STOCKHOLM EVALUATION UNIT

EVALUATION OF

MSF MATERNAL HEALTH PROJECT IN KHOST, AFGHANISTAN

(2016 – 2024)

JANUARY 2025

This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

It was prepared independently by Dauod Khuram.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGMENTS

This report represents the end result of collective efforts by numerous individuals across multiple MSF offices, and I would like to extend my heartfelt gratitude to all those who contributed at various stages of the evaluation.

Special thanks are due to the MSF-SEU team, the Consultation Group members, and the Technical Referents for their unwavering support and guidance throughout the evaluation process. Their collaboration and constructive feedback were invaluable in ensuring the evaluation's quality and relevance.

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The Knowledge House is also proud of its field implementation team, especially the female field researchers, for their dedication and resilience in completing data collection within the planned timeframe. Despite the new restrictions imposed by Afghanistan's De-facto authorities on women's social conduct, their resourcefulness and determination enabled them to access target communities and gather high-quality data under challenging circumstances.

Finally, on behalf of The Knowledge House, I extend our best wishes to MSF. We hope that the findings and recommendations from this evaluation will help MSF further strengthen maternal and neonatal healthcare services in Afghanistan, making a lasting impact on the health and well-being of the communities they serve.

Dauod Khuram

Lead Evaluator

ACRONYMS

AfDHS	Afghanistan Demographic Health Survey
AHS	Afghanistan Health Survey
ALCS	Afghanistan Living Conditions Survey
AMA	Afghanistan Midwifery Association
AMS	Afghanistan Mortality Survey
ANA	Afghanistan Nursing Association
ANMC	Afghanistan Nursing and Midwifery Council
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
BScN	Bachelor of Science in Nursing
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHCs	Comprehensive Health Centres
CHNEP	Community Health Nursing Education Programme
CHWs	Community Health Workers
CME	Community Midwifery Education
CQI	Continuous Quality Improvement
EPHS	Essential Package of Hospital Services
FHAG	Family Health Action Group
FHHs	Family Health Houses
FP	Family Planning
GNDP	General Nursing Diploma Programme
HMIS	Health Management Information System
HPs	Health Posts
HQIP	Harmonised Quality Improvement Programme
ICU	Intensive Care Unit
IMCI	Integrated Management of Childhood Illnesses
KMH	Khost Maternity Hospital
KPH	Khost Provincial Hospital
MICS	Multiple Indicators Cluster Survey

MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health
NCDs	Non-Communicable Diseases
NICU	Neonatal Intensive Care Unit
NRVA	National Risk and Vulnerability Assessment
PGME	Postgraduate Medical Education
QI	Quality Improvement
SBM	Standards-Based Management
SEU	Stockholm Evaluation Unit
SHCs	Sub-Health Centres
SPSS	Statistical Package for Social Studies

EXECUTIVE SUMMARY

BACKGROUND

The Khost Maternal Health Project, implemented by Médecins Sans Frontières (MSF), is a critical intervention in Khost, Afghanistan, aiming to reduce maternal and neonatal mortality by providing Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). This evaluation, conducted by The Knowledge House (TKH), examines the project's relevance, effectiveness, impact, and sustainability, offering evidence-based recommendations for future improvements. Afghanistan's challenging healthcare landscape and Khost's growing population underscore the urgency of improving maternal health services in the province.

EVALUATION OBJECTIVES

Document key successes, derive learned lessons, and offer practical recommendations to support informed institutional decision-making.

EVALUATION METHODOLOGY

The evaluation employed a mixed-methods approach, integrating quantitative and qualitative data. It included:

- Exit Survey Interviews: Conducted with 180 respondents in 5 CHCs, 2 CHC+, KMH, and KPH.
- Key Informant Interviews (KII): 12 KIIs (6 female and 6 male).
- Focus Group Discussions (FGDs): 6 Female FGDs (42 participants) and 2 Male FGDs (17 participants).
- In-Depth Interviews: 29 IDIs with Community Leaders and CHWs (8 female and 21 male).
- Health Worker Interviews: 24 interviews (7 Doctors, 14 Midwives, and 3 Obstetrics Specialists) all female.
- Health Facility Assessments and Observation: 9 health facilities
- Secondary Data Analysis: In-depth routine data analysis

KEY FINDINGS

RELEVANCE

The Khost Maternal Health Project addressed critical gaps in maternal and neonatal health services in Khost province, aligning with both community needs and global healthcare standards. The demand for institutional deliveries grew significantly, evidenced by a shift from 18.4% in 2003 to 83.5% in 2023, demonstrating the project's role in promoting facility-based births. Focus group discussions highlighted a strong preference for institutional deliveries, with participants noting that access to free services and skilled care were significant motivators. However, challenges such as limited transportation, economic constraints, and sociocultural barriers still led some families to opt for home deliveries.

The project's focus on delivering CEmONC services through KMH and supporting BEmONC at district-level health facilities effectively addressed local priorities. Community members expressed satisfaction with improvements in service availability and quality at MSF-supported health centres. However, the province's maternal health infrastructure remained uneven, with many facilities unable to fully meet minimum service delivery standards due to equipment and staffing gaps.

APPROPRIATENESS

The approaches employed by the Khost Maternal Health Project were largely appropriate and well-executed, though certain gaps highlight opportunities for improvement. The provision of CEmONC services at KMH, with its robust infrastructure and high standards of care, has been pivotal in addressing critical maternal and neonatal health needs in Khost province. MSF's support to CHCs and CHC+ improved access to BEmONC services at the community level but did not fully address systemic issues such as medicine shortages, healthcare worker behaviour, and community trust. As a result, CHCs were often bypassed in favour of KMH or private providers. Community engagement activities demonstrated cultural sensitivity and successfully fostered local acceptance, yet gaps in targeted health promotion, outreach, and clarity about KMH's admission criteria limited their overall impact.

COHERENCE

The MSF Khost Maternal Health Project's interventions were well-aligned with Afghanistan's maternal health policies and the health system in Khost province. By delivering CEmONC and supporting EPHS facilities (CHCs, CHC+, and PH), the project addressed critical gaps in maternal and neonatal healthcare. However, the project did not fully capitalise on potential synergies with other health actors in Khost. Greater collaboration with stakeholders such as CARE International, IRC, provincial health authorities, and Khost Teaching Hospital could have strengthened referral pathways, enhanced the dissemination of KMH's admission criteria, and improved health promotion strategies.

EFFECTIVENESS

The project has effectively reduced maternal and neonatal morbidity and mortality in Khost. KMH provided life-saving services, managing high-risk pregnancies and complicated deliveries that could not be handled by other facilities. The hospital's comprehensive care included emergency obstetric surgeries, neonatal intensive care, and robust infection control measures. Additionally, the support provided to Khost Provincial Hospital (KPH) and eight district-level health centres strengthened the healthcare delivery ecosystem, ensuring that normal and less complicated births could be managed closer to patients' homes. This approach reduced travel time for families and minimised the risk of delays in receiving care.

The evaluation revealed persistent gaps in service delivery at the CHCs level. Key facilities lacked essential medical equipment and medicines, which hindered their capacity to manage obstetric complications effectively. For example, shortages of lifesaving medications such as ergometrine and neonatal resuscitation tools at several CHCs limited their readiness to handle emergencies. These gaps forced patients to rely heavily on KMH, even for manageable cases, straining its capacity.

IMPACT

The project had a transformative impact on maternal and neonatal health outcomes in Khost. Home deliveries decreased sharply, and neonatal mortality rates saw significant reductions. KMH's provision of round-the-clock CEmONC services ensured that women experiencing complications had access to timely, high-quality care. The hospital's role as the only fully functional CEmONC centre in the province also highlighted the critical importance of centralised, high-capacity facilities in addressing severe obstetric emergencies.

The reliance on KMH for normal deliveries highlighted a systemic dependency on MSF. While MSF-supported CHCs played an essential role in providing basic care, their limited capacity to manage obstetric complications necessitated families bypassing CHCs in favour of KMH.

EFFICIENCY

The efficient utilisation of resources was evident in KMH's ability to manage a high volume of complex cases while maintaining quality standards. The support provided to CHCs/CHC+, including staff salaries (midwives, nurses, and cleaners) and provision of medical supplies, improved service delivery across the province. Nevertheless, efficiency challenges emerged due to BPHS sub-optimal funding for CHCs/CHC+ and KPH. Equipment and medicine shortages at district-level CHCs limited their ability to function as effective first-line care providers.

SUSTAINABILITY

Sustainability remains a critical concern for the Khost Maternal Health Project. While MSF's interventions have improved maternal and neonatal healthcare outcomes, their long-term impact depends on the capacity of local health systems to sustain these gains. The evaluation highlighted significant gaps in the resilience of the local health infrastructure, with many facilities reliant on MSF's support for staffing, equipment, and supplies. Strengthening local health systems, particularly at the district level, is essential to ensure continuity of care once MSF reduces its inputs.

RESILIENCE OF THE LOCAL HEALTH SYSTEM

The resilience of the local health system, particularly the MSF-supported CHCs, CHC+, and KPH, remained constrained by systemic gaps that limited their ability to deliver consistent and quality maternal and neonatal healthcare services. While MSF's support was instrumental in ensuring 24/7 service availability at eight CHCs/CHC+ and enabling KPH to manage increased obstetric and neonatal caseloads, broader challenges persisted. Key gaps in essential resources, including shortages of medicines and critical medical equipment, significantly impacted the readiness of these facilities to manage normal deliveries and obstetric emergencies effectively. Training deficiencies in key practices, such as neonatal resuscitation, the management of postpartum haemorrhage, and the use of partographs, further limited the capacity of these facilities to deliver high-quality care. Workforce limitations were compounded by concerns about healthcare worker behaviour, with instances of delayed patient attendance and disrespectful treatment reported during FGDs and exit interviews, undermining community trust. The evaluation also highlighted limited community engagement and contribution. Strengthening resilience will require a multifaceted approach that addresses these

supply-side and demand-side gaps while leveraging MSF's support to build a stronger and more sustainable local health system.

RECOMMENDATIONS

1. ***Enhancing BEmONC Services at CHCs/CHC+***

Collaborate with the BPHS implementing organisation in Khost to ensure consistent availability of medical supplies, functional equipment, and essential medicines.

2. ***Enhancing Neonatal Healthcare Services***

Expand breastfeeding and neonatal care counselling services at KMH. Actively collaborate with BPHS implementing organisation to equip CHCs/CHC+ and KPH with adequate neonatal care tools.

3. ***Enhancing Postnatal Care at KMH***

Implement pre-discharge counselling and provide PNC cards and pictorial leaflets on family planning, breastfeeding, and postpartum care at KMH. Strengthen referral linkages between KMH and local health facilities to ensure continuity of postnatal care.

4. ***Expanding Health Promotion***

Expand institutional approach to health promotion and community engagement by empowering CHWs and health facility staff with tailored Information, Education, and Communication (IEC) materials. Focus health promotion activities on dispelling misconceptions about facility-based deliveries, increasing awareness of KMH admission criteria, and promoting birth preparedness.

5. ***Promoting Local Ownership***

Collaborate with and support the BPHS implementor to initiate and promote community contributions to address infrastructure and supply gaps at CHCs/CHC+ facilities. Mobilise communities to contribute in-kind (e.g., construction materials) or financially (e.g., small donations).

6. ***Strengthening Collaboration with Other Actors***

Establish stronger collaboration with organisations such as CARE International, IRC, and provincial health authorities. Form collaborative frameworks to ensure an integrated approach to healthcare delivery in Khost province.

7. ***Strengthening the Referral System***

Engage private healthcare providers and the broader community to increase awareness of KMH admission criteria. Strengthen referral pathways to reduce delays in care and enhance the efficiency of maternal and neonatal healthcare across the province.

INTRODUCTION

The evaluation of the Khost Maternal Health project was MSF's strategic effort to enhance accountability, foster continuous improvement, and facilitate organisational learning. This evaluation was internally driven, reflecting MSF's commitment to using evaluations not only to satisfy external donor requirements but also to drive internal growth and development.

The evaluation was guided by a comprehensive Terms of Reference (Annex – IV) with the primary objectives of documenting key successes, extracting lessons learned, and providing practical recommendations for informed institutional decision-making.

The Knowledge House (TKH) conducted this evaluation from June to December 2024, deploying a ten-member team comprising a Lead Evaluator, Quality Assurance Lead, Field Manager, Field Coordinator, and six Field Researchers (three female and three male). The evaluation was carried out in close collaboration with MSF-SEU and the Consultation Group (CG) established for this purpose. This collaboration ensured feedback and validation of the evaluation design and methodology, coordination and debriefing on fieldwork activities, validation of preliminary findings, feasibility assessment of potential recommendations, and dissemination and promotion of the evaluation findings for uptake and implementation.

This report presents a comprehensive account of the evaluation process and outcomes. It includes background and contextual information, an overview of the Khost Maternal Health Project, a description of the methodology and sampling approaches employed, an analysis of the evaluation's limitations, detailed findings, and conclusions and recommendations derived from the evaluation.

BACKGROUND AND CONTEXT

Afghanistan's population, estimated at 34.26 million, comprises 24.18 million (71%) rural, 8.57 million (24%) urban and 1.5 million (5%) nomads[1]. Due to the absence of a comprehensive population-based information mechanism, such as census or a nation-wide vital registration system, these population statistics rely on estimates primarily based on the 1979 census and the 2003 – 2005 household listing. The first demographic survey using modern methods was carried out in 1972 – 1974, followed by the first-ever official census in 1979[2] which registered a population of 15.5 million for the country (85% rural and 15% urban). The current official population estimates are predominantly extrapolated by applying the population growth rate factors to the 1979 census data and the 2003 – 2005 household listing. The lack of accurate population figures coupled with the population movements, poses critical challenges for planning health and other development interventions, especially those linked with resource allocation, such as the Basic Package of Health Services (BPHS), which applies cost-per-capita budget allocation mechanism. Khost province shows a significant discrepancy between official estimated and local population figures.

[1] National Statistics and Information Authority (2023). *Afghanistan Population Estimates for the Year 1401 (2022 – 2023)*: NSIA, Kabul.

[2] Country Studies. (2011). *Country Studies*. [Viewed 16 May 2024]. Available from: http://countrystudies.us/afghanistan/36.htm

Historically, Afghanistan's health infrastructure was inadequate and mostly limited to urban centres. In 1965, before the conflict, Afghanistan had only 19 primary health centres and 60 hospitals to serve an estimated population of 12.5 million[3]. The protracted conflict since 1978 exacerbated the situation, placing Afghanistan among the worst in global health indicators. While little authentic data is available from 1978 to 2002, post-2002 assessments revealed dire health conditions: life expectancy at birth was 55 years[4], maternal mortality ratio (MMR) was 1,600 per 100,000 live births[5], under-five mortality rate (U5MR) was 172 per 1,000 live births[6], infant mortality rate (IMR) was 115 per 1,000 live births[6], 8.7% of children under-five were acutely malnourished, and 60.5% were stunted[7].

Since 2002, Afghanistan's health sector has made notable recovery. The Ministry of Public Health (MoPH) introduced the BPHS and the Essential Package for Hospital Services (EPHS) to focus on key health issues through an integrated and standardised approach. Access to primary health care services improved from 8.5% to more than 60%[15], life expectancy at birth increased from 55 to 64 years[4], and maternal and under-five child mortality declined[15]. Table 1 presents a comparative analysis of key health indicators since 2002.

[3] World Health Organization & Candau, Marcolino Gomes. (1966). *The work of WHO, 1965: annual report of the Director-General to the World Health Assembly and to the United Nations*. World Health Organization. https://apps.who.int/iris/handle/10665/85784

[4] WHO. (n.d.). *Afghanistan data | World Health Organization*. [online] Available at: https://data.who.int/countries/004.

[5] Bartlett L, Whitehead S, Crouse C. *Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability - Summary of findings, 2002. Available:* https://reliefweb.int/report/afghanistan/afghanistan-among-worst-places-globe-womens-health-say-unicef-and-cdc

[6] UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS2/South%20Asia/Afghanistan/2003/Final/Afghanistan%202003%20MICS_English.pdf [Accessed 26 May 2024].

[7] Ministry of Public Health (MoPH) Afghanistan (2014). *National Nutrition Survey Afghanistan (2013)*. [online] ReliefWeb, pp.33–34. Available at: https://reliefweb.int/report/afghanistan/national-nutrition-survey-afghanistan-2013 [Accessed 26 May 2024].

Table 1. Key Health Indicators in Afghanistan since 2003*

INDICATORS	2003 MICS[8]	2006 AHS[9]	2008 NRVA[10]	2010 AMS[11]	2013 NRVA[12]	2015 AfDHS[13]	2016 ALCS[14]	2018 AHS[15]	2023 MICS[16]
Infant mortality rate (per 1,000 live births)	115	129	111	65	48	45	N/A	41	46
Under-five mortality rate (per 1,000 live births)	172	191	161	84	91	55	N/A	50	55
Neonatal mortality (per 1,000 live births)	N/A	N/A	N/A	25	N/A	22	N/A	23	24
Home deliveries (%)	88.5	85.4	N/A	67	N/A	52	49.5	41	33.3
Skilled birth attendance (%)	14.3	18.9	23.9	32	39	51	53.4	58.8	67.5
DPT3/PENTA3 coverage (%)	30	34.6	43	N/A	N/A	58	N/A	60.8	65.2

* The national surveys conducted between 2003 and 2023 used varying methodologies (survey design, sampling methods, and sample sizes). Some of the observed variances may be due to these methodological differences – no inter-rating assessments have been conducted to factor such differences.

[8] Multiple Indicator Cluster Survey 2003: UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3/Afghanistan/2003/Final/Afghanistan%202003%20MICS_English.pdf [Accessed 26 May 2024].

[9] Afghanistan Health Survey 2006: Ministry of Public Health (MoPH) Afghanistan (2007). *Afghanistan Health Survey (2006)*. Kabul: MoPH.

[10] National Risk and Vulnerability Assessment 2007-8: The World Bank Group. (n.d.). *Afghanistan Poverty Assessment: NRVA 2007-08*. [online] Available at: https://www.worldbank.org/en/news/feature /2012/05/31/Afghanistan-poverty-assessment [Accessed 21 May. 2024].

[11] Afghanistan Mortality Survey 2010: The World Bank Group. (n.d.). *Afghanistan - Mortality Survey 2010*. [online] Available at: https://microdata.worldbank.org/index.php/catalog/1322 [Accessed 22 May. 2024].

[12] National Risk and Vulnerability Assessment 2013: Krishnan, N., Tan, X., Wieser, C. and Yde-Jensen, T. (n.d.). *Poverty and Equity Global Practice The World Bank*. [online] Available at: https://documents1.worldbank.org/curated/en/Afghanistan-A-Socio-Economic-Profile-2013-2014.pdf.

[13] Afghanistan Demographic and Health Survey 2015: U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

[14] Afghanistan Living Conditions Survey 2016-17: Central Statistics Organization (2018). *Afghanistan Living Conditions Survey 2016-17*. [online] Kabul: CSO., ReliefWeb. Available at: https://reliefweb.int/report/afghanistan/afghanistan-living-conditions-survey-2016-17 [Accessed 26 May 2024].

[15] Afghanistan Health Survey 2018: Ministry of Public Health (MoPH) (2019). *Afghanistan Health Survey 2018*. [online] Kabul: NSIA and KIT Royal Tropical Institute. Available at: https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf [Accessed 26 May 2024].

[16] Multiple Indicator Cluster Survey 2022-2023: UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

Despite these improvements, the general health status in Afghanistan remained poor, particularly in rural and remote areas, and especially for women, newborns and children under five. The maternal mortality in Afghanistan is still considered to be one of the highest in the world. The Reproductive Age Mortality Survey (RAMOS) conducted in four districts of four provinces (1999 – 2002) reported an estimated national maternal mortality ratio of 1,600 per 100,000 live births[17]. Following this, the Afghanistan Mortality Survey (AMS, 2010) and the Afghanistan Demographic Health Survey (AfDHS, 2015) were conducted and reported the maternal mortalities of 327[18] (AMS 2010) and 1,291[19] (AfDHS, 2015) per 100,000 live births. Given the huge difference between the two follow-up surveys, findings from both surveys were not considered to be representing the national maternal mortality in Afghanistan and, as such, the MoPH estimated the MMR of 661 per 100,000 births, based on the World Health Organisation's estimates[20]. While Basic and Comprehensive Health Centres are designed to provide Basic Emergency Obstetric and Neonatal Care (BEmONC), many are not adequately staffed, equipped, and provided with essential medical supplies to perform BEmONC services[20].

Afghanistan has seen a significant reduction in under-five mortality rate over the past two decades, yet it still has one of the highest infant mortality rates, as it constitutes 82% of the total under-five mortality[21]. According to the Afghanistan Health Survey 2018, the under-five mortality rate is 50 per 1,000 live births, of which 41 deaths take place before a child's first birthday. Afghanistan ranks the fourth highest in the world for neonatal mortality (23 per 1,000 live births) as it constitutes 56% of the total infant mortality, and it is speculated that a significant number of deaths during the neonatal period take place during the first eight days after childbirth[21]. Leading causes of U5M include sepsis/meningitis (19.9%), birth complications (19.8%) and pneumonia (17.2%), with infectious diseases accounting for 62.8% of under-five deaths[21]. Among neonates, birth complications (44.1%), neonatal sepsis and pneumonia are major causes of death[21].

Maternal and child malnutrition is prevalent in Afghanistan as 44.7% of all children under the age of five are stunted (height for age z-score below -2SD) and 3.7% are reported to have wasting (weight for height z-score below -2SD)[22]. Similarly, 45% of childbearing age women are reported to have iron-deficiency[23].

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[17] Bartlett L, Whitehead S, Crouse C. *Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability - Summary of findings, 2002. Available:* https://reliefweb.int/report/afghanistan/afghanistan-among-worst-places-globe-womens-health-say-unicef-and-cdc

[18] The World Bank Group. (n.d.). *Afghanistan - Mortality Survey 2010.* [online] Available at: https://microdata.worldbank.org/index.php/catalog/1322 [Accessed 22 May. 2024].

[19] U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

[20] WHO. (n.d.). *Afghanistan data | World Health Organization*. [online] Available at: https://data.who.int/countries/004.

[21] Ministry of Public Health (MoPH) (2019). *Afghanistan Health Survey 2018*. [online] Kabul: NSIA and KIT Royal Tropical Institute. Available at: https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf [Accessed 26 May 2024].

[22] UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

[23] Ministry of Public Health (MoPH) Afghanistan (2014). *National Nutrition Survey Afghanistan (2013)*. [online]. Available at: https://reliefweb.int/report/afghanistan/national-nutrition-survey-afghanistan-2013 [Accessed 26 May 2024].

According to Afghanistan Demographic and Health Survey (2015), Afghanistan faces a double burden of diseases, with a high incidence of non-communicable diseases (NCD) and injuries alongside maternal and child health issues and communicable diseases; ischemic heart disease and stroke are leading causes of death for adults[24]. The BPHS and EPHS packages have not been substantially updated to address emerging disease patterns.

KHOST PROVINCE

Khost province is situated in the southeastern part of Afghanistan, sharing borders with Pakistan to the east and south, and Paktia and Paktika provinces to the north and west. Khost is comprised of 13 districts, including Bak, Gurbuz, Jaji Maidan, Matun (Khost City), Mandozai, Musa Khel, Nadershakot, Qalandar, Sabari, Shamal, Spera, Tani, and Terezai. The majority of the inhabitants in Khost are Sunni Muslims, and Pashto is the predominant language spoken by all in Khost.

The people of Khost maintain traditional customs and practices, which are deeply rooted in their daily lives and community interactions. The population of Khost is primarily composed of six Pashtun tribes: Khostwal, Mangal, Gurbuz, Zadran, Sabari, and Tani[25]. The intricate clan, tribal, and ethnic composition of the society is deeply intertwined with Pashtunwali, the traditional code of conduct governing the Pashtun way of life[25]. This customary law plays a pivotal role in shaping the norms, behaviours, and conflict resolution mechanisms within these tribes, fostering a strong sense of identity and cohesion among the people of Khost, and making it essential for engaging effectively with the community and implementing culturally appropriate interventions[25].

The population estimates for Khost varies from 659,102[26] reported by the National Statistics and Information Authority (NSIA) in 2023 (used as official figure) to 1.5 million used by the EPI (Essential Programme on Immunisation) authorities as target population for Khost. Furthermore, it is estimated that between 75,000 to 100,000 people from North Waziristan, Pakistan crossed into Khost in 2014[27]. These individuals fled their homes due to the Pakistani military's operation in North Waziristan aimed at combating insurgent groups. The majority of these displaced persons have settled in the Gurbuz district. This influx of Pakistani nationals from Waziristan has significantly impacted the local demographics and has not been counted in the NSIA official population estimates. Also, following the Pakistan government's announcement of 3rd October 2023 regarding the repatriation of undocumented Afghan residents, a total of 733,300 Afghans were forcibly returned to Afghanistan between October 2023 and October 2024. More than half of the returns (65%) were made through the Torkham border in Nangarhar, followed by Spin Boldak (32%) in Kandahar, and 3% through

[24] U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online], pp.245-246. Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

[25] The Heinrich Böll Stiftung. (n.d.). *Khost's Tribes: Between a Rock and a Hard Place | Heinrich Böll Stiftung*. [online] Available at: https://www.boell.de/en/2011/01/04/khosts-tribes-between-rock-and-hard-place [Accessed 12 May. 2024].

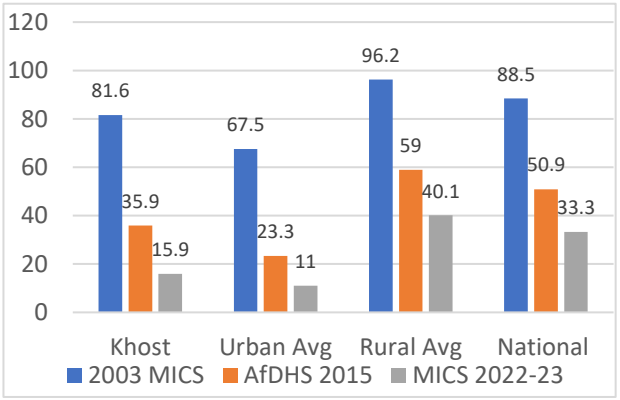
[26] National Statistics and Information Authority (2023). *Afghanistan Population Estimates for the Year 1401 (2022 – 2023)*: NSIA, Kabul.

[27] UNHCR (2020). Evaluation of UNHCR's Country Operation, Afghanistan. [online] UNHCR. Available at: https://www.unhcr.org/sites/default /files/legacy-pdf/5fa151b67.pdf [Accessed 27 May 2024].

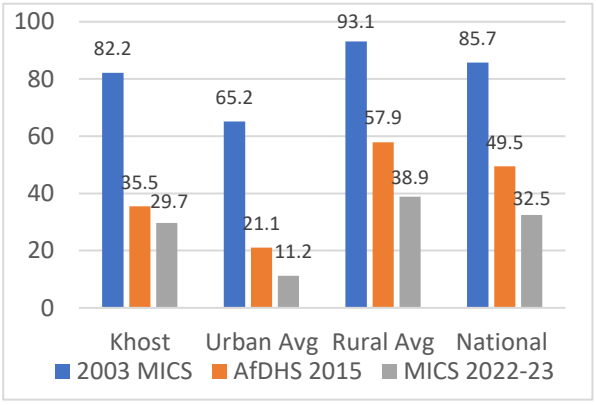
Ghulam Khan in Khost province[28]. The lack of accurate population figures, coupled with the population movements, poses critical challenges for planning health and other development interventions, especially the Basic Package of Health Services (BPHS), which applies a cost-per-capita budget allocation mechanism. Khost province shows a significant discrepancy between official NSIA estimated and local population figures.

As presented in Figure 1 below, over the past two decades, Khost has made remarkable strides in improving maternal and neonatal health based on data from three different surveys that provided province-level disaggregated findings (2003 MICS, AfDHS 2015, and MICS 2022-23).

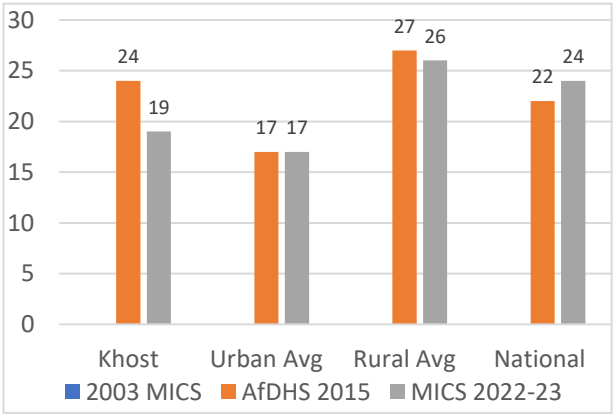
Home Deliveries



Deliveries Assisted by Unskilled Birth Attendants



Neonatal Mortality Rate



Caesarean Section

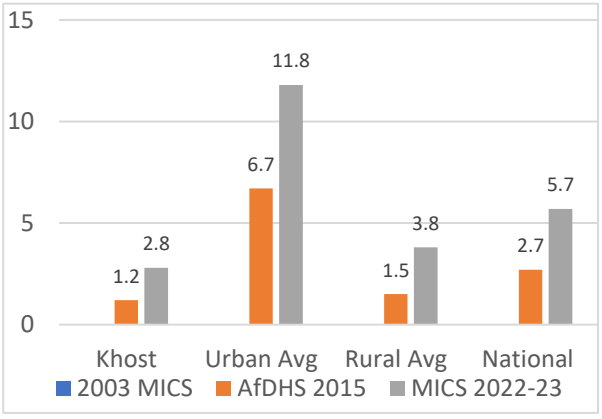


Figure 1. Trends of Key Maternal and Child Health Indicators for Khost Province

[28] UNHCR (2024). *Pakistan-Afghanistan - Returns Emergency Response #23*. [online] UNHCR Operational Data Portal (ODP). Available at: https://data.unhcr.org/en/documents/details/111500 [Accessed 22 Feb. 2025].

In Khost, the percentage of home deliveries decreased substantially from 81.6% in 2003[29] to 35.9% in 2015[30], and further to 15.9% in 2022-23[31]. This decline indicates a substantial shift towards institutional deliveries over the past two decades in Khost province. These figures indicate that Khost has made more significant progress in shifting from home to institutional deliveries compared to the broader rural and national contexts. MICS 2022-23 reports the percentage of deliveries assisted by unskilled attendants at 29.7%, compared to the rural average of 38.9% and the national average of 32.5%.

Khost also has made significant progress in reducing neonatal mortality rates. As presented in Figure 1 above, in 2015, Khost had a neonatal mortality rate of 24 per 1,000 live births[30], which decreased to 19 by 2022-23[31], reflecting an improvement in neonatal health outcomes.

Based on data from two surveys that provided province-level disaggregated findings (AfDHS 2015 and MICS 2022-23), the percentage of Caesarean Section (C – Section) remained lower than the overall rural, urban, and national average, as presented in Figure 1 above.

OTHER ACTORS IN KHOST PROVINCE

A number of other organisations operate in Khost province, providing various healthcare services, including reproductive healthcare interventions. The following table provides an overview of the different actors currently active in Khost province.

Table 2. Healthcare Providers/Actors Mapping of Khost Province

ACTORS	SCOPE OF WORK
HealthNet-TPO	Provides BPHS services in all 13 districts and running 276 HPs, 22 SHCs, 5 Mobile Health Teams, 10 BHCs, 10 CHCs, and 2 CHC Plus facilities. Provides EPHS through Khost 177-bed Provincial Hospital (in-patient departments are General Medicine, Surgery, Orthopaedic – Traumatology, O&G, Paediatrics and Neonatology). The current contract is till end of March 2025, with no clarity, at this point, on its extension or continuity.
CARE	Running 11 BHCs and 10 FHHs in Matun, Gurbaz, Terezayi, Bak, Sabari, Jaji Maidan, Musa Khil, Gurbuz and Sabari districts. Focused on delivering Sexual and Reproductive Healthcare services along with Gender-Based Violence services.

[29] UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS2/South%20Asia/Afghanistan/2003/Final/Afghanistan_English.pdf [Accessed 26 May 2024].

[30] U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report [Accessed 27 May 2024].

[31] UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

HADAAF	Healthcare services in Gulan refugee camp (Gurbaz district) and community-based nutrition programme in Matun, Ismail Khel, Ali Sher, and Tanai districts.
Khost Teaching Hospital	Built in 2009 over four-stories, the hospital had been dormant until 2021 despite being equipped with advanced medical equipment and a rehabilitation in 2018, mainly due to the lack of operating costs. The hospital started functioning in 2022 after ICRC's support for staff salary and medical supplies. The ICRC funding came to an end in April 2023, after which the hospital became barely functional. Only one-fifth of the existing staff (more than 250) receive a salary from MoHE.
Private Sector	More than 110 private healthcare providers and facilities are estimated to be active in Khost, concentrated in Khost's centre. The scope of their services varies from basic obstetric, such as birth delivery by midwives, to advance gynaecological services by gynaecologists. Operating from private health facilities (clinics and hospitals) and private maternity homes (often in residential houses).
IRC	Supporting 11 CHC and 6 BHC for Infection Prevention and Control, nutrition (focused on women of reproductive age and children under five) in Spera, Nadir Shah Kot and Sabari districts.
MSI	Started running a Centre in Matun in 2022, providing family planning, ANC, PNC, vaccination, and nutrition services.
NAC	Running 1 BHC and 2 FHHs in Matun and supports a Nursing and Midwifery Education Programme in Khost.
Afghan Red Crescent Society (ARCS)	Running a BHC in Tani District, a MHT, and 6 upgraded SHCs (staffed with male and female doctors, midwife, nutrition counsellor, and vaccinator) in Matun, Bak, Mandozai, Tani, Matun and Sabari districts.
HMLO	Running 2 BHCs and 8 SHCs in Nadir Shah Kot, Jaji Maidan, Musa Khel, Sabari and Lakan districts.

A total of 104 health facilities of various types are currently providing healthcare services in Khost province (other than KMH), as presented in Table 3 below. The distribution of health facilities, especially those operating from purpose-built facilities, has not been thoroughly assessed, and as part of TKH's initial consultations for this evaluation, concerns were raised about the optimal accessibility of all the catchment area population to some of the health facilities. On the other hand, according to the BPHS hierarchy of health facilities, District Hospitals (DHs) play a crucial role in ensuring optimal continuum of care in the BPHS lather of services. However, the current BPHS setup in Khost does not have any provision for DH as part of the package. A 30-bed district hospital was built in Sabari district in 2017 to serve as a first reference centre for Bak, Zazai Maidan, and Terezio districts. The building remained dormant, for various reasons, after the construction was completed in 2017[32].

[32] Pajwok (2024). *Built 7 years ago, Khost hospital gets damaged without use*. [online] Pajwok. Available at: https://pajhwok.com/2024/05/29/built-7-years-ago-khost-hospital-gets-damaged-without-use/ [Accessed 29 May 2024].

Table 3. Health Facilities Profile of Khost Province

HEALTH FACILITIES	HADAAF	ARCS	CARE	HMLO	HN-TPO	IRC	MoHE	MSI	NAC	Total
Sub Health Centre	0	6	0	8	22	0	0	0	0	36
Family Health House	0	0	10	0	0	0	0	0	2	12
Mobile Health Team	7	1		0	5	0	0	0	0	13
Basic Health Centre	0	1	11	2	10	2	0	0	1	27
Comprehensive Health Centre	1	0	0	0	10	0	0	0	0	11
Comprehensive Health Centre Plus	0	0	0	0	2	0	0	0	0	2
Provincial Hospital	0	0	0	0	1	0	0	0	0	1
Teaching Hospital	0	0	0	0	0	0	1	0	0	1
Other	0	0	0	0	0	0	0	1	0	1
Total	8	8	21	10	50	2	1	1	3	104

KHOST MATERNAL HEALTH PROJECT (BACKGROUND)

Initiated in 2011, Khost Maternal Health Project in Afghanistan stands as one of MSF's largest maternal health improvement initiatives globally. The project aims to reduce neonatal and maternal mortality in Khost province by providing Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services at the MSF-operated Khost Maternity Hospital (KMH). The primary target group includes women of childbearing age in Khost province experiencing pregnancy-related complications, ensuring they receive the critical care they need, as presented in the Table 4 below.

