest child. The age of the youngest child at the time of the survey as reported by the care taker was (Mean 14.7 SD 8.6) months. Therefore, only a very small proportion of the respondents in the sample were eligible for the ANC and PNC services provided by the MHT. So, the low coverage of services are due to the short period of exposure of the communities to the SC MHT\ services and the way the survey was planned and conducted.

Figure 4: ANC health facility availed by study participants (n=99)



The one–to-one counselling on nutrition, health check-ups and self-care was provided as a package of services under ANC and it was evident that study participants received it, and group counselling. See table 5.

Table 5: Type of ANC counseling received by women

	Overall n=98	SC MHT n=4
One on One counseling	82%	100%
Group counseling	22%	25%
Meditation	1%	0%
None	3%	0%
Media	2%	0%
Other	5%	0%

2.1.3 PNC

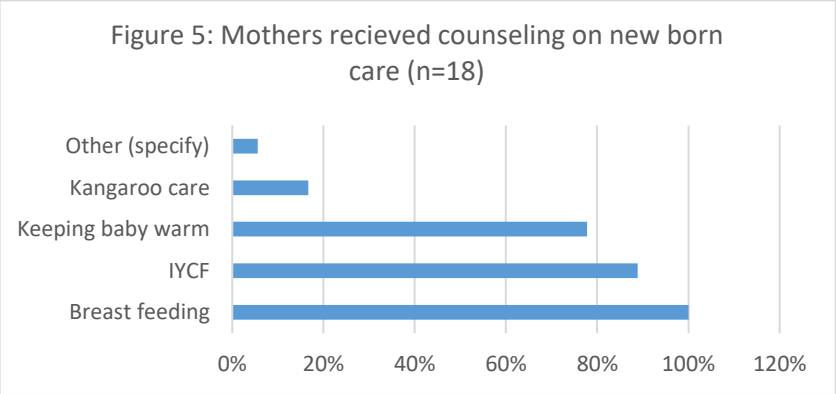
Post-natal care to be initiated within minutes after birth and continues after the discharge of mother till minimum of 6 weeks of monitoring at home. In Afghanistan less than half of the mothers and neonates receive required clinical monitoring within the health facility and even lesser at home (35.1%) [11,12]. The continuum of post-partum and new born care guidelines by UNICEF and WHO highlights the necessity of frequent follow-up visits by either community health workers or primary healthcare staff. The study findings showed that a quarter of respondents received check-ups after child birth (25%) at a health facility or at discharge from hospital. Out of these who received postpartum care, one respondent received care from a SCI-AF midwife.

2.1.4 New born care and Child health

New-born care was measured on awareness and practices related to IYCF including the source of information; health seeking behaviour for new-born related illness. The questions were concerned with the following:

- Information received on neonatal care
- Breastfeeding practices
- Kangaroo mother care
- New-born illness and referral mechanism

It was evident that women who received clinical examination post birth, also received information pertaining to kangaroo care keeping baby warm and breastfeeding and general IYCF. Out of one fourth of the study respondents who received postpartum care, 18 (70%) received the



[11] Jhpiego, USAID, and UNICEF. Publication. *Afghanistan National Maternal and Newborn Health Quality of Care Assessment 2016*. Baltimore, Maryland: Jhpiego Corporation, 2017.

[12] Afghanistan Health Survey 2018 MoPH KIT

essential new-born care related information and the most common source was from midwives followed by treating doctor. Among these 18, one (5.6%) received counselling from a SC MHT midwife.

The breastfeeding practices were assessed on three areas:

- Early initiation of breastfeeding (EIBF)
- Feeding of colostrum
- Exclusive Breastfeeding (EBF)

World Health Organization (WHO) recommends mothers start breastfeeding their infants within the first hour after birth and exclusively breastfeed them for the first 6 months of their life[13]. Breastfeeding decreases the infant's risk of developing diarrhoea, otitis media, and obesity as well as being a cost-effective intervention that decreases morbidity and mortality in the infant[14]. Research studies highlighted that delaying feeding for just one hour after birth can increase a child's chance of dying by 30 per cent in the first weeks after birth[15]. Studies have revealed that initiating breastfeeding within the first hour after birth decreases the infant mortality rate from 19–22%[16]. The delay in breastfeeding initiation practices can be correlated to limited awareness on IYCF received during post-natal period. In the survey, less than half of the women respondents suggested initiating breastfeeding within one hour and the rest did within 24 hours over to 2-3 days. This is the same tendency revealed by National Nutrition Survey 2013, which shows 69% of women nationally reported early initiation of BF within one hour and 88% within 24 hours.

Exclusive Breast feeding (EBF) is widely practiced in Afghanistan due to cultural norms and acceptability. A study has highlighted varied socio-physiological factors linked to EBF such as child gender, number of children, normal deliveries versus caesarean section[17]. A large number of our study respondents gave colostrum to their youngest children (90%). This can be correlated to EBF and most of the respondents claimed practicing the same (98%) (table 6). The key source of information was MHT staff (27%) .

Table 6: Colostrum and EBF practices

Parameter	**N**	**%**
Fed 'colostrum' (yellowish thick milk) to your baby	85	90%
While EBF you did not give any other liquids besides breast milk, including water	92	98%
(For how many months did you exclusively breastfeed		
0-2	0	0%

[13] Horta BL, Victora CG. Long-term effects of breastfeeding: A systematic review. World Health Organization. 2013 [cited 2019 Aug 18]. Accessed from: https://www.who.int/maternal_child_adolescent/documents/breastfeeding_long_term_effects/en/.

[14] Rajeshwari K, Bang A, Chaturvedi P, Kumar V, Yadav B, Bharadva K, et al. Infant and young child feeding guidelines: 2010. Indian Pediatr. 2010;47(12):995–1004.

[15] UNAMA. "WORLD BREASTFEEDING WEEK SPOTLIGHTS ISSUE OF NUTRITION OF AFGHAN INFANTS." *UNITED NATIONS ASSISTANCE MISSION IN AFGHANISTAN*, August 2013. https://unama.unmissions.org/world-breastfeeding-week-spotlights-issue-nutrition-afghan-infants.

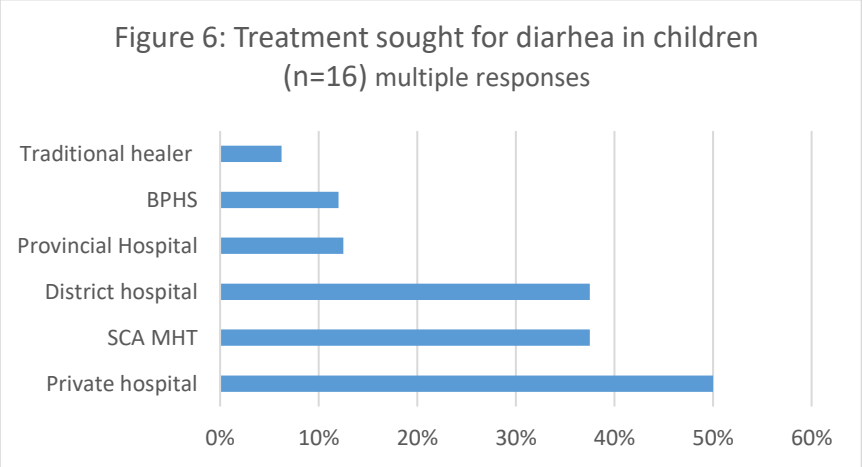
[16] Jamei F, Ostovar A, Javadzade H. Predictors of exclusive breastfeeding among nulliparous Iranian mothers: Application of the theory of planned behavior. Int J Pediatr. 2017;5(3):4457–67.

[17] Rahimi, Bilal & Mohamadi², Enayatullah & Stanikzai, Muhammad & Wasiq, Abdul & Khan, Mirza & Chc, Qalacha & Head, & Kandahar, Afghanistan. (2020). Determinants of Exclusive Breastfeeding Practices in Kandahar, Afghanistan: A Cross-Sectional Analytical Study. 10.22038/ijp.2019.42987.3601.

