FINAL REPORT NOVEMBER 2015

SAVE THE CHILDREN

CHILDREN OF URUZGAN FINAL EVALUATION

AMIN
CONSULTING GROUP امین

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- Government of the Islamic Republic of Afghanistan
- Ministry of Public Health
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- Uruzgan Municipality
- Afghanistan Centre for Training and Development
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- New York University
- The Asia Foundation
- The Burnet Institute
- UNICEF
- Welfare Association for the Development of Afghanistan

Cover photo: Interview with school teacher in Chora district, Uruzgan (ACG 2015)

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LIST OF ACRONYMS

ACG	Amin Consulting Group
ACTD	Afghanistan Centre for Training and Development
AHDS	Afghanistan Health and Development Services
ANC	Antenatal care
ARTF	Afghanistan Reconstruction Trust Fund
BHC	Basic health centre
BPHS	Basic Package of Health Services
CBE	Community-based education
CEC	Community education committee
CERP	Commander's Emergency Response Program
CHC	Comprehensive health centre
CHW	Community health worker
CHS	Community health supervisor
CoU	Children of Uruzgan
DFAT	Department of Foreign Affairs and Trade
DFIDUK	Department for International Development
ECCD	Early childhood care and development
EMIS	Education Management Information System
EPHS	Essential Package of Hospital Services
EQUIP	Education Quality Improvement Project
FHAG	Family health action group
GIRoA	Government of the Islamic Republic of Afghanistan
GLiTTA	Girls Learning to Teach - Afghanistan
HADAAF	Humanitarian Assistance and Development Association of Afghanistan
HMIS	Health Management Information System
HSC	Health sub-centre
INSET	In-service training
IPCC	Interpersonal communication and counselling
IR	Intermediate result

ISAF	International Security Assistance Force
MAM	Moderate Acute Malnutrition
MCH	Maternal and child health
MHT	Mobile health team
MNC	Maternal and newborn care
MoE	Ministry of Education
MoPH	Ministry of Public Health
NERS	Nutrition education and rehabilitation session
NESP3	National Education Strategic Plan III
NRVA	National Risk and Vulnerability Assessment
NGO	Non-government organisation
OTP	Outpatient Therapeutic Program
PED	Provincial Education Directorate
PH	Provincial Hospital
PHD	Provincial Health Directorate
PPP	Public-private partnerships
PRT	Provincial Reconstruction Team
QPEP	Quality Primary Education Project
SAM	Severe Acute Malnutrition
SHN	School health and nutrition
STAGES	Steps Towards Access to Girls Education
TAF	The Asia Foundation
TT	Tetanus Toxoid
TTC	Teacher Training Centre
UMEP	Uruzgan Monitoring and Evaluation Program
WADAN	Welfare Association for the Development of Afghanistan
WASH	Water, sanitation and hygiene
WHO	World Health Organisation

Note about the evaluating research provider: Amin Consulting Group is an Afghan-owned, directed and managed research organisation with its roots in Southern Afghanistan (Uruzgan, Helmand and Kandahar) that has carried out significant beneficiary monitoring and evaluation research for donors including the UK Department for International Development, the Australian Department of Foreign Affairs and Trade and the Danish International Development Agency since 2012. ACG worked with two international consultants for this evaluation project, who oversaw and advised on methodology quality and who co-led analysis and reporting.

EXECUTIVE SUMMARY

Introduction

In May 2015, Save the Children engaged Amin Consulting Group (ACG) to undertake an evaluation of the AUD35.7million Children of Uruzgan (CoU) program, funded by the Australian Department of Foreign Affairs and Trade (DFAT). The independent evaluation focused on collecting and collating evidence about the extent to which the program delivered on its intended goal, objectives and intermediate results (IRs), and also considered what potential exists for longer-term impact and the sustainability of benefits beyond the life of the program.

Background

Uruzgan is one of Afghanistan's least-developed and remote provinces, located in the south of the country between Kandahar, Helmand and Daykundi. It has six districts: Tirin Kot (where the provincial centre is located), Dehrawod, Chora, Charchino (also called Shahidi Hassas), Khas Uruzgan and Gizab. It is isolated, insecure and lacks adequate healthcare and education services.

The CoU program focused on healthcare and education with two key objectives:

1) Increase access and use of Maternal and Child Health (MCH) services including the treatment of acute malnutrition, and 2) Increase access to basic education and improve delivery of comprehensive education services for children. Work undertaken by the program was organised into integrated projects. Activities were delivered across four areas of IRs: IR1 Access: Increase access to essential MCH and nutrition services and basic education; IR2 Quality: Enhance quality of MCH and nutrition services and education services; IR3 Demand: Create awareness and enhance demand for utilisation of MCH, nutrition services and basic education; and IR4 Policy & Research: In conjunction with global academic institutes, conduct research to support and inform on-going programming in MCH, nutrition and basic education in Afghanistan.

To deliver the program, Save the Children partnered with non-profit, non-political and non-governmental Afghan civil society organisations – primarily the Afghanistan Health & Development Services (AHDS), the Afghanistan Centre for Training and Development (ACTD), the Humanitarian Assistance and Development Association of Afghanistan (HADAAF) and later during the program's implementation, the Welfare Association for the Development of Afghanistan (WADAN).

Methodology

The evaluation team was mindful of the need to ensure no harm was caused by the research process, using a results orientated evaluation methodology which looked at outputs, outcomes, effectiveness, sustainability, and equity. The evaluation applied a mixed methods approach of document review, qualitative focus groups and interviews with key informants, community stakeholders and program beneficiaries. Quantitative data analysis of third-party sources of information about the program and about healthcare and education in Uruzgan was also conducted. Primary field research was collected by the evaluation team's researchers in Uruzgan from 1 August to 2 September 2015 in the districts of Tirin Kot, Chora, Dehrawod and Gizab. In total, 328 respondents participated in the research. Of these, 115 (35%) of the respondents were women and girls.

Equity

Improving the situation of women and girls within Uruzgan was central to the CoU program. Healthcare-oriented activities saw women trained as community health workers (CHWs), midwives and nurses, and as part of the family health action groups (FHAG). Education activities ensured that women and girls were the beneficiaries of newly constructed schools and community-based education (CBE) classes and that women were trained as early childhood care and development (ECCD) teachers. Cross-cutting elements of the program aimed to inculcate a more positive view of women's rights within the community via the training of religious leaders. Community members consulted by the evaluation team noted the training of women and girls as midwives and teachers as a particularly noteworthy achievement of the program. The graduation of women from midwifery and teacher training courses was noted as supporting the slow evolution in the province of a more positive attitude towards women
and girls working.

The program's engagement with ulema[1] and mullahs, through community interaction and training, was also remarked on by community beneficiaries, as having helped to foster improved perceptions about women and girls' participation in education and attendance at healthcare facilities. This engagement with religious leaders at community level was noted by program staff as critical to enable program access to women and girls in particular.

A positive, gradual evolution in perceptions about the cultural treatment of women and girls in Uruzgan was reported to the evaluation team in some communities consulted. As a community health supervisor (CHS) from Gizab said, 'women should become educated and they should not be given in *baad* [2]. 'The evolution in community attitude towards women and girls should not be overstated but any incremental progress is a significant general achievement towards which CoU may claim to have contributed. The women and girls most directly impacted by the program were those who directly participated in program training and initiatives.

Health

The available quantitative and qualitative evidence suggests that there has been a significant improvement in the MCH status of the population of Uruzgan since the program commenced. A decrease in the maternal and neonatal mortality rates was indicated by the Health Management Information System (HMIS) and data collected by the CoU program suggested a decrease in malnutrition. The qualitative interviews conducted by the evaluation team corroborated these findings that maternal and childhood mortality and malnutrition has been decreasing across Tirin Kot, Dehrawod, Chora and Gizab. For example, health professionals specifically stated that the death rate of mothers and children had decreased, that vaccinations had been preventing deaths, and that malnutrition was reduced. As one of the largest projects conducted in Uruzgan with a focus on MCH and addressing malnutrition, there is inferential evidence to suggest that changes identified can be attributed to the CoU program.

[1] An ulema is a body of Muslim scholars, the members of which are recognised as having specialist knowledge of Islamic sacred law and theology.
[2] 'Baad, occurs in the context of a past crime or local conflict. The family of the wrongdoing party resolves the matter by giving an unmarried girl or girls to the family that has been wronged.

The extent to which CoU was the largest contributor to change depended on the location in which its activities were delivered and how many other healthcare activities had taken place in a similar timeframe. For example, in remote mobile health team locations across the province, CoU's activities were among some of the only healthcare initiatives undertaken and the program can validly be regarded as a leading contributing factor to improved healthcare metrics in those areas. In Tirin Kot provincial centre however, CoU was one of a number of programs supporting improved healthcare objectives. Nonetheless, even in Tirin Kot, CoU was recognised as a leading contributor of improved healthcare services, alongside the Afghan government. A CHS stated for example, that the main factor behind improved MCH data was 'the government and Save the Children, who have constructed clinics.'

Access to health services

The CoU program contributed to access to MCH and nutrition services in Uruzgan during the program period. In all districts visited by the evaluation team, improvements in access were reported as a result of the creation of new health sub-centres and mobile health teams and newly trained CHWs. The numbers of patients in Uruzgan health facilities increased continuously during the course of the program. Women and girls were able to attend health facilities as much as, if not more than, boys and men. In such a conservative province where women had traditionally been prevented from accessing healthcare services due to the lack of female healthcare workers and poor cultural acceptance of access, this was a significant achievement. The majority of community members consulted remarked on a significant change in the healthcare services in their area. For example a senior health official in Tirin Kot said 'noticeable change has been seen in the services for mothers and children, the number of clinics have increased and people now have easy access to health services [3].' Women and children, including girls, appear from the available data to now have expanded access to healthcare. Accessibility for Afghans with a disability and for those in remote locations in Uruzgan - particularly those in Gizab district - remains a challenge.

Quality of health services

Respondents to the evaluation team's field research also broadly reported improved satisfaction with the quality of locally - available healthcare during the course of the CoU program. Qualitative fieldwork suggested that the perceived improvement in healthcare quality was linked to the construction of new clinics, the availability of mobile health teams, better equipment and medical supplies at clinic locations and in particular, to the training of new and more capable health workers. This view was reported by both community beneficiaries of healthcare services as well as by healthcare professionals. The programmatic assessment carried out by the evaluation team of the quality of CoU supported health facilities in Dehrawod, also showed that the level and frequency of antenatal care (ANC) visits had significantly increased from 2012 to 2014. The health clinics where such quality assessments were undertaken by the evaluation team demonstrated mid-range quality against the indicators, which represents a major achievement. Key informant respondents who commented on healthcare improvements in Uruzgan often attributed recent positive changes in healthcare quality to Save the Children, their partners or to directly identified CoU activities. The program appears to have been a significant contributor to an improvement in healthcare quality.

[3] Consultations with local government officials (2015) Interview by ACG August 2015.

Demand for health services

Save the Children delivered a number of initiatives designed to increase demand for health services. There is evidence to suggest that the CoU program built on already changing perceptions on healthcare and expectations to increase demand for better healthcare. The data available for vaccination rates in Uruzgan shows an increase in the Penta 3 vaccination for children under 23 months [4] in the province over the program implementation period. Community attitudes towards health changed positively since the beginning of the program. For example, in Tirin Kot, a CHS worker said that 'positive change has come to the minds of people. Previously people did not know the importance of vaccines so that's why they would not have them, but now they understand the importance of vaccines so they give vaccines to their children.'

Available evidence suggests that more demand was created for healthcare services during the CoU implementation period. The programmatic baseline and endline study on maternal and newborn care (MNC) in Dehrawod district showed that mothers in that district were much more likely to use a skilled birth attendant, less likely to deliver their child at home, and more likely to deliver their child in a Ministry of Public Health (MoPH) clinic at the endline, than had been the case prior to CoU activities commencing. All of those consulted by the evaluation team in Uruzgan in 2015 reported that they thought the people of Uruzgan were more likely to seek out healthcare services now, compared to four years ago.

Education

Enrolment data from the Ministry of Education indicates a slow but gradual improvement in general education levels in Uruzgan over the term of the CoU program. Both female and male enrolment has improved gradually. An assessment of literacy of CBE students in Dehrawod from June to November 2013 shows a marked increase in literacy with 50% of them being able to read a story after six months. The majority of education professionals consulted by the evaluation team in Tirin Kot, Dehrawod, Chora and Gizab stated that there has been a positive change in the level of education of the population since 2011. Unlike for healthcare, where CoU was one of the only non-Afghan government change agents in recent years, the education sector has been supported by a wider range of projects. Nonetheless, there is some evidence to suggest that the changes identified in education can be attributed, at least in part, to the CoU program. The majority of participants gave examples of the programmatic activities of CoU as having had an impact; many also specifically mentioned Save the Children as an important actor in improving education in the province.

Access to education

Newly constructed and refurbished schools and community-based education classes increased access to education in Uruzgan. Since 2011, the number of education facilities increased in the province. CoU was directly responsible for the construction of six school facilities and refurbishment of 58. Qualitative fieldwork indicated that there was an improvement in access to education services generally across the province, with elders, men and women in the community all recording positive views about their children's schooling access. CBE classes were noted as an important way for

[4] Penta 3 - a three-course vaccination covering whooping cough, hepatitis B, influenza, tetanus toxoid and diphtheria.

access to be enhanced to remote parts of the province that were under-serviced by government school facilities. Limitations in education access remain most notable for certain beneficiary groups, such as girls, children with a disability and those living in particularly remote communities.

'There is no doubt that small projects like the construction of parks, digging of water wells, and libraries increased the trust of the community.' Representative for the Department of Women's Affairs. Tirin Kot.

Quality of education services

CoU-supported educational facilities that had quality assessments undertaken by the evaluation team found that those institutions achieved mid-range results against the indicators. Teaching quality and equipment availability were reported as being satisfactory. These quality assessments were corroborated by the majority of community members reporting satisfaction with the education provision in their area. Positive changes during the last four years were remarked upon, in terms of schools being better-equipped and teachers being better-trained.

For example an education manager in Dehrawod stated that now 'we have a number of skilled teachers, the system of education has been computerised, a number of schools have been repaired and equipped, local classes have been constructed... Save the Children has trained our workers so that their capacity has increased.'

Demand for education

There is evidence of a change in education seeking behaviour among the community members of Uruzgan. Parents are now more likely to want to send their children to school than prior to the CoU program commencing. In order to improve demand for education services for the target communities of Uruzgan, Save the Children undertook a number of initiatives such as the capacity building of religious leaders to advocate for the importance of education. Changing attitudes towards education have translated into greater demand. For example, the majority of the education professionals interviewed by the evaluation team stated that they thought the people of Uruzgan were more likely to seek out education services now (in August/September 2015) than ever before. CoU may be inferred to have contributed, along with other Afghan government and donor-funded initiatives, to enhance demand for education services.

Policy and research

The research and pilot studies undertaken by CoU were used to inform some national level policy and practice however as the majority were carried out in Year 3 of the program this limited the extent to which they could inform the program's operations. The stakeholders interviewed by the evaluation team regarding the program's policy and research component highlighted issues of inconsistent CoU staffing of this area and that the program did not have a well-planned approach to evolve the program's design on the basis of research findings. As a Save the Children staff member said, 'the reality of it was that research was a low priority.' The research that was conducted, despite potentially not being clearly integrated into the program's design or operation, was reportedly of high quality. The program may have contributed to some provincial level policy reform concerning the local administration and management of national-led healthcare and education initiatives.

Program design, implementation and process

Save the Children used a program strategy designed specifically to work in a fragile and volatile context such as Uruzgan. This strategy ensured that implementation of the program was flexible and able to adapt to the changing priorities and circumstances of the program. It was particularly appropriate for the insecure and politically and socially complex operating context. The six month scoping stage undertaken at the start of the program was very effective in building trust and ensuring the community were brought into the process. The community development and mobilisation activities, such as the construction of parks and digging of water wells, were also designed to, and were successful in, helping to build community trust and support for the program's activities.

Donor and Save the Children local programming and decision-making flexibility aided the effectiveness of the program's implementation. Across Uruzgan, nearly all local government representatives commented that the way the program was implemented was well-suited to the context. This view was shared by all DFAT and Save the Children respondents. In Tirin Kot, Dehrawod, Chora and Gizab all of the healthcare professionals and education professionals consulted also agreed.

Sustainability

The program had a clear plan for sustainability and embedded sustainability elements into specific activity designs. At an activity level, training programs in particular were devised to enable graduates of the training the best possible chance of continuing to support one another as a learning and practitioner community. Healthcare initiatives were closely coordinated with the Afghan government's provincial health approach and a number of health facilities and clinic refurbishments were handed over and now form part of the Afghan government's healthcare infrastructure. Some healthcare activities however did close completely. Likewise, a number of the education elements of the program, such as the newly-constructed and refurbished schools, were taken over by the Provincial Education Directorate (PED).Other education activities however, primarily some of the CBE classes and the ECCD classes had to be closed because there was no government department or other organisation willing or able to manage them.

Those consulted in the community about the CoU program had mixed opinions about whether or not the changes contributed to by Save the Children and its partners would be sustained. There was a belief that the changes in people's attitudes and desires for healthcare and education would sustain to a certain extent. The training provided to religious leaders about the cultural acceptability of women and girls accessing healthcare and education was cited as an example of an activity that had a good chance of enhancing the sustainability of CoU-led change. Nonetheless, the closure of some project initiatives and the discontinuation of new training activities were noted as significant challenges to the province's ability to staff education and healthcare facilities adequately. Without further skills training funded to take place locally, to enable local communities to train and staff their own healthcare and education facilities, many of the positive changes achieved by CoU are expected to unravel by both community members and healthcare and education professionals. Uruzgan remains a remote, insecure and conservative province – it will be a major challenge for the province to attract qualified personnel – even to the provincial centre in Tirin Kot, let alone to rural areas in the districts.

Conclusions and recommendations

Although there were attempts to focus on particularly needy beneficiary groups, specific activities were not always aimed at addressing equity concerns, particularly with regards to those people with disabilities. There were activities targeted for women and girls, however some female beneficiaries felt that they could have been consulted more directly during the life of the program. For example, the education professionals from Tirin Kot pointed out that 'the program would have been more effective if the chief of the women's department and female teachers were consulted. Women should have been given a budget in the program or a garden or a market so that they could sell their handmade products in that market [5].

Recommendation

Although women and girls were a major component of the proposal and design and many projects did specifically address them, they were not included in the design of such elements themselves. As such, an opportunity was missed to ensure that women and girls contributed directly to programming for themselves, and that the projects were the right ones. It is recommended that more efforts should be placed on including women and girls directly in the design and operation of the program and that this is accompanied by clear monitoring of outcomes for them in order to increase knowledge and understanding about what has been achieved for these groups in comparison to the general population and where and how services to them can be further improved.

There were differences in the level and extent of the improvements in access and quality in healthcare as compared to education. This appears to be attributable to a number of different factors. First, the school construction element of the program ran into difficulty. It was management-time-consuming and led to misunderstanding with the Uruzgan government [6]. As a result refurbishment was prioritized over construction. Second, Save the Children's NGO partners in healthcare were much more experienced and efficient than the original NGO partners for education. The original two education partners were not operating effectively and there were allegations of corruption. One staff member explained that the education partners that were selected 'were not able to implement our program according to our standards so we terminated the contract' [7]. Another added 'this is why we had a steady flow of NGOs for education. We could have improved the selection process – that delayed programming with education because every time we had to keep changing partners [8].' Third, the health directorate had minimal staff turnover in comparison to the education directorate, who also had limited capacity, as a staff member stated 'the capacity of the education directorate was not what we expected. During my time four or five education directors were in place. It's hard to keep orientating them about the program and ensuring that we understand the new director from the beginning [9].'

[5] Education professionals Tirin Kot.
[6] Key informant interview with senior program representative by ACG, August 2015.
[7] Ibid.
[8] Key informant interview with senior program representative by ACG, August 2015.
[9] Key informant interview with senior program representative by ACG, August 2015.

Recommendation

Although it is clear that the program adapted as well as it could to issues with the capacity of both education partners and the education directorate, it appears that more could have been done to mitigate these problems from the start. For example, if a plan for capacity building and co-planning of certain, limited aspects of the program - with the education directorate - had been a part of the program's design, earlier and more sustained trust could have been established between the directorate and program personnel. The directorate could also potentially have been more effectively co-opted into the program's implementation and its successes. Constructive engagement with the education directorate is essential for sustainability of program achievements, and this is something that should be addressed in future programming where such a relationship is key to programmatic success. In future programming it will also be important for a cost/benefit and sustainability analysis to be conducted about the comparative value of educational facility refurbishment compared to large-scale new school construction. A more robust education partner recruiting system may also be helpful to introduce.

There is clear evidence to suggest that IR4 was not planned as effectively as it could have been nor that there was consistent leadership driving this component forward from the beginning. Without staff skilled in research techniques, management of this component of the program lacked direction and many opportunities to ensure appropriate baselines were in place, were missed. The research carried out at the end of the program was not able to influence the program's activities in the way it had been conceived in the design phase of the program.

Recommendation

Full program baseline and end line monitoring and evaluation should be embedded within all future projects and programs. In future programs with specific research elements it is recommended that research is an integral part of the program from the beginning and designed to aid program delivery. In addition, ensure such components are assigned staff with a clear mandate and research skills and experience to drive the component forward in a strategic way. Program design "checkpoints" may also be beneficial to introduce, to enable learning from the program's implementation to be incorporated into activity design mid-way through implementation.

The program design was well-suited to the context in that it allowed for flexibility, adaptability and an extensive period of trust-building and community mobilisation. One suggestion for improved program design, discussed above, is that a more comprehensive approach to monitoring and evaluation research could have been integrated into the overall program approach, as well as into more of the program's individual projects and activities.

Recommendation

Ensure that future programs learn from the success of enabling a long scoping stage. The general flexibility and adaptability of this program enabled by close engagement with the funding agency is also a potentially replicable achievement. The built-in community engagement and community development project component of the program was successful and should be utilised in other, similar programs where community access may otherwise be impeded. An area for improvement is that future programs could more effectively embed monitoring and evaluation into program design from the outset.

The program aimed to be sustainable and embedded sustainability planning into a number of its activities. However, sustainability should have been better prepared-for and sustainability aims should have more realistically taken into account limited government capacity. Sustainability planning may have benefited from being a core focus for the program, particularly in later years when residual Afghan government capability after the closure of the Provincial Reconstruction Team (PRT) became clear. Although there was an attempt to embed sustainability into the program, more could have been done to ensure that there was a smoother transition at the end of the program to Afghan government leadership of an expanded and improved healthcare and education system in Uruzgan.

Recommendation

It is recommended that sustainability planning is periodically revisited during each year of large programs in light of what had and had not been achieved in terms of the original plan for the proposal to ensure sustainability. In particular, sustainability may need to focus more on how to ensure sufficient resourcing is available to healthcare and educational facilities established during a program's implementation, and how community take-up of management of initiatives can be better planned-for once a program concludes.

01 INTRODUCTION

This final report provides an overview of the evaluation approach and presents the conclusions of the ACG evaluation of the Children of Uruzgan project. Findings are based on review of Save the Children internal reporting, ACG-conducted qualitative field research and, where available, secondary sources of quantitative data.

Save the Children Australia engaged ACG in May 2015 to undertake a final evaluation of their AUD35.7m Children of Uruzgan program, funded by DFAT. CoU was DFAT's largest grant awarded to a single organisation in Afghanistan. It commenced in 2011 and recently concluded field operations in June 2015. The program has been credited with delivering significant healthcare and education improvements in Uruzgan, one of Afghanistan's most under-serviced and remote provinces.

'... if we compare the people with 2011, we see they want more services ... previously they would demand oil, wheat, and biscuits but now they want healthcare and education services.'
CHW, Chora, Uruzgan

The independent evaluation focused on collating available evidence about the extent to which the program delivered on its intended goal, objectives and intermediate results, and also considered what potential exists for longer-term impact and the sustainability of benefits beyond the life of the program. Analysis of CoU results was informed by three sources of evidence: (1) internal Save the Children program documents and monitoring reports, (2) primary qualitative research in the form of interviews and focus groups with key informants and community beneficiaries conducted by ACG, and (3) secondary sources of quantitative data about healthcare and education in Uruzgan, where such information was relevant and available.

It is important to recognise the limitation of assessing sustainability and longer-term impact from a program when the evaluation was conducted at the same time that field operations concluded. Limited time had elapsed between activities concluding in the latter phases of the program and when evidence was collected and analysed. Another limitation affecting the evaluation was that there was no whole of program baseline or agreed set of program level results by Save the Children or DFAT upon program commencement. As such, there was no cohesive, overarching data set that could be drawn upon to inform an objective evaluation of all program components. Save the Children did conduct routine monitoring and complete component-specific baselines and endlines for some elements of the CoU program. This data is drawn on extensively in the evaluation but does not comprehensively specify higher-level indicators from which impact or outcome evaluation assessment can be evaluated.

ACG has organised the final report, following this brief introduction, as follows:

- **Section 2** sets out ACG's **methodology** for completing the evaluation.
- **Section 3** includes **background** information relevant to an evaluation of the Children of Uruzgan program and Save the Children's intervention design.
- **Section 4** summarises the **principle findings** of the evaluation, organising analysis and sources of key evidence by questions that Save the Children was interested to evaluate.
- **Section 5** makes concluding observations and specifies any recommendations arising from the evaluation that may be relevant to future programming.

02 BACKGROUND

2.1 Design of the program

The CoU program was designed by Save the Children in response to a request from the Australian Government to contribute to addressing the gaps in Afghan government health and education service delivery in Uruzgan. Due to the region's lack of security and stability, the Australian Government was engaged in a civil-military intervention in the province at the time that CoU was designed and commenced. The program started in June 2011 and field operations concluded in June 2015, eighteen months after the withdrawal of Australian troops from the province.

CoU was designed around two key objectives:

1. Increase access to and use of Maternal and Child Health [10] services including the treatment of acute malnutrition
2. Increase access to basic education and improve delivery of comprehensive education services for children

Individual projects and their activities were devised around four Intermediate Results (IRs) relating to the achievement of the two stated objectives:

- IR1 **Access**: Increase access to essential MCH and nutrition services and basic education
- IR2 **Quality**: Enhance quality of MCH and nutrition services and education services
- IR3 **Demand**: Create awareness and enhance demand for utilisation of MCH, nutrition services and basic education
- IR4 **Policy & Research**: In conjunction with global academic institutes, conduct research to support and inform on-going programming in MCH, nutrition and basic education in Afghanistan

The program was designed as a series of interrelated and integrated work packages, delivered through a large number of individual projects and activities that could be scaled-up and scaled-back as the context demanded (see Annex 1: Detailed Program Framework). This approach helped the program to implement conflict sensitive and appropriate initiatives across the province, including in remote and insecure areas, as stability and access conditions changed over time. The integrated approach to delivery also ensured that a large volume of development support could be delivered to local communities in a short period of time – with activity teams working independently but with good coordination.

In order to tackle the challenges and limitations inherent to the particular context of Uruzgan, Save the Children partnered with national civil society organisations with good knowledge of the province, and strived to collaborate with existing provincial, district and community development councils and committees as well as local health and education councils (known asshuras).

[10] Program design initially used the phrase "Mother and Child Health". This was changed to Maternal and Child Health by Save the Children.

A key feature of the program was its approach to community engagement and the close collaboration with local partners. This culturally-sensitive approach helped the program team to generate trust in the local community for program activities to be supported. Building incremental local trust was essential for the program to fulfil its mandate to focus on improving women's healthcare and girls' education in particular.

2.2 Rationale for the program

Save the Children's explicit goal was 'to enhance access, quality and use of basic health and education services for children and their families living in the 6 districts of Uruzgan Province in Afghanistan.'

The CoU program was designed by Save the Children as a healthcare and education development program to be implemented amidst instability, insecurity and active conflict in Uruzgan province. Despite the funding partner – DFAT – having considered stabilisation objectives as important in their decision to fund the CoU program, it is clear that Save the Children approached the program's design and implementation entirely as a development initiative [11].

