Formative Evaluation of the Integrated Management of Acute Malnutrition (2013-2019) Afghanistan

Final Evaluation Report 30th January 2021

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Disclaimer

The opinions expressed are those of the evaluation team, and do not necessarily reflect those of UNICEF. Responsibility for the opinions expressed in this report rests solely with the authors. Publication of this document does not imply endorsement by UNICEF of the opinions expressed.

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ACRONYMS

ACF	Action Contre la Faim/ Action Against Hunger
AFSeNA	Afghanistan Food Security National Agenda
AFSNP	Afghanistan Food Security and National Plan
ANDS	Afghanistan National Development Strategy
ATR	Access Transform Reach
BHC	Basic Health Centre
BNA	Bottleneck Analysis
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard
CBHC	Community Based Health Care
CBNP	Community Based Nutrition Package
CHC	Comprehensive Health Centre
CHS	Community Health Supervisor

CHW	Community Health Worker
CMAM	Community Based Management of Acute Malnutrition
CTC	Community-based Therapeutic Care
DH	District Hospital
EPHS	Essential Package of Hospital Services
EUM	End User Monitoring
FGD	Focus Group Discussion
FHAG	Family Health Action Group
GAM	Global Acute Malnutrition
GCMU	Grants Contracting Management Unit
GoIRA	Government of Islamic Republic of Afghanistan
HMIS	Health Management Information System
IDP	Internally Displaced Person
IEC	Information Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INGO	International NGO
IP	Implementing Partner
IPD	Inpatient Department
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring & Evaluation
MAM	Moderate Acute Malnutrition
MAMI	Management of Acute Malnutrition in Infants
MHNT	Mobile Health and Nutrition Team
MoPH	Ministry of Public Health
MUAC	Mid-Upper Arm Circumference
NAF	Nutrition Action Framework
NC	Nutrition Counsellor
NGO	Non-Governmental Organisation
NNC	National Nutrition Cluster
NND	National Nutrition Database
NNGO	National NGO
NNS	National Nutrition Survey
NNSS	National Nutrition Surveillance System
NPCC	Nutrition Programme Coordination Committee
NPNS	National Public Nutrition Strategy
NSAG-TB	Non-State Armed Group – Taliban

OPD	Outpatient Department
QA	Quality Assurance
QoC	Quality of Care
P4P	Pay for Performance
PH	Provincial Hospital
PLW	Pregnant and Lactating Woman
PMO	Performance Management Office
PND	Public Nutrition Directorate
PNE	Provincial Nutrition Extender
PNO	Provincial Nutrition Officer
PNS	Public Nutrition Strategy
RH	Regional Hospital
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RUSF	Ready to Use Supplemental Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SCM	Supply Chain Management
SDG	Sustainable Development Goal
SEHAT	System Enhancement for Health Action in Transition
SHC	Sub-Health Centre
SM	Strengthening Mechanism
SMART	Standardised Monitoring and Assessment of Relief and Transition
SO	Strategic Objective
SOP	Standard Operational Procedure
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SP	Service Provider
SR	Strategic Result
SUN	Scale-Up Nutrition
TOR	Terms of Reference
TWG	Technical Working Group
U5	Under 5
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USD	US dollars
WAZ	Weight for Age Z-score
WFH	Weight For Height
WFP	World Food Program
WHO	World Health Organization
WHZ	Weight for Height Z-score

Executive Summary

Evaluation features

This is the first formative evaluation of Integrated Management of Acute Malnutrition (IMAM) in Afghanistan. It has been undertaken to gather evidence on the processes and results of IMAM in order to contribute to enhancing the programme's performance and strategies to deliver effective results. The evaluation primarily serves the information needs of the Ministry of Public Health (MoPH) of the Government of the Islamic Republic of Afghanistan (GoIRA) and its partners who are involved in preventing and treating acute malnutrition in children under 5 and in pregnant and lactating women. The evaluation examines IMAM services from 2013 to 2019 which coincides with the IMAM scale-up and the National Public Nutrition Strategy 2015-2020. IMAM is evaluated for its relevance, efficiency, effectiveness, coverage and sustainability and provides recommendations to inform effective programme implementation.

The evaluation was conducted using a mixed methods and participatory approach, generating quantitative and qualitative data and using a variety of sources to enable triangulation. Data collection methods and tools were adapted for the Afghanistan context. Data was collected from February to July 2020. All data collection in provinces was conducted by a national data collection agency. Data sources used to inform the evaluation findings included documentary evidence, key informant interviews and focus group discussions conducted at national, provincial, health facility and community levels, quantitative data and photos from health facilities and coverage surveys at community level.

Context

Afghanistan is one of the world's most complex humanitarian emergencies, characterised by escalating conflict causing over one million people to be living in new and prolonged displacement. In late 2019, the Afghanistan Humanitarian Response Plan estimated that 9.4 million people were in need of some form of humanitarian and protection assistance in 2020. An estimated 2.54 million children under 5 years and 563,000 pregnant and lactating women are affected by acute malnutrition, and 690,000 children are at risk of severe acute malnutrition (SAM). Direct and indirect violence against government facilities and staff and against humanitarian personnel and assets continues to challenge delivery of health and nutrition services.

Integrated Management of Acute Malnutrition

IMAM is a public health approach to address acute malnutrition emphasising community participation, active case finding and high treatment coverage enabling access to a continuum of care for children with severe (SAM) or moderate acute malnutrition (MAM) and for Pregnant and Lactating Women (PLW) with MAM. For children with acute malnutrition without medical complications treatment is given at community-based health facilities, and for those with complications at inpatient hospital facilities. Initially implemented as a vertical programme for the treatment of SAM within hospitals and community based health facilities, IMAM was integrated into the Basic Package of Health Services (BPHS) in 2010 and Essential Package of Hospital Services (EPHS) in 2014, and implemented for the MoPH by local NGOs, the BPHS and EPHS contract holders. This integration into public health structures was accompanied by the development of national guidelines for IMAM. These integrated the treatment of children with MAM or SAM into OPD and IPD in 2014, and were endorsed by the GoIRA, UN agencies and BPHS / EPHS partners under the coordination of the National Nutrition Cluster (NNC). By 2019, IMAM services for the treatment of SAM has been scaled up to all 34 provinces.

Key findings and Conclusions

Relevance: The IMAM approach in Afghanistan is relevant and appropriate. An appropriate enabling environment exists for IMAM services to be implemented and scaled up. Since 2013, this has enabled IMAM services to undergo a remarkable expansion to achieve universal programme coverage by district (for OPD SAM treatment). However national nutrition policies and strategies need to be strengthened with the inclusion of specific IMAM-related indicators and targets for strategic objectives and intermediate results.

The evolution of national nutrition guidelines and Nutrition Standard Operating Procedures (SOP) (2015) has been less coherent. One inconsistency is calculation of acute malnutrition burden based on WHZ prevalence data alone leading to inequitable targeting, under-estimation of commodity needs and overestimation of programme performance. Since 2018, where up-to-date prevalence data has been available, burden estimates have been calculated using combined GAM. However in the majority of provinces WHZ prevalence data from the 2013 NNS is used to calculate burden. Burden estimates need to be calculated using combined GAM based on WHZ, MUAC and oedema.

The latest version of the IMAM guidelines (2018) should be rolled out with immediate effect to ensure appropriate implementation and quality programme delivery. The Nutrition SOP currently being updated (2020/1) is a great improvement. Further review should address inconsistencies between sections to facilitate the improvement of equitable IMAM case coverage especially with regards to screening and referral of infants < 6 months. Future iterations of IMAM guidelines should also account for WHO updates (due 2021) and the inclusion of practical measures for infants and children with disabilities.

The expansion of services has largely achieved vertical equity through annual retargeting of OPD-MAM services toward areas of greatest need which has nuanced the evolution of universal coverage. Some inequity exists in access to treatment as a result of insecurity and availability of treatment due to insufficient funding for nutrition commodities. The lack of specific data to evaluate the accessibility of ethnic minorities and Kuchi populations and anecdotal reports of poor behaviour of health staff towards these communities warrants closer monitoring and reporting to ensure equitable access and accountability of health staff.

Programme data indicates that IMAM services have been sensitive to variations in the prevalence of acute malnutrition due to short term and seasonal nutritional stressors, responding to increased need by admitting more children and PLWs for treatment.

Effectiveness: The IMAM approach in Afghanistan has been effective at achieving its purpose. From 2013-2019, 880,000 children with SAM and 600,000 children with MAM have been admitted and cured representing an estimated 185,000 (range 113,000-228,000) lives saved. Programme performance for OPD & IPD SAM met or exceeded national standards for cure rate and default at national level. Further reductions in mortality and morbidity could be achieved through improving outcomes in OPD-MAM that have underperformed during 2017-2019.

Bottlenecks to quality service delivery include a lack of availability of trained clinical staff and nutrition commodities at primary care level, ineffective coordination mechanisms (particularly at provincial level), limited supervision of quality of care and the delegation of IMAM-related, clinical roles to Nutrition Counsellors. These could be mitigated by strengthened monitoring, supervision and coordination of IMAM activities, particularly at provincial level and by the inclusion of IMAM in pre-service training for medical and nursing staff.

The majority of carers and PLWs who were receiving treatment for IMAM services were generally satisfied with the services they were receiving. Negative perceptions about services most often related to stock shortages, waiting time and staff behaviour. Commodity shortages mostly affected OPD MAM services but also prevented scale up of OPD SAM services in 2019, driven by challenges in securing adequate funding. Evidence-based simplification of protocols and commodity rationing, coupled with strong community sensitisation about the changes, strengthened end user monitoring and the provision of community feedback mechanisms for complaints provides potential for improved effectiveness and rational use of resources.

In general, health facility staff and community outreach workers exhibited high levels of motivation to deliver IMAM services. However delayed salary or salary deductions on the basis of performance indicators were reported in some provinces. Negative staff behaviour was also reported by many caregivers contributing to reduced uptake of treatment services and case coverage.

Coverage: Geographic coverage for SAM treatment has expanded to almost all districts and the majority of health facilities exceeding treatment coverage targets. Some hard-to-reach communities have access to SAM and MAM treatment services through mobile health and nutrition teams.

However there has been little improvement in case coverage for IMAM services which remains lower than national standards. The recruitment of nutrition counsellors and liaison at community level has had a positive effect on coverage, although community outreach for IMAM still remains weak. Monitoring visits should assess of the existence and effectiveness of community outreach for IMAM based on national guidance.

The primary barriers preventing carers and PLWs from accessing treatment include a lack of awareness about IMAM services, inaccessibility due to distance and/or insecurity, cultural norms and previous negative experiences at health facilities. While previous coverage surveys identified corrective actions to improve coverage, there is limited evidence that action plans to improve case coverage are implemented by IPs. Province-specific work plans would help overcome these barriers. Provincial Nutrition Committees (PNC) should be assigned the authority and responsibility of overseeing action plans and PNOs should be able to hold IPs to account for their delivery.

Efficiency: OPD SAM and MAM services operating out of Sub-Health Centres and Mobile Health and Nutrition Teams for OPD SAM are less efficient per child cured owing to the reduced admissions and increased cost of implementation.

The IMAM database compiles programme data from all IMAM services enabling disaggregated analysis to facility level and is accessible to national and provincial stakeholders. Few IMAM related indicators are included in the national HMIS however in February 2020, 12 indicators were in the process of being incorporated. Parallel IMAM databases exist for Supply Chain Management, nutrition assessments and SAM and MAM programme data which can lead to inefficiencies.

Joint monitoring for the Sehatmandi project has led to the development of a merged system of monitoring of OPD SAM and MAM. However there is no evidence of the results of joint monitoring being used to develop context specific action plans. There is also limited evidence of effective end user monitoring (EUM) and / or of community feedback mechanisms. These could be included within the Sehatmandi quality of care monitoring system. Further revision of Sehatmandi quality of care indicators would also provide for better coherence between IMAM and GMP services.

Evidence from assessments, monitoring and databases has been used to improve programme performance however in most cases processes are completed in parallel for SAM treatment and MAM treatment services.

Bottleneck analyses and periodic reviews of the IMAM database tend to be the main approaches to implement improvements to programme performance. Updates to global guidelines and funding challenges have also led to adaptations to programming enabling a more efficient delivery of treatment.

IMAM-related coordination mechanisms (including the NNC, IMAM TWG and the AIM TWG) operate efficiently at central level and there are no overlaps or duplications between them although they are not well attended by IPs. The NPCC progresses certain aspects of the NPNS, however its ability and effectiveness to coordinate nutrition activities is limited. At zonal and provincial level, Provincial Nutrition Committees operate regularly in all provinces however they also face attendance issues from IPs. If IPs were accountable to the PNOs, the efficiency of PNCs could be improved.

Sustainability: The integration of IMAM into the BPHS and EPHS has facilitated the expansion of the programme to provide universal coverage although in implementation it remains a vertically implemented programme in primary health services. Facilitating sustainability through further functional integration into IMCI and growth monitoring programmes is feasible but would require clear role definitions for front line staff, and careful monitoring and coordination mechanisms to prevent the marginalisation of IMAM.

The cost of the IMAM programme is unsustainable without external financial support or similar funding from the GoIRA. Further development of the programme needs to be balanced between the comparative cost effectiveness of increasing coverage within the current IMAM framework, and the affordability of scaling up geographic coverage to lower level health facilities. The current low case coverage of IMAM leaves scope for doubling the effectiveness of the programme without further geographic expansion resulting in the lives of an estimated 80,000 children under 5 saved each year. Further scaling up of geographic coverage would also facilitate greater equity for hard-to-reach populations. However continuing funding limitations and future forecasts of funding shortfalls suggest that neither may be feasible. Funding limitations could be mitigated through simplifications of treatment protocols, some of which have been piloted and appear to have been successful.

Improvements to case coverage and cost effectiveness also require a strengthening of systems for information management, coordination and decision making, supervision, EUM and accountability with corresponding strengthening of guidelines, SOPs and policies. Evolving research suggests the possible integration of IMAM with developmental programming, which would contribute to the achievement of SDGs and the ANDS.

Recommendations

Overall recommendations	Action Points	Priority	Type	Responsible
1. Improve accuracy of IMAM burden and caseload estimation.	Revise estimates of the burden of wasting and commodity needs using combined GAM (MUAC, WHZ and oedema) establishing an updated baseline by anthropometric survey	High	Enabling environment / Planning	PND / IMAM TWG
2. Implement evidence-based simplified protocols ensuring mitigation of commodity shortages and	2.1. Finalise TWG review of evidence for simplified protocols 2.2. Provide timely communication to communities and service users prior to implementation of evidence-based protocol changes	High	Supply (Commodity)	PND / UNICEF / WFP / IPs

accountability to communities.	2.3. Develop an action plan to mitigate the impact of commodity shortages in partnership between health shuras, FHAG and health facilities including a communication plan for prolonged shortages.			
3. Strengthen treatment protocol implementation at facility and community level.	3.1. Audit and complete the distribution of 2018 IMAM guidelines, including supporting job aids, equipment and relevant staff responsibilities to all health facilities in appropriate local languages 3.2. Provide orientation on implementation of updated protocols emphasizing use of all independent criteria, screening of infants and treatment of infants in OPD-SAM 3.3. Improve periodic monitoring of community outreach activities for IMAM services	High	Quality of care	PND / IMAM TWG / IPs
4. Provide equitable access and coverage to age-appropriate IMAM treatment for infants < 6 months.	4.1. Screen all infants and children aged 1 – 59 months using MUAC during systematic and active case finding, and growth monitoring activities in the community and refer for further risk assessment in OPD-SAM 4.2 Establish a fixed cut-off of WAZ < -2 for infants < 6 months for referral from GMP to the health centre for further risk assessment in OPD-SAM	High	Equity / Coverage	PND / IMAM TWG
5. Enhance effectiveness of provincial level IMAM coordination mechanisms and coordination with Regional Nutrition Clusters and national IMAM TWG.	5.1. Disaggregate IMAM routine data to provincial level to facilitate analysis and action planning to address service barriers, incorporating reviews of technical and coverage assessments. 5.2. Strengthen accountability of EPHS and BPHS implementers to the PNO at provincial level through mandated reporting to provincial coordination committees at least quarterly 5.3. Integrate attendance at provincial coordination meetings into EPHS & BPHS quality monitoring mechanisms	Medium	Coordination / Enabling environment	PND / National and Regional Nutrition Clusters / Provincial Nutrition Committees / PNO / AIM TWG
6. Establish and rollout community accountability mechanisms for IMAM services.	6.1. Establish independent community feedback mechanisms in emergency and non-emergency settings through district and provincial health shura to provide EPHS / BPHS holder accountability to communities 6.2. Sensitise communities in appropriate major and minor local languages on patient's rights through Health Shura in accordance with the MoPH National Health Strategy 2016-2020 (Strategic Area 4, Result 4) – specifically for this evaluation on rights and expectations for IMAM services 6.3. Strengthen end user monitoring and reporting to provincial and national level coordination mechanisms by: a. Including identification of ethnic / kuchi origin in patient registration and monitoring	High	Accountability / Demand	PND / UNICEF / WFP / Nutrition Cluster

	equitable IMAM service access during supervision visits b. Reporting EUM indicators from SCM and Quality of Care checklists			
7. Revise Sehatmandi IMAM quality of care indicators:	7.1. For indicator 18: Review cure rate for IMAM & revise in line with IMAM national guideline standards 7.2. For indicator 19: Adjust screening protocols to be consistent with IMAM screening (MUAC for infants and children 1-59 months, WAZ for infants and children < 2 years at GMP, WFL/H for children < 5 years) 7.3. Consider inclusion of other meaningful indicators of IMAM quality, for example: a. Accurate / timely IMAM reporting b. Effective SCM for nutrition commodities c. Absence of complaints from community members d. Participation in provincial coordination mechanisms e. Timely completion of supervision reports by nutrition officers to each health facility	Low	Quality of care	GCMU / IMAM TWG
8. Revise indicators & targets in national nutrition strategic plans and policies.	8.1. Establish clear measurable baselines and / or targets for nutrition service indicators in national strategy documents 8.2. Review the use of the Balanced Score Card as the indicator of quality-of-care in nutrition services	High	Strategic	PND / IMAM TWG
9. Revise IMAM guidelines & Nutrition SOP based on latest evidence and ensure coherence.	9.1. Update IMAM guidelines and nutrition SOP incorporating: a) Evidence-based simplified approaches which have been successfully piloted in Afghanistan b) Updated WHO recommendations (expected 2021) c) Addressing the needs of children with disabilities by making provision for the special needs of disabled children in the guidelines and including the recording and reporting of disabled children in registers and monthly reports d) Ensure coherence of IYCF and growth monitoring activities between SOP sections and IMAM guidelines	Medium	Enabling environment	PND / IMAM TWG
10. Incorporate key training on IMAM into the pre-service training curricula of medical and nursing staff to mitigate the effects of rapid turnover of staff		Medium	Supply (HR)	MoPH / Ministry of Education / PND / IMAM TWG

1. Introduction

1.1. Overview of evaluation

This report presents the methodology, findings, lessons learned, conclusions and recommendations of the formative evaluation of the Integrated Management of Acute Malnutrition (IMAM) approach in Afghanistan. The evaluation, which is the first formative evaluation of the IMAM approach to be completed in Afghanistan, was commissioned by UNICEF Afghanistan and covers the 2013-2019 period. The evaluation was completed in 2020 by Action Against Hunger UK. As set out in the evaluation Terms of Reference (Annex 1), the evaluation aims to provide all stakeholders involved in the implementation of IMAM with evidence to improve programme performance and uptake.

1.2. Background and context

1.2.1. Country context

The Islamic Republic of Afghanistan, is a landlocked country at the crossroads of Central and South Asia with a population of 35.5 million[1], composed mostly of ethnic Pashtuns, Tajiks, Hazaras, and Uzbeks. Half of the population, nearly 17 million people, live in conflict affected areas and many areas (103 districts) are hard to reach[2].

Afghanistan is one of the world's most complex humanitarian emergencies, characterised by escalating conflict causing over one million people to be living in new and prolonged displacement. The crisis in the country has been ongoing for over 18 years, and humanitarian needs, driven by armed conflict, natural disasters and poverty, are on the rise.

In 2018, between January and October, conflict and drought displaced an estimated 551,000 people from their homes and resulted in 8,050 civilian casualties (January-September)[3]. This overwhelmed health and education facilities. In late 2019, the December 2019 update of the Afghanistan Humanitarian Response Plan estimated that 9.4 million people were in need of some form of humanitarian and protection assistance in 2020, increasing from 6.3 million in 2019 with 2 million children living in conflict-affected areas. Direct and indirect violence against humanitarian personnel and assets/facilities continued to challenge humanitarian access.

Food security and the nutritional status of many in Afghanistan is consistently fragile. This is reflected in poor performance across a number of nutritional indicators. Of the 117 countries ranked in the 2019 Global Hunger Index, Afghanistan is placed 108th, with the hunger status categorised as 'serious'. This low ranking is driven by a high prevalence of stunting, an indicator of persistent undernutrition; and wasting, a marker of acute undernutrition and a strong predictor of mortality in children under five. In 2020 an estimated 2.54 million children under 5 years and 563,000 pregnant and lactating women are affected by acute malnutrition, and 690,000 children are at risk of severe acute malnutrition (SAM).[4]

[1] UNDP Afghanistan page: https://www.af.undp.org/content/afghanistan/en/home/countryinfo.html (accessed 12/20)
[2] Humanitarian Action for Children appeal, 2020-21, UNICEF
[3] Afghanistan Humanitarian Response Plan January 2018 – December 2021, December 2019 update
[4] Afghanistan Nutrition Cluster Annual report 2019

1.2.2. Management of acute malnutrition

A programme for the management of acute malnutrition was started in 1996 in one district by an INGO. In 2003 the Public Nutrition Directorate (PND) was established within the Ministry of Public Health with responsibility for technical oversight and coordination of nutrition interventions in all provinces. In 2008, with the support of UNICEF, Oxfam Novib and local NGOs, the PND introduced community-based therapeutic care (CTC) for the treatment of Severe Acute Malnutrition (SAM) for children aged less than five years, in four provinces. The CTC approach was subsequently renamed the Community-based Management of Acute Malnutrition (CMAM) and then the Integrated Management of Acute Malnutrition.

1.2.3. Integrated Management of Acute Malnutrition

IMAM is a public health approach to address acute malnutrition emphasising community participation, active case finding and high treatment coverage enabling access to a continuum of care for children with moderate (MAM) or severe acute malnutrition (SAM). Pregnant and lactating women (PLW) who are suffering from SAM and MAM can also access treatment in facilities where IMAM services are available. For children with acute malnutrition without medical complications, treatment is given at community-based health facilities, and for those with complications at inpatient hospital facilities.

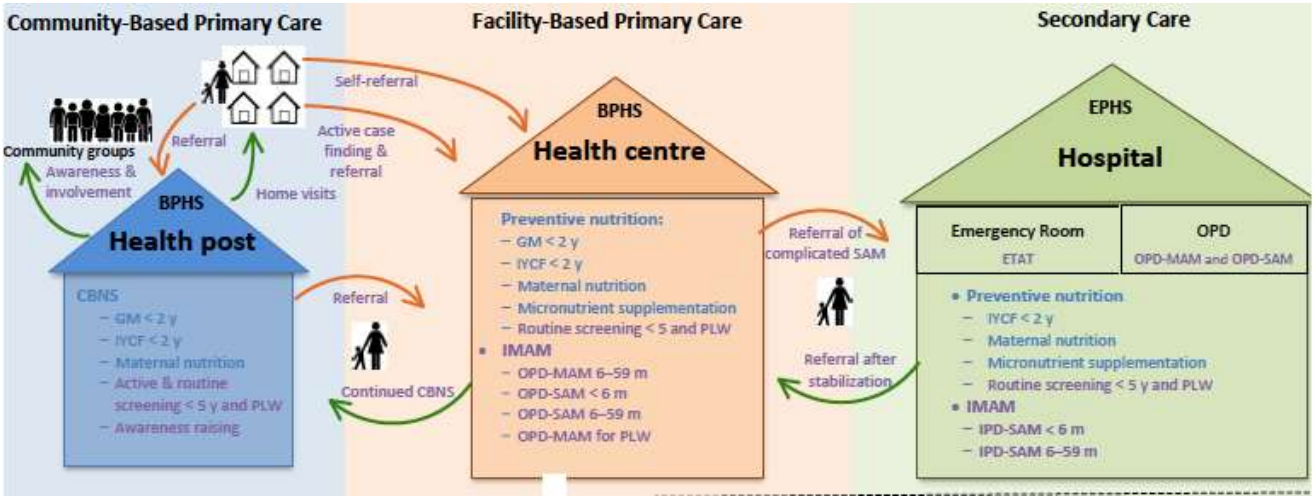
Initially implemented as a vertical programme for the treatment of SAM within hospitals and community based health facilities, IMAM was integrated into the Basic Package of Health Services (BPHS) in 2010 and Essential Package of Hospital Services (EPHS) in 2014. In Afghanistan, the government outsources the delivery of health care services to approximately 20 national NGOs in 31 out of 34 provinces. National NGOs are required to deliver the EPHS and BPHS packages of services in their province or provinces. The BPHS package includes facility and community-based primary healthcare services in health centres and communities and the EPHS package includes secondary healthcare services delivered in hospitals. In three provinces, the government manages all healthcare services through the “Strengthening mechanism”.

The integration of IMAM into public health structures was accompanied by the development of national guidelines for IMAM. These integrated the treatment of children with MAM alongside SAM into OPD in 2014, and were endorsed by the GoIRA, UN agencies and BPHS / EPHS partners under the coordination of the National Nutrition Cluster (NNC) led by UNICEF.

Figure 1 maps IMAM service implementation (marked in purple) in the Afghanistan health system[5] and how they integrate with preventive nutrition services (marked in blue).

[5] Source: IMAM national guidelines, 2018

FIGURE 1: MAP OF IMAM IMPLEMENTATION IN THE AFGHAN HEALTH SYSTEM



Key: CBNS: Community based nutrition services; GM: Growth Monitoring; IYCF: Infant and Young Child Feeding;

The nutrition cluster was first activated in Afghanistan in 2011. Since then, it has been coordinating emergency nutrition interventions throughout the country with the support of more than 50 national and international NGOs. It is co-chaired by UNICEF and the PND.

Between 2014 and 2019, IMAM services for the treatment of SAM were scaled up in all 34 provinces, increasing from 557 to 1422 health facilities with the objective of increasing the coverage of SAM treatment services by 10-15% per annum[6]. Access to treatment for children less than 5 years with MAM increased more slowly from 559 health facilities to 774 over the same time period[7]. The number of facilities with operational OPD MAM services were limited by the acute malnutrition rates of the province and whether it was classified as an emergency or non-emergency province. From 2015, only provinces classified as 'emergency provinces' by the NNC partners implemented OPD MAM treatment services; the classification criteria for the emergency status of the province varied during the period. From 2018, provinces prioritised for intervention were those with global acute malnutrition (GAM) of above 10-15% for children under five years, where greater than 70% of PLWs were at nutritional risk.

In 2018 and 2019 the PND and UNICEF set the objective of providing access to treatment to 50% of the total estimated number of children under five years with SAM (also known as "burden"). These targets were exceeded in both years with 52% of the burden reached in 2018 and 53% in 2019. OPD MAM admissions fell short of targets during the evaluation period due to funding shortfalls limiting the availability of stock[8]. Total SAM admissions of children aged 1-59 months from 2013-2019 were 1.42 million. Total MAM admissions of children aged 6-59 months during the same period were 1.3 million.

In provinces with a SAM prevalence of greater than 3% and where no inpatient hospital facility was available, stabilisation centres were established in larger comprehensive health centres (CHC+) with 24 hour medical care. Where treatment of SAM was not accessible, OPD SAM treatment was established at SHCs.

[6] Guidance note for Severe Acute Malnutrition (SAM) Scale up plan, May 2018

[7] Service availability data for OPD SAM and MAM is based on data shared by the UNICEF Nutrition team in November 2019 originating from the IMAM database

[8] Burden and target data is included in Annex 15 for the evaluation period

Other than the PND, government departments involved in IMAM include:

- **Child and Adolescent Health Department** (CAHD) within the **Reproductive Maternal, Newborn, Child and Adolescent Health Directorate** (RMNCAHD) providing leadership on the implementation of the integrated Management of Child Illnesses (IMCI) including screening and admission of children with acute malnutrition.
- **Community Based Health Care Department** (CBHC) coordinates the extensive community based outreach programmes including the identification of children with acute malnutrition and referral to treatment and the activities of health Shuras and FHAGs with their role in providing information about, and encouraging engagement with health services.
- **Grants Management Contract Unit** (GMCU) of the MoPH manages the activities of the EPHS and BPHS service providers under the System Enhancement for Health Action in Transition (known as the 'Sehatmandi') project. Funded by the World Bank, the U.S. Agency for International Development (USAID) and European Union (EU), the GMCU contracts the service providers at provincial level while the **Performance Management Office** (PMO) monitors service provision and manages payments based on performance (known as P4P), based on 11 indicators – including growth monitoring for children – and with financial penalties for poor performance rating, although none of the performance indicators include monitoring IMAM programme performance.
- **General Directorate of Curative Medicine** (GDCM) provides overall leadership and technical oversight of hospital care services, with technical and logistical support from PND on the inpatient treatment of children with SAM requiring hospitalisation and supply of the relevant treatment products.

IMAM commodities are not included in the Essential Medicines list and are therefore delivered in a parallel system to other medicines. UNICEF procures treatment products for IPD and OPD SAM and WFP procures treatment products for OPD MAM. Based on quarterly orders from implementing partners, coordinated by the PND, UNICEF and WFP then distribute IMAM commodities to provincial level. Implementing partners then manage distribution to facilities.

The Nutrition programme of UNICEF Afghanistan has a strategic focus to reduce all forms of maternal, infant, young child and adolescent malnutrition, particularly wasting and stunting. As such one of four nutrition priority areas includes "care and treatment of severe acute malnutrition for emergency and regular programming including cluster coordination". This is closely linked to another of its priority areas which is systems strengthening of the Afghan government and the building of an enabling environment to deliver nutrition sensitive and nutrition specific interventions[9].

Supporting the care and treatment of SAM is the most costly of the four priority areas which UNICEF supports with approximately $45 million of the nutrition programmes $180 million annual budget being spent on nutrition commodities for IMAM[10].

1.2.4. Policy context

Since 2017 and building on pillar 5, health and nutrition, of the Afghan National Development Strategy (2017-2030), IMAM services have expanded within the framework of the 'triple nexus approach.' This is to ensure

[9] UNICEF Afghanistan Nutrition Programme Strategy note 2017-2019
[10] Interview with Maureen Gallagher, Chief of Nutrition UNICEF, February 2020

policy and programme coherence, and establish linkages to actions for improving nutrition and food security, as reflected in the Afghanistan Food Security and Nutrition Agenda (AFSeNA).

The AFSeNA considers food and nutrition as a human right requiring alignment with global declarations, initiatives and targets while emphasising good governance, ownership, community participation and gender equality. Specifically for nutrition, the AFSeNA aims to ensure policy and programme coherence towards achieving the relevant Sustainable Development Goals (SDGs).

The National Public Nutrition Strategy 2015-2020 (NPNS) aims to reduce nutrition related mortality and morbidity and contribute to the economic development of the nation through the timely use of high quality, evidence based nutrition specific and sensitive interventions through four intermediate results:

(i) increase the availability of essential nutrition services for children under 5 years with acute malnutrition from 34% to 80%
(ii) improve nutrition behaviours and practices ensuring the use of a minimal acceptable diet in children 6-23 months from 16% to 40%
(iii) Improve the quality of nutrition services and products evaluated through the use of the Balanced Score Card (BSC)
(iv) Strengthen the social, regulatory and political environment for nutrition through increasing funding from the $21.7M baseline in 2015.

IMAM services constitute a major part of the NPNS 2015-2020. The Results Framework of the strategy, which is framed around the four intermediate results, includes many sub-intermediate results which include IMAM-related intervention areas and indicators. These are included in Annex 11.

1.2.5. IMAM funding

The implementation of BPHS and EPHS is funded by the Sehatmandi project[11]. This funding covers all of the operational costs of the Service Providers (SPs) to deliver IMAM services (alongside other health services) apart from the cost of IMAM treatment products which are procured from 'off budget'[12] funding by UNICEF for SAM treatment services (annual cost approximately $40 million)[13] and by WFP for MAM services. This funding mostly comes from short-term, emergency funds which are often unpredictable.

For the 40% of the population living outside of government-controlled districts, IMAM is financed and operates through emergency health and nutrition partners coordinated by the National Nutrition Cluster. In addition, the NNC is responsible for coordinating bi-lateral funding for off-budget specific health and nutrition interventions, in development and emergency contexts.

2. Evaluation features

2.1. Rationale

The evaluation has been undertaken to gather evidence on the processes and results of IMAM in order to contribute to: i) promoting accountability among stakeholders and partners; ii) evidence-based policymaking in preventing and treating acute malnutrition among affected children and PLWs; iii) organizational and

[11] Between 2018 and 2022, $600 million is allocated to the Sehatmandi project
[12] 'Off-budget' funding is the colloquial term for IMAM funding which falls outside of the Sehatmandi project
[13] Including inpatient and outpatient SAM treatment supplies. Source: Interview with Maureen Gallagher, Chief of Nutrition, UNICEF Afghanistan, 19 February 2020

global learning, and improving programming on effective treatment of children and PLWs diagnosed with acute malnutrition. The evaluation serves the information needs of both primary and secondary audiences involved in the assessment and management of malnutrition in Afghanistan. This includes:

- The Government of the Islamic Republic of Afghanistan (GoIRA) (including the Public Nutrition Directorate (PND) and Ministry of Public Health (MoPH)), the United Nations (UN) (including UNICEF (United Nations Children's Fund) Nutrition and Social Policy, Evaluation, and Research (SPEAR) programmes, World Food Programme (WFP) and World Health Organisation (WHO), implementing partners for the Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS), non-BPHS[14] partners, the National Nutrition Cluster (NNC) and recipients of IMAM services **(primary users).**
- Stakeholders for whom the results of this evaluation may be beneficial include the World Bank (funding the SEHAT-MANDI programme), Grants Contracting Management Unit (GCMU, GoIRA), Directorate of Monitoring & Evaluation Health Information System (MoPH), other national clusters, MoPH departments and government and non-government actors implementing programmes such as WASH, food security/ livelihoods and education which may be complementary to IMAM's effort to reduce malnutrition **(secondary users)**.

2.2. Objectives

As set out in the evaluation's original Terms of Reference (ToR) (full version in Annex 1), the main objective of the evaluation is to yield results that will contribute to enhancing the programme performance and strategies to deliver effective results through:

- Assessing the progress made and identifying gaps, good practices and lessons learned
- Evaluating the programme's relevance, efficiency, effectiveness and sustainability
- Generating knowledge and providing recommendations that will be useful for strengthening the programme performance, advocacy and policy dialogue on acute malnutrition among children, lactating and pregnant women.

The evaluation identifies gaps and provides recommendations to:

1. Identify strategies for developing policy on effective implementation of IMAM interventions in addressing acute malnutrition issues, improving the quality of services, and achieving equitable outcomes for children at the national level
2. Assessing the contribution of related cross-cutting issues such as coordination and management; gender and equity considerations; capacity development; advocacy and policy development; and information/data management to improving programme effectiveness.

The full terms of reference for this evaluation is presented in the Annex 1.

2.3. Scope of evaluation

The evaluation covers all activities included within the IMAM approach[15] from 2013 to 2019. All provinces and districts with IMAM services in Afghanistan are within the scope of the evaluation. This includes 1422

[15] This includes Community screening and sensitisation activities for IMAM and treatment of SAM and MAM in the inpatient and outpatient wards of hospitals and health facilities

OPD SAM facilities and their catchment areas (774 of which offer OPD MAM) and 180 IPD SAM facilities. The evaluation includes all curative implementation modalities of IMAM outlined in Figure 1 (indicated by purple writing).

Based on the National Public Nutrition Strategy of the Government of Afghanistan, the evaluation examines the IMAM's performance in the following four areas[16]:

1. Increasing access to nutrition services and products for children and their families
2. Improving nutrition behaviour and practices among target groups
3. Improving the quality of nutrition services and products
4. Strengthening the social, regulatory and political environment for nutrition

All partners responsible for implementing IMAM are incorporated within the evaluation including the Basic Package of Healthcare Services (BPHS) and Essential Package of Hospital Services (EPHS) partners, the MoPH and international NGOs. The evaluation also encompasses UNICEF, WFP and WHO as providers of technical, operational and financial support to the implementation of IMAM.

The evaluation encompasses all target groups of IMAM in Afghanistan including:

- Children aged 6-59 months with moderate acute malnutrition (MAM) or Severe Acute Malnutrition (SAM) without complications who are treated in OPD SAM and MAM
- Pregnant and lactating women with MAM who are treated in OPD MAM
- Children aged 0-59 years with SAM with medical complications who are treated in the IPD-SAM.

2.4. Evaluation criteria and questions

The evaluation criteria for the evaluation were the Organisation for Economic Cooperation and Development (OECD) / Development Assistance Committee (DAC) criteria of **relevance**, **effectiveness**, **efficiency** and **sustainability**. The Terms of Reference for the evaluation included questions under each of these criteria.

During the inception visit for the evaluation in May 2019, the Evaluation Steering Committee (ESC)[17] agreed that the information needs of key stakeholders had changed since the evaluation was commissioned. Therefore, with the support of the Evaluation Team, the evaluation questions were redeveloped by the ESC. **Coverage** was assigned as an additional criterion as a result of consultations during the inception phase. The revised (and final) list of evaluation criteria and questions are included in Table 1. The evaluation matrix in Annex 2 provides more detail about the data collection methods and data sources for each of the evaluation questions.

[16] These are the four intermediate results of the National Public Nutrition Strategy 2015-2020

[17] The Evaluation Steering Committee is co-chaired by the Director of the MoPH's Research and Evaluation Coordination Directorate and the PND. It is also comprised of representatives of UNICEF, WFP, WHO and various international NGOs involved in IMAM in Afghanistan

TABLE 1: REVISED EVALUATION QUESTIONS FOR IMAM FORMATIVE EVALUATION

Evaluation criteria	Revised evaluation questions
Relevance	To what extent is IMAM situated/in compliance with existing structures at various levels (national, sub-national and field level)?
	Have issues related to equity been considered in IMAM service delivery and access, (gender, geography, prioritization of areas where need is greatest)? What measures could be proposed to improve targeting?
	To what extent have IMAM inputs evolved to respond to the local context, needs and priorities?
Efficiency	To what extent has delivery of IMAM services been efficient using the following modalities: • SHCs (sub health centres) and mobile health teams? • Presence of an international NGO as provider of technical support to a national NGO?
	How complementary are the IMAM related M&E systems (IMAM database, M&E database, SCM and EUM)? Are there any duplications/overlaps?
	To what extent has the gathered evidence been used to inform programme performance, detect and resolve bottlenecks on time?
	How complementary are the IMAM related forums, included nutrition related forums with IMAM component? Are there any duplications/overlaps?
Coverage	What is the geographic coverage of IMAM services against estimated national, provincial needs? How has this changed since start of IMAM?
	To what extent is IMAM reaching those in hard to reach areas?
	What are the success factors, challenges faced in reaching the target populations?
	Are there any differences in take up of IMAM services and what are the reasons for these differences (if any)?
	To what extent has the expansion of geographical and programmatic coverage been accompanied by quality service provision?
Effectiveness	To what extent are service users satisfied with IMAM services? And what are their perceptions about programme purpose?
	To what extent are IMAM supplies timely, being used/functional, appropriate and distributed via pharmacy/health system? What is the effect of lack of supplies?
	To what extent does service delivery meet expected quality? What are the key bottlenecks/constraints that need to be addressed in order to meet required quality of services?
	To what extent do implementing partners have the required capacity to deliver IMAM services?
	To what have specific IMAM interventions/activities helped to achieve the planned results and targets (including treatment of children and mothers for malnutrition?
	What have been enabling and hindering factors/challenges?
	How motivated and satisfied are front line staff to deliver IMAM services? What are the constraining factors including staff workload?
Sustainability	To what extent has IMAM been integrated into the health system services and how does this affect provision of IMAM services?
	To what extent can PND continue to implement and scale up IMAM without financial, technical, logistical and other (including supplies) support from internal and external agencies?
	What systems, policies, strategies, capacities, (at national, provincial, regional, district, community levels) have been/need to be developed so that IMAM can continue to be implemented and scaled up without internal and external support?
	To what extent is there coordination across IMAM stakeholders and implementing partners at various levels?
	What are the gaps and barriers to coordination and the effect of these on IMAM services? Are there any duplications?

2.5. Methodology

2.5.1. Overview

The evaluation was conducted using a mixed methods and participatory approach, generating quantitative and qualitative data and using a variety of sources to enable triangulation of information and ensure data validity. The methodology is described in more detail in the Inception report for this evaluation.

Data collection methods and tools were adapted for the Afghanistan context. The sampling approach and data analysis conducted were in line with the evaluation's inception report which, along with all data collection tools, was reviewed and signed off by the ESC prior to the start of data collection.

Primary and secondary data was collected by the Evaluation team from February to May 2020. Two international consultants conducted interviews with key staff in Kabul and collected secondary data. All data collection in provinces was conducted by a national data collection agency (ATR Consulting)[18].

2.5.2. Data sources

Data sources used to inform the evaluation findings included a) documentary evidence, b) primary qualitative key informant interviews and focus group discussions conducted at national, provincial, health facility and community levels, c) quantitative data and photos from health facilities and d) coverage surveys at community level.

- **Documentary evidence:** The Evaluation Team (ET) consulted a range of documentation and data to address evaluation questions and enable triangulation of primary findings. A full bibliography can be found in Annex 3. The types of documents and data reviewed included strategies, policies, briefing notes, national health and nutrition guidelines; coordination mechanism meeting minutes, bulletins and reports; journal articles; nutrition assessment reports; and provincial level IMAM programme performance data and facility data for the evaluation period.
- **Key informant interviews with IMAM stakeholders at national and provincial level.** The evaluation team conducted 28 interviews with national-level health and nutrition personnel from the GoIRA, UN agencies, National NGOs (NNGOs) and International NGOs (INGOs). A half-day workshop was also conducted with eight members of the Nutrition Cluster. The full list of national-level key informants is available in the Annex 4.
- **Key informant interviews (KII) and focus group discussions (FGD)** were conducted with a range of respondents in sampled provinces, districts and health facilities. At provincial level, the respondents were Provincial Nutrition Officers, Provincial Nutrition Extenders, CBHC (Community Based Health Care) coordinators and implementing partner nutrition managers. In health facilities, the respondents were doctors, nurses, midwives, nutrition counsellors, community health supervisors, health shura members and carers of malnourished children. In communities, the respondents were carers of U5 children, Pregnant and Lactating Women (PLWs), Health Shura members, community health workers, Family Health Action Group (FHAG) members, imams and village leaders. All data collection instruments are available in Annex 7. **In total, 414 KIIs and FGDs were conducted with key informants;** 212 at the community-level, 178 at the health-facility level, and 24 at the provincial level. For disaggregated figures, see Annex 6.

