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

Report

December 2025

Preface

To be added

Acknowledgements

To be added

List of Acronyms

Acronym	Complete Description
ADB	Asian Development Bank
AIR	American Institutes for Research
ANC	Antenatal Care
ANC4	Antenatal Care Fourth Visit
ARTF	Afghanistan Reconstruction Trust Fund
ATE	Average Treatment Effect
BHC	Basic Health Centers
BPHS	Basic Package of Health Services
CATI	Computer-Assisted Telephone Interview
CBH&NP	Community-Based Health and Nutrition Programme
CBHC	Community-Based Health Care
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CHC	Comprehensive Health Center
CHWs	Community Health Worker
CHR	Community Health Roadmap
CRC	Convention on the Rights of the Child
DD	Digital Dialogue (Online Survey Format)
DfA	De facto Authorities
DHIS2	District Health Information Software 2
DiD	Difference-in-Differences
ENT	Ear, Nose, and Throat
EOCs	Emergency Operation Centers
EPHS	Essential Package of Hospital Services
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
GEEW	Gender Equality and the Empowerment of Women
GEROS	Global Evaluation Reports Oversight System
GFF	Global Financing Facility
HER	Health Emergency Response
HIVA	High-impact Value-addition
HMIS	Health Management Information System
HQ	Headquarters
ICC/ESOMAR	International Chamber of Commerce/ European Society for Opinion and Marketing Research

Acronym	Complete Description
IMNCI	Integrated Management of Newborn and Childhood Illness
IQCS	Integrated Quality Control System
IRB	Institutional Review Board
ITA	Interim Taliban Authority
ITS	Interrupted Time Series
KII	Key Informant Interview
LiST	Lives Saved Tool
LNOB	Leave no one behind principle
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCH-HB	Maternal and Child Health Handbook
MICS	Multiple Indicator Cluster Survey
MNCAH	Maternal, Newborn, Child, and Adolescent Health
MoPH	Ministry of Public Health
NCDs	Non-Communicable Diseases
NFA	Novel Financial Arrangement
NGO	Non-governmental Organization
ORB	Opinion Research Business International
P4P	Pay-for-performance
PHC	Primary Health Center or Care
PII	Personally Identifiable Information
PNC	Postnatal Care
PPH	Post-partum Haemorrhage
PSM	Propensity Score Matching
ROSA	UNICEF's South Asia Regional Office
RUTF	Ready-to-use Therapeutic Food
SBCC	Social and Behavioural Change Communication
SC	Steering Committee
SDGs	Sustainable Development Goals
SHC	Secondary Health Care or Sub-Health Centers
SP (IP)	Service Provider (Implementing Partner)
TPM	Third-party Monitoring
TOR	Terms of Reference
UN	United Nations
UNEG	United Nations Evaluation Group

Acronym	Complete Description
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WB	World Bank

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Executive Summary

Context

Afghanistan's health system operates in an extremely fragile context marked by prolonged conflicts, economic collapse following the August 2021 political transition, and severe restrictions on women's mobility and participation. The Health Emergency Response (HER)/ Novel Financing Arrangement (NFA) programme, implemented by UNICEF in Afghanistan, is a large-scale humanitarian health intervention designed to sustain and strengthen the delivery of essential health services in a context of prolonged crisis. The programme supports the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) nationwide through contracting-out modality with non-governmental service providers, as well as high Impact Value-Added (HIVA) component[1], which enhances maternal, newborn, child, and adolescent health (MNCAH) services.

Evaluation purpose and objectives

The purpose of this evaluation is to assess the performance and added value of UNICEF's HER/NFA programme in Afghanistan and its contribution to meeting beneficiaries' needs. The evaluation focused on interventions related to PHC through the BPHS, Secondary Health Care or Sub-Health Centers (SHC) through the EPHS, and HIVA services between January 2022 and December 2024[2]. More specific objectives of the evaluation included examining: (i) performance, comparative value-add, effectiveness, and relevance of the HER/NFA programme; (ii) complementarities, differences, and synergies between health service packages, focusing on HIVA delivery, and (iii) cost-efficiency.

The primary users of this exercise are UNICEF Afghanistan, partners such as World Bank (WB), the Asian Development Bank (ADB), bilateral donors, implementing partners (such as SPs), the de-facto MoPH, beneficiaries, members of the Health Sector Technical Working Group (HSTWG), health and nutrition facilities, and healthcare and nutrition professionals. Secondary users range widely and cover health and nutrition clusters, UNICEF's South Asia Regional Office (ROSA) and Headquarters (HQ), other UN agencies and NGOs in Afghanistan, other de-facto ministries, academic and research institutions, and health policy advocacy groups.

Evaluation Methodology

This evaluation employed a utilization-focused, mixed-methods design to assess the performance, value-added, and cost-efficiency of the HER/NFA programme. Quantitative methods included interrupted time series (ITS) analysis of HMIS/DHIS II data, Lives Saved Tool (LiST) modeling to estimate potential maternal and newborn lives saved, and cost-efficiency analysis comparing investments with changes in service utilization before and after the UNICEF-led transition to HER/NFA. Qualitative evidence was collected through key informant interviews with stakeholders and service providers, complemented by anonymous AI-enabled digital surveys of implementers and healthcare providers. Findings were systematically triangulated across data sources and methods, with cross-cutting integration of gender, equity, disability, human rights, and "leave no one behind" considerations to ensure relevance for vulnerable populations and policy decision-making.

[1] Please refer to the section 2.2 for more information.

[2] Please note that the evaluation team also leveraged secondary data from 2018 to 2022 and 2025 to add to the rigor of the methodological approach. For more information, please refer to sections 3 and 4.

Key Evaluation Findings: HER/NFA performance, value-add, relevance, and effectiveness

Relevance: The HER/NFA programme is highly relevant to the country population and its needs, providing donor-funded vital health care across the country. Qualitative respondents consistently point to the programme's evidence-based monitoring, staff capacity building, and the prioritization of female staffing, which reinforces HER/NFA's appropriateness in the current context.

Coverage: Service coverage has expanded under UNICEF's management through new facilities, mobile vaccination teams, and targeted community outreach, improving access in remote areas and reducing "white zones" (no coverage areas). However, medicine shortages, seasonal access barriers, and travel distances still limit coverage.

Coordination: HER/NFA programme generated clear value-add through coordination, monitoring, and community engagement, driving increased service utilization, improved data quality, and stronger accountability, particularly in rural and hard-to-reach areas, despite persistent constraints in medicines and infrastructure. Increased community trust drove higher demand that now often exceeds facility capacity.

Impact/Effectiveness: Stakeholders and implementers alike believe the programme has improved healthcare availability, quality, and female and child health outcomes. Programme performance and effectiveness improved significantly under UNICEF management, with HER/NFA-supported facilities consistently outperforming non-HER/NFA facilities on most service delivery indicators, including outpatient visits, ANC4, institutional deliveries, childhood illness care, and vaccinations between 2022-2024. Compared to 2020, ITS analysis showcased that HER/NFA facilities demonstrated sustained improvements across multiple service delivery indicators between 2022-2024, including higher outpatient visits, childhood illness visits, vaccination uptake, ANC4 visits, and institutional deliveries. Adverse trends in maternal (due to major and other complication) and perinatal mortality and family planning in later years are largely attributable to external shocks, including restrictive policies affecting women's access to care and large-scale population returns, suggesting that observed gains in female health outcomes likely understate the programme's true impact. Qualitative analysis suggests that community outreach efforts were extremely successful in preventing cases of diarrhoea and anaemia, suggesting that the programme's gains may be understated when looking at facility-level outcomes only. Some programmatic weaknesses that prohibit effectiveness are gaps in medicine availability, limited facility infrastructure in remote areas, and declining training opportunities in recent years. The HER/NFA programme's QQM results show system-wide improvements in health facility quality of care over time, with steady gains across structural quality, content of care, and outcome quality, indicating that quality improvement efforts under the programme have strengthened service readiness, clinical practice, and service outcomes. Expanded coverage of three key MCH interventions (ANC visits, facility deliveries, and caesarean deliveries) translated into substantial health impact, with LiST modelling estimating 10,600 lives saved (4,923 neonatal lives saved, 2,429 maternal lives saved, and 3,245 stillbirths averted) between 2023-2025, and projections indicating that over 56,000 additional lives could be saved by 2030 if coverage reaches 90%.

Equity/LNOB, disability, and gender equality: The quantitative trend analysis suggests that UNICEF's rural health facilities performed similarly to the full sample in realizing increases in outpatient visits, diarrhoea visits, anaemia detection, institutional deliveries, and ANC visits. HER/NFA programme delivered meaningful equity gains for women, girls, and rural populations through improved access to female providers and outreach services, while people with disabilities and displaced groups remain less visible in outcomes and rising returnee inflows are increasing pressure on services. Child vaccination provision by UNICEF health facilities was similar for boys and girls.

Sustainability: The programme's implementation of community-level preventative care efforts to reduce incidences of common child health morbidities like diarrhoea and increase vaccination rates served as an important achievement in a country with vulnerable child health. Key stakeholders anticipate a reduction in funding; dependence on donor funding and growing constraints around female workforce retention pose key challenges to programme longevity.

Key Evaluation Findings: Health service packages, focusing on HIVA delivery

Relevance: The focus of the HIVA intervention on MCH has added significant value in terms of quality of care to the provinces it has serviced, according to qualitative respondents, proving particularly relevant in a country with worsening female health outcomes. The inclusion of HIVA shifted service delivery from coverage-focused to quality-focused maternal and newborn care, adding high-impact clinical interventions, equipment, and targeted capacity building that directly address leading causes of maternal and neonatal mortality, while complementing BPHS and EPHS packages.

Impact/Effectiveness: The evaluation team conducted an iteration of the quantitative trend analysis solely for the provinces covered by HIVA services throughout the intervention period. The analysis revealed substantial increases in total outpatient visits, ANC visits, and facility deliveries for HIVA facilities compared to 2020 baseline service utilization. Qualitative evidence pointed to improved referral pathways, provider competencies, and continuity of care across the maternal-newborn continuum. Increases in perinatal mortality observed in HIVA provinces in 2023-2024 are explained by external demand shocks rather than declining quality, particularly large-scale returnee inflows into high-burden provinces, such as Herat, which intensified caseload pressure on maternity and newborn services.

Equity/LNOB, disability, and gender equality: The HIVA intervention was designed with equity/LNOB in mind, providing MCH-related care to 10 provinces with the poorest MCH outcomes. Qualitative evidence points to improved female staff capacity building efforts, as well as increased female staff presence among HIVA facilities, serving to expand not just quality of care but female access to care. HIVA delivered disproportionate benefits for women, adolescent girls, high-risk newborns, rural populations, and displaced groups by improving access to skilled female providers, strengthening referrals, and prioritizing life-saving care for the most vulnerable, thereby reducing inequities in maternal and newborn health outcomes.

Sustainability: HIVA's systematic training of midwives has improved the lasting impacts of healthcare availability, by combatting reductions in female health staff to continue improving maternal and child health, despite ongoing societal restrictions faced by women, suggesting that at least some aspects of HIVA intervention may be a necessary way forward to continue effectively reaching women in some of the most difficult contexts in the country. HIVA improved coordination and effectiveness through standardized training, strengthened referral pathways, and embedded quality improvement systems; however, long-term sustainability is uncertain due to delivery costs, shrinking donor funding, and limited ownership or absorption by de facto authorities.

Key Evaluation Findings: Cost-Efficiency

HER/NFA programme demonstrated strong cost-efficiency at scale, delivering nationwide health services and allocating a majority of resources directly to service providers, ensuring that funding translated into frontline service delivery.

The evaluation team combined the results of the quantitative trend analysis with programme budget data to compare the cost-efficiency of service utilization under Sehatmandi to the current HER/NFA programme. **Compared to the pre-transition Sehatmandi programme, HER/NFA programme achieved higher service outputs per dollar invested**, with the additional investment between 2022-2024 financing

substantial efficiency gains, including nearly 20% more outpatient and diarrhea visits respectively, 38% higher ANC4 coverage, 22% higher anemia detection, and over 6% more facility deliveries relative to a 2020 baseline. Over time, HIVA investments have produced disproportionate efficiency gains in high-impact MCH services, particularly ANC visits and facility deliveries, indicating that while HIVA is less cost-efficient at scale than BPHS, it delivers focused returns aligned with its objective to reduce preventable maternal and newborn mortality.

Lessons Learned

The evaluation highlights several high-impact strategies with strong potential for scale-up, including prioritization of life-saving MCH interventions, systematic capacity building, community outreach and prevention, mobile service delivery, and integrated monitoring systems that foster accountability. Quantitative findings show particularly strong efficiency gains for ANC uptake and anemia detection among girls, underscoring the value of targeted MCH investments. Community outreach emerged as a critical success factor, improving awareness, care-seeking behavior, and demand management by shifting prevention and early action to the community level. Sustaining access for women depends heavily on expanding non-formal training and retention pathways for female health workers, with midwifery training cited as an effective and scalable solution. Finally, standardized monitoring and reporting systems have proven reliable, well-accepted by service providers, and replicable across diverse contexts, making them a strong foundation for future programming.

Conclusions

The HER/NFA programme was highly relevant and value-adding in stabilizing Afghanistan's health system during a period of extreme fragility, particularly by safeguarding maternal, newborn, and child health and preventing large-scale service collapse. Quantitative and qualitative evidence consistently shows that UNICEF's stewardship, strengthened rural coordination, robust monitoring, and health-worker capacity building were central to maintaining service continuity.

Service delivery performance improved markedly after the 2022 transition, with HER/NFA-supported facilities outperforming non-HER/NFA facilities across most indicators, including outpatient visits, childhood illness care, vaccinations, ANC4 attendance, institutional deliveries, and anaemia detection among girls. Interrupted time series analysis confirms sustained increases in outpatient visits, childhood illness care (including diarrhea), vaccination uptake (Penta3 and Measles1), ANC4 attendance, institutional deliveries, and anaemia detection among girls compared with a 2020 baseline. Increases in maternal (due to major and other complication) and perinatal mortality observed in 2024 reflect nationwide trends and are linked to external shocks, such as restrictive policies affecting women and large-scale returnee inflows, suggesting that programme impacts on women's and newborn health are likely understated.

Availability, accessibility, and quality of care improved, particularly in rural and underserved areas, driven by expanded outreach, mobile teams, new service points, and strengthened supervision. Rising utilization reflects growing community trust and improved quality of care, although demand now exceeds capacity in many facilities. Performance remains constrained by medicine shortages, procurement delays, and infrastructure gaps, while family planning outcomes declined in 2024 due to heightened social and policy barriers affecting women's mobility and autonomy, underscoring the need for stronger demand-side and protection-informed approaches.

The integration of HIVA strengthened quality-focused maternal and newborn care through high-impact interventions, equipment, and specialized training, generating additional gains in ANC attendance and facility deliveries. Perinatal mortality increases in HIVA provinces are best explained by demographic shocks and caseload pressure rather than declining quality of care.

Overall, HER/NFA programme demonstrated strong cost-efficiency, translating large-scale financing into measurable gains in essential service utilization and delivering clear value for money in a highly constrained context. However, anticipated funding reductions and limited prospects for de-facto authority ownership pose sustainability risks, requiring continued prioritization of high-impact MCH services, community-level prevention, and non-formal pathways to train and retain female health workers

Recommendations

Recommendations were developed based on the findings and conclusions of the report. More information, such as action points, timeframe, and responsible units, is available under the 'Recommendation' section of the report.

1. Advocate for sustained and predictable international financing to prevent systemic health service collapse.
2. Prioritize and protect high-impact maternal, newborn, and child health interventions under constrained funding scenarios.
3. Invest in sustainable female health workforce pipelines through non-formal and alternative training pathways.
4. Invest in system resilience rather than short-term service expansion alone.
5. Address critical system bottlenecks to protect service quality and efficiency.
6. Strengthen demand-side and protection-informed approaches, particularly for family planning and women's access to care.

1 Introduction

UNICEF Afghanistan has managed interventions delivered by a share of the health facilities in Afghanistan since the political transition in the country in 2021. These interventions are delivered via the Health Emergency Response (HER)/Novel Financing Arrangement (NFA) programme, funded by the World Bank and Asian Development Bank respectively. The current evaluation of HER/NFA was commissioned by UNICEF Afghanistan. The evaluation was guided by the Terms of Reference (ToR) and the inception report, including an evaluation matrix, and employed a mixed-methods approach (please see Annex E for ToR and Annex F for the inception report).

The purpose of this evaluation was to review the effects and added value of the HER/NFA programme on Afghanistan's health system and its contribution to meeting beneficiaries' needs. The evaluation focused 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 between 2022 and early 2025.

The report comprises of seven chapters and includes all necessary annexes. Chapter 2 describes the background and context. Chapter 3 demonstrates the purpose, objectives, users, and scope of the evaluation. Chapter 4 covers the evaluation framework, including key evaluation questions, design and methodology. Chapter 5 describes the results and findings of the evaluation, lessons learned and good practices. Chapter 6 presents conclusions of the evaluation and Chapter 7 details recommendations to strengthen UNICEF's health programming in Afghanistan in future years.

2 Background and context

2.1 Healthcare system and situation in Afghanistan

Afghanistan is a landlocked country situated between Central and South Asia, with an estimated population of roughly 42 million, approximately 73% dwelling in rural areas.[3] The country has a turbulent political history, with the Taliban now in control as the de facto authorities (DfA) since August 2021. This leadership is not diplomatically recognized internationally, apart from Russia[4] and the national economy has seen drastic reductions since 2021, driven by suspension of financial support from international bodies, the freezing of public assets, and embargoes.[5] Women have suffered significant reductions in freedom under DfA leadership - women and girls are prohibited from travelling without a male chaperone (mahram), denied high school and university education, and prohibited from entering numerous public spaces or workplaces.[6] According to the Afghanistan Gender Index, women exercise only 17.3% of their potential rights and freedoms.[7] The sustainability of healthcare delivery has been threatened since 2021, compounded by shortages of health professionals (especially female), the brain drain of Afghanistan, and disruptions in community-based delivery.[8] Preventable diseases, including measles and acute watery diarrhea, exacerbate risks of morbidity and mortality, with under-five mortality estimated at 55 deaths per

[3] World Bank. (2025). Urban Population – Afghanistan. Available at: https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=AF

[4] Crisis Group. (2025). Available at: https://www.crisisgroup.org/asia-pacific/afghanistan-russia-internal/russia-becomes-first-state-recognise-taliban-rightful-afghan-government

[5] 4 UN. (2024). Unanimously Adopting Resolution 2763 (2024), Security Council Renews Mandate of Taliban Sanctions Monitoring Team. Available at: https://press.un.org/en/2024/sc15935.doc.htm

[6] Think Tank European Parliament. (2024). Women's rights in Afghanistan: an ongoing battle. Available at: https://www.europarl.europa.eu/thinktank/en/document/EPRS_BRI%282023%29747084

[7] UN Women. (2025). Gender Index 2024. Available at: https://www.unwomen.org/sites/default/files/2025-06/gender-index-2024-afghanistan-en.pdf

[8] WHO. (2024). Health System Performance in Afghanistan 2023–2024. Geneva: WHO

1,000 live births.[9] Children under 15 represent roughly 43% of the population, forming a large cohort with significant health, developmental and nutritional needs.[10]

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.[11] 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.[12] Maternal mortality remains critically high, estimated at 620 deaths per 100,000 live births in 2023, totaling around 7,600 maternal deaths annually.[13] 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.[14] 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 this number in some provinces exceeding 30%).[15] Effective coverage of key reproductive, maternal, newborn, child and adolescent health interventions varies considerably, vitamin A supplementation reaches 72% of children aged six months and above, exclusive breastfeeding is practiced for 63% of infants for six months, and skilled birth attendance and institutional delivery rates are relatively high at 68% and 66%, respectively.[16] 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 integrated management of newborn and childhood (IMNCI) and antenatal care (ANC), effective utilization remains limited due to supply-demand gaps, quality issues, and restrictions on women's mobility.[17]

Afghanistan's healthcare system operates in the midst of a protracted humanitarian crisis, including instability, internal displacement, food insecurity, pervasive poverty, and drought. The system also suffers from critical underfunding: health expenditure was around 23% of GDP in 2022.[18] Heavy reliance on external aid[19] is 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.[20] 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-

[9] UNICEF. (2024). Afghanistan WASH Thematic Report (January – December 2023).
[10] World Bank. (2025). Urban Population – Afghanistan. Available at: https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=AF
[11] 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
[12] 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
[13] 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.
[14] UNICEF Afghanistan. (2022-2023). Afghanistan Multiple Indicator Cluster Survey (MICS).
[15] UNICEF Afghanistan. (2022). Afghanistan national nutrition SMART survey.
[16] UNICEF Afghanistan. (2022-2023). Afghanistan Multiple Indicator Cluster Survey (MICS).
[17] Ibid.
[18] World Bank. (n.d.). Current health expenditure (% of GDP). Afghanistan. Available at: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AF
[19] 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
[20] 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

of-pocket household expenditures (77.2%), followed by donor contributions (19.3%).[21] These factors, along with recurrent disease outbreaks, such as dengue fever and measles, and the lingering impact of the COVID-19 pandemic, place immense 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 BPHS and EPHS have substantially increased health facility coverage across the country.[22] Additionally, the establishment of the Community-Based Health Care (CBHC) Programme in 2003, which has been executed by BPHS contractors, 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.[23] This impact is reflected in the substantial increase in CHWs from 2,682 in 2005 to 29,596 in 2017.[24] 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 universal health care and the Sustainable Development Goals (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 the nationally representative Multiple Indicator Cluster Survey (MICS) 2010-2011, skilled birth attendance stood at 38.6% and ANC coverage (at least one ANC visit with a skilled health personnel) at 47.9%, and both increased – to 67.5% and 76.4% respectively – by the MICS 2022-2023.[25,26]

Afghanistan, however, still has a long way to go towards achieving universal health coverage and equitable access to healthcare services. As of 2025, Afghanistan has made some progress towards SDG 3 (good health and well-being), but it still faces major challenges to achieving this goal. For example, maternal mortality shows improvements from 1,273 in 2001 to 521 in 2023 (per 100,000 live births) but remains high; under-5 mortality has similar trends from 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%).[27,28] 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.[29] 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

[21] 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

[22] 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

[23] 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

[24] Ministry of Public Health. (2017). Community-based Health Care Data.

