2023:12 | Sida Decentralised Evaluation

FCG Sweden and Tana Copenhagen

Evaluation of MSI Reproductive Choices Afghanistan, with a focus on the project funded by Sweden

Final Report

Sida

Evaluation of MSI Reproductive Choices Afghanistan, with a focus on the project funded by Sweden

Final Report
April 2023

Jups Kluyskens
Annica Holmberg

Sida Decentralised Evaluation 2023:12 Sida

Authors: Jups Kluyskens, Annica Holmberg

Sida Decentralised Evaluation 2023:12

Date of final report: 2023-04-12

Art. no. Sida62646en

urn:nbn:se:sida-62646en

This publication can be downloaded from: www.sida.se/en/publications

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

Visiting address: Rissneleden 110, 174 57 Sundbyberg
Postal address: Box 2025, SE-174 02 Sundbyberg, Sweden
Telephone: +46 (0)8-698 50 00. Telefax: +46 (0)8-20 88 64
E-mail: sida@sida.se Web: sida.se/en

Table of contents

Abbreviations and Acronyms

BCC	Behaviour Change Communication
BHC	Basic Health Center
CHW	Community Health Workers
CSE	Comprehensive Sexuality Education
FGD	Focus Group Discussion
FP	Family planning
HDN	Humanitarian-Development Nexus
IDP	Internally Displaced Persons
INGO	International Non-Governmental Organisation
KIIs	Key Informant Interviews
LAPM	Long-acting and permanent methods
mCPR	Modern Contraceptive Prevalence Rate
MNCH	Mother, Newborn and Child Health
MSC	Most Significant Change
MSF	Médicines Sans Frontières
MSI	MSI Reproductive Choices
MSIA	MSI Afghanistan
MSEK	Million Swedish Kroner
BGO	Non-Governmental Organisation
PAC	Post Abortion Care
PC	Provincial Coordinators
RH	Reproductive Health
RL	Religious Leader
Sida	Swedish International Development Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
BGO	Non-Governmental Organisation

Preface

This evaluation was contracted by Sida through the Sida Framework Agreement for Evaluation Services, and conducted by Tana Copenhagen.

This report was prepared by the evaluation team consisting of Team Leader Jups Kluyskens and Team Members Annica Holmberg and Aziz Amin Ahmadzai. The team includes two consultants in Afghanistan, Dr Hadisa Mayar and Dr Mohibullah Mehraban, who conducted the fieldwork. Independent quality assurance was provided by Derek Poate.

The team is grateful to MSI (Isabelle Sykes and Ellora Howie) and MSI Afghanistan and in particular Dr Yaqoob Muslih and Dr Zuhal Sulaiman Haares for their overall in country guidance and support to the team in the field.

Executive Summary

This report presents the findings, conclusions, and recommendations of the Evaluation of MSI Reproductive Choices' programme regarding increasing access to quality Sexual and Reproductive Health and Rights (SRHR) services and products in Afghanistan with a focus on the work funded by Sweden.

FINDINGS

Relevance. The programme objectives are relevant to the needs of women and to some extent to men and respond to Sida's strategic objectives in Afghanistan. The programme is relevant to the health sector in Afghanistan. Since the regime change in August 2021, the programme remains relevant and has become more urgent since it is now implemented in the context of a humanitarian crisis. MSIA has a satisfactory and probably the only possible approach to SRHR assessed against Sida's comprehensive approach to SRHR.

Coherence. MSIA has become more of an extension of public services where the latter fails to provide SRH services and MSIA has a clear mission on family planning (FP) and women's reproductive health. MSIA fills an important gap in a vast country where SRH services and particularly FP are insufficient. MSIA contributed to capacity building in the public sector through both sharing guidelines and contributing to curricula development during the period before the regime change. MSIA's coordination and collaboration is limited with other actors. The value added is that MSIA's services create trust through female-to-female services and are free.

Effectiveness. The programme has achieved limited results in the second and third year of implementation due to the political context while the first year of implementation was far beyond expectation. The programme effectively targets women in remote areas and applies the principle to leave no one behind. Evidence on targeting vulnerable groups is limited and the concept is insufficiently elaborated upon in terms of discrimination and is not grounded in a Huma Rights Based Approach. MSIA has, amongst others, clinics, mobile clinics, midwives and community health worker to implement the programme which are all effectively used to increase access to FP but knowledge and skills to deliver in a humanitarian context vary considerably. The Results Framework has some shortcomings: indicators are limited and some outputs could be better defined and measured.

Efficiency. The methods used for implementation were cost efficient but bank transfers and cash withdrawals caused significant delay beyond MSI/MSIA control. COVID-19 affected the number of people coming to the clinics negatively, but MS ladies managed

to work from home and the effects were mitigated to the extent possible. Staff turnover affected the implementation of the programme and continues to do so.

Gender Equality. MSIA has contributed to improve the targeted women's access to reproductive choices and SRH services, creating one basic condition for gender equality. A lack of a thorough discussions with staff on what gender equality is about, and that the overall gender analysis did not translate into integration of gender dimensions in the different programme activities, demonstrates insufficient focus on gender mainstreaming.

Human Rights Based Approach (HRBA). The programme has not been planned or implemented from a HRBA, yet demonstrates some aspects of a basic rights perspective. MSIA aims to deliver services where there are gaps in public health service, but the service delivery has not been used to set an example. The lack of a deeper knowledge on gender equality also affects how HRBA is understood.

CONCLUSIONS

Relevance

MSIA's work is relevant and continues to be relevant. MSIA's contribution to SRH/FP in remote and urban areas is relevant and the relevance is growing due to increased poverty and demand. The work is based on solid knowledge about the local contexts and adapted to the realities that limit women's reproductive choices. MSIA has a satisfactory and probably the only possible approach to SRHR assessed against Sida's comprehensive approach to SRHR.

Coherence

1. MSIA contributed to capacity building in the public sector through both sharing guidelines and contributing to curricula development in the first year of implementation after which work with the public sector was limited due to the regime change. MSIA fills an important gap in a vast country where SRH services and FP are insufficiently provided for. MSIA serves many clients who would otherwise not have access to FP services.
2. MSIA coordination and collaboration with other actors in the health sector is limited.

Effectiveness

1. MSIA's work has been less effective when looking at the three outcomes and has suffered from external factors which were not expected. Its contribution to the health system is effective in that it is an extension of SRH services that respond to needs from women who may otherwise not be served.
2. MSIA contributes to increased awareness on FP at community level. The evaluation concludes that information from women who already have received services at the

clinics, play an equal or more prominent role in advising other women to seek support at the clinic in contrast to the Community Health Workers (CHW).
3. MSIA reaches underserved and hard to reach areas but the overall strategies to leave no one behind does not translate into deliberate measures on how to reach those women and girls within the poor population that might face the biggest challenges in accessing the SRH services.
4. Key services provided in clinics and through mobile clinics are critical to increase modern Contraceptive Prevalence Rate. The CHW can motivate women to come to the clinic but there is no attention to gender equality or human rights and their knowledge about these approaches and SRH/FP is limited.
5. The results framework has some shortcomings, including too few outcomes and limited indicators. The absence of a ToC limits the understanding of how the different outcomes come together.

Efficiency

1. Given COVID-19 and the takeover of the Taliban in August 2021 the management of MSIA in Kabul has responded as best as it could securing staff, continuing services where possible and adapting as best as possible. MSIA response to COVID-19 was adequate.
2. Operations suffered from external factors as well as transferring money to Kabul and supply chains interruptions which affected the clinics and MS ladies in providing commodities to clients.
3. Staff turnover has affected efficient implementation of the programme and continues to do so.

HRBA and gender equality

1. The programme has a gender sensitive approach and is sensitive to a basic human rights perspective. Providing SRH services to women in poverty is strategic in ensuring that there are basic conditions for women to enjoy better health and have greater influence over their reproduction. A lack of structured and consistent gender mainstreaming of the programme, including the absence of building staff knowledge and capacity on gender equality, means that MSIA has not embraced a more gender responsive approach.

RECOMMENDATIONS

(Based on the assumption that the regime will stay and health circumstances for women and children will deteriorate)

To MSI and MSIA

1. Given the dramatic consequences since the regime change on the health sector in general and access to SRH services for women in particular, MSI and MSIA should review the emerging reports that analyse the consequences for the health sector and design the next phase based on this prognosis and rethink its position among other actors.

2. Diversify funding and exhaust opportunities to work more closely with other actors in the humanitarian domain. A mapping of the different actors in the provinces would help MSIA position itself better vis à vis actors. In addition, a deeper analysis between and within different groups of rights holders could strengthen the principle of leaving no one behind.
3. Develop an Afghanistan strategy from a humanitarian perspective. Use such strategy as an opportunity to destigmatize SRHR services by framing it as a necessary health intervention. Consider where additional expertise could be relevant such as focus on young people, gender equality, HRBA in headwinds and/or conflict settings, etc.
4. Develop a Theory of Change and corresponding results framework and improve reporting across the results chain. Improve indicators to better capture change, including attitudes and behavioral change and consider progress indicators. Where relevant report on results financed by other donors if this reinforces results financed by Sida. Consider diversifying among target groups that are considered 'vulnerable' or 'poor'.
5. Improve, capitalize and expand the existing services on FP (outreach) through improving the skills and capacities of CHWs. MSIA could better complement the clinical services by further strengthening the outreach work through equipping the CWHs with more in-depth knowledge on FP and also on women's and girls' rights.
6. To secure that rights-holders are reached, the programme needs articulated strategies for reaching women with different disabilities, women that face different types of stigmas, minority groups, and those women and girls whose freedom of movement is so restricted that they will not come to the clinics without special targeted actions (e.g., home visits, interventions by trusted community members, counselling/mediation, or similar).
7. Expand the number of staff for MS ladies and mobile clinics responding to an assumed growing demand.
8. A more deliberate effort to build staff knowledge and capacity to promote gender equality, and to start to introduce HRBA to both programmatic and implanting staff would strengthen the relevance of the programme and work more towards Sida's comprehensive approach considering the contextual limitations.
9. Staff retention will be an issue in the medium and long term and consider how MSI can contribute to training the next cohorts possibly in collaboration with other actors. This could offset the threat that a new cohort of female employees may not come on the labor market if the regime continues with the current imposed restrictions that women cannot attend secondary and tertiary education.

To Sida:

1. Continue to support MSIA based on a programme with a strong results framework and clearly elaborated strategic choices.
2. Continue to support a programme that remains in the same geographical areas of intervention and that focuses on strengthening and expanding services, including in remote areas and targeting a growing, poor population.

3. Engage in discussions with MSI and MSIA on how gender equality and HRBA approaches can be strengthened and where a deeper approach possibly could be piloted considering a changing context.
4. Create opportunities for MSIA to collaborate more closely with partners in country supported by Sida and others such as the UN.
5. Consider whether support to MSIA could provide learning opportunities for the Humanitarian-Development Nexus and what learning goals could be jointly defined.

1 Introduction

1.1 BACKGROUND, PURPOSE AND OBJECTIVES

This is the end evaluation of the Marie Stopes International Reproductive Choices' (MSI) programme regarding increasing access to quality Sexual and Reproductive Health and Rights (SRHR[1]) services and products in Afghanistan (hereafter the programme), January 2019 – December 2021. The evaluation covers the current Sida agreement with MSI, including the project extension from January 2019 - December 2022. Sida supports part of the country programme with project support, focusing on 8 provinces.[2]

The primary purpose or intended use of the evaluation is to provide Sida with a good understanding of the Marie Stopes International Reproductive Choices Afghanistan (MSIA) programme and results, its value-added and its role in the overall structure of providing Sexual and Reproductive Health (SRH services in the Afghanistan context (i.e., the collaboration with other partners and the strengthening of the health care system in terms of capacity, structures, institutions etc.)

MSI Reproductive Choices is a global international non-governmental organisation (NGO) working in 37 countries, with its headquarters in London, U.K. The country office in Afghanistan is headed by a Country Director based in Kabul.[3] MSlA works with SRHR, raising awareness and increasing access for women to affordable services and products preventing unintended pregnancies and maternal deaths. (See chapter 3 for more information on MSIA and the programme.)

The purpose of the evaluation is to

- Provide a good basis for Sida's future support, advocacy and dialogue in the area of SRHR in Afghanistan.
- Help Sida and its partner MSIA to assess the progress of the ongoing intervention of MSIA in Afghanistan (with a focus on the Swedish-funded program) to provide Sida and MSIA with input to upcoming discussions concerning the preparation of a new phase of the intervention.

[1] The programme result framework speaks about SRH services which is the term that will be used in the report to describe the programme activities.

[2] Though Sida's support is technically a project, the evaluation report will refer to the intervention as Programme.

[3] MSIA is entirely staffed by Afghan nationals, except for one staff member from Pakistan.

- Serve as input for Sida's decision on how Sida's future support to SRHR in Afghanistan can be most strategic and relevant.[4]

The Evaluation rationale

The evaluation was carried out at a time when Sida's support to MSIA is ending and Sida plans to assess continued support to MSIA's program. Sida has funded the program for ten years but not commissioned any specific evaluation, even though Sida's contribution to the program was included in the 2015 evaluation of MSIA's programme.[5] It is important for Sida to understand the role of MSIA, its country programme and ability to operate, given the changes in the political context, the revisions in donor policy and the new aid architecture in the country. It is also important for Sida to understand MSIA's added value, comparative advantage and the cost effectiveness of its programme and, most importantly, how MSIA can influence SRH services beyond MSIA's specific programmes.

The objective of the evaluation is to provide Sida with information on the results, value added and role of MSIA and MSIA's work in Afghanistan. The following areas have been evaluated:

- The relevance, coherence and effectiveness of the intervention. Recommendations are formulated as an input to upcoming discussions concerning the preparation of a new phase of the intervention and support to SRHR in Afghanistan.
- The questions aim to provide Sida with an understanding of the strategic value of continued support to MSIA or/and to other actors delivering SRHR in Afghanistan.

1.2 EVALUATION CRITERIA AND QUESTIONS

The evaluation questions as given in the ToR are outlined below. Under the effectiveness criterion there was one efficiency question which now appears under a separate criterion efficiency.

Relevance: Is the intervention doing the right thing?

1. To what extent has the programme **objectives and design responded to the needs of women and men** and how has it strengthened reproductive services in

[4] Terms of Reference (ToR), page 3.
[5] Program Evaluation Marie Stopes International Afghanistan (MSIA) January 8, 2015.

Afghanistan[6]? Has the programme continued to do so now that the circumstances have changed?

Coherence: How well does the intervention fit?

1. How compatible has the intervention been with **other interventions** in the country?
2. How does MSIA **relate, coordinate and collaborate with other stakeholders** working with SRHR and primary health care?
3. What is the **role, value added and comparative advantage of MSIA** in the Afghani context? In what ways has MSIA used its capacities within and beyond the program, for example for strengthening other partners and the broader health care system? How could the health sector learn and make best use of MSIA's knowledge and experience?

Effectiveness: Is the intervention achieving its objectives?

1. To what extent has the intervention achieved its intended **results (from the original proposal/log frame)**?
2. Which intended **results were achieved / not achieved**? Why?
3. In what thematic areas, regions and components has the program been **most successful** and what are the reasons for **success and failure**?
4. To what extent have MSIA **reached, included and achieved results** for specifically vulnerable groups and groups that are stigmatized in the society?
5. To what extent was the chosen **implementation strategies** effective?[7] Was the program implemented in a conflict sensitive manner?
6. Has the **M&E system** delivered robust and useful information that could be used to assess progress towards outcomes and contribute to learning?

Efficiency

1. Were the implementation methods cost-efficient?

[6] This includes assessing the opinions on needs by MSIA staff, the beneficiaries, community leaders and other important stakeholders such as humanitarian actors, Sehatmandi service providers or UN agencies.

[7] That includes: the partnership approach (working with religious and community leaders etc.), the implementation modalities, i.e. training of community health workers, MS Ladies, satellite centres, working in schools etc.

Other questions:

1. Has the project had any positive effects on **gender equality**? Could gender mainstreaming have been improved in planning, implementation or follow up? How has the project dealt with **psychosocial harm?**
2. Has the project been implemented in accordance with the poor people's perspective and a **Human Rights Based Approach**? Can it be said to have had a people centred design, with a focus on and based on input from the people needing the services?

The evaluation includes a summary of the **lessons learnt and recommendations**, as well strategic choices for Sida supporting SRHR and MSIA in the coming years, taking into account the conclusions in the evaluation, the needs in the country and the new political context.

Given the COVID-19 epidemic and the regime changes in August 2021 and subsequent decrees on the limitation of women to work and study, the team revisited the ToR questions in the Inception Report and expected that most questions could be answered but that both facts would affect the data collected.

1.3 SIDA'S FUNDING AND STRATEGY

The programme is funded under two Sida strategies for Afghanistan (strategy from 2014-2019, extended to 2021 and from 2021 to 2024) and provides a contribution of 45 million Swedish Kronor (MSEK) to the original programme. Sida's focus in the first two strategies was on development rather than humanitarian. The programme had a no cost extension until 31 December 2022, amongst others, due to slow disbursements during the COVID-19 pandemic. In addition, the Taliban takeover in August 2021 drastically changed the conditions for aid in Afghanistan and also affected the implementation of the programme. Sida continued to support the Afghan people without direct cooperation with the Afghan state and also amended its strategy.[8]

Key focus areas of Sida's Afghanistan strategy include: 1) peaceful and inclusive societies; 2) strengthened democracy and gender equality and increased respect for human rights and the principles of the rule of law; 3) education and health, including increased access to good quality health care, including respect for sexual and reproductive health and rights; and 4) inclusive economic development and sustainable livelihoods with focus on the environment, climate and sustainable natural resource

[8] Grant agreement, page 4, 2019, 06.07. The grant agreement stipulates 7 provinces.

management.[9] Afghanistan has been Sida's largest bilateral support programme, but from 2023 it has been reduced due to the new Swedish Government' prioritisation of support to Ukraine.[10]

1.4 STRUCTURE OF THE REPORT

The structure of the Report is as follows:

First, we sketch the background of the evaluation including a brief introduction to the programme, the evaluation questions and Sida's funding in chapter 1. In chapter 2 we present the methodology used, including the methods for data collection and limitations. In chapter 3, we present the MSIA programme followed by findings in chapter 4. The findings follow the evaluation questions and clearly mark where limitations in data collection occurred and how this affected the findings and limitations. In chapter 5, we present the conclusions, in chapter 6 lessons learnt and finally in chapter 7 we present the recommendations.

The 10 annexes of the report include the ToR (annex 1), stakeholders (Annex 2), the evaluation matrix (Annex 3) MISA programme (Annex 4) data collection tools (Annex 5), documentation (Annex 6), List of interviewees (Annex 7), the revised outcome and output overview, (Annex 8), the results framework overview (Annex 9), and a results data overview (Annex 10).

[9] Swedish strategy for development cooperation with Afghanistan 2022-2024 unofficial translation. No date. Sida developed guidelines and pre-conditions for its support to Afghanistan outlined in a one pager in English. While the programme has suffered in implementation from the Taliban takeover, the programme components and geographical scope remained unchanged.

[10] This was confirmed during an interview with a Sid representative.

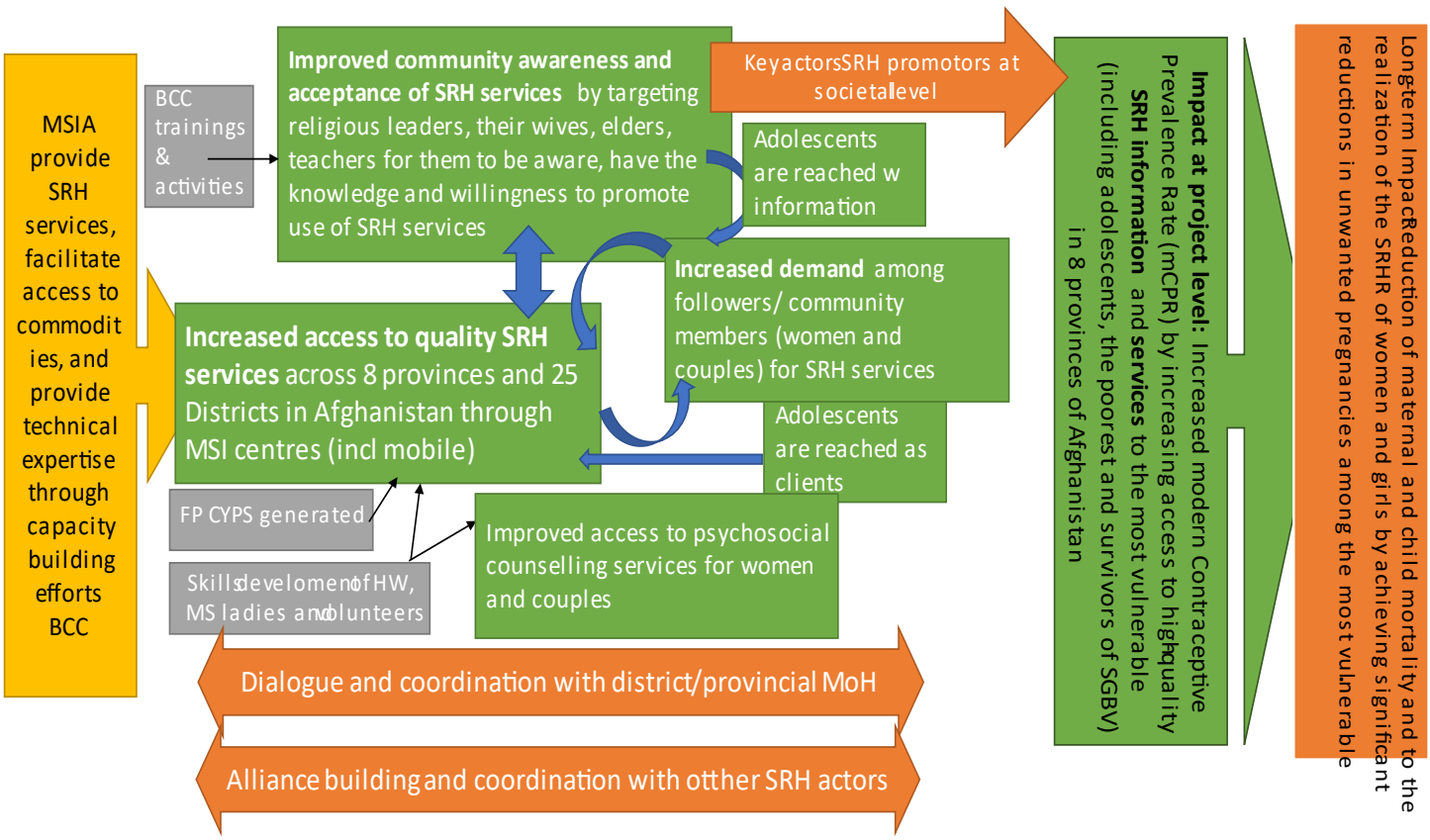
2 Methodology

2.1 OVERALL APPROACH

2.1.1 Theory Based

The overall approach consisted of a theory-based approach using the Theory of Change (ToC) that the team developed in collaboration with MSI and MSIA. The ToC is basis for probing the design and achievements of the programme using different methods and data collection tools outlined below. The ToC has been the framework to test underlying assumptions and how different implementation steps have evolved in leading, or not, to overall goal and achievements of the three outcomes. This included how the programme has adapted and responded to the Taliban takeover, added value, comparative advantage, and the cost-effectiveness of its programme and, most importantly, how MSIA can influence reproductive services beyond MSIA's specific programmes. (See above Evaluation Rationale).

Figure 1: The above illustrates the interpretation of the current Theory in Use



2.1.2 MSIA's The logical framework

During the Inception Period, the evaluation team discovered that the programme design had four and not three outcomes due to having two results in one outcome. The evaluation has therefore examined the four following outcomes and related outputs some of which have changed or were unattainable due to the regime change. The outcomes and outputs below are therefore the ones that the team has examined. The team also developed new assumptions. For a full overview, see Annex 9. New outcome 4, however, had limited activities. Also, policy work after the regime change has not been possible. Moreover, due to external factors the nature of the psychosocial counselling changed.

Table 1: Outcome and output deconstruction

Outcome and outputs	Comment
1. Improved community awareness and acceptance of SRH services and increase demand (women's and couples) for SRH services	This outcome harbours two results, first increased awareness (output) that will lead to acceptance (attitude change at outcome level), and second, the acceptance will lead to increased demand (behaviour change outcome).
Outputs to Outcome 1	
1.1 Religious leaders share SRH messages *1.2 Radio programmes expand SRH knowledge*	The first output is still valid and in use. The second output was possible during the first years of implementation but is no longer applicable.
2. Increased access to quality SRH services across 8 provinces and 25 Districts in Afghanistan	No comments or change at outcome level.
Outputs to Outcome 2	
2.1 FP CYPS[11] generated *2.2 Adolescents are reached as clients* *2.3 Updated curriculum in nursing and midwifery Schools*	Outputs 1 and 2 are still applied. The discussion noted that by adolescent, this indicator refers to married adolescents, while information sharing under outcome 1 can refer to unmarried boys and girls. Indictor 3 is partly met through previous work; the curriculum is being revised by the ministry of Education but MSIA can no longer advocate for changes.
3. (Old Outcome) Improved access to psychosocial counselling services for survivors of violence and remove policy barriers to enable women and girls to exercise their SRHR	The outcome harbours two results and these need to be separated. The first part, now new Outcome 3, needs to be revised to Improved access to psychosocial counselling services for women and couples. The terminology of survivors of violence is no longer appropriate in the new context.