3-5	0	0%
6-8	93	97%
9-11	0	0%
12-14	1	1%

Only a small number of study participants stated facing new-born complications (8%) and the chief complaint was respiratory infections. Data from the study highlights that referral for new-born chest infections were made by BPHS, EPHS or private midwives. However, referrals to higher health facilities were zero. Further in-depth discussion with the HPRO field supervisor and team revealed that most of the mothers in the study delivered at one of the BPHS or EPHS health facilities and upon discharge they are told to reach out to the MHT if they face any complication. The families were told at these HFs that the quality of services and medicine provided by the MHT are of good quality.

The other common ailment cited by study participants was diarrhoea, with one fifth (19) of the respondent's experiencing diarrhoea among their children in the past two weeks of the data collection period. Of these the caretakers sought care for 16 (84%) of children with diarrhoea. When asked about where they sought care; half reported seeking care from private providers, more than a third approached the SC MHT. (Figure 6).



2.1.5 Vaccination

Mthers were asked if their youngest child had been vaccinated, 89% reported their youngest child was either fully or partially vaccinated. 9% reported they were vaccinated at the SC MHT.

2.1.6 Nutrition

5.2.1.1. Awareness and perceptions about breast milk

According to studies by the United Nations, about half of Afghan children are not breastfed. Health experts in Afghanistan also highlight that the role of peer counselling has often been overlooked resulting in low EBF. There are various layers to breastfeeding such as predominant breastfeeding (PBF)[18], early initiation of breast feeding (EIBF)[19], continued

18 "Predominant breastfeeding" means that the infant's predominant source of nourishment has been breast milk (including milk expressed or from a wet nurse as the predominant source of nourishment). However, the infant may also have received liquids (water and water-based drinks, fruit juice) ritual fluids and ORS, drops or syrups (vitamins, minerals and medicines).

19 "Early Initiation of Breastfeeding" Start breastfeeding to new born babies within one hour from delivery

breastfeeding (CBF[20]) and introduction of solids and semi-solids (ISSS). Offering herbal drinks with breastfeeding to infants below 6 months is widely practiced in Afghanistan especially in rural communities. DHS 2015 have shown PBF rate being 69%[21]. Additionally, CBF rate is high till a child is 12 months old and it declines significantly by the second year complemented by suboptimal complementary feeding practices and high bottle-feeding rate. CBF is also affected by education of mother, urban rural disparity, wealth status of household and food security.

The study findings hint at reservation and limited information on duration of breastfeeding especially EBF and ISSS along with misconceptions related to bottle feeding (table 7).

Table 7: Awareness and perception on breast feeding on Likert scale

Parameters	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Infant formula and breast milk have the same health benefits	5%	4%	15%	68%	8%
Breast milk contains all the essential nutrients for a new-born	33%	57%	6%	4%	0%
colostrum contains essential antibodies necessary to help the child's immune system	26%	61%	11%	2%	0%
The benefits of breastfeeding are limited to a specific time period	21%	24%	36%	20%	0%
When a mother gets pregnant, she should stop breastfeeding	1%	29%	12%	58%	0%
Formula-feeding is more convenient than breastfeeding	0%	2%	18%	74%	6%
If a mother is weak after birth, she cannot breastfeed her baby	0%	3%	4%	91%	2%
It is not safe to breastfeed a baby if he/she has jaundice	0%	4%	6%	88%	2%
Formula-fed babies gain weight quicklier than breastfed infants	0%	5%	43%	49%	4%
Breast milk is the ideal food for babies	43%	57%	0%	0%	0%
Breastfeeding is more convenient than formula feeding	41%	58%	1%	0%	0%
Breastmilk is less expensive than formula	47%	50%	2%	1%	0%
Breastfeeding improves the bonding between mother and infant	50%	50%	0%	0%	0%

Table 8: Awareness and perception on breastfeeding (Beneficiaries vs non-beneficiaries)

Questions	SCI-AF	Agree/ strongly agree	Neutral/disagree/ strongly/disagree	P-Value
Infant formula and breast milk have the same health benefits.	Non-Beneficiary	6	94	0.202
	Beneficiary	13	87	
Breast milk contains all the essential nutrients for a newborn.	Non-Beneficiary	87	13	0.271
	Beneficiary	93	7	
Fella/colostrum contains essential antibodies necessary to help the child	Non-Beneficiary	83	17	0.223
	Beneficiary	91	9	
The benefits of breastfeeding are limited to a specific period of time.	Non-Beneficiary	47	53	0.713
	Beneficiary	43	57	
When a mother gets pregnant, she should stop breastfeeding.	Non-Beneficiary	28	72	0.816
	Beneficiary	30	70	
	Non-Beneficiary	2	98	

20 "Continuous Breast Feeding" Mothers who continue to breastfeeding after six month to 24 months

21 Abul-Fadl, A.M. & Nishtar, Noureen & Al-Yassin, Samaah & Al Jawaldeh, Ayoub. (2019). Status of Breastfeeding in the Central Asian Countries of Eastern Mediterranean Region. http://www.mcfcare.org/journal/Review/RV_15_5.pdf. 10.6084/m9.figshare.8940167.

Formula-feeding is more convenient than breastfeeding.	Beneficiary	2	98	0.919
It is not safe to breastfeed a baby if he/she has jaundice.	Non-Beneficiary	0	100	0.028
	Beneficiary	9	91	
Fella/touch should not be given to the baby.	Non-Beneficiary	6	94	0.38
	Beneficiary	2	98	
Formula-fed babies gain weight more quickly than breastfed infants.	Non-Beneficiary	4	96	0.533
	Beneficiary	7	93	
Breastmilk is the ideal food for babies.	Non-Beneficiary	100		
	Beneficiary	100		
Breastfeeding is more convenient than formula feeding.	Non-Beneficiary	98	2	0.349
	Beneficiary	100	0	
Breastmilk is less expensive than formula.	Non-Beneficiary	96	4	0.643
	Beneficiary	98	2	
Breastfeeding improves the bonding between mother and infant.	Non-Beneficiary	100		
	Beneficiary	100		

5.2.1.2. Severe Acute Malnutrition

Malnutrition is an indicator of social and political instability as it represents a multifaceted problem linked to poverty, food insecurity, and poor hygiene and health. Afghanistan has one of the world's highest rates of stunting in children under the age of five: 41 percent[22]. Almost four out of every 10 children under five years of age in Afghanistan (37%) are stunted and one in ten children (9.5%) are wasted. Malnutrition is considered a key determinant of morbidity and mortality among children in Afghanistan. It potentiates the risks of death by approximately 45% among children (WHO, 2016). The period from birth to 24 months is known as the critical window for the physical, intellectual, and behavioral growth of infants and young children. After the age of 2 years, it is impossible to reverse the negative consequences of malnutrition resulting from inappropriate breastfeeding and complementary feeding practices among infants and young children. High levels of chronic stunting and wasting linked to prevalent acute malnutrition is indicative of chronic nutritional deficiency among under five Afghan children.

In this study sample, 54 (55%) of participating mothers had SAM children, most of whom fall under the age group of 0-23 months (90%). Overall, 30% of the SAM cases utilized the MHT services for SAM children. (table 9).

Table 9: SAM children coverage in the summative evaluation by SC MHTs and overall

child age group (months)	SAM cases (N)	%	SAM cases reported they visited SC MHT	%
0-11	22	40%	7	32%
12-23	27	50%	7	26%
24-35	3	6%	1	33%
36-48	2	4%	1	50%
Total	54		16	30%

[22] UNICEF. "Nutrition." UNICEF Afghanistan, January 21, 2021. https://www.unicef.org/afghanistan/nutrition.

