



USAID | **AFGHANISTAN**
FROM THE AMERICAN PEOPLE

Rural Expansion of Afghanistan's Community-based Healthcare Program

Measuring Program Outcomes through Household Surveys

September 2006

This report was authored by REACH Program staff: Omid Ameli, Monitoring and Evaluation Advisor; Paul Ickx, Management Information System Advisor; and Sallie Craig Huber, Program Manager for Planning, Monitoring and Evaluation. It was produced for review by the United States Agency for International Development (USAID).

This report has been prepared and printed by the Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program. REACH is a USAID-funded program implemented by Management Sciences for Health (MSH) under contract EEE-C-00-03-000-21-00. Partners include the Academy for Educational Development (AED), JHPIEGO, Technical Assistance, Inc. (TAI), and the University of Massachusetts at Amherst.

The views expressed in this publication do not necessarily reflect the views of the United States of Agency for International Development or the United States Government

Table of Contents

Acknowledgments.....	v
Acronyms.....	vii
Executive Summary.....	1
Background and Purpose.....	3
Methodology.....	4
Survey process.....	5
Sampling.....	6
Identifying the respondents.....	7
Data collection tools.....	8
Quality control measures.....	8
Limitations of the survey.....	11
Findings.....	13
Why the EOP findings are presented separately for Rounds 1 and 2 and for Round 3.....	14
Findings for Rounds 1 and 2 EOP data.....	14
Changes at the grant catchment area level.....	18
Round 3 baseline and EOP survey data.....	19
NGO grantees' perspectives on the usefulness of the LQAS experience.....	24
Annex 1	EOP Household Survey Questionnaires
Annex 2	Midterm Household Survey Questionnaires
Annex 3	Overall REACH Results: Comparing Baseline and EOP Status
Annex 4	Grants Catchment Area Level Results
Annex 5	Samples Used for Various Analyses of REACH Household Survey Data

Acknowledgments

The REACH household surveys, culminating in this report, are the result of the labor of many REACH staff and partners. The authors wish to acknowledge and thank the following individuals, who played important roles at various stages in the development of this product:

- REACH NGO grantees (listed alphabetically): ADRA, AHDS, AKDN, BDF, BRAC, CAF, CHA, CoAR, Ibn Sina, IMC, Medair, Merlin, NAC, NPO/RRAA, RCA, SC/UK, SC/US, SDF, STEP, and WVI, which did the actual work of data collection, data quality control, and data analysis in their own catchment areas;
- REACH grants officers for their role in overseeing NGO implementation of the household surveys;
- Maria Miralles, former REACH Program Manager for Monitoring and Evaluation, for developing the original survey plan, training material, and tools;
- Khalid Rahim for contributing to the NGO training, conducting site visits, reviewing translated survey material, and providing continuous technical assistance to the NGOs for survey planning;
- Ahmad Roshan for training NGO partners and monitoring their data analysis and completion of end-of-project (EOP) household survey reports and for data analysis of the overall survey findings;
- Ryoko Yokoyama, Hafiz Hafizullah, and Jafar Hussein, for development of the survey database and for contributing to NGO training and survey planning;
- Dr. Rahila Juya, former REACH National Gender Program Officer, for pretesting the midterm and EOP questionnaires;
- Ceallaigh Reddy and Barbara Timmons, MSH/Cambridge Office of Communications and Knowledge Exchange, for editorial assistance;
- the Afghan Ministry of Public Health and other members of the USAID/REACH team, for their continuous support and encouragement.

Acronyms

ANC	antenatal care
ARI	acute respiratory infection
BPHS	Basic Package of Health Services
CA	catchment area
CAAC	Catchment Area Annual Census
CHC	Comprehensive Health Center
CHW	Community Health Worker
CPR	contraceptive prevalence rate
DPT	diphtheria, pertussis, tetanus
EOP	end-of-project
FP	family planning
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illness
LQAS	Lot Quality Assurance Sampling
MoPH	Ministry of Public Health
NGO	nongovernmental organization
PNC	postnatal care
REACH	Rural Expansion of Afghanistan's Community-based Healthcare Program
SA	supervisory area
TT	tetanus toxoid
USAID	United States Agency for International Development

REACH NGO Grantees Participating in the Household Surveys

ADRA	Adventist Development and Relief Agency
AHDS	Afghan Health and Development Services
AKDF	Aga Khan Development Foundation
BDF	Bakhtar Development Foundation
BRAC	BRAC Afghanistan
CAF	Care of Afghan Families
CHA	Coordination of Humanitarian Assistance
CoAR	Coordination of Afghan Relief
Ibn Sina	
IMC	International Medical Corps
Medair	(International Humanitarian Aid Organisation)
Merlin	Medical Emergency Relief International
NAC	Norwegian Afghanistan Committee
NPO/RRAA	Norwegian Project Office/Rural Rehabilitation Association for Afghanistan
SC/UK	Save the Children UK
SC/US	Save the Children US
SDF	Sanayee Development Foundation
STEP	STEP Health and Development Organization
WVI	World Vision International

Executive Summary

The USAID-funded Rural Expansion of Afghanistan’s Community Based Health Care (REACH) Program is a three-year project to increase the use of basic health services by women and children residing primarily in rural areas. REACH uses a grant mechanism to expand service delivery to over six million Afghans in 14 provinces and in Kabul, the capital city. Services are provided through Afghan and international nongovernmental organization grantees.

REACH trained its grantees to undertake household surveys at several points during their grants to measure coverage and increases in use of health services in the communities where they worked, and provided regular coaching and quality control during the survey process.

Using a unique but proven survey methodology—Lot Quality Assurance Sampling (LQAS)—REACH grantees measured the status of 10 indicators that reflect the health status of women and children. These 10 indicators were divided into three categories—reproductive health, safe motherhood and child health—in keeping with the REACH program objectives. Because REACH made grants in two phases, survey findings were divided to show the outcome results for those grants that ran for more than two years (Rounds 1 and 2 grants) and those that ran for only one year (Round 3). Findings are presented below.

Overall REACH results: Comparing baseline and EOP status

Indicators		Rounds 1 and 2 Grants*		Round 3 Grants†	
		Baseline (Early 2004)	EOP (Early 2006)	Baseline (Early 2005)	EOP (Early 2006)
		%		%	
Reproductive health	Contraceptive prevalence	16.2	25.9	27.3	38.7
	Knowledge about two modern contraceptive methods	21.0	52.9	41.4	61.1
Safe motherhood	Births attended by a skilled attendant	12.2	23.2	32.4	35.6‡
	Mothers attending one ANC visit	26.1	38.8	35.8	46.6
	Mothers receiving at least 1 TT injection	44.3	60.0	50.8	54.6‡
	Mothers receiving PNC after delivery	15.7	26.2	34.5	41.7‡
Child health	Children 1–2 fully immunized (DPT3)	14.7	37.4	29.1	37.5
	Children 1–2 receiving vitamin A therapy	67.4	77.8	82.6	85.2‡
	Children exclusively breastfed first 6 months	62.6	66.3‡	58.0	63.1‡
	Mothers reporting appropriate care-seeking behavior	24.9	41.5	43.3	58.0

The shaded indicators denote REACH program key results.

Notes:

*Rounds 1 and 2 grants started in late 2003 and the population represented by this survey is 4.1 million living in 79 rural districts.

†Round 3 grants started in January 2005 and the population represented by this survey is 2.3 million living in 25 rural districts and 6 sectors of Kabul city. These data are presented separately since the grants started later and there was a shorter period in which to measure results. Also, over 40% of people in this sample reside in the urban area of Kabul.

‡The difference between these baseline and EOP findings is not statistically significant.

These findings provide important measures of the outcome results of REACH interventions in addressing the program's strategic objective of increased use of healthcare services by women and children. In addition, these data provide a baseline for the measurement of future health program interventions. The LQAS methodology used to obtain these data provides a practical measurement and monitoring tool for continued regular use by the Ministry of Public Health, nongovernmental organizations, and other service providers to track future changes in key health indicators, both in Afghanistan and elsewhere.

Background and Purpose

The USAID-funded Rural Expansion of Afghanistan's Community-based Healthcare Program (REACH) is a three-year project to increase the use of basic health services by women of reproductive age and children under five in rural areas. Through REACH's nongovernmental organization (NGO) performance-based grants initiative, the Basic Package of Health Services (BPHS) is being delivered to more than 6.4 million Afghans in selected underserved districts of 14 provinces and six sectors of Kabul City.

Household surveys were undertaken by REACH NGO grantees at baseline, midterm (for selected grants), and end-of-project (EOP) to capture information on basic health services coverage and outcomes in the communities they serve. The baseline and EOP surveys measured the status of 10 indicators that reflect the health status of women and children. Grantee NGOs use this information to better understand health status and needs as well as health practices in the communities they serve, and to help them plan their activities accordingly.

The results of these surveys provide important measures of the outcome results of REACH interventions to address the program's strategic objective of increased use of health services, as well as providing a practical measurement and monitoring tool to be used by the Ministry of Public Health (MoPH), NGOs, and other service providers on a regular basis to track future changes in key health indicators.

REACH chose to use the Lot Quality Assessment Sampling (LQAS) methodology for these surveys. One of the first large-scale applications of LQAS in public health, this experience in Afghanistan helped NGOs adequately assess the impact of health interventions at local and provincial levels in a challenging postconflict environment. Other advantages and benefits of using this approach for NGOs, REACH, and MoPH included:

- producing statistically valid estimates of outcome indicators useful for decision-making at multiple levels;
- providing data for immediate analysis and use at the local level;
- affording the possibility of incremental sampling if coverage areas increase;
- permitting realistic target setting at the local level;
- allowing prioritization of technical assistance needs within each implementation area;
- decentralizing the survey process;
- offering the possibility of quick midterm assessments.

Although the LQAS methodology was largely unknown in Afghanistan before its introduction by REACH, nearly all REACH NGO grantees were able to use it successfully to collect data and analyze their own survey results after receiving adequate training and technical assistance from REACH.

Methodology

The REACH Program targets two groups of health care consumers: women of reproductive age and children under the age of five. The household survey focused on the types of services that relate most directly to improvements in morbidity and mortality among these groups. The 10 specific indicators measured through the household survey can be divided into the following three key categories: reproductive health, safe motherhood, and child health (Table 1).

Table 1. List of REACH outcome indicators and their definitions

	Indicator*	Definition
Reproductive health	Contraceptive prevalence rate	Proportion of currently married, not pregnant women who are using (or whose partner is using) a modern contraceptive method
	Knowledge about two modern contraceptive methods	Proportion of currently married, not pregnant women who can name at least two modern contraceptive methods
Safe motherhood	Births attended by a skilled attendant	Proportion of mothers having a living child under 1 year old whose latest delivery was attended by a doctor, nurse, or trained midwife
	Mothers attending one antenatal care visit	Proportion of mothers having a living child under 1 year old who made at least one antenatal care visit to a doctor, nurse, or trained midwife during their latest pregnancy
	Mothers receiving tetanus toxoid injections	Proportion of mothers having a living child under 1 year old who received at least one dose of tetanus toxoid during their latest pregnancy
	Mothers receiving postnatal care after delivery	Proportion of mothers having a living child under 1 year old whose latest delivery was followed by a visit to a doctor, nurse, or trained midwife
Child health	Children 1–2 fully immunized (DPT3)	Proportion of children 1–2 years old who received at least three doses of DPT vaccine as recorded in the child's vaccination card
	Children 1–2 received vitamin A therapy	Proportion of children 1–2 years old who received vitamin A drops during the previous six months
	Children exclusively breastfed during first six months	Proportion of children under 1 year old who were exclusively breastfed for the first six months of their lives
	Mothers reporting appropriate care-seeking behavior	Proportion of children under 2 years old with an episode of either diarrhea, ARI, or fever during the past two weeks whose mothers reported appropriate care-seeking practices

*The shaded indicators denote REACH program key results.

These indicators are considered essential for measuring the outcome of BPHS implementation, that is, determining whether service providers are offering adequate coverage to the populations in their catchment areas.

Survey interviews were held with four types of respondents (see Table 2). A special questionnaire was developed for each group to address topics particularly relevant to REACH goals and objectives (see Annex 1 for the EOP questionnaires).

Table 2. Respondent groups and indicators assessed for each group

Respondent Groups	Indicators Covered
Mothers of children 0–11 months	Antenatal and postnatal care, breastfeeding practices, tetanus toxoid immunization
Mothers of children 12–23 months old	Immunization, vitamin A
Married women aged 15–49 years old who are not currently pregnant	Contraceptive knowledge and use
Mothers of sick children 0–23 months old	Care-seeking behavior

This report records the process and findings of the REACH baseline and EOP household surveys by Round 1, 2, and 3 NGO grantees of the REACH program. Awards for Rounds 1 and 2 BPHS grants were made between October 2003 and March 2004. Round 3 grants were awarded in December 2004.

