



Impact evaluation of UNICEF Afghanistan's Mother and Child Cash Transfer (MCCT) Programme 2024-2025

Inception Report

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Acronyms and Abbreviations

ACO	Afghanistan Country Office
ADB	Asian Development Bank
AFG	Afghanistan
AFN	Afghani
AI	Artificial Intelligence
ANC	Antenatal Care
BCM	Beneficiary Contact Monitoring
BPHS	Basic Package of Health Services
CAPI	Computer Assisted Personal Interview
CBA	Cash-Based Assistance
CFM	Community Feedback Mechanisms
CWG	Cash Working Group
DFA	De facto authorities
DID	Differences-in-Differences
EPHS	Essential Package of Hospital Services
EQA	External Quality Assessment
ET	Evaluation Team
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
GDPR	General Data Protection Regulations
GEEW	Gender Equality and the Empowerment of Women
GEEWG	Gender Equality and the Empowerment of Women and Girls
GEROS	Global Evaluation Reports Oversight System
GPS	Global Positioning System
GRM	Grievance redress mechanism
HCF	Healthcare facilities
HER	Health Emergency Response
HH	Household
HQ	Headquarters
IE	Impact Evaluation
ILO	International Labour Organisation
IP	Implementing Partners
IPW	Inverse Probability Weighting
IRB	Institutional Review Board
KAP	Knowledge, attitudes and practices
KFW	Kreditanstalt für Wiederaufbau
KII	Key Informant Interview

LTA	Long-Term Agreement
MAM	Moderate Acute Malnutrition
MCCT	Mother and Child Cash Transfer
MEB	Minimum Expenditure Basket
MICS	Multi-Indicator Cluster Survey
MNH	Maternal and Newborn Health
ODK	Open Data Kit
OECD-DAC	Organisations for Economic Cooperation and Development-Development Assistance Committee
PDM	Post-Distribution Monitoring
PHC	Primary Healthcare
PLW	Pregnant and Lactating Women
PMD	Planning, Monitoring and Data
PMU	Project Management Unit
SAM	Severe Acute Malnutrition
SBCC	Social and Behaviour Change Communication
SOP	Standard Operating Procedure
SWAP	System Wide Action Plan
TCTR	Total Cost to Transfer Ratio
TOC	Theory of Change
TOR	Terms of Reference
UNAMA	United Nations Assistance Mission in Afghanistan
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNDSS	United Nations Department for Safety and Security
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Emergency Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNU-MERIT	United Nations University Maastricht Economic and Social Research Institute on Innovation and Technology
UNU-WIDER	United Nations University World Institute for Development Economics Research
USAID	United States Agency for International Development
USD	United States Dollar
VSNU	Universiteiten van Nederland
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

1. Introduction

Households in Afghanistan face multi-sectoral and multi-dimensional challenges to their lives and livelihoods. Despite cautious emergence of signs of optimism related to macro-economic stability, food security and political stability, humanitarian assistance plays an essential and fundamental role in promoting and protecting lives. Among the most vulnerable portion of the population are children; fulfilment and promotion of their rights are largely dependent on their caregivers. As part of their critical contribution to the coordinated transitional assistance in Afghanistan, UNICEF Afghanistan has placed a renewed emphasis on the first 1,000 days of life under two years of age. Recent data, including the Multiple Indicator Cluster Survey (MICS), have highlighted the extent of the risks facing children and their mothers during this critical phase of life – a phase that pays economic and social dividends throughout the rest of their lives.

In partnership with the Asian Development Bank and other development partners, UNICEF Afghanistan has developed a multi-sectoral cash transfer programme – the Mother and Child Cash Transfer (MCCT) – to deliver essential cash transfer and Social and Behavioural Change engagement to pregnant and lactating women (PLW) and mothers of children under two years of age. Cash transfers of up to 20 USD (United States Dollar) per month will be delivered quarterly to all eligible households within eligible districts for a period of 18 months. In addition, the MCCT programme will consist of Social and Behavioural Change engagement conducted at community level in eligible districts. This engagement will seek to increase utilisation of healthcare facilities, increase compliance with ante and post-natal check-ups and immunisation, as well as the adoption of optimal feeding strategies and purchase of nutritious commodities. All eligible households – those with a pregnant or lactating woman or with a child under the age of two – in an eligible district will be registered to receive the transfer. The MCCT will be implemented in four provinces: Kunar, Badghis, Samangan and Zabul. The provinces and districts eligible for the MCCT were identified on the basis of a multi-stage selection process. Provinces were identified on the basis of four indicators, with rank position used to generate an index of eligibility, with districts selected on the basis of the prevalence of Global Acute Malnutrition (GAM) at district level¹. In the selection of both provinces and districts, accessibility and security concerns played a role in selection, as did the need to ensure no overlap with a similar cash transfer programme implemented by the World Food Programme (WFP) and World Bank (WB).

As part of their commitment to ensuring accountability to affected populations, and in line with UNICEF's revised evaluation policy, UNICEF Afghanistan has commissioned an independent impact evaluation of the MCCT programme. The purpose of the impact evaluation is to assess the MCCT programme's achievement of its intended outcomes, while also evaluating programme design and implementation against OECD-DAC criteria, integrating cross-cutting dimensions, identifying and measuring – to the extent possible -

¹ Province selection was performed on the basis of a composite score based on rank position in multiple dimensions: Multi-Dimensional Poverty indicator (Income, Expenditure and Labor Force Survey, 2020), Stunting (MICS 2022-2023), neo-natal mortality rate (MICS 2022-2023), infant mortality rate (MICS 2022-2023), proportion of married women by number of antenatal care visits (MICS 2022-2023). The selection of Provinces does not follow rank dominance precisely as some Provinces were considered ineligible due to, *inter alia*, security reasons and the remaining Provinces were shared between WFP and UNICEF. Districts within selected Provinces were selected on the basis of the Global Acute Malnutrition rate. Similar to the Province selection process, the selection of Districts does not precisely follow rank dominance as some Districts were considered ineligible due to, *inter alia*, insecurity or inaccessibility.

unidentified outcomes, and deriving lessons and best practices applicable to future social protection programming in Afghanistan. In addition, the evaluation is expected to generate rigorous academic papers which can partially bridge the paucity of rigorous evidence generated in fragile and conflict-afflicted areas. The evaluation has a number of specific objectives, which in turn inform the evaluation matrix that guides the evaluation. **The specific objectives of the impact evaluation are the following:**

- **Relevance of the MCCT design and implementation:** To assess the extent to which the programme design, and implementation are relevant, coherent and appropriate for the needs of beneficiaries. To demonstrate opportunities for improving the design and implementation of MCCT and similar programmes in Afghanistan.
- **Programme effectiveness:** To evaluate the effectiveness of the programme in achieving its desired results. To identify strengths and weaknesses, internal and external factors, including enablers and barriers, and lessons learned from the implementation of the MCCT programme.
- **Programme impact and achievement of results:** To assess the extent to which the programme has an impact on beneficiary households. To identify the pathways through which the programme achieved its intended (and unintended, if any) results.
- **Sustainability of the programme:** To assess the financial and political sustainability of the programme in the medium and long term.
- **Programme cost-efficiency:** To assess the extent to which the programme efficiently utilized inputs to conduct activities to achieve the results.
- **Integration of cross-cutting areas:** To examine the integration of gender, disability, equity, and human rights in the programme design and implementation.
- **Collaboration and coordination:** To assess the programme's collaboration and coordination with key stakeholders and partners, and determine their influence on the programme's results.

The intended users of the evaluation include, but are not limited to, the UNICEF Afghanistan Country Office, the UNICEF Regional Office of South Asia, UNICEF global users, humanitarian and development actors operating in Afghanistan and other similar fragile and conflict afflicted areas, as well as the de facto authorities.

The evaluation is expected to cover the duration of the programme, which was expected to be January 2024 to approximately May 2025. However, due to circumstances outside the control of UNICEF Afghanistan, the implementation of the programme has been delayed.

The impact evaluation will employ **mixed methods approach**. The use of a mixed-methods approach enables a greater depth in the evaluation, and permits the **triangulation** of results identified in the impact evaluation. Within the quantitative component, a quasi-experimental design will utilize **differences-in-differences with an inverse-probability weighting (IPW)** approach to generate evidence on the effectiveness of the intervention and its impact on the target population. The impact evaluation will be **utilization-focused**, and will adopt a **participatory approach**, alongside integration of cross-cutting issues such as **gender, human rights, disability, and equity** across all stages. The evaluation is supported by primary data collection of both qualitative and quantitative data from households across treatment provinces. The quantitative and qualitative survey tools will operationalise the evaluation matrix and MCCT logframe to the extent possible. Quantitative data collection will take place over three waves, with a panel approach envisaged. A first wave will be conducted prior to the implementation of the MCCT and will constitute the baseline, with a second wave approximately six months later, and a third wave at the end of the

programme. Data will be collected from treatment and control districts. Qualitative data collection will take place concurrently with the baseline and the endline quantitative data collection waves. Data will be collected from women in treatment and control districts through Focus Group Discussions. Key informant interviews, programme documentation, financial information and academic literature will play an essential supporting role in triangulating and adding credibility to findings and recommendations.

In addition, working in collaboration with UNICEF Afghanistan Country Office (ACO), the Evaluation Team (ET) from UNU-MERIT (United Nations University Maastricht Economic and Social Research Institute on Innovation and Technology) has proposed a series of intense household nudges to a specific sub-set of the quantitative evaluation sample. These intensive sessions will deliver nudges framed through a gender power dynamic lens, and the proposed evaluation design allows to the ET to test whether intensive household nudges have an effect on utilisation of healthcare services over and above provision of cash and cash complemented by community-level social behavioural change engagement.

The rest of the inception report proceeds as follows: Section 2 provides additional information on the background and context, focusing on the situation in Afghanistan, and gives a more detailed overview of the MCCT programme, including the theory of change and monitoring framework. Section 3 presents the impact evaluation's purpose, objectives, and scope. Section 4 outlines the evaluation framework covering evaluation criteria and questions. Section 5 covers the impact evaluation methodology, focusing on approach and methods; data and information sources and collection methods; sample size and sampling; data analysis; risks, limitations and mitigation strategies; quality assurance; ethical considerations; and management arrangements. Section 6 consists of a proposed workplan and list of deliverables.

2. Background and context

2.1. Situation in Afghanistan

Households and individuals in Afghanistan currently face intense cultural, political and economic vulnerabilities that result in a significant risk of harm to a multi-dimensional spectrum of well-being domains. Afghanistan remains both a protection and protracted emergency, with more than 20 million people in need of humanitarian assistance (UNOCHA, 2024). In the first half of 2023, 29.2 million people were in need of humanitarian assistance. While estimates suggest that the number of people in need of humanitarian assistance will fall in 2024, it remains more than half of the population. Food insecurity and health deprivations were among the largest sources of humanitarian need in 2023 – 19.1 million people required food security assistance and 17.6 million required health assistance in the first six months of 2023 (UNOCHA, 2023). While in 2024 the number of people expected to require food security assistance has fallen to 15.8 million, this should be interpreted cautiously. Agricultural output may rise or fall as a result of El Nino: additional rainfall will potentially increase output of winter crops, but heavy precipitation can also cause floods and landslides that lead to crop destruction, increased livestock mortality and thus impacting human health and nutrition (FAO, 2023). Moreover, other socio-economic conditions are still expected to play a key role in mitigating access to food in the marketplace and therefore high poverty rates, and high unemployment remain a concern in achieving food security (UNOCHA, 2024). The number of people expected to require health assistance has risen to 17.9 million, with high burdens of trauma and disease and the world's highest rates of maternal and under 5 mortality rates (UNOCHA, 2024).

Maternal and child health is facing a perfect storm in Afghanistan: marked and sudden increases in poverty as well as drought in 2022 have led to a concerning increase in malnutrition and malnourishment rates,

while severe restrictions imposed on female autonomy in the wake of regime change in summer 2021 may limit the ability of women to seek appropriate maternal healthcare. Findings from the 2022-2023 Multiple Indicator Cluster Survey (MICS) data highlight the extent of the risk a child born in Afghanistan faces. Nationally, the under-5 mortality rate over the past four years prior to the survey was 55 per 1,000 live births with a neonatal mortality rate of 24 over the same period. There is significant provincial heterogeneity. In the four provinces where the MCCT is currently expected to take place, the under 5 mortality rate is below the national average in Kunar (53 per 1,000 live births), Badghis (49) and Samangan (49), and substantially above average in Zabul (80). Similarly, the neonatal mortality rate is above average in Zabul (38 per 1,000 live births) and below average in Kunar (23), Samangan (17) and Badghis (21) (UNICEF, 2023a). While just over three quarters of women had at least one antenatal visit by a skilled provider nationally, the proportion of women having the recommended four or more antenatal care visits falls to one third (UNICEF, 2023a). There is also significant regional variation. In provinces where the MCCT is currently expected to take place, antenatal care coverage was below the national average in Kunar (at least one antenatal care (ANC) visit - 58; at least 4 ANC visits - 16), Samangan (70; 18), Zabul (66; 13) and Badghis (40; 9) (UNICEF, 2023). Coverage of post-natal care follows a similar pattern, though with overall much lower coverage rates – nationwide, slightly above one third of respondents reported postnatal care within two days for either mother or child (UNICEF, 2023). Regionally, access to post-natal care for either mothers or new-borns was higher than the national average in Kunar (62 and 67 respectively), but lower in Samangan (33; 32) and Zabul (13; 15). Access in Badghis was approximately consistent with the national average (UNICEF, 2023a).

Uptake of healthcare, including ante and post-natal care is a function of a broad range of determinants (Herwansyah et al., 2022), including female decision-making autonomy (Hou & Ma, 2013) and socio-economic status (Goudet et al., 2018; Mumtaz et al., 2019). A study in Afghanistan found that a household's urbanity, wealth and access to transport were significant determinants of maternal healthcare utilization (Mumtaz et al., 2019), corroborating the literature. In addition, ante and post-natal maternal nutritional status is associated with long-term child development, growth and health outcomes (Black et al., 2013).

Low basic and full immunization rates (UNICEF, 2023a) may lead to a life course marked by health complications in an environment characterised by weak health systems and limited health infrastructure (UNOCHA, 2024). Nationwide, just over one third of children aged 12 to 23 months received a basic course of vaccinations, falling to 16% of children aged 24 to 35 months receiving a full course of immunization; more than a quarter of children aged 24 to 35 months nationwide received no vaccinations (UNOCHA, 2024).

As the number of people in need rises, so do the rates of malnutrition and malnutrition-adjacent indicators. The situation of children may be more precarious; the fulfilment of their right to be free from hunger and thirst is often entirely dependent on others and our quantitative understanding of intra-household dynamics on food sharing is limited (Black et al., 2013; Silwal et al., 2020). Data from the 2022-2023 MICS show relatively high stunting rates. Nationally, approximately 45% of children are stunted – up to 61% in Zabul (UNICEF, 2023a). Rates of wasting are similarly of concern, with approximately 4% of children wasted (UNICEF, 2023a).

A review of the global literature on the effectiveness of cash transfers provides an insight into the results that may be potentially expected, and helps to inform the programme Theory of Change. Cash transfers have been shown to play an important role in facilitating greater use of health facilities, promoting dietary

diversity and reductions in stunting (Bastagli et al., 2019) , with the same evidence base urging careful attention is paid to design features of the programme. Limited evidence exists of differential outcome between males and females within a household, though this may be a function of limited sample size and the design of the programme (ibid). However, there is evidence that provision of (conditional) cash transfers to female-headed households led to greater uptake of maternal healthcare than among male-headed households (Bastagli et al., 2019; World Bank, 2011), while transfers provided directly to mothers was associated with a statistically significant increase in use of clinics but conditional cash transfers provided to men yielded no significant increase in the use of clinics (Akresh et al., 2012; Bastagli et al., 2019). The unique circumstances in Afghanistan may moderate the potential impact identified in this global review. The same set of unique circumstances also results in a limited pool of previous studies to draw on. However, recent empirical evidence from Afghanistan suggests that a targeted cash transfer and productive asset transfer, along-side SBCC (Social and Behavioural Change Communication), delivered to ultra-poor women has positive effects on a battery of well-being indicators (including consumption, asset ownership, and financial and labour market inclusion) several years post-intervention and in the aftermath of successive covariate shocks (Bedoya et al., 2023).

The inclusion of cash+ into social protection has become increasingly common based on the strong theoretical linkages (Roelen et al., 2017; Martorano & Sanfilippo, 2017). Evidence paints a mixed picture of the effectiveness of cash+ interventions, particularly cash alongside nutrition-based SBCC. A recent meta review highlighted that cash complemented by nutrition messaging has no identifiable effect on anthropometric measures, though with positive results identified on illness among children and poverty (Little et al., 2021). However, results of a recent experimental approach in Myanmar finds that provision of cash and nutrition-related SBCC results in increased consumption of proteins compared to cash alone and control groups, as well as a reduction in stunting (Fields & Maffioli, 2021). Recent scholarship from Niger has shown that while cash transfers increased household consumption and food security, the additional provision of nutrition-focused SBCC messages increased the food security of children, highlighting the importance of provision of knowledge transfers in addition to cash transfers (Premand & Barry, 2022). The provision of cash with nutrition SBCC also appears to yield greater poverty reducing effects compared to cash alone (Ahmed, Hoddinott & Roy, 2019; Calvo & Dercon, 2009; Little et al., 2021). Provision of cash alongside primary healthcare has reduced child mortality (Guanis, 2013; de Es, 2019; Little et al., 2021).

Cash transfers have become a commonplace and important tool in the humanitarian response toolbox, building on the extensive body of evidence of the effectiveness of cash transfers in a range of dimensions (Bastagli et al., 2019) as well as the greater cost effectiveness of cash transfers over in-kind provision of resources (Bailey & Hedlund, 2012; Hidorbo et al., 2014; Gentilini, 2014; Lind et al., 2023). In their recent review of 97 cash plus social and behaviour change (cash+) programmes in low, medium and high intensity crisis settings, Lind et al. (2023) find that the most commonly employed cash+ component is provision of skills or capacity building (nearly universal – 92%), with slightly more than half of programmes offering ‘sensitisation’ and just 10% of crisis-setting programmes offering access to health services. The low number of studies offering access to health care as a cash+ component in conflict settings may limit the applicable body of evidence on the effectiveness of this provision. In the context of conflict, provision of cash alongside nutrition training yielded an appreciable and significant increase in dietary diversity and improvements in stunting (Kurdi et al., 2022; Kurdi, 2021).

Cash-based assistance (CBA) has been a routine part of UNICEF’s programming in Afghanistan since 2020, including humanitarian programming as well as programmes supporting nutrition, health, child protection and education (UNICEF, 2023b). Cash – notably physical cash – was expected to form up to 21% of assistance in Afghanistan in 2023 (UNICEF, 2023b). On the basis of the broadly positive evaluation of CBA (UNICEF, 2023b), UNICEF Afghanistan, as part of their commitment to protecting, promoting and fulfilling rights of children in Afghanistan, will implement Mother and Child Cash Transfer (MCCT) in four provinces of Afghanistan (Kunar, Samangan, Badghis, and Zabul). The design of the MCCT leverages the efficacy of cash transfers in promoting and fulfilling health, nutrition and empowerment outcomes with the benefits of a cash+ design.

2.2. MCCT Programme

On the basis of the extensive evidence on the risks to maternal and child health in Afghanistan, UNICEF Afghanistan developed the Mother and Child Cash Transfer (MCCT) programme. The programme, part of UNICEF’s renewed focus on pregnant and lactating women and the first 1,000 days of a child’s life, aims to contribute to the empowerment of women, build the capacity of and encourage utilisation of community structures, and integrate linkages with health and nutrition services. In addition, the programme is to contribute to strengthening the development-humanitarian nexus (Nimeh et al., 2020) as well as act as a foundational block in a future social protection system in Afghanistan. The programme has a number of specific objectives, including: (i) increasing purchasing power to meet unmet needs during and after pregnancy, (ii) addressing financial barriers to accessing health and nutrition services, (iii) strengthening linkages to health and nutrition services, (iv) improving knowledge and influencing behavioural change in relation to health seeking behaviour and good maternal and child health practices, (v) generating evidence to inform future programming and the design of social protection programmes in Afghanistan.² The programme has, from the outset, inter-sectoral linkages included in the design and consists of a number of sub-components as a result. The full package of MCCT sub-components will be delivered to eligible individuals – pregnant and lactating women and mothers of children under two years old – in treatment districts identified across four provinces. The MCCT is expected to be delivered to reach more than 61,000 households.

The full MCCT package consists of:

- i. Quarterly cash transfers of 60 USD during 18 months
- ii. Social and behavioural change package of activities
- iii. Linkages to health and nutrition services
- iv. Research and evidence generation activities
- v. Cross-cutting components

Cash transfers

Transfers will be made using hard currency quarterly at distribution points located close to health facilities to facilitate interlinkages with and uptake of health services. Findings from previous evaluations in Afghanistan indicate that sufficient financial infrastructure exists in Afghanistan to complete the transfer using digital currency (UNICEF, 2023b). However, the same evaluation – as well as supporting documentation provided by UNICEF ACO – notes that low levels of digital penetration and literacy among

² Lifted (near verbatim) from UNICEF ACO-provided UNICEF materials.

intended beneficiaries render this modality challenging. Transfer values were determined with reference to the Minimum Expenditure Basket (MEB) calculated by the Afghanistan Cash Working Group (CWG) of which UNICEF is a member. The April 2023 MEB was determined to be 243.36 USD, with health expenditure constituting 20% of the MEB (49.39 USD). At the outset, UNICEF had intended to nearly fully meet the health portion of the MEB (49.39 USD) alongside a 10% buffer (c. 22 USD) with a transfer worth 69 USD. However, this transfer value was revised down to 20 USD per month (60 USD per quarterly transfer). The downward revision of the transfer value was made on the basis of a number of relevant factors according to documents and information provided by the ACO.

First, there have been substantial changes in the health services landscape in Afghanistan as a result of the Health Emergency Response. During the period May 2022 – December 2023, a more than 300m USD grant to UNICEF by the Afghanistan Resilience Trust Fund (previously Afghanistan Reconstruction Trust Fund), Global Financing Facility and the World Bank enabled the provision of a Basic Package of Health Services and Essential Package of Hospital Services in Afghanistan. The grant facilitated provision of and encouraged the uptake of healthcare across primary and secondary healthcare facilities, with a specific focus on maternal, newborn, child and adolescent health in specific regions of the country. The funding has enabled greater provision of services and greater access to public healthcare facilities, and as a result, the healthcare component of the transfer has been drawn down. Moreover, the ADB is funding UNICEF to support High-Impact Value-Added (HIVA) interventions, emphasizing maternal and child healthcare and nutrition across all Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) facilities. Second, broader macroeconomic indicators played a role in transfer value setting. Recent macroeconomic stability and consequent reduced fear over price inflation plays a determining role, as does a desire to be coherent with gender-specific mean and median per capita incomes or social assistance nationally. Third, programme design and sustainability considerations play an important role. A reduced transfer value enables UNICEF to deliver transfers over a longer period with predictable periodicity, duration and transfer value. Finally, coherence with a similar programme jointly delivered by the World Food Programme and the World Bank was deemed important for community cohesion.

Transfer values are insensitive to the size of households and are of fixed notional value throughout the duration of the programme. Transfers will be delivered to beneficiaries in Afghani (AFN) as hard currency. Programme design and budgeting on the part of UNICEF is, according to ACO, conducted in US Dollars. Households are eligible to receive – and budgeted to receive - 20 USD per month, in transfers received quarterly (60 USD per transfer). The value of the transfers in AFN will be determined by the purchase of Afghani in preparation for the first transfers. Changes to the AFN will be adjusted upwards in the event that there is significant inflation in either the headline rate of inflation between disbursements, or in the event that food prices rise. Transfers will never be reduced in absolute value.

Social and Behavioural Change Engagement

Social and behavioural change is expected to play a critical role in the programme theory of change. A wide range of theoretical and empirical work (see previous paragraphs) supports the inclusion of this package of work to facilitate key spending and healthcare utilisation decisions necessary to activate the link between an income shock to a household and desired intermediate and overall outcomes. The SBC component is expected to engage and empower communities through knowledge on the transfers as well as health, nutrition, immunisation, and hygiene topics related to the health of a child's first 1,000 days, build the capacity of implementing partners and community-based structures to maximise programme coverage of

eligible households and to deliver SBC interventions. Finally, the SBC component is intended to facilitate evidence generation through SBC specific assessments. To facilitate this, there will be two key SBC programme components. First, all households will receive information on the MCCT programme during visits to disbursement sites to facilitate full participation in the programme. Second, communities will receive SBC throughout the duration of the programme focusing on a number of health, nutrition, immunization and hygiene behaviours related closely to the overall programme objectives and programme theory of change. Different channels and platforms will be used to deliver assets, with different intended audiences³. Assets will be delivered through Implementing Partners to all targeted location. The evaluation strategy section outlines the intended strategy that the Evaluation Team, in careful and close cooperation with the UNICEF ACO, will use to evaluate the SBC packages.

Linkages to health and nutrition services

The programme is both explicitly and implicitly linked with health and nutrition services, though with a number of important assumptions. Programme design documentation suggests that cash transfers will be delivered close to healthcare facilities, with the intention of facilitating easy access to health services during visits to disbursements. There are no conditions attached to the transfer – attendance at a clinic is not a prerequisite to transfer receipt, and transfers may be spent according to household preferences. The proximity link requires the assumption that quality and culturally relevant healthcare is available at the healthcare facility. This assumption is bolstered by the extensive funding channelled into the provision of a basic package of healthcare services (BPHS) and essential package of hospital services that facilitate the ‘equitable and uninterrupted’ delivery of basic healthcare through primary healthcare facilities, including at district hospitals, and hospital services at provincial and regional hospitals. The BPHS package is particularly relevant, containing packages of work focused on maternal and newborn care, child health and immunization, public nutrition, communicable disease treatment, mental health, disability and physical rehabilitation, and the regular supply of pharmaceuticals. In addition, a package of high-impact value added interventions specifically for maternal, new-born, child and adolescent health at primary and secondary healthcare facilities are being delivered in specific regions in Afghanistan. These packages of work, supported by UNICEF, are made possible by grant funding from the Afghanistan Resilience Trust Fund, the Global Financing Facility, the World Bank, and the Asian Development Bank (ADB).

