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Mid-term Evaluation

The Health Services Support Project (HSSP)

**by
USAID
in the
Islamic Republic of Afghanistan**

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ACRONYMS AND ABBREVIATIONS

| | |
|------------|---|
| AFSOG | Afghan Society of Obstetricians and Gynecologists |
| AMA | Afghanistan Midwives Association |
| BCC | Behavior change communication |
| BPHS | Basic Package of Health Services |
| CBHC | Community based health care |
| CGHN | Consultative Group on Health and Nutrition |
| CHS | Community health supervisor |
| CHW | Community health worker |
| CME | Community midwifery education |
| DH | District Hospital |
| DMPA | Depot Medrox Progesterone Acetate (progestin-only injectable) |
| EmOC | Emergency obstetric care |
| EPHS | Essential Package of Hospital Services |
| ETS | Effective Teaching Skills |
| EU | European Union |
| FP | Family planning |
| GCMU | Grants and contracts management unit of MoPH |
| GII | Gender Implementation Index |
| GRR | Gender and reproductive rights |
| HCI | Health Care Improvements Project |
| HMIS | Health management information systems |
| HP | Health posts |
| HSSP | Health Services Support Project |
| IEC | Information, education and communication |
| IMCI | Integrated management of childhood illnesses |
| IP | Infection Prevention |
| IPC/C | Interpersonal counseling and communication |
| IR | Intermediate result |
| IRC | University Research Company |
| ISAF | International Security & Assistance Force |
| Jhpiego | An affiliate of Johns Hopkins University |
| LRP | Learning resource package |
| MoHE | Ministry of Higher Education |
| MoPH | Ministry of Public Health |
| NGO | Non-governmental organization |
| NMEAB | National Midwifery Education Accreditation Board |
| PDQ | Partnership defined quality |
| PHCC | Provincial Health Coordination Committee |
| PPG | Performance-based partnership grants |
| PPH | Post-partum hemorrhage |
| PRT | Provincial Reconstruction Teams |
| QA | Quality assurance |
| RH | Reproductive Health |
| RUD | Rational use of drugs |
| SPS | Strengthening Pharmaceutical Systems Project |
| Tech-Serve | Technical Support to the Central and Provincial Ministry of Public Health |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

1. EXECUTIVE SUMMARY

1.1 ENVIRONMENT & BACKGROUND

Health services in Afghanistan have been crippled by over 30 years of war and civil strife and, as a result, the return to democratic governance in 2001 presented daunting challenges in addressing the health sector. Only about 400 health facilities were marginally functioning with population coverage at 9%. Since then significant progress has been made: over 1,600 health facilities are now operating and coverage is estimated at some 75%.

Strategically, the Ministry of Public Health (MoPH) delivers a Basic Package of Health Services (BPHS) and an Essential Package of Hospital Services (EPHS) through NGOs from the District level on down. USAID supports 13 of Afghanistan's 34 provinces. The remaining 21 provinces are supported by the World Bank and the European Union. MoPH manages USAID's grant awards to 26 NGOs through the Grants & Contracts Management Unit (GCMU) at MoPH that is supported by Tech-Serve. The funds, themselves, are directed through WHO. The next round of two-year grants will be implemented in October 1, 2009. At that time USAID funds will be channeled through the Ministry of Finance.

The Health Services Support Project (HSSP) followed on from USAID's Rural Expansion of Afghanistan's Community-Based Healthcare (REACH) project (2003 – 2006). Over the life of REACH significant progress was made in improving health delivery. Between 2004 and 2006 the number of fully immunized children under the age of two went up from 14.7% to 37.9%; the contraceptive prevalence rate increased by 9% (from 16.26% to 25.4%); knowledge about at least two family planning methods by women of reproductive age went up from 21% to 52%; and the number of women who gave birth in the presence of a trained birth attendant increased 10% (from 12.2% to 22.9%).

Significant challenges remain. Nationally, there has been little change in the high maternal mortality rate (1,600 per 100,000 births); infant mortality rates (115 per 1,000 births); child mortality rates (172 per 1,000 live births); and a high fertility rate remains (Total Fertility Rate at 6.26). Infectious diseases continue to be a problem. Diarrheal diseases, respiratory infections, vaccine preventable diseases and TB, poor hygiene and lack of safe water are notable concerns along with a general lack of prevention awareness; shortages of trained health workers - notably a lack of female health workers; and social and cultural constraints to women's access to services. The mountainous nature and winter weather in parts of Afghanistan, as well as insurgency activities, are significant challenges to health delivery and access.

USAID Afghanistan's 2005 Mission Strategic Plan set out to strengthen successes to date, and build a **better educated and healthier population**. This is supported by Intermediate Result (IR) 7.1 that is designed to help the MoPH to **increase the health of women of reproductive age and children under the age of five**.

Four sub-results support IR 7.1: **7.1.1: Expand access to basic and secondary health services; 7.1.2: Improve the ability of individuals, families and communities to protect their health; 7.1.3: Improve the quality of health services and health**

systems; **7.1.4: Increase the utilization of the private sector to provide health services and products.**

1.2 THE HSSP PROJECT

The Health Services Support Project (HSSP) is a Cooperative Agreement launched on July 1, 2006 on a four year plus three month's budget of \$19,141,074, and was due to end September 30, 2010. Subsequently, in February 2009, a modification to the Agreement was made that extended the project to March 31, 2011 and increased the budget to \$38,910,949.

HSSP is led by Jhpiego with two sub-contractors: Save the Children and the Futures Group with responsibilities for the Behavioral Change Communications (BCC) and NGO capacity building components respectively.

1.3 EVALUATION TIMING, PROCESS AND SCHEDULE

AS part of USAID/Afghanistan's Annual Evaluation Plan, a mid-term evaluation of HSSP was scheduled for early 2009 and the evaluation team was in-country between March 23 and May 12, 2009. A Work Plan was produced and amended after input from the USAID COTR (see Appendix B) and a briefing and orientation meeting was held at USAID on March 26. The evaluation team attended a series of presentations and information gathering meetings with HSSP management and IR teams; visited five provinces – Hirat, Takhar, Badakhshan, Bamyan and Kabul, interviewing Provincial Health officers; visited a total of seven NGOs and 21 health facilities; interviewed six senior MoPH staff and the staff at Tech-Serve, MSH BASICS and COMPRI-A. The team met 20 NGOs at a routine monthly coordination meeting and sent them a detailed questionnaire. On April 20th a mid-assignment de-briefing was held at USAID. The draft evaluation report was presented to USAID, along with a Power Point presentation of main findings and recommendation on May 4th.

The consultancy was managed under contract with the USAID SUPPORT project managed by Checchi and Company Consulting, Inc (with a sub-contract to Louis Berger Group) and supported by that project's staff, security and facilities infrastructure in Kabul.

1.4 EVALUATION FINDINGS AND RECOMMENDATIONS

INTERMEDIATE RESULT 1 -- Strengthened and developed systems that support service delivery quality.

The primary components of this IR are to improve quality of health services within BPHS through implementation of a quality assurance (QA) process; to provide MoPH and implementing PPG-NGOs with systematic and verifiable performance standards that are measurable through baselines and both internal and external assessments; to establish a QA management system through QA Committees at MoPH central and provincial levels and through a range of collaboration with MoPH technical departments and task forces; to build the capacity of the 26 PPG-NGOs through management and supervisory skills

training, and to support collaboration and experience sharing of the NGO community through establishing HSSP Provincial Coordinators and through a newsletter.

FINDINGS & RECOMMENDATIONS

HSSP has achieved substantial results through the introduction of the QA process. Sustainable QA Committees have been established within the MoPH on national and provincial levels, within NGO management and within their facilities' operations.

HSSP tracks both training and QA implementation through systematic processes: pre and post training evaluations and percentage successes in achieving QA standards set for the 13 BPHS health areas selected for inclusion (the 14th area, gender, is presently incorporated across other areas). Evaluation of these results showed that the average pre-test score for training across 42 courses reviewed was 43.4% and the average post-test score 77.7%. To date 28 facilities have accomplished a baseline, two internal and one external assessment and the scores tabulated. External assessments scored over 80% achievement for implementing QA standards for EPI, IP, ANC and BCC areas. The remaining scores range from the lowest (Drug Management at about 65%) to just under 80%. The three lowest scoring areas (under 70%) were Drugs Management, FP and New Born Care. Analysis of a further 75 facilities will be completed mid-2009.

NGOs that responded to the evaluation questionnaire and field interviews at NGO offices and facilities confirmed the significant improvements to their capacity building and quality of service delivery that the QA process (and technical training under IR 2) had achieved. Three primary areas for possible improvement were noted from the questionnaire:

More NGO collaboration: Almost half of the respondents requested more coordination and collaboration between NGOs beyond the present routine and monthly meetings and the PPG/PCN Newsletter. These meetings are the remit of HSSP's Provincial Coordinators. Structurally HSSP is already responding to this through the appointment of one Coordinator for each province in 2009. Presently they have eight Coordinators.

Training Needs Met: About one third of the respondents felt that their training needs could be improved. The most significant reason appeared to be that of training replacement or new staff. One NGO reported a 20% turnover rate in two years. They would prefer that these staff be trained quickly rather than wait for HSSP's course schedules. More training was requested at the provincial level.

Training Content: Almost one quarter of respondent felt that training content could be improved. In the evaluation's review of this issue it was felt that the participatory and empowering models of training could be reinforced.

Other insights that the questionnaire and field interviews threw up were that not a few NGO implementation offices lacked dedicated trainers to train facilities' staff and most mentioned the issue of budgetary constraints. In reviewing this, the evaluation team was informed by GMCU that within the grants for 2009/ 2011 a line-item budget had been set for training at 1.5% of total budgets. This seemed modest. At the same time it has to be noted that whereas HSSP sets targets for fully implementing the QA process across facilities all NGOs were endeavoring to expand QA across as many facilities as they could, although the quality and weight of training to non-HSSP mandated facilities varied considerably.

Coverage Issues: The PMP for IR 1 does not set facilities coverage numbers for QA accomplishment, although HSSP adds targets to it. It does not include Health Posts. It only measures success in achieving QA standards across those implementing it. HSSP reported that their target for 2010 was to have introduced QA in 144 facilities with 108 achieving fully the QA process. The total number of facilities is assumed at 369. However about 100 more will be added in October this year when the new round of NGO grants will consolidate World Bank and EU clusters within USAID provinces under these USAID grants, as well as appoint only one NGO implementer per province (although they may sub-contract). This will bring the total of facilities to about 469, excluding Health Posts. USAID's project modification requests HSSP to expand QA facilities only to end year four (2010). This issue of coverage needs to be addressed between USAID and HSSP. The capacity of HSSP to support the capacity building and training needs of NGOs to expand to more facilities than presently targeted by 2010 is reasonable, considering their increased budget and capacity to increase staff. One constraining factor is, however, that HSSP is also expanding the number of BPHS areas and these new areas will have to be introduced to existing QA facilities. The capacity of NGOs to accomplish expansion to more facilities, including Health Posts, by the end of 2010 must be doubted, particularly as they will be restructuring their networks over the 2009/10 year as well. All the same coverage is projected to be rather low.

Recommendations:

- Revisit QA coverage target with the 13 new provincial lead PPG-NGO grantees (expected to be appointed in June 2009). Agree targets for replication training by numbers of facilities and Health Posts. Present proposed target to USAID and agree on any revisions to present targets if feasible.
- Analyze and report needs assessments for management and technical training by each PPG-NGO to end 2010. Restructure training needs in light of expanded NGO operations (additional management and sub-contracting training), and arrange new training schedule on an NGO specific needs basis and, as far as possible, at the provincial level.
- If necessary add training on invoicing and payment procedures through the Ministry of Finance to NGO finance managers.
- Address the need for a quick, practical response to NGO replacement staff training needs.
- Review and, if required and feasible, add additional empowerment models to training.
- Ensure new Provincial Coordinators are well trained including on-the-job training with existing Coordinators.
- Discuss with PPG-NGOs issues of retaining staff after training and what incentives might be put in place to resolve – contractual agreements to remain

after training; merit pay increases after evaluation of improved performance after training.

Longer-Term recommendations:

- Develop sustainability measurements models across new NGO networks, QA Committees and at training establishments (including training budget needs after September 2010 and at March 2011); using these monitoring models for each institutional element: MoPH QA Committees; NGO management and training replication; training establishments, and facilities training needs present to USAID the modalities and time-scale for a self-sustainment situational analysis projected at end 2010 and end of project.
- USAID to set deadline for this sustainability report linked to the utilization of inputs in consideration of the scope for a new project beyond 2011.

INTERMEDIATE RESULT 2: Increased number and performance of BPHC service providers, especially women in rural and underserved areas

IR 2 set out to increase the number of skilled female providers by technically and financially supporting community and hospital midwifery education programs; to increase the numbers trained, and support deployment of those trained, notably in rural areas; support the National Midwifery Education Accreditation Board (NMEAB) to improve accreditation standards and to assist schools to achieve quality and performance improvements; support the Afghan Midwives Association (AMA) to increase its membership and improve members' services, strengthen overall capacity in leadership and management, and its financial sustainability and capacities to support and promote the profession of midwifery; support the development of the Afghan Society of Obstetricians & Gynecologists (AFSOC) to strengthen the Society and improve obstetrics care; support a Prevention of Postpartum Hemorrhage at home births demonstration project which was established and supported under ACCESS Afghanistan and then expanded under HSSP; support the development and implementation of a National Reproductive Health (RH) strategy and national RH in-service training strategy for clinical courses across the BPHS and EPHS health areas, the development of standards for these courses, and to train national trainers and NGO staff; to introduce the QA process for obstetrics and new born care to regional maternity hospitals; in collaboration with Tech-Serve to strengthen Post Partum Family Planning services within the BPHS.

FINDINGS AND RECOMMENDATIONS

Midwifery: HSSP's midwifery education program has been a significant success through support to the Afghan Midwifery Association, the National Midwifery Education Board, and through Community Midwifery Education (CME) programs in seven provinces and two hospital midwifery programs. Currently 191 community midwives and 245 hospital midwives are enrolled in supported courses. Since the project's inception 333 hospital and community midwives have graduated, from a target of 300 community midwives. USAID's project Modification supports a new batch of midwives to be graduated in 2010.

HSSP is assisting the MoPH to address issues of the placement of community midwives after graduation. At the facilities level the evaluation noted the steady increases in

deliveries and that midwives seemed to be easily making the targets set for them. HSSP is participating in on-going discussions relating to deliveries after hours at the BHC level, and the utilization of BHC midwives for at-home deliveries.

E-learning: E-learning tools are somewhat limited, based on non-internet CDs. The first CD on the active management of third-stage labor has been produced and field tested and is being followed by two further CDs.

