World Vision®

FINDING SOLUTIONS

for Women's and Girls' Health and Education in Afghanistan

2016 | A meta-analysis of 10 projects implemented by World Vision between 2007-2015 in Western Afghanistan

BACKGROUND

Afghanistan made significant improvements toward the Millenium Development Goals (MDGs) by reducing the maternal mortality rate (MMR) from 1200 in 1990 to 400 in 2015, and cutting in half the number of deaths registered among children under five (CU5) for the same period.

The three-decades long conflict, however, continues to be a barrier to development. The major factor in poor maternal and child health is the low coverage of essential interventions with wide disparities between various wealth quintiles.

Antenatal care (ANC) coverage (by a doctor, nurse, or midwife) is low in Afghanistan. Only 48 per cent of women receive care one or more times from skilled health personnel (MICS 2010). Over 60 per cent of births are attended with the assistance of non-skilled personnel. More than half of births occur at home, at 65 per cent (MICS 2010).

Only 54 per cent of babies are breastfed within one hour of birth, while 84 per cent of newborns in Afghanistan start breastfeeding within one day of birth, with notable differences by region (MICS 2010). 54 per cent of children ages six months and under are exclusively breastfed (NNS 2013).

There are major concerns with the reach of vaccination coverage in Afghanistan. Only 18 per cent of children between the ages of 12 - 23 months are fully vaccinated, while one in four children receive no vaccination before the age of one, leaving only 31 per cent of Afghan children who possess vaccination cards (MICS 2010).

The prevalence of diarrhoea in children under age five is 23 per cent and pneumonia is 19 per cent, varying by region (MICS 2010). Approximately 54 per cent of children with diarrhoea received oral rehydration salt (ORS) or some kind of recommended home fluid (MICS 2010). Only 61 per cent of children with pneumonia are taken to an appropriate care provider with 64 per cent receiving antibiotics (MICS 2010).

The health situation in the Western Provinces of Afghanistan (Badghis, Ghor) is appreciably worse than in other parts of the country. In terms of women's health, the health sector continues to struggle with inadequate infrastructure, impaired access to health services, chronic shortage of skilled health providers, poor information systems and weak implementation of the newly approved national health policy.

World Vision (WV) International has prioritised improving maternal, newborn and child health and nutrition (MNCH/N) especially for fragile contexts including Afghanistan[1].

In 2015 WV commissioned Aga Khan University to perform a meta-analysis to evaluate the impact and sustainability of World Vision Afghanistan (WVA) programming, with a focus on health. Twelve programmes were included in the analysis, seven of which were part of MNCH/N.

The programmes were implemented from 2007 to 2015 in various districts in three provinces of Western Afghanistan - Ghor, Badghis and Herat - and reached a total of 243,476 direct beneficiaries, of whom 135,563 were women and girls (78,936 and 56,627 respectively).

The objectives of the MNCH/N programme evaluations were to:

- perform in-depth analysis to assess programme effectiveness and impact
- identify the best practices with highest impact for scaling up programming in fragile context
- identify limitations and provide recommendations.

Both qualitative and quantitative assessments were conducted in order to understand the different aspects and impacts of programme implementation in very fragile context zones. Limitations were also identified along with suggestions for ways forward.

FINDINGS

A total of ten programmes funded by various donors were evaluated (two of them ongoing)[2]. The programmes were mostly designed to improve maternal and new-born, child health and nutrition such as antenatal care, birth, postnatal, immunisation, growth monitoring, disease and infections prevention and treatment and infant, young-child feeding promotion. Programmes also focused on improving education, child protection, water, sanitation and hygiene (WASH), agriculture, home gardening, livelihood and income generation. This paper covers only indicators for women and girls health. Major programme activities focused on capacity building (e.g., human resources and infrastructure development), advocacy/ awareness, community mobilisation, behaviour change communication (BCC) and supplies provision. Programmes targeted vulnerable population groups such as: women, children, youth, street children, people living with HIV/AIDS and people living in geographically remote locations with lack of access to basic needs.

A scale assessing long term sustainability indicated that three of the ten programmes had a high probability of sustainability, six had partial probability and one had a low probability of sustainability.

1. World Vision International commitment to Every Woman Every Child Global Strategy. Available at: http://www.everywomaneverychild.org/commitments/all-commitments/world-vision-international#sthash.prYvsacS.dpuf

2. USAID, HSSP, JHPIEGO, DFATD (CIDA), DFID, Australian NGO Cooperation Programme, AusAID, private funding sources from WV USA/UK/Australia.