[18] Assess Transform Reach (ATR) Consulting

- **Quantitative data and photos from health facilities.** Programme quality checklists, register records, and photographs were collected from sampled health facilities. Using KoboCollect on tablets, data collectors completed 9 inpatient department (IPD) and 39 outpatient department (OPD) quality checklists, and took a total of 100 photographs of treatment cards, treatment registers, monthly reports and stock rooms in selected health facilities. The teams also recorded OPD SAM register records from 38 health facilities, OPD MAM U5 register records from 17 health facilities and OPD MAM PLW register records from 10 health facilities.
- **Coverage surveys at community level.** Coverage surveys were conducted in 53 villages with carers of acutely malnourished children and PLWs. This involved data collection teams conducting exhaustive case finding to record all acutely malnourished children and PLWs and / or children and PLWs enrolled in IMAM and the application of questionnaires to identified cases.

2.5.3. Sampling criteria for data collection in provinces

The sampling criteria for provinces, health districts, health facilities and villages is summarised in Table 2.

TABLE 2: SUMMARY OF SAMPLING CRITERIA FOR PROVINCES, HEALTH DISTRICTS, HEALTH FACILITIES AND VILLAGES

Level of sampling	Total planned	Total visited	Sampling method	Sampling criteria (if relevant)
Zone	7	7	n/a	All zones
Province	7	7	Purposive	-Provinces from 3 priority levels -High / low coverage provinces -Different configurations of partner support
Health districts	14	14	Purposive	High and low performance district based on SAM treatment admissions and performance data[19]
Hospital	14	9	n/a	All district hospitals in selected districts
CHC	14	11	Random	n/a
SHC / BHC / MHNT	28	23	Random	n/a
Villages for qualitative investigation	56	52	Purposive	2 near and 2 far villages in CHC catchment area
Villages for coverage survey	56	53	Purposive	2 near and 2 far coverage villages in CHC catchment area

One province was purposively sampled and visited for field data collection in each of the 7 geographical zones specified by the UNICEF nutrition team[20]. Provinces were sampled to ensure that there was a representative sample of provinces from each of the three priority levels specified in the Terms of Reference (ToR). In each province, a high performing and a low performing health district were selected based on IMAM programme performance. In each health district, 3-4 accessible health facilities were selected using random sampling: where possible, at least one of each health facility type was selected from Regional Hospitals (RH) or

[19] High and low performance was assessed based on SAM treatment admissions data and on cure and default rates. Admissions for all districts were compared with expected admissions (based on population and SAM prevalence in the province) to calculate an indirect coverage estimate. Cure and default rates were also compared. The highest performing district out of all districts in a province were selected (i.e. the district with the indirect coverage of SAM treatment and high cure and default rates) and the districts with the lowest performance were selected using the same criteria

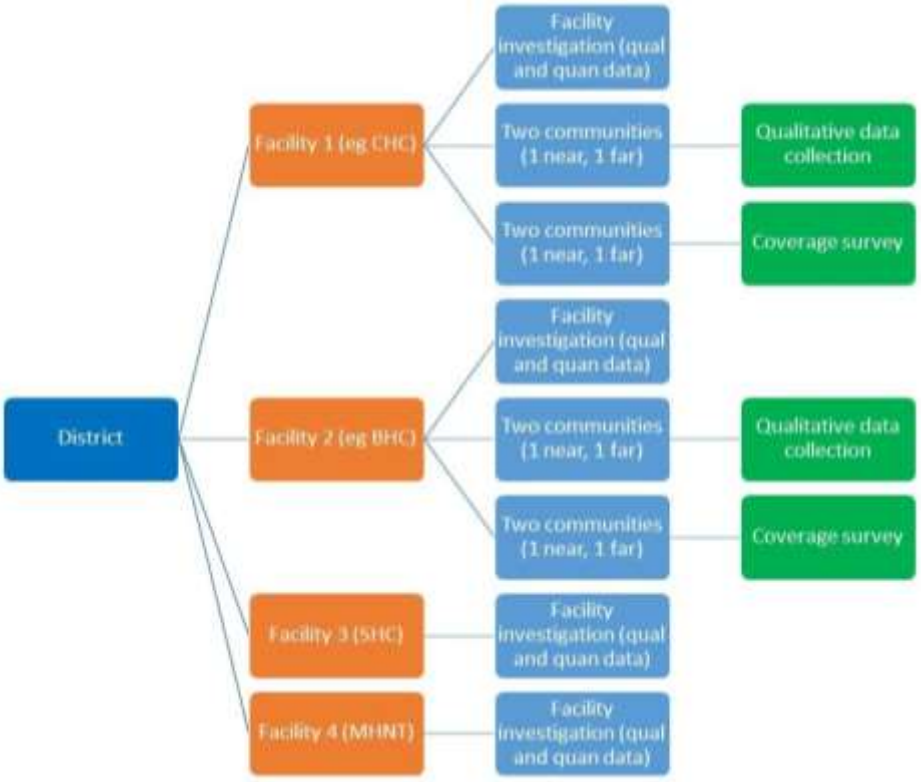
[20] Northeast, Northwest, Central, Eastern, Western, Southeast and South

Provincial Hospitals (PH) at provincial level; and District Hospitals (DH), Comprehensive Health Centres (CHC), Basic Health Centres (BHC), Sub-health centres (SHC) and mobile health and nutrition teams (MHNT) at district level. The districts and health facility types planned and visited are summarised in Table 1 and listed in Annex 5. It was not possible to visit all health facilities and villages as planned due to insecurity (more in "Limitations" section below).

To avoid harm to participants and data collection teams, data collection was not conducted in GoIRA-designated 'white areas'. Sampling of districts and health facilities was completed in collaboration with the data collection agency based on the latest security and access information. In the event of any reported insecurity in a district selected for sampling, substitutes were identified. Enumerators were also instructed to follow WHO guidance to avoid being infected by or passing on Covid-19.

In each district, in the catchment areas of two health facilities, four villages were purposively sampled: two for qualitative data collection and two for coverage surveys. On arrival at health facilities, data collection teams selected two villages near the health facility and two far from the health facility based on a defined selection criteria. Figure 2 displays the sampling approach used for the selection of villages for qualitative and quantitative data collection.

FIGURE 2: SAMPLING APPROACH A DISTRICT LEVEL



In provinces, sampling of target key informants to interview for **qualitative data collection** was completed with the data collection agency during the planning phase prior to data collection. A sample of key informants at each level (listed in section 2.5.2.) were selected in each province, health facility and community and mapped onto a qualitative sampling matrix to ensure representativeness of all key informant types and to avoid the risk of selection bias by a data collection team. If, on arrival, a particular key informant or group of key informants was not available, the data collection teams selected another key

informant or group of key informants based on the field guidance shared with data collection teams. If there were multiple key informants available in a given location, it was the data collection team leader to select the key informant/s to interview or to participate in the focus group discussion based on availability of key informants. Selection bias was a risk during the selection of key informants as data collection teams relied on facility staff or outreach staff to select targeted key informants. However the evaluation team judged that this would have a minimal impact on findings (more information in Limitations section below).

During the **LQAS coverage surveys** in selected villages, data collection teams conducted exhaustive screening to identify all children and pregnant and lactating women who fulfilled the defined "case definitions":

Children aged 6-59 months who are SAM or MAM and/or who are currently enrolled in the OPD-SAM or OPD-MAM and *Pregnant and Lactating Mothers (mothers who have children up to 6 months old) who are MAM and/or who are currently enrolled in the OPD-MAM*

With the help of CHWs, teams used door-to-door sampling to locate children and PLWs who fell within these case definitions, in addition to asking other community members if they knew of children or PLWs who met the case definition (expressed in culturally appropriate terms). LQAS coverage surveys do not require a minimum sample size to be reached. The sample size equates to the number of cases identified in each location visited and based on these results, and on the number of covered cases identified, it is possible to classify coverage in each location. LQAS coverage surveys were completed in 53 villages. However, due to data collection teams failing to follow protocols adequately, it was only possible to classify coverage of acute malnutrition services for children aged 6-59 months in 32 villages, and for PLWs in 33 villages (more information in Limitations section below).

2.5.4. Data analysis and triangulation

Semi-structured interviews and FGDs were chosen as the main sources of qualitative data because they allow the flexibility to ask follow-up questions not included in the interview guide based on responses of the key informants. Interview guides were tailored based on key informant type and were arranged thematically to facilitate the development of a coding framework in line with the evaluation matrix and allow for iterative triangulation between interviews at all levels. Due to involvement of a wide range of stakeholders in KIIs, qualitative data sources proved particularly relevant to assess the effectiveness, efficiency, coverage and potential sustainability of the programme. Responses from KIIs at national level were categorised and summarised using Nvivo software. At provincial level key responses by participants were summarised by question type in three assimilation excel sheets (based on respondent type). During the analysis phase, the percentages of different groups of respondents who made certain statements and who fulfilled certain criteria were calculated. All percentages referred to in the findings section and the corresponding sample sizes or "N" value are listed in Annex 16.

Similarly, at provincial level, quantitative data collected from health facilities was compiled, cleaned and analysed to assess the quality and effectiveness of service provision and adherence to treatment protocols.

The Afghanistan National IMAM guidelines (2018) set the standard of service delivery for the evaluation of IMAM components, alongside accepted international standards of practice. Documentary evidence and programme data from the national nutrition database was triangulated with field level findings to address questions related to the relevance and efficiency criteria. Findings were compared to targets set in relevant IMAM documents to assess the level of achievement of the programme and contributing factors. Findings

were also linked to the Results and Intermediate Results of the NPNS 2015-2020 strategic framework (included in Annex 11).

Coverage survey results were analysed using the Lot Quality Assurance Sampling (LQAS) classification system, which uses a relatively small sample size to classify coverage on a three-tier scale of low (<30%), moderate (30-60%) or high (>60%) according to 2018 Afghanistan IMAM guidelines. These coverage findings were triangulated with quantitative health facility data and KIIs to identify factors that affect coverage.

2.5.5. Quality assurance processes

During data collection in provinces, ATR's data collection teams were monitored by six MoPH monitors. Three of the monitors were managed by the Evaluation Team and three were managed by the Research and Evaluation Coordination Department (RC&E) of the Public Nutrition Directorate.

The three monitors managed by the Evaluation Team oversaw qualitative and quantitative data collection at provincial level and in health facilities and communities in all seven provinces using various monitoring tools. The findings from their monitoring were then reported to the Evaluation Team on a weekly basis. The three monitors managed by the RC&E visited three provinces and shared the findings from their monitoring visits with the ESC.

In summary, for the teams which they monitored, the monitors managed by the Evaluation Team all reported that protocols were followed adequately. More details about the monitoring findings are available in the evaluation's Data Collection Report[21].

2.5.6. Limitations

Overall the evaluation was conducted in line with the intended plan and methodology[22]. However, due to the extensive geographical scope of the evaluation and the challenges of conducting an evaluation of government-run nutrition services in Afghanistan, there were a number of limitations as described below.

- *Remote supervision of primary data collection:* Due to the number of locations that needed to be visited for primary data collection, the poor security situation in many of the sampled locations and the language barriers, the data was collected by a local agency. The lead evaluator trained a team of master trainers in Kabul who trained enumerators from each province. Supervised by the master trainers, enumerators collected data in each province. As such, all primary data collection was supervised remotely by the Evaluation Team. While quality assurance mechanisms were in place to mitigate errors, this represented an important limitation and contributed to challenges with the quality of some of the data (outlined below).
- *Exclusion of insecure districts in provinces:* The data collection agency reviewed the district sampling framework and removed inaccessible districts based on the latest security status. This therefore represents selection bias as the data collected from provinces was only representative of accessible districts and facilities. While some efforts were made by the data collection agency to collect qualitative data from inaccessible facilities through telephone interviews, these took place in very few provinces.
- *Selection bias of key informants in communities for qualitative data collection:* While data collection teams were assigned target key informants or groups of key informants to interview, the selection of

[21] Available on request
[22] Described in detail in the inception report

these key informants was made by health facility staff or by community outreach staff, which therefore risked selection bias. To mitigate this where possible the data collection teams selected the key informants who they would like to interview. Data collection teams also made it clear to participants that they were an independent data collection agency and the responses of the key informants would be anonymised. Therefore the risk of the bias strongly affecting the findings of the evaluation judged to be low.

- *Challenges encountered during data collection:* Some of the important issues encountered during data collection and mitigating measures are outlined in Table 3. More details can be found in the Data Collection Report. While the majority of sampled locations were visited successfully, some of the data that was collected was not as accurate or of required quality. This was largely due to protocols not being followed correctly. Also for some of the data, protocols in data labelling were not completed adequately due to translation issues. The impact of these errors on the overall evaluation findings was limited owing to the existence of multiple data sources. However the poor quality of the coverage survey data meant that it was impossible to calculate accurate LQAS coverage classifications in many of the districts visited by teams.

TABLE 3: FIELD DATA COLLECTION LIMITATIONS AND MITIGATING MEASURES

Data source	% completed	Issues with quality	Mitigation, *Lessons learned*
Coverage surveys	93% (inaccessibility due to insecurity; human error)	Sampling and data collection protocols not followed; discrepancies between datasets; poor labelling	Use of triangulated data to ensure reliability. *More capacity building for data collectors and Quality Assurance (QA) team (use of an electronic summary sheet)*
Key informant interviews	86% (inaccessibility due to insecurity)	Missing metadata; transcript duplication; missing interview responses; poor translation; protocols not followed	Call-backs to key informants by QA team; monitoring visits by MoPH monitors; data omission or triangulation
Quality checklists	99% (human error)	N/A	
Register records	71% (human error; protocols not followed)	N/A	
Photographs	34% (protocols not followed; poor quality; covid-19)	Poor quality photographs and poor labelling due to lack of effective training of data collectors and QA team	*Coinciding Ramadan with data collection; lack of follow up by QA team who was mostly focused on qualitative data.*

2.5.7. Ethics

The evaluation director was responsible for the ethical oversight and conduct of the evaluation, in close collaboration with the lead evaluator and the data collection agency. The Institutional Review Board (IRB) of the MoPH reviewed the inception report of the evaluation and provided written approval to the Evaluation Director in December 2019[23].

[23] Approval was accorded in a printed and signed letter. A copy of this can be shared on request.

The evaluation followed the UNEG ethical guidelines[24] to fulfil the obligations to respondents who participated in this evaluation. The evaluation team independently and impartially conducted this evaluation with no conflicts of interest and are fully accountable for the work produced. The evaluation has been produced with utmost rigour to ensure credibility of results.

These included:

- **Respect for dignity and diversity**: the evaluation team respected the differences in culture, local customs, religious beliefs, gender, disability, age and ethnicity and the potential implications of these when carrying out the evaluation. The evaluation team aimed to minimise any risk of disruption to the respondents, provide ample notice and respect their privacy. The data collection agency emphasised these messages throughout the training it completed with the data collection teams.
- **Rights:** the evaluation team ensured that data collectors treated evaluation participants as 'autonomous agents' who were required to provide consent prior to participating in data collection. This was verified in the following ways:
    - Training on seeking consent was included by the data collection agency during data collector trainings
    - All quantitative and qualitative data collection forms included clear explanations about the reason for data collection, how the data would be used and that their responses will be completely anonymous. Quantitative data collection forms included skip logic at the start of questionnaires. If a key informant declined to participate in data collection, the questionnaire would end and the data collector would end the interview. Qualitative data collection forms included a question at the start of the interview guide to ask that the key informant was happy to proceed with the interview. All consent statements are included in the data collection forms in Annex 7.
    - For high level interviews in Kabul, explanation was provided at the start of the interview about the evaluation. Consent was implied by their participation.
    - External monitors who were employed by UNICEF verified that consent was sought by data collectors during interviews by completing 'back-check' questionnaires with at least one key informant in each facility or community that they visited[25]. During data collection the UNICEF monitors prepared and shared with the lead evaluator weekly reports summarising their findings (including verification that consent was sought for interviews). The lead evaluator reviewed the weekly reports as soon as they were shared.
- The participants of data collection were selected as per the defined sampling methodology. The evaluation team also complied with codes of conduct governing vulnerable groups, such as young people[26].
- **Redress.** Participants were provided sufficient information to seek redress and how to register a complaint by the data collection team leaders as part of the data collection agency's standard process.
- **Confidentiality**: The evaluation team respected respondent's right to provide information in confidence and make them aware of the scope and limits of confidentiality. As mentioned above, at

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24 Available at http://www.unevaluation.org/document/detail/102

25 43 questionnaires were completed by monitors to verify that consent had been sought by data collectors prior to the start of the interview

26 Following guidance outlined at http://www.childethics.com/. Data collection involved the collection of anthropometric measurements of children under 5 following consent from the carer present. No data collection was completed with adolescents.

province level all quantitative and qualitative data collection forms included an explanatory statement which stated that names of respondents would not be recorded.

- **Avoidance of harm**: Data collection was conducted in a number of insecure districts and provinces, some of which were under the control of Non-State Armed Groups (NSAG). In these locations, all key informants were given the option to not participate if they did not feel safe or comfortable to do so. This also applied to data collection agents, who reserved the right to not conduct data collection if they did not feel safe in an area.

  Data security: Data collected during the evaluation has been stored systematically and securely and in line with ACF's data protection policy, which has been updated to be fully compliant with the 2018 GDPR standards. Data has been stored in a way that makes it available and clearly accessible to the evaluation team only. If requested and following appropriate anonymization, the data can also be shared with UNICEF. Data will be retained for a period, as determined in consultation with UNICEF, and then deleted upon approval from UNICEF.

2.5.8. Integration of gender, equity and human rights

The Evaluation Director was also responsible for ensuring that gender, equity and human rights were considered throughout the planning and implementation of the evaluation. This included:

- **During inception:** Equity in terms of gender, geographical access, age, disability and marginalised population groups were included as central themes of analysis in one of the evaluation questions (3.1.3).
- **During planning:** Given that pregnant and lactating women are a key target of IMAM services and that women are most often the primary carers of children under 5, a higher percentage of respondents at community level were female than male. However groups of male carers were also targeted as key informants during data collection and the majority of key community representatives were male therefore overall 41% of community level participants were male. The selection of villages for qualitative and quantitative data collection was done based on distance between the village and the health facility. Where marginalised groups were encountered, where possible they were interviewed. Data collectors were recruited locally to ensure that they could communicate with all population groups in their district.
- **During data analysis and report writing:** Key IMAM documents were analysed for compliance to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and to UNICEF's Core Commitments to Children (CCC) (see Section 3.1.1).

3. Evaluation Findings

3.1. Relevance

Summary: *This section presents findings related to alignment of Afghanistan's IMAM policies and strategies with national health strategies and international IMAM; extent to which there is an enabling environment for the implementation of IMAM; whether IMAM inputs have evolved over time and if IMAM services are equitable. Where a finding relates to an Intermediate and Sub-Intermediate result from the NPNS results framework in Annex 11, a reference is added in brackets after the finding.*

Key findings:

- **The IMAM approach in Afghanistan is relevant and appropriate.** Strategy and policy documents provide a coherent enabling environment for IMAM that closely aligns to wider strategies on national development (IR 4, Sub-IR 4.4). However in the NPNS results framework, while Sub-intermediate results include indicators, there are no baseline or target figures included.
- **Nutrition guidelines and standard operating procedures have evolved in response to the emergence of new approaches to treatment**, however the updates are not synchronised and gaps in coherent practice are evident at field level (IR 3, Sub-IR 3.1)
- **The existing policy and strategy framework has enabled the IMAM programme to expand access to treatment for acute malnutrition.** This evolution has been in line with national strategies to provide universal coverage, including hard to reach geographic areas and populations. The programme is nuanced enough to ensure **priority access according to needs** defined by the population nutritional status. This is evidence of **vertical equity** (IR 1, Sub-IR 1.1)
- **IMAM has shown responsiveness to seasonal nutritional stressors, by increasing availability of treatment during emergencies**, although this has been affected at times by supply management issues (IR 1, Sub-IR 1.1)
- Targeting issues include the **strong tendency to use a single anthropometric criterion for estimation of burden and nutrition supply needs**. IMAM programme eligibility criteria underestimates these needs. This is reinforced by the contradictory guidance between the IMAM guidelines and the nutrition standard operating procedures. Although this creates horizontal inequity in targeting, it is mitigated by functional equity in IMAM programme enrolment at field level.
- **IMAM admissions data indicates that there is gender equity (Guiding Principle of NPNS), with gender ratios of admissions being within the expected range**. However, a **significant horizontal inequity** is evident in **access to treatment for infants <6 months** where changes to treatment protocols have not been accompanied by appropriate measures to ensure their proper enrolment into treatment.

3.1.1. To what extent is IMAM situated / in compliance with existing structures at various levels (national, sub-national and field level)?

Overarching National Commitments and Alignment with International Goals

The Afghanistan Food Security and Nutrition Agenda (AFSeNA[27]) Strategic Plan identifies roles, responsibilities and coordination structures for the GoIRA and NGO stakeholders at central level. The Agenda is a multi-sectoral initiative which demonstrates the Afghan government's commitment to improve the food security and nutrition situation in the country. The AFSeNA and Afghanistan National Development Strategy (ANDS) **form an overarching policy and strategic framework for other nutrition strategies, including IMAM,** with key activities to **support the BPHS and EPHS service providers and ensure the availability of adequate human resources,** a pre-requisite for integration.

Derived from AFSeNA, the Food Security and Nutrition Public Awareness and Advocacy Plan (2018-2023) and Afghanistan Food Security and Nutrition Plan (AFSNP) (2019-2023)[28] form a triple nexus approach, linking emergency with development and peacebuilding[29]. This framework provides for strategic alignment of eleven national priority programmes for the achievement of the Sustainable Development Goals (SDG) as a means of tackling the underlying factors contributing to inequity and insecurity in Afghanistan. It also provides for strategic alignment and coherence of priority nutrition programmes for the achievement of the SDGs 2.1[30], 2.2[31] and 17.14[32].

National Public Health and Nutrition Commitments

The Nutrition Action Framework (NAF - 2012) is a multisectoral initiative across 5 ministries to address **maternal and children undernutrition** with a focus on the 1000 days approach for the development and implementation of nutrition strategies and programs and explicitly address the causes of undernutrition in Afghanistan and reduce stunting in children by 5% by 2017. Although prevention and treatment of SAM is included, no target was set to reduce acute malnutrition in children under 5 or PLWs.

The Ministry of Public Health Strategy (2016-2020) strategic objective 3.1 targets reductions in malnutrition through improved nutrition facilitated by strengthened in-country capacity. The MoPH listed nutrition interventions as a fundamental priority in the first pillar of the Strategic Plan 2013-2020 approving the delivery of maternal and child nutrition services through BPHS and EPHS[33].

IMAM Commitments

IMAM was integrated into the Public Nutrition component of BPHS in 2014 followed by a rapid scale of IMAM services across all provinces and districts, although concerns about capacity, financial resources and quality continue to persist in many provinces.

Strategies contributing to an enabling environment for IMAM include:

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[27] Established in 2012 and formally launched in 2017
[28] Afghanistan Food Security and Nutrition Plan 2019 to 2023, 2018
[29] Arsalai, Shams, & Ahimbisibwe, 2020
[30] SDG 2.1 – End hunger and ensure that people have access to sufficient and nutritious food all year round
[31] SDG 2.2 – End Malnutrition in all its forms
[32] SDG 17.14 – Enhance policy coherence for sustainable development
[33] BPHS was published in 2010 and EPHS in 2005

- **National Public Nutrition Strategy (2015-2020**): Emphasises that evidence-based interventions must be sustainably implemented with adequate quality and high coverage and tracked through a systematic program-monitoring and surveillance system. The strategy sets as its goal "To reduce nutrition related mortality and morbidity and contribute to economic development of the nation" and includes a strategic objective, intermediate results and sub-intermediate results directly related to IMAM. However while sub-intermediate results include indicators, there are no measurable baseline or target values included.
- The **National Reproductive, Maternal, Child and Adolescent Health Strategy** (2017-2021): Aims to increase the coverage, quality and utilisation of reproductive health services related to nutrition.
- The **Nutrition Promotion and Behaviour Change Strategy** (2015-2020) aims to improve health seeking behaviour and practices and promoting improved health and hygiene practices.
- The **Community-based Health Care (CBHC) Strategy** (2015-2020) aims to contribute in reduction of morbidity and mortality rates, particularly among mothers and children, especially in underserved areas, although there is no explicit linkage to IMAM.
- The **Community based Nutrition Package (CBNP)** (2017) aims to promote a range of community-based growth monitoring and nutrition through BPHS partners, with UNICEF and IHSAN support and funding. Sehatmandi performance indicators for CBNP are not coherent with IMAM protocols.

IMAM guidelines (2018) introduce the outpatient Management of Acute Malnutrition in Infants (MAMI) largely in accordance with international MAMI guidelines and provide clearer linkages between the integrated programme and localised responses to emergencies although specific guidance establishing linkages between OPD SAM treatment to SFP is absent implying a need for improved linkages at field level (see Annex 17).

The Standard Operational Procedure (SOP) Guideline for Nutrition in BPHS and EPHS[34], integrates guidance on multiple nutrition programmes with the national IMAM guidelines. There are several inconsistencies in guidance between individual sections of the SOP and the IMAM guidelines. The unpublished draft SOP (2020) addresses several of these inconsistencies, however inconsistencies remain and require technical review for coherence.

The methodology for the estimation of the burden of acute malnutrition according to WHO growth standards, which is included in the Nutrition SOP, is not coherent with the admission criteria for IMAM and the omission of MUAC potentially underestimates the true burden.

3.1.2. To what extent have IMAM inputs evolved to respond to the local context, needs and priorities?

Early CMAM guidelines were revised and focus was changed according to evolving needs and a change of focus from emergency to development. Following integration of IMAM into the EPHS in 2014 IMAM guidelines were updated in 2018 to include greater operational guidance on the implementation of surge capacity in emergencies enabling appropriate responses to scaling up according to need.

Targeting continued to evolve. The strategy for geographical targeting was driven by two components; (i) universal coverage for SAM treatment (to BHC level) and (ii) donor driven service provision based on need as defined by nutrition indicators. Within the overarching aim to provide universal coverage of SAM treatment, the prioritisation of services for the treatment and prevention of SAM was aimed at provinces with SAM

[34] Finalised through the PND and GDPM in 2015. This document formed the base document for WHO and UNICEF trainings to follow.

prevalence > 3%, whereas no preventative services (OPD-MAM) were implemented unless already existing in provinces with a SAM prevalence < 3%.

Funded by the Canadian Department of Foreign Affairs, Trade and Development and supported by WHO and UNICEF, the MoPH implemented the National Nutrition Surveillance system through 175 facility-based and 963 community-based sentinel sites as a means to increase equitable and gender sensitive access to nutrition services.[35] [36] Funding for the sentinel sites was discontinued in 2018.

Funding continued to evolve during the evaluation period. System Enhancement for Health Action in Transition (SEHAT)[37] funding supported the development of CMAM and later IMAM and evolved into the Sehatmandi project in 2017, which covered 60% of Afghanistan under government control (40% was supported by the National Nutrition Cluster emergency response). During the evaluation period, UNICEF and WFP funded all national IMAM nutrition supplies through emergency funding,

Since 2017, funding against humanitarian appeals in Afghanistan has fallen consistently from 99% to 57% in 2017 including that for nutrition supplies. In 2019, IMAM services faced a 43% gap in UNICEF funding, requiring a rationalisation of the dosage of RUTF given to each child in five provinces with an aim to mitigate the risk of stockout of RUTF and reduce costs by 30%.

Performance assessment measures have continued to evolve. From 2019, the Sehatmandi Project regulated funding of BPHS contract holders imposing 'meaningful penalties' for poor performance. For IMAM the expected performance standards for cure rate exceed that of national treatment guidelines and international guidance. The performance standards are not coherent with IMAM programme implementation where all children aged 6-59 months should be screened with MUAC. The requirement for 95% of children aged less than 2 to be screened for weight for height every month in health facilities sets an unrealistic goal.

IMAM has been responsive to changing circumstances and needs resulting in improved outcomes. Responsiveness of the IMAM programme to national and local need is identified from examination of the enrolment and outcome trends over time in comparison with annual nutritional stressors during the year (indicated by the seasonal calendar in Table 4). Figures 3 and 4 illustrate the total number of admissions of children 0-5 years with SAM and MAM by month during the evaluation period.

TABLE 4: SEASONAL CALENDAR OF NUTRITIONAL STRESSORS IN AFGHANISTAN

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Season	Winter			Spring			Summer			Autumn		
Common natural disasters (based on review of ReliefWeb)	Avalanches	Flash floods, Floods and landslides				Drought						
Agriculture			Spring wheat planting season		Second season planting	Wheat harvest			Second season harvest			
Livestock			Livestock migration to higher altitudes					Livestock migration to lower altitudes				
Food security	Lean season											

[35] Afghanistan National Nutrition Surveillance System Bulletin 3, 2016

[36] Chinjekure, A et al, ENN, 2018

[37] Supported by the World Bank, United States Agency for International Development (USAID), European Union (EU) and managed by the Grants Contracting Management Unit (GCMU) in conjunction with United Nations (UN) funding

FIGURE 3 ADMISSIONS OF CHILDREN 0-59 MONTHS WITH SAM TO THE IMAM PROGRAMME DURING 2013-19 (SOURCE: IMAM DATABASE)[38]

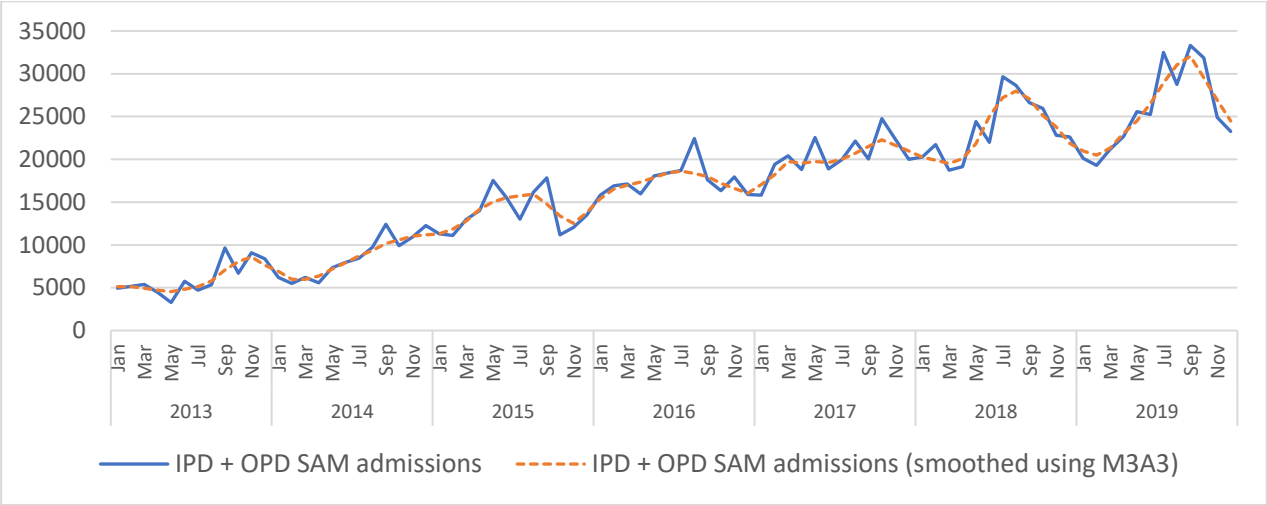
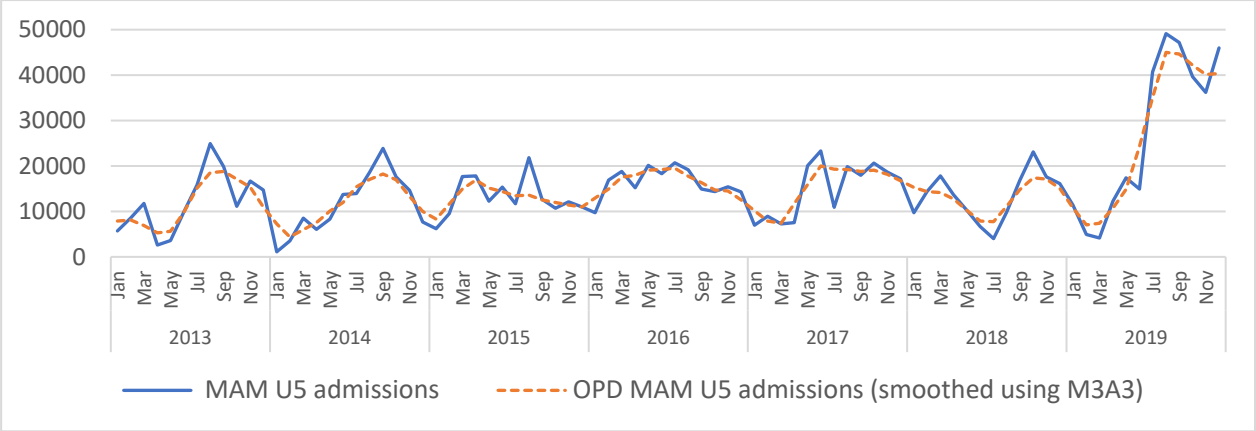


FIGURE 4 ADMISSIONS OF CHILDREN 0-59 MONTHS WITH MAM TO THE IMAM PROGRAMME DURING 2013-19, (SOURCE: IMAM DATABASE)



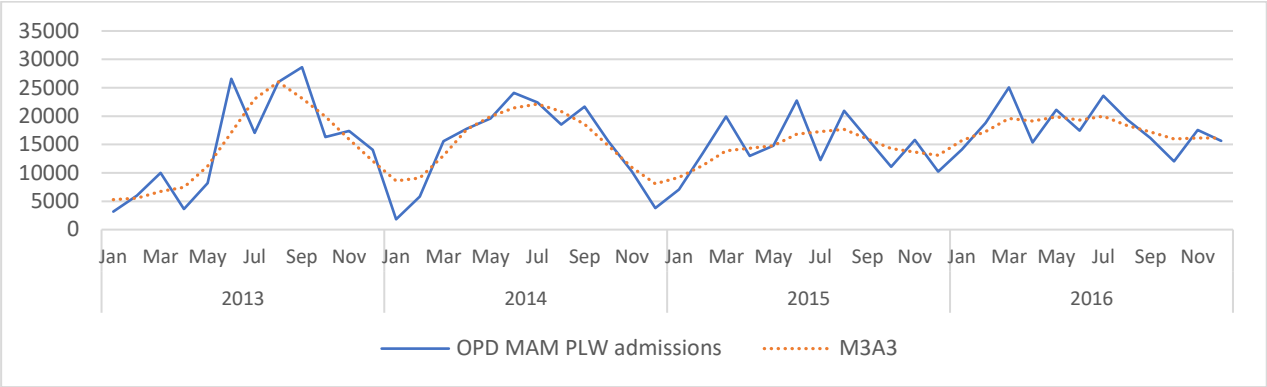
Typical variation in the prevalence of malnutrition is reflected in the smoothed admission trends for children with either SAM and MAM indicating that the programme is responsive to seasonal nutrition stressors. Admission peaks in OPD SAM and MAM tend to fall between May and September which coincides with the end of the lean season. The general upward trend in admissions for SAM results from the increased availability of treatment through IMAM programme expansion. Similar effects are seen for a relatively stable trend in admissions for MAM. However, the geographic coverage of treatment increased far less over the same time period. The peak in 2019 indicates that there were previously unmet needs and that increased RUSF supply was the driving factor.

Figure 5 illustrates the trend in admissions for PLWs from 2013-2019. The trends are notable for the same smoothed annual trends to those for children, reflecting increased admissions resulting from nutritional

[38] A second line is added to the charts showing the admissions data smoothed over time using M3A3. With the M3A3 smoother, the data are smoothed by taking the medians of sets of three successive data points (M3). The results are then smoothed by taking the arithmetic means of sets of three successive smoothed data points (A3)

stressors and similar saw toothed trends each year. The trends likely reflect the same treatment access issues.

FIGURE 5 TRENDS IN ADMISSIONS OF PREGNANT AND LACTATING WOMEN DURING 2013-19 (SOURCE: ANNUAL IMAM PERFORMANCE REPORTS 2013-2016)



3.1.3. Have issues related to equity been considered in IMAM service delivery and access, (gender, disability and geography, prioritization of areas where need is greatest)? What measures could be proposed to improve programme targeting?

Equity in terms of geographical access: The National Nutrition Strategy (2015) targets an improvement of SAM treatment coverage (by district) from 34% to 80% by 2020. By 2019 almost all districts nationwide had SAM treatment available in approximately 85% of health facilities. Whilst aiming for universal coverage, expansion was prioritised to provinces with elevated prevalence of SAM and MAM[39]. This approach is consistent with the aim to provide vertical equity through universal coverage whilst responding to changing needs based on estimates of burden of acute malnutrition. Access to treatment for children less than 5 years with Moderate Acute Malnutrition (MAM) increased more slowly from 559 health facilities to 774 over the same time period.

For programming purposes, the annual burden of SAM and MAM is defined by the IMAM eligibility criteria of low MUAC, low WHZ and nutritional edema; these measures of malnutrition identify different children. Although admission to IMAM treatment is functionally equitable, since children are enrolled for treatment according to all criteria, only one form of wasting is used for targeting. Since 2018, in provinces where recent prevalence data has been available, burden estimates have been calculated using combined GAM. However for the majority of provinces[40] the estimation of supply needs and the number of children to be reached is estimated using WHZ data alone from the National Nutrition Survey (NNS) in 2013. The exclusion of the MUAC & edema criteria from targeting represents horizontal inequity[41] and results in the underestimation of need and the overestimation of programme performance (targets achieved). The actual target achieved will include children eligible by MUAC, oedema and WHZ.

[39] According to SMART surveys and with annual review of targeting.
[40] 2018 caseload estimates for SAM and MAM children under 5 were calculated using WHZ data for 65% of provinces
[41] Vertical equity refers to equity among individuals, communities or across geographical areas while **horizontal equity** refers to equity among groups or sub-groups (e.g., defined by ethnicity, age groups or anthropometric eligibility for treatment)

IPD IMAM services are available in all provinces and the majority of districts in line with EPHS standard 6.3[42]. The expansion of inpatient facilities has not universally favoured emergency designated areas, suggesting that expansion has been largely based on achieving equity through universal coverage.

Gender equity: The CEDAW (12.1/12.2) require equitable access be provided to health services and adequate nutrition in pregnancy and lactation. UNICEF's CCC also provide an institutional level requirement to ensure gender equity in nutrition programmes[43].

Strategic result 3.9 of the MoPH strategy (2016-2020) require gender and human rights to be mainstreamed in all MoPH programmes. BPHS guidelines include a requirement for 'gender training' to BHC level. Indicator 7 of the BPHS Balanced Scorecard provides benchmarks for staffing in health facilities, however this provides an overall assessment of the full staffing capacity and does not monitor gender equity in staffing. In contrast the EPHS BSC specifically incorporates gender equity measures and positive gender equity scores were reported in recent years.

Interviews with community members **indicated a desire for equal numbers of male and female OPD staff so that they can be seen by health staff of the same sex**. Monitoring of gender equity in BPHS service provision would potentially address cultural issues currently presenting a barrier to access and coverage.

A sample of data from February 2020 for all IPD facilities provides a 0.99:1 female to male ratio among admissions **reflecting gender equity.** This indicates that enrolment to IPD facilities overall is gender equitable, however data indicates that some facilities do not use MUAC (which selects more females), resulting in inequitable admission for females. The wider implementation of the MUAC admission criterion in IPD would result in more female admissions.

OPD SAM admissions data from 2013-19 indicates an average male-to-female ratio of 1:1.23. Given that the majority of admissions to outpatient services are based on MUAC (which would result in the admission of more girls) **this indicates that enrolment is gender equitable.**

The evaluation findings indicated some evidence of **gender inequity at community level**. To travel to the health centre requires permission of the husbands or family, delaying access and/or the ability to continue treatment. Cultural norms may not affect gender equity for children in treatment but will negatively affect coverage by preventing women from accessing treatment.

Age equity: In 2020 the prevalence of wasting in infants in Afghanistan was estimated to be 15.3%[44], nearly 2.5 times higher prevalence than that of children aged 6-59 months, however, infants accounted for just 0.15% of admissions in OPD-SAM and 28.8% of IPD admissions in 2019. This disparity strongly suggests that the needs of infants with or at risk of acute malnutrition are not currently being adequately met. This is due to challenges in identification and referral of eligible infants at community level.

Disability: Policy, strategy and programme documents include guidance for provision of services for disabled populations and by doing this create an enabling environment. The MoPH[45] promotes advocacy for the

[42] "Hospitals must be rationally distributed so their services are accessible on an equitable basis for the entire population."

[43] 1.8 (gender equality in humanitarian action), 2.2 (humanitarian action is regularly assessed against CCC) and 6 (children and women access relevant information about nutrition programme activities).

[44] Wasting among infants under 6 months: a silent public health problem in Afghanistan, NNC 2019 bulletin

[45] 2016-20 SR 3.4

effective implementation of disability services[46] while the public nutrition strategy refers to core values and the rights to health, especially for children and other vulnerable groups, although not specifically addressing disability.

