
# Impact Evaluation of the Afghanistan Health Emergency Response (HER) and Novel Financing Arrangement (NFA) Program

## Inception Report

**September 2025**

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## Acronyms and Abbreviations

| | |
|---|---|
| ADB | Asian Development Bank |
| AIR | American Institutes for Research |
| ANC | Antenatal Care |
| ATE | Average Treatment Effect |
| BPHS | Basic Package of Health Services |
| CATI | Computer-Assisted Telephone Interview |
| CBHC | Community-Based Health Care |
| CHWs | Community Health Worker |
| CHR | Community Health Roadmap |
| DiD | Difference-in-Differences |
| EOCs | Emergency Operation Centers |
| EPHS | Essential Package of Hospital Services |
| FGD | Focus Group Discussions |
| HER | Health Emergency Response |
| HIVA | High-impact value-addition |
| HMIS | Health Management Information System |
| ICC/ESOMAR | International Chamber of Commerce/ European Society for Opinion and Marketing Research |
| IQCS | Integrated Quality Control System |
| IRB | Institutional Review Board |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MoPH | Ministry of Public Health |
| NFA | Novel Financing Arrangement |
| NGO | Non-governmental Organization |
| ORB | Opinion Research Business International |
| PHC | Primary Health Center or Care |
| PNC | Postnatal Care |
| PII | Personally Identifiable Information |
| PSM | Propensity Score Matching |
| SC | Steering Committee |
| SP (IP) | Service Provider (Implementing Partner) |
| TPM | Third-party Monitor |
| TOR | Terms of Reference |
| UNICEF | United Nations Children's Fund |
| WASH | Water, Sanitation, and Hygiene |
| WHO | World Health Organization |
| WB | World Bank |

# 1. Introduction

This Inception Report (IR) is for the impact evaluation of Health Emergency Response (HER)/Novel Financing Arrangement (NFA) program, commissioned by the UNICEF's independent evaluation function. The evaluation is guided by the Terms of Reference (ToR), attached as **Error! Reference source not found.**.

This IR details the context, subject of the impact evaluation, purpose, objectives and scope and methodology for the work. The IR is produced to ensure a common understanding among the key stakeholders involved in the impact evaluation process. The inception phase will be followed by data collection and a reporting and analysis phase, with a final impact evaluation report to be produced by October 2025, with preliminary findings to be available by the end of August.

The purpose of this impact evaluation is to assess the impact and added value of the HER/NFA program on Afghanistan's health system and its contribution to meeting beneficiaries' needs. The evaluation will focus on interventions related to the Basic Package of Health Services (BPHS), the Essential Package of Hospital Services (EPHS), and High-Impact Value-Added (HIVA) health services up to early 2025.

The IR comprises of six chapters and includes all necessary annexes. The overall IR corresponds to UNICEF's Global Evaluation Reports Oversight System (GEROS) quality checklist for the IR, as well as United Nations Evaluation Group (UNEG) and UNICEF guidelines and standards for evaluation.

Chapter 2 describes the background and context, including the impact evaluation object. Chapter 3 demonstrates the purpose, objectives, users, and scope of the evaluation. Chapter 4 covers the evaluation framework, including key evaluation questions. Chapter 5 describes the proposed methodology, including data collection tools, risks, limitations and mitigation strategies, quality assurance, ethical considerations and management arrangements to conduct the evaluation. Chapter 6 presents a proposed work plan and deliverables.

# 2. Background and Context

## Healthcare system and situation in Afghanistan

Between 2012 and 2023, under-five mortality in Afghanistan decreased at an average annual rate of 2.3%, reaching 56 deaths per 1,000 live births in 2023, with wide provincial disparities, from 16 deaths per 1,000 in Kapisa to 120 per 1,000 in Nooristan.[1] Neonatal deaths now represent two-thirds of all child deaths, with approximately one newborn dying every ten minutes from preventable causes such as premature birth complications and birth asphyxia.[2] Maternal mortality remains critically high, estimated at 620 deaths per 100,000 live births in 2023, totaling around 7,600 maternal deaths annually.[3] The total fertility rate stands at 5.4 live births per woman, with the adolescent birth rate at 62 per 1,000 girls aged 15-19.[4] Malnutrition is widespread: 44.7% of children under five are stunted, and 3.7% are wasted, while 20.8% of women of reproductive age suffer from malnutrition, with some provinces exceeding 30%.[5] Effective coverage of key RMNCAH interventions varies considerably, vitamin A supplementation reaches 72% of children aged six months and above, exclusive breastfeeding is practiced by 63% of infants for six months,

[1] UN Inter-agency Group for Child Mortality Estimation. (n.d.). All-cause mortality estimates (Afghanistan). Available at: https://childmortality.org/all-cause-mortality/data/estimates?indicator=MRY0T4&refArea=AFG
[2] Sharif, H., et al. (2023). Access to care in Afghanistan after August 2021: a cross-sectional study exploring Afghans' perspectives in 10 provinces. Conflict and Health, 17(1). Available at: https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-023-00558-8
[3] WHO, UNICEF, UNFPA, World Bank, & UNDESA/Population Division. (2025). Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank and UNDESA/Population Division. Geneva: World Health Organization.
[4] UNICEF Afghanistan. (2022-2023). Afghanistan Multiple Indicator Cluster Survey (MICS).
[5] UNICEF Afghanistan. (2022). Afghanistan national nutrition SMART survey.

and skilled birth attendance and institutional delivery rates are relatively high at 68% and 66%, respectively.[6] However, neonatal care interventions such as skin-to-skin contact (16%), birth weight measurement (23%), and postnatal health checks (34%) show much lower coverage. Despite 75-84% of health facilities offering essential services like IMNCI and antenatal care, effective utilization remains limited due to supply-demand gaps, quality issues, and restrictions on women's mobility.[7]

Afghanistan's healthcare system operates in the midst of a protracted humanitarian crisis, including persistent conflict, internal displacement, food insecurity, pervasive poverty, and drought. The system also suffers from critical underfunding, health expenditure was around 23% of GDP in 2022.[8] Heavy reliance on inconsistent external aid[9] is now threatened by recent donor funding reductions. The healthcare workforce faces serious challenges, particularly the deterioration of the female health workforce following the ban on female medical education, jeopardizing women's access to care in a country where only female providers can attend to women and girls. Significant shortages of healthcare professionals persist in rural areas, resulting in unequal access to quality care.[10] In 2021, total health expenditures under the Interim Taliban Authority (ITA) and the former Government amounted to around USD 3 billion. The main financial sources were out-of-pocket household expenditures (77.2%), followed by donor contributions (19.3%).[11] These factors, along with recurrent disease outbreaks, such as dengue fever and measles, and the lingering impact of the COVID-19 pandemic, adds an extra pressure on the health and well-being of the population, especially women.

Despite this challenging context, Afghanistan has made noteworthy progress in strengthening its primary healthcare (PHC) system over the past two decades. The introduction and implementation of the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) have substantially increased health facility coverage across the country.[12] Additionally, the establishment of the Community-Based Health Care (CBHC) Program in 2003 was instrumental in extending health services to remote communities by introducing Community Health Workers (CHW) to bridge the gap between communities and the formal health system which bolstered the BPHS.[13] This impact is reflected in the substantial increase in CHWs from 2,682 in 2005 to 29,596 in 2017.[14] Building on the foundation of the CBHC, the Community Health Roadmap (CHR) was introduced in 2019 to provide a framework aimed at strengthening PHC in alignment with global efforts towards UHC and the SDGs. The roadmap addresses gaps in CBC, tackles emerging challenges, scales up community health services, and seeks to improve service quality and delivery at the grassroots level. The combined effect of these initiatives has been an improvement in national health indicators. For example, as per MICS 2010-2011, skilled birth attendance

[6] UNICEF Afghanistan. (2022-2023). Afghanistan Multiple Indicator Cluster Survey (MICS).
UNICEF Afghanistan. (2022). Afghanistan national nutrition SMART survey.
[7] Ibid.
[8] World Bank. (n.d.). Current health expenditure (% of GDP). Afghanistan. Available at: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AF
[9] Ministry of Public Health. (2021). Afghanistan National Health Accounts. Available at: https://moph.gov.af/sites/default/files/2023-05/NHA%202021%20final%20report%20%28English%29-%2020-May-2023.pdf
[10] World Health Organization (WHO). (2023). *Afghanistan's health system suffers critical underfunding, calls for donor support*. https://www.who.int/news/item/18-08-2023-afghanistan-s-health-system-suffers-critical-underfunding--calls-for-donor-support
[11] ACAPS. (2024). Afghanistan. Spotlight on social impact (July–October 2023). Available at: https://reliefweb.int/report/afghanistan/acaps-thematic-report-afghanistan-spotlight-social-impact-july-october-2023-09-january-2024
[12] Mohammed, R. N., Khawari, A., Shaguy, J. A., Abouzied, A. (2023). A GIS-based approach to identifying communities underserved by primary health care services—An Afghanistan case study. Frontiers in Public Health 11: 1209986. Available at: https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1209986/full
[13] Newbrander, W., Ickx, P., Feroz, F., & Stanekzai, H. (2014). Afghanistan's basic package of health services: its development and effects on rebuilding the health system. *Global public health*, *9 Suppl 1*(Suppl 1), S6–S28. https://doi.org/10.1080/17441692.2014.916735
[14] Ministry of Public Health. (2017). Community-based Health Care Data.

stood at 38.6% and antenatal care coverage (ANC – at least one visit with a skilled health personnel) at 47.9% both which increased to 67.5% and 76.4% respectively by the MICS 2022-2023.[15,16]

Afghanistan, however, still has a long way to go towards achieving universal health coverage and equitable access to healthcare services. As of 2025, progress towards SDG 3 (good health and well-being) had major challenges noted in Afghanistan with variable progress across key metrics. While still high, moderate improvement trends were seen in maternal mortality, from 1,273 in 2001 to 521 in 2023 (per 100,000 live births) and under 5 mortality 125 in 2001 to 56 in 2023 (per 1,000 live births) but stagnations were evident in neonatal mortality (34.3 per 1,000 live births) and universal health coverage (40.9%)[17,18]. Further, a 2022 geospatial analysis by WHO Afghanistan revealed that approximately 25% of the population (9.5 million people) are 'underserved', which indicates limited access to essential healthcare services.[19] Restrictions on women's mobility and participation in the workforce also create substantial impediments to healthcare access, particularly demand and utilization of maternal, newborn, and child health services. Given funding shortages, the health system continues to grapple with inadequate infrastructure, a shortage of essential medical supplies, and critical under-equipping of many healthcare centers, particularly in rural areas.[20] Despite existing policies, recent implementation experiences and the changing landscape within communities, certain aspects of the program, particularly the operational elements of the CBHC/CHR and incentivization mechanisms, warrant reconsideration. Furthermore, better integration with community-based nutrition programs is imperative to establish a comprehensive Community-Based Health and Nutrition Program (CBH&NP).[21]

Commencing in early 2004, the Ministry of Public Health (MoPH) initially oversaw the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) via a 'contracting out' approach. Non-governmental organizations (NGOs) were contracted as Service Providers (SPs) to administer services at the provincial level. However, following the shift in authorities in August 2021, the responsibility for BPHS and EPHS contracting transferred to the United Nations (UN), specifically managed by UNICEF. Since assuming this role, UNICEF has maintained collaborative efforts with SPs and other private sector entities to sustain and broaden the availability of fundamental health services. Their focus has been on enhancing care quality and fostering equitable access to health services.[22]

In 2021, the national health policy and strategy underwent updates, including a review of BPHS and EPHS, resulting in a proposed updated framework termed the "Integrated Package of Essential Health Services" (IPEHS). However, due to the political transition in August 2021, these revisions were not formally launched. Subsequently, the de-facto authorities (DfA) introduced a slightly modified National Health Policy but have yet to adopt a revised National Health Strategy or updated service package. Notably, since 2010, the BPHS package has remained unchanged, despite the country's epidemiological shifts and evolving disease burdens. The intended periodic review, typically every 3-4 years, has not been implemented. For instance, the current BPHS package lacks interventions for non-communicable diseases (NCDs) despite the country's disease burden and lifestyle-related risk factors.[23]

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[15] Central Statistics Organization (CSO) and UNICEF. (2012). Afghanistan Multiple Indicator Cluster Survey 2010-2011.
[16] UNICEF. (2023). Afghanistan Multiple Indicator Cluster Survey 2022-23.
[17] UNICEF. (2023). Countdown to 2023 Country Profile: Afghanistan. Accessible: Afghanistan Profile Page 1 - Countdown 2030 - UNICEF DATA
[18] Sachs, J.D., Lafortune, G., Fuller, G., Iablonovski, G. (2025). Financing Sustainable Development to 2030 and Mid-Century. Sustainable Development Report 2025. Paris: SDSN, Dublin: Dublin University Press. DOI: https://doi.org/10.25546/111909
[19] WHO Afghanistan. (2025). Health Information Hub. Available at: https://dashboard.whe-him.org/index.php/maps-3/
[20] Médecins Sans Frontières (MSF). (2023). Persistent barriers to access healthcare in Afghanistan. Available at: https://www.aerzte-ohne-grenzen.de/sites/default/files/2023-02/Afghanistan_Barrieren_Zugang_Gesundheitsversorgung_Bericht_2022.pdf
[21] Internal document review.
[22] Ibid.
[23] Ibid.

Given the evolving landscape, ongoing discussions between the de-facto Ministry of Public Health (de-facto MoPH) and UNICEF highlight the necessity to reconsider the service package, integration levels among diverse community health and primary healthcare facility types, and the alignment between mobile clinics and health facilities. Despite significant improvements in healthcare coverage and outcomes, a considerable unfinished agenda persists in Afghanistan's healthcare landscape. Challenges, such as disparities in healthcare utilization and outcomes, substandard service quality, fragile health infrastructure, inefficiencies in health services management, inadequate access to all components of the Basic Package of Health Services (BPHS), deficient referral systems for secondary and tertiary care, poor stakeholder coordination, very high out-of-pocket spending, supply shortages, limited capacity in both public and private sectors, scarcity of skilled healthcare professionals particularly in rural areas, and insufficient accountability and community engagement continue to pose significant hurdles.[24]

### Health Emergency Response (HER)/Novel Financing Arrangement (NFA) Program[25]

UNICEF initially assumed partial responsibility as the executing agency for the provision of BPHS/EPHS services from November 2021 to June 2022, transitioning to full responsibility from July 2022 to the present. The Afghanistan Reconstruction Trust Fund (ARTF), Global Financing Facility (GFF), and the World Bank jointly approved a USD 333 million grant to UNICEF, spanning from May 2022 to the end of December 2023. This funding served as crucial support for the continuous delivery of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) in Afghanistan. UNICEF is in charge of managing the provision of essential primary and secondary healthcare services through the 'contracting- out' approach, collaborating with Service Providers (SPs). The primary objective is to augment the utilization and enhance the quality of essential health services provided at public health facilities across the nation. The program continues the 'contracting-out' modality through SPs from September 2024 through June 2025.

The ADB Novel Financing Arrangement (NFA) project's scope encompasses targeting 733 health facilities and their associated communities with BPHS/EPHS provisions alongside complementary, need-based, and tailored HIVA interventions. This comprehensive approach seeks to address the specific health needs of these regions, thereby aiming for a more effective and responsive healthcare delivery system. Under NFA 1.0 (Jan 2022–Dec 2023), HIVA interventions were implemented in nine provinces across the southern and western regions, focusing on high-impact measures to reduce maternal and newborn mortality. Key interventions included scale-up of misoprostol for PPH prevention, calcium supplementation during pregnancy, chlorhexidine for umbilical cord care, introduction of new family planning methods, strengthened newborn care, provision of the Maternal and Child Health Handbook (MCH-HB), and capacity building for health workers. Building on this, NFA 1.5 expands to ten provinces with a more defined HIVA package emphasizing quality of care, immediate survival gains, and evidence generation through operational and implementation research. It also strengthens synergies with BPHS/EPHS, technical partners (MSH/AFIAT, WHO), and applies targeted technical support, performance-based approaches, and measures to address both supply- and demand-side barriers, with a strong focus on equity.

Although project implementation has transitioned from the Ministry of Public Health (MoPH) to UNICEF, the tools, instruments, and service delivery models through third parties have been sustained and

Neyazi, N. et al. (2023). Non-communicable diseases in Afghanistan: a silent tsunami. The Lancet, 401(10393), 2035–2036. Available at: https://doi.org/10.1016/S0140-6736(23)01084-4

[24] Ibid.

[25] Please note that information in this sub-section is coming from internal document review and the following source: UNICEF. (2023). HER Programme Document. Performance-Based Programme Document for Delivery of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) and other Healthcare Services.

capitalized upon. The project's design incorporates the requisite adaptability to respond to an ever-evolving sectoral landscape. It remains receptive to implementation realities, on-ground challenges, data availability, insights garnered from monitoring activities, and continuous operational learning. Moreover, recognizing its prominent role in the health sector and robust technical capacity in Afghanistan, the World Health Organization (WHO) assumes a pivotal position. WHO's involvement encompasses essential capacity strengthening initiatives, specifically focusing on quality control of medical supplies, bolstering data infrastructure, and fortifying emergency preparedness and response mechanisms.

The program is structured around four key program outputs:

- Management of equitable and uninterrupted delivery of quality Basic Package of Health Services (BPHS) through primary health care (PHC) facilities including district hospitals.
- Management of equitable and uninterrupted delivery of quality Essential Package of Hospital Services (EPHS) through provincial and regional hospitals[26].
- Management of the provision of value-added high impact (HIVA) interventions for Maternal, Newborn, Child, and Adolescent Health (MNCAH) at PHC and secondary healthcare (SHC) facilities in the respective province(s) in Southern and Western regions.[27]
- Responding to Acute Emergencies.

Within UNICEF's health service provision framework, there are three distinct service packages: Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) which were taken over from the MoPH as part of HER and a specialized set of high-impact value-added (HIVA) interventions designed to address critical healthcare needs.

### Program Output 1: Management of equitable and uninterrupted delivery of quality BPHS through PHC facilities including district hospitals

Across the country, Basic Package of Health Services (BPHS) is extended via around 3,919 public health facilities as recorded in the Health Management Information System (HMIS) for the year 2022. Among these facilities, the Health Emergency Response (HER) project encompasses 2,411 establishments, constituting approximately 62% of the total. These HER-supported facilities include a range of health facilities such as Reproductive Health Centers (2), Public Hospitals (16), District Hospitals (78), Comprehensive Health Centers (381), Basic Health Centers (772), Sub-Health Centers (1,079), Maternity Waiting Homes (24), Family Health Houses (34), and various other Primary Health Care (PHC) facilities, including those within correctional facilities like prison health facilities (25).[28] Table 1 provides an overview of the BPHS elements and services.

*Table 1. BPHS elements and services[29]*

| | |
|---|---|
| **Maternal and new-born care** | • Antenatal care<br>• Delivery care<br>• Postpartum care<br>• Family planning |

[26] Please note that not all provincial and regional hospitals are covered by the programme.

[27] Please note that this was not part of the USD 333 million grant from ARTF, GFF, and World Bank and was part of the ADB NFA project.

[28] UNICEF. (2023). HER Programme Document. Performance-Based Programme Document for Delivery of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) and other Healthcare Services.

[29] Islamic Republic of Afghanistan Ministry of Public Health. (2010). A Basic Package of Health Services for Afghanistan. Available at: https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/afg-cc-46-01-guideline-2010-eng-basic-package-health-services.pdf

| | |
|---|---|
| | • Care of the new-born |
| **Child health and immunization** | • Expanded Program on Immunization (EPI)<br>• Integrated Management of New-born and Childhood Illness (IMNCI) |
| **Public nutrition** | • Screening (assessment), prevention, treatment, and management of acute malnutrition<br>• Prevention of chronic malnutrition and micronutrient deficiencies |
| **Communicable disease treatment** | • Control of tuberculosis<br>• Control of malaria<br>• Prevention of HIV and AIDS |
| **Mental health** | • Mental health education and awareness<br>• Case identification, diagnosis, and treatment |
| **Disability and physical rehabilitation services** | • Disability awareness, prevention, and education<br>• Provision of physical rehabilitation services<br>• Case identification, referral, and follow-up |
| **Regular supply of essential drugs** | • Ensuring essential medicines are available and well stocked in health facilities and prescribed to patients as required. |

### Program Output 2: Management of Equitable and Uninterrupted Delivery of Quality EPHS Services through Provincial and Regional Hospitals

The Essential Package of Hospital Services (EPHS) is dedicated to enhancing the health outcomes of Afghanistan's population, primarily by reducing maternal, newborn, infant, and child mortality and morbidity. EPHS services adhere to stringent guidelines and requirements, delivered by a proficient cadre of trained healthcare professionals, comprising doctors, midwives, nurses, and laboratory technicians, with robust quality assurance measures in place. EPHS facilities, namely hospitals at the provincial and regional levels, are pivotal in the healthcare ecosystem. They offer outpatient care services and secondary diagnostic and treatment options, functioning as referral points for facilities operating under the Basic Package of Health Services (BPHS).

These hospitals, aligning with EPHS guidelines, cater to a spectrum of specialized healthcare services, encompassing gynecology, obstetrics (inclusive of cesarean sections), neonatal care, postpartum care, and management of associated complications. Additionally, they focus on nutrition, orthopedics, trauma care, emergency and surgical interventions, intensive care, management of COVID-19 cases, addressing medical conditions arising from outbreaks and disasters, respiratory and gastrointestinal healthcare, ear, nose, and throat (ENT) services, as well as eye care and dental services. These specialized provisions within provincial and regional hospitals adhere to the specific directives outlined in the EPHS guideline, ensuring comprehensive and specialized healthcare delivery.

Table 2 offers a comprehensive overview of the Essential Package of Hospital Services (EPHS) available at both regional and provincial hospitals.

*Table 2. EPHS services at regional and provincial hospitals*[30]

| | |
|---|---|
| **Clinical and Diagnostic Services** | • Inpatient services<br>→ General and specialized surgical services (operating theatre, anesthesia, recovery room services, and sterilization services)<br>→ Obstetrics and gynaecology services (Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC))<br>→ Pediatric services (including therapeutic feeding centers)<br>→ General and specialized medical services<br>→ Ophthalmology and ear, nose, and throat services<br>→ Mental health and psychiatric services<br>→ Dental services (in Regional Hospitals)<br>→ Forensic medicine<br><br>• Emergency department open and staffed 24 hours<br>• Outpatient services including dental services.<br>• Hospital pharmacy<br>• Physiotherapy services<br>• Laboratory, blood transfusion services and blood bank<br>• X-ray and ultrasound services<br>• Endoscopy services<br>• CT scan (Kabul only at tertiary hospital level) |

### Program Output 3: Management of provision of high impact value-added (HIVA) interventions for MNCAH

UNICEF is supporting high-impact value-added (HIVA) health services, as reflected in national guidelines, emphasizing maternal and child healthcare and nutrition across all Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) facilities situated in the nine provinces of Afghanistan's southern and western regions until 2024. Specifically, these targeted provinces encompass Herat, Kandahar, Badghis, Farah, Ghor, Helmand, Nimroz, Urozgan, and Zabul. The selection of these provinces was based on two primary criteria: firstly, their low health indicators as per deprivation analysis, and secondly, their recent expansion of access following the political transition. Daikundi was added in 2024.

In addition to inputs allocated for health worker salaries, essential medicines, and operational expenses within the BPHS and EPHS frameworks, supplementary resources are imperative to comprehensively address the health needs of the population. These resources are geared towards facilitating the provision of high-impact, value-added interventions that cater to maternal, newborn, child, and adolescent health at both secondary and primary healthcare levels, extending support to communities as well.

These essential resources and interventions collectively contribute to a more comprehensive and holistic approach to healthcare, particularly focusing on vulnerable groups such as mothers, newborns, children, and adolescents in these specific regions of Afghanistan. The specific services within each of these areas are provided in Table 3 below.

[30] Islamic Republic of Afghanistan Ministry of Public Health. (2005). The Essential Package of Hospital Services for Afghanistan. Available at: https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/afg-cc-46-01-guideline-2005-eng-essential-hospital-services.pdf

*Table 3. High-impact Value-added Interventions (HIVA)*

| | |
|---|---|
| **High-impact interventions for maternal and newborn mortality reduction** | • Scale up of Misoprostol through health facilities and community health platforms to prevent post-partum haemorrhage (PPH) ensuring adherence to the approved Ministry of Public Health guidelines<br>• Expansion of the use of Chlorhexidine for umbilical cord care<br>• Scale up of two new family planning methods:<br>  ○ Sub-dermal contraceptive implants, offered as postpartum or interval method (first dose: CHW; second dose: self-administered by women in presence of health provider or CHW; third dose: self-administered at home)<br>  ○ Sub-cutaneous depot medroxyprogesterone acetate implants inserted by skilled birth attendants at health facilities.<br>• Strengthening new-born care at BPHS/EPHS facilities with needful supplies and equipment and training based on needs and capacity assessment<br>• Provision and use of Maternal Child Health Handbook (MCH-HB) |
| **Supplies for treatment of severe acute malnutrition (SAM) and for maternal and newborn care** | • Provision of supplies including, but not limited to:<br>  ○ Ready-to-use Therapeutic Food (RUTF) (supplied by UNICEF)<br>  ○ Measurement equipment<br>  ○ IEC materials |
| **Addressing MHPSS and adolescent health with a particular focus on adolescent PLWs** | • Provision of quality of MHPSS services with provision of essential medicines by dedicated counsellors at BPHS and EPHS facilities and through community-level interventions including MHNT (adding psychosocial counsellors) and CHWs under supervision of dedicated technical supervisor per province from the SP<br>• Urgent adolescent sexual and reproductive health interventions for young people, especially adolescent girls and young women, to increase their access to, and availability and uptake of, SRH services |
| **Basic WASH facilities and Infectious Prevention and Control (IPC) practice in health facilities** | • Undertake assessments to evaluate the needs of health facilities<br>• Work towards ensuring availability of a standard package of water and sanitation facilities at BPHS and EPHS facilities in the province<br>• Focus on facilities that require repair and rehabilitation to achieve standard functionality<br>• Promote Infection Prevention and Control practices |
| **Capacity building for health workers including in-service training across various interventions in BPHS/EPHS** | • In addition to usual BPHS/EPHS in-service training, there is an ADB project to support but not limited to the following key capacity building activities:<br>  ○ High Impact Interventions for prevention of post-partum haemorrhage (PPH) with Misoprostol; use of Chlorhexidine for umbilical cord care; and two new family planning methods.<br>  ○ New-born care both at facility and community levels<br>  ○ Adolescent health and gender training for health workers and CHWs |
| **Community engagement, behavior change and demand generation** | • Strengthening health promotion at HFs, ensuring needful equipment (TV, solar panel etc) and health educator at each HF<br>• Production of social and behavioural change communication (SBCC) material<br>• Mass and social media campaigns<br>• Assessment of behaviour change<br>• Interpersonal communication training for health workers and CHWs<br>• Capacity building of local structures |

| | |
|---|---|
| | • Community engagement interventions through CHWs and community influencers, CSO and NGOs |

Building upon the previous Health Emergency Response (HER) Project supported by the ARTF and the ADB-funded project focusing on HIVA interventions, the ADB project took over funding responsibilities for ten provinces situated in the southern, western, and central regions of Afghanistan. Notably, Daikundi has been added to the project's coverage area. This initiative aims to:

1. Support the provision of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) within these ten provinces.
2. Tailor HIVA interventions based on specific needs within these regions.
3. Strengthen project management and implementation through various strategies, including management accompaniment, technical support provided by WHO, robust supervision and monitoring mechanisms, and third-party monitoring conducted both by UNICEF and external partners. [This is also part of the HER programme].