Preventing Post Partum Hemorrhage at Homebirth Pilot Study – The results of this pilot initiative were highly encouraging. CHWs were trained in assisting pregnant women to identify and manage bleeding and hemorrhage and to provide Misoprostol should a trained provider not be accessible. In the control area 25.7% of pregnant women had used any uterotonic and 96.2% in the intervention area; self-perception of having experienced a hemorrhage in the control area was 49.3% and in the intervention area 11.0%. The MoPH has decided to roll out the pilot study to cover 20,000 pregnant women to test out, further, the feasibility of the intervention on a larger scale, notably drug management issues as this is a concern of WHO. This component has been included in USAID's HSSP Modification to 2011.

Mental Health -- HSSP has supported MoPH to develop a mental health reference manual for BPHS and EPHS. Next, HSSP will develop a mental health learning resource package and train national trainers and then health providers. It is also noted that a range of additional areas within the BPHS has been added to HSSP within the Project;s Modification to 2011,

In-Service Training – HSSP has conducted a total of 169 training events covering 35 courses to 4,189 participants since July 2006. Participants included 203 MoPH staff at the national level; 313 at the provincial level; 1,990 NGO office staff; 1,677 NGO facilities staff, and 6 from the private sector.

Some emphasis has been placed on the integrated management of childhood illnesses (IMCI) in collaboration with the RH Task force at the MoPH. A New Born Working Group was established, QA standards for IMCI and a competency based learning resource package (LRP) developed. Basic and Advanced courses were designed. Twenty-four part-time trainers were selected by MoPH located in five Regional Provinces – half male and half female. Four training sessions were conducted at end 2008 to 34 NGO staff and 62 health providers. Five sessions are planned for 2008/09 to about 80 health care providers.

Emergency Obstetrics Care (EmOC) Training – EmOC training is undertaken through 15 trainers of which six are based in Kabul, the others in other training schools in other provinces. They train trainers who train doctors and midwives. The trainers interviewed in Kabul reported that they were generally satisfied with HSSP training, however they felt that the courses offered were little different from those they had received in 2003, and they would have preferred more up-dated courses. They also felt that the training was too short. In addition, as these trainers are also practicing in the training hospital they have inadequate time to fulfill the demands of training that have steadily grown.

Post-Training Follow-up – HSSP acknowledged that there had been gaps identified in post-training follow-up and these gaps were being rectified. A new HSSP Task Force had

been created and was moving ahead to complete its strategies and create new implementation tools for implementation at the time of this evaluation.

Strengthening Family Planning (FP) within the BPHS – FP QA standards had been created and incorporated into all QA facilities; a community-based post-partum FP training Package and an effective teaching skills (ETS) package developed as well as a condom use job aid for facilities staff. The Progestogen only pill (POP) and injectable contraceptive (DMPA) had been added to the method mix. 1,400 health providers had been trained in POP. To December 2008 nine FP training courses had been undertaken to 65 health providers, 63 NHO staff and 11 MoPH staff. HSSP is working with the MoPH to create a national RH strategy and national standardized system for FP delivery. A national RH training center is planned. TA to the RH unit at MoPH continues and the implementation of the RH QA process in five regional hospitals is underway.

USAID's HSSP Modification stresses the need to collaborate closely with Tech-Serve and to create linkages with the Community-Based Health Care (CBHS) department to expand the community based contraceptive usage project started by REACH with a focus on the post-natal period.

Family Planning at the facilities level – In general almost all facilities had stocks of family planning commodities. Midwives did have records of estimates of the total number of women of reproductive age in the area served by their facilities but they could not easily report what percentage of the total they were serving. However those who could give some estimates quoted figures ranging from 7% to 25%, and all agree that these figures were low. Most stated that it was up to the CHWs and community to increase demand on services. Target setting for both FP counseling and deliveries at facilities appear to be too low. Counseling issues are covered under Section 1.6.

Community Nurse Education (CNE) – HSSP has begun the process of expanding its remit to increase the number of female providers by including community nursing education (CNE), and support a National Education Accreditation Board or the integration of nursing into the National Midwifery Education Accreditation Board.

Recommendations:

- Explore with COMPRI-A issue of BHC midwives related to private sector midwives; participate in resolutions to BHC midwives' provision of after-hours services, and support to home deliveries.
- Continue to address community midwives' placement issues.
- Explore with EmOC trainers their request for more up-dated training and their work load (related, also, to Recommendations under the longer term assessment of training institutions under IR 1).
- Assess training needs for those already trained in respect to the list of new BPHS areas that have been added.
- Consider shifting FP even more towards Child Spacing terminology and health benefit.

- Other technical training issues are addressed under IR 1.
- Other behavioral change issues are discussed under IR 3.

INTERMEDIATE RESULT 3: Improved capacity and willingness of communities, families and individuals to make informed decisions about their health and support and sustain health seeking behaviors

The seven primary components of IR 3 are to: build the capacity of the IEC/ Health Promotion department at MoPH; assist in the production of a National IEC/ BCC strategy; distribute existing REACH materials and produce new health education materials for facilities; build the capacity of NGOs to develop and manage BCC and community mobilization activities; increase the community's participation in the ownership of health services; improve the dialogue between communities and facility-based service providers; mobilize religious leaders in support of BCC activities; and increase advocacy for improved health services and the adoption of appropriate preventive behaviors.

FINDINGS AND RECOMMENDATIONS

Partnership Defined Quality (PDQ) – Officially launched in three provinces, with expansion planned to all provinces, PDQ aims to build community involvement and a sense of ownership over health facilities. This component is built into the QA process. Facilities' staffs were highly supportive of this initiative as were Health Shura leaders interviewed. The most stated result has been to create community-based emergency transportation arrangements. Other initiatives mentioned were to help up-grade facilities. However in most facilities visited the response was more that PDQ had allowed communities to express their needs, for example to provide transport to facilities, but no resolution has been forthcoming. As with the whole QA process many NGOs had expanded QA beyond HSSP's roll-out plan.

Support to the Health Promotion Department – HSSP has achieved substantial results in support of the Health Promotion unit. It has been transformed from a printing shop to a core IEC/ Health Promotion unit with an approved National Health & Nutrition Communications Strategy and a revived IEC Task Force. BCC training has been undertaken to MoPH staff and regional IEC officers. The department now implements significant IEC/ BCC programs for donors. The department is, however, highly dependent on its director who will leave shortly for higher-education purposes.

BCC, Interpersonal Communications and Counseling (IPC/C) and PDQ Capacity Building of NGOs, Pre-Service Institutions – HSSP has created BCC standards across client satisfaction, PDQ and IPC/C methodologies; trained service providers in these standards; developed a Religious Leaders training manual, and implemented training across BPHS health component areas, community mobilization, PDQ, IPC/C and in Health Shura management and community linkages.

Evaluation Team Review of IEC, BCC and IPC/C Environment and Progress – HSSP has begun the task of addressing the imperatives needed to shift the emphasis from a purely health education approach to achieving a longer-term aim of addressing the more complex approaches needed to achieve successful results in the social and behavioral

change environment that will lead women, in particular, to take charge of their health needs and the needs of their children. At all facilities the evaluation team visited, standard health education approaches were still being followed with very little two-way communication and no discussions being held with those being counseled concerning the constraints they may have that impede their actions and how they may be overcome. The obvious example would be to ask what constrains them to practice family planning, and if any suggested their husbands did not agree, to suggest that it could be arranged for a male CHW or Health Shura members to approach the husband. However this whole infrastructure would have to be put in place to service these behavioral and social constraints issues. At the same time counseling materials, posters and materials retain more standard health education approaches.

Both within the MoPH Health Promotion Department's strategies and within HSSP's BCC manuals and training this issue is introduced. But because the specific behavioral change issues are not yet fully defined and specific strategies and messages developed these materials appear to be more theoretical than practical. At the same time some NGOs are well versed in these behavioral change methodologies but many are not and, as the RH director at MoPH pointed out, there are many players but no coordinated approach to defining behavioral change strategies across all BPHS areas, and this is sorely needed. HSSP is working within this arena only in respect to gender where it is instituting a research piece to explore these issues. HSSP ensures that posters and other material is available at facilities. The evaluation found good coverage of posters but many were placed too high on walls and were quite complex with significant numbers of illustrations and text.

Recommendations:

- HSSP should continue to stress the importance of behavioral change approach initiatives, although to end of project HSSP should develop those precise approaches only for the Gender component.
- Within HSSP, to better define new materials produced to be used for counseling and those to be seen by those who cannot read; to develop behavioral change strategies within the gender component (under IR 4).

Longer-term Recommendations

- Behavioral change strategies and relevant messages and materials will need to be put in place across each BPHS area and across the whole communications arena -- from MoPH, on down to the development of behavioral change management at the NGO level, to the development and management of community-based networks, and across the creation of behavioral/ social change strategies through rapid formative research processes; the development of messages and the training needed to deliver them.
- It is suggested that USAID should consider a follow-on project that would integrate these inputs across all relevant players.

INTERMEDIATE RESULT 4: Integrated gender awareness and practice into BPHS service delivery

IR 4 sets out to institutionalize gender within the BPHS and MoPH; to support the Gender & Reproductive Rights Unit at MoPH; to mainstream gender issues throughout all interventions and in NGO hiring practices; to undertake gender research and to implement gender training courses to increase awareness about gender issues and integrate gender-sensitive practices into the BPHS (specifically women's empowerment and decision making, male involvement, and gender sensitive interpersonal communication and counseling); and to implement community-based Family Health Action groups.

FINDINGS & RECOMMENDATIONS

HSSP has done well to mainstream gender issues across the BPHS and the QA process; to establish a Gender Integration Index (GII), as well as assisting the Gender & Reproductive Rights (GRR) unit at MoPH to produce their annual work plans; mainstreamed gender within the Health Promotion Unit; participated in gender Task Force Meetings; worked with GCMU to integrate gender issues into NGO work plans, and is working with Tech-Serve to develop Family Health Action Groups including acting as host to its first Workshop; is proceeding with a delayed research piece on gender issues, and has undertaken a TV drama program.

To date 11 gender training sessions have been undertaken to 248 health providers and NGO staff.

Field interviews with NGO staff and at facilities demonstrated a strong awareness of gender issues. In practice, however, the primary response was towards the issue of employment of female staff and health workers. Within NGO offices the result was mixed with some doing well others struggle to hire female staff.. At facilities all but one out of sixteen had at least one female provider beyond a midwife. Seven had both a female doctor and vaccinator, for example. All expressed the need for more female providers but that they were hard to find.

Surprisingly, in twelve facilities where the gender issue was explored in more depth with male senior staff, only one stated that gender was of very great importance in increasing demand; four stated it was not a major issue and six appeared ambivalent about it. In general it was not very clear how many facilities' staff had been trained on gender issues or how that training had been shared across all staff.

Recommendations:

- Proceed with gender research project – define precise behavioral change initiatives to move beyond standard health education/ advocacy-style approaches.
- Inputs received from communities through the PDQ component need to be analyzed and, where innovations to the problem solving of inputs are produced, shared across NGOs. Those issues that are difficult to resolve need to be analyzed and solutions sought and those solutions fed back to communities for mutual resolution.

1.5 HSSP AND REALTIONSHIP WITH SUB-CONTRATORS & HEAD-OFFICES

Jhpiego (lead contractor), the Futures group ((NGO capacity building) and Save the Children (BCC/IEC component) report satisfactory relationships. One issue that the evaluation team addressed was that the weaknesses within the behavioral change communications agenda could have been strengthened through more interaction with Save the Children internationally. However as the HSSP project had only a limited mandate to fully address behavioral change issues, beyond research within the gender component this issue is of only marginal significance. Jhpiego reports satisfactory inputs from Baltimore and its Regional Offices. For example, the Regional Director actively participates in HSSP's annual Work Plan process.

1.6 HSSP AND COLLABORATION

Both HSSP and Tech-Serve report that excellent working relationships and collaboration exists between them and they see no significant gaps or overlap conflicts. HSSP has fewer implementation overlaps with COMPRI-A, although this evaluation suggests they more actively cooperate on issues relating to private and public sector midwives where, in fact, they may be the same people and within the context of the utilization of BHC midwives within communities. HSSP works well with Provincial Reconstruction Teams (PRTs) and the International Security & Assistance Force (ISAF) through their USAID's COTR and through attending bi-weekly PRT coordination meetings. HSSP has shared handbooks, IEC/ BCC materials and QA standards manuals with PRTs. HSSP collaborates with the University Research Company (URC) that is implementing QA standards in three provinces, and has employed the HSSP QA standards. HSSP also collaborates with the Strengthening Pharmaceutical Systems Project (SPS) in support of its drugs management component.

1.7 REVIEW AND REVISIONS TO THE PROJECT'S PMP

HSSP is revising its PMP in light of USAID project Modification and increased budget. Two issues particularly need to be addressed: that of adding QA implementation coverage targets under IR 1, including Health Posts, and, notably in IR 3, that results are tracked though an MoPH/ GCMU household survey for which the last results over the life of the project is expected to be 2009 while the project will end in 2011, thus diluting an end of project evaluation.

It is recommended that HSSP add targets for those facilities and Health Posts that will have undertaken baselines, and those that will have completed the full evaluation criteria, and as percentages of all facilities and Health Posts.

It is also suggested that further indicators be added that can be tracked from routine M&E and HMIS data to offset the issue relating to household surveys and to strengthen the project's accomplishment indicators. Under IR 1 these could be to add Facilities Management and Drug Management indicators; under IR 2 to add, where possible, the percentage of deliveries performed at CHCs and BHCs as a percentage of all deliveries, as well as the number of family planning visits to CHCs and BHCs as a percentage of women of reproductive age. Indicators concerning the Post Partum Hemorrhage project could also be added. Under IR 3 the number of immunizations given at CHCs, BHCs and Health Posts could be added, as well as a general indicator on the total number of clients

served. A BCC indicator could be taken from the BCC component area within the BPHS QA tracking. The number of facilities implementing PDQ, and as a percentage of all facilities, could also be added by facility level. Under IR 4 an indicator that tracks the number of female staff, beyond midwives, as a percentage of all staff could be added.

Those indicators proposed above that are not directly attributable should be moved to the SO level. Further areas where HSSP works that are not appropriately reflected in the PMP should be considered to ensure that no unrelated indicators are included and that all of HSSP's work is reflected.

2. INTRODUCTION & BACKGROUND

2.1 ENVIRONMENT

Health conditions in Afghanistan are among the worst in the world, where civil society and health services have been crippled by over 30 years of war and civil strife. The return to democratic governance in 2001 began a process to rebuild the country's health infrastructure and significant strides have been made. In 2001 fewer than 400 health facilities were in operation and only about 9% of the population had access to service. Since then over 1,600 health facilities have been renovated, leased or built, and staffed. By 2006 an estimated 75% of the population had some access to basic health care.

