Evaluation of the Community-Based Nutrition Programme (CBNP)

Evaluation Brief

Afghanistan remains one of the world's most fragile countries, with one of the highest hunger index scores globally. The ongoing economic recession, political regime change, and effects of the COVID-19 pandemic threaten to erode progress against child undernutrition. To address these challenges, the Community-Based Nutrition Programme (CBNP) was designed in 2017 and implemented nationwide. The CBNP provided comprehensive nutrition-specific and nutrition-sensitive interventions within a minimum service package delivered at the community level to increase access to and demand for quality, cost-effective health care – including maternal and newborn health services – for the most marginalized and vulnerable populations. The evaluation measured the CBNP's coverage, relevance, efficiency, effectiveness, sustainability, coherence, and impact on child feeding practices among parents and caregivers of children aged 6–23 months in Afghanistan's Parwan, Ghazni, and Herat provinces and covered CBNP implementation from January 2020 to December 2023. The evaluation employed mixed methods, collecting and analysing both quantitative and qualitative data. Methods included post-intervention survey (N=4,5090), in-depth interviews (86), focus group discussions (28 FGDs covering 210 people), key informant interviews (41), and analysis of secondary data.

Evaluation findings

Quality of design and approach: UNICEF staff and partners perceived the CBNP as a trustworthy programme for improving children's nutrition. Target communities found services provided by Community Health Workers (CHWs) useful and beneficial, including health education, essential nutrition and health supplies, such as micronutrient powder, vaccinations, and personalized health advice. The programme's key strength was its capacity-building phase, which utilized and strengthened existing human resources. However, stakeholders' perceptions of the implementation phase were less positive than those of the capacity-building phase.

The CBNP targeting strategy was generally considered relevant. However, many stakeholders expressed concern about gaps in future targeting strategy, particularly "white areas" (areas without health posts) and "fixed areas" (areas surrounding health facilities) that the CBNP did not reach.

The programme aligned with national and regional nutrition policies and strategies. Its objectives to reduce malnutrition, enhance maternal and child health, encourage breastfeeding, and address individual nutritional needs were consistent with Ministry of Public Health policies and strategies. The CBNP also aligned with UNICEF's global and regional nutrition strategies. The programme's strategic focus on child stunting, wasting, and micronutrient deficiencies corresponded with addressing "child malnutrition in all its forms". The programme strategy harmonized with other UNICEF priorities, including building resilience in vulnerable communities, empowering children and young people, and adhering to the Convention on the Rights of the Child.

CBNP mobilized equal numbers of men and women for community events. However, women's access to services varied due to household responsibilities, limited family support, distance and infrastructure challenges that included the conditions of roads, and weather. The change of regime restricted female movement, negatively affecting women's access to CBNP services.

Programme effectiveness: Programme data showed most capacity-building phase indicators, and some implementation indicators achieved their targets, a view supported by household surveys and focus group discussions/in-depth interview findings. Exceptions included access indicators, such as the identification and referral of children under 5 with moderate or severe acute malnutrition (achievements below 50 per cent) and growth monitoring coverage (inconclusive achievement). Underachievement in referrals stemmed from insufficient functional referral mechanisms and community-level support.

During the COVID-19 pandemic, some programme activities were suspended, and participation decreased. The change in the regime resulted in forced migration and negatively impacted targets through the restriction of women's movement and delays in the signing of memorandums of understanding (MoUs). The programme adapted through innovative approaches, including remote consultations, socially distanced meetings, and mobilizing women to attend health posts rather than conducting home visits.

Household surveys showed improved caregiver knowledge and practice in pregnancy care and nutrition. Improvements included prenatal care practices such as antenatal care, postnatal care, iron and folic acid supplementation, and knowledge of breastfeeding practices. This led to improved breastfeeding practices, including timely initiation and exclusive breastfeeding. Minimum diet diversity declined, potentially due to deteriorating food security. While handwashing practices showed no improvement, availability of handwashing stations with water and soap increased significantly. Survey results indicated significant changes in household gender dynamics, with reduced women's participation in decision-making, potentially related to the new regime.