Table 4. Khost Maternal Health Project Result Hierarchy (Logframe)

GENERAL OBJECTIVE		
Mortality and morbidity related to maternal and neonatal health are reduced in Khost province		
Specific Objective		
The women of Khost province with pregnancy related complications will make use of the comprehensive emergency obstetric and neonatal care provided in Khost Maternity Hospital and MSF supported CHCs and KPH		
Expected Results		
1: Quality Comprehensive Emergency Obstetric care is available in MSF KMH	2: Quality neonatal care is made available at MSF KMH	3: Comprehensive ICU care is provided to obstetrical critical patients and KMH ICU admission criteria are respected
4: High quality Obstetrical related surgeries service +BTL are available for obstetrical complicated cases 24/7	5: Quality auxiliary and transversal services are available in KMH and obstetrical/medical care are provided according to universal standards of precaution	6: Strengthening the referral system/community awareness related to SRH topics in the districts for all women with pregnancy related complications and at-risk

		pregnancies from community to KHM and conducting a maternal/neonatal mortality surveillance

To fulfil the six (6) expected results, the project activities included:

- **Expected results 1 and 2:** Operating a dedicated CEmONC centre at KMH, one of three such facilities in the province, providing specialised neonatal and maternal care, particularly for complicated deliveries. This centre features a 60-bed maternity unit, a 32-bed neonatal unit, and two operating theatres.
- **Expected result 3:** Quality comprehensive emergency obstetric care is made available at KMH, alongside specialised neonatal care and comprehensive ICU services for critical obstetrical patients, adhering to established ICU admission criteria.
- **Expected result 4:** High-quality obstetrical surgeries and bilateral tubal ligation (BTL) services are provided 24/7 for complicated obstetrical cases.
- **Expected result 5:** Quality auxiliary and transversal services at KMH ensure that obstetrical and medical care meet universal standards of precaution and safety.
- **Expected result 6:** Additionally, the project focuses on strengthening the referral system and increasing community awareness related to sexual and reproductive health (SRH) topics. This involves educational campaigns and community engagement to ensure women with pregnancy-related complications and at-risk pregnancies are efficiently referred from the community to KMH, and conducting maternal and neonatal mortality surveillance to monitor and improve health outcomes.

In 2016, the KMH project extended its support to Khost Provincial Hospital, Nadirshah Kot CHC+, and Gurbaz CHC. This support was further extended in 2017 to include Lakan, Khulbesat/Sabari, and Ali Sher CHCs, and in 2021, Jaji Maidan and Daragai/Tani CHCs, along with Zorkot/Musa Khel CHC+, were added. This support included (i) providing salary funding for additional midwives, (ii) supplying medical consumables periodically, and (iii) offering training to allow women without obstetric complications to give birth closer to their homes. Additionally, (iv) MSF donates medicines and supplies to Khost Provincial Hospital to enhance its capacity to provide comprehensive emergency obstetric and neonatal care. Through these multifaceted activities, the Project aims to significantly improve maternal and neonatal health outcomes in Khost province. Table 5 below, provides an overview of the supported CHCs/CHC+ along with their performance.

Table 5. MSF Supported CHCs

DISTRICT	HF NAME	DELIVERIES (ANNUAL AVG 2013 – 2015)	DELIVERIES (ANNUAL AVG 2016 – 2017)	DELIVERIES (ANNUAL AVG 2018 – 2021)	DELIVERIES (ANNUAL AVG 2022 – 2024)
Gorbuz	Gorboz CHC (Supported from 2016)	145	328	1182	1584
Jaji Maidan	Jaji Maidan CHC (Supported from 2021)	261	417	905	839
Khost (Matoon)	Lakan CHC (Supported from 2017)	141	221	1227	1321
Musa Khel	Zorkot/Musa Khel CHC+ (Supported from 2021)	99	140	572	1223
Nadershakot	Nadirshah Kot CHC+ (Supported from 2016)	270	248	757	731
Sabari (Yaqoobi)	Khulbesat/Sabari CHC (Supported from 2017)	133	374	1936	1350
Tanay	Daragai/Tani CHC (Supported from 2021)	180	346	1489	1601
Terezai (Ali Sher)	Ali Sher/Terezai CHC (Supported from 2017)	153	96	810	1112

Additionally, MSF rehabilitated the Terezai (Ali Sher), Jaji Maidan, Zarkot (Musa Khel), and Mandozai CHCs, along with extending the maternity ward at Khost Provincial Hospital. These efforts aimed to enhance the infrastructure for optimal maternal healthcare services at these facilities.

OBJECTIVE OF THE EVALUATION (SCOPE)

The primary objectives of this evaluation were to document key successes, derive lessons learned, and offer practical recommendations to support informed institutional decision-making. The evaluation provides a comprehensive assessment of the implementation of the Khost Maternal Health project from 2016 to 2024, focusing on its performance across key evaluation criteria: relevance, appropriateness, coherence, effectiveness, impact, and sustainability.

A specific area of interest for this evaluation was generating evidence to support the development of a tailored strategy for enhancing the resilience of the local maternal health system, enabling it to play a greater role in delivering maternal and neonatal services. Additionally, the evaluation sought to identify factors contributing to the dependency on KMH for maternal healthcare, particularly for normal birth deliveries managed through Khost Maternity Hospital. The evaluation responded to the following evaluation questions:

- **Relevance:** How relevant is the project when considering the needs and expressed needs of the population and the principles and priorities of the organisation?
- **Appropriateness:** Given the context and the project objective of promoting resiliency of the health system and actively engaging communities, how appropriate is the approach taken by MSF to reducing morbidity and mortality for women with pregnancy related complications?
- **Coherence:** Is MSF's intervention coherent and compatible with maternal health policies and other interventions in Khost?
- **Effectiveness:** How can the project become more effective in achieving its objectives and promoting resilience and sustainability of local health systems?
- **Impact:** What has been the positive impact of MSF's maternal health intervention in Khost, and how can it improve its potential for impact? Have there been unintended or negative consequences of MSF's intervention, and how can MSF improve mitigation?
- **Efficiency:** How can MSF improve the efficiency of the resources being used in the project?
- **Sustainability:** How can MSF improve the sustainability of its intervention by ensuring net benefits are preserved in the long-term?

METHODOLOGY

TKH employed a mixed-method (qualitative and quantitative) design exploring demand side and supply side perspectives to achieve the evaluation objectives. The methodology included conducting a detailed review of relevant literature and project documents, analysing secondary data, and collecting primary qualitative and quantitative data. These elements were designed to provide a comprehensive understanding of the project's relevance, appropriateness, coherence, effectiveness, efficiency, impact, and sustainability. Figure 2 below, provides a conceptual framework of the evaluation.

SUPPLY SIDE (KMH, KPH, & 8 CHCS/CHC+ AT THE DISTRICT LEVEL)		DEMAND SIDE (COMMUNITY AND PATIENTS/CLIENTS)
Capacity for Service Provision: ▪ Equipment functionality ▪ Drug availability ▪ Staffing– meeting minimum staffing guidelines ▪ Provider knowledge ▪ Staff received training in last year ▪ Clinical guidelines ▪ Infrastructure ▪ Patient record and confidentiality Provision of B/C EmONC Services: ▪ Patient-Provider Care Index (quality of patient-provider interface under a range of items) ▪ Proper sharps disposal and infection prevention ▪ Average B/C EmONC services per month ▪ Delivery care according to Minimum Service Package	How can the Khost Maternal Health Project enhance its effectiveness in reducing morbidity and mortality among women with pregnancy-related complications, while promoting the resilience and sustainability of local health systems and ensuring long-term benefits with reduced reliance on MSF's presence?	Patients/Clients Perception: ▪ Patient perceptions of Quality (Obtained through Exit Interviews). ▪ Overall Patient Satisfaction (Obtained through Exit Interviews). Community Engagement: ▪ Awareness of maternal healthcare services. ▪ Engagement of health Shuras in community mobilisation and service delivery. ▪ Healthcare (maternal health) seeking behaviour at the community

Figure 2. Evaluation Conceptual Framework

The Evaluation Matrix (Annex – I) provides elaboration of the evaluation questions in more depth.

REVIEW OF RELEVANT LITERATURE AND PROJECT DOCUMENTS

The literature review served as a critical foundation for shaping the evaluation's design and guiding the development of its theoretical and methodological frameworks. This phase involved a

comprehensive analysis of project documents, technical and strategic literature, and external publications, ensuring the evaluation was thorough, evidence-based, and aligned with broader maternal and neonatal health standards.

Annex II outlines the complete list of project documents, MSF literature, and external documents and datasets reviewed and analysed as part of this evaluation. This comprehensive review informed the findings, conclusions, and recommendations presented in this report.

REVIEW OF PROJECT DOCUMENTS

Key project documents, including the project proposal, logframe, and other operational materials, were meticulously reviewed to evaluate the alignment of planned activities with implementation and results. This process provided insights into the project's objectives, expected outcomes, and operational priorities, allowing TKH to assess the extent to which these goals were achieved. MSF's technical and strategic literature offered additional context, coherence, and benchmarks, enabling TKH to position the project's performance within organisational standards and best practices. This analysis helped identify strengths, weaknesses, gaps, and opportunities for improvement, ensuring that the evaluation is thorough, evidence-based, and capable of providing actionable recommendations for the Khost Maternal Health Project and MSF as a whole.

The evaluation critically reviewed past assessments and evaluations, particularly the 2016 Anthropological study[33], to determine how well the previously established findings and recommendations from studies and evaluations were integrated into the project activities.

REVIEW OF EXTERNAL PUBLICATIONS

To contextualise findings and benchmark the project's relevance, appropriateness, effectiveness, and impact, the evaluation reviewed external academic papers, government reports, policy documents, and other publications. These materials provided valuable insights into maternal, neonatal, and child health trends, as well as the socio-economic, political, and environmental context in Khost province. This process involved comparing the project's goals, implementation strategies, and outcomes with established standards, best practices, and findings from similar initiatives documented in external literature.

The review enabled comparisons between MSF's strategies and those documented in similar initiatives, particularly concerning BEmONC, CEmONC and community engagement. This benchmarking ensured that the evaluation not only measures the project's impact (reducing mortality and morbidity related to maternal and neonatal health in Khost province) but also its alignment with broader objectives and its applicability as a replicable model for future initiatives.

[33] Tell it to my mother-in-law. (2016), Women's sexual and reproductive health and perception of and access to maternal health care services in Khost province, Afghanistan

ANALYSING SECONDARY DATA

As outlined in Table 6 below, the analysis of medical data collected from KMH, KPH, eight CHCs/CHC+, and other health facilities served as an important component of the evaluation. This secondary data provided valuable insights into maternal and neonatal services, contributing to the development of the evaluation design and facilitating the triangulation and validation of findings from primary data collection.

The evaluation team recognised the limitations of medical data from non-MSF-supported facilities, which were sourced from the national HMIS database. These limitations included potential biases, incomplete records, and missing information. The team remained vigilant in addressing these challenges to ensure the reliability and robustness of the evaluation findings.

Table 6. Secondary Data (Routinely Collected Medical Data) Analysis Framework

ROUTINELY COLLECTED SECONDARY DATASETS	ANALYSIS MEASURES
Routinely collected medical data at KMH (2016 – 2024) ▪ Total admissions in KMH ▪ Admissions referred by other HFs ▪ Total deliveries at KMH ▪ Total DOCs managed at KMH (by categories) ▪ Total C-Section performed at KMH ▪ Maternal and neonatal mortalities in KMH (including their audit report) ▪ Bed Occupancy Rates (maternity and Neonatal Units) ▪ Average length of stay at KMH ▪ Residential details/location of those benefited from KMH Routinely collected medical data at KPH (2016 – 2024) ▪ Total admissions in KPH ▪ Admissions referred by other HFs ▪ Total deliveries at KPH ▪ Total DOCs managed at KPH (by categories) ▪ Total C-Section performed at KPH ▪ Maternal and neonatal mortalities in KPH (including their audit report) ▪ Bed Occupancy Rates (maternity and Neonatal Units) Routinely collected medical data in all other HFs including MSF supported CHCs/CHC+ (2004 – 2024)	KMH users' profiling: assessing: ▪ Referral patterns: proportion of patients that required CEmONC by referral status (self-referred or referred by other health facilities) ▪ Residential location (districts): how residents of 13 districts (proportionate to their population) similarly or differently benefited from CEmONC and BEmONC at KMH [factors for uneven distribution will be probed further through primary data collection] Case-load analysis: the extent to which: ▪ CEmONC services are provided at KMH compared to KPH and other facilities in the province [factors for high and low share of caseload will be probed further through primary data collection] ▪ BEmONC services are provided at KMH compared to other facilities in the province [factors for high and low share of caseload will be probed further through primary data collection] ▪ HFs (other than MSF supported CHCs/CHC+ and KPH) contribute to providing BEmONC services. Trend analysis: the extent to which: ▪ Utilisation of services varied after introducing admission criteria for KMH (at KMH, KPH, and CHCs/CHC+) ▪ Utilisation of services varied at KMH, KPH, and CHCs/CHC+ after MSF's support to 8 CHCs/CHC+ and KPH ▪ Utilisation of services varied at KMH, KPH, and CHCs/CHC+ after changes in BPHS implementors

▪ Total deliveries conducted ▪ Complicated and high-risk cases referred to other HFs ▪ Maternal and neonatal mortalities recorded	▪ Utilisation of services varied at KMH, KPH, and CHCs/CHC+ after the operation of new partners (IRC, CARE and others) and discontinuation of others (ICRC support to Khost Teaching Hospital) ▪ How utilisation of services varied at KMH, KPH, and CHCs/CHC+ after the regime change in Aug 2021? ▪ Patterns of service utilisation during Covid-19 pandemic in KMH, KPH, and other HFs <u>Coverage of maternal and neonatal services:</u> ▪ Are the volume and distribution of services sufficient to meet needs (using parameters such as managed DOCs and/or CS ratios to population and adjusted Crud Birth Rate (CBR)? ▪ Does coverage of services differ according to districts (especially hard to reach areas)?

SUPPLY-SIDE ASSESMENT METHOD

The evaluation assessed the extent to which the MSF-supported primary health facilities at the community level (6 CHCs and 2 CHC+), secondary health facilities at the provincial capital (KPH), and MSF-managed KMH were ready and prepared to deliver BEmONC and CEmONC services to their respective catchment populations. This assessment covered key factors such as staffing, infrastructure, equipment availability, skillsets, operational hours, and medical supplies. It also explored measures required for continuum of care for high-risk pregnancies, potential DOC cases, and neonatal cases. The evaluation also examined the current and potential roles of communities in promoting and supporting maternal and neonatal healthcare services.

A mixed-methods approach incorporating both qualitative and quantitative data collection methods was employed, including:

KEY INFORMANT INTERVIEWS (KIIS)

12 Key Informant Interviews (KIIs) were conducted with major stakeholders in maternal and neonatal health, including six female and six male participants. These interviews provided expert opinions and valuable insights into critical areas such as the delivery of BEmONC services (at FHHs, BHCs, and CHCs/CHC+), CEmONC services (at KMH and KPH), referral mechanism, and community engagement. The key topics discussed during these interviews are summarised in Table 7 below.

This approach ensured the qualitative data collected was comprehensive and contextually rich, offering valuable perspectives on maternal and neonatal healthcare service delivery. Additionally, the KIIs provided actionable insights on strategies for effectively engaging communities in promoting and supporting maternal and neonatal services. Further details on the profiles of the key informants interviewed are provided in Annex III.

<u>Table 7.</u> Core Topics for Key Informant Interviews (KIIs)

Role of KMH in the Province

- Exploring the needs for CEmONC at KMH and/or dependency on KMH.
- Exploring how other actors in the province can make the best use CEmONC at KMH.

Other CEmONC centres in Khost Province

- Role of KPH, and how KPH can complement the services at KMH or vice versa.
- Potential for other CEmONC centres in Khost, including Khost Teaching Hospital

Availability and Quality of Maternal and Neonatal Services at Community Level

- The scope and scale of maternal and neonatal services provided by primary health facilities in the community (FHHs, BHCs, and CHCs/CHC+)
- Exploring the current challenges faced by FHHs, BHCs, and CHCs/CHC+ in delivering maternal and neonatal services, and ways to overcome these challenges.
- Actors (other agencies) involved in delivering primary maternal and neonatal healthcare services.
- Examining the commitment to continuing maternal and neonatal service delivery by other actors.
- Current measures for addressing high-risk Pregnancies and DOC cases by other actors at FHHs, BHCs, and CHCs/CHC+.

Referral System and Awareness of KMH Admission Criteria

- Exploring functionality and effectiveness of the referral system.
- Gauging awareness of KMH admission criteria.

Role of the Private Sector in Delivering Maternal and Neonatal Services

- Discussing the pros and cons, scope and scale, and perception of engaging the private sector.

Community Engagement Approaches

- Investigating the extent of community involvement in promoting maternal and neonatal services.
- Community ownership for maternal and neonatal services at the community level.
- Identifying learned lessons and challenges faced.

HEALTH WORKERS INTERVIEW

The evaluation conducted interviews with 24 health workers from 5 CHCs, 2 CHC+, KPH, and KMH, as shown in Table 8 below. These interviews gathered data on the qualifications of the health workers, their training and capacity development in core maternal and neonatal care, skillsets for performing essential obstetric procedures, challenges faced in carrying out their duties, and their overall level of motivation.

Table 8. Health Workers Interview Sample

HEALTH FACILITY	DOCTOR	MIDWIFE	SPECIALIST	TOTAL
KMH	0	2	2	4
KPH	1	2	1	4

Nadershakot CHC+	1	1	0	2
Zorkot/Musa Khel CHC+	1	1	0	2
Alisher CHC	1	3	0	4
Gurbaz CHC	1	1	0	2
Lakan CHC	0	2	0	2
Sabari CHC	1	1	0	2
Daraqai CHC	1	1	0	2
Total	7	14	3	24

HEALTH FACILITY ASSESSMENT

The evaluation included a comprehensive health facility assessment of the 7 MSF-supported (5 CHCs and 2 CHC+), KPH and KMH to evaluate their capacity to deliver BEmONC and CEmONC services in alignment with minimum standards as outlined in the BPHS. The health facility assessment focused on evaluating critical areas of BEmONC and CEmONC service delivery across KMH, KPH, and eight MSF-supported CHCs/CHC+. Key assessment areas included the scope of services, availability of essential medications, service provision capacity, and adherence to clinical guidelines. The evaluation examined whether facilities operated 24/7, their capacity to manage obstetric and neonatal emergencies, and the availability of skilled healthcare providers trained in essential practices like neonatal resuscitation.

The assessment utilised a self-developed structured questionnaire focusing on key parameters outlined in Table 9 below. The questionnaire was administered through interviews with relevant personnel at each health facility, including facility in-charges, healthcare providers, pharmacists, administrative staff, and others. This approach enabled a thorough evaluation of the readiness and performance of these facilities in providing essential maternal and neonatal healthcare services.

Table 9. Health Facilities Assessment Parameters

ASSESSMENT AREAS	DETAILS
Scope of C/B EmONC Services	▪ Evaluate the extent to which CHCs/CHC+ are open 24 hours a day, 7 days a week to provide continuous access to maternal and newborn care. ▪ Assess the availability of skilled birth attendants trained to manage basic and comprehensive obstetric emergencies. ▪ Assess the availability of skilled healthcare providers trained to perform neonatal resuscitation.
Availability of Essential Medications and Interventions	▪ Assess the availability of parenteral antibiotics, uterotonics, and anticonvulsants required for managing obstetric complications such as pre-eclampsia or eclampsia.
Capacity for Service Provision	▪ Assess the functionality of equipment and medical devices essential for B/C EmONC services, ensuring they are operational and maintained properly. ▪ Review staffing levels to determine the extent to which KMH, KPH, and CHCs/CHC+ meet minimum staffing guidelines for B/C EmONC services, including the presence of skilled healthcare providers.

ASSESSMENT AREAS	DETAILS
	▪ Assess the knowledge and training of healthcare providers in B/C EmONC practices and protocols, whether staff received relevant training in the last year. ▪ Review the availability and adherence to clinical guidelines for managing obstetric emergencies and neonatal care. ▪ Evaluate the infrastructure of KMH, KPH, and CHCs/CHC+, including the adequacy of facilities and amenities for providing B/C EmONC services.
Provision of B/C EmONC Services	▪ Evaluate infection prevention practices and waste disposal and adherence to infection control protocols. ▪ Determine the average number of B/C EmONC services provided per month to assess the workload and capacity of KMH, KPH, and 8 CHCs/CHC+ to meet the demand for obstetric care. ▪ Assess the delivery of care according to the Minimum Service Package for B/C EmONC, ensuring that essential interventions are provided in line with established guidelines.

DEMAND-SIDE ASSESSMENT METHOD

To assess the demand-side perspective of maternal and neonatal health, this evaluation employed a multifaceted approach that focused on several key areas. These included healthcare-seeking behaviour and preferences, community perceptions of the quality of maternal and neonatal services, barriers to accessing care, and cultural and social factors influencing maternal health. The evaluation also explored local community engagement and support for maternal and neonatal health, as well as challenges in accessing services and overall satisfaction with the care provided.

By using both qualitative and quantitative methods (as detailed below), the evaluation aimed to capture the depth and complexity of community views, with a particular emphasis on strategies to engage and empower communities. A special focus was given to producing evidence that can support MSF in finding ways to engage and support communities to enhance resilience of local health structures and increase community-level awareness of and engagement with maternal health issues; assessing the extent to which local communities feel a sense of ownership or demonstrate a willingness to support local health facilities and promote optimal care at the community level.

FOCUS GROUP DISCUSSIONS (FGDS)

The evaluation conducted 8 Focus Group Discussions (FGDs) with various community groups to explore their perceptions regarding maternal and neonatal services at the community level. FGD participants, who were community members with recent childbirth experience, were selected in consultation with the respective CHWs applying the following selection criteria.

Table 10. Number of FGDs and Participants Selection Criteria

FGDS LOCATIONS AND PARTICIPANTS	PARTICIPANTS SELECTION CRITERIA
6 Female FGDs: 42 Participants	1- Who are aged 25 to 49 years

Gurbaz, Zorkot/Musa Khel, Nadershakot, Khulbesat/Sabari, Daragai/Tani, and Ali Sher	2- Who gave birth (either at home or in in a health facility) in the last 1 -2 years 3- Has been living in this community for at least 3 years
2 Male FGDs: 17 Participants Lakan and Ali Sher	1- Who are aged 25 to 49 years 2- Who had childbirth in the family (either at home or in in a health facility) in the last 1 -2 years 3- Has been living in this community for at least 3 years

Efforts were made to include women who had delivered at home or men who had childbirth delivery at home. Male FGDs were held in the community, while female FGDs took place in convenient locations for participants, such as the CHWs' homes. Further details on the profiles of the FGD participants are provided in Annex III.

These discussions provided a platform for community members to share their lived experiences, including the availability and quality of maternal and neonatal healthcare services they have experienced, the decision-making process and timing at the household level about seeking care, as well as the challenges and barriers they encountered in accessing maternal and neonatal care. Participants also offered suggestions for improving maternal healthcare services.

IN-DEPTH INTERVIEWS (IDIS)

The evaluation conducted 29 in-depth interviews (IDIs) with a diverse group of stakeholders, including 16 CHWs (8 female and 8 male), 13 male local Health Shura members, and 8 community elders. These interviews aimed to gather insights into individuals' perceptions, behaviours, and attitudes concerning maternal and neonatal healthcare, as well as their views on the healthcare services required to address community needs effectively. Table 11 below, provides an overview of the IDI discussion topics.

Table 11. In-depth Interviews Discussion Topics

RESPONDENTS	AREAS OF DISCUSSION
16 Community Health Workers (CHWs) (8 Female and 8 Male)	▪ Opinions on the quality and availability of services at their CHC/CHC+ ▪ Perceived challenges and improvement measures for maternal healthcare at BHCs and CHCs/CHC+ ▪ Birth preparedness topics included in home visits ▪ First preference for maternal healthcare services in the community ▪ Decision-making process for place of birth delivery at the household level and the role CHWs play ▪ Perceptions of barriers for pregnant women in accessing maternal health services (including decision-making processes, stakeholders, and delays at the household level, reaching health facilities, and receiving care)
13 Community Leaders and Shura Members (All Male)	▪ Opinions on the quality and availability of services at their CHC/CHC+ ▪ Perceived barriers in accessing maternal health services by community members (including decision-making processes, stakeholders, delays,

	and reasons for delays at the household level, reaching health facilities, and receiving care) ▪ Perceived challenges and improvement measures for maternal healthcare at BHCs and CHCs/CHC+ ▪ First preference for maternal healthcare services in the community ▪ Decision-making process for place of birth delivery at the household level ▪ Potential roles in enhancing maternal healthcare service delivery in CHCs/CHC+

EXIT SURVEY/INTERVIEW

The evaluation conducted 180 exit interviews with patients who had utilised childbirth delivery healthcare services at 5 CHCs, 2 CHC+, KPH, and KMH. These surveys aimed to collect feedback on respondents' experiences with obstetric and newborn care. The exit interviews specifically focused on:

- Assessing patients' experiences with B/CEmONC services.
- Identifying strengths and weaknesses in the delivery of B/CEmONC services.
- Understanding patients' satisfaction levels and preferences regarding B/CEmONC services.
- Gathering feedback about the quality of services and thoughts to enhance the delivery of B/CEmONC services.
- Household decision-making perspectives about maternal and neonatal care.
- Barriers in accessing maternal and neonatal care.
- Knowledge and understanding of the MSF admission criteria.

As presented in Table 12 below, a representative sample of 180 project beneficiaries were selected using a simple random sampling approach among patients who have recently received childbirth delivery services at designated healthcare facilities using the health facilities' patient registers. This approach allowed for disaggregation by geography, gender, residential status, and other relevant factors.

Table 12. Exit Interview Survey Sample

HEALTH FACILITY	SELF REFERRED	REFERRED BY OTHER HF	TOTAL
MSF KMH	15	15	30
KPH	14	16	30
Nadershakot CHC+	15	0	15
Zorkot/Musa Khel CHC+	15	0	15
Ali Shir CHC	23	0	23
Gurbaz CHC	15	0	15
Kholbasat CHC	15	0	15

Lakan CHC	22	0	22
Dargai CHC	15	0	15
Total	26	31	180

Respondents for the exit interviews were chosen according to specific criteria to guarantee the validity and representativeness of the collected data. For the CHCs and CHC+, that had less than 2 deliveries caseload per day for most of the facilities, the following criteria were used:

1- Every mother after giving birth and when they are stable and ready to be discharged

2- At least 7 mothers who gave birth in the health facility

3- Mothers visiting a health facility after maximum 7 days of birth delivery

4- Every other PNC client/visitor until a total of 8 interviews was reached

For KPH and KMH, specific respondent selection parameters were applied to ensure data validity and representation. These parameters accounted for the high patient volume at both facilities, which averaged over 30 self-referred childbirth cases per day and approximately 4 cases referred from other facilities daily. Tables 13 and 14 below, present the respondents selection procedures employed for self-referred and other-facility-referred respondents' selection.

Table 13. Self-Referred Cases Exit Interview Respondents Selection Procedure

EXIT INTERVIEW SCHEDULE	1ST INTERVIEW*	2ND INTERVIEW	3RD INTERVIEW	4TH INTERVIEW	5TH INTERVIEW
Day one	6th Discharged	19th Discharged	32nd Discharged	45th Discharged	58th Discharged
Day two	5th Discharged	18th Discharged	31st Discharged	44th Discharged	57th Discharged
Day three	3rd Discharged	16th Discharged	29th Discharged	42nd Discharged	55th Discharged
Day four**	2nd Discharged	15th Discharged	28th Discharged	41st Discharged	54th Discharged

* First interview randomly selected using Rand between 1 to 13 (interview interval)

** Covered non-response (those did not provided consent to be interviewed) or if the cases remain lower than estimated

Table 14. Other Health Facility Referred Exit Interview Respondents Selection Procedure

EXIT INTERVIEW SCHEDULE	1ST INTERVIEW*	2ND INTERVIEW	3RD INTERVIEW	4TH INTERVIEW	5TH INTERVIEW
Day one	1st Discharged	2nd Discharged	3rd Discharged	4th Discharged	5th Discharged
Day two	1st Discharged	2nd Discharged	3rd Discharged	4th Discharged	5th Discharged

Day three	1st Discharged	2nd Discharged	3rd Discharged	4th Discharged	5th Discharged
Day four**	1st Discharged	2nd Discharged	3rd Discharged	4th Discharged	5th Discharged

*Every referred-in discharge to be interviewed given the number of referred-in cases

** Covered non-response (those did not provided consent to be interviewed) or if the cases remain lower than estimated

LIMITATIONS

The evaluation faced the following challenges that may have influenced the scope and findings of the study:

- **Security-Related Challenges:** Due to ongoing border conflict, Jaji Maidan CHC had to be excluded from the assessment. To compensate for this, exit interviews, IDIs, and FGDs originally planned for Jaji Maidan were conducted in Ali Sher and Lakan. While this adjustment helped maintain the overall sample size, it may have limited the representation of insights specific to the Jaji Maidan context.
- **Low Caseloads in Health Facilities:** Some health facilities experienced a lower-than-expected number of delivery cases during the evaluation period. This necessitated extending the data collection timeframe to ensure an adequate sample size for analysis. However, this extension could have introduced slight variations in facility utilisation trends due to temporal differences.
- **Reliability of medical data from non-MSF-supported health facilities:** The reliability of medical data from non-MSF-supported health facilities was a key limitation, as this data, sourced from the national HMIS database, could not be fully trusted. BPHS project payments have been performance-based, tied to specific indicator achievements (including birth deliveries), potentially introducing bias. Additionally, HMIS data had not been regularly validated to assess its accuracy, leading to issues such as incomplete records and missing information. Acknowledging these challenges, the evaluation team remained vigilant, employing cross-referencing and rigorous analytical methods to mitigate the impact of these limitations.

The evaluation employed adaptive measures to minimise the impact of these limitations, ensuring the findings remained comprehensive and representative of the maternal and neonatal healthcare context in Khost province.

ETHICAL CONSIDERATIONS

The evaluation adhered to high safety and ethical standards, and maintained integrity. All team members, including field researchers, were trained in principles of safety, do-no-harm, confidentiality, dignity and self-determination, and non-discrimination. Informed consent was obtained from all participants, ensuring voluntary participation with the option to withdraw at any time. Participants

were informed about the evaluation's objectives, risks, and benefits through an information sheet before their verbal consent was obtained.

The evaluation team members committed to TKH's Code of Conduct on ethics and safety, which covered the requirements of MSF's Ethical Guidelines[34], throughout the process.

OBLIGATIONS OF THE EVALUATOR

The evaluation team upheld key professional principles to ensure the credibility and integrity of the evaluation process. Independence and impartiality were maintained, avoiding bias and presenting a balanced assessment of the project's strengths and weaknesses. Credibility was maintained by basing findings on reliable data and robust methodologies, while conflict of interest was avoided to preserve the evaluation's objectivity.

The team emphasised honesty and integrity, accurately representing their expertise and adhering to professional standards. Accountability was ensured by delivering results within the agreed timeline and budget, with careful financial management throughout the evaluation process.

OBLIGATIONS TO PARTICIPANTS

The evaluation upheld principles of dignity, diversity, and respect, ensuring cultural and social sensitivities were observed. Field researchers, guided by local coordinators and supported by MSF's community engagement team, followed culturally appropriate practices, particularly in matters of sexual and reproductive health. Data collection methods and tools were carefully designed to align with community norms, and interviews were conducted privately without photographs or unnecessary questioning.

Participants' rights were prioritised, including their autonomy and ability to make informed, voluntary decisions without pressure. Comprehensive information about the evaluation's purpose, process, and potential risks or benefits was provided before verbal consent was obtained. Efforts were made to ensure fair representation of marginalised groups, such as displaced persons and individuals with disabilities, to promote inclusivity.

Confidentiality was maintained by anonymising personal data and reporting findings in aggregated manner. The evaluation also sought to minimise risks and burdens on participants while maximising benefits, avoiding harm, and maintaining the integrity of the evaluation process.

[34] MSF. (2022). *Médecins Sans Frontières – SEU Ethical Guidelines*. [Viewed 13 April 2024]. Available from https://evaluation.msf.org/sites/default/files/2023-01/GUI_2022_SEU_MAIN_EthicalGuidelines.pdf

DATA PROTECTION AND SECURITY

TKH maintained robust data protection and security measures throughout the evaluation process, adhering to ethical standards and the European General Data Protection Regulation (GDPR) regulations.

Measures include:

- **Data Collection:** Data collected in the field was promptly transferred to the field coordinator, ensuring minimal risk of unauthorised access.
- **Personal Identifiers:** Respondent identities and any other personal information were anonymised through coding, preventing attribution of views to individuals.
- **Secure Storage:** Data is protected through password-protected, role-based access systems.
- **Training:** Team members were trained in data security best practices, including managing potential requests from local authorities without disclosing sensitive information.
- **Backup and Disposal:** Data is regularly backed up, and secure disposal protocols are in place for permanent deletion post-evaluation.

In case of data breaches, TKH has incident response procedures to address, contain, and prevent future occurrences. These practices ensure confidentiality, integrity, and compliance while maintaining stakeholder trust.

FINDINGS

The findings of this evaluation are drawn from a comprehensive data collection process, utilising a mixed-methods approach to ensure a thorough and balanced assessment. Data sources include exit survey interviews with 180 respondents across 5 CHCs, 2 CHC+, KMH, and KPH, as well as insights from 12 KII (6 female and 6 male), 6 female FGDs (42 participants), 2 male FGDs (17 participants), 29 In-depth Interviews (8 female and 21 male), and interviewing 24 health workers (female). Additionally, the evaluation conducted detailed assessments of 9 health facilities and an in-depth analysis of secondary data, including routine health facility records, as outlined in Section: Methodology.

The findings are presented in alignment with the evaluation questions specified in the Terms of Reference (ToR). These evaluation questions guided the assessment along key evaluation criteria, including relevance, appropriateness, coherence, effectiveness, efficiency, impact, and sustainability. This structured approach ensures that the report addresses the full scope of the evaluation objectives and provides actionable insights into the before-mentioned evaluation questions both from demand and supply perspectives.

RELEVANCE

Relevance was defined as the extent to which MSF's maternal and neonatal services, provided through the Khost Maternal Health project, were tailored to address the specific needs of women and newborns in Khost province.

The relevance of the Khost Maternal Health project was assessed by examining both demand and supply perspectives and how they intersected to meet communities needs effectively. On the demand side, the evaluation explored maternal and neonatal health priorities within Khost communities, taking into account local cultural and social norms to understand what families prioritised in maternal and neonatal healthcare. On the supply side, the evaluation assessed how well the CEmONC services provided at KMH, along with MSF's support to KPH and eight CHCs/CHC+, aligned with the community needs, determining the extent to which these services directly addressed the maternal and neonatal health demands of the population in Khost province. This dual approach offered a comprehensive view of the project's relevance to the specific context and population needs in Khost province.

DEMAND-SIDE: ALIGNMENT WITH LOCAL PRIORITIES AND NEEDS

Khost province has experienced a notable rise in institutional birth deliveries over the years, with the MICS 2023[35] survey reporting that more than three-quarters (83.5%) of childbirths occur in health

[35] Multiple Indicator Cluster Survey 2022-2023: UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

facilities as compared to 18.4% in 2003[36] and 64.1% in 2015[37]. This positive trend reflects a growing awareness among families about the benefits of institutional childbirth deliveries attended by skilled birth attendants. Findings from FGDs and in-depth interviews confirmed that childbirth in health facilities was the preferred choice for communities in Khost province. Both male and female participants consistently expressed a strong preference for institutional deliveries over home childbirths. A community leader in Zor Khot highlighted:

"Nowadays, very few births take place at home because people are more aware of the risks associated with childbirth. Most births now take place at nearby health centres because these centres provide free services."

Findings from FGDs and in-depth interviews revealed challenges such as economic constraints at the household level, lack of transportation, the absence of accompanying attendants, and road closures due to heavy rain occasionally hindered access to health facilities, forcing some families to opt for home childbirths despite their preference for childbirth at health facility. Additionally, conservative cultural norms, as highlighted by FGD participants in Nadershakot and Daragai (Tani), along with domestic conflicts, such as tensions between mothers and daughters-in-law or between husbands and wives, were cited as reasons for home delivery, resulting in neglect of pregnant women's need for facility-based childbirth care. A female FGD participant in Nadershakot highlighted:

"……due to domestic household issues or tensions (between mother and daughter-in-law or husband) the women are not taken to health facility for birth delivery."