Research and evidence generation

Conflict and fragility can interact with and exacerbate common household vulnerabilities to increase the sensitivity of households and reduce their adaptive capacity, creating an enhanced risk of harm; these same regions are expected to play host to an increasing share of the world’s poor within the next decade (Bedoya et al., 2023). Humanitarian and development policies and programmes in these parts of the world are, therefore, critically important to protecting and promoting lives and livelihoods. To ensure that humanitarian spending is as impactful and cost effective as possible, particularly in a context of high humanitarian demand and limited resources, evidence generation, such as policy research or impact evaluation is essential. However, there are manifold practical and methodological challenges to conducting high quality, rigorous policy evaluation in fragile and conflict-affected areas. From the outset of the programme, UNICEF has ensured that evaluation, research and evidence generation is at the centre of the MCCT. Internally, routine post-distribution monitoring (PDM) will play a critical role in generating

³ The SBC team at UNICEF ACO is finalizing the list of SBC assets/packages and their modalities (August 2024).

accountability and identifying implementation challenges in ‘real time’. Externally, the evaluation that is the subject of this inception report will generate rigorous and high quality evidence on the effectiveness of the programme for women and children living in some of the most challenging conditions found in the world.

Cross-cutting components

Cross-cutting components have been integrated throughout the design of the evaluation. Where possible, the evaluation log-frame is gender disaggregated, and outcomes will be operationalised using gender-specific variables where feasible. However, limits remain in the extent to gender disaggregate all outcomes. For example, measuring intra-household dynamics in food consumption are difficult to estimate without use of diary-based methods which are challenging to implement in areas of low literacy. Furthermore, both the quantitative and qualitative components will ascertain the extent to which beneficiaries are able to access disbursements safely, access and gain satisfaction from community feedback mechanisms, and the extent to which disbursement sites and staff therein uphold the dignity of disbursements. The qualitative surveys will, in addition to these components, also assess the extent to which intra-household and community tension has been moderated or mediated by the transfers. Moreover, the household behavioural nudges are designed in conjunction with UNICEF’s own gender-specialist colleagues as well as external gender experts.

Eligibility and targeting

Beneficiary selection and identification was a multi-stage process. Provinces were selected on the basis of a battery of indicators including a Multidimensional Poverty Indicator (LFS, 2020), stunting rate (MICS 2022-2023), neonatal mortality rate (MICS 2022-2023), infant mortality rate (MICS 2022-2023) and proportion of women receiving four antenatal visits (MICS 2022-2023). A province selection running index was formed on the basis of rank position within each of the dimensions. The province selection running index is non-exclusively used to select provinces for programme implementation – province selection does not obey rank dominance as other factors including political and security-based considerations are also used in decision making. Furthermore, provinces are distributed between UNICEF and WFP for programme implementation, with no overlapping provinces. Within provinces, districts are identified on the basis of their Global Acute Malnutrition (GAM) rate, ranked within provinces. Similar to provinces, the rank order is not exclusively obeyed with political and security-based considerations playing a role in decision making. The provinces and districts identified for the programme implementation at the time of writing is outlined in Table 1.

Table 1 Province and district selection

Badghis	Kunar	Samangan	Zabul
Ghormach	Bar Kunar	Aybak	Daychopan
Ab Kamari	Shigal	Ruy-e-Duab	Kakar
	Narang	Dara-e-Suf-e-Payin	
	Watapur	Khuram Wa Sarbagh	

Source: UNICEF ACO provided documentation. Information is correct at the time of writing (July 2024).

Households are considered eligible for inclusion in the MCCT programme if they contain a pregnant or lactating woman (PLW) or a child under the age of two years old⁴. Enrolment into the programme is done on the basis of an eligibility survey conducted prior to the commencement of the programme. The selected districts will be fully covered at the time of enrolment with all those meeting the eligibility criteria. No enrolment into the programme is possible after the initial enrolment survey, and households' eligibility is fixed after enrolment. Despite the temporary nature of eligibility, households eligible for the programme at enrolment remain enrolled in the programme throughout its duration.

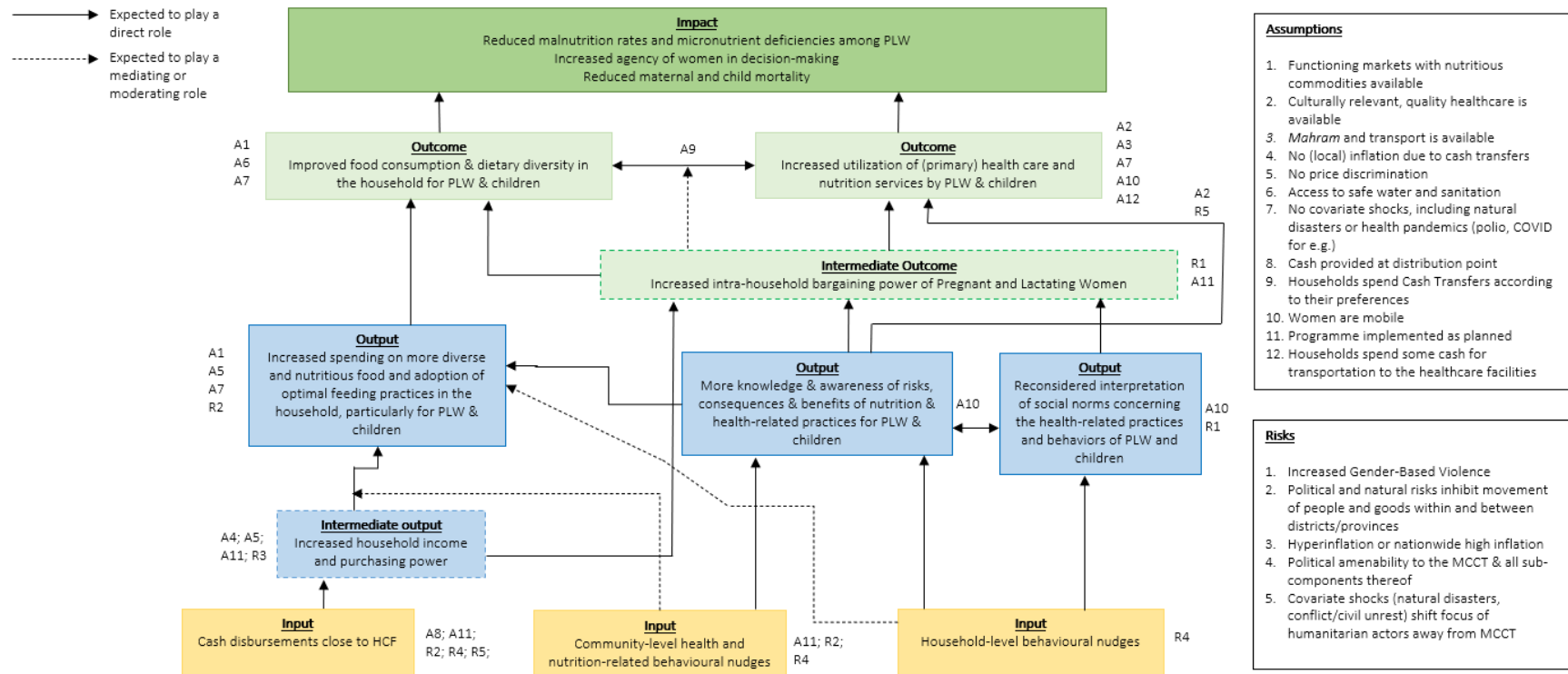
Cash-related communication providing information on MCCT programme characteristics and eligibility will be delivered at distribution points and during registration. Community-level SBC interventions will take place in communities in targeted districts.

MCCT Theory of Change (TOC)

The MCCT programme is underpinned by a programme theory of change that outlines the expected linkages, assumptions, risks, moderators or mediators that exist between inputs and programme outcomes and impacts. The programme Theory of Change has undergone several rounds of revision. The initial Theory of Change proposed in the Terms of Reference that form the basis of the evaluation of the MCCT underwent revision during the inception mission by the Evaluation Team to Kabul in January 2024. The Theory of Change reproduced in Figure 1 is the product of a second round of discussions and written feedback with stakeholders in the evaluation management group and the UNICEF Regional Office South Asia. The previous iteration of the programme Theory of Change can be found in **Annex 2 – Programme Theory of Change**.

⁴ This will include non-lactating females. Moreover, this will also include households with absent mothers, where another female may take care of a child (becoming a primary beneficiary of the programme) or a male is the only caregiver to a child (being a primary beneficiary of the programme).

Figure 1 Revised MCCT Programme Theory of Change



The programme Theory of Change (Figure 1) outlines the pathways through which the programme inputs are anticipated to achieve outputs, outcomes and impacts. At the heart of the MCCT are the two key components: cash transfers and social and behavioural change. Cash transfers, which act as an external stimulus to household income are anticipated to have either a price or income effect on the purchase of specific commodities, enabling greater consumption and diversification of food and/or expenditure on healthcare. In the short-run, it is assumed that there is no draw-down of household labour supply, particularly given the small transfer value. Greater consumption of nutritious commodities – and the adoption of optimal feeding strategies – is expected to lead to improved food consumption and dietary diversity in the short to medium term, with longer-term impacts on nutritional anthropometric measures. The cash is also expected to directly affect women’s mobility, creating the economic potential for accessing healthcare. Social and behavioural change components are anticipated to modify household attitudes and behaviours, in conjunction with information on the risks, consequences and benefits of health and nutrition related practices. In turn, this catalyses a potential reaction between an economic stimulus and nutrition and health outcomes. There are a number of assumptions in this process, those factors which are not directly controllable or measurable that may mediate the strength of relationship between components. Similarly, there are risks; these risks may entirely sever connections, or render components unfeasible. The operationalisation of the impact, outcomes, intermediate outcomes and outputs is summarised in Table 12.

3. Evaluation purpose, objectives, users, and scope

3.1. Evaluation purpose and objectives

The purpose and objectives of the evaluation are (partially) in line with those outlined in the Terms of Reference (Annex 1 – Terms of Reference), though the objectives have undergone minor revisions subsequently. The **purpose of the impact evaluation** is to assess the MCCT programme’s achievement of its intended outcomes, while also evaluating programme design and implementation against OECD-DAC (Organisation for Economic Cooperation and Development-Development Assistance Committee) criteria, integrating cross-cutting dimensions, identifying and measuring unidentified outcomes, and deriving lessons and best practices applicable to future social protection programming in Afghanistan. The evaluation is intended to generate evidence on the extent to which the MCCT package of interventions have realised the intended outcomes identified in the programme Theory of Change and as operationalised in the evaluation logframe (see **Table 12** in the annex). In addition, the evaluation is expected to assess the programme design and implementation against standard OECD-DAC evaluation criteria of impact, relevance, effectiveness, efficiency, sustainability and coherence, as well as the extent to which cross-cutting dimensions are integrated into the programme. The evaluation is expected to identify and measure, where possible, the presence and extent of unidentified outcomes. The evaluation is also expected to identify lessons learned and best practices that can inform the design and implementation of future programmes in Afghanistan or comparable contexts. Given the paucity of evidence on the impact of and best practices in designing and delivering social protection policies in conflict-afflicted or fragile contexts, sharing and disseminating findings are an essential part of the evaluation. This is expected to be done through the publication of technical evaluation reports, internal dissemination, stakeholder dissemination, a series of Working Papers, academic publications, and conference presentations.

The **specific objectives** of the impact evaluation are the following:

- **Programme impact and achievement of results:** To assess the extent to which the programme has an impact on beneficiary households. To identify the pathways through which the programme achieved its intended (*and unintended to the extent possible*) results.
- **Relevance of the MCCT design and implementation:** To assess the extent to which the programme design, and implementation are relevant, coherent and appropriate for the needs of beneficiaries. To demonstrate opportunities for improving the design and implementation of MCCT and similar programmes in Afghanistan.
- **Programme effectiveness:** To evaluate the effectiveness of the programme in achieving its desired results. To identify strengths and weaknesses, internal and external factors, including enablers and barriers, and lessons learned from the implementation of the MCCT programme.
- **Sustainability of the programme:** To assess the financial and political sustainability of the programme in the medium and long term.
- **Programme cost-efficiency:** To assess the extent to which the programme efficiently utilized inputs to conduct activities to achieve the results.
- **Integration of cross-cutting areas:** To examine the integration of gender, disability, equity, and human rights in the programme design and implementation.
- **Collaboration and coordination:** To assess the programme’s collaboration and coordination with key stakeholders and partners, and determine their influence on the programme’s results.

3.2. Evaluation users and use

The primary and secondary users and uses are outlined in Table 2 below. All stakeholders will be involved in the process of evaluation through the variety of modalities ranging from providing necessary documentation to key informant interviews to inform the evaluation findings and recommendations.

Table 2 Evaluation users and uses

Level	Evaluation users	Uses
Primary users	UNICEF Afghanistan, particularly the Social Policy, SBC, Nutrition, Health, Project Management Unit (PMU), Planning, Monitoring and Data (PMD) unit, and Gender sections, along with the senior management in the country office	<ul style="list-style-type: none"> To review and improve the Mother and Child Cash Transfer (MCCT) programme and inform the future of similar integrated social protection programmes in Afghanistan. To use insights from this evaluation to inform the future of social protection programmes in the next Country Programme Document, other necessary strategies, documents, and cooperation and partnerships arrangements. To provide evidence on lessons learned for better operationalization of integrated social protection programmes. To strengthen humanitarian and development nexus programming. To contribute to the overall evidence base of the country office.
	UNICEF's implementing partners	<ul style="list-style-type: none"> To improve the collaboration and coordination between UNICEF and implementing partners on integrated social protection programmes. To provide evidence on lessons learned for better operationalization of integrated social protection programmes.
	UN agencies, funds and programmes working on humanitarian and development programming in Afghanistan including World Food Programme (WFP), World Health Organisation (WHO), United Nations Development Programme (UNDP), UN Women, United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), United Nations Assistance Mission in Afghanistan (UNAMA) etc.	<ul style="list-style-type: none"> To strengthen humanitarian and development nexus programming. To provide evidence on lessons learned for better operationalization of integrated social protection programmes. To review and improve the Mother and Child Cash Transfer (MCCT) programme and inform the future of similar integrated social protection programmes in Afghanistan.

	Donors and development agencies (ADB, World Bank, etc.)	<ul style="list-style-type: none"> To provide evidence on lessons learned for better operationalization of integrated social protection programmes. To provide insight on the cost-effectiveness and cost-efficiency of transfers provided as direct support.
	Cash and Voucher Working Group	<ul style="list-style-type: none"> To provide evidence on the effectiveness of cash transfers in a humanitarian and emergency setting. To provide insights on the potential unintended consequences of the use of transfers in a humanitarian and emergency setting.
	De Facto Authorities and ministries	<ul style="list-style-type: none"> To advocate for the provision of (targeted) social assistance in Afghanistan. To provide insights relevant to the consideration of national adoption or design of a similar programme.
	Beneficiaries	<ul style="list-style-type: none"> Accountability and advocacy for the needs of pregnant and lactating women and children living in Afghanistan.
Secondary users	UNICEF Regional Office in South Asia and UNICEF Headquarters (HQ)	<ul style="list-style-type: none"> To provide evidence on the effectiveness of cash transfers in a humanitarian and emergency setting. To provide insights on the potential unintended consequences of the use of transfers in a humanitarian and emergency setting. To review and improve the Mother and Child Cash Transfer (MCCT) programme and inform the future of similar integrated social protection programmes in humanitarian and emergency settings.
	Other UN agencies globally and global humanitarian and development partners	<ul style="list-style-type: none"> To provide evidence on the effectiveness of cash transfers in a humanitarian and emergency setting. To provide insights on the potential unintended consequences of the use of transfers in a humanitarian and emergency setting.
	Policy makers in fragile and conflict-affected areas	<ul style="list-style-type: none"> To provide evidence on the effectiveness of cash transfers in a humanitarian and emergency setting.

		<ul style="list-style-type: none"> • To provide insights on the potential unintended consequences of the use of transfers in a humanitarian and emergency setting.
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3.3. Evaluation scope

This evaluation is intended to be an impact evaluation over the full duration of the MCCT programme. The evaluation has been integrated into the design of the MCCT through close, cooperative and productive cooperation between the Evaluation Team and UNICEF ACO. The evaluation baseline will be conducted prior to the commencement of the disbursement of transfers in districts to be sampled as part of the evaluation. The endline will be conducted towards the end of the disbursement cycle, where possible. In addition, close cooperation with UNICEF’s internal monitoring team responsible for post-distribution monitoring will ensure that as much data as possible is included in the evaluation. There are a wide range of assessment methods and assessment criteria covered by this evaluation (see the evaluation matrix). Our analysis will combine experimental and non-experimental data to identify changes in outcomes for treated households. The analysis will be complemented by a qualitative approach to explore the potential pathways through which the intervention affects the outcomes of interest.

The geographic scope of the evaluation is limited to the districts and provinces covered by the MCCT programme in Afghanistan. These provinces and districts are summarised in Table 1. The findings are not representative more widely due to the narrow programme parameters and beneficiary selection method.

The temporal scope of the programme covers the duration of the MCCT programme. At inception, the programme design envisages quarterly payments over a total period of 18 months. This is anticipated at inception to be 2024-2025. The baseline data collection phase will precede the roll-out of transfers in sampled evaluation districts, while the endline will occur after the final transfers have been dispersed.

The evaluation will focus exclusively on the core components and mechanisms through which components are expected to operate. These are defined in the programme theory of change and include the inputs, outputs and outcomes of the programme. These components include: social protection, social and behavioural change, nutrition and healthcare seeking behaviours. Social protection consists of the cash transfer component as a targeted social assistance programme. This focuses on evaluating the adequacy of transfers, and assessing the relevance of transfers to beneficiaries and to explore whether achievement of intended coverage was materially influenced by cross-cutting issues such as gender norms or disability. The report will, where information from key informants allows, comment on the extent of coherence and cohesion between other social assistance or social protection programmes. Social and behavioural change will examine the extent to which nudges and activities at different levels have a material influence on the demand for agency by women within a household, identified as a key barrier to healthcare seeking behaviour in Afghanistan. Nutrition is explored through common household measures of access to food and expenditure. Healthcare seeking behaviour includes assessing the extent to which households access healthcare, and includes vaccination coverage.

The key themes to be explored in the evaluation include PLW and child health and nutrition, social and behavioural change. Under PLW and child health and nutrition, Knowledge, Attitudes and Practices to good feeding and nutrition practises and self-reported practices related to feeding women and infants in the

household will be covered. The evaluation team does not expect the programme to materially influence the propensity to be unwell, changes in healthcare seeking behaviour or attitudes to healthcare seeking are expected. Under social and behavioural change, the evaluation team expects there to be changes in the demand for agency related to healthcare seeking behaviour. Cross-cutting themes throughout the evaluation include gender, disability, equity and human rights. Where relevant throughout the evaluation, specific emphasis will be placed on understanding the extent to which gender and disability may play an explanatory role in observed results or whether the evaluation team expects heterogenous results as a result of these factors. Qualitatively, the evaluation will understand the extent to which these factors were mainstreamed in the programme's design. Finally, the evaluation will comment on the extent to which the programme promoted equity and human rights in its design.

3.3.1 Any changes in the scope compared to Terms of Reference (TOR)

During the inception phase, and particularly during the inception mission to Kabul on the part of the Evaluation Team from 20th – 26th January 2024, the scope of the Terms of Reference underwent a number of changes. These are detailed below.

To provide a comprehensive evaluation of the impact of social and behavioural change components of the MCCT programme, an additional SBC component has been added to the MCCT programme design in evaluation districts. To do so, the impact evaluation will now have 4 arms: (i) control; (ii) cash only; (iii) cash plus community SBC; and (iv) cash plus community SBC + household level SBC. This latter group will receive cash, community-level SBC interventions plus the household level nudge intervention. The selected households will receive nudges focusing on gender dynamics and healthcare seeking behaviour. The intensive household nudging intervention will be completed by specially trained social mobilisers who will visit households six times over approximately six months. During these visits, lasting approximately 60 minutes, social mobilisers will engage with beneficiaries and other household members. Each home visit focuses on one of three topics: Health care visits; Maternal and child nutrition; and Immunization. As a consequence, there has been an increase in the sample size. A further 600 households per round have been added to the evaluation sample increasing it to 2400 households in total per round. More information is available under the 'Evaluation Methodology' section.

4. Evaluation framework

The evaluation is guided by a number of evaluation criteria and evaluation questions outlined below.

4.1. Evaluation criteria and questions

The impact evaluation is guided by OECD DAC evaluation criteria, namely relevance, effectiveness, efficiency, impact, sustainability, and coherence, as well as the non-OECD DAC criteria of coverage. These evaluation criteria are operationalised by evaluation questions and sub-questions. Cross-cutting issues, such as gender, disability, equity, and human rights, are integrated into the evaluation through a number of evaluation sub-questions and specific indicators. Table 3 reflects the evaluation matrix covering evaluation criteria, questions, sub-questions, indicators, data source, and predicted strength of evidence.

Table 3 Evaluation matrix - Evaluation question, approach and anticipated strength of evidence

Evaluation objective	Sub-evaluation questions	Indicator for measurement	Data source	Predicted strength of evidence
Evaluation criteria 1: Impact & achievement of results				
Evaluation question 1: To what extent has the MCCT programme had short- and medium-term effects on beneficiary lives?				
<p>Programme impact and achievement of results: To assess the extent to which the programme has an impact on beneficiary households. To identify the pathways through which the programme achieved its intended results.</p>	<p>What are the impacts of the MCCT programme on healthcare utilisation and food consumption and dietary diversity among beneficiary households?</p>	<p>Utilization of Primary Healthcare (PHC) for any reason among PLW & infants <2</p> <p>Expenditure on nutritious food stuffs</p> <p>Household food consumption</p> <p>Food security and dietary diversity</p>	<p>Primary quantitative data (UNU-MERIT surveys)</p> <p>Primary quantitative data (UNICEF PDM data)</p> <p>Administrative data on PHC attendance</p> <p>Primary qualitative data</p>	<p>Very strong, triangulated</p>
	<p>What are the impacts of the community-level SBC on the healthcare and nutrition Knowledge, Attitudes and Practices among beneficiary households?</p>	<p>Knowledge, Attitudes and Practices</p>	<p>Primary quantitative data (UNU-MERIT surveys)</p> <p>Primary qualitative data</p>	<p>Very strong, triangulated. However, careful implementation of SBC required to prevent contamination of experimental assignment to SBC methodologies</p>
	<p>What are the impacts of the household-level SBC nudging on the utilization of health care facilities among beneficiary households?</p>	<p>Utilization of PHC for any reason among PLW & infants <2</p>	<p>Primary quantitative data (UNU-MERIT surveys)</p>	<p>Very strong, triangulated. However, careful implementation of SBC required to prevent contamination of experimental assignment to SBC methodologies</p>

	What are the reasons for observed effects? What are the main drivers of positive impacts?	Reflection on and description of factors	Primary quantitative data (UNU-MERIT surveys) Primary qualitative data	Strong , non-triangulated but rigorous quantitative methods can be used
	What are the impacts on household spending on nutritious food?	Household food expenditure	Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data)	Strong , partially corroborated
	What are the impacts on household expenditure on healthcare (of any type)?	Household healthcare expenditure	Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data)	Strong , partially corroborated
Evaluation question 2: What were the gender-specific outcomes?				
Programme impact and achievement of results: To assess the extent to which the programme has an impact on beneficiary households. To identify the pathways through which the programme achieved its intended results.	What were the effects on intra-household bargaining power and decision-making?	Female or joint decision making on the use of resources Female or joint decision making on utilising PHC	Primary quantitative data (UNU-MERIT surveys) Primary qualitative data	Strong , partially corroborated
	What are the gender-specific impacts on women's visits to a healthcare facility for any reason?	Number of visits to a PHC for any reason	Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data) Administrative data on PHC attendance	Strong, non-triangulated
	What are the gender specific impacts of the MCCT on nutrition and food security?	Gender-specific food security and nutrition indicators Consumption among all household members	Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data)	Strong , partially corroborated
Evaluation criteria 2: effectiveness				
Evaluation question 3: What are the major factors influencing progress in achievement or non-achievement of the outcomes (internal and external factors?)				