Out of total SAM cases, household visits were performed for 33% of cases (17 out of 54). . It was evident from the data that MHT health staff were complementing BPHS health staff in monitoring and continuum of SAM care. Close to half of the household visits of SAM cases were performed by SCI-AF MHT staff. Eight out of the 17 (47%) SAM cases were visited by the SC MHT staff at home. The visit to household varies from once a week to once a month and exhibited compliance to SAM assessment guidelines. However, RUTF, Vitamin A and deworming were supplied to less than half of SAM cases. The various reports by agencies working in nutrition space in Afghanistan indicated the supply and procurement issue with RUTF which is a roadblock to addressing SAM needs[23].

Seven out of 54 study respondents having SAM mentioned edema in the feet. The data analysis of seven cases highlights only two cases received vitamin A, four cases deworming, one case RUTF and none was hospitalised. Overall, 89% of the caretakers for SAM children reported to have received IYCF counselling. The results were almost similar for the SC MHTs.

Table 10: Treatment received by SAM and oedematose cases

Treatment received by SAM children					**Treatment of edematose SAM children**			
	Overall		**By SC MHT**		**Overall**		**By SC MHT**	
Vitamin A	34	63%	11	69%	2	29%	0	0
Deworming	26	48%	7	44%	4	57%	0	0
RUTF/RUSF	14	26%	5	31%	1	14%	0	0
Nothing	18	33%	5	31%	3	43%	0	0
Mothers received IYCF counseling	48	89%	15	94%	7	100%	0	0
Denominators	54		16		7		0	0

[23] Gallagher, Maureen L, Martin Ahimbisibwe, Muhebullah Latifi, Zakia Maroof, Said Shamsul Islam, and Mursal Manati . "One UN for Nutrition in Afghanistan - Translating Global Policy into Action: A Policy Shift to Tackle Wasting." Field Exchange 63, June 2020. https://www.ennonline.net/fex/63/afghanistannutritionglobalpolicy.

5.3. Complaint Management System and Beneficiary Satisfaction

5.3.1. Complaint management

Study participants were asked if they knew about where and whom to complain to if they have any; 77% did not know about such a mechanism, 22% said they never had a complaint and one said yes. The results were slightly different in the 46 participants who reported to have used at least one service of SC MHT. Among the 46 who had used SC MHT services, one person said she knew and cited SC MHT staff as the focal point for complaint raising. The rest 61% did not know about the mechanism and 37% said they never complained. Table 11 present results on awareness about complaint redressal mechanism.

Table 11. Awareness of the complaint redressal system

	Aware of where to complain if any							
	Yes		No		Never complained		Total	
Used SC services	1	2%	28	61%	17	37%	46	100%
Did not use SC service	0	0%	48	91%	5	9%	53	100%
Total	1	1%	76	77%	22	22%	99	100%

5.3.2. Beneficiary satisfaction

The satisfaction was measured using confirmatory statements on five points Likert scale on following aspects. All the 99 study participants (including 46 who had received at least one service from SC MHT) were asked questions about their experience of the services they received

- ANC, PNC, Immunization, Child service, psychosocial counselling and nutrition services meeting expectation
- Behavior of SCI-AF staff
- Attitude of SCI-AF staff
- Gender sensitive to women needs.

Overall satisfaction score is 66% including those who never received services from SC MHT. The satisfaction was lower for psycho-social counselling and nutritional services. The participants were less satisfied with the behavior and attitude of the staff and with gender sensitive services (table 12).

This table however presents results for all study participants irrespective of whether they received the SC MHT services or not. The table 13 presents segregated results for those participants who received any of the SC MHT services and those how did not.

Table 12: Study participants' satisfaction score

Parameters N=99	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Antenatal services provided by MHT are meeting expectation of clients	8%	68%	21%	3%	0%
Post Natal services provided by the MHT are meeting expectation of clients	9%	67%	16%	8%	0%
Immunization services provided by the MHT are meeting expectation of clients	6%	54%	27%	12%	0%
Child health services such as diarrhoea and respiratory illness management are meeting expectation of clients	5%	59%	28%	8%	0%
Psychosocial counselling services provided by MHT meets expectation of clients	4%	57%	28%	11%	0%
nutrition related services such as management of SAM cases provided by MHT meets expectation of clients	6%	54%	30%	10%	0%
Health worker behaviour is very good	4%	60%	11%	21%	4%
Health worker attitude is very good	5%	58%	11%	22%	4%
Health workers are sensitive to gender needs of women	12%	51%	21%	15%	1%
TOTAL Average	**7%**	**59%**	**21%**	**12%**	**1%**

In the table 13 below satisfaction categories were collapsed to two (one group = strongly agree and agree and the other group= neutral, disagree and strongly disagree) and then compared between those who used at least one of SC MHT services and those who did not at all.

As can be seen from the table 13, people who used SC MHT services are much more satisfied than those who never used MHT services. This may mean they never used the services or that they used services from other facilities but are less satisfied with those.

Table 13: Satisfaction of study participants (who received SC services vs who did) not receive)

Parameters	Received SC service No (n=53) Yes(n=46)	Strongly Agree/ Agree	Neutral /Disagree /Strongly Disagree	P Value
ANC services provided by MHT met expectation of clients	No	60%	40%	<0.01
	Yes	93%	7%	
PNC services provided by the MHT met expectation of clients	No	60%	40%	<0.01
	Yes	96%	4%	
Immunization services provided by the MHT met expectation of clients	No	36%	64%	<0.01
	Yes	91%	9%	
Child health services such as diarrhea management, respiratory illness met expectation of clients	No	40%	60%	<0.01
	Yes	93%	7%	
Psychosocial counselling services provided by MHT met expectation of clients	No	34%	66%	<0.01
	Yes	91%	9%	
Nutrition services such as management of SAM cases provided by MHT met expectation of clients	No	36%	64%	<0.01
	Yes	89%	11%	
Health worker behavior is very good	No	45%	55%	<0.01
	Yes	87%	13%	
Health worker attitude is very good	No	43%	57%	<0.01
	Yes	87%	13%	
Health workers are sensitive to gender needs of women	No	42%	58%	<0.01
	Yes	89%	11%	
Overall	**No**	**44%**	**56%**	
	Yes	**91%**	**9%**	

Community leaders interview show a high level of satisfaction with the MHT services as one of the community leader puts it:

> *We are 100% happy with the program. The medicines they bring here, they give them to women and children. …….. We did not feel that they do no give us the medicines (means they give us). They behave with us properly. They told us about their mission as well.*

Another elder states:

> *You (SC MHT) have done very good with us so we are so happy. These doctors have freed us from the disease.*

5.4. Project Management

Different categories of stakeholders such as community representatives (community leader), MHT Head, SCI-AF staff members, PPHD were interviewed to explore and understand various aspects of project management. A total of 10 KIIs were conducted. Responses obtained from them have been categorized into the following thematic areas.

5.4.1. Coordination with key stakeholders

The key stakeholders in the emergency health and nutrition services were provincial and district health department functionaries, district governor office, community representatives

and SCI-AF health staff. There is substantial evidence that shows close coordination with district public health office officials at different stages of the project implementation. The interview with MHT coordinator at DPHO and review of project monitoring reports suggests officials with SCI-AF team were jointly communicating on developing MHT selection area (white areas), monitoring visits and challenges related to implementation. However, DPHO flagged the issue of SCI-AF poor active participation during the monthly team meetings despite their regular presence, such as in PHCC or PHO, providing limited sharing of information on project updates with them, while SCI-AF mentioned sharing project achievements in PHCC. The conflicting information from the two sources might show that there are issues other than coordination such as over expectation from the project. But that could not be identified through the evaluation. PPHD M&E manager was convinced that the health administrators of the districts monitored mobile teams regularly and got feedback from the services they provided.