Survey process

In many respects, the REACH household survey initiative reflects the success of REACH technical assistance to grantee NGOs. While a number of partners considered the LQAS methodology too new and complex to be implemented by grantee NGOs in Afghanistan, both Afghan and international NGOs successfully completed the survey with training and technical assistance provided by REACH staff. Table 3 describes the survey process for NGO grantees during Rounds 1 and 2. For these grantees, the process consisted of three surveys conducted at baseline, midterm, and recently at the end of the project. The baseline was conducted in early 2004; these NGOs also completed a midterm survey in mid-2005. The EOP survey was completed by April 2006. For Round 3 grantees, the requirement for a midterm survey was eliminated due to the shorter duration of the grants.

Table 3. REACH household survey process and roles of NGOs and REACH in a decentralized survey process

Roles	Baseline Survey Early 2004	Midterm Survey Mid-2005	EOP Survey Early 2006
NGO grantees	Pre-survey and sampling, data collection, computerization of data, analysis at the local level		
REACH staff	Development of questionnaires and tools, training and technical assistance, oversight and data quality control, analysis at the provincial and REACH levels		

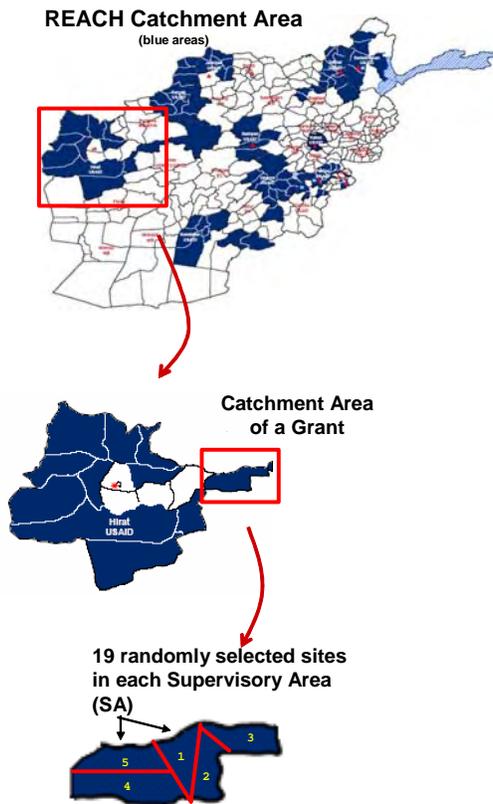
With support and oversight by REACH staff, all NGOs carried out a pre-survey to guide their sampling plans. They recruited and trained the surveyors, collected data, computerized the data, and carried out the analysis at the local level. The role of REACH was to develop and pre-test the questionnaires and survey tools, provide training and ongoing technical assistance, oversee the survey planning and data quality control through offline and online measures, and perform the REACH-wide compilation and analysis of the data.

For the EOP survey, the NGOs received two rounds of refresher training in sampling, survey implementation, and data analysis between December 2005 and April 2006. The data collection and computerization of data took place between January and April. All REACH grantees completed their EOP surveys in the allotted time.

Sampling

Lot Quality Assurance Sampling (LQAS) methodology was used for the REACH household survey.¹ This sampling strategy begins with the identification of catchment areas (CAs), usually areas covered by each of the REACH BPHS grants (normally a district or a cluster of districts). The grantees were coached to divide each CA into at least five supervisory areas (SAs), each consisting of several villages or communities served by one health facility (see Figure 1). To ensure compatibility of data over time, the division of CAs into SAs remained the same for the baseline, midterm, and EOP household surveys.

Figure 1. Delineation of a catchment area and its division into supervisory areas (Cheshtisharif District, Herat Province, Western Afghanistan)



Random sampling is the cornerstone of LQAS. With guidance from REACH staff, the NGO grantees performed systematic random sampling in each of their SAs. Different random samples were taken at baseline, midterm, and end-of-project, making it highly unlikely that the same household would be selected for different surveys. Grantee technical staff, appointed and trained to carry out this task, developed the sampling plan. REACH technical staff reviewed and approved all sampling plans before data collection began.

¹ Joseph J. Valadez, William Weiss, Corey Leburg, and Robb Davis, *A Trainers' Guide for Baseline Surveys and Regular Monitoring: Using LQAS for Assessing Field Programs in Community Health in Developing Countries* (NGO Networks for Health, December 2001).

Sample size was determined according to the principles of LQAS as outlined in the Valadez manual, which calls for the random selection of 19 interview locations or households per SA. A sample of 19 households provides an acceptable level of statistical error (90–95% confidence interval at different levels of analysis) in order to make management decisions. Table 4 presents the breakdown of sample size at different levels.

Table 4. Sample size at different geographic levels

Level	Sample Size
National (all REACH catchment areas)	N _{baseline} = 4,237; (Rounds 1 and 2 = 3,249; Round 3 = 988) N _{EOP} = 3,725 (Rounds 1 and 2 = 2,737; Round 3 = 988)
Province	N ≥ 95
Catchment area of a grant	N ≥ 95
Supervisory area of a health facility	N = 19

The total sample size at EOP was 3,725 households. The EOP sample size was smaller than the baseline because one NGO had oversampled its catchment area for the baseline survey.

The composition of the population covered by the surveys in the Rounds 1 and 2 grant areas is different from that of Round 3. Rounds 1 and 2 grants cover purely rural areas, representing a total population of nearly 4.1 million² living in 79 rural districts. The EOP sample size for these grants was 2,737.

Among the Round 3 grants, the sample size for both baseline and EOP surveys was 988. The total population represented by this sample is 2.3² million, who live in 25 rural districts and six sectors of Kabul City. Of this 2.3 million, approximately 1 million (43%) are urban dwellers living in the abovementioned sectors of Kabul City. Due to the large proportion of urban respondents and the later start date and shorter grant duration, Round 3 data have been analyzed and are presented separately.

In each randomly selected household, one person from each of the four respondent groups listed in Table 2 was interviewed. Respondent groups were permitted to overlap in each selected household, with one exception—no overlaps were allowed between the first and second groups (mothers of children 0-11 months and mothers of children 12-23 months of age) because the data from these two groups were to be aggregated for certain indicators. If, in a selected household, all expected respondent groups were not represented, interviewers were instructed to move to the next nearest household.

Identifying the respondents

For Rounds 1 and 2 grantees, division of the grantee CAs into SAs remained the same for the midterm and EOP household surveys as for the baseline household survey. At the baseline stage, SAs were identified by providing district maps to REACH NGOs. A list of villages or settlements was compiled to estimate the number of households in each SA and derive a sampling frame. For the baseline survey, NGO grantees conducted a pre-survey to verify existing village listings in each SA and estimated the number of households in each village. The lists of villages and the population of each, which were developed in 2004 for the baseline survey, were updated by all NGO grantees for the EOP survey sampling because the population of villages and settlements might have changed over time. Wherever the national Health Management Information System (HMIS) Catchment Area Annual Census (CAAC) had been performed, NGOs used the CAAC results to update their sampling plans. In the absence of CAAC data, sampling plans were updated by contacting local authorities. The third step in identifying the respondents was to use systematic random sampling principles to identify 19 households in each SA.

² Based on the Afghanistan Central Statistics Office 2002–2003 population data set.

Data collection tools

Separate questionnaires were used to collect information from each of the four respondent groups. (See Annex 1 for the EOP Survey Questionnaires). Because the respondents were women, the principal interviewer in each survey team also had to be a female (see Figure 2). In most cases, one survey team consisting of one man and one woman collected the information from one SA

Figure 2. A female surveyor interviewing a woman in Badakhshan Province



Although the definition of the ten indicators and the language of corresponding questions in the EOP questionnaires remained exactly the same as the baseline, a few new questions were introduced in the EOP survey (see Annex 1 with color-coded questions highlighting newly added items). Some of the new questions were added to measure the same indicators by using alternative definitions (e.g., exclusive breastfeeding practices, Question 10a in Questionnaire 1). Some other questions were added after the results of the baseline household survey showed that additional information was needed to further analyze certain indicators (e.g., source of family planning methods currently in use, Question 11 in Questionnaire 3). Finally, two sets of questions were added specifically to assess quality of care for family planning and integrated management of childhood illness (IMCI) services (Question 13 in Questionnaires 3 and 4).

Quality control measures

Because the survey process was decentralized, REACH undertook rigorous measures to assure the quality of data collected. Offline (pre-survey) and online (during the survey) quality control procedures were applied during both baseline and EOP household surveys. As an offline measure, REACH staff closely scrutinized each NGO's random sampling process, the cornerstone of the LQAS methodology. NGOs did the sampling themselves by using a structured sampling process and undergoing a pre-survey assessment. NGO sampling protocols, indicating exact interview locations

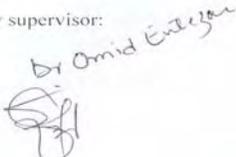
and including village names and serial number of households in those villages, were then reviewed separately with each NGO through face-to-face meetings and/or e-mail. After REACH had checked and cleared the sampling process, NGOs received approval to proceed into the data collection phase of the survey.

An additional offline quality control measure involved verification of interviewer accuracy for each of the four questionnaires. After training, NGOs were required to test each interviewer using a structured methodology and standardized tools. Those with less than 90% accuracy in data collection were either dismissed or retrained until they obtained 90% accuracy.

During the data collection phase, REACH required the following three quality control measures involving onsite supervision:

- Assigned NGO survey supervisors met with each survey team and reviewed the completeness of questionnaires with the survey team every day. Incomplete questionnaires were returned to the team and the interview was repeated.
- For some NGOs, survey supervisors accompanied survey teams on each of their visits.
- One interview location in each SA (5% of each SA sample) was re-surveyed to assess correct selection of the household according to the sampling protocol, correct selection of the respondents, reliability of data collected, and completeness of the questionnaires. If flaws were found in any of these measures, survey teams were required to re-survey the entire SA. REACH staff accompanied NGOs during the re-survey. A completed re-survey record is reproduced in Figure 3.

Figure 3. Record of re-survey in REACH EOP Household Survey in Kabul Province

REACH End of Project Household Survey Re-survey record	
NGO Name:	STEP
Grant ID:	02-02
Province:	KABUL
Interview location details (to be re-surveyed) (this information comes from the sampling protocol)	
Supervisory Area No.:	7
District name:	CHAR-ASIA
Village name:	GALA-e-RASHID
Random Household Serial No.:	47-48-49
Re-survey results (Find the household(s) that was/were interviewed. You can track this down by using the name of the head of the household, serial number of the household etc)	
- Does the actual interview location matches the planned interview location serial number?	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no
- Are all of the respondents to four questionnaires correctly selected based on the definition of target groups?	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no
- (After repeating all four interviews) are there 5 or less than 5 questions in all four questionnaires where the new responses differ from those previously recorded by the survey team?	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no
Re-survey overall result:	<input checked="" type="checkbox"/> acceptable <input type="checkbox"/> non-acceptable
Name of the survey supervisor:	
Signature:	

REACH held workshops with all NGOs before they undertook data analysis at the CA level. Quality control of data entry was carried out on the first day of these workshops. NGOs cross-checked hard copies of the questionnaires with the data they had entered in their analysis databases. To expedite this process, only those questions being used for analysis were checked. If necessary, data were then edited and cleaned.

Finally, REACH required EOP household survey reports from each NGO using a standard report template. Successful completion of these reports was a prerequisite for final grant payments. REACH staff assessed these reports to ensure the quality of aggregated data through checking, re-analyzing in many cases, and cross-checking with the data in the NGOs' databases. Discrepancies were communicated to the NGOs for resolution before the final survey reports were accepted and final grant payments made.

Analysis of the findings

The LQAS methodology produced data for decision-making at multiple levels. This was possible due to the LQAS sampling frame, which makes the survey findings particularly useful as a management tool for the implementing NGOs. The lowest level which yields data for NGO decision making is the SA. At this level NGO grantees can identify poor, medium and good performance for each indicator (see Table 5). They defined for each SA whether its performance for the indicator was acceptable by taking the average baseline value of the indicator as threshold. Then they repeated the exercise with the projected target value of each indicator as threshold. Each SA was defined as acceptable or not acceptable for these two values. An SA not acceptable for both the baseline average and the target value was classified as "high risk" for that indicator. An SA acceptable for the baseline value, but not acceptable for the target value was classified as "medium risk" for that indicator. Finally an SA acceptable for both the baseline value and the target value was classified as "low risk" for that indicator. For each indicator, the NGO obtained a ranking of the SAs in the catchment area, reflecting high, medium or low risk. For the managers this corresponded with high, medium and low priority for additional inputs needed to obtain results in each SA. This feature of the LQAS allows the implementing NGO to focus its attention on those SAs where performance is poorest. To facilitate communicating the status of an SA, a color coding was applied, using red for high risk, high priority SAs, yellow for medium risk, medium priority SAs, and green for low risk, low priority SAs.

Above the SA level, the sample size is sufficient to allow compilation of the value of each indicator. The statistical precision of the resulting information at each level varies. The right hand column of Table 5 shows the errors of estimation at each level.