At the time of the CoU program's design Uruzgan was, and it remains, one of the most under-developed, least accessible and culturally conservative provinces in Afghanistan. CoU was designed to provide improved healthcare and education services where the central Afghan government was unable, due to significant insecurity challenges facing government officers and government-funded service delivery. CoU aimed to support an estimated group of 300,000 beneficiaries who were in severe need of basic health and education services with a particular focus on women and girls and those in remote and under-serviced communities [12]. These groups were regarded as the most urgently in need of better healthcare and education services and the least likely to benefit from Afghan government service delivery over the planned duration of the program.

The identified program rationale, as set out in the Save the Children proposal, was to:

- address issues of skills shortages in the areas of healthcare and education
- support critical infrastructure
- strengthen the capacity of the provincial government to deliver basic services in line with the core needs identified in the Australian government's needs assessment [13].

One final aim of the program was to conduct research during the course of the program to improve the design and the implementation of future development projects. The program also aimed to cooperate as much as possible with the Government of the Islamic Republic of Afghanistan (GIRoA) and its provincial representatives to inform education and health policies and ensure the sustainability of the program.

[11] Key informant interview with former DFAT PRT representative, August 2015.
[12] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011, p.20.
[13] AusAID (2010) Comprehensive Needs Assessment for Uruzgan Province, Afghanistan Phase One, August 2010.

2.3 Uruzgan province

Uruzgan is located in the southern region of Afghanistan. It is bordered by Kandahar and Helmand provinces to the south and south-west, by Zabul to the east, and by Daykundi to the north. The province is particularly mountainous (70%), rural and has poor infrastructure. It currently has six districts: Tirin Kot (where the provincial centre is located), Dehrawod, Chora, Charchino - also called Shahidi Hassas, Khas Uruzgan and Gizab (noting that the latter is administered as part of Uruzgan but remains formally part of Daykundi province). Approval for a seventh district (Chenartu) remains pending at parliament.

The particular geography of Uruzgan has meant that traditionally it has been difficult to reach from other parts of the country. It has been isolated from cultural and technological innovations and developments. The road to Kandahar was in significant disrepair and mostly inaccessible until it was repaired through the International Security Assistance Force (ISAF) funding support in 2008-09. Until late 2013, the province did not have a civilian airport. The isolation of the province is one reason behind its lack of adequate healthcare and education services. Another reason is the general insecurity attributed to the province – particularly in rural areas away from the provincial centre in Tirin Kot. The US and Australian Army maintained a continuous presence in the province from 2005-2014 with other ISAF-contributing nations such as the Netherlands also contributing significant forces to the stabilisation and securitisation of the region [14].

2.3.1 Uruzgan tribal demographics

Uruzgan is overwhelmingly populated by ethnic Pashtuns, with approximately 90% of the population speaking Pashtu. The main non-Pashtun minority is the Hazara community, comprising an estimated 8% of the population and who are mostly concentrated in the districts of Gizab and Khas Uruzgan. Within the Pashtun majority, the Zirek Durrani tribe (consisting of the Barakzai, Popalzai, Alokozai and Achekzi sub-tribes) make up an estimated 60% of the population, with the Panjpai Durrani (made up of the Noorzai and Alizai sub-tribes) comprising the next largest proportion of 18% and the Ghilzai (Hotak, Toki and Suleimankhel) comprising 9% [15]. Provincial decision-making authority within the Afghan government has been largely focused in the Zirek Durrani tribal groups since the fall of the Taliban and the arrival of US forces in 2005. More specifically, the Popalzai tribes have been credited with having significant influence over government funding dispersal and security conditions in the province throughout the implementation period of the CoU program. These demographic features of the program's implementation context have been noted by members of the former Australian-led Provincial Reconstruction Team (PRT) in 2013 as potentially influencing how government healthcare and education services were developed in Uruzgan [16]. Demographics were particularly relevant to the CoU program due to the influence of tribal dynamics on cultural conservatism.

[14] See generally, The Australian Army (2013) "Australia's contribution in Uruzgan acknowledged".
[15] Uruzgan Provincial Reconstruction Team briefing to Save the Children CoU program team in 2013, based on PRT UMEP data shared with Save the Children in 2013.
[16] Ibid.

2.3.2 Security in Uruzgan

Tribal rivalries have been credited as being a major factor behind insecurity in the province but since 2001, many battles between ISAF forces and armed actors have also taken place, and have cost the lives of many civilians. Local communities in Uruzgan have been largely unprotected by Afghan government police or military forces since 2005 and many roads in the province have remained insecure. The security situation in Uruzgan in 2015 has been noted as having potentially deteriorated following the withdrawal of ISAF forces in 2014 [17]. The evaluation team's field research was itself disrupted by insecurity as the Taliban endeavoured to expand its control over the province in the Afghan summer of 2015 [18]. Insecurity has affected Afghan government police and non-government organisation (NGO) aid workers, including tragically, CoU program staff who were killed in 2013 and 2015 [19].

2.3.3 The situation of women and girls in Uruzgan

Within Uruzgan, women and girls have historically suffered from high rates of illiteracy and poor access to education and healthcare services. Although there have been improvements in the rights of women and girls in Afghanistan since 2001, prior to commencement of the CoU program the women and girls of Uruzgan were some of the most disadvantaged and restricted in the country. In 2004 a new constitution was adopted in Afghanistan guaranteeing women equal rights and in 2009 the Law on the Elimination of Violence Against Women banned and set new penalties for underage and forced marriage, domestic violence, rape, forced prostitution, and other abuses against women. In some areas of Afghanistan and particularly the capital Kabul, women have assumed government posts, run for office, and re-engaged with all aspects of Afghan society. In Uruzgan however, women remain almost completely excluded from provincial power and politics.

Uruzgan society is strongly influenced by tribal affiliations, and tribal identity significantly influences views on the roles that women can acceptably play in society. Whilst Hazara women enjoy slightly more freedom than Pashtun women in the province, the province is one of the most demarcated in the country [20]. On average, Hazara women enjoy moderately better rates of literacy than the almost non-existent literacy of women from Pashtun tribes [21]. In many parts of Uruzgan, strong opposition still prevails against the education of women altogether, or to their care by male healthcare workers. These views are particularly strong among Pashtun tribes, and slightly less so among Hazara communities.

[17] Wroe, D (2015 ")Afghan province sliding back towards Taliban control" The Sydney Herald 30th May 2015.
[18] Marty, F (2015) "Update: Taliban launch sustained attacks in Uruzgan province" IHS Jane's Defence Weekly 1st June 2015.
[19] AFP/Reuters 2015 "Five aid workers killed in Afghanistan after abduction by Taliban: officials" ABC News 11th April 2015. Available at <http://www.abc.net.au/news/2015-04-12/five-abducted-aid-workers-killed-in-afghanistan-officials/6386316>
[20] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011.
[21] Jacinto, L (2014) "Why are Afghan candidates wooing the Hazara vote?" France 24, 27th March 2014.

In practice, women in Uruzgan experience severe restrictions on access to education, work and health care. This has made their access to healthcare and education facilities difficult. In general, in Afghanistan, women are expected to be escorted by a male relative or husband or risk being labelled as "immoral". In practice, women in Uruzgan are often not permitted to leave their house at all - even with a male escort. While education is far more accessible in Afghanistan today than it was under Taliban rule, more than half of all girls in the country still do not attend school and Afghan women continue to suffer from some of the worst literacy, poverty, and life expectancy rates in the world [22]. These problems are even more marked in Uruzgan.

Girls are often forced to marry immediately after puberty and give birth before their bodies have fully developed. In addition, girls suffer from cultural incidents of '*baad*" and '*baadal*". *Baad*, occurs in the context of a past crime or local conflict. The family of the wrongdoing party resolves the matter by giving an unmarried girl or girls to the family that has been wronged. *Baadal* is an exchange of girls between families, each married to a male member of the other family in order to remove the obligation of both families to pay a dowry [23].

2.3.4 Healthcare in Uruzgan prior to the CoU program's implementation

At the beginning of the CoU program, health services in Uruzgan were the worst performing in the country in terms of access. In terms of healthcare provision, the Afghanistan national Basic Package of Health Services (BPHS) was providing basic services. A total of 14 public health facilities – one provincial hospital (PH), six comprehensive health centres (CHCs), six basic health centres (BHCs) and one health sub centre (HSC) - were functional in the province in 2009, making Uruzgan the province with the fewest health facilities in the country. While the national ratio in 2008-2009 was one health facility (from national hospital to health sub-centre) for 13,928 inhabitants, in Uruzgan this ratio was 1 for 23,821 [24,25].

In 2012, 74% of the people in Uruzgan rated the availability of medical care/the availability of clinics and hospitals as quite bad [26], or very bad. Access to healthcare was therefore a crucial issue for the province. Planned health facilities were reportedly not established by the government due to a combination of poor security and difficulties attracting qualified medical personnel to work in the province. In 2008 it was reported that of the technical healthcare staff working in Uruzgan, 90% were from other provinces. High staff turnover was credited to poor living conditions [27].

[22] Human Rights Watch (2012) "I HAD TO RUN AWAY" The Imprisonment of Women and Girls for "Moral Crimes" in Afghanistan.
[23] Ibid.
[24] MoPH (2010) A Basic Package of Health Services for Afghanistan July 2010 Kabul.
[25] Islamic Republic of Afghanistan, Central Statistics Organisation.
[26] The Asia Foundation 2015. Survey of the Afghan People - Uruzgan data.
[27] Assessment by DCU (2008) closely coordinated with Ghazanfar Institute of Health Science (GIHS), Uruzgan provincial health directorate, local BPHS implementer and other stake holders in the province.

Low rates of access to healthcare in Uruzgan translated into poor maternal and child healthcare. In 2012, in Dehrawod, it was reported that 57% of women had not seen any health professional during their pregnancy [28]. Nationally, 43% of Afghan women were recorded as not receiving any antenatal care in the same year [29]. In 2011 in Uruzgan, just 17% of deliveries were assisted by a skilled birth attendant [30]. The rate of under 5 mortality in Afghanistan was one of the highest in the world, reported at 102 deaths for 1000 births in 2010 [31]. Acute malnutrition was one of the major causes for the poor condition of health among Uruzgani children. In 2011, 17.6% of children aged 0 to 59 months in Uruzgan were found to be malnourished [32].

2.3.5 Education in Uruzgan prior to the CoU program's implementation

The lack of infrastructure and access to education has considerably affected overall literacy levels in Uruzgan. The situation prior to the CoU program's implementation was dire. It was estimated in 2010 that 81% of children aged 7 - 13 in the province did not attend school, and of those students who did attend, less than 10% were girls [33]. The quality of education for children who attended school was extremely poor. Only 17% of teachers were reported as being professionally qualified (having completed their education beyond grade 12) [34]. Only 28% of all teachers were women in the country but in Uruzgan, out of 1,319 teachers, only 56 (0.4%) were female [35].

Female teachers are particularly critical to ensuring greater participation and enrolment of girls in school, particularly beyond grades 3 and 4 and especially in rural areas. Girls' enrolment was considerably lower in Uruzgan in 2011 than in the rest of the country, amounting to 13% of the total enrolment in general education against 39% on average in Afghanistan [36]. The strongest barrier to girls' education in the province was (and reportedly continues to be) the lack of community and cultural support. In 2010, while 31% of Afghans quoted illiteracy as the biggest problem for women in the country [37], only 9% of Uruzgani respondents to a nationwide survey agreed with this statement [38].

[28] Children of Uruzgan 2014. Improving maternal and newborn care. Save the Children, January.
[29] Afghan Public Health Institute, Ministry of Public Health, Central Statistics Organisation, ICF Macro, Indian Institute of Health Management Research, & World Health Organisation Regional Office for the Eastern Mediterranean. 2011. Afghanistan Mortality Survey 2010. Calverton.
[30] MoPH & Grants and Services contracts Management Unit 2013. Household survey. Kabul.
[31] AMICS 2010.
[32] AHDS (2011) Uruzgan Nutrition Survey April 2011, Uruzgan.
[33] Three Years Later: a Socio-political Assessment of Uruzgan Province from 2006 to 2009, The Liaison Office, September 2009.
[34] AusAID (2010) Comprehensive Needs Assessment for Uruzgan Province, Afghanistan Phase One, August 2010.
[35] Ibid.
[36] Ministry of Education of Afghanistan (2015). Education statistics. Kabul.
[37] The Asia Foundation (2014). Custom analysis: services in Uruzgan.
[38] The Asia Foundation (2015). Survey of the Afghan People - Uruzgan data.

2.3.6 Healthcare and education interventions in Uruzgan

With the arrival of international development efforts and international security forces after 2001, the evidently poor condition of healthcare and education services in Uruzgan led to several donor-funded interventions prior to the CoU program. Since 2005, the main healthcare programs have been the MoPH's roll-out of the BPHS and Essential Package of Hospital Services (EPHS), focused on improving access to quality healthcare across Afghanistan [39]. The overall cost of implementation of the 2009 BPHS across Uruzgan was USD 17.90 million from the World Bank and non-bank sources [40]. From 2011, the BPHS and EPHS in Uruzgan were implemented by the Afghan NGO AHDS [41], who also worked with international organisations such as Cordaid and Save the Children. Cordaid was granted approximately EUR 3.1 million (AUD5 million) for the implementation of the BPHS and EUR 1.2 million (AUD1.9 million) for that of the EPHS from EuropeAid [42]. Cordaid and AHDS acted jointly with the secondary aim of building the capacity of the latter to ensure the sustainability of the two projects. Their joint action has carried on up to this date albeit with reduced funding [43].

Through the BPHS the Uruzgan provincial hospital was constructed and upgraded in Tirin Kot. Comprehensive and Basic Health Centres were also funded across the province. Further upgrades to district health centres were also provided through the Netherlands and Australian PRT programming and US Commander's Emergency Response Program (CERP) funds. The Netherlands military provided development courses for the training of skilled medical personnel locally within Uruzgan from 2008 – 2010. Ambulances and medication was also purchased to stock local health facilities [44].

In the education sector, extremely low literacy rates were recognised by consecutive PRT lead nations as well as the need to construct new schools and to train teachers. While CoU was the most ambitious education program undertaken with a sole focus on Uruzgan province, it was by no means the only education-focused initiative. Since 2007, Germany and the Netherlands governments for example have invested approximately AUD110 million in the province, including a significant number of school construction projects in Chora, Dehrawod and Tirin Kot. Nation-wide initiatives funded through the World-Bank administered Afghanistan Reconstruction Trust Fund (ARTF) such as the Quality Primary Education project (QPEP) and the Education Quality Improvement Project (EQUIP) were also funded by multiple donors and focused on constructing and rehabilitating primary and secondary schools for boys across Uruzgan's districts, and for girls in Khas Uruzgan, Gizab, Chora and Tirin Kot.

[39] MoPH (2010) A Basic Package of Health Services for Afghanistan July 2010 Kabul.
[40] The World Bank (2015) "Afghanistan - Support to Basic Package of Health Services (Strengthening Health Activity for Rural Poor" 2015.
[41] AHDS (2013) Annual Report.
[42] Cordaid (2013) "Basic Healthcare Uruzgan" 2013.
[43] Cordaid (2013) "Support for hospital in Uruzgan continues" 30th September 2013.
[44] Beeres, R (ed) (2012) Mission Uruzgan: Collaborating in Multiple Coalitions for Afghanistan 2012 Amsterdam.

Other projects dealt with both healthcare and education in Uruzgan. This was the case of the Dutch Consortium Uruzgan, whose members included Save the Children and Cordaid. The project was implemented between 2009 and 2013 and received 14 million Euros (AUD21.4 million) in funding. The project most notably resulted in the training of 45 mid-level health professionals and provided literacy skills to 1,400 adults including 560 women [45]. With the withdrawal of ISAF forces from Uruzgan province in 2013, direct donor-funded programming in Uruzgan has diminished significantly. Funding for education and healthcare instead became primarily directed through Afghan government channels, apart from the CoU program which continued through to June 2015.

[45] ZOA (2013) Dutch Consortium Uruzgan, 2013.

03 METHODOLOGY

The evaluation focused on the extent to which the program's intermediate results led to the achievement of the overall program goal and two objectives. The improvement of maternal and child health, nutrition and basic education services for the target communities were appraised, and the contribution of the CoU program reviewed, on the basis of changes in **access**, **quality** and **demand** from the community. Evidence of the impact of the program on women and girls was a specific focus for the evaluation team given the particular emphasis of CoU on this beneficiary group.

3.1 Ethics and sensitivities

The evaluation team was mindful of the need to ensure no harm was caused by the research process and always sought to minimise the possibility of distress arising as a result of participation in the consultations. Care was taken at all stages of the process to avoid unnecessary intrusion into the private lives of participants, the fostering of false hopes and expectations or the creation of unnecessary anxiety. Participation in interviews and focus groups was based on the freely given, informed consent of the participants. Comprehensive training was provided to the field research team on how to apply and follow the industry-standard ESOMAR Guidelines [46] for how to conduct research with children, and Save the Children's Child Safeguarding protocols [47] ahead of field work commencing. The strict adherence of field researchers with the Guidelines was supervised and verified by ACG's district field research managers.

3.2 Methodological approach

3.2.1 Evaluation objectives and the questions Save the Children sought to answer

The scope of the evaluation was specified in Save the Children's evaluation terms of reference (included in Annex 2 to this report), which was defined and clarified during the project's inception phase. In particular, the evaluation methodology was designed by the evaluation team to collect available evidence about results and achievements of CoU against the program goal, objectives and IRs. These IRs were initially defined in Save the Children's funding proposal to DFAT ahead of the program's commencement, and were later refined by the CoU program team.

In order to evaluate the extent to which the program objectives and IRs were achieved, the evaluation team utilised a results orientated evaluation methodology which looked at:

- **Outcomes**: Does the evidence suggest a positive or negative change (directly, indirectly, intended or unintended) and to what extent can the CoU program be ascribed contributory responsibility for the change recorded or reported?
- **Outputs**: To what extent the desired intermediate results were achieved?
- **Effectiveness**: How effective was the program in its design and programmatic methods and to what extent did this effect the desired results?

[46] ESOMAR (2009) *Interviewing children and young people,* ESOMAR World Research and guidelines, 2009.
[47] Save the Children (2015), *Child safeguarding policy,* 2015.

- **Sustainability**: To what extent does the evidence or findings suggest achievement sustainability or potential for a change to continue after the CoU program has ceased?
- **Equity**: Assessment of CoU's ability to bring about tangible outcomes for women and girls, Afghans with disabilities, Afghan minorities in Uruzgan and remote and under-serviced communities.

The evaluation team assessed the extent to which the IRs had been achieved, and the contributing enablers and constraints to achieving the specific program objectives. The evaluation focused at the outcome (effects) level of the program, with some assessment also of the potential longer-term impact and sustainability of benefits arising from the program.

The evaluation team designed the methodology in order to collect evidence for the informed assessment of the CoU program from the following evaluation questions.

See Table 1.

Table 1: Evaluation question matrix

Evaluation Question	Research Methods used
To what extent has CoU contributed to improved MCH, nutrition and basic education services for the target communities, particularly women and girls?	Quantitative data analysis, Literature review, Focus groups, interviews
Has there been any change in the MCH, nutrition and education status of the population of Uruzgan since the program commenced and if so, to what extent can this be attributed to CoU?	Quantitative data analysis, Literature review, Focus groups, interviews
Have community attitudes towards health and education changed since the start of the program, and if so in what ways?	Literature review, Focus groups, interviews
Has there been any change in health-and education-seeking behaviour among community members since the start of the program?	Focus groups, interviews
To what extent have the community development projects (village wells, women's parks, libraries, solar panels etc.) contributed to improving the lives of people in Uruzgan?	Quantitative data analysis, Literature review, Focus groups, interviews
To what extent has the program delivered benefits for the most marginalised members of the target communities, including women and children (especially girls), people with a disability, ethnic and linguistic minority groups, remote communities?	Literature review, Focus groups, interviews
Has there been any change in attitudes among community leaders and members regarding the roles of women and girls in society since the start of the program?	Literature review, Focus groups, interviews
Has the program delivered any unexpected outcomes or changes, positive or negative?	Focus groups, interviews
Has the program contributed to any provincial or national level policy reform?	Literature review, Focus groups, interviews
Has research and pilot studies undertaken by CoU been used to inform MCH, nutrition and education policy or practice in any way?	Focus groups, interviews
Was the implementation strategy adopted appropriate for the insecure, and politically and socially complex operating context?	Focus groups, interviews
What is the potential for the long-term sustainability of any program results that have been achieved?	Quantitative data analysis, Literature review, Focus groups, interviews

3.3 Mixed-methods approach

As depicted in table 1 above, the evaluation applied a mixed methods approach of document review, qualitative focus groups and interviews with key informants and community stakeholders and beneficiaries, and quantitative data analysis (where such pre-existing data was relevant and available).

In the first instance, basic data analysis of the healthcare and education context in Uruzgan and a program documentation review allowed the evaluation team to understand the program, identify overall trends and to make some preliminary judgements regarding the extent to which IRs may expect to have been achieved. These initial suppositions were then tested through qualitative field work results and further quantitative data assessment.

Primary field work research was conducted by evaluation team researchers in Uruzgan from 1 August to 2 September 2015. Qualitative field research comprised 27 focus groups and 65 interviews with a combination of key informants relevant to the CoU program and healthcare and education in Uruzgan, as well as potential community beneficiaries of CoU interventions at district level in the province. This qualitative field research enabled the evaluation team to enrich its understanding of the extent to which the CoU program had achieved its outcome results, effectiveness, equity and sustainability.

3.3.1 Desk-based documentation review

The desk-based review began with a careful analysis of the existing data and documentation on the CoU program. The available qualitative and quantitative data was plotted against the overall objectives and the IRs in order to reveal gaps in the evidence base that could inform the evaluation results.

3.3.2 Quantitative data review

Existing CoU programmatic data was plotted against each year of the program's operation and against individual program activity baseline data where available.

1. **CoU programmatic research**: Two pieces of programmatic research were used for the desk-based evaluation:

- the Maternal and Newborn Care baseline and endline study in Dehrawod,
- the CBE classes literacy surveys.

Both were useful as they showed clear baseline and endline evolution, directly linked to the performance of the CoU program. However, their methodology only allowed for a small sample to be measured and as such, the representativeness of the research cannot be ascertained (i.e. how useful it is to understand this intervention's potential effectiveness across Uruzgan province).

Table 2: Main sources of information for the evaluation

	Main sources of information for the evaluation	
	Quantitative	**Qualitative**
Desk based review	Save the Children programmatic reports: • CoU annual reports (Year 1, 2 and 3) Quarterly reports • Programmatic baseline and endline research on health • Programmatic baseline and endline research on education Data from other organisations: • Extracts from the Uruzgan Monitoring and Evaluation Program (UMEP) report • The Asia Foundation (TAF) reports • World Bank • World Food Program • UN Interagency group for Mortality Estimation • UNICEF • Surveys and reports from NGOs and local stakeholders	• AusAID (now DFAT) Needs assessment • Save the Children Uruzgan proposal • Save the Children strategic research • Case study documents • CoU annual reports (Year 1, 2 & 3) • Programmatic research on access to health • Programmatic research on girls' education • Programmatic research on education & conflict • Fieldwork data • Case studies and qualitative research informing the CoU Mid Term Review (commissioned by DFAT)
Primary research	Data from the Government of Afghanistan: • MoPH annual reports (BPHS reviews) • Health Management Information System (HMIS) • Education Management Information System (EMIS)	Stakeholder interviews with: • Save the children staff • Local government stakeholders Focus groups with: • NGO staff, health facility staff • Teachers, school management and school state institutions • Pregnant women, mothers of newborns, young mothers • Community groups and elders • School-aged children (girls & boys)

2. **Secondary data sources**: Data from other sources was then assessed for its relevance to the evaluation questions being examined by the evaluation team and analysed where appropriate. It is important to note that for many of the evaluation questions, reliable quantitative data was simply not available.

The data sources examined by the evaluation team are summarised in the below list. More detailed examination of each data source and how they were used by the evaluation is set out in Annex 3: Data sources referenced by evaluation.

- Afghanistan Mortality Survey, 2010.
- Basic Package of Health Services data report, 2010.
- Government of Afghanistan, Ministry of Public Health HMIS data for Uruzgan.
- Government of Afghanistan, Ministry of Education EMIS data for Uruzgan.
- National Immunization Coverage Survey, Afghanistan (2013).
- National Nutrition Survey (UNICEF and MoPH), 2013.
- National Risk and Vulnerability Assessment (NRVA) data reports for 2009 and 2013.
- The Asia Foundation (TAF), *Survey of the Afghan People,* Uruzgan-specific data set, provided by TAF to DFAT annually.
- UN Inter-agency group for Child Mortality Estimation data report.
- UNICEF 2012 antenatal care database.
- Uruzgan Household Survey Report, AHDS, 2013.
- Uruzgan Monitoring and Evaluation Program healthcare and education data provided to the CoU program team by the Uruzgan PRT.
- Uruzgan Nutrition Survey, 2012.
- World Bank 2011 literacy data report.
- World Food Program Food Security findings, 2008.

3.3.3 Qualitative information assessment

Initial qualitative research was undertaken during the desk-based research phase using the Save the Children needs analysis, Save the Children and partner programmatic documentation, case studies and other related evaluation material from Uruzgan. This information was used to assess the evaluation questions and the extent to which the program's IRs may have been achieved. The qualitative aspect of the review provided detail to the initial information collected from the available quantitative data analysis.

Where data gaps were identified in relation to key evaluation questions, and where key findings were recorded, became the focus for the evaluation team's specific design of primary field research topic guides. The evaluation team used the opportunity for primary qualitative field research to address these gaps and to ensure findings were validated by qualitative beneficiary and key informant responses wherever possible.

3.4 Primary research conducted

Primary research was conducted in Kabul and Uruzgan province in Afghanistan, as well as with current and former representatives of DFAT and program key informants outside of Afghanistan. The purpose of the primary research was to provide a rich source of additional data with which to verify the desk-based research and to fill any existing gaps in knowledge. The primary research was an opportunity for the research team and for Save the Children to hear the voices of key program stakeholders and community beneficiaries, and understand how the program may have made a difference to Uruzgani people's lives.

The evaluation team consulted with the following beneficiaries as part of the primary research: Afghan and Australian Government stakeholders; Save the Children staff; CoU research partners; CoU implementing partner NGOs; Uruzgan health facility staff; Uruzgan teachers, school management and school state institutions; maternity nurses, mothers of newborns, young mothers; community groups and elders; and school-aged children (girls and boys).

3.4.1 Uruzgan research sample

The districts of Tirin Kot,Chora, Dehrawod and Gizab were selected for research by the evaluation team in consultation with Save the Children staff. Gizab represents a remote, difficult to access region where work was carried out with traditionally marginalised Hazara communities, and the other three districts represent locations where the most integrated and comprehensive CoU programming was conducted.

The accessibility of villages in Tirin Kot, Dehrawod and Chora for field research visits (as opposed to Khas Uruzgan, for example) was also an important consideration.

Below: Map of Uruzgan showing the selected districts for field research. Research was conducted with men, women and children in each of the selected districts.

Figure 1: Uruzgan map highlighting districts where research was undertaken in blue.

Specific locations within each district were selected for field research, based on the following criteria agreed between Save the Children and the evaluation team during the evaluation project's inception phase:

1. Security and accessibility
2. Whether women and children may be accessible at the village location while upholding ethical research guidelines
3. Whether Save the Children staff could introduce the research team to a relevant contact point at the village to enable arrangement of key informant interviews and focus group discussions with relevant beneficiaries and in an appropriate setting.

03

In close consultation between Save the Children's program staff in Uruzgan and Kabul, and the field research and evaluation team, the following locations were identified as suitable for inclusion in the evaluation field research plan:

Tirin Kot:

- Malalai primary, middle and high school for girls in the east of Tirin Kot city
- Sayed al Khan primary, middle and high school for boys in Tirin Kot city
- One CBE class in the suburbs of Tirin Kot city
- Tirin Kot city provincial hospital
- Merabad health sub-centre
- Yaklinga health clinic

Chora:

- Chora central primary, middle and high school for boys and girls in different villages
- Central comprehensive health centre in Chora town
- Commander Akhter Mohamad health sub centre

Dehrawod:

- Naw Abad area primary, middle and high school
- Central comprehensive health centre in Dehrawod town
- Emarzai area

Gizab:

- Beri primary, middle and high schools (Hazara girls in attendance)
- Zen health sub-centre in a Hazara area
- Gizab town

The table below summarises the research conducted in Uruzgan province.