The BPHS guidelines (2010) highlight disability awareness, case identification, referral and follow up, whilst the EPHS hospital standards require that the hospital services are accessible to those with disabilities and that these services should complement those offered through the BPHS. The IMAM guidelines address disability in the procedure for assessing the child although there is no provision for the reporting of disabled children in registers or monthly reports. All of the hospital facilities assessed and 85% of outpatient facilities provided physical access for people with disabilities

Nomad and IDP populations: The BPHS (2010) states that every implementer must cover IDP and nomad populations in their province. The community-based health care (CBHC) strategy (2015-2020) (Objective 1) aims to scale up CBHC services and initiatives to 90% of uncovered and underserved areas in rural settings and 60% of poor urban and nomad population by 2020. The MoPH Strategy 2016-20, strategic result 3.7, aims to provide increased coverage of services in rural and nomad settings through the deployment and retention of staff, however neither the NPNS (2015-2020) nor the IMAM Scale up Plan (2018) specifically mention nomads or IDPs. The IMAM guidelines (2018) also do not contain specific guidance on meeting the needs to IDPs or nomads. However evaluation data from nomadic communities benefiting from IMAM services indicates that nomad communities are able to communicate effectively with health facility staff. Therefore the lack of guidance in the IMAM guidelines is not a significant problem.

3.2. Effectiveness

Summary: *This section presents findings related to the extent to which the various determinants of effective IMAM treatment were evident and how these determinants contributed towards achieving IMAM's purpose. These include key supply determinants (adequate human resources and commodities) and the quality of care provided in facilities. Cure rates were assessed as an indicator of the quality of IMAM services. The section also provides findings related to IMAM services from the perspectives of community members who have benefitted from services, health facility staff and community outreach volunteers who deliver services. Where a finding relates to an Intermediate and Sub-Intermediate result from the NPNS results framework in Annex 11, a reference is added in brackets after the finding.*

[46] Repeated in result 3 of the CBHC strategy 2015-20

Key findings:

- **The IMAM approach is effective and achieving its purpose (NPNS Guiding principle).** The SAM treatment programme treats SAM children in inpatient and outpatient departments to prevent mortality while the MAM treatment programme treats MAM children and PLWs in outpatient departments to prevent children from becoming SAM and to prevent further morbidity. An estimated 185,000 children aged 0-5 years were saved from 2013 to 2019.
- The most significant bottlenecks to effective service delivery were **lack of availability of trained staff in health facilities** and **inconsistent supplies of RUSF and Supercereal for OPD MAM**.
- **The availability of staff trained on IMAM was inadequate, especially in outpatient IMAM services**. This was due to high staff turnover and the lack of resources needed to implement regular IMAM trainings. This resulted in high staff workload at facility level, with Nutrition Counsellors responsible for managing all IMAM services (including the clinical aspects which they are not trained to do). As such IMAM protocol errors and mistakes and omissions from treatment cards and IMAM registers were common and staff motivation in some provinces was low. Delayed salary payments, or payment of staff based on the achievement of P4P indicators, were also noted in some provinces.
- **IPD and OPD SAM services met or exceeded national standards for cure rate and default at national level (IR 3, Sub-IR 3.1). However, OPD MAM cure rates for U5 fell short of national standards from 2017-2019 largely as a result of high number of defaults linked to RUSF supply challenges.** Extremely high cure rates were reported in many facilities, however these are to be treated with caution considering errors found in register completion and stock shortages.
- **The quality of IMAM programme implementation by implementing partners varies (IR 3, Sub-IR 3.1)**. Technical support and supervision by PND and UN agencies has helped to overcome some of the quality gaps. However the capacity of implementing partners to participate in and contribute to IMAM coordination mechanisms and to provide regular, effective supervision to ensure the delivery of quality services needs to be improved.
- **Perceptions of IMAM services amongst frontline staff, carers and PLWs are overall positive (IR 2, Sub IR 2.1 and 2.3)**. Majority of frontline staff consider IMAM to be a valuable and effective service benefitting some of the most vulnerable groups in society. Carers and PLWs spoke positively about the treatment products and the clear, simple explanations provided by facility staff about their child's condition.
- **Negative perceptions about OPD services amongst carers and community members arose due to stock shortages, waiting time and staff behaviour.** In particular the "stop-start" nature of the OPD MAM scale up strategy negatively affects the perceptions of community members about all IMAM services and potentially about other health services.

3.2.1. To what extent are service users satisfied with IMAM services? And what are their perceptions about programme purpose?

The majority of carers and PLWs (80%) interviewed across all provinces who were receiving treatment from IPD SAM, OPD SAM or OPD MAM were generally satisfied with the programme. Carers of children in IPD SAM and PLWs enrolled in OPD MAM were generally more positive about services than carers of children in the OPD SAM or MAM. The majority of PLWs and carers (81%) stated that treatment products are very

effective at helping children and PLWs recover and feel better. Other positive comments related to health facility staff communicating with carers and PLWs in their own languages and using easy to understand language. **Responses from carers of children in OPD SAM and MAM** reflect the national median result for the Overall Client Satisfaction and Perceived Quality of Care Index in the Balanced Scorecard (BSC) of 2018 (69.9/100)[47]. **Overall 73% of carers of children aged 6-59 months who were in the OPD MAM or OPD SAM programme had a positive view of the programme**[48].

User satisfaction varied across the provinces and districts. In Parwan, 86% of carers and PLWs said they and their communities were very satisfied with the programme overall. High coverage results (>60%) were also noted from villages in Parwan indicating that where there is a positive community perception about the IMAM programme, this can lead to higher treatment coverage.

Negative service user perception varied at district-level and province level. For example 36% of carers living in Kunduz had a negative view of staff behaviour. Further investigation revealed that this was more prevalent in facilities where staff had not received training on nutrition owing to high staff turnover in the province. This may have been due to the fact that an implementing partner with relatively limited experience in delivering IMAM was responsible for delivering BPHS services in Kunduz.

Negative perceptions about OPD services were due to stock shortages, waiting time and staff behaviour. All PLWs enrolled in OPD MAM and 87% of carers with children in OPD SAM or MAM cases reported **product shortages at some point during treatment**[49]. There is a risk that respondents may have provided inaccurate information to this question in order to receive more IMAM commodities. However even if this is the case, a significant proportion of carers experienced shortages at some point during treatment. The LQAS coverage survey conducted in Shinwar (Nangarhar) also confirmed that, out of the 14 non-covered cases identified, 43% of carers said they had not taken their child to the health facility due to witnessing stock breaks during previous visits or because they "do not know someone in the health facility". Low LQAS survey results were also linked to negative community perceptions in two provinces indicating that poor perception of the programme at community-level can lead to low case coverage.

61% of carers and PLWs reported **waiting times** of an hour or more. This correlates with the frequent comments from health facility staff about being overburdened with cases. **Poor behaviour from staff** was also reported by 40% of PLWs and carers of U5 children in the programme. This included experiencing rudeness or aggressiveness (64%), preferential treatment to those with money or connections (22%) or negligence and inadequate information (19%). Negative experiences with IMAM services have also been reported in previous coverage survey reports[50].

Awareness about the purpose of IMAM is mixed. 55% of PLWs and carers with U5 children in an IMAM service demonstrated a basic understanding of the programme's purpose[51]. 37% of PLWs and carers of U5 children had limited awareness of the programme purpose, terminology, referral process or eligibility criteria.

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[47] BPHS Balanced scorecard, 2018

[48] Data collection tools used during key informant interviews did not require data collectors to specify which IMAM service the child was attending (OPD SAM or MAM). More detail in Limitations.

[49] Out of 215 carers of OPD SAM/MAM cases interviewed, 87% had experienced a stock out at some point. 46% of these mentioned the frequency. Where frequency was given, 70% mentioned frequent shortages.

[50] A review of SAM Management in Afghanistan, 2016

[51] As demonstrated by an understanding that treatment products are given for free to malnourished U5 children and PLWs at the health facility to make them stronger

Lack of understanding of carers about eligibility criteria was also confirmed at health facility level; 10% of health facility staff interviewed reported being confronted by carers who mistakenly demanded treatment products despite their children not suffering from acute malnutrition[52].

Nutrition education sessions were perceived overwhelmingly positively and were confirmed to be taking place by 83% of health shura members. However the sessions are not reaching all potential service users; only 47% of carers and PLWs confirmed attendance at nutrition education sessions. This could contribute to misunderstandings about the purpose of the IMAM programme and negative experiences at health facilities. Also 50% of health shura members stated sessions happen at irregular intervals, and 55% said sessions take place monthly or less frequently.

The National Public Nutrition Strategy (2015-2020), Community-Based Health Care Strategy (2015-2020) and IMAM National Guidelines (2018) all emphasise the importance of involving caretakers in child healthcare and improving feeding and care practices through individual counselling and health and nutrition education sessions in group settings provided by CHWs and FHA groups. The National Public Nutrition Strategy (NPNS) strategic framework includes "Number of community gathering sessions conducted by CHW" as an indicator for the improved knowledge of caretakers and community members on nutrition behaviours and practices. However the strategic framework does not contain baseline, target values or a means of verification for this indicator.

3.2.2. To what extent are IMAM supplies timely, being used/functional, appropriate and distributed pharmacy/health system? What is the effect of lack of supplies?

IPD services: In hospitals, the availability of IMAM supplies is variable. The balanced scorecard for EPHS in 2017 indicated that few hospitals reported a good availability of drugs in OPD (<10%) or inpatient pharmacies (<50%). Improvements were noted in 2018 and a support mission of the World Bank in 2018 concluded that medicines were available and stock-outs infrequent. Evaluation data indicates that there are low incidents of stock outs and expired nutritional stocks. Some front line staff indicated problems with both medicines and nutritional products, however management generally indicated that facilities did not experience stock issues. While the percentage of stock out months for F75, F100 and RUTF were less than 2%[53], 11% of facilities had expired stocks of these products. In Nangarhar, staff reported having no stock of F100 "most of the time". In one province, the PNO noted that "demonstration medicines" were sometimes kept for supervision or evaluation visits to indicate adequate stocks, whereas the medicines were actually in short supply.

OPD services: In outpatient facilities (including CHCs, BHCs, SHCs and MHNTs), availability of supplies is also variable with more shortages for OPD MAM than for OPD SAM products*.* RUTF shortages were reported in 45% of facilities visited. Total stock out months were 18 or 4.5% of the total[54]. At least one health facility in each province experienced shortages, however Urozgan was the worst affected with four out of the five health facilities reporting a stock out of RUTF during the previous 12 months**.** RUSF shortages were reported for at least one of the previous 12 months in 90% of health facilities visited. Total stock out months were 45 or 21% of the total[55]. Supercereal stock out months were 43 months or 30% of the total[56]. One facility reported that it had no shortages of Supercereal during the previous 12 months.

[52] Refer to Section 3.2.2 for more details.
[53] F75, F100 and RUTF were 1.9%, 0.9% and 0.9%
[54] Out of a possible total of 396 months (33 x 12)
[55] Out of a possible 216 months of supply
[56] Out of a possible 144 months of supply

Overall, 87% of carers of U5 children reported that there had been shortages of stock while their child had been enrolled in the OPD SAM or MAM programme. This affected all 7 provinces, although the extent to which each province was affected by the shortages varied. Almost all carers in Nangarhar and Paktika and approximately 80% of carers in Parwan, Jowzjan and Urozgan reported experiencing shortages. 50% of carers reported shortages in Herat and Kunduz. Due to limitations with data collection, it was not possible to disaggregate shortages between carers of OPD SAM and OPD MAM carers[57]. However OPD MAM services were not available in any of the health facilities visited in Herat or Kunduz as these were not classified as priority provinces during 2019 or 2020 indicating that OPD MAM shortages were the primary shortages noted by carers. 84% of carers reported that shortages happened often.

Most carers with children in the OPD reported that they do not share IMAM products (66%), however more than 50% of PLWs shared Supercereal with other family members. Where it was noted that there was sharing of commodities, it was often found that carers had a lack of awareness relating to acute malnutrition and a misunderstanding of eligibility criteria for U5 children in the OPD programme. For example:

> "*I get 14 packs and I share it among my three children. One of my children is in the programme but all my three children are malnourished but they took only one of [my] children in the programme*" (Carer, Urozgan)

No carers or PLWs said that they sold IMAM products in the local bazaar or elsewhere, however 26% of community members said that they had seen IMAM products for sale in the local bazaar sold either by carers (80%) or by health facility staff (20%). Leakage into local markets as well as monitoring and mitigation strategies to prevent the sale of products is often discussed in the IMAM Technical Working Group.

Where shortages occurred, 10% of carers and PLWs indicated that doctors asked carers and PLWs to purchase products from private pharmacies or go to the bazaar. Some carers of U5 children in OPD stated that they received varying quantities of RUTF or RUSF sachets depending on the availability of stock. Review of monthly reports also indicated varied use of stock possibly as a result of errors in treatment protocols[58].

Of the community members who knew of carers and PLWs who had defaulted from IMAM services, 58% said that they had stopped attending due to shortages. For example:

> "*I took him to clinic and the doctors gave him [treatment products] two times. [After that], the doctors said that no more is available in the clinic. We faced shortage of [treatment products] and I got [disappointed] and finally I stopped going to clinic*." (Carer in Bagram, Parwan)

Similarly, where carers of children U5 said that they knew of non-covered acutely malnourished children in the community, 60% said that their carers had not visited facilities because of stock shortages. This was corroborated with LQAS results where villages with low coverage results were often located in the catchment areas of health facilities facing frequent stock shortages (e.g. Shinwar district in Nangarhar). The views of carers were supported by 21% of Community Health Workers who stated that stock breaks contribute to children defaulting in their communities. Interviews with PLWs also indicate that some malnourished PLWs do not try to access the programmes as they expect there to be shortages of products.

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[57] Data collection tools used during key informant interviews did not require data collectors to specify which IMAM service the child was attending (OPD SAM or MAM). More detail in Limitations.

[58] See section 3.2.3

Causes of commodity shortages: The reasons identified by respondents for stock outs of IMAM commodities include national stock shortages, road blockages, change of BPHS / EPHS contract holder and late submission of requests for restocking. Implementing partners reported that they often receive only a proportion of the stock they request. One IP indicated that they received 60-70% of requested quantities of RUTF. UNICEF confirmed that during 2019, due to funding shortfalls[59], they were unable to honour the required stock requests of partners. Funding shortfalls also halted the geographic scale up of OPD SAM services in 2019 and compelled UNICEF and partners to adopt a reduced product usage protocol in five provinces.

Challenging supply chains and weak logistic systems within provinces undermine the extent to which distribution is timely and can be responsive to any changes in need. In some provinces implementing partners lack resources and capacity to complete effective distribution at a provincial level resulting in health facilities experiencing stockouts. There was evidence of this because in provinces where UNICEF confirmed that they had delivered requests for RUTF in full during 2019, some stock breaks of RUTF were still observed at health facility level during the completion of quality checklists (e.g. in Urozgan 80% of facilities had experienced RUTF stock outs of at least one month during the previous 12 months). In order to overcome capacity issues, Nutrition Supply Chain Management Standard Operating Procedures were published and rolled out in 2017. However capacity and resourcing challenges persist.

3.2.3. To what extent does service delivery meet expected quality? What are the key bottlenecks/ constraints that need to be addressed in order to meet required quality of services?

The quality of IMAM service delivery is assessed based on whether or not the determinants of a quality "enabling environment" for IMAM are in place. The determinants include the following: availability of qualified staff members at facility and community level; availability of suitable infrastructures to admit and treat patients and to store commodities; availability of assessment equipment and guidance documents; and availability of sufficient quantities of commodities and drugs. Assessing each of these determinants can help to identify the key bottlenecks to the delivery of quality services.

The strategic results framework of the National Public Nutrition Strategy (NPNS) 2015-2020 assesses progress annually on Intermediate Result (IR) 3 (Improved quality of nutrition services and products) based on the "Quality of service provision" indexes in the EPHS and BPHS Balanced Score Cards (BSC). These indexes are based on a review of all services provided by BPHS and EPHS partners, including nutrition services. The indicator included in the NPNS 2015-2020 is described as "Service delivery points improved quality as per score card" (Annex 2) however it is not clear how the indicator is calculated, what the baseline value is or what the target values are during the strategy period. Additional IMAM quality assurance checklists are used during joint monitoring visits completed by PND and UNICEF staff.

Evaluation data from quality assurance checklists indicate that IPD and OPD IMAM quality of care is variable. Detailed findings can be found in Annexes 13 and 14. Findings are summarised in Table 5.

TABLE 5 SUMMARY OF FINDINGS FROM IPD AND OPD IMAM SERVICES

	Positive findings	Negative findings

[59] For RUTF alone, UNICEF requires $20-25million per year

IPD **(9 facilities visited)**	- The provision of appropriate guidelines and standard operational procedures - The provision of Information Education and Communication (IEC) materials for patient education - The provision of recent training in IMAM (particularly for nursing staff) - The provision of functional equipment - Documented supervision visits	- Lack of application of all admission criteria - Register entries incomplete - Miscalculations in prescription of therapeutic milk - Incorrect application of discharge criteria according to reporting category
OPD **(39 facilities visited)**	- Minimum staffing requirements achieved to operate OPD SAM and MAM services in facilities - Good availability of IMAM / nutrition guidelines and IEC materials in facilities - IMAM trainings taking place at least annually, if not more regularly in most provinces - Availability of functioning tools to be able to measure and admit acutely malnourished children and PLWs	- Poor adherence to IMAM protocols due to new staff not being trained on IMAM - Lack of consistency and errors in calculating WHZ - Poor treatment card and register completion contributing to mis-reporting of results to provincial and national level - Shortage of space to safely store IMAM supplies - Regular shortages of IMAM supplies (especially RUSF and Supercereal)

Source: IMAM evaluation data, March-April 2020

The key bottlenecks to quality service delivery are discussed below.

Availability of qualified staff members at facility level

IPD services: In IPD IMAM wards, minimum staffing levels for the implementation of IMAM[60] were met in 44% of facilities. 100% of facilities were reported as being staffed with a paediatrician; 40% of paediatricians reported having received no IMAM training and 89% received no IYCF training. Some paediatricians who reported not receiving IMAM training had received training from WHO which suggests that they may have received IPD SAM training. None of the hospitals in the evaluation reported vacancies of IPD nurses and all IPD nurses confirmed having received training on IMAM. Midwives were missing in 5 out of 9 facilities. 44% of hospitals were not staffed with nutrition counsellors, however Nutrition Counsellors are not required at Regional and Provincial hospitals according to IMAM Nutrition Guidelines (2018). Only one facility was confirmed as having a psychosocial counsellor.

All IMAM trained staff in IPD facilities had been trained within the 2 years prior to the evaluation. Evidence suggests that IMAM trainings were conducted annually, however some staff were currently untrained due to their more recent recruitment.

OPD services: OPD wards in hospitals had good availability of doctors, nurses and nutrition counsellors, however similar to the IPD wards, there were no psychosocial counsellors in any OPD wards of hospitals and midwives posts were vacant in some facilities.

In Comprehensive Health Centres (CHC), Basic Health Centres (BHC), Sub health centres (SHC) and Mobile Health and Nutrition Teams (MHNT), the minimum staff requirement for IMAM was met in 59% of OPD facilities visited. This exceeds the BPHS BSC (2018) national median for "Staffing index" (34.4). All CHCs visited

[60] Minimum requirement for IPD SAM (based on IMAM guidelines, 2018): Paediatrician, Nurse and Midwife

had the minimum staff requirement, however smaller facilities (BHCs and SHCs) often lacked key personnel for IMAM including Nutrition counsellors, Midwives and Community health supervisors.

The majority of staff in facilities with OPD IMAM services (71%) had benefitted from IMAM trainings within the previous 12 months, however across all facilities, less than 50% of all key staff members (OPD Doctors, OPD Nurses, Midwives, Nutrition Counsellors and Community Health Supervisors) had attended IMAM initial or refresher trainings. Community health supervisors (CHS) were the least trained of all key staff members with just 19% confirming that they had been trained on IMAM. Fewer OPD staff members had been trained on IYCF; in 68% of facilities, at least one staff member had received IYCF training indicating that most key staff members involved in delivering IMAM services may not be equipped with up-to-date appropriate knowledge on the prevention of malnutrition or giving appropriate post treatment advice to avoid relapse. Some staff interviewed during data collection indicated that the poor availability of the trained staff was partly driven by the high turnover of frontline staff.

Absence of trained staff in health facilities and the delegation of all IMAM-related responsibilities to Nutrition Counsellors affected the quality of IMAM service delivery. Staff reported being overworked and completing roles that they would not do normally. There was evidence of errors in register and report completion particularly where there was high GAM prevalence and consequently high admissions. This was particularly common for Nutrition Counsellors (NCs). OPD checklist data indicated that in 21% of facilities, NCs were responsible for admitting and discharging children from the OPD programme which is beyond the scope of their job description and training. In 49% of facilities, NCs were recorded as the only staff member responsible for recording the anthropometric details of children indicating that in some facilities, all responsibilities for IMAM have been passed onto NCs. Admission and discharge criteria are not solely based on anthropometry but require clinical assessments that should only be given by appropriately trained doctors or nurses. This is likely to have contributed to the numerous errors observed in registers.

During data collection in facilities, major errors were observed in key IMAM protocols. 28% of staff in OPD facilities were unable to name all three IPD SAM admissions criteria; 33% of staff made major errors in the calculation of the quantity of RUTF to distribute[61]. Serious errors in register completion also noted. For example in 70% of facilities, numerous cases were identified in the registers which had been admitted more than three months previously with **no** discharge information. OPD MAM registers for U5 and PLWs in many facilities were also missing discharge criteria for the majority of cases admitted during 2019. Errors in calculation of milk rations were also observed in IPD facilities; 67% of facility staff in IPD provided completely incorrect answers when asked to calculate the quantity of F100 to distribute based on weight data. Other significant violations of IMAM protocols included:

- **Incorrect discharge protocols in IPD;** in the context of IMAM hospitals should be expected to discharge the majority of cases as transfers to OPD, however the vast majority of registers in 9 facilities assessed, record outcomes as 'cured' rather than transferred to OPD resulting in overestimation of performance by overestimating cured cases.
- **In the majority of OPD facilities, there was strong evidence that facility staff are not calculating WFH Z-score measurements and/or are unable to interpret the measurements correctly using WFH Z-score** reference tables. Across the 7 provinces visited, only 7% of OPD SAM cases were admitted to the programme based on WFH Z-score and the majority of these were in 9 facilities in 3 provinces

[61] This is the combined percentage of health facility staff who calculated a quantity of RUTF which was incorrect by MORE than 5 sachets. Detailed results are included in Annex 14.

(Herat, Jawzjan and Parwan). Nutrition survey data indicates that approximately 25-55% of children are SAM only by WFH, indicating that many SAM children are being missed at admission. Where WFH Z-scores had been calculated in OPD facilities, 50% were found to be incorrect. Where weight and height measurements had been recorded at discharge, there was also evidence of children being discharged when they were still MAM by WFH.

- **OPD SAM treatment cards indicated incomplete medical checks at admission and discharge at MAM status instead of well-nourished status.** In 50% of health facilities a significant number of the required fields were not completed on the first page of the treatment cards. This indicates that the appropriate health checks were not completed on admission and that the correct drugs and antibiotics were not administered as required which are a central pillar of their treatment for lower mortality risk. In the two BHCs visited in Herat, the treatment and ration cards indicated that where OPD SAM cases had been discharged as cured, they were discharged when they had reached MAM status, rather than when they had become well-nourished. This is especially concerning in Herat where there are no OPD MAM services operating.

Availability of qualified staff members at community level. Availability of CHWs in the catchment areas of OPD health facilities is good and the majority of CHWs confirmed that they had been trained on IMAM. OPD checklist findings indicated that 16% of health facilities reported minor shortages in the required number of CHWs. Based on interviews with CHWs, 75% confirmed having received a training on IMAM related responsibilities. However just a third of carers of acutely malnourished children enrolled in IMAM confirmed they had been referred into the programme by a CHW indicating that community-level screening for IMAM is weak[62].

Availability of suitable infrastructures to admit and treat patients and to store commodities. Evaluated against 7 criteria assessing the quality of supply chain management, 56% of IPD facilities and 30% of OPD facilities provided appropriate and adequate storage facilities and monitoring of nutrition products. The most common shortfalls related to temperature checking (47% of storerooms lacked thermometers) and signs of rodents and insects (43%). Photos of storerooms supported these findings in some provinces. This reflects the BPHS BSC infrastructure index for these provinces.

Availability of assessment equipment and guidance documents. Where OPD IMAM services were available, staff members were found to have the documents and tools to be able to admit and treat acutely malnourished children and PLWs. However 33% of IPD and OPD facilities were found to have no nutrition or IMAM guidelines. Where available the IMAM guidelines were the version published in 2014. Outdated guidelines compromise the quality of the programme since many protocols and operational guidance have been updated since 2014. The revised guideline for treating infants <6m with SAM in OPD has not been operationalised as evidenced by a lack of screening and admission to care of infants[63].

Equipment for taking anthropometric measurements was available and in a good state in nearly all facilities visited (including MUAC, height boards and weighing scales). One weakness noted was the absence in 44% facilities of weight and health tables for staff to use to calculate the weight-for-height (WFH) Z-score of children under 5. This indicates that WFH Z-score is not being calculated systematically by health facility staff and corroborates with the findings above.

[62] More detail in section 3.3.3.
[63] More detail in section 3.1.3.

Availability of sufficient quantities of commodities and drugs. The results were mixed, with management level staff generally indicating no stock issues, whilst front line staff indicated problems with both medicines and nutritional products. In one province it was reported that medicine shortages were in part due to complicated procurement procedures and funding issues. The lack of stock or stock outs of nutrition products compromise programme quality through increased potential for default and poor perception of the programme at community level resulting in low coverage.

3.2.4. To what extent do implementing partners have the required capacity to deliver IMAM services?

Between 2013 and 2019, **implementing partners admitted and cured 880,000 SAM children and 600,000 MAM children**[64]. This is commendable considering that before 2013, many IPs had never implemented acute malnutrition treatment services.

Evaluation data indicates that the capacity of BPHS and EPHS partners to deliver quality IMAM services varies. For example in Kunduz the NNGO JACK had been operating OPD SAM programmes for just two years compared to NNGOs in other provinces (which had been implementing IMAM for at least 7 years). IMAM quality assurance findings in Kunduz were some of the worst seen throughout all provinces visited with 63% of health facility staff and CHWs interviewed in Kunduz stating they had never been trained on IMAM. In spite of this, 83% of facilities visited in Kunduz had reported OPD SAM cure rates of 99% or 100% in 2019. However there were no photos available of treatment cards or registers to verify that these rates were correct due to data collection errors and it is highly unlikely that these cure rates were accurate, especially considering the insecure situation in Kunduz and the frequent stock shortages mentioned by many carers and community members. However while some NNGOs may lack the necessary experience of delivering quality IMAM services, their experience of delivering health and nutrition interventions in the province means that they are better able to negotiate access to hard-to-reach areas and groups due to their established relations with groups such as the Taliban.

IP capacity to participate and engage in coordination was found to be weak at national level and in some provinces. At national level, participation of NNGOs in coordination mechanisms during 2019 was poor. Meeting minutes indicate that in 2019, approximately 30% of national NNGOs attended the monthly national nutrition cluster meeting and one NNGO attended the IMAM Technical Working Group. NNGOs are also reported to be absent from Provincial Nutrition Committee meetings and that individuals from IPs who do attend meetings lack sufficient decision-making power to address programme issues raised. Anecdotal evidence from interviews with IPs indicates that they have insufficient capacity and are therefore unable to regularly attend coordination meetings.

The data collection and reporting systems of almost 70% of IPs were reported to be strong and adequate. The National Nutrition Database is credited with facilitating and improving the use of data. However 30% of IPs were described as having weak and insufficient reporting systems which may result in the reporting of inaccurate data. This has implications for and may undermine the credibility of findings and their use for programme adaptations.

Evaluation data indicated infrequent monthly supervision visits to facilities by IP nutrition officers however limited data was available to assess the quality of supervision provided by IP Nutrition officers. Since 2015, the PND has required all implementing partners to recruit one nutrition officer for every 50 health facilities offering OPD SAM. Where OPD MAM services are operating, WFP requires IPs to recruit another, OPD MAM-

[64] Source: National Nutrition Database

focused nutrition officer or to employ "Program Assistant Teams" to monitor OPD MAM. The recruitment of nutrition officers to supervise nutrition services is included as an evidence-based activity in the strategic framework of the NPNS 2015-2020[65]. While there is no data to indicate progress on this activity, if IPs do not have a sufficient number of Nutrition Officers in post, then they are penalised by the PMO. The primary responsibility of nutrition officers is to supervise the nutrition services in the health facilities which they are responsible for by completing monitoring checklists in health facilities, devising monthly action plans for health facilities and conducting nutrition training where necessary. He / she also prepares stock requests and makes distribution plans for nutrition commodities (including IMAM).

In IPD facilities, data indicated that in 33% of facilities, the IP Nutrition officer had visited during the last 12 months (one had visited monthly, the others 4 times in total). However the data also indicated that in facilities where the IP Nutrition Officer had not visited, the PNO and PNE had visited the facility during the course of the year. Similarly, in OPD facilities, IP Nutrition Officers had visited in only 41% of facilities during the previous 12 months. However, again it appears that supervision visits from PNOs and PNEs are more regular. Evidence from photographs of registers detailing recent admissions suggests that in some IPD and OPD facilities supervision visits do take place, with several instances of the incorrect application of protocols being highlighted and in some cases the register signed by the supervisor, however it is not clear who highlighted the errors (the IP nutrition officer or other supervisors).

3.2.5. To what extent have specific IMAM interventions/ activities helped to achieve the planned results and targets (including treatment of children and mothers for malnutrition)? What have been enabling and hindering factors/challenges?

National annual "coverage" targets for the percentage of children with SAM treated increased annually from 19% to 50% during the evaluation period (Annex 15 presents the targets for number of children with SAM treated in IPD and OPD, OPD-MAM and PLWs during the period 2014-2019 (where data was available)). These targets were exceeded each year (101–117% of targets achieved). 27.3% of districts were reported as achieving 100% or more SAM 'coverage'. However the method of measurement of performance against the target should be caveated. The HRP caseload database from 2018 shows that in 65% of provinces the calculation of caseload estimates was made using WHZ score data only[66]. Where 2013 data is used, the number of children with SAM is underestimated due to lack of inclusion of children suffering from acute malnutrition based on MUAC and oedema. IPD and OPD SAM admissions are also combined which may lead to double counting (a child admitted to the IPD SAM may be transferred to the OPD SAM and recorded as a new admission). When recalculated for corrected estimates of annual caseload that include estimates based on combined MUAC and WHZ burdens, the percentage of districts **achieving 100% of more SAM coverage falls to 5.2%** and the **percentage of districts exceeding 50% SAM coverage falls to 21.5% districts**[67]. As such targeting of children, commodity requirements and programme performance would be more reliably established using all of the IMAM enrolment criteria. Use of the WHZ criterion only to estimate caseload and commodity requirements in the majority of cases may also partially explain stock outs of commodities for SAM treatment.

[65] The indicator in the NPNS is the *Number of nutrition officers positions filled at the sub-national/ facility level*

[66] From the results of the 2013 National Nutrition Survey

[67] Based on 13 SMART surveys across 7 provinces between 2015 and 2019 the median estimate of prevalence of wasting by combined MUAC and WHZ is 1.67 x the prevalence of MAM by WHZ alone, and 2.3 x the prevalence of SAM by WHZ alone. Combined MUAC, WHZ and oedema prevalences were not available in the nutrition assessment database.

The annual coverage targets for children with MAM varied between 33-40%. The number of children admitted to OPD MAM exceeded the target in 2015 (111%) but subsequently fell to 38% of target in 2018 and 67% in 2019. The lower performance for MAM treatment services was in part due to financial constraints resulting in shortages of nutrition products. Data for PLWs is patchy but indicates that targets were exceeded in 2015/6. No data was available for 2017-19.

IPD and OPD SAM cure rates have largely met or exceeded national standards for cure rate and default based on data recorded in the National Nutrition Database. Since 2013, **IPD SAM cure rates** have met or exceeded the national standard of 75%. Annual **cure rates of OPD SAM** have remained in excess of 75% and have therefore exceeded national standards. With the exception of 2013, default rates have consistently remained below 15% (although in 2019 default rates came close to exceeding 15%). There is variation in OPD SAM cure rates between provinces, however overall, cure rates improved overtime during the evaluation period. In 2013, 31% of provinces reported cure rates less than 75%. By 2019, this had reduced to 4 provinces (out of 34). However based on 2019 performance data in the NND, 56% of provinces failed to meet the target cure rate for SAM treatment (85%), as set in the quality of care indicators for the Sehatmandi project.

Cure rates for OPD MAM for children aged 6-59 months exceeded national standards between 2013 and 2016. However from 2017 to 2019, they fell below 75% due to a significant rise in default rates. During the seven years leading up to 2019, default rates were consistently high for the OPD MAM U5 programme only dropping below 15% once in 2014. See "Hindering factors" below. However reported performance rates should be interpreted with caution. In some provinces, OPD SAM and MAM cure rates are likely to be inflated and defaulters underreported due to errors and inconsistencies in reporting[68].

<u>Enabling factors</u>. Where acutely malnourished cases have been treated through to cure, significant enabling factors include positive perceptions of carers about IMAM products and about care received as well as CHWs, FHAGs and Health shura members encouraging carers and PLWs to continue receiving care. CHWs also follow up active cases in communities, however this is not consistent in all communities[69].

<u>Hindering factors</u>. Where cure rates of IMAM services have not met national standards, high default rates were the cause**.** In 2019, OPD SAM default rates in 41% of provinces exceeded the set standard of <15%. Of the seven provinces visited, Nangarhar reported the highest OPD SAM default rates during 2019 (31%). Data collected from communities indicated that where defaults occur, they are most often due to access challenges. These are caused by distance, insecurity or heavy snow in mountainous provinces, children migrating out of the area and lack of follow up by community outreach teams.

For OPD MAM services, evidence from the coverage surveys triangulated with interviews and document review suggests that stock breakages at national level contributed significantly to the high rates of default reported in OPD MAM services for children U5 and PLWs. Among the provinces visited for data collection, Parwan reported the highest default rates for OPD MAM U5 in 2019, which largely occurred in May / June. According to staff in facilities visited, for a third of 2019, no RUSF was available in Parwan's facilities. In the worst affected facility, there was no stock available for the whole of 2019. Supercereal was also reported to be absent from Parwan's facilities for the majority of 2019. Given that the timings of Parwan's stock shortages and defaults occur during similar periods as the defaults in other provinces, this indicates that there was a nationwide shortage of OPD MAM commodities in the first half of 2019. Also in provinces visited where OPD

[68] See section 3.2.3.
[69] See section 3.3.3.

MAM operated, facility staff and community members reported stock shortages of RUSF and Supercereal much more frequently than shortages of RUTF.

Late admissions into care also contribute to poor cure rates. Across all provinces visited, the median MUAC at admission in all OPD SAM facilities was 11cm, with 62% of facilities assessed recording median MUACs at admission of 11cm or less. A lower MUAC on admission typically results in higher risk of morbidity and mortality, increased length of treatment and increased risk of default or non-cure. A median of 11cm indicates relatively timely admission to treatment, especially when the majority of IMAM services operate in rural contexts.

From 2013-2019, an estimated 185,290 lives have been saved (range 113,362 to 227,805) by the OPD SAM and MAM treatment programmes for children under 5. Calculations for these estimates are included in Annex 20.

3.2.6. How motivated and satisfied are front line staff to deliver IMAM services? What are the constraining factors including staff workload?

Health facility and community outreach workers across the different provinces exhibited high levels of motivation and a desire to contribute to the success of the programme. There was consensus that IMAM is an effective approach to address malnutrition, particularly in children, and saves lives. Many health facility staff and outreach workers reported pride in contributing to improving the health of the next generation of Afghanis. These reflected findings reported in the 2018 BPHS Balanced Scorecard where 88% of health workers identified a sense of personal responsibility as a key motivating factor for their work. Despite the positive views about IMAM, health facility workers and outreach staff described a **number of factors which reduced their motivation and broader job satisfaction as described below.**

Low staffing levels and high patient volumes. 75% of health facility staff in all provinces visited stated that patient numbers were high and staff capacity limited. The high number of patients and insufficient workforce capacity was also found to affect the quality of care provided to patients. In provinces with limited numbers of trained staff and high SAM and MAM caseloads, especially large number of errors were observed in register completion and in adherence to IMAM protocols[70].

The integration of IMAM has increased the scope of work for some health care staff such as midwives. Their role has expanded to address all healthcare needs related to PLWs and children under five and all IMAM activities. It is probable that the quality of other health services provided by staff members has decreased following the roll out of IMAM. However no data was available to confirm that this was the case. The introduction of the Nutrition Counsellor role would have helped mitigate the burden on other health facility staff, however there was evidence that Nutrition Counsellors were being delegated responsibilities beyond their training and pay grade[71].

Supervision and support. Supervision visits at health facilities are reported to be high. Evaluation data indicates that supervision is primarily provided by government staff and UN staff rather than by the implementing partner Nutrition officer[72]. 85% of staff reported receiving supervision during monitoring visits or phone calls from key focal points. All forms of support and communication were valued by staff interviewed and contributed to staff feeling better equipped for their roles, which in turn increased their

[70] More detail in section 3.2.3
[71] Idem
[72] More details in section 3.2.4.

motivation. In some provinces supervision is limited by the security situation. The majority of doctors (inpatient and outpatient), midwives and inpatient facility nurses said that they were satisfied with the supervision they received. However, nurses who worked in outpatient facilities and nutrition counsellors said that the supervision they received was insufficient as they were rarely supervised.

The motivation levels and productivity of **community outreach workers** was also affected by regular supervision visits. 91% CHWs and CHS' reported receiving either regular or some supervision. This mostly consisted of monthly meetings at the health facility with the CHS and other CHWs. All interviewees spoke positively about these supervision sessions as they provided opportunities for CHWs to interact with others, share challenges and feel part of a broader network.

Training. There was significant provincial variation in the proportion of health care workers stating they had received training on IMAM, ranging from 4% to 55%[73]. The lack of training on IMAM was generally not associated with feelings of demotivation but those who did receive training consistently spoke positively of the experience and impact on their ability to provide high quality care. 76% CHWs stated that they felt that they had received enough training. Without sufficient training, CHWs felt ill equipped to provide necessary community sensitisation.

Availability of resources. The lack of resources affected the motivation of some health facility staff and created a more challenging working environment. The most common of these related to stock breaks which resulted in patients becoming frustrated with health facility workers. These challenges to motivation were reported particularly in provinces with higher levels of insecurity and at community level in health facilities where stock breaks were experienced more frequently.

In addition 33% of CHWs in 40% of provinces mentioned that their associated facilities experience frequent stock breaks.[74] Encouraging parents to return to facilities, when stock breaks are frequent, is reported to be challenging and demotivating for CHWs. **However, according to the CHWs interviewed, resourcing challenges rarely limited the ability of CHWs to conduct community screening**. Only 4% reported not conducting any screening of children or PLWs in the community. The vast majority (78%) used a MUAC tape to carry out screening, as well as scales and height boards in some cases. However, 20% of CHWs described having no materials to conduct sensitisation activities.

Infrastructure of health facilities. Inappropriate working environments impacted the ability of 10% health facility workers to provide quality care. In particular, female nurses and nutrition counsellors described often providing consultations in hallways as they lacked a designated consultation room in which to conduct consultations on breast-feeding in privacy.

Remuneration. Late payment of salaries had a negative impact on motivation for health facility workers in three provinces (Nangarhar, Paktika and Kunduz). Late payment of health facility staff salaries was also noted by key informants at central level with some stating that payment of staff salaries is often linked with Sehatmandi "P4P" indicators. **Some CHWs also cited lack of remuneration as a factor that affected their motivation** as they felt that it was an unfair expectation for them to deliver work on a voluntary basis. This, along with competing priorities, reduced the amount of time CHWs could dedicate to their activities. Some implementing partner staff felt that the strengthening of CHW remuneration was essential to improve motivation for outreach workers. **Access. Barriers to accessing IMAM services experienced by community**

[73] Idem.

[74] Details on stock breaks are further described in section 3.2.2.

members were commonly cited by CHWs as a key challenge to the completion of their roles[75]. Some suggested that they should be more than a referral mechanism and should also be able to provide treatments to community members.

3.3. Coverage

Summary: *This section provides findings related to how the geographic and treatment coverage of IMAM services have evolved and quality of these services. Also presented are the most common barriers to coverage facing service providers and to service uptake by communities as well as the strategies and innovations employed to overcome these. Where a finding relates to an Intermediate and Sub-Intermediate result from the NPNS results framework in Annex 11, a reference is added in brackets after the finding.*

Key findings (cont.):

- **A significant factor limiting the reach of IMAM is the lack of effectiveness of IMAM community outreach services (IR 1, Sub IR 1.3).** Only a third of acutely malnourished cases are referred for treatment by CHWs and a half of carers interviewed in the community confirmed their child had not been screened at home previously. Participation in nutrition education sessions by carers of children under 5 and PLWs was weak indicating further that CHWs are not conducting house to house visits as they should.
- **Lack of awareness of the existence of IMAM services was the most common reason why carers or PLWs did not seek treatment**. Other significant factors included the inaccessibility of health facilities (relating to distance and / or topography), cultural factors and previous negative experiences at health facilities.

BPHS and EPHS packages of health and nutrition services and creation of the nutrition counsellor role to support IMAM services at facility level and to encourage carer and PLW participation (IR 3, Sub IR 3.1).

- **Based on government standards for case coverage of IMAM services, coverage of OPD SAM services is low to moderate (approximately 35%)**. During the evaluation period, there was no evolution of coverage estimates indicating that the barriers to access which prevent carers and PLWs from coming to health facilities remained constant. However, coverage varied between provinces and districts.

3.3.1. What is the geographic coverage of IMAM services against estimated national, provincial needs? How has this changed since start of IMAM?

The strategic framework of NPNS 2015-2020 includes for IR 1 (Increased access to and availability of nutrition services and products) the indicator: "Treatment coverage for children U5 with acute malnutrition" with a baseline value of 34% and target value for 2020 of 80%. This does not distinguish between the treatment coverage of MAM and SAM.

