End-Line Project Evaluation

Afghanistan Crisis Appeal Project Evaluation

World Vision, Afghanistan

Report submitted by:

AZC Training & Consulting

Address all correspondence to:

Phone: +93 790 10 10 75

Email: Info@azc.org.af

mabdalla@azc.org.af

Evaluation Team:

Musiho Abdala, Evaluation Team Leader

Wahidullah Zarabi, Final Evaluation consultant

Table of Contents

Executive Summary 1
Project Relevancy 1
Project Effectiveness 2
Project Efficiency 3
Project Impact 3
Sustainability 3
Project Challenges 4
Lessons Learnt 4
Conclusions 5
Recommendations 6
1.0 Introduction 1
1.1 Afghanistan Context 1
1.2 Evaluation Objectives 2
Figure 1: Core Humanitarian Standards (CHS) 2
1.3 Project Implementation locations 3
1.4 Methodology 3
Figure 2: Data Collection Methods and Respondents 4
2.0 Evaluation Results 4
2.1 Demographic Characteristics of PLWS and HHs 4
2.2 Results per the Core Humanitarian Standards (CHS). 5
CHS 1: Communities and people affected by crisis receive assistance 5
CHS 2. Communities and people affected by the crisis have access 9
CHS 3. Communities and people affected by crisis are not negatively affected 30
Humanitarian response strengthens local capacities and avoids negative effects 30
CHS 4: Communities and people affected by crisis know their rights 33
CHS 5. Communities and people affected by crises have access to safe. 34
CHS 6. Communities and people affected by the crisis receive coordinated 35
CHS 7: Communities and people affected by crisis can expect delivery 36
CHS 8: Communities and people affected by crisis receive the assistance 37
CHS 9: Communities and people affected by crisis can expect 38
Summary of Relevance, Effectiveness, Efficiency, Impact and Sustainability 39
Presentation of Output Table 50

Figures and Tables:

Figure 1: Core Humanitarian Standards (CHS) 2
Figure 2: Data Collection Methods and Respondents 4
Figure 3: Number of Children in Household 4
Figure 4: Distance to the Closest Clinic/ Health Facility 10
Figure 5: Children or Adults in Households with Disability 12
Figure 6: Delivery of Children at a Healthcare Facility 13
Figure 7: Postnatal Care (PNC) After Delivery 13
Figure 8: Time taken to first put (NAME) to the breast 17
Figure 9: Access to Functional Safe Spaces 18
Figure 10: Level of awareness of child protection issues and provision 20
Figure 11: Support to Caregivers 21
Figure 12: Percentage of Community Members Collecting Water from Improved Water Sources 22
Figure 13: Percentage of households with access to safe water facilities 23
Figure 14: Percentage of PLWs and HHs always used latrine 24
Figure 15: Percentage of PLWs and HHs using soap and water for handwashing. 25
Figure 16: Percentage of HHs affected by water-borne diseases before 25
Figure 17: Extent to which the benefits are likely to continue/last 31

LIST OF ACRONYMS AND ABBRIVIATIONS

AAP	Accountability to Affected Populations (People)
ANC	Antenatal Care
AWD	Acute Watery Diahorea
BPHS	Basic Package for Health Services
CBCPC	Community Based Child Protection Committees
CPAN	Child Protection Action Network (CPAN)
CP AoR	Child Protection Area of Responsibility
CPMS	Minimum Standards for Child Protection in Humanitarian Action
CU5	Children under 5 years of age
DNH	Do No Harm
EPHS	Essential Package for Hospital Services
FHH	Family Health House
GBV	Gender-based Violence
HRP	Humanitarian Response Plan
IEC	Information, Education, Communication
IMAM	Integrated Management of Acute Malnutrition
IPD SAM	Inpatient Department for Severe Acute Malnutrition
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practices
MAM	Moderate Acute Malnutrition
MEAL	Monitoring, Evaluation, Accountability, Learning
MHNT(s)	Mobile Health and Nutrition Team(s)
MHPSS	Mental Health and Psychosocial Support
MHT(s)	Mobile Health Team(s)
MoPH	Ministry of Public Health
OPD SAM	Outpatient Department for Severe Acute Malnutrition
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PSEA	Prevention of Sexual Exploitation and Abuse
PSS	Psychosocial Support
SAM	Severe Acute Malnutrition
WASH	Water Sanitation and Hygiene
WV (A)	World Vision (Afghanistan)

Executive Summary

This report presents the evaluation results of the Afghanistan Crisis Appeal project. This marks the end of a two years' project implementation, it shows the extent to which the interventions have intervention achieved the intended results and whether resources were used efficiently and effectively. The report focuses on all the three project thematic sectors of health and nutrition, WASH and protection in Herat (Kushka Kona and Kushka Rabat Sanghi) using KIIs, FGDs, secondary data and structured questionnaire. The evaluation took place in the districts where the DEC supported the 22 FHHs. This provided evidence of project successes, lessons learned, challenges and opportunities for improvement. *The project's desired outcome was that "affected communities will be supported through improved access to life-saving health and nutrition services, WASH and protection.*

Methodology

The evaluation used a mixed evaluation design that combined qualitative and quantitative data collection methods from primary data sources (respondents from randomly selected households) and secondary data sources. Data collection methods included household surveys, focus group discussions (FGD), key informant interviews, document reviews, and internet sources. A total of 52 individuals were interviews and 8 FGDs were conducted with the relevant stakeholders such as: WVA project staff at medium and senior level; relevant provincial MHNTs in the district level, community people and community leaders. Besides the interviews, the data collection team also directly observed the project outputs and deliverables in the sties in order to make sure that collect tangible evidences of changes brought about by the project and also check the quality of deliverables. Lastly, in order to validate the project findings, surveys conducted using survey questionnaires to obtain quantitative data from the project beneficiaries around the project outputs and results. Totally 713 questionnaire distributed to the project beneficiaries (PLWS and HHs) to be filled out. The questionnaire format is attached in Annex 4. Of the 713 total target sample for the survey, 346 PLWS participants and 367 HHs attended in the interview and questionnaires were filled. This represent 100% response rate on the questionnaire. According to Babbie (1990), any response rate of 50% and above is adequate for analysis. Therefore, a 100% response rate is perfect.

Respondents included, among others, 4,444 female (PLW) respondents, male respondents, community leaders, health workers, protection committees, and cluster leaders (health, nutrition, WASH, protection). This number was divided almost equally between the districts of Kushka Kohna and Kushka Rabat Sangi.

Project Relevancy

Health, nutrition, WASH, and protection projects are highly relevant in Afghanistan as they address critical health needs, improve living conditions, protect vulnerable populations, and contribute to long-term development. By investing in these areas, Afghanistan can strive towards a healthier and more resilient society. Herat province, like other provinces in Afghanistan,

suffered from a number of health problems, including high infant mortality, high maternal mortality, and the prevalence of waterborne diseases. The health intervention was related to improving access to health services, improving disease prevention and control measures, and strengthening the overall health system in the project area. Regarding nutrition, Afghanistan has one of the highest rates of chronic malnutrition in the world, affecting a significant number of children. The lack of access increases the risk of waterborne diseases such as diarrhea, which can be especially deadly for children. Therefore, it was important for the Afghanistan Crisis Appeal project to provide clean drinking water, proper sanitation, and hygiene education to prevent the spread of disease and improve overall health. Regarding protection, Herat had initially been affected by protracted conflict, displacement, and widespread violence, which posed threats to the safety, well-being, and rights of the population, particularly women, children, and vulnerable groups. It was therefore relevant to provide safe spaces psychosocial support and legal assistance to survivors of violence.

Project Effectiveness

The project reached an estimated 80,000 women, men and children with health and nutrition services (Men: 14,000, Women: 28000, boys: 18,000, Girls: 20,000). For each FHNC, WV installed four Conex/containers and two separate portable latrines (1 for men and 1 for women). The project recorded an increased access to basic healthcare services from estimated 45% to 88%. Deliveries happening in the homes reduced from 64% to 47%. Access to health facilities increased from 63% in 2021 (OCHA,) to 88%. These achievements were attributed to bringing the medical teams and health services closer to the community was also an appropriate intervention. C

The project provided safe drinking water, improved sanitation infrastructure, and promoted hygiene practices to prevent water-related diseases. A total of five (5) WASH groups were established and trained in the targeted villages. Each group consisted of 10 members (3 women, 6 men 1 male/female with a disability). Sensitization and coordination meetings were held with district elders and community leaders for better facilitation and implementation of WASH activities and establishing WASH groups. Hygiene promotion training was conducted for the five (5) WASH groups, training 50 people (30 males and 20 females). The trained WASH groups conducted hygiene promotion that reached 2,214 individuals (608 women, 655 men, 372 boys and 579 girls). Initially, only 13% of Afghans had access to safe drinking water and this number increased to 64% in Kushk (Rubat-i-Sangi) and 100% in Kushk-i- Kuhna.

A total of 2600 individuals (50% male, 50% female) benefited from Mental Health and psychosocial support (MHPSS) in protection programmes (1300 in Kushk-i- Kuhna and 1300 in Kushk- Rubat-i-Sangi. Under case management, WV provided support to children and caregivers (when assented to, appropriate, and needed), including individualized PSS to children and their caregivers; parenting support to caregivers; and referrals to access medical and other basic services. WV provided children with a protected environment in which they could participate in

organized activities to play, socialize, learn, and express themselves and ensured they benefit from PSS. The parenting skills obtained are expected to provide children with a secure and loving environment, which helps foster their emotional well-being. To ensure protection, safety and dignity, especially of women and children, who bear the biggest burden in fetching water, participation of women, children (girls and boys) and persons with disability were prioritized as their views and opinions were sought in determining technology choice and siting of WASH systems.

Project Efficiency

Project staff were also provided with necessary resources, materials, and tools needed for the implementation of activities. This included medical equipment, health and nutrition supplies, WASH infrastructure materials, protection kits, educational materials, etc. Adequate provision of resources enabled staff to carry out their roles effectively. There were no budgetary challenges in terms inadequacy and misappropriation. Regarding timeliness, World Vision (WV) requested the project end date to be extended from 30-June-2023 to 31-December 2023. This enabled WV to deliver the revised activities well. The project was completed within the allocated budget and funds were utilized efficiently. There was also stakeholder satisfaction with the quality and standard of the project outputs, such as health services delivered, nutritional support provided, availability of clean water and sanitation facilities, and protection services offered.

Project Impact

The Afghanistan Crisis Appeal Project led to increased access to the health and nutrition services, increased access to clean water, sanitation, and hygiene services and vulnerable and at-risk Children and adults reached with protection services and information, in Kushka Kohna and Kushka Rabat Sangi districts of Herat province. A total of 12250 individuals constituting 82% achievement in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts had improved access to safe water, hence reducing the risk of waterborne illnesses such as diarrhea, cholera, and typhoid. Initially, most households, 74.5% used unsafe water sources[1]. While no baseline figures are provided, a total of 5200 individuals constituting 72% of the target sample accessed mental health or psychosocial support (MHPSS) in health programmes. A total of 1400 individuals received treatment for severe acute malnutrition (SAM) in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts constituting 100% of the target sample while 600 (100%) were sensitised around nutrition requirements for U5s and PLWs. Also, a total of 3365 women and newborns received maternal and newborn care through FHH in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts constituting 89% achievement.

Sustainability

The project was implemented within the existing health structures which expected to last for a long time. The capacity building played a crucial role in the success and sustainability of health,

[1] DEC Afghanistan Crisis Appeal Narrative Plan

nutrition, WASH, and protection projects. Training and equipping local staff, healthcare workers, and community members with the necessary knowledge and skills is vital for the continued operation of the projects and for the communities to maintain the positive changes achieved. The supported communities including traditional midwives are anticipated to continue with positive health behaviour practices, hence enhancing project sustainability.

Project Challenges

1. Gaining acceptance and cooperation from the government officials and communities was difficult due to ideological differences and potential skepticism towards external interventions. In order to enhance acceptance, the project team organized introductory meetings with local leaders and existing community structures, including Shura village, religious leaders and water management committees, and guides them on cross-cutting issues such as conservation, gender and inclusion.

2. The country's rugged terrain and limited transportation and communication networks posed challenges in reaching remote areas with vital health and nutrition services. These conditions also made it difficult to transport necessary equipment, supplies, and medical personnel to the affected locations.
3. Afghanistan has a conservative cultural and social context that influenced the acceptance and implementation of health, nutrition, WASH, and protection programs. To ensure acceptance, the interventions were designed with sensitivity to local cultural practices and beliefs to ensure acceptance and maximize impact.
4. Staff turnover and identification of the qualified health personnel was among the top foreseen challenges. To ensure there are enough human resources for health and other sectors, WV developed a bulk recruitment approach, which allowed the programmes to identify an appropriate number of human resources to join the response. In addition, as part of the response, WV ensured that new staff receive proper orientation, continued supervision and development and ensure timely project implementation based on the accepted project standards.
5. A significant currency fluctuation was observed since the collapse of the previous government and it had a potential impact on project implementation and costs of project materials and inputs such as fuel, rental vehicle costs, pharmaceuticals, etc.

Lessons Learnt

A number of lessons were learnt from the Crisis Appeal project and these included the following:

1. Building the capacity of community structures in health, nutrition, WASH, and protection issues highlights the importance of community ownership. By including the community in the project planning, implementation, and monitoring and building their capacity, it ensures that the interventions are culturally appropriate, meet the actual needs of the people, and are sustainable in the long term.

2. One of the key lessons in safeguarding, accountability, and protection issues is the need for strong reporting and monitoring systems. This involves establishing mechanisms where individuals can safely and confidentially report any concerns or incidents related to health, nutrition, WASH, and protection. Regular monitoring and follow-up on reported cases is crucial to ensure timely interventions and prevent further harm
3. Need for integrated approach: Another important lesson learnt is the effectiveness of an integrated approach in addressing health, nutrition, WASH, and protection issues. Integration allows for a holistic and comprehensive approach where all the various components related to health, nutrition, WASH, and protection are considered together. This approach recognizes that these issues are interrelated and addressing them in isolation may not yield optimal results. Integration also promotes coordination and collaboration among different sectors and stakeholders involved in addressing health, nutrition, WASH, and protection issues. This collaboration helps in sharing knowledge, expertise, and resources, leading to more effective and sustainable solutions.
4. Addressing the needs of women and girls and ensuring accountability in health, nutrition, WASH, and protection requires a multi-faceted approach that recognizes their specific needs, challenges existing gender inequalities, and actively involves them in decision-making processes
5. Training and equipping local staff, healthcare workers, and community members with the necessary knowledge and skills is vital for the continued operation of the projects and for the communities to maintain the positive changes achieved.
6. Gender disparities exist in access to and control over resources and services, and addressing these disparities is essential for achieving improved health outcomes. Projects need to ensure equal participation and benefits for both men and women, and include gender-sensitive approaches in all aspects of the interventions.
7. Monitoring and evaluation: Regular monitoring allows for timely adjustments and improvements, while evaluation provides evidence of the project's success and lessons learnt for future interventions. These processes help ensure accountability and transparency in the use of resources and contribute to evidence-based Afghanistan Crisis Appealision-making.
8. Collaboration and coordination: Health, nutrition, WASH, and protection projects require collaboration and coordination among different stakeholders, including government agencies, NGOs, and international organizations.

Conclusions

Herat's Health, Nutrition, Washing and Protection Project has made great strides in improving the well-being and general health of the population. The project focuses on improving access to health services, vaccination and awareness campaigns. The nutrition component of the project successfully combated child malnutrition and stunting through screening, provision of nutritious

foods, nutritional supplements, and healthy eating education programs. WASH interventions have effectively increased access to clean water, sanitation, and hygiene practices, resulting in reduced waterborne diseases and improved overall hygiene standards in communities. Meanwhile, the protection part of the project has succeeded in ensuring the safety and well-being of vulnerable populations, including women, children and the elderly, by providing support, advocacy and access to legal services. Finally, the project engaged local communities and enabled them to take responsibility for their health, nutrition, hygiene and protection needs through community-based initiatives and training programs.

Recommendations

1. Ensuring that communities and people affected by crisis receive appropriate and relevant assistance in a country like Afghanistan requires a comprehensive and collaborative approach involving multiple stakeholders. These include; further needs assessment, local community engagement, collaboration with NGOs and Humanitarian Organizations and contextualize the assistance.
2. There is need for further coordination and collaboration with relevant stakeholders, engagement with local communities and capacity building of local organizations and institutions to deliver assistance effectively. This will help to ensure that communities and people affected by a crisis have access to timely humanitarian assistance requires a multi-faceted approach involving coordination, collaboration, and a deep understanding of the local context.
3. There is need for integrating resilience-building measures into humanitarian action, focusing on strengthening community resilience to future shocks and stresses. This can include improving access to basic services, supporting livelihood opportunities, promoting social cohesion, and supporting infrastructure that withstands natural disasters.
4. To make Communities and people affected by crisis know their rights and entitlements, this should start raising awareness in affected communities about their rights and entitlements. This can be done through public information campaigns, community meetings, and workshops. Use various channels such as radio, television, posters, and social media to disseminate information.
5. Given the limited access to medical services, there is a need for investing in mobile health clinics or establishing health centers that can increase access to medical care and provide basic health services to communities that are otherwise underserved.
6. Malnutrition is a significant public health issue in Afghanistan which needs to be improved further. This can be done by raising awareness about the benefits of breastfeeding and providing support to mothers to initiate and sustain breastfeeding. This can be done through counseling, training healthcare providers, and creating breastfeeding-friendly environments. Women and children can also be provided with essential micronutrient supplements such as iron, folic acid, and vitamin A, particularly during pregnancy and

early childhood. These supplements can address deficiencies that may arise due to limited dietary diversity.