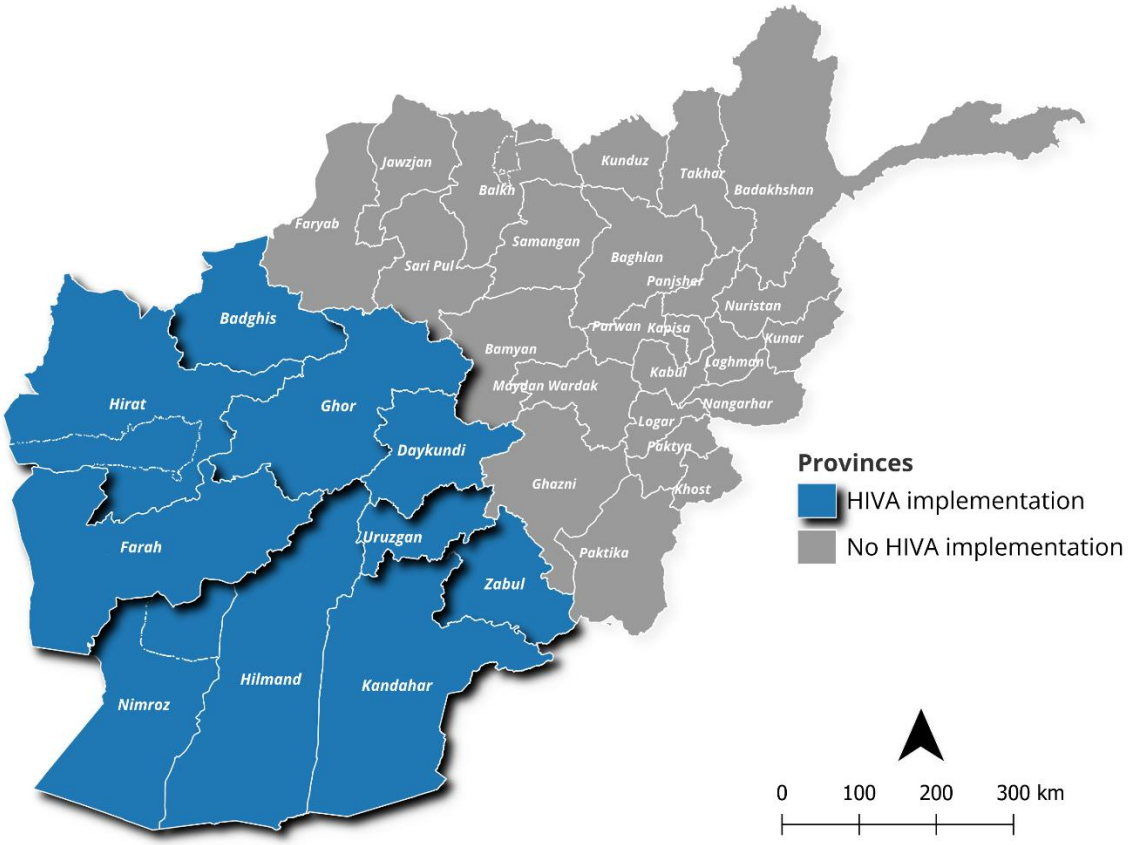



*Figure 1. Provinces in Afghanistan highlighting HIVA Implementation*

### Program Output 4: Responding to Acute Emergencies

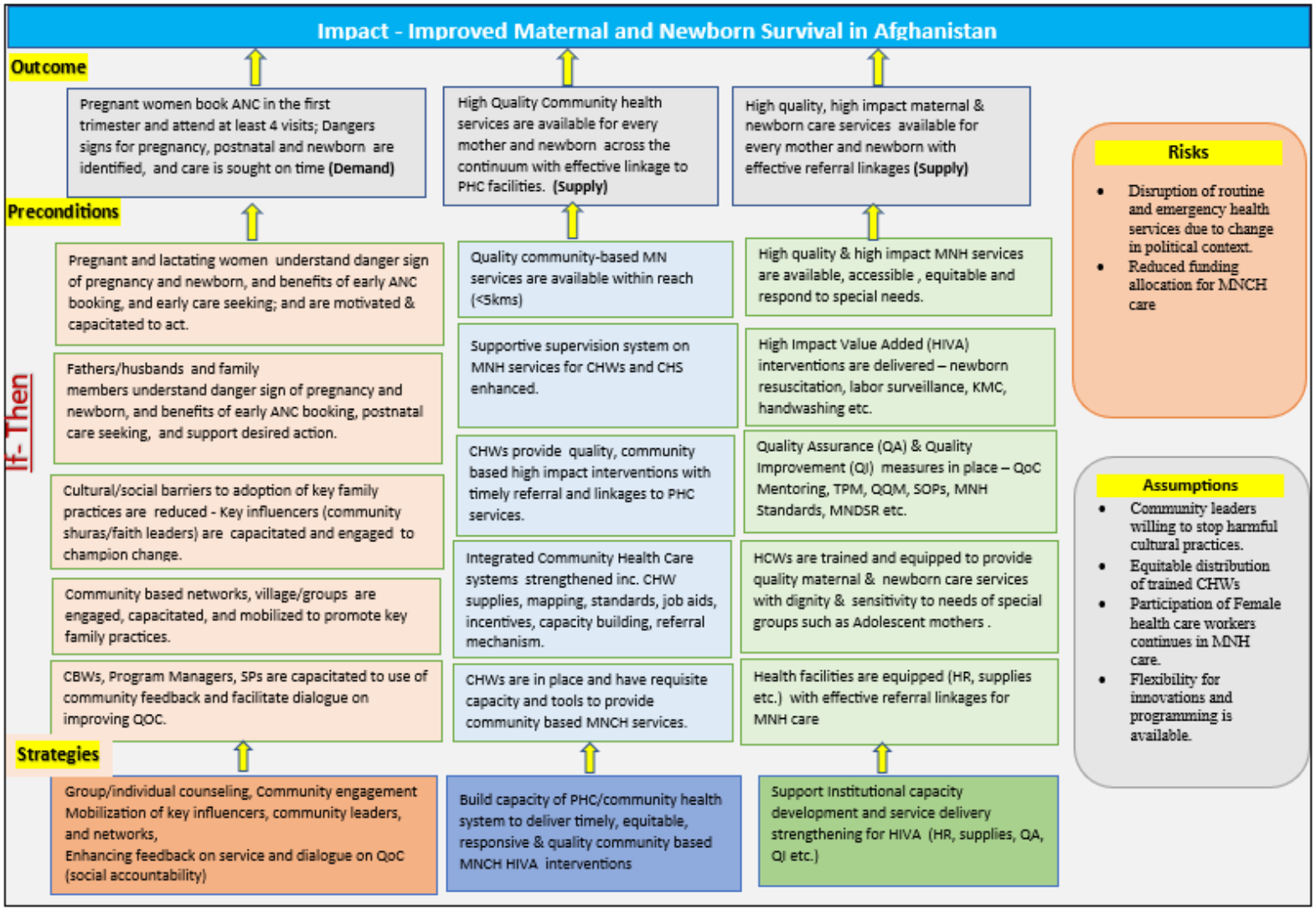
The Service Provider (SP) is mandated to establish a comprehensive emergency response strategy and plan, designed to meticulously investigate, validate, and efficiently coordinate responses to various emergencies. These encompass a wide spectrum, including natural disasters, like earthquakes, floods,

droughts, among others, disease outbreaks such as Vaccine-Preventable Disease (VPD) outbreaks, acute watery diarrhea, and other communicable diseases, as well as man-made emergencies, like conflicts and mass casualty incidents.

An essential responsibility of the SP involves the maintenance of emergency response committees at provincial, district, and health facility levels. This entails meticulous coordination of emergency preparedness services in collaboration with all pertinent stakeholders well in advance.

The **Theory of Change** was only shared for the HIVA component, as showcased below.

*Figure 2. Theory of Change for the HIVA component*



# 3. Evaluation Purpose, Objectives, Users, and Scope

The **purpose** of this impact evaluation is to assess the impact and added value of the HER/NFA program[31] on Afghanistan's health system and its contribution to meeting beneficiaries' needs. The evaluation will focus on interventions related to Primary Health Care (PHC) through the BPHS, Secondary Health Care (SHC) through the EPHS, and HIVA services up to 2025.

Specifically, the evaluation aims to enable learning about the relevance, effectiveness, impact, efficiency and sustainability of health interventions following UNICEF's 2022 takeover of programming in a subset of Afghanistan's health facilities – including successes and challenges – to generate lessons for UNICEF, its partners, and other stakeholders that can inform future programming, policies and resources adaptations, as well as adaptations to the ongoing interventions to better serve the needs of beneficiaries. The impact evaluation results can be used to enhance health interventions in Afghanistan's health facilities in the future and thereby improve population-level health outcomes.

More specific **objectives** of the impact evaluation include the following:

- **Impact, comparative value-add, effectiveness, and relevance of the HER/NFA program:** Assess the program's impact and effectiveness with regards to health and service delivery outcomes by contrasting HER/NFA-supported and non-HER/NFA-supported facilities, including the trend from 2022 to 2024. Evaluate and compare the service delivery, including availability, accessibility, and quality of care[32], in HER/NFA-supported health facilities versus non-HER/NFA facilities. Evaluate program relevance, achievement of results and to maintaining health and nutrition systems and addressing the needs of beneficiaries including those of marginalized and hard-to-reach communities, and potential sustainability.
- **Complementarities, differences, and synergies between health service packages:** Examine the complementarities, differences, and synergies between BPHS, EPHS, and HIVA interventions. Compare the additional impact of HIVA interventions in provinces where they have been implemented (9 provinces between 2022 and 2023, and 10 provinces in 2024) against provinces where only BPHS/EPHS were in place (25 provinces in 2022-2023 and 24 provinces in 2024).
- **Cost-efficiency:** Examine cost-efficiency of the HER/NFA program and its packages in attaining the expected results and looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same). This includes an assessment of resources (human and financial), risk management and mitigation measures.

**Evaluation users and use:** The findings and recommendations from the external evaluation will be used to further shape the future of the health program and packages in Afghanistan.

The **primary users** of this exercise are: UNICEF Afghanistan, donors such as World Bank (WB), Asian Development Bank (ADB), and bilateral donors, implementing partners and service providers, de-facto Ministry of Public Health, WHO Afghanistan, beneficiaries, health and nutrition facilities, and healthcare and nutrition professionals. The primary users will utilize the evaluation findings to inform strategic decision-making, strengthen program design, and improve implementation of health interventions within

[31] The HER/NFA programme encompasses all three service packages (BPHS, EPHS, and HIVA), currently funded by the World Bank in 24 provinces and the ADB in 10 provinces. Please note that before 2024, BPHS and EPHS packages were funded by the World Bank in 34 provinces and the ADB funding HIVA package in 9 provinces under NfA 1.0.

[32] Assessment of quality of care will be addressed through qualitative interviews with healthcare management, healthcare professionals, as well as recipients of healthcare in the community.

Afghanistan. For UNICEF Afghanistan, results will guide adjustments to the HER/NFA program and enhance accountability to donors and beneficiaries. Donors, such as WB, ADB, and bilateral partners, will use the evidence to assess program effectiveness, justify continued or future funding, and align resources with demonstrated health outcomes. Implementing partners, service providers, and the de-facto Ministry of Public Health can leverage the findings to improve service delivery and optimize health system performance, ensuring interventions under BPHS, EPHS, and HIVA remain responsive to community needs. Health and nutrition facilities, and healthcare and nutrition professionals can utilize the findings to understand the healthcare landscape in Afghanistan, the effectiveness of currently implemented interventions, and based on findings and recommendations, call for and/or implement improvements to health service delivery in the country. Beneficiaries will benefit from the improvements of health services provision based on findings and recommendations.

**Secondary users** range widely and cover health and nutrition clusters, UNICEF's South Asia Regional Office (ROSA) and UNICEF Headquarters (HQ), other UN agencies and non-governmental organizations in Afghanistan, other de-facto ministries, academic and research institutions, and health policy advocacy groups. Secondary users will apply the evaluation insights to shape policy dialogue, regional strategies, and advocacy efforts for stronger health systems in Afghanistan and similar contexts. Health and nutrition clusters, UNICEF ROSA, and HQ will use the findings to inform regional priorities and global learning on Primary Health Care and system resilience in fragile settings. Academic institutions and research organizations may draw on evidence to generate new knowledge and advance discourse on health policy, while other UN agencies, NGOs, and advocacy groups will use the findings to support coordination, influence policy reforms, and advocate for sustained investment in essential health services.

### Scope of the exercise:

The **temporal scope** of this evaluation will focus on the program from 2022 until early 2025 and will also leverage pre-intervention secondary data to add to the rigor of the methodological approach from 2018.

The **geographic scope** of this evaluation will cover health facilities, both HER, HER/NFA with HIVA, and non-HER/NFA supported across all provinces using available secondary and administrative data. Primary data collection, comprised of health facility observations and qualitative interviews, will happen across 10 provinces[33] of Afghanistan (please refer to the methodology section). Health facility observations will be collected among all 10 provinces. Qualitative data will be collected in two provinces: Helmand and Kabul. The selection of Kabul is crucial to capture perspectives of health facility staff and beneficiaries alike in the province of the greatest population density, which faces unique challenges in itself. On the other hand, Helmand health facilities are faced with higher rates of child mortality and notably greater gender barriers than other provinces. Helmand was also selected for qualitative data collection to ensure the coverage of a HIVA province. For more information on sampling and limitations, please refer to the methodology section.

The **thematic scope** of the evaluation will also look on various critical aspects, namely packages (BPHS, EPHS, and HIVA), availability, access, quality of care, health outcomes, integration and synergies of health service packages, cost-efficiency, cross-cutting areas (e.g., gender, disability, equity, human rights, climate, and 'leave no one behind' considerations), and monitoring and evaluation. The evaluation will explore whether program consequences differ for girls, women and other marginalized populations, where secondary data is available to examine such heterogeneities, and probe gender dimensions in

[33] If the data collection is permitted in the field.

collecting qualitative data. The evaluation will focus on identifying the performance of UNICEF's health programming between 2022 and 2025 across the entire country of Afghanistan.

## 4. Evaluation Framework and Questions

The technical approach will be guided by key evaluation questions spanning three main themes: (1) program impact and comparative value-added; (2) complementarities and synergies between health service packages; and lastly (3) cost-efficiency. The evaluation matrix below lists illustrative indicators and proposed data/methods for each set of questions.

*Table 4. Preliminary evaluation matrix*

| Evaluation questions | Illustrative indicators | Data tools |
|---|---|---|
| **Evaluation Theme: Impact[34], comparative value-add, effectiveness, and relevance of the HER/NFA program** | | |
| **Q1. What has been the impact, comparative value-add, effectiveness, and relevance of the HER/NFA program on targeted health outcomes in HER/NFA-supported facilities vis-a-vis non-HER/NFA-supported facilities?**<br><br>Q1.1. What impact has HER/NFA supported health facilities had on the availability, accessibility, demand and quality of healthcare services vis-à-vis non-HER/NFA-supported facilities?<br><br>Q1.2. How have impact, value-added, and key trends evolved from 2022 to 2024? How effective and relevant has the program been to address the needs?<br><br>Q1.3 How does the impact and comparative value of HER/NFA vary for different sub-populations, such as girls, women, people with disabilities, rural residents and marginalized groups (e.g. displaced groups)? | • Institutional delivery<br>• Child vaccination<br>• Antenatal and post-natal check-ups<br>• Perceived accessibility and quality of services<br>• Perceived changes in availability, accessibility, and quality over time | • DiD analysis<br>• KIIs with key stakeholders from organizations such as the de-facto MoPH, WB, ADB, UNICEF, and WHO (along with the inception interviews conducted with WB, ADB, FCDO, WHO, EU, UNDP, UNFPA, WFP, Gavi, Global Fund, and Gates Foundation)[35]<br>• FGDs with service providers, health care professionals and community members<br>• LiST |
| **Evaluation Theme: Complementarities, differences, and synergies between health service packages** | | |
| **Q2. How does the inclusion of HIVA[36] interventions influence health service delivery and outcomes? What are the differences, additional impacts, complementarities, and synergies of integrating BPHS, EPHS, and HIVA interventions?** | • Perceived alignment between packages<br>• Perceived impact of HIVA on access and quality of services | • DiD analysis<br>• KIIs |

[34] The term 'impact' is used in line with the proposed methodology, which follows an impact evaluation design, while acknowledging that this is not a population-level clinical trial.
[35] Please refer to the methodology section for more information on KIIs and FGDs.
[36] As HIVA is still in its early stages with varying levels of implementation, this assessment will also serve as a critical baseline to establish the current landscape, measure initial conditions, and provide a foundation for tracking progress and impact over time.

| | | |
|---|---|---|
| Q.2.1. How has HIVA influenced different sub-populations, such as girls, women, people with disabilities, rural residents and marginalized groups (e.g. displaced groups)?<br><br>Q2.2. How does the integration of HIVA affect coordination, effectiveness, and sustainability of health service delivery models?<br><br>Q2.3. How has the program's reconfiguration evolved between 2022–2024, and what impact has it had on outcomes? | • Service uptake (changes between 2022 and 2024) | • FGDs with service providers, health care professionals, and community members |
| **Evaluation Theme: Cost-efficiency** | | |
| **Q3. How cost-efficient is the HER/NFA program in achieving its expected results and looking at changes over time (e.g., has the cost-efficiency increased, decreased, or remained the same)?**<br><br>Q3.1. How does the cost-efficiency of the HER/NFA program vary between different service packages (BPHS/EPHS and HIVA), and how has this evolved over time? | • Perceived cost-efficiency<br>• Estimated expenditure per component<br>• Estimated cost-efficiency per component, package, and service delivery platform (as feasible given data constraints) | • Cost analysis<br>• Literature review<br>• WHO OneHealth Tool<br>• KIIs with UNICEF, WHO, de-facto MoPH, donors, service providers |

# 5. Evaluation Methodology

## 5.1. Evaluation design and approach

Employing a **mixed methods approach**, the impact evaluation will collect and analyze both quantitative and qualitative data, enhancing convergence and validity through **triangulation**. The methodology would incorporate **quasi-experimental design** to assess the impact of the program by comparing the outcomes of treatment and control groups.[37, 38, 39] Techniques like **propensity score matching (PSM)**, **difference-in-differences (DiD), and Lives Saved Tool (LiST) modeling** will be used to minimize biases, assess causality, and compare outcomes.[40, 41] **The use of existing secondary and administrative data** (for details please refer to the following sub-sections) will be crucial in providing a robust foundation for identifying patterns and shifts over time from 2022 to early 2025. Additionally, leveraging secondary data will enable a more cost-effective and time-efficient analysis, offering insights into the broader systemic shifts.

Moreover, the evaluation follows OECD-DAC criteria of the relevance, effectiveness, impact, efficiency, and sustainability. The impact evaluation is designed to be **utilization-focused**, aiming to inform key decisions and leverage evidence for ongoing program 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 **gender, human rights, disability, climate, equity, and 'leave no one behind' considerations** and **quality of monitoring and evaluation systems** across all stages, encompassing key informant interviews and focus group discussions. The evaluation will ensure that tools, data collection, analysis, and reporting fully integrate cross-cutting issues. Special attention will be given to ensuring the **accessibility of data collection tools**.

**For the cost-efficiency component**, the evaluation will assess different implementation modalities over time while acknowledging the unique context of Afghanistan and the significant variability across provinces, settings, and service delivery models.

This section will describe the data (quantitative and qualitative) leveraged for the analysis as well as an overview of the utilized methodological approaches.

[37] SAGE Publications. (2019). *Quasi-experimental and single case designs*. Available at: https://us.sagepub.com/sites/default/files/upm-binaries/89876_Chapter_13_Quasi_Experimental_and_Single_Case_Designs.pdf

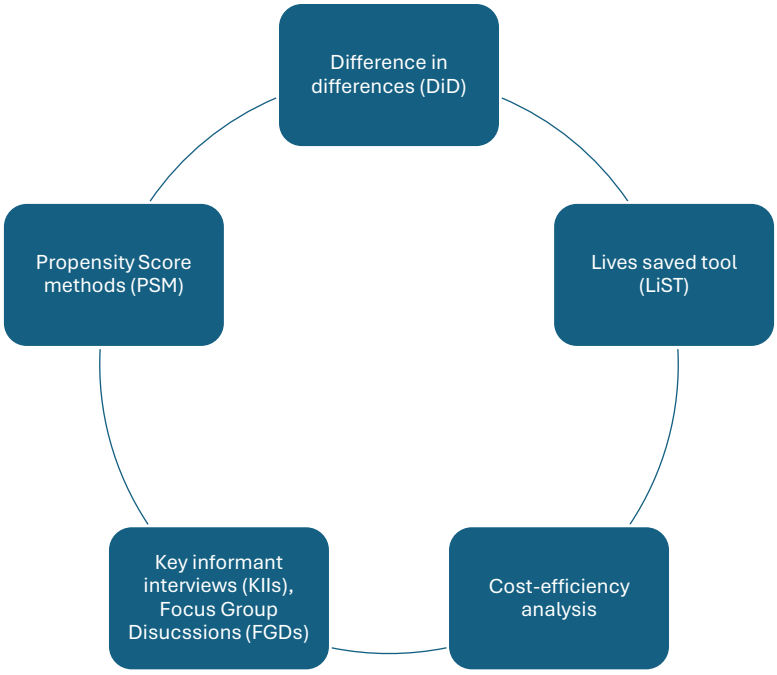
[38] Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Available at: https://www.courses.sas.upenn.edu/opus/course/soc-259c/

[39] Harris AD, McGregor JC, Perencevich EN, Furuno JP, Zhu J, Peterson DE, Finkelstein J. (2006). *The use and interpretation of quasi-experimental studies in medical informatics.* Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC1380192/

[40] Rosenbaum, P. R., & Rubin, D. B. (1985). *Constructing a control group using multivariate matched sampling methods that incorporate the propensity score*. The American Statistician, 39(1), 33-38. Available at: https://doi.org/10.1080/00031305.1985.10479383

[41] Angrist, J. D., Pischke, J. S. (2009). *Mostly Harmless Econometrics: An Empiricist's Companion*. Princeton University Press. Available at: https://press.princeton.edu/books/ebook/9781400830391/mostly-harmless-econometrics

*Figure 3. Methodology employed in evaluation*




## 5.2. Evaluation methods, data collection tools, and sampling

The evaluation will leverage data from different existing and primary sources for the analysis. Specifically, the evaluation will utilize health facility listings indicating which facility received BPHS/EPHS and HIVA during any intervention year, health system time series data collated via the HMIS and District Health Information Software 2 (DHIS2), annual household survey data under the Whole of Afghanistan Assessment (WoAA), third-party monitoring data, MICS 2022-2023 data through LiST, 2018 Afghanistan Health Survey, primary observation data from select health facilities, and primary qualitative data via KIIs and FGDs from select stakeholders. Given that these data inputs are reported and collected from different units, they can help verify information and/or allow the evaluation team to understand whether changes at the facility level led to downstream effects on individuals and households. For example, the different data streams will reveal whether any observed increase in health facility visits for the treatment of child diarrhea (as reported in the HMIS) occurs in conjunction with an increase in household reports of care seeking for child illness (as reported in the WoAA). By combining information from multiple sources, the evaluation team will be able to triangulate information and conduct extrapolations if necessary to provide a fuller picture than what would be able to be conveyed using just one or two sources. The main data sources are described below as well as the measures that will be pulled from these sources to analyze whether and how they have been influenced by UNICEF's health programme. These measures will serve as the outcome variables in the empirical models used for this analysis and accordingly, the evaluation team refers to these as outcome variables or outcomes[42] throughout the remainder of the report.

[42] Outcome variables in this context refer to outcomes of interest in statistics, referring to the specific and measurable variables used to test whether the program achieved its intended effects.

### *5.2.1. Quantitative Data Sources*

**Health facility list**

To identify treatment status (i.e. whether or not a health facility was under UNICEF management during the years of interest from 2022-2025), the evaluation will rely on the UNICEF-provided master sheet of facilities by program and year. For each full year in the period of interest, facilities will be classified into the following categories: (1) HER facility, no HIVA, (2) HER/NFA facility, with HIVA, (3) comparison facility. This listing also contains location information, specifically province and district, and facility type.

**Health facility-level data**

The quantitative analysis will primarily rely on secondary data sources that provide information on key indicators/outcomes at the facility- or population-level over time. Health-facility level information will be pulled from two sources.

First, the evaluation will utilize HMIS/DHIS2 data. Managed by the de-facto MoPH, these data provide information on the provision of health services by month for all the health facilities in the country. Data is available for outcomes, such as outpatient visits for specific morbidities (i.e., child diarrhea, hypertension and antenatal visits). The specific outcome variables that will be sources from these data are discussed below. The DHIS2 aggregates the facility-level data for the country's different administrative levels. The evaluation will use annual-facility-level data from the HMIS since this will provide information at the most disaggregated level. The HMIS/DHIS2 information used will be sourced from the earliest pre-intervention year available to implement a PSM approach to account for pre-existing differences across HER/NFA and non-HER/NFA facilities that might bias evaluation findings.

