

Mid-Term Review of the Family Health House Model, Afghanistan



Family Health House Model, Afghanistan



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United Nations Population Fund (UNFPA)

Country Office Afghanistan

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Acronyms

AHS	Afghanistan Health Survey
AMA	Afghan Midwives Association
ANC	antenatal care
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
BHC	basic health centre
BPHS	Basic Package of Health Services
CAAC	Catchment Area Annual Census
CHC	comprehensive health centre
CHW	community health worker
CME	Community Midwifery Education
CMW	community midwife
CYP	couple-year protection
DH	district hospital
EmONC	emergency obstetric and newborn care
EPHS	Essential Package of Health Services
FGD	focus group discussion
FHAG	Family Health Action Group
FHH	Family Health House
GBV	gender-based violence
HMIS	Health Management Information System
HP	health post
HRH	Human Resources for Health
HSC	health sub-centre
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illness
IP	implementing partner
MDG	Millennium Development Goal
MHT	mobile health team
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health
MST	Mobile Support Team
MTR	mid-term review
NGO	non-governmental organization
PHCC	public health coordination committee
PNC	postnatal care
PPHD	Provincial Public Health Directorate
PSC	Programme Steering Committee
RH	reproductive health
RHD	Reproductive Health Directorate
RMNCH	reproductive, maternal, newborn, and child health
SBA	skilled birth attendance
TOR	terms of reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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The authors hope that those involved in this project, especially the policymakers at central level, MoPH, donors and UNFPA, find this report helpful in preparing the next phase of the FHH project and, ultimately, in taking such services to all under-served communities, so that no woman should die giving birth and that all newborns survive and have a healthy start in life and grow to be proud, healthy Afghan citizens. It has been a privilege to serve such a worthy project.

Della R Sherratt, Khalid Sharifi

Operational Definitions

- Efficiency:** The assessment of efficiency considers or examines how economically optimal inputs of the project (financial, human, technical and material resources) have been used to produce outputs (results). It attempts to link outputs to resources expended and assesses whether this has happened as economically and feasibly as possible, and the extent to which the quantity and quality of the results justify the quantity and quality of the means used to achieve them, and whether they were achieved on time.
- Effectiveness:** The assessment of effectiveness considers or examines the extent to which the FHH project has achieved its planned results, including outputs and outcomes and the extent to which the achievement of these results were a consequence of UNFPA's support and interventions, in collaboration with its stakeholders, and other factors.
- Relevance:** The assessment of relevance examines the degree to which the outputs/ outcomes/ benefits of the project are in line with national priorities and needs, UNFPA priorities and those of the relevant stakeholders. It considers whether the strategies and interventions are relevant for the environment under which UNFPA operates in Afghanistan.
- Sustainability:** The assessment of sustainability considers the likelihood that the stream of benefits produced by the project will continue after external assistance ceases. It is concerned with measuring whether the benefits of the intervention are likely to continue after the assistance and support from UNFPA, donors and government have ceased. It considers how durable the support to stakeholders and beneficiaries was in building internal systems and processes, building capacity and transferring knowledge expertise and information about maternal and reproductive health, family planning, Adolescent Sexual and Reproductive Health, and gender based violence.

Executive Summary

Despite the rapid changes that have taken place in the country over the last decade, particularly the impressive decline in the maternal mortality ratio (MMR) and neonatal and child death, Afghanistan is still struggling to ensure basic health services are accessible to Afghan women and newborns. In response to the then very high MMR, in 2003 Afghanistan introduced the BPHS which aimed to reach all Afghans through basic health centres (BHC), comprehensive health centres (CHC), and district hospitals (DH), in addition to health posts (HP) staffed with female and male community health workers (CHW). However, in its implementation, the BPHS could not reach all Afghans, particularly those in very remote or sparsely populated areas. This led to the revision of the BPHS and the inclusion of health sub-centres (HSC), as a lower level health facility than the BHC, with mobile health teams (MHT), to expand health services to very remote areas. However, areas remain which are under-served or unserved, known as 'white areas'. Around 18 per cent of the population live in such very remote areas, over two hours walk from the nearest BPHS facility.

Afghanistan's health system encourages innovative interventions which expand the coverage of health services. Accordingly, the United Nations Population Fund (UNFPA), in collaboration with the MoPH, introduced and piloted the Family Health House (FHH) model. This project aims to increase access to reproductive, maternal, neonatal and child health (RMNCH) services in un-served and under-served districts, thereby reducing morbidity and mortality. The pilot scheme commenced in 2009 and was implemented in selected areas of three provinces: Bamyan, Daykundi and Faryab, through national non-governmental organizations (NGOs) with experience of BPHS service delivery. Recently, the FHH project was expanded to un-served areas of Herat province, but as these were to only begin functioning in the months following the MTR, this data was not included.

The FHH model

The FHH is a community-based health facility which aims to increase access to basic RMNCH services and bridge the gap between HP and HSC. The FHH model comprises four components: the FHH itself, HPs, Family Health Action Groups and community health shura.

a) **Family Health House:** The FHH is a simple community-based health facility, known as the Ashiana-e-Sehi in the vernacular, established in areas which lie a minimum of 10 km from the nearest BPHS facilities. It covers a population of 1,500-3,000 people. The FHH is staffed by a community midwife (CMW) trained in the Community Midwifery Education (CME) programme. The FHH provides basic RMNCH services and establishes a timely referral system to BPHS facilities.

b) **Health Post:** Each FHH is supported by an HP staffed with a male and female CHW who have received the standard CHW training. The HP provides limited basic health services to the community, promotes standard health behaviours, particularly RMNCH, and bridges between the community and the FHH.

c) **Family Health Action Group:** The FHAG is a group of 10-15 volunteer women belonging to the local community who receive a basic orientation in promoting key health messages, particularly RMNCH related messages, and encourage their communities to utilize the FHH.

d) **Community Health Shura:** The shura, known locally as the Shura-e-Sehi, comprises key community leaders and is formed based on community-based health care procedures and guidelines.

A Mobile Support Team (MST) comprising a doctor or nurse, midwife, vaccinator, and a driver supports the FHH model. The MST provides periodical technical and managerial support to FHHs and provides

immunization and basic health services in remote villages surrounding the FHHs. The MST is expected to gradually transfer its role to the nearest BPHS facility.

The mid-term review of the Family Health House project

The mid-term review (MTR) was designed to be in line with UNFPA guidelines for evaluations and was conducted by two external consultants, one national and one international. The focus of the review was to assess project design, implementation and progress in terms of their relevance, effectiveness, efficiency, sustainability, and institutional arrangements and governance and coordination. These findings should assist UNFPA and implementers with reviewing and, if needed, revising the project design for the next phase, as well as by donors in making decisions about further support to the projects. Finally, and most importantly, the findings will assist central policymakers decide if it is possible to integrate this model into the national BPHS.

A high-level multi-stakeholder Task Force was established to oversee and provide guidance for the MTR under the leadership of a senior official of the MoPH, the RHD Director, who reported to the chair of the overall Project Steering Committee for FHH, the Director-General of the Department of Policy, Planning and International Development.

The MTR used a mixed approach which aimed to maximize participation by all stakeholders. This included a desk review, interviews with a wide range of stakeholders at provincial and central levels, community members, CMWs and clients, focus group discussions (FDGs) with community health shura and FHAG members. Additionally the MTR undertook a physical review of a sample of 17 of the FHHs, representing approximately 20 per cent of the 80 active FHHs in the three target provinces. In all, 14 separate tools were applied.

The MTR took place between November 2014 and February 2015 in Faryab, Bamyán and Daykundi provinces where FHH are already established. More than 269 stakeholders contributed. At the central level these included MoPH policymakers, representatives of donor agencies, UNFPA, IP managers, UN agencies such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), World Bank, and the Afghan Midwives Association (AMA), the country's professional association for midwives. At the provincial level these included governors, members of the provincial council and Provincial Public Health Directorate (PPHD), and at the community level, the community health shura, FHAG, CHWs, and patients.

At the time of the MTR in 2014, there were 80 active FHHs benefiting an estimated 200,000 people across the three provinces. An additional 44 FHHs (nine in Herat and 35 in Daykundi) are expected to come on line during 2015. The 17 FHHs reviewed cover a catchment population of 41,153, or roughly 20 per cent of the total target catchment population for the project. The FHHs were reviewed using a standard checklist based on criteria established in the project document. Direct observation of the FHH facility and its functionality included a review of available Health Management Information System (HMIS) data to assess performance.

Findings of the MTR

Relevance

The FHH pilot modality is fully aligned with government priorities, policies, and strategies such as the Afghanistan National Development Strategy, Afghanistan National Health and Nutrition Policy and Strategy, Reproductive Health Policy and Strategy, Community Based Health Care (CBHC) Service Policy and Strategy, and the BPHS. These strategies all prioritize the expansion of reproductive health, mother and newborn care to all Afghans, which is the focus of the FHH model. Furthermore, CMWs are trained through the CME programme which is aligned with the Afghanistan National Health Workforce Plan 2012-2016 as part of the government's efforts to strengthen the health system.

The FHH model is fully in line with UNFPA global strategies for enhancing women's rights and empowerment, addressing gender equity, and contributes to Afghanistan's Millennium Development Goal (MDG) targets for health and national development.

The FHH model is established in so-called ‘white areas’ and meets the unmet needs of these deep rural communities.

Although a reliable and updated population count for catchment areas is not available, most established FHHs cohere with their establishment criteria, and are located in areas with a population of 1,500 to 3,000 people. Most FHHs also meet their distance criteria; although distance data is based on very rough estimates, most FHH are, as the criterion dictates, more than 10 km from the nearest BPHS facility, while a few are closer (under 10 km) or very much further (up to 70 km). FHH located closer than 10 km from the nearest BPHS facility are most likely underutilized while the FHHs located very far may face challenges with proper and timely supervision, monitoring, and referral.

Effectiveness

Assessment of the effectiveness of FHH is hindered by the paucity of outcome data. However, stakeholders at the national, provincial, and community levels perceived that FHHs fulfil the unmet need for RMNCH services to scattered populations in under-served areas where the project has been implemented. The main reasons for the project’s effectiveness, most stakeholders suggested, include: 1) IPs had good support from UNFPA, who helped also with planning; 2) IPs have had good collaboration with the community; 3) the FHH model directly addresses geographic, cultural and economic barriers to accessing care and services in these remote areas.

The HMIS data, used as proxy outcome data, suggests that FHH model was effective; it expanded basic RMNCH services to over 200,000 people in ‘white areas’ who had not been reached through the BPHS. The overall FHH contribution to the overall provincial first antenatal care (ANC), first postnatal care (PNC), and institutional delivery was around 12 per cent each in 2014 across the three provinces of Bamyan, Daykundi, and Faryab. In addition, FHH led to more than 4,500 couple-years of protection in the above-mentioned provinces.

In term of outputs from the FHH project, implementation was successful; 64 per cent (80) of planned FHHs are established and functional while 28 per cent (35) are in process as the CMW is still in CME training. In addition, 8 per cent (nine) of planned FHHs were not established or were closed down after establishment mainly due to weak planning and monitoring of the selection of FHH and CMW candidates and in the deployment stage. Among the CMWs who completed the CME programme, 94 per cent were deployed and 95 per cent of these retained and now provide basic RMNCH service to their communities.

At time of review, the FHH project had achieved 65 per cent of its planned HPs (manned by CHWs), FHAG, and community health shura, while 28 per cent were under process. The project missed 7 per cent of its planned community structure as nine FHH were either not established or dropped altogether.

The FHH is expected to establish a referral system from the community to BPHS facilities to manage the referral of high-risk cases in an effective and timely manner. Although a referral mechanism has been established between some FHHs and BPHS facilities, there is still a long way to go in establishing an effective and timely two-way referral system.

Efficiency

The IPs recruited and utilized the required staff and utilized the technical expertise of UNFPA and MoPH. Although the involvement of MoPH departments was limited when implementation began, steps are being taken to involve more of them at the central level which could lead to gains in project outputs.

IPs have procured and supplied required medical and non-medical equipment to FHHs as specified in the FHH Concept Note. IPs have also utilized the allocated funding for construction, raised community funding and completed the construction of FHHs. However, the location of some FHHs still poses a major challenge to the 24-hour availability of RMNCH services; in some cases they are up to a 60 minute walk from the CMW’s house, which suggests inadequate planning and monitoring of locations by UNFPA and IPs in the establishment phase.

All FHHs are supplied regularly with essential drugs and medical supplies, which facilitate their full functionality. However, there is variation in the essential drugs and medical supplies supplied from the list provided in the FHH concept. The push-based mechanism of supply to FHH challenges the efficient use of allocated resources.

The project's Annual Work Plan (AWP) guides the funding modality and quarterly disbursement of funds from UNFPA to IPs. Accountability and transparency are addressed in project implementation to ensure that expenditure aligns with the AWP. For this purpose, three key measures were used; the work plan monitoring reports, internal control systems of IPs, and an annual independent audit of the project by an international auditing company. Interviews at the central level showed that all IPs were satisfied with UNFPA's funding arrangements and commented that funds were disbursed speedily once they had completed the necessary paperwork.

CMW training followed the standard curriculum for the MoPH community midwifery programme followed by two months additional training on 12 topics. In addition to this training, however, CMWs should have a practical internship period in BPHS facilities prior to deployment to FHH.

Although CMWs are mainly trained on basic RMNCH services and Integrated Management of Childhood Illnesses (IMCI), communities expect them to provide medical consultations unrelated to RH to other adults as well. However, stakeholders, particularly at the national level had a concern on the capacity of CMWs in offering adult non-RH services, in particular, medical consultations. Moreover, offering non-RH services through FHH mean that less time is available for RH services, including outreach and follow-up in the community. If non-RH services, particularly the medical consultations are to be considered it should be regulated and midwives should be trained, equipped with the right knowledge and skills.

The MTR attempted to analyse the cost-benefit of the project but this was not feasible due to the lack of disaggregated cost data, as well as impact and outcome level data, as the project is still underway and there are currently no end line results. However, a simple assessment of the cost shows that on average the establishment cost per FHH (*estimated average cost of CME per student, estimated average cost of construction per FHH, and estimated average cost of equipment and furniture per FHH*) is about USD 29,000. On average, USD 7,623 is required for direct annual running costs per FHH.

Sustainability

The implementation of FHH, as with other health interventions, is donor dependent. However, there is huge support and willingness amongst MoPH officials at the central and provincial levels as well as IPs to continue and scale up the intervention. There is also great willingness to institutionalize FHH into the health system to expand basic health services in the very remote areas where FHHs function. The persistence of 'white areas' justifies the continuation of FHH services. Furthermore, the World Bank, the main BPHS funder under the SEHAT Project, is willing to fund FHH alongside other BPHS facilities, if it is integrated within the BPHS.

The FHH model appears to provide an equitable service, as it complements BPHS and meets the unmet need for RMNCH services amongst hard-to-reach communities. FHHs contribute to raising awareness and utilization of RMNCH services. The availability and functionality of FHHs in such under-served communities contribute to the reduction of maternal and infant mortality.

Institutionally, the FHH model built partnerships at the national level to contribute to the health workforce for RMNCH services by training CMWs. The project built partnerships at the provincial and community levels, and ensured the involvement of stakeholders, which strengthened community ownership and participation. Establishing community structures e.g. community health shura, CHWs, and FHAGs are perceived as critical for promoting the utilization of RMNCH services in remote communities. However, there is concern that appointing only one CMW per FHH is a high-risk strategy; if the midwife is sick, on leave or away on training, for instance, there is no one to provide the necessary services.

Institutional arrangements, governance, and coordination

The UNFPA Letter of Agreement with IPs, and the AWP, establish the institutional arrangements between UNFPA and IPs. The FHH's Programme Steering Committee (PSC) is a strong governance structure, which provides oversight and guidance on implementation of the FHH model. IPs believe they have good working relationships with the MoPH at the local and provincial levels, but less so at the central level, where communication occurs through UNFPA.

Monitoring has enabled swift decisions and logical adjustments to be made to the work plans. IPs have expressed appreciation for UNFPA's technical support and monitoring, which they feel has helped them maintain quality and achieve their targets.

Summary and recommendations

The MTR found the FHH pilot project to be highly relevant, effective and reasonably efficient, although some areas of efficiency could be strengthened. The implementation was successful, although there were difficulties at the start. Communication and coordination between all parties (UNFPA, MoPH at all levels, donors, and IPs) have been strengthened and form a strong foundation for moving into the next phase of the project. As such, there seems to be good reason to integrate the FHH concept into the BPHS national programme and expanding it to all 'white areas' willing to join the initiative.

Based on these findings the following recommendations are made:

- 1) **Strengthening support to FHHs located very far from the BPHS facility:** It is recommended that IPs further assess the functionality model of FHHs located very far from the nearest facility and develop strong support mechanisms to ensure their effectiveness.
- 2) **Conducting Catchment Area Annual Census:** It is strongly recommended that a quality Catchment Area Annual Census (CAAC) be conducted each year in the catchment of FHHs, as per the standard HMIS procedure manual, to identify and update the catchment population for each FHH. A CAAC for each FHH should be conducted immediately.
- 3) **Revising the list of indicators for FHHs:** It is recommended that the list of indicators for FHHs be revised and separate indicators be included for each ANC and PNC visit to monitor progress and ensure compliance with reproductive health guidelines.
- 4) **Strengthening the effective two-way referral system:** It is strongly recommended that IPs closely monitor referrals from FHHs to BPHS, coordinate the referral system with BPHS provincial and field managers, and develop innovative approaches, e.g. the use of mobile technology to arrange and follow up on referral cases.
- 5) **Exploring feasibility of internships for CMWs before deployment to FHH:** To strengthen the self-confidence of CMWs and ensure FHHs are effective from the start, it is strongly recommended that an internship period of 2-3 months with the nearest BPHS be instituted for newly graduated CMWs prior to their deployment to an FHH. The internship will provide an opportunity to CMWs to get practical experience of independent management of FHHs.
- 6) **Creating a backup mechanism for FHHs:** It is recommended that the feasibility of innovative approaches to ensure continuity of RMNCH service through FHHs if CMWs are temporarily absent be explored.
- 7) **Developing Standard Operating Procedures Manual:** It is recommended that UNFPA, IPs and MoPH should, as a matter of urgency, develop a set of Standard Operating Procedures to guide and standardize the implementation of FHH.
- 8) **Developing an action plan for follow-up of MTR:** It is recommended that UNFPA and IPs review the findings of the MTR and develop an action plan to address areas needing improvement in the FHH model.

- 9) **Continuing and expanding the FHH model:** The FHH model is an effective and efficient intervention, therefore it is recommended that existing FHHs be continued and the feasibility of further expanding the intervention in similar settings be explored.
- 10) **Integrating the FHH model into the MoPH BPHS package:** Continuing oversight of the FHH model is recommended to review and explore the feasibility of institutionalizing the model into the health system for remote areas of Afghanistan.

Country Profile and Context of the Mid-Term Review

Chapter 1

1.1 About Afghanistan

Afghanistan is a large, mountainous, landlocked country, which is classified as one of the least developed countries in the South and Central Asian region. The United Nations Human Index ranking is 176.¹ Its terrain and climatic conditions render large parts of the country isolated for considerable periods, sometimes up to six months of the year. These are only two of the many challenges facing the country today, as it emerges from a lengthy period of unrest and conflict. Although considerable improvements have been made in relation to all social indicators, those related to health remain low, relative not only to the region, but internationally. The relatively low Contraceptive Prevalence Rate (21.8 per cent any method and 19.9 per cent any modern method as last estimated in 2010) understandably results in higher than regional averages in Fertility Rate (estimated at 5.1-5.6), which in turn contributes to the fact that an estimated 60 percent of the population is aged 20 or less.² High fertility, poverty and limited access to professional reproductive health care are key factors contributing to the high maternal and newborn mortality and morbidity. The Afghanistan MoPH signed the Millennium Declaration in 2004 and the timeframe for achieving the MDGs was extended to 2020.³

Afghanistan has, however, made significant progress in rebuilding its health system, despite years of continuous conflict. According to a maternal mortality survey in four districts, the country had one of the highest maternal mortality ratios in the world, estimated at 1,600 per 100,000 live births in 2002.⁴ However, the Afghanistan Mortality Survey in 2010 estimated that the pregnancy related mortality ratio had fallen to 327 per 100,000 live births,⁵ while the United Nations estimated maternal mortality in 2013 at 400 maternal deaths per 1,000 live births.⁶ Data for infant mortality also shows a reduction, from 76 deaths in the first year of life per 1,000 live births in 2009, to 71 in 2010.⁵ According to the

¹ United Nations Development Programme (UNDP). *Human Development Report 2013: The Rise of the South: Human Progress in a Diverse World*. New York: UNDP 2013.

² Afghanistan Central Statistics Organization (CSO) and United Nations Common Country Assessment 2012. Kabul: United Nations, 2013.

³ Islamic Republic of Afghanistan Ministry of Public Health (MoPH). *National Health Policy 2005–2009* and *National Health Strategy 2005–2006*. Kabul: Ministry of Public Health, 2005.

⁴ Bartlett, L.A, S. Mawji, S. Whitehead, C. Crouse, S. Dalil, D. Ionete, P. Salama, and the Afghan Maternal Mortality Study Team. Where giving birth is a forecast of death: Maternal mortality in four districts of Afghanistan, 1999-2002. *Lancet* 2005; Vol.365: 864–870.

⁵ Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India], and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. *Afghanistan Mortality Survey 2010*. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO. [AMS 2010]

⁶ World Health Organization. *Trends in Maternal Mortality 1990 to 2013: Estimates by WHO UNICEF UNFPA World Bank and the United Nations Population Division*. Geneva: World Health Organization, 2014.

latest National Reproductive Health Strategy,⁷ other RH indicators have also improved. For example, the use of any modern birth spacing or family planning method among married women increased from 10 per cent in the Multiple Indicator Cluster Survey (MICS) 2003⁸ to 19.9 per cent by 2010.⁹ The Afghanistan Health Survey (AHS) 2012 showed receipt of antenatal care by pregnant women had increased by an estimated 54 per cent and assistance at childbirth by skilled birth attendants by 47 per cent.¹⁰ Despite these impressive changes, it is clear considerable efforts and investment are required to ensure all women and children have access to basic health care, especially for basic care in and after pregnancy and specifically for care by a skilled health care provider at the time of birth. According to the most recent available data, in urban areas, the percentage of deliveries assisted by skilled health personnel is 75 per cent, falling to 32 per cent in rural areas and only 13 per cent amongst Kuchi (nomads). Furthermore, there are variations in skilled birth attendance among the different regions of Afghanistan; the north-eastern region has the highest rate of Skilled Birth Attendance (SBA) (42.9 per cent) and the southern region the lowest at 21.2 per cent. There is also critical variation among the provinces; SBA coverage rates are lowest in Helmand, Ghor, Badghis, and Nuristan provinces, at less than 10 per cent.¹¹

Although there has been remarkable progress in increasing institutional deliveries in the past years, less than half of the deliveries take place in health institutions. According to AHS 2012, only 40.5 per cent of women who gave birth in the two years preceding the survey were delivered in an institution (30 per cent public institution and 10 per cent private).

Women face a wide range of socioeconomic and cultural factors which affect care-seeking for delivery from a skilled birth attendant. Reasons for not seeking care in a health facility encompass a wide range of knowledge, beliefs, access, social, cultural, and economical factors. More than one-third of women (35 per cent) believed that it was not necessary to give birth in a health facility, and 19 per cent said that it was not customary. About half of the women said that it was due to a lack of money, distance to the health facility, or transportation problems that made them opt for delivery at home. Around 14 per cent had no one to accompany them, while 13 per cent of women reported that they did not go to the health facility to deliver the baby because there were no female providers available. In addition, 12 per cent of deliveries did not take place in a health facility due to security concerns.¹²

Despite the expansion of the BPHS, universal access to basic health care remains a major challenge. Although access to basic health care services has improved, with an increase from 61 per cent of the population living within two hours of the nearest health facility using their usual mode of transportation in 2006, to 82 per cent in 2012. Meanwhile, the proportion of people who live more than two hours away using their usual form of transportation dropped by half (from 40 per cent in 2006 to 18 per cent in 2012). However, around a fifth of the Afghan population still have limited access to basic health care services.

In response to this situation, the United Nations Population Fund (UNFPA) initiated the FHH model to expand the coverage of basic RMNCH services to very remote areas with limited or no access to BPHS facilities. The FHH model not only provides physical access to remotes areas, it addresses the reasons for not seeking delivery care from a skilled birth attendance described above.

At the inception of the FHH project, a 2012 Concept Note reported that the majority of settlements in UNFPA's focus provinces - Bamyan, Daykundi and Faryab - were located outside the catchment area of a stationary health facility or more than 10km (a 3 hour walk) from the nearest such facility. Bamyan and Daykundi provinces are situated in Afghanistan's central highlands where the topography with high

⁷ Islamic Republic of Afghanistan Ministry of Public Health. *National Reproductive Health Strategy (2012–2016)*. RH Task Force MoPH, Kabul; Ministry of Public Health, 2013.

⁸ Central Statistics Organization, Afghanistan Transitional Authority & United National Children Fund (UNICEF). *Afghanistan Multiple Indicator Cluster Survey 2003*. Kabul: CSO, 2003.

⁹ AMS 2010.

¹⁰ Islamic Republic of Afghanistan, Ministry of Public Health, Johns Hopkins Bloomberg School of Public Health, Indian Institute of Health Management Research. *Afghanistan Health Survey 2012*. Kabul: MoPH 2013. [AHS 2012]

¹¹ Central Statistics Organization. *National Risk and Vulnerability Assessment 2011-12. Afghanistan Living Condition Survey*. Kabul: CSO, 2014. [NRVA 2011-12].

¹² AMS 2010.

mountains and deep valleys makes travel very difficult and sometimes impossible, especially during the snowy winter season.

1.2 Profile of catchment areas for FHH project

Bamyan province:¹³ Located in the highlands of Afghanistan, the province covers an area of 17,414 km² comprising mostly dry, mountainous terrain with a number of rivers. Nearly the whole province is mountainous or semi-mountainous, with only 1.8 per cent comprising flat land. The province is divided into seven districts with a total population of around 439,900. Around 216,900 are female and 87,900 of these are women of childbearing age (15-49 years).

Around 80 per cent of the population of Bamyan lives in rural districts while 20 per cent lives in urban areas. The major ethnic groups are Hazara followed by Tajik, Tatar and Pashtun. Dari is spoken by 96 per cent of the population and 98 per cent of the villages. In another 24 villages with a population of approximately 5,000 the main language spoken is Pashtu. Bamyan province is only a summer area for Kuchi, who do not stay here during the winter. In the summer 962 households of long range migratory Kuchi come to Bamyan province from Nangarhar, 300 households from Logar and 80 households from Balkh. Access to summer pastures is severely constrained in this province. An additional 2,000 households from Logar, 970 from Nangarhar, 662 households from Balkh, 517 households from Khost, 370 households from Samangan, and 50 households from Saripul have designated Bamyan province as their preferred summer area. The Kuchi population in the summer is 2,255 individuals.

Basic infrastructure such as water and sanitation, energy, transport and communications is required for private sector expansion, equitable economic growth, increased employment and accelerated agricultural productivity in the province. On average only 8 per cent of households use safe drinking water. While 91 per cent have direct access to their main source of drinking water within their community, 9 per cent of households have to travel for up to an hour to access drinking water.

The health status, particularly the women, is among the worst in the country. Provincial maternal mortality data is not available but outcome level data show that 47 per cent of deliveries are conducted by SBAs, which predicts a poor health status for women in the province.¹⁴ The health status of children is also unsatisfactory. Whilst provincial level mortality data is not available for children under five, nutritional data suggests that 51 per cent are stunted and 25 per cent are underweight.¹⁵

Daykundi province:¹⁶ The province is located in the central highlands and covers an area of 16,655 km². Almost all (96.6 per cent) is mountainous or semi-mountainous with only 2.6 per cent of the terrain made up of flat or semi-flat land. The province is divided into nine districts with a total population of around 417,500. Around 203,100 are female including 83,500 of childbearing age (15-49 years). The provincial capital is Nili, which has about 30,058 inhabitants.

Around 99 per cent of the population of Daykundi lives in rural districts. The major ethnic groups in Daykundi province are Hazara (86 per cent), followed by Pashtun (8.5 per cent), Baluchi (3.5 per cent) and Sayeed (2 per cent). Dari is spoken by 91 per cent of the population and 85 per cent of the villages. The second most common language is Pashtu, spoken by majorities in 151 villages. Turkmani is spoken in two villages and Baluchi is spoken in one.

On average only 3 per cent of households use safe drinking water. While 68 per cent have direct access to their main source of drinking water within their community, 23 per cent have to travel for up to an hour to access drinking water, and for 10 per cent drinking water is up to three hours away.

¹³ National Area-Based Development Programme / Islamic Republic of Afghanistan Ministry of Rural Rehabilitation and Development, Bamyan Provincial Profile (undated).

¹⁴ AHS 2012.

¹⁵ Islamic Republic of Afghanistan Ministry of Public Health, *National Nutrition Survey 2013*. Kabul: MoPH 2014. [NNS 2013].

¹⁶ National Area-Based Development Programme / Islamic Republic of Afghanistan Ministry of Rural Rehabilitation and Development, Daikondi Provincial Profile (undated).

Only 7 per cent of roads in the province are able to take car traffic in all seasons, and 61.5 per cent can take car traffic in some seasons. There are no roads at all in a third (31.1 per cent) of the province.

The health status is poor. Provincial maternal mortality data is not available but outcome level data shows that only 32 per cent of deliveries are conducted by skilled birth attendants.¹⁷ Provincial level mortality data for children under five is not available, but 42 per cent of children under five are stunted and 22 per cent are underweight.¹⁸

Faryab province: ¹⁹ The province is situated in the western part of the northern region of Afghanistan and covers 21,146 km². Around 63 per cent of the province is mountainous or semi-mountainous terrain while 30 per cent is flat. The province is divided into 13 districts with a total population of 981,200. Around 480,400 are female including 196,240 women of childbearing age (15-49 years). The provincial capital is Maimana which has a population of about 68,055.

Around 89 per cent of the population of Faryab live in rural districts, while 11 per cent live in urban areas. The major ethnic groups are Uzbeks and Pashtuns followed by Tajiks and Turkmens. Uzbeki is spoken by over 53.5 per cent of the population and 49 per cent of the villages. The second most common language is Dari, spoken by majorities in 311 villages representing 27 per cent of the population. Pashtu is spoken by 17 per cent of the villages and 13 per cent of the population.

The number of Kuchis in Faryab province varies by season. In winter 98,220 people, or 4 per cent of the overall Kuchi population, stay in Faryab, living in 28 communities. About 85 per cent are short-range partially migratory, and 15 per cent are settled. Two-thirds of migratory Kuchis are partially migratory which means some of the community remain behind in summer. Currently, the most important summer areas for short-range migratory Kuchi are Qaisar Kohistan, Maimana, Dawlat Abad, Almar and Shirin Tagab districts of Faryab province (in decreasing order of importance). In both winter and summer the Kuchi mostly stay in one location. During the summer some 230 households come to Faryab province from Balkh province, bringing the Kuchi population in the summer to 101,460 individuals. A total of 5,068 Kuchi households from Faryab are reported as living in IDP camps.

The health status in Faryab is poor. Outcome level data shows that 14 per cent of deliveries are conducted by SBAs, which suggests that women's health status in the province is poor.²⁰ The health status of children is also poor. Nutritional data shows that 48 per cent of children under five years of age are stunted and 18 per cent are underweight.²¹

1.3 Health system in target areas

Afghanistan's health system is still weak although the quality of health services has improved in the last five years according to MoPH data.²² The BPHS is the foundation of the health care system and is the strategy by which the country seeks to ensure that the most important and effective health interventions are made accessible to all Afghans. Access to basic healthcare has increased from 8 per cent in 2001 to 57 per cent in 2010. Recognizing the need to prioritize health services for women in pregnancy and childbirth, and for newborn health care, Afghanistan has reintroduced the cadre of

¹⁷ AHS 2012.

¹⁸ NNS 2013.

¹⁹ National Area-Based Development Programme / Islamic Republic of Afghanistan Ministry of Rural Rehabilitation and Development, NABDP / MRRD, Faryab Provincial Profile (undated).

²⁰ AHS 2012.

²¹ NNS 2013.

²² Islamic Republic of Afghanistan. Ministry of Public Health, Johns Hopkins Bloomberg School of Public Health, Indian Institute of Health Management Research. *Afghanistan Basic Package of Health Services Balanced Scorecard National Report 2012-13*. Kabul: MoPH, 2014.

professional CMWs, selecting young women, with community input, and training them in a new CME curriculum specifically designed for Afghanistan and meeting international standards.²³

According to the latest draft of the new Human Resources for Health (HRH) strategy, the number of health facilities with at least one female health workers has increased from 45 per cent in 2000 to 74 per cent in 2011. The number of health facilities providing BPHS has increased from 1,087 in 2004 to 1,784 in 2011 and 1,977 in 2014. There remains, however, a critical shortage of HRH, and Afghanistan is well below the WHO recommendation of 2.3 doctors, nurses and midwives per 1,000 population.²⁴ Despite the expansion of the BPHS, access to health facilities remains a challenge; while nationally 86 per cent of the population (99 per cent urban and 82 per cent rural) live less than two hours from the nearest public clinic, 14 per cent of rural dwellers are 2-6 hours from the nearest public clinic and 3.1 per cent are more than six hours away.²⁵ Physical access to a health facility is even more difficult for women, considering the socioeconomic, gender status, and cultural norms in rural community.

The health workforce is characterized by skill-mix imbalance, inequitable HRH distribution, low HRH production capacity compared with health system needs and population demands, absence of training in certain specialties (e.g. medical engineering, medical technology, nutrition and environmental health), weak capacity for HRH management at both national and provincial levels, lack of a clear continuous professional development strategy and career pathway mechanisms, weak governance, and poor regulation over the private sector, in addition to low government investment in HRH training and production.

The Government of Afghanistan has taken steps to improve access to and equity of essential health care services and to ensure that the health sector plays its role in the realization of the national development strategy for all Afghans. In 2014 with assistance from WHO and the European Union Technical Cooperation Programme, a comprehensive national HRH strategy was developed which goes beyond the numbers and addresses the HRH issues in a holistic manner.

The BPHS was first introduced in March 2002, in response to the country's fragile situation after decades of conflict. Designed by the Government in consultation with donors and NGOs, the BPHS remains the key instrument in making sure that the most important and effective health interventions are made accessible to all Afghans.²⁶ BPHS has two purposes: 1) to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities; and 2) to promote a redistribution of health services by providing equitable access, especially in under-served areas.

Originally, three levels of health facilities were identified in BPHS 2003 and 2005: the basic health centre (BHC), comprehensive health centre (CHC), and district hospital (DH). Furthermore, health posts (HP) staffed by female and male community health workers were established in order to bridge the community with health facilities. The experience of implementing BPHS 2005 revealed that health care services could not reach all Afghans and two new level of health services - MHTs and health sub-centres (HSC) - were instituted in the revised BPHS 2010.²⁷

The BPHS provides a comprehensive list of services: maternal and neonatal health; child health and immunization; public nutrition; communicable disease control; mental health care; and disability referrals. It also includes a supply of essential drugs offered at all BPHS health facilities.