Table 3: Summary of Interviews and Focus Groups conducted in Uruzgan

	Beneficiaries accessed in Uruzgan	
	Male	**Female**
Tirin Kot (Provincial centre & surrounding rural areas)	2 FGD - Community members (19) 1 FGD - CBE students (4) 1 FGD - High School students (10) 1 FGD - Teachers, school managers (10) 5 KIIs - GIRoA/PC representatives 4 KIIs - STC implementing NGOs 2 KII - Health Clinic staff & management 1 KII - STC personnel 2 data interviews - GIRoA officials	1 FGD - Mothers & Pregnant women (10) 1 FGD - CBE students (5) 1 FGD - School Students (9) 2 FGD - Teachers (21) 2 KII - Health Clinic Workers 1 KII - GIRoA Official
Chora	2 FGD - Community members (19) 1 FGD - School Students (10) 1 FGD - Teachers, school managers (10) 4 KII - Health Clinic staff & management 2 KIIs - GIRoA representatives	1 FGD - Mothers & Pregnant women (10) 1 FGD - School Students (10) 2 KII - Health Clinic staff & management
Dehrawod	2 FGD - Community members (19) 1 FGD - School Students (9) 1 FGD - Teachers, school managers (11) 3 KII - Health Clinic staff & management 2 KIIs - GIRoA representatives	1 FGD - School Students (9) 1 FGD - Mothers & Pregnant women (8) 2 KII - Health Clinic staff
Gizab	2 FGD - Community members (20) 1 FGD - School Students (10) 1 FGD - Teachers (10)	1 FGD - Mothers & Pregnant women (10) 1 FGD - School Students (10)
TOTAL	**213 male participants (43 boys)**	**115 female participants (43 girls)**

In total, 328 beneficiaries participated in the research, 115 of whom were women and girls (35%). Participants were interviewed individually or participated in focus groups, arranged in rural health and education facilities as well as in town centres in Tirin Kot, Chora, Dehrawod and Gizab. The final sample size ensured that key research questions could be answered robustly.

3.4.2 Facility quality assessments

The evaluation team carried out simple, limited quality assessments of one health clinic facility and one CBE facility in each district. The formats for these quality assessments were based on a simplified version of the GIRoA MoPH community health clinic assessment form and the Save the Children CBE assessment form.

3.4.3 Kabul research sample

Research participants interviewed in Kabul included representatives of:

- the Ministry of Education (MoE)
- the MoPH
- the Provincial Council of Uruzgan
- UNICEF
- Save the Children's implementing NGO partners ACTD, AHDS, HADAAF and WADAN
- Save the Children's head office in Kabul
- Australian government officials with DFAT in Kabul, and an Uruzgan representative in the parliament of Afghanistan.

3.4.4 Other locations research sample

Interviews were conducted with Save the Children current and former staff and DFAT current and former staff involved in the program, and with personnel from research institutions who were engaged with the program's IR 4 (Policy and Research).

3.4.5 Translation

Research field notes taken by hand were entered into a computer in Pashtu or Dari by the primary field researcher themselves, within 48 hours of the interview or focus group being conducted. This helps to ensure data integrity will be maintained from collection. The quality of these were then verified by the Project Director and the Research Manager, and finalised. Agreed Pashtu/Dari results transcripts were submitted to a single, pre-approved evaluation team Dari and Pashtu translator. All English translations were checked in the first instance by the translator themselves, then by the evaluation team Project Director, and finally by one of the international members of the team.

3.5 Methodology for analysis, and presentation of findings

The research team separately analysed quantitative and qualitative data sets. Quantitative data was collated simply, using Microsoft Excel software to plot change over time graphs for key data sets. Simple analysis was conducted where baseline and endline data was available to establish progress against health and education indicators.

Qualitative data was examined to provide narrative depth to findings relevant to the evaluation questions. Data was organised according to relevant topics and IRs and tagged using an approach similar to Glaser & Strauss (1967) [48]. Each stakeholder group was analysed together in order to establish the views of different and key beneficiary groups.

The available evidence and data was then triangulated to provide the research team with an overall understanding of the program's achievement against the evaluation questions.

[48] Glaser, B & Strauss, A (1967) "The Discovery of Grounded Theory: Strategies for Qualitative Research" 1967, Chicago.

Presentation of qualitative data

In general, majority opinions from the qualitative data have been prioritised over minority opinions, unless the minority opinion represents a finding that is deemed particularly interesting or useful. Where possible, in the presentation of the qualitative information, the specific numbers of participants, as opposed to 'majority' or 'minority' views are mentioned. This was often not possible however. Also, where numbers are mentioned, please note that the total number of participants listed may not always reflect the number of people in the focus group as both those who responded, and the way in which each respondent was recorded varied according to question and field research report.

04 KEY FINDINGS

4.1 Overall goal and key objectives

The CoU intervention was a complex and ambitious program with a number of cross cutting and integrated components. Its overall aim was to "enhance access, quality and use of basic health and education services across the districts of Uruzgan province in Afghanistan [49]." The rationale for the design of the program was borne out of direct observation of the needs of the community as well as primary and secondary information sources [50]. It had two distinct components - health and education - comprising a variety of interventions with sequential activities. These main components were supported by a range of cross cutting interventions designed to "a) foster community engagement and support and b) contribute to the development of a more informed policy and advocacy agenda [51]."

The stated **goal for the program** was to 'enhance' access, quality and use of basic health and education services. With this simple formulation, **it can be assessed as achieved**. Similarly, the program's two stated objectives: (1) to "Increase access and use of Maternal and Child Health services including the treatment of acute malnutrition" and (2) to "Increase access to basic education and improve delivery of comprehensive education services for children", both aim simply to provide some form of improvement. As with the goal, the evaluation's findings show a clear improvement in relation to **each objective** and therefore each can be assessed as **having been achieved**.

[49] Save the Children (2011) Uruzgan Proposal to AusAID9th March 2011. p.21.
[50] Save the Children (2011) Uruzgan Proposal to AusAID9th March 2011. pp. 21-22 Primary sources included Save the Children Uruzgan staff, provincial MoPH and MoE representatives, local NGOs, international organisations and UN agencies. Secondary sources included AusAID's comprehensive assessment of Uruzgan in 2010, assessment of Uruzgan Report 2009 by Asia Foundation, national Basic Package of Health Services guidelines and Uruzgan Provincial Development Plan.
[51] Save the Children (2011) Uruzgan Proposal to AusAID9th March 2011. pp. 22.

Table 4: Summary of achievements by the CoU program of its stated programmatic goal and objectives. All were achieved according to evidence available and according to their formulation.

Program Goal	Objective 1	Objective 2
Enhance access, quality and use of basic health and education services in the seven districts of Uruzgan province in Afghanistan.	Increase access and use of Maternal and Child Health services including the treatment of acute malnutrition.	Increase access to basic education and improve delivery of comprehensive education services for children.
√ Achieved	√ Achieved	√ Achieved
CoU programmatic review suggested improvements across all districts. This triangulated with findings from available data and qualitative findings that indicated access, quality and demand improvements in healthcare and education.	Programmatic review of CoU documents, the available data and the qualitative research findings show that there had been an increase in access to MCH services and improved treatment of malnutrition in Uruzgan during the CoU program's delivery.	Qualitative interview research validated available data and programmatic documents to indicate that there has been an increase in access to basic education, and improved delivery of comprehensive education services for children in Uruzgan province.

The CoU program has undoubtedly achieved significant positive results for the people of Uruzgan. The extent to which each of the goal and two objectives for the program were achieved, and how, and to what extent the cross cutting interventions contributed to this achievement is what the evaluation team have endeavoured to address. Benefits flowing to women, girls and remote communities are a particular focus, as is the extent to which sustainability objectives were achieved. It is also important to note that, at times, the contribution of CoU programming towards observable improvement trends in healthcare and education in Uruzgan over the course of the program's implementation has been difficult to reliably assess.

4.2 Equity

Improving the situation of women and girls within Uruzgan was a central aim of the CoU program. The integrated program approach meant that the healthcare, education and cross-cutting elements all aimed to contribute to an overall aim of improving equity between men and women in Uruzgan province. For example, in healthcare women were trained as CHWs, midwives and nurses, and as part of the FHAG, and in education components they were the beneficiaries of newly constructed schools, CBE classes and trained as ECCD teachers. Similarly, cross cutting elements of the program aimed to inculcate a more positive view of women's rights within the community via the training of religious leaders. Within IR 3.1.1, 145 (out of the target of 165) religious leaders were trained in Women's Rights modules [52]. This intervention was roundly noted by beneficiaries as having a positive impact on sustainable improvements in the perception of women in the community.

An element of the program that research respondents often noted as beneficial was the training of women and girls in professions such as midwifery and teaching. For example, under IR 1.1.4. the program set up a Community Midwifery Education school in Tirin Kot and 24 (of a target of 24) midwives and 22 (target 26) nurses graduated in June 2015. This element of the program was reportedly well received by much of the community. In a positive sign for the sustainability of cultural change, it may be that demand for and acceptance of girls' involvement with such activities improved during CoU's implementation. Anecdotal evidence is that sixty girls expressed interest for the CoU midwifery training as opposed to 12 recorded as having expressed interest in 2009 for an earlier, similar pre-COU training effort. Of the 24 midwives trained, 21 were deployed to communities to work as health workers.

In terms of education, another training initiative provided training to girls in their final year of school as a way to encourage them to become teachers after their schooling finished. IR 1.2.3 – Increase number of female teachers - was originally conceived as a Fast Track Teacher Training initiative and was carried out with 20 girls from Shashpur Girls' High School in Khas Uruzgan [53]. It was later re-worked and re-named 'Girls' Learning to Teach Afghanistan' (GLiTTA) and was delivered instead in Year 3 in Tirin Kot Malalai Girls School. Among the 30 students involved in the program, 10 became teachers at the conclusion of the CoU program. Twelve others had gone to teacher training classes and were expected to start teaching afterwards. Eight more had not yet graduated and were still in grade 12 at the time that CoU concluded.

[52] The final 20 did not attend due to the security incident in 2015, which prevented Save the Children from being able to call them together.
[53] Save the Children of Uruzgan Program Annual report (Year 2).

Figure 2: Outcomes for students of the GLiTTA program.

Key

12 Students who have gone to the Teacher Training Centre

4 Students who have started teaching whilst also going to the TTC

6 Students who have started teaching while they finish Grade 12

8 Students who are in Grade 12

Source: Save the Children (2015)

Under IR1.2.1 [54], three of the 142 CBE teachers engaged under CoU were women and 145 women (out of a target of 145) were engaged as ECCD facilitators. Having increasing numbers of women graduate from such courses is beneficial to support the evolution of the community's development of a more positive attitude towards women and girls working.

Training ulema and mullahs about the rights of women and girls to work and contribute to Afghan society was noted as also helping to spread better perceptions of women and girls holding jobs in education and health. This work with religious leaders was reported to the evaluation team as enabling key members of the community to be influenced, which helped to change opinions and to make program efforts with women and girls more palatable to the broader community. In particular, the fact that mullahs and tribal leaders were documented as having sent their own daughters to nursing training provided by CoU meant that they led, by their example, a more enlightened approach to women and girls receiving training and working outside of the home.

In Chora, a healthcare professional explained that 'previously when AHDS would give training to the women and girls hardly any were prepared to attend but now lots of women and girls have graduated from the training... For example two daughters of a mullah graduated as midwives and that changed the minds of people about work and the education of women and girls [55].'

In Gizab, a CHS worker commented that CoU worked alongside other programs to improve the acceptance of women and girls receiving education and working in the community, for example he said, 'most of the organisations such as TLO and Checchi have worked in the field of gender, and have trained tribal leaders in the rights of the women. People have understood that women have

[54] Please see Annex 1 for a detailed explanation of the IRs relevant to the program.
[55] *Healthcare and education in Uruzgan* (August 2015) [Interview] CHC, Chora. Female healthcare professionals

the right to education, women should be given their share in heritage, women should perform social works, and women should become educated and they should not be given in *baad* [56].'

Indeed, perceptions of a wider cultural shift in terms of the general treatment of women and girls was reportedly apparent in some of the communities consulted. For example, a focus group of education professionals from Chora widely agreed with a common view that 'previously people would give their daughters in *baad* but now they are not being given in *baad* and they are saying that if we do this, our daughters will face lots of problems after getting married.' One also said that 'previously parents would marry their daughters to who they wish but now they do so according to the wishes of their daughters [57].' This was also specifically seen in Dehrawod where a male member of the community indicated that there had been a change in perceptions of women and girls; 'now people have been made to understand that they should not give their daughters in *baad* but they should be allowed to marry according to their wishes [58].'

It was apparent that in general there were changes in the community attitude towards women and girls, however these changes were not dramatic but small and incremental. Across Uruzgan, 10 out of 11 local government representatives believed that there was now a different attitude towards women compared to four years prior [59]. All of the healthcare professionals consulted stated that they had seen evidence of a different attitude towards women in the last four years [60]. The majority of education professionals also agreed but the change was less marked by education professionals than had been reported by healthcare professionals.

For example in Tirin Kot there were some mixed opinions - an education professional explained 'change has happened from messages given by scholars, mobile teams, TV and the radio', but a small number said that no changes have been seen [61].

[56] *Healthcare and education in Uruzgan* (August 2015) [Interview] Zayn Clinic, Gizab. Female healthcare professionals.
[57] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz High School, Chora. Male teachers and school management.
[58] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Masjid, Dehrawod. Elders and male community members.
[59] Local government representatives (2015) Interview by ACG August 2015 Uruzgan
[60] *Healthcare and education in Uruzgan* (August 2015) [Focus groups] Yaklinga Clinic, Tirin Kot, Comprehensive Health Centre, Chora, Zayn Clinic, Gizab, Comprehensive Health Centre, Dehrawod. Male healthcare professionals & *Healthcare and education in Uruzgan* (August 2015) [Interviews] Yaklinga Clinic, Tirin Kot, Comprehensive Health Centre, Chora, Comprehensive Health Centre, Dehrawod. Female healthcare professionals.
[61] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male teachers and school management & *Healthcare and education in Uruzgan* (August 2015) [Focus group] Malaly High School, Female teachers and school management Groups 1 and 2.

When the community members were consulted it was noted by the field research team that many of the elders and men were reluctant to discuss the women and girls in their lives, particularly those in Tirin Kot and Gizab [62]. In Dehrawod however, seven out of 10 elders and men stated that their opinion on women and girls had changed [63] and in Chora, 10 out of 16 elders and men said their opinion of women had changed [64]. Whilst a slight majority of women in Tirin Kot, Chora and Gizab reported that community opinion of women and girls had changed in the last four years, a minority of women agreed with one woman's statement that 'no changes have taken place for women - previously women are taking care of their children, doing housework, and I think only housework is suitable for women [65].' Children consulted were more explicit that there was a continuing difference between girls and boys. For example, both boys and girls in Gizab stated that there is a difference for girls and boys in terms of education access [66]. All 10 boys agreed 'that there is not that much of a difference but our culture and traditions don't accept us to allow girls to get education on the same scale as boys [67].'

It is likely that the greatest impact of program efforts was experienced by the women and girls who were directly involved in program initiatives. As a Save the Children staff-member explained 'all of the women we surveyed in the ECCD program reported a big change in terms of multiple levels of empowerment; their husbands were nicer to them, people greeted them in the street and they were invited to weddings [68].' One female CHW in Dehrawod said 'lots of changes can be seen in the minds of people regarding women. A big example is myself - I was not allowed outside of the home but now I am a volunteer and I go to workshops and I even have permission to go to the homes of those people who are ill and give them health advice [69].' It seems that the effect of this also helped other women to feel more positive about their future. For example, a women consulted in Tirin Kot said 'I am very happy that I see female doctors in clinics and in hospital, may Allah give success to our government that it trains other female doctors as well so that our problems are decreased [70].'

[62] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga, Tirin Kot. Elders and male community members &Healthcare and education in Uruzgan (August 2015) [Focus group] Zayn Clinic, Gizab. Elders and male community members.
[63] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Masjid, Dehrawod. Elders and male community members.
[64] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Chora Community Hall, Chora. Elders and male community members.
[65] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Pregnant mothers, mothers of newborns.
[66] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged boys&Healthcare and education in Uruzgan (August 2015) [Focus group] Beri School, Gizab. School-aged girls.
[67] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged boys.
[68] Key informant interview conducted with senior program representative by ACG, August 2015.
[69] *Healthcare and education in Uruzgan* (August 2015) [Interviews] Comprehensive Health Centre, Dehrawod. Female healthcare professionals.
[70] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Dehrawod. Women.

4.3 Health

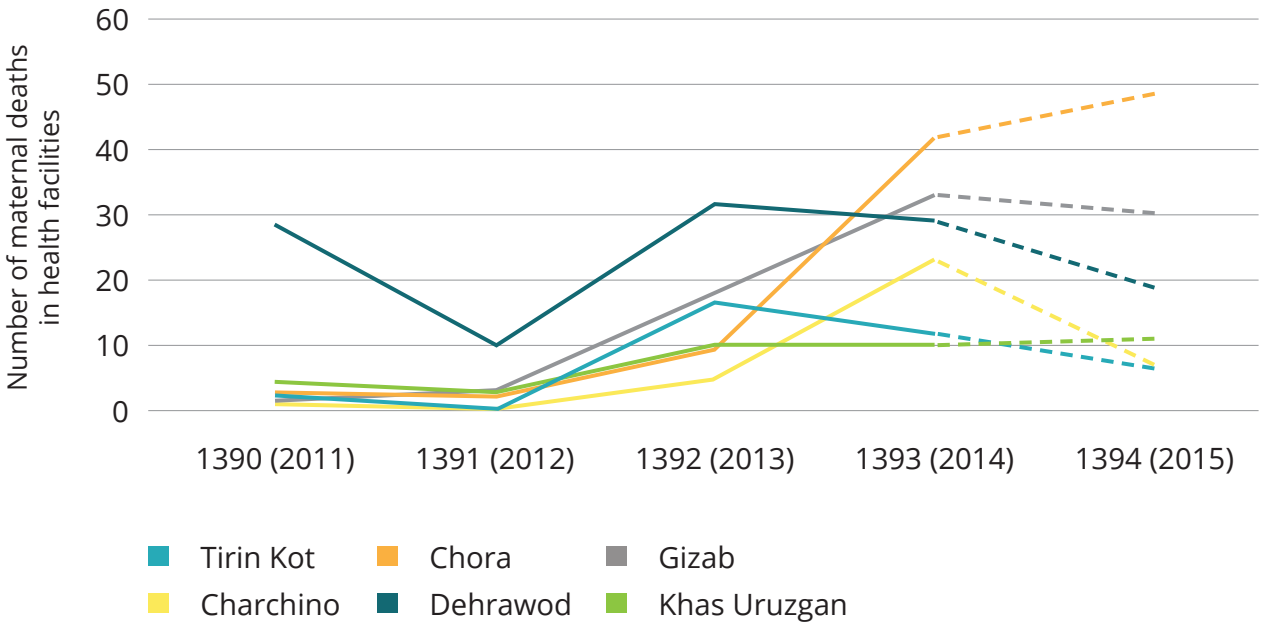
4.3.1 Changes in the healthiness of the population

The available quantitative and qualitative evidence suggests that there has been a significant change in the MCH status of the population of Uruzgan since the CoU program commenced. While it is difficult to pinpoint the contribution of CoU to this change, the scale of the program and its specific focus on MCH results enables an inference to be drawn that CoU had a direct important impact on bringing about these improvements. Better general security in the province, better roads infrastructure and an improved general awareness of and demand for MCH are also likely to have contributed. Uruzgan has also witnessed a gradual general improvement in the overall healthiness of the population over the past decade or more. For example, a senior CoU program representative noted that in general in Uruzgan 'maternal and newborn mortality has decreased over the last 13 years [71].'

[71] Interview by ACG with senior program representative, August 2015.

Figure 3: HMIS data show an initial increase in maternal mortality followed by a decrease after 2014. Estimates for the year 1394 are based on data collected in the first two months of the year.

Yearly maternal mortality rates in health facilities per district:

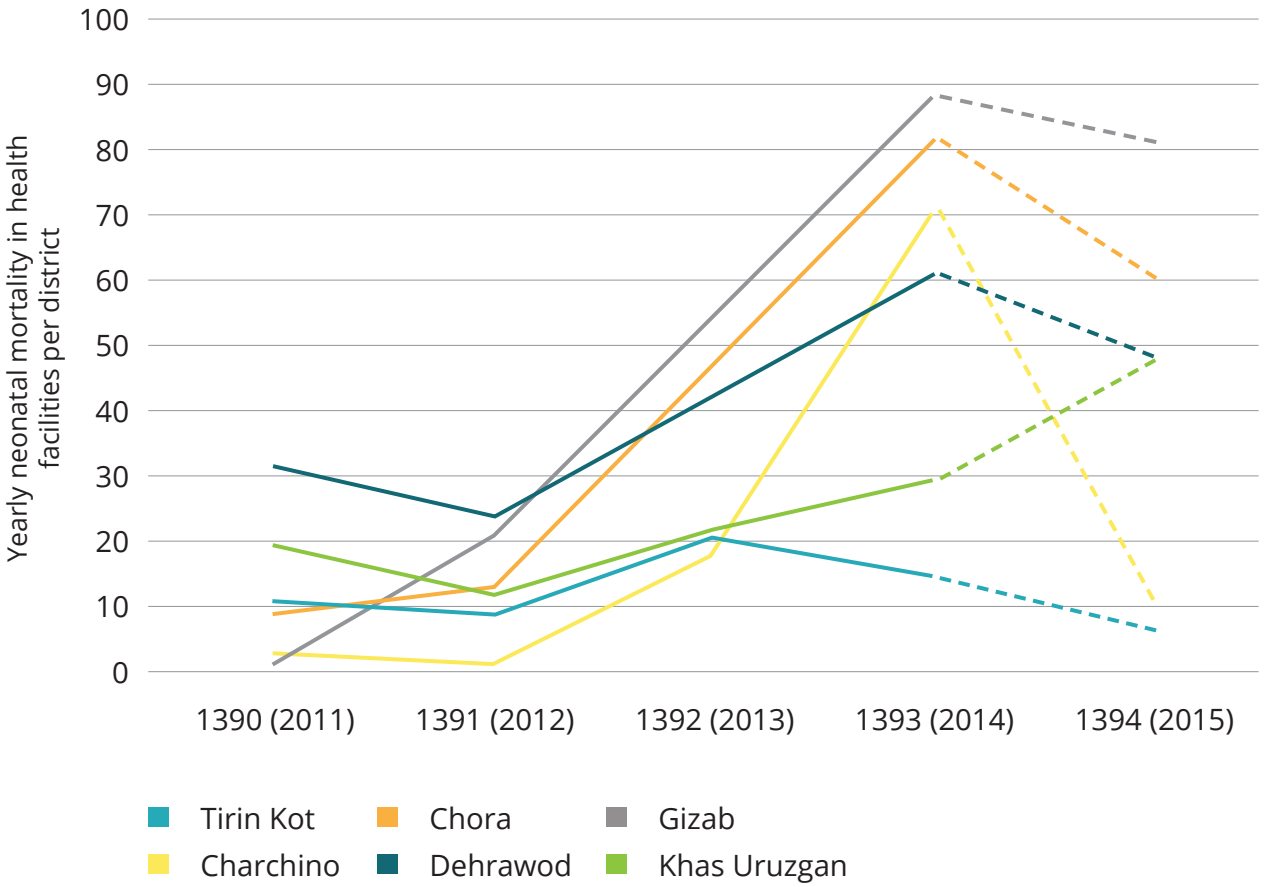


Source: Health Management Information System (2015). Monthly Integrated Activity Report 1390-1394. Ministry of Public Health, Kabul

Maternal mortality rates in the province rose and then significantly reduced during the CoU program cycle according to government HMIS data. The observed trends seem to show an initial increase in number of recorded deaths in health facilities, particularly in Dehrawod and Tirin Kot where programmatic activities were more pronounced. By 2014, figures for maternal deaths in Dehrawod were similar to those recorded in 2011 (28 in 2011 and 29 in 2014). Low maternal death figures in 2011 in other districts may have been due to a lack of medical facilities being available. With fewer medical facilities, fewer women were under medical care and as a consequence fewer maternal deaths were occurring in situations where they were reported.

Figure 4: Neonatal mortality has increased since 1390 but the data from the two first months of the year 1394 show that this trend is likely to have shifted.

Yearly neonatal mortality in health facilities per district:

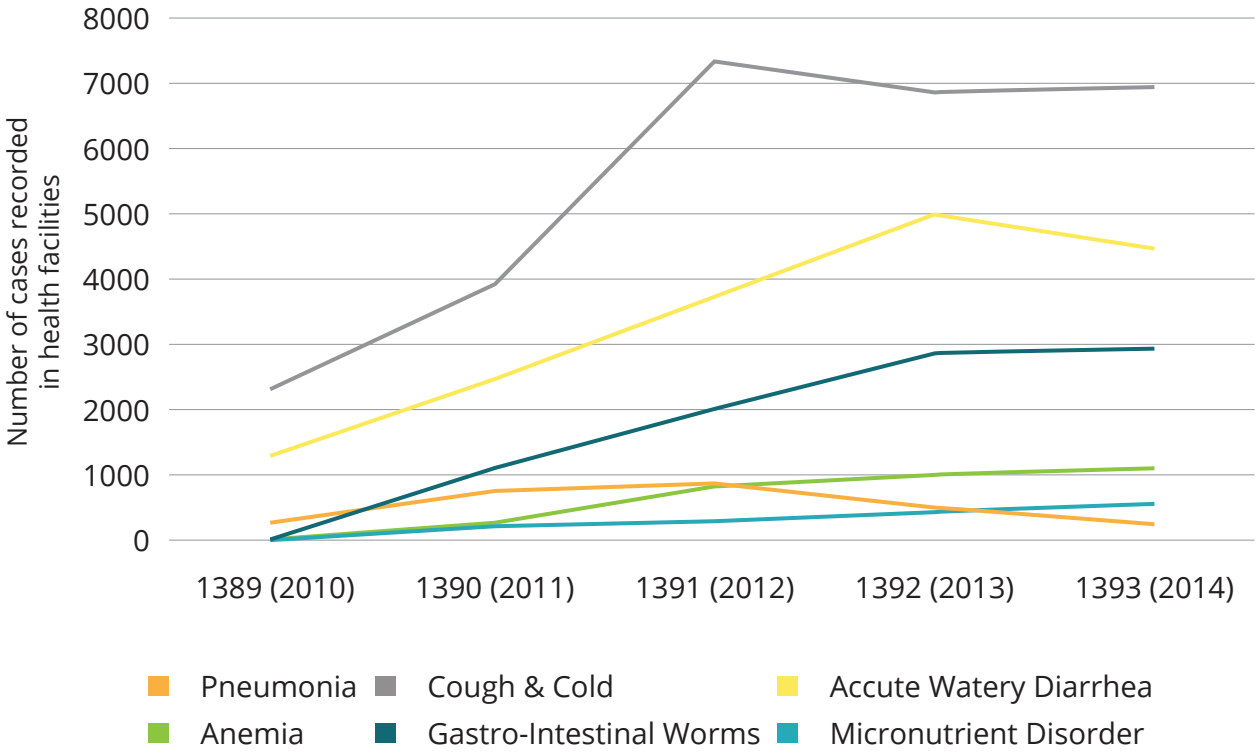


Source: Health Management Information System 2015. Monthly Integrated Activity Report 1390-1394. Ministry of Public Health, Kabul

Neonatal mortality rates (the first 28 days of life) in Uruzgan also rose and then significantly reduced during the CoU program cycle based on Government HMIS data. It is likely that this shows increased recording followed by a decrease in recorded deaths.

