BritishRedCross

Afghanistan Comprehensive Community Based Health Intervention (CCBHI)

Final Evaluation

December 2016

Ahmad Zubair Fattahi, Independent Consultant

International Federation
of Red Cross and Red Crescent Societies

Table of Contents

Acronyms

ARCS	Afghanistan Red Crescent Society
ANDF	Afghanistan National Peace and Development Framework
BHC	Basic Health Centre
BRC	British Red Cross
CBHFA	Community-Based Health and First Aid
CCBHI	Comprehensive Community-Based Health Intervention
CHC	Comprehensivele Health Centres
CHF	Swiss Franc
DiD	Difference-in-Difference
FDG	Focus Group Discussion
GDP	Gross Domestic Product
HDI	Human Development Index
HH	Household
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross and Red Crescent Societies
NS	National Society (ARCS)
MHT	Mobile Health Team
MAIL	Ministry of Agriculture, Irrigation and Livestock
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
PHCC	Provincial Health Coordination Committee
PMF	Performance Measurement Framework
PNS	Partner National Societies
SHC	Sub-Health Centre
SMART	Specific, Measureable, Attainable, Realistic and Time bound
YPE	Youth Peer Education Project
WASH	Water, Sanitation and Hygiene

Executive Summary:

The Comprehensive Community-Based Health Intervention (CCBHI) programme has been implemented by the Afghanistan Red Crescent Society (ARCS) in Balkh, northern Afghanistan, and funded by British Red Cross (BRC) through the International Federation of the Red Cross and Red Crescent Societies (IFRC) since 2008. The programme will be completed by the end of quarter one, 2017. It seeks to improve access to safer water and sanitation, promote hygiene practices, improve health awareness and first aid services and food security at community level for 23,000 households.

CCBHI objective: To contribute to improved health status of the targeted beneficiaries in, targeted districts of Balkh province	**Outcome 1** - Access to quality preventative, promotional and curative services during emergency and normal situation is increased
	Outcome 2 - Health awareness, promotion and first aid services at the community level are improved;
	Outcome 3 - Access to safe drinking water, sanitation facilities increased, and positive health and hygiene practices of community people improved
	Outcome 4 - Households consume greater diversity of food
	Outcome 5 - Institutional capacity of ARCS improved to deliver appropriate and timely health services.

Over the course of programme implementation, the CCBHI programme has gone through geographical as well as thematic expansion. Initially the programme was implemented in six villages of the Balkh Province. In 2011, 3 additional villages were added to the programme; another 6 villages were added in 2012. The food security component was added in 2014.

Evaluation Objective:

This report presents findings of the final evaluation. The purpose of this evaluation was to assess the outcomes of Afghanistan CCBHI programme in Balkh and the role of ARCS, IFRC and BRC in its implementation and to identify practical ways to improve the programme design and management.

Specific objectives were:

1. To measure change against baselines and control groups.
2. To understand to what extent the Project have been accepted by the host communities, and to gauge how well the legacies of the Project will exist and be maintained in the targeted geographical areas once ARCS activities end.
3. To inform the development of a wider health review in Afghanistan by the International Federation following the CCBHI and Community-Based Health and First Aid (CBHFA) models of working, as developed by IFRC with other partner national societies (PNSs).

Main Evaluation Findings:	
Achievements:	> The gross total number of direct beneficiaries reached through health, WASH, food security and nutrition interventions as of July 2016 was 113,025 people. > The eight-year programme included the following: - Hardware activities: 109 wells constructed; 18 wells rehabilitated and repaired; 701 latrines built; 10 disposal pit constructed; 189 household gardening package distributed; and 592 household chicken package distributed. - Software activities: 1,660 volunteers trained; 10 grandmother committees established (each committee has 20 members); 6 water user associations established; and a significant number of training workshops organized.
Relevance and appropriateness:	> The CCBHI programme was deemed to highly relevant and aligned to the context of Afghanistan, the health strategy of ARCS and the Ministry of Public Health in Afghanistan. > The programme was not however well integrated into ARCS systems but seen more of an overall pilot approach. The management of the CCBHI was separate from that of the Community-Based Health and First Aid (CBHFA) although CCBHI is an application of CBHFA approach with added components. > The participation of community members in the programme is a significant and successful strength of the CCBHI supporting decision making. > The CCBHI programme model is now being implemented in Nangarhar and Samangan provinces through financial support from the Swedish and Australian Red Cross Societies respectively. There was however limited indication on collaboration and coordination in terms of joint planning, capacity development, monitoring and knowledge sharing of Balkh-CCBHI programme with other CCBHI programmes implemented by ARCS and managed by IFRC.
Coverage:	> The programme was implemented across 15 villages in Balk province with food security piloted in 4 villages. > The programme aimed for wider coverage rather than adopt specific need-based approaches in the selection of food security component beneficiaries or households.

Effectiveness:	In the pilot villages prior to the start of the programme the baselines reflected a rate of 257 deaths per 1,000 births across the villages targeted indicating the rational for their targeting. This fell to 141 per 1000 in 2010. Additional communities were added which then increased the overall child mortality of 168 per 1000 in 2011/12. The end line evidence recorded in 2016 that the rate had dropped significantly to 34 deaths per 1,000 births. > Since the programme initiation, contraceptive usage in the pilot areas increased from a position of practically zero (3%) to 15% in 2010 and in all areas from 17% in 2010-12 to 58% in 2016. > Deliveries attended by a skilled health worker increased from 4% in 2008 to 25% in 2010 in pilot areas and in all areas from 30% (baseline) to 66% in 2016. > Breastfeeding in target villages has increased from 16% in 2014 to 51% in 2016. > The knowledge on how to treat a child with diarrhoea increased from 5% in 2008 to 19% in 2010 and in all areas from 24% in 2010-12 to 53 per cent in 2016. > From 2014 to 2016 there was a 23% increase in food preservation in target villages. > Egg (protein) consumption among children under 5 years of age has increased from 3.2% in 2014 to 13.4% in 2016. > Consumption of bean nuts and seeds among children under 5 years has also increased from 3.2% in 2014 to 15% in 2016. > The programme does have a logic framework but targeting was limited or poor, undermined by not have a Performance Management Framework from the outset. > Independent monitoring of the programme activities had been undertaken but limited to very few (three) over its lifetime. > Deteriorating security situation has been flagged in every report since 2010, however the programme security risk mitigation strategy was not evident.
Efficiency:	> Total expenditure as of July 2016 is CHF 1,666,495. - 45% of expenditure is on supplies & construction. - 24% personnel salary. - 9% training and workshop. - 22% operation related expenditure.

	> 46% (personnel + operation expenditure) expenditure on operation related areas is of note for a charity programme that is mainly run by volunteer-ism. > Delivery rate (executed budget/planned budget) is 78% which is relatively low primarily based on the deteriorating security situation and prolong administrative and logistical procedures of ARCS cited as the main reasons for the lower delivery rate.
Impact:	> The programme has been able to increase interaction among community members in the form of community participation in councils, organizing health awareness raising campaigns and creation of barter economy where households exchange food products with each other. > The programme has increased the overall quality of sanitation and hygiene and its awareness and practice in all villages significantly.
Sustainability:	> Behavioural change caused by the programme (i.e. hand-washing and other hygiene practices) are most likely to be sustainable. > Whether communities will repair the infrastructure constructed by the programme is questionable and is determined by the level of repairs required and financial means of the communities. > Poultry component: the programme team had to intervene this year to control the spread of disease killing chickens in the targeted area but engagement of veterinary assistance through local authorities facilitated by the programme lessoned the negative impact. > Kitchen gardening: has proven to be successful in households that have access to sufficient water to be used for watering the garden but failed in small number of cases where water access was limited or had poor water management expertise. As a result, sustainability of kitchen gardening is questionable to a degree. > The programme has lost nearly 50% of male volunteers in three villages primarily through a combination of security, migratory and economic pressures which for ARCS will be a major risk.

Recommendations	Responsibility	Priority
Relevance and appropriateness		
1. Integrate the CCBHI programme with other ARCS health programmes, particularly with CBHFA and define the singular model for all community health interventions.	ARCS	High
2. Create a consortium of CCBHI programmes to allow joint planning, monitoring and sharing of knowledge and information.	IFRC	Medium
3. Sign MoU with MoPH to clarify the roles and responsibilities of CCBHI volunteers and CHWs to avoid duplication and ensure better volunteers complement each other's work.	ARCS	High
4. Coordinate all food security activities with MAIL and other development agencies working the targeted areas to support cross learning and innovation.	ARCS	High
5. Expand further efforts related to consultation with community members. Utilise Friday Prayer Ceremony for dissemination of information.	ARCS	Low
6. Include feasibility of an activity while selecting beneficiaries. Targeting most needed beneficiaries who might not be able to fully utilise programme resources could lead to wastage of resources as in the case of kitchen gardening where water provision might be scarce.	ARCS - IFRC	High
Coverage		
7. Any decision on geographical and thematic expansion should be made based on availability of resources to avoid running risk of biased selection of beneficiaries.	All	Medium
8. While concentration of activities within a particular geographic area could reduce operational costs and prove to be more efficient, it may lead to targeting beneficiaries who might not be most needed. It is recommended that future food security components use selection tools that allow the selection of the most needed households.	IFRC and ARCS	Medium

Effectiveness		
9. Integrate result-based-management into all phases of the programme life cycle. Develop logical framework that has SMART'er indicators and targets; develop performance measurement framework; develop monitoring plan and monitoring tools and consider benefits monitoring.	All	High
10. It is highly recommended to move from annual planning and budgeting to multi-year planning process. Develop a work plan and budget for the entire duration of the programme and subdivide activities per year or by milestones. If necessary, revise annual plans accordingly.	All	High
11. Development of annual plans and budget in the absence of an overarching work plan runs the risks of becoming activity driven. Without having a specific result/target in mind, activities may only generate outputs and do not contribute to achievement of outcomes.	All	Medium
12. Develop Theory of Change for all future programmes	All	High
13. Contract third party monitoring agent if security situation does not allow IFRC and BRC to monitor programme sites.	ARCS, IFRC	Medium
14. Third party monitors are increasingly being utilised in Afghanistan by development agencies and even humanitarian agencies such as ICRC. Regular independent monitoring is crucial to ensure resources are spent as planned.	All	High
15. Any major changes to the programme or outside set tolerances or parameters, including management considerations, should be consulted with all programme stakeholders and well documented through a robust escalation process linked to risk management protocols (see below).	ARCS, IFRC	Medium
16. Develop risk assessment and mitigation plan, including security management protocols for all activities and staff/volunteers. The risk assessment should clearly state the level of risk and risk tolerance along with well-defined mitigation measures, including closing down an activity.	All	High
17. Conduct stakeholder mapping for all future activities to indicate what other development partners are doing in the targeted areas.	ARCS, IFRC	Medium

18. Clearly capture contribution of other development partners in targeted areas in the progress report.	ARCS, IFRC	Medium
19. Adapt need-based approach for selection of beneficiaries.	All	High
Efficiency		
20. Future interventions must bring down operation cost as much as possible security permitting.	BRC and IFRC	High
21. Develop risk assessment and mitigation plan for all activities. The Risk assessment should clearly state the level of risk and risk tolerance along with well-defined mitigation measures, including closing down an activity.	ARCS and BRC	High
21. Building capacity of ARCS is one of the main objectives of IFRC, partner National Societies and even the CCBHI programme. Any future intervention should develop activities for capacity development of ARCS, particularly the OD, logistics and finance departments. IFRC, in particular, mush focus on building institutional capacity of ARCS through existing programmes.	IFRC	High
23. Related to the previous recommendation, it is highly recommended to conduct capacity assessment before delegating responsibilities to a programme stakeholder. First address capacity gaps, then transfer responsibilities.	IFRC	High
24. Develop Human Resources Plan to indicate how many people need to be recruited on full-time, part-time and consultancy bases.	IFRC	High
Sustainability		
25. Future interventions should create a mechanism for establishment of a community fund to be used for repairing and rehabilitation or remedial work.	ARCS	Medium
26. Programme beneficiaries should be trained on how to address outbreak of disease or linked to actors or agents that can.	ARCS	High
27. Train beneficiaries on examples such as drip-irrigation for kitchen gardening and other water management practices. Connections to other agencies or actors to help with will support its longevity.	ARCS	High
28. Automatic volunteer recruitment process should be introduced so that when a volunteer leaves the village s/he could be automatically replaced by another volunteer, where possible. There should be better mechanisms for volunteer management in place where community engagement is in place.	ARCS	Medium

1. Background

Field visit by Project Engineer to one of the newly constructed wells in Ismail Khil village of Khulm District.

