Program Evaluation
Marie Stopes International Afghanistan (MSIA)

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Evaluation team & authors

Prof Anthony Zwi, HEARD@UNSW
Dr Qudratullah Nasrat, ORCD
Ms Jessica Botfield, HEARD@UNSW
Mr Atal Khan Gardiwal, ORCD
Dr Nasir Maidanwal, ORCD
Dr Tahir Khan, ORCD

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ACRONYMS

BHC	Basic Health Center
BPHS	Basic Package of Health Services
CBD	Community-based Distributors
CHW	Community Health Workers
EPHS	Essential Package of Hospital Services
FGD	Focus Group Discussion
FP	Family planning
HDI	Human Development Index
HF	Health Facility
HFA	Health Facility Assessment
HMIS	Health Management Information System
IDI	In-depth Interview
INGO	International Non-Governmental Organisation
IRB	Institutional Review Board (Afghanistan)
MNCH	Mother, Newborn and Child Health
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoPH	Ministry of Public Health
MoRA	Ministry of Religious Affairs
MoWA	Ministry of Women's Affairs
MSI	Marie Stopes International (UK)
MSIA	Marie Stopes International Afghanistan
OCP	Oral Contraceptive Pill
ORCD	Organization for Research and Community Development
PAC	Post-Abortion Care
SRH	Sexual and reproductive health
UNFPA	United Nations Population Fund
UNSW	The University of New South Wales, Australia
WHO	World Health Organization

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EXECUTIVE SUMMARY

Background

a) Following an open competitive process, the Evaluation Team comprising researchers and evaluators from the Health, Rights and Development group at The University of New South Wales (HEARD@UNSW), Australia, and the Organisation for Research and Development (ORCD), Afghanistan were selected.
b) Key evaluation questions and objectives were identified in advance by Marie Stopes International.
c) The methodology and further refinement of evaluation questions were undertaken by the Evaluation team and submitted to MSI and MSIA for approval.
d) Ethics approval was obtained from both the University of New South Wales and the Institutional Review Board, Afghanistan. Delays with obtaining local ethics approval limited time available for fieldwork and analysis.

Objectives and overview of methods

a) The Evaluation drew on mixed methods and included review of available literature (both peer-reviewed and grey literature), review and analysis of secondary data, health facility assessments, and collection of qualitative data through key informant interviews and focus group discussions.
b) Interviews sought to elicit the perspectives and insights of government officials and policy makers (at national and provincial levels), MSI program managers and advisors, MSIA managers and staff, and province-based NGOs and other stakeholders. Focus Group Discussions were held with MSIA staff and MSIA clients who are all women, who utilise their services.
c) The Evaluation was undertaken in three provinces – Kabul, Herat and Balkh. Limited information in relation to Faryab, the fourth province in which MSIA operates, was available.
d) Fieldwork in Afghanistan was undertaken by the ORCD team in collaboration with team members from HEARD@UNSW. The latter also undertook a number of interviews over skype, primarily with MSI program managers and related staff, and donor community members.

Results

Results were assessed against the primary objectives and 10 research questions:

Objective 1: Assess the effectiveness (access, equity, quality, and efficiency) and capacity of MSIA

1. What have been the outcomes in terms of access, equity, quality, and efficiency, as defined by MSI's results-based framework?
    - MSIA services are considered to be of good quality, accessible, trustworthy, delivered by caring staff, and directed at all Afghans without any form of discrimination on the basis of religion or ethnicity.
    - Female-only clinics seen as culturally appropriate and safe
    - MSIA offers a safe space, for both clients and health care workers, in which SRH services for women can be offered.
    - MSIA is reaching a number of people through a range of avenues, including word of mouth, community-based distributors, and announcements by Mullahs
    - A small number of informants identified what they saw as limitations within the services offered, primarily around the charges for some services, cost of transport to a service, and the urban-focus of MSIA
    - While there is usually a good supply of commodities, there are occasional stock-outs

2. Has there been an effect on the capacity of the MOPH and BPHS/ EPHS service providers in terms of enhanced policy environment, increased clinical competency, availability of services, and/or improved planning and delivery of reproductive health services?
    - MSIA has introduced a number of innovative programs within Afghanistan and these have contributed to opening and expanding the "policy space" within which improved sexual and reproductive health services can be delivered and relevant policies and guidelines developed and implemented.
    - MSIA works closely with different branches of government, including the MoPH, MoWA and MoRA, at both central and provincial levels – while most relationships are working extremely well, some gaps or weaknesses identified
    - MSIA advisors within MoPH and MoRA support the Ministry and its capacity development, as well as help to advocate for and support policy change and implementation.
    - MSIA has contributed to a number of policy advances (e.g. guidelines for post-abortion care, family planning methods added to the Essential Drugs List and Special Drugs List)
    - MSIA programme is not fully aligned with the BPHS and EPHS given its primary focus on reproductive health

3. Has MSIA's strategic partnerships with key MoPH, UN, donor and civil society stakeholders had an effect on strengthening its work and the health system in Afghanistan?
    - There is generally good knowledge of, and support for, the services offered by MSIA by relevant government bodies.
    - MSIA is contributing to health systems strengthening through the development of policies and clinical guidelines, and support and training of MSIA and government staff (mostly MoPH).
    - Weaknesses within the MSIA program relate to inconsistent engagement with relevant government and public health authorities – in some Provinces this is excellent while in others there is room for improvement. MSIA could be playing a greater role in relation to health system strengthening by ensuring services are in keeping with the BPHS and that coordination with other service providers is maintained at a high level.
    - Greater attention to submitting required data to MoPH and to participating in a wider range of coordination activities with other service providers and policy makers is required.
    - A small number of informants identified what they saw as limitations within the services offered, including inadequate attention to collaboration and coordination with MoPH especially in Kabul Province, and their work which at times is seen as outside of the Afghan health system.

4. What is the coherence, relevance and sustainability of the MSIA programme in Afghanistan?
    - MSIA has established a clear niche in providing FP and PAC services
    - Client numbers are increasing across a range of service delivery areas
    - Positive relationships with religious leaders are necessary for MSIA's consolidation and sustainability; the positive relationships established require ongoing attention

Objective 2: Determine MSIA's progress and achievements against set objectives

5. What is the progress towards achieving the overall objectives of the MSIA programme and effectiveness of activities conducted under this programme model?
    - The services provided by MSIA make a positive contribution to enhancing the availability of, and access to, SRH services for women in Afghanistan.

- MSIA has introduced a number of innovative programs within Afghanistan, including services directed at young women offering a wide range of family planning methods and technologies; providing 'women only' services which are seen to be safe by clients and staff; toll-free hotline; working with Mullahs and their wives to promote awareness and acceptance of family planning; promoting social marketing and community-based distribution of family planning methods; establishing post-abortion care services and instituting appropriate clinical standards; and a range of other advocacy and information activities.

Objective 3: Determine the overall impact of the project from 2009 to present

6. What has been the impact (expected and unexpected) for intended programme beneficiaries in terms of increased knowledge, access to and uptake of family planning and sexual and reproductive health services in the districts where Marie Stopes International Afghanistan is delivering its services?
   - Many informants highlighted the positive changes that are occurring in this area in Afghanistan – birth spacing is becoming more acceptable and more widely practiced in Afghanistan

7. Have MSIA programme activities had an impact on perceptions and awareness of FP amongst leaders (including religious leaders) and communities in target provinces?
   - MSIA work closely with and have good relationships with community and religious leaders
   - Awareness is growing and positive change is occurring amongst religious families and community members
   - Many clients emphasised the positive role Mullahs have had in informing them about the importance of birth spacing.
   - MSIA has undoubtedly contributed to creating an environment and social and policy space within which birth spacing and FP can be promoted

8. How has MSIA attempted to involve both men and women in its programmes and what has been the impact for men and women at the individual and community level, particularly in terms of access to FP services and information?
   - Good mix of male and female staff members across MSIA, although most management positions are held by males and the number of female employees within the Kabul head office is relatively low
   - Female-only clinics seen as culturally appropriate and safe
   - Involvement of young men has received limited attention to date.

9. What has been the impact (expected and unexpected) for intended project beneficiaries in terms of improved quality of life and strengthening SRH rights?
   - Women are having fewer children in Afghanistan than ever before, and maternal mortality is declining. While these cannot be attributed to MSIA, it is widely accepted that MSIA are contributing, along with other civil society organisations and the Government, to this trend.
   - MSIA is unable to address all of the very substantial challenges facing women in Afghanistan, but they are making a significant contribution
   - MSIA are recognised as contributing to establishing a climate in which women's health, rights and other concerns can be raised and addressed – thereby contributing, directly and indirectly, to the empowerment of women and the promotion of gender equity.

- Contribution by MSIA to successful policy outcomes - e.g. approval of PAC guidelines, establishment of reproductive health caucus, new family planning methods added to Essential Drugs List and Special Drugs List.

10. Has MSIA contributed to the achievement of MDG 4 and 5 in Afghanistan?
    - MSIA has undoubtedly contributed, positively, to promoting achievement of MDGs 4 and 5 in Afghanistan. Quantifying this contribution was not possible within the present Evaluation.

Objective 4: Provide recommendations to inform possible options for how family planning services could continue to be provided in MSIA target areas, and on how current programme activities could be improved to achieve this

Recommendations

A. Current services provision

i) Additional **MSIA services should be provided in under-served areas and this should be offered at low or no cost**. This will help ensure that more vulnerable, poor and marginalized women are able to access these SRH services, especially in relatively under-served and more poor communities (e.g. rural and remote areas, marginalized groups, poorer people, and returnees). Many informants indicated they would like to see MSIA services expanded; this represents a vote of confidence in these services. While some criticized the policy of charging user fees, staff and clients acknowledged that those in financial need are able to access services for free.

ii) MSIA services should be **extended beyond current provision in four Provinces and primarily in urban areas**. Informants at all levels of the system would like to see greater availability of services in a wider range of settings while ensuring accessibility to those most poor. This should receive explicit attention and be prioritised: reaching vulnerable, marginalised, poor and ethnic minority communities.

iii) Additional effort should go into **informing communities of the availability of MSIA services**. MSIA should **consider offering clinics in areas deemed safe by women, such as within or near the Women's Garden** in Kabul. Services should be **promoted through radio, loudspeakers** and other avenues.

iv) At all services **ensure availability of supplies and commodities at all times**. Where clinic supplies are likely to run, consider instituting an emergency system to get supplies to relevant services *before* any disruption of services occurs.

v) **Expand portfolio of activities directed at adolescents and youth**; possibly including school-based activities. Improve and build on relationships with Ministry of Women's Affairs, Ministry of religious Affairs, Ministry of Public Health and Ministry of Education.

vi) **Enhance record-keeping systems** by speeding up access to the CLIC system which will allow a shift to digital systems, enable more comprehensive client-focused support and information, will **improve the interface with the MoPH** and will facilitate **potential use for a wider range of monitoring, evaluation and research applications**.

vii) Continue general engagement with community through a variety of mechanisms to **enhance awareness of birth spacing and family planning**, and of the range of technologies available to do so. **Reinforce links** with Religious leaders, members of government, civil servants, civil society, health professionals and media around value of birth spacing and women's ability to control fertility.

B. Services development – for consideration

i) MSIA should **place more emphasis on working with particularly vulnerable groups** including **IDPs, nomads, Kuchis and returnees** from Pakistan. The latter population is increasing rapidly and will undoubtedly have needs in relation to SRH. Improved liaison with the Ministry for Returnees should be explored further, while also offering services directly to, or working with other NGOs and MoPH providers that are already working with, these populations.

ii) Consider potential to **offer a wider range of women's and children's health services directly or in collaboration with others,** such as addressing gender-based violence, dealing with women's malignancies and associated screenings (cervical, ovarian and breast cancer); and extending availability of child health services in particular **immunization and the promotion of breast-feeding**.

iii) In selected settings consider **offering a 24-hour service**.

iv) Establish a **suite of services directed at male clients and extend those directed at male leaders**. This may require identifying and working with a particular team on media and advertising, establishing additional or separate clinics so as not to detract from the female-friendly, women-only services currently available.

v) Consideration should be given to **establishing longer-term MSIA sites that can be developed and enhanced** instead of renting space within the facilities of others, as suggested by some community members, provincial authorities, and BPHS implementers.

vi) While consideration of **improved transport** of community members to and from MSIA services was mentioned by a number of informants, it is likely that a more cost-effective means of responding is through the enhancement of outreach and mobile services and working with other providers already present at peripheral sites. This deserves careful further analysis.

vii) A number of MSIA **staff sought enhanced transport to and from work** so as to build on the security they perceive while working within safe-for-women setting.

C. Partnerships and relationships

i) Establish **stronger relationships** with MoWA, MoRA and MoPH; explore links with Ministry of Education. In relation to all government ministries, at central and provincial levels, enhance communication and coordination.

ii) Provide more **transparent annual plans and targets**, agreed between different authorities and MSIA, and monitored over time.

iii) **Consolidate, reinforce and extend collaboration** with religious leaders, their families and the MoRA.

iv) **More actively engage with wider health system developments** and activities including regular participation in health sector meetings and briefings and BPHS coordination meetings. Establish a strategy for actively ensuring coordination between MSIA and MoPH and BPHS implementing NGOs.

v) MSIA should **gradually transform itself from primarily a service provider to an organisation with technical expertise that provides support to and capacity development within the health sector** and to become a **repository of experience, expertise and research insights** in relation to sexual and reproductive health and family planning. **MSIA could more routinely provide support to BPHS implementers** in relation to sexual health promotion, reproductive health, family planning, birth spacing, post-abortion care and gender.

vi) Devote **greater attention to networking and collaboration**, including the development of joint projects with other organisations (both local and international), as well as research and training bodies.

D. Training, recruitment and research

i) MSIA should **consolidate its role in demonstrating innovative practice** and facilitating training and support of specialised staff dealing with sexual and reproductive health across the Afghan health system, in collaboration with MoPH and other providers

ii) MSIA should **invest more heavily in training and up-skilling existing staff**, including in relation to management, leadership and gender-equity training

iii) **Recruitment of women and promotion of women into leadership positions**

iv) Consider recruiting a **project worker (?expatriate given access issues) to support new project development and funding mobilisation** which will be sustainable over longer term period

v) **Increase depth and breadth of training** (both in-country and internationally where appropriate); MSIA team members can travel to India, for example. or elsewhere for intensive ongoing training activities with MSI (UK) counterparts as well as those working in related settings elsewhere.

vi) MSI UK team members should travel to Afghanistan to better appreciate the context and work with the MSIA team to **download and document lessons and experience**; some external facilitation may assist this process.

vii) MSIA can **explore mechanisms to train BPHS clinic staff** in various provinces on family planning specific issues.