Building on an example from Cambodia, and recognizing its limitations in health care provision, the MoPH initially contracted out health services to a network of local and international NGOs in 31 provinces which covered approximately 95 per cent of the country's population. In the provinces of Kapisa and Parwan, the BPHS was introduced through the MoPH Strengthening Mechanism, a pilot

²³ Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. *Midwifery* 2007; 23:226–3.

²⁴ Islamic Republic of Afghanistan Ministry of Public Health. *National Human Resources for Health Strategy 2015–2020*. To appear.

²⁵ NRVA 2011-12.

²⁶ Islamic Republic of Afghanistan Ministry of Public Health. *Basic Package of Health Services - Revised July 2010*, Kabul: Ministry of Public Health, 2010.

²⁷ Ibid.

programme supported financially by the World Bank, where management was contracted under the same conditions and with targets set for NGOs.

According to *Afghanistan's Basic Package of Health Services 2010: An Assessment of the Costs*,²⁸ BPHS is currently offered nationwide through a network of 67 DHs, 388 CHCs, 468 HSCs, 34 MHTs, 807 BHCs, and 10,277 HPs.

BPHS also provides a referral mechanism to the Essential Package of Health Services (EPHS) in order to ensure a complete and integrated health system in which a functioning hospital system exists that could accept referrals of complicated cases and conditions from HPs, BHCs, and CHCs. The EPHS was endorsed by the MoPH in July 2005. For each level of hospital – district, provincial, and regional and specialty – the EPHS identifies what the hospital should provide, including what diagnostic services should be available; what equipment is necessary for providing the services; the elements of the Afghanistan Essential Drug List needed; and minimum and recommended staffing levels.²⁹

While BPHS included the services provided by district hospitals, the EPHS provides a complete and comprehensive list of services beyond BPHS services. Together, BPHS and EPHS represent the basic and essential elements of the health system.

Health post: The HP is the lowest level of the BPHS, and is staffed by a female and a male CHW who provide limited basic health services. Each HP has a catchment of 1,000-1,500 people or 100-150 families.

Health sub-centre: The HSC is an intermediate health delivery facility bridging the service gap between HPs and other BPHS facilities. The HSC has a catchment of 3,000-7,000 people and is expected to be a maximum of two hours walking distance from communities in remote areas. Each HSC has a core of three staff: nurse, midwife, and a cleaner/ guard. Based on need, a vaccinator may also be hired to serve the community.

Basic health centre: The BHC is the primary level of BPHS facility and serves a catchment population of 15,000-30,000. The BHC includes a doctor/ nurse, midwife, vaccinator, cleaner, and guard.

Mobile health team: The MHT was included in the structure of BPHS to reach remote villages geographically hard to access areas through intermittent visits. The MHT is staffed by a male doctor or nurse, a community midwife or female nurse, a vaccinator, and a driver.

Comprehensive health centre: The CHC is a primary higher level facility, with a catchment population of 30,000-60,000. The CHC is staffed by a doctor in addition to a nurse, midwife, vaccinator, cleaner, and guard.

District hospital: The DH is the first level referral centre for lower level health facilities and offers in-patient services. It serves a cluster of districts with a combined population of 100,000-300,000.

Health system in Bamyan province

In Bamyan primary health care is provided through the BPHS via 23 HSCs, two MHTs, 24 BHCs, nine CHCs, and three DHs. CHWs provide very basic community health care services. The BPHS is implemented by the international NGO, AKF, and an Afghan NGO, the Afghanistan Agency for Development Assistance (AADA). This is through a contract-out process funded by MoPH and the United States Agency for International Development (USAID), through which the MoPH and PPHD have the stewardship role for the health system and monitor its progress in the province. The provincial hospital in Bamyan offers secondary health care and is the referral centre for all BPHS facilities in the province.

Around 25-30 per cent of deep rural and isolated areas have limited or no access to any level of basic

²⁸ Islamic Republic of Afghanistan Ministry of Public Health, Health Economics & Finance Directorate, Kabul: Ministry of Public Health, November 2012.

²⁹ Islamic Republic of Afghanistan MoPH Basic Package of Health Services - Revised July 2010. Kabul: Ministry of Public Health, 2010.

health care.

Health system in Daykundi province

In Daykundi primary health care is provided through the BPHS via 14 HSCs, two MHTs, 12 BHCs, seven CHCs, and three DHs. CHWs provide very basic community health care services. The BPHS is implemented by the international NGO, PU-AMI, and an Afghan NGO, MOVE Welfare Organization. This is through a contract-out process funded by MoPH and the World Bank, through which the MoPH and PPHD have the stewardship role for the health system and monitor its progress in the province. The provincial hospital in Daykundi offers secondary health care and is the referral centre for all BPHS facilities in the province.

Around 25-30 per cent of deep rural and isolated areas have limited or no access to any level of basic health care.

Health system in Faryab province

In Faryab primary health care is provided through the BPHS via 11 HSCs, four MHTs, 21 BHCs, 16 CHCs, and two DHs. CHWs provide very basic community health care services. The BPHS is implemented by two Afghan NGOs, AADA and SAF. This is through a contract-out process funded by MoPH and USAID, through which the MoPH and PPHD have the stewardship role for the health system and monitor its progress in the province. The provincial hospital in Faryab offers secondary health care and is the referral centre for all BPHS facilities in the province.

Around 25-30 per cent of deep rural and isolated areas have limited or no access to any level of basic health care.

1.4 UNFPA assistance to the MoPH in addressing high maternal and neonatal mortality

UNFPA assists the Government of Afghanistan meet its development obligations to Afghan citizens and, specifically, helps the MoPH address the country's high rate of maternal and neonatal mortality. As part of this effort, UNFPA works with MoPH, the provincial governments and local community leaders to pilot a new way of giving women in under-served and hard-to-reach areas access to reproductive health care by a professional midwife who is supported by and linked to the health system, in particular to a referral centre for obstetric and early neonatal complications.

The third UNFPA country programme for Afghanistan (2010-2013), which was ongoing at the time of this review, sought to achieve the following outcomes and outputs: "By 2013 utilization of high quality reproductive health information and maternal health and family planning services is increased in selected and under-served provinces" and "Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and postnatal care, basic and comprehensive emergency obstetric care and fistula treatment."³⁰

The FHH pilot project is one of the key strategies to achieving the results specified in the UNFPA Country Programme for Afghanistan: "*Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender responsive and meet human rights standards for quality of care and equity in access*" and "*increased national capacity to deliver comprehensive maternal health services*". It is also in line with the

³⁰ United Nations Population Fund. Third Country Programme for Afghanistan 2010-2013. Available at: https://drive.google.com/file/d/0B9g_VysVwJvrMGZIODMwZWEtODdmYi00MDE4LWEyOTYtNzNhYjM2NWUzM2I0/view.

outcome and outputs of UNFPA’s Global Strategic Plan 2011,³¹ and the Global Strategic Plan 2014-2017.³²

As such, the FHH model will contribute to the achievement of the health related MDGs 4, 5 and 6 through improved access to and uptake of the BPHS, emergency obstetric and newborn/early neonatal care (EmONC), skilled attendance at birth and modern methods of voluntary family planning/ birth spacing.

The Family Health House Model Project began in the last quarter of 2009 and is being implemented in selected areas of the three target provinces, Bamyán, Daykundi, Faryab, with a recent extension into Herat. The aim of the project is to increase access to RMNCH services in un-served and under-served districts to reduce reproductive, maternal, neonatal and child morbidity and mortality. The pilot builds on and is supported by efforts which began prior to its commencement, i.e. assisting with supporting MHTs and building a cadre of professional community-based midwives. These efforts run concurrently with the FHH project. The aim of the pilot project was to develop an effective health service delivery system which is both affordable and acceptable to women and the community, and can be managed within the resources available to the MoPH.

1.5 The Family Health House model

The FHH model aims to increase access to RMNCH services in unserved and under-served districts thereby to reduce reproductive, maternal, neonatal and child morbidity and mortality. At the time of the MTR over 80 FHHs were either in operation or about to be brought online, and nine MSTs were operating.

According to the Concept Note, the specific objectives of the FHH model are to:

- (1) Increase the access (physical, social, economic) of communities living in remote areas to RMNCH services;
- (2) Improve the quality of health services through training and capacity building for CMWs, HPs, FHAGs as well as management staff of the project;
- (3) Establish a functional referral system through FHH linkages with higher level health facilities;
- (4) To improve access and utilization of family planning/ birth spacing services through regular supplies and by involving men in community health shuras;
- (5) Strengthen community mobilization and ownership of the project through community structures such as the community health shuras and FHAGs to improve decision-making and support the operations of the FHH;
- (6) To contribute to the elimination of GBV.

The FHH, known also as the Ashiana-e-Sehi, is managed by a CMW and assisted by two CHWs, one male and one female. The FHH is also supported by an MST which is expected to visit the FHH every three to four months for administrative and technical support and supervision and to provide some primary health care services not offered by the CMW. In terms of awareness and advocacy at the community level, the CMW is supported by and works in close cooperation with the community health shura (Shura-e-Sehi),

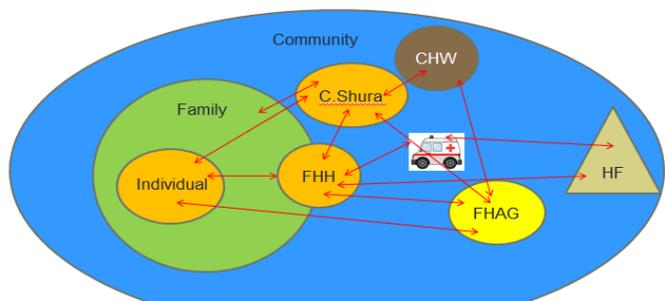


Figure 1. FHH model in relation to community and BPHS

³¹ United Nations Population Fund. Midterm review of the 2008-2013 strategic plan. (DP/FPA/2011/11).

³² United Nations Population Fund. THE UNFPA Strategic Plan, 2014-2017. <http://www.unfpa.org/resources/strategic-plan-2014-2017>.

comprising male and female elders and the Family Health Action Groups (FHAG), a group of women volunteers who are responsible for 10-15 families each.

The MST is made up of four higher-level professionals, usually including a medical doctor or nurse, a midwife, a vaccinator/ female health educator and a driver/ male health educator. The driver sometimes also provides some administrative assistance to the MST. Each MST covers a cluster of FHHs. Figure 1 illustrates the relationships between the different components of the FHH with families and BPHS facilities.

Clear criteria have been developed for establishing each FHH. These are:

- (1) Catchment population of 1,500-3,000 (exceptionally, 4,000).
- (2) Located more than three hour walk/ donkey ride, or 10+km from the nearest health facility.
- (3) Community participation, especially from women, including an agreement to help construct the building and to support and protect the security of the CMW.
- (4) FHH can be constructed adjacent to, or inside, the residence of the CMW.
- (5) A suitable female candidate from the local community is willing to train and be deployed back as a CMW.

The FHH is owned and led by the local community who contribute roughly 30 per cent of costs. In some areas the community contribution has been 100 per cent, whilst in some poor areas it has been less than 30 per cent. The FHHs are focused on providing basic RMNCH services; antenatal care, skilled birth attendance, postnatal care, newborn care, and family planning. The CMWs are also trained to screen the nutritional status of children under five years of age, and treat common childhood diseases through the provision of Integrated Management of Newborn and Childhood Illness (IMNCI). The FHHs are expected to establish a referral system between community and BPHS facilities for the effective and timely referral of at risk mothers, newborns, and children under five.

The selected areas were agreed, with full participation, by the MoPH, provincial governors, local leaders including shuras, UNFPA and the IPs. Once the area was selected, project activities commenced, including monthly or bi-monthly visits of an MHT made up of similar personnel as the MSTs who provide the BPHS while the CMW completes her training course (two years plus an additional two months of training in additional subjects appropriate for FHH deployment). In year two of the CMW training, the building of the FHH commences. On graduation and after deployment, the visits from the MHT are phased out and replaced by the MST.

1.6 FHH project outcome and expected results

The project aims to deliver the following results:

- (1) Improve the health and wellbeing of communities living in areas un-served in Bamyan, Daykundi, and Faryab provinces.
- (2) Decrease maternal and neonatal mortality and morbidity; and, enhance and promote community and family action, health promoting practices and values that improve reproductive health in the catchment areas as intermediate outcomes.
- (3) Increase antenatal, postnatal, family planning and neonatal health coverage; and, promote community participation and ownership towards utilization of reproductive health services in the catchment areas as immediate outcomes.

FHH project outputs

The following five outputs will contribute to the achievement of the immediate outcomes:

1. Mobile Health Teams deployed, CMW graduated and functioning well in operational FHH providing reproductive health services in collaboration with CHWs to the catchment population in Bamyan, Daykundi and Faryab.
2. Train and deploy community midwives in the family health houses in [Bamyan, Daykundi and Faryab] sample provinces.

3. Utilize community based systems to mobilize resources and collective action towards construction of FHH.
4. Promote the formation and strengthening of Community Health Shuras at FHH locations and more in adjacent villages.
5. Male and female CHWs and FHAGs promote household action to improve health seeking behaviour.

This MTR endeavoured to assess the extent to which the project has been implemented according to the plan and the progress being made towards achieving the expected outputs. It was not possible to say if outputs would be reached in all areas, due to the staged process by which the FHH project has been implemented, and because some FHHs have only just started to function. It is, therefore, too early to tell if they will achieve outputs 4 and 5 above.

Purpose and objectives of mid-term review of the Family Health House model

Chapter 2

In 2014, partly in response to the evaluation of its Third Country Programme, UNFPA with MoPH and other partners, agreed to undertake a MTR of the FHH model. The MTR is intended to specifically look at the project's achievements and help make decisions about the potential for integrating the model into the national BPHS programme.

2.1 Purpose of the external mid-term review

The main purpose of the external review is to determine the efficiency, effectiveness, relevance and sustainability of implementing the FHH model. The MTR will also highlight facilitating factors and limiting factors, including opportunities and challenges (see Annex 1: TOR for MTR.)

While a review of the FHH project was part of UNFPA's Third Country Programme Review³³ it was only possible to conduct the baseline assessment in 2013, rather than before the project or at its commencement. Thus the MTR will also help to determine whether there has been progress at the community level in increasing access to quality and affordable RMNCH services.

Since the review collected data mainly, but not exclusively, using qualitative methods, the analysis of indicators at outcome, and output levels was generated from the data collected and interpreted during the data analysis and report writing, based on findings from respondents on how the project is being implemented and achievements at the point of last routine reporting. As this is a mid-term review, which was conducted in a short timeframe, and the unavailability of relevant data, it was not possible to consider impact indicators. However, the analysis did consider some proxy indicators for the pilot areas.

2.2 Objectives of the mid-term review (based on TOR)

- (i) To determine the impact³⁴ and benefits of the FHH project at community and provincial level in terms of addressing the health needs of communities and its contribution to the progress made in the areas of increasing access to maternal health and family planning services, as per UNFPA's Results Resources Framework;
- (ii) To provide MoPH, UNFPA, donors and other important stakeholders an independent assessment of the relevance and performance of the FHH pilot project;
- (iii) To determine the extent of coordination and collaboration of respective stakeholders (MoPH, UNFPA, donors, and implementing partners) in the implementation of the project and provide recommendations to further improve coordination and collaboration to enhance its sustainability; and

³³ United Nations Population Fund (Afghanistan). Evaluation of UNFPA Country Programme 2010–2014, December 2013. Available at: <http://web2.unfpa.org/public/about/oversight/evaluations/document.unfpa;jsessionid=D5D21CA82CEC4EE7CF1615157E3B851F?page=doclist&method=view&docId=138>.

³⁴ Due to lack of time and relevant data to measure impact, it is only possible to determine perceptions of impact in terms of benefits, and the process indicators.

- (iv) To determine the most appropriate modality, governance structure, management, operations and funding of the FHH project to ensure its sustainability.

The review was planned to be conducted over two months starting from 9 November 2014. It was proposed to cover the three provinces of Bamyan, Daykundi, and Faryab. It was decided not to include Herat as the project there was at its initial stage, with health services provided by the MHT, and training of selected candidates to become CMWs still underway.³⁵

The Terms of Reference (TOR) for the MTR was discussed with all major stakeholders at the central level, and it was agreed that inputs should include feedback from consultations with the governors, IPs in the respective provinces, PPHDs, district health centres and provincial hospitals, FHH and communities, MoPH, Midwifery School, donors and UN agencies.

2.3 Beneficiaries of the mid-term review

Primary beneficiaries

The primary beneficiaries are the various directors within the MoPH, Governors, Health Service Managers at all levels, community leaders, UNFPA, FHH donors, and IPs. The MoPH will use the lessons learnt and best practices to help monitor and strengthen health service delivery for the remaining period of the FHH project, and make decisions on replicating this model in similar settings.

UNFPA will use the MTR to improve its own programmes and identify areas that need strengthening for maximum results.

Secondary beneficiaries

The secondary beneficiaries of the review are women, men, adolescent boys and girls who access family planning, maternal, neonatal, and child health services. Midwifery training institutions may use the results of the MTR to improve their pre- and in-service programmes.

2.4 Geographical Scope of the Review

The MTR consultants, in collaboration with UNFPA, MoPH and IPs, selected areas in each project province (Bamyan 6 FHH sites; Daykundi 3 active and 1 under process; and Faryab 7), identifying a total of 17 active FHHs or approximately 20 per cent of all operational FHHs (numbering 80) at the time of the MTR (see Figure 2).

³⁵ In Herat, the MHTs were functional and serving the communities, and nine students were receiving CME training for deployment in 2016, but the FHHs themselves had not been established. The FHHs are to be constructed in 2015 and be fully functional in 2016.

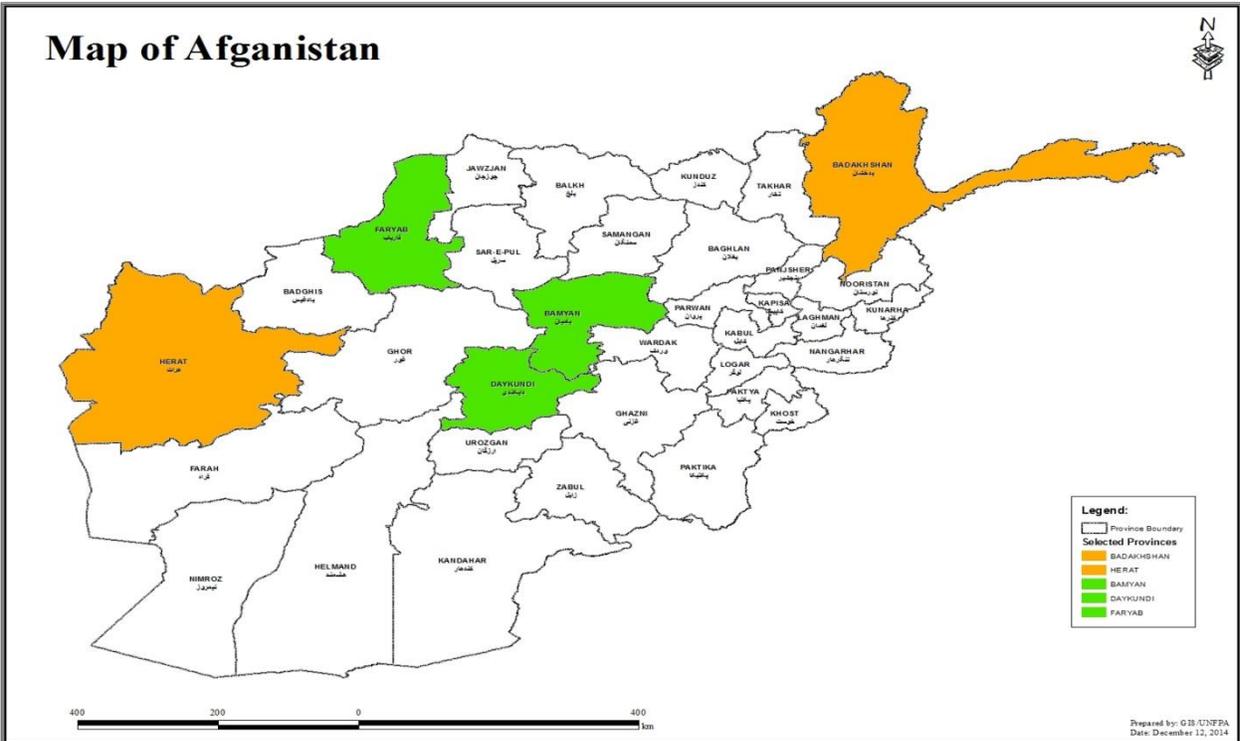


Figure 2. Provinces where the FHH project has been or is in the process of being implemented. (Badakhshan, while not a full project area, has an MHT in operation and this thus shown on this map)

2.5 Limitations of the mid-term review

The MTR's limitations include security issues at the time which meant that some very remote FHHs could not be included in the field observations. In addition, only the national consultant could undertake field observations outside Kabul. In the original fieldwork plan, FHHs were to be visited directly for observation. However, Faryab FHHs could not be visited due to security limitations. Instead, CMWs and members of the community shura and FHAGs were asked to come to Maimana, the provincial capital and bring the relevant documents for review. As a result, only the observation of the physical structure of FHHs was omitted from the analysis.

The lack of outcome level data hindered an analysis of the effectiveness of outcome level indicators and the cost-benefit analysis. A baseline survey had been conducted to assess outcome indicators in the catchments, but took place after implementation was well underway. Furthermore, as the project is still in progress, no end line survey data is available to compare progress from the baseline. However, FHH data reported and recorded in the HMIS was analysed as proxy for outcome indicators.

It was not possible to disaggregate specific data available in the field and analyse for age distribution, in particular. The HMIS records patients attending health facilities in only two age categories: under five years of age, and five years of age and above. Secondary data suggests that many young women are married at an early age and commence their reproductive lives almost as soon as they are married, as fecundity is highly valued.

Finally, although ideally interviews of female respondents should have been conducted by a female interviewer, none were available who possessed the requisite skills including language ability. To mitigate this, extensive discussions took place between the national and international consultants on how best to address the more gender sensitive questions. These were left to the end of the interview by which time it was hoped that the interviewee would be feeling more comfortable being interviewed by a male. The interviews were discussed beforehand with male leaders in the community, to ensure they would not raise any issues or disagree with having women participate.

2.6 Mid-term review process and quality assurance

The MTR was a systematic and participatory process and provided an opportunity to capture diverse opinions about the FHH model and facilitate triangulation. The process is illustrated in Figure 3.

The MTR taskforce comprised staff from MoPH departments (reproductive health, Community Based Health Care or CBHC, HMIS), IPs, DFATD, Canada, and UNFPA who reviewed and commented on the design and tools of the MTR. The taskforce also oversaw the progress of the MTR. During the process, the MTR Taskforce and the FHH PSC were updated about the MTR and provided preliminary results from field data collection. The first draft of the report was shared with UNFPA for review and feedback, and was followed by a verification workshop with IPs as well as presentation of the MTR at taskforce and PSC meetings. The comments of different stakeholders were considered in the revision.

Quality assurance mechanisms are specified in the TOR (Annexe 1). The establishment of a Task Force to oversee the MTR was intended to act as a quality check. Interim findings were discussed with Task Force members and regular and periodic reports were made where any issue or concern regarding the findings were discussed and clarified. As far as possible, all data collected during field observations was checked and verified with the MoPH and IPs. Findings were triangulated to look for consistency and identify specific issues and/ or differences, which were then further investigated and discussed with UNFPA and/ or the MoPH. The draft report was shared with UNFPA who collated comments which were conveyed to the authors for the final report.

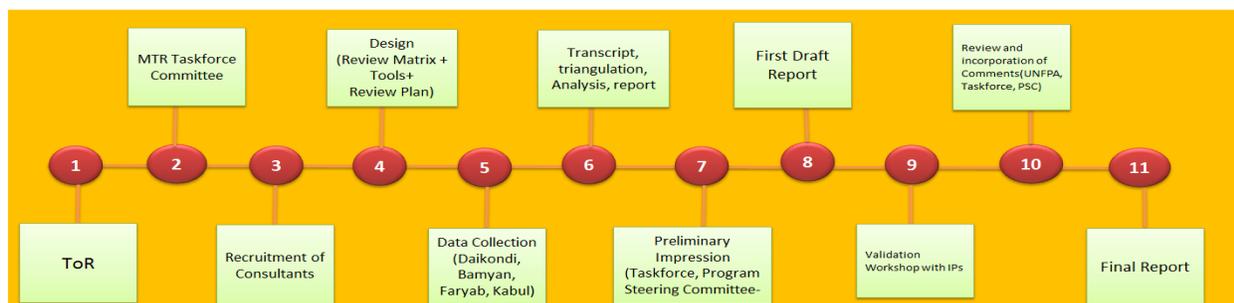


Figure 3. MTR process and quality assurance

The design of the MTR endeavoured as far as feasible to follow the UNFPA guidelines for evaluation.³⁶

3.1 Overview

The MTR used a mixed approach, which was designed to be as participatory as possible, employing qualitative and quantitative methodologies. In Kabul, key informants included the MoPH as well as donors, UNFPA and senior managers of IPs who were interviewed. At the provincial level, the governor, members of the provincial council, PPHD, BPHS managers, and provincial IP managers were interviewed. At the community level, CMWs working at the FHHs, CHWs, beneficiaries of FHHs, and health providers at BPHS facilities participated in the MTR. FGDs were used to explore the opinion of community health shura and FHAGs. Observation was used to verify issues at the FHH level; a full list of persons/ stakeholders consulted is provided in Annex 3. Available HMIS data was used for quantitative analysis.

An MTR Task Force was appointed by the MoPH to oversee the MTR and give guidance where needed under the chairmanship of a senior MoPH official, the Acting Director of the Reproductive Health Department. The chair of the Task Force reported to the chair of the FHH Steering Committee, the General Director of Policy Planning and International Relations. The consultants reported to the Task Force regularly, and discussed issues of concern, delays etc., as they arose. The Task Force also reviewed and commented on the TOR, final design and tools. See Annex 1 for a complete account of the membership, role and responsibilities of the Task Force.

All qualitative data collected was cross-checked with UNFPA, the IPs and the MoPH. Sample sizes of field sites were agreed with UNFPA and a travel itinerary for the national consultant was developed. Sites for data collection and proposed travel itineraries were agreed with the MoPH and IPs to ensure representativeness and that provincial and field staff would be available.

A total of 14 tools were developed and applied. These were developed initially by the national consultant and then reviewed and commented on by the Task Force, and then by the international consultant. See Annex 5 for Review Matrix and Annex 4 for list of all tools used for the MTR.

The MTR had five phases:

1. Design of methodology and tools
2. Desk review (by international consultant)
3. Data collection (provincial to be conducted by national consultant and central level data to be collected by the international consultant)
4. Analysis of the data and sharing with key stakeholders (both consultants)
5. Final Report (primarily international consultant in consultation with, and comments from, the national consultant and UNFPA)

³⁶ United Nation Population Fund. *Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA*. Available at <http://www.unfpa.org/admin-resource/how-design-and-conduct-country-programme-evaluation-unfpa>.

The MTR analysed the FHH model in the context of the purpose and objectives of the project based on the criteria of (i) relevance (ii) effectiveness, (iii) efficiency, (iv) sustainability and/or perceived impact at community level (see operational definitions for each at the start of this report). Importantly, the review also considered the governance and management structures for coordination and collaboration and their contribution to project success, and further tried to gauge how easily these processes could be integrated into existing MoPH structures for the governance of BPHS services.

The review endeavoured to consider how effective processes, such as the monitoring, had been and, where feasible, how gender was addressed.

Finally, the review considered the extent to which the project made links with and had coherence with related UNFPA programmes and contributed to the UNFPA Country Programme and Global Business Plan. All data once cleaned was triangulated as far as possible for analysis.

3.2 Mid-term review methodologies

The MTR used a mix of qualitative and quantitative approaches and built on the methodologies and findings of earlier assessments done in country (see Annex 2 for a list of major documents reviewed during the MTR). For further details on the tools refer to Annex 4: Summary of the Tools used in the MTR and Annex 5 Review Matrix.

Methodologies included:

- i. **Desk review:** of relevant government and UNFPA key documents, to validate, augment and contextualize secondary data in order to respond to the review objectives. Documents were reviewed according to Tool 1 (see below and Annexe 4)
- ii. **Key informant interviews (telephone or face-to-face):** using semi-structured interview guides. Face to face interviews were conducted with staff and stakeholders at community, district, provincial and central levels who have been associated with the programme, in order to gain information, data and gather their opinions and views on the FHH Project. Specifically, information was gathered on their views of the implementation process, relevancy, effectiveness, institutional arrangements, coordination and on sustainability, including potential for future expansion/ integration into the national BPHS package. The interviews were open enough to explore issues as they arose. Interviews ended by asking the participant what they thought needed to be done to improve either the plan itself (if they were implementers) or what resources or support they needed (if they were users). Interviews typically lasted 30-90 minutes. A separate tool was developed for each stakeholder group. The tools in the field and at the province level were applied by the national consultant using local languages. These interviews were open enough to explore issues as they arose, and ended by asking the participant what they thought needed to be done to improve either the plan itself (if they were implementers) or the resources or support they needed (if they were users). Each interviews lasted approximately 30-90 minutes. Consent was obtained before proceeding with the interview after explaining the purpose of the MTR and what the questions would cover. All interviewees were promised anonymity for individual responses. The field and provincial data was later transcribed and translated into English by the national consultant once he returned to Kabul. The central level interviews (in Kabul) were conducted in English by the international consultant. Responses from each interview was then included into a thematic matrix to aid analysis.
- iii. **Focus group discussion:** FGDs were conducted with the community health shuras and FHAGs of FHHs visited for the review. FGD with men and women were organized separately, allowing the voices of women to be heard. A pre-developed FGD guide was applied to discussions. The FGDs elicited opinions on health status and health seeking care of women in pregnancy, delivery, postpartum, and family planning before and after the FHH project. The aim was to explore the acceptance, satisfaction and perceived benefits of the FHH model. The FGDs also explored the opinions of participants on the process by which FHHs were established and their

functionality. Finally, the FGDs explored gender issues and societal norms around gender and access of women to FHHs. The FGDs were led by the national consultant who was fluent in the main local language. Sound recordings of the FGDs were transcribed, translated into English and analysed using major themes.

- iv. **Other participatory methods:** such as direct observation to check the functionality of FHHs, availability of equipment, recording keeping etc. were also used. These observations were conducted by the national consultant when visiting FHHs and used a predetermined checklist.
- v. **Quantitative data collection:** The national HMIS database was used to extract the RMNCH services reported by BPHS facilities and FHHs in Faryab, Bamyān, and Daykundi provinces. One year data for 2014 (Jadi to Hoot 1392 and Haml to Qaus 1393) was used to analyse basic RMNCH services e.g. antenatal and postnatal care, delivery, family planning, and referral.

3.3 Overview of tools used

Tool 1 For Desk Review: The tool was designed to specifically look at relevance and coherence between the project design, implementation and national policies, strategies and plans, as well as coherence with UNFPA planning, including the Country Programme, Global Strategy and Business Plan. The tool was applied by the International Consultant prior to field observation, and helped highlight specific issues to be covered during the field observation and interviews with central level policymakers, and as a prompt for reviewing the tools designed by the national consultant.

Tools 2-6 for semi-structured interviews: Five key informant interview guides were produced, each designed to elicit specific information relevant to particular stakeholders.

Tools 2a-2g: These seven tools were very similar; they were developed for interviews with the policymakers at the central level (MoPH and donors) to gather their views on relevance, sustainability and institutional arrangements, governance and coordination, with some specific questions for each individual policymaker to elicit responses according to their area of expertise/ responsibility.

Tool 3 specifically looked at management of IPs to gather data on effectiveness, efficiency, their views on sustainability of the FHH model and issues related to institutional arrangement, governance and coordination, including monitoring by UNFPA.

Tool 4 was developed for interviews with key UNFPA staff and looked at sustainability, effectiveness, efficiency and institutional arrangements with MoPH, IPs and donors, and governance and coordination.

Tool 5 was developed specifically for provincial governors, members of the Provincial Council, provincial health department staff who oversee BPHS, Provincial Health Committee members and BPHS managers, to consider their views on the relevance of the FHH model, effectiveness in terms of implementation and delivery of BPHS services, and for local governors, on issues of institutional arrangements, governance and coordination.

Tool 6 was designed to elicit responses from CMW running FHHs. An adapted version of this tool was used to interview CHWs, clients and BPHS health service providers in related provinces to gather their views on effectiveness and check details about implementation.

Tool 7-11 comprised observation checklists and were used for walk through/ direct observation to assess the functionality and effectiveness of FHHs. They were based on the FHH Concept Note, including the criteria established for choosing FHH sites (Tool 7); the checklist for establishing FHHs, if establishment met agreed criteria (Tool 8); a checklist of physical structure of FHHs if they met the agreed design (Tool 9); a checklist for general management of FHHs (Tool 10); and observation checklist for general FHH functionality (Tool 11) where functionality was defined by the optimal availability of technical staff, functional equipment, and pharmaceuticals and family planning commodities, as described in the FHH Concept Note.

Tool 12 and 13 collected specific, relevant HMIS data related to the three provinces; Tool 12 collected basic HMIS performance data and Tool 13 was assessed aspects of the effectiveness of the FHH model, as specified in Question 4 of the MTR terms of reference:

Question 4: Whether the activities of the project and interventions by partners and stakeholders contributed to the following at community/provincial and national levels;

- Improvement in ANC and PNC coverage;
- Increased deliveries at FHHs and relevant health facilities;
- Increased deliveries attended by skilled birth attendants;
- Increase in the number of skilled birth attendants, particularly midwives;
- Increased contraceptive use and uptake by the target population;
- Increased young people accessing and utilizing FHH facilities for [sexual and reproductive health] services;
- Increased in nutrition screening of children [under five].

Tool 14 guided FDGs with community health shuras and FHAGs to elicit views on the extent to which project design aligned with community needs, and the extent to which the communities deemed that the interventions and strategies were relevant and acceptable, given their cultural and religious contexts.

3.4 Review matrix and specific questions used

In designing the MTR, consideration was given to the specific questions in the TOR (Annex 1), and the wishes of the MoPH and donors for evidence to guide next steps. Both the design report and tools were shared with the MTR Taskforce and revised based on their feedback and that from UNFPA. Criteria for the evaluation and the Review Matrix were also reviewed, commented on and approved separately by UNFPA and the MTR Taskforce (of which UNFPA was also a member).

In analysing the data the MTR applied the following criteria:

Relevance

The extent to which the FHH project and interventions were consistent with national policies, priorities and needs of the Government and communities in addressing the RMNCH needs of remote communities, specifically:

1. The extent to which the project design is in line with national RMNCH needs and priorities and those of target communities;
2. The extent to which the Government of Afghanistan and targeted communities deem that the interventions and strategies are relevant and acceptable to them, given their cultural and religious contexts;
3. The extent to which current and proposed interventions under FHH project are within the framework of BPHS and EPHS;
4. Additionally the MTR considered the extent to which the FHH project was in line with and relevant to the UNFPA Country Programme and UNFPA global priorities, strategies and plan.