7. Given the fact that there were still some HHs with limited access to clean drinking water and sanitation facilities, there is a critical need to expand access to clean drinking water and sanitation facilities. This can be done by investing in building and refurbishing more water supply systems, wells, boreholes, and pipelines to provide clean drinking water to communities across the country.
8. While substantial progress was achieved in enhancing malnutrition, there is a need for improving access to nutritious food, providing nutritional supplements, and conducting nutrition education campaigns in order to combat malnutrition and enhance the overall health of vulnerable populations.
9. Additional initiatives that focus on improving prenatal care, safe delivery practices, and access to essential healthcare services for women and children can save lives and improve health outcomes. This can be done by additional efforts to promote early and regular prenatal care visits for pregnant women. There is also a need for additional efforts to educate women and their families about the importance of prenatal care, nutrition, and hygiene practices. This could include initiatives such as community-based antenatal care programs and mobile health clinics.
10. Future interventions need to focus on child protection initiatives to prevent and respond to various forms of child abuse, neglect, exploitation, and violence. Some common child protection initiatives include establishment of laws and policies, child helplines and hotlines, child-friendly spaces, awareness campaigns and child protection training and capacity-building.
11. There is a need for initiatives that focus on prevention, awareness-raising, and strengthening support services for survivors of violence can help create safer communities and improve overall well-being.
12. Given the fact that some HHs missed out on PSS, implementing programs that provide mental health support, trauma counseling, and psychosocial services can help alleviate the burden of psychological distress and enhance overall well-being.
13. Enhancing child protection in Afghanistan requires a comprehensive approach involving various stakeholders, including the government, non-governmental organizations (NGOs), communities, and individuals. Here are some strategies that can help enhance child protection in Afghanistan: The government need to be engaged to enact and enforce robust laws that protect children from abuse, neglect, exploitation, and violence. This includes ratifying and implementing international conventions and protocols related to child protection. There is also need to improve child welfare services: Establish and strengthen child protection services, including child helplines, safe shelters, and counseling centers, where children can report abuse or seek help. Provide adequate training and resources to social workers and child protection professionals.

1.0 Introduction

This report presents evaluation results for the Afghanistan Crisis Appeal Project. This being the end of project evaluation, it presents the extent to which the intervention achieved the intended outcomes, whether the resources were used efficiently and effectively. The report highlights evidence of the project's success, lessons learnt, challenges and areas for improvement focusing on all the three sectors of Health and Nutrition, WASH and Protection in Herat (Kushka Kohna and Kushka Rabat Sangi)

1.1 Afghanistan Context

The Disaster and Emergency Committee launched an Afghanistan appeal on the 15th of December 2021 to address the increased humanitarian needs in the country following the COVID-19 pandemic, renewed conflict, loss of jobs and livelihoods, economic collapse and drought. Humanitarian needs quickly escalated with 59% of the population in need of humanitarian assistance with 18.1 million people in need of health services. 95% of households in Herat did not have sufficient food and none of the female-headed households, leading to a Global Acute Malnutrition rate of 12.8%.

Following the economic collapse and curtailed capacity of public institutions, WASH needs increased with three quarters using unsafe water and the same number using less than 20 liters per person per day. With the upheaval in Afghanistan women and children increasingly felt unsafe and an increase in protection were seen, while at the same time services for protection were less accessible. With the development of new policies and decrees since 2021 humanitarian space has shrunk with women restricted in their movement and girls excluded from higher education.

According to UN experts, the situation of women and girls' rights in Afghanistan had reverted to that of the pre-2002 era when the DFA last controlled the country, effectively erasing progress on women's rights in the intervening 20 years. The projection period between November 2022 and April 2023 is characterized by a significant deterioration in the acute malnutrition situation. During the projection period, 2 provinces in IPC AMN Phase 4 (Critical) will likely remain similar, while 15 provinces in IPC AMN Phase 3 (Serious) will likely deteriorate to IPC AMN Phase 4 (Critical). A total of 17 provinces will likely be in IPC AMN Phase 4 (Critical): Badakhshan, Paktika, Badghis, Balkh, Farah, Faryab, Ghazni, Ghor, Jawzjan, Kabul Urban, Kandahar, Logar, Nangarhar, Nuristan, Panjshir, Uruzgan, and Zabul. During the projection period, 9 provinces will likely deteriorate from IPC AMN Phase 2 to 3. A total of 17 provinces will likely be in IPC AMN Phase 3 (Serious): Parwan, Kabul Rural, Kapisa, Wardak, Daikundi, Bamiyan, Laghman, Kunar, Khost, Helmand, Nimroz, Samangan, Sar-e-pul, Kunduz, Baghlan, Takhar and Herat. Factors that contribute to this critical acute malnutrition situation are strongly linked to the accelerated morbidity and increased risk of common diseases that affect child nutrition such as diarrhea (Acute Water Diarrhea) and acute respiratory infection (ARI) during the winter season, compared to the current period.

Severe winter weather conditions, with temperatures well below freezing in most of the country, have increased the number of acute respiratory infections. More than 25,000 cases were reported in December 2022[2]. In 2023, an estimated 28.3 million people (two thirds of Afghanistan's population) will need urgent humanitarian assistance to survive as the country enters its third consecutive year of drought-like conditions and the second year of crippling economic decline, while still reeling from the effects of 40 years of conflict and recurrent natural disasters. Of 28.3 million people, 14.7 million are in extreme need (severity 4), 6.4 million are women and 15.2 million are children; 6.1 million live in urban areas and 22.2 million live in rural areas, and 15 percent of all households have at least one member with a disability. There are needs in every province of the country, with extreme need in 33 out of 34 provinces and 27 out of 34 major cities/provincial capitals with the rest in severe need, indicating how widespread the crisis is across the country.

1.2 Evaluation Objectives

WV commissioned this evaluation to generate relevant information for learning from the Afghan Crisis response, to inform decision making and accountability to WV stakeholders and humanitarian architecture. The evaluation was a basis upon WV can determine what works well, and what could be improved in future Afghanistan Crisis Appeal and WV responses/interventions. With that background, the evaluation should have reflected on the Core Humanitarian Standards (CHS).

Figure 1: Core Humanitarian Standards (CHS)

CHS	Description
CHS 1:	Communities and people affected by crises receive assistance appropriate and relevant to their needs. Quality Criterion: Humanitarian response is appropriate and relevant
CHS 2:	Communities and people affected by the crisis have access to the humanitarian assistance they need at the right time. Quality Criterion: Humanitarian response is effective and timely.
CHS 3.	Communities and people affected by crises are not negatively affected and are more prepared, resilient, and less at-risk as a result of humanitarian action. Quality Criterion: Humanitarian response strengthens local capacities and avoids negative effects
CHS 4:	Communities and people affected by crises know their rights and entitlements, have access to information and participate in decisions that affect them. Quality Criterion: Humanitarian response is based on communication, participation, and feedback
CHS 5.	Communities and people affected by crises have access to safe and responsive mechanisms to handle complaints. Quality Criterion: Complaints are welcomed and addressed

[2] UNICEF, 21st February, 2023: Acute respiratory infections double as Afghanistan's children face the harshest winter in a decade: https://reliefweb.int/report/afghanistan/acute-respiratory-infections-double-afghanistans-children-face-harshest-winter-decade#:~:text=Severe%20winter%20weather%20conditions%2C%20with,in%20the%20last%20three%20years.

CHS 6	Communities and people affected by the crisis receive coordinated, complementary assistance. Quality Criterion: Humanitarian response is coordinated and complementary
CHS 7:	Communities and people affected by crises can expect delivery of improved assistance as organizations learn from experience and reflection. Quality Criterion: Humanitarian actors continuously learn and improve
CHS 8:	Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. Quality Criterion: Staff are supported to do their job effectively and are treated fairly and equitably
CHS 9:	Communities and people affected by crises can expect that the organizations assisting them are managing resources effectively, efficiently and ethically. Quality Criterion: Resources are managed and used responsibly for their intended purpose

The intended outcomes of the project were ***"Affected communities are supported through increased access to life-saving health and nutrition services, WASH, and protection***". With specific indicators, the project had three (3) outputs as indicated below:

- ✓ **Output 1:** Targeted to reach 66,720 women, men and children with health and nutrition services (Men: 11,081, Women: 20,647, boys: 16,913, Girls: 18,079)
- ✓ **Output 2:** Affected community members have increased access to clean water, sanitation, and hygiene services:
- ✓ **Output 3:** Vulnerable and at-risk Children and adults reached with protection services and information, in Kushka Kohna and Kushka Rabat Sangi districts of Herat Province

1.3 Project Implementation locations

The project was implemented in the following areas:

Sectors	Location
Health and Nutrition	Herat (Kushka Kohna and Kushka Rabat Sangi)
WASH	Herat (Kushka Kohna and Kushka Rabat Sangi)
Protection	Herat (Kushka Kohna and Kushka Rabat Sangi)

1.4 Methodology

The evaluation adopted a mixed evaluation design blending qualitative and quantitative data collection methods from primary data sources (respondents from randomly selected households) and secondary data sources. Data collection methods consisted of Household Surveys, Focus Group Discussions (FGD), Key Informant Interviews, Documents Reviews and Internet Sources. Respondents included among others: Female (PLW) respondents, male respondents, community leaders, health workers, protection committees, cluster leads- Health, Nutrition, WASH and Protection.

The table below summarizes the primary and secondary data collection methods, data sources and respondents who participated in the evaluation.

Figure 2: Data Collection Methods and Respondents

Data Collection Methods	Data Sources/Respondents	Number Reached
Focus Group Discussions	PLWS	8
Key Informant Interviews	Cluster	4
	PLWS	0
	Project Staff in Kabul and Herat	4
	WV UK	0
	MHNTs	24
	Community Leaders	20
Household (Participant) based Surveys	PLWS	346
	HHs	367
	WAHS	60
Documents Review	Implementation reports	
	Cluster reports	

2.0 Evaluation Results

2.1 Demographic Characteristics of PLWS and HHs

The evaluation reached a combined total of 714 PLWS and HHs with all respondents being women and housewives. 2 of them were tailors, 1 was carpet weave and 1 was a teacher. In addition, of the 384 total target sample for the survey, 384 participants filled and returned a completed copy of the questionnaire with 100% response rate

Figure 3: Number of Children in Household

Response	Frequency	Percent
Zero (00)	32	4.5
One (01)	172	24.1
Two (02)	227	31.8
Three (03)	187	26.2
Four (04)	66	9.2
Five (05)	23	3.2
Six (06)	3	.4
Total	**714**	**100.0**

The average number of children per household was 4, while the total average household size was 6. Relatively large families were attributed to lack of access to modern contraception methods particularly in rural areas. This lack of availability and knowledge about birth control methods contributes to higher fertility rates.

2.2 Results per the Core Humanitarian Standards (CHS).

This section focused on the extent to which Afghanistan Crisis Appeal Project achieved its intended objectives and desired outcomes. This was analyzed in accordance with the Afghanistan Crisis Appeal Project funding targeted sectors which included; Health, Nutrition, Water and sanitation hygiene and Protection, focusing on the Core Humanitarian Standards (CHS).

CHS 1: Communities and people affected by crisis receive assistance appropriate and relevant to their needs.

As per the project design, the Core Humanitarian Standards (CHS) for assessment under this section included the following:

i. Extent to which the intervention selected the most appropriate interventions (activities) for the targeted sectors - Health, Nutrition, Water and sanitation hygiene and Protection and locations
ii. Extent to which the interventions were appropriate for gender, environment/climate, and geographical needs?
iii. The differences made by the intervention under Health, Nutrition, Water and sanitation hygiene and Protection
iv. And the sector where the intervention differences were realized most- Health, Nutrition, Water and sanitation hygiene and Protection?

a. Most appropriate interventions (activities) for the targeted sectors

Through FGDs and KIIs, the most appropriate interventions (activities) for the targeted sector included provision of pre- and post-natal care as well as access to skilled birth attendants. The project provided primary healthcare to the affected populations in critical need of life-saving medical assistance in the areas where the health system collapsed and was not able to provide services to the population. The provision of pre- and post-natal care as well as access to skilled birth attendants was enhanced by the institution of standard skilled birth personnel (midwife) who assisted the live birth as well as provision of ANC, PNC, and newborn care in the project targeted location. Women attending ANC were informed of ways to access referral pathways in case of emergencies, including obstetric emergencies.

Bringing the medical teams and health services closer to the community was also an appropriate intervention. Each team consisted of five medical professionals (a doctor, midwife, nutrition nurse, a vaccinator, and a community health promoter), who together managed the day-to-day operation of the MHNTs for the project life. The health intervention was also appropriate since it enhanced the prevention and treatment of a number of diseases such as acute respiratory infection (ARI), diarrhea, communicable and non-communicable diseases, which are the primary causes of morbidity and mortality in Afghanistan. This was an appropriate intervention because initially around 64% of deliveries happen in the home and by the end of the project, this number had reduced to 47%. A community leader in Khosh Robat Sanigi stated that:

> *"This project helped to increase access to healthcare services, including reproductive health, maternal care, vaccinations, and preventive care. The women and girls benefited more because of being visited for health support and being encouraged to express themselves when in need of support"*

The vaccination activity provided children under 5 (CU5) with necessary immunizations, such as Bacillus Calmette–Guérin (BCG), Penta, Measles and Oral Poliovirus Vaccines (OPV) and other Afghanistan MoPH listed vaccination. This intervention was appropriate because initially there was very low immunization coverage at the national level as indicated by various surveys such as Afghanistan Health Survey (AHS) and Immunization Coverage Evaluation Survey (CES). For example, the National Risk and Vulnerability Assessment (NRVA) Survey 2008 estimated the coverage of fully immunized children to be 37%[3]

A mobile vaccinator for Afghanistan Crisis Appeal project pointed out as follows:

> *"This project was relevant because there was a high prevalence of communicable diseases, also known as "immunizable diseases." These diseases are preventable through vaccinations, but due to various challenges, many Afghan citizens were not receiving the necessary vaccines, leading to outbreaks and health complications. The Afghanistan Crisis Appeal project helped to fill this gap"*

The Afghanistan Crisis Appeal project was relevant to the Afghanistan context because the country faces numerous health challenges, including high maternal and child mortality rates, malnutrition, infectious diseases (such as tuberculosis, malaria, and hepatitis), and inadequate access to basic healthcare services. A community leader in Khosh Robat Sanigi is quoted as follows:

> *"The project has brought many changes such as improvements in children's care and nutrition and a sense of desire care for good health, something which was missing prior to the start of the intervention"*

b. Appropriateness for gender, environment/climate, and geographical needs

Gender: Afghanistan has a deeply patriarchal society where women often face various barriers in accessing healthcare and nutrition services. The gender-responsive approach was embraced to ensure that women and girls, including the disabled are not further marginalized and have equal opportunities to benefit from the project.

The project was appropriate to women and girls since they often face limited access to reproductive health services, leading to higher rates of maternal mortality. Additionally, the project addressed gender-specific issues by providing reproductive health services and improving access to safe sanitation facilities. All the KIIs (100%) indicated that the intervention was appropriate for gender, environment/ climate, and geographical needs of the target

[3] Farzad F, A Reyer J, Yamamoto E, Hamajima N. Socio-economic and demographic determinants of full immunization among children of 12-23 months in Afghanistan. Nagoya J Med Sci. 2017 Feb;79(2):179-188. doi: 10.18999/nagjms.79.2.179. PMID: 28626253; PMCID: PMC5472543.

communities. For example, water is a significant concern in Herat Province as it faces chronic water shortages. Limited rainfall, high evaporation rates, and low water storage capacity contribute to this issue. The province heavily relies on its main river, Hari Rud, for water supply, irrigation, and hydropower generation One project staff noted as follows:

> *"The project was also relevant because of selecting the most vulnerable people especially the women, girls, children and the disabled who initially had limited access to clean water health facilities. By prioritizing these groups, the project aimed to address specific barriers they face and ensure that they could access lifesaving health services".*

Thus, the Afghanistan Crisis Appeal project enhanced increased access to basic healthcare services by 88%, including maternal and child health services. The health and nutrition assistance received by communities in Herat (Kushka Kohna and Kushka Rabat Sangi) was appropriate since the country faces a range of health and nutrition issues, for example, despite some improvements in child undernutrition, with rates of stunting declining from 41 percent in 2013 to 37 percent in 2018, the level of stunting has remained 'very high' according to the World Health Organisation's classification. Over two million children under 5 are stunted.1 Food insecurity has been on the rise since 2018, and in the first half of 2021 over 42 percent of the population was facing high levels of acute food insecurity[4].