> *"The SCI-AF also come to our monthly PHC meetings and in case if an issue happens, when the war has taken place in ZHERI and PANJWAI Districts, so they were not able to work out of fear, And a meeting for this issue was held, which was a few months ago, and then we were continuing the services along with these teams who are now back in their district. Yes, it has been done."*- PPHD In-charge

Community leaders played a pivot role in mobilisation of local resources necessary for program implementation. Community was largely involved in planning of sites and location for MHT consultation whether it is tent or a community hall. Community leader worked as a bridge between SCI-AF and households for communication about scheduled visits or issues pertaining to MHT service provisioning.

> *"We bring people together. We have provided space for the team. If there is a controversy, we will prevent it. If doctors have a problem at the clinic or at the village level, we solve it."*- Community Leader

Internally, meetings between the Save the Children's office in Tokyo and Afghan office were held monthly and the medium of communication was primarily by email.

5.4.2. Internal Monitoring, Evaluation, Supervision, and Learning

Monitoring was implemented at three levels: stakeholder-based monitoring involving provincial, districts and community actors; monitoring of beneficiaries by SCI-AF staff; SCI-AF staff monitoring by project coordinator and SCJ.

A clear guideline for monitoring and evaluation were laid down as narrated by MHT head. The satisfaction of the beneficiaries who received the services from these three mobile teams was monitored by a SCI-AF MEAL team. The MEAL team visited the site daily and conducted face to face interviews with beneficiaries along with the focus group discussions and prepared reports and shared it with the SCI-AF officials. If there were any problems in the services pointed out by the people or the beneficiaries, then it was shared with the responsible officials in the SCI-AF office and in this way the quality of services were ensured.

> *"The quality of service is determined by three things: 1. Our clients are increasing day by day. 2. Patients we call for a second time ask them if our services have improved your life and*

health.3. Patients say that clinical medicine (medicine provided by public health facilities) *is more effective than the market* (People get from private pharmacies)."-Head of Clinic

PPHD was equally involved in monitoring of MHT service delivery occasionally and the gaps were shared with SCI-AF team through feedback reports.

> *"Yes, there were some medicines shortages with teams and some important tools that were not available, we shared the full feedback report with them. there were some problems in the vaccine section and registration section. We reported these problems to them and they implemented them as soon as possible."*-PPHD In-charge

PPHD was equally involved in monitoring of MHT service delivery occasionally and the gaps were shared with SCI-AF team through feedback reports.

5.5. Achievement of Project outputs

The project was able to accomplish access to gender-sensitive primary health services to 29,578 IDPs, returnees, and residents in the host communities but slightly fall short on provisioning of psychosocial services due to several uncontrollable environmental factors detailed out in 3.5. The project also achieved against planned targets, with many cases beyond the original targets, for screening and treatment of acute malnutrition among PLW and children under five years of age, in addition to IYCF counselling. Comparing the data captured by SCJ with HMIS data recorded at MoPH, slight variation in data was observed which can be attributed to the different ways the two mechanisms counted clients. The MoPH HMIS usually excludes beneficiaries that are provided OPD services at second time for the same condition while the SCJ MIS may have counted every OPD consultation as a new case. (Table 14)

Table 14: Project achievements against LFA outputs

Provide emergency health and nutrition services to IDPs, returnees, conflict-affected people, and children in particular, among vulnerable populations, in two districts of Kandahar Province (Zhari and Panjwayi) and improve their access to health and nutrition services

Outcome	Output indicators	Zhari		Panjwayi		Overall			as per MoPH HMIS	Remarks
		Target	SCJ MIS	Target	SCJ MIS	Target	Achieved	%		
1. 27,000 IDPs, returnees, and residents in the host communities will have access to gender-sensitive primary health services and psychosocial support.	1.1 Number of health consultations provided by emergency mobile health and nutrition teams	12,375	11,500	24,750	32,867	37,125	44,367	120%	22,787	
	1.2. Number of children under the age of five who have received treatment for acute respiratory infections, diarrhoea, or malaria	1,493	1,645	2,987	6,051	4,480	7,696	172%	NA	
	1.3. Number of individuals who have attended psychosocial support (in individual or group sessions) 2 or more times	577	299	1,156	522	1,733	821	47%	NA	The root cause of not reaching to the estimated target is due to ongoing conflicts.
	1.4 Number of community awareness raising campaigns on nutrition and health: Six	2	2	4	4	6	6	100%	NA	
2. Children under the age of five and pregnant and lactating women (PLW) will be screened for malnutrition and those with acute malnutrition will be	2.1 Number of children under the age of five and PLW who have been screened for malnutrition: 4,886 children and 2,052 PLW.	1628	2205	3258	7214	4886	9419	193%	7386	Children
		684	891	1368	2342	2052	3233	158%	NA	PLW
	2.2 Number of children aged six to 59 months who have been diagnosed with severe acute malnutrition (SAM) and have been enrolled in the Integrated	129	168	258	279	387	447	116%	NA	

treated. Better access to information on nutrition services and care will prevent maternal and child malnutrition.	Management of Acute Malnutrition (IMAM) program: 387 children.									
	2.3 Number of PLW who have received infant and young child feeding (IYCF) counselling	576	2195	1152	2936	1728	5131	297%	NA	
	2.4 Number of PLW and children under the age of five who have been provided with and consumed micronutrient supplements	684	826	1368	7321	2052	8147	397%	NA	PLW
		514	1402	1028	10234	1542	11636	755%	NA	Children

5.6. Challenges and limitation

The key challenges faced by the project during implementation were:

- Access limitation to the previous service delivery points (SDPs) identified in collaboration with health partners and Kandahar PPHD due to the ongoing conflicts and IEDs in Zhari and Panjwai districts with hundreds of direct beneficiaries dropping-out.
- Turn-over of front-line (MHT) staff due to security concerns and COVID-19.
- Most of the selected SDPs inside the villages were took over by IDPs displaced due the ongoing conflicts. Between the first and second visit, the teams were supposed to find another SDPs at the same village

5.7. CHS compliance

CHS1: Communities and people affected by crisis receive assistance appropriate and relevant to their needs.

Kandahar is struggling on several grounds such as the presence of anti-government forces, refugees, displaced populations, and other factors including poverty. Kandahar also has the highest IMR, under-5 mortality rate along with acute malnutrition in the country. In order to achieve Universal Health Coverage (UHC) the Afghanistan MoPH introduced the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The BPHS includes district hospital that covers about 100,000-300,000 people, a Comprehensive Health Centre (CHC) that covers 30000-60,000 people a Basic Health Centre (BHC) that covers 15000-30000 people a Sub Health Centre (SHC) that covers about 15000 people[24]. Considering the fact that basic health centres (BHC) and SHCs are under-utilized, the rationale behind inclusion of Mobile Health Teams (MHTs) in the MOPH policy was that establishing more BHCs/SHCs in remote areas would result in the creation of more underutilized health facilities. A better alternative is therefore to create mobile health teams, such as provided by this project,which are considered to be more effective in terms of increasing access to health services and are more feasible.

CHS2: Communities and people affected by crisis have access to the humanitarian assistance they need at the right time

The emergency health and nutrition services by project complemented coverage to some extent in the areas where is no basic health services and for IDPs of two districts of Kandahar. The MHTs provided a total of 44,367 OPD consultations through the three MHTs. In the wake of the high demand for basic health and nutritional services, the introduction of MHT by the project was timely. However, the service provision was not consistent; the target areas for MHT had largely shifted once due to conflict and active fighting. In November of 2020 the services were downsized in more remote areas due to insecurity and resumed in December 2020 in the areas near to the Kandahar city which were secure. Therefore, access to services were reduced in the remote areas. Nonetheless, the remote villages had negligible access to health services prior to SC MHT and planned project targets were exceeded excluding

[24] Basic Package of Health Services Guideline MoPH

psychosocial support that were challenged by insecurity. Additionally, the demand for malnutrition screening, referral and treatment was high which the project was able to address partially mainly due to insecurity and active conflict.