E. Additional issues for consideration

i) **Unmarried young people also need attention**; current emphasis on 'young married women' should be expanded.

ii) Consider **placing a policy advisor in support of both the MoWAs and the MoE** to expand space for debate about women's health and sexual and reproductive health and rights. This would complement advisors currently within the MoPH and MoRA.

iii) MSIA should give **more priority to participating in higher level health and related policy forums** such as the Health Sector Steering Committee or its subcommittees; the Consultative Group on Health and Nutrition (CGHN); and should present its work to the donor coordination meeting in Kabul.

iv) Develop **research section to explore, document, analyse and report relevant issues** in an ongoing way; this may be facilitated by establishing partnerships with specific trusted institutions in Afghanistan and abroad

v) Commence project development activities around **appropriate means and mechanisms to work innovatively and constructively with men**, with an emphasis on young men; this requires innovation and research but should be actively progressed.

vi) **Widen social franchising network** possibilities; this may assist in reducing inequity in rural and outlying areas by working with existing private sector and other providers.

vii) **Evaluation Team recommend that MSI and MSIA be invited by their respective Boards and funders, to respond in writing to these recommendations.**

1. INTRODUCTION AND BACKGROUND

The Islamic Republic of Afghanistan (hereafter Afghanistan) is a land-locked country situated in south-central Asia. The country has experienced conflict since the 1970's, with a Soviet invasion in 1979, a take-over by the Taliban in mid-1990, and an international coalition, led by the United States, which toppled the Taliban in 2001. Three decades of civil war, political instability and a collapsed economy resulted in Afghanistan being one of the world's poorest countries, with health and development seriously affected.

Afghanistan has a population of nearly 30 million people (World Health Organization, 2014). The Human Development Index (HDI) is 0.468, ranking Afghanistan 169th of 187 rankings (UNDP, 2014). The HDI measures and ranks countries on the basis of economic and social development and is compiled from data on life expectancy, mean years of expected and actual schooling, and gross national income per capita. The United Nations Development Program also computes a Gender Development Index which incorporates gendered inequalities into its assessment of social and economic development; this ranks Afghanistan as 147 of 148 countries with available data (UNDP, 2014).

While data on maternal mortality and other health indicators are likely to be imprecise, some indication of the state of health in Afghanistan is possible. The maternal mortality ratio (MMR) has been estimated by the United Nations as 450 deaths per 100,000 live births in 2010 – a considerable decline from the estimated 1,600 deaths per 100,000 live births in 2003. Afghanistan has reduced both infant and child mortality over the past decade – in 2012 under-five mortality was 102 deaths per 1,000 live births, a 60% reduction from 257 per 1000 live births in 2003. The infant mortality rate (IMR) has been reduced from 165 deaths per 1000 live births in 2003 to 74 deaths per 1,000 live births in 2012 (Ministry of Economy, 2013).

The Contraceptive Prevalence Rate in Afghanistan remains low (21%) but has improved considerably from 5% recorded in 2003 (Ministry of Economy, 2013; Multi Indicator Cluster Survey 2003 and 2011). Knowledge of a method of family planning was 92% in 2010 (Afghanistan Mortality Survey, 2010) revealing a substantial gap between "knowledge of" and "use of" contraceptives. Table 1 summarises progress in relation to a number of health and development indicators:

Table 1: Afghanistan - Relevant health and development indicators

Indicator	2003 data	2010/12 data
Under-5 mortality rate (deaths per 1,000 live births)	257	102
Infant mortality rate (deaths per 1,000 live births)	165	74
Maternal mortality ratio (deaths per 100,000 live births)	1,600	450*
Births attended by skilled birth attendants	6%	40%
Contraceptive prevalence rate	5%	21%
Total fertility rate	6.2	5.1

*(Ministry of Economy, 2013) (**UN figure considered more reliable)

Despite such improvements, however, health and development indicators remain poor. The Afghanistan Mortality Survey 2010 estimated that approximately 67.2% of deliveries took place at home, and the majority of mothers and newborns (71.5%) did not receive a postnatal check-up (Afghan Public Health Institute et al., 2011). Significant disparities also exist, notably between males and females, urban and rural areas, and in relation to socio-economic status, education and other determinants of health. Urban women are twice as likely as rural women to use a method of family planning, and contraceptive use increases rapidly among women as levels of education and income rise (AMS 2010).

Since 2001 the Ministry of Public Health (MoPH), with the technical and financial assistance of multiple international donors and implementing organisations, has committed to improving the health and wellbeing of Afghan populations, with a particular focus on women and children. Afghanistan endorsed the Millennium Declaration in 2004, but, as with other conflict-affected and fragile states, faced a range of challenges in implementing Millennium Development Goal (MDG)-focused interventions. Notable amongst these has been ongoing insecurity compounding the situation. Afghanistan responded by adding a ninth goal to the usual eight MDGs: the promotion of peace and security (Ministry of Economy, 2013).

Family planning and reproductive health are a priority in the national development strategy of Afghanistan and within the MoPH. Not only is access to high quality health care and comprehensive family planning and reproductive health services a basic human right (Temmerman et al, 2014) but family planning is one of the most cost-effective approaches to reducing maternal and child mortality. Despite this, however, these services remain out of reach for many Afghans (MoPH, 2010). Such services should be accessible and user-friendly, and should not only address the clinical needs of clients, but should do so with the utmost respect, dignity, privacy and gender-sensitivity.

Marie Stopes International (MSI), a leading international non-governmental organisation (INGO) dealing with family planning and reproductive health, was established in Afghanistan in 2002. Since then it has worked in partnership with the Afghan Ministry of Public Health, the Ministry of Religious Affairs and Ministry of Women's Affairs, to deliver appropriate sexual and reproductive health (SRH) services to the community.

The MSI Afghanistan (MSIA) program includes the provision of quality SRH and family planning (FP) services through its fixed and mobile clinics, social marketing and health promotion activities. MSIA services are focused on four provinces of Afghanistan: Kabul, Herat, Balkh, and Faryab. In addition, MSIA provides technical support to the MoPH, primarily in the areas of policy development and clinical training. MSIA supports the MoPH to improve access to maternal, child and reproductive health services through the provision of high quality clinical services, technical support and training, advocacy and social marketing.

Afghanistan continues to experience a high level of political instability along with a deteriorating security situation. The country is at a key point in its national development and transition from a high level of dependence on international support to underpin security, capacity development, and political processes. While achievements have been considerable, the establishment of key institutions has been fragile and much remains to be done. Nevertheless, state-building has progressed with Government

ministries and departments established, key sectoral policies and strategies developed and taken forward, and key services organised and delivered.

The health sector has made significant progress in rebuilding the health system despite ongoing conflict and challenges of transition (see, for example, Michael et al, 2013). The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) serve as standard minimum packages of care to be delivered at each level of the health system. The health sector is still largely dependent on external aid, with Government expenditure accounting for only 5.6% of total expenditure, while international donors contribute about four times as much (20.8%) of total expenditure (Afghan Ministry of Public Health, 2013). Out of pocket expenditure is the main source of health financing and accounts for 73.6% of the total (Afghan Ministry of Public Health, 2013). Difficult geographic terrain especially in the centre and north of the country and dispersed populations in the south are key challenges facing access to, and coverage of, health services. Uncertain budget availability hampers longer-term planning, capacity development, and institutional stability for both government and civil society. Gender inequities persist although significant advances, for example in relation to schooling for girls, have been made. The engagement of women in government, the professions, and civil society has increased and there is some space open for the promotion of, and advocacy around, sexual and reproductive rights and access to services. Civil society is active and incorporates both local and international NGOs. The sustainability of those dependant on external funding support is uncertain given the current political and funding climate.

MSIA clearly operates in a highly dynamic space. It simultaneously influences, and is influenced by, many contextual issues and the broader projects related to health systems strengthening and state-building in Afghanistan.

2. EVALUATION BACKGROUND

2.1 Aim

Contextualise and assess the contribution of MSIA to promoting gender equity, women's health and wellbeing in Afghanistan, and identify mechanisms to further strengthen positive contributions where feasible.

2.2 Objectives

The Evaluation sought to:

- Assess the effectiveness (access, equity, quality, and efficiency) and capacity of MSIA
- Determine MSIA's progress and achievements against set objectives
- Determine the overall impact of the project from 2009 to present
- Provide recommendations to inform possible options for how family planning services could continue to be provided in MSIA target areas, and on how current programme activities could be improved to achieve this

2.3 Evaluation questions

A number of key evaluation questions had been identified by MSI (UK) and MSIA – these informed the approach to, and content of, the analysis. While these issues have been addressed in the description which follows, they are presented in a more integrated fashion rather than as a point by point discussion of the following questions. They have also been reordered to improve the flow in presentation of results and discussion:

Objective 1: Assess the effectiveness (access, equity, quality, and efficiency) and capacity of MSIA

1. What have been the outcomes in terms of access, equity, quality, and efficiency, as defined by MSI's results-based framework?
2. Has there been an effect on the capacity of the MOPH and BPHS/ EPHS service providers in terms of enhanced policy environment, increased clinical competency, availability of services, and/or improved planning and delivery of reproductive health services?
3. Has MSIA's strategic partnerships with key MoPH, UN, donor and civil society stakeholders had an effect on strengthening its work and the health system in Afghanistan?
4. Assess the coherence, relevance and sustainability of the MSIA programme in Afghanistan.

Objective 2: Determine MSIA's progress and achievements against set objectives

5. What is the progress towards achieving the overall objectives of the MSIA programme and effectiveness of activities conducted under this programme model?

Objective 3: Determine the overall impact of the project from 2009 to present

6. What has been the impact (expected and unexpected) for intended programme beneficiaries in terms of increased knowledge, access to and uptake of family planning and sexual and reproductive health services in the districts where Marie Stopes International Afghanistan is delivering its services?
7. Have MSIA programme activities had an impact on perceptions and awareness of FP amongst leaders (including religious leaders) and communities in target provinces?
8. How has MSIA attempted to involve both men and women in its programmes and what has been the impact for men and women at the individual and community level, particularly in terms of access to FP services and information?
9. What has been the impact (expected and unexpected) for intended project beneficiaries in terms of improved quality of life and strengthening SRH rights?
10. Has MSIA contributed to the achievement of MDG 4 and 5 in Afghanistan?

Objective 4: Provide recommendations to inform possible options for how family planning services could continue to be provided in MSIA target areas, and on how current programme activities could be improved to achieve this

3. Evaluation Methodology

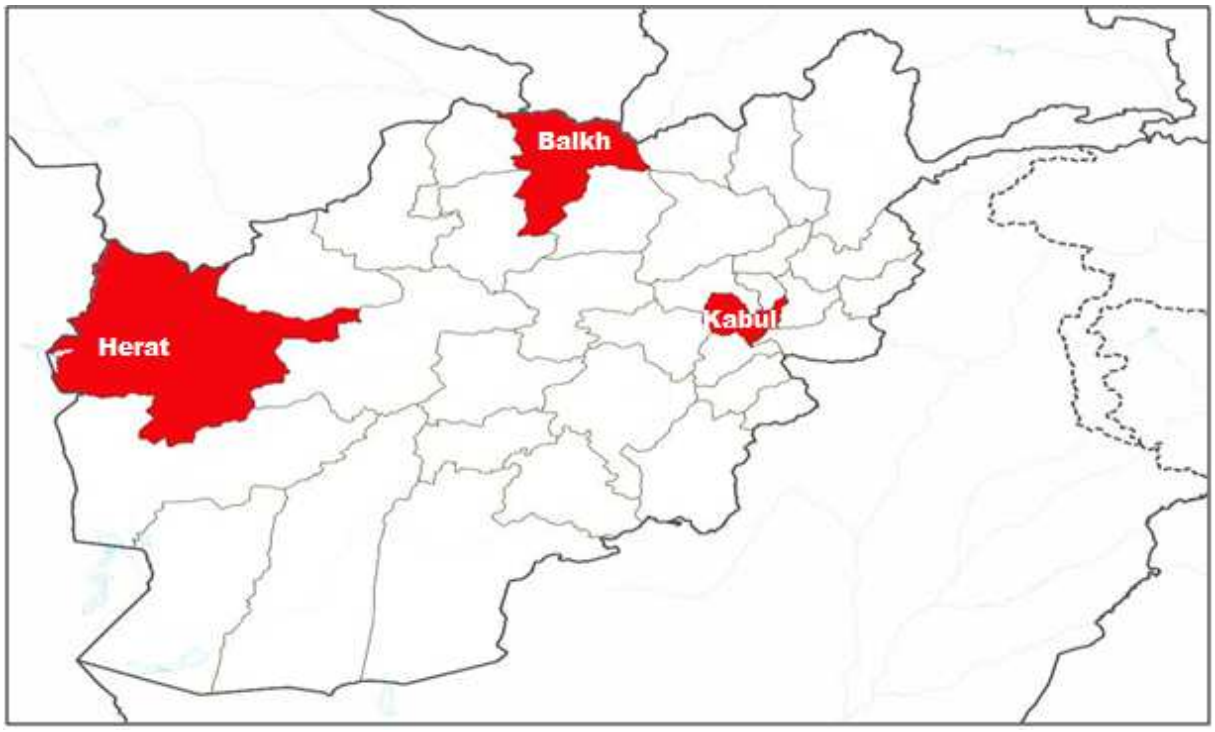
3.1 Setting

The evaluation was conducted in three provinces in Afghanistan, as requested by MSIA. These three provinces were Kabul, Herat and Balkh; where data are available from Faryab these too are presented. However, due to time, resource and security constraints no fieldwork was undertaken in Faryab.

Along with the advice of MSIA, criteria for selection of provinces included:

- reflecting the range of MSIA activities and operations underway;
- secure areas in which evaluators could operate safely and effectively;
- physical and geographic access.

Figure 1: Provinces of Afghanistan in which evaluation was conducted



Additional description of the provincial characteristics and context is presented below, as well as in Tables 2 and 3:

Kabul Province is the capital of Afghanistan and is located in a valley with a population of 4,0865,500. Of these 3,950,300 reside in Kabul City (Central Statistics Office (CSO), 2013). A total 157 health facilities (HFs) including 22 speciality hospitals are located in this province. 99% of all HFs are staffed with at least one female health worker. According to MoPH-HMIS (2014), the overall literacy rate is 52 % in the province and the immediate basic health services (availability of a health facility in under one hour) could be accessed by 85%. Only 78% of population have access to safe drinking water (MoPH-HMIS, 2014). MSIA supports four HFs in this province.

Herat Province is located in the western part of the country with a total population of 1,816,100 (Central Statistics Office-CSO, 2013). The province has a total of 100 health facilities, including one regional hospital and 70% of these health facilities are staffed with at least one female health worker. The overall literacy rate is 24.3% in the province (MoPH-HMIS, 2014). Immediate basic health services (availability of a health facility in under one hour) could be accessed by 96%. Only 53% of population have access to safe drinking water (MoPH-HMIS, 2014). MSIA is supporting a total of seven HFs in this province (2 fixed, 2 mobile, 3 satellite).

Balkh Province is located in the northern part of the country with a total population of 1,271,300 (Central Statistics Office-CSO, 2013). There are 107 health facilities, 7 mobile clinics, 32 Sub-health Centers, 43 Basic Health Centers, 14 Comprehensive Health Centers, 8 district hospitals, and 1 regional hospital with a total of 500 beds. Approximately, 97% of these health facilities are staffed with at least one female health worker. The overall literacy rate is 37.8% in the province (MoPH-HMIS, 2014). Immediate basic health services (availability of a health facility in under one hour) could be accessed by 96%. Only 67% of the population have access to safe drinking water (MoPH-HMIS, 2014). MSIA supports 9 HFs in Balkh province (3 fixed, 4 satellite and 2 mobile clinics).