Table 1. Overview of Health Programmes

Outputs	Outcomes	Impacts	Sustainability score (max 24)	Targets reached
Project: Midwifery extension (funded by WV US). Objectives: Reduce maternal and infant morbidity and mortality rates and improve quality of care to babies and mothers. Improve employment opportunities for midwives.				
Workshops conducted, sensitisation of stakeholders, trainings conducted, midwives enrolled, performance score, number of delivery per staff, number of midwives employed, postnatal home visit	Quality of care, standards of care followed	Maternal morbidity, maternal mortality, infant morbidity, infant mortality	20	72%
Project: Community Midwifery Education (CME) Herat (funded by USAID/HSSP/JHPIEGO) Objectives: Training midwives to reduce maternal and infant morbidity and mortality rates and improve quality of care to babies and mothers.				
Establishment of infrastructure, faculty recruitment, number of students graduated, number of students practicing one year post-graduation	Quality of services		19.3	Data not determined from the available documents
Project: CME Ghor (funded by USAID/HSSP/JHPIEGO) Objectives: Training midwives to reduce maternal and infant morbidity and mortality rates and improve quality of care to babies and mothers.				
Student recruitment, capacity building of community midwives	Quality of services		18.3	Data not determined from the available documents
Project: STI/HIV/AIDS Education and Prevention - SHAPE (funded by ANCP) Objectives: Building health systems' capacities to offer (sexuallly transmitted infections) STIs and HIV/AIDS services, providing services for high risk groups, and reducing risks and vulnerability and improving treatment of STI and HIV.				
Population reached, knowledge about centre and its services, HIV knowledge, condom distribution	Women using modern contraception, access facilities, women offered and accepted counseling,	Reduction in treatable diseases	21	>80%

Outputs	Outcomes	Impacts	Sustainability score (max 24)	Targets reached
Project: Better Health for Afghan Mothers and Children - BHAMC (funded by USAID and WV) Objectives: Maternal and newborn care, infant and young child feeding, prevention and control of diarrhoea, improved case management of pneumonia and immunisation utilising community health workers (CHWs).				
Clean birth kits distributed, training of health care providers (HCP)	Skilled birth attendance (SBA), emergency referrals, health seeking for pneumonia, zinc during diarrhoea, early breastfeeding (EBF) for 6 months, early initiation of breastfeeding, 4 ANC visits, tetanus toxoid (TT) vaccines, measles vaccine,	Weight gain, underweight (<2 years)	18.3	37%
Project: Integrated Maternal & Child Health and Child Protection - IMCH-CP (funded by DFID) Objectives: Improve maternal, newborn and child health practices through strengthening community health systems. Improve awareness about child protection.				
	Early initiation of breastfeeding, (diphtheria, pertussis, and tetanus) DPT immunisation, measles immunisation, ORS use, one ANC visit, four ANC visits, child protection awareness	Acute Respiratory Infections (ARI) Incidence, diarrhoea episodes	16.7	Data not determined from the available documents

Key Results

The analysis suggests that various capacity building, awareness, commodity provision, logistic support and m-Health innovations led to a positive impact on women/maternal health outcomes. Although the quality of evidence building processes did not always meet initial high standards[3], given the difficult and complex implementation setting, the evidence shows that women's and maternal health and nutrition related programmes led to improved contraceptive use by 322 per cent, antenatal care by 36 per cent, skilled birth attendance by 37 per cent, early initiation of breastfeeding by 37 to 59 per cent and a 50 per cent increase in tetanus toxoid (TT) vaccinations.

Education programmes led to a 56 per cent improvement in school attendance, 29 per cent greater promotions to next level, a 10 per cent increase in continuation of education to next year, a 21 per cent increase in teachers attending training, a 9 per cent improvement in parents' perceptions of school, a 91 per cent increase in birth spacing practices and improved coverage of essential vaccines and care seeking for children.

3. Evidence quality, rated by three reviewers, was based on four domains: assessment design, tools, data analysis and evaluation. Out of 16 maximum scores the health programmes scored 6.7 - 7.7.