Figure 5: Number of recorded illnesses among Uruzgani children has increased over the course of the program including measles (two in 1389 against 219 in 1393). Rather than a deterioration of Uruzgani children's health status, this is likely to be the result of an improved recording of illnesses and therefore improved access to health facilities and better healthcare-seeking behaviours (as evidenced by Figure 11).

Childhood illnesses in Uruzgan:



Source: HMIS (2015)

Child under five mortality figures are not available for Uruzgan province, however figures available for childhood illnesses show that after a peak in 2013, the number remains steady.

Figure 6: Since the beginning of the program global malnutrition (percentage of children screened who have either MAM or SAM) has decreased consistently from 29 to 10 percent.

	Year 1 (2012)	Year 2 (2013)	Year 3 (2014)	Year 4 (Jan - May 2015)
Children screened by CoU	2,503	8,152	29,553	10,299
Children with Moderate Acute Malnutrition (MAM)	549	1,618	3,829	1,000
Children with Severe Acute Malnutrition (SAM)	168	286	428	76
Percentage of children screened suffering from Acute Malnutrition	28.65%	23.36%	14.40%	10.45%

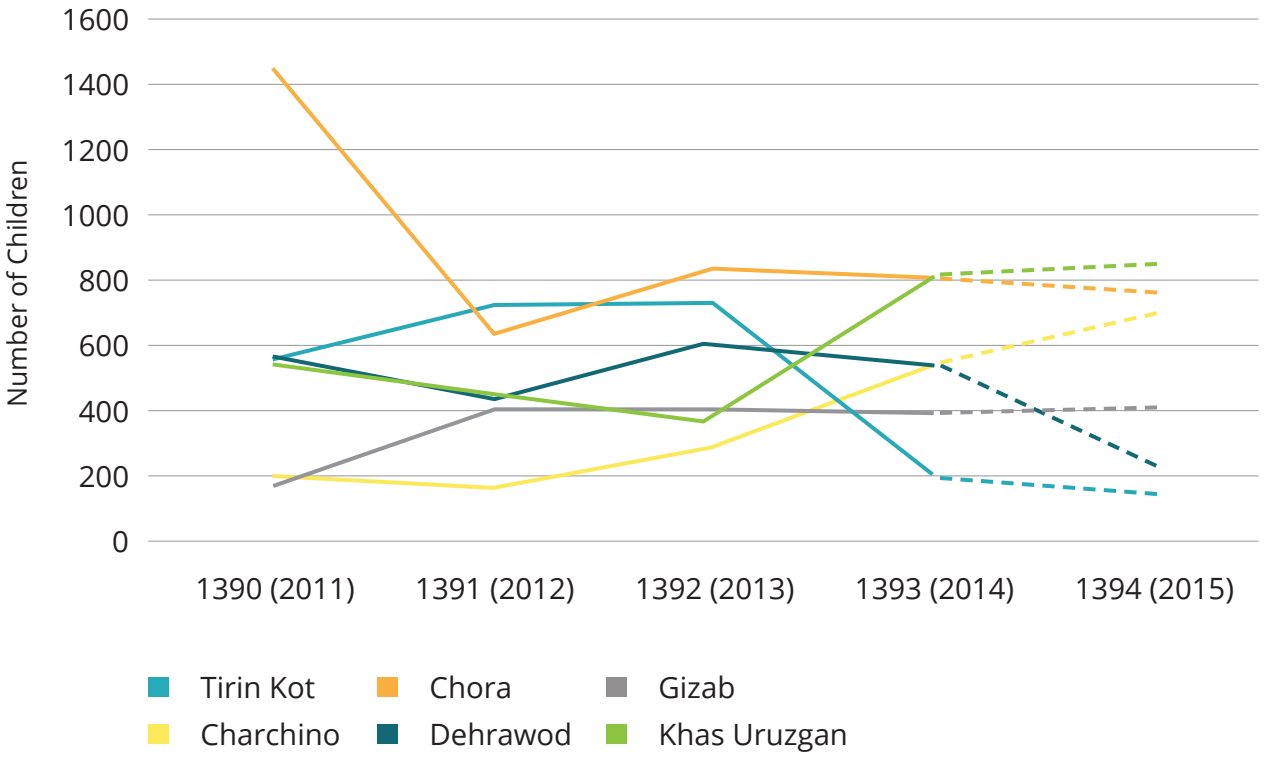
Source: Save the Children - Children of Uruzgan

Malnutrition data from the CoU program shows that the rate of malnutrition in the target program areas has decreased.

Malnutrition data from the CoU program shows that the total number of children with malnutrition has decreased, and that this is consistent across all of the districts. The qualitative interviews corroborate the findings that malnutrition is being acknowledged and treated in the province.

Figure 7: The number of children referred for treatment of acute malnutrition has dropped in the three districts in which CoU focused its work on malnutrition.

Children referred for malnutrition:



Source: HMIS (2015)

The communities consulted in Uruzgan consistently reported that there has been an improvement in maternal and child health and nutrition in the last four years. For example, across Uruzgan all 11 of the local government representatives interviewed, said that they had seen a difference in the healthiness of the population of Uruzgan in the last four years. One in Dehrawod said that the 'death rate of children has decreased and in the same manner 80% of the children have been given vaccines [72].' This was echoed by community research respondents in the districts where each district described a similarly positive improvement in maternal and child health and nutrition.

[72] Interviews with Local Government Representatives (2015) Interview by ACG August 2015. It is suggested that the 80% figure be regarded as a reference to "many" as no official percentages were available to the interviewee. The observation is anecdotal.

All of the health professionals consulted in Tirin Kot, Dehrawod, Chora and Gizab unanimously reported that there had been a positive change in the health and nutrition status of the population in the last four years. For example, one midwife from Tirin Kot said 'according to my point of view all of the malnourished children in Uruzgan have been identified and their treatment has started. Vaccines have been administered and disease has been restricted so that mortality in mothers and children has decreased. We haven't had any reported deaths of mothers or children for a month [73].'

In Dehrawod, a CHS said that 'previously we would report five children and about three women dying in a month but we haven't had to report a death of children or women in two to three months [74].' This was echoed in Chora [75]. In Gizab, a CHS stated that the 'mortality of mothers has decreased all over the district... malnutrition has decreased because malnourished children have been screened and given treatment [76].' At community level, separate focus groups conducted with elders and men and with women, all reported positive changes in the last four years. For example, all ten female respondents from Gizab agreed with one of their group's comments that their community was healthier now than it was four years ago. They explained that 'previously deliveries would take place in homes and it would take the lives of lots of children and mothers but now deliveries take place in the clinic so the death rate has decreased [77].'

[73] *Healthcare and education in Uruzgan* (August 2015) [Focus group], Yaklinga Clinic, Tirin Kot. Male Healthcare professionals.
[74] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Dehrawod. Male Healthcare professionals.
[75] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Chora. Male Healthcare professionals.
[76] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Female Healthcare professionals.
[77] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Pregnant mothers, mothers of newborns.

Figure 8: A male health worker in an Uruzgani health post (Save the Children).

There is strong inferential evidence to suggest that changes identified can be attributed to the CoU program. Some participants were unable to specifically identify CoU or Save the Children as the instigator of the improvements seen, however the majority of them pinpointed the programmatic activities of CoU as having a direct impact. A number of participants in each of the districts consulted were also able to articulate that the CoU program caused these improvements. For example a CHS from Dehrawod said 'foreigners, the PRT, Save the Children, Australia and Holland have helped us so much and now our people are very happy which has increased trust of people in the organisations, especially those organisations that work in the field of education and healthcare [78].

4.3.1 Access to healthcare

In order to improve MCH, nutrition and basic health services for the target communities of Uruzgan, Save the Children undertook a number of initiatives designed to improve access to services in IR1: Increasing access to essential maternal and child health and nutrition services. Health sub centres and mobile health teams were established, community health workers were trained in maternal and child health and nutrition, and extended support in terms of supplies and training were given to these new professionals.

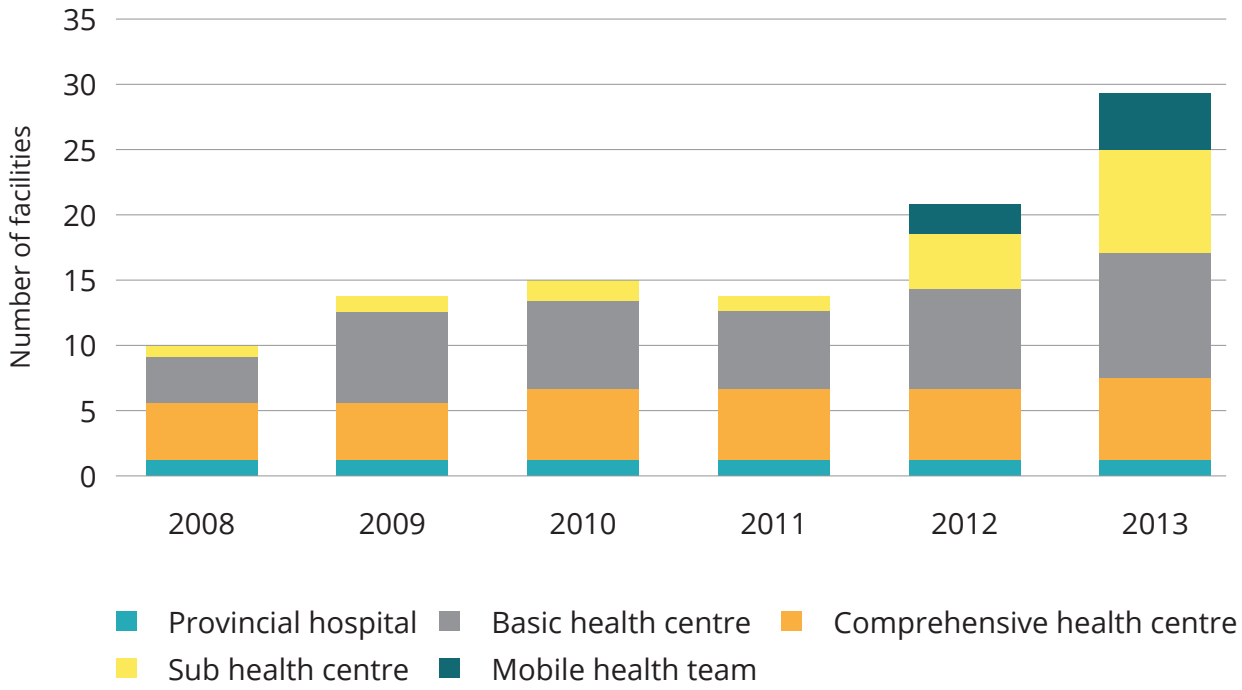
[78] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Dehrawod. Male healthcare professionals.

Since 2011, the number of health centres in Uruzgan has increased. There remains only one provincial hospital (as in December 2013) but at the end of the CoU program there were seven, as opposed to six CHCs, and nine as opposed to six BHCs. Eight health sub centres (compared to one at the start of the program) and four new mobile health teams were also established [79]. AHDS noted different numbers of new facilities, recording one additional BHC and two mobile health teams as having been established, including one in a prison [80]. CoU, within IR 1.1.1 "Expanding basic package of health services to remote and under-serviced communities", contributed to these numbers by establishing six (one more than the target of five) health sub-centres and five (target five) mobile health teams. One of these mobile health teams was later replaced by a health sub centre in 2014 and one in Gizab was closed in 2015 due to a lack of staffing and monitoring challenges [81]. CoU was also responsible for the establishment of health posts and setting up 40 private clinics under IR 3.1.5 "Public Private Partnership" providing both medical and non-medical materials. The public private partnership (PPP) clinics provided 163,599 outpatient consultations with a ratio of 57% of women and 41% of children under 5 years of age.

[79] PRT Uruzgan Monitoring Evaluation Project data shared with Save the Children, December 2013.
[80] MoPH & Grants and Services contracts Management Unit (2013). Household survey December 2013 Kabul.
[81] Save the Children (2015). Children of Uruzgan Year 4 Quarterly Report. May 2015.

Figure 9: Number of health facilities has increased since the beginning of the program.

Health Facilities in Uruzgan:



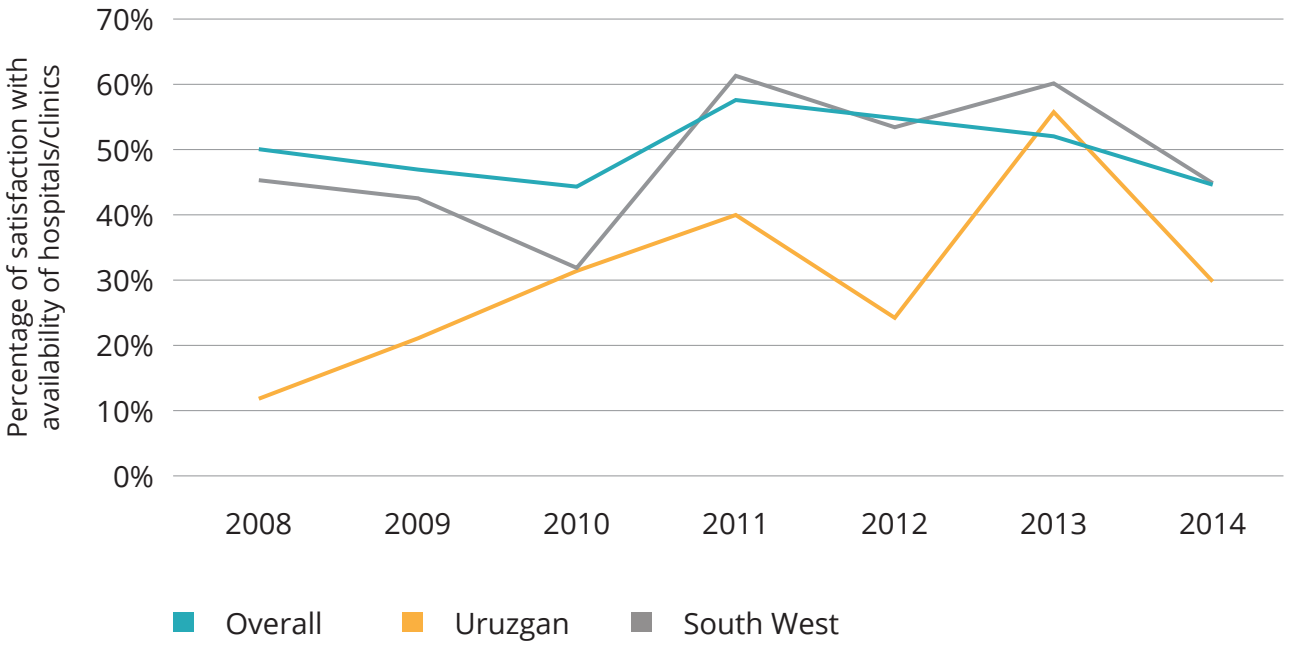
Source: MoPH (2012) & UMEP (2013)

The perceived availability of health clinics has fluctuated in Uruzgan over the life cycle of the CoU program, however there is evidence to suggest that it has increased more recently. 33% of the community said that they had access to clinics and hospitals always or often in 2014 [82].

[82] The Asia Foundation 2015. Survey of the Afghan People - Uruzgan data.

Figure 10: Hospitals and Clinics are more available in Uruzgan than before according to Uruzganis. However, rates of availability remain lower than national and regional rates.

Availability of hospitals/clinics:



Source: The Asia Foundation (2014). Custom analysis: services in Uruzgan

One of the initiatives that was particularly commonly noted by research respondents was the training of CHWs and CHS. In total, 270 (of an original target of 264) CHWs were trained and a total of 549 CHWs and CHS' (male and female) were trained in a summer module (target was 546). 541 were later trained in a winter module (target was 546). This paved the way for other aspects of IR1 to be achieved, for example, IR 1.1.2 and IR 1.1.3. As part of 1.1.2, CHWs were able to treat up to 20,820 cases of diarrhoea and 34,652 cases of acute respiratory infections. Additionally, 7,895 of the most serious cases of preventable illness were referred by CHWs. As part of IR 1.1.3 a comprehensive nutrition rehabilitation approach was achieved through the delivery of 761 (target 675) nutrition education and rehabilitation sessions (NERS) and 50,507 children aged six to 59 months were screened for malnutrition, including 46% of girls. A campaign which treated 18,687 pregnant and lactating women and 5,064 for Iron Deficiency Anaemia and treated an additional 45,767 children with zinc to limit the impact of diarrhoeal diseases (target was 10,000) was also carried out.

The majority of community members consulted by the evaluation team reported perceiving a significant change in the healthcare services available in their area. The creation of new health sub-centres and mobile health teams and newly trained CHWs increased access, and small projects such as solar powered lighting also assisted clinics to function after dark. The equipping of clinics, provision of new midwives and other health professionals and the existence of mobile teams were mentioned by all types of beneficiaries consulted. These positive views about healthcare access were consistently expressed across the districts of Tirin Kot, Dehrawod and Chora. For example a health manager in Tirin Kot said 'noticeable change has been seen in the services for mothers and children, the number of clinics have increased so now people have easy access to the health services in far situated regions, mobile teams have been set up and are providing services including vaccines to the communities [83].'

Health professionals in Dehrawod, Chora and Gizab agreed that there had been many positive changes in healthcare in the last four years and the majority of male and female community members consulted in Tirin Kot, Dehrawod, Chora and Gizab also reported better access. For example in Chora a man said 'previously there were fewer midwives so no one would take their pregnant wives to the clinic because they thought "there are male doctors in the clinic and we don't want our women be treated by male doctors [84]."' In Tirin Kot and Chora women reported that it was easier to obtain healthcare for themselves and their children in the last four years [85,86]. However women from Gizab reported that it was less easy to obtain healthcare. It seems that continuing remoteness of health centres was making things difficult for some of the women in that district. One explained that 'I have come far, from Tagabdra village to get to the health facilities [87].'

Access for key beneficiary groups

The program was able to deliver some health benefits to the most marginalised members of the target communities. Women and girls have accessed services continuously, in equal, or greater, numbers than men. The majority of the community consultations also reflected that the majority of women and girls were accessing services.

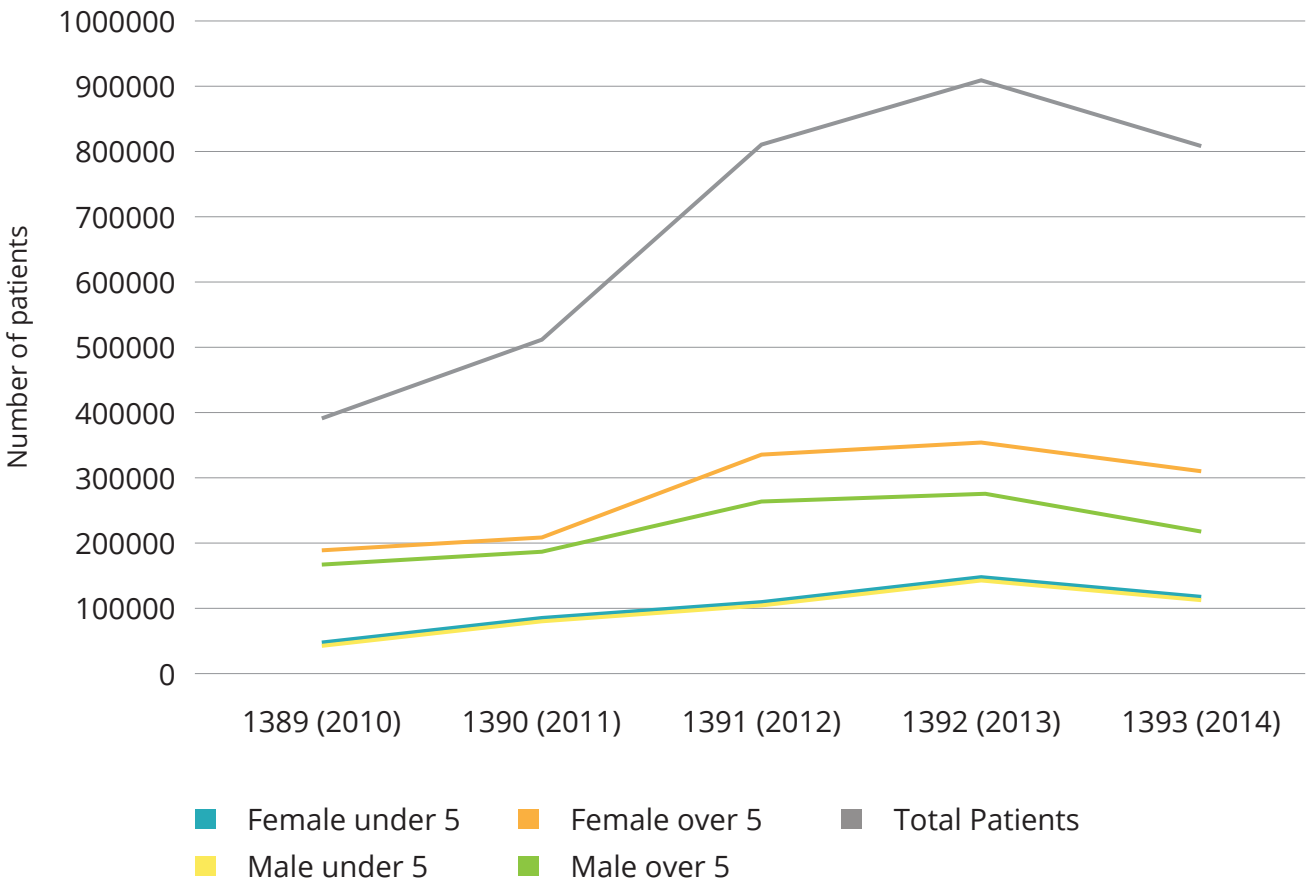
[83] Consultations with local government officials (2015) Interview by ACG August 2015.
[84] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Chora Community Hall, Chora. Elders and male community members.
[85] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Pregnant mothers, mothers of newborns.
[86] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Chora. Pregnant mothers, mothers of newborns.
[87] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Pregnant mothers, mothers of newborns.

Nevertheless, there was a mixed opinion from the community about the extent to which people with a disability, ethnic and linguistic minority groups and remote communities were in receipt of an improved level of service during the course of CoU's implementation.

Data on child patients to healthcare services shows that girls are treated in similar, or greater, numbers to boys in Uruzgan.

Figure 11: Numbers of patients in Uruzgan health facilities has continuously increased during the course of the program for males and females. A greater number of patients suggests a greater accessibility of health facilities.

Patients treated in Uruzgan Health Facilities:



Source: HMIS (2015)

The majority of healthcare professionals in Tirin Kot, Dehrawod, Chora and Gizab noted that women and children, and to a lesser extent people with disabilities, had access to their services. Women and girls reported that they did have access to healthcare, and this seemed to be an improvement from before, for example as one women from Tirin Kot explained 'up until now most of the people didn't respect women and didn't allow them to the clinic whenever they become sick [88].' There was evidence to suggest however, that some women still found access challenging. For example, whilst the majority of women and girls in Gizab said they had good access, some said they had concerns about lack of security, and 'negative traditions in the minds of people towards women [89]' and the girls in Gizab said that the security situation impeded travelling to the health centre [90].

The people that continue to lack access to healthcare in Uruzgan are those from remote locations. For example, a midwife in Dehrawod stated that 'approximately all of the people have access to the services but there are some people who don't have access who are living in far regions and whose economic situation is weak and those whose [road] route is damaged.' Similarly, the healthcare professionals of Gizab reported a lesser number of women were able to access their services and that the situation was worse for those in remote areas. A midwife stated that 'it is to be mentioned that people of Zayn region are situated very far from each other so one sub centre is not enough for them, and the number of sub centres should be increased [91].' Although the majority of boys in high school in Tirin Kot thought that there was easy access to a health centre (7 out of 10) the rest felt that they lived too far away from a clinic to have easy access [92].

4.3.2 Quality of healthcare

In order to improve MCH and nutrition services for the target communities of Uruzgan, Save the Children undertook a number of initiatives designed to improve quality under IR.2 "Enhance quality of MCH and nutrition services [93]." For example, within IR 2.1.1 Community based Maternal and Newborn Care services (MNC) were improved by training female CHWs and FHAG members (women volunteers) and FHAGs were established and 237 (target 500) members were trained. This led to 1,946 deliveries being assisted by a skilled birth attendant meaning that the number of safe deliveries between Year 1 and Year 2 of the project improved by 42.2%. As well as safe deliveries, 6,774 pregnant mothers received antenatal visits and 7,989 new mothers received postnatal visits. Quality was also improved by the cross cutting elements of IR3.1.5, under which there was advanced training of 68 health professionals, solar panels were set up in 26 health facilities/offices and in all health posts in Uruzgan and the hospital was equipped.

[88] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Pregnant mothers, mothers of newborns.
[89] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab, Pregnant mothers, mothers of newborns.
[90] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged girls.
[91] *Healthcare and education in Uruzgan* (August 2015) [Interview] Zayn Clinic, Gizab. Female healthcare professionals.
[92] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan High School, Tirin Kot. School-aged boys.
[93] Although the number of CHWs trained and oriented fell short of the set target with 61 female CHWs trained and 41 male CHWs oriented instead of 100 in both cases.

With regards to the quality of services delivered, there is limited data available. A cross-sectional knowledge, attitudes and practices survey of 899 mothers with children aged 0-6 months was carried out to measure maternal and newborn care in Dehrawod district. The survey found that the level and frequency of antenatal care visits increased significantly between 2012 to 2014, implying that there had been an increase in the quality of services delivered to the mothers of Dehrawod. It is reasonable to assume that as the FHAGs were also set up in Chora a similar result may have been achieved in that district. In other districts there was a lot of work undertaken to improve quality, access and demand for MNC but they did not have FHAGs. Despite this, figure 13 taken from the HMIS indicates similar trends for first ANC visits to health facilities in all districts but Tirin Kot and Gizab where more women are seeking ANC visits.

Figure 12a and b: The MNC survey conducted in Dehrawod shows that pregnant women are seeking more antenatal care in 2014 than they were in 2012.

12a) 2012 Dehrawod:

Key

57.30% of mothers who have had no ANC visit

42.70% of mothers who have had at least 1 ANC visit

Source: Children of Uruzgan - Save the Children

12b) 2014 Dehrawod:

Key

10.04% of mothers who have had no ANC visit

58.06% of mothers who have had at least 1 ANC visit

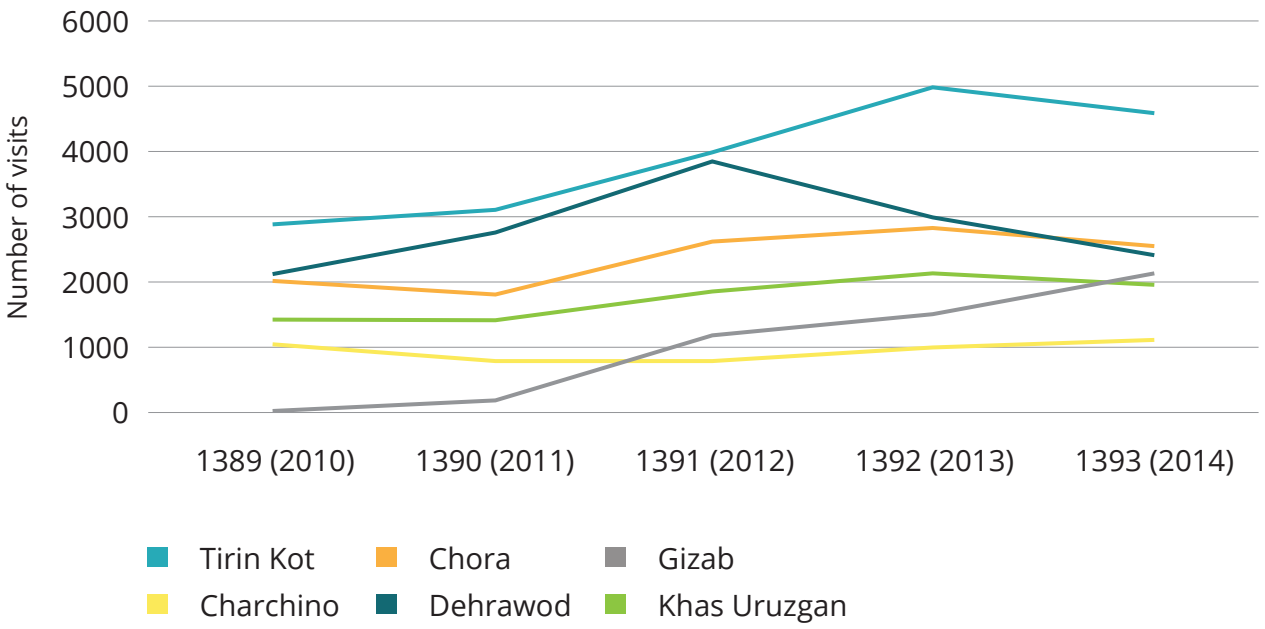
15.45% of mothers who have had 2 - 3 ANC visits

16.12% of mothers who have had more than 4 ANC visits

Source: Children of Uruzgan - Save the Children

Figure 13: The majority of districts have seen in increase in women using antenatal care.