The Evaluation, as described further below, focused on four levels of the system:

1. Community
2. Health facilities / services delivery
3. Provincial, including interface with other sectors and stakeholders
4. National, including policy level

Figure 2: Photograph - MSIA mobile clinic in Balkh province

Table 2: General profile of the provinces examined

	Province				National	Source
Characteristic	**Kabul**	**Balkh**	**Faryab**	**Herat**		
Population	4,086,500	1,271,300	964,600	1,816,100	27,500,000	CSO 2012 -2013
Population Density / km^2	903	79	46	33	39	
Map URL	Attached	Attached	Attached	Attached	Attached	www.aims.org.af
Distance from national capital[1] (km)	0	424	719	1062		Google
Overall literacy rate[2]% (Male Female)	47.5 (64,31)	28.5 (38,19)	19 (28, 10)	26.5 (35, 18)	26 (39, 12)	NRVA 2011
Life expectancy at birth					62(M), 64(F)	AMS 2010
Total fertility rate					5.1	AMS 2010

Table 3: Health profile of the provinces examined

	Province				National	Source
Characteristics / Provinces	**Kabul**	**Balkh**	**Faryab**	**Herat**		
Total MSIA Health Facilities; (BPHS HFs including Hospitals)	4 (158)	3 (99)	1 (57)	2 (100)	10 (1901)	HMIS 2014
Percentage of population with access to nearest health facility within one hour by any means of transport	96%	82%	49%	85%	57.4%	NRVA 2007/08
12-23 months fully immunized	73%	27%	25%	43%	37.2%	
Skilled Birth Attendance Coverage	73%	28%	16%	24%	24%	
% of Health Facilities With At Least One female Health Worker	88%	84%	92%	69%		

3.2 Summary of timeline associated with evaluation

- Contract issued – 7 August 2014
- Contract signed – 28 August
- UNSW ethics approval (policy level / key informants) – 29 August
- Afghan IRB approval submitted – 8 October
- Evaluation protocol approved by MSI – 15 October
- Higher level interviews conducted – Mid-Sept to current
- Afghan IRB approval received – 17 November
- Fieldwork undertaken in provinces – Late-Nov to early December
- Preliminary findings provided for Finnish quality assurance board meeting – Late Nov
- Data analysis – November/December
- Draft report submitted – 24 December
- Final report submitted – 8 January 2015

3.3 Background literature

Documents provided by MSIA, as well as related policies and strategies from the MoPH and other stakeholders were identified. Additional material was sourced from leading multilateral organisations such as the World Health Organization (WHO) and UNICEF where relevant. Afghan policy documents and other locally available publications were obtained from the Resource Centre located in Afghan Ministry of Public Health (MoPH). Google Scholar was used to identify additional reports and publications of potential interest in English, using key words including “MSIA”, “Marie Stopes”, “Evaluation”, “Reproductive Health”, “Family Planning” and “Afghanistan”. Among the materials examined were peer-reviewed and grey literature, MSI and MSIA documents, Government policies and strategies, and country-based surveys and data (e.g. MICS, AMS and NRVA), as relevant.

Additional materials were sourced to better understand and describe the changing context of maternal, newborn and child health (MNCH), sexual and reproductive health (SRH), and rights in Afghanistan. The Evaluation Team sought to understand the current political and policy context, and to situate MSIA activities and interventions within this broader context.

3.4 Study Design and Rationale for Choice of Methods

The Evaluation utilised mixed methods. The Evaluation Team reviewed secondary data from MSIA and the MoPH, along with qualitative insights derived from in-depth interviews and focus group discussions (FGDs) in three provinces. Health facility assessments (HFAs) undertaken in six facilities supported by MSIA (four CHCs and 2 mobile services), sought to explore elements of their performance. At the same time, these HFAs allowed modest observations of facilities and service delivery in relation to family planning and reproductive health to be made, along with review of the HMIS and other records.

3.4.1. Settings

Data were collected from 6 health facilities in three provinces. These venues also provided a base for client and staff interviews or FGDs. In each province, interviews were conducted with the following range of informants:

1. MSIA clients (all female)
2. MSIA clinic staff
3. Provincial health personnel (NGOs and public sector)
4. Provincial Religious Affairs Director
5. MSI Provincial Coordinators
6. Provincial Public Health Directors
7. Provincial Reproductive Health Officers
8. Provincial Women Affairs Directors
9. Provincial Public Health Coordination Committee members
10. Community and religious leaders

At national level, the following categories of people were also interviewed:

1. Donor representatives
2. Senior personnel - Ministry of Religious Affairs
3. Senior Personnel - Ministry of Women's Affairs
4. Senior Personnel - Reproductive Health Directorate - Ministry of Public Health
5. Senior Personnel - Human Resources Directorate / Ministry of Public Health
6. MSI staff
7. MSIA Project Managers

A total of six FGDs were conducted involving Provincial Public Health Coordination Committee (PPHCC) members, community health facility staff, and community members (clients). All participants of client FGDs were female.

3.4.2. Sampling, selection and recruitment of informants

Sampling

Data were collected from 37 in-depth interviews and 13 focus group discussions (FGDs). The 37 in-depth interviews (IDIs), also referred to as key informant interviews (KIIs), included purposively selected informants: 8 MSIA program staff (7 men, 1 woman), 5 clinic staff (all women), and 16 (8 men and 8 women) policy level government staff in centre and provinces , 2 clients (both women), 3 community and religious leaders (2 women and one man) and 3 other NGO staff (2 men and one woman). One policy level interview was not conducted as the informant indicated no knowledge of the issues under discussion. A planned FGD with the PPHCC members in Kabul did not take place because no PPHCC meeting was held during the data collection period.

The KIIs were conducted using a semi-structured interview guide. A structured Health Facility Assessment checklist captured information about the performance of a selection of health facilities

run by MSIA. The health facilities were selected based on security of the location and representation of all types of MSIA health facilities.

FGDs were conducted with a range of participants, including MSIA female clients, MSIA clinic staff, community members from Local Health Committees, and representatives from Provincial Public Health Coordination Committees. All participants were issued with the approved Consent Form for their informed consent and signature.. A FGD with male clients was planned, but abandoned given lack of male clients attending MSIA clinics. The FGDs were facilitated by one member of the Evaluation team and recorded and documented by another. Female research associates facilitated FGDs with the female clients using a semi-structured FGD guide. The Evaluation Team recruited only those clients who felt comfortable and willing to take part on a voluntary basis. The interviews were conducted in all three provinces as initially planned; no additions were made.

All KIIs and FGDs were recorded with the help of a digital sound recorder. Subsequently the recorded voices were converted to verbatim transcripts. Transcripts in local language were translated into English to facilitate analyses. The recording assisted the evaluators to make more comprehensive notes and convey meaning accurately (Green and Thorogood, 2004).

Selection

Clients who used MSIA services were selected from both rural and urban areas. In Kabul, all the clients were from urban areas. In Herat and Balkh provinces, 50% were rural and 50% urban. Those below 18 years of age, having little interest or awareness of the topic, and those declining to participate were excluded. A total five clients (two in Herat and three in Kabul) declined to participate in the FGDs because they stated they did not have time to participate in the study. These clients were replaced by others attending the same health facility.

Recruitment

The Evaluation Team sought recruitment assistance from MSIA, BPHS NGO Managers and officials of the Ministry of Public Health (MoPH) in the three provinces; they provided a list of staff and of their health facilities (HF). At all levels, volunteers were sought through word-of-mouth, ensuring that potential participants understood that participation was entirely voluntary. One key informant declined to be interviewed as he said he knew nothing about MSIA activities. Two key informants from Kabul initially declined to be interviewed; one declared he did not support MSIA. These two key informants were, however, subsequently interviewed and expressed their concerns within the interview. There were no refusals in the province-based fieldwork.

3.4.3. Data collection methods

Semi-structured interview and FGD guides were developed for the interviews and FGDs. Notes were taken during both, as well as being digitally recorded and subsequently transcribed for analysis. Additional data sources and methods were used in order to triangulate emerging insights, including observation, health facility assessments, and examination of secondary data derived from MSIA documentation and the Health Management Information System (HMIS).

Guides and the HFA tool were designed in consultation with MSI, MSIA and other relevant stakeholders so as to ensure sensitivity to the socio-cultural context. The interviews and FGDs were largely open-ended but included semi-structured components to cover the following:

1. Participant background
2. Engagement with MSI or related services
3. Impact of MSI interventions on intended beneficiaries
4. Stakeholder and community involvement in MSIA program interventions
5. Assessment of strength and limitations of MSIA activities and programs
6. Recommendations and comments regarding scope for improvement and future sustainability

3.4.4. Pilot Testing

A one-day training session was conducted for all data collectors and other staff of ORCD who were involved in this evaluation. This opportunity was used to ensure that all understood the tools and could implement them properly. The health facility assessment tool was not piloted in advance.

The following modifications were made to the interview questions based on the outcomes of the pilot:

1. The Evaluation team developed separate FGD guidelines for each category of respondents as well as guidelines for how the interviews and FGDs were to be undertaken.
2. Some questions were rephrased to ensure that interviewees would understand them. Interviewers were trained on how to probe semi-structured interview questions in order to elaborate on issues discussed.
3. Additional tips, hints and guidance were identified and shared.

3.4.5. Ethical Considerations

Ethics approval was obtained from the Human Research Ethics Advisory Panel B at UNSW Australia (approval no. 14 112) as well the Institutional Review Board at the Ministry of Public Health Afghanistan (see approval letter; Annex 1).

To ensure voluntary participation and avoidance of coercion, written informed consent was received from every participant (Shahnazarian, et al, 2013). In addition, the interviewees were assured of their anonymity. To abide by the Afghan cultural norms where male cannot talk to women who have no prior acquaintance (Bagboy, 2010), female data collectors conducted most of the interviews with those females willing to participate.

All fieldwork notes and transcripts were secured in a locked cabinet in the ORCD Kabul Office. Hard copies will be stored for five years and then destroyed. The entered data was coded and secured in a password-protected computer folder which was safe from unauthorized access.

3.4.6. Analytic Approach

All interview and FGD transcripts, and HFAs, were coded and data categorized systematically. Most of this was done manually, although several interviews undertaken by the UNSW team were initially coded using the NVivo 10 software package. The first step of manual coding involved formatting the interview transcripts into tables and summarising key findings from the different groups of stakeholders. Each transcript was placed in a separate column within an Excel spreadsheet, with a different sheet being reserved for each type of informant. A summary Word document was subsequently produced, which identified either consensus or differing views, as well as relevant quotes reflecting informant viewpoints. These were summarised by theme, highlighting key perspectives on MSIA and its role in Afghanistan.

Figure 3: Photograph – MSIA service, Herat province

4. KEY FINDINGS

4.1 Access, equity, and quality of MSIA program

General

The majority of informants were positive about the MSIA program and believe it to be of value to Afghanistan. Overall, informants believed services to be accessible, equitable, of high quality, and offered through supportive staff.

Many staff suggested the problem of insecurity was a challenge for them in providing services, and for people accessing their services.

Access

Most informants (including clients, staff, and community members) suggested that MSIA services are generally accessible, from both a geographic, financial, and social point of view. However while many noted that MSIA services are cheaper than most, a number of informants indicated that many still could not afford this and that services should be provided for free. Others also noted that those who don't live in close proximity to a service, or live in a more remote area, have trouble reaching a service due to the cost of transport.

A provincial health official indicated his view that MSIA services were most accessed by those better off, and that services were often inaccessible to those most poor, even if they were at very low cost or free,: *'people who are benefited from the MSIA services, lots of them have high and middle economy, but [those] whom are in low condition of economy they are not afford from charges even they are not able to pay a small amount'.* A large number of informants highlighted the importance of providing free services for many in the community given the low incomes of community members in Afghanistan. This finding is supported by those from the MSIA 2013 exit interview report, which indicates that less than 15 % of MSIA client are living under the national poverty line.

Almost all informants suggested that MSIA should expand and extend their services in order to reach more people – *'vulnerable and marginalised people should be given proper coverage'*. One senior government official supportive of MSIA, suggested that *'when MSIA is establishing a health facility, they should do a situation analysis to avoid duplication of services and to provide services to the people who need it. They should map health services and target white areas. Cities are fully covered and have hospitals and clinics. MSIA should provide services in rural areas'*.

Clients and other informants said that MSIA is reaching a number of people through a range of avenues, including word of mouth, community-based distributors, announcements by Mullahs, Mullahs' wives, various media, television and radio. Findings from both the MSIA 2012 and 2013 exit interview reports show that the most common types of media used by clients were TV and Radio, with numbers increasing between 2012 and 2013. This suggests advertising through these channels would reach a high number of people, although findings from the 2013 exit interview report show that 60% of clients interviewed had heard about MSIA services from someone they knew, and only 10% through TV/radio and internet.

Acceptability, cultural sensitivity and satisfaction

In-depth interviews with MSIA clients revealed that MSIA services were attractive to them, as they helped people avoid *'unplanned and unwanted pregnancy'*. The services were seen to be positive and clients indicated that they would refer their relatives and friends to MSIA services. Clients highlighted the '*good and inexpensive services'* which are offered *'without any prejudice or discrimination'*.

Clients indicated that MSIA services had *'good images'* at community level and that people trust the service. They found MSIA staff to be supportive and *'trustful'*. They valued the fact that MSIA staff maintained confidentiality and *'keeping privacy'*. A senior government official indicated that MSIA services are appreciated: *'Clients are very happy and the clients come here and tell me about the quality of MSIA services'* she said, adding *'If they don't trust them then they cannot work. Government is evaluating their programs and will ban their services if they do not perform very well'.*

Many informants noted that birth spacing is becoming more acceptable in Afghanistan, although perhaps more so in urban areas. They noted that many people are supportive of this, even mothers-in-law and husbands, including in some rural areas where people tend to be more conservative. An in-depth interview with a client in Balkh indicated that '*there is a huge difference between me and my grandmother thinking about birth spacing, because at that time there was no such service for providing FP education to people but due to MSIA services my mother's mind changed positively regarding FP methods. She is using methods for having space'*.

One informant reported anecdotally that MSIA is seen by some as a provider of abortion services; no additional comments along these lines were made but this represents a risk and potential for stigmatisation to occur.

Support of religious leaders

Virtually all informants highlighted the importance of securing the support of religious leaders. One senior official in a relevant ministry highlighted the power and influence of these community leaders: *'People have trust of the religious leaders. Tens or hundreds times advertisements through televisions and radios will not be that much efficient as that of religious leaders who say the same issue only once.'*

Client in-depth interviews in Balkh indicated that MSIA has good relationships with the community and with religious leaders and that through these leaders *'our men can get important information about family planning which is not against Islam'*. This was reiterated by a Ministry of Religious Affairs official who emphasised close links between MSIA and religious leaders: '*The main thing about MSIA is that they have got the religious leaders' support. When the mobile clinics of MSIA are going somewhere, the religious leaders are there to help them especially in the case of resistance from community members. The community members accept everything said by a religious leader.'*

A Provincial Reproductive Health leader indicated that they were working closely with both religious leaders and MSIA. '*Yes they are supportive of birth spacing. We have arranged a zone conference with the support of UNFPA for religious leaders for the sake of awareness and importance regarding the family planning and birth spacing. The religious and spiritual leaders were invited from different provinces like Farah, Nimroz and Ghor provinces. They were taught and trained in good manner. The trainers explained these issues in the light of Islam. They have agreed with different family planning methods and signed an agreement stated that the birth spacing is really required for the good health of both mother and child, proper growth of children and as well as for the healthy, successful and happy community. MSIA has played an important role. For example the services they are providing in our two clinics are for the sake of increase family planning users. Indeed they have played a vital role.'*

Equity

Most informants suggested there are no issues of discrimination for clients accessing MSIA services – that all people are able to benefit equally from their services. The main barriers to access identified were cost (of the service and/or transport) and geographical location of services.