Effectiveness

The review assessed the extent to which the activities of the project contributed to achievement of project outputs and outcomes or related results at community level and national level, specific the review:

1. Assessed the extent to which the project results and planned targets were achieved;
2. Highlighted major factors that influenced the achievement or non-achievement of planned results and targets;
3. Assessed the extent to which the current implementation modality contributed to the achievement of planned results and targets and in particular the realization of benefits to communities as far as these could be ascertained at this point in the project life cycle;

4. Whether the activities of the project and interventions by partners and stakeholders contributed to the following at community/provincial levels;
 - a. Improvement in ANC and PNC coverage;
 - b. Increased number of births taking place in an institution (FHHs and health facilities);
 - c. Increased number of births attended by skilled birth attendants;
 - d. Increase in the number of functional skilled birth attendants, particularly midwives;
 - e. Increased contraceptive use and uptake by the target population; and
 - f. Increased number of young people accessing and utilizing FHH facilities for sexual and reproductive health services.

Efficiency

The review looked at the implementation of the FHH project to date to assess how efficiently inputs and resources were utilized to produce the results or outputs in respect of the following:

1. The extent to which the FHH project has utilized the skills of UNFPA and IP staff to achieve planned results and targets;
2. If the staffing set-up of the IPs and FHH project was appropriate for effective and efficient implementation;
3. If the modality of procurement and distribution of supplies from UNFPA to IPs and FHH was sufficient and timely for the efficient implementation of the project;
4. If the funding modality and disbursements was sufficient, effective and timely to ensure efficient implementation of FHH activities and interventions by IPs and FHH staff;
5. If the capacity building programme of midwives and other staff was sufficient and timely to enable the effective and efficient implementation of FHH activities and interventions;
6. The measures taken during planning and implementation phase of the project to ensure that resources were utilized efficiently;
7. The extent to which the project addressed equity, efficiency and rights, applying a needs-based approach to health care for communities; how these approaches were balanced to ensure maximum net gains; and who accessed and benefited from the project interventions.

Sustainability

In assessing the sustainability of the project, the following were considered:

1. The extent to which the positive benefits of the FHH project and its interventions could be seen by communities and Government to justify continued investments in the project in future years (including a basic rapid assessment of cost-effectiveness of the FHH modality);
2. The extent to which partners (IPs and Government) have the financial capacity to maintain and sustain the benefits from the interventions when UNFPA and other donor support ceases or is scaled down;
3. The extent to which the MoPH and Provincial Health Directorate would like to institutionalize the strategies and activities of the project in their policies/procedures and corporate plans and organizational budgets;
4. The feasibility of integrating the FHH concept into BPHS;
5. The extent to which human resources development, capacity building training, career path planning and appropriate incentives have been factored into the FHH project and overall policy and strategy of Government to ensure staff retention, career progression and sustainability within the healthcare system.

Institutional arrangements, governance and coordination

The opinions and views of stakeholders was also sought on the following:

1. The extent to which the overall governance structure, institutional arrangements and collaborations with UNFPA, MoPH, IPs, the AMA and other relevant stakeholders have contributed to the progress that the project has made or otherwise towards its planned results and intended benefits to communities;

2. Whether the leadership, technical advice and support provided by UNFPA were to the satisfaction and standards of the MoPH, IPs, FHHs and community health shuras and whether this contributed to the achievement of planned results and benefits of the project;
3. Whether the IPs performed their role and functions well and effectively resulting in the achievement of planned results, targets and the realization of benefits to communities;
4. The areas in which UNFPA, MoPH, IPs and other stakeholders could have done better or need to address in order to improve overall project implementation;
5. Whether the current governance and institutional arrangements allow for strong collaboration, consultation, coordination and reporting of progress in implementation, and if not, to suggest alternative governance structures to strengthen project implementation and reporting; and
6. The extent to which HMIS and the monitoring and evaluation systems of UNFPA and IPs were able to support planning, project management, implementation, resource allocation, reporting, decision-making and the achievement of results.

3.5 Data analysis

All the relevant documents were reviewed according to their purpose. Policy and planning documents including the original FHH Concept Note and proposal documents to donors, as well as standards and guidelines, were reviewed for cross-policy consistency, and links to the FHH concept and project documents to assess for relevance. Progress reports, mission reports, annual work plans, IP annual reports, monitoring reports including those from donors and IPs as well as UNFPA, and trip reports were analysed to identify issues related to effectiveness, efficiency, institutional arrangements, governance and coordination as well as issues of concern and how these were addressed.

Data from interviews and focus group discussions was analysed using a standard thematic matrix to look for consistency and identify major themes emerging from responses.

HMIS data for the three provinces (Daykundi, Bamyan, and Faryab) was extracted from the national database for 2014 (Jadi-Hoot 1392 to Haml-Qaus 1393). Data was input into a standard Excel spreadsheet which was used to make basic arithmetical calculations, summative, mean, mode and median, as well as minimum and maximum ranges analysis.

The costing analysis used basic data provided by IPs and UNFPA. Costs were mainly categorized as establishment costs; capital costs and construction costs, and the annual running cost of a FHH.

The findings of the MTR are presented under headings corresponding to the criteria outlined in the TOR: *relevance, effectiveness, efficiency, sustainability and institutional arrangements, governance and coordination* (see the Review Matrix in Annex 5) and are based on triangulation of all data collected.

The narrative is illustrated by references to graphs and summary tables where appropriate. Full details and tables for all findings can be found in Annex 7.

A score is given for each criteria, the scoring system used can be seen in Annex 8.

4.1 Profile of participants

Approximately 270 individual respondents contributed to the MTR. In all, 170 separate data sheets from the field observations were completed by the national consultant, covering 232 persons. See Tables 1 and 2 below for a profile of participants from provincial and community levels.

Table 1. Profile of province level participants

Respondent category	Daykundi		Bamyan		Faryab		Subtotal		Total
	M	F	M	F	M	F	M	F	
Provincial governor	1		1		1		3	0	3
Provincial council	1		3	1	4		8	1	9
PPHD	1			1	1		2	1	3
BPHS manager	1		1		1		3	0	3
IP manager of FHH	1		1		1		3	0	3
Staff of nearest BPHS	3		2	2	4	2	9	4	13
Staff of provincial hospital				1	1	1	1	2	3
Midwife FHH		3		6		7	0	16	16
Midwife MST	1			1		1	1	2	3
Nurse MST	3		1		1		5	0	5
Vaccinator MST			1		1		2	0	2
Clients/ patients		4		2			0	6	6
CHW	2	2	1	5	2	4	5	11	16
Community health shura	26	4	41	2	10		77	6	83
FHAG		21		33		10	0	64	64
Total	40	34	52	54	27	25	119	113	232

Table 2. Profile of participants from community health shura

	Bamyan	Daykundi	Faryab	Total
Number of shura members who participated	43	30	10	83
Education level of shura members				
Illiterate	23	28	1	52
Able to read and write	5	2	3	10
Primary school	4	0	0	4
Secondary school	3	0	0	3

High school	1	0	1	2
Higher (university)	3	0	0	3
Professional education	4	0	5	9
Age of participants (year)				
Mean	45	44	45	45
Median	46	44	44	45
Min	22	18	30	18
Max	75	75	60	75
Mode	50	40	35	50
Gender of participants				
Male	41	26	10	77
Female	2	4	0	6

A total of 38 individual respondents participated at the central level, of whom 11 were high-level policymakers in MoPH, including both the Acting Minister and the Deputy Minister for Technical Affairs. The profile of participants at central level is shown in Table 3 below.

Table 3. Profile of central level participants

Respondent Category	M	F	Total
MoPH	9	2	11
NGO (IP)	5	0	5
NGO non IP	4	0	4
Donors	3	4	7
UNFPA	3	2	5
UN agencies (WHO, UNICEF)	3	2	5
World Bank, European Union	2	0	2
Total	29	13	42

Most interviews were with heads of departments/ sections; some included other members of the department, and one interview was conducted as a teleconference call as the individual was no longer in country.

All interviews at the central level were conducted in English by the international consultant following as closely as possible the interview schema in semi-structured Interview Tool 2, except for one multilateral organization who was not available at the time the international consultant was in country. This interview was conducted by the national consultant, who then shared the findings directly with the international consultant. In addition to the interviews there was a review of 17 FHHs, with a total catchment population of 41,157³⁷ (for further details of data collected during MTR field observation see Additional Data Tables in Annex 7).

Multiple data sources were used. As far as possible, data was checked, validated and then triangulated. A standard framework was applied based on UNFPA Evaluation guidelines. (See Annex 5 for overview of Review Matrix).

Ultimately, however, the final responsibility for interpretations of the data, as well the opinions expressed in this report, rest with the two evaluators. Any errors or mistakes are the responsibility of the authors.

³⁷ This figure is taken from the population data collected during field observations and may differ from HMIS data as given in Annex 7.

4.2 Relevance

4.2.1 Score: (scale range 1–4)

4	The programme is fully in line with and supportive of government and UNFPA strategies and policies, and responds to community needs. Decisions to make changes were timely and logical. Evidence of realistic planning (eventually, but not at the beginning), achievable but not always aspiration targets were established, and good timely monitoring was evident.
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In terms of relevance, specifically the MTR endeavoured to assess the extent to which the interventions and FHH design:

- Is in line with national needs and priorities and those of the communities in which FHH is located;
- Is considered relevant and acceptable to the Afghanistan Government, specifically MoPH
- If targeted communities deem that the interventions and strategies are relevant and acceptable to them, given their cultural and religious contexts; and
- If the current and proposed interventions under FHH project are within the BPHS framework and provide opportunities for access to the EPHS, i.e. if there is a functional referral mechanism to EPHS;
- If it builds on existing interventions, such as the CME programme; and
- The extent to which the FHH project is in line with UNFPA Country Programme outputs and results framework, and as such contributes to the overall Global Programme and Business Plan for UNFPA.

In the following sections, the results for relevance are summarized as alignment with the national priorities, MoPH health system strengthening and reporting structure, alignment with UNFPA priorities, and coherence with criteria for establishment of the FHH as specified in the FHH Concept.

4.2.2 Alignment of project with Afghanistan’s priorities

The purpose of the FHH is to expand basic RMNCH services to under- and unserved communities in rural parts of Afghanistan, and is fully aligned with national policies and strategies. The Afghanistan National Development Strategy 1387-1391 (2008-2013)³⁸ calls for “*working with communities to improve the reach of government health services while empowering the communities*” and has as its core values, human rights, gender equity and decreasing inequity, priority to rural areas and cultural appropriateness. The FHH project incorporates all of these. The FHH concept also aligns with the National Health and Nutrition Policy 2012-2020³⁹, National Reproductive Health Policy 2012-2016⁴⁰ and National Reproductive Health Strategy 2012-2016, which, in its strategic approaches to RMNH, refers to strengthening community-based services by increasing the number of CMWs deployed close to where women live, as well as promoting community partnerships. In this respect the FHH pilot project is proving to be very successful and the deployment and retention rates of CMWs after graduation are slightly higher than those quoted for regular CME programmes. Furthermore, the FHH is aligned with the BPHS⁴¹ which prioritizes delivery of RMNCH services across the country. The Community Based Health Care (CBHC) Policy and Strategy⁴² of MoPH promotes community-based networks to promote utilization of health, and particularly RMNCH, services, through health posts and network of CHWs, community health shura, and FHAG which are key components of the FHH concept.

³⁸ Islamic Republic of Afghanistan. *Afghanistan National Development Strategy 2008-2013: A Strategy for Security, Governance, Economic Growth and Poverty Reduction*. Kabul: IRA, 2008. (ANDS 2008–2013).

³⁹ Islamic Republic of Afghanistan. Ministry of Public Health. *National Health and Nutrition Policy 2012-2020*. Kabul: MoPH, 2012.

⁴⁰ Ibid.

⁴¹ Islamic Republic of Afghanistan Ministry of Public Health. *Basic Package of Health Services - Revised July 2010*, Kabul: Ministry of Public Health, 2010.

⁴² Islamic Republic of Afghanistan Ministry of Public Health. *Community Based Health Care Policy and Strategy*. Kabul: MoPH, 2010.

Echoing the views of more than one respondent, an IP manager commented that this is:

“in reality [the] only way to get basic services, RH services, to these remote communities. MHTs can provide some but they only visit on a periodic basis; the FHH/ CMW is available 24 hours [a day], seven days a week. Also, everyone can have access; the community knows this and there are no bias or selection criteria for who can have the services of the FHH/ CMW - they [CMW] are for all people in the catchment area. When we see at the local level and compare with BPHS areas, FHHs are conducting more activities.”

—IP Manager

4.2.3 Alignment with the Ministry of Public Health’s health system strengthening and reporting mechanism

The MoPH intends to ensure availability of health workforce with required competencies across the country to provide health care services, including CMWs trained in CME.⁴³ Furthermore, the MoPH has developed a standardized HMIS for all public facilities to record and report on health care service delivery using standard HMIS forms, registration books and the HMIS database.⁴⁴ The FHH’s recording and reporting mechanism is aligned with the national HMIS and regularly reports to the MoPH to enter FHH data into the national HMIS database.

4.2.4 Alignment with UNFPA priorities

The FHH project shows great alignment with UNFPA’s Global Strategic Objectives and Business Plan and Country Programme Action Plan.⁴⁵ Because the FHH project is located in some of the poorest regions of the country, not only is it meeting the expected result for *increasing utilization of health services in the remote and under-served areas*, but is also helping the MoPH address the equity gap, a priority on the Global Business Plan. Additionally, the emphasis on the education of young women to become CMWs and on supporting them after training, not just deploying them to remote facilities but ensuring they have community support through agreements with community shuras and the establishment of FHAGs, also helps to forward UNFPA’s aim to improve women’s empowerment. From field observations it was apparent that almost all stakeholders held high opinions of CMWs, and that they were respected and afforded a high status, as comments from two CMWs from different provinces demonstrate.

“All of them [members of shura and FHAG] are supportive; however, literate people, teachers, mollah imam and tribal leaders, are more influential people and are supportive. Particularly, the mollah iman is very supportive, although he opposed family planning at the beginning of my work. It was a misunderstanding and misconception about family planning. The imam thought that family planning prevents an already established pregnancy. Also he had another misconception about family planning, that it causes permanent sterility in women. I had several discussions with him, explained how family planning methods work, and removed all misconceptions and misunderstandings around family planning. Once he learned that it is just prolonging the space between two pregnancies, he supports and promotes birth spacing as well.”

— CMW, Faryab Province

In response to the interviewer’s prompt to describe how the community shura supports her, a CMW said:

“One time a man came to the FHH and asked me to administer his injection. I checked the injection; it was Benzyle Penicillin that had been dissolved 24 hours before, according to the man. I told him

⁴³ Islamic Republic of Afghanistan Ministry of Public Health. *Human Resource for Health Policy and Strategy*. Kabul: MoPH 2009.

⁴⁴ Islamic Republic of Afghanistan Ministry of Public Health. *Health Management Information Procedure Manual*. Kabul: MoPH 2011.

⁴⁵ UNFPA Afghanistan. Country Programme Action Plan (CPAP) 3 and 4. Available at: <https://www.unfpa.org/sites/default/files/portal-document/UNFPA-GOIRA-CPAP-2015-2019-EN-Signed.pdf>.

that it should be used only up to six hours [after being dissolved] and I could not inject because it has already been degraded after six hours. He did not accept this and insisted I administer the injection. Finally, he broke the bottle and left the FHH. I shared this issue with shura members and they called the person to attend the meeting. After discussion with shura members, he apologized for what he did and said: 'I did not know'. Shura members have told me to share any challenge I face at the FHH and they are ready to support me."

– CMW, Bamyan Province

4.2.5 Response to community need

The Afghanistan Mortality Survey 2010⁴⁶ revealed the reasons for not seeking delivery care from a skilled birth attendant can be broadly categorized into five groups, namely, perception of services, accessibility, service-related concerns, security concerns, and other reasons. The most frequently reported reason for not seeking care was access to services, which included a lack of money (64 per cent), transportation problems (58 per cent), and distance to the facility (57 per cent). Other reasons were related to perception of need for maternity services. Some women thought that care was neither necessary (27 per cent) nor customary (15 per cent). The FHH approach addresses all five types of reasons for not seeking delivery care from a skilled birth attendant.

From data from the desk review, interviews with policymakers and decision makers at central and provincial levels and in the community, and especially community leaders, the FHH project is considered not only highly relevant, but is the only way that these remote areas are able to access basic RMNCH health care as the typical comments below show:

"The result of household survey we conducted in 2011 and 2013 in Faryab province, showed there are remarkable improvements in the coverage of ANC, PNC, delivery, and family planning, which is the contribution of 33 FHH in the area. FHHs are very effective in raising awareness of community regarding health and health seeking behaviour. Before FHHs, almost all deliveries took place at home and women were transferred to a clinic or hospital only if they had pregnancy and had delivery complications but never attended for ANC and PNC. Since the establishment of FHHs, women visit FHHs for ANC, delivery, and PNC; this is a huge change. At least 2000-3000 people are living in the catchment of each FHH and receiving services that are complements to BPHS coverage. In summary, FHHs are effective because they have contributed to raising awareness and improving health seeking behaviour; they have increased covered of RH services; FHH services are affordable for the people as they are in their own community and do not need transportation and other costs; and FHHs are culturally acceptable as the midwives are from the local communities and serving their own community."

– BPHS manager

"FHH is an absolute fundamental and successful experience in [province].... The BPHS facilities were established with the aim to expand the BPHS services across the provinces. [However], the experience of implementation of BPHS shows that coverage is 65-75 per cent. This means, what was expected from BPHS on paper does not come true in the field, because BPHS selection criteria was mainly based on population and less attention was paid to how close the population and villages are located. With the geographical challenges and scattered location of villages, BPHS could not fill the gap of 25-35 per cent. This situation is compounding by poor roads and transportation in deep rural areas. In such a situation, FHH are established in those areas where the people have no or limited access to BPHS facilities. [Furthermore], FHH are providing RH services, particularly ANC, delivery and newborn care, PNC, and family planning, which are in the focus of health policy and strategy as well as BPHS. FHH link communities with BPHS clinics through its referral system. I can say, with the priority RH services, FHH has contributed to the reduction of maternal and newborn death in the communities they serve. In this case, FHH is in line with the national and local priorities and the services meet the most urgent health needs of women. Although we have 33 FHH spread across seven districts, we need to expand it in to all districts to fill the gap of uncovered areas by BPHS."

⁴⁶ AMS 2010.

– Provincial public health director

As such the review considers the FHH model to be highly relevant and consistent with national policies, priorities and needs of the Government, for the maternal and neonatal health, health education and nutrition components of BPHS, as described in various policies and strategy statements.⁴⁷ In addition, the review shows the FHH project meets the needs of communities in addressing their reproductive health needs in a culturally acceptable way.

“The nearest clinic to our area is located around four hours walk from our village. Transportation was limited, expensive, and unaffordable for most of the people due to low income and poor economic status of families. Most of the patients were treated at home using the local traditional medicine. Most of the deliveries took place at home with the support of elder woman in the village [traditional birth attendants]. The decision to move the woman to the hospital for delivery was made mostly when the woman got bleeding or any other complication. In such a situation, people had experienced different outcomes of pregnancies; the lucky women reached the clinic or hospital and recovered, while the unlucky women died on the way to or at the hospital. In addition, there were people who could not transfer even the complicated deliveries and had to stay home and seek support of Daia [traditional birth attendant] either died before delivery, during, or after delivery. At the same time, there were uncomplicated deliveries managed by Daia without complications”.

“Thank Allah (SWT) the situation has improved a lot. A midwife is available 24 hours in our area. The pregnant women visit the midwife and receive advice regarding her baby. The midwife assists the women during delivery at the Ashiana [FHH] where it is safe and clean. If there is any bleeding, the midwife has medicine to control bleeding. If there is any risk, the midwife informs the pregnant women and her family in advance to move her to the clinic or hospital.”

–Comments from a community shura, Faryab

It is difficult to see how the more than 200,000 residents⁴⁸ of the 80 target communities currently covered by the project could have received the basic RMNCH health services they need without the FHH project. This point was reiterated constantly during the interviews with central level stakeholders, a typical comment from the MoPH was:

“At provincial level, Governors are very happy. Local level community are very happy, community satisfaction with services is very high - they now feel safe someone to look after them, they can go to any time, [who is] always there.

Relationships between CMW and CHW very good and collaborative, better than in Health Post/ sub health post. CMW in HF [regular static health facility] is very busy with health facility issues, so they have no time to go to community and be close with community and engage in community activities.”

–Senior officer, MoPH

In terms of the relevance of specific target areas for the project, there is unanimous consensus that the focus is totally in line with the government’s desire to address inequity and take basic services to all Afghan citizens. According to the Concept Note, prior to the implementation of this project it was estimated that “the majority of the settlements are located beyond the catchment areas of stationary health facilities or 10 kms (3 hours walk) from the nearest health facility”⁴⁹. The MTR confirmed that the majority of the population in the target areas do live in the most remote mountainous and hard-to-reach areas and, apart from the FHHs, there are no existing initiatives to reach them with 24/7 healthcare services (which are essential for saving the lives of mothers and babies); the only way these communities could previously access services is by ad hoc periodic mobile teams. Even though there are long terms plans to expand road networks to connect some of the communities to places where static facilities exist, most stakeholders feel this remains a long way off and there will remain of risk of

⁴⁷ For example: ANDS, Health and Nutrition Policy, Health and Nutrition strategy, BPHS, RH policy and guideline, CBHC policy.

⁴⁸ Total population in the project area over three provinces, is estimated from the field observation notes.

⁴⁹ UNFPA Concept Note on Family Health House. Kabul: UNFPA, 2012.

roads blocked during winter by heavy snowfall. In addition, the distance between where people live and the nearest static health facility is too far for women to travel when in labour, during the night, or without an accompanying male relative.

4.2.6 Coherence with agreed criteria for establishing FHH

Population

In discussing relevance it should be born in mind the rationale for the FHH pilot project was specifically to respond to the need to take basic RMNCH services to the most remote, under and non-served ‘white areas’. The FHH Concept Note clearly states this should not been seen as an alternative to health sub-centres or basic health centres, as described below:

The FHH Concept and recommendations agreed with MoPH states that each FHH should cover between 1,500 to 3,000 populations (or in exceptional cases 4,000 people). Beyond that, Sub-centres or Basic Health Centres are to be established according to BPHS criteria by the BPHS donor/implementer under MoPH.

– FHH Concept Document

Field observation and review

From the observations and data collected during the field observation, it appears that in most cases the criteria as established in the Concept Note were complied with. However, it needs to be highlighted that there was no standardized method for estimating population. IPs in Daykundi, Bamyan, and Faryab have all used different sources to estimate the catchment populations of FHHs, including rapid assessment by CHWs, a CAAC and in some places, data from the Expanded Programme on Immunization (EPI).

Although CAAC⁵⁰ is generally regarded as the most reliable method for estimating catchment population and should be conducted annually, it is not as yet routinely used. In Faryab for example, CAAC was conducted once, but some villages were not included due to security problems. Although CAAC was conducted once by the initial IP in Bamyan and Daykundi, the documentation was not available to the review team, as the current IP did not have copies of these. Moreover, the current IP was not using the initial population calculations, due to lack of confidence about quality.

Although updated and reliable CAAC data is not available, the estimated population according to the IP documents showed that of the 80 functional FHH, one was established in an area with a population of 1,500, 49 in areas with 1,500-3,000 people, and 31 in areas with more than 3000-3500 people. A review of the profile of all 80 functional FHHs show the mean population to be 2,309, with the minimum of 1,500 and a maximum of 3,584. Population data is summarized in Table 4 with additional data in Annex 7.

Table 4. Number of FHHs by catchment population classification

Catchment population of FHH	Daykundi	Bamyan	Faryab	Total
<1500	0	0	0	0
1500	0	1	0	1
1501-2000	3	12	0	15
2001-2500	11	11	1	23
2501-3000	4	0	6	10
>3000	5	0	26	31
TOTAL FHH	23	24	33	80

Source: IP Documents

⁵⁰ Islamic Republic of Afghanistan Ministry of Public Health. *Human Resource for Health Policy and Strategy*. Kabul: MoPH 2009; Islamic Republic of Afghanistan Ministry of Public Health. *Health Management Information Procedure Manual*. Kabul: MoPH 2011.

It is clear that there is no consistent methodology for estimating population size and therefore assessing functionality, and planning, especially for commodities and essential drugs, may potentially be compromised. It would be desirable for all IPs to be required under their Memorandum of Understanding with UNFPA to use the CAAC methodology annually to identify the real population served by each FHH, and thereby strengthen planning and evaluation of performance. The conduct of the CAACs however must be comprehensively supervised and monitored in line with MoPH guidelines.⁵¹

Location of FHH in relation to BPHS static facilities

In terms of the location of the FHH the Concept Note recommends:

The FHH location must not be closer than three hours by walk or donkey ride from another health facility or 10 km. Preference will be given to the most remote settlements meeting the other criteria though this often clashed with local political interests.

– FHH Concept Document

Field observation and review

The review of IP documentation for the 80 functional FHHs in Bamyan, Daykundi, and Faryab and 35 under the process FHH in Daykundi revealed that five are located in the catchment areas of HSCs, 41 in BHC areas, 48 in CHC areas, 17 in DH areas, and 4 in the catchment of provincial hospital, as shown in Table 5 below, with further details in Annex 7.

Table 5. Nearest health facilities to FHH sites

Type of health facility	Daykundi (round 1 & 2)	Daykundi (round 3)	Bamyan	Faryab	TOTAL
Health sub-centre (HSC)	0	1	4	0	5
Basic health centre (BHC)	7	13	11	10	41
Comprehensive health centre (CHC)	11	12	2	23	48
District hospital (DH)	5	5	7	0	17
Provincial hospital	0	4	0	0	4
TOTAL FHH	23	35	24	33	115

Source: IP Documents

MTR field observations found that FHHs located near HSCs and BHCs may face challenges in referral as both type of facilities, particularly HSCs, are run by limited staff, with a limited capacity to receive referral cases. Thus referral to HSCs, as the nearest BPHS facility, is ineffective if the facility is not staffed with a physician with EmONC skills. Unable to provide the necessary interventions for managing complications, the facility would need to refer the patient further, inevitably leading to delays in effective care. This point is discussed further under effectiveness and in Chapter 5.

As can be seen in Table 6 below, the mean distance of FHH from the nearest static health facility (across all FHHs in all three target provinces) is 21 km, and ranges between 6 km and 70 km.

⁵¹ Ibid.

Table 6. Distance of nearest health facilities from FHHs

Distance (km)	Daykundi (round 1 & 2)	Daykundi (round 3)	Bamyan	Faryab	All three provinces
Mean	26	25	17	15	21
Median	25	22	15	13	20
Mode	25	30	15	10	30
Min	10	10	8	6	6
Max	70	50	30	39	70

Source: IP Documents

The data from the IPs, although a rough estimation, suggests that only nine FHHs are located less than 10 km from the nearest BPHS health facility. At least two, Panjab and Waras districts of Bamyan province, were visits. At the time of the field visit, at least five (4.5 per cent) of the FHHs were located 20 km or more (and up to 70 km) from the nearest BPHS facility.

The FHH concept has identified the lower limit for distance of FHH from the nearest health facility, whilst leaving open the upper limit. Based on field observations, FHHs located closer than 10 km from the nearest health facility, particularly if it is a DH, is less likely to be utilized optimally. This is because up to 10km, the health facility, particularly if it is a DH, is considered the direct catchment for any health facility. People have easy access to the facility and develop trust in the facility, its services and staff. Therefore, unless the facility is not properly functioning or staff are not deemed competent, people prefer to use the health facility rather than FHH. This is demonstrated for one FHH

Box 1. Utilization of an FHH located less than 10 km from a static health facility

FHH Dahan-e-Rumi is located 8 km from DH Waras, Bamyan and is underutilized, particularly for births - only 2 per cent take place in the FHH. When this was raised with the CMW, she stated that families call an ambulance from DH Waras when a woman is in labour.

Services provided/ expected/ performance	2014 (Jadi 1392-Qaus 1393)												TOTAL
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
First antenatal visit (conducted)*	4	3	2	1	4	3	3	5	2	3	3	0	33
First postnatal visit (expected: population 1500)**	5	5	5	5	5	5	5	5	5	5	5	5	60
Performance toward expected (%)	80	60	40	20	80	60	60	100	40	60	60	0	55
Other antenatal visit (conducted)*	0	2	5	2	2	3	2	3	2	2	2	0	25
Other antenatal visit (expected: population 1500)**	15	15	15	15	15	15	15	15	15	15	15	15	180
Performance toward expected (%)	0	13	33	13	13	20	13	20	13	13	13	0	14
First postnatal visit (conducted)*	3	2	2	1	2	0	2	2	2	2	2	0	20
First postnatal visit (expected: population 1500)**	5	5	5	5	5	5	5	5	5	5	5	5	60
Performance toward expected (%)	60	40	40	20	40	0	40	40	40	40	40	0	33
Other postnatal visit (conducted)*	0	0	1	0	1	0	0	2	2	2	1	0	9
Other postnatal visit (expected: population 1500)**	10	10	10	10	10	10	10	10	10	10	10	10	120
Performance toward expected (%)	0	0	10	0	10	0	0	20	20	20	10	0	8
Normal delivery at facility (conducted)*	0	0	0	1	0	0	0	0	0	0	0	0	1
Normal delivery at facility (expected: population 1500)**	5	5	5	5	5	5	5	5	5	5	5	5	60
Performance toward expected (%)	0	0	0	20	0	0	0	0	0	0	0	0	2

* Source: Original data (conducted): HMIS Database

** Source: Catchment Population: IP document

in Box 1.

Meanwhile, FHHs located very far from the nearest health facility with a medical physician who can manage obstetric and or neonatal complications, particularly those more than 20 km away, face a number of challenges, especially in terms of referrals from the FHH to a health facility if a

complication arises. In addition, supervision of FHH by the nearest health facility, as required under the FHH Concept Note guidelines, may be a challenge if the FHH is located very far from the health facility. It may be possible that FHHs located near the BPHS health facilities could in the future become satellite health facilities of the CHC or BHC. FHHs which are very far from a static health facility should have greater support from the MST if no other alternative is available.

4.3 Effectiveness

4.3.1 Score: (scale range 1–4)

3-4	<p>Programme implementation exceeded expectations in the individual areas where FHHs have been established, but the number of FHHs established is lower than initially envisaged. Implementation at the beginning was not as effective as it could have been, but much work has been done to address the issues and progress is generally now back on track. Data is missing to demonstrate if some expected results will be met, especially the increase in adolescents and youth’s utilization of sexual and reproductive health services. The programme is leading to a shift in the way services have or should be been delivered and is influencing new ways of thinking about service delivery and how to engage with the community as partners. Managers and stakeholders are extremely happy with the programme thus far.</p>
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The MTR were asked to assess the extent to which the activities of the project contributed to achievement of project outputs and outcomes or related results at community level and national level, specifically:

- The extent to which the project results and planned targets were achieved to date.
- The major factors that influenced the achievement or non-achievement of planned results and targets.
- Whether the activities of the project and interventions by partners and stakeholders contributed to the following:
 - I. Increased ANC and PNC visits;
 - II. Increased deliveries at FHHs and relevant health facilities;
 - III. Increased deliveries attended by skilled birth attendants;
 - IV. Increase in the number of skilled birth attendants, particularly midwives (*available and providing services*);
 - V. Increased contraceptive use and uptake by the target population; and
 - VI. Increased number of young people accessing and utilizing FHH facilities for SRH services.

The results of the MTR for effectiveness of FHH model are summarized under the outcome and output of implementation of FHH model in Daykundi, Bamyán and Faryab provinces.

4.3.2 Outcome level results of implementation of FHH model in Afghanistan

The paucity of outcome level data hindered analysis of the effectiveness of outcome level indicators. A baseline survey was conducted and assessed the outcome indicators in the FHH catchments; however, it took place after implementation had begun. Since the project is in progress, mid-term or end-line survey data is not yet available to compare progress from the baseline. Therefore, the actual FHH data reported and recorded in the HMIS database was used as a proxy for outcome indicators.

Perceived increase in service delivery utilization and coverage

From interviews with community leaders, clients and during focus group discussions with women in FHAGs in the community, it is clear that the FHH+MST project was very successful in increasing access and utilization of basic RMNH services for otherwise unserved populations.

From comments made during field observations, it appears that most communities were not accessing BPHS services before the start of the FHH.

Many women in all three provinces reported that prior to the FHH they had nowhere to go for health care during pregnancy, childbirth or after birth. Moreover, they were more than happy with the services of the FHH and often recommended them to other women in their community. Community elders (shura) in the villages visited confirmed that prior to the FHH women in their village often had nowhere to go for health care.

Cost, distance and difficulty of travel were the main factors that many gave for not going to a static health facility, although concerns were also expressed related to privacy and not being treated well at facilities outside the FHH catchment area.

It is hard to say exactly what the achievements have been in terms of increase service utilization and coverage, as the data available does not allow rigorous comparisons, particularly the lack of clarity regarding updated figures for catchment population. However, from the data available from IPs and HMIS, more women year on year are accessing services in FHHs. Moreover it appears that in 2014, across all three provinces, more than 26,448 women gave birth with an approved midwife⁵², which is a significant increase on 2013. In total, in 2013-2014, 7,637 pregnant women gave birth attended by a midwife in the FHH, or by the MST, who would have previously had no professional care.

In 2013 more than 20 women with life-threatening complications in pregnancy and during or soon after childbirth were referred to higher-level facilities for treatment to save their lives. A review of the 2014 HMIS data shows that of the 2,800 referrals from FHHs across the three provinces, 81 related to major obstetric complications, 900 were children under five years of age with moderate to severe malnutrition, and more than 1,800 were suspected TB cases (see Annex 7). Whilst it is not certain that these referrals would not have occurred had the FHH not been in place, comments from community men and women suggest that the timing of the decision to refer, cost, and the difficulty of arranging transport would have delayed the referral; indeed, the referral would probably not have happened. Moreover, it is certain that the treatment given alongside referral would not have not been possible without a trained CMW in place.

In terms of contraceptive acceptance the annual reports from IPs and the analysis of HMIS data for 2014 shows a very positive increase year on year. There is however no standard template for IPs to prepare their annual reports and not all IPs reported utilization data in the same way; most count the number of consultations and not new clients or couple-years of protection (CYP).⁵³

Box 2. Where did women get services before FHH?

“Most of them gave birth at home and only few families who could pay to rent a car went to Ulqa [DH]. Other women had to stay home and give birth at home. The lucky woman gave birth and the unlucky died.”

“There was no clinic in this area; the nearest clinic was located one hour by car from here. There is no public transportation system, people have to rent a car to transfer a patient to clinic which costs up to 2000 AFS and people could not afford the cost for every case. In such situations, women usually did not go anywhere during pregnancy and gave birth at home assisted by elder woman of the family of relative or village who were experienced in delivery. Some of the *Daia* [traditional birth attendant] were experienced and could help the woman and some other were not and could not help, but they were the only hope for women. If a woman got bleeding during pregnancy, families decided to rent a car and transfer the patient to a clinic. It also happened that women could not reach the clinic and died on the way...”

– Two women from different areas of Daykundi

⁵² Total deliveries in three provinces in 2014: FHH 2,926; HSC 2,930; BHC 7,180; CHC 13,412).