Table 2. Summary of Estimates According to Programmes and Interventions

Outcomes	Estimate	RR [95% CI]	p-value
IMCH-CP			
• Community level health systems strengthening • Formation of health shuras • Capacity building of CHWs • BCC • Community mobilisation • Child Protection			
One ANC visit	↓81%*	0.19 [0.12, 0.31]	<0.00001
Four ANC visits	↓9%	0.91 [0.34, 2.44]	0.85
Early initiation of breastfeeding	↑59%*	1.59 [1.44, 1.77]	<0.00001
Measles immunisation	↑454%*	5.54 [3.66, 8.39]	<0.00001
DPT3 immunisation	↑498%*	5.98 [3.87, 9.26]	<0.00001
ARI incidence	↑9%	1.09 [0.92, 1.29]	0.31
Diarrhoea episodes	↑6%	1.06 [0.88, 1.28]	0.54
ORS use	↑101%*	2.01 [1.67, 2.40]	<0.00001
BHAMC			
• Maternal and newborn care (MNC) • Infant and young child feeding (IYCF) • Prevention and control of diarrhoea • Improved case management of pneumonia • Immunisation • Formation of health shuras • Capacity building of CHWs			
Inter-pregnancy interval of >23 months	↓6%	0.94 [0.81, 1.09]	0.41
Current contraceptive use	↑322%*	4.22 [2.56, 6.97]	<0.00001
TT vaccine	↑38%*	1.38 [1.28, 1.48]	<0.00001
SBA	↑37%*	1.37 [1.14, 1.64]	0.0006
Postnatal visits	↑17%	1.17 [0.95, 1.44]	0.15
Exclusive breastfeeding (EBF)	↑47%*	1.47 [1.26, 1.72]	<0.00001
Early initiation of breatfeeding	↑37%*	1.37 [1.26, 1.48]	<0.00001
Minimum feeding practices	↓44%*	0.56 [0.46, 0.67]	<0.00001
Vitamin A supplementation	↑50%*	1.50 [1.34, 1.68]	<0.00001
Measles vaccine	↑17%*	1.17 [1.00, 1.38]	0.06
DPT3 vaccine	↓22%*	0.78 [0.67, 0.92]	0.002

Outcomes	Estimate	RR [95% CI]	p-value
Care seeking for childhood pneumonia	↑60%*	1.60 [1.47, 1.74]	<0.00001
ORS use	↓19%	0.81 [0.65, 1.01]	0.06
Appropriate malaria treatment	↑43%*	1.43 [1.33, 1.53]	<0.00001
ITN use	↑*‡	16.80 [8.97, 31.48]	<0.00001
Handwashing by mothers	↓29%*	0.71 [0.61, 0.82]	<0.00001
Point of use water treatment	↓28%*	0.72 [0.53, 0.96]	0.03
Underweight (0-23 months children)	↓45%*	1.45 [1.21, 1.74]	<0.0001
CommCARE (mobile platform) for Operations Research - CommCare-OR			
• Use of mobile technology in increasing utilisation of MNC services and in improving knowledge of danger signs in pregnancy, delivery and in neonates • CHW capacity building • Training of health shuras			
Any ANC	↑36%*	1.36 [1.1, 1.69]	0.005
At least four ANC	↑6%	1.06 [0.58, 1.94]	0.85
Iron supplementation	↑27%*	1.27 [1.00, 1.61]	0.05
Know two danger signs of pregnancy	↑22%	1.22 [0.99, 1.49]	0.06
Saved money	↑16%	1.16 [0.86, 1.55]	0.33
Coordinated with health facility	↑260%*	3.60 [1.39, 9.33]	0.008
Birth plan	↑20%*	1.20 [1.00, 1.44]	0.05
Arrange transport	↑22%	1.22 [0.75, 1.97]	0.42
Facility delivery	↑25%	1.25 [0.96, 1.63]	0.1
Early initiation of breastfeeding	↑12%	1.12 [0.96, 1.31]	0.14
Danger signs of newborn	↔	1.00 [0.94, 1.06]	1.00
Postnatal visits	↔	1.00 [0.71, 1.41]	1.00

Outcomes	Estimate	RR [95% CI]	p-value
Food for Education (FFE)			
• Take-home food rations • School supplies • Teacher training • Administrator training • Health and nutrition campaign ORS/Vitamin C • Community development • School infrastructure improvements • Early childhood care and development (ECCD) Spaces			
School attendance	↑56%*	1.56 [1.53, 1.58]	<0.00001
Promotion	↑29%*	1.29 [1.28, 1.30]	<0.00001
Continuation of education to next year	↑10%*	1.10 [1.09, 1.12]	<0.00001
Adequate school supplies	↑529%*	6.29 [4.14, 9.56]	<0.00001
Teachers attending training	↑21%*	1.21 [1.06, 1.38]	0.004
Parental school perceptions	↑9%*	1.09 [1.02, 1.17]	0.01
Health and nutrition education at school	↑282%*	3.82 [2.78, 5.25]	<0.00001
Vitamin C and ORS at school	↑ *‡	205 [12.91, 3255.97]	0.0002
Parental contribution to school	↑*‡	17.79 [7.50, 42.22]	<0.00001
Parental groups	↑5%	1.05 [0.93, 1.19]	0.40
ECD promote educational quality	↑30%*	1.30 [1.18, 1.44]	<0.00001
Early Childhood Care and Development Spaces (ECCDS)			
• Establishing within school locations a safe space for children of pre-school age to learn age-appropriate competencies and to get ready for transition into primary school • Training of mothers			
Birth spacing practices	↑91%*	1.91 [1.66, 2.20]	<0.00001
Coverage of essential vaccines	↑151%*	2.51 [2.11, 2.98]	<0.00001
Care seeking for children	↑629%*	7.29 [5.13, 10.36]	<0.00001
CHW visits	↑6%	1.06 [0.82, 1.37]	0.68

Key: ↑ Increase; ↓ Decrease; ↔ No impact; ‡ Inflated RR due to near zero baseline coverage; * Statistically significant impact; Interventions with significant intended impact.