<p>Programme effectiveness: To evaluate the effectiveness of the programme in achieving its desired results. To identify strengths and weaknesses, internal and external factors, including enablers and barriers, and lessons learned from the implementation of the MCCT programme.</p>	<p>What are the internal or design enablers and barriers that influenced the achievement or non-achievement of the results?</p>	<p>Reflection on and description of internal enablers and barriers</p>	<p>Primary quantitative data (UNU-MERIT surveys) Primary qualitative data</p>	<p>Strong/moderate, partially corroborated</p>
	<p>What are the external enablers and barriers that influenced the achievement or non-achievement of the results?</p>	<p>Reflection on and description of external enablers and barriers</p>	<p>Primary qualitative data</p>	<p>Moderate, partially corroborated</p>
	<p>To what extent are the activities and outputs of the programme consistent with the objectives of the programme?</p>	<p>Programme implementation against pre-implementation plan Integration of best practice and previous evidence in transfer value setting, SBC and overall programme design Extent to which the programme inputs are supported by a coherent programme ToC? Extent to which cross-cutting issues integrated in the design of the programme</p>	<p>Primary qualitative data Programme documentation</p>	<p>Strong, partially-triangulated</p>
	<p>To what extent are the ongoing or previously completed cash transfer programme/projects likely to influence the impacts and outcomes of the MCCT programme?</p>	<p><i>Programme alignment and differences</i></p>	<p>Primary qualitative data Desk review</p>	<p>Moderate, partially-triangulated and qualitative-only</p>
<p>Evaluation criteria 3: relevance & coverage</p>				
<p>Evaluation question 4: To what extent are the MCCT programme design and implementation coherent with and relevant to beneficiary needs?</p>				

<p>Programme effectiveness: To evaluate the effectiveness of the programme in achieving its desired results. To identify strengths and weaknesses, internal and external factors, including enablers and barriers, and lessons learned from the implementation of the MCCT programme.</p>	<p>To what extent is the design and implementation of the programme sensitive to the needs and realities of the target population?</p>	<p>Needs assessment or findings from previous studies or surveys on deprivation and vulnerability Self-reported relevance from beneficiary households Community (beneficiary and control) perceptions on appropriateness of targeting</p>	<p>Previous studies/surveys (including MICS) Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data) Primary qualitative data</p>	<p>Strong, triangulated.</p>
	<p>To what extent is the value of the transfer and regularity of the cash transfers adequate?</p>	<p>Proportion of actual household expenditure met by transfer Alignment of transfer delivery frequency with market activities Extent to which transfer is aligned with seasonal market price fluctuations</p>	<p>Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data) Administrative data on market prices Primary qualitative data</p>	<p>Very strong, triangulated</p>
<p>Evaluation question 5: To what extent does the design and implementation of the programme consider gender, disability, equity and human rights?</p>				
<p>Integration of cross-cutting areas: To examine the integration of gender, disability, equity, and human rights in the programme design and implementation.</p>	<p>To what extent is the MCCT gender responsive and based on a sound gender analysis?</p>	<p>Improved gender equality and women's empowerment</p>	<p>Primary qualitative data Programme documentation</p>	<p>Moderate, non-triangulated & non-representative</p>
	<p>To what extent is the MCCT sensitive to disability, equity and human rights considerations?</p>	<p>Beneficiaries are able to access programmes without protection challenges, and with dignity. The programme does not induce protection challenges. The programme does not exclude groups based on disability, ethnicity or class.</p>	<p>Primary quantitative data (UNU-MERIT surveys) Primary quantitative data (UNICEF PDM data) Primary qualitative data Administrative data - Community Feedback Mechanisms (CFM) data</p>	<p>Strong, triangulated</p>
<p>Evaluation question 6: To what extent are beneficiaries able to access transfers?</p>				
<p>Relevance of the MCCT design and implementation: To assess the extent to which the programme</p>	<p>To what extent are intended beneficiaries able to access transfers?</p>	<p>Realisation rates Coverage rates</p>	<p>Primary quantitative data (UNU-MERIT surveys)</p>	<p>Strong, triangulated</p>

<p>design, and implementation are relevant, coherent and appropriate for the needs of beneficiaries. To demonstrate opportunities for improving the design and implementation of MCCT and similar programmes in Afghanistan.</p>		<p>Proportion of beneficiaries that redeem the full schedule of transfers</p> <p>Proportion of beneficiaries that report accessing disbursement sites without safety issues</p> <p>Proportion of people living with disabilities that report accessing disbursement sites without issue</p>	<p>Primary quantitative data (UNICEF PDM data)</p> <p>Administrative data (registration data and realisation rates)</p> <p>Primary qualitative data</p>	
	<p>To what extent do intended beneficiaries attend SBC meetings?</p>	<p>Attendance rates</p> <p>Coverage rates</p>	<p>Primary quantitative data (UNU-MERIT surveys)</p> <p>Primary quantitative data (UNICEF PDM data)</p> <p>Administrative data (registration data and realisation rates)</p> <p>Primary qualitative data</p>	<p>Strong, triangulated</p>
<p>Evaluation criteria 4: sustainability, lessons learned and best practices</p>				
<p>Evaluation question 7: To what extent is the programme sustainable in the medium and long-term?</p>				
<p>Sustainability of the programme: To assess the financial and political sustainability of the programme in the medium and long term.</p>	<p>How can the MCCT programme be replicated at the national level? And what would it take to scale-up the MCCT to a national level?</p>	<p>Qualitative assessment of readiness and capacity at national level</p>	<p>Primary qualitative data</p> <p>Programme/other documentation</p>	<p>Moderate, partially corroborated. It is subject to the willingness of interlocutors within <i>de facto</i> authorities (DFA) to engage</p>
	<p>How can the MCCT inform the design of future similar programmes in Afghanistan or similar contexts?</p>	<p>Lessons learned and best practices identified in the design and implementation of the programme</p>	<p>Primary qualitative data</p> <p>Programme/other documentation</p>	<p>Moderate, partially corroborated.</p>
<p>Evaluation criteria: efficiency</p>				
<p>Evaluation question 8: To what extent is the MCCT programme (cost) efficient?</p>				

Programme cost-efficiency: To assess how the programme efficiently utilized inputs to conduct activities to achieve the results	How cost efficient or cost effective is the MCCT programme?	Cost effectiveness Cost efficiency	Administrative data (financial data) Primary quantitative data (UNU-MERIT surveys)	Strong , non-triangulated
	What are the affected population and other stakeholder costs associated with accessing the programme?	Beneficiary access costs as a proportion of transfers	Primary quantitative data (UNU-MERIT surveys) Primary qualitative data	Strong , non-triangulated
Evaluation criteria 5: coherence, collaboration and coordination				
Evaluation question 9: To what extent has UNICEF Afghanistan collaborated with partners and leveraged complementary resources?				
	What are the potential synergies between the MCCT programme and other programmes or projects implemented in the same locations?	Strength of coordination or collaboration with stakeholders (weak, fair, strong)	Primary qualitative data	Moderate , this requires significant input from stakeholders outside the project to be assessable

5. Evaluation methodology

The purpose of this section is to specify the overall approach, methodology, data collection tools, data analysis, quality assurance, ethical considerations, risks, limitations and mitigation strategies, and management arrangements that will guide the analysis, interpretation and key evaluation deliverables.

5.1. Evaluation approach and methods

To provide the most robust approach possible, the impact evaluation will employ a **mixed methods approach**. The use of a mixed-methods approach enables a greater depth in the evaluation, and permits the **triangulation** of results identified in the impact evaluation. In the quantitative component, a quasi-experimental design will utilize **differences-in-differences with an inverse-probability weighting (IPW)** approaches to generate evidence on the effectiveness of the intervention and its impact on the target population. The following sections explore the opportunities and limitations for each of the three key analysis methods and processes: (i) quantitative, (ii) qualitative, and (iii) cost-effectiveness analysis. The impact evaluation will be **utilization-focused**, aiming to inform key decisions and leverage evidence for ongoing programme and organizational enhancements. A **participatory approach** will be adopted, closely engaging key stakeholders to foster meaningful participation and ownership throughout the evaluation process and its outputs. The evaluation will systematically integrate cross-cutting issues such as **gender, human rights, disability, and equity** considerations across all stages. Special attention will be given to ensuring the accessibility of data collection tools. The following sections summarise the sub-components that constitute the overall evaluation.

Quantitative

Quantitative analysis will draw together findings from primary data collected through face-to-face surveys (UNU-MERIT data, as well as UNICEF PDM surveys) with administrative data obtained from a number of sources, including data from clinics as well as from UNICEF. As part of the quantitative analysis, a number of different and complementary approaches will be employed, detailed below.

Quasi-experimental approach utilizing difference-in-differences (DID) combined with an inverse-probability weighting (IPW) method to estimate the impact of cash and community-based SBC messages on health, nutrition and food consumption on outcomes and impacts. Matched units in the treatment and control group are used to reduce the bias induced through the non-random selection of treatment and control districts. Subject to the suitability of the MICS data, the evaluation team may be able to verify the parallel trends assumption which helps to test the validity of the matched DID approach.

Households in the quantitative sample of households to be surveyed consists of a control group (Group A) and three different treatment groups (Groups B, C, D) – see Figure 2.

Figure 2 Evaluation design - treatment arms

	Group A	Group B	Group C	Group D
MCCT cash transfer		Cash & cash-related information on eligibility and design	Cash & cash-related information on eligibility and design	Cash & cash-related information on eligibility and design
Community-level SBC			Health, nutrition, immunisation and hygiene-related SBC interventions	Health, nutrition, immunisation and hygiene-related SBC interventions
Household-level SBC				Behaviour-specific nudges

Group A will constitute the control group – these are households located in *provinces* selected to receive the MCCT, but who live in non-eligible districts to receive the MCCT (see the section on data collection for more detail). Districts are selected by UNICEF for inclusion in the programme on the basis of district level Global Acute Malnutrition (GAM) rates. In order to maximise comparability, the evaluation team selects treatment and control districts for inclusion in the evaluation on the basis of the smallest difference in GAM rates. Within each district, a sampling frame of mosques to approximate community structures (i.e., all households going to the same mosque) will be used. This helps to identify the target population (households with pregnant or lactating women).

Group B in the treatment group will only receive cash and cash-related communication on the MCCT programme, including but not limited to information on eligibility, programme objectives, duration, etc.

Group C will receive cash and a community level SBC intervention⁵. At community level, engagement on a set of topics related to programme outcomes including nutrition and health will be delivered by UNICEF’s contracted implementing partners. These interventions will engage with communities on a set list of topics identified by UNICEF as instrumental for achieving programme outcomes.

From group C, a random subsample will comprise **group D** who will receive cash, a community-level SBC plus the household level nudge intervention. The selected households will receive nudges focusing on gender dynamics and healthcare seeking behaviour. Previous qualitative work in Afghanistan has identified the important role that gender norms play in determining healthcare utilisation.

The intensive household nudging intervention will be completed by specially trained social mobilisers. These social mobilisers, working in fixed pairs of men and women to comply with Afghanistan-specific social norms, will visit households six times over approximately six months. During these visits, lasting approximately 45 minutes, social mobilisers will engage with beneficiaries and other household members

⁵ The SBC team at UNICEF ACO is finalizing the list of SBC assets/packages and their modalities (August 2024).

(anticipated to be the beneficiary’s mother-in-law and the head of the household, if present) using a semi-structured guide. These scripts will engage with specific health seeking or health care utilisation behaviours (an example of the scripts can be found in **Annex 6 – Intensive household nudging overview and example script**). Having established a rapport with the beneficiaries and household members, the social mobilisers will engage in an interactive dialogue with households on some of the topics engaged with during the community-level SBC. During this process, households will discuss the relevance of these topics and messages to their lives and communities – a process in line with the approach outlined in Chambers (1994). Subsequently, the social mobilisers will bring the discussion to the nudging part of the script which addresses the topics from a gender power dynamics perspective. The scripts will address a specific health seeking behaviour or topic through a gendered norms lens. **Each home visit focuses on one of three topics: Health care visits; Maternal nutrition; and Immunization.** These scripts will be drafted using existing literature on the subject, including key literature written in-context, as well as by engaging with groups such as gender and SBC experts within ACO. The Evaluation Team also consists of experts in the field.

Table 4 provides an overview of the content, location, frequency and evaluation group by different SBC interventions, specifically cash-based communication, community-level SBC, and household-level behaviour-specific nudges.

Table 4 Overview of the content, location, frequency, and evaluation group by SBC categories

Category of SBC	Content summary	Location	Frequency	Evaluation group
Cash-based communication	Frequency of payments Duration of payments Value of transfers Transfer/redemption process Eligibility Purpose of cash transfer Importance of using it to meet the needs of PLW and children	Distribution sites	Each disbursement cycle	B, C, D
Community-level SBC interventions	Knowledge on nutritious foods Knowledge on safe food preparation/Water, Sanitation and Hygiene (WASH) Knowledge on the importance of healthcare utilisation, ante/post-natal check-ups, immunisation	Communities	<i>To be determined with UNICEF ACO</i>	<i>C, D</i>

Household-level behaviour-specific nudges	Gendered household dynamic on health-seeking decision-making	Households	Six visits during the first six months	D
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Qualitative

Qualitative research will consist of a blend of key-informant interviews (KIIs) with relevant staff and stakeholders, and focus group discussions (FGDs). This information will be essential to enrich and complement the quantitative research in identifying factors that may undermine or strengthen the fulfilment of the OECD-DAC evaluation criteria. Qualitative data collection will focus on the reasons behind observed results, as well as cross-cutting issues that are ill-suited to quantitative data collection techniques. In addition, key informant interviews will provide insight on the internal and external factors that might influence the extent to which the programme can be expected to meet its objectives. This will also influence the extent to which the programme may be sustainable in the long-run. Questions in the qualitative research tool operationalise relevant components of the evaluation matrix and logframe, both directly and indirectly. The sample of beneficiaries is not intended to be representative, but is instead intended to ensure that the voices of minority groups, or groups for whom fully accessing and benefiting from the MCCT may be hindered by specific household or individual factors, are heard. It is not necessary that these households are the same households over both rounds of data collection. Data will be collected by specially trained enumerators, and all identifying markers will be removed from data at the earliest possible moment. Participants will be able to withdraw their consent to be part of the sample until the moment of analysis. The ability to remove households from the sample will be by use of a numeric key which will be held exclusively by the Evaluation Team, and ultimately destroyed in line with ethical research guidelines.

Cost-effectiveness analysis

Administrative data on the cost of delivering the MCCT programme, including staff, operational and capital costs associated with, *inter alia*, programme design, transfer setting, negotiations and discussions, targeting, registration and enrolment, transfer delivery, any ongoing Beneficiary Contact Monitoring (BCM), appeals and dispute mechanisms. Costs are limited to those in ledger or budget data as collated by the UNICEF programme team. This data, in addition to the impact estimates calculated throughout the evaluation would enable calculation of Total Cost to Transfer Ratio (TCTR) or the Alpha Ratio.⁶ In addition, it may be possible to identify the Omega ratio⁷ to compare the cost-effectiveness of the cash only component and the cash+ components. However, all analysis under this section heavily relies on the provision of administrative data on costs on the part of UNICEF.

5.2. Data collection tools

The impact evaluation will collect both qualitative and quantitative primary data from samples of respondents in treatment districts (Groups B, C, D) and control districts (Group A). All treatment provinces

⁶ This is the inverse of the TCTR and is expressed as the ratio of the value of transfers to total administrative and transfer costs.

⁷ The Omega cost-effectiveness ratio compares two ratios. Both ratios take an outcome measure (for example, Minimum Dietary Diversity for Women) as the numerator, and the denominator is the cost of delivering the respective modality (Tirivayi et al., 2018).

will form part of the sample, though only specific districts will be sampled. Quantitative data will be collected over three rounds of data collection – a baseline, midline and endline. Because of the non-random cluster design (districts for the MCCT are not sampled at random, but rather on the basis of Global Acute Malnutrition rates), obtaining a baseline value of outcome variables is critically important. Table 5 summarizes the data collection approach for the impact evaluation.

Table 5 Data collection approach summary

Evaluation component	Phase			Variables of interest
	Baseline	Mid-line	End-line	
Quantitative data				
Primary quantitative data with sampled households in treatment and control districts	Face-to-face	Face-to-face†	Face-to-face	Food security indicators Health utilization indicators Household demographic and livelihood indicators Outcome indicators
Primary quantitative data collected by UNICEF as part of the Post-Distribution Monitoring process	Conducted after each distribution, not conforming to baseline, midline or endline			Food security indicators Household demographic and livelihood Outcome indicators
Administrative data from sample‡ maternal care clinics	Secondary	Secondary	Secondary	Utilisation of facilities pre and post treatment (e.g., number of visits, compliance with ante /post-natal courses), vaccine take-up Anthropometric measures
Qualitative				
Primary qualitative data collected (FGDs, KIIs)	Face-to-face & online		Face-to-face & online	Knowledge, attitude and practices (KAP) on micronutrient awareness, WASH practises, infant nutrition, child health Community and intra-household cohesion Intra-household dynamics and sharing Accessibility, safety and dignity of disbursement sites Unanticipated effects of transfers
Photograph analysis/generative Artificial Intelligence (AI)	Face-to-face		Face-to-face	Quality of facilities to be benchmarked against standards Possible use of generative AI to obtain community input on what Healthcare Facilities (HCFs) should look like
Cost-effectiveness analysis				

Administrative data on cost of delivering programme, including staff, operational and capital costs	Secondary	Secondary	Secondary	Cost of delivering programmes to generate Total-Cost to Transfer Ratio (TCTR), omega ratio, cost effectiveness values
Notes: † using a blend of remote data collection with a small sub-set of face-to-face verification surveys it may be possible to transition the mid-line away from full face-to-face data collection to reduce the financial evaluation burden. Given this is sub-optimal, this remains a back-up solution. ‡ This proposal assumes that data at HCFs are not digitised and therefore visits to HCFs are necessary to obtain data. To reduce the financial burden of this component, the evaluation team proposes collecting data solely from those HCFs visited as part of the research.				

Literature review & desk review

External documentation will play an important role in the evaluation. Scientific and academic literature will play an essential role in building the intensive household nudges, as well as making significant contributions to the analysis. A review of previous best practice in high quality academic publications will assist in ensuring that the quantitative and qualitative analyses is as robust as possible. In addition, academic literature will assist in situating and explanation of any results and findings, providing essential corroboration and triangulation. External literature will play an important role in translating findings to recommendations and conclusions.

A desk review of programme documentation provided by UNICEF has provided essential programme information relevant to the design and conduct of the evaluation. In addition, the desk review of UNICEF programme documents will provide partial information to assess evaluation criteria, primarily sustainability and collaboration and coordination. The desk review data will be used to provide an information landscape which can be drawn upon to support and triangulate other evidence, including information from key informants.

Field observations

Field observations are expected to play a supplementing role in the analysis. Field reports from enumerators, and particularly field supervisors, and transect walks on the part of the Evaluation Team will help give contextual relevance to the quantitative and qualitative findings, and in particular help transition from observed quantitative results to conclusions and recommendations. In addition, photograph analysis will help to build information that may be used as a variable to assess the quality and accessibility of health facility infrastructure. Artificial Intelligence can help to classify images and find common traits to build quantitative information on health facilities that is otherwise unobtainable. Similarly, respondents can be asked for the factors they look for in a healthcare facility – what features and facets they have reason to value – and this can be fed into generative AI tools to highlight the differences between what infrastructure currently exists and what users would value.

Secondary data analysis

Administrative data will be requested from relevant parties. This can include data on number of visits to health clinics, anthropometric data, as well as registration data from UNICEF and implementing partners. In addition, financial data on implementing the programme will be requested from ACO. Administrative data on registration is essential to estimate coverage rates and redemption rates. Administrative data from grievance redress mechanisms (GRM) and community feedback mechanism (CFM) centres can help the Evaluation Team understand the extent to which programmes remain accessible to all intended

beneficiaries. Programme disaggregated ledger data on the budgeted and actual costs of the programme are essential to calculate a number of important metrics related to cost efficiency and cost effectiveness. The evaluation team will work with the ACO during the in-country missions to obtain and review the data. This process will be supported by key informant interviews. This will be instrumental in conducting the cost efficiency and cost effectiveness analysis. This data will be stored securely and analysed to provide partial assessment of a number of evaluation questions.

Photograph analysis/generative AI

Photographs of health clinics will be taken during visits to communities that form part of the sample. These can help to give meaning to observed results on health-seeking behaviour by giving insight onto the observed qualities of health clinics in communities. Depending on the quality and coverage of clinics with photographs, this will be fed into the analysis as well as in the write-up of findings. In addition, during qualitative data collection, respondents may be asked to describe the qualities they look for in health clinics, and these prompts can be fed into generative AI tools. The resulting images can be compared against the pictures of actual clinics to observe whether there may be an expectations gap on clinics that may give partial explanation to observed healthcare seeking behaviour.

Focus group discussions

Focus group discussions with beneficiaries will explore the perspectives of beneficiaries on the *reasons* behind observed results, and provide essential input on the relevance of transfers to beneficiary households. At baseline, FGDs will be used to test the terminology, to understand what potential beneficiaries understand and expect the impact of transfers to be, and to understand intra-provincial or intra-district differences. At end-line, the FGDs will be used to test the preliminary hypotheses, conclusions and validate recommendations. They will also provide insight into unintended consequences of the programme, that can occur either due to design and/or implementation. Purposive sampling will be undertaken to ensure that a broad diversity of voices is included in the evaluation, with an emphasis on those minority voices that might not be adequately amplified by quantitative samples. As a benchmark, this proposal suggests a sample size of approximately 64 FGDs covering 8 participants per each FGD to avoid over saturation and the inefficient use of resources. Focus-group discussions enable to gather a broader range of voices efficiently, while also helping understand how community norms may shape behavioural responses to transfers. The FGDs will be conducted at both baseline and endline, with FGDs distributed evenly between the two waves, and across districts. Women – as direct intended beneficiaries of the MCCT programme – will be invited to participate. Previous experience suggests that indirect beneficiaries – male head of households, for example – are reticent to attend qualitative research. Instead, community leaders (expected to be male) will be invited to participate in the key informant interviews.

Key informant interviews

Key-informant interviews (around 50) with key staff and stakeholders across national, province, and district levels will identify the lessons learned, best practices and unanticipated consequences of the MCCT and its implementation. These interviews will be essential for assessing the extent to which the programme is likely to achieve its objectives, the sustainability of the programme and the factors that will influence the roll-out of the programme at a national level. Key informants to be interviewed will be identified through a stakeholder mapping conducted with UNICEF Afghanistan, and will involve staff at HCFs, UNICEF Afghanistan, Ministry of Health, ADB, other UN partners, community leaders, and implementing partners.

Household survey

The quantitative household survey will capture values for as many as possible of the indicators identified to serve as proxy measures for the underlying outcomes and impacts of the programme. The survey will balance comprehensive coverage of indicators with an urgent desire for parsimony, to respect respondents' time. Data will be collected using electronic tablets by specially trained enumerators from the Afghanistan-based data collection firm Samuel Hall (more information on the roles and responsibilities is provided in Annex 4). Enumerators will work in pairs to ensure compliance with local customs and practice. During the visit to a surveyed household, the male enumerator will engage with the male head of household and ask questions intended for the head of the household; the female enumerator will deliver the part of the survey intended for the beneficiary - to the woman in question. The quantitative survey contains a number of modules. These include questions on demographic and household characteristics, questions on income sources, consumption expenditure, food insecurity modules, knowledge, attitudes and practices, intimate partner violence, and a health module. The full survey can be found in Annex 5 – Data collection tools. The survey operationalises relevant indicators from the evaluation matrix and the logframe; some questions are not direct operationalisations of the question and may require further calculations. Some questions are not directly related to the logframe or evaluation matrix, but are necessary to provide control variables for regressions, or to test balance at baseline.

5.2.1. Sample size and sampling

In total, 2,400 households will be sampled and interviewed three times – 1,800 in districts that receive the MCCT and 600 households in districts that do not receive the MCCT. Figure 3 describes the distribution of the sample between groups. The evaluation aims to measure the minimal detectable effect size, given that the budget allows to sample only 1,200 households in Groups C and D. The minimal detectable effect size is a crucial parameter because it explains any level of impact below which the evaluation team cannot accurately distinguish the effect from zero, even if it exists. As a result, the minimal detectable effect also helps to identify the threshold below which a policy intervention may be considered unsuccessful. To identify the relevant parameters for power calculation analysis, relevant literature and MICS data for Afghanistan were consulted with a focus on two outcomes of interest: “Baby received prenatal care (at least once)” – whether women in the MICS 6 Afghanistan survey reported at least one prenatal care visit - and “Delivery in an institution.” The latter variable assessed whether women had given birth in a medical facility or institution, as opposed to in their own home.

For the first variable, "Baby received prenatal care (at least once)", the average is 0.78, and the standard deviation is 0.41. Considering a power of 80%, the value of 0.067 is the minimal detectable effect size in a study with these characteristics—meaning an increase of about 8.5% in the variable of interest. For the second variable, "Delivery in an institution", the average is 0.66, and the standard deviation is 0.47. Considering a power of 80%, the value of 0.0761 is the minimal detectable effect size for a study with these characteristics—meaning an increase of more than 10% in the variable of interest.

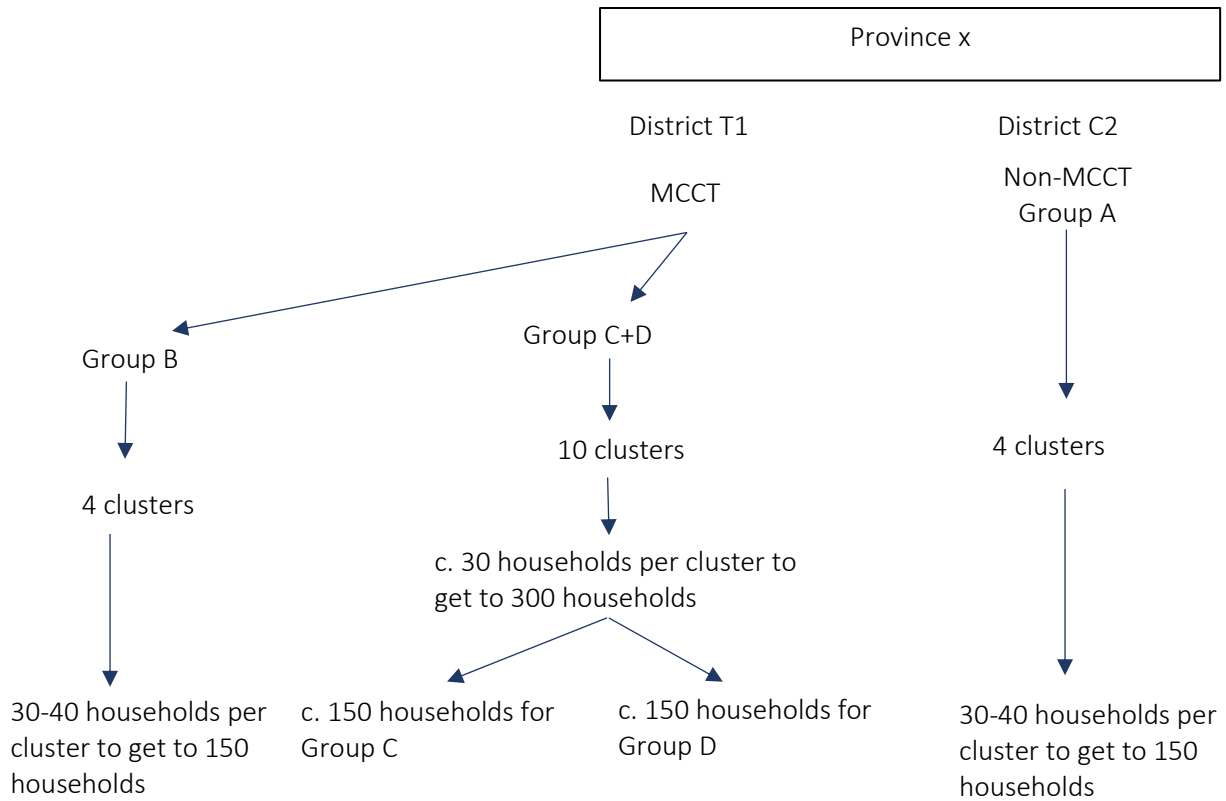


Figure 3 Sampling distribution in a given province

A multi-stage sampling strategy will be applied. First, using satellite images, mosques (or other community cluster points used, e.g. markets) will be identified as a starting point for systematic random sampling. In the treatment districts, 14 clusters will be selected (taking account security and accessibility concerns) and randomly allocated to Group B or Group (C+D). Secondly, in each cluster, enumerators will be instructed to sample a specific number of households in a given and specific location (street, for e.g.), using the *n*th household approach. The sampling allocation will account for density of households, increasing the sample in more densely populated neighbourhoods. This method of sampling cannot *a priori* guarantee that a household contains a beneficiary. However, in the absence of reliable geo-location data – a notoriously unreliable process with research tablets, and with evidence of global positioning system (GPS) jamming in the region – this option is a reasonable compromise. During the baseline, and with the consent of the household, a small sticker or marker will be left with the household to assist in identification in future data collection rounds. In Group C+D, half of the households will be randomly selected for participation in the intensive household nudging experiment. The districts identified by the evaluation team to serve as treatment and control districts – see Table 6) in the sample are provisional and may be subject to change based on a number of exigent factors (see 5.4. Risks, limitations, and mitigation strategies).