[25] Central Statistics Organization (CSO) and UNICEF. (2012). Afghanistan Multiple Indicator Cluster Survey 2010-2011.

[26] UNICEF. (2023). Afghanistan Multiple Indicator Cluster Survey 2022-23.

[27] UNICEF. (2023). Countdown to 2023 Country Profile: Afghanistan. Accessible: Afghanistan Profile Page 1 - Countdown 2030 - UNICEF DATA

[28] 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

[29] WHO Afghanistan. (2025). Health Information Hub. Available at: https://dashboard.whe-him.org/index.php/maps-3/

healthcare centers, particularly those in rural areas.[30] Operational elements of the CBHC/CHR and incentivization mechanisms warrant reconsideration, and better integration with community-based nutrition programmes is imperative to establish a comprehensive Community-Based Health and Nutrition Programme (CBH&NP).[31]

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 DfA introduced a slightly modified National Health Policy but are 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.[32]

Given the evolving landscape, ongoing discussions between the de-facto Ministry of Public Health (de-facto MoPH) and health partners highlight the necessity of reconsidering the service package, integration across diverse community health and primary health care 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 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.[33]

2.2 Health Emergency Response (HER)/Novel Financing Arrangement (NFA) Programme

The Health Emergency Response (HER)/ Novel Financing Arrangement (NFA) programme, implemented by UNICEF in Afghanistan, is a large-scale humanitarian health intervention designed to sustain and strengthen the delivery of essential health services in a context of prolonged crisis. The programme supports the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) nationwide through contracting-out modality with non-governmental service providers, as well as high Impact Value-Added (HIVA) component, which enhances maternal, newborn, child, and adolescent health (MNCAH) services. The programme's duty bearers include state and non-state actors, such as UNICEF (overall programme manager), the WB and ADB (partners), WHO (technical assistance), and the de-facto MoPH and PPHDs (de-facto authorities).

The HIVA component directly responds to the needs of women, adolescent girls, rural communities, and marginalized groups by strengthening lifesaving MNCAH interventions, improving quality of care, addressing nutrition and mental health needs, and enhancing community engagement and demand

[30] 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
[31] Internal document review.
[32] Ibid.
[33] Ibid.

generation. The programme recognizes that sustaining access alone is insufficient and therefore prioritizes quality, equity, and responsiveness to the specific needs of vulnerable rightsholders.

Additionally, the HER/NFA programme supports the efforts of Sustainable Development Goals (SDGs) 3: Ensure healthy lives and promote well-being for all at all ages, particularly:

SDG 3.1: Reduce the global maternal mortality ratio

SDG 3.2: End preventable deaths of newborns and children under five

SDG 3.7: Ensure universal access to sexual and reproductive health services

SDG 3.8: Achieve universal health coverage (UHC)

The programme also contributes to SDG 5 (Gender Equality) through increased access to female health workers and gender-sensitive services, and SDG 10 (Reduced Inequalities) by prioritizing underserved and crisis-affected populations. Key SDG-aligned indicators include antenatal care coverage, skilled birth attendance, institutional deliveries, postnatal care utilization, immunization coverage, and maternal and neonatal mortality reporting.

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 across 34 provinces. UNICEF has been in charge of managing the provision of essential primary and secondary healthcare services through the 'contracting- out' approach, collaborating with Service Providers (SPs). From January 2024 until March 2025, World Bank-supported BPHS and EPHS packages have been implemented in 24 provinces, with the remaining 10 supported by ADB along with HIVA interventions in the same 10 provinces.[34]

ADB provided USD 100 million-worth support under NFA 1.0 from January 2022 to December 2023 for nine provinces implementing HIVA interventions parallel to BPHS/EPHS. From January 2024 to June 2025, ABD support scaled up to ten provinces with HIVA interventions along with taking over BPHS/EPHS in these provinces with the budget of USD 200 million.[35]

The primary objective has been to augment the utilization and enhance the quality of essential health services provided at public health facilities across the nation. The programme continues the 'contracting-out' modality through SPs from September 2024 until now.

UNICEF manages programme oversight, financing, procurement, and performance monitoring, while service providers deliver services at primary, secondary, and community levels. At the time of implementation, the programme was fully operational, covering over 2,405 functional health facilities across Afghanistan, including health posts, basic and comprehensive health centers, district hospitals, provincial hospitals, and regional hospitals.[36]

The primary rightsholders of the HER/HIVA intervention are women, newborns, children, adolescents, and vulnerable populations, including internally displaced persons (IDPs), returnees, nomadic populations, and persons living in remote and hard-to-reach areas. Particular emphasis is placed on pregnant and lactating women (PLWs), newborns, children under five, and adolescent girls. The intervention predominantly

[34] Internal documentation.
[35] Ibid.
[36] Ibid.

targets rural and underserved areas, where access to essential health services is limited and maternal and newborn mortality remains high. The programme reaches populations through both facility-based services and community-based health care (CBHC) platforms, delivered by trained male and female Community Health Workers (CHWs). Although exact beneficiary numbers vary by province and service type, the programme serves millions of Afghans annually, with service utilization data disaggregated by sex, age, and service category through the national Health Management Information System (HMIS). Disability-disaggregated data remains limited but are partially addressed through disability and rehabilitation services within BPHS and EPHS.

The ADB NFA project's scope encompasses 733 health facilities and their associated communities with BPHS/EPHS provision alongside complementary, need-based, and tailored HIVA interventions. This comprehensive approach seeks to address the specific health needs of targeted HIVA 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 interventions to reduce maternal and newborn mortality. 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. HIVA interventions were happening parallel to BPHS/EPHS supported by World Bank. In 2024, ADB scaled up support to include Daikundi, making it ten provinces having HIVA interventions under NFA1.5 along with BPHS/EPHS packages being implemented in the same provinces by ADB.

Key HIVA interventions included scale-up of misoprostol for post-partum haemorrhage (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 expanded 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 provided BPHS/EPHS packages in the same ten provinces, strengthened synergies with technical partners (MSH/AFIAT, WHO), and applied 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 MoPH to UNICEF, the tools, instruments, and service delivery models established in Sehatmandi through third parties have been sustained and capitalized upon. In fact, the intervention is implemented through a multi-layered partnership structure where UNICEF serves as the principal executing and coordinating agency, contracting national and international NGOs as Service Providers; WHO provides technical leadership in quality assurance, disease surveillance, and emergency preparedness; de facto MoPH and PPHDs provide policy guidance, coordination, and regulatory oversight. Community structures, including CHWs, Health Shuras, Family Health Action Groups, and Community Development Councils, link households with health facilities and facilitate accountability. These stakeholders are connected through formal coordination mechanisms, such as Provincial Public Health Coordination Committees, Health Cluster platforms, referral networks, and shared monitoring systems (HMIS, TPM, and third-party verification) to ensure vertical and horizontal integration across community, primary, and secondary levels of care.

HER/NFA and HIVA design incorporate the requisite adaptability to respond to an ever-evolving sectoral landscape. The programmes remain receptive to implementation realities, on-ground challenges, data availability, insights garnered from monitoring activities, and continuous operational learning. 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.

UNICEF's health programming is structured around four key programme outputs:

I. Management of equitable and uninterrupted delivery of quality BPHS through PHC facilities, including district hospitals.
II. Management of equitable and uninterrupted delivery of quality EPHS through provincial and regional hospitals.
III. Management of the provision of HIVA interventions for Maternal, Newborn, Child, and Adolescent Health (MNCAH) at PHC and SHC facilities in certain province(s) in Afghanistan's southern and western regions.[37]
IV. Response to Acute Emergencies.

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

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

In 2022, the Health Management Information System (HMIS) recorded 3,919 public health facilities delivering BPHS across Afghanistan. The HER/NFA projects support 2,411 of these facilities, representing approximately 62% of the total facilities. HER/NFA facilities include 2 Reproductive Health Centers, 16 Public Hospitals, 78 District Hospitals, 381 Comprehensive Health Centers (CHCs), 772 Basic Health Centers (BHCs), 1,079 Sub-Health Centers (SHCs), 24 Maternity Waiting Homes, 34 Family Health Houses, and other PHC facilities in correctional facilities including 25 prison health facilities[38]. Table 1 summarizes the BPHS elements and services.

Table 1. BPHS elements and services[39]

Maternal and new-born care	• Antenatal care • Delivery care • Postpartum care • Family planning • Care of the new-born
Child health and immunization	• Expanded Programme on Immunization (EPI) • Integrated Management of New-born and Childhood Illness (IMNCI)
Public nutrition	• Screening (assessment), prevention, treatment, and management of acute malnutrition • Prevention of chronic malnutrition and micronutrient deficiencies
Communicable disease treatment	• Control of tuberculosis • Control of malaria • Prevention of HIV and AIDS

[37] 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.
[38] 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.
[39] 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

Mental health	• Mental health education and awareness • Case identification, diagnosis, and treatment
Disability and physical rehabilitation services	• Disability awareness, prevention, and education • Provision of physical rehabilitation services • 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.

Programme 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 summarizes the EPHS services available at both regional and provincial hospitals.

Table 2. EPHS services at regional and provincial hospitals[40]

	• Inpatient services → General and specialized surgical services (operating theatre, anesthesia, recovery room services, and sterilization services) → Obstetrics and gynaecology services (Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC)) → Pediatric services (including therapeutic feeding centers) → General and specialized medical services → Ophthalmology and ear, nose, and throat services → Mental health and psychiatric services → Dental services (in Regional Hospitals) → Forensic medicine • Emergency department open and staffed 24 hours

[40] 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

Clinical and Diagnostic Services	• Outpatient services including dental services. • Hospital pharmacy • Physiotherapy services • Laboratory, blood transfusion services and blood bank • X-ray and ultrasound services • Endoscopy services • CT scan (Kabul only at tertiary hospital level)

Programme Output 3: Management of provision of 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 initially until December 2023. Specifically, these targeted provinces encompassed 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. During that period (known as NFA 1.0), ADB-supported HIVA interventions were happening in parallel to World Bank-support BPHS/EPHS packages. Fron January 2024, ADB expanded HIVA interventions to ten provinces, including Daikundi, and assumed responsibilities for BPHS/EPHS delivery in those provinces, as part of the NFA 1.5). This has been the delivery modality until June 2025, with SAFE being introduced from July 2025.

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 (with high level of prioritization of maternal, newborn, child, and adolescent health).

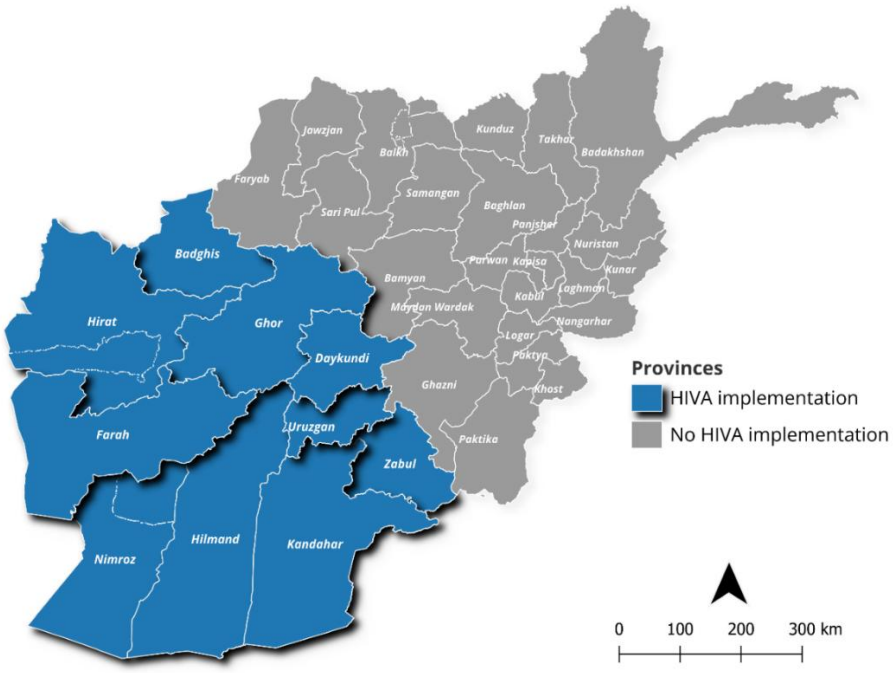
Table 3. HIVA Interventions

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
	• Expansion of the use of Chlorhexidine for umbilical cord care
	• Scale up of two new family planning methods:
	  ○ 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)
	  ○ Sub-cutaneous depot medroxyprogesterone acetate implants inserted by skilled birth attendants at health facilities.
	• Strengthening new-born care at BPHS/EPHS facilities with needful supplies and equipment and training based on needs and capacity assessment
	• Provision and use of Maternal Child Health Handbook (MCH-HB)

Supplies for treatment of severe acute malnutrition	• Provision of supplies including, but not limited to:
	  ○ Ready-to-use Therapeutic Food (RUTF) (supplied by UNICEF)
	  ○ Measurement equipment

(SAM) and for maternal and newborn care	○ 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 • 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 • Work towards ensuring availability of a standard package of water and sanitation facilities at BPHS and EPHS facilities in the province • Focus on facilities that require repair and rehabilitation to achieve standard functionality • 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: ○ 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. ○ New-born care both at facility and community levels ○ 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 • Production of social and behavioural change communication (SBCC) material • Mass and social media campaigns • Assessment of behaviour change • Interpersonal communication training for health workers and CHWs • Capacity building of local structures • Community engagement interventions through CHWs and community influencers, CSO and NGOs

Figure 1. Provinces in Afghanistan highlighting HIVA Implementation (NFA 1.5)



Programme Output 4: Responding to Acute Emergencies

UNICEF requires Service Providers (SP) 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, disease outbreaks such as vaccine-preventable disease outbreaks, acute watery diarrhea, other communicable diseases, as well as man-made emergencies, like conflicts and mass casualty incidents.

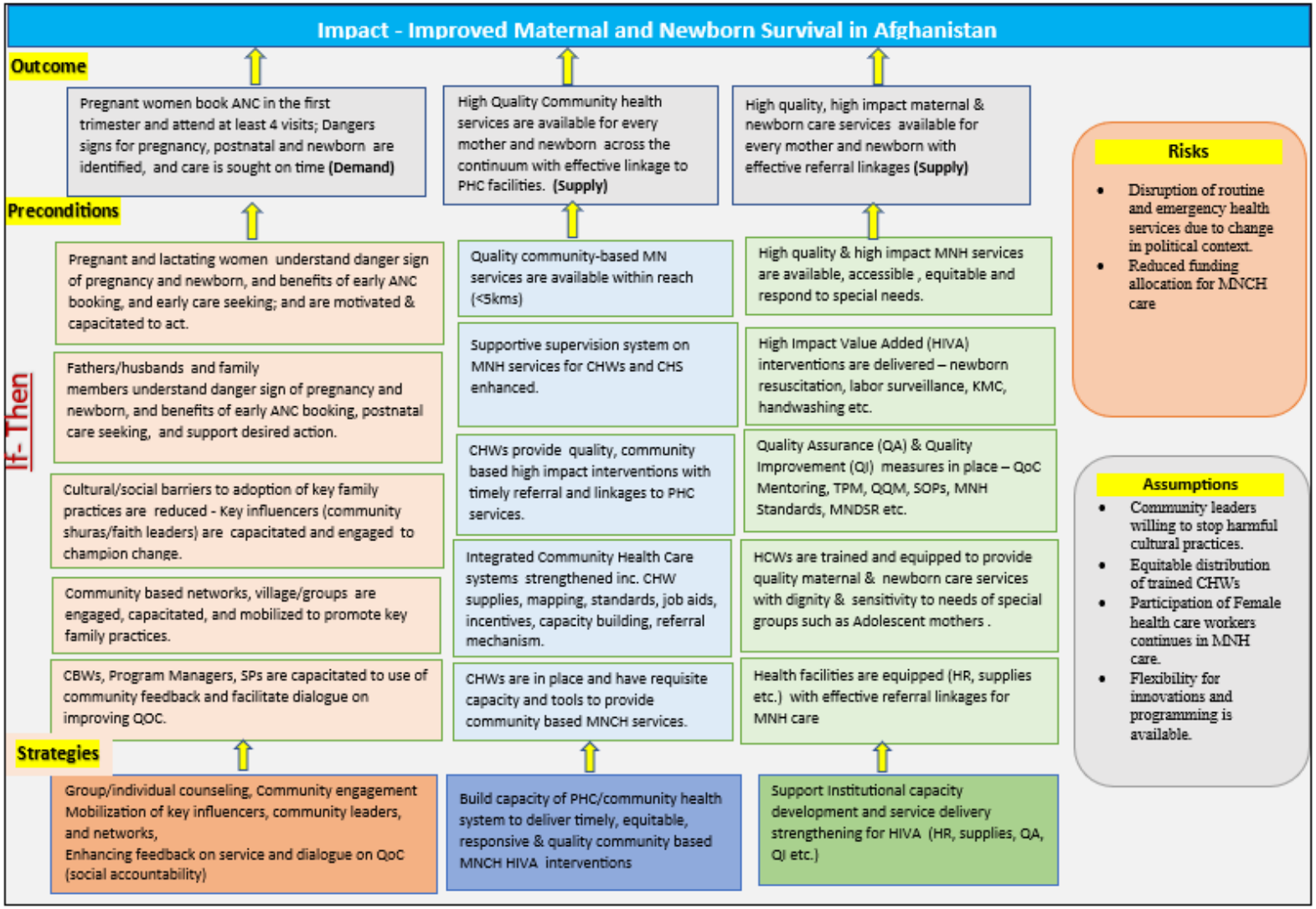
An essential responsibility of SPs involves the maintenance of emergency response committees at the provincial, district, and health facility levels. This entails meticulous coordination of emergency preparedness services in collaboration with all pertinent stakeholders well in advance.

Theory of Change: Figure 2 demonstrates the theory of change (ToC) delivered through the HIVA component of the HER/NFA programme: HIVA contributes to improved maternal and newborn survival in Afghanistan by ensuring that proven, life-saving maternal and newborn health (MNH) interventions are delivered with quality, equity, and continuity of care. The programme strengthens community and facility health systems so that high-impact interventions are available within reach of every mother and newborn. By building the capacity of community health workers and facility-based providers, equipping health facilities, and strengthening referral linkages, HIVA improves the availability, accessibility, and quality of essential MNH services across the continuum of care.

While the HER/NFA programme did not articulate a single, consolidated Theory of Change covering the programme in its entirety, the HIVA component reflects a clear and coherent change pathway within the broader intervention framework. HIVA simultaneously strengthens demand for timely care by empowering women, families, and communities to recognize danger signs and seek care early, and supply by improving the quality and responsiveness of MNH services. Through community engagement, early ANC promotion, and effective community–facility linkages, the HIVA pathway supports earlier care-seeking, improved service utilization, and continuity of care, ultimately contributing to reductions in preventable maternal and newborn deaths and improved survival outcomes.

The **Theory of Change** for the HIVA component is showcased below.

Figure 2. Theory of Change for the HIVA component



3 Evaluation purpose, objectives, use, and scope

The **purpose** of this evaluation is to assess the performance and added value of UNICEF's HER/NFA programme in Afghanistan[41] and its contribution to meeting beneficiaries' needs. The evaluation focused on interventions related to PHC through the BPHS, SHC through the EPHS, and HIVA services between January 2022 and December 2024.[42]

Specifically, the evaluation aimed to enable learning about the relevance, coverage, effectiveness, impact, efficiency, coordination 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 to inform future programming, policies and resources adaptations, as well as adaptations to the ongoing interventions to better serve the needs of beneficiaries, including vulnerable beneficiaries such as girls, women and residents of hard-to-reach regions. The evaluation results are meant to be used to enhance provision of services via Afghanistan's health facilities in the future and thereby improve population-level health outcomes and offer programmatic areas of opportunity to realize efficiency gains in the face of a tightening global funding reality.

More specific **objectives** of the evaluation included the following:

- → **Performance, comparative value-add, effectiveness, and relevance of the HER/NFA programme:** Assess the programme's performance and effectiveness with regards to health service delivery by contrasting the performance of HER/NFA-supported facilities before and after UNICEF takeover of these facilities in 2022, including the trend in each intervention year between 2022 and 2024. Assess and compare service delivery, including availability, accessibility, and quality of care, in HER/NFA-supported health facilities before and after the onset of UNICEF programming. Evaluate programme relevance and achievement of results towards 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 programme and its packages in attaining the expected results and looking at cost-efficiency over time.

Evaluation users and use: The findings and recommendations from this external evaluation are expected to be used to further shape the future of the health programme and packages in Afghanistan.

The **primary users** of this exercise are UNICEF Afghanistan, partners such as World Bank (WB), the Asian Development Bank (ADB), bilateral donors, implementing partners (such as SPs), the de-facto MoPH, beneficiaries, members of the Health Sector Technical Working Group (HSTWG), health and nutrition

[41] The HER/NFA programme encompasses all three service packages (BPHS, EPHS, and HIVA), funded by the World Bank in 24 provinces and the ADB in 10 provinces from January 2024 to March/June 2025. Please note that before 2024, BPHS and EPHS packages were funded by the World Bank in 34 provinces and the ADB-funded HIVA package in 9 provinces under NFA 1.0. Under NFA 1.5, ADB supported 10 provinces with HIVA package and administered BPHS/EPHS packages in the same provinces from January 2024 to June 2025.

[42] Please note that the evaluation team also leveraged secondary data from 2018 to 2022 and 2025 to add to the rigor of the methodological approach.

facilities, and healthcare and nutrition professionals. The primary users will utilize the evaluation findings to inform strategic decision-making, strengthen programme design, and improve implementation of health interventions within Afghanistan. For UNICEF Afghanistan, results will guide adjustments to the HER/NFA programme and enhance accountability to donors and beneficiaries. Health partners, such as WB, ADB, and bilateral partners, will use evidence to assess programme effectiveness, justify continued or future funding, and align resources with demonstrated health outcomes. Implementing partners (including SPs), and the de-facto MoPH are expected to 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 Headquarters (HQ), other UN agencies and NGOs 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 PHC 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. For more details on evaluation stakeholders and specific uses, please refer to the inception report available in Annex G.