First ANC visits to health facilities:



Source: HMIS (2015)

HMIS data shows more women now go to health facilities for antenatal care visits in Gizab and Tirin Kot. In other districts numbers have been stable or have only slightly increased. In Dehrawod numbers of first ANC visits increased until 2012 but decreased again to reach similar levels to 1389 (2010).

The six health clinics checked for quality by the evaluation team demonstrated mid-range quality against the indicators, which was a significant achievement for the province and the CoU program.

Figure14: Health facilities were assessed against the agreed indicators which were rated by field monitors as either Achieved, Partially achieved or Not achieved. In almost all of them the indicators met satisfactory levels of achievements.

Indicators	Tirin Kot Yaklinga Clinic	Tirin Kot Merabad Clinic	Dehrawod Central Clinic	Chora Central Clinic	Chora Sub Centre	Gizab Zen Sub Centre
The health clinic has all necessary equipment and the staff knows how to use it appropriately	●	●	●	●	●	●
The health clinic has vaccinations and immunisation campaigns in the community	●	●	●	●	●	●
The clinic provides maternal and child healthcare and its staff has been trained to deal with pregnant mothers and newborns	●	●	●	●	●	●
The clinic provides drop-in/outpatient consultations for the community and reaches out to remote or isolated communities	●	●	●	●	●	●
The clinic keeps tracks of the patients. Staff is able to identify specific needs and refer the patients to appropriate services through cooperation with other health facilities	●	●	●	●	●	●
Clinic staff are skilled and able to provide good healthcare thanks to good relations with patients	●	●	●	●	●	●
The clinic is aware of CoU program and its achievements in the community in the field of health	●	●	●	●	●	●

The majority of community members consulted by the evaluation team voluntarily discussed indicators of improved quality related to healthcare services in their area. Many specified the improved equipment and supplies at clinics, new midwives and other health professionals and the existence of mobile teams as indicators of improved quality. Of the 11 local government representatives consulted across Uruzgan, all said that they had seen a difference in the provision of healthcare in the last four years. One in Tirin Kot said of quality 'private clinics have been strengthened so that they deliver services for mothers and children, the number of health workers has increased and their capacity has increased as well. Doctors, midwives, nurses and other workers have been trained in the Cure hospital of Kabul which has had good results [94].'

The majority of community members - male and female - consulted in Tirin Kot, Dehrawod, Chora and Gizab reported that they were satisfied with the healthcare provision in their area. For example, the men and elders in Dehrawod agreed with a statement raised that, 'previously doctors would not get trained but now they are getting trained and now they have become good [practitioners] and now people are being treated very well'. This focus group specifically mentioned the contribution of Save the Children in relation to these perceived improvements. One respondent from the focus group noted that 'it is clear that most of the help has been provided to our clinics and hospitals by foreigners, Save the Children and the PRT [95].' In general, across Uruzgan, the women consulted were equally satisfied. For example the women consulted in Chora agreed that 'healthcare services have got better [96].'

[94] Consultations with local government officials (2015) Interview by ACG August 2015.
[95] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Masjid, Dehrawod. Elders and male community members.
[96] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Chora. Pregnant mothers, mothers of newborns.

Figure 15: Female students with a teacher at a midwifery school in Uruzgan (Save the Children).

4.3.1 Demand for healthcare

Community demand for healthcare reportedly increased since the start of the CoU program. Despite the view raised by a CoU program staff member, that 'in the four years we were actually only engaging for 3.5 and that is not enough... to change a lifetime's activity [97], there is evidence to suggest that the CoU program was able to build on already changing perceptions in the community for the need for quality healthcare.

In order to improve demand for healthcare services for the target communities of Uruzgan, Save the Children undertook a number of initiatives under IR3 Demand: "Create awareness and enhance demand for utilisation of MCH and nutrition". Within IR 3.1.1, 165 religious leaders were trained in health modules and within IR 3.1.2, seven health facility shuras (target seven) and 202 health post shuras (target 189) were reorganised or established. 2,189 of their members (target 1,428) were trained in community mobilisation and leadership. During Year3 of the project the number of health facilities and health post shuras conducting planned meetings against their action plans increased from 39% to 92%. Within IR 3.1.3, 184 health officials (out of the planned 175) and NGO management staff were trained in Interpersonal Communication and Counselling (IPCC) including 32 women. These activities all aimed at galvanising community support and knowledge of healthcare.

[97] Key informant interview conducted with senior program representative by ACG, August 2015

Community attitudes towards health changed positively since the beginning of the program. All of the healthcare professionals, and the majority of elders and men consulted reported that community attitudes towards healthcare had seen a positive change in the last four years. One professional from Gizab noted that 'most deliveries now take place under the supervision of midwives but previously they would have taken place in homes, now all people give their children vaccines so that's why paralysis and other killing diseases have been restricted [98].' The elders and men consulted in Tirin Kot, Chora, Gizab and Dehrawod generally agreed that the community was more concerned about having good healthcare now compared to four years before [99,100,101,102].

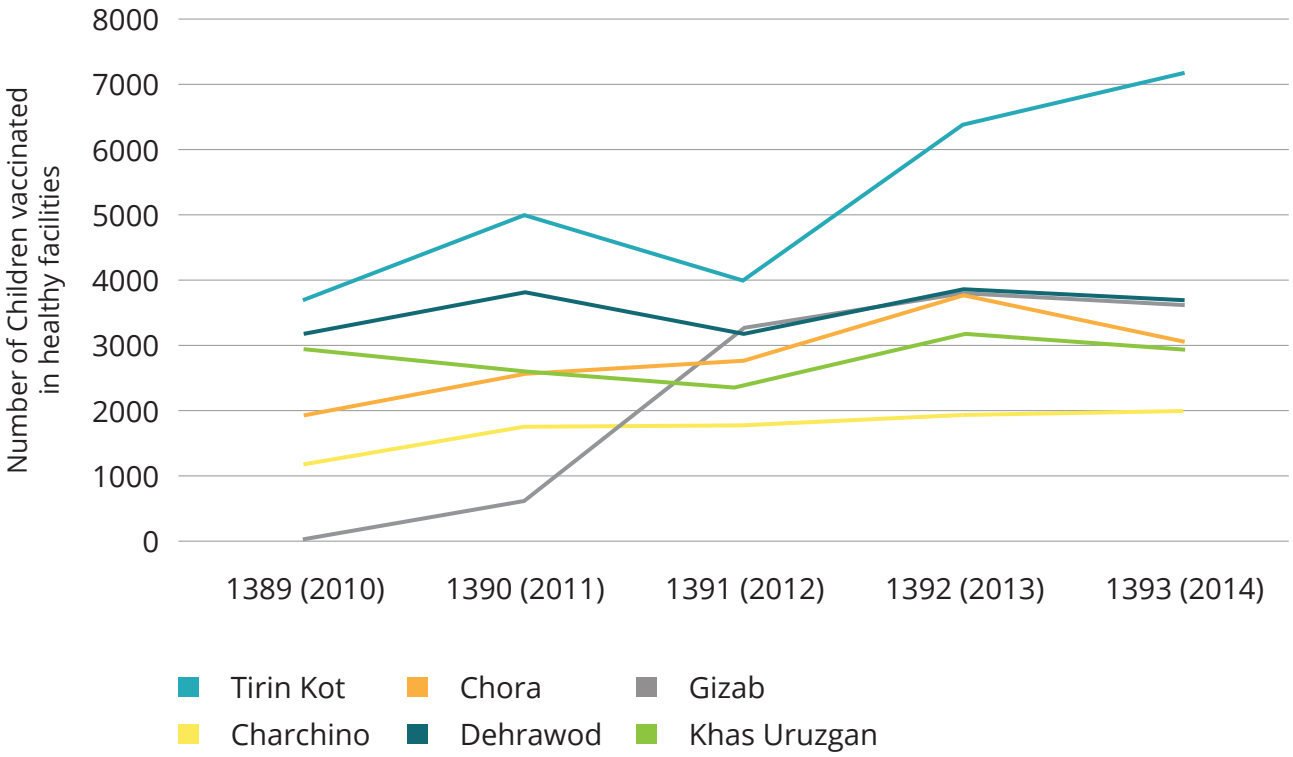
The data available for vaccination rates in Uruzgan suggests that the community have become more demanding of healthcare. There was an increase in the use of the Penta 3, measles and the oral polio vaccination during the implementation of CoU. As a CHS from Tirin Kot said 'positive change has come to the minds of the people. For example previously people did not know the importance of vaccines so that's why they would not have them but now they understand the importance of vaccines so they give vaccines to their children now [103].'

This change in perceptions may have been impacted by community awareness initiatives. As one health professional from Chora said, 'those health councils set up by Save the Children delivered messages of healthcare to the far regions through the mosque and they stated the importance of healthcare, so as a result now lots of people want healthcare services [104].' The change in perceptions may also likely have been connected to an increase in healthcare access and improvement in quality. For example, the 40 PPP clinics set up by CoU under IR 3.1.5. provided Penta 3 vaccines to 2,406 children under 12 months and measles vaccines to 2,314 children under 12 months. Mothers in Uruzgan now appear to be much more likely to seek advice and to vaccinate their children.

[98] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Male healthcare professionals.
[99] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga, Tirin Kot. Elders and male community members.
[100] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Chora. Elders and male community members
[101] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Masjid, Dehrawod. Elders and male community members.
[102] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Elders and male community members.
[103] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Male healthcare professionals.
[104] *Healthcare and education in Uruzgan* (August 2015) Comprehensive Health Centre, Chora. Male healthcare professionals.

Figure 16: The number of Penta 3 vaccinations performed in health facilities in Uruzgan has increased since the start of the program.

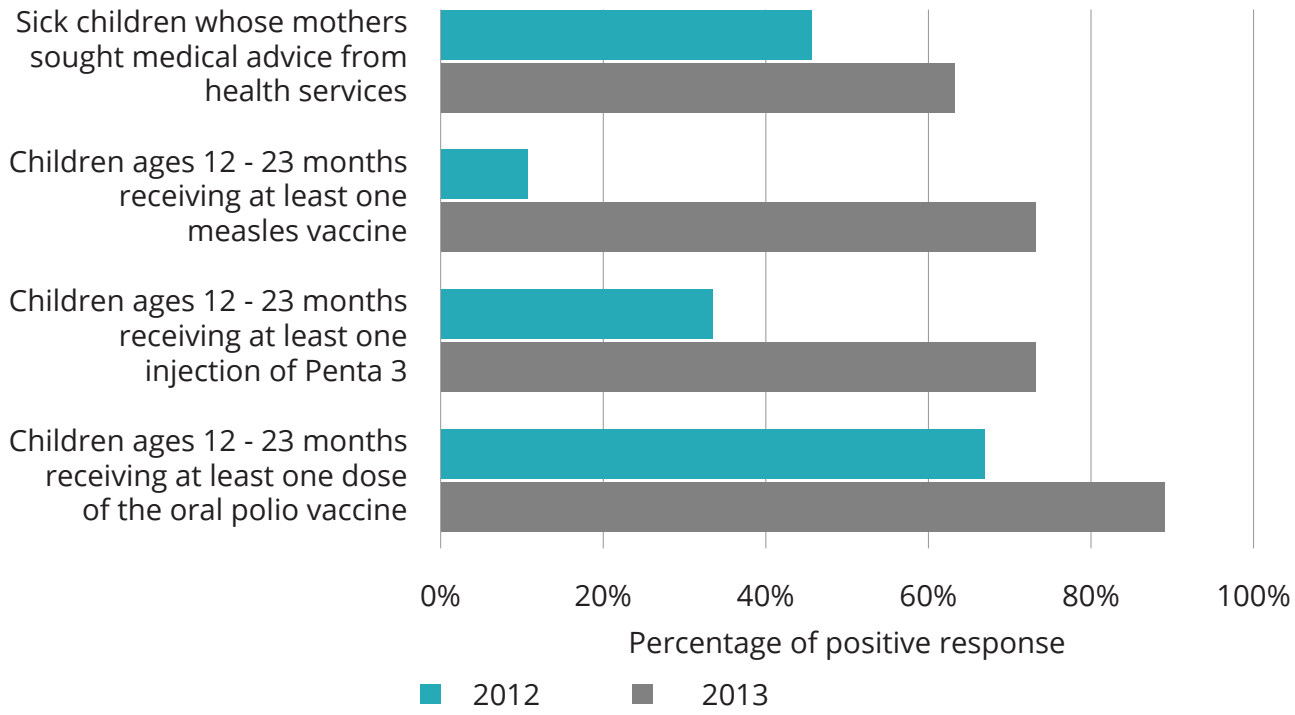
Penta 3 vaccination of Uruzgani under 23 months:



Source: HMIS (2015)

Figure 17: Women in Uruzgan were more likely to seek vaccinations for their children in 2013 compared to 2012.

Vaccination and health-seeking behaviours in Uruzgan:

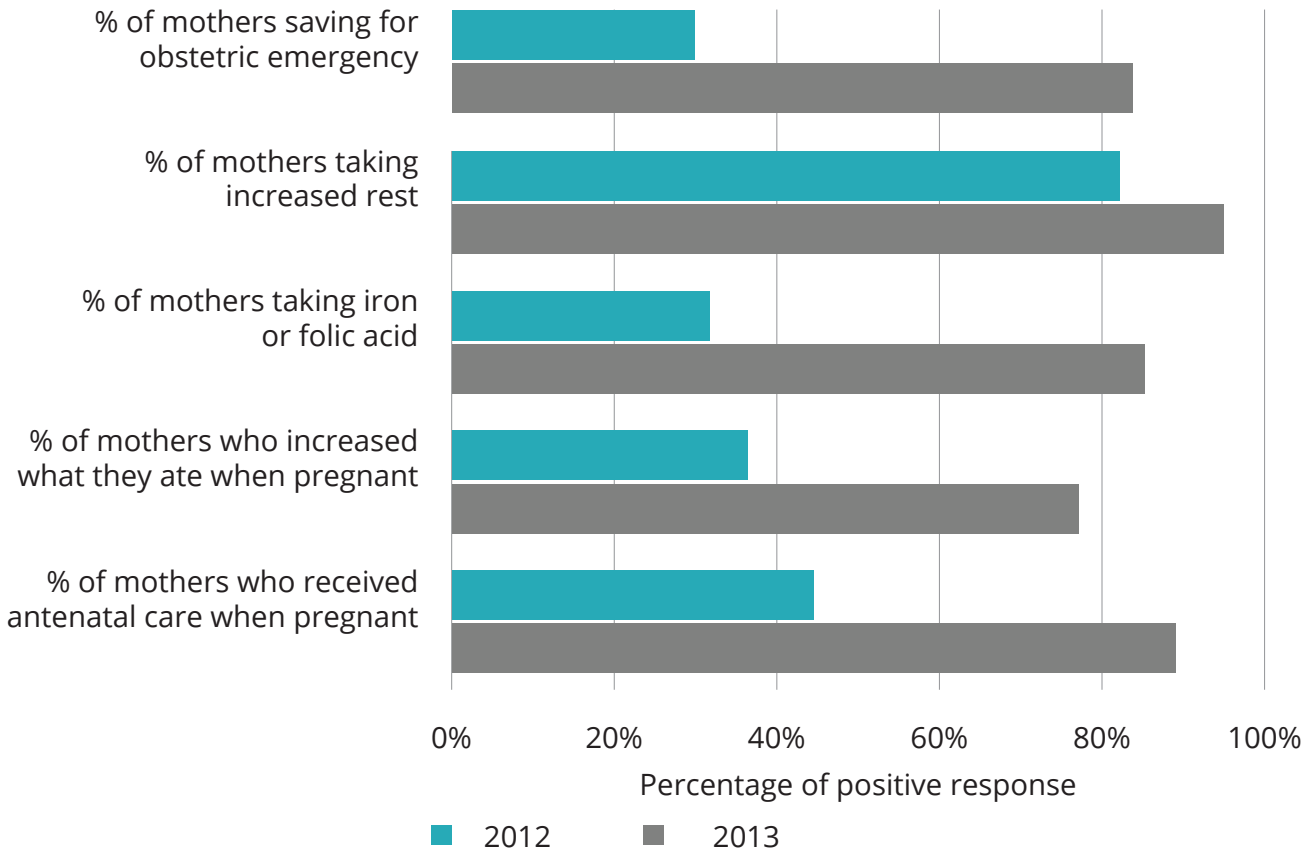


Source: Children of Uruzgan (2013) "Maternal Management of Childhood Illnesses in Uruzgan" Save the Children

There is clear evidence that the demand for healthcare in Uruzgan over the course of the CoU program's implementation reflected a change in health seeking behaviour among the members of the community. Families were more likely to actively seek out health facilities and professionals when in need or in an effort to prevent illness. For example, the programmatic baseline and endline studies in maternal and newborn care conducted in Dehrawod, showed that prospective mothers exhibited behaviour that would increase the likelihood of their pregnancy being successful.

Figure 18: the MNC survey conducted by CoU shows expecting women are more likely to adopt recommended behaviours during pregnancy. Health-seeking behaviours increased.

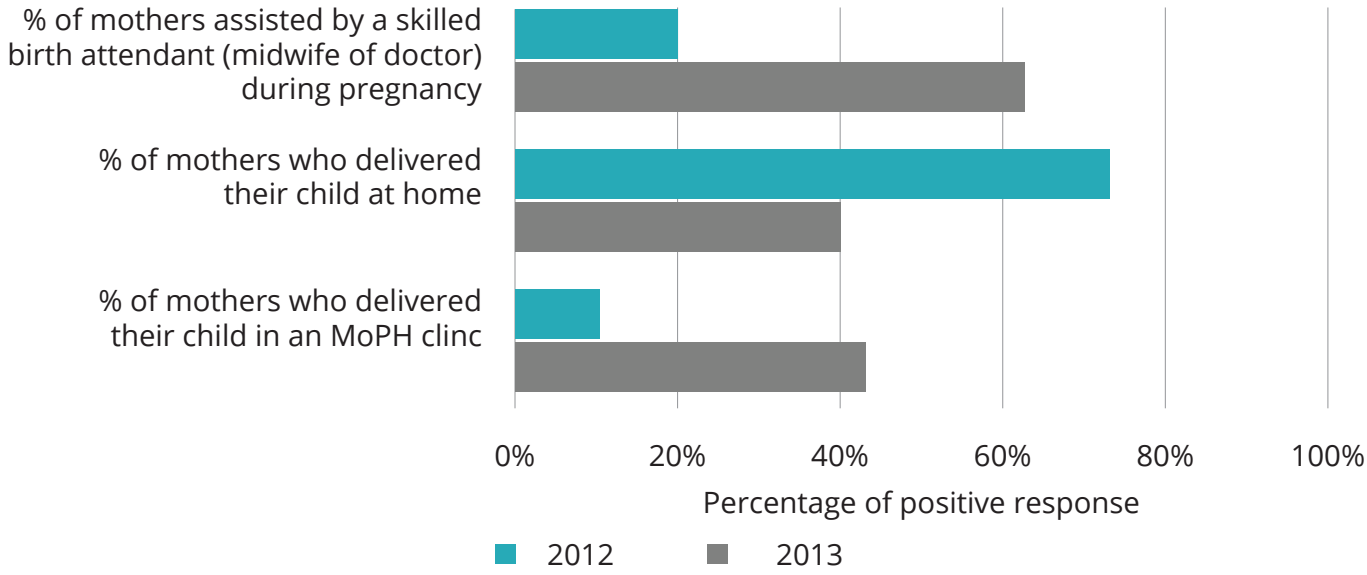
Behaviours during pregnancy:



Source: Children of Uruzgan (2013) "MNC survey in Dehrawod" Save the Children

Figure 19: The survey conducted in Dehrawod showed more mothers delivered in a health facility and in the presence of a skilled birth attendant in 2013 compared to 2012.

Deliveries in Dehrawod:



Source: Children of Uruzgan (2014) "Improving maternal and newborn care" Save the Children, January

Mothers in Dehrawod were much more likely to use a skilled birth attendant, less likely to deliver their child at home, and more likely to deliver their child in a MoPH clinic in 2013 compared to 2012.

The majority of those consulted in Uruzgan reported that they thought the people of Uruzgan were more likely to seek out healthcare services compared to four years before. All 11 local government officials consulted across Uruzgan agreed [105]. In addition, all of the healthcare professionals in Tirin Kot, Dehrawod, Chora and Gizab said that people in their district were more likely to seek out health services now than four years ago. One CHS in Dehrawod explained that 'now they are coming to the clinic so much more compared to before and you can see them standing in line for a doctor and for a midwife [106].' The majority of children consulted in Tirin Kot and Chora explained that they used clinics if someone in their family was ill. In Chora, all of the boys and girls consulted said that if someone in their family was sick then they were taken to the clinic, and the majority of them mentioned that this happened 'quickly'. This appears to be a recent practice as one girl explained 'previously we would take medicine how we wished but now we don't because it is said in the schools not to take medicine without the good advice from a doctor [107].' The situation in Gizab was more mixed with some of the children reporting that if someone in their family was sick 'we use homemade medicine' because they didn't have a nearby clinic and others stating that they went to the clinic 'as soon as possible [108].'

4.4 Education

4.4.1 Changes in education levels of the population

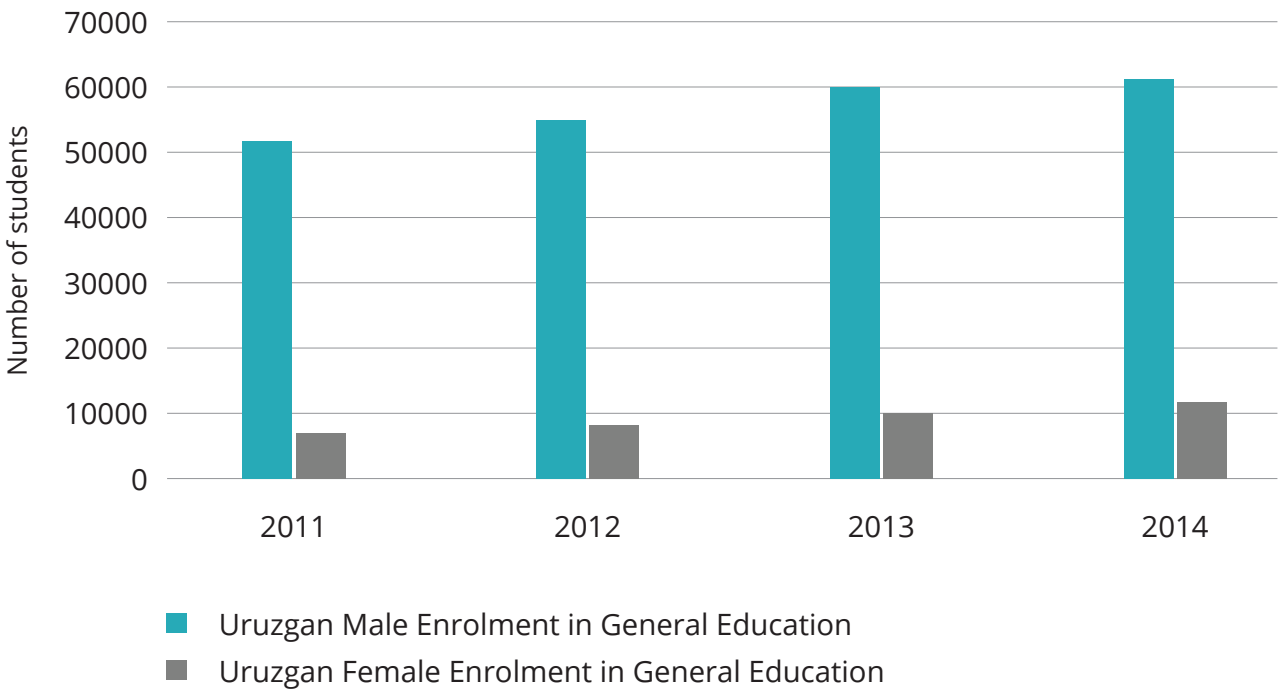
The available quantitative and qualitative evidence suggests that there has been some change in the education level of the population of Uruzgan since the CoU program commenced. It appears that there was a slow and gradual improvement in education levels of the community, however this tended to impact boys more than girls.

Enrolment data from the MoE shows a slow but gradual improvement in the number of children enrolled in general education. This appears to be part of a gradual trend upwards and there was no clear acceleration during the program period.

[105] Local government officials (2015) Interview conducted by ACG August 2015. Uruzgan.
[106] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Dehrawod. Male healthcare professionals.
[107] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz Primary School, Chora. School-aged girls.
[108] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged boys & *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged girls.

Figure 20: Both female and male enrolment have increased gradually.

Enrolment in Uruzgan:

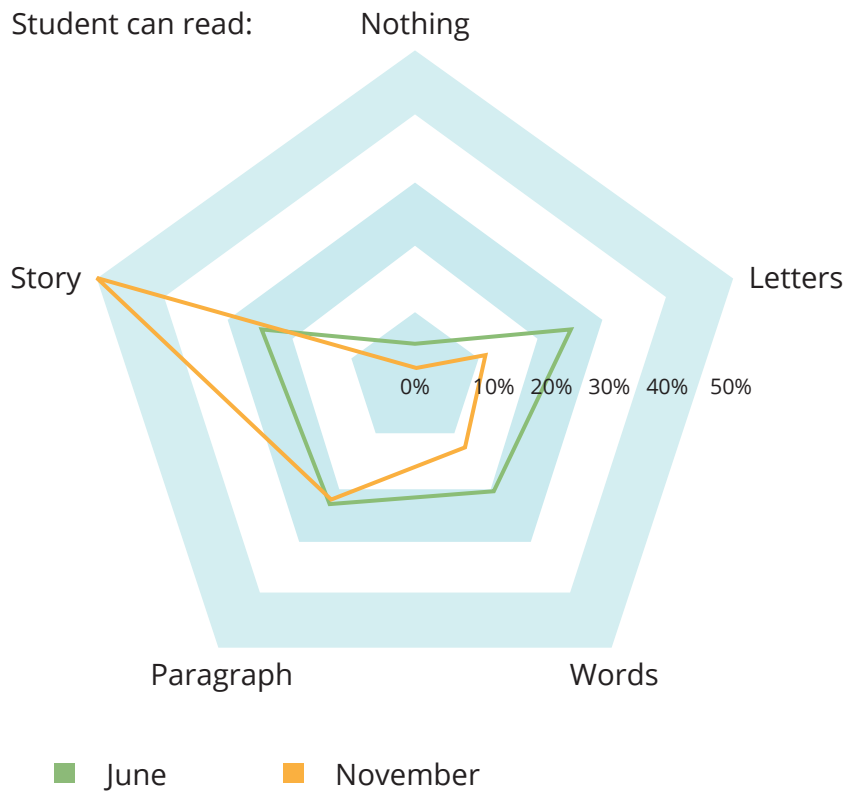


Source: GIRoA - MoE

An assessment of literacy in CBE students from June to November 2013 shows a marked increase in literacy. However, there is no further data available to assess literacy in general across the province, nor data that covers the whole program period. Given the limited data available, it is difficult to infer a general increase in the literacy of the population during the program period.