Table 6 Identification of sample treatment and control districts for household survey

Badghis	Status	Kunar	Status	Samangan	Status	Zabul	Status
Ghormach	Receives MCCT	Bar Kunar	Receives MCCT	Aybak	Receives MCCT	Daychopan	Receives MCCT
Ab Kamari	Receives MCCT & Sampled	Shigal	Receives MCCT	Ruy-e-Duab	Receives MCCT	Kakar	Receives MCCT & Sampled
<i>Jawand*</i>	Does not receive MCCT & Sampled	Narang	Receives MCCT	Dara-e-Suf-e-Payin	Receives MCCT	Atghar	Does not receive MCCT & Sampled
		Watapur	Receives MCCT & Sampled	Khuram Wa Sarbagh	Receives MCCT & Sampled		
		Dara-e-Pech**	Does not receive MCCT & Sampled	Hazrat-e-Sultan	Does not receive MCCT & Sampled		

Among the sample of households that completed the quantitative survey, certain households will be contacted to take part in the qualitative component. Across the districts, 64 FGDs will be conducted in both the base and endlines, with an even split (see Table 7). The purposive sample will not speak representatively; however, it will provide an important insight into dimensions unexplored by the quantitative sample.

Table 7 FGD Distribution by wave, district and group

Wave	District	Women		Men	
	Treatment	Close to HCF	Further from HCF	Community leaders	
Baseline	District 1	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds	18+ year olds	
	District 2	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds	18+ year olds	
	District 3	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds	18+ year olds	
	District 4	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds	18+ year olds	
	Control				
	District 1	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds		
	District 2	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds		
	Baseline FGDs: 32				
	Endline	Treatment	Close to HCF	Further from HCF	Community leaders
		District 1	18-25 year olds 25+ year olds	18-25 year olds 25+ year olds	18+ year olds
District 2		18-25 year olds	18-25 year olds	18+ year olds	

	25+ year olds	25+ year olds	
District 3	18-25 year olds	18-25 year olds	18+ year olds
	25+ year olds	25+ year olds	
District 4	18-25 year olds	18-25 year olds	18+ year olds
	25+ year olds	25+ year olds	
Control			
District 1	18-25 year olds	18-25 year olds	
	25+ year olds	25+ year olds	
District 2	18-25 year olds	18-25 year olds	
	25+ year olds	25+ year olds	
Endline FGDs: 32			
Total project FGDs: 64			

5.2.2 Data analysis tools

For the analysis of the quantitative data, the ET will use Stata as the main statistical software package. All data files will be stored as .dta files. The syntax will be written and stored as .do files for easy replication later on.

Qualitative data will be anonymised and coded. Both deductive and inductive coding passes will be made over the data. The qualitative findings will be used to provide an assessment of the relevant evaluation questions in their own right, while also providing additional support to quantitative findings through a process of triangulation. Depending on the scope of the qualitative data from the FGDs, the use of Atlas.ti for the analysis will be considered.

The photographs taken during the field work will be coded qualitatively similar to how qualitative data is analysed – using inductive coding structures in software packages such as Atlas.ti or Nvivo.

5.3. Integration of gender, disability, equity, and human rights in evaluation

Cross-cutting themes are integrated throughout the evaluation (i.e., inception, data collection and reporting and dissemination). A particular focus is placed to ensure that evaluation design, methodology, tools, and data collection scope and processes are completely aligned with the UN System-Wide Action Plan (UN SWAP) 2.0 prescribed accountability framework for mainstreaming Gender Equality and The Empowerment of Women (GEEW) by incorporating all relevant indicators and dimensions during analysis and reporting phases. Moreover, the use of a mixed methods approach will capture more thoroughly the extent to which cross-cutting issues were mainstreamed throughout the subject of the evaluation, as well as the extent to which cross-cutting issues may have influenced observed outputs or outcomes. Diverse data sources will be triangulated and assessed to provide as broad a picture as possible on cross-cutting issues. Primary qualitative data will specifically ask questions on the extent to which cross-cutting issues have been adequately considered in programme design, or whether cross-cutting issues may present a break in the foreseen relationship between inputs, outputs and outcomes in the programme theory of change. Both quantitative and qualitative data collection tools elicit information on the extent to which programme design maintains and upholds their dignity and human rights. Secondary data sources, including gender assessments, reports from external partners, reports from implementing partners as well as primary data collection with key informants will provide a broader picture on the gender and cross-cutting landscape in Afghanistan which will help to give greater context to findings.

5.4. Risks, limitations, and mitigation strategies

The evaluation is exposed to a significant number of risks and limitations that might weaken or undermine the strength of the evidence and conclusions the Evaluation Team is able to draw, as well as undermining the extent to which the Evaluation design can be implemented in a timely fashion, or at all.

There is a **small but material risk that the MCCT programme is terminated before its commencement** by decisions made outside the direct influence of the UNICEF Afghanistan Country Office. This naturally presents an insurmountable challenge to the evaluation and there is no mitigation strategy available. There is a further risk that specific components of the MCCT programme are removed from the pre-implementation plan as a result of discussions with parties including but not limited to the *de facto authorities* in Afghanistan. In mitigation, UNICEF and the Evaluation Team have worked together to design a culturally-sensitive programme and evaluation. In adaptation, the Evaluation Team will work in conjunction with UNICEF ACO to re-design an evaluation to suit the altered MCCT design.

Districts identified in this inception report as treatment and control districts may be subject to change for reasons beyond political adjustments. Upon completion of the initial round of enrolment, further districts may be wrapped into the programme on the basis of budget space. These districts are likely to be the next districts with respect to the GAM prevalence score – the same districts identified as control districts. While this process will take place before the baseline data collection exercise, it does prevent the completion of sampling and mobilisation prior to the completion of enrolment. The Evaluation Team is unable to mitigate against this particular risk. The Evaluation Team will work closely with the Evaluation Manager to ensure that these risks are communicated as soon as possible and develop an adapted treatment and control district.

In the presence of widespread multi-dimensional deprivation, high humanitarian need and a plethora of actors in the humanitarian space, the **vanishing control group** is a prescient concern. Province and district selection was done on the basis of continuous measures of a latent vulnerability. The most suitable control group is, therefore, a district that was closest with respect to the GAM rate used in district selection to the targeted district. However, given their vulnerability and deprivation, these districts are likely to be enrolled into subsequent transfer programmes other than the MCCT. This material change to the circumstances of households in that district would render it an inappropriate control group. It would be unethical and contrary to all humanitarian norms to restrict the roll out of further transfers in pursuit of the preservation of a control group. The extent to which a mitigation strategy exists would depend on the scope and scale of the programme implemented that vanished the control group, and would also limit the number of mitigation strategies available. The Evaluation Team relies on the Evaluation Manager to highlight any programmes that present a credible threat to the existence of the control group.

Cultural norms limiting the autonomy of women may result in women being excluded from participation in qualitative research as direct respondents, and may prevent respondents from being afforded the privacy and confidentiality that is essential for collecting meaningful data. This is particular concerning if information on sensitive topics is to be collected. If privacy and confidentiality cannot be guaranteed the interview will be terminated, to safeguard the well-being of participants. In line with survey techniques used globally, a survey may be fielded among men in the household in an adjacent location to create some degree of privacy. In line with cultural norms, male-female pairs of enumerators will be fielded for both components of the data collection.

Security remains an ever present challenge to the conduct of research in Afghanistan, for both international and local staff. All data collection exercises will be taken in line with UN-imposed restrictions. In conjunction with security personnel or services, including United Nations Department for Safety and Security (UNDSS), a method of working will be established to ensure safe and secure communication and an evacuation plan put in place. UNU-MERIT and Samuel Hall will work with the *de facto* authorities at district, province and national level to ensure that there is awareness and consent for the research to take place. However, precise travel plans and data collection programmes will not be shared in advance. Where possible, community elders will be engaged to facilitate access to communities without hindrance. There may be further interference on the part of the *de facto* authorities during data collection. Full engagement with the *de facto* authorities and compliance with local norms will help to reduce the risk of this delay occurring.

The evaluation team anticipates attrition from the data collection exercise, and from the programme. In a fragile and conflict-prone region, some areas may become inaccessible physically or using telecommunication methods. Where possible, the data collection exercise proposed will form a panel dataset, offering the richest possible analysis. If attrition from the panel is not conditional on key outcome variables, this may not present a significant problem. However, non-random attrition may introduce biases. As a result, the baseline will oversample households to account for high attrition rates of the evaluation is assured through dual and complementing processes. Within the Evaluation Team, internal policies play an important role in ensuring quality. Additionally, UNICEF has established Quality Assurance processes.

Administrative data from sampled health care facilities on attendance and any anthropometrics measures plays an important role in the empirical strategy in an impact evaluation, as well as enriching and strengthening the analysis. The Evaluation Team understands that, in context, this may be difficult data to obtain. All researchers engaged by UNU-MERIT are bound by a moral, ethical and legal code of conduct on the management and storage of information and UNU-MERIT has strict data storage and sharing protocols in place to safeguard the data and the privacy of individuals. This mitigation factors notwithstanding, if it is thought that this information could place respondents at any undue risk of harm this component will be dropped.

5.5. Quality assurance

The assessment will meet UNICEF's expectations regarding quality of assessment processes and deliverables as articulated in the UNICEF-adapted United Nations Evaluation Group (UNEG) Norms and Standards. This includes:

- Ensuring the quality of data and information collected and integrity of analysis reflected in the evaluation deliverables;
- Ensuring that the data collection processes adhere to UNICEF-adapted UNEG Norms and Standards;
- Ensuring that the qualitative and quantitative evidence gathered is comprehensive and robust enough to make an informed assessment in line with the evaluation's objectives, and in support of the conclusion and recommendations; and,
- Managing all data collection, analysis, reporting, and communication.

At all times, the evaluation team will ensure the quality of data by maintaining validity, consistency and accuracy in all analytical and reporting phases. Furthermore, the institute guarantees independence of evaluation and research and elimination of conflict of interest.

At the project level, and depending on the type of the assignment, UNU-MERIT strives to:

- Ensure close and rigorous supervision by the team leader of evaluators and local consultants with clear lines of communication and responsibility along with regular communication to identify and solve problems as they arise.
- Ensure all local research firms or consultants are screened prior to engagement, with references and evidence of past experience and qualifications sought. A competitive tendering process is undertaken, followed by an interview and selection process. All local researcher firms or consultants are required to sign agreements to comply with all relevant ethical research principles and regulations along with additional voluntary commitments.
- Prior to the commencement of data collection exercises, all enumerators receive training from UNU-MERIT directly, or receive training approved by UNU-MERIT on conducting ethical research, obtaining informed consent, conduct and security in the field, ensuring privacy, confidentiality and anonymity of respondents, conducting rigorous research.
- Ensure that, when working with children or vulnerable persons, appropriate safeguarding procedures are in place and adhered to at all times by UNU-MERIT researchers and those persons acting in their name.

Throughout the project, UNU-MERIT will remain in close contact with the evaluation manager and the management team, ensuring regular information on the process of work undertaken on their behalf. As part of this, milestones will be set. In case potential issues arise, these would therefore be recognized early in the process and addressed accordingly through consultation with the client. Complementing the internal UNU-MERIT processes, a second level of quality assurance of all deliverables will be undertaken by the UNICEF evaluation manager and the Management Team. UNICEF has appointed individuals and convened teams to support the evaluation and jointly ensure rigour and compliance with UNEG Evaluation Norms and Guidelines. The evaluation is supported by an evaluation manager – Kamilla Nabiyeva – who is responsible for overseeing the implementation of the evaluation and facilitating important relationships and connections between the Evaluation Team, UNICEF and national bodies. A management team has, additionally, been convened. This team is, along with the evaluation manager, responsible for ensuring that the evaluation is conducted in compliance with ethical norms and guidelines, as well as ensuring all evaluation products issuing from the evaluation are coherent, relevant and implementable. A reference group, consisting of internal and external experts in relevant fields, will contribute to the design of the evaluation, providing technical input and quality assurance to key deliverables, and participate in key evaluation meetings. In addition, they will play a key role in disseminating the findings and ensuring that they are as useful as possible to relevant policymakers.

5.6. Ethical considerations

The evaluation will be conducted in accordance with the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, the United Nations Evaluation Group Norms and Standards (2016), and the United Nations Evaluation Group Ethical Guidelines. The evaluation will also adhere to UNICEF-Adapted UNEG Evaluation Reports Standards (2017), UNICEF Policy on Personal Data Protection (2020), and UNICEF Standard on Information Security (2018). To ensure impartiality, the evaluation team will take into account the views of all interviewees and contacted stakeholders. This evaluation will be conducted in line **with these norms and standards, including but not limited to:** independence, impartiality, credibility, no conflict of interest, honesty, integrity, and accountability.

Internally, UNU-MERIT ensures accountability to affected populations by ensuring that all evaluations and research are done in diligent compliance with all ethical and scientific principles, and by ensuring the voices of participants are faithfully recorded *and* analysed. Any work that UNU-MERIT undertakes is subject to internal ethical procedures and guidelines as set out by the Ethical Review Committee of Maastricht University. Research and evaluations undertaken at Maastricht University is subject to the Netherlands Code of Conduct by the Universiteiten van Nederland (VSNU).⁸ It is also subject to the General Data Protection Regulations of the European Union.⁹ As a UN entity, it is bound to UN regulations pertaining to child labour, sexual exploitation and abuse.¹⁰

Integrity is upheld through the thorough and consistent implementation of established research and evaluation principles and norms, including but not limited to those detailed in previous sections on Quality Assurance. Integrity is further upheld through the careful selection and training of enumerators, and the careful oversight of data collection, storage and analysis. Impartiality and independence are achieved through the construction of a contractual relationship between the Evaluation Team and UNICEF that enables the facilitation of the project without compromising the Evaluation Team's independence and impartiality. The Evaluation Team has, at the outset of the project, confirmed that there is no known conflict of interest and undertakes to ensure that any future conflicts of interest, either real or perceived, arising are made known to the Evaluation Manager at the earliest possible moment.

Privacy and respect of rights is assured through multiple complementary evaluation components. Privacy will be assured through the careful construction of and compliance with data storage and management protocols, including ensuring that enumerators are bound by confidentiality agreements and all personal information is removed from any data collection tablets. All data storage and analysis will be done in compliance with UNU-MERIT's established data storage processes. These in turn are compliant with international principles. Respect of rights is primarily assured through the careful training of enumerators to respect the rights of participants that are enshrined in the conduct of ethical research. Enumerators will be trained to ensure that participants are aware of their rights under these conventions, and ensure that informed consent is obtained prior to the collection of any data (qualitative or quantitative).

Accuracy, completeness and reliability are a constant part of analysis conducted at UNU-MERIT. The Evaluation Team will ensure that all data is recorded and analysed faithfully, and that findings and recommendations are traceable to specific analysis or sources. In addition, quantitative findings will be subject to usual replicability requirements of academic research. Quantitative analysis will be performed using Stata, a script-based analysis software that ensures every step taken in the analysis process can be replicated by an external person equipped with the script and the raw data. These codes and the anonymised data must be made available by the Evaluation Team upon request in line with UNU-MERIT's

⁸ Please refer to:

https://www.nwo.nl/sites/nwo/files/documents/Netherlands%2BCode%2Bof%2Bconduct%2Bfor%2BResearch%2BIntegrity_2018_UK.pdf

⁹ Please refer to <https://gdpr-info.eu>

¹⁰ Including the following protocols: (1) Secretary General's bulletin on prohibition of discrimination, harassment, including sexual harassment, and abuse of authority (ST/SGB/2008/5); (2) Secretary General's bulletin on prevention of workplace harassment, sexual harassment and abuse of authority (ST/SGB/2005/20); (3) Secretary General's bulletin on special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13)

research and evaluation principles. Any issues that arise throughout the process will be reported immediately to any appropriate authorities and brought to the attention of the Evaluation Management where relevant.

Lastly, the evaluation will go through an Institutional Review Board (IRB) process to seek ethical clearance from the relevant institutions to be identified by UNICEF ACO.

5.7. Management arrangements

To facilitate the implementation of the evaluation of UNICEF Afghanistan's MCCT programme, UNICEF has appointed an Evaluation Manager. The role of the Evaluation Manager is to provide quality assurance support to the Evaluation Team, facilitate internal and external access to key informants, and provide detailed internal documents necessary for the completion of the evaluation, as well as those necessary for drawing conclusions. The Evaluation Manager is further responsible for convening the management team and the reference groups, and ensure that knowledge products and necessary information is disseminated to the management teams, reference group and any relevant stakeholders, and seek their input where relevant. The Evaluation Manager is further responsible for the monitoring and assessment of key deliverables as agreed in the inception report.

The evaluation is further supported by the Management Team and the Reference Group. The Management Group is intended to provide expert insight as well as to facilitate access to information and key informants, and ensure smooth data collection process and credible analysis. The Reference Group is intended to provide insight from diverse and inter-disciplinary perspectives to improve the scope of the analysis, to ensure previously unforeseen components are included in the analysis and knowledge products.

The Evaluation Team has internal procedures to manage the evaluation, including internal administrative support, and support to ensure compliance with research ethics and data storage rules and regulations applicable. The Evaluation Team consists of experts in their respective fields that jointly contribute to ensuring that the evaluation design and resulting analysis is conducted rigorously and accountably. The project is led by a Team Leader with decades of experience in the field. The Team Leader is responsible for ensuring that the evaluation is conducted in line with any applicable rules and regulations as well as facilitating the connection between the Evaluation Manager and the Evaluation Team. The biographies of the Evaluation Team members can be found in Annex 3 – Team Biographies.

6. Evaluation workplan and deliverables

The submission and acceptance of the inception report marks the end of the preparation phase for the MCCT evaluation, and in particular for the baseline data collection. Table 8 specifies the project key deliverables. However, given the uncertainty about the actual start of the MCCT implementation at the time of writing, no dates can be provided for the deliverables beyond the final inception report.

Further progress in the evaluation is contingent on a number of external factors out the control of the Evaluation Team and the UNICEF ACO. These are specified and noted in the inception report. In close cooperation with the UNICEF ACO, local evaluation partners and implementing partners, the detailed further workplan for the baseline data collection and analysis is envisaged as in Table 9. Finally, summary workplans are provided for the mid-line and end-line evaluations in Table 10 and Table 11.

Table 8 Project key deliverables

#	Deliverable	Expected date of completion
1	Revised inception report	5 April 2024
2	Inception report presentation	10 April 2024
3	Final inception report	19 April 2024
4	BASELINE	
5	Draft baseline report	
6	Revised baseline report	
7	Baseline report presentation	
8	Final baseline report	
9	Academic publication based on baseline	
10	MID-LINE EVALUATION	6 months after baseline
11	Draft inception report	
12	Revised inception report	
13	Inception report presentation	
14	Final inception report	
15	Draft mid-line evaluation report	
16	Revised mid-line evaluation report	
17	Mid-line evaluation presentation	
18	Final mid-line evaluation report	
19	Academic publication based on mid-line	
20	END-LINE EVALUATION	18 months after baseline
21	Draft inception report	
22	Revised inception report	
23	Inception report presentation	
24	Final inception report	
25	Draft end-line evaluation report	
26	Revised end-line evaluation report	
27	Presentation end-line evaluation report	
28	Final end-line evaluation report	
29	Academic publication based on endline	

Table 9 Detailed work plan baseline

Weeks after inception report acceptance

										1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2				
Baseline		1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	
		Aug ust	Late August- Septemb er	Late Septemb er- October	October- Novemb er	Novemb er- Decemb er	Decemb er- January 25	January- February																					

Preparation

- Obtain permission from/sign MoUs with DFA (UNICEF)
- Enrolment, verification and final district selection (UNICEF)
- Test tools for data collection (questionnaires, FGD and KII guides)
- Identify and agree community cluster strategy for Groups B-D with UNICEF ACO
- Agree semi-structured script guide for social mobilisers with UNICEF ACO
- Prepare material for enumerator and social mobiliser training
- Submit evaluation design and tools for ethical approval
- Translate tools and training materials into Dhari and Pashtu
- Programme CAPI (tablets and/or phones)
- Test tools and train enumerators for data collection (in country mission)



Data collection baseline

- Conduct sampling preparation work
- Collect household survey data
- Implement FGDs
- Hold KIIs and take pictures of HCFs
- Collect administrative data
- Transcription and translation of FGDs and KIIs
- Data cleaning survey data



Data analysis and report writing

- Analysis of survey data (mainly descriptive)
- Analysis of qualitative data (FGDs, KIIs)
- Review admin data, photos and notes from the field
- Draft baseline report
- Present and validate baseline report (online)
- Finalize baseline report
- Disseminate baseline report
- CAPI: Computer Assisted Personal Interview



Table 10 Summary workplan Phase 3: Mid-line evaluation

	weeks (starting 6 months after baseline data collection)																													
	1	2	3	4	5	6	7	8	9	0	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2			
Mid-term evaluation																														
Inception & Preparation																														
In-country mission																														
Data collection mid-term evaluation																														
In-country mission																														
Data analysis and report writing																														

Table 11 Summary workplan Phase 4: End-line evaluation

	weeks (starting 12 months after mid-line data collection)																													
	1	2	3	4	5	6	7	8	9	0	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2		
Final evaluation																														
Inception and Preparation																														
In country mission																														
Data collection mid-term evaluation																														
In country mission																														
Data analysis and report writing																														
In country mission																														

Annex 1 – Terms of Reference

The final Terms of Reference made available by UNICEF ACO is provided for reference here.

UNICEF AFGHANISTAN REQUEST FOR CONTRACT FOR SERVICES

SHORT TITLE OF ASSIGNMENT
Impact Evaluation of UNICEF Afghanistan Mother and Child Cash Transfer Programme (MCCT)
BACKGROUND
<p>Afghanistan is facing unprecedented humanitarian crisis and its longstanding issues have snowballed into a complex crisis which presents a real risk of escalating into a humanitarian catastrophe with massive human and social economic costs. The number of People in Need (PiN) has progressively increased by over 300% from 9.4 million people in January 2020 to a staggering 28.3 million people (almost 66 per cent of the population) in 2023. Children are among the most vulnerable in Afghanistan comprising 54.4 percent of those in need. Moreover, an estimated 2.3 million children are expected to suffer from acute malnutrition in 2023 with 875,000 expected to suffer from severe malnutrition (HNO 2023). In addition, an estimated 840,000 pregnant women and lactating mothers are likely to suffer from acute malnutrition (HNO 2023). Over 32% of the provinces in Afghanistan have high stunting levels at between 40% to 66% (MICS, 2023) a grim testament of the dire conditions facing women and children in Afghanistan.</p> <p>While considerable progress has been made in Afghanistan in improving the maternal and newborn health (MNH) in the last two decades; this has been largely attributed to increased availability of health facilities providing the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Despite the notable improvements, data continues to show wide variation in terms of utilization of services. For example, the data from the 2015 AfDHS shows significant disparities for antenatal care and safe deliveries such as only 5.9% of women in Badghis giving birth in a healthy facility compared to 46.2% in Bamyan and 35.5% in Kandahar. Recent data from the Multiple Indicator Cluster Survey conducted by UNICEF indicates that the proportion of women attending antenatal care is as low as 6% in some provinces e.g., Nuristan compared to 63% in Bamyan.</p> <p>Women face several barriers including socio-economic barriers ranging from conservative cultural values limiting their movement and decision-making power, illiteracy, and lack of awareness of the benefits of different maternal healthcare options, and high transport costs to reach health facilities. Main barriers to accessing MNH care in Afghanistan include distance to health facilities, transportation and other costs incurred in reaching health facilities, cost of medicines, perceived quality of care and Socio cultural and religious factors. The change in regime in August 2021 has resulted in regressive policies and worsened the already weak governance system giving limited hope for ensuring women and girls rights via the state system as witnessed by the successive bans on women’s right to education and right to work. At the same time, the United Nations Development Programme (UNDP) estimates that around 97 per cent of Afghans have plunged into poverty as of mid-2022, up from 47 per cent in 2020 severely compromising families and care givers’ abilities to ensure that children’s needs and rights are met.</p> <p>Cash transfers are a proven mechanism to address demand side constraints in achieving a range of needs and rights of children across the lifecycle within the first 1000 days of life. They not only address financial barriers faced by households to access goods and services, but when combined with relevant accompanying measures, can also serve as a powerful vehicle/incentive for changing behaviours, social norms and realizing social and economic outcomes across a wide range of areas including, food security, health, and education. Importantly, cash transfer programs that are designed in a complementary and</p>

integrated manner with evidence generation embedded can provide a strong basis for informing a nascent social protection system.

Since November 2021, UNICEF has delivered cash transfers to at least 308,000 unique households in Afghanistan reaching over 2.2 million individuals (including 1.4 million children) with unconditional cash transfers to allow them to meet a broad range of needs including health, nutrition, education, protection, and other basic needs, as well as needs arising due to specific external factors such as harsh winters. Among the beneficiaries, at least 24,000 families with pregnant and lactating women, have so far been supported with cash transfers under UNICEF’s Mother and Child Cash Transfer (MCCT) Programme with the aim of improving access to institutional health services and meeting other needs related to out of pocket health expenses and nutritious foods.

UNICEF is planning to scale-up the current MCCT programme in five provinces in Afghanistan (Kunar, Badghis, Samangan and Zabul) to give children a positive start in life by addressing the underlying drivers of poverty and deprivation with a primary focus on the first 1000 days of life. The first 1000 days of life are the most critical for survival and growth, yet this is the point in the lifecycle when children are the most vulnerable and voiceless. This is also an age group where the rights and status of women in society intersect with children’s survival and well-being. Women and girls are among the most marginalized in Afghan society with systematic denial of their rights and the reversal of progress made in the past few years. For these reasons, the programme will target households with; children under the age of two years, pregnant women, and lactating women with predictable transfers over a period of 18 months. The key objectives of the programme are:

- a. Overcome financial barriers to accessing health and nutrition services.
- b. Improve knowledge and influence behavioral change in relation to health seeking behavior and positive maternal and child health practices.
- c. Generate evidence to inform future programming and the design of social protection and safety net programmes.