Scope of the evaluation:

The **temporal scope** of this evaluation focused on UNICEF health programming in Afghanistan from January 2022 until December 2024, leveraging secondary data from 2018 to 2022 and 2025 to add to the rigor of the methodological approach.

The **geographic scope** of this evaluation is national, covering health facilities across Afghanistan receiving either HER/NFA or HER/NFA with HIVA across all 34 provinces using available secondary and administrative data. Primary data collection comprised of both qualitative interviews with key stakeholders and SPs administered by telephone, as well as a 15-minute online survey with SPs and health facility staff and management. The provincial coverage of SP interviews (both KII and online survey) was limited to areas with HER/NFA implementation and with SP oversight. In total, 27 out of 34 provinces are represented in the final sampling of SP qualitative data. The evaluation team relied on a sample of SPs provided by UNICEF; SP focal point information was not provided by the UNICEF evaluation team for the provinces of Daikundi, Wardak, Jawzjan, Kunduz, Farah, Ghazni, and Nangarhar. The provinces of Kunduz, Farah, Ghazni, and Nangarhar administered direct implementation through UNICEF and therefore are not observed in the sample of SPs as of November 2025 for a limited period. The sample was purposefully selected and is not representative of SPs at the provincial level or otherwise; the sample is meant to deepen understanding of quantitative findings. For more information on sampling and limitations, please refer to section 4.3.

The **thematic scope** of the evaluation was related to various critical aspects, such as availability, access and quality of care (with availability of health service packages), change in health outcomes, integration and synergies of health service packages (BPHS, EPHS, and HIVA), cost-efficiency, and monitoring and

evaluation. All of these were assessed with a cross-cutting lens considering e.g. gender, disability, equity, human rights, and 'leave no one behind' principles to ensure commitments to rights-based frameworks such as the Convention on the Rights of the Child (CRC), Core Commitments for Children (CCC), Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and Gender Equality and the Empowerment of Women (GEEW). The quantitative analysis incorporated health indicators particularly relevant for girls, women and other marginalized populations. Qualitative data was collected to probe project coordination, service delivery, coverage, as well as at-risk and gender dimensions of service delivery and accessibility.

Changed to the initial scope

Due to unforeseen obstacles and inability to obtain authorizations to commence primary data collection, the following changes were made to the scope of the evaluation since inception:

1. From impact to contribution: While the original project scope set out to compare HER/NFA facility performance to non-HER/NFA-supported facilities in Afghanistan, the evaluation team pivoted to a descriptive evaluation of UNICEF-supported facilities over time. This pivot was necessary for the following methodological reasons: 1) The comparison group facilities (i.e., non-UNICEF-supported facilities) did not exhibit parallel trends in outcomes when compared with the treatment facilities in pre-treatment time periods, and 2) the makeup of the comparison group facilities differed substantially from the treatment group facilities in terms of facility type and scope. Thus, a causal inference design was not feasible, as a viable counterfactual could not be identified. The revised methodology incorporates an interrupted time series (ITS) approach from baseline (2020) across four years of programme intervention. This evaluation is no longer considered an impact evaluation, due to the absence of a counterfactual group.

2. Evaluation Questions: Due to the removal of the comparison group, the evaluation question EQ1 and sub-component EQ1.1 were changed from their original versions:

Q1 [original]. What has been the impact, comparative value-add, effectiveness, and relevance of the HER/NFA programme on targeted health outcomes in HER/NFA-supported facilities vis-a-vis non-HER/NFA-supported facilities? Q1.1 [original]. 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?

The change in evaluation questions can be seen in Table 4 below, reflective of the revised methodology that considers only UNICEF-supported health facilities in Afghanistan during the period of interest (2022-2025) relative to baseline (2020).

3. Primary Data Collection Scope: At inception, the evaluation team planned to collect primary data of health facilities through observation, across 40 facilities and 10 provinces. However, the necessary authorization to conduct facility observations was not obtained, and thus this intended data stream was lost. The scope of qualitative data was reduced due to the same setback; because of this, FGDs across community members and health professionals were dropped. In lieu of these two components, the evaluation team conducted significantly more KIIs with stakeholders and Service Providers[43], as well as online surveys with SPs and health managements (recruited through snowballing). While the shifted project strategy provided high-level implementary and design forward perspectives, it lacked perspective at the beneficiary level. Despite setbacks, primary data collection went forth with stakeholders, as well as with Service Providers and health facility management within UNICEF-supported provinces, as an opportunity to provide feedback on the HER/NFA programme.

[43] At inception, 5 stakeholder interviews and 2 SP interviews were planned, whereas the final project scope included 15 stakeholder KIIs and 24 SP KIIs.

4. Geographic scope change: A key constraint on data collection at inception was the geographic coverage of qualitative interviews, which was only planned across two provinces due to financial constraints (Helmand and Nangarhar). However, with the changed scope relying on UNICEF-supported solicitation of interview participants, all KIIs were shifted to be conducted via phone, the final approach includes a wider range of SPs. In total, 24 provinces were covered (see section 4.3 for a list of exclusions).

5. Outcomes of Focus: The evaluation team intended to assess some outcomes of interest which were dropped from the scope, due to data unavailability or data quality issues. For example, the evaluation team intended to measure the availability of key drug stocks (e.g., misoprostol, contraceptive pills, etc.) over time through HMIS data, but the reporting was too inconsistent month-to-month to rely upon for analysis. Many additional indicators of HER/NFA interventions were not available in the HMIS dataset, and Annex H provides a comprehensive list of which interventions could be matched with HMIS data.

4 Framework, Methodology and approach

4.1 Evaluation framework

The evaluation team created an evaluation matrix by developing the proposed evaluation questions in the ToR via inception stage discussions with UNICEF Afghanistan, evaluation Steering Committee, an internal technical working group, and desk review (of programme documents, national survey data, such as the yearly Whole of Afghanistan Assessments and peer-reviewed literature). The evaluation matrix below lists illustrative indicators and data/methods for each set of questions and includes the DAC criteria of relevance, efficiency, effectiveness, impact, and sustainability, as well as humanitarian criteria of coverage and coordination. In addition, the evaluation leveraged AI-powered digital survey technology to anonymously reach programme implementers; crucial innovation that secured primary data despite logistical setbacks. The technical approach of the evaluation was guided by the key evaluation questions spanning three main themes: (1) programme performance and comparative value-added; (2) complementarities and synergies between health service packages; and lastly (3) cost-efficiency.

Table 4. Shortened evaluation matrix[44]

Evaluation questions	Illustrative indicators	Methodological tools[45]
Evaluation Theme: Performance, comparative value-add, effectiveness, and relevance of the HER/NFA programme		
Q1: What has been the performance, comparative value-add, effectiveness, and relevance of the HER/NFA programme with regards to targeted health outcomes in HER/NFA-supported facilities since UNICEF takeover of these facilities in 2022 relative to how these facilities performed in prior years?		
Q1.1. What influence have HER/NFA supported health facilities had on the **availability, accessibility, demand** and **quality** of **healthcare services** after initiation of UNICEF programming in 2022 vis-à-vis earlier years? **Q1.2.** How have **performance, value-added,** and **key trends evolved** from	• Institutional deliveries • Child vaccination, specifically Penta3 doses and Measles 1 doses for children 0-23 months • Pregnant women receiving four ANC visits	• Interrupted time series (ITS) analysis • KIIs with key stakeholders from organizations such as, the WB, ADB, UNICEF, and WHO (along with the

[44] For a full evaluation matrix, see Annex I.

45 Please refer to the methodology section (section 4.2) for more information on methodological tools.

2022 to 2024? How effective and relevant has the programme been to **address the needs?** **Q1.3**. How does the **performance/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)?	• Perceived accessibility and quality of services • Perceived changes in availability, accessibility, and quality over time	inception interviews conducted with WB, ADB, FCDO, WHO, EU, UNDP, UNFPA, WFP, Gavi, Global Fund, and Gates Foundation) • Online survey with SPs and health facility management and staff
Evaluation Theme: Complementarities, differences, and synergies between health service packages		
Q2: How does the inclusion of HIVA[46] interventions influence health service delivery and outcomes? What are the differences, additional impacts, complementarities, and synergies of integrating BPHS, EPHS, and HIVA interventions?		
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)? **Q2.2.** How does the integration of HIVA affect coordination, effectiveness, and sustainability of health service delivery models? **Q2.3.** How has the programme's reconfiguration evolved between 2022–2024, and what impact has it had on outcomes?	• Perceived alignment between packages • Perceived impact of HIVA on access and quality of services	• KIIs with UNICEF, WHO, donors, service providers • Online survey with SPs and health facility management and staff
Evaluation Theme: Cost-efficiency		
Q3: How cost-efficient is the HER/NFA programme in achieving its expected results and how has the cost-efficiency changed over time?		
Q3.1. How does the cost-efficiency of the HER/NFA programme vary between different service packages (BPHS/EPHS and HIVA), and how has this evolved over time?	• Estimated expenditure per person • Estimated cost-efficiency of outputs, including comparative analysis pre and post UNICEF transition • Perceived cost-efficiency	• Cost analysis • Quantitative comparison of costs and outputs over time • KIIs with UNICEF, WHO, donors, service providers

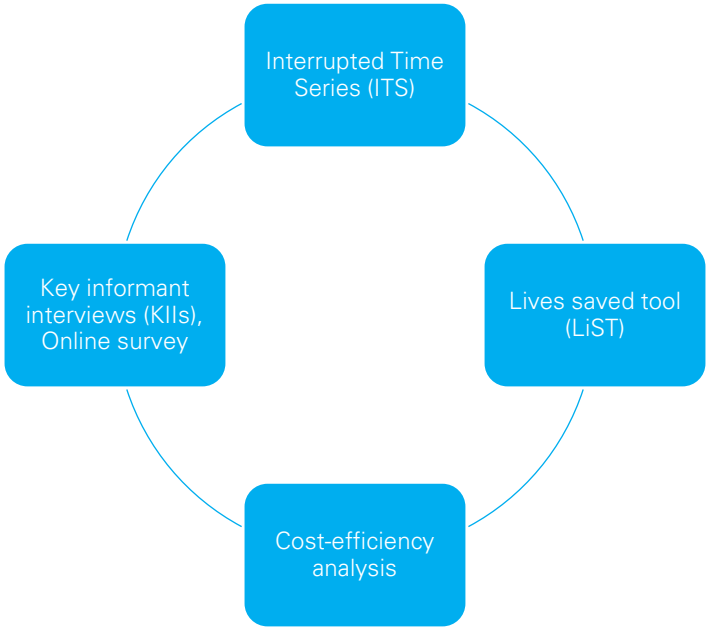
[46] As HIVA has undergone several iterations of implementation design, this evaluation will also serve as a critical baseline to establish the current landscape, measure initial conditions, and provide a foundation for tracking progress and impact over time.

4.2 Evaluation design and approach

Employing a **mixed methods approach**, this evaluation combined both quantitative and qualitative data and methods to assess the performance and value-added of UNICEF's health facilities which delivered HER/NFA and HIVA services in Afghanistan between 2022-2024. The methodologies used included: (1) interrupted time series (ITS) analysis of health indicator data, (2) Lives Saved Tool (LiST) modeling to estimate the potential number of lives saved due to the coverage achieved nationally on three select MCH interventions in Afghanistan, (3) cost-efficiency analysis examining the costs of the HER/NFA programme alongside increases in key service utilization outputs, as well as comparing costs and outputs pre and post UNICEF transition, and (4) analysis of primary qualitative data collected via key informant interviews (KIIs) with stakeholders and SPs, as well as online surveys with SPs and health facility management and staff (see Figure 3). Findings were triangulated across the various methodological components and data sources to overcome limitations arising from individual methods/sources and allow for a rich understanding of the topic.

Analyses 1 and 4 assessed evaluation questions on the performance of UNICEF's health interventions (evaluation questions 1 and 2), including evolution of trends between 2022-2024. Analysis 2 provides insights into the scale of downstream health benefits and what these could mean in terms of national scaleup of select interventions included under the UNICEF programmes covered by evaluated questions 1 and 2. Analysis 3 presents the costs of HER/NFA alongside improvements in important service utilization metrics to address evaluation question 3, illustrating the intervention's "bang for buck"[47] both currently and in comparison to the prior health system arrangement under Sehatmandi.

Figure 3. Methodologies employed in this Evaluation



[47] Meaning getting good value and worth of results for the money or effort spent/getting the most impact for the least cost.

The evaluation was designed to be **utilization-focused**, intended to inform decisions for ongoing programme and organizational improvements. A **participatory approach** was used, engaging key stakeholders at various stages to foster ownership throughout the process. The evaluation systematically **integrated gender, human rights, disability, equity, and 'leave no one behind' considerations**, by incorporating questions on these topics in the KIIs and online survey, and prioritizing health indicators particularly relevant to girls, women and other vulnerable populations in the secondary data analysis to embed the evaluation methods in commitments to rights-based frameworks such as CRC, CCC, CEDAW and GEEW. The evaluation ensured that guides, data collection, analysis, and reporting fully integrated cross-cutting issues. The evaluation mainstreamed disability considerations; special attention was given to the accessibility of data collection tools. The overall report follows UNICEF's Global Evaluation Reports Oversight System (GEROS) quality checklist, as well as United Nations Evaluation Group (UNEG) and UNICEF guidelines and standards for evaluation.

4.3 Data and Sampling

This evaluation relied on several sources of data. The evaluation team leveraged secondary and administrative sources of information, including health facility listings indicating which facility received UNICEF health programming during any intervention year, health system time series data collated via the Health Management Information System (HMIS)/District Health Information Software 2 (DHIS2), third-party monitoring data, MICS 2022-2023 data, Whole of Afghanistan survey data, UNICEF administrative data on programme costs and World Bank project financing reports. The team also collected qualitative data during the evaluation period via KIIs from select stakeholders and SPs, and fully anonymous online survey conducted among a wider pool of SPs and health facility management and staff. By combining information from multiple sources and weaving in key perspectives from stakeholders and programme implementers, this report triangulates information to provide a fuller picture of the performance of the HER/NFA programme. Detailed information on each data source is provided below.

4.3.1 Quantitative Data Sources

The evaluation leveraged several data sources for the quantitative analysis, those that allowed for an understanding of how health indicators and other health-related measures (such as programme costs) trended during the intervention years, particularly in relation to the pre-intervention period.

Health facility list

The evaluation team relied on the UNICEF-provided master sheet of facilities which contained information on which facilities were managed by UNICEF (either under the standalone HER/NFA or HER/NFA and HIVA programmes) during the years 2022-2024. There were 2,406 facilities covered by UNICEF management during this period, 745 of which implemented HIVA interventions. The UNICEF master list also contains location information, specifically province and district, and facility type which is an important determinant of service provision (since facilities of different types provide different levels and types of services).

Health facility-level data

The quantitative analysis relied on secondary data sources that provide information on key indicators/outcomes at the facility-level over time.

First, the evaluation utilized 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. HMIS/DHIS2 aggregates facility-level data for the country's different administrative levels. UNICEF extracted data on health facility-level indicators (such as total outpatient visits, child health outcomes such as measles 1 doses and number of girls detected with anemia, family planning measures such as number of condoms distributed, institutional deliveries) and population catchment data for treatment facilities

and shared these with the evaluation team. The team used data at the facility-month level for each year between 2018 and 2024, intending to incorporate several years of pre-intervention and post-intervention data into the analysis. Annex A presents an overview of the process used to clean the HMIS data.

Second, the evaluation also utilized third-party monitoring (TPM) reports provided by UNICEF to gain contextual information to inform the different analyses. Findings from TPM reports were triangulated with findings from this evaluation and included where relevant.

Population health indicators

The evaluation relied on demographic information and health indicators from several sources, including the MICS round conducted in Afghanistan in 2022-2023 and the Afghanistan Health Survey in 2018. The evaluation team sourced additional data on population distributions and birth rates from World Bank Open Data. Population survey data are incorporated into the LiST model as baseline inputs, and the additional World Bank data were used to adjust estimates of facility births as a proportion of total births over time.

Cost Data

UNICEF provided several administrative documents necessary for the cost-efficiency analysis, including a document with aggregate grant details for NFA 1.0, NFA 1.5, HER 1 (Parent Project), HER AF1, and HER AF2, as well as a document detailing the amount of each grant that was directly allocated to the service providers (SPs). Detailed budget documents for NFA 1.0 and NFA 1.5 were also provided. Disbursement data was obtained from World Bank reports, such as the June 2025 Implementation Status and Results Report for HER[48] and the Implementation Completion Report Review for Sehatmandi[49]. Data from the Afghanistan National Statistics and Information Authority and exchange rates were used to adjust 2022 funding levels to 2025 US dollars.

Online Survey

The team also administered short online surveys (approximately 15 minutes) through a fully anonymous single link access point. The survey focused on programme delivery and capacity questions catered to on-the-ground professionals, in lieu of facility-level observations.[50] The online survey platform is AI-powered, providing instant translation, transcription, and aggregation of findings.

Table 5. Online Survey Sample

Type of Interview	*Participants*	*Number of Contacted Respondents*	*Number of Refusals/No Response*	*Number of Interviews Started*	*Number of Interviews Retained*	*Total Completed*
Online Surveys	*Service Providers*	*298*	*266*	*32*	*25*	*33†*
	Health Facility Management/	0*	-	8	4	

[48] Cros, M. J. (2023). *Disclosable version of the ISR – Afghanistan Health Emergency Response (HER) Project – P178775 – Sequence No. 10 (English)*. Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/099060325052520518

[49] IEG Review Team. (2024). *Afghanistan: Afghanistan Sehatmandi (English)*. Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/099011924174058746

[50] At project inception, it was planned to collect facility-level observation data, however this exercise was not realized due to roadblocks in the permissions process.

	Health Professionals					
	Other‡	-	-	7	4	

*The evaluation team relied on snowball recruitment via SPs to reach Health facility management and staff respondents.

ˈ Although 33 responses were retained through the online survey, only 25 completed the survey in its entirety. To maximize data points, in total 33 interviews were retained among those that completed programme-based interview questions (past demographic information) ranging from 19% to 100% survey completion.

‡Respondents were recruited from the same pool as Service Providers and Health Facility Management/Professionals but did not provide their job title during the online survey, likely out of concerns for anonymity.

The evaluation team obtained the online survey sample through initial recruitment of the SP list provided by UNICEF, with additional efforts to encourage snowball recruitment (which were largely unsuccessful due to a high degree of respondent scepticism due to lack of permissions from the de facto MoPH). The evaluation team reached out to the base group of SP KII participants (n=24) alongside a more extensive list of SP focal points (n=298) to complete a 15-minute survey, to gather insights about their perceptions of HER/NFA programme delivery. As part of the snowball sampling, the evaluation asked the cohort to share the invitation with their health management and health professional team of staff. The targeted sample did not receive any incentives, but the evaluation team delivered periodic reminders via WhatsApp to complete the survey and to share it with their colleagues. In total, 47 online respondents started the interview, although a portion of the cohort did not finish to the end.[51] Of the online sample, the evaluation team retained 33 respondents who completed at least a portion of non-demographic questions; 25 of those completed the interview in its entirety. Among the 33 successful online survey respondents, 18 were SPs from the headquarters, 7 were provincial SPs, and 4 were health facility management or staff; 4 respondents did not identify as any category. All respondents who took up the online survey were male with a tertiary level of education (University, Technical School or Grad School). The provinces included in the online survey sample are Badakhshan, Badghis, Balkh, Daikundi (n=2), Farah, Faryab (n=5), Herat, Kabul (n=10), Kapisa, Khost (n=2), Laghman, Logar, Nangarhar, Panjshir, Saripul, Urozgan (n=2), and Zabul – a total of 17 provinces. Due to both the mode of recruitment (WhatsApp messages), as well as the method of snowball recruitment, the final sample distribution is 1) highly dependent on the willingness to engage from the SPs, in which case those in Kabul were over-represented in the online survey and 2) respondents must have a phone and internet access, possibly skewing respondents to more urban areas. Among the 33 SPs and health facility management and staff that took the online survey, 42% (n=14) noted having over 10 years of experience in Afghanistan's health system while 36% (n=12) had between 4-10 years - showing that the majority of the online sample have experience in the health system both before and after the HER/NFA programme rollout.

Scope Changes

Original Quantitative Plan: The HMIS/DHIS2 information was sourced from the earliest pre-intervention year available to implement a difference-in differences (DiD) approach to identify outcomes attributable to the HER/NFA programme while also accounting for pre-existing differences across UNICEF and non-UNICEF facilities. The WoAA annual household surveys were intended to be used to provide population-level information for multiple years in the pre- and post-UNICEF intervention period. Additionally,

[51] Significant drop-off was noted in the online survey exercise, with an initial 47 respondents entering the survey but only 33 answering questions of substance past individual-level demographic characteristics. Within the survey, there was still some degree of drop-off with n=29 completing a majority of the survey and n=25 finishing to the end.

observations of health facilities were planned via primary data collection across 40 health facilities, both UNICEF-supported and non-UNICEF supported across 10 provinces, selected through random selection.

Modification: The evaluation team pivoted to a descriptive interrupted time series (ITS) evaluation of UNICEF-supported facilities over time, from baseline (2020) across four years of programme intervention. The team abandoned the DiD approach given evidence of non-parallel trends across treatment groups in the pre-intervention period and since the validity of DiD relies on the parallel trends assumption. Also, there was an overall lack of comparability between UNICEF and non-UNICEF facilities. It is worth noting that for post-intervention changes to be attributed to the intervention, outcomes in treatment and comparison groups would have needed to evolve similarly during the pre-intervention period. WoAA analysis was also excluded from the final evaluation because WoAA data did not include sufficiently detailed geographic information to enable linking populations to facilities to assign treatment status. Due to complications attaining permissions, the health facility observations were replaced by an online survey completed by SPs, health facility management, and health facility workers.

4.3.2 Qualitative Data Sources and Sampling

Evaluation results rely on the collection and triangulation of qualitative data across key stakeholders and SPs to assess perceptions of HER/NFA programme performance along dimensions that cannot be assessed by quantitative data sources alone, such as coordination and sustainability.

Although the qualitative data 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 programme outcomes. This type of data is particularly valuable in understanding localized barriers and facilitators to programme success, offering insights that are often overlooked in quantitative approaches alone.