CHS3: Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action

The awareness session on nutrition and counselling on IYCF within the community generated awareness and presumably improved health seeking behavior. This also generated awareness on SC MHT services, understanding on SCI-AF work and government stakeholders. SCI-AF rolled out the program through participation of community leaders and district officials which prevented building negative perceptions towards the program and SCI-AF within the community. In addition, the involvement of directorate of health in supervision and monitoring at planning and execution stage ensured gaps in supply chain or human resource were addressed as needed.

CHS4: Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them

Information provided during awareness sessions in the community was on when to seek treatment for ailment, and beneficiaries thus become aware about their entitlement for health services.

CHS5: Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.

The two layered complaint redress system was implemented as per discussion with SCI-AF and PPHD M&E officer. The two mechanisms included SCI-AF team and PPHD/ DPHO. However, respondents cited low information on the complaint redress system. Among the 46 who had used SC MHT services, one person said he knew and cited SC MHT staff as the focal point for complaint raising. The rest 61% did not know about the mechanism and 37% said they never complained. The awareness was higher among community leaders who are the gate keepers for facilitating access to services by the communities. This awareness of the elders ensured trust building among all the stakeholders and allowed for a relatively successful implementation of the project. The complaints were resolved locally with the facilitation from community leaders. The informal structure functions well in a traditional system like Afghanistan.

However, the low response (61% of those who used SC MHT services did not know about the mechanism) to awareness on existing formal complaint management system for resolving issues, highlights a gap in awareness levels among beneficiaries. The lack of information on complaint management system was also observed among government functionaries. As table 12 presents, overall high satisfaction of sample population of the study who used the SC MHT service at least once is evident comparing those who did not use any service or used other health facilities.

CHS6: Communities and people affected by crisis receive coordinated, complementary assistance

The Memorandum of Understanding (MoU) of the project has been signed with the PPHD. Reporting and supervision was part of project management cycle as per information collated through interviews and desk review. The documentary assessment and interview with provincial health department highlight that government functionaries had been made aware of the project activities on a timely basis. Approval and guidance at different stages were sought with PPHD especially during increased conflict and Covid lockdown. DPHO also coordinated visits with SCI-AF team during MHT visits.

CHS7: Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.

The PPHD interview acknowledged they monitored the activities of the MHTs and any shortcoming they identified were communicated to SCI-AF in Kandahar who immediately addressed those. SCI-AF representative in Kandahar talked about monitoring and mechanisms of communicating with communities namely the complaint box that each MHT would carry with it to the villages and an SCI-AF Kabul office-based mechanism that would collect information from the field and learn about the challenges of the program implementation.

CHS8: Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.

CHS9: Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically

The HR competency assessment, resource assessment is not covered under the scope of summative evaluation. However, the functional and active involvement of various district authorities in monitoring and supervision is a sound example of good management and efficiency as reflected in CHS8 & 9.

6. Value assessment of project intervention

Assessing project intervention using JPF evaluation framework, it can be attested that emergency health and nutrition services to IDPs, returnees, conflict-affected people, including children was highly relevant to community needs (CHS1), such intervention was timely and almost all planned outputs achieved thus effective (CHS2), exhibited impact on vulnerable population malnutrition health status (CHS3) and was implemented through coordinated efforts of stakeholders (CHS6). Henceforth, the project was well worthy of implementation.

7. Recommendations

- There has been wide awareness on EBF, continued breastfeeding (CBF) among SC women beneficiaries which fulfils the project outcome of better access to information on nutrition services through infant and young child feeding (IYCF) counselling. Futures program are encouraged to prioritise focussing on continued breastfeeding (CBF) and early initiation of breast feeding (EIBF) within the IYCF counselling. The breastfeeding practices significantly affected by infant gender in the country and therefore it is also beneficial to address socio-cultural issues with emphasis on bringing gender equality within the health promotion program for achieving nutritional goals.
- The project focused more on ANC, PNC and malnutrition screening service provision and counselling on IYCF and maternal health. However, Afghanistan has large problem of chronic nutritional deficiency which stems from acute malnutrition, inadequate dietary diversity, insufficient amounts of food, coupled with poor hygiene conditions. In given situation, incorporating into future programme or seeking collective action of humanitarian organisations in providing counselling on WASH, dietary diversity, food security targeted to women in reproductive age group will be helpful in generating more holistic and long-lasting effects that the project alone cannot address.
- Providing service in conflict and volatile settings can be disrupted anytime by active fight and this is more so for fixed medical facilities than mobile health service provisions. No immediate prospect on stability requires flexible approaches such as mobile health service provided by this project for addressing the health and nutrition needs of the population affected by the conflict. It is essential for mobile health provision to liaise closely with host community that can generate a sense of ownership on projects and enable for the projects to secure safe space on service provision and access to timely security information.
- Community outreach and community engagement and dialogue, for identifying SAM cases need to be strengthened to improve the provisioning of nutritional services to SAM cases. The IMAM guidelines should be followed for screening in the community and referral of cases either to MHT or BPHS health facilities. Active adaptive case finding approach such as above can be integrated in the future emergency health and nutrition program.
- While it was evident in the study that sample population used the SC MHT service at least once were satisfied with all indicators including the gender sensitiveness of MHT staff, WHO gender sensitive health facilities and services guidelines for Afghanistan can strengthen the future SC's interventions further in emergency health and nutrition sector. The WHO guidelines have been developed based on the acknowledgement that Women are disproportionately impacted by gender-related barriers in accessing health services in Afghanistan due to restricted decision-making and mobility, and gender norms that prohibit interaction with males outside the family. Increasing gender-responsive health service delivery in Afghanistan would reduce barriers to access for women to gender sensitive services such as domestic violence, unwanted pregnancies, child neglect and mental health can lead to progress in achieving gender and health equity.

Annexes: Data collection tools

Confidential for research purpose only

1. Form

Beneficiary Interview: PLW/care taker of children under five

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Beneficiary Verbal Informed Consent

***Instructions for the Interviewer**: The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about food and nutrition. This information will help the SCA in improving their project work. However, there is no immediate or direct benefit to you for participating.

2.1.7 Procedures

2.1.8 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your village. If you agree, we will ask you to answer several questions availability of health services and access to health service from the MHT. We will ask you these questions in another room, without the presence of any health worker

2.1.9 Risks /Discomforts

The questions will take less than one hour to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.10 Confidentiality

2.1.11 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you or your family member. We will not tell any community member, or household member about the information you provide. All the information collected will be stored in a locked area.

2.1.12 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence. If you decided not to participate, you or your family member will get the same care that he or she would otherwise receive.

2.1.13 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? ☐ Yes ☐ No

Signed by interviewer after subject has verbally consented

1. IDENTIFICATION

Province Name: ……|_____| Province Code: …….. |__|__|__|

District Name: …… |_____| District Code: …….. |__|__|__|

Village Name: ……|_____|Code: …….. |__|__|__|__|__|

Interview ID number:

SECTION I : SOCIO –ECONOMIC PROFILE		
No	**Question**	**Code**
101	How old were you in your last birthday?	Age in completed years ☐☐ Do not know ……..99
102	What is your highest level of education?	Illiterate……..……1 Less than secondary school ……..2 Secondary school ----------3 -Bachelor's degree ----------4 Master's degree ----------5 Other(specify) ----------96
103	What is your current marital status?	Married ……..……1 Widow ……..2 Separated, not staying with husband.3 Divorced ……..…....5 Other (specify) ……..……96
104	What was your age at first marriage?	Age in completed years ☐☐ Do not know ……99
105	What is your main occupation?	Agriculture- own land ……..……1 Agriculture-labor ……....…….2 Casual labor ……..…..3 Self-employed/Business.....…….4 Service/salaried ……..…….....5 Housewife ……...……6