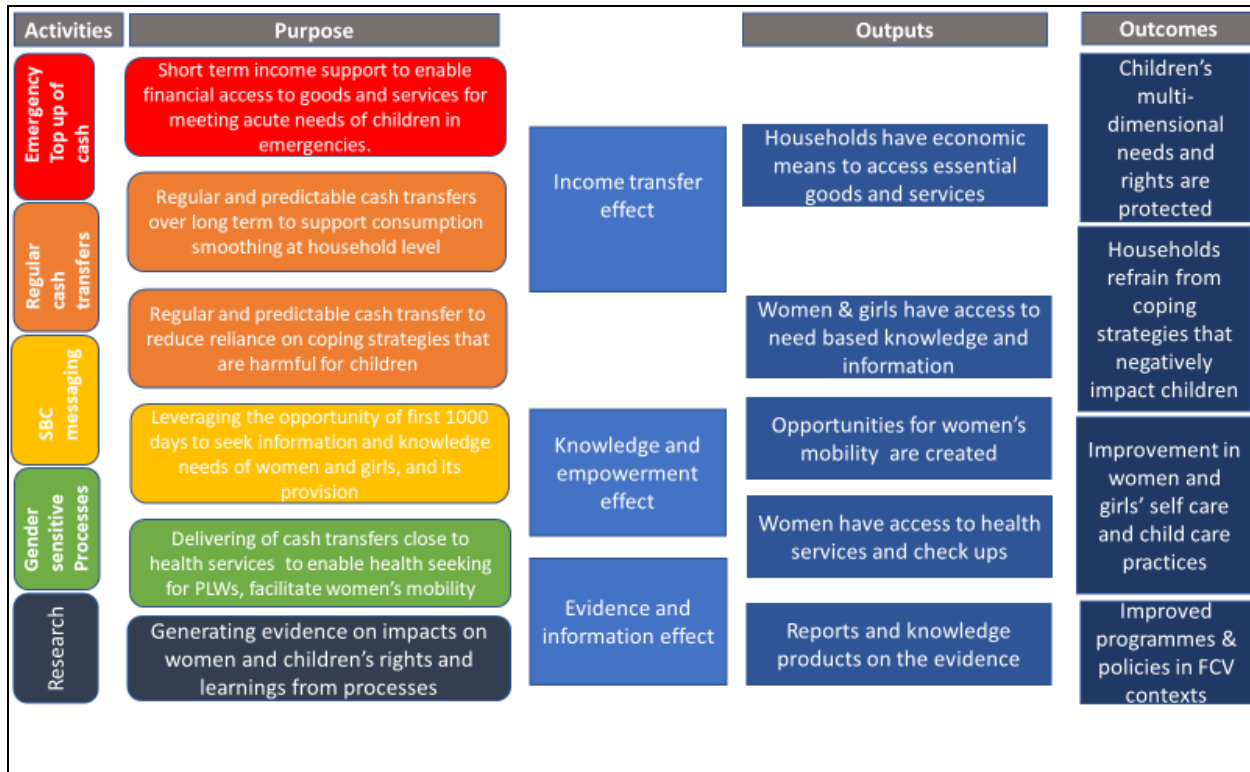
The Key Programme Design Components are;

1. Provision of quarterly cash transfers (20 USD per month) to households with pregnant and lactating women with children under the age of two years.
2. Social behavioral change communication with a focus on health and nutrition outcomes.
3. Linking pregnant and lactating women to health and nutrition services.
4. Research, evaluation, and broader evidence generation and learning agenda to systematically capture outcomes for women and children, and effectiveness of programme design features, implementation processes and operational mechanisms to serve as the basis for developing a nascent social protection system in Afghanistan.

Theory of Change and Expected Results

The programme is expected to contribute to the consistent fulfillment of children’s basic needs, reduction in adoption of coping strategies with negative impacts on children, enhanced self-care among women and girls as well as improvement in child caring practices, and robust evidence to influence an improvement in policies and programmes on social protection in contexts impacted by fragility, conflict, and violence.

Figure 1: MCCT theory of Change



PURPOSE

The purpose of this assignment is to generate and share evidence from the MCCT programme on the impacts of the programme interventions in realizing the intended and unintended outcomes of the project and contribute to improving the design and implementation of MCCT programme, demonstrate opportunities for improving the design and implementation of similar programmes and inform the development of the social protection system in Afghanistan.

The users of the study findings will include UNICEF Afghanistan, UNICEF globally, the De Facto Authorities (DFA), other UN Agencies, NGOs implementing cash programmes in Afghanistan, Agencies implementing cash worldwide in contexts like the Afghanistan context and the academia.

OBJECTIVES

The objectives of the assignment are to;

1. Design of methodology and conduct of a comprehensive baseline of the MCCT programme covering all MCCT targeted geographical areas.
2. Undertake a mid-term impact evaluation after 9 months of implementation and a final impact evaluation following the completion of the programme after a period of 18 months covering targeted geographical locations by the MCCT programme.
3. Identify the impacts of the MCCT programme design, operational frameworks and project implementation on project objectives and demonstrate where evident, possible adjustments to maximize on the strengths and minimizing the weaknesses of the design and operational frameworks in the implementation of the MCCT programme and beyond.
4. As part of the assignment, undertake at least two academic publications in relevant knowledge hubs such as academic journals and other public information repositories including within and outside UNICEF.

The above four workstreams will refer to the UNICEF Afghanistan country strategy on MCCT as well as specific MCCT programme design components.

SCOPE OF WORK/ WORK ASSIGNMENT
<p>Thematic Scope</p> <p>The MCCT programme is comprised of four core elements which are (i) provision of cash transfers to households with pregnant and lactating women with children under two years age; (ii) linkage of pregnant and lactating women to health and nutrition services and (iii) undertaking social behavioral change communication activities to ensure improved and sustained health seeking behavior, knowledge and practices for pregnant and lactating women and children.</p> <p>The final thematic element is research and evaluation which encompasses the scope of this assignment and will entail;</p> <p>Research Questions</p> <p>Effectiveness Questions</p> <ol style="list-style-type: none"> 1. What are the impacts of the MCCT programme on health and nutrition outcomes of pregnant and lactating women and children? 2. Which programme components/features and processes of the MCCT programme contributed significantly than others to achieve the programme impacts and outcomes and why? 3. What are the impacts of the Social Behaviour Change Communication on the health seeking behaviour and maternal and child health care behavior, knowledge, and practices of pregnant and lactating women, families, and communities? 4. In the event of a crisis, what would be the impact of an emergency cash transfer on ensuring that the targeted population and children can meet their acute needs in times of crisis? 5. What is the impact of the MCCT programme design feature of facilitating cash distributions close to health facilities on the health seeking behaviour and mobility of pregnant and lactating women and their children? 6. To what extent are the programme design and implementation modalities effective? Where, when, and why? 7. To what extent are the activities and outputs of the programme consistent with the objectives of the programme? 8. To what extent are the programme objectives likely to be achieved? <p>Relevance Questions</p> <ol style="list-style-type: none"> 9. To what extent is the design and implementation of the programme sensitive to the needs and realities of the target population? 10. What are the impacts of the programme on gender relations at the household and community level? 11. To what extent are the ongoing 12. or previously completed cash transfer programme/projects likely to influence the impacts and outcomes of the MCCT programme? <p>Efficiency Questions</p> <ol style="list-style-type: none"> 13. To what extent is the value of transfer and regularity of the cash transfers adequate? To what extent are the unique needs of pregnant and lactating women and children under two met within the objectives of the programme?

14. What are the potential synergies between the MCCT programme and other programmes/projects implemented in the same locations?
15. How efficient are the delivery processes at each stage of implementation likely to be in the context of time, resources, and coordination between different actors?
16. What are the affected population and other stakeholder costs associated with accessing the programme?
17. What are the impacts of the programme beyond the affected population and communities?

Sustainability Questions

18. How can the MCCT programme be replicated at the national level? and what would it take to scale up the MCCT programme to a national level?

Themes

- i. Determining the current ability of programme beneficiaries to meet their basic needs, identify their expenditure patterns and overall, their socio-economic and household conditions.
- ii. Determining the level of access to health and nutrition services for pregnant and lactating women and their children and the factors that positively or negatively influence their access to health and nutrition services, considering the differences in geographic areas and different practices and norms in these areas.
- iii. Assessing the affected population's (pregnant and lactating women) current level of health seeking behaviour, knowledge and nature and state of their health and nutrition care practices and the change due to the programme.
- iv. Determining the aggregate impact of the main programme components i.e., cash transfer, social and behaviour change communication and interlinkages with health and nutrition services among the affected population.
- v. Highlighting the extent to which cash distribution near health facilities and encouraging presence at cash distribution sites has contributed to increased women's mobility and exposure to health services and health seeking behaviour.
- vi. Determining the effectiveness of the theory of change i.e., how the main components of the programme (cash transfer, social and behaviour change communication and interlinkages with health and nutrition services) interlink to influence the best health and nutrition outcomes for pregnant and lactating women and children.
- vii. Determining the unintended impacts of the programme among the affected and unaffected population such as enabling parents to relax their household's budget constraints and thus improve their home environment thereby reducing the effects of financial strain and deprivation and the stress associated with this, as well as possibly intra household dynamics (including gender and allocation of resources) and consequently improving parental capacity to nurture and interact with their children and the wider community not targeted by the programme (spill over effects, both positive and negative; perceptions and acceptance by wider community, men and religious leaders).
- viii. Identifying design and operational strengths and weaknesses and proposing measures to overcome identified weaknesses based on lessons learned from the implementation and

their implications of MCCT programme taking into consideration the evolution of the future social economic, political, and environmental context in Afghanistan.

- ix. Identifying important context specific and environmental factors such as poverty, health, protection/peace and security, culture (religion), ethnicity and tribal relations, economic development, education and literacy and emergencies and the overall humanitarian situation that may negatively and positively influence outcomes for targeted beneficiaries.
- x. Identify intended and unintended outcomes for targeted and non-targeted households especially pregnant and lactating women and children through appropriate study methodologies applicable to the Afghanistan context
- xi. Determine the project design and operational strengths, challenges, and weaknesses. Any unintended impacts of the design and implementation itself. Identify how the design and implementation challenges and weaknesses can be addressed prior to the commencement of the project implementation, continued implementation after midline evaluation and to inform post project roll out of similar interventions following the final evaluation
- xii. Identify any other themes emerging during the study because of the fieldwork and analysis that may be of interest to UNICEF implementation of the MCCT programme and beyond.

Geographical Scope

The assignment will cover MCCT priority provinces of Kunar, Samangan, Badghis and Zabul. These provinces have been prioritized based on a combination of multi-dimensional poverty, stunting, infant mortality, neo-natal mortality, and attendance of antenatal care. Within these provinces, specific districts have been selected based on the prevalence of acute malnutrition and shared in Annex 2. The actual registered households per district and the final districts to be included in the project will be shared at contracting.

METHODOLOGY

Design: The identified LTA (Long-Term Arrangement) holders will determine and propose the most appropriate evaluation design to cover the three phases (Baseline, Midline and Endline) of the evaluation and comprehensively articulate how the methodology/ies selected will be designed and implemented to demonstrate the impacts of the programme in line with the programme objectives.

- a. Overcome financial barriers to accessing health and nutrition services.
- b. Improve knowledge and influence behavioral change in relation to health seeking behavior and positive maternal and child health practices.
- c. Generate evidence to inform future programming and the design of social protection and safety net programmes.

Methodology: The Long-Term Arrangement holders identified to undertake this assignment will design the methodology, tools, and implementation strategy, conduct the field survey, and produce a baseline report, midline report and endline report for this Impact Evaluation. The methodology will consider the following

- I. The proposed Long Term Arrangement holders will propose an experimental design (treatment and control) while relying on a thorough and statistically relevant sampling method that will determine the sample sizes for both treatment and control groups that should be statistically relevant.
- II. The assignment will use mixed methods combining qualitative and quantitative methods for data collection and analysis from both primary and secondary sources. The quantitative

surveys will be aligned to the project theory of change and will measure the key outcome and impact indicators and intermediate outcomes. Qualitative data will be sourced from any existing and relevant literature and primary data while clearly articulating the sequencing of the quantitative and qualitative data collection and analysis as well as the rationale for, purpose and approach to a mixed methods approach.

III. The proposed Long Term Arrangement holders will consider the sufficiency of the proposed study questions and where necessary propose relevant additional questions that could better draw out the impacts and outcomes of the evaluation.

IV. The survey will consider other benefits and services that beneficiaries have access to, whether provided by UNICEF, other UN Agencies, De Facto Authorities (DFA), NGOs and other stakeholders that may influence the outcome of the evaluation and challenge the attribution of causality to interventions by this project. The Long-Term Arrangement holders are expected to highlight these complexities in their proposals.

V. The submitted proposals will highlight the specific approaches to be employed in collecting primary and secondary data and particularly primary data considering the challenging operational context in Afghanistan vis a vis drawing information from the project target population. UNICEF confirms the feasibility of accessing primary data through high-frequency phone surveys. For secondary data, UNICEF will share existing programme documents and other relevant literature, policies, strategy documents, project proposals, plans, partnership agreements, post distribution monitoring reports (if available), and other documents that may be requested relevant to the scope of work.

I. Highlight their study assumptions and ethical considerations, limitations, and mitigation measures

The Long-Term Arrangement holders will detail their proposed methodology in the proposal and ensure that their proposal is articulated in detail in line with the proposed assessment matrix. UNICEF anticipates that elaborating the methodology at inception will have no financial implications.

Key activities for the LTA holders

Evaluation Phase	Detailed Activities	Duration	Deliverable	Payment Schedule
Planning	Literature review (strategies and programme design documents)	3 weeks	Detailed plan for entire assignment.	20%
	Consultation meeting with relevant UNICEF team(s)			
	Engagement with all relevant stakeholders (UNICEF internal and external stakeholders)			
	Finalize theory of change, monitoring and evaluation framework, log frame and detailed baseline and Evaluation plan			
	Presentation of baseline and Evaluation plan and endorsement of plan by UNICEF			
Baseline	Baseline Inception meeting			20%
	Detailed planning and preparation for baseline including tools and methodologies to			

	<p>be employed and strategy and content for enumerator training</p> <p>Draft Baseline Inception report produced and disseminated</p> <p>Draft Baseline Inception Report presented and validated at a Workshop</p> <p>Final Baseline Inception Report produced</p> <p>Baseline data collection and analysis</p> <p>Draft Baseline report and presentation</p> <p>Review of draft Baseline report and feedback</p> <p>Dissemination of Baseline findings</p> <p>Submission Final Baseline report following review workshop with stakeholders and highlighting conclusions and recommendations from participants</p> <p>Publication from Baseline study</p>	24 weeks	<p>Inception report and presentation.</p> <p>Baseline report and presentation.</p> <p>Academic publication.</p>	
Mid-term Evaluation	<p>Inception meeting on Mid-term Evaluation</p> <p>Detailed planning and preparation for Mid-term Evaluation including tools and methodologies to be employed and strategy and content for enumerator training</p> <p>Draft Mid-term Evaluation Inception report produced and disseminated</p> <p>Draft Mid-term Inception Report presented and validated at a Workshop</p> <p>Final Mid-term Inception Report produced</p> <p>Mid-term Evaluation data collection & analysis</p> <p>Draft Mid-term Evaluation report & presentation</p> <p>Review of draft Mid-term Evaluation report and feedback</p> <p>Dissemination of Mid-term Evaluation findings</p> <p>Submission of Final Mid-term Evaluation report following review workshop with stakeholders and highlighting conclusions and recommendations from participants</p> <p>Publication from Mid-term Evaluation study</p>	24 weeks	<p>Inception report.</p> <p>Mid-term Evaluation report.</p> <p>Academic publication.</p>	30%
Final Evaluation	<p>Inception meeting on final Evaluation</p> <p>Detailed planning and preparation for final Evaluation including tools and</p>		<p>Inception report.</p>	30%

methodologies to be employed and strategy and content for enumerator training	24 weeks	Evaluation report. Academic publication.	
Draft Final Evaluation Inception report produced and disseminated			
Draft Final-evaluation Inception Report presented and validated at a Workshop			
Final-evaluation Inception Report produced			
Evaluation data collection & analysis			
Draft Final Evaluation report and presentation			
Review of draft Evaluation report and feedback			
Dissemination of Evaluation findings			
Submission of Final Evaluation report following review workshop with stakeholders and highlighting conclusions and recommendations from participants			
Publication from Evaluation study			

QUALIFICATIONS, SPECIALIZED EXPERIENCE AND ADDITIONAL COMPETENCIES REQUIRED

The evaluation team should comprise one Technical Team Leader and enough technical team members to ensure the assignment's successful implementation. Team members proposed in the technical proposal document must be available for their assigned tasks during the assignment. The Long-Term Arrangement holder should have the following competencies, experience, and qualifications and it is mandatory that the Long-Term Arrangement holders should partner with a local company/institution to collect the data & this should be elaborated in the technical proposal.

Team composition from the LTA holder

The Team Leader:

Qualification: An advanced degree (Masters or PhD) in economics, statistics, public policy, evaluation, research methodology, sociology, or other social science related field from an internationally recognized institution with specific skills in mixed methods approach, project operational evaluations.

Experience:

- At least ten years' experience in leading the design and conduct of evaluations and assessments of development programmes particularly those related to social protection and cash transfers.
- Experience conducting research and or evaluations in emergency/humanitarian contexts and or contexts like Afghanistan.
- Prior experience leading research or evaluation teams on assignments for UNICEF or other UN agencies.
- Excellent written and oral report drafting skills in English. Experience in producing high end academic publications in peer reviewed journals.
- Strong interpersonal, communication, reporting, and organizational skills.

- Familiarity with or experience working with UNICEF and/or other similar UN organizations or development agencies particularly in programmes related to social protection.
- Necessary skills and experience in ethical research practices
- Experience in engaging with children appropriately and ethically.
- Understanding of human rights, equity, and gender-based approaches to programming and evaluation/research.
- Project operational review/assessment experience

Team members:

Subject Matter Expert:

Qualification: An Advanced degree (Masters or PhD) in economics, statistics, public policy, evaluation, research methodology, sociology, or other social science related field from an internationally recognized institution

Experience

- Seven years' experience in the design and conduct of evaluations and assessments of development programmes particularly those related to social protection and cash transfers.
- Five years' experience in conducting evaluations, at least 4 evaluations on social protection programmes.
- Experience in conducting participatory research and evaluations on social protection related projects/programmes.
- Demonstrate experience engaging with children appropriately and ethically.
- Understanding of human rights, equity, and gender-based approaches to programming
- Mixed methods and economic multiplier evaluation/research skills.
- Project operational review/assessment experience

Data Analyst:

Education qualification: Master of Statistics, Mathematics or Economics

Experience:

- Excellent analytical and research experience, including a sound knowledge of qualitative and quantitative research methods with strong technical experience in study design.
- Three years of experience in mixed methods data analysis

Profile of a local partner company

Registration with authorities: Registered with De-Facto Authorities in Afghanistan

Team composition of the member from the local partner company: Gender balanced.

Data collection Supervisors

Education qualities: Minimum of bachelor's degree

Experience:

- Five years of experience in data collection/enumeration in Afghanistan.
- Two years of experience in supervising data collectors/enumerators.
- Knowledgeable about the current environment of Afghanistan.
- Ability to work independently and respond to feedback in a timely and professional manner.

- Experience in a complex and high threat environment.
- Strong interpersonal, communication and organizational skills.
- Demonstrate experience engaging with children appropriately and ethically.
- Fluency in Dari/ Pashto and English to oversee field data collection.

Data collectors/Enumerators

Education qualification: Bachelor's degree

Experience:

- Two years' experience in data collection in Afghanistan.
- Fluency in Dari/ Pashto and English to oversee field data collection.
- Strong interpersonal, communication and organizational skills.
- Demonstrate experience engaging with children appropriately and ethically.

Note: The evaluation team proposed is expected to be available for the duration of the assignment and the team leader is expected to undertake at least three in-country mission during the assignment, preferably during the inception phase, baseline study and final evaluation study. Any changes to the proposed core team after offer of contract will be exceptional and subject to UNICEF approval.

PAYMENT SCHEDULE

Payment will be made upon submission and acceptance of the specified deliverables and submission of an invoice according to the following schedule:

Main deliverable	Indicative timeline after contract signing	Payment schedule
Finalization of Inception and planning including presentation and submission of endorsed Baseline and Evaluation plan.	3 weeks	20%
Completion of baseline study as per agreed workstream and deliverables in the workplan (attached as annex) including submission of final report and academic publication.	24 weeks	20%
Completion of mid-term evaluation study as per agreed workstream and deliverables in the workplan (attached as annex) including submission of final report and academic publication.	24 weeks	30%
Completion of Final evaluation study as per agreed workstream and deliverables in the workplan (attached as annex) including submission of final report and academic publication.	24 weeks	30%

CONDITIONS OF WORK

Ethical principles:

Research methods and procedures for obtaining informed consent should be consistent with UNICEF Ethical and Principal Guidelines for the reporting on children and young people under 18 years old (<http://childethics.com>)

Confidentiality:

Data collected under this assignment will be treated as strictly confidential. The rights of distribution and/or publication will reside solely with UNICEF. Data collected cannot be used for any purpose not related to this assignment. The contracted institution will not retain any data related to this assignment after completion of deliverables; all datasets will be transferred to UNICEF.

ASSESSMENT OF CONTRACTUAL RISKS AND PLANNED RISK RESPONSES

Risk	Risk response
Untimely completion of the deliverables	The contract supervisor will hold weekly, or bi-weekly meetings as deemed necessary to discuss progress, challenges, and solutions to resolve issues.
Poor quality of the deliverables	The deliverables including the inception, baseline and evaluation reports and academic publications as well as presentation of preliminary findings will be quality assured by the contract manager. In addition, the inception report will be reviewed by an independent ethical review body before proceeding to data collection and will have to be endorsed by a reference group/steering committee.
Change in team composition	The contract manager will oversight the changes in team composition and ensure that changes are in line with the requirement of the assignment.

Operation Procedure and Work Condition

All travel & accommodation is the responsibility of the LTA holder to arrange.

Technical Evaluation Criteria

TECHNICAL CRITERIA FOR EVALUATION		
TECHNICAL CRITERIA	POINTS TO CONSIDER	Score
Overall Response	<ul style="list-style-type: none"> • Completeness of response • Overall concord between TOR/needs and proposal 	5
Key Personnel	<ul style="list-style-type: none"> • Experience of team leader and key staff members that will work on this assignment (should include their CV's and detail of relevant experience and qualifications) • Composition and experience of proposed staff with similar projects 	20

	<ul style="list-style-type: none"> Experience of proposed sub-contracted companies/institutions and their proposed personnel 	
Proposed Methodology and Approach	<ul style="list-style-type: none"> Proposed methodology for assignment Project management, monitoring, and quality assurance process 	35
Examples of similar work completed in the past	<ul style="list-style-type: none"> Examples of similar work completed in the past 	10
TOTAL SCORE		70
TECHNICAL CRITERIA	POINTS TO CONSIDER	Score

The Technical Proposal has a total evaluation value of 70 points. Technical Proposals receiving 49 points or more will be considered technically responsive, and the financial proposal will be opened. Proposals which are not considered to be technically compliant and non-responsive will not be given further consideration.

Financial Proposal

The currency of USD should be used for international Long Term Arrangement holders having legal entity outside of Afghanistan. No other currencies are accepted in proposing financial proposal.

The total amount of points allocated for the price component is [30]. The maximum number of points will be allotted to the lowest price financial proposal opened and compared among invited LTA holders who obtain the threshold points in the technical component evaluation. All other price proposals will receive points in inverse proportion to the lowest price, e.g.:

$$\text{Score for "Price proposal X"} = \frac{\text{Max. Score for price proposal (e.g., 30)} * \text{Price of lowest priced proposal}}{\text{"Price of proposal X"}}$$

Total Technical and Financial = 100 Points

FINANCIAL PROPOSAL RESPONSE FORMAT

See Annexure

ANNEXES

Annex 1: FINANCIAL PROPOSAL RESPONSE FORMAT (attached)

Annex 2: Tentative list of Districts and target Population (*Final evaluation districts to be based on final registration of the affected population. Final list of evaluation districts to be shared at contracting*)

Zone	Province Name	District Name	2023 Population	PLWs	MCCT Implementation
Western Zone	Badghis	Ghormach	74,716	5,977	Yes

Western Zone	Badghis	Ab Kamari	121,638	9,731	Yes
Western Zone	Badghis	Qadis	142,096	11,368	Yes
Western Zone	Badghis	Jawand	113,993	9,119	Yes
Western Zone	Badghis	Muqur	35,190	2,815	
Western Zone	Badghis	Bala Murghab	152,631	12,210	
Western Zone	Badghis	Qala-e-Naw	114,346	9,148	
Eastern Zone	Kunar	Chapa Dara	41,240	3,299	
Eastern Zone	Kunar	Bar Kunar	43,355	3,468	Yes
Eastern Zone	Kunar	Marawara	33,378	2,670	
Eastern Zone	Kunar	Shigal	65,996	5,280	Yes
Eastern Zone	Kunar	Narang	48,744	3,900	Yes
Eastern Zone	Kunar	Watapur	41,390	3,311	Yes
Eastern Zone	Kunar	Dangam	32,318	2,585	
Eastern Zone	Kunar	Dara-e-Pech	71,398	5,712	
Eastern Zone	Kunar	Ghazi Abad	49,879	3,990	
Eastern Zone	Kunar	Nurgal	31,929	2,554	
Eastern Zone	Kunar	Sar Kani	47,678	3,814	
Eastern Zone	Kunar	Chawkay	49,122	3,930	
Eastern Zone	Kunar	Nari	45,984	3,679	
Eastern Zone	Kunar	Asad Abad	44,717	3,577	
Eastern Zone	Kunar	Khas Kunar	38,569	3,086	
Northern Zone	Samangan	Aybak	175,337	14,027	Yes
Northern Zone	Samangan	Ruy-e-Duab	70,209	5,617	Yes
Northern Zone	Samangan	Dara-e-Suf-e-Payin	100,355	8,028	Yes
Northern Zone	Samangan	Khuram Wa Sarbagh	60,104	4,808	Yes
Northern Zone	Samangan	Hazrat-e-Sultan	76,701	6,136	
Northern Zone	Samangan	Feroz Nakhchir	19,513	1,561	
Northern Zone	Samangan	Dara-e-Suf-e-Bala	88,866	7,109	
Southern Zone	Zabul	Daychopan	53,942	4,315	Yes
Southern Zone	Zabul	Kakar	50,624	4,050	Yes
Southern Zone	Zabul	Atghar	18,980	1,518	Yes
Southern Zone	Zabul	Mizan	36,140	2,891	Yes
Southern Zone	Zabul	Shamul Zayi	40,712	3,257	
Southern Zone	Zabul	Qalat	81,946	6,556	
Southern Zone	Zabul	Nawbahar	15,391	1,231	
Southern Zone	Zabul	Shinkay	36,393	2,911	
Southern Zone	Zabul	Tarnak Wa Jaldak	54,605	4,368	
Southern Zone	Zabul	Shah Joi	89,770	7,182	
Southern Zone	Zabul	Arghandab	49,230	3,938	
TOTAL			2,559,125	204,726	

Annex 2 – Programme Theory of Change

The MCCT Theory of Change has undergone a number of revisions. An initial Theory of Change was provided in the Terms of Reference provided by UNICEF ACO. This is reproduced in Figure 4.