Figure 21: In Dehrawod, CBE students have shown better levels of literacy in the endline survey with 50% of them being able to read a story.

Literacy levels of CBE students:



Source: Children of Uruzgan (2014) "ASER Results endline data" CBE class survey, November

Figure 22: A community-based education class in Uruzgan (Save the Children)

Whilst a number of community members were able to identify and praise CoU program activities related to education, there was less discussion around an improved education level of the population. It is possible that this is because such an outcome can be difficult for a population to identify, however, the limited measurement of this outcome means that conclusions regarding the achievement of increased levels of education can only be speculative. The majority of education professionals consulted in Tirin Kot, Dehrawod, Chora and Gizab stated that there has been a change in the level of education of the population since 2011. In Chora, one said that the 'education level has increased because people have been encouraged to get education and because people understand the importance of education.' Another stated that 'if this kind of education environment was available to us before then we would be educated people by now [109].'

There is some evidence to suggest that the changes identified in education can be attributed, at least in part, to the CoU program. The majority of participants gave examples of the programmatic activities of CoU as having had an impact and many also specifically mentioned the work of Save the Children. For example, an education professional in Tirin Kot said 'previously teachers were not skilled and they were not familiar with the new teaching methods but now they have been given workshops in new teaching methods [110].' In addition, a teacher in Dehrawod was able to link the

[109] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz High School, Chora. Male Teachers and school management.
[110] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male Teachers and school management.

changes to Save the Children. He said 'previously there were no schools or preparation classes and no one would help us but now, thanks to Allah, Save the Children came and started projects, and people understood the value of education and that education is good thing and it is the right of every male and female to have education [111].'

Figure 23: Uruzgani child playing in an early childhood care and development class (Save the Children)

4.4.2 Access

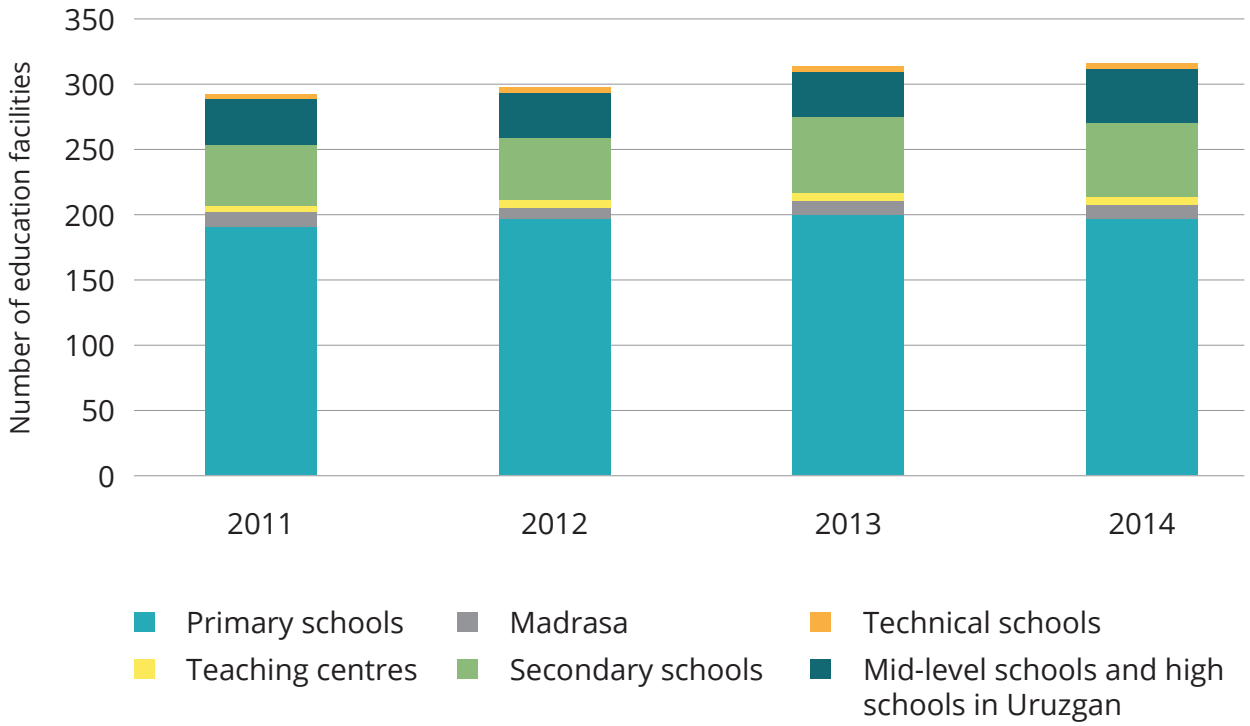
Newly constructed and refurbished schools and CBE classes increased access to education. During the course of the program, Children of Uruzgan constructed six schools and refurbished 58 others under 1R 1.2.1[112]. Small projects such as providing water wells and toilets in schools also aided access to education. Under IR1.2.6 water, sanitation and hygiene (WASH) facilities were provided or upgraded to 50 schools in Uruzgan and 10 received solar-powered hand-washing stations.

In order to improve basic education services for the target communities of Uruzgan, Save the Children undertook extensive work to increase the number of accessible schools. Whilst the initiative was initially aimed at being purely a construction project, the focus changed to refurbishment and existing facility upgrades due to the construction element being assessed by the program's Chief of Party as overly cumbersome, inefficient and having significant potential to cause friction with Uruzgan's Provincial Education Directorate (PED).

[111] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz School, Dehrawod. Male Teachers and school management.
[112] Save the Children (2014). Children of Uruzgan Year 3 Annual Report. May 2014

Figure 24: The number of education facilities in Uruzgan by school type.

Number of education facilities in Uruzgan:



Source: GIRoA - MoE

In 2011, there were 190 primary schools, 29 mid-level schools and high schools, 48 secondary schools, 13 Islamic schools (madrasa), three technical schools, and four teaching centres [113]. By 2014, there were 197 primary schools, 42 mid-level schools and high schools, 13 Islamic schools, five technical schools, and four teaching centres [114]. Four primary schools were closed between 2013 and 2014. This seems to have mainly affected the enrolment of girls in primary schools, which dropped from 10,156 to 9,639 during this period [115].

In general, the school construction and refurbishment element of the CoU program increased the number of students accessing education in the province. 2,890 male students attended the newly constructed schools and 23,739 students attended the refurbished schools, of whom 1,864 were girls. In addition to schools, under IR 1.2.2, the CoU program increased access to non-formal education with the establishment of 142 (target 140) operational CBE classes. They provided education to 3,894 students (target 3750), including 974 girls (25% - target 35%). There was a 92% average attendance (target was 80%) and a 98% re-enrolment rate. ECCD groups were also established under IR1.2.5. At the end of Year 4 of the program 70 ECCD classes were operational (target 70) providing education to 1305 children including 690 girls (target 1300). Attendance at the ECCD classes was 99% (target 80%) for both boys and girls.

Access to education for key beneficiary groups

There was a mixed opinion reported to the evaluation team by community-level respondents about the extent to which women and girls were able to benefit from education services. An education professional from Dehrawod said that 'fewer girls access schools because only one or two schools exist in the centre of Dehrawod [116].' Nevertheless, the majority of women interviewed at community level – in Tirin Kot, Chora and Gizab - said that they felt women and girls could access education services as easily as men and boys. Given the significant difference in availability of educational facilities suitable for women and girls in the province, this expressed sentiment from women in the community level research group, may have reflected their general lack of demand for women and girls' education. In Tirin Kot, those women who felt they did not have the same access to education as men, explained that 'women don't have any kind of high or primary school except Malalai High School in the centre. We have only a limited number of female teachers [117].' Some boys in Chora reported that 'it is very difficult for those girls whose families do not allow them to get education'. However these views were not mentioned by any of the girls who participated in the research [118].

[113] Ministry of Education of Afghanistan (2015). Education statistics. Kabul.
[114] Ministry of Education of Afghanistan (2015). Education statistics. Kabul.
[115] McGeough, P (2015) "Taliban returns: How Oruzgan is crumbling after Australia left Afghanistan" The Sydney Herald, June 2015.
[116] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz School, Dehrawod. Male teachers and school management.
[117] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Tirin Kot, Pregnant mothers, mothers of newborns.
[118] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz High School, Chora. School-aged boys. &Healthcare and education in Uruzgan (August 2015) [Focus group] Markaz Primary School, Chora. School-aged girls.

The girls in Gizab who said that they couldn't access school explained that this was because the school was very far, there were not any female teachers and 'because those girls who are going to school - people have bad minds about them [119].'

The majority of respondents identified that children with a disability and those in remote communities were less likely to receive education. The education professionals in Dehrawod said that 'disabled boys who are very far from school do not have access because our schools don't have any kind of transportation'. The education professionals of Chora stated that 'those children who don't have access to our services are children of far regions.' All ten of the education professionals from Gizab said that '30% disabled, 70% children have access to education.' They explained that those who could access school were those who live where 'security is good', and those whose home is near to the school [120]. The majority of children consulted in Tirin Kot, Chora and Gizab reported that they could easily access education facilities, however they were clear that it would be harder to get education for children who live far away from schools, those who are orphans, those who are poor and 'those children whose parents don't know the importance of education [121].'

4.4.3 Quality of education services

In order to improve basic education services for the target communities of Uruzgan, Save the Children undertook a number of initiatives designed to improve the quality of services in IR2 Quality: "Enhance the quality of education services". One of the main initiatives was under IR 2.2.1 and aimed to improve the teaching and school management skills of teachers and school principals/ head teachers. As part of this 543 (target 600) teachers in formal schools received training, mostly in in-service training (INSET 1) (12 days), with others receiving specialised training in grade four-six science, or child rights under Islam. In addition, 80 school principals (target 60) were provided with at least five days of training. 140 teachers also received an advanced pedagogical training (INSET 2) which lasted nine days. Further, under IR 2.2.2, eight science and mathematics teachers were supported and deployed to high schools throughout the province and to the Teacher Training College in Tirin Kot. These trained teachers taught 238 students among whom 43 were girls. They also provided 35 boys with preparation for University entrance exams.

The 15 education facilities checked for quality by the evaluation team demonstrated mid-range quality against the indicators. Once again this represents a significant achievement for Uruzgan.

[119] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged girls.
[120] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri High School, Gizab. Male teachers and school management.
[121] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged boys & *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged girls.

Figure 25: Schools were assessed against the agreed indicators, which were rated by field monitors as either Achieved, Partially achieved or Not achieved. In almost all of them the indicators were rated as partially achieved, although only two schools in Dehrawod managed to completely achieve at least one indicator.

Indicators	Tirin Kot Malalai High School	Tirin Kot Malalai Middle School	Tirin Kot Malalai Primary School	Tirin Kot Sayed al Khan High School	Tirin Kot Sayed al Khan Middle School	Tirin Kot Sayed al Khan Primary School	Dehrawod High School	Dehrawod Middle School	Dehrawod Primary School	Chora Central High School	Chora Central Middle School	Chora Central Primary School	Gizab Beri High School	Gizab Beri Middle School	Gizab Beri Primary School
The teacher interacts with all students in a positive and respectful manner	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
An area or space for learning exists that is safe for all learners	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Schools and other learning environments are accessible to the populations they serve in terms of hours, locations and fees	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Teachers are present for their classes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Teachers are provided continuous support to improve their practice in key areas specific to their role Learning is supported through the use of relevant visual aids and other teaching materials	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Teachers ask individual questions and interact with the learners	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

The majority of community members were satisfied with the education provision in their area and had noticed positive changes in the last four years in terms of schools being equipped and teachers being trained. For example, all 11 local government representatives from across Uruzgan stated that they had seen a difference in the provision of education in the last four years. One in Dehrawod stated that now 'we have a number of skilled teachers, the system of education has been computerised, a number of schools have been repaired and equipped, local classes have been constructed... Save the Children has trained our workers so that their capacity has increased.' Many of the representatives from local government pointed to the activities of the CoU program and Save the Children as being the instigators of improvements in education [122]. The majority of elders and men in Tirin Kot, Dehrawod, Chora and Gizab agreed that they were satisfied with the education in their area and had seen an improvement in the last four years [123]. Equally, the majority of women in Tirin Kot, Chora and Gizab felt that there had been an improvement in education in their area over the past four years. Focus group participants commonly cited the construction and repairs of schools, teachers having been trained, and people understanding the importance of education as evidence of improvement [124].

In a positive signpost for the sustainability of educational demand in Uruzgan, all of the children consulted had clear ambitions and goals which they thought they could achieve with education. Many of the boys and girls had ambitions to become an engineer or to 'serve my country'. Girls mentioned that they would like to become a doctor, pilot, a midwife, 'chief of women affairs department' and a 'defender of women's rights'. The boys were commonly keen to study further. One in Tirin Kot explained that 'because I am an intelligent student I hope that in future I can study in Kabul and then in a foreign place and come to my own country after getting my education complete and serve the people
of the country [125].' The majority of children consulted stated that they liked education. For example one of the girls in Chora said 'we like school because we are encouraged by our father and we are told that if we do your studies so you will become doctor or engineer in the future and you will get money [126].' Only two boys in Gizab said they did not enjoy school because 'our teachers do not teach fairly and force students by hitting [127].'

4.4.4 Demand for education

There is clear evidence of a change in education seeking behaviour among the community members of Uruzgan during the CoU program's implementation. The community are more likely to want to send their children to school than was the case four years' before. As one CoU program staff member stated 'in 2010 and 2011 the community were knocking on our door asking for food items – emergency packages – they saw the NGO as just providing food relief, and it was very hard

[122] Local Government rep (2015) Interview by ACG August 2015 Uruzgan
[123] *Healthcare and education in Uruzgan* (August 2015) [Focus groups] Zayn Clinic, Gizab, Masjid, Dehrawod, Comprehensive Health Centre, Chora. Elders and male community members.
[124] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab.
[125] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan High School, Tirin Kot. School-aged boys.
[126] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz Primary School, Chora. School-aged girls.
[127] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Beri School, Gizab. School-aged boys.

to get them to send their children to school. Then in 2013 they came to the office and asked for community-based education programs [128].'

In order to improve demand for education services for the target communities of Uruzgan, Save the Children undertook a number of initiatives under IR 3 Demand: "create awareness and enhance demand for basic education services". For example, under IR 3.1.1 there was capacity building of religious leaders to advocate for the importance of education. 145 religious leaders (target 165) were trained in the education modules. Under IR 3.1.2 142 new community education committees (CECs) (target 140) and 58 school shuras (target 50) were supported. 474 shura members (target 352) received training, 426 CEC members were trained.

Those consulted across the districts reported a greater demand for education. All of the education professionals in all of the districts, except Dehrawod where there was a majority, said that there had been a positive change in attitudes towards education since the start of the program. For example, in Tirin Kot, one said, 'every council has a meeting with parents of the children every two months and they explain the importance of education to them and positive changes have come to the minds of the people.' Another said 'people have been given messages through the media as well [129].' In Chora, one said 'previously people would make their children work but now they have allowed their children to get education [130].' The elders and men of Tirin Kot, Dehrawod, Chora and Gizab all agreed that their community were more concerned about having good education now than they were four years ago [131,132,133,134]. In turn, it seems that attitudes towards education have translated into the community seeking out education more than before. For example, the majority of the education professionals stated that they thought the people of Uruzgan were more likely to seek out education services than before. One in Tirin Kot,said 'now people are wanting more services. Because people have got the importance of education from workshops and from the training provided to tribal leaders [135].'

[128] Key informant interview conducted with senior program representative by ACG, August 2015
[129] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male Teachers and school management. &Healthcare and education in Uruzgan (August 2015) [Focus group] Malali High School, Tirin Kot. Female Teachers and school management. Group 1 and 2. [130] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Markaz High School, Chora. Male teachers and school management.
[131] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga, Tirin Kot. Elders and male community members.
[132] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Masjid, Dehrawod. Elders and male community members.
[133] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Chora Community Hall, Chora. Elders and male community members.
[134] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Elders and male community members.
[135] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male teachers and school management & *Healthcare and education in Uruzgan* (August 2015) [Focus group] Malaly High School, Tirin Kot. Female teachers and school management Group 1 and 2.

4.5 Policy and research

The CoU program may have contributed to some reform of policy approaches in healthcare and education planning at the provincial level. It is less likely that CoU research had an influence at national level. More could have been done to target and influence provincial and national level policy makers on healthcare and education.

Under IR4 Policy and Research, Save the Children delivered a number of research and policy initiatives. The original proposal set out the main aims for the research: "to document how Save the Children engages in three underserviced districts in Uruzgan province; conducting a student learning achievement assessment for each year of the program; in Year 3 and 4 conducting research on Young Women/Mothers literary, ECCD and the girl's high school teacher training (GLiTTA) components; undertaking academic research to support the operational research focusing on training CHWs and Family Health Action Group members to provide basic maternal and newborn care services at home [136]."

Of these components, the academic research under IR 4.1.1 was conducted quite late, in Year 3 of the program. This severely limited the extent to which it could inform program operations and activity design. Earlier work was conducted under IR 4.1.2, however the extent to which research findings were presented and shared with key stakeholders including governments, donor organisations, working groups and other partner organisations was limited. Senior CoU staff did make some presentations to Ministry staff in Kabul and participated in technical working groups, however it is likely that there could have been more activities undertaken through this component to engage more thoroughly on the program's policy reform objectives. A full list of activities undertaken through this component of the program can be found in Annex 4.

The research and policy component suffered from a lack of leadership and consistent staffing in general, and a lack of staff understanding of the aims of the research component and how it was to be implemented. The first year of the program suffered operationally from the early departure of the Chief of Party as well as the resignation of the Research Manager after just six months. The Research Manager role thereafter suffered from a lack of a clear organisational articulation of the responsibilities and expectations of the incumbent and a turnover in personnel. The research that was attempted during this time was noted by a key informant interviewee as 'ok but the people who had done the Save the Children research on healthcare weren't skilled or qualified to do research – they had little real understanding of qualitative techniques for good quality research. This meant that the data was pretty suspect. Quantitative data from BPHS wasn't reliable either because of the vested interests in how it was prepared [137].' Indeed the research conducted at this time 'we threw in the bin – we didn't think it was good enough [138].'

A concern raised by interviewees was that research was not commissioned strategically. As a CoU program staff member commented, 'the problem we had with research is that it was pull driven rather than push driven. We felt like we didn't know what we wanted to know... In the reality of it research was a low priority [139].' This was an opinion shared by a researcher contracted to support

[136] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011. pp. 56.
[137] Key informant interview with independent researcher, by ACG, August 2015
[138] Key informant interview with senior program representative by ACG, August 2015.
[139] Ibid.

the CoU program, 'I had the impression that they hadn't thought about IR4 enough. With the loss of the Research Manager early in the program, this component became very much an afterthought. The way we were engaged and the delays in our research getting started, plus the lack of any concerted attempt to engage with us about the findings, suggested to me that Save the Children were just trying to tick the box [140].'

The majority of research was carried out towards the end of the program. This research was of high quality however was unable to inform the program because of the timing of it and the timeframes involved with academic research. The research on girls' education by New York University [141] was mainly focused on contributing towards 'a global body of research' rather than being a useful assessment of the program or a lessons learned exercise. The idea was that it was 'contributing to [Save the Children's] work anywhere and everywhere and contributing to public collective knowledge and that it could be used in any way - it could be used to develop future programs or not [142].' Indeed it appears that there was little belief that the academic research could or should influence the program's implementation once it was underway. One researcher noted that 'one of the ideas was to use our research to inform the program's design. But our research came a long way after the design was agreed and the project plan had been agreed [143].' The view from CoU program staff however, was that 'it probably wouldn't have informed anything. The research they were aiming for was more academic and that wouldn't have informed programming anyway [144].' A CoU researcher agreed, questioning that 'nobody appeared to take it seriously nor ever really intended to apply the research to healthcare service provision design. What was the point then? [145]'

At the provincial level, across Uruzgan, 8 out of 11 local government representatives stated that the program had contributed to provincial policy on healthcare and education, however, this was mainly articulated as implementing existing government policy rather than influencing policy reform. A staff member explained that Save the Children: 'were actively participating in the provincial health meeting' and 'participated in the other committees and contributed to drafting and checking the provincial development plan'. CoU program personnel were also involved in reviewing provincial government plans for healthcare and education that were later presented in Kabul [146].

At the national level, by the end of the program some limited achievements may have been made in relation to influencing national policy on healthcare and education. For example, as a result of CoU coordination meetings with MoPH and MoE about the School Health and Nutrition project, a Memorandum of Understanding was signed by the Ministry of Health and the Ministry of Education regarding the improvement of school health and nutrition nationwide. In addition, experience gained through the implementation of ECCD was used to advocate for change in early childhood education, in particular influencing the National Education Strategic Plan III (NESP3). In turn, an ECCD curriculum has been developed by CoU and shared with MoE. Although there is no

[140] Key informant interview with independent researcher, by ACG, August 2015
[141] *Increasing Girls' Access to Education while Remaining Sensitive to Conflict: Understanding Community Responses to International Interventions in Uruzgan, Afghanistan, Jehanzaib Khan and Dr Dana Burde*
[142] Key informant interview with independent researcher, by ACG, August 2015
[143] Id.
[144] Key informant interview with senior program representative by ACG, August 2015
[145] Key informant interview with independent researcher, by ACG, August 2015
[146] Key informant interview with senior program representative by ACG, August 2015.

expectation that they will take it on as is, Save the Children staff hope that it might in future be recognised as contributing to a national package for ECCD. Save the Children is also promoting the package through its other ECCD programs and it is being shared with other development partners. Finally, the results of "Community Based Maternal and Newborn care" research were also shared with MoPH.

4.6 Program design, implementation and process

Save the Children used a program strategy designed specifically to work in a fragile and insecure context such as Uruzgan. This strategy ensured that implementation of the program was flexible and able to adapt to the changing priorities and circumstances of the context. It was particularly appropriate for an insecure and politically and socially complex operating environment. The six months scoping stage undertaken at the start of the program and the inclusion of community development projects as part of the program's community engagement plan, were very effective in enabling CoU program staff to gain access to communities and to constructively engage with communities throughout the implementation process. In addition, the donor and Save the Children's flexibility in agreeing implementation priorities and adjusting project plans aided the overall effectiveness of the program.

The proposal document stated the original understanding of the security situation and the constraints to the program: 'the main challenge for implementation of the projects at provincial level remains security and the instability of the province. Warring factions, such as the Taliban, rebels, warlords and bandits try to use the presence of NGOs as a means to intimidate the local population. What is seen as collaboration with foreign elements or foreign culture is punished [147].' The context was considered carefully as a key influencer on the program's theory of change. The presence of a resistant culture required Save the Children to take a more structured community engagement approach. Small development projects such as the building of wells was incorporated into the overall program's design.

One CoU program team member described this element of the program, noting, 'That's how they could move into the communities. They won hearts and minds of the people very gently, then could talk about health and education. They had to be flexible: 'these people just put a well in, now we can talk to them about other things. It was a province with a great resistance and fear of the unknown [148] .'

An important positive lesson remarked on by DFAT and Save the Children interviewees was that a six month planning phase at the start of the program really helped the program team to understand the context and to design appropriate community engagement strategies. One staff member noted 'the long timeframe – the ability to carefully engage with communities, the attention paid to community engagement and mobilisation – the care that was shown in the different tribes – balancing between them, taking time to show results and win trust and demonstrate to government and non-government that we're genuine in our goals and not taking sides – and we were able to do that by people believing what we said when we said what we were doing [149].' Another noted that

[147] Save the Children (2011) Uruzgan Proposal to AusAID9th March 2011. pp. 16.
[148] Key informant interview with senior program representative, by ACG August 2015.
[149] Key informant interview with senior program representative, by ACG August 2015.

'our approach made us more of a partner - and it allowed a better relationship to foster [150].

The positive community engagement approach was reflected in the findings from consultations with the community. In Tirin Kot a respondent said that the CoU program was effective because 'the projects were implemented according to the conditions and traditions of the people of Uruzgan –for example there was a separate place for the training of midwives and separate female teachers teaching them. Also female health workers were trained by female teachers [151].' In Chora, a health sub-centre manager said that because the program was 'implemented with the scholars and tribal leaders all of the people gained trust in the program and it increased the trust of the community towards other organisations [152].'

A key element of the program's community engagement strategy was the implementation of small scale community development and improvement projects. Community mobilisation and development activities were designed for CoU to build trust and support for the health and education outcomes.

Under IR 3.1.5, 294 (target 200) small-scale projects for community development were undertaken. The majority of projects were bore-wells but also included irrigation projects, upgrades to madrassas, latrines, CBE classes and health facility renovations. Although targets were not reached in Charchino and Khas Uruzgan, they were exceeded in Tirin Kot, Dehrawod, and Chora. In addition, a number of medium-sized grants were given for the construction of parks and libraries, and projects such as the drug addiction prevention and treatment centre were established.

The community development projects contributed to improving the lives of people in Uruzgan. They fostered trust and created a conducive environment for the successful engagement of the community in the overall delivery of the CoU program. Across Uruzgan, 10 out of 11 local government representatives consulted were aware of the community initiatives having been implemented and were happy with the results. For example, the representative for the Department of Women's Affairs in Tirin Kot agreed that 'yes there is no doubt that small projects like the construction of parks, digging of water wells, or libraries increase the trust of the community [153].'

There is evidence to suggest that where the community development projects took place, they increased the trust of the local community in the program. For example, children participating in a focus group in Tirin Kot agreed with one of the group member's statement that 'these things such as water wells, culverts, solar panels are very beneficial and the community needs these things so it has increased the trust of the community towards organisations because some of the problems of the community have been solved [154].' There appeared to have been less impact seen in the

[150] Key informant interview with senior program representative, by ACG August 2015.
[151] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Male healthcare professionals.
[152] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Comprehensive Health Centre, Chora. Male healthcare professionals.
[153] Local government representatives (2015) Interview conducted by ACG August 2015 Uruzgan
[154] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Malaly High School, Tirin Kot. School-aged girls, *Healthcare and education in Uruzgan* (August 2015) [Focus group] Khairo Karez CBE centre, Tirin Kot, School-aged boys and girls, & *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan High School, Tirin Kot, School-aged boys Groups 1 and 2.

community development initiatives in Gizab than in other districts. None of the focus groups in Gizab mentioned an increase in trust with Save the Children in the way that those consulted in the other districts had done.

Save the Children staff were clear that the program had to be flexible. The proposal states that 'in light of the fluidity of the security environment in Uruzgan province and the inherent challenges of accessing remote and under-serviced areas, the overriding principles must therefore be flexibility and adaptability... an approach of constant analysis, monitoring and review of project activities to ensure that the project remains relevant and appropriate to its context [155].' It was explained by a CoU program staff member that 'we changed the project every year based on lessons learned. We saw the training of religious leaders was good to enhance healthcare demand so we used them for education also. We saw that there were community midwives needed... and so did something about that too. Due to the security situation in Gizab we also were flexible and relocated the planned CDP projects to secure districts [156].'

Nevertheless, in terms of ways that the program could have been implemented more effectively, a number of local government representatives mentioned that they would have preferred greater communication and coordination with the local administration. For example, one government official in Dehrawod stated that 'it would have been good if Save the Children could have implemented
the program with the coordination of related departments and monitored it better [157].' In Gizab, the healthcare professionals said the program could have been improved by asking the advice of the community and having their 'priorities taken into account, and there should have been more coordination with the government and local organisations [158].

4.7 Sustainability

Concerns were raised in the DFAT Mid Term Review of the CoU program that 'sustainability' planning is poorly suited to highly unpredictable transitional contexts and that a 'much more relevant concept in these contexts is 'resilience' (the likelihood of benefits surviving change) [159] .' Nevertheless, the program aimed to be sustainable and embedded a number of specific elements to aid sustainability. For example, building a relationship with the relevant provincial line departments and increasing the capacity of the MoE provincial and district departments (IR 2.2.2) [160] ; ensuring that there was improved capacity of Save the Children and partner staff to carry out project activities successfully (IR2.3.1); and the built in mobilisation time of three to six months to ensure that the right people could be recruited for each project and activity [161].