Almost all informants requested that MSIA services be extended to more rural and remote areas and other provinces, as currently they are only available in more urban and 'wealthier' areas.

Issues of equity within MSIA itself were also explored in the Evaluation. There is a good mix of male and female staff members across MSIA, although most management positions are held by males and

the number of female employees within the Kabul head office is relatively low. It was suggested that this is due to a lack of qualified female staff. Indeed, Michael et al (2013) cite a number of analysts making this point (p. 330). It was also noted that some skill-sets are rare in Afghanistan which can make recruitment of any staff (male or female) difficult.

Client in-depth interviews added yet another dimension of equity: *'family planning is not the responsibility of women but it is common responsibility of men and women'.* A prominent female national leader also indicated that family planning remains an absolute priority: *'Having more children should not be a hobby for parents but should be for providing them better life conditions',* highlighting the importance of this area of social and health policy as imperative for Afghanistan's future. She drew attention also to the growing population size in the country and the challenge this will pose to government budgets and services delivery.

Quality

Client in-depth interviews in Balkh indicated appreciation for the *'good check-up, good medicine and they keep privacy'*, highlighting a number of dimensions of quality. In-depth interviews also highlighted the *'good behaviour of staff'* within the MSIA services.

Most informants found the quality of MSIA services to be high, and that the clinic they visited was clean. General cleanliness of clinics was also observed during the HFAs, except for one clinic which the evaluator suggested could have been cleaner.

Both clinical and management staff commented that while there is usually a good supply of commodities, there are occasional stock-outs, which one manager interviewed found to be *'quite dispiriting'*. A clinical staff member said that it *'takes a bit long time'* (to receive medicines and other supplies). Another suggested that even when supplies arrive on time the expiry date may be near. Overall though, staff were happy with the level and timing of supplies.

4.2 Impact and effectiveness of MSIA

Range of programs

MSIA are undertaking a range of activities in Afghanistan, with many innovative ideas and some thinking *"out of the box"*. One of these includes working with Mullahs and their wives, a program regarded highly by a wide range of informants, including those associated with Religious Affairs. MSIA has also established a toll-free hotline which provides information on FP issues to both males and females, receives client calls and queries, offers advice about clinic locations, services available and hours of operation, and follows up distribution and sale of family planning products. Advice on dealing with gender-based violence is planned from January 2015 onwards.

MSIA has also placed advisors within two government Ministries (MoPH, MoRA) which simultaneously supports these ministries and their capacity development, while also helping to advocate for relevant policy changes and their implementation.

In relation to general services provision, MSIA operates out of both fixed and mobile facilities, thus increasing flexibility and the availability of services in especially difficult contexts. They also have

actively promoted community-based distributors in order to extend the availability of family planning supplies.

Impact on intended program beneficiaries at the individual and community level

Many informants from a variety of stakeholder positions highlighted the positive changes that are occurring in this area in Afghanistan. Birth spacing is becoming more acceptable and people are having fewer children.

Clinical staff similarly noted that their services are being welcomed, even in rural areas which *'was not the case few years before'*. One staff member stated that '*During my very first days at the clinic there were hardly 3 or 4 clients of family planning in the whole day but now we are having 30 to 40 clients per day which is a huge difference'.*

Many MSIA clients agreed that they now know of the importance of birth spacing which can be attributed to MSIA programs – *'now our husbands want birth spacing and they are using condom'* (client in Balkh province). Another said *'I gave birth to two kids year by year. Later on I started acting upon birth spacing and took the gap of seven years for giving birth to my third child'.*

Many clients emphasised the positive role Mullahs have had in informing them about the importance of birth spacing. Religious and community leaders also reiterated this point, noting that they have observed a positive change in attitudes to birth spacing, and people are having fewer children.

Several clients suggested that although there are Mullahs who are not in favour of birth spacing, that *'keeping space is our own work, we do it, we not listen to Mullah, we have interest to keep spacing, this is important for us, not what mullah says'* (client in Balkh province). This highlights the increasing agency that community members exercise in relation to their own family planning choices.

Impact on perceptions and awareness of family planning amongst religious and community leaders

There is considerable acknowledgement and support for the innovative MSIA program directed at Mullahs and their wives, right down to village level. Religious leaders are extremely influential in Afghanistan and their support (or opposition) for family planning makes a considerable difference. A number of informants drew attention to the fact that family planning is in keeping with Islam and that Mullahs are therefore often supportive of this.

Working with religious leaders not only extends the availability of information and knowledge about family planning, but also encourages these influential members of the community to convey their increasingly positive views to their extended families and the broader community.

One key informant from a religious family declared that she had only two children after 13 years of marriage, and that although she might want one or two more children, her family has told her not to do so saying *'fewer kids are good for happy and better life'*. Such attitudes would not have been heard as recently as one decade ago.

Many religious leaders are aware of, and supportive of, family planning methods (also evidenced in the MSIA religious leaders Knowledge, Attitudes and Practice [KAP] survey conducted in 2013). MSIA

has run workshops with UNFPA and religious leaders and discussed issues ranging from family planning to the value of breastfeeding, itself a valuable means of extending the time before the next pregnancy.

'Many significant changes have been made among villagers, community leaders and religious scholars … we had many meetings in this regard, many changes have been made, perhaps I can say about 70% changes have been made'.

Mullahs are encouraged to share information on family planning and birth spacing in a culturally appropriate way. The estimated number of males who received these messages in mosques during 2012 was 7,200, and based on MSIA's 2013 data, this has increased to 8,500 (documented in MSIA Year 2 Narrative report). One respondent reported *'The religious leaders themselves are explaining and giving preference to family planning and birth spacing issues while this was not the case at the past'.*

Religious leaders are generally supportive and have responded well to opportunities to work together with MSIA and the Ministry of Religious Affairs.

Impact on government and policy

MSIA works closely with different branches of government, including the MoPH, MoWA and MoRA, at both central and provincial levels. In Herat, for example, the MoWA leader indicated strong partnership with MSIA and *'100% support'*, emphasising that MSIA is a *'good co-worker'*.
MSIA have had significant impact on policy in Afghanistan over the years since their establishment and operation in the country. The positioning of one advisor at MoPH and one at MoRA has contributed to advocacy efforts and the development of progressing policies.

In relation to the latter, MSIA has contributed to a number of policy advances. These include the development of guidelines for post-abortion care, which have been approved, thus highlighting a degree of flexibility within the policy environment. Another notable MSIA-supported success has been in relation to having new family planning methods added to the Essential Drugs List. These include implants, Misoprostol for Post-Partum Haemorrhage (PPH), and the Progesterone-only Contraceptive Pill. These have been officially registered, with protocols on how to use them finalised. Emergency contraceptive pills have also been added to the national Special Drugs List.

MSIA also established the Reproductive Health Caucus, a cross-party group of male and female Members of Parliament who are willing to champion issues, raise the profile of SRH, and advocate around important and emerging issues.

Some tensions regarding the role of family planning are, however, still discernible. One provincial health leader was more critical and implied that family planning advocacy and information in general is linked to other [social and political] issues and this is detrimental to advancing family planning: '*Creating trust is very important and leads to attitudes changes. Unfortunately, political, economic and social issues are incorporated in some publications that I have at hand. It should be taught to people that FP is not a political issue so they will accept it easily.'*

4.3 MSIA's strategic partnerships and the health system

As noted previously, MSIA works with a range of Afghan Ministries and organisations at central, provincial and local levels. Informants indicated that many of these relationships are working extremely well, while a number of gaps or weaknesses were also identified. Concern was expressed, for example, about poor relationships with the Kabul Provincial Health Directorate, while others commented on the excellent relationships with other parts of the MoPH.

In Herat the Ministry of Women's Affairs were very positive about their interaction with MSIA. One area in which improvements were suggested was in relation to more transparent annual plans and targets which could be agreed between the different authorities and MSIA and then monitored over time.

Capacity development

Actors and organisations working in Afghanistan should contribute to building national capacity and capabilities. In relation to MSIA, some of this is explicit and some implicit. MSIA has not clearly identified health systems strengthening as one of its objectives, but it contributes to this objective in a variety of ways. These include the development of policies and clinical guidelines, and support and training of MSIA and government staff.

MSIA contributed to building the capacity of managers within the MoPH and to the capabilities of clinical staff in a number of settings. While this type of role seems to be reasonably well established in relation to MoPH, this is not clearly the case for other Ministries. For example, an informant from the MoWA suggested that MSIA is no longer contributing directly to capacity building whereas it was previously doing so.

With respect to MSIA staff, they are generally very satisfied with the support and working conditions offered by their employer. While they seek opportunities to develop their own leadership, management and clinical skills, they also indicate considerable satisfaction with the level of training provided by MSIA and hoped that this would continue and increase. The majority of clinical staff requested additional training opportunities in relation to family planning refresher courses and other competency updates.

Coordination

One informant suggested that MSIA needs to establish an active and more explicit coordination mechanism with the BPHS implementing NGOs. This could take the form of attending regular meetings, exposure visits, and/or exchange programs between other service providers and MSIA. In one province it was noted that MSIA are not currently participating in, or reporting to, Provincial MoPH Coordination forums. An informant at the MoRA also suggested that MSIA should devote more attention to participating in relevant meetings; MSIA was arguably less involved with their department compared to other organizations with a similar mandate.

MSIA are, however, working closely with the central MOPH Reproductive Health Department and with Kabul Provincial Women's Directorate; they attend their technical and policy forums. Most informants from NGOs also stated that MSIA has been working closely with them; a contrast again with the critical view of their relationship with some members of the MoPH who were dissatisfied

with the level of communication and coordination. It was suggested that MSIA should explore mechanisms through which to update the MoPH about their activities in different provinces of the country, such as through a regular presentation to donor and MoPH fora.

A summary point was that the MSIA programme was not fully aligned with the BPHS and EPHS given its primary focus on reproductive health. Furthermore it was alleged that MSIA operated outside of the standard health system. An informant suggested that if one is not aligned with the BPHS or EPHS then *'you are out of the system'*, you are a *'vertical program'*, and only *'focusing on one area of the health system'*.

4.4 MSIA contribution to MDGs 3, 4 and 5 in Afghanistan

A number of informants highlighted the fact that women are having fewer children in Afghanistan than ever before and that maternal mortality has declined. A client in-depth interview indicated that as the birth rate decreased so too did *'the chance that women die during pregnancy and delivery'*. While the reduction in birth rate cannot be attributed to MSIA, it is widely accepted that they are contributing, along with other civil society organisations and the Government, to this trend.

It was noted that MSIA is unable to address all of the very substantial challenges facing women in Afghanistan, but that they nevertheless make a contribution: *'We have one proverb in Afghanistan - that the existence/availability of something is better than nothing. If we compare MSIA with other NGOs as the BPHS implementers, they are providing a small portion of overall health services. Their existence is important because they are providing a small portion of overall health services but these are very important to the member of the community'.*

Others made a similar point at a general level, arguing *'There is significant reduction in morbidity and mortality of mothers and children. It is obvious that MSIA has also contributed that among others because MSIA is providing reproductive health and related services'.*

MSIA are recognised as contributing to establishing a climate in which women's health, rights and other concerns can be raised and addressed. In this respect they are contributing, directly and indirectly, to the empowerment of women and the promotion of gender equity.

4.5 Coherence, relevance & sustainability of MSIA program

Evidence of increasing demand is seen in relation to client numbers, which appear to be going up. Several informants made this observation with respect to client numbers, which is also supported by MIS data that shows an increase in MSIA client numbers. MSIA's Impact 2 indicators also show steady growth between 2004 and 2013 in uptake of FP methods; with FP users reportedly increasing from 9782 in 2004 to 283,615 in 2013, thus averting a number of pregnancies including those which may be unintended. The quantitative charts and tables below, drawn from the national Health Management Information System, illustrate substantial expansion of FP activities and couple years of protection, plus other services, through MSIA facilities. The Evaluation was, however, unable to verify these reported data.

A number of informants highlighted the increase in client volume that they personally had observed, often increasing from a handful when services were first established to up to 100 clients attending an MSIA clinic on an average day. Where clients are contributing to costs, these funds are fed back into the organisation to help support the provision of services for free to those most poor, or to developing new initiatives.

It is apparent that positive relationships with religious leaders are necessary for MSIA's consolidation and sustainability. There are indications that this is being achieved. An example was a statement from a senior Imam and leader within the Ministry of Religious Affairs, which indicates that religious leaders took a careful look at MSIA and have deemed them a valuable partner in promoting health and development in Afghanistan: *'The religious leaders studied about MSIA and given them advices to increase or either decrease some of things MSIA were focusing on. The services can be provided to the people of community according to the rules and regulations of Islam'.* This highlights also the importance of responsiveness and clear communication with the many stakeholders in Afghan society.

A small number of commentators from different organisations in a provincial setting suggested that MSIA should invest in its own physical structures and clinic buildings instead of operating out of rented spare rooms belonging to other agencies. They argued that this impermanence detracts from MSIA, does not contribute sufficiently to developing national infrastructure, and is often not ideal in terms of light, space, comfort and signage. Despite this the majority of informants suggested that MSIA services are of high quality; this is also supported by MSIA's 2013 Quality Technical Assessment report results, in which they scored 93.8% overall. MSIA's 2013 exit interview report similarly found that 93.2 % of clients were "satisfied or very satisfied with their overall experience at an MSI facility" and 98.8 % would recommend MSIA to a friend.

A number of informants suggested that MSIA should extend their services beyond family planning, as the needs are so complex in Afghanistan. Gender-based violence was identified as a widespread concern, and if MSIA are the only nearby clinic available they must help to *'resolve these issues'*. This informant acknowledged that addressing this and other women's health issues are not necessarily core to MSI internationally, but should be considered given the needs within the Afghan context.

One MSI staff member suggested that MSI head office might have a *'low understanding of the context'* , asserting that Afghanistan is a very different and unique operating environment to many other places in which MSI is active. This comment aimed to highlight two issue: the importance of MSI Head Office staff traveling to Afghanistan and gaining a greater appreciation of contextual challenges; and the importance of MSIA staff having a greater degree of flexibility to formulate and shape local programs and interventions.

4.6 Health Facility Assessment

A structured health facility assessment (HFA) was carried out in 6 health facilities (3 in Balkh, 2 in Herat and one in Kabul province). Among these 4 were fixed clinics and two mobile services. Health facilities in Afghanistan, 'on average', offer services to approximately 25,000 people within their catchment area.

In all MSIA health facilities visited, IUDs, implants, OCPs and injectable methods of family planning were offered. Vasectomies were not offered and all services were directed almost solely at female clients. As indicated below (section 4.7), this was seen by both staff members and clients as a particular strength of the MSIA services.