⁵³ A summary index for all forms of family planning available; it denotes the amount of time a couple is protected based on the contraceptive method(s) used.

The lack of disaggregated data for service delivery in the IP annual reports does not allow the MTR to comment on an increase in the number of young people accessing and utilizing FHH facilities for sexual and reproductive health services. However, it is known that many young girls do begin their reproductive lives early and therefore, many of the service users would have been young or adolescent women.

Table 7. FHH performance in 2014

Description	Daykundi (23 FHH)	Bamyan (24 FHH)	Faryab (33 FHH)	TOTAL (80 FHH)	
Catchment population (estimated)	60,561	48,000	103,603	212,164	
First ANC visit	3,289	1,204	7,114	11,607	
First PNC visit	1,409	750	4,604	6,763	
Facility delivery	565	416	1,945	2,926	
Family planning method distributed	Oral pills (cycle)	4,184	3,689	6,303	14,176
	Condom (dozen)	3,638	1,693	2,989	8,320
	Injectable	3,717	2,225	4,008	9,950
	IUD	34	30	72	136
	Couple-Year Protection*	1,618	1,043	1,913	4,574
Referral	Major complication	36	16	29	81
	Moderate and severe	152	173	582	907
	TB suspected case	176	1,271	432	1,879

*CYP: Oral Pills (Cycle) 15 cycles per CYP; Condom: 150 units per CYP; Injectable 4 doses per CYP; IUD 3.5 CYP per IUD inserted

Both of the main IPs (MOVE and AADA) expressed the opinion that the FHH model is not only effective, it is the only equitable way to provide services to women and children:

“This is in reality the only way to get basic services, RH services to these remote communities. MHTs can provide some but they only visit on periodic basis; the FHH/ CMW is available 24 hours a day, seven days a week. Also, everyone can have access, the community knows this and there is no bias or selection criteria for who can have the services of FHH/ CMW - they [CMW] are for all people in catchment area.

When we see at the local level and compare with BPHS areas, FHHs are conducting more activities.”

–IP manager

Finally it is felt that a major reason for the effectiveness of the FHH pilot project in encouraging women to use the services, is:

“the fact that the services are available 24/7; the community knows the services are there for them and, importantly, the community have confidence that there will be someone there if they go.”

– IP senior manager

FHH contributions to overall BPHS service delivery

As part of the MTR, a detailed analysis was done of available HMIS data to validate the information from IPs and to compare service utilization between FHHs and other static health facilities offering BPHS. FHH and BPHS data for Bamyan, Daykundi, and Faryab were extracted from the HMIS database for 2014 (Jad 1392 to Qaus 1393). Subsequently, the data was analysed for ANC, delivery, PNC, and family planning. Although the analysis looked at the performance of FHH vis-à-vis the HSC, as the lowest level BPHS health facility, those two are not comparable. In terms of population, the HSC is established in areas with a minimum population of 7,000, while FHH serves 1,500-3,000 people. In terms of human resources, the HSC is run by three staff members: a nurse, midwife and cleaner/guard, and sometimes a vaccinator as a fourth, while the FHH is run only by a CMW. Although the analysis intended to compare the performance of FHH and BPHS facilities proportionate to their catchment population, the latter is not included in the HMIS which limits the analysis to compare absolute rather than proportionate numbers. However, the comparison provides a general impression about FHH performance compared to the lowest level BPHS facility.

Furthermore, the analysis was intended to compare ANC and PNC visits separately, but the HMIS recording and reporting system includes only the ‘First ANC’ and ‘other ANC’ visits where the latter collectively covers the second to fourth and subsequent ANC visits. Similarly, the HMIS recording and reporting system is limited to ‘First PNC visit’ and ‘other PNC visits’ where the latter covers the second and third PNC visits. In addition, the MTR expected to analyse the HMIS for ANC, PNC, family planning, and delivery by age category (15-20, 20-30, and 30-49), but the HMIS database is not designed to include this data.

An analysis of HMIS data for FHH and BPHS facilities in 2014 at the provincial level suggests that FHH played a key role in expanding and increasing the coverage of basic health services, particularly reproductive health services, to remote areas where FHH are functioning, specifically in relation to ANC, PNC, and births attended by a skilled birth attendant or CMW. In this analysis HMIS data for BPHS (HSC, BHC, CHC) and FHH in three provinces were considered.

Antenatal visit

From the 2014 HMIS data (Jad 1392-Qaus 1393), around 11,000 of the first ANC visits out of a total of 88,663 in BPHS facilities, excluding DH, in Daykundi, Bamyan, and Faryab provinces were undertaken at FHH (see Figure 3 below). As such, FHH is making a large contribution at the primary health care level to the delivery of ANC services in these provinces. On average, FHHs provided 12 per cent of first ANC consultations in the three provinces: Daykundi 20 per cent, Bamyan 7 per cent, and Faryab 11 per cent). FHHs provided 12 per cent of all ANC first visits compare to 10 per cent provided by HSC. However, there is variation in provincial performance of FHH and HSC (Bamyan: FHH 7 per cent, HSC 20 per cent, Daykundi: FHH 20 per cent, HSC 13 per cent, Faryab: FHH 11 per cent, HSC 7 per cent).

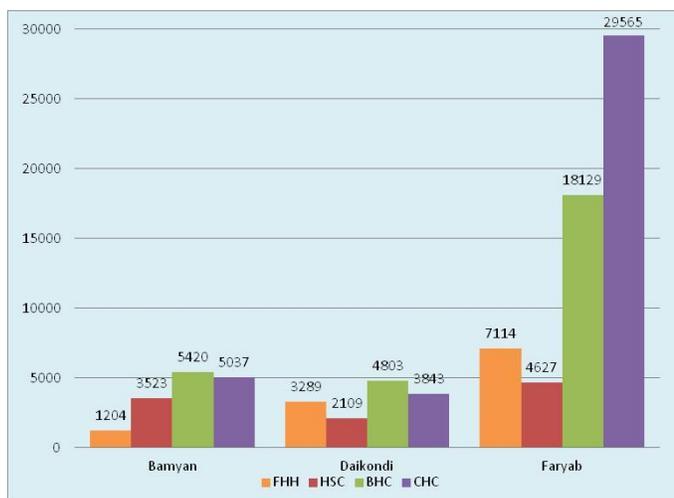


Figure 4. Number of first ANC visits conducted by FHH and BPHS facilities, 2014 (Source: HMIS database)

However, comparison of the average first ANC per FHH and HSC for 2014 provide a better understanding of performance. The average annual first ANC visit per FHH and HSC are 145 and 190 respectively across the three provinces. A review of HMIS registers and randomly selected ANC cards during the field observation revealed that completion of the four expected ANC visits during pregnancy

(the minimum requirement in MoPH guidelines) is a major concern. According to IP management this is mainly due to seasonal migration of populations to *Ailaaq*.⁵⁴ However, four ANC was not part of their targets because in National HMIS only first ANC is target and reported and ANC 2, 3, and 4 are reported as other ANC visits for which there is no target. This might be the issue that IPs has paid less attention to completion of four ANC visits.

Skilled birth attendance

In terms of the coverage of births by an SBA, 2,926 out of the 26,448 normal deliveries conducted in primary health care facilities of Daykundi, Bamyan, and Faryab provinces in 2014 were at FHHs (see Figure 5). This constitutes 11 per cent of all normal deliveries in primary facilities; 12 per cent in Daykundi, 8 per cent in Bamyan and 12 per cent in Faryab. FHHs and HSC contribute equally to the SBA indicator; as illustrated in Figure 5, FHH and HSC each conducted more than 2,900 deliveries, however, further analysis shows that average number of deliveries conducted per FHH per year across the three provinces is 37 compared to 54 per HSC.

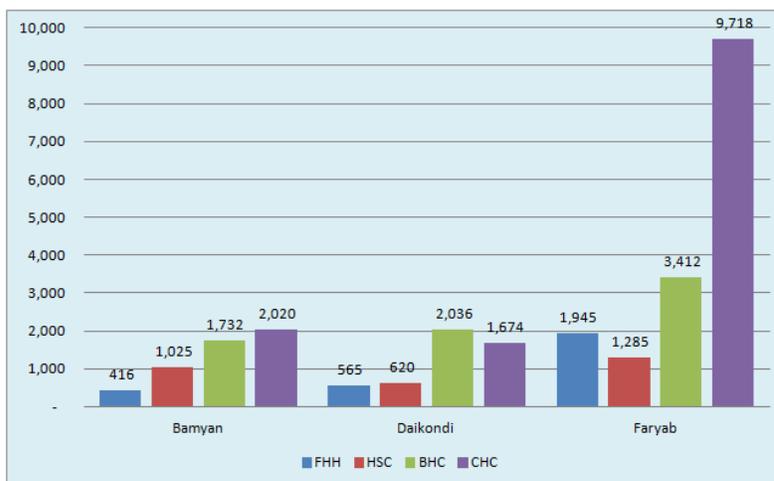


Figure 5. Number of normal deliveries conducted at FHH and BPMS facilities, 2014 (Source: HMIS database)

Postnatal care

The first PNC visit is critical for ensuing neonatal survival. Around 6,700 (12 per cent) of all first PNC visits of around 56,000 conducted at the primary health care level in Daykundi, Bamyan, and Faryab provinces in 2014 took place at a FHH (see Figure 6). As with other indicators the figures for each province show small variations (Daykundi 16 per cent, Bamyan 8 per cent and Faryab 12 per cent). FHHs provide on average 12 per cent of total first PNC services, compared to 9 per cent for HSCs. However, the average number of first PNC visits per FHH per year is 84 compared to 94 for HSC. HMIS data and field observations reveal that completion of three PNCs after birth - the minimum requirement in MoPH guidelines - is a major concern. According to the IP management, this is attributable to the seasonal migration of populations to *Ailaaq* or summer pastures. However, measuring three PNC visits was not part of their targets as in the HMIS only the first PNC is reported separately, with the second and third visits reported as 'other PNC visits' for which there are no targets. Thus IPs may have paid less attention to completing the three recommended PNC visits.

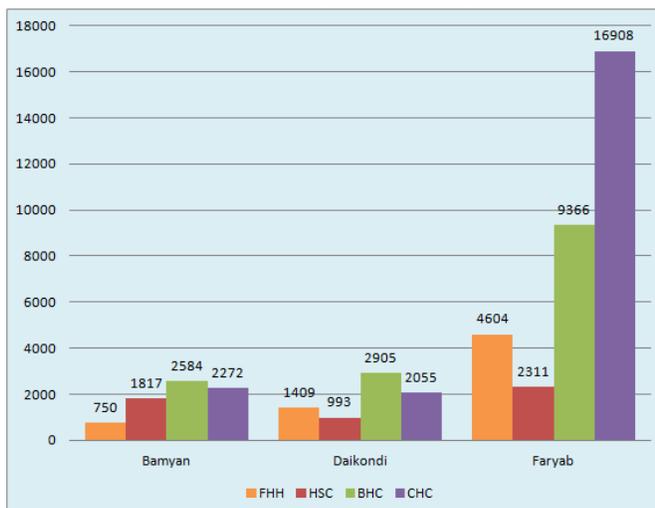


Figure 6. Number of PNC visits conducted by FHH and BPMS facilities, 2014 (Source: HMIS database)

⁵⁴ As most people in countryside areas are pastoralists, they take their animals to graze in the mountains and hills for six months.

It is clear from the analysis of the 2014 HMIS data that FHHs are making a significant contribution to achieving the national targets for PNC. Given that they are situated in such remote, poor and traditional areas with no experience of accessing public health services or modern health care, this is a significant finding.

The contribution of FHH to national targets is even more impressive if average figures and consultation data across different types of facilities are analysed, given that the services are provided by a CMW with assistance from only two CHWs whereas other facilities have, or should have, more staff. In theory such visits are not made as an emergency; they can be planned and women and families can make arrangements to travel, although costs and time are still an issue. FHHs provide a relatively high number of other PNC consultations, compared to the number of consultations provided by other facilities with more staff.

Family planning services

FHHs have contributed to increased uptake of family planning services across the three provinces. The HMIS analysis for 2014 show that FHHs across the three provinces provided over 14,000 clients with oral pills, over 9,000 with injectable contraceptives, over 8,000 with condoms, and inserted 136 IUDs (Figure 7). In 2014 a total 40,283 CYP was provided through BPMS facilities (CHC, BHC, HSC) and FHHs across the three provinces, of which 4,574 (11 per cent) was the FHH contribution. Details of family planning services provided through FHH and BPMS facilities are illustrated in Figure 7.

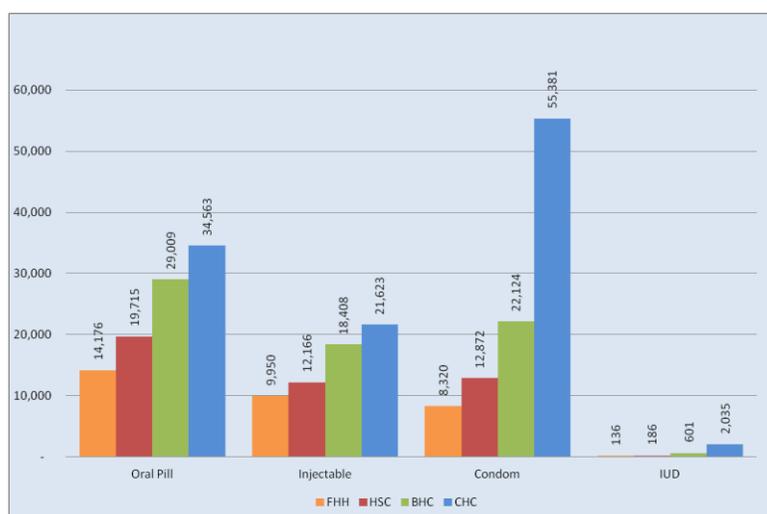


Figure 7. Contraceptives distributed through FHH and BPMS facilities, 2014 (Source: HMIS database)

Beside the FHHs, Health Posts in the catchment of FHHs contributed to increased access to family planning services across the three provinces. However, HMIS data analysis for the year 2014 (Jadi1392-Qaus1393) show that FHHs in Bamyan and Daykundi⁵⁵ distributed more than 7,500 contraceptive methods, which provided an estimated CYP of 923.

Medical consultation and treatment

CMWs are not currently qualified to provide a wide range of medical consultation and treatment for a wide age range. Quality medical consultation and treatment has received the least attention in MST supervision and monitoring visits and by FHH project staff.

Unregulated medical consultation and treatment through the FHHs would be associated with inappropriate diagnosis and treatment which could lead to worsening medical conditions, inappropriate prescriptions, using up essential drugs ineffectively and an increase in antibiotic resistance.

However, comments by provincial governors, PPHD, and community shura members suggest that the medical consultations and treatment are essential in environments where FHHs are the only option especially in the winter. Moreover, provision of medical consultation and treatment services through

⁵⁵ FHHs in Faryab are not registered with national HMIS data and are excluded from analysis.

FHHs needs be regulated to guide CMWs on which cases they should treat and which ones should be referred.

Referral of cases to higher level health facilities

FHHs have contributed to increased referral of cases to higher BPHS facilities for proper diagnosis and timely treatment. In particular, timely referral of major obstetric complications has saved the lives of mothers and infants. HMIS analysis of FHHs across the three provinces for the year 2014 shows that FHHs referred 81 cases of major obstetric complications, 900 cases of moderate and severe malnutrition, and 1,800 suspected cases of TB to higher BPHS/ EPHS facilities.

Field observations and reviews

Field observations and interviews with BPHS staff, managers and HFs suggest that an effective two-way referral mechanism has not been established between FHH and BPHS facilities. Referrals from FHHs to BPHS facilities are well coordinated with BPHS managers and heads of BPHS facilities, although there are some variations between the provinces as well as FHHs. The difficulty of arranging transportation for referral from FHH to a BPHS facility also hindered the effective referral system. Although there are good examples of well-established community transportation arrangements they are not consistent across or even within provinces.

The community initiated transportation arrangements at some FHHs in Faryab are an example of best practices in this area. In these areas, community health shuras have assigned three vehicles from the catchment area to manage referral from FHH to higher level health facilities. The contact details of the three drivers is available at the FHH and the CMW or community shura can contact them in case of need. The drivers have agreed with the community shura to charge only for fuel consumption.

Referrals of cases from CHW to FHH was well established at all FHHs visited during the MTR; the referral sheet of CHWs are stored at FHHs and reviewed with CHWs at monthly meetings.

Community buy-in

The FHH concept is heavily dependent on community willingness to cooperate and be active partners in this project. Not only does the community have to want the FHH to be located in their area, they have to select a woman who will train as a CMW, and the family have to agree to support her and her work for a minimum of five years on her return. Additionally, the community must also provide land or in kind support, and help construct the FHH, help run the FHH, assist the CMW, encourage women to use the FHH, establish transport referral systems and mechanisms, and assist with referrals for higher level medical treatment.

Comments received at all levels and from the responses gathered during field observations, this aspect of the project has been highly successful and at times impressive, despite initial challenges.

Field observation and review

From the review of IP documents during the field observations it is clear that community health shura ('Shura-e-Sehi') and FHAG have been established at each FHH visited.

The Shura-e-Sehi documents show that its job description has been signed by shura members and is available at FHHs. The training documents of FHH project however, show that in most cases, the shura members had not received capacity building training, particularly on community leadership and participation for health, social and community mobilization, and health promotion and communication. This may explain some of the comments from the CMW about wishing for greater support from the Shura-e-Sehi.

Meetings of the Shura-e-Sehi are held at each FHH regularly and minutes are recorded and stored at the FHH. FHAG and CHWs also participate in some shura meetings. A review of the minutes shows that shura meetings are deeply focused on providing logistical support, e.g. renovation and maintenance, including mud plastering the roof before the winter season, water supply, painting rooms, constructing

latrines, and digging wells for FHH. Some weak points also appeared in the review which affect the functionality of the Shura-e-Sehi:

- The job description of the Shura-e-Sehi is the only related document available at FHHs, which describes only their responsibilities.
- Participation of shura members in monthly Shura meetings is weak; less than half of community shura members attend.
- Shura meetings are more logistically oriented in terms of support for the FHH rather than health oriented to identify the health needs of the community, bridge between the community and the FHH, and improve the quality of health service delivery.
- The minutes comprise a review of the previous meeting, discussion on solutions for problems and plans for the next month. In Faryab the minutes also include decisions made, and who and how decisions should be followed up. This more comprehensive format should also be used in Bamyan and Daykundi.

It is also clear from comments from the FDGs with the Shura that they are very supportive of the FHH and value their new amenity:

“This valley is around 30km from Bamyan city and around 15-20km from BHC Kalo. There is no other clinic in this area. The road conditions are still not good from Dahan-e-Sad Berg to this area. It is a very narrow road, which is associated with a high risk of blockage during the winter due to heavy snow. Transportation was also very limited at the time before Ashiana-e-Sehi [FHH] and people’s economic status was poor. On top of this, the knowledge of people about health and health seeking, especially for pregnancy and delivery, was very low. In this situation, women did not and could not go anywhere during pregnancy unless there was a problem such as bleeding and had to transfer to Bamyan hospital. Almost all deliveries took place at home assisted by the local Daia [traditional birth attendant] who were elderly and experienced women of the village but were not trained. Only complicated cases of delivery which the Daia could not help were transferred to hospital. The normal deliveries were ok; mother and baby were safe, however complicated cases were at risk of loss of life of mother or baby or both. We have experiences of such cases in the village. At least three women died due to delivery in this valley 1-2 years before the Ashiana.”

– Comment from focus group discussion at an FHH

The community and shura did not just provide support to the establishment of the Ashiana (FHH), the continued and not just in words alone:

“At the beginning we constructed two rooms for the Ashiana to which people donated the land and contributed in the provision of beams for the roof. However, later on, when the Ashiana started its activities, it was realized the two rooms were not enough. Again the shura decided to collect contributions from the community and built two more rooms.”

– Comment from focus group discussion at an FHH, Daykundi

Field observations show, however, that initially there were some issues with having the community fully understand the concept. For example, some FHHs are not located based on the specified criteria in the FHH Concept Note (See Annex 7, FHH Building and Environment Assessment). This may indicate that the selection of CMWs and location of FHHs was perhaps done independently, or that there were issues with the initial selection of FHH site. IPs readily accept there were initial difficulties with explaining the FHH concept to the community and, that this stage took longer than initially envisaged. From the comments of the IPs and provincial and district managers it appears that these early difficulties no longer exist; whether it the FHH concept is now more widely understood, or that IPs’ capacity for engaging with the communities has increased, is hard to say.

4.3.3 Output level results

Established functional FHHs

On reviewing all the documents and from the initial plans and agreements between UNFPA, respective donors, mainly the Canadian Department of Foreign Affairs, Trade and Development, and the IP, it is

clear that progress in terms of the number of FHHs established has been slower than initially expected. According to UNFPA's final briefing document (2012) UNFPA initially aimed to establish 165 FHHs, 66 with their own regular funds and the rest with donor support. Initially only the Canadian donor agreed to support the project. The number of FHHs envisaged was ambitious and aspirational and it was later agreed to adjust the numbers.

It appears that in the beginning there was an unrealistic expectation and consideration of the length of time it took to have the initial mapping and agreements with communities to decide on where the FHH should be located. Once this decision was made then it took time to identify a suitable candidate to train as a CMW; in at least one case, the IP and community confirmed that the location of the FHH had to be changed as, despite all efforts, no suitable candidate could be found who met the selection criteria.

Where there were sufficient numbers selected, UNFPA supported the IP to train the CMWs in a special cohort at the nearest NGO training facility. Where numbers are small, it may be necessary to use government training facilities and to wait for the next available entry. This happened when the FHH project was rolled out to Herat where, only nine CMWs were to be trained; not enough to form a special cohort. The had to wait until the next intake, and the government training institute only had one intake per year.

At the time of the MTR, 80 FHHs were found to be active, although more had originally been established (seven dropped out, one because the midwife died and no replacement was available, and the others for family or personal reasons; see Annex 7). Another 35 are being established and the trainee midwives were completing their second phase of programmes at the time of the MTR. The new CMWs were expected to return to their villages a few months following the MTR.

It is clear from reviewing the project documents and report for IPs, as well as from the field work and interviews with stakeholders at the central level, the initial process of mapping and establishing the sites for the FHH, including selected suitable candidates for CME, takes much longer than was initially envisaged. In addition, it appears that the involvement of the MoPH was not initially well coordinated, however the MoPH reports the communication and coordination with UNFPA is vastly improved and is now very good. Finally, in one province the IP had to be changed in 2012 for operational reasons.

It is not surprising, therefore, that the targets for the first year of the project were not met (see Table 7 below). After this first year, targets for numbers of FHHs to be established per year and work plans were revised and all agreed the more recent targets are more realistic.

Table 8. Planned and actual numbers of FHH established

Province (IP)	Planned total as per initial proposal	2012		2013		2014		Under Process	Total Active at MTR (Nov/Dec 2014)(%) ****
		Planned for year	Achieved (%)	Planned new	Achieved (%)	Planned new for 2015	Achieved (%)		
Bamyan	26	17	17(100%)	9	7(78%)*				24(92%)
Daykundi	58	9	9(100%)	14	14(100%)	35	0**	35(60%)	23(40%)
Faryab	40	40	36(90%)***						33(82%)
TOTAL	124	66	62(93%)	23	21(91%)	35	0	35(28%)	80(64%)

* Completed the training but could be deployed.
 ** The 35 planned in Daykundi are expected to be functional after the graduation of new CMWs by the end of 2015.
 *** Four FHHs were not established due to wrong selection of CMWs, three established FHHs were dropped in the first year.
 **** Nine (8%) of total FHH were either not established or closed.

Source: UNFPA and IP documents

Established functional community based structures

Each FHH is supported by an HP staffed by a male and female CHW, a community health shura (male and female), and FHAGs. IP documents and field visit observations show that there were 80 active HPs (80 female CHWs, 79 male CHWs), 173 FHAG, and 123 community health shura at the time of MTR. In addition, FHHs were supported by nine MSTs each staffed with a medical doctor/nurse, a midwife, a vaccinator, and a driver.

Table 9. Number of active FHH, HP, FHAG, and MST

Province	Plan output/ performance	FHH	HP	CHW female	CHW male	FHAG (10-15 women)	Community health shura	MST
Bamyan	Plan	26	26	26	26	52	26 (male and female)	2
	Active(%)	24 (92%)	24 (92%)	24 (92%)	24 (92%)	48 (92%)	24 (92%)	2 (100%)
Daykundi	Plan	58	58	58	58	116	23 (male and female)	4
	Active (%)	23 (40%)	23 (40%)	23 (40%)	23 (40%)	46 (40%)	23 (40%)	4 (100%)
	Under Process (%)	35 (60%)	35 (60%)	35 (60%)	35 (60%)	70 (60%)	35 (60%)	
Faryab	Plan	40	40	40	40	80	40 (male and female)	3
	Active (%)	33 (82%)	33 (82%)	33 (82%)	33 (82%)	66 (82%)	33 (82%)	3 (100%)
Total	Plan	124	124	124	124	248	124	9
	Active (%)	65%	65%	65%	65%	65%	65%	100%
	Under Process (%)	28%	28%	28%	28%	28%	28%	
	Dropped (%)	7%	7%	7%	7%	7%	7%	

Source: UNFPA and IP documents

Increased number of CMWs

In terms of increasing the number of midwives available and offering services in these remote 'white areas', the project has had considerable success.

To date 125 women were enrolled in CME in Bamyan, Daykundi, and Faryab, of whom 89 (71 per cent) successfully completed their training, with 36 (29 per cent) ongoing. Of those who completed, 84 (94 per cent) were deployed back to their villages to provide midwifery care and services. Of the 84 deployed, 80 (95 per cent) were still providing services at the time of the MTR. A review of IP documents reveals that there was a reasonable coherence with the selection criteria as outlined in the FHH Concept document (see Box 1).

A review of the profile of CMWs enrolled in CME programmes shows that the mean level of education

Box 3: Criteria for selection of CMW

The FHH model recommends that local girls with no less than six years education may be selected for training as CMW to subsequently staff FHH. Communities not providing such education opportunities sometimes if not always do not sufficiently treasure girls' education for being prioritized as FHH location. They should meet the following criteria:

- Minimum 18 years old
- 10 grade or at least school grade 8 graduation,
- Preferably married, but not earlier than at age 16
- Proposed by the community and committed to work in FHH upon graduation.

Eligible women have to pass tests and interviews before being confirmed by a provincial and district committee composed of the PPHD, female and male representatives of provincial councils, community health councils and district/village leaders and the BPHS implementer of the pilot province. The head of each of the trainees' families gives a letter committing that they will support his daughter, sister (in case the head of the family is brother) or wife to attend the school for the period of training without any interruption, and to serve the community.

at the time of enrolment was 6th grade, with a maximum of grade 14 education⁵⁶ (See Annex 7).

The level of education for the majority of CMWs entrants (62%) was 6th-9th grades of schooling; 10 per cent of CMEs had 10th grade schooling and 27 per cent had above 10th grade schooling. However, the experience from the third round of selection in Daykundi, which was ongoing at the time of the MTR, shows that almost all students have school education level of 9th grade and above.

Around 79 per cent of CMWs were aged 18 years or above at the time of enrolment, while 21 per cent were aged 17-18 years. Although the selection criteria called for married women where possible, 57 per cent of CMW were single at the time of enrolment, with 42 per cent married, and 1 per cent widowed. At least two of the 17 CMWs who participated in the MTR confirmed they were married at the age of 15, which is contrary to the selection criteria. The detail of profile of CMW who participated in the MTR is summarized in Annex 7.

A review of the personnel files of the 17 CMWs who participated in the MTR shows that all had passed the CME entrance exam. Both female and male representatives of provincial councils, and district/village leaders and the BPHS implementer of the pilot province were involved in the selection process (except for the first and second selection rounds in Daykundi) to introduce the CMW candidate to the community and to the selection committee. The whole selection process appears very participatory and supportive of building community ownership.

Finally, all CMW have a commitment letter of five years working following completion of CME programme. Furthermore, the male head of each trainee's family gave a letter committing that he would support her to attend the school for the period of training without any interruption and to serve the community by staffing the FHH thereafter. The commitment letter also confirms that the trained CMWs would be placed in their communities of origin to provide the services stipulated in their job description. However, there was no standard format for the commitment of the CMW, her family or the Shura-e-Sehi, indeed some of the commitments were written on notebook paper.

The training of the CMWs followed the national CME curriculum, but added two months to cover subjects considered necessary for working in an isolated areas, including training in Integrated Management of Childhood Illnesses.

Not unexpectedly, many of the married students training in Kabul had young children who had to accompany them during the training; a few more gave birth during their training. As such the CME schools had to accommodate not only the male partners who accompanied the female students, but also their young children.

On visiting the CME training institution in Kabul, the institution and dormitories were clean, warm and well maintained. Classrooms and skills laboratories were relatively well equipped with a large number of visual aids and other teaching and learning materials. The young children looked healthy, well cared for and happy.

The question of whether being married was helpful was raised during interviews with CMWs. Many said they thought being married should be a requirement for selection.



CMWs undergoing CME programme in Kabul with their head of school, January 2015

⁵⁶ According to MoPH and UNFPA informants, initially the education criterion for entry into the CMW programme was 6th grade in 2009 because the literacy rate was then lower. In 2012 the education criterion was revised upwards.

“Both [married and single] have advantage and disadvantage. Married students may get pregnant which affects the study programme of the student and her performance. At the same time the level of understanding of the married is better than single. Also, the married women has a clear future for the continuation of her work at the FHH as she is living with her husband in the area where the FHH was established. Single girls are also good; they have good concentration and can learn better. However, the disadvantage is that her future is not clear; if she marries someone from another area, she should leave FHH. Meanwhile, if she marries someone who does not allow her to work, she had to stay home. In both cases, the FHH will be deactivated.”

—CMW respondent

4.4 Efficiency

4.4.1 Score: (scale range 1–4)

3.5	Planned programme inputs and reporting were, in the main, timely. Reasons for delays were given and based on sound rationale. Not all activities were implemented to the full, but good rationale was given for any shortfalls. Most, but not all targets were met. Most of the available resources were used, but there are issues with management of essential drugs and medicines which require further action.
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In terms of efficiency (see the operational definition used to determine efficiency), the MTR assessed the implementation of the FHH project to date to ascertain how efficiently the inputs and resources were utilized to produce the results, or outputs, in respect of the extent to which the FHH+MST project has to date:

1. utilized the skills of UNFPA and IP staff/ human resources to achieve planned results and targets; and
2. created a staffing set-up (establishment) for IPs and FHH which is appropriate for effective and efficient implementation;
3. a sufficient modality of procurement and distribution of supplies from UNFPA to IPs and FHHs and MSTs for efficient implementation;
4. the funding modalities and disbursement mechanisms which are sufficient, effective and timely to ensure efficient implementation;
5. ensured that the capacity building programme for midwives and other staff is sufficient and timely for effective and efficient implementation;
6. undertake a cost benefit analysis with the lowest level of BPHS in these pilot provinces.

In assessing the efficiency of the project and its implementation, the MTR have endeavoured to identify:

- a) what measures were taken during planning and implementation phase of the project to ensure that resources were utilized efficiently; and
- b) to what extent did the project address the equity, efficiency and rights and needs based approach of health care and the communities? How did the project design and implementation balance these approaches to ensure maximum net gains? Who has access to and benefits from these interventions?

Efficiency is a very difficult criteria to assess, especially at the mid-point of any project, especially with a new innovation such as a pilot project (one which has not been tried and evaluated before) where there are always lessons to learn at the beginning. As a pilot project, however, the FHH+MST appears to have reasonably efficient, though less so at the beginning.

The initial selection of IPs in Bamyan province, does not appear to have been as rigorous as in the other provinces. The decision to change IP in the second year appears to have been a logical and sensible decision as the current IP has extensive experience of working with the province, especially on BPHS.

4.4.2 Staffing issues

In terms of staff utilization within UNFPA and IPs, as well as utilization of MoPH expertise, to ensure successful implementation and achieve the expected results, many of those interviewed expressed the view that initially more could have been achieved.

IP staffing levels appear more than adequate. It is good that all the IPs have been able to recruit a midwife to work in the MHT/MSTs to ensure appropriate technical assistance during mobile outreach. The project does appear to have heavy management and supervision costs but this is likely due to the fact that these communities are so remote and therefore monitoring takes up a great deal of IP management time.

Comments from central stakeholders led to some concern that project design did not sufficiently involve the relevant departments in MoPH centrally; most of the detailed dialogue appears to have taken place at province and local level, with only the Reproductive Health department heavily involved at the central level. However there was unanimous agreement that this has now been rectified and UNFPA is taking steps to appropriately involve all relevant departments and to facilitate closer working relationships between the various departments within MoPH at central level and the individual IPs.

In terms of utilizing staff and skills within UNFPA office, again, more could be done to involve all departments. Inherent to the work of an organization like UNFPA is the fact that the time available for working across programmes can be limited. UNFPA has tried to involve the Gender team in short courses for CMWs to build their capacities to recognize and respond to gender-based violence, the Family Planning team and the Communication team, to develop materials to inform stakeholders and the community about the FHH concept. The production of a DVD is a prime example of how the wider UNFPA team, including Communications can be utilized. Inevitably more can always be done and suggestions have been provided to UNFPA on how this could be achieved.

4.4.3 Modality of procurement and distribution mechanism

UNFPA have undertaken the majority of the procurement of equipment, for example, vehicles, IEC materials on FHH, and books. Procurement of other equipment, drugs, medical supplies, and construction of FHH is the responsibility of IP. IPs have greatly appreciated UNFPA's support in this area and commented that procurement has been both timely and, in their view, efficient, with the exception of one IP which commented on how long it took to procure a vehicle (the delays for which were outside UNFPA control).

Equipment and materials are of high quality and from the observations of physical infrastructure all the necessary equipment, as outlined in the FHH Concept Note is in place.

One of the main concerns, given the remoteness of the villages, is how to maintain infection prevention measures which are crucial, especially for intrapartum care. A waste disposal system has been established in FHHs across the three provinces; at least from physical observation in Daykundi and Bamyan, it was evident that birthing rooms are equipped with waste baskets covered by plastic bags. Incinerators for disposal of medical waste, as well as a deep well for disposal of biological wastes, were constructed. Although water supply systems have been installed in FHH buildings in Daykundi and Bamyan, in some FHHs there was no water source beside the house of midwife and the communities provided water to the FHH. All incinerators at the FHHs visited were constructed using a standard structure, except FHH Kata Saib in Daykundi, where a small metallic stove was used.

All IPs commented that adequate funds had been made available for the construction of the FHHs, and UNFPA had been flexible and responsive to requests for changes in the budget to meet needs in different places. The FHH Concept Note envisions the FHH being constructed with local labour and using local materials as far as possible. Communities are expected to contribute to the construction,

giving land or materials, or in kind. From the observations the physical buildings seen were of high quality and complied with the recommendations in the agreements made with the IPs.