[155] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011. pp. 21
[156] Key informant interview with program representative, by ACG August 2015.
[157] Local government representative (2015) Interview by ACG August 2015
[158] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Male healthcare professionals.
[159] Save the Children (2013) *Mid-Term review* Save the Children November 2013. p. 28.
[160] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011. pp. 47-48.
[161] Save the Children (2011) Uruzgan Proposal to AusAID 9th March 2011. P. 50.

At the close of the program, a number of CoU projects within the healthcare element were handed-over to the Afghan government to become part of the province's health infrastructure. For example, the health posts, sub centres and mobile health clinics established and staffed under IR1.1.1 were absorbed into the provincial operations of AHDS in coordination with the Provincial Health Directorate (PHD) under the BPHS program. Nevertheless, both AHDS and MoPH indicated to Save the Children that it was likely that the mobile health teams would be replaced by static clinics due to their high operational cost. The PPPs were due to be supported by HealthNetTPO (a Dutch NGO) from early 2016.The Provincial Heath Directorate was planning on providing supervision (but not monetary support) until that time.

Despite being merged into existing Afghan government health infrastructure, there were a number of concerns raised that the quality of services would decline. As one local government representative said 'these positive changes we have seen, will gradually decrease. A good example is medicine – it is so in demand but we have few supplies, the salaries that were being given by Save the Children are not being given by the government now, so you can see that now most of doctors have resigned from their jobs'

Similar to healthcare, a number of the education elements of the program were taken over by the PED. For example, the construction and refurbishment of schools in IR 1.2.1. was undertaken in coordination with the PED. Teaching school and management skills support to the formal schools identified under IR2.2.1 was to be delivered by the PED at the close of the program. It was deemed that there would be no need for further MoE capacity building under IR 2.2.2. at the end of the program however it was not possible to verify the capacity of the PED in this evaluation. Concerns were raised by community research respondents about the PED's capacity and how this would impact on the long term sustainability of CoU program success. In Tirin Kot, Dehrawod, Chora and Gizab there was considerable concern raised among education professionals. A typical example is that 'our teachers would have been given enough salary by Save the Children but now that is not being given to them so they are compelled to leave their jobs. Another thing is that every school needs to be repaired after sometime but there is no budget for the repairs. Another thing is that Save the Children had lots of workshops for training teachers with new methods but now they are not trained [162].' Similarly one woman in Tirin Kot said 'the government is so weak and involved in corruption, and cannot deliver services to our children and teachers. All of the schools have been constructed by organisations and have helped so much, if these organisations were not there all of these services would get damaged [163].'

Of the 142 CBE classes established under IR. 1.2.2, 51 were absorbed into mainstream schools managed by the PED. Of the remaining 91 classes with children who needed either one or two more years before the children are ready to transition to mainstream school, UNICEF agreed to support 73 (18 were in Gizab and Khas Uruzgan and remote and were deemed too difficult to monitor). Nevertheless, there were concerns from the community about this. A local government representative in Dehrawod said, 'the local classes which were constructed by Save the Children are now deactivated, and in the same manner skilled teachers were being given salaries by Save

[162] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male teachers and school management.
[163] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Yaklinga Clinic, Tirin Kot. Pregnant mothers, mothers of newborns.

the Children but now with the shortage of salaries a shortage in teachers can be seen as well [164].' In response, a Save the Children staff member explained that 'unfortunately teacher salaries were delayed for a month or two due to UNICEF systems taking some time to come online with the PED, but the arrangements are in place and salaries have been paid since July [165].'

With regards to training for professionals, the majority of program training elements were not deemed necessary to sustain. For example, the training given to CHWs through IR 1.1.2, IR 1.1.3, IR 2.1.1, and IR 3.1.4 was not to be continued. Similarly, the NGO and health facility staff trained through IR.3.1.3, were not to be trained further. Whilst it can be assumed that once people have been trained in something they are likely to retain some knowledge and continue to work to a higher level than prior to their training, one should not disregard issues such as staff turnover, lack of staff motivation over time, and needing to ensure that staff continue to be trained in new technologies and methods. All of these factors means that the sustainability of the benefits of skills training during the program are likely to wane over time without organisations or government bodies continuing to invest in such staff. This was certainly a concern among the health professionals consulted in Tirin Kot, Dehrawod, Chora and in Gizab. Many had negative opinions about the sustainability of CoU-initiated services and improvements [166].' In Gizab, a CHW echoed a much repeated worry that 'it is said that the number of midwives, nurses, skilled doctors, and volunteers is decreasing because they are not given enough salary [167].'

Some other elements of the program were unable to be continued in Uruzgan. For example, increasing the number of female teachers through IR.1.2.3 and the GLiTTA training package was taken up by the UK Department for International Development (DFID) Steps Towards Access to Girls Education (STAGES) consortium and is being implemented in other provinces in Afghanistan but not in Uruzgan. The ECCD package under IR.1.2.5 was also taken up by the STAGES consortium and was being implemented by Save the Children International (SCI) in 3 provinces however no viable handover solution for supporting the already existing ECCD classes in Uruzgan had been identified at the close of the program. With regards to school health and nutrition (IR 1.2.6.) most modules had been completed in Uruzgan and so were not continued.

The government steering and technical committee comprising of MoE and MoPH representatives was established to identify how school health and nutrition (SHN) components could be institutionalised in national programs. In turn the school shuras that were set up or reorganised under IR 3.1.2 were not deemed to require any post program support. Similarly, the capacity building of NGO staff under IR.2.3.1, the capacity building of religious leaders under IR 3.1.1, and the community development projects under IR3.1.5 finished altogether.

[164] Local Government representatives (2015) Interviews by ACG August 2015 Uruzgan.
[165] Key informant interview with program representative, by ACG August 2015.
[166] *Healthcare and education in Uruzgan* (August 2015) [Focus groups] Yaklinga Clinic, Tirin Kot, Comprehensive Health Centre, Chora, Zayn Clinic, Gizab, Comprehensive Health Centre, Dehrawod. Male healthcare professionals. & *Healthcare and education in Uruzgan* (August 2015) [Interviews] Yaklinga Clinic, Tirin Kot, Comprehensive Health Centre, Chora, Comprehensive Health Centre, Dehrawod. Female healthcare professionals.
[167] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Male healthcare professionals.

A number of health projects closed completely, such as the drug treatment and counselling centres under IR 3.1.2 and the training of education shuras under IR 3.1.2. With regards to other medium-sized health grants (IR.3.1.5), because they responded to immediate community needs they were not deemed to require further support. In terms of the other elements of health provision, with regards to IR 1.1.4, the community midwife education school received MoPH accreditation, and the community health nursing education program received formal accreditation in June 2015. Nevertheless, these programs are no longer operating as it was felt that there was already over-capacity compared to demand for female health professionals.

Many community respondents regarded the closing of services as worrying, and an indication that the changes in healthcare and education would not last. For example, one man in Chora said 'these midwives who have been trained need updated information about healthcare so that they can face every dangerous condition of pregnant women and children; when they are not trained with the latest updates there won't be any benefit of this old information that they have so it mean no lasting change has taken place in field of healthcare.' There was indeed a great deal of concern expressed from the community about the closure of the CoU program. As one woman from Gizab said 'when Save the Children closes its office lots of problems will be seen in the field of education and healthcare [168].'

The majority of those consulted in the community had mixed opinions about whether or not the changes provided in the CoU program would be sustained or not. There was a belief that the changes in people's attitudes and desires for healthcare and education would sustain to a certain extent. For example, a man in Chora said 'these changes which have taken place in the field of healthcare will last because the people of Chora district are mature and they will take care of these changes so that they live safely and have good access to medicine [169].' Similarly a woman in Gizab said 'people now understand the importance of education and the government is supporting it so the level of education is increasing day by day in the community [170].'

[168] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Pregnant mothers, mothers of newborns.
[169] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Chora Community Hall, Chora. Elders and male community members.
[170] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Zayn Clinic, Gizab. Pregnant mothers, mothers of newborns.

05 CONCLUSIONS AND RECOMMENDATIONS

5.1 Answering the research questions

5.1.1 Has there here been any change in the MCH, nutrition and education status of the population of Uruzgan since the program commenced and if so, to what extent can this be attributed to CoU?

The maternal and neonatal mortality rates suggest an increase in the recording of deaths and a reduction in maternal and neonatal deaths throughout the life cycle of the program. Malnutrition data shows that the total number of children with malnutrition has decreased. Many stakeholders, particularly healthcare professionals, could point to a decrease in the frequency of maternal and child deaths in their clinics and malnutrition being increasingly acknowledged and treated across Tirin Kot, Dehrawod, Chora and Gizab where interviews and focus groups took place. Enrolment data from the MoE shows a slow but gradual improvement in education enrolment and the program assessment of literacy shows a clear improvement in the literacy of CBE students. Whilst a number of community members consulted were able to identify and praise program activities related to education, there was less discussion around an improved education level of the population. There is inferential evidence to suggest that the changes identified in healthcare were significantly contributed to by the CoU program. A number of stakeholders specifically referenced Save the Children or programmatic activities of CoU. The evidence about which education outcomes can be specifically attributed to CoU programming is harder to evaluate.

5.1.2 To what extent has CoU contributed to improved MCH, nutrition and basic education services for the target communities, particularly women and girls?

There is evidence to suggest improved maternal and child health, nutrition and basic education services have been provided to the target communities in Uruzgan. The number of patients in Uruzgan health facilities has continuously increased during the course of the program and women and girls are able to attend health facilities as much, if not more than men and boys. A greater number of patients suggests a greater accessibility of health facilities. There appears to have been a vast improvement in the quality and access of healthcare services, with healthcare professionals explaining that their clinics have been properly equipped and that they have new staff and also better trained staff. Those commenting on healthcare improvements attributed the positive changes to Save the Children, their partners or the CoU programmatic activities, suggesting that the program has contributed to the improvement. In turn, qualitative fieldwork indicates that there has been an improvement in both access and quality of education services, with elders and men and women in the community being positive about their children's schooling across all of the districts. Local government representatives also attested to the training of teachers and their higher skills. There was attribution of these improvements in education to the CoU program and Save the Children however CoU's efforts in relation to education must be examined against the backdrop of significant donor activity in the education space.

5.1.3 Have community attitudes towards health and education changed since the start of the program, and if so in what ways?

Community attitudes towards health and education appear to have changed positively since the beginning of the program. All of the healthcare workers and the majority of education workers reported that there had been positive changes in healthcare and education since the start of CoU's implementation. Increasing the supply and quality of healthcare and education seems to have also helped to change attitudes towards these services.

5.1.4 Has there been any change in health and education seeking behaviour among community members since the start of the program?

There is clear evidence of an increase in health and education seeking behaviour among the population, which is linked to the other elements of the program in terms of access and quality. The programmatic baseline and endline studies in Dehrawod show a clear upward trajectory with women showing health seeking behaviour that benefited themselves and their children. Vaccination data and the extremely positive views from health and education professionals working across the consulted districts indicates that this practice can be seen to reflect a trend across the province as a whole.

5.1.5 To what extent have the community development projects (village wells, women's parks, libraries, solar panels etc.) contributed to improving the lives of people in Uruzgan?

Community mobilisation and development activities were designed for CoU to build trust and support for the health and education outcomes and this is what they achieved. The majority of those consulted were happy with the results of the community development projects and they contributed to improving the lives of the people in Uruzgan. The community development projects also appeared to increase demand for the healthcare and education elements of the program once the community could see the help that CoU was able to deliver.

5.1.6 To what extent has the program delivered benefits for the most marginalised members of the target communities, including women and children (especially girls), people with a disability, ethnic and linguistic minority groups, remote communities?

CoU's programming directly targeted at women and girls conveyed significant benefits. Women and girls were trained as midwives and nurses in their communities, as CHWs and as members of FHAGs and this led to increased confidence and skill sets. The limited data available indicates that women and girls did benefit from health and education services generally, however services were less able to reach those with a disability or those in remote communities.

5.1.7 Has there been any change in attitudes among community leaders and members regarding the roles of women and girls in society since the start of the program?

There appears to have been a shift in reported attitudes by male community leaders towards women and girls which was shown through engagement with Save the Children's programmatic activities. It appears that although other actors had also been working to improve equity for girls and women since 2001, the CoU program may have helped to accelerate this process to ensure that women were given key skills that could help them and their communities practically whilst at the same time inculcating a different opinion about the role and status of women in Uruzgan. Training of religious leaders was a notable achievement of the program in helping communities to better understand the role women could play in contemporary Afghan society.

5.1.8 Has the program contributed to any provincial or national level policy reform?

Although there were gains at the provincial level and informing the national government in healthcare and education, there seems to have been limited progress in the area of influencing policy. Better communication with both local and national level stakeholders from the outset of the program could have meant there was more impact in this area.

5.1.9 Has research and pilot studies undertaken by CoU been used to inform MCH, nutrition and education policy and practice in any way?

The research and pilot studies that were completed were done so towards the end of the program rather than the beginning. As such, their ability to inform MCH, nutrition and education policy and practice was limited. Studies undertaken appeared to reflect and report on practice rather than provide a basis with which to improve it. The research completed was done so in isolation from the rest of the program.

5.1.10 Was the implementation strategy adopted appropriate for the insecure, and politically and socially complex operating context?

The six-month scoping stage undertaken on commencement of the program was regarded as an effective way to ensure the program was implemented in a conflict and culturally sensitive manner. This time ensured that the community were brought into the process of activity design. DFAT and Save the Children's flexibility to adjust programming was also noted as aiding the effectiveness of the program. These elements meant that the program demonstrated a strategy that was appropriate for the Uruzgan context. Indeed, DFAT commented 'the program was a high quality investment. It scored incredibly highly for effectiveness and efficiency [171].'

5.1.11 Has the program delivered any unexpected outcomes or changes, positive or negative?

The program did not deliver any significant positive or negative unexpected outcomes or changes. It did deliver some small positive changes that were unexpected. For example, DFAT remarked that because of the slow start and underspend 'two women's safe spaces were funded from interest earned. That was very positive [172] ' Save the Children staff also noted that there was increased capacity building of their own staff [173]. At the community level in Uruzgan there was some reporting of positive and some negative changes that were unexpected to them. However, while community members might not have expected these changes, many of them had been planned for in the program design.

[171] Key informant interview with DFAT representative by ACG, August 2015.
[172] Key informant interviews with DFAT representatives, by ACG August 2015.
[173] Key informant interview with senior program representative by ACG, August 2015.

5.1.12 What is the potential for the long-term sustainability of any program results that have been achieved?

The likelihood of sustainability of program results appears to be mixed. Whilst some of the elements of the program have continued, some have ended. Others may not be expected to continue without further donor funding or technical support. Program-influenced changes in healthcare and education access and quality may decline as professional staff become more difficult to attract to Uruzgan. The capacity building of key professionals such as midwives, nurses, male and female teachers and doctors are not likely to be sustained. With a lack of on-going training there is likelihood that technical skills and competence will diminish over time. Although new and refurbished schools and clinics may have been taken over by the government, if they are not stocked, maintained and repaired then their benefit to the community will decline. It is likely that the level of service quality will be the first area that witnesses degradation. Perhaps the most resilient aspect of the programs' sustainability will be its contribution towards changing community attitudes. For example by training midwives, teachers, community health workers and religious leaders, it can be reasonably expected that new attitudes fostered and supported will be sustained for some time.

5.2 Recommendations

5.2.1 Equity

Although there were attempts to focus on particularly needy beneficiary groups, specific activities were not always aimed at addressing equity concerns, particularly with regards to those people with disabilities. There were activities targeted for women and girls, however some female beneficiaries felt that they could have been consulted more directly during the life of the program. For example the education professionals from Tirin Kot pointed out that 'the program would have been more effective if the chief of the women's department and female teachers were consulted. Women should have been given a budget in the program or a garden or a market so that they could sell their handmade products in that market [174].'

Recommendation

Although women and girls were a major component of the proposal and design and many projects did specifically address them, they were not always included in the design of such elements themselves. As such, opportunities were missed to ensure that women and girls contributed directly to programming for themselves, and that the projects were the right ones. It is recommended that more efforts should be placed on including women and girls directly in the design and operation of the program and that this is accompanied by clear monitoring of outcomes for them in order to increase knowledge and understanding about what has been achieved for these groups in comparison to the general population and where and how services to them can be further improved.

[174] *Healthcare and education in Uruzgan* (August 2015) [Focus group] Sayed al Khan, Tirin Kot. Male teachers and school management.

5.2.2 Healthcare and Education

There were differences in the level and extent of the improvements in access and quality in healthcare as compared to education. This appears to be attributable to a number of different factors. First, the school construction element of the program ran into difficulty. It was management-time-consuming and led to misunderstanding with the Uruzgan government [175]. As a result refurbishment was prioritised over construction. Second, Save the Children's NGO partners in healthcare were much more experienced and efficient than the original NGO partners for education. The original two education partners were not operating effectively and there were allegations of corruption. One staff member explained that the education partners that were selected 'were not able to implement our program according to our standards so we terminated the contract' [176]. Another added 'this is why we had a steady flow of NGOs for education. We could have improved the selection process – that delayed programming with education because every time we had to keep changing partners [177].' Third, the health directorate had minimal staff turnover in comparison to the education directorate, who also had limited capacity, as a staff member stated 'the capacity of the education directorate was not what we expected. During my time four or five education directors were in place. It's hard to keep orientating them about the program and ensuring that we understand the new director from the beginning [178].'

Recommendation

Although it is clear that the program adapted as well as it could to issues with the capacity of both education partners and the education directorate, it appears that more could have been done to mitigate these problems from the start. For example, if a plan for capacity building and co-planning of certain, limited aspects of the program - with the education directorate - had been a part of the program's design, earlier and more sustained trust could have been established between the directorate and program personnel. The directorate could also potentially have been more effectively co-opted into the program's implementation and its successes. Constructive engagement with the education directorate is essential for sustainability of program achievements, and this is something that should be addressed in future programming where such a relationship is key to programmatic success. In future programming it will also be important for a cost/benefit and sustainability analysis to be conducted about the comparative value of educational facility refurbishment compared to large-scale new school construction. A more robust education partner recruiting system may also be helpful to introduce.

5.2.3 Research and policy

There is clear evidence to suggest that IR4 was not planned as effectively as it could have been nor that there was consistent leadership driving this component forward from the beginning. Without staff skilled in research techniques, management of this component of the program lacked direction and many opportunities to ensure appropriate baselines were in place, were missed. The research

[175] Key informant interview with senior program representative by ACG, August 2015.
[176] Key informant interview with senior program representative by ACG, August 2015.
[177] Key informant interview with senior program representative by ACG, August 2015.
[178] Key informant interview with senior program representative by ACG, August 2015.

carried out at the end of the program was not able to influence the program's activities in the way it had been conceived in the design phase of the program.

Recommendation

Full program baseline and endline monitoring and evaluation should be embedded within all future projects and programs. In future programs with specific research elements it is recommended that research is an integral part of the program from the beginning and designed to aid program delivery. In addition, ensure such components are assigned staff with a clear mandate and research skills and experience to drive the component forward in a strategic way. Program design "checkpoints" may also be beneficial to introduce, to enable learning from the program's implementation to be incorporated into activity design mid-way through implementation.

5.2.4 Program design, implementation and process

The program design was well-suited to the context in that it allowed for flexibility, adaptability and an extensive period of trust-building and community mobilisation. One suggestion for improved program design, discussed in 5.2.3 above, is that a more comprehensive approach to monitoring and evaluation research could have been integrated into the overall program approach, as well as into more of the program's individual projects and activities.

Recommendation

Ensure that future programs learn from the success of enabling a long scoping stage. The general flexibility and adaptability of this program enabled by close engagement with the funding agency is also a potentially replicable achievement. The built-in community engagement and community development project component of the program was successful and should be utilised in other, similar programs where community access may otherwise be impeded. An area for improvement is that future programs could more effectively embed monitoring and evaluation into program design from the outset (see above 5.2.3).

The program aimed to be sustainable and embedded sustainability planning into a number of its activities. However, sustainability should have been better prepared-for and sustainability aims should have more realistically taken into account limited government capacity. Sustainability planning may have benefited from being a core focus for the program, particularly in later years when residual Afghan government capability after the closure of the PRT became clear. Although there was an attempt to embed sustainability into the program, more could have been done to ensure that there was a smoother transition at the end of the program to Afghan government leadership of an expanded and improved healthcare and education system in Uruzgan.

Recommendation

It is recommended that sustainability planning is periodically revisited during each year of large programs in light of what had and had not been achieved in terms of the original plan for the proposal to ensure sustainability. In particular, sustainability may need to focus more on how to ensure sufficient resourcing is available to healthcare and educational facilities established during a program's implementation, and how community take-up of management of initiatives can be better planned-for once a program concludes.

ANNEX 01: PROGRAM IMPLEMENTATION FRAMEWORK

Result-Based Framework for the Children of Uruzgan program

Goal: to enhance access, quality and use of basic health and education services in the 6 districts of Uruzgan Province in Afghanistan.			
1)Increaseaccessand use ofMaternaland Child Health (MCH) servicesincludingthe treatmentofacutemalnutrition 2) Increase accesstobasiceducation andimprove delivery of comprehensiveeducationservicesforchildren			
IR1(Access):IncreaseaccesstoessentialMCH andnutritionservices;andbasiceducation. IR1.1HealthInterventions: • IR 1.1.1 Expanding basic package of health services toremote and under-serviced communities • IR1.1.2 Community case management of childhoodillnessesespecially pneumonia; diarrhoeaandfever • IR 1.1.3Managingacutemalnutrition throughа comprehensivenutritionrehabilitationapproac h. • IR1.1.4 Increasing accessofmothersand newborns toMaternal andNewbornCareservices (MNC)throughmidwifes IR1.2 EducationInterventions: • IR1.2.1Constructionofschoolstohelpimprove accesstoeducationalservices,particularlyforgi rls • IR1.2.2Increaseaccesstonon-formal education opportunities for girls and boys in targeted communities • IR1.2.3Increase number of female teachers • IR1.2.4 Establish Young Women / Mother's Literacy groups • IR1.2.5 Establish Early Childhood Care and Development (ECCD) groups • IR1.2.6 SchoolHealth Education and WASH provision	IR2(Quality):Enhance qualityofMCHand nutritionservices;andeducationservice s: IR2.1HealthInterventions: • IR 2.1.1 Operational Research: Community basedMaternalandNewborn Careservices (MNC)bytrainingfemale CHWs andFamily HealthActionGroup (womenvolunteers) IR 2.2 Education Interventions • IR2.2.1Improved teachingandschool management skillsofteachers andschool principals/headteachers • IR2.2.2Improved relationship withand increasedcapacityofMoEprovinciala nd districtdepartments • IR 2.2.3 Increased capacity for the TeacherTrainingCollegeinUruzgan • I R 2.2.4 Increased participation of girls andboysinstudentgroups IR 2.3 Cross cutting • IR2.3.1Improved capacity ofSavethe Children andpartnerstaffto carryout projectactivitysuccessfully	IR3(Demand): Createawareness and enhance demand forutilizationofMCH, nutritionservices;andbasiceducation. IR 3.1 Cross cutting: • IR3.1.1Capacity buildingofreligious leaderstoadvocateforimportanceof healthandeducation • IR3.1.2Enhancecommunitysupport for improved health services and qualityprimaryeducation forgirlsand boysintargetedcommunities • IR 3.1.3Capacity buildingofNGO managementandhealthfacilitystaffin IPC/Candhealtheducation • IR 3.1.4 Increase community awarenessthroughIECmaterials • IR3.1.5Small-scale community improvement programtosupportthe communityengagementprocess	IR4(Policy andResearch):In conjunction withglobal academic institutes, conductresearchtosupport andinformon-going policyand programmingin MCH,nutrition and basiceducationinAfghanistan IR 4.1 Research and Policy Intervention s: • IR4.1.1Establish academiclinks between theAfghanistan Research Instituteandacademicinstitutionsin Australia andacrosstheworld providingthe opportunityto design andconductoperational researchin theareasofMCH,nutrition andbasic education. • IR4.1.2Document program interventions andbestpracticeand presentandshareevidence of interventions withkeystakeholders includinggovernments, donor organisations, workinggroupsand otherpartnerorganizations • IR4.1.3Establish linkages and enable information gathered through this program to support Save the Children's global campaigns including the 'Everyone' campaign and 'Rewrite the Future'

ANNEX 02:

TERMS OF REFERENCE FOR AN EVALUATION OF THE CHILDREN OF URUZGAN PROGRAM, URUZGAN PROVINCE, AFGHANISTAN

BACKGROUND

The *Children of Uruzgan* (CoU) Program is Save the Children Australia's flagship program in Afghanistan. Funded by the Australian Department of Foreign Affairs and Trade (DFAT) (budget: AUD $35.7m), CoU is one of the most ambitious development programs ever undertaken by an Australian NGO.

CoU was initiated as part of the Uruzgan Provincial Reconstruction Team's efforts to rapidly deliver services that the Afghan Government was unable to provide in an environment of instability and insecurity. The program was designed as part of broader Australian, Afghan and international efforts to improve perceptions of government legitimacy and it represents Save the Children's participation in a unique chapter of Australia Aid, operating alongside the Australian Government's civil-military intervention until the withdrawal of Australian troops in 2013 and continuing beyond the withdrawal. The start-up phase of CoU commenced in June 2011 and programming activities will conclude by September 2015.

The purpose of CoU is to enhance access to, quality of and demand for basic health and education services in the seven districts of Uruzgan province. CoU aims to reach an estimated 300,000 beneficiaries with a particular focus on women and girls, ethnic minorities and those in remote and under-serviced communities.

In addition to the focus on health and education outcomes for communities in the region, the program also aims to conduct research and pilot studies to demonstrate good practice and effective methodology and ultimately influence national level health and education policy.

The CoU program design established two specific objectives and four intermediate result (IR) areas related to *access*, *quality* and *demand* for health, nutrition and education services, as well as conducting research to build an *evidence base* to inform future programming and policy in these sectors:

Specific Objectives:

1. Increase access and use of Maternal and Child Health (MCH) services including the treatment of acute malnutrition
2. Increase access to basic education and improve delivery of comprehensive education services for children

Intermediate Results:

IR1 *(Access)*: Increase access to essential MCH and nutrition services and basic education

IR2 *(Quality)*: Enhance quality of MCH and nutrition services and education services

IR3 *(Demand)*: Create awareness and enhance demand for utilisation of MCH, nutrition services and basic education

IR4 *(Policy & Research)*: In conjunction with global academic institutes, conduct research to support and inform on-going programming in MCH, nutrition and basic education in Afghanistan

The detailed components of the intermediate result areas are included in Annex 1.

Purpose and Scope of the Evaluation

Routine monitoring conducted throughout the CoU program lifecycle has focused largely on the delivery of *outputs*. This has been backed up by a series of case studies, baseline and endline assessments and research studies conducted to showcase particular aspects of the program such as the training school for midwives, results of a reading assessment for students in community-based education, and the engagement of religious and community leaders in the program to foster support for health and education initiatives.

The purpose of this final program evaluation is to assess the extent to which the intermediate results have been achieved and the overall program objectives realised. The evaluation will focus at the *outcome* (effects) level as well as assessing the potential for longer-term impact and sustainability of benefits beyond the life of the program.

The evaluation will analyse changes that have occurred in the target communities since the inception of CoU and assess if and/or how CoU has contributed to these. In addition to assessing the extent to which CoU has been effective in improving health and education outcomes for communities in Uruzgan Province, the evaluation will also examine the extent to which the program has been able to influence local, provincial and national health and education policies and practice.

Women and girls are a key constituency for CoU and the evaluation will place particular emphasis on the extent to which the program has considered and addressed gender issues, and the resulting effects, throughout its lifecycle. The evaluation will consider the extent to which CoU has delivered benefits for, and influenced any change in the lives of, the most marginalised groups including women and girls, ethnic and linguistic minority groups, people with a disability and the most remote communities in the locations where the program has been delivered.

Finally, the evaluation will consider the enablers and constraints to achieving the program's stated objectives in the complex and insecure Uruzgan operating context. It will examine the approaches Save the Children has adopted to deliver the program and how efficient and effective these have been.