Figure 1: MCCT theory of Change

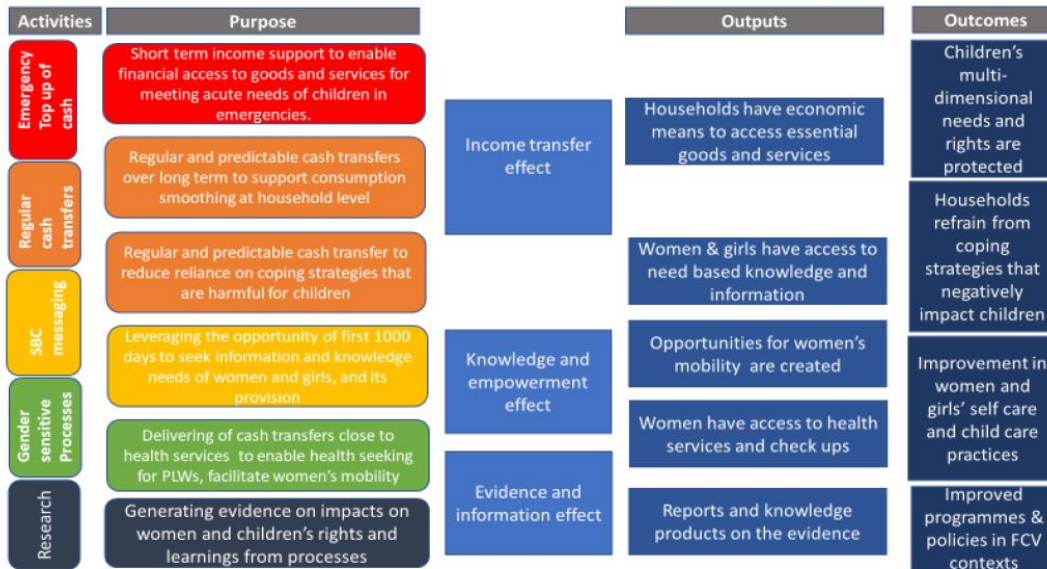


Figure 4 Original Theory of Change from UNICEF ACO Terms of Reference

Annex 3 – Team Biographies

Franziska Gassmann is Professor of Social Protection and Development at UNU-MERIT and Maastricht University. At UNU-MERIT, she is the Head of the UNU-MERIT Graduate School and member of the Management Team. She has 28 years of experience as a researcher, teacher and consultant on poverty and social policy issues. Professor Gassmann is an applied economist/social scientist experienced in the development of monitoring systems, indicators and data collection methods (both quantitative and qualitative) that allow the assessment of poverty and social protection policies. She is the coordinator of the social protection specialization of the MSc Program in Public Policy and Human Development at Maastricht University and leader of the social protection research. Franziska Gassmann has advised international organizations, such as UNICEF, the World Bank, the Asian Development Bank, Organisation for Economic Cooperation and Development (OECD), International Labour Organisation (ILO), United Nations Development Programme (UNDP) and national governments. She has been the principal investigator of more than 30 research and project grants up to a monetary value of 2 million Euro. Her project experience covers more than 15 countries in Europe, Asia and Africa. She is regularly teaching in graduate programmes (MSc, PhD) in the field of welfare economics, social protection and public policy analysis (certified university teacher BKO), and executive training programmes.

Alexander Hunns is a quantitative humanitarian social protection researcher at UNU-MERIT with a significant track record as a quantitative and qualitative researcher and senior evaluator. For the last six

hears, his research and project experience has focused on humanitarian settings designing and implementing policy evaluations including primary data collection in Kenya's Dadaab, Kakuma and Kalobeyei refugee camps in Kenya, as well 13 districts in Malawi. Alex was recently evaluation architect and lead analyst in an evaluation of an energy subsidy programme in Moldova using secondary data, playing a similar role in a project estimating the impact of COVID-19 and the war in Ukraine on Serbian households for UNICEF Serbia. Other recent work has included researching and designing social protection training modules for UNICEF Cambodia, and UNESCAP Bangkok. Alex has conducted academically rigorous research both independently and as part of commissioned evaluation work for UN bodies. Alex holds a dual MSc/MPP in Public Policy and Human Development, specializing in Social Protection Policy Design and Finance from Maastricht University/UNU-MERIT (the Netherlands) along with a BA in Liberal Arts and Sciences from University College Maastricht (the Netherlands).

Eleonora Nillesen is Professor of Public Policy and Development at UNU-MERIT and Maastricht University, the Netherlands. Eleonora is a development economist using field experiments to assess the causal impact of development interventions on topics related to gender, technology, agriculture, labor markets and informal institutions. She conducts large-scale household surveys and behavioral experiments in various countries in Sub-Saharan Africa, MENA and South-East Asia, and has published on these topics in leading economics journals including the American Economic Review, Journal of Public Economics, and Journal of Development Economics and the Journal of Economic Behavior and Organization. She has ample experience in conducting primary data collection in challenging post-conflict environments including Burundi, Liberia and DR Congo. Eleonora currently leads two large-scale impact evaluations on urban infrastructure in Madagascar and Tunisia respectively and is involved various smaller field experiments in Paraguay, Ethiopia, India and Mexico.

Bruno Martorano is Associate Professor at UNU-MERIT and Maastricht University. Prior to this he has worked at the ETH Zurich - NADEL Center for Development and Cooperation in Zurich, Institute of Development Studies in Brighton, UNICEF Office of Research in Florence and the University of Florence, and has held consultancies for the University of North Carolina - Chapel Hill, University of Antwerp, United Nations Conference on Trade and Development (UNCTAD), United Nations University World Institute for Development Economics Research (UNU-WIDER), UNIDO, UNDP and the World Bank. He holds a PhD in Development Economics from the University of Florence. Bruno's research interests include social protection, policy evaluation, inequality and poverty. Exploring micro and macro issues and using different econometric techniques, Bruno's work contributes to the political economy literature that seeks to understand how it is possible to create a sustainable and inclusive process of economic development. The ultimate goal of Bruno's research is to produce results that have practical and actionable implications for policy. Bruno's cross-disciplinary research and work experience – both in academic and international institutions – has enabled him to build his skills and confidence to conduct academic and policy-oriented research and produce rigorous, tailored research outputs targeted at a range of audiences, including policymakers, practitioners and academics.

Annex 4 – Roles and responsibilities – UNU-MERIT & local data collection partner

To support data collection in Afghanistan, UNU-MERIT has appointed a local research firm based in Kabul to provide logical expertise, enumerator hiring and supervision, and expertise on local norms and customs. Working with a local research and evaluation partner is a common part of UNU-MERIT's protocols when conducting primary data collection. It enables rich and contextually relevant data collection to be undertaken, to enable a credible and rigorous evaluation. For this purpose, Samuel Hall has been appointed. The following summarises the expectations and duties of Samuel Hall with respect to their legal relationship with UNU-MERIT.

UNU-MERIT has contracted to design and conduct an evaluation of the MCCT and its Social Behavioural Change strategy. The evaluation strategy designed by UNU-MERIT requires primary data to be collected from individuals and households in selected villages in specified districts. The assignment for which Samuel Hall is being contracted includes the following principle activities:

- i. Collection of quantitative data from 7,200 households split evenly across three waves of data collection, namely: baseline, midline and endline.
 - a. Deliverable: translated surveys
 - b. Deliverable: surveys coded into Open Data Kit (ODK) or equivalent data collection software
 - c. Deliverable: a raw dataset in Stata format
 - d. Deliverable: a clean dataset in Stata format (all data and labels must be in English)
 - e. Deliverable: a codebook in English
 - f. Detailed field reports from supervisors and the data collection manager/
- ii. Collection of qualitative data from participants in up to 64 FGDs and key-informant interviews with up to 50 key informants split evenly across two waves of data collection, namely: baseline and endline.
 - a. Deliverable: translated qualitative research instruments
 - b. Deliverable: raw audio files containing the recordings of qualitative data collection
 - c. Deliverable: transcription files (in original language) of all qualitative output
 - d. Deliverable: English language translations of all transcriptions
 - e. Detailed field reports from supervisors and the data collection manager
 - f. Any and all other research material (flipcharts, etc.)
- iii. The provision of administrative and evaluation support to these two principle activities, including but not limited to support with ethics review processes, obtaining necessary permits and any other activities necessary to deliver the evaluation envisaged in points (i) and (ii).

All deliverables listed above – fulfilment of which payment is made conditional – must be delivered within **four weeks** of the completion of data collection activities of the respective data collection exercise.

Under each activity, Samuel Hall will be responsible for the supervision and conduct of all data collection and data entry activities. Samuel Hall will be responsible for ensuring that all the costs associated with hiring and employing enumerators are covered by the budget submitted as a foundation for this Contract. Samuel Hall will ensure that all enumerator hiring and retention is done in compliance with local laws and regulations. Samuel Hall will ensure that any and all relevant permits, licenses and permissions necessary

to undertake research in Afghanistan are obtained prior to the commencement of data collection and undertake that the costs are denoted in the budget that form the foundation of this Contract.

Samuel Hall will ensure that any and all enumerators and staff engaged with this project comply with the restrictions of any and all licenses, permits and permissions for conducting research in Afghanistan. In addition, Samuel Hall will ensure that enumerators comply with principles of ethical research. Samuel Hall will ensure that enumerators have received adequate training to undertake the project in compliance with the aforementioned stipulations. Training material will be drafted jointly by UNU-MERIT and Samuel Hall, with UNU-MERIT approval of training material required before training delivery. Samuel Hall will ensure that, prior to the commencement of any data collection exercises, any and all staff involved in data collection and entry sign binding confidentiality agreements and take all necessary measures to ensure data collected remains private and confidential, and that no data remains on personal devices. Samuel Hall will share data storage and collection methodologies with UNU-MERIT. Samuel Hall will be responsible for the provision of data collection tools (e.g. data collection tablets with appropriate software, stationery equipment), will be responsible for ensuring they are charged and suitable for use. Samuel Hall will be responsible for ensuring that data remains secure and confidential throughout the process.

The selection of research sites and the design of any sampling (and replacement) strategy will be determined by UNU-MERIT and deviations from sampling procedures at any level must be taken in full agreement with UNU-MERIT. All survey tools will be provided by UNU-MERIT, while Samuel Hall will be responsible for the translation and coding of all research instruments.

Annex 5 – Data collection tools

Data collection tools are provided as supplementary documents. The documents include:

- *Quantitative data collection tool*
- *Focus Group Discussion Guide*
- *Key Informant Interview Guide*

Quantitative data collection tool is added/shared as a **separate Excel file**.

Clinic observation tool is added/shared as a **separate Excel file**.

Focus Group Discussion Guide:

Baseline Focus Group Discussion Guide

Enumerator checklist¹¹:

- *Ensure that all participants have been informed of their rights under informed consent*
- *Ensure that all participants have been recorded or signed giving their consent to the FGD and to the recording of the session*
- *Ensure that you have notepads and pens and the guide*
- *Ensure you have completed the FGD participant information sheet*
- *Ensure that all participants are comfortable and happy to begin*

¹¹ The evaluation team will incorporate information on GRM and CFM once obtained from the social protection team.

Informed consent

Thank you for agreeing to participate in a discussion for this study conducted by UNU-MERIT, a research institute based in the Netherlands. My name is *[say your name]* and I am a research assistant working for Samuel Hall – a company based in Afghanistan hired by UNU-MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to monitor and evaluate the Mother and Child Cash Transfer here in Afghanistan [*Non-beneficiary guide: “programmes here in Afghanistan”*]. Specifically, this study is designed to understand the extent to which the Mother and Child Cash Transfer has met the needs of people like you, and what can be done to improve the Mother and Child Cash Transfer. [*Non-beneficiary guide: remove preceding sentence.*]

Today I will be asking you about your experiences and your opinions about the Mother and Child Cash Transfer [*Non-beneficiary guide: “Today I will be asking you about your lives and experiences living in this community.”*].

UNU-MERIT will analyse the information you give to us today, and make recommendations to UNICEF on how to improve the programme [*Non-beneficiary guide: “programmes here in Afghanistan”*].

We will treat all information you give us today as confidential. We will only ever use your words anonymously. All information that could identify you will be removed from the data. Nobody will be able to identify you from any of your words that we quote in the report. Fully anonymised transcripts and analysis will be given to UNICEF for secure storage on their servers once the analysis has been completed and the reports have been published. Anonymised data from these sessions may also be used in academic publications. Nobody will be able to identify you from these words used in academic publications. Nobody at UNICEF, nor the government, will ever be given access to your name or personal details.

We would also like to ask you to keep what is discussed here today confidential. Please don't talk to those outside this group about who attends, or what people say. You would expect others to keep what you say confidential – please offer others the same respect.

There is no direct benefit to participating in this discussion. I do not work for the UN or the authorities in Afghanistan and I cannot influence the assistance you receive. However, the things you tell me today will be faithfully recorded and analysed. This analysis and the recommendations we make will be presented to UNICEF who may use these findings to make better programmes.

Your participation in this discussion is entirely voluntary. If you do not want to answer any specific questions, or if you want to leave at any point, that is fine – just let me know. You may ask to withdraw your consent after the completion of the discussion, until the point that we publish our findings. Your name or any personal identifying information will never be published.

Do you have any questions? [*wait for responses*]

The process today will take approximately one hour.

I would like to record this discussion so that I have an accurate record of our conversation. It will only be accessed by researchers within our team, and will never be given to any other persons. After the information is transcribed, the recording will be destroyed. Do I have your permission to begin recording?

[Wait for response]

Great- thank you.

Kindly confirm for the recording that I have explained your rights as a participant to you and that you voluntarily agree to participate in this study.

[Wait for response]

Kindly state your name for the tape, and that you consent to being recorded here today.

Participant information sheet

<i>Enumerator: when handing this to the participant, write in this box the number corresponding to the participant's position</i>	
Age	
District of residence	
Village	
Marital status	
Are you currently pregnant?	
How many children under the age of 2 do you have?	
Do you have a disability?	

Questions

1. Could we please start with a brief round of introductions – would each of you tell us your name, and how long you’ve lived in [District/Village].
2. Tell us about life in [District/Village]. Are households like yours able to make ends meet? *If not, why not? What are the challenges that households like yours face?*
3. Are households like yours able to feed their families? Are they able to feed their children or their babies? *If not, why not? What are the challenges that households like yours face? Are the challenges related to affording food? Are the challenges related to finding food in the market place? Do all household members get equal access to food, even when resources are scarce? If not, who gets prioritised in the household?*
 - a. If problems with food/feeding children: How do problems with food/feeding children affect the atmosphere in the household, and in the community?
4. Do households like yours in this community access healthcare when pregnant, or when children need help in this household? *If not, why not? Why are households like yours not visiting healthcare facilities? Do you have access to health care? Do you think that men and women, boys and girls need different access to healthcare? In your households, do men and boys go to health clinics more or less often than women and girls?*
5. To what extent are you satisfied with the healthcare facilities in this district? *Is culturally relevant healthcare available when you visit the facilities? Is culturally relevant healthcare available when you visit the facilities with men and boys? Is culturally relevant healthcare available when you visit*

the facilities with women and girls? To what extent do you feel satisfied with the quality or professionalism of the healthcare staff?

6. *How do you usually travel to the healthcare facility? To what extent do you consider visits to health facilities affordable for households like yours?*
7. *To what extent do you feel able to feed yourself and your children a balanced diet? Is this all the time or some of the time? What are the factors that influence that ability?*
8. *To what extent are you or your communities aware of ailments like malnutrition, anaemia, vitamin A deficiency? Are you aware of the risks or consequences of these ailments? Are you aware of how to prevent these ailments?*
9. *To what extent do you feel comfortable understanding and implementing safe water, hand, food and toilet hygiene? Are you aware of the risks or consequences of improper water, hand, and food hygiene? What are the reasons why you are not able to implement safe water, hand, and food hygiene?*
10. *To what extent do you feel confident and able to feed your child a diet that meets their nutritional needs? Do you think that boys and girls need different amounts or types of food? Are you aware of the risks or consequences of a poor diet in young children? What are the reasons that best describe why you are not able to feed your child a diet that meets their nutritional needs?*

Thank you very much for your time.

Endline Treatment Focus Group Discussion Guide

Enumerator checklist¹²:

- *Ensure that all participants have been informed of their rights under informed consent*
- *Ensure that all participants have been recorded or signed giving their consent to the FGD and to the recording of the session*
- *Ensure that you have notepads and pens and the guide*
- *Ensure you have completed the FGD participant information sheet*
- *Ensure that all participants are comfortable and happy to begin*

Informed consent

Thank you for agreeing to participate in a discussion for this study conducted by UNU-MERIT, a research institute based in the Netherlands. My name is *[say your name]* and I am a research assistant working for Samuel Hall – a company based in Afghanistan hired by UNU-MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to monitor and evaluate the Mother and Child Cash Transfer here in Afghanistan *[Non-beneficiary guide: “programmes here in Afghanistan”]*. Specifically, this study is designed to understand the extent to which the Mother and Child Cash Transfer has met the needs of people like you, and what can be done to improve the Mother and Child Cash Transfer. *[Non-beneficiary guide: remove preceding sentence.]*

¹² The evaluation team will incorporate information on GRM and CFM once obtained from the social protection team.

Today I will be asking you about your experiences and your opinions about the Mother and Child Cash Transfer [Non-beneficiary guide: “Today I will be asking you about your lives and experiences living in this community.”].

UNU-MERIT will analyse the information you give to us today, and make recommendations to UNICEF on how to improve the programme *[Non-beneficiary guide: “programmes here in Afghanistan”]*.

We will treat all information you give us today as confidential. We will only ever use your words anonymously. All information that could identify you will be removed from the data. Nobody will be able to identify you from any of your words that we quote in the report. Fully anonymised transcripts and analysis will be given to UNICEF for secure storage on their servers once the analysis has been completed and the reports have been published. Anonymised data from these sessions may also be used in academic publications. Nobody will be able to identify you from these words used in academic publications. Nobody at UNICEF, nor the government, will ever be given access to your name or personal details.

We would also like to ask you to keep what is discussed here today confidential. Please don't talk to those outside this group about who attends, or what people say. You would expect others to keep what you say confidential – please offer others the same respect.

There is no direct benefit to participating in this discussion. I do not work for the UN or the authorities in Afghanistan and I cannot influence the assistance you receive. However, the things you tell me today will be faithfully recorded and analysed. This analysis and the recommendations we make will be presented to UNICEF who may use these findings to make better programmes.

Your participation in this discussion is entirely voluntary. If you do not want to answer any specific questions, or if you want to leave at any point, that is fine – just let me know. You may ask to withdraw your consent after the completion of the discussion, until the point that we publish our findings. Your name or any personal identifying information will never be published.

Do you have any questions? *[wait for responses]*

The process today will take approximately one hour.

I would like to record this discussion so that I have an accurate record of our conversation. It will only be accessed by researchers within our team, and will never be given to any other persons. After the information is transcribed, the recording will be destroyed. Do I have your permission to begin recording?

[Wait for response]

Great- thank you.

Kindly confirm for the recording that I have explained your rights as a participant to you and that you voluntarily agree to participate in this study.

[Wait for response]

Kindly state your name for the tape, and that you consent to being recorded here today.

Participant information sheet

<i>Enumerator: when handing this to the participant, write in this box the number corresponding to the participant's position</i>	
Age	
District of residence	
Village	
Marital status	
Are you currently pregnant?	
How many children under the age of 2 do you have?	
Do you have a disability?	
Are you currently receiving the MCCT?	
How many MCCT transfers have you received?	
When was the last time you received a transfer through the MCCT?	
When was the last time you participated in an SBC session?	

1. Could we please start with a brief round of introductions – would each of you tell us your name, and how long you've lived in [District/Village].
2. Tell us about life in [District/Village]. Are households like yours able to make ends meet? *If not, why not? What are the challenges that households like yours face?*
3. Are households like yours able to feed their families? Are they able to feed their children or their babies? *If not, why not? What are the challenges that households like yours face? Are the challenges related to affording food? Are the challenges related to finding food in the market place? Do all household members get equal access to food, even when resources are scarce? If not, who gets prioritised in the household?*
 - a. If problems with food/feeding children: How do problems with food/feeding children affect the atmosphere in the household, and in the community?
4. Do households like yours in this community access healthcare when pregnant, or when children need help in this household? *If not, why not? Why are households like yours not visiting healthcare facilities? Do you have access to health care? Do you think that men and women, boys and girls need different access to healthcare? In your households, do men and boys go to health clinics more or less often than women and girls?*
5. To what extent are you satisfied with the healthcare facilities in this district? *Is culturally relevant healthcare available when you visit the facilities? ? Is culturally relevant healthcare available when you visit the facilities with men and boys? Is culturally relevant healthcare available when you visit the facilities with women and girls? To what extent do you feel satisfied with the quality or professionalism of the healthcare staff?*
6. How do you usually travel to the healthcare facility? To what extent do you consider visits to health facilities affordable for households like yours?
7. To what extent do you feel able to feed yourself and your children a balanced diet? *Is this all the time or some of the time? What are the factors that influence that ability?*

8. To what extent are you or your communities aware of ailments like malnutrition, anaemia, vitamin A deficiency? *Are you aware of the risks or consequences of these ailments? Are you aware of how to prevent these ailments?*
 - a. *Do you feel that the SBC sessions that you may have attended have changed your perceptions?*
9. To what extent do you feel comfortable understanding and implementing safe water, hand, food and toilet hygiene? *Are you aware of the risks or consequences of improper water, hand, and food hygiene? What are the reasons why you are not able to implement safe water, hand, and food hygiene?*
 - a. *Do you feel that the SBC sessions that you may have attended have changed your perceptions?*
10. To what extent do you feel confident and able to feed your child a diet that meets their nutritional needs? *Are you aware of the risks or consequences of a poor diet in young children? Do you think that boys and girls need different amounts or types of food? What are the reasons that best describe why you are not able to feed your child a diet that meets their nutritional needs?*
 - a. *Do you feel that the SBC sessions that you may have attended have changed your perceptions?*
11. I would now like to think about the MCCT programme. How has this programme changed your households spending patterns?
 - a. Thinking specifically of spending on food ? what has changed and why?
 - b. Thinking specifically of spending on healthcare? What has changed and why?
12. How does your household use the cash assistance provided?
 - c. What items to you usually buy with the cash?
 - d. If you buy food, what kind of food do you buy with the cash?
 - e. Do you think that males and females require different kinds or amounts of food? How is this organised within your household?
 - f. Do you have conflicts or arguments about who uses the money, or what it is spent on?
13. Do you think the money provided is enough? *If not:*
 - a. Are there times when you or your family members are hungry? If so, when and why? *Do men and women, boys and girls experience hunger the same/as often in households like yours?*
 - b. How do you cope when you do not have enough food?
 - c. Are certain members of the family prioritized when there's not enough good? If so, who?
 - d. Are there situations that you are not seeking health care because of lack of money?
 - e. Are there any goods or services your household need, but that you are not able to buy with the money from the MCCT? *Why? (probe: service not offered; goods not on the market)*
14. Are there any challenges associated with accessing the disbursement sites?
 - f. Do you experience any challenges on the way to or from the disbursement sites? If yes, what challenges? Do these challenges affect men and women, boys and girls equally?
 - g. Do you experience challenges while at the disbursement sites? If yes, what challenges?
 - h. Did you report these problems to the UNICEF helpline? Was this dealt with to your satisfaction?

15. ONLY FOR FEMALE GROUP: Who in your household typically goes to the disbursement site to collect the transfers?
 - a. Who in your household decides who will go to the disbursement site?
 - b. What are the challenges that prevent you from going yourself?
 - c. If you could, would you want to go yourself?
16. Are the disbursement sites dignified? *If not, why not? If yes, what makes them dignified?*
17. Are the right people in this community receiving assistance through the MCCT programme? *If not, can you elaborate?*
18. Are all households in this community able to access the assistance? Are there people living with disabilities, for example, who are not able to access the assistance? *What kind of challenges do those households that struggle to access assistance face?*
19. Have you attended the SBC sessions offered as part of the programme?
 - i. If yes, what did you like/not like about the sessions?
 - j. If no, why not?
20. To what extent have these sessions changed your perceptions of healthcare in your household and this community?
 - k. *If so, how? Has it made people change the value they place on healthcare?*
 - l. *If no change, why not?*
21. Has the MCCT changed how often your household accesses healthcare or the type of health care professional or facility you visit? *If so, how or why? If not, why not?*
22. Are there still barriers to accessing healthcare in this community? *If so, what? Is access a problem? Is quality a problem? Is culturally relevant healthcare a problem? Is safety a concern?*
23. Do you and your families in this community consult a trained doctor when you are pregnant or your child is unwell?
24. If you could describe a good quality hospital or primary healthcare clinic, what are the words you would use to describe it? How would you picture it?
25. To what extent have the SBC sessions changed the perceptions of nutrition in this community and in your household?
 - m. *If so, how?*
 - n. *If not, why not?*
26. Are there still challenges accessing good nutrition in this community and in your household?
 - o. *If so, what? Is access a problem? Is availability a challenge? Is safe water and food a challenge?*
 - p. *If not, what does a common diet look like in your household?*
27. Is there anything else you would like to tell me about the MCCT programme that we have not discussed yet today?

Thank you very much for your time.

Key informant interview guides:

Key informant interview guide – UNICEF staff, humanitarian organizations

Thank you for agreeing to participate in an interview for this study conducted by the UNU-MERIT, a research institute based in the Netherlands. My name is [name] and I am part of the research team from UNU-

MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to conduct an impact evaluation of the Mother and Child Cash Transfer here in Afghanistan.

You have the option to choose your level of anonymity:

- i. Your job title and/or organisation will be used in the report, but your name will not appear in the annex
- ii. Only your organisation will be used in the report and annex

You may also ask to be consulted before your words are used directly in the report.

The transcripts of this conversation, in accordance with your anonymity preferences, will be given to UNICEF for secure storage on their servers once the analysis has been completed and the reports published. In addition, the information provided here may be used in academic research publications as part of this evaluation. This may mean that your entirely anonymised data is stored on the servers of publication houses.

There is no direct benefit to participating in this discussion. However, the things you tell me today will be faithfully recorded and analysed and may be used in our report which will be presented to UNICEF and other relevant stakeholders.

Your participation in this discussion is entirely voluntary. If you do not want to answer any specific questions, or if you want to leave at any point, that is fine – just let me know. You may ask to withdraw your consent after the completion of the interview, until the point that we publish our findings. Your name or any personal identifying information will ever be published.