All FHHs visited were located outside and a 1-60 minute walk from the midwife's house in line with recommendations and guidelines. All FHHs in Bamyan was constructed in line with the proposed sketch provided in the Concept Note, with two rooms and a toilet, while the four FHHs visited in Daykundi had four rooms and a toilet. The IP in Daykundi had mobilized additional community contributions, particularly for beams for roofing, which allowed the allocated budget to stretch to two additional rooms. The new sketch and previous communication with the community on community mobilization had been shared by IP with UNFPA who had approved it. Although water supply systems had been installed in FHHs in Bamyan and Daykundi, only one FHH in Daykundi had water. All FHHs visited had an incinerator near the FHH. The details of the FHHs and environment assessment are summarized in Table 10 below.

Table 10. FHH building and environment assessment

	Daykundi(N=4)	Bamyan (N=6)
Location of FHH inside the midwife house	0	0
Location of FHH attached to the midwife house	0	0
Distance of FHH from midwife house		
Mean (minutes walk)	17	18
Minimum (minutes walk)	1	2
Maximum (minutes walk)	60	60
Number of FHHs located more than 10 minutes from midwife's house	1	2
Sketch of the FHH in line with Concept Note	0	6
Number of rooms in FHH	4	2
Number of bathroom in FHH	1	1
Availability of incinerator in FHH	4	6
Availability of water supply in FHH	1	0

Some issues suggest that the initial design for the physical building was not as good as it could be. Some communities recognized early that two rooms were not sufficient and have built extra rooms. In one of the FHHs in Bamyan for example, one room was allocated for outpatients, ANC visits, dressing, dispensary, and a drug and logistics store, while the growth monitoring of children under five was performed in the corridor. The second room was allocated for delivery and newborn care and PNC for the first six hours. In a few FHHs (those with two-room buildings), the bathroom inside the FHH was used as the drug and logistics store. There was no storage space for firewood for heating in the winter.

In Daykundi FHHs, the additional number of rooms allowed the CMW to have space for different activities; one room was used for outpatients, ANC, and the dispensary. The second room was subdivided into two small rooms; one with a door opening to the outpatient room and used for drug and logistics storage, while the other had a door leading outside the FHH building and was used to store of firewood or fuel for heating in the winter. The third room was a delivery room and the mother and newborn was observed for six hours after delivery in the fourth room. At least one of the FHHs visited had no road access and was not easily accessible, particularly for pregnant women.

In terms of drugs and medical supplies the project has not been as successful as in other areas. Review of documents of essential drugs and medical supplies distributed to FHHs in Daykundi, Bamyan, and Faryab revealed discrepancies between the proposed list of essential drugs and medical supplies described in the FHH concept and the real supplies distributed to FHHs across the three provinces mentioned above.

The following are the major discrepancies between the list of essential drugs and medical supplies in the FHH Concept Note and the actual distribution to FHHs.

1. Some items described in the list of essential drugs and medical supplies in FHH concept are not supplied.
2. Some items which are not described in the list of essential drugs and medical supplies in the FHH Concept Note are distributed to FHHs, some of which may be beyond the capacity and scope of work of the FHH and its CMW, such as tab. Quinine, amp. Aminophylline, vial Hydrocortisone and Salbutamol respirator solution for use in nebulizers 5mg (as sulfat)/ml). Even the list of additional drugs and medical supplies distributed in the three provinces differ from each other.

The quantities of supplied items did not comply with those specified in the FHH Concept Note, with some less than specified, and others three times higher than the specified quantity.

Reviewing monthly consumption there also appears some issues with use and possible over-use of some items (such as Amoxicillin) and under-use of others. There is no supporting information in IP reports which discusses drugs and medical supplies and utilization, other than that this is supposed to be checked by the MST during its visits, therefore it is not possible to comment further, other than to conclude this is an area where more attention and analysis is needed.

4.4.4 Funding modality and financial disbursements

Funding arrangements from UNFPA to IPs were based on the agreed AWP. The disbursement of funds from UNFPA to IPs was based on quarterly expenditure reports and fund requests for the next quarter in line with the AWP. The approved financial disbursement from UNFPA to the IP and from the IP to its provincial office was via bank transfer.

Accountability and transparency are two key issues addressed in the implementation of the FHH project to ensure alignment of expenditure with the agreed AWP. For this purpose, three key measures were used; work plan monitoring report, internal control system of IP, and annual independent audits.

The work plan monitoring report shows technical progress towards the planned activities and results achieved that is supplemented with expenditure for each activity produced. The report is prepared by the IP and submitted to UNFPA quarterly, and is checked and verified by UNFPA's technical and operational staff to ensure alignment of technical progress and expenditure with the AWP.

IPs have established an internal control mechanism as per their policy at their main and provincial offices to ensure accountability and transparency of funds received and expenditure related to the FHH project.

The annual independent audit is assigned by UNFPA to audit the FHH project and provide an independent view of disbursement and expenditure to ensure accountability and transparency.

From the interviews at the central level, all IPs were satisfied with the funding arrangements from UNFPA and commented that funds were disbursed speedily once they (as IP) had completed the necessary paperwork/ reports. Delays were mainly due to their own issues with getting information and reports to UNFPA. However all commented that UNFPA had been very helpful in explaining processes, helping them prepare reports and generally assisting in building their own capacity for project management. Indeed a senior manager at one of the IPs said that he felt one of the many benefits of the project had been the development of his own capacity to manage, thanks to UNFPA's technical assistance and capacity building.

IPs also commented on the willingness of UNFPA to be flexible when issues were highlighted and budgets needed to be altered:

“UNFPA are very helpful, and come to the office to help develop budgets. The initial budget was based on costs from elsewhere where similar work was done. But then UNFPA have been very willing to alter / be flexible, to meet the needs once these are identified.”

– IP senior manager

When IPs were asked how efficient the FHH project was they pointed to the fact that for the cost of running one MHT, which cannot offer 24/7 health care services, they believe they can run six FHHs. When comparing costs in AWP for MHT/MST and FHH this does appear to be true, but different IPs have different ways of calculating their budgets, for example some put travel costs under ‘Running Costs MST/MHT’ and others do not. Thus it is not so easy to show precisely what the costs are and compare them. It is true however that on average the MHTs were only able to spend three days per month in each catchment area, and it is clear from the reports that the actual number of births assisted by the MHTs was very small. Therefore, comparing services through FHH and MHTs (the only current options for these remote areas), it is clear that the FHH modality is not only the best and most efficient and effective modality, is ultimately the only way to offer meaningful services to remote communities.

4.4.5 Capacity development of CMWs

The training of FHH CMWs followed the 24 month standard curriculum for community midwifery programme of the MoPH.⁵⁷ In addition, UNFPA added a two month training following the completion of the standard CME to enhance the technical and managerial capacity of CMWs. The additional trainings focused on: 1) Community mobilization and establishing of health shuras; 2) HMIS; 3) Community mapping and organizing referral, and home visits; 4) Primary health care and the Concept of Public Health Care in Afghanistan (BPHS and EPHS); 5) First aid; 6) Integrated management of childhood illnesses (IMCI); 7) Infection prevention; 8) Health facility management at the primary health care level; 9) the Minimum Initial Service Package; 10) Gender Based Violence (GBV) training; 11) Role of FHHs in polio campaigns and routine referral of flaccid paralysis; 12) Psychosocial counselling training.

The initial FHH Concept Note acknowledged that even with these additional two months of training the CMWs assigned to FHHs would require additional support and capacity building, given they would be working as lone providers in very remote areas. Consequently it was agreed that with project funds 10 days of in-service training annually would be available to each CMW after deployment. According to IPs this did happen in the first year, whereby groups of CMWs were invited and funded to complete a 10 day refresher course with additional training on IMCI and/ or GBV. It appears however that CMWs preferred quarterly meetings which were also considered by IPs to be more useful, as they would reduce the time the CMW was away from the FHH and therefore the days the FHH was not operational (this point is discussed further in Chapter 5).

The review of FHH documents and interviews with CMWs, including verification of training with certificate of training, revealed that in addition to the additional two months, midwives of Daykundi have received 5 out of 12 proposed additional trainings following graduation from CME, while in Bamyan they had received 4 out of 12, and in Faryab 11 out of 12. However, most of additional training topics in Bamyan and Daykundi had already been covered in the additional two months training following completion of CME programme (see Annex 7).

Field observation and interviews revealed that newly graduated CMWs had experienced practical challenges in organization and management of FHH activities in the first three months following deployment. The CMWs and field managers of project believed that an internship period of 2-3 months at the nearest BPHS was essential for newly graduated CMWs prior to their deployment. This internship would provide the opportunity to CMWs to get practical experience of independently managing the FHH.

Many stakeholders, especially at the central level, raised concerns during the MTR that the CMWs are not adequately prepared during the CME to offer non-RH services to adults, in particular, medical

⁵⁷ Islamic Republic of Afghanistan Ministry of Public Health. *Curriculum for Community Midwifery Education*. Kabul: MoPH 2009.

consultations. Yet it is clear from looking at the workloads and work registers of the CMWs and especially their referrals and drug utilization, that CMWs are consulted regularly for such services. CMWs do have training in IMCI and caring for the health of children under five.

Some stakeholders suggested that CMWs be given a short course in *Integrated Management of Adult Diseases*, whilst many others felt this would not be useful and CMWs should concentrate on providing RMNCH services. Indeed some suggested that to add adult health care to the CMW job description may be counterproductive; the confidence that women will be treated in a private, women-only environment could be compromised. Moreover adding this could mean that less time is available for reproductive health services, including outreach and follow up in the community. Some stakeholders who participated in the MTR were not in favour of expanding the CMW job description to adult general medical conditions, despite a general acceptance within the MoPH that medical consultation and treatment of cases by CMW should be included in their terms of reference.

Not all CMWs met the educational entry criteria, mainly because there was no one with the required education level who was willing and could be supported to be trained as a CMW. It was, however, noted that in the later selection rounds the education level of potential recruits was higher.

Finally, CMWs are still not considered as a new category of health professional in the Civil Service payroll, which is important for the career development of CMWs.

4.4.6 Cost benefit analysis

The MTR was expected to undertake a cost benefit analysis with the lowest level of BPHS in pilot provinces. However, the review of documents of IP showed that such an analysis is not possible.

A cost-benefit analysis involves translating all benefits and costs into monetary terms, including non-marketed environmental, social and other impacts. The benefits from an action are compared with the costs (including the opportunity costs) within a common analytical framework.⁵⁸

In the case of the FHH as a health intervention, the impact can be translated to maternal mortality ratio, infant mortality, and the outcome as ANC and PNC coverage, SBA coverage, and the contraceptive prevalence rate (CPR). However, in the case of FHH, there was a data gap, which limited further analysis on cost benefit.

From the cost side, disaggregation for all the capital costs as well the running costs of FHH should be available to calculate the total cost of intervention. However, some of the disaggregated costs were not available e.g. cost of community mobilization at the start of project and cost of land donated by the community, which are both capital costs. In addition, cost of supervision and monitoring per FHH visit during a year, which is part of the running cost, was not disaggregated by fuel, time of IP monitors, and salaries were not disaggregated per visit.

From the benefit side, there was baseline survey data on key outcome level health indicators related to the catchment of FHHs; however, the baseline survey was conducted during implementation rather than before the start of the project. Meanwhile, there is no other survey on outcome indicators (mid-term survey) or end-line survey as the project is continuing to compare the mid-term with the baseline. For more details about the cost-benefit analysis model for FHH, please refer to Annex 8.

The reviewers were asked during a PSC meeting to supply information on the costs of the FHH. However in all countries getting services to the most remote areas always involves greater expenditure and thus the equity issue needs to be carefully considered in assessing costs. Set-up costs are also difficult to compare, in that involvement and ownership by the community was not considered when establishing other static BPHS facilities, but appears to have been critical in this project. Moreover, the impact and potential benefits of this community involvement/partnership are difficult to calculate unless the project has been running for some time and an assessment of actual sustainability can be measured.

⁵⁸ World Health Organization. Guideline for Conducting Cost-Benefit Analysis of Household Energy and Health Interventions. Geneva: WHO, 2006.

Although some basic costing information is available, caution should be used given that the cost for each AWP is not shown in a standardized way (per FHH) and the expenditure report of IPs are also not per FHH, therefore errors may have occurred.

The approach of BPHS Assessment of Cost⁵⁹ was used as a guide to calculate the annual direct operating expenditures for each FHH, the direct resources used exclusively by FHH for the year 2014 were collected from IPs.

- **Salaries and wages** include the base salary and any series of bonuses and allowances as applicable (overtime allowances, working conditions allowances, travel allowances).
- **Drugs and disposables** include the direct costs of drugs, disposables (gloves, sutures), and medical supplies.
- **Training and development** include all training, education, and staff development costs and associated expenses related to travel and course materials.
- **Other operational expenses** include utilities (electricity, water, and gas consumption costs), communication (telephone), office supplies, housekeeping, security, laundry, maintenance (building, equipment and furniture).

Meanwhile, the capital cost of FHH at the start of FHH was included in this analysis.

- **Capital expenses** include capital resources, equipment, and furniture for each FHH.
- **Cost of construction of FHH:** The FHHs were constructed through community contribution, therefore, direct cost paid by the project and community contribution is recorded separately.
- **Cost of CME:** The total cost of CME programme.

The analysis shows establishment cost and the average direct running cost of a FHH summarized in the following table.

Type of Cost	Average cost per FHH
1) Average capital cost per FHH	USD 4500
2) Average cost of construction per FHH	USD 5,028
3) Average cost of CME per student	USD 15,000 (18 months standard CME +2 months additional) USD 19,866(24 months standard CME +2 months additional)
4)Average annual direct running cost per FHH	USD 7,623

The FHH model supported construction of a locally made building as per the proposed sketch in the FHH Concept Note cost on average USD 5,028, of which 70 per cent was supported by the project and the remainder by the community. In addition, the community donated land for construction of FHH, the value of which was not calculated. If the value of land is also considered, the community contribution may raise to more than 50 per cent.

⁵⁹ Islamic Republic of Afghanistan Ministry of Public Health. Afghanistan Basic Package of Health Services 2010: An Assessment of the Costs. Kabul: MoPH 2012.

Table 11. Cost of FHH

Province	Faryab			Bamyan			Daikondi			Total of MTR Provinces (Faryab, Bamyan, Daikondi)			AVERAGE COST PER FHH		
Number of FHH (CMW)	33			24			23			80			1		
Population covered by FHH	103,603			48,000			60,561			212,164			2,652		
Parameters	AFA	USD	%of	AFA	USD	%of Total	AFA	USD	%of	AFA	USD	%of	AFA	USD	%of Total

Annual Running Cost of FHH (2014)

	Faryab			Bamyan			Daikondi			Total			Average		
Salary and Wages	5,546,569	95,631	0	5,015,441	86,473	0	4,190,808	72,255	0	14,752,818	254,359	0	184,410	3,179	0
Drugs and Medical Supplies	4,414,676	76,115	0	2,391,318	41,230	0	3,922,641	67,632	0	10,728,636	184,976	0	134,108	2,312	0
Training Cost	765,699	13,202	0	-	-	-	708,435	12,214	0	1,474,134	25,416	0	18,427	318	0
Other Operational Expenses	1,933,371	33,334	0	3,343,574	57,648	0	3,138,278	54,108	0	8,415,223	145,090	0	105,190	1,814	0
Total Expenditure	12,660,315	218,281	1	10,750,333	185,351	1	11,960,162	206,210	1	35,370,810	609,842	1	442,135	7,623	1
Annual Cost Per Capita	122	2		224	4		197	3		167	3		167	3	
Annual Cost Per FHH	383,646	6,615		447,931	7,723		520,007	8,966		442,135	7,623		442,135	7,623	

Initial Capital Cost of FHH at the starting phase

	Faryab		Bamyan		Daikondi		Total	
	33 FHH		24 FHH		23 FHH		80 FHH	
Capital Cost of FHH	AFA	USD (1USD=58AFA)	AFA	USD (1USD=58AFA)	AFA	USD (1USD=58AFA)	AFA	USD (1USD=58AFA)
Medical Equipment for FHH in beginning of project	4,026,000	69,414	2,928,000	50,483	2,760,000	47,586	9,714,000	167,483
Furniture FHH for FHH in beginning of project	4,785,000	82,500	3,480,000	60,000	2,070,000	35,690	10,335,000	178,190
Reference Books for FHH for FHH in beginning of project	396,000	6,828	288,000	4,966	230,000	3,966	914,000	15,759
TOTAL(Medical Equipment, Furniture, Reference Book)	9,207,000	158,741	6,696,000	115,448	5,060,000	87,241	20,963,000	361,431
* Capital Expenditure(Medical Equipment, Furniture, and Reference Books for FHH) per FHH	279,000	4,810	279,000	4,810	220,000	3,793	262,038	4,518
Construction of FHH (IP/UNFPA)	5,742,000	99,000	4,176,000	72,000	6,455,982	111,310	16,373,982	282,310
Construction of FHH Community Contribution	2,970,000	51,207	1,200,000	20,690	2,783,973	48,000	6,953,973	119,896
TOTAL Cost of FHH Construction	8,712,000	150,207	5,376,000	92,690	9,239,954	159,310	23,327,954	402,206
** Cost of Construction per FHH	264,000	4,552	224,000	3,862	401,737	6,927	291,599	5,028
*** Value of donated land for FHH		-		-		-		-

CME Cost

	Faryab		Bamyan		Daikondi	
Number of Students	40		26		23	
Total Cost of CME	32,480,000	560,000	23,374,000	403,000	26,501,244	456,918
****Cost of CME per student	812,000	14,000	899,000	15,500	1,152,228	19,866

* Capital Expenditure in Bamyan and Faryab is higher than Daikondi as in those provinces 9 additional items were purchased which were not included in the FHH list of equipments

** Construction cost of FHH in Bamyan and Faryab are based on 2 rooms model while in Daikondi is based on 4rooms model

***Community donated a piece of land for construction of FHH, however, the monetary value of land is not recognized.

**** CME Cost in Faryab and Bamyan are based on 18months standard CME + 2 additional months while in Daikondi is based on 24 months standard CME + 2months additional

As Table 11 shows, the direct running costs for each FHH may not be as prohibitive as one may think, although actual calculations are not easy due to the way budgets are constructed and the lack of a clear estimate of total catchment population. Added to these direct costs are the usual costs related to supervision, drug supply medicines, general administration and training of CMWs that would be needed for any service delivery point if the women in these communities had access to services elsewhere. Therefore, the table only considers what might be deemed “additional costs” for the FHH modality. According to the most recent BPHS costing, the cost per capita for the BPHS package is USD 5 per capital per annum,⁶⁰ therefore adding small amounts for these small but not insignificant populations would require additional budgets. However, as discussed in Chapter 5 there may some economies that can be made or service delivery points may be re-profiled based on a more detailed analysis of population size and needs.

In terms of set-up costs it is difficult to estimate with any accuracy costs related to the time and travel for mapping and selecting the location of the FHH and the construction of the FHH, for which it is expected that the community would contribute 30 per cent on average. In interviews, UNFPA estimated USD 2,500 per FHH for construction of the building but this can vary, as some of the IPs mentioned that communities contributed different amounts. In one area the community built the FHH with almost no financial support from the IP and there is concern that the current design may not be adequate.

4.5 Sustainability

4.5.1 Score: (scale range 1–4)

4	There is consensus that the pilot model of BHSP service delivery using FHHs with support from MSTs is good and should be expanded to other areas, but they are waiting to review the information from the MTR.
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In terms of sustainability, the review considered the extent to which the positive benefits of the FHH+MST project and its interventions justify continued investments by partners to the project in future years; the extent to which partners (IPs and Government) have the financial capacity to maintain and sustain the benefits from the interventions when UNFPA and other donor support ceases or is scaled down; and the extent to which MoPH and the Provincial Health Directorate would like to institutionalize the strategies and activities of the project in their policies/ procedures and corporate plans and organizational budgets, and how feasible this would be.

The MTR assessed the sustainability of FHH model considering three aspects: financial, technical, and institutional (Figure 8).

4.5.2 Financial sustainability

Stakeholders at the national and provincial levels perceived that the implementation of FHH model, like any other health project such as the BPHS, is heavily dependent on external support. However, there were a strong willingness to continue and scale up the model.

Overall there is huge support from within the MoPH to integrate the FHH modality into the BPHS ‘white areas’. Senior officials in MoPH agree that there is no issue with this, as the project is fully in line with government policy on increasing equity.

Once the MoPH have officially adopted the modality for ‘white areas’ the department responsible for issuing contracts to NGOs will include it in the basic package of services to be delivered.

The World Bank confirmed that if the FHH modality is integrated into the MoPH’s basic package then it may be funded through SEHAT. BPHS was always intended to be flexible in the original design therefore there would be no reason it would not be funded as long as it delivers the basic health package.

⁶⁰ Ibid.

Many stakeholders inside and outside the MoPH believe that this modality is the only feasible way to reach remote areas, which is essential from a human rights perspective, and also to contribute to nation building through community partnership and long term stability.

One of the international NGOs (Save The Children), the current IP in Badakhshan, adopted a similar model earlier than the FHH Concept Note and thus cover a larger population. When interviewed, Save the Children said:

“FHH is the only way to ensure equitable access to these communities which cannot access other service delivery points because of the geographical situation. Some parts of the (our) Province are completely cut off for long periods in the winter. Because of the where the Province sits, many of the BPHS services are delivered by Tajikistan nationals, which whilst they do a good job, it isn’t perceived by the community as being serviced by their own; whereas with FHH the health professional is from their own community, is known by the community and supported by the community.”

– Save the Children senior management

There is however general concern within MoPH at all levels, that currently and (in the view of many) for the foreseeable future, such services will only be available if supported by donors, given the country context and the high level of donor dependency.

Some senior officials expressed their opinion that the project was sustainable even if donor funds were not available, because of community ownership and because the CMW is from and resides in the area; services would continue, and communities themselves would recompense her.

4.5.3 Technical sustainability

The FHH model provides basic RMNCH services to the remote and under-served communities, which have not yet been reached despite remarkable progress toward expanding the coverage of BPHS in recent years. Considering the functionality of the FHH model, it is not only aligned with national health priorities, the FHH is complementary to BPHS in its further expansion of basic RMNCH services to so-called ‘white areas’ to meet the unmet need of communities and contribute to equity in health. It is widely perceived by stakeholders that the FHH package in such difficult-to-reach and scattered communities has contributed to raising awareness of health issues in general and RMNCH services in particular. Furthermore, FHHs promote RMNCH components and create demand for RMNCH services, particularly ANC, PNC, SBA, and family planning, in the catchment of the FHH network. The perceived benefit of FHHs from the community perspective, as well as the review of HMIS data, suggest that FHHs have contributed to positive behaviour change towards the utilization of RMNCH services. Ultimately, availability and functionality of FHH in such under-served communities where it is the only option for the community can contribute to the reduction of maternal and infant mortality through provision of basic RMNCH services and timely identification and referral of high risk pregnancies and obstetric complications.

4.5.4 Institutional sustainability

CMW training is the key element of the FHH model and contributes to health system strengthening and increases local health workforce capacities. Training under the CME programme was widely participatory, with collaborations at the national level with the MoPH, at the provincial level with local government and the provincial council, and with local communities. The CMWs were selected from the communities, trained, and deployed back to their own settings to operationalize the FHHs.

It became clear from the comments of IPs, CMWs, the community and from observations during the MTR that having only one CMW per FHH is a high-risk strategy. One of the features for the success of the FHH is felt to be the availability of the midwife and community members' assurance that if they visit the FHH there will be someone there to assist them. However as was observed and discussed by many stakeholders, when the midwife is sick, on leave or away on trainings etc., there is no one to provide the necessary services. Given the age profile of the CMWs recruited, it is very likely that many will require time away from their workplace to have their own babies. Indeed one IP told the interviewer of one case where the CMW was harassed by the community who were demanding her services even though she herself was supposed to be on maternity leave.



Figure 8. Sustainability model of FHH

From interviews with CMWs in the FHHs there is already growing disquiet regarding the disparity (or at least perceived disparity) between their remuneration (USD 240 per month equal to Afs 14,400), and the higher monthly take home pay of CMWs in static BPHS,⁶¹ due to all the additional allowances they can access. Salary was examined during the MTR and this perceived discrepancy is discouraging point for FHH CMWs, as noted by CMWs, BPHS and IP managers. Such disquiet could result in loss of FHH CMWs as they attempt to find jobs in BPHS facilities; IP reported that at least a few CMWs of Bamyan and Faryab have attempted this in the past, but were dissuaded. The IP keeps the diploma until the five years CMWs commit to are up, so they are not able to move without the IP's agreement.

IPs and UNFPA are aware of the problem of having FHHs staffed by only one CMW and are looking for solutions. One IP recruited an additional midwife as a member of the MST, so she can stand in for the CMW if she is away. IPs have also reduced the duration the CMW is away from her FHH for in-service training/ refresher training, by offering shorter courses. This has been mainly because the CMWs prefer this, but it also ensures less time away from the FHH at any one time. Whilst these strategies offer some resolution, they are not without challenges. For example, where the FHH is attached to the CMW's residence it may not be possible to have a CMW from elsewhere stand in. Such solutions may not be possible if the CMW is away for a prolonged period of time. This could be overcome by having an additional room in the FHH that visiting staff can use, but this needs further consideration and it is not clear that there are sufficient additional midwives who can or would be willing to do short "stand-ins"; (i.e. locum type attachments). In addition, if there are ways in which additional or temporary staff can be found to cover for periods when CMWs are on leave, there may be need for additional accommodation.

Establishing and expanding community support structures through community health shura, CHWs and FHAGs are other elements of FHH model that are perceived as creating social capital and critical mass

⁶¹ Based on data collected in all three provinces during MTR field observations. The basic salary of a midwife with a minimum 18 month midwifery education and based on an eight hour working day (40 hours per week) was a fixed Afs 8,900 in 2012 with an annual increment of 5 per cent. The NSP assigned a hardship allowance of 50 per cent of basic salary, 100 per cent, 200 per cent, and 250 per cent for semi-urban, rural, deep rural, and isolated areas, respectively for female health personal, including the midwife, to motivate health personnel to work in remote areas. However, there is no explicit limitation for community midwives to receive such a hardship allowance. However, based on interviews with BPHS project managers, CMW working in BPHS facilities receive the hardship allowance despite being selected from the local community and living there. In addition, the NSP consider another type of incentive for staff working in BPHS facilities, the provincial grading. Health personnel working in BPHS facilities in Bamyan and Faryab are entitled to receive an additional 20 per cent of monthly basic salary, while in Daykundi the entitlement is 30 per cent as top up to basic salary. Moreover, the NSP considers Afs 400 per night for night duty for mid-level health personal, including midwives working in BPHS facilities.

for the promotion of healthy behaviours and the utilization of RMNCH services as they are from the local communities familiar with social norms and local contexts.

The sustainability of the FHH model is summarized in Figure 8.

4.6 Institutional arrangements, governance and coordination

No scoring system was developed for this item, as it was included in the MTR after consultation with stakeholders to determine the extent to which the overall governance structure, institutional arrangements and collaborations with UNFPA, MoPH, IPs, AMA and other relevant stakeholders have contributed to the progress that the project has made towards its planned results and intended benefits to communities.

Specifically, this is to determine whether the leadership, technical advice and support provided by UNFPA were to the satisfaction and standards of the MoPH, IPs, FHH and community health shuras and whether that has contributed to the achievement of planned results and benefits of the project:

1. Whether relevant implementing partners performed their role and functions well and effectively that has resulted in the achievement of planned results, targets and the realization of benefits to communities;
2. Identify/ define some of the areas in which UNFPA, MoPH, IPs and other relevant stakeholders could have done better or address to improve overall project implementation;
3. Whether the current governance and institutional arrangement amongst the different stakeholders allow for strong collaboration, consultation, coordination and reporting of progress in implementation; if not suggest alternative governance structures to strengthen project implementation and reporting; and
4. The extent to which HMIS and the UNFPA and IP monitoring and evaluation systems were able to support planning, project management, implementation, resource allocation, reporting, decision-making and the achievement of results.

Many of the responses to the above questions have already been given or alluded to under the previous sub-headings.

UNFPA-IP letter of understanding: UNFPA signed letter of understanding with IPs which supplemented with AWP. The two documents clarify the role and responsibility of each partner.

There is almost unanimous support for the project and appreciation of UNFPA's technical leadership for implementing this project, although in the initial period communication between UNFPA and the MoPH at the central level was not as strong as it could have been or is today. However, apart from the FHH Concept Note, there is no other operation procedure manual to guide and standardize the establishment and implementation of FHH.

Governance structure for implementation of FHH: The PSC for implementation of FHH model is a strong governance structure that was established to provide oversight to the implementation process and further guidance for successful implementation of the FHH model. The PSC comprises of the MoPH, UNFPA, donors, and IPs under the leadership of the General Directorate of Policy and Planning Department of MoPH. Specifically, the role of PSC is to provide high-level, strategic oversight to the project; provide high-level quality assurance for project results; facilitate the coordination and implementation of project activities across institutions; review the project activities, and their adherence to the work plan set forth in the project document and approve any modifications/revisions as may be necessary; and review the progress of the project. The PSC meets biannually and as required throughout the life of the project to review the progress of implementation of FHH model.

Coordination: The annual review workshop is the highest level coordination mechanism between UNFPA, MoPH and IPs. During the annual workshop the parties review the progress of implementation of project, identify the strengths, weakness, and develop the next AWP. Quarterly and biannual reviews with IPs are used to review progress towards the AWP; however, a review of documents shows

this mechanism either has not been regularly organized or structurally documented. At the provincial level, IPs coordinate implementation with the provincial PHCC where all health partners, including the BPHS and EPHS implementing partner, coordinate activities. However, field observation revealed that apart from PHCC there is no regular technical coordination between FHH and BPHS implementing partners to coordinate field level activities, particularly referral from FHH to BPHS facilities and involvement of BPHS facilities in supervision of FHH. However, the existence of such a bilateral coordination was strongly felt by both BPHS and FHH managers. Furthermore, IPs believe they have good working relationships with the MoPH at local and provincial levels, but less so at the central level, where communications occur through UNFPA.

There is need for still greater communications between UNFPA, MoPH, IPs and other stakeholders, such as AMA. The initial lack of communication at the beginning was felt by all stakeholders to be much better now. However, when asked how the project could be improved there were a number of comments that referred to strengthening communications and more for strengthening collaboration. One such comment was made by a senior official of the MoPH:

“It would be better if MoPH had direct relationship with IPs as well as UNFPA. Possible by quarterly meetings. Also the annual report on progress should be made at the RH Task Force.

[Moreover it] would be better if UNFPA could support a focal point in MoPH to help with communications, as staff turnover is a problem, also staff shortages in relevant departments, so it is not always possible for same person to go to meets be available when needed.

Regular reports by IP on project should be made at provincial level to provincial health coordination committee.”

– Senior officer, MoPH

Both IPs and MoPH think that it would be beneficial if communications between IPs and the central level MoPH were direct, perhaps by IPs presenting progress reports at the Reproductive Health Taskforce meeting at the provincial coordinating committee. This has already been discussed with UNFPA and steps are being taken to involve IPs in central coordination meetings on BPHS and EPHS.

HMIS and UNFPA and IP monitoring and evaluation: In terms of inter-partner collaboration, all parties at the community and provincial level felt there are good arrangements. Three key approaches have been used by UNFPA and IPs to monitor the progress of project implementation; the work plan monitoring reports completed quarterly by IPs and submitted to UNFPA; biannual review meetings between UNFPA and IPs; and field monitoring visits by UNFPA and IP managers. Although UNFPA and senior IP managers in their Kabul offices conducted field monitoring visits of provincial offices and FHHs, at least in the year before MTR, the frequency of these visits was not regular. Although the field monitoring mechanism of UNFPA and IPs to FHH sites was not strong enough at the initial stages, it improved during the course of project. The IP managers acknowledged the positive effect of these field monitoring visits on improving implementation of the FHH project. Monitoring has enabled swift decisions and logical adjustments to be made to the work plans. IPs have expressed appreciation of technical monitoring by UNFPA and consider that this has helped them maintain quality and achieve their targets. One IP said:

“When small mistakes or gaps were found by UNFPA (from monitoring missions) these were identified immediately with IP and UNFPA help to discuss and take action to rectify.”

– IP senior managers

All FHHs have been implementing the standard national HMIS recording and reporting tools and transferred the HMIS data of FHHs to the national HMIS database. In addition, all FHHs and HPs functional in FHH catchments were registered with the HMIS department in the MoPH and have their code numbers, except for Faryab HPs which had not yet been registered. Although FHHs apply the standard HMIS tools and reporting mechanism, the HMIS data was not properly used for planning e.g. essential drugs and medical supplies were not supplied based on consumption in the past quarter.

Meanwhile, the HMIS itself has limitations around ANC and PNC reporting. The standard HMIS recording and reporting mechanism allows the first ANC visit and first PNC visit to be recorded and reported, while subsequent visits are recorded and reported collectively as “other ANC” and “other PNC” visits. This lack of disaggregated data limits close monitoring of ANC and PNC visits and compliance with the national reproductive health guidelines requiring at least four ANC visits and three PNC visits.

4.7 Human rights and gender

4.7.1 FHH and human rights

During FGDs with community health shura and FHAG across the three provinces, community practices around ANC, delivery, PNC, and family planning before and after the establishment of the FHHs were discussed. Most of the men and women respondents across the three provinces felt that women had not received any care from health personnel during pregnancy, delivery, and after delivery before the establishment of the FHH. Furthermore, they perceived that short birth spacing was a major challenge for most women. The participants felt that multiple factors contributed to this. Knowledge of pregnancy care, skilled birth attendance and care after delivery was very low among both men and women. Customarily women sought care and support from an elder family member, mainly the mother or mother-in-law, during pregnancy and after delivery. Furthermore, almost all deliveries took place at home with the support of an elder family member or other older, experienced, women of the village. Respondents perceived that care from health personnel was sought only when women had heavy bleeding during delivery. In this situation, arranging transport was the major challenge that further worsened the situation, and even led to the death of the women before reaching the clinic or hospital. Several respondents shared the stories of such incidents in their families or village.

“My daughter was pregnant and her delivery got complicated at home. Finally, we transferred her to Nili Hospital and [she] got operated. Unfortunately, the baby was already dead but my daughter was rescued.”

– Male member of a community health shura, Daykundi

Distance to a clinic or hospital, availability and arrangement of transportation, affordability of transportation (which could cost Afs 2,000-3,000, which was not easy for families in deep rural areas), were among the factors hindering seeking health care during pregnancy, delivery, or after. In addition, most FHAG members felt that women in remote areas are very dependent on the decisions and availability of men at home. If men are not available or unwilling to accompany their female relatives, woman cannot arrange transportation to visit a health facility. Furthermore, it was universally perceived by women that delivery at home was a generally accepted norm in their society and had been so for generations.

However, when the respondents of FGDs with community health shuras and FHAGs were asked about the situation of women after establishment of FHHs, the absolute majority of both women and men respondents agreed that the FHH had bridged all the gaps and made life easier for women. They saw that the midwife was from their own village and was familiar with the community, culture, and language of the people, and was available around the clock. In addition, respondents commented that women did not need to wait for men, seek permission, or their accompaniment to visit the FHH and did not need transportation or money, as FHHs services were free, including delivery. However, most respondents felt that building this level of trust in the FHH had not been easy; it had taken a few months to make the FHHs fully functional and trusted by the community. The community respondents, as well as the CMWs themselves, believed that multiple factors had contributed towards building trust in FHHs. The most critical was the involvement and support of the community shura who promoted utilization of FHH at the community level, particularly some key members such as Mullah Imams, teachers, or tribal leaders. FHAG and CHWs were also perceived as strong change agents. Some other respondents felt that the communication and behaviour of the CMWs themselves were vital factors which contributed to building trust between individuals and families on one hand and the FHH on the other. Furthermore, some of the members of the shura, FHAG, and CMWs believed that sharing the experiences of women who had delivered at the FHH with other women in the village was a vital factor for FHH utilization. Most CMWs also felt that the support of MST, as well as CBHC, teams in negotiating and meeting communities at the initial stage of establishing FHHs was another contributing factor in building trust with the community.