The province currently has 55 BPHS and non-BPHS health facilities providing childbirth services, including 12 FHHs, 27 BHCs, 11 CHCs, 2 CHC+, 1 MSI clinic, and 3 hospitals (Khost Teaching Hospital, KPH and KMH). Following is the range of delivery services provided through these health facilities.

Table 15. Number of Health Facilities in Khost Province and their Scope of Childbirth Services

HEALTH FACILITIES	SUMMARY OF CHILDBIRTH SERVICES
27 BHCs and 12 FHHs	▪ Open 8 hours a day (Saturday to Thursday) ▪ Skilled birth attendants during working hours ▪ Conduct normal childbirths/deliveries ▪ Refer deliveries requiring additional procedures
4 CHCs and MSI Clinic	▪ Open 8 hours a day (Saturday to Thursday) ▪ Conduct normal childbirths/deliveries ▪ Conduct assisted vaginal deliveries ▪ Refer deliveries requiring additional procedures
6 CHCs and 2 CHC+	BEmONC

[36] Multiple Indicator Cluster Survey 2003: UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3/Afghanistan/2003/Final/Afghanistan%202003%20MICS_English.pdf [Accessed 26 May 2024].

[37] Afghanistan Demographic and Health Survey 2015: U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

	▪ Open 24 hours a day (7 days a week) ▪ Skilled birth attendants available all the time ▪ Possibility of parenteral antibiotics, uterotonics, and anti-convulsant ▪ Possibility of manual removal of placenta, uterine evacuation (vacuum aspiration), instrumental delivery (vacuum extraction), and basic neonatal resuscitation
KMH and KPH	CEmONC ▪ Open 24 hours a day (7 days a week) ▪ Skilled birth attendants available all the time ▪ Possibility of parenteral antibiotics, uterotonics, and anti-convulsant ▪ Possibility of manual removal of placenta, uterine evacuation (vacuum aspiration), instrumental delivery (vacuum extraction), and basic neonatal resuscitation ▪ Possibility of surgical management (C-section, hysterectomy, and others), blood transfusion, and care of low-birthweight or sick neonates

As outlined above, the majority of health facilities in Khost province, including Khost Teaching Hospital, primarily handled normal deliveries and referred complicated cases. Of the 55 health facilities providing childbirth services in the province, only 8 facilities (6 CHCs and 2 CHC+) offered BEmONC and 2 (KMH and KPH) delivered CEmONC services to handle direct obstetric complications. MSF's Khost Maternal Health project was instrumental in directly delivering CEmONC services at KMH, supporting 6 CHCs and 2 CHC+ in delivering BEmONC services, and assisting KPH in delivering CEmONC services.

The World Health Organisation (WHO) recommends a minimum of one CEmONC and four BEmONC facilities for every 500,000 people[38]. Applying this standard to Khost province, which has an estimated population of 1,400,000[39], up to three CEmONC and 12 BEmCNC facilities would be needed to adequately serve the population's maternal and neonatal health needs.

Key informants, interviewed at the provincial capital, highlighted that KMH is the only fully operational CEmONC facility in Khost capable of handling all types of complicated pregnancies that require specialised delivery care. While KPH was also a designated CEmONC centre, this evaluation found that it was not fully staffed, equipped, or supplied to provide the full range of CEmONC services required for high-risk cases, such as complex obstetric procedures/manoeuvres to deal with direct obstetric complications, to all patients in need with optimal quality and satisfaction. A key informant highlighted:

"Khost Maternity Hospital provides life-saving services in Khost provinces because these essential services are not available anywhere else, including at Khost Provincial Hospital."

[38] World Health Organization, United Nations Population Fund, Mailman School of Public Health. Averting Maternal Death and Disability and United Nations Children's Fund (UNICEF (2009). Monitoring emergency obstetric care: a handbook. *Who.int*, [online] pp.10–11. doi: https://www.who.int/publications/i/item/9789241547734.

[39] Ranging from 659,102 estimated by NSIA to 1.5 million (estimated by EPI), KMH project uses 1.4 million as total population

Globally, about three-quarters (73%) of all maternal deaths are caused by direct obstetric complications, including haemorrhage (27.1%), eclampsia/pre-eclampsia (14%), and sepsis (10.7%)[40], and patterns for Afghanistan are not different. This underscores the critical need for functional B/C EmONC services, along with an effective referral system, to deal with direct obstetric complications and reduce maternal and neonatal mortality. In this context, the BEmONC services provided through 6 CHCs and 2 CHC+ played a vital role in handling certain direct obstetric complications at the community level and providing essential initial medical care and stabilisation before referring cases to CEmONC facilities for advanced treatment.

Community priorities regarding maternal and neonatal health, as revealed through 8 FGDs (6 female and 2 male), highlighted several key themes. Participants emphasised the importance of having accessible maternity services at the community level, which significantly reduced travel time for expectant mothers and their accompanying family members. Affordable transportation and reduced indirect costs were also identified as critical factors enabling families to access care. Additionally, the availability of skilled birth attendants 24/7 was a top priority, ensuring that emergency and routine maternal and neonatal care needs could be met at any time. Participants acknowledged the improvements in the quality of care following MSF's support to the local health facilities (CHCs) in their communities. Below is the summary of key themes that emerged from FGDs concerning communities' maternal and neonatal healthcare needs and priorities.

Table 16. Themes and Key Insights

THEMES	KEY INSIGHTS
Availability of skilled birth attendants 24/7	Being sure about the availability of midwives or doctors at night, available 24/7 ambulance services at the health facility
Accessible maternity services at the community	Reduced travel time, easy to find transportation, can access when it is raining, familiar with the CHCs in the community
Affordable cost	Affordable transportation cost, food and other essentials could be supplied from home

Further, a female FGD participant in Dargai highlighted.

"Before, many women used to give birth at home and faced many problems because their families could not afford or [did not] want to take pregnant women to Khost, especially during the night, and some even lost their lives. Now our problems have been solved in this clinic, and we can access easily this CHC both during the day and at night."

As such, the Khost Maternal Health project's support to 8 CHCs/CHC+ and KPH in delivering BEmONC and CEmONC services was relevant to the maternal and neonatal health needs and priorities identified by participants in this evaluation.

[40] Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., Gülmezoglu, A.M., Temmerman, M. and Alkema, L. (2014). Global causes of maternal death: a WHO systematic analysis. The Lancet. Global health, [online] 2(6), pp.e323-33. doi: https://doi.org/10.1016/S2214-109X(14)70227-X.

SUPPLY-SIDE - HEALTH FACILITIES READINESS

On the supply side, health facilities' readiness was examined to determine if KMH and MSF-supported health facilities (5 CHCs, 2 CHC+, and KPH) were adequately equipped and staffed, and provided required CEmONC and BEmONC services to address high-risk pregnancy needs effectively.

Availability of Medical Equipment in Health Facilities

The evaluation assessed the availability and functionality of medical equipment required to deliver BEmONC and CEmONC services in 9 health facilities, including 5 CHCs, 2 CHC+, KPH, and KMH. 16 key equipment items were assessed to create an index of medical equipment availability and functionality across these facilities.

As illustrated in Figure 3 below, KMH, Nadershakot CHC+, and Gurbaz CHC emerged as the best-equipped facilities, with all 16 assessed items present and fully functional at the time of evaluation, ready to deliver required maternal and neonatal care in these facilities. However, notable gaps in essential medical equipment were identified across the remaining 6 health facilities including KPH, as follows:

- **Two Sterile Towels for Newborns:** Available in only 6 out of 9 facilities, indicating limited capacity for maintaining sterile conditions during newborn care. KPH, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ did not have this.
- **18- or 16-Gauge Needles:** Present in 6 out of 9 facilities, highlighting challenges in performing certain medical procedures, especially parenteral antibiotics, uterotonic, and anticonvulsant administration in under-resourced settings. Ali Sher CHC, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ did not have this.
- **Hand Scrubbing Brushes:** Available in 7 out of 9 facilities, raising concerns about infection control practices in the two facilities (Ali Sher and Khulbesat/Sabari CHCs) without this critical item.
- **Neonatal Resuscitation Trolleys:** Found in 7 out of 9 facilities, leaving gaps in managing neonatal emergencies in two facilities (Ali Sher and Dargai CHCs).
- **Clean Delivery Kits:** Present in 8 out of 9 facilities, suggesting that the facility (KPH) was prepared for safe delivery.
- **Manual Vacuum Aspiration (MVA) Kits:** Found in 8 out of 9 facilities, required for managing specific obstetric complications - Zorkot/Musa Khel CHC+ did not have this.
- **Foetal Stethoscopes (Pinards):** Present in 8 out of 9 facilities. Zorkot/Musa Khel CHC+ did not have Pinard required for monitoring of foetal health during delivery.

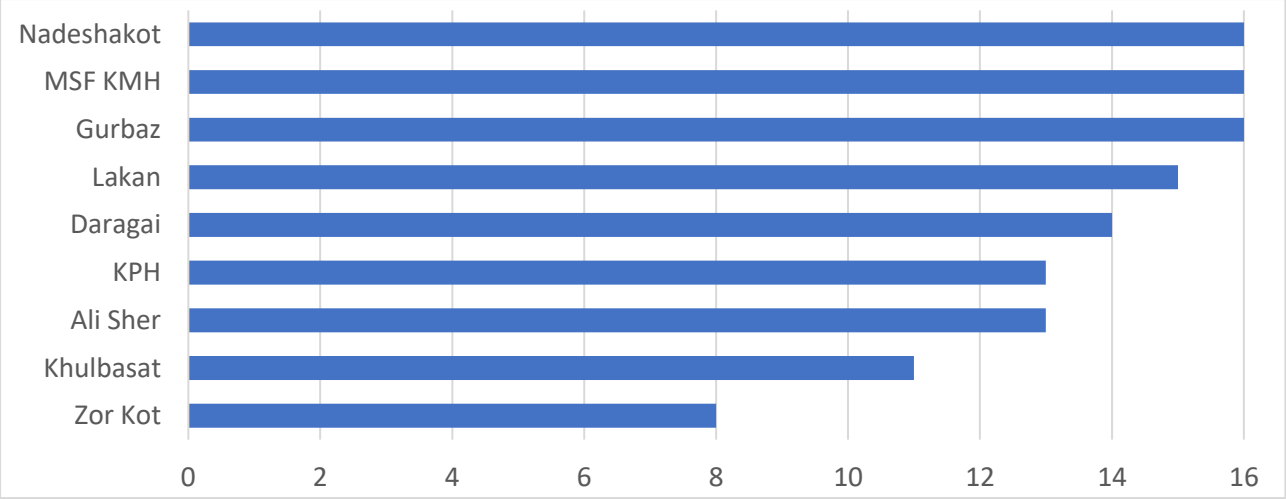


Figure 3. Availability of Essential Medical Equipment at Health Facilities

These findings underscore disparities in the availability of medical equipment among the assessed health facilities. While some facilities like KMH, Nadershakot and Gurbaz CHCs demonstrated full readiness for required maternal and neonatal care, gaps in essential equipment across others compromise the ability of health facilities to consistently deliver high-quality services, especially in Zorkot/Musa Khel CHC+ and Khulbesat/Sabari CHC along with KPH. Addressing these gaps, particularly in equipment and supplies essential for parenteral medication, infection prevention and neonatal resuscitation, is crucial for ensuring quality maternal and neonatal care and meeting the maternal and neonatal healthcare needs of people in Khost province.

Availability of Essential Medicines in Health Facilities

The evaluation also included a review of the availability of essential medicines required for BEmONC and CEmONC services across 9 health facilities (5 CHCs, 2 CHC+, KPH, and KMH). Key medicines critical for maternal and neonatal healthcare were assessed to evaluate the readiness of these facilities to handle routine and emergency childbirth cases effectively.

As illustrated in Figure 4 below, the findings revealed notable gaps in the availability of some essential medicines, summarised as follows:

- **Anti-Tetanus Serum (ATS):** Available in only in KMH, indicating a critical gap in the prevention and treatment of neonatal and maternal tetanus in other health facilities including KPH.
- **Glucose (5% and 10%) Isotonic Solutions:** Was not available in Daragai/Tani and Gurbaz CHCs, essential for managing dehydration and other metabolic emergencies.
- **Ringer Lactate:** Was not available in Daragai/Tani and Gurbaz CHCs, essential for resuscitation in cases of obstetric emergencies such as haemorrhage or sepsis.
- **Paracetamol:** Was not available in Khulbesat/Sabari and Ali Sher CHCs, critical for pain relief and fever management in mothers.
- **Ciprofloxacin:** Was not available in KPH and Lakan CHC, an important antibiotic for preventing and managing postpartum infections.

- **Ergometrine:** Was missing in Ali Sher, Daragai/Tani, Gubaz, and Lakan CHCs and Nadershakot CHC+, which poses a significant concern as it is crucial for preventing and treating postpartum haemorrhage.

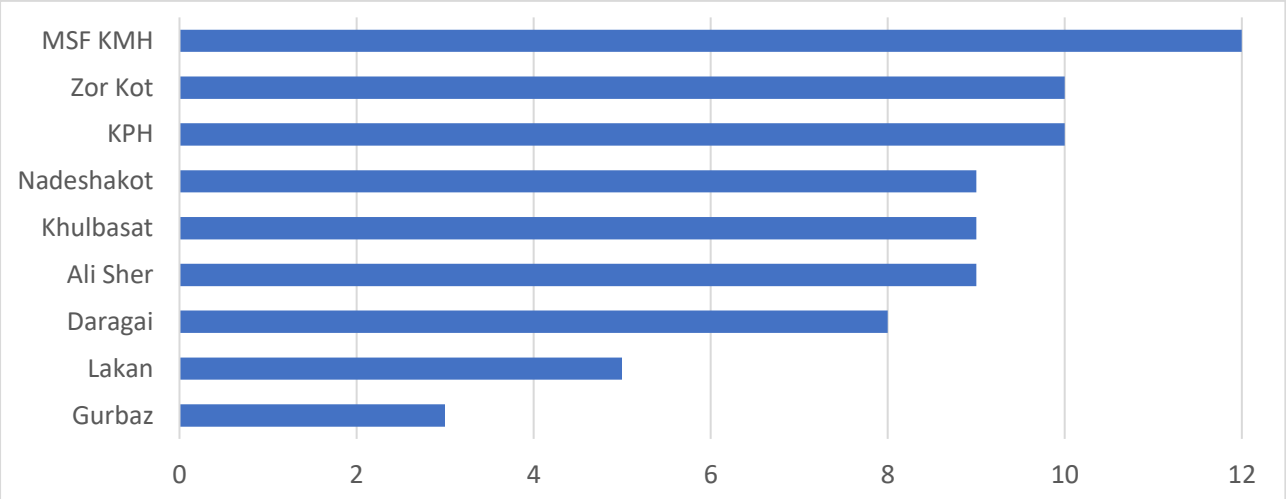


Figure 4. Availability of Essential Medicine at Health Facilities

Gaps in the availability of essential medicines, particularly Ringer Lactate, Glucose (5% and 10%), and Ergometrine, were found to significantly impact the ability of health facilities to deliver critical maternal and neonatal health services. This issue was particularly evident in Gurbaz, Lakan, and Daragai/Tani CHCs, where shortages were noted during the evaluation. Additionally, the shortage of essential medicines in the CHCs/CHC+ emerged as a recurring concern (theme) among FGD participants, who emphasised that these shortages posed a significant barrier to meeting maternal and neonatal healthcare needs in the CHCs/CHC+ in their communities. A female FGD participant in Ali Sher highlighted:

"The services at this CHC are beneficial for our community. When my baby was born, they immediately vaccinated her, I was kept under observation for 8 hours to recover and received required care. The only issue I faced was that some of the medicine I needed were not available. Now the entire community knows about this issue (shortage of medicine) at our CHC and is really concerning"

SUPPLY – SIDE: SERVICES PROVIDED

The evaluation of the nine health facilities' capacity to deliver BEmONC and CEmONC services revealed certain gaps in the provision of BEmONC services at the CHC level. While all facilities operated 24/7 and provided antenatal care (ANC), delivery, and postnatal care (PNC) services (except KMH, which did not offer ANC services), some critical services for managing direct obstetric complications were either not performed or were hindered by a lack of essential medicines and equipment.

As detailed in Table 16 below, Ali Sher CHC, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ reported providing parenteral antibiotics, uterotonics, and anticonvulsants but lacked the 16- and 18-gauge needles (at the time of evaluation) required for these procedures. Furthermore, Ali Sher,

Daragai/Tani, and Khulbasah CHCs did not confirm the availability of procedures for the removal of retained products of conception using D&C or manual vacuum aspiration. Although all nine facilities confirmed offering neonatal resuscitation services, Ali Sher and Daragai/Tani CHCs lacked neonatal resuscitation trolleys, and Khulbesat/Sabari CHC did not have an infant Ambu bag, limiting their capacity to perform neonatal resuscitation effectively.

CEmONC services were primarily performed at KMH and KPH. Nadershakot and Zorkot/Musa Khel CHC+ provided surgical management (C-section) and blood transfusion services in emergency cases only, handling just 3-4 cases annually. The delivery of specialised care for low birth weight or sick neonates was restricted to KMH and KPH.

Table 17. EmONC Services Availability at 5 CHCs, 2 CHC+, KPH, and KMH

SERVICES OFFERED	NO OF HFS	REMARKS
Open 24 hours a day (7 days a week)	All 9 HFs	
Antenatal Care (ANC) services	8 out of 9 HFs	KMH did not offer ANC services
Postnatal Care (PNC) services	All 9 HFs	At KMH to those staying more than 24 hours in the facility
Parenteral administration of antibiotics for mothers	All 9 HFs	Ali Sher CHC, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ did not have 16 and 18 gage needles at the time of assessment (Detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness)
Parenteral administration of uterotonics	All 9 HFs	Ali Sher CHC, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ did not have 16 and 18 gage needles at the time of assessment (Detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness)
Parenteral administration of anticonvulsants for management of pre-eclampsia and eclampsia	All 9 HFs	Ali Sher CHC, Khulbesat/Sabari CHC, and Zorkot/Musa Khel CHC+ did not have 16 and 18 gage needles at the time of assessment (Detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness)
Manual removal of placenta	All 9 HFs	
Removal of retained products of conception using D&C or manual vacuum aspiration	6 out of 9 HFs	Ali Sher, Daragai/Tani, and Khulbasah CHCs did not confirm offering these services
Assisted vaginal delivery using Manual Vacuum Extraction (MVA) or forceps	All 9 HFs	
Neonatal resuscitation	All 9 HFs	Ali Sher and Dargai CHCs did not have neonatal resuscitation trolley and Khulbesat/Sabari CHC did not have

		infant Ambu bag (Detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness)
Surgical management (C Section)	4 out of 9 HFs	Nadershakot and Zorkot/Musa Khel CHC+ confirmed the capacity for doing C-Section (by male surgeon) only in emergency situations (3 – 4 cases annually)
Blood transfusion	4 out of 9 HFs	Nadershakot and Zorkot/Musa Khel CHC+ confirmed doing fresh blood transfusion
Care of low birth weight or sick neonates	2 out of 9 HFs	KMH and KPH only

Gaps in the delivery of BEmONC services at the CHC/CHC+ level was perceived to have significantly impacted community trust in locally available maternal and neonatal care at the CHCs, resulting in a preference for delivery services at KMH. The inability of CHCs to perform critical procedures, such as removal of retained products of conception or neonatal resuscitation due to shortages of essential equipment and supplies, contributed to perceptions of inadequate care at the CHCs among community members. As a result, many families, especially those who could afford it, chose to bypass CHCs and seek care at KMH, even for normal deliveries that could have been safely managed at the CHC level.

Responding to the first preference of birthplace, FGD participants from Zorkot/Musa Khel, Nadershakot, Khulbesat/Sabari, and Daragai/Tani highlighted that families often opted for KMH or KPH because they perceived the KMH and KPH were better supplied with essential medicine and had better quality of care. A participant from Khulbesat/Sabari shared:

"Those who can afford and don't have transportation issues they will take their pregnant women to KMH or KPH otherwise in this CHC. Because in the health facility both the mother and the baby child receive much better care compared to the CHC in our community."

This increased reliance overloaded KMH, particularly with normal deliveries, diverting KMH's resources to managing normal deliveries that could have been handled at CHCs. As presented in Figure 5 below, routine health facilities data[41] analysis corroborated this trend, showing that in 2023 over 40% of pregnant women from Ismail Khel, Bak, Sabari, Nadershakot, Shemal, Terezayi, and Matun districts chose to deliver at KMH. This influx of normal delivery cases placed additional strain on KMH, while placing additional burdens on families, including higher transportation costs and longer travel time in accessing maternal and neonatal services compared to CHCs in their communities. Addressing these gaps at the CHC level is essential to restore community confidence and reduce the burden on KMH.

[41] Recorded at the Health Management Information System (HMIS) for all health facilities in Khost

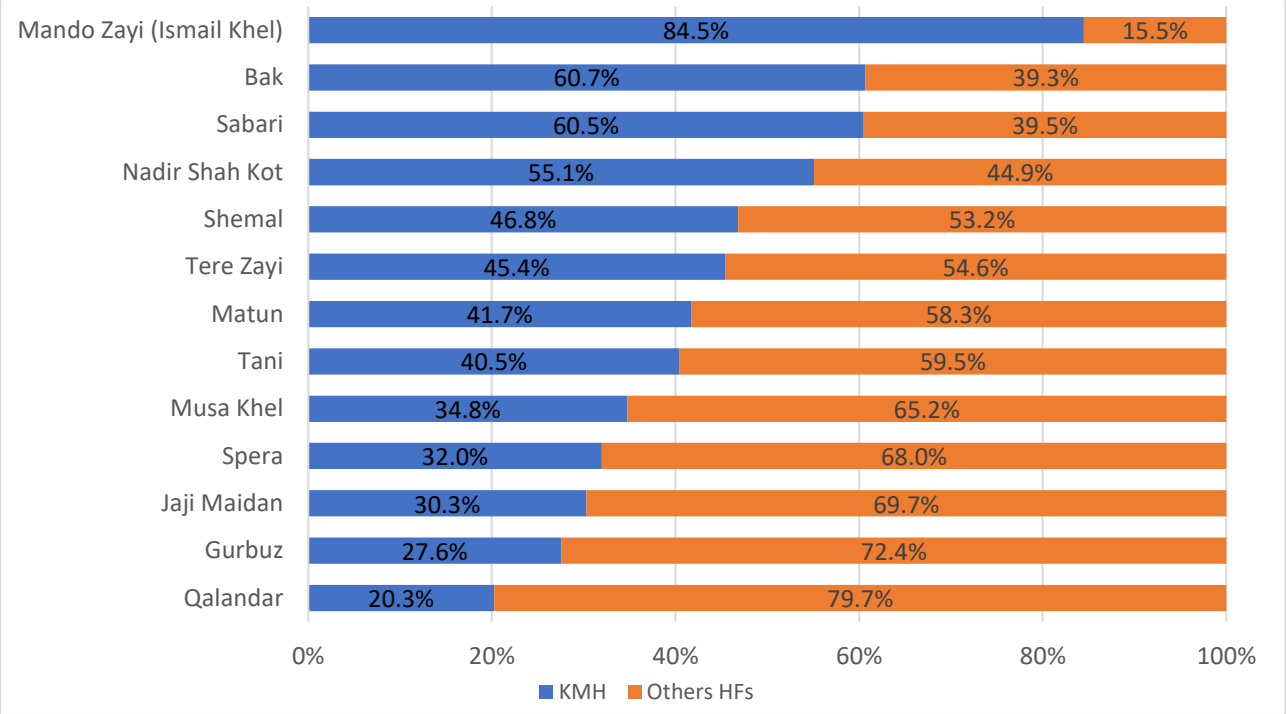


Figure 5. District-wise Institutional Deliveries Trend and KMH Share

APPROPRIATENESS

Appropriateness was defined as the extent to which the approaches taken by MSF contributed towards reducing morbidity and mortality for women with pregnancy related complications, considering the local context and the project's objective of promoting resiliency of the local health system and actively engaging communities.

The approaches employed by the Khost Maternal Health project included delivering CEmONC services at KMH, supporting 6 CHCs and 2 CHC+ to deliver BEmONC and KPH to deliver CEmONC services, and community engagement and health promotion activities in KMH (health education) and communities. This evaluation assessed the extent to which each of these approaches were appropriately designed and executed in order to reduce maternal and neonatal morbidities and mortalities.

APPROPRIATENESS OF CEmONC SERVICES AT KMH

KMH, a secondary healthcare facility, functions as a fully operational CEmONC centre, delivering reliable maternal and neonatal care to the 1.4 million residents of Khost province[42]. The facility included a 60-bed maternity unit, a 32-bed neonatal unit (with an 8-bed NICU), and two operating theatres. As one of two CEmONC facilities in the province, KMH played a critical role in managing complicated deliveries and providing specialised care for mothers and newborns.

[42] Ranging from 659,102 estimated by NSIA to 1.5 million (estimated by EPI), KMH project uses 1.4 million as total population.

The high delivery standards maintained by MSF at KMH were evident from acceptable case fatality rates for both mothers and neonates (respectively, 0.11% among DOCs and 7.6% among those referred to neonatology), meeting the expected results of the project. The availability of 24/7 comprehensive emergency obstetric care, including obstetrical surgeries and bilateral tubal ligation (BTL) services, alongside quality ICU services, underscored the appropriateness of KMH's approach in meeting critical maternal health needs. Auxiliary and transversal services further enhanced the safety and quality of care, adhering to universal precautions and safety standards.

While KMH provided first PNC services to mothers staying longer than 24 hours, those discharged earlier were required to seek follow-up care from other health facilities. As more than 60% of maternal deaths occur during the postpartum period[43], there was a need for strengthened measures to ensure discharged mothers were aware of and connected to postnatal care in their communities. This includes pre-discharge counselling, issuing PNC cards and pictorial information leaflets containing details on postnatal care, family planning, and exclusive breastfeeding. While the evaluation did not identify postpartum maternal deaths of mothers who delivered at KMH, there was no system to track mothers during the first six weeks following delivery.

Neonatal care services, particularly those in the NICU for low-birthweight and infected newborns, were found to be of high quality. However, certain areas required improvement, including enhanced nutrition and breastfeeding counselling and hands-on training for mothers, especially for low-birth-weight babies. Given the low literacy levels of mothers (94% of exit interview respondents were illiterate), such counselling and training would help improve neonatal outcomes. Additionally, referral systems linking newborns to other facilities for postnatal checkups and vaccinations could further enhance care continuity.

Exit interviews and in-depth discussions revealed that KMH is widely regarded as a facility of choice for birth deliveries. Women appreciated its adherence to local cultural norms and provision of a woman-friendly environment, including gender-segregated patient and visitor flows, women-only spaces staffed by female healthcare providers, fully enclosed consultation rooms, separate entry points and waiting areas for men and women, and strong privacy measures throughout. These elements were key factors influencing their preference for KMH. This cultural sensitivity, combined with the facility's high-quality care, underscores the appropriateness of KMH's approach in meeting the maternal and neonatal healthcare needs of the community.

APPROPRIATENESS OF MSF'S SUPPORT TO CHCS AND KPH

MSF's support to 6 CHCs, 2 CHC+, and KPH as part of the Khost Maternal Health Project was found to be appropriate in its efforts to enhance maternal and neonatal healthcare services at both community and provincial levels. Beginning in 2016 with Gurbaz CHC and Nadershakot CHC+, adding Zorkot/Musa Khel CHC+ and Lakan and Khulbesat/Sabari CHC in 2017, the initiative expanded by 2021 to include Musa Khel, Jaji Maidan, and Terezayi CHCs, totalling eight facilities, as presented in Figure 6 below.

[43] World Health Organisation (2022). *WHO Recommendations on Maternal and Newborn Care for a Positive Postnatal Experience*. [online] Available at: https://iris.who.int/bitstream/handle/10665/352658/9789240045989-eng.pdf?sequence=1.

The support included funding for additional staff (two midwives and one cleaner per CHC/CHC+ to enable 24/7 service delivery) and ad-hoc pharmaceutical supplies donations. Similarly, KPH benefitted from the addition of 12 midwives, 4 nurses, and 4 cleaners, alongside periodic supplies of medicines.

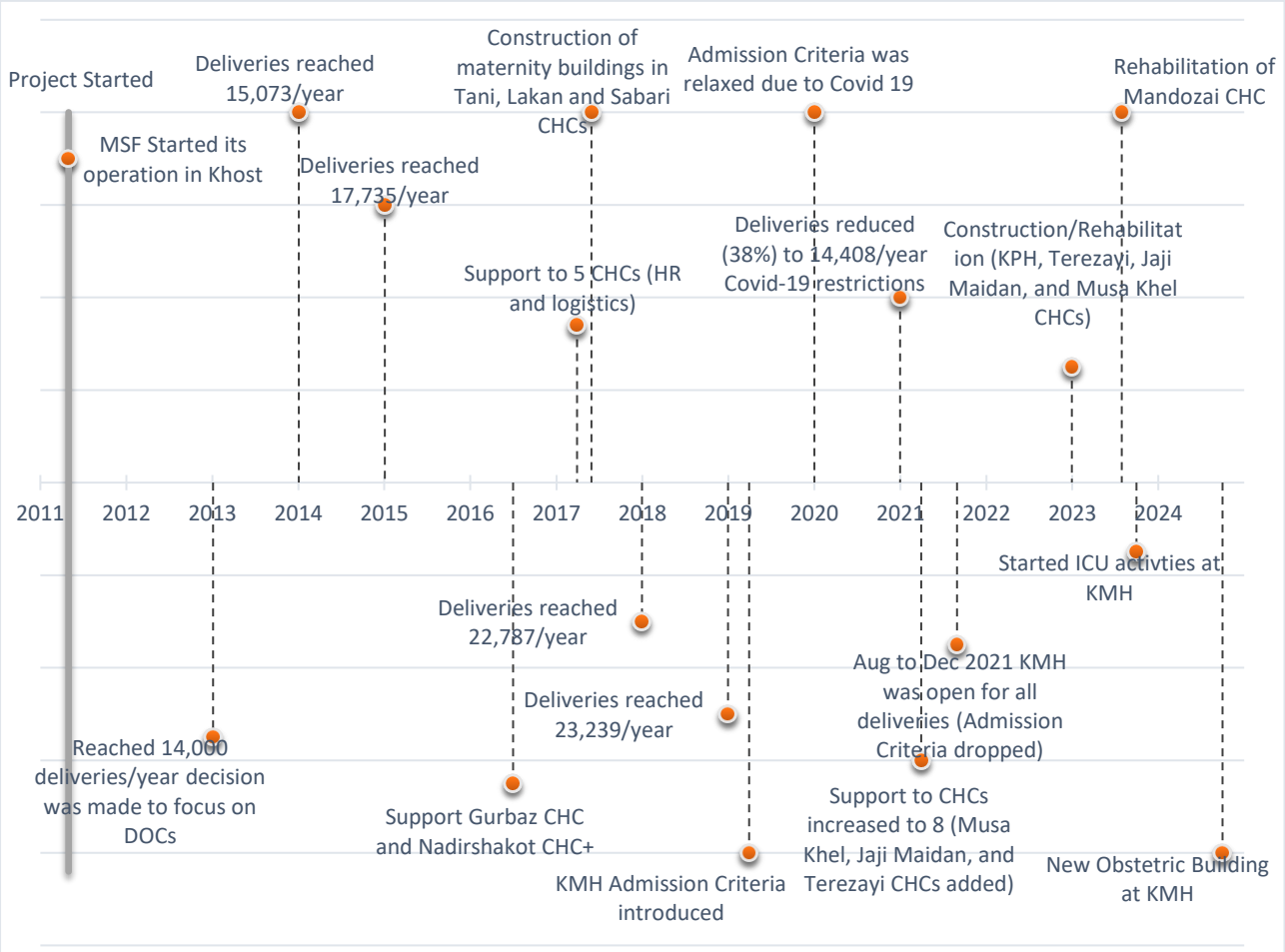


Figure 6. Timeline of Key Events of KMH Project (Supporting CHCs and Others)

At the CHC and CHC+ level, the addition of midwives enabled the provision of round-the-clock maternal and neonatal services, improving access to BEmONC at the community level. However, persistent shortages of medicine and medical supplies negatively impacted community perceptions of the quality of care provided at these facilities. This issue was compounded by concerns over the behaviour of healthcare workers at these CHCs/CHC+, as shared in focus group discussions (FGDs). Participants from four FGDs, with the recent experience of childbirth, reported delayed and disrespectful care during their recent labour at the CHCs/CHC+, perceived to have further eroded communities' trust in local services. As a result, families who could afford alternative options often bypassed local CHCs and CHC+ in favour of seeking services at KMH, KPH, or private providers, as reported by focus group discussion (FGD) participants. A participant with childbirth experience at a CHC shared her perspective about healthcare worker behaviour:

"…….some of them (health workers) behaved really bad and bad words were used for me when I was in pain. The healthcare workers should not use bad words to the patients or treat them badly, the patients should be treated well because they are in pain….."

These shortcomings highlighted that while MSF's support was necessary to ensure service availability 24/7, nor did it address the community's perception of care quality, which is essential for enhancing utilisation of maternal and neonatal services at CHCs/CHC+.

These findings highlight the need for not only improving the availability of medicines and supplies but also addressing healthcare worker behaviour to rebuild community trust and ensure better maternal and neonatal outcomes at the CHC level.

Khost Provincial Hospital

MSF's support to KPH, including the addition of 4 nurses, 12 midwives[44], and 4 cleaners, was instrumental in enhancing the facility's capacity to deliver CEmONC services. With a total capacity of 177 in-patient beds (56 in Internal Medicine, 46 in Surgery, 54 in Paediatrics including 10 NICU beds, and 21 in Obstetrics and Gynaecology), KPH served as a critical referral centre and placed to play a critical role in providing maternal and neonatal healthcare under the EPHS Health Emergency Response (HER) project. However, the maternal and neonatal services at KPH remained under-resourced, with gaps in staffing, equipment, and medical supplies that hindered the delivery of quality care.

While the additional human resources supported by MSF helped manage the increased volume of obstetric and neonatal cases, critical challenges persisted at KPH hindering its capacity to deliver optimal maternal and neonatal services. The facility's infection prevention and control measures were sub-optimal, some key essential medical equipment required for optimal care was non-functional (as presented in Section Findings> Relevance> Supply-Side - Health Facilities Readiness) and healthcare workers did not consistently adhere to fundamental practices such as the use of partographs. These issues underscore the need for capacity development initiatives, including health facility management, technical skill enhancement, exposure visits to KMH, and biomedical engineering support to maintain and repair critical equipment.

Although MSF's contribution of additional staff was valuable, these efforts alone were insufficient to address the systemic gaps in service delivery at KPH. The evaluation also found that KPH had the highest client dissatisfaction rate among the 9 health facilities assessed, highlighting the urgent need for broader interventions to improve the quality of care and patient experience.

APPROPRIATENESS OF COMMUNITY ENGAGEMENT INITIATIVES (ACTIVELY ENGAGING COMMUNITIES)

Community engagement initiatives of the Khost Maternal Health project were two-fold: engaging community elders as part of accountability process and enhancing community acceptance about KMH,

[44] Total number of nurses and midwives at KPH (at the time of this evaluation): nurses 46 (including 4 deployed from MSF's support) and midwives 22 (including 12 deployed from MSF's support)

and conducting health promotion outreach sessions aimed to enhance communities' awareness on sexual and reproductive health. These initiatives targeted both healthcare users and broader community members, aiming to enhance maternal and neonatal health outcomes.

Engaging Community Leaders

Engaging community elders, leaders, and religious leaders (Mullahs) was innovatively appropriate in gaining acceptance through accountability to local community. Engaging these members of the community provided required support for the project implementation, especially in areas such as adapting KMH services to local cultural norms, introducing admission criteria, managing expectations, and gathering feedback on the services provided at KMH through bi-annual meetings with these community leaders. In-depth interviews conducted with two members of this consultative group revealed their comprehensive awareness of the services and their willingness to support KMH.