Table 5. LQAS outcome information at each analysis level

Level	Type of Information (Sample Size)	Error of Estimation
National/all REACH program districts	XX% (N _{baseline} = 4,237;* N _{EOP} = 3,725)**	~ 2 %
Province	YY % (N ≥ 95)	4–10 %
Local/catchment area of a grant	ZZ % (N ≥ 95)	4–10 %
Local/supervisory area	High/medium/low risk (N = 19)	< 10% probability for misclassification

* N = sample size, number of households

** One NGO oversampled its catchment area in the baseline stage.

Limitations of the survey

Due to the security situation in Kandahar and Khost provinces, five districts were not surveyed at the EOP stage.

A total of 205 SAs in 26 NGO catchment areas were included in the EOP survey. Data from 196 SAs are included in comparisons made between baseline and EOP values of indicators. The remaining 9 SAs were excluded due to lack of comparable data from the baseline survey. These SAs were not a part of the baseline household survey sampling plans and were added only at the EOP stage. In Bamyan and Yakawalang districts of Bamyan province, Cheqcheran district in Ghor, and Baghlan district in Baghlan province, the baseline survey sampling plans missed segments of the districts. This issue was corrected at the EOP stage when these four additional SAs were created, sampled, and surveyed. These additional data are excluded when comparing the baseline versus EOP values of the indicators.

Five new SAs in Wakhan district of Badakhshan are also not included in comparisons between baseline and EOP values of indicators in one NGO catchment area, due to lack of comparable data from the baseline survey. This NGO had already conducted a baseline survey in this district soon before the introduction of the LQAS methodology. At that stage, REACH agreed that the NGO did not need to repeat the survey using the LQAS methodology. This NGO decided to use the same methodology it used for the baseline in undertaking midterm and EOP surveys. REACH's earlier decision was later reversed so that the NGO adopted the LQAS, and five new SAs were created in this district. Results of the surveys in these new SAs are not included in comparisons between baseline and EOP values for this NGO's catchment area.

Notes on the Midterm Household Survey Methodology

In addition to performing baseline and EOP assessments of the key outcome indicators for all grants (Rounds 1, 2, and 3), Rounds 1 and 2 NGO grantees conducted midterm household surveys in mid-2005. Round 3 grantees did not undertake a midterm survey due to the short duration of those grants and resulting limited time to undertake three rounds of surveys.

The Midterm Household Survey was highly focused, both in terms of number of indicators assessed and geographical areas where measurements were undertaken. The objective of this survey was to measure progress on three REACH three key indicators only in those SAs that had been judged the lowest performing at the baseline and thus the highest-priority areas for additional technical assistance within a grantee's catchment area. Performance at the baseline stage was measured against the average for the CA on each indicator. This SA was selected for the midterm survey.

The three indicators assessed in the midterm survey were the contraceptive prevalence rate, the percentage of deliveries attended by skilled birth attendants, and the rate of full immunization (with three doses of diphtheria, pertussis, and tetanus [DPT3] as the proxy measure). Figure 4 illustrates the approach to identification of the SAs requiring special attention and thus a targeted midterm survey.

Figure 4. Using baseline household survey findings at the SA level to prioritize one area for conducting a follow-up survey (midterm household survey)

	Contraceptive prevalence rate	Births attended by a skilled attendant	Children 1-2 fully immunized (DPT3)		
District/ Supervisory Area	Baseline status	Baseline status	Baseline status		
SA-1	●	●	●	●	Low Priority
SA-2	●	●	●	●	High Priority
SA-3	●	●	●	●	Medium Priority
SA-4	●	●	●		
SA-5	●	●	●		
Catchment Area (%)	21.3	4.3	10.3		

The REACH midterm survey followed the same sampling frame as the baseline for each selected SA. However, a new set of 19 random locations was identified using the LQAS sampling principles.

Data collection and analysis of data. The midterm survey focused only on high-priority SAs in an NGO grant catchment area and it provided information only at that level. This survey did not provide a new quantitative estimation for the three indicators. The survey questionnaire was simplified to a three-page checklist where the results could be recorded and analyzed concomitantly (see Annex 2). In the selected SAs, the midterm survey was continued only until a decision about the new status of the SA could be made. This decision showed whether there had been a change in the status of each indicator. Whenever these decisions were reached for all three indicators, the survey was stopped to save additional data collection time and expense. Findings of the midterm survey were used primarily for management purposes, both to measure progress in the areas that were given additional attention after the baseline survey and to identify areas requiring additional targeted technical assistance.

Findings

While the results of the Baseline Household Survey for Rounds 1 and 2 NGO grants have been reported elsewhere,³ this report represents the first formal presentation of the results of the EOP surveys by all REACH NGO grantees. It also presents the results of midterm surveys for Rounds 1 and 2 grantees and the baseline results for Round 3 grantees.

Overall Findings of the Midterm Household Survey

The midterm survey was carried out in 27 high-risk SAs. The survey did not provide a new measurement of coverage for the three target indicators. Like the baseline survey, the midterm survey applied the LQAS analysis approach to classify the performance of a given SA, in comparison with targets set at the time of the baseline data analysis.

The findings of midterm household survey are presented in Figures 5, 6, and 7. Improvement is seen for all three indicators, grossly indicated by the dramatic decrease in the number of low-performing SAs (in red). The most remarkable improvement is in the DPT3 vaccination rate, for which no more low-performing areas were identified during the midterm assessment.

Figure 5. Number of low-performing SAs for DPT3 vaccination rate

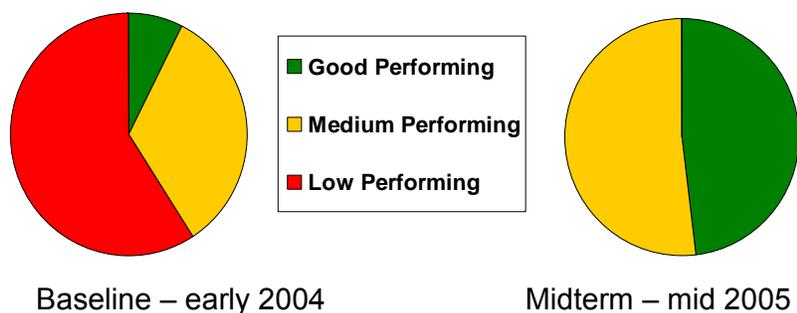
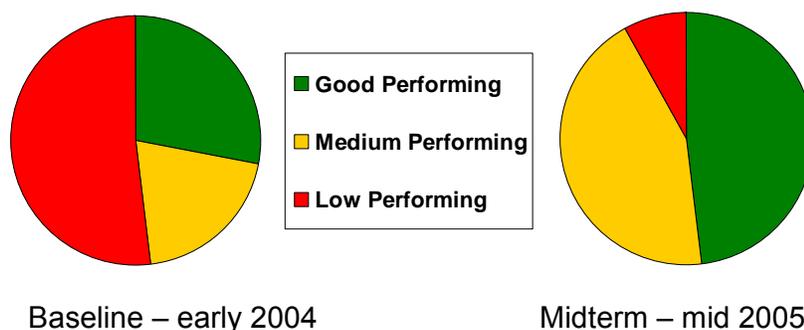
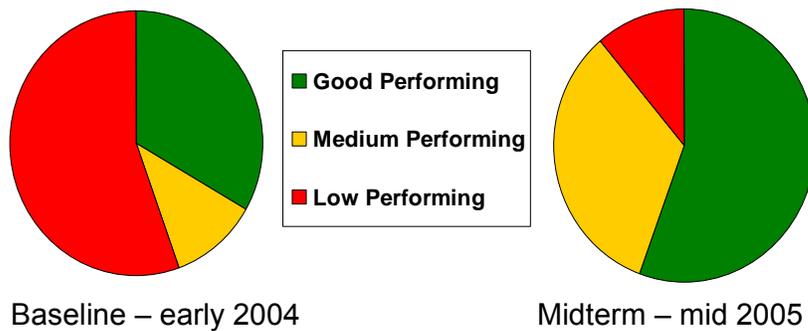


Figure 6. Number of low-performing SAs for contraceptive prevalence rate



³ Omid Ameli, Paul Ickx, and Sallie Craig Huber, *NGO Grantees' Baseline Household Survey: Report on the Results* (MSH/REACH, Afghanistan, October 2004).

Figure 7. Number of low-performing SAs for deliveries attended by skilled birth attendants



NGOs used the midterm household survey findings to assess progress as well as to adjust their EOP targets. In many cases, NGO grantees also used the midterm findings to set new targets. If improvements were noticed in the surveyed SAs, NGOs were also encouraged and supported to focus on a new round of high-priority SAs for targeted technical assistance following the midterm assessment. Two NGOs conducted additional midterm surveys in other high-priority SAs in their catchment areas.

Why the EOP findings are presented separately for Rounds 1 and 2 and for Round 3

Data for Round 3 grants are analyzed and presented separately from those for Rounds 1 and 2 because Round 3 grants started later and thus the grant duration was shorter. Also, more than 40% of the population covered by Round 3 grants is urban. Because of a high level of urban representation in the Round 3 dataset, the baseline values are higher overall than the baseline values of Rounds 1 and 2 grants. Also, while all 10 indicators show some improvement in Round 3 grants, 5 of the 10 findings are not statistically significant. This is probably due to the shorter timeframe between the baseline and EOP surveys for these grants. The overall REACH results for both data sets are presented in Annex 3.

Findings for Rounds 1 and 2 EOP data

Between the 2004 and 2006 surveys (Rounds 1 and 2 grants), the contraceptive prevalence rate (CPR) improved almost 10 percentage points and knowledge about at least two modern contraceptive methods increased two and one-half times (see Figure 8). Both of these improvements are statistically significant.

Data from the national Health Management Information System (HMIS), developed and introduced over the same period with technical assistance from REACH, shows that much of this improvement can be attributed to expansion of family planning services and activation of trained Community Health Workers (CHW) who are authorized to provide some contraceptive methods (orals, injectables, and condoms) at the community level. Figure 9 demonstrates the growth in provision of family planning services during 2005 as recorded by the HMIS. Provision of contraceptives by CHWs increased nearly eight-fold during the year so that by the end of 2005 the CHWs' overall contribution accounted for well over half of the total family planning services provided. Services are presented in this figure in terms of couple-months of protection, a concept developed for use by the REACH Program to assist NGO grantees with regular monitoring of grant performance.

Figure 8. Baseline and EOP status of reproductive health indicators in REACH Rounds 1 and 2 grants

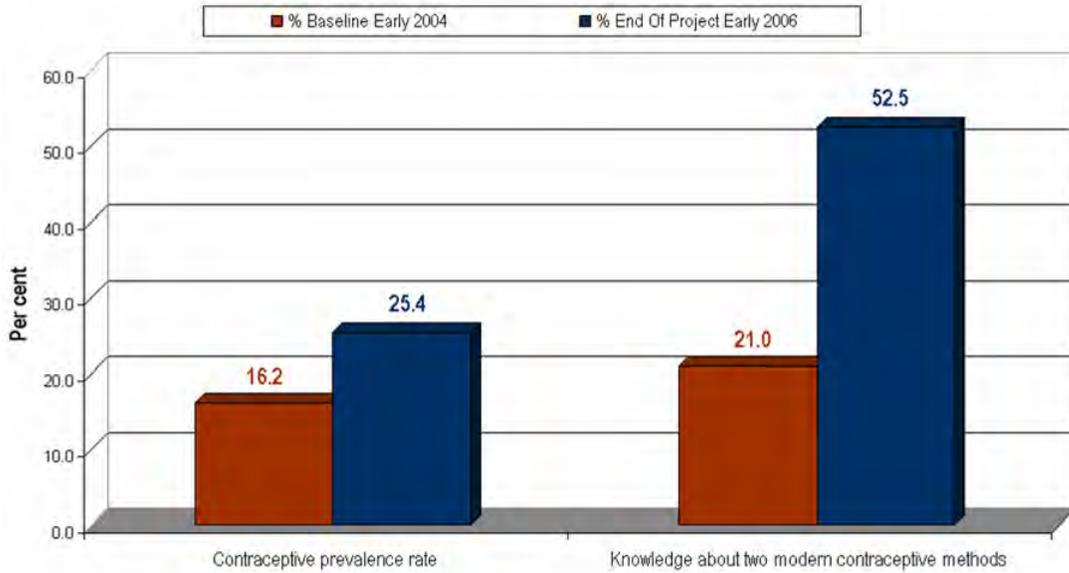
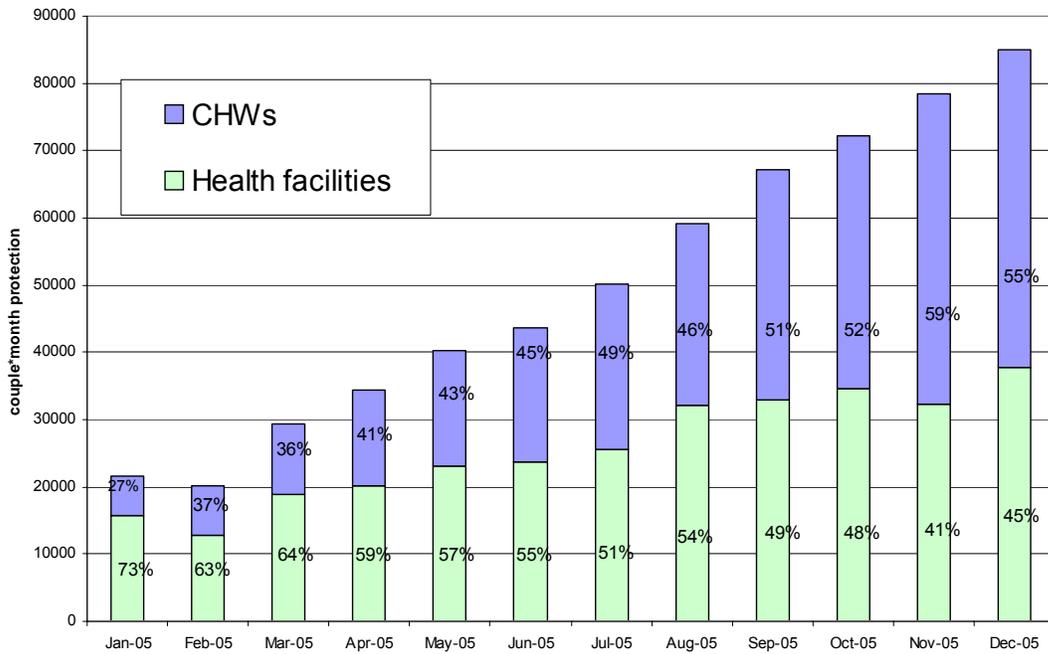