RECOMMENDATIONS

The following recommendations are designed to build on the strengths of the country programmes and enable WVA to deliver impact at-scale through enhanced and focused advocacy, community participation and partnership capacity building in programme monitoring to promote quality in real-time. The recommendations are grouped around the four bottlenecks or barriers for achieving sustainable impact at-scale:

1. Creation of an Enabling Environment for Effective Health Programming

WVA works with multiple levels of decision makers to support the successful implementation of health programmes. Advocacy to high-level government decision makers through continued participation in health cluster meetings is a key strength of the country team. Advocacy, however, should focus on critical interventions and strategies:

- Institutionalisation of effective models such as the 'Positive Deviance Model' for health behaviour change, 'Timed and Targeted Counseling' sensitive curriculum for effective health service delivery of CHWs;

- Advocacy for targeting training to optimise local services such as increasing the number of trained CHWs and midwives in underserved areas or vocational training (e.g. World Vision SHAPE programme to support livelihoods and help communities leverage available opportunities).

At the local level, WVA works effectively with Tribal Village Councils, known as shuras (comprised of respected elders), who are an effective entry point to establishing new health services at the village level as well as resolving local conflicts. The WVA programmes ensured that shuras were an integral part of the basic health package. Their role, however, should be strengthened to service in a local governance capacity by enhancing participation to include goal setting for new services (e.g., what health problems are a concern to the Tribal Village Council, what health indicators would they like to see improve, and how can they provide oversight?). Increased participation in the programme cycle of the Tribal Village Council will improve accountability of local programmes, strengthen local ownership and have the potential to improve local sustainable impacts.

2. Improving Supply of Essential Health Services

WVA-led behaviour change strategies have significantly improved key family practices and health care-seeking behaviours. Infrastructure creation and improvement and provision of supplies (e.g. neonatal room and maternity wards, HIV and STI diagnostic and treatment services, training of health cadres) enabled access to lifesaving services.

WVA and local implementing partners must continue to work closely with Tribal Village Councils and local health authorities to identify local women to be trained as CHWs or volunteers and community midwives, particularly in the least served areas.

Protecting funds to assist advocacy efforts at the local and national level for investing in the cost of essential services in fragile contexts in order to improve access to quality services is strongly recommended.

3. Creating Local Demand for Effective Health Services

WVA has implemented communication strategies to ensure stakeholder awareness about important health services. Money saving mechanisms helped in generating community resources for access to essential health services (antenatal, birth and pediatric). The application of mobile health innovation was a successful model for improved household practices and health service utilisation. Further efforts, however, are required to meet and promote local demand.

Enabling local communities and stakeholders to actively provide information and have platforms could strengthen communication strategies and generate local demand. WVA has to consider ways to improve targeting of stakeholder active participation and communication strategies with the aim of involving women and other under-represented groups. For example, organising

meetings for women or providing women with specific information about who they might speak to about their health service needs and demands. Qualitative documentation of community demand and actions should be maintained.

Continuous Programme Quality Improvements

WVA has implemented important health services in a fragile context for which the country office should be commended. The documentation and evaluation, however, of these same implemented services can be improved. Baseline/endline evaluations should include indicators that match the stated goals of the programme and, where feasible, consider a comparison sample. The evaluation plans should be reviewed by the national office and advisors from the outset of implementation.

Importantly, the weakest area is programme monitoring that supports the use of 'real-time' data to improve the quality of implemented health services. For example, the use of tools such as supervision checklists to identify in regular reviews what practices are followed well and what practices might require a refresher training.

The key recommended strategy is to strengthen the competencies of local implementing partners that WVA works with to:

- Improve design and use of programme monitoring tools to improve programme quality,
- Improve critical reflection and use of available data (i.e., action learning) to make decisions and take actions to improve the quality of health programmes (e.g. decide topic of refresher training based on identified gaps in health worker competencies and improve timings of health services to increase local uptake).

World Vision is a global Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. World Vision serves all people, regardless of religion, race, ethnicity, or gender.

World Vision Middle East and Eastern Europe Regional Office, 62 Perikleous street, Nicosia 2021, Cyprus
Office: +357 22 870277, meer_dli@wvi.org, http://wvi.org/meero