The strength of the HMIS/DHIS2 dataset is that it covers the entire universe of formal health facilities in Afghanistan for the period of interest and therefore will allow the evaluation to compare HER/NFA and non-HER/NFA trends in outcomes across the entire country. However, given that HMIS/DHIS2 data are reported by facilities, there could be reporting errors (mistakes made in entering data or purposive reporting of incorrect numbers) and missing data. Two sets of analyses will be performed with the HMIS/DHIS2 data to account for potential issues related to missing data and outliers. For the first set of results, when analyzing any outcome, the facilities that have a lot of missing data (e.g. more than one year missing) and facilities that report outliers will be dropped. For the second set of results, a standard methodology will be utilized to adjust for incompleteness in routine health data as recommended by the WHO Data Quality Assurance toolkit. These measures aim to provide a clearer estimate of service delivery accounting for known external causes of incomplete data in HMIS/DHIS2.[43] Another limitation with the HMIS/DHIS2 data lies in the potential for the quality of the data to be influenced by UNICEF's programming. Reporting by facilities into the HMIS/DHIS2 is a contractual obligation of service providers selected to run health facilities under the HER/NFA program. As a result, data reporting by HER/NFA facilities is high and there are significant quality assurance checks conducted on the data from these facilities as these are used in calculating performance scores for pay for performance purposes. Importantly, reporting requirements and third-party monitoring (TPM) oversight creating differences in data completeness and accuracy in HER/NFA facilities compared to non-HER/NFA facilities are not recent changes; rather, successive programs have been implemented over the past 10-15 years (Sehat, Sehatmandi, SHARP) and these have steadily strengthened reporting systems in what are currently HER/NFA facilities. The non-HER/NFA health facilities may not have similar incentives to report regularly and accurately or routine checks on quality. The potential influence of UNICEF's programming on the

[43] WHO. (2022). Data quality assurance. Module 1. Framework and metrics. https://www.who.int/publications/i/item/9789240047365

quality of the main source of secondary data for this analysis could lead to bias in the estimates identified and should be borne in mind while interpreting results.[44,45] The evaluation team will examine indicator patterns across HER/NFA and non-HER/NFA facilities in the pre-intervention years to speak to the extent to which treatment groups differed in their reporting at baseline.

Second, the evaluation will utilize data collected during third-party monitoring (TPM) data and visits to verify HMIS data for a subset of HER/NFA facilities and to triangulate findings. These data will be reviewed to gain contextual information and inform development of the primary data collection tool to be implemented in the subset of facilities visited for observations. For example, it will capture whether facilities have at least one female health worker on the day of the survey as was measured in the 2024 TPM data.

Whole of Afghanistan Assessment (WoAA)

The WoAA annual household surveys are conducted by REACH, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the multi-agency Inter-Cluster Coordination Team to measure needs across various domains: health, nutrition, education, food security, and other sectors. The strength of these data is that they provide population-level information for multiple years in the pre- and post-UNICEF intervention period. Data will be sourced from multiple years to contrast population-level trends across districts with a high concentration of HER/NFA facilities and districts with a low concentration of HER/NFA facilities (more details on the methodology are provided below). The reason for reliance on a district-level indication of treatment status is that the WoAA data only contain province and district of residence for households. Finer locational information, such as village or GPS coordinates, is not available for use.

Selection of Provinces for Primary Data Collection

To support secondary data analysis, health facility observations data is to be collected across 10 provinces, which have been selected to capture variation in potential predictors and correlates of health outcomes: population, child mortality rates, stunting rates, presence of sanitization infrastructure and healthcare utilization. The choice of provinces reflects logistical concerns, necessitating some provinces with difficult (often mountainous) terrain, but including some provinces that have these characteristics. Through these criteria, the following provinces have been selected. A detailed excel sheet can be found in Annex 6.

[44] Note that it is not possible to distinguish between genuine missing data and zero patients on HMIS/DHIS2 indicators since both show up as missing in the extracted data. In other words, if a facility has no report on diarrhea in a given month, it could mean that the facility did not report that month or that the facility did not receive any diarrhea patients that month.

[45] The reason why it is not possible to adjust for differential changes in data quality across HER/NFA and non-HER/NFA facilities in the post-intervention period is because it is theoretically possible for UNICEF's health programming in conjunction with reporting mandates and data quality checks to impact data values in either direction. For example, UNICEF's interventions could improve health and lead to accurate reporting, thus leading to fewer neonatal deaths being reported on average in UNICEF facilities. Alternatively, it is possible that UNICEF's health interventions are not able to move neonatal mortality on average, but data checks are able to correct the measurement of neonatal mortality which was previously being underreported. In this latter case, neonatal mortality would appear to increase on average in UNICEF facilities. There is no way of knowing the extent to which UNICEF's data quality measures are shaping the data and to therefore adjust for this.

Table 5. Selected provinces' performance on select measures and indication of which provinces have the biggest share/burden on the measures (among all provinces in the country)[46]

| Region | Province | Share of population/ households | Under-5 mortality rate (per 1,000 live births) | Stunting Rate (% moderate and severe) | Presence of Sanitation Infrastructure (% with sewer connection) | Health care Utilization – at least 4 ANC visits % | Mountainous terrain |
|---|---|---|---|---|---|---|---|
| - | National average | - | 55 | 44.7 | 3.4 | 33.4 | |
| **Central** | **Kabul** | 18.3 | 31 | 35.3 | 1 | 49.8 | |
| **Central** | **Maidan Wardak** | 2.0 | 64 | 39.6 | 0 (Rank 1) | 29.7 | Yes |
| **Eastern** | **Nangarhar** | 4.5 | 49 | 47.7 | 9.1 | 40.8 | |
| **Eastern** | **Laghman** | 1.6 | 62 | 41.4 | 1 | 32.3 | |
| **Northern** | **Takhar** | 3.9 | 66 | 46.4 | 0.8 | 37.2 | |
| **Northern** | **Sar-e-Pul** | 2.2 | 60 | 43.4 | 0.2 | 40.3 | |
| **Southern** | **Zabul** | 0.9 | 80 | 61.6 (Rank 2) | 0 (Rank 1) | 12.5 (Rank 4) | |
| **Southern** | **Helmand** | 3.5 | | | | 26.4 | |
| **Western** | **Badghis** | 1.9 | 49 | 54.1 (Rank 7) | 0.7 | 9 (Rank 3) | |
| **Western** | **Herat** | 8.1 | 65 | 35 | 3.8 | 34.7 | |

Among the purportedly selected sample of 10 provinces, Nangahar and Helmand have been selected for primary data collection of qualitative interviews. The province of Nangahar was selected for qualitative data collection primarily based on its population density, to ensure that health facilities serving a significant portion of the country's population are represented. This allows for in-depth insights into the most common healthcare experiences of those receiving treatment from UNICEF-supported facilities (HER/NFA). The province of Helmand was selected for qualitative data collection based on poor health outcomes and the presence of HIVA interventions, allowing for qualitative analysis surrounding health facilities supported by both BPHS/EPHS and HIVA interventions, an important evaluation objective.

Primary quantitative data from select health facilities

Observation data from a sample of health facilities will be collected using a standardized checklist to capture infrastructure, supplies and services. In addition to being useful for data triangulation, the information from these observations will provide valuable context and insights into on-the-ground realities. Health facility observations will be completed in 40 health facilities during the study: two HER/NFA health facilities and two non-HER/NFA health facilities across 10 provinces (see Table 6), totaling to 20 health facility observations of treatment groups and 20 of comparison groups. These facilities are randomly selected after stratification across treatment status. Ten of the 20 HER/NFA facilities selected for visits are from HIVA-intervention provinces, allowing for insights on HIVA-specific services.

[46] UNICEF. (2023). Afghanistan Multiple Indicator Cluster Survey 2022-23, Summary Findings Report.

Table 6. Sample allocation of health facility observations

| Province | Number of HER/NFA Facilities | Number of non-HER/NFA Facilities | Total |
|---|---|---|---|
| **Kabul** | 2 | 2 | 4 |
| **Maidan Wardak** | 2 | 2 | 4 |
| **Nangarhar** | 2 | 2 | 4 |
| **Laghman** | 2 | 2 | 4 |
| **Takhar** | 2 | 2 | 4 |
| **Sar-e-Pul** | 2 | 2 | 4 |
| **Zabul** | 2 | 2 | 4 |
| **Helmand** | 2 | 2 | 4 |
| **Badghis** | 2 | 2 | 4 |
| **Herat** | 2 | 2 | 4 |
| **Total** | **20** | **20** | **40** |

To perform health facility observations, enumerators will fill out a standardized survey to measure different organizational aspects, such as catchment population, patient volume, staff numbers, infrastructure and supplies, available infrastructure (such as sanitation stations), and verify data reporting via the HMIS on select indicators. The checklist questions will be aligned with the TPM framework wherever possible, enabling comparisons between HER/NFA-supported and non-HER/NFA-supported facilities.

Observation data is particularly susceptible to interviewer bias due to the subjective nature of the data collection process. To mitigate this bias, diligent enumerator training and field preparation is vital. All interviewers will take part in multi-day training designed to cover study objectives, questionnaire content, observational techniques, team structures, and field logistics. The training will include in-depth coverage and practice of the observation questionnaire. All facility protocols, medical equipment, and health terminology included in the observation will be explained, and pictured, if possible, in order to ensure familiarity with the questionnaire content. Interviewer protocols will also be practiced, tested, and if needed corrected, through a series of pilot interviews conducted prior to the commencement of fieldwork. Other measures will be taken to ensure unbiased data collection, such as controlling for busy periods of facility operation and limiting enumerator time spent at a given facility. These measures, coupled with the observation questionnaire's intentional design to decrease potential for subjective or biased results, will work to ensure the reliability and integrity of the observation data.

The observation survey will be administered using CATI technology, through the platform SurveyToGo, to permit secure and standardized data collection using a predeveloped form. The use of online survey platforms allows for continuous interaction with data collection and real-time quality control. For example, data will be reviewed and flagged for outliers or issues, such as implausible observation visit durations. Timely feedback allows for these issues to be checked and corrected, if necessary, and guarded against during future observations.

### *5.2.2. Qualitative Data Sources*

Qualitative data analysis will include contextual information and insights that pertain to the impact of HER/NFA facilities, collected through key informant interviews (KIIs) and Focus Group Discussions (FGDs). Aside from national level interviews, all qualitative interviews will be limited to two provinces which we purportedly selected among the sample of provinces selected for health facility observation data: Nangarhar and Helmand. Although the qualitative data collected through this evaluation is not intended

to be statistically generalizable, it plays a crucial role in enriching the overall analysis. It allows for meaningful triangulation of quantitative findings by providing contextual depth, exploring the lived experiences of beneficiaries, and illuminating the social, cultural, and environmental factors that influence program outcomes. This type of data is particularly valuable in understanding localized barriers and facilitators to program success, offering insights that are often overlooked in quantitative approaches alone.

Qualitative participatory methods are well-suited to provide in-depth perspectives and detail to accompany the quantitative impact evaluation for the following reasons:

- Implementation of program activities require detailed descriptions of what happens and how people responded to the program.
- People's experiences typically vary in important ways, and hence it is critical to capture diverse respondents' experiences and perceptions of their experiences and, more importantly, for these experiences to be captured in their own words. To ensure that the qualitative data reflects a diverse range of perspectives, the sampling strategy is intentionally designed to capture variation both geographically and institutionally. First, the two selected provinces have been chosen specifically because they are likely to represent atypical contexts, settings where health service delivery under UNICEF support may face unique challenges or deviate from standard implementation conditions. Within each province, a purposive sampling approach will be used to include a broad spectrum of health facility catchment areas. This includes an equal number of focus group discussions (FGDs) with respondents from BPHS/EPHS-supported facilities and HIVA-supported facilities. This design allows for systematic comparison across different service delivery models while constrained to a limited sample size.
- The process of any program implementation is fluid and dynamic, so it cannot be fairly summarized on a single rating scale, a qualitative approach allows the respondents to further elaborate.

Key Informant Interviews (KIIs)

KIIs will be conducted at the national, provincial, and community/facility level: at the national level, interviews will be held with key stakeholders from the de-facto Ministry of Public Health, UNICEF, the World Health Organization, the World Bank, and the Asian Development Bank. Moreover, the evaluation team has already conducted inception interviews with WB, ADB, FCDO, WHO, EU, UNDP, UNFPA, WFP, Gavi, Global Fund, and Gates Foundation. The inception interview with the de-facto MoPH has been delayed and is still pending.

At the provincial level, interviews with NGO service providers will be conducted. Stakeholders at the national and provincial levels have valuable insights into the design, implementation, impact and cost-efficiency of the program. These stakeholders are likely to perceive high-level nuances in implementation and outcomes across implementation packages. At the community and facility level, KIIs will be conducted among health care professionals and community influencers to assess community access, use, and attitudes towards facility services and quality from the lens of facility administrators and community leaders.

*Table 7. Implementing Partners by Province*

| Province | Implementing Partner |
|---|---|
| **Helmand** | RELIEF INTERNATIONAL-MEDICAL REFRESHER COURSES FOR AFGHANS (RI-MRCA) |
| **Nangarhar** | JUST FOR AFGHAN CAPACITY AND KNOWLEDGE (JACK)) |

*Table 8. Sample allocation of KIIs during the data collection stage (not including inception interviews[47])*

| Location* | Respondents | Total* |
|---|---|---|
| **Kabul (National Level)** | De-facto Ministry of Public Health | 1 |
| **Kabul (National Level)** | UNICEF Afghanistan | 1 |
| **Kabul (National Level)** | WHO Afghanistan | 1 |
| **Kabul (National Level)** | World Bank | 1 |
| **Kabul (National Level)** | Asian Development Bank | 1 |
| **Nangarhar** | Service provider (JACK) | 1 |
| **Helmand** | Service provider (RELIEF INTERNATIONAL-MEDICAL REFRESHER COURSES FOR AFGHANS) | 1 |
| **Nangarhar** | Health facility management HER | 2 |
| **Helmand** | Health facility management HIVA | 2 |
| **Kabul** | Community influencers | 2 |
| **Nangarhar** | Community influencers | 2 |
| | **TOTAL** | **15** |

**Please note that stakeholder mapping will be conducted and some interviews may take place as group KIIs.*

Focus Group Discussions (FGDs)

In addition to the KII interviews, FGDs will be conducted at the community/facility level and include health care professionals of HER and HIVA facilities, community health workers and community members to gain deeper insights into the outcomes of HER/NFA service delivery in practice, and assess community access, use, and attitudes towards facility services and quality from the lens of facility staff and community members and beneficiaries. This process will involve twelve (12) FGDs among a targeted sample of adults (aged 18 and over) that match the criteria specified below. Each FGD is expected to have 6-8 people.

[47] The evaluation team has already conducted inception interviews with WB, ADB, FCDO, WHO, EU, UNDP, UNFPA, WFP, Gavi, Global Fund, and Gates Foundation. The inception interview with the de-facto MoPH has been delayed and is still pending.

*Table 9. Sample allocation of FGDs*

| Location* | Respondents | Total FGDs |
|---|---|---|
| **Nangarhar** | Health care professionals HER | 2 |
| **Helmand** | Health care professionals HIVA | 2 |
| **Nangarhar** | Community health workers HER | 2 |
| **Helmand** | Community health workers HIVA | 2 |
| **Nangarhar** | Community members HER | 2 |
| **Helmand** | Community members HIVA | 2 |
| | **Total** | **12** |

## 5.3. Data Analysis

In this section, a description of the analytical approaches proposed to evaluate the HER/NFA program, and its HIVA component, are presented.

### *Secondary Quantitative Data*

The secondary quantitative data analysis will rely on DiD, PSM and LiST, and UNICEF's Equitable Impact Sensitive Tool (EQUIST[48]) methodologies. This subsection includes more detail on the assessment outcomes and a description of the methods.

Health outcomes of interest

Select outcomes that are representative for each outcome category will be analyzed to provide an understanding of how UNICEF's programming has affected key measures of interest. The number of outcomes within each category will be limited to guard against issues associated with multiple hypothesis testing (MHT). When analyzing a large number of outcomes, there is a non-trivial probability of drawing false conclusions. Importantly, the likelihood of finding significant effects increases with the number of tests conducted.[49] Note, while outcomes were selected based on their importance for each outcome category, the evaluation team can explore replacing some of these outcomes with others and/or adding more based on the interests of UNICEF and other stakeholders.

[48] The evaluation team is reviewing the EQUIST analysis.

[49] Shaffer, J. P. (1995). Multiple hypothesis testing. *Annual review of psychology*, *46*(1), 561-584.

**Table 10. Tentative list of secondary data analysis outcomes[50]**

| Outcome category | HMIS/DHIS2 analysis outcome variables[51] | WoAA/LiST analysis outcome variables |
|---|---|---|
| **Maternal and newborn care** | - Family planning (availability of most common family planning method – e.g. condoms, oral pills)<br><br>-Patients receiving four antenatal visits<br><br>-Institutional delivery (facility-based normal and assisted delivery)<br><br>-Maternal mortality (maternal death to major or other complication)<br><br>-Neonatal mortality | Please refer below to 'Analysis using the LiST approach'. |
| **Child health and immunization** | -Outpatient visit for diarrhea<br><br>-Child vaccination (Penta3 and measles) | -Child diarrhea in the past two weeks |
| **Adolescent health** | Number of girls tested for anemia | |
| **Mental health** | -Patients presenting with mental disorder (such as severe mental disorder, attempted suicide) | |
| **Non-communicable diseases** | -Outpatient visit for diabetes (1 and 2)<br><br>-Outpatient visit for hypertension | |
| **Supplies/Staff availability/ Health service access** | -Stock status of 2-3 key drugs (such as oral rehydration salts (ORS) and Misoprostol) | -Health related expenditures in the past 30 days<br><br>-Households accessed healthcare if they needed healthcare in the past three months |

PSM and DiD Estimation using DHIS2 data

In the first part of the secondary data analysis, DHIS2 data will be used to look at differences in outcomes of interest across the following three groups: (1) the comparison health facilities that did not receive UNICEF support during the period of interest (2022-2025), (2) the health facilities that received the full package of HER/NFA interventions, including HIVA (these would be the UNICEF-supported facilities in 9 provinces until 2023 and 10 provinces in 2024), and (3) the health facilities that received HER (without HIVA). The HMIS/DHIS2 dataset is expected to span several years prior to the initiation of UNICEF management of health facilities (e.g. 2018-2021) and several years post-UNICEF management (2022-2024).

[50] Please note that the evaluation team will review availability of data from HMIS/DHIS2 and based on the results, some variables may be dropped or changed. The document with preliminary analysis will explain in detail.

[51] Outcome variables in this context refer to outcomes of interest in statistics, referring to the specific and measurable variables used to test whether the program achieved its intended effects.

Methods: To set this analysis up, the list of UNICEF-supported facilities (HER/NFA) will be merged with the DHIS2 data. The product will be a dataset at the facility-year level with a variable that indicates which facilities are HER/NFA with HIVA facilities, which are HER without HIVA facilities and which are non-HER/NFA facilities.

The complete dataset of health facilities will be used to conduct analysis. In other words, the comparison group for the analysis will comprise all non-HER/NFA facilities in Afghanistan. Regional characteristics (prevailing in the areas surrounding health facilities) are expected to shape health outcomes, and these characteristics might systematically vary across regions served by HER/NFA facilities and regions served by non-HER/NFA facilities. To account for such differences in characteristics, ***a propensity score method (PSM)*** will be used to construct weights to account for observable differences in baseline characteristics across treatment and comparison facilities.[52]

To implement PSM, a logit model will be run to estimate the propensity of health facilities to be managed by UNICEF (the overall treatment measure).[53] The propensity scores will be used as weights (specifically inverse probability weights or IPW) when estimating the outcome model that is described below. Essentially the weights will minimize selection issues arising from features unrelated to UNICEF's programming that could bias the results of the evaluation, balancing the treatment and comparison groups before effects on outcomes are estimated.[54] Note that IPW likely provide more accurate and reliable estimates relative to traditional PSM approaches, such as matching.[55] The practice is to predict treatment with measures that likely influence both treatment and outcome variables, excluding variables that might be shaped by the treatment (i.e. post-treatment measures that might stem from the intervention) to avoid bias.

The HMIS data appear to be the primary source of information at the facility level and so the evaluation team will pull variables from the HMIS to proxy for pre-intervention characteristics such as catchment size/patient load, location, level of economic development and disease burden when estimating facilities' propensity scores.

**Table 11. Variables considered for PSM**

| Characteristics to be accounted for | HMIS Variable(s) used to proxy for the characteristic of interest | Year used for propensity score estimation |
|---|---|---|
| **Catchment size/patient load** | Total outpatient visits for all morbidities | 2018 |

[52] Rosenbaum, P. R., & Rubin, D. B. (1985). Constructing a control group using multivariate matched sampling methods that incorporate the propensity score. The American Statistician, 39, 33–38; Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference.* Houghton, Mifflin and Company.

[53] The practice is to predict treatment with measures that likely influence both treatment and outcome variables, excluding variables that might be shaped by the treatment to avoid bias. Therefore, the evaluation team will plan include baseline (pre-2022) characteristics such as facility's total number of outpatient visits (a proxy for catchment size), district (for location), drug stocks (to proxy for level of economic development) and outpatient visits for specific diseases (to proxy for disease burden) when estimating facilities' propensity scores. After running this model, the team will estimate each facility's propensity to receive UNICEF's intervention.

[54] Caliendo, M., & Kopeinig, S. (2008). Some practical guidance for the implementation of propensity score matching. Journal of Economic Surveys, 22, 31–72; Imbens, G. W. (2004). Nonparametric estimation of average treatment effects under exogeneity: A review. Review of Economics and Statistics, 86, 4–29.

[55] Wang, X., Oraby, T., Mao, X., Sun, G., & Schneider, H. (2025). Re-evaluating causal inference: Bias reduction in confounder-effect modifier scenarios. *Decision Support Systems*, *192*, 114435.

| | | |
|---|---|---|
| | Facility type | 2025 (Earlier data not available) |
| **Location** | District fixed effects | 2025 (All data uses 2025 identifiers) |
| **Level of economic development** | ORS, misoprostol, availability (will reflect resource availability and infrastructure concerns) | 2018 |
| **Disease burden** | Diarrhea (reflects WASH conditions) | 2018 |
| | Malaria (infectious disease) | 2018 |
| | Diabetes 1, 2 or Hypertension (non-communicable disease) | Still checking what is the earliest year of data |
| | Still birth + neonatal death (maternal health and nutrition) | 2018 |

The ***DiD methodology*** will identify the impact of UNICEF interventions. Essentially, the average change in outcomes between different time periods for the treatment group(s) (HER/NFA facilities) will be compared with the average change between the same times for the comparison group (non-HER/NFA facilities). The comparison groups help account for the influence of external factors (such as policy changes and financial trends) that are likely to have similar consequences for facilities across the country. The assumption is that in the absence of UNICEF programming, its facilities would have performed like the non-HER/NFA facilities and the non-HER/NFA facility trends therefore represent the counterfactual. Any differences in UNICEF facility trends over and above non-HER/NFA facility trends are plausibly driven by UNICEF's interventions.

The following model will be used for the DiD analysis:[56]

$$Y_{ft} = \beta_0 + \beta_1 HER_f + \beta_2 HIVA_f + \beta_3 2022 + \beta_4 2023 + \beta_5 2024 + \beta_6 (HER_f \times 2022) + \beta_7 (HER_f \times 2023) + \beta_8 (HER_f \times 2024) + \beta_9 (HIVA_f \times 2022) + \beta_{10} (HIVA_f \times 2023) + \beta_{11} (HIVA_f \times 2024) + \delta_f + \varepsilon_{ft} \quad (1)$$

Where $Y_{ft}$ is an outcome for facility $f$ in year $t$ (such as number of institutional deliveries), with the years potentially being between 2018 and 2024 (dependent how many years of pre-intervention data are available). $\beta_0$ is the constant. $HER$ is an indicator variable which takes the value 1 for all health facilities that receive UNICEF's HER/NFA program but not HIVA, and 0 for other facilities. The coefficient on this variable captures differences in outcomes between HER/NFA-only facilities and comparison facilities in the pre-intervention or baseline period. $HIVA$ is an indicator variable for UNICEF facilities in the provinces where HIVA is implemented and its coefficient accounts for pre-intervention differences between HIVA and comparison facilities. The time dummies are 2022, 2023 and 2024, and these indicate how outcomes in comparison facilities look in these years relative to the pre-intervention period.

The DiD coefficients are provided in equation (1) by the interaction terms $\beta_6 - \beta_{11}$. For example, $\beta_6$ conveys the DiD estimate for HER in 2022 – the plausible impact of HER in the first year of UNICEF management. This coefficient indicates whether the difference observed specifically in HER facilities between the pre-intervention period and 2022 is distinct from the difference observed in the comparison group during the same period. Similarly, the DiD estimate for HIVA in 2022 is $\beta_9$. Other than that, $\delta$ is a

[56] Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference.* Houghton, Mifflin and Company.

vector of facility-level control variables at baseline such as district fixed effects – these controls will help increase prevision of the coefficient estimates. $\varepsilon$ is the error term. Here the propensity score weights described above and cluster standard errors at the facility level will be used.

An alternative is to estimate a version of (1) in which just an overall treatment indicator for all UNICEF-supported facilities (irrespective of whether or not they receive HIVA or not) is included to estimate the influence of any type of HER/NFA programming versus non-HER/NFA programming.

Heterogeneity analysis: For all the analysis, heterogeneity by different characteristics will be investigated, such as type of facility/service provider, rural location, and gender of patient/individual (to the extent that these data are available). The heterogeneity analyses will entail running model (1) separately on different strata (such as on rural facilities).

To investigate heterogeneity in facility performance by type of health facility (facility type will be sourced from the master sheet of facilities), it is proposed to conduct estimation for primary outcomes separately for the following facility types: (1) comprehensive health centers (~400 facilities), (2) basic health centers (~800), (3) subhealth centers (~1,000), and (4) hospitals (~150).

It is important to note that statistical power tends to be lower when conducting analyses for sub-samples and therefore results for some of these investigations might only be able to provide suggestive evidence of differences across various characteristics.