4.7.2 Gender inequality and gender based violence

Respondents in FGD with community health shura and FHAGs across the three provinces were asked to share their opinions on marriage practices and decision-making processes related to engagement and marriage for boys and girls in their communities. Generally, the responses of respondents in Daykundi and Bamyan were different from those of respondents in Faryab, although in the latter there was variation from district to district. Most respondents in Bamyan and Daykundi felt that early marriage and child marriage is rare in their community and boys and girls themselves are generally part of decision-making, although the situation had been different some years ago. The general belief was that multiple factors had contributed to this change in the last decade. Wider access to schooling, the availability of high school, opportunity and willingness to pursue higher education, widespread access to satellite TV with national and international channels, and knowledge about the legal age for marriage of girls and boys according to the national constitution were among the factors highlighted by respondents.

“The vast majority of houses in Bamyan and Daykundi which were visited during the MTR had at least one [satellite] dish television receiver installed on the roof of houses.”

– Observation of national consultant during field visits to Bamyan and Daykundi

In addition, most respondents of community health shura and FHAG felt that CMWs, shuras, and FHAGs also promoted the involvement of boys and girls in decision-making about marriage and that they contributed to the knowledge of people at risk of early and child marriage.

In Faryab province, early and child marriage as a common practice was widely acknowledged in the FGDs, although there was variation between districts. Furthermore, FGD participants repeatedly acknowledged that decisions on marriage were made by male heads of families. Poor access to school in some areas, societal norms, poor economic status of families where the family of the girl receives Afs 300,000-500,000 as bride price, and poor access to media, were acknowledged as contributing factors.

Respondents from community health shuras and FHAGs were asked about the common types of GBV practices in their communities. The responses varied across the three provinces. In Bamyan and Daykundi rare cases of domestic violence were acknowledged by respondents while in Faryab, beating of woman by husband and other family members, and domestic violence was considered as a consequence of polygamy. A man married more than one wife was perceived to be common in some parts of the rural part of Faryab, although its prevalence was different from district to district.

CMWs interviewed across the three provinces acknowledged having clients with some levels of depression due to domestic violence, although this varied across the provinces – it was widely acknowledged in Faryab but was less common in Daykundi and Bamyan. The midwives commented that they had received GBV training and had the knowledge and skills to provide counselling.

Although gender inequality and GBV is perceived to be higher in Faryab compared to Bamyan and Daykundi, the FHAGs are perceived to be very active. Although the process of forming such groups required a longer period in Faryab compared to Daykundi, the FHAGs in Faryab felt they could easily get together and meet the CHWs and CMWs, as they were from the same village and community.

4.7.3 Women’s empowerment

Respondents of community health shuras and FHAGs and CMWs were asked about the opinions of the community, particularly girls, about CMWs at FHHs. Most of the respondents felt that when the FHHs were established, it was difficult to mobilize enough girl candidates for the CME programme, particularly in the first two rounds, as it was not culturally acceptable for families to send their girls or women for education away from the family. However, the experience of CME and deployment of CMWs at the FHHs and services provided to communities had led to positive social changes. Some of the

respondents felt that the CMWs were role models for female pupils to continue and complete their education.

“My daughter completed the midwifery programme and now working at Ashiana-e-Sehi [FHH],now my second daughter completed her school and has enrolled in community nursing programme.”

– Male member of a community health shura

Despite the rapid changes that have taken place in the country over the last decade, in particular in terms of the impressive reduction of the maternal mortality ratio and neonatal deaths, Afghanistan is still struggling to ensure basic health services are accessible to Afghan women and newborns. The most recent estimates of population with access to the BPHS, as defined by MoPH policy, is estimated to be 80-85 per cent, with wide inter-country and even inter-province variations.

In 2008, UNFPA began working with partners to expand access to basic services to some of the most remote and inaccessible areas of the country, referred to as 'white' areas, using MHTs. It soon became clear that whilst MHTs were acceptable to the majority of these populations who had hitherto had no access to formal health care services, there were serious limitations, especially when it came to provision of services for and around childbirth. Whilst MHTs were able to provide much needed health education and counselling, routine outpatient services, medical consultations for non-urgent medical conditions, even undertake limited laboratory testing and or refer patients for further investigations and treatments, they could not provide the much needed services at one of the most crucial times for pregnant women and newborns, immediately prior to, during and soon after childbirth, which requires services to be available 24/7.

In 2010, UNFPA began discussions with senior health staff in the provinces they were working, especially the Provincial Health Director and existing implementing partners, to consider a new way of providing basic health services, specifically to women, newborns and young children, in line with the Government's stated priorities.

Following success in recruiting young women to train as CMWs, and taking into account the geographical location of these isolated and remote areas, some which were totally inaccessible during winter months, the concept was formulated for the provision of community maternal and newborn health using community partnerships for establishing FHHs, or Ashiana-e-Sehi. This concept was shared with the MoPH at the central level, who were willing to try out a new idea, and with donors. With support from the Canadian Embassy, work commenced on implementing the FHH project. To prepare communities for utilizing the services of the CMW who were selected by and from within the communities support for the MHTs continued whilst the CMW was being trained using the existing CME programme, but adding two months to build additional skills considered necessary for FHH CMWs with only two Community Health Workers to assist them.

Once the CMW completed her programme she returned to her village and under the agreements signed between the CMW, her family and community she was expected to provide services to the community for at least five years. Recognizing that even with the additional two months of training, the CMWs would have some limitations when it came to general medical conditions, and to provide her with supportive supervision, the project added the concept of refocusing the MHT to become an MST; thus the modality is also known as FHH+MST.

Relevance

FHH alignment with national priorities

From data collected during the MTR it appears clear that the new above mentioned FHH pilot modality is totally in line with the Government's National Development Strategy 1387-1391 (2008-2013) which calls for *"the concept of working with communities to improve the reach of government health services while empowering the communities"* and has, as underlying core values, human rights, gender

equity, decreasing inequity priority to be given to the rural areas and cultural appropriateness, all features of the FHH modality.

The FHH concept is also in line with relevant MoPH policies and strategies, e.g. the National Health and Nutrition Policy, National Reproductive Health Policy and Strategy 2012-2016, HRH Policy, CBHC Policy and Strategy, and BPHS, and strengthens community-based services by increasing the number of CMWs deployed close to where women live, as well as promoting community partnerships. In this respect the pilot project is proving to be very successful and the deployment and retention rates of FHH CMWs after graduation are slightly higher than those quoted for women who go through regular CME programmes.

FHH alignment with UNFPA priorities

Given that health is a major contribution to national development, especially health of women, the project is not only totally in line with UNFPA global strategies for enhancing women's rights and women's empowerment, and addressing gender equity, but also contributes to reaching the national MDG targets for health in Afghanistan and contributing to national development.

FHH response to community need

Despite the remarkable expansion of BPHS, 18 per cent of the rural population of Afghanistan live more than two hours travel time from the nearest public clinic, 14 per cent are up to six hours away, and 3.1 per cent are more than six hours from the nearest public clinic. FHHs are established in such areas where people, particularly women, have limited access to a public facility. Given the impressive buy-in and partnerships formed with communities the project has made a significant contribution not only in terms of economic improvement, by reducing out-of-pocket expenditures and costs of health care, and reducing the overall burden of ill-health, especially for women and newborns, but is contributing to stability in the areas by helping communities feel empowered and responsible for their health care.

Coherence with criteria for establishment of FHH

Most of the FHHs are established in coherence with the population criteria (1,500-3,000) identified in the FHH Concept Paper. However, availability of reliable population data is a challenge which hinders proper planning and performance monitoring. Furthermore, most FHHs meet the distance criterion, or a minimum of 10 km from the nearest BPHS facility. Although available distance data is a very rough estimation, most FHHs are located more than 10 km from the nearest BPHS facility. However, a few FHH are located closer (less than 10 km) from the nearest BPHS facility, or very far (up to 70 km). FHH located less than 10km from the nearest BPHS facility are most likely to be underutilized while those located very far may face challenges with proper and timely supervision, monitoring, and referral.

Effectiveness

Outcome level performance

Assessment of effectiveness of FHH at the outcome indicator level is hindered due to paucity of outcome data. However, the proxy outcome data suggests that FHH are effective; it expanded the basic RMNCH services to more than 200,000 people who live in 'white areas' which were not reached by the BPHS.

Data collected during the MTR show that this modality is making significant contributions for reaching targets for reproductive health service delivery in the three target provinces. The overall FHH contribution to provincial first ANC and first PNC is 11 per cent each, and to institutional delivery is 12 per cent. Moreover these services are provided to women and children in some of the most remote and inaccessible areas of Afghanistan. As such, the pilot project is proving a useful mechanism for redressing the current equity gap in health care.

Furthermore, stakeholders at the national, provincial, and community level perceived that FHHs meet the unmet need for RMNCH services of a scattered population living in under-served areas.

Output level performance

In term of outputs produced through the FHH project, it seems the implementation of FHH was successful; 64 per cent (80) of planned FHHs have been established and are functional while 28 per cent (35) are in process as the CMWs are still in CME training. In addition, 8 per cent (9) of the planned FHH were either not established or closed during the months after establishment mainly due to weak planning and close monitoring in the selection of FHH and candidates for CME and at the deployment stage. Furthermore, among the CMWs who graduated from CME, 94 per cent were deployed and 95 per cent continue to provide basic RMNCH service to their community.

From the data provided during the MTR, it would appear that the FHH+MST pilot project is successful in terms of effectiveness. The main reasons for its success and effectiveness as suggested by most of the stakeholders include: 1) IPs have had good support with/ from UNFPA, who helped also with planning; 2) IPs have had good collaboration with community; 3) the FHH modality directly addresses barriers to accessing care and services in these remote areas (geographic, cultural and economic).

When attempting to look at cost-effectiveness, the benefit other than actual costs of service delivery need to be taken into consideration, for example, benefits gained from reducing the overall burden of ill-health; benefits to be gained by empowering communities and addressing the gender inequity, for example, anecdotally community members commented that the enrolment of girls has increased since establishment of FHH in their area. Whilst the IPs do not have actual data to evidence this increase, the comment is worthy of further investigation, as increasing the education of girls has been shown to have significant economic and health benefits to both women and newborns.

Other benefits also need to be considered, including directly addressing the barriers to accessing health care from other sources due to cultural as well as geographic issues, but also costs (especially out-of-pocket costs which will be discussed further in Chapter 5).

Overall, the reviewers agree with the IPs that in terms of effectiveness their expertise working with community has both increased and been beneficial in achieving the targets and helping to establish the FHHs. In addition, UNFPA's technical expertise has been timely and is highly valued. In addition, UNFPA has been very responsive to the needs of the community and IPs. Moreover, it has been willing to be flexible and readily adapted to change when shown there was need. This is seen as critical when establishing any new project, but especially one where there are as yet few lessons or standard operating procedures to follow.

There is a strong belief among IPs that FHH modality is more effective than some aspects of BPHS; both IPs are also implementers of BPHS, so believe they can compare.

However despite the impressive achievements to date, there are a number of challenges and concerns that the project should address as it moves forward, these include:

Lack of proper calculations of catchment population and coverage data. In a number of documents different figures are given for the size of the population, moreover almost all data seen was not disaggregated by sex and age. There appears to be no standard way of calculating population size, yet this is important for estimating service delivery needs, (estimated pregnancies births etc.) and for assessing and measuring coverage.

Without reasonably accurate population estimates and calculations, including differentiating not just population (which is available although rarely reported in the annual reports, but also service users by age and gender, it is difficult to measure the true effectiveness of the modality to provide equitable, accessible services.

Moreover, given that the populations for the FHH are quite small, it should be possible with time for the CMW to increase coverage year on year and eventually to supply services to the majority of pregnant and postnatal women and newborns and young children, even though it may not always be possible to attend all births given the nature and unpredictability of childbirth. Measuring coverage could be a better way of assessing performance. It may also help with management and supervision to highlight FHHs where there are difficulties occurring, if coverage decreases for example.

Need to strengthen the referral system. Having an effective referral system is crucial for long term success of this project, especially given the long distances between the FHH and the nearest facility which can offer adequate services for the management of complications in pregnancy and during and after childbirth, including for neonatal complications. In the FHH Concept Note (2012) it is stated that the CMW in the FHH should refer women, newborn and children to the nearest static health facility, yet often the nearest facility does not have any more capacity (in terms of equipment or capacity of staff) to manage/treat the condition and therefore needed to refer on. This results in delays in reaching the place where proper action can take place. Moreover, because the CMWS in the FHH are aware that the nearest facility is staffed by someone who has done the same programme as herself there is resistance to making a referral.

Although telecommunication networks are still being developed across the country, there is rapid improvement in communication and UNFPA and partners could look at other ways of linking the FHH CMW to the nearest EmONC service site, using modern technology. Even just giving a mobile phone and making connections would be helpful so that the midwife can call a specialist if she needs advice.

In addition it may be possible to look for ways to strengthen the links and relationship between the FHH CMW and the nearest EmONC centre. For example, giving the CMW a short internship in the EmONC facility before she is deployed to the FHH after graduation may be very beneficial for building a respectful relationships between the two and thus make it easier for the CMW to make a referral, especially if the reasons for the internship were made explicit to CMW and staff in the EmONC, and it was not seen as additional training. Another suggestion could be to include a midwife or physician from the nearest EmOC facility on the supervision team occasionally. Another could be to consider ways in which some of the in-service training could be conducted at the EmONC facility. Finally, it would be useful for both the EmONC facility and for the CMWs' ongoing development, to formulate a process whereby there are regular meetings between groups of CMWs from the district and EmONC staff to review cases in a kind of peer-to-peer review process.⁶² This will not only assist with the CMWs development, but also help keep the EmONC facility sensitized to the issues and conditions under which the CMW at the FHH operates, and will create more awareness to staff in the EmONC facility about cultural and other conditions their clients live in. Experience from elsewhere has shown this to be a very good method of bring about quality improvements.

Efficiency

Staffing issues

The IPs recruited and utilized the required staff of FHH and utilized the technical expertise of UNFPA and MoPH department. Although involvement of MoPH departments was limited at the beginning of the implementation of the FHH model, steps are currently being taken to involve more MoPH departments at the central level and it could be that involving all departments more effectively could lead to gains in project outputs.

Furthermore, in terms of how efficient the project has been to date, the modality of involving the community, whilst time consuming and consuming of human resources does appear to be beneficial and, in the end is ultimately an efficient way of getting services to these remote communities.

Procurement modality and distribution mechanism

IPs have procured and supplied the required medical and non-medical equipment of FHH as specified in the FHH concept. Meanwhile, IPs have utilized the allocated fund for construction of FHHs along with raised community fund and completed the construction of FHHs. Although the original sketch of FHH

⁶² See Enges et al 2002 for one example of peer-to-peer review in midwifery. Although the process is widely used in developed countries it is only beginning to be applied in low-resource settings, but there is every reason to assume it could be useful if applied and facilitated properly. It would be wise to begin with a small study as action research. The methodology draws on similar ways of conducting sympathetic (i.e. non-judgmental/ no fault/ blaming) reviews of maternal deaths, which can be started by looking at/ reviewing near-miss cases, or just referrals from the FHHs that have occurred in the last six months to consider how to improve the referral (from decision to refer up to treatment) if similar cases happened again.

building included two rooms, the IP in Daykundi raised additional community contributions and revised it to four rooms in consultation with UNFPA. The four room model seems more appropriate and ensures proper organization and proper application of infection prevention measures. However, the location of some FHHs very far - up to 60 minute walk - from the CMW's house is a major challenge for availability of RMNCH service around the clock. This suggests inadequate monitoring of process by the IPs and UNFPA during the establishment phase.

Ensuring that FHHs are located at the community level according to the criteria can help render greater effectiveness, as it is noted during the field observations interviews, that in at least one case where the FHH was not located close to the CMW home, she was unable to offer services during the night, whereas when the FHH was located close by, as per the FHH Concept Note, the communities were accessing services day and night.

All FHHs are supplied regularly with essential drugs and medical supplies which facilitates full functionality. However, variation in the essential drugs and medical supplies supplied from the list provided in the FHH Concept Note and a push based mechanism of supply to FHH challenges the efficient use of allocated resources for this purpose.

Funding modality and disbursement mechanism

The project AWP guides the fund modality of FHH and disbursement of funds from UNFPA to IP on a quarterly basis. The approved financial disbursement from UNFPA to IP and from IP to provincial office is through a bank transfer mechanism.

Accountability and transparency are two key issues addressed in implementation of the FHH project to ensure alignment of expenditure with agreed AWP. For this purpose, three key measures were practiced; work plan monitoring report, internal control system of IP, and annual independent audit of project.

From the interviews at the central level, all IPs were satisfied with the funding arrangements from UNFPA and commented that funds were disbursed speedily once they (as IP) had completed the necessary paperwork/reports. Delays were mainly due to their own issues with getting the needed information and reports to UNFPA. However all commented that UNFPA had been very helpful in explaining the processes, helping them prepare reports and generally assisted them in building their own capacity for project management. Indeed one senior management in one of the IPs responded that he felt one of many benefits of the project has been the development of his own capacities to manage, thanks to the technical assistance and capacity building by UNFPA.

The actual costs for operating the FHH are not easy to calculate, given that each IP offers a number of different interventions alongside the FHH, all of which are logical and appear most worthy. Some of the current costs may be reduced with better management of the essential drugs and medicines chain, but this needs further investigation.

Capacity building

The training of CMWs followed the MoPH's standard 24 month curriculum for community midwifery followed by two months additional training in 12 priority topics. Despite this, CMWs and IP managers felt that CMWs needed an internship period in BPHS facilities prior to deployment.

Although CMWs are mainly trained in basic RMNCH services and IMCI, there are expectations from communities to provide medical consultation to adults as well. However, stakeholders, particularly at the national level, had concern regarding the current capacity of CMWs to offering adult non-RH services, in particular medical consultations. Yet it is clear from looking at workloads and work registers of the CMWs and especially the referrals and drug utilizations, that CMWs are being consulted regularly for adult non-RH services (CMWs are trained for under-five health and IMCI). Moreover, offering non-RH services through FHH means that less time is available for RH services, including outreach and follow up in the community.

From studies elsewhere, whereby midwives have been given a multiplicity of tasks, this has almost always proved to have a negative impact on work patterns, retention and quality of services provided for many reasons, but many to do with burn out, overload and general dissatisfaction with the work - them not being able to concentrate/give sufficient time to the aspects of the job they initially chose, i.e. midwifery.

If non-RH services, particularly the medical consulting, are provided they should be regulated and midwives should be equipped with the right knowledge and skills. This would mean that CMW should be allowed legally to do medical consultation and treatment and that common diseases should be included in the pre- and post-services training of CMWs. A standard treatment guideline for FHH should be adapted in line with the national standard treatment guidelines for primary health care recently developed by the MoPH. This would necessitate a review and revision of the CME programme. Furthermore, it is crucial that all medical consultations and treatment should be strictly followed in supervision and monitoring of FHH.

Finally it is noted that not all CMWs, particularly in the first two rounds of CME, met the educational entry criteria, mainly because there was no one with the required education level who was willing and could be supported to train as a CMW. It was however noted that in the later selection rounds the education level of potential recruits was higher. This lower than recommended education level in some CMWs is of concern and may be a potential problem as the public health system develops further, as these CMWs may not be eligible for government posts (as they do not meet basic entry requirements, usually a minimum of grade 12, but this had not been fully decided at the time of the MTR). Where this has happened in other countries, these midwives are discriminated against and are left as auxiliary/ associate level staff, even though they have undergone the same programme and function the same as their colleagues who have the required entry level. This seems unfair and disrespectful to women who are making such a contribution to Afghanistan's public health system and service delivery network. Career development and plans should be offering as an option for CMWs wishing to undertake a bridging programme so they can continue their studies and advance their career options.

Cost-benefit

The MTR explored the feasibility of the cost-benefit analysis of FHH. However, due to lack of detailed disaggregated cost data as well as paucity of outcome level data as the project is still on going. However, the simple assessment of cost of FHH shows that on average an estimated USD 29,000 is the establishment cost of a FHH while it requires an estimated USD 7,623 annually for the direct running of a FHH in remote area.

Sustainability

Financial sustainability

There is a huge support and willingness among the MoPH officials at the central and provincial levels as well as IPs for integration of FHH model into BPHS to expand the provision of basic health services to 'white areas', which justifies the continuation of FHH services. Furthermore, the World Bank, the main supporter of BPHS implementation under the SEHAT Project, is willing to fund FHH like other BPHS facilities if it is adopted into BPHS.

However, there was concern at different levels that the project is donor dependent although it is community based. Continuity of the FHH model at the community level without external support would be a major challenge.

Technical sustainability

Technically, FHH model provides equitable service as it is complementary to BPHS and meets the unmet need of RMNCH services of hard-to-reach communities. The FHH contributed to raising awareness and utilization of RMNCH services. Availability and functionality of the FHH in such underserved communities contribute to the reduction of maternal and infant mortality.

Institutional sustainability

Institutionally, the FHH project builds partnership at the national level to contribute to health workforce for RMNCH services through training CMWs. It builds partnerships at the provincial and community level and ensured the involvement of stakeholders which strengthened community ownership and participation. Establishing community structures e.g. community health shura, CHWs, and FHAGs is perceived as critical for promotion and utilization of RMNCH services in remote communities.

Staffing of FHHs may not be sustainable: It became clear from comments of IPs, CMWs, the community and from observations during the MTR that having only one CMW per FHH is a high risk strategy; when the midwife is sick, on leave or away on training, etc., there is no one to provide the necessary services.

There is compelling evidence to show that not giving staff, especially in remote rural areas sufficient and frequent time away from their work station, or giving them opportunities to further their studies has a detrimental impact on retention as well as staff morale, which in turn can lead to reductions in quality of care (see Mbembe et al 2013 for a review of the literature). Therefore, if CMWs are not free to be absent from their workplace for leave of any kind, there is a high risk of them become demoralized and stopping to provide care, or worse, to provide poor quality care. This is very likely given that from interviews with CMWs in the FHHs there is already growing disquiet within their ranks regarding the disparity (or at least perceived disparity) between their remuneration and the higher monthly take home pay of CMWs working in static BPHS, due to all the additional allowances they can access. It also is possible that the current support given by families to assist the CMW to provide services 24/7 is in part due to the fact that the CMW salary is the only regular income available to the family. As such, if the FHH modality is incorporated into government ownership without guarantees that CMW salaries will be maintained (as far as such guarantees are possible given the country context), effectiveness and sustainability may not be maintained.

Institutional arrangements, governance, coordination

A letter of understanding with IPs, and the AWP, clarify the institutional arrangement between UNFPA and IP.

The PSC for implementation of FHH model is a strong governance structure which oversees the implementation process and provide further guidance for successful implementation.

In terms of coordination, IPs believe they have good working relationships with MoPH at local and provincial levels, but less so at central level, where communications is through UNFPA.

Although IPs are presenting progress reports at the Provincial Coordinating committee, involvement of FHH project in central coordination meetings on BPHS and EPHS might be more beneficial. Moreover the MTR Taskforce which was established to oversee the MTR, has provided an opportunity for greater sharing of progress at the central level and is driven by MoPH and UNFPA.

In terms of inter-partner collaboration, all parties at the community and provincial level felt there have been good arrangements.

Monitoring has enabled swift decisions and logical adjustments to be made to the work plans. IPs have very much appreciated the technical monitoring by UNFPA and consider this has assisted them maintain quality and achieve their targets.

Human rights and gender

FHHs have been established in remote areas where access to health services, particularly RMNCH services is limited due to multiple physical, socioeconomic, and cultural barriers. FHHs could bridge all the barriers and provide services basic RMNCH services, fulfilling their basic right to health in their community.

The FHH model is totally community based with high acceptance by community. It has mobilized community human resources and formed them as community health shura, FHAG, CHW, and CMWs.

These together work as a critical mass for change in their community to promote healthy behaviour and address gender inequality and GBV.

The MTR found the FHH pilot project to be highly relevant, effective and reasonably efficient, although some areas of efficiency could be strengthened. The implementation has been successful, although the start was a little difficult. Communications and coordination between all parties (UNFPA, MoPH at all levels, donors, and IPs) have been strengthened, and there is good collaboration and coordination for moving the next phase of the project. As such, there is good reason for integrating the FHH concept into the BPHS national programme and expanding it to all ‘white areas’ willing to be partners for the provision of RMNCH through the FHH modality.

Based on the results of MTR and conclusions, the following recommendations are made to address some of the concerns raised in the review.

Relevance

- 1) Some FHHs established do not meet the distance criteria for establishment (10 km from the nearest BPHS facility) which are associated with underutilization (if less than 10 km) or face challenges of supervision, monitoring, and referral (if very far). Hence, it is strongly recommended to strengthen the planning and monitoring of the establishment of FHHs through the active involvement of IP managers from the main office as well as UNFPA. In addition, it is recommended that IPs further assess the functionality model of FHHs located very far from the nearest facility and develop strong support mechanism to ensure their effectiveness.

Effectiveness

- 2) Lack of reliable population data on the catchment of FHHs is a major challenge for proper planning and monitoring performance. Therefore, it is strongly recommended to conduct a high quality CAAC survey as per the standard HMIS procedure manual to identify a reliable catchment population for each FHH.
- 3) Currently only the first ANC and first PNC are performance indicators for FHH while future ANC and PNC visits receive less attention. It is strongly recommended to revise the list of indicators for FHHs and include a separate indicator for each ANC and PNC visit to closely monitor progress and ensure compliance with reproductive health guidelines. Although the standard HMIS system allows recording and reporting only the first ANC and first PNC and provide space for collecting reporting of other ANC and PNC visits, the HMIS system provides the opportunity for recording and reporting for BPHS facilities where the result based financing format is implemented. Therefore, it is recommended to introduce this format for recording and reporting by FHH in consultation with the HMIS department of the MoPH.
- 4) Based on field observations, an effective two-way referral system between FHH and BPHS facilities is in its very initial stage and has not been established in some FHHs. To strengthen the referral system from FHH to BPHS, it is strongly recommended that IPs closely monitor referral cases from FHH to BPHS, coordinate the referral system between FHH and BPHS with BPHS provincial and field managers, and develop innovative approaches e.g. use of mobile technology for arrangement and follow up of referral cases.

- 5) Based on the outputs produced, nine CMWs (10 per cent of all enrolled to CME) completed the CME training and either did not join the FHH after graduation or left the job within the first months of the establishment of the FHH. This suggests a need to strengthen the selection process of candidates for CME programme at the initial phase of project. Hence, it is strongly recommended UNFPA should very closely monitor the progress of assessment and selection of candidates for enrolment to the CME programme if the FHH model is to be scaled up to other settings.

Efficiency

- 6) To strengthen the self-confidence of CMWs and ensure effective inauguration of FHH, an internship period of 2-3 months in the nearest BPHS is essential for newly graduated CMWs prior to deployment to FHH. The internship will provide an opportunity to CMWs to get practical experience of independent management of FHH. Meanwhile, a strong mentorship mechanism in the first six months after deployment of CMWs to the FHH should be established to provide effective technical support to CMWs to translate their knowledge to practice.
- 7) Supply of essential drugs and medical supplies to FHHs should comply with the standard list of essential drugs and medical supplies provided in the FHH Concept Note. Meanwhile, UNFPA should monitor closely compliance of field practice with the FHH Concept Note.
- 8) The mechanism of supply to FHHs should be based on need and past consumption of FHH. This mechanism will minimize expiration of medicine at FHHs.

Sustainability

- 9) As the FHH project is fully dependent on donor support, UNFPA and MoPH may work together on developing a comprehensive sustainability plan for continuation of existing FHHs as well as possible expansion to other similar settings.
- 10) To address the issue of staffing, including coverage when CMW is away for more than a few days, it is recommended IPs and UNFPA should explore different approaches and local initiatives to propose a replacement mechanism. Deployment of the MST midwife or of a midwife from the nearest CHC or DH could be a solution; however, its practical arrangements should be explored.
- 11) UNFPA, along with IPs and MoPH, should review the salary structure of the CMW at FHH and agree how to address the issue of 24/7 working as well as the hardship allowance arrangement in BPHS which creates discrepancy between the monthly remuneration of CMWs at FHHs and in the BPHS.

Institutional arrangements, governance, coordination

- 12) UNFPA IPs and MoPH should, as a matter of urgency, develop a Standard Operating Procedures manual that covers not only procedures for mapping communities to identify most appropriate places for FHHs, but also processes by which to calculate catchment populations, setting up and support to shuras and FHAGs, supervision, management of drugs and medicines and establishing an effective referral network for the FHHs.

General recommendations

- 13) UNFPA and IPs should review the findings of the MTR and develop an action plan to address the areas which need further improvement in the existing FHH project.
- 14) Compliance with the expected ANC and PNC visits and effective referral system are among the key issues. Therefore, it is recommended to explore the feasibility of innovative approaches such as use of mobile phone technology to address these critical issues. Such technology has been successfully utilized elsewhere and is well documented in the literature.
- 15) Considering the FHH model and its functionality in 'white areas' to provide RMNCH services to women and children where access to static BPHS facilities is none or limited, the FHH model is an effective and efficient intervention. While the continuation of the existing FHHs are strongly recommended, it is also recommended to explore the feasibility of further expansion of FHH

intervention in similar settings within the provinces where FHH is being implemented and in to other provinces with similar characteristics.

- 16) Exploring the feasibility of institutionalizing the FHH model will need at least two departments to join together for oversight: CBHC and RH, and therefore MoPH may consider maintaining some sort of 'oversight committee' to keep this modality under review and explore the feasibility of institutionalizing it into Afghanistan's health system structure serving remote areas.

List of Annexes

Annex 1: Terms of Reference for MTR

Annex 2: Documents consulted

Annex 3: List of persons consulted

Annex 4: Summary of tools used for MTR

Annex 5: Mid-Term Review matrix

Annex 6: Profiles of participants in MTR field observations

Annex 7: Additional data tables from field observations

Annex 8: Cost-benefit analysis model for FHH

Annex 9: MTR score matrix

Annex 10: References

Annex 1: Terms of Reference: Mid-term Review of Family Health House (FHH-MST) and Mobile Support Team (MST) Model

1. Introduction

Maternal and child morbidities and mortalities in Afghanistan are among the highest in least developed and developing countries. The overall goal of the Family Health House-Mobile Support Team (FHH-MST)⁶³ project is to reduce maternal and child morbidities and mortality through increasing access of communities to quality and affordable health services. UNFPA collaborates with donors and the Ministry of Public Health (MoPH) in supporting the construction of FHHs, training of relevant staff and provision of health services in selected isolated and under-served regions/provinces/districts in Afghanistan to enhance communities' access to basic health services. Construction of these FHHs was largely in districts and communities that did not have access to health facilities that offer Basic Package of Health Services (BPHS).

2. Background and Context

Afghanistan is classified as a Least Developed Country (LDC) and being landlocked, mountainous and rugged, is one of the most disadvantaged countries in the Central and South Asia regions. Fertility rate is high at 5.1 children per woman and population growth rate estimates in 2012 ranged from 2.2 to 2.6 per cent. According to the World Bank⁶⁴ economic update, the GDP growth rates have grown steadily in the past years and reached an all-time high in 2012 of 14.4 per cent. However, in 2013 it drastically declined to 3.6 per cent. A growing population and the recent decline in GDP put pressure on income distribution, as measured by income per capita or GDP per capita. Income per capita stood at US\$680 in 2012. Low or falling GDP per capita translates to low and falling disposable incomes. Families are left with limited option to spend income on consumption goods and less on savings and household expenditure on education and health that would be deemed as investment in nature. Low income per capita and low disposable income constrains members of household's access to health services.

Compounded with this, Afghanistan was ranked 176 of the 186 countries in the UNDP Human Development Index⁶⁵. Its Health Index as measured by Public Expenditure as % of GDP has declined from 2.3% in 2000 to 0.9% in 2010. Life expectancy has however increased from 55 in 2000 to 61 in 2012. Investment and subsequent improvement in public health services have contributed to the increase in life expectancy. However, the additional investment is needed in the health and education sectors in order to sustain some of the gains that have been realized and to realize the net gains in the quality of life.

The government reports that the maternal mortality has decreased from 1,600 per 100,000 live births to 327 in 2010⁶⁶. UN estimates for 2013 is 400 per 100,000 live births. While this substantial decline has been a result of strong commitment of government and development partners to maternal health services, when compared to other neighbouring countries in the region, maternal mortality in Afghanistan is still very high. For instance, the Bangladesh DHS conducted in 2010, reported a maternal

⁶³ Whilst some project documentation referred to this as a FHH-MST project, for the sake of clarity, this MTR refers to it throughout as the FHH model/ project.

⁶⁴ Joya, Omar; Khan, Faruk. 2014. Afghanistan economic update. *Afghanistan Economic Update*. Washington DC : World Bank Group. <http://documents.worldbank.org/curated/en/2014/04/19425195/afghanistan-economic-update>.

⁶⁵ United Nations Development Programme. *UNDP Human Development Report 2013: The Rise of the South: Human Progress in a Diverse World*. UNDP. Available at: <http://hdr.undp.org/en/2013-report>.

⁶⁶ The MoPH puts the maternal mortality ratio at 327 per 100,000 live births. In AMS 2010, it is cited as the pregnancy related mortality ratio.

mortality ratio of 194 deaths per 100,000 live births and for Pakistan the ratio was reported at 297 deaths per 100,000 live births based on the 2006/2007 DHS⁶⁷.

The infant mortality rate per 1,000 live births has declined from 76 in 2009 to 71 in 2011. Significant investment in the training of midwives and health personnel and the construction of health facilities that offer BPHS have resulted in increased deliveries performed by skilled birth attendants at health facilities. In addition, USAID report on Maternal Health Care Trends, highlighted notable improvements in ante-natal care coverage in the percentage of women who received ante-natal care from a skilled birth attendant for their last live births in the five years preceding the survey, from 54% of women whose last birth was 36-59 months before the survey to 65% of women whose last live birth was 0-11 months before the survey.

In this context, it is noted that significant progress has been made in reducing maternal mortality and infant mortality, increasing deliveries by skilled birth attendants and improving in ante-natal care coverage. These improvements can be attributed to the huge investment made during the past years in reproductive health and health systems strengthening. Continued investment in the health sector is crucial to sustain the gains over the past years and to ensure that the health sector is able to meet most of the MDG targets and the health needs.

Thus, this calls for continuous review and assessments of strategies and projects in reproductive health and in the health sector. This would enable the health sector to continue to build on what is already operational and to determine lessons learned and best practices that can be utilized to enhance policy, strengthen implementation modalities and for service delivery and achieve various reproductive health targets.