Stakeholders' experiences typically vary, and hence it is critical to capture diverse respondents' experiences and perceptions of their experiences. More importantly, capturing their experiences in their own words ensures that the qualitative data reflects a breadth of perspectives. The sampling strategy is intentionally designed to capture variation both geographically and institutionally. The following sections describe the qualitative collection exercises carried out during the evaluation period, which comprised of KIIs.

The team conducted one-on-one KIIs with key stakeholders and service providers, with each interview lasting 60 minutes. The following key themes guided each interview: programme design, programme delivery, equity towards at-risk groups/LNOB, and sustainability. The team utilized standardized discussion guides on a semi-structured level, depending on the extent to which a participant was able to speak to a specific area of expertise.

Table 6. Qualitative Sampling Framework*

Type of Interview	*Participants*	*Number of Contacted Respondents*	*Number of Refusals/No Response*	*Number of Interviews Started*	*Number of Interviews Retained*	*Total Completed*
KIIs	Key Stakeholders[4]	23	8	15	15	39
	Service Providers	66	42	24	24	

*Breakdown of interviews by organization, including Inception interviews, can be found in Annex G.

[†]During the inception phase, an additional 9 interviews were conducted with 24 global health stakeholders. Findings from these interviews are included in the Inception Report, as included in Annex F.

Key Stakeholder KIIs

The evaluation team identified stakeholders who maintain active involvement in the HER/NFA programme, such as implementers (UNICEF), donors (WB, ADB), and other vested parties (WHO, GAVI, Global Fund), as eligible to be interviewed[52]. The following key themes guided each interview: programme design, programme delivery, equity towards at-risk groups/LNOB, and sustainability. The UNICEF evaluation management team purportedly selected the sample, based on participant expertise of the HER/NFA programme design, implementation, and delivery. During the interviewing process, the evaluation team requested additional requirements on KII participant knowledge to ensure suitable coverage of evaluation questions by area of expertise.

Service Provider KIIs

Service Providers are the non-governmental organizations, or implementing partners, both national and international, that manage the provincial operations of the HER/NFA programme.

Provincial scope: The evaluation team obtained a sample of SP focal points and key staff from UNICEF, covering 27 of the 34 provinces. The evaluation team excluded the seven missing provinces (i.e. Daikundi, Wardak, Jawzjan, Kunduz, Farah, Ghazni, and Nangarhar) from the sample.[53] The final sample includes interviews with representatives from 24 provinces (one interview per province). For three provinces (i.e. Bamyan, Baghlan and Nooristan), the data collection team was unable to get a response from the Service Providers.

Participant selection: The evaluation team selected a preliminary sample of SP KIIs from a list of SP focal points, sorted at the provincial level to maximize geographic coverage. The evaluation prioritized participants with relevant knowledge of the HER/NFA programme (of the provided sample, those with roles not relevant to healthcare, service delivery, management, or programme logistics were removed from the sample, such as security officers). The final two interviews targeted Technical Health Directors to ensure sufficient coverage of health service delivery-related evaluation questions.

Scope Changes

The evaluation team modified the scope of qualitative data collection due to challenges with obtaining permissions. The following changes were adopted:

Original: KIIs were supposed to 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 was not materialized.

Modified: The evaluation team only conducted KIIs at the national (with Key Stakeholders) and provincial level (with SPs).

[52] Inception interviews included Key Stakeholders from ADB, EU, GAVI, Global Fund, WFP, UNFPA, UNDP, World Bank, WHO, Gates Foundation, FDCO, and UNICEF.

[53] The provinces of Kunduz, Farah, Ghazni and Nangarhar are direct implementation provinces without SPs to contact (since November 2025 and for limited period of time). The provinces of Daikundi, Wardak and Jawzjan are managed by SPs, but the evaluation team was unable to get contact information for these provinces.

Original: In addition to the KII interviews, FGDs were supposed to be conducted at the community/facility level and include health care professionals of HER/NFA 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 would have involved twelve (12) FGDs among a targeted sample of adults (aged 18 and over) that match the criteria specified below. Each FGD was expected to have 6-8 people.

Modified: The evaluation team replaced FGDs with a quantitative online survey that was distributed through provincial-level SPs to other SPs, health facility management, and health facility staff.

4.4 Data analysis

This section describes the analytical approaches employed to assess the HER/NFA programme and its HIVA component.

4.4.1 ITS analysis

The evaluation team used data reported by UNICEF facilities as part of the HMIS database to estimate health service delivery provision related to the following domains: total outpatient care, child health, non-communicable diseases, family planning, and perinatal health. Table 7 presents the HMIS measures which served as the outcome variables in the empirical models used for this part of the analysis and accordingly, these are referred to as outcome variables or outcomes throughout the remainder of the report.[54]

The team used an interrupted time series (ITS) methodology to assess how outcome variables have looked on average in UNICEF facilities during each of the intervention years relative to the pre-intervention period.[55] ITS is a research method that descriptively approximates programme performance by comparing trends before and after the initiation of the programme. For this evaluation, HMIS facility-month level data was kept only for the facilities classified as receiving UNICEF programming by the UNICEF master list.

[54] Select outcomes that are representative for each outcome category were analyzed to provide an understanding of how UNICEF's programming has affected key measures of interest. The number of outcomes within each category was 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. Shaffer, J. P. (1995). Multiple hypothesis testing. Annual review of psychology, 46(1), 561-584.

[55] The evaluation team had originally intended to use HMIS reports from both UNICEF and non-UNICEF facilities over pre- and post-intervention years to assess using difference-in-differences (DiD) estimation whether there were differential service delivery patterns in the former types of facilities between 2022 and 2024. However, data explorations showed that there was a lack of parallel trends on many of the outcome variables during the pre-intervention period, a requirement for the implementation of DiD (see Annex B). The different trends in the pre-intervention period likely stem from contracting-out and pay-for-performance arrangements like Sehat, Sehatmandi and SHARP that were previously implemented in what are now UNICEF facilities and that likely contributed to differences in outcomes and reporting systems across UNICEF and non-UNICEF facilities. Additionally, differential changes in reporting across UNICEF and non-UNICEF facilities during the intervention years could stem not only from health impacts of UNICEF's interventions, but also from UNICEF's oversight of data quality in its facilities. The team therefore was unable to implement DiD for a comparative analysis of HMIS data. The team had also planned to conduct DiD analysis of population-level health indicators from annual Whole of Afghanistan Assessment surveys but did not proceed because of the lack of parallel trends identified using HMIS data.

Table 7. Health measures examined in the ITS analysis

Outcome variable category	Outcome variable	Description
Facility caseload	Total outpatient visits	Aggregated across different morbidities and patient categories
Child health	Diarrhea outpatient visits	Across different types of diarrhea, including acute watery (with and without dehydration) and acute bloody
	Penta3 doses	Third dose of the pentavalent vaccine which provides protection from a number of life-threatening diseases: Diphtheria, Pertussis, Tetanus, Hepatitis B and Hib. For children 0-23 months
	Measles 1 doses	For children 0-23 months
	Girls detected with anemia	For females of all ages
Non-communicable diseases	Hypertension outpatient visits	Number of outpatient visits for people with hypertension (first time visits and follow-up visits)
Family planning	Condoms distributed (dozens)	Number of units distributed
	Oral pills distributed (cycles)	Number of units distributed of progestogen-only pills (POP), combined oral contraceptive pills (COC)
Birth-related outcomes	Antenatal care visit – Fourth (ANC4)	Number of 4th antenatal care visits attended by pregnant women
	Institutional deliveries	Normal and assisted deliveries at facility
	Maternal deaths	Maternal deaths due to major or other complications
	Neonatal deaths and stillbirths as a proportion of institutional and home deliveries	Perinatal deaths within facility-level catchment area

The team estimated the following ITS model to track health service delivery in HMIS facilities over time:

$$Y_{ft} = \beta_0 + \beta_1 2022 + \beta_2 2023 + \beta_3 2024 + \delta_d + \gamma_m + T' + \varepsilon_{ft} \quad (1)$$

Where β_1- β_3 are indicator variables for each year of the intervention: these convey the average common change borne by UNICEF facilities in each month in an intervention year relative to baseline. δ is a vector of district fixed effects – these restrict comparisons to facilities within the same district, γ_m are month

fixed effects (to account for seasonal variation in reports), and T' are facility type fixed effects since different types of facilities are likely to see different types and volumes of health care.[56] ε is the error term. The team clustered standard errors at the facility level (since observations over time for a facility are not independent). The team estimated specification (1) using linear probability modelling and also gauged the sensitivity of results for mortality outcomes using poisson generalized linear model estimation.[57]

Reports in 2018 appear to be very low in facilities across Afghanistan, calling into question the completeness of data in the earliest year (see Annex Figures 1 – 12 in Annex B). The evaluation team therefore decided to keep 2018 only for the descriptive evaluation of the data, but it is not included in the main quantitative analysis. The team estimated specification (1) using different post-2018 baseline years. The results section presents estimates from the preferred model in which 2020 is treated as the reference year (to avoid using 2021, the year of the political transition as part of the baseline) and there is an additional time fixed effect included for the year 2021.

The evaluation team investigated heterogeneity in the ITS results by running model (1) separately on different strata: (1) for the most urban and most rural areas of Afghanistan, (2) by type of facility/SP, (3) by gender of patient (this pertains only to the child vaccination outcomes), and (4) for the nine provinces that received the HIVA component consistently during the intervention years.

The team identified which areas of the country are more urban and more rural from a 2024 publication on national population characteristics by Afghanistan's National Statistics and Information Authority (NSIA).[58] The team sourced data on provincial rural and total populations to estimate the share of each province constituted by the rural population. The country is largely rural with 88% of province being rural on average (95% is the median). The team specifically explored whether ITS results varied in the provinces having less than 70% rural population (four of the 34 provinces in the country) and the provinces having 95% or more rural population (17 provinces).

To investigate heterogeneity in facility performance by type of health facility (facility type was sourced from UNICEF's master sheet of facilities), the estimation was conducted separately for the following facility types: (1) CHCs (around 400 facilities), (2) BHCs (around 800), (3) SHCs (around 1,000), and (4) hospitals (around 100).

The HIVA province-focused ITS estimation is conducted for areas where HIVA was implemented in each intervention year (2022-2024): Herat, Kandahar, Badghis, Farah, Ghor, Helmand, Nimroz, Urozgan, and Zabul. Daikundi was excluded in the analysis as it was added later (e.g., in 2024).

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.

4.4.2 LiST modelling approach

The analysis of HMIS/DHIS2 data was supplemented with the LiST modeling component. 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 of the health interventions to produce estimates of lives saved over time due to these interventions throughout a country.[59] One of the key benefits of the LiST model is the ability to simultaneously model the outcomes

[56] Health facility categories include CHCs, BHCs, SHCs, hospitals, family health houses, mobile health teams and 'others'.
[57] These robustness checks assess mortality counts by facility-month.
[58] NSIA. (2024). Estimated Population of Afghanistan 2024-2025.
[59] https://www.livessavedtool.org/about.

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.

The LiST approach was used to model the potential impacts of **three MCH interventions** prioritized under UNICEF's BPHS, EPHS, and HIVA health interventions: facility deliveries, cesarean deliveries, and ANC visits. Note that the modeling exercise was conducted for the country as a whole and not just areas covered by UNICEF programming (because of limitations with conducting LiST for sub-national units combined with the distribution of both UNICEF and non-UNICEF facilities within each district). As a result, the modeled estimates of lives saved should be interpreted as reflecting the potential population-level change of increased coverage of selected interventions in Afghanistan overall, rather than as outcomes directly attributable to UNICEF-supported facilities alone. Even though it does not showcase specific UNICEF's contribution, it provides a reasonable approximation of the scale of health benefits associated with the selected types of interventions prioritized under HER/NFA and HIVA. When triangulated with facility-level utilization trends, qualitative evidence, and cost-efficiency analysis, the findings remain useful for understanding the programme's contribution to national health gains and informing strategic decision-making.

The LiST model is programmed to estimate lives saved due to a certain menu of health interventions. The evaluation team first sought to identify which of these LiST interventions overlapped with MCH interventions enhanced under UNICEF's BPHS, EPHS, and HIVA facilities *and* had service provision information available via the HMIS/DHIS2 database (or other data sources) – see Table 8. These were the interventions for which the LiST analysis was able to make projections. In other words, the LiST approach focused on a subset of interventions implemented under UNICEF's health programmes in Afghanistan between 2022 and 2025 for which the evaluation team had robust HMIS data. See Annex A for LiST-specific data cleaning notes. Note that the outcome variables used for the previously described ITS analysis did not perfectly align with the interventions focused on in the LiST model, as the LiST analysis is constrained to a specific set of MCH interventions. Annex H provides a table of all HER/NFA interventions alongside HMIS data availability and LiST inclusion.

Table 8.MCH services prioritized by UNICEF's Health Programmes for which country-level service provision information is available for the years of focus and that have corresponding interventions in the LiST model

Service utilization data	Data source	LiST interventions
First ANC visit	HMIS	Syphilis detection and treatment
Fourth ANC visit	HMIS	Hypertensive disorder case management
		Diabetes case management
Facility delivery	HMIS	Clean birth environment
		Assisted vaginal delivery
		Immediate drying and additional stimulation
		Thermal protection

		Antibiotics for preterm PROM Neonatal resuscitation Manual removal of placenta MgSO4 for eclampsia Antibiotics for maternal sepsis Uterotonics for postpartum hemorrhage Removal of retained products of conception Blood transfusion
Cesarean delivery	HMIS	Cesarean delivery

Nationally representative household data was used to estimate baseline country-level demographic patterns (e.g. annual births) and pre-intervention coverage of each intervention highlighted for the LiST analysis. LiST incorporates 2022-23 MICS data to capture Afghanistan's coverage rates for these interventions in 2022. To estimate increases in coverage across Afghanistan during the period of focus (2022-2024), HMIS/DHIS2 data was used, similarly to the methodology in Safi et al., 2023.[60] The evaluation team evaluated the percentage change in service utilization for each intervention over these years and applied this percentage change to the baseline coverage to estimate coverage over time. The team also consulted existing third-party monitoring data to verify that the coverage increases demonstrated with HMIS/DHIS2 data were realistic for the given context. Once all the coverage information for the selected interventions during the years of interest were imputed into the LiST analytic platform, the tool translated the raw coverage numbers to effective coverage rates for the constellation of interrelated interventions (Table 6). For example, the LiST model does not contain specific impact estimates for lives saved attributable to receiving a fourth ANC visit, but LiST assumes that such visits are associated with receiving case management for hypertension and diabetes, and the tool imputes an estimate of effective coverage for these interventions that is derived from ANC coverage estimates. The LiST model uses these products to subsequently estimate the number of lives saved attributable to increased access to the select MCH interventions in Afghanistan between 2022 and 2024. Note that the accuracy of the LiST estimates hinges on the validity of underlying assumptions about the relationship between enhanced coverage through increased service utilization and intervention quality and effectiveness.

A second, prospective LiST analysis was also conducted to project the number of potential lives saved under an ambitious scenario in which coverage rates for the three key interventions reach 90% by 2030. For this analysis, HMIS/DHIS2 data were used to estimate coverage through 2025, and linear interpolation was employed to estimate rates between 2026-2029, with the 2030 coverage rate of 90%.

4.4.3 Cost-efficiency analysis

The evaluation team conducted a cost-efficiency analysis to explore the extent to which the HER/NFA programme increases the rate of health service delivery. First, the analysis lays out the total costs of the HER/NFA programme in terms of disbursements through June 2025, and presents these costs alongside

[60] 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.

the number of facilities served and the size of the total target population, which was provided in the health facility dataset from UNICEF. The analysis also assesses the proportion of each grant allocated directly to SPs.

To explore cost-efficiency, the evaluation team endeavoured to compare costs and key service utilization under the current UNICEF-managed system with the previous Sehatmandi programme. Using the methodology of Anderson et al. (2021) as a guide, the team translated the results of the ITS analysis into percentage change in service utilization from the Sehatmandi period to the current HER/NFA structure. That is, the coefficients of the ITS analysis, which represent average monthly change per facility, were multiplied by 12 (to aggregate from monthly to yearly) and then by 2,406 to derive the aggregated annual increase in outcomes for all UNICEF-supported facilities. These aggregated increases were then compared to 2020 baseline values to produce the percentage increase in service utilization for each year. Then, the costs of the Sehatmandi programme were adjusted for inflation and exchange rates to 2025 US dollars in order to compare the increase in funding under HER/NFA to the increase in key service utilization. The results of this analysis show the current "bang for buck"[61] being achieved by the HER/NFA programme in comparison to the prior funding structure. The analysis is repeated for facilities receiving NFA funding for HIVA implementation.

The quantitative review of cost data was supplemented with contextual qualitative data from KIIs which provided perspectives and experiences relating to the programme budget and financing structures, clarified key cost drivers, provided insight as to why costs may be higher in certain contexts, and highlighted implementation mechanisms that may lead to higher cost savings. KIIs also explore disruptions in purchasing power and salary provision that have occurred as a result of currency fluctuations.

4.5 Limitations and mitigation measures

This evaluation has certain limitations which are described below along with strategies adopted to mitigate any impacts these might have on the validity of evaluation findings.

Evaluation: As discussed above, this evaluation was originally intended to be an impact evaluation, focusing on identifying the impacts of UNICEF programming via DiD methodology and a comparison of pre- and post-HMIS data across UNICEF and non-UNICEF facilities. The evaluation team, however, identified a lack of parallel trends and an overall lack of comparability between the treatment group and comparison group, which precluded a DiD approach. Accordingly, the team pivoted to examining data for UNICEF facilities over time with an ITS methodology which can provide suggestive evidence of programme performance but cannot definitively point to causality.

Primary Data: The inability to procure permissions from the de facto MoPH significantly impeded the collection of primary data. The evaluation team replaced the initial plans to collect facility-level observation data with administering online surveys. Despite permissions being unobtained, the team managed to collect information among SPs at the Headquarters and provincial levels, through both KIIs and online surveys. Despite all efforts, the evaluation team encountered a degree of hesitancy among petitioned respondents, with several indicating that they had not been alerted about the evaluation. In fact, the evaluation team was unable to conduct SP KIIs in three provinces due to SP refusal: Bamyan, Baghlan, and Nooristan. While Baghlan province only had 2 available contacts to recruit from thus making non-contact unsurprising, Bamyan and Nooristan had comparable numbers relative to other interviewed provinces (10 or more), suggesting that other factors may have driven nonresponse. In particular, the online survey effort was treated with greater skepticism among the recruited cohort: of a total of 298 recruited SP respondents (plus snowball recruiting which was seldom taken up), only 33 took up the

[61] Meaning getting good value and worth of results for the money or effort spent/getting the most impact for the least cost.

survey, despite single-link full anonymization practices and UNICEF-supported notices for survey dissemination. Moreover, the use of a snowball sampling approach may introduce self-selection and selection bias, as participants are more likely to refer individuals within their own networks who share similar characteristics or views, potentially leading to a more homogeneous sample and over-representation of certain perspectives. Therefore, the evaluation team mitigated this risk by triangulating findings across multiple data sources and methods and systematically cross-checking emerging themes to validate consistency and reduce the influence of any single network or viewpoint.

The qualitative data collected through the evaluation comprises implementers, designers, and stakeholders invested in the programme's success. On top of this, community member FGDs were not realized during the project due to lack of authorizations to commence primary data collection from the de-facto MoPH. Without first-hand beneficiary-level perspectives in combination with a sample concentrated among those that have designed and implemented the programme, the success of the HER/NFA's programme achievement may lack varied perspective and direct insight on how community access and service provisions for marginalized groups have evolved through the HER/NFA programme.

Estimation of HIVA: The evaluation team conducted the ITS analysis for the subset of facilities implementing HIVA interventions (N=745), and results for several outcomes lacked statistical significance. It is likely that the smaller sample size of HIVA facilities reduced the statistical power of the analysis, making statistically significant findings less likely; however, the size and direction of the model coefficients remained suggestive of positive outcomes despite the lack of statistical significance.

4.6. Quality assurance and ethical considerations

The evaluation firm applied its internal quality assurance (QA) framework throughout this evaluation, which included standard processes and tools to ensure quality in team recruitment, contractual oversight, performance management, troubleshooting, resource planning, time management, and technical QA. Further, the internal procedures ensured the evaluation adhered to quality and ethics principles while meeting the specific requirements of the UNICEF GEROS Handbook. Moreover, UNICEF Afghanistan, through the evaluation manager, evaluation management team, internal technical working group, and evaluation steering committee, has provided extra layers of quality assurance. For more details on quality assurance, please refer to the inception report available in Annex F.

The evaluation followed UNICEF's Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis[62], UNEG Code of Conduct[63], UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation[64] and UNEG Ethical Guidelines for Evaluation[65]. These frameworks guided the application of UNEG's and UNICEF's core principles:

- Integrity: ensuring truthful and accurate data collection, transparency regarding the evaluation's purpose and origin, and maintaining independence throughout the process.
- Accountability: providing clarity on the evaluation approach and the intended use of participants' responses, with full responsibility for ethical conduct and reporting.

[62] UNICEF. (2021). UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis. Available at: Branded Procedure Template
[63] UNEG. (2008). UNEG Code of Conduct for Evaluation in the UN System. Available at: UNEG Code of Conduct for Evaluation in the UN system | UNEG
[64] UNEG. (2024). UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations. Available at: UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations | UNEG
[65] UNEG. (2020). UNEG Ethical Guidelines for Evaluation. Available at: UNEG Ethical Guidelines for Evaluation | UNEG

- Respect: implementing culturally appropriate communication and consent procedures in Dari and Pashto, and scheduling data collection to accommodate women's daily routines.
- Beneficence: adapting methods to mitigate risks associated with restrictions on women's participation, whether as staff or beneficiaries, thereby prioritizing safety and minimizing harm.
- Justice: giving consideration to who benefits and who carries the burden of evidence generation.

The evaluation adhered to UNICEF-Adapted UNEG Evaluation Reports Standards (2017)[66], UNICEF's Disability-inclusive evaluations guideline (2022)[67], UNICEF Policy on Personal Data Protection (2020)[68], and UNICEF Standard on Information Security (2018)[69]. The evaluation received Ethical/Institutional Review Board (IRB) approval and clearance from the global institution.