The healthcare system had been severely affected by decades of conflict. The areas of Herat, just like it is in most parts of the country, lack basic healthcare infrastructure and facilities, making it difficult for people to receive essential medical services. It was therefore appropriate and relevant for WV to support affected communities through increased access to life-saving health and nutrition services, WASH, and protection.

The Afghanistan Crisis Appeal project was relevant because Herat province, just like other parts of Afghanistan, has limited water resources, resulting in inadequate access to clean drinking water and proper sanitation facilities. This leads to the high prevalence of waterborne diseases like diarrhea, cholera, and typhoid.

The Afghanistan Crisis Appeal project provided safe drinking water, improved sanitation infrastructure, and promoted hygiene practices to prevent water-related diseases. This was done by targeting water supply infrastructure at a community-level and made available to all community members, provided at least 15 litres per person per day[5]. To enhance good water quality, water quality testing was conducted at the point of collection as per WHO and ANSA guidelines and standards. In addition, hygiene was distributed based on the Sphere and WASH Cluster standards and included some items such as 250gm bathing soap, 200gm laundry soap and 10-20ltr water collection and storage containers among others[6], all of which has contributed to improving sanitation infrastructure, and promoting hygiene practices to prevent water-

[4] Integrated Food Security Phase Classification. (2021). Afghanistan Integrated Food Security Phase Classification Snapshot: April 2021
[5] DEC Afghanistan Crisis Appeal Narrative Plan
[6] Ibid

related diseases. Initially, only 42 percent of Afghans had access to safe drinking water, and only 27 percent of the rural population had access to sanitation facilities[7].

Environment/Climate: Afghanistan experiences a range of environmental challenges, including a harsh climate, extreme temperature variations, and natural disasters such as droughts and floods, all of which have negative health implications including disease outbreak. The Afghanistan Crisis Appeal project contributed to reduction of waterborne infectious and vector-borne diseases by constructing water sources. According to the Whole of Afghanistan Assessment REACH report (WoAA 2021), 13% of households relied on inadequate water sources at the time of data collection. In Kushk (Rubat-i-Sangi) 64% of HHs have access to a source of safe drinking-water while in Kushk-i- Kuhna the figure is 100%

Geographical Needs: Afghanistan's geographical diversity, with mountainous regions and remote rural areas, poses significant challenges in delivering health and nutrition services. The Afghanistan Crisis Appeal project considered these geographical needs to ensure easy access to health care services. For example, the mobile health and nutrition teams (MHNTs) were supported to provide timely integrated primary health care services including MPHSS and nutrition services in remote/hard to reach and underserved areas for the general population and, in particular, for CU5 and women of childbearing ages. Safe water was provided to affected households through rehabilitation of 23 non-functional/damaged water system (solar powered or gravity fed) and construction of 34 new solar powered piped water systems. Water quality will be ensured by conducting 3 water quality tests per system, with regular monitoring at source and distribution points.

c. Differences made by the intervention under Health, Nutrition, Water and sanitation hygiene and Protection

The Afghanistan Crisis Appeal project contributed to provision of lifesaving health services to the general population who are living in the project catchment areas, in particular, to CU5 and women of childbearing age. In 2018, almost 87% of the population accessed health services within two hours' distance[8] and this number increased to 88% as a result of the Afghanistan Crisis Appeal project. Nutrition sector on the other hand focused on CU5 and PLWs and in particular for those who are suffering from acute malnutrition. Initially, more than half of all children under the age of 5 were chronically malnourished; one-third were underweight and nearly one in five suffered from acute malnutrition[9]. However, 100% of individuals with severe acute malnutrition (SAM) received treatment.

According to a multi sectoral assessment conducted in March 2022 by World Vision, most households, 74.5% used unsafe water sources but this number was increased by 100%. This was as a result of construction of clean water sources, latrines, and handwashing stations. Hygiene

[7] USAID: 2020, Rural Water, Sanitation and Hygiene: https://www.usaid.gov/afghanistan/fact-sheet/rural-water-sanitation-and-hygiene-0#:~:text=OVERVIEW,the%20age%20of%20five%2C%20annually.
[8] WHO, 2018
[9] World Vision 2014: A weapon against the cycle of malnutrition, https://reliefweb.int/report/afghanistan/weapon-against-cycle-malnutrition

education was conducted and behavior change campaigns, emphasizing the importance of handwashing, proper sanitation practices to prevent waterborne diseases. For protection, there was the establishment of safe spaces or child-friendly spaces for vulnerable populations, such as children, women, and IDPs.

Initially, it was estimated that only 3% of people visiting health centres were offered help for their mental health[10] and this was very low compared to the recommended target of 10-15%. However, as a result of the intervention, 72% of individuals began accessing mental health or psychosocial support (MHPSS) in health programmes. The psychosocial support services, included counseling and trauma healing activities. The intervention also strengthened child protection systems, including the identification and referral of child abuse cases. A number of awareness campaigns on human rights, child protection, and legal aid services were also conducted.

From the above findings, it can be commended that ensuring that communities and people affected by crisis receive appropriate and relevant assistance in a country like Afghanistan requires a comprehensive and collaborative approach involving multiple stakeholders. These include; further needs assessment, local community engagement, collaboration with NGOs and Humanitarian Organizations and contextualize the assistance.

CHS 2. Communities and people affected by the crisis have access to the humanitarian assistance they need at the right time. Quality Criterion: Humanitarian response is effective and timely

The key variables for evaluation under CHS 2 included the following:

i. Extent to which the intervention achieved intended objectives under Health, Nutrition, Water and sanitation hygiene and Protection
ii. Extent to which adaptations to context created the intended objectives
iii. How has the political environment influenced programming, what was its effect on effectiveness and timeliness and how did the programme respond to shifts in the political environment?
iv. Use appropriate communication, participation, and feedback mechanisms?
v. Extent to which staff and structures supported implementation supported achievement of desired competencies/ skills to implement interventions
vi. Extent to which cash interventions contributed towards achieving objectives

Extent to which the intervention achieved intended objectives under Health, Nutrition, Water and sanitation hygiene and Protection

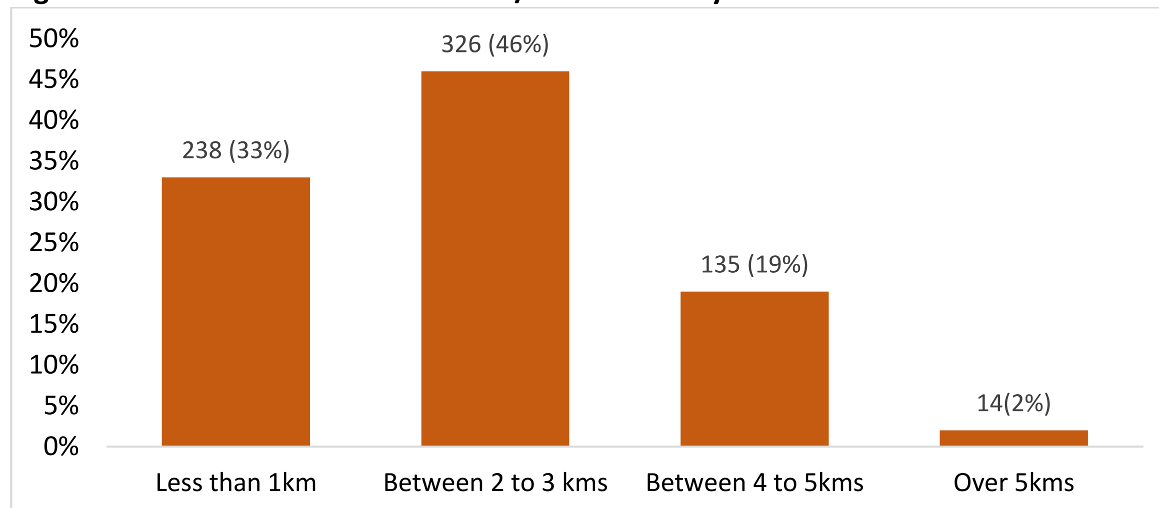
Health Sector

The health sector focused on the provision of lifesaving health services to the general population who are living in the project catchment areas, in particular, to CU5 and women in childbearing ages. The Afghanistan Crisis Appeal project enhanced increased access to primary health care

[10] DEC Afghanistan Crisis Appeal Narrative Plan

services for children, women, men and people with disabilities. Earlier statistics in the DEC Afghanistan Crisis Appeal Narrative Plan indicate that around 64% of deliveries happened in the home but this number was reduced to 47%. Bringing the medical teams and health services closer to the community was a remarkable achievement as 88% of the target beneficiaries accessed basic health services.

Figure 4: Distance to the Closest Clinic/ Health Facility



A good number of PLWs and HHs (33%) had their closest clinic/ health facility located in a distance of less than 1km while 46% had to walk for between 2 to 3 km and 19% had to walk for between 4 to 5 km. 2% of the PLWS and HHs were over 5 km away from their closest clinic/ health facility. Generally, 98% of the population have access and they are within 5km and only 2% are out of the standard coverage. In terms of hours spent, the average walking speed for a person is usually around 5 kilometers per hour. Therefore, it takes an average person around 0.5 hours, or 30 minutes, to walk 2 and a half kilometers. The results therefore indicated that 79% (33% +46%) of PLWS and HHs spent an average of 2 hours to reach the nearest facility which is in line with World Health Organization (WHO) recommendations. But this situation may not be the case for pregnant women in a mountainous area in Afghanistan who may also be carrying a CU5. Generally, there were still some PLWS and HHs who had no close health facilities. A PLW in Shaqaie village in Robat Sangi district pointed out as follows:

> *"No, we don't have easy access medical services because we don't have clinic here, the next clinic is so far and people don't have money and means of transport to go to the clinics. For example, Torghundi clinic is 2 hours far from us".*

Another PWLS in Kolari village:

> *We have access to life-saving medical assistance provided with primary healthcare; if we get sick, we can easily get first aid because the health shelter is available to us*

a. Family Health Homes (FHH) for newborn care services

With WV support, 35% of the PLWs and HHs had been approached by health professionals for FHH for newborn care services in a period of less than 1-week while 32% had been approached in a period of between 2 to 3 weeks. Others (33%) had been approached after 3 weeks. While the recommended time by UNICEF is within the first 24 to 48 hours after delivery which was not met to a large extent, at least there was evidence of follow-up visits after childbirth for the newborn. In total 89% of the beneficiaries had been approached by FHH for newborn care services although for different numbers of times, for example, 16% had been visited once (16%), 20% twice, 42% more than 3 times and 22% had not been visited. Despite progress, there were reported cases of inadequate maternal and newborn care. Through FGDs, another PWLS beneficiary from Robat Sangi district pointed out as follows.

> *"They give us some medicines but without examination, sometimes we are lucky and we find a doctor and we are given medicine but in some case doctors are not there and this makes the situation bad".*

FGDs with some HHs from Robat Sangi district, it was revealed that cultural and traditional practices in Afghanistan can hinder women from seeking proper healthcare during pregnancy and childbirth. These practices include home births, reliance on traditional birth attendants, and limited decision-making power for women regarding their healthcare.

b. How long PLWs and HHs had been approached for FHH for newborn care services

Response	Frequency	Percent
Less than 1 week	222	35%
Between 2 to 3 weeks	207	32%
After 3 weeks	207	33%
Total	**636**	**100%**

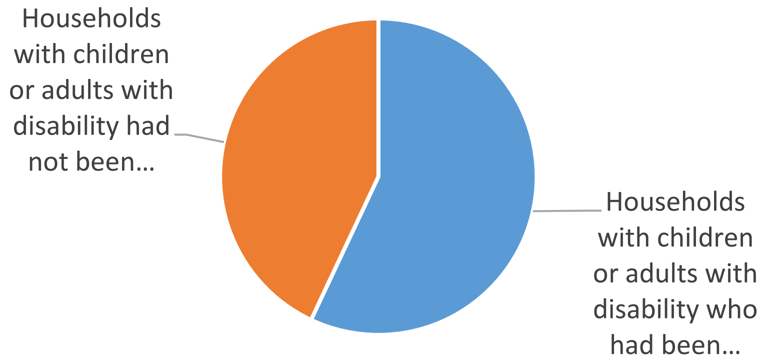
Through KIIs with project staff and local leadership, it was revealed that the early visit by medical teams is essential to assess the baby's overall well-being, check for any immediate complications, and provide postnatal care, and support breastfeeding and maternal health. However, only 19% of the beneficiaries (PLWs and HHs) had been approached by FHH for newborn care services within the recommended timeframe. Some of the project staff indicated that the poor terrain was pointed out as one of the factors for the difficult access to remote regions. In addition, lack of proper roads, infrastructure, and transportation options was reported to impede medical teams' ability to reach affected areas in a timely manner.

c. Children or Adults in Households with Disability

70% of Women of reproductive age, persons with disability and girls were prioritized during the distribution of hygiene kits. A total of 16.7% households had either a child or adult with disability. In the last month, 9% of households (PLWs and HHs) with children or adults with disability had been visited once while 15% had been visited twice and 33% visited more than 3 times. In total

at least 57% of households with children or adults with disability had been visited and 43% had not been approached by the MHNTs or any responsible health personnel.

Figure 5: Children or Adults in Households with Disability

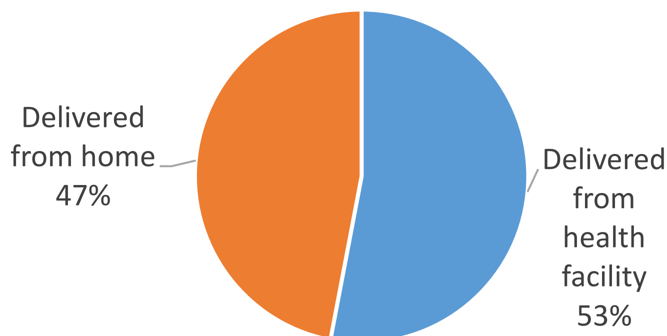


KII with some project staff and community leaders indicated that children and adults with disabilities often received specialized healthcare services that are tailored to their unique needs.

d. Treatment of Pregnant and Lactating Women (PLW)

Through KIIs with project staff, it was revealed that the treatment of pregnant and lactating women especially vaccination was crucial for promoting maternal health, ensuring optimal fetal and neonatal outcomes, supporting successful breastfeeding, preventing mother-to-child transmission of infectious diseases, and improving long-term health outcomes for both the mother and the child. Primary data indicate that 78% of the PLWs were treated in the last 12 months and 67% received prenatal care during your pregnancy. The majority of the PLW (83%) had visited healthcare providers during pregnancy, although there are differences in the number of times. 36% visited at least 2 times, and 33% 3 had visited while 14% had visited once and 16% had not visited. However, for pregnant women 4 times visit is the standard and there were still more improvements needed for the treatment of PLW.

Figure 6: Delivery of Children at a Healthcare Facility

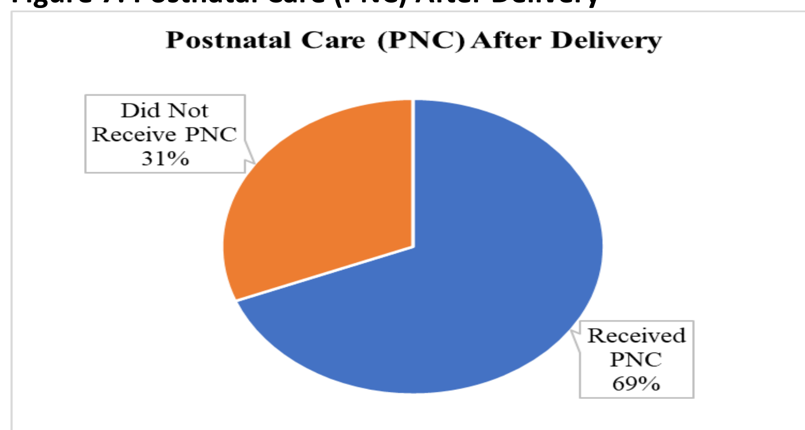


Slightly more than half of the PWLs (53%) indicated to have delivered their children from health facilities while a good number (47%) had delivered from home, this was an improvement since before the Afghanistan Crisis Appeal intervention 64% of deliveries were done from home. Nevertheless, PLWs and HHs indicated that there are still some households delivering babies from home. However, this can contribute to high risk of maternal bleeding, complications, and infections during childbirth[11].

e. Postnatal Care (PNC) After Delivery

Of the PLWs who delivered from health facilities, 69% received postnatal care after delivery and the remaining 31% had not received any form of postnatal care. In 2018, national statistics indicated that only 37.4% of women received any postnatal care from a skilled health provider[12]. The results indicate substantial improvement in access to postnatal care from 37.4% to 69%.

Figure 7: Postnatal Care (PNC) After Delivery



[11] Dahab R, Sakellariou D. Barriers to Accessing Maternal Care in Low Income Countries in Africa: A Systematic Review. Int J Environ Res Public Health. 2020 Jun 16;17(12):4292. doi: 10.3390/ijerph17124292. PMID: 32560132; PMCID: PMC7344902.