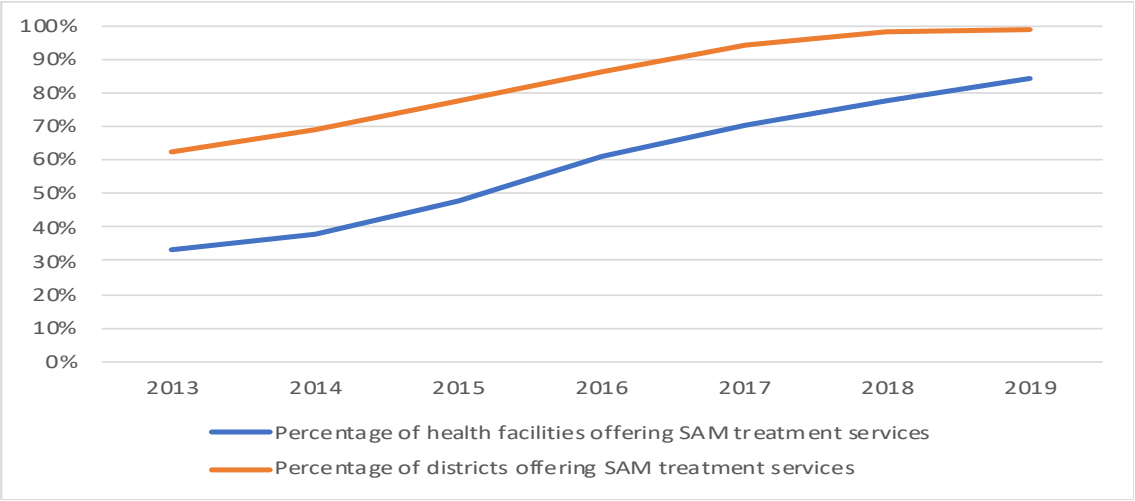
IMAM **geographic coverage** (also known as "Availability" coverage) refers to the percentage of health facilities offering IMAM services. The denominator for calculating geographic coverage of OPD services includes all types of hospitals and health centres including Sub Health Centres. Health posts are excluded as

[75] More details in section 3.3.4.

acutely malnourished children cannot be admitted to care at health post level. In 2019 this included a total of 1,982 facilities in 408 districts in 34 provinces[76]. When IMAM was integrated into the BPHS and EPHS in 2013, both OPD SAM and OPD MAM were available in 28% of health facilities.

In December 2014, the PND, WFP, UNICEF and the Nutrition Cluster launched joint planning for the geographical targeting of OPD SAM and MAM services. The plan aimed to increase OPD SAM geographic coverage by 10-15% per year until it achieved universal coverage of OPD SAM to the level of BHCs[77]. **Between 2013 and 2019, OPD SAM geographic coverage increased consistently year on year, meeting or exceeding the MoPH's target for annual scale up by 10-15%**. By 2019 OPD SAM services had reached 99% of districts and 72% of health facilities (Figure 6). While OPD SAM geographic coverage increased at national level, the increase in geographic coverage was not consistent across all provinces. In 9% of provinces there were fewer active facilities in 2019 than in 2013[78] indicating that the reach of the IMAM programme reduced in these provinces. There was also a consistent scale up of **IPD SAM services** during the same period **from 87 facilities in 2013 to 175 facilities in 2019**.

FIGURE 6 EXPANSION OF SAM TREATMENT SERVICES IN AFGHANISTAN (2013-19)



(SOURCE: IMAM DATABASE, SHARED FEBRUARY 2020)

OPD MAM services were also to be scaled up during the evaluation period, but owing to limited resources, they were only scaled up in "priority" provinces (based on rates of SAM/GAM or the existing presence of OPD MAM services). The criteria for classifying priority and non-priority provinces evolved during the evaluation period[79]. By 2019 **OPD MAM services for children U5 and PLWs were available in 70% of districts and 38% of health facilities**.

[76] IMAM Perf data review 2019
[77] Scale up plan, 2018
[78] Paktya (24% reduction), Badakhshan (23% reduction) and Nuristan (6%)
[79] See section 3.1.2

The geographic coverage estimates presented here do not account for accessibility to IMAM services. While OPD SAM is available in 72% of health facilities, it is not necessarily accessible to 72% of the Afghan population. Inaccessible areas due to insecurity or remoteness are not covered by government clinics but are managed by emergency health and nutrition partners under the National Nutrition Cluster. Coverage in these areas is discussed below.

Case coverage assesses the percentage of a target population (e.g. SAM children under 5) who access treatment. The PND set the national standards for treatment coverage as follows: Poor: 0-30%; Moderate: 30-60%; High: 60-100%. During the evaluation period, 28 coverage surveys assessed the treatment coverage of OPD SAM services (five using the SLEAC[80] methodology and 23 using the SQUEAC[81] methodology) covering 21% of districts in 62% of provinces. **The average coverage estimate[82] of all coverage surveys completed was 34.9% ranging from 14.4% to 58.5%.** During the evaluation period, there was no identifiable evolution of coverage estimates indicating that the barriers to access which prevent carers and PLWs from coming to health facilities have remained constant throughout the evaluation period[83].

Treatment coverage of acute malnutrition services for children under 5 (combined for OPD SAM and MAM) was high in 60% of villages, moderate in 22% of villages and low in 22% of villages. Meanwhile treatment coverage of OPD MAM programmes for PLWs was high in 36% of villages, moderate in 18% of villages and low in 45% of villages. However, weak adherence to case finding protocols are likely to have overestimated coverage rates in the majority of villages[84].

Leading factors likely to have **contributed to the increase in coverage rates** include:

- The integration of IMAM into the BPHS and EPHS leading to extensive geographic scale up of IMAM services to facility-based primary care and secondary care, including the scale up of OPD IMAM services to MHNTs and SHCs.
- Increased capacity of health facilities to admit acutely malnourished cases due to capacity building of thousands of front line health workers on IMAM and recruitment of new facility based roles to support IMAM at facility level (e.g. Nutrition Counsellors)

Hindering factors include:

- Inconsistent and insufficient roll out of acute malnutrition screening and referral and community sensitisation about acute malnutrition to community-based primary care
- Accessibility challenges facing many carers and PLWs due to distance, topography and/or insecurity or due to cultural norms preventing carers and PLWs from visiting health facilities
- Negative community perceptions of health facilities and / or IMAM due to poor behaviour of staff at health facilities, stock shortages and long waiting times

3.3.2. To what extent is the programme reaching those in hard to reach areas?

While BPHS partners are able to provide health and nutrition services in areas of the country which are not under government control (accounting for approximately 40% of the population[85]), many district areas are

[80] Simplified Lot quality assurance sampling evaluation of access and coverage
[81] Semi quantitative evaluation of access and coverage
[82] Using either the point or single coverage estimators
[83] More details in section 3.3.4
[84] See "Limitations"
[85] Deconnick, H, IMAM Service Implementation in Afghanistan: A Situation Analysis, 2017

inaccessible due to insecurity or remoteness. These are known as "white areas". There is limited information about the populations of white areas however a "Hard-to-Reach" assessment in 2020 reached populations in 120 districts (29% of all districts) in 25 provinces.

During the evaluation period, the PND developed and shared guidelines for the integration of nutrition services into Mobile Health Teams. As such, in some "white areas", nutrition services which include IMAM are managed by emergency nutrition partners grouped under the National Nutrition Cluster or are managed by BPHS partners directly or with the support of INGOs. They are also operated by the MoPH in provinces covered by the Afghan government's Strengthening Mechanism (SM).

Based on reported IMAM data, the coverage of MHNTs is limited. Until 2018, only six provinces reported admissions from MHNTs (Badakhshan, Herat, Jawzjan, Kandahar, Kunduz and Laghman). In 2019 nine more provinces started to report admissions into MHNTs with especially high admissions (approx. 5,000) of OPD SAM and MAM cases being reported in Kandahar and Daykundi. In 2019, a total of 1.8% (n=5091) and 3.7% (n=11964) of children U5 were reported by MHNTs for OPD SAM and MAM[86] respectively. However, these figures should be viewed with caution. In the national nutrition database, many admissions which appeared to be from MHNTs were not coded as "Mobile Clinics" and so the actual admissions may be higher.

Without accurate population data in white areas it is difficult to estimate what percentage of target populations are being reached. However given that significant admissions (over 1,000 per year) were reported from 6 provinces for the majority of the evaluation period and the HTR assessment covered "white area" populations in 25 provinces, this indicates that **at most 25% of target populations are being reached by MHNTs.**

Measures for improving access to hard-to-reach communities should not focus exclusively on overcoming physical barriers such as distance and insecurity. Nomadic communities are located within the catchment areas of BPHS partners as well as in the "white areas" of 15 provinces. At times their access to services is limited by prejudice (i.e. ethnic slurs) leading to some feeling excluded by health facility staff. Since 2020 steps have been taken to increase service provision for nomadic populations. In collaboration with PND and UNICEF the Nomads Directorate trained staff in 19 clinics (including 11 mobile clinics) across 15 provinces with nomadic populations as part of an externally funded, 18 month project.

The Health Impact M&E Framework in the MoPH Strategy 2016-2020 sets a target for 2020 for 96% of the population to be able to access health care within 2 hours. This is far from being achieved. Responses from KIIs indicated that 50% of carers and PLWs lived more than 2 hours walk from the nearest health facility. The LQAS survey results indicated that 28% of all respondents lived more than one hour's walk from the nearest health facility. Inaccessibility due to distance was also cited as the primary reason for non-attendance to the health facility by 17% all non-covered cases. Therefore even where health facilities are located in "accessible" catchment areas supported by BPHS partners, communities face challenges in reaching facilities due to distance or time to travel to the facility.

3.3.3. What are the success factors and challenges faced in reaching the target populations?

Factors that have increased the reach of IMAM

Extensive geographic scale up of IMAM services: By 2019, at least one component of IMAM was available in 99% of districts in all health facilities down to Basic Health Centre level (with the exception of approximately

[86] This figure is likely to be higher.

50 BHCs). OPD IMAM services had also been integrated into more than 180 SHCs and nearly 50 MHNTs by 2019. As acute malnutrition treatment was integrated into existing health structures, the geographic scale up did not require the construction of any additional facilities or storage.

Integration of acute malnutrition treatment into EPHS and BPHS: From 2013, IMAM was integrated into the EPHS and BPHS packages of health and nutrition services. Along with the geographical scale up, from 2013-2019, 11,000 staff in OPD facilities and wards and 2,000 staff in IPD wards were trained on IMAM. The majority of medical staff nationwide were therefore equipped with the knowledge and tools to diagnose and treat SAM and MAM in children and MAM in PLWs. Acute malnutrition diagnosis and treatment was also integrated into IMNCI guidelines making it the responsibility of all medical personnel in health facilities to treat acute malnutrition in the same way they would treat any other disease.

Improved nutrition capacity in health facilities: The nutrition counsellor (NC) role was created in 2017 to support nutrition activities in all health facilities down to BHC level. More than 2,000 NCs were recruited and trained between 2017 and 2019 and operate in all 34 provinces. All NCs are female high school graduates (aged 20 to 21) with the majority originating from the districts or provinces in which they work. KIIs indicated **strong motivation of NCs to complete their roles even if some are overburdened with heavy workloads.** As well as supporting screening and growth monitoring in health facilities, the NCs also conduct nutrition education sessions with PLWs and carers of children. Therefore they are able to engage with mothers and PLWs, promote IMAM services and encourage those enrolled to continue treatment. However based on anecdotal evidence from some key informants, implementing partners in some provinces faced challenges recruiting sufficient numbers of NCs due to the low levels of literacy amongst girls (e.g. in Paktika).

Community involvement in IMAM programme: Engagement of key community members in the promotion of IMAM services has proven successful at increasing reach. Approximately 50% of village leaders, imams, members of community health shura and Family Health Action Groups (FHAG) indicated that they participate in regular meetings with health facility staff (once or twice a month) and are informed about services available at the health facility. However few knew that PLWs were also targeted by the programme. Most of those who did not attend meetings recognised RUTF and RUSF sachets and knew of the purpose of the programme. All who were aware indicated that they promoted the programme to community members. Furthermore, in 2019, in order to increase the coverage of treatment, mothers in three districts in Herat were trained on the use of MUAC tapes. Following the training, admissions increased by more than 200% compared to the previous year.

Promotion of IMAM services on TV and radio: 20% and 10% of carers and PLWs had heard about IMAM services via the TV and radio respectively. Where village leaders and imams had not heard about IMAM from meetings, many had heard about it via TV and radio. Limited information was shared about multimedia campaigns to promote IMAM services however it is clear that they are also important mediums for increasing the reach of the population.

Challenges in reaching target populations

Weak community outreach for IMAM: The community outreach component of IMAM was considered by a number of key informants at national level to be the weakest component of IMAM. This was supported by evaluation data from communities. CHWs are required to complete house-to-house screening on a monthly basis using MUAC tapes in their villages. However only 35% of carers of acutely malnourished children and PLWs who were enrolled in the programme said that they had been referred by CHWs. Half said that it had been peers or relatives who had advised them to go to the health facility. Of the carers of acutely

malnourished children interviewed during coverage surveys in villages, 54% said that their child had never been screened at home with a MUAC tape previously. A much greater proportion of non-covered cases had never been screened (86%), than those that were covered by the OPD SAM or MAM programme (21%). This indicates the importance of screening in achieving high levels of treatment coverage and of increasing the reach of the programme. Of those that had been screened at home, just 36% had been screened during the previous 30 days (21% had been screened 1-6 months previously and 43% more than 6 months previously). 80% of health facility staff also said that they received incorrect referrals from the community although most said that these were only occasional.

Community screening is not consistently poor across all provinces and districts. Median MUAC at admission for SAM and MAM cases admitted to services can serve as an indicator of the effectiveness of community screening by outreach staff. Median MUACs from health facilities varied, with 72% of facilities recording Median MUACs at admission for OPD SAM cases of 11cm or above (which indicates relatively timely admission to treatment). However, data from some facilities indicated very low median MUACs indicating weak or absent community level screening.

With regards to the follow up of absentee cases, responses from health facility staff indicated that 60% of CHWs conducted follow up visits. However 30% of staff reported having to conduct follow up themselves.

Limited data was available to justify the causes of poor house to house screening. However anecdotal evidence from interviews with CHWs and other key informants suggests that the heavy workloads of CHWs and lack of remuneration contribute to the lack of house-to-house visits.

Insecurity and distance are also key challenges preventing target populations from reaching IMAM services from reaching target populations[87].

3.3.4. Are there any differences in take up of IMAM services and what are the reasons for these differences (if any)?

There were differences in take up of IMAM services across provinces*:* Based on coverage surveys completed in 2013-2018 in districts where OPD SAM services operate, treatment coverage ranged from 14.4% (Bagdis, 2015) to 58.5% (Nangarhar, 2018).[88] Based on the evaluation's LQAS results 56% of villages visited were classified as having high coverage (>60%). However weak adherence to case finding protocols are likely to have caused coverage rates to be overestimated in the majority of villages[89]. Furthermore, 61% of community members who participated in interviews stated that they knew malnourished PLWs or children in their communities who were not enrolled in the programme. Of the provinces visited low coverage and high default rates were more prominent in Nangarhar, Paktika, Uruzgan and Kunduz, while higher coverage and lower default rates were more prominent in Parwan, Herat and Jowzjan.

In Afghanistan, multiple factors can affect the uptake of IMAM services by carers of acutely malnourished children or PLWs. These include barriers (negative factors) and boosters (positive factors) and can generally be disaggregated into factors which are physical (e.g. distance, rivers or security situation), temporal (e.g. travel time to clinic or responsibilities at home), social (such as household dynamics or stigma), financial (e.g.

[87] More detail in section 3.3.2.

[88] The majority of coverage estimated were calculated using the single coverage estimator, however a number of the earlier assessments used the point coverage estimator. Details of all assessments completed in Annex.

[89] See "Limitations"

perceived cost of care) or relating to the quality of care (e.g. behaviour of staff or stock availability). These barriers and boosters varied between provinces and this reflects differences in take up of IMAM services.

Interviews with a range of community members[90] during the evaluation and data from the coverage surveys indicated that the following **barriers prevent carers from attending treatment**:

- **Lack of awareness about IMAM services:** Across the 7 provinces visited, 45% of community respondents stated that non-covered cases do not attend IMAM services due to a lack of awareness of the existence of treatment or misconceptions about the programme. This was the reason most frequently mentioned in nearly all provinces. Misconceptions included belief that IMAM is not free or that treatment products are harmful. Lack of awareness about IMAM services was also the most common reason for non-attendance which was mentioned by carers of non-covered cases (38%) and non-covered PLWs (37%) during the LQAS coverage survey.
- **Inaccessibility was also found to be one of the main barriers to coverage**. 36% of all community-level respondents interviewed said that carers and PLWs do not enrol in the programme due to the distance from their home to health facilities or due to the cost of transportation. During interviews conducted with carers of non-covered cases, 18% of carers and 16% of PLWs mentioned inaccessibility as a barrier. Distance was also a common barrier in all coverage survey reports completed during the evaluation period. Community members also reported that inaccessibility causes carers to default[91]. **Coverage classifications in villages found no significant correlation between treatment coverage and distance to health facilities.** However this may have been due to data collection teams not following the correct protocols when selecting villages to visit.
- 24% respondents stated that **cultural norms contribute to low coverage**. Among those, 71% of responses related to women who were forbidden from visiting health facilities without their husband or a family member. Another 43% related to community members' mistrust of health services (belief that services are provided by infidels) and/or their preference for traditional medicine or religious solutions. Mention of cultural norms as barriers to case coverage were most frequent in Uruzgan, Paktika and Nangarhar. This was corroborated by coverage survey findings with 15% of carers of non-covered cases and 7% of non-covered PLWs stating that **cultural factors** (lack of company for the journey, husband refusal, and shame) contribute to non enrollement in IMAM.
- **24% of respondents** reported that non-covered cases do not join IMAM due to **negative experiences at health facilities (including stock shortages, poor staff behaviour and long waiting times**). In Kunduz and Nangarhar in particular, this was a significant barrier to access. This was also confirmed as a barrier by carers of non-covered cases and of non-covered PLWs during the LQAS coverage surveys. Negative past experience at health facilities was also stated as the main reason carers and PLWs default. In low coverage districts identified by coverage surveys from 2014-2017, previous rejection of children from facilities was also identified as a barrier to coverage.
- **12% of respondents reported that security issues** prevent carers from enrolling in IMAM, due to road closures, risk of bombs or Taliban intimidation. Of the provinces visited for data collection, security was identified as a barrier to access in four provinces, most prominently in Uruzgan and

[90] Including carers of OPD SAM and MAM cases, carers of non-malnourished children, PLWs, male and female community members, imams, village leaders, FHAG members, Health shura members

[91] More detail in section 3.2.5.

Kunduz. Additionally, coverage surveys conducted in 2014-2019 in Paktika, Khost, Hazrat Sultan, Samangan and Nangarhar also identified insecurity as a barrier to access.

Boosters to case coverage

Where coverage was found to be high, the primary factors facilitating access to services included **positive perception of IMAM in the community, proximity to health facilities, options for childcare support** and **adequate community outreach.**

Positive perception of IMAM in the community encourages higher treatment coverage. 75% of community members living in areas identified as having high coverage by the LQAS coverage surveys reported being very satisfied with the IMAM programme. This finding is consistent with the results of coverage surveys for OPD SAM conducted in 2013-2018.

Proximity to health facilities also appeared to be a booster of case coverage. 67% of respondents living in high coverage areas reported living less than 30 minutes' walk from health facilities offering IMAM services.

The ability for carers and PLWs to leave their children with a spouse or relatives emerged as another booster to treatment coverage. 8% of carers and PLWs who are enrolled in the IMAM programme reported that adhering to their treatment was not difficult because they were able to leave their other children with relatives in order to visit health facilities. This was also noted as a positive factor influencing coverage in a relatively high coverage district in Nangarhar in 2019[92].

Community outreach by CHWs was found to be a booster to coverage in high coverage areas during coverage surveys conducted in 2015 and 2018. In Nangarhar, food and cooking demonstrations by CHWs and the use of IEC materials in villages were identified as boosters for coverage. However as discussed in Section 3.3.3, while there appear to be pockets of strong IMAM community outreach, **in general community outreach is weak**. Coverage survey findings often indicated that communication about IMAM through "word-of-mouth" in the community was more effective at encouraging carers to attend services than screening by CHWs.

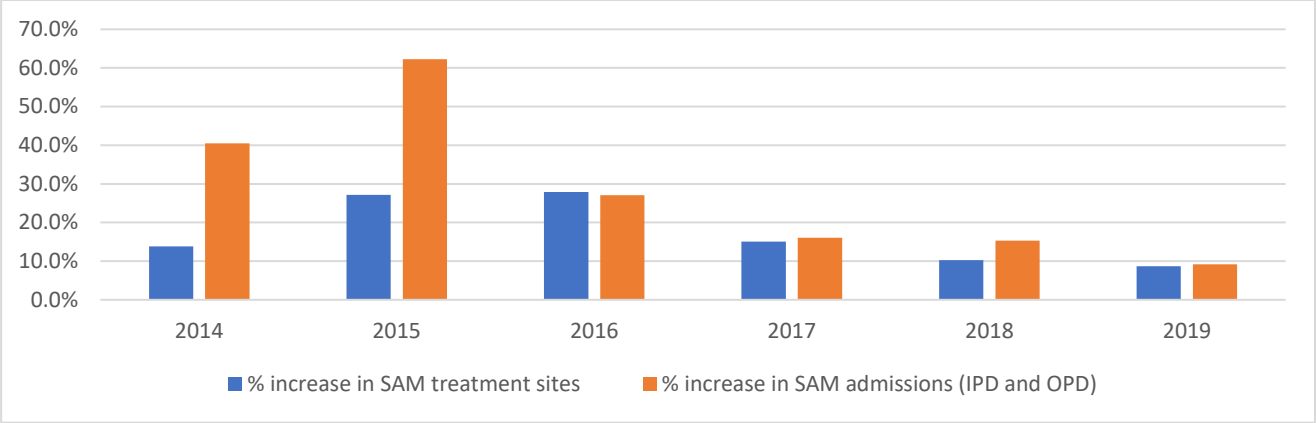
3.3.5. To what extent has the expansion of geographical and programmatic coverage been accompanied by quality service provision?

SAM treatment sites scaled up by 255% from 557 in 2013 to 1422 in 2019. Admissions to SAM treatment services increased by 423% during the same period from 72,923 in 2013 to 308,545 in 2019 indicating that the geographic scale up of services has been exceeded by the percentage increase of admissions.

Further analysis (Figure 7) indicates that with the exception of 2016, in comparison to the previous year, the percentage increase in SAM treatment admissions has matched or exceeded the percentage increase in SAM treatment facilities every year. The large increases in admissions in 2014 and 2015 are partly due to the scale up of OPD SAM services to larger facilities (e.g. district hospitals and CHCs) with large catchment areas.

FIGURE 7 PERCENTAGE SCALE UP OF SAM TREATMENT SITES AND SAM TREATMENT ADMISSIONS DURING EVALUATION PERIOD

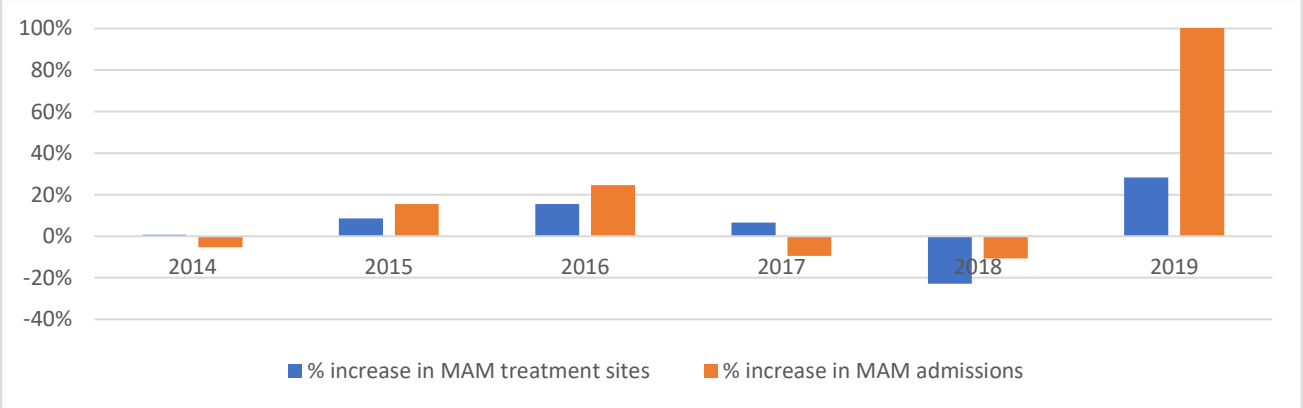
[92] SQUEAC report, Nangarhar province, 2019 (ACF)



(Source: IMAM service availability data and NND)

The number of facilities offering MAM treatment for children U5 increased by 33% during the evaluation period (2013: 559; 2019: 744). Admissions increased by 123% during this period. However, MAM geographic coverage and admissions fluctuated based on the annual changes in priority and non-priority provinces. The majority of the increase in admissions was seen in 2019 when admissions more than doubled compared to 2018.

FIGURE 8 PERCENTAGE SCALE UP OF MAM TREATMENT SITES AND MAM TREATMENT ADMISSIONS DURING EVALUATION PERIOD

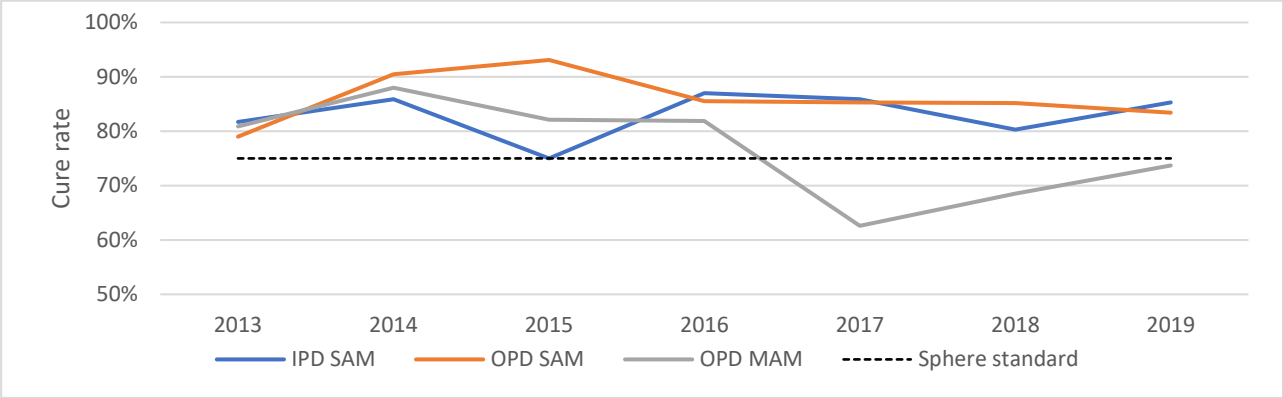


(Sources: IMAM service availability data and NND)

During this period, the cure rates of IPD and OPD SAM remained largely constant. Overall, this indicates that, **based on performance indicators, as SAM treatment facilities and admissions have increased, quality of care has remained constant** (Figure 9). OPD MAM treatment cure rates have declined slightly overtime.

The dip in cure rates in OPD MAM was largely driven by poor stock availability during 2017 and 2018. However both the SAM and MAM treatment cure rates should be interpreted with caution as evaluation findings indicate that cure rates may be overestimated in some health facilities.

FIGURE 9 REPORTED CURE RATES IN IPD AND OPD SAM AND OPD MAM FOR CHILDREN U5 DURING EVALUATION PERIOD



(Source: IMAM database, February 2020)

Quality of service provision in facilities was strongly linked to the availability of trained human resources[93]. Where IMAM services had been recently established (during 2019), quality measures were found to be poorer in comparison with facilities in the same districts where IMAM services had been operating for longer.

Following large scale trainings on IMAM in 2014-2016, initial and refresher IMAM trainings were completed at provincial level on an annual basis during the 2017-2019 period. Therefore during the scale up of IMAM services (especially OPD SAM services), the PND and partners set out to ensure that there was sufficient availability of trained human resources in facilities. However evaluation findings indicated that in the provinces visited, while some facility staff had been trained on IMAM it was rare that all necessary staff had been trained and where quality gaps were observed, it was almost always linked to relevant staff members not being trained. This was found to be partly linked to high turnover of front line staff and partly to geographical scale up. For example, in Parwan in Charikar district, two BHCs which had started providing OPD SAM services in 2019 indicated poor quality of care in terms of timeliness of admissions, correct completion of treatment cards and registers and evidence of outreach reach in comparison with the other facilities visited in the district (a PH and a CHC). Further investigation found that, unlike staff in the PH and CHC, staff in the BHCs had not received a comprehensive week long training on IMAM. Similar findings were observed in Herat and Urozgan.

In many provinces, the "stop-start" nature of the OPD MAM scale up strategy has negatively impacted community perception of all IMAM services contributing to low treatment coverage, poor adherence to treatment and poor behaviour of staff. OPD MAM services for children U5 and PLWs are rolled out to provinces based on an annual review of GAM rates using a threshold of 10% and other criteria[94]. Based on this system, a certain number of provinces will commence OPD MAM services while others will phase out

[93] See section 3.2.3.

[94] During the evaluation period, owing to resource limitations, OPD MAM services were only implemented in "Priority" provinces. Priority and Non-priority provinces were determined by the rate of SAM or GAM in children under 5 and the existing presence of OPD MAM services in the province. See R3.

services from year to year. If a province phases out OPD MAM services, supply of commodities will end and carers will be turned away when they arrive to receive treatment. Evaluation data indicated that 87% of carers with children in OPD reported previous stock shortages. While it was not always possible to determine which commodity they referred to (RUTF or RUSF) it is probable that shortages related to RUSF given that RUTF shortages were found to be very rare in the health facilities visited. However the message that there was no stock would have been passed onto other community members who may have SAM or MAM children. As a result, the inconsistency of MAM supplies due to the phasing in and out of OPD MAM services in provinces is likely to affect the community confidence of all IMAM services. This also affected treatment coverage with LQAS findings indicating that 10% of carers of non-covered U5 cases and 11% of PLWs did not travel to the facility as they had heard there was no stock in the facility.

3.4. Efficiency

Summary: *This section provides findings relate to the efficiency of IMAM services through different delivery mechanisms. It also provides an assessment of the complementarity and effectiveness of IMAM-related M&E*

Key findings:

- In comparison with Basic Health Centres, OPD SAM and MAM services operating out of **Sub-Health Centres** are less efficient per child cured. **Mobile Health and Nutrition Teams** are also less efficient per child cured for OPD SAM, but slightly more efficient for OPD MAM due to the large number of children reached through these services.
- Assessment of one project indicates that **INGO technical support for national NGOs** with no prior experience of implementing IMAM services can result in sustained quality of care.
- **IMAM related databases:** The IMAM database is accessible to national and provincial stakeholders and enables disaggregated analysis to facility level (IR 3, Sub IR 3.4). However few IMAM-related indicators are included in national HMIS. Parallel databases monitor Supply Chain Management and results from nutrition assessments.
- **IMAM monitoring systems:** Parallel monitoring systems exist for SAM and MAM treatment although joint monitoring for the Sehatmandi project has led to the development of a merged system. Implementing partners lack the capacity to effectively monitor IMAM services due to the high workloads of nutrition officers and to inadequate monitoring tools (which tend to focus on IMAM outputs rather than quality of care). There is also limited evidence of the development of quality improvement action plans following monitoring visits (IR 3, Sub IR 3.2)
- **Evidence from bottleneck analyses has been used to improve programme performance**. In most cases assessments are completed in parallel for SAM treatment and MAM treatment services. Updates to global guidelines and funding challenges have also led to adaptations to programming enabling a more efficient delivery of treatment. However action plans to improve coverage developed following coverage surveys are not followed up (IR 4, Sub IR 4.2)
- **IMAM related forums operate efficiently at central level.** The NNC, IMAM TWG and the AIM WG are the most active although they are not well attended by IPs. While the Nutrition Programme Coordination Committee (NPCC) progresses certain aspects of the **NPNS, its ability and effectiveness to coordinate nutrition activities is limited (IR 4, Sub IR 4.1)**
- No **overlaps or duplications were evident between coordination mechanisms**. At zonal and provincial level, Provincial Nutrition Committees operate regularly in all provinces however these also face attendance issues due to IPs workloads (IR 4, Sub IR 4.1)

systems and coordination mechanisms and improvements to service delivery. Where a finding relates to an Intermediate and Sub-Intermediate result from the NPNS results framework in Annex 11, a reference is added in brackets after the finding.

3.4.1. To what extent has delivery of IMAM services been efficient using the following modalities?

- SHCs (sub health centres) and mobile health teams?
- Presence of an international NGO as provider of technical support to a national NGO?

OPD IMAM services have been operating from Sub-Health Centres (SHCs) and Mobile Health and Nutrition Teams (MHNTs). Rolling out services to these two facility types has proven effective at increasing the coverage of services both within government-controlled areas (for SHCs) and in the white areas (MHNTs).

IMAM services (including OPD SAM and MAM) were first introduced into **SHCs** in 2013. Between 2013 and 2019, SHCs admitted and discharged as cured 49,688 SAM children (5.6% of all SAM cases) and 19,979 MAM children (3.4% of all MAM cases). Cure rates for both OPD SAM and OPD MAM from SHCs were comparable with the cure rates of all other health facilities. Based on the IMAM guidelines (2018), SHCs comprise of three team members involved in delivering IMAM services: an OPD nurse, a midwife and a nutrition counsellor. The average number of SAM and MAM children cured per staff member in SHCs and BHCs (for comparison) are shown in Table 6[95]. **Data indicates that, in comparison with BHCs, SHCs have been marginally less efficient when it comes to the delivery of OPD SAM services and significantly less efficient for OPD MAM treatment**. However this only considers the number of children cured per annum by staff member. Additional factors which would negatively affect the efficiency of SHCs include the additional resources needed to transport IMAM products to SHCs (which are typically located in more remote areas in the provinces) and the additional costs involved in the supervision of SHCs.

OPD SAM and MAM services were also integrated into **MHNTs** in 2013. During the evaluation period, MHNTs discharged as cured 7,552 SAM cases (0.9% of the total for all health facilities) and 17,692 MAM cases (3% of the total). For OPD SAM and OPD MAM, the cure rates reported from MHNTs were higher in comparison with other types of health facilities, averaging 89% and 90% respectively. **The higher performance rates may be due to the fact that approximately 50% of MHNTs were operated by international NGOs. The efficiency of MHNTs is comparable to SHCs for OPD SAM (19 cases cured per staff member per year**). However for OPD MAM, in comparison with BHCs, **higher efficiency is noted, with each staff member discharging as cured an average of 31 cases per year.** There is limited evidence to explain why this is the case however it may be due to the fact that the MHNT teams are smaller than those in static facilities.

The 2018 Nutrition Cluster logframe estimated that it costs $100,000 to establish an emergency mobile team or MHNT. MHNTs cure an average of 150 SAM and MAM children per year in total, therefore the average cost per child successfully cured is approximately $660 per child. **This is considerably more than the average cost of treating a child in OPD SAM ($100) or an OPD MAM child in a permanent facility ($37)** (based on costs included in the same logframe)**.**

TABLE 6 AVERAGE NUMBER OF SAM AND MAM CHILDREN DISCHARGED AS CURED BY STAFF MEMBER FROM OPD SAM AND OPD MAM FROM SHCS AND BHCS FROM 2013-2019

	OPD SAM	OPD MAM
BHCs	24	22

[95] BHCs have four staff members implicated in IMAM services: Doctor, Nurse, Nutrition Counsellor and Midwife

SHCs	20	11
MHNTs	19	31

(Sources: IMAM service availability data and IMAM database, February 2020)

Limited evidence is available to assess the extent to which INGO technical support to a National NGO is efficient. At the time of data collection, technical support was being provided by a number of INGOs to BPHS partners with the implementation of IMAM services. One example included the provision of technical support by Action Against Hunger to BRAC who has been the implementing partner responsible for the delivery of BPHS and EPHS services in Helmand province since 2017. Between April 2017 and March 2018, ACF Afghanistan provided technical support to the BRAC team with the implementation of OPD SAM services. This was the first time BRAC had implemented OPD SAM services in Afghanistan. There is limited data available to assess the quality of the support provided. However from the start of the support, OPD SAM cure rates in Helmand were reported at being above the national standards for cure rate (75%) and remained consistently higher following the end of ACF's support. Coverage assessments completed using the SQUEAC methodology at baseline and endline indicate a minor but not significant increase in treatment coverage[96].

3.4.2. How complementary are the IMAM related M&E systems (IMAM database, M&E database, SCM and End User Monitoring (EUM)? Are there any duplications/overlaps?

The evolution of IMAM from an emergency CTC programme has been mirrored in the evolution of separate databases and M&E systems for IMAM and related health and nutrition programming. There is no single system in use for M&E related to IMAM. International organisations involved in IMAM, such as USAID and WFP, have created their own monitoring systems for IMAM, thus engendering parallel structures, and in some cases resorting to third party monitoring.

Information Management Systems. All IMAM-related databases are housed within the MoPH with several maintained by PND.

The HMIS database, as reflected in the Afghan Nutrition Database, currently collects monthly provincial screening data reporting the number of children screened and those with MAM or SAM. In early 2020, **seven further IMAM related indicators had been proposed for inclusion. Some indicator definitions are not well defined and may create some overlap.** These indicators appropriately overlap with monitoring activities of the IMAM programme and so could be transferred to the HMIS relatively easily. However the current list of indicators and proposed indicators for HMIS **do not include underweight by WAZ or stunting by Height to Age Z-score (HAZ),** which:

1. Limits the capacity to integrate IMAM and preventative programming in line with the ANDS and AFSNP
2. Limits the capacity to measure progress towards SDG 2.2 except by national nutrition survey

As of 2019, the GoIRA was assessing the use of the DHIS-2 information system as a data warehouse to overcome some of the issues with the vertical separation of information systems. Some technical issues were encountered during testing and the project is in progress[97].

[96] Baseline coverage estimate: April 2017: 35.6% (95%CI: 24-49.3%); Endline coverage estimate: March 2018: 40.3% (95%CI: 31.7-49.8%)

[97] https://community.dhis2.org/t/dhis2-as-national-data-warehouse-in-ministry-of-public-health-afghanistan/37264

The IMAM database can be accessed by all implementing partners to encourage evidence-based decision-making. Evidence from interviews indicated that the database has a user-friendly dashboard enabling the analysis of data down to provincial, district and health facility level. Findings also indicate that the use of the database has resulted in sharing and discussion of findings amongst nutrition stakeholders at national and provincial level[98]. Timely reporting of data by implementing partners was cited as a challenge with the NNC reporting a "timely reporting rate" of 92% in 2019. As such follow up of partners who do not report in a timely manner takes place.

However, there is evidence of poor data quality being reported into the IMAM database. Evaluation data showed discrepancies between the data in registers and monthly reports in some facilities. Furthermore in the IMAM database extremely high cure rates of OPD SAM and MAM services (95% and above) were reported in many facilities where was multiple evidence of poor quality of care[99] were noted. Achieving such high cure rates in these health facilities would be extremely unlikely. This therefore suggests either errors in treatment protocols by staff or misreporting of performance rates, possibly to meet the Sehatmandi Quality of Care (QoC) target for cure rates (87% in 2019).

National level caseload estimation & commodity requirement. Databases and spreadsheets used to calculate the burden of SAM and MAM, nutrition commodities required and programme performance focus primarily on the use of WHZ prevalence data. In some provinces more recent SMART survey data MUAC and oedema prevalences are also presented but a combined figure for wasting by both WHZ and MUAC, required for accurate calculation of burden, is absent. The ordering of supplies is done by the PNO at provincial level through the SCM database; SCM SOP guidance clearly establishes the need to plan commodity requirements based on all IMAM eligibility criteria for forecasting and stock management purposes. **This gap between planning and operational use potentially overestimates programme performance[100] and leads to deficits in ordering of supplies.**

Facility evaluation mechanisms (national and provincial level). In the NPNS strategic plan, the quality of the performance of the BPHS and EPHS implementers is measured annually across a range of domains using the Balanced Scorecard mechanism which do not measure specific IMAM programme indicators.

Before joint monitoring plans started to be managed by the PMO, there were duplicate activities and visits. To avoid these duplications the PMO now coordinates all technical departments and is composed of 12 technical advisors and Performance Management officers who are each responsible for 2 or 3 provinces, working as the single point of contact with BPHS partners. The technical advisors conduct quarterly Quality of Care monitoring, by conducting joint monitoring visits with provincial nutrition officers or extenders and IP nutrition officers.

The Sehatmandi project M&E framework includes two Quality of Care indicators relating to IMAM which assess BPHS performance with "meaningful financial penalties for poor performance". However the indicators, which relate to screening (18) and cure rates (19), are not consistent with or technically

[98] More information in next section

[99] For example errors and omissions in photos of registers treatment cards and evidence of stock outs and poor staff behaviour toward carers.

[100] See section 3.2.5.

appropriate for IMAM[101] or growth monitoring protocols and set unrealistic targets. As such the Sehatmandi M&E framework may encourage false reporting in order to achieve IMAM targets.

Field level supervision. Recent efforts have been made to merge nutrition programme indicators during supervision visits to health facilities. The checklist for nutrition activities provided in the IMAM guidelines is a multi-nutrition programme checklist, the IMAM component of which focuses on capacity to implement services rather than outcomes that measure service quality. The monitoring checklists for different IMAM services go into more detail however still predominantly focus on the capacity of services rather than outcomes that can be used to monitor quality.

The "**Quality assurance standards" checklists for OPD and IPD IMAM services** are reportedly used for joint monitoring and provide a strong framework for quality assessment with built in mechanisms for verification and end user monitoring of the appropriate delivery of services and the effectiveness of nutrition counselling.

The SCM-SOP provides end-user monitoring[102] with informed consent and detailed instructions for the enumerator. The questionnaire includes demographic, relationship and education questions but only focusses on the usage of "plumpynut". **The RUTF-related questions are somewhat appropriate to monitor usage of the product but are, in several instances, potentially leading questions or require binary Yes/No when questions on recall (similar to food security assessment or IYCF knowledge) would be more informative.** The method of data collection requires a joint supervision visit of PND, UNICEF and implementing partner to visit randomly selected households in the community.

3.4.3. To what extent has the gathered evidence been used to inform programme performance, detect and resolve bottlenecks on time?