[11] Family Planning Couple-years of protection.

3. New outcome 3: Improved access to psychosocial counselling services for women and couples	New outcome 4. Policy barriers removed to enable women and girls to exercise their SRHR. However, this outcome needs to be put on hold, or even to be excluded for the rest of the programme period, due to the current context. The discussion also noted that this part of the original Outcome 3, did not have any indicators and that the policy barriers were not identified.
Outputs to Outcome 3	
1.1 Women receive psychosocial counselling at a facility or through the dedicated contact centres 1.2 *Women in prison reached with service delivery*	Indicator 3.2 does not explicitly address the outcome since women in prison are not mentioned at that level. However, MSIA did reach out to women in prison during the first years of the programme. It was also noted in the discussion that this component is currently not possible to implement.
Outcome 4	
4.Removal of policy barriers to enable women and girls to exercise their SRHR	

2.2 UTILISATION-FOCUS

The evaluation was undertaken with a utilization focus and the team has included the following steps to ensure relevance to different stakeholders.

1. Identified, organized, and engaged the primary intended users.
2. Discussed with the intended users its priority purposes and components of the programme, including the identification of target groups.
3. Focussed on ToR evaluation questions to increase utilisation as well as respond to the ToR on future actions.
4. Developed a ToC underlying the design of the programme and discussed the results framework.
5. Various briefings were organised to update Sida on the progress of the evaluation due to security and safety issues in country as well as new restrictions that were announced in the course of undertaking the work.
6. Due to inherent complexity of the regime change and the appearing humanitarian crisis the team decided to interview additional persons, including Sida's Head of development cooperation in Stockholm and the former Afghanistan lead for Sida. Also, three different UN agencies were interviewed, the regional director Asia/Pacific from MSI as well as the Swedish Committee for Afghanistan. Finally, another key contributor to MSIA, Finland, was interviewed.

In addition, to the above, there were numerous meetings both with Sida ad MSI/MSIA to discuss risks and to adapt the approach so that the evaluation would stay true to the overall evaluation purpose but at the same time ensure that MSIA operations were not jeopardized by the attention the data collection could bring to the clinics and thus to

MSIA's work. That would have had a negative effect on the programme and the evaluation. Each field trip to the provinces was cleared by MSIA from a risk and security protocol perspective, and the evaluation team adapted the approach to stakeholders to the situation in each province.

2.3 METHODS AND TOOLS FOR DATA COLLECTION

The methods included:

1. **ToC workshop.** The ToC workshop was organised to discuss the logical framework that underpins MSIA's programme. It revealed some shortcomings in design, including Indicators were missing to measure the progress of some of the outcomes, and some of the planned work was not captured in the results framework, as e.g., the work with women in prison. The approach of MSIA to gain acceptance at community level only captured the contribution of one key actor, the religious leaders, while the effect of other actors' work (religious leaders' wives, MS ladies, peer educators, etc.) was not monitored through the indicators.
   The definition of the original outcome 3 indicates that the framework was not directly based on an actor or barrier analysis and thus not identifying indicators that would help MSIA to measure progress towards the removal of "policy barriers to enable women and girls to exercise their SRHR". It also raises questions on how the desired results in the programme proposal was discussed between MSI/MSIA and Sida.
2. **Document Review.** The team reviewed all relevant documents and prepared an overview of the annual reports against the original results framework to assess progress over time. See Annex 9.
3. **Stakeholder Mapping**. A stakeholder mapping was developed to ensure broad coverage of stakeholders at various levels and adapt along the way. For the field work the stakeholders were identified with support from MSIA, including MS Ladies and Provincial Coordinators (PCs). The stakeholder mapping was broadened with suggestions from Sida to interview more people about the effects of the new context on the programme. See Annex 2.
4. **Field work.** The local team visited four provinces (Kabul, Nangahar, Bakht and Herat) and interviewed 113 persons. Also, all MS ladies and provincial coordinators in all eight provinces were included in the Sida support and these were interviewed to get a good coverage of all the provinces that the programme supports. The field work took extra time due to security reasons and considerable preparations. For an overview of the field work location and number of people interviewed see Annex 7.
5. **Semi-structured individual and group interviews**. The team conduced Key Informants Interviews (KII) with different stakeholders, including, two MSIA management staff, two MSI staff based in London, and one based in the Asia region, three UN agencies in country, three Sida staff in Stockholm and one former Sida programme staff.

6. **Data analysis.** The team structured all the data according to categories: document review overview, data consolidation of the different interviews. For the field work we categorised answers according to the four provinces and across provinces for the same stakeholders (for example, all clinical staff across the four provinces). A validation meeting was organised among all team members to discuss the data.
7. **A presentation of preliminary findings** was organised together with key MSI and MSIA staff to validate the findings and the way forward.
8. **A final workshop** will be organised to present the report.

2.4 PROCESS OF ANALYSIS AND DEVELOPING CONCLUSIONS

There are different tools which were used in a sequenced way for data analysis and triangulation: the document review, interview results, field work data, and preliminary presentation of findings.

1. The document review was based on MSIA's framework for which we prepared a table using MSIA's annual reporting for all the years. See Annex 9. This table was shared with MSI and MSIA before each interview so the interviewee could comment on these data.
2. For the interviews the team used different interview formats depending on the interviewee, including different interview guides for the field work. See Annex 5. We then organised the responses per evaluation matrix question and coded the answers. For the field work we organised and analysed the data per provinces as well as per stakeholder category (for example all community health workers (CHWs), and clinical staff among the four provinces). We listed answers based on highest frequencies of similar answers and noted anything specific to province, context, interviewees, etc. We organised a validation meeting within the team to check the field data against our analysis. Based on this system we drafted a first text with findings per question.
3. Once we had a draft text that reflected all the evaluation matrix questions, we organised these according to the EQs and introduced subchapters to present our key findings. Each chapter ends with an overview of key findings in a box.
4. The available evidence is mixed. First the reporting on results against the results framework is limited due to activities not performed while other activities are introduced which are not reflected in a revised framework. The reporting is therefore not always consistent. As the years progress most of the identified targets are partially met or not met. Hence evidence of performance from the document review is limited. The team, however, assumes that it is plausible that the performance would have been better if the external factors had had not such an impact on the programme and affected the implementation of activities. At the same time the team used the ToC to assess performance as well as design of the programme. See above discussion on ToC.
5. The data from the interviews provide additional evidence against the outputs in the results framework and were used to triangulate data. Moreover, it also provided

evidence on some of the assumption that accompany the results framework. As noted under limitations, the field data are not a representative sample. See below 2.7

6. Interviews with Sida, MSI and donors provided the team with additional data on the programme and in particular its added value, its position and how it has navigated the external challenges such as COVID-19 and the regime change.
7. The conclusions were built on the findings from the analysis highlighting the key overall insights, successes, and shortcomings.
8. The lessons learned consider potential implications of the report findings beyond the scope of findings and feeds into organisational learning for both Sida and MSI. It also provides reflections on what could be considered for future programming.
9. Possible future programming is built on the assumption that the Taliban government would remain in place and that the humanitarian situation will continue. The team organised additional interviews with MSI, Sida as well as donors in country to explore their perspective and the extent to which this corresponded or strengthened our findings and conclusions.

2.5 ATTRIBUTION/CONTRIBUTION ANALYSIS

In terms of contribution analysis, we alert the reader to the fact that COVID-19 and the regime change had such a profound impact on the implementation of the programme that the evidence supporting the ToC is limited. Given that the ToC was developed in close collaboration with MSI and MSIA we do observe how the links in the ToC are working based on *programme design* and the team feels confident that we can comment on that deriving evidence from the interviews and the document review. The assumptions have also changed considerably (for example continued collaboration with the health ministries and other public sector entities was no longer possible and rights holders had limited influence of programme design) and finally a key influencing factor is that the development paradigm in which this programme was designed has shifted to a humanitarian situation and thus in a predominantly unpredictable situation with considerable uncertainty. The latter has been confirmed by our interlocutors.

2.6 ETHICS AND PARTICIPATION

Both ethics and participation were considered in close collaboration with MSIA and MSIA, including a draft and the agreed consent form. Consent was asked for all interviews and there were no refusals. See Annex 5. MSIA has also guided the team at various stages of the evaluation and mobilised respondents informing them about the purpose of the evaluation and that their participation was voluntary. Anonymity and confidentiality of individual informants has been fully respected, the team only knows in which province the respondents are located and what type of respondent it was, for example, client or CHWs.

The local consultants are a married couple, and both have medical backgrounds and are well aware of social stigmas, sensitivity related to cultural and religious beliefs and aware of the restrictions that the regime announced. Where relevant the interviews were

female to female in a safe and private space. Consultations were held in relevant local languages. Interpreters were not used – rather one of the team members translated all the interviews guides and notes since the local consultants worked in different languages. There have been some challenges with the translation of technical concepts related to development perspectives and programme management used in the interviews. See section limitation below 2.7.

2.7 LIMITATIONS

1. Sida's and MSI's stance on working with the government. In turn, exposure to the government could harm the MSIA programme and all that are associated with it. This meant that the evaluation could not consult either national or local duty-bearers. This limitation was discussed and agreed upon with Sida.
2. Limitations in ascertaining contribution. There are other health providers and donors active in the same provinces as MSIA but it has not been possible to get a reliable overview, including what the public sector clinics and hospitals do in terms of similar services that MSIA provides. There are, however, clear indications that MSIA clinics refer to public medical centres and hospitals in the health chain. In addition, since there is no longer a formal engagement with government the questions related to MSIA's contribution to the (public) health sector cannot be answered. However, one of the interviewees mentioned that public clinics have been closed since the regime change potentially increasing demand, but geographical areas are now known so the team could not assess the effect on the programme. The team, however, has collected data on MSIA's contribution within the current context which has become predominantly humanitarian.
3. Translation of English concepts related to SRH have different wording in the various languages and the team tried to use concepts that are familiar with the respondents which MSIA supported. It was also noted that some of the MSIA staff in the clinics may not be familiar with specific FP terms.
4. The evaluation team has used concepts based on MSIA advice. This might have affected loss of nuances from the original guides but meant a more inclusive and participatory approach.
5. Respondents have been hesitant and/or fear to elaborate given the sensitivity of SRHR, human rights and gender equality in the current context. This has affected the data collected and respondents gave short answers. Some may also have been somewhat scared not expanding in the conversations or giving examples. This could also be the case for CHWs since they are employed by government which the team learned during the review period. In hindsight this may have affected their answers.
6. The local team was recruited based on the requirement from Sida that there should be one woman and one man, their medical knowledge, the fact that they could travel as a couple (and that the female team member did not need another family chaperon), and their availability and willingness to travel to the selected provinces. All together this meant that we could not recruit evaluators with vast experience from collecting data on sensitive matters, or process-oriented and rights-based interview techniques, which has affected the data in probing answers further. This

has impacted the quality of the interviews. For example, when respondents talked about medicine or equipment, or mentioned challenges or problems in non-specific manner, there was no additional questioning on what these refer to. To mitigate this limitation, the Team Leader and the Senior Evaluator followed-up a number of issues with the local team members.

7. The number of people interviewed was 113. People were selected with the support of MSIA. For clients the selection was random depending on who agreed to be interviewed after visiting the clinic. For the number of staff, MSIA guided the team to staff and MS ladies. The overall number of staff and operational clinics changes. The team knew beforehand that the sample would not be representative given the limitations of travel, severity and willingness of people to speak. This is maybe most notable with the number of community stakeholders and the fact that due to the risk assessment made and agreed upon with Sida, MSI and MSIA, no interviews could be held with governmental officials.
8. The team prepared on outcome overview that identified a fourth outcome. The evidence for this outcome (removal of policy barriers to enable women and girls to exercise their SRHR) in the document review is very limited and does not provide adequate and corresponding data to the outcome in the results framework. Rather, it appears to be an assumed results under the total of activities in the original outcome and the team could not detect a specific correspondence between the new outcome and activities. In addition, not engaging with government in year 2 and 3 of the programme meant that any advocacy or other activity was impossible.
9. The security situation posed serious challenges to the planning of each provincial visit. In fact, for each province, a decision was made in close dialogue with MSIA office in Kabul if the evaluation team could go ahead and visit the next province in line. This meant constraints in planning how to reach different stakeholders and priority was given to stakeholders with direct engagement in the programme at the cost of external actors. Consequently, the team could not gather adequate data on other healthcare providers, e.g., INGOs. This was also partly due to MSIA's limited exposure to other actors in this field.
10. During the review period of this report, it appeared that activities funded by other donors are relevant for and strongly interlinked with the Sida-funded work while the results framework only reports on results related to Sida support. This constitutes a limitation. During the review, the team added such relevant information in footnotes to provide additional evidence to the reader while it was not part of the objective of this evaluation.
11. The team had insufficient data to assess the overall question what other actors Sida could support. This question is also dependent on Sweden's engagement with the current regime. As indicated in the findings 4.1 and 4.2 below it is the impression of the evaluation team, that establishing SRH services with a strong focus on FP for any new actor would be very difficult under the current circumstances. To our knowledge and based on the evidence in this report, there is no other active CSO with SRHR competence in the country that could replace the work of MSIA.

3 Presentation of the Programme[12]

The "MSIA programme regarding increasing access to quality Sexual and Reproductive Health and Rights (SRHR) services and products in Afghanistan" January 2019 – December 2021, is funded under two Sida strategies for Afghanistan[13] and provides a contribution of 45 million Swedish Kronor (MSEK) to the original programme. The programme had a no cost extension until 31 December 2022, due amongst other reasons, to slow disbursements during COVID-19. In addition, the Taliban takeover in August 2021 drastically changed the conditions for aid in Afghanistan and also affected the implementation of the programme. Sida continued to support the Afghan people without direct cooperation with the Afghan state and also amended its strategy.[14]

The MSIA programme is managed from MSIA head office in Kabul by a director assisted by different technical staff, with provincial coordinators in each[15] province and 31 clinics, including mobile clinics, distributed among the 14 provinces.[16] In addition to service being provided at the clinics, MS ladies provide services to clients. MSI London provides technical back-stopping and supervise the programme together with the management in Kabul.

3.1 THE OVERALL OBJECTIVES OF THE MSIA COUNTRY PROGRAMME

The overall goal of the programme is to contribute to the reduction of maternal and child mortality and to the realization of the SRHR of women and girls by achieving significant reductions in unwanted pregnancies and unsafe abortions among the most vulnerable.

The specific objective of the part of the programme funded by Sida is to increase the modern Contraceptive Prevalence Rate (mCPR)[17] by increasing access to high-quality SRH information and services to the most vulnerable including adolescents, the poorest

[12] A more comprehensive presentation of the programme is provided in Annex 3.

[13] The strategy from 2014-2019, extended to 2021 and the strategy from 2021 to 2024.

[15] This refers to the overall Programme which includes other donors.

[16] The number of clinics and staff change over the evaluation period.

[17] The percentage of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used.

and survivors of Sexual and Gender Based Violence (SGBV) in eight provinces of Afghanistan.

The overall objectives for the Sida funded intervention are:

1. improve community awareness and acceptance of SRH services and increase demand (from women and couples) for Sexual and Reproductive Health (SRH) services,
2. increase access of quality SRH services across 8[18] provinces and 25 districts in Afghanistan,
3. improve access to psychosocial counselling services for survivors of violence and remove policy barriers to enable women and girls to exercise their SRHR[19]

In addition, with the Sida funding the intervention has aimed to continue supporting MSIA's capacity and systems development on a cross cutting level to ensure programme performance and maximum results.[20]

The programme provides a comprehensive range of SRH services, e.g., family planning (FP) and post-abortion care (PAC) services in eight provinces (Kabul, Balkh, Herat, Kandahar, Kunduz, Nangahar, Jawzjan and Helmand).[21] The services reach women and girls in remote, rural, semi-urban and urban areas where no other health services are available. MSIA's programming is specifically designed to meet the needs of the most vulnerable groups, with a focus on those living in poverty, those without alternative access to care, and other marginalized groups, such as people with disability, youth and internally displaced persons (IDPs). Through Sida's project support, seven centers, five mobile health teams, 250 CHWs and 14 MS Ladies[22] are providing quality services to women and girls.[23].

3.2 IMPLEMENTATION ARRANGEMENTS

According to the programme documents MSIA works with a number of implementers and partners, including government structures mainly at provincial and district levels, hospitals, local NGOs and associations, community-based organisations and persons, and other health professionals and organisations. The 250 CHWs that work with MSIA are part of the established healthcare system rather than employed directly by MSIA. See Annex 2 for an overview of stakeholders. Since the Taliban regime, the programme

[18] The program application stated seven provinces which was then altered to eight.

[19] Idem page 4.

[20] Project Document, page 4.

[21] FP is understood here to be the practice of controlling the number of children one has and the intervals between their births. It includes information and access to contraceptives.

[22] These are: "Qualified midwives providing community based, accessible, and quality assured FP services together with ANC, PNC and under 5 basic primary health care". From MSIA Capacity Statement, no date, 2 pages. Second footnote on page 2.

[23] The number of staff has changed over the years.

does not work directly with governmental structures apart from limited collaboration with some governmental hospitals (mainly referrals of patients) and a certain level of formal coordination related to necessary authorizations and permits.

The service provision and awareness raising on SRH, aim at increasing access to quality SRH services and SRHR information for adolescent girls, women and young couples in particular. A key component of the program is Behaviour Change Communication (BCC) targeting religious leaders and their wives, elders in the community, health workers, as well as the community at large. The programme achievement is dependent on the support from these local actors to promote the knowledge, awareness of SRH services and willingness to use the services.

In relation to Sida's and MSI's overall approach to SRHR, it is worth noting that the focus of the services and information provided is on FP methods, SRH of the women and girls, including PAC. The clinics also cover more general services to mother and child health. During the first years of the evaluated programme phase, it was also possible to focus on S/GBV, something the current political context impedes. The context before the regime change in August 2021 allowed for a more comprehensive SRHR approach, but since then does not. The SRH approach of the programme is contextualised to Islam and local culture. MSIA has a guidance for health providers: Islamic teachings on maternal and reproductive health.[24]

In the fall of 2022, the programme was faced with a devastating uncertainty that female workers were no longer allowed to work. The uncertainty was to a large extent resolved when the health sector was exempted and MSIA received official notice that they could continue their services.

Staffing patterns have changed over the years. The document shared on the plans for the extension period highlight the following staffing pattern for the entire programme (including Sida funded staff). MSIA, […] has an established presence in Afghanistan, with operations currently in 14 of 34 provinces. In 2020, MSIA's employed 350 staff, had 31 static centres, four mobile outreach teams, and worked with 23 midwife entrepreneurs.[25]

3.3 MSIA'S FIT WITH SIDA'S AFGHANISTAN STRATEGY

The MSIA programme responds to the third key focus areas of Sida's Afghanistan strategy: education and health, including increased access to good quality health care,

[24] MSI, no date.

[25] MSIA Capacity Statements. 2022, page 1.

including respect for sexual and reproductive health. The programme also, to a certain extent, relates to the focus on gender equality of the second strategy area of Sweden.[26]

3.4 FINANCIAL SUMMARY

The budget was agreed at the beginning as presented below. Changes were made due to slow disbursements. Also, the exchange rates between SEK and USD affected the expenditures. This has resulted in a cumulative loss of USD. 288.258,92 at 2022.

Table 2. Original budget

Budget SEK at the beginning of the Programme 2019-2022				
	Year 1	**Year 2**	**Year 3**	**Total**
Total Budget	**14.741.803**	**15.011.101**	**15.724.353**	**45.477.257**
Indirect Cost	1.621.598	1.651.221	1.729.679	5.002.498
Grand Total Budget	**16.363.401**	**16.662.322**	**17.454.032**	**50.479.755**

During the years of implementation changes occurred to the budgets, decreases, increases and changes to budget lines. These were based on changing fees and salaries, number of people recruited, increase of costs, security threats and not being able to implement activities. Due to COVID-19 and the programme hibernation for several month in 2019-2020 there was an underspend of USS 599,841 for 2021 according to the financial reporting.

Table 3. Draft overview for all years after amended budgets, including extension 2022. In USD. Prepared by MSI

	2019	2020	2021	2022
I. Carrying from previous years				
(+) Cumulative ingoing balance from the below working		155.082,51		260.220,01
(-) Cumulative outgoing balance			(32.145,85)	
II. Distribution of cash	1.291.148,64	590.036,64	1.182.920,99	1.539.187,22
III. Available fund=I+II	1.291.148,64	745.119,15	1.150.775,14	1.799.407,23
Accumulative FX (gain)/Loss	(106.688,64)	(203.200,28)	(399.071,27)	(288.258,92)

[26] Swedish strategy for development cooperation with Afghanistan 2022-2024 unofficial translation. No date. Sida developed guidelines and pre-conditions for its support to Afghanistan outlined in a one pager in English. While the programme has suffered in implementation from the Taliban takeover, the programme components and geographical scope remained unchanged.

Working				
Spend	1.136.066,13	777.265,00	890.555,13	1.502.154,20
Fund receipt	1.291.148,64	590.036,64	1.182.920,99	1.539.187,72
Budget	1.184.460,00	493.525,00	987.050,00	1.650.000,07
Ingoing (or outgoing) balance = Spent vs fund received	155.082,51	(187.228,36)	292.365,86	
FX (gain) or lose = Budget Vs Fund received	(106.688,64)	(96.511,64)	(195.870,99)	110.812,35

The above table, with preliminary data for 2022, shows that the extension, while an exchange loss occurred, has enabled MSIA to carry out activities and used the underspent in 2020 (COVID-19) in 2021 and the highest spent of the Programme in 2022. The numbers in red show the ingoing and outgoing balance with some funds left in 2022. The final reporting on the budgets and expenditures is due in September 2023.

3.5 MSI REPORTING

MSI has a robust attribution policy in place to ensure that there is a trackable and verifiable link between donor funds, service delivery and project outcomes. Each service delivery channel is given an unique cost centre code within its financial system which allows it to monitor service delivery and assure the integrity of data and reporting. Whenever impact and results of a project are reported, they are all directly attributable to that specific donor. For head office staff and costs, a proportional percentage of their costs are allocated to each project according to project portfolio.

Sida's financial contributions are reflected in MSIA's reporting system in such a way that maternal deaths avoided, unintended pregnancies averted, and unsafe abortion averted come directly from the number of clients seen by Sida-funded channels so can be directly attributed. See section effectiveness 4.3.1 In some instances MSIA reports refer to outcomes in more general terms, for example, "Increase access to quality SRH services across 19 provinces and 43 centers in Afghanistan", then Sida is not the only donor funding projects in those provinces and are thus sharing the results.

It must also be noted that other donors contribute to MSIA and are interlinked with Sida contributions and work. See also 4.3.5.

4 Findings

In each sub-chapter below, we present the different evaluation criteria where each evaluation question is presented, followed by supportive information and a findings statement that responds to the question. The boxes with summary of findings present the overall findings per evaluation criterion.

4.1 RELEVANCE: IS THE INTERVENTION DOING THE RIGHT THING?

4.1.1 To what extent has the programme objectives and design responded to the needs of women and men and how has it strengthened reproductive services in Afghanistan27? Has the programme continued to do so now that the circumstances have changed?

The programme objectives are relevant to the needs of women and to some extent to men and respond to Sida's strategic objectives in Afghanistan. MSIA's focus is on communities and their needs, including in remote areas where public services are less present and accessible and where the Taliban has a strong presence since the beginning of the programme. Security issues were already present, including how clients could get access to services and notably FP.

The field data demonstrated a considerable knowledge gap among rights-holders in general on FP choices and their application, which requires broad outreach strategies, tailored awareness raising, and key decision makers and advocates for FP to be involved, which ultimately would lead to behaviour change. Document data show that activities related to awareness raising were limited. It must be noted, however, that with the Taliban takeover, there are significant constraints on awareness-raising activities. All public spaces which previously allowed for reaching women and girls in the segregated congregations are closed (e.g., schools, universities, bath houses, parks and female mosques).

The relevance of the programme is based on a combination of these factors to which MSIA applies a high level of flexibility without losing sight of women needs that can change over time, the need to involve members of the community and to have services close to these communities, including mobile practices. The programme focuses on

[27] This includes assessing the opinions on needs by MSIA staff, the beneficiaries, community leaders and other important stakeholders such as humanitarian actors, Sehatmandi service providers or UN agencies.

women and married girls and their right to informed decision on their reproduction, which is highly relevant in the Afghan context. The applied gender approach is assessed as sensitive and limited (See 4.5.1). MSIA has operated within what they assess as possible when it comes to gender equality, which means providing SRH services to women, and to employ female staff. The services target women who have a subordinate position in society, men are targeted to ensure approval of services to their wives or other female relatives. To further ensure women's access to SRH services, including FP, MSIA seeks approval and acceptance from religious and traditional leaders in the communities served by the clinics.

The programme is also relevant to the health sector and was so in particular before the Taliban takeover. It provided essential services where public services were lacking. Moreover, it was contributing to the sector through training and curriculum development (knowledge building), using the existing referral system and sharing results.

Some activities were not implemented or partially implemented due to COVID-19 and the regime change.