[12] Afghanistan Fact Sheet 2018: https://www.ennonline.net/attachments/3142/NEX-Asia-1_WEB_9-11.pdf

PWLS in Kolari village noted as follows:

> *"At the time of birth, the midwives are normally ready for the birth of the child, and if we have basic illness nesses such as headache, we easily get the medicine we need, so we have had improvement in accessing health services care"*

f. Taking children for check-ups or follow-up appointments

96% of the PLWs and HHs had children and they all (100%) took their young ones for check-ups or follow-up appointments. Only 62% took the children for check-ups or follow-up appointments on a regular basis (often) and 38% not often. It is also evident that there are still PLWs and HHs who do not take their children for regular check-ups or follow-up appointments which can lead to missed or delayed diagnoses, inadequate treatment and management of existing conditions, increased risk of preventable illnesses, poor mental health support, and potential legal implications. Initially, only 2% of population were living in more than 5km and while this distance had been bridged as a result of the Afghanistan Crisis Appeal Project, there were still cases of poverty and high levels of unemployment in Herat province that contribute to financial barriers in accessing healthcare services. Nevertheless, 100% of the PLWs and HHs acknowledged to be taking children for check-ups or follow-up appointments. Majority (70%) were also comfortable asking healthcare providers for information and advice about their child's health and well-being.

Immunization and Maternal Care

The focus on this section was due to the fact that immunization of children is of utmost importance as it protects them from dangerous diseases, saves lives, prevents complications, reduces healthcare burden, ensures long-term health, and promotes the overall well-being of children and society as a whole. On a positive note, 88% of the PLWs and HHs knew the importance of immunization and maternal care in preventing illnesses and ensuring good health for their child and themselves and had also received recommended vaccines for their child's age (72%). The evaluation results revealed that 88% of women had had their children vaccinated totaling to 13433 children being supported during the project period. Most PLWs who delivered their babies from home also took their children for immunization. Generally, the results indicate increased access to health services as noted by PWL in *Kolari village:*

> *"Our newborns receive maternal and newborn care from the health nest whenever the mother and baby need medicine and health care. Actually, we get the care of mother and baby both during pregnancy and after pregnancy by ambulatory healthcare nest. We have also been told mothers to eat more vitamin foods and fruits during pregnancy and feed children with breast milk in their first six months of life".*

Nutrition Sector

Nutrition sector on the other hand focused on CU5 and PLWs and in particular for those who were suffering from acute malnutrition. Specifically, focus was on the number of individuals screened for malnutrition, number of individuals with severe acute malnutrition (SAM) receiving treatment and number of individuals sensitized around nutrition requirements for U5s and PLWs. The following results were obtained:

a. Number of individuals screened for malnutrition

World Vision intervention started by ensuring that households are diagnosed with malnutrition and in total 16000 individuals were diagnosed (8000 in Kushk-i- Kuhna and another 8000 in Kushk- Rubat-i-Sangi). KIIs with health providers revealed that screening tools helped to identify individuals at risk of malnutrition and address undernourishment and improve the overall health and well-being of individuals. One PWL in Kushk-i- Kuhna pointed out as follows:

> *"I and my child was found out to have malnutrition and doctor told me eat fruit and good foods, then the medical team came and taught us how we can treat our children but no access to safe spaces provided"*

b. Number of individuals with Severe Acute Malnutrition (SAM) receiving treatment

As per baseline data, the global acute malnutrition (GAM) rate in Herat is 12.8% (SAM: 2.5% and MAM: 10.30%). Secondary data /project reports indicate that a total of 1400 individuals were reported to have been treated (700 in Kushk-i- Kuhna and another 700 in Kushk- Rubat-i-Sangi). Given the total target of 1600, the (GAM) rate reduced to 12.0% (SAM: 2.0% and MAM: 10.0%). KIIs with some health teams revealed that proper treatment helped prevent developmental delays, physical impairments, and cognitive deficits associated with malnutrition. In addition to the treatment, the PWLs and households were often given health advise in relation to malnutrition. A PWLs in Haji Rahmat village asserted as follows:

> *We have access to medical clinic and doctors always teach us what we should do, what to eat and the reasons we should clean areas we live. The medical team also told us that pregnant women should live in an area without stress and anxiety, should take care of themselves and keep clean and eat on time.*

Another PWLs in Haji Rahmat village pointed out as follows:

> *"Also for newborn were encouraged to breastfeed for atleast 2 years for the good health of the child"*

c. Number of individuals sensitized around nutrition requirements for U5s and PLWs

A total of 600 individuals were sensitized around nutrition requirements for U5s and PLWs (300 in Kushk-i- Kuhna and another 300 in Kushk- Rubat-i-Sangi). While progress was made, more intervention is still needed in the area of malnutrition. PWLS in Kolari village noted as follows:

> *"My children are all healthy, but for those who are suffering from malnutrition, food is given and they are included in the nutrition program, but in my opinion, their food is not enough and they are not treated as they should be because there is very little food".*

Malnourished Children

The evaluation results showed that only 13.4% (SAM+MAM) of the children less than 5 years of age (CU5) had Severe Acute Malnutrition (SAM) treated. The figure (13.4%) was far above the WHO target to reduce the prevalence of children under 5 years of age with Severe Acute Malnutrition (SAM) to less than 5% by 2025. In addition, only 14% of the households had malnourished children who received inpatient services for malnutrition, during the project period.

According to the latest data available from the WHO, approximately 3.8% of children under the age of 5 in Afghanistan had severe acute malnutrition (SAM) in 2019. This number may be the same or a little different from the situation in Herat (Kushka Kohna and Kushka Rabat Sangi). It can therefore be concluded that despite substantial progress in the reduction of cases of underfeeding in Herat province of Afghanistan is still a significant concern for UNICEF, WHO and government. Data from KII with local leadership indicate that one of the primary reasons for malnutrition in Herat province is food insecurity since the region is prone to droughts, which severely affect agricultural production and food availability. Limited access to nutritious food and poor dietary diversity contribute to high rates of malnutrition. Additionally, poverty and a lack of resources make it challenging for families to afford nutritious food and access healthcare services still exist among some households.

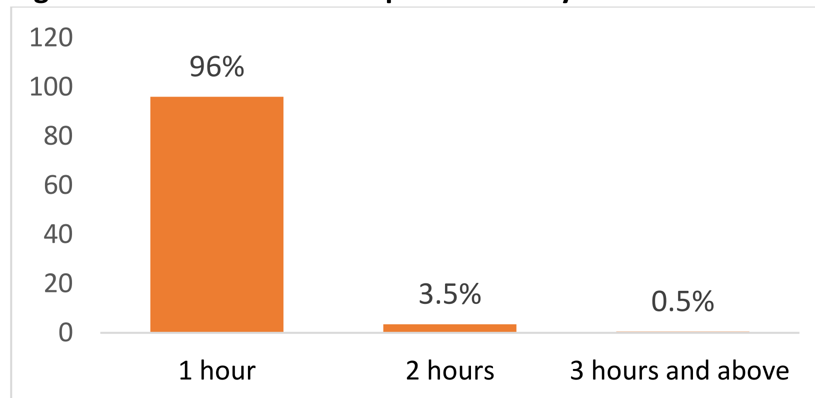
Breast-feeding

In the context of Afghanistan Crisis Appeal intervention, breast feeding is one of the practices that was encouraged to enhance the nutritional status of children under 5 years of age (CU5). Sensitizing mothers about the importance of breastfeeding not only benefited the health and well-being of the infants but also the mothers themselves, the environment, and society as a whole. One medical staff pointed as follows:

> *"The early initiation of breastfeeding allows the baby to receive colostrum, the thick and concentrated first milk, which is rich in essential nutrients and helps protect the baby against infections".*

Accordingly, the majority of the lactating mothers (96%) took one hour and in some cases less before they first put their baby the breast. This is in line with the WHO recommendation that mothers initiate breastfeeding within the first hour after birth, if possible. In Afghanistan, it is common for babies to be breastfed immediately after birth. The national statistics also indicate that typically, newborns are placed on their mother's chest for skin-to-skin contact and encouraged to breastfeed within the first hour after delivery[13].

Figure 8: Time taken to first put their baby to the breast



The results indicated improved breastfeeding practices where, 89.9% of the households (PLWs and HHs) acknowledged to have given their baby as a drink for a period of 6 months or more than 6 months. This is in line with WHO and UNICEF recommendations that infants should be exclusively breastfed for the first six months of their life. It is therefore evident that the lactating mothers had knowledge that infants should receive only breast milk and no other liquids or solid foods during this time. Through FGDs with PLWs, it was noted that after six months, they start complementary foods while breastfeeding continues up to two years of age or beyond and this is why 46.8% of the children under five were reported to be breastfeeding. The lack of breastfeeding by some mothers was attributed to a number of factors such as mothers inadequate milk, new pregnancy, mothers' illness, children being 2 years and above and belief that breastfeeding is harmful to the child's teeth and brain.

Protection

The protection intervention was implemented to ensure that vulnerable and at-risk children and adults are reached with protection services and information. The target for the protection intervention includes vulnerable and at-risk boys, girls, and women who are susceptible to abuse, exploitation, neglect, and violence in the targeted community. The key indicators included the following:

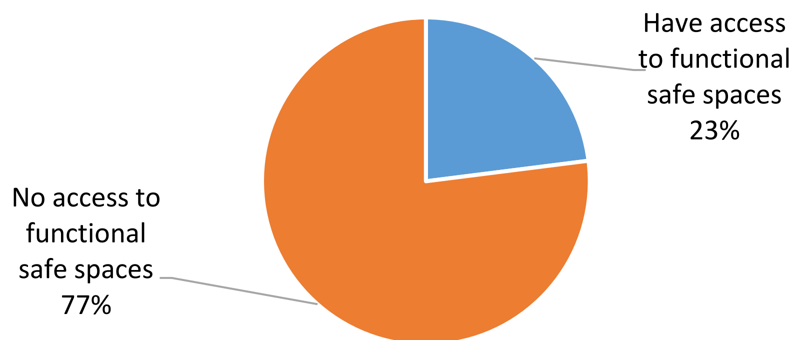
i. Number of functional safe spaces established for [women & girls/children/ families/ other]
ii. Number of [individuals/ children/ women] benefitting from mental health or psychosocial support (MHPSS) in protection programmes
iii. Number of individuals referred for legal assistance/advice [by advice type]

[13] Newborn Health Situation Analysis (March 2008)

a. Number of functional safe spaces established for women & girls/children/ families

The space refers to a child-friendly species designated specifically for children, not to other groups, so the heading does not reflect the intent of the child-friendly spaces under child protection. However, the evaluation results indicated that only 23% of the PLWs and HHs reported having access to functional safe spaces established for women & girls/children/ families. Majority (77%) did not have access to functional safe spaces, an indication that they lacked a supportive environment that is free from any form of harassment, discrimination, violence, or abuse. Having no access to safe space also implied limited empowerment to express themselves, share their experiences, and seek help if needed.

Figure 9: Access to Functional Safe Spaces



Secondary data indicate that the Afghanistan Crisis Appeal intervention focused on strengthening the protective environment by providing psychosocial support (PSS) and case management services for at-risk children and families; strengthening community-based Child Protection Committees through training and capacity development support; conducting awareness-raising activities on key child protection issues, and strengthening parents' capacity on parenting skills and providing them with PSS services. One local leader in Shaqaie village in Robat Sangi district pointed out as follows

> *"Awareness-raising activities helped to promote positive change which was seen through community rejection of bad practices such as delayed immunization that put children at risk".*

Case Management services: through child, family, and community-focused strategies and coordination with other actors, WV identified children at risk of harm or who have experienced harm. WV provided support to children and caregivers (when assented to, appropriate, and needed), including individualised PSS to children and their caregivers; parenting support to

caregivers; and referrals to access medical and other basic services. One care giver in Khosh Robat Sanigi pointed out as follows:

> **"***we were trained to serve as role models for children, shaping their behavior and values and supporting them to seek support especially the medical help for their well-being and we have always done our work"*

Psychosocial support: WV provided children with a protected environment in which they could participate in organised activities to play, socialise, learn, and express themselves and ensured they benefit from PSS. The parenting skills obtained are expected to provide children with a secure and loving environment, which helps foster their emotional well-being. One caregiver/ PWLs in Kolari village noted as follows:

> *"we were taught how to be patient, and responsive to our children's needs, how to build good relationship with children for their better physical and emotional growth".*

Secondary data indicate further indicate that the Afghanistan Crisis Appeal established four community-based child protection committees (CBCPC), each with 20 members, aiming to strengthen the community-based child protection systems for preventing and responding to child protection issues and built their capacity. These structures are expected to continue functioning even at the end of the project. One religious leader pointed out as follows:

> "*we always put an eye on all our children in the village to ensure that they are safe and disciplined since they are the future leaders"*

To ensure protection, safety and dignity, especially of women and children, who bear the biggest burden in fetching water, participation of women, children (girls and boys) and persons with disability were prioritised as their views and opinions were sought in determining technology choice and siting of WASH systems.

b. Number of individuals/ children/ women benefiting from mental health or psychosocial support (MHPSS) in protection programmes

The child protection psychosocial support focused on children and parents and care givers. Afghanistan Crisis Appeal project supported group-based psychosocial support sessions organized for 600 boys and girls. Overall, group-based psychosocial support sessions provided a valuable platform for individuals to connect, gain support, learn new skills, and develop a sense of empowerment, ultimately improving their mental well-being.

Sessions for mother support groups were organized for 100 female caregivers which provide caregivers with validation and reassurance that they are not alone in their struggles and that their feelings and experiences are normal. One member of PLWS through FGD pointed out as follows:

"Mother support groups allow us to form meaningful social connections with other mothers in similar stages of parenting. These connections have led to long-term friendships and cooperation in the community".

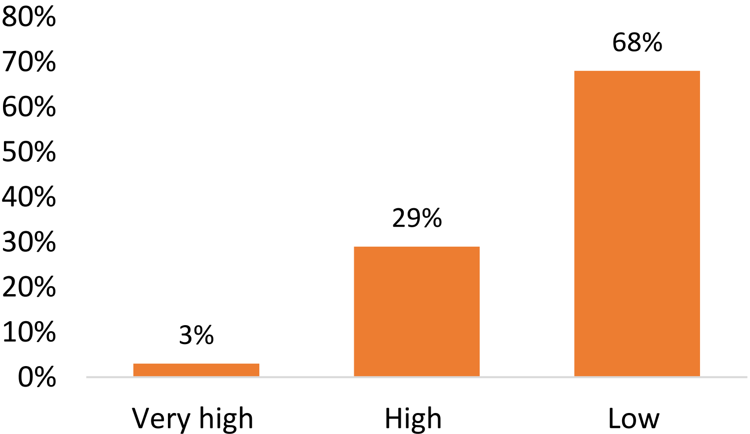
PSS and information packs were distributed to 400 adults and 800 children which helped to provide education and knowledge, equip caregivers with coping strategies, enhance the quality of care, and improve the caregiver-client relationship. Through FGDs, one PLWs was quoted to have said as follows:

"Psychosocial support packs have helped me improve my caregiving skills, understand the needs of the person I am caring for, and I can now ensure a safe and nurturing environment".

Community awareness sessions on protection and safeguarding were organized, reaching 720 community members. One community leader pointed out that awareness sessions empowered community members to speak up about abuse and safeguard themselves and others from potential harm. By providing information on rights, boundaries, and available support services, individuals were equipped with the tools they needed to protect themselves and seek help when needed.

A total of 2600 individuals benefited from mental health or psychosocial support (MHPSS) in protection programmes (1300 in Kushk-i- Kuhna and another 1300 in Kushk- Rubat-i-Sangi). A total of 34% of the PLWs and HHs had individuals/ children/ women benefiting from mental health or psychosocial support (MHPSS) in protection programmes. On the other hand, 66% were not and missed out on mental health or psychosocial support which is crucial for overall well-being, productivity, relationships, coping with challenges, prevention of mental illness, and reducing stigma.

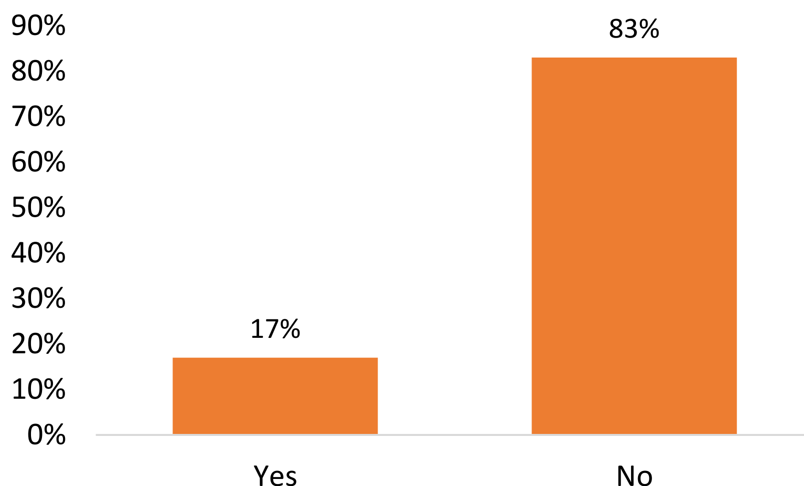
Figure 10: Level of awareness of child protection issues and provision of psychosocial support services



Only 31% (3% + 29%) of the PLWs and HHs had a high level of awareness child protection issues and provision of psychosocial support services while 68% had low levels of awareness. In the context of this evaluation, the lack of proper awareness and support services for child protection can lead to increased healthcare costs in the long run, as children may require more extensive medical and psychological interventions to address the consequences of abuse or neglect.