Health Promotion Activities at KMH

The project conducted health promotion and awareness raising sessions through 4 Health Promoters (2 male and 2 female) at KPH. The health education sessions at KMH (IPD wards and in waiting areas) were primarily focused on various neonatal and maternal health topics, including breast feeding, infant and young child feeding, danger signs in pregnancy, importance of antenatal care and safe pregnancy, danger signs in new-borns, care for the sick child, routine vaccination, kangaroo mother care, family planning and hygiene practices. The health promotion activities were delivered in the form of patient's education, counselling, and general health education targeting both patients and their companions/chaperons (male and female). The health promotion approaches at KMH could better benefit from need-based mechanisms that are tailored to specific target groups and focus on key priority topics. These could include:

- **Patient Training and Counselling:** Providing breastfeeding guidance to mothers of low-birthweight and premature babies, as well as first-time mothers, delivered by trained counsellors.
- **Premature Baby Care:** Counselling on home care practices for premature infants to ensure proper management and follow-up.
- **PNC and Family Planning:** Offering comprehensive counselling to all mothers upon discharge, focusing on recovery, newborn care, and family planning options.
- **Targeted Messages for Chaperones/Attendants:** Educating attendants about KMH admission criteria, the importance of birth preparedness (including transportation, finances, and support), recognising danger signs during pregnancy, and understanding the essential components of care for normal deliveries.

These tailored approaches would help address the unique needs of patients and their families, ensuring more effective communication, better health outcomes, and improved utilisation of maternal and neonatal health services.

Outreach Health Promotion Activities

Outreach health promotion sessions in MSF-supported 6 CHCs and 2 CHC+ were conducted by 3 pairs of health promoters (3 female and 3 male). These sessions covered four health facilities per week and addressed a variety of topics, including the importance of antenatal care (ANC), nutrition during pregnancy, health facility deliveries, postnatal care (PNC), birth spacing, hygiene, and vaccination.

This evaluation found that the existing outreach health promotion approaches of the Khost Maternal Health project were not adequately appropriate in engaging communities to improve maternal and neonatal health outcomes. The current outreach health promotion approach primarily targeted CHCs/CHC+ visitors and selected villages in the catchment areas of these MSF supported 8 CHCs/CHC+. The 6 health promoters covered only four health facilities per week, promoting the before-mentioned diverse set of topics, which did not have specificity, focus and expanded reach, and were perceived to have limited impact. A more impactful approach would require collaborating with BPHS implementor and other organisations to enhance reaching more communities and people with focused messages. Engaging CHWs, Community Health Supervisors (CHSs), and Health Educators in all facilities would allow for the delivery of focused, community-tailored health promotion messages, addressing specific needs and ensuring greater community involvement.

Findings from this evaluation, based on 8 FGDs (6 female and 2 male), 180 exit interviews, and 29 IDIs (8 female and 21 male), highlighted a critical gap in community awareness regarding the quality of maternity services, awareness about KMH admission criteria, danger signs of high-risk pregnancies, and the importance of birth preparedness. These gaps significantly influenced healthcare-seeking behaviours and the choice of childbirth location.

Perceptions of good-quality maternity services were associated with facilities where women in labour were immediately attended to by healthcare workers, laboratory tests were conducted, injectable medications were administered, and advanced imaging diagnostics (e.g. ultrasounds) were performed. Presented below are the emerging themes about perceived quality of good maternity healthcare from 8 FGDs (6 female and 2 male):

Table 18. Themes and Key Insights

THEMES	KEY INSIGHTS
Timely attendance	Mothers are attended to (by healthcare workers) in a timely manner after reaching the health facility and their vitals (especially blood pressure) are checked
Lab tests	Lab tests are performed to delivering mothers, especially blood test
Injectable medications	Mothers were administered injectable medicine, especially IV infusions
Ultrasound examination	Having an ultrasound (*locally called television exam*) as part of the delivery process indicated high quality of care (perceived to be mostly available in private facilities)

The above themes for good quality maternity care emerged in response to asking for the reasons of preferred place of birth and perceived good quality of maternity services, based on 6 female FGDs (42 participants with less than two years of recent birth delivery history) and 2 male FGDs (17 participants who had a childbirth in the family in less than 2 years).

These factors significantly influenced healthcare-seeking behaviour, leading many families to bypass CHCs in their communities for normal deliveries and opt for KMH, which was perceived as being better equipped and supplied. While certain interventions like timely attendance of women in labour by health workers are essential, other practices, such as lab tests, injectable medications, and advanced diagnostics (ultrasound), may not be necessary for uncomplicated cases. These misconceptions require targeted health education for both women and their families.

Neither the FGD participants nor the 16 CHWs interviewed (8 male and 8 female) were aware of the KMH admission criteria, and 4 healthcare workers (out of 20 in 7 CHCs/CHC+ and KPH) were also unfamiliar with these criteria. This lack of clarity was perceived to have contributed to the overburdening of KMH with normal deliveries that could have been managed at CHCs. Socialising the admission criteria more effectively, particularly through community health workers (CHWs) and community health supervisors (CHSs), could help redirect uncomplicated deliveries to local facilities. The community's understanding of high-risk pregnancy danger signs was limited to bleeding (antepartum and postpartum) as the only sign they could identify. Additionally, communities and families lacked awareness of the concept of birth preparedness, such as planning for transportation, finances, and attendants to pregnant women in advance, which was a significant factor contributing to the first and second delays in maternal care, as outlined in Section Findings> Relevance> Demand-Side: Alignment with Local Priorities and Needs.

The project's current health promotion outreach model, relying on a small number of health promoters (3 pairs) covering diverse topics[45] in a limited geographic area was insufficient to address the broader needs of the community. With only 4 health facilities reached per week, the project's health promotion coverage remained constrained, limiting its ability to deliver focused, community-specific messages. Empowering CHWs and other health facility staff with tailored information, education, and communication (IEC) packages could enable more effective dissemination of health messages. Additionally, engaging all organisations involved in healthcare delivery to harmonise health promotion efforts could amplify the impact.

While community engagement initiatives were well-intentioned and culturally sensitive, they fell short in addressing specific maternal and neonatal health needs. Tailored health promotion activities, improved dissemination of KMH admission criteria, and strengthened collaboration with CHWs and other healthcare providers can enhance the effectiveness and appropriateness of health promotion initiatives. By refining these approaches, the KMH project can better address community health challenges and further improve maternal and neonatal outcomes.

[45] Importance of antenatal care, nutrition during pregnancy, health facility deliveries, postnatal care (PNC), birth spacing, hygiene, and vaccination

COHERENCE

Coherence was defined as the extent to which MSF's Khost Maternal Health project's interventions were compatible with maternal health policies and other interventions in Khost province.

The Khost Maternal Health project's interventions were coherent with maternal health policies and other interventions in Khost province. The project demonstrated alignment with Afghanistan's maternal health priorities by aiming to improve access to quality maternal and neonatal healthcare services. Specifically, the provision of standard CEmONC services addressed critical gaps in secondary care, consistent with national health strategies. Similarly, its collaboration with CHCs, CHC+ and KPH on maternal and neonatal health services supported the delivery of a Basic Package of Health Services (BPHS) and Enhanced Package of Hospital Services (EPHS) in Khost province.

However, the evaluation found that the project's potential for synergy with other health actors in Khost province was not fully realised. Although the project's support to HN-TPO filled critical gaps in service delivery at CHCs/CHC+ and KPH, stronger collaboration with other stakeholders (CARE international, IRC, provincial health authorities, Khost Teaching Hospital, and private healthcare providers) could have enhanced the coherence of interventions. For instance: joint initiatives to strengthen the referral system, socialising KMH admission criteria, and developing a collaborative health promotion mechanism for better health promotion outcomes. A key informant from another organisation involved in delivering maternal and neonatal services highlighted:

"…in my opinion, if a meeting is held between the relevant clinical implementing agencies and MSF the referral system can be strengthened. The referral system needs to be reviewed and strengthened."

Similarly, engaging private healthcare providers in Khost province could be an opportunity to strengthen the coherence of the Khost Maternal Health project, particularly in addressing gaps related to KMH's admission criteria. Private facilities often serve as the first point of contact for many families seeking maternal healthcare (35% of respondents to exit interview received ANC from private providers, and 33% of referrals to KMH were from private providers), but limited knowledge about KMH's services and admission requirements among private healthcare workers has contributed to unnecessary referrals and overcrowding at KMH. Establishing an engagement mechanism with private providers can ensure that these stakeholders are well-informed about KMH's criteria for admission. This would not only streamline referrals for high-risk pregnancies to KMH but also enable private providers to appropriately manage uncomplicated deliveries, reducing the burden on KMH's resources. Additionally, fostering collaboration between KMH and private providers can encourage adherence to standardised maternal health protocols, promote mutual learning, and improve overall healthcare service delivery in the province. A doctor in a private hospital highlighted:

"I have heard about MSF, ……., in my opinion, they (KMH) handle very few patients and refer most of them to Khost Provincial Hospital, saying that the patients don't fit their criteria. I don't know about their (KMH) admission criteria."

Another midwife, providing maternity services from her home, highlighted:

"I have handled many complicated cases, including postpartum haemorrhage, incomplete abortion, and threatened abortion. ….. However, if patients with eclampsia and preeclampsia come to me or show symptoms of it, I immediately refer them to MSF hospital (KMH)."

EFFECTIVENESS

Effectiveness was defined as the extent to which the project's defined objectives were achieved, highlighting key factors that influenced its progress and how the project can become more effective in achieving its objectives and promoting resilience and sustainability of the local health system.

Effectiveness was assessed through a dual lens, examining both supply and demand aspects and their interaction in delivering maternal and neonatal healthcare services. On the supply side, the evaluation focused on the performance of health facilities, the referral system, and the capacity of healthcare providers to deliver maternal and neonatal healthcare services in Khost. On the demand side, the evaluation assessed patient satisfaction with the BEmONC and CEmONC services provided at KMH, KPH, and 8 CHCs/CHC+, as well as the barriers patients faced in accessing these services. This integrated approach provided a comprehensive understanding of the Khost Maternal Health Project's effectiveness within the context of the local healthcare system and the needs of the population in Khost province.

SUPPLY-SIDE: PERFORMANCE OF HEALTH FACILITIES

Performance of health facilities was assessed by the extent to which KMH and MSF-supported health facilities (5 CHCs, 2 CHC+, and KPH) were able to effectively handle obstetric emergencies, as a way of contributing towards reducing maternal and neonatal deaths. While KMH had established performance indicators within its project logical framework, CHCs/CHC+ and KPH lacked facility-specific indicators for maternal and neonatal health, making it challenging to evaluate and compare the performance of these assessed health facilities.

Performance of KMH

KMH has played a pivotal role in providing maternal and neonatal healthcare services to the population of 1.4 million in Khost province. As illustrated in Figure 7 below, KMH has consistently accounted for a substantial share of total deliveries recorded in the public sector in Khost province, contributing over 40% of all reported deliveries (ranging from 44% in 2022 to 40.2% in 2024).

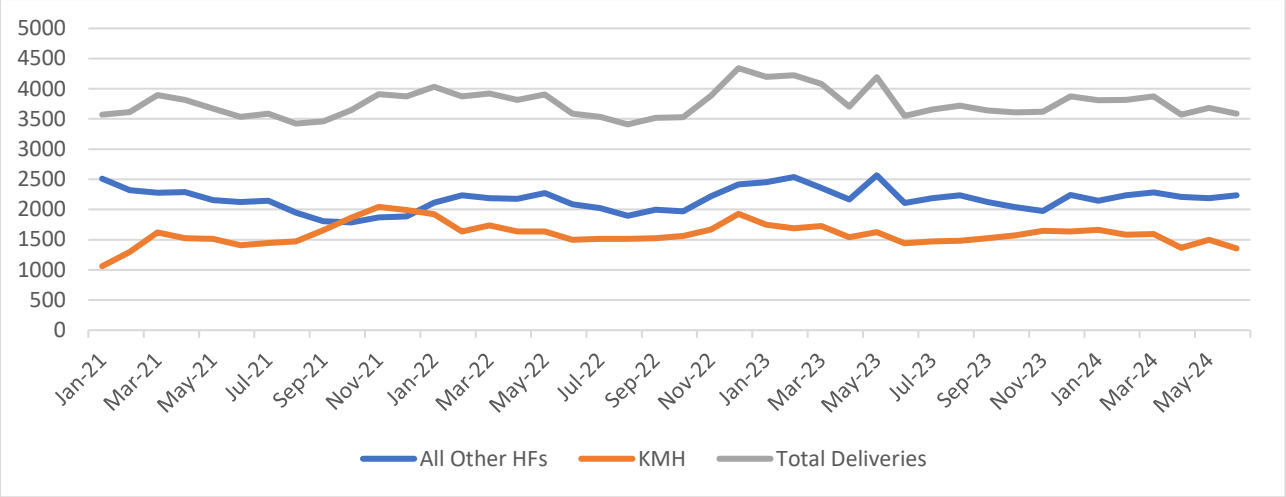


Figure 7. Three-Year Trend of Institutional Birth Deliveries in Khost and KMH Share

As presented in Table 19 below, from January to October 2024, an average of 1,457 deliveries per month were conducted at KMH, reflecting a slight decline compared to the monthly averages of 1,591 in 2023, 1,649 in 2022, and 1,574 in 2021. This modest decline may be attributed to several factors, including increased utilisation of private sector healthcare services, the growing contribution of 13 BHCs (11 operated by CARE and 2 by IRC) established in 2023, and the proactive referral of normal delivery cases from KMH to KPH. Despite this modest reduction in total deliveries, the proportion of handled direct obstetric complications (DOCs) steadily increased over the years: 15% in 2021, 18% in 2022, 20% in 2023, and reaching 22% in 2024. Notably, in 2024 the project exceeded its target of achieving more than 20% of deliveries classified as DOCs.

Table 19. Trend Analysis of Birth Delivery Cases in KMH

YEAR	DELIVERIES	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	TOTAL
2021	Total deliveries	3,975	4,449	4,570	5,894	18,888
	Normal Deliveries (%)	85%	82%	85%	88%	85%
	Total DOCs (%)	15%	18%	15%	12%	15%
2022	Total deliveries	5,294	4,771	4,549	5,151	19,765
	Normal Deliveries (%)	87%	84%	80%	78%	82%
	Total DOCs (%)	13%	16%	20%	22%	18%
2023	Total deliveries	5,158	4,604	4,479	4,850	19,091
	Normal Deliveries (%)	83%	81%	79%	78%	80%
	Total DOCs (%)	17%	19%	21%	22%	20%
2024*	Total deliveries	4,838	4,214	4,006	1,515	14,573
	Normal Deliveries (%)	77%	78%	77%	80%	78%
	Total DOCs (%)	23%	22%	23%	20%	22%

*January to October 2024 (Quarter 4 of 2024 only includes October data)

In 2024, KMH managed an average of 323 direct obstetric complication (DOC) cases per month, accounting for 85% of all DOC cases reported in Khost province, with only two CEmONC centres (KMH and KPH). While the total number of deliveries at KMH decreased in 2024 compared to 2023, 2022, and 2021, the proportion of DOC cases handled by KMH saw a notable increase: 40% higher than in 2021, 11% higher than in 2022, and 4% higher than in 2023. This trend underscores KMH's growing role in managing high-risk cases and preventing maternal deaths, as evidenced by its effective handling of DOC cases with an exceptionally low case fatality rate of 0.11% in KMH. Figure 8 below, illustrates the 4-year DOC trend in KMH.

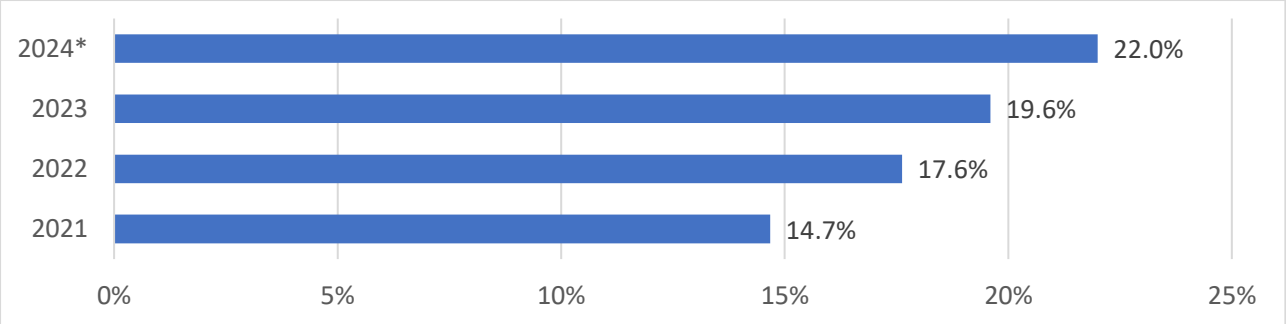


Figure 8. Proportion of DOCs in KMH (Percentage of Total Deliveries)

In 2021, 2022, and 2023, caesarean sections accounted for only 4% of total deliveries at KMH. However, this rate increased to 6% in 2024. From January to October 2024, KMH performed an average of 71 caesarean sections per month, representing 70% of all C-sections conducted in the public sector across Khost province. While KMH aimed to maintain a maximum C-section rate of 5% of total deliveries, this threshold was exceeded by 1% in 2024, with the project remaining within the target threshold in prior years.

Maternal mortality at KMH has remained consistently low, reflecting adherence to standard medical practices, the availability of skilled health workers, and sufficient medical equipment and supplies. In 2024, only two maternal deaths were reported, compared to four in 2023, five in 2022, and three in 2021.

The 32-bed neonatal unit at KMH, including 8 NICU beds, had an average of 157 admissions per month in 2024, ranging from 113 in July 2024 to 209 in October 2024. The neonatal case fatality rate[46] for admitted cases at neonatal unit was 7.2% in 2024[47], 9.9% in 2023, 8.2% in 2022, and 7% in 2021, well within the project target of less than 10%. The evaluation found that the neonatal case fatality rate consistently remained below 10%, except during June to November 2023, peaking at 13.9% in October 2023 (caused by an infectious disease outbreak).

[46] Considering all admitted neonates as a single neonatal illness

[47] January to October 2024

The evaluation findings underscore KMH's significant contribution to reducing maternal and neonatal mortality in Khost province through its well-structured and efficient maternal and neonatal healthcare services. With consistently low maternal mortality rates (ranging from 2 to 5 deaths annually between 2021 and 2024) and a neonatal case fatality rate averaging 7.2% in 2024, KMH has demonstrated adherence to high medical standards, supported by skilled health workers, adequate equipment, and essential supplies.

SUPPLY-SIDE: REFERRAL SYSTEM

This evaluation assessed the referral mechanism to explore the extent to which it contributed towards continuum of care and contributed towards provision of timely life-saving interventions for high-risk pregnancies.

At the community level, all interviewed female CHWs (6 IDIs) confirmed promoting institutional birth delivery during their household visits by encouraging pregnant women to seek facility-based delivery care. However, CHWs lacked comprehensive awareness and job-aid materials to identify danger signs of pregnancy. Aside from bleeding (antepartum and postpartum), neither of them was aware of KMH admission criteria. As such, the CHWs did not confirm identifying and referring pregnant women with danger signs of pregnancy to health facilities.

As presented in Table 18 below, at the time of this evaluation, there were 676 active CHWs in Khost province (365 female and 311 male) trained and managed by CARE and HN-TPO. Empowering these CHWs with orientation on danger signs of pregnancy, job-aid materials, and awareness of KMH admission criteria could significantly improve the referral system. CHWs could also play a vital role in disseminating KMH admission criteria within their communities, which would require coordinated efforts and collaboration with CARE and HN-TPO.

A number of pictorial job-aid materials for CHWs, focused on high-risk pregnancy, have already been developed which could be reproduced and distributed to CHWs. Similarly, the current KMH admission criteria could be converted into a pictorial format, given that many CHWs are illiterate, visual representations would ensure better comprehension. Pictorial demonstrations have been proven effective in other programmes in Afghanistan and could similarly enhance the understanding and communication of KMH admission criteria within communities.

Table 20. Number of Active CHWs in Khost Province

DISTRICTS	CARE			HN-TPO			TOTAL MALE CHWS	TOTAL FEMALE CHWS
	Male CHWs	Female CHWs	Total CARE	Male CHWs	Female CHWs	Total HN-TPO		
Baak	0	6	6	17	17	34	17	23
Esperah	0	0	0	21	21	42	21	21
Gorbuz	11	11	22	16	16	32	27	27
Jaji Maidan	5	11	16	22	22	44	27	33

Maton	8	32	40	30	30	60	38	62
Musa Khel	4	4	8	23	23	46	27	27
Nadershakot	2	2	4	47	47	94	49	49
Sabri (Yaqoobi)	5	11	16	33	33	66	38	44
Shoml	0	0	0	13	13	26	13	13
Tanay	0	0	0	32	32	64	32	32
Tirzayi (Ali Sher)	0	12	12	22	22	44	22	34
Grand Total	35	89	124	276	276	552	311	365

At the health facility level, data from medical records indicate that, on average, 6.8% of cases in KMH and 3.1% in KPH in 2024 were referred from other health facilities, as presented in Figure 9 below. While the proportion of referred cases to KMH has increased from 4% in 2021 to 6.8% in 2024, a significant number of cases in both KMH and KPH were self-referred, highlighting a functional gap in the existing referral mechanism in Khost.

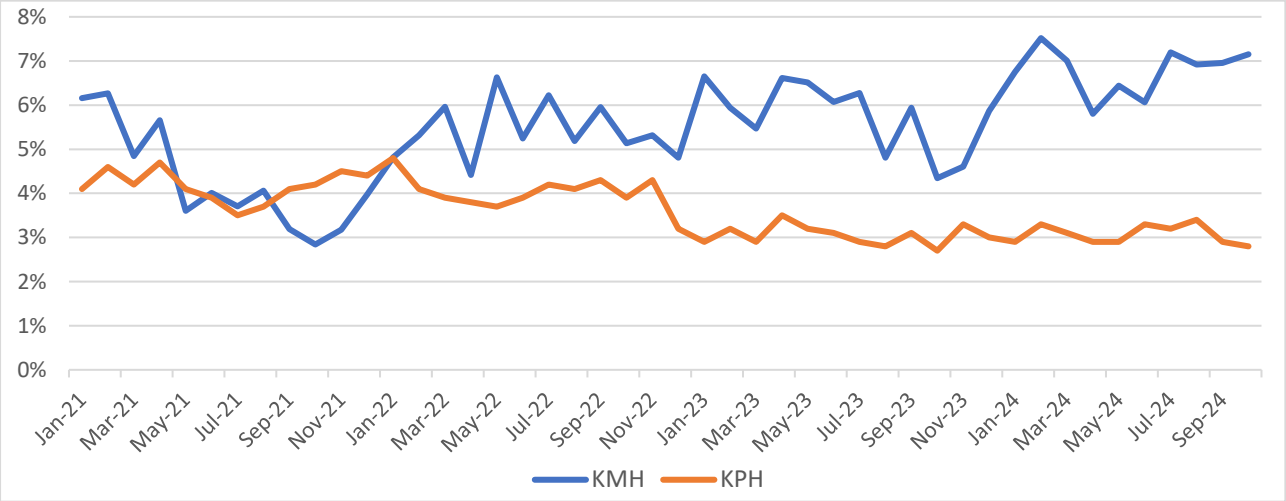


Figure 9. Four-Year Trend of Referred in Cases as % of Total Admissions at KMH and KPH

Referrals from 5 CHCs and 2 CHC+ in 2024 according to health facilities record varied, ranging from 17.3% in Zorkot/Musa Khel CHC+ to 22.6% in Lakan CHC, with the majority directed to KMH. However, exit interviews with referred cases at KMH and KPH revealed that CHCs/CHC+ contributed only a minor share of referrals. As shown in Figure 10, private healthcare providers emerged as the primary referral source.

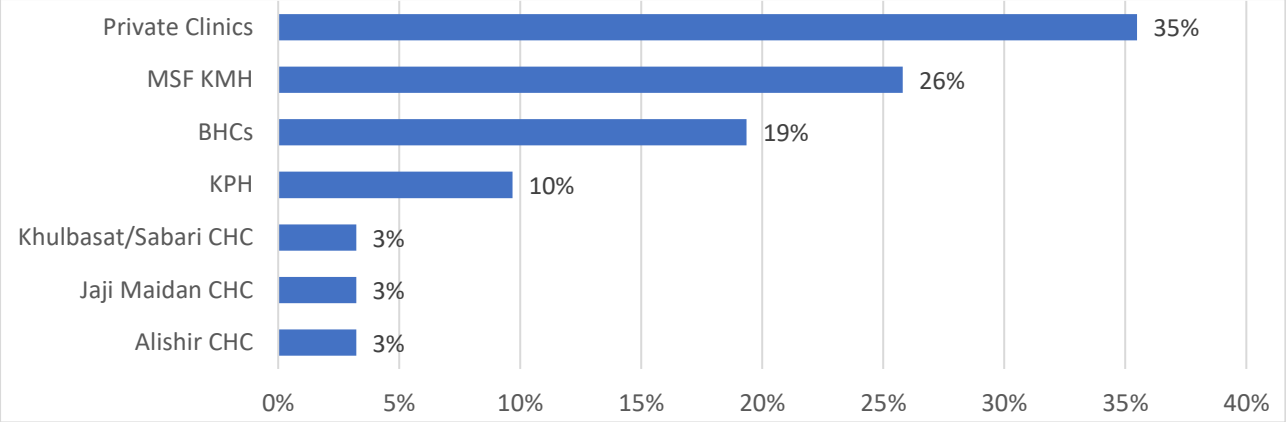


Figure 10. Referral Sources to KMH and KPH based on Exit Interviews

The referral patterns varied between KMH and KPH. As presented in Figure 11 below, in KMH majority of pregnant women participated in exit interviews who were referred by other health facilities (N=15) were referred by private clinics (33%) and BHCs (33%). Indicating an increasing role by private service providers and BHCs.

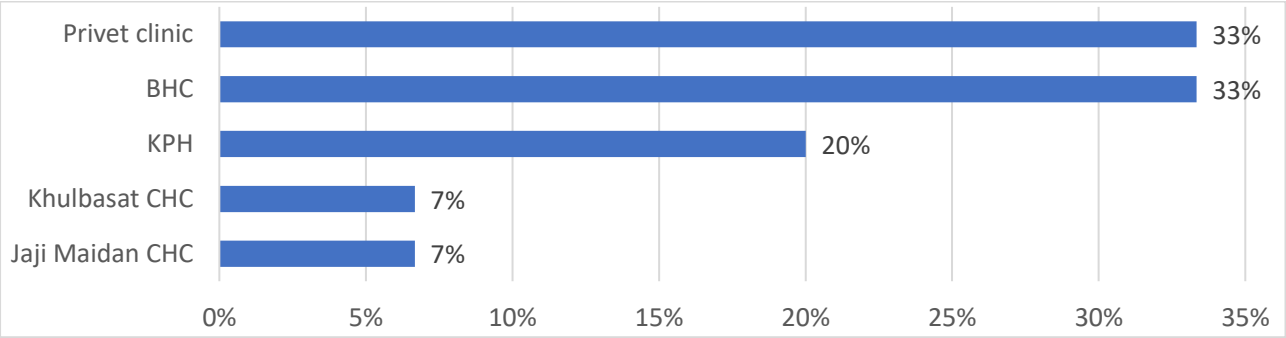


Figure 11. Referred Cases Sources to KMH based on Exit Interviews

At KPH, half (50%) of the referred participants of exit interviews in KPH (N=16) as part of this evaluation were referred by KMH, followed by 38% referrals by the private sector, as presented in Figure 12 below.

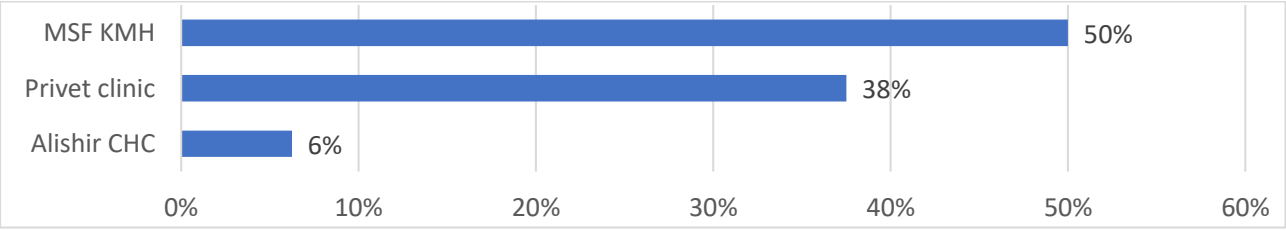


Figure 12. Referred Cases Source to KPH based on Exit Interviews

The private sector emerged as a significant source of referrals to both KMH and KPH. However, there is currently no formal mechanism to engage private healthcare providers at the provincial level, presenting an opportunity to strengthen referral coordination and collaboration.

As highlighted in Section Findings> Appropriateness> Appropriateness of CEmONC Services at KMH, both KMH and KPH provided first postnatal care (PNC) services only to mothers who remained hospitalised for more than 24 hours. Those discharged earlier had to seek follow-up PNC care independently at other health facilities without formal referrals to specific facilities in their communities for PNC, neonatal check-ups, or family planning services. Establishing a referral mechanism to guide discharged mothers toward appropriate follow-up care facilities is essential to ensuring continuum of care for mothers and newborns after delivery at KMH and KPH.

SUPPLY-SIDE: STAFF TRAINING AND CAPACITY

As part of this evaluation, 24 healthcare workers were interviewed across 5 CHCs, 2 CHC+, KPH, and KMH to assess their training and capacity-building experiences on essential EmONC components. These components included the management of postpartum haemorrhage (PPH), eclampsia and pre-eclampsia, newborn resuscitation, diagnosis and treatment of postpartum infections, and the use of the partograph.

The findings from health worker interviews revealed significant gaps in training. Of the 24 health workers interviewed, only 1 in KMH reported receiving training on diagnosing and treating postpartum infections, 2 (in KMH) on the use of the partograph, 3 (1 in Gubaz CHC and 2 in KMH) on newborn resuscitation, 4 (1 in Ali Sher, 1 in Gurbaz CHCs, and 2 KMH; 17% of all interviewed) on the diagnosis and management of eclampsia and pre-eclampsia, and 8 (2 each in KMH, KPH, and Lakan CHC, and 1 each in Gurbaz and Daragai/Tani CHCs; 33% of all interviewed) on managing postpartum haemorrhage (PPH) within the past 12 months. Training opportunities also varied by facility. Health workers in Zorkot/Musa Khel and Nadershakot CHC+ and Sabari CHC reported no training in any of these areas. Furthermore, apart from KMH, none of the interviewed health workers received training on managing postpartum haemorrhage or using the partograph, highlighting critical gaps in capacity-building efforts across most health facilities.

As part of the health facility assessment of 5 CHCs, 2 CHC+, KPH, and KMH, the evaluation assessed some of the key EmONC procedure that requires continuous capacity development such as management of premature rapture of membrane (PROM) and the administration of corticosteroid. As presented in Table 21 below, 7 health facilities (out of 9 assessed) confirmed administering antibiotics in PROM cases to prevent infection, including KPH, and of those that were performing this procedure only 3 health facilities (out of 7) confirmed having anyone trained in the past two years on this procedure. Similarly, 6 health facilities confirmed administering corticosteroid in preterm labour, of which only two confirmed having anyone trained in this procedure in the past two years.

The health workers were also accustomed to using partograph as a routine practice for monitoring labour progress. 3 out of total 24 interviewed health workers were found not to be using a partograph while managing labour cases.

Table 21. Critical EmONC Procedures at Health Facilities and Staff Training

HEALTH FACILITIES	ADMINISTRATION OF ANTIBIOTICS IN PROM TO PREVENT INFECTION		ANYONE TRAINED ON USE OF ANTIBIOTICS FOR PROM CASES IN HF IN THE PAST 2 YEARS		ADMINISTRATION OF CORTICOSTEROIDS IN PRETERM LABOUR		ANYONE TRAINED ON USE OF CORTICOSTEROIDS IN PRETERM LABOUR IN PAST 2 YEARS	
	Yes	No	Yes	No	Yes	No	Yes	No
Ali Sher	0	1	0	1	0	1	0	1
Daragai/Tani	1	0	0	1	1	0	0	1
Gurbaz	1	0	1	0	1	0	0	1
KPH	1	0	0	1	1	0	0	1
Khulbesat/Sabari	0	1	0	1	0	1	0	1
Lakan	1	0	1	0	1	0	1	0
KMH	1	0	1	0	1	0	1	0
Nadeshakot	1	0	0	1	1	0	0	1
Zorkot/Musa Khel	1	0	0	1	0	1	0	1
Total	7	2	3	6	6	3	2	7

The gaps in training and inconsistent adherence to essential EmONC procedures, such as managing PROM, administering corticosteroids in preterm labour, and routine use of partographs, directly impact maternal and neonatal health outcomes. Without adequate training and consistent practice, healthcare workers may fail to deliver timely and effective care, increasing the risk of complications and timely referral of high-risk labour cases. This not only compromises the quality of care but also diminishes the community's trust in CHCs, CHC+, and KPH as reliable healthcare providers. When families perceive these facilities as incapable of addressing critical obstetric and neonatal emergencies, they may bypass them in favour of private clinics or directly seek care at KMH, further overburdening KMH and exacerbating inequities in service delivery. These gaps highlight the critical need for targeted capacity-building initiatives to enhance the quality and reputation of services at primary (CHCs and CHC+) and secondary healthcare facilities.

DEMAND-SIDE: PATIENT SATISFACTION

Patient satisfaction was evaluated through exit interviews with 180 mothers who delivered at 5 CHCs, 2 CHC+, KPH, and KMH. The assessment was based on 11 parameters reflecting their experiences during labour and delivery. These parameters included the cleanliness of beds and wards, cleanliness

of toilets, privacy in examination and delivery rooms, the quality and availability of services during labour and postpartum, availability of medicines, overall quality of care, healthcare workers' behaviour with patients, waiting time to be seen after arrival to the health facility, respectfulness of healthcare workers with the patients, out-of-pocket expenses, and the health facility's operating hours.

As shown in Figure 13 below, women who delivered at Khulbesat/Sabari and Ali Shir CHCs reported no dissatisfaction across the 11 parameters. At KMH, 1% of respondents expressed dissatisfaction with the expenses incurred during their visit to KMH. Similarly, 2% of respondents at Lakan, Daragai/Tani, and Gurbaz CHCs reported dissatisfaction due to the unavailability of required medicines at the time of delivery.

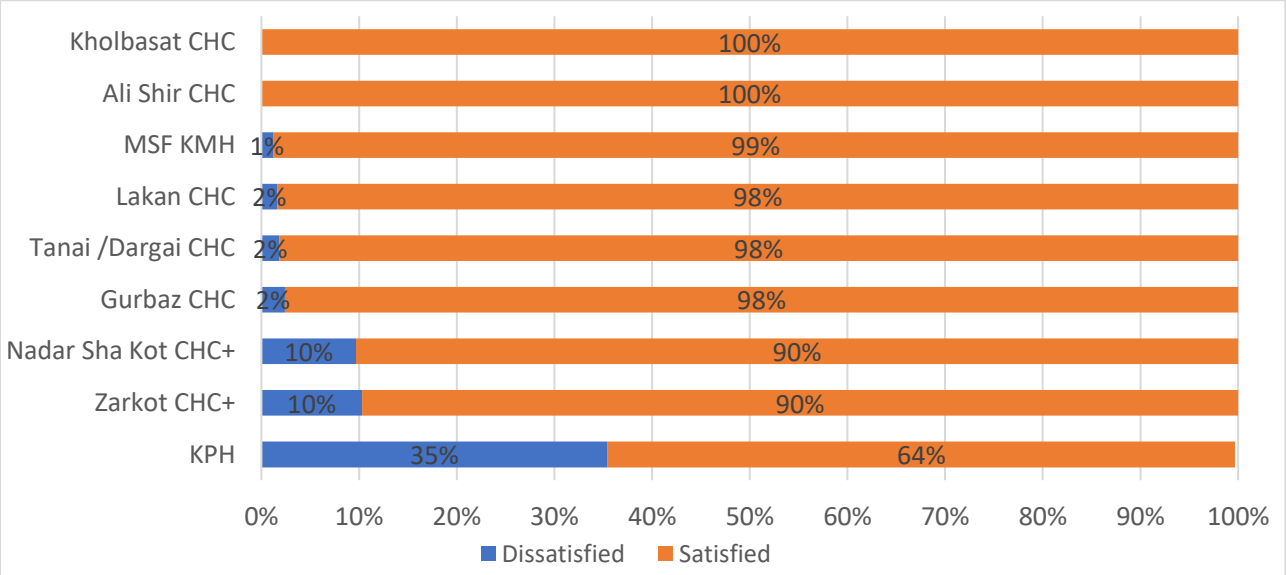


Figure 13. Overall Patient Satisfaction by Health Facility

As highlighted in Figure 13 above, KPH recorded the highest levels of patient dissatisfaction across the 11 parameters assessed during exit interviews. Over two-thirds (73%) of women who delivered at KPH reported dissatisfaction with the availability of required medicines. Additionally, 50% expressed dissatisfaction with healthcare workers' behaviours, 43% with out-of-pocket expenses incurred, 40% with the overall quality of care, and others as presented in Figure 14 below, including concerns highlighted about the lack of privacy in examination and delivery rooms.