Figure 9. Improved provision of family planning services through REACH supported facilities and CHWs (by couple-months of protection)*

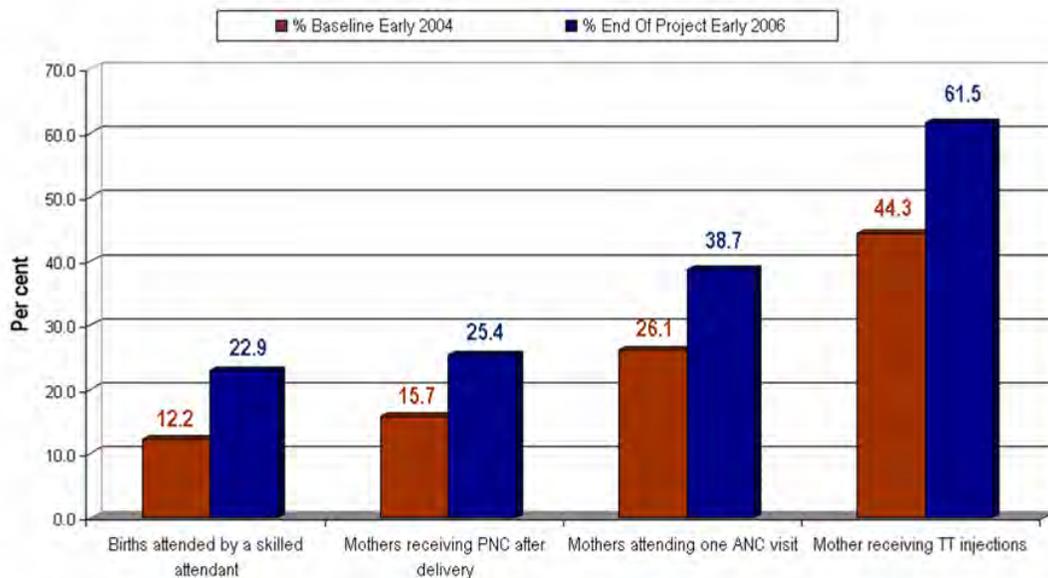


Source: Afghanistan's National Health Management Information System

* Couple-months of protection is a concept used by the REACH Program to assist NGO grantees with grant monitoring.

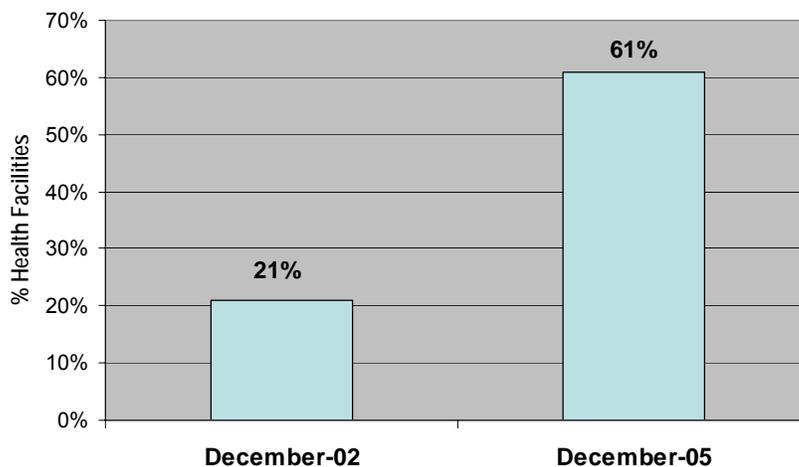
Among safe motherhood indicators, improvement is seen in all four measurements. A key REACH indicator, deliveries attended by trained doctors, nurses, or midwives, nearly doubled compared to the baseline status. Postnatal and antenatal care coverage increased by about 10 and 12 percentage points, respectively, and tetanus toxoid immunization coverage for pregnant women also improved by more than one-third. All four changes presented in Figure 10 are statistically significant.

Figure 10. Baseline and EOP status of safe motherhood indicators in REACH Rounds 1 and 2 grants



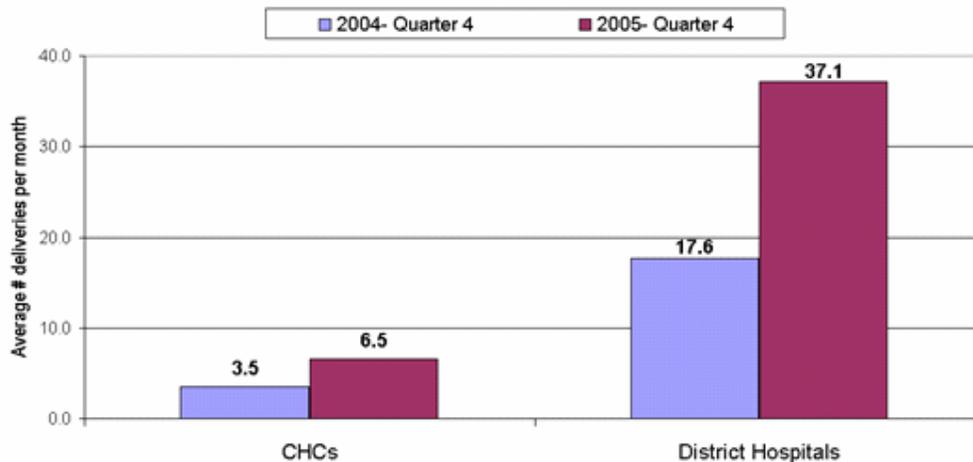
Apparently, the improvements in safe motherhood indicators and in births attended by trained attendants, in particular, can be attributed to expanded capacity as well as real increase in number of services provided. According to the national HMIS, the proportion of health facilities in REACH program districts with at least one female doctor, nurse, or midwife almost tripled by December 2005 compared to the situation before the start of the REACH grants as measured by the Afghanistan National Health Resource Assessment in December 2002 (see Figure 11). In terms of service outputs, the average number of deliveries per month per health facility also increased dramatically.

Figure 11. Proportion of REACH facilities with female MD, nurse, or midwife



In the last quarter of 2004, a monthly average of 3.5 deliveries took place in REACH Comprehensive Health Centers (CHCs). This figure almost doubled during the following year. The same trend applies to the district hospitals. Comparing the last quarters of 2004 and 2005, the average number of deliveries more than doubled in these hospitals (see Figure 12).

Figure 12. Average number of deliveries per month by type of facility (REACH-supported facilities)



Source: National Health Management Information System

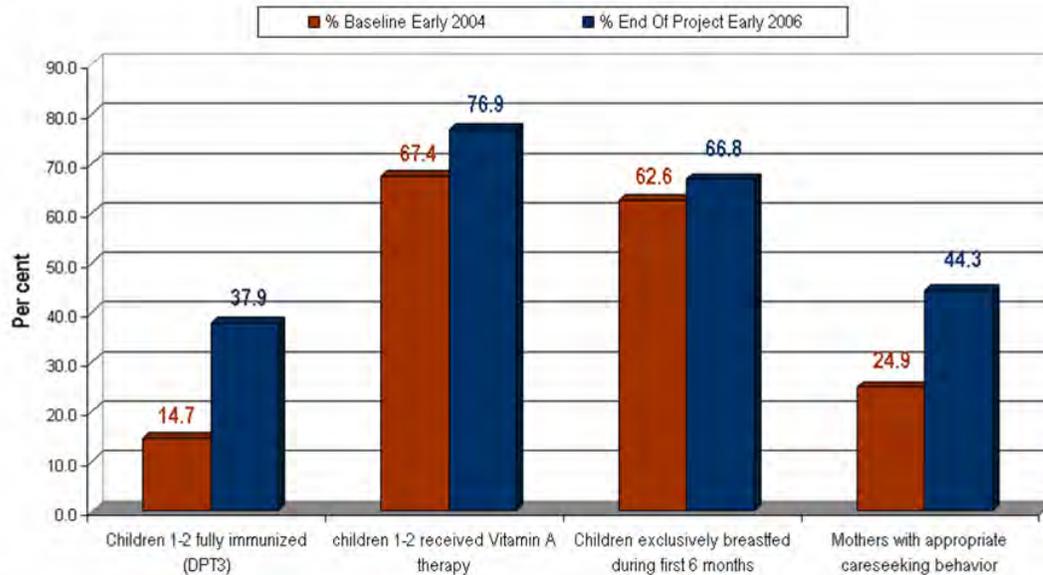
The EOP household survey results show that the DPT3 coverage improved more than two and one-half times over the baseline measure (see Figure 13). It is important to note that the REACH survey verified vaccination coverage by asking to see the child’s vaccination card. A positive response was given on this measure only if the card documented that a full course of three DPT vaccinations had been received. This approach to measuring immunization coverage differs from the approach of the Expanded Programme on Immunization and other surveys in Afghanistan, which accept the respondent’s recall of immunizations if no card is available.

Two other child health indicators also showed improvement. Prevalence of appropriate care-seeking behavior increased nearly 20 percentage points to 44 percent. This indicator demonstrates whether mothers of children under 2 years of age who have recently had one of the following three conditions—diarrhea, fever, or acute respiratory infection—could report correct care-seeking practices. Coverage for vitamin A therapy, already high at the baseline measurement, also showed significant improvement, with over three-fourths of all children covered.

The improvement in vaccination coverage in REACH grantee areas can be attributed mainly to an expanded capacity to provide vaccination in the clinics and through community-based outreach. Vehicles, cars, or motorbikes were purchased to boost vaccination outreach activities. The improvement in care-seeking behavior of families may be attributed to REACH’s information, education, and communication initiatives, including the development of educational materials for use at both health facilities and in the community, as well as to the educational role of CHWs in the communities.

The one indicator that shows minimal or no change in the EOP survey is exclusive breastfeeding. The modest improvement in this indicator proved to be statistically insignificant.

Figure 13. Baseline and EOP status of child health indicators in REACH Rounds 1 and 2 grants



Changes at the grant catchment area level

Annex 4 provides comprehensive comparisons between baseline and EOP survey findings for all indicators. Across all catchment areas of Round 1 and Round 2 grants, the DPT3 vaccination rate demonstrated an invariable positive trend. The improvements ranged from a minimum of +6 % in one CA in Jawzjan to a maximum of +54% in Paktika.

Three other indicators showed a similar but not totally positive trend: TT vaccination for pregnant women, knowledge about at least two modern contraceptive methods, and births attended by trained birth attendants. The average change for these indicators was +17% for TT vaccination, +32% for knowledge about at least two modern contraceptive methods, and +11% for births attended by trained providers.

For two indicators, more than one-third of the CAs showed a decline: children 1–2 years who received vitamin A therapy and children exclusively breastfed during first 6 months. The decline ranged from –5 to –39%.

Four CAs showed a decline in almost half of the indicators: –1 Gulran (Herat), –2 Rabat Sangi (Herat), –3 Taloqan, Kalafghan, Rustaq, Bangi, Farkhar, Chah Ab (Takhar), and –4 Khojadoko, Qarqin, Khamyab (Jawzjan).