Figure 11: Support to Caregivers

In order to carry out the work of caregiving to vulnerable children, WV trained 90 women from existing/newly formed Family Health Action Groups (FHAGs)/female volunteers to improve early case detection of severely ill children[14]. Only 17% of the female caregivers had been supported to conduct home PSS activities with their children and provided platforms for peer engagements.



c. Number of individuals referred for legal assistance/advice [by advice type]

Only 13% of the PLWs and HHs had access to legal assistance/advice in case it is required while 82% did not have access to such assistance and 4% were not sure. Through KIIs with HHs, it was revealed that traditional practices and cultural norms can act as barriers to accessing legal assistance. For example, in some areas, community disputes are resolved through informal mechanisms like tribal councils or local elders, which may not align with formal legal processes. However, the common type of legal assistance/advice received included; mediation and alternative dispute resolution mechanisms that help communities resolve conflicts and disputes outside of the formal court system, inheritance, good behaviour in the community, counseling and guidance.

Water, Sanitation and Hygiene

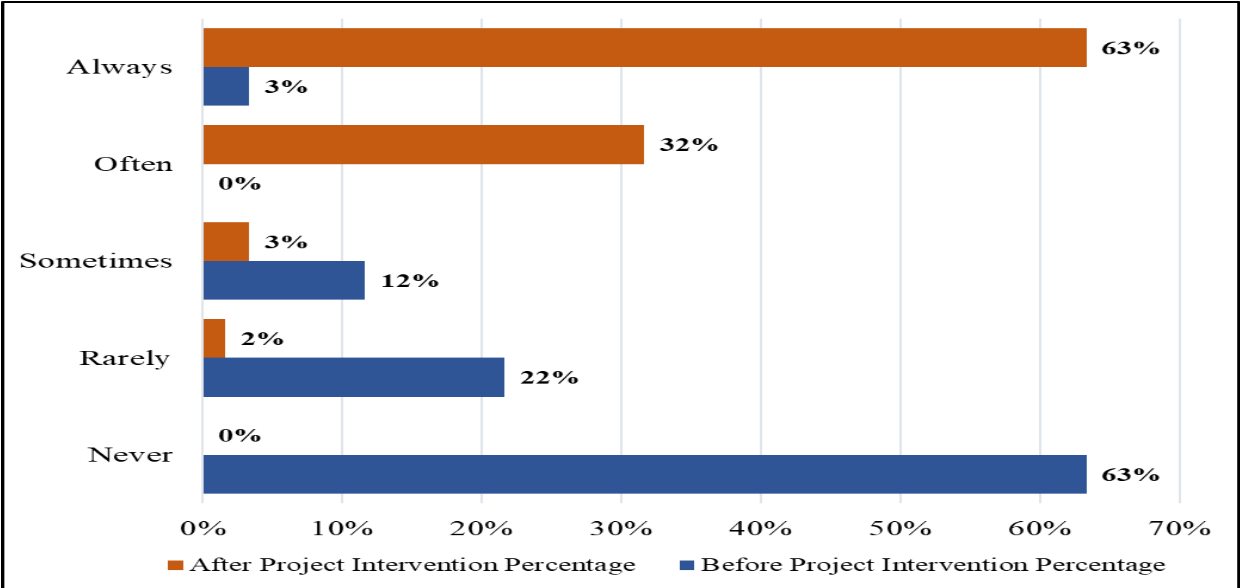
The target groups under the WASH sector included children, women, girls, persons with disability, and the elderly who are often the most vulnerable and more impacted with lack of access to safe water and sanitation. The key indicators under WASH included the following:

[14] DEC Afghanistan Crisis Appeal Narrative Plan

Rehabilitation of water points and access to safe drinking water

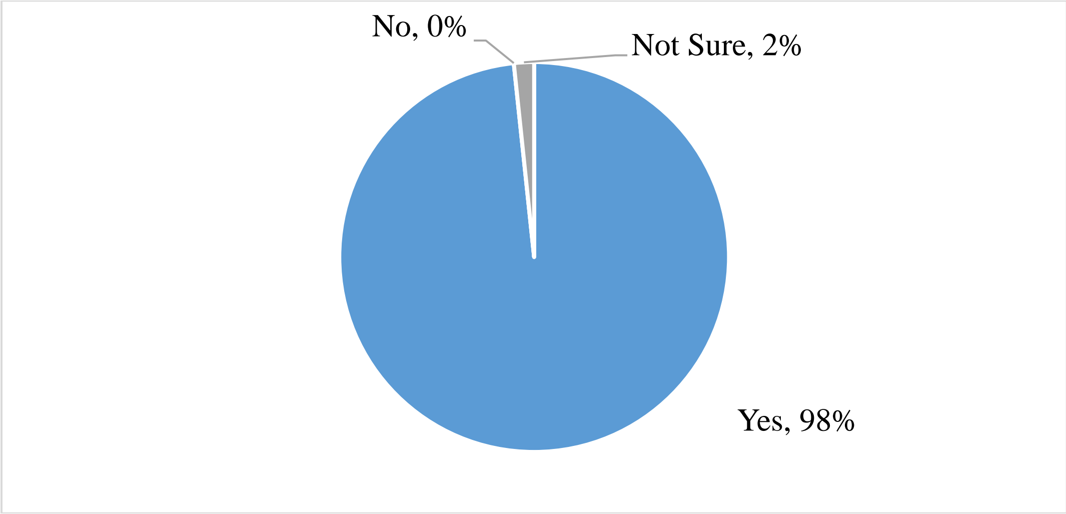
A total of 03 solar powered piped water networks were constructed at community level. KIIs with community leaders Solar powered piped water networks were recommended to reduce operational costs by eliminating the need for fossil fuels or electricity to operate pumps. There was also rehabilitation of 01 non-functional water systems and conducted water quality testing of 4 water systems (new and rehabilitated). With the establishment and training of the 4 water management committees/groups on operation and maintenance, safe water management and water treatment, the project registered an increase in the percentage of community members collecting water from improved water sources.

Figure 12: Percentage of Community Members Collecting Water from Improved Water Sources



Before the project intervention more than half of the respondents 63% (38/60), had no access to improved water sources and 22% (13/60) rarely collected water from improved sources, that is more than a third of the respondents. Only 3% (2/60) always collected water from improved water sources. This puts them at a high risk of water borne diseases. After the project implementation, there was great improvement where 63% (38/60) of the HHs always collected from improved water sources. This is an improvement from the 3% before the project implementation. After the project implementation, none of the respondents 0% (0/60) never collected water from the improved water source, compared to 63% (38/60) before the project intervention.

Figure 13: Percentage of households with access to safe water facilities, promote good sanitation and hygiene practices



Majority of the households (98%) reported having access to safe water facilities, promoting good sanitation and hygiene practices and this was so close to the specific target set by the SDGs to achieve 100% access to safe drinking water for all households by the year 2030. The same percentage of HHs (98%) had promoted good sanitation and hygiene practices. 98% (59/60).

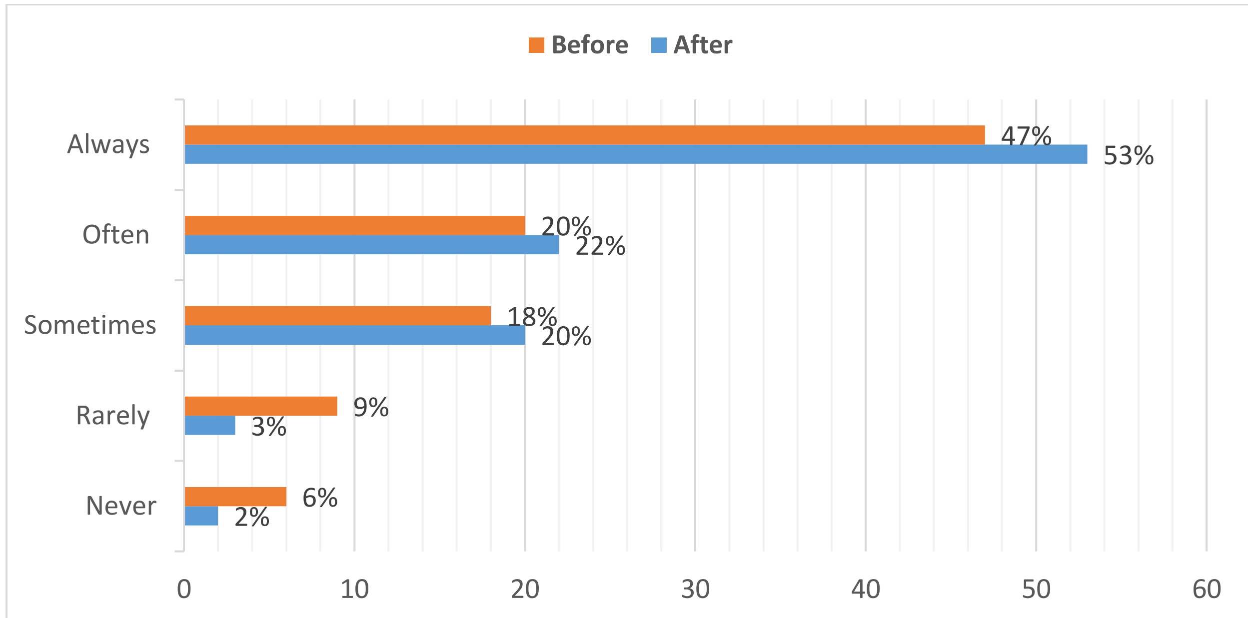
Supply of cluster standard hygiene kits

A total of 900 households out of the targeted 1000 were supplied with cluster standard hygiene kits to targeted communities including transportation leading to 90% level of achievement. In a FGD with PLWs it was revealed that the cluster standard hygiene kits played a vital role in promoting good hygiene practices, preventing the spread of disease, supporting marginalized groups, empowering individuals, and ensuring community resilience in emergencies.

Latrine Usage

The PLWs and HHs were asked to indicate how often they used latrines before and after the project intervention. After the intervention 53% (31/59) of the respondents always used latrines, 22% (13/59) often used latrine, 20% (12/59) sometimes use latrine, 3% (2/59) rarely use latrine and 2% (1/59) never use latrines. This was an improvement since more people used latrines as compared to before the intervention as indicated in the chart below despite the need for more intervention to ensure that all PLWs and HHs always use latrines.

Figure 14: Percentage of PLWs and HHs always used latrine



Hand Washing

The PLWs and HHs were asked to indicate how often they used soap and water for handwashing before the project intervention. Before the project intervention, out of the 60 selected WASH beneficiaries, 60% (36/60) never used soap and water for handwashing while 28% (17/60) rarely used soap and water for washing hand, 8% (5/60) sometimes used soap and water and 2% (1/60) often used water and soap for handwashing while 2% (1/60) always water for washing hands. After the project intervention the number of respondents using soap and water for washing hands increased from 2% (1/60) to 48% (29/60). And those who never use soap and water for hand washing are reduced from 60% (36/60) to 0% (0/60), this is a 100% percentage change.

Figure 15: Percentage of PLWs and HHs using soap and water for handwashing before and after the project intervention.

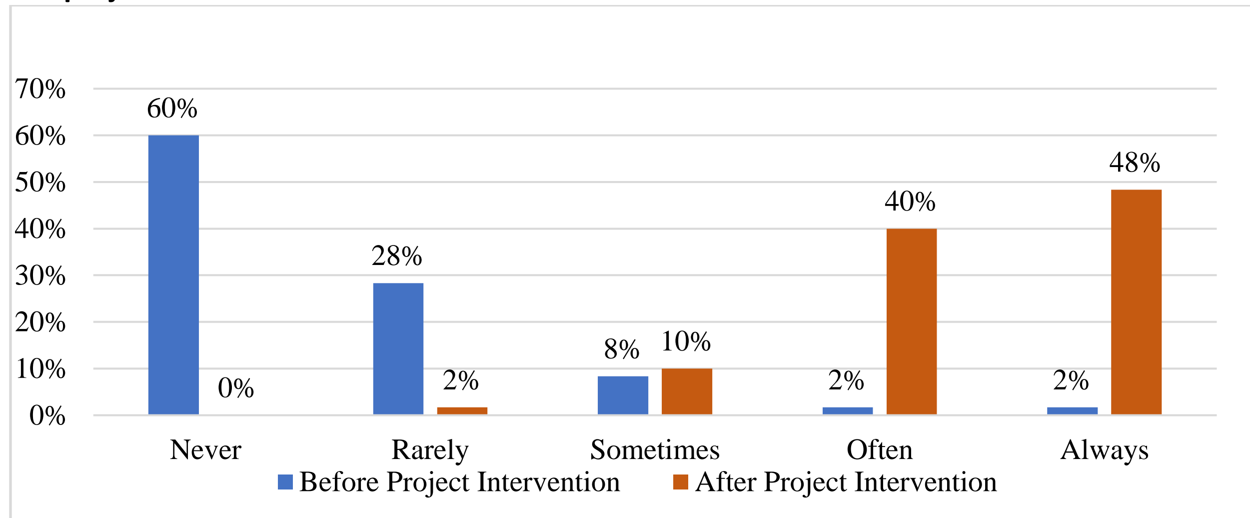
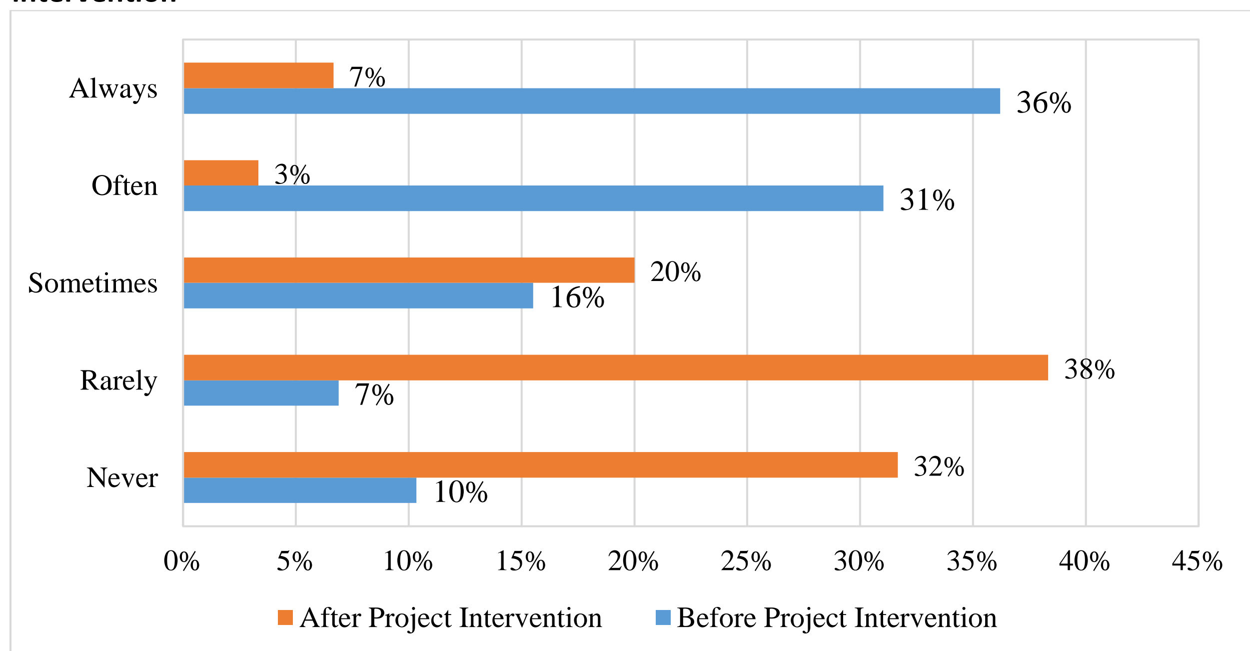


Figure 16: Percentage of HHs affected by water-borne diseases before and after project intervention



Before the project intervention 36% (21/58) of HHs were always affected by water borne diseases, 31% (18/58) often affected, 16% (9/58) were sometimes affected, 7% (4/58) were rarely affected by water borne disease and 10% (6/58) were never affected by water borne disease. After project intervention the number of respondents who were never affected by waterborne diseases increased from only 10% to 32%. And those always affected by water borne disease reduced from 36% to 7 % after project intervention.

Extent to which adaptations to context created the intended objectives

A number of project adaptations as a process of adjusting or modifying Afghanistan Crisis Appeal Project activities to better suit changing circumstances were embraced. One of such adaptations was the request for project extension. The project end date was extended from 30-June-2023 to 31- December 2023 which enabled WV to deliver the revised activities.