These findings align with observations made by the evaluation team, which identified significant gaps in infection prevention practices, particularly in delivery rooms and the NICU, as well as shortages of essential medicines and equipment (see Section Findings> Relevance> Supply-Side - Health Facilities Readiness). Given KPH's role as a key referral facility, such high levels of dissatisfaction are likely to negatively impact community perceptions and reduce the willingness of pregnant mothers to seek delivery services at the facility.

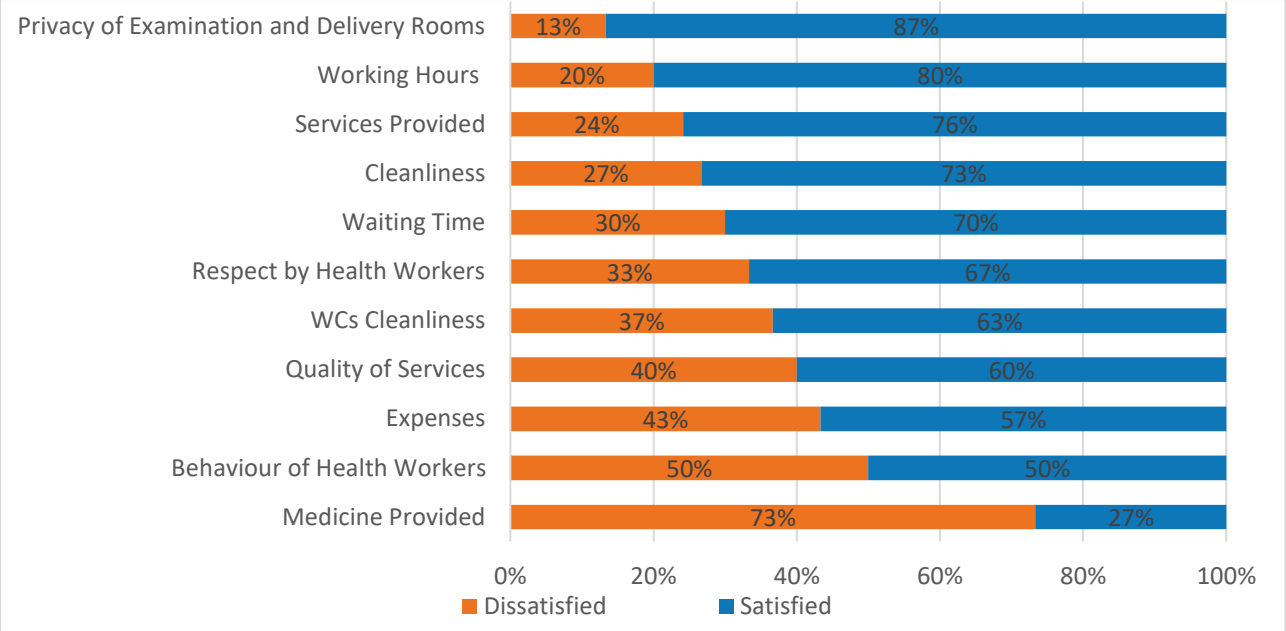


Figure 14. Patient's Satisfaction Parameters Measured in KPH

Patient satisfaction levels were notably low in Nadershakot and Zorkot/Musa Khel CHC+, with several overlapping dissatisfying parameters between the two health facilities. As illustrated in Figure 15 and 16 below, the availability of medicines emerged as the most significant concern, with 53% of patients in Zorkot/Musa Khel and 40% in Nadershakot CHC+ expressing dissatisfaction regarding the availability of necessary medicines during childbirth. Additionally, 13% of respondents from both facilities reported dissatisfaction with the overall quality of services, and 13% in both health facilities reported dissatisfaction with the waiting times before they were seen by a health worker. Similarly, 7% of the respondents in both health facilities expressed concerns about the behaviours of health workers.

Findings from FGDs triangulate/reinforce these findings from exit surveys, highlighting multiple underlying issues. FGD participants frequently mentioned the unavailability of essential medicines, reported inappropriate behaviours by health workers, and some mothers in labour felt disrespected. Delays in attending pregnant women in labour by health workers in CHCs were another common concern among the FGD members. A female FGD participant in Zorkot/Musa Khel highlighted:

"The challenges we face at this CHC are that medicines are either unavailable or, if available, it is not given to the patients. ……. Another specific issue is the bad behaviour and attitude of the female staff (midwives), because they are not qualified enough ……."

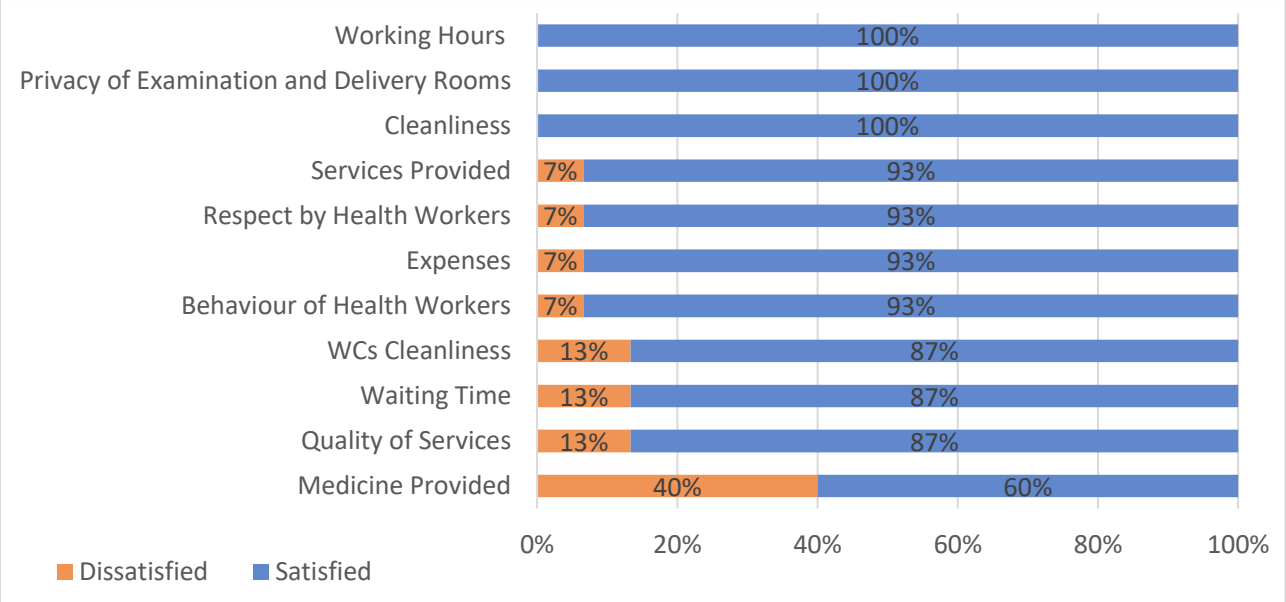


Figure 15. Patient's Satisfaction Parameters Measured in Nadershakot CHC+

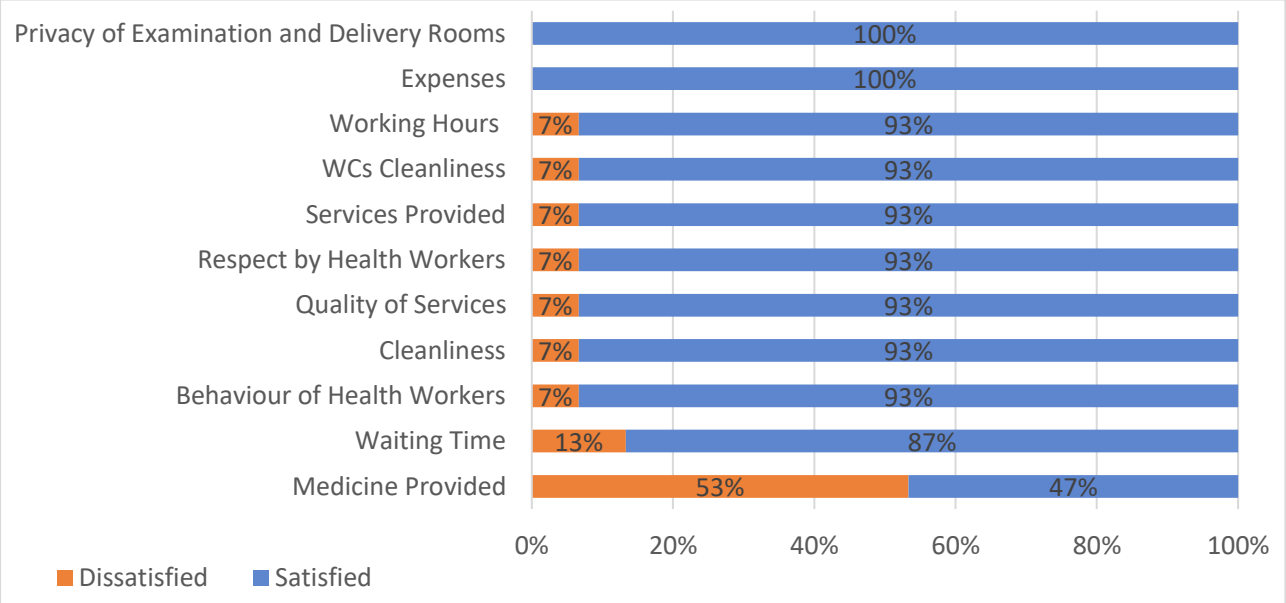


Figure 16. Patient's Satisfaction Parameters Measured in Zorkot/Musa Khel CHC+

DEMAND-SIDE: BARRIERS TO CARE

The evaluation assessed the effectiveness of MSF's efforts in addressing cultural, social, and logistical barriers that hinder women from seeking timely maternal and neonatal healthcare. In a highly conservative and tribal society like Khost, such barriers significantly influence healthcare-seeking behaviours for women. KMH emerged as a facility of choice for many women due to its culturally sensitive and women-friendly environment. The hospital's patient and visitor flow were thoughtfully designed to respect local cultural norms, particularly those related to reproductive health, allowing women to access care with dignity and privacy. Community members participated in FGDs, KIIs, and IDIs consistently described KMH as a predominantly women-only facility, which enhanced its

acceptability in a conservative context. The hospital's patient-centred, culturally sensitive operational model was repeatedly highlighted during field-level interactions conducted for this evaluation.

On the other hand, all community members (both male and female) who participated in this evaluation indicated that their first preference for childbirth was a health facility. This represents a major shift in healthcare-seeking behaviour, likely influenced by KMH's culturally adaptive approach, active engagement with community elders, and incorporation of their inputs into service delivery, contributing to a significant reduction in home deliveries, as documented MICS 2003[48], AfDHS 2015[49], and MICS 2023[50] (81.6% in 2003, 35.9% in 2015, and 15.9% in 2023 respectively). Additionally, as shown in Figure 17 below, there has been a marked increase in institutional births since MSF began operating in Khost in 2012, underscoring the hospital's pivotal role in driving this positive trend.

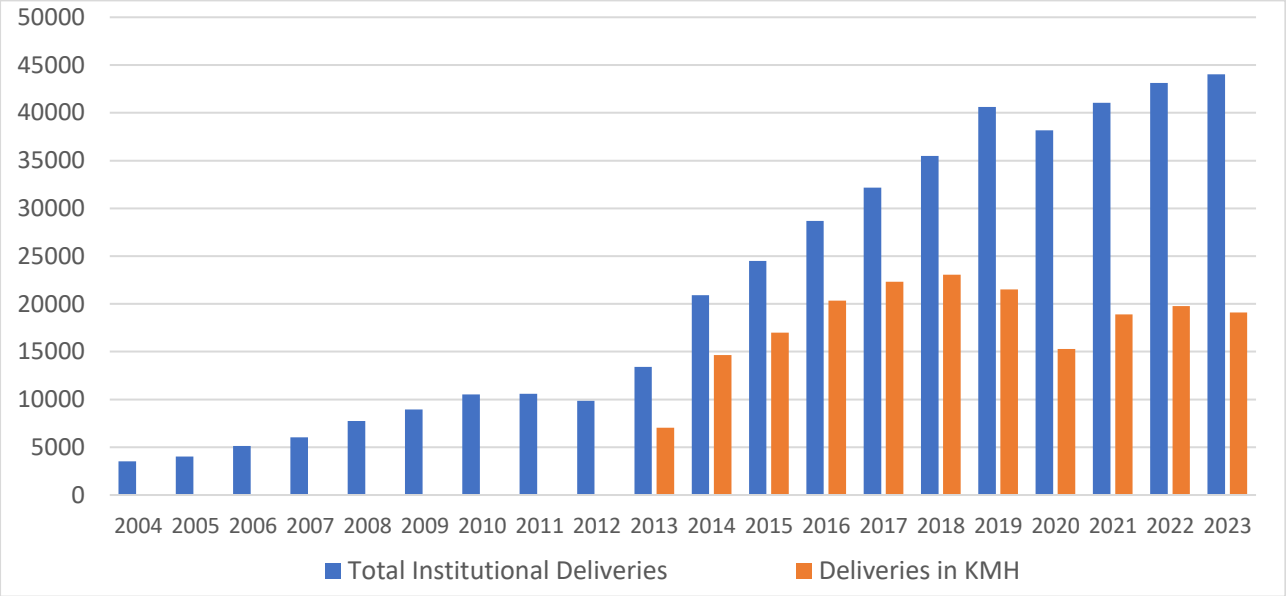


Figure 17. Institutional Deliveries Trend in Khost (2004 – 2023) and KMH Share

The data on institutional birth deliveries in Khost health facilities (excluding KMH) reveals notable fluctuations over the years, reflecting changes in the healthcare system's capacity and utilisation patterns.

As presented in Figure 18 below, from 2004 to 2011 and prior to KMH establishment, there was a steady increase in institutional deliveries in Khost province, rising from 3,536 in 2004 to a peak of

[48] Multiple Indicator Cluster Survey 2003: UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3/Afghanistan/2003/Final/Afghanistan%202003%20MICS_English.pdf [Accessed 26 May 2024].

[49] Afghanistan Demographic and Health Survey 2015: U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

[50] Multiple Indicator Cluster Survey 2022-2023: UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

10,591 in 2011. However, between 2013 and 2018, a significant decline was observed, with birth deliveries outside KMH dropping to a low of 6,274 in 2014. This decline coincided with the establishment and increasing utilisation of KMH, which handled a high number of deliveries during this period, peaking at 20,351 in 2016, 22,315 in 2017, 23,061 in 2018, and 21,530 in 2019.

Starting in 2019, institutional deliveries outside KMH began to increase. By the end of 2019, the number of deliveries had risen to 19,072, and this upward trend continued, reaching 24,925 by 2023. This resurgence was aligned with the introduction of KMH admission criteria in mid-2019, which likely redirected more patients to other health facilities.

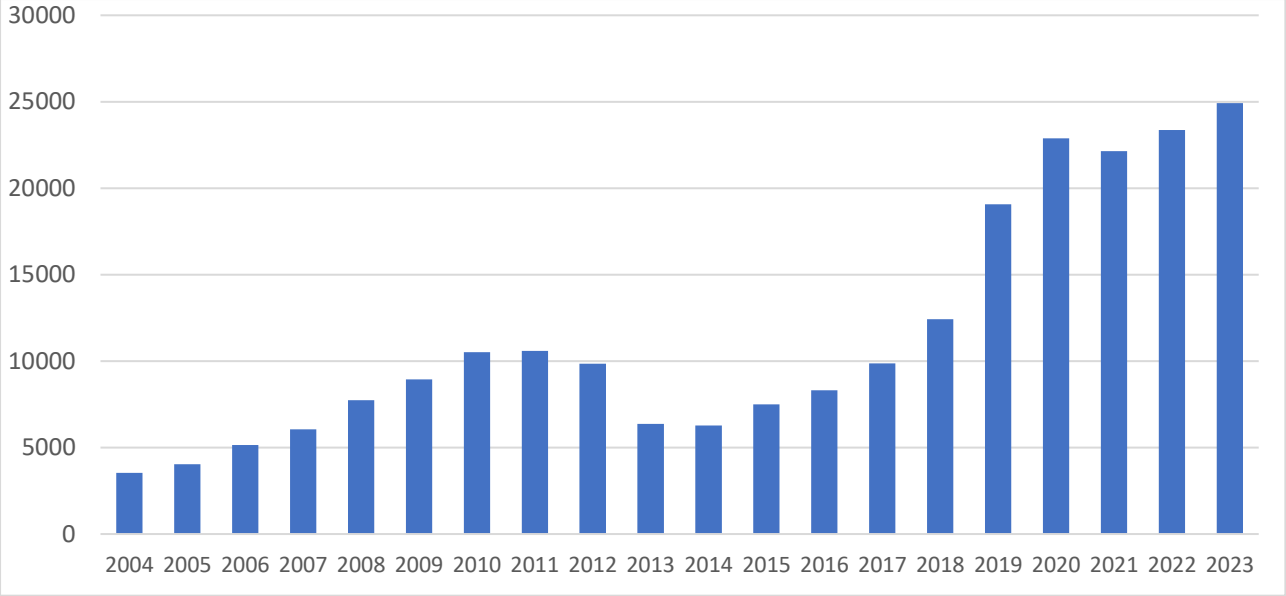


Figure 18. Institutional Deliveries Trend in Khost (2004 – 2023) Excluding KMH

While conducting this evaluation, the current De-facto government introduced new restrictions on women's social conduct, including regulations on dress, travel, employment, and other aspects of daily life. In exploring the potential impact of these restriction on women's healthcare-seeking behaviour, female FGD members in Lakan, Gurbaz, and Ali Sher districts voiced concerns that the requirement for women to be accompanied by a *Mahram*[51] could hinder timely access to healthcare services. These restrictions, they noted, could lead to delays, especially in emergencies where a *Mahram* might not be readily available. In contrast, participants from other districts, particularly men, emphasised that the restrictions outlined in the decree by the Taliban Supreme Leader were aligned with cultural practices already in place in Khost. As a result, they did not perceive these restrictions as likely to create new challenges for women's access to healthcare in their communities.

Three delays

[51] Husband or other male relative/family member who could not be married by the woman, such as father, brother, uncle, and others

This evaluation explored factors contributing to the three recognised delays during childbirth that heighten maternal mortality and morbidity risks, including:

- **First Delay:** Delay in decision-making at the household level about the place of delivery (seek care)
- **Second Delay:** Delay in reaching a health facility
- **Third Delay:** Delay in receiving adequate health care after arrival at the health facility

First Delay: Delay in Seeking Care Decision Taking

To assess the first delay (decision-making at the household level about seeking healthcare), exit interview participants were asked how long it took from the onset of labour pains to decide where to give birth. A cut-off point of 3 hours was set, with delays exceeding this duration classified as a "first delay." As illustrated in Figure 19 below, only 30% of cases experienced this delay. The majority (46%) reported making a decision within 1 to 3 hours after the onset of labour pains, indicating a relatively prompt response in most households.

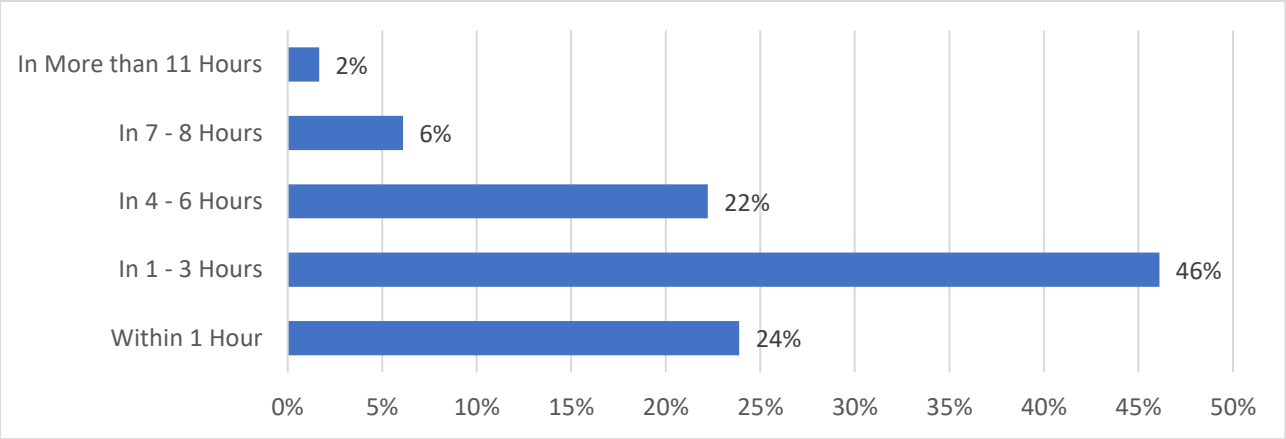


Figure 19. Time to Decide about Place of Birth (by Family from Onset of Labour Pain)

As presented in Table 22 below, while the overall incidence of the first delay among exit interview respondents was relatively low (30%), it varied significantly across health facilities. Mothers who delivered at Zorkot/Musa Khel CHC+ reported the highest proportion of first delays (60%), followed by Gurbaz CHC (47%) and Nadershakot CHC+ (33%). In contrast, the remaining health facilities reported rates below the overall average of 30%.

Table 22. Time to Decide about Place of Birth (from Onset of Labour Pain) by Health Facility

HEALTH FACILITIES		WITHIN 1 HOUR	IN 1 - 3 HOURS	IN 4 - 6 HOURS	IN 7 - 8 HOURS	IN MORE THAN 11 HOURS	TOTAL
Ali Shir CHC	N	1	16	6	0	0	23
	%	4%	70%	26%	0%	0%	100%
Gurbaz CHC	N	1	7	5	1	1	15

	%	7%	47%	33%	7%	7%	100%
Kholbasat CHC	N	1	12	2	0	0	15
	%	7%	80%	13%	0%	0%	100%
KPH	N	10	12	7	0	1	30
	%	33%	40%	23%	0%	3%	100%
Lakan CHC	N	4	12	6	0	0	22
	%	18%	55%	27%	0%	0%	100%
KMH	N	14	9	5	1	1	30
	%	47%	30%	17%	3%	3%	100%
Nadarsha Kot CHC+	N	6	4	3	2	0	15
	%	40%	27%	20%	13%	0%	100%
Tanai /Dargai CHC	N	4	7	4	0	0	15
	%	27%	47%	27%	0%	0%	100%
Zarkot CHC+	N	2	4	2	7	0	15
	%	13%	27%	13%	47%	0%	100%
Total	N	43	83	40	11	3	180
	%	24%	46%	22%	6%	2%	100%

Among respondents who experienced a delay of more than 3 hours in deciding to seek healthcare (first delay), the most commonly reported factor was uncertainty and the need to arrange transportation (32%). This was followed by the unavailability of a companion (20%) and waiting for the family decision-maker to return home (19%). These are the top three reasons as illustrated in Figure 20 below.

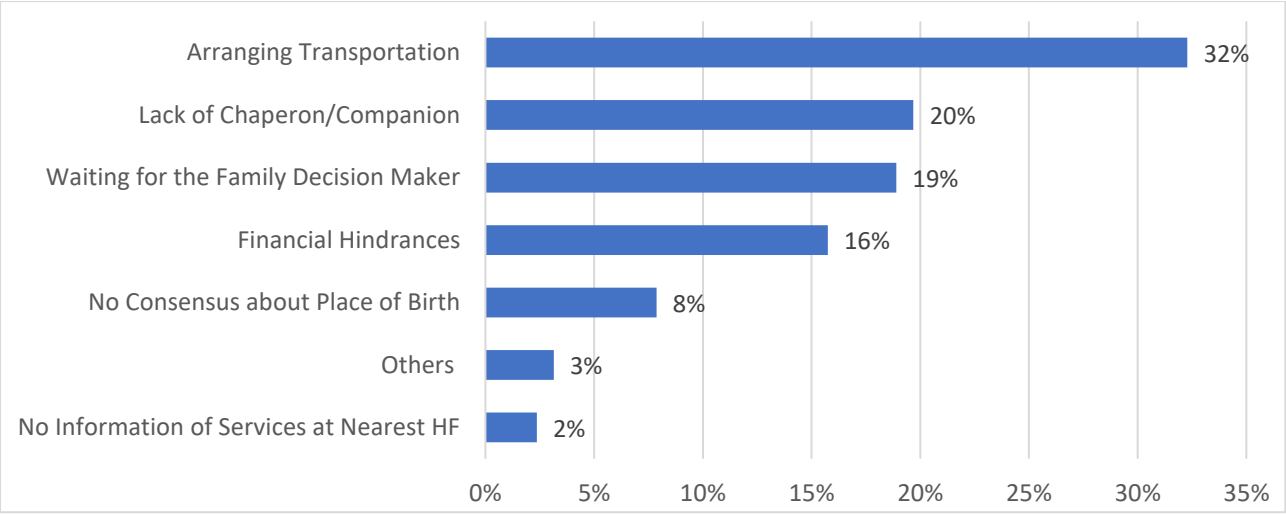


Figure 20. Reasons for the First Delay

Participants in FGDs were asked to describe the decision-making process at the household level regarding the place of birth, highlighting the roles of key family members and the factors considered when deciding on the location for childbirth. Based on the recurring themes that emerged across all six female FGDs, the following diagram was developed to illustrate the decision-making process.

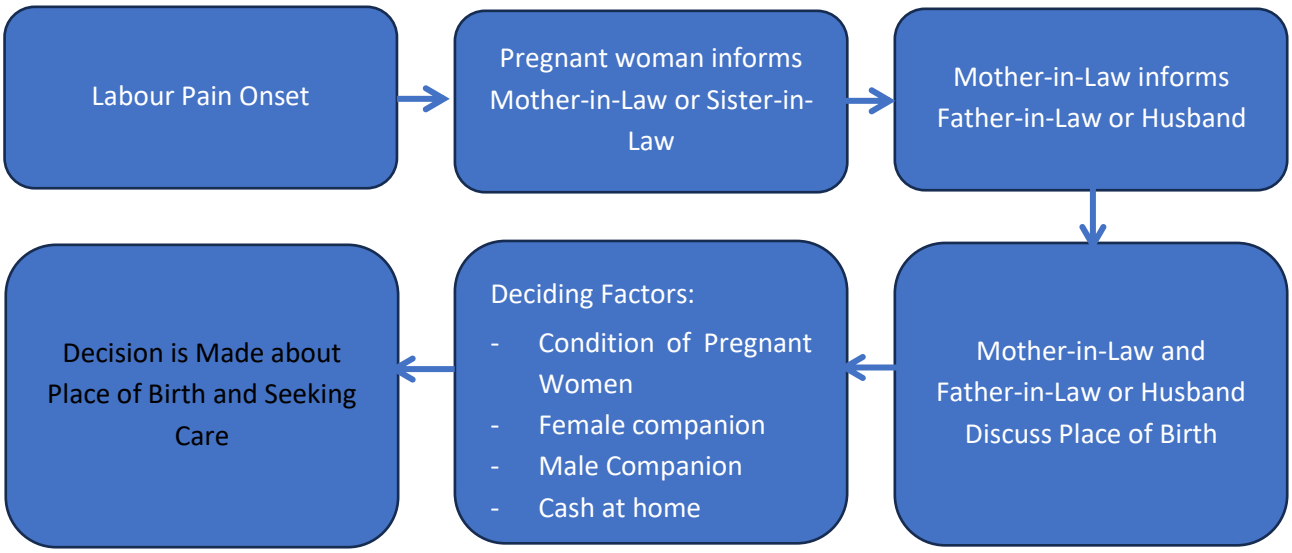


Figure 21. Decision-making Process Regarding Place of Birth According to FGD Participants

Second Delay: Delay in reaching a health facility

To evaluate the second delay in childbirth care, respondents were asked how long it took to reach a health facility after the household decision was made. A threshold of 3 hours was used to define the second delay. Cases where travel time exceeded 3 hours were categorised as experiencing this delay. As shown in Figure 22 below, only 19% of respondents faced a second delay. The primary reasons cited were poor road conditions and adverse weather, including heavy rain and elevated water levels in canals that obstructed road access.

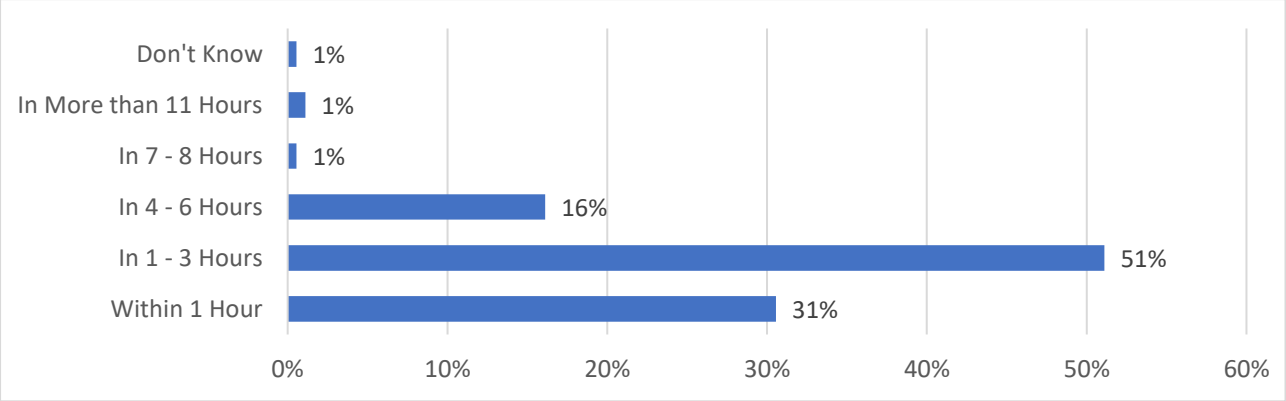


Figure 22. Time to Reach Health Facility (Second Delay)

Third Delay: Delay in receiving adequate healthcare

The third delay, which occurs when women in labour experience delays in receiving care after arriving at a health facility, was evaluated by asking respondents how long it took for health workers to attend to them. A threshold of 30 minutes was established. Cases where healthcare was provided in more than 30 minutes were classified as experiencing the third delay. As shown in Figure 23 below, 37% of respondents reported waiting over 30 minutes to receive healthcare after reaching health facility. The primary reasons cited during exit interviews included the unavailability of healthcare workers at the facility, healthcare workers were unprepared, and respondents were not unaware of the specific cause of the delay.

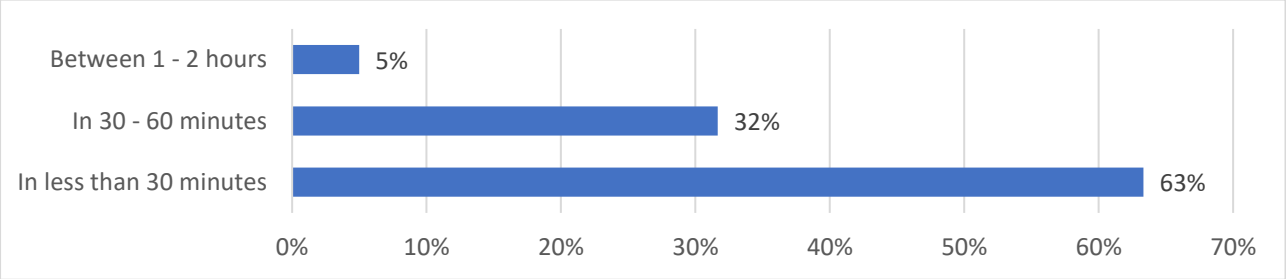


Figure 23. Time Taken to Receive Healthcare after Arriving at Health Facility

As shown in Table 23 below, the proportion of pregnant women experiencing third delay varied significantly across health facilities. Khulbesat/Sabari CHC recorded the highest proportion of mothers experiencing third delay (60%), followed by Zorkot/Musa Khel CHC+ (53%) and Ali Shir CHC (52%). In contrast, KMH and Daragai/Tani CHC had the lowest reported levels of third delay, with only 7% of mothers affected, reflecting higher efficiency and quality of care at these facilities.

Table 23. Time Taken by Health Facilities to Provide Care to Women in Labour

HEALTH FACILITY		IN LESS THAN 30 MINUTES	IN 30 - 60 MINUTES	BETWEEN 1 - 2 HOURS	TOTAL
Ali Shir CHC	N	11	11	1	23
	%	48%	48%	4%	100%
Gurbaz CHC	N	8	6	1	15
	%	53%	40%	7%	100%
Kholbasat CHC	N	6	8	1	15
	%	40%	53%	7%	100%
KPH	N	16	12	2	30
	%	53%	40%	7%	100%
Lakan CHC	N	15	7	0	22
	%	68%	32%	0%	100%
MSF KMH	N	28	1	1	30
	%	93%	3%	3%	100%

Nadersha Kot CHC+	N	9	4	2	15
	%	60%	27%	13%	100%
Tanai /Dargai CHC	N	14	1	0	15
	%	93%	7%	0%	100%
Zorkot/Musa Khel CHC+	N	7	7	1	15
	%	47%	47%	7%	100%
Total	N	114	57	9	180
	%	63%	32%	5%	100%

Interviews with local leaders further underscored KMH's role as a trusted healthcare provider in the province. Leaders acknowledged KMH as a role model facility due to its operational standards and ability to respect cultural sensitivities. However, they also emphasised that while KMH's efforts have been effective in encouraging women to seek care, barriers persist. For instance, the cost of transportation[52] to the hospital remains a significant obstacle, particularly for families living in remote areas. Additionally, traditional gender norms and the need for male family members' consent to seek care continue to delay women's access to healthcare.

FGDs with community members highlighted those logistical barriers, such as the lack of timely transportation and financial constraints, coupled with limited awareness about high-risk pregnancy signs, further compounded delays in seeking care. In some cases, women opted for home births due to the influence of elder family members, who preferred traditional birthing methods over institutional deliveries.

Addressing these barriers requires continued community engagement through culturally appropriate messaging, expanding awareness campaigns about maternal health risks, and strengthening collaborations with local leaders and male decision-makers to foster a more supportive environment for women's healthcare. Enhanced accessibility to KMH through transport assistance programs or community-based referral mechanisms could also further reduce delays and ensure timely care for women in need.

RESILIENCE OF THE LOCAL HEALTH SYSTEM

The resilience of the local health system, particularly MSF supported CHCs, CHC+, and KPH, remained limited due to persistent systemic gaps that hindered their capacity to deliver consistent and quality maternal and neonatal healthcare services. While MSF's support[53] has been critical in ensuring 24/7 service availability at 8 CHCs/CHC+ and helping KPH to manage the increased volume of obstetric and neonatal cases, it has not fully addressed broader systemic challenges, which continue to affect the resilience of the local health system. This evaluation found that strengthening the resilience of CHCs,

[52] For self-referred cases, the cost of transportation for cases referred by MSF-supported CHCs and CHC+ are reimbursed by KMH

[53] Funding for additional staff (2 midwives and 1 cleaner per CHC/CHC+, and for KPH 12 midwives, 4 nurses, and 4 cleaners) and ad-hoc pharmaceutical supplies donations

CHC+, and KPH requires a multifaceted approach that addresses the following supply-side and demand-side gaps.

GAPS IN ESSENTIAL RESOURCES

Key gaps in essential resources, identified through assessment of the 8 CHCs/CHC+ and KPH, significantly impacted the readiness and functionality of CHCs, CHC+, and KPH. Shortages of essential medicines, as detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness, undermined the capacity of facilities to manage normal deliveries and obstetric emergencies effectively. Additionally, insufficient essential medical equipment (detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness) further limited the ability of these CHCs/CHC+ and KPH to deliver optimal Basic and Comprehensive EmONC respectively.

WORKFORCE LIMITATIONS

The availability of adequately trained healthcare workers emerged as a critical bottleneck, limiting the ability of CHCs, CHC+, and KPH to deliver quality maternal and neonatal healthcare services. Interviews with 20 healthcare workers across 7 CHCs/CHC+ and KPH revealed significant gaps in training on core maternal and neonatal care practices. For instance, only 1 out of 20 workers had received training in neonatal resuscitation, 6 in the management of postpartum haemorrhage, 2 in the management of pre-eclampsia and eclampsia, and none in the management of postpartum infections or the use of partographs.