Strategically the Ministry of Public Health (MoPH), operating nationally and through provincial health authorities, introduced a Basic Package of Health Services (BPHS) and an Essential Package of Hospital Services (EPHS), and these packages form the essential core platform for health service delivery throughout Afghanistan. The BPHS and EPHS packages are delivered, from the District level on down, by a range of international and domestic NGOs under competitive grants.

Thirteen provinces are allocated to USAID support, both to finance NGO service delivery and in the provision of technical support. There are 26 NGOs working within USAID's provinces who receive funding through Performance-based Partnership Grants (PPG). Grants are awarded through a dedicated Grants & Contracts Management Unit (GCMU) at MoPH, supported by the Tech-Serve project. USAID's funding presently flows through WHO.

A new round of PPG-NGO 2-year grants are to be negotiated in May/ June this year for a start date of October 1.

The remaining twenty one provinces are supported through the World Bank and the European Union. The BPHS and EPHS package are delivered through a range of health facilities with a descending level of service. These are: District Hospitals (DH), Comprehensive Health Centers (CHC); Basic Health Centers (BHC); some Sub-Centers, and Health Posts (HP). At the community level volunteer Community Health Workers (CHW) extend services and collaborate with Health Shuras (and village leadership groups) and are supervised by Community Health Supervisors (CHS) based at health facilities.

While impressive progress has been made, significant challenges remain. Nationally there has been little change in the high maternal mortality rate (1,600 per 100,000 births); infant mortality rates (115 per 1,000 births); child mortality rates (172 per 1,000 live births), and a high fertility rate (Total Fertility Rate at 6.26). Infectious diseases continue to be a problem. Diarrheal diseases, respiratory infections, vaccine preventable diseases and TB, poor hygiene and lack of safe water are notable concerns along with a general lack of prevention awareness; shortages of trained health workers, notably a lack of female health workers, along with social and cultural constraints to women's access to services. The mountainous nature and winter weather in parts of Afghanistan, as well as insurgency activities, are significant challenges to consistent health delivery and access.

All the same, along with the creation of a sustainable health service network, successes must be acknowledged. In USAID provinces, between 2004 and 2006, the contraceptive prevalence rate increased by 9% (from 16.26% to 25.4%); knowledge about at least two family planning methods by women of reproductive age went up from 21% to 52%; the number of women who gave birth in the presence of a trained birth attendant increased 10% (from 12.2% to 22.9%); the number of fully immunized children under the age of two went up from 14.7% to 37.9%.

USAID Afghanistan's 2005 Mission Strategic Plan set out to strengthen successes to date, and build **a better educated and healthier population** and this is supported by Intermediate Result (IR) 7.1 that is designed to help the MoPH to **increase the health of women of reproductive age and children under the age of five.**

Four Sub-results support IR 7.1:

7.1.1: Expand access to basic and secondary health services

7.1.2: Improve the ability of individuals, families and communities to protect their health

7.1.3: Improve the quality of health services and health systems

7.1.4: Increase the utilization of the private sector to provide health services and products

The Health Services Support Project (HSSP) was established by USAID in 2006 to support the mandates expressed in 7.1.1, 7.1.2 and 7.1.3 along with a collaboration mandate to 7.1.4 and with a requirement to collaborate with other USAID contractors active in support of IR 1.7.

2.2 PROJECT HISTORY

HSSP followed on from the USAID-funded REACH project (2003-2006) under the lead management of MSH.

REACH achieved significant results in an environment where USAID support increased the coverage of health services in their provinces from half a million people to 7.4 million people. The REACH project was dedicated to a broad range of improvements to the delivery and quality of health services across building the capacity of MoPH - including

the provision of management support to the Grants and Contracts Management Unit (GCMU) at MoHP that contracts USAID-funded NGOs; training healthcare workers; increasing the numbers of female health workers, most specifically midwives and in community mobilization; and ensuring drug supplies and deliveries. Near to the end of the project REACH took over responsibilities for the private sector initiative's Social Marketing program.

REACH came to an end in 2006 and USAID re-structured the project into three parts. In broad terms the new Tech-Serve project, led by MSH, retained the MoPH strengthening component down to the provincial level. The COMPRI-A Project, led by the Futures Group, took on the Social Marketing component, and the HSSP project, led by Jhpiego, with Futures Group and Save the Children as primary sub-contractors, was designed to work at the national and district levels to build capacities of BPHS implementing NGOs and improve quality of health services within BPHS; increase the number of health workers, especially women in rural areas; generate demand for health services; and integrate gender awareness and practice into the BPHS.

2.3 BRIEF OVERVIEW OF THE HSSP PROJECT

The Health Services Support Project (HSSP) was launched on July 1, 2006 on a four year plus three month's budget of \$19,141,074, and was due to end September 30, 2010 under a Cooperative Agreement. Subsequently, in February 2009 a modification to the Agreement was made that extended the project to March 31, 2011 and increased the budget to \$38,910,949.

HSSP is led by Jhpiego with two sub-contractors: Save the Children and the Futures Group with responsibilities for the Behavioral Change Communications (BCC) and NGO capacity building and gender components respectively. The project is managed under four IRs within which primary activities are briefly noted here:

Intermediate Result 1: Strengthened and developed systems that support service delivery quality.

The primary components of this IR are to improve quality of health services within BPHS through implementation of a quality assurance (QA) process; to provide MoPH and implementing PPG-NGOs with systematic and verifiable performance standards that are measurable through baselines and both internal and external assessments; to establish a QA management system through QA Committees at MoPH central and provincial levels and through a range of collaboration with MoPH technical departments and task forces; to build the capacity of the 26 PPG-NGOs through management and supervisory skills training, and to support collaboration and experience sharing of the NGO community through establishing HSSP Provincial Coordinators.

Intermediate Result 2: Increased number and performance of BPHC service providers, especially women in rural and underserved areas

IR 2 set out to increase the number of skilled female providers by technically and financially supporting community and hospital midwifery education programs; to increase the numbers trained, and support deployment of those trained, notably in rural areas; support the National Midwifery Education Accreditation Board (NMEAB, established in 2005) to improve accreditation standards and to assist schools to achieve

quality and performance improvements; support the Afghan Midwives Association (AMA) to increase its membership and improve members' services, strengthen overall capacity in leadership and management, and its financial sustainability and capacities to support and promote the profession of midwifery; support the development of the Afghan Society of Obstetricians & Gynecologists (AFSOC) to strengthen the Society and improve obstetrics care; support a Prevention of Postpartum Hemorrhage at home births demonstration project which was established and supported under ACCESS Afghanistan and then expanded under HSSP; support the development and implementation of a National Reproductive Health (RH) strategy and national RH in-service training strategy for clinical courses across the BPHS and EPHS health areas, the development of standards for these courses, and to train national trainers and NGO staff; to introduce the QA process for obstetrics and new born care to regional maternity hospitals; in collaboration with Tech-Serve to strengthen Post Partum Family Planning services within the BPHS.

Intermediate Result 3: Improved capacity and willingness of communities, families and individuals to make informed decisions about their health and support and sustain health seeking behaviors

The seven primary components of IR 3 are to: build the capacity of the IEC/ Health Promotion department at MoPH; assist in the production of a National IEC/ BCC strategy; distribute existing REACH materials and produce new health education materials for facilities; build the capacity of NGOs to develop and manage BCC and community mobilization activities; increase the community's participation in the ownership of health services; improve the dialogue between communities and facility-based service providers; mobilize religious leaders in support of BCC activities; and increase advocacy for improved health services and the adoption of appropriate preventive behaviors.

Intermediate Result 4: Integrated gender awareness and practice into BPHS service delivery

IR 4 sets out to institutionalize gender within the BPHS and MoPH; to support the Gender & Reproductive Rights Unit at MoPH; to mainstream gender issues throughout all interventions and in NGO hiring practices; to undertake gender research, and to implement gender training courses to increase awareness about gender issues and integrate gender-sensitive practices into the BPHS (specifically women's empowerment and decision making, male involvement, and gender sensitive interpersonal communication and counseling); and to implement community-based family health action groups.

3. PURPOSE & APPROACH TO THE EVALUATION

3.1 TIMING & PURPOSE

USAID Afghanistan requested a mid-term evaluation of the HSSP project to be undertaken early in 2009. The primary purpose was to assess progress to date in achieving deliverables; to recommend any shifts to project strategies and implementation effort over the second half of the project; and to help guide strategies and directions for any new follow-on project. The Scope of Work (SOW) envisaged a final, detailed evaluation report of findings and recommendations and draft recommendations for any future project after 2011.

A copy of the SOW is attached at Appendix A.

3.2 TEAM APPROACH AND SET-UP OF ACTIVITIES

The evaluation commenced in country on March 23, 2009. The evaluation team attended a series of presentations and information gathering meetings with HSSP management and IR team leaders over the first two days of the assignment and sketched out a key informants list and a process for selecting provinces, NGOs, facilities and collaborating partners to visit. A Work Plan was produced and amended after input from the USAID CTO (see Appendix B), and a briefing and orientation meeting was held at USAID on March 26.

4. EVALUATION ACTIVITIES

4.1 SUPPORT

The consultancy was managed under contract with the USAID SUPPORT project managed by Checchi and Company Consulting, Inc. (with a sub-contract to Louis Berger Group) and supported by that project's staff, security and facilities infrastructure in Kabul.

4.2 SET-UP AND ACTIVITIES

Following steps to set-up the evaluation process over the first five days of the assignment the team spent two weeks visiting five provinces – Hirat, Takhar, Badakhshan, Bamyan and Kabul, interviewing Provincial Health Officers; a total of seven NGOs and 21 health facilities, including five facilities that have not yet formally implemented the HSSP QA process. In between these field visits, and for the following three days, the team interviewed six MoPH staff and the staff at Tech-Serve, MSH BASICS and COMPRI-A as well as further information gathering visits to HSSP.

On April 20th a mid-assignment de-briefing was held at USAID.

The draft evaluation report was presented to USAID, along with a Power Point presentation of main findings and recommendation on May 4th.

For a detailed list of activities see Appendix C.

5. EVIDENCE & FINDINGS OF ANALYSIS

5.1 INTERMEDIATE RESULT 1 -- Strengthened and developed systems that support service delivery quality.

Developing and introducing QA to facilities – HSSP worked to develop performance standards for priority components of each of the 14 health areas within the BPHS covered by the project in consultation with respective MoPH departments; established QA Committees at MoPH at the national and provincial levels and within NGO management structures and in each facility; established monitoring and tracking mechanisms to

institutionalize evaluation and rectification tools; established a realistic roll-out to facilities in three phases, starting Phase 1 in five provinces; moving to eight provinces, and gradually expanding to all 13 USAID provinces.

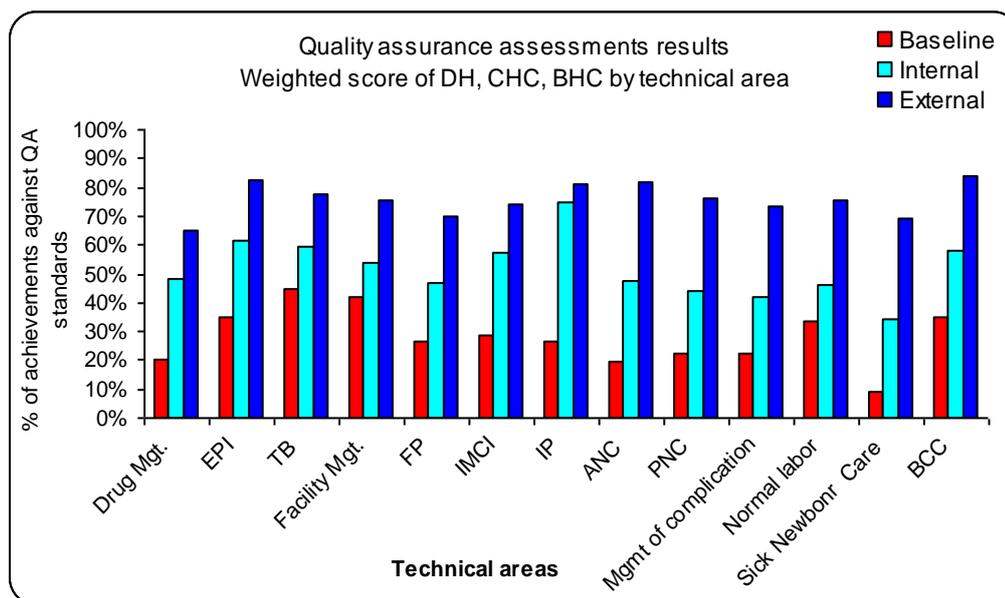
Monitoring and Evaluation tools – A systematic range of tools has been developed to track the effectiveness of training across both QA management and technical training for each health area; QA baselines were first established for each facility and tracked through both an internal and an external evaluation after one year. Finally the project tracks impact through a number of indicators established within its Performance Monitoring Plan (PMP). The evaluation team analyzed data supplied by HSSP; sent a written questionnaire to the NGOs implementing the QA process after a meeting with 20 of them at a routine NGO collaboration meeting in Kabul, and held individual interviews with seven NGOs and at 21 health facilities in five provinces.

Number of Facilities Implementing QA processes to date and planned – In all present USAID provinces HSSP reports that there are 369 health facilities, that is DH, CHC and BHC excluding Health Posts. HSSP has data from 98 facilities that have launched the QA process and conducted a baseline, one internal and a second external assessment. The data have been tabulated for 28 facilities. The remainder is expected to be completed mid-2009. HSSP has set a target of establishing QA in at least 144 facilities by end September 2010. However at October 1, 2009 when the new 2009/10 to 2011/12 NGO grant cycle will be implemented a change in strategy will be put in place. Only one NGO will be awarded a contract per province (although they may include sub-contractors) and, in some USAID provinces where World Bank or EU NGO clusters operate, they will be consolidated under the USAID grants. This is expected to increase the number of facilities by, at most, 100. At October 1, 2009, therefore, there is expected to be about 469 facilities and by October 2010 at least 144 will have launched, fully the QA process and, according to the PMP 75% of them, or 108, will achieve a fully functioning QA system. In addition it is noted that USAID's HSSP Modification does not set a specific target for EOP but does state that the process should not continue beyond the end of year four (2010). Note that most NGOs have launched QA in many more facilities than the above data indicates. This is discussed in more detail in the NGO evaluation report below.

At the same time USAID's funding to NGOs will be shifted from WHO to the Ministry of Finance.

Health Posts – QA Standards have been established by HSSP for Health Posts and NGOs have extended QA to many of them. To date baselines have been conducted for 170 Health Posts and 300 more are to be completed by end 2009. It is noted that Health Posts have been added since the project's inception and is seen as a pilot, and are not included in the present PMP.