The regime change meant that some activities had to stop (see 4.3.2 below). The strengthening of SRH services in Afghanistan has a strong focus on providing the services to those who would otherwise not have the option to FP. The programme's contribution to SRH services during the previous regime was not used to raise claims on what the public system should provide. In the current situation, where the Taliban is in power this needs-based approach has evolved, and **the relevance of the programme and its contribution is now in the context of a humanitarian crisis.**

Consulted donors confirm that the Taliban takeover has caused similar problems to health workers and due to the worsening economic situation, weak public systems and increased demand for services, including more need for SRH services. **The clear message is that in such restricted circumstances MSIA's work becomes even more relevant and necessary.**

The design of the programme remains relevant (MSI's objectives and approach, the implementation using CHWs, MS ladies and referrals) but new realities and responding in a flexible way to the externally caused changes became paramount. MSIA also provided other health services to respond to additional needs which should not compromise the goal of bodily autonomy of women and girls through qualitative and demand driven FP, including access to post-abortion care'[28], and other SRH services.

[28] According to UNICEF unsafe abortion is the main cause of maternal death.

The design is based on what can be accepted given religious and cultural norms and what the most relevant way to engage is. Moreover, MSIA is sensitive to whether they are wanted and accepted, and the programme design includes relevant elements of awareness raising.

MSIA has proven a high level of creativity to adapt language and approaches to FP without losing sight of the original goals. This was confirmed by interviews with MSI and MSIA also to offset any risks to MSIA's work. This has been a challenge given that most community health workers have a narrow understanding of FP and gender equality. This is also proved to be true for some of the clinical staff, who demonstrated that they have more of a mother and child health perspective, rather than promoting women's ability to choose and to have access to birth control options. Interviews, however, confirm in particular the *growing* need for FP in combination with returning clients who have found their way to MSIA services. The drivers for such need are a combination of poverty[29], created demand through the (mobile) clinics, the support from community leaders and that services are free. See also added value below 4.2.3.

The relevance of the programme is also assessed against Sida's comprehensive approach to SRHR, and expectations on partners to apply a transformative or at least responsive approach to gender equality and HRBA. **The evaluation finds that MSIA has a satisfactory and probably the only possible approach to SRHR** in current Afghanistan**.** The broader mother and child-oriented services allow MSIA to continue to provide FP, but it will be important to ensure that attention to FP stay as high as possible to remain a relevant partner to Sida's focus on SRHR as a standalone right, and as a means to promote gender equality. [30]

Box 1: Summary Box on findings Relevance

- The programme objectives are relevant to the needs of women and to some extent to men and respond to Sida's strategic objectives in Afghanistan.
- The programme is relevant to the health sector.
- The relevance of the programme and its contribution is now implemented in the context of a humanitarian crisis.
- The design of the programme remains relevant.
- MSIA has proven a high level of creativity to adapt language and approaches to FP without losing sight of the original goals and thus remain relevant.
- The evaluation finds that MSIA has a satisfactory and probably the only possible approach to SRHR assessed against Sida's comprehensive approach to SRHR.

[29] The data show repeated references to 'poor' people which is not elaborated upon by MSIA. Poor can be understood and perceived from difference perspectives and also be a stigma in itself.

[30] MSIA's mission remains unchanged and will be focused on SRHR.

4.2 COHERENCE: HOW WELL DOES THE INTERVENTION FIT?

Interviews with different stakeholders in the four provinces confirm that the needs are high and that MSIA fills a much-needed gap in particular in areas where clients have limited access and where clients are poor so other services they cannot afford even if they were available. More recently women also come to clinics for other services than those related to FP. This was already the case in 2021 but now they also come with children and other health care needs outside of the remit of the MSIA services and clinics. MSIA will refer women to specialized hospitals in case they need further treatment, including for mental health services, nutrition, or any other services not included in MSIA's package of services. More women are now coming through this channel, beyond those solely looking for SRHR services, and this is expected to continue as the situation continues.

The data, however, question to what extent clinics could deal with some of these issues – to the extent possible-given that most women are poor and face considerable challenges. This implies that adjacent services may become more prominent. It is not clear what the cause is, but various interlocutors pointed to the regime change and the effects on women and their families in general and mostly the increasing poverty levels. Given the latter MSIA has become an extension of public services but with a relevant mission on SRH and women's reproductive health in a context where the regime leadership has not provided any support to tackle the increasing challenges other than approval for MSIA to offer services.

4.2.1 How compatible has the intervention been with other interventions in the country?

The programme is compatible since it provides services to those in need and is an extension of the public services. It collaborates through referrals in the health chain.

Data to answer this question has been limited due to the fact that the evaluation was not able to get a relevant overview of the key actors that would be considered compatible within the public sector, the humanitarian cluster system or combination of these two. Interviewees (external stakeholders and MSI) to the extent that they could comment on MSI and MSIA brought forward several points:

MSIA is meeting needs of clients in the SRHR area and supplements where access to public services is limited particularly in remote areas and areas where the Taliban had a strong hold for a long time and fewer INGOs were working. Also, the number of 'poor people' serviced may imply that they would not have access to private clinics if they were available.

There is a working relationship with the public sector health facilities under health clusters and notably the referral system where MSIA can refer clients. This has,

however, deteriorated since August 2021, though most consulted clinics confirmed that they still refer clients to the public hospitals.

MSIA contributed to capacity building in the public sector through both sharing guidelines and contributing to curricula development, and through inviting public health workers to trainings, but this reduced after the regime change. In fact, the (KIIs) with clinical staff showed that some of the clinics seem to have stop interactions with other health sector actors (public and private) totally.

MSIA is a member of the Health Cluster *of the UN humanitarian cluster system*. It collaborates with UNFPA and coordinates with UNICEF, UN Women and WFP but with limited results also due to the changed circumstances. MSIA is also part of the Afghanistan health cluster. MSIA is a member of various medical associations, including Afghanistan Society of Obstetricians and Gynaecologists (AFSOG) and NGO forums such as the Agency Coordinating Body for Afghan Relief and Development (ACBAR). Although some collaboration with other INGOs such as Médicines Sans Frontières (MSF), the Norwegian committee and Save the Children, existed there seems to be few other collaborations. The evaluation noted that there seems to be no coordination or exchange of information between MSIA and the Swedish Committee for Afghanistan, one of Sida's biggest partners, that has a large health component as part of their programme, including trainings of midwifes.

4.2.2 How does MSIA relate, coordinate and collaborate with other stakeholders working with SRHR and primary health care?

MSIA coordination and collaboration is limited. It is not very visible and known to other actors.

After the regime change it no longer collaborated with government structures. MSIA has an explicit approach not to work with government structures since the regime change. This also reflects Sweden's position where state building is no longer a priority but rather a focus on people who need services. Most donors to the UN organisations focus on support to the heath sector in the humanitarian context and consider MSIA as a complementary actor (also in future).

MSIA works in a vast humanitarian landscape with many actors mostly in selected provinces. Donors focus on both the public system and humanitarian assistance depending on the type of agency or programme. MSIA annual reporting provides (see table 1 below in effectiveness section) an overview of how many clients have been served that may otherwise not have been served given their proximity to communities and the long standing build up trust and relationship**. As such it serves communities on FP where government structures fail.**

The Embassy in Kabul has been closed and all operations are now managed from Stockholm, so Sida has not been in a good position to facilitate and coordinate as much. Sida is supporting a number of other NGOs in the health field and there is no evidence that these NGOs meet and coordinate with MSIA or vice versa.

MSIA collaborates with representatives from the public health systems (referral, training, coordination through provincial coordinators) but this is now limited since the regime came to power and due to donor sanctions on the regime. Due to the sensitivity of SRHR and the general hostility seen over the past months towards I/NGOs MSIA has taken a cautious approach.

MSIA is part of the UN cluster system. Active donors in the health cluster appear to all suggest that MSIA is not so visible while they know what MSI is doing in other countries (so MSI has a reputable name) but they don't know where they work and what their services consist of. Donors regret that MSIA is less visible despite the fact that MSIA participates in various clusters and task force meetings and has the staff to do so.

4.2.3 What is the role, value added and comparative advantage of MSIA in the Afghani context?

ROLE: MSIA fills an important gap in a vast country where SRH services and FP are insufficient. In particular in remote and rural areas where access is difficult, mobile clinics and MS ladies provide relevant services supported by creating demand for such services through community health workers, religious leaders and their wives and community mobilizers. Mobile clinics can reach out to those areas where clients cannot travel or come to the clinic. However, when MS ladies worked from home during COVID-19 some women may not have been reached due to their limitations on travel.

The focus here seems to be primarily on FP (birth spacing), to be able to control the number of children and their spacing is key for both women's health and empowerment process. However, **there is no evidence that the approach to creating demand for SRH services is put into a broader awareness of gender equality or a rights perspective**. Servicing particular communities in these areas implies that they fulfil a role where public services are lacking and private services are not affordable. Their role is affected by external factors, including increasing poverty of their clients who come to the clinic for other services than what MSIA can provide.

VALUE ADDED: Women to women services increases the level of trust and privacy. Men are not present during consultations. This has allowed the operations to continue. The KIIs did not provide any evidence of couples being served with psychosocial counselling. GBV can no longer be openly discussed since the existence of GBV is not accepted by the Taliban regime.

The services are free which is a key component since those living in remote and rural areas are affected by (growing) poverty and cannot afford private care. Moreover, clinics and MS ladies can organise referrals which helps clients enter the health chain for more complicated needs.

In terms of contribution to the health sector and SRHR, MSIA adds to extent the coverage of SRH services in Afghanistan and where public services falls short and private care is unaffordable. Moreover, the fact that donors stopped funding the about

2500 health clinics after the regime change affects the demand. MSIA, may therefore also respond to an overflow of patients who cannot be longer served in public health clinics.[31] There are a few examples where public clinics refer to MSIA clinics, but this is an exception.[32]

COMPARATIVE ADVANTAGE. The team had limited access to other providers in the health sector. Data indicate that the added value is greater than the comparative advantage and notable in providing service where the public sector falls short. MSIA's capacity statement from 2022 states that: "We estimate that more than 10% of the total demand for voluntary birth spacing[33] in Afghanistan in 2021 was satisfied by services supported by MSIA, contributing to an increase in the modern contraceptive prevalence rate."[34]

4.2.4 In what ways has MSIA used its capacities within and beyond the program, for example for strengthening other partners and the broader health care system?

There is limited evidence that MSIA has strengthened partners of the health system with Sida funding[35].

At the beginning of the programme the collaboration with government was regular and MSIA contributed through curriculum development, training and coordination. This has reduced significantly since the regime change. In fact, the **limited** interactions have been driven by donor requirements (as a result of sanctions) of not recognizing the 'de-facto' regime. MSIA sustained implementation were possible with recognizing the donors' sanctions. Collaboration with and contribution to the public sector is therefore limited. MSIA's own capacities have also been challenged and notably staff turnover, which is continuous, including people who left the country. There is no evidence that partners have been strengthened. Due to donors suspending aid MSIA is most likely responding to needs that would otherwise by met in the public system.

---

[31] Maintaining access to quality sexual and reproductive health services and products in Afghanistan, short programme proposal for the extension period 01-0-2022 until 31-12-2022.

[32] MSIA has 17 satellite clinics (1 of which is funded by the SIDA project) which are MSIA clinics nested within public hospitals. This has proved to be a successful approach to ensure women have access to a range of quality FP and PAC services within a generally under-resourced public hospital. It also allows MSIA to benefit from footfall, and the public hospitals to be able to focus on delivering other essential services.

[33] Demand satisfied is calculated by dividing mCPR by total demand. Total demand for FP is calculated by adding mCPR + unmet need.

[34] MSIA Capacity Statement, page 1.

[35] The evaluation team take note that this aspect raised by Sida in the evaluation was not part of the programme objectives. MSI informed that "MSIA's health system strengthening work is predominantly funded by other donors and has been scaled back since the Taliban came back into power. It was not a significant component of the SIDA project."

4.2.5 How could the health sector learn and make best use of MSIA's knowledge and experience?

This question could best be answered by making it reciprocal given the current context: what the sector can learn from MSI and MSIA and what can MSI and MSIA learn from the sector since they both need each other.

MSIA's work on FP and the method used to reach out to the most marginalised and vulnerable women deserves to be shared and further developed in the new context, including reaching out to an increasing number of clients most of whom face increasing poverty.

The humanitarian situation and regime change has put serious restraints on some of the outputs and precisely those that are sensitive: gender equality, human rights and thus advocacy through media and counselling, for example. It has been impossible to continue such activities while MSIA also adapted. For example, the counselling continued under general terms but the support they provided to women in prisons had to be abandoned. The interviews show that MSIA has been 'thrown back to core functions' such as FP and community mobilisation and that activities related to gender equality have not been continued due to the restrictive ad challenging political context for SRH. Interviews with CHWs refer to community mobilisation as being in line with 'Islamic teaching', in other words what is acceptable and birth spacing is the most common concept used to refer to FP.[36]

Box 2: Summary Box on findings Coherence

- MSIA has become an extension of public services but with a relevant mission on FP and women's reproductive health.
- MSIA contributed to capacity building in the public sector through both sharing guidelines and contributing to curricula development (only year 2019)
- MSIA coordination and collaboration is limited. It is not very visible and known to other actors.
- MSIA fills an important gap in a vast country where SRH services and particularly FP are insufficient. There is limited evidence that MSIA has strengthened partners in the health system.

[36] MSI developed Guidance for health providers: Islamic teachings on maternal and reproductive health, no date not on the website. "Numerous Islamic academics and practitioners have written on the topics of reproductive health, family planning and safe abortion. In every context these issues are sensitive and complex, but across the Islamic world we are increasingly seeing an emerging consensus informed by the desire to protect and promote the health of women and children. Clarifying and amplifying these teachings and interpretations is important to both facilitate the delivery of lifesaving services and to counter some of the prevailing misinformation, stereotyping and assumptions that can prevent people from seeking and receiving care. To support these efforts, we have undertaken a literature review and condensed findings into a format that we hope will be useful for our providers, and the community organizations and policy makers with which we work, bringing in examples and recommendations from religious leaders and healthcare providers from across the Muslim world". First page.

- Value added is that MSIA's services create trust through female-to-female services and are free.

4.3 EFFECTIVENESS: IS THE INTERVENTION ACHIEVING ITS OBJECTIVES?

4.3.1 To what extent has the intervention achieved its intended results (from the original proposal/log frame)? Which intended results were achieved / not achieved? Why?

The programme has achieved limited results in the second and third year of implementation while the first year of implementation was far beyond expectation. The contrast is stark and remarkable due to:

1. The emerging effects of COVID-19 and the regime change that led to cancelling a number of activities or not starting them (media activities, advocacy, parts of couple counselling, work with teachers.).
2. Activities that changed (location, focus, staff turnover, some of the Sida-funded sites were temporarily paused after mid-June and July 2021 due to the ongoing conflict before the fall of Kabul to the Taliban).
3. Leadership change and the creation of new, relevant positions at the MSIA office in Kabul.

The table below summarizes results based on various data sources: i) MSIA's impact modelling which uses a specific methodology (which the team could not verify) and which is used for overall annual reporting; ii) the annual reports provide client data per outcome which the team added. The impact modal refers to *estimates* while the reporting against outcomes and the overview do not always correspond with the estimates. The team has no means of verifying how programme results contribute to the impact modelling. The results framework has been heavily impacted by COVID-19 and regime change and it is actually questionable what the team can say about this. The results framework has also weaknesses (lack of sufficient indicators, for example on behavior change) that do not allow for detailed monitoring relevant to the outcomes. We have therefore reported how many of the indicators have been met, underperformed or performed beyond the target.[37] See Annex 10 for a full overview.

Table 4: Results per year from MSIA annual reports

Years	Target	Actual	Results	Client numbers
2019				

[37] For a full overview of the different data sources used see Annex 10 and for an overview of results against the results framework, see Annex 9.

Outcome 1: Unintended pregnancies averted*	12,148	84,946	699%	115,216 total of which 68,994 (60%) were (FP) and (PAC) 28,228 (25%) were clients under 24 years old. 2,323 clients received psychosocial counselling in Herat and Balkh.
Outcome 2: Unsafe abortions averted*	4,756	1,1680	24 %	
Outcome 3: Maternal deaths averted*	11	470	427%[38]	
2020				
Outcome 1: Unintended pregnancies averted	28,004	23,784	85%	77,318 client visits for FP and PAC, 6% of these visits being from adolescents aged 15-19 years old. 327 clients with psychosocial counselling in Herat and Balkh.
Outcome 2: Unsafe abortions averted	9,247	9,591	104%	
Outcome 3: Maternal deaths averted	24	19	79%	
2021				
Outcome 1: Unintended pregnancies averted	28,004	15,334	55%	52,469 clients visited for FP and PAC services, with 15% of those visits coming from teenagers aged 15 to 19. 7,039 clients psychosocial counselling through psychosocial therapists in the provinces of Herat and Balkh.
Outcome 2: Unsafe abortions averted	9,247	5,380	58%	
Outcome 3: Maternal deaths averted	24	8	33%	

The first year the performance is well beyond expectation and it plausible that the subsequent years would have shown continued progress if the external factors had not occurred. The data clearly demonstrate how the programme has been affected in first instance by external factors (COVID-19 and regime change) as well as by internal factors (staff turnover, leadership change, underspent of resources). There is an overall decline in results from 2019 onwards. The number of clients that received psychosocial counselling increased significantly in 2021. The team could not verify this upward trend.

[38] These percentages were not provided in the annual report and added by the team for comparison.

Data from Interviews suggest that despite the decline it has been remarkable that MSIA has been able to continue operations in what are considered exceptionally challenging circumstances. They are of the opinion that the team and MSIA have been resilient to withstand these shocks and continue operations.

All provincial coordinators interviewed, and most consulted clinical staff shared that the number of clients has progressively increased since it was clear that the female clinical staff could continue working, and that they see that they are reaching the client level as before the COVID-19 pandemic and the regime change. However, it is worth noting that many of the respondents said that there was no major difference before or after the regime change, that they have continued to provide the same kind of services. That is somewhat contradicted with the reported numbers that show a significant decline in served clients and desired quantitative results. It is plausible that the COVID-19 effect had a prolonged effect on the number of clients coming to the clinics.

ADDITIONAL DATA ON RESULTS

Awareness raising is effective but not developed from an HRBA

The interviews provide evidence of quality and much appreciated services. Despite the challenges in the context, the clinics have been able to operate. Main issues have been to maintain the desired level of quality through shortage of medicine, and in some clinics lack of equipment like for instance for ultrasound. Clients confirm good treatment, that privacy is respected, and that they have been helped with their health issues. The KII provided evidence of awareness among staff on client-oriented services, and some of the clinical staff shared that they had recently been trained in safeguarding principles. However, they had no notion of rights-based working methods and were neither exposed to a rights-based approach to staff from MSIA. (See section 4.5.2 for discussion on HRBA).

It was not possible to assess if awareness raising on FP options was based on a rights of women's empowerment discussion (women have the right to know about the options for their own sake, make free choices about her body, and decide what is best for her health) since details on how the first counselling with women was not explained. However, the responses from both clients and clinical staff indicate that FP was rather phrased as an issue of the wellbeing of the family and healthy mothers. It is logical to use this discourse in external communication but the discussions with the women could still be based on women's rights to decide over their own bodies. Particularly since consultations take place in a private space and from female to female. As discussed under relevance the clinical staff seemed to lack that level of gender awareness.

All consulted clients that had visited the MSIA clinics for some time, shared stories of how the information they received at the clinic raised their awareness both about family planning options and how to plan for wanted pregnancies. Quite a few also shared that their children had also been attended to.

Yes, I am observing a longer gap between births compared to before so that my health and psychological problems are reduced, and we are doing this with the consent of our husbands. (KII with woman visiting MSIA clinic)

Compared to the past, my life has changed a lot. Before I use to have a child every year, but now I have complete information about FP, and I use it for space between births. Now I and my children are healthy, and we can have a stable economy. (KII with woman visiting MSIA clinic)

Awareness raising and mobilisation of women adequate but role of men limited. The consulted women visiting the clinics said that they had support from their husbands and families, and most had relatives also using the services of the clinic. Though they said that the husband and mother-in-law were supportive of them using FP, all also said that it would be good to have more targeted activities towards the men, and also the mothers-in-law, for them to be better informed. Something the evaluation team understands that there might be both knowledge gaps and levels of resistance to the woman's freedom to make her own choices for her body.

I want them to give our husband and mother-in-law separate training so they also have complete knowledge about these services. (KII with woman visiting MSIA clinic)

CHW's also felt welcomed by communities and supported and men, including religious leaders, were open to their work but all within the context of their position in society and Islamic teachings. Several references were made to religious leaders mentioning women's health in their preaching.

CHW's skills and role are limited other than motivating women to come to the clinic with approval of husbands.[39] Related to targeted awareness-raising actions, is the outreach work of MSIA. Among the clinical staff it is only the staff working at the mobile clinics and the MS ladies that interact directly with the community in a broader sense. Staff at the clinics informed that they only meet those clients that come to the clinics, among the 30 interviewed clinical staff only one shared that she sometimes works outside the clinic.[40] The community health workers and other supportive community members provide only very general information, support women to get to the clinics, but do not have the capacity to provide a more in-depth awareness raising on SRHR and women's and girls' rights. Normally they have a low level of education and have not been trained to be peer-educators but play more the role as the link

[39] The SIDA project has 250 CHWs. CHWs are usually placed by MoPH close to other health facilities but this is not the case for CHWs supported under this programme. Instead, they work in remote areas at the request of community leaders.

[40] MSI informs about the practice of health shura, or health committee, conducts meetings at the clinic level to share feedback and discuss MSIA services. MSIA service providers are connected to mothers-in-law, youth, and elder women of the community. MSIA service providers are conducting BCC sessions and health awareness to these groups at the MSIA sites. However, this information was not shared by the consulted clinical staff. In the annual reports the meetings are referred but not the expected behavioral change.

between the clinics and the community. The interviews with community mobilizers and religious leaders and their wives confirm this. The lack of information material and other tools (unfortunately not specified in the interviews) and the confidence to discuss SRH issues beyond informing that the services are available at the clinic are a missed opportunity to increase awareness.

Services are relevant to clients and of considerable quality with some difference among provinces. In addition to the evaluation team's KIIs with clients, MSI shared a recent survey on client's satisfaction with provided services[41]. The survey results showed that "clients were pleased with the quality of care and their experience, except for one instance in Kabul province." Just over 90 % of respondents said they were "very satisfied" and 7 % rated it as "satisfied". 88% of respondents stated that they were "very likely" to recommend MSI and 6% rating it as "likely".[42] The survey just like KIIs states that the women were happy with the quality of care, the security and safety measures and the respectful treatment they received from MSI staff. One important data from the survey, not captured in the KIIs was that "clients noted that their providers communicated with them in a language that was easy for them to understand"[43]. The survey report notes that there were differences between provinces and that the clients were less satisfied in Kandahar, Helmand, Kabul, and Herat, the last two being provinces included in the sample of the evaluation.

Another interesting result of the survey is from where the women heard about the services. Just like in the KIIs the main sources were previous clients, relatives and neighbors. Out of the 93 total responses, those options corresponded to 65 responses, 15 had been informed by CHWs, 9 through promotional materials, 3 through television and 1 from social media. The fact that only 16 percent stated that they had received the information from CWH raises questions on the effectiveness of their work.[44]

Gender awareness is often equalled with service providers being female rather than position of women in society and gender equality. Overall, the Provincial Coordinators (PCs) were happy with the results and did not see any major changes from before or after the regime change. They rather stressed the negative effects COVID-19 had on the services, affecting both staff and clients. They shared that they continue as before, that staff has been trained on various matters and saw no capacity gaps among staff. The PCs said that it is important to stress that MSIA reaches women who do not know anything about FP, which means that they need to start from scratch but also that

[41] CEI survey is a standard MSI survey that is being administered annually across all MSI partner countries including MSIA. Client Exit Interviews Summary Report MSI REPRODUCTIVE CHOICES AFGHANISTAN, January 2023.

[42] Ibid.

[43] Ibid.

[44] In order to address this issue, MSIA re-allocated one mobile health team to the Chantal district, where most of the CHWs are located. The mobile health team connected with CHWs and through close coordination provided SRH and FP counselling and services in the mentioned district.

they reach some of the most vulnerable women. They saw gender equality mainly to be about employing women and provide services to women by women. However, some demonstrated a deeper gender awareness, e.g.: "*In my opinion, women are a marginalised group in the country; they are suffering from all kinds of deprivations. While they are also human, and they have the same right as others, especially health-based rights. They should have full support in this sector." (KII with PC)*

MS ladies are an effective link between reaching clients and the services MSIA provide, including through clinics. The MS ladies conduct an impressive work, reaching a large number of women both with services and information. They are well connected with the communities. They used to *"go door by door to help and counsel people"* as one MS lady phrased it. They now offer services from their own homes. This could be a good alternative able approach, but it also means that women with little or no freedom to leave their homes might not be reached.

The MS ladies confirmed that they get support from community leaders: *The religious and traditional leaders have fully supported us. They announce and preach about the services we provide. Their own family visit our home too. (KII with MS lady).*

As with the clinical staff, the MS ladies saw the benefit of the services mainly from a family perspective though they stressed the importance of women having good health:

When a mother knows about her FP, she raises her children well. And this makes opportunity for good education and education brings change (KII with MS lady)

Their life changes, their mind change, mortality decreases, and they know about their health. (KII with MS lady).

4.3.2 In what thematic areas, regions and components has the program been most successful and what are the reasons for success and failure?

The programme effectively targets women in remote areas and to leave no one behind.