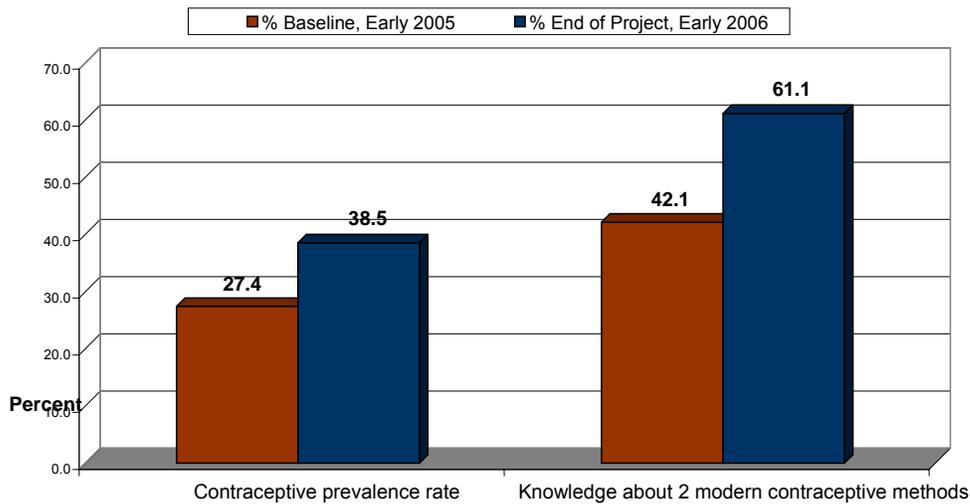
Paktika catchment area showed an average 40 percentage point improvement in almost all indicators. This finding makes this grant an obvious outlier compared to other grants. Records of the survey quality control activities and a preliminary investigation do not support the possibility of bias due to sampling, data collection, or data entry flaws. Further investigation is recommended to identify best practices in Paktika or determine other possible sources of bias.

Round 3 baseline and EOP survey data

The baseline values of all of the indicators for Round 3 grants are higher than the values of the indicators in Rounds 1 and 2 (see Annex 3). This is due to high proportion of the urban population included in this survey group. More than 40 percent of the population represented by Round 3 data lives in six sectors of Kabul City.

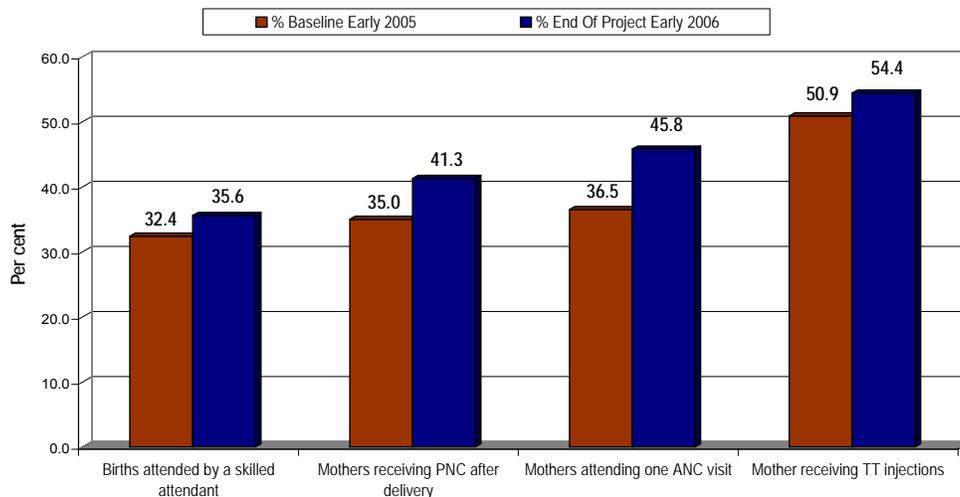
Despite the shorter duration of Round 3 grants, both reproductive health indicators show levels of improvement similar to those in the Rounds 1 and 2 survey. A greater than 11 percentage point improvement in the CPR and 19 percentage point increase in knowledge about at least two contraceptive methods was found (see Figure 14). Both changes are statistically significant.

Figure 14. Baseline and EOP status of reproductive health indicators in REACH Round 3 grants



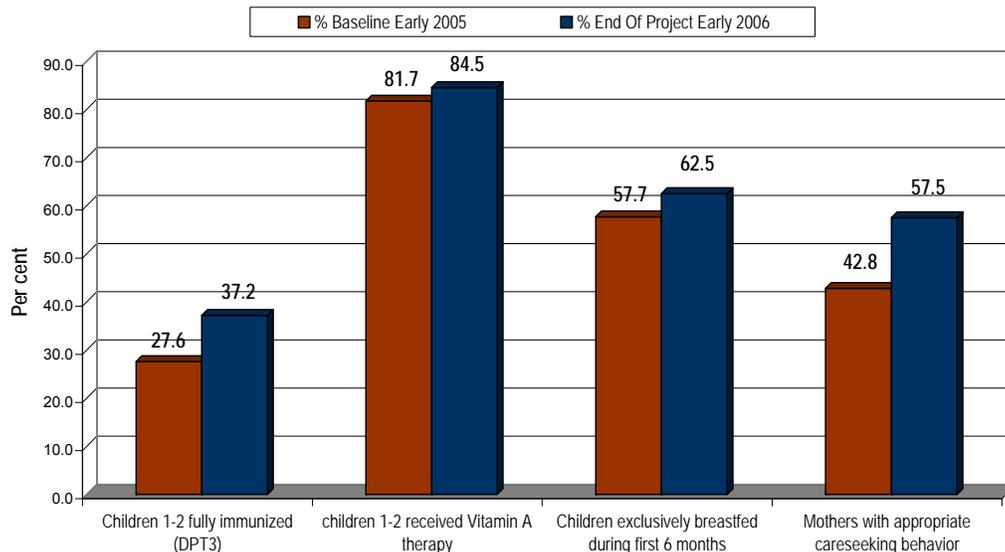
Three of the four safe motherhood indicators show only modest improvement that is not statistically significant. These include births attended by skilled birth attendants, mothers receiving PNC after delivery, and TT immunization of pregnant women. Coverage of antenatal care, however, improved by more than 9 percentage points, which is statistically significant (see Figure 15).

Figure 15. Baseline and EOP status of safe motherhood indicators in REACH Round 3 grants



Two out of four child health indicators improved significantly over the baseline status: DPT3 vaccination rate and prevalence of appropriate care-seeking behavior (see Figure 16). Modest improvements in the number of children receiving vitamin A and exclusive breastfeeding were not statistically significant.

Figure 16. Baseline and EOP status of child health indicators in REACH Round 3 grants



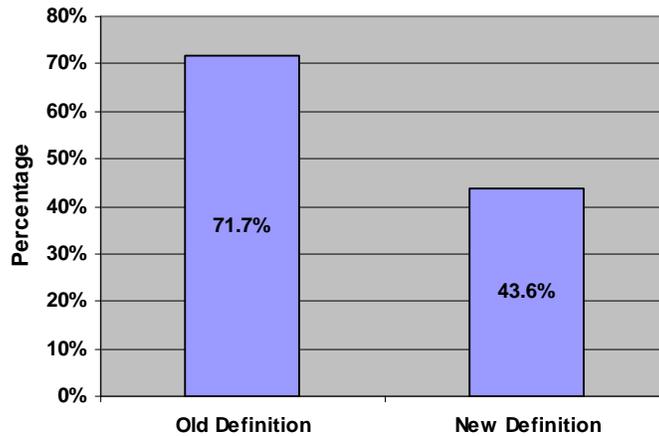
Analysis of questions added to the EOP survey

Several new questions were added to the EOP survey either at the request of other partners or to attempt to clarify responses to the baseline survey. It is hoped that these new details can be further studied in any follow-on surveys to measure change over time. Some of these questions were analyzed using the total sample of R1+R2+R3 and a few additional districts, not included in the original baseline and excluded from the EOP analysis. The total number of households in this population is 1,205,165, against the 1,181,503 in the REACH EOP analysis. The results below are based on the data of the sample drawn from the 1,205,165 households, which is slightly different from the sample used to compare baseline and EOP (see Annex 5).

1. Exclusive breastfeeding

The comparison between EOP and Baseline uses all women that claimed exclusively breastfeeding their infant up till 6 months of age. With this definition, 71.7% of infants were exclusively breastfed. An additional question asked mothers of infants under 12 months of age what food was given in the 24 hours before the survey. Only those infants receiving only breast milk, and, where appropriate, prescribed medicine or ORS, were counted as exclusively breastfed. This gives an average of 43.6%.

Figure 17: Exclusive breastfeeding – comparing definitions

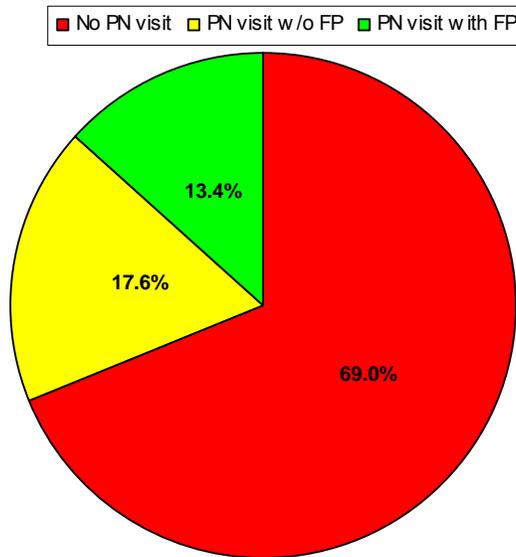


Future assessments should use the “new definition” of exclusive breastfeeding.

2. Missed opportunities for Family Planning

Postnatal care visits are excellent opportunities for discussing family planning with women. A question was added to Questionnaire 1 to assess whether a contraceptive was offered to women that received postnatal care. Only 31 percent of the women received a postnatal check-up. Less than half (43.1%) of the women that claimed to have received postnatal care also confirmed that a family planning method had been offered during the postnatal consultation. This indicates room for improvement by diminishing the lost opportunities, through increasing the number of women that receive postnatal check-ups, and routinely offering contraceptives during postnatal check-ups.

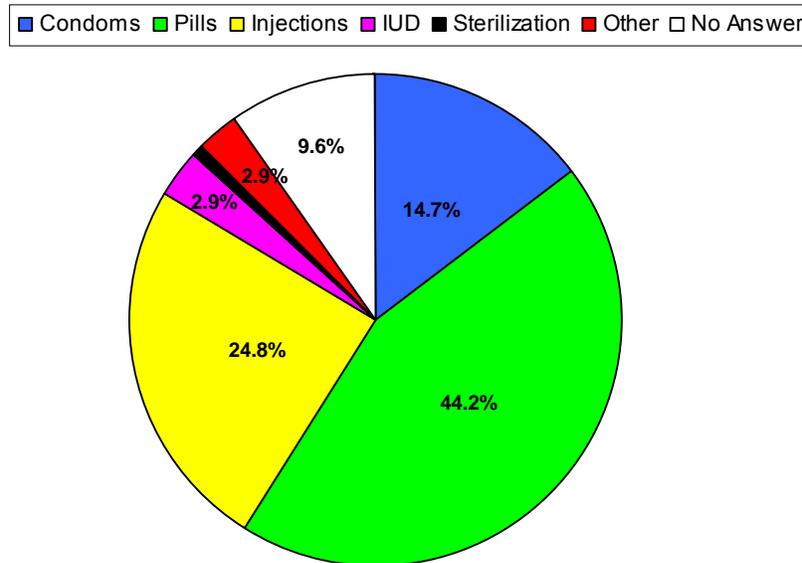
Figure 18: Missed opportunities for Family Planning



3. Contraceptive method mix.

The contraceptive prevalence rate (women reporting that they or their partner are using at least one modern method of family planning) in this sample is 34.6 percent. Almost half (44.2%) of these women reported using oral contraceptives and almost one-fourth (24.8%) reported using injectable contraceptives. Condoms were mentioned less frequently (14.7%), and IUDs rarely (2.9%). Hardly any (>1%) mentioned permanent contraceptive methods. Almost a tenth (9.6%) of the interviewed women did not mention the specific method used (see Figure 19).

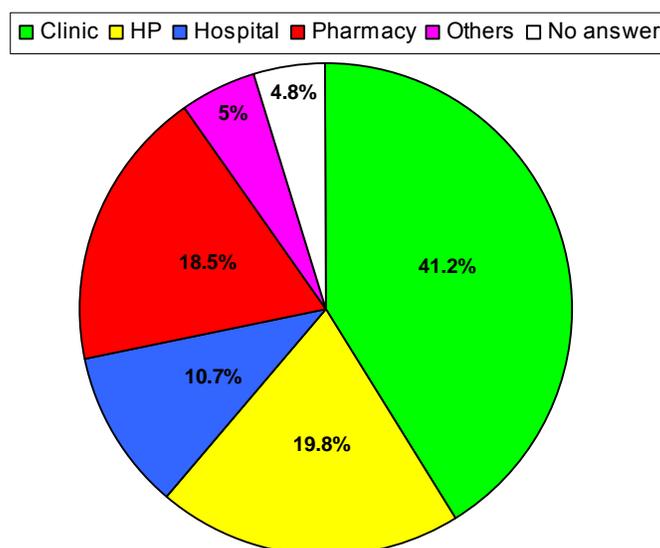
Figure 19: Contraceptive Method Mix



4. Where was the family planning method obtained?

Users of modern contraceptive methods were asked where the method was obtained. More than two-fifths (41.2%) claimed they obtained the method at a clinic (BHC or CHC) Both the health post (19.8%) and the pharmacy (18.5%) were mentioned by almost a fifth of the FP users. About a tenth (10.7%) of the FP users claimed they obtained their method at a hospital. Other sources were mentioned by 5% of the users; this includes private practitioners (1.3%) and non-pharmacy commercial outlets (2.4%). The question was not answered by 4.8% of the users (see Figure 20).