Mean Quality Improvement Scores by Health Area -- HSSP collected data to assess QA results across 13 health intervention areas within the BPHS (the 14th area had not been separated out at the time of baselines; now, however, gender is assessed in area 14 as well as being integrated into the 13 other areas). The results are shown below for the first 23 facilities that have completed a full QA cycle, which includes the baseline, two internal and second external assessments, and the results analyzed.



The above data demonstrate the very significant improvements to the quality of health delivery achieved through the QA process. More detailed analysis shows that if 70% of the external quality achievement is set as the base for successful achievement, the three areas most in need of follow-up would be Drugs Management, FP, and Sick New Born Care. In analysis of each facility's successes it is noted that, in general, there is consistency of improvement across all facilities excepting some weaknesses in four out of the five BHC/CHCs reporting in Takhar province and one out of four in Paktia province. Further comments on the BCC area are included under IR 3.

Pre and Post test scores of HSSP Training -- (note that the following sections address all training to NGOs' and facilities' staff, including training that is established under IR 2, for convenience) -- The evaluation team was able to spot-check the relative effectiveness of training across 42 courses where pre and post test training results were available.

The average pre test score across all courses was 43.4%. The average post test score was 77.7%. The greatest increase between pre and post test results appear to have been accomplished within gender training with a pre test average score of 31.6% and a post test average score of 84.9%. The lowest base pre test score appears to be for Interpersonal Communications and Counseling at 23.75% with a post test score of 58.25%.

NGO Responses to Questionnaire – Fifteen NGOs responded to the evaluation team's questionnaire concerning the HSSP project and its impact on building capacity and QA in their operations. The following is a summary of the comments of those NGOs who scored any specific question at 3 or less, out of 5 (five being excellent; three average and one poor). It must be pointed out that the overall scores and opinions expressed in the questionnaire were highly positive and the evaluation team explores these lower scores as a tool to better understand constraints and weaknesses for further review.

1. How effective was the process to identify your training needs?

Five respondents scored their answer 3 or less (out of 15). Comments included a request for more advanced notice of courses (presently 10-15 days is given); a request to up-date course schedules regularly so as to better meet training needs; a request for better tools to help NGOs assess their training needs and to tailor training more precisely to those needs. In addition a primary issue seems to revolve around that of training replacement staff, and the difficulties of getting them trained quickly; that is to match an immediate training need with the HSSP training schedule. One NGO reported a 20% staff replacement rate over two years.

2. Rate the content quality of HSSP training courses.

Four out of 15 scored this question at a 3 (average). No comment was requested.

3. Rate effectiveness of training methodology.

Three out of 15 rated this request at a 3 (average). No comments.

4. To what extent were courses relevant to QA issues faced at NGO facilities.

Only one scored this at a 3 (average) with no comment. In general NGOs found the range of courses met facility needs.

5. Sharing of lessons learned, problem solving and communications with other NGOs.

Seven scored this section a 3 (somewhat effective). Comments were that HSSP should employ more Coordinators as there were only eight covering all 13 provinces. They requested one Provincial Coordinator per province; NGOs could engage in cross-supervision, and more provincial coordination meetings could be held. Note: The project will have 13 Coordinators by May this year.

6. Tracking success of training in the NGO's health programs.

All respondents scored this a 4 or 5. Most admitted that of all training received only HSSP undertook thorough pre-and post-training analysis.

7. To what extent this success could be contributed to HSSP?

Only two out of 14 scored this a 3 (somewhat). Comments from one NGO were that they had only replicated training to 40% of their health facilities so far, the inference being that they would have liked to have extended training to more of them to date, and that (at least as far as this NGO is concerned) only doctors, midwives and CHSs had been trained so far, not nurses, vaccinators or administration staff. There were also two comments somewhat critical of the fairness in the way recognition awards were allocated!

8. Exploring the extent to which training had been extended to non-HSSP facilities.

Respondents reported very significant efforts to extend training to facilities that had not yet been formally selected for HSSP QA training, and it is important to note that HSSP supplies training to all facilities, not only those formally implementing the QA process. This is significant as it demonstrates the extent to which HSSP inputs have been institutionalized within the NGOs being supported. By far the most popular course offered, to a total of 161 non-HSSP facilities, was MDR/ RUD. The next most popular courses given to between 20 and 30 CHC and BHC staff were: IP,QA, IMC, gender, FP, PFP, IPCC and PDQ. Courses given to fewer than 20 facility staff were: BCC, HRM, new born care, mental health, effective supervisory skills, report writing, HR management, POP, HMIS and ETS. In total the 11 NGOs who reported training to non-HSSP facilities, they had trained 1,237 staff.

9. General comments and comments on constraints and problems.

In general all NGO respondents were highly positive towards the capacity building inputs they had received from HSSP. The introduction of a systematic QA process was the most evident response and all agreed this process had significantly improved their operations, with several reporting that the success of the program helped to build more effective, provincial-based decentralization in their organizations. In general, the primary constraining issues mentioned were: a lack of dedicated trainers within their provincial organizations; budgetary constraints for replication resulting in an insufficient depth to replication training; a request for more management training. A significant issue was that of staff turnover and problems of training replacements quickly enough to sustain quality improvements, and a request for more training in provinces, rather than in Kabul, is evident. A further comment was that training results were not fed back to the individual trained.

Other constraints mentioned included: difficulties in hiring female staff and a continued low level of community response.

Cross-check with field interviews by evaluation team -- In general inputs received from field interviews with NGOs and at facilities were similar to those expressed in the written questionnaires. All NGOs were dedicated to expanding QA and training across all facilities as far as they practically could (including to Health Posts). The issue of dedicated trainers also came up. In one province the NGO had recently hired two dedicated trainers and was struggling to get them trained and to fit their training into the HSSP training schedule. Several NGOs were employing other staff, with other responsibilities, for training (the Health Director or Technical Director for example) and these dual responsibilities clearly impacted on the amount of training that could be accomplished. However, across all NGOs the dedication to expand training across both QA supported and non-QA supported facilities was quite extraordinary. Most NGOs stated that while they appreciated that HSSP was dedicated to a rather slow pace in the development of HSSP QA to all facilities, and that they admitted this was sensible in respect to their capacity limitations, they would have liked to have moved faster to cover all their facilities. It is probable that the constraining issues were both the lack of dedicated training personnel and management, budgetary issues.

Most NGOs interviewed understood that HSSP could not offer direct budgetary support to training, specifically at the facilities level. At the same time they had limited line-item budgets for this task. All hoped that the next round of PPG grants (to be awarded in May/June and implemented October 1, 2009) will allow more training budgets (notably to hire dedicated trainers). In this respect GCMU reported that training budgets for the next round of grants would be no more than 1.5% of total budgets. We estimated this at about \$15,000 per annum for the average grantee. This appears modest, at best.

At the facility level the most common appreciation of HSSP inputs that was not as clearly stated in the written questionnaire to NGOs, was that for the PDQ component. This expressed the facilities' emphasis on the need to be more pro-active in gaining community support and, through that, greater demand created.

The evaluation felt that although participatory training models are employed by HSSP the courses did appear to be too heavily reliant on Power Point presentations and courses could be adjusted to include more participatory and empowering processes.

Assessing variations between the implementation of NGOs across provinces – In general there appeared to be little variation between provinces and facilities in the kinds of training identified as being required and in the results of training. All facilities seemed to judge the effectiveness of HSSP in three similar ways: an increase in deliveries by midwives; an increase in immunizations, and that the introduction of PDQ had given them a focused methodology to improve outreach to communities in tangible ways. Two variables were, however, evident. One was that facilities visited mostly reported few problems with drug supply even though they were seeing increased demand. This was not true everywhere, however. In Bamyan province a Health Shura leader mentioned that drug supply was an important issue in his province. In his opinion insufficient analysis had been done on the extent to which those returning from Iran and Pakistan were analyzed to ensure adequate drugs were available. In addition they needed increased supplies pre-winter because they had to give CHWs and Health Posts three months stock to tide them over the months when they were cut-off by Winter snows from routine supply (although this issue is not within the mandate of HSSP). The other variable was the quality of CHS staff who trained CHWs. Some were younger and more active; others were older and more traditional, and seemed to lack the level of rapport with CHWs that would be required to make them effective. PDQ appeared to be implemented in similar ways across all facilities as were BCC and health education activities, beyond language differences.

MOPH inputs – The QA process at the central MoPH level was originally established as a Committee under the Chairmanship of the Afghan Public Health Institute (APHI) but has more recently been shifted under the Health Services Provision Directorate (HSPD). It has been well established and institutionalized at MoPH and it appears clear that within the context of the broader issue of a growing strategic imperative to seek standardization across all USAID, World Bank and EU provinces, the standardization of the HSSP QA process within the present, national M&E/ HMIS format is being actively considered. At the provincial levels QA Committees are also well established but inconsistencies in the depth and weight of commitment across all provinces are noted.

Expanding health areas within BPHS by HSSP – HSSP's work plan for 2008/09 adds a number of components to the BPHS package being supported. These are: to set standards for nutrition, malaria, blood transfusion, C-Sections, mental health and strengthening of NGO management standards. USAID's HSSP Modification adds to this the strengthening or the addition of stock management, laboratory skills and report writing skills. It also adds that HSSP should reserve budgets to respond to unanticipated training needs identified during the QA monitoring and tracking processes or identified by GCMU.

Expanding Provincial Coordinators – HSSP will expand its present 8 Provincial coordinators to one per province or thirteen in 2009.

Communications with, and incentivization of, NGOs – HSSP publishes a PPG/PCH Newsletter to help in sharing and up-dating technical and project implementation issues between NGOs and between them and the project. Regular monthly meetings are organized between the project and NGOs with each NGO taking turns to host it. HSSP

also adds depth to training follow-up through sending short message services (SMS) through mobile phones as reminders to implement the skills learned.

Provincial Coordinators are responsible to:

- Coordinate efforts between NGOs and share lessons learned
- Manage and supervise quality assurance process in their provinces
- Manage, supervise and facilitate the training process (TNA, conduct training and post training follow-up).

On a broader front HSSP has instituted measures for rewarding success by NGOs and by facilities that achieve the highest QA scores and, in support of this, Model Health facilities have been established in five provinces to date.

In view of the difficulties in communications with more isolated and insecure health facilities USAID's HSSP Modification includes an innovative solution to facilitate patient referrals and allow providers to communicate better with NGO field offices through HSSP purchase of 199 CODAN radios.

CONCLUSIONS – The establishment and institutionalization of the QA process across MoPH on all levels and within the NGOs and facilities' operations is a very significant achievement. The primary issue is that of the extent to which the QA program is being rolled out and the level of facilities' coverage that may be realistically achieved, and the fact that more facilities will be added at October 2009. HSSP's present goal is to achieve 144 QA facilities by end September 2010 with 75% of them fully functional (108). The total number of facilities, including the 100 new facilities to be added in October 2009, will be about 469. HSSP will therefore be covering only about 30% of all facilities. HSSP does, in fact hope to achieve more.

At the same time further "depth" is being proposed to add new interventions to the process that would require existing QA facilities to be trained in these new initiatives. There is some risk involved in that the need to add depth to existing QA initiatives will mitigate against the need to achieve the targets for QA roll out and coverage.

HSSP itself has the capacity to implement the components proposed with an increased budget and a realistic plan to increase its staff appropriately.

However the extent to which the NGO community also possesses adequate capacity is an issue that needs to be analyzed within the contexts of a new strategy and work plan that HSSP has begun to draft in response to USAID's Project Modification to 2011.

In addition, the re-structuring of the "mix" of NGOs at October 2009 with new grants and with one "lead" NGO per province, while no major disruptions to operations are to be expected, the new system will require NGOs to take over the management of health facilities from each other, build staff capacities to handle both more sub-contracts and larger operations, and some disruptions are probable. This process should commence in May/ June 2009 when the final grants will be negotiated by GCMU for implementation October 1.

The issue of replication training costs borne by NGOs and their capacity to manage and adequately fund their internal and external training needs is complex. On the one hand NGOs, naturally, complain about inadequate training budgets and, yet, they have succeeded in expanding QA, if not perhaps adequately, to more facilities that HSSP commits them to accomplish, or reports. All professionals enjoy training and there is a risk that relatively unlimited budgets lead to unnecessary training, hence the constraint of 1.5% of budgets being the maximum allowable by GCMU. The issues of dedicated trainers as against part-time trainers, particularly as lead NGOs will now be managing larger networks than before, is an important issue; the problems of quickly training replacement or newly hired staff, and the lack of feed-back to those trained are all issues that need to be addressed through analysis.

The evaluation could not accurately assess the true quality of replication training by NGOs within facilities. A numbers of indicators did throw up some measures of concern in considering whether the QA process could be expanded much further from the 144 facilities presently assumed. Did NGOs have adequate staff for replication training? Did facilities receive adequate materials for reference and for sharing with other facility staff beyond those explicitly trained? Was training too focused on individuals and not adequately focused on groups within facilities?

The shift of USAID's funding to NGOs implementation activities, from a mechanism through WHO to the Ministry of Finance is noted.

RECOMMENDATIONS

- Revisit QA coverage target with the 13 new provincial lead PPG-NGO grantees (expected to be appointed in June 2009). Agree targets for replication training by numbers of facilities and Health Posts. Present proposed target to USAID and agree on any revisions to present targets if feasible.
- Analyze and report needs assessments for management and technical training by each PPG-NGO to end 2010. Restructure training needs in light of expanded NGO operations (additional management and sub-contracting training), and arrange new training schedule on an NGO specific needs basis and, as far as possible, at the provincial level.
- If necessary add training on invoicing and payment procedures through the Ministry of Finance to NGO finance managers.
- Address the need for a quick, practical response to NGO replacement staff training needs.
- Review and, if required and feasible, add additional empowerment models to training.
- Ensure new Provincial Coordinators are well trained including on-the-job training with existing Coordinators.

- Discuss with PPG-NGOs issues of retaining staff after training and what incentives might be put in place to resolve – contractual agreements to remain after training; merit pay increases after evaluation of improved performance after training.

THE LONGER TERM VISION AND IMPLICATIONS FOR A FOLLOW-ON PROJECT

- Develop sustainability measurements models across new NGO networks, QA Committees and at training establishments (including training budget needs after September 2010 and at March 2011); using these monitoring models for each institutional element: MoPH QA Committees; NGO management and training replication; training establishments, and facilities training needs present to USAID the modalities and time-scale for a self-sustainment situational analysis projected at end 2010 and end of project.
- USAID to set deadline for this sustainability report linked to the utilization of inputs in consideration of the scope for a new project beyond 2011.

5.2 INTERMEDIATE RESULT 2: Increased number and performance of BPHS service providers, especially women in rural and underserved areas

Midwifery Education Program – HSSP currently supports Community Midwifery Education (CME) programs in seven provinces (Jawzjan, Takhar, Khost, Badakhshan, Bamyan, Pakyta and Ghor) and two hospital midwifery programs in Kabul and Hirat. Two more in Balkh and Nangarhar have been completed.