While the programme has been significantly affected by COVID-19 and the regime change it appears that the combination of components responds well to MSI's strategy. MIS's overall mission is "By 2030, no abortion will be unsafe and everyone will have access to contraception." The strategy has 6 goals and in particular goal 1 'leave no one behind' resonates strongly with MSIA and with three components: i) increase access to the last mile beyond the reach of national healthcare systems, ii) establish public sector partnership models to transition towards national SRHR, and iii) expand access to adolescent sexual and reproductive health care. The collaboration with the national health system has been minimised except for referrals.

The programme targets youth to some extent

The focus on 'youth' has been mentioned a few times. Table 4 provides an overview of the client age groups that come to the clinics and for the years 2019 it was 25 % under 24 years of age, for 2020 it was 6% (age 15-19) and for 2021 15% (age 15-19). The Results Framework shows an increase in the percentage of center clients "adolescents". External observers noted that MSIA's focus on youth – also due to increased child marriages – would be an important area to focus on.

The team could not determine significant variations among provinces. The KIIs across the stakeholders show a high level of similarity.

ToC. The programme builds on various elements: having the services available through trained staff, including mobile clinics, clinical work, mobilising the community meaning creating demand for these services and focussing on those that cannot afford the services and have no knowledge about their options for FP. The different elements reinforce each other in design as the ToC demonstrates but the linkages between service provision and mobilising the community have various shortcomings and notably *the prevention element* reducing women's risks to unsafe practices (see numbers in table 1); the *gender component* providing women with awareness about their health rights; and choices about the reproductive lives. MSIA's proximity to the communities, however, and building up trust creating safe spaces for women in clinics is available which reinforces opportunities for more women to come to the clinics. The data confirm this that woman to women mobilisation is stronger than the CHW's role for example. The team could not verify to what extent rights holders have an influence on the design of the programme.

The ToC assumptions have been affected and notably the assumptions that government structures would support MSIA work.

4.3.3 To what extent have MSIA reached, included and achieved results for specifically vulnerable groups and groups that are stigmatized in the society?

Evidence on targeting the so-called vulnerable groups is limited and the concept is not sufficiently elaborated upon in terms of different and intersecting forms of discrimination. The general use of "poor people" made it difficult to assess to which extent deliberate actions to reach the most marginalised women had been employed. As a result, the role of CHWs on identifying such groups is limited.

MSIA does not record such data on clients yet evidence from interviews on women with disabilities, poor people and refugees suggest that these are reached out to. However, there was no evidence on deliberate strategies on how to reach groups discriminated against and persons with disabilities were only mentioned on direct questions from the team. When describing who they serve, clinical staff, CHWs, MS ladies and PCs referred to 'poor people' and refugees. For Nangahar the so-called refugees come from other provinces and are Internally Displaced Persons (IDPs) putting additional pressure on the available clinics and staff. There is no evidence of an

approach on how to deal and motivate persons with disabilities and what their specific needs are.

The evidence here is weak in terms of what is considered a disability which could also imply that CHW need to overcome those that suffer from stigma's.

4.3.4 To what extent was the chosen implementation strategies effective?[45] Was the program implemented in a conflict sensitive manner?

The implementation strategies combined demonstrates that various ways are effectively used to increase SRH services notably to those who may otherwise not be reached but knowledge and skills to deliver in a humanitarian context vary considerably.

Through Sida's support, seven centres, four mobile health teams, 250 CHWs and 13 MS Ladies are providing quality services to women and girls in Afghanistan.[46]

As the ToC outlines there is a demand and supply to the services in which creating demand for services play a vital role in ensuring increase in SRH services to meet the three goals of MSIA (reduce maternal deaths, reduce unwanted pregnancies an unsafe abortions). **Working with critical persons in the community who can mobilize women is a relevant approach but its effectiveness is limited CHWs and religious leaders having limited knowledge about FP.** Using a variety of delivery channels, however, enables MSIA to better reach women and girls from diverse areas. The mobilization also includes referring to MSIA clinics for services that they cannot provide, such as long-acting and permanent methods (LAPM) and PAC. There has also been outreach to other partners such as teachers and Madrassa schools and while the number of people reached are reported there is no evidence on how this has contributed to awareness, prevention and demand. Clinics have client boxes for feedback but with a high illiteracy levels and lack of knowledge the feedback may not contribute to increased effectiveness. What appears effective is the snowball effect that women have on other women and that birth spacing may not only be relevant to women's health but also to the increasing poverty conditions families experience.

In terms of the chain of services in a hierarchical system the MS ladies appear critical in terms of their knowledge and skills yet they are few given the growing community needs.

[45] That includes: the partnership approach (working with religious and community leaders etc.), the implementation modalities; i.e. training of community health workers, MS Ladies, satellite centres, working in schools etc.

[46] Please note that these numbers changed due to staff turnover and effects on clinics since the regime change.

There has been no conflict sensitive approach in a formal sense rather MSIA reacted to changes in Taliban strong hold provinces based on what they could do or not which led to reduced services, stopping with mobile services in some instances.[47] In some cases, it also took considerable effort to convince the authorities to continue their work being subjected to a high level of arbitrariness. In addition, MSIA has applied a risk lens to all its work avoiding any confrontation that would undermine its operations, including low visibility and downplay references to 'gender' and 'human rights-based' work.

4.3.5 Has the M&E system delivered robust and useful information that could be used to assess progress towards outcomes and contribute to learning?

The M&E system has some shortcomings. There is no traceable relation between the outcomes and the overall objective of the programme

The main issue with the Results Framework is that the indictors to assess progress are not very robust. For example, at community level only the contribution of one key actor, the religious leaders, is monitored while the effect of other actors' work (MS ladies, peer educators, etc.) was not monitored through the indicators. In addition, reporting is not consistent with indicators as activities changed over time and the framework or annual reports lack further explanation other than the effects of external factors. There is no link among the three outcomes and the objective of the programme. Moreover, if there are other donors to the country programme then this needs to be considered. While the impact tool MSI uses helps monitor and understand high-level impact of MSIA's contraceptive and PAC service provision, such as the number of maternal deaths averted and cost savings to the public health system, it does not correspond logically with the results framework and may be better used separately. The tool is a relevant way to demonstrate MSIA's contribution to national family planning and broader health outcomes to advocate for enhancing access to FP and PAC with government and other key stakeholders.

The assumptions of the results framework have not held to the extent that support from governments structures was no longer the case after the regime change, media outlets closed, MSIA's services were interrupted by security concerns, and commodity supplies were interrupted. The assumption that religious leaders would continue to accept MSIA's services could be questioned since the above discussion as well as section 4.5.1 and 4.5.2 shows shortcomings in gender equality and human rights-based approaches. MSIA, however, states that the religious leaders MSIA works with are allies and therefore it can sustain SRH activities in a highly conservative environment.

[47] Conflict sensitivity is an approach to ensure that interventions do not unintentionally contribute to conflict, but rather, strengthen opportunities for peace and inclusion.

The monitoring of changes and other shortcomings of the results framework

KIIs confirm that all staff report to their superior but that this could be improved, including their capacities. It appears that there is no focus on reporting on how approaches work while such training was provided. The CHWs, amongst others, cannot report on anything related to gender (apart from that they have a significant number of female staff) since they are not aware and have no knowledge of gender equality or human rights. This is a serious shortcoming. In the results framework, indicators were missing to measure the progress of some of the outcomes, and some of the planned work was not captured in the outputs.

As noted in 3.5 other donors contribute to MSIA and have interlinked activities with Sida funded work which reinforce results or lack of results. For Sida to fully understand how its support leads to results it would be beneficial to report on such activities and results.

Box 3: Summary Box on findings on Effectiveness

- The programme has achieved limited results in the second and third year of implementation due to the political context while the first year of implementation was far beyond expectation.
- Evidence on targeting vulnerable groups is limited and the concept is insufficiently elaborated upon in terms of discrimination and does not include a HRBA perspective.
- The programme effectively targets women in remote areas and to leave no one behind.
- Awareness raising and mobilisation of women is adequate but the role of men limited.
- The implementation strategies combined demonstrates that various ways are effectively used to increase access to FP but knowledge and skills to deliver in a humanitarian context vary considerably while the project was not designed nor was it intended to be a humanitarian project.
- The Results Framework has some shortcomings: indicators are limited and some outputs could be better defined and measured. In addition, other donor's contributions have an impact on Sida's funded work.

4.4 EFFICIENCY

4.4.1 Were the implementation methods cost-efficient?

The methods for implementation were cost efficient but bank transfers and cash withdrawals caused significant delay beyond MSI/MSIA control. The cash flow transfer affected all agencies working in Afghanistan

Funds were received in time from Sida. There has been considerable issue with bank transfers to Kabul. After the takeover of Kabul by the Taliban, the banking services were no longer available, and these services were almost closed across the country. The limitation on cash withdrawals has had a negative impact on MSIA operations—and perhaps a life-threatening effect on the lives of many Afghan women and girls,

affecting their access to SRH services.[48] MSI has had to change its systems for transporting funds to Afghanistan in order to pay employees, activities, and operational costs as a result of this.

MSIA implemented a well-defined risk mitigation approach, lowering the security risk to its employees and clients.

There were no reasonable alternatives to the underspend in 2019 due to COVID-19 and the regime change which caused delays, lack of timely access to commodities, not implementing activities due to safety risks and political uncertainties. With the support of the MSI headquarters, MSIA installed COVID-19 control measures and rolled out safety practices.[49] It also considered relevant security risks and took mitigation measures.

COVID-19 affected the number of people coming to the clinics negatively but MS ladies managed to work from home and the effects were mitigated to the extent possible.

Interviewees mention that as a result of COVID-19 clients were hesitant to come to the clinics due to health risks. There are, however, recurrent issues such as lack of resources to pay for transport that have affected the demand for services. This is region and district specific, though. MSIA has in many instances put in resources and means to reach poor communities through mobile clinics, including community mobilizers. The regime change has also affected the demand for services and notably uncertainty emerged when a decree was issued that women need to be chaperoned to travel and certain professions could no longer be performed by females. The uncertainty was to a large extent resolved when the health sector was exempted and MSIA received official notice that they could continue their services. Both COVID-19 and the regime change did also affect the female staff who continued their work from home and managed to continue delivering services. This could imply, however, that some women could not be reached who were not in a position to travel to a MS lady who was working from home. COVID-19 also had an effect on the delivery of commodities and the supply was interrupted due to cuts in the supply chain. In particular the supply of condoms was affected. Unlike several other organizations, MSIA did not suspend services during that time.

Staff turnover affected the implementation of the programme

Staff turnover has been a challenge to implementing the programme but this is not unique to MSIA. The original number of staff changed over time but no accurate numbers are available. All MSIA's master trainers have left the organization in 2020. To offset this MSIA plans to contract other national trainers present in the country who

[48] MSIA Annual Report, 2021, page 19.

[49] MSIA, Annual Report, 2021, page 20.

are currently working with other organizations. A training plan based on needs assessments was developed.[50] The staff turnover is a continuous problem that MSIA is suffering from.

MSIA improved its internal systems, including financial reporting and hired an accountant in 2020. Sida has questioned MSIA's reporting over the years and MSIA responded satisfactory.

Box 4: Summary of findings on Efficiency

- The methods for implementation were cost efficient but bank transfers and cash withdrawals caused significant delay beyond MSI/MSIA control.
- COVID-19 affected the number of people coming to the clinics negatively, but MS ladies managed to work from home and the effects were mitigated to the extent possible.
- Staff turnover affected the implementation of the programme and continues to do so.

4.5 OTHER QUESTIONS:

4.5.1 Has the project had any positive effects on gender equality? Could gender mainstreaming have been improved in planning, implementation or follow up? How has the project dealt with psychosocial harm?

The findings show that the programme has contributed to improve women's access to reproductive choices and SRH services, which are fundamental rights and important components in the strive towards gender equality and women's empowerment. However, the effect is limited to create conditions for gender equality, which is assessed as what is possible given the challenging context. The subordination of women with regard to make independent choices concerning their reproduction and bodily autonomy remains as before, but the access to SRH services and the possibility to make informed decisions on which FP methods to use, and the possibility to space pregnancies and births, contribute to women's better health and create better living conditions for them and their families.51 The services are mainly rooted in a perspective of mother and child and the wellbeing of the family, and not with a focus on women's rights to bodily autonomy. This is of course a pragmatic choice made by MSI/MSIA based on what is possible in the Afghan context. However, as discussed above, one thing is how the rationale for SRH services is communicated externally, another thing is how the programme is gender mainstreamed. The evaluation finds weaknesses both in the gender analysis, the implementation and monitoring.

[50] MSIA Annual Report, 2021, page 19.

[51] The programme does not aim to challenge the patriarchy, but for women to exercise their reproductive rights.

The main reason behind this, according to the evaluation team, is the lack of a thorough discussions on what gender equality is about, and that the overall gender analysis did not translate into strategies how to integrate gender dimensions in the different programme activities. The evaluation recognizes the effectiveness in having only female staff at the clinics and the method to collaborate with the wives of religious leaders is strategic. But these measures are about navigating in a very patriarchal environment, with the purpose to enable the services. The programme is assessed as gender sensitive, but there has been no structured and strategic guidance from the programme management on how to gender mainstream activities, and there was no evidence of trainings on gender equality to staff or volunteers. Such trainings could both have enhanced the overall knowledge and application in gender mainstreaming and how to apply gender sensitive measures possible to the specific contexts and situations the female clients find themselves in.

The current context did not allow data collection on activities related to psychosocial harm. The reports on the operations prior to August 2021 contain very little data on this component and the evaluation team was not able to validate previously reported results with any couples or staff directly involved in those counselling sessions.

Box 5: Summary of findings on Gender Equality

- The findings do not indicate positive effects on gender equality.
- A lack of a thorough discussions with staff on what gender equality is about, and that the overall gender analysis did not translate into integration of gender dimensions in the different programme activities, demonstrates insufficient focus on gender mainstreaming.

4.5.2 Has the project been implemented in accordance with the poor people's perspective and a Human Rights Based Approach? Can it be said to have had a people centred design, with a focus on and based on input from the people needing the services?

The programme has not been planned or implemented from a Human Rights-Based Approach (HRBA) yet demonstrates some aspects of a basic rights perspective. The MSIA programme responds well to women's need for SRH services, though MSIA cannot always meet all demands relate to SRH services or medicine in all clinics. The approach is in accordance with poor people's perspectives and the programme design was confirmed by MSIA to be based on broad consultations with community members. It is also based on the lessons learned from a rather long period of implementation, and services are adapted to the specific realities in different provinces where MSIA operates. MSI/MSIA conduct regular client satisfaction surveys which provide important input to work plans and new programme phase according to MSIA Kabul staff. As discussed above the satisfaction of the women is very high, and the KIIs with clients confirmed that the clinical staff and the MS ladies have a good and respectful approach to them.

The rights-based principles of accountability, transparency, (meaningful) participation, and active non-discrimination can be both goals and principles that permeate the implementation and follow-up of programme activities. For obvious reason MSIA can no longer claim accountability or transparency of the government in power, but advocacy work was neither salient before the Taliban takeover though the results-framework includes advocacy issues. The main result in that area was the contribution to revision of the curricula, which of course is a key issue, and an indirect way to exercise influence.

MSIA aim to deliver services where there are gaps in public health service, but the service delivery has not been used to set example (this is how public health should provide SRH services) or when it was possible to influence the public health sector through training public health workers with the MSIA approach. Claims on the previous governments' accountability are not visible in the reporting.

When it comes to HRBA as a process, the evaluation finds the programme design to be built on rather hierarchal structures where each function operates on instructions from superior level. There was a lack of practice of participatory planning or monitoring with different staff. The KIIs did not evidence any articulated strategies how to counteract discriminatory attitudes and behaviors between staff or between MSIA staff and rights-holders. The consulted MSIA staff did not provide any examples of downward accountability through efforts to report back to the community of the progress of the programme.[52] The programme does not harbour a deliberate HRBA, though there are elements of rights-based principles put in practice, and the approach was an unknown concept to staff in the provinces. Consulted staff at the MSIA Kabul office demonstrated that they were familiar with the concept. **The lack of a deeper knowledge on gender equality also affects how human rights are understood.** As an illustration one clinical staff said that since the service is from woman to woman, there can be no discrimination. Though this is just one person's statement, it indicates that clinical staff might not have been involved in discussions on how power displays in different situations based on position, age, education, relationship, etc. It was obvious that staff are aware of the discrimination some wives are being exposed to from their mothers-in-law, so one could expect a similar awareness on doctor/nurse – client relations. It should be noted that several staff shared that they recently had been trained on safeguarding principles.

Box 6: Summary of findings on HRBA

- The programme has not been planned or implemented from a Human Rights-Based Approach (HRBA), yet demonstrates some aspects of a basic rights perspective.

[52] MSI shared that PCs report back to the community is done through the Health Committee/Health Shura). This has been conducted within the sites, and community elders are regularly participating in this committee.

- MSIA aims to deliver services where there are gaps in public health service, but the service delivery has not been used to set an example.
- When it comes to HRBA as a process, the evaluation finds the programme design to be built on rather hierarchal structures where each function operates on instructions from superior level.
- The lack of a deeper knowledge on gender equality also affects how human rights are understood.

5 Conclusions

Relevance

MSIA's work is relevant and continues to be relevant in the new context and notably now that public clinics are restrained. MSIA's contribution to SRH/FP in remote and urban areas is relevant and the relevance is growing due to increased poverty and demand.

MSIA provides important, lifesaving and much-necessary support to women's sexual and reproductive health and provides women with qualitative care and options for their family planning. The work is based on solid knowledge of the local contexts and adapted to the realities that limit women's reproductive choices. MSIA seeks acceptance from religious leaders and does not challenge societal norms directly, but the services provided open possibilities to make informed and better decisions on FP for the women MSIA reaches.

MSIA has a satisfactory and probably the only possible approach to SRHR assessed against Sida's comprehensive approach to SRHR.

Coherence

MSIA contributed to capacity building in the public sector through both sharing guidelines and contributing to curricula development (only year 2019).

MSIA coordination and collaboration in the health sector is limited. It is not very visible and known to other actors, although it interacts with some, and in particular since the regime change.

MSIA fills an important gap in a vast country where SRH services and FP are insufficiently provided for. There is limited evidence that MSIA has strengthened partners in the health system. MSIA, however, can service many clients who would otherwise not have access to FP services.

Effectiveness

MSIA's work has been less effective when looking at the three outcomes and has suffered from external factors which were not expected. The external factors could not have been anticipated and without them, the programme would have been more effective. Its contribution to the health system is – despite the challenges - effective in that it is an extension of SRH services that respond to needs of women who may otherwise not be served and cannot afford private health care.

MSIA contributes to increased awareness on FP at community level. The role of religious and traditional leaders, as well as community health workers is important. However, the evaluation concludes that information from women who already have received services at the clinics, play an equal or more prominent role in advising other women to seek support at the clinic. The CHWs do not have sufficient skills and knowledge to play a real peer-educator role in the community. Where there are mobile clinics and/or MS ladies there seem to be a stronger information outreach, but it is through the direct contact with the services that women first get qualified information about FP options.

It is clear that MSIA reaches underserved and hard to reach areas and that the clients are living in poor and hard conditions. The fact that the services are free play a crucial role for the accessibility of poor women. However, the overall strategies to leave no one behind does not translate into deliberate measures on how to reach those women and girls within the poor population that might face the biggest challenges in accessing the SRH services. This is also the case for people who may be discriminated upon.

Key services provided in clinics and through mobile clinics are critical to increase modern Contraceptive Prevalence Rate. MS ladies are effective and key in the chain of services, including the number of clients they can reach. Community mobilisation has limitations due to cultural and religious norms present in the community as well as the perceived status of women. Moreover, the CHW can motivate women to come to the clinic but there is no attention to gender equality or human rights and their knowledge about these approaches and SRH/FP is limited.

Awareness raising and mobilisation of women is adequate, but the role of men is limited: the latter have an approval role and emphasize women's health in general.

MSIA's reporting system - based on the results framework - is output based. The results framework has some shortcomings, including too few outcomes. In some cases, there are no indicators and the barriers to achieving results are not identified and measured. The absence of a ToC limits the understanding of how the different outcomes come together.

The implementation strategies combined demonstrate that various ways are effectively used to increase access to FP but knowledge and skills to deliver in a humanitarian context vary considerably.

Efficiency

Given COVID-19 and the takeover of the Taliban in August 2021, the management of MSIA in Kabul has responded as best as it could securing staff, continuing services where possible and adapting as best as possible. The regime change has caused additional impediments for the mostly female staff and MSIA has been flexible and cautious at the same time to continue its work.

Operations suffered from external factors as well as transferring money to Kabul and supply chain interruptions which affected the clinics and MS ladies in providing commodities to clients.

Response to COVID-19 was adequate.

Staff turnover has affected the efficient implementation of the programme and continues to do so.

HRBA and gender equality

The programme has a gender sensitive approach and is sensitive to a basic human rights perspective. Providing SRH services to women in poverty is strategic in ensuring that there are basic conditions for women to enjoy better health and have greater influence over their reproduction. This alone does not lead to gender equality but is an important factor in women's possibility to become empowered. However, the evaluation concludes that the lack of structured and consistent gender mainstreaming of the programme, including the absence of building staff knowledge and capacity on gender equality, means that MSIA has not embraced a more gender responsive approach. Even with the increasingly difficult context, it is possible to raise staff awareness and as all the clients suggested, include targeted actions towards men.

6 Lessons Learnt

The evaluation findings clearly demonstrate that the regime change had a significant impact on the implementation of the programme and this begs the question how MSI, MSIA and Sida can move forward assuming that no changes can be expected or worse, that more restrictions will affect women's lives.

A first lessons is that MSIA's programme operates in a humanitarian setting while Sida intended the programme to be implemented in a development setting. The Humanitarian-Development Nexus (HDN) became a more overarching discussion during the evaluation on how this programme could be positioned in such context, what the emerging trends are in SRHR and what this could imply for MSI, MSIA and donors such as Sida. A key point that is emerging is how these perspectives can be reconciled and be more effectively connected, working towards achieving collective outcomes that reduce need, risk and vulnerability, over multiple years.

A second lesson that emerged is that MSI's strategy applies a universal model which is development oriented. While MSI also works in other humanitarian settings it appears that the situation on the ground is a determining factor in what a programme can achieve. The Afghanistan case teaches us that the context provides the background for what can be achieved and not the universal model. The learning question for MSI would be how a programme can be responsive to such humanitarian situation. This calls for relevant definitions of concepts to the Afghan situation and clever approaches to push further, for example, on gender equality, HRBA and behavioral change. This provides a learning opportunity for MSIA how it can effectively target key populations in a humanitarian setting. Reflections on MSIA's positioning could be based on analysis of the context and how it can complement what others are doing. Analysis on the effects of the regime change is emerging and could feed into such reflections. [53] The team has therefore recommended that MSI considers a strategy for Afghanistan. This learning could also support MSI to strengthen its position globally since protracted crisis are increasing.

A third lesson is about how strong the SRHR focus should be. The data clearly show that women come for other services to the clinic and while MSI may not wish to compromise its core business, what other services would be relevant (nutrition, child

[53] The maternal and child health crisis in Afghanistan, John Hopkins, Center for Public Health and Human Rights 2022, Persistent Barriers to Access Health Care in Afghanistan, Medicines sans Frontières, 2022; Potential impact of the ban on female workers in humanitarian response on maternal and reproductive health, UNFPA 2022; Potential Implications of Sehatmandi project suspension on maternal health and family planning. Technical Brief 10, UNFPA November 2021.

services, etc)? Should MSIA seek closer collaboration with others to provide an extended service to women? Amongst the reason to consider this is also MSIA's outreach to people living in poverty and those living in remote areas and MSI embracing leaving no one behind. If the women coming the clinics for other services and is this related to increasing poverty than MSI would need to define poverty and how it impacts the demand for SRH services and whether adjacent services would be another way to reach women to provide SRHR.

A fourth lesson is that MSI's positioning and role changes in a humanitarian context and that it provides opportunities for MSI to respond to emergencies and to build capacity for the long term. It is clear that the mCPR is expected to drop dramatically so what is MSI's response and what are its key partners to work with? MSIA could strengthen its added value in this context based on its experience over the last few years and focus on where it could support to counter the downward mCPR trend. This could also boost collaboration with other actors, diversify financial resources which are currently limited.

7 Recommendations

Based on the assumption that the regime will stay and health circumstances for women and children will deteriorate, the evaluation provides the following recommendations:

To MSI and MSIA:

1. Design the next phase of the programme based on the assumption that the regime stays and that effects on health and SRH and maternal and child health will deteriorate. Given the dramatic consequences since the regime change on the health sector in general and access to SRH services for women in particular, MSI and MSIA should review the emerging reports that analyse the consequences for the health sector and what this means for the position of MSI's programming. These reports also contain relevant prognosis on the deterioration of SRH service to women and should help MSIA rethink in collaboration with others (such as the UN and other NGOs) where their work is most relevant and could be most effective.
2. As a consequence of the above recommendation and in response to the MSI strategy diversify funding and exhaust opportunities to work more closely with other actors in the humanitarian domain. Actively seek opportunities to collaborate with UN agencies and INGOs that focus on SRH. Given the situation since the regime change the humanitarian support will increase and opportunities arise where MSIA could position itself strongly with existing clinics and approaches to SRH/FP. A mapping of the different actors in the provinces would help MSIA position itself better vis à vis actors. In addition, a deeper analysis between and within different groups of rights holders could strengthen the principle of leaving no one behind.
3. Develop an Afghanistan strategy from a humanitarian perspective that adapts the MSI model to the context based on the fact that MSI's strategy paper is a universal model to SRHR, FP, and PAC. Consider the literature and prognoses that has been published for the health sector in Afghanistan and reposition based on added value. Use such strategy as an opportunity to destigmatize SRHR services by framing it as a necessary health intervention. Consider where additional expertise could be relevant such as focus on young people, gender equality, HRBA in headwinds and/or conflict settings, etc.
4. Develop a ToC and corresponding results framework and improve reporting across the results chain. Improve indicators to better capture change, including attitudes and behavioural change and consider progress indicators. Where relevant report on results financed by other donors if this reinforces results financed by Sida. Consider diversifying among target groups that are considered 'vulnerable' or 'poor'. Provide definitions.
5. Improve, capitalize and expand the existing services on FP (outreach) through improving the skills and capacities of CHWs. MSIA could better complement the clinical services by further strengthening the outreach work through equipping the CWHs with more in-depth knowledge on FP and also on women's and girls' rights. The clinical staff could play a much more active role in enhancing basic skills of the

CHW, and engage in some of the community outreach activities. The latter should include a focus on the rights-holders in the most vulnerable situations.