Overview of FHH-MST⁶⁸ Project

The FHH-MST project has been implemented since the start of 2012 in targeted provinces. The aim of the project was to increase access to reproductive, maternal, newborn and child health (RMNCH) services in un-served and under-served districts to reduce reproductive, maternal, neonatal and child morbidities and mortalities. The targeted provinces for the implementation of FHH-MST are: Bamyan, Daykundi, Faryab, and Herat. To date, a total of 80 FHHs are operating in these provinces. The specific objectives of the FHH-MST projects are:

- (i) To increase access (physical, social, economic) of communities living in remote areas to RMNCH services;
- (ii) To improve quality of health services through training and capacity building activities of community midwife, health posts (HPs), family health action groups (FHAGs) as well as management staff of the project;
- (iii) To establish functional referral system through establishing FHH-MST linkages with higher level health facilities;
- (iv) To improve access and utilization of family planning/birth spacing service through regular supplies and male involvement in Community Health *Shuras*;
- (v) To strengthen community mobilization/ownership through the establishment of community structures such as the Community Health *Shuras*, FHA Groups to decision-making and to support the operations of the FHH-MST;
- (vi) To contribute to the elimination of Gender Based Violence (GBV).

⁶⁷ Aman, Mohammad Iqbal, Bashir Noormal, Khwaja Mir Islam Saeed, and Mohammad Hafez Rasooly. 2013. Maternal Health Care Trends in Afghanistan. DHS Working Papers No. 97. Calverton, Maryland, USA: ICF International. - Available at: <http://dhsprogram.com/publications/publication-WP97-Working-Papers.cfm#sthash.co7yxPmX.dpuf>.

⁶⁸ FHH Concept Note provides detailed information and rationale for the project.

The FHH is managed by a Community Midwife (CMW) and assisted by a HP comprised of two CHWs - a male and female. The FHH is also supported by MST on monthly basis and this is the reason that it is called FHH-MST. In terms of awareness and advocacy at the community level, the CMW is supported by the Community Health *Shuras*, largely made up of male and female elders in the communities and the FHAGs.

The FHH-MST offers the following services to communities:

- (i) Antenatal, deliveries and postnatal care services;
- (ii) Family Planning services;
- (iii) Integrated Management of Childhood Illnesses;
- (iv) Outpatients Department;
- (v) Vaccination services through Mobile Support Teams (MSTs);
- (vi) Follow up of Malaria and TB treatment; and
- (vii) Referrals and follow up of Psychiatric disorders.

UNFPA's country programme for Afghanistan (2010-2013) has the following results at outcome and output level respectively: ***“By 2013 utilization of high quality reproductive health information and maternal health and family planning services is increased in selected and under-served provinces”*** and ***“Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment”***.

In this connection, FHH-MSTs is one of the key strategies to achieving the results specified in the UNFPA Country Programme for Afghanistan and is also in line with UNFPA's global strategic plan outcome and outputs of: ***“Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender responsive and meet human rights standards for quality of care and equity in access”*** and ***“Increased national capacity to deliver comprehensive maternal health services”***.

3. Purpose of the Review

While review of FHH-MST was part of third Country Programme (CP3) Review, the FHH-MST project has not been specifically reviewed or evaluated since its inception in 2011. In addition, the baseline assessment was conducted in 2013 whereas it should have been conducted before the establishing of FHH-MSTs project (before in 2012). Thus, the purpose of this Review is to determine whether progress has been made at community level in increasing access of communities to quality and affordable health services. It will also examine progress towards achieving the specific objectives of the project as outlined in the Concept Note and the impact and benefits of the FHH-MST services at community level in selected provinces in addressing their health problems and needs. The Review will also examine the scale of the project, its cost effectiveness, its efficiency of the modality of implementation and its future sustainability. It will determine whether the FHH-MST can be effectively integrated within the BPHS on a, needs based and functional basis for expanding reproductive, maternal and newborn health service delivery to remote areas. It will also determine lessons learned, best practices and specific recommendations that can be utilized to further strengthen the FHH-MST-CMW modality.

4. Objectives and Scope of the Review

The specific objectives of the MTR are:

- (i) To determine the impact and benefits of the FHH-MST project at community and national level in terms of addressing the health needs of communities and its contribution to the progress

- made in the areas of maternal health and family planning services as per UNFPA's Results Resources Framework;
- (ii) To provide MoPH, UNFPA, Donors and other important stakeholders an independent assessment of the relevance and performance of the FHH-MST project;
 - (iii) To determine the extent of coordination and collaboration of respective stakeholders (MoPH, UNFPA, Donors, University of Kabul, and Implementing Partners) in the implementation of the project and provide recommendations to further improve coordination and collaboration to enhance its sustainability; and
 - (iv) To determine the most appropriate modality, governance structure, management, operations and funding of the FHH-MST project to ensure its sustainability.

The review will be conducted in two months starting from November 09, 2014. It will cover the three selected provinces of Bamyan, Daykundi, and Faryab. Herat is not included as the FHH is currently not functional given the project is in its early phase in this province. The review would involve consultations with the Governors, Implementing Partners in the respective provinces, Provincial Health Directorates, District Health Centers and provincial hospitals, FHH-MST and communities, Ministry of Public Health, Midwifery School, Donors and UN agencies.

5. Review Questions

The Review will analyze the FHH-MST project in the context of the purpose and objectives of the project based on the criteria of (i) relevance (ii) effectiveness, efficiency, sustainability and/or impact at community level. Importantly, it will examine the governance and management structure of coordination and collaboration amongst different stakeholders and its contribution to project success.

*Relevance*⁶⁹

The Review will examine the extent to which the FHH-MST project and interventions are suited and consistent with national policies, priorities and needs of the Government and communities in addressing their health needs, specifically:

- (i) The extent to which the project design was in line with national needs and priorities and communities;
- (ii) The extent to which the Afghanistan Government and targeted communities deem that the interventions and strategies are relevant and acceptable to them, given their cultural and religious contexts; and
- (iii) The extent to which current and proposed interventions under FHH-MST project are within the framework of Community Based Health Care (CBHC), Basic Packages of Health Services (BPHS) and Essential Packages of Hospital Services (EPHS).

*Effectiveness*⁷⁰

Assess the extent to which the activities of the project contributed to achievement of project outputs and outcomes or related results at community level and national level, specifically:

⁶⁹ The assessment of relevance examines the degree to which the outputs/outcomes/benefits of the project are in line with national priorities and needs, UNFPA priorities and relevant stakeholders. It considers whether the strategies and interventions are relevant for the environment under which UNFPA operates in Afghanistan.

⁷⁰ The assessment of effectiveness considers or examines the extent to which the FHH project has achieved its planned results, including outputs and outcomes and the extent to which the achievement of these results were as a consequence of UNFPA's collaborative support with relevant stakeholders and interventions and other factors.

- (i) The extent to which the project results and planned targets were achieved;
- (ii) Highlight major factors that influenced the achievement or non-achievement of planned results and targets;
- (iii) The extent to which the current implementation modality contributed to achievement of planned results and targets and in particular the realization of benefits to communities;
- (iv) Whether the activities of the project and interventions by partners and stakeholders contributed to the following at community/provincial and national levels;
 - a. Improvement in ANC and PNC coverage;
 - b. Increased utilization rate of FHH-MST;
 - c. Increased deliveries at FHHs and relevant health facilities;
 - d. Increased deliveries attended by skilled birth attendants;
 - e. Increase in the number of skilled birth attendants, particularly midwives;
 - f. Increased contraceptive use and uptake by the target population; and
 - g. Increased young people accessing and utilizing FHH-MST facilities for Sexual Reproductive Health (SRH) services.

Efficiency⁷¹

In the implementation of the FHH-MST project, assess how efficient the inputs and resources were utilized to produce the results or outputs in respect of the following:

- (i) The extent to which the FHH-MST project has utilized the skills of UNFPA and Implementing partners staff/human resources to achieve planned results and targets;
- (ii) Is the staffing set-up of the Implementing Partners and FHH-MST project appropriate for the effective and efficient implementation of the project;
- (iii) Is the modality of procurement and distribution of supplies from UNFPA to Implementing Partners and FHH-MST sufficient for the efficient implementation of the project;
- (iv) Is the funding modality and disbursements sufficient, effective and timely to ensure the efficient implementation of FHH-MST activities and interventions by IPs and FHH-MSTs staff;
- (v) Is the capacity building programme of midwives and other staff sufficient and timely to enable the effective and efficient implementation of FHH-MST activities and interventions;
- (vi) What measures were taken during planning and implementation phase of the project to ensure that resources were utilized efficiently;
- (vii) The extent to which the project addressed the equity, efficiency and rights and needs based approach of health care and the communities. How do we balance these approaches to ensure maximum net gains? Who will access and benefit from these interventions?
- (viii) undertake a cost benefit analysis with the lowest level of BPHS in these pilot provinces

Sustainability⁷²

In the Review and assessment of the sustainability of the project, determine the following:

⁷¹ The assessment of efficiency considers or examines how economically optimal inputs of the project (financial, human, technical and material resources) have been used to produce outputs (results). The assessment of efficiency attempts to link outputs to resources expended and assesses whether this happened economically and as feasible as possible and the extent to which the quantity and quality of the results justify the quantity and quality of the means used to achieving them and whether they were achieved on time.

⁷² The assessment of sustainability considers the likelihood of the continuation of the stream of benefits produced by the project following the ending of the external assistance. It is concerned with measuring whether the benefits of the intervention are likely to continue after the assistance and support from UNFPA, donors and government have ceased. It considers how durable has been the support to stakeholders and beneficiaries in building internal systems and processes, building capacity and transferring knowledge expertise and information about maternal and reproductive health, family planning, adolescent sexual and reproductive health (ASRH), and gender based violence.

- (i) The extent to which the positive benefits of the FHH-MST project and its interventions to communities and Government justify the continued investments by partners to the project in future years;
- (ii) The extent to which partners (implementing partners and government) have the financial capacity to maintain and sustain the benefits from the interventions when UNFPA and other donor support to the project ceases or scaled down;
- (iii) The extent to which the Ministry of Public Health and Provincial Health Directorate would like to institutionalize the strategies and activities of the project in their policies/procedures and corporate plans and organizational budgets;
- (iv) The feasibility of the FHH-MST concept to be integrated into BPHS; and
- (v) The extent to which human resources development, capacity building training and career path planning and appropriate incentives have been factored into the FHH-MST project and overall policy and strategy of Government to ensure staff retention, career progression and sustainability within the health care system.

Institutional Arrangements, Governance and Coordination⁷³

In the Review of the project, determine the following in consultation with stakeholders:

- (i) The extent to which the overall governance structure, institutional arrangements and collaboration with UNFPA, MoPH, Implementing Partners, AMA and other relevant stakeholders have contributed to the success and progress that the project has made, or otherwise, towards its planned results and intended benefits to communities;
- (ii) Whether the leadership, technical advice and support provided by UNFPA were to the satisfaction and standards of the MoPH, Implementing Partners, FHH-MST and Community Health Shuras and whether that has contributed to the achievement of planned results and benefits of the project;
- (iii) Whether relevant implementing partners performed their role and functions well and effectively that has resulted in the achievement of planned results, targets and the realization of benefits to communities;
- (iv) Identify/define some of the areas in which UNFPA, MoPH, Implementing Partners and other relevant stakeholders could have done better or address to improve overall project implementation;
- (v) Whether the current governance and institutional arrangement amongst the different stakeholders allow for strong collaboration, consultation, coordination and reporting of progress in implementation; if not suggest alternative governance structures to strengthen project implementation and reporting; and,
- (vi) The extent to which UNFPA monitoring and evaluation (M&E) system and Implementing Partner M&E system and health management information system (HMIS) were able to support planning, project management, implementation, resource allocation, reporting, decision-making and the achievement of results.

The review will include specific recommendations for policymakers.

5. Stakeholder⁷⁴ **Participation**

⁷³ Governance and coordination considers the leadership, management and institutional arrangements of the project and the governance structure by UNFPA, donors, MoPH, and implementing partners in terms of technical advice, coordination, consultations, and reporting, funding modality, backstopping support in respect of the project and how it has contributed to the relevance, effectiveness, efficiency and sustainability of the project.

The success of this Review hinges on a full stakeholder consultation and participatory Review that provides meaningful participation of all project partners, beneficiaries of the project and other interested parties. Stakeholder participation forms a critical component of the Review design and planning, data and information collection, the documentation of findings and development of the Review report and dissemination of Review results through a participatory approach. The stakeholder consultation and participation list (sent as Annexe)

Additionally, stakeholder participation is also strengthened through the participation of partners/stakeholders in the Review Management Committee (EMC) and Review Reference Group (ERG).

The TOR of the FHH-MST Review has been shared with MoPH, Donors and IPs and their comments have been incorporated into the final TOR.

6. Methodology and Approach

The Review will be a participatory process involving Country Office (CO) staff, beneficiaries, government, and implementing partners to continue to preserve the sense of ownership and set the stage to openly address issues and challenges and propose solutions or corrective measures to be addressed in the next phase of the FHH-MST project. A participatory process will primarily focus on assessing progress towards the achievement of results and defining actual benefits to communities and at the same time fostering an environment for learning and knowledge sharing.

The Review will follow United Nation's Evaluation Group (UNEG) norms and standards for Review as well as all UNFPA ethical guidelines, norms and standards. The Consultants will jointly with the Afghanistan CO and other stakeholders, design the overall Review approach and data collection methods using a mixed method approach which includes a mix of qualitative and quantitative data collection methods and secondary data sources, to respond to the Review objectives and answer the Review questions. The Review methodology should highlight the following:

- List of key information sources i.e. UNFPA stakeholders (CO staff, partners, donors, project beneficiaries, both male and female);
- Measures to ensure that the Review addresses gender equality, human rights issues and vulnerable groups;
- Sampling approaches for different data collection methods, including area and stakeholders to be represented, procedures to be used and sampling size, level of precision required;
- Data collection instruments;
- Data collection methods i.e. use of triangulation to ensure that the credibility of information gathered;
- Types of data analysis;
- Reference indicators and benchmarks where relevant; and,
- Reporting and communication mechanisms during the course of consultation and discussion with UNFPA Country Office.

The International and National Consultants should to the extent possible include in the design of the Review methodology the integration of gender and rights based approaches in the assessment of project interventions and ensure that results have contributed to equality, participation, empowerment, social transformation and inclusiveness of gender, women and disadvantaged groups.

⁷⁴ The stakeholders include the provincial authorities, such as governor, the PPHD, provincial women directorate, education directorate, district level governments, and provincial offices of IPs as well as the communities. In addition, the donors' communities, UN agencies, HQ of IPs, and other government ministries are important stakeholders at the central/national level.

The Review will adopt the following methodologies:

- (i) Desk review of the project documents, quarterly reports of the project, project reports to donors, HMIS data of various Implementing Partners;
- (ii) Interview with partners and stakeholders listed in the stakeholder consultation and participation list;
- (iii) Focus group discussions with project stakeholders and beneficiaries to determine implementation of activities and possible results of these activities as per the project concept note and project objectives; and,
- (iv) FHH-MST project site visit, inspection and assessment of facilities, equipment and services.

7. Ethics

The Review of the project will be conducted ethically, legally and with due regard for the welfare of those involved in the Review , especially women, children and members of other vulnerable or disadvantaged groups and in accordance with UNEG’s Ethical Guidelines (sent as Annex via email). Due consideration will also be given to beneficiaries and other stakeholders on confidentiality of information and privacy during consultations and personal interviews.

8. Review Reference Documents

The documents that will be made available to the Consultants to facilitate the Review is attached as (sent as Email).

9. Review Management - Roles and Responsibilities

The Review will be managed by a Review Management Committee (RMC) comprising of the following staff:

- (i) Dr Wilfred Ochan - Deputy Representative, UNFPA
- (ii) Dr Mohira Babaeva - RH Advisor, UNFPA
- (iii) A Representative from RHD/MoPH
- (iv) A Representative from CBHC/MoPH
- (v) A Representative from HMIS/MoPH
- (vi) A Representative from Implementing Partners
- (vii) Dr Ahmadullah Molakhail -Programme Coordinator for Sub-national Programme- UNFPA
- (viii) A representative from UNICEF
- (ix) Jone Navakamocea - M&E Specialist, UNFPA

The RMC will be responsible for the following roles:

- (i) Provide overall technical guidance and quality assurance on every process of the Review ;
- (ii) Review and endorse the terms of reference of the Review ;
- (iii) Recommend the TOR to the UNFPA Representative for approval before submission to APRO and to the Review Office for review and approval in accordance with UNFPA Review guidelines;
- (iv) Selection and initial endorsement of the consultant;
- (v) Review and approve Inception Report;
- (vi) Review and approve the Review Report

The FHH-MST Project Manager and focal point will be responsible for the following:

- (i) Develop in consultation with the M&E Specialist a stakeholder consultation and participation list;

- (ii) Coordination and setting up meeting schedules with beneficiaries and all stakeholders in consultation with IPs, MoPH and Donors;
- (iii) Facilitate the Consultant's access to all background documents;
- (iv) Make travel arrangements and in-country consultations with IPs of FHH-MST, and project beneficiaries in Kabul and in the provinces; and
- (v) Allocation of an office space to the Consultant/Evaluator for work and review.

The M&E Specialist shall be the Review Manager and will be responsible for the following:

- (i) Overall coordination of the Review roles and responsibilities with the Consultant;
- (ii) Facilitate the Consultant's access to background documents and other resources;
- (iii) Coordinate UNFPA COs internal review processes; and
- (iv) Coordinate with UNFPA COs management approval of all Review deliverables.

The Deputy Representative of the UNFPA CO shall be responsible for quality assurance of the Review in accordance with UNFPA and Davison of Oversight (DOS) Review guidelines. The Representative will have overall responsibility for the Review.

10. Deliverables

1. Review Design Report/Concept

Following the review of the proposed TOR and relevant documents of the FHH-MST Project and discussing the Review with Afghanistan CO, the team leader should submit a Review Design Report. The design report in a nutshell should briefly describe the Review Team's understanding of the FHH-MST project Review, its objectives, scope, the country and project contexts, the UNFPA strategic response and programme and Review methodological approaches and framework and Review processes and their work plan in partially responding to the Review TOR. It also provides a clear indication of how the Consultants/Review Team view and understand their tasks and plans to achieve the objectives of the Review.

Therefore, within **10 days** of the award of the contract, the Consultants shall submit an electronic copy of a draft design report to UNFPA CO Review Manager. The design report provides an opportunity for UNFPA CO and the Consultants to ensure that their interpretations of the TOR are mutually consistent. The Review Manager will coordinate the internal review and approval of the design report from the ERG, MoPH, the UNFPA Representative, and APRO which will serve as an agreement between UNFPA Country Office, MoPH and the Consultants on how the Review shall be conducted.

The Consultants shall make oral or written presentation/briefing of the design report to the Afghanistan Country Office, MoPH and its stakeholders. The Review Manager shall obtain written comments on the design report from the RMC to the Consultants within 5 days of the report's submission or completion of the oral presentation, whichever comes later. The Afghanistan CO reserves the right to modify the TOR in response to the design report.

2. Draft Review Report

The evaluator shall submit an electronic copy of a draft Review report to UNFPA's Review Manager no later than Dec 20, 2014. The draft report should be thoroughly copy edited to ensure that comments from UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum.

The Consultants/Evaluators shall make a debriefing presentation to the UNFPA Representative, MoPH, and other relevant staff on the submission of the draft Review report.

After review of UNFPA CO and stakeholders of the draft report, the Review Manager shall coordinate written comments on the draft report from UNFPA Country Office, stakeholders, including other UN agencies, and in-country partners and shall submit these to the Consultants. Based on these comments, the Consultants shall correct all factual errors and inaccuracies and make changes related to the report's structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The Consultants will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the Consultants will submit a revised draft Review report, which may lead to further comments from UNFPA. After the second round of review and, if necessary, further revision to the draft Review report, the Consultants can then submit the final report pending UNFPA CO's approval.

The draft Review report will also be shared with APRO for their review and comments on the quality of the report as per established UNEG guidelines and standards.

Final Report

The recommended structure of the final report is provided (sent as Annexe via email) to this TOR and the Consultants should follow this as closely as possible. The report must contain a self-contained executive summary that provides a clear, concise presentation of the Review's main conclusions and key recommendations and reviews salient issues identified in the Review. All deliverables must be in English. The main body of the report should be no more than a maximum of 50 pages plus annexes. The recommendations must be limited to 5 to 8 prioritized recommendations. While the final set of recommendations is the sole responsibility of the Consultants, the CO would like to work with the Review team during a half-day session to discuss, refine, clarify and make actionable each recommendation, as deemed appropriate by the Consultants.

11. Review Workplan

The work plan spells out the roles and responsibilities of all those involved in the FHH-MST project Review. It details all specific tasks to be undertaken, the deliverables as well as the time lines involved.

Annex 6 outlines key activities, persons responsible, outputs and timelines of the work plan. The Gant Chart outlining deliverables, timelines and responsibilities of relevant staff has been developed and will be used internally for the purposes of scheduling and implementation of Review activities.

The FHH-MST project Review is expected to take place in two months starting from November, 2014. The number of working days for the Consultants temporarily set at 37 working days for the national consultant and 28 days for the international consultant; and will be distributed among the different phases of the Review process depending on their involvement in the completion of specific tasks and/or activities. The level of effort will also vary depending on the role of the International Consultant and the National Consultant. The consultancy fee will be set accordingly to reflect effort, responsibilities and experience.

The Consultants are expected to submit a draft Review report with a debriefing with the UNFPA Representative, relevant staff and also other partners no later than Dec 20, 2014.

The Consultants will be remunerated according to the following schedule:

- (a) 20 per cent of payment upon completion of a satisfactory design report;
- (b) 30 per cent upon successful completion of field work; and,

(c) 50 per cent upon submission of a satisfactory final report.

12. Budget

The budget to conduct the FHH-MST project Review has been sourced from regular resources and has been allocated accordingly. The budget will cover the following:

- (i) The Consultants' fees based on the number of days worked and the agreed daily honorarium;
- (ii) The cost of all international travels from the country of usual residence including return ticket, daily stipend allowance (DSA) and terminals;
- (iii) The costs of local transportation to and within the provinces/districts for consultations; and
- (iv) Any other incidental expenditure directly related to the Review such as printing, faxes, telephone calls

The budget is estimated based on the number of days worked or duration of consultancy, daily consultancy fee, daily subsistence allowance (DSA), travel and incidental expenditures.

13. Composition of the Review Team

The International Consultant will have overall responsibility for providing guidance and for coordinating and producing the draft and final reports. He/she will also be responsible for the quality assurance of all Review deliverables. He/she will be responsible for interviewing development partners, government and implementing partners at the national level and will be expected to undertake data collection in one province (Bamyan).

The National Consultant will be responsible for the primary architecture of data collection tools, interfacing with local and provincial authorities. He/she should have expertise in the area of UNFPA's mandate and knowledge of reproductive and maternal health, family planning and capacity building. She/He be responsible for data collection in two provinces (Faryab, Daykundi). He/she will conduct focus group discussions with project beneficiaries.

Annex 2: Documents consulted

Documents consulted

1. Family Health House-Mobile Support Team (FHH-MST) Concept Note
2. Afghanistan Maternal Mortality Survey (AMS), 2010-2011
3. Country Programme Document (CPD), 2010-2013
4. Country Programme Action Plan (CPAP), 2010-2013
5. UNDP Human Development Report - *The Rise of the South: Human Progress in a Diverse World*, 2013
6. Maternal Health Care Trends in Afghanistan, DHS Working Paper 97, USAID, 2013.
7. Afghanistan MDG Report, 2010
8. National Reproductive Health Policy, 2012-2016
9. National Reproductive Health Strategy, 2012-2016
10. Report on the Conference on Promoting Family Planning in Afghanistan
11. UNFPA Country Programme 3 Evaluation Report
12. CP 3 Evaluation Management Response Report
13. NRVA Report (2011-2012)
14. Basic Package of Health Services (BPHS)
15. Essential Package of Hospital Services (EPHS)
16. UNFPA Strategic Plan 2014-2017
17. UNFPA Afghanistan Country Programme Document (CPD)2010-2013
18. UNFPA Afghanistan Country Programme Action Plan (CPAP) 2010-2013
19. Review of UNFPA's Country Programme in Afghanistan 2010-2013
20. UNFPA Afghanistan Country Programme Document (CPD) 2015-2019
21. FHH-MST Quarterly Project Report
22. FHH-MST Donor Reports
23. Country Office Annual Report (COAR) 2010, 2011, 2012, 2013
24. FHH-MST COGNOS Reports
25. FHH-MST AWP (2012, 2013, 2014)
26. Steering Committee Meeting Minutes and Presentations
27. Afghanistan Basic Package of Health Services 2010: an assessment of the costs.
28. Afghanistan National Health Accounts with Sub Accounts for RH 2011-2012
29. DFATD Report of Monitoring Mission, Daykundi, Family Health Houses Project

Annex 3: List of persons consulted

UNFPA Afghanistan Country Office

- | | |
|-------------------------------|--|
| 1. Dr Annette Sachs Robertson | UNFPA Representative |
| 2. Dr Wilfred Ochan | Deputy UNFPA Representative |
| 3. Dr Mohira Babaeva | RH Advisor |
| 4. Dr Ahmadullah Molakhail | Programme Coordinator for Sub-national Programme |
| 5. Dr Mohammed Reza Dadbig | Daykundi Provincial Coordinator (based in Daykundi Field Observations) |
| 6. Dr Abdul Malik Faize | National Programme Officer |
| 7. Malin Bogren | Consultant/Midwifery Technical Officer |

Ministry of Public Health

- | | |
|-------------------------|---|
| 1. Dr Ahmad Jan | Acting Minister, Public Health / Deputy Minister, Public Health Policy and Planning |
| 2. Dr Najia Tariq | Deputy Minister, Technical Affairs |
| 3. Dr Sohaila Ziaee | Acting Director, RH |
| 4. Dr Nezamudin Jalil | RH Coordinator |
| 5. Dr Shaka Hatat | RH Programme Officer |
| 6. Dr Sayed Habib Arwal | National Coordinator of CBHC |
| 7. Dr Qadir Qadir | General Director of Policy and Planning & International Relations |
| 8. Dr Ihasullah Shahir | General Director Human Resources for Health |
| 9. Dr Ebn-e-Amin | Director Dept Monitoring and Evaluation |
| 10. Dr Qhosraw | Head of Monitoring Section, Dept M&E |
| 11. Dr Sayed Habib | Head of Department, HMIS |
| 12. Dr Hemati | Director, Grant Control & Management Unit |
| 13. Dr Ali Shah Aalwi | Director, Child and Adolescent Health |

IMPLEMENTING PARTNERS

MOVE

- | | |
|------------------------|----------------------------------|
| 1. Dr Malok Khalili | General Director |
| 2. Dr Latif Rashid | Programme Director |
| 3. Dr Hussain Muzafery | Project Manager, Nilli, Daykundi |

ACTD

- | | |
|--------------------------|---|
| 1. Dr Abdurrahman Shahab | General Director |
| 2. Dr Farhad Farahmand | Director Programme Development and Research |
| 3. Dr Lutfullah Amin | Project Manager, Herat City. Herat |

AADA

- | | |
|-------------------------|--|
| 1. Dr Asharafuddin Aini | General Director |
| 2. Dr Najeeb Baleegh | M&E and Programme Development Director |
| 3. Dr Munir Ramz | Project Manager (Field Observations), Maimana City, Faryab |

SCI

- | | |
|-----------------------|--------------------|
| 1. Dr Mustafa Karim | Programme Director |
| 2. Dr Qadir Baqakhail | Programme Officer |

CMW School- Kabul

- | | |
|----------------------------------|-----------------|
| 1. Dr Wasima (+students & staff) | Project Manager |
|----------------------------------|-----------------|

PARTNERS

Afghanistan Midwives Association

- | | |
|-------------------|-----------------------|
| 1. Mursal Musawi | Executive Director |
| 2. Massoma Jafari | Acting Vice President |

UNICEF

- | | |
|---------------------|--|
| 1. Dr Sherin Varkey | Head of Health and Nutrition programme |
| 2. Dr Malalai | |
| 3. Dr Khaksar | Child Survival Officer |

USAID

- | | |
|---------------------|--|
| 1. Sharmina Sultana | |
| 2. Dr Shirsha | |

World Bank

- | | |
|-------------|----------------|
| 1. Ahmalzai | The World Bank |
|-------------|----------------|

World Health Organization

- | | |
|----------------------|--|
| 1. Patta Chikvaidze | Medical Officer, Reproductive, Maternal, Newborn, Child and Adolescent Health |
| 2. Dr Adela Mubashir | National Programme Officer, Reproductive, Maternal, Newborn, Child and Adolescent Health |

DONORS

DFATD, Canada

- | | |
|-----------------------|--|
| 1. Renata Pistone | First Secretary (Development - Health)
Afghanistan Embassy of Canada |
| 2. Nasir Ebrahimkhail | Senior Programme Officer, DFATD.
Embassy of Canada. |
| 3. Dr Palwasha Anwari | Health Advisor for DFATD.
Afghanistan Embassy of Canada |
| 4. Geneviève Bussière | (via Skype) Development Officer
Afghanistan Programme
Asia Pacific Branch (Development)
Foreign Affairs, Trade and Development Canada |

Italy

- | | |
|---------------------|---|
| 1. Azzurra Chiarini | Gender Advisor
Italian Development Cooperation Office, Italian Embassy |
|---------------------|---|

Annex 4: Summary of tools used for MTR

Name of Tool	Overview of Review Questions	Target group
Tool 1: Desk Review	Relevance: Q1,2 Effectiveness: Q1,2,3 Efficiency: Q1,2,3,4,5,6 Institutional Arrangement, Governance, Coordination: Q1,2,3	
Tool2: SSI guide for Policymakers	Relevance: Q1 and 2 Sustainability: Q2,3,4 Institutional Arrangement, Governance, Coordination: Q1,4,5 Effectiveness: Q2,3	-Director of RH -Director of CBHC -Director of P&P
Tool 3: SSI Programme Managers of IP	Efficiency: Q1,2,3,4,5,6,7 Sustainability:Q5 Institutional Arrangement, Governance, Coordination:Q1, 4, 5, 6	-IP-Manager
Tool 4: SSI Programme Managers of UNFPA	Effectiveness: Q2,3 Efficiency: Q1,2,3,4,5,6,7 Institutional Arrangement, Governance, Coordination:Q1, 4, 5, 6	UNFPA FHH Manager
Tool 5: SSI PPHD	Relevance: Q1,2 Effectiveness:Q2.3 Sustainability:2,3,4 Institutional Arrangement, Governance, Coordination:1,4,5,6	PPHD
Tool6: SSI Community Midwife	Effectiveness: Q1,2,3	CME
Tool 7: Checklist for Selection of FHH-Province	Effectiveness:1,2,3	FHH
Tool 8: Checklist for Selection of FHH-Field	Effectiveness:1,2,3	FHH
Tool 9: Checklist for Physical Structure of FHH	Effectiveness:1,2,3	FHH
Tool10: Checklist for General Management of	Effectiveness:1,2,3	FHH

Name of Tool	Overview of Review Questions	Target group
FHH		
Tool 11: Observation Checklist FHH Functionality	Effectiveness: 1,2,3	FHH
Tool 12: Checklist for HMIS Performance Data	Effectiveness: 1,2,3	FHH
Tool 13: HMIS Analysis for FHH Programme	Effectiveness: 1,2,3	FHH
Tool 14: FGD Guide with Community Health Shura	Relevance 1, 2	Community Health Shura

Annex 5: Mid-Term Review matrix

	Review Question	Issues for Review	Review/Data Collection Method	Respondent	Reference Tool
Relevance⁷⁵					
Objective	The review will examine the extent to which the FHH-MST project and interventions are suited and consistent with national policies, priorities and needs of the Government and communities in addressing their health needs, specifically:				
	1. The extent to which the project design was in line with national needs and priorities and communities;	<ul style="list-style-type: none"> • MDG, ANDS, UNFPA Mandate, UNDAF • Relevancy of FHH with NHNP, NHNS, RH strategy, CBHC, HR policy • Relevancy of FHH services to community need, • Relevance of FHH infrastructure, staffing, equipment, supplies to FHH services, • Opinion of Community on FHH 	-Desk review: NHNP, NHNS, RH Policy, CBHC, BPHS, EPHS, FHH concept Project contract SHARP and SEHAT Document Key Informant Interview FGD	<u>MoPH Policy level:</u> Policy and Plan RH, CBHC, HR, HMIS, M&E, GIHS, <u>Provincial level:</u> PPHD, BPHS Manager, Governor, Member of Provincial Council Central: World Bank-SEHAT; USAID; European Union Community Health Shura (male and female)	Tool1 Tool #2 Tool #5 Tool # 14

⁷⁵ The assessment of relevance examines the degree to which the outputs/outcomes/benefits of the project are in line with national priorities and needs, UNFPA priorities and relevant stakeholders. It considers whether the strategies and interventions are relevant for the environment under which UNFPA operates in Afghanistan.