The evaluation will focus at both national (Kabul) and provincial (Uruzgan) levels. Districts and communities to be included in the provincial level field work will be selected in consultation with Save the Children in accordance with agreed criteria including but not limited to the level of programming in different districts, community profiles, degree of government control, remoteness and security.

Objectives and Key Evaluation Questions

The overall objective of this final evaluation exercise is to assess the extent to which the stated program objectives and intermediate results have been realised. The evaluation will focus at the outcome level (effects) and will be guided by the following key questions:

Overarching questions:

- To what extent has CoU contributed to improved MCH, nutrition and basic education services for the target communities, particularly women and girls?

- Has there been any change in the MCH, nutrition and education status of the population of Uruzgan since the program commenced and if so, to what extent can this be attributed to CoU?

Sub-evaluation questions:

- Have community attitudes towards health and education changed since the start of the program, and if so in what ways?
- Has there been any change in health- and education-seeking behaviour among community members since the start of the program?
- To what extent have the community development projects (village wells, women's parks, libraries, solar panels etc) contributed to improving the lives of people in Uruzgan?
- To what extent has the program delivered benefits for the most marginalised members of the target communities, including women and children (especially girls), people with a disability, ethnic and linguistic minority groups, remote communities?
- Has there been any change in attitudes among community leaders and members regarding the roles of women and girls in society since the start of the program?
- Has the program delivered any unexpected outcomes or changes, positive or negative?
- Has the program contributed to any provincial or national level policy reform?
- Has research and pilot studies undertaken by CoU been used to inform MCH, nutrition and education policy or practice in any way?
- Was the implementation strategy adopted appropriate for the insecure, and politically and socially complex operating context?
- What factors have acted as enablers or constraints to the successful implementation of the program?
- What is the potential for the long-term sustainability of any program results that have been achieved?

METHODOLOGY

An independent, external consultant will be recruited to lead this evaluation. The consultant will develop the evaluation methodology in consultation with representatives from Save the Children's Kabul and Melbourne Offices. It is envisaged the methodology will include but not necessarily be limited to:

- Literature review of relevant background documentation (country documentation, policy documents, assessments etc)
- Desk review of CoU program level documentation including program design document, monitoring and evaluation data, progress reports, meeting and workshop reports, case studies, research reports
- Synthesis and analysis of quantitative program monitoring data across the life of the program
- Gathering and analysis of provincial and national level secondary health and education data
- Interviews with Save the Children's CoU partner organisations in Uruzgan and Kabul
- Interviews with provincial government officials and community and religious leaders in Uruzgan
- Focus group discussions with program beneficiaries including community members, health workers, teachers, children
- Interviews with relevant key informants at national level in Afghanistan including government officials, relevant technical and policy advisors, relevant UN representatives (eg UNICEF), INGO representatives
- Interviews with DFAT representatives in Kabul and Canberra and selected other donors (eg GIZ)

- Interviews with relevant Save the Children staff in Kabul and Melbourne

Save the Children will work closely with the consultant on the design of this evaluation including agreeing key documents for review, the list of key respondents for interview, and inputting into and signing off on the proposed tools and approaches including interview tools to be administered.

Where data does not already exist (for example secondary health and education data) the consultant will need to generate ways to measure change that stand up to critical analysis.

Intended Audience

The findings of this evaluation will be disseminated to key stakeholders at provincial and national level in Afghanistan including policy makers, donors, academics and peer NGOs as well as key stakeholders in Australia including the Department for Foreign Affairs and Trade (DFAT), academics and peer NGOs. It is anticipated DFAT will use the findings to inform future programs in similar complex operating environments as well as to showcase the investment in CoU. The research component of CoU is intended to inform Government of Afghanistan health and education policy, planning and delivery. Beyond the specific research products produced by CoU, the findings from this evaluation will be shared with the relevant Ministries to inform them of the progress in health and education delivery in Uruzgan Province and analyse the potential for further use of CoU research products for health and education programming within Uruzgan and nationally. Save the Children will use the findings to inform current and future health and education programming, drawing in particular on lessons for programming in complex, insecure and highly marginalised settings.

Deliverables

The key deliverables for this evaluation are the following:

- An inception meeting in Kabul with relevant Save the Children and external stakeholders (DFAT, Afghanistan government officials, partners, peers, academics) to present the evaluation approach, engage stakeholders and seek inputs and advice
- An inception report (8 pages maximum) outlining the detailed work plan for conducting the evaluation, a timeframe for completion of each step, an agreed list of resources to be reviewed and analysed, and an outline of the methodology to be used (including core questions).
- A one-day workshop in Kabul to present and discuss preliminary key findings to relevant Save the Children and external stakeholders including donors, partners, government officials and peer organisations.
- A final report that concisely presents the main findings and recommendations with regards the overall objective and key questions outlined in this terms of reference, incorporating feedback from Save the Children and other relevant stakeholders. The final report will be no more than 30 pages (ex annexes) and include an executive summary, introduction, background, scope and limitations, key findings and recommendations.
- An inventory of all background materials reviewed during the evaluation (bibliography).
- Any data gathered and analysed during the evaluation (including notes from interviews).

The Consultant

The successful consultant should have the following skills:

- Knowledge and expertise in design and delivery of development programs in Afghanistan
- Experience working in multi-cultural environments

- Demonstrable experience in monitoring and evaluating health and education programs, including the development and use of quantitative and qualitative data collection tools and participatory evaluation methods
- Strong analytical skills
- Excellent report writing skills
- Knowledge of Uruzgan Province desirable
- Willingness to work in insecure environments

It is essential that the successful consultant can operate independently in Afghanistan, including in Uruzgan Province. Save the Children expects the successful consultant to engage local research capacity to collect and analyse provincial and national level data, including collection of field level data from Uruzgan Province. As noted above, the specific sites for provincial level data collection will be agreed jointly between the consultant team and Save the Children in accordance with established criteria.

TIMEFRAME

An indicative timetable for the evaluation is provided below. The exact schedule will be agreed between the successful consultant and Save the Children Australia.

Indicative Date	Event/Activity
April 2014	Terms of Reference finalised and advertised
May 2014	Contract signed Detailed workplan and agreed timeframe Sharing and review of key documents and data Briefing Inception meeting in Kabul
May 2014	Literature review Develop Methodology for review including interview and FGD tools Evaluation methodology and tools agreed and signed off by Save the Children
June –July 2014	Field work in Uruzgan and Kabul
August 2014	Analysis Workshop to present and discuss preliminary findings with Save the Children staff and key external stakeholders
August 2014	Initial draft report submitted to Save the Children
August/September 2014	Feedback provided on draft report
September 2014	Submission of final report to Save the Children

MANAGEMENT AND LOGISTICS

Save the Children Australia will be responsible for contracting and managing the external consultant. Save the Children Afghanistan will facilitate the consultant's access to all relevant background materials and monitoring data. Save the Children Afghanistan will facilitate relevant introductions to key individuals and respondents in the selected districts where field work will be undertaken in Uruzgan Province but the consultant and their team will need to manage provincial level logistics including travel to selected sites. The consultant is responsible for all necessary translation and transcription.

CONFIDENTIALITY

All data collected during this exercise will become the property of Save the Children and will not be shared with third parties without the express permission of Save the Children.

INSURANCE

The successful consultant will be required to have in place insurance arrangements appropriate to provision of the requirements in this Terms of Reference including travel insurance.

OTHER

Save the Children is committed to ensuring a safe environment and culture for all children with whom we come in contact during the course of our work. Any external person involved in this evaluation will be required to comply with Save the Children's Child Safeguarding Policy and sign the Code of Conduct.

Annex 1. CoU specific objectives and intermediate result areas

CoU has two specific objectives and four intermediate result (IR) areas. Each IR is broken down into detailed components as shown in the table below.

Specific Objectives:

1. Increase access and use of Maternal and Child Health (MCH) services including the treatment of acute malnutrition
2. Increase access to basic education and improve delivery of comprehensive education services for children

Intermediate Results:

IR1 *(Access)*: Increase access to essential MCH and nutrition services and basic education

IR2 *(Quality)*: Enhance quality of MCH and nutrition services and education services

IR3 *(Demand)*: Create awareness and enhance demand for utilisation of MCH, nutrition services and basic education

IR4 *(Policy & Research)*: In conjunction with global academic institutes, conduct research to support and inform on-going programming in MCH, nutrition and basic education in Afghanistan

Intermediate Results for Health Interventions	
IR 1.1.1	Expanding Basic Package of Health Services to remote and underserved communities
	Train community health workers
	Establish health sub-centres
	Establish mobile health teams
IR 1.1.2	Community-based integrated management of childhood illnesses
IR 1.1.3	Managing acute malnutrition through a comprehensive nutrition rehabilitation approach
IR 1.1.4	Increasing access of mothers and newborns to maternal and newborn care services through midwives and nurses
IR 2.1.1	Community-based maternal and newborn care services by training female Community Health Workers and Family Health Action Group members
IR 3.1.2	Community support for health services
IR 3.1.3	Capacity building of NGO management and health facility staff in interpersonal communication IPCC and counselling
IR 3.1.4	Increase community awareness through IEC materials
IR 3.1.5	Utilise public-private partnerships in the health sector to expand quality and coverage of health services
IR 3.1.5	Reduce drug dependency and usage through the drug treatment and counselling centres
IR 3.1.5	Medium-sized grants
Intermediate Results for Education Interventions	
IR 1.2.1	Construction and refurbishment of schools and WASH facilities to help improve access to educational services, particularly for girls

IR 1.2.2	Increased access to non-formal education opportunities for girls and boys in targeted communities
IR 1.2.3	Increased number of female teachers
IR 1.2.4	Establish adult literacy groups
IR 1.2.5	Establish early childhood development groups
IR 1.2.6	School health and nutrition
IR 2.2.1	Improved teaching and school management skills of teachers and school principals/head teachers
IR 2.2.2	Improved relationship with and increased capacity of Ministry of Education provincial and district departments
IR 2.2.3	Increased capacity for the Teacher Training College in Uruzgan
IR 2.2.4	Increased participation of girls and boys in student groups
IR 3.1.2	Community support for education
Intermediate Results for Community Mobilisation and Capacity Building Interventions	
IR 2.3.1	Improved capacity of Save the Children and partner staff to carry out project activities successfully
IR 3.1.1	Capacity building of religious leaders to advocate for importance of health and education
IR 3.1.5	Small-scale community improvement program to support the community engagement process
IR 3.1.5	Medium-sized grants
Immediate Results for Policy and Advocacy Interventions	
IR 4.1.1	Establish academic links between the Afghanistan Research Institute and academic institutions in Australia and across the world providing the opportunity to design and conduct operational research in the areas of maternal and child health, nutrition and basic education
IR 4.1.2	Document program interventions and best practice and present and share evidence of interventions with key stakeholders including governments, donor organisations, working groups and other partner organisations
IR 4.1.3	Establish linkages and enable information gathered through this program to support Save the Children's global campaigns including the 'Everyone' campaign and 'Rewrite the Future'

Annex 2. Key documents (as at March 2015)

Many of the documents listed below are available at the Children of Uruzgan website: www.childrenofUruzgan.org.au; others will be shared with the successful consultant as required.

Program documents
Program proposal
Uruzgan Safety and Security Plan
ID and DNH Strategy
Performance, monitoring and evaluation plan
Conflict sensitivity and contextual analysis
Mid Term Review
Budget
Activity reports
Start-up phase, quarterly, midyear and annual reports (*approx. 18*)
Research reports under IR4
Access Restricted (report on remote monitoring)
Community perceptions of barriers to health care
Conflict-sensitive education approaches
Girls education and conflict sensitivity
Understanding Risk
Children's Voices
Report on CoU and civil-military programming
Baseline/endline surveys and reports
SHN baseline
CIMCI baseline
CIMCI endline
MNC baseline Dehrawod
MNC endline Dehrawod
MNC baseline Chora
ECD KAP survey
CBE EGRA baseline
CBE endline brief (includes ASER baseline data)
Basic education survey
Evaluation of the DTC
Case studies
Approximately 30 studies
Curricula
ECD
GLiTTA
Helping all Children Learn

ANNEX 03: DATA SOURCES REFERENCED BY EVALUATION

Below we set out the relevant data sources identified and examined by ACG's evaluation team to inform the evaluation evidence collection and analysis:

1) PRT Uruzgan Monitoring and Evaluation Program (UMEP) data provided to Save the Children:

- **Description:** The UMEP data provided by the Uruzgan PRT to Save the Children presents the results of a research commissioned by DFAT and which was conducted in 2012 and 2013. It focused on Afghan perceptions of the capacity and sustainability of government services in Uruzgan province, Afghanistan. Two main topics were provided as data and limited analysis to Save the Children by the Uruzgan PRT: Healthcare and Education.
- **Use in the evaluation:** The data showed the clear demand for education and healthcare in Uruzgan and a general impression of improvement in both fields, which were backed up by quantitative data and these results have been used where possible among the report. However, the time period and focus on governance means it is not possible to use the data for hard outcome indicators. Notably two thirds of Uruzganis credited the government with the improvement in the quality of healthcare.

2) The Asia Foundation (TAF), *Survey of the Afghan People*, data:

- **Description:** The Asia Foundation conducted early reports on Afghanistan people between 2011 and 2015. They provided us with the details of responses for Uruzgan, allowing us to compare broad trends between the local and national levels.
- **Use in the evaluation:** The reports were useful to see the evolution of certain indicators during the duration of the program in Uruzgan and compare it to the evolution of opinions among the rest of Afghans. However, due to security reasons, some questions could not be answered for one or several years. Moreover, the details of respondents were not available. The TAF data corroborated the findings of the UMEP report in showing the demand for education and health. It also went deeper by touching at gender issued and perceived solutions.

3) World Bank:

- **Description:** The World Bank provided complementary data on literacy in Afghanistan in 2011.
- **Use for the evaluation:** This data was used as a reference when comparing national evolutions of literacy levels in Afghanistan.

Available at: http://databank.worldbank.org/data/reports.aspx?source=2&country=AFG&series=&period=

4) UN Inter agency group for Child Mortality Estimation:

- **Description:** The UN Inter agency group for Child Mortality Estimation informed the desk based review on levels of child, infant, and under 5 mortality in Afghanistan.
- **Use for the evaluation:** These levels were used as a reference to compare national and provincial levels in the field of child mortality.

Available at: http://www.childmortality.org/index.php?r=site/compare

5) UNICEF:

- **Description:** UNICEF had data on antenatal care for the year 2012 in Afghanistan as part of their general database of key indicators on the country.
- **Use in the evaluation:** The desk review used UNICEF data for an endline in number of ANC visits provided to pregnant mothers in Afghanistan. This data was used for comparison purposes with Uruzgan - specific data.

Available at: http://www.unicef.org/infobycountry/afghanistan_statistics.html

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6) Afghanistan Mortality Survey 2010:

- **Description:** The Afghanistan Mortality Survey was an all-encompassing survey of mortality in Afghanistan. It contains data on General, Child and Maternal mortality for the year 2010, as well as related rates and indicators.
- **Use in the evaluation:** This survey was useful in providing the desk review with a baseline of mortality rates in Afghanistan and also details on maternal health, number of ANC visits, and conditions of deliveries. However, the lack of a follow up survey (one is due in the next year) means it is not possible to use it to assess outcome results. Further, the survey does not give province-specific data and cannot be used for Uruzgan directly.

7) National Risk and Vulnerability Assessment:

- **Description:** This assessment was implemented by the Central Statistics Organisation of the Government of the Islamic Republic Afghanistan and was produced with the assistance of the European Union. Two waves of research have been conducted to date, one for the years 2007 and 2008, published in 2009, and one for the years 2011 and 2012, published in 2013. Both of them aimed at assessing the living conditions in Afghanistan. Among the themes covered by the assessments are education, gender equality and health. Some of the indicators treated include literacy rates, school attendance, and access to education facilities, ANC coverage, and conditions of deliveries.
- **Use in the evaluation:** This data was used for general information about Uruzgan and Afghanistan such as demographic and social indicators. They were also used to get a snapshot of the 2015 conditions of access to education facilities in Uruzgan and how they compare to the rest of the country. Other data from the NRVA such as literacy and attendance to education facilities were also used to triangulate existing data.

8) Ministry of Public Health, Government of Afghanistan

- **Description:** The Ministry of Public Health has a large quantity of statistics it has collected throughout the country and per province, through an annual report conducted in 2009 (1387). But the richest database is the Health Management Information System which gathers all the data from Health facilities in Uruzgan.
- **Use for the evaluation:** This data was used for an analysis of the evolution of attendance in health facilities, profile of patients, and typology of their health needs. This informs the evaluation of Children of Uruzgan projects, and their appropriateness to the local context. This also show what have changed in the province since the beginning of the project, and what still needs to be done.

9) Ministry of Education, Government of Afghanistan:

- **Description:** This data contained quantitative data on school enrolment per level, gender, province and type of school.
- **Use for the evaluation:** They show similar increase in overall enrolment in Uruzgan and in Afghanistan, even though female enrolment remains relatively much lower in Uruzgan. Interestingly it shows contradicting trends in the number of schools. While at the national level, stronger enrolment went along a reduction of the number of education facilities (except for religious schools), Uruzgan has seen a consistent increase in the number of education establishments.

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10) World Food Program:

- **Description:** The World Food Program has monitored Food Security in Afghanistan and released bulletins presenting their findings in 2007-2008. They have also collected information on Uruzgan specifically which was used to establish an analysis of evolution of Food Security in the province between 2005-2008.
- **Use for evaluation:** These document served the evaluation as a baseline on the topic of nutrition and provide insight on general trends in Uruzgan regarding nutrition and malnutrition. These show a pre-existing trend in the improvement of nutrition which occurred during the duration of the project and could qualify the instrumentality of the Children of Uruzgan project.

11) National Nutrition Survey:

- **Description:** The National Nutrition Survey was developed by the Ministry of Public Health with the help of UNICEF in 2013. It provides a comparison of malnutrition and access to water and hygiene facilities in Afghanistan and per province including Uruzgan.
- **Use for evaluation:** This source was used as a snapshot of the nutrition and hygiene status of Uruzgan during the year 2013. This showed how Uruzgan compares to the rest of Afghanistan in terms of nutrition. By triangulation with other sources this survey also served as a comparison point with baseline data in the relative position of Uruzgan to other provinces.

12) National Immunization Coverage Survey Afghanistan 2013:

- **Description:** This survey, conducted in 2013, was organised by the General Directorate of Preventive Medicine & National EPI Office Ministry of Public Health and the Central Statistics Office, with the help of the UNICEF. The aim of the survey was estimate the levels of immunisation coverage at national and sub-national levels among children aged 12-23 months and Tetanus Toxoid (TT) immunisation coverage among mothers of children 0-11 months.
- **Use for evaluation:** This survey was used for evaluating vaccination status in 2013. The evolution of the vaccination levels was estimated against the outputs of the Children of Uruzgan program. This also provided information on the position of Uruzgan compared to the rest of the country. Finally, it provided insight on the reason for no immunisation and was used to assess if the methodology proposed by Children of Uruzgan regarding vaccination were appropriate. The survey suggested that Children of Uruzgan was correct in its assessment of factors hindering vaccination, and attempted to address all of them but infrastructural ones.

13) Uruzgan Household Survey Report:

- **Description:** This survey was conducted in 2013 by the Afghan Health and Development Services to measure the achievements of the NGO since 2011. It focusses on the three districts of Uruzgan were projects have been implemented: Tirin Kot, Chora, and Dehrawod.
- **Use for evaluation:** This report informed the evaluation by looking into practices and knowledge of Uruzganis in the fields of contraception and Maternal care. More importantly it provided a reference for the assessment of Children of Uruzgan by highlighting the results of a similar project. Finally, it provided a more localised view of key indicators by focussing on only three of the six districts of the province. This was useful to highlight potential contrasts with other districts.

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14) Basic Package of Health Services 2010:

- **Description:** This report was drafted in 2010 as a successor to the 2003 version of the BPHS, which was already revised in 2005. Its aim was to reassess the needs of Health Services across Afghanistan and shift national policies and practices accordingly. It exposes the needs of Afghan and the government's priority for health services.
- **Use for evaluation:** The BPHS provided valuable information on the types of services available in the health facilities and on the typology of illnesses. This information was triangulated with the HMIS data for Uruzgan to highlight the specific needs of Uruzgani and the specific context of the province. This was essential to assess the appropriateness of the inputs of the Children of Uruzgan project, as well as the situation of Uruzgan at the beginning of the project compared to the national level. This among other things showed rather the Children of Uruzgan program was in accordance with the government's policy on the delivery of health services.

15) Uruzgan Nutrition Survey for estimation of prevalence of malnutrition and Infant and Young Child Feeding:

- **Description:** This survey was part of the "Bolstering the Nutrition Components of BPHS-EPHS" project implemented by AHDS in partnership with Cordaid in the Uruzgan province between 2011 and 2012. It provided an endline for the project by measuring major nutrition key indicators.
- **Use for the evaluation:** This survey was used to complement the data available on nutrition in Uruzgan. It was used in comparison with the Uruzgan Household Survey Report to show evolutions in Tirin Kot, Dehrawod, and Chora.

ANNEX 04: RESEARCH & POLICY (IR4) REPORTS & ACTIVITIES

- Children of Uruzgan (2014) "Maternal and newborn care survey" January 2014: A cross-sectional knowledge, attitudes and practices survey of 899 mothers with children aged 0-6 months in Dehrawod district.
- Children of Uruzgan (2012) "Early childhood development survey" September 2012: A cross-sectional knowledge, attitudes and practices survey of 836 mothers with children aged 3-6 years in Tirin Kot, Dehrawod and Chora districts.
- Children of Uruzgan (2015) "Nutrition assessment" May 2015: An anthropometric survey of children aged 6-59 months and pregnant and lactating women in 497 households in Tirin Kot, Dehrawod and Chora districts.
- Children of Uruzgan (2014) "Early grade reading and maths assessment" June 2014: Children 5-10 years old in CoU-supported CBE classes were assessed on their reading and maths skills.
- Lamey, J (2015) "Children's Voices" April 2015: Participatory research with children in Uruzgan occurred during Year 3 with the theme "positive visions of the future."
- Burde, D & Khan, J(2014) "Increasing Girls' Access to Education while Remaining Sensitive to Conflict: Understanding Community Responses to International Interventions in Uruzgan, Afghanistan" 2014.
- Coghlan, B (2014) "Health service utilisation and health-seeking behaviours" November 2014: This research project was conducted in partnership with the Burnet Institute, Australia. It examined the health-seeking behaviours of individuals, households and communities in Uruzgan province and how these relate to CoU's health programming. The findings pointed to a need for more community awareness to bridge the gap between citizens and the health system. Dr Ben Coghlan of Burnet made a presentation via video-link to MoPH officials and other stakeholders in Kabul in November 2014.
- Sims, D (2014) "Understanding risk" 2014: A research paper was completed on the different ways in which staff engaged in the CoU program perceive and respond to risk. The report was submitted to DFAT in August 2014.
- Barber, R (2012) "A Review of Remote Monitoring Practices in Uruzgan Province" (Access Restricted) November 2012: Researched and written by Rebecca Barber, Humanitarian policy and advocacy advisor, Save the Children. This paper aimed to increase understanding of the challenges faced in developing and implementing remote monitoring strategies, and to provide recommendations for improving program oversight in areas that cannot regularly be accessed by non-local staff. Recommendations are aimed primarily at development actors in Uruzgan, however they may also be of broader relevance to development actors elsewhere in Afghanistan and around the world. The findings from this paper were also presented at the 8th International Lessons Learned Conference in Sydney (3-6 December 2012 and at the regular AusAID Afghanistan Working Group Meeting in Canberra (13 December 2012).
- Maranto, R, Shirzad, A, Stannard, H & Zahid, M (2013) "Children of Uruzgan: reflecting on conflict-sensitive education approaches in a conflict zone" October 2013: This paper, written by Save the Children staff, examined CoU's community-based education utilising the International Network for Education in Emergencies guiding principles on conflict-sensitive education programming. The paper was delivered on a panel at the World Conference on Humanitarian Studies from 24-27 October 2013 in Istanbul, Turkey.
- Conference of the Comparative and International Education Society (CIES) 2013: CoU successfully submitted two papers and one poster to the annual CIES conference held from 10-15 March 2013 in Toronto, Canada. The papers included: 1) Burde & Khan "Relation between promotion of education rights and sensitivity towards culture regarding women and girls", 2) CoU "What it takes for women in Uruzgan province to access education: examples of successful community mobilisation efforts in southern Afghanistan" (poster); and 3) "Children of Uruzgan: reflecting on conflict-sensitive education approaches in a conflict zone".

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- Brief on Community-based education 2014: A brief on CBE programming was published during Year 3. It outlined CoU's approach to community education and explained the methods through which the program aimed to improve and maintain the quality of education being provided through the CBE classes. The brief also contained results from an assessment of student literacy as well as a case study and photos.
- Brief on School health and nutrition 2014: A brief was developed to explain CoU's approach to School Health and Nutrition programming. This was particularly useful to inform national MoE and MoPH officials as they began the process of considering ways to enhance school health programming throughout Afghanistan. The brief was submitted to DFAT in November 2014.
- Brief on Public-private partnerships for health 2014: A brief was developed to better explain the approach being taken by CoU to its public-private partnerships in Uruzgan. The brief outlined the rationale for partnering with private health practitioners, detailed the training and administrative systems that support the approach, and outlined some of the key achievements and lessons learned through the process. The report was submitted to DFAT in August 2014.
- Health presentations in Kabul 2014: On 17 June 2014, the Senior Technical Manager for Health presented the results of CoU's Maternal and newborn care project to the national Community-Based Health Care Task Force.
- Guest lecture 2014: On invitation from the University of Sydney, CoU team members from Melbourne presented a guest lecture to students undertaking a masters course in International Policy Management at the Australian School of Government. Save the Children were invited in their capacity as an international organisation to demonstrate the challenges of administering international programs in third world or developing contexts. The presentation was well received and students provided positive feedback on their impressions of CoU and the work of Save the Children.
- Save the Children (2014) "The State of the World's Mothers" 2014: Save the Children's flagship global report, "The State of the World's Mothers," placed special focus on Afghanistan in 2014, noting that it had moved 33 places up the index despite the significant challenges facing the country. The CoU program contributed to this worldwide campaign for enhanced focus on Maternal care by successfully placing an op-ed in Melbourne's Herald Sun on 8 May 2014. The article focussed on improvements that have been made to Maternal and child health in Uruzgan, especially a drop in Maternal and infant mortality, through a combination of improved services and increased knowledge among mothers and their communities. It had a circulation of 400,000 and also highlighted the contribution of Australian Aid in this outcome.
- CoU symposium: Convened on 7 May 2015 to coincide with the exhibition opening in Melbourne, this event was co-hosted by Deakin University and brought together a wide variety of academics and practitioners to discuss CoU experience and wider aid topics.
- Photo Exhibitions: An exhibition showcasing images from CoU took place in multiple locations in 2015: Melbourne (May-June), Sydney (June-Aug), Canberra (Aug-Sep) and Kabul (September). It involved the development of a photo-book that provides a good overview of the program and its achievements. The Australian Embassy in Afghanistan hosted the Kabul exhibition event.
- Parliament house: The Australian Foreign Minister and other officials attended a special event at the national parliament on 12 August to see the photo exhibition and announce the new program to be implemented in Afghanistan as a no-cost-extension of CoU. The same day, a CoU research report was presented to government officials at a closed meeting.
- The Melbourne Writers Festival 2015 incorporated CoU in a variety of ways, with a focus on the needs of children on conflict zones. It included famous authors and journalists along with Save the Children staff.

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- Community engagement event: Save the Children convened a panel event with other NGOs in Afghanistan to discuss community engagement methods using the experience of CoU as a basis for discussion. It took place in Kabul on 14 September 2015.
- London: A final series of events were expected to take place in London in September 2015. These were in preparatory stages at the time of the evaluation and were planned to include a symposium with the University of London, workshops with Save the Children UK and a lecture at Manchester University.