In addition, all fixed health facilities distributed a number of family planning-related consumables within the community via community-based distributors (CBDs). These CBDs not only distributed family planning methods outside of the health facility but also participated in awareness-raising and other campaigns around promoting awareness and use of short-term and longer-term family planning methods.

Health facilities also offered Post Abortion Care (PAC), utilising MVA and Misoprostol. Induced abortion was undertaken in situations where legal pre-requisites were met, notably and most commonly in cases related to incest, saving the life of the mother, and protecting the physical health of the women involved. Family planning was routinely offered to all PAC clients, during antenatal care, after delivery, during post natal care and during child vaccination activities. Those in charge of the health facilities visited were trained in PAC and permanent family planning methods.

Systems to ensure availability of drugs and consumables were in place. As indicated elsewhere, stock-outs were rare. Client registration systems recorded consumption, and restocking reportedly usually took place in a timely fashion. Of 6 health facilities visited, only one had experienced a stock out (condoms and implants) in the previous six months. In order to prevent stock outs most facilities had reserve stock.

All health facilities had very good and updated registration books including space for noting new clients, those switching between services, referrals, complications from PAC services, and client follow ups. Facility staff held regular meeting for discussing the services data and implementation progress. No graphs or other visual materials regarding facility progress and development were seen or displayed or made available to the Evaluation team members.

All fixed health facilities had an incinerator for waste disposal and a separate sharp box for used items. Solid waste was disposed and transported outside of the health facilities.

4.7 Secondary Quantitative Data Analysis

The Evaluation protocol and methods did not include primary quantitative data collection given time and resource constraints. The Evaluation team did, however, draw on available secondary data from the National Health Management Information System (HMIS) in order to assess aspects of MSIA activities. The HMIS is a passive reporting system from health facilities to provincial MoPH Office and electronically from Provincial MoPH to central MoPH. The accuracy and validity of the data has not been carefully assessed.

An important indicator of utilization of family planning (FP) services is Couple Years of Protection (CYP). CYP is the estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed to clients during that period. It measures the scale of program activity but is not intuitively easy to understand for those outside the field.

The data are collected according to the Afghan (Solar) Calendar. Each Afghan year corresponds to March 21 until March 20 of the next Gregorian year. Year 1385 corresponds to 21 March 2006 to 20 March 2007 and year 1393 corresponds to 21 March 2014 to 20 March 2015, for example.

Figure 4: Total couple years of protection (CYPs) in MSIA Health Facilities (all provinces)

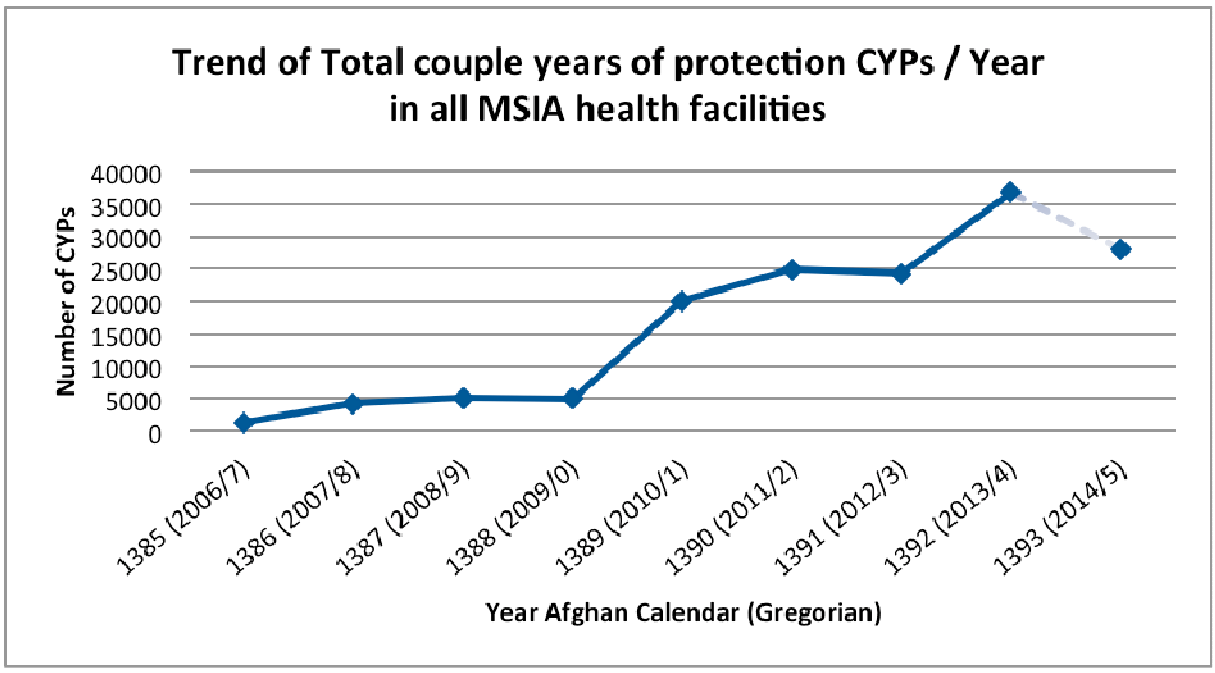


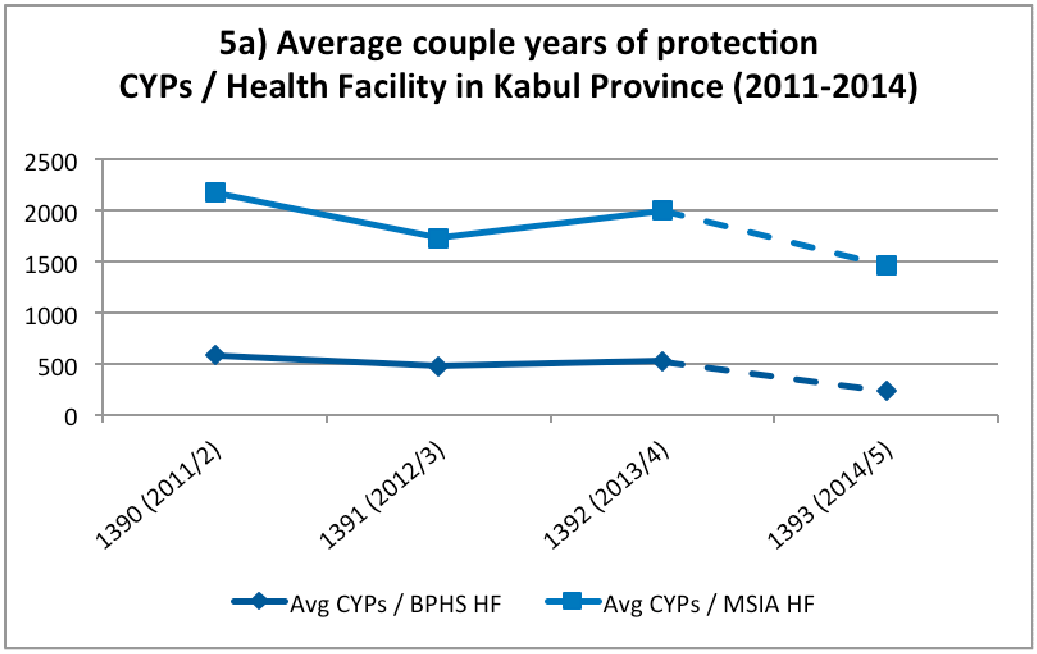
Figure 4 shows an upward trend in total CYPs offered through MSIA health facilities in the country. The graph shows marked increases in CYP from around 5000 in the early period of operation to at least 30000 in recent years. An annual increase in the number of MSIA clients is apparent. MSIA worked in an additional two provinces (Bamyan and Badakhshan) during the steep increases in 1388 (2009/10) and 1391 (2012/3), and recruited Community Based Distributers in 1388 (2009/10), which may help explain these extensions of coverage.

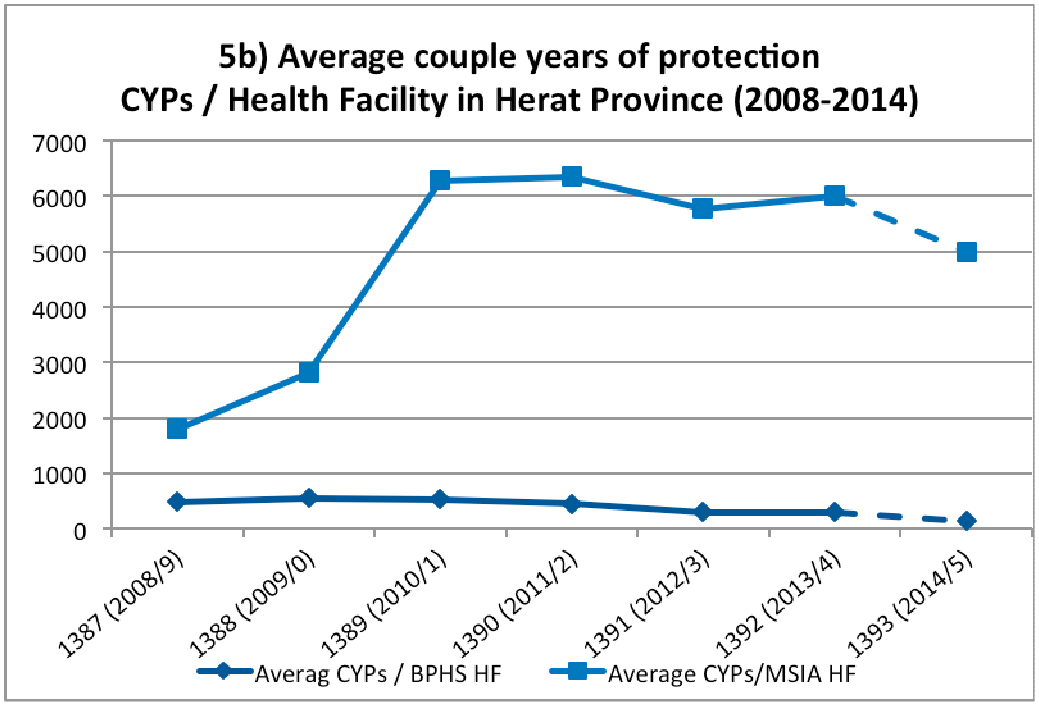
As in all the graphs presented above and below, the downward trends in 1393 (2014/5) reflects incomplete data collection, covering only the first 6 months instead of the full year. If extended to the full year it is likely that further increases in CYPs beyond that of 1392 (2013/4) would be evident.

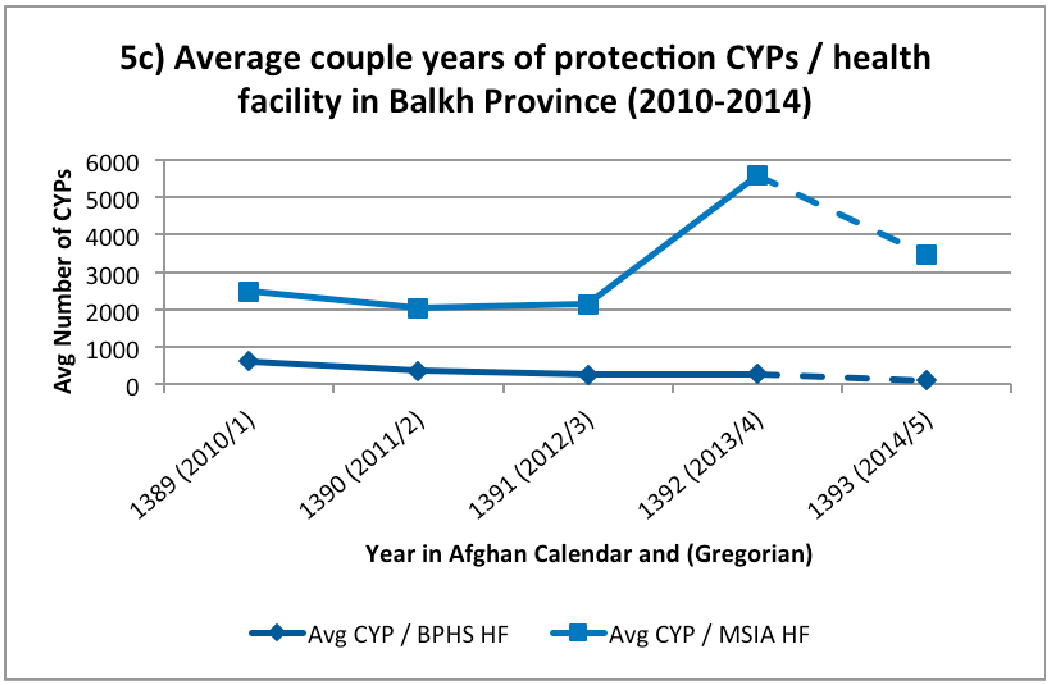
Figures 5 a-d present average CYP per health facility over time. This is calculated as dividing the total number of CYPs in a given province by the total number of health facilities in the specified province to provide a figure for average number of CYPs per facility per province per year. The graphs illustrate some increase in average CYPs in MSIA health facilities in most provinces and then plateauing of service provision, although interpretation requires access to the most recent data. In most cases the MSIA services show an increase over time whereas the average CYPs in BPHS health facilities show slight decreases over time in all four provinces. MSIA average CYP rates are much higher than those offered by regular BPHS services. Variations in average CYPs in MSIA health facilities are likely to reflect erratic reporting to HMIS.

MSIA does not regularly provide HMIS reports to MoPH and many blank cells were observed during inspection of monthly MSIA data in HMIS database. The types, population covered and utilization of health facilities differs by province.

Figures 5 (a, b, c, d) Average number of CYPs / health facility in each MSIA province







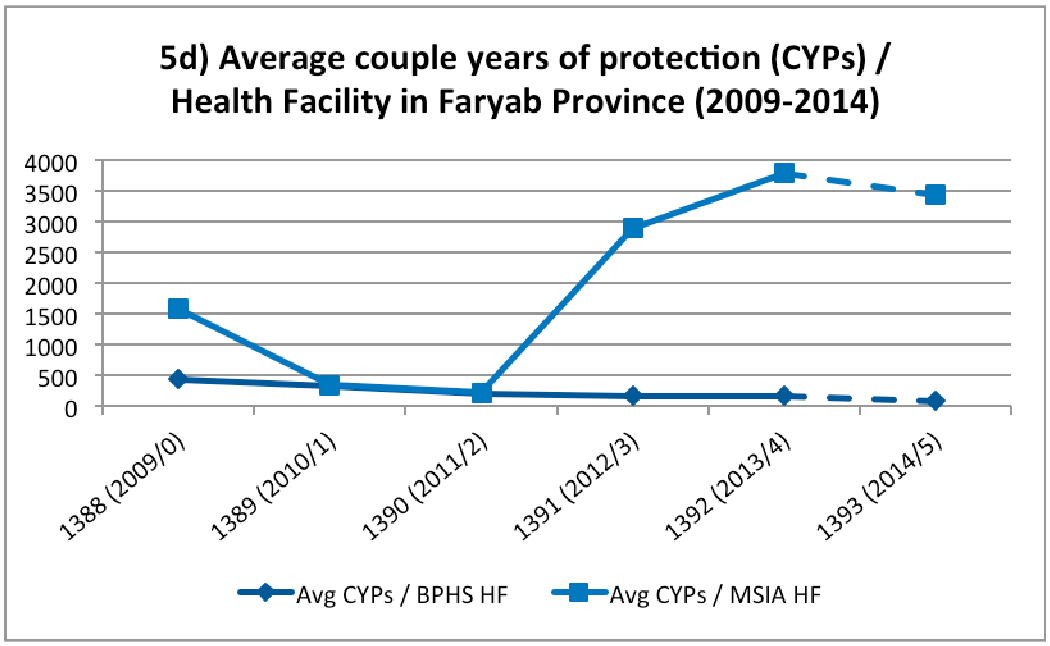


Table 4 overleaf provides data in a different format to illustrate the average couple years of protection (CYP) per health facility over time in each of the provinces in which MSIA is operating, and compares these with BPHS services. Two important features are evident. First, there has been an encouraging and substantial extension of CYPs offered through Afghan and MSIA services over the last 5 years – with CYPs being offered across a wider range of provinces and services, and increasing from around 5000 per year in 2009 to over seven times that number by 2014. Secondly, these data reveal that an average MSIA health facility provides about 20 times the coverage offered by other providers, an impressive achievement.