The Comprehensive Community-Based Health Intervention (CCBHI) programme has been implemented by the Afghanistan Red Crescent Society (ARCS) in Balkh, northern Afghanistan, and funded by British Red Cross (BRC) through the International Federation of the Red Cross and Red Crescent Societies (IFRC) since 2008. The programme will be completed by the end of quarter one in 2017. The programme seeks to improve access to safer water and sanitation, promote hygiene practices, improve health awareness and first aid services and food security at community level for 23,000 households.

The CCBHI programme was designed after an internal rapid assessment carried out jointly by ARCS and the IFRC in late 2006. The assessment revealed that there was a significant need for health and hygiene promotion activities and for safe drinking water in the catchment areas of basic health

centres. In 2008, the CCBHI programme focused on providing health promotion activities, water and sanitation (construction of hygienic latrines, safe drinking water schemes) and the initiation of curative health services in six villages across three districts[1] of Mazar province by ARCS and direct support of IFRC through financial and technical support from the BRC.

BRC conducted a mid-term evaluation of the programme in 2011. The evaluation method included measurement of change between all the baseline data collected in 2008 against the data collected in 2010. Evaluators found that water and sanitation and maternal, neonatal and child health interventions had demonstrated significant impact in programme intervention areas.[2] Based on the positive findings of the mid-term evaluation, the programme was expanded to include a further three additional villages, increasing the total number of programme intervention sites to nine locations.

Shafiqa, residence of Den Hasan village; one the beneficiaries of health and WASH project with Sultan Mohammed, IFRC Senior health manager.

1 Khulm District: Deh Warda and Deh Hasan. Balkh District: Qarloq and Hasan Khil. Shortepa District: Arigh Batoor and Joy Wakil

2 For further details, please refer to the mid-term evaluation report.

Following a rapid assessment in 2012, the CCBHI programme was further expanded to include an additional six new villages in Balkh province. In addition to geographical expansion, the ARCS and IFRC considered thematic expansion of the programme to include a food security component to enhance the potential impact of the programme. The rationale for the thematic expansion was grounded on the fact that improvement of maternal, neonatal and child health is difficult if not impossible, in the presence of wide-spread food insecurity highlighted during the programme Implementation Review in late 2013 and its recommendation to introduce a food security component as a result. Food security assessment in targeted areas was conducted in 2014 and the food security activities (poultry and kitchen gardening) implemented in 2015 to 2017.

"Now our children eat eggs and we sell eggs too so that we can purchase other food items. Our children's physique has improved a lot; previously the doctors will usually tell us that our children are malnourished, but now they are doing much better".

Focus Group Discussion

ARCS volunteer with children operating newly installed water pump.

Map 1: CCBHI communities, Balkh Province

Villages in Balkh Province, covered by BRC funded Health programme in Afghanistan

Timeline of CCBHI geographical expansion 2008 - 2016

Year	Province	District	Village
2008	Balkh	Balkh	Hasan Khil
2008	Balkh	Balkh	Qarloq
2012	Balkh	Dawlatabad	Charbagh Saidan
2012	Balkh	Dawlatabad	Joy Arab
2012	Balkh	Dawlatabad	Qarshygak
2012	Balkh	Dawlatabad	Yakh Dan
2011	Balkh	Dedadi	Turkmania
2011	Balkh	Khulm	Baba Sidiq
2008	Balkh	Khulm	Deh Hasan
2008	Balkh	Khulm	Deh Warda
2012	Balkh	Khulm	Ismail Khil
2012	Balkh	Khulm	Sultan Darmada
2008	Balkh	Shortepa	Arigh Batoor
2011	Balkh	Shortepa	Basheerly
2008	Balkh	Shortepa	Joy Wakil

N.B.
- Location of Basheerly in Shortepa is unknown.
- Turkmania appears to be in Mazar-e-Sharif.

i) Programme Components

The overall objective of the CCBHI programme was to improve the health and well-being of vulnerable communities comprising of 23,000 households through:

- Improved access to quality preventative, promotional and curative services during normal situations and emergencies.
- Improved health awareness, promotion and first aid services at community level.
- Improved access to safe drinking water, increased access to sanitation facilities, and improve health and hygiene practices of people in the targeted communities.
- Improved consumption of diversified food.
- Improved institutional capacity of ARCS to deliver appropriate and efficient preventive health services.

"The programme means that people are more aware now. They have got a lot more health-related information".

Focus Group Discussion with men

Table 1 Project Objectives and Outcomes

CCBHI objective: To contribute to improved health status of the targeted beneficiaries in, targeted districts of Balkh province	**Outcome 1** - Access to quality preventative, promotional and curative services during emergency and normal situation is increased
	Outcome 2 - Health awareness, promotion and first aid services at the community level are improved;
	Outcome 3 - Access to safe drinking water, sanitation facilities increased, and positive health and hygiene practices of community people improved
	Outcome 4 - Households consume greater diversity of food
	Outcome 5 - Institutional capacity of ARCS improved to deliver appropriate and timely health services.

Maternal, Newborn and Child Health

The community-based integrated programme was initiated to build up community resilience by involving community people in the designing and decision making process thus leading to long term sustainable resilience across the communities. The volunteers (both female and male) trained through this the programme played an important role in changing the behaviour of the communities and to adopt healthier hygiene practices; the provision of and increase access to primary health care provision; and the provision of first aid in times of emergencies. CCBHI volunteers were also the link in the referral to health care facilities and health information in the communities and for the ARCS as the source of information in times of disasters/emergencies necessary for immediate response.

Recognising that grandmothers / mothers-in-law play very important and powerful roles in maternal and child health / nutrition within Afghan culture, ten grandmothers' committees across the programme communities were created with a total of around 200 members. These committees received training in breast feeding / child nutrition and reproductive health. The Grandmothers' Committees encouraged health seeking behaviours and to convince other conservative husbands/fathers to let their wives /daughters to seek health and maternal care in the nearest health facility as and when needed.

The Grandmothers' Committees have taken the lead in encouraging women to seek better maternal and child health care services and guiding young mothers to take better care during pregnancy and in proper new born and child care which will reduce the risks to maternal and child morbidity and mortality cases.

Water pump installed by ARCS.

Water, Sanitation and Hygiene promotion

Hygiene promotion and health awareness campaigns were continuously carried out by community volunteers, complimented by the construction of wells and household latrines with the involvement of the community beneficiaries. The provision of safe drinking water through construction of wells and sanitary latrines together with the hygiene promotion was expected to contribute to a decrease in the number of water-borne disease incidents in the communities. Trained mechanics from the villages were expected to be able to undertake any necessary repair and maintenance of the wells.

Food security and nutrition

The expansion of support to include a food security and nutrition intervention was added in 2014 to meet the diverse needs of the communities and to complement the other programme components leading to a greater level of impact across the communities.

Assessments conducted in 2014 identified the different wealth groups and their food security problems resulting in a number of recommendations for inclusion of food security activities in the targeted villages following the identification of significant needs to improve nutritional standards.

A food security baseline study was conducted in four targeted villages (two pilot case and two control areas) of Dawlat Abad and Khulm districts across 882 households. The findings from the baseline survey informed the food security project design and as a result, poultry farming and kitchen garden harvesting interventions were initiated in two target programme villages in Dawlat Abad and Khulm district in 2014/2015.

Model latrine with composting and hand-washing facilities as installed by ARCS.

Mrs Maria one of the poultry beneficiaries in Deh Hassan village.

"Poultry is not just helping us in feeding my children, it also supports my family economically as my husband is jobless and he is not in a position to solve the routine expenses of my children especially in providing stationeries for schools of my children like notebook and pens".

Maria, a 40 year old lady resident of Deh Hasan village is also a beneficiary of the project. Maria added that she is able to support the basic needs of her family by selling surplus eggs.

Ms Maria feeding her new chickens, provided by ARCS

The implementation of this project was coordinated with the local Provincial Agriculture Department which benefited from training support on proper vegetable gardening and poultry management to beneficiary households. Training on mother and child nutrition was also included to raise awareness on proper preparation of nutritious food and awareness to prevent malnutrition and nutritional deficiencies problems. This was initiated by ARCS' CCBHI health educator programme staff with the support of trained Community-Based Health and First Aid (CBHFA) volunteers.

Project management arrangements

The programme was implemented through the ARCS North Regional office based in Mazar-e-Sharif from 2014 having previously been managed by the ARCS Balkh Branch.
ARCS North had a team of between 4-6 officers at one time during the programme period (Manager, Male/Female Health educators and a food security officer) and recently managed by the Programme engineer following the departure of the Programme Manager in 2015, based in Mazar-e Sharif, responsible for the implementation of the programme and supported administratively by the IFRC sub-delegation in Mazar-e-Sharif.

The field implementation activities were supervised and monitored by the programme engineer, the food security officer and the health educators staff with technical and PMER support from IFRC health team, lead by the IFRC Health Delegate and a Senior Health Manager based in Kabul.

Photo: © ARCS

Community-Based Hygiene Promotion in Khulm Deh Hashan, Balkh province.

Table 2 Summary of project implementation

Project formulation	First phase			
2006	2008	2009	2010	2011
Afghanistan Red Crescent Society (ARCS) conducted internal rapid assessment: The assessment recognised the need for health and hygiene promotion activities and access to safe drinking water in the catchment areas of basic health centres. **The Comprehensive Community-Based Health Initiative Programme (CCBHI)** was designed as a five year project (2008-2012) with a focus on community-based health activities including health promotion, health education, and water and sanitation as well as provision of curative health services.	Staff recruited. Baseline Study conducted. 40 volunteers in hygiene promotion and first aid trained in Balkh and Shortepa Districts.	100 volunteers recruited and trained in first aid and health education. Twenty Seven wells constructed. 10 waste disposal pits built. Six water user's committee established. 32 latrines in Deh Warda and 45 latrines in Deh Hassan villages of Khulm district constructed.	120 men and 120 women volunteers were trained in health and hygiene promotion and first aid in the project areas. 80 male volunteers trained on reproductive health. Health and hygiene campaigns conducted in Deh Hasan village of Kholm, Hasan Khil village of Balkh and Arigh Batoor village of Shortepa (200). Sixteen wells constructed. 60 latrines in Arigh Batoor and 55 in Joy Wakil villages of Shortepa constructed. Nine dysfunctional wells rehabilitated in Kholm District	Mid-term evaluation conducted. It was estimated that 10,000beneficiaries were reached in the three districts. Programmeme extended to include 3 new villages. An extra one in both Shortepa and Khulm and a new one in Deh Dadi. The target population is 6,384 people. 120 volunteers trained on CBHFA approach 100 volunteers trained on reproductive health 120 volunteers trained on health and hygiene promotion. 3 promotional hygiene practice health campaigns organized. 4 wells constructed. 7 dysfunctional wells rehabilitated. 40 latrines completed in Qarluq village in Balkh district.
	Khulm District: Deh Warda and Deh Hasan Balkh District: Qarloq and Hasan Khil Shortepa District: Arigh Batoor and Joy Wakil			Three additional villages. Baba Sidiq in Khulm Basheerly in Shortepa Turkmania in Dedadi.