Sustainability: Several improved behaviours, particularly in prenatal care and breastfeeding, indicated the potential for sustainability. Focus group discussions and interviews supported the possibility of lasting behaviour change beyond the programme. However, many key informants expressed concern that sustainable behaviour change requires continuous support over a longer period (3-5 years minimum) beyond the current CBNP capacity-building duration.

Community health workers (CHWs) and community health supervisors acquired the necessary knowledge and skills through training, including practical counselling and supervision skills adaptable to other work. The implementation of the programme through HPs and CHWs, which are main components of the Primary Health Care programme, can ensure sustainability of the CBNP. However, the sustainable application of CBNP-introduced knowledge requires supporting conditions, including continuous refresher training for CHWs, supervision, follow-up, and financial support (incentives) – none of which were available sufficiently. Basic Package of Health Services partners, responsible for CHW follow-up support during implementation, provided insufficient support due to limited commitment and accountability. The voluntary nature of the CHW system in Afghanistan and reliance on external financial support for health/nutrition services created sustainability vulnerabilities.

Programme achievement and contribution: Analyses showed a significant and positive impact on prenatal care practices, and service access, including antenatal care, postnatal care, and iron and folic acid supplementation. Similar improvements emerged in knowledge of exclusive and continued breastfeeding and the use of oral rehydration solutions for diarrhoea, providing solid evidence of CBNP's contribution.

Among enablers, CBNP utilized existing human resources (i.e., CHWs) at community levels, instead of creating parallel structures, and strengthened them through effective training programme with user-friendly materials and tools, supported by the technical support of Nutrition Extenders. Additionally, community mobilization sessions (CMSs) contributed to awareness raising and sensitization of community level stakeholders on the importance

of nutrition and balanced diet, which helped knowledge dissemination widely and supported behaviour change among caregivers.

CHWs faced common challenges, including time constraints, long distances to households, work overload, illiteracy, and a lack of incentives. Their advanced age and high turnover limited their ability to effectively provide nutrition services. Food availability and access remained challenging for diet diversification due to economic constraints, traditional crop preferences, limited access to cultivation training, and a lack of family support. Price increases and poverty resulted in poor food intake, particularly among women. Household survey indicators – including minimum dietary diversity for women, household dietary diversity score, and household food insecurity score – demonstrated a clear deterioration in food security from baseline data collection to post-intervention/endline.

Management, governance, and resourcing: The CBNP management structure operated at national, provincial, district, and community levels to ensure effective planning, monitoring, and implementation. Non-governmental organizations collaborated with the Ministry of Public Health to provide additional resources and support, though ministry engagement decreased after the regime change. While technical human resources met basic needs, overall staff shortages and governance issues, including absence of focal persons among the nutrition extenders, limited the achievement of intended results. Training tools and methods were generally effective but needed improvements, including a shorter training-of-trainers duration, extended CHW training, and strengthened Community Health Supervisor supervision. Underfunded areas included CHW incentives, supervisor travel support for monitoring, and food demonstration implementation. The CBNP approach demonstrated efficiency through its preventive focus, the use of local human resources, and the enhancement of community support. However, high communication material costs, particularly for CBNP kits, presented an efficiency challenge.

Monitoring, evaluation, and knowledge management: CBNP data reporting occurred through two systems: monthly implementation partner reports during capacity building and Health Management Information System indicators during implementation. Major reporting challenges included CHW illiteracy and workload, which affected accuracy and completeness. Remote locations and weather conditions delayed data collection and impacted information quality. Insufficient BPHS partner monitoring of CHWs created challenges for data accuracy and accountability. The absence of consolidated national-level data limited effective decision-making. The separate management of CBNP and Health Management Information System reports without synthesis, along with the unclear use of data in coordination meetings, indicated room for improvement, also including in the theory of change and indicators.

Cross-cutting integration: While CBNP's design centred on community-based concepts, an analysis of service access showed that all vulnerability factors (distance to health posts, immigration status, maternal education, and disability) negatively influenced access to community-based nutrition services, indicating the need for improved participation efforts among vulnerable groups.