DiD estimation using household-level WoAA data

In the next part of the analysis, population-level data – specifically, the WoAA surveys – will be used to look at differences in outcomes of interest across (1) households likely benefitting from comparison health facilities, (2) households likely benefitting from UNICEF's full package of HER/NFA interventions, including HIVA, and (3) households likely benefitting from UNICEF's HER without HIVA.

Methods: To set this analysis up, first, all household-level data from the annual WoAA surveys between 2021 and 2024 will be stacked. The WoAA survey program has varied survey features (such as population groups surveyed and seasonality) across different survey rounds.[57] Accordingly, the WoAA program alerts users to the fact that findings from the different rounds of the survey might not always be comparable. It is therefore recommended that the WoAA results be interpreted with caution. This caveat will be included when presenting results from the WoAA data.

The WoAA data contains province and district of residence for the households surveyed, but they do not share village information or GPS coordinates. Therefore, it is not possible to map households to the health facility they reside closest to. Alternatively, it is proposed to construct a proxy for exposure to UNICEF health programming at the district level since that is the finest geographic information available for the WoAA households. Specifically, the list of UNICEF-supported facilities (HER/NFA) will be used to compute the share of total facilities that are HER/NFA and non-HER/NFA. Districts where majority of facilities are UNICEF managed (e.g. $\geq 75\%$ ; but the evaluation team will identify the best threshold to use based on the distribution in the data) will be classified as HER/NFA districts and other districts as non-HER/NFA districts.

This data will be used to create a list of districts with their treatment status (HER/NFA and non-HER/NFA) that will then be merged with the WoAA data set from 2021 and 2024. The product will be a dataset at

[57] REACH. (2024). Whole of Afghanistan Assessment 2024. Preliminary Findings Presentation.

the household-year level with a variable that indicates the treatment status for each household. Note that if there are not sufficient districts categorized as HER/NFA with HIVA, it might be more meaningful to just consider a UNICEF versus no-UNICEF programming split when analyzing the WoAA data. As mentioned below in describing the empirical model, the WoAA analysis will include province fixed effects to ensure that households are compared only to other households living in the same province since provinces can have very different health determinants from one another. Since the type of UNICEF programming (only HER or HER/NFA with HIVA) is stratified at the province-level, it will not be possible to compare the different UNICEF programs when conducting the WoAA analysis.

Since WoAA data is available for pre- and post-intervention years, the evaluation team will estimate a DiD specification to explore whether health outcomes trend differently across HER/NFA and non-HER/NFA districts between baseline and intervention years.

The estimate will use the following model, which is similar to specification (1). Here each coefficient for each intervention year relative to the pre-intervention year of 2021 will be identified:

$$Y_{hdt} = \alpha_0 + \alpha_1 HER_d + \alpha_2 HIVA_d + \alpha_3 2022 + \alpha_4 2023 + \alpha_5 2024 + \alpha_6 (HER_d \times 2022) + \alpha_7 (HER_d \times 2023) + \alpha_8 (HER_d \times 2024) + \alpha_9 (HIVA_d \times 2022) + \alpha_{10} (HIVA_d \times 2023) + \alpha_{11} (HIVA_d \times 2024) + \delta_{hd} + \varepsilon_{hdt} \quad (2)$$

Where $Y_{hdt}$ is an outcome for household h in district d in year $t$ (such as number of institutional deliveries), with the years being between 2021 and 2025. All other coefficients are similar to (1), but here the reference year is 2021. So for example, $\alpha_1$ captures differences between HER and comparison districts at baseline/2021 and $\alpha_8$ represents whether the change in HER districts between baseline and 2024 is different from the change in comparison districts over the same time period. $\delta$ is a vector of household control variables such as province fixed effects, urban/rural residence, gender of the household head and household composition (i.e. number of members in different age categories). Standard errors will be clustered at the district level.

Heterogeneity analysis: Heterogeneity analysis will be conducted for the WoAA analysis based on households' urban/rural residence, displacement status and presence of a member living with disabilities.

Analysis using the LiST approach

The analysis of secondary data will be supplemented with an analysis using the Lives Saved Tool (LiST). While the previously described analyses seek to estimate the impact of HER/HIVA interventions on key health outcomes, LiST assumes a specific level of effectiveness for critical health interventions and projects the impact of enhanced coverage of these interventions throughout the country. LiST is a deterministic model that combines published estimates of effectiveness for select maternal and child health (MCH) interventions with country-specific demographics and coverage rates to produce estimates of lives saved over time.[58] One of the key benefits of the LiST model is the ability to simultaneously model the outcomes of multiple interventions without double-counting impacts, making it ideally suited to project the impact of large-scale health system improvements. However, the LiST model is deterministic in its assumption of intervention impact, as it does not vary assumptions of effectiveness according to the implementing context, and thus the quality of the tool's results is dependent upon the validity of the underlying assumptions. By combining the LiST analysis with multiple analyses of secondary data, it is possible to verify the tool's assumptions and thus corroborate its output.

[58] https://www.livessavedtool.org/about

The LiST will be used to model the enhanced coverage of specific MCH interventions due to the expansion of BPHS, EPHS, and HIVA to project the interventions' impact on lives saved. This analysis using LiST will complement the impact analyses by simultaneously modeling increased coverage of critical interventions and aggregating all outcomes into the number of potential lives saved. In order to conduct the LiST analysis, interventions will be matched from LiST to MCH interventions enhanced by BPHS, EPHS, and HIVA facilities and tracked in HMIS/DHIS2 datasets. Note that the indicators used for the previously described secondary data analysis may not perfectly align with the indicators in the LiST analysis, as the LiST analysis is constrained to the specific MCH interventions built into the model. For the LiST analysis, the following interventions will be included:

- ANC visits
- TT2 vaccination of pregnant women
- Institutional delivery
- Cesarean delivery
- Uterotonics for postpartum hemorrhage
- Penta-3 vaccination
- Measles vaccination
- ORS treatment for diarrhea
- Severe acute malnutrition (SAM) treatment

Nationally representative household data will be used to estimate baseline coverage of each intervention. LiST currently incorporates 2022/23 MICS data for most interventions, and any gaps in baseline coverage data will be supplemented with data from the 2018 Afghanistan Health Survey and/or the 2015 Demographic and Health Survey. To estimate increases in coverage from 2022-2024, HMIS/DHIS2 data will be used, similarly to the methodology in Safi et al., 2023.[59] The analysis will evaluate the percentage change in service utilization for each intervention type over the selected timeframe and apply this percentage change to the baseline coverage to estimate coverage over time. Once all the coverage and intervention data are imputed into LiST, the tool will be used to estimate the number of lives saved attributable to increased access to critical MCH interventions over time. Note that the accuracy of the LiST estimates hinge on the validity of underlying assumptions about the relationship between enhanced coverage through increased service utilization and intervention quality and effectiveness.

### *5.3.1. Cost Analysis*

The evaluation team will conduct a comprehensive cost-efficiency analysis to assess the extent to which the HER/NFA program delivers health services efficiently. To the extent that data are available, the team will pay explicit attention to cost trends over time (2019-2024) and across service packages (BPHS/EPHS versus HIVA). With the cost-efficiency analysis, cost drivers will be identified to create an understanding of the cost structure of HER/NFA, which can then be used to pinpoint areas for enhanced efficiencies. UNICEF and partners will provide detailed program cost data, disaggregated by year and intervention package, and the evaluation team will supplement gaps in cost data with a literature review of comparable cost estimates. UNICEF will also facilitate access to cost data from non-HER/NFA/HIVA facilities to support cost-efficiency comparisons with these facilities. A rigorous cost analysis and subsequent cost-efficiency analysis depends on accessing accurate and reliable cost data that is sufficiently detailed and disaggregated to support comparative analyses. The evaluation team will review budgets, expenditure

[59] Safi, N., Anwari, P., Sidhu, L., Ibrahimi, A. G., Rasekh, A., Naseri, S., ... & Chikvaidze, P. (2023). The need to sustain funding for Afghanistan health system to prevent excess morbidity and mortality. *Eastern Mediterranean health journal*, *29*(2), 119-125.

reports, program documents, and funding policies to understand the operating budgets and funding sources for each package. The evaluation team will take note of the currency in which costs are reported and adjust for currency fluctuations over time (e.g., using World Bank deflators to adjust all cost data to constant USD values).

The quantitative review of cost data will be supplemented with qualitative data from key informant interviews to contextualize the cost data. These KIIs will provide perspectives on and experiences with the program budget and population served as well as the benefits and challenges of current funding levels and financing structures. The KIIs will also identify necessary HER/NFA resources that may not appear on expenditure documents, such as in-kind and donated resources, and any rigid constraints on resources that may preclude optimal use (e.g., funds available for a narrow range of activities that could be used more efficiently under more flexible use parameters). KIIs will help clarify the key cost drivers, provide insight as to why costs may be higher in certain contexts than others, and highlight any implementation mechanisms that may be linked with higher cost savings. KIIs will also supplement quantitative analyses to explore disruptions in purchasing power that may occur as a result of currency fluctuations.

Once sufficient cost data are collected, cost data will be stratified by service package (BPHS/EPHS and HIVA) and by year. If available, unit costs will be categorized according to common cost categories, such as capital costs, personnel costs, equipment costs, training costs, and overhead costs. Special attention will be given to inputs with uses that overlap (e.g., capital or personnel that are used for multiple programs), using activity-based costing principles to estimate allocations attributable to the intervention or program being analysed. If the data differentiate personnel and non-personnel expenditures by type of service provided, the team will link such cost data to specific service provision data. The team will distinguish between fixed costs (e.g., durable equipment) and costs that vary according to the number of people served (e.g., vaccines delivered). Using this information, the evaluation team will create a cost database that contains basic descriptive information and, if data are sufficiently detailed, information that will allow analysis of cost variations by package, geography, scale, and group served (e.g., IDPs, women/children, minorities).

To answer questions of cost-efficiency, the cost data will be combined with service provision data, such as the utilization rate for each type of intervention provided, as well as with key outcome data, such as maternal and infant survival, where feasible. To the extent that costs can be disaggregated by service provided, the team will assess the cost per facility delivery and the cost per fully immunized child across BPHS/EPHS facilities, as well as the cost per child treated for severe malnutrition and the cost per woman receiving prenatal cash transfers at HIVA facilities. These analyses will assess the relationship between costs and outcomes over time, to reveal any time trends in cost-efficiency. The evaluation will also examine cost-efficiency differences by service package, comparing across facilities providing BPHS, EPHS, and HIVA. If the impact analysis of secondary data reveals significant effects on health outcomes, then the cost analysis can be combined with these effects in a type of cost-effectiveness analysis called a cost-consequence analysis. A cost-consequence analysis is well-suited for interventions targeting multiple outcomes, as it presents a comprehensive overview of costs and effects attributable to an intervention.

#### *5.3.2. Observation Data*

The observation data from facilities will be analyzed with descriptive statistics (e.g. means). The findings from this analysis will be used to provide an understanding of the trends observed in the HMIS/DHIS2 data by collecting deeper information on the key outcomes for the secondary data analysis and also serve to verify some of the secondary data information. Observations of facility outputs can also inform cost-efficiency comparisons.

#### *5.3.3. Qualitative Data*

Qualitative data will be used to triangulate and provide robustness to quantitative findings, as well as provide richness to the underlying assumptions and contextual implications within the impact evaluation. Qualitative participatory methods are particularly well-suited to provide additional perspectives and detail to the impact evaluation, by adding first-hand experiences and responses to the program, capture diverse and overlooked perspectives, and capture the fluid program dynamics that may not easily be summarized by quantitative measurement alone.

Key Informant Interviews (KIIs) will also contextualize cost data and explain efficiency patterns:

- Identify uncaptured resources: In-kind contributions (e.g., community health workers) and funding constraints.
- Diagnose drivers of efficiency changes:
  - "Since 2020, what factors reduced HIVA's cost per malnutrition case treated?"
  - "Why does BPHS outreach show lower costs per visit than static clinics?"
- Triangulate package differences:
  - "What makes HIVA's cost structure distinct from BPHS (e.g., transport, bundled services)?"

#### *5.3.4. Results Triangulation*

Given that the evaluation utilizes different types of data and methodologies, each part of the analysis will have specific strengths but also certain drawbacks because of data limitations. The strength of the evaluation will lie in the ability to bring together insights and findings from different analyses to answer the evaluation questions. For example, facility observations will validate select measures from the HMIS/DHIS2. In the final report, the different results will first be presented separately, but then also included in collated findings relating to the same outcomes, program features and trends to provide a comprehensive understanding of program performance. For example, if there are significant takeaways on child mortality impacts from the HMIS/DHIS2 analysis and comments on challenges encountered in improving neonatal survival in the qualitative interviews, these will be highlighted in a Discussion section. Note that the evaluation team will seek to gain clarification and greater context on noteworthy trends noticed during preliminary secondary data analysis in subsequent primary data collection exercises and will triangulate across the different sources of information. Specificities of how different tools will be triangulated are reflected under the evaluation matrix.

### 5.4. Integration of gender, equity, human rights, climate, disability and 'leave no one behind' into the evaluation

This evaluation incorporates rigorous exploration of outcomes through the lens of marginalized and high-vulnerability groups, including of women and children, those with physical and mental impairments, and ethnic and religious minorities, of whom may be more likely to be beneficiaries of HER/NFA treatments than non-vulnerable populations. While conducting quantitative analysis, the team will explore whether there is heterogeneity in program performance by different criteria. For example, the team will examine differences across more and less developed provinces/districts. Importantly, the WoAA data contains proxies for displacement status, which will allow the team to look for differences in outcomes across those who are displaced and those who are not. At the same time, information on disability is also available in the WoAA data and therefore the evaluation team will investigate heterogeneity in results based on the presence of a member living with disabilities.

In the qualitative component of the evaluation, the team will address important vulnerability-based heterogeneity through both KIIs and FGDs by asking respondents specifically about the extent to which vulnerable groups have been considered during the program design and implementation, and to what extent these groups have been able to access and utilize HER/NFA facilities. Implementation-based questions will be asked to key stakeholders and NGO service providers, while access and care-based questions will be asked among KIIs and FGDs of health service professionals and community members and influencers. This component of the evaluation seeks to understand the extent to which gender integration has been achieved through both program design (pre-UNICEF takeover) and implementation (an ongoing and iterative process) to provide a holistic assessment of the HER/NFA program and provide insights on areas of focus for continued improvement informed by data.

The evaluation design, methodology, tools, and data collection scope and processes are fully aligned with the United Nations System-Wide Action Plan (UN SWAP) 2.0 prescribed accountability framework for mainstreaming Gender Equality and The Empowerment of Women (GEEW)[60] by incorporation of all relevant indicators and dimensions across all evaluation phases. The desk review and data collection will explore equity, human rights, climate, and 'leave no one behind' considerations.

## 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. The evaluation team is deeply familiar with the UNEG and UNICEF norms and standards, and will fully comply with both. Prior to submitting any deliverables (even drafts) to UNICEF, all reports are carefully reviewed by an independent internal quality reviewer.

Independent Internal Quality Assurance Reviewer: The firm assigned an independent quality reviewer with research and evaluation expertise to serve as the QA reviewer on this project. Dr Marlous de Milliano will serve as the project's independent QA reviewer. Dr. de Milliano has extensive experience working for UNICEF, having led more than ten UNICEF projects in the past five years on topics related to among others health, nutrition, and ECD. She will be able to provide technical advice on any of the ongoing evaluation components, and she will ensure the overall quality and rigor of the research design, analysis, and final drafts.

The findings from qualitative and quantitative data will be validated through on-going deliberation and reflections across the team to ensure that findings are triangulated and conclusions and recommendations are supported by multiple sources. The team will work closely with UNICEF evaluation project lead and implement their feedback on all key deliverables.

**Primary data collection**

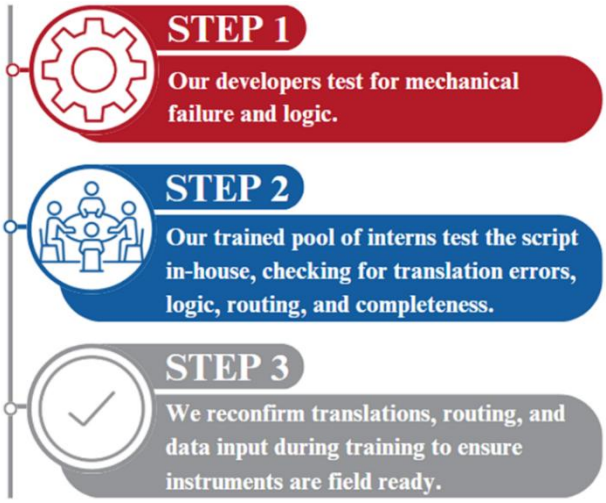
ORB International has 10+ working relationships with the local research firm selected for this project and thus able to ensure that the company is capable of completing required data collection in a timely manner while adhering to the highest standards of rigor.

[60] United Nations-System Wide Action Plan 2.0. 2019. *Accountability Framework for Mainstreaming Gender Equality and The Empowerment of Women (GEEW) In United Nations Entities Framework and Technical Guidance*; Version Available at: https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/How%20We%20Work/UNSystemCoordination/UN-SWAP/UN-SWAP-2-TN-en.pdf. Accessed 31 May 2025.

**Quantitative Data Collection Quality Control**

*Scripting*

ORB will script face-to-face surveys. ORB's scripting process reduces technical difficulties during fieldwork, increases the speed of data return, and allows for near-real-time quality control feedback. ORB scripts all questionnaires in tablet interviewing platform, SurveyToGo. SurveyToGo's structure and scripting mechanisms provide a flexible and technically sound platform to execute surveys with complicated routing, instructions, and data collection. SurveyToGo allows for tracking over 40 metadata indicators for quality control, which enables ORB to comprehensively verify all data.




**Training and Pilot**

Effective interviewer recruitment and training are essential to ensure the collection of quality data. ORB strives to select supervisors and interviewers who have previously conducted interviews on face-to-face research projects, are well-educated, and are fluent in appropriate languages. All enumerators have been screened against current sanction lists. In addition, ORB requires local partners to submit interviewer and supervisor lists to be verified against an internal roster of interviewer performance based on previous research projects, and ORB removes anyone with poor performance in advance of the training.

*Interviewer Training*

Interviewer training will consist of two parts. First, ORB will conduct virtual training-of-trainers with the field coordinator(s) and supervisors to cement the evaluation design, align training goals, answer questions, and ensure in-depth understanding. Second, trainers will administer a **general enumerator training** over 3 days and will comprise the following elements:

- Introduction to the project and its objectives;
- Sampling techniques and processes;
- Introducing the survey to the respondent;
- A reminder of key interviewing techniques;
- A reminder of the quality control framework and requirements for the study;
- A question-by-question review of the questionnaire;
- Group completion of the questionnaire;
- Several one-on-one practice interviews;
- And a session on how to correctly fill out the contact sections on the tablets and properly record refusals and break-offs.

Immediately following training, ORB will **pilot the questionnaire.** ORB's Quality Control staff will review each survey and debrief the team to showcase the GPS locations of their pilot interviews, as well as play

the audio recordings of some of their questions, noting 'good' and 'poor' interviewing behavior. ORB will then conduct **full debrief** with both the supervisors and enumerators, discussing any cognitive or technical issues with the instruments (which will be sent to UNICEF) and review each enumerator's performance for final enumeration team selection.

ORB will provide UNICEF with a training summary report with dates and locations of training, topics covered, and any issues experienced in training. No pilot data will count towards the final sample.

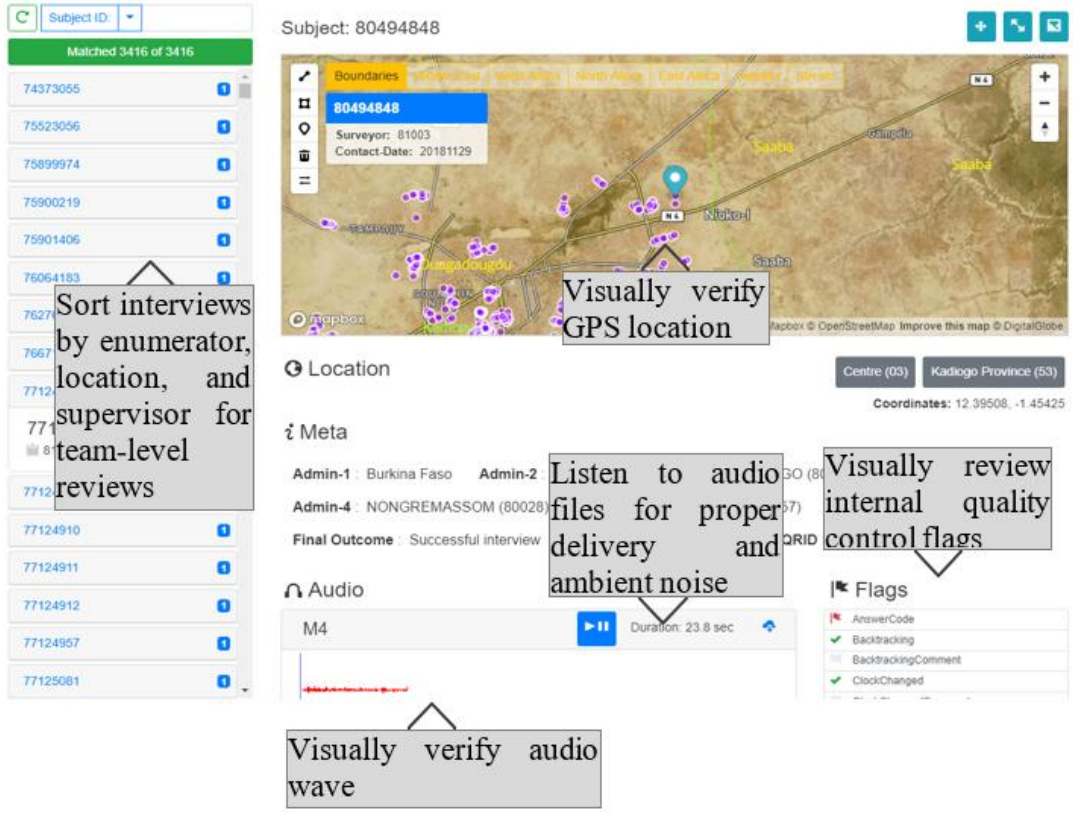
*Quality Control During Fieldwork*

ORB takes data quality seriously while understanding the need for timely and cost-effective surveys. To this end, ORB leverages a comprehensive **Internal Quality Control System (IQCS)** that relies on three cornerstones, regardless of the fieldwork mode:

1. **Daily team feedback**. ORB researchers download data **daily** and review it to ensure enumerators properly record data, visit the assigned locations, properly and sufficiently record open-ended questions, and are on track with the project schedule. This enables our team to immediately catch and prevent fraud, as well as flag any other issues with the fieldwork. This system augments traditional fieldwork controls, such as interviewer training, team-based fieldwork, and field supervision to ensure all data is verified.
2. **Metadata**. All fieldwork is conducted using Android tablets and scripting that integrates vast metadata including the following:
    a. Length of interview: ORB relies on **NetDuration**, a variable automatically calculated in SurveyToGo that is calculated based on a timer, rather than by subtracting the start time from the end time which can result in irregular interview lengths (e.g., negative lengths).
    b. Audio recording consistent with the length of interview placed throughout the questionnaire. While the voice of the respondent is generally inaudible, ORB can ascertain whether an interview was conducted or not, as well as the gender of the respondent, based on the interviewer's voice and ambient noise.
    c. Programming timestamps throughout the questionnaire to check for any unusually rapid completion times of sections (this is a useful way to check if interviewers are rushing through a questionnaire or skipping particularly sensitive sections).
    - Plotting GPS coordinates: ORB tracks the coordinates of each interview to review the spacing of interviews within a sampling point to check for proper sampling procedures; ORB verifies 100% of all GPS coordinates for data.
    - IP addresses: online panel providers check the IP address of each respondent during survey completion to ensure they are in the correct location.

**ORB's QC Platform**. Data is uploaded **daily** to ORB servers via Wi-Fi or 3G connections and ORB's proprietary software enables immediate review and feedback by ORB researchers. The software includes 46 automatic quality control checks in addition to the metadata checks described above that flag an interview based on any irregularities. These quality control checks include flags, such as contradicting opinions or calculating the difference between a respondent's reported age on two questions.

*Figure 4. Integrated Quality Control System (IQCS) Website Screen Shot*




**Qualitative Quality Control**

ORB collects transcripts and recordings from two separate audio devices uploaded onto the secure servers. When possible, ORB researchers virtually listen or attend in person to provide additional quality control and feedback. The quality control team completes a review of these transcripts and audio files, inclusive of timestamps and GPS tagging, and confirms via audio check that each respondent's voice matches their reported gender. All rejected discussions are re-fielded. ORB provides transcripts of the interviews at the discretion of the client and utilizes the transcripts as described in the following analysis section.

**Stages of Quality Assurance**

The evaluation employs a three-level process of quality assurance by ORB and UNICEF. The quality assurance at the level of data collection will be ensured first by ORB that performs its internal quality control measures by applying standard procedures as described above. The second level of quality assurance of all deliverables will be undertaken by the UNICEF evaluation manager and the management team. The third level of quality assurance will be supported by an internal technical group and Steering Committee, that will be responsible for the content quality control and feedback on key deliverables, including this inception report, preliminary findings and final reports.

At any stage of fieldwork, ORB will promptly inform UNICEF of on-the-ground realities including security concerns that prevent or delay fieldwork, and the plan of action to resume fieldwork as promtly as possible. This process may likely involve the selection of replacement health facilities that are not

experiencing security concerns. A field report will be provided to indicate any other environmental factors that may have impacted responses.

## 5.6. Ethical Considerations

ORB and AIR uphold the highest ethical standards of conduct based on their fundamental duty to protect the rights of all human subjects who participate in their research. This is especially important when conducting research and evaluations among vulnerable populations, including children and pregnant women; marginalized, persecuted, exiled or refugee populations; ethnic or religious minorities; and those with cognitive and physical impairments. Interviewing health facility beneficiaries will likely increase the chance of interaction with vulnerable populations, making ethical considerations a front and center priority during this research activity.