Table 4: Average CYPs per health facility in MSIA and BPHS health facilities in MSIA provinces

Province	Herat		Kabul		Balkh		Faryab		Total CYPs (whole country)
Year (Afgh/Gregorian)	MSIA	Others	MSIA	Others	MSIA	Others	MSIA	Others	
1385 (2006/7)	0	0	0	0	0	0	0	0	1259
1386 (2007/8)	0	0	0	0	0	0	0	0	4282
1387 (2008/9)	1321	472	0	0	0	0	0	0	5174
1388 (2009/0)	2264	552	0	0	0	0	1132	444	5024
1389 (2010/1)	5755	523	0		1855	626	0	338	19997
1390 (2011/2)	5919	439	1590	583	1681	364	0	215	24902
1391 (2012/3)	5478	295	1249	475	1881	257	2724	165	24319
1392 (2013/4)	5707	297	1469	526	5296	280	3613	173	36792
1393 (2014/5)	4851	137	1231	235	3339	124	3354	84	27995

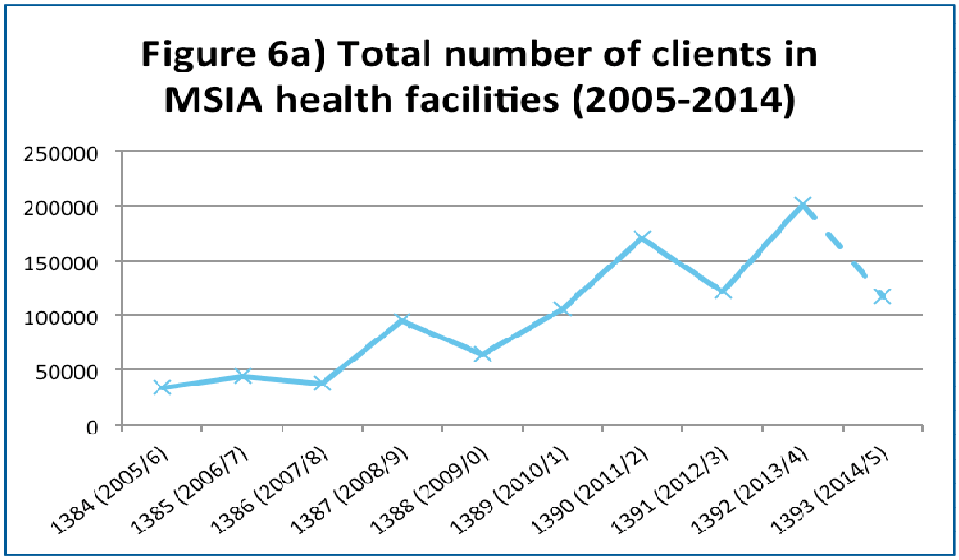
Table 5 below provides insights into the delivery of a broader range of reproductive and child health services over nearly a decade. There is clear evidence of substantial increases in all services – including CYP, first antenatal care visit, delivery with a skilled birth attendant, child vaccination and general out patient attendances. Most show marked increases (CYP, OPD and PENTA 4 in particular) while skilled birth attendance has decreased and first ANC attendance is somewhat erratic.

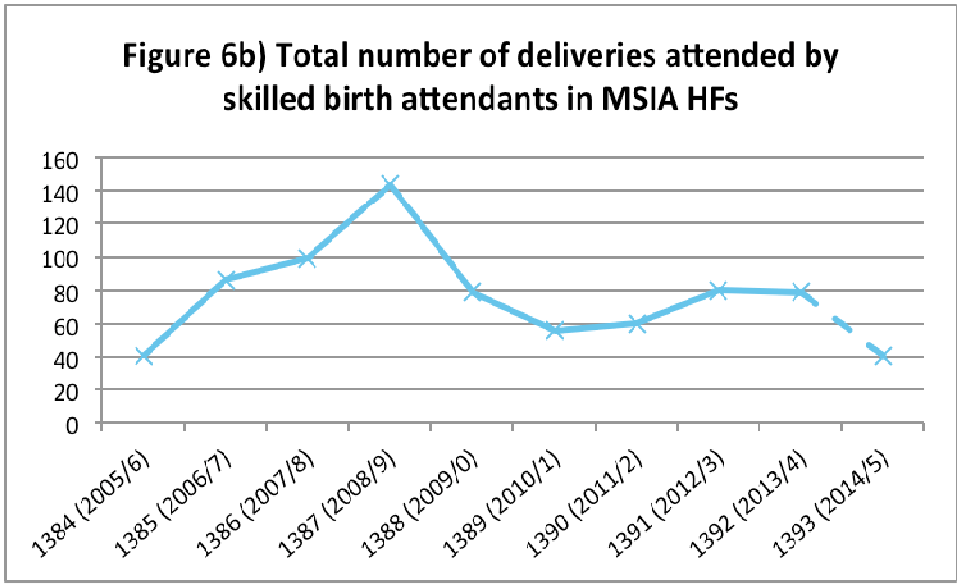
Table 5: Other Reproductive Health Indicators and General Patient Load in MSIA Health Facilities

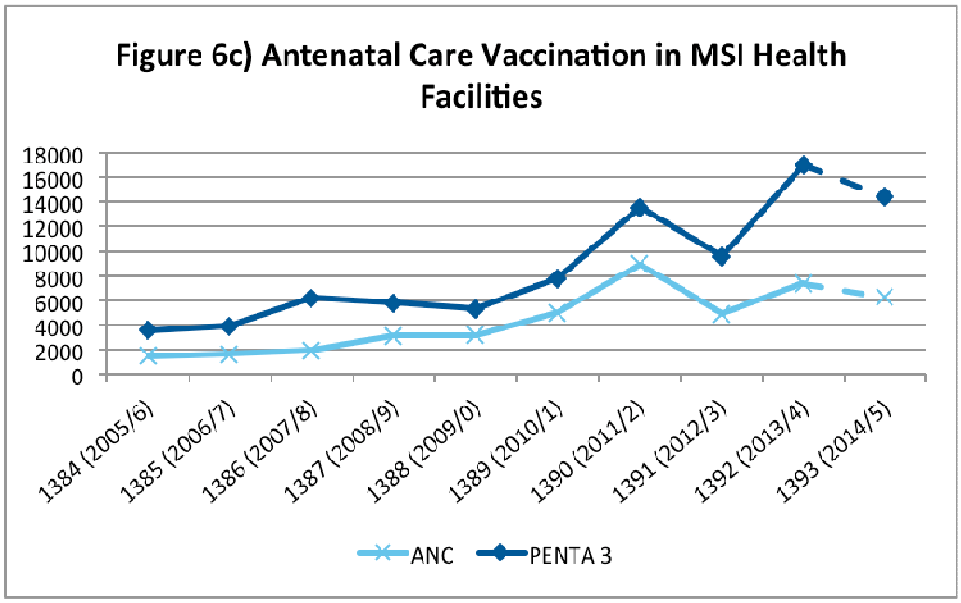
Year	Indicators				
	PENTA 4	CYP	First ANC	SBA	OPD
1384 (2005/6	2082	375	1490	41	34577
1385 (2006/7)	2283	1125	1628	86	44679
1386 (2007/8)	4265	5334	1961	99	38448
1387 (2008/9)	2708	5985	3102	144	95281
1388 (2009/0)	2124	6145	3171	79	64360
1389 (2010/1)	2822	16170	4982	56	105757
1390 (2011/2)	4596	20142	8937	60	171121
1391 (2012/3)	4632	19341	4936	80	122173
1392 (2013/4)	9627	29597	7351	79	201700
1393 (2014/5)	8168	22415	6257	41	117479

(Note: **PENTA 3**: Children 0 - 11 months old received three doses of PENTA vaccine; **CYP**: Couple years of protection; **ANC**: Pregnant women received at least one antenatal care visit from a skilled healthcare professional; **SBA**: Deliveries attended by a skilled health professional in a health facility; **OPD**: Total number clients of a health facility)

Figures 6 (a, b, c) Total number of clients, deliveries, antenatal care vaccinations







These graphs reveal a gradual increase in general patient load, antenatal care and vaccination in MSIA health facilities and the increase is consistent among all three indicators. A considerable increase in the number of institutional deliveries decreases sharply in recent years; this may reflect the hand-over of Bamyan and Badakhshan clinics to relevant PPHD offices in 2009. Another factor that may have played a part is the decision by MSIA to establish daylight working hours instead of offering 24-hour services for deliveries which would have greatly reduced numbers.

Emerging data-related recommendations include placing emphasis on MSIA reporting to the HMIS and MoPH so as to avoid any incompleteness or delays. This requires management attention. These data also suggest that the provision of MSIA technical support to BPHS health facilities would substantially improve utilization of FP and facilitate much wider coverage of the Afghan community. These data demonstrate substantial achievements and offer encouragement to MSIA to further expands its services.

4.8 Summary of strengths, weaknesses, achievements, challenges

Strengths and achievements

- MSIA has developed a clear niche in relation to providing FP and PAC
- Female-only clinics are seen as culturally appropriate and safe – both for clients and for female staff
- Generally good relationships with government, particularly MoPH and MoRA – '*fairly well embedded with public sector*', - and has successfully overcome barriers to advocating and discussing a number of sensitive issues (e.g. PAC, emergency contraception, implants)
- Contribution to successful policy outcomes including approval of PAC guidelines and establishment of reproductive health caucus
- Innovative activities, including social marketing, working with mullahs and mullahs' wives, and supporting well placed advisors within government
- Most government authorities at provincial level supportive of MSIA services
- Community members and MSIA staff generally happy with MSIA services
- Contributing to to advancing MDGs 3, 4 and 5 (gender equity, maternal and child health)

Challenges faced by MSIA

- Very challenging environment – insecurity, gender inequality, changing donor engagement
- Afghanistan facing multiple transitions and at early stage of nation-building
- Changing government landscape alongside importance of personal relationships

Weaknesses/limitations in service delivery

- Limitations to working across broader geographic range – insecurity, inadequate resources and MSI model which seeks to encourage a sustainable model for reproductive health commodities
- Not working within BPHS nor offering a full range of primary care services
- Working in urban and often 'wealthier' areas; may result in neglect of more vulnerable and marginalised groups who have difficulty with fees and location/transport
- Availability of some supplies and commodities is erratic

4.9 Summary of findings against MSIA Strategic Plan

MSIA identified seven strategies and guiding principles in their Strategic Plan for 2011-2015 (MSIA, unpublished). This has guided MSIA activities and initiatives over this period. Significant progress has been made; additional issues have also been raised by this Evaluation that warrant consideration.

1. **Create Strategic Partnerships with Government and Civil Society Organisations (CSOs):** MSIA works with a range of government ministries and civil society organisations at central, provincial and local levels. While most of these relationships demonstrate effective partnerships are working extremely well, several gaps or weaknesses were also identified that could continue to be improved on. (See section 4.2 and 4.3; Recommendations Part C).
2. **Re-positioning MSIA Nationally as Technical Support to the MoPH:** MSIA have positioned themselves well with respect to the MoPH, and has contributed significantly to advocacy efforts and the development of progressing policies. Many within MSIA and its range of partners would like to see this strategic role broadened and deepened. (See section 4.2 and 4.3; Recommendations part C).
3. **Using Key BCC and Media Channels to Strategically Target Young People (aged 14-24**): Current MSIA focus is on 'young married women'; in relation to this population it is achieving a great deal by increasing awareness and availability of services. The involvement of other groups such as unmarried women (such as female students in schools, universities and certain workplaces) and young men has received much less attention to date. The positive relationships established with parts of the MoPH can be extended and developed with links to other ministries including Education, Religious Affairs, Refugees and Repatriation, and youth-orientated NGOs. More attention to media strategies] may also be warranted. (See Recommendations part A, B and E).
4. **Increasing the Focusing on LTP Methods:** MSIA offer a wide range of FP methods through their services, and continue to advocate for the registration of additional methods in Afghanistan. MSIA has successfully contributed to the development of policies and clinical guidelines to facilitate expansion of available methods and their delivery at an appropriate standard of care.
5. **Improved Cost Recovery in Contraceptive Social Marketing:** Social marketing activities cover a range of products. Innovative programs have been initiated but limited information is available about their extent and quality; this would require additional focused work.
6. **Targeting Gatekeepers such as Religious Leaders:** MSIA has implemented an effective set of activities to engage with the Ministry of Religious Affairs, as well as directly with religious leaders and their wives. These activities have focused on identifying culture- and faith-sensitive approaches to promoting family planning, breast-feeding and other women's health promotion activities (see section 4.1, 4.2 and 4.5). Such engagement is crucial to safely offering services to Afghan communities. Building on these trusting links may offer opportunities to extend advocacy and information activities more broadly.
7. **Building MSIA Staff Capacity:** MSIA has invested considerably in capacity development. It provides support and training to its own staff as well as certain cadres within the public sector. It could extend this to support and train service providers in a wider range of services, including those offered by other NGOs – local and international. An area warranting further attention is supporting MSIA mid-level managers, especially women, to take on a broader set of roles in relation to MSIA's advocacy, representation, fund-raising, service-delivery, strategic

development, research, partnerships and data management activities. MSI Head Office support is required to take this forward given the relatively low management capacity base within Afghanistan and the limited opportunities for in-country training; supporting MSIA staff to participate in training outside of Afghanistan should also be considered where appropriate. (See Recommendations part D).

5. Research Process: Strengths, Limitations and Lessons Learned

5.1 Research design

Independent assessment complemented by mixed methods research drawing on qualitative analyses along with examination of secondary and health facilities data are informative. They help triangulate and critique organisational perspectives and narratives and subject these to independent scrutiny. Green and Thorogood (2004) argue that an exploratory qualitative design triangulated with other data such as health facility assessments and secondary analyses are robust. Using multiple methods, and drawing on their own experiences, expertise and disciplinary backgrounds, the Evaluation Team were able to develop a firm understanding of the operating environment in Afghanistan. More quantitative data collection was neither feasible nor appropriate in the given context, due to limited time and resources.

The KIIs and FGDs constituted a substantial part of the methodology of this evaluation and represent a strength. They allowed the Team to explore more deeply the viewpoints of participants, at times revealing unanticipated new insights.