Lessons learned

1. Evidence-based donor engagement strategies will ensure sufficient funding to meet CBNP programme objectives.
2. Investments in follow-up capacity building are equally important for scaling up.
3. Full integration of CBNP with BPHS will be paramount to sustainability.
4. Formative analysis on gender-responsive SBC strategy will be needed to enhance CBNP's effectiveness.
5. A flexible arrangement of CBNP duration would benefit ensuring the effectiveness of capacity building.
6. The application of CBNP in mobile clinics or other innovative methods for remote and uncovered zones should be considered.
7. Clear roles and responsibilities among stakeholders are essential for efficient governance structures for community-based nutrition.
8. Effective community participation requires a good community strategy.
9. Multi-sector and inter-agency coordination is essential for enhancing programme impact.

Evaluation conclusions

Conclusion 1: The design and approach of the CBNP capacity-building phase were perceived as acceptable, relevant, and useful among the stakeholders and beneficiaries. The programme design and approach were aligned with national and UNICEF nutrition policy and strategies. The targeting strategy of CBNP was also regarded as relevant; however, further improvement was needed to reach “white areas." Access to community events under the CBNP programme was equitable among men and women. Restricted female movement following the regime change, however, has negatively influenced accessibility to CBNP services among women.

Conclusion 2: Most of the performance indicators for the capacity-building phase achieved the targets, except for a few gaps. Caregivers demonstrated improved knowledge and practices for pregnancy care and nutrition. The effectiveness for diet diversity, food security, and women's empowerment was not confirmed due to the influence of the regime change and deteriorating socio-economic conditions.

Conclusion 3: Improvements in several behaviours indicated the potential for sustainability, but it requires continuous support over a longer period beyond the current duration of the CBNP capacity building. Sustainable application of the CBNP-introduced knowledge and skills by CHWs would require a supportive environment.

Conclusion 4: A positive and significant impact was detected on knowledge and practices of prenatal care and nutrition, contributing to improved outcomes. Economic constraints and traditional norms limited access to and the availability of diverse foods, as represented by a set of different indicators.

Conclusion 5: The management structure for the CBNP programme was well-organized to ensure effective planning, monitoring, and implementation, while training tools and methods were relevant and effective for participants, with room for improvement. Efficiency in resource utilization was supported by a focus on prevention, the utilization of locally available human resources, and the enhancement of community support.

Conclusion 6: The internal M&E system of CBNP consisted of two reporting channels: CBNP reports for the capacity-building phase and HMIS for the implementation phase. Insufficient compilation, consolidation, and synthesis of the data limited the opportunity for effective utilization of the report in decision-making.

Conclusion 7: CBNP's design, model, and approach were formed around the core concept of "community-based" to increase access to and demand for health care delivery for vulnerable populations. However, the analysis found some room for further improvement to reach the most vulnerable.

Evaluation recommendations

Recommendation 1: Diversify funding sources and secure long-term commitments to sustain the programme through continuation of follow-up support to ensure full integration of CBNP in CBHC platform and BPHS.

Recommendation 2: Systematically integrate the CBNP into the BPHS through adaptation of the pay-for-performance indicators and review/update of CHW selection criteria and incentive scheme.

Recommendation 3: Develop gender-responsive SBC strategies, especially with focus on diet diversity and improved access to health/nutrition services.

Recommendation 4: Review and update the CBNP advocacy strategy for community engagement to involve community and religious leaders, as well as existing community groups, for community mobilization, engagement, and sustainability.

Recommendation 5: Introduce focal persons among nutrition extenders for efficient management for CBNP, with clear roles and responsibilities, enhance the training programme for CHWs and CHSs to strengthen their knowledge and skills, and develop targeted strategies to support families facing financial constraints, ensuring equitable access to nutrition and health services.

Recommendation 6: Identify and liaise with existing food security and reproductive health programmes of the UN agencies and NGOs for strategic coordination.

Recommendation 7: Explore potential partnership with other sectors for multi-sector programming.

Recommendation 8: Strengthen community-based nutrition information and monitoring systems for decision-making.

Recommendation 9: Consider application of CBNP in mobile clinics or establishing new HPs for remote and uncovered zones.

Recommendation 10: Strengthen knowledge and awareness among CHWs and CHS on the needs of improved access to health/nutrition services among the most vulnerable groups in the community (e.g., people and children with disabilities, vulnerable groups, etc.).