Figure 20: Where did FP users obtain the FP method?



The large majority of the contraceptives are obtained in the public sector (health posts, clinics and hospitals), where most services are provided by the REACH-funded NGOs. In addition, many of the pharmacies mentioned are not necessarily commercial pharmacies, but pharmacies attached to hospitals.

5. Method mix by source of contraceptives

Figure 20 showed that almost 80% of clients obtained their contraceptive from clinic, health post or pharmacy. Comparing the method mix for these three sources draws the attention to a peculiar finding. Both at clinic and pharmacy, clients are more likely to end up with either an oral contraceptive or a contraceptive injection than a condom. Health posts seem to provide condoms twice as frequently as clinics and three times as frequently as pharmacies. Health posts provide contraceptive injections less frequently than clinics and pharmacies. One reason may be that the provision of contraceptive injections is a rather recently implemented policy of the MoPH and not all health posts have been provided with this contraceptive. Also, CHWs are only trained in its use during the third phase of the CHW training.

Figure 21: Method mix by source of contraceptives

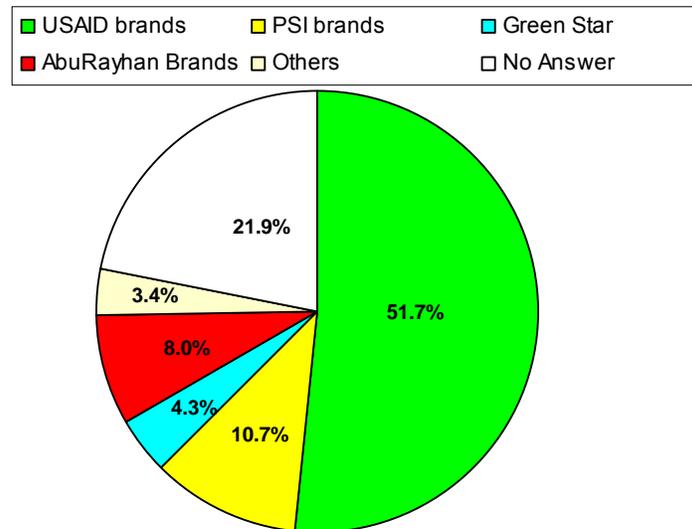
Where Obtained	Pill		Condom		Injection	
	#	%	#	%	#	%
Hospital	47	61.0%	8	10.4%	22	28.6%
Clinic	222	43.2%	69	13.4%	223	43.4%
HealthPost	122	47.7%	77	30.1%	57	22.3%
Pharmacy	76	59.4%	11	8.6%	41	32.0%
Private	2	33.3%	0	0.0%	4	66.7%
Shop	3	37.5%	2	25.0%	3	37.5%
Total	472	47.7%	167	16.9%	350	35.4%

Clinics provide contraceptive injections as frequently as oral contraceptives. At hospitals and pharmacies pills are provided twice as frequently as contraceptive injections. There may be need for more information on injectable contraceptives in these facilities.

5. Brands of Pills and Condoms used

The majority (51.7%) of users of oral contraceptives and condoms mentioned one of the contraceptive brands provided by USAID through REACH. Slightly more than 10 percent were using contraceptives made available through social marketing in Afghanistan. Eight percent used contraceptives marketed in Iran and 4 percent used contraceptives marketed in Pakistan. Other brands were mentioned by 3.4 percent of the users, including the brand distributed by Marie Stopes (0.4%). One fifth of the users (21.9%) were not able to name the brand they used (see Figure 22).

Figure 22: Brands of Pills and Condoms



6. Satisfaction of clients

Additional questions assess the satisfaction of FP users and mothers that consulted with a sick child. The detailed analysis these questions is under way and will be distributed in a separate report. It will allow to monitor this aspect of quality of care in the future.

NGO grantees' perspectives on the usefulness of the LQAS experience

As noted above, REACH required each NGO to submit an EOP household survey. The standard template for this report included questions of the NGOs about their experience in using the LQAS methodology. A review of these responses revealed a generally positive assessment of the household survey experience with only a few complications and challenges.

On the positive side, many of the NGOs mentioned that undertaking these surveys at least twice, and three times in the case of Rounds 1 and 2 grantees, gave them opportunities to:

- improve management of their grants;
- identify strengths and weaknesses in project implementation;
- accurately measure the outcome of their efforts at the community level and above;
- enhance the quality of services;
- establish better relations with the communities they served.

One NGO summarized these positive impressions as follows:

“One of the best things about LQAS methodology is that it evaluates progress made in each SA and helps project staff make appropriate plans for further improvements in health service delivery.”

Another mentioned that “the LQAS methodology is very practical and efficient not only for providing comprehensive information on health activities but, in any other project impact assessments, the method could be effective and informative.”

Negative assessments of the methodology mentioned by a few of the grantees referred primarily to cultural and security issues that impeded implementation of the survey, including:

- difficulty in finding female interviewers;
- security concerns, such as landmines and opium poppy eradication efforts, which made villagers distrustful of strangers entering the community;
- poor roads and other geographic constraints;
- winter weather conditions, which limited access to survey villages.

The positive assessments, however, far outweighed the negative. One NGO commented that the simplicity of the methodology, its cost-effectiveness, and satisfying results made it “very useful for us and we wish that this method would be accepted as the national tool for undertaking similar surveys in Afghanistan.”

Conclusions and Recommendations

Use of the LQAS methodology to measure REACH Program results on the scale in which it was used in Afghanistan was a high-risk venture. Fortunately this initiative had a successful outcome for all. REACH was able to demonstrate definitive outcome results of its work in rebuilding the health care system in Afghanistan and increasing the use of basic health services. REACH’s partner NGOs were able to collect and use the data from their intervention areas for both reporting and management purposes. The MoPH and USAID were pleased to have access to reliable REACH Program results in a very short period of time.

The major recommendation resulting from REACH’s experience with this methodology for undertaking household surveys is that the use of LQAS should be further developed and expanded for use in measuring health outcome indicators throughout Afghanistan. REACH’s EOP survey findings should be used as the baseline for the newly funded USAID health services project. The LQAS methodology would also lend itself to additional use in measuring the results of other development interventions, such as education projects, in Afghanistan and elsewhere.

Annex 1. EOP Household Survey Questionnaires

REACH
Access to Quality Health Services Program

End of Project Household Survey

Due: End of Quarter _____

Name of NGO: _____

Grant ID: _____

Supervisory Area No.: _____

Description of Supervisory Area Surveyed:

Name of Supervisor: _____

Signature of Supervisor: _____

Start date of survey: _____

End date of survey: _____

Checklist for covered respondents:

- | | |
|---|---|
| <input type="checkbox"/> Mother of child 0 to 11 months | <input type="checkbox"/> Woman 15 to 49 years, not pregnant |
| <input type="checkbox"/> Mother of child 12-23 months | <input type="checkbox"/> Mother of sick child 0-2 years |

DIRECTIONS

Step 1: Introduce yourself and explain the purpose of the survey.

Introduce yourself to the appropriate person. Explain that you are conducting a survey of randomly selected households in the area of _____ clinic/hospital. Show the letter of introduction from your NGO and/or provincial health authority if needed. You may also be introduced by a community leader.

Explain the purpose of the survey. The survey will provide valuable information about the community so that the _____ clinic/hospital can provide the services that the community needs. Ask for permission to conduct the survey in with selected members of the household. Answer any questions that may be asked of you.

Step 2: Complete summary sheet of household members

The intent of the summary sheet is to inventory all household members. The total number of household members will be used to calculate the average number of people living in households, in a village and catchment area. Similarly, the number of people in different groups of interest (e.g., women of reproductive age and children less than 5 years) can be estimated.

Begin by listing the name of the head of the household and work your way across the sheet. Complete one row as appropriate for each member of the household, including infants.

Step 3: Conduct interviews with selected household members

Review the summary sheet and identify one eligible respondent for the target groups of interest. The sample should reflect the following:

↑ Mother of a child 0 to 11 months (Respondents to Questionnaire 1)

OR

↑ Mother of a child 12 to 23 months old (Respondents to Questionnaire 2)

AND

↑ Married women 15 to 49 years of age *not currently pregnant* (Respondents to Questionnaire 3)

AND

↑ Mother of a sick child 0 to 23 months old (Respondents to Questionnaire 4)

Note 1: Respondents to questionnaire 1 and 2 are considered mutually exclusive; however, the same woman can be eligible for responding to questionnaires 1, 3 and 4, or 2, 3 and 4.

Note 2: Likewise, do not interview two separate mothers from the same household for questionnaires 1 and 2! If you interview a mother with questionnaire 1 in a household, you must go to the next nearest household to identify and interview a mother for questionnaire 2. You can apply questionnaires 3 and 4 to either of the two women.

Note 3: All 4 types of questionnaires must be completed at each interview/random location, either by interviewing 2 or more eligible women.

Then,

- ✓ Ask to briefly interview the selected respondent, preferably in a private setting. Explain the purpose of the interview and that it will take more than 10 minutes.
- ✓ Assure the respondent of confidentiality (that results will never be used to identify her).
- ✓ Obtain permission to conduct the interview.

Step 4: Complete the interview

Ask if the interviewee has any questions and address them. Thank her for her time.

Survey Start Year		A. Household information									
Household Number	1 2 3 4 5 6 7 SA					Village			District	Province	
Tick interviewee	Children				Adults more than 15 years (born before 1370 (1991))			Sex M/F	A1. Population		
	5 to 14 years ✓	2 to 4 years ✓	12 to 23 months ✓	0 to 11 months ✓	Currently pregnant? ✓	Marital Status S/M/D/W	Year of Birth		Name of Household Member	SN	
											1*
											2
											3
											4
											5
											6
											7
											8
											9
											10
											11
											12
											13
											14
											15
											16
											17
											18
											19
											20

Definitions:

Instructions:

Marital Status: S=Single, M=Married, D=Divorced, W=Widowed	* indicates "household head"
	Identify mothers of children 0 to 23 months of age
	Circle the SN of the persons to be interviewed in this household

Name of data collectors: 1) _____ 2) _____

Date of interview: _____ Time started: _____ : _____ Time finished: _____ : _____

QUESTIONNAIRE 1: MOTHER OF CHILD 0 TO 11 MONTHS

<p>[a] 0 to 6 months [b] 7 months to 11 months [c] 12 months or more -----></p>	<p>1. How many months old is the youngest child? (<i>confirm name and age from summary sheet</i>)</p> <p>STOP AND CHANGE TO QUESTIONNAIRE 2</p>
<p>[a] Your home [b] Home of another person [c] Hospital [d] Clinic [e] Health post</p>	<p>2. Where did you give birth to “name”?</p>
<p>[a] No one [b] A friend or relative [c] A dai [d] Trained midwife [e] Nurse or doctor</p>	<p>3. Who helped you with the delivery of “name”? Who else? PROBE FOR MOST QUALIFIED PERSON</p>
<p>[a] No [b] Yes, C-section [c] Yes, other _____</p>	<p>4. Were there any complications during the delivery?</p>
<p>[a] Yes [b] No → Q 7 [c] Don't remember → Q 7</p>	<p>5. <u>While pregnant with</u> “name”, did you receive a visit from a community health worker or did you go to a clinic to receive information about your pregnancy?</p>
<p>[a] Doctor [b] Nurse/midwife [c] Auxiliary midwife [d] Trained DAI [e] CHW [f] Other, specify: _____</p>	<p>6. What person did you see? Anyone else? PROBE FOR MOST QUALIFIED PERSON</p>
<p>[a] Yes (<u>number</u>) [b] No [c] Don't remember</p>	<p>7. <u>While pregnant</u> with “name” did you get an injection in the arm (shoulder)?</p> <p>CONTINUE ON BACK SIDE OF THIS PAGE</p>

<p>[a] Yes [b] No → Q 10 [c] Don't remember</p>	<p>8. <u>After giving birth</u> to “name”, did anyone check your health?</p>
<p>[a] Doctor [b] Nurse/midwife [c] Auxiliary midwife [d] Trained dai [e] CHW [f] Other, specify: _____</p> <p>[a] Hospital [b] Clinic [c] Health Post [d] Other, Specify: _____</p> <p>Days: _____ Weeks: _____</p> <p>[a] Yes [b] No</p>	<p>9. Who checked your health? PROBE FOR MOST QUALIFIED PERSON</p> <p>9a. Where did you check your health?</p> <p>How many days or weeks after the delivery was your health checked for the first time? (write “00” if checked same day)</p> <p>9b. Were you offered a family planning method after your health check up?</p>
<p>[a] Yes [b] No</p>	<p>9c. Are you or your partner <u>currently</u> using something or using any method to delay or avoid getting pregnant?</p>
<p>[a] Yes [b] No → Q 14</p> <p>[a] Vitamin/Medicine/ORS [b] Water with or without sugar [c] Juice, tea, or any herbal [d] Solid food [e] Liquid food [f] Powdered milk [g] Cow or other animal milk [d] Breast milk</p>	<p>10. Did you ever breastfeed “name”?</p> <p>10a. Since this time yesterday till now, which one of these items did “name” receive? (Prompt each item)</p>
<p>[a] Within first hour [b] Within first 8 hours [c] After first 8 hours</p>	<p>11. How long after the delivery did you first breastfeed “name”?</p>

<p>[a] Yes → 14 [b] No</p>	<p>12. Are you breastfeeding “name” now?</p>
<p><input type="text"/> <input type="text"/> months</p>	<p>13. For how long did you breastfeed “name”? IF LESS THAN ONE MONTH WRITE “00” months</p>
<p>[a] Have not begun (still breastfeeding only) [b] Before 4 months [c] After 4 months, before 6 months [d] After 6 months</p>	<p>14. How long after birth did you start giving food other than breast milk to “name”?</p>

QUESTIONNAIRE 2: MOTHER OF CHILD 12 TO 23 MONTHS

The following questions refer to a child 12 to 23 months only. Confirm the name and age from the summary sheet.