During the evaluation period, two bottleneck analyses of SAM treatment were completed at national level. A Bottleneck Analysis (BNA) in 2017 identified a number of improvements since the 2015 BNA but also some persisting and new challenges affecting IMAM activities. Some of the key bottlenecks identified were weak supply chain management, including poor stock management, and low prioritisation of the community component of IMAM. **This evidence has informed several notable recommendations to address the identified challenges:**

- **Improved supply change management (SCM)**: These include the introduction of a supply chain management standard operating procedures in 2017 accompanied by a large scale training programme on supply chain management. PNOs and IP nutrition managers in all provinces confirmed that training had taken place and that as a result, SCM has improved. This has helped to strengthen stock storage processes including the integration of the first-in-first-out (FIFO) stock management (evaluation data indicated that 83% of OPD facilities were using FIFO).
- **Improvement of the community component of IMAM:** The strengthening of the community component of IMAM included scaling up CHW training in line with the Community Based Nutrition Package (CBNP). By 2019, training on the CBNP had been rolled out in 19 provinces.
- **Recruitment of nutrition counsellors for each health facility:** The 2017 BNA identified high staff workload as a bottleneck to the achievement of effective treatment. As such, a recommendation

[101] Screen for WHZ for children < 2 yrs. and MUAC for children 23-59 months. The denominator is not age disaggregated and results in incorrect calculations. A cure rate target of 87% by 2021 is unrealistic in many contexts including hard to reach areas and may inhibit attempts to attain high coverage

[102] Form 4 – Household Interview Questionnaire

(that has largely been achieved) was to hire a nutrition counsellor to support nutrition services in each facility offering SAM treatment. Evidence from multiple sources has indicated the positive contribution of nutrition counsellors to the effective delivery of IMAM services.

Sehatmandi joint monitoring visits are conducted in all health facilities to assess the quality of care indicators of the Sehatmandi project. The results of these visits inform the Quality of Care indicators and the establishment of Performance Improvement Plans (PiP). However the extent to which the PiPs are used and the impact that they have on quality improvement is not known and no information was available to confirm that joint monitoring visits had taken place as planned. **Regular visits to facilities are meant to be completed by IP nutrition officers when he/she conducts nutrition programme monitoring and on-the-job training (if required). Each visit should lead to the development of monthly action plans for the facility.** There is limited evidence that supervision visits are effective at improving programme quality. Evaluation data also indicates that supervision visits from IP Nutrition Officers in many provinces are rare owing to the large number of facilities each IP nutrition officer has to supervise (up to 50). The protocol violations noted in high proportion of facilities (see Annexes 13 and 14) also indicate that in many facilities supervision is rare and/or PiPs and monthly action plans are ineffective at contributing to quality improvement.

Key informants at national and provincial level reported that the IMAM database is regularly reviewed by national and provincial level stakeholders to identify locations with poor performance and plan corrective measures. Agendas from Nutrition Cluster meetings and IMAM TWG confirm that this is taking place at national level. Key staff at provincial level in all provinces visited (including PNOs, PNEs, IP nutrition managers, CBHC coordinators) also confirmed that IMAM results were reviewed and discussed during provincial and zonal coordination mechanisms. Most key informants confirmed that priorities are agreed and action plans set to address the issues identified however there is no evidence to confirm how his takes place. Evaluation data indicates discrepancies of reported programme performance data[103]. The IMAM TWG minutes from 2019 indicate that such discrepancies are noted and discussed by partners.

Between 2013 and 2019, 28 coverage surveys took place across 21 provinces to estimate treatment coverage and assess positive and negative factors influencing the coverage of IMAM[104]. All of the coverage surveys were implemented by the Nutrition Surveillance team of Action Against Hunger on behalf of the PND and Nutrition cluster partners. Key results from the surveys are compiled and shared with members of the Nutrition Cluster and the AIM working group. Findings are also presented to AIM working group members. In 2016, findings from 19 coverage surveys were compiled into a summary report and presented at a workshop with national stakeholders. This lead to the development of an action plan to improve the coverage of IMAM which was shared with stakeholders. No information is available about the implementation of the action plan. Individual coverage surveys also led to the development of province-specific action plans following the presentation of results. However while survey reports indicate that action plans were established following most coverage surveys, it is unclear to what extent provincial stakeholders implement the action plans. Coverage estimates from multiple surveys in the same provinces indicate limited improvements in coverage overtime suggesting that the action plans to improve coverage have not been fully implemented by partners.

There is evidence of adaptive programming which is informed by and incorporates changes to global guidelines. In 2019 underfunding created a shortfall in RUTF relative to need, therefore a simplified protocol

[103] More detail in previous section

[104] The majority of coverage surveys only assessed the coverage of OPD SAM. Only two assessed OPD MAM services.

with a reduced ration of RUTF was implemented in five pilot provinces in order to minimise the impact of under-funding and maximise the number of children able to receive treatment. This has been closely monitored by the IMAM Technical Working Group.

3.4.4. How complementary are the IMAM related forums, included nutrition related forums with IMAM component? Are there any duplications/overlaps?

The National Public Nutrition Strategy (NPNS) details the key coordination mechanisms with non-government agencies which are required for effective implementation of the overarching nutrition strategy. This includes coordination mechanisms required for IMAM. However, within the NPNS there are limited details about the coordination approach of IMAM or of the mandates and objectives of different coordination mechanisms. Also the details do not extend to provincial level coordination. The coordination mechanisms most closely related to IMAM are summarised in Table 7.

TABLE 7 IMAM RELATED COORDINATION MECHANISMS AT NATIONAL LEVEL IN AFGHANISTAN

Coordination Mechanism	Chaired by/ secretariat	Key participants	Meeting Frequency	Main Areas of Work / Objectives
Nutrition Program Coordination Committee (NPCC)	PND Director/ PND	Donor agencies, UN agencies, technical agencies (MI, GAIN)	Monthly	Coordinates the National Public Nutrition Policy and Strategy (PNPS). Also linked with AFSeNA and NAF.
Nutrition Cluster	UNICEF / PND	Bi-lateral donor agencies, UN agencies, NGOs, PND	Monthly	Nutrition in emergency
IMAM Technical Working Group	PND	NGOs, UN agencies, private sector, donors, other technical departments of MoPH	Quarterly and as needed	To discuss and decide key technical aspects of IMAM
Assessment and Information Management working group (AIM WG)	PND	NGOs, UN agencies, private sector, donors, other technical departments of MoPH	Quarterly and as needed	

(Source: NPNS 2015-2020)

The NPCC is chaired by the PND and is scheduled to meet on a monthly basis. Based on minutes received, over a two year period only three meetings took place, one in 2018 and two in 2019. As well as the PND, these were attended primarily by donors and UN agencies. However, **in many instances there is overlap between the IMAM TWG and the NPCC.**

Based on minutes received, between 2017 and 2020 the IMAM TWG (which is supposed to meet quarterly) took place on seven of the planned 12 occasions. Meetings were more regular in 2018 than 2019 when only one meeting appears to have taken place. Minutes from previous meetings indicate that attendees are relatively limited, particularly NNGOs. For example, the June 2018 meeting was attended by key UN agencies (UNICEF, WFP and WHO), some INGOs (ACF, MEDAIR, Premiere Urgence) and NNGOs (AHDS, Move, AKDS) and FEWS-NET. The IMAM TWG works in collaboration with the NNC to discuss technical issues relating to IMAM and, in some cases to conduct / commission operational assessments. No minutes were received from

AIM WG meetings however based on anecdotal findings from interviews, meetings take place periodically to plan nutrition assessment activities and to discuss findings from surveys completed.

The NNC is co-chaired by UNICEF and PND. The NNC appears to be active and established. Of the 12 planned monthly meetings, nine took place in 2019. These were very well attended by numerous stakeholders from UN, international NGO and donor agencies. However, based on minutes, on average only 10 NNGOs out of 30 who deliver IMAM services attend on a regular basis. The meetings also include key updates and challenges faced at a provincial level indicating effective coordination with zonal Nutrition Clusters. **The moderate to strong attendance and regularity of the NNC meetings indicate that, in place of the NPCC, the NNC plays a leading role at national level in coordinating nutrition-related activities** (not only those linked to emergency response). Minutes indicate that the vast majority of agenda items relate to IMAM. In contrast, while the NPCC plays an important role in furthering the advancement of the PNPS**, it rarely acts as a forum for the coordination of activitie**s.

At provincial level, the majority of respondents reported that key coordination mechanisms for IMAM include Provincial Nutrition Committees (PNC) (chaired by the PNO and also attended by the IP Nutrition manager, PNE and CBHC coordinator). Other mechanisms mentioned include the Provincial Health Committee and Provincial Development Committee. Zonal Cluster meetings also take place at the 6 zonal capitals chaired by the UNICEF Zonal Nutrition Officers.

No minutes were available to review from zonal or provincial level coordination mechanisms. In provinces visited for the evaluation, provincial level key informants (PNO, PNEs, IP Nutrition Managers and CBHC coordinators) confirmed that PNC meetings are taking place regularly. In three provinces, respondents noted that participation at PNCs was often poor or that those that did attend did not have adequate decision making powers. In two provinces, IP representatives mentioned that they are often unable to attend due to heavy workloads and low resources. Generally key informants felt that **provincial coordination mechanisms were effective with clear agendas, minutes and action points and that there was limited overlap with other coordination mechanisms**. However it was reported that **provincial meetings lack accountability mechanisms and that actions are not followed up.** PNOs (who chair PNCs) have very limited authority over the IP NMs and CBHC coordinators (who are accountable to their managers and to the PMO of the government). This indicates **that at provincial level, PNOs are constrained in their ability to coordinate nutrition activities.**

3.5. Sustainability

Summary: *This section provides findings related to sustainability of IMAM services including its integration into the health system and the extent to which the government can continue to implement and scale up services without external support. There is also discussion related to IMAM systems, policies, strategies and capacities that need to be developed to ensure the continued implementation and expansion of quality IMAM services.*

Key findings:

- **The Afghan government has the political will to take full ownership of IMAM implementation**. This has been evidenced in recent years by the **integration of IMAM into the BPHS and EPHS which has also facilitated the expansion of the programme to provide universal coverage (IR 4, Sub IR 4.1).** However it still remains a vertically implemented programme in primary health services.
- **Further functional integration into IMNCI and growth monitoring programmes is feasible** but would require clear definition of roles for front line staff, and careful monitoring and coordination mechanisms to prevent marginalisation of IMAM.
- **The cost of IMAM services is unsustainable without continued external financial support.** IMAM services have faced consistent funding shortfalls since 2017. **There are opportunities for the delivery of IMAM to be more cost-effective**, such as achieving target OPD SAM cure rates with a reduced ration of RUTF. Other simplified approaches could also be piloted (IR 4, Sub IR 4.3)
- **Increasing case coverage could result in greater proportion of target population being reached** without the need to continue geographical expansion of services, however this would result in a corresponding increase in commodity requirements (IR 1, Sub IR 1.1)
- Improvements to the monitoring of quality of care outcomes in IMAM could help to bridge the disconnect between technical capacities at central level and in frontline facilities.
- The quality of care indicators of the Sehatmandi project could be adjusted to enhance accountability for coordination at provincial level and accountability to affected populations at community level.
- There is potential in future to integrate GMP and IMAM and to combine efforts to tackle wasting and stunting which would transition IMAM from a humanitarian programme into a development programme.

  Government-led nutrition coordination mechanisms exist at national and provincial level (IR 4, Sub IR 4.1). However **effectiveness is limited** due to lack of attendance by implementing partners. This is driven by the weak accountability that exists between the PND and implementing partners. Coordination is also centralised with few examples of provincial level input into central level decision making.

3.5.1. To what extent has IMAM been integrated into the health system services and how does this affect provision of IMAM services?

During its evolution from an emergency CTC / CMAM programme, IMAM has been progressively integrated into the health system in Afghanistan. The development of integrated guidelines in 2014 established standardised protocols for implementers to follow and brought together the treatment of MAM and SAM into the OPD setting with integrated protocols for triage and management. Functional integration was established through integrating the management of acute malnutrition into the BPHS and EPHS contracts for health services in 2014, although in practice, IMAM is operated as a vertical programme within OPD. In IPD CMAM treatment was integrated into the general paediatric ward environment within provincial and some district hospitals, although some issues around referral systems from primary care settings to provincial hospitals remained until EPHS integration.

Through the expansion of service coverage nationally and provincially the IMAM programme in primary care has remained a vertically operated programme. In 2016, IMAM was partially integrated into IMCI in terms of anthropometric and clinical assessment but **linked to IMAM protocols only through guidance to consult national IMAM guidelines for further details of treatment**. In 2018 nutrition officer posts and nutrition counsellor posts within the BPHS were developed to enhance the supervision, nutrition capacity and maintain quality service provision. The evaluation found that the responsibilities for IMAM service delivery, including admission and discharge, had largely been passed over to nutrition counsellors. It was not clear at which point the clinician / nutrition counsellor roles were functionally separated since OPD-SAM treatment cards were incomplete, lacking details of clinical assessment, triage or the prescription of medicines, however the quality of service provision was negatively affected. **This is of great concern since clinical assessment is necessary to ensure appropriate safe triage and prescription of antibiotics and poses a barrier to further integration.**

To be more cost effective and sustainable, **IMAM should not be implemented as a vertical programme, however full integration into children's OPD services risks a continued marginalisation of nutrition assessment and triage within the IMCI framework and a deterioration in treatment coverage through a lack of systematic assessment.** Further integration of IMAM into BPHS OPD services can only be safely achieved through the updating of IMCI guidelines to include simple, functional treatment guidance for other childhood illnesses as has been done in other contexts to date. However such integration would necessitate clear roles and responsibilities for medical and nutritional staff and their participation in assessment, ongoing care and discharge.

3.5.2. To what extent can PND continue to implement and scale up IMAM without financial, technical, logistical and other (including supplies) support from internal and external agencies?

The cost of the IMAM programme is unsustainable without continued external financial support. Even with external financial support, IMAM services have faced consistent funding shortfalls since 2017. A UNICEF report of 2019[105] indicates that the treatment of SAM was only 64% funded. In several provinces this led to a piloting of reduced ration RUTF protocols to save 30% on the cost of treatment. The 2020 nutrition programmes faced an 84% funding gap ($34,744,362). Current plans for integration aim to put RUTF on the list of essential medicines and seek further funding for RUTF under the Sehatmandi project supported by the

[105] Afghanistan Humanitarian situation report No. 3, January – December 2019

World Bank, USAID and EU. However it is difficult to envisage how the IMAM programme can sustain its current size or scale up without considerably increased external financial support.

In the context of the ANDS and the contribution of IMAM towards the achievement of SDGs, relieving inequities and peacebuilding, it will be a political decision for the GoIRA, UN organisations and donor agencies as to the extent of financial support IMAM continues to receive.

Further scale up of the programme needs to be balanced with the comparative cost effectiveness and affordability of scaling up within the current IMAM framework. From a technical perspective the reassessment of the burden of malnutrition will inflate the numbers of acutely malnourished children in need of treatment. There are options for the implementation of a range of simplified protocols that can make efficiency savings to some extent and the potential to increase the case coverage within the current IMAM programme framework. In terms of lives saved, increasing case coverage could potentially double the number of lives saved annually to approximately 80,000 (median estimate). This increased case coverage would vastly increase the needs and cost of RUTF supply but would be more cost efficient than continued expansion. However improvements to case coverage and cost effectiveness require a strengthening of systems for information management, coordination, decision making, supervision, EUM and accountability with corresponding strengthening of guidelines, SOPs and policies.

However, after more than 10 years of implementing treatment for acute malnutrition, evidence shows that considerable technical capacity exists in Afghanistan. This report discusses elsewhere why this capacity often is not translated into quality front line service delivery. The IMAM TWG does not currently have its equivalent structures at regional or provincial level, however such **a mechanism holds potential to decentralise this technical capacity to provincial level and improve the quality of service delivery**.

Current logistical support for the supply chain IMAM commodities is provided by UNICEF and WFP with the end point of service delivery to provincial level and subsequent distribution by the BPHS partners. The efficacy of the supply chain was not evaluated to estimate the cost effectiveness of transitioning the supply of nutrition commodities through national distribution networks. However, while the current reliance on UNICEF and WFP to procure commodities for IMAM is not sustainable in the long term, in the short to medium term the current system is likely to ensure a more reliable pipeline of supplies than passing the responsibility onto implementing partners and / or the government.

3.5.3. What systems, policies, strategies, capacities, (at national, provincial, regional, district, community levels) have been/need to be developed so that IMAM can continue to be implemented and scaled up without internal and external support?

Health services in Afghanistan are implemented by a network of national NGO BPHS and EPHS contract holders with complex funding streams. An IMAM programme with universal coverage operating independently of any internal or external support within an Afghan National Health Service is some way from being achieved. However there are options for further strengthening national capacities for more cost effective service delivery within the current system.

Capacities. The disconnect between technical capacities at central level and the quality of care in frontline IMAM service delivery appears to be related to structural barriers and a gap in the implementation of monitoring systems. The deployment of Nutrition Officers and Nutrition Counsellors should bring about significant improvements in the quality of care. These deployments are supported by various supervision and quality checklists for nutrition officer, PNO and joint monitoring visits. The integrated nutrition programme

supervision checklist focuses on inputs that support implementation. However the move towards efficiency reduces the extent to which IMAM quality of care outputs are monitored. Conversely IMAM-specific checklists are more detailed and allow more extensive and objective quality outputs to be monitored. Also with some minor developments the IMAM-specific checklist could be harmonised with HMIS systems to produce the necessary data for monitoring of various indicators. The Quality of Care checklists for joint monitoring visits are more objective still, require means of verification and embed strong elements of end user monitoring. A drawback is that the increasing complexity of the checklists limits their deployment in monitoring the quality of the IMAM programme due to the workload of the Nutrition Officers. **However with some adjustments the monitoring of the quality of care outcomes in IMAM could be strengthened.**

Elements of EUM are incorporated into the SCM SOP and QoC checklists, however both are implemented through infrequent joint monitoring visits. This evaluation was not able to determine the frequency or number of past occurrences or the actions taken as a result of feedback from the deployment of EUM. In interviews at senior levels, it was indicated that "end user monitoring doesn't exist". The deployment of a wide coverage EUM mechanism would be a positive development in SCM and ensuring the equitable fulfilment of patient's rights according to the MoPH health Strategy.

There is currently **no mechanism for accountability to communities** that facilitates reporting of abuses or denial of rights independently of BPHS / EPHS contract holders. The development of such a system allowing feedback of complaints (i.e. beneficiary feedback mechanism) via the PNO to central levels would parallel the systemic EUM and combined with the leverage of Sehatmandi quality of care indicators, and the monitoring of ethnicity in health and nutrition registers could ensure equitable service delivery which fulfils patient's rights for IMAM treatment and other health and nutrition services.

Technical capacities and coordinated responses to programming needs at provincial level are inhibited by a lack of accountability at provincial and local levels. Further development of accountability for coordination at provincial level through the leverage provided by the Sehatmandi project offers scope for improvement[106].

Simplified approaches to treatment. A range of simplified approaches to treatment are currently in use or in development in other contexts that offer the potential for more cost effective service delivery. A summary of these approaches and details of existing piloting in Afghanistan are included in Annex 19.

Integration of GMP and IMAM. Current directions in research suggest that children with combined wasting and stunting (WaSt) with weight for age < -3z are at high risk of mortality (higher than that of moderate acute malnutrition). Safe and effective treatment protocols for RUTF dosage and treatment intensity have not yet been defined. However this approach allows the integration of GMP and IMAM at community level and the possibility of early treatment and follow up by an accountable CHW. If MUAC, oedema and WAZ became the standard admission criteria (replacing WHZ) then based on NNS 2013 data the implications for caseload would be minimal:

- Prevalence WAZ < -3z = 9.7% (8.9-10.6)
- Prevalence WHZ < -2z = 9.5% (8.7-10.4)

The **additional advantage of such an approach is in the transitioning of IMAM into a development programme, mitigating inequity in pursuit of SDGs and contributing to the ANDS.**

[106] See section 3.5.4.

Policies & Strategy environment. From a policy and strategy perspective there is commitment at the uppermost levels of government to transition to ownership of all MoPH functions including IMAM. This is demonstrated in the National Health Strategy through statements such as "Afghanistan has designated 2015–2024 as its 'Transformation Decade,' to be marked by the gradual hand over of program and financial responsibilities by international supporters to the Afghan government, using a self-reliance model". This broader country financial strategy is mirrored in the public health strategy through commitments to strengthening country ownership. To achieve this, the strategy outlines and defines mutual accountability in a number of ways including putting the MoPH in the driving seat to manage the development agenda of the health sector, specifying that donor and development partner support is demand driven only and ensuring that, where external support is provided, it is flexible. The MoPH also commits to hold itself accountable and take actions to address issues relevant to corruption and lack of transparency.

Similarly, ownership is foregrounded as one of 12 policy statements in the NPNS 2015-2020. The strategy states "ownership, partnership and responsibilities: Goals, objectives and strategies are jointly agreed upon and pursued by the relevant government sectors and its private sector partners, and supported by the international community through coordinated actions and funding allocation determined by the national plans". **Together, these strategies demonstrate political will from the GoIRA to take full ownership of IMAM implementation.**

As previously discussed, the policy and strategy environment forms a coherent framework for IMAM although there are **gaps in the identification of specific targets for IMAM indicators that require development in future iterations.**

At **operational level there is a need to revise the current Nutrition SOPs (published in 2015)**. The current structure siloes different nutrition programmes into separate sections, each presumably developed by the separate nutrition TWGs. Despite being under the coordination of PND, there are inconsistencies and duplications of protocols and messaging between sections that require greater coherence when next updated.

Patient's rights and the requirement for EUM are documented in current policy and strategy documents from a service perspective. Mechanisms to ensure these rights and relevant accountabilities require further development and clarification.

3.5.4. To what extent is there coordination across IMAM stakeholders and implementing partners at various levels?

PND already plays an active role in key coordination mechanisms (as evidenced in 2.4.4). **The Nutrition Program Coordination Committee (NPCC) is a pivotal mechanism to further the advancement of the NPNS and therefore to oversee and ensure IMAM's effectiveness and sustainability.** The lead role of the PND further strengthens the potential longevity of this coordination mechanism (in addition to the various TWGs which it coordinates). However, the relative infrequency of the meetings suggests the NPCC is not sufficiently embedded into programme organisation and decision making. This decreases the extent to which it is integral to management of nutrition services thereby decreasing its sustainability. Improving the regularity (not necessarily frequency), of the NPCC could increase the extent to which it can be relied on to address key challenges and enable planning.

In contrast, the National Nutrition Cluster (NNC) meetings are more frequent, regular and well attended. This builds momentum for partners to engage with the coordination mechanisms and rely on them as a forum to

which they can raise and address programming challenges. However, as the Cluster meetings are led by UNICEF their sustainability depends on a transfer of ownership and responsibility to the PND.

At a provincial level, IMAM-related coordination mechanisms centre around the Provincial Nutrition Committee (PNCs). Attendance of PNCs is moderate however their effectiveness is constrained as the chair of mechanism (Provincial Nutrition Officers) do not line manage the implementing partner nutrition managers or CBHC coordinators. Integrating implementing partner participation and adherence to agreed action plans with EPHS and BPHS quality standards would help improve the effectiveness of PNCs.

Supporting provincial level partners to play a more demonstrable role on central level decisions could also improve sustainability of provincial level coordination mechanisms. At present coordination is centralised with few examples of provincial level input into central level decision making. Strengthening the role of provincial coordination in upstream decision making could increase the participation in provincial mechanisms.

At national level the IMAM and AIM working groups play important roles in progressing technical discussions and discussing survey findings. However data indicates that these types of coordination mechanisms are missing at provincial level. Establishing these mechanisms at provincial level would play an important role in decreasing the burden of discussions in the PNC and in providing the space to discuss survey findings (such as coverage surveys) and take ownership of action plans to improve IMAM performance and reach.

3.5.5. What are the gaps and barriers to coordination and the effect of these on IMAM services? Are there any duplications?

During the evolution of CMAM, as it was an emergency programme, coordination was under the National Nutrition Cluster (co-chaired by PND and UNICEF). The NNC, attended by the implementing BPHS / EPHS partners, was the repository for IMAM technical knowledge from where evaluations were conducted, programme expansion was facilitated and guidelines initially developed.

Since the integration of IMAM, PND houses several coordination committees including the Nutrition Programme Coordination Committee and programme-specific technical working groups including IMAM. However the NNC meetings have remained the de facto coordination mechanism for IMAM. **This lack of transfer of ownership for coordination to the GoIRA and its subsequent delegation to provincial level inhibits the development of technical capacity, coordination and accountability at provincial level. These gaps do not facilitate the strengthening of the quality, equity or sustainability of service delivery.**

The transition of the emergency CMAM programme into the developmental IMAM programme with universal coverage suggests the need to transfer ownership of coordination to the PND as the primary mechanism with NNC providing co-chaired coordination for emergency interventions. Similar arrangements are already in operation at provincial level with provincial level nutrition coordination mechanisms chaired by the PNO with regional nutrition cluster inputs. However, with the administrative and funding complexities of the IMAM programme in Afghanistan and the financial consequences of this transfer of ownership, this would likely be unsustainable.

4. Lessons learned

Completion of an evaluation of IMAM in Afghanistan

This was the first formative evaluation of IMAM completed in Afghanistan. The inception visit in May 2019 served as a critical stage of the planning process. During and after the inception visit the ESC, with the support of the evaluation team, revised the evaluation questions and added an additional evaluation criteria. This was an important stage as it enabled partners in Afghanistan to review and update the original objectives and questions included in the ToR (first been drafted in 2018).

Data collection at provincial level was completed by a data collection agency with extensive experience of conducting data collection in all provinces of Afghanistan. However there were issues of data quality which came about during the data collection and data sharing processes. The impact of these led to adjustments in the planned analysis approach and delays in the evaluation timeline. Supervision of data collection by the Evaluation Team could have helped mitigate some the issues encountered however this was not possible due to security constraints and to the rapid spread of Covid-19 during training and data collection. Three external monitors (employed by UNICEF) were assigned with monitoring the activities of data collectors to ensure that they adhered to quality and ethical standards. Their monitoring reports were reported back to the evaluation team on a regular basis during data collection. However, as data collection took place simultaneously across all provinces, it was only possible for them to monitor activities of a small number of teams at one point in time.

In future evaluations, participation of the evaluation team during data collector training and during the first days of data collection and the availability of more external monitors to oversee data collection would mitigate quality issues.

Rapid scale up of IMAM has contributed towards achievement of nutrition strategy outcome

The rapid expansion of IMAM services coverage between 2013 and 2019 in Afghanistan was made possible thanks to the ambitious scale up plan implemented by the MoPH, UN agencies and implementing partners. While some quality issues remain, evidence from this evaluation shows that implementing partners and the MoPH succeeded in admitting and curing 880,000 SAM children and 600,000 MAM children during this period, leading to an estimated 185,290 lives being saved. Given that CMAM was only integrated into the BPHS package of services in 2010 (and the EPHS package of services in 2014), this is a commendable achievement and indicates that implementing partners recognise the importance of tackling acute malnutrition and recognise it as a component of the services which they are responsible for delivering.

Nutrition Counsellors play a key role in the success of IMAM

The creation of the Nutrition Counsellor role has proven to play an important role in the success of IMAM services. Given that Nutrition Counsellors are all female community members who are a similar age to many pregnant women or new mothers coming through facilities, they are able to share the load of screening at facility level while passing on key messages relating to infant and child feeding and the importance of adherence to IMAM services. Evaluation data indicated that Nutrition Counsellors have high levels of motivation to complete their roles. However health facility leads should ensure that they only complete tasks which they have been trained to complete, that they have adequate space in which to work and that they are not overburdened.

5. Conclusions and Recommendations

5.1. Conclusions

Based on the findings presented in the previous section, the conclusions are summarised below for each of the DAC criterion. Where relevant, the related Intermediate or Sub Intermediate result from the NPNS 2015-2020 are referenced. Recommendations are also referenced in each section and included in full in the second part of this chapter.

Relevance: The evaluation found that the IMAM approach in Afghanistan is relevant and appropriate. An enabling environment exists for IMAM services to be implemented and scaled up. Since 2013, this has enabled IMAM services to undergo a remarkable expansion to achieve universal programme coverage by district (for OPD SAM treatment), supported by a coherent national policy and strategy framework. This shows good progress towards the achievement of IR 4 of the NPNS 2015-2020 (Strengthened social, regulatory and political environment for nutrition). However national nutrition policies and strategies need to be strengthened with the inclusion of specific IMAM-related indicators and targets for strategic objectives and intermediate results (*Recommendation 8.1*).

The evolution of national nutrition guidelines and Nutrition Standard Operating Procedures (SOP) (2015) has been less coherent with several inconsistencies in guidance leading to potentially significant effects on IMAM implementation and coverage. One such example is calculation of national, provincial and district level estimations of the acute malnutrition burden based on WHZ prevalence data alone leading to systemically inequitable targeting, under-estimation of commodity needs and overestimation of programme performance. Since 2018, where up-to-date prevalence data has been available, burden estimates have been calculated using combined GAM. However in the majority of provinces WHZ prevalence data from the 2013 NNS is used to calculate burden. Burden estimates should be calculated using combined GAM based on WHZ, MUAC and oedema (*Recommendation 1*).

At the time of data collection (Feb 2020), the IMAM guidelines (2018) were in the process of being translated into Dari and Pashtoo and had not been distributed to any health facilities. There is an urgent need to distribute them to all facilities offering IMAM services and to provide orientation to ensure appropriate implementation and quality programme delivery *(Recommendations 3.1 and 3.2)*. The Nutrition SOP currently being updated (2020/1) is a great improvement. Further review should address repetition and inconsistencies between sections to facilitate the improvement of equitable IMAM case coverage especially with regards to screening and referral of infants < 6 months *(Recommendation 4.1 and 4.2)*. Future iterations of IMAM guidelines should also account for WHO updates (due 2021) and the inclusion of practical measures for infants and children with disabilities (*Recommendation 9.1*).

The expansion of services has largely achieved vertical equity through annual retargeting of OPD-MAM and OPD SAM services toward areas of greatest need which has nuanced the evolution of universal coverage showing very good progress towards the achievement of Sub-IR 1.1 of the NPNS (Improved availability of essential nutrition services at public and private facilities). Some inequity exists in access to treatment as a result of insecurity and availability of treatment due to insufficient funding for nutrition commodities. The lack of specific data to evaluate the accessibility of ethnic minorities and Kuchi populations and anecdotal reports of poor behaviour of health staff towards these communities warrants closer monitoring and reporting to ensure equitable access and accountability of health staff.

Programme data indicates that IMAM services have been sensitive to variations in the prevalence of acute malnutrition due to short term and seasonal nutritional stressors, responding to increased need by admitting more children and PLWs for treatment. Admission trends over time for MAM and SAM children and PLWs demonstrate patterns which suggest bottlenecks in the availability of nutrition commodities.

Effectiveness: The IMAM approach in Afghanistan has been effective at achieving its purpose. From 2013-2019 inclusive, 880,000 children with SAM and 600,000 children with MAM have been admitted and cured representing an estimated 185,000 (range 113,000-228,000) lives saved. Programme performance for OPD & IPD SAM met or exceeded national standards for cure rate and default at national level. Further reductions in mortality and morbidity could be achieved through improving outcomes in OPD-MAM that have underperformed during 2017-2019.

Bottlenecks to quality service delivery (IR 3 of the NPNS 2015-2020) include a lack of availability of trained clinical staff and nutrition commodities at primary care level, ineffective coordination mechanisms (particularly at provincial level), limited supervision of quality of care and the delegation of IMAM-related, clinical roles to Nutrition Counsellors (which they are not trained to complete). These could be mitigated by strengthened monitoring, supervision and coordination of IMAM activities, particularly at provincial level and by the inclusion of IMAM in pre-service training for medical and nursing staff *(Recommendation 10)*.

The majority of carers and PLWs who were receiving treatment for IMAM services were generally satisfied with the services they were receiving. Negative perceptions about services most often related to stock shortages, waiting time and staff behaviour. Commodity shortages mostly affected OPD MAM services but also prevented scale up of OPD SAM services in 2019, driven by challenges in securing adequate funding. Evidence-based simplification of protocols and commodity rationing, coupled with strong community sensitisation about the changes, strengthened end user monitoring and the provision of community feedback mechanisms for complaints provides potential for improved effectiveness and rational use of resources *(Recommendations 2.1, 2.2, 2.3, 6.2 and 6.3).*

In general, health facility staff and community outreach workers exhibited high levels of motivation to deliver IMAM services. This was driven by collective responsibility to address malnutrition in children and to save lives. However delayed salary payments or salary deductions on the basis of performance indicators were reported in numerous provinces. Negative staff behaviour was also reported by many caregivers and community members contributing to reduced uptake of treatment services and case coverage. These should be closely monitored at provincial level, possibly through the Sehatmandi project monitoring system.

Findings indicate two unintended negative results of the introduction of IMAM services to the BPHS package of services. The first being the additional burden of work on health facility staff due to high caseloads of acutely malnourished children and PLWs. As indicated above this contributed to quality issues with IMAM which were identified during the evaluation however it is likely that other health services available from facilities have also suffered. The second is the impact of regular shortages of IMAM supplies on community perceptions of government health services. Shortages of IMAM supplies were mentioned by many carers and other community members. While it was not always possible to identify which supplies they were referring to, this may contribute to community members losing confidence in the health facility and its staff affecting adherence to care for all health services. This may also be exacerbated by the poor behaviour of health facility staff due to being overburdened by SAM and MAM cases.

Coverage: Geographic coverage for SAM treatment has expanded to almost all districts and the majority of health facilities exceeding treatment coverage targets (demonstrating good progress towards IR 1.1). Some

hard-to-reach communities have access to SAM treatment services through mobile health and nutrition teams. However there has been little improvement in case coverage for IMAM services which still remains lower than national standards.

The recruitment of nutrition counsellors and liaison at community level (through health shuras and family health action groups) has had a positive effect on coverage, although community outreach for IMAM still remains weak in spite of the extensive network of CHWs (limiting the achievement of Sub IR 1.3). Monitoring visits should therefore include the assessment of the existence and effectiveness of community outreach for IMAM based on national guidance (*Recommendation 3.3*). The primary barriers to coverage for carers and PLWs include a lack of awareness about IMAM services (largely due to a lack of community outreach activities), inaccessibility due to distance and/or insecurity, cultural norms and previous negative experiences at health facilities. While previous coverage surveys identified corrective actions to improve coverage, there is limited evidence that action plans to improve case coverage are followed up and implemented by IPs. Therefore coordinated, province-specific work plans are required to overcome these barriers and reach more children and PLWs *(Recommendation 5.1)*.

Provincial Nutrition Committees (PNC) should be assigned the authority and responsibility of overseeing the implementation of these action plans and PNOs should be able to hold IPs to account for delivery of the action plans (*Recommendation 5.2*). Attendance at PNCs should be incorporated into the Sehatmandi quality of care indicators (*Recommendation 5.3*).

Efficiency: OPD SAM and MAM services operating out of Sub-Health Centres and Mobile Health and Nutrition Teams for OPD SAM are less efficient per child cured owing to the reduced admissions and increased cost of implementation.

The IMAM database is accessible to national and provincial stakeholders and compiles programme data from all IMAM services enabling disaggregated analysis to facility level which contributes to the achievement of Sub IR 3.2). During the evaluation period, few IMAM related indicators were included in the national HMIS however at the time of data collection (February 2020), 12 indicators were in the process of being included in the HMIS. Parallel databases exist including for Supply Chain Management, results from nutrition assessments and SAM and MAM programme data which can lead to inefficiencies.

Some joint monitoring, such as for the Sehatmandi project, has led to the development of a merged system of monitoring of OPD SAM and MAM therefore supporting progress towards Sub IR 3.2. However there is no evidence that the results of joint monitoring are used to develop context specific action plans. By including this in the Sehatmandi quality of care monitoring system, IPs would be compelled to conduct regular monitoring in all health facilities offering IMAM services and to develop action plans to address problems identified (Recommendation 7.3). Furthermore revision of Sehatmandi indicators would provide for better coherence between IMAM and GMP services (*Recommendations 7.1 and 7.2*). There is also limited evidence of effective end user monitoring and / or of community feedback mechanisms *(Recommendations 6.1 and 6.3).*

Evidence from assessments, monitoring and databases has been used to improve programme performance (demonstrating progress on Sub IR 4.2) however in most cases processes are completed in parallel for SAM treatment and MAM treatment services. Bottleneck analyses and periodic reviews of the IMAM database tend to be the main approaches to implement improvements to programme performance. Updates to global guidelines and funding challenges have also led to adaptations to programming enabling a more efficient delivery of treatment.

IMAM-related coordination mechanisms operate efficiently at central level and there are no overlaps or duplications between them (indicating progress towards Sub IR 4.1). The National Nutrition Cluster, IMAM TWG and the AIM WG are the most active although they are not well attended by IPs. While the NPCC progresses certain aspects of the NPNS, its ability and effectiveness to coordinate nutrition activities is limited. At zonal and provincial level, Provincial Nutrition Committees operate regularly in all provinces however also face attendance issues due to the workload of IPs and to the fact that IPs are not accountable to the PNOs (who chair the PNCs) (*Recommendations 5.2 and 5.3*).

Sustainability: The integration of IMAM into the BPHS and EPHS has facilitated the expansion of the programme to provide universal coverage although in implementation it remains a vertically implemented programme in primary health services. Facilitating sustainability through further functional integration into IMCI and growth monitoring programmes is feasible but would require clear role definitions for front line staff, and careful monitoring and coordination mechanisms to prevent the marginalisation of IMAM *(Recommendation 3.1)*.

The cost of the IMAM programme is unsustainable without external financial support (Sub IR 4.3). Further development of the programme needs to be balanced between the comparative cost effectiveness of increasing coverage within the current IMAM framework, and the affordability of scaling up geographic coverage to lower level health facilities. The low case coverage presently achieved by the IMAM programme leaves scope for doubling the effectiveness of the programme without further geographic expansion and could result in the lives of an estimated 80,000 children under 5 saved each year. Delivering the activities in action plans established during coverage surveys would go some way to decreasing the barriers to access faced by many carers and PLWs who know of the existence of IMAM services, but who cannot or will not access them (*Recommendation 5.1*). Further scaling up of geographic coverage would facilitate greater equity for hard-to-reach populations in line with national health and nutrition policies and ANDS. However continuing funding limitations and future forecasts of funding shortfalls suggest that neither may be feasible. This could be mitigated through simplifications of treatment protocols which would contribute towards improved cost effectiveness and / or potentially allow greater case and geographic coverage.

Improvements to case coverage and cost effectiveness require a strengthening of systems for information management, coordination and decision making, supervision, EUM and accountability with corresponding strengthening of guidelines, SOPs and policies. Evolving research suggests the possible integration of IMAM with developmental programming, which would contribute to the achievement of SDGs and the ANDS.

5.2. Recommendations

The recommendations were developed initially by the evaluation team and presented in the first draft of the report to partners in Afghanistan. Following review by partners and two subsequent meetings with the IMAM TWG, the recommendations were revised by the evaluation team. The final recommendations and related action points are listed in Table 8. The table also details which sub-section of the Findings section (Section 3) where the evidence to support each recommendation is to be found.