In conducting this impact evaluation, ethical considerations are guided by the United Nations Evaluation Group (UNEG) and UNICEF Ethical Standards for Evaluation.[61] The evaluators are committed to upholding the core obligations of independence, impartiality, credibility, and accountability, ensuring that findings are free from bias and conflicts of interest. All team members will adhere strictly to professional codes of conduct to maintain transparency and objectivity throughout the evaluation process. Ethical safeguards for participants are designed to respect the dignity, rights, and cultural diversity of individuals and communities involved, particularly in a context marked by conflict and vulnerability. Participation will be entirely voluntary, with informed consent obtained, and the right to self-determination and withdrawal fully respected. Measures will be taken to ensure fair representation of diverse groups and strict confidentiality of all personal data, with protocols in place to prevent any form of harm or retribution. In cases where the evaluation involves children, the team will follow the UNICEF Procedures for Ethical Research Involving Children, including child-sensitive interview practices, parental consent, and mechanisms to ensure child safety and well-being at all stages.

ORB additionally complies with the International Chamber of Commerce/ European Society for Opinion and Marketing Research (ICC/ESOMAR) Code on Market and Social Research, which sets out detailed ethical guidelines for recording and observation techniques, data protection and privacy, and conducting research. As such, it takes all possible steps to ensure they are not disturbed or harmed by the experience of being interviewed and that their rights and interests are fully safeguarded. These steps include:

1. Anonymizing responses and safeguarding data. GPS readings are only included at the analytical dataset level to remove the chance of identifying a respondent based on location. ORB's IQCS platform is disaggregated from substantive data so that audio checks can only be tied to specific respondents with a separate list of enumerator IDs.
2. The use of ORB proprietary information, including personally identifiable information (PII), is restricted to those who need it. Employees only use files relevant to their assigned projects. Employees cannot use personal email addresses for company work or forward any ORB or client proprietary information to personal email accounts.
3. Treating consent as a process, not an act. ORB fully communicates that respondents can withdraw consent at any moment, even to only certain parts of the questionnaire.

Furthermore, ORB maintains an internal policy on Modern Slavery & Human Trafficking applicable to all individuals working at all levels, including contractors, agency staff, agents, or any other person associated with ORB, or any of its subsidiaries or their employees. For this assignment, the ORB team will obtain

[61] These references are available at the following link: https://www.unicef.org/evaluation/resources

ethical approval from AIR's in-house institutional review board and via UNICEF Afghanistan through existing long-term agreement with an institutional review board.

**Software and Data Privacy**

ORB's interviewing program, SurveyToGo, provides robust data protection capabilities to ensure data is only accessible by authorized personnel. SurveyToGo creates a separate memory location within enumerator electronic devices to ensure no other application accesses its data. Survey data becomes inaccessible to enumerators after each survey is completed. Data is transmitted from the field to ORB servers at the end of every day via Wi-Fi or 3G connections and immediately erased from the device. If the electronic device is lost or stolen, ORB can delete survey data from that device's memory. Transmitted data is housed in SurveyToGo Amazon AWS data centers and is only accessible to staff with two-factor authentication log-ins.

As an assurance to the ethical considerations of this impact evaluation, the evaluation team (comprised of ORB and AIR) have applied for IRB approval through AIR's in-house IRB for all secondary data analysis. For primary data collection, UNICEF will facilitate IRB approvals upon inception approval.

## 5.7. Risks, Limitations, and Mitigation Strategies

The evaluation team has extensive experience facing and overcoming challenges associated with managing and conducting evaluations of development programs including health programs, including in Afghanistan and other conflict-affected areas. The team has established strategies to address challenges in resourceful ways, attempting to mitigate risk without compromising the quality of the evaluation. This section discusses potential challenges that may arise during the evaluation of the HER/NFA program including those noted in the TOR as well as some additional considerations.

*Table 12. Identified Risks and Mitigation Strategies*

| Potential risk | Proposed mitigation strategy |
|---|---|
| **Challenges with data availability and quality that hinder robustness of the impact evaluation methods** | • During the secondary quantitative data analysis, review the existing data from DHIS2, MICS, de-facto Ministry of Public Health, UNICEF and WoAA surveys for completeness and quality.<br>• Discussion of the extent to which conditions/assumptions of impact evaluation methods are met with the existing data so that results can be interpreted with care.<br>• Combine multiple sources of existing data to guard against excessive reliance on a single source.<br>• Supplement existing data with additional data collection, as needed (for example, during qualitative data collection). |
| **Compressed evaluation timeframe** | • Build in extra time for inevitable delays obtaining ethical approvals and collecting data.<br>• Regularly update all stakeholders on evaluation progress and plans.<br>• Maintain flexibility and adapt plans as needed in consultation with key stakeholders. |
| **Significant differences between treatment and comparison group prior to intervention (the possibility that study findings might be driven by pre-existing differences)** | • Account for preexisting differences across HER/NFA facilities and non-HER/NFA facilities using PSM methods and pre-intervention covariates to reduce selection bias. |

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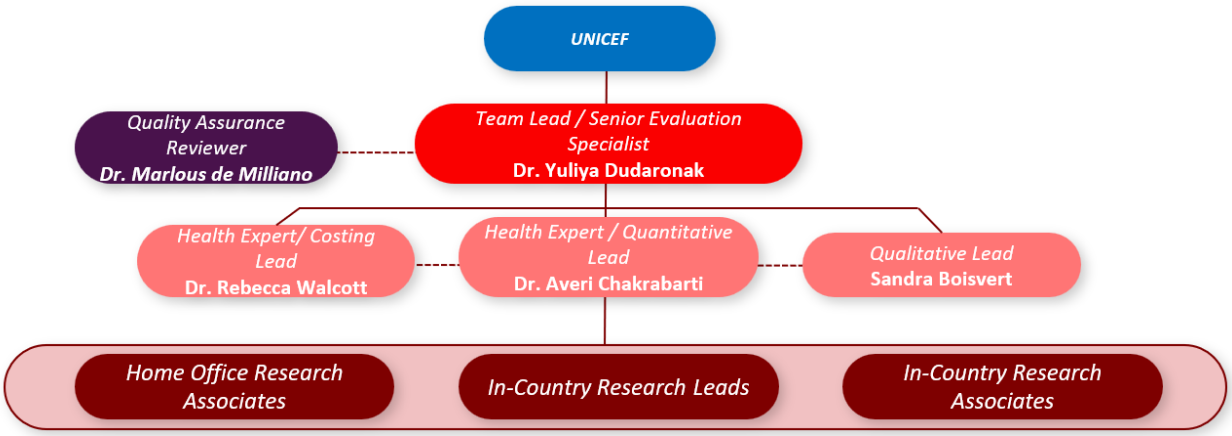
|---|---|
| | • Discussion of the extent to which conditions/assumptions of impact evaluation methods are met with the existing data so that results can be interpreted with care. |
| **Lack of population-level health data that can be matched to health facilities (since WoAA data does not have granular geographic information)** | • Designation of treatment status (HER only, HER/NFA with HIVA, non-HER/NFA) at the district-level (based on whether the majority of health facilities in the district are UNICEF or not) to estimate potential consequences of UNICEF programming on population-level outcomes from WoAA. |
| **Assigning treatment status at the district level might not fully capture the complexities if facility-level care seeking – e.g. there could be cross-district movement and certain populations (such as displaced populations) might reside along district borders and seek care across borders** | • Conduct sensitivity check of WoAA results after dropping areas with high share of displaced populations. |
| **Limited access to local communities, especially for female staff** | • Engage local leaders and organizations.<br>• Work with enumerators who are from evaluation areas.<br>• Ensure fieldwork locations are safe and accessible prior to sending field staff.<br>• Leverage ORB team's established relationships, trust and rapport; use local languages and culturally appropriate data collection instruments.<br>• Use continuous monitoring and feedback to promptly address emerging challenges faced by female staff.<br>• Incorporate participatory approaches to give greater agency to participants. |
| **Gaps or inconsistencies in primary data** | • Closely review data (both qualitative and quantitative, including high-frequency checks of survey data) as they are collected to verify completeness and accuracy.<br>• Digitally record qualitative interviews and focus groups.<br>• Use multiple methods to enable triangulation.<br>• Incorporate existing data and monitoring data to enhance the evidence base. |
| **Lack of alignment between underlying LiST assumptions and specific Afghanistan context** | • Secondary data analyses of country-specific health outcomes to identify any misalignment and provide context for adjustment of LiST estimates. |
| **Limited access to cost data** | • The team will conduct the most robust cost-efficiency analysis feasible given the data provided and LOE constraints.<br>• Literature review of costs can supplement some lack of data, but disaggregated expenditures are necessary for meaningful comparisons between packages/platforms/funding structures. |
| **Evaluation stakeholders with differing priorities and perspectives** | • Engage and establish trust and rapport with stakeholders during the inception phase.<br>• Establish a clear communication and information-sharing protocol during the inception phase.<br>• Engage in thoughtful discussions about the evaluation matrix and inception report.<br>• Allow ample time throughout the evaluation to discuss the process and methods being used. |

| | |
|---|---|
| **Lack of statistically meaningful implications from qualitative data** | • While qualitative data provides rich insight into the impact evaluation, findings extracted from the qualitative interviews alone cannot be attributed to statistically significant program impacts. |
| **Limitations to primary data collection** | • In an ideal setting, primary qualitative data would be collected across 10 provinces. This has been limited to two to account for budgetary constraints. |
| **Challenges with gender-disaggregated data and gender integration into the evaluation** | • The secondary quantitative data analyses' ability to explore gender heterogeneities is limited by the availability of gender-disaggregated data on outcomes of interest; nevertheless, when possible, the team will conduct tests to check for gender differences. Some of the outcomes are focused specifically on girls and women – e.g. girls detected with anemia and maternal mortality. The qualitative investigation investigates both gender imbalances from the supply side by looking at female healthcare professionals, and training received by health staff on gender-based training, and from a demand side by assessing gender barriers to access and utilize healthcare from the lens of community members, community workers, and healthcare professionals. |
| **Potential biases due to funding source** | • The amount and nature of donor funding (e.g. the source) would be important to control for. If UNICEF is able to provide comprehensive data on the number and identity of donors, and amount of support per facilities for the period of interest (baseline and intervention years), these can certainly be controlled for in the estimation model. |

## 5.8. Management Arrangements

To facilitate the implementation of the evaluation of UNICEF's HER/NFA program and HIVA treatments, the team structure is as shown below:

*Figure 5. Team Organization*




The management structure is arranged based on management and technical expertise. The Evaluation Team has internal processes to provide checks and balances, monitor the ongoings of the impact evaluation, provide administrative support and effective client communication, and provide credible and ethical research.

The evaluation is commissioned by UNICEF's independent evaluation function and will be managed by an Evaluation Manager. The standard UNICEF evaluation quality control protocols and processes will be followed to ensure close management throughout the assignment, the Evaluation Manager will be the final approving authority, as per the Evaluation Policy.

An evaluation management team will be established to support this assignment and will be closely engaged in overseeing the evaluation process. The team will comprise of the Evaluation Manager and technical representatives from the health section and will provide access to data and documentation and insights into issues under discussion.

An internal technical group and Steering Committee will be formed to provide insights into issues under discussion, particularly in the inception phase during which a suitable methodology is determined, review all deliverables, including the inception report, emerging evidence summary presentations and the final report, and take part in workshops for the presentation and discussion of emerging findings, for validation and providing further comments.

# 6. Evaluation Workplan and Deliverables

This assignment is expected to span five months, beginning in late June 2025 and running through October/November 2025. The timeline accounts for UNICEF's help to facilitate an expedient IRB approval process as well as the receipt of a formal permission letter from the de-facto Ministry of Public Health and its delivery to provincial and district levels to ensure no delays in beginning fieldwork.

## 6.1. Data Collection and Analysis Phase

Upon project inception, the evaluation team has applied for IRB approval of secondary data analysis via AIR's in-house IRB. Upon approval of the inception report, UNICEF will facilitate an IRB approval for primary data collection. ORB will submit all documents including the full methodology and final translated instruments to AIR's in-house IRB and the IRB institution that UNICEF has a long-term agreement with.

Once approved, ORB will proceed with primary data collection through interviews and focus groups, as well as with the collation of secondary and administrative data. Evaluation team members will perform quality control and clean the data on a rolling basis as we obtain it, which will provide a head start to data analysis. Once all data are collected, collated, and cleaned, the team will analyze the data according to the processes described in the methodology section. The data collection and analyses phase will span seven weeks, contingent on UNICEF facilitating de-facto MoPH permissions ahead of planned data collection inception, and confirmation of all samples to be utilized in data collection. Otherwise, data collection and thus analysis of data collection will be delayed accordingly.

## 6.2. Reporting, Drafting, and Dissemination Phase

As part of the emphasis on early and continual stakeholder engagement, the evaluation will prepare a preliminary version of the report for feedback before producing the finalized version. ORB will share the first draft with initial, triangulated findings following data analysis, and will prepare a stand-alone Evaluation Brief and PowerPoint presentation to be delivered to relevant stakeholders. The evaluation team will also try to prepare a manuscript of the evaluation for publication in peer-reviewed journals, while ORB may need additional time to do so.

Below ORB's proposed project timeline can be found.

*Table 13. Project Timeline*

| Activity | June | July | | | | August | | | | September | | | | October | | | | November | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Week | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 |
| **Contract signature** | | | | | | | | | | | | | | | | | | | | |
| **Kick-off meeting** | | | | | | | | | | | | | | | | | | | | |
| **Document review** | | | | | | | | | | | | | | | | | | | | |
| **Draft inception report** | | | | | | | | | | | | | | | | | | | | |
| **UNICEF review** | | | | | | | | | | | | | | | | | | | | |
| **Final inception report** | | | | | | | | | | | | | | | | | | | | |
| **Data collection*** | | | | | | | | | | | | | | | | | | | | |
| **Data analysis** | | | | | | | | | | | | | | | | | | | | |
| **Draft final report** | | | | | | | | | | | | | | | | | | | | |
| **UNICEF review** | | | | | | | | | | | | | | | | | | | | |
| **Validation meeting** | | | | | | | | | | | | | | | | | | | | |
| **Revised final report** | | | | | | | | | | | | | | | | | | | | |
| **Evaluation brief** | | | | | | | | | | | | | | | | | | | | |
| **Manuscript submitted** | | | | | | | | | | | | | | | | | | | | |

*The timeline for data collection hinges on permissions being obtained from the de-facto Ministry of Public Health, as well as IRB approval before the start of fieldwork, as well as UNICEF confirmation of the health facility observation data sample, KII interviewees, and FGD health facility locations. Given that de-facto MoPH permissions has not been obtained as of September 2025, the overall project will assuredly extend into November.

# Annexes

## Annex 1. Terms of Reference

### Title

Impact Evaluation of the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) Program 2022-2025

### Purpose, Objectives, Use and Scope

**The purpose** of this impact evaluation is to assess the impact and added value of the HER/NFA program[1] on Afghanistan's health system and its contribution to meeting beneficiaries' needs. The evaluation will focus on interventions related to Primary Health Care (PHC) through the Basic Package of Health Services (BPHS), the Essential Package of Hospital Services (EPHS), and High-Impact Value-Added (HIVA) health services up to 2025. The evaluation aims to generate evidence on key successes, challenges, and lessons learned. This evaluation will provide evidence-based insights to inform future programming, policy decisions, and resource allocation for strengthening Afghanistan's health system.

More specific **objectives** of the impact evaluation include the following:

- **Impact, comparative value-add of the HER/NFA program, and achievement of results:** Assess the program's impact on maternal and newborn survival, including morbidity and mortality and the differences in service delivery outcomes between HER/NFA-supported and non-HER/NFA-supported facilities, including the difference from 2022 to 2024. Evaluate and compare the service delivery, including availability, accessibility, and quality of care, in HER/NFA-supported health facilities (sampled from 2,400 facilities) versus non-HER/NFA facilities (sampled from 1,600 facilities). Evaluate the achievement of results and program's contribution to maintaining health and nutrition systems and addressing the needs of beneficiaries including those of marginalized and hard to reach communities.
- **Complementarities, differences, and synergies between health service packages:** Examine the complementarities, differences, and synergies between BPHS, EPHS, and HIVA interventions. Evaluate the additional value of a unified and standardized service delivery model. Compare the additional impact of HIVA interventions in provinces where they have been implemented (9 provinces between 2022 and 2023, and 10 provinces in 2024) against provinces where only BPHS and EPHS were in place (25 provinces between 2022 and 2023 and 24 provinces in 2024).
- **Cost-efficiency:** Examine cost-efficiency of the HER/NFA program and its packages in attaining the expected results and looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same). This includes an assessment of resources (human and financial), risk management and mitigation measures.

**Evaluation use:**

The findings and recommendations from the external evaluation will be used to further shape the future of the health program and packages in Afghanistan. The **primary users** of this exercise are: UNICEF Afghanistan, donors such as World Bank (WB) and Asian Development Bank (ADB) and bilateral donors, implementing partners and service providers, de-facto Ministry of Public Health, WHO

Afghanistan, designated service providers, beneficiaries, health and nutrition facilities, and healthcare and nutrition professionals. **Secondary users** range widely and cover health and nutrition clusters, other UN agencies and non-governmental organizations in Afghanistan, other de-facto ministries, academic and research institutions, and health policy advocacy groups.

**Scope of the exercise:**

The **temporal scope** of this evaluation will focus on activities from 2022 until early 2025. The **geographic scope** will cover a sample of basic health and sub-health centres supported by both HER/NFA and non-HER/NFA across provinces of Afghanistan and its regions. The **thematic scope** of the evaluation will also look on various critical aspects, namely packages (BPHS, EPHS, and HIVA), availability, access, quality of care, health outcomes, integration and synergies of health service packages, cost-efficiency, cross-cutting areas (e.g., gender, disability, equity, human rights, climate, and environmental and social safeguards), and monitoring and evaluation (M&E).

## Evaluation Questions

The main indicative evaluation questions are presented herein using the key impact evaluation's themes and followed by indicative hypotheses. It is expected that these will be further refined and agreed upon during the inception phase in consultation with the Evaluation Steering Committee and Internal Technical Working Group.

*Table 14. Tentative evaluation themes, questions, sub-questions, and indicative hypotheses*

| Evaluation Themes | Evaluation Questions (and sub-questions) | Indicative hypotheses (H) |
|---|---|---|
| **1. Impact, comparative value-add of the HER/NFA program, and achievement of results** | **Q1. What has been the impact and comparative value-add of the HER/NFA program on targeted health and nutrition outcomes in HER/NFA-supported facilities vis-a-vis non-HER/NFA-supported facilities? What impact HER-supported health facilities had on the availability, accessibility, and quality of healthcare services vis-à-vis non-HER-supported facilities? How have impact, value-add, and key trends evolved from 2022 to 2024?**<br><br>Q1.1. To what extent has the HER/NFA program led to improving health and nutrition outcomes such as improving maternal and newborn survival, reducing morbidity and mortality, compared to control areas where the program was not implemented? What patterns and shifts can be observed in service delivery, health outcomes, and program effectiveness from 2022 and 2024?<br><br>Q1.2. What is the overall availability, accessibility, and quality of services delivered by HER/NFA-supported health facilities, and how do they meet the needs of the communities they serve? How effectively has the program affected access to and utilization of essential health services, particularly for marginalized and hard-to-reach populations?<br><br>Q 1.3. How does service delivery, including availability, accessibility, and quality of care, differ between HER/NFA-supported health facilities and non-HER/NFA-supported facilities? What differences exist in health service utilization | **H1: The HER/NFA program has significantly improved health outcomes in areas where it has been implemented compared to non-HER/NFA supported health facilities.**<br><br>**H2: Health facilities supported by the HER/NFA program have higher service availability, accessibility, and quality compared to non-HER/NFA-supported facilities.**<br><br>**H3: The HER/NFA program has significantly reduced disease burden (morbidity) in facility catchment areas where it has been implemented compared to catchment areas of facilities where it has not been implemented.**<br>**H4: The key trends in outcome have significantly evolved from 2022 to 2024.** |

| | | |
|---|---|---|
| | and patient outcomes between HER/NFA-supported and non-HER/NFA-supported facilities?<br><br>Q1.4. What lessons from the comparison between treatment and control groups can inform future health interventions? | |
| **2. Complementarities, differences, and synergies between health service packages** | **Q2. How does the inclusion of HIVA interventions influence health service delivery and outcomes compared to provinces without them?[2] What are the differences, additional impacts, complementarities, and synergies of integrating BPHS, EPHS, and HIVA interventions? How has the program's reconfiguration evolved between 2022–2024, and what impact has it had on outcomes?**<br><br>Q2.1. How do BPHS, EPHS, and HIVA interventions complement each other in improving service delivery, health outcomes, and system efficiency? To what extent has the reconfiguration of the program impacted its outcomes?<br><br>Q2.2. What additional impact do HIVA interventions have on health service access, quality, and patient outcomes in provinces where they have been implemented compared to those relying solely on BPHS and EPHS?<br><br>Q2.3. How does the integration of HIVA interventions affect the overall effectiveness, coordination, and sustainability of health service delivery models?<br><br>Q2.4. What lessons can be drawn from the comparison between provinces with and without HIVA interventions to optimize future health service integration? | **H5: The integration of HIVA interventions with BPHS and EPHS results in better health outcomes compared to areas where only BPHS and EPHS are implemented.**<br><br>**H6: The program's reconfiguration between 2022-2023 and 2024 has led to improved efficiency, service delivery, and outcomes.** |
| **3. Cost-efficiency and governance** | **Q3. How cost-efficient is the HER/NFA program in achieving its expected results and looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same)?**<br><br>Q3.1. To what extent is the HER/NFA program cost-efficient in delivering health services and achieving the desired outcomes?<br><br>Q3.2. How has the cost-efficiency changed over time, has it increased, decreased, or remained the same, and what factors have contributed to these changes?<br><br>Q3.3. How does the cost-efficiency of the HER/NFA program vary between different service packages (BPHS/EPHS and HIVA), and how has this evolved over time? | **H7: The HER/NFA program is more cost-efficient in delivering health services compared to non-HER/NFA-supported facilities.** |

## Evaluation Approach, Methodology, and Ethical Considerations

Employing a **mixed methods approach**, the impact evaluation will collect and analyze both quantitative and qualitative data, enhancing convergence and validity through **triangulation**. The methodology would incorporate **quasi-experimental design with post-only comparison** to assess the impact of the program by comparing the outcomes of treatment and control groups.[3, 4, 5] Techniques like **propensity score matching (PSM)** and **difference-in-differences (DiD)** will be used to minimize biases, assess causality, and compare outcomes. Before conducting the post-only comparison, PSM will be applied to match treatment and control facilities on similar characteristics (e.g., catchment area, patient load,

donor support, types of facilities, geographic location, healthcare infrastructure, etc.). After the matching process, DiD can be used in a post-only context to compare the **average treatment effect (ATE)** between the treatment and control facilities, by analyzing differences in outcomes between both groups after the intervention.[6, 7] **The use of existing secondary and administrative data will be crucial** in providing a robust foundation for identifying patterns and shifts over time from 2022 to 2024. Additionally, leveraging secondary data will enable to conduct a more cost-effective and time-efficient analysis, offering insights into the broader systemic shifts.

Moreover, the impact evaluation is designed to be **utilization-focused**, aiming to inform key decisions and leverage evidence for ongoing program 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 **gender, human rights, disability, climate, ESS, and equity considerations** and **quality of monitoring and evaluation (M&E) systems** across all stages, encompassing key informant interviews and focus group discussions. The evaluation will ensure that tools, data collection, analysis, and reporting fully integrate cross-cutting issues. Special attention will be given to ensuring the **accessibility of data collection tools**.

**Key comparative metrics**:

- **Health outcomes**: Compare maternal and newborn survival, reductions in morbidity and mortality, and health service utilization between both facilities and over time.
- **Service delivery (availability, quality of care, and accessibility)**[8]: Assess differences in service availability (e.g., outpatient visits, immunization coverage, ante-natal and post-natal care, and institutional delivery), service quality (e.g., patient satisfaction, provider competencies), and health service accessibility (e.g., distance to facilities, availability of staff) and utilization.
- **Cost-efficiency**: Analyze the cost-effectiveness of service delivery by HER/NFA-supported facilities and of the HER/NFA program overall, looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same).

**For the cost-efficiency component**, the evaluation will assess different implementation modalities over time while acknowledging the unique context of Afghanistan and the significant variability across provinces, settings, and service delivery models. A direct comparison with other countries may not be feasible and a more context-specific approach, such as pairing similar settings to analyze different NGO, health facility, and service delivery models, will yield more relevant insights.

At a minimum, the following **data gathering methods** are recommended:

- **Desk and Literature Review:** Conduct a systematic desk review encompassing key documents, peer-reviewed journal articles, program materials, project proposals and reports, and the like.
- **Administrative and Secondary Data:** Utilize administrative and secondary data judiciously, such as HMIS and DHIS 2 databases, UNICEF databases, including MICS, secondary administrative data, third-party monitoring (TPM) data, health facility administrative data, data from other programs, etc. to optimize efficiency in the evaluation process.
- **Key Informant Interviews (KIIs) and Focus Group Discussions:** Conduct interviews with key decision-makers, technical staff, health stakeholders in Afghanistan, including but not limited

to de-factor ministries, health cluster, UN agencies, extenders, service provides, etc. Engage in focus group discussions with community members and healthcare professionals.

- **Observations:** Conduct on-site visits to health facilities, clinics, and community-based service delivery sites for first-hand observations and a contextual understanding of the operational environment.
- **Cost-Analysis:** Perform a thorough cost-efficiency and cost-effectiveness analysis of the health program and its packages to evaluate resource utilization and the overall economic impact.

Data collected through various tools will be systematically triangulated to ensure robustness.

**Suggested sampling** is depicted below (the bidders can propose an enhanced sampling strategy and size in the technical proposal, with further refinement during the inception stage to ensure methodological rigor).

For this impact evaluation, a counterfactual analysis will be constructed to assess the difference in health and nutrition service delivery outcomes between treatment and control facilities. The treatment facilities will consist of a sample of basic health and sub-health centres that are supported by the HER/NFA program. These facilities will be drawn from the 2,400 HER/NFA-supported health facilities. The control group will include comparable basic health and sub-health centres located within 1,600 non-HER/NFA health facilities. Propensity Score Matching (PSM) will be employed to match control and treatment facilities based on similar baseline characteristics to ensure comparability between the two groups.