The evaluation is also grounded in a rights-based framework, drawing on international human rights instruments including the Convention on the Rights of the Child (CRC) [70], the Core Commitments for Children in Humanitarian Action (CCC) [71], and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) [72], which underscore children's and women's rights to adequate nutrition and health. In line with the CRC's principles of non-discrimination, best interests of the child, and the right to survival and development, the evaluation assessed whether health interventions reached the most vulnerable children equitably and contributed to improved health outcomes. The CCC framework informed the evaluation's focus on accountability, quality of service delivery, and the protection of children in humanitarian settings. CEDAW principles guided the analysis of gender dimensions. To the extent possible, the design, data collection, and analysis integrated these elements by disaggregating data by sex and age, examining equity in service coverage across provinces, and assessing the extent to which programme implementation upheld the rights and dignity of beneficiaries.

In terms of Evaluation Conduct, the team considered views from all interviewees and stakeholders to ensure impartiality. Methods caused no physical or psychological harm to participants and options were provided to participants to stop immediately when risks outweighed benefits.

The team followed evaluation obligations: independence, impartiality, credibility, no conflict of interest, honesty, integrity, and accountability paying particular attention to obligations toward female participants meaning, respect for dignity and diversity, rights, confidentiality, and avoidance of harm.

Confidentiality and consent to participate and record was assured at all times. Information was kept confidential and used only for evaluation purposes. Procedures were in place to address or report risk and refer participants for support if needed.

Data and information were analyzed for accuracy, completeness, and reliability per UNEG and UNICEF policies and guidelines. Transparency in data accessibility, presentations, and reports was maintained.

[66] UNICEF. (2017). UNICEF-Adapted UNEG Evaluation Reports Standards. Available at: UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf
[67] UNICEF. (2022). Disability-Inclusive Evaluations in UNICEF. Available at: Disability-Inclusive Evaluations in UNICEF
[68] UNICEF. (2020). UNICEF Policy on Personal Data Protection. Available at: UNICEF Policy on Personal Data Protection
[69] UNICEF. (2018). UNICEF Standard on Information Security. Available at: UNICEF Security Requirements.pdf.pdf
[70] United Nations General Assembly. (1989). Convention on the Rights of the Child. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child
[71] UNICEF. (2020). Core Commitments for Children in Humanitarian Action. Available at: https://www.unicef.org/media/87611/file/Core%20Commitments%20for%20Children%20(English).pdf
[72] United Nations General Assembly. (1979). Convention on the Elimination of All Forms of Discrimination Against Women. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women

Qualitative and quantitative data (written, audio, video, observation) were anonymized. Only the team and evaluation management accessed data, stored on secure servers maintained by ORB/AIR and UNICEF. All data remained UNICEF's intellectual property and was not used for other purposes.

5 Evaluation findings

This section presents findings for each evaluation question.

5.1 HER/NFA performance, value-add, effectiveness, and relevance

Key findings

- HER/NFA programme was highly relevant and effective in stabilizing Afghanistan's health system after 2022, delivering sustained improvements in maternal, newborn, and child health service utilization and demonstrating clear value-add compared to pre-transition performance despite worsening external constraints.
- Programme performance and effectiveness improved significantly under UNICEF management, with HER/NFA-supported facilities consistently outperforming non-HER/NFA facilities on most service delivery indicators, including outpatient visits, ANC4, institutional deliveries, childhood illness care, and vaccinations between 2022-2024. Compared to 2020, ITS analysis showcased that HER/NFA facilities demonstrated sustained improvements across multiple service delivery indicators between 2022-2024, including higher outpatient visits, childhood illness visits, vaccination uptake, ANC4 visits, and institutional deliveries. Adverse trends in maternal (due to major and other complication) and perinatal mortality and family planning in later years are largely attributable to external shocks, including restrictive policies affecting women's access to care and large-scale population returns, suggesting that observed gains in female health outcomes likely understate the programme's true impact.
- HER/NFA programme generated clear value-add through coordination, monitoring, and community engagement, driving increased service utilization, improved data quality, enhanced quality of care, and stronger accountability, particularly in rural and hard-to-reach areas, despite persistent constraints in medicines and infrastructure. The HER/NFA programme's QQM results show system-wide improvements in health facility quality of care over time, with steady gains across structural quality, content of care, and outcome quality. Increased community trust drove higher demand that now often exceeds facility capacity.
- HER/NFA programme delivered meaningful equity gains for women, girls, and rural populations through improved access to female providers and outreach services, while people with disabilities and displaced groups remain less visible in outcomes and rising returnee inflows are increasing pressure on services.
- Expanded coverage of three key MCH interventions (ANC visits, facility deliveries, and caesarean deliveries) translated into substantial health impact, with LiST modelling estimating 10,600 lives saved (4,923 neonatal lives saved, 2,429 maternal lives saved, and 3,245 stillbirths averted) between 2023-2025, and projections indicating that over 56,000 additional lives could be saved by 2030 if coverage reaches 90%.

EQ1: What has been the performance/impact, comparative value-add, effectiveness, and relevance of the HER/NFA programme with regards to targeted health outcomes in HER/NFA-supported facilities after UNICEF takeover of these facilities in 2022 relative to how these facilities performed in prior years?

Findings from all data sources confirm that the HER/NFA programme was highly relevant in targeting issues of maternal and child health, as well as providing enough overall emergency support to prop up the Afghan health system in a time of need. Quantitative analyses illuminate programme effectiveness over time, and a comparison of these outcomes with programme investments over time (see EQ 3) reveal the substantial

value-add of HER/NFA. Qualitative respondents primarily tie this impact to improved coordination efforts in rural areas, extensive monitoring and reporting, and capacity building efforts.

Descriptive statistics indicated that HER/NFA facilities showed sustained improvements in reporting and performance after 2018, remaining above non-HER/NFA facilities except in family planning, while both HER/NFA and non-HER/NFA facilities experienced rising maternal (due to major and other complication) and neonatal mortality beginning in 2023 (for figures, please refer to Annex B). In 2018, reporting across all indicators was very low in HER/NFA facilities, followed by a sharp increase in 2019. From that point onward, HER/NFA facilities generally reported higher levels than non-HER/NFA facilities. From 2020 onward, HER/NFA facilities largely sustained or further increased their reported numbers, consistently remaining above those of non-HER/NFA facilities. The main exception is in family planning indicators; after 2020, distribution of oral pills and condoms rose steeply in non-HER/NFA facilities, surpassing levels observed in HER/NFA facilities. Finally, mortality indicators (maternal and neonatal deaths) rose in both HER/NFA and non-HER/NFA facilities starting in 2023.

Despite implementation limitations like medicine procurement and infrastructural integrity, SPs, key stakeholders, and online respondents found the HER/NFA programme to be effective at positively impacting health outcomes. Results from the ITS analysis combined with qualitative triangulation provide key insights on this evaluation question for a range of health outcomes.

Based on ITS analysis, HER/NFA facilities demonstrated sustained improvements across multiple service delivery indicators between 2022-2024, including higher outpatient visits, childhood illness visits, vaccination uptake, ANC4 visits, and institutional deliveries compared with 2020. Family planning distribution initially increased before declining in 2024, while maternal (due to major and other complication) and neonatal deaths showed modest but notable increases in the later intervention years.

Table 9 below shows ITS results for different categories of outcomes across all UNICEF facilities (both those that provide the standalone HER/NFA services and those that provide additional HIVA interventions) – outpatient visit volumes, child health, non-communicable diseases, and family planning. Table 10 contains results for various prenatal care and birth-related outcomes.

Total outpatient visits: The results indicate an increase in facility-level outpatient visits to UNICEF facilities in each intervention year relative to 2020. On average, a UNICEF facility received about 4,800-6,600 additional outpatient visits over baseline per year during the intervention. KII participants attribute this increase to a gain in community trust in and knowledge of the health system, as well as increased accessibility and quality of care. With this increase in care provision, a significant share of online survey respondents (comprised of SPs and health facility management and staff) indicated that patient demand often exceeds the ability of facilities to provide care.

Diarrhea visits: Diarrhea visits were higher on average in UNICEF facilities in each intervention year: about 420-600 additional visits per facility over baseline per year during the intervention period. Successful programme efforts to prevent diarrhea, through community outreach campaigns (as detailed by qualitative respondents), likely result in the underestimation of the programme's influence on diarrhea prevalence among catchment populations, which is calculated through quantitative analysis based on patient visits alone.

Child vaccination: The team assessed changes on two different vaccination measures – Penta3 and Measles1. UNICEF facilities administered more doses of each of these vaccines throughout the intervention period (2022-2024) relative to baseline. Note though that the magnitude of the average increases is not large: 12-60 additional Penta3 doses per facility per year and 36-84 additional Measles1 doses per year. Findings indicate average annual facility visit increases of 48 to 60 Penta 3 vaccinations in 2022 and 2023 but a slight decline is noted in 2024 with increments of only 12 doses per year. This is

supported by TPM reports where an early upward trend in vaccinations is noted in initial HER implementation followed by a decline in 2024[73]. Qualitative evidence confirms that these efforts were realized through the HER/NFA programme, and that mobile vaccination teams made this impact possible in hard-to-reach areas.

Girl anemia: Detection of anemia among girls was higher in UNICEF facilities between 2022 and 2024 than in 2020, presumably because the facilities were testing more individuals. Qualitative evidence also points to improvements in data reporting through the programme.

Hypertension: UNICEF facilities received more hypertension-specific visits during intervention years than in 2020: on average, a facility saw 36-108 more patients per intervention year than during baseline. According to qualitative findings, while the capacity to detect hypertension increased through the HER/NFA programme through staff capacity building, the ability to treat these cases was unchanged due to unavailable medicines for the treatment of this disease.

Family planning: The team included two family planning measures in the analysis pertaining to the distribution of condoms and oral pills. UNICEF facilities increased distribution in the first two years of the intervention (2022-2023) relative to the baseline. However, UNICEF-facility level distribution of family planning methods declined in 2024. The distribution of contraceptives is much more stigmatized in comparison to maternal and child health interventions, according to interviewed SPs, which may in part explain the decrease in distribution post-2024.

ANC4 visits: As Table 10 shows, the average UNICEF facility saw 36-72 more ANC4 visits per year during the intervention period (2022-2024) relative to baseline (2020), showing how the programme has improved service delivery for pregnant women. SPs suggested that the community education provided through health posts increased community knowledge on the benefits of seeking prenatal care at least four times throughout pregnancy, which could explain the increase in demand for pregnancy care.

Institutional deliveries: UNICEF facilities conducted more institutional deliveries in each year of the intervention period relative to baseline, with the average facility performing 24-36 more deliveries per intervention year relative to baseline. This is supported by TPM reports which also indicate positive increases in facility deliveries in a sample of UNICEF facilities[74]. Interviewed SPs suggest this can in part be attributed to community outreach efforts that encourage prospective mothers to seek institutional care.

Maternal deaths (due to major and other complication): There were no significant changes in maternal deaths (due to major and other complication) in UNICEF facilities in the first two years of the intervention. In 2024, there was an increase in maternal deaths at the facility level. Results are robust for maternal death counts when estimation is conducted using poisson generalized linear models, a specification particularly suitable for count data (see Table C3 in Annex C). Stakeholders indicate that these results are likely foremost attributable to newly introduced laws in 2024[75] rather than the programme itself. On top of this, a staggering number of Afghan refugees that fled to Iran in 2021 without legal status were forced to return, with over 1 million returnees in 2025 alone,[76] of which the majority have been women and children, with the hardest hitting provinces being ones of HER/NFA programme delivery (Herat has received 38% of returnees and Kabul has received 22%).[77] These external factors have strained the health system and

[73] Particip GmbH, & KIT Royal Tropical Institute. (2024). TPM HER2 – Round 4: Key findings – Final report (UNICEF Third Party Monitoring, verification period October–December 2024/Mizan-Qaws 1403).
[74] Ibid.
[75] The DfA passed the Law on the Promotion of Virtue and the Prevention of Vice in August 2024.
[76] Naseh, Mitra. (2025). One of the World's Largest Refugee Populations, Afghans Have Faced Increasing Restrictions in Iran | Migration Policy Institute. Available at: https://www.migrationpolicy.org/article/afghan-refugees-iran
[77] OCHA. (2025). Afghanistan Returnees Overview. Available at: Afghanistan Returnees Overview (as of 26 July 2025) | OCHA

increased the share of vulnerable groups in need of care, and provide plausible explanation for increases in recorded maternal deaths.

Perinatal deaths: The team assessed changes in perinatal death[78] as a proportion of births reported by the facility to occur in its catchment area (aggregated of institutional deliveries and home deliveries). Findings indicate a small decline in perinatal deaths in 2022 (results show an average 0.1 percentage point decline during the months in 2022) and an increase in 2024 (a 0.3 percentage point increase during the months in 2024). The 2023 estimate is statistically insignificant.[79]

With a cross-temporal analysis it is important to consider external factors that may also influence health delivery outcomes that occurred during the same period of analysis: in August 2024, the DfA passed the *Law on the Promotion of Virtue and the Prevention of Vice.* This law implemented strict restrictions on how women could appear in public, including the requirement to be accompanied by a mahram (male guardian) in public, among others, that pose barriers to women seeking healthcare. Therefore, any notable declines in health outcomes, particularly related to female health and family planning that shift downwards starting in 2024, are likely impacted at least in part by this policy. In fact, the descriptive graphs of trends across UNICEF and non-UNICEF health indicator trends in Annex B suggest similar broad patterns in the progression of health measures during the intervention years, thus pointing to common external factors playing a role in shaping health nationwide during the period of focus. The gains of the HER/NFA programme on institutional delivery and other female-health related outcomes are likely understated due to concurrent policies that decrease availability of care to women.

[78] The outcome variable here is still births plus neonatal deaths as a share of institutional deliveries and home deliveries.
[79] Results were similar using poisson generalized linear models (see Table C3 in Annex C). Note that the poisson models assess the count of neonatal deaths and stillbirths at the facility-month level.

Table 9: Total outpatient visits, child health, non-communicable diseases and family planning

	(1) Total outpatient visits	(2) Diarrhea outpatient visits	(3) Penta3 doses 0-23 months	(4) Measles1 doses 0-23 months	(5) Girls detected with anemia	(6) Hypertension outpatient visits	(7) Condoms distributed (dozens)	(8) Oral pills distributed (cycles)
2021	76.07***	12.06***	-1.37***	-0.31	3.81***	2.51***	0.67	2.57***
	(12.24)	(1.88)	(0.35)	(0.35)	(0.90)	(0.70)	(0.52)	(0.57)
2022	398.30***	50.37***	3.70***	6.82***	18.49***	6.74***	1.85***	3.77***
	(21.12)	(2.79)	(0.39)	(0.43)	(1.29)	(0.91)	(0.70)	(0.68)
2023	549.13***	45.18***	4.99***	4.77***	19.03***	8.74***	2.08**	3.25***
	(26.00)	(2.98)	(0.41)	(0.41)	(1.50)	(1.17)	(0.88)	(0.87)
2024	436.96***	36.84***	1.11***	2.97***	12.68***	2.70**	-3.29***	-5.01***
	(24.41)	(2.78)	(0.42)	(0.43)	(1.53)	(1.22)	(1.03)	(0.90)
Observations	144,360	144,360	144,360	144,360	144,360	144,360	144,360	144,360
R-squared	0.70	0.51	0.60	0.58	0.41	0.43	0.36	0.46

Standard errors in parentheses are clustered at the facility level. *** p<0.01, ** p<0.05, * p<0.1. Regressions control for month fixed effects, facility type fixed effects and district fixed effects. Data included for years between 2020 and 2024. Ordinary least squares/linear probability modelling is used for all estimations.

Table 10: ANC and birth outcomes

	(1)	(2)	(3)	(4)
	ANC4 visits	Institutional deliveries	Maternal deaths	(Neonatal deaths + stillbirths) as a proportion of births
2021	1.43***	2.00***	0.00	-0.00*
	(0.16)	(0.37)	(0.00)	(0.00)
2022	3.15***	1.69***	-0.00	-0.00**
	(0.22)	(0.38)	(0.00)	(0.00)
2023	5.72***	2.98***	-0.00	0.00
	(0.25)	(0.47)	(0.00)	(0.00)
2024	5.52***	2.31***	0.01***	0.00***
	(0.27)	(0.53)	(0.00)	(0.00)
Observations	144,360	144,360	144,360	144,360
R-squared	0.39	0.56	0.02	0.02

Standard errors in parentheses are clustered at the facility level. *** p<0.01, ** p<0.05, * p<0.1. Regressions control for month fixed effects, facility type fixed effects and district fixed effects. Data included for years between 2020 and 2024. Births (used as the denominator of the outcome variable in column 5) aggregate monthly institutional and home births reported by facilities. Ordinary least squares/linear probability modelling is used for all estimations.

Using HMIS data for the entire country, the **LiST analysis** provided insights on the potential number of lives saved due to the coverage achieved on three select MCH interventions in Afghanistan during the three-year period of focus: ANC visits, facility deliveries, and cesarean deliveries. The LiST analytic component applies to a select subset of interventions included in UNICEF's EPHS, BPHS and HIVA packages, and this analysis thus excludes interventions which are 1) not incorporated into the LiST platform, and/or 2) lack sufficient HMIS/DHIS2 data for the years 2022-2024. The evaluation team limited the analysis to changes in coverage rates for the three selected interventions, and the LiST analysis modelled lives saved attributable to enhanced coverage of ANC visits, facility deliveries, and cesarean deliveries. Please refer to Annex H for more information on availability of data and key indicators.

It is important to emphasize that while the three interventions included in this analysis are those that were prioritized by UNICEF's health programming, the benefits described are modeled for the entire country population, not just those exposed to UNICEF's programming. That is, the evaluation team included national estimates of coverage increases for key interventions in the model due to geographic limitations of the model inputs and the fact that districts in Afghanistan contain both UNICEF and non-UNICEF facilities, which makes sub-national estimates of lives saved difficult to isolate and impossible to attribute to UNICEF-specific facilities.

LiST analysis results indicate that the coverage rates achieved Afghanistan-wide for **ANC visits, facility deliveries, and cesarean deliveries** between 2023 and 2025 produced a projected total of 4,923

neonatal lives saved, 2,429 maternal lives saved, and 3,245 stillbirths averted for the three-year period of focus. Year 2022 serves as the baseline year for the LiST analysis; therefore, the model does not estimate "lives saved" for that year relative to itself. LiST calculates lives saved based on changes in intervention coverage compared to a baseline; since 2022 defines that reference point, there is no counterfactual improvement against which to estimate lives saved for 2022. While, in principle, lives saved could be modeled by comparing 2022 coverage to an earlier historical baseline (e.g. 2021), this was not feasible in the current analysis due to the absence of nationally representative MICS coverage data prior to 2022-2023.

Table 11 reports the lives saved for each year. The results represent the additional lives saved over a three-year period attributable to enhanced coverage of these three key MCH interventions in Afghanistan after 2022. These results reflect retrospective projections based on estimated coverage rates for a three-year period.

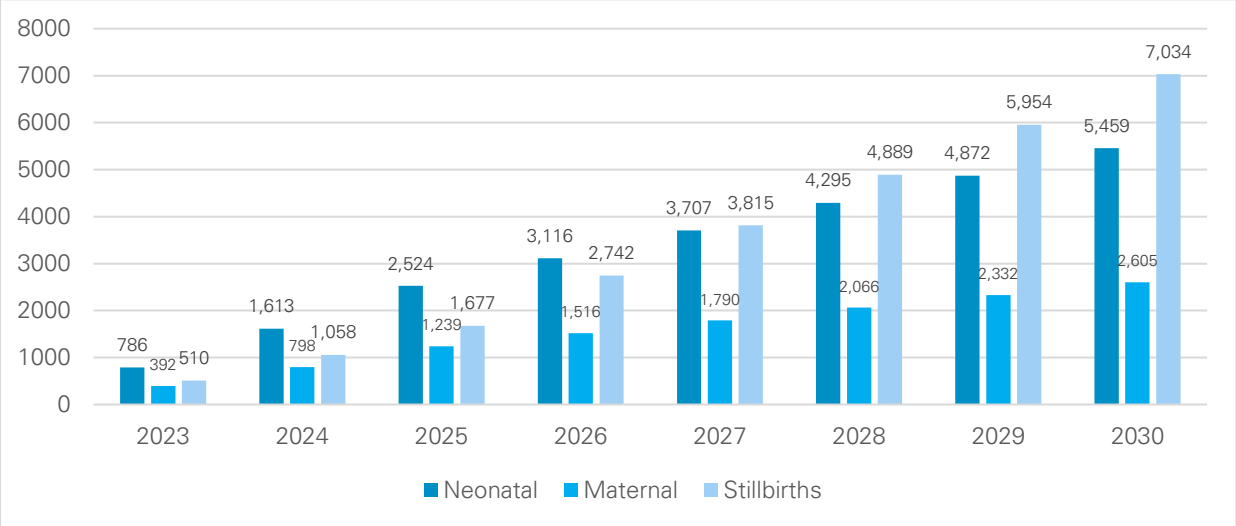
Table 11: Lives saved attributable to enhanced coverage of ANC visits, facility deliveries, and caesarean deliveries, 2023-2025

	2023	2024	2025	Total
Neonatal	786	1,613	2,524	4,923
Maternal	392	798	1,239	2,429
Stillbirths averted	510	1,058	1,677	3,245

[a] The estimate of child lives saved excludes neonatal lives saved

Figure 4 illustrates an additional LiST modeling exercise, assuming 90% coverage of the three key interventions in 2030. That is, the values represented for years 2023-2025 reflect the retrospective analysis conducted using HMIS data, and the values for 2026-2030 represent hypothetical lives saved under the continuing expansion of intervention coverage nationwide. **Using the LiST model to project impacts attributable to increased coverage of three key MCH interventions reveals substantial increases in lives saved for years 2023-2025;** the analysis projects nearly 11,000 lives saved over the three years. **The subsequent projection through year 2030 shows an additional 56,000 lives saved that could be realized if coverage rates increase to 90%.**

Figure 4: Projected lives saved attributable to reaching 90% coverage of ANC visits, facility deliveries, and caesarean deliveries, 2023-2030



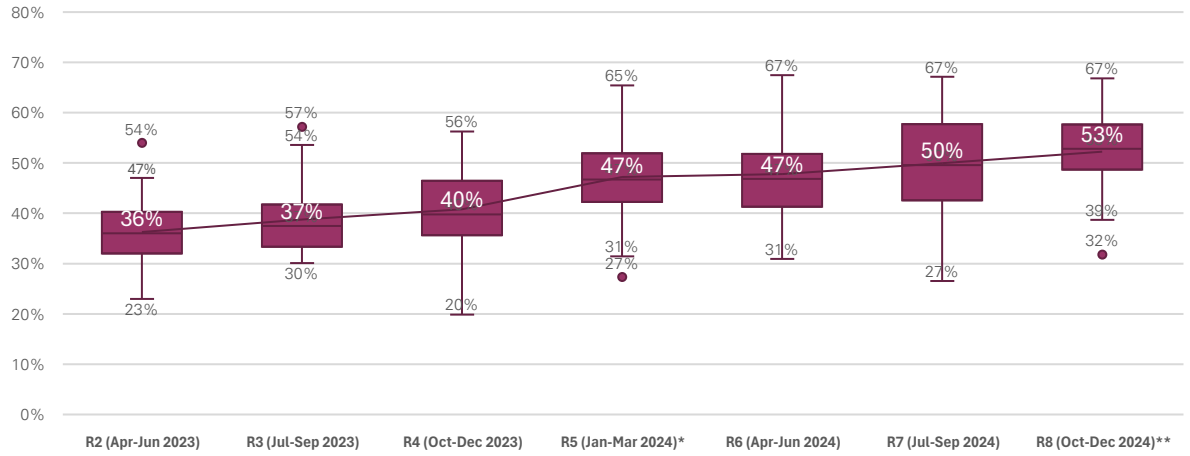
EQ1.1: What influence/impact has HER/NFA-supported health facilities had on the availability, accessibility, demand and quality of healthcare services after initiation of UNICEF programming in 2022 vis-à-vis earlier years?