TABLE 8: RECOMMENDATIONS AND ACTION POINTS FROM THE FORMATIVE EVALUATION OF IMAM IN AFGHANISTAN

Overall recommendations	Action Points	Related finding section(s)	Priority	Type	Responsible
1. Improve accuracy of IMAM burden and caseload estimation.	Revise estimates of the burden of wasting and commodity needs using combined GAM (MUAC, WHZ and oedema) establishing an updated baseline by anthropometric survey	3.1.1	High	Enabling environment / Planning	PND / IMAM TWG
2. Implement evidence-based simplified protocols ensuring mitigation of commodity shortages and accountability to communities.	2.1. Finalise TWG review of evidence for simplified protocol to treat SAM using reduced dosage of RUTF and consider adoption of other simplified protocols[107] 2.2. Provide timely communication to communities and service users prior to implementation of evidence-based protocol changes 2.3. Develop an action plan to mitigate the impact of commodity shortages in partnership between health shuras, FHAG and health facilities including a communication plan for prolonged shortages.		High	Supply (Commodity)	PND / UNICEF / WFP / IPs
3. Strengthen treatment protocol implementation at facility and community level.	3.1. Audit and complete the distribution of 2018 IMAM guidelines, including supporting job aids, equipment and relevant staff responsibilities to all health facilities in appropriate local languages 3.2. Provide orientation on implementation of updated protocols emphasizing use of all independent criteria, screening of infants and treatment of infants in OPD-SAM	3.2.3. 3.2.3.	High	Quality of care	PND / IMAM TWG / IPs

[107] Examples of other simplified protocols included in Annex 19

	3.3. Improve periodic monitoring of community outreach activities for IMAM services	3.3.3. and 3.4.3.			
4. Provide equitable access and coverage to age-appropriate IMAM treatment for infants < 6 months.	4.1. In addition to all children aged 6-59 months, screen all infants aged 1-6 months using MUAC during systematic and active case finding and growth monitoring in the community and refer for further risk assessment in OPD-SAM 4.2 Establish a fixed cut-off of WAZ < -2 for infants < 6 months for referral from GMP to the health centre for further risk assessment in OPD-SAM	3.1.3. 3.1.3.	High	Equity / Coverage	PND / IMAM TWG
5. Enhance effectiveness of provincial level IMAM coordination mechanisms and coordination with Regional Nutrition Clusters and national IMAM TWG.	5.1. Disaggregate IMAM routine data to provincial level to facilitate analysis and action planning to address service barriers, incorporating reviews of technical and coverage assessments. 5.2. Strengthen accountability of EPHS and BPHS implementers to the PNO at provincial level through mandated reporting to provincial coordination committees at least quarterly 5.3. Integrate attendance at provincial coordination meetings into EPHS & BPHS quality monitoring mechanisms	3.4.3. 3.4.4. 3.4.3. and 3.4.4	Medium	Coordination / Enabling environment	PND / National and Regional Nutrition Clusters / Provincial Nutrition Committees / PNO / AIM TWG
6. Establish and rollout community accountability mechanisms for IMAM services.	6.1. Establish independent community feedback mechanisms in emergency and non-emergency settings through district and provincial health shura to provide EPHS / BPHS holder accountability to communities 6.2. Sensitise communities in appropriate major and minor local languages on patient's rights through Health Shura in accordance with the MoPH National Health Strategy 2016-2020 (Strategic Area 4, Result 4) – specifically on rights and expectations for IMAM services 6.3. Strengthen end user monitoring and reporting to provincial and national level coordination mechanisms by:	3.2.1. and 3.4.4. 3.2.1. and 3.2.2.	High	Accountability / Demand	PND / UNICEF / WFP / Nutrition Cluster

	c. Including identification of ethnic / kuchi origin in patient registration and monitoring equitable IMAM service access during supervision visits d. Reporting EUM indicators from SCM and Quality of Care checklists	3.1.3, 3.2.2. and 3.4.3.			
7. Revise Sehatmandi IMAM quality of care indicators:	7.1. For indicator 18: Review cure rate for IMAM & revise in line with IMAM national guideline standards 7.2. For indicator 19: Adjust screening protocols to be consistent with IMAM screening (MUAC for infants and children 1-59 months, WAZ for infants and children < 2 years at GMP, WFL/H for children < 5 years) 7.3. Consider inclusion of other meaningful indicators of IMAM quality, for example: a. Accurate / timely IMAM reporting b. Effective SCM for nutrition commodities c. Absence of complaints from community members d. Participation in provincial coordination mechanisms e. Timely completion of supervision reports by nutrition officers to each health facility	3.4.3 3.4.3 3.4.3.	Low	Quality of care	GCMU / IMAM TWG
8. Revise indicators & targets in national nutrition strategic plans and policies.	8.1. Establish clear measurable baselines and / or targets for nutrition service indicators in national strategy documents 8.2. Review the use of the Balanced Score Card as the indicator of quality-of-care in nutrition services	3.1.1.	High	Strategic	PND / IMAM TWG
9. Revise IMAM guidelines & Nutrition SOP based on latest evidence and ensure coherence.	9.1. Update IMAM guidelines and nutrition SOP incorporating: a) Evidence-based simplified approaches which have been successfully piloted in Afghanistan b) Updated WHO recommendations (expected 2021) c) Addressing the needs of children with disabilities by making provision for the	3.1.1.	Medium	Enabling environment	PND / IMAM TWG

	special needs of disabled children in the guidelines and including the recording and reporting of disabled children in registers and monthly reports d) Ensure coherence of IYCF and growth monitoring activities between SOP sections and IMAM guidelines				
10. Incorporate key training on IMAM into the pre-service training curricula of medical and nursing staff to mitigate the effects of rapid turnover of staff		3.2.3.	Medium	Supply (HR)	MoPH / Ministry of Education / PND / IMAM TWG

6. ANNEXES

6.1. Annex 1: Terms of Reference for evaluation

UNICEF AFGHANISTAN REQUEST FOR A CONTRACT FOR SERVICES (INSTITUTIONS)

SHORT TITLE OF ASSIGNMENT		
Formative Evaluation of Integrated Management of Acute Malnutrition (IMAM) Programme		
REQUESTING SECTION	Social Policy, Evaluation, & Research (SPEAR)	
SUPERVISOR (CONTRACT MANAGER)	OIC of SPEAR	
GRANT	Non-grant	
WBS	0060/A0/07/880/009/001	
PROPOSED DURATION	16 weeks over a period of one year	NOTES / COMMENTS
PROPOSED START DATE/END DATE	20/12/18-19/12/19	This TOR is addressed to LTA holders currently under contract with UNICEF ACO to provide high quality technical expertise in evaluation of nutrition sector programmes under category of service 3: scaling up access to SAM treatment
TYPE OF PROCUREMENT EOI, RFP, RFQ, ITB	RFP	
SUPPLY PLAN LINE NUMBER		
LOCATION OF REQUIRED SERVICES	Kabul, and sampled locations from Herat, Ghor, Daikundi, Bamyan, Balkh, Sar-e-Pul, Kunduz and Takhar provinces	
ESTIMAED VALUE MAY EXCEED CRC THRESHOLD (Yes/No)	Yes	

Need for procurement of institutional services is reflected in the AWP/ Supply plan or is in response to a specific request	YES
The tasks cannot be completed by UNICEF staff or counterparts	YES
TOR is clearly defined with tangible, measurable deliverables or an end-product and with payments (contract fee) clearly linked to these	YES
TOR includes a description of the specific activities and timeframes for completion of the activities	YES

The TOR includes performance indicators for evaluation of results (e.g. timeliness or quantitative measures)		YES
SIGNED FOR AGREEMENT		
Recommended by …… Programme Chief Date/Time……	Reviewed by …… Supply Manager Date/Time……	Approved by …… Deputy Representative OR Chief of Operations Date/Time……

UNICEF AFGHANISTAN
TERMS OF REFERENCE FOR SERVICES – INSTITUTIONS

SHORT TITLE OF ASSIGNMENT

Formative Evaluation of Integrated Management of Acute Malnutrition (IMAM) Programme

Background

Outpatient management of acute malnutrition was introduced in Afghanistan in 2008 to address the high caseload of acute malnutrition in children under 5. Initially, Community-based Management of Acute Malnutrition (CMAM) was introduced to integrate the management of acute malnutrition into the health system. In practice, the nutrition partners were implementing the CMAM with the support of the Nutrition Cluster as an emergency response mechanism. In order to address the need at all levels and develop a sustainable programming model, the Ministry of Public Health (MoPH) scaled up the management of acute malnutrition through Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) and redirected its focus from “emergency focused” to “development and sustainable programming”.

The BPHS offer outpatient management of acute malnutrition services through five types of health facilities, ranging from Health Sub Center (HSC), Basic Health Center (BHC), Mobile Health Team (MHT), Comprehensive Health Center (CHC); and District Hospital (DH)- for outpatient and inpatient services)). While essential package of health services (EPHS) provide inpatient management of severe acute malnutrition with medical complication services through three types of health facilities ranging from DH, Provincial Hospital (PH) and Regional Hospital (RH). In addition, community outreach activities which include active screening, referral and follow up acutely malnourished children is an integral part of community-based nutrition package (CBNP) provided by BPHS through Health Posts (HP) at the community level.

The results of the first services that were delivered through the BPHS and EPHS in Takhar, Badakhshan, Balkh and Herat provinces indicated that there was a need for a comprehensive and integrated guideline that would provide clear guidance to help the health workers in proper detection and management of acute malnutrition of different levels. By January 2014, the MoPH had endorsed the Integrated Management of Acute Malnutrition (IMAM). The IMAM guidelines were developed by MoPH and UNICEF to improve the integrated management of

acute malnutrition within the national health system through using a holistic approach to prevention and treatment of acute malnutrition. The IMAM guidelines cover:

- Detection of acute malnutrition among patients at different levels of health facilities
- Treatment through outpatient and inpatient departments
- Counseling of mothers and caretakers
- Assessing /managing the main causes of malnutrition, such as: micronutrients, infant and young child feeding practices and home-based caring.

Detailed Programme Description

The IMAM programme is being implemented harmoniously by the Government of Afghanistan, public health institutions and BPHS and EPHS package implementing partners at district levels throughout the country. Since its introduction, the IMAM programme has been scaled up in 34 provinces and covers nearly 78 percent (313/399) of the districts today. From 2014 to Mid-2017, In-Patient Department of Severe Acute Malnutrition (IPD-SAM) services expanded from 87 to 138 health facilities (15% increase since 2014) in 34 provinces. Similarly, Out-Patient Department of Severe Acute Malnutrition (OPD-SAM) services scaled up from 377 (19%) to 843 (42%) health facilities in 34 provinces. The number of provinces where Out-Patient Department of Moderate Acute Malnutrition (OPD-MAM) services are present increased from 22 to 26, and the number of health facilities increased from 490 to 529.

The IMAM has covered over a million children diagnosed with SAM and MAM since 2014. The current performance status of IMAM is above the Sphere Standards (>75% for admission and <15% for defaulter rates), yet the cure and defaulter rates are found below these standards for management of severe acute malnutrition in Badghis, Faryab, Kabul, Sarepul, Uruzgan, and Wardak for the OPD/IPD SAM management services. The formative evaluation of IMAM for children and women with acute malnutrition is important for identifying ways to increase the coverage, scale-up, and measure to what extent it meets the needs of the most vulnerable and marginalized children. The evaluation results are expected to contribute to improving the performance of the interventions in challenging locations of the country.

This formative evaluation is being initiated to measure the extent to which the IMAM has met the needs of the population and gather lessons learned. The evaluation results are expected to deliver recommendations that will contribute to improving the programme performance. The audience of the evaluation are the Government of Afghanistan, UNICEF, WFP, WHO, BPHS and non BPHS implementing partners, and other stakeholders

Evaluation Purpose

The main purpose of the formative evaluation is to gather evidence on the results of the IMAM and contribute to:

- Promoting accountability among stakeholders and partners
- Informing evidence-based policymaking in preventing and treating acute malnutrition among affected children, plus pregnant and/or lactating women
- Contributing to organizational and global learning and improving programming on effective treatment of children diagnosed with acute malnutrition.

Evaluation Objectives

The evaluation's main objective is to yield results that will contribute to enhancing the programme performance and strategies to deliver effective results through:

1. Assessing the progress made and identifying gaps, good practices and lessons learned
2. Evaluating the programme's relevance, efficiency, effectiveness and sustainability
3. Generating knowledge and providing recommendations that will be useful for strengthening the programme performance, advocacy and policy dialogue on acute malnutrition among children, lactating and pregnant women.

The recommendations that the evaluation will deliver will be geared towards:

1. Identifying strategies for developing policy on effective implementation of IMAM interventions in addressing acute malnutrition issues, improving the quality of services, and achieving equitable outcomes for children at the national level.
2. Assessing the contribution of related cross-cutting issues such as coordination and management; gender and equity considerations; capacity development; advocacy and policy development; and information/data management to improving programme effectiveness.

Evaluation Scope

The scope of the evaluation is the overall IMAM programme activities and implementation strategies at the national level for the period 2013- 2017. IMAM interventions in this time period have been a collaboration among UNICEF, WFP, WHO, MoPH-Government of Afghanistan, and implementing partner NGOs. The evaluation will also consider trends from 2010 when the Community Management of Acute Malnutrition (CMAM) model was in place, before later evolving into IMAM in 2014. The evaluation is therefore expected to highlight trends of acute malnutrition cases and actions implemented by the Government of Afghanistan and partners from 2010 to 2017 as well.

Considering the national nutrition strategies of the Government of Afghanistan, the evaluation will examine the IMAM's performance in:

1. Increasing access to nutrition services and products for children and their families
2. Improving nutrition behaviour and practices among target groups
3. Improving the quality of nutrition services and products
4. Strengthening the social, regulatory and political environment for nutrition

The evaluation will be conducted in line with United Nations Evaluation Group (UNEG) standards and the Organization for Economic Cooperation and Development (OECD) / Development Assistance Committee (DAC) criteria.

It is intended that the methodology and work plan be flexible enough to allow for new issues and questions that may emerge during the conduct of the evaluation to be addressed.

Evaluation Questions

The evaluation will assess relevance, effectiveness, efficiency and sustainability of IMAM and the extent to which it contributed to equitable and equality-based outcomes for children. The evaluation will be

conducted according to the OECD-DAC and UNICEF/UNEG evaluation criteria through the following evaluation questions that will be refined/expanded on further by the evaluation team.

Relevance Questions

Relevance questions refer to the extent to which the IMAM interventions are relevant to the needs of the children and their mothers and the capacity of government partners. The study will compare how the design, and particularly the IMAM interventions were aligned to the needs of children, mothers and government. This will provide an understanding of the suitability of the IMAM design and approach and provide answers for the way forward. The IMAM design and scaling up was also expected to meet the capacity needs of the government staff working in the health and nutrition sectors to address acute malnutrition. The following 5 core questions, as well as new questions, will respond to the evaluation objectives:

1. Did the IMAM interventions adequately target the needs of the poorest quartile, remote populations and the most vulnerable children? (Ask for each component of IMAM).
2. To what extent were IMAM activities gender-proportionate? Was the incidence of MAM/SAM in girls vs. boys adequately addressed in implementers' interventions?
3. Are there any issues related to gender, geographic or other form of equity in IMAM service delivery and access that are evident? What measures could be proposed to improve programme targeting?
4. To what extent have IMAM capacity development activities covered the development needs of communities and Government partners in preventing and treating acute malnutrition?
5. How are the efforts of UNICEF and other implementing partners in treating acute malnutrition aligned with the national priorities in nutrition?

Effectiveness Questions

The effectiveness questions are designed to measure extent to which the IMAM programme was implemented as planned, the contribution of various stakeholders to the programme's implementation, what the interim outputs and outcomes of the programme are. The questions will measure programme performance against stated objectives, validating if the program did what it set out to do and to what extent.

1. To what extent have IMAM interventions met the needs of children and their mothers? Have the expected outputs and outcomes been realized through the IMAM programme? If there are shortfalls, what are the contributing factors?
2. How developed and successful are the specific IMAM components and strategies (community outreach and mobilization, screening/enrolment, feeding, treatment, information management, follow up) and the interventions (as per the programme logic model) in realizing overall programme objectives?
3. Have all targeted number of children diagnosed with SAM and MAM, and their families been reached in the planned timeline?
4. Are there relapsed cases of children who were treated? If so, what are the issues that caused SAM and MAM among those children again?
5. Have partners achieved the optimum level coverage for acute malnutrition treatment?
6. Have the counselling services led by UNICEF to mothers and caretakers yielded substantive results in terms of enhancing the knowledge of mothers and caretakers of the nutrition needs of children?
7. How effective is the vertical and horizontal coordination (involvement of various sectors) in planning and implementing IMAM?
8. How strong is the national /sub-national engagement and ownership of IMAM programme (including national budget allocations)?

9. Was the supply system established by UNICEF, WFP and WHO able to deliver programme implements as planned/needed?
10. Was the technical support (training, monitoring) provided by UNICEF, WHO and WFP adequate in imparting requisite skills/knowledge?
11. Was support from the PND, nutrition extenders, and nutrition counsellors to HFs at provincial levels sufficient?
12. Was the support provided by CHWs to HPs at community level adequate to enable them to address SAM/MAM cases?

Efficiency Questions

The following efficiency questions are designed to assess inputs/activities and their relationship to outputs and outcome. This means the evaluation will make an assessment of the degree to which the outputs were achieved and utilized by the beneficiaries. It is expected that much of the information on efficiency will be drawn from secondary data and less from primary data, as a cost effectiveness study will not be conducted. Core questions are shown below:

1. Are implementing partners' investments to implement IMAM sufficient to achieve intended results in the context of the country?
2. To what extent has partnership of IPs and government (at different levels and in different provinces) been able to support the delivery of the programme results?
3. Are programme monitoring and reporting systems gathering credible evidence on the response to MAM/SAM, measuring results, detecting and preventing bottlenecks on time?
4. To what extent does the service delivery meet expected quality standards? What factors have contributed to meeting quality standards? Where quality standards are not met, what are the key bottlenecks/constraints that need to be addressed in order to meet quality standards?
5. How timely has service delivery during the scale up process been, especially through mobile teams?

Sustainability and Scaling Up Questions

Sustainability for ongoing projects will be based on system- and agency-level changes evidenced over time and a study of incentives for change at the individual, and health organization levels. This will include an assessment of system compatibility/ readiness to determine how much change is required by beneficiaries/ partners to maintain project results, the premise being, the more change required, the harder to sustain, unless there are commensurate incentives to make up for the 'cost' of changing.

1. Have stakeholders set up a system at the national level that will continue responding to acute malnutrition cases effectively without external support?
2. To what extent do mothers and caretakers who received counselling sessions continue practicing the knowledge that they gained through the IMAM?
3. How systematically has institutional capacity development been pursued at all levels for long term sustainability of the programme? What more needs to be done?
4. Where IMAM services have reached the intended/target populations, how far have they been integrated into the country health system?
5. To what extent have IMAM supply components been integrated into the MoPH regular supply or medicine list? What have been the barriers, if any, to integration?
6. How successful has the IMAM scale-up program in term of expanding coverage and service delivery?
7. To what extent have the humanitarian and development services/programs/projects complemented each other in terms of programing? How quickly have humanitarian and

development actors responded to the needs of local populations? What are the impediments to getting stakeholders and communities to become more involved in problem solving?

Evaluability

Due to the absence of solid baseline data and considering the overall framework of IMAM, this evaluation will not cover possible impact of the interventions. Available databases and monitoring systems have data that will be used to evaluate relevance, effectiveness, efficiency and sustainability of the IMAM interventions.

The programme's interventions are evaluable through qualitative and quantitative methods, and additional secondary data can be obtained for pre and post comparison analysis on the programme performance. The programme Theory of Change will be used as a basis to establish a clear relationship between programme inputs, activities, outputs and outcomes.

Limitations

Security challenges and possible limited access to the target groups may impede timely implementation of data collection activities. Additionally, limited reliable secondary data and absence of proper documentation at the provincial and district levels, and in the target health facilities may pose challenges in the evaluation process.

Evaluation Design and Methodology

The evaluation design must be based on primary and secondary data collection. A critical stage before producing an inception report is to conduct detailed desk research on IMAM programme reports, related documents, materials, and data that will be used to asses: a) the nature of the programme interventions; b) the availability of data and c) to develop appropriate evaluation design, sampling strategy, and analytical approach. The research in the inception phase will include: a) document reviews; b) consultations and interviews with UNICEF and partners; c) pilot testing of data collection instruments.

Evaluation methodology should be based on mixed methods, participatory, gender, equity and human rights based approaches. Two types of data will be collected:

Primary data will be collected through qualitative and quantitative methods, such as surveys, interviews and Focus Group Discussions (FGDs). The participants of the primary data collection will be:

1. Mothers and caretakers
2. Community people including Community Health Workers (CHWs), Family Health Action Group (FHAG), and Health SHURA
3. Health workers, and BPHS/EPHS workers
4. UNICEF Nutrition Section
5. Ministry of Health, WFP, WHO and other stakeholders (2-3 LNGOs and INGOs)
6. IMAM technical working group members.

Secondary data can be collected through the programme databases and monitoring systems from MoPH and UNICEF including:

1. National Nutrition Database
2. National Nutrition Surveillance System
3. 2017 Smart surveys and Rapid assessments

4. Afghanistan nutrition cluster Bulletin-Issue 1, 2018

Data collection activities must be accompanied with photographic evidence and collected via real-time data collection technologies (such as Open Data Kit).

Sampling

The evaluation team is required to develop and present their sampling strategy in the technical proposals. The sample sizes for each target data source should be sufficient to allow generalization of findings to the larger population targeted by the programme. Sampling for quantitative and qualitative data collection should be drawn based on the following criteria:

1. 17 Provinces with SAM > 3 percent, received collaborative support of UNICEF and WFP in all accessible districts. (Badakhshan, Samangan, Badghis, Nimroz, Helmand, Kandahar, Urozgan, Zabul, Ghazni, Paktika, Wardak, Paktia, Khost, Nengarhar, Laghman, Kunar and Nooristan provinces).
2. 8 Provinces with SAM < 3 percent where MAM management services are functioning, MoPH and partners maintained the services and ensured SAM and MAM management is integrated in the same facilities. MoPH and NGOs used the same partners. (Herat, Ghor, Daikundi, Bamyan, Balkh, Sar-e-Pul, Kunduz and Takhar provinces).
3. 9 Provinces where WFP did not implement programming due to funding constraints and other reasons. (Farah, Faryab, Jawzjan, Logar, Kabul, Parwan, Kapisa, Panjsher and Baghlan provinces).

Cases for the qualitative in-depth assessments should be selected from the OPD-SAM and IPD-SAM databases.

Data Collection Tools

The form and content of the data collection tools should adequately capture valid and accurate information on the main programme indicators that are needed to answer key evaluation questions. Information/data collected from surveys, interviews, and focus group discussions with sampled groups should be anonymized, and documented with the consent of the interviewees. The evaluation team will be responsible for developing, piloting and translating all data collection tools and it is expected that data will be collected via real-time data collection technologies (such as Open Data Kit). All data collection tools (surveys, interview content, and FGD protocols) must be culturally appropriate given the local context in Afghanistan.

Data Analysis and Findings

Data must be disaggregated by gender, location and ages of respondents. Data analysis must cover the IMAM performance according to the SPHERE Standards. The analysis will cover findings according to determined evaluation criteria and assessments of the local socio-economic and political issues and any other assumptions and risks that can potentially have an effect on changing the course of the expected results.

Evaluation Management

The evaluation will be managed by the Evaluation Specialist under the overall oversight and guidance of the Chief of the SPEAR Section and the IMAM ERG comprised of technical focal points from key stakeholders like UNICEF Nutrition Section, WHO, WFP, and MoPH. UNICEF ACO/SPEAR Section will lead the evaluation process and ensure that it is conducted according to UNICEF Evaluation Policy and UNEG Norms and Standards.

Quality assurance

An Evaluation Reference Group (ERG) will be constituted and include technical officers from UNICEF ACO, representatives from MoPH, WHO, WFP, and others who will review evaluation deliverables and provide regular comments on the evaluation's scope, methodology, analytical approach, findings, conclusions and

recommendations. The evaluation team will be accountable to the ERG in respect to how feedback from ERG is taken incorporated in evaluation outputs. The evaluation team will also prepare an audit plan prior to commencing fieldwork specifying the steps in place to verify the accuracy/reliability of data/information gathered.

Ethical procedures

All evaluations of programmes falling under the MoPH in Afghanistan are subject to approval by an Institutional Review Board (IRB), therefore the evaluation team will be required to submit the final version of the inception report and data collection tools to MoPH for IRB approval before commencing the fieldwork. The evaluation team should take into account the process of preparing and submitting documents, plus the timeframe for acquiring IRB approval in their workplan.

Evaluators are required to identify any potential ethical issues and must disclose in writing any past experiences and their relationships, including of their families and friends to the object of the evaluation. Evaluators must exercise independent judgement and not be influenced by statements of view of any party, including:

1. Be impartial and produce a comprehensive presentation strengths and weaknesses of the policy, programme and take due account of the view of stakeholders based on unbiased findings;
2. Illustrate evidence on verified findings and lessons learned;
3. Exercise honesty, integrity and respect for dignity and diversity;
4. Produce evaluation reports based on fair representation of knowledge, vulnerable groups, gender and ethnic groups.

Evaluators are required to receive informed consent from participants before involving them in the data collection process and respect their right to provide information in confidence. The data collection team must inform participants about the scope and limits of confidentiality, and ensure that their data/information cannot be accessed by non-authorized persons or traced back to them. It is essential to prepare risk management plans to minimalize potential harm to participants and the data collection team before commencing fieldwork.

Confidentiality

Evaluators must obtain permission from UNICEF to disclose any evaluation materials and keep raw data and protocols in concealment. Data must be securely retained or disposed according to UNICEF's policy on the disposal of records. All materials collected and evaluation products remain the property of UNICEF and the contractor must not share this information without explicit written permission of UNICEF.

Dissemination and advocacy of evaluation findings

UNICEF will assume primary responsible for the dissemination of evaluation products and the uptake of evaluation findings and recommendations by Government and implementing partners. The evaluation results should contribute to evidence based policy making and programming for children.

The evaluator will contribute to the dissemination of evaluation products through:

1. Publishing a full evaluation report and distributing it among partners
2. Compiling a 2-4-page report summary/brief of the evaluation process, findings, and recommendations with both vivid infographics and brief text

3. Delivering a PowerPoint presentation to key programme stakeholders to share evaluation findings

Location and Duration of Consultancy

The assignment will be based in Kabul during the inception and reporting phases, and in target sample provinces during training and data collection. It is estimated that the assignment will require up to 16 weeks to complete, but a substantive evaluation timeline and level of effort for each evaluation team member will be agreed on before finalizing the contract.

Activities, Deliverables & tentative Timelines		
Inception Phase	**Timeframe**	**Payment Schedule**
1. Desk review of IMAM's key programme documents. 2. Sampling strategy from technical proposal is refined and a representative sample size identified. 3. Data collection tools are developed, translated, and pilot tested. 4. Evaluation methodology and analytical framework is developed 5. Inception report is produced and submitted to UNICEF and ERG members for review and feedback. 6. The report must be cleared by the ERG before it is finalized. The consultant will be required to revise the inception report based on feedback from the committee. The inception report and contents therein must adhere to the quality standards and ethical considerations specified in the ethics review and quality assurance procedures of UNICEF ACO.	4 weeks	20%
Deliverables: 1. Draft inception report with clear evaluation methodology, sampling strategy, and analytical approach 2. Data collection instruments developed, translated, and piloted 3. Finalized inception report with feedback from ERG incorporated 4. Presentation of summary of finalized inception report to ERG		

Data Collection Phase	Timeframe	Payment Schedule
1. Lead training of recruited data collection team on evaluation background, survey instruments, and data collection protocols. It is essential that the trainings cover ethical and quality assurance procedures of UNICEF. 2. Lead and assure the quality of the trainings for the fieldwork team members. Ensure that the enumerators have adequate capacity to conduct quality data collection. 3. Conduct pilot testing in two sampled provinces. Ensure that the data collection tools are tested properly and adjusted according to the pilot test results, if necessary. 4. Lead the data collection work and submit daily progress reports to UNICEF. 5. Conduct data quality assurance exercises/audits to verify accuracy and validity of data collected and submit quality assurance report. 6. At the conclusion of data collection, submit a fieldwork report summarizing conduct of data collection, conditions in sample areas, issues/difficulties faced, coping mechanisms adopted, and so on. 7. Provide clean datasets, plus FGD and interview transcripts from all sampled data sources	8 weeks	40%

Deliverables:

1. Daily fieldwork progress reports
2. Consolidated report summarizing fieldwork activities and outputs
3. Report from audit/quality assurance exercises

Data Analysis & Report Writing Phase	Timeframe	Payment Schedule
1. Clean, scrutinize and analyse data from surveys, KIIs and FGDs 2. Produce and share draft evaluation report with UNICEF. 3. Revise draft evaluation report based on feedback from ERG members.	4 weeks	40%

4. Submit finalized evaluation report, plus 2-4-page summary report with key findings and infographics to ERG. 5. Prepare and deliver presentation of evaluation findings, lessons learned and recommendations to ERG members and other stakeholders		

Deliverables:

1. Cleaned datasets and transcripts of FGDs and interviews.
2. Draft evaluation report
3. Finalized evaluation report with feedback from ERG incorporated
4. 2-4-page report brief with infographics and text
5. Presentation of summary of final evaluation report including methods, analysis, data sources, findings, and recommendations to key stakeholders

Qualifications, competencies, and experience required

The evaluation team should be composed of one Team Leader and a sufficient number of team members to ensure the successful implementation of the assignment. Team members proposed in any bidding document must be available for the duration of their assigned tasks.

The contractor is expected to have a data collection team onboard to conduct the data collection in sampled programme areas around Afghanistan.

It is expected that the evaluation team will comprise some evaluators who speak Dari/Pashto and can play a facilitating role vis-à-vis non-Dari/Pashto-speaking team members particularly for interviews, FGDs, and piloting of data collection tools during the inception phase. For the data collection phase, it is essential for data collection team members to be fluent in Dari/Pashto.

The evaluation Team Leader will oversee the entire evaluation process which will involve working with the data collection team, UNICEF Evaluation Manager, and ERG members. The Team Leader will be responsible for timely and quality deliverables. The Team Leader should have:

- Advanced degree in nutrition, health, statistics, economics, or other social science related field.
- At least five years of experience in managing, designing and conducting complex evaluations of large scale nutrition programmes and related community based health programmes
- Exposure to nutrition programming in emergency contexts, including in Afghanistan is an advantage.

- In-depth knowledge of and experience in the work of UNICEF and/or other UN agencies or development organizations implementing nutrition programmes;
- Demonstrated ability to deliver high-quality written work in English, and to engage effectively with stakeholders at all levels.

The core evaluation team should specify evaluation team members and assign the Level of Effort for each team member in their technical proposal in addition to CVs and tasks that each will be responsible for. The team leader will be responsible for timely and accurate submission of stipulated deliverables throughout the duration of this assignment. The evaluation team should be gender balanced and comprised of members who possess the following qualifications & competencies:

- At least a bachelor's degree in nutrition, health, statistics, economics, and other social science related field.
- At least 5 years of work experience in design, analysis and reporting for evaluations of large scaled nutrition programmes.
- At least 5 years of experience in qualitative/quantitative data analysis and visualization.
- Nutrition programming, research & evaluation expertise and experience in producing high quality reports
- In-depth knowledge of and experience in human rights, equity and gender based approaches to nutrition programming
- Strong written and spoken communication and facilitation skills.
- Experience working directly with mothers and children in cultural contexts similar to or in Afghanistan.
- Experience of using child-friendly participatory techniques in data collection.
- Experience managing data collection in remote and conflict affected settings.
- Fluency in English
- Fluency in Dari and Pashto

The contractor must have a national data collection team onboard before commencing the work. The national team must have sufficient number of staff members and field workers to conduct all required data collection.

The contractor should verify that evaluation team members included in their submission possess the required skills and competencies as stipulated in this TOR.

Assessment of contractual risks and planned risk responses

Risks:

- The quality of deliverables may not meet the standards of UNICEF.
- Some team members may leave or drop out.

Mitigation measures/planned risk responses:

- The contractor will get acquainted with the standards of UNICEF and expectations before the commencement of the work

- The work of the contractor will be monitored and the quality of it will be assured by the ERG throughout the evaluation process
- The contractor will be obliged to train extra team members who will be on standby to replace those who may drop out or whose performance is deemed to be unsatisfactory during the fieldwork.

Operational Procedures and Work Conditions

UNICEF will support the Evaluation Team in desk research and data collection through provision of required documents, materials and secondary data and establishing contacts with key programme stakeholders.

UNICEF does not provide transport, accommodation, insurance and other logistical support for institutions. The vendor will be responsible for their own security, office space, equipment, and travel arrangements.

The contractor will be expected to provide their own office space for their staff while in Kabul and in provinces. The staff employed by the evaluation team are expected to use their own computers, mobile phones, and electronic data collection devices. The identified institutional contract will be responsible for all required logistics for the assignment such as: transport and travel to and within Kabul and target sample areas, accommodation, insurance, security and all related logistical arrangements required for the assignment.

Evaluation Criteria

After opening of proposals, each proposal will be assessed on its technical merits and subsequently on its price. The proposal with the best combined score of technical merit and price will be recommended for award of the contract. UNICEF will set up an evaluation panel composed of technical UNICEF staff and their conclusions will be forwarded to the internal UNICEF Contract Review Committee. The evaluation panel will first evaluate each response in compliance with the requirements of this RFP. Responses deemed not to meet all of the mandatory requirements will be considered non-compliant and rejected at this stage without further consideration. Failure to comply with any of the terms and conditions contained in the RFP, including provision of all required information, may result in a response or proposal being disqualified from further consideration. The proposal will be evaluated against the following:

TECHNICAL CRITERIA FOR EVALUATION - INSTITUTIONS		
TECHNICAL CRITERIA	POINTS TO CONSIDER	Score
Company profile & Experience	Demonstrated proof of producing high quality evaluations. Please provide at least three evaluation reports relevant to the nutrition sector.	5
	Team Leader has advanced degree in nutrition related field and at least 5 years of work experience in managing, designing and conducting complex evaluations of large scale programmes on nutrition, health, and related interventions aimed at combating childhood malnutrition. Please provide CV of Team Leader.	10

	Evaluation team members have at least 5 years of work experience in nutrition programming or evaluation in developing country and/or emergency contexts; skills in quantitative and qualitative data analysis and visualization; and experience managing data collection teams in conflict affected countries. Please provide CVs of evaluation team members	10
Proposed Methodology and Approach	Sampling methods are appropriate to the context of Afghanistan and the sample size for each data source is representative of the population. Please provide sampling methodology.	20
	Evaluation methods are quantitative and qualitative; involve participation of communities, households, community leaders and service providers; analytical approach is appropriate to answer key evaluation questions. Please provide evaluation methodology & analytical framework.	20
	Work plan is thorough and has risk mitigation measures	5
TOTAL SCORE		70
TECHNICAL CRITERIA	POINTS TO CONSIDER	Score

Proposal (s) scoring 70 % - i.e. 49/70 or more following Proposal Evaluation will be listed and included for review of Analysis and Evaluation on The Financial Offer

Price Proposal

The total amount of points allocated for the price component is [30]. The maximum number of points will be allotted to the lowest price proposal that is opened and compared among those invited firms/institutions which obtain the threshold points in the evaluation of the technical component. All other price proposals will receive points in inverse proportion to the lowest price; e.g.:

Max. Score for price proposal (e.g. 30) * Price of lowest priced proposal

Score for "Price proposal X" = ----------

"Price of proposal X"

Total Technical and Price= 100 Pts

FINANCIAL EVALUATION FORMAT- INSTITUTIONS	
DELIVERABLES	COST (USD)
Inception Phase	

Data collection phase	
Data analysis & report writing phase	
TOTAL	

Cost Breakdown

Task	Resource to be deployed (Staff title)	Number of days to be deployed	Rate	Total
01				
02				
03				
Total				

Costs should be detailed according to each task using the template above and costs quoted should include all the traveling expenses including air fare, transport, DSA and Insurance to Afghanistan and within Afghanistan. Contractor will be responsible for their own accommodation. UNICEF can assist in booking of UNHAS flights for travel within country. Please note:

1. All flights should be in economy class only.
2. All travel & accommodation is the responsibility of the bidder to arrange. UNICEF may assist in booking of UNHAS/UNAMA flights for travel within the country, where required.
3. All costs should be shown exclusive of VAT. In accordance with the exemption from Tax in article II, section 7 of the convention of the Privileges and Immunities of United Nations, 1946, UNICEF is exempted from all taxes + duties.

6.2. Annex 2: IMAM evaluation matrix

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
Relevance	R1: To what extent is IMAM situated/in compliance with existing structures at various levels (national, sub-national and field level)?	• Description of existing health structures • Guidelines on positioning IMAM within existing structures • Actual positioning against guidelines or otherwise (if guidelines don't exist	• Guidance documents • Previous assessment reports/situation analysis • Health/IMAM official interviews (at all relevant levels) Other relevant actor interviews	• Document review • Key Informant Interviews (KIIs)
	R2: Have issues related to equity been considered in IMAM service delivery and access, (gender, disability and geography, prioritization of areas where need is greatest)? What measures could be proposed to improve programme targeting?	Targeting criteria/actual targeting • Province v province • Dari v Pashto (and other languages) • Tribal areas v non-tribal areas • Nomads (mobile teams) • Urban v Rural • Alignment/discrepancies between need and actual targeting • Admission profiles by Mid Upper Arm Circumference (MUAC) & Weight for Height (WFH) (More females w/ MUAC admissions about = or more boys with WFH). • Age / gender profile of admissions • Provisions made for children with disabilities (identification, accessibility, treatment and reporting)	• Population data (disaggregated) • Who? what ? Where? (3W) programme info • Interviews with officials and clinicians • Nutrition strategy documents • Data from OPD-SAM and OPD-MAM cards • Sex disaggregated programme reports / databases	• Secondary data review • Document review • KIIs • Analysis of data from OPD-SAM and OPD-MAM cards • Remote sampling of treatment cards • Remote sampling of programme reports / data bases

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	R3: To what extent have IMAM inputs evolved to respond to the local context, needs and priorities?	• Admissions over time • Admission trends responsive to nutritional stressors • Discharge outcomes • Discharge trends over time • Appropriate treatment protocols • Quantity of supplies, budgets, levels of technical support, changes in guidelines/protocols • Changes in needs, context, priorities • Beneficiary perceptions of IMAM services	• National database • National / Provincial / District level nutrition surveys • Semi Quantitative Evaluation of Access and Coverage (SQUEAC) survey reports • Routine programme data • HMIS reports • Interviews with officials and clinicians, beneficiaries • Seasonal calendars of nutritional stressors • Situational analyses • Nutrition strategy Documents • Guidelines • Field observations	• Secondary data review • Key informant interviews • Document review • Observation • checklists • Beneficiary Questionnaires/ interviews
Efficiency	E1: To what extent has delivery of IMAM services been efficient using the following modalities: - SHCs (sub health centres) and mobile health teams? - Presence of an international NGO as provider of technical support to a national NGO?	• Number treated / service delivery unit • Timely treatment admission and discharge • Comparison of treatment outcomes • Comparison of lengths of stay in treatment • Differences in access to treatment • Absenteeism and default	• Health Management information System (HMIS) reports • Routine programme data • OTP card analysis • Qualitative data from community based KIIs • Lot Quality Assurance Sampling (LQAS) data	• KII – Government of Islamic Republic of Afghanistan (GoIRA) • KII community leaders • KII / Focus group discussions (FGD) beneficiaries • OPD-SAM / OPD-MAM card sampling • LQAS survey
	E2: How complementary are the IMAM related M&E systems (IMAM database, M&E database, SCM and	Description of IMAM Monitoring and Evaluation (M&E) systems	M&E Manuals/ Standard Operational Procedures (SOPs) Interviews with M&E staff and users of M&E products/systems	Document Review Interviews

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	EUM)? Are there any duplications/overlaps?	Examples of consistencies /inconsistencies /overlaps /duplications across IMAM M&E systems		Review of field records in relation to M&E (verifications?)
	E3: To what extent has the gathered evidence been used to inform programme performance, detect and resolve bottlenecks on time?	Description of IMAM M&E systems Examples of consistencies/ inconsistencies/overlaps /duplications across IMAM M&E systems Dissemination of evidence-based changes of interventions Dissemination of evidence-based training, Information, Education and Communication (IEC) materials	M&E Manuals/SOPs Interviews with M&E staff and users of M&E products/systems	Document Review Interviews Review of field records in relation to M&E (verifications?)
	E4. How complementary are the IMAM related forums, included nutrition related forums with IMAM component? Are there any duplications/overlaps?	Examples of interventions based on credible evidence / analysis Examples of bottlenecks detected and solutions Overlaps/ duplications in mandates for different forums Complementarity of UNICEF / GoIRA nutrition strategies Complementarity of GoIRA coordination structures and UN nutrition cluster	Bottleneck Analysis (BNA) / dashboards Programme reports Relevant Officials Policy documents Strategy documents Minutes of meetings Who? What? Where? (3 W) documents UN / GoIRA coordination structure documentation	Document review Interviews
Coverage	C1: What is the geographic coverage of IMAM services against estimated national, provincial needs? How has this changed since start of IMAM?	• Comparison of nutrition survey data vs. programme admissions / discharge data. Met need = cure rate x coverage • Admission numbers match with policy / strategy targets (indirect estimate) • Disaggregate targets and achievements by province (if possible)	• Programme performance data over time • Historical programme documents and reports • IMAM services mapping over time • Community-based coverage survey • Carers of non-covered and defaulted cases • Health facility staff	• Key informant interviews • Document review • Beneficiary interviews • Beneficiary questionnaires

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
		• Admission trends of MAM / SAM • Admission trends in areas of expansion relevant to context • Review of year on year targets and timeline of expansion (number of sites / geographical coverage) • Geographical coverage of IMAM services over time • Reasons for non-attendance to IMAM programme for carers of non-covered cases • Reasons provided for cases that have defaulted	• Coverage surveys and meta analyses	
	C2: To what extent is the programme reaching those in hard to reach areas?	• Programme coverage in these areas/to these populations against listed hard to reach areas • Mapping of programme sites vs. population • Mapping of prevalence of malnutrition vs. programme sites • Treatment coverage in surveyed communities	• List/definition of hard to reach areas /populations • IMAM coverage data (disaggregated by district and province) • Needs assessments • Interviews with officials, implementing partners • FGD with populations in these areas • Population data (disaggregated) • 3W programme info • Facility records /records of implementing partners • Coverage surveys and meta analyses • Carers of non-covered and defaulted cases	• LQAS coverage evaluation • Secondary data analysis • Interviews • FGDs/ beneficiary questionnaire • Review of documents/records

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
			• Health facility staff	
	C3: What are the success factors, challenges faced in reaching the target populations?	List/examples of success factors/challenges perceived	• Existing research/evaluations • Situation analysis • Interviews with officials/implementing partners • FGD with populations in hard to reach areas (pending accessibility) • Carers of non-covered and defaulted cases • Health facility staff	• LQAS coverage evaluation • Document review • Interviews • FGDs
	C4: Are there any differences in take up of IMAM services and what are the reasons for these differences (if any)?	• Level of take up of imam services Incidence of differences/lack of differences (according to need	• Disaggregated assessment/treatment data • Facility records Interviews with officials/clinicians facility staff	• Document review • Secondary Data review • Interviews
	C5: To what extent has the expansion of geographical and programmatic coverage been accompanied by quality service provision?	• Admission trends of MAM / SAM • Increasing ratio of MAM: SAM • Discharge outcomes (cure > 75%, Deaths < 10%, default < 15%) • Timeline for expansion of programme in relation to need • Admission trends in areas of expansion relevant to context • Geographical coverage • Case coverage according to context	• Routine programme data disaggregated by province • Disaggregated data for MAM / SAM • Programme Documentation Former coverage surveys	• Health Management information System (HMIS) reports • LQAS coverage evaluation • Beneficiary questionnaires • Document review • Treatment records • information retrieval • Key informant Interviews • Beneficiary

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
				• Interviews/ questionnaire
Effectiveness	EF1: To what extent are service users satisfied with IMAM services? And what are their perceptions about programme purpose?	• List of programme purpose as perceived by IMAM service users • Level of satisfaction of IMAM service users • Impressions of IMAM from community members in selected communities for qualitative data collection • Impressions of IMAM from officials and hospital directors • Impressions of IMAM from health facility staff	• Programme beneficiaries • IMAM officials/implementing partners • Previous user satisfaction surveys	• Beneficiary questionnaire • Beneficiary FGDs • Key informant interviews (with officials, hospital staff and health centre staff) • Document review/ data on user satisfaction/perceptions
	EF2: To what extent are IMAM supplies timely, being used/functional, appropriate and distributed pharmacy/health system? What is the effect of lack of supplies?	• Time taken from requests for supplies v delivery of supplies • Extent of use of supplies and for what purpose • Perceived appropriateness to serve the need • Supply distribution mechanisms • Examples of incidences of delay in/lack of supplies and effects	• IMAM Implementing staff • Documents detailing information related to supplies • IMAM officials and agencies providing supplies • Beneficiaries	• Beneficiary questionnaire • Key informant interviews • Document review
	EF3: To what extent does service delivery meet expected quality? What are the key bottlenecks/ constraints that need to be	• Service delivery v service delivery indicators • Examples of bottlenecks • Appropriate ward environment • Appropriate admission	• Observation of quality service delivery through observation checklists • Review of IPD/ OPD-SAM / OPD-MAM cards / monthly	• Field observations • Observation checklists • Key informant interviews • Beneficiary questionnaires

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	addressed in order to meet required quality of services?	• Discharge outcomes compared to Sphere minimum standards and national guidelines • Treatment protocols conform to United Nations standards (WHO / • UNICEF / national guidelines) • Contextually appropriate length of stay in treatment • Appropriate use of antibiotics / medicines • Appropriate rations of therapeutic milk / Ready to Use Therapeutic Food (RUTF) / Ready to Use Supplementary Food (RUSF) • Assessment of pharmacy stock-outs	reports for adherence to quality indicators • Ward observations • Guidelines • Treatment records • Key informants • Beneficiaries • National Guidelines	• Document review
	EF4: To what extent do implementing partners have the required capacity to deliver IMAM services?	• Capacity needs assessments • Trainings (pre post assessments) • Staffing • Current availability of trained human resources by implementing partner	• Interviews with officials and clinicians, implementing partners • Beneficiary interviews • Documents	• Key informant interviews • Beneficiary questionnaires • Document review
	EF5: To what extent have specific IMAM interventions/activities helped to achieve the planned	• Planned targets v actual achieved for given results areas	• OPD-SAM / OPD-MAM treatment cards • IPD treatment cards	• Document review • Beneficiary Questionnaire

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	results and targets (including treatment of children and mothers for malnutrition)? What have been enabling and hindering factors/challenges?	• Examples of enabling/hindering factors	• National guidelines • Various stakeholders interviews • Documents Beneficiary questionnaire	• Field observations • KII with officials / clinicians
	EF6: How motivated and satisfied are front line staff to deliver IMAM services? What are the constraining factors including staff workload?	• Perceptions of frontline staff and others on their level of motivation and workload • Number of staff /population targeted • Views of target beneficiaries • Actual Staffing v needed staffing	• Documents • Frontline staff, their supervisors and other stakeholders including implementing agencies	• KIIs • FGDs • Document review
Sustainability	S1: To what extent has IMAM been integrated into the health system services and how does this affect provision of IMAM services?	• Impressions of IMAM from officials and hospital directors • Human resource commitments • Financial commitments • Coordination meetings • Training • Supportive supervision • Effective commodity management • Assessment of capacity to implement based on theoretical / practical knowledge	• Observation of protocol implementation • Key informants • Pharmacy records	• Observation checklist • Bottleneck analysis • Treatment records information retrieval • Key informant interviews • Document review
	S2: To what extent can PND continue to implement and scale up IMAM without financial, technical, logistical and other (including supplies) support from internal and external agencies?	• Impressions of IMAM/other officials • and hospital directors • Human resource commitments • Financial commitments • Commodity management	• Documents Interviews with stakeholders	• Document review • Interviews

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	S3: What systems, policies, strategies, capacities, (at national, provincial, regional, district, community levels) have been/need to be developed so that IMAM can continue to be implemented and scaled up without internal and external support?	• Impressions of IMAM from officials and hospital directors	• Documents Interviews with stakeholders	• Document review • Interviews
	S4: To what extent is there coordination across IMAM stakeholders and implementing partners at various levels?	• Evidence of coordination in nutrition and nutrition sensitive policies / guidelines Participation in sectoral / inter-sectoral coordination meetings • Examples of improved planning & implementation	• Documents • Interviews with stakeholders	• Document review • Interviews
	S5: What are the gaps and barriers to coordination and the effect of these on IMAM services? Are there any duplications?	• Examples of gaps/barriers Examples of duplications	• Documents (tors of coordination mechanisms, minutes) • Interviews with stakeholders	• Document review • Interviews

6.3. Annex 3: List of documents and data consulted

1. Government of Islamic Republic of Afghanistan

Multisector initiatives

- Afghanistan Food Security and Nutrition Agenda. Food Security and Nutrition Public Awareness and Advocacy Framework and Plan 2018-2023
- Afghanistan Food Security and Nutrition Agenda (AFSANA). A Policy and Strategic Framework, December 2012.
- SUN Movement Afghanistan Country Dashboard 2018, April 2019.
- Afghanistan National Development Strategy. An Interim Strategy for Security, Governance, Economic Growth & Poverty Reduction, Volume 1. January 2006.
- Draft Nutrition Action Framework (2012-2016), April 2012.
- Afghanistan Food Security and Nutrition Plan 2019 to 2023. November 2018

2. Ministry of Public Health

PND Strategies, SOPs and guidance

- National Public Nutrition Policy and Strategy (2009-2013), January 2010.
- National Public Nutrition Policy and Strategy (2015-2020), March 2015.
- National Public Nutrition Strategy (2019-2023)
- Nutrition Supply Chain Management Standard Operating Procedures, 2017.
- Integrated Management of Acute Malnutrition National Guidelines, January 2018.
- Operational Guide for implementing the National Maternal, Infant and Young Child Strategy (2019- 2023), 2018.
- Standard Operating Procedure (SOP) for Quality Improvement (QI) of Integrated Management of Acute Malnutrition (IMAM) Services in Afghanistan, April 2018.
- Afghanistan 2015 WFP and UNICEF IMAM planning for 2015, November 2014.
- Note on IMAM 2015 Joint Planning, December 2014.
- Guidance Note for Severe Acute Malnutrition (SAM) Scale Up Plan, May 2018.
- Standard Operational Procedure Guideline For Nutrition in BPHS & EPHS, January 2015.