		Others (specify) ……..……..…….96
SECTION 2 : REPRODUCTIVE HISTORY		
201	How many living children do you have?	☐☐ ☐☐ Sons Daughters
202	What is the age of youngest child (in months)	☐☐
SECTION 3: MATERNAL HEALTH : ask these questions related to the youngest child		
301	Where did you receive antenatal care for the youngest child? (DO NOT narrate the options)	Community Health worker ----------1 SCA Mobile Health Team……2 Health Sub centre ……...3 Basic health centre.....4 Community health centre……5 District hospital …….....6 Provincial Hospital ……..……..……...7 Private hospital ……..……..8 Did not go anywhere……..9 Other (specify) ……..96
302	What kind of services did you receive during pregnancy	One –o-one counselling by counsellor……1 Group counselling by counsellor or therapist…..2 Group exercises or meditation …….3 Others (specify)…….4
303	During your pregnancy with [NAME], did you take combined iron and folic acid (IFA) supplements?	1.....Yes 2.....No 99…….DK 88.....No response
304	For how many days did you take IFA	Number of days _____
SECTION 4: NEW BORN CARE & IYCF: Instruction: Check if child is less than 24 months		
401	In what month and year was [NAME] born?	Month: |__|__| Year: |__|__|__|__|
402	Did your child receive any checkup after birth?	Yes……1

		No……2 → skip to 406	
403	Who did the check-up? Multiple response	CHW ……..…….....1 Dai ……..……....2 SCA Midwife ……..3 Nurse ……..…...4 Doctor ……5 Other (specify)…….…..96	
404	Did you receive any advice on the following for new born care? YES -1 NO-2 → [SKIP TO 406] [RECORD ALL MENTIONED]	Cord care	
		Bathing the baby	
		Danger signs of illnesses in newborn	
		Kangaroo care	
		Keeping baby warm	
		Breast feeding	
		IYCF	
		Other (specify)	
405	Who told you about new born care? [RECORD ALL MENTIONED]	Local Dai	
		CHW	
		ANM	
		Nurse	
		Doctors	
		SCA MHT health promoter	
		SCA MHT health midwife	
		Other SCA MHT staff	
		Other (specify)	
406	When did you first breastfeed your baby?	Immediately within 1 hour after birth.1 Within 24 hrs ……...2 Between 2 to 3 days …3 After 3 days ……..4 Never breastfed…5 [SKIP TO 411] Other (specify) ……96	
407	Did you feed 'colostrum' (yellowish thick milk) to your baby)?	Yes……1 No…….....2	

408	For how many months did you exclusively breastfeed [NAME]? This means you did not give [NAME] any other liquids besides breastmilk, including water. *[record # whole months. Record 88 if no response. Record 99 if she does not remember]*	Number of months |__|__|	
409	Are you currently breast feeding (Name)	Yes……1 No…….....2	
410	Who told you about exclusively 'colostrum' / breastfeeding? Yes-1 No-2 [RECORD ALL MENTIONED]	CHW	
		SCA MHT midwife	
		SCA MHT Health worker	
		Nurse	
		Doctors	
		Health worker at Health Facility	
		Local Dai	
		Friends/relatives	
		Other (specify)	
411	Was there any complication with the new born?	Yes……1 No……..2 ⟶ [SKIP TO 501]	
412	What was the complication? Yes-1 No-2 [RECORD ALL MENTIONED]	Difficulty in breathing	
		Jaundice	
		Low birth weight	
		Congenital anomaly	
		Swallowed amniotic fluid	
		Fever	
		Refusal to feed	
		Jittery	
		Convulsion	
		Other (specify)	
413	Who referred the new born to this SCA MHT?	CHW……1 Midwife ……2 Self referred ……3 Doctor ……..4 Other (specify) ---……5	

414	Was your child referred to higher facilities such as CHC/ DH/ PH/RH	Yes……1 No……...…..2 → [SKIP TO 416]
415	Who referred to Higher facilities	CHW……1 Midwife ……2 Self referred ……...3 Doctor ……..…..4 SCA MHT midwife……5 SCA MHT health worker..6 Other (specify) ---……7
416	Have you received any information related to feeding child with other food sources?	Yes……1 No……...…….....2
417	Who gave you this information? Multiple response	CHW……..1 Midwife ……2 Friend/family member …3 Doctor ……4 SCA MHT midwife……5 SCA MHT health promoter…6 Other (specify) ---……..7

SECTION 5: CHILD HEALTH

501	Is your youngest child vaccinated	Yes fully vaccinated……..1 (all vaccines taken) Yes partially vaccinated…2 (some vaccine taken) No……...…….....3 (No vaccine taken			
502	Which vaccine taken	BCG OPV 0,1,2,3,4 Penta 1,2,3 Measles 1, 2 Other please specify			
503	Where was your child vaccinated	SCA MHT……1 Outreach from other HF…….2 Other fixed center ……..3			
504	Information source	Immunization card …..1 Recall of care taker….2			
505		Fear related to vaccination		Vaccine was not available	

	If not vaccinated Why did not you vaccinate your child?	No knowledge		Health provider not available	
		Religious belief		MHT/ Health facility far away	

DIARROHEA MANAGEMENT		
506	Did your child have diarrohea in the last 2 weeks?	Yes……..1 No……2 [SKIP to 510]
507	Did you seek treatment for diarrohea?	Yes……1 No……..2 → [SKIP TO 510]
508	Where did you seek treatment? Multiple response	CHW ……..……..……1 SCA MHT …….....2 Health Sub centre …..……3 Basic health centre centre ….....4 Community health centr…….....5 District hospital ……...6 Provincial Hospital……..7 Private hospital ……..8 At home ……..9 Traditional healer ……..10 Other (specify) ..……..96
509	How many days after diarrhoea did you first seek treatment?	Days ☐☐
510	Was the child given zinc at any time since (he/she) started having diarrohea?	Yes……1 No…….....2 Don't know…….99

Section 6 Nutrition attitude

For the next few questions, I am going to ask you to tell me if you strongly agree, agree, are neutral, disagree or strongly disagree with the following statements:						
Sn	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
600	Infant formula and breast milk have the same health benefits.	1	2	3	4	5
601	Breast milk contains all the essential nutrients for a newborn.	1	2	3	4	5

602	*Fella*/colostrum contains essential antibodies necessary to help the child's immune system.	1	2	3	4	5
603	The benefits of breastfeeding are limited to a specific period of time.	1	2	3	4	5
604	When a mother gets pregnant, she should stop breastfeeding.	1	2	3	4	5
605	Formula-feeding is more convenient than breastfeeding.	1	2	3	4	5
606	If a mother is weak after birth, she cannot breastfeed her baby.	1	2	3	4	5
607	It is not safe to breastfeed a baby if he/she has jaundice.	1	2	3	4	5
608	*Fella/touch* should not be given to the baby.	1	2	3	4	5
609	Formula-fed babies gain weight more quickly than breastfed infants.	1	2	3	4	5
610	Breastfed babies are healthier than formula-fed babies.	1	2	3	4	5
611	Breastmilk is the ideal food for babies.	1	2	3	4	5
612	Breastfeeding is more convenient than formula feeding.	1	2	3	4	5
613	Breastmilk is less expensive than formula.	1	2	3	4	5
614	Breastfeeding improves the bonding between mother and infant.	1	2	3	4	5

SECTION 7: SAM Instruction: This section is only applicable for children diagnosed with SAM		
701	Is your child diagnosed with SAM	Yes……1 No…….2 [SKIP to section 8]
702	When was it diagnosed with SAM?	Days Months
703	Does any health worker visit home to check your child	Yes……1 No…….....2 Don't know…….99
704	Who visit home to check your child	CHW……...1