6. To secure that rights-holders are reached, the programme needs articulated strategies for reaching women with different disabilities, women that face different types of stigmas, minority groups, and those women and girls whose freedom of movement is so restricted that they will not come to the clinics without special targeted actions (e.g., home visits, interventions by trusted community members, counselling/mediation, or similar).
7. Expand the number of staff for MS ladies and mobile clinics responding to an assumed growing demand and train them with targeted approaches as mentioned under recommendation 5.
8. A more deliberate effort to build staff knowledge and capacity to promote gender equality, and to start to introduce HRBA to both programmatic and implanting staff would strengthen the relevance of the programme and work more towards Sida's comprehensive approach considering the contextual limitations. The evaluation team welcomes the ongoing process within MSI to put in place technical guidance for Gender Equality and Social Inclusion (GESI) Mainstreaming and Integration. MSI has also developed a staff capacity building package and encourage the mandatory inclusion gender equality and HRBA in the package.
9. Staff retention will be an issue in the medium and long term and consider how MSI can contribute to training the next cohorts possibly in collaboration with other actors. This could offset the threat that a new cohort of female employees may not come on the labor market if the regime continues with the current imposed restrictions that women cannot attend secondary and tertiary education.

To Sida:

1. Continue to support MSIA based on a programme with a strong results framework and clearly elaborated strategic choices.
2. Continue to support a programme that remains in the same geographical areas of intervention and that focuses on strengthening and expanding services, including in remote areas and targeting a growing, poor population.
3. Engage in discussions with MSI and MSIA on how gender equality and HRBA approaches can be strengthened and where a deeper approach possibly could be piloted considering a changing and conservative context.
4. Create opportunities for MSIA to collaborate more closely with partners in country supported by Sida and others such as the UN.
5. Consider whether support to MSIA could provide learning opportunities for the Humanitarian-Development Nexus and what learning goals could be jointly defined.

Annex 1: Terms of Reference

Terms of Reference for the Evaluation

MSI REPRODUCTIVE CHOICES AFGHANISTAN, WITH A FOCUS ON THE PROJECT FUNDED BY SWEDEN

Date: 24 May 2022

1. General information

1.1 Introduction

On 15 August 2021, the Taliban leaders announced the restoration of the Islamic Emirate of Afghanistan. After the take-over, Sweden and many other donors decided to halt all transfer of resources to the regime, directly or indirectly through partners. To guide the funding to Afghanistan in this regard, Sida formulated guidelines that were added to the operational plan and that stated that no programs may discriminate on the basis of gender or ethnicity. Institutionalized discrimination or institutionalized violations of human rights can never be accepted by Sweden and support was therefore to be provided independently from the government budget and by actors that enjoy sufficient autonomy to ensure programmatic non-discrimination and compliance with basic human rights.

The regime has gradually imposed more restrictions on both women and men, where women are severely affected. At national level, girls are not allowed to attend school beyond grade six (though are some regional and local difference, for example some provinces, notably Baghlan, Faryab, Kunduz, Jowsjan and Balkh, have reopened secondary schools and girls can sometimes continue to go private schools beyond grade six in some areas).

Also, women need a male chaperon for travelling, all gatherings outside of the home need to be gender segregated and, with the most recent restriction, women need to cover their faces. Women are also restricted in the workforce. Enforcement of these restrictions varies by province and the decisions of individual Taliban officials, but the overall effect is a curtailing of women's opportunities, rights and freedoms, making women and girls lives extremely limited. The economic situation has also worsened, and poverty increased. The only positive affect of the take-over is that the security situation has improved in most parts of the country.

The Swedish Ministry of Foreign Affairs has revised the Swedish Strategy on Development Cooperation with Afghanistan, in light of the changes in the political context.

1.2 Evaluation object: Intervention to be evaluated

The Swedish International Development Cooperation Agency (Sida) has been giving project support to MSI Reproductive Choices Afghanistan (MSIA) 2012 in consequent phases. MSlA works with sexual and reproductive health and rights, raising awareness and increasing access for women to affordable services and products preventing unintended pregnancies and maternal deaths. The new regime has allowed MSIA to continue with most projects as before.

With support from the Sida, MSIA is currently undertaking Sida supported activities in Afghanistan's eight provinces (Kabul, Balkh, Herat, Kandahar, Kunduz, Nangahar, Jawzjan, and Helmand). Sida funds seven MSIA centres, four mobile health teams, 250 CHWs and 13 MS Ladies who provide quality reproductive health services to women and girls in Afghanistan. MSIA reaches women and girls in remote, rural, semi-urban and urban areas through these different channels. Emphasis is placed on expanding community understanding and acceptance of SRHR services, increasing demand among women and couples and improving access. In 2021, 109,629 women and girls in Afghanistan had access to high-quality SRHR information, education, and services as a result of the Sida project.

MSI Reproductive Choices (MSI) is a global international NGO working in 37 countries, with a headquarters in London. The country office in Afghanistan is headed by a Country Director based in Kabul.

MSI conducted an evaluation of the Afghan programme "Program Evaluation Marie Stopes International Afghanistan" and submitted the report to Sida in January 2015. Among the recommendations implemented after the evaluation, MSI expanded into harder to reach rural areas, added a component to address gender-based violence and initiated closer collaboration with the general health care system.

Sida gives support to UN Women and has before the take-over of the Taliban, contributed to the Sehatmandi project through the World Bank ARTF fund. Sida’s core support to the Swedish Afghanistan committee also includes SRHR, among other services, to the training of mid-wives.

Afghanistan has high infant and maternal mortality death rates (not so high when it comes to under-five mortality). During the last decades, the rate of pregnancy among teenage girls has decreased sharply and is currently below the rate in for example Bangladesh. There have thus been improvements for women and girls during the last decades, but there is still much to be done to improve the rights and opportunities of women and girls in the country. It remains to be seen what happens now, since the take-over of the new regime.

The evaluation object is MSI’s programme in Afghanistan, with a particular focus on the Swedish funded project. Sida wishes to better understand how the Swedish funded project relates to MSIA’s overall program and strategy in Afghanistan and how

Sweden, through the choice of partners and areas of focus, can best support the strengthening of reproductive services in Afghanistan.

During this proposed evaluation it is highly important to maintain confidentiality and avoid the potential for any adverse repercussions. Interviewee's initials will thus be kept unknown, and their information will not be shared with any parties, including within the evaluation report. To remove personal identifiers, aliases will be used. Before the submission of the report, proofreading will be conducted by MSIA to suggest how to rephrase any sensitive words that may cause harm to the staff and program.

The evaluation should review a range of issues, including, for example:

MSIA Goals

- Assess goals/objectives of the Swedish funded intervention and MSIA's country program, problem analysis and logical framework.

MSIA and other actors/initiatives

- Assess the context in Afghanistan, other actors working on SRHR and the role and added value of MSIA in relation to the needs, to programs of other actors and to the strengthening of reproductive services in the country.
- Assess how MSIA's interventions compares and relates to other initiatives (donor or government funded), particularly to the Sehatmandi health care program or the programs on basic health services that has succeeded that program. This includes how MSI coordinates and support integration of services, collaborates with other health partners, division of coverage areas etc with other actors providing similar services and the relation between MSIA and health care system overall with a focus on primary health care.

MSIA and target groups

- How MSIA identifies target groups and partners for service provision, for advocacy, capacity building (such as beneficiaries, other service providers, the SRHR sectors as a whole, community and religious leaders etc).
- Assess the achievements of the program in relation to target groups, results etc., both in terms of quality and quantity. This should be analysed both in terms of the results in relation to the result framework and other, non-intended results.
- Identify the needs of girls and women and their access to broader health services and their preferences and opinions on the services that SMIA has provided and on services related to SRHR in general. Understand to what extent and how SMIA has been listening to the girls' and women's voices?

MSIA and donors

- Outline MSIA's country program, its focus and the role of Sida and other donors. Identify the geographical area of the Swedish funded MSIA interventions and those funded by other donors and review MSIA's approach in dividing the country programme according to various donors.

MSIA implementation

- Outline implementation arrangements and systems for follow up and monitoring.
- Assess funds budgeted and spent, the division of funds on different types of costs and estimates on cost-efficiency.
- Identify challenges and successes related to cross-cutting issues relevant for the object (e.g., Human Rights Based Approach, gender equality, conflict, environment and climate change).
- Assess how successful MSIA's programme has been in responding to shocks/ cultural and political upheaval of the past year and how the program over the years has handled other challenges in the Afghani context.

The evaluation should take into consideration previous evaluations commissioned by Sida or others, for example the evaluation from 2015, accounting for the many changes in the program and the context. Even so, this evaluation could potentially be useful as a baseline for the evaluation.

For further information, the intervention proposal is attached as Annex D.

The intervention logic or theory of change of the intervention may be further elaborated by the evaluator in the inception report, if deemed necessary.

1.3 Evaluation rationale

The evaluation will be carried out at this point in time as Sida's support to MSIA is ending and Sida plans to assess continued support to MSIA's program. Sida has funded the program for ten years but not commissioned any specific evaluation, even though Sida's contribution to the program was included in the 2015 evaluation of MSIA's program. It is important for Sida to understand the role of MSIA, its country program and ability to operate, given the changes in the political context, the revisions in donor policy and the new aid architecture in the country. It is also important for Sida to understand MSIA's added value, comparative advantage and the cost effectiveness of its program and, most importantly, how MSIA can influence reproductive services beyond MSIA's specific programs.

The evaluation will be an important input in to Sida's choice of partner, focus and dialogue issues in the area of SRHR for the coming strategy period. It is Sida's intention that the conclusions and recommendations from the evaluation will be useful for both parties in strategic planning and future program development.

2. The assignment

2.1 Evaluation purpose: Intended use and intended users

The primary purpose or intended use of the evaluation is to provide Sida with a good understanding of the MSIA program and results, its value added and its role in the overall structure of providing SRHR services in the Afghanistan context (i.e., the collaboration with other partners and the strengthening of the health care systemin terms of capacity, structures, institutions etc. Does MSIA have a catalytic role and how is this used. How is MSIA integrated within the health care system etc.). Sida also wants to get a better and holistic understanding how it best can support SRHR in Afghanistan, with a focus on long term and sustainable solutions.

The purpose of the evaluation is thus to provide a good basis for Sida's future support, advocacy and dialogue in the area of SRHR in Afghanistan. In sum, the evaluation has the following main purposes:

- Help Sida and its partner MSIA to assess progress of on-going intervention of MSIA in Afghanistan (with a focus of the Swedish funded program) to provide Sida and MSIA with input to upcoming discussions concerning the preparation of a new phase of the intervention,
- Serve as an input for Sida's decision on how Sida's future support to SRHR services in Afghanistan can be most strategic and relevant.

The primary intended user of the evaluation is Sida's Unit for Afghanistan. However, the purpose is also that MSIA should find the evaluation useful for its future program in Afghanistan and inform programming in other similar contexts. The evaluation could also be useful for other SRHR service providers in the country as well.

The evaluation is to be designed, conducted and reported to meet the needs of the intended users and tenderers shall elaborate in the tender how this will be ensured during the evaluation process.

2.2 Evaluation scope

Some of the work will be conducted as a desk study, but the study should, if possible, include field visits to selected MSIA sites in Afghanistan and interviews with staff, stakeholders (to be guided by steering committee) and consenting clients that would be guided by local consultants. Field visits would be planned in close coordination with MSIA, and following MSIA security and safeguarding guidelines. The safety and security of the MSIA team and the evaluation team will be prioritised at all times.

The geographical areas selected would be those receiving Swedish support and others as well if deemed relevant for the evaluation questions. If needed, the scope of the evaluation may be further elaborated by the evaluator in the inception report.

2.3 Evaluation objective: Criteria and questions

The objectives of this evaluation are to provide Sida with information on the results, value added and role of MSIA and MSIA's work in Afghanistan. The purpose is also to provide Sida with a sound basis for an assessment of future support to SRHR in Afghanistan. The following areas should thus be evaluated:

- The relevance, coherence and effectiveness of the intervention. Recommendations should be formulated as an input to upcoming discussions concerning the preparation of a new phase of the intervention and support to SRHR in Afghanistan.
- The questions should provide Sida with an understanding of the strategic value of continued support to MSIA or/and to other actors delivering SRHR in Afghanistan.

The evaluation questions are relevance, coherence and effectiveness:

Relevance: Is the intervention doing the right thing?

- To what extent has the programme **objectives and design responded to the needs of women and men** and how has it strengthened reproductive services in Afghanistan[54]? Has the programme continued to do so now that the circumstances have changed?

Coherence: How well does the intervention fit?

- How compatible has the intervention been with **other interventions** in the country?
- How does MSIA **relate, coordinate and collaborate with other stakeholders** working with SRHR and primary health care?
- What is the **role, value added and comparative advantage of MSIA** in the Afghani context? In what ways has MSIA used its capacities within and beyond the program, for example for strengthening other partners and the broader health care system? How could the health sector learn and make best use of MSIA's knowledge and experience?

Effectiveness: Is the intervention achieving its objectives?

- To what extent has the intervention achieved its intended **results (from the original proposal/log frame)**?
- Which intended **results were achieved / not achieved**? Why?

[54] This includes assessing the opinions on needs by MSIA staff, the beneficiaries, community leaders and other important stakeholders such as humanitarian actors, Sehatmandi service providers or UN agencies.

- In what thematic areas, regions and components has the program been **most successful** and what are the reasons for **success and failure**?
- To what extent have MSIA **reached, included and achieved results** for specifically vulnerable groups and groups that are stigmatized in the society?
- To what extent was the chosen **implementation strategies** effective?[55] Was the program implemented in a conflict sensitive manner? Were the implementation methods cost-efficient?
- Has the **M&E system** delivered robust and useful information that could be used to assess progress towards outcomes and contribute to learning?

Other:

- Has the project had any positive effects on **gender equality**? Could gender mainstreaming have been improved in planning, implementation or follow up? How has the project dealt with **psychosocial harm?**
- Has the project been implemented in accordance with the poor people's perspective and a **Human Rights Based Approach**? Can it be said to have had a people centred design, with a focus on and based on input from the people needing the services?

The evaluation should include a summary of the **lessons learnt and recommendations**, including a few scenarios and strategic choices for Sida for supporting SRHR and MSIA in the coming years, taking into account the conclusions in the evaluation, the needs in the country and the new political context.

Questions are expected to be developed in the tender by the tenderer and further refined during the inception phase of the evaluation.

2.4 Evaluation approach and methods

It is expected that the evaluator describes and justifies an appropriate evaluation approach/methodology and methods for data collection in the tender. The evaluation design, methodology and methods for data collection and analysis are expected to be fully developed and presented in the inception report. The evaluation team might also need to find flexible and innovative approaches to overcome hurdles relating to issues relating to COVID-19, security and the new restrictions on women.

The evaluator is to suggest an approach/methodology that provides credible answers (evidence) to the evaluation questions. Limitations to the chosen approach/methodology and methods shall be made explicit by the evaluator and the consequences of these limitations discussed in the tender. The evaluator shall to the

[55] That includes: the partnership approach (working with religious and community leaders etc.), the implementation modalities; ie training of community health workers, MS Ladies, satellite centres, working in schools etc.

extent possible, present mitigation measures to address them. A clear distinction is to be made between evaluation approach/methodology and methods.

A *gender-responsive* approach/methodology, methods, tools and data analysis techniques should be used[56].

Sida's approach to evaluation is *utilization-focused*, which means the evaluator should facilitate the *entire evaluation process* with careful consideration of how everything that is done will affect the use of the evaluation. It is therefore expected that the evaluators, in their tender, present i) how intended users are to participate in and contribute to the evaluation process and ii) methodology and methods for data collection that create space for reflection, discussion and learning between the intended users of the evaluation.

In cases where sensitive or confidential issues are to be addressed in the evaluation, evaluators should ensure an evaluation design that do not put informants and stakeholders (including MSIA) at risk during the data collection phase or the dissemination phase. It would be most advantageous to include two local consultants, one woman and one man.

The evaluators should hold discussions with a wide range of stakeholders including where feasible representatives of the target group, other service providers, relevant UN agencies. The list of proposed stakeholders is to be included in inception report and will be guided by the steering group to ensure the safety and security of the evaluators and MSIA team is prioritised.

2.5 Organisation of evaluation management

This evaluation is commissioned by Sida's Unit for Afghanistan. The intended users are Sida, MSIA and other stakeholders working with SRHR in Afghanistan. Sida, MSIA and MSI representatives will form a steering group which has contributed to and agreed on the ToR for this evaluation. The steering group will review and approve the inception report and the final report of the evaluation. The steering group will participate in the start-up meeting of the evaluation, as well as in the debriefing/validation workshop where preliminary findings and conclusions are discussed.

[56] See for example UNEG United Nations Evaluation Group (2014) Integrating Human Rights and Gender Equality in Evaluations http://uneval.org/document/detail/1616.

2.6 Evaluation quality

All Sida's evaluations shall conform to OECD/DAC's Quality Standards for Development Evaluation[57]. The evaluators shall use the Sida OECD/DAC Glossary of Key Terms in Evaluation[58] and the OECD/DAC Better Criteria for Better Evaluation[59]. The evaluators shall specify how quality assurance will be handled by them during the evaluation process.

2.7 Time schedule and deliverables

It is expected that a time and work plan is presented in the tender and further detailed in the inception report. Given the situation with COVID-19 and security, the time and work plan must allow flexibility in implementation. The evaluation shall be carried out between 1st of September 2022 and 1st of March 2023. The timing of any field visits, surveys and interviews needs to be settled by the evaluator in dialogue with the main stakeholders during the inception phase.

The table below lists key deliverables for the evaluation process. Alternative deadlines for deliverables may be suggested by the consultant and negotiated during the inception phase.

Deliverables	Participants	Deadlines
1. Start-up meeting/s Stockholm and virtual	Sida staff, MSIA, consultant	Tentative 1st September
2. Draft inception report	Consultant	Tentative 22nd September
3. Comments from intended users to evaluators (alternatively these may be sent to evaluators ahead of the inception meeting)	Sida, MSIA	Tentative 6th October
4. Inception meeting virtual meeting	Consultants, MSIA, Sida	Tentative 10th October
5. Data collection, analysis, report writing and quality assurance	Evaluators	Tentative 10th October - 8th December
6. Debriefing/validation workshop (meeting)	Consultants, MSIA, Sida	Tentative 8th December
7. Draft evaluation report	Consultant	Tentative 29th December
8. Comments from intended users to evaluators	MSIA, Sida	Tentative 16th January
9. Final evaluation report	Consultant	Tentative 30th January

[57] OECD/DAC (2010) Quality Standards for Development Evaluation.

[58] Sida OECD/DAC (2014) Glossary of Key Terms in Evaluation and Results Based Management.

[59] OECD/DAC (2019) Better Criteria for Better Evaluation: Revised Evaluation Criteria Definitions and Principles for Use.

10. Possible Seminar		Tentative and 2nd February

The inception report will form the basis for the continued evaluation process and shall be approved by Sida before the evaluation proceeds to implementation. The inception report should be written in English and cover evaluability issues and interpretations of evaluation questions, present the evaluation approach/methodology *including how a utilization-focused and gender-responsive approach will be ensured*, methods for data collection and analysis as well as the full evaluation design, including an *evaluation matrix* and a *stakeholder mapping/analysis*. A clear distinction between the evaluation approach/methodology and methods for data collection shall be made. All limitations to the methodology and methods shall be made explicit and the consequences of these limitations discussed.

A specific time and work plan, including number of hours/working days for each team member, for the remainder of the evaluation should be presented. The time plan shall allow space for reflection and learning between the intended users of the evaluation.

The final report shall be written in English and be professionally proof read. The final report should have clear structure and follow the layout format of Sida's template för decentralised evaluations (see Annex C). The executive summary should be maximum 3 pages.

The report shall clearly and in detail describe the evaluation approach/methodology and methods for data collection and analysis and make a clear distinction between the two. The report shall describe how the utilization-focused approach has been implemented i.e., how intended users have participated in and contributed to the evaluation process and how methodology and methods for data collection have created space for reflection, discussion and learning between the intended users. Furthermore, the gender-responsive approach shall be described and reflected in the findings, conclusions and recommendations along with other identified and relevant cross-cutting issues. Limitations to the methodology and methods and the consequences of these limitations for findings and conclusions shall be described.

Evaluation findings shall flow logically from the data, showing a clear line of evidence to support the conclusions. Conclusions should be substantiated by findings and analysis. Evaluation questions shall be clearly stated and answered in the executive summary and in the conclusions. Recommendations and lessons learned should flow logically from conclusions and be specific, directed to relevant intended users and categorised as a short-term, medium-term and long-term.

The report should be no more than 35 pages excluding annexes. If the methods section is extensive, it could be placed in an annex to the report. Annexes shall always include the Terms of Reference, the stakeholder mapping/analysis and the Evaluation Matrix. Lists of key informants/interviewees shall not be published but should be shared

between the consultant and the Steering Committee. The inclusion of personal data in the report must always be based on a written consent.

The evaluator shall adhere to the Sida OECD/DAC Glossary of Key Terms in Evaluation[60].

The evaluator shall, upon approval by Sida/Embassy of the final report, insert the report into Sida's template för decentralised evaluations (see Annex C) and submit it to Nordic Morning (in pdf-format) for publication and release in the Sida publication database. The order is placed by sending the approved report to Nordic Morning (sida@atta45.se), with a copy to the responsible Sida Programme Officer as well as Sida's Evaluation Unit (evaluation@sida.se). Write "Sida decentralised evaluations" in the email subject field. The following information must always be included in the order to Nordic Morning:

1. The name of the consulting company.
2. The full evaluation title.
3. The invoice reference "ZZ980601".
4. Type of allocation: "sakanslag".
5. Type of order: "digital publicering/publikationsdatabas.

2.8 Evaluation team qualification

In addition to the qualifications already stated in the framework agreement for evaluation services, the evaluation team shall include the following competencies:

- Knowledge of SRHR and health care sector
- Knowledge of Afghanistan: knowledge of the situation for women in Afghanistan, rural traditional societies in the country and the challenges in providing SRH services in the country

It is also important that the team includes national consultants, both male and female that can talk to people of both genders. They should also have local language fluency in order to reduce the risk of miscommunication.

It is desirable that the evaluation team includes the following competencies:

Culturally sensitive and diplomatic manner.

A CV for each team member shall be included in the call-off response. It should contain a full description of relevant qualifications and professional work experience.

[60] Sida OECD/DAC (2014) Glossary of Key Terms in Evaluation and Results Based Management.

It is important that the competencies of the individual team members are complimentary.

The evaluators must be independent from the evaluation object and evaluated activities, and have no stake in the outcome of the evaluation.

Please note that in the tender, the tenderers must propose a team leader that takes part in the evaluation by at least 30% of the total evaluation team time including core team members, specialists and all support functions, but excluding time for the quality assurance expert.

2.9 Financial and human resources

The maximum budget amount available for the evaluation is 800 000 SEK.

Invoicing and payment shall be managed according to the following: The Consultant may invoice a maximum of 200 000 SEK after approval by Sida/Embassy of the Inception Report and a maximum of 600 000 SEK after approval by Sida/Embassy of the Final Report and when the assignment is completed.

The contact person at Sida is Elizabeth Narrowe at Sida's Unit for Afghanistan. The contact person should be consulted if any problems arise during the evaluation process.

Relevant Sida documentation will be provided by Elizabeth, as well as contact details to intended users (cooperation partners, Swedish Embassies, other donors etc.).

The evaluator will be required to arrange the logistics such as booking interviews, preparing for the visit etc., including any necessary security arrangements.

3. Annexes

Annex A: List of key documentation

- Project document
- Annual reports and audits
- Sida's assessments of Reports
- Swedish strategies for Development Cooperation with Afghanistan
- Sida's annual result reports to the government

Annex B: Data sheet on the evaluation object

Information on the evaluation object (i.e., intervention)	
Title of the evaluation object	Support to Marie Stopes International Afghanistan and its programme in Afghanistan
ID no. in PLANIt	PLANit:11639
Dox no./Archive case no.	18/000910
Activity period (if applicable)	2018-2022
Agreed budget (if applicable)	42 million SEK

Main sector[61]	Health, Sexual reproductive health and rights (SRHR)
Name and type of implementing organisation[62]	Marie Stopes International Afghanistan, Civil Society Organisation
Aid type[63]	Development cooperation, project support
Swedish strategy	Strategy for Afghanistan 2021-2024

Information on the evaluation assignment	
Commissioning unit/Swedish Embassy	Sida's Unit for Afghanistan
Contact person at unit/Swedish Embassy	Elizabeth Narrowe
Timing of evaluation (mid-term, end-of-programme, ex-post, or other)	End of programme and assessment of new intervention
ID no. in PLANIt (if other than above).	