Currently 191 community midwives and 245 hospital midwives are enrolled in supported courses. Since the project's inception 333 hospital and community midwives have graduated, from a target of 300 community midwives graduated. USAID's project Modification supports a new batch of midwives to be graduated in 2010.

HSSP is developing e-learning tools to support midwifery training for use by Midwifery Community Schools. These are somewhat limited and based on non-internet CD tools. The first CD on the active management of third-stage labor has been produced and field tested and is being followed by two further CDs on FP counseling that is completed pending field testing and on immediate new born care.

Support to the National Midwifery Education Accreditation Board - HSSP has supported improved accreditation and processes at midwifery schools through technical assistance and workshops and has supported a number of technical issues such as the priority to ensure placement of rural-based graduates in rural areas.

Support to the Afghan Midwifery Association – HSSP supported the establishment of a governing body made up of representatives from 24 provinces and helped build support services and membership to over 1,100 midwives; supported the AMA Congresses; and held management and leadership courses as well as in-service training.

Issues concerning midwives and midwifery services that surfaced from field interviews - Community midwives are based at both CHC and BHC facilities, however only CHC facilities provided midwifery services at their facilities after 4:00 PM. At the CHC level all facilities visited provided “after-hours” services either through the midwives who were resident at the facility or through bringing in extra help from midwives in other facilities if necessary. At some BHC facilities, where midwives lived close to the facility, and many did, they responded that if a delivery was necessary they would open up the facility for that purpose. However in a few facilities, mostly those that were in peri-urban areas there was too little contact between BHC midwives and the local community for this service to be provided. In these cases midwives claimed that they advised women to go to a CHC if they needed to deliver after hours but they did not seem to track those that did or did not do so. It was also possible that in some cases midwives assisted with deliveries in homes but none responded that they actually did this, even those midwives living close to a BHC that offered no after-hours services.

In general most facilities used the notable increase in deliveries by their midwives as the most productive example of the success of the QA process in their facilities. Statistically deliveries were increasing but it was mentioned that this may be caused by the introduction of free services in 2008 (one facility responded that they used to charge \$1 per delivery). However the number of deliveries was still relatively small with a typical BHC delivering one to seven babies a month; CHC 10 to 71 and DH 29 to over 250.

The evaluation noted that each midwife or midwifery team reported that they had targets for the number of deliveries to be achieved. However these targets appeared to be lower than the deliveries they were already achieving.

Support to the Afghan Society of Obstetricians & Gynecologists – HSSP helped to rebuild this association and to re-launch it in 2007 with a new constitution that has been approved by the Ministry of Justice and the election of a new president.

Prevention of Post Partum Hemorrhage at Homebirth Demonstration Project – Considering the high level of home births in Afghanistan, often unattended by a trained midwife, this pilot set out to establish the safety, acceptability, feasibility and program effectiveness of providing uterotonic, specifically Microprostaglandin, through community-based CHWs, to women who deliver at home. The pilot covered six districts in three provinces and included three districts as a control area. The results have been highly encouraging. CHWs were trained through their Community Health Supervisors (CHS) in assisting pregnant women to identify and manage bleeding and hemorrhage, and where support to go to a health facility or find a trained midwife failed, to take Misoprostol correctly. CHWs were provided the drug and trained to manage stock and return un-used stocks. In the control area 25.7% of pregnant women had used any uterotonic (primarily at a health facility) and 96.2% in the intervention area; self-perception of having experienced a hemorrhage in the control area was 49.3% and in the intervention area 11%. It was noted that CHWs were reaching women who had no prior knowledge of the availability of any health services and that ANC visits and deliveries at facilities increased in the intervention area. The MoPH has decided to roll out the pilot study to cover 20,000 pregnant women to test out, further, the feasibility of the intervention on a larger scale, and this component has been included in USAID’s HSSP Modification to 2011.

In-Service Training -- HSSP has conducted a total of 169 training events covering 35 courses to 4,189 participants since July 2006. Participants included 203 MoPH staff at the national level; 313 at the provincial level; 1,990 NGO office staff; 1,677 NGO facilities staff, and 6 from the private sector.

Under IR 2 an emphasis has been placed on newborn care in collaboration with the RH Task force at the MoPH. At the start initial QA analysis demonstrated a baseline of effectiveness close to zero. A Newborn Working Group was established, QA standards for IMCI and newborn care developed, newborn care in-service training system at national level was established which included developing a competency based learning resource package (LRP), designing Basic and Advanced courses, developing 24 part-time trainers were selected by MoPH located in five Regional Provinces – half male and half female, conducting five sessions for 2008/09 to about 80 health care providers. Issues of provision of adequate supplies for newborn support at health facilities have been a constraint with NGOs reporting that they have included resolutions to this issue in their grants applications for the new 2009/11 grants. HSSP has been providing technical and financial support to the IMCI department of MoPH to train PPG NGOs' staff on IMCI. Five IMCI case management course have been conducted and there are plans to conduct four more in 2009.

Emergency Obstetrics Care (EmOC) Training – EmOC training is undertaken through 15 trainers of which six are based in Kabul, the others in other training schools in other provinces. They train trainers who, in turn, train doctors and midwives. EmOC training commenced in 2002/03 and the training undertaken by HSSP has been regarded as refresher-training by those trained. The trainers reported that they were generally satisfied with HSSP training, however they responded to the question on training quality that the courses offered were little different from those they had received in 2003, and they would have preferred more up-dated courses. They also felt that the training was too short. In addition, as these trainers are also practicing in the training hospital they have inadequate time to fulfill the demands of training that have steadily grown.

Post-Training Follow-up – HSSP acknowledged that there had been gaps identified in post-training follow-up and these gaps were being rectified. The project had been slow to implement effective follow-up to 2008 and each training component had independently managed the follow-up process. NGOs tended to give low priority to training follow-up as well. This issue was being thoroughly addressed. A new HSSP Task Force had been created and was moving ahead to complete its strategies and create new implementation tools for implementation at the time of this evaluation. The aim is to have the NGOs and MoPH institutionalize this process and continue to use it beyond HSSP to ensure proper follow-up after training.

Strengthening Family Planning (FP) within the BPHS – FP QA standards had been created and incorporated into all QA facilities; a community-based post-partum FP training Package and an effective teaching skills (ETS) package developed as well as a condom use job aid for facilities staff. The Progestogen-only pill (POP) and injectable contraceptive (DMPA) had been added to the method mix through gaining approval from MoPH for these products to be included providing the providers were well trained, most importantly CHWs, although they were not permitted to give the first DMPA injection. 1,400 health providers had been trained in POP. To December 2008 nine FP training

courses had been undertaken to 65 health providers, NGO staff and 11 MoPH staff. HSSP is working with BPHS implementing NGOs to supervise and monitor the cascade of postpartum family planning training courses for CHWs, as well as CHWs and CHSs to strengthen service delivery at the community level in order to ensure quality of training and service delivery.

More broadly HSSP is working with the MoPH and NGOs to implement RH strategy which is the national standardized system for FP and other RH service delivery. A national RH training center is planned by MoPH.

TA to the RH unit at MoPH continues and the implementation of the RH QA process in five regional hospitals is underway.

USAID's HSSP Modification stresses the need to collaborate closely with Tech-Serve and to create linkages with the Community-Based Health Care (CBHS) department and will expand the community based contraceptive usage project started by REACH. Through the FP department train trainers and ensure policy level components are in place; provide new IEC materials for CHWs and community members. The focus is to be on the post-natal period.

Family Planning at the facilities level – In general almost all facilities had stocks of family planning commodities, including those held by midwives. Those midwives did have records of estimates of the total number of women of reproductive age in the area served by their facilities but they could not easily report what percentage of the total they were serving. However those who could give some estimates quoted figures ranging from a low of 7% to 25%, and all agreed that these figures were low. Most stated that it was up to the CHWs and community to increase coverage.

Community Nursing Education – HSSP has begun the process of expanding its remit to increase the number of female providers by including community nursing education (CNE) and the training of community nurses. USAID's HSSP Modification confirms that work that has already started on this initiative – to support the development of a national CNE program in order to accelerate Global Fund investments through developing a competency-based job description and CNE curriculum; national policy and standards, and support a National Education Accreditation Board or the integration of nursing into the National Midwifery Education Accreditation Board.

Mental Health

HSSP has supported MoPH to develop a mental health reference manual for BPHS and EPHS. Next, HSSP will develop a mental health learning resource package and train national trainers and then health providers.

Pre-service Evaluation

An Evaluation of Pre-service Midwifery Education, which began in the previous reporting period, continues in this reporting period and informed the discussions during the midwifery education curriculum revision workshop. The qualitative and quantitative data collected from interviews with graduated midwives (Phase I) were analyzed, and the

results of the analysis were used to guide the midwifery education curriculum revision in January 2009.

Phase II of the evaluation, including interviews with female community members (clients and non-clients of the graduated midwives), MoPH relevant officers (reproductive health, human resources, provincial health directors), representative of AMA and NMEAB, and managers of the midwifery schools were conducted. A sub sample of midwives was trained in a specifically designed register to document their actual services. The interviews are being analyzed qualitatively. The document review process is also in progress since the start of the evaluation. The midwives have already been sent back to their working place and the data collection is ongoing. The results of the different data collection activities and those of the document review will be synthesized in the final report of the evaluation. Work on the report is in progress. Estimation of deaths averted as a result of this intervention will be conducted at headquarters, after feasibility of the process is reconfirmed. The cost effectiveness analysis will be conducted next project year (October 2009).

CONCLUSIONS: The IR 2 component is to be applauded for achieving a number of notable successes across its components. The midwives training efforts have been widely applauded.

Two on-going issue within the midwifery program that continue to be addressed are how midwives are selected to become community-based midwives rather than hospital based, and the issue of providing “after-hours” services at the BHC level.

The issue of after-hours services at the BHC level would, ideally, be resolved through increasing the numbers of midwives available at that level in order to provide after-hours services similar to that provided through CHC facilities. Building the required number of midwives to accomplish this will, however, take time. In the meantime the issue of the utilization of BHC midwives for home delivery services may conflict with the realistic assumption that they may be doing so but not reporting it. In addition the creation of a lower tier of entirely community-based TBAs may offer an alternative in the longer term.

The issue of a broader expansion of the Post Partum Hemorrhage pilot rests on concerns, primarily from WHO, on the wisdom of distributing Misoprostol through community-based systems without prescription or other physician or pharmacists oversight. The completed pilot study appears to have put any concerns such as this to rest, but they linger in respect to the issues of maintaining the level of inputs achieved within the pilot on a much larger scale. The response from MoPH has been to broaden the project to 20,000 pregnant women to test out this issue on a broader scale. This is the correct strategic approach and has been confirmed as approved within USAID’s Modification of the HSSP project.

USAID’s proposal to focus on the post-natal period is realistic in that midwives are well placed to begin this process and they doing this, quite well, at the facilities level now even though the numbers of deliveries, and therefore, counseling opportunities are still a relatively small percentage of all deliveries.

RECOMMENDATIONS BOTH SHORT AND LONGER TERM

- Explore with COMPRI-A issue of BHC midwives related to private sector midwives; participate in resolutions to BHC midwives' provision of after-hours services, and support to home deliveries.
- Continue to address community midwives' placement issues.
- Explore with EmOC trainers their request for more up-dated training and their work load (related, also, to Recommendations under the longer term assessment of training institutions under IR 1).
- Assess training needs for those already trained in respect to the list of new BPHS areas that have been added.
- Consider shifting FP even more towards Child Spacing terminology and health benefit.
- Other technical training issues are addressed under IR 1.
- Other behavioral change issues are discussed under IR 3.

5.3 INTERMEDIATE RESULT 3: Improved capacity and willingness of communities, families and individuals to make informed decisions about their health and support and sustain health seeking behaviors

Launching Integrated Partnership Defined Quality (PDQ) into the QA process – PDQ is designed to promote a sense of community ownership of facilities and to lead to better dialogue between facilities and the community served by them. HSSP first undertook a scoping and enquiry exercise for PDQ in five QA Phase 1 provinces (Kabul, Paktya, Takhar, Hirat and Bamyan). PDQ was, first, added to the QA component and then training of trainers in PDQ implemented. To date PDQ has been officially replicated in Kabul, Bamyan and Takhar provinces although as with all QA components NGOs are replicating the effort across more facilities that they are officially mandated to do so.

Inputs on PDQ from NGO and field visits by evaluation team – PDQ was found in almost all facilities visited in Kabul, Takhar, Hirat, Bamyan and in the District Hospital in Badakhshan. All facilities implementing PDQ were highly supportive of the initiative and were actively implementing it. In those facilities where Health Shura leaders were interviewed they, too, were active in exploring PDQ initiatives. One mentioned that it had helped bring the Mullah's into the QA process. The most commonly mentioned initiatives were to improve access to facilities and to arrange transport, particularly to bring women in for deliveries and for emergency care. One Shura leader, in Kabul province, had, for example, formed a pool of available transport that could be called up in emergency. Many had, however, simply identified the fact that this issue appeared to be a priority as a result of PDQ enquiries within communities, but they were still seeking solutions – for example to request that the facility obtain another ambulance. Other initiatives noted were to ask the community to come together and provide support to up-grade facilities – building a new wall around the facility; retiling floors; building a new waiting room were mentioned. However, in general, the most common response to PDQ was that it had

strengthened the relationship between the facility and the community and this had helped increase the number of births performed at the facility.

Anecdotally, the evaluation team still wondered whether a real sense of ownership was being created within communities. Both facility staff and Shura leaders still appeared to possess something of a top-down, authoritative approach to communities. Where communities were asked what could the facility do to serve them better, while the question may be appreciated, there was no certainly that a quick and tangible resolution could be achieved, and where communities were asked to think of some way to get involved in improving the facilities themselves we have to wonder how many could do anything or that it would lead to a sense of self-ownership within the community at large. All the same, in general, the PDQ initiative has been a very significant achievement and has done a great deal to strengthen the QA process.

Support to MoPH – HSSP has actively supported the development of the Health Promotion Department at the MoPH. A National Health & Nutrition Communications Strategy, 2008 to 2013, has been produced and approved by the MoPH Executive Board; the IEC Task Force has been revived and was holding regular meetings; BCC training had been undertaken to MoPH staff and Regional IEC officers; HSSP had distributed IEC materials remaining from the REACH project, reprinted REACH materials, and developed a range of new IEC materials on birth spacing, DMPA flip charts, FP wall charts, and a PPH job aid as well as distributing MoPH and GAVI IEC material to NGOs. They had also supported the MoPH Reproductive Health Department in promoting and celebrating National Safe Motherhood Day and the Community Based Health Care Department in arranging a national CHW conference.