		Midwife ……2 Friend/family member ……3 Doctor ……..….4 SCA MHT midwife……5 SCA MHT health promoter……6 Other (specify) ---……7
705	How frequently health worker visit your home	Once a week Once in 15 days Once is month Whenever MHT visit the village Don't know Never
706	How frequently do you visit SCA MHT	Once a week Once in 15 days Once is month Whenever MHT visit the village Don't know Never
707	Does SCA MHT health worker use IMCI(GM) chart to classify your case of malnutrition	Yes……1 No…….....2
708	Did the SCA MHT health worker measure child arm circumference (MUAC) during every visit	Yes……1 No…….....2
709	Did the SCA MHT health worker measure child height during every visit	Yes……1 No…….....2
710	Did you receive counselling/information on child feeding practices	Yes……1 No…….....2
711	Did your child suffer from edema in feet	Yes……1 No…….....2
712	Did your child receive vitamin A	Yes……1

		No…….....2
713	What treatment did your child receive? Select all that are mentioned	Vit A……..1 Deworming……..2 RUTF/RUSF……3 Nothing…….4 Hospitalized…….5 Other specify……6 None……..7
Section 8 Beneficiary Feedback (CHS questions)		
801	Are you aware where and who to make complaints if there is any?	MHT staff SCA staff in Kandahar PHO/DPHO Health Shura in the village Other please specify
803	Are complaints addressed on timely fashion?	Yes……1 No…….....2 Never complained……3 Don't know…….99 If 2, 3 or 99 skip to 901
804	Is corrective action shared with complainant?	Yes……1 No…….....2 Don't know…….99
805	Can you share a instance where complaint was made and addressed by MHT	

Section 9: Beneficiary Satisfaction

		Strongly agree	agree	Nutral/ NA	Disagree	Strongly disagree
901	Antenatal services provided by MHT are meeting expectation of clients	1	2	3	4	5
902	Post Natal services provided by the MHT are meeting expectation of clients	1	2	3	4	5

903	immunization services provided by the MHT are meeting expectation of clients	1	2	3	4	5
904	child health services such as diarrhea management, respiratory illness and others are meeting expectation of clients	1	2	3	4	5
905	Psycho social counselling services provided by MHT meets expectation of clients	1	2	3	4	5
906	nutrition related services such as management of SAM cases provided by MHT meets expectation of clients	1	2	3	4	5
907	Health worker behavior is very good	1	2	3	4	5
908	Health worker attitude is very good	1	2	3	4	5
909	Health workers are sensitive to gender needs of women	1	2	3	4	5
915	Suggest areas for improvement					

** Thank you for your time and information**

Confidential for research purpose only

2. Form

Key Informant Interview- SCA Project Coordinator & Senior Health and Nutrition Manager

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Verbal Informed Consent

***Instructions for the Interviewer**: The following is to be read verbatim to the participant prior to the consultation and interview. If the participant then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study: This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. You have been selected to participate in an interview. We would like to ask you some questions about the MHT by SCA. This information will help the SCA project in improving their future project work. However, there is no immediate or direct benefit to you for participating.

2.1.14

2.1.15 Procedures: To obtain the necessary information, you have been chosen purposively to participate from among the SCA staff. If you agree, we will ask you to answer several questions the MHT and its services. We will ask you these questions in another room, without the presence of any person.

2.1.16 Risks /Discomforts: The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.17 Confidentiality: During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member. Your name will not be recorded. All the information collected will be stored in a locked area.

2.1.18 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

2.1.19 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? ☐ Yes ☐ No

Signed by interviewer after subject has verbally consented

Participant characteristics	
Job title	
Organization	
Sex	
Age	
Contact number	

Is coordination meetings conducted regularly with SCA Tokyo? when was the last meeting held and what was discussed? What actions were taken

1. Are coordination meetings held with PHO, DPHO? When was the last time the meeting was held? What was discussed in the recent meeting? What decision was made?

1. Are beneficiaries satisfied? How is beneficiary satisfaction monitored or ensured?

2. Due to covid and insecurity in Kandahar, how project management was adapted to this situation? What changes were made in implementation

3. Could you tell me how much is community involved in the project:
   Prob: Is community involved in planning, execution of project?
   Is community involved in monitoring of the project?
   Is community informed of the findings?
   Is the community actively sharing concerns and feedback?
4. Is complaint redressal functioning?
5. Who are the identified staff to answer issues from community?
6. How long does it take to address any complaint?
7. Is the complaint mechanism accessible, effective, confidential and safe for their use?

8. How is monitoring reports feedback incorporated in the project implementation? How complaints and feedback mechanism providing inputs to implementation team on ground?

9. How community awareness initiatives has brought change in awareness level and behaviors at household level and individual level, how change can be supported with evidence

Thank you for your participation in the interview

Confidential for research purpose only

3. Form

KII community leader SCA

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Beneficiary Verbal Informed Consent

Instructions for the Interviewer*: The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about the MHT services . This information will help the SCA in improving their project work. However, there is no immediate or direct benefit to you for participating.

2.1.20

2.1.21 Procedures

2.1.22 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your village. If you agree, we will ask you to answer several questions availability of health services and access to health service from the MHT. We will ask you these questions in another room, without the presence of any health worker

2.1.23 Risks /Discomforts

The questions will take less than one hour to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.24 Confidentiality

2.1.25 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you or your family member. We will not tell any community member, or household member about the information you provide. All the information collected will be stored in a locked area.

2.1.26 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence. If you decided not to participate, you or your family member will get the same care that he or she would otherwise receive.

2.1.27 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? ☐ Yes ☐ No

Signed by interviewer after subject has verbally consented

2. IDENTIFICATION

Province Name: ……|_____| Province Code: ……. |__|__|__|

District Name: …… |_____| District Code: …….. |__|__|__|

Village Name: ……|_____|Code: …… |__|__|__|__|__|

Interview ID number:

Interview Date:

Section 1. Questions about the status of MHT service provision *(Please probe or ask follow-up questions as appropriate):*

1.1 Are you happy with the SCA MHT health service provision to community/village in your area? Why or why not?
1.2 Could you tell us what you do and don't like about the SCA health and nutrition services in your area? Please give reasons or examples.
1.3 What are your suggestions to improve the current health and nutrition services in your community?
1.4 Are you involved in the planning process of health services? *(Probe: are the community remembers are participating in improving MHT services?)*

Section 4. Questions about the utilization of healthcare services *(Please probe or ask follow-up questions as appropriate):*

4.1 How does the MHT address the common health and nutrition issues in your community?

4.2 In your opinion what proportion of children in your community are SAM ? Are these screened or treated by MHT?

4.3 Do women come to the MHT for maternal services? Probe: Do women come for ANC, delivery (emergency) and PNC services? What are reasons women may not use these services in your community?

Section 5. Questions about the MHT facilities, related infrastructure and accessibility *(Please probe or ask follow-up questions as appropriate):*

5.1 What do you think about the frequency of MHT visit in your area? Is it sufficient and regular? Probe: is regularity or follow up care is provided

5.2 Are health and nutrition services such as immunization, ANC, PNC, diarrhea mgmt, ARI mgmt. SAM are adequate and provided by competent staff?

5.3 What change has happened in behavior and awareness level on health and nutrition in the community and at household level because of MHT health educator community awareness activities?

5.4 What do you think about the challenges that people may face when they try to visit this MHT? *(probe whether these barriers include insecurity, lack of transportation, geographical barriers, socio-cultural issues such as absence of a Mahram, lack of trust of the health facility, lack of money, lack of awareness about the services provided by the health facility or any other reason, or poor/disrespectful behavior of the health workers)* Have these challenges changed over time?

5.5 How can these challenges be addressed?

Section 6. Questions about the complaint redressal and feedback and coordination
(Please probe or ask follow-up questions as appropriate):

6.1 Is there a complaint redressal system and feedback is shared with complainant?

6.2 Does complaints or feedbacks lead to improvements in service delivery?

6.3 Are there mechanisms at the community level to facilitate service delivery by MHT and to improve referral and seeking care and healthy practices? Please explain

6.4 What role does the community elders play in improving access to and utilization of MHT services

Closure: Is there anything else you would like to share with us?