Do you have any questions? *[wait for responses]*

I would like to record this interview so that I have an accurate record of our conversation. It will only be accessed by researchers within our team, and will never be given to any other persons. After the information is transcribed, the recording will be destroyed. Do I have your permission to begin recording?

[Wait for response]

Great- thank you.

Kindly confirm for the recording that I have explained your rights as a participant to you and that you voluntarily agree to participate in this study. Please also confirm which level of anonymity you would like to receive.

[Wait for response]

Kindly state your name for the tape, and that you consent to being recorded here today.

1. Thank you for taking the time to speak to us today. Please tell us your name and your job title. Remember, the level of anonymity you selected previously still applies, this information is just for our records and to help inform our analysis.

2. We are here to talk today to the Mother and Child Cash Transfer run by UNICEF in Afghanistan. How familiar are you with the programme? How does your present role involve the MCCT programme? *Were you involved/consulted on the design of the programme?*
3. To the best of your knowledge, are the objectives of the MCCT clearly formulated on the basis of a theory of change, and clearly communicated to stakeholders like you?
4. [Baseline only] To what extent do you think that the MCCT programme is likely to meet its objectives? If likely, why? If not likely, why? *This might be because of unforeseen challenges, because of policy design choices, or any other factors*
5. [Mid/endline only] To what extent do you think that the MCCT has been effective in meeting its objectives? *What are the factors that have led there to be (no) impact of the programme? Have there, to your knowledge, been unintended consequences of the MCCT programme? If so, please detail*
6. [Mid/endline only] To what extent have you observed changes in community tensions throughout the duration of the MCCT? *To what extent is this attributable to the MCCT programme?*
7. Do you think that the MCCT programme design is relevant to the needs of beneficiaries? If not, why not? *This could be the value of the cash transfer, the complementary services design, the frequency of transfers, the disbursement of cash near healthcare facilities*
8. Thinking more generally about vulnerability and poverty here in Afghanistan - do you think that the right people are reached with the MCCT? *Who or which communities would be more appropriate to target?*
9. Do you think that gender has been adequately mainstreamed through the design of the programme? *How could gender better be mainstreamed? Do the complementary services (SBC+ and connections to primary healthcare) serve to improve the equality and position of women in Afghanistan? What about unintended consequences for women as a result of the programme?*
10. To what extent have the needs of all intended beneficiaries been taken into account when designing the programme, and particularly the accessibility of distribution sites? *Are disbursement sites dignified?*
11. Is the programme sensitive to the needs of women and children living with a disability in beneficiary communities? *This could be the modality, the adequacy of transfers, etc.*
12. To what extent is the MCCT programme coherent with other programmes by humanitarian organisations here in Afghanistan? *This could be in terms of beneficiary overlap, for e.g. Is there, to your knowledge, a coherent understanding of vulnerability in Afghanistan?*
13. To what extent is the MCCT programme coherent with other programmes run by the DfA?
14. Is the MCCT programme sustainable in the long term? *To what extent can resources – domestic or international – be mobilised to create long-term sustainable programming? Is there sufficient awareness and support in the DfA to nationalise the MCCT programme?*
15. Is there anything else that you would like to talk to me about with respect to the MCCT that I have not asked you about?

Key informant interview guide – primary healthcare facility staff

Thank you for agreeing to participate in an interview for this study conducted by the UNU-MERIT, a research institute based in the Netherlands. My name is *[say your name]* and I am a research assistant working for Samuel Hall – a company based in Afghanistan hired by UNU-MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to conduct an impact evaluation of the Mother and Child Cash Transfer here in Afghanistan.

You have the option to choose your level of anonymity:

- i. Your job title and/or organisation will be used in the report, but your name will not appear in the annex
- ii. Only your organisation will be used in the report and annex

You may also ask to be consulted before your words are used directly in the report.

The transcripts of this conversation, in accordance with your anonymity preferences, will be given to UNICEF for secure storage on their servers once the analysis has been completed and the reports published. In addition, the information provided here may be used in academic research publications as part of this evaluation. This may mean that your entirely anonymised data is stored on the servers of publication houses.

There is no direct benefit to participating in this discussion. I do not work for the UN or the authorities in Afghanistan. However, the things you tell me today will be faithfully recorded and analysed and may be used in our report which will be presented to UNICEF and other relevant stakeholders.

Your participation in this discussion is entirely voluntary. If you do not want to answer any specific questions, or if you want to leave at any point, that is fine – just let me know. You may ask to withdraw your consent after the completion of the interview, until the point that we publish our findings. Your name or any personal identifying information will ever be published.

Do you have any questions? *[wait for responses]*

I would like to record this interview so that I have an accurate record of our conversation. It will only be accessed by researchers within our team, and will never be given to any other persons. After the information is transcribed, the recording will be destroyed. Do I have your permission to begin recording?

[Wait for response]

Great- thank you.

Kindly confirm for the recording that I have explained your rights as a participant to you and that you voluntarily agree to participate in this study. Please also confirm which level of anonymity you would like to receive.

[Wait for response]

Kindly state your name for the tape, and that you consent to being recorded here today.

1. Thank you for taking the time to speak to us today. Please tell us your name and your job title. Remember, the level of anonymity you selected previously still applies, this information is just for our records and to help inform our analysis.
2. We are here to talk today to the Mother and Child Cash Transfer run by UNICEF in Afghanistan. Have you heard of the MCCT programme?
3. How does your present role involve the MCCT programme? *Were you involved/consulted on the design of the programme?*
4. Have the objectives of the MCCT programme been clearly explained to you?
5. What are you and your clinic expected to do as part of the MCCT programme?
6. With the resources available for your clinic, is your clinic able to meet its expectations under the MCCT programme?
7. To what extent are beneficiaries of the MCCT able to access services at this clinic when they come to redeem their transfers? *Are there specific services that are not available, but are commonly sought? This could be things like treatment for specific illnesses, or maternity services, vaccination?*
8. To what extent do you feel that the MCCT programme is relevant to the needs and lives of women and children of young infants in this area?
9. [Baseline only] To what extent do you think that the MCCT programme is likely to meet its objectives? If likely, why? If not likely, why? *This might be because of unforeseen challenges, because of policy design choices, or any other factors.*
10. [Mid/endline only] To what extent do you think that the MCCT has been effective in meeting its objectives? *What are the factors that have led there to be (no) impact of the programme? What are the factors that have led there to be no impact of the programme? Have there, to your knowledge, been unintended consequences of the MCCT programme? If so, please detail.*
11. What are the biggest challenges that women and mothers of infants face in this community? *This could be affordability of care, long waiting times, culturally relevant healthcare, access to medicine?*
12. Have you noticed a change in the pattern of people in this community coming to this healthcare facility? *This could be positive or negative. This could be a change in the number of people coming, or the type of ailment/reason they come to the clinics.*
13. What are the biggest barriers to women and the mothers of infants in this community to accessing healthcare? *Are these barriers tackled by the MCCT in your opinion?*
14. Have you observed any consequences of the MCCT that you did not expect to observe? *If so, please elaborate.*
15. [Mid/endline only] To what extent have you observed changes in community tensions during the lifetime of the programme?
16. Is there anything else that you would like to talk to me about with respect to the MCCT that I have not asked you about?

Key informant interview guide – community leaders

Thank you for agreeing to participate in an interview for this study conducted by the UNU-MERIT, a research institute based in the Netherlands. My name is *[say your name]* and I am a research assistant working for Samuel Hall – a company based in Afghanistan hired by UNU-MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to conduct an impact evaluation of the Mother and Child Cash Transfer here in Afghanistan.

You have the option to choose your level of anonymity:

- i. Your job title and/or organisation will be used in the report, but your name will not appear in the annex
- ii. Only your organisation will be used in the report and annex

You may also ask to be consulted before your words are used directly in the report.

The transcripts of this conversation, in accordance with your anonymity preferences, will be given to UNICEF for secure storage on their servers once the analysis has been completed and the reports published. In addition, the information provided here may be used in academic research publications as part of this evaluation. This may mean that your entirely anonymised data is stored on the servers of publication houses.

There is no direct benefit to participating in this discussion. I do not work for the UN or the authorities in Afghanistan. However, the things you tell me today will be faithfully recorded and analysed and may be used in our report which will be presented to UNICEF and other relevant stakeholders.

Your participation in this discussion is entirely voluntary. If you do not want to answer any specific questions, or if you want to leave at any point, that is fine – just let me know. You may ask to withdraw your consent after the completion of the interview, until the point that we publish our findings. Your name or any personal identifying information will ever be published.

Do you have any questions? *[wait for responses]*

I would like to record this interview so that I have an accurate record of our conversation. It will only be accessed by researchers within our team, and will never be given to any other persons. After the information is transcribed, the recording will be destroyed. Do I have your permission to begin recording?

[Wait for response]

Great- thank you.

Kindly confirm for the recording that I have explained your rights as a participant to you and that you voluntarily agree to participate in this study. Please also confirm which level of anonymity you would like to receive.

[Wait for response]

Kindly state your name for the tape, and that you consent to being recorded here today.

1. Thank you for taking the time to speak to us today. Please tell us your name and your role here in the community
2. We are here to talk today to the Mother and Child Cash Transfer run by UNICEF in Afghanistan. Have you heard of the MCCT programme?
3. How does your present role involve the MCCT programme? *Were you involved/consulted on the design of the programme?*
4. To what extent do you feel that feedback from the community has been integrated into the design of the programme?
5. Have the objectives of the MCCT programme been clearly explained to you?
6. To what extent do you feel that the MCCT programme is relevant to the needs and lives of women and children of young infants in this area?
7. [Baseline only] To what extent do you think that the MCCT programme is likely to meet its objectives? If likely, why? If not likely, why? *This might be because of unforeseen challenges, because of policy design choices, or any other factors*
8. [Mid/endline only] To what extent do you think that the MCCT has been effective in meeting its objectives? *What are the factors that have led there to be (no) impact of the programme? What are the factors that have led there to be no impact of the programme? Have there, to your knowledge, been unintended consequences of the MCCT programme? If so, please detail*
9. What are the biggest challenges that women and mothers of infants face in this community? *This could be affordability of care, long waiting times, culturally relevant healthcare, access to medicine?*
10. What are the biggest challenges that households in this community face when trying to eat healthy and balanced diets? *Are these adequately addressed by the MCCT programme?*
11. What are the biggest barriers to women and the mothers of infants in this community to accessing healthcare? *Are these barriers tackled by the MCCT in your opinion?*
12. To what extent have you observed changes in tensions in households in this community, or in this community, during the lifetime of the MCCT programme?
13. Is there anything else that you would like to talk to me about with respect to the MCCT that I have not asked you about?

Informed consent – clinic observation & photographs

My name is *[say your name]* and I am a research assistant working for Samuel Hall – a company based in Afghanistan hired by UNU-MERIT. The research team at UNU-MERIT has been asked by UNICEF Afghanistan to monitor and evaluate the Mother and Child Cash Transfer here in Afghanistan. *[Non-beneficiary districts: “programmes here in Afghanistan”]*. As part of this research, we want to look at health facilities like this to record information about the physical attributes of the clinics and take some photographs. We will not take photographs of staff or patients at the clinic.

This process will involve me walking around the clinic and recording some information about the clinic in my survey tool, and I will also take some photographs. This process will not involve collecting any information about patients, nor any other personal identifying information about staff or patients at this clinic. You are welcome to accompany me during this process.

UNU-MERIT will analyse this information and make recommendations to UNICEF on how to improve the programme *[Non-beneficiary districts: “programmes here in Afghanistan”]*.

All the information you give us today will be treated as confidential. This clinic will be given an identifying number which will not allow any person outside the UNU-MERIT research team to identify this clinic. There will be no repercussions from participation, and the results of this process will not influence in any way the funding available to this clinic. The anonymised information collected here today will be given to UNICEF at the conclusion of the evaluation process for secure storage on their servers. This study has been approved by an ethics review board by UNICEF Afghanistan.

There is no direct benefit to participating in this discussion. I do not work for the UN or the authorities in Afghanistan and I cannot influence directly decisions on health policy. However, anything you do tell me and the data I collect here will be faithfully recorded and analysed. This analysis and the recommendations we make will be presented to UNICEF who may use these findings to make better programmes.

Your participation – and therefore the participation of this clinic – is entirely voluntary.

Please select which options apply and confirm your consent to participate by providing your name and job title below.

I consent to photographs being taken of this clinic

I consent to the enumerator completing the enumerator checklist

Name _____

Job title _____

For enumerator use only

District _____

Village/mosque _____

Clinic name _____

Annex 6 – Intensive household nudging overview and example script

SBC++ Post-Inception Summary

Introduction

Social and Behavioural Change Engagement (SBC+) plays an essential role in the Theory of Change of the MCCT. The programme Theory of Change shows that cash transfers are expected to play a direct and unmediated role in delivering health, nutrition and food consumption outcomes and impacts. As key inputs in the programme Theory of Change, community and individual SBC are also expected to play both direct and mediating roles in achieving health, nutrition and food consumption outcomes, while household decision-making is also an explicit part of the pathway between inputs and outcomes. Both the community level SBC activities and the individual-level household nudge (SBC+) components are expected to be important in influencing household decision-making – but which SBC approach is most effective in influencing household decision-making? Creating rigorous and plausible evidence on the extent to which programme design elements contribute to the achievement of intended results is a central purpose of the evaluation and is particularly important in Afghanistan where a paucity of rigorous evidence can hinder the generation of evidence-based policy making.

To partially cover this evidence deficit, the Evaluation Team has proposed an experimental SBC+ approach within the broader SBC strategy (see Inception Report). The intention is to test empirically whether a household level communication intervention is effective in changing health-seeking behaviour among pregnant and lactating women and their households. Within Treatment Group C (see Inception Report and slide deck), clusters (and households) will be randomly allocated to either the control group C1 or the treatment group C2 (referred to D in inception report), which will receive the SBC+ intervention. Our sample will consist of 48 clusters (mosque catchment areas) and 25 households within each mosque catchment area, half of which will be exposed to the SBC++ intervention. Households in the treatment group C2 (D) will receive in-person visits from social mobilisers – **specially trained fixed pairs of men and women** that routinely conduct similar projects as part of their work – during which a number of different topics will be discussed and a series of nudges will be provided using a **gendered household power dynamic frame**.

The information below is a partial reproduction of the guide that will be provided to social mobilizers to facilitate the home visits they will conduct as part of the SBC+ component. This guide is a summary of the extensive and in-depth training that UNU-MERIT will deliver to social mobilizers prior to the commencement of their field activities. The SBC+ intervention consists of six home visits over approximately 5-6 months with visits spaced at 3-4 week intervals. The home visits cover a range of topics related to the assumptions and linkages in the programme Theory of Change. The home visits also vary in terms of their pedagogical approach. Three home visits – 1, 3 and 5 - will follow a pure informational treatment strategy; the remaining three visits – 2, 4 and 6 - will be interactive and aim to inform and facilitate intra-household discussions between participants with small exercises. The sequence of the sessions alternates the two types of home visit i.e. one informational treatment home visit; then the more interactive visit. Specifically:

- I. Health care visits (Informational Treatment)
- II. The work we do (Interactive Session)
- III. Maternal nutrition (Informational Treatment)
- IV. Household income (Interactive Session)
- V. Immunization (Informational Treatment)
- VI. A gift from the heart and The magic box (Interactive Session)

The Informational Treatment sessions should last approximately 60 minutes while the interactive sessions should last approximately 90 minutes. Both are composed of three main stages:

- Introduction (15 minutes – culturally-relevant greetings);
- Core section (30 minutes for the Informational sessions, 60 minutes for the Interactive sessions);
- Farewell (up to 15 minutes).

The main difference between the two types of sessions is related to the duration of the Core section (see below), which lasts approximately 60 minutes in the case of the Informational Treatment sessions and 90 minutes in the case of the Interactive sessions.

In the **introduction** and **farewell** parts, the social mobilizers should adhere to customary rituals relevant to the context. This can include taking tea and exchanging formal greetings at the start, and formally concluding the session and extending their gratitude to the family hosting the social mobilisers. During all visits, men and women are strictly separated in line with customs practiced in Afghanistan with male social mobilisers sitting with any men in the household, and female social mobilizers sitting with any women in the household.

The **core section** is the meeting's centerpiece, demanding detailed guidance. To guide social mobilisers, UNU-MERIT will provide a semi-structured guide to assist the social mobilisers in addition to extensive and in-depth training, in-person in Afghanistan. The core section is further divided into two parts. The first part – a reflective section - is the same format in each of the six sessions. The second part – an intensive intra-household communication exercise – is different depending on whether the session uses an informational treatment or interactive treatment. The rest of the section summarises the content of the two sections that comprise the core section.

Core section part 1: Reflection on SBC Engagement. This part aims to reinforce the overall community-level SBC intervention's purpose. Community-level UNICEF SBC engagement assets focusing on session topic will be revisited and discussed with the household. Given the varying needs of beneficiaries, some of these messages will be customized. Specifically: for health care visits, separate scripts will be created for antenatal and postnatal care; for maternal nutrition, distinct scripts will be prepared for during pregnancy and after birth. This approach ensures that the SBC messages are both relevant and specific to the characteristics of the beneficiaries.

Core section part 2: Intensive intra-household communication. This part varies according to the type of treatment used in the session.

a) Information treatment. Sessions 1, 3 and 5 aim to offer a narrative based on gendered household power dynamics that are expected to increase healthcare access and its perceived value. This document includes one **example** illustrating how social mobilizers can effectively communicate messages during their home visits, utilizing a gendered household power dynamic framing (script 1). The example script provided in this document focuses on antenatal care up-take, an integral part of healthcare utilization.

N.B.: The semi-structured guides for social mobilizers aims to offer a structured conversational framework and guidance on key points to discuss. The evaluation team will not prescribe verbatim what social mobilizers should say during home visits. However, for illustrative purposes, the evaluation team wrote out a full script below to serve as examples to UNICEF and the social mobilizers of how a conversation could run. The antenatal script includes quotations from scripture extracted from the United States Agency for International Development (USAID) document titled "Muslim Khutbah Guide to Save the Lives of Mothers and Newborns: A Toolkit for Religious Leaders".

b) Interactive exercise. Sessions 2 and 4 aim at promoting an understanding of women's contribution to household economics among household members by looking at the different household activities undertaken by women during the day.

The three interactive sessions are adaptations of "Zindagii Shoista: Enabling economic empowerment through income generating activities (IGAs)" which was a workshop developed to strengthen household economies and complementing the Zindagii Shoista intervention designed to reducing violence against women and girls in Tajikistan. The project promoted a transformation of attitudes and social norms within families and aimed to strengthen relationships and empower women. The evaluation team considered three specific sessions and adjusted them to the Afghan context. Taking inspiration from this project, the evaluation team aims to raise awareness about the actual contributions of women to the household and to help participants understand what makes up their household income. Below are the goals and descriptions of each session.

SESSIONS 1, 3, 5 – INFORMATION SESSION

Example of the Script: Script 1. ANTENATAL CARE (Power Dynamics)

Section	Time to complete	Key elements/phrases to be included in the discussion
<p><i>Before discussion begins</i></p>	<p>0</p>	<p><i>Look for the household identifier and verify that you are at the right house, and that this household is in your assigned treatment arm.</i></p> <p>Record who is present in the session, even if they are there only for part of the visit <u>at any time during the meeting.</u></p> <p>Please ensure that all key participants are present at the respective gender groups. In the women’s group, the recipient of the MCCT should be present, along with other women in the household willing to participate. This could include a mother or sister in law. In the male group, the spouse of the beneficiary should be present, along with other male householders willing to participate. Their involvement is crucial as decision-making often rests with the head of the household (typically male) and the beneficiary’s mother-in-law, making them significant recipients of the messaging.</p> <p>Please also note their role in the family or their relation to the beneficiary.</p> <p><u>Person 1 (beneficiary):</u> Age (approximate): Sex: Relation to household head: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person 2</u> Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person n</u> Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old?</p>

		<p>Present for the whole session? [If no] how long were they present?</p>
Introduction	15minutes	<p>[If meeting household (HH) for the first time] Introduce yourself(ves), explain your credentials</p> <p><i>The aim is to put the household at ease, earn their trust and respect. In your notebook, make notes about what you observe about household dynamics, about the beneficiary or any children.</i></p>
Recall and listening	15 minutes	<p>You may have seen around the community that UNICEF, working with the Ministry of Public Health, are trying to help women like you access antenatal care visits. Have you seen any of these messages around this community?</p> <p>[Necessary number of antenatal care visits and their timing] [Scheduling of antenatal care visits and locations where antenatal care services are available] [Importance of completing all antenatal care visits during pregnancy]</p> <p>IMPORTANT: To foster a more interactive session, it's highly recommended to intersperse the discussion of messages with engaging questions. For instance:</p> <p>“What does this mean to you and your family?” “Do you find these messages relevant to your household?” “How do these concepts apply to your daily life?” “Are these practices or ideas familiar to you?” “What obstacles does your household or community face in achieving these goals?”</p> <p>Remember, these questions should be distributed throughout the discussion, rather than asked all at once, to encourage ongoing engagement and reflection.</p>
Information treatment	15 minutes	<p>[Power dynamics]</p> <p>A child born to us is a precious gift. Does this gift come easily and without hardship? No, sadly pregnancy and childbirth can be the most dangerous times of a women`s life. We must be careful to ensure these special gifts are delivered to us safely.</p> <p>This means that we need healthy women. A strong family starts with a strong woman and mother. When it comes to having healthy kids, it all starts with a healthy mum. A mum who feels good can also take better care of her children and help them grow up healthy and the family to get respected and stronger.</p>

		<p>There are steps we can take to make the delivery of our children safer. One of our first steps is for the pregnant mother to visit a health care facility as early as possible to make sure that she and her baby are doing well. We should seek the advice and knowledge of people trained and experienced in caring for expectant mothers and in delivering babies. They can tell us about the signs (what to look for) that mean we should seek care immediately.</p> <p>When it is time for the baby to be born, we should plan for the expectant mother to deliver at a health center or at home with experienced birth attendants. We should value the skills and education of these health care professionals during this challenging time of pregnancy and childbirth.</p> <p>The health of women is very important for our families and our household economy. When women are healthy, the family is healthier. Let's remember that when we take care of our women, we're taking care of our families and our future. The proper use of resources during pregnancy is seeking the knowledge and services of trained health care professionals. Women should have at least 4 health care visits during her pregnancy so that the health care worker can identify problems that may require care. During these health visits, the woman will receive medicines to protect her and the baby.</p> <p>This responsibility to seek health care is shared by both the woman and her husband. Husbands are tasked with caring for their wives in all situations. Pregnancy and childbirth are especially important times of responsibility for the husband when your treatment of your wife is tested. These are critical times that test a husband's commitment to his wife. It's a time when both partners can fulfil their responsibilities and do what is right for their family.</p> <p>Let us not reject these gifts but embrace them and use them to protect our precious families. It's important for families to allocate resources to ensure a safe pregnancy and delivery. Women are at the heart of the family's financial stability. They manage household finances, nurture children, and contribute significantly to the family's prosperity. Prioritizing the well-being of women during pregnancy and childbirth is essential for the overall health and stability of the family. Let us celebrate and be grateful for the children Allah has sent us.</p>
Farewell	15 minutes	<p><i>Social mobilizers should adhere to the customary rituals of the context, bidding farewell to the hosting family through formal greetings and expressions of gratitude.</i></p> <p>Thank you for your time today, we know these things are so important to this community, we are happy we were able to talk about [topic] today.</p> <p>Social mobilizer: summarize key points of the message provided.</p>

		Remember, help and advice is always available. You can try these numbers for advice, or visit the clinic!
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Session 2: The Work We Do

Aim: To raise awareness about the actual contributions of women to the household – some of these are financial but there are many other important contributions that are sometimes not taken into account. This is meant to emphasize the importance of taking good care of them.

Description: Male and female family members analyze family members' contributions by completing the exercise in the male and the female group separately. Once completed, the information is exchanged between the two groups. The final part of the exercise focuses on discussing the results.

Section	Time to complete	Key elements/phrases to be included in the discussion
<i>Before discussion begins</i>	0	<p><i>Look for the household identifier and verify that you are at the right house, and that this household is in your assigned treatment arm.</i></p> <p>Ensure you have: flip chart, flip chart paper, pens, marker (if desired), sets of pictograms.</p> <p>Record who is present in the session, even if they are there only for part of the visit <u>at any time during the meeting.</u></p> <p>Please ensure that all key participants are present at the respective gender groups. In the women’s group, the recipient of the MCCT should be present, along with other women in the household willing to participate. This could include a mother or sister in law. In the male group, the spouse of the beneficiary should be present, along with other male householders willing to participate. Their involvement is crucial as decision-making often rests with the head of the household (typically male) and the beneficiary’s mother-in-law, making them significant recipients of the messaging.</p> <p>Please also note their role in the family or their relation to the beneficiary.</p> <p><u>Person 1 (beneficiary):</u> Age (approximate): Sex: Relation to household head: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person 2</u> Age (approximate): Sex:</p>

		<p>Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person n</u> Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p>
Introduction	15 mins	<p><i>The aim is to put the household at ease, earn their trust and respect. In your notebook, make notes about what you observe about household dynamics, about the beneficiary or any children.</i></p> <p><i>Take tea if offered</i></p>
Recall and listening	15 minutes	<p>You may have seen around the community that UNICEF, working with the Ministry of Public Health, are trying to help women like you access [healthcare facet]. Have you seen any of these messages around this community?</p> <p>[Summary of community level SBC assets]</p> <p>IMPORTANT: To foster a more interactive session, it's highly recommended to intersperse the discussion of messages with engaging questions. For instance:</p> <p>“What does this mean to you and your family?” “Do you find these messages relevant to your household?” “How do these concepts apply to your daily life?” “Are these practices or ideas familiar to you?” “What obstacles does your household or community face in achieving these goals?”</p> <p>Remember, these questions should be distributed throughout the discussion, rather than asked all at once, to encourage ongoing engagement and reflection.</p>
Interactive session	60 minutes	<p>Explain the aim of the session: to raise awareness about the actual contributions of women to the household. Some of these are financial, but there are many other important contributions that might not be taken into account.</p> <p>Explain that successful household economies are the result of lots of different contributions from household members. We often consider income as an important contribution to a household’s economy, but</p>

	<p>there is also a lot of work that is not paid that goes into making it a home.</p> <p>Explain to participants that in this exercise we will look at the contributions made by some of the men and women in this household.</p> <p>Activity:</p> <p><i>Within each group</i></p> <ol style="list-style-type: none"> i. Take two flip chart sheets and draw an analogue clockface on each of the sheets – one labelled ‘AM’ and the other ‘PM’ ii. Place them in the middle of the group iii. Take the stack of pictograms and spread them out near the sheets on which the clockfaces are drawn iv. <i>In the male group:</i> Ask the spouse of the beneficiary (or other male family member if not present) to place the pictograms near the hours on the clockface to show when they conducted that particular activity v. <i>In the female group:</i> Ask the beneficiary to place the pictograms near the hours on the clockface to show when they conducted that particular activity <p>At the end of this, do the following:</p> <ol style="list-style-type: none"> vi. Take two new sheets and draw an analogue clockface on each – one labelled ‘AM’ and the other ‘PM’ vii. Place them in the middle of the group viii. <i>For the male group:</i> repeat the activity in iv but thinking about the activities done by the female beneficiary of the MCCT ix. <i>For the female group:</i> repeat the activity in v but thinking about the activities done by the male spouse of the female beneficiary <p>Now inform participants that they are going to swap the papers created with the male or female group respectively.</p> <p>Discussion will now be about the timesheets that were swapped. Guiding questions might include:</p> <ul style="list-style-type: none"> - What time do men and women wake up? - At what time in the morning do the men and women do their first activity of the day that is for other family members? - At what time in the evening do the men and women do the last activity of the day that is for other family members? - What are the main activities that women do at home? How much time is spent on each activity? - What are the main activities that men do at home? How much time is spent on each activity? - How much time do women spend earning money? - How much time do men spend earning money? - How much time do women spend relaxing or doing something for themselves? - How much time do men spend relaxing or doing something for themselves?
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		<p>Ask the participants what this exercise tells us about the different contributions to the home. Have you learned anything new from it?</p> <p>Summarise by saying that women’s work at home is often valued less than men’s work, as women may not bring in household income. However, this exercise has shown that women work very long hours and do a lot for other people. How would households function without someone washing clothes, looking after the children, cooking meals and growing food in the garden?</p>
Farewell	15 mins	<p><i>Social mobilizers should adhere to the customary rituals of the context, bidding farewell to the hosting family through formal greetings and expressions of gratitude.</i></p> <p>Thank you for your time today, we know these things are so important to this community, we are happy we were able to talk about [topic] today.</p> <p>Social mobilizer: summarize key points of the message provided.</p> <p>Remember, help and advice is always available. You can try these numbers for advice, or visit the clinic!</p>

Session 4: Household Income

Aim: To allow participants to understand what makes up their household income; to examine the value of subsistence agriculture and the value of paid and unpaid work.