Additionally, as part of the health facility assessment, the evaluation found similar gaps in training for specific emergency obstetric and neonatal care procedures. While 6 out of 8 assessed facilities (7 CHCs/CHC+ and KPH) reported administering antibiotics in cases of premature rupture of membranes (PROM), only Lakan CHC had any staff trained on this procedure within the past two years. Similarly, although 5 facilities confirmed administering corticosteroids in preterm labour, only one had staff trained in this practice during the same period.

These training gaps were compounded by issues in healthcare worker attitudes and behaviours. Findings from FGDs and exit interviews highlighted delays in attending to patients and instances of disrespectful treatment toward women in labour, further eroding community trust in local health facilities (as detailed in Section Findings> Effectiveness> Demand-Side: Patient Satisfaction). Addressing these deficiencies in workforce capacity and conduct was found essential in improving resilience of local health facilities.

COMMUNITY CONTRIBUTION AND OWNERSHIP

Despite the potential for community involvement in strengthening healthcare services, the evaluation found limited engagement and contribution from local communities toward improving maternal and neonatal health at their local facilities. Findings from 13 in-depth interviews highlighted that while community leaders and members highly value maternal health services, particularly due to cultural sensitivities surrounding women's privacy, their participation has remained largely passive.

Opportunities for community contributions, such as addressing infrastructure gaps (e.g., separate male and female waiting areas) and supporting maintenance and operations, remain untapped (as detailed in Section Findings> Sustainability). Increased community engagement could play a pivotal role in fostering a sense of ownership among local communities toward their health facilities. This, in turn, could open pathways for community contributions, such as covering some human resource costs or other operational needs, ultimately contributing to the resilience and sustainability of these facilities.

RELIANCE ON KHOST MATERNITY HOSPITAL

The evaluation identified a significant reliance on KMH for maternal and neonatal healthcare services. KMH accounted for over 40% of all institutional deliveries in Khost province and managed approximately 70% of total Direct Obstetric Complications (DOCs). This dependency is driven by several interconnected factors that undermined the capacity of local health facilities (CHCs, CHC+, and KPH) to handle normal deliveries and manage obstetric complications effectively, leading to patients bypassing these facilities in favour of KMH, even for routine cases. The key factors contributing to this reliance include:

TRUST DEFICIT IN LOCAL HEALTH FACILITIES

The trust deficit in CHCs, CHC+, and KPH was identified as a key factor driving reliance on KMH, leading patients to bypass local health facilities in favour of KMH (as detailed in Section Findings> Relevance> Supply – Side: Services Provided). Persistent shortages of essential medicines and critical medical equipment (detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness) were identified to have diminished community confidence in local health facilities. Moreover, healthcare worker behaviour, including delayed attendance and instances of disrespect towards women in labour, has been reported as a significant concern by community members during FGDs and exit interviews. These issues contributed to a perception of inadequate and substandard care at local health facilities, prompting families to choose KMH even for normal delivery cases.

MISPERCEPTIONS ABOUT QUALITY MATERNAL HEALTHCARE

Another key factor contributing to the reliance on KMH, identified by the evaluation, was community misperceptions about what constitutes quality maternal healthcare. As detailed in Section Findings> Appropriateness> Community Engagement Initiatives (outreach Health Promotion Activities), community members equated high-quality care with availability of advanced interventions such as lab tests, injectable medications, and imaging (e.g. ultrasound), which are not always necessary for normal deliveries. These perceptions, shaped by a lack of awareness and misinformation, led families to bypass local CHCs and CHC+ facilities and seek care directly at KMH, even for uncomplicated cases.

LACK OF AWARENESS ABOUT KMH ADMISSION CRITERIA

As detailed in Section Findings> Appropriateness> Community Engagement Initiatives, neither the FGD participants nor the 16 interviewed CHWs (8 male and 8 female) were aware of the KMH admission

criteria. Additionally, 4 healthcare workers (out of 20 in 7 CHCs/CHC+ and KPH) were also unfamiliar with these criteria, along with other stakeholders in the province, including other implementing organizations (excluding HN-TPO) and private service providers. This lack of awareness among communities, healthcare workers in CHCs/CHC+, and other stakeholders about KMH's admission criteria has contributed to the reliance on KMH. Many families seeking care at KMH were unaware that the facility is primarily designed for managing high-risk pregnancies and complications. As a result, KMH was frequently overwhelmed by normal delivery cases that could be effectively managed at CHCs, CHC+, or KPH.

EFFICIENCY

Efficiency was defined as the extent to which resources, including staff, time, supplies, were used in the best possible way to delivery maternal and neonatal healthcare services.

RESOURCE ALLOCATION

KMH demonstrates a high level of efficiency in resource utilisation. The facility was found well-supplied with essential medicines, medical equipment, and consumables necessary for managing obstetric emergencies and routine maternal and neonatal care. Unlike other health facilities in the region, KMH has consistently ensured timely procurement and availability of resources to meet patient needs. Staff salaries were paid promptly, contributing to workforce motivation and retention, which was critical in a high-demand setting like KMH. Despite its heavy caseload of more than 1,800 admissions per month and handling 70% of the province's C-sections and more than 40% of total institutional birth deliveries in the province, KMH maintains operational efficiency, minimising stockouts and service disruptions.

The evaluation found that the 5 CHCs, 2 CHC+, and KPH in Khost faced significant challenges in resource allocation, undermining their efficiency in delivering quality maternal and neonatal healthcare. Critical gaps in the availability of essential medicines and equipment were observed, particularly in KPH, where over two-thirds of exit interview respondents expressed dissatisfaction with medicine availability. Similarly, Zorkot/Musa Khel and Nadershakot CHC+ reported that 53% and 40% of patients, respectively, were dissatisfied due to medicine shortages. The supply of equipment across facilities remained inconsistent, with some CHCs reporting adequate tools for routine care but a lack of specialised equipment for managing obstetric emergencies. For example, there were reports of incomplete kits for procedures as detailed in Section Findings> Relevance> Supply-Side - Health Facilities Readiness.

One of the primary reasons for these inefficiencies was the limited budget allocation under the BPHS - HER programme. With only US$ 5 per capita per year allocated for healthcare in Khost, this funding was reported insufficient to meet the growing needs of the population, especially when the actual population is believed to exceed the formally recognised figure of 659,102. The underestimation of the population, which exacerbates resource shortages, was perceived to have resulted in frequent stockouts of medicines and limited availability of equipment in health facilities.

OPERATIONAL HOURS

KMH and MSF-supported health facilities, including the 5 CHCs and 2 CHC+, were operational 24/7, ensuring that maternal and neonatal healthcare services were accessible when needed. This constant availability maternal and neonatal services was perceived to be particularly critical in a context like Khost. KMH stood out as a well-functioning facility, offering uninterrupted services with adequately scheduled staff shifts to manage high patient inflows. While KMH has implemented systems to maintain adequate staffing during all hours, gaps in emergency readiness were observed in some CHCs and CHC+. Exit interviews and focus group discussions highlighted concerns in Zorkot/Musa Khel and Nadershakot CHC+, where delays in attending to emergencies were attributed to unavailability of healthcare workers. On the other hand, KPH, as a key referral hospital in the province, operates 24/7 but struggled to meet emergency demands due to staffing shortages and inefficiencies in resource allocation. Delays in attending to patients after arrival, often exceeded 30 minutes, as reported by 37% of the respondents to exit interview.

COMMUNITY HEALTH WORKERS (CHWS) INTEGRATION

This evaluation found that CHWs in Khost were not fully and effectively integrated into maternal and neonatal healthcare services. Although they played a role in promoting facility-based deliveries, their involvement in critical aspects such as birth preparedness, identifying high-risk pregnancies, and socialising KMH's admission criteria remained inadequate. The current focus of CHWs was heavily skewed toward general health promotion rather than targeted maternal and neonatal health interventions and were not adequately provided with job-aid materials, especially flipcharts on specific maternal and neonatal issues which they could use in their household visits.

As detailed in Section Findings> Effectiveness> Supply-Side: Referral System there are 676 CHWs (311 male and 365 female) in Khost, managed by HN-TPO and CARE International. Findings from focus group discussions and in-depth interviews with CHWs indicated that their communication efforts lack depth in conveying vital information about maternal health. For example:

- There was little focus on educating families about the importance of early identification and referral of high-risk pregnancies.
- Birth preparedness, including promoting planning transportation and saving for healthcare expenses for households with pregnant women, was rarely emphasised in their interactions.
- Lack of knowledge about KMH admission criteria.

Enhancing the integration of CHWs into maternal and neonatal healthcare through their managing agencies (HN-TPO and CARE) can significantly improve service efficiency and community awareness. This approach can help CHWs address prevalent misconceptions about quality maternal care, such as the availability of timely attendance for women in labour, access to lab testing, injectable medicines, and advanced imaging services like ultrasounds. By equipping CHWs with accurate information and resources, they can guide communities in selecting the appropriate healthcare facilities for birth delivery, ensuring better utilisation of services and reducing burden of normal deliveries in KMH.

IMPACT

Impact was defined as the lasting change that MSF's services, through the Khost Maternal Health project, have had on communities.

To evaluate the impact of MSF's presence in Khost province on maternal and neonatal outcomes, particularly maternal and neonatal mortality, this assessment analysed mortality trends reported in national surveys over the years and used proxy indicators. While the evaluation did not directly measure mortality, the findings offer critical insights into the role of MSF-supported services.

Afghanistan lacks province-specific maternal mortality ratio (MMR) data, with the only national-level MMR assessment provided by the Afghanistan Demographic and Health Survey (AfDHS) in 2015. However, substantial progress in proxy indicators signals notable improvements in maternal health in Khost. For instance, the proportion of deliveries assisted by skilled birth attendants rose substantially from 17.8% in 2003 to 64.5% in 2015, and further to 70.3% in 2023, as reported by MICS 2003[54], AfDHS 2015[55] and MICS 2023[56], respectively. Similarly, the proportion of deliveries via C-section increased from 1.2% in 2015 (AfDHS 2015) to 2.8% in 2023 (MICS 2023).

Given that KMH accounts for more than 40% of all institutional deliveries in Khost and manages 70% of directly obstetric complications (DOCs) in the province, its contributions have likely played a pivotal role in driving these improvements.

On the other hand, the neonatal mortality rate in Khost province has shown remarkable improvement over the years, reflecting significant progress in newborn care. In 2015, AfDHS reported 24 neonatal deaths per 1,000 live births in Khost, a figure higher than the national average of 22 per 1,000 live births in 2015. However, by 2023, MICS recorded a decline in Khost's neonatal mortality rate to 19 per 1,000 live births, while the national average increased to 24 per 1,000 live births from 22 per 1,000 live births in 2015.

KMH's substantial role in this improvement cannot be overlooked. With a 32-bed neonatal care capacity and contributing with managing 70% of DOCs (conditions often associated with neonatal deaths), KMH has likely been a critical factor in reducing neonatal mortality. KMH's targeted neonatal interventions and comprehensive obstetric care have strengthened the province's capacity to save newborn lives.

A profound transformation in healthcare-seeking behaviour is evident in Khost, with a noticeable shift toward facility-based childbirth. All community members, both male and female, who participated in

[54] Multiple Indicator Cluster Survey 2003: UNICEF (n.d.). *Afghanistan - Progress of Provinces (Multiple Indicator Cluster Survey 2003)*. [online] *www.unicef.org*. UNICEF. Available at: https://mics-surveys-prod.s3/Afghanistan/2003/Final/Afghanistan%202003%20MICS_English.pdf [Accessed 26 May 2024].

[55] Afghanistan Demographic and Health Survey 2015: U.S. Agency for International Development. (2016). *Afghanistan Demographic and Health Survey 2015 - Key Indicators Report | Document | Afghanistan*. [online] Available at: https://www.usaid.gov/afghanistan/document/afghanistan-demographic-and-health-survey-2015-key-indicators-report.

[56] Multiple Indicator Cluster Survey 2022-2023: UNICEF (2023). *Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023 | UNICEF Afghanistan*. [online] Available at: https://www.unicef.org/afghanistan/reports/afghanistan-multiple-indicator-cluster-survey-mics-2022-2023.

this evaluation expressed a strong preference for health facilities as their first choice for childbirth. This marked a significant departure from traditional practices that heavily relied on home deliveries and demonstrates growing trust in institutional care.

This change was largely attributed to KMH's culturally adaptive approach, which respected local norms and traditions while delivering high-quality maternal and neonatal care. The hospital's proactive engagement with community elders and its responsiveness to their inputs was revealed to have played a pivotal role in reshaping perceptions about healthcare services. Such efforts have not only enhanced the community's confidence in facility-based births but also contributed to a substantial reduction in home deliveries.

Since MSF commenced operations in Khost in 2012, there has been a marked increase in institutional births. This surge underscores KMH's role as a driver of positive behavioural change, providing culturally sensitive, patient-centred care that aligned with community needs. KMH's impact goes beyond service provision. It fosters a long-term cultural shift toward prioritising safe, institutional childbirth, thereby improving maternal and neonatal outcomes across the province.

SUSTAINABILITY

Sustainability was defined as the extent to which the improvements MSF/KMH brought to maternal and neonatal health in Khost could continue without external support.

MSF's presence in Khost has undoubtedly strengthened the maternal and neonatal healthcare system, but questions remain regarding its long-term sustainability. While MSF has provided critical services, including over 40% of institutional deliveries and managing 70% of cases involving direct obstetric complications (DOCs), there are limited indications of systemic capacity building aimed at enabling the local healthcare system to function independently. The reliance on MSF for vital components such as staffing, medical supplies, and operational costs suggests that the transition to local ownership is still a distant goal.

Training local healthcare workers, midwives, and doctors is essential for sustainability, but this evaluation found gaps in capacity-building efforts. While MSF has likely contributed to skill enhancement through its operations, there is little structured training or mentorship reported that explicitly aims to prepare local personnel to take over MSF's roles. Given the absence of provincial-level investments in healthcare and the extremely low BPHS budget of around $5 per capita annually in Khost, coupled with a growing population, the dependency on MSF to maintain service delivery remains high. For a sustainable transition, MSF needs to integrate structured training programs, strengthen the capacity of existing health facilities, and work collaboratively with national stakeholders to build a resilient healthcare system that can sustain its gains over the long term.

This evaluation examined the extent to which communities in Khost have taken ownership of the services delivered by local health facilities and their potential role in enhancing maternal and neonatal healthcare. Findings from 13 in-depth interviews (IDIs) with community leaders, many of whom also

served as members of Health Facility Shuras (Community Boards), revealed a strong prioritisation of maternal services due to Pakhtunwali traditions emphasising women's privacy. However, despite this prioritisation, community leaders and members have had limited involvement in addressing issues at their local health facilities. Beyond promoting institutional childbirth, there is untapped potential for communities to contribute, either in cash or in kind, to improving healthcare services at CHCs and CHC+ facilities instead of solely relying on NGOs or the government.

Operational challenges identified during health facility assessments indicate areas where community contributions could play a pivotal role. For instance, Khulbesat/Sabari and Ali Sher CHCs and Nadershakot CHC+ lacked appropriate separate waiting areas for men and women. A healthcare provider shared their concern:

"….there is no separate male waiting area. Male patients are roaming in corridors or setting outside in the premises of the health facility. Which is of concern for some of the pregnant women crossing them to access the maternal and reproductive health services."

In Khulbesat/Sabari CHC, health workers also reported challenges in maintaining infection prevention and control (IPC) in the maternal and child health unit due to infrastructure issues. The unit's design included only a single drainage point, requiring water from cleaning the delivery room to pass through other areas. Frequent clogging of the drainage further complicated IPC efforts.

Addressing such infrastructure gaps, like constructing separate waiting areas or resolving drainage issues, presents an opportunity for community involvement. Leveraging local resources and community contributions could enhance service delivery, increase ownership, and improve sustainability, especially in light of uncertainties surrounding BPHS continuity. By fostering greater community engagement, these facilities could better meet the needs of their populations while enhancing their resilience and utility.

CONCLUSIONS

The Khost Maternal Health Project has played a pivotal role in improving maternal and neonatal health outcomes in Khost province through its culturally sensitive, patient-centred, and high-quality maternal and neonatal healthcare services. KMH, as the only fully functional CEmONC facility in the province, accounted for over 40% of all public sector institutional deliveries and managed a significant share of high-risk obstetric cases (70% of total DOC cases), contributing towards reductions in maternal and neonatal mortality rates. The project's integration of community engagement and alignment with cultural norms has contributed to a significant shift in healthcare-seeking behaviour, with a significant rise in institutional deliveries since MSF began its operations in 2012.

However, systemic challenges must be addressed to ensure the long-term sustainability and resilience of the maternal health system. The evaluation identified gaps in the readiness and capacity of CHCs, CHC+, and KPH to deliver BEmONC and CEmONC services. These gaps, including shortages of essential medicines, equipment, adequately trained staff, and behaviour of health workers, have undermined the quality and community trust in local health services. The heavy reliance on KMH for normal deliveries is driven by gaps in the readiness and capacity of other facilities (CHCs, CHC+, and KPH), community misconceptions about what constitutes quality maternal healthcare (such as the perceived necessity of lab tests, injectable medications, and imaging for all deliveries), and a lack of awareness regarding KMH admission criteria. This reliance has overstretched KMH's resources, highlighting the critical need to address the afore-mentioned factors to increase the share of other health facilities in handling normal deliveries and reduce the burden on KMH.

Community engagement efforts were instrumental but revealed room for improvement in addressing specific maternal and neonatal health challenges. Enhanced health promotion activities, effective dissemination of KMH admission criteria, and strengthened collaboration with CHWs, CHSs, and private healthcare providers could mitigate delays and improve the continuum of care. Additionally, a functional referral system and targeted capacity-building initiatives for healthcare workers are critical to overcoming barriers and ensuring high-quality services at all levels.

The findings underscore the necessity of a multi-stakeholder approach to foster a sustainable maternal healthcare system. By collective efforts building the capacity of local health facilities, equipping healthcare providers with the necessary skills and resources, and actively engaging communities, MSF, in collaboration with other actors in the province, can enhance the resilience of Khost's maternal and neonatal health system. This will not only reduce dependency on KMH but also ensure equitable and quality care for the province's growing population.

RECOMMENDATIONS

Based on the evaluation findings and the comprehensive analysis of supply- and demand-side factors, the following recommendations aim to enhance maternal and neonatal health services in Khost province, focusing on relevance, appropriateness, sustainability, effectiveness, and community engagement:

⇒ Recommendation 1: Enhancing BEmONC Services at CHCs/CHC+

MSF's support to 6 CHCs and 2 CHC+ (covering the costs of two midwives and one cleaner per facility) enabled them to provide 24/7 delivery services. However, these facilities were not fully functional as BEmONC centres due to issues such as the unavailability of basic essential medicines (including Ringer Lactate and painkillers), equipment, and medical supplies (including 16- and 18-gauge needles). This led to a lack of community confidence in the services provided at CHCs/CHC+ and prompted families to bypass these centres even for normal deliveries. It is recommended to actively collaborate with the BPHS implementing organisation in Khost to ensure the consistent availability of the necessary equipment, medicines, and supplies. Additionally, these requirements should be formalised in future MoUs with BPHS implementing agencies to promote systemic improvements.

⇒ Recommendation 2: Enhancing Neonatal Healthcare Services

Only 13% of interviewed health workers (3 out of 24) had received training in newborn resuscitation, with a shortage of basic equipment for neonatal resuscitation (including resuscitation trolleys and Ambu bags) at CHCs/CHC+. Additionally, there were gaps in breastfeeding counselling and hands-on training for mothers, especially for low-birth-weight babies, at KMH. To address these issues, it is recommended to enhance breastfeeding and neonatal care counselling services at KMH, especially to mothers of low-birthweight babies and include capacity development opportunities for CHCs/CHC+ personnel. Also, active collaboration with BPHS implementing organisation is essential to ensure the availability of critical neonatal equipment, which should also be incorporated into future MoUs with BPHS implementing organisations.

⇒ Recommendation 3: Enhancing Postnatal Care at KMH

KMH provided first PNC services to mothers staying longer than 24 hours, but those discharged earlier were required to seek follow-up care from other health facilities. Since more than 60% of maternal deaths occur during the postpartum period, it is recommended to ensure discharged mothers are aware of and connected to postnatal care in their communities. It is recommended to undertake pre-discharge counselling, issue PNC cards, and provide pictorial information leaflets containing details on postnatal care, family planning, and exclusive breastfeeding. Measures as such will also strengthen the linkages with local health facilities.

Recommendations 4-5 (of 7) →

⇒ Recommendation 4: Health Promotion

The current outreach model relies on a small number of health promoters covering diverse topics in a limited geographic area. Empowering CHWs and other health facility staff with tailored information, education, and communication (IEC) packages could enable more effective dissemination of health messages. Engaging all organisations involved in healthcare delivery to harmonise health promotion efforts could amplify the impact. While the current community engagement initiatives were well-intentioned and culturally sensitive, they fell short in addressing specific maternal and neonatal health needs. Tailored health promotion activities focused on addressing misconceptions about quality care and promoting the importance of facility-based deliveries, improved dissemination of KMH admission criteria, and strengthened collaboration with CHWs and other healthcare providers can enhance the effectiveness and appropriateness of health promotion initiatives. It is recommended that MSF expand its institutional approach towards health promotion and community engagement by collaborating with the BPHS implementing organisation and CARE to reach all 676 CHWs in the province. This effort should include supporting CHWs' training to identify high-risk pregnancies and promote birth preparedness (including addressing first and second delays), ensuring they have job aids like pictorial tools to support awareness activities. Empowering CHWs in disseminating KMH admission criteria and encouraging the use of CHCs for normal deliveries.

⇒ Recommendation 5: Promote Local Ownership

Encourage community contributions to address infrastructure and supply gaps at CHCs and CHC+ facilities, fostering a sense of ownership and sustainability. Findings from this evaluation revealed a strong emphasis on the importance of maternal health services to the communities due to Pakhtunwali traditions concerning women's privacy. Despite such importance, community leaders and members have had limited involvement in addressing issues at their local health facilities. Beyond promoting institutional childbirth, there is untapped potential for communities to contribute, either in cash or in kind, to improving healthcare services at CHCs and CHC+ facilities instead of solely relying on NGOs or the government. Operational challenges identified during health facility assessments indicate areas where community contributions could play a pivotal role. For instance, Khulbesat/Sabari and Ali Sher CHCs and Nadershakot CHC+ lack appropriate separate waiting areas for men and women. Therefore, it is recommended to collaborate with the BPHS implementing organisation in Khost to initiate and promote community contributions aimed at addressing infrastructure initially and expanding to other areas such as supply gaps. This approach would leverage local resources to improve service delivery, foster a stronger sense of ownership, and enhance the sustainability of healthcare services. Additionally, providing technical support to the BPHS implementor and sharing best practices from KMH can further strengthen their capacity to mobilize community involvement effectively.

Recommendations 6-7 (of 7) →

⇒ Recommendation 6: Collaboration with Other Actors

The evaluation found that the project's potential for synergy with other health actors in Khost province was not fully realised. Although the project's support to HN-TPO filled critical gaps in service delivery at CHCs/CHC+ and KPH, stronger collaboration with other stakeholders (such as CARE International, IRC, provincial health authorities, Khost Teaching Hospital, and private healthcare providers) could have enhanced the coherence of interventions. For example, joint initiatives to strengthen the referral system, socialise KMH admission criteria, and develop a collaborative health promotion mechanism could result in better health promotion outcomes. It is recommended to establish stronger partnerships with these stakeholders to maximise the project's impact and ensure a more integrated approach to healthcare delivery in Khost province.

⇒ Recommendation 7: Referral system

The referral system assessment revealed a mixed picture. While community health workers (CHWs) actively promoted institutional birth delivery, they lacked comprehensive training and awareness to identify and refer high-risk pregnancies effectively. Referrals from CHCs and CHC+ were very low, with private healthcare providers emerging as the primary referral source. As such, it is recommended to raise awareness about KMH admission criteria among private healthcare providers and the general community. Empowering Khost's 676 active CHWs (including 365 female CHWs) through training on pregnancy danger signs, providing job-aid materials, and raising awareness of KMH admission criteria could significantly improve the referral system. Joint initiatives with stakeholders such as the BPHS implementor, CARE International, IRC, provincial health authorities, Khost Teaching Hospital, and private clinics should be established to strengthen the referral network.

ANNEXES

ANNEX I: EVALUATION MATRIX

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
Relevance	EQ 1: Do the objectives of the project correspond with identified needs?	Extent to which the project and its objectives are aligned with identified needs	Stakeholders' perceptions of the alignment between identified needs and the project and its objectives	- Document review - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews - 24 Health Workers Interview
Appropriateness	EQ2: Are the strategies and activities appropriate for the project objectives?	Extent to which the strategies and activities adopted are aligned with the objectives	Stakeholders' perceptions of the alignment between the strategies/ activities and the objectives	- Document review - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews - 24 Health Workers Interview
	EQ3: Are the project's strategies/ activities contextually appropriate?	Extent to which the strategies and activities adopted are contextually appropriate over time	Stakeholders' perceptions of whether strategies and activities adopted are contextually appropriate over time	
Effectiveness	EQ4: To what extent have the defined objectives been achieved? What were reasons for achievement or non-achievement of objectives?	Extent to which the activities have achieved the project objectives to date	Evidence demonstrating outputs/ results of the project to date are contributing to / in line with the project objectives	- Project reports, other reports - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews - 24 Health Workers Interview
			Stakeholders' perceptions of the results achieved or not achieved so far of the activities implemented in achieving the project objectives to date	
	EQ5: Were the activities carried out as originally planned?	Extent to which the activities were carried out as planned	Evidence linking actual activities to planned activities	

EVALUATION CRITERIA	EVALUATION QUESTION	JUDGEMENT CRITERIA	INDICATORS	DATA SOURCES
	EQ6: What can be done to make the project more effective?	Extent to which strategies/ activities have changed based on changing contexts or lessons learnt	Evidence linking changed strategies/ activities to contextual changes	
Impact	EQ7: What difference has the project made in terms of policy/practice both nationally and internationally?	Extent to which the project has influenced policy/practice nationally and internationally	Evidence showing policy or practice changes	Project reports, other reports - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews 24 Health Workers Interview
	EQ8: What is the proportion of the target population reached?	Extent to which the target audience has been reached	Evidence of the target population being defined and the percentage been reached	
Efficiency	EQ11: Were activities/strategies implemented with the best use of available financial resources and time?	Extent to which efficient use of resources was made	Evidence of best use of resources (financial, human, time)	Project reports, other reports - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews 24 Health Workers Interview
Sustainability	EQ12: Will the project be sustainable?	Extent of transferring the project to a more permanent home or base	Evidence that suggests the project is embedded within existing structures and will continue?	Project reports, other reports - 12 KIIs - 7 HF Assessments - 29 In-depth Interviews - 8 FGDs - 180 Exit Interviews 24 Health Workers Interview

ANNEX II: LIST OF DOCUMENTS CONSULTED

External documents, data, and literatures reviewed:

- Afghanistan Multiple Indicators Cluster Survey (MICS 2000)
- Afghanistan Multiple Indicators Cluster Survey (MICS 2003)
- Afghanistan Health Survey Report (2006)
- National Risks and Vulnerability Assessment Report (NRVA 2007-08)
- Afghanistan Mortality Survey (2010)
- Afghanistan National Nutrition Survey (2013)
- National Risks and Vulnerability Assessment Report (NRVA 2013)
- Afghanistan Demographic and Health Survey (AfDHS 2015)
- Afghanistan Living Conditions Survey (ALCS 2016-17)
- Afghanistan Health Survey (AHS 2018)
- Afghanistan Multiple Indicators Cluster Survey (MICS 2022 - 23)
- Basic Package of Health Services
- Essential Package of Hospital Services
- National RMNCAH Strategy 2017 – 2021
- Sehatmandi Review Reports 2019
- Afghanistan Health System Review 2020
- NSIA Year Book 2023: Women and Men in Afghanistan
- Independent Assessment of the Design and Performance of Primary Health Care in Afghanistan 2020
- The Work of WHO 1965: Annual Report of the Director General to the World Health Assembly and to the United Nations
- National HMIS data for Khost (2004 to 2023)

MSF documents, data, and literature reviewed:

- Khost Maternal Health Project Document 2024
- Khost Maternal Health Project Medical Strategy 2024
- Khost – Overview of CHCs
- Khost Maternal Health Project – Admission Criteria
- Khost Maternal Health Project – Logframe
- Mission Mental Health and Psychosocial Support (MHPSS) Strategy 2022
- Khost Maternal Health Project Multi Year Operational Plan (2020 to 2024)
- Referral Criteria from CHC to MSF Khost Hospital
- Project Special Agreement – Khost Maternal Health Project
- Memorandum of Understanding (MoU) between MSF and HealthNet-TPO (2023)
- Memorandum of Understanding (MoU) between MSF and HealthNet-TPO (2024)
- “tell it to my mother-in-law”: Women’s Sexual and Reproductive Health, their Perspective of and access to Maternal Healthcare services in Khost Province, Afghanistan
- Khost Maternity Hospital M&E Dataset
- MSF Essential obstetric and newborn care: Practical guide for midwives, doctors with obstetrics training and health care personnel who deal with obstetric emergencies (MSF CEmONC guideline)

- Operational Prospects: OCB 2020 – 2023
- Strategy Paper: Delivering High-impact Interventions to Meet the Health Needs and Demands of the Most Vulnerable (OCB Medical Department 2020 – 2023)
- Stockholm Evaluation Unit Guidelines: Evaluation Manifesto (A Compass for Navigating Complexity)
- Strategic Orientations (2020 – 2023)
- Stockholm Evaluation Unit Guidelines: Ethical Guidelines for Evaluation
- Stockholm Evaluation Unit Guidelines: Evaluation Framework (SEU Steering Committee Paper)
- Who's who: MSF's Institutional Layout

ANNEX III: RESPONDENTS PROFILE (FGD, KII, AND IDIS)

RESPONDENTS	DISTRICT	GENDER	LEVEL OF EDUCATION	AGE (RANGE)
Respondent 1	Gurbaz	Female	Not Educated (Cannot Read and Write)	26 to 39 Years
Respondent 2	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 6	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 7	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 8	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 9	Gurbaz	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	26 to 43 Years
Respondent 2	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	
Respondent 6	Zorkot/Musa Khel	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Nadirshah Kot	Female	Not Educated (Cannot Read and Write)	27 to 39 Years
Respondent 2	Nadirshah Kot	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Nadirshah Kot	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Nadirshah Kot	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Nadirshah Kot	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	27 to 39 Years
Respondent 2	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	

Respondent 6	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	
Respondent 7	Khulbesat/Sabari	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	26 to 38 Years
Respondent 2	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 6	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 7	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 8	Tanai (Dargai)	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Ali Sher	Female	Not Educated (Cannot Read and Write)	30 to 47 Years
Respondent 2	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 3	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 4	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 5	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 6	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 7	Ali Sher	Female	Not Educated (Cannot Read and Write)	
Respondent 1	Ali Sher	Male	University Graduate	38 to 70 Years
Respondent 2	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 3	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 4	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 5	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 6	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 7	Ali Sher	Male	Primary School	
Respondent 8	Ali Sher	Male	High School	
Respondent 9	Ali Sher	Male	No Formal Education (Can Read and Write)	
Respondent 10	Ali Sher	Male	Not Educated (Cannot Read and Write)	
Respondent 1	Lakan	Male	Secondary School	31 to 70 Years
Respondent 2	Lakan	Male	High School	
Respondent 3	Lakan	Male	Secondary School	
Respondent 4	Lakan	Male	Primary School	

Respondent 5	Lakan	Male	High School	
Respondent 6	Lakan	Male	High School	
Respondent 7	Lakan	Male	University Graduate	

ANNEX IV: EVALUATION TERMS OF REFERENCE

Médecins Sans Frontières (MSF) is an international medical humanitarian organization committed to providing quality medical care to people in crisis situations around the world, when and where they need it, regardless of their religion, ethnicity, or political views. Our core principles are neutrality, impartiality, independence, medical ethics, témoignage, and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units responsible for managing and guiding evaluations of MSF's operational projects, and works mainly with the Brussels Operational Centre. For more information, visit our website evaluation.msf.org.

Fostering a culture of evaluation is a strategic priority for accountability, continuous improvement, and organisational learning. MSF does not only evaluate because of external requirements, such as donor requirements. These terms of reference should be considered as a starting point for the evaluation process. The evaluator(s) are invited to challenge them and suggest, for example, different or additional perspectives, as they see fit during the creation phase. The evaluation process must be based on a sound methodology to achieve credible results and must also ensure that values and use are at the forefront. The evaluation must involve and include the different actors and counterparts adequately throughout the process.

Evaluation of **MSF's Khost Maternal Health Project in Afghanistan 2016 – 2024**	
Start date:	April 2024
Duration:	9 months
Requirements:	Interested applicants should submit: 1) A proposal describing how this evaluation is to be carried out (including the budget in a separate dossier), 2) CV(s), and 3) a written sample of previous work
Deadline:	2359hrs CET on April 14th, 2024
Send to:	evaluations@stockholm.msf.org marked "KHOST"
Please note:	The evaluation will require a site visit to the project, which will be planned during the initiation phase, through discussions with the project, the Consultation Group, and the SEU Evaluation Officer.

Background

The Khost Maternal Health Project in Afghanistan is one of MSF's largest maternal health projects in the world. It was initiated in 2011, with the objective of reducing neonatal and maternal mortality (estimated

nationally at 396 maternal deaths per 100,000 live births in 2015[57], and 638/100,000 for neonatal mortality in 2017[58]). The general objective of the project is that "*sexual and reproductive health related morbidity and mortality are reduced in Khost Province*" with the specific objective that "*women of Khost province with pregnancy related complications will make use of the comprehensive emergency obstetric and neonatal care provided in Khost Maternity Hospital*".

Today, the project includes the MSF-operated Khost Maternity Hospital (KMH, one of three Comprehensive Emergency Obstetric and Neonatal Care, CEmONC, facilities in the district), and support to eight primary healthcare structures in the district (salary funding to increase maternal health staff levels, ad-hoc logistics support, ad-hoc medical donations, with limited MSF supervision). The project operates with an annual budget of approximately six million euros, employing 12+ international mobile staff and over 475 locally recruited staff providing over 18,000 deliveries per year. In addition to the core activities of the project, MSF also provides ad-hoc medical donations to the Khost Provincial Hospital, operated by implementing partners of the Ministry of Health. At the same time, MSF maintains an emergency response capacity which has been activated in 2023 in response to earthquakes in the area.

Project history

The project began providing services in 2012 in a rehabilitated military hospital, providing access to CEmONC maternal health services to the population of Khost District. In its first six weeks, the project was affected by a serious security incident (bomb blast), but since resuming activities the same year there was a rapid increase in the number of deliveries being provided by MSF in the KMH. The project aims to focus on providing care for expected cases of direct obstetric complications (DOCs) and mothers with risk factors. The project chose to target this population to avoid impacting the resiliency of the existing health system and ensure MSF's resources were allocated to providing a high quality of care to the most at-risk patients. While the primary project objectives of reducing maternal and neo-natal mortality and morbidity are captured in the project log-frame, there is a desire to pursue the additional objective of promoting the resiliency of the existing health system in the long term, acknowledging the instable and harsh socio-political and socio-economic situation in Afghanistan.

This has been a challenge for the project, as the services offered are in high demand and there has been pressure on MSF to extend its services beyond its target population. In the period from the project opening to 2018– 2019, the number of deliveries provided by MSF grew rapidly, with more than 23,000 deliveries on an annual basis for each of those years. In the years since, the overall number of deliveries has trended downwards – to approximately 18,000 deliveries in 2022 – as the project sought to re-strengthen its focus on its target population with two principal strategies.

First, by ensuring adherence with admission criteria, and establishing referral pathways for patients who do not meet those criteria to seek maternal care in other health structures, and in some cases providing punctual support (medical donations) to those facilities. In practice, this is a challenge. Second, since 2016, the project has provided support to primary healthcare centres in the hospital catchment area, with the

[57] Afghanistan Health Survey 2015: https://www.kit.nl/wp-content/uploads/2018/10/08-23-2016-Afghanistan-Health-Survey-2015-Final-Report.pdf

[58] Index Mundi, 2017: https://www.indexmundi.com/facts/afghanistan/mortality-rate

dual aim of improving the available services in those facilities for non-complicated deliveries and supporting the detection and referral patients meeting MSF's criteria to the KMH. As of 2024, the project supports eight primary healthcare centres with capacity building, funding to increase maternal health staff levels, logistic upgrades and support, medical donations, and MSF supervision when possible.