When asked whether the **availability and accessibility** of basic health services has changed since the transition to UNICEF management in 2022, a majority of online survey respondents (30/33) and interviewed SPs said that the availability of care improved as a result of the HER/NFA programme. SPs noted that this increased availability was especially pertinent in rural and hard-to-reach areas. SPs attribute most of this improvement to the establishment of health centers and posts in remote areas, as well as the utilization of mobile vaccination teams. Improvements in coordination were significant, as SPs and stakeholders praised the use of data-driven decisions to ensure the continuity of care in these remote areas even with limited seasonal accessibility. In addition to increased availability in hard-to-reach areas, stakeholders noted a stabilization of preexisting healthcare facilities, highlighting training and enhanced monitoring as key contributors. Although the availability of sufficient female health workers continues to be a challenge in healthcare accessibility, SPs note that UNICEF has made great efforts to mitigate this issue, and that the challenges posed are not unique to the HER/NFA programme. Stakeholders specifically pointed towards female staff availability as a strength, noting its direct relationship to women accessing care. For the quantitative trends on availability of services, please refer to the EQ1 above (specifically tables 9 and 10 and annex B).

On **quality of care**, HER/NFA programme's strong Quantified Quality Metrics (QQM) provide a comprehensive, standardized framework to assess health facility performance across structural, process, and outcome dimensions of quality. The QQM system captures structural quality through domains such as general management, hygiene, OPD services, family planning, laboratory capacity, essential drug management, maternity care, EPI, and antenatal care, ensuring facilities meet minimum service standards, have functional infrastructure, trained staff, essential medicines, and proper governance mechanisms. Content quality assesses clinical practice against national and WHO protocols across priority conditions (e.g. pneumonia, diarrhea, TB, labor, postnatal and antenatal care, family planning), examining the full clinical pathway from history-taking to diagnosis, treatment, counselling, and follow-up. Outcome quality focuses on service results for children under five and family planning clients, including client satisfaction. Complementing this, health workforce assessments track staff availability, timely salary payments, gender balance, training (including GBV), and job satisfaction, while functionality verification evaluates drug and consumable availability, storage conditions, equipment readiness, non-P4P services, and hospital governance. Together, these domains enable objective measurement of service readiness, clinical quality, workforce performance, and governance, supporting continuous quality improvement, accountability, and evidence-based management of health services.

The overall QQM results show a steady and sustained improvement in health facility performance over time. Mean QQM scores increased consistently from 36% in R2 (Apr-Jun 2023) to 53% in R8 (Oct-Dec 2024), reflecting progressive strengthening across structural, content, outcome, workforce, and functionality domains. This upward trend indicates that quality improvement measures implemented under the programme are translating into measurable gains at facility level. Performance gains are evident not only in mean scores but also in the upward shift of overall score distributions. Upper performance thresholds increased from approximately 54-57% in 2023 to around 67% by mid-late 2024, suggesting that higher-performing facilities continue to improve while overall system capacity strengthens. Although variability remains, particularly among lower-performing facilities, the minimum scores also improved over time, indicating gradual reduction in the lowest levels of quality.

Figure 5: Overall QQM performance from April 2023 to December 2024



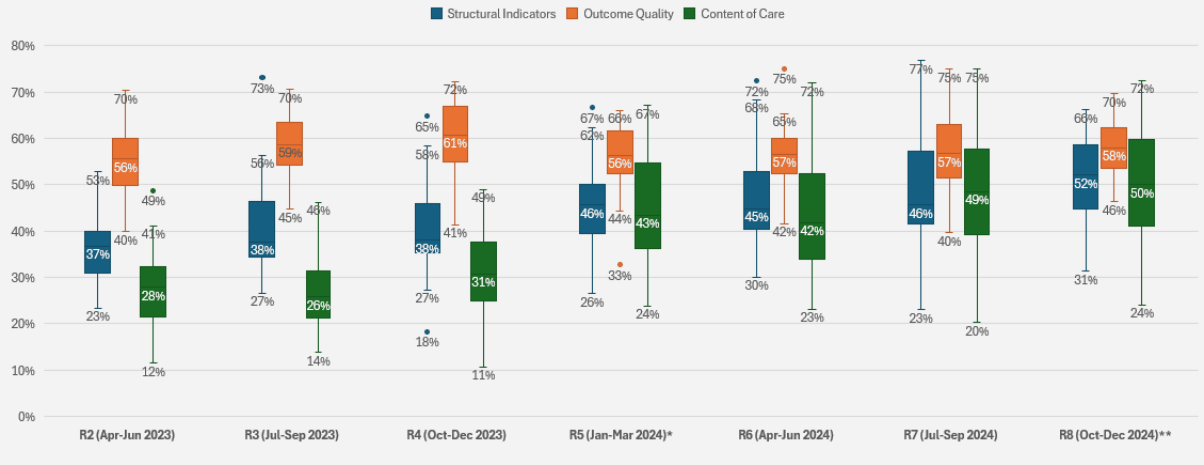
*R5 The reporting period was January to March 2024. However, due to contractual delays the data collection was concluded in July 2024.

** In R8, 8 provinces have not concluded data collection and hence have not been included in the analysis – Badghis, Daikundi, Farah, Kapisa, Khost, Laghman, Nangarhar and Zabul.

Disaggregated QQM results by component show consistent improvements across structural quality, outcome quality, and content of care over successive reporting rounds, reflecting balanced progress in service readiness, clinical practice, and results.

Outcome quality remained the strongest-performing component throughout the period, with mean scores increasing from 56% in R2 (Apr-Jun 2023) to 58% by R8 (Oct-Dec 2024), indicating sustained gains in service outcomes and client-facing results across facilities. Structural quality demonstrated steady and meaningful improvement over time, with mean scores rising from 37% in R2 to 52% in R8. This trend reflects improvements in facility management systems, infrastructure, equipment availability, hygiene conditions, governance arrangements, and essential service readiness. The upward shift in both mean and upper-range values suggests that investments in systems strengthening and facility functionality are translating into tangible quality gains. Content of care, while starting from a lower baseline, showed the largest relative improvement across the reporting period. Mean scores increased from 28% in R2 to 50% in R8, highlighting notable progress in adherence to clinical protocols, case management quality, counselling, and continuity of care across priority services.

Figure 6: QQM performance by component from April 2023 to December 2024



*R5 The reporting period was January to March 2024. However, due to contractual delays the data collection was concluded in July 2024.

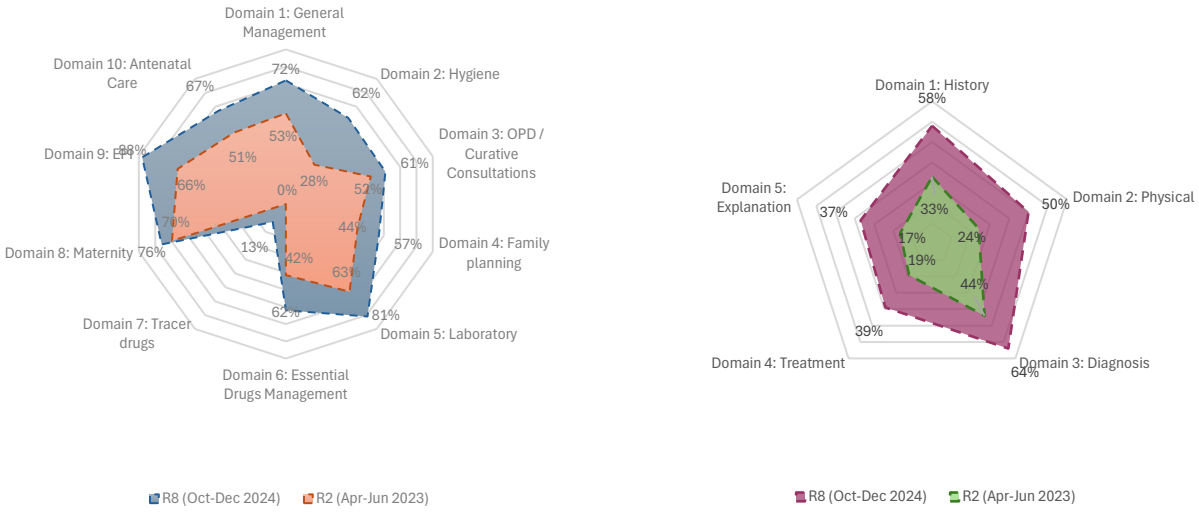
** In R8, 8 provinces have not concluded data collection and hence have not been included in the analysis – Badghis, Daikundi, Farah, Kapisa, Khost, Laghman, Nangarhar and Zabul.

Domain-level analysis shows substantial improvements in both structural quality and content of care between R2 (Apr-Jun 2023) and R8 (Oct-Dec 2024), indicating broad-based strengthening of health facility systems and clinical practice over time.

For structural indicators, strong gains are observed across nearly all domains. The most pronounced improvements are seen in hygiene (28% to 62%) and essential drug management (42% to 62%), highlighting improvements in infection prevention and availability of medicines. Significant progress is also evident in laboratory services, which increased from 63% in R2 to 81% in R8, along with OPD/curative consultations (52% to 61%), and family planning (44% to 57%). General management improved markedly from 53% to 72%, indicating stronger facility governance, reporting systems, and administrative processes. Maternity and EPI domains remained comparatively strong, reaching 76% and 88% respectively by R8, while antenatal care improved from 51% to 67%.

For content of care, all assessed clinical domains demonstrate clear upward trends. History-taking improved from 33% to 58%, while physical examination rose from 24% to 50%, reflecting better clinical assessment practices. Diagnosis showed strong performance overall, increasing from 44% in R2 to 64% in R8, suggesting improved clinical decision-making. Gains were also observed in treatment (19% to 39%) and explanation/counselling (17% to 37%), although these domains continue to lag behind others.

Figure 7: Structural Indicators and Content of Care Performance, R2 v R8



*R5 The reporting period was January to March 2024. However, due to contractual delays the data collection was concluded in July 2024.

** In R8, 8 provinces have not concluded data collection and hence have not been included in the analysis – Badghis, Daikundi, Farah, Kapisa, Khost, Laghman, Nangarhar and Zabul.

Almost all online survey respondents (30/33) have seen improvements in the **quality of care** since 2022 and most believe that patient health outcomes have improved somewhat or significantly during the same period (27/33), which is in line with TPM data. Both SP and stakeholder KII participants widely believe that the quality of care has increased under UNICEF management. KII participants attribute this to the implementation of high quality and routine monitoring. This monitoring, coupled with UNICEF's involvement to help SPs resolve issues that arise, ensures quality of care amongst HER/NFA facilities. Additionally, participants recognized significant efforts to increase health worker capabilities through training and capacity building opportunities. Many SPs note that the same apps used to fill out quality control checklists include resources and knowledge checks for health workers, helping to increase and ensure quality of provider knowledge. However, many SP respondents think that these

capacity building opportunities have decreased in recent years – with a more prominent emphasis during early transition years.

The perceptions of stakeholders and implementers alike are overwhelmingly positive of the impacts of HER/NFA, however a small minority of online respondents believe that patient outcomes have declined since 2022 (3/33); two of these cases mention believing that the extensive monitoring may be too restricting, and gaps in medicine supply reduce efficiency, a commonly cited issue among many interviewed SPs and stakeholders. A few stakeholders cite reductions in efficiency due to extensive monitoring, as they view the time spent monitoring as an opportunity cost to patient-facing healthcare work, suggesting that health outcomes could be maximized through re-prioritization.

Stakeholders emphasized that UNICEF has established effective community feedback and accountability mechanisms, enabling community members to freely raise complaints or concerns through direct communication channels with UNICEF and health facilities, including a dedicated hotline. This responsive follow-up system has been widely viewed as strengthening trust in health services and ensuring timely resolution of operational and facility-related issues, thereby contributing to improved service quality and community confidence.

Some factors may impede both the **quality and availability** of healthcare, such as limited electricity coverage and bathroom availability. Among online respondents, while very few indicate an absence of toilets from facilities which they oversee (3/29), many indicate that electricity access is only available at times or across some facilities (17/29). This points to a potential limitation of effective service delivery due to possible impacts on medical equipment use, availability of nighttime services, and medicine availability for non-shelf stable drugs. While many SPs note that UNICEF has provided funding for the renovation of health structures to address these types of issues, the consensus is that this area requires much more attention. According to SPs, the use of non-medical buildings (like rental houses) for medical purposes has been relied on to expand healthcare coverage through the HER/NFA programme, posing concerns of quality standards. In many instances, SPs noted that these restrictions are leading to poor scores on QQM evaluations, especially since an entire section of QQM is based on structural requirements. Stakeholders also mentioned how quality of care has been negatively impacted by restrictions on infrastructural investments, with some facilities lacking private rooms, female toilets, water, and sanitation.

Although interviewed SPs denote keeping up with patient **demand for care**, most online survey respondents (25/29) say that patient demand often exceeds health facility supply, while only three respondents say that supply keeps up with demand. To mitigate this, qualitative respondents suggest that the efforts of the HER/NFA programme to prevent instances of non-communicable diseases have made meaningful strides in reducing patient demand. A majority (22/26) of online survey respondents indicated that HER/NFA did implement diarrhea prevention interventions, such as community awareness campaigns and ORS distribution. Many state that these efforts reduced incidences and severity of diarrhea among catchment populations, especially among children (8 mentions). In contrast, respondents from SP and stakeholder KIIs believe the HER/NFA programme has led to a significant increase in the demand for basic health services. Respondents attribute this change to the affordability of care, increase in trust in health providers, and the provision of community outreach programmes, which make community members aware of the availability of services.

SPs do not report issues with facilities being unable to meet demand in terms of care providers; however, there have been numerous complaints about lacking medication supplies. This is rooted in extensive discourse surrounding the provision of medicines under the HER/NFA programme. SPs note that before the transition to UNICEF management, a list of 240 essential medications was used as the baseline stock for medical facilities. The HER/NFA programme reduced this list to 140, only 100 of which are provided by UNICEF. SPs find the procurement of the additional 40 to be challenging due to the need to comply with extensive quality control measures. Additionally, shipping delays are frequent due to unpredictable border closures and changing political circumstances. This has proven to be a

roadblock to consistent and efficient procurement, impacting the ability to keep up with patient demand for conditions requiring these medications. Stakeholders were less critical, noting procurement as an issue, but a worthy trade-off to assure medications met high quality standards.

EQ1.2: How have performance/impact, value-added, and key trends evolved from 2022 to 2024? How effective and relevant has the programme been to address the needs?

The programme is extremely relevant and effective to address the needs of Afghans, unanimously agreed among qualitative participants, as it effectively provided necessary care through the HER/NFA. When considering the effectiveness of the programme, respondents mostly comment on successfully keeping the health system afloat through a period where it otherwise would have collapsed. Though this highlights strength in the programme's design to address immediate health needs, it also suggests that more could be done to fine-tune the efficiency and sustainability of the programme. In particular, funding and infrastructural restrictions pose significant barriers and faith in the programme's impact in the face of funding cuts.

As the **ITS results** in Tables 9 and 10 above show, UNICEF facilities improved health service delivery in each intervention year relative to baseline on domains such as outpatient care, child health and NCD delivery. On family planning, UNICEF facilities did better than baseline in initial intervention years (2022 and 2023) but worse in 2024. On birth-related measures, there were mixed results. UNICEF facilities made improvements on ANC service delivery and institutional births during each intervention year. However, there were increases in maternal (due to major and other complication) and neonatal mortality in certain years. Note that descriptive plots of data suggest that these increases in mortality occurred during this period across both UNICEF and non-UNICEF facilities (see Figures 1k and 1l in Annex B). The quantitative insights are further reflected under the main evaluation question (EQ1) above.

Overall, qualitative participants believe that the implementation of the HER/NFA programme has become increasingly efficient and well-coordinated over time, allowing for high-quality, and a wide-reaching impact. Online respondents mostly follow suit, with 27/33 believing that the HER/NFA programme has procured positive patient outcomes since 2022. Online respondents mentioned programmatic features, such as monitoring standards (6 mentions), professional capacity building (7 mentions), and the expansion of community outreach for awareness building and/or preventive action (8 mentions) as reasons for increased gains. SP interviewees echo these reasons, stating that a main driver of change has been the systematic monitoring systems that have not only made the process of data collection more reliable and transparent, but also have grown digital databases and expanded access to this data which allows programme decisions to be evidence-based and therefore more effective. Additionally, these procedures have shaped a "culture of accountability" among SPs and health providers, benefiting quality of care. Investment into capacity-building efforts for health providers also contributes to higher value outputs, including in person training, gender-based training, and access to online resources.

Stakeholders were mostly satisfied with the coordination and implementation of the HER/NFA programme, with many emphasizing the value-added from the implementation of community outreach effort in strengthening community trust and service utilization. Qualitative respondents agree that community-level prevention and promotion of service utilization is necessary to maximize efficiency and equity. From a more critical lens, some stakeholders questioned the implementation of the pay-for-performance (P4P) systems that utilize financial incentives to improve health outcomes under underperforming SPs, noting that these systems are too complex and have led SPs to sometimes neglect issues that had the greatest consequences for catchment populations.

In terms of programme evolution, SPs note that employee retention remains a key challenge: one of the primary drivers is the provision of salaries. Although SPs have noted that the HER/NFA programme has been successful at ensuring on-time salary payments, complaints emerge that the salary amounts are low. The provision of salaries in U.S. dollars exacerbates this issue, as recent fluctuations in

exchange rates mean less money in workers' pockets. This negatively impacts worker morale and contributes to high turnover. On top of a decreasing pool of female health worker candidates, these factors pose a threat to the sustainability of HER/NFA's gains in this area.

EQ1.3: How does the performance/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)?

Heterogeneity analyses of HMIS data was performed using the ITS approach to examine whether UNICEF's health programming had different consequences for different sub-groups. When probing heterogeneity (see results in Tables C4-C16 in Annex C), the evaluation team observed some differences across strata for certain outcomes though as noted above, sample sizes vary across different strata and therefore power is variable for the different regressions. Differences are noted when estimates for any outcome in multiple years in a given strata vary from the corresponding estimates in the full sample.

Similar to the overall analysis, both urban and rural facilities realized increasing numbers of outpatient visits and ANC visits for all intervention years. Rural facilities also increased the number of facility deliveries across all intervention years, but these increases were only marginally significant for years 2022 and 2024. Unlike the main analysis, there were no detectable increases in the distribution of family planning methods (condoms or pills) for the rural strata. Urban facilities exhibited statistically significant increases in all measures of service utilization for 2022 and 2023, but not for 2024.

With regard to health facility type, all facility types saw an increase in outpatient and diarrhea visits during the intervention years, and CHCs, BHCs, and SHCs also realized an increase in ANC visits. In CHCs, condom distribution did not vary significantly from baseline in any intervention year, and pill distribution did not vary from baseline in 2022 and 2023. BHCs saw no significant differences on hypertension visits, family planning distribution and institutional deliveries in 2022 and 2023, and on perinatal mortality proportions in any intervention year. Additionally, hypertension visits and institutional deliveries decreased for BHCs in 2024. There were no differences on vaccinations in hospitals between baseline and intervention years, with the exception of a significant increase on measles vaccines in 2022. The proportion of perinatal deaths (neonatal deaths plus stillbirths) in hospitals was significantly different from baseline only in 2023 when it was higher.

Table C16 shows that UNICEF facilities performed fairly similarly on male and female vaccination. In other words, there were similar increases in vaccinating boys as well as girls during the intervention years (the only exception is the estimate for boys in 2024 which is positively signed but only marginally significant).

Among most qualitative respondents, the change in how maternal and fetal health cases are treated under the HER/NFA health system since 2022 is apparent, with overwhelming positive responses in terms of the quality of care that has been concentrated on female and child health outcomes. When discussing heterogenous barriers to healthcare, online respondents noted women (14/26) most frequently, followed by rural community members (10/26). However, less than half of online survey respondents believe that any one group experiences unique barriers to healthcare, and eight respondents said that no group experiences barriers. This suggests that SPs and health facility personnel may more readily consider barriers in terms of those who are recipients of healthcare, rather than those who cannot access care to begin with. Despite this awareness gap, when probed, many online respondents were able to identify specific barriers: accessibility restrictions for women are the most widely identified barriers to healthcare with frequent mention of the need to be chaperoned by 'Mahrams'. KII respondents noted significant efforts on UNICEF's part to combat these barriers through prioritization of hiring of female health workers and vaccinators and community outreach programmes that inform women of the care available to them. Of the online survey respondents, only 4/29 indicate that health facilities under their supervision have partial (3) or no (1) female health worker coverage, highlighting that UNICEF has achieved significant coverage despite persisting barriers. Additionally, SPs

have noticed that community outreach efforts were successful at reducing adolescent pregnancies, showing the impact of HER/NFA on a huge issue specific to girls.