Description: Women and men gather in two separate rooms Participants analyze male and female family members' contributions by completing the exercise in their gender group, and then the information is exchanged between the groups. The final part of the exercise focuses on discussing the results.

Section	Time to complete	Key elements/phrases to be included in the discussion
<i>Before discussion begins</i>	0	<p><i>Look for the household identifier and verify that you are at the right house, and that this household is in your assigned treatment arm.</i></p> <p>Ensure you have: Flip chart, flip chart paper, coloured pens, marker, pictograms, market price list.</p> <p>Record who is present in the session, even if they are there only for part of the visit <u>at any time during the meeting.</u></p>

		<p>Please ensure that all key participants are present at the respective gender groups. In the women’s group, the recipient of the MCCT should be present, along with other women in the household willing to participate. This could include a mother or sister in law. In the male group, the spouse of the beneficiary should be present, along with other male householders willing to participate. Their involvement is crucial as decision-making often rests with the head of the household (typically male) and the beneficiary’s mother-in-law, making them significant recipients of the messaging.</p> <p>Please also note their role in the family or their relation to the beneficiary.</p> <p><u>Person 1 (beneficiary):</u> Age (approximate): Sex: Relation to household head: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person 2</u> Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p><u>Person n</u> Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p>
Introduction	15 mins	<p><i>The aim is to put the household at ease, earn their trust and respect. In your notebook, make notes about what you observe about household dynamics, about the beneficiary or any children.</i></p> <p><i>Take tea if offered</i></p>
Recall and listening	15 minutes	<p>You may have seen around the community that UNICEF, working with the Ministry of Public Health, are trying to help women like you access [healthcare facet]. Have you seen any of these messages around this community?</p>

		<p>[Summary of community level SBC assets]</p> <p>IMPORTANT: To foster a more interactive session, it's highly recommended to intersperse the discussion of messages with engaging questions. For instance:</p> <p>“What does this mean to you and your family?” “Do you find these messages relevant to your household?” “How do these concepts apply to your daily life?” “Are these practices or ideas familiar to you?” “What obstacles does your household or community face in achieving these goals?”</p> <p>Remember, these questions should be distributed throughout the discussion, rather than asked all at once, to encourage ongoing engagement and reflection.</p>																												
<p><u>Interactive part</u></p>	<p>60 minutes</p>	<p><i>In each group</i></p> <p>When participants have gathered, explain that in this session we are going to think about types of income in a household.</p> <p>On a flipchart sheet, draw the outline of a table as follows</p> <table border="1" data-bbox="597 1010 1417 1394"> <thead> <tr> <th>Person 3</th> <th>Person 2</th> <th>Person 1</th> <th>Income (money)</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Income (goods, own production)</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Explain that a household’s income can come from money that comes into the home, but also goods that are produced in the home.</p> <p>Ask participants within each group to think about the types of income that this household receives. As households say types of income that this household receives, write them in the table. Probe for different types of income, including pensions, rent, interest on savings and from remittances sent by family members working abroad. Some households also have a small enterprise that they make money from (e.g. selling honey or small household items). This should also be on the list.</p> <p>Then ask participants within the groups to think about the things they produce and consume in this household. What commodities are <i>produced</i> by this household (for example in a kitchen garden)?</p>	Person 3	Person 2	Person 1	Income (money)																Income (goods, own production)								
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		<table border="1"> <thead> <tr> <th>Person 3</th> <th>Person 2</th> <th>Person 1</th> <th>Income (money)</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td>Wages</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Pension</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Remittances</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Income (goods)</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Goat meat</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Mint</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Pomegranates</td> </tr> </tbody> </table> <p>In the next step, in the monetary income rows, ask up to three people in the group to report to which type of income they contribute to the household in a typical month. Do not record their name. If a person contributes a type of income, put an x in the box. If they do not know, put a question mark.</p> <p>In the 'Income (goods)' rows, ask up to three people in the group to report to which type of goods production they contribute to the household in a typical month. Ask the group to think about how much it would cost to buy these items at the market. This value in Afghani is how much you would write in the box. <i>Note to social mobilizer: if they do not know, please use the value on the market price list.</i></p> <p>Now swap the sheets you have completed with the other group of the other sex.</p> <p>Review the sheet of the other group with your own group.</p> <p>Ask participants to sum together how much income (goods) was generated by own production in each group. If both men and women contributed to a single source, split the value in half.</p> <p>Discuss that we are often told that women 'do no work' and bring in no money for the household. Ask participants what we have learned from this exercise about the financial value of women's work.</p> <p>Conclude by saying that this exercise has shown us that women engage in important activities that bring value to the home. These are often not well recognised. We have also learned that households in which more people earn money usually have more income. This is important for us to consider as we embark on the journey to improve the financial position of our households. Thank participants for their contribution in the session and agree on the time and place for the next meeting.</p>	Person 3	Person 2	Person 1	Income (money)				Wages				Pension				Remittances				Income (goods)				Goat meat				Mint				Pomegranates
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Farewell	15 mins	<i>Social mobilizers should adhere to the customary rituals of the context, bidding farewell to the hosting family through formal greetings and expressions of gratitude.</i>																																

		<p>Thank you for your time today, we know these things are so important to this community, we are happy we were able to talk about [topic] today.</p> <p>Social mobilizer: summarize key points of the message provided.</p> <p>Remember, help and advice is always available. You can try these numbers for advice, or visit the clinic!</p>
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Session 6: The Magic Box

Aim: To help female beneficiaries build their self-esteem and introduce the process of negotiation

Description: Only female beneficiaries will participate in the self-esteem game. Male household members will perform a placebo game. Afterwards both male and female respondents participate in the case of the lemon.

Section	Time to complete	Key elements/phrases to be included in the discussion
<i>Before discussion begins</i>	0	<p><i>Look for the household identifier and verify that you are at the right house, and that this household is in your assigned treatment arm.</i></p> <p>Ensure you have: small box, with a lid, and a small mirror</p> <p>Record who is present in the session, even if they are there only for part of the visit <u>at any time during the meeting.</u></p> <p>Please ensure that all key participants are present at the respective gender groups. In the women’s group, the recipient of the MCCT should be present, along with other women in the household willing to participate. This could include a mother or sister in law. In the male group, the spouse of the beneficiary should be present, along with other male householders willing to participate. Their involvement is crucial as decision-making often rests with the head of the household (typically male) and the beneficiary’s mother-in-law, making them significant recipients of the messaging.</p> <p>Please also note their role in the family or their relation to the beneficiary.</p> <p><u>Person 1 (beneficiary):</u> Age (approximate): Sex: Relation to household head: Is this person pregnant? Does this person have a child aged under 2 years old?</p>

		<p>Present for the whole session? [If no] how long were they present?</p> <p>Person 2 Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p> <p>Person n Age (approximate): Sex: Relation to beneficiary: Is this person pregnant? Does this person have a child aged under 2 years old? Present for the whole session? [If no] how long were they present?</p>
Introduction	15 mins	<p><i>The aim is to put the household at ease, earn their trust and respect. In your notebook, make notes about what you observe about household dynamics, about the beneficiary or any children.</i></p> <p><i>Take tea if offered</i></p>
Recall and listening	15 minutes	<p>You may have seen around the community that UNICEF, working with the Ministry of Public Health, are trying to help women like you access [healthcare facet]. Have you seen any of these messages around this community?</p> <p>[Summary of community level SBC assets]</p> <p>IMPORTANT: To foster a more interactive session, it's highly recommended to intersperse the discussion of messages with engaging questions. For instance:</p> <p>“What does this mean to you and your family?” “Do you find these messages relevant to your household?” “How do these concepts apply to your daily life?” “Are these practices or ideas familiar to you?” “What obstacles does your household or community face in achieving these goals?”</p> <p>Remember, these questions should be distributed throughout the discussion, rather than asked all at once, to encourage ongoing engagement and reflection.</p>
Interactive component	15 minutes	<p>Female group:</p>

		<p>Begin by asking: “Who do you think is the most special person in the whole world?”</p> <p>3. After allowing the participants to respond, you may continue: “Well, I have a magic box with me, and you can look inside and discover who the most special person in the world is.”</p> <p>4. Give the participant a chance to look into the box. Ask: “Who do you see?” Then say: “Isn’t she amazing?”</p> <p>5. Ask participants the following questions:</p> <ul style="list-style-type: none"> - How did you feel looking at yourself in the mirror? - How did it feel being given a compliment? - Were you surprised with the feedback you got? - Do you realise that you are indeed special? - What made you realise that you are special? - Do you have any doubts? What made you doubtful? <p>6. Explain that the box is valuable to us because it allows us to see ourselves and that we are indeed special. We each have unique gifts and we are alive. Considering the events going on in the world, we are indeed blessed.</p>
<p><u>Farewell</u></p>	<p>15 mins</p>	<p><i>Social mobilizers should adhere to the customary rituals of the context, bidding farewell to the hosting family through formal greetings and expressions of gratitude.</i></p> <p>Thank you for your time today, we know these things are so important to this community, we are happy we were able to talk about [topic] today.</p> <p>Social mobilizer: summarize key points of the message provided.</p> <p>Remember, help and advice is always available. You can try these numbers for advice, or visit the clinic!</p>

Annex 7 – Bibliography and documents reviewed

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Topic	Document name/Description	Date finalized	Author
Province and district selection	Final Provinces and Districts		UNICEF
	General Ranking of Provinces and Districts		UNICEF
	MCCT Provinces and Districts prioritization		UNICEF
Kunar anonymized data	Kunar Data APWDO	Nov-23	UNICEF
	Kunar Survey form APWDO	Nov-23	UNICEF
SBC	Positive Change for Children Through Cash Transfer SBC MCCT		UNICEF
	SBC for MCCT Programme Presentation	Nov-23	UNICEF
	Session handout SBC - MCCT		UNICEF
	Child's Rights in Islam Module		UNICEF
	Exploring Socio behavior Factors Behind Child Wasting in Afghanistan	Oct-22	ATR
	MCCT SBC Two-pager	Jan-24	UNICEF
	SBC Qualitative Research of Cash for Education Project Endline Evaluation	Dec-23	UNICEF
	MCCT SBC presentation	Dec-23	UNICEF
	SBC Implementing Partners (IP) (geographic details)		UNICEF
	Systematic Behavior Change Intervention to contribute to the prevention of Wasting and Stunting of Children in Afghanistan TOR	Sep-23	UNICEF
	Improve evidence generation for key practices related to health and nutrition and capacity building of various stakeholders and frontline worker on SBC TOR	Jan-24	UNICEF
	MCCT Evaluation with SBC Summary	Feb-24	UNICEF
	Session Handout SBC - MCCT		UNICEF
	Messages		UNICEF
		Afghanistan 2022-23 MICS	May-23

National Survey reports	Afghanistan-Multidimensional Poverty Index	2019	NSIA
CBA in Afghanistan	Standard Operating Procedure (SOP) - CBA UNICEF Afghanistan	Jul-21	UNICEF
Barriers to healthcare for women	Health Sector Transition Strategy 2023-2025	May-23	UNICEF
	Health Emergency Response (HER) Programme Document Overview	Feb-23	UNICEF
	Gender Analysis of Barriers to Immunization in Afghanistan	Aug-23	UNICEF
	Rapid Gender Analysis Afghanistan	Nov-23	GiHA working group
	Gender barriers are worsening women's access to health care in Afghanistan	Sep-22	The Lancet
	Afghan women and access to health care in the past 25 years Commentary	2021	The Lancet
	Persistent barriers to access healthcare in Afghanistan	2022	Medicins Sans Frontiers
	Rural Women's Access to Health: Poverty, insecurity and traditions are the main obstacles	Jul-21	Afghanistan Analysts Network
	Barriers associated with care-seeking for institutional delivery among rural women in 3 provinces of Afghanistan (AFG)	2018	BMC Pregnancy and Childbirth
Relevant evaluations and reports on Afghanistan	AFG Humanitarian Access Severity Overview	Jul-23	UNOCHA
	Revised Humanitarian Reponse Plan Afghanistan 2023	2023	UNOCHA
	Policy Brief for Afghanistan	Feb-22	UNICEF
	Afghanistan MICS Report 2022-2023	May-23	UNICEF
	Evaluation of CBA programme	Dec-23	UNICEF
	Gender & adolescents' programmes mid-year report	Jul-22	UNICEF
	UNICEF Afghanistan Humanitarian Situation Report No. 11	Nov-23	UNICEF
	Evaluation of UNICEF L3 Response in Afghanistan	Sep-23	UNICEF
	Basic Primary Health Service Package		UNICEF
Sustainable improvement of food security and nutrition practices of children and women in Afghanistan Proposal to Kreditanstalt für Wiederaufbau (KfW)	Aug-22	UNICEF	

	MCCT Design and Strategy to scale up	Jul-23	UNICEF
	MCCT IE presentation	Dec-23	UNICEF
	Rationalisation of MCCT Revision		UNICEF
	Afghanistan MCCT Concept 2023-2025	Jul-21	UNICEF
Inception reports and checklist	Comments matrix_final		UNICEF
	Evaluation of the CARD and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia Inception Report	Oct-17	UNICEF
	Checklists for Evaluation/Research Quality Assurance		UNICEF
	Baseline Assessment of UNICEF ESS Inception Report	Mar-23	UNICEF
	Inception Report Checklist (Global Evaluation Reports Oversight System (GEROS) Compliant)		UNICEF
	Evaluation of the Multilingual Education National Action Plan in Cambodia Inception Report	Sep-18	UNICEF
	Outcome Evaluation of the Education Capacity Development Partnership Fund Phase I and II	Sep-17	Capacity Development Partnership Fund Steering Committee Secretariat
Management arrangements	MCCT Impact Evaluation (IE) - Information note	Dec-23	UNICEF
	MCCT IE - Management arrangements	Dec-23	UNICEF
	Norms and Standards for Evaluation presentation	2016	UNEG
	Ethical Guidelines for Evaluation	2020	UNEG
	GEROS Ratings Template	Dec-19	UNICEF
	Revised evaluation policy	Aug-23	UNICEF
	Branded Presentation Template		UNICEF
	Ethical Considerations when Using Social Media for Evidence Generation	Jun-18	Innocenti
	GEROS Evaluation Quality Assessment (EQA) Standard Template	Sep-21	UNICEF
	Ethical Research Involving Children	Sep-13	Innocenti
	Evaluation Acronyms		UNICEF
	Evaluation of Impact Strategy and Action Framework	Mar-23	UNICEF

	Evaluation Report Template		UNICEF
	Evaluation Use in Practice	Jan-20	UNEG
	How to design and manage Equity-focused evaluations	2011	UNICEF
	GEROS Handbook for UNICEF Staff and Independent Assessors	Jun-17	UNICEF
	UNICEF GEROS Handbook	Jun-17	UNICEF
	Inter Agency Humanitarian Evaluation on General Equality and the Empowerment of Women and Girls (GEEWG)	Oct-20	IAHE
	Revised Evaluation Policy of UNICEF	Jun-18	UNICEF
	UNEG Norms & Standards for Evaluation	Nov-17	UNEG
	UNICEF Guidance on Gender Integration in Evaluation	Sep-19	UNICEF
	UNICEF Procedure Ethical Standards in Evidence Update Presentation	Apr-21	UNICEF
	UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis	Apr-21	UNICEF
	UNICEF Style Book	Feb-22	UNICEF
	UNICEF evaluation presentation	2023	UNICEF
	UNICEF Adapted UNEG Evaluation Reports Standards	Jun-17	UNICEF
	UNICEF Guidance on Gender Integration in Evaluation	Sep-19	UNICEF
Updated versions Jan 2024	MCBP IE Baseline Survey		World Bank
	MCBP IE Baseline Survey clean		World Bank
	MCBP Impact Evaluation Concept Note		World Bank
	Sumamry of seven MCBP district health services analysis		World Bank
PMU	Cases		UNICEF
	Credentials		UNICEF
	MCCT Data Presentation		UNICEF
	PDM form		UNICEF
	Registration form		UNICEF
Gender	Rapid Gender Assesment ToR (Zabul and Samangan)		UNICEF
	UNICEF Facts and Figures Health	Dec-23	UNICEF

	UNICEF Facts and Figures Social Protection	Dec-23	UNICEF
	Final MCCT Evaluation TORs-cleaned version	Oct-23	UNICEF
	MCCT Impact Evaluation TOR	Oct-23	UNICEF
	Equity Analysis	Apr-24	UNICEF
	IT and GeoSight Requirement for Equity Analysis	Apr-24	UNICEF
	Equity Analysis Results Presentation and Discussion	May-24	UNICEF

Annex 8 – Evaluation logframe

Table 12 Evaluation logframe

Level in the TOC	Component	Indicator	Sources & means of verification	Assumptions (A) and risks (R)
Input	Cash disbursements	% of planned disbursements that take place and on schedule	Administrative data – UNICEF/IP	R: Data is not collected or collated by IP, or not shared A: No exogenous influence on the implementation of the MCCT programme
		% of registered households that collect transfers per distribution	Administrative data – UNICEF/IP	R: Data is not collected or collated by IP, or not shared A: No exogenous influence on the implementation of the MCCT programme
		% of registered households that collect transfers at every distribution	Administrative data – UNICEF/IP	R: Data is not collected or collated by IP, or not shared A: No exogenous influence on the implementation of the MCCT programme
		% of beneficiaries that report accessing transfers without safety concerns	Administrative data – UNICEF/IP	R: Data is not collected or collated by IP, or not shared A: No exogenous influence on the implementation of the MCCT programme

		% of beneficiaries that report transfer distribution sites are dignified	UNU-MERIT survey evaluation survey – mid & endline Secondary data – GRM & CFM	A: No exogenous influence on the implementation of the MCCT programme
		% of beneficiaries living with a disability that report accessing transfers	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme
		% of beneficiaries that receive transfers according to schedule	Administrative data – UNICEF/IP	R: Data is not collected or collated by IP, or not shared A: No exogenous influence on the implementation of the MCCT programme
		% of beneficiaries that report being aware of the programme and their entitlement under the programme	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme
		% of beneficiaries that are aware of CFM and Grievance Mechanisms	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme
		% of CFM cases that are dealt with within a given timeframe	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme
Input	Community-level health and nutrition related behaviour nudges	% of planned community-level engagements that took place and on schedule	Administrative data – UNICEF/IP	A: No exogenous influence on the implementation of the MCCT programme
		% of respondents that report being aware of community-level SBC	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme
		% of respondents that report actively participating in community-level SBC	UNU-MERIT survey evaluation survey – mid & endline	A; No exogenous influence on the implementation of the MCCT programme
Input	Household-level behavioural nudges delivered	% of planned household-level engagements that take place and on schedule	Administrative data – UNICEF/IP	A: No exogenous influence on the implementation of the MCCT programme
		% of respondents that report actively participating in	UNU-MERIT survey evaluation survey – mid & endline	A: No exogenous influence on the implementation of the MCCT programme

		household-level behavioural nudges		
Output	Increased spending on more diverse and nutrition food ¹³	Increase in expenditure (Afghani)	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: No price discrimination A: No nationwide/local inflation A: No exogenous influence on the implementation of the MCCT programme
		Increase in Dietary Diversity Score (index point increase) <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: No price discrimination A: No nationwide/local inflation A: No exogenous influence on the implementation of the MCCT programme
Output	Adoption of optimal feeding practices, particularly among PLW & infants	Increase in % of households that report achieving Minimum Dietary Diversity for Women <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: No price discrimination A: No nationwide/local inflation A: No exogenous influence on the implementation of the MCCT programme
		Increase in % of households that report achieving Minimum Acceptable Diet for Infants	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: No price discrimination

¹³ Intermediate output's (increased household income and purchasing power) indicators are identical; therefore, for the purposes of not duplicating, the intermediate output is not reflected.

		<i>*Some degree of gender disaggregation (not necessarily representative)</i>		A: No nationwide/local inflation A: No exogenous influence on the implementation of the MCCT programme
Output	Greater knowledge & awareness of risks, consequences and benefits of nutrition & health-related practices for PLW & children	Increase in % of households that report positive attitudes to Knowledge, Attitudes and Practices questions on nutrition and feeding <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds	A: Women’s mobility is not further limited A: There is no increase in gender-based violence
Output	Reconsidered interpretation of social norms concerning health-related practices and behaviours of PLW & children ¹⁴	Increase in the demand for agency index score <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – midline	A: Women’s mobility is not further limited A: There is no increase in gender-based violence
		Increase in % respondents reporting joint or female-alone decision making in household consumption and healthcare <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds	A: There is no increase in gender-based violence
Outcome	Improved food consumption & dietary diversity	Increase in Food Consumption Score	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: Access to safe water & sanitation

¹⁴ Intermediate outcome’s (increased intra-household bargaining power of pregnant and lactating women) indicators are identical; therefore, for the purposes of not duplicating, the intermediate outcome is not reflected.

				A: No covariate shocks
		Increase in Dietary Diversity Score	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: Access to safe water & sanitation A: No covariate shocks
		Reduction in the Household Hunger Score	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: Access to safe water & sanitation A: No covariate shocks
		Reduction in the proportion of children 6-23 months living in extreme or moderate food poverty	UNU-MERIT survey evaluation survey – all rounds	A: Functioning markets with nutritious commodities available A: Access to safe water & sanitation A: No covariate shocks
Outcome	Increased utilization of primary healthcare and nutrition services by PLW & children	Increase in % of households reporting visits to healthcare facilities for any reason	UNU-MERIT survey evaluation survey – all rounds	A: Culturally relevant, quality, healthcare is available A: <i>Mahram</i> and local transport available A: No covariate shocks A: Women’s mobility is not further limited A: Households spend a portion of their income on transportation to healthcare facilities
		Increase in % of children receiving any vaccination <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds Administrative data – healthcare clinics, UNICEF	A: Culturally relevant, quality, healthcare is available A: <i>Mahram</i> and local transport available A: No covariate shocks A: Women’s mobility is not further limited

				A: Households spend a portion of their income on transportation to healthcare facilities
		Increase in % of women attending ante-natal clinics <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds Administrative data – healthcare clinics, UNICEF	A: Culturally relevant, quality, healthcare is available A: <i>Mahram</i> and local transport available A: No covariate shocks A: Women’s mobility is not further limited A: Households spend a portion of their income on transportation to healthcare facilities
		Increase in % of women & infants attending post-natal clinics <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds Administrative data – healthcare clinics, UNICEF	A: Culturally relevant, quality, healthcare is available A: <i>Mahram</i> and local transport available A: No covariate shocks A: Women’s mobility is not further limited A: Households spend a portion of their income on transportation to healthcare facilities
		Increase in % of household accessing nutrition services at healthcare facilities/ clinics <i>*Some degree of gender disaggregation (not necessarily representative)</i>	UNU-MERIT survey evaluation survey – all rounds Administrative data – healthcare clinics, UNICEF	A: Culturally appropriate nutrition services are routinely available A: <i>Mahram</i> and local transport available A: No covariate shocks A: Women’s mobility is not further limited A: Households spend a portion of their income on transportation to healthcare facilities

Impact	Reduced malnutrition rates	Decrease in % of MCCT beneficiary households diagnosed with GAM, Moderate Acute Malnutrition (MAM) or Severe Acute Malnutrition (SAM) <i>*Some degree of gender disaggregation (not necessarily representative)</i>	<i>Not observable during impact evaluation timeline</i>	
Impact	Reduced prevalence of micronutrient deficiencies among PLW	Decrease in % of MCCT beneficiary households diagnosed with or experiencing micronutrient deficiencies <i>*Some degree of gender disaggregation (not necessarily representative)</i>	<i>Not observable during impact evaluation timeline</i>	
Impact	Increased agency of women in decision-making	Increase in % of women that report being able to influence household decisions <i>*Some degree of gender disaggregation (not necessarily representative)</i>	<i>Not observable during impact evaluation timeline</i>	
Impact	Reduced maternal mortality rates	Decrease in maternal mortality rates among MCCT beneficiary households <i>*Some degree of gender disaggregation (not necessarily representative)</i>	<i>Not observable during impact evaluation timeline</i>	
Impact	Reduced child mortality	Decrease in child mortality rates among MCCT beneficiary households	<i>Not observable during impact evaluation timeline</i>	

		<i>*Some degree of gender disaggregation (not necessarily representative)</i>		
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