PND staff capacity

- Public Nutrition Training, Facilitators Guideline for Physicians, Midwives/Nurses, Community Health Supervisors, and Nutrition Supervisors, January 2015.
- Training material for "Public Nutrition in BPHS Standard Operation Procedures and Guideline" training course for supervisors and PNOs, undated.
- Job Description for Nutrition Officer, November 2008.
- Job description for Nutrition Counsellor, October 2016.

PND Coordination mechanisms

- Minutes for 4 NPCC meetings between July 2018 and December 2019.
- Minutes for 7 meetings of the IMAM Technical Working Group between December 2016 and January 2020.
- Agenda for the 21 December 2015 IMAM TWG meeting.

M&E

- Afghanistan National Nutrition Surveillance System Bulletin, issues 2-13; July 2014 to September 2018.
- Workshop Report on Nutrition Information Management (NIM) in Afghanistan, July 2018.
- MoPH BPHS Monitoring Checklist, July 2019.
- MoPH Scoring And Instructions for Monitoring Checklist, undated.
- MoPH Monitoring Checklist Field Manual Instructions for Monitors, undated.
- Various IMAM related M&E tools (in English):

- Therapeutic surveillance sheet
- OPD SAM treatment and follow up card
- Medical Surveillance Sheet (MSS)
- Homebase treatment card
- Home visit recording form
- Home visit questionnaire
- Defaulter tracing questionnaire
- Micronutrients tally sheet
- IYCF tally sheet
- Case mapping tally sheet
- OPD MAM PLW Monthly Report (current)
- OPD MAM PLW Monthly Report (former)
- OPD MAM PLW Project Completion Report
- MN Monthly Report
- IYCF Monthly Report
- IPD and OPD SAM Monthly Report
- BMS Code Violation Monitoring Report
- OPD MAM Register Books
- OPD MAM Referral Slip
- IPD and OPD Quality Standards Checklists
- Nutrition Monitoring Checklist
- Flour Fortification Monitoring Checklist
- BPHS Monitoring Checklist

Local Nutrition and Food Security surveys and assessments

- Nutrition & Mortality SMART survey reports for SMART surveys conducted by:
  - ACF in Samangan (2017), Ghor (2011, 2014, 2015), Takhar (2011, 2017), Parwan (2016), Panjshir (2016), Paktika (2015), Paktia (2015), Nuristan (2015), Nirmoz (2017), Nangarhar (2011, 2015, 2016), Laghman (2011, 2015), Kunar (2015), KIS (2011), Khost (2015), Kapisa (2016), Jawzjan (2017), Helmand (2017), Ghazni (2016), Farah (2017), Daikundi (2017), Bamyan (2011, 2012, 2017), Balkh (2015), Badghis (2016);
  - AHDS in Uruzgan (2011);
  - HN-TPO in Nangarhar (2012);
  - AMI in Kunar (2012);
  - SCI in Kandahar (2014) and Jawzjan (2012);
  - MEDAIR in Kandahar (2016) and
  - InterSOS in Kandahar (2017)
- Rapid Nutrition Assessment reports by ACF in Panjshir (2015), Nangarhar (2018), Laghman (2017), Host, Gulan camp (2015), Kabul (2016), Helmand (2015, 2017), Ghor (2015, 2016).
- MUAC Survey Report by MEDAIR in Badakhshan (2011).
- Consultancy Report on Health and Nutrition, Caritas, October 2012.
- Strengthening Data and Programme Quality by Identifying Barriers and Bottlenecks to Enhance Effective Coverage of Integrated Management of Acute Malnutrition (IMAM) / Severe Acute Malnutrition (SAM) Services in Afghanistan, August 2017.
- A review of SAM management in Afghanistan: Lessons from 2013-2015, June 2016

National Nutrition and Food Security surveys, assessments and databases

- 2004 Afghanistan National Nutrition Survey, MoPH, Unicef, CDC, National Institute for Research on Food and Nutrition (INRAN) and Tufts University, 2004.
- 2010/11 Afghanistan Multiple Indicator Cluster Survey, UNICEF and Central Statistics Organisation, June 2012.

- Associated 2010/11 AMICS fact sheets on Water Sanitation, Reproductive Health, Child Protection, Child Health, Child Development, Child Mortality, HIV/AIDS, Literacy & Education, and Nutrition, undated.
- Drought Impact Emergency Food Security Assessment In Fourteen Affected Provinces Of Afghanistan Second Phase Report, November 2011.
- 2013 National Nutrition Survey report and associated provincial fact sheets and prevalence maps (wasting, stunting, underweight).
- 2013 National Nutrition Survey national presentation material
- Afghanistan Food Security Cluster Seasonal Food Security Assessment, 2017.
    - Seasonal Food Security Assessment April-June 2016
    - Seasonal Food Security Assessment May-June 2015
    - Seasonal Food Security Assessment May-July 2014
    - Seasonal Food Security Assessment July-September 2013
- 2015 Afghanistan Demographic and Health Survey, January 2017.
- 2010 Afghanistan Mortality Survey, November 2011.
- Afghanistan Living Conditions Survey 2013-2014. National Risk and Vulnerability Assessment, 2016.
- National Risk and Vulnerability Assessment 2011-12. Afghanistan Living Condition Survey, 2014.
- National Risk and Vulnerability Assessment 2007/8. A profile of Afghanistan, October 2009.
- Afghanistan Health Indicators Fact Sheet, March 2014.
- Afghanistan Nutrition Cluster Database of Nutrition Assessment Results (2014-2017), September 2017.
- AFG Nutrition Database, March 2017.

Immunisation, Health Promotion, Child and Adolescent Health and CBHC

- National Guidelines on Micronutrients (Prevention, Control and Treatment), March 2010.
- Community Based Health Care Strategy (2015-2020), October 2014.
- National Nutrition Communication Strategy 2015-2020, June 2016.
- End Malnutrition: Let Every Child Bloom. Module for the 2 Day Training of Village Volunteers under the Community Based Nutrition Program, May 2017.
- Pictorial Nutrition Monitoring and Promotion Card, April 2017.
- Community Nutrition Monitoring and Promotion Chart, April 2017.
- Community Based Nutrition Programme Child Nutrition Tracking Register, undated.
- CBNP Monitoring Report for Community Health Supervisors, undated.
- Community Based Nutrition Programme Monthly Health Post Pictorial Monitoring Report, undated.
- Seasonal Food Availability Calendar, undated.
- Various MoPH nutrition educational material translated into English
- End Malnutrition: Let Every Child Bloom. A Facilitators Manual for Training Nutrition Mobilizing Teams, June 2017.
- End Malnutrition: Let Every Child Bloom. Field Manual for Facilitators, June 2017.
- Community Based Nutrition Programme Nutrition Flipbook, June 2017.
- Community Case Management Charts for CHWs, December 2018.

BPHS and EPHS

- The Balanced Scorecard Report. Essential Package of Health Services, 2018. (KIT Royal tropical Institute, MoPH)
- The Balanced Scorecard Report, Basic Package of Health Services. November 2018
- The Balanced Scorecard Report, Basic Package of Health Services. August 2016
- The Balanced Scorecard Report. Afghanistan Hospitals, August 2016.
- Afghanistan Health Survey 2018, April 2019. (KIT, NSIA, MoPH)
- Performance Management Standard Operating Procedures For the Sehatmandi Project, June 2019.
- The Essential Package of Hospital Services for Afghanistan, July 2005.
- A Basic Package of Health Services for Afghanistan, July 2010.

- National Health Strategy 2016–2020. Sustaining Progress and Building for Tomorrow and Beyond, September 2016.
- National Reproductive, Maternal, Newborn, Child, & Adolescent Health (RMNCAH) Strategy 2017–2021, March 2017.

2. UN Agencies

WHO

- Regional strategy on nutrition 2010–2019 and Plan of action, 2011.

WFP

- WFP Food Security Assessment report, August 2011.
- Afghanistan country strategic plan (2018–2022), May 2018.
- Dataset of TSFP projects (Jan-Dec 2019)

UNICEF

- UNICEF Afghanistan Nutrition Programme Strategy Note (2017-2019), 2017.
- Humanitarian Action for Children 2020-2021. Afghanistan. 2020.
- Afghanistan, Zero Hunger Strategic Review, October 2017.
- Afghanistan Country programme document 2015-2019, September 2014.
- Management of Severe Acute Malnutrition in children: Working towards results at scale, 2015.
- Afghanistan Humanitarian Situation Report No. 3, January-December 2019.

OCHA

- Afghanistan Weekly Humanitarian Update, December 2019.
- Afghanistan Weekly Humanitarian Update, January 2019.
- Humanitarian Response Plan Afghanistan 2018 - 2021. 2020 Mid-year Revision, June 2020.

IPC

- Integrated Food Security Phase Classification Report #10, October 2018.

3. Humanitarian Coordination Mechanisms

Humanitarian Coordination Team

- Humanitarian Response Plan January-December 2017, November 2016.
- Humanitarian Response Plan 2018-2021, December 2017.
- Humanitarian Response Plan 2018-2021. Revised Financial Requirements due to Drought, May 2018.
- Humanitarian Response Plan 2018-2021. 2019 Update, December 2018.
- Humanitarian Response Plan 2018-2021. 2020 Revision, December 2019.
- 2016 Afghanistan Humanitarian Response Plan Nutrition Cluster Logframe, October 2015.
- 2016 Afghanistan Humanitarian Response Plan. Nutrition Cluster Beneficiaries, July 2016.
- 2017 Afghanistan Humanitarian Response Plan Nutrition Cluster Logframe
- 2018 Afghanistan Humanitarian Response Plan Nutrition Cluster Logframe with Budget
- 2017 Afghanistan Humanitarian Needs Overview. November 2017.
- 2018 Afghanistan Humanitarian Needs Overview. December 2017.
- 2020 Afghanistan Humanitarian Needs Overview. December 2019.
- 2019 Afghanistan Nutrition Cluster Annual Report, January 2020.
- Linking humanitarian, development and peace-building policies and programmes to improve nutrition in Afghanistan, Nutrition Exchange, April 2020.

National Nutrition Cluster

- Afghanistan Nutrition Cluster Bulletin, issue 3 Jan-Dec 2015, 2015.
- CHAP 2017 Vulnerability Analysis Framework, Nutrition Cluster, 2017.
- Nutrition Cluster Accountability of Affected Population Toolkit
- Afghanistan Nutrition Assessments Synthesis 2015-2018.

- Afghanistan Nutrition Cluster 2017 Annual Report, March 2018.
- Nutrition Cluster Situation and Response Dashboard, January-May, 2018
- Severity of Acute Malnutrition in Afghanistan map, December 2018.
- Nutrition Cluster Coordination Mechanisms Focal Points map, April 2018.
- Afghanistan Nutrition Cluster IMAM services 3W (WHO, WHAT, WHERE) map, October 2018.
- Afghanistan Nutrition Cluster IMAM services 3W (WHO, WHAT, WHERE) map, January 2018.
- Minutes for 9 Nutrition Cluster Coordination Meeting between January 2019-December 2019.
- Afghanistan Nutrition Cluster Coordination Performance Monitoring Final Report, October 2019.
- Afghanistan Nutrition Cluster Annual report 2019

4. External partners

World Bank

- Afghanistan: Sehatmandi Project (P160615) and Programmatic Advisory Service and Analytics Implementation Support Review, Aide Memoire, September-October 2018.
- Nutrition Implementation Support Mission Outputs, November 2018.
- Nutrition Implementation Support Mission Outputs, March 2019.

5. Academic articles and reports

- Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study, N. Akseer, et al., Lancet Global Health, 2016.
- Scale-up of IMAM services in Afghanistan, A. N. Qarizada, et al., ENN, 2018.
- International Conference on Nutrition – 20 Years Later (ICN+20), National Nutrition and Food Security Country Paper, FAO/WHO, 2012.
- Screening for maternal and child malnutrition using sentinel-based national nutrition surveillance in Afghanistan, A. Chinjekure, et al., ENN, 2018.
- Exploring the health system for sustainable and integrated acute malnutrition services applying a systems lens: the case of Afghanistan, Safi S. et al., International Journal of Integrated Care, 2018.
- Improving nutrition in Afghanistan through a community-based growth monitoring and promotion programme: A pre–post evaluation in five districts, M. Mayhew, et al., Global Public Health, 2014.
- Save the Children Children Of Uruzgan Final Evaluation Report, AMIN Consulting Group, November 2015.
- Hard to Reach Districts Assessments, REACH Afghanistan, July 2020.
- IMAM Service Implementation in Afghanistan: A Situation Analysis, Hedwig Deconinck, September 2017.
- End of Mission Report: Consultancy for Revising the Integrated Management of Acute Malnutrition Service Delivery Package for Afghanistan, Hedwig Deconinck, February 2018.

6.4. Annex 4: Key informants interviewed in Kabul

Name	Organization	Department	Role	Date of interview
Maureen Gallagher	UNICEF	Nutrition	Chief of Nutrition	17/02/2020
Ahmad Nawid Qarizada	UNICEF	Nutrition	Nutrition Specialist	19/02/2020
Said Yaqoob Azimi	UNICEF	Nutrition	Information management specialist (Nutrition)	19/02/2020
Nafisa Qani	UNICEF	Nutrition	Nutrition officer (Kabul)	27/02/2020
Bismillah Enayat	UNICEF	Nutrition	Nutrition officer (Jalalabad)	24/02/2020
Atiqulla Amira	UNICEF	Nutrition	Nutrition officer (Mazar Sharif)	23/02/2020
Muzlifa Khan	UNICEF	Nutrition	Nutrition officer (Kandahar)	18/02/2020
Beka Teshome	UNICEF	Nutrition Cluster	Cluster Co-lead	06/04/2020
Palwasha	UNICEF	IYCN team	CBNP coordinator	26/02/2020
Dr. Shams	WHO	Nutrition	Nutrition Officer	18/02/2020
Martin Ahimbisibwe	WFP	Nutrition	Chief of Nutrition	23/02/2020
Dr Elham	WFP	Nutrition	Nutrition Specialist	27/02/2020
Dr. Bawary	MoPH	IMAM TWG	IMAM TWG Chair / IMAM Officer	25/02/2020
Morsal Manati	MoPH	Public Nutrition Directorate	PND Director and chair of NPCC	25/02/2020
Hamed zia Dashti	MoPH	Public Nutrition Directorate	NiE officer	20/02/2020
Dr. Noorzad	MoPH	Grants and services contract management unit (GCMU)	GMCU nutrition focal point?	25/02/2020
Dr Mir Gul Halimi	MoPH	Nomad directorate	Nutrition Technical Officer	25/02/2020
Dr. Shaker Hadad	MoPH	RMNCH directorate	Project Manager	20/02/2020
Dr. Motawali	MoPH	Child and adolescent health department (IMNCI)	Head of IMNCI	20/02/2020
Shamilla	MoPH	Strengthening mechanism	SM Manager	20/02/2020
Lema Rasool	MoPH	Health promotion department	HP Officer	20/02/2020
Dr Ludin	MoPH	Sehatmandi	Senior Advisor for Sehatmandi (Former PND Director)	26/02/2020

Dr Ad Salam Bawarzay	OHPM	Paktika	M&E coordinator	25/02/2020
Dr. Lenet and Abdullah	ACF	Health and Nutrition Department	Head and Deputy Health and Nutrition department	27/02/2020
Dr. Mansoor	SCI	Health and Nutrition Department	Senior Health and Nutrition Advisor	16/03/2020
Dr. Shafiqullah Safi	FHI 360	Health and Nutrition Department	Former IMAM officer	26/02/2020
Dr. Sarah Safi	USAID	Health department	Project Management Specialist (Health)	24/02/2020
Dr. Habib Ahmadzai	World Bank	Health, Nutrition and Population sector	Health Specialist	24/02/2020

6.5. Annex 5: Summary of districts and health facility types visited

Province	District	RH	PH	DH	CHC	BHC	SHC	MHNT	Total facilities by province	Communities (Qualitative)	Communities (LQAS)
Kunduz	Dashte Archee				2				**7**	4	4
	Kunduz	1			1	2		1		4	4
Jowzjan	Khowaja di koh				1	1	1		**5**	4	4
	Aaqcha			1		1				2	3
Parwan	Chaharekar		1		1	2			**7**	4	4
	Bagram				1	2				4	4
Nangahar	Kot				1	2			**4**	4	4
	Shinwar			1						4	4
Herat	Herat	1						1	**7**		
	Ghoryaan			1		2				4	4
	Zindah Jan				2					4	4
Urozgan	TereenKot		1		1		2	1	**7**	2	2
	Chenartoo				1		1			4	4
Paktika	Orgun			1		2			**6**	4	4
	Sharan		1			1	1			4	4
GRAND TOTAL		**2**	**3**	**4**	**11**	**15**	**5**	**3**	**43**	**52**	**53**

RH: Regional hospital; PH: Provincial hospital; DH: District hospital; CHC: Comprehensive Health Centre; BHC: Basic Health Centre; SHC: Sub Health Centre; MHNT: Mobile Health and Nutrition Team

6.6. Annex 6: Summary of KII participants at provincial level

		NANGARHAR	PAKTIKA	HERAT	PARWAN	URUZGAN	JOWZJAN	KUNDUZ	**TOTAL**
PROVINCIAL STAKEHOLDERS									
PNO	F	0	0	0	0	0	1	0	**1**
	M	1	1	1	1	0	0	1	**5**
PNE	F	0	1	0	0	0	0	0	**1**
	M	1	0	0	0	0	1	1	**3**
CBHC coordinator	F	0	0	0	0	0	0	1	**1**
	M	1	1	1	1	1	1	0	**6**
BPHS/EPHS nutrition manager or officer	F	0	0	0	0	0	0	1	**1**
	M	1	0	1	0	0	0	1	**3**
IP nutrition manager	M	0	1	0	0	1	0	0	**2**
IP technical manager	M	0	1	0	0	0	0	0	**1**
Total		**4**	**5**	**3**	**2**	**2**	**3**	**5**	**24**
HEALTH FACILITY AND COMMUNITY OUTREACH STAFF									
Paediatrician	M	1	2	2	1	1	0	1	**8**
IPD nurse	F	1	1	1	1	0	1	0	**5**
	M	0	1	0	0	1	0	0	**2**
OPD nurse	F	2	0	1	0	0	0	0	**3**
	M	0	2	0	4	2	0	0	**8**
	U*	0	0	0	1	0	0	0	**1**
Nurse**/ midwife	F	0	0	1	0	0	2	4	**7**
	M	0	0	0	0	3	0	1	**4**
OPD doctor	M	3	2	3	4	1	1	2	**16**
Nutrition counsellor	F	1	2	2	2	1	6	4	**18**
	M	0	0	0	1	0	0	0	**1**
	U	0	0	1	0	0	0	0	**1**
CHW	F	0	0	5	0	0	4	6	**15**
	M	6	7	4	8	5	3	2	**35**
	U	1	0	0	0	0	0	0	**1**
CHS	F	0	0	1	0	0	0	3	**4**
	M	3	4	3	4	3	1	1	**19**
	U	0	0	0	0	0	1	0	**1**
Vaccinator	F	0	0	1	0	0	0	0	**1**
Doctor/CHC lead	M	0	0	0	0	1	1	3	**5**
Laboratory employee	M	0	0	1	0	0	0	0	**1**
Total		**17**	**21**	**26**	**26**	**18**	**20**	**27**	**156**
COMMUNITY MEMBERS									
Carer of case(s) enrolled in IPD SAM	F	0	1	0	1	1	1	1	**5**
	M	0	1	0	0	0	0	0	**1**
Carer of case(s) enrolled in OPD MAM	F	2	1	0	1	1	6	6	**17**
	M	13	2	0	0	0	1	3	**19**
	F	1	0	4	4	3	0	1	**13**

		NANGARHAR	PAKTIKA	HERAT	PARWAN	URUZGAN	JOWZJAN	KUNDUZ	**TOTAL**
Carer of case(s) enrolled in OPD SAM	M	6	1	1	0	0	0	0	**8**
Carer of case(s) enrolled in the programme***	F	19	1	35	41	19	21	47	**183**
	M	0	8	15	15	10	5	3	**56**
Community member with U5 children	F	6	8	4	0	0	5	7	**30**
	M	8	16	14	0	4	6	6	**54**
PLW enrolled in OPD MAM		3	4	0	4	0	3	0	**14**
PLW not enrolled in OPD MAM		26	14	0	10	0	15	0	**65**
Health Shura member	M	6	5	7	7	6	5	5	**41**
Imam	M	3	4	4	3	3	3	4	**24**
Village leader	M	5	3	4	4	3	1	4	**24**
FHAG member	F	4	2	2	2	0	0	0	**10**
	M	0	1	2	0	0	0	0	**3**
Total		**102**	**72**	**92**	**92**	**50**	**72**	**87**	**567**

6.7. Annex 7: Final data collection tools

Quantitative data collection tools

Data collection tool	Link
IPD Quality checklist	Adobe Acrobat Document
OPD quality checklist	Adobe Acrobat Document
PLW covered case questionnaire	Adobe Acrobat Document
PLW non covered case questionnaire	Adobe Acrobat Document
Children U5 covered case questionnaire	Adobe Acrobat Document
Children U5 non-covered case questionnaire	Adobe Acrobat Document
Summary sheet for LQAS coverage survey (U5)	Adobe Acrobat Document
Summary sheet for LQAS coverage survey (PLW)	Adobe Acrobat Document

Combined qualitative data collection tools:

Adobe Acrobat Document

6.8. Annex 8: Data collection report and Data collection Quality Assurance reports

Data collection report (prepared by Evaluation Team):

Adobe Acrobat Document

Data collection quality assurance report (prepared by data collection agency):

Adobe Acrobat Document

6.9. Annex 9: Community Based Health Care Strategy 2015-2020

Objective 1: To scale up CBHC services and initiatives to 90 % of uncovered and underserved areas in rural setting and 60% of poor urban and nomad population by 2020.

KI- 1*:* Increase coverage of community-based health care services in white areas in a rural setting, ensuring establishment of 6,000 Health Posts and 10,000 family health action Groups through basic package of health services implementer NGOs in close coordination with the MoPH Grant and Contract Management Unit (GCMU)

KI.2: Increase coverage of community based health care services for nomads through provision of technical support to the Nomad Health Directorate for the establishment of 1,000 health posts and health Shuras in nomad settings.

Objective # 2: To improve the quality of community based primary health care services at household level

KI.1: Strengthen the capacity of CBHC elements and related structures

KI.2: Ensure supportive supervision, monitoring visits and advocacy for the CBHC program

KI.4: Establish national, provincial and international networking of CBHC to exchange knowledge, share experiences, and identify best practices to be scaled up to other areas

Objective # 3: To empower communities to identify their own health needs and take initiatives to solve identified health problems

KI.1: Enhance active community participation through capacity development of the health shura members strengthen the relationship between health facilities and the communities, involving the community in decision making about their own health issues, promoting women's participation in the health system and mobilize community resources to support health programs

KI.2: Incorporate new initiatives/best practices with community based health care program at the country level

Indicators

Suggested key indicators that will allow tracking progress of the strategy implementation are:

1. Number of new health posts established during the last year
2. Number of new FHA Groups established during the last year
3. Number of new health posts established for Kuchi population in a year
4. Number of new CHWs trained in urban settings in a year
5. Number of Female CHSs recruited in line with set criteria in a year
6. Number of cities/provinces run CBHC program for poor urban setting in a year
7. Proportion of CHWs received need-based revised supply kit?
8. Proportion of health posts supervised by CHSs and other health facility staff on monthly bases
9. Number of health Shuras trained on Community Governance Guideline in a year
10. Number of Central CBHC team members included in MoPH Tashkeel in a year
11. Percentage of target provinces visited by the CBHC monitoring team in a year
12. Number of advocacy meetings conducted for up gradation of CBHC unit to directorate level or above in a year
13. Percentage of Afghan population receive door step quality CBHC services in a year
14. Percentage of Afghan population changed their health seeking behavior through CBHC interventions in a year

Authors note: Job description of CHW is from 2009. Does not include screening for acute malnutrition or provision of treatment services

6.10. Annex 10: Ministry of Public Health Strategy 2016-2020

Result 1: Enhanced, strengthened, and accountable health sector governance decisively instituted, with strong and visible leadership and evidence-based advocacy at all levels

- SR1.4 Improved public perception of the health sector and effective advocacy at the national and sub-national levels.

Result 2: Strengthened, expanded, and sustainable health system with well-functioning institutions

- SR2.3 Enhanced and effective multilevel stakeholders' (health and non-health) dialogue, coordination, and collaboration for health system strengthening.
- SR2.7 Strengthened financial management systems for improved program efficiency.
- SR2.8 Improved procurement system and supply chain management for quality and timely health services, goods, works, and products.

Result 3: Reduced preventable death, illness, and disability through provision of cost- effective, high impact, evidence-based public health interventions

- SR.1 Reduced incidence and prevalence of acute and chronic malnutrition. [Indicator result only targets reduction in stunting]
- SR3.2 Improved access and utilization of reproductive, maternal, neonatal, child, and adolescent health services.
- R3.4 Heightened advocacy and effective implementation of disability and physical rehabilitation services.
- R3.7 Empowered communities through health knowledge, skills and attitude, actions, supportive environment, and public health policies.
- SR3.9 Gender and human rights mainstreamed in all MoPH programs.

Result 4: Improved and expanded quality health services provided in an equitable and sustainable manner across all geographic areas and population groups through more effective and efficient use of existing resources, achieving better value for money

- SR4.1 Enhanced access to improved and updated quality BPHS and EPHS services. [Target 120 new public health facilities per year]
- SR4.2 Improved quality of and increased access to a wide range of tertiary services. [Indicator = patient satisfaction index. Target increase of 2.5% per year – baseline 73.9%]
- Strategic result 4.3 Improved pharmaceutical services management, ensuring increased access (physical accessibility, availability, affordability, and acceptability) and rational use [indicator = % of stock out of the essential medicines. Baseline 35% , 2020 target 10%]

Result 5: Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner

- Strategic result 5.2 Strengthened systems for effective Human Resource for Health (HRH) management [Proportion of health facilities with at least one female health worker baseline 65% target 85%]
- SR5.4 Health workforce capacity adequately developed based on health system needs. [% of MoPH Tashkeel employees completing related in- service trainings baseline 0% target 75%]

Result 6: Strengthened monitoring, evaluation, surveillance, health information, and an improved culture of learning and knowledge management, resulting in increased evidence-based decision making and practices at all levels of the health system

- SR6.1 Strengthened, effective, and visible MoPH governance of the health information system (research, evaluation, monitoring, HMIS, surveillance, and vital statistics).

- SR6.2 Operations and health systems research, monitoring, evaluation, vital statistics, HMIS, and surveillance actively supported including capacity building, and conducted, and associated findings and knowledge products effectively disseminated. [Number of provinces that monitor at least 90 percent of health facilities once in a year baseline 0 target 30/34]
- SR6.3 M&E frameworks and responsive surveillance systems developed, strengthened, and effectively used, leading to improved data collection, utilization, and dissemination at all levels.
- SR6.5 Improved culture of knowledge and evidence- based decision-making practices at all levels.

Health impact M&E framework

Indicator: Access to health within 2 hours: Baseline 91% target 96%

6.11. Annex 11: National Public Nutrition Strategy 2015-2020

Strategic objectives 2009-2013 integrated into 2015-2020 cycle:

Strategic Objective-3 (SO-3): To strengthen case management and increase access to quality therapeutic feeding and care at health facility and community levels

Strategic Objective-5 (SO-5): To monitor the nutritional situation in Afghanistan and strengthen the monitoring and evaluation of nutrition strategies and programs, in order to inform development planning and emergency responses

Strategic Objective-6 (SO-6): To ensure that responses to treat and prevent moderate acute, severe acute and chronic malnutrition are timely and appropriate, and that increases in Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) are effectively managed

The 2015-2020 Strategy and strategic results framework is indicated in the figures below. The strategic results framework has been edited to show relevant indicators for IMAM:

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GOAL: To reduce nutrition related mortality and morbidity and contribute to economic development of the nation

STRATEGIC OBJECTIVE: Timely use of high quality, evidence based nutrition specific and sensitive services throughout Afghanistan

INTERMEDIATE RESULT 1

Increased access to nutrition services and products

Sub IR1.1. Increased availability of essential nutrition services at public and private facilities

Sub IR 1.2 Improved availability of nutrition products

Sub IR 1.3 Strengthened community based nutrition services

INTERMEDIATE RESULT 2

Improved nutrition behaviours and practices of public

Sub IR 2.1: Improved knowledge of caretakers and community leaders/influencers on optimal nutrition behaviours

Sub IR 2.2 Increased awareness and engagement of media in promotion of optimal nutrition behaviours and products

Sub IR 2.3 Increased basic nutrition education for front line workers in health, education, agriculture

INTERMEDIATE RESULT 3

Improved quality of nutrition services and products

Sub IR 3.1 Strengthened capacity of service providers and facilities to deliver nutrition interventions

Sub IR 3.2 Improved performance monitoring of nutrition services

Sub IR 3.3 Improved quality assurance system for nutrition products

Sub IR 3.4 Strengthened nutritional status

INTERMEDIATE RESULT 4

Strengthened social, regulatory and political environment for nutrition

Sub IR 4.1 Strengthened the stewardship and governance role of MoPH in leading and coordinating multi-sectoral nutrition programs

Sub IR 4.2 Improved capacity to generate and use knowledge and evidence for nutrition programming and policy

Sub IR 4.3 Increased resources for nutrition

Sub IR 4.4 Strengthened nutrition policies,

Assumption:

Government and development partners remain committed;

Political, security situation remain stable;

Other sectors responsible for nutrition sensitive interventions remain cooperative

No major emergency or crisis occurred

Targets and Indicators

Results	Indicators	Baseline (2015)	Targets (2020)
GOAL: To reduce nutrition related mortality and morbidity and contribute to economic development of the nation	Child mortality rate	97 /1000 Live Birth	65/ 1000 Live Birth
STRATEGIC OBJECTIVE: Use of high quality, evidence based nutrition specific and sensitive services throughout Afghanistan	Stunting among children < 5 Anaemia among women of reproductive age	40.9 % 40%	35.9% 30%
INTERMEDIATE RESULT 1 **Increased access to and availability of nutrition services and products**	Treatment coverage for children <5 with acute malnutrition	34 %	80 %
INTERMEDIATE RESULT 2 **Improved nutrition behaviours and practices of public**	Use of minimum acceptable diet in children 6-23 months	16.3 %	40%
INTERMEDIATE RESULT 3 **Improved quality of nutrition services and products**	Service delivery points improved quality as per score card		
INTERMEDIATE RESULT 4 **Strengthened social, regulatory and political environment for nutrition**	Overall budget allocated for nutrition $US per year	21.7 M	

Strategic Framework

Strategic approach	Interventions areas	Illustrative Activities/evidence-based actions	Indicators
Ultimate outcome - Goal To reduce nutrition related mortality and morbidity and contribute to economic development of the nation			
Intermediate Results – 1 Increased access to nutrition services and products			
Sub Intermediate Results			
1.1 Increased availability of essential nutrition services at public and private facilities			
Essential Nutrition Actions (ENA) focused on the 1000 day window of opportunity	Infant and Young Child Feeding and Caring Practices	Provision of IEC materials to the Health facilities	*Number of health facilities supporting monitoring of national legislation on marketing of breast milk substitutes* *Proportion of health facilities with adequate nutrition IEC materials (a list of materials to be included as a check list)* *Proportion of health facilities with nutrition SOP guideline*
	Integrated management of acute malnutrition for under five children	Provide In-patient and Out-patient services for management of acute malnutrition	*Proportion of health facilities with no stock outs of nutrition treatment products in the last 3 months* *% of health facilities that provide IMAM (IPD-SAM, OPD-SAM and OPD-MAM)* *% of children 0 -59 months with acute malnutrition who were admitted for treatment (IPD-SAM, OPD-SAM and OPD-MAM) in the last 3 months* *Proportion of children 0 -59 months with acute malnutrition who did NOT default from IMAM programme (IPD-SAM, OPD-SAM in the last 3months*

			Proportion of children 0- 59 months with acute malnutrition who were cured IPD-SAM, OPD-SAM and OPD-MAM) in the last 6 months
	Maternal nutrition-pregnant and lactating mothers Integrated Management of acute malnutrition for pregnant and lactating women	Conduct skilled counselling and support for improved dietary intake for lactating women (Promotion of nutrient rich foods: eggs, milk, liver, pulses (beans, lentils, chickpeas) and fortified food (iodized salt, fortified wheat flour and oil) Provide supplementary foods to pregnant and lactating women according to the admission criteria on integrated management of acute malnutrition guidelines.	*Proportion of pregnant women reporting having received information and counselling on dietary diversity by a health worker* *Proportion of pregnant and lactating women with acute malnutrition who are receiving food supplements*
	Nutrition of sick children under five	Promotion use of food based dietary guideline developing and implementing nutrition protocols for sick children e.g. low birth weight, preterm etc.,	*Proportion of caregiver of sick infants aged 0-23 months who received IYCF counselling – feeding during illness from health workers*
Nutrition in the context of Emergency	Nutrition cluster coordination Nutrition assessment during emergency Management of acute malnutrition during emergency	Coordination with other active stakeholders in emergencies Conduct rapid nutritional assessment in emergency affected areas Monitor food safety of nutrition commodities for use in emergencies Screening and referral for acute malnutrition during emergencies Children and women with acute malnutrition access appropriate management services	*Number of cluster coordination meeting at national level* *Number of Provinces conducting regular cluster coordination meeting at provincial level* *Number of provinces with emergency response plan in place* *Number of RNA conducted in emergency affected areas*

	Access to Micronutrients from fortified foods , supplements or micronutrient preparations Infant and young child feeding (e-IYCF) accessed by affected women and children during emergency	Blanket, targeted food distribution & micronutrient supplementation, as appropriate in emergencies Provide vitamin A deworming to children under 5 in the emergency affected areas Provision of micronutrient powder for children under 5 in the emergency affected areas. Providing education and skilled counselling and support on infant and young child feeding at health facility level Support monitoring of national regulation of marketing of breast milk substitute	*Number of children screened and referred for acute malnutrition during emergencies* *Proportion of children 0 -59 months with acute malnutrition who were admitted for treatment (IPD-SAM, OPD-SAM and OPD-MAM) during emergencies* *Proportion of children & women with acute malnutrition who were admitted for treatment (OPD-MAM) during emergencies* *Number of beneficiaries received Blanket, targeted food distribution & micronutrient supplementation, as appropriate in emergencies* *Number of 6-59 months received vitamin A and deworming in the emergency affected areas* *Number of children 6-59 months received micronutrient powder for children in the emergency affected areas.* *Proportion of caregiver of infants aged 0-23 months who received IYCF counselling in the emergency affected areas* *Number of violation against National Regulation on Promotion and Support of child feeding with breast milk reported during emergencies*
1.2 Improved availability of nutrition products			

Supply chain management for all nutrition products	Provision of therapeutic food for treatment of acute malnutrition Support secure delivery chain of critical supplies	Developing standard operation producers for supply chain management Procure and distribute essential nutritional commodities (micronutrient supplements, MNP for home fortification, therapeutic milks and foods) and equipment (anthropometric and others) as per the SOP Establishing systems to support the procurement, storing and delivery of critical supply such as therapeutic food etc	*% of health facilities with no stock-out of nutrition products for treatment of acute malnutrition among children under five*
1.3 *Strengthened community based nutrition*			
Community outreach for essential nutrition actions focussed on 1000 days window	Community based Infant and Young Child Feeding and Caring Practices	Providing community support on infant and young child feeding through CHW, family action groups, shuras etc. Provide community support for appropriate complementary feeding through CHW, family action groups, shuras etc. Provision of IEC materials to the health post/ CHW) Promoteproper hygiene practices, and timely seeking of health care.	*Proportion of health post/CHW reporting having had no stock-outs of MUAC tapes* *Proportion of health post/CHW with adequate materials/job aids/counselling cards etc. to promote optimal IYCF practices and handwashing with soap at community level*
	Management of acute malnutrition	Community mobilization for integrated management of acute malnutrition Conduct active screening, referrals and follow up of malnourished children by CHW Recipes for locally available food for treatment of MAM and prevention of SAM	*Number of health posts providing management of acute malnutrition for children under five*

Promote Innovations in provision of nutrition services	Request for applications on innovative approaches	Use new technology e.g. Rapid SMS to communicate information on referrals between community-level workers and facility to minimize the need for additional facility visits by community workers.	*Number of children referred-in with acute malnutrition from communities*
Intermediate Results – 2: Improved nutrition behaviours and practices of public			
Sub Intermediate Results			
2.1: Improved knowledge of caretakers and community leaders/influencers on optimal nutrition behaviours			
Community-centred approach that empowers communities with knowledge and tools to address their own nutrition issues	proper feeding during and after illness for children	Develop adapt and disseminate harmonised IEC/BCC material on Nutrition in 1000 Days (Job aids, booklets, brochures, wall charts) Conduct community growth monitoring and promotion as apart of collective accountability on nutrition at community level	*Number of community gathering session conducted by CHW*
Interpersonal and peer to peer counselling Supporting Family Health Action Groups to focus on nutrition			*% of family health action group conducted in community*
2.2 Increased awareness and engagement of media in promotion of optimal nutrition behaviours and products			
Mobilize mass and community media to play leading advocacy and information dissemination role for nutrition and care during the first 1000 days of life, through mass communication and campaigns	Awareness creation on maternal and child nutrition through mass media using	Using media free times to promote nutrition messages Conduct mass media campaigns both at National media and local stations (TV spots, Radio spots, documentary, billboards) on key themes of nutrition in the first 1000 days of life (Pregnant women, Lactating Mother, Children 0-6months, Children 6-23Monhts)	Number of Mass media and below the line campaigns conducted on nutrition during first 1000 days Number of media executives and media producers oriented and trained on nutrition first 1000 special days campaign