While access varies by geographic province, the majority of stakeholders note an overall improvement of access, with most of Afghanistan's population living close to facilities. In contrast, online respondents mentioned ongoing barriers faced among rural communities, like long distances to the nearest facility, difficult roads, and lack of ambulance services. Qualitative evidence indicates that significant strides were made through the HER/NFA programme to increase access in these areas. Many previous 'white zones' are now connected to care due to the opening of new facilities and utilization of health posts and mobile vaccination teams: however, many of these new facilities face significant infrastructural limitations through the addition of rental spaces that were not designed as health facilities. Additionally, SPs note strategic planning to predict and stock facilities that become inaccessible due to winter weather has ensured the continuity of care and supplies in communities that previously faced medicine shortages throughout the winter season.

While a majority of online respondents are able to identify at least one group that faces unique barriers to receiving healthcare in Afghanistan (18/26), they do not widely identify people with disabilities as having unique barriers to receiving healthcare (7/26). Although few SPs and stakeholders commented directly on accessibility for disabled persons, SPs did report that some facilities lacked the proper infrastructure for the facility to be fully accessible. Additionally, these struggles are exacerbated by some long travel times that require transit through uneven or mountainous roads. While it is well-documented that Afghanistan has seen spikes in internal displacement[80] and large-scale returns from neighbouring countries like Iran and Pakistan[81], without access to firsthand community-level perspectives, it is unclear the extent to which displaced persons have been made aware and benefited from the HER/NFA programme. When it comes to the perspective of Service Providers, marginalized groups like returnees and displaced persons are treated equally and receive the same care regardless of their identity. While some stakeholders mentioned that returnees are a population of interest, they how commented how the inflow of retuning populations is increasing the catchment populations in certain high-returnee provinces. This suggests that to maintain the current rate and level of service delivery, the HER/NFA programme would have to expend more if returnee inflows continue.

[80] iDMC. (2025). Country Profile: Afghanistan. Available at: Available at Afghanistan | IDMC - Internal Displacement Monitoring Centre

[81] UNHCR. (2025). Iran-Afghanistan -Returns Emergency Response. Available at: Iran-Afghanistan Returns Emergency Response 15 - 30 July 2025

5.2 Health service packages, focusing on HIVA delivery

Key findings

- The inclusion of HIVA shifted service delivery from coverage-focused to quality-focused maternal and newborn care, adding high-impact clinical interventions, equipment, and targeted capacity building that directly address leading causes of maternal and neonatal mortality, while complementing BPHS and EPHS packages.
- HIVA integration generated additional gains in service utilization and clinical readiness, with HIVA-supported provinces showing increases in outpatient visits, ANC4 attendance, and institutional deliveries, and qualitative evidence pointing to improved referral pathways, provider competencies, and continuity of care across the maternal-newborn continuum.
- HIVA delivered disproportionate benefits for women, adolescent girls, high-risk newborns, rural populations, and displaced groups by improving access to skilled female providers, strengthening referrals, and prioritizing life-saving care for the most vulnerable, thereby reducing inequities in maternal and newborn health outcomes.
- Increases in perinatal mortality observed in HIVA provinces in 2023-2024 are explained by external demand shocks rather than declining quality, particularly large-scale returnee inflows into high-burden provinces, such as Herat, which intensified caseload pressure on maternity and newborn services.
- HIVA improved coordination and effectiveness through standardized training, strengthened referral pathways, and embedded quality improvement systems; however, long-term sustainability is uncertain due to delivery costs, shrinking donor funding, and limited ownership or absorption by de facto authorities.

EQ2: How does the inclusion of HIVA[82] interventions influence health service delivery and outcomes? What are the differences, additional impacts, complementarities, and synergies of integrating BPHS, EPHS, and HIVA interventions?

The inclusion of High Impact Value-Added (HIVA) interventions has strengthened health service delivery by shifting the focus from service availability alone to the quality and effectiveness of maternal and newborn care. While the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) ensure broad coverage, HIVA adds targeted clinical interventions, specialized equipment, and capacity-building measures that directly address leading causes of maternal and newborn mortality.[83] Key HIVA interventions include labour and delivery management, newborn resuscitation, care of preterm and low-birth-weight infants, and postnatal care, resulting in improved clinical readiness and more effective service provision at both facility and community levels. HIVA also complements and reinforces BPHS and EPHS by strengthening referral linkages, quality assurance systems, and provider competencies across the continuum of care. This is seen through qualitative and online evidence that points to reduced gaps in service coverage through the implementation of HIVA.

Upon conducting the ITS analysis specifically for the nine provinces[84] that received HER/NFA plus HIVA services in all intervention years, the evaluation team noted several similarities with the overall analysis, such as increases in outpatient visits, ANC visits, and institutional deliveries for intervention years 2022-2024 (though the increase in institutional deliveries for 2022 is marginally significant).

[82] As HIVA is still in its early stages with varying levels of implementation, this evaluation 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.

[83] High Impact Value Added Interventions (HIVA) for Maternal and Newborn Health, 2023

[84] Please note that Daikundi was excluded from the analysis as it was only added under HIVA in 2024.

However, quite a few estimates in the HIVA analysis failed to achieve statistical significance, likely because of small sample size[85].

With regard to mortality outcomes, HIVA facilities experienced small in size but statistically significant increases in perinatal mortality in both 2023 and 2024 (see Annex tables c17 and c18). The observed increase in reported perinatal deaths in 2023 and 2024 can be plausibly triangulated to substantial population inflows into Herat province, a key HIVA implementation province. Programme monitoring and qualitative evidence indicate rising strain on maternal and newborn health services during this period, particularly in high-volume facilities, coinciding with increased demand from newly returned populations.[86, 87] Desk-based evidence confirms that Herat has been one of the primary destinations for returnees, receiving a significant share of cross-border inflows from Iran. In addition, the province's conservative social context may further influence care-seeking behaviors, particularly for women and newborns, potentially compounding service delivery challenges. As of mid-2025, Herat consistently ranks among the top provinces of intended return, with large numbers entering through the Islam Qala border crossing, which accounts for the majority of returns from Iran.[88]

Importantly, the returnee profile is predominantly composed of families, with women and children representing a substantial proportion of arrivals, and a high share of households facing acute vulnerabilities, including lack of shelter, food insecurity, limited documentation, and restricted access to services. The convergence of these dynamics provides a credible explanatory context for rising perinatal mortality. The rapid influx of returnees has increased pressure on already overstretched health facilities in Herat, particularly maternity wards and newborn care units. On top of this, many returning women arrive late in pregnancy, with limited continuity of antenatal care, heightened nutritional risk, and constrained mobility, all of which elevate the risk of adverse birth outcomes. For newborns, delayed care-seeking, overcrowded facilities, and increased caseloads in special care units further compound mortality risks during the critical perinatal period.[89]

Taken together, the triangulation of programme data, qualitative insights, and population movement evidence suggests that the increase in perinatal deaths in Herat during 2023–2024 is not likely indicative of declining quality of care, but rather heightened demand pressures driven by large-scale return movements. This finding underscores the importance of maintaining and adapting HIVA interventions in high-inflow provinces to ensure that quality-focused maternal and newborn care can be sustained under conditions of demographic shock and humanitarian stress.

EQ2.1: How has HIVA influenced different sub-populations, such as girls, women, people with disabilities, rural residents and marginalized groups (e.g. displaced groups)?

HIVA interventions have had a differentiated and equity-oriented influence on vulnerable sub-populations. Women and adolescent girls benefit from improved quality of antenatal and postnatal care, strengthened knowledge of obstetric complications, and expanded access to postpartum family planning. ITS analysis finds significant gains on ANC4 visits and institutional deliveries within HIVA provinces suggesting that the targeted care has paid off. Newborns at highest risk, including preterm, low-birthweight, and sick infants, benefit from HIVA-supported interventions. Rural residents, displaced populations, and underserved communities benefit from improved availability and enhanced referral systems, which reduce delays in care-seeking and access to life-saving services. By

[85] E.g., on diarrhea visits in 2023-2024, anemia in all intervention years, on hypertension visits in 2022-2023 (there is a statistically significant decrease on hypertension in 2024), condom distribution in 2022-2023, and pill distribution in all intervention years. In other words, evidence of intervention period changes relative to baseline on service provision varies across service type in HIVA provinces.

[86] HER/NFA Programme Document

[87] UNHCR. (2025). Iran-Afghanistan Returns Emergency Response. Available at: Iran-Afghanistan Returns Emergency Response 15 - 30 July 2025

[88] Ibid.

[89] Ibid.

preventing complications and improving survival during the critical perinatal period, HIVA also contributes to the reduction of inequities in health outcomes.

In the current national context, which faces significantly reduced freedoms for women[90], a rapidly growing numbers of returnees (over 1 million in 2025)[91], many of whom being women and children (72% of returns reached by UNHCR), and the most significant share of returnee populations settling in Herat (38% of all returns)[92], HIVA offers an important and relevant solution to mitigate maternal and child health challenges in areas that need additional care efforts.

Overall, respondents across qualitative channels believe that HIVA increased access to care for marginalized groups - the availability of female health workers has been an instrumental reason for this. Stakeholders noted the positive impact through the HIVA programme's focus on women, particularly regarding reductions in maternal and newborn deaths. Comparing online survey responses among respondents overseeing facilities within HIVA provinces versus non-HIVA provinces, all HIVA respondents (8/8) reported that the facilities they manage maintain at least one female health provider available during operating hours, while some non-HIVA respondents indicated that there may be only partial or no coverage of female health providers (4/21[93]). SPs in HIVA regions mention an exceptional impact on girls through the reduction of adolescent pregnancies. SPs say that UNICEF has targeted this area through community education and provision of kits to apply to pregnant girls under 18 years old. Stakeholders also mentioned mental health as an important inclusion in HIVA, and that further expansion of mental health care would be particularly beneficial for women and displaced populations. Additionally, SPs in HIVA regions were more likely to emphasize increases in access to care for rural populations, as well as availability of resources and outreach efforts concerning maternal and child health. Qualitative respondents mentioned mobile vaccination campaigns, educational opportunities for new mothers, and availability of emergency kits for AWD in HIVA regions as being particularly impactful for women and children.

While the HER/NFA programme covers treatment costs for BPHS, EPHS and HIVA interventions, SPs mentioned that out-of-pocket payment may be required for additional services not covered by the programme (like orthopedics, cancer treatments, neurological care, or more advanced medical needs), or in the case that the UNICEF-supported facility does not have the required medicine in stock. According to online survey data, respondents in HIVA provinces are more likely to indicate that patients never pay out of pocket (3/7 reporting never) compared to those in non-HIVA provinces (4/19 reporting never) scenarios which are driven by either 1) medicine supply shortages or 2) lack of service availability; either because patient demand exceeds available care, or treatment needs are not covered through the programme, in which case patients are redirected to non-HER/NFA healthcare. These results could indicate that the additional services provided under the HIVA intervention package provide added value in targeting the additional health needs on top of BPHS and EPHS. Stakeholder interviews corroborate this theory - referencing how HIVA has been used to target wider health issues by using maternal or antenatal care as entry points to detect and address other needs; routine screenings or immunizations for children or expectant mothers can lead to treatment of health concerns not necessarily tied to pregnancy that are detected in these visits, such as hypertension. While these results are not conclusive, it does suggest that the additional HIVA package may provide better healthcare coverage than BPHS and EPHS alone, preventing patients from incurring additional bills. Reducing the incidence rate where patients pay out of pocket for necessary medication may lead

[90] Think Tank European Parliament. (2024). Women's rights in Afghanistan: an ongoing battle. Available at: https://www.europarl.europa.eu/thinktank/en/document/EPRS_BRI%282023%29747084

[91] OCHA. (2025). Afghanistan Returnees Overview. Available at: Afghanistan Returnees Overview (as of 26 July 2025) | OCHA

[92] UNHCR. (2025). Iran-Afghanistan -Returns Emergency Response. Available at: Iran-Afghanistan Returns Emergency Response 15 - 30 July 2025

[93] The remaining 12 survey respondents dropped out of the interview before reaching this question, indicating why this result is not out of the 33 total included in the report.

to increased patient demand and healthcare utilization, especially among the poor, highlights an achievement of HIVA in making healthcare more accessible and extensive.

Key stakeholders noted that integrating HIVA within BPHS and EPHS platforms has enabled efficient, facility-level delivery of complementary services, strengthening continuity of care while also enhancing health worker skills through cross-learning across service packages.

EQ2.2: How does the integration of HIVA affect coordination, effectiveness, and sustainability of health service delivery models?

The integration of HIVA within BPHS and EPHS has strengthened vertical programme integration by way of community-based services, standardized trainings and gender-based care, and reinforced referral pathways. This integrated approach reduces fragmentation that is more apparently observed among non-HIVA facilities under the HER/NFA programme.

Service Providers indicated that a major driver of HIVA effectiveness was the systematic training of midwives across HIVA regions. For example, HIVA funding has allowed Skill-labs to be set up at a provincial level, allowing midwives from nearby areas to receive training on essential skills for maternal and child health. Given the barriers to formal education of female health workers, this not only improves accessibility of the HIVA programme but also increases sustainability by providing long term skills to women through a pathway outside of the formal education system, showing a path for long-term female worker retention. SPs also praised the HIVA for the provision of necessary medical equipment, as well as implementation of quality improvement plans. However, SPs in HIVA regions put much less emphasis on coordination and quality improvements than non-HIVA SPs. Instead, HIVA SPs mostly focused the conversation on improved availability and accessibility of care. This could be because coordination efforts in HIVA provinces were less forefront compared to the HIVA-specific designs towards MCH outcomes, or possibly because the availability of care was especially low in these regions before UNICEF implementation, therefore change in this area was most obvious.

From a sustainability perspective, HIVA interventions are embedded within national health system structures, including essential medicines lists, clinical guidelines, monitoring mechanisms, and capacity development platforms. By building the skills of health workers, strengthening quality improvement systems, and utilizing existing service delivery platforms, HIVA enhances system resilience and supports the long-term sustainability of maternal and newborn health gains in a fragile and resource-constrained context. While many stakeholders noted HIVA's integration on top of the BPHS and EPHS to be cost-efficient by use of pre-existing platforms and cross-training of health workers to provide added quality of care and expanded services, some mentioned that the addition of HIVA resulted in funds being drained more quickly, likely negatively impacting the sustainability of the programme. Concerns pointing to the accelerated fund utilization driven by HIVA intervention signal the need to consider increased geographic targeting, or improved package integration to reduce overlap and continue realizing the added impacts of the HIVA programme in the challenging national environment.

EQ2.3: How has the programme's reconfiguration evolved between 2022–2024, and what impact has it had on outcomes?

Between 2022 and 2024, the programme underwent reconfiguration from a primarily coverage-oriented service delivery model toward a targeted, quality-focused approach, with the phased introduction of HIVA interventions layered onto the BPHS and EPHS. In 2022, HIVA Phase 1 was implemented in nine high-burden provinces, focusing on select high-impact maternal and newborn health interventions that were not fully resourced under BPHS and EPHS, such as misoprostol for postpartum haemorrhage, calcium supplementation, chlorhexidine for cord care, strengthened newborn resuscitation, and initial investments in newborn care equipment and training. This phase emphasized rapid deployment of life-saving commodities and skills in priority facilities and

communities, responding to persistently high maternal and neonatal mortality despite relatively high institutional delivery rates.[94]

From 2023 to 2024, the programme transitioned into HIVA Phase 2, the reconfiguration also expanded the scope of HIVA to include more comprehensive quality improvement measures, such as on-site mentoring, simulation-based training, and investments in special care newborn units and referral-level services.[95]

SPs believe that quality of care has improved greatly in HIVA facilities; stakeholders also believe HIVA has overall benefited health outcomes in provinces of implementation. The implementation of quality control and monitoring procedures in HIVA regions have been a key factor in making positive strives towards improving maternal and child health outcomes, according to SPs. Due to the regional targeting of provinces with lower health outcomes, the implementation of strict monitoring was vital to ensure that HIVA programmes were being implemented in accordance with UNICEF quality standards. However, SPs note challenges in monitoring these hard-to-reach facilities, due to requirements for female monitors to be accompanied alongside the seasonal impassibility of routes to facilities (mostly seen during winter conditions in mountainous regions). The addition of HIVA implementation produced positive gains according to 8/8 online respondents in HIVA provinces, who believe that the quality, availability, and accessibility of health services have improved since 2022. In addition, 6/8 HIVA respondents believe that patient health outcomes have improved during this period, while two remain unsure. Examining responses between HIVA and non-HIVA online respondents, HIVA provinces have improved infrastructure availability compared to non-HIVA provinces, with 6/8 HIVA respondents confirming laboratory access and uninterrupted electricity in all managed facilities compared to only 10/21 non-HIVA respondents indicating laboratory availability and 6/21 confirming uninterrupted electricity. Stakeholders noted the positive impact through the HIVA programme's focus on women, particularly regarding reductions in maternal and newborn deaths. Additionally, all HIVA respondents (8/8) reported that the facilities they manage maintain at least one female health provider available during operating hours which is a vital indicator of ensuring availability of care for women. Qualitative respondents in HIVA regions have noted reductions in adolescent pregnancies through community outreach efforts. Quantitative analysis also shows that HIVA efforts were successful in achieving higher perinatal proportions in HIVA regions in both 2023 and 2024 (see Annex tables c17 and c18).

Despite indication of gains through HIVA integration, many are doubtful of its sustainability resulting from a combination of higher implementation costs incurred through HIVA on top of BPHS and EPHS package deliveries, paired with insecure donor funding support. Online survey respondents in HIVA-supported regions also express more doubt of the sustainability of the current programme than those in non-HIVA provinces, echoing concerns from key stakeholders that the HIVA delivery package cannot be sustained indefinitely if not taken over by the de facto government.

On further impacts/contributions, please refer to the results reflected under the EQ2 above.

[94] High Impact Value Added Interventions (HIVA) for Maternal and Newborn Health, 2023
[95] Ibid.

5.3 Cost-efficiency

Key findings

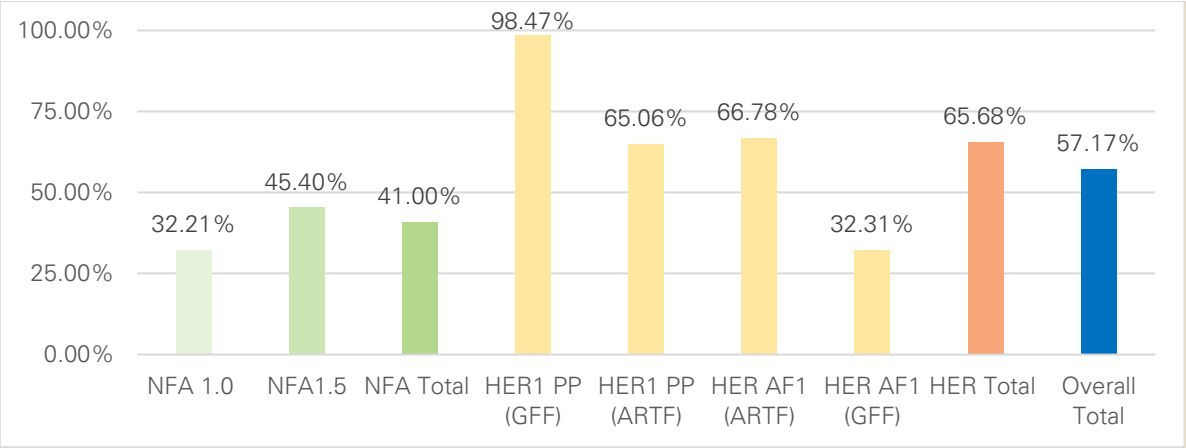
- HER/NFA programme demonstrated strong cost-efficiency at scale, delivering nationwide health services and allocating a majority of resources directly to service providers, ensuring that funding translated into frontline service delivery.
- Compared to the pre-transition Sehatmandi programme, HER/NFA programme achieved higher service outputs per dollar invested, with the additional investment between 2022-2024 financing substantial efficiency gains, including nearly 20% more outpatient and diarrhea visits respectively, 38% higher ANC4 coverage, 22% higher anemia detection, and over 6% more facility deliveries relative to a 2020 baseline.
- Over time, HIVA investments have produced disproportionate efficiency gains in high-impact MCH services, particularly ANC visits and facility deliveries, indicating that while HIVA is less cost-efficient at scale than BPHS, it delivers focused returns aligned with its objective to reduce preventable maternal and newborn mortality.

EQ3: How cost-efficient is the HER/NFA programme in achieving its expected results and how has the cost-efficiency changed over time?

World Bank documents, ADB documents, and UNICEF administrative grant data show that approximately $870 million has been disbursed for the HER/NFA programme between February 2022 and June 2025. HMIS data reveal that this funding directly benefited a total of 2,405 health facilities, serving a total catchment population of over 29 million people. Estimating the cost per person served over the programme's 40 months in action produces a cost of approximately $9 per person per year under the HER/NFA programme.

Using administrative data from UNICEF, Figure 8 compares the percentage of each grant that is allocated to the service providers (SPs). HER grants tended to allocate a higher percentage of funding to SPs than NFA grants (66% and 41%, respectively). Overall, about 57% of the total $870 million was allocated directly to SPs. It is important to note that between July 2022 and December 2023, the World Bank financed the BPHS and EPHS packages across all 34 provinces, while ADB's NFA 1.0 (January 2022-December 2023) supported HIVA interventions in nine provinces. From January 2024, the World Bank continued to support BPHS and EPHS implementation in 24 provinces until March 2025, with new financing commencing in April 2025. In parallel, ADB scaled up its support under NFA 1.5, expanding HIVA interventions to 10 provinces and assuming responsibility for BPHS and EPHS delivery in those provinces through June 2025, followed by the launch of the subsequent SAFE phase in July 2025.