In addition to the general sampling strategy for treatment and control groups, specific attention will be given to evaluating the impact of HIVA interventions. The evaluation will compare outcomes between provinces that have implemented HIVA interventions (9 provinces between 2022-2023 and 10 provinces in 2024) and those that have only implemented BPHS and EPHS (25 provinces between 2022-2023 and 24 provinces in 2024). The selection of HIVA-implemented provinces will be based on the availability of data and the degree of implementation, ensuring that the comparison is between provinces where HIVA interventions have been fully integrated versus those with only the basic packages. This sampling strategy will also include the HIVA-implemented facilities, allowing for the comparison of health outcomes, service quality, availability, and accessibility between HIVA and non-HIVA areas. The evaluation will assess whether HIVA interventions provide additional value and improvement over the health services offered under BPHS and EPHS.

The sampling will include both rural and urban areas, with particular emphasis on marginalized and hard-to-reach populations, ensuring a comprehensive representation of diverse demographic and geographic groups where health facilities exist. This approach will guarantee that the evaluation reflects variations in service availability, accessibility, and outcomes between urban and rural settings, as well as across provinces with differing levels of healthcare infrastructure.

A stratified random sampling technique will be used to select the health facilities, ensuring that diverse geographic and socio-economic contexts are adequately represented. Facilities will be selected proportionally based on population size, health service needs, and the overall healthcare delivery context within each province. This sampling methodology will ensure that the sample is representative of the entire spectrum of health service delivery across Afghanistan. To strengthen the validity of

comparisons between intervention and non-intervention areas, the evaluation will account for potential confounding factors that could impact the results. For example, if control areas receive funding or resources from other donors, it may reduce the measurable differences between the two groups. This will be systematically assessed and addressed in the analysis.

The sample size will be determined based on the total number of basic health and sub-health centres within each group, taking into account factors such as population density, health service access, and variations in service needs. Cochran's formula will be applied to determine a statistically representative sample of beneficiaries within the catchment areas of the selected healthcare facilities. The final sample will be statistically powered to detect significant differences in outcomes between the treatment and control groups, thereby providing a reliable estimate of the HER/NFA program's impact on maternal and newborn health, service quality, and overall health system strengthening.

Further technical discussions are needed to determine the most effective methodologies for utilizing and integrating existing datasets such as MICS, DHIS 2, and similar sources. Additionally, exploring potential gaps and complementary data sources will be crucial for a more comprehensive understanding of the evolving trends. The evaluation will also explore utilization of LiST, which involves selecting key "tracer" interventions from the BPHS, EPHS, and HIVA packages, such as immunization, antenatal care (ANC), and emergency obstetric care (EOC), and estimating their effective coverage before and after implementation, as well as across intervention and non-intervention areas.

**Anticipated risks in the management of this evaluation with corresponding mitigation measures, alongside the evaluation ethics, quality, and confidentiality, are documented in the full version of the Terms of Reference.**

## Evaluation Schedule and Deliverables

A timeline of around five months is envisaged for the evaluation, **from mid-April 2025 and mid-September 2025, with preliminary results to be shared by end of June 2025.** The evaluation team should allocate reasonable effort to ensure the timely submission of all the deliverables. The proposed organization of the evaluation phases is as follows:

**Inception phase (two weeks):** During this phase, the evaluation team is expected to gain a deep understanding of the proposed documentation, assess possible information gaps, refining the scope, methods, and critical stakeholders. The main deliverable for this phase will be a short inception report, presenting a detailed description of the final scope; revised methodological approach, including any data collection and analytical instruments; preliminary evidence from the initial desk review and critical informant consultations; as well as the structure of the final report and an updated timeline for deliverables. It is expected that a short meeting will be planned with the Steering Committee/Reference Group and Internal Technical Working Group for the presentation of the inception report plan and discussion.

**Data collection and analysis phase (eight weeks):** Additional documentation, secondary and primary data will be collected using instruments previously piloted during the inception phase. The main deliverable for this phase is all data gathered is analyzed, including preliminary data, stored in a secure repository, cleaned, and processed to ensure the anonymity of key informants**. A presentation with emerging findings is also expected during this phase. Meetings with the Steering Committee/Reference Group and Internal Technical Working Group will be scheduled.**

**Report drafting and dissemination phase (ten weeks):** The main deliverables for this phase are the preliminary draft of the final report and the final agreed report. In addition, it is expected that the main findings, conclusions, recommendations, and lessons learned will be presented to the Steering Committee/Reference Group and other relevant stakeholders, with a stand-alone Evaluation Brief and PowerPoint to be delivered. Additionally, it is anticipated that the firm will submit the evaluation for publication in peer-reviewed journals.

- Other interim products are:
- Minutes of key meetings with the Reference Group;
- Monthly progress reports;
- Copy of the anonymised data collected during the evaluation;
- Manuscript for publication in peer-reviewed journals; and
- Presentation materials for the meetings with the Steering Committee/Reference Group and Internal Technical Working Group. These may include PowerPoint summaries of work progress and conclusions to that point.

## Footnotes

[1] The HER/NFA program encompasses all three service packages (BPHS, EPHS, and HIVA), currently funded by the World Bank in 24 provinces and the ADB in 10 provinces. Please note that before 2024, BPHS and EPHS packages were funded by the World Bank in 34 provinces and the ADB funding HIVA package in 9 provinces under NfA 1.0.

[2] As HIVA is still in its early stages with varying levels of implementation, this assessment will also serve as a critical baseline to establish the current landscape, measure initial conditions, and provide a foundation for tracking progress and impact over time.

[3] SAGE Publications. (2019). *Quasi-experimental and single case designs*. Available at: https://us.sagepub.com/sites/default/files/upm-binaries/89876_Chapter_13_Quasi_Experimental_and_Single_Case_Designs.pdf

[4] Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Available at: https://www.courses.sas.upenn.edu/opus/course/soc-259c/

[5] Harris AD, McGregor JC, Perencevich EN, Furuno JP, Zhu J, Peterson DE, Finkelstein J. (2006). *The use and interpretation of quasi-experimental studies in medical informatics.* Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC1380192/

[6] Rosenbaum, P. R., & Rubin, D. B. (1985). *Constructing a control group using multivariate matched sampling methods that incorporate the propensity score*. The American Statistician, 39(1), 33-38. Available at: https://doi.org/10.1080/00031305.1985.10479383

[7] Angrist, J. D., Pischke, J. S. (2009). *Mostly Harmless Econometrics: An Empiricist's Companion*. Princeton University Press. Available at: https://press.princeton.edu/books/ebook/9781400830391/mostly-harmless-econometrics

[8] The Tanahashi framework defines effective coverage as the outcome of a sequential process, where each stage adds conditional factors that determine health system performance for a given intervention. It measures five key determinants, from availability coverage (service accessibility) to effective coverage (proportion of individuals receiving quality care that leads to health benefits). Identifying and analyzing gaps at each stage helps pinpoint system inefficiencies, address barriers, and guide resource allocation for improvements. The framework will be further examined and incorporated into the inception report.

The Abridged Terms of Reference (April 2025) made available by UNICEF Afghanistan is provided for reference here.

## Annex 2. Evaluation Team

Our evaluation team brings together highly qualified and dedicated international and local experts to undertake the evaluation activities. The ORB team comprises research and technical experts who bring in-depth knowledge of and extensive experience in conducting rigorous evaluations of health programs, including in Afghanistan and other conflict-affected areas.

**Dr. Yuliya Dudaronak**, our team leader and Senior Evaluation Specialist, is a research director with over 10 years of mixed-method research experience, including survey data design, collection and analysis. She has experience working in countries all over the world, with a focus on the Middle East and Africa. Her research work in Afghanistan has included serving as the Project Lead for a multi-wave, nationally representative, quantitative study seeking to better understand international relations, domestic issues, and security within the country. She has also worked on multiple projects focusing on health outreach in various LMICs for the Gates Foundation, with research topics including evaluations of women's health initiatives, COVID-19 perceptions, and vaccine acceptance/hesitancy. Her analytical experience includes inferential and target audience analysis. Her other past research includes research topics such as health, distribution of aid, gender, human rights, security, and governance, with a focus on conducting evaluations in environments with internal displacement or refugee populations. Dr. Dudaronak holds a PhD in Sociology from the University of Virginia.

**Dr. Averi Chakrabarti**, our quantitative lead and health expert, is an Economist at AIR with over 10 years of experience using quantitative research methods to investigate issues related to health, nutrition, gender, child well-being and social protection in LMICs. Dr. Chakrabarti has published in peer-reviewed journals such as BMJ Open, Plos Global Public Health, Journal of Adolescent Health, Public Health Ethics, SSM-Population Health, Journal of Development Economics and Food Policy. Her publications are on topics such as routine child immunizations in India during the COVID-19 pandemic, the impact of supplementary immunization activities on routine vaccination coverage in LMICs, deforestation and infant mortality in Indonesia, HIV testing among the partners of adolescent girls in Kenya, the effects of cash transfers on child nutritional status in Zambia, and the influence of diet-focused behavioral interventions on non-communicable diseases in LMICs. Her current and recent work includes leading an impact evaluation of an adolescent health intervention in India; providing advisory services for the Gates Foundation to establish and maintain a monitoring system to assess the effectiveness of digital financial services programming across multiple countries; designing and implementing evaluations of school interventions in rural Zambia. Dr. Chakrabarti holds a PhD in Public Policy from the University of North Carolina at Chapel Hill and has previously held public health research fellowships at Harvard University and the University of Pennsylvania. She is fluent in English and Bengali.

**Dr. Rebecca Walcott**, the costing lead and health expert, is an Economist in the International Development Division at AIR. Dr. Walcott specializes in economic evaluation, quantitative analysis, program evaluation, and applied policy analysis. She brings 10 years of experience developing costing tools and has conducted economic analyses for health initiatives, ECD programming, and education interventions. She currently leads the cost study component and financial analysis of a mixed-methods evaluation of the UNICEF-funded Philippine Multisectoral Nutrition Project, as well as a cost study for a Gates-funded education initiative in Senegal. Previously, she contributed to a global synthesis of cost-effectiveness evidence for nutrition-sensitive interventions and led an ROI analysis for an undergraduate education program that estimated benefits in terms of future earnings potential. She has published peer reviewed journal articles on the economic burden of tuberculosis, the implications of state COVID-19 policies, and multiple evaluations of health interventions. Dr. Walcott has experience collaborating in multidisciplinary teams

with partners at local, state, national, and international levels. Dr. Walcott holds a Ph.D. in Public Policy from the University of Washington.

**Ms. Sandra Boisvert**, the qualitative lead, holds an M.A. in Economics from the University of British Columbia and has over 6 years of experience conducting impact evaluations for development programming. Since joining ORB, Sandra has managed evaluative research projects across 16 countries, including leading client management, data collection, quality control, and analysis. Previous research has focused on governance, foreign affairs, and evaluation of information campaigns. Her extensive analysis experience includes segmentation, spatial, and regression analysis. Previously, Sandra worked with the World Bank as acting project manager for impact evaluation projects, taking responsibility for collection, management and handling of administrative and primary datasets, writing well-documented, reproducible code, and creating descriptive statistics, regression analysis, literature reviews, data visualization, and spatial analysis as per project needs.

**Dr. Marlous de Milliano**, the QA Reviewer, is a senior economist at AIR with 12 years of experience in socio-economic research focused on child well-being, nutrition, health, ECD and social protection in development and humanitarian settings. At AIR, she has been the team lead or quantitative lead for over 15 evaluations and studies, including ten UNICEF-funded studies. Dr. de Milliano is very familiar with the complexities of conducting research in humanitarian and conflict-affected settings, contributing to studies on displaced populations and crisis affected communities for clients including the World Bank Group, the World University Service of Canada, UNHCR and UNICEF. Her current and recent work includes a UNHCR-funded multi-country mixed methods impact evaluation of cash-based interventions in humanitarian settings; a UNICEF Malawi-funded evaluation of the impact of shocks on household well-being outcomes including health and nutrition. She was also recently the team lead on a UNICEF evaluation of the NICHE program in Kenya, a cash plus program targeted at pregnant women or women with a child below the age of three who receive a cash top-up, nutrition and health counselling and parenting messages. As part of this evaluation, Dr. de Milliano conducted a cost-efficiency analysis of the various components of the integrated service package. Dr. de Milliano holds a PhD in Public Policy from the University of North Carolina at Chapel Hill.

**Ms. Angela Moturi**, the quantitative research assistant, based in Nairobi, Kenya holds a master's in public health (MPH, Environment and Health) from the London School of Hygiene and Tropical Medicine. She brings experience in health program evaluations, routine data systems strengthening and development research. Her work has focused on leveraging geospatial techniques in uncovering geographic disparities in health, education and gender metrics in Sub Saharan Africa. Some of her work has been published in several peer-reviewed public health journals including the Malaria Journal and BMC Health Services Research.

**Ms. Rebecca Ford**, the qualitative research assistant, holds an M.S. in Clinical Mental Health Counselling from Syracuse University and has over 3 years of experience in international qualitative research. She has experience working across Latin and South America, Africa, and Asia, including direct research experience in twenty-three countries. Her areas of focus center on public health, social inequalities, and international development, but have also included topics such as security, governance, and green energy. She is experienced in managing all aspects of the qualitative research project, including instrument design, translation, training, fieldwork management, conducting In-Depth Interviews (IDIs), data cleaning, and analysis. She is very familiar with the complexities and unique problem solving necessary to conduct qualitative research in challenging environments, having recently conducted elite interviews across remote parts of Africa and South Asia with constantly changing environments and limited access to internet. She also has experience conducting interviews with elite experts in sectors such as public policy,

security, and governance. Rebecca's previous projects include managing multi-country studies evaluating the strength of local health systems for capacity-building initiatives.

**Ms. Lauren Lash**, the primary data collection research assistant, holds a B.A. in Middle Eastern Studies and biology from the University of Virginia and has over 3 years working across various research fields. She has worked in countries across the Middle East and Africa, focusing on quantitative work. Her areas of focus include the sociopolitical environment(s) of the Middle East and North Africa, governance systems in the MENA region, and survey development. She is very familiar with conducting fieldwork in difficult environments, having worked on quantitative surveys measuring quality of life and aid assistance in refugee camps in conflict regions. Her work in aid evaluation also extends to include mixed-methods evaluations of cash-based interventions, leaning on knowledge of vulnerable aid distribution and socioeconomic consequences of migration.

**Ms. Alexis Eck**, the primary data collection research assistant, holds a B.A. in Global Studies with a concentration in Global Public Health from the University of Virginia and has over 3 years working in quantitative research. Since joining ORB, Alexis has executed health, gender, and security related research projects, including managing fieldwork for nationally representative surveys in South and Southeast Asia and Sub-Saharan Africa. Specifically, Alexis contributed to a multi-national survey measuring confidence in the Human Papillomavirus (HPV) vaccine, giving her experience providing culturally informed health recommendations. She is well-versed in ORB's sampling, fieldwork management, and quality control procedures and will contribute to data cleaning, analysis, and reporting.

## Annex 3. Roles and Responsibilities

*Table 15. Team Composition*

| Team member | Expertise | Role | Responsibilities |
|---|---|---|---|
| **Yuliya Dudaronak** | Impact evaluation<br>Team management | Team leader / Senior Evaluation Specialist | Project management, stakeholder communication, reporting results, and oversight of project activities and timeline |
| **Averi Chakrabarti** | Quantitative methods<br>Health Research<br>Research design<br>Technical expertise | Health Expert/ Quantitative Lead | Quantitative research design, enumerator training, analysis, writing, and reporting results |
| **Sandra Boisvert** | Qualitative methods<br>Research design<br>Technical expertise | Qualitative Lead | Qualitative research design, enumerator training, analysis, writing, and reporting results |
| **Rebecca Walcott** | Quantitative methods<br>Health research<br>Cost analysis<br>Technical expertise | Health expert/ Costing Lead | Cost-efficiency research, analysis, writing, and reporting results, providing health expertise to quantitative team |
| **Marlous de Milliano** | Impact evaluations<br>Technical expertise | Quality assurance reviewer | Project oversight and quality review |
| **Angela Moturi** | Quantitative methods and analysis | Quantitative Research Associate | Quantitative data cleaning and analysis, literature review, and writing |
| **Rebecca Ford** | Qualitative methods and analysis | Qualitative Research Associate | Qualitative data cleaning and analysis, project admin, literature review, and writing |
| **Lauren Lash** | Team management<br>Technical expertise | Primary data collection Research Associate | Data collection team oversight, recruitment, and training |
| **Alexis Eck** | Team management<br>Technical expertise | Primary data collection Research Associate | Data collection team oversight, recruitment, and training |

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# Annex 5. Evaluation tools

## General informed consent form

Hello, it is nice to meet you. We are from an evaluation team assessing health capacity and outcomes in Afghanistan. *[The purpose will be added based on the type of stakeholder, more information ae reflected below in the tools].*

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 anonymized 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.

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 will never be published.

I would like to record this discussion so that I have an accurate record of our conversation. It will only be accessed by evaluators 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 both interview and recording?

[Wait for response]

If yes, proceed. If not, terminate.

## Observation Instrument

| | | |
|---|---|---|
| Module A: Introduction | | |
| Date | Date | Day:<br>Month:<br>Year: |
| Enum_ID | Enumerator ID | |
| Adm1 | Region | |
| Adm2 | Province | |
| Adm3 | District | |
| Facility | Facility ID | |
| Facility_name | Facility name | |
| Photo_verify1 | *Enumerator: Please take a photo of the entrance of the health facility including the health facility name/sign* | Photograph |
| contact | *Enumerator: Identify the person in charge of the facility (or the senior most person who is available today).* | |
| Consent | Enumerator to read out: We are from a research team assessing health capacity in Afghanistan's health facilities. To help us understand your services, the population you serve and the challenges you face, we would like to ask you - the person in charge of your facility (or the senior most person who is available today) some questions about your infrastructure, staff, patients and related topics. We will also walk around and take some notes based on our observations. In addition, we will ask select health workers and patients some questions about their work. All information you provide will be kept strictly confidential by the research team and will be used only for the purposes of this study. Your name and any personally identifiable information (PII) will not appear in any report, publication, or presentation. However, confidentiality has limits: if during this study you disclose any information regarding the abuse of a child or other criminal behavior, we are required by law to report it to the appropriate authorities. We will take photographs strictly for quality control purposes. These images will be reviewed only by the research team and will not include identifiable features such as faces.<br><br>Do you consent to participate in our visit? | 0 = No >> End of interview. (final outcome = refused)<br><br>1 = Yes |
| Resp_name | Name of respondent | |
| Resp_gender | Respondent gender | 1 = Female<br>2 = Male |
| Module B: Infrastructure, staffing and service proxies | | |
| Catchment_aware | Do you know how many people reside in the area that is serviced by your health facility? | 0 = No<br>1 = Yes >> skip next question |

| | | |
|---|---|---|
| | Enumerator: Encourage the respondent to provide an estimate if they are uncertain. | |
| Catchment_aware1 | [if catchment_aware = 0] Does anyone else working at this facility today know how many people reside in the area that is serviced by the health facility? | 0 = No<br>1 = Yes |
| Catchment_respondent | [if catchment_aware = 0] Enumerator: Ask to speak to the person who knows the catchment population | |
| Catchment_size | [if catchment_aware = 1 or Catchment_aware1 =1] How many people reside in your health facility catchment area?<br>Enumerator: If the respondent cannot give a precise number encourage them to provide an estimate | Integer ( must be great or equal to 0) |
| Patient_volume | On average, how many patients visit this facility during a typical week?<br><br>Enumerator: If the respondent is unsure of the 'typical week', ask them for an estimate for the past week. | Integer ( must be great or equal to 0) |
| Travel_duration | How long do most of your patients travel to reach your facility? | 1 = Less than 30 minutes<br>2 = 30-60 minutes<br>3 = More than 60 minutes |
| Travel_mode | By what transportation mode does most of your patients travel to reach your facility? | 1= By foot<br>2=Bicycle<br>3= Bus or communal van<br>4= Motorcycle<br>5= Car<br>6= Taxi<br>97 = Other (Specify)<br>98 = Don't Know |
| Phone_available | Does your facility have a dedicated working phone available for communication with a general hospital or other services you might want to seek advice from or refer patients to? | 0 = No<br>1 = Yes |
| *Thank you for your response. Can you please show me where the patient rooms are located so that I can verify the number of patient rooms within the facility?* | | |
| *Enumerator: Answer the following question based on your observations* | | |
| Electricity_available | Does there appear to be working electricity in the health facility?<br>Enumerator: If lights are off, turn a light on to check. | 0 = No<br>1 = Yes |
| Number_rooms | How many rooms appear to be used in the facility for patient services?<br><br>*Enumerator: Including rooms patients are waiting in to be seen.* | Integer (must be great or equal to 0) |
| Room_privacy | Does it appear that the patient consultation rooms afford confidentiality to patients? | 0 = No<br>1 = Yes, full privacy<br>2= Yes, some privacy |
| Photo_verify2 | Enumerator: Take a photo of an empty patient room | Photograph |
| Waiting_room | How many patients can you see waiting to see a healthcare provider? | Integer (must be great or equal to 0) |
| Enumerator: Ask the following questions to the respondent | | |
| Healthworkers_all | How many health workers work at this facility? | Integer (must be great or equal to 0) |

| | | |
|---|---|---|
| Healthworkers_today | How many health workers are present in the facility today? [Cannot exceed healthworkers_all] | Integer (must be great or equal to 0) |
| Healthworkers_female | How many of these health workers are female? [Cannot exceed healthworkers_all] | Integer (must be great or equal to 0) |
| *Enumerator: Ask to see the health facility's laboratory?* | | |
| Enumerator: Answer the following questions based on your own observation | | |
| Lab_services | Can you confirm that the facility has a space to provide laboratory services? | 0 = No<br>1 = Yes |
| Photo_verify3 | [if lab_services = 1] Enumerator: Take a photo of the laboratory | Photograph |
| Lab_tech | [if lab_services = 1] Is there a medical laboratory technician available in the facility today? | 0 = No<br>1 = Yes |
| Waste_pit | Does the facility have a waste pit available for use?<br>**Reminder: a waste pit is a designated underground area, lined or unlined, covered with a lid used for the safe disposal of oftentimes hazardous healthcare waste.** | 0 = No<br>1 = Yes |
| Waste_pit_features | [if waste_pit=1] Please examine the waste pit and select all of the relevant safety features of the waste pit: (SELECT ALL THAT APPLY) | 1= A closed lid<br>2 = Proper signs<br>3= Fencing or concrete surrounding<br>4 = No visible external spillage<br>96 = None of the above |
| Waste_pit_check | [if waste_pit = no] Please ask the respondent how they dispose of hazardous medical waste. | 1. Incinerator<br>2. Trash cans<br>3. Other (specify)<br>99 Don't know/No response |
| Photo_verify4 | [if waste_pit = 1] Enumerator: Take a photo of the waste pit | Photograph |
| Toilet_male | Is there a toilet facility available for male patients and/or staff to use? | 0 = No<br>1 = Yes |
| Toilet_female | Is there a toilet facility available for male patients and/or staff to use? | 0 = No<br>1 = Yes |
| [if toilet_male = yes OR toilet_female = yes] *Enumerator: Enter one of the toilets at random (alternate male, female toilets each visit): if there is more than one [male/female] bathroom that is available to enter, go to the second one on the left.* | | |
| Toilet_sanitary | [if toilet_male = yes OR toilet_female = yes] How clean is the toilet facility? | 1 = Very clean<br>2 = Moderately clean<br>3 = Dirty |
| Water_available | [if toilet_male = yes OR toilet_female = yes] Is water available for use in the toilet facility? | 0 = No<br>1 = Yes, collected water<br>2= Yes, tap water (with running water)<br>3= Yes, other (specify) |
| Photo_verify5 | [if toilet_male = yes OR toilet_female = yes] Enumerator: Take a photo of the bathroom | Photograph |
| Stock | *Enumerator: Ask the health facility representative to show you their stocks for the following drugs/commodities.* | |

| | | |
|---|---|---|
| | Does the facility have any existing stocks of: | |
| Stock_condoms | Condoms | 0 = No<br>1 = Yes |
| Stock_oral | Oral contraceptives (COC, POP) | 0 = No<br>1 = Yes |
| Stock_para_liquid | Paracetamol (acetaminophen) 120 mg/5 ml, in 60 ml (Syrup) | 0 = No<br>1 = Yes |
| Stock_para_tab | Paracetamol (Acetaminophen) 500 mg (Tab) | 0 = No<br>1 = Yes |
| Stock_misopro | Misoprostol 200 µg (Tab) | 0 = No<br>1 = Yes |
| Stock_ORS | Oral rehydration salts (ORS) 20.5 g (Powder) | 0 = No<br>1 = Yes |
| Stock_syringe | Syringes (for immunization, among other services) | 0 = No<br>1 = Yes |
| Stock_coldpacks | Cold boxes and/or cold packs | 0 = No<br>1 = Yes |
| Module C: Verification of health records | | |
| *Enumerator: Ask to see the facility's records and type in information for the following indicators for the last month:* | | |
| Records_when | What month are you recording data for? | MONTH SELECTION |
| ENUMERATOR: INDICATE NUMBER OF REPORTED CASES FOR THE MONTH OF [INSERT MONTH | | |
| Records_drha_1 | Diarrhea – Acute watery (With dehydration) – New Total | Integer (must be great or equal to 0) |
| Records_dhra_2 | Diarrhea – Acute watery (Without dehydration) New Total | Integer ( must be great or equal to 0) |
| Records_hprt_new | Hypertension – New Total | Integer ( must be great or equal to 0) |
| Records_diabetes | Diabetes Type 2 – New total | Integer ( must be great or equal to 0) |
| Records_newborn | Newborn alive – Number of cases | Integer ( must be great or equal to 0) |
| Record_mental_new | Severe mental disorder – New Total | Integer ( must be great or equal to 0) |
| Record_measles | Measles (first dose) 0-11m | Integer ( must be great or equal to 0) |
| Photo_verify6 thru 8 | Three goods will be randomly selected for photo verification | Photograph x 3 |
| Thank you for your assistance. I will now be required to conduct a brief interview with a doctor who is available for a 5-minute conversation. Is a doctor available right now or should I take a seat in the waiting room?<br><br>Enumerator: Please wait for a doctor to become available. If necessary, you can schedule an appointment for later in the day to complete the survey. | | |
| Module D: Health worker reports | | |
| *Enumerator: Approach one of the health workers not busy seeing patients and ask them the following questions* | | |
| Consent_2 | Enumerator to read out: We are from a research team assessing health capacity in Afghanistan's health facilities. To help us understand your services, the population you serve and the challenges you face, we would like to ask you | 0 = No >> Enumerator: please find another doctor or nurse that is available to answer this interview. |

| | | |
|---|---|---|
| | a couple questions about your experience in this workplace. All information will remain confidential and anonymous.<br><br>Do you consent to participate in our visit? | 1 = Yes |
| Staff_gender | What is your gender? | 1= Female<br>2=Male |
| Training_any | Have you received training on gender-based violence in the past while working at this facility? | 0 = No<br>1 = Yes<br>98 = Don't Know<br>99 = No Response |
| Training_when | [IF training_any =1] When was the last time you received training on gender-based violence while working at this facility? | DATE SELECTION<br>98 = Don't Know<br>99 = No Response |
| Salary_receive | Have you received salary for the past 3 months within 10 days of the end of each month? | 0 = No<br>1 = Yes<br>98 = Don't Know<br>99 = No Response |
| Salary_how | How are you paid your salary from this facility?<br>SELECT ALL THAT APPLY. | 1 = Bank transfer<br>2 = Cash<br>3 = Other (specify)<br>98 = Don't Know<br>99 = No Response |
| Drugs_available | Think about the patients you saw in the last 7 days. How much of the time did your facility have availability of the drugs you wished to prescribe to your patients? | 1 = All of the time<br>2 = Most of the time<br>3 = Some of the time<br>4 = None of the time |
| Comment: Enumerator, leave any additional comments you may have regarding your visit. | | |

## FGD Guides

**FGD Consent Form**

**Informed Consent – Afghanistan Health System Study Focus Group Discussions (FGDs)**

Hello, My name is [Moderator Name], and I work on behalf of the Opinion Research Center of Afghanistan (ORCA), an organization that carries out research activities throughout your country.