<p>[a] Yes [b] Yes, but lost it → 4 [c] Never had a card → 4</p>	<p>1. Do you have a card where “name’s” vaccinations are noted? If YES: May I see it?</p>																																												
<table border="1"> <thead> <tr> <th></th> <th>Day</th> <th>Month</th> <th>Year</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>P0</td><td></td><td></td><td></td></tr> <tr><td>P1</td><td></td><td></td><td></td></tr> <tr><td>P2</td><td></td><td></td><td></td></tr> <tr><td>P3</td><td></td><td></td><td></td></tr> <tr><td>D1</td><td></td><td></td><td></td></tr> <tr><td>D2</td><td></td><td></td><td></td></tr> <tr><td>D3</td><td></td><td></td><td></td></tr> <tr><td>Meas</td><td></td><td></td><td></td></tr> <tr><td>Vit A</td><td></td><td></td><td></td></tr> </tbody> </table>		Day	Month	Year	BCG				P0				P1				P2				P3				D1				D2				D3				Meas				Vit A				<p>2. Copy dates of each antigen from the card, write “00” when card shows vaccination was given, but date is missing or illegible</p> <p>BCG Polio 0 Polio 1 Polio 2 Polio 3 DPT 1 DPT 2 DPT 3 Measles Vitamin A (most recent)</p>
	Day	Month	Year																																										
BCG																																													
P0																																													
P1																																													
P2																																													
P3																																													
D1																																													
D2																																													
D3																																													
Meas																																													
Vit A																																													
<p>[a] Yes [b] No [c] Don’t know</p>	<p>3. Has “name” received any vaccinations that are not recorded on the card? CONTINUE WITH QUESTION 8</p>																																												
<p>Complete the following only if the answer to question 3 is ‘Yes’.</p>																																													
<p>[a] Yes (_____ number) [b] No [c] Don’t know</p>	<p>4. Has “name” ever been given any ‘vaccination drops in the mouth’ to protect him/her from getting polio?</p>																																												
<p>[a] Yes (_____ number) [b] No [c] Don’t know</p>	<p>5. Has “name” ever been given ‘vaccination injections’ in the mid-outer surface of thigh – to prevent him/her from getting DPT (tetanus, whooping cough, diphtheria)?</p>																																												
<p>[a] Yes (_____ number) [b] No [c] Don’t know</p>	<p>6. Has “name” ever been given ‘vaccination injections’ in the outer part of upper right arm at the age of 6 months or older – to prevent him/her from getting measles within the last year?</p>																																												
<p>[a] Yes [b] No [c] Don’t know</p>	<p>7. Has “name” received drops from a vitamin A capsule from a health worker during the last six months? (<i>describe a green and red capsule</i>)</p> <p>CONTINUE ON BACK SIDE OF THIS PAGE</p>																																												

[a] Yes [b] No → 12	8. Did you ever breastfeed “name”?
[a] Within first hour [b] Within first 8 hours [c] After first 8 hours	9. How long after the delivery did you first breastfeed “name”?
[a] Yes → 12 [b] No	10. Are you breastfeeding “name” now?
<input type="text"/> <input type="text"/> months	11. For how long did you breastfeed “name” IF LESS THAN ONE MONTH WRITE “00” months
[a] Have not begun (still breastfeeding only) [b] Before 4 months [c] After 4 months, before 6 months [d] After 6 months	12. How long after birth (at what age) did you start giving other foods than breast milk?

QUESTIONNAIRE 3: MARRIED WOMEN 15–49 YEARS OLD, NOT PREGNANT

_____ (number) IF “1” → Question 3	1. How many of your children are under the age of five? (including “name,” if this is a mother)
_____ (number)	2. How old is your youngest child (“name” if known)?
_____ (number)	3. How old is the child born before your youngest child/“name”?
[a] Yes → STOP [b] No [c] Unsure	4. Are you presently pregnant?
[a] Yes [b] No [c] Don’t know	5. Do you want to have another child in the next 2 years?
[a] Yes [b] No → STOP	6. Have you heard of any methods that a man or woman can use to avoid pregnancy?
[a] Pill [b] Injection [c] Condom [d] IUD [e] Sterilization (male/female) [f] Other _____ [g] None	7. Can you name or describe some methods? (Check all those that are mentioned)
[a] Hospital [b] Clinic [c] Health Post / CHW [d] Pharmacy [e] Other health provider [f] Shop [g] Friend/relative [h] Other: _____ [z] Don’t know	8. Do you know a place where you could obtain a product/method for child spacing? (Check all those that are mentioned)
[a] Yes [b] No	9. Have you ever used any modern birth spacing method? (Don’t ask if already mentioned) CONTINUE ON BACK SIDE OF THIS PAGE
[a] Pill	10. Are you or your partner <u>currently</u> using something or using any

<input type="checkbox"/> [b] Injection <input type="checkbox"/> [c] Condom <input type="checkbox"/> [d] IUD <input type="checkbox"/> [e] Sterilization (male/female) <input type="checkbox"/> [f] Other _____ <input type="checkbox"/> [g] None			method to delay or avoid getting pregnant? Which method are you using?
<input type="checkbox"/> [a] Hospital <input type="checkbox"/> [b] Clinic <input type="checkbox"/> [c] Health Post / CHW <input type="checkbox"/> [d] Pharmacy <input type="checkbox"/> [e] Private health provider <input type="checkbox"/> [f] Shop <input type="checkbox"/> [g] Other: _____			11. Where did you receive this product?
<input type="checkbox"/> [a] USAID (Blue Lady or condom) <input type="checkbox"/> [b] PSI (#1 or OK) <input type="checkbox"/> [c] Green Star (Nova or Satti) <input type="checkbox"/> [d] Marie Stopes (Aramesh) <input type="checkbox"/> [e] Aburayhan/Iran (LD or HD) <input type="checkbox"/> [f] Other (record the name) _____			12. [if pill or condom is used, ask to see the product] What is the product brand?
			13. If you received the product at a hospital, clinic or from a CHW, how will you rate the following about your encounter?
NOT SATISFIED	IN BETWEEN	SATISFIED	
			13a. Availability of different choices of the methods
			13b. Privacy
			13c. Competence of the provider
			13d. Explanation of the method prescribed
			13e. Answering your questions about the method
			13f. Waiting time
			13g. Cleanliness of the place
			13h. Behavior of the health providers

QUESTIONNAIRE 4: MOTHERS OF SICK CHILD (0-2 years)

<p><i>The following questions refer to a child with diarrhea, cough or convulsions during the two week period prior to the survey only. Confirm the name and age from the summary sheet.</i></p>	
<p>[a] Diarrhea → Question 2 [b] Illness with cough → Q 6 [c] Fever/convulsions → Q 9 [d] Other: _____ STOP</p>	<p>1. What illness did your child “name” have during the last two weeks? PROMPT to get an answer. If the response includes more than one sickness, focus on the first one mentioned only.</p>
<p>[a] Nothing [b] Fluid from ORS packet [c] Home-made fluid [d] Pill or syrup [e] Injection [f] IV – intravenous [g] Home/herbal medicines [h] Other, specify: _____</p>	<p>2. What was given to treat the diarrhea? NOTE ALL MENTIONED</p>
<p>[a] Less [b] The same [c] More [d] Nothing to drink [e] Don’t know/not sure</p>	<p>3. When “name” had diarrhea, was he/she offered less than usual <u>to drink</u>, about the same as usual or more than usual?</p>
<p>[a] Less [b] The same [c] More [d] Nothing to eat [e] Don’t know/not sure</p>	<p>4. When “name” had diarrhea, was he/she offered less than usual <u>to eat</u>, about the same as usual or more than usual?</p>
<p>[a] Yes → Q 12 [b] No → STOP</p>	<p>5. Did you seek advice/treatment outside the home for the diarrhea?</p>
<p>[a] Yes [b] No [c] Don’t know</p>	<p>6. When “name” had the illness with cough, did he/she breathe faster than usual with short/fast breaths?</p>
<p>[a] Yes [b] No → STOP</p>	<p>7. Did you seek advice/treatment for the cough/fast breathing?</p>

<input type="checkbox"/> [a] Same day <input type="checkbox"/> [b] Next day <input type="checkbox"/> [c] Two days <input type="checkbox"/> [d] Three or more days	<p>8. How long after you noticed that “name” had cough/fast breathing did you seek advice?</p> <p>SKIP TO 12</p> <p>CONTINUE ON BACK SIDE OF THIS PAGE</p>		
<input type="checkbox"/> [a] Yes <input type="checkbox"/> [b] No <input type="checkbox"/> [c] Don’t know	<p>9. Does “name” have fever now?</p>		
<input type="checkbox"/> [a] Yes <input type="checkbox"/> [b] No → STOP	<p>10. Did you seek advice/treatment for the fever?</p>		
<input type="checkbox"/> [a] Same day <input type="checkbox"/> [b] Next day <input type="checkbox"/> [c] Two days <input type="checkbox"/> [d] Three or more days	<p>11. How long after you noticed that “name” had fever did you seek advice?</p>		
<p>Health provider:</p> <input type="checkbox"/> [a] Hospital <input type="checkbox"/> [b] Clinic <input type="checkbox"/> [c] Health Post <input type="checkbox"/> [d] CHW <input type="checkbox"/> [e] Pharmacy <input type="checkbox"/> [f] Other _____ <p>Other source:</p> <input type="checkbox"/> [g] Shop <input type="checkbox"/> [h] Friend/relative <input type="checkbox"/> [i] Other: _____	<p>12. Where did you seek advice or treatment? Where else?</p> <p>NOTE ALL MENTIONED</p> <p>Name of facility: _____</p>		
<p>13. How will you rate the following about your encounter with the health care provider?</p>			
<p>NOT SATISFIED</p>	<p>IN BETWEEN</p>	<p>SATISFIED</p>	
			<p>Behavior of the health providers</p>
			<p>Competence of the provider</p>
			<p>Availability of services at the facility</p>

			Availability of the medicine prescribed
			Explanation of the treatment prescribed
			Answering questions about illness and treatment prescribed
			Cleanliness of the facility
			Waiting time
			Privacy

Annex 2. Midterm Household Survey Questionnaires

Questionnaires for Monitoring Household Survey

Respondents: MARRIED WOMEN 15–49 YEARS OLD, NOT PREGNANT																							
Organization:						Province:						Grant ID:						Catchment Area No.:					
District:						Supervisory Area:						Start Date:						Population:					
Village Name:																						Baseline	Target
																						%	
Household Serial No.:																						Decision Rule	
Is there a woman between ages of 15 to 49 in your Household who is Married but currently not pregnant?																							
Indicator: % women of reproductive age (15-49 years) who are using (or partner is using) a contraceptive method.																		Total Correct in SA (Numerator)		SA. Status			
<i>Are you or your partner <u>currently</u> using something or using any method to delay or avoid getting pregnant? Which method are you using?</i>						Correct Responses Key Put a 1 if either ‘a’ through ‘e’ responses or any combination, except ‘f’ and ‘g’																	

<p>1. Put 0 if mother does not have the vaccination card and if mother shows the vaccination card please proceed as follow:</p> <p>2. Put 1 if all three DPT shots are recorded on the vaccination card.</p> <p>If not, then:</p> <p>3. Put 1 if at least one DPT shot recorded on the vaccination card and two additional shots can be recalled by the mother.</p> <p>4. If none of the above, then put 0</p>																									<p>A. Meets the Baseline and Targets</p> <p>B. Meets the Baseline only.</p> <p>C. Meets neither the Baseline nor the Targets.</p>
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Annex 3. Overall REACH Results: Comparing Baseline and EOP Status

Indicators		Rounds 1 and 2 Grants*		Round 3 Grants†	
		Baseline (Early 2004)	EOP (Early 2006)	Baseline (Early 2005)	EOP (Early 2006)
		%		%	
Reproductive health	Contraceptive prevalence	16.2	25.9	27.3	38.7
	Knowledge about two modern contraceptive methods	21.0	52.9	41.4	61.1
Safe motherhood	Births attended by a skilled attendant	12.2	23.2	32.4	35.6‡
	Mothers attending one ANC visit	26.1	38.8	35.8	46.6
	Mothers receiving at least 1 TT injection	44.3	60.0	50.8	54.6‡
	Mothers receiving PNC after delivery	15.7	26.2	34.5	41.7‡
Child health	Children 1–2 fully immunized (DPT3)	14.7	37.4	29.1	37.5
	Children 1–2 receiving vitamin A therapy	67.4	77.8	82.6	85.2‡
	Children exclusively breastfed first 6 months	62.6	66.3‡	58.0	63.1‡
	Mothers reporting appropriate care-seeking behavior	24.9	41.5	43.3	58.0

The shaded indicators denote REACH program key results.