Output 1: **The project will reach in total 80,000 women, men and children with health and nutrition services** (Men: 14,000, Women: 28000, boys: 18,000, Girls: 20,000)

Based on strategic discussions, in March 2023, between the WHO, UNICEF, health implementing NGOs and the Ministry of Public Health (MoPH), the Mobile Health and Nutrition Teams (MHNTs) were changed to Fixed Health and Nutrition Centres (FHNCs) to standardize services provided and improve accountability and transparency. Therefore, the Afghanistan Crisis Appeal project was re-designed to support the same targeted populations and locations through a fixed health and nutrition service delivery modality from the end of April 2023. For each FHNC, WV installed four (4) Conex/containers and 2 separate portable latrines (1 for men and 1 for women). The project ensured that water is available in the centers and provided locally made incinerators and septic tanks, to ensure waste from each FHNC is managed properly.

Four (4) FHNCs provided timely integrated primary health care services, including Mental Health and Psychosocial Support (MPHSS) and nutrition services, in remote/hard to reach and underserved areas for the general population and, in particular, for children under 5 years of age (CU5) and women of childbearing ages.

Within the framework of the project, the four (4) FHNCs served the same two (2) northern districts of Herat province (Kushke Kohna and Kushke Robatsani). In providing the healthcare services, the FHNCs and Family Health Houses (FHH) conducted the triage daily, ensuring children and adults with any type of disability are among the top priority groups seen by health workers. In addition, women and children with disabilities receive appropriate health education through FHNCs and link with the relevant entities for further support.

Each FHNC team consisted of five (5) medical professionals (a doctor, midwife, nutrition nurse, a vaccinator, and a community health promoter), who together will manage the day-to-day operation of the FHNCs for the project life. To mitigate situations such as sickness, leave or absenteeism of key team members (e.g. Doctor or midwife), the project reserved staff that was on standby to fill gaps, thus ensuring the team is complete at all times.

Existing comprehensive district health facilities, provincial level maternity hospital, pediatric hospital and regional hospital served as referral health facilities for this project. As part of the referrals, the project covered the transportation costs and the treatment costs, where necessary.

The project ensured that the 22 FHHs meet the revised MoPH standards for the FHHs, such as diagnosis and treatment of Malaria, treatment of Leishmania, as well as first aid support for injuries and checking vital signs for the general population. In addition, the project provided maintenance and renovation of the centers to provide a conducive environment for the staff to demonstrate their skills and to the beneficiaries who are using the FHHs.

CU5 in drought-affected and remote areas were supported in receiving treatment for critical cases of SAM through inpatient care services through cash transfers. However, the cash intervention was dropped due to the increased costs.

Discontinued Output 2: Affected community members have increased access to clean water, sanitation and hygiene services:
The remaining funds from this output were reallocated to health, nutrition and protection activities. The costs were incurred for this output from 1st July2022 to 25th December 2023. During this period, five (5) WASH groups were established and trained in the targeted villages. Each group consisted of 10 members (3 women, 6 men 1 male/female with a disability). Sensitisation and coordination meetings were held with district elders and community leaders for better facilitation and implementation of WASH activities and establishing WASH groups. Hygiene promotion training was conducted for the five (5) WASH groups, training 50 people (30 males and 20 females). The trained WASH groups conducted hygiene promotion that reached 2,214 individuals (608 women, 655 men, 372 boys and 579 girls).

The community engagement processes had also been initiated for all five (05) villages (Abbarik Ulya, Sia Kamar and Yaka Darakht in Robat Sagni district and Khajaha and Koklam Ulya in Kushke Kuhna district). Technical assessments were done in coordination with (PRRD). In addition, WV conducted primary water quality tests and results were satisfactory. Furthermore, two (02) WASH staff participated in harmonized community led total sanitation (CLTS) training conducted by WVA WASH public health engineer.

Revised Output 2: Vulnerable and at-risk Children and adults reached with protection services and information, in Kushka Kohna and Kushka Rabat Sangi districts of Herat Province
Summary of protection interventions with revised entry points for service provision and targets:

No	Activity	Entry points	Target	Achievement
1	Provision of psychosocial support services	School facilities (ECD and CBE)	900	648
		Health and nutrition centres	400	288
2	Parenting skills development	School facilities (ECD and CBE)	700	700
		Health and Nutrition centres	600	600
3	Case management services, including individual protection assistance	School facilities (ECD and CBE)	50	50
		Health and nutrition centres	200	200
4		School facilities (ECD and CBE)	350	350

	Support community-based child protection committees, including trainings	Health and nutrition centres	170	170

*ECD: Early childhood development; CBE: Community Based Education

Following the ban of female staff from working in sectors other than education, nutrition, and health, the implementation approaches were done by both male and female staff. While all child protection activities (PSS, case management, parenting skills development, and supporting community-based child protection structures) continued to be implemented, the way they had been designed to integrate protection activities with WV's nutrition, health, and education sectoral interventions. The adaptation used nutrition and health services and education service provision, specifically early childhood education and community-based education, as entry points.

Case Management services: In adapting the case management services provision to the recent changes, the services were coordinated from the FHNCs. A social worker was embedded with the health and nutrition team. The child protection case management referral system was aligned with the health services and further revisions were made to include and capture protection services to ensure all protection services and service providers are captured for children, girls, and women. In the service provision, social workers, both male and female, conducted home visits along with health and nutrition staff, who will also be conducting home visits.

Psychosocial support: Adapting the PSS service provisions, the services continued to be delivered in tandem with health, nutrition, and education services. The animators organized the PSS sessions where: (1) WV had the SAM and MAM children; and (2) WV provided maternal and infant activities through the FHNCs.

Establish and build the capacity of a Community-Based Child Protection structure to prevent and respond to child protection concerns: As part of the process of adapting, the CBCPC was linked with the health and nutrition committees in the community and the school management committees in the schools. Members of the existing mechanisms and structures got more training on basic child protection to be able to engage systemically. This allowed the continuation of the implementation of community-based protection, including capacity building without being seen as a separate protection intervention. This approach allowed for reaching both male and female community members with protection messages and capacity building. Basic awareness raising sessions will continue to be conducted in the FHNCs and schools to familiarize the community with the available services.

The political Environment

The political environment influenced programming, and had some effect on effectiveness and timeliness. In KIIs with some project staff, it was revealed that under current rule, women are prohibited from seeking employment and are effectively excluded from participating in the workforce including in some NGO activities. Moreover, the ban undermined Afghanistan Crisis Appeal project efforts to promote gender equality and women's empowerment. The project responded to shifts in the political environment by ensuring that women work in sectors of education and health which is acceptable by the government.

Use of appropriate communication, participation, and feedback mechanisms

KII with project staff indicate that the Afghanistan Crisis Appeal project worked in collaboration with local community-leaders and established partnerships to ensure wider community participation and ownership of the project. The project also involved marginalized groups, such as women, girls, children, and people with disabilities, by providing them with equal opportunities to participate and contribute their perspectives. The project organized regular community feedback sessions, where different stakeholders voiced their opinions and suggestions directly to project staff for possible intervention. KII with project staff also indicate that the Afghanistan Crisis Appeal project embraced regular monitoring, documentation of the effectiveness of project activities to ensure continuous improvement in communication, participation, and feedback processes.

Extent to which staff and structures supporting implementation were supported to achieve desired competencies/ skills to implement interventions

Secondary data indicate that different categories of staff were supported in different ways. For example, the local staff were supported with policies and procedures that helped in the protection and support of both male and female workforces in the workplace. In addition, WV ensures that employee's roles and assignments are clearly defined and understandable, and the work environment is as safe as possible for all staff and partner organizations. In addition, adequate training and feedback on performance was provided, areas for rest and relaxation were provided, especially for the field-based staff and for lactating female staff to feed their children. The staff were also protected from discrimination and treated equally. Communication channels were provided for employees to raise concerns, such as hotline and whistleblowing.

> *"Furthermore, WV ensured that there are trained peer supports providing staff care support and interventions from time to time and as needed. During the COVID time, WV established Corporate Allowance for Workforce Death and Emergency Health Treatment Cases linked to the COVID-19 pandemic and other security related risks as they arose".*

The Mobile Health and Nutrition Teams (MHNTs) were provided with timely integrated primary health care services including MPHSS and nutrition services in remote/hard to reach and underserved areas for the general population and, in particular, for CU5 and women of childbearing ages. Within the framework of the project, five MHNTs were supported (3 MHNTs established under phase 1 and based on the needs and meeting with the communities there was readiness to add 2 more teams in the same districts) in two northern districts of Herat province (Kushke Kohna and Kushke Robatsani)

Five (5) WASH groups were established and trained in the targeted villages. Each group consisted of 10 members (3 women, 6 men 1 male/female with a disability). Sensitisation and coordination meetings were held with district elders and community leaders for better facilitation and implementation of WASH activities and establishing WASH groups.

The Afghanistan Crisis Appeal project also established and built the capacity of a Community-Based Child Protection structure to prevent and respond to child protection concerns. In addition, 40 volunteers were identified during the first phase to support the implementation of the project. Four community-based child protection committees (CBCPC), each with 20 members, aiming to strengthen the community-based child protection systems for preventing and responding to child protection issues were established.

In summary, ensuring that communities and people affected by a crisis have access to timely humanitarian assistance requires a multi-faceted approach involving coordination, collaboration, and a deep understanding of the local context. Some strategies that can be employed include; further coordination collaboration with relevant stakeholders, engagement with local communities and capacity building of local organizations and institutions to deliver assistance effectively.

CHS 3. Communities and people affected by crisis are not negatively affected and are more prepared, resilient, and less at-risk as a result of humanitarian action. Quality Criterion:

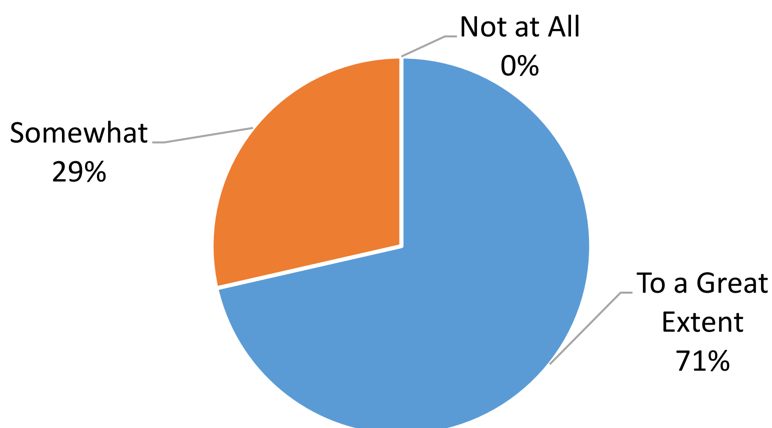
Humanitarian response strengthens local capacities and avoids negative effects

CH3 focused on the following indicators:

i. Extent to which the benefits are likely to continue/last
ii. How reinforced capacities and structures will sustain the interventions
iii. How the interventions strengthen local capacities while avoiding negative effects?
iv. Difference that intervention made towards environmental safeguards
v. Differences in results across groups, gender, and geographical locations
vi. How the intervention generated significant positive or negative effects/ unintended effects on the environment

Figure 17: Extent to which the benefits are likely to continue/last

KII with project staff, Mobile Health and Nutrition Teams (MHNTs) indicate the Afghanistan Crisis Appeal project benefits are likely to last or continue.



The reasons for likely continuation of the project benefits included; stakeholder involvement and the community engagement processes that was initiated for all five (05) villages (Abbarik Ulya, Sia Kamar and Yaka Darakht in Robat Sagni district and Khajaha and Koklam Ulya in Kushke Kuhna district). Stakeholder engagement promoted collaboration and coordination among different actors, including government agencies, local leadership, donors, and communities.

Strengthening the capacity and empowering local institutions, such as water management committees, health centers, and local leadership, increased their ability to continue delivering, maintaining, and managing health, nutrition, WASH and protection services even after the project ends. In addition, empowering local institutions promoted ownership and participation of local communities in decision-making processes for the sustainability of the project.

The awareness campaigns on health, nutrition, WASH, and protection employed culturally sensitive and appropriate communication methods to educate the community about preventive measures, nutrition practices, hygiene, and child protection. This knowledge is likely to last even when the project comes to the end.

How reinforced capacities and structures will sustain the interventions

The Afghanistan Crisis Appeal project strengthened the capacity of stakeholders; they acquired the necessary knowledge and skills to continue implementing and sustaining the project's activities even after external support ends. The project worked with consultation with community development councils, local leaders/village shura's and faith leaders which was a right way for implementation process. This enhanced the long-term impact of the project, as

stakeholders are equipped to address ongoing health, nutrition, WASH and protection challenges in their communities. In addition, the Afghanistan Crisis Appeal project, was implemented within the provincial health structure in Afghanistan, aims to ensure the delivery of essential healthcare services to the population, improve health outcomes, and provide access to quality healthcare facilities. To avoid negative effects, the local leaders were involved in the planning and implementation of programs to ensure that interventions are culturally appropriate and community-driven.

Differences in results across groups, gender, and geographical locations in and entitlements, have access to information and participate in Decisions that affect them. Quality Criterion: Humanitarian response is based on communication, participation, and feedback.

At household level, people were supported through increased access to life-saving health and nutrition services, WASH, and protection. Children and mothers had increased access to quality community-based healthcare in their respective villages. In addition, women and children with disabilities received proper health education through MHNTs and linked to the relevant entities for further support

In two districts of Herat province (Kushke Kohna and Kushke Robatsani districts), the project provided safe water facilities, promotion of good sanitation and hygiene practices. The project also provided psychosocial support (PSS) and case management services for at-risk children and families; strengthened community-based Child Protection Committees through training and capacity development support; increased awareness on child protection issues and strengthened parents' capacity on parenting skills and provision of psychosocial support services. Case Management services were provided through child, family, and community-focused strategies in coordination with other actors. In addition, the project provided support to children and caregivers including individualized PSS to children and their caregivers; parenting support to caregivers; and referrals to access medical and other basic services.

In a nut shell, ensuring that communities and people affected by crises in countries like Afghanistan are not negatively affected, and are more prepared, resilient, and less at-risk as a result of humanitarian action, requires additional engaging with and empowering of local actors, including community-based organizations and local authorities. This ensures that humanitarian action is contextually relevant, culturally sensitive, and involves the active participation of affected communities.

CHS 4: Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them. Quality Criterion: Humanitarian response is based on communication, participation, and feedback.

The key variables for CHS4 included the following:

1. How the participants accessed information about the project, and their entitlements
2. How the project engaged participants in decision making?
3. Measures taken to engage all different groups in the community and how their input is collected and reflected in the response and programme
4. Availability of groups that were excluded
5. Appropriateness of the communication, participation, and feedback

The participants accessed information about the project, and their entitlements in different ways, for example, project staff, including field workers and community mobilizers, were often deployed in project areas to work closely with beneficiaries (PLWs and HHs, children and people with disabilities). They provided information about the project, entitlements, and how to access them. Regular meetings and community gatherings were also organized where beneficiaries directly interacted with project staff.

Local leaders acted as intermediaries between WV and the communities. They disseminated information about the project, its goals, and the entitlements available to community members. They used their influence and communication networks to ensure that information reaches every individual in the community. In order to ensure that the right messages are passed, the project staff were trained to work in partnership with different stakeholders such as such as, religious and community leaders, opinion leaders and community shuras.

The project engaged participants in decision making through community meetings and consultations through community meetings stakeholders such as, religious and community leaders, opinion leaders, teachers, youth, community shuras, and representatives from other informal structures that are relevant to the context. Special attention was attached to marginalized groups, for example through identification of protection concerns, nutrition and sanitation requirements.

The Afghanistan Crisis Appeal project organized regular community meetings where participants provided input, discussed their needs, and made decisions collectively. This was done through open discussions, voting, or consensus-building processes

To engage all different groups in the community in the health, nutrition, WASH (water, sanitation, and hygiene), and protection, several measures were taken and these included; conducting comprehensive assessments to understand the specific needs of different groups within the

community. This helps in identifying their requirements and preferences, and tailoring the project accordingly. In addition, the Afghanistan Crisis Appeal project actively involved marginalized and vulnerable groups such as women, children, people with disabilities, and IDPs. In addition, the marginalized groups were encouraged to actively participate in decision-making processes regarding health, WASH, nutrition and protection projects. Their inclusion ensured that their specific needs and concerns are addressed appropriately. This was done through community meetings, social gatherings.
There was also regular monitoring and evaluation of the project to assess the inclusiveness of the interventions and identify any barriers or gaps in reaching all groups. This helped in adjusting strategies and enhancing the project's impact. For example, after discontinuation of output 2 (Affected community members have increased access to clean water, sanitation and hygiene services), remaining funds from this output have been reallocated to health, nutrition and protection activities. The communication, participation, and feedback mechanisms were appropriate since they enhanced community engagement, effectiveness and efficiency of the project. This is in line with the Theory of Change statement as follows:

> "*When the community actively participates and provides feedback, it ensures that the interventions are better tailored to their specific needs, preferences, and cultural contexts. This leads to increased acceptance and adoption of the project's initiatives, resulting in better health, nutrition, WASH, and protection outcomes".*

Additional engagement of community and carrying out of targeted campaigns to raise awareness about the rights and entitlements of individuals affected by the crisis is commended. This could involve disseminating information through various channels such as radio, television, social media, community meetings, and local organizations.