Study Objectives: I am with a team that is conducting interviews to learn more about the Afghan healthcare system, your experiences within the system, and how you have seen the system change throughout recent years.

IF HEALTH PROFESSIONAL OR COMMUNITY HEALTH WORKER: You have been selected to participate in this discussion because of your firsthand experience working within the healthcare system. We are interested in learning more about the insight that you have collected during your time providing patient care.

IF COMMUNITY MEMBER: You have been selected to participate in this discussion due to your residency in the catchment area of one of our facilities of interest. We are interested in learning more about your experience receiving care, and those that you have observed of your fellow community members.

This conversation will last approximately 90 minutes. Before we proceed, I will read you your rights as a participant in this research.

Risks and Benefits to Participants: Participation in this study is not expected to pose any physical, psychological, or social risks. You are free to skip any question you do not wish to answer. There are no direct financial benefits to you for participating, but your contribution will help improve health services in Afghanistan.

Confidentiality and Mandatory Reporting: All information you provide will be kept strictly confidential by the research team and will be used only for the purposes of this study. Your name and any personally identifiable information (PII) will not appear in any report, publication, or presentation. However, confidentiality has limits: if during this study you disclose any information regarding the abuse of a child or other criminal behavior, we are required by law to report it to the appropriate authorities. Additionally, in order to preserve the privacy of fellow respondents, you are asked to keep the group discussion confidential. Due to the group environment of the discussion, the research team cannot guarantee that fellow participants will maintain the confidentiality of the discussion.

Use and Potential Reuse of Data: Data collected during this study will be analyzed and stored in a secure database. A de-identified dataset (with all personal identifiers removed) may be created for analysis and may be archived for future research related to the efficiency of the healthcare system. Data will not be used for any purpose unrelated to this study.

Respondent Rights: You have the right to refuse to participate, not answer all questions, or leave the interview at any time. With this understanding, we encourage you to share openly and honestly throughout this discussion.

Video and Audio Recording and Disclaimer: This interview will be audio recorded, and may be video recorded with your permission, so that we can ensure we have accurately captured your views. Audio recordings are a requirement to continue with the interview, with video recording being optional but encouraged. Any audio and video recordings will remain exclusively with ORCA and our partner.

Silent Observers: This interview may be livestreamed (audio and video) to members of the research team. You will not be able to see or hear the observers, and so the presence of any silent observers should not impact your ability to remain open throughout the interview. We assure any livestreaming will be done through private platforms and will be observed exclusively by our research team.

Sensitivities: Please note that this discussion may address topics that you find painful, distressing, or otherwise difficult to speak about openly. We encourage you to bear this mind in agreeing to participate. Please let us know if you have any objection to participating in this interview and also if you have any questions before we start.

If you have any questions after you have completed the interview, please reach out to the following contact:

Bilal Ahmad, Project Manager (ORCA), bilal.ahmad@orca.com.af

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Are you willing to participate in this interview? Yes / No (Circle the respondent's choice)

Are you willing to have this interview livestreamed to our research staff? (Must be 'Yes' to video record) Yes / No (Circle the respondent's choice)

May I audio record this interview? (Must be 'Yes' to participate) Yes / No (Circle the respondent's choice)

May I video record this interview? (Must be 'Yes' to video record) Yes / No (Circle the respondent's choice)

Respondent's Signature: _____Oral Consent Given:_____

Moderator's Name: _____Signature:_____ Date:_____

**Health Professionals FGD Guide**

## Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from UNICEF-supported health facility professionals.*

There will be four (4) total health professional FGDs (two HER and 2 HER + HIVA).

## Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 90 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
Before we start, do you have any questions for me?

## Introduction Questions

I'd like to open with a discussion about your specific role working in a health facility in Afghanistan.

1. Can you describe the nature of your role in your health facility?
    a. What kind of facility do you work at? What is your specific role/job title? What services are you responsible for providing?
2. How long have you been working in healthcare? Throughout that time, have you worked for the same facility, in a similar role?

## Program Design Questions

As you may know, in 2021 the management of many public healthcare facilities in Afghanistan transitioned from the Ministry of Public Health to the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). Starting in June 2022, UNICEF took sole responsibility for the administration of these health service facilities in Afghanistan through the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) programs. These programs provide funding for the Afghan public health system and are the basis of the Basic Package of Health Services (BPHS), Essential Package of Hospital Services (EPHS) , and High Impact Value Addition (HIVA) services which are provided at your facility.

We want to ask you some questions about UNICEF's HER/NFA program and how it has been implemented in your facility.

3. First, I want to ask you about your experience working in the healthcare system before the implementation of the HER/NFA program.
    a. In your experience, what were the main shortcomings of the healthcare system in Afghanistan, BEFORE the transition to UNICEF management in June 2022? Do you think these issues have since been addressed, or are being addressed, after implementation?

## Program Delivery Questions

4. Since the transition to HER/NFA in 2022, what changes have been made, if any, that most impact your ability to perform your job on a daily basis?
    a. In your opinion, how do these changes impact the community that the health facility serves? Have these changes resulted in any unexpected or unintended outcomes?

5. How much do you think the **availability of basic health services** for your patients has changed since the transition to sole UNICEF management in June 2022?
    a. Since the transition…
        i. Have you noticed a change (positive or negative) in patient volume?
        ii. Have you noticed a change (positive or negative) in the availability of essential health supplies in your facility? Please explain.
        iii. Have you noticed a change (positive or negative) in the facility's available resources needed to run the facility (ex. Clean water, electricity, sewage, temperature regulated medication storage)?
    b. In your opinion, have any of these changes led to increased healthcare use in your community?

6. How much do you think the **quality of health services** has changed for your patients since the transition to sole UNICEF management in June 2022?
    a. Since the transition…
        i. Has there been a change in the time it takes for patients to receive care? Please explain.
        ii. Has your facility implemented new quality of care standards or changes in how quality of care is monitored? Please explain.
        iii. Have you noticed a change in the number of training and capacity building opportunities for you or your colleagues?
            a. **Optional**. If yes, do you believe that these have led to improvements in the quality of care provided to patients? Across what areas? Please explain.
            b. If your facility participates in community outreach programs, has there been any change in these programs? This can be in the frequency or quality of the programs.

7. **PRIORITY.** How much do you think **patient health outcomes have changed** since the transition to sole UNICEF management in June 2022? Since the transition,

a. **Have you noticed any changes to issues concerning maternal and fetal health since the transition?**
b. **PRIORITY. Have you noticed increased numbers of births and c-sections since the transition?**
c. Have you noticed any changes in vaccination rates since the transition to UNICEF management
d. Have you noticed any changes in the prevalence of child malnutrition since the transition to UNICEF management?
e. Would you attribute these changes to the new healthcare program or to external factors? Please explain.

8. How effectively do you think health professionals are supported under HER/NFA?
    a. Has there been a noticeable change in the compensation of employees at your health facility? This can be in the amount, frequency, or quality of the compensation.
    b. Optional. How satisfied with you with your current compensation?

9. Overall, what do you think are the biggest challenges in delivering quality care under the health system management since June 2022?
    a. How, if at all, do you think UNICEF's program could do a better job of alleviating these challenges impact efforts?
    b. Do you feel that your feedback reaches decision-makers? Why or why not?

10. Right now, in what areas do you feel most supported by your facility management and the greater healthcare system? How does this help you perform better as a healthcare provider?
    a. Has your trust in the health system improved or declined since 2022?

## Considering At-Risk and Vulnerable Groups

11. When providing care to your patients, do you find it difficult to support certain people from different groups (for example, women, children, people with disabilities, detained persons)?
    a. If so, why do you think this is? Is it a lack of training on how to address their needs, a lack of resources to provide specialized care, barriers to these groups seeking care, or something else?
    b. Optional. What changes do you think would be most impactful in alleviating these issues?
    c. To what extent do you believe the community that you service is able to identify female health emergencies?

12. **PRIORITY.** From your experience, how have women been involved (or excluded from) the provision of healthcare in your community?
    a. If you are a woman, what was the experience like of attaining your medical training? What challenges existed for you?
    b. Do you and your colleagues receive gender awareness training? If so, how often? Do you feel these training are impactful?
    c. How do you think the current involvement of women in healthcare affects patient outcomes?

d. What do you think has been missing from UNICEF'S efforts to improve equitable healthcare access and outcomes in your community? Is there anything you would change or add?

## Overall Implementation and Sustainability

Finally, I'd like to ask you some questions about the sustainability of the HER/NFA and how your facility will function long term.

13. Overall, do you see any issues with sustaining the level of functionality and the quality of care that your health facility is currently providing?

14. Based on any changes that you have seen in your facility since the implementation of HER/NFA in June 2022…
    a. Do you think that program's efforts will help improve access to health facilities in your community? Why or why not?
    b. Do you think that program's efforts will help improve the quality of healthcare in your community? Why or why not?

Thank you for your time.

**Community Health Workers FGD Guide**

## Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from UNICEF-supported health post professionals.*

There will be four (4) total community health worker FGDs.

## Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 90 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

## Introduction Questions

I'd like to open with a discussion about your specific role working as a community health worker in Afghanistan.

1. Can you describe the nature of your role providing healthcare to your community?
    a. Please describe the health posts that you work for. What services are you responsible for providing? What community outreach programs do you service, and what do you do for them? How long have you worked in health services in this community?

## Program Design Questions

As you may know, starting in June 2022, UNICEF took sole responsibility for the administration of the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) programs. These programs provide funding for the health services which are provided in your community.

We want to ask you some questions about how the HER/NFA program has been implemented in your community and how that impacts your daily work as a Community Healthcare Worker.

2. I want you to think about your experience working as a community healthcare worker SINCE the HER/NFA program began servicing this area starting in 2022.
    a. What has been the biggest frustration with the healthcare system in general since this transition?
    b. What about your biggest frustration specifically working at your health posts? Have you heard of your colleagues mention any specific frustrations either?
        i. How do these issues affect your ability to provide high quality, timely care to your patients?
    c. What change(s) do you think would be needed to overcome those barriers in the future? Please explain.

## Program Delivery Questions

3. Since this community has been serviced by the HER/NFA program starting in 2022, what changes have been made, if any, that most impact your ability to perform your job on a daily basis?
    a. In your opinion, how do these changes impact your community? Have these changes resulted in any unexpected or unintended outcomes?

4. How much do you think the **availability and quality of basic health services** for your patients has changed since the transition to sole UNICEF management in June 2022?
    a. Since the transition…
        i. Have you noticed a change (positive or negative) in the number or nature of patient referrals to/from health facilities in your community? Please explain.
        ii. Have you noticed a change (positive or negative) in the availability of essential health supplies at your post? Please explain.
        iii. Has there been any change in the quality, frequency, or nature of the community outreach programs that you provide? This can be in the frequency or quality of the programs.
        iv. Have health posts in your community implemented new quality of care standards or changes in how quality of care is monitored? Please explain.
    b. In your opinion, have any of these changes led to increased healthcare use in your community? Has it led to improved health?

5. How effectively do you think health professionals are supported under the HER/NFA program (since 2022)
    a. Does anything prevent you from providing quality healthcare? Please explain why or why not.

6. Right now, in what areas do you feel most supported by your health post management, parent facility, and greater healthcare system? How does this help you perform better as a healthcare provider?
    a. Has your trust in the health system improved or declined since 2022?

## Considering At-Risk and Vulnerable Groups

7. When providing care to your patients, do you find it more difficult to support certain people from different groups (for example, women, children, people with disabilities, detained persons, people speaking different languages)?
    a. If so, why do you think this is? Is it a lack of training on how to address their needs, a lack of resources to provide specialized care, barriers to these groups seeking care, or something else?
    b. What changes do you think would be most impactful in alleviating these issues?
    c. To what extent do you believe the community that you service is able to identify female health emergencies?

8. From your experience, how have women been involved (or excluded from) the provision of healthcare in your community?
    a. If you are a woman, what was the experience like of attaining your medical training? What challenges existed for you?
    b. Do you and your colleagues receive gender awareness training? If so, how often? Do you feel these training are impactful?

c. How do you think the current involvement of women in healthcare affects patient outcomes?

9. Do you care for populations in primarily urban areas, rural areas, or both? In your opinion, how (if at all) does geographic location contribute to health access and outcomes in your community and surrounding communities? Do you know of people who struggle to seek care because of distance or lack of transportation to the nearest health post?
    a. If so, has this gotten better, worse, or stayed the same since June 2022?

10. Overall, since June 2022, would you say that health equity in your community is improving? Think of both healthcare **access** and **provisions** for at risk groups?
    a. What do you think has been missing from UNICEF'S efforts to improve equitable healthcare access and outcomes in your community? Is there anything you would change or add?

11. **PRIORITY.** Have you distributed information to the community you serve to reduce the incidence or severity of diarrhea?
    a. Have you followed any other procedure by guidance of the local health facility to reduce the incidence of diarrhea, and if yes what are they?
    b. How effective do you believe these interventions have been at reducing and preventively treating cases of diarrhea?
    c. IF yes to any of the above efforts: Have these efforts been guided by the recommendation of your parent health facility or elsewhere?

## Overall Implementation and Sustainability

Finally, I'd like to ask you some questions about the sustainability of the HER/NFA and how the community health system will function long term.

12. Overall, do you see any issues with sustaining the level of functionality and the quality of care that your health post is currently providing? Please explain.

13. Based on any changes that you have seen in your community health posts since the implementation of HER/NFA in June 2022…
    a. Do you think that program's efforts will help improve access to health posts and quality of care in your community? Why or why not?
    b. Do you think that program's efforts will help improve health outcomes over the long-term? Why or why not?

Thank you for your time.

**Community Members FGD Guide**

## Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from Community member FGDs.*

There will be four (4) total Community Members Focus Group Discussions.

## Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 90 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

## Introduction Questions / Warmup

1. Please tell me a little bit about your role in your community.

As you know, the health care system in Afghanistan has suffered in the past decade due to volatility caused by conflict, and exacerbated from internal displacement, increased poverty, loss of livelihood, increased food insecurity, malnutrition, and ongoing disease outbreaks.

2. Have you seen firsthand how these factors have impacted the quality of health care in your community?
    a. Which, if any, of these elements, have you heard about or experienced?

## Understanding Barriers to Healthcare

3. I'd like to start by asking, for you personally, what are the main reasons that you would get health services from your local health facility? Do you attend the health facility for urgent care, for vaccines and disease prevention, for disease and illness treatment, surgical procedures?
    a. How likely are you to go to the health facility if you feel sick? Please explain.
    b. Generally speaking, do you trust in health professionals to take care of you and improve your health when you feel sick? Why or why not?

4. In your community, are there any physical or geographic barriers that prevent you or someone you know from accessing healthcare? These could be things like too much distance to the nearest health facility, lack of access to transportation, physical impairments, flooding, no way to cross a river, among other things. Please explain.
    a. And if yes, to what extent do you believe these barriers have prevented you (or someone you know) from accessing healthcare?
    b. If respondent has faced barriers: Do you believe that you would be more likely to use health services if you were better able to access the health facility, for example via transportation services or the existence of a closer facility? How do you think that this would impact your quality of life?
    c. if having better ways to access the health facility WOULD NOT increase likeliness of going to the facility: Why do you feel that having improved access to the health facility would not be enough to encourage you to use the health facility? What more would need to be done? Please explain.

5. Have you, or someone you know, ever been deterred from accessing healthcare due to difficulty reading, or lack of understanding (intimidation) about healthcare? Have you noticed other stigmas that have prevented you or someone you know from getting medical attention? What are they?
    a. **Optional**. And if yes, to what extent do you believe these barriers have prevented you (or someone you know) from accessing healthcare?

6. Do you believe that you would be more likely to use health services if you were provided with information on how to access the health facility and the healthcare that is provided? How do you think that this would impact your quality of life?
    a. If no to the above question: Why do you feel that being provided with additional resources and information about the health facility and its services would not be enough to encourage you to use the health facility? What more would need to be done? Please explain.
    b. In the past three years, have you received any information or promotional materials about the health facility's administration of vaccines? This could be from social media, pamphlets, word of mouth, among other ways. If yes, from where did you hear about this and how effective was the information provided?
    c. **Optional**. To what extent do you think that illiterate community members are included in health awareness campaigns? Could more be done? Please explain.

7. Are there any other things that have prevented you or someone you know from accessing the health facility that we have not yet talked about? What are they?

## Program Delivery Questions

Thank you for your responses. As you may already know, starting in June 2022, there was a change in oversight of the local health facility from the Ministry of Public Health to UNICEF.

Now I will ask about your perceptions about the health facility (as it is today).

8. **PRIORITY.** To what extent would you say that basic health services are **available without disruption** through the health facility? Please explain.
    a. And based on your knowledge, do you believe the availability of basic health services is better or worse than it was before 2022? Why do you think that is?
    b. If respondent said that basic health services are consistently available:, Has reliable health services made you more likely to go to the health facility? Why or why not?
    c. If respondent said that basic health services are NOT consistently available: Has unreliable health services made you less likely to go to the health facility? Why or why not?
    d. In your opinions, how easy or difficult is it for you to…
        i. Find healthcare providers?
        ii. Receive referrals or find a facility that provides the services you require?

9. If you have been to a health facility since 2022, in your opinion, how would you rate the quality of basic health services that is provided in your community health facility?
    a. How would you rate the:
        i. Cleanliness of facilities?
        ii. Availability of medical supplies when you need them?
        iii. Availability of electricity and water in health facilities?
        iv. Knowledge of healthcare providers?
    b. Was your healthcare provided for free or were you required to pay?
        i. If you were required to pay, how much? Did it impact your willingness to return to the health facility for future health needs?

10. **PRIORITY.** Have you received information on how to prevent and treat diarrhea? If yes, from where have you received this information? Have you noticed a reduction in diarrhea in your household? Why or why not?

11. From your own personal experience and what you have seen in your community, how effective has healthcare at your facility been since June 2022?
    a. Do you believe there has been an improvement in the quality of health services provided? Why or why not?
    b. Do you think the health facility is well-equipped to treat and contain diseases like measles and dengue? Please explain.
    c. If you are or know any pregnant women, adolescent pregnancies, mothers, and young children, how well do you think the health facility has taken care of their health needs? Please explain.
    d. How satisfied are you with the health facility's ability to care for yours or your family's health issues?

12. What, if anything, is missing from the current health system in your community? What more should be aimed for?

## Considering At-Risk and Vulnerable Groups

13. Thinking about how health varies in your community, what barriers or challenges do you think affect the health of specific groups differently?
    a. Women
    b. Children
    c. **Optional.** Persons with disabilities
    d. **Optional.** Detained persons
    e. **Optional.** What changes do you think would be most impactful to improve health outcomes for the people we discussed?

14. How effectively do you think the health facility provides healthcare **access and quality care** for all members of your community, including at-risk groups, such as women and children?
    a. How effectively do you think the health facility provides treatments for at-risk groups? Do you think that more needs to be done in health facilities to adequately treat these groups of people?

## Sustainability

15. Overall, what do you think will be the long-term impact of the health facility's role in the community? Do you think that the health of your community will improve over the next five years? Why or why not?

Thank you for your time.

## KII Guides

**KII Consent Form**

**Informed Consent – Afghanistan Health System Study Key Informant Interviews (KIIs)**

Hello, My name is [Moderator Name], and I work on behalf of the Opinion Research Center of Afghanistan (ORCA), an organization that carries out research activities throughout your country.

Study Objectives: I am with a team that is conducting interviews to learn more about the Afghan healthcare system, your experiences within the system, and how you have seen the system change throughout recent years.

IF KEY STAKEHOLDER: You have been selected to participate in this discussion because of your firsthand experience designing and implementing the HER/NFA program in Afghan health facilities. We are interested in learning more about your experience working on the HER/NFA program and your opinions on how the implementation of this program is impacting health outcomes.

IF NGO SERVICE PROVIDER OR HEALTH FACILITY MANAGMENT: You have been selected to participate in this discussion because of your firsthand experience implementing health care programs and facilitating the provision of care in your community. We are interested in learning more about the insight that you have collected during your time in your management role.

IF COMMUNITY INFLUENCER OR CSO: You have been selected to participate in this discussion due to your participation in the promotion of health initiatives in your community. We are interested in learning more about your experience working with these initiatives and the observations you have made about your community while completing this work.

This conversation will last approximately 60 minutes. Before we proceed, I will read you your rights as a participant in this research.

Risks and Benefits to Participants: Participation in this study is not expected to pose any physical, psychological, or social risks. You are free to skip any question you do not wish to answer. There are no direct financial benefits to you for participating, but your contribution will help improve health services in Afghanistan.

Confidentiality and Mandatory Reporting: All information you provide will be kept strictly confidential by the research team and will be used only for the purposes of this study. Your name and any personally identifiable information (PII) will not appear in any report, publication, or presentation. However, confidentiality has limits: if during this study you disclose any information regarding the abuse of a child or other criminal behavior, we are required by law to report it to the appropriate authorities.

Use and Potential Reuse of Data: Data collected during this study will be analyzed and stored in a secure database. A de-identified dataset (with all personal identifiers removed) may be created for analysis and may be archived for future research related to the efficiency of the healthcare system. Data will not be used for any purpose unrelated to this study.

Respondent Rights: You have the right to refuse to participate, not answer all questions, or leave the interview at any time. With this understanding, we encourage you to share openly and honestly throughout this discussion.

Video and Audio Recording and Disclaimer: This interview will be audio recorded, and may be video recorded with your permission, so that we can ensure we have accurately captured your views. Audio recordings are a

requirement to continue with the interview, with video recording being optional but encouraged. Any audio and video recordings will remain exclusively with ORCA and our partner.

Silent Observers: This interview may be livestreamed (audio and video) to members of the research team. You will not be able to see or hear the observers, and so the presence of any silent observers should not impact your ability to remain open throughout the interview. We assure any livestreaming will be done through private platforms and will be observed exclusively by our research team.

Sensitivities: Please note that this discussion may address topics that you find painful, distressing, or otherwise difficult to speak about openly. We encourage you to bear this mind in agreeing to participate. Please let us know if you have any objection to participating in this interview and also if you have any questions before we start.

If you have any questions after you have completed the interview, please reach out to the following contact:

Bilal Ahmad, Project Manager (ORCA), bilal.ahmad@orca.com.af

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Are you willing to participate in this interview? Yes / No (Circle the respondent's choice)

Are you willing to have this interview livestreamed to our research staff? (Must be 'Yes' to video record) Yes / No (Circle the respondent's choice)

May I audio record this interview? (Must be 'Yes' to participate) Yes / No (Circle the respondent's choice)

May I video record this interview? (Must be 'Yes' to video record) Yes / No (Circle the respondent's choice)

Respondent's Signature: _____Oral Consent Given:_____

Moderator's Name: _____Signature:_____ Date:_____

**Key Stakeholders KII Guide**

## Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from Key Stakeholders.*

Key stakeholders include respondents engaged in the development and implementation of the HER/NFA program from the following organizations:

Ministry of Public Health
UNICEF Afghanistan Health Expert
WHO Afghanistan

## Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 60 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

## Introduction Questions

I'd like to open with a discussion about your specific role in the development, implementation, and oversight of the HER/NFA program in Afghanistan.

1. IF MoPH: Can you please tell me about your role at the Ministry of Public Health? How long have you worked in the health sector?
2. Can you describe the nature of your involvement in the HER/NFA program?
    a. Which areas of the HER/NFA program (development, implementation, oversight) are you involved in?

## Program Design Questions

Next, I'd like to focus specifically on the HER/NFA program design.

3. In your opinion, what were the main shortcomings of **the healthcare system in Afghanistan BEFORE the implementation of the HER/NFA program**? Do you think these issues have since been addressed, or are being addressed, after implementation?
    a. Do you feel like the right improvements have been prioritized through the HER/NFA program? Why or why not?
        i. What, if anything, gets in the way of effective program implementation?

**4.** Since healthcare among a subset of facilities in Afghanistan has transitioned to UNICEF oversight via the Health Emergency Response, (starting in 2022), what has been the most significant change you have observed **in the way that health service packages are managed?**

5. What aspects have been the greatest strengths of the HER/NFA program structure by UNICEF?

a. Thinking about the cost structure of each package (BPHS, EPHS, HIVA), where have there been gains in cost-efficiency compared to non-HER/NFA supported facilities?
b. IF UNICEF What are the programmatic and beneficiary-level outcomes of integrating BPHS, EPHS, and HIVA interventions?