Second phase

2012-2013	2014	2015	2016
Community Based Health Intervention Project developed. CCBHI programme expanded to 6 new villages in Balkh province in addition to the existing 9 following a rapid assessment. 27 semi-deep and 1 deep well constructed. 154 sanitary latrines with hand washing facility constructed. 260 volunteers (120 male and 140 female) trained in CBHFA approaches six villages. 300 (140 male and 160 female) trained on health and hygiene promotion. 180 received refresher training for CBHFA. 40 trained in reproductive health (20 male and 20 female) in Yakhdan village in Dawlatabad. First grandmother committee established in Turkmania village. 80 grandmothers trained in CBHFA and reproductive health. CCBHI Project Implementation Review conducted. Food Security and Nutrition Workshop organized in Dubai from 18-21 November 2013.	100 volunteers trained in hygiene promotions. Five grandmothers committees (100 volunteers) established. 8 reproductive health care workshops organized (six groups of women and 2 groups of men). 10 wells constructed. 15 latrines constructed. Food Security Assessment Conducted.	Food Security Component Introduced. 189 HH received market garden package (seed packs, fencing material and tools). 189 men trained on gardening management (71 in Deh Hasan and 118 in Charbagh Sayaden Village). 217 HH received chicken package and set up a chicken house (20 chickens/HH). 10 poultry management trainings conducted. 217 men/women volunteers trained on child and maternal nutrition. 40 grandmothers committee members trained. 170 Latrines constructed. 170 hand washing facility constructed. 140 people trained on latrine maintenance. 25 wells constructed. 80 volunteers trained in hygiene promotions. 400 HH visits to promote good hygiene. 2 community events to promote good hygiene.	Eleven community wells rehabilitated. 8600 HH visits to promote good hygiene, 375 HHs received Chicken Package and poultry management training.

Six additional villages added
Khulm District: Ismail Khil and Sultan Darmada
Dawlatabad District: Qarshygak, Joy Arab, Charbagh Saidan and Yakh Dan

ii) Evaluation Objectives and Method

The purpose of this final evaluation was to assess the outcomes of Afghanistan CCBHI programme in Balkh; the role of ARCS, IFRC and BRC in its implementation; and to identify practical ways to improve any future programme design and its management.

The specific objectives were:

1. To measure change against the baselines and control groups;
2. To understand to what extent the programme has been accepted by the host communities and to gauge how well the legacies of the programme will exist and be maintained in the targeted geographical areas once ARCS activities end;
3. To inform the development of a wider health review in Afghanistan by the International Federation following the CCBHI and Community-Based Health and First Aid (CBHFA) models of working as developed by IFRC with other partner national societies (PNSs).

The evaluation process was divided into following three phases:[3]

i. *Data Collection*: BRC recruited two independent national consultants to conduct field visits and collect data along with ARCS staff. The data collection phase was completed between July-September 2016.
ii. *Data analysis and production of initial evaluation report*: BRC technical team conducted the data analysis and the independent local consultants produced the initial evaluation report in October 2016[4].
iii. *Production of final report*: BRC contracted another independent consultant to write the final report based on data analysis and the initial report as the parties were unable to complete the initial terms of reference. The final report completed in December 2016 – January 2017.

Demonstration of hand-washing practices by ARCS community-based heatlh volunteer.

[3] Terms of Reference available on request from British Red Cross
[4] Annex I summaries the results of the data analysis.

Methodology:

Both qualitative and quantitative data collection method including household survey, FGDs, and key informants interview were used as part of the evaluation methodology [5].

a) Household Survey:
The household surveys were conducted by ARCS staff and volunteers in 12 villages across four districts.

Table 4: Targeted Districts, Villages and FGDs Target Groups

District	Village	Number of Sample Households
Khulm	Deh Warda	87
	Deh Hasan	122
	Baba Sidiq	25
	Ismail Khil	61
	Sultan Darmada	28
Balkh	Qarluq	15
	Hasan Khil	15
Deh Dadi	Turkmania	55
	Dawlatabad	160
Dawlatabad	Joy Arab	53
	Qarshygak	405
	Yakh Dan	50
Total		**1076**

[5] A complete methodology of field protocols is available on request from British Red Cross

b) Focus Group Discussion (FGDs):

In addition to household survey, ARCS staff conducted focused-group discussion with beneficiaries clustered around particular Project activities (maternal and child health, WASH, food security). There were 12 FGDs in four targeted districts.

s/n	District	Village	FGDs Target group
1	Khulm	Deh Hasan	Vegetable focus group-women
2			Maternal child health-women
3			Chicken focus group-men
4			WASH-men
5	Dawlatabad	Charbagh Saidan	Chicken focus group-women
6			Maternal child health –men
7			Vegetable focus group –men
8			WASH-Women
9	Balkh	Hasan Khil	Maternal child health-women
10			WASH-Men
11	Dedadi	Turkmania	Maternal child health-men
12			WASH-women

c) Key Informants Interview:

Key informant interviews were conducted with external and internal stakeholders including project staff.

s/n	Target group	Number of KIIs
1	Community Leader	2
2	Head of grandmother committee	2
3	ARC Management at the regional level	1
4	Regional Health Officer	1
5	Federation Field officer	1
6	Food Security Officer	1
7	Project Officer	1
8	BRC Management	1

d) Data Analysis

Analysis was performed between all baselines combined (2008-2012) and end-line 2016 to test for change in outcomes using the general and maternal/neonatal/child health weights as appropriate, applied to the 2016 data. Baseline data weights were assumed to be 1.0.

Additionally, a comparison of 2014 and 2016 food security questions was done using the Difference-in-Difference method [6].

All analysis was conducting using Epi Info 3.5.4. All FDGs were recorded and transcribed.

Evaluators analysed transcripts of FDGs for triangulation of findings as well as to understanding the unintended impacts of the Project at the community level.

Abdullah residence of Charbagh-e-Saydan village with ARCS health officer.

[6] The difference-in-differences method is used for impact assessment. It compares the changes in outcomes over time between a population that is enrolled in a programme (the treatment group) and a population that is not (the control group).

e) Limitations

Sampling - The information provided and in the original draft report on how the sampling frame was calculated for the respective villages, whilst developed and training carried out by BRC health and Food Security technical advisors with the two field consultants and subsequently through them with the field CBHFA volunteers in Mazar e-Sharif as outlined in Annex III, it is worth noting that it was difficult to determine whether it was followed or not in the field.

The details given on the household sampling method (systematic random sampling) was developed during the planning meeting in Dubai. The data collection team supposedly followed the protocol; however, data collection process was not monitored to ensure minimum deviation from the protocol. As such, the author of this report is not in position to verify the extent of household sampling method strictly followed by data collection team. Reliability of data might have been compromised.

Data collection methods – it is worth noting that in some cases, past ARCS volunteers were present as part of a small number of Focus Group discussions. The consultant however felt confident that this did not undermine the findings from reviewing the transcripts and recordings of the interviews.

Another limitation relates to analysis derived from KIIs and FGDs. The author of this report was not present during FGDs and KIIs and had to rely on transcripts of FGDs and KIIs for data analysis. The reader should cautiously take findings and recommendations of this report due to limitations in data collection and analysis.

It should be acknowledgement though that the analysis is dependent on the quality of the notes recorded / taken. As the consultant was not present during the field work, the consultant's judgement has been taken following the review of these notes taken second hand (is Dari and independently translated into English).

Should any critical assessment of the findings be made, the recommendations given can only be based on this limitation.

Other specifics that might have had a limiting factor on the evaluation are as follows:

- *Insecurity limiting safe access to communities*. At this stage, 3 communities out of a total of 15 supported were not possible to be visited.
- *Availability of key stakeholders*. A number of key staff was required to support the implementation of the evaluation although recognized that some implementing staff of ARCS had left and was not possible to consult with during the final report stage. This was significant and did come to fruition. Two ARCS programme staff and one IFRC Health Manager had left Afghanistan in 2016.
- *Limited M&E systems in place*. During the programme lifetime, there have been limited mechanisms to link the outputs and outcomes to the initial log-frame indicators and historical data was not available.
- *Food security outputs within the controls influence findings*. There is a small time margin where food security activities might contaminate the control groups. To ensure compliance of the control groups, it was agreed that the food security activities would be commenced in 2016 before the evaluation but at a time when the maturity of the products would not be reached before the evaluation. There is an indication that some of the products sold could have also reached the controls but questionable as to whether this was substantial enough to influence the findings significantly.

2) Findings:

i) Relevance and Appropriateness:

Afghanistan continuously ranks near the bottom of the Human Development Index (HDI) table[7]. The latest HDI score for Afghanistan is 0.465 positioning the country at 171 out of 186 countries in the HDI global ranking. The overall health situation, in particular, is significantly alarming in Afghanistan. Lack of access to standard health services, clean water, sanitation and hygiene and diversified nutrition are among the main factors contributing to low health indicators in the country.

With an overall objective of 'contributing to improve the health status of the targeted beneficiaries in targeted districts of Balkh province', the Comprehensive Community-Based Health Intervention (CCBHI) programme is highly relevant and much needed in the context of Afghanistan. The 2008 baseline study in the targeted areas clearly shows the dire health situation. Some of the findings are presented below: [8]

- Under-5 child mortality rate of **257 deaths per 1,000** births.
- Only **4% of deliveries** attended by a skilled health worker.
- **5% of population** had knowledge of how to treat a child with diarrhoea.
- **40% access** to safe drinking water.
- ARCS food security and WASH project beneficiaries in one of the target villages in Charbagh syedan, Deh Hassan of Balkh province.

Photo: ARCS & IFRC

The inclusion of a food security component in 2015 was also appropriate and relevant considering the wide food insecurity in Afghanistan. According to the Afghanistan Living Condition Survey 2013-2014;

"Food insecurity based on the food consumption score and food-based coping strategies is estimated at 33 percent (9.3 million people) of total population. Among them, an estimated 3.4 million (or 12 percent) are severely food insecure, and 5.9 million (or 21 percent) moderately food insecure". **(p.117).**[9]

Food insecurity in rural areas was estimated at 36% compared to 30% in urban areas (ibid). The 2014 ARCS Afghan Food Security Assessment in the targeted areas also found poor dietary practices and food insecurity in the programme targeted areas (for further information please refer to the report).

The CCBHI programme clearly meets certain needs of targeted communities. While addressing reproductive and child health issues, the programme focuses on improving water and sanitation facilities, and health and hygiene practices, and on changing health behaviour to access proper curative and reproductive health services. The addition of the food security component to complement the health interventions, albeit later in the programme lifetime, was still deemed to be a much needed contribution to the overall impact of the programme.

ARCS food security and WASH project beneficiaries in one of the target villages in Charbagh syedan, Deh Hassan of Balkh province.

[7] HDI provides a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living.
[8] For further information, refer to the 2008 Report of Baseline Study, BRC.
[9] http://www.cso.gov.af/Content/files/ALCS%202013-14%20Main%20Report%20-%20English%20-%2020151221.pdf

Mr Zaher, one of the poultry beneficiaries in Charbagh Saydan village

Sayed Zaher, a 32 year old resident of Charbagh Saydan village has four children, with the youngest being 7 months old. He works as a construction labourer on daily wage basis to support the family expenses. Nowadays the demand for construction work in the city is decreasing and some time it is quite difficult for him to find work on a daily basis and earn money. As a beneficiary in this project Zaher received training on poultry management and was supported with 20 chicken (18 hens and 2 roosters), feeds and material for chicken shelter. After four months, the chickens lay 70-80 eggs per week. Half of the eggs are consumed by the family and half sold in the market which earns up to 280 Afghanis per week. The additional income was used to buy essential foods items and medicines in case of any sickness in the family.

Zaher narrates that one of his child was suffering from growth problem. When he took his child to the clinic, the doctor advised him to feed the child with eggs, chicken meat and cow's milk, to supplement the lack of calcium and iron intake of his son. The family was so grateful on the produce they gained from the chicken as it provides supplemental nutrients to their meal from eggs and additional weekly income.

"Day to day, life is getting better and better". Says Zaher.

Fatima Sayed Zaher's daughter, Charbagh Saydan village.

CCBHI Relevance with ARCS Health Strategy and Programmes

Community-based volunteer-centred programmes are highly relevant and much needed in the context of Afghanistan; the ARCS health strategy is geared to develop such programmes utilizing Community-Based Health and First Aid (CBHFA) tools of which CCBHI is an application of CBHFA approach with additional components added. As such, the CCBHI programme meets the objectives of the ARCS health strategy. Due to alignment with ARCS health strategy, the CCBHI programme has gone through constant geographical expansion in Balkh province and beyond. The CCBHI programme is also being implemented in Nangarhar and Samangan provinces with support from the Swedish and Australian Red Cross Societies respectively.