			Number of TV spots, radio spots, documentary and billboards including unifying logo/branding for nutrition first 1000 special days campaigns disseminated and aired
Intermediate Results 3: Improved quality of nutrition services and products			
Sub-Intermediate Results			
3.1 Strengthened capacity of service providers and facilities to deliver nutrition interventions			
- Nutrition to be recognized as core competencies of health providers - Update nutrition knowledge and competencies of health care providers	- In-service training - Pre-service nutrition education - Accredited degree education in public nutrition - Creating positions within the health system that require a nutrition certificate - Strengthen the capacity and role of PND within MoPH	- Conduct initial and refresher trainings BPHS/EPHS personnel - Create a system of mandatory training on nutrition as a continues education program for health professionals - Include Nutrition in Nursing, midwifery and physicians curricula - Increase number of nutrition officers in sub national/facility level - Establish training tracking database within PND - Advocate to strengthen the role of PND within MoPH - Develop and update nutrition guidelines and SOPs	# of health personnel received in-service training # of public and private institutes/universities included nutrition curricula in their system # of staff obtained a post graduate diploma or degree on nutrition # of nutrition officers positions filled at the sub-national/ facility level # of guidelines developed and updated
3.2 Improved performance monitoring of nutrition services			
- Involvement of MoPH different departments - Innovative approaches - Strengthening M&E system	- Establishing service delivery of ENA quality standards - Performance improvement system in MoPH - Community involvement in monitoring especially in areas with insecurity - Use of technology to monitor activities	- Conduct joint monitoring with M&E and GCMU in monitoring nutrition services - Develop, update and apply monitoring checklists, reporting forms and feedback system - Create communication/feedback mechanisms between facility and community-level through periodic meetings and supportive supervision - Include and update nutrition indicators in the national monitoring checklist and third party evaluations	*# of monitoring visits conducted* *% of improvement in performance based on monitoring follow up*

3.3 Improved quality assurance system for nutrition products			
Focus on special foods with claims of additional nutrition value (fortified food, ready to use complementary food, therapeutic food)	- Developing Standards, regulations and quality assurance monitoring system - Involving multi-sectoral stakeholders	- Develop food fortification regulation - Develop guidelines on quality assurance of nutrition products - Monitor fortified foods standards Monitor quality and safety of nutrition products (special foods i.e. fortified food, complementary food)	*FF regulation endorsed* *# of guidelines developed for quality assurance of nutrition products* *% of special food samples certified based quality assurance standards*
3.4 Strengthened nutritional status monitoring and surveillance system			
- Facility and community based sentinel site surveillance (non-probabilistic) - Population based probabilistic surveys	- Maintain and strengthen nutrition surveillance system - Conduct small scale population based surveys - Disseminate reports of surveys for decision making and programmatic use	Refresher training of staff on nutrition surveillance, updating guidelines, distributing data collection tools and equipment Conducting population based surveys Disseminate surveys reports	*# of bulletins generated from Nutrition Surveillance system* *# of small scale surveys conducted* *# of events conducted for dissemination and advocacy*
Intermediate Results – 4: Strengthened social, regulatory and political environment for nutrition			
Sub-Intermediate Results			
4.1 Strengthened the stewardship and governance role of MoPH in leading and coordinating multi-sectoral nutrition programs			
Involving the leadership of sectors to support the follow up actions taken by technical levels	- AFSANA/ NAF - NPCC - National board of Fortified food - National committee on BMS code - SUN movement	- Advocate for activation of high level steering committee of AFSANA - Lead NAF sub-committee meetings - Strengthen NPCC meetings - Establish/Strengthen national board of FF - Strengthen National committee on BMS code - Enrol Afghanistan in SUN movement - Conduct joined multi-sectoral monitoring and assessment of nutrition programs	*# of AFSAN high level steering committee meetings* *# of NAF meetings chaired by MoPH* *# of NPCC meetings chaired by PND* *% coverage of use of fortified food at household level* *# BMS code violations monitored and followed up* *# of joined monitoring with multi-sectoral body*
4.2 Improved capacity to generate and use knowledge and evidence for nutrition programming and policy			
Culture and ability to use data for decision making	- Applied research - Evaluation of projects	- Establish Nutrition institute - Establish collaboration with a similar institute	*# of studies conducted* *# of events for dissemination of the results of studies*

Generating evidences for scaling up and advocacy	- Use of Secondary data for knowledge generation in nutrition	- Conduct evaluation of pilot and innovative activities - Conduct applied researches - Conduct secondary analysis of existing data on nutrition and interpret findings - disseminate findings for decision making	*# of reports generated/ published*
4.3 Increased resources for nutrition programs			
advocacy and supporting national champions	- National budget line for nutrition in the government budget - Continuous advocacy with the international development partners	- Advocacy with the policy makers and high level decision makers at the government and donors community - Design long term nutrition projects for funding through MoF/Donors - Develop/disseminate an estimate of benefit-to-cost ratio of feasible large-scale public nutrition interventions	*# of advocacy meetings conducted* *# of nutrition projects designed* *% of nutrition fund allocated by the government increased* *% of nutrition fund allocated by donors increased*
4.4 Strengthened nutrition policies, standards and regulations			
Evidence-based, Inclusive, Follow up	- Institutional and human capacity building,	*- Conduct need assessment*	*# of nutrition policies, standards and regulations developed/amended* *% of improvement in implementation of standards/ regulations*

6.12. Annex 12: National Nutrition Communication Strategy

Optimal Behaviour	Current Behaviour/Practice	Key Barrier	Key Facilitator
Key optimal behaviour 1: early case detection of acute malnutrition cases in community by health workers and community elders.	In most areas community is not involved in active case findings, most of the cases normally detect by HFs when parents bring their children to receive medical services for other medical complications.	Due to low awareness of community regarding malnutrition most of the cases come to HFs in severe form, and early case detection is very rare.	Community is not well informed regarding malnutrition, consequences of malnutrition, and early case findings, so they assume that malnutrition should be treated by medicine and some time the term of malnutrition assume as body normal adaption and hereditary problems
Key optimal behaviour 2: referral of malnutrition cases by community to HFs for proper treatment and follow up of malnutrition cases by community during and after treatment.	Community is not involved in case detection referral and follow up of acute malnutrition, and children has been taken by parents to HFs for treatment seeking without primary contact with community health workers.	Low awareness of community health workers and community elders for proper case findings, referral follow up of under treatment children for trend of growth and getting improvement.	To improve knowledge of community health workers and community elders to properly refer the children after first contact with them, as well by having proper knowledge they will follow the children who are in under treatment to make sure that parents strictly follow guidance which are provided by HF worker for treatment of their children. To improve knowledge of parents regarding malnutrition and change their perception for recognizing of malnutrition, they should know that malnutrition is not body adaption and hereditary problem

Key optimal behaviour 3 All parents know the proper feeding of children in different ages and illnesses, and for any negative changes in children growth they contact HFs to receive relevant counselling to prevent malnutrition in their children	i. The parents feed their children like adults and they do not focus on feeding of children in different ages and health condition. ii. The parents assume that negative growth changes happening due to heredity specification, as well they think that these changes are physiological.	The parents of the children are not fully informed regarding feeding of their children with local available food resources, meanwhile they do not know the difference of children feeding in different stages of life and during illnesses.	.Parents should be informed by different communication means to know proper feeding of their children by using of local available food resources, if their children find any signs and symptoms of malnutrition should be taken to HF by parents for treatment.
Key optimal behaviour 4 Acute malnourished children have been taken by parents for treatment to HFs at early stage of disease and continue the treatment until their children become healthy.	Parents do not pay attention to negative changes in growth of their children which are primary stage of acute malnutrition. In most of the time parents take their children to traditional healers for treatment of malnutrition. when the children do not get improvement with these treatments as last option, they bring children to HFs which is the severe stage of disease.	Parents are not fully informed regarding signs and symptoms of malnutrition, and seeking relevant services for treatment of their children to get improvement. parents cannot determine the malnutrition signs and symptoms in early stage, and for services seeking instead of health facility they go to traditional health providers for treatment of children.	The knowledge of care takers should be increased through different communication tools to recognize signs and symptoms of malnutrition on early stage and seek the proper treatment.

6.13. Annex 13: Results from quality checklists completed in IPD IMAM wards

Quality standard	Definition	Result
Availability of required human resources	% of facilities with required staff for nutrition services (based on IMAM guidelines 2018)	44%
Availability of key documents	% of facilities with copy of IMAM guidelines available on ward	78%
	% of facilities with flowchart of operational guidelines available on ward	78%
	% of facilities with IYCF guidelines available on ward	78%
	% of facilities with breastfeeding counselling guidelines available on ward	89%
IMAM training	% of facilities where paediatricians had participated in IMAM training	45%
	% of facilities where IPD Nurses had participated in IMAM training	100%
	% of facilities where IMAM training (initial or refresher) had taken place within the previous 12 months	78%
IYCF training	% of facilities where at least one staff member was trained on IYCF	100%
	% of facilities where **more than one** staff member had been trained on IYCF	33%
Equipment	% of facilities with functional MUAC tapes	100%
	% of facilities with functional scales	100%
	% of facilities with functional height board	100%
	% of facilities where **no** errors were observed in use of equipment	89%
	% of facilities with weight for height tables (WHO 2006 growth standards)	100%
Knowledge and adherence to protocols	% of facilities where **no** errors were given in admission criteria	89%
	% of facilities where **no or minor** errors were made in calculation of F75 calculation	33%
	% of facilities where **no or minor** errors were made in calculation of F100 calculation	33%
Stock availability and storage	% of facilities without >3 months stock break of F75 in previous 12 months	100%
	% of facilities without >3 months stock break of F100 in previous 12 months	100%
	% of facilities without >3 months stock break of RUTF in previous 12 months	100%
	% of facilities with storage facilities meeting all criteria of SCM SOP	22%

6.14. Annex 14: Results from quality checklists completed in OPD IMAM wards

Quality standard	Definition	Result
Availability of required human resources for IMAM	% of facilities with required staff for delivery of IMAM services (based on IMAM guidelines 2018)	59%
	% of BHCs with required staff for IMAM services (14 visited)	64%
	% of MHNTs with required staff for IMAM services (2 visited)	50%
	% of SHCs with required staff for IMAM services (4 visited)	75%
	% of CHCs with required staff for IMAM services (10 visited)	100%
	% of DHs with required staff for OPD SAM / MAM services (4 visited)	25%
	% of PHs with required staff for OPD SAM / MAM services (4 visited)	0%
	% of PHs with required staff for OPD SAM / MAM services (2 visited)	0%
Availability of key documents	% of facilities with copy of IMAM guidelines available in facility	67%
	% of facilities with flowchart of operational guidelines available in facility	59%
	% of facilities with IYCF guidelines available in facility	69%
	% of facilities with breastfeeding counselling guidelines available in facility	74%
IMAM training	% of facilities where OPD doctor has participated in IMAM training	43%
	% of facilities where OPD nurse has participated in IMAM training	46%
	% of facilities where nutrition counsellor has participated in IMAM training	46%
	% of facilities where midwife has participated in IMAM training	30%
	% of facilities where CHS has participated in IMAM training	19%
	% of facilities where IMAM training (initial or refresher) had taken place within the previous 12 months	71%
IYCF training	% of facilities where at least one staff member has been trained on IYCF	68%
	% of facilities where **more than one** staff member has been trained on IYCF	29%
Equipment	% of facilities with functional MUAC tapes for children under 5	97%
	% of facilities where **no** errors were observed in use of MUAC tape on children U5	87%
	% of OPD MAM facilities with functional MUAC tapes for PLWs	93%
	% of facilities where **no** errors were observed in use of MUAC tape on PLW	93%
	% of facilities with functional scales	100%
	Correct use of scales demonstrated	92%
	% of facilities with functional height board	100%
	% of facilities where correct use of height boards was observed	92%
	% of facilities with weight for height tables (WHO 2006 growth standards)	66%
Knowledge and adherence to protocols	% of facilities where **no** errors were provided in admission criteria for children to OPD SAM	79%
	% of facilities where **no** errors were provided in admission criteria for children to IPD SAM	72%
	% of facilities where **no** errors were provided in admission criteria for OPD MAM (children and PLWs)	97%
	% of facilities where **no or minor** errors were made in calculation of sachets of to distribute to SAM child (weight 5.2kg)	74%
	% of facilities where **no or minor** errors were made in calculation of sachets of to distribute to SAM child (weight 8.6kg)	56%
	% of facilities where discharge criteria had been recorded for **all** cases discharged from OPD SAM more than 3 months prior to visit	51%
Stock availability and storage	% of months out of previous 12 months with full stock availability of RUTF	96%
	% of months out of previous 12 months with full stock availability of RUSF	79%
	% of months out of previous 12 months with full stock availability of Supercereal	70%
	% of facilities with storage facilities meeting all criteria of SCM SOP	30%

6.15. Annex 15: Programme coverage: targets vs achieved during evaluation period

	SAM (IPD+OPD)				
	Burden	Target new admissions	Target %	Achieved new admissions	Achieved %
2014	517596	98900	19%	100150	101%
2015	517596	155279	30%	160160	103%
2016	423520	171770	41%	201470	117%
2017	593681	237472	40%	245071	103%
2018	544523	271400	50%	282563	104%
2019	577929	289738	50%	308545	106%
	MAM U5				
	Burden	Target new admissions	Target %	Achieved new admissions	Achieved %
2015		140309		155730	111%
2016	764021	254743	33%	199018	78%
2017	739408	295763	40%	178317	60%
2018	1081363	423545	39%	160118	38%
2019	1214984	485993	40%	323832	67%
	MAM PLW				
	Burden	Target new admissions	Target %	Achieved new admissions	Achieved %
2014					
2015		105342		177183	168%
2016		213502		261272	122%
2017	395859	158344	40%		
2018	443063	177225	40%		
2019		191257			0%

6.16. Annex 16: List of percentages and corresponding N values

Section	Statement	%	corresponding value
3.1.3	Outpatient facilities provided physical access for people with disabilities	85%	33
3.2.1.	Carers and PLWs across all provinces who were receiving treatment from IPD SAM, OPD SAM or OPD MAM who were generally satisfied with the programme	80%	220
3.2.1.	PLWs interviewed who were in the OPD MAM programme that had a very positive view of the programme overall	85%	10
3.2.1.	Carers of children aged 6-59 months who were in the OPD MAM or OPD SAM programme and had a positive view of the programme	73%	183
3.2.1.	Carers and PLWs in Parwan who said that their communities were very satisfied with the programme	86%	57
3.2.1	Carers and PLWs who stated they believe treatment products are effective at helping children and PLWs recover and feel better	81%	160
3.2.1.	PLWs enrolled in IMAM who reported shortages	100%	14
3.2.1.	Carers with children in OPD SAM or MAM cases who reported product shortages	87%	144
3.2.1.	Carers and PLWs reported waiting times of an hour or more	61%	91
3.2.1.	PLWs and carers of U5 children in the programme reporting poor behaviour from staff	40%	84
3.2.1.	Within PLWs and carers of U5 children in the programme reporting poor behaviour from staff, PLWs and carers of U5 children in the programme reporting rudeness or aggressiveness	64%	54
3.2.1.	Within PLWs and carers of U5 children in the programme reporting poor behaviour from staff, PLWs and carers of U5 children in the programme reporting preferential treatment	22%	19
3.2.1.	Within PLWs and carers of U5 children in the programme reporting poor behaviour from staff, PLWs and carers of U5 children in the programme reporting negligence or lack of information	19%	16
3.2.1.	Carers living in the province of Kunduz who had a negative view of staff behaviour	36%	13
3.2.1	Carers who said they had not taken their child to the health facility due to witnessing stock breaks during previous visits or because they "do not know someone in the health facility"	43%	6
3.2.1.	PLWs and carers with U5 children in the IMAM who understood the programme's purpose	55%	122
3.2.1.	PLWs and carers of U5 children who had limited awareness of the programme purpose	37%	82
3.2.1.	Health facility staff interviewed who reported being confronted with carers who mistakenly demanded to receive treatment products despite their children not suffering from acute malnutrition	10%	8
3.2.1.	PLWs and carers across all provinces who said that they had participated in nutrition education sessions	47%	141
3.2.1.	Health Shura members, imams and village leaders who reported that sessions take place in their communities	83%	63
3.2.1.	Health Shura members, imams and village leaders who reported that sessions take place at irregular intervals	50%	19
3.2.1.	Health Shura members, imams and village leaders who reported that sessions take place monthly or less frequently	55%	21
3.2.2.	Facilities that had expired stock of F75	11%	1
3.2.2.	Facilities that had expired F100	11%	1
3.2.2.	Facilities that had expired RUTF	11%	1

3.2.2.	Health facilities that reported RUTF shortage of at least 1 month in the previous 12 months	45%	39
3.2.2.	Health facilities that reported RUSF shortage of at least 1 month in the previous 12 months	90%	19
3.2.2.	Carers of U5 children in the OPD programme who reported that there had been shortages of stock while their child had been enrolled in the OPD SAM or MAM programme.	87%	199
3.2.2.	Carers in Herat who reported shortages	50%	10
3.2.2.	Carers who reported shortages in Parwan	89%	40
3.2.2.	Carers who reported shortages in Kunduz	50%	34
3.2.2.	Carers who reported shortages in Jowzjan	76%	16
3.2.2.	Carers who reported shortages in Urozgan	92%	34
3.2.2.	Carers who included more details about frequency of shortages and reported that they happen often	84%	70
3.2.2.	Carers who mentioned health facility stock shortages as one of the main challenges they faced when providing care for their children	15%	41
3.2.2.	Carers of U5 children in OPD who stated that they share their children's treatment products	14%	9
3.2.2.	Carers of U5 children in OPD who stated that they had seen the treatment products sold in the market	47%	27
3.2.2.	Carers of U5 children in OPD who stated that they had seen the treatment products sold in the market and who said that health facility staff recommended they source treatment products from outside of the clinic due to shortages.	59%	19
3.2.2.	Carers of U5 children in OPD who stated that they had seen the treatment products sold in the market and who stated they saw health facility workers selling the products at the market.	25%	8
3.2.2.	Carers who said doctors asked them to purchase products from private pharmacies or to the bazaar.	10%	22
3.2.2.	PLWs who said doctors asked them to purchase products from private pharmacies or to the bazaar.	10%	1
3.2.2.	Carers who reported receiving treatment products monthly instead of weekly or bi-weekly	27%	17
3.2.2.	Carers who reported they received varying amounts from one visit to the next	30%	19
3.2.2.	Carers who stated, unprompted, that they had gone to private health facilities due in part to frequent shortages taking place at government facilities.	3%	8
3.2.2.	PLWs who stated, unprompted, that they had gone to private health facilities due in part to frequent shortages taking place at government facilities.	8%	1
3.2.2.	Health facility workers and community outreach staff who discussed stock breaks as a challenge	26%	11
3.2.2.	Carers who mentioned poverty as one of the main challenges to providing care.	75%	203
3.2.2.	Carers who said yes when asked whether they knew carers in their community who had defaulted on the programme	75%	41
3.2.2.	Carers who mentioned that they knew carers who had stopped attending the OPD programme because of shortages, or that they themselves had defaulted for this reason	58%	24
3.2.2.	Carers who said that there were malnourished U5 children who did not attend the programme in their community	60%	151

3.2.2.	Among carers who said that there are malnourished U5 children not in IMAM in their community, carers who said that carers did not join the programme because of stock shortages.	30%	48
3.2.2.	Health facility and community outreach workers who stated that shortages contributed to defaulting rates.	21%	9
3.2.2.	Among PLWs who stated that there are other malnourished PLWs in the community who are not in the OPD programme, PLWs who said that the reason they have not tried to get into the programme is that they expect products to be unavailable.	40%	3
3.2.2.	Among PLWs who stated that there are other malnourished PLWs in the community who are not in the OPD programme, PLWs who did not mention shortages as a reason they defaulted	42%	5
3.2.2.	Health workers and community outreach staff who mentioned that stock breaks were a barrier to access	4%	4
3.2.2.	Health workers who presumed rationing of products by health facility workers for their own friends and family	4%	3
3.2.2.	Community outreach staff who presumed rationing of products by health facility workers for their own friends and family	2%	2
3.2.3.	Paediatricians who reported receiving no IYCF training	89%	8
3.2.3.	Facilities where IYCF guidelines were available	78%	7
3.2.3.	Hospitals not staffed with nutrition counsellors	44%	4
3.2.3.	Facilities that met minimum staff requirement for IMAM	59%	23
3.2.3.	Other health facility staff mentioned that nutrition counsellors had greatly improved the capacity challenges.	30%	6
3.2.3.	Facilities where NCs are responsible for admitting and discharging children from the OPD programme	21%	8
3.2.3.	Facilities where NCs were recorded as the only staff member responsible for recording the anthropometric details of children	49%	18
3.2.3.	facilities with OPD IMAM services that had benefitted from IMAM trainings within the previous 12 months	71%	24
3.2.3.	CHSs confirming that they had been trained on IMAM	19%	7
3.2.3.	Facilities where at least one staff member had received IYCF training	68%	26
3.2.3.	Facilities where more than one staff member had received IYCF training	29%	11
3.2.3.	Facilities where exit criteria for cases admitted more than three months prior to the visit was missing from registers	70%	18
3.2.3.	OPD SAM cases admitted to the programme based on WFH Z-score	7%	161
3.2.3.	Health facilities where a significant number of the required fields were not completed on the first page of the treatment cards	50%	3
3.2.3.	Facilities that did not have weight and health tables	44%	13
3.2.3.	Hospital locations where opinions on stock issues differed	50%	2
3.2.3.	IPD facilities that provided appropriate and adequate storage facilities and monitoring of nutrition products.	56%	9
3.2.3.	OPD facilities that provided appropriate and adequate storage facilities and monitoring of nutrition products.	30%	8
3.2.3.	Storerooms that lacked thermometers	47%	14
3.2.3.	Storerooms that showed evidence of animal droppings or insects	43%	13
3.2.3.	Health facility staff and CHWs interviewed in Kunduz stating they had never been trained on IMAM	64%	17
3.2.4.	Facilities visited in Kunduz that had reported OPD SAM cure rates of 99% or 100% in 2019	83%	5

3.2.4.	National NNGOs from NNC who attend the monthly national nutrition cluster meeting	30%	10
3.2.4.	Provinces where PNOs or PNEs stated that NNGOs were often absent from Provincial Nutrition Committee meetings or sent inappropriate representatives	43%	3
3.2.4.	Implementing partners who described coordination mechanisms positively	86%	6
3.2.4.	Implementing partner nutrition focal points who stated that absence at meetings undermined the effectiveness of coordination.	40%	9
3.2.4.	Provincial nutrition officers, extenders and BPHS/EHPS coordinators who described systematic collection and use of data.	70%	5
3.2.4.	IPD facilities where the IP Nutrition officer had visited during the last 12 months	33%	3
3.2.4.	OPD facilities where the IP Nutrition officer had visited during the last 12 months	41%	16
3.2.5.	Districts reported as achieving 100% or more SAM 'coverage'.	27,30%	21
3.2.5.	Districts reported as achieving 100% or more SAM 'coverage' with corrected estimates of annual caseload that include estimates of combined MUAC and WHZ burdens	5,20%	4
3.2.5.	Districts that achieved the target for 50% of all children to access SAM treatment	21,50%	17
3.2.5.	Districts covered during coverage surveys assessing the treatment coverage of OPD SAM services over the evaluation period	21%	86
3.2.5.	Provinces covered during coverage surveys assessing the treatment coverage of OPD SAM services over the evaluation period	62%	21
3.2.5.	Villages where treatment coverage of acute malnutrition services for children under 5 was high	60%	18
3.2.5.	Villages where treatment coverage of acute malnutrition services for children under 5 was moderate	22%	7
3.2.5.	Villages where treatment coverage of acute malnutrition services for children under 5 was low	22%	7
3.2.5.	Villages where treatment coverage of OPD MAM programmes for PLWs was high	36%	12
3.2.5.	Villages where treatment coverage of OPD MAM programmes for PLWs was moderate	18%	6
3.2.5.	Villages where treatment coverage of OPD MAM programmes for PLWs was low	45%	15
3.2.5.	Provinces that reported cure rates less than 75%	31%	9
3.2.5.	Provinces that failed to meet the target cure rate for SAM treatment (85%)	56%	19
3.2.5.	Provinces where OPD SAM default rates exceeded 15%	41%	14
3.2.5.	Provinces reporting default rates of 25% or higher	40%	10
3.2.5.	Facilities recording median MUACs at admission of 11cm or less	62%	21
3.2.6.	Health facility staff in all provinces visited who stated that patient numbers were problematically high or conversely, workforce numbers were insufficient	75%	32
3.2.6.	Outpatient doctors who stated that patient numbers were challenging and affected their motivation	55%	6
3.2.6.	Midwives who stated that patient numbers were challenging and affected their motivation	100%	7
3.2.6.	Outpatient nurses who stated that patient numbers were challenging and affected their motivation	83%	5
3.2.6.	Inpatient nurses who stated that patient numbers were challenging and affected their motivation	60%	3

3.2.6.	Nutrition counsellors who stated that patient numbers were challenging and affected their motivation	100%	3
3.2.6.	Inpatient doctor who stated that patient numbers were challenging and affected their motivation	100%	1
3.2.6.	Vacancies in outpatient facilities	5,20%	11
3.2.6.	Health facility staff asked who stated that they received supervision from key focal points.	85%	57
3.2.6.	Health facility staff asked who explicitly stated that they required more supervision	17%	12
3.2.6.	IPD Nurses who stated that they didn't receive any supervision at all.	58%	7
3.2.6.	Nutrition counsellors who stated they did not feel that the supervision they received was sufficient	42%	8
3.2.6.	Nurses in inpatient facilities who felt they received sufficient supervision	83%	6
3.2.6.	Doctors in outpatient facilities feeling well supervised	78%	14
3.2.6.	Midwives who stated that they received supervision	71%	7
3.2.6.	Midwives who stated they did not feel that the supervision they received was sufficient	15%	1
3.2.6.	CHWs and CHS' that were asked about the amount of supervision who received regular or some supervision	91%	64
3.2.6.	CHWs and CHS' that were asked about the amount of supervision who received regular supervision	85%	60
3.2.6.	CHWs and CHS' that were asked about the amount of supervision who received some supervision	6%	4
3.2.6.	CHWs and CHS' who were asked and said they received enough or some training	76%	61
3.2.6.	CHWs interviewed across 40% of provinces who mentioned that their associated facilities experience stock breaks.	33%	9
3.2.6.	CHWs who said they sometimes experienced refusals but with support from village elders they always managed to convince community members	50%	5
3.2.6.	CHWs who never faced refusals	30%	3
3.2.6.	CHWs who experiences frequent refusals	20%	2
3.2.6.	CHWs who did not conduct any screening of children or PLWs in the community	4%	3
3.2.6.	CHWs who used MUAC tape to carry out screening, as well as scales and height boards in some cases for screening	78%	59
3.2.6.	CHWs who described only having MUAC tapes available.	20%	10
3.3.1.	Districts with OPD SAM services by 2019	99%	403
3.3.1.	Health facilities with OPD SAM services by 2019	72%	1422
3.3.1.	Provinces where there were fewer active facilities in 2019 than in 2013	9%	3
3.3.1.	Health facilities with OPD MAM services by 2019	38%	744
3.3.2.	Admissions reported by MHNTs for OPD SAM for children U5	1,80%	5091
3.3.2.	Admissions reported by MHNTs for OPD MAM for children U5	3,70%	11964
3.3.2.	Carers and PLWs who stated they lived more than 2 hours walk from the nearest health facility	50%	46
3.3.2.	LQAS survey respondents who said that they lived more than one hour's walk from the nearest health facility.	28%	60
3.3.2.	Non-covered cases who cited inaccessibility due to distance as the primary reason for non-attendance to the health facility	17%	23
3.3.3.	Health facility workers who described frequent incorrect referrals	80%	42

3.3.4.	Community members who stated that they knew malnourished PLWs or children in their communities who were not enrolled in the programme.	61%	275
3.3.4.	Informants at community-level in areas of low coverage identified during LQAS coverage surveys who identified cultural norms as a barrier facing service users	55%	25
3.3.4.	Informants at community-level in areas of low coverage identified during LQAS coverage surveys who identified lack of awareness as a barrier facing service users	53%	24
3.3.4.	Informants at community-level in areas of low coverage identified during LQAS coverage surveys who identified inaccessibility as a barrier facing service users	35%	16
3.3.4.	Informants at community-level in areas of low coverage identified during LQAS coverage surveys who identified negative experience at health facilities as a barrier facing service users	44%	20
3.3.4.	Informants at community-level across 7 provinces who stated that non-covered cases do not join IMAM due to a lack of awareness	45%	127
3.3.4.	Carers of non-covered cases who mentioned lack of awareness as the most common reason for not joining the programme	38%	24
3.3.4.	Non-covered PLWs who mentioned lack of awareness as the most common reason for not joining the programme	37%	
3.3.4.	Informants at community-level across 7 provinces who stated that non-covered cases do not join IMAM due to inaccessibility	36%	103
3.3.4.	Carers of non-covered cases who mentioned inaccessibility as a reason for not joining the programme	18%	11
3.3.4.	Non-covered PLWs who mentioned inaccessibility as a reason for not joining the programme	16%	12
3.3.4.	Informants at community-level in Uruzgan who stated that non-covered cases do not join IMAM due to inaccessibility	59%	22
3.3.4.	Informants at community-level in Parwan who stated that non-covered cases do not join IMAM due to inaccessibility	29%	10
3.3.4.	Informants at community-level in Paktika who stated that non-covered cases do not join IMAM due to inaccessibility	24%	11
3.3.4.	Informants at community-level across 7 provinces who stated that non-covered cases do not join IMAM due to cultural norms	24%	68
3.3.4.	Informants at community-level across 7 provinces who stated that the cultural norms related to women being forbidden from visiting health facilities when they or their children need care and/or having to wait for their husbands to be available	71%	48
3.3.4.	Informants at community-level across 7 provinces who stated that the cultural norms related to community members' mistrust of health services (often due to their belief that services are provided by infidels) and/or their preference for traditional medicine or religious solutions	43%	29
3.3.4.	Informants at community-level in Uruzgan who stated that non-covered cases do not join IMAM due to cultural norms	45%	15
3.3.4.	Informants at community-level in Paktika who stated that non-covered cases do not join IMAM due to cultural norms	33%	15
3.3.4.	Informants at community-level in Nangarhar who stated that non-covered cases do not join IMAM due to cultural norms	31%	24
3.3.4.	Carers of non-covered cases who stated that social factors (such as lack of company for the journey, husband refusal, and shame) are the reason they have not enrolled in IMAM	15%	9
3.3.4.	Non-covered PLWs who stated that social factors (such as lack of company for the journey, husband refusal, and shame) are the reason they have not enrolled in IMAM	7%	5

3.3.4.	Informants at community-level across 7 provinces who stated that non-covered cases do not join IMAM due to negative experiences at health facilities	24%	67
3.3.4.	Informants at community-level in Kunduz who stated that non-covered cases do not join IMAM due to negative experiences at health facilities	36%	17
3.3.4.	Informants at community-level in Nangarhar who stated that non-covered cases do not join IMAM due to negative experiences at health facilities	31%	18
3.3.4.	Carers of non-covered cases who stated that negative experiences at health facilities are the reason they have not enrolled in IMAM	18%	11
3.3.4.	Non-covered PLWs who stated that negative experiences at health facilities are the reason they have not enrolled in IMAM	25%	19
3.3.4.	Informants at community-level across 7 provinces who stated that non-covered cases do not join IMAM due to insecurity	12%	33
3.3.4.	Informants at community-level in Uruzgan who stated that non-covered cases do not join IMAM due to insecurity	35%	13
3.3.4.	Informants at community-level in Kunduz who stated that non-covered cases do not join IMAM due to insecurity	23%	11
3.3.4.	Community-level respondents who stated that visiting the health facilities is difficult for mothers of young children who lack external support for childcare duties	28%	24
3.3.4.	Community members living in areas identified as having high coverage by the LQAS estimates who reported being very satisfied with the IMAM programme	75%	40
3.3.4.	Community members living in areas identified as having high coverage by the LQAS estimates who reported living at a walking distance of health facilities that offer IMAM services (30 minutes or less).	67%	4
3.3.4.	Carers and PLWs who are enrolled in the IMAM programme who reported that adhering to their treatment was made easier thanks to their proximity to health facilities	9%	6
3.3.4.	Carers and PLWs who are enrolled in the IMAM programme who reported that adhering to their treatment was not difficult because they were able to leave their children with relatives in order to visit the health facilities	8%	5
3.4.2.	Provincial-level key informants who reported that the current system does not work well and that provincial-level actors do not consistently share performance data	19%	4

6.17. Annex 17: IMAM guidelines 2018: Inconsistencies with new approaches to treatment

A review of the IMAM guidelines (2018) highlighted a number of inconsistencies with new approaches to treatment:

- The guidelines target children 0-5 years, although it clarifies in the body of text that children less than 1 month old are **not treated under IMAM and should be referred to a neonatal unit**.
- The guideline introduces an independent criterion of 'visible severe wasting' for all infants. This is inconsistent with the MAMI guidance of 2018, which suggests it is **not a reliable substitute for anthropometry but can be used where the infant's length is less than 45cm or weight for age cannot be determined**.
- Eligibility for treatment according to the Weight for Age Z-score (WAZ) criterion for infants is determined by 'moderate' or 'severe' drop across 'WAZ lines'. The **definition of moderate and severe drops are not provided** and **absolute WAZ cut offs are not provided** as suggested in MAMI guidance.
- The reporting format for OPD SAM does **not indicate any non-anthropometric enrolment categories for infants less than 6 months** (e.g. visible wasting, drops across WAZ lines, inability to breastfeed effectively).
- The guidelines provide clearer guidance that infants less than 6 months should be screened for malnutrition in the community **although the means of doing this are not made explicit in the guidance or annexed assessment forms;** there is mention of the **emerging evidence of the use of Mid-Upper Arm Circumference (MUAC) in infants although this is not integrated into guidance.**
- Growth monitoring of children less than 2 years is suggested as a screening method in the community with children with growth faltering potentially being referred for further assessment (**although the concomitant use of MUAC in growth monitoring is not mentioned**).
- The potential for CHWs to teach mothers how to use MUAC tape and screen for oedema is noted **without further explanation of the 'Mother's MUAC approach'**[108].
- Disability is mentioned in relation to assessment of the child and as an indication for nasogastric feeding but does not provide specific guidance or modifications for enrolment or treatment in IMAM, which is consistent with a relative absence of guidance at international level.

[108] The State of Acute Malnutrition: 'The Family MUAC approach' https://www.acutemalnutrition.org/en/Family-MUAC

6.18. Annex 18: Review of IMAM quality assurance checklists

In Afghanistan, MoPH M&E teams and GCMU technical teams use the "Quality Assurance Checklist" to score quality in each health facility visited. Progress is then assessed by the percentage improvement of the score following subsequent quality assurance visits. The forms comprise 13 sections covering different aspects of IMAM service delivery including availability of trained human resources, equipment availability, assessment and triage, medications given, nutritional treatment, follow up care, IYCF counselling, discharge criteria, registration, tracking and reporting, links with community and stock checks.

The quality assurance standards included in the form include all of the required quality standards to ensure that acute malnutrition diagnosis and treatment is conducted at health facility level and is in line with the quality standards set out in the IMAM guidelines (2018).

Limitations of the quality assurance checklist include the absence of detailed questions to assess the quality of community outreach for IMAM and a risk of subjectivity in the scoring of questions.

6.19. Annex 19: Summary of simplified approaches for IMAM

Summary of potential simplified approaches for IMAM which could be considered by the IMAM TWG and piloted in Afghanistan:

- *Reduced ration RUTF protocol*: Funding constraints forced UNICEF and partners to adopt this approach in 5 provinces in 2020. If, on evaluation, the approach is found to be safe and effective, this should be scaled up to more provinces to save approximately 40% on the cost of RUTF and reduce the logistical burden
- *Single product (RUTF) treatment for MAM and SAM*: Single product treatment simplifies procurement and supply chain management and can promote efforts at programme integration although the cost of MAM treatment does increase over the cost of RUSF. Recommend for piloting including looking at cost effectiveness and social consequences.
- *Reduced treatment intensity*: Reducing the frequency of visits, especially where access to treatment may be difficult for climatic, topographical or cultural reasons can improve compliance with treatment and reduce default. During 2020 this was trialled globally with a reduction the frequency of visits due to Covid 19. In some contexts, this has resulted in poor outcomes.
- *Family MUAC approach*: Regular screening for malnutrition and self-referral promotes timely, cost effective admission and treatment and improves case coverage. Caregivers are supplied with and taught to use the MUAC tape for self-referral removing the necessity of regular formal screening exercises at community level and the CHW role as a gatekeeper for IMAM. This also promotes a demand driven and rights based approach to IMAM implementation
- *MUAC & oedema only admission criteria*: Simplified admission criteria may be useful to further decentralise treatment and follow up to community level where limitations to facilities, equipment, staffing and training constrain the use of weight for height criteria. Prior to piloting, more analysis is needed to estimate how many children would be missed.
- *CHW treatment and follow up*: The treatment of uncomplicated MAM/SAM by CHWs at community level overcomes barriers such as distance, cultural constraints, time related constraints, ethnicity or other issues to promote effective and high coverage treatment. This approach however requires CHW accountability through salary or incentivisation. The implementation of IMAM by a cadre of CHWs may go some way to mitigate restrictions in the further expansion or contraction of the IMAM programme. Recommendation is to pilot approach and to assess effectiveness of treatment and impact on CHW workload.

6.20. Annex 20: Calculations of lives saved estimates for OPD SAM and MAM programmes for children under 5

Table 1 shows number of OPD-MAM and combined IPD and OPD-SAM children cured from the IMAM programme and the respective cure rates between 2013 to 2019.

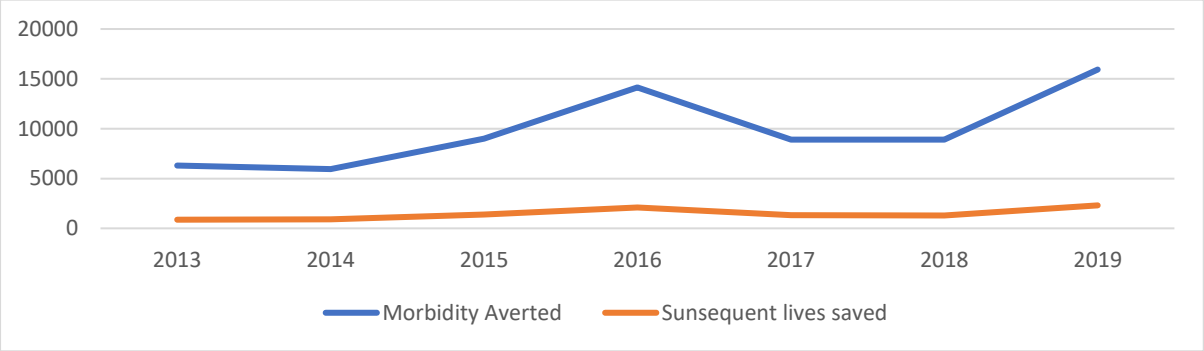
Table 1: Number of children cured and relevant cure rates for OPD-MAM and total SAM treated between 2013 to 2019

		2013	2014	2015	2016	2017	2018	2019
MAM	*Cured*	54242	51249	77585	121886	76698	76771	137338
	Cure rate	80.9%	88.0%	82.1%	81.9%	62.6%	68.5%	73.7%
SAM	*Cured*	44798	72082	116990	158115	176355	209536	232657
	Cure rate	79.7%	89.4%	89.6%	85.7%	85.4%	84.7%	83.6%

(Source: IMAM database, shared February 2020)

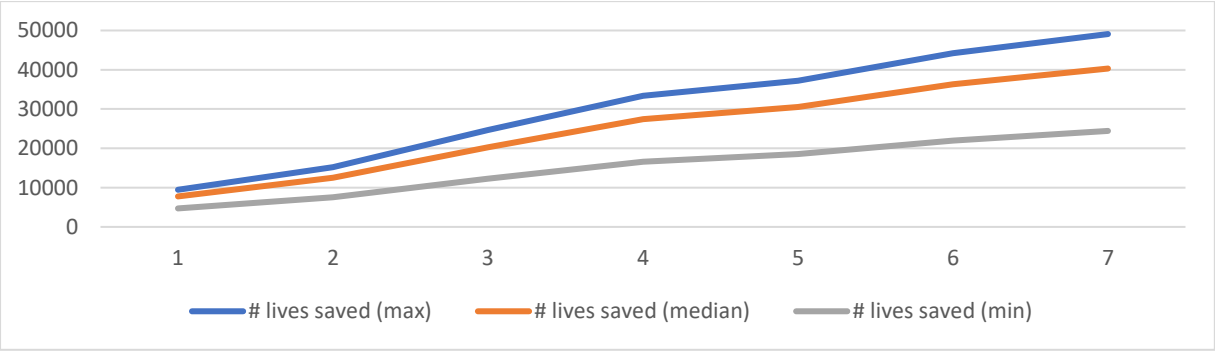
Figure 1 illustrates the SAM morbidity avoided through access to treatment and the subsequent deaths averted through access to MAM treatment. From 2013-2019 the IMAM programme has prevented 69,109 children from becoming SAM consequently saving 10,215 of those lives in OPD-MAM. Through the SAM treatment available in IPD and OPD-SAM an estimated 175,075 (range 106,106 to 213,222) lives have been saved. Total estimated lives saved by the IMAM programme from 2013 to 2019: 185,290 (range 113,362 to 227,805).

FIGURE 19 SAM MORBIDITY AND SUBSEQUENT LIVES SAVED THROUGH TREATMENT IN OPD- MAM 2013-2019



(Source: Evaluation team, October 2020)

FIGURE 20 LIVES SAVED THROUGH TREATMENT IN IPD AND OPD-SAM 2013-2019



(Source: Evaluation team, October 2020)