BCC, Interpersonal Communications and Counseling (IPC/C) and PDQ Capacity Building of NGOs, Pre-Service Institutions – HSSP has created BCC standards across client satisfaction, PDQ and IPC/C methodologies; trained service providers in these standards; developed a Religious Leaders training manual, and implemented training across BPHS health component areas, community mobilization, PDQ, IPC/C and in health Shura management and community linkages.

Evaluation Team Review of IEC, BCC and IPC/C Environment and Progress – HSSP has begun the task of addressing the imperatives needed to shift the emphasis from a purely health education approach to achieving a longer-term aim of addressing the more complex approaches needed to achieve successful results in the social and behavioral change environment that will lead women, in particular, to take charge of their health needs and the needs of their children.

The Health Promotion Department at the MoPH has made substantial progress in understanding the need to shift from purely health education approaches to more behavioral change approaches, and the National Health Communications Strategy document clearly articulates this need. However their capacity to implement a national BCC and IPC/C strategy is largely limited to the Head of the Department and he will be leaving on extended educational leave shortly. The Head of the RH Department appreciates, also, that each intervention within the BPHS essentially requires its own behavioral change component and that this approach is presently somewhat piecemeal

across Departments and across implementing agencies (and various NGOs and donors) and needs to be pulled together.

HSSP's BCC and IPC/C manuals and training tools also define the weaknesses of purely health education approaches but because the precise behavioral change issues and messages are yet to be defined, these materials, while excellent in their own way, are naturally more theoretical than useful to those who receive that training.

The result of this important gap in introducing precise behavioral change modifications to health education message were clearly observed in the field by the evaluation team. In general facility staffs retain entirely health education approaches to those they counsel. Posters, counseling cards or cloth flip charts are employed. In all facilities posters were in abundant supply, usually lining walls and placed rather too high to be properly seen. Most posters were complex and with too many words and must appear almost incomprehensible to those who cannot read. In all facilities traditional health education formats are being presented to mothers and pregnant women. Very little, if any, two-way communication was being achieved. In the rare case where efforts were seen to accomplish it that effort was limited to simply asking "Do you understand?" and the answer was always "Yes!"

In a more mature behavioral change environments the counselor would have at least asked a set of behavioral constraint questions such as, "What difficulties would you face in deciding to practice family planning?" and if the answer was, "My husband will not agree" the counselor would have been trained to provide some form of satisfactory answer, such as "Will you be able to ask a male CHW or Shura member to talk to him first?" or other appropriate response. At the same time an FP behavioral change initiative would have a specific component that addressed this issue, and Health Shuras and CSWs would have been included as influencers within it and be already supporting the processes involved within the community, ideally backed up by local mass- and traditional media.

Responses were mixed where the evaluation team was able to discuss this issue of behavioral change communications with NGOs directly. Clearly NGOs, such as Save the Children, are well versed in behavioral change approaches, others are clearly not so capable. The issue that was brought up, however, was that within the BPHS none of the NGOs volunteered that they had a mandate, under HSSP, to create these kinds of behavioral change approaches.

HSSP's Modification to 2011 -- It is noted that within USAID's HSSP Modification to 2011 the primary additional remit under IR 3 is to ensure that IEC materials are available in all health facilities, notably the increased facilities that will be created through the integration of non-USAID facilities within USAID provinces, and to expand the PDQ component to all USAID provinces.

CONCLUSIONS: Within its mandate HSSP has achieved significant results in moving towards improved approaches to the health education remit, notably in its support to the Health Promotion Department at MoPH, a department that has developed significant capabilities although limited in its management capabilities. However HSSP's mandate has been a limited one in that its primary remit has been to build the capacity of NGOs to deliver better services through its facilities at the DH, CHC and BHC levels, with an extension to HPs and in training CHW trainers. It is reasonable to say that the project has

successfully expanded its previously limited remit in working together with Tech-Serve and others to introduce the Family Action Groups below the Health Post level.

HSSP certainly could not have taken on the responsibility to create the detailed behavioral change approaches and messages that would need to be created through formative research for each of the BPHS components and to train and manage this process from MoPH Departments, through the Health Promotion Department; to NGOs on down to CHWs and the community level. Within this constraint they have fully met their obligations within their contract.

RECOMMENDATIONS

- HSSP should continue to stress the importance of behavioral change approach initiatives, although to end of project HSSP should develop those precise approaches only for the Gender component.
- Within HSSP, to better define new materials produced to be used for counseling and those to be seen by those who cannot read; to develop behavioral change strategies within the gender component (under IR 4).

LONGER-TERM RECOMMENDATIONS

- Behavioral change strategies and relevant messages and materials need to be put in place across each BPHS area and across the whole communications arena -- from MoPH, on down to the development of behavioral change management at the NGO and community levels; to the development and management of community-based networks, and across the creation of behavioral/ social change strategies through rapid formative research processes; the development of messages and the training needed to deliver them.
- It is suggested that USAID should consider a follow-on project that would integrate these inputs across all relevant players.

5.4 INTERMEDIATE RESULT 4: Integrated gender awareness and practice into BPHS service delivery

Mainstreaming within HSSP – A project Gender Task Force and a Gender Integration Index (GII) has been created to track the extent that gender issues are addressed across programs, office policies and procedures, and in hiring practices.

Support to MoPH – HSSP has worked with the Gender & Reproductive Rights (GRR) unit at MoPH to assist them to produce their annual work plans; adapted to the Afghanistan environment the WHO gender and reproductive health manual; participated in Task Force meetings; developed a one-group e-mail account; worked with the Health Promotion Unit to support gender mainstreaming into BCC/IEC strategies; and worked with GCMU to integrate gender components into this year’s PCH-NGO contracts, and

hosted the first Women's Action Group (now Family Health Action Group) workshop and follow-on activities (see below for further details).

Gender Integration into QA and Training – Gender has been integrated into the QA process, including the QA standards manuals, and the production of a gender training manual. To date 11 training sessions in gender have been undertaken to 248 health providers and NGO staff (about half of the male and half female).

Gender Research -- HSSP is presently undertaking a research project within the context of developing formative research within the BCC and behavioral change agenda, and support the creation of more specific gender strategies, message and materials.

Family Health Action Groups – Within IR4 HSSP is working with the MoPH and with Tech-Serve to develop community-based Family Health Action Groups. These action groups (comprised of 10 – 12 women) would be created from clusters of between 10 to 15 families supported by one appointed woman within the group. She would work to support the outreach activities of CHWs to help engender healthy homes and lifestyles, promote the use of health services, to build a strong information and referral system that helps CHWs attend to pregnancies, deliveries, and illnesses. HSSP is leading the process, hosted the first workshop of this joint initiative followed by the establishment of central Family Health Action Group taskforce, and most recently the Family Health Action Group start-up and orientation workshop. During the workshop provincial Family Health Action Group committees were established for phase one provinces, terms of reference for the committees developed, 7 health facilities per province selected. The next steps are to select a Health Post per each selected health facility, orient Health Shura on the process and support the baseline evaluation.

Gender over Television -- HSSP has financially supported the development and airing of a two-language, ten-minute TV drama addressing safe motherhood, increased ANC and PNC visits, as well as women's empowerment, gender sensitive communications, and the promotion of men's involvement in RH in general.

Field Inputs to Gender Component – The evaluation team explored gender issues within their questionnaire to NGOs and their field visits to NGOs and facilities.

In general the first response to questions concerning gender was in respect to female staffing. All facilities reported that they were paying attention to this issue as it seemed important to make sure that as far as possible women received services from female providers. Within sixteen facilities where this issue was thoroughly explored all but one had trained female staff in addition to Midwives. Seven had both female doctors and vaccinators; six had female vaccinators only; one had both a female vaccinator and a female CHS, and one had a female CHS. All of them agreed that more female staff would be advisable but added that it was not easy to find adequate female staff.

At the NGO office level the situation was quite mixed. Most NGOs reported that they were actively trying to create a better mix of male and female staff but some had no senior female staff.

In respect to the impact of gender training the most common response was centered around the encouragement of husbands to attend births but in no case were any data

available to indicate the result. One issue was that not all facilities spontaneously admitted to receiving gender training and in those that did it was often not clear who had received it or that it had been widely shared. However it was clear that in almost all facilities it was understood that gender was included within the QA manual.

Most facilities referred us to midwives when it came to further exploration of gender issues. However one of the most startling inputs was that few facilities appeared to accept that gender was a very significant issue. Most midwives responded that it was an issue with some women and their spouses but was exclusively relevant to family planning only. When asked if it was important beyond that very few agreed that it was, at least for most families. In fact at 12 facilities where this issue was more fully explored with senior staff, who were all male, only one stated that gender was of very great importance; four stated it was not an issue at all and six appeared ambivalent about it.

In general, within the FP and RH counseling environment, there were good references to husbands' involvement in decision making -- for example, to join with his wife in counseling; know about and decide on a preferred method; and to ensure transport arrangements. All the same, as discussed within the BCC and behavioral change section of this evaluation under IR 3, there was an assumption that simply stating that these activities by husbands were advisable was sufficient, but did not address how those husbands who might resist taking these actions should be addressed.

It was not evident, in observing counseling in practice, how many husbands of pregnant women or those women being counseled on family planning were actually being reached and counseled. When asked about this the general response from facilities' staff was that this was a matter that needed to be addressed more fully at the community level and through the CHWs.

CONCLUSIONS: HSSP has made a significant start to mainstreaming gender through the QA process and there is no doubt that the issue in respect to staffing, both within NGOs and at their facilities, is well entrenched with the most significant constraint being, primarily, the lack of available female staff.

However, as with the BCC and behavioral change imperatives, as outlined under IR 3, the application of gender issues within a broader behavioral change strategy is still weak.

This behavioral change strategy would, necessarily, have the most impact through being integrated into the need for formative research across all BPHS components, and be fully integrated into the community-based behavioral change IPC/C delivery networks that would result from this.

It is interesting to note that HSSP is directly involved in both these initiatives. They are taking a lead in undertaking the necessary formative research to better define the behavioral determinants within gender issues, and they have included, under IR 4, the formation of Family Health Action Groups (even though gender will form only a part of the this activity).

In some measure HSSP's involvement in both these activities adds risk. Taking on the formative research for gender may appear to strengthen the somewhat ad hoc approach to

addressing behavioral change strategies across all BPHS components as discussed more fully under IR 3. Taking on an involvement in the development of Family Health Action Groups moves the HSSP project into the arena of community-based communications networks that are complex and difficult to manage, and require focused attention on behavioral change management and good counseling to succeed.

RECOMMENDATIONS

- Proceed with gender research project – define precise behavioral change initiatives to move beyond standard health education/ advocacy-style approaches.
- Inputs received from communities through the PDQ component need to be analyzed and, where innovations to the problem solving of inputs are produced, shared across NGOs. Those issues that are difficult to resolve need to be analyzed and solutions sought and those solutions fed back to communities for mutual resolution.

5.5 HSSP RELATIONSHIP WITH SUB-CONTRACTORS & HEAD-OFFICES

Jhpiego's primary subcontractors are the Futures Group (NGO Capacity Building and gender) and Save the Children (BCC/IEC component). All report a satisfactory relationship. The evaluation team did bring up the issue that the BCC component appeared too heavily involved in more traditional IEC and health education approaches and that the behavioral change imperatives for good counseling, within BCC, were too academic and did not include precise behavioral change objectives and messages. This issue is more fully addressed under IR3. The question was that as Save the Children were well versed in behavioral change methodologies why had this resource not been more fully accessed? The reasonable answer was that the HSSP project had no mandate or budget for creating and developing the formative research that would be necessary, across all the BPHS initiatives, to fully explore behavioral change strategies, although they had begun this process for the gender component.

Jhpiego makes good use of its head office and regional offices. For example when preparing work plans Jhpiego's Regional Director participates in the whole process of evaluating lessons learned with IR teams at an annual retreat. Routine oversight is supplied from Jhpiego in Baltimore, notably on management, staffing, financial and budgetary issues

5.6 HSSP RELATIONSHIPS WITH USAID AND OTHER PROJECTS

HSSP works and collaborates with a wide range of other USAID projects, including:

Tech-Serve -- HSSPs' primary need in respect to collaboration with other USAID funded projects is to collaborate closely with Tech-Serve. The original allocation of responsibilities between each project took some time to clarify and mature, according to both parties, but both report that these issues have been overcome and neither reports any difficulties, overlaps or gaps between their respective mandates. Both appreciate, however, that over time they have begun to move towards more direct collaboration within community-based components, notably to work together to move into community-based initiatives, notably to create linkages with the Community-Based Health Care

(CBHS) department to expand the community based contraceptive usage project started by REACH, and the development of Family Health Action Groups. Both HSSP and Tech-Serve report that they see no problems in this form of collaboration and that they are working well together.

COMPRI-- A – HSSP and COMPRI-A generally see each other as working in separate environment, COMPRI-A in the private/ commercial sector and HSSP in the public/ NGO sector. They do, however, collaborate together in sharing research inputs and materials, and COMPRI-A uses HSSP FP materials in its work to more generally promote family planning (including long-term methods), beyond its brand promotions for short-term methods. They meet together at least monthly. Both have supported the Health Promotion Unit at MoPH although COMPRI-A accepts that its inputs have been primarily related to mass media use, and that HSSP has done the bulk of the work in developing the Unit. Both support the Afghan Midwives Association in that COMPRI-A trains private sector midwives and HSSP NGO midwives. There may be overlaps here as it is probable that NGO midwives are also acting as private midwives. This evaluation suggests that HSSP and COMPRI-A should collaborate together to gain some clear insights into this issue for inputs into recommendations made by this evaluation under IR 2 in respect to the work of midwives within BHCs. COMPRI-A reports that it has made some progress in developing community-based distribution systems through midwives and others but these initiatives have been limited since the introduction of free public sector/ NGO distribution in 2008. This has, obviously, made it more difficult to introduce COMPRI-A's branded products through NGO midwives, CHWs and the developing Family Health Action Groups. This issue needs to be further addressed through COMPRI-A, HSSP and Tech-Serve, working with the MoPH, to see whether some innovations can be created to permit NGO midwives, CHWs and Family Health Action Groups to sell COMPRI-A commodities in order to create some form of incentives for them. COMPRI-A experience to date is that some consumers will choose to pay for FP commodities even in the face of free supply.

Provincial Reconstruction Teams (PRT) and International Security & Assistance Force (ISAF) -- HSSP also works with the US military, ISAF and PRT groups within the “soft side” of counter-insurgency (COIN) strategies relating to improving health care coverage. The primary liaison contact is through the project's USAID CTO. HSSP attends bi-weekly coordination meetings and notes that collaboration has been significantly improving over the last year or so. Issues have been to ensure that PRT groups who may wish to build a new health facility, for example, liaise with MoPH and NGO stakeholders to ensure that it does not overlap with existing facilities. HSSP has shared handbooks, IEC material and QA standards with these PRT teams.