In addition to CCBHI programmes, the ARCS current health programmes also includes four other programme areas namely Community Based Health and First Aid (CBHFA), Mobile-Health Teams (MHTs), Basic health Centres/ clinics (BHC) and Youth Peer Education (YPE) for HIV prevention, sexual and reproductive health.

Coordination and linkage of the Balkh-CCBHI programme with other ARCS health programmes were not strong. Although the CCBHI is an example of CBHFA in practice with wider scope, the management of the CCBHI was separate from that of the CBHFA programmes.

The CCBHI programme applied CBHFA approach and tools to address mother and child health but with additional focus on improving water and sanitation practices in communities and latterly the inclusion of the pilot nutritional support component.

There is also limited evidence of integration and coordination with other ARCS health programmes namely MHT, BHC and YPE. ARCS has 5 BHCs and one MHT in Balkh province. The CCBHI programme can strengthen its position by establishing links and working relation with ARCS health services programmes although this model was seen primarily as a pilot model but integration could have happened earlier. It is a model that had greater potential in terms of impact and should be looked at as a default in the future.

As mentioned earlier, CCBHI programmes are also being implemented in Nangarhar and Samangan provinces through financial support from the Swedish and Australian Red Cross Societies respectively. There was limited evidence to show collaboration and coordination in terms of joint planning, capacity development, monitoring and knowledge sharing of Balkh-CCBHI programme with other CCBHI programmes other than through peer to peer PNS initiated communications. There was little evidence through the IFRC and ARCS initiated engagements.

ARCS community health volunteer, showing hand-washing to children in Charbagh-e- Sayedan village of Dawlatabad district.

Although the CCBHI programme is in alignment with the ARCS health strategy and has been effectively managed and able to achieve significant progress and meet most of its objectives as will be explained in following sections, it does however appear to be a stand-alone programme disconnected from other ARCS health programmes and should be addressed in the future. Complete integration of the CCBHI programme within ARCS health department should be realized and agreed as the core model for all community health engagements otherwise it runs the risk of being sidelined from active participation in shaping future ARCS health programmes and activities. This should be highlighted within the overall ARCS Health review on-going at present.

The CCBHI programme has the potential of turning into a huge success story demonstrating effective application of CCBHI approaches; however, this cannot be achieved by running the programme in parallel from other ARCS health programmes and should be addressed as a high priority.

CCBHI Relevance with MoPH and other line ministries

The ARCS health strategy is much aligned with the Ministry of Public Health (MoPH) strategy and its Basic Package of Health Services (BPHS). As such, the CCBHI programme is also naturally aligned with the overall MoPH strategic focus and long term targets.

ARCS Community health volunteer conducts personal hygiene session for a group of children in Charbagh Sayden village in Dawlat Abad district.

The BPHS recognizes and highly values community members' participation in mobilizing communities in National Immunization Days (NIDs) for Polio immunization, in health awareness campaigns and in referrals of patients to BHCs.

The ARCS Health department works closely with the MoPH both at the central and provincial levels and this is reinforced by ARCS Regional Health Officers participation in Provincial Health Coordination Committee (PHCC) meetings. However, coordination with MoPH volunteers and workers at the field level has shortfalls. MoPH has been looking at embedding Community Health Workers (CHWs) in almost all communities who are responsible for doing exactly what CCBHI and CBHFA volunteers are undertaking but it is not clear whether this is duplicated by ARCS or not. Coordination and collaboration between CCBHI volunteers and CHWs was not clear and although there was no evidence to show this has happened across the CCBHI targeted communities, it is still a risk. To avoid duplication and ensure CCBHI volunteers and CHWs better complement each other, it is highly recommended that ARCS and MoPH work on formalisation of their relation at the field level through agreeing on a MoU.

The food security or nutritional enhancement component of the CCBHI is alignment with the development goals of the government of Afghanistan. Poverty eradication and reduction of food insecurity are among the top development priorities of Afghanistan and have been captured in all national development plans including the latest Afghanistan National Peace and Development Framework (ANDF) 2017-2021[10]. Introduction of poultry farming and kitchen gardening are among the most prevalent, accepting and positive methods for tackling food insecurity and expansion of dietary diversification in Afghanistan. The Ministry of Agriculture, Irrigation and Livestock (MAIL) and a number of national and international organisations have been implementing such programmes across the country over the last five years with benefiting results.

Beneficiary household outside a newly constructed chicken house

"When the chickens started to lay eggs, eggs became cheap in the village and so you could buy eggs cheaper with less money, This meant that even people not in the chicken keeping programme became (indirect) beneficiaries".

Beneficiary in women's focus group discussion.

Beneficiary household outside a newly constructed chicken house.

[10] http://afghanistan-un.org/wp-content/uploads/2016/10/ANPDF.pdf

The level of coordination between the CCBHI and other programmes that work in food security in targeted areas is not known although there has been some interaction through the local MAIL authorities by the programme team. It is highly recommended that ARCS and IFRC actively coordinate all food security related activities with MAIL and other development agencies to avoid duplication and help in cross learning from past and present success stories and failures.

Beneficiary Participation and Selection

The participation of community members in the programme is a one of the key strengths of the CCBHI, and fundamental to any community health intervention. The collaboration with community members (community councils and grandmothers' committees) is a strong component of the CCBHI programme. Many of the CCBHI team leaders are members of community councils themselves. There is strong evidence that community members take active part in the activities and help in the programme design, targeting and implementation management and monitoring which is a real success.

Selection of beneficiaries for all programme activities is done through community councils. One representative from 20 families sits in the community council. Focus group discussions revealed that community members actively participated in all stages of programme implementation. Active participation of community members has prevented "strongmen and elite" to influence implementation of the programme in their favour. Persons of personal influence contrary to the benefits of the communities or in positions external that could have a negative influence, especially in authority, is a widespread concern across all development programmes in Afghanistan. As per CCBHI progress reports and the field evidence from the focus group discussions, this risk has been nullified through active participation of community members.

Participants in all 4 focused groups discussions on food security and nutrition mentioned that villages were surveyed and only eligible people were selected for the food security and nutritional support components.

Only one respondent out of most communities consulted who was aware of the food security activities said he was not consulted and as such was not provided any support although he acknowledged that his nephew is one of the beneficiaries of the programme and he does through this secondary channel. Whilst

ARCS Food Security officer during monitoring visit to one of kitchen guarding beneficiaries in Charbagh saydan Village of Dowlatabad district.

"I am the influential person in this village. I am a commander, but still I have not received anything from the programme. All decisions were made by the community members".

Respondent in a focused group discussion with men in Deh Hasan village of Khulm district in response to the question of if 'strongmen and elite' have influenced programme implementation.

Health Committee member, Dahward Village of Kulom district.

it might not be possible to consult with every community member, it is important to ensure maximum participation in future activities to avoid confusion and miscommunication that could lead to the misperception of exclusion. Friday prayer ceremonies are often the best time for informing community members about upcoming activities. It is recommended that future interventions utilise Friday Prayers to disseminate information about programme plans to ensure all are consulted in the future but again this was not found to be a significant issue with this programme.

The focus ground discussions did reveal some shortcomings in the process of beneficiary selection for kitchen gardening. Although the availability of water was considered while selecting beneficiaries for gardening component, all households surveyed had access to water but the programme did not determine whether the available water was enough to be also used for kitchen gardening. As a result, gardening activity has been more successful with those households that had access to abundant water to be used for watering the garden. All FGD respondents gave examples of a few failed kitchen gardening due to lack of water but more importantly in their ability to demonstrate and practice good water management awareness and activities, including the use of brown water.

Beneficiary family in Khulm Deh Hasan district.

Recommendations

Recommendations	Responsibility	Priority
> Integrate the CCBHI programme with other ARCS health programmes, particularly with CBHFA and define the singular model for all community health interventions.	ARCS	High
> Create a consortium of CCBHI programmes to allow joint planning, monitoring and sharing of knowledge and information.	IFRC	Medium
> Sign MoU with MoPH to clarify the roles and responsibilities of CCBHI volunteers and CHWs to avoid duplication and ensure better volunteers complement each other's work.	ARCS	High
> Coordinate all food security activities with MAIL and other development agencies working the targeted areas to support cross learning and innovation.	ARCS	High
> Expand further efforts related to consultation with community members. Utilise Friday Prayer Ceremony for dissemination of information.	ARCS	Low
> Include feasibility of an activity while selecting beneficiaries. Targeting most needed beneficiaries who might not be able to fully utilise programme resources could lead to wastage of resources as in the case of kitchen gardening where water provision might be scarce.	ARCS - IFRC	High

ii) Coverage:

The BRC funded CCBHI programme is being implemented in 15 villages across Balkh province. Balkh has been until recently a relatively secure province in the Northern Afghanistan with approximately 1.2 million people. The province was chosen for three reasons:

1. In rural Balkh there was poor water and sanitation infrastructure, and high child mortality (also evidenced from baselines which were higher than the national average).
2. There was relative peace and access with gaps in coverage or support.
3. Established IFRC and ARCS branch and regional offices present.

As mentioned previously, initially the programme covered only 6 villages in three districts and subsequently expanded the coverage to 9 villages and ultimately to 15 villages across 5 districts.

The geographical expansion (breadth) along with the timeline is presented in the following table and shown in Map 1.

Table 6 Time-line of CCBHI geographical expansion

		Districts				
		Khulm	**Balkh**	**Shortepa**	**Dedadi**	**Dawlatabad**
2008	**Villages**	Deh Warda	Qarloq	Arigh Batoor		
		Deh Hasan	Hasan Khil	Joy Wakil		
2011		Baba Sidiq		Basheerly	Turkmania	
2012		Ismail Khil				Qarshygak
		Sultan Darmada				Joy Arab
						Charbagh Saidan
						Yakh Dan

The decision on geographical expansion was made based on the findings of 2011 mid-term review that found the programme had been able to contribute in the improvement of health indicators in the initial 6 targeted programme sites.

The 'depth' of the programme was reconsidered in 2014 after a food security assessment was conducted in Deh Hassan and Charbagh Saidan villages of Khulm and Dawlatabad districts. Table 7 presents main outputs of the Programme over the last 8 years at the time of the evaluation[11].

Table 7 Summary of main outputs

Output	Unit	Quantity
Wells Constructed	No	109
Well Rehabilitated	No	18
Latrines Constructed	No	701
Disposal pits constructed	No	10
Gardening Support	HH	189
Poultry farming	HH	592

[11] Further interventions are planned in 2017 as part of the agreement with the control communities

Girl feeding chickens provided by ARCS.

While all programme activities have been implemented across the 15 villages, the food security component has been so far implemented in only two villages (Deh Hassan and Charbagh Saidan), while additional two villages (Deh Warda and Qarshygak) are planned to be covered during 2016/17 having agreed to act as controls in this pilot. As the programme is expected to complete in the first quarter of 2017, remaining villages activities are not covered in the above summary but were used as a comparison between the pilot and control communities.

Considering food insecurity is a widespread phenomenon across the rural Afghanistan, the targeting of these four villages was not clear regarding their selection as compared to others. Likewise piloting new activities in a select number of villages was also not clear why this was done during the last stages of the programme cycle. It was recognized that piloting should be considered in the early stages of programme implementation rather than last stage, it was however noted that its inclusion was necessary to compliment the health work but should have been done earlier. The findings showed that any support, aided households well-being and longer term resilience.

Selective or pilot approaches that lead to excluding certain communities could cause conflict among communities or lead to sense of alienation and perception of biased and prejudice selection among communities left out by the programme. All communities showed concerns regarding their respective food security and nutrition and the programme would have benefited from testing the pilots earlier over the programme time-line and the rolling it out across all communities.