CHS 5. Communities and people affected by crises have access to safe and responsive mechanisms to handle complaints. Quality Criterion: Complaints are welcomed and addressed.

1. WV's feedback mechanism and how it inclusively meets the needs of different targeted beneficiaries
2. The aspect as to whether the feedback was in line with WV policy, welcomed and addressed
3. How the project monitored the flow of feedback and complaints mechanisms to ensure they are being used by a range of community members and to understand whether communities (particularly vulnerable children and marginalized groups) are satisfied with the system
4. How safe and inclusive were feedback mechanisms designed for different groups or communities

5. How the collected feedback contributed to the overall country humanitarian architecture (AAP) working groups?

KIIs with project staff and secondary data indicate that WV implemented regular monitoring and evaluation activities that helped to gauge the effectiveness of the health, nutrition, WASH, and protection interventions. This included collecting data on key performance indicators, and monitoring the progress made towards achieving project goals. The Afghanistan Crisis Appeal project actively sought feedback from the project beneficiaries to ensure that their needs and expectations were being met. This was consultative meetings and regular interactions with the project beneficiaries especially the PLWs and HHs and community leaders. The regular meetings and consultations held helped to gather their feedback, suggestions, and concerns, and to address any issues that may arise.

While the number of feedback received could not be ascertained, the feedback mechanisms were culturally sensitive and appropriate for the target groups or communities in Afghanistan. The feedbacks were addressed through DEC project redesign where significant changes were made to improve project functionality and overall effectiveness and these were made known to different stakeholder. This included considering social contexts, cultural norms, and local practices. Feedback mechanisms were designed in a way that respects and incorporates the cultural values and beliefs of the communities they serve. In a nutshell, the feedback helped in understanding the specific needs and gaps in the health, nutrition, WASH, and protection sectors. It provided valuable insights into the challenges faced by communities and helped identify areas that require immediate attention and adaptations. However, there was still need for additional widespread awareness campaigns to ensure affected communities are informed about the existence of complaint mechanisms and how to access them. This can be done by utilizing various communication channels, including radio, television, social media, and local community networks, to reach a wider audience. Given the fact that less than 15% of the community members had access to legal assistance, there is need to make sure that the complaint mechanisms are easily accessible to everyone, including marginalized populations and people with disabilities.

CHS 6. Communities and people affected by the crisis receive coordinated, complementary assistance. Quality Criterion: Humanitarian response is coordinated and complementary.

1. How well did the interventions fit with other partners' interventions?
2. Extent to which the interventions complemented each other
3. To what extent did the interventions complement or reinforce country priorities?
4. How WV’s intervention was compatible with other interventions in the country, sector, or institution

The interventions fit with other partners' interventions, such as the Health Cluster, Nutrition Cluster, WASH Cluster, and Protection Cluster. There are currently six clusters, including: Emergency Shelter and Non-Food Items (ES-NFI), Food Security and Agriculture (FSAC), Health, Nutrition, Protection and Water, Sanitation and Hygiene (WASH), as well as the Education in Emergencies Working Group. The Protection Cluster hosts four sub-clusters, including: Child Protection in Emergencies, Gender Based Violence, Housing, Land and Property Task Force and Mine Action[15]. To complete on this, timely primary health and nutrition care services were provided for the general population (88% of the target beneficiaries) and in particular for children under 5 years of age (CU5) and women in child bearing ages. A total of 2600 individuals accessed mental health or psychosocial support (MHPSS) in health programmes with 72% level of achievement. A total of 14,00 (100%) individuals with severe acute malnutrition (SAM) received treatment and while 89% of women and newborns received maternal and newborn care to through FHH.

CHS 7: Communities and people affected by crisis can expect delivery of improved assistance as organizations learn from experience and reflection. Quality Criterion: Humanitarian actors continuously learn and improve.

The key variables for CHS 7 included the following:

1. How WV promoted continuously learn and improvement
2. How often did the project convene joint meetings with community committees?
3. How the project documented consultation of outcomes, and used these outcomes to influence design and implementation of interventions
4. Extent to which the interventions adapted to the changing context

Promoting continuous learning in health, nutrition, WASH (water, sanitation, and hygiene), and protection interventions was done through training and capacity building opportunities for staff members and stakeholders involved in implementing these interventions. This included workshops and staff meetings. In addition, WV implemented a robust monitoring and evaluation system to regularly assess the progress, effectiveness, and impact of the interventions. This included collecting and analyzing data, conducting surveys and assessments, and finally involving external experts for independent evaluations. All WV staff had access to health, nutrition, WASH, and protection interventions data and all were encouraged to document and share their experiences through case studies and reports. The project adopted some modifications based on the situation, for example, b*ased on strategic discussions, in March 2023, between the WHO, UNICEF, health implementing NGOs and the Ministry of Public Health (MoPH), the Mobile Health and Nutrition*

[15] https://response.reliefweb.int/afghanistan/inter-cluster-coordination

Teams (MHNTs) are to change to Fixed Health and Nutrition Centres (FHNCs) to standardise services provided and improve accountability and transparency[16].

Continuous improvement and adaptation was conducted. There was regular review and reflection on the interventions, identify lessons learned, and adapt strategies and approaches based on new evidence and feedback. For example, as part of the process of adapting, the CBCPC was linked with the health and nutrition committees in the community and the school management committees in the schools.

CHS 8: Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. Quality Criterion: Staff are supported to do their job effectively and are treated fairly and equitably.

CH8 variables included the following:

1. How were project staff supported to implement interventions?
2. How were female staff supported to do their job/ implement interventions?
3. How effective were existing support structures/ resources (internal and external) to staff?

Project staff also received regular supervision and technical support from senior staff members. This ensured that they had guidance and assistance in implementing the project activities effectively. Supervision involved site visits, meetings, and regular communication to address any challenges, provide feedback, and ensure quality implementation.

Project staff were also provided with necessary resources, materials, and tools needed for the implementation of activities. This included medical equipment, health and nutrition supplies, WASH infrastructure materials, protection kits, educational materials, etc. Adequate provision of resources enabled staff to carry out their roles effectively.

WV created a supportive work environment which was important for the well-being of project staff. This included providing a safe and conducive workplace, ensuring their safety during field visits, and fostering a culture of respect and collaboration. One WV staff pointed out as follows:

"Building a strong team and providing opportunities for staff to share experiences and learning contributed to a supportive work environment".

WV put in place policies that promote gender equality and women's empowerment. These policies created a favorable environment for female staff to work and implement interventions without facing discrimination or barriers based on their gender. *F*emale staff members received specific training to enhance their knowledge and skills in the areas of health, nutrition, WASH,

[16] World Vision - DEC Project Redesigned

and protection. This training helped them acquire the necessary expertise to effectively carry out their responsibilities and implement project intervention.
WV established safe spaces for female staff members to work in. These safe spaces included designated female-only areas within offices or field sites, where female staff could comfortably engage with communities and beneficiaries

The health system was boosted with five (5) medical professionals (a doctor, midwife, nutrition nurse, a vaccinator, and a community health promoter), who together will manage the day-to-day operation of the FHNCs for the project life. Some of the existing support structures were supported with renovation and others constructed. As pointed out earlier, there was construction of 03 solar powered piped water networks at community level, conducted rehabilitation of 01 non-functional water systems in 01 communities and conducted water quality testing of 4 water systems (new and rehabilitated).

CHS 9: Communities and people affected by crisis can expect that the organizations assisting them are managing resources effectively, efficiently and ethically. Quality Criterion: Resources are managed and used responsibly for their intended purpose.

1. How well were resources managed or used?
2. How did the project safeguard against Do-No-Harm, PSEA among others?
3. How did the project protect beneficiaries' information/data?
4. How did the project adapt to implement interventions on time?
5. Was their value for money while delivering project interventions?

The first stage for enhancing proper resource utilization was the needs assessment to identify the specific requirements project beneficiaries. `WV staff ensured that resources were prioritized based on the identified needs and the project's goals and objectives. This involves allocating more resources to areas with the greatest needs or where they can have the most significant impact. The Afghanistan Crisis Appeal project developed a comprehensive and realistic budget that aligns with the project's objectives and priorities. This budget allocated resources for all necessary components such as personnel, equipment, supplies, training, and monitoring and evaluation. The project also implemented robust monitoring and evaluation systems to track the utilization of resources and assess the effectiveness and efficiency of interventions. This helps identify any resource wastage or areas where resource allocation needed adjustment.

The project safeguarded against Do-No-Harm and promoted a culture of Prevention of Sexual Exploitation and Abuse (PSEA). Clear policies and procedures that explicitly address Do-No-Harm and PSEA in all aspects of the project were developed and implemented. One project staff pointed out as follows:

“.......... Among the training provided with the aspects of Do-No-Harm and PSEA which included understanding the principles, recognizing signs of exploitation or abuse, reporting mechanisms, and consequences for non-compliance”

To protect beneficiaries’ information/data, privacy policy that outlines how beneficiary information is collected, used, and protected. The beneficiaries were made aware of the purpose and intended use of their data and obtained their informed consent. On a positive note, there were no exceptions to obtaining consent.

Besides, the project end date was extended from 30-June-2023 to 31 December- 2023 which enabled WV to deliver the revised activities outlined and also attain value for money. Value for money was achieved given the effectiveness, cost-effectiveness of the project's inputs (financial resources, staff, and infrastructure) and its achieved outputs and outcomes as per the logical framework.

Summary of Relevance, Effectiveness, Efficiency, Impact and Sustainability

Project Relevancy

Health Sector: Relevancy was measured against needs of the beneficiaries (PLWs and HHs, children and people with disabilities) and National Health Promotion Strategy 2014-2020 whose goal was to ensure increase in access to health services17. As indicated in the DEC Afghanistan Crisis Appeal Narrative Plan 2018, 18.1 million people were need health assistance, of which 3.19 million were children under 5 (CU5). The infant mortality rate was 46.5 per 1,000 births, the maternal mortality rate was projected to be 638 deaths per 100,000 births18. Herat, just like other provinces of Afghanistan was characterized numerous health challenges, including high infant mortality rates, maternal mortality rates, and prevalence of waterborne diseases. In 2017, Herat had a high rate of under five children (58 per 1000 live births) while this number was 55 per 1000 at national level[19]. In 2002, the maternal mortality ratio for Herat province was 593 maternal deaths/100,000 live birth[20] and Kushk (Rubat-i-Sangi) and Kushk-i- Kuhna were not of an exception. The Afghanistan Crisis Appeal Project was therefore, relevant to address the health challenges in Afghanistan and Herat province in particular. In support of this, one WV project staff noted as follows:

“Koshk-e-Kohne was an insecure place before 2021 and in new government when there become a bit safe NGOs could start their work there and they are really in need people for health and nutrition projects”.

---

[17] National Health Promotion Strategy 2014-2020

[18] DEC Afghanistan Crisis Appeal Narrative Plan

[19] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. Afghanistan Demographic and Health Survey 2015 (2015 AfDHS). January 2017. P131.

[20] Physicians for Human Rights@2002. Maternal Mortality: https://s3.amazonaws.com/PHR_Reports/afghanistan-herat-maternal-mortality-2002.pdf

Another project staff pointed out as follows:

> *The project was relevant because one of the biggest challenges in Afghanistan is health.*

Nutrition Sector: Afghanistan has one of the highest rates of chronic malnutrition globally, affecting a significant number of children[21].According to UN Office for the Coordination of Humanitarian Affairs, in 2002 Herat had a malnutrition rate of 26.4% and a severe acute malnutrition rate of 6.6 %[22]. The health intervention was therefore, relevant to enhance access to healthcare services, disease prevention and control measures, and strengthen the overall health system in the project area. This was done by establishment of three Mobile Health & Nutrition Teams to provide services across 170 villages[23]. KII with project staff and local leadership indicate that the Afghanistan Crisis Appeal project was relevant for improving access to nutritious food, promoting breastfeeding, and implementing interventions to prevent and treat malnutrition. Secondary data also indicate that the period between November 2022 and April 2023 was characterized by a significant deterioration in the acute malnutrition situation[24]

WASH Sector: KII with project staff revealed that initially, the in the two districts of Herat province (Kushke Kohna and Kushke Robatsani districts), access to clean water and proper sanitation facilities was severely limited, particularly in rural areas. This lack of access increases the risk of waterborne diseases, such as diarrhea, which can be fatal, especially for children. It was therefore relevant for the Afghanistan Crisis Appeal project to provide safe drinking water, adequate sanitation facilities, and hygiene education to prevent the spread of diseases and improve overall health.

Protection: Another project staff indicated that Herat province (Kushke Kohna and Kushke Robatsani districts) were initially affected by protracted conflict, displacement, and widespread violence, which posed threats to the safety, well-being, and rights of the population, particularly women, children, and vulnerable groups. It was therefore relevant to provide safe spaces psychosocial support and legal assistance to survivors of violence.

Project Effectiveness

Health Sector: Project effectiveness focused on the measure of how well the Afghanistan Crisis Appeal project achieved its objectives and delivered the desired outcomes. Accordingly, the project reached a total of 80,000 women, men and children with health and nutrition services (Men: 14,000, Women: 28000, boys: 18,000, Girls: 20,000). For each FHNC, WV installed four (4)

[21] UNICEF 2019 - "Afghanistan: Nutrition" - https://www.unicef.org/afghanistan/nutrition
[22] https://reliefweb.int/report/afghanistan/afghanistan-maslakh-nutritional-survey-draws-criticism
[23] World Vision Afghanistan: https://www.wvi.org/stories/afghanistan/mobile-health-and-nutrition-team
[24] Terms of Reference, Disaster Emergency Committee (Dec) Project Evaluation, V4. 12 July 2023

Conex/containers and 2 separate portable latrines (1 for men and 1 for women). As part of the referrals, the project covered the transportation costs and the treatment costs, where necessary. The project ensured that the 22 FHHs meet the revised MoPH standards for the FHHs, such as diagnosis and treatment of Malaria, treatment of Leishmania, as well as first aid support for injuries and checking vital signs for the general population. In addition, the project provided maintenance and renovation of the centers to provide a conducive environment for the staff to demonstrate their skills and to the beneficiaries who are using the FHHs. CU5 in drought-affected and remote areas were supported in receiving treatment for critical cases of SAM through inpatient care services through cash transfers. However, the cash intervention was dropped due to the increased costs. One project staff was quoted as follows:

"*90 % of the people got better now, before they didn't want to vaccine but now they themselves are calling us for vaccine".*

A PLWs from village: Kolari pointed out as follows:

> *"Yes, during pregnancy, the midwife examines us and tells us what to eat and not to lift heavy objects and what to do during pregnancy."*

A total of five (5) WASH groups were established and trained in the targeted villages. Each group consisted of 10 members (3 women, 6 men 1 male/female with a disability). Sensitization and coordination meetings were held with district elders and community leaders for better facilitation and implementation of WASH activities and establishing WASH groups. Hygiene promotion training was conducted for the five (5) WASH groups, training 50 people (30 males and 20 females). The trained WASH groups conducted hygiene promotion that reached 2,214 individuals (608 women, 655 men, 372 boys and 579 girls). An estimated 82% of the total beneficiaries (12250) in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) had improved access to safe water, hence reducing the risk of waterborne illnesses such as diarrhea, cholera, and typhoid.

A total of 2600 individuals benefited from mental health or psychosocial support (MHPSS) in protection programmes (1300 in Kushk-i- Kuhna and another 1300 in Kushk- Rubat-i-Sangi). Vulnerable and at-risk Children and adults reached with protection services and information, in Kushka Kohna and Kushka Rabat Sangi districts of Herat Province. The animators organized the PSS sessions where: (1) WV had the SAM and MAM children; and (2) WV provided maternal and infant activities through the FHNCs.

Project Efficiency

Project staff were also provided with necessary resources, materials, and tools needed for the implementation of activities. This included medical equipment, health and nutrition supplies, WASH infrastructure materials, protection kits, educational materials, etc. Adequate provision of

resources enabled staff to carry out their roles effectively. There were no budgetary challenges in terms inadequacy and misappropriation.

Project Impact

The Afghanistan Crisis Appeal Project led to increased access to the health and nutrition services, increased access to clean water, sanitation, and hygiene services and vulnerable and at-risk Children and adults reached with protection services and information, in Kushka Kohna and Kushka Rabat Sangi districts of Herat province. For example, a total of 12250 individuals constituting 82% achievement in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts had improved access to safe water, hence reducing the risk of waterborne illnesses such as diarrhea, cholera, and typhoid. In the context of this evaluation, people with increased access to these services are more likely to lead healthier lives, have higher life expectancies, and experience improved overall well-being.