Key contextual developments have also prompted MSF to adapt. One important moment was the COVID-19 pandemic, when the project significantly reduced its bed capacity to apply more stringent Infection Prevention Control (IPC) protocols and avoid the hospital becoming a source contamination. As a result, many patients who would otherwise have been admitted were turned away and total deliveries provided in 2020 dropped to 14,360. This raised concerns of availability of care to those patients, strains on the capacity of the surrounding health system in times of a pandemic, and for potential damage to relationships with the community. Another important moment arose during the political transition in Afghanistan in late 2021. During this period, the project revised its admission criteria so any patient seeking maternal care could be admitted. As the situation stabilized, admission criteria were subsequently re-applied.

Overall, in the period from 2019 – 2023, there has been a gradual reduction in the overall number of deliveries provided at KMH, as well as a corresponding increase in the proportion of deliveries provided with DOCs and by caesarean. MSF is now looking to develop a longer-term strategy for the future direction of the project, including developing a strategy to foster resilience in the local maternal health system and reduce reliance upon MSF presence for maternal health care. One component of this is to pilot new approaches to community engagement – some of which are already being developed in the project. The aim of this initiative is to find ways of engaging and supporting communities which can enhance resilience of local health structures, capacities of community health workers and increase community-level awareness of and engagement with maternal health issues.

While MSF does not envisage the closure of Khost in the foreseeable future, it is concerned that its intervention has created dependency on MSF presence to ensure the populations access to free, quality maternal health care and has undermined the resilience of the overall health system. The project is interested in implementing measures to foster greater resilience and reduce dependency upon MSF presence. That dynamic remains challenging, as capacity of other actors is limited, donor support to Afghanistan is declining and humanitarian organizations face heightened challenges to operate in some parts of the country. MSF is noting an increase in private medical services, which do not offer services free of charge and pose financial barriers to some patients.

Purpose and intended use

The purpose of this evaluation is to assess the implementation of the Khost Maternal Health Project from 2016 – 2024 to inform strategic discussions in late 2024 during the Annual Review of Operations (AROs). A special area of interest in these discussions will be to adapt its strategy, including developing a strategy to foster resilience in the local maternal health system and reduce reliance upon MSF presence for maternal health care.

So far, the project has implemented measures which seek to facilitate that general aim: such as support to primary healthcare centres, establishing referral pathways for non-complicated deliveries, reinforced and sensitized communities around admission criteria. Lessons learned from this evaluation, including those components and others, will inform those discussions.

Evaluation Questions

- How **relevant** is the project when considering the needs and expressed needs of the population and the principles and priorities of the organization?
- Given the context and the project objective of promoting resiliency of the health system and actively engage communities, how **appropriate** is the approach taken by MSF to reducing morbidity and mortality for women with pregnancy related complications?
- Is MSF's intervention **coherent and compatible** with maternal health policies and other interventions in Khost?
- How can the project become more **effective** in achieving its objectives and promoting resilience and sustainability of local health systems?
- What has been the positive **impact** of MSF's maternal health intervention in Khost, and how can it improve its potential for impact? Have there been unintended or negative consequences of MSF's intervention, and how can MSF improve mitigation?
- How can MSF improve the **efficiency** of the resources being used in the project?
- How can MSF improve the **sustainability** of its intervention by ensuring net benefits are preserved in the long-term?

EXPECTED DELIVERABLES

- **Inception Report**

The initial report should include a detailed evaluation proposal, including a description of the project's theory of change, as well as the evaluation methodology and protocol, further elaborating on the evaluation proposal. MSF places a high value on the creation phase, especially when it comes to ensuring a shared understanding of a complex assessment.

- **Sense-making session**

Lead a structured sense-making session with the consultation group and key MSF stakeholders to document the project's theory of change. The theory of change should document project objectives and strategies which may not be fully captured in the project log frame.

- **Actor Mapping**

Review the project and mission actor-mapping related to maternal health in Khost province, identify any gaps and identify potential to increase MSF engagement with key actors in the sector.

- **Real-time learning**

Debriefing with the team in Afghanistan, in connection with the field visit.

Ongoing feedback to the evaluation consultation group as preliminary results emerge.

- **Draft Evaluation Report**

The draft evaluation should address the evaluation questions and the stated objective of the evaluation in light of the intended use, based on the analysis, findings and conclusions and, where applicable, lessons learned and/or recommendations.

- **Working Session**

As part of the report writing process, a working session will be held with the Commissioner, members of the Consultation Group and the SEU Evaluation Officer. The evaluation team will present the preliminary results, gather feedback, and facilitate a discussion on the recommendations (either to co-create recommendations or, if they have already been developed, to discuss their feasibility).

- **Final Evaluation Report**

The final report will have considered the comments received during the working session and the written comments from the feedback loop.

- **Dissemination and use**
    - Presentation and discussion of the final evaluation report and a shorter summary report to the general MSF public as a webinar.
    - Short-form communication product to share evaluation results with partners, patients, and communities (e.g., pamphlet, poster).
    - Further sense-making exercises, workshops, and dissemination and use activities may be suggested in the proposal, during or at the end of the evaluation process.
- **Uptake session**: **1-3 months after** the report finalization and dissemination, the evaluator should conduct an uptake session with the consultation group and other MSF stakeholders in the project to assess the understanding and reaction to the evaluation findings; with a view of fostering additional possibilities for evaluation uptake and use within the project strategy.

Key deliverables (Initial Report, Draft Report, and Final Report) will be addressed through a feedback loop, which will gather feedback from the Consultation Group (see below, *Practical Implementation of the Evaluation*). Each deliverable is reviewed by the SEU and approved by the Evaluation Commissioner.

PROPOSED TOOLS AND METHODOLOGY

In addition to the initial evaluation proposal submitted as part of the application, a detailed evaluation protocol will be prepared by the reviewers during the initial phase, following access to the documentation and initial discussions with the evaluation consultation group. The initial report will include a detailed explanation of the proposed methods, including community participation, and their rationale based on validated theories. It will be reviewed and validated as part of the creation phase in coordination with the SEU.

RECOMMENDED SECONDARY SOURCES

- Routinely collected medical data (raw data from medical databases)
- Project documents (project proposals, logical frameworks, strategies, agreements between MSF and local authorities and health actors, situation reports, annual reports, project visit and end-of-mission reports, organizational charts, project budgets, evaluation reports, etc.)
- National, regional, and global strategies, documentation and guidelines.
- External literature and documentation.
- MSF and OCB strategic documents including strategic orientations, operational perspectives, medical service strategy, and guiding principles.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	Flexible. The SEU believes that a team might add value to the process (rather than an individual).
Timeline	Sense-making / Theory of Change: May 15, 2024 Inception report: May 30, 2024 Working session: July 20, 2024 Final Report (first draft): August 15, 2024 Final Report (completed): Sept 15, 2024 Uptake session: October 2024 (Annual review of operations)

The SEU engages a Consultation Group (CG) in this evaluation process with the goal of increasing understanding, buy-in, learning during the process, and the quality of the results. The CG is headed by a Commissioner (they contributed to the finalization of this ToR).

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

The assessment requires an individual or team of individuals who can demonstrate competencies in the following areas.

Requirements

- Professional credentials in humanitarian evaluation, or equivalent education/experience.
- Master's in public health (or equivalent education/experience) is essential.
- Experience in maternal health programming at the CEmONC level and community engagement strategies / participatory methods.
- Knowledge of Afghan context, with strong preference for in-country experience in Afghanistan.
- Fluency in English (spoken and written).

Assets

- Experience and/or understanding of MSF.
- Additional languages that can be used in the evaluation process (e.g. Pashtun).

APPLICATION PROCESS

The application must consist of a technical proposal, a budget proposal, a CV, and a sample of previous work. The proposal should include consideration of how adherence to ethical standards for evaluations will be considered throughout the evaluation, as well as how the values and perspectives of different stakeholders will be incorporated into the process. The evaluator(s) will be expected to demonstrate an understanding of the evaluand and its context and take this into account in the methodology as well as in the establishment of the team.

Bids must include a separate quote for all services, quoted in Euros (EUR). The budget should show the consulting fees based on the number of working days planned over the entire period, both in their entirety and as a per diem fee. Travel expenses, if any, do not need to be included, as the SEU will arrange and cover them. Please note that MSF *does* not pay per diems. The level of effort should be proposed by the evaluator(s). The evaluator(s) will not be hired full-time during the period.

MSF is committed to applying responsible data protection principles in all its activities, including assessments, respecting both humanitarian principles and the European GDPR. During the evaluation process, you will potentially have access, collection, storage, analysis, and possibly disposal of MSF's and its patients' sensitive and personal data and information (SPDI). Please take particular note of the SEU's ethical guidelines when preparing your proposal, taking into account the tools and solutions you will use, how you will work to mitigate any data incidents, and how you will dispose of the data collected once the evaluation is complete.

Applications will be evaluated based on the ability of the submitted proposal to understand the key deliverables in accordance with this ToR, a methodology relevant to achieving the expected outcomes, and the overall capacity of the evaluator(s) to complete the work (i.e., inclusion of CVs of proposed evaluators, reference to previous work, certification, etc.).

Interested teams or individuals must apply to **evaluations@stockholm.msf.org** marked **KHOST no later than by 2359hrs CET on April 14th, 2024.** We would appreciate it if you could submit the necessary documents as separate attachments (proposal, budget, CV, work sample, etc.). Do indicate in your application email on which platform you have seen this job opening.

ANNEX V: EVALUATION TOOLS

ETHICAL REQUIREMENTS AND CONSENT: KIIS, IDIS, AND EXIT INTERVIEWS

Researcher Checklist (completed before starting Interview)	
Particulars	Yes/No
Greet the respondent and thank him/her for taking the time to participate in this interview	
Introduce yourself and your role	
Explain the purpose of the discussion: "We would like to ask few questions regarding your experience and perspective about maternal and neonatal health and healthcare in Khost province. The information you share with us today will be used to identify measures for improving maternal and neonatal health in Khost".	
Ask if there is any question or clarification needed	

Ask if the key informant is ready to proceed. If ready obtain the following informed consent from key informant (interview participant).

Informed Consent
This consent form describes the evaluation and helps you decide if you want to participate. It provides important information about your participation in this interview, about the risks and benefits of your participation, and about your rights as a participant. By providing verbal consent you are agreeing to participate in this study. – If you have any questions about anything in this form, you should ask the evaluation team for more information. – Do not agree to participate in this interview unless we answered your questions, and you decide that you want to be part of this study. WHAT IS THE PURPOSE OF THIS STUDY? The purpose of this evaluation study is to assess factors that contribute towards improving maternal and neonatal health in Khost province. We gather key informants' perspective and experience to identify areas for improving maternal and neonatal health. WHAT WILL HAPPEN DURING THIS INTERVIEW? From what you know, we will be asking you about your knowledge and perspective on pregnancy, birth preparedness, birth delivery, postnatal care situation, services, and challenges in Khost. We will be also about parameters that can contribute towards improving maternal and neonatal health and services in Khost. You are invited to participate to this interview and your answers are confidential and will not be shared with any other people. The records of this interview will be anonymous and private, the statements will not be attributed to you. You have the right not to participate or to stop participating at any time. If you do not understand a question, please ask me to explain it to you. If a question makes you uncomfortable, we will skip the question and go to the next question. It is important to say that there are no right or wrong answers for these questions, just tell us what you think or feel.

HOW LONG WILL I BE IN THIS INTERVIEW?

If you agree to keep, take taking part in this interview, your involvement will last for an hour.

WHAT ARE THE RISKS OF THIS INTERVIEW?

There are no questions that might make you uncomfortable and what you discuss here will not be attributed to you.

WHAT ARE THE BENEFITS OF PARTICIPATION?

You will not benefit from your participation. However, we hope that, in the future, other people might benefit from this study because your answers will help the service providers to better address the needs of pregnant women and children.

WILL IT COST ME ANYTHING TO BE IN INTERVIEW?

You will not have any cost for being in this discussion. If you decide to be in this study, you may stop participating at any time. If you decide not to be in this study, or if you stop participating at any time, you won't be penalised or lose any benefits for which you otherwise qualify.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for your participation. Taking part in this interview is completely voluntary.

HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL?

We will keep your participation in this study confidential. To help protect your confidentiality, we are not recording your name and personal details and the responses you provide will not be attributed to you.

This consent form is not a contract. It is a written explanation of what will happen during the interview if you decide to continue to participate. You are not waiving any legal rights by agreeing to participate in this study.

Ask for permission and consent.

EXIT INTERVIEW QUESTIONNAIRE

	Yes	No
Consent obtained?	1	2 (Thank the respondent and close the interview after inserting the interview code)

Identification			
100	Name of the Health Facility:		
101	Patient's Name:		
102	Patient age	Years |__|__|	
103	Can you (the respondent) read and write?	Yes..... 1 No 2	
104	How many years of school have you (the respondent) completed?	None ..... 0 Years ..... |___|___| DK.... 99	
105	Number of pregnancies	A. 0 - 1 B. 2 - 3 C. 4 - 5 D. 6 or more	
106	Type of care received today	A. Delivery Postnatal care B.	
107	What would be your first preference for receiving maternal health services (ANC, birth delivery, PNC?	A. This health facility B. Khost Provincial Hospital C. MSF Maternity Hospital D. Private service provider E. CHWs F. Family members G. Others ( ) Specify	Choose one option only
108	Why would you consider this as a first preference for maternal health services?	A. Proximity to home B. Affordability C. Quality of care D. Experienced staff E. Experienced staff F. Privacy G. Positive past experience H. Recommendation by others I. My family members preference J. Others ( ) Specify	Choose one option only

109	Where did you have your previous birth deliveries (the birth deliveries before this one)?	A. This health facility B. Khost Provincial Hospital C. MSF Maternity Hospital D. Private service provider E. At home F. Other place ( ) Specify	Choose one option only
110	Did you experience any complications during your previous pregnancy or delivery?	A. Yes, during pregnancy B. Yes, during delivery C. Yes, during both pregnancy and delivery No complications D. Not applicable (this is my first pregnancy) E.	Choose one option only
111	What type of delivery did you have in your previous birth(s)?	A. Normal delivery B. Cesarean section (C-section) C. Assisted vaginal delivery (e.g., forceps or vacuum) D. Other (please specify): ( ) E. Not applicable (this is my first pregnancy)	Choose one option only

Information about your visit to this health facility *Introduce this section by saying,* "I'd like to ask you some questions about your pregnancy and birth delivery."		
120	When did you have your child delivered?	A. Today B. Days ago
121	Did you have any ANC during your pregnancy?	A. Yes B. No (Go to Q 122)
121A	If Yes to Q 121 (from where)	A. This health facility B. CHWs C. Other health facility (Specify:) D. Not applicable
122	Were there any birth complication in current birth delivery?	A. Yes B. No (Go to Q 123)
122A	If Yes to Q 122 (what where the complications)	List he birth complications: t A. ( ) B. ( ) C. ( ) D. Not applicable

122B	If Yes to Q 122 (did you know in advance about these complications)	A. Yes B. No (Go to Q xx)
122C	If Yes to Q 122B (who told you about these complications)	A. Healthcare providers in this health facility B. CHWs C. Family members (Specify:) D. Healthcare providers in other health facility (Specify: who) E. Others (Specify:)
123	How soon after labor pains began you or your family decided to take you to this health facility?	A. Immediately (within 1 hour) (Go to Q 124) B. Within 1-3 hours (Go to Q 124) C. Within 4-6 hours (Go to Q 123A) D. Within 7-10 hours (Go to Q 123A) E. More than 11 hours (Go to Q 123A) F. Don't know
123A	If C, D, or E to Q 123 (ask: What were the reasons for the delay in deciding)	A. Lake of transportation B. Financial constraints C. Previous negative experience D. Uncertainty to deliver at home or go to health facility E. Uncertainty about availability of healthcare services or staff in the nearest health facility F. Waiting for the family decision maker G. Unavailability of companion H. Others (Please specify:)
124	Could you please explain the decision making process about place of child birth delivery in your household?	A. [TAKE A NOTE OF THE DESCRIPTION] B. Not responded C. Don't know
125	After you or your family decided to go to the health facility for birth delivery, how long did it take to get to the health facility?	A. Immediately (within 1 hour) (Go to Q 126) B. Within 1-2 hours (Go to Q 126) C. Within 3-6 hours (Go to Q 125A) D. Within 7-10 hours (Go to Q 125A) E. More than 11 hours (Go to Q125A F. Don't know (Go to Q 126)
125A	If B, C, D, or E to Q 125 (ask: What were the reasons for the delay in getting to the health facility)	A. Lake of transportation B. Poor road condition or distance C. Bad weather made it difficult to reach

		D. Natural barriers (flooding, landslides, raining and others) E. Arranging money for transportation F. Unavailability of companion G. Others (Please specify:)
126	After reaching the health facility, do you feel that there was any delay in receiving the care you needed during your delivery?	A. Yes, there was a significant delay. B. Yes, but the delay was not significant. C. No, I received care in a timely manner.
127	After reaching the health facility, how long did you wait to be initially assessed or examined after arriving at the health facility?	A. Less than 30 minutes B. 30 minutes to 1 hour (Go to Q 127A) C. 1 to 2 hours (Go to Q 127A) D. More than 2 hours (Go to Q 127A)
127A	If B, C, or D, 127 (ask: What were the reasons for the delay)	A. Unavailability of health workers (midwives and B. doctors) Unavailability of necessary equipment and medicine C. Healthcare staff were not adequately prepared and efficient in providing care upon your arrival D. Others (Please specify:

Client satisfaction					
Now, I would like you to think of your last visit. I'm going to read you a series of questions about different aspects of services you received during that visit. If you are very satisfied with this aspect, then out of 4, give it 4. If you are very dissatisfied with it, then out of 4, give 1. You can also give 2 or 3, depending on how satisfied or dissatisfied you are with the services you received during your last visit. For example, if you had a very good horse and you were very happy with it, and someone asked you *"how satisfied are you with your horse?"*, then you out of 4, you would probably give it 4. If your horse was not very good and you were very unhappy that you bought it, then would give 1.	1 = Very dissatisfied	2 = Dissatisfied	3 = Satisfied	4 = Very satisfied	Score = Level of satisfaction

144a	How satisfied are you with the health facility cleanliness?	1	2	3	4	
144b	How satisfied are you with the cleanliness of the toilets in this health facility?	1	2	3	4	
147	How satisfied are you with how the health workers explained your illness?	1	2	3	4	
148	How satisfied are you with how the health workers explained your treatment?	1	2	3	4	
149	How satisfied are you with the ease of getting the medicines the health workers prescribed?	1	2	3	4	
151	How satisfied are you with privacy during your visit?	1	2	3	4	
152a	How satisfied are you with the amount of time the health worker spent with the patient?	1	2	3	4	
152c	How satisfied are you with the amount of time you spent waiting to be seen by a health provider?	1	2	3	4	
152d	How satisfied are you with the respectfulness of the health providers?	1	2	3	4	
152e	How satisfied are you with the cost of this visit to the health facility?	1	2	3	4	
152f	How satisfied are you with the hours during which the health facility is open?	1	2	3	4	
152g	How satisfied are you with your overall visit?	1	2	3	4	

Thank the person very much for their participation.

HEALTH WORKERS INTERVIEW QUESTIONNAIRE

	Yes	No
Consent obtained:	1	2

GENERAL HEALTH WORKER INFORMATION			SKIP
100	Health Worker Tracking No.	|___|___|	
101	A. Interviewer code |___|___|___|___|	B. Date: - -	
102	A. Facility name: _____	B. Facility ID code: |___|___|___|___|	
103	Location	A. Province _____ B. District _____ C. Community _____	
104	Type of health facility	Provincial Hospital ..... 1 Maternity Hospital ..... 2 CHC Plus..... 3 CHC .....4 BHC .....5 OTHERS.....6 (SPECIFY) _____	
105	Sex of the health worker	Male ..... 1 Female 2	
106	Position of the health worker as designated	Doctor ..... 1 Nurse/ Assistant doctor ..... 2 Midwife ..... 3 Vaccinator ..... 4 Other ..... 5 *Specify* _____	
107	How many year(s) and month(s) have you worked at this facility?	Years |___|___| Months |___|___|	

113	What is your qualification	Doctor (general practitioner) ..... 1 Doctor (specialist) ..... 2 Midwife ..... 3 Community Midwife ..... 4 Nurse Technician ..... 5 Other ..... 6 *Specify*	

Staff Training				
126	How many days of technical training related your everyday work have you had <u>outside</u> the facility in the past 12 months? IF HE/SHE CAN'T REMEMBER EXACTLY, ASK THEM TO TELL YOU THE APPROXIMATE NUMBER.	Days of training ..... |___|___|___| Write 000 if you didn't receive any training outside the facility in the last 12 month; Write XXX if you don't know or don't remember		
127	How many days of technical training related to your everyday work have you had <u>within</u> facility in the past 12 months? IF HE/SHE CAN'T REMEMBER EXACTLY, ASK THEM TO TELL YOU THE APPROXIMATE NUMBER.	Days of training ..... |___|___|___| Write 0 if you didn't receive any training within the facility in the last 12 months; Write XXX if you don't know or don't remember		
		In-Service Training		
128	For each subject listed, please, circle 1 if you received in-service training in the past 12 months. If you have never received training in that field or you received it more than 12 months ago, circle 3.	In the last 12 months	More than 12 months ago or Never	

128a	IMCI	1	3	
128c	Tuberculosis	1	3	
128d	Malaria	1	3	
128e	FP Methods	1	3	
128f	Maternal and neonatal health	1	3	
128g	Universal precautions	1	3	
128h	Nutrition	1	3	
128k	Psychosocial services	1	3	
128i	Mental health	1	3	
128j	Common disabilities	1	3	
128m	Covid - 19	1	3	
129	Have you received training in an area that is not listed here?	Yes ..... 1 No 2		If "2" →200
130	If yes, please, describe them in the space provided.	a)_____ b)_____		

2A. HEALTH WORKER SATISFACTION

In this part of the questionnaire we would like to ask you some questions regarding your satisfaction with your current job. All answers are confidential and any identifying information will be removed. There are short 37 questions, plus 5 if your facility receives funds from the RBF project, which means it receives performance-based payments.

Please read carefully and circle one of the answers for each question, according to how you personally feel about the statement made. The answers range from 1, which you strongly disagree with the statement, to 4, which means you strongly agree with the statement. There is no right or wrong answer, so please, do not spend long time thinking about each question, simply try to circle the answer that best describes your feelings.

4 = "STRONGLY AGREE"

3 = "AGREE"

2 = "DISAGREE"

1 = "STRONGLY DISAGREE"

Example 1: The statement says, "I really like red color". So, if you like red color but it is not your favorite color, you will choose 3. It means you agree with the statement but not that strongly, since you like it but not that much.

Example 2: The statement says, "It is very difficult to plant flowers". If you find that planting flowers is very easy, you will choose 1, because you strongly disagree with the statement.

No.	HOW MUCH DO YOU AGREE WITH THE STATEMENT?	1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree
200	I know what is expected of me in this job	1	2	3	4
201	This job allows me to use all my skills	1	2	3	4
202	I understand my daily duties at this job	1	2	3	4
203	In this job management rarely interferes in my work	1	2	3	4
204	This job allows me to use my personal judgment in carrying out the work	1	2	3	4
205	There are unnecessary procedures in this job that take time away from my actual work	1	2	3	4
206	I am often asked to do things that are not my duties	1	2	3	4
207	I often have to work extra hours in this job	1	2	3	4
208	This job provides me with adequate opportunities to learn new skills	1	2	3	4
209	This job provides me with adequate opportunities to participate in training programs	1	2	3	4
210	I know how much I will get paid at the end of each month in this job	1	2	3	4
211	I have to work extra to have enough money for my family	1	2	3	4
212	The benefits we receive (such as housing, transportation allowance and others) are as good as most other jobs offer in Syria	1	2	3	4

213	I understand the types of benefits that I am supposed to receive in this job	1	2	3	4
214	There are few rewards for those who work here	1	2	3	4
215	There is really too little chance for promotion in this job	1	2	3	4
216	People get ahead as fast here as they do in other organizations	1	2	3	4
217	Those who do well on the job stand a fair chance of being promoted	1	2	3	4
218	In this job work assignments are not fully explained	1	2	3	4
219	I can get help from my supervisor when I need it	1	2	3	4
220	My supervisor never gives me any feedback about how well I am doing in my job	1	2	3	4
221	When I do a good job, I receive the recognition from my supervisor	1	2	3	4
222	I have good working relationships with my colleagues	1	2	3	4
223	I find I have to work harder at my job because of the incompetence of people I work with	1	2	3	4
224	I have all the necessary equipment and tools to do my job well	1	2	3	4
225	This facility provides adequate medicine to provide good quality of care	1	2	3	4
226	Physical condition of the building I work in is adequate	1	2	3	4
227	I worry a lot about my family's and my own security living in this community	1	2	3	4
228	There is adequate security in the facility to do my job properly	1	2	3	4
229	People in this facility/hospital do not have to worry often about getting fired	1	2	3	4
230	I can keep this job as long as I want	1	2	3	4
231	Staff in this facility have opportunities to participate in developing facility's budget	1	2	3	4

232	Staff in this facility have opportunities to express their opinions	1	2	3	4
233	The rules for salary payments are fair	1	2	3	4
234	My supervisor is unfair to me	1	2	3	4
235	I feel like I am rewarded fairly for the work I do	1	2	3	4
236	Overall, I am satisfied with this job	1	2	3	4

2B. HEALTH WORKER MOTIVATION

In this part of the questionnaire, we are asking you about WHY you work in this Health Facility. All answers are confidential and any identifying information will be removed. There are 21 questions.

Please read carefully and circle one of the answers for each question, according to how you personally feel about the statement made. The answers range from 1, which means you strongly disagree with the statement, to 4, which means you strongly agree with the statement. There is no right or wrong answer, so please, do not spend long time thinking about each question, simply try to circle the answer that best describes your feelings.

4 = "STRONGLY AGREE"

3 = "AGREE"

2 = "DISAGREE"

1 = "STRONGLY DISAGREE"

Example 1: The statement says, "I really like winter". So, if you like winter but it is not your favorite time of the year, you will choose 3. It means you agree with the statement but not that strongly, since you like it but not as much as maybe spring.

	HOW MUCH DO YOU AGREE WITH THE STATEMENT?	1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree
250	I work in this job because I have a chance to help other people through my work	1	2	3	4
251	I work in this facility because it plays an important role in the community	1	2	3	4
252	I work here because it makes me feel important	1	2	3	4
253	I only work here to get so that I can get paid	1	2	3	4
254	I frequently think of quitting this job	1	2	3	4
255	I feel I should personally take the credit or blame for the results of my work on this job	1	2	3	4
256	I do this job because my family would be disappointed if I quit	1	2	3	4

257	I work here because of opportunities for promotion	1	2	3	4
258	I sometimes feel my work here is meaningless	1	2	3	4
259	I work in this job because it allows me to decide how my work is organized	1	2	3	4
260	I work in this facility because it has sufficient resources I need to do my job (medicine, equipment, infrastructure)	1	2	3	4
261	I work in this job because it allows me to use my skills	1	2	3	4
262	I do this job because it gives me respect in the community	1	2	3	4
263	I work here because it is located in a safe area	1	2	3	4
264	I work here because of good benefits I receive (Note: all benefits – housing, transportation, anything else you receive – think overall)	1	2	3	4
265	I don't care much about the quality of work here	1	2	3	4
266	I work in this job because I can accomplish something worthwhile in this job	1	2	3	4
267	I work here because it provides long term security for me	1	2	3	4
268	I work here because I have no other choice	1	2	3	4
269	I feel a very high degree of personal responsibility for the work I do on this job	1	2	3	4
270	I work in this job to gain God's grace	1	2	3	4
271	Overall, I feel very motivated to do my job	1	2	3	4

INFORMANTS QUESTION GUIDE: HN-TPO AND CARE KEY

Questions:	Answers:
GQ1: What specific initiatives does HealthNet-TPO/CARE undertake to support maternal and neonatal health in	

Khost? What successes and challenges have you experienced in delivering these services?	
GQ2: How will you describe the role of MSF in providing maternal and neonatal healthcare in Khost province?	
GQ3: What are the current challenges – social, cultural, geographical, political - faced in providing maternal and neonatal services in Khost, and how can these be addressed?	
GQ4: How would you assess the availability and quality of maternal and neonatal services at the community level (FHHs, BHCs, CHCs)? How the maternal (especially birth delivery) services could be further improved at the FHHs, BHCs, and CHCs? And what would be the challenges in this regard?	
RQ1: How relevant is the MSF operation when considering the needs of the population in Khost and priorities for improving maternal and neonatal health?	
RQ2: What are the best practices of MSF's maternal and neonatal health project in Khost? Why?	
RQ3: How relevant is MSF's intervention in managing high-risk pregnancies and birth complications? Who else in the province is providing such services? And who else in Khost province have the potential to contribute or contribute further in managing high-risk pregnancies and birth complications?	
RQ4: Which areas of the MSF operation needs improvement? Which improvements are required?	
AQ1: How appropriate is the approach taken by MSF to reducing morbidity and mortality for women with pregnancy related complications? MSF's Maternity Hospital in Khost (with 60 bed capacity) is primarily designed to tackle high-risk pregnancies and obstetric complications, how this facility could balance between conducting normal deliveries and complicated deliveries? What do you think about the admission criteria that is currently in place for MSF Maternity Hospital in Khost?	
AQ2: From your perspective, how resiliency of the health system (FHHs, BHCs and CHCs) could be promoted and communities could be actively engaged? Who are the main stakeholders in this regard? How is MSF contributing towards promoting local health system resilience (FHHs, BHCs, and CHCs) and engaging communities? Who else can play a role in this regard?	

AQ3: How well are the healthcare facilities managed by HNTPO/CARE equipped to handle high-risk pregnancies and complications? How well they are staffed? And how well they are supplied?	
AQ4: What measures are currently in place for dealing with high-risk pregnancies at FHHs, BHCs, and CHCs managed by your organisation? How can these measures be improved?	
AQ5: What is the level of collaboration between you and MSF and other healthcare providers in the province? How can this collaboration be improved? How effective is the referral system for maternal and neonatal healthcare in Khost province?	
AQ6: What are your views on the involvement of the private sector in providing maternal and neonatal healthcare in the province? What is the role of the private sector in delivering maternal and neonatal services in Khost? What are the pros and cons of engaging with the private sector in healthcare delivery?	
EQ1: How can the MSF project become more effective in achieving its objectives of reducing morbidity and mortality for women with pregnancy related complications, and promoting resilience and sustainability of local health systems?	
EQ2: What community engagement approaches are being adopted in Khost (by all stakeholders) to promote maternal and neonatal services at the community level? What has been MSF's contribution in this regard?	
EQ3: To what extent are communities involved in promoting these services? Who (which stakeholder) can play a critical role in this regard?	
EQ4: What lessons have been learned and what challenges have been faced in community engagement?	
ImQ1: What has been the positive impact of MSF's maternal health intervention in Khost, and how can it improve its potential for impact?	
ImQ2: Have there been unintended or negative consequences of MSF's intervention, and how can MSF improve mitigation?	
EfQ1: To what extent the required services for reducing morbidity and mortality for women with pregnancy related complications were available on time and in the right quantities and quality for all those who need such services?	

SQ1: How can MSF improve the sustainability of its intervention by ensuring net benefits are preserved in the long-term?	
SQ1: Are the benefits likely to be maintained for an extended period after the project ends?	
Is there anything else you would like to add about delivery of maternal and neonatal healthcare services in Khost province? What are your key recommendations for improving these services?	

KEY INFORMANTS QUESTION GUIDE: PROVINCIAL PUBLIC HEALTH DIRECTORATE

Questions:	Answers:
GQ1: What specific initiatives does NGOs undertake to support maternal and neonatal health in Khost?	
GQ2: How will you describe the role of MSF in providing maternal and neonatal healthcare in Khost province?	
GQ3: What are the current challenges – social, cultural, geographical, political - faced in providing maternal and neonatal services in Khost, and how can these be addressed?	
GQ4: How would you assess the availability and quality of maternal and neonatal services at the community level (FHHs, BHCs, CHCs)? How the maternal (especially birth delivery) services could be further improved at the FHHs, BHCs, and CHCs? And what would be the challenges in this regard?	
RQ1: How relevant is the MSF operation when considering the needs of the population in Khost and priorities for improving maternal and neonatal health?	
RQ2: What are the best practices of MSF's maternal and neonatal health project in Khost? Why?	
RQ3: How relevant is MSF's intervention in managing high-risk pregnancies and birth complications? Who else in the province is providing such services? And who else in Khost province have the potential to contribute or contribute further in managing high-risk pregnancies and birth complications?	
RQ4: Which areas of the project needs improvement? Which improvements are required?	

AQ1: How appropriate is the approach taken by MSF to reducing morbidity and mortality for women with pregnancy related complications? MSF's Maternity Hospital in Khost (with 60 bed capacity) is primarily designed to tackle high-risk pregnancies and obstetric complications, how this facility could balance between conducting normal deliveries and complicated deliveries? What do you think about the admission criteria that is currently in place for MSF Maternity Hospital in Khost?	
AQ2: From your perspective, how resiliency of the health system could be promoted, and communities could be actively engaged? Who are the main stakeholders in this regard? How is MSF contributing towards promoting local health system resilience and engaging communities? Who else can play a role in this regard?	
AQ3: How well are the healthcare facilities in Khost equipped to handle high-risk pregnancies and complications? And, how well they are staffed?	
AQ4: What is the level of collaboration between MSF and other healthcare providers in the province? How can this collaboration be improved? How effective is the referral system for maternal and neonatal healthcare in Khost province?	
AQ5: What are your views on the involvement of the private sector in providing maternal and neonatal healthcare in the province?	
EQ1: How can the MSF project become more effective in achieving its objectives of reducing morbidity and mortality for women with pregnancy related complications, and promoting resilience and sustainability of local health systems?	
EQ2: What community engagement approaches are being adopted in Khost (by all stakeholders) to promote maternal and neonatal services	
at the community level? What has been MSF's contribution in this regard?	
EQ3: To what extent are communities involved in promoting these services? Who (which stakeholder) can play a critical role in this regard?	
EQ4: What lessons have been learned and what challenges have been faced in community engagement?	
ImQ1: What has been the positive impact of MSF's maternal health intervention in Khost, and how can it improve its potential for impact?	
ImQ2: Have there been unintended or negative consequences of MSF's intervention, and how can MSF improve mitigation?	

EfQ1: To what extent the required services for reducing morbidity and mortality for women with pregnancy related complications were available on time and in the right quantities and quality for all those who need such services?	
SQ1: How can MSF improve the sustainability of its intervention by ensuring net benefits are preserved in the long-term?	
SQ1: Are the benefits likely to be maintained for an extended period after the project ends?	
Is there anything else you would like to add about delivery of maternal and neonatal healthcare services in Khost province? What are your key recommendations for improving these services?	

KEY INFORMANTS QUESTION GUIDE: KHOST TEACHING HOSPITAL

Questions:	Answers:
GQ1: What specific initiatives does the Teaching Hospital undertake to support maternal and neonatal health in Khost? What is your current capacity for delivering maternal services? What successes and challenges have you experienced in delivering these services?	
GQ2: How will you describe the role of MSF in providing maternal and neonatal healthcare in Khost province?	
GQ3: What are the current challenges – social, cultural, geographical, political - faced in providing maternal and neonatal services in Khost, and how can these be addressed?	
GQ4: How would you assess the availability and quality of maternal and neonatal services at your hospital? How the maternal (especially birth delivery) services could be further improved at your hospital? And what would be the challenges in this regard? RQ1: How relevant is the MSF operation when considering the needs of the population in Khost and priorities for improving maternal and neonatal health?	
RQ2: What are the best practices of MSF's maternal and neonatal health project in Khost? Why?	
RQ3: How relevant is MSF's intervention in managing high-risk pregnancies and birth complications? Who else in the province is providing such services? And who else in Khost province have the potential to contribute or contribute further in managing high-risk pregnancies and birth complications?	
RQ4: Which areas of the MSF operation needs improvement? Which improvements are required?	
AQ1: How appropriate is the approach taken by MSF to reducing morbidity and mortality for women with pregnancy related complications? MSF's Maternity Hospital in Khost (with 60 bed capacity) is primarily designed to tackle high-risk pregnancies and obstetric complications, how this facility could balance between conducting normal deliveries and complicated deliveries? What do you think about the admission criteria that is currently in place for MSF Maternity Hospital in Khost?	