	<p>2. The extent to which the Afghanistan Government and targeted communities deem that the interventions and strategies are relevant and acceptable to them, given their cultural and religious contexts.</p>	<ul style="list-style-type: none"> • Acceptance of MoPH policymakers about FHH • Acceptance of MoPH provincial level managers about FHH • Acceptance of FHH service providers • Acceptance of Community members 	<p>Key Informant Interview</p> <p>FGD</p>	<p>MoPH Policy level: HR, RH, CBHC, Policy and Plan, HMIS, M&E, GIHS, Provincial level: PPHD, BPHS Manager, Governor, Member of Provincial Council Health Provider;; Client Community Health Shura (male and Female)</p>	<p>Tool # 2</p> <p>Tool#5</p> <p>Tool # 6</p> <p>Tool # 14</p>
	<p>3. The extent to which current and proposed interventions under FHH-MST project are within the framework of Basic Packages of Health Services (BPHS) and Essential Packages of Hospital Services (EPHS).</p>	<ul style="list-style-type: none"> • Relevancy of the current FHH proposed plan: selection of location, services, HR • Relevancy of FHH services with BPHS • Relevancy of FHH with EPHS • Relevancy of FHH with CBHC • Relevancy of FHH with MHT 	<p>Desk review:</p> <p>FHH concept/ project description</p> <p>BPHS</p> <p>EPHS</p>		<p>Tool#1</p>

Effectiveness⁷⁶

Objective	Assess the extent to which the activities of the project contributed to achievement of project outputs and outcomes or related results at community level and national level, specifically				
	1. The extent to which the project results and planned targets were achieved;	Project original target for each province Project achievements	Desk review UNFPA CPAP, Project contracts(AWPs), Project reports		Tool #1
	2. Highlight major factors that influenced the achievement or non-achievement of planned results and targets;	Constraints & Facilitating factors	Desk Review: IP Progress reports		Tool #1
			Key informant interview	UNFPA: Sub National Manager MoPH: PPHD IP Managers: Kabul and province BPHS Manager	Tool #4 Tool # 5 Tool # 3
	1. The extent to which the current implementation modality contributed to achievement of planned results and targets and in particular the realization of benefits to	<ul style="list-style-type: none"> • Selection of CME • Selection of FHH • Networking of FHH-HP-MST-Community Shura-Referral HF • Supervision • Monitoring, 	Review of IP Reports: Selection of CME and FHH		Tool #7
			Key informant interview	UNFPA: Sub National Manager MoPH: PPHD	Tool # 4
			FGD	IP Managers: Kabul	Tool # 5

⁷⁶ The assessment of effectiveness considers or examines the extent to which the FHH-MST project has achieved some of its planned results, including outputs and outcomes and the extent to which the achievement of these results were as a consequence of UNFPA's collaborative support with relevant stakeholders and interventions and other factors.

	communities;	<ul style="list-style-type: none"> • Reporting 		and province	
		<ul style="list-style-type: none"> • FHH Functionality: • Effective availability of staff of FHH and MST • Availability of functional equipment • Availability of pharmaceuticals 	Observation check - FHH	Community Midwife-FHH Community Health Shura	Tool#6 Tool#14 Tool #7,8,9,10.11.12
	3. Whether the activities of the project and interventions by partners and stakeholders contributed to the following at community/provincial and national levels;				
	✓ Improvement in ANC and PNC coverage;	HMIS Review	HMIS Analysis: -Annual performance of FHHs(output indicators) HMIS Validity and accuracy: -HMIS Consistency between HMIS report and the FHH register		HMIS Database Tool # 12, 13
	✓ Increased deliveries at FHHs and relevant health facilities;	HMIS Review			Tool # 12, 13
	✓ Increased deliveries attended by skilled birth attendants;	HMIS Review			Tool # 12, 13
	✓ Increase in the number of skilled birth attendants, particularly	HMIS Review			Tool # 12, 13

	midwives;		-Accuracy of HMIS Reports		
	✓ Increased contraceptive use and uptake by the target population; and	HMIS Review			Tool # 12, 13
	✓ Increased young people accessing and utilizing FHH-MST facilities for SRH services.	HMIS Review			Tool # 12, 13

Efficiency⁷⁷					
Objective	In the implementation of the FHH-MST project, assess how efficient the inputs and resources were utilized to produce the results or outputs in respect of the following:				
	1. The extent to which the FHH-MST project has utilized the skills of UNFPA and Implementing partners staff/human resources to achieve planned results and targets;	<ul style="list-style-type: none"> • UNFPA Inputs to project • IP Inputs 	Desk review Project contract IP Progress Report Key informant Interview	UNFPA: Sub-national Manager IP: Managers	Tool #1 Tool # 4 Tool # 3
	2. Is the staffing set-up of the Implementing Partners and FHH-MST project appropriate for the effective and efficient implementation of the project;	<ul style="list-style-type: none"> • Staff allocation of UNFPA • Staff allocation of IP at the National Level • Staff allocation of IP at the Provincial level • Staff allocation of FHH-MST 	Desk review Project contract IP Progress Report Key informant Interview	UNFPA: Sub-national Manager IP: Managers	Tool #1 Tool # 4 Tool # 3
	3. Is the modality of procurement and distribution of supplies from UNFPA to Implementing Partners and FHH-MST sufficient for the efficient implementation of the project;	<ul style="list-style-type: none"> • Procurement and supply chain • Medical equipment • Non-medical equipment • Essential drugs 	Desk review Project contract IP Progress Report, Consumption Reports Key informant Interview	UNFPA: Sub-national Manager IP: Managers	Tool #1 Tool # 4

⁷⁷ The assessment of efficiency considers or examines how economically optimal inputs of the project (financial, human, technical and material resources) have been used to produce outputs (results). The assessment of efficiency attempts to link outputs to resources expended and assesses whether this happened economically and as feasible as possible and the extent to which the quantity and quality of the results justify the quantity and quality of the means used to achieving them and whether they were achieved on time.

		<ul style="list-style-type: none"> • Medical supplies 			Tool # 3
	4. Is the funding modality and disbursements sufficient, effective and timely to ensure the efficient implementation of FHH-MST activities and interventions by IPs and FHH-MSTs staff;	<ul style="list-style-type: none"> • Funding scheme • Disbursement procedure 	<p>Desk review</p> <p>Project contract</p> <p>IP Progress Report</p> <p>Key informant Interview</p>	<p>UNFPA: Sub-national Manager, Finance Managers</p> <p>IP: Managers</p>	<p>Tool #1</p> <p>Tool # 4</p> <p>Tool # 3</p>
	5. Is the capacity building programme of midwives and other staff sufficient and timely to enable the effective and efficient implementation of FHH-MST activities and interventions;	<ul style="list-style-type: none"> • Type of refresher trainings • Need for refresher training • Decision-making on type of trainings 	<p>Desk review</p> <p>Project contract</p> <p>IP Progress Report</p> <p>Key informant Interview</p>	<p>UNFPA: Sub-national Manager, Finance Managers</p> <p>IP: Managers</p>	<p>Tool #1</p> <p>Tool # 4</p> <p>Tool # 3</p>
	6. What measures were taken during planning and implementation phase of the project to ensure that resources were utilized efficiently;	<ul style="list-style-type: none"> • Transparency in fund utilization • Accountability in fund utilization 	<p>Desk review</p> <p>Project contract</p> <p>IP Progress Report</p> <p>Key informant Interview</p>	<p>UNFPA: Sub-national Manager, Finance Managers</p> <p>IP: Managers</p>	<p>Tool #1</p> <p>Tool # 4</p> <p>Tool # 3</p>

	<p>7. The extent to which the project addressed the equity, efficiency and rights and needs based approach of health care and the communities? How do we balance these approaches to ensure maximum net gains? Who will access and benefit from these interventions?</p>	<ul style="list-style-type: none"> • Location of FHH • Access of women, men, and children to health service 	<p>Desk review</p> <p>Project contract</p> <p>IP Progress Report</p> <p>Key informant Interview</p>	<p>UNFPA: Sub-national Manager, Finance Managers</p> <p>IP: Managers</p>	<p>Tool #1</p> <p>Tool # 4</p> <p>Tool # 3</p>
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Sustainability⁷⁸					
Objective	In the review and assessment of the sustainability of the project, determine the following:				
	1. The extent to which the positive benefits of the FHH-MST project and its interventions to communities and Government justify the continued investments by partners to the project in future years;	<ul style="list-style-type: none"> • Annual ANC visits provided • Annual skilled deliveries attended • Annual PNC visits provided • Annual FP methods used • Annual Screening of Children for Nutritional Status • Annual patients consulted through OPD • Annual Vaccination doses to children and women • #Follow up of Malaria and TB • Annual Referral of cases to higher level 	HMIS Analysis		Tool #13
			FGD	Community Health Shura	Tool # 14
	2. The extent to which partners (implementing partners and government) have the financial capacity to maintain and sustain the benefits	<ul style="list-style-type: none"> • MoPH financial planning for FHH • IP financial Planning for FHH 	Key informant interview	MoPH:RH,P&P,CBHC IP: Managers World Bank -SEHAT USAID	Tool #2 Tool # 3

⁷⁸ The assessment of sustainability considers the likelihood of the continuation of the stream of benefits produced by the project following the ending of the external assistance. It is concerned with measuring whether the benefits of the intervention are likely to continue after the assistance and support from UNFPA, donors and government have ceased. It considers how durable has been the support to stakeholders and beneficiaries in building internal systems and processes, building capacity and transferring knowledge expertise and information about maternal and reproductive health, family planning, ASRH and gender based violence.

	<p>overall policy and strategy of Government to ensure staff retention, career progression and sustainability within the health care system.</p>	<p>province if she leave the job,</p> <ul style="list-style-type: none"> Plan for care development of Community Midwife 			
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<i>Institutional Arrangements, Governance and Coordination</i> ⁷⁹					
Objective	In the Review of the project, determine the following in consultation with stakeholders:				
	1. The extent to which the overall governance structure, institutional arrangements and collaborations with UNFPA, MoPH, Implementing Partners, AMA and other relevant stakeholders have contributed to the success and progress that the project has made or otherwise towards its planned results and intended benefits to communities;	<ul style="list-style-type: none"> Role of different stakeholders in FHH 	Desk review Project Contract		Tool # 1
			Key Informant Interview	MoPH: RH,CBHC IP: Manager UNFPA: Sub-national Manager AMA: President	Tool #2 Tool # 3 Tool # 4
	2. Whether the leadership, technical advice and support provided by UNFPA were to the satisfaction and standards of the MoPH, Implementing Partners, FHH-MST and Community Health Shuras and	<ul style="list-style-type: none"> Level of satisfaction of IP technical support from UNFPA 	Key Informant Interview	IP: Manager (Kabul, Provicne)	Tool #3

⁷⁹ Governance and coordination considers the leadership, management and institutional arrangements of the project and the governance structure by UNFPA, Donors, MoPH, Implementing Partners in terms of technical advice, coordination, consultations, reporting, funding modality, backstopping support in respect of the project and how it has contributed to the relevance, effectiveness, efficiency and sustainability of the project.

	whether that has contributed to the achievement of planned results and benefits of the project;				
	3. Whether relevant implementing partners performed their role and functions well and effectively that has resulted in the achievement of planned results, targets and the realization of benefits to communities;	<ul style="list-style-type: none"> • Role of IP in CME Selection, FHH Establishment, Equipment and Supply, supervision, monitoring, reporting • Areas need improvement: • Design, implementation, support, coordination, monitoring, Report 	<p>Desk review: Project contract Progress Report CME Selection and training report FHH Establishment document Interview (Supervision, monitoring, reporting) Observation Key Informant Interview</p>	<p>Community Midwife-FHH FHH structure and environment MoPH: RH, P&P, CBHC UNFPA: Sub-national IP: Project Managers PPHD: Community Midwife-FHH</p>	<p>Tool # 1 Tool # 6 Tool #8 Tool #2 Tool # 4 Tool #3 Tool #5 Tool #6 Tool #2 Tool #3 Tool #4</p>
	4. Identify/define some of the areas in which UNFPA, MoPH, Implementing Partners and other relevant stakeholders could have done better or address to improve overall project implementation;				
	5. Whether the current governance and institutional arrangement amongst the different stakeholders allow for strong collaboration,	<ul style="list-style-type: none"> • Role of stakeholders in FHH Process: • Role of PHCC in FHH • Role of provincial Education Department 	<p>Key Informant Interview</p>	<p>MoPH: RH, CBHC IP: Manager UNFPA: Sub-national Manager AMA: President</p>	

	consultation, coordination and reporting of progress in implementation; if not suggest alternative governance structures to strengthen project implementation and reporting;	<ul style="list-style-type: none"> • Role Provincial council • Role of Community • Coordination with IP and MoPH 			
	6. The extent to which UNFPA M&E system and Implementing Partner M&E system and HMIS were able to support planning, project management, implementation, resource allocation, reporting, decision-making and the achievement of results.	<ul style="list-style-type: none"> • UNFPA M&E Systems • IP M&E System • MoPH: M&E System 	<p>Desk review:</p> <p>Project M&E</p> <p>Project Report Progress</p> <p>Key Informant Interview</p>	<p>MoPH: HMIS, RH, CBHC</p> <p>IP:</p>	<p>Tool #1</p> <p>Tool #2</p>

Annex 6: Profile of participants in MTR field observations

Table 12. Profile of participants in MTR

Respondent Category	Number of Target Group Participated in MTR								Total
	Daykundi		Bamyan		Faryab		Subtotal		
	M	F	M	F	M	F	M	F	
Provincial governor	1		1		1		3	0	3
Provincial council	1		3	1	4		8	1	9
PPHD	1			1	1		2	1	3
BPHS manager	1		1		1		3	0	3
IP manager of FHH	1		1		1		3	0	3
Staff of nearest BPHS to FHH	3		2	2	4	2	9	4	13
Staff of provincial hospital				1	1	1	1	2	3
Midwife FHH		3		6		7	0	16	16
Midwife MST	1			1		1	1	2	3
Nurse MST	3		1		1		5	0	5
Vaccinator MST			1		1		2	0	2
Client/ patients		4		2			0	6	6
CHW	2	2	1	5	2	4	5	11	16
Community health shura	26	4	41	2	10		77	6	83
FHAG		21		33		10	0	64	64
Total	40	34	52	54	27	25	119	113	232

Table 13. Profile of community health shura participants

	Bamyan	Daykundi	Faryab	Total
No of shura participants	43	30	10	83
Education levels of shura members				
Illiterate	23	28	1	52
Able to read and write	5	2	3	10
Primary school	4	0	0	4
Secondary school	3	0	0	3
High school	1	0	1	2
Higher (university)	3	0	0	3
Professional education	4	0	5	9
Ages of shura participants (years)				
Mean	45	44	45	45
Median	46	44	44	45
Min	22	18	30	18
Max	75	75	60	75
Mode	50	40	35	50
Gender of shura participants				
Male	41	26	10	77
Female	2	4	0	6

Table 14. Profile of FHAG participants

	Bamyan	Daykundi	Faryab	Total
No of FHAG participants	33	21	10	64
Education levels				
Illiterate	18	8	7	33
Able to read and write	3	0	0	3
Primary school	5	10	2	17
Secondary school	0	0	0	0
High school	6	3	1	10
Higher (university)	1	0	0	1
Professional education	0	0	0	0
Ages of FHAG participants (years)				
Mean	33	22	34	30
Median	30	20	32	26
Min	20	15	20	15
Max	65	50	55	65
Mode	22	20	40	20

Table 15. List of FHHs included in field data collection

No.	Province	District	Implementing Partner	FHH Name	FHH ID
1	Bamyan	Bamyan	MOVE	Ahangaran FHH	3091
2	Bamyan	Panjab	MOVE	Shebar Tagabbarg FHH	3202
3	Bamyan	Panjab	MOVE	Dahan-e-Baldarghoto FHH	3200
4	Bamyan	Waras	MOVE	Qawm-e-Mirza FHH	3096
5	Bamyan	Waras	MOVE	Dahan-e-Rami FHH	3199
6	Bamyan	Shebar	MOVE	Sadbarg Kalo FHH	3092
7	Daykundi	Nilee	MOVE	MST3 FHH	3179
8	Daykundi	Meramoor	MOVE	Katasib FHH	3087
9	Daykundi	Shahrestaan	MOVE	Jamaloq FHH	3209
10	Daykundi	Shahrestaan	MOVE	Waras FHH	3221
11	Faryab	Pahstoon-Kot	AADA	Bucha FHH	3152
12	Faryab	Almaar	AADA	Chagatak FHH	3164
13	Faryab	Qaysaar	AADA	Arakalik	3159
14	Faryab	Balcheraagh	AADA	Neshar FHH	3168
15	Faryab	Garzewan	AADA	Yukhan FHH	3161
16	Faryab	Khowaja-Sabz-Posh	AADA	Shubakhto FHH	3170
17	Faryab	Dawlat Abad	AADA	Dawlat Abad FHH	3167

Table 16. Active health facilities in Bamyan province

Districts	Provincial Hospital	DH	CHC	BHC	HSC	FHH	MST
Bamyan centre	1	0	3	2	7	1	0
Panjab	0	1	1	4	5	8	1
Waras	0	1	1	5	10	9	1
Yakowlang	0	1	3	4	5	4	0
Kahmard	0	0	1	3	1	1	0
Sayghan	0	0	0	3	1	0	0
Shebar	0	0	0	3	1	1	0
TOTAL	1	3	9	24	23	24	2

Table 17. Active health facilities in Daykundi province

Districts	Provincial Hospital	DH	CHC	BHC	HSC	MHT	FHH	MST
Kijran	0	0	1	2	1	0	0	
Kiti	0	1	0	1	1	0	0	1
Khedir	0	0	1	1	3	0	0	1
Bandar	0	0	2	0	2	0	4	
Ashtarlai	0	0	1	2	2	1	5	1
Nilli	1	0	0	2	1	0	0	0
Shahristan	0	1	0	3	1	1	4	1
Miramor	0	1	2	1	3	0	10	
TOTAL	1	3	7	12	14	2	23	4

Table 18. Active health facilities in Faryab province

Districts	Population	Provincial Hospital	DH	CHC	BHC	HSC	MHT	FHH
13	1,0191,000	1	2	16	21	11	4	33

Annex 7: Additional data tables from field observations

Table 19. Catchment population of FHHs included in MTR

No	Province	District	Nam of FHH	Catchment
1	Daykundi	Shahrestan	Jamaloq	2,100
2	Daykundi	Miramor	Katasib	2,800
3	Daykundi	Shahrestan	Waras	3,000
4	Bamyan	Center	Ahangran	2,170
5	Bamyan	Shebar	Sadbarg	2,200
6	Bamyan	Waras	Qume Merza	1,980
7	Bamyan	Waras	Dahan Ramee	1,500
8	Bamyan	Panjab	Dahan Baldarghoto	2,000
9	Bamyan	Panjab	Shebar	2,130
10	Faryab	Gurziwan	Yokhan	3,350
11	Faryab	Bilcheragh	Neshar	1,792
12	Faryab	Khoja Sabzposh	Shubakhto	3,199
13	Faryab	Almar	Cheghatak	2,770
14	Faryab	Dawlat Abad	Takhat-e-Parwardi	2,680
15	Faryab	Pashtonkot	Bocha	5,406
16	Faryab	Qaisar	Arkalik	2,080

Source: IP Documents

Table 20. Distance of FHHs included in MTR from the nearest health facility

No	Province	District	FHH	Nearest HF	Type Nearest HF	KMs from the nearest HF
1	Daykundi	Miramor	Kataseb	Jawz CHC	CHC	20
2	Daykundi	Shahristan	Waras	Ulqan DH	DH	45
3	Daykundi	Shahristan	Jamaloq	KadanakBHC	BHC	10
4	Daykundi	Nilli	Moshnog	NilliPH	PH	40
5	Bamyan	Bamyan center	Ahangaran	Topchi	SHC	15
6	Bamyan	Shiber	Sadbarg	Kalow	BHC	10
7	Bamyan	Panjab	Shiber	Panjab	DH	15
8	Bamyan	Panjab	DahaneBalderghoto	Panjab	DH	8
9	Bamyan	Waras	QomeMerza	Waras	DH	25
10	Bamyan	Waras	DahaneRami	Waras	DH	8
11	Faryab	Gurziwan	Yokhan	Tagabsha	BHC	10
12	Faryab	Bilcheragh	Neshar	Bilcheragh	CHC	17
13	Faryab	Khoja	Shubakhto	Khoja	CHC	15
14	Faryab	Almar	Cheghatak	Almar	CHC	8
15	Faryab	Dawlat Abad	Takht-e-Parwardi	Dawlat Abad	CHC	9
16	Faryab	Pashtonkot	Bocha	Kata Qala	CHC	20
17	Faryab	Qaisar	Arkalik	Qaisar	CHC	14

Table 20. Location of FHHs included in MTR from the residence of CMW

No	Province	District	FHH	Within the CMW Residence	Attached to Residence	Adjacent Plot	Distance (Minute Walk)
1	Daykundi	Miramor	Kataseb	No	No	No	60min
2	Daykundi	Shahristan	Waras	No	No	Yes	1min
3	Daykundi	Shahristan	Jamaloq	No	No	Yes	<1min
4	Daykundi	Nilli	Moshnog	No	No	Yes	2min
5	Bamyan	Bamyan	Ahangaran	No	No	No	10min
6	Bamyan	Shiber	Sadbarg	No	No	No	20min
7	Bamyan	Panjab	Shiber	No	No	Yes	2min
8	Bamyan	Panjab	Dahane	No	No	Yes	<1min
9	Bamyan	Waras	QomeMerza	No	No	No	60min
10	Bamyan	Waras	DahaneRami	No	No	Yes	<1min

Table 21. Distribution of FHH across the three provinces

Province	District	Planned	Active	Drop Out	Under Process
Daykundi	Miramor	10	10	0	3
	Shahristan	4	4	0	4
	Ashtarlai	5	5	0	3
	Sangtakht				
	Bandar	4	4	0	4
	Khedir	0	0	0	10
	Nilli	0	0	0	4
	Kijran	0	0	0	3
	Kiti	0	0	0	4
	Sub-Total		23	23	0
Bamyan	Bamyan center	1	1	0	0
	Shiber	1	1	0	0
	Kakhmard	1	1	0	0
	Yakawlang	4	4	0	0
	Panjab	10	8	2	0
	Waras	9	9	0	0
	Sub-Total		26	24	2
Faryab	Pashtonkot	11	10	1	0
	Kohistan	9	6	3	0
	Qaisar	8	7	1	0
	Almar	4	3	1	0
	Gurziwan	4	3	1	0
	Blecheragh	1	1	0	0
	Dawlat Abad	1	1	0	0
	Khuja				
	Sabzpush	2	2	0	0
	Sub-Total		40	33	7
TOTAL		89	80	9	35

Table 22. Distribution of drop outs and reason for drop out of CMWs

	No. of CMW
Distribution of drop out by district	
Pashtonkot	1
Kohistan	3
Qaisar	1
Almar	1
Gurziwan	1
Reasons for drop out	
Family problem	3
Mental Health problem	1
Security problem	2
Died	1
Marital status of drop out midwives	
Single	4
Married	3

Table 23. Profile of Community Midwives of FHHs

	Daykundi (Round1&2)(%)		Daykundi* (Round3)(%)		Bamyan (%)		Faryab (%)		All 3Provinces (%)	
No of CMW Enrolled to CME	23		36		26		40		125	
No of CMW Completed CME	23	100%	0		26	100%	40	100%	89	
No. of CMW Deployed to FHH	23	100%	0		24	92%	37	93%	89	94%
No. of Active CMW Working at FHH	23	100%	0		24	92%	33	89%	80	95%
Age of CMW at the time of Enrolment to CME										
Mean	19		20		26		20		21	
Minimum	16		16		16		16		16	
Maximum	29		28		44		33		44	
Median	18		18.5		23		18.5		19	
Number of CMW 18 Years and over at the time of enrolment to CME	16	70%	31	86%	22	92%	30	75%	99	80%
Number of CMW 16-17 Years at the time of enrolment to CME	7	30%	5	14%	2	8%	10	25%	24	20%
Marital Status of CMW at the time of Enrolment to CME										
Single	15	65%	20	56%	15	63%	20	50%	70	57%
Married	8	35%	16	44%	9	38%	19	48%	52	42%
Widow	0	0%	0	0%	0	0%	1	3%	1	1%
School Education of CMW at the time of Enrolment to CME										
Minimum Education	6		8		8		6		6	
Maximum Education	12		13		12		14		14	
Mean	9		11		9		9		9	
Median	9		11		8		9		9	
Description of School Education of CMW at the time of Enrolment to CME										
6 th	4	17%	0	0%	0	0%	6	15%	10	8%
7 th	2	9%	0	0%	0	0%	8	20%	10	8%
8 th	4	17%	1	3%	13	54%	4	10%	22	18%
9 th	7	30%	10	28%	3	13%	15	38%	35	28%
10 th	2	9%	6	17%	4	17%	0	0%	12	10%
11 th	3	13%	6	17%	2	8%	1	3%	12	10%
12 th	1	4%	11	31%	2	8%	4	10%	18	15%
Above 12 th	0	0%	2	6%	0	0%	2	5%	4	3%

*Daykundi Round 3 is ongoing

Table 24. Profile of Community Midwives who participated in MTR

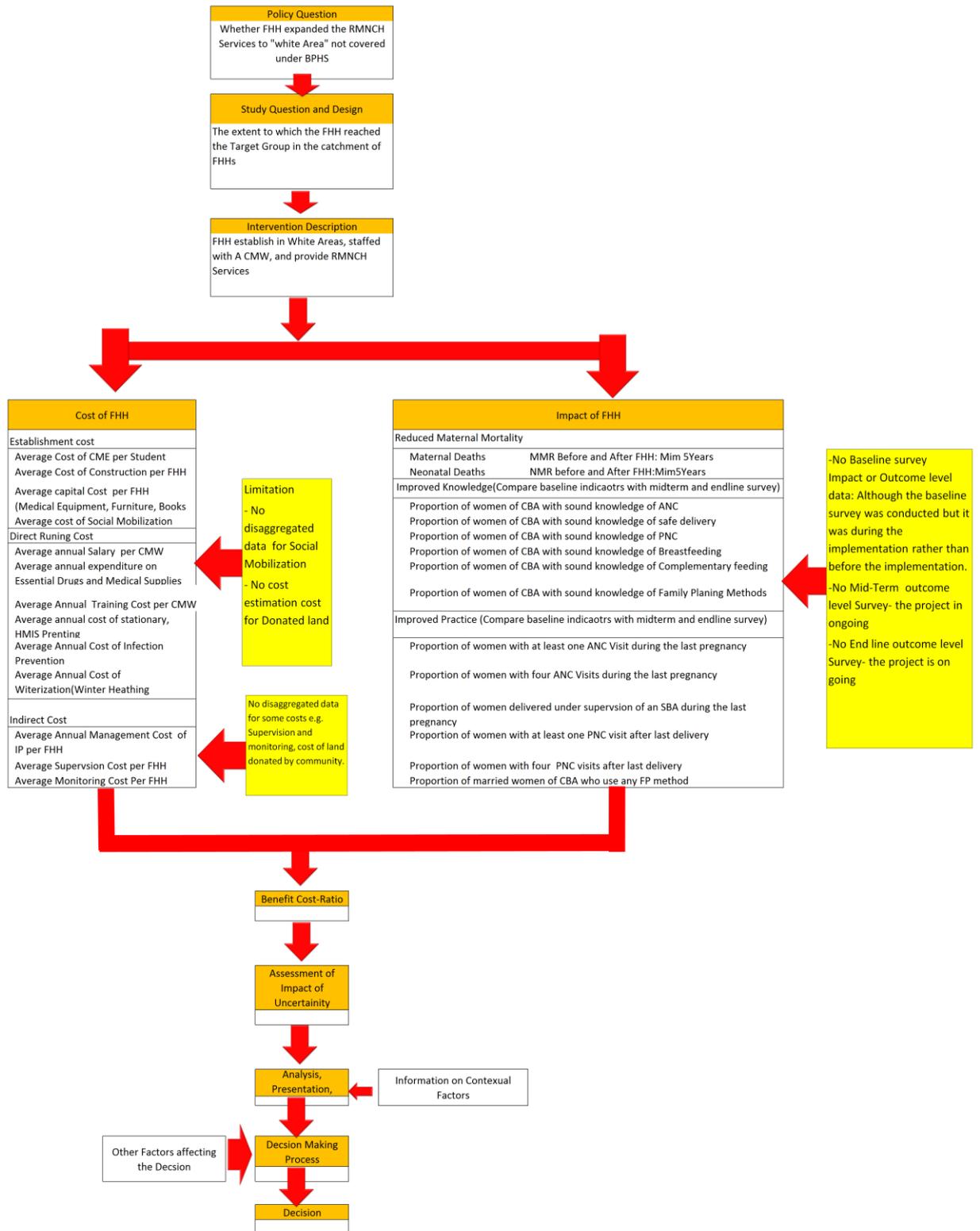
No	Province	District	Name of FHH	Year of birth Community Midwife	Startin g date of CME	Gradu ation Date from CME	Curre nt Age (Year)	Age at the time of Enrol ment to CME (Year)	Education level before CME	Current Marital status	Marital Status at the time of enrolmen t to CME	Commitment period to work at FHH	
												From	To
1	Daykundi	Miramor	Kataseb	1994	2010	2012	20	16	6	Single	Single	2012	2016
2	Daykundi	Shahristan	Waras	1982	2011	2013	32	29	9	Married	Married	2013	2017
3	Daykundi	Shahristan	Jamaloq	1992	2011	2013	22	19	8	Single	Single	2013	2017
4	Daykundi	Nilli Bamyan center	Moshnog	1995	2013	2015	19	18	10	Married	Married	2015	2020
5	Bamyan	Shiber	Ahangaran	1984	2009	2011	30	25	8	Single	Single	2012	2016
6	Bamyan	Panjab	Sadbarg	1980	2009	2011	34	29	8	Married	Married	2012	2016
7	Bamyan	Panjab	Shiber DakhaneBalder ghoto	1989	2011	2013	25	22	9	Single	Single	2013	2017
8	Bamyan	Panjab	ghoto	1987	2011	2013	27	24	8	Married	Single	2013	2017
9	Bamyan	Waras	QomeMerza	1985	2009	2011	29	24	8	Married	Married	2012	2016
10	Bamyan	Waras	DahaneRami	1989	2011	2013	25	22	8	Married	Single	2013	2017
11	Faryab	Pashtonkot	Bucha	1992	2009	2011	22	17	7	Single	Single	2012	2016
12	Faryab	Qaisar	Arkalik	1990	2009	2011	24	19	7	Single	Single	2012	2016
13	Faryab	Almar	Chaghatak	1992	2009	2011	22	17	12	Married	Married	2012	2016
14	Faryab	Gurziwan	You khan	1990	2009	2011	24	19	9	Married	Married	2012	2016
15	Faryab	Blecheragh Dawlat	Neshir Takht	1992	2009	2011	22	17	9	Married	Married	2012	2016
16	Faryab	Abad Khuja	Parwardi	1986	2009	2011	28	23	9	Married	Married	2012	2016
17	Faryab	Sabzpush	Shobakhtoo	1991	2009	2011	23	18	9	Single	Single	2012	2016

Table 25. Referrals

	Province	District	FHH	Date of Referral			Age of patient			Gen der	Refer centre	Diagnosis
				Year	Month	Date	Year	Month	Days			
1	Daykundi	Shahrest	Jamaloq	9	5	21		3	M	DH Ulqan	S.MN(Severe	
2	Daykundi	Shahrest	Jamaloq	9	4	25		7	F	DH Ulqan	Fever +Icterus	
3	Daykundi	Shahrest	Jamaloq	9	4	24	5		M	DH Ulqan	HP	
4	Daykundi	Shahrest	Jamaloq	9	4	24	43		F	DH Ulqan	S.Brocellosis	
5	Daykundi	Miramor	Kata Saib	9	5	1	39		F	DH Ulqan	Suspected TB	
6	Daykundi	Miramor	Kata Saib	9	6	9	20		F	DH Ulqan	UTI	
7	Daykundi	Miramor	Kata Saib	9	6	23	25		F	BHC Jawos	Bone pain	
8	Daykundi	Miramor	Kata Saib	9	8	14	42		F	DH Ulqan	Suspected TB	
9	Bamyan	Panjab	Shebar	9	5	10	1		M	DH Panjab	Severe	
10	Bamyan	Panjab	Shebar	9	5	5	30		F	DH Panjab	Suspected TB	
11	Bamyan	Panjab	Shebar	9	5	19	1		F	DH Panjab	Severe	
12	Bamyan	Panjab	Shebar	9	6	7	1		F	DH Panjab	Burning	
13	Bamyan	Panjab	Shebar	9	7	6	50		F	DH Panjab	Arthritis	
14	Bamyan	Panjab	Shebar	9	7	6	20		F	DH Panjab	Prolong Labour	
15	Bamyan	Panjab	Shebar	9	7	16	1		F	DH Panjab	Pneumonia	
16	Bamyan	Panjab	Shebar	9	7	21	60		F	DH Panjab	Hypertension	
17	Bamyan	Panjab	Shebar	9	8	11	22		F	DH Panjab	Abdominal Pain and bleeding	
18	Bamyan	Panjab	Shebar	9	9	12	40		F	DH Panjab	Suspected TB	
19	Bamyan	Panjab	Shebar	9	9	16	20		F	DH Panjab	Feis Prosziteson	
20	Bamyan	Panjab	Dahan Baldergho	9	5	21	40		F	DH Panjab	Suspected TB	
21	Bamyan	Waras	Qaumi	9	0	0	0					
22	Bamyan	Waras	Dahan	9	5	6	2		M	DH Waras	Burning	
23	Bamyan	Waras	Dahan	9	5	18	30		F	DH Waras	PID	
24	Bamyan	Waras	Dahan	9	6	19	25		F	DH Waras	Suspected	
25	Bamyan	Waras	Dahan Ramee	9	6	22	20		F	DH Waras	Itching of inside the abdomen	
26	Bamyan	Waras	Dahan	9	8	20	29		F	DH Waras	Suspected TB	
27	Bamyan	Shebar	Sadbarg	9	0	0	0					
28	Bamyan	Bamyan	Ahangara	9	6	19	4		M		Malnutrition	
29	Bamyan	Bamyan	Ahangara n	9	8	26	21		F		Premature delivery plus low birth weight of newborn and respiratory distress	

Annex 8: Cost benefit analysis model for FHH

Source: Adapted from Guidelines for conducting cost–benefit analysis of household energy and health interventions. WHO:2006



Annex 9: MTR score matrix

Score	4	3	2	1
Relevance (and responsiveness)	The programme was fully in line with and supportive of government and unfpa strategies and policies, and responds to community needs. Decisions to make changes were timely and logical. Evidence of realistic planning, including establishing achievable but aspiration targets and good timely monitoring was evident	The programme was basically in with government and or UNFPA policies and strategies, but did not offer any new innovations and was not directly responding to needs of target populations. Logic was not supported by evidence. Rationale for all interventions was not always clear. Targets were achievable, but not aspiration (targets set were very low)	The programme was not in conflict with government and or UNFPA policies and strategies, but logic and rational for interventions were not evidence-based or were based on outdated ideas and or thinking. Targets were often missing and or monitoring did not allow validation of or measuring of targets.	The programme intention was basically in line with government strategies but logic was not evidence- based and or beneficiaries were not clear. Interventions did not directly address needs of those in most need.
Effectiveness	The programme implementation has led to achieving more than expected at this point. The programme has led/ or is leading to a shift in the way services have or should be delivered and or is influencing new ways of thinking/ service delivery.	The programme implementation has to date enabled achievement of most of the expected results in all provinces. Managers and stakeholders at all levels are generally happy with results thus far.	The programme implementation has not been as successful in all areas and expected results have not been achieved in one of the three provinces. Some areas/aspects of the programme are giving concern to some managers and/or stakeholders.	The programme implementation has to date been slow and many of the expected results have not been achieved in most of the target areas. Stakeholders have concerns about some aspects of the programme or programme implementation
Efficiency	All inputs were timely, annual work plans were agreed on time and based on feedback from previous year or good evidence. Sound monitoring resulted in timely and logical decision- making. All targets were met as planned. Maximum use was made of all	Planned programme inputs and reporting were in the main timely, reasons for delays were based on sound rationale. Not all activities were implemented to the full, but good rationale was given for any shortfalls. Most,	Programme activities, including monitoring were not always clearly stated in annual work plans and some delays resulted in changes being made or ad hoc implementation of activities. Reasons for delays were not	The programme activities suffered from many delays due to poor management and reporting or disbursement of funds. Programme documents and or AWP were poor lacked integrity and or achievable

Score	4	3	2	1
	available resources (including human, and financial)	but not all targets were met. Most of the available resources were used, but opportunities existed for greater use in some areas.	given. Monitoring reports lacked rigor or were not always available. Annual Targets were often missed or none were made.	targets.
Sustainability	There is consensus that the pilot model of BHSP service delivery using Family Health Houses is good and should be expanded to other areas	There is some agreement that the FHH model is useful, but some stakeholders have legitimate concerns but these are being addressed by UNFPA and IPs with MoPH	There are a few concerns that the model is not sustainable or is too costly. Concerns are not being discussed or addressed by the relevant parties	There are major concerns that the pilot is not sustainable and cannot be integrated into the regular public health system

Annex 10: References

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Family Health House Model, Afghanistan



A patient consults a community midwife at a Family Health House in Bamyan province