Another strength resulted from the fact that both local Team members and participants shared similar socio-cultural traits, thus enabling the researchers to interact effectively, and with a certain degree of trust, and social interaction with participants. The deep understanding of the traditions, culture and characteristics of the areas covered was another study strength.

In some cases male researchers interviewed females (with their consent) and this, plus the fact that Team members were from another province, may have imposed some limitations. In exploring issues with Government officials, other NGOs, and staff of MSI and MSIA, each will have had his or her own narrative they would be seeking to convey. The Evaluation Team therefore sought insights from a range of perspectives and informants so as to triangulate insights with other forms of evidence to confirm or dispute perspectives raised.

Most of the fieldwork was conducted by researchers with similar backgrounds and working experience to health programme managers and service providers. This may have simultaneously established a degree of trust while at times may have biased informants towards highlighting issues they expected the researchers to be seeking. During the data collection, analysis and write-up phases, the expatriate team members questioned local team members and sought additional insights regarding the viewpoints conveyed and evidence of their importance.

5.2 Rigour

According to Litva and Jacoby (2002), rigour in qualitative research confers a degree of credibility on the study findings. Can insights reported be believed? Do they accurately reflect the perspectives elicited?

Rigour was promoted in a number of ways in this Evaluation. The original aim and evaluation questions were transformed into an Evaluation Protocol by the Evaluation Team. This was reviewed by MSI, MSIA and two ethical review boards, all of which suggested further quality enhancements that were implemented. An Evaluation Advisory Group comprising a number of expatriates skilled in sexual and reproductive health evaluations offered useful insights and tools, such as the Health Facility Assessment, which were modified for use in this setting.

The Evaluators made clear their independence from MSIA in undertaking all data collection. The confidentiality of issues raised in interviews and FGDs was reiterated. Data collection sought evidence of both positive and negative insights, and wherever possible of confirmatory evidence. Key informants originated from a variety of stakeholder positions: within government from different Ministries and at central and provincial levels. Those within MSI and MSIA reflected perspectives from Program Management to Funding and Service Delivery. In addition to key informant interviews, FGDs with MSI staff were conducted and sought to open collective spaces for critique (positive or negative) of the organisation. Client perspectives were sought through both FGDs and a small number of individual interviews.

Fieldwork took place with the organisational support and engagement of local MSIA staff and provincial officials. Participants were assured of confidentiality and made their own informed decision whether or not to participate. Several potential participants declined to participate. The Evaluators had a good understanding of the local health system context which facilitated exploration of MSIAs role and performance. Shared language and culture facilitated communication. Transcribed data were organised to identify both shared and divergent opinions where present. Triangulation was consistently sought with other data sources. While time and resource constraints did not ensure "saturation" (no new data), the consistency of insights contributes to Evaluation Team confidence.

This Evaluation placed substantial weight on the context within which MSIA works in Afghanistan, as well as the context of health system development and nation-building. The multi-disciplinary team comprising Afghan and expatriate researchers helped facilitate a culture of context-sensitive analysis which we hope will contribute to broader debate regarding sexual and reproductive health, gender equity, services delivery, nation-building and the role of civil society in Afghanistan.

5.3 Limitations

Limitations were identified prior to, during and in the latter stages of this Evaluation. Insecurity, time and resources, limited what was feasible in terms of fieldwork. The Evaluation Team worked well together and contributed substantially more time and energy than that budgeted.

A significant constraint for the Team was the inability for all team members to meet in Kabul and work together on developing the methods and approach to data collection and analysis. The UNSW

team were denied permission to travel; for future reference meeting in a third mutually accessible country during preparation and/or analysis would have been valuable. Nevertheless, the Evaluation Team 'met' on average for at least an hour weekly through skype and maintained a strong set of minutes, action points, and documentation. Some data were also collected by the UNSW team via skype interviews rather than face-to-face, with some loss of relationship-building.

The accuracy and validity of national data collections is inconsistent, with some inbuilt biases such as better data from urban areas which also have access to better trained staff, better services and technology. Given the short timeframe, more ethnographic methods were not employed with undoubted loss of insights. Impediments to accessing key databases were experienced resulting in materials not being available to the Team when required.

The Team have a good understanding of the data available in Afghanistan through the experienced ORCD researchers. It was more difficult to obtain data from less secure sites; both more remote clinics in the provinces covered and from Faryab province, which has poorer health outcomes in general than the other three provinces covered.

Primary data collection through community-based surveys, exit polls of service users, interviews with non-users, were not feasible but would have enhanced the insights derived from the Evaluation. Insecurity precluded travel to some sites and may have biased findings towards better functioning services. As is well known, gender and cultural barriers may impede the development of a more nuanced understanding of MSIA performance and activities. The local Team members brought in considerable understanding of the political economy of the country, development of its health system, and socio-cultural context. However, these team members were mostly male and medical professionals, which may have influenced how they were seen when collecting data, even when females research support staff were sub-contracted to assist. The Australia-based UNSW team brought in experience and insights from elsewhere, and worked in close partnership with ORCD to manage the process and documentation of the Evaluation.

The counterfactual – what would have happened in the absence of MSIA engagement in Afghanistan – is impossible to assess. Furthermore, changes underway are influenced by multiple factors, many non-specific. Secular changes underway will influence outcomes, as will the activities of MSIA itself. These reinforce one another, especially if one recognises the importance of context to policy and services development. As such, seeking "attribution" or direct impact for particular outcomes, such as declining maternal mortality or increasing contraceptive coverage, is difficult. Nevertheless, this Report seeks to provide data from a variety of sources to help identify what we know, whether this is validated and verified by other sources, and what interpretation can be placed upon these observations. Our analysis is informed and reflects the "big picture" – it is not and was never intended to be a micro-assessment of particular service components, but rather an evaluation of the MSIA Program at large and the contribution it has, and continues to make, in Afghanistan.

Different models of policy-making are discernible in most settings (see for example Colebatch, 2009): a combination of an authoritative approach (top-down), along with structured interaction with key stakeholders (such as MSIA) and social construction from the community up, are all likely to be taking place. Any intervention around gender, women's health and equity, and birth spacing may open opportunities for wider conversation and debate, contributing to and influencing a climate in which more progressive policy and services delivery becomes possible. Direct links of cause and effect are not likely to be clearly discernible in such settings.

6. RECOMMENDATIONS

A. Current services provision

i) Additional **MSIA services should be provided in under-served areas and this should be offered at low or no cost**. This will help ensure that more vulnerable, poor and marginalized women are able to access these SRH services, especially in relatively under-served and more poor communities (e.g. rural and remote areas, marginalized groups, poorer people, and returnees). Many informants indicated they would like to see MSIA services expanded; this represents a vote of confidence in these services. While some criticized the policy of charging user fees, staff and clients acknowledged that those in financial need are able to access services for free.

ii) MSIA services should be **extended beyond current provision in four Provinces and primarily in urban areas**. Informants at all levels of the system would like to see greater availability of services in a wider range of settings while ensuring accessibility to those most poor. This should receive explicit attention and be prioritised: reaching vulnerable, marginalised, poor and ethnic minority communities.

iii) Additional effort should go into **informing communities of the availability of MSIA services**. MSIA should **consider offering clinics in areas deemed safe by women, such as within or near the Women's Garden** in Kabul. Services should be **promoted through radio, loudspeakers** and other avenues.

iv) At all services **ensure availability of supplies and commodities at all times**. Where clinic supplies are likely to run, consider instituting an emergency system to get supplies to relevant services *before* any disruption of services occurs.

v) **Expand portfolio of activities directed at adolescents and youth**; possibly including school-based activities. Improve and build on relationships with Ministry of Women's Affairs, Ministry of Religious Affairs, Ministry of Public Health and Ministry of Education.

vi) **Enhance record-keeping systems** by speeding up access to the CLIC system which will allow a shift to digital systems, enable more comprehensive client-focused support and information, will **improve the interface with the MoPH** and will facilitate **potential use for a wider range of monitoring, evaluation and research applications**. Ensure accurate and timely submission of data to MoPH.

vii) Continue general engagement with community through a variety of mechanisms to **enhance awareness of birth spacing and family planning**, and of the range of technologies available to do so. **Reinforce links** with Religious leaders, members of government, civil servants, civil society, health professionals and media around value of birth spacing and women's ability to control fertility.

B. Services development – for consideration

i) MSIA should **place more emphasis on working with particularly vulnerable groups** including **IDPs, nomads, Kuchis and returnees** from Pakistan. The latter population is increasing rapidly and will undoubtedly have needs in relation to SRH. Improved liaison with the Ministry for Returnees should be explored further, while also offering services directly to, or working with other NGOs and MoPH providers that are already working with, these populations.

ii) Consider potential to **offer a wider range of women's and children's health services directly or in collaboration with others,** such as addressing gender-based violence, dealing with

women's malignancies and associated screenings (cervical, ovarian and breast cancer); and extending availability of child health services in particular **immunization and the promotion of breast-feeding**.

iii) In selected settings consider **offering a 24-hour service**.

iv) Establish a **suite of services directed at male clients and extend those directed at male leaders**. This may require identifying and working with a particular team on media and advertising, establishing additional or separate clinics so as not to detract from the female-friendly, women-only services currently available.

v) Consideration should be given to **establishing longer-term MSIA sites that can be developed and enhanced** instead of renting space within the facilities of others, as suggested by some community members, provincial authorities, and BPHS implementers.

vi) While consideration of **improved transport** of community members to and from MSIA services was mentioned by a number of informants, it is likely that a more cost-effective means of responding is through the enhancement of outreach and mobile services and working with other providers already present at peripheral sites. This deserves careful further analysis.

vii) A number of MSIA **staff sought enhanced transport to and from work** so as to build on the security they perceive while working within safe-for-women setting.

C. Partnerships and relationships

i) Establish **stronger relationships** with MoWA, MoRA and MoPH; explore links with Ministry of Education. In relation to all government ministries, at central and provincial levels, enhance communication and coordination.

ii) Provide more **transparent annual plans and targets**, agreed between different authorities and MSIA, and monitored over time.

iii) **Consolidate, reinforce and extend collaboration** with religious leaders, their families and the MoRA.

iv) **More actively engage with wider health system developments** and activities including regular participation in health sector meetings and briefings and BPHS coordination meetings. Establish a strategy for actively ensuring coordination between MSIA and MoPH and BPHS implementing NGOs.

v) MSIA should **gradually transform itself from primarily a service provider to an organisation with technical expertise that provides support to and capacity development within the health sector** and to become a **repository of experience, expertise and research insights** in relation to sexual and reproductive health and family planning. **MSIA could more routinely provide support to BPHS implementers** in relation to sexual health promotion, reproductive health, family planning, birth spacing, post-abortion care and gender.

vi) Devote **greater attention to networking and collaboration**, including the development of joint projects with other organisations (both local and international), as well as research and training bodies.

D. Training, recruitment and research

i) MSIA should **consolidate its role in demonstrating innovative practice** and facilitating training and support of specialised staff dealing with sexual and reproductive health across the Afghan health system, in collaboration with MoPH and other providers

ii) MSIA should **invest more heavily in training and up-skilling existing staff**, including in relation to management, leadership and gender-equity training

iii) **Recruitment of women and promotion of women into leadership positions**

iv) Consider recruiting a **project worker (?expatriate given access issues) to support new project development and funding mobilisation** which will be sustainable over longer term period

v) **Increase depth and breadth of training** (both in-country and internationally where appropriate); MSIA team members can travel to India, for example. or elsewhere for intensive ongoing training activities with MSI (UK) counterparts as well as those working in related settings elsewhere.

vi) MSI UK team members should travel to Afghanistan to better appreciate the context and work with the MSIA team to **download and document lessons and experience**; some external facilitation may assist this process.

vii) MSIA can **explore mechanisms to train BPHS clinic staff** in various provinces on family planning specific issues.

E. Additional issues for consideration

i) **Unmarried young people also need attention**; current emphasis on 'young married women' should be expanded.

ii) Consider **placing a policy advisor in support of both the MoWAs and the MoE** to expand space for debate about women's health and sexual and reproductive health and rights. This would complement advisors currently within the MoPH and MoRA.

iii) MSIA should give **more priority to participating in higher level health and related policy forums** such as the Health Sector Steering Committee or its subcommittees; the Consultative Group on Health and Nutrition (CGHN); and should present its work to the donor coordination meeting in Kabul.

iv) Develop **research section to explore, document, analyse and report relevant issues** in an ongoing way; this may be facilitated by establishing partnerships with specific trusted institutions in Afghanistan and abroad

v) Commence project development activities around **appropriate means and mechanisms to work innovatively and constructively with men**, with an emphasis on young men; this requires innovation and research but should be actively progressed.

vi) **Widen social franchising network** possibilities; this may assist in reducing inequity in rural and outlying areas by working with existing private sector and other providers.

vii) **Evaluation Team recommend that MSI and MSIA be invited by their respective Boards and funders, to respond in writing to these recommendations.**

7. CONCLUSION

This external independent Evaluation has identified significant strengths of the MSIA program. We report on these strengths, as well as identify limitations, areas for improvement and further considerations. We offer insights that may be of value in considering future funding and further development of the MSIA program.

Despite some concerns regarding poor coordination, MSIA has clearly established itself as a reliable and trustworthy provider of reproductive health services in Afghanistan, with an emphasis on young women and their access to family planning technologies and services. MSIA has established itself as an important contributor to enhancing women's health and wellbeing, and while placing a specific figure on what has been achieved is both difficult and controversial, it is apparent that MSIA are

contributing to the reduction of maternal mortality and improved infant and child health outcomes in Afghanistan.

The Evaluation Team members are confident that MSIA has been a positive force within the Afghan health system and has contributed in a variety of ways to a range of positive outcomes. These result from the services provided, engagement with communities, and the contribution to enhancing policy and practice at Central and Provincial levels.

There are many challenges facing MSIA. Some of these reflect the broader security and "aid" context, along with Afghanistan's experiences in terms of state-building, nation-building and, hopefully, peace-building. Other challenges result from how development assistance and support is usually provided, whether to government or civil society, focused on some provinces and sectors, short-medium- or longer-term, and the extent to which enhanced national institutions and services are the objective.

The main weaknesses noted relate to the limited services outside of four provinces, the concentration on urban and to some extent 'better-off' segments of the population, and the call from a variety of Government Ministries at both Provincial and Central level for more engagement with a range of sectors and services within the health and social system more broadly.

Our recommendations identify specific areas for improvement and attention within and beyond the current suite of programs, activities and services. MSIA has matured and developed over time, has won the trust of its clients, its own staff, many government officials and others. It operates in areas that are insecure and characterised by gendered inequalities, and appears to do so in a non-confronting and supportive way. It assists in opening out space for enhanced service provision and advocacy around women's health and rights despite the constrained context.

We recommend that MSIA receive funding for both a broader and deeper engagement in Afghanistan. MSIA has established itself, in a challenging and complex situation marred by insecurity, distrust and fragmentation. It is seen as a capable provider of innovative services for an often vulnerable segment of the population. It has contributed directly and indirectly to opening space for reproductive health and women's rights, but has yet to position itself in support of a broader set of objectives around health systems strengthening, the promotion of gender equity, and attention to those most poor or vulnerable.