It was noted though that the CCBHI programme suffered from a lack of required significant financial investment to target all households across the 15 villages under the food security component, reflective of the present global shrinkage in donor funding for Afghanistan. BRC has had some success in attracting some donor funding, complimented by its own funding reflecting its prioritisation of Afghanistan which is worth noting. The programme could

have followed a more robust need-based approach to target most vulnerable households only although it is again aware that any targeting across vulnerable communities does have its own concerns and issues. A need-based selection criterion could have allowed the programme to select beneficiaries from all villages rather than from a select few although again with the limited funding, would have been costly in doing so.

Data from the Afghanistan Living Condition Survey 2013-2014 (presented in the table 8) shows that food insecurity is highly dependent on characteristics of households. Although average food insecurity in rural areas is 36%, it ranges from 23.4% to 71.3%. Food insecurity is particularly high in rural households headed by a female (71.3%), followed by rural households headed by a person younger than 20 (51.2%). Food insecurity is also high in households headed by a person older than 65 (42.1%).

On the other hand, food insecurity is 23.4% in rural households headed by a person who has education at tertiary level. These figures add weight to the selection process but was noted by the evaluators that communities asked that the food security interventions targeting be more widespread. Following a meeting in 2015 with community leaders, the request to limit the inputs to just one per household (either poultry or kitchen garden) would be more accepting and allow an increase in households supported. This had the potential to dilute the impact at household level but assurances that cross bartering between households would negate this risk. By doing so, the issue of acceptance and possible access issues were also reduced.

Balkh Deh Harshan Community with well constructed under CCBHI Programme.

Percentage of food-insecure households, by residence, and by selected household characteristics

Household characteristic		Residence			
		National	Urban	Rural	Kuchi
Household size	1-2 persons	45.0	30.2	49.6	0.0
	3-5 persons	40.5	33.2	44.5	16.7
	6-8 persons	35.4	29.7	39.1	11.6
	9-10 persons	30.9	29.4	33.1	9.0
	11-14 persons	27.3	29.2	28.8	4.8
	15 persons or more	24.7	23.2	26.9	0.0
Age of head of household	Less than 20	48.5	55.6	51.2	7.5
	20-44	36.2	31.9	39.4	11.4
	45-64	32.2	28.0	35.3	9.7
	65 and above	37.4	29.6	42.1	13.6
Marital status of head of household	Married	34.6	29.8	37.9	10.9
	Divorced or widowed	47.6	38.7	50.4	25.0
	Never married	42.2	41.4	44.6	6.8
Sex of head of household	Male	34.7	30.0	38.0	11.0
	Female	67.1	58.2	71.3	0.0
Attained education of head of household	No formal education	39.5	39.7	41.9	11.6
	Primary	31.1	31.0	31.6	5.7
	Secondary	25.3	21.6	28.3	0.0
	Tertiary		17.3	23.4	0.0

Recommendations

Recommendations	Responsibility	Priority
> Any decision on geographical and thematic expansion should be made based on availability of resources to avoid running risk of biased selection of beneficiaries.	All	Medium
> While concentration of activities within a particular geographic area could reduce operational costs and prove to be more efficient, it may lead to targeting beneficiaries who might not be most needed. It is recommended that future food security components use selection tools that allow the selection of the most needed households.	IFRC and ARCS	Medium

iii) Effectiveness:

Health & WASH

All health indicators have significantly improved in targeted areas since the inception of the programme in 2008. Table 9 shows data from start of the programme, mid-line assessment and end line assessment; progress achieved from mid-line assessment to end-line assessment; and progress achieved during the course of the programme.[12]

While progress is eye-catching, evaluators cannot determine the full level of attribution of the CCBHI programme towards the achievements of the programme. Without a doubt CCBHI volunteers and staff have played major role in raising level of awareness in communities (contribution), but role of other development agencies working in the health sector, including the Afghanistan government, cannot be underestimated although information at this time is challenging to collate.

CCBHI can take credit for outputs, e.g. number of awareness raising campaigns or number of grandmother committees, which occur as a direct result of inputs of the programme (attribution), but CCBHI cannot claim absolute responsibility for the outcomes such as reduction in child mortality which is driven by a number of factors including access to health clinics but should be accredited with significantly contributing to the overall findings.

[12] For graphical presentation please refer to *annex I – Field findings.*

Table 9 Progress of the CCBHI

Indicator	Unit	Pilot sites				All sites			
		2008	2010-2012	Progress		2010-2012	2016	Progress	
				Change	% Change			Change	% Change
Under 5 Child Mortality	Number	256.7	141.3	-115.4	-45%	167.5	33.8	-133.7	-80%
Safer Water Dry Season	Percentage	40.2%	84.2%	44%	109%	71.6%	84.9%	13%	19%
Soap or Ash for hand-washing	Percentage	9.6%	60.8%	51%	533%	49.2%	65.4%	16%	33%
Modern Contraception Used	Percentage	3.1%	14.7%	12%	374%	17.3%	57.8%	41%	234%
ANC with skilled health worker	Percentage	3.2%	37.3%	34%	1066%	37.0%	70.5%	34%	91%
Last childbirth attended by skilled health worker	Percentage	4.0%	25.0%	21%	525%	29.9%	66.4%	37%	122%
Knowledge of treating diarrhoea	Percentage	4.7%	19.3%	15%	311%	23.8%	52.8%	29%	122%
Medical assistance sought if a child had diarrhoea	Percentage	63.7%	54.5%	-9%	-14%	66.1%	79.2%	13%	20%
Knowledge of dehydration danger sign	Percentage	25.8%	85.6%	60%	232%	66.9%	96.5%	30%	44%
Knowledge of pneumonia signs	Percentage	47.5%	79.1%	32%	67%				
Appropriate action in event of pneumonia	Percentage	57.9%	91.7%	34%	58%	57.3%	96.0%	39%	68%
Nutrition During Pregnancy - eating only the same or less than usual	Percentage					38.1%	18.8%	-19%	-51%
Iron Supply during pregnancy	Percentage					61.4%	64.9%	4%	6%
Defecation in open air	Percentage	48.3%	17.4%	-30.9%	-64%	19.6%	6.3%	-13%	-68%
Defection in earthen latrine	Percentage	50.1%	61.8%	11.7%	23%	79.6%	60.1%	-20%	-24%
Colostrum given to most recent child	Percentage					90.9%	98.9%	8%	9%
Exclusive breastfeeding for 6 months	Percentage					16.4%	50.6%	34%	209%

Grandmother committee being trained in health messaging by ARCS Health officers.

"Health visitors are very good. They see us once a month or at the time of need. They give us messages regarding health and health awareness, and advise us on how to take care of children."

Focus Group discussion with men.

The districts where the programme has been implemented at the latter period of the programme can be deemed relatively rich in terms of government health facilities (table 10) now in place. There is now a district hospital in each of the programme locations, except for Shortepa. In addition to district hospitals, there are 5 comprehensive health centres (CHC), 15 basic health centres (BHC), 9 sub-health centres and two mobile health teams in addition to 2 clinics run by charities. Certainly the existence of equipped health facilities with nurses, midwives and doctors have also contributed in achievement outcomes related to reduction of under 5 child mortality, ANC with skilled health worker and attendance of a midwife or a doctor during child delivery but the level of engagement was not possible to determine across the lifetime of the programme and both the primary/curative with the community engagement need to be seen as complimenting each other in achieving such positive results. Neither part can do so singularly.

The existence of health facilities does not undermine achievement of the programme; it means that CCBHI and other stakeholders have all contributed in improving overall health condition in the targeted areas. It is only that the evaluators are not able to exactly determine or calculate the level of CCBHI attribution, just its contribution towards the overall changes.

Table 10 Health Facilities in programme sites

Districts	District Hospital	Comprehensive Health Centre (CHC)	Basic Health Centre (BHC)	Mobile Clinic (MHT)	Sub-Health Centre (SHC)	Other clinics
Balkh	1	1	5	1	1	
Dawlatabad	1	1	3		4	
Shortepa		1	3		1	
Dedadi	1		2		1	2
Khulm	1	2	2		2	

Similarly, calculating attribution in regards to improvements in the knowledge area (i.e. Knowledge of pneumonia signs and Knowledge of dehydration danger sign) is likely challenging as the MoPH community health workers also undertook similar activities at the community level where present. This information was not possible to determine during the evaluation from the MoPH. However, the collective work of volunteers, both CCBHI and others, has resulted in significant increase of knowledge among communities.

The establishment of 'Grandmothers' Committees' by the CCBHI programme is innovative and has proven to be again significant and effective in raising awareness. Grandmothers enjoy high respect not only in their own families but also by the rural communities at large. As such they play an important role in encouraging health seeking behaviour and are able to advice and guide young women on health issues and convince otherwise conservative husbands and fathers to let their wives and daughters seek health services and undergo medical treatment in a health facility, as and when necessary. This change in mind-set has definitely contributed to reducing maternal morbidity and mortality in the targeted areas.

Food Security & Nutritional contribution

Food security activities have been recently implemented; as such actual effectiveness may take more time to be realized. Still the data shows improvement in number of indicators including: child ate green leafy vegetables in last 24h, child ate orange coloured vegetables in last 24h, child ate orange coloured fruit in last 24h, child ate eggs in last 24h and child ate beans nuts or seeds in last 24h (refer to table 11).

It is worth noting however that indicators related to food insecurity in general have actually worsened across Afghanistan during the last couple of years. During the 2014 food security assessment survey only 9.6% of interviewees acknowledged that someone within the household 'went to sleep hungry in last 4 weeks'. This figure has now increased to 19.9% during 2016 end-line survey. The score for 'no food in the last 4 weeks because of insufficient resources' has also increased to 12.4% from the base of 10.3%. Number of positive response to the question of 'anyone not ate day or night in last 4 weeks' has also increased by 1.3 points.

Beneficiaries (father and daughter) of poultry showing the product of its chickens in Saydan District of Dowlatabad District.

The drop in these indicators is understandable as the overall economy of Afghanistan has slowed down in the last two years mainly due to reduction of international military expenditure in the country coupled with political uncertainties caused after the 2014 presidential election. The GDP growth rate has decreased from 5% in 2014 to almost 1% in 2016. Unemployment and underemployment have also increased over the last two years. Considering the fact that CCBHI food security activities were not comprehensive and only meant to increase the nutritional value of the household food basket, it would be unrealistic to expect the programme to offset the negative effects of the overall economic slowdown on nutrition in the target communities.

To calculate the exact impact of the CCBHI food security activities on the targeted communities by nullifying external factors, the Difference-in-Difference (DiD) model has been used to quantify progress in the programme sites and that of control villages. Data and analysis are presented in table 11.

The DiD analysis does not show much progress. Actually indicators in the control groups show better progress in 6 out of 8 areas (highlighted in red in table 11). In other words, communities that have not received CCBHI assistance show better progress compared to communities that had been targeted by the programme. Evaluators are not in a position to comment on the exact reason for this result, but the following points could be considered as contributing factors in order of likely reasons:

1. Control group selection mistake: if the control group is being supported by another development agency, then it cannot be considered for comparison purposes or where, which might be likely, is there is leakages into control communities. Communities are benefiting from produce making its way into control group markets.

2. The programme might have targeted less vulnerable groups for the pilot: If a programme supports households that are not considered absolutely food insecure, the programme will have lesser or limited achievement in terms of reducing food insecurity given the possible coping mechanisms of these households.

3. Food security activities were not well designed or appropriate to the targeted communities. This is less likely given the overall level of food insecurity across Afghanistan and the semi-arid Balkh province in particular.

4. Survey mistakes: selection method of interviewees could have been not rigorous enough to generate reliable data. This could be plausible but given the selection protocols developed [13], it is difficult to know whether this was followed.

Programme Management

The following concerns in programme management were observed by the evaluation team:

Result Based Management:

- The CCBHI programme has not followed principles of result-based management. Programme logical framework does not have sufficiently SMART [14] targets for outcomes and outputs; it only states an overall objective without specifying numerical targets that need to be achieve.
- The programme also does not have Performance Measurement Framework (PMF). Objective assessment of success or failure of a programme or even activity with PMF is difficult, if not impossible.
- Related to the above points, the programme developed annual plans that included list of activities and outputs. The programme did not have one overarching plan of action and budget for the entire duration of the programme which would have helped to determine gaps in support and should have been developed by ARCS with IFRC support. This would have helped partners to determine multi-year inputs and financing.
- In the absence of a complete logical framework and PMF and a multiyear plan, the CCBHI programme appears to be activity driven rather than being result oriented.