University Research Company (URC) – HSSP also collaborates with the URC Health Care Improvements (HCI) project that is, also, implementing QA standards in three provinces. This is clearly a project that overlaps with HSSP. URC has, however, taken up HSSP's QA standards within their project and HSSP believes that the two projects can, and do, share lessons learned and are generally supportive of each other. However the issue remains that as MoPH moves to integrate strategies and technologies across all providers and provinces and that HSSP's QA standards are now institutionalized within the MoPH, it is unclear how the HCI project's inputs can be widely replicated.

Strengthening Pharmaceutical Systems Project (SPS) – HSSP works closely with SPS within its component on the rational use of drugs.

Other – HSSP has worked with other USAID programs such as with Counterpart International and the Capacity Development Project (CDP) but there is no longer any activity in this area.

5.7 REVIEW OF THE PERFORMANCE MONITORING PLAN (PMP)

HSSP is in the process of reviewing its PMP in light of its new USAID Modification and has deferred finalizing it pending inputs from this evaluation. The following notes are designed to support this process.

The present PMP contains two general Purpose indicators that exclude Kabul City and report the percentage of births attended by a skilled attendant at home or a health facility, and the contraceptive prevalence rate. The information was collected for the baseline in 2006 from REACH project inputs; in 2007 from the MoPH/ GCMU household surveys that, it is assumed will be repeated in 2009. It is not expected that a further household survey will be conducted until 2011. The 2009 survey will be conducted too late for tracking the 2010/11 final evaluation of HSSP.

Attribution of HSSP's inputs for these Purpose indicators cannot be expected, notably, births attended at home and because of the significant contribution that the private sector provides to contraceptive provision, as is to be expected. Attribution is an issue of inputs specific to the indicators for each Intermediate Result.

A further Purpose indicator may be added to reflect an under-five outcome. Immunization is suggested.

Intermediate Result 1 Indicators:

1.1 and 1.2 – the first two indicators refer to the percentage of facilities that have implemented QA and have undertaken baselines, two internal assessments and one external assessment, and the percentage that has met compliance standards (to be set by MoPH QA Committee).

The evaluation suggests that what is missing here is an indicator of how many facilities, out of all USAID province facilities, have been included in the QA program. It is proposed that two new indicators should be added: a) The total number of facilities that have undertaken a QA baseline and the percentage of those facilities against all facilities, and b) The total that have undertaken a baseline, two internal and an external assessment, and the percentage of those against the number of all facilities. Presently the target set is 144 facilities. It is suggested that this target be revisited as the new PMP is revised to reflect the project's Modification.

At the same time Health Posts have been added to the program. However this activity is still being undertaken as a pilot. HSSP and USAID need to confirm the extent to which this pilot is to be expanded, and to what targets. If they are to be formally added it is suggested that these should be included, separately, covering appropriate indicators across

the number that have baselines, and as a percentage of total Health Posts, and appropriate indicators of success similar to the facilities indicators.

1.3 and 1.4 – These two indicators set out to establish a results framework for QA achievement across the number of health post and basic health center referrals made to a higher level of facility, and the percentage of HSSP-trained supervisors performing according to standards. The referrals indicator should be dropped or moved to the SO level as project attribution is not possible. It is suggested that two further indicators be added to add more depth: an indicator relating to Facilities Management and Drug Management as these are two indicators within the BPHS QA assurance technical areas.

Intermediate Result 2.

The seven indicators for IR 2 appear adequate. However under 2.6 and 2.7 - the numbers of deliveries performed at a facility and the number of family planning visits to facilities - cannot realistically be attributed to the project and should be moved to the SO level.

It is suggested that a further indicator be added covering the initial Post Partum Hemorrhage trial and subsequent expansion.

Intermediate Result 3.

There are six indicators under IR 3. However four of these indicators are to be tracked from MoPH/ GCMU household surveys and it is assumed that the last year that data will be available for HSSP purposes will be 2009. It is suggested that additional outcome indicators could be considered so that success can be assessed for 2010/11 for evaluation purposes. It is also suggested that adding the number of immunizations given at the different levels of facilities; and the total number of clients served by each level of facility may be useful if moved to the SO level. Indicators relating to BCC under the BPHS QA assurance technical areas should be added. The indicator concerning the budget of the Health Promotion department should be dropped as it does not really reflect an attribution.

Under 3.2 which covers PDQ standards achievement, it would be useful to add the number of facilities implementing PDQ and as a percentage of all facilities.

Intermediate Result 4.

Two indicators track gender issues the percentage of QA participating facilities achieving 80% of the gender standard and the percentage of providers trained in gender and demonstrate gender awareness. It is suggested that a further indicator of coverage should be included, such as the percentage of facilities that have received gender training as against the total number of facilities would be useful. An indicator that tracked the number of female staff (excluding midwives) as against total staff may also be useful, including across doctors, injectionists, nurses and CHS.

Taking this advice into consideration, there may still be areas where HSSP works that are not appropriately reflected in their PMP. They should review this to ensure that no unrelated indicators are included and that all of HSSP's work is reflected.

APPENDIX A

SCOPE OF WORK

USAID/Afghanistan's Health Service Support Project

I. PURPOSE

To conduct a mid-term evaluation of ACCESS Health Service Support Project (HSSP) and make necessary recommendations according to findings.

II. BACKGROUND

USAID/Afghanistan re-opened in 2002 following decades of civil conflict and pressing humanitarian needs. USAID/Afghanistan has made substantial contributions to the reconstruction of the health sector through service delivery by various projects, such as Tech-Serve, Health Service Support Project, Support to Wazir Akbar Khan Hospital and the Social Marketing Project (COMPRI-A).

The USAID-funded HSSP is currently being implemented by JHPIEGO. The current cooperative agreement was signed July 1, 2006 and will end September 30, 2010. Prior to the award of this contract, USAID/Afghanistan was supporting service delivery and basic health services under the REACH project.

The ACCESS Health Service Support Project (HSSP) is a four-year Associate Award from USAID to improve service delivery and the quality of basic health services in Afghanistan. In concert with the Ministry of Public Health (MOPH), HSSP provides support to nongovernmental organizations (NGOs) to improve the planning, management, implementation and monitoring of the delivery of a high-quality Basic Package of Health Services (BPHS)—the framework of primary and secondary health service delivery—in 13 provinces in Afghanistan. The objective of HSSP is to improve the quality of services provided to women of reproductive age and children under the age of 5 years. HSSP is expected to achieve results in four areas:

Strengthen and develop systems that support service delivery quality: This result is intended to assist those NGOs providing BPHS and EPHS services develop management, administrative, financial and clinical quality assurance systems. Historically, in Afghanistan as well as other countries in the world, establishing a system that consistently assures medical quality is the most difficult, yet important to implement. However, the MOPH and USAID expect that clinical quality systems receive significant emphasis in the project.

HSSP is working with the Afghan Public Health Institute (APHI) of the MOPH and local partners to expand implementation of the quality assurance (QA) process to initiate lasting change in the quality of sustainable health services and the performance of health care providers. In collaboration with the APHI, ACCESS developed a harmonized set of evidenced-based QA standards for 14 priorities of the BPHS. These standards were adapted for application in district hospitals, comprehensive health centers and basic health centers.

Increase the number and performance of BPHS service providers, especially women in rural and underserved areas: One of the major barriers to providing effective health

care to women and children is the shortage of well-trained service providers, especially female health workers. Therefore, HSSP is focusing on training community midwives and developing a system that consistently recruits students from underserved areas, who will return to their local areas after completing training.

Improve the capacity and willingness of communities, families and individuals to make informed health decisions and support and sustain health-seeking behaviors.

In addition to the lack of a preventive mindset, there is limited knowledge of health related issues in Afghanistan. There is need to educate the public on such things as disease, nutrition and personal hygiene, clean water, occupational safety and a myriad of other issues. HSSP is expected to develop solid health public education messages with the primary objective to increase knowledge, access and use of services by women of reproductive age, and of children under the age of five.

Integrate gender awareness and practices into BPHS service delivery. This result is based on the premise that BPHS and EPHS services will not fully meet the MOPH goal of reducing maternal mortality, or infant and child morbidity and mortality in Afghanistan unless they have an explicit mandate to develop a deep awareness, understanding and responses to the needs of women, and to gendered constraints to women's and children's health. The intention of this result is to ensure that gender awareness and practices are integrated into health service delivery in Afghanistan.

METHODOLOGY

Before initiating assessments, the evaluation team will develop evaluation questions guiding the evaluation process which will be approved by OSSD before the evaluation process begins. The Evaluation Team will use the following methodology to conduct the evaluation.

Document Review/Data Analysis: Team members will review the HSSP agreement; USAID/Afghanistan strategy document; REACH evaluation report; quarterly and annual reports, and other relevant documents.

Key Informant Interviews: The team will conduct interviews and focus groups with a variety of stakeholders including MOPH staff, BPHS NGO implementers, Community Midwifery Education and Institute of Health Services grantees, Afghanistan Midwives Association members, USAID staff, other donors, sub grantees and partners in Afghanistan.

Self Assessment: The HSSP team composed of JHPIEGO, Futures Group and Save the Children US will respond to a self assessment questionnaire put together by the Evaluation Team and approved by OSSD for final use. The team will review the answers and discuss with HSSP management. The following are required evaluation questions:

1. According to the key stakeholders, what is the technical quality of the program's activities?
2. How do you rate the success of the project against the defined program objectives and what are your recommendations to help inform future work plans in the current agreement to ensure goals are met?
3. How adequate has support been from headquarters and how well has the partnership between JHPIEGO, Futures group and Save the Children worked?

4. What are the ingredients of success for the post-partum hemorrhage pilot? How will it be mainstreamed and scaled up after HSSP ends?
5. How will the quality assurance activities be institutionalized?
6. What additional support would be required to facilitate Community midwives to work outside of facilities for increased access to assisted deliveries?

IV. DELIVERABLES

The team will be responsible for producing the following final deliverables:

- List of Study Questions provided to OSSD within two days of arrival in Kabul.
- Work Plan and schedule provided to OSSD within five days of arrival in Kabul.
- Draft & Final Questionnaire that will be used for self- assessment, to be approved by OSSD.
- Power Point Presentation on the results and outcomes of the project.
- Evaluation Report (following standard reporting format and Branding Guidelines), including clear and concise answers to questions, and recommendations.
- Included as an Annex in the Final Report will be a draft program description for an amended and/or follow-on program to meet the objective and Intermediate Results laid out for HSSP in a sustainable manner.
- The evaluation team will take at least five field trips.
- A draft Final Report will be due no later than five days before the Evaluation Team is scheduled to depart Kabul, and said Final Report will be limited to 45 pages, excluding Annexes, and include a copy of the original Scope of Work for this activity. An outline of the Final Report is provided below:

Executive Summary

The Executive Summary will state the development objectives of the program/project evaluated; purpose of the evaluation; study method; findings; conclusions, lessons learned and future design implications.

Table of Contents

Introduction

The context of what is evaluated including the relevant history demography socioeconomic and basic political arrangements.

Body of the Paper

1. The purpose and study questions of the evaluation.
2. Brief description of the program
2. Team Composition.
3. Evidence /Findings and their Analysis --of the study related to the questions.
4. Conclusions drawn from the analysis of findings stated succinctly.
5. Recommendations.

APPENDICES shall include:

1. A copy of the scope of work,
2. The relevant USAID targets and results (Operational Plan Program Elements)
3. A list of documents consulted
4. Individuals and Agencies contacted

5. Technical Topics including study methodology if necessary
6. Schedule of activities in an Excel format.

V. TEAM MEMBERS

The Evaluation Team shall consist of two expatriates with 10+ years of maternal and child health expertise in low-income countries with USAID and/or other donors, and two CCNs as translators administrative assistants. Team members will be required to travel to pre-determined locations throughout Afghanistan to obtain an understanding of the program's field activities.

A six day work week is authorized for this activity. This activity is proposed to begin in Kabul on or about Jan 1 – Feb 12, 2008

APPENDIX B

WORK PLAN FOR THE ASSESSMENT OF HSSP IN AFGHANISTAN

The Health Services Support Project (HSSP) Evaluation team, proposes the following workplan for the Assessment of the HSSP in Afghanistan.

A. SCHEDULE OF DELIVERABLES:

Work Plan and schedule of activities*: March 25, 2009
 List of Evaluation Questions: March 28, 2009
 Final Self Assessment Questionnaire: March 28, 2009
 Power Point Presentation on results: April 28, 2009
 Evaluation Report first draft: April 28, 2009
 Evaluation Report final draft: May 4, 2009

*schedule of activities will be up-dated as changes occur

B. INTERVIEWS:

The assessment team will meet with appropriate individuals from the following organizations. (A detailed list of people interviewed will be provided in the evaluation report.)

United States Government

- USAID - OSSD
- USAID Implementing Partners
 - HSSP Team
 - Futures Group
 - Save the Children
 - TechServe
 - MSH

GIRoA

- Ministry of Health and various departments therein
 - Health promotion department ,
 - Rep. Health Department
 - CBHCD
- Human Resources Dept
- APHI
- Genders and reproductive right (GRR)
- GCMU- Don Palmer and Brad Dollis
- Policy and Planning (was GCMU director)

Other Partners/Stakeholders

- NGOs
- Technical advisory group
- Central QA committee
- National trainers
- CME staff
- Trained Health Facility staff
- Afghan Midwives Association

C. METHODOLOGY, ORGANIZATION AND ANALYSIS PLAN

The evaluation team will collect information through written documents, key informant interviews and discussions with GIRoA officials, project implementers, participants, partners and stakeholders. The team will develop a self assessment questionnaire which the HSSP team (consisting of all partners – JHPEIGO, Futures and Save the Children) will complete by a specific date. The results of this will be discussed with the evaluation team and used in the development of findings, conclusions and recommendations. The team will visit 5 field sites to discuss the work of the HSSP and observe project implementation first hand.

D. PRELIMINARY REPORT OUTLINE

Executive Summary

The Executive Summary will state the development objectives of the program/project evaluated; purpose of the evaluation; study method; findings; conclusions, lessons learned and future design implications.

Table of Contents

Introduction

The context of what is evaluated including the relevant history demography socioeconomic and basic political arrangements.

Body of the Paper

The report will be a stand-alone document, understandable by anyone unfamiliar with the HSSP. The body of the report will respond to the evaluation questions approved by OSSD and follow that sequence of questions. The report will include the following.

1. The purpose and study questions of the evaluation.
2. Brief description of the program
3. Team Composition.
4. Evidence /Findings and their Analysis --of the study related to the questions.
5. Conclusions drawn from the analysis of findings stated succinctly.
6. Recommendations.