Annexes

Annex A: List of key documentation
Annex B: Data sheet on evaluation object
Annex C: Decentralised evaluation report template
Annex D: Project/Programme documents

[61] Choose from Sida's twelve main sectors: education; research; democracy, human rights and gender equality; health; conflict, peace and security; humanitarian aid; sustainable infrastructure and services; market development; environment; agriculture and forestry; budget support; or other (e.g. multi-sector).

[62] Choose from the five OECD/DAC-categories: public sector institutions; NGO or civil society; public-private partnerships and networks; multilateral organisations; and other (e.g. universities, consultancy firms).

[63] Choose from the eight OECD/DAC-categories: budget/sector support; core contributions/pooled funds; project type; experts/technical assistance; scholarships/student costs in donor countries; debt relief; admin costs not included elsewhere; and other in-donor expenditures.]

Annex 2: Stakeholders

Stakeholder Mapping:

Who *(stakeholders, disaggregated as appropriate) Consider adding email address if you know this.*	**What** *(their role in the intervention)*	**Why** *(purpose of involvement in the evaluation)*	**Priority** *(how important to be part of the evaluation process)*	**When** *(stage of the evaluation to engage them)*	**How** *(ways and capacities in which stakeholders will participate) Include data source that they will participate in*
Individuals/organizations who can respond to MSI Afghanistan results, including changes since the Taliban are in power					
SIDA					**All through interview**
Elizabeth Narrowe, Sida, elizabeth.narrowe@sida.se Sida person preceding Elizabeth	Management	Empower/ Manage	High	Throughout the evaluation	Client/Managing evaluation Informant Support throughout the evaluation IR, draft and final reports and briefings
Emma Nilenfors HUMASIEN/ Former Head of Afghanistan Unit Sida (now in NY)	Management	Empower/ Manage	High	Data collection	
MSI/HQ London					**All through interview**
Ellora Howie, Senior Programme Manager, ellora.howie@MSIChoices.org	Management	Empower/ Manage	High	Throughout the evaluation	Informant Support throughout the evaluation IR, draft and final reports and briefings

Rachel Cullen, Director of Government and Multilateral Programmes Rachel.Cullen@MSIChoices.org	Management	Empower/ Manage	High	Throughout the evaluation	Informant Support throughout the evaluation IR, draft and final reports and briefings
Isabelle Sykes, Senior Technical Advisor Isabelle.Sykes@MSIChoices.org	Management	Empower/ Manage	High	Throughout the evaluation	Informant Support throughout the evaluation IR, draft and final reports and briefings
Charis Kuma, Regional Programme Officer charis.kuma@MSIChoices.org	Management	Empower/ Manage	High	Throughout the evaluation	Informant Support throughout the evaluation IR, draft and final reports and briefings
Dr.Raman Shrestha, RME-Manager raman.shrestha@mariestopes.org.np	Management	Empower/ Manage	High	Throughout the evaluation	Informant Support throughout the evaluation IR, draft and final reports and briefings
MSI/Afghanistan	Different roles in implementation	Empower/ Manage	High	Throughout the evaluation Data collection and reports	Informant Audience throughout the evaluation
Dr Muslih, Country Director Yaqoob.Muslih@msiafghanistan.org	Different roles in implementation	Empower/ Manage	High	Throughout the evaluation Data collection and reports	Informant Support throughout the evaluation IR, draft and final reports and briefings
Zuhal Haares, Research lead Zuhal.Haares@msiafghanistan.org	Different roles in implementation	Empower/ Manage	High	Throughout the evaluation Data collection and reports	Informant Support throughout the evaluation IR, draft and final reports and briefings
Partners					
Partners in country	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	

At national level					
Sehatmandi health care programme or the programmes on basic health services	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant
Médecins Sans Frontiéres (MoU in Jowzjan)	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant
MSI/A through social marketing (funded via other projects) to ensure EC is available (from prodoc)	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant
Afghan Midwifery Association	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant
Referral centers (CHWS, community mobilizers, religious leaders, health educators, private hospitals and pharmacies)	Referral sources	Contribute			
Afghan Society of Obstetrician and Gynecologists (AFSOG)	Support Advocacy	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant
SPECIFIC NETWORKS/ ASSOCIATIONS					
Afghan National Blind Association	Support people with disability	Empower	High	Informant Data collection and report	Informant
Refa association	Support people with disability	Empower	High	Informant Data collection and report	Informant
Anjomani Roshandalan.	Support people with disability	Empower	High	Informant Data collection and report	Informant
NGOs (JACK, HNTOP, BDN, AADA)	Implementation	Empower/ Contribute	High	Informant Audience Data collection and reports	Informant

MSIA Staff					
MSIA clinic staff					
Provincial health personnel					
MSI Provincial Coordinators					
MSIA clients					
MSI Trained Religious leaders/ Community Mobilisers	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
MSI trained religious leaders' wives	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Hospitals	Implementation	Empower/ Contribute	High	Informant Data collection and reports	Informant
MSIA centres	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Media outlets/supporters	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Trainers (national and MSI trainers)	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
MS ladies / Midwives	Implementation	Empower/ Contribute	High	Informant Audience	Informant
Mobile clinics and staff	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
At community level					
Religious leaders	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Community Health Workers	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Counseling providers other than CHW	Implementation	Empower/ Contribute	High	Informant Data collection	Informant
Right holders/ beneficiaries					
At community level					
Madrassa Students		Contribute	High	Informant	Informant

Government school students		Contribute	High	Informant	Informant
Adolescents married		Contribute	High	Informant	Informant
Adolescents not married		Contribute	High	Informant	Informant
IDPs		Contribute	High	Informant	Informant
Targeted poor people (lack of access and awareness)		Contribute	High	Informant	Informant
Others? Psychosocial consolers and Gyn and obstruct Doctors		Contribute	High	Informant	Informant
Donors and others who can comment on the work of MSI/MSIA		Empower/ Contribute	High	Data collection and reports	Informant Audience
Swedish Committee for Afghanistan In the Provinces and Kabul	Actor working in the same field	Empower/ Contribute	High	Data collection and reports	Informant Audience
Feminist Action for Afghanistan (particularly on changes since the takeover)	Actor working in the same field	Empower/ Contribute	High	Data collection and reports	Informant Audience
UN Women (mentioned in ToR)		Contribute	High	Data collection and reports	Informant Audience
ARTF Fund ?		Contribute	High	Data collection and reports	Informant Audience
Donors in country? multilateral and other bilateral?		Contribute	High	Data collection and reports	Informant Audience
WHO					
UNFPA					
Other interest groups who are not directly participating in the intervention but relevant					
Academics					
Previous Evaluation Team?					

Annex 3: Evaluation Matrix

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
RELEVANCE	R1 To what extent has the programme **objectives and design responded to the needs of women and men?**	- Evidence of rightsholders and other beneficiaries that the programme responds to their needs - Evidence of rightsholders and other beneficiaries that the programme design is based on consultations/monitoring discussions with them - Evidence of a gender sensitive approach in the design of activities and appropriate measures to meet the needs of adolescent girls and women - Evidence of active measures to include hard to reach groups - Evidence that government entities responsible for SRHR benefit from the programmes support and improve targeted women and men in the provinces	- Desk review of documents - KIIs interview guides - Group interview guides	- *Documents:* Programme proposal, results framework, annual reports - *Stakeholders*: Sida, MSI, MSIA, stakeholders I country	Analysis of right's holders view combined with the key contributions from religious leaders, for example. Analysis of the approach that MSIA took and how well suited this was to reach and motivate rightsholders, those suffering from extreme poverty and vulnerable groups. MSC could also support this analysis.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
		- Evidence of other services available in the communities			
	i) how has it strengthened reproductive services in Afghanistan[64]? ii) has the programme continued to do so now that the circumstances have changed?	- Evidence of the relevant approaches used to improve services - Evidence of increased capacity at all levels of the intervention. - Evidence of RH services reaching previously excluded groups (or something like that) - Evidence of effects of the Talban takeover both informal and formal structures ????	- Desk review of documents - KIIs interview guides	- *Documents:* Programme proposal, results framework, annual reports, capacity building reports - *Stakeholders:* Sida, MSI, MSIA, stakeholders I country	
	Did the design respond to the needs of women and men? What were the factors hindering or facilitating implementation?	-Evidence of how those groups were consulted -Evidence on the identification of vulnerable groups with the support of interlocutors like teachers or religious leaders	- KIIs interview guides - MSC - Group/individual interviews	- *Stakeholders:* Sida, MSI, MSIA, Teachers, Community leaders, MS ladies	Analysis of right's holders view combined with the key contributions from religious leaders, for example. Analysis of the approach that MSIA took and how well suited this was to reach and motivate rightsholders, those suffering from extreme poverty and vulnerable groups.

[64] This includes assessing the opinions on needs by MSIA staff, the beneficiaries, community leaders and other important stakeholders such as humanitarian actors, Sehatmandi service providers or UN agencies.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	How did the Programme identify vulnerable groups?				MSC could also support this analysis
COHERENCE	C1 How compatible has the intervention been with **other interventions** in the country?	Evidence of coordination with other actors within the health sectors Evidence of search for synergies/joint planning, shared experiences, with other SRH interventions	- Desk review of documents - KIIs interview guides	*Documents:* MoUs minutes of meetings, workshop, etc. *Stakeholders:* Sida/MSI/MSIA, donors, ARTF representative, government and NGOs in country	
	C2 How does MSIA **relate, coordinate and collaborate with other stakeholders** working with SRHR and primary health care?	- Appropriateness of mechanisms for collaboration and coordination with other interventions such as UN agencies, NGOs and other stakeholders	- Desk review of documents - KIIs interview guides	*Documents:* MoUs minutes of meetings, workshop, etc. *Stakeholders:* Sida/MSI/MSIA, donors, ARTF representative, government and NGOs in country	
	C3: What is the **role, value added and comparative advantage of MSIA** in the Afghani context?	Statements on added value/appreciation by other SRH actors Statements on added value/appreciation by the MoH	- Desk review of documents - KIIs interview guides	*Documents:* MoUs minutes of meetings, workshop, etc. *Stakeholders:* Sida/MSI/MSIA,	Listing of added values from the different categories of stakeholders. Comparative analysis before and after takeover of the Talban. Analysis of the position of the Programme in the different provinces and current new activities in new provinces

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
				donors, ARTF representative, government and NGOs in country	
	i) In what ways has MSIA used its capacities within and beyond the program, for example for strengthening other partners and the broader health care system? II) How could the health sector learn and make best use of MSIA's knowledge and experience	- Evidence of effective channels for capacity building (for example curriculum development) that has increased the knowledge of SRHR care providers.	- Desk review of documents - KIIs interview guides	*Documents:* MoUs minutes of meetings, workshops, capacity building reports, curriculum use and training *Stakeholders:* Sida/MSI/MSIA, donors, ARTF representative, government and NGOs in country	Analysis of whether the Programme has increased quality and sustainability among different actors, including avoiding duplication.
	How has the takeover of the Taliban affected coherence? Is this takeover universal for the health services in all provinces where the programme operates?	- Evidence of negative or positive changes to the implementation (donor coordination)	- KIIs interview guides	- *Stakeholders:* Sida, MSI, MSIA, stakeholders I country	Analysis of the effects and develop a comparison before/after considering that the health landscape is not government driven but many actors exist but to different degree in the provinces
EFFECTIVENESS	E1. To what extent has the intervention achieved its intended	- Extent of achievement of output results against set targets	- Desk review of documents - Use of ToC	- *Documents:* Programme proposal,	Analysis of the data against the log frame; then assessment on the ToC against the original log frame identifying changes

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	results (from the original proposal/log frame)?	- Factors facilitating achievement of results - Factors hindering achievement of results - Appropriateness of the results framework to measure results - Evidence on ability to adapt to changing context and revision of ToC/RF - Evidence that "most vulnerable" groups have been reached (according to MSIA's definition) - Evidence of gender integrations and results of the same	- KIIs interview guides	results framework, annual reports - *Stakeholders:* Sida, MSI, MSIA, stakeholders I country	based on what the documents tell us and hat evidence comes from the new data. Contribution Analysis MSC
	I) Which intended **results were achieved / not achieved**? Why? II) In what thematic areas, regions and components has the programme been **most successful** and what are the reasons for **success and failure**? III) To what extent have MSIA **reached, included and**	- Reported results validated by targeted groups, including health workers, MoH, and by external stakeholders - Evidence by MSC stories, or similar	- Desk review of documents - Use of ToC - KIIs interview guides	- *Documents:* Programme proposal, results framework, annual reports. Financial and Budget reports on adjustments, implementation strategies and approaches to reach the vulnerable	Overview of the log frame to assess results. Overview of the new data according to interviews supplementing the log frame, including where outputs were not achieved or achieved. Contribution analysis MSC

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	achieved results for specifically vulnerable groups and groups that are stigmatized in the society?			- *Stakeholders:* Sida, MSI, MSIA, stakeholders I country. Rights holders interviews and/or their representatives	
	E2. To what extent was the chosen **implementation strategies** effective?[65]	- Appropriateness of the implementation strategies and the ability to adapt if circumstances change - Factors facilitating achievement of results - Factors hindering achievement of results - Appropriateness of the implementation of gender sensitive integrations and right-based principles (transparent, accountable, participatory, inclusive and non-discriminatory ways of	- Desk review of documents - KIIs interview guides	- *Documents:* Programme proposal, results framework, annual reports. Financial and Budget reports on adjustments, implementation strategies and approaches to reach the vulnerable	Review approaches and strategies and score from high to low including responding to changed circumstances mitigating low progress of the outputs

[65] That includes: the partnership approach (working with religious and community leaders etc.), the implementation modalities; i.e. training of community health workers, MS Ladies, satellite centres, working in schools etc.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
		working) in the programme process		- *Stakeholders:* Sida, MSI, MSIA, stakeholders I country. Rights holders interviews and/or their representatives	
	To what extent did the key implementation actors continue their work uninterruptedly?	- Evidence that the Taliban take over did not undermine their routine activities. - Evidence that the targeted communities continued their level of trust	- Desk review of documents - KIIs interview guides	- MSIA staff - Rights holders - Other actors	Categorisation and ranking of hindrances and mitigation strategies. MSC, including Taliban take over effects.
	i) Was the programme implemented in a conflict sensitive manner?	-Availability and relevance of the conflict approach to the implementation of the programme	- Desk review of documents - KIIs interview guides	Documents review, *Stakeholders:* government, NGOs, rightsholders, donors	Analysis of the systematic application of the conflict lens, including adaptation/mitigation after Taliban takeover. Ranking according to outputs.
	E3. Has the **M&E system** delivered robust and useful information that could be used to assess progress towards outcomes and	- Availability of programme data/information for all levels (outputs and outcomes) - Availability of programme data/information on outreach to girls and women, and to vulnerable groups as defined by MSIA	- Desk review of documents - KIIs interview guides	Documents review, *Stakeholders:* Sida, MSI/MSIA	Analysis of the M&E system. Overview of strengths and weaknesses.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	contribute to learning?	- Timeliness, reliability and relevance of programme data/information			
	How has the takeover of the Taliban affected effective implementation of the programme?	- Evidence of negative or positive changes to the implementation, including reaching beneficiaries in remote areas	- KIIs interview guides	*Stakeholders:* Sida, MSI, MSIA, stakeholders in-country	Analysis of the effects and listing these according to different stakeholders.
	Has COVID-19 affected the implementation of the Programme? How?	- Evidence of how MSIA mitigated the effects of the pandemic	- KIIs interview guides	*Stakeholders:* Sida, MSI, MSIA, stakeholders in country	Analysis of the effects of the pandemic on the different programme outcomes.
EFFICIENCY (in relation to question E2)	EF1. Were the implementation methods cost-efficient?	- Adequacy and appropriateness of staffing capacity at all levels during implementation - Timeliness in funds disbursement and financial reporting (absorption capacity)	- Desk review of documents - KIIs interview guides	Document review, budgets and expenditures *Stakeholders:* HR staff interviews MSI, MSIA	Analysis of the capacity, budgets and expenditures.
GENDER EQUALITY	GE1. Has the project had any positive effects on **gender equality**?	Evidence of attitudes and/or behaviour changes a) among health workers towards women clients b) among religious leaders and elders towards women's access to FP/RH c) among husbands and mothers in law on women's access to FP/RH and/or right to live without violence	- Desk review of documents - KIIs interview guides	Document review, *Stakeholders:* HR staff interviews MSI, MSIA	Analysis of how GE has featured systematically in implementation. Including changes in female/male roles of service delivery. MSC

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	I) Could gender mainstreaming have been improved in planning, implementation or follow up? II) How has the project dealt with **psychosocial harm?**	Evidence of gender mainstreaming of the programme Evidence of planned gender results/gender monitoring Quality of methods for psychosocial counselling	- Desk review of documents - KIIs interview guides	Document review, *Stakeholders:* HR staff interviews MSI, MSIA	Analysis of increased progress over time, including when the context changed. Analysis of differences among provinces where Taliban was a strong hold already before the implementation.
HUMAN RIGHTS BASED APPROACH	HRBA1. Has the project been implemented in accordance with the poor people's perspective and a **Human Rights Based Approach**?	Evidence of HRBA at objective/outcome level Evidence of practice of programme processes enabling a) transparency, b) MSIA and programme key actors' accountability towards rights holders, programme participants Evidence of use of participatory and inclusive methods in all stages of the programme cycle, including active measures do counteract discriminatory attitudes, behaviours, attitudes towards disability and structures Evidence on measures to reach "the vulnerable" as defined by MSIA and monitoring of the same	- Desk review of documents - KIIs interview guides	Document review, *Stakeholders:* HR staff interviews MSI, MSIA	Analysis of the data from documents and interviews and how MSIA consulted, informed and included rights holders.
	I) Can it be said to have had a people centred design, with a	Evidence of HRBA in practice	- Desk review of documents	Document review,	Analysis of the data from documents and interviews and how MSIA consulted, informed and included rights holders.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	focus on and based on input from the people needing the services?	Evidence of participatory planning, monitoring and evaluation. Evidence of programme design being based on research based on consultation with rightsholders	- KIIs interview guides	*Stakeholders:* HR staff interviews MSI, MSIA Rights holders	MSC
	Has the takeover of the Taliban affected the HRBA approach?	Evidence of positive and negative effects	KII's Interview Guides	*Stakeholders:* HR staff interviews MSI, MSIA Rights holders	Analysis of changes and listing these according to stakeholders.

Annex 4: MSIA Programme

The "MSIA Programme regarding increasing access to quality Sexual and Reproductive Health and Rights (SRHR) services and products in Afghanistan" January 2019 – December 2021, is funded under two Sida strategies for Afghanistan (strategy from 2014-2019, extended to 2021 and from 2021 to 2024) and provides a contribution of 45 million Swedish Kronor (MSEK) to the original programme. The programme had a no cost extension until 31 December 2022, due amongst other reasons, to slow disbursements during Covid. In addition, the Taliban takeover in August 2021 drastically changed the conditions for aid in Afghanistan and also affected the implementation of the programme. Sida continued to support the Afghan people without direct cooperation with the Afghan state and also amended its strategy.[66]

The MSIA programme is managed from MSIA head office in Kabul with provincial coordinators in each[67] province and 31 clinics, including mobile clinics, distributed among the 14 provinces.[68] In addition to service being provided at the clinics, MS ladies provide services to clients in their homes (previous approach) or at the home of the MS lady (current set-up). The MSIA programme is managed in Kabul by a director assisted by various other staff in charge of implementation, monitoring, finance and more recently security. In London two staff provide technical back-stopping and supervise the programme together with the management in Kabul. An Asia and Pacific director is responsible for twelve countries in the region, including Afghanistan.

The overall objectives of the MSIA country programme

The overall goal of the programme is to contribute to the reduction of maternal and child mortality and to the realization of the SRHR of women and girls by achieving significant reductions in unwanted pregnancies and unsafe abortions among the most vulnerable.

The specific objective of the part of the programme funded by Sida is to increase the modern Contraceptive Prevalence Rate (mCPR) by increasing access to high-quality SRH information and services to the most vulnerable including adolescents, the poorest and survivors of Sexual and Gender Based Violence (SGBV) in eight provinces of Afghanistan.

[67] This refers to the overall programme which includes other donors.

[68] The number of clinics and staff change over the evaluation period.

The overall objectives for the Sida funded intervention are:

1. improve community awareness and acceptance of SRH services and increase demand (from women and couples) for Sexual and Reproductive Health (SRH) services,
2. increase access of quality SRH services across 8[69] provinces and 25 districts in Afghanistan,
3. improve access to psychosocial counselling services for survivors of violence and remove policy barriers to enable women and girls to exercise their SRHR[70]

In addition, with the Sida funding the intervention has aimed to continue supporting MSIA's capacity and systems development on a cross cutting level to ensure programme performance and maximum results.[71]

The programme is providing family planning (FP) and post-abortion care (PAC) services in eight provinces (Kabul, Balkh, Herat, Kandahar, Kunduz, Nangahar, Jawzjan and Helmand) of Afghanistan. MSIA provides a comprehensive range of SRH services. Almost all service delivery points provide antenatal and postnatal care; contraceptive counselling and services; sexually transmitted infection (STI/HIV) testing and treatment; PAC; integrated management of childhood illness (IMCI); laboratory services; psychosocial counselling for gender-based violence (GBV); and behavior change communication (BCC) for contraceptive services and referrals. High-quality services are provided to all women, including marginalized women in remote and rural areas where no other health services are available. MSIA's programming is specifically designed to meet the needs of the most vulnerable groups, with a focus on those living in poverty, those without alternative access to care, and other marginalized groups, such as people with disability, youth and IDPs.Through Sida's project support, seven centers, five mobile health teams, 250 CHWs and 14 MS Ladies are providing quality services to women and girls in the eight provinces. MSIA reaches women and girls in remote, rural, semi-urban and urban areas through these different channels.[72]

Implementation arrangements

According to the programme documents MSIA works with a number of implementers and partners, including government structures at all levels (but mainly at provincial and district levels), hospitals, partners such as local Non-Governmental Organisations (NGOs) and associations, community-based organisations and persons, existing MSI mobile clinics, CHW, MS ladies or midwives and other health professionals and

[69]The program application stated seven provinces which was then altered to eight.

[70] Idem page 4.

[71] Project Document, page 4.

[72] The number of staff has changed over the years.

organisations. See Annes 2 for an overview of stakeholders. Since the Taliban regime, the programme does not work directly with governmental structures apart from limited collaboration with some governmental hospitals (mainly referrals of patients) and a certain level of formal coordination related to necessary authorizations and permits.

The programme provides services and raises awareness on SRH, aiming at increasing access to quality SRH services and SRHR information for adolescent girls, women and young couples in particular. A key component of the programme is Behaviour Change Communication (BCC) targeting religious leaders and their wives, elders in the community, health workers, as well as the community at large. The programme achievement is dependent on the support from these local actors to promote the knowledge, awareness of SRH services and willingness to use the services.

In relation to Sida's and MSI's overall approach to SRHR, it is worth noting that the focus of the services and information provided is on family planning methods, sexual and reproductive health of the women and girls, including PAC. The services at the clinics also cover more general services to mother and child health. During the first phase of the evaluated programme phase, it was also possible to focus on S/GBV, something the current political context impedes. Independent of government in power, the Afghan context does not allow for a comprehensive SRHR approach, e.g., the programme does not provide Comprehensive Sexuality Education (CSE) to children and adolescents, address sexual rights, or offer SRH services to unmarried adolescents. The SRH approach of the programme is contextualised to Islam and local culture. MSIA has a Guidance for health providers: Islamic teachings on maternal and reproductive health.[73]

Staffing patterns have changed over the years. The document that outlines what will be undertaken during the extension period highlight the following staffing pattern for the entire programme (so not only Sida funded). MSIA, a branch of MSI Reproductive Choice (MSI), has an established presence in Afghanistan, with operations currently in 14 of 34 provinces. In 2020, MSIA's employed 350 staff, had 31 static centres, four mobile outreach teams, and worked with 23 midwife entrepreneurs.[74]

[73] MSI, no date.

[74] MSIA Capacity Statements. 2022, page 1.

Annex 5: Data Collection Tools, Field Work Overview and Consent Form

Generic interview guides per stakeholder

Instructions

General information to be shared with all stakeholders that have not already been informed of the purpose and scope of the evaluation:

- The evaluation will inform Sida on their future support to MSIA
- The evaluation covers the current Sida agreement with MSI, including the project extension January 2019 - December 2022.
- The objective of the evaluation is to provide Sida with information on the results, value added and role of MSIA and MSIA's work in Afghanistan.
- Information shared in the interview will be anonymous and no person will be quoted in the report without prior consent.
- The information will be used for the evaluators' analysis of MSIA's work in Afghanistan and will be synthesized in an evaluation report.
- Taking part in the evaluation is voluntary and the team will need explicit consent from all stakeholders demonstrating their willingness to be interviewed.