AQ2: From your perspective, how the maternal and neonatal services in your hospital could be further improved to contribute towards improving maternal and neonatal health in Khost? Who are the main stakeholders in this regard? Who else can play a role in this regard?	
AQ3: How well is your hospital equipped to handle high-risk pregnancies and complications? How well they are staffed? And how well they are supplied?	
AQ4: What measures are currently in place for dealing with high-risk pregnancies at your hospital? How can these measures be improved?	
AQ5: What is the level of collaboration between you and MSF and other healthcare providers in the province? How can this collaboration be improved? How effective is the referral system for maternal and neonatal healthcare in Khost province?	
AQ6: What are your views on the involvement of the private sector in providing maternal and neonatal healthcare in the province? What is the role of the private sector in delivering	
maternal and neonatal services in Khost? What are the pros and cons of engaging with the private sector in healthcare delivery?	
EQ1: How can the MSF project become more effective in achieving its objectives of reducing morbidity and mortality for women with pregnancy related complications, and promoting resilience and sustainability of local health systems?	
ImQ1: What has been the positive impact of MSF's maternal health intervention in Khost, and how can it improve its potential for impact?	
ImQ2: Have there been unintended or negative consequences of MSF's intervention, and how can MSF improve mitigation?	
EfQ1: To what extent the required services for reducing morbidity and mortality for women with pregnancy related complications were available on time and in the right quantities and quality for all those who need such services?	
SQ1: How can MSF improve the sustainability of its intervention by ensuring net benefits are preserved in the long-term?	
SQ1: Are the benefits likely to be maintained for an extended period after the project ends?	

Is there anything else you would like to add about delivery of maternal and neonatal healthcare services in Khost province? What are your key recommendations for improving these services?	

PRIVATE HEALTH WORKER INTERVIEW QUESTIONNAIRE

	Yes	No
Consent obtained:	1	2

GENERAL HEALTH WORKER INFORMATION			SKIP
101	A. Interviewer code |___|___|___|___|	B. Date:	
102	A. Facility name: _____		
103	Location	A. Province _____ B. District _____ C. Community _____	
104	Type of health facility	Private Hospital..... 1 Private Clinic..... 2 Private House..... 3 OTHERS .....4 (SPECIFY) _ ____	
106	What is your qualification	Doctor (general practitioner) ..... 1 Doctor (specialist) ..... 2 Midwife ..... 3 Community Midwife ..... 4 Nurse Technician ..... 5 Other ..... 6 *Specify* _____	
107	How many year(s) and month(s) have you worked at this facility?	Years |___|___| Months|___|___|	
113	Number of health workers in this facility	Doctor (general practitioner) ..... [ ] Doctor (specialist) ..... [ ] Midwife ..... [ ] Community Midwife ..... [ ] Nurse Technician ..... [ ] Other ..... [ ] *Specify*	

Staff Training

126	How many days of technical training related your everyday work have you had outside the facility in the past 12 months? IF HE/SHE CAN'T REMEMBER EXACTLY, ASK THEM TO TELL YOU THE APPROXIMATE NUMBER.	Days of training ..... |___|___|___| Write 000 if you didn't receive any training outside the facility in the last 12 month Write XXX if you don't know or don't remember		
127	How many days of technical training related to your everyday work have you had within facility in the past 12 months? IF HE/SHE CAN'T REMEMBER EXACTLY, ASK THEM TO TELL YOU THE APPROXIMATE NUMBER.	Days of training ..... |___|___|___| Write 000 if you didn't receive any training outside the facility in the last 12 month Write XXX if you don't know or don't remember		
		In-Service Training		
128	For each subject listed, please, circle 1 if you received in-service training in the past 12 months. If you have never receiving training in that field or you received it more than 12 months ago, circle 3.	In the last 12 months	More than 12 months ago or Never	
128a	Postpartum hemorrhage management	1	3	
128c	Pre-eclampsia/eclampsia treatment	1	3	
128d	Newborn resuscitation	1	3	
128e	Handling postpartum infections	1	3	

128f	Basic Emergency Obstetric and Newborn Care (BEmONC)	1	3	
128g	Use of Partograph	1	3	
128h	Assisted birth delivery and managing complications	1	3	
128k	Psychosocial services	1	3	
128i	Nutrition	1	3	
128j	FP Methods	1	3	
128m	IMCI	1	3	
129	Have you received training in an area that is not listed here?	Yes ..... 1 No 2		If "2" ➔200
130	If yes, please, describe them in the space provided.	a)_____ b)_____		

Daily Activities			
131	How many hours do you work in a day?	Hours ..... |___|___|___|	
132	Do you have night duties?	Yes..... 1 No 2	
133	If Yes how many nights in a week?	Nights ..... |___|___|___|	If "No" ➔134
133A	If Yes for night duties, do you feel safe during the night duties in the health facility?	Yes..... 1 No 2	
133B	If Yes for night duties, do you have comfortable place to stay during the night duties in the health facility?	Yes..... 1 No 2	
133C	If Yes for night duties, do you have any family or social pressure for night duties?	Yes..... 1 No 2	
134	Do you have all required equipment and tools for doing your job?	Yes..... 1 No 2	If "Yes" ➔135

134A	If no, please explain what have been missing		
135	Do you have all required medicine and pharmaceuticals available in the health facility for doing your job?	Yes..... 1 No 2	If "Yes" ➔136
135A	If no, please explain what have been missing		
136	Do you use Partograph for all birth deliveries you attend?	Yes..... 1 No 2	
136A	If Yes, could you please show those you have used in last month.		
136B	If No, could you please provide the reasons		
137: How would you rate quality of maternal and neonatal healthcare services provided at your facility?			
138	Are you aware of the MSF's admission criteria and referral requirements?	Yes..... 1 No 2	
138A	If yes, could you please explain or show the criteria		

Other Questions:

1. Could you please explain how did you start this private practice?

1. What specific services do you offer to expectant and new mothers? [List all the mentioned services]

2. Who are most of your patients and where they are coming from, and why?

3. What protocols do you have in place for handling emergencies during labor and delivery?

4. How do you ensure the safety and well-being of both mother and baby during your care?

5. Can you provide examples of how you have handled challenging situations in the past?

6. Where do you refer your complicated cases? Could you please explain the referral mechanism?

7. Have you heard of the MSF maternity hospital? If so, what is the contribution of this hospital in Khost province?

8. How many private maternity hospitals, clinics, and homes are active here in Khost?

9. Why people prefer to have birth deliveries in private maternity homes? [List the reasons with details]

10. What are your fees, and what is included in your service packages? [List the fee structure)

Thank you very much for taking the time to complete this

KEY INFORMANTS QUESTION GUIDE: COMMUNITY HEALTH WORKERS (CHWS)

Questions:	Answers:
GQ1: What specific you undertake to support maternal and neonatal health in your community? What successes and challenges have you experienced in delivering these services?	
GQ2: What are the current challenges – social, cultural, geographical, political - faced by women to receive maternal and neonatal services in your community, and how can these be addressed?	
GQ: How would you assess the availability and quality of maternal and neonatal services in your community? How the maternal (especially birth delivery) services could be further improved in your community? And what would be the challenges in this regard?	
SpQ1: How would you describe the quality of maternal healthcare services provided by the health facilities in your community? [ask for the name of the name of the health facility]	
SpQ2: From what you know, to which extent birth deliveries are taking place at home and why? To which extent the birth deliveries are taking place in the nearest health facility? And to which extent pregnant women are taken to other health facilities far from your community, and why?	
SpQ3: Are there specific maternal healthcare services that are lacking or need improvement in the health facility serving your community? If so, what are the main challenges in delivering maternal healthcare at this health facility [specify the health facility (BHC or CHC) serving the CHW's community]	
SpQ4: What measures or resources do you think could help improve maternal healthcare services in the nearest health facility? [if not mentioned probe for skilled healthcare workers, medicine, opening hours, privacy, and others]	
SpQ5: What information and services do you provide during home visits regarding birth preparedness? And how do you do this?	
SpQ6: How do you ensure that pregnant women and their families are prepared for safe childbirth?	
SpQ7: What is the first preference for maternal healthcare services in your community (e.g., CHC, BHC, private clinics)? Why do community members prefer these services?	

SpQ9: Who (in the household) usually makes the decision about where a woman will give birth?	
SpQ10: What role do you play in influencing this decision?	
SpQ11: What are the main barriers that pregnant women face in accessing maternal healthcare services? [probe for barriers at the household level, community level, and health facility level]	
SpQ12: Can you describe any delays that occur in decision-making at the household level, reaching healthcare facilities, and receiving services? What do you think are the reasons for these delays?	

Thank you very much for taking the time to speak with me today. Your insights and experiences are incredibly valuable to our project. Your feedback is crucial in helping us understand the current state of maternal and neonatal healthcare services in Khost province.

KEY INFORMANTS QUESTION GUIDE: COMMUNITY LEADERS AND SHURA MEMBERS

Questions:	Answers:
GQ1: What specific you undertake to support maternal and neonatal health in your community? What successes and challenges have you experienced in delivering these services?	
GQ2: What are the current challenges – social, cultural, geographical, political - faced by women to receive maternal and neonatal services in your community, and how can these be addressed?	
GQ4: How would you assess the availability and quality of maternal and neonatal services in your community? How the maternal (especially birth delivery) services could be further improved in your community? And what would be the challenges in this regard?	
SpQ1: How would you describe the quality of maternal healthcare services provided by the health facilities in your community? [ask for the name of the name of the health facility]	
SpQ2: From what you know, to which extent birth deliveries are taking place at home and why? To which extent the birth deliveries are taking place in the nearest health facility? And to which extent pregnant women are taken to other health facilities far from your community, and why?	

SpQ3: Are there specific maternal healthcare services that are lacking or need improvement in the health facility serving your community? If so, what are the main challenges in delivering maternal healthcare at this health facility [specify the health facility (BHC or CHC) serving the CHW's community]	
SpQ4: What measures or resources do you think could help improve maternal healthcare services in the nearest health facility? [if not mentioned probe for skilled healthcare workers, medicine, opening hours, privacy, and others]	
SpQ5: What is the first preference for maternal healthcare services in your community (e.g., CHC, BHC, private clinics)? Why do community members prefer these services?	
SpQ6: Who (in the household) usually makes the decision about where a woman will give birth? How do community leaders and Shura members can influence this decision?	
SpQ7: What role do you see for yourself and other community leaders in enhancing maternal healthcare service delivery in the health facility serving your community?	
SpQ8: What are the main barriers that pregnant women face in accessing maternal healthcare services? [probe for barriers at the household level, community level, and health facility level]	
SpQ9: Can you describe any delays that occur in decision-making at the household level, reaching healthcare facilities, and receiving services? What do you think are the reasons for these delays?	
SpQ10: How can you help to address the barriers and challenges faced by pregnant women in accessing healthcare services?	

Thank you very much for taking the time to speak with me today. Your insights and experiences are incredibly valuable to our project. Your feedback is crucial in helping us understand the current state of maternal and neonatal healthcare services in Khost province.

HEALTH FACILITY ASSESSMENT QUESTIONNAIRE

Time surveying starts: |___|___|hours:|___|___| minutes

1. GENERAL INFORMATION Identification and location of the facility

101	A. Interviewer code |___|___|___|___|	B. Date: |___|___| |___|___|
102	A. Facility name: _____	B. Facility ID code: |___|___|___|___|
103	Location	A. Province: _____ B. District: _____ C. Community: _____
108	Service levels available	Outpatient only ..... 1 Inpatient only ..... 2 Both out and inpatient 3
109	Health facility capacity (number of beds)	A. Not Applicable (if CHC) go to Q201 B. Obstetrics/Maternity and Gynecology: ___ C. Internal Medicine (Male): _____ D. Internal Medicine (Female): _____ E. Surgery (Male): _____ F. Surgery (Female): _____ G. Pediatric: _____ H. ICU: _____ I. Others: _____ H. TOTAL BEDS:
110	How much time does it usually take to travel by car from Khost center to this health facility during the summer season? (One way)	|___|___| hours |___|___| minutes

2. DESCRIPTION OF THE FACILITY		OUTPATIENT ONLY	INPATIENT ONLY	BOTH OUT- AND INPATIENT	NO SERVICE
201	Is there heating facility for patients during winter?	1	2	3	4
202	Is there cooling facility for patient during summers?	1	2	3	4
203	How reliable is the facility's electricity supply?	Electricity available 24 hours per day .....1 Electricity available most of the day .....2 Electricity available few hours per day .....3 No electricity/generator.....4			
204	How reliable is the facility's main water source?	Water available 24 hours per day .....1 Water available most of the day .....2 Water available few hours per day 3			
NOTE: For this section walk around the health facility and LOOK FOR YOURSELF, recording your observations.					

Repairs		Few or no repairs needed	Many repairs needed	Not present
205	Windows	1	2	3
206	Doors	1	2	3
207	Facility interior walls	1	2	3
208	Facility exterior walls	1	2	3
209	Roof condition	1	2	3
210	Grounds, fence/wall	1	2	3
211	Facility flooring	1	2	3
Cleanliness		Satisfactory	Not satisfactory	Not present
212	Toilets for staff	1	2	3
213	Toilets for patients	1	2	3
214	Total Number of Toilets	For Staff	For Patient	
		Male [ ], Female [ ]	Male [ ], Female [ ]	
Privacy		Yes	No	Observations
215	Separate waiting areas for male and female			
216	Privacy measures in place in reproductive health services area (including ANC, Delivery room, and PNC)			

PERSONNEL AT THE FACILITY		Number who have been working in the facility during past month	
		Male	Female
	Outreach Workers		
215	Community Health Supervisor		
216	Community Health Workers		
	Health Providers		
217	Nurses (male)		
218	Nurses (female)		
219	Midwife		

220	Doctors (general practitioners) male		
221	Doctors (general practitioners) female		
222	Obstetricians and Gynecologist		
223	Assistant Physician/Mid-level Health Worker		
224	Pharmacy technician		
225	Lab technologist/ technician		
226	Health facility management staff		
227	Support staff		
228	Other Health Worker (specify and insert numbers)		

	MEDICAL WASTE MANAGEMENT	
229	How does this facility finally dispose of medical waste (including sharp and infectious medical wastes)?	BURN INCINERATOR: Chamber industrial (800–1000+ °c) .....1 Chamber drum/brick ..... 2 OPEN BURNING: Flat ground – no protection ..... 3 Pit or protected ground ..... 4 DUMP WITHOUT BURNING: Flat ground – no protection ..... 5 Covered pit or pit latrine ..... 6 Open-pit – no protection ..... 7 Protected ground or pit ..... 8 REMOVE OFFSITE: Stored in covered container ..... 9 Stored in other protected environment .... 10 Stored unprotected ..... 11 OTHER ..... 96 (SPECIFY) _____
230	Is the incinerator functional today?	YES..... 1 NO 2

		DON'T KNOW 88
:231	Does this facility have any guidelines on health care waste management? IF YES, ASK: May I see the guidelines?	YES, observed ..... 1 YES, reported, not seen..... 2 NO 3

	REPROCESSING OF REUSABLE MEDICAL EQUIPMENT						
231	Now I would like to know about items for sterilizing or high-level disinfecting (HLD) equipment. For each item listed below ask if it is available and if the item is functioning today.	AVAILABLE			FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
231A	Electric autoclave (pressure and wet heat)	1	2	3	1	2	88
231B	Electric dry heat sterilizes	1	2	3	1	2	88
231C	Non-electric autoclave (pressure and wet heat)	1	2	3	1	2	88
231D	Heat source for non-electric equipment	1	2	3	1	2	88

	PRECAUTIONS FOR INFECTION PREVENTION AND CONTROL			
	Ask and observe* if the following measures used for infection control are available in the areas of this hospital today. *Briefly walk around the main service areas of the hospital for adults and children (if there are multiple sites, indicate the worst situation observed)			
232	Indicate if the followings were reported and observed.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
232A	Floor: swept; no obvious dirt or waste	1	2	3
232B	Counters/tables/chairs: wiped clean; no obvious dust or waste	1	2	3
232C	Needles, sharps outside sharps box	1	2	3
232D	Staff were wearing appropriate uniforms	1	2	3

232E	Staff were wearing id badges	1	2	3
232F	Waste receptacle bin with lid and plastic bin liner clearly marked, for example, by label or color, for infectious non-sharp waste	1	2	3
232G	Does the waste receptacle for infectious non-sharp waste have a functional foot pedal to open it?	1	2	3
232H	Sharps container (“safety box”)	1	2	3
232I	Sharps box overflowing or torn/pierced	1	2	3
232J	Bandages/infectious waste lying uncovered	1	2	3

MEDICAL EQUIPMENT AND FURNITURE Check to see whether any essential medical equipment and/or furniture that is needed to deliver health care services is not currently available in each of the departments. ASK RESPONSIBLE PERSON IN EACH OF THE DEPARTMENT				
233	Is there any essential medical equipment that you need to deliver health care services and not currently available at?	NOT PRESENT	PRESENT, NOT WORKING	Specify those not present or not working
233A	OPD Departments	1	2	
233B	ANC Room	1	2	
233C	Delivery Room	1	2	
233D	In-patient unit (CHC plus only)	1	2	
233E	Surgical Ward (Male)	1	2	
233F	Obstetrics and Gynecology Ward	1	2	
233G	ICU	1	2	
233H	Operation Theater	1	2	
233I	Laboratory	1	2	
233J	Imaging (Radiology) Department	1	2	
233K	Others, please specify	1	2	
233L		1	2	
233M				

	MCH Equipment	PRESENT AND WORKING	NOT PRESENT, NOT WORKING, OR NOT COMPLETE	Remarks for those not present, not working
234	Clean delivery kit	1	2	
235	Tape measure for ANC	1	2	
236	Lamp	1	2	
237	Neonatal resuscitation Trolley	1	2	
238	Specula	1	2	
239	Basic emergency obstetric care kit	1	2	
240	Hysterectomy set	1	2	
241	MVA (Manual Vacuum Aspiration) set	1	2	
242	Resuscitation Trolley	1	2	
243	Ambubag for infant, child, and adult	1	2	
244	Laparotomy set	1	2	
245	Scissor	1	2	
246	One umbilical cord clamp or sterile tape or sterile tie	1	2	
247	Suturing material	1	2	
248	Clean razor blade	1	2	
249	Examination gloves	1	2	
250	Sterile cotton or gauze (to clean baby's mouth and nose	1	2	
251	Hand soap or detergent	1	2	
252	Hand scrubbing brush	1	2	
253	Sterile tray	1	2	
254	Plastic container with a plastic liner for to dispose the placenta	1	2	
255	Plastic container with a plastic liner for medical waste (gauze, etc)	1	2	

256	Stethoscope, adult	1	2	
257	Stethoscope, Pinard fetal	1	2	
258	Sphygmomanometer	1	2	
259	Kidney basin	1	2	
260	Steel bowl	1	2	
261	Protective apron and plastic draw sheet	1	2	
262	Tourniquet	1	2	
263	Two sterile towels (one to receive the baby, one for active management)	1	2	
264	Baby scale (infant weighing scale)	1	2	
265	Artery Forceps	1	2	
266	Forceps, dressing	1	2	
267	Forceps, uterine	1	2	
268	Needle holder	1	2	
269	Syringes and disposable needles	1	2	
270	16-or 18-gauge needles	1	2	
271	Speculum, vaginal	1	2	
272	Clamps (hemostats)	1	2	
273	Suction pump, hand or foot operated	1	2	
274	Vacuum extractor	1	2	
275	Uterine dilator Uterine dilator	1	2	
276	Curette, uterine	1	2	
277	Vaginal retractor	1	2	
278	Ambu bag	1	2	
279	Guerdal airways Guedel airways – neonatal, child and adult	1	2	

3. DELIVERED SERVICES					
Which of the services are provided at this health facility?		OUTPATIENT ONLY	INPATIENT ONLY	BOTH IN- AND OUTPATIENT	NOT OFFERED
301	Normal birth deliveries	1	2	3	4

302	Assisted birth deliveries	1	2	3	4
303	Direct Obstetric Complication management	1	2	3	4
304	Post-partum hemorrhage	1	2	3	4
305	Antenatal Care	1	2	3	4
306	Post-natal care	1	2	3	4
307	Neonatal resuscitation	1	2	3	4
308	Others (Specify)				

	Please mark the services provided by the hospital	YES			NO SERVICE
		OUTPATIENT ONLY	INPATIENT ONLY	BOTH OUT- AND INPATIENT	
	OBSTETRIC/GYNAECOLOGIC PROCEDURES				
309	Dilatation and curettage (D&C) or vacuum aspiration for evacuation of uterus	1	2	3	4
310	Episiotomy, cervical and vaginal laceration repair	1	2	3	4
311	Obstetric fistula repair	1	2	3	4
312	Caesarean section	1	2	3	4
313	Any abortion services	1	2	3	4
314	Under what conditions are abortion services provided?	MEDICAL EMERGENCY ONLY..... 1 BOTH MEDICAL EMERGENCY AND ELECTIVE AS ALLOWED BY LAW 2			

	DELIVERY AND NEWBORN CARE SERVICES	
314A	Does this facility offer any delivery and newborn care services?	YES.....1 NO 2

	Ask to be shown the location in the facility where delivery and newborn care services are provided. find the person most knowledgeable about delivery and newborn care services in the facility. introduce yourself, explain the survey and ask the following questions. I am interested in learning about the delivery services available in this facility. First, I will be asking about practices and staffing and then I would like to go into the delivery room to assess equipment and supplies.	
315	Are delivery and newborn care services offered in the outpatient or inpatient service area?	Outpatient .....1 Inpatient.....2 Both out- and inpatient areas.....3
316	Does the facility provide 24-hour coverage for birth delivery services?	YES.....1 NO 2
317	Is a skilled birth delivery service provider present at the facility or on-call in near proximity 24 hours a day, including weekends, to provide delivery care?	YES, 24 hours onsite .....1 YES, not 24 hours onsite, but 24 hours on-call .....2 No skilled provider available 24 hours 3

ROUTINE DELIVERY AND IMMEDIATE POSTNATAL NEWBORN CARE PRACTICES			
	Please tell me if any of the following are routinely practiced for deliveries in this facility:	YES	NO
318	Active management of third-stage labour (AMTSL), including oxytocin within 1 minute after delivery, controlled cord traction and fundal massage after delivery of placenta	1	2
319	Administration of oxytocin immediately after birth to all women for the prevention of postpartum hemorrhage	1	2
320	Monitor and manage labor using a partograph	1	2
	Now I want to know about routine practices in this facility for newborn care immediately postpartum. For each practice I mention, please tell me If this is a routine practice that is expected to be implemented for all newborns in this facility.	YES	NO
321	Hygienic cord care: cut with sterile item; and apply disinfectant	1	2
322	Thermal protection (drying baby immediately after birth and wrapping)	1	2

323	Immediate skin to skin contact	1	2
324	Immediately (within 1 hour) putting the newborn to the breast	1	2
325	Rooming in (i.e., the newborn stays with the mother)	1	2
326	Delayed cord clamping	1	2
327	Have you or any provider(s) of delivery service received any training that addressed any essential newborn care at birth in the past 2 years?	YES..... 1 NO 2	

MANAGEMENT OF COMPLICATED DELIVERIES				
	Please tell me if any of the following interventions for the management of complications, during and after pregnancy and childbirth, have been carried out in the past 12 months by providers of delivery services as part of their work in this facility: IF NOT WITHIN THE PAST 12 MONTHS, ASK: Is this because the service is not offered or because there were not cases requiring the service?	YES	NO	
			SERVICE NOT OFFERED	TRAINED STAFF BUT NO CASES
328	Parenteral administration of antibiotics (IV or IM) for mothers	1	2	5
329	Parenteral administration of oxytocic for treatment of postpartum hemorrhage (IV or IM)	1	2	5
330	Parenteral administration of magnesium sulfate for management of preeclampsia and eclampsia (IV or IM)	1	2	5
331	Assisted vaginal delivery using manual vacuum extraction (MVE) or forceps	1	2	5
332	Manual removal of placenta	1	2	5
333	Removal of retained products of conception using D&C or manual vacuum aspiration	1	2	5
334	Neonatal resuscitation with bag and mask	1	2	5
335	Caesarean section	1	2	5
336	Blood transfusion	1	2	5

337	Does this facility administer antibiotics for preterm PROM (premature rupture of membranes) to prevent infection?	YES..... 1 NO 2
338	Have you or any provider(s) of delivery service received any training related to the use of antibiotics for preterm PROM in the past 2 years?	YES..... 1 NO 2
339	Does this facility administer corticosteroids for preterm labour to the mother to prevent respiratory complications in the newborn?	YES..... 1 NO 2
340	Have you or any provider(s) of delivery service received any training related to the use of corticosteroids for preterm labour in the past 2 years?	YES..... 1 NO 2
341	How long do women who have uncomplicated delivery in this facility most commonly remain prior to being sent home?	LESS THAN 24 ..... 1 24–48 HOURS ..... 2 2 OR MORE FULL DAYS ..... 3 WIDE VARIATION 4
342	Are maternal death reviews conducted routinely for women who die in this facility within 6 weeks of giving birth? By routine, I mean there are defined criteria for when a maternal death review will be carried out and a defined process for conducting the review.	YES, ROUTINELY ..... 1 YES,TIMES..... 2 NO ..... 3 NEVER HAD A MATERNAL DEATH 4
343	Are perinatal death reviews conducted routinely for stillbirths and livebirths who die within 7 days of birth? By routine, I mean there are defined criteria for when a perinatal death review will be carried out and a defined process for conducting the review.	YES, ROUTINELY..... 1 YES, SOMETIMES ..... 2 NO 3

IMAGING AND SPECIALTY TREATMENT SERVICES		
Now I would like to know about specific diagnostic and treatment services that may be available for patients in this facility. PROVIDE EXAMPLES OF THE TYPES OF DIAGNOSTIC AND TREATMENT PROCEDURES YOU ARE INTERESTED IN FROM THE LIST BELOW AND FIND THE MOST KNOWLEDGEABLE PERSON FOR THESE PROCEDURES. THERE MAY BE MULTIPLE RESPONDENTS AND THE PROCEDURES MAY TAKE PLACE IN MULTIPLE SETTINGS. THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM THE CURRENT LOCATION.		
No.	Question	Result

	For each item I mention please tell me if the procedure or treatment is offered in this facility. If yes, please tell me if the equipment needed for the procedure is available and functioning today, whether staff trained to carry out the procedures are available either full or part time, and, where applicable, if results are interpreted onsite or sent offsite for interpretation.	IS THIS PROCEDURE OFFERED?		EQUIPMENT		TRAINED STAFF FOR CONDUCTING PROCEDURE/ THERAPY			RESULTS INTERPRETED	
		YES	NO	Equipment available and functioning today	Equipment not available Or not functioning today	Yes, onsite full time	Yes, onsite part time	Not available	Onsite	Offsite
344	Electrocardiogram (ECG)	1	2	1	2	1	2	3	1	2
345	Ultrasound	1	2	1	2	1	2	3	1	2
346	Does this facility perform any imaging procedures?	YES.....1 NO 2								

6. ESSENTIAL DRUGS								
Review the stock control card or drug registry for each of the drugs listed. Check to see whether each drug has been continuously available for the past 30 days. Then select three boxes or bottles of each drug and check the expiration date. Do not let facility staff pick out drugs for you. Pick them out yourself randomly.			(a) Has the item been <u>continuously</u> available for the past 30 days? If 1 ➔ "c"		(c) Are expired items present?			
			Yes	No	Yes	No, drug stocks are current	No expiry date visible	Drug is not present
601	Chlorpheniramine Maleate	injection 10 mg/ml in 1ml ampoule	1	2	1	2	3	4

	(Chlorphenamine)							
602	Erythromycin(Ethyl succinate)	Suspension 100 mg per ml 100 ml bottles	1	2	1	2	3	4
603	Doxycycline	capsule/tablet 100 mg (hydrochloride)	1	2	1	2	3	4
604	Gentamicin	injection 10 mg (as sulfate)/ml in 2-ml vial	1	2	1	2	3	4
605	Ciprofloxacin	Tablet 250 mg	1	2	1	2	3	4
606	Ethambutol	Tablet 400 mg	1	2	1	2	3	4
607	Metronidazole	injection 500 mg in 100	1	2	1	2	3	4
608	Adrenaline	injection 1 mg (as hydrochloride or hydrogen tartrate) in	1	2	1	2	3	4
		1ml ampoule						
609	Atropine	Injection 1mg per ml .	1	2	1	2	3	4
610	Atenolol	Tablet 50 mg	1	2	1	2	3	4
611	Methyl Dopa	Tablet 250 mg	1	2	1	2	3	4
612	Acetyl salicylic acid (Acetylsalicylic Acid)	Tablet 100 mg	1	2	1	2	3	4
613	Gentian Violet (Methyl Rosanilinium Chloride)	aqueous solution 0.5% (or crystals) OR aqueous solution 1% (or crystals)	1	2	1	2	3	4
614	Nystatin	ointment 100,000 IU, vaginal	1	2	1	2	3	4
615	Chlorine releasing comp.	Powder for solution	1	2	1	2	3	4
616	Hydrocortisone	powder for injection 100 mg (as sodium succinate) in vial	1	2	1	2	3	4
617	Anti Tetanus Serum(ATS)	Injection 1500 IU ampoule	1	2	1	2	3	4

618	Ergometrine	injection 200 microgram (hydrogen maleate)	1	2	1	2	3	4
619	Oxytocin	injection 10 IU in 1-ml ampoule	1	2	1	2	3	4
620	Chlorpromazine	injection 25 mg (hydrochloride)/ml in 2ml ampoule	1	2	1	2	3	4
621	Fluoxetine	Tablet 20 mg	1	2	1	2	3	4
622	Salbutamol	inhalation (aerosol) 100 microgram (as sulfate) per dose	1	2	1	2	3	4
623	Glucose	injectable solution 10% isotonic 5% isotonic	1	2	1	2	3	4
624	Zinc	Zinc Dispersible Tablet 20mg strip of ten	1	2	1	2	3	4
625	Emergency Contraceptives (Levonorgestrel	Oral ingestion tablet, 1 tablet or 2 tablet per pack	1	2	1	2	3	4
626	Dexamethasone	Eye drop	1	2	1	2	3	4
627	Chlorhexidine (CHX) 7.1% gel	7.1% gel	1	2	1	2	3	4
628	Is there any essential medicine that you need to have at this facility and not currently available?		YES				NO	
			1				2	
621	If “Yes” to Q 607l ask. Can you please name these essential medicine?							

FOCUS GROUP DISCUSSION GUIDELINE

FGD Facilitator Checklist (completed before starting FGD)	
Particulars	Yes/No
Greet the participants and thank them for taking the time to attend the discussion.	
Introduce yourself and your role	
Explain the purpose of the discussion: "We would like to ask few questions regarding your experience and perspective about maternal and neonatal health and healthcare in your community. The information you share with us today will be used to identify measures for improving maternal and neonatal health in Khost".	
Provide overview of ground rules: "Respect other participants' opinions. You have been asked to participate in the discussion voluntarily, so remember that you are not obliged to answer all our questions and you can leave the discussion whenever you like. We will not record your names anywhere. Identifiable or personal information will not be disclosed with any external parties. We also would like you to keep all information you have heard here today, especially from other participants, private, so please do not share it with anyone".	
Present the note taker: "This is my colleague [*name*]. She will take notes that we can use later to remember the main points discussed here today, as we analyse the information afterwards. As mentioned, these will not be shared with external parties, and we will not attribute quotes to anyone".	
Ask if there is any question or clarification needed	

Ask if all are ready to proceed. If all are ready obtain the following informed consent from each of the FGD participant.

Informed Consent
This consent form describes the evaluation and helps you decide if you want to participate. It provides important information about your participation in this FGD, about the risks and benefits of your participation, and about your rights as a participant. By providing verbal consent you are agreeing to participate in this study. – If you have any questions about anything in this form, you should ask the evaluation team for more information. – You may also wish to talk to your family or friends about your participation in this study. – Do not agree to participate in this FGD unless we answered your questions, and you decide that you want to be part of this study. WHAT IS THE PURPOSE OF THIS STUDY? The purpose of this evaluation study is to assess factors that contribute towards improving maternal and neonatal health in Khost province. We gather community members' perspective and experience to identify areas for improving maternal and neonatal health. WHAT WILL HAPPEN DURING THIS FOCUS GROUP DISCUSSION? From what you know, we will be asking the FGD participants about their knowledge and perspective on pregnancy, birth preparedness, birth delivery, postnatal care services provided at the community and health facilities. We will be also discussing about parameters that contribute towards your decision making for pregnancy and birth delivery related healthcare. You are invited to participate to the FGD along with other members. Your answers are confidential and will not be shared with any other people, and that you also don't share the discussion with anyone after the FGD is completed. The records of this study will be anonymous and private, the statements will not be attributed to any of the FGD member. Whether you choose to keep being part of the FGD is up to you. There will be no effect on you and your family, neither it will affect the treatment or care you receive nor your relationship with healthcare service providers. You have the right not to be in the FGD or to stop participating at any time. If you do not understand a question, please ask me to explain it to you. If a question makes you uncomfortable, we will skip the question and go to the next question. It is important to say that there are no right or wrong answers for these questions, just tell us what you think or feel.

HOW LONG WILL I BE IN THIS FGD? If you agree to keep taking part in this FGD, your involvement will last for an hour. WHAT ARE THE RISKS OF THIS FGD? There are no questions that might make you uncomfortable and what you discuss here will not be attributed to you. WHAT ARE THE BENEFITS OF PARTICIPATION? You will not benefit from your participation. However, we hope that, in the future, other people might benefit from this study because your answers will help the service providers to better address the needs of pregnant women and children. WILL IT COST ME ANYTHING TO BE IN FGD?

You will not have any cost for being in this discussion. If you decide to be in this study, you may stop participating at any time. If you decide not to be in this study, or if you stop participating at any time, you won't be penalised or lose any benefits for which you otherwise qualify.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for your participation. Taking part in this FGD is completely voluntary.

HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL?

We will keep your participation in this study confidential. To help protect your confidentiality, we are not recording your name and personal details and the responses you provide will not be attributed to you.

This consent form is not a contract. It is a written explanation of what will happen during the FGD if you decide to continue to participate. You are not waiving any legal rights by agreeing to participate in this study.

Ask for permission and consent.

If any participant has expressed reluctance to continue tell him/her gently that he/she may leave now before you start.

S/N	Age (in years)	Gender	Education [1]None, [2]Know how to read and write, [3]Primary School, [4]Secondary School, [5]High School, [6]University, [7]Other (please specify)	Consented [1]Yes, [2]No
1				
2				
3				
4				
5				
6				
7				
8				
9				

First, let's talk about the quality and availability of maternal & neonatal services at your CHC. 1. How would you describe the quality of maternal and neonatal healthcare services at your CHC? 2. What about the availability of these services? Are they accessible when needed?	
Now, let's discuss your recent experiences with these services. 1. Can you share your recent experiences with maternal healthcare services at the CHC? 2. Were there any specific services or aspects that you found particularly helpful or lacking?	
Let's move on to the challenges you might have faced and your suggestions for improvement. 1.What challenges have you faced in accessing maternal healthcare services at the CHC or BHC? 2.Are there any specific issues related to the quality of care provided? 3.What improvements would you suggest for maternal healthcare services at your CHC?	
Now, let's discuss the barriers to access maternal health services. 1.Who typically makes the decision about where to deliver the baby in your household? Who makes the decision? And why? When is it decided where to deliver a baby in the household? What factors are taken into account for this? 2.Can you describe the decision-making process and any challenges associated with it? 3.What are the main reasons for delays in reaching healthcare facilities for maternal services? How these delays could be avoided? 4.How easy or difficult it is receiving timely maternal healthcare services once the pregnant mother is taken to the health facility? If difficult, please explain why it is difficult?	
Let's talk about your preferences for maternal healthcare services. 1. What is your first preference for maternal services (birth delivery) in your community – home or health facility? Why? If health facility, which health facility and why? 2. Have there been any changes in preferences over time? What influenced these changes?	

Lastly, let's discuss the role of the community. 1. How involved is the community in promoting and utilizing maternal healthcare services? 2. What role do you think the community can play to enhance the delivery of these services at CHCs?	