6. What aspects, if any, have been the greatest challenges in the program design of HER/NFA?
   a. **Optional.** Were the challenges related to implementing partners, budget and resources, participants, external influences/elements? Something else?
   b. **Optional.** What change(s) do you think would be needed to overcome those barriers in the future? Please explain.
   c. How effective do you think the logistics are of having multiple service providers serve different provinces in Afghanistan?
   d. if anyone but MoPH: Has volatility of currency impacted program capacity or service delivery?
      i. If yes, how so?
      ii. If no, how has the program overcome this challenge?
   e. Do you think that the program design of the HER/NFA program has contributed to or limited program efficacy? Please explain.

7. **PRIORITY.** Based on your knowledge, what factors might explain why the performance of HER/NFA-supported facilities has varied across different years since its inception? **Is there anything that would initially lead to health outcomes in HER/NFA facilities performing better than non-HER/NFA facilities (i.e. in 2022) yet tapered beneficial effects in recent years (i.e. in 2024)?**
   a. Are there particular circumstances or factors that may have contributed to improved outcomes in non-HER/NFA facilities from 2023 to the present?

8. **PRIORITY.** ASK TO UNICEF, WHO: **How do data reporting standards differ between HER/NFA facilities and non-HER/NFA facilities?**
   a. In your view, what factors might explain these differences?
   b. Considering the history of HER/NFA facilities before their hand-off to UNICEF, is it possible that these facilities already had stronger reporting practices even before the HER/NFA program was implemented (for example, due to more frequent reviews or oversight)? Please explain why or why not.

9. **Optional.** In your experience working with the HER/NFA program, what factors do you feel have contributed to or detracted from developing productive relationships between government officials, UNICEF, and other oversight agencies to improve health care delivery in Afghanistan?
   a. Is there anything that you think might help improve coordination efforts across these sectors?

## Program Delivery Questions

10. What is the most significant change that you have **noticed in the way that health service packages are delivered** since the HER/NFA program has launched?
    a. How do you attribute these changes to the program itself? Are there aspects you attribute to external factors out of the program's control?
    b. And to follow that, have there been any unexpected or unintended outcomes as a result of the HER/NFA program?

11. How effective do you think the HER/NFA program has been at improving the availability and quality of basic health services? Please explain.
    a. What aspects of the HER/NFA program make it effective/ineffective at improving healthcare availability?
       i. **Optional.** In what ways do these aspects differ from before the implementation of HER/NFA?

ii. **Optional.** In your opinion, has this led to increased beneficiary use of healthcare? Why or why not?

b. What aspects of the HER/NFA program make it effective/ineffective at improving healthcare quality?
   i. In what ways do these aspects differ from before the implementation of HER/NFA?
   ii. **Optional.** In your opinion, has this led to increased beneficiary trust in healthcare? Why or why not?
   iii. In your opinion, have changes in patient outcomes affected public perceptions and demand for healthcare? Why or why not?

12. IF UNICEF. High Impact Value added (HIVA) interventions were assigned to nine provinces with notably worse health outcomes than the rest of the country (Herat, Kandahar, Badghis, Farah, Ghor, Helmand, Nimroz, Urozgan, and Zabul). How effective do you think the HIVA intervention has been at bridging the gap in health outcomes?
    a. As you may know, under HIVA implementation, the cost per malnutrition case treated has decreased since 2020. What factors have played a role in the reduction of this cost?

13. **PRIORITY.** IF UNICEF, WHO: "To your knowledge, has the HER/NFA program implemented interventions aimed at reducing the incidence or severity of diarrhea among its catchment populations compared to non-HER/NFA facilities? If so, what were these procedures (perhaps awareness campaigns, information dissemination, or other community-based activities), and how effective do you believe they have been at reducing and preventively treating cases of diarrhea?"

## Considering At-Risk and Vulnerable Groups

14. How effective do you think the HER/NFA program has been at improving health equity in Afghanistan, thinking of both healthcare **access** and **provisions** for at risk groups?

15. **Optional.** Overall, what do you think has been missing from HER/NFA program's efforts to improve equitable healthcare access and outcomes in Afghanistan? Is there anything you would change or add?

16. **PRIORITY.** To UNICEF, WHO: How does the HER/NFA program design impact various health outcomes differentially?
    a. How does the program incentivize and treat child health and antenatal care?
    b. How does the program incentivize the treatment of hypertension and family planning? Can you think of any reason why non-communicable disease and family planning services might have not been delivered as effectively as child health and antenatal care services?
    c. Imagine two different healthcare recipients located in the same district. One receives treatment for Hypertension from an HER/NFA facility, and one receives care from another facility. How do external factors beyond program delivery affect health outcomes differentially across health indicators?

## Overall Implementation and Sustainability

Finally, I'd like to ask you some questions about the sustainability of the HER/NFA program's impacts in the future.

17. Do you think that program's efforts will help improve health facility access and health outcomes over the long-term? Why or why not?
    a. **Optional.** What are some obstacles you foresee in maintaining the program's achieved improvements in healthcare availability and quality in the future?
    b. Is there anything you would change about the program to improve sustainability of its impacts?

18. **Optional**. What, if anything, was missing from the program's impact efforts? What more should be aimed for?

Thank you for your time.

**NGO Service Provider KII Guide**

## Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from NGO Service providers.*

There will be two (2) total service provider KIIs. Service providers include those engaged in the delivery of the HER/NFA program, and may include actors from a selection of the following organizations:

| Province | Implementing Partner |
|---|---|
| Helmand | RELIEF INTERNATIONAL-MEDICAL REFRESHER COURSES FOR AFGHANS (RI-MRCA) |
| Nangarhar | JACK |

## Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 60 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

## Introduction Questions

I'd like to open with a discussion about your specific role in the implementation and oversight of the HER/NFA program in Afghanistan.

1. Can you describe the nature of your role in the HER/NFA program?
    a. Which aspects of the HER/NFA program delivery are you involved in?
    b. What was your role, if different from current, in the healthcare system before the transfer to UNICEF's management?

## Program Design Questions

Next, I'd like to focus specifically on how the HER/NFA program's implementation has supported the availability and quality of healthcare in Afghanistan.

2. Overall, how effective do you think the management of healthcare has been under UNICEF?
    a. What aspects have been the greatest strengths of the new management structure of the HER/NFA program by UNICEF?

3. In your opinion, what were the greatest challenges of the healthcare system in Afghanistan BEFORE the implementation of the HER/NFA program?
    a. Do you think these issues are now being addressed? Why or why not?

b. How effectively has the program prioritized key areas of improvement? Please explain.

4. Since healthcare in your province has transitioned to HER/NFA, what has been the most significant change you have observed in the way that health service packages are managed and delivered?
    a. Have you noticed any changes in the primary responsibilities of the Service Provider (yourself and your organization)? Please explain.
    b. Do you attribute changes to UNICEF directly or other external factors? Please explain.

5. What aspects, if any, have been the greatest challenges in navigating the program logistics of HER/NFA?
    a. **Optional.** Were the challenges related to UNICEF oversight, budget and resources, procurement of supplies or funding flows, participants, external influences/elements? Something else?
    b. **Optional.** What change(s) do you think would be needed to overcome those barriers in the future? Please explain.
    c. Has volatility of currency impacted program capacity or service delivery?
        i. If yes, how so?
        ii. If no, how has the program overcome this challenge?
    d. Do you think that the program design of the HER/NFA program has contributed to or limited program efficacy? Please explain.

6. **PRIORITY.** How does your organization account for differences in patient demand that vary between densely populated areas versus sparsely populated areas?
    a. Have you noticed issues with overstock of medical supplies and medicine in more remote areas? If yes, how is this issue handled? Have you noticed an issue with supply wastage in these circumstances?

7. **PRIORITY.** In what circumstances do patients pay out-of-pocket for healthcare?
    a. How much would they be expected to pay on average in these circumstances?
    b. How have situations requiring patients to pay out-of-pocket affected patient demand for care?

8. **Optional.** How effectively do you think Service Providers are supported under UNICEF?
    a. Have there been any barriers to productive coordination?
        i. How could coordination be improved to better meet the health needs of Afghanistan?
    b. Does anything prevent you from providing effective health facility oversight? Please explain why or why not.

9. **PRIORITY.** How do data reporting standards differ between HER/NFA facilities and non-HER/NFA facilities?
    a. In your view, what factors might explain these differences?
    b. Considering the history of HER/NFA facilities before their hand-off to UNICEF, is it possible that these facilities already had stronger reporting practices even before the HER/NFA program was implemented (for example, due to more frequent reviews or oversight)? Please explain why or why not.

10. **PRIORITY.** Can you describe how your facility has integrated digital documentation systems into routine health reporting, and what measures are in place to ensure the accuracy and reliability of the data being recorded and submitted?
    a. How has data documentation changed since the start of HER/NFA program. Has there been an increase, decrease or no change in the quality of data documentation?
    b. What aspects of reporting still rely on paper, and why?
    c. How is data quality (e.g., completeness, accuracy, timeliness) monitored or validated?
    d. What challenges or successes have you experienced with the transition to digital reporting?

11. **PRIORITY.** Are you and your colleagues aware of QQM? To what extent is QQM being adopted within the facilities that you oversee?
    a. If yes, what components has your team found particularly useful about QQM?
    b. Are there any barriers that prevent facilities from using QQM?

## Program Delivery Questions

12. How effective do you think the (HER/HIVA) program has been at improving the availability and quality of basic health services?
    a. What aspects of the HER/NFA program make it effective/ineffective at improving healthcare availability?
        i. In what ways do these aspects differ from before the implementation of HER/NFA?

13. Do you think that there has been a change in the availability of health services? Please explain.
    a. Do you think there has been a change in the availability of sanitation facilities?
    b. How has infrastructure and facility maintenance changed, if at all, since UNICEF took over?

14. What aspects of the HER/NFA program make it effective/ineffective at improving healthcare quality?
    a. In what ways do these aspects differ from before the implementation of HER/NFA?
    b. IF INEFFECTIVE: How can the program implementation be changed to increase the effectiveness in this area?

15. **PRIORITY.** To your knowledge, has the HER/NFA program implemented interventions aimed at reducing the incidence or severity of diarrhea among its catchment populations compared to non-HER/NFA facilities? If so, what were these procedures (perhaps awareness campaigns, information dissemination, or other community-based activities), and how effective do you believe they have been at reducing and preventively treating cases of diarrhea?

## Considering At-Risk and Vulnerable Groups

16. **Optional.** Thinking about how health outcomes vary amongst the population, what barriers do you think affect the health outcomes of specific groups in your country?
    a. Women
    b. Children
    c. **Optional.** Persons with disabilities
    d. **Optional.** Detained persons

17. **PRIORITY.** From your experience, how have women been involved (or excluded from) the provision of healthcare in Afghanistan?
    a. How effective has the HER/NFA (HER/HIVA) program been at expanding access to female health providers?
    b. How effective has the program been at delivering gender awareness training?
    c. How effective has the program been at providing targeted care and information services to pregnant adolescents?

18. **PRIORITY.** How does the HER/NFA program design impact various health outcomes differentially?
    a. How does the program incentivize and treat child health and antenatal care?
    b. How does the program incentivize the treatment of hypertension and family planning? Can you think of any reason why non-communicable disease and family planning services might have not been delivered as effectively as child health and antenatal care services?
    c. Imagine two different healthcare recipients located in the same district. One receives treatment for Hypertension from an HER/NFA facility, and one receives care from another facility. How do

external factors beyond program delivery affect health outcomes differentially across health indicators?

19. How effective do you think the HER/NFA program has been at improving health equity in Afghanistan, thinking of both healthcare access and provisions for at risk groups? What do you think, if anything, has been missing from HER/NFA program efforts?

### Overall Implementation and Sustainability

Finally, I'd like to ask you some questions about the sustainability of the HER/NFA program's impacts in the future.

20. Do you think that HER/NFA program's efforts will help improve health facility access and health outcomes over the long-term? Why or why not?
    a. **Optional**. What are some obstacles you foresee in maintaining the program's achieved improvements in healthcare availability and quality in the future?
    b. Is there anything you would change about the program to improve sustainability of its impacts?

21. **Optional**. What, if anything, was missing from the program's impact efforts? What more should be aimed for?

Thank you for your time.

**Health Facility Management KII Guide**

### Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from NGO Service providers.*

There will be four (4) total health facility management KIIs (1 BPHS+EPHS in Province 1, 1 BPHS + EPHS in Province 2, and 1 HIVA supported facility).

### Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 60 minutes. Everything you share with us will remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

### Introduction Questions

I'd like to open with a discussion about your specific role as a health facility manager in Afghanistan.

1. Can you describe the nature of your role in health facility management?
2. How long have you been working in healthcare? Throughout that time, have you worked for the same facility, in a similar role?

## Program Design Questions

As you may know, starting in June 2022, UNICEF took sole responsibility for the administration of the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) programs. These programs provide funding for the Afghanistan health system services provided at your facility. We want to ask you some questions about UNICEF's HER/NFA program and how it has been implemented in your facility.

3. What have been the biggest challenges in the structure of the healthcare system since this transition to the HER/NFA program in June 2022?
    a. Have you or your colleagues experienced any challenges in regard to your region's implementing partner (service provider), budget and resources, patient management, external influences/elements? Something else?
    b. **Optional.** What change(s) do you think would be needed to overcome those barriers in the future? Please explain.

4. In your experience working under UNICEF since June 2022, what factors do you feel have contributed to productive health facility management in order to improve health care delivery in your facility?
    a. Have you seen any barriers to productive health facility management in your workplace?
    b. **Optional.** Is there anything that you think might help improve health facility management?
    c. How has staff morale or turnover been impacted under the HER/NFA program?

## Program Delivery Questions

5. What is the most significant change that you have noticed **in terms of health service delivery** since the transition to the HER/NFA project in June 2022?
    a. **Optional.** In your opinion, have these changes made any noticeable impacts on the community that the health facility serves? What have they been?

6. How much do you think the **availability of basic health services** for your patients has changed since the transition to sole UNICEF management in June 2022?
    a. Since the transition…
        i. Has the volume of patients changed since 2022? If yes, how significantly?
        ii. **Optional.** Have you noticed a change (positive or negative) in the nature of patient referrals to/from health facilities in your community? Please explain.
        iii. Have you noticed a change (positive or negative) in the availability of essential health supplies in your facility? Please explain.
        iv. Have you noticed a change (positive or negative) in the availability of basic resources needed to run the facility (ex. Clean water, electricity, sewage, temperature regulated medication storage)?
    b. In your opinion, have any of these changes led to increased healthcare use in your community?

7. How much do you think the **quality of health services** has changed for your patients since the transition in June 2022?
    a. Since the transition…
        i. Has there been a change in the time it takes for patients to receive care? Please explain.
        **ii. Has your facility implemented new quality of care standards or changes in how quality of care is monitored? Please explain.**
        iii. Have you noticed a change in the number of training opportunities for you or your colleagues?
        iv. If your facility participates in community outreach programs, has there been any change in these programs? This can be in the frequency or quality of the programs.

8. How effectively do you think health professionals are supported under HER/NFA?

a. Has there been a noticeable change in the compensation of employees at your health facility? This can be in the amount, frequency, or quality of the compensation.
b. Does anything prevent your staff from providing quality healthcare? Please explain why or why not.

9. **PRIORITY.** How much do you think **patient health outcomes have changed** since the transition to HER/NFA in June 2022? Since the transition,
   a. **PRIORITY. Have you noticed any changes to issues concerning maternal and fetal health since the transition?** Please explain.
   b. **PRIORITY. Have you noticed increased numbers of births and c-sections since transition?**
   c. **Optional.** Have you noticed any changes in vaccination rates? Have you noticed any changes in the prevalence of child malnutrition?
   d. Would you attribute these changes to the new healthcare program or to external factors? Please explain.

10. **PRIORITY.** Has your facility implemented interventions aimed at reducing the incidence or severity of diarrhea among its catchment population? If so, what were these procedures (perhaps awareness campaigns, information dissemination, or other community-based activities), and how effective do you believe they have been at reducing and preventively treating cases of diarrhea?

11. **PRIORITY.** How does your facility keep up with patient demand? Would you say that demand often exceeds available supplies, that supplies often keep up with demand, or that supplies often exceed demand?
   a. [If supplies often exceed demand] Have you noticed issues with overstock of medical supplies and medicine in more remote areas? If yes, how is this issue handled? Have you noticed an issue with supply wastage in these circumstances?
   b. [If demand is equal to or greater than supplies] In the circumstance where supplies are not available to provide treatment, what care is provided to the patient?

12. **PRIORITY.** In what circumstances do patients pay out-of-pocket for healthcare?
   a. How much would they be expected to pay on average in these circumstances?
   b. How have situations requiring patients to pay out-of-pocket affected patient demand for care?

13. **PRIORITY.** Can you describe how your facility has integrated digital documentation systems into routine health reporting, and what measures are in place to ensure the accuracy and reliability of the data being recorded and submitted?
   a. How is data quality (e.g., completeness, accuracy, timeliness) monitored or validated?
   b. What challenges or successes have you experienced with the transition to digital reporting?

## Considering At-Risk and Vulnerable Groups

14. Thinking about how health outcomes vary amongst the population, what barriers do you think affect the health outcomes of specific groups in your community?
   a. Women
   b. Children
   c. **Optional.** Persons with disabilities
   d. **Optional.** Detained persons

15. **PRIORITY.** From your experience, how have women been involved (or excluded from) the provision of healthcare in your facility?
   a. How effective has the HER/NFA program been at expanding access to female health providers?
   b. How effective has the program been at delivering gender awareness training?

16. Does your facility service populations in primarily urban areas, rural areas, or both? In your opinion, how (if at all) does geographic location contribute to health access and outcomes in your community and surrounding communities?
    a. If you believe it does contribute, how has the transition to HER/NFA addressed differences in vulnerability related to geographic location? Do you think there is more that the program should be doing?

17. **PRIORITY.** How does the program incentivize and treat child health and antenatal care?
    a. How does the program incentivize the treatment of hypertension and family planning?
    b. Can you think of any reason why non-communicable diseases and family planning services might have not been delivered as effectively as child health and antenatal care services under the HER/NFA program?

18. How effective do you think the program has been at improving health equity in your community, thinking of both healthcare **access** and **provisions** for at risk groups?

### Overall Implementation and Sustainability

Finally, I'd like to ask you some questions about the sustainability of the HER/NFA program's impacts in the future.

19. Overall, what do you think will be the long-term impact of UNICEF's HER/NFA program in your community?
    a. Do you think that program's efforts will help improve access to health facilities in your community? Why or why not?
    b. Do you think that program's efforts will help improve the quality of healthcare in your community? Why or why not?
    c. Do you think that the program's efforts will increase the capacity of the health system to function without assistance from UNICEF in the future?

20. **Optional.** What have been the biggest challenges in delivering quality care under the health system management since June 2022?
    a. What, if anything, is missing from the UNICEF's program's impact efforts? What more should be aimed for?

Thank you for your time.

**CSO and Community Influencer KII Guide**

### Purpose

*To gather insights and perspectives on the relevance, effectiveness, efficiency, impact, and sustainability of the HER/NFA program from CSOs and Community Influencers.*

There will be four (4) total CSO and Community Influencer KIIs.

### Consent

Hello, it is nice to meet you. We are a research team trying to learn more about the UNICEF-supported health facilities in Afghanistan. This interview should take no more than 60 minutes. Everything you share with us will

remain confidential and anonymous. I will not mention your name in reports related to this project, so please feel free to speak candidly throughout our conversation.

- May I please record this interview? The recording is just to ensure my report accurately reflects your comments and will not be published.
- Before we start, do you have any questions for me?

## Introduction Questions / Warmup

1. Now, please tell me about your role in your community. Through what ways are you connected to your community, and do you have especially close ties with certain subpopulations? How have you been involved in helping people in your community be informed and receive healthcare?

As you know, the health care system in Afghanistan has suffered in the past decade due to volatility caused by conflict, and exacerbated from internal displacement, increased poverty, loss of livelihood, increased food insecurity, malnutrition, and ongoing disease outbreaks.

2. Have you seen firsthand how these factors have impacted the quality of health care in your community?
    a. Which, if any, of these elements, have you heard about or experienced?

## Understanding Barriers to Healthcare

3. In your community, are there geographic barriers or transportation issues that prevent community members from accessing healthcare? What are they?
    a. And if yes, to what extent do you believe these barriers are preventing the community from having access to and utilizing healthcare?
    b. Do you believe that these physical barriers affect some community members more than others? If yes, who do you believe is the most affected? Please explain.

4. In your community, are there any non-physical barriers, like literacy or stigmas, that prevent community members from accessing healthcare? What are they?
    a. And if yes, to what extent do you believe these barriers are preventing the community from having access to and utilizing healthcare?

## Program Delivery Questions

As you may know, starting in June 2022, UNICEF took sole responsibility for the administration of some health facilities in Afghanistan through the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) program. We want to ask you some questions about the UNICEF-supported facility in your community.

5. What is the most significant change that you have noticed since the healthcare program (HER) was implemented in June 2022?
    a. Have there been any other significant events or changes in your community that would impact how the healthcare system functions during this time?

6. Since June 2022, how effective do you think the new healthcare program has been at improving the availability and quality of basic health services in your community?

7. Since June 2022, how effective do you think the new healthcare program has been at improving the quality of basic health services in your community?
    a. Availability of medical supplies
    b. Education of healthcare providers

8. From what you have seen, how has the impact of the healthcare program on the community changed since the HER/NFA program launched in June 2022?
    a. Has the program improved the quality of health services provided to the community? Why or why not?
    b. Have you noticed a difference in the treatment and containment of diseases, such as measles and dengue fever, since 2022? If yes, how much do you attribute this to changes in the healthcare system?
    c. Have you noticed a difference in the services available for pregnant women, mothers, and young children? If yes, how much do you attribute this to changes in the healthcare system?
    d. Have you noticed a difference in the availability or promotion of vaccines? If yes, how much do you attribute this to changes in the healthcare system?
    e. **Optional.** From your perspective, has there been a significant increase or decrease in other specific health issues? How much do you attribute this change to the change in healthcare program? Please explain.

9. What, if anything, is missing from the current health system in your community? What more should be aimed for?

10. Have you participated in any consultations with the local health facility, UNICEF or other health partners?

## Considering At-Risk and Vulnerable Groups

11. Thinking about how health outcomes vary amongst the population, what barriers do you think affect the health outcomes of specific groups in your country?
    a. **Optional.** Women
    b. **Optional.** Children
    c. **Optional.** Persons with disabilities
    d. **Optional.** Detained persons
    e. **Optional.** What changes do you think would be most impactful in reducing the vulnerability of these groups to systematically worse health outcomes?

12. How effectively do you think the healthcare system since June 2022 has improved healthcare **access** for at risk groups, such as women and children?
    a. How effective do you think healthcare treatments are for at-risk groups? Do you think that more needs to be done in health facilities to adequately treat these groups of people?
    b. To follow up, have you witnessed any adolescent pregnancies in the past four years? If yes, how effectively do you think the healthcare system cared for these cases? Please explain.

13. How effectively do you think the health facility has promoted health care and provided information on health care services to the community since 2022?
    a. Have you witnessed any social media campaigns related to public health care aimed at increasing awareness?
    b. Have you yourself participated in community outreach to increase community healthcare use?
    c. Have you noticed any attitude or behavior changes in how the community views and accesses healthcare services since the HER/NFA program launched in June 2022? Please explain.
    d. **Optional.** To what extent do you think that illiterate community members are included in health awareness campaigns? Could more be done? Please explain.

14. Overall, what do you think has been missing from UNICEF'S efforts to improve equitable healthcare access and outcomes in your community? Is there anything you would change or add? Are there any populations that need more specialized support?

## Overall Implementation and Sustainability

15. Overall, what do you think will be the long-term impact of the health facility's efforts in your community in the next 5 years?

16. How prepared is the current health system to adapt and respond to changing health sector or political environments?

Thank you for your time.

## Annex 6. Sampling approach for primary data collection

The selection of 10 provinces was based on data from the most recent MICS survey and NSIA's estimated population of Afghanistan 2024-2025 on several factors (e.g. key health indicators and/or economic correlates), ensuring that the evaluation team included the most populous provinces and provinces that experience different types of health deprivation. The evaluation team also ensured that provinces are logistically accessible to enumerators give evaluation costs.

1. Provincial share of households: The provincial share represents the proportion of households in a specific province relative to the total number of households across all provinces. It is calculated using the following formula: Provincial share (%) = (Number of households in the province/ Total number of households in all provinces) × 100
2. Child mortality rate: Number of deaths among children under age five years (per 1,000)
3. Stunting rate: Percentage of children with moderate and severe stunting
4. Presence of Sanitation Infrastructure: Percentage of households with a sewer connection
5. Health care Utilization: Proxied for with percentage receiving at least 4 antenatal care visits
6. Difficult terrain: The presence of mountainous terrain which may impede healthcare utilization rates

Note: While other indicators may be considered relevant in the selection of provinces, many additional selection indicators of interest are highly correlated with the ones utilized for this impact evaluation.

As a result, two provinces were selected within each of the five UNICEF regions.

As a result, to ensure a balanced and insightful analysis, the evaluation team purposively selected two provinces per region, with the aim of capturing a geographically and socio-economically diverse sample, which face unique challenges in service delivery and utilization.

When it comes to the selection of healthcare facilities, four health facilities will be randomly selected using a random number generator applied to a complete list of UNICEF-supported healthcare facilities in that province.

For the qualitative part, two provinces were purposively selected from within the sample of 10 provinces (via criteria stated above).

1. One province was selected for qualitative data collection largely based on criteria 1, to ensure that health facilities responsible for a significant share of the country's population are reflected in qualitative data, thus providing in-depth information on the most common experience of healthcare for those who receive treatment from UNICEF-supported facilities.
2. One province was selected largely based on the remainder of the above criteria aside from criteria 1, to ensure that health facilities which are challenged with poorer health outcomes are captured to provide insight into the difficulties faced in access and use of healthcare in more challenging environments. This province was also selected based on the presence of HIVA interventions within this province.

Limitations of the sampling approach:

1. Findings from purposively selected provinces cannot be statistically generalized. They will reflect only the conditions in the selected provinces and may not represent diversity within the broader population.

2. The choice of provinces is influenced by subjective criteria, introducing certain selection bias. This may lead to overrepresentation or underrepresentation of certain population groups or service delivery patterns.
3. Because the sample is not probability-based, the survey cannot produce population-weighted estimates. This limits the ability for MICS comparisons.

A detailed excel sheet will be shared with the final inception report.