ARCS food security officer visiting a kitchen gardening beneficiary in Charbagh-e-Sayedan village of Dawlatabad district.

[13] A complete methodology of field protocols is available on request from British Red Cross
[14] SMART: Specific, Measurable, Attainable, Realistic and Time bound

Table 11 Measuring change in Programme sites and control group using DiD

		Anyone went to sleep hungry in last 4 weeks	No food in last 4 weeks because of insufficient resources	Anyone not ate day or night in last 4 weeks	Child ate green leafy vegetables in last 24h	Child ate orange coloured vegetables in last 24h	Child ate orange coloured fruit in last 24h	Child ate eggs in last 24h	Child ate beans nuts or seeds in last 24h
Programme	2014 (A)	9.6%	10.3%	10.3%	2.8%	7.6%	0.0%	3.2%	3.2%
	2016 (B)	19.9%	12.4%	11.6%	8.1%	10.1%	6.1%	13.4%	15.0%
Difference (B-A)		10.3%	2.1%	1.3%	5.3%	2.5%	6.1%	10.2%	11.8%
Control	2014 (C)	10.0%	10.4%	9.8%	2.0%	8.2%	0.2%	1.6%	2.2%
	2016 (D)	23.0%	11.2%	7.0%	9.1%	12.9%	3.0%	13.5%	14.8%
Difference (D-C)		13.0%	0.8%	-2.8%	7.1%	4.7%	2.8%	11.9%	12.6%
Difference-in-Difference	B-D	-3.1%	1.2%	4.6%	-1.0%	-2.8%	3.1%	-0.1%	0.2%
	A-C	-0.4%	-0.1%	0.5%	0.8%	-0.6%	-0.2%	1.6%	1.0%
	(B-A) - (D-C)	-2.7%	1.3%	4.1%	-1.8%	-2.2%	3.3%	-1.7%	-0.8%

New hand-washing facilities.

Monitoring:

- Programme and ARCS staff have regularly monitored the programme sites. However, in the absence of a PMF the monitoring missions appear to be more of supervision rather than monitoring in a sense of assessing whether activities are leading to intended outcomes. Whilst advanced, the introduction of benefits management or monitoring mechanisms would have been really helpful although would have required sizeable investment in terms of training and implementation across the management personnel to do so. It is still something to be considered.
- Independent monitoring has been occasionally conducted. Information gathered from progress reports alone indicates that there was no recorded IFRC field monitoring visits carried out of the programme from 2012 to 2015. During 8 years of the programme, IFRC has only conducted 3 field monitoring visits (2009, 2010, 2015)[15] outside of the joint BRC/ IFRC technical reviews and the mid-line assessment. Considering the fact that IFRC remained distant from implementation of the programme, the evaluation team cannot verify the effectiveness of technical support provided by the IFRC to the CCBHI programme. It may well be that there were field monitoring visits carried out but these have not been recorded in the annual reporting platforms and would show a weakness again in the programme's PMF.
- BRC Health delegate monitored programme site only once in 2009. Considering the fact that BRC had delegated monitoring and supervision to IFRC, lack of BRC monitoring is understandable. In the absence of sufficient monitoring by IFRC, however, the programme should have recruited third party monitoring agent or mechanisms.

Other observations:

- Supervision and management of the programme was shifted to Balkh regional office from the Balkh Branch office in 2014. The decision was made without consultation with BRC or documenting reasons for shifting the programme home. Whatever the rationale might be, delegating programme implementation to a ARCS regional office is against internal rules of the National Society. Regional offices have supervision, coordination and facilitation role; implementation is the sole responsibility of the branch office. ARCS, however sensitive, should have made this none.
- Starting from 2011 progress reports, deteriorating security situation has been constantly cited as one of the main challenges faced by the programme. The development of robust risk mitigation plans would have been helpful but is noted that this might have been dependent on the process of developing a wider National Society Security Framework, being supported by the ICRC in 2015/2016 following the roll out of the ICRC assessment process on acceptance and safer access which is on-going.

Hand pump and well being used by beneficiary family.

[15] IFRC has frequently visited the Project office in Mazar, however monitoring visits to the project site is only limited to three occasions (reference: Progress Reports).

Recommendations:

Recommendations	Responsibility	Priority
> Integrate result-based-management into all phases of the programme life cycle. Develop logical framework that has SMART'er indicators and targets; develop performance measurement framework; develop monitoring plan and monitoring tools and consider benefits monitoring.	All	High
> It is highly recommended to move from annual planning and budgeting to multi-year planning process. Develop a work plan and budget for the entire duration of the programme and subdivide activities per year or by milestones. If necessary, revise annual plans accordingly.	All	High
> Development of annual plans and budget in the absence of an overarching work plan runs the risks of becoming activity driven. Without having a specific result/target in mind, activities may only generate outputs and do not contribute to achievement of outcomes.	All	High
> Develop Theory of Change for all future programmes	All	Medium
> Contract third party monitoring agent if security situation does not allow IFRC and BRC to monitor programme sites.	All	High
> Third party monitors are increasingly being utilised in Afghanistan by development agencies and even humanitarian agencies such as ICRC. Regular independent monitoring is crucial to ensure resources are spent as planned.	All	High
> Any major changes to the programme or outside set tolerances or parameters, including management considerations, should be consulted with all programme stakeholders and well documented through a robust escalation process linked to risk management protocols (see below).	ARCS, IFRC	Medium
> Develop risk assessment and mitigation plan, including security management protocols for all activities and staff/ volunteers. The risk assessment should clearly state the level of risk and risk tolerance along with well defined mitigation measures, including closing down an activity.	All	High
> Conduct stakeholder mapping for all future activities to indicate what other development partners are doing in the targeted areas.	ARCS, IFRC	Medium
> Clearly capture contribution of other development partners in targeted areas in the progress report.	ARCS, IFRC	Medium
> Adapt need-based approach for selection of beneficiaries.	All	High

iv) Efficiency:

As of July 2016, the total programme expenditure is approximately[16] CHF 1,666,495. Programme funds have been spent on following areas:

- 45% of expenditure is on supplies and construction.
- 9% training and workshop.
- 24% personal salary.
- 22% operation related expenditure.

The ratio of operational/programme expenditure can be seen to be particularly high for a programme that is mainly run by volunteers but consideration needs to be factored in to the time issues that activities take to be implemented due to the security considerations that often delay or impact efficiencies in implementation. The above first two expenditure areas (combined 54%) include direct expenditures on beneficiaries (programme) whilst the last two expenditure areas (combined 46%) are operational cost of the programme. Operational/programme ratio is 0.85; meaning the programme has spent CHF 85 to deliver CHF 100. The evaluators are aware of the lack of evidence obtainable during the evaluation of other similar programmes to determine whether this is acceptable in the implementation of community programmes or has direct correlation with external factors could not be determined.

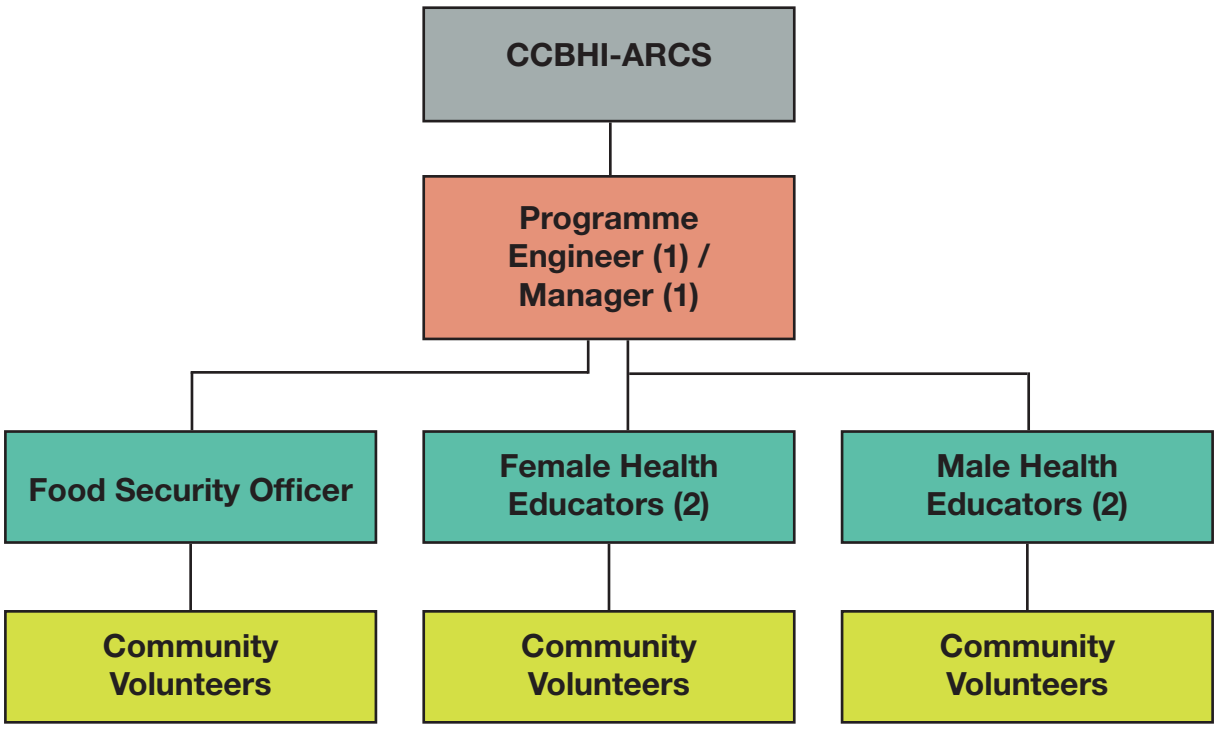
The programme had on average 5-6[17] full-time staff during the programme lifetime, but personnel salary constitutes 24% of overall expenditure with budget lines built into the programme budgets for ARCS management at regional and HQ levels plus IFRC programme monitoring, delegate and technical support plus the IFRC global administrative charges for reporting and financial management including security management. The CCBHI has paid salary or top-ups to number of other people that were not full-time programme staff. As the programme does not have an approved Human Resources Plan, evaluators could not verify the exact contribution of non-programme staff to the programme. It is a standard practice across all programmes through IFRC and the value added of the IFRC needs to be clearly articulated.

The delivery rate (Executed Budget/Planned Budget) of CCBHI programme is 78%, which is relatively low. Deteriorating security situation since 2010 has been flagged out as the main reason for delays in implementation of the programme. Unstable security condition in Shortepa district in particular caused prolonged delays. With the increase in security threats in the two villages of Shortepa, the CCBHI programme transferred its activities to two alternative villages in Dawlatabad district. Even in the new villages, security threat remained high but ARCS was able to stabilise the situation, albeit after delays.

Handing over of procurement procedures by IFRC to the ARCS logistic department as part of the ongoing strategic capacity building area of the National Society in 2014, caused further delays in implementation of the programme. Delay was caused due to the lengthy procurement process of National Society. The material or 'hardware' part of programme, including construction of 65 latrines and 10 wells, that were planned for 2014 were carried out to the following year as the ARCS logistics department could not complete the procurement processes required. It appears ARCS has not taken any effective step to simplify its procurement system as 'long administrative and logistic procurement procedures of ARCS' was cited as one of the main challenges of the programme in the latest progress report. This also been stated in other programme reviews and not singular to this programme. IFRC should look at means to step in or take back responsibilities where significant delays occur in future rather than exasperate these further from no action. The lack of communication was equally an issue to partners who could have jointly pressured ARCS with IFRC to address these systematic issues.

[16] This figure was calculated by adding financial data derived from annual progress reports. IFRC was not able to generate a financial report for the duration of the Project. Actual expenditure could be higher or lower than the figure presented here.
[17] The programme had a full time programme manager supporting the health work until 2015. The role was taken over by the programme engineer after the departure of the manager/doctor.