Notes:

*Rounds 1 and 2 grants started in late 2003 and the population represented by this survey is 4.1 million living in 79 rural districts.

†Round 3 grants started in January 2005 and the population represented by this survey is 2.3 million living in 25 rural districts and 6 sectors of Kabul city. These data are presented separately since the grants started later and there was a shorter period in which to measure results. Also, over 40% of people in this sample reside in the urban area of Kabul.

‡The difference between these baseline and EOP findings is not statistically significant.

Annex 4. Grants Catchment Area–Level Results (Rounds 1 & 2)

Province	NGO	District-SA	Indicators (Per cent)																			
			Reproductive Health				Safe Motherhood								Child Health							
			Contraceptive prevalence rate		Knowledge two modern contraceptive methods		Births attended by a skilled attendant		Mothers receiving PNC after delivery		Mothers attending one ANC visit		Mother receiving TT injections		Children 1-2 fully immunized (DPT3)		children 1-2 received Vitamin A therapy		Children exclusively breastfed during first 6 months		Mothers with appropriate careseeking behavior	
			Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP
Herat	WVI	Cheshtisharif	21.3	39.6	3.5	74.5	4.3	42.9	13.9	27.7	17.8	55.2	50.1	65	10.3	61.7	64.2	77.4	58.4	28.7	32.1	70.8
	CHA	Ghorian, Zindajan, Kuhsan, Asraskan, Shindand, Farsi	25.7	30.2	40.5	64	12.9	26.9	16.7	21.1	13.6	43	42	57.4	22.5	35.8	92.5	99.5	57.6	60.7	40.1	36
	NPO/RRAA	Gulran	27.1	19.4	52.6	71.2	4.5	13.4	11	22.9	20.3	23.8	16.1	33.7	7.3	20.3	78.9	64.9	68.6	68.4	20.4	17
	NPO/RRAA	Rabat Sangi (RS)	36.9	15.1	66.1	64.5	7.5	9	15.6	12.8	31.1	31.6	35.8	40.4	13	32.5	75.7	70.6	64.1	66.4	32.4	16.2
	CoAR	Karukh	24.5	28.5	14.4	93.6	14.4	9.8	18.7	13.7	27.3	93.5	40.3	69.4	10.6	23.9	45.3	46.4	69.6	55.4	41.7	66.1
Ghor	WVI	Ghaghchran	4.9	22	10.1	33.6	0	19.1	4.6	15.6	4.6	18	12.1	64.2	0	44.9	38.2	75	74	88.9	4.7	35.5
Kabul	BRAC	Paghman-1	24.9	53.7	25.4	98.8	26.9	61	17.1	78.9	43.9	91.7	81.7	91.1	15.8	50.1	58.5	98.8	54.2	75.2	26.3	61.8
	IMC	Shakardara, Guldara, Qarabaq	15.4	34.3	12.7	59.4	25.2	32.4	12.8	44.8	40.1	47.2	68.5	66.8	17.3	41.5	72.3	67.3	52.7	63.6	31.2	45.9
	STEP	Farza, Mirbachakot, Kalakan	16.1	36.5	20	46.2	34.9	23.8	27.2	58.7	64.7	71.9	69.4	74.5	16	56.3	75.4	84.2	62.6	48.2	30.1	42
Ghazni	SDF	Dih Yak, Zana Khan	11.9	13.9	0	36.1	7.7	22.9	10.8	32.2	26.6	27.4	34.2	74.5	10	38.7	60.7	55.6	62.1	75	16.8	50.9
	BDF	Nawur, Ajristan	3.1	13	27.1	34.5	4.2	19.2	3.4	18.5	11.3	15	29.3	71	8.4	34.5	10.6	97.6	67.4	85	23.5	51.4
	SDF	Jaghori, Mallistan	9.9	21.1	38.9	23.5	8	19.3	12.9	25	26.1	40.9	37.5	49.8	9.9	49	58.1	63	49.3	62.3	22.1	45
	BDF	Bahramshahid	12.9	39.9	17.3	41	14.7	27.4	15.8	28	51.9	28.9	47	71.4	39.7	50.8	81.9	82.5	66.1	72.1	50.2	71.5
Bamyan	ADRA	Waras, Panjab	15.3	27.8	19.8	42.6	4	5.3	6.4	10.4	14.5	20.7	13.8	40.1	1.4	35.4	77.3	64.5	24.3	45.9	4.2	41.7
	IMC	Bamyan, Yakawalang	24.1	24	17.1	72	7.7	10	18.2	26	26.5	53	32.5	71	13.3	49	77.4	44	34.4	53	41	42
Khost	IMC	Qalandar, Bak, Gurbuz, Musa Khel	29.7	51	25.9	84	17.6	41	9	56	16	75	35.8	83	9.3	23.0	66.1	98.0	88.5	69.0	48.1	65.0
Paktia	Ibn Sina	Gardez, Zurmat, Sayid Karam, Jadran/Shwak/Shamal, Chamkani/Jaji	17.8	14.8	9.5	53.5	23.8	33.6	15.8	21	35	56.6	47.2	61.4	15.7	27.6	40.9	67.3	70.1	62.5	17	46.8
Paktika	IMC	Sharan, Yousofkhil, Omna, Urgun, Nika, Gayan	20.8	65.3	12.8	83.3	18	60	19.1	62	9.1	59.8	38.8	92.5	18.9	73.2	57.9	29.2	72.1	74.9	20.7	88.2
Baghlan	BDF	Baghlan, Baghlane Jadid	6.2	17.6	17.5	58.8	12	21.1	7.2	23.6	39	51.4	39.7	68.6	4.1	46.3	49.1	82.7	82.8	72.3	18.5	37.5
Takhar	Merlin	Taloqan, Kalafghan, Rustaq, Bangi, Farkhar, Chah Ab	12.3	25	3	6.5	6.8	6.2	11.4	6.1	20.1	7.1	36.2	52	6	26.9	65.2	79	60	70.9	19.3	17.9
	CAF	Darqad, YangiQala, KhwajaBahudin, Dast-e-Qala, Khwajaghor	6	19	13	56	3.6	6	10.2	19	26.2	37	35.6	58	19.2	51	64.1	76	71.2	71	20.9	54
Badakhshan	Medair	Raghistan, Raghistan, Kohistan, Yawan, Khwakhan, Baharak, Shohada, Wardooj	2.7	23.4	1	50.9	4.1	9.4	7.8	25.7	8.3	26	40.9	61.4	2.5	25.1	77.3	83.5	91.8	60.5	25.7	48.4
	AKDN	Ishkashim, Zebak	9.9	11.1	7.1	59.6	2.4	6.3	15.2	10	46.6	40.3	62	62.7	13.1	46.7	92.6	82.7	70.6	86.2	26.3	73.7
Jawzjan	SCAUS	Khojadoko, Qarqin, Kharmayab	6	3.3	8.8	15.2	11.3	22.9	33.2	26.6	42.9	42.7	45.3	46.9	15.5	21.6	76.1	37.6	70.2	71.8	27.1	33.8
	SCAUK	Aqcha, Fayzabad, Mardian, Mingajik, Darzab	17.5	33.5	23.7	54.7	14.9	27.3	31.3	41.6	45.5	43.9	59.8	74.1	20.4	37.7	80.1	62.4	57.9	75.2	34.3	59.8
Faryab	SCAUS	Khanicharbagh, Andkhoy, Qurghan, Qaramqul	24.4	14.7	11.9	14.2	37.5	49	48.2	39.2	45.9	63.4	83	94.3	51.4	61.6	77.1	85.1	46	49	33.2	38.9
	CHA	Dawlat Abad, Shirin Tagab, Khoja Sabz Posh, Maimana, Pashtoonkot, Kohistanat	8.9	12.9	18.1	64.5	4.4	15.8	9.7	13.9	23.9	28.9	56.8	48	12.1	24.1	69.4	88.9	71.2	71.7	13.1	35.3

Annex 4. Grants Catchment Area–Level Results (Round 3)

Province	NGO	District-SA	Indicators (Per cent)																			
			Reproductive Health				Safe Motherhood								Child Health							
			Contraceptive prevalence rate		Knowledge two modern contraceptive methods		Births attended by a skilled attendant		Mothers receiving PNC after delivery		Mothers attending one ANC visit		Mother receiving TT injections		Children 1-2 fully immunized (DPT3)		children 1-2 received Vitamin A therapy		Children exclusively breastfed during first 6 months		Mothers with appropriate careseeking behavior	
			Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP	Baseline	EOP
Herat	NPO/RRAA	Kushke-Kuhne	0	25.8	53.7	63	14.2	4.3	10.3	4.3	19.4	13.1	66.7	32.9	24.2	18.8	64.9	60.1	63.5	72.5	12.8	26.4
Kabul	CAF	Nahia 4, 9, 10, 11, 15, 16	49	49	74	82	77	78	56	74	64	76	54	49	54	55	98.5	98	54	33	65	71
Kabul	STEP	Charasiab, Mosai, Deh Sabz	12.8	31.1	19.8	55.6	24.7	37.2	18.2	37	34	60.7	41.4	74.8	10.7	25.7	88.2	79.3	56.4	47.8	44.8	56.9
Ghazni	NAC	Andar, Qarabagh, Muqor, Gilan, Nawa, Aband, Giro	22.4	49	15.3	58	12.3	15	40.1	36	22.7	34	56.5	60	18.2	21	80.4	82	52	60	29.3	67
Baghlan	CAF	Markuz burka, Flowol, Tangi Murch, Shorqodoq, Hazar Qala	4.5	3	29.1	34	8.7	6	16.1	14	26.3	36	30.6	51	11.2	26	57.1	89	56.5	65	18.1	30
Takhar	CAF	Warsaj, Chal, Ishkamish	13.7	4	26.3	52	1.7	6	17.8	15	14.8	40	53.8	75	17.8	35	92.2	83	63	62	24.8	50
Badakhshar	Merlin	Shahr-e-Buzorg, Kishim, Teshkan, Taqab, Jare Shahbaba, Fayzabad, Argoo, Yaftal	16.7	33.9	15.2	60.4	7.5	10.4	11.7	19.6	6.8	22.7	17.4	49	8.3	40.6	50.6	67.4	57.7	68.3	27.7	43.2
Faryab	SCAUS	Gorziwan, Belcheragh	11.6	13.7	5.4	61.3	5.2	9.5	7.3	18.9	8.3	21	45.2	65.5	6.2	19.9	91.6	82.4	67.2	28.4	21.1	54.9
Kandahar	AHDS	Arghandab, Dand, Maywand, Khakrez, Whawalikot	28.9	26	53.9	37.2	11.1	12.1	29.9	21.7	33.9	25	54	11.7	10.1	11.2	76.6	79.4	65.9	76.8	34.4	37.7

Annex 5. Samples Used for Various Analyses of REACH Household Survey Data

Type of Supervisory Areas (SAs)	No. of SAs	Households represented by the sample ♣ (from NGOs pre-surveys)	Composition of the population	Sample size (EOP)	Available data through LQAS	Contribution to the analysis of different strata of data in this report
Round 1 and 2	144	754,473	Rural	2,737	Both baseline and EOP	Included in Round 1 and 2 aggregated values of indicators; also included in Rounds 1, 2 and 3 aggregated values of indicators.
Round 3	52	427,090 (137,554 in Kabul City)	Rural and urban (includes 5 SAs in Kabul City)	988 (95 in Kabul City)	Both baseline and EOP	Included in Round 3 aggregated values of indicators; also included in Rounds 1, 2 and 3 aggregated values of indicators.
Added at EOP stage	9	23,602	Rural	171	Only EOP	Four of these SAs were added during REACH grant modifications; 5 others are in Wakhan district of Badakhshan where AKDN conducted a baseline survey using a different methodology. In these SAs, LQAS was only implemented at the EOP stage. Therefore, they are not included in Rounds 1, 2 and 3 aggregated values of indicators where comparison to a baseline was required; where comparisons with baseline are not made (such as calculation of new indicators) this data was included.
Dropped at EOP stage	7	Not available	Rural	0 (baseline sample size 133)	Only baseline	Six SAs in Kandahar and one in Khost were dropped at the EOP stage because of security challenges. The data is not included in any calculations.

♣- No. of households represented by samples are used for calculating weighted proportions and confidence intervals.