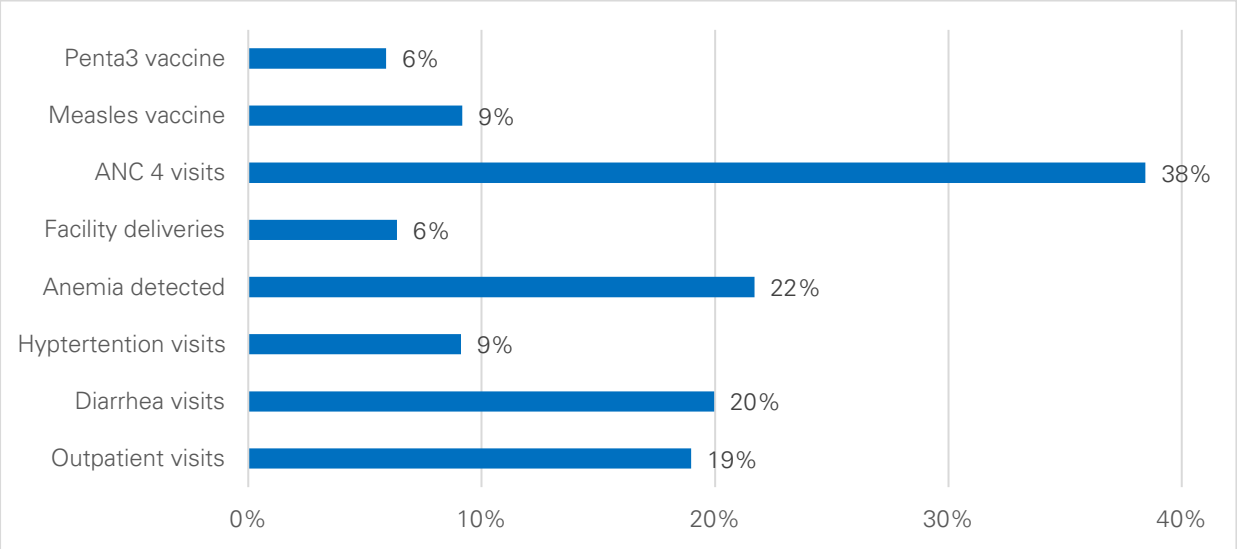
Figure 8: Allocation of HER/NFA grants to Service Providers



In a comparison of cost-efficiency over time between Sehatmandi and HER/NFA, the analysis compares the costs and outcomes of Sehatmandi to the additional costs and increased health service utilization under HER/NFA. World Bank documents list the total investment in Sehatmandi to be $407.52 million, from March 2018 through June 2022, which is adjusted to $444 million in 2025 USD. Because year 2020 is the baseline year in the ITS analysis and occurs two-thirds of the way through the Sehatmandi funding period, the analysis considers the cost to achieve the 2020 outcomes to be equal to two-thirds of the total costs of Sehatmandi: $296 million. Similarly, because the ITS analysis of HER/NFA outcomes spans 2022-2024 (does not include 2025), the analysis proportionally adjusts the total HER/NFA disbursements and considers the cost of HER/NFA for these three years to be approximately $783 million. Thus, the additional investment of HER/NFA for the period 2022-2024 is approximately $487 million.

Figure 9 displays the aggregated outcomes of the ITS analysis in terms of proportional increase over the base year of 2020, demonstrating the efficiency gains achieved through the HER/NFA investment. Compared to 2020 baseline service utilization, the additional investment of $487 million funded substantial increases in the rate of service utilization for the population. For example, the number of outpatient visits during 2022-2024 was nearly 20% higher than a hypothetical three-year period using 2020 visit rates. Fourth ANC visit rates increased drastically (38%), detection of anaemia increased by 22%, and facility deliveries increased by more than 6%.

Figure 9: Efficiency gains in service utilization for 2022-2024, compared to 2020

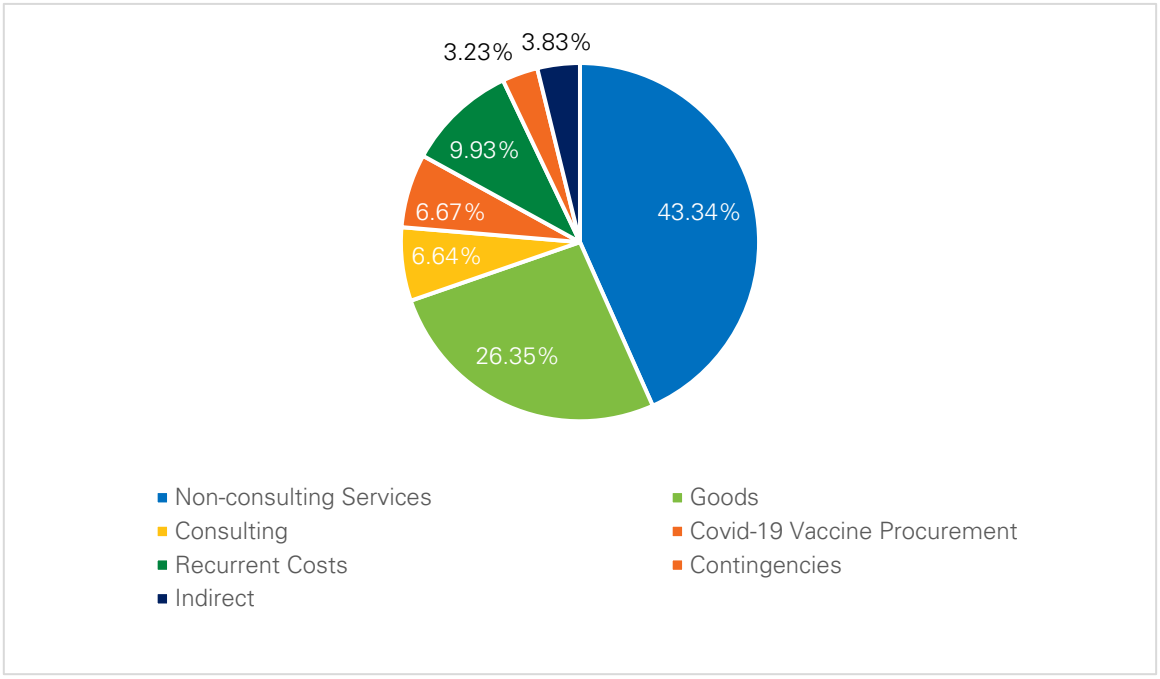


EQ3.1: How does the cost-efficiency of the HER/NFA programme vary between different service packages (BPHS/EPHS and HIVA), and how has this evolved over time[96]?

Similar to the previous analysis, the evaluation team examined the cost-efficiency of health facilities receiving the HIVA package (N=745). First, the team analysed NFA 1.0 and NFA 1.5 budget documents to assess the overall resource allocation of the NFA grant programme (Figure 10). Nearly half of the budget is designated for non-consulting services (43%), largely in the form of direct transfers to SPs, while just over a quarter is used for the procurement of goods (26%). The remainder is divided between consulting costs, vaccine procurement (under NFA 1.0 only), recurrent costs, contingencies, and UNICEF's indirect costs.

[96] This part of the question covers the comparison between pre-UNICEF/Sehatmandi and post-UNICEF period. There is not enough HMIS data for Sehatmandi years to construct a slope in order to compare year-over-year.

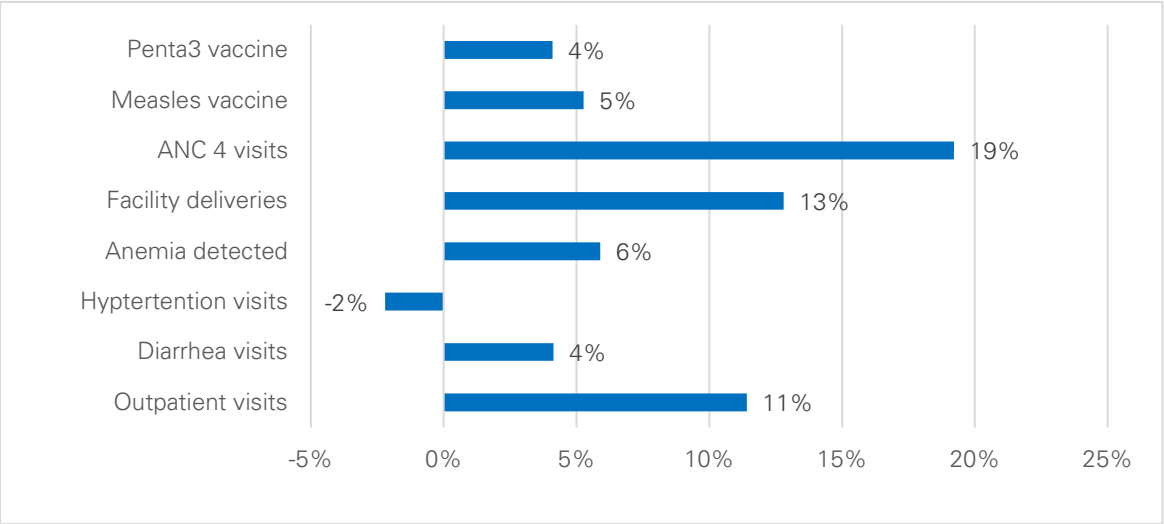
Figure 10: Resource Allocation of NFA 1.0 and 1.5 grants



Next, the evaluation team estimated the proportional funding for these 745 facilities under Sehatmandi. In terms of catchment population, HIVA facilities serve approximately 9.8 million people, which is about 33.8% of the total population served by HER/NFA. If about $296 million was required under Sehatmandi to achieve overall 2020 service utilization outcomes, then the cost portion estimated for HIVA facilities is approximately $100 million. A proportional adjustment of total NFA disbursements for outcomes achieved during the 2022-2024 period produces a cost of $270 million. Thus, the additional investment in HIVA facilities for NFA during 2022-2024 is estimated at $170 million.

To examine the cost-efficiency of this additional investment in HIVA facilities, the evaluation team aggregated the outcomes of the ITS analysis in terms of proportional increase over the base year of 2020. Figure 11 displays the results, illustrating the efficiency gains in key service utilization during three years of HIVA implementation compared to a hypothetical three-year period using 2020 values as a baseline. All measures of service utilization except for hypertension visits increased under the HIVA intervention, with ANC visits and facility deliveries increasing the most (19% and 13%, respectively). This disproportionate increase in the efficiency of MCH interventions is in line with the types of interventions targeted by the HIVA package. It is worth noting that hypertension visits are not a core target of the HIVA package.

Figure 11: Efficiency gains in service utilization for HIVA facilities in 2022-2024, compared to 2020



In terms of perceived cost-efficiency across packages, stakeholders expressed that the BPHS package has the best value compared to other packages, as it offers the highest health returns with limited resources through the provision of primary services, like immunizations, maternal and antenatal care. When considering scalability, stakeholders frame cost efficiency as a major factor because BPHS offers basic coverage to many, rather than more specialized interventions to a smaller subset of the population.

6 Lessons Learned

The evaluation team identified several successful programme strategies with high potential for scale-up, including the prioritization of life-saving MCH interventions, systematic capacity building, community awareness outreach and preventative care efforts, mobile health teams, and integrated monitoring standards to produce a culture of accountability. The quantitative analysis showed particularly substantial efficiency gains for increases in ANC visits and anaemia detection in girls.

Despite limitations imposed by political contexts, **MCH interventions improved under HER/NFA due to the combined systematized approach to improve both accessibility to care and quality of care.** Community outreach efforts were vital to this success. Outreach efforts under HER/NFA informed women of the resources available to them and what care they should seek before, during, and after pregnancy. These educational opportunities provided opportunity for catchment populations to learn how to care for themselves and encouraged community members to seek care at health facilities. Community outreach will remain vital in all future programming efforts to ensure health mitigation efforts start at the community level to reduce the incidence rate of common illnesses and minimize the demand strain on facilities, allowing for targeted focus on life-saving interventions.

Another vital aspect of current and future health programming is the hiring and retention of female health workers. Because the candidate pool is shrinking due to female education restrictions, provision of female health worker training outside of the formal education system is essential for maintaining healthcare access to female beneficiaries. Qualitative respondents praised UNICEF's midwife training opportunities as an effective solution, and therefore these programs should be maintained/expanded in future programming.

Additionally, the current monitoring and reporting systems have been well integrated amongst SPs despite the wide array of NGOs contributing to efforts. Quality checks of facility data are a fine-tuned system that produce reliable results. SPs are comfortable identifying problems and reaching out to UNICEF to get support where needed. These accomplishments highlight that the current system is scalable and reproduceable across many regions and actors. Because these systems have been

successfully implemented, maintaining the same procedures would be the best way forward for future programming.

7 Conclusions

HER/NFA programme was highly relevant and value-adding in stabilizing Afghanistan's health system, particularly in safeguarding maternal, newborn, and child health during a period of acute fragility. Across quantitative and qualitative evidence, the programme is consistently described as essential to "keeping the health system afloat," providing emergency continuity of services where system collapse was a credible risk. Its relevance and effectiveness were driven by strengthened coordination, especially in rural and hard-to-reach areas, robust monitoring and reporting, and sustained investments in health worker capacity building.

Service delivery performance improved markedly under UNICEF management, with HER/NFA-supported facilities consistently outperforming non-HER/NFA facilities across most utilization indicators between 2022 and 2024. Interrupted time series analysis confirms sustained increases in outpatient visits, childhood illness care (including diarrhea), vaccination uptake (Penta3 and Measles1), ANC4 attendance, institutional deliveries, and anaemia detection among girls compared with a 2020 baseline. At the same time, increases in maternal deaths (due to major and other complication) and perinatal mortality observed in 2024 mirror nationwide trends and are credibly linked to external shocks, such as restrictive policies affecting women's mobility and care-seeking and large-scale returnee inflows into high-burden provinces. These contextual factors suggest that the programme's positive effects on women's and newborn health outcomes are likely understated.

Availability, accessibility, and quality of care improved, particularly in rural and previously underserved areas. These gains were driven by expanded outreach, the establishment of new health centres and posts, deployment of mobile vaccination teams, and strengthened supervision and planning to ensure continuity in inaccessible districts. Quality improvements are widely attributed to routine monitoring, responsive follow-up with service providers, and targeted trainings, including digital tools embedded within quality assurance systems. The HER/NFA programme's QQM results show system-wide improvements in health facility quality of care over time, with steady gains across structural quality, content of care, and outcome quality. These findings indicate that quality improvement efforts under the programme have strengthened service readiness, clinical practice, and service outcomes across facilities. At the same time, increased community trust and awareness translated into higher demand for services, which in many facilities now exceeds available capacity. This highlights both the programme's success in restoring confidence in the health system and the limits imposed by persistent resource constraints.

Despite these gains, performance was constrained by structural and commodity bottlenecks that affect both quality and efficiency. Medicine shortages, procurement delays, and border or political disruptions remain a key limitation. Facility infrastructure gaps, including inconsistent electricity, inadequate water and sanitation, limited privacy, and reliance on rental buildings, undermine quality standards and constrain the delivery of nighttime and equipment-dependent care.

Family planning represents the main area of relative underperformance. Quantitative trends show early gains in contraceptive distribution in 2022-2023 followed by marked declines in 2024. Qualitative evidence points to intensified stigma and restrictive social and policy conditions affecting women's mobility and public presence as key drivers, underscoring that demand-side barriers beyond supply-side delivery are shaping outcomes. Sustaining reproductive health access will require stronger community engagement and protection-informed approaches.

The integration of HIVA shifted service delivery from a predominantly coverage-focused model toward a quality-focused approach for maternal and newborn care. HIVA added high-impact clinical interventions, equipment, and specialized training, such as midwife skills laboratories, newborn resuscitation, and mentoring, which strengthened clinical readiness, referral pathways, and provider

competencies beyond BPHS and EPHS alone. HIVA-supported provinces showed additional gains in ANC attendance, outpatient visits, and institutional deliveries. Increases in perinatal mortality observed in HIVA provinces during 2023-2024 are explained by external demand shocks, particularly large-scale returnee inflows into high-volume provinces, such as Herat, which intensified caseload pressure and late presentation.

HER/NFA demonstrated strong cost-efficiency relative to the pre-transition funding structure, translating large-scale financing into clear, measurable gains in essential health service utilization. A substantial share of resources flowed directly to service providers, ensuring that investments were converted into frontline service delivery. Compared to the 2020 baseline, additional investments between 2022 and 2024 financed significant efficiency gains, including increases in outpatient and childhood illness visits, substantial improvements in ANC4 coverage, higher anemia detection among girls, and more facility-based deliveries. This demonstrates strong value for money in a highly constrained operating environment. Anticipated funding contractions and the absence of ownership or absorption by de facto authorities pose significant risks to the future sustainability. Sustaining gains will require adaptive prioritization of high-impact MCH interventions, continued investment in community outreach and prevention to manage demand, and urgent expansion of non-formal pathways to train and retain female health workers, on whom women's access to care increasingly depends.

8 Recommendations

The recommendations below stem from the evaluation findings and overall conclusions. These are based on the analysis of both quantitative and qualitative data. Recommendations prioritize efficiency gains in the face of a decreased funding reality.

#	Recommendation	Actions to implement recommendation	Timeframe	Responsibility (e.g. Units)
1.	**Advocate for sustained and predictable international financing to prevent systemic health service collapse**	• Intensify advocacy to maintain minimum financing levels for Afghanistan's health system, emphasizing evidence that HER/NFA programme delivers strong value for money and that funding reductions would reverse gains in maternal, newborn, and child health and increase preventable mortality. • Engage key bilateral, multilateral, and philanthropic donors through targeted high-level briefings, clearly outlining the health and mortality implications of funding contraction scenarios and the minimum funding thresholds required to sustain core services. • Promote financing predictability as a priority alongside funding volume, encouraging multi-year commitments or phased disbursement arrangements to reduce service disruptions and enable more effective planning.	6 months	UNICEF Afghanistan – senior management, health section; Key partners and donors
2.	**Prioritize and protect high-impact maternal, newborn, and child health interventions under constrained funding scenarios**	• Integrate explicit prioritization criteria into programme planning and donor discussions, ensuring that trade-offs under reduced funding are guided by evidence on mortality reduction, equity impacts, and service continuity rather than across-the-board cuts. • Apply scenario-based planning to safeguard essential MCH services, clearly articulating which interventions would be maintained, scaled back, or paused under moderate and severe funding contraction scenarios.	1 year	UNICEF Afghanistan – senior management, health section; Key partners and donors (HSTWG)

#	Recommendation	Actions to implement recommendation	Timeframe	Responsibility (e.g. Units)
		● Align implementing partners and service providers around prioritization decisions, communicating protected services clearly to prevent uneven implementation and service disruption at facility level.		
3.	**Invest in sustainable female health workforce pipelines through non-formal and alternative training pathways**	● Expand non-formal training pathways (e.g., skills labs, modular certification, on-the-job mentoring, simulation-based training) that operate outside formal education systems ● Map critical female health workforce gaps by cadre and geography, prioritizing midwives, nurses, CHWs, and vaccinators. ● Standardize accelerated refresher and upskilling packages for existing female staff, enabling task-shifting and rapid deployment to maternity, newborn, and community outreach services under surge conditions. ● Rely on midwives to alleviate reductions in skilled female labor in coming years. Provide more provincial level midwifery training.	1 year	UNICEF Afghanistan – health section WHO HSTWG
4.	**Invest in system resilience rather than short-term service expansion alone**	● Sustain and expand community-based preventive efforts to reduce demand pressures on health facilities and optimize the effective use of programme resources. ● Develop targeted strategies to maximize the impact of CHWs**.** Ensure CHWs are informed on local contexts to better address community issues, for example regions with large numbers of returnees may require specific contextual care. ● Collaborate with community influencers and CHWs to better identify and address gaps in service access and promote upward learning by ensuring that insights from	1-2 years	UNICEF Afghanistan – senior management, health section; Key partners and donors

#	Recommendation	Actions to implement recommendation	Timeframe	Responsibility (e.g. Units)
		community-level actors are systematically communicated to Service Providers and relevant stakeholders. ● Embed resilience indicators into routine monitoring frameworks, tracking service continuity, stock-out frequency, staff turnover, and referral functionality alongside utilization metrics. ● Prioritize flexible and multi-use investments (e.g., shared equipment, cross-trained staff, integrated service platforms) that support multiple service lines rather than single-purpose expansion.		
5.	**Address critical system bottlenecks to protect service quality and efficiency**	● Establish a rapid feedback mechanism to make the system more responsive to identified supply gaps, rather than relying solely on top-down decision-making. ● Adjust the supply chain to reduce susceptibility to border issues and delivery delays; consider developing list of trusted within-country suppliers. ● Explore shifting total procurement of all 140 essential medications under UNICEF. ● Operationally prioritize minimum infrastructure standards (electricity, WASH, privacy). ● Encourage facilities to allocate dedicated emergency funds to address urgent repairs and essential upgrades in a timely manner.	6 months – 1 year	UNICEF Afghanistan – health section; supply section
6.	**Strengthen demand-side and protection-informed approaches, particularly for family planning and women's access to care**	● Scale up availability of family planning methods. ● Improve community awareness of family planning methods by raising community trust in the use of contraceptive methods through community leaders and influential community members in order to mitigate stigma.	1-2 years	UNICEF Afghanistan – health section; supply section; SBC section; Key partners (UNFPA and WHO)

#	Recommendation	Actions to implement recommendation	Timeframe	Responsibility (e.g. Units)
		● Integrate family planning into entry points, such as antenatal, postnatal, and child health visits, to reduce stigma and increase uptake without requiring additional care-seeking.		

9 Annexes

Please refer to the separate document. The list of annexes is reflected below.

ANNEX A: Quantitative data cleaning

ANNEX B: Exploration of parallel trends across UNICEF and non-UNICEF facilities

ANNEX C: Additional data tables

ANNEX D: Qualitative instruments

ANNEX E: Terms of Reference

ANNEX F: Inception Report

ANNEX G: Breakdown of interviewed stakeholders

ANNEX H: LIST mapping

ANNEX I: Evaluation Matrix

ANNEX J: Bibliography and documents reviewed

ANNEX K: Ethical approval