We recommend that these issues, and this repositioning, be considered by MSIA, MSI (UK), donors, and the government of Afghanistan. In doing so, expectations should be around extending to other geographic areas and to more rural areas within the Provinces in which MSIA operates, as well as attention to a range of areas in which innovative responses can be further developed or consolidated. The latter include initiatives in relation to sexual and reproductive health promotion with younger women and girls through the education system, engagement with young men through new programs of activities, and engagement with a network of media and partner organisations providing services in different parts of the country. Such repositioning may be negotiated over a number of years, and will require working with a wider range of government Ministries, potentially including not only Religious Affairs, Women's Affairs, and Public Health, but also Education and Returnees. Future efforts may reconceptualise the different roles of MSIA from a focus on providing care, to supporting the development of appropriate policies, provision of good quality care, and

responsiveness to the community. Closer working relationships with government and the range of other providers working with Afghan women is also indicated from our evaluation.

Further support, along with strategic investments and activities to underpin an expanded Program is likely to bring positive returns for the Afghan population. MSIA should be supported to address their needs in a constructive, context-sensitive fashion, at community, provincial and national levels.

Ferdowsi, a famous Afghan poet, has suggested that to succeed one must sometimes be a wolf, and sometimes be a lamb. MSIA needs to tackle important and provocative areas, opening them out for debate and critique and extend services where they are absent. In order to succeed, however, it needs to work carefully and sensitively and build on what has been achieved, respecting culture and working with key state and non-state actors. For MSIA to secure sexual and reproductive health rights for women and men in Afghanistan – it too needs to sometimes be the wolf and sometimes be the lamb.

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9. ANNEXES

1. IRB approval letter
2. Breakdown of informants
3. Summary of findings

ANNEX 1. IRB APPROVAL

Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Institutional Review Board

جمهوری اسلامی افغانستان
وزارت صحت عامه
انستیتوت ملی صحت عامه افغانستان

د افغانستان اسلامی جمهوریت
د عامی روغتیا وزارت
د افغانستان د عامي روغتیا ملي انستیتوت

Date: 17/Nov./2014

No. ۴۷۹۸۰۱

To: **Prof. Anthony Zwi**
Professor of Global Health and Development
School of Social Sciences, Faculty of Arts and Social Sciences
The University of New South Wales (Australia)

Subject: Approval for proposal entitled, **"Program Evaluation: Marie Stopes International (Afghanistan)".**

Dear Sir,

Institutional Review Board, Ministry of Public Health has examined and reviewed your proposal entitled, **"Program Evaluation: Marie Stopes International (Afghanistan)".**
We are pleased to note satisfactory response therefore, your study is approved. However, we reserve the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for six months, the approval is valid for one year and the exact date of research project implementation (start and end) should be informed to IRB secretary.

You are bound to share the result of your study with National Health Research Coordination Committee ANPHI/MoPH prior any dissemination plan.

Sincerely,

Bashir Noormal *MD, MPH*
Director General
Afghanistan National Public Health Institute (ANPHI) &
Chairman, Institutional Review Board (IRB)
Ministry of Public Health

Telephone No.: +93 (0) 20 29 22 435
Email Address: anphi@moph.gov.af
Website : www.anphi.moph.gov.af
Postal Address: 3rd Floor of Main Building of Ministry of Public Health, Masoud Circle, Wazir Akbar Khan, Kabul-Afghanistan

+93 (0) 20 29 22 435 :نمبر تیلفون
anphi@moph.gov.af :آدرس الکترونیکی
www.anphi.moph.gov.af :صفحه انترنتی
منزل سوم تعمیر اصلی وزارت صحت عامه، چهارراهی مسعود، وزیر اکبرخان مینه ، کابل-افغانستان :آدرس پستی

ANNEX 2. BREAKDOWN OF INFORMANTS

Province	Institution	HF Type	# of participants		HF Assess-ment	FGD	KII
			Male	Female			
Kabul	MOPH	NA	1				1
		NA	1				1
		NA	1				1
		NA		1			1
	MSIA	NA	3	1			4
		NA	1				1
	MORA / Centre	NA	1				1
	MOWA	NA		1			1
		NA		1			1
	Parliament	NA		1			1
	Karte Parwan Clinic	CEN01		1	1		1
				10		1	
				5		1	
	Total		**8**	**21**	**1**	**2**	**14**
Balkh	MSIA clinic	Center 9		1	1		
	MSIA clinic	NA		1			1
	MSIA clinic	NA		1		1	
	MSIA clinic	NA		1		1	
	MSIA clinic	Mobile		1	1		
	MSIA clinic	NA		1			1
	MSIA clinic	NA		1		1	
	MSIA Mazar office	NA	1				1
	MSIA Mazar office	NA	1				1
	Government departt	NA	1				1
	Government departt	NA		1			1
		NA	1			1	
		NA	1				1
		NA	1			1	
		NA		1			1
		NA	1				1
	Total		**7**	**9**	**3**	**5**	**9**

Province	Institution	HF Type	# of participants		HF Assess-ment	FGD	KII
			Male	Female			
Herat	MSIA Clinic	Centre#6 Fixed clinic		1			1
	MSIA Clinic	Centre#6 Fixed clinic		1		1	
	MSIA Clinic	Centre#6 Fixed clinic		1		1	
	MSIA Clinic	Centre#6 Fixed clinic			1		
	MSIA Clinic	Mobile Clinic		1			1
	MSIA Clinic	Mobile Clinic		1		1	
	MSIA Clinic	Mobile Clinic			1		
	MSIA Main Office Herat	NA	1				1
	MSIA Main Office Herat	NA	1				1
	Government Officials	NA	1				1
	Government Officials	NA		1			1
	Government Officials	NA	1				1
	Government Officials	NA		1			1
	NGO Network	NA	1				1
				1			1
	Local Health Committee	NA		1		1	
	Local Health Committee	NA		1			1
	Local Health Committee	NA		1			1
	Provincial Public Health Coordination Committee	NA	1			1	
	Total		**6**	**11**	**2**	**5**	**12**
Grand total			22	42	**9**	**13**	**37**

ANNEX 3. SUMMARY OF FINDINGS

Objectives	Evaluation questions	Summary of findings	Summary of recommendations
1. Assess the effectiveness (access, equity, quality, and efficiency) and capacity of MSIA	1. What have been the outcomes in terms of access, equity, quality, and efficiency, as defined by MSI's results-based framework?	• MSIA services are considered to be of good quality, accessible, trustworthy, delivered by caring staff, and directed at all Afghans without any form of discrimination on the basis of religion or ethnicity. • Female-only clinics seen as culturally appropriate and safe • MSIA offers a safe space, for both clients and health care workers, in which SRH services for women can be offered. • MSIA is reaching a number of people through a range of avenues, including word of mouth, community-based distributors, and announcements by Mullahs • A small number of informants identified what they saw as limitations within the services offered, primarily around the charges for some services, cost of transport to a service, and the urban-focus of MSIA • While there is usually a good supply of commodities, there are occasional stock-	• Additional MSIA services should be provided in under-served areas and this should be offered at low or no cost. Many informants indicated they would like to see MSIA services expanded; this represents a vote of confidence in these services. While some criticized the policy of charging user fees, staff and clients acknowledged that those in financial need are able to access services for free. • MSIA services should be extended beyond current provision in four Provinces and primarily in urban areas. Informants at all levels of the system would like to see greater availability of services in a wider range of settings while ensuring accessibility to those most poor. This should receive explicit attention and be prioritised: reaching vulnerable, marginalised, poor and ethnic minority communities. • MSIA should place more emphasis on working with particularly vulnerable groups including IDPs, nomads, Kuchis and returnees. • In selected settings consider offering a 24-hour service. • Additional effort should go into informing communities of the availability of MSIA services. • MSIA should consider offering clinics in areas deemed safe by women, such as within or near the Women's Garden in Kabul. • Services should continue to be promoted through radio, loudspeakers and other avenues. • At all services ensure availability of supplies and commodities at all times. • Expand portfolio of activities directed at adolescents and youth

	2. Has there been an effect on the capacity of the MOPH and BPHS/ EPHS service providers in terms of enhanced policy environment, increased clinical competency, availability of services, and/or improved planning and delivery of reproductive health services?	• MSIA has introduced a number of innovative programs within Afghanistan and these have contributed to opening and expanding the "policy space" within which improved sexual and reproductive health services can be delivered and relevant policies and guidelines developed and implemented. • MSIA works closely with different branches of government, including the MoPH, MoWA and MoRA, at both central and provincial levels – while most relationships are working extremely well, some gaps or weaknesses identified • MSIA advisors within MoPH and MoRA support the Ministry and its capacity development, as well as help to advocate for and support policy change and implementation. • MSIA has contributed to a number of policy advances (e.g. guidelines for post-abortion care, family planning methods added to the Essential Drugs List and Special Drugs List) • MSIA programme is not fully aligned with the BPHS and EPHS given its primary focus on reproductive health	• More actively engage with wider health system developments and activities including regular participation in health sector meetings and briefings and BPHS coordination meetings. • Establish a strategy for actively ensuring coordination between MSIA and MoPH and BPHS implementing NGOs. • MSIA could more routinely provide support to BPHS implementers in relation to sexual health promotion, reproductive health, family planning, birth spacing, post-abortion care and gender. • MSIA can explore mechanisms to train BPHS clinic staff in various provinces on family planning specific issues. • Consider placing a policy advisor in both the MoWAs and the MoE. This would complement advisors currently within the MoPH and MoRA.
	3. Has MSIA's strategic partnerships with key MoPH, UN, donor and civil society stakeholders had an effect on strengthening its work and the health system in Afghanistan?	• There is generally good knowledge of, and support for, the services offered by MSIA by relevant government bodies. • MSIA is contributing to health systems strengthening through the development of policies and clinical guidelines, and support and training of MSIA and government staff (mostly MoPH). • Weaknesses within the MSIA program relate to inconsistent engagement with relevant government and public health authorities – in some Provinces this is excellent while in others there is room for improvement. MSIA could be playing a greater role in relation to health system strengthening by ensuring services are in keeping with the BPHS and that coordination with other service providers is maintained at a high level. • Greater attention to submitting required data to MoPH and to participating in a wider range of coordination activities with other service providers and policy makers is required. • A small number of informants identified what they saw as limitations within the services offered, including inadequate attention to collaboration and coordination in some provinces, and at times their work is seen as outside of the Afghan health	• Establish stronger relationships with MoWA and MoRA; explore links with Ministry of Education and Ministry for Returnees • In relation to all government ministries, at central and provincial levels, enhance communication and coordination. • Consider potential to offer a wider range of women's and children's health services directly or in collaboration with others, such as addressing gender-based violence, dealing with women's malignancies and associated screenings, and extending availability of child health services in particular immunization and the promotion of breast-feeding. • Target services at, or work with other NGOs and MoPH providers that are already working with, particularly vulnerable groups including IDPs, nomads, Kuchis and returnees from Pakistan • Devote greater attention to networking and collaboration, including the development of joint projects with other organisations (both local and international), as well as research and training bodies.

		system.	
	4. Assess the coherence, relevance and sustainability of the MSIA programme in Afghanistan.	• MSIA has established a clear niche in providing FP and PAC services • Client numbers are increasing across a range of service delivery areas • Positive relationships with religious leaders are necessary for MSIA's consolidation and sustainability; the positive relationships established require ongoing attention	• Consideration should be given to establishing longer-term MSIA sites that can be developed and enhanced instead of renting space within the facilities of others, as suggested by some community members, provincial authorities, and BPHS implementers. • MSIA should invest more heavily in training and up-skilling existing staff, including in relation to management, leadership and gender-equity training • MSI UK team members should travel to Afghanistan to better appreciate the context and work with the MSIA team to explore lessons and experience • Develop research section to explore, document, analyse and report relevant issues in an ongoing way
2. Determine MSIA's progress and achievements against set objectives (see MSIA strategic plan)	5. What is the progress towards achieving the overall objectives of the MSIA programme and the impact and effectiveness of activities conducted under this programme model?	• The services provided by MSIA make a positive contribution to enhancing the availability of, and access to, SRH services for women in Afghanistan. • MSIA has introduced a number of innovative programs within Afghanistan, including services directed at young women offering a wide range of family planning methods and technologies; providing 'women only' services which are seen to be safe by clients and staff; toll-free hotline; working with Mullahs and their wives to promote awareness and acceptance of family planning; promoting social marketing and community-based distribution of family planning methods; establishing post-abortion care services and instituting appropriate clinical standards; and a range of other advocacy and information activities.	
3. Determine the overall impact of the project from 2009 to present	6. What has been the impact (expected and unexpected) for intended programme beneficiaries in terms of increased knowledge, access to and uptake of family planning and sexual	• Many informants highlighted the positive changes that are occurring in this area in Afghanistan – birth spacing is becoming more acceptable in Afghanistan	

	and reproductive health services in the districts where MSIA is delivering its services?		
	7. Have MSIA programme activities had an impact on perceptions and awareness of FP amongst leaders (including religious leaders) and communities in target provinces?	• MSIA work closely with and have good relationships with community and religious leaders • Awareness is growing and positive change is occurring amongst religious families and community members • Many clients emphasised the positive role Mullahs have had in informing them about the importance of birth spacing. • MSIA has undoubtedly contributed to creating an environment and social and policy space within which birth spacing and FP can be promoted	• Continue general engagement with community through a variety of mechanisms to enhance awareness of birth spacing and family planning, and of the range of technologies available to do so. • Reinforce links with Religious leaders, members of government, civil servants, civil society, health professionals and media around value of birth spacing and women's ability to control fertility. • Consolidate, reinforce and extend collaboration with religious leaders, their families and the MoRA.
	8. How has MSIA attempted to involve both men and women in its programs and what has been the impact for men and women at the individual and community level, particularly in terms of access to FP services and information?	• Good mix of male and female staff members across MSIA, although most management positions are held by males and the number of female employees within the Kabul head office is relatively low • Female-only clinics seen as culturally appropriate and safe • Involvement of young men has received limited attention to date.	• Establish a suite of services directed at male clients and extend those directed at male leaders. This may require identifying and working with a particular team on media and advertising, establishing additional or separate clinics so as not to detract from the female-friendly, women-only services currently available. • Unmarried young people also need attention; current emphasis on 'young married women' should be expanded. • Recruitment of women and promotion of women into leadership positions
	9. What has been the impact (expected and unexpected) for intended project beneficiaries in terms of improved quality of life and strengthening SRH	• Women are having fewer children in Afghanistan than ever before, and maternal mortality is declining. While these cannot be attributed to MSIA, it is widely accepted that MSIA are contributing, along with other civil society organisations and the Government, to this trend. • MSIA is unable to address all of the very substantial challenges facing women in Afghanistan, but they are making a significant	

	rights?	contribution • MSIA are recognised as contributing to establishing a climate in which women's health, rights and other concerns can be raised and addressed – thereby contributing, directly and indirectly, to the empowerment of women and the promotion of gender equity. • Contribution by MSIA to successful policy outcomes - e.g. approval of PAC guidelines, establishment of reproductive health caucus, new family planning methods added to Essential Drugs List and Special Drugs List.	
	10. Has MSIA contributed to the achievement of MDG 4 and 5 in Afghanistan?		
4. Provide recommendations to inform possible options for how family planning services could continue to be provided in MSIA target areas, and on how current programme activities could be improved to achieve this		See section 6 for all recommendations