One project staff noted as follows:

> *"There huge difference in our community, for example, before intervention of project there was no health facility, no one knew about nutrition and vaccination, nor after intervention people understand about all"*

A total of 5200 individuals constituting 72% of the target sample accessed mental health or psychosocial support (MHPSS) in health programmes. Overall, mental health or psychosocial support (MHPSS) enhanced mental well-being, reduced psychological distress, facilitated recovery and resilience, and helped prevent long-term mental health issues, and promoted community recovery and resilience leading to overall quality of life.

In addition, the Afghanistan Crisis Appeal Project led to reduction in severe acute malnutrition (SAM). A total of 1400 individuals received treatment for severe acute malnutrition (SAM) in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts constituting 100% of the target sample while 600 (100%) were sensitised around nutrition requirements for U5s and PLWs. By reducing severe acute malnutrition, sustainable development goals such as ending poverty, ensuring food security, achieving good health and well-being, and promoting gender equality can be achieved. The Afghanistan Crisis Appeal Project was therefore, an integral part of creating a sustainable and prosperous future for all.

Increased attention and investments in maternal and newborn care contributed to the upward trend in more women and newborns receiving these essential healthcare services. Accordingly, a total of 3365 women and newborns received maternal and newborn care through FHH in both Kushk-i- Kuhna and Kushk (Rubat-i-Sangi) districts constituting 89% achievement.

A total of 6615 households were provided with hygiene kits. Through KII with project staff and some local leadership, hygiene kits helped prevent the spread of diseases by providing essential items that promote proper hand hygiene, personal cleanliness, and sanitation.

Sustainability

The project was implemented within the existing health structures which expected to last for a long time. The project team in partnership with community leaders and existing community structures that include the village Shura, faith leaders and Water Management Committees to enhance sustainability. The capacity building of health facility staff played a crucial role in the success and sustainability of health, nutrition, WASH, and protection projects and this knowledge was transferred to communities for future implementation. Training and equipping local staff, healthcare workers, and community members with the necessary knowledge and skills is vital for the continued operation of the projects and for the communities to maintain the positive changes achieved. The supported communities are anticipated to continue with positive health behaviour practices, hence enhancing project sustainability. In addition, availability of traditional midwifery is likely to lead to project sustainability. In KII with one project staff, it was pointed out that traditional midwifery has a long history in Afghan culture, and many women continue to rely on these experienced birth attendants for childbirth and postnatal care. These traditional midwifes enhanced their knowledge because they were watching the recommended methods of delivery management which is likely to go on in the future. This therefore, means that while traditional midwives offer valuable support, there is also a need to integrate their practices with modern healthcare services to ensure safe and effective maternal and neonatal care.

Project Challenges

Acceptance and Cooperation: Gaining acceptance and cooperation from the government officials and communities was difficult due to ideological differences and potential skepticism towards external interventions. Building trust and rapport with local authorities and communities was crucial for successful implementation. In order to enhance acceptance, the project team organized introductory meetings with local leaders and existing community structures, including Shura village, religious leaders and water management committees, and guides them on cross-cutting issues such as conservation, gender and inclusion. Awareness raising and information dissemination targeted the entire community, delivering messages that included ways to refer vulnerable or marginalized groups to appropriate help through cross-sector coordination with colleagues in conservation, health and nutrition.

Limited transportation and communication networks: The country's rugged terrain and limited transportation and communication networks posed challenges in reaching remote areas with vital health and nutrition services. These conditions also made it difficult to transport necessary equipment, supplies, and medical personnel to the affected locations.

Extreme weather conditions: Afghanistan experiences extreme weather conditions, including droughts, harsh winters, and flash floods, which to some extent disrupted access to clean water, sanitation facilities, and healthcare services. These weather challenges resulted in an increased risk of waterborne diseases, malnutrition, and other health-related issues

Cultural Sensitivity: Afghanistan has a conservative cultural and social context that influenced the acceptance and implementation of health, nutrition, WASH, and protection programs. To ensure acceptance, the interventions were designed with sensitivity to local cultural practices and beliefs to ensure acceptance and maximize impact. This was done through involvement of local community leaders/shuras and stakeholders to ensure cultural appropriateness and help gain community acceptance. In Afghanistan's conservative and patriarchal society, engaging with male colleagues, community leaders, and beneficiaries was challenging for female staff. Cultural norms regarding female interactions with males impacted on their ability to gain trust and deliver services.

Staff turnover and identification of the qualified health personnel was among the top foreseen challenges. To ensure there are enough human resources for health and other sectors, WV developed a bulk recruitment approach, which allowed the programmes to identify an appropriate number of human resources to join the response. In addition, as part of the response, WV ensured that new staff receive proper orientation, continued supervision and development and ensure timely project implementation based on the accepted project standards.

Inflation rate and currency fluctuation: a significant currency fluctuation was observed since the collapse of the previous government and it had a potential impact on project implementation and costs of project materials and inputs such as fuel, rental vehicle costs, pharmaceuticals, etc.

The ongoing war between Russian and Ukraine further impacted the supply routes and the cost of various supplies.

Shortage of nutrition supplies: may have caused a significant impact on quality of the nutrition curative services. To ensure adequate stock, in addition to supplies received from UNICEF and WFP, coordination is done with these organisations to receive and provide adequate quantity of nutrition supplies. WV requested nutrition supplies through its GIK programme to ensure timely availability of adequate supplies to meet the requirement of the different projects across the targeted districts.

Evaluation challenges:

- ✓ In most parts of the Koshk Kohna female data collectors were not allowed to ask questions when they were alone. These restrictions stem from traditional beliefs aimed at preserving conservative social norms and ensuring the safety and reputation of women.
- ✓ Both male and female respondents did not allow to record their voice in KII and FGD. In Afghan society, there are conservative cultural and traditional norms that discourage individuals, particularly women, from participating in public activities that may expose their identity, such as recording their voices.
- ✓ Most of the villages were quite far from the center of the district and access to these areas was a big challenge for the evaluation team.

Lessons Learnt

A number of lessons were learnt the Afghanistan Crisis Appeal project and these included the following:

One of the lessons learned is "need for integrated approach", because these sectors are interconnected and have a significant impact on each other. An integrated approach can maximize resources, strengthen coordination, and ensure that interventions are mutually reinforcing, leading to better health, improved WASH infrastructure, proper nutrition, and enhanced protection for all individuals and communities.

Importance of community engagement and participation: One of the main lessons learnt from health, nutrition, WASH (water, sanitation, and hygiene), and protection projects in Afghanistan is the significance of involving and engaging the local communities. By including the community in the project planning, implementation, and monitoring, it ensures that the interventions are culturally appropriate, meet the actual needs of the people, and are sustainable in the long term.

Need for integrated approach: Another important lesson learnt is the effectiveness of an integrated approach in addressing health, nutrition, WASH, and protection issues. These sectors are interconnected and addressing them separately might result in limited impact. By integrating interventions across these sectors, a more holistic approach can be taken, leading to better health outcomes for the population. However, managing an integrated approach for a health, nutrition, and protection project can be challenging, but with proper planning and coordination, it can be effectively implemented. This can be through clear definition of project objectives, identification of key stakeholders, conduct a needs assessment, develop an integrated work plan and establishment of coordination mechanisms. National and local health departments can play an important role in implementing integrated approaches by coordinating programs and policies across different sectors.

Importance of capacity building: Capacity building plays a crucial role in the success and sustainability of health, nutrition, WASH, and protection projects. Training and equipping local

staff, healthcare workers, and community members with the necessary knowledge and skills is vital for the continued operation of the projects and for the communities to maintain the positive changes achieved.

Resilience building: Working in a challenging context like Afghanistan requires a focus on resilience building. Health, nutrition, WASH, and protection projects need to incorporate strategies that help communities withstand and recover from shocks and stresses, such as conflict, natural disasters, or epidemics. This includes strengthening healthcare systems, establishing early warning systems, and promoting community-based disaster preparedness.

Gender mainstreaming: Lessons learnt show the importance of gender mainstreaming in health, nutrition, WASH, and protection projects. Gender disparities exist in access to and control over resources and services, and addressing these disparities is essential for achieving improved health outcomes. Projects need to ensure equal participation and benefits for both men and women, and include gender-sensitive approaches in all aspects of the interventions.

Monitoring and evaluation: Effective monitoring and evaluation mechanisms are crucial for measuring the impact and effectiveness of health, nutrition, WASH, and protection projects in Afghanistan. Regular monitoring allows for timely adjustments and improvements, while evaluation provides evidence of the project's success and lessons learnt for future interventions. These processes help ensure accountability and transparency in the use of resources and contribute to evidence-based decision -making.

Collaboration and coordination: Health, nutrition, WASH, and protection projects require collaboration and coordination among different stakeholders, including government agencies, NGOs, and international organizations. Lessons learnt emphasize the importance of establishing strong partnerships, sharing resources and expertise, and avoiding duplication of efforts. Collaboration at all levels helps maximize the impact and reach of the projects and ensures a comprehensive response to the needs of the communities.

Conclusions

The health, nutrition, WASH, and protection project in Herat made significant progress in improving the well-being and overall health of the population. The project's focus on health enhanced access to healthcare services, vaccinations, and awareness campaigns. The nutrition component of the project successfully addressed malnutrition and stunting in children through screening, the provision of nutritious food, supplements, and educational programs on healthy eating. WASH interventions have effectively improved access to clean water, sanitation facilities, and hygiene practices, leading to a decrease in waterborne diseases and improved overall hygiene standards in communities. On the other hand, the protection component of the project succeeded in ensuring the safety and well-being of vulnerable populations, including women, children, and elderly, by providing support, advocacy, and access to legal services. Lastly, the

project engaged local communities, empowering them to take ownership of their health, nutrition, hygiene, and protection needs through community-based initiatives and training programs.

Recommendations

1. Ensuring that communities and people affected by crisis receive appropriate and relevant assistance in a country like Afghanistan requires a comprehensive and collaborative approach involving multiple stakeholders. These include; further needs assessment, local community engagement, collaboration with NGOs and Humanitarian Organizations and contextualize the assistance.
2. Ensuring that communities and people affected by a crisis have access to timely humanitarian assistance requires a multi-faceted approach involving coordination, collaboration, and a deep understanding of the local context. Some strategies that can be employed include; further coordination collaboration with relevant stakeholders, engagement with local communities and capacity building of local organizations and institutions to deliver assistance effectively.
3. Ensuring that communities and people affected by crises in countries like Afghanistan are not negatively affected, and are more prepared, resilient, and less at-risk as a result of humanitarian action, requires additional engaging with and empowering of local actors, including community-based organizations and local authorities. This ensures that humanitarian action is contextually relevant, culturally sensitive, and involves the active participation of affected communities.
4. There is need for integrating resilience-building measures into humanitarian action, focusing on strengthening community resilience to future shocks and stresses. This can include improving access to basic services, supporting livelihood opportunities, promoting social cohesion, and supporting infrastructure that withstands natural disasters.
5. To make Communities and people affected by crisis know their rights and entitlements, this should start raising awareness in affected communities about their rights and entitlements. This can be done through public information campaigns, community meetings, and workshops. Use various channels such as radio, television, posters, and social media to disseminate information.
6. Given the limited access to medical services, there is a need for investing in mobile health clinics or establishing health centers that can increase access to medical care and provide basic health services to communities that are otherwise underserved.
7. Malnutrition is a significant public health issue in Afghanistan which needs to be improved further. This can be done by raising awareness about the benefits of breastfeeding and providing support to mothers to initiate and sustain breastfeeding. This can be done through counseling, training healthcare providers, and creating breastfeeding-friendly environments. Women and children can also be provided with essential micronutrient

supplements such as iron, folic acid, and vitamin A, particularly during pregnancy and early childhood. These supplements can address deficiencies that may arise due to limited dietary diversity.

8. Given the fact that there were still some HHs with limited access to clean drinking water and sanitation facilities, there is a critical need to expand access to clean drinking water and sanitation facilities. This can be done by investing in building and refurbishing more water supply systems, wells, boreholes, and pipelines to provide clean drinking water to communities across the country.

9. Additional efforts are needed for educating and promoting proper hygiene practices in rural communities that can have a significant impact on reducing illnesses. This can be done by involving community leaders, religious leaders, and local influencers in promoting hygiene practices. These individuals hold a strong influence in rural communities and can help spread the message effectively.

10. While substantial progress was achieved in enhancing malnutrition, there is a need for improving access to nutritious food, providing nutritional supplements, and conducting nutrition education campaigns in order to combat malnutrition and enhance the overall health of vulnerable populations.

11. Additional initiatives that focus on improving prenatal care, safe delivery practices, and access to essential healthcare services for women and children can save lives and improve health outcomes. This can be done by additional efforts to promote early and regular prenatal care visits for pregnant women. There is also a need for additional efforts to educate women and their families about the importance of prenatal care, nutrition, and hygiene practices. This could include initiatives such as community-based antenatal care programs and mobile health clinics.

12. Given the fact that some HHs missed out on PSS, implementing programs that provide mental health support, trauma counseling, and psychosocial services can help alleviate the burden of psychological distress and enhance overall well-being. In addition, there is a need for more initiatives that focus on prevention, awareness-raising, and strengthening support services for survivors of violence can help create safer communities and improve overall well-being.

13. Enhancing child protection in Afghanistan requires a comprehensive approach involving various stakeholders, including the government, non-governmental organizations (NGOs), communities, and individuals. Here are some strategies that can help enhance child protection in Afghanistan: The government need to be engaged to enact and enforce robust laws that protect children from abuse, neglect, exploitation, and violence. This includes ratifying and implementing international conventions and protocols related to

child protection. There is also need to improve child welfare services: Establish and strengthen child protection services, including child helplines, safe shelters, and counseling centers, where children can report abuse or seek help. Provide adequate training and resources to social workers and child protection professionals.

14. Future interventions need to focus on child protection initiatives to prevent and respond to various forms of child abuse, neglect, exploitation, and violence. Some common child protection initiatives include establishment of laws and policies, child helplines and hotlines, child-friendly spaces, awareness campaigns and child protection training and capacity-building.

Presentation of Output Table

Planned Output	Sector	Indicator	Admin level 1	Admin level 2	Location type			
#output	#sector	#indicator	#adm1	#adm2		Final Target	Achievement	%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	No. of individuals accessing basic health services [specify type]	Herat	Kushk-i-Kuhna	Host	40000	35200	88%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages			Herat	Kushk (Rubat-i-Sangi)	Host	40000	35200	88%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	No. of individuals accessing mental health or psychosocial supp ort (MHPSS) in health programmes	Herat	Kushk-i-Kuhna	Host	3600	2600	72%

Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	No. of individuals accessing mental health or psychosocial supp ort (MHPSS) in health programmes	Herat	Kushk (Rubat-i-Sangi)	Host	3600	2600	72%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	No. of health facilities supported/rehabilita ted [specify how …]	Herat	Kushk-i-Kuhna	Host	0	0	0
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	No. of health facilities supported/rehabilita ted [specify how …]	Herat	Kushk (Rubat-i-Sangi)	Host	0	0	0
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutriti on	No. of individuals screened for malnutrition	Herat	Kushk-i-Kuhna	Host	8000	8000	100%

Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutriti on	No. of individuals screened for malnutrition	Herat	Kushk (Rubat-i-Sangi)	Host	8000	8000	100%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutritio n	No. of individuals with severe acute malnutrition (SAM) receiving treatment	Herat	Kushk-i-Kuhna	Host	700	700	100%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutriti on	No. of individuals with severe acute malnutrition (SAM) receiving treatment	Herat	Kushk (Rubat-i-Sangi)	Host	700	700	100%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutriti on	No. of individuals sensitised around nutrition requirements for U5s and PLWs	Herat	Kushk-i-Kuhna	Host	300	300	100%

Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Nutriti on	No. of individuals sensitised around nutrition requirements for U5s and PLWs	Herat	Kushk (Rubat-i-Sangi)	Host	300	300	100%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	#of women and newborns who received maternal and newborn care to through FHH	Herat	Enjil	Host	840	748	89%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	#of women and newborns who received maternal and newborn care to through FHH	Herat	Ghoryan	Host	2940	2617	89%
Timely primary health and nutrition care services are provided for the general population and in particular for children under 5 years of age (CU5) and women in child bearing ages	Health	#of women and newborns who received maternal and newborn care to through FHH	Herat	Karrukh	Host	2940	2617	79%

Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of water points rehabilitated/ constructed	Herat	Kushk (Rubat-i-Sangi)		0	0	0
Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of water points rehabilitated/ constructed	Herat	Kushk-i-Kuhna		0	0	0
Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of HHs with access to a source of safe drinking-water [by source or provision type]	Herat	Kushk (Rubat-i-Sangi)		9800	6272	63%
Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of HHs with access to a source of safe drinking-water	Herat	Kushk-i-Kuhna		2450	6174	100%
Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of HHs provided with hygiene kits containing […]	Herat	Kushk (Rubat-i-Sangi)		4900	4410	90%
Affected community members have increased access to clean water, sanitation and hygiene services	WASH	No. of HHs provided with hygiene kits containing […]	Herat	Kushk-i-Kuhna		2450	2205	90%

Annexes:

Annex 1: List of key documents reviewed

Annex 2: List of Semi-structured questions for KII Interviews

Annex 3: Survey questionnaires