E: ILLUSTRATIVE INTERVIEW QUESTIONNAIRE

HSSP EVALUATION QUESTIONS

A. Assessment of Results and Impact of the Project

1. Summary M&E Table (example of one line from the PMP)

| Objectives | Indicators | BLD % | 9/08 Status² | Final Target | Explanation or Reference |
|--|---|-----------------|--------------------------------|---------------------|---------------------------------|
| Increased utilization of the Basic Package of Health Services | % of births attended by skilled attendants (at home or health facility) | 21 ¹ | 24.3 | | |
| ¹ this comes from the REACH Project (final evaluation?? What year?) ; true baseline is expected to be around 17.7% ² need to update these stats for the evaluation report | | | | | |

2. Discuss progress in each of the four Intermediate Result areas. In this section:

- i. How do you rate the success of the project against the defined program objectives and what are your recommendations to help inform future work plans in the current agreement to ensure goals (objectives) are met? Discuss the results and outcomes of the project as measured by comparison of the baseline and most recent monitoring data available.
- ii. According to the key stakeholders, what is the technical quality of the program's activities?
- iii. Describe factors affecting achievement of specific project objectives and outcomes. For objectives/indicators not on track, discuss contributing factors.
- iv. For each result area, what are the main successes and lessons learned?
- v. Discuss special outcomes, and unexpected successes or constraints.
- vi. If the project will be continued, describe how the lessons learned should be applied to future activities.
- vii. Conclusions and Recommendations

3. Results: Cross-cutting approaches (address each section applicable)

Examples of cross-cutting approaches include behavior-change strategies, community mobilization, partnership-building activities and training (e.g., negotiations, agreements achieved, linkages formed), outreach strategies, advocacy or community or awareness-building strategies, and strengthening information management systems. The evaluation team may discuss any other cross-cutting activities that may be pertinent to the project. Please include modifications and explanations/rationale for those modifications, and cross-cutting activities added to the work plan.

Describe how activities have had/will have:

- An effect or impact on the project.
- An impact on the lessons learned to date.
- Potential for scaling-up or expanding the project.
- Links to future activities.

a. Community Mobilization

- Briefly describe the approach of each NGO and what was implemented.
- How effective was the approach?
- Were the objectives for the approach met?
- What are the provincial/regional differences that existed or should have existed?
- What lessons were learned for future efforts?
- Is there demand in the community for project activities to continue? How was this measured?
- What are the plans for sustainability when the project ends?
- Are the sustainability plans realistic?
- Conclusions and Recommendations

b. Communication for Behavior Change

- Briefly describe the approach of each NGO and what was implemented
- Did the project go beyond awareness raising to effect behavior change?
- Was the CBC plan implemented as expected?
- Did the project use any formative/qualitative research to inform the CBC plan
- In what ways did the formative research inform the CBC plan?
- To what extent was the CBC plan effective in promoting BC at the facility and community levels?
- What CBC knowledge/skills were imparted to key stakeholders (implementing NGOs, MOH, APHI, etc)
- Conclusions and Recommendations

c. Capacity Building Approach

Discuss the capacity strengthening results of this project. This may include how the project improved the capacity of the public sector partners, local NGOs and/or community-based partners. Use the questions below to guide the assessment.

- i. NGO Strengthening** - Describe the outcomes of any assessment, formal or informal, conducted at the outset and conclusion of the project to determine the organizational and technical capacities of NGO partners.
 - How have the organizational and technical capacities of the NGO partners changed since the beginning of the project? What factors/interventions have most contributed to those changes?
 - From whom else are NGOs receiving assistance? Did that assistance compete or complement what HSSP was doing?
 - What impact has the increased capacity had on the NGO's management ability and fiscal standing?
 - What are the best practices and lessons learned in capacity building of NGO partners?
 - Conclusions and Recommendations

ii. Training

- What were the training objectives?
- Were the training objectives met?
- What was the training impact on performance?
- How did HSSP justify the amount of training provided to MoPH and NGOs when the amount provided differed from that requested?
- Please be sure to look at RPM training.
- How effective was the training approach?
 - What evidence is there that suggests that the training implemented has resulted in new ways of doing things, or increased knowledge and skills of the participants?
 - What were the best practices and lessons learned?
 - What are the plans for sustaining these training activities once the project closes?
 - What are the sustainability plans for training? Are they realistic?
- Conclusions and Recommendations

(a) Health Systems Strengthening (HSS)

- i.** What were the activities at the Hospital level? What were the results? How were these tracked?
- ii.** What were the activities at the District Hospital (DH), Comprehensive Health Center (CHC), Basic Health Center (BHC), and Health Post (HP) level? What were the results? How were these tracked?

For each facility:

- What was the approach for improvement of service delivery at health facilities? What tools did the project use for health facility assessments? Were the tools effective for measuring change? What was the approach for strengthening health worker performance? How did the project address the gaps between performance standards and actual performance? How were changes in performance monitored and evaluated? Were health worker performance objectives met?
- Discuss linkages between these facilities and the communities.
- What were the lessons learned in terms of HSS?
- What are the plans for sustaining HSS activities and results once the project closes? Are the sustainability plans realistic?
- What did the grantee accomplish related to building the governance capacity of civil society institutions (e.g., village health committees) or government institutions (e.g., district MOH, municipal government)?

- iii. What clear evidence is there to suggest the increased capacity of these institutions to manage themselves, attract local resources, etc.?
- iv. Conclusions and Recommendations

e. Policy and Advocacy

- What policy and evidence based advocacy activities did the grantee engage in? With which stakeholders and in country partners?
- What kind of evidence did grantee share?
- Did grantee form part of any high-level/national technical committees?
- Did grantee contribute to change, refine or update any local or national policies or impact any resource allocation decisions?
- How did grantee help to create an enabling policy environment in the country?
- Conclusions and Recommendations

f. Sustainability Strategy

- What does the grantee expect to be sustained? How likely is it that this will be sustained?
- What are the ingredients of success for the post-partum hemorrhage pilot? How will it be mainstreamed and scaled up after HSSP ends?
- What is the plan for sustainability of Midwifery Training and the AMA? How successful is this plan likely to be?
- How will the quality assurance be institutionalized?
- Conclusions and Recommendations

B. Client Collaboration

- Describe this project's collaboration with the USAID Mission, particularly related to the role this project played in contributing to the Mission's overall health objectives.
- Describe this project's collaboration with USAID PRT representatives and the US Military.
- Describe this project's coordination and overlap with other projects.
- How does this project collaborate with the MoPH and ensure the buy-in of the GIROA?

C. Contextual Factors that Influenced Results

Discuss additional contextual factors that influenced the results and how these factors contributed positively to or constrained the outcomes of the project. These might include the following:

- *Natural disasters, conflict and civil unrest, other unforeseen conditions*
- *How does the project contribute to the USG's COIN strategy?*
- *Additional resources or influx of commodities from other donors in the project area*
- *Other grantee-related or unrelated projects running in the same region which might have shared resources or built off common platforms including Title II, education, child sponsorship, water and sanitation or micro-enterprise*
- *Any other issues identified by the team during the course of the evaluation that are not covered by these guidelines.*

D. Project Management Evaluation

a. Planning

- i. How inclusive was the project planning process and what effect did this have on the implementation process?
- ii. To what extent was the work plan practical?
- iii. What were the gaps in the project start up process and how were they addressed by the project staff?

b. Supervision of Project Staff

- i. Was the supervisory system adequate?
- ii. Is the supervisory system fully institutionalized and can it be maintained?
- iii. Is there evidence that the project's approach to strengthening supervisory systems has been adopted beyond the project?

c. Human Resources and Staff Management

- i. Are essential personnel policies and procedures of the grantee and partner organizations in place, to continue project operations that are intended to be sustainable?
- ii. Describe the morale, cohesion and working relationships of project personnel and how this affected project implementation.
- iii. Describe the level of staff turnover throughout the life of the project, and the impact it has had on project implementation and the process followed for changeovers with expatriate staff.
- iv. Have plans been developed to facilitate staff transition to other paying jobs at the end of the project?

d. Financial Management [to be completed with the field staff and lead evaluator]

- i. Discuss the adequacy of the grantee's and partners' financial management and accountability for project finances and budgeting. If the project budget was adjusted, explain why. Do the project implementers have adequate budgeting skills to be able to accurately estimate costs and elaborate on budgets for future programming?
 - ii. Are adequate resources in place to finance operations and activities that are intended to be sustained beyond this cooperative agreement?
 - iii. Was there sufficient outside technical assistance available to assist the grantee and its partners to develop financial plans for sustainability?
- e. Logistics**
- i. What impact has logistics (procurement and distribution of equipment, supplies, vehicles, etc.) had on the implementation of the project?
 - ii. Is the logistics system sufficiently strong to support operations and activities that are intended to be sustained?
- f. Information Management**
- i. How effective was the system to measure progress towards project objectives?
 - ii. Was there a systematic way of collecting, reporting and using data at all project levels? Cite examples of how project data was used to make management or technical decisions.
 - iii. Is the project staff sufficiently skilled to continue collecting project data/information and to use it for project revisions or strengthening?
 - iv. Did the project conduct or use special assessments, mini survey focus groups, etc. to solve problems or test new approaches? Give examples of the research, use of data, and outcomes.
 - v. To what extent did the project strengthen other existing data collection systems (i.e. government)?
 - vi. Do the project staff, headquarters staff, local level partners, and the community have a clear understanding of what the project has achieved?
 - vii. How have the project's monitoring and impact data been used beyond this child survival project?
- g. Technical and Administrative Support**
- i. Discuss types and sources, timeliness, and utility of external technical assistance the project has received to date.
 - ii. What assistance did the project need that was not available? How could grantee headquarters and/or USAID better plan for the technical assistance needs of grantee projects?
 - iii. Discuss grantee headquarters and regional technical and managerial support of the field project. Approximately how much time has been devoted to supporting this project?
- h. HSSP Partnership Performance**

- a. How adequate has support been from HQ?
- b. How well has the partnership between JHPEIGO, Futures group and SC worked?

i. Management Recommendations

- i. List the overall management recommendations, in terms of planning, training, supervision, human resources, financial management, logistics, information management, and technical support.

E. Summary of most important Conclusions and Recommendations

- a. Based on the data from the baseline and most recent monitoring results, presented in the summary chart, discuss whether the objectives will likely be met and outcomes achieved, and the conclusions regarding the success of the project in meeting its objectives.
- b. Discuss any other key results such as demonstrated increases in organizational or community capacity, health systems strengthening, policy changes, and others.
- c. Describe the most important achievements, constraints and other factors affecting project performance.
- d. Outline the best practices and lessons learned
- e. Present any recommendations for USAID the project staff and collaborating partners regarding future work or directions. Comment on the project's potential for sustainability.
- f. Describe potential for scale-up and expansion of the project to the rest of the country

APPENDIX C

HSSP Evaluation Team Schedule

| Day | Date | Activity |
|------------|-------------|--|
| Sat | 21-Mar- | Travel Day -- Depart Washington DC |
| Sun | 22-Mar- | Travel Day -- Overnight Dubai |
| Mon | 23-Mar- | Arrive Kabul - Briefing on SUPPORT Compound & Security/Mobile phones distributed |

| | | |
|------------|----------------|---|
| Tue | 24-Mar- | Meeting with HSSP staff, project presentation, key informants, id.field visits |
| Wed | 25-Mar- | Finalize field visits; meetings: 9:00 - 10:30 Prov. Coordinators; 10:30 - 12:00 IR 3 Team meeting |
| Thu | 26-Mar- | Finalize & submit evaluation questions to OSSD; Attend NGOs meeting- 12:30- 2:00; 2:30 meet OSSD |
| Fri | 27-Mar- | Non-Work Day |
| Sat | 28-Mar- | Evaluation team draft HSSP self-assessment questionnaire/submit to OSSD |
| Sun | 29-Mar- | HSSP meetings: IR2 - 9-11; IR1- 11:00 - 2:00; IR4- 2:00-4:00 |
| Mon | 30-Mar- | Evaluation team to Herat 8:00 |
| Tue | 31-Mar- | Herat |
| Wed | 1-Apr- | Herat |
| Thu | 2-Apr- | Return from Herat to Kabal |
| Fri | 3-Apr- | Bonnie drives to Takhar |
| Sat | 4-Apr- | Bonnie inTakhar/Richard in Kabul province field visits |
| Sun | 5-Apr- | Bonnie in Takhar/Richard in Kabul province field visits |
| Mon | 6-Apr- | Bonnie to BDK - Richard in Kabul province field visits |
| Tue | 7-Apr- | Bonnie in BDK/Richard in Kabul official interviews |
| Wed | 8-Apr- | BK flies back to Kabul from Kunduz/ Richard in Kabul official interviews |
| Thu | 9-Apr- | Team, Kabul- based interviews |
| Fri | 10-Apr- | Non-Work Day |
| Sat | 11-Apr- | Team, Kabul-based interviews |
| Sun | 12-Apr- | Evaluation team to Bamyan |
| Mon | 13-Apr- | Bamyan |
| Tue | 14-Apr- | Bamyan and Return to Kabul |
| Wed | 15-Apr- | Team analyse data. Bonnie to MSH |
| Thu | 16-Apr- | Management Discussion HSSP 09:00 -- analysis HSSP monitoring data |
| Fri | 17-Apr- | Non-Work Day -- Bonnie/ Richard analyse field visits and NGO Questionnaire data |
| Sat | 18-Apr- | Bonnie departs for Dubai/ Washington -- Richard analyse data |
| Sun | 19-Apr- | Richard -- start report writing |
| Mon | 20-Apr- | report writing |
| Tue | 21-Apr- | report writing |
| Wed | 22-Apr- | report writing |
| Thu | 23-Apr- | report writing |
| Fri | 24-Apr- | Non-Work Day |
| Sat | 25-Apr- | report writing |
| Sun | 26-Apr- | report writing |
| Mon | 27-Apr- | report writing |
| Tue | 28-Apr- | report writing |
| Wed | 29-Apr- | report writing |
| Thu | 30-Apr- | report writing |
| Fri | 1-May- | Non-Work Day |
| Sat | 2-May- | report writing |
| Sun | 3-May- | report writing |
| Mon | 4-May- | Draft Report submitted to OSSD - PP presentation of the key results and outcomes |
| Tue | 5-May- | OSSD reviews report |
| Wed | 6-May- | OSSD reviews report |
| Thu | 7-May- | Feedback from OSSD on report |
| Fri | 8-May- | Non-Work Day |

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| Sat | 9-May- | Revise and finalize report |
| Sun | 10-May- | Revise and finalize report |
| Mon | 11-May- | SUPPORT Submits Final Report OSSD |
| Tue | 12-May- | Travel Day -- Richard -- Depart Kabul for Dubai |
| Wed | 13-May- | Travel Day -- Dubai to Washington DC |