Notes to data collectors in Afghanistan:

In addition to the above:

- Tell the respondent how long the interview will be.
- If possible, get a written consent after explaining the purpose of the evaluation and how the shared information will be used. If the respondent cannot read/write, record the consent.
- If you record the interview, you also need a consent from the respondent that she/he is fine with that. Otherwise, just take notes.
- Ensure that the interview is held in a safe and secluded space with no bystanders.
- Ensure that you talk to both women and male elders, that you speak to both religious leaders and their wives. As far as possible look for a fair gender balance between the respondents.
- If interviewing a couple, make sure that both husband and wife are invited to respond to the questions. "Now we would like to hear from the wife… "Now we would like the husband to respond to the question about…"
- If interviewing a minor, consent is needed from their parents. See specific guides.
- If possible, talk directly to respondents that are identified as vulnerable (with disabilities, from remote village (if present when you are visiting the clinic), so that their voices are heard and you are not only told things about them.
- If interviewing individual (or small group discussion with) MSIA staff, ensure that supervisor (or other kind of manager) is not present.

- No MSIA staff/manager should be present when interviewing different external stakeholders, including staff at the clinics. It is ok that they introduce you, but should then leave for you to conduct the interview without them.

The generic interview guides are stakeholder-specific and need to be further adapted to local contexts and the type of persons you interview. The questionnaires follow the evaluation questions and the indicators identified in the evaluation matrix (presented in part here). Please note that you might not be able to raise all questions in all interviews but make sure that all questions are covered by the total of interviews per stakeholder category.

Evaluation questions	Indicators
RELEVANCE	
R1 To what extent has the programme **objectives and design responded to the needs of women and men?**	- Evidence of rightsholders and other beneficiaries that the programme responds to their needs - Evidence of rightsholders and other beneficiaries that the programme design is based on consultations/monitoring discussions with them - Evidence of a gender sensitive approach in the design of activities and appropriate measures to meet the needs of adolescent girls and women - Evidence of active measures to include hard to reach groups .. Evidence that government entities responsible for SRHR benefit from the programmes support and improve targeted women and men in the provinces
i) how has it strengthened reproductive services in Afghanistan[75]? ii) has the programme continued to do so now that the circumstances have changed?	- Evidence of the appropriateness of approaches used to improve services - Evidence of increased capacity at all levels of the intervention. - Evidence of RH services reaching previously excluded groups (or something like that) - Evidence of effects of the Talban takeover both informal and formal structures ????
Did the design respond to the needs of women and men? What were the factors hindering or facilitating implementation? How did the programme identify vulnerable groups?	-Evidence of how those groups were consulted -Evidence on the identification of vulnerable groups with the support of interlocutors like teachers or religious leaders
COHERENCE	
C1 How compatible has the intervention been with **other interventions** in the country?	Evidence of coordination with other actors within the health sectors Evidence of search for synergies/joint planning, shared experiences, with other SRH interventions

[75] This includes assessing the opinions on needs by MSIA staff, the beneficiaries, community leaders and other important stakeholders such as humanitarian actors, Sehatmandi service providers or UN agencies.

Evaluation questions	Indicators
C2 How does MSIA **relate, coordinate and collaborate with other stakeholders** working with SRHR and primary health care?	- Appropriateness of mechanisms for collaboration and coordination with other interventions such as UN agencies, NGOs and other stakeholders
C3: What is the **role, value added and comparative advantage of MSIA** in the Afghani context?	Statements on added value/appreciation by other SRH actors Statements on added value/appreciation by the MoH
i) In what ways has MSIA used its capacities within and beyond the programme, for example for strengthening other partners and the broader health care system? II) How could the health sector learn and make best use of MSIA's knowledge and experience	- Evidence of effective channels for capacity building (for example curriculum development) that has increased the knowledge of SRHR care providers.
How has the takeover of the Taliban affected coherence? Is this takeover universal for the health services in all provinces where the programme operates?	- Evidence of negative or positive changes to the implementation (donor coordination)
EFFECTIVENESS	
E1. To what extent has the intervention achieved its intended **results (from the original proposal/log frame)**?	- Extent of achievement of output results against set targets - Factors facilitating achievement of results - Factors hindering achievement of results - Appropriateness of the results framework to measure results - Evidence on ability to adapt to changing context and revision of ToC/RF - Evidence that "most vulnerable" groups have been reached (according to MSIA's definition) - Evidence of gender integrations and results of the same
I) Which intended **results were achieved / not achieved**? Why? II) In what thematic areas, regions and components has the programme been **most successful** and what are the reasons for **success and failure**? III) To what extent have MSIA **reached, included and achieved results** for specifically vulnerable groups and groups that are stigmatized in the society?	Reported results validated by targeted groups, including health workers, MoH, and by external stakeholders Evidence by MSC stories, or similar

Evaluation questions	Indicators
E2. To what extent was the chosen **implementation strategies** effective?[76]	- Appropriateness of the implementation strategies and the ability to adapt if circumstances change - Factors facilitating achievement of results - Factors hindering achievement of results . Appropriateness of the implementation of gender sensitive integrations and right-based principles (transparent, accountable, participatory, inclusive and non-discriminatory ways of working) in the programme process
To what extent did the key implementation actors continue their work uninterruptedly?	- Evidence that the Taliban take over did not undermine their routine activities - Evidence that the targeted communities continued their level of trust
i) Was the programme implemented in a conflict sensitive manner?	-Availability and relevance of the conflict approach to the implementation of the programme
E3. Has the **M&E system** delivered robust and useful information that could be used to assess progress towards outcomes and contribute to learning?	- Availability of programme data/information for all levels (outputs and outcomes) - Availability of programme data/information on outreach to girls and women, and to vulnerable groups as defined by MSIA - Timeliness, reliability and relevance of programme data/information
How has the takeover of the Taliban affected effective implementation of the programme?	- Evidence of negative or positive changes to the implementation, including reaching beneficiaries in remote areas
Has COVID-19 affected the implementation of the programme? How?	Evidence of how MSIA mitigated the effects of the pandemic
EFFICIENCY (in relation to question E2).	
EF1. Were the implementation methods cost-efficient?	- Adequacy and appropriateness of staffing capacity at all levels during implementation - Timeliness in funds disbursement and financial reporting (absorption capacity)
GENDER EQUALITY	
GE1. Has the project had any positive effects on **gender equality**?	Evidence of attitudes and/or behaviour changes a) among health workers towards women clients b) among religious leaders and elders towards women's access to FP/RH c) among husbands and mothers in law on women's access to FP/RH and/or right to live without violence
I) Could gender mainstreaming have been improved in planning, implementation or follow up?	Evidence of gender mainstreaming of the programme Evidence of planned gender results/gender monitoring Quality of methods for psychosocial counselling

[76] That includes: the partnership approach (working with religious and community leaders etc.), the implementation modalities; i.e. training of community health workers, MS Ladies, satellite centres, working in schools etc.

Evaluation questions	Indicators
II) How has the project dealt with **psychosocial harm?**	
HUMAN RIGHTS BASED APPROACH	
HRBA1. Has the project been implemented in accordance with the poor people's perspective and a **Human Rights Based Approach**?	Evidence of HRBA at objective/outcome level Evidence of practice of programme processes enabling a) transparency, b) MSIA and programme key actors' accountability towards rights holders, programme participants Evidence of use of participatory and inclusive methods in all stages of the programme cycle, including active measures do counteract discriminatory attitudes, behaviours, and structures Evidence on measures to reach "the vulnerable" as defined by MSIA and monitoring of the same
I) Can it be said to have had a people centred design, with a focus on and based on input from the people needing the services?	Evidence of HRBA in practice Evidence of participatory planning, monitoring and evaluation. Evidence of programme design being based on research based on consultation with rightsholders
Has the takeover of the Taliban affected the HRBA approach?	Evidence of positive and negative effects

Interview guides

Take note of the full name of the person, title/position (if relevant), her/his sex, date, and location of the interview. For MSI and MSIA staff, including clinical staff and MS ladies, ask how long they been with the organisation/the programme.

Interview guide MSI London

The questions can be divided between different interviews, depending on the role and responsibilities of the interviewee.	
Scooping interview	• *Please advise us on the stakeholders list. Are there any key stakeholders missing? Are there any stakeholders we should exclude from the list due to safety and security reasons? If so, please elaborate (arguments to be noted for the limitations in the report).* • *Are we in agreement on the ToC?* --- • All relevance questions below. • Please describe your overall approach to coordination with other stakeholders (not only in the Afghan context). • Are there any SRHR initiatives/actors that you have worked with more closely (prior/after the shift of the regime)? • What do you see as the main achievements? • What do you see as the major gaps (based on what has been possible to implement)? • Please describe your main methods used addressing norms, value and attitudinal changes. • What are your main lessons from the last year's programme implementation? What is key for us to follow-up on? • Please tell us about the experience from the dialogue and coordination with Sida.
Data collection interview	
Relevance (If all raised during the scoping interview, no need to repeat.)	1. How would you describe the relevance of the programme? What do you see as its main strengths in relation to the context, to SRHR needs, gender equality, human rights? 2. How do you see the relevance of the programme in relation to Sida's priorities and Sweden's country strategy? 3. Please describe how the participation of rights-holders looked like when developing the programme? How were women consulted? How were men consulted? 4. Please describe in what way you integrated gender equality dimensions in the programme design. 5. Please describe in what way you integrated gender equality dimensions in the programme design?
Coherence	6. How were your plans for coordinating with other actors in the health sector? What were the strengths and weaknesses in the coordination? 7. How has the takeover of the Taliban affected coherence? Is this takeover universal for the health services in all provinces where the programme operates?
Effectiveness	8. Share the harvested reported results. Ask for reflection on the reports. 9. What do you see as the main achievements? 10. What do you see as the major gaps (based on what has been possible to implement)? 11. How useful has the programme results framework been for your structured monitoring and reporting? Have you seen any needs of revising the framework (level of ambition of outputs or outcomes, redefining indicators, or adjusting assumptions)?

	12. How would you assess your own reporting (MSIA to MSI, MSI to the donor)? What do you see as your strengths and weaknesses when it comes to PMEL?
Efficiency	13. How would you rate the staff's capacity to implement the programme? Have there been any capacity gaps? Is any key function vacant? Have you had sufficient staffing to deliver the results, to monitor and report? 14. Did you get the funds on time? Did you report on time, any need of revisions in narrative or financial reporting? 15. Any delays caused by internal processes such as admin/audit/compliance?
Gender equality	16. How would you describe your approach to gender equality? 17. In what way did you need to adapt this approach to the Afghan context (previous and current regimes)?
HRBA	18. How would you describe your HRBA? 19. In what way did you need to adapt this approach to the Afghan context (previous and current regimes)? 20. How have you aligned you work to Sida's HRBA? (Are you aware of Sida's toolbox on HRBA and how the perspectives of rights and people living in multidimensional poverty steer Swedish development cooperation?)

Interview guide MSIA

Different staff will respond to different set of questions. Interviews can be held individually or in small groups conversations.

The questions can be divided between different interviews, depending on the role and responsibilities of the interviewee.	
Scooping interview	• Before starting please advise us on SRHR and gender terminology to be used in the interviews. Could you share a glossary in English and Pashtu, Dari? • Please also advise us on the stakeholder list. Preferably we would like to interview the same type of stakeholders per province. Are there any key stakeholders missing? Are there any stakeholders we should exclude from the list due to safety and security reasons? If so, please elaborate (arguments to be noted for the limitations in the report). • Please describe your overall approach to coordination with other stakeholders • Please describe your main methods used addressing norms, value and attitudinal changes. • What are your main lessons from the last year's programme implementation? What is key for us to follow-up on? • How has the takeover of the Taliban affected coherence? Is this takeover universal for the health services in all provinces where the programme operates?
Data collection interview	
Relevance (If all raised during the scoping interview, no need to repeat.)	1. How would you describe the relevance of the programme? What do you see as its main strengths in relation to the context, to SRHR needs, gender equality, human rights? 2. Please describe how the participation of rights-holders looked like when developing the programme? How were women consulted? How were men consulted? How were minors consulted? 3. Please describe in what way you integrated gender equality dimensions in the programme design.

	4. Please describe in what way you integrated gender equality dimensions in the programme design?
Coherence	5. Please describe how you interact with governmental bodies (prior to the Taliban takeover, and during the last year)? 6. In what way, if any, has the programme contributed to strengthening the health system in Afghanistan? 7. Please describe how you interact with other actors in the health sector? Please provide some concrete examples? 8. Are there any other SRHR initiatives that you coordinate with (at general level or in specific provinces/districts)? 9. Has Sida invited you to any meetings with other partners to Sida working with similar issues? 10. How has the takeover of the Taliban affected coherence? Is this takeover universal for the health services in all provinces where the programme operates?
Effectiveness	11. Share the harvested reported results. Ask for reflection on the reports. 12. What do you see as the main achievements? 13. What do you see as the major gaps (based on what has been possible to implement)? 14. What factors have enabled progress towards the desired results/changes? 15. What factors have disabled progress towards the desired results/changes? 16. Can you describe how the capacities of different targeted actors have increased? (MSIA staff, clinical staff, MS ladies, MoH representatives, and others.) 17. How useful has the programme results framework been for your structured monitoring and reporting? Have you seen any needs of revising the framework (level of ambition of outputs or outcomes, redefining indicators, or adjusting assumptions)? 18. Based on the progress and what you have learned from the programme implementation, what would you have changed in your methods/strategies/priorities during the past regime (before the Taliban takeover)? 19. In what way did COVID-19 affect the implementation of the programme? 20. How would you describe your approach to conflict sensitivity and Do no harm? 21. What would you have done differently if you had considered the Taliban takeover in your risk assessment? 22. How do you assess the MSIA team's capacity in monitoring and evaluation? Is there any need of capacity development in the area?
Efficiency	23. How would you rate the staff's capacity to implement the programme? Have there been any capacity gaps? Is any key function vacant? Have you had sufficient staffing to deliver the results, to monitor and report? 24. Did you shift resources as a result of the regime change or any other time? Why? 25. Did you get the funds on time? Did you report on time, any need of revisions in narrative or financial reporting?
Gender equality	26. Please tell us in what way the programme has contributed to shifts in attitudes and/or behaviours related to women's and girls' rights to access to SRH services? 27. In what way, if any, has the programme contributed to increase gender equality in the districts/provinces where the programme is being implemented?

	28. Please describe how you analysed the gender situation when designing the programme? How have you planned for and followed-up on gender equality aspects? 29. How do you assess the MSIA team's capacity to gender mainstream? Is there any need of capacity development in the area?
HRBA	30. Please describe how you took human rights principles and the perspective of people living in poverty into account when planning the programme? 31. How have you monitored rights-based principles such as meaningful and active participation of rights-holders, the principle of non-discrimination, transparency (and access to information) towards the communities and rights-holders where MSIA work, etc.? 32. Have you shared the progress of the programme with the local communities where you work? 33. How have you aligned you work to Sida's HRBA? (Are you aware of Sida's toolbox on HRBA and how the perspectives of rights and people living in multidimensional poverty steer Swedish development cooperation?)

Interview guide clinical staff

Individual or FGD (then select some of the questions, make sure that the remaining questions are covered in other FGDs or individual interviews).

Start with Effectiveness and Efficiency, those questions will speak directly to the work the interviewee does.

Effectiveness	1. What kind of services do you provide? 2. Looking at the services you provide here at the clinic, what are you most proud of? 3. Can you share any examples where you have seen positive change in the client's/clients' life? 4. Do you engage in any outreach activities (beyond the clinic)? (e.g., home visits, visit to remote villages, tele counselling, or other?) 5. Have you received any trainings from MSIA? If yes, on what and when? What did you learn? How have you used the knowledge? 6. Can you share data from how many clients have been served by the clinic over the last years? (If only MSIA funded sufficient with that data, if several funding channels, see if it is possible to get the data on MSIA services.) 7. Are you aware of the MSIA programme plans for this clinic (mobile, centre, or other type)? 8. Have you taken part in any monitoring activities/provided data on your work to MSIA? If so, in what way?
Efficiency	9. What makes you SRH service provision easy? 10. What makes you SRH service provision difficult? 11. How would you describe the working situation the last year? What is different from previous years? 12. Any factors that have impacted (positive or negative) on the efficiency of the SRH services? 13. How would you fair the staffing at the clinic compared to what you planned to achieve through the programme period?
Relevance	14. In what way is this programme important?

	15. Who are the groups that benefit most from the SRH services provided in the clinic/s?
Coherence	16. How does your clinic coordinate with other clinics in the province? Have you been able to share lessons learned from the work you do together with MSIA with other health workers? 17. How do you coordinate with the MoH and at what level?
Gender equality	18. Please tell us how your work contributes to the improvement of women's and girls' lives? Is this still possible since the regime change? 19. Are there any issues on girls' or women's health needs and rights that you feel that you cannot respond to at this clinic? 20. Do you refer clients to other clinics? If so, to which clinics/hospitals?
HRBA	21. Can you tell us about your approach to clients? What do you do to make them comfortable? What kind of information do you share? Are you able to keep privacy in the consultations? Does this continue since the regime change?
	22. Anything else you want to tell us?

Interview guide MS ladies – individual

Follow the protocol above

Start with Effectiveness and Efficiency, those questions will speak directly to the work the interviewee does.

Effectiveness	1. Please tell me about your work. What are you most proud of? 2. What methods do you use to reach out to the community and the women that (most) need your support? 3. Do you feel that what you do has support from religious/traditional leaders and/or the community? If yes, how? If no, please explain? 4. Who else support your work? 5. How do you engage with the clinics? 6. How many women have you helped the last year (approximately)? In what way did you assist them ad what was the result? 7. Can you share a story of where you have seen that the programme has changed the life of a girls or a woman, or maybe how attitudes have changed in the community? 8. Have you received any trainings from MSIA? If yes, on what and when? What did you learn? How have you used the knowledge? 9. How do you report the work you do to MSIA? Who is your main contact at MSIA?
Efficiency	10. What makes your work easy? 11. What makes your work difficult? 12. Do you have the necessary equipment and other support you need for your work?
Relevance	13. In what way is this programme important? 14. Who are the groups that benefit most from your work in the community?
Coherence	15. Do you coordinate your work with any other health workers present in your community?
Gender equality	16. Please tell us how your see that your work helps women's and girls' life?
HRBA	17. How do you reach out to women and girls that are difficult to reach?

	18. Do you succeed in providing services to women with disabilities, with women living in remote areas, women and girls living in extreme poverty, remote areas? What are the main challenges, and how can you/the programme overcome those? 19. How do you participate in planning of the work? 20. Does MSIA report to you on the progress of the programme (here and in other villages and provinces)? If so, in what way? 21. How are you supported so that you can do your work in a safe manner, not putting you or other women at risk?
	22. Anything else you want to tell us?

Interview with Health educators

Follow the protocol above

Effectiveness	1. Please tell me about your work. What is your role in MSIA's programme? 2. What methods do you use to reach out to the community and the women that (most) need your support? 3. Explain how you engage with the community? 4. Describe the people that you reach out to? (age, gender, etc.) 5. What are you most proud of so far when you look back at your work as health educator? 6. Do you feel that what you do has support from religious/traditional leaders and/or the community? If yes, how? If no, please explain? 7. Who else support your work? 8. Can you share a story of where you have seen that the programme has changed the life of a girl or a woman, or maybe how attitudes have changed in the community? 9. Have you received any trainings from MSIA? If yes, on what and when? What did you learn? How have you used the knowledge? 10. How do you report the work you do to MSIA? Who is your main contact at MSIA?
Efficiency	11. What makes your work easy? 12. What makes your work difficult? 13. Do you have the necessary equipment and other support you need for your work?
Relevance	14. In what way is this programme important? 15. Who are the groups that benefit most from your work in the community?
Coherence	16. Do you coordinate your work with any other health workers present in your community?
Gender equality	17. Please tell us how your see that your work helps women's and girls' life?
HRBA	18. How do you reach out to women and girls that are difficult to reach? 19. Do you succeed in providing services to women with disabilities, with women living in remote areas, women and girls living in extreme poverty, remote areas? What are the main challenges, and how can you/the programme overcome those? 20. How do you participate in planning of the work? 21. Does MSIA report to you on the progress of the programme (here and in other villages and provinces)? If so, in what way? 22. How are you supported so that you can do your work in a safe manner, not putting you or other women at risk?

	23. Anything else you want to tell us?

To be further developed in dialogue with MSIA.

Interview with community mobiliser

Effectiveness	1. Please tell me about your work. What is your role in MSIA's programme? 2. What methods do you use to reach out to the community and the women that (most) need your support? 3. Explain how you engage with the community? 4. Describe the people that you reach out to? (age, gender, etc.) 5. What are you most proud of so far when you look back at your work as community mobiliser? 6. Do you feel that what you do has support from religious/traditional leaders and/or the community? If yes, how? If no, please explain? 7. Who else support your work? 8. Can you share a story of where you have seen that the programme has changed the life of a girl or a woman, or maybe how attitudes have changed in the community? 9. Have you received any trainings from MSIA? If yes, on what and when? What did you learn? How have you used the knowledge? 10. How do you report the work you do to MSIA? Who is your main contact at MSIA?
Efficiency	11. What makes your work easy? 12. What makes your work difficult? 13. Do you have the necessary equipment and other support you need for your work?
Relevance	14. In what way is this programme important? 15. Who are the groups that benefit most from your work in the community?
Coherence	16. Do you coordinate your work with any other health workers present in your community?
Gender equality	17. Please tell us how your see that your work helps women's and girls' life?
HRBA	18. How do you reach out to women and girls that are difficult to reach? 19. Do you succeed in providing services to women with disabilities, with women living in remote areas, women and girls living in extreme poverty, remote areas? What are the main challenges, and how can you/the programme overcome those? 20. How do you participate in planning of the work? 21. Does MSIA report to you on the progress of the programme (here and in other villages and provinces)? If so, in what way? 22. How are you supported so that you can do your work in a safe manner, not putting you or other women at risk?
	23. Anything else you want to tell us?

To be further developed in dialogue with MSIA.

Interview guide religious leaders, their wives, and traditional leaders/elders

See the protocol

Effectiveness	1. Please tell us what you know about MSIA's work? 2. How have they engaged you in their work? 3. In what way, if any, do you support them in providing health services/information to women? 4. What do you think about the services of the clinic/the work of MS ladies do? 5. How do you inform people in the community about MSIA's work?
Relevance	6. ***If they said that they think the work is important***, ask them why it is relevant and for whom? (for the family, the couple, the women, society, etc.)
Coherence	7. Have you shared your experience with any other religious leaders/elders/traditional leaders from other villages/provinces? If so, can you tell us what you shared and how the other leaders responded?
Gender equality	8. To the religious leaders and their wives, ask if the talk about women's health issues when the preach/talk about social matters (imams, Mullah), or when they meet women in the community (wives to the religious leaders). 9. Are there any women that are not reached by the health services? Why?
HRBA	10. How did/does MSIA inform you about their work and about the progress of their programme? 11. How can the clinics and other services reach more women/women that are hard to reach?
	12. Anything else you want to tell us?

To be further developed in dialogue with MSIA.

Interview guide Clients visiting the clinics

Please follow the protocol above. Make sure that
a) the interview is voluntary,
b) that you get expressed consent from the person you approach, and
c) that there are no bystanders while conducting the interview

Mixed criteria	1. Is this the first time you come to the clinic? How did you know about the services? 2. In what way can the clinic /MS lady help women? 3. Have you, or anyone in your family, or any other woman you know, been helped by the clinic /MS lady before? Could you tell us how? 4. If the services at the clinic/from the MS lady were not available, what would happen to you and other women? 5. To women that have used the services over a period of time: If you look back to the time before you first got services from the clinic/support from the MS lady, and your situation today, is there anything that has changed in your life because of the support you got? Could you tell us about the change? 6. When you think of the support you need for your health, is there any services that you miss? 7. To clients at the clinic and that have been there before: Is there anything the clinic need to improve so that you feel fine/safe/comfortable when you visit the clinic? 8. Have you participated in any discussion held in the community on family planning or women's health issues? If so, do you remember when it was and who organised the discussion?

	9. If you look back in time, have you changed the way you think about women's possibility to plan their family? Do you get support from your husband and the family in the way you are thinking? 10. Do you have any recommendations to the clinic how they could reach out to the men or other family members (like mother in-laws)? 11. Anything else you would like to tell us?

To be further developed in dialogue with MSIA.

Interview guide Couples

As above, follow the protocol before starting the interview.

Mixed criteria	1. Is this the first time you come to the clinic as a couple? If not first time, for how long have you been receiving counselling? 2. How did you know about the services? 3. What kind of support do you hope to get? What kind of support are you getting at the clinic? 4. Do you know if any other couples that have received support from the clinic? Did they tell you about their experience? 5. To couples that have used the services over a period of time: If you look back to the time before you first got counselling, and your situation today, is there anything that has changed in your life because of the support you got? Could you tell us about the change? 6. To clients at the clinic and that have been there before: Is there anything the clinic need to improve so that you feel fine/safe/comfortable when you visit the clinic? 7. Have you participated in any discussion held in the community on women's health issues? If so, do you remember when it was and who organised the discussion? 8. Anything else you would like to tell us?

To be further developed in dialogue with MSIA.

Interview guide young rights-holders

To be discussed and developed in dialogue with MSIA

Interview guide Teachers

Relevance	
Coherence	
Effectiveness	
Gender equality	
HRBA	

Interview guide community members

When possible, talk to random community members. You do not need to record their names but take note of their sex. Tell them what you are doing in very general terms (avoid sharing too much information): "We are looking into the work of the health clinic".

Ask them what they know about the clinic, what kind of services it provides, and if any in their family has used the services (as far as they know).

Do they know if there has been any information to the community about women health issues by the clinic staff, the MS ladies or any leaders in the community?