Thank you!

Confidential for research purpose only

4. Form

Key Informant Interview- Department of Health Representatives

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Beneficiary Verbal Informed Consent

***Instructions for the Interviewer**: The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study:

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about the MHT by SCA. This information will help the SCA project in improving their project work. However, there is no immediate or direct benefit to you for participating.

2.1.28 Procedures: To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your organization. If you agree, we will ask you to answer several questions about health services by the MHT. We will ask you these questions in another room, without the presence of any person.

2.1.29 Risks /Discomforts

The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.30 Confidentiality

During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member, or household member about the information you provide or your name, which will not be recorded. All the information collected will be stored in a locked area.

2.1.31 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

2.1.32 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? ☐ Yes ☐ No

Signed by interviewer after subject has verbally consented

Participant characteristics	
Job title	
Organization	
Sex	
Age	
Contact number	

10. Can you tell me how much you are informed of the SCA MHT health and nutrition services in Zerai and Panjwayee districts? (probe: project scope, status, completion, outcome and impact? selection of areas?

11. Is coordination meetings conducted regularly with SCA? when was the last meeting held and what was discussed?

12. Two districts and 15 areas are selected for MHT,? What was the basis for selection of these districts and areas? Has the health and nutrition situation improved among households after the start of the program. If so, how? If not, why not?

13. In your view are beneficiaries served well as per the need by competent staff? (Probe: what gaps do you see in the project and what would you recommend to improve it)?

14. How often monitoring visit by department officials were conducted? What were the findings of last visit? Were the findings shared with SCA and how the recommendations were incorporated in the project? Please share report if you have.

15. In your view does SCA has system of beneficiary feedback and improving project management based on feedback. How far community is involved in planning and monitoring of MHT services

16. What are the initiatives taken under project to bring sustainability? Please share your ideas and inputs

Thank you for your participation in the interview

Confidential for research purpose only

5. Form

Key Informant Interview- health facility head

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Verbal Informed Consent

***Instructions for the Interviewer**: The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study: This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. You have been selected purposively to participate in an interview about the health services provided by the MHT by SCA. We would like to ask you some questions about the MHT by SCA. This information will help the SCA project in improving their future project work. However, there is no immediate or direct benefit to you for participating.

2.1.33 Procedures: To obtain the necessary information, you have been chosen purposively to participate from among the health facility staff. If you agree, we will ask you to answer several questions the MHT and its services. We will ask you these questions in another room, without the presence of any person.

2.1.34 Risks /Discomforts: The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.35 Confidentiality: During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member. Your name will not be recorded. All the information collected will be stored in a locked area.

2.1.36 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

2.1.37 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? ☐ Yes ☐ No

Signed by interviewer after subject has verbally consented

Section 1. General information	
Date	|_____|:|____| |____|:____| |_____|:|_____||_____|:|_____| DD MM YYYY
Name, title and contact details of the interviewee	
Interview start time	|____|____| |___|___| HH MM
Interview end time	|____|____| |___|___| HH MM
Interviewer name	
Interviewer Code	|___|___|___|___|

Section 2: Facility Identification	
1. Facility name	
2. Facility code	|___|___|___|___|___|___|
3. District Name	

Section 3. Questions about the status of health service provision *(Please probe or ask follow-up questions as appropriate):*

1. How do you usually evaluate health care service provision in this MHT ?
    a. Is the scope provided the same as that specified for this facility type? Please elaborate.
    b. How do you evaluate/ensure the quality of service provision?
    c. In your opinion, what are the most important challenges/gaps in service provision in this MHT?
2. How can the health service provision be improved in this MHT? What has been done to date to improve health services at this facility?
3. What do you think about the supply and demand of health services in this MHT?
    a. Does it meet the demand of people? Why or why not? Please explain!
    b. What hours and days of week this facility operate?
4. How is the vaccination coverage in the catchment area of this MHT?
    a. What approach is used to ensure OPV coverage in the community? Do you think this was successful? Why or why not?
    b. What approaches are used to increase Penta-3 and Measles coverage in the community? Do you think these were successful? Why or why not?
5. What is the referral rate of this MHT? Is it appropriate? For what services are patients referred to other facilities?

a. Which referral facilities are most frequently recommended? How far are these facilities from your MHT catchment area?

b. What proportion of the referred patients is able to go to the referral site?

Section 4. Questions about the utilization of healthcare services *(Please probe or ask follow-up questions as appropriate):*

1. What is your opinion about the healthcare services utilization in this MHT? Do you think people have trust in the services of MHT? Please give reasons *(Please probe if it is underutilized or over utilized, ask for explanation)*

2. According to your opinion, what are the key barriers against utilization of health services?
3. *(Probe for the following:*
   - *insecurity,*
   - *transportation*
   - *lack of awareness about the health services*
   - *sociocultural barriers*
   - *behavior of the health workers*
   - *poverty*
   - *quality of health care services*
   - *better health services in private sector)*

4. How can healthcare service utilization be improved in this MHT? What approaches have been tried? What worked/ didn't work and why?

Section 5. Questions about the condition of the health facilities, related infrastructure and accessibility *(Please probe or ask follow-up questions as appropriate):*

1. What do you think about the location of this MHT?

   a. Do people have to walk more than one hour to reach to this MHT?
   b. Was accessibility considered when the facility site was selected?

2. What do you think about the challenges that people may face when they try to visit this MHT now? *(probe for insecurity, transportation, geographical barriers, socio-cultural issues such as absence of a Mahram and lack of trust to the MHT, money, lack of awareness about the services provided by the MHT or any other reason, behavior of the health workers)* Have these challenges changed over time?

3. How can these challenges be addressed? What approaches have already been tried? How successful was this approach (please ask for examples)?

Section 6. Questions about the catchment area and targeted population *(Please probe or ask follow-up questions as appropriate):*

4. What is the catchment area population of this MHT?

5. According to your opinion, does this MHT meet the needs of its catchment area population? (If the answer is yes, please ask why the respondent thinks so. If the answer is no, ask for how it does not and ways to improve it.)

   a. Does your facility do any sort of evaluation to estimate catchment population?

6. Is the catchment area population adequate with respect to this MHT's capacity?

   a. If no, is the facility too small to cope with the population size? In what ways?

   b. If adequate, how much larger a population is the facility equipped to serve? Do you think people in the catchment area adequately utilize this facility? Why or why not?

7. Do you think that population health has improved in the catchment area of this MHT in the last 1 years? (If yes, how? If no, why?)

Section 7. Questions about the status of health workers sufficiency and availability *(Please probe or ask follow-up questions as appropriate):*

1. What do you think about the number of health workers in this MHT? Are there enough expert health professionals in each category? If not, what types are needed, how many of each, and why are they needed?

2. What challenges do you face in terms of availability of human resources in this MHT?
   a. Are there enough health workers available? Is there any vacant position currently? Is the PHD aware of the vacancy?

3. How can the aforementioned challenges be addressed?

Section 8. Questions about the drug supply and availability in the MHT *(Please probe or ask follow-up questions as appropriate):*

1. What do you think about the medication supply to this MHT? *(is it adequate? If not, why?)*

2. What do you think about the availability of medications currently in this MHT?

3. What do you think about the quality of the medications available in this MHT?

4. What is current stock-out rate of drugs, in number of days?
   a) What do you do when a stock-out is detected?
   b) What measures have been taken by the management team to reduce stock outs and improve drug management (e.g., availability)?

Section 9. Questions about the working hours of health facilities *(Please probe or ask follow-up questions as appropriate):*

1. What are the regular working hours of health workers in this facility?

2. How important are working hours of this MHT? Please explain!

3. Are all employees attending the facility until the end of the official time?

4. What challenges do you face in terms of managing working hours of your employees?

5. How can these challenges be addressed? Please elaborate!

Closure: Is there anything else you would like to share with us?
Thank you!