Figure 1: CCBHI Programme management and Implementation structure



It is worth noting that the delays in the procurement processes including tendering is from the wider issues over corruption endemic in Afghanistan and a number of tender processes were halted and re-issued following legitimate or worries over the results of these processes. There are always considerations with being efficient and with Afghanistan, being robust enough so there are no integrity issues. The evaluators did not look specifically at any integrity issues but none were reported connected to this programme.

However, it is worth noting that IFRC's hand over of logistics and procurement in 2014 is a clear case that affected the timeliness of activities within this programme. ARCS Logistics capacity was not capable of undertaking the required work quickly and efficiently at this time which resulted in significant delays in work being carried out. Undertaking of capacity assessment prior to delegation of responsibility could have minimised challenges that the programme faced in the last two years.

'The programme staffs received indirect warning by unknown group in Dawlatabad district that field visits to the communities was halted for a while which caused delay in digging of wells and conducting of trainings to volunteers. With the support of community leaders, security was guaranteed and implementation of activities was continued'.

(2013 Annual Progress Report)

Recommendations:

Recommendations	Responsibility	Priority
> Future interventions must bring down operation cost as much as possible security permitting.	BRC and IFRC	High
> Develop risk assessment and mitigation plan for all activities. The Risk assessment should clearly state the level of risk and risk tolerance along with well defined mitigation measures, including closing down an activity.	ARCS and BRC	High
> Building capacity of ARCS is one of the main objectives of IFRC, partner National Societies and even the CCBHI programme. Any future intervention should develop activities for capacity development of ARCS, particularly the OD, logistics and finance departments. IFRC, in particular, mush focus on building institutional capacity of ARCS through existing programmes.	IFRC	High
> Related to the previous recommendation, it is highly recommended to conduct capacity assessment before delegating responsibilities to a programme stakeholder. First address capacity gaps, then transfer responsibilities.	IFRC	High
> Develop Human Resources Plan to indicate how many people need to be recruited on full-time, part-time and consultancy bases.	IFRC	High

"After having my first harvest of Gandana (Afghan leeks), I cooked Ashak (a traditional Afghan dish) and even shared with my neighbours. I really felt good about it, it made me happy".

Focus Group Discussion with women

A food security project family in Qarshiqak village during monitoring by project team member.

v) Impact:

What are the positive and negative, intended and unintended consequences of the Programme?
As described in the effectiveness section, the programme has been able to generate number of 'intended' positive changes in the programme communities This section will only cover unintended positive or negative consequences of the programme.

In total 12 focused group discussion (FDG's) were held with programme beneficiaries. FDG participants mentioned number of positive spin-offs within the community.

These include:

- Some of the community members who had financial resources built their own latrines based on the learnings from the programme. These members learned the benefit of having a latrine and also learned how to construct one. Other community members also want to have their own latrines now but cannot afford to do so due to budgetary constraints.
- Having a common well in the area has increased cooperation among family members who use the well. If the well needs repairing or remedial work carried out, each household contributes some money to be used in this regard.
- Overall knowledge of sanitation has increased within the community. All WASH FGD respondents mentioned that they believe their community is cleaner now compare to the past.
- The poultry component has reduced the price of eggs in the community from 7 Afghanis to 3 Afghanis. Households that benefited from the poultry support sell eggs to neighbours or the local store owners. Overall consumption of egg has now increased as those who have not directly benefited from food security programme can now buy eggs from local store given their lower costs. The unintended benefit to non-beneficiaries within the communities showed that households could now afford eggs whereas in the past they could not, increasing their own household nutritional food basket.
- Food security activities have also created a barter economy within the villages and across villages. A number of women mentioned that they exchange eggs with other goods with their neighbours.
- The barter economy has also increased overall interaction among women in the community.
- FGD's with women also revealed that food security activities had a positive impact on their empowerment and boosting their self-esteem.

"Now, I go to my neighbour to exchange egg with something else. I use this opportunity to talk with my neighbour about different issues. I really enjoy these chitchats".

Focus Group Discussion with Women

vi) Sustainability:

Behavioural change caused by the programme (i.e. hand-washing and other hygiene practices) are the most likely to be sustainable without further ARCS interventions. It is well-known that once a habit is formed (such as hand-washing), the action becomes automatic and second-nature; as such sanitation habits advocated and caused by the programme should remain sustainable. Similarly, awareness raising activities such as 'knowledge of how to identify danger signs of diarrhoea and pneumonia' will have long lasting effect. It is very unlikely that community members would forget these health messages anytime soon.

Sustainability of other achievements such as access to clean drinking water, however, remains questionable and dependent on the financial strengths of the communities. Whilst members of one community mentioned they collect money from households to repair the well, another FGD respondents argued they do not have financial resources to pay for repairs. Remedial works are more likely to be able to be covered through these remittances practices across the communities but significant repairs will stretch even the more 'wealthier' communities.

Although the programme has trained technicians in maintenance in each community, the CCBHI programme has had to cover some rehabilitation work across a number of wells constructed by the programme. Whether communities will rehabilitate or be able to undertake major repairs for wells on their own remains unclear.
The programme also had to intervene this year to control spread of disease killing chickens in the targeted area.

The poultry management training should cover topics related to 'steps taken during outbreak'. Instead of contacting the programme, beneficiaries should have directly reached out to the relevant local authorities, having had this connection in place by the programme. The programme should train or secure the relevant local entities to undertake this as part of the programme work, to all beneficiaries on how to address outbreaks to prepare them to take practical steps in the absence of the programme.

Kitchen gardening has proven to be successful in households that have access to sufficient water to be used for watering the garden but failed in small number of cases where water access was limited or had poor water management expertise. As a result, sustainability of kitchen gardening is questionable to a degree. The CCBHI could have introduced water management understanding and awareness in techniques such as drip-irrigation in areas that lack sufficient water which would have helped to mitigate some of the risks raised concerning limited water access. Whilst overall water availability was taken into consideration in the selection of the pilot locations, it was not robust enough to look at household practices and even to understand whether the use of 'brown' water was an option to water the kitchen gardens. The long term potential is possible but needs to have greater understanding of household water management practices coupled with injecting understanding on strong water management techniques. Working with other agencies and actors outside the Red Cross/Crescent will benefit the longer term support to these communities beyond the lifetime of the programme.

"Seasonal viral diseases such as colibacillosis caused death to 43 chickens in eight beneficiaries' farms in Deh Hassan village of Khulm district. The outbreak was reported by the community volunteers to the ARCS programme staff. The team took necessary action by consulting the provincial agriculture department and coordinated for vaccination of all chickens in the area. All chickens of the mentioned villages have been vaccinated and the outbreak has been successfully controlled".

(2016 Report, p.5).

Hand-washing workshop by ARCS health officer.

Institutionalisation of volunteer-ism within the community, at least among male community members, has yet to be achieved. As per the latest progress report:

> "During follow-up activities, it was found that 50% decrease of (male) volunteers in three targeted villages of Khulm and Dawlatabad districts. The reason behind this was mainly economic problems, as most of volunteers have left their villages and moved to the city for labour work".

(2016 Progress Report, P. 7).

Again, whilst this is not just specific to this programme's longer term potential, it is common across all development work and the sector in general over the last couple of years. The risk on the loss of skilled and other human resources, most for security and economic pressures, both within and migrating outside the country will continue and ARCS needs to factor this in their programme planning process.

Long term funding remains one of the major risks to sustainable programmeming. Without the ability to attract multi-year funding risks the Society's acceptance, access or even own survival if it has to take on the financial burden if donors or partners cannot sustain the programme commitments. Longer term financial planning is necessary to ensure programmes of this length are able to meet their obligations without doing more harm than good.

Abdul Jamil, beneficiary of poultry project.

Applying of knowledge gained in poultry training; Abdul Jamil, 50 year old man said, the time when we received chicken from Afghan Red Crescent Society (ARCS) the weather was too hot in summer. In order to keep the chickens alive and protected, we applied all the skills learned from the training provided by ARCS. We kept the coops cleaned and vaccinated the chickens as well as fed them properly. We also installed a coolant shield made of thorns and bushes against the windows of the coop and poured water on it. Thus, the coop was made cool and the chicken survived the intense summer heat. Taking care of chickens and keeping them healthy resulted in good produce of eggs for the family.

Mr Abdul Jamil during interview.

Recommendations	Responsibility	Priority
> Future interventions should create a mechanism for establishment of a community fund to be used for repairing and rehabilitation or remedial work. For example, a minimum monthly fee of around 5-10 Afs can be collected from each household and put in a basket to be used for rehabilitation purposes.	ARCS	Medium
> Programme beneficiaries should be trained on how to address outbreak of disease or linked to actors or agents that can.	ARCS	High
> Train beneficiaries on examples such as drip-irrigation for kitchen gardening and other water management practices. Connections to other agencies or actors to help with this will support its longevity.	ARCS	High
> Automatic volunteer recruitment process should be looked at so that when a volunteer leaves the village s/he could be automatically replaced by another volunteer, where possible.	ARCS	Medium
> There should be better mechanisms for volunteer management in place where community engagement is in place.	ARCS	Medium

Hygiene promotion activities being undertaken by ARCS.

3. Conclusions:

Improving health status of rural Afghanistan is a priority of the government, donor community, ARCS and other development partners and is one of the main risks facing Afghanistan. The CCBHI programme has made valuable contribution in achievement of this target in the 15 villages supported in Balkh province. Almost all health indicators show significant improvement in areas where the programme has been implemented.

Certainly, the CCBHI programme has achieved its main objective:

'To contribute to improved health status of the targeted beneficiaries in, targeted districts of Balkh province'.

ARCS Health officer.

The biggest asset of the programme is the fact it works with communities and heavily relies on volunteers. This strategy increases community ownership and participation and the role of Grandmother committees in support women to be more health aware and through their advocacy role, in enabling women and young girls to access the relevant health care services otherwise restricted to them.

The reduction in the level of child mortality over the lifetime of the programme is, in itself, the one defining result regardless of the level of attribution. The programme would have been a contributing factor in these communities and the ability of the ARCS to continue to be accepted, be able to access these remote or hard to reach communities and to work where others are becoming less able to do so reinforces the rational for the continued support in this work. It is also not expensive to run; on average its annual budget is CHF 200,000 but the ration between direct and indirect costs need to be made aware and addressed even if it is purely on advocacy grounds.
Evaluators strongly believe that ARCS, BRC and IFRC should continue community driven programmes such as the CCBHI to improve the overall health status of rural population of Afghanistan. However, to increase effectiveness, ensure better efficiency and sustainability, future programmes should pay more attention to programme management issues particularly adoption of RBM, development of human resources plan, risk assessment and mitigation plans and shift to multi-year planning and budgeting. To avoid the risk of alienation and maximizing the opportunity to leverage from other resources, future interventions should be better coordinated with other ARCS health programmes and those of development partners and
other agencies.

To support this work, regular monitoring should become centrepiece of all future interventions. If security situation does not permit IFRC to conduct regular monitoring, the organisation should look at third party monitors which are being increasingly used in Afghanistan even by humanitarian agencies such as ICRC.

Finally, the evaluators found the results of this programme to be commendable and 'going the extra mile' to help those most vulnerable and in need remains the focus of the Red Crescent in Afghanistan and its partners.