Interview guide local/provincial duty-bearers (Government)

Introduction	1. Please tell us what you know about MSIA's work here in the province/district? 2. In what way have MSIA engaged with you?
Relevance	3. What kind of needs of the women does the programme respond to?
Coherence	4. In what way does the work MSIA fit with the government's work in the health sector? 5. Do you coordinate with different health actors, and if so in what way, and if so is MSIA part of this coordination?
Effectiveness	6. What do you know about the programmes results? Have you had any meetings with MSIA on the programme progress? 7. Have you received any technical support from MSIA during the last years? 8. To your knowledge, has any staff of the MoH received any trainings held by MSIA? 9. Other issues you would like to share?

Interview guide external stakeholders: international and national CSOs, other donor agencies, UN programme staff, etc.

Introduction	1. Please tell us what you know about MSIA's work here in the province/district or nationally?
Coherence	2. Have you coordinated with MSIA in any way (at activity level, networking, alliance/coordinating meetings, or other)? If so, please share in what way and on what issues. 3. Has MSIA shared their lessons learned from their country programme with you? Have you shared your lessons learned with them?
Relevance	4. Based on the knowledge you have on the work that MSIA conducts in Afghanistan, what is your view on the relevance of their work in relation to a) health services in general, b) SRH services in particular, c) health system strengthening, and/or d) the promotion of bodily autonomy/rights of girls and women.

Draft Consent Form for interviewees

You are being asked to participate in an evaluation study that is being conducted by a research team on behalf of Sida (Swedish International Development Organisation) which is supporting MSI Afghanistan.

Before you decide, it is important for you to understand why the evaluation is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

Please read out the text below if applicable.

What is the purpose of this study?

The purpose of this evaluation is to understand how MSI has supported you and learn about your knowledge, attitudes, and practices of family planning and reproductive health services in MSIA.

What participation means to you?

You were selected for this study because you live in Balkh, Herat or Nangahar or Kabul Province and you have used the services at the clinic or through the health workers in your community. You participate in this evaluation at your own will.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

You can decide whether you wish to speak to both of us or to either one (female or male).

What will I have to do?

You will be involved in an interview with us (Dr. Mohib and Dr. Harisa) or a group discussion with others who are also being served by MISA and also living in this province. You will be asked to share your thoughts on how you experience the services of this clinic, in this province.

Will my taking part in this study be kept confidential?

Please note that we will not be revealing your identity. We will not be recording your name, your dwelling location, and any other information that can identify you as a person.

The interview will be held in private and everything you say will be held in strictest confidence. You are free to end the interview at any stage without giving a reason. If you do not want to answer any question then you may say so. If you do not want to take part in the interview, you will receive the same service as always at the clinic,

What will happen to the results of the evaluation?

The results of the study will be published in a report and there will be no reference to your name and identity. The results will be disseminated to Sida, MSI and MSIA. The report will be public but no names will be included.

Is there any risk involved in the study?

There is no risk when involved in this evaluation. The team strictly adheres to the Ethical Principles as set out by the WHO. If, for whatever reason, you feel uncomfortable when answering questions regarding sexual health, you may decline to answer any question which makes you uncomfortable.

Is there any benefit for me to join the study?

There is no direct benefit to you for participating in this study, but your participation will help MSIA to improve their services

Who can I contact for further information?

If you have any questions about the study, or you would like to know more about the study you may you call the Marie Stopes MSIA office in Kabul (number xxx)

Knowledge, attitudes, and practices of family planning in MSIA

I have gone through the information sheet and understand what will happen if I take part in the evaluation. All my questions about the evaluation have been answered. I have been told that I can withdraw from this study without giving a reason. I have been informed that Dr Mohib and Dr, Hadisa are the investigators for this evaluation and I have their contact details.

I am happy to take part in this study.

Are you willing to participate in this interview?
(Please check yes or no.)

Yes		No	

Signatures:

Witness/Interviewer: _____ Date: __ __ - __ __ - __ __

Annex 6: Documentation

Sida Afghanistan strategies, including latest change after Taliban take over.

Sida agreement with MSI

Sida Appraisal of MSI Afghanistan Programme

Sida/MSI contract and contract changes

Sida budget notes

Sida Risk registrer

MSI concept note

MSI programme document

MSI Annual Reports 2019,2020,2021

MSI Narrative Reports 2019,2020,2021

MSI financial Reports 2019, 2020, 2021

MSI budgets, amendments and audits

MSI Works plans, 2019,2021, 2022

Notes on Amendments, emails exchanges on amendments,

Program Evaluation Marie Stopes International Afghanistan (MSIA) January 8, 2015

Financial data from MSI and auditors reports.

Annex 7: List of Interviewees

Name	Position	Organisation
Sida		
Elizabeth Narrowe	Programme manager (on leave since 01.01.2023)	Sida
Jessica Pellrud	Programme Manager a.i.	Sida
Eva-Charlotte Roos	SRHR specialist	
Maria Lundberg	Head of Afghanistan Unit	Sida, Stockholm
Emma Nilenfors	Former Head of Afghanistan Unit	Sida, Stockholm
MSI London		
Ellora Howie	Senior Programme Manager, Global Funding.	MSI
Isabelle Sykes	Senior Technical Advisor, Asia Regional Support Team	MSI
Nicole Raatgever	Regional Director MSI Asia	MSI
MSI Afghanistan		
Dr. Yacoob Muslih	Director	MSIA
Dr. Zuhal Sulaiman Haares	Health Support and Research Team leader	MSIA
Donors and other external stakeholders		
Sanna Käki	Programme Officer	FINNIDA
Dr. Paata	SRHR specialist	WHO Afghanistan
Stenly Hely Sajo	Head of Programme a.i. / Humanitarian Coordinator for UNFPA Afghanistan	UNFPA Afghanistan
Fouzia Shafique		UNICEF
Alexandra Hanson		UNICEF
Dr. Mnaziri,	Head of Maternal and Newborn Health	UNICEF
Dr. Ahmad Shah Pardis	Health programme manager, Kabul	Swedish Committee of Afghanistan

List of MSIA Sites

No	Name	Province	Quantity	No of clinics
1	Clients visiting the clinic	Kabul	10	**8 clinics and 2 mobile units**
2	Clinical Staff	Kabul	6	
3	MSI Office Staff	Kabul	8	
4	Religious leader	Kabul	1	
5	Health educator	Kabul	1	
6	Provincial Coordinator		1	
TOTAL				**27**

6	Clients visiting the clinic	Nangarhar	4	**4 clinics and 2 mobile units**
7	Clinical Staff	Nangarhar	5	
8	Health educator	Nangarhar	2	
9	Religious leader	Nangarhar	2	
10	CHWs	Nangarhar	2	
11	Provincial Coordinator		1	
TOTAL				**16**
11	Clients visiting the clinic	Balkh	10	**5 clinics, 2 mobile units and 6 MS ladies**
12	Clinical Staff	Balkh	16	
13	CHWs	Balkh	20	
14	Religious leader	Balkh	1	
15	Health educator	Balkh	2	
16	MS lady	Balkh	1	
17	Provincial Coordinator		1	
TOTAL				**51**
17	MS lady	Herat	6	**3 clinics, 2 mobile units and 6 MS ladies**
18	Clinical Staff	Herat	3	
19	Provincial Coordinator		1	
TOTAL				**10**

Annex 8: Revised Outcome and Output Overview

Outcome and outputs	Comment	Assumptions (draft)
4. Improved community awareness and acceptance of SRH services and increase demand (women's and couples) for SRH services	This outcome harbours two results, first increased awareness (output) that will lead to acceptance (attitude change at outcome level), and second, the acceptance will lead to increased demand (behaviour change outcome).	**Assumption1:** Outreach to religious leaders and others to discuss norms and values is based on strong approach based on influence and MSIA has good and strong relations with stakeholders who will commit and agree to the work they do and that this will continue. **Assumption2:** MSIA is providing commodities, services and training so they have some control over the quality of the services they provide. **Assumption3:** There is continued and sufficient staff presence for the service delivery, including stock for family planning services.
Outputs to Outcome 1		
1.3 Religious leaders share SRH messages *1.4 Radio programmes expand SRH knowledge*	The first output is still valid and in use. The second output was possible during the first years of implementation but is no longer applicable.	
5. Increased access to quality SRH services across 8 provinces and 25 Districts in Afghanistan	No comments or change at outcome level.	**Assumption 1:** The hierarchical levels in the health system (province and district) are male-dominated and approval levels for the Programme have been uninterrupted **Assumption 2:** Actors: MSIA actively sought collaboration in the existing and new provinces with other actors in

		country and outside to make the programme effective, sustainable and coherent.
Outputs to Outcome 2		
2.4 FP CYPS[77] generated *2.5 Adolescents are reached as clients* *2.6 Updated curriculum in nursing and midwifery Schools*	Outputs 1 and 2 are still applied. The discussion noted that by adolescent, this indicator refers to married adolescents, while information sharing under outcome 1 can refer to unmarried boys and girls. Indictor 3 is partly met through previous work; the curriculum is being revised by the ministry of Education but MSIA can no longer advocate for changes.	**Assumption 1** MSIA reaches out to young people uninterrupted with information, including through the role of teachers **Assumption 2:** The willingness and roles of teachers remains unchanged **Assumption 3:** The curriculum is relevant to MSIA programme and its staff and services
6. Improved access to psychosocial counselling services for survivors of violence and remove policy barriers to enable women and girls to exercise their SRHR	The outcome harbours two results and these need to be separated. The first part, now new Outcome 3, needs to be revised to Improved access to psychosocial counselling services for women and couples. The terminology of survivors of violence is no longer appropriate in the new context. New outcome 4. Policy barriers removed to enable women and girls to exercise their SRHR. However, this outcome needs to be put on hold, or even to be excluded for the rest of the programme period, due to the current context. The discussion also noted that this part of the original Outcome 3, did not have any indicators and that the policy barriers were not identified.	
New outcome 3 Improved access to psychosocial counselling services for women and couples		
Outputs to Outcome 3		
3.1 Women receive psychosocial counselling at a facility or through the	Indicator 3.2 does not explicitly address the outcome since women in prison are not mentioned at that level. However, MSIA did reach out to women in prison during the first	No assumption

[77] Family Planning Couple-years of protection.

dedicated contact centres 3.2 *Women in prison reached with service delivery*	years of the programme. It was also noted in the discussion that this component is currently not possible to implement.	
Outcome 4		
Removal of policy barriers to enable women and girls to exercise their SRHR		

Annex 9: Results Framework Overview 2019-2021

Please note that the yellow numbers are actual achievements per year. In addition, some of the annual reports also report on other achievements not necessarily related to an indicator. In most cases these are additional activities. This could also be part of a response to the changed circumstances. Numbers are also affected by intimal reporting against 7 provinces and later against 8. Also, the number of (mobile) clinics and staffing patterns have changed over time affecting the results.

Level	Objective	Project Indicators	Year 1	Year 2	Year 3	Total	Reporting	Means of verification	Assumptions
Goal	Contribute to the reduction of maternal and child mortality and to the realisation of the SRHR of women and girls by achieving significant reductions in unwanted pregnancies and unsafe abortions among the most vulnerable.	Reduction in maternal mortality rate.					-	UN / World Bank: Trends in Maternal Mortality Report or Afghanistan Demographic Health Survey.	NB: This is not an indicator that MSIA would measure. It is assumed that a number of contributors in Afghanistan will contribute to a reduction in MMR over a number of years, therefore this is not something that MSIA will expressly measure contribution to.
Objective	Increase the mCPR by increasing access to high-quality SRH information and services to the most vulnerable (including adolescents, the poorest and survivors of SGBV)	Number of unintended pregnancies averted as a result of MSIA services by EoP*	27.035 84,946	28.004 23,784	28.828 15,334	83.867	Annually	Impact 2 model	Government SRH policies and departments continue to be supportive of MSIA's work. Communities and religious leaders remain accepting of MSIA's services

	in seven provinces of Afghanistan.	Number of unsafe abortions averted by EoP*	8.830 1168	9.247 9591	9.516 5380	27.593	Annually	Impact 2 model	Security challenges do not impact considerably on MSIA's operations
		Number of maternal deaths averted by EoP*	29 470	24 19	22 8	75	Annually	Impact 2 model	
trained 1,200 youth volunteers on SRH/ FP services. Outcomes	Outcome 1: Improve community awareness and acceptance of SRH services and increase demand (from women and couples) for SRH services	Indicator 1.1: Religious leaders receive training as Master RL trainers with refresher training annually	8 75 wives	8 0	8 26	8	Annually	Training records	Communities and religious leaders remain accepting of MSIA's services
		Indicator 1.2: 35 Madrassa teachers trained by Master RL trainers to deliver BCC messages in Madrasas in Year 1 and ongoing	35	35 0	35 41	35	Annually	Training records	Religious Leaders and the Ministry of Education continue to be supportive of MSIA's work within Madrasas.

		refresher training Years 2 & 3							
		Indicator 1.3: Madrassa students reached each year with messaging	1.750	1.750 0	1.750 1750	5.250	Annually	Madrassa educator reports	Religious Leaders and the Ministry of Education continue to be supportive of MSIA's work within Madrasas.
		Indicator 1.4: 24 Health Educators trained by MSIA to deliver health messages in government schools	24	24 24	24 30	24	Annually	Training records	Religious Leaders and the Ministry of Education continue to be supportive of MSIA's work within Government schools.
		Indicator 1.5: Government school students reached each year with messaging	2.500	2.500 75	3.000 2669 (girls)	8.000	Annually	Health educator reports	Religious Leaders and the Ministry of Education continue to be supportive of MSIA's work within Government schools.

		Through religious leaders wives t clients were referred to MSIA sites for SRH and FP services.	4,897	1,042					
		trained 1,200 youth volunteers on SRH/ FP services.	1200						
		Indicator 1.6: Religious leaders trained in SRH by Master RL trainers in Year 1 and ongoing refresher training Years 2 & 3	400	400 0	400 101	400	Annually	Training records	Communities and religious leaders remain accepting of MSIA's services
		Indicator 1.7: Number of people reached annually with BCC	40.000 10,000	40.000 1887	40.000 9,856	40.000	Annually	MSIA estimate based on size of the mosque	Communities and religious leaders remain accepting of MSIA's services

		messages through Religious Leaders in Mosques							
		Indicator 1.8: TV spots aired in Kabul, Kandahar, Nengahar, Helmand each year	40 0	40 4	40 0	120	Annually	Contracts with TV companies People reached estimated through online media measurement service, e.g. Geopoll	Media outlets are open to supporting MSIA mass media campaigns
		Indicator 1.9: Radio spots aired in Kabul, Kandahar, Nengahar, Helmand	160	160 0	160 80	480	Annually	Contracts with radio companies People reached estimated through online media measurement service, e.g. Geopoll	
		Indicator 1.10: Calls received at the contact centre (FP &	1.000	1.050 297	1.103 700	3.153	Annually	Call centre reports	Increased demand for call centre services due to systems inprovement and increased marketing.

		Psychosocial contact centre)							
	Outcome 2: Increase access of quality SRH services across 7 Provinces and 25 Districts in Afghanistan	Indicator 2.1 200,000 CYPs generated by the end of the project	64.500 96,813	65.500 53,471	70.000 35072	200.000	Annually	SUN, InforBI	Community support results in more women who are not using contraceptives seeking FP services. MSIA service delivery is minimally interrupted by security issues. Service delivery mechanisms are appropriate, acceptable, available and of sufficient quality to meet the needs of women and girls in Afghanistan Continuous supply of contraceptive commodities
		Indicator 2.2 4% of centre clients are adolescents by end of project	3,3% 12%	3,5% 6%	4,0% 15%		Annually	CLIC, Exit Interviews	Increased awareness of MSIA services amongst adolescents through engagement with Madrasas and Government schools Behaviour change strategies are effective at reaching adolescent target groups Acceptance by the community for young

									people to access services and confidence of young people to access services through MSI sites
		Indicator 2.3 90% of clients would recommend MSIA to a friend or family (Client Exit Interview)	88%	89% no reporting	90% not possible		Annually	Exit Interviews	Positive recommendation is an appropriate proxy for client care quality and accepability; Accessibility and availability of clients willing to be interviewed
		MSI staff conducting training./ information	3 orientation sessions for 200 students.	health educators visited six schools and conducted six orientation sessions for 75 students.					

	# of FP clients	68,994 301 below 15 8033 (15-19) 19894 (20-24) 40766 (over 25)	77,318 and PAC 31,335 FP by age: 4,234 (15-19)	52,469 clients visited project funded sites for FP and PAC services, with 15% of those visits coming from teenagers aged 15 to 19 685 visits were from under 15. 14,396 visits aged 20-24,. 7,354 visits from clients aged 15-19,				
	Technical support to Afghan Midwifery Association (AMS)	4 meetings						
	Number of clients referred by religious leaders	17,455	1,042	1,398				
	Update nursing and midwifery school's curriculum							

		in five provinces by end of project year 3 only							
		non PF services provided			57,160 clients received non-FP services				
	Outcome 3: Improve access to psychosocial counselling services for survivors of violence and remove policy barriers to enable women and girls to exercise their SRHR	Indicator 3.1 Women receive psychosocial counselling at a facility or through the dedicated contact centre (Herat and Balkh only for all years)	1.300 2,323	1.400 327	1.500 132	4.200	Annually	CLIC	Service delivery mechanisms are appropriate, acceptable, available and of sufficient quality to meet the needs of women and girls in Afghanistan

		Indicator 3.2 400 outreach services delivered in prison in Year 1 of the project Indicators changed in year 3 to 700	400 632	200 189	100 3,996 (these are FP service excluding condoms),	700	Annually	MIS, CLIC, Project Reports	Service delivery mechanisms are appropriate, acceptable, available and of sufficient quality to meet the needs of women and girls in prision in Afghanistan The Ministry of Justice and Interior continues to be supportive of MSIA's work.
		Indicator 3.3 RH officers receive leadership and management training to roll out new policies in their provinces each year	9 0	9 0	10 11	28	Annually	Training records	RH officers are available and able to attend training on cascading MoPH policies and guidelines down to district level. BPHS and EPHS partner forum is established
		Indicator 3.4 30 select groups are oriented on stopping virginity tests	30 0	30 0	30 10 groups of people (306 individuals) were trained on AVT in Kabul province	90	Annually	Project Reports Policy/guidance change Informal reports of unacceptability of this practice in	Government departments continue to be supportive of MSIA's work. Groups are interested in participating in orientation

								public hospitals Meeting records	
		competency of providers assessed	17	90%	5 centers and 8 MS ladies performed well in these assessments, achieving over 90% in each area of quality indicators				

* using MSI's Impact2 calculator

Annex 10: Results Data Overview

Table 1: Annual results based on MSI's impact model as reported in annual reports[78]

Years	Savings to the Afghan health system	Unintended pregnancies	Unsafe Abortions averted	Maternal deaths prevented	Clients' numbers
2019	No data	84,946	11,860	470	115,216 total of which 68,994 (60%) were (FP) and (PAC) 28,228 (25%) were clients under 24 years old. 2,323 clients received psychosocial counselling in Herat and Balkh
2020	£803,000	23,784	9,591	18	77,318 client visits for FP and PAC, 6% of these visits being from adolescents aged 15-19 years old. 327 clients with psychosocial counselling in Herat and Balkh
2021	No data	15,334	5,380	8	52,469 clients visited for FP and PAC services, with 15% of those visits coming from teenagers aged 15 to 19. 7,039 clients psychosocial counselling through psychosocial therapists in the provinces of Herat and Balkh.
2022	No data	No data	No data	No data	No data

[78] https://www.msichoices.org/media/3320/impact-2-introductory-guide-june-2018-1.pdf

Table 2: Results per year from MSIA annual reports

Years	Target	Actual	Results
2019			
Outcome 1: Unintended pregnancies averted*	12,148	84,946	699%
Outcome 2: Unsafe abortions averted*	4,756	1,168 typo?	24 %
Outcome 3: Maternal deaths averted*	11	470	427%[79]
2020			
Outcome 1: Unintended pregnancies averted	28,004	23,784	85%
Outcome 2: Unsafe abortions averted	9,247	9,591	104%
Outcome 3: Maternal deaths averted	24	19	79%
2021			
Outcome 1: Unintended pregnancies averted	28,004	15,334	55%
Outcome 2: Unsafe abortions averted	9,247	5,380	58%
Outcome 3: Maternal deaths averted	24	8	33%
Total outcome 1			

Table 3 Results against the Results Framework based on annual reporting and MSIA impact report.

The first two rows are based on MSIA's reporting. For the three outcomes, the team assessed how many indicators were met per outcome given that many activities did not take place. Year one has a beyond projection achievement and years 2 and three show significant decline.

Objectives	Outcome	Overall Results by the end of 2021	Comments
Contribute to the reduction of maternal and child mortality and to the realisation of the SRHR of women		MSIA contributed	MSIA does not measure this but assumes that various actors contribute to this. Table xxx

[79] These percentages were not provided in the annual report and added by the team for comparison.

Objectives	Outcome	Overall Results by the end of 2021	Comments
and girls by achieving significant reductions in unwanted pregnancies and unsafe abortions among the most vulnerable.			above shows part of the picture: number of unsafe abortions and reduced maternal deaths
Increase the mCPR by increasing access to high-quality SRH information and services to the most vulnerable (including adolescents, the poorest and survivors of SGBV) in seven[80] provinces of Afghanistan.		MSIA contributed Unintended pregnancies 83.867 Number of unsafe abortions averted 27.593 Number of maternal deaths averted 75.	
Outcome 1: Improve community awareness and acceptance of SRH services and increase demand (from women and couples) for SRH services	There were sets of activities against 8 indicators	Year 1 Beyond projection Year 2: Only one indictor met out of 10. Year 3: out of 10 indicators 1 beyond projection, one met and 6 below projection or not implemented	MSIA contributed. but activities were not achieved due to COVID -19 and regime change.
Outcome 2: Increase access of quality SRH services across 8 Provinces and 25 Districts in Afghanistan	There were sets of activities against 3 indicators	Year 1 beyond projection, Year 2 one indicator beyond projection out of 3, others low performance due to external factors Year 3 one beyond projection, two below or not implemented	MSIA contributed. but activities were not achieved due to COVID -19 and regime change.
Outcome 3: Improve access to psychosocial counselling services for survivors of violence and remove	There were sets of activities against 4 indicators	Year 1 beyond projection for all 4, Year 2: below projection out of 4 indicators	MSIA contributed. but activities were not achieved due to COVID -19 and regime change.

[80] The programme was implemented in eight provinces: Kabul, Balkh, Herat, Kandahar, Kunduz, Nangahar, Jawzjan, and Helmand.

Objectives	Outcome	Overall Results by the end of 2021	Comments
policy barriers to enable women and girls to exercise their SRHR		Year 3: two beyond projection and two below.	

The box below provides an additional overview of MSIA's results, including from years before Sida's current support 2019. Please note that Sida also supported the programme before 2019. The team is in no position to triangulate these numbers: i) there are more donors to the Programme than Sida; ii) clinics and staffing changed over time. There is no evidence based on the team's ToR that MSIA provides training to private sector sides. This could be related to how different funding modalities are used to fund the entire Programme. The team used MSIA's annual reporting as a basis since the data provided are by definition linked – according to MSI- to Sida resources.

Box 1: MSIA's capacity statement 2021 (not specific to Sida but to overall funding)

Over the past five years MSIA has provided more than **1.8 million** women and girls with a wide range of high-quality, client-center reproductive health services. We estimate that more than 10% of the total demand for voluntary birth spacing1 in Afghanistan in 2021 was satisfied by services supported by MSIA, contributing to an increase in the modern contraceptive prevalence rate.

MSIA currently operates and supports a total of 43 centers; 10 mobile outreach teams serving remote rural populations, 40 MSI Ladies (MSLs)2; and provides direct training and support to 30 independent private sector sites. In addition, MSIA has launched a new contact center in 2022 (toll-free number 07 07 700 400) to provide advice and information related to women's health and wellbeing.

Impact

In 2021 MSIA served an estimated 389,000 women in Afghanistan with reproductive health services, generating over 261,000 couple-years of protection (CYPs), in turn averting an estimated 227,000 unintended pregnancies and 250 maternal deaths and saving over an estimated £7.7 million in direct healthcare costs.

Source: MSIA capacity assessment, 2022

Evaluation of MSI Reproductive Choices Afghanistan, with a focus on the project funded by Sweden

This report presents the findings, conclusions, and recommendations of the Evaluation of MSI Reproductive Choices' program in Afghanistan, with a focus on increasing access to SRHR services and products, particularly funded by Sweden. Key findings include program relevance, limited coherence in collaboration with other partners, limited effectiveness due to external factors, cost-efficient implementation with operational challenges, and limited contributions to gender equality and basic rights. The report concludes that MSIA's work remains relevant, but effectiveness has been affected by external factors, including the regime change in 2022. Strategies of inclusion to reach marginalised women need improvement, and the results framework should be improved. Recommendations include reviewing the consequences of regime change, diversifying funding, and collaborating with other actors. Sida is recommended to continue support, engage on gender equality and HRBA, collaborate with partners, and explore learning opportunities for the Humanitarian-Development Nexus. In addition, Sida could also play a role in improving coherence among other actors, including those that its supports.

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

Visiting address: Rissneleden 110, 174 57 Sundbyberg
Postal address: Box 2025, SE-174 02 Sundbyberg, Sweden
Telephone: +46 (0)8-698 50 00. Telefax: +46 (0)8-20 88 64
E-mail: sida@sida.se Web: sida.se/en

Sida