Annex I: Programme Result - Graphs

Figure 1: Under 5y mortality per 1000 live births (5 year rolling average)

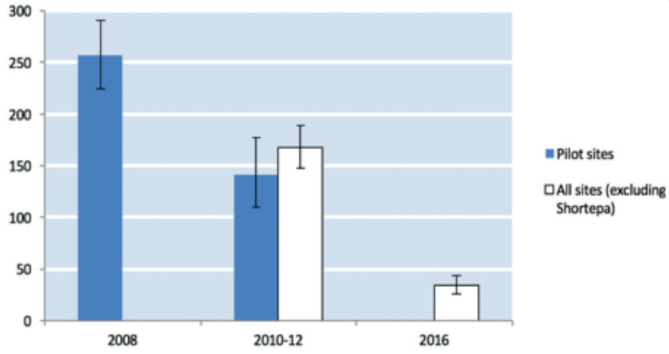


Figure 2: Safer water (or treated water) used in dry season

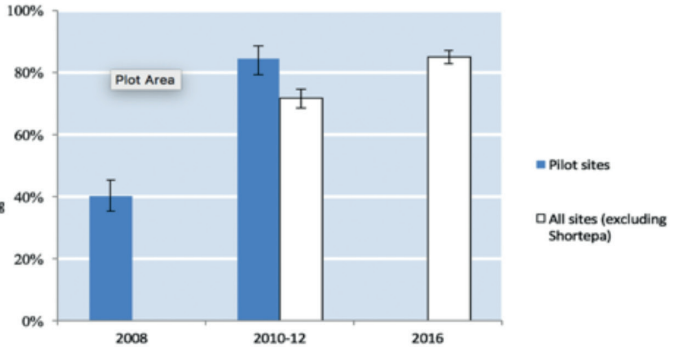


Figure 3: Water source constructed by Red Crescent (where construction is relevant)

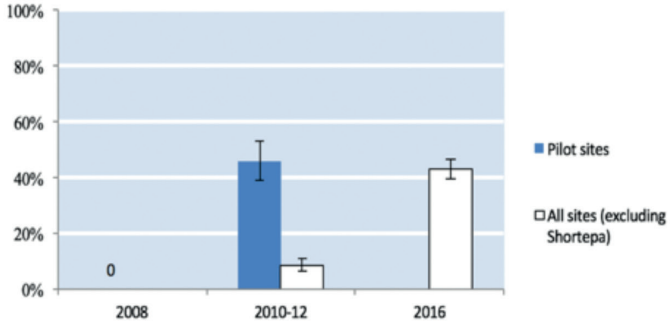


Figure 4: Soap or Ash for Handwashing (observed)

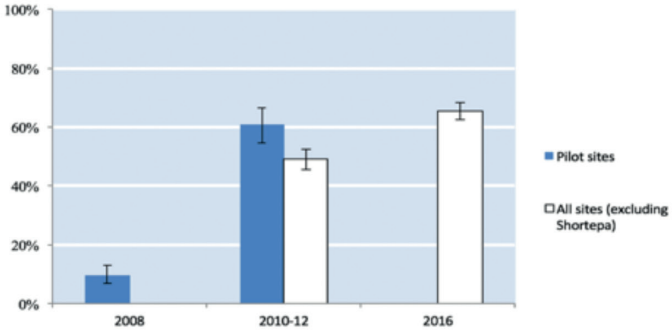


Figure 6: Handwashing Before Handling Food and after Defecation (self reported)

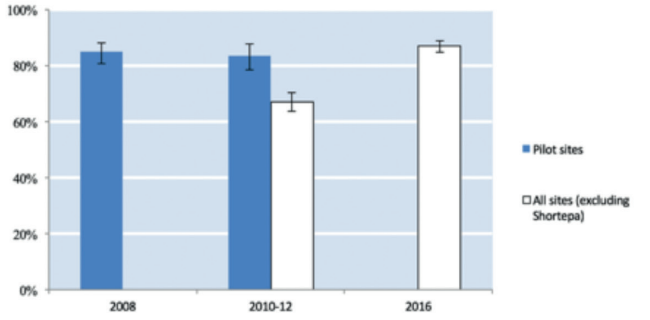


Figure 7: Place of defecation by type

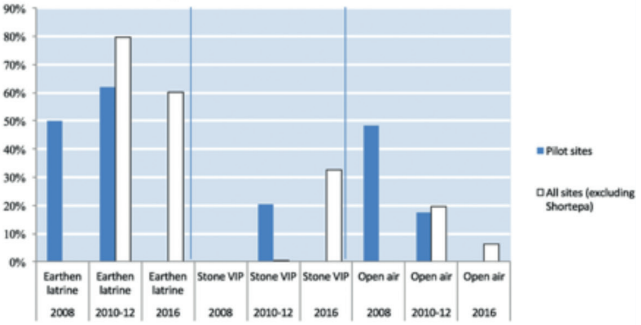


Figure 8: Modern contraception used in last 12 months

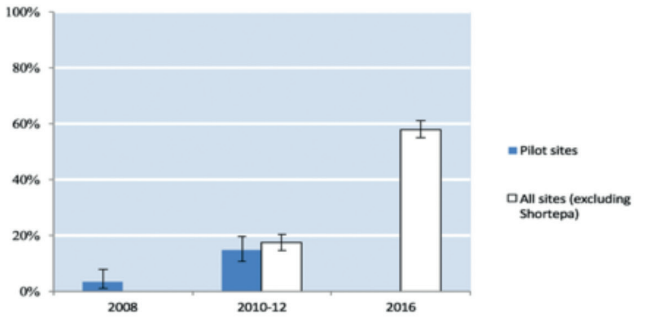


Figure 9: ANC with skilled healthworker during the last pregnancy

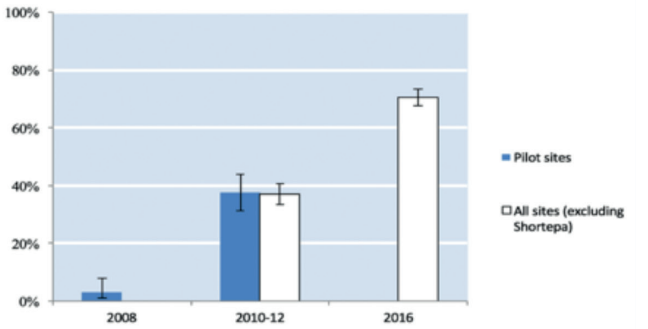


Figure 11: Any rehydration would be given if a child had diarrhoea
This measure assumes they may not be able to visit a medical practitioner in time

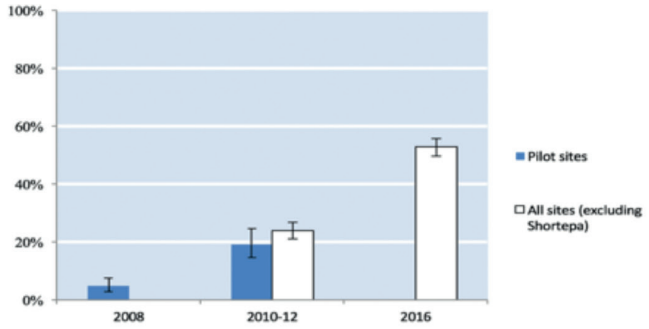


Figure 10: Last childbirth attended by skilled health worker

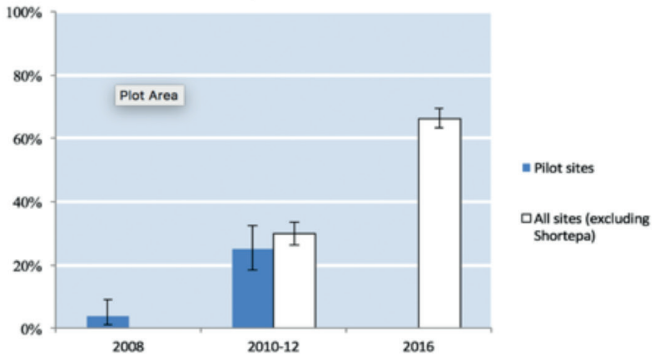


Figure 12: Any rehydration would be given or medical assistance sought if a child had diarrhoea

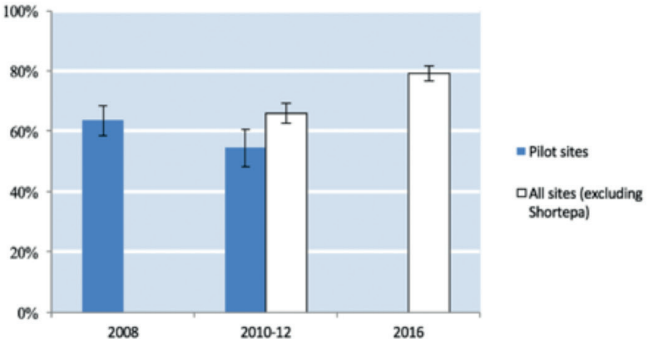


Figure 13: Any medicine given without rehydration if a child had diarrhoea

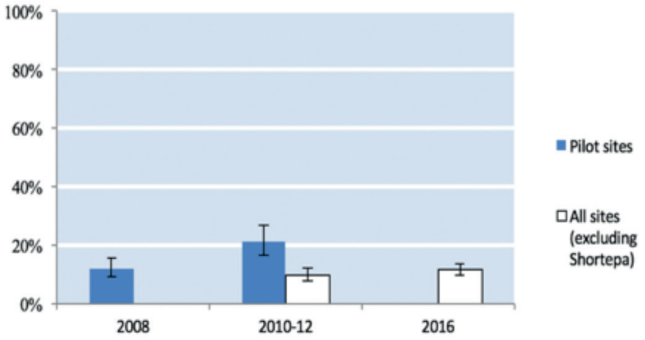


Figure 14: Appropriate action in event of pneumonia (seek medical help, consult RC volunteer, treat antibiotics)

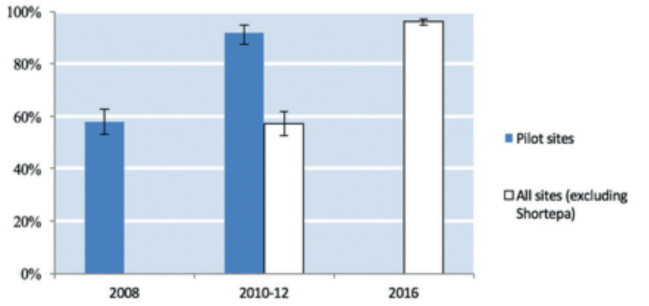


Figure 15: Any danger sign of dehydration recognised

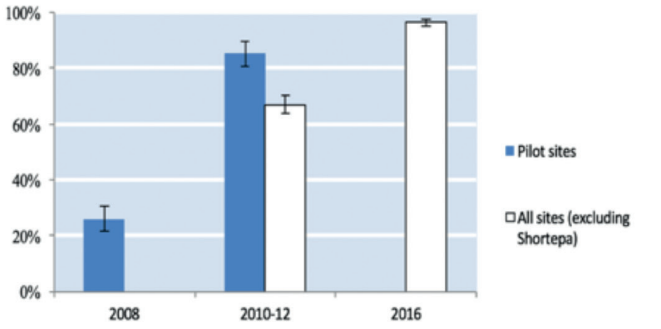


Figure 16: Any danger sign in diarrhoea to seek medical assistance recognised

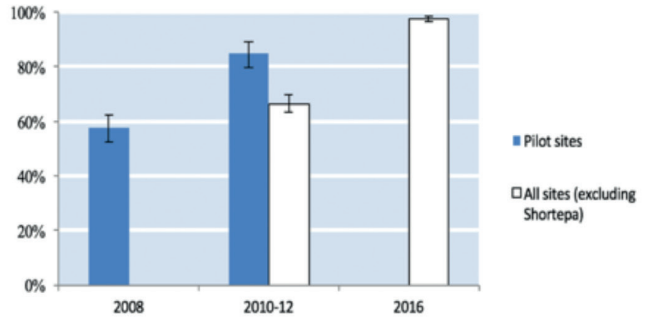
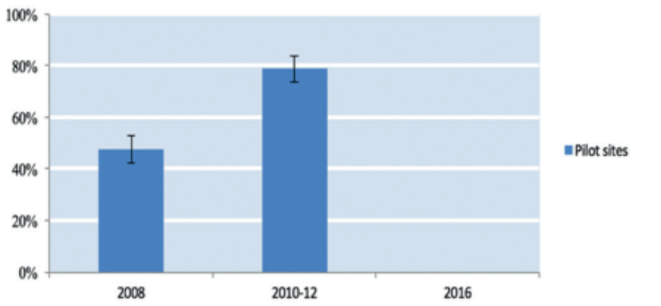


Figure 17: Any specific sign of pneumonia recognised



Ballk Khulm Deh Hashan district. ARCS undertaking role play with community on health practices