HEALTH PROTECTION & RESEARCH ORGANISATION

موسسه حفاظت و تحقیقات صحی

د روغتیا د ساتنې او څېړنې موسسه

Integrated Humanitarian Response in Balkh Province through Food Security, Nutrition & WASH interventions to the communities

Third Party Project Evaluation Report

March, 2023

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JAPAN PLATFORM

Acknowledgements

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The findings within this document, however, are entirely the responsibility of the technical team and lead/author.

HPRO

March 2023

Disclaimer

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Abbreviations

AFN	Afghani
COVID	Corona Virus Infectious Disease
CHW	Community Health Worker
CHP	Community Hygiene Promotor
CSI	Coping Strategy Index
DoRR	Department of Refugees and Returnees
FCS	Food Consumption Score
HHs	Households
HPRO	Health Protection and Research Organisation
IDP	Internally Displaced Peoples
IPC	Integrated Food Security Phase Classification
IYCF	Infant and Young Child Feeding
JPF	Japan Platform
KII	Key Informant Interview
LFA	Logical Framework
MAM	Moderate Acute Malnutrition
MORR	Ministry of Refugees and Repatriation
MUAC	Mid upper Arm Circumference
NGO	Non-Government Organisation
ODK	Open Data Kit
PDM	Post-Distribution Monitoring
rCSI	Reduced Coping Strategy Index
RFP	Request for Proposal
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SCJ	Save The Children Japan
ToR	Terms of Reference
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Program

Introduction

1. Introduction

1.1. Overview

Third-party project evaluations are essential accountability and learning initiatives that JPF regularly undertakes jointly with its member NGOs for quality improvement. This is more so for in Afghanistan where JPF and the member NGOs have no access to the project sites due to restrictions associated with the Japanese government funding. Local implementing partners/local offices remotely managed by the members NGOs implement project activities and forefront of daily communication with project stakeholders as well as project beneficiaries.

Given drastic situational changes in Afghanistan, JPF with consultation with the member NGOs, decided the third-party project evaluation planned for five projects in Afghanistan funded by year 2021 budget to focus on assessing and documenting outcomes (immediate impact) rather than exhausting limited resource by conducting summative and/or program evaluation. A request for proposals (RFP) was made to solicit proposals to conduct Third-party project final evaluation services for five JPF projects and Health Protection & Research Organization (HPRO), a Kabul based NGO, has been nominated to provide the service based on competitive selection process.

1.2. Afghanistan Hunger and Food Insecurity

Afghanistan has been subjected to decades of complex and protracted conflicts, combined with a changing climate, gender inequalities, rapid urbanization, underemployment and the economic fallout of the COVID-19 pandemic. Over half of the country's population lives below the poverty line, and food insecurity is on the rise, largely due to conflict and insecurity cutting off whole communities from livelihood opportunities. 18.9 million people are identified as acutely food insecure, including hundreds of thousands who have been displaced by conflict since the beginning of the year 2021. Undernutrition is one of particular concerns in women, children, displaced people, and returnees, households headed by women, people with disabilities and the poor. Despite progress in recent years, undernutrition rates are now increasing and 2 million children are malnourished. Every year, some 250,000 people on average are affected by a wide range of environmental disasters including floods, droughts, avalanches, landslides and earthquakes. The impact of disasters and dependency on water from rain or snowmelt severely limit the productivity of the agricultural sector, which consequently affects the food security situation in Afghanistan[1].

1.2.1. Current Food Security Situation in Balkh

Balkh province is situated in the northern part of Afghanistan, bordering Uzbekistan in the North, Tajikistan in the North-East, Kunduz province in the East, Samangan province in the South-East, Sar-ePul province in the South-West and Jauzjan province

[1] World Food Programme, Country Brief, 2022
https://www.wfp.org/countries/afghanistan

in the West. The capital city of the province is Mazar-e-Sharif, one of the biggest commercial and financial centres of Afghanistan[2].

In rural areas, COVID-19 has had minimal impact on agricultural activities. Agricultural land, both irrigated and rainfed, was reportedly cultivated at average levels, with slightly more cultivation than last year. Oilseed and horticulture, which are main cash crops, were planted on time. During the start of 2019/20 wet season, precipitation deficits were reported, but precipitation later in the season made up for earlier deficits and allowed crops to mature.

Like other provinces, measures have been taken to limit the exposure of residents to COVID-19, including lockdowns in urban areas lasting from early April through late May. These restrictions resulted in food price increases during the lockdown period and severely restricted income earning in urban areas. Balkh Province has also reported an influx of returnees from Iran and a significant reduction in remittances from Iran, Pakistan, and Turkey due to COVID-19.

According to MAIL data, wheat flour prices remained stable in the Mazar market between April and May 2021, but remained 37 percent higher than prices at the same time last year and 50 percent higher the three-year average. As a result, the terms of trade between casual labor and food were 13 percent lower than the same time last year and 21 percent lower than the three-year average. Furthermore, above-average sheep prices have not been sufficient to offset high wheat prices. As a result, the pastoralists' terms of trade – between livestock and wheat flour – also remained 11 percent below average.

In rural areas, most households are currently consuming own-produced food from the harvest. However, labor opportunities, handicraft sales, and remittances have been significantly impacted by the COVID-19 pandemic and have not yet returned to typical levels. As a result, many poor households are likely unable to meet all essential non-food needs, with Stressed (IPC Phase 2) outcomes expected. In urban areas, reduced income-earning due to below average labor opportunities and reduced remittances is also expected to impacting households. Due to lack of alternative livelihood means, dependence on markets for food, and insufficient humanitarian assistance, many poor urban households are unable to meet all food needs, with Crisis (IPC Phase 3) outcomes likely [3].

1.2.2. WASH situation in Balkh province

As per a study [4] which conducted needs assessment regarding WASH in Balkh province, 70 % of the families are using from unprotected hand dug wells, 23 % of the

[2]Naval Post Graduate School, Provincial Profile, Balkh
https://nps.edu/documents/105988371/107571254/Balkh_PDP_Provincial_profile.pdf/09d635b2-a75b-49e8-88c2-94d26ab54f7f
[3] FEWSNET, Afghanistan Food Security Outlook, 2020-21
https://fews.net/sites/default/files/documents/reports/AFGHANISTAN_Food_Security_Outlook_FINAL.pdf

[4] International Medical Corps, Emergency WASH Needs Assessment Report, 2019
https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/2019/11/Host-Communities-WASH-Needs-Assessment-in-Dawlatabad-District-of-Balkh-Province-by-IMC-%289-Octoberl-2019%29.docx

total families using from shallow wells equipped with hand pumps and other 7 % of total families using water from other unsafe water sources (river, ponds and canals).

75 % of the families do not wash their hands with water and soap after contact with feces and before contact with food in their HHs and 75 % of families are not possessing soaps in their HHs.

94.30 % of the families are using simple pit vault latrines, 5.70 % of the total families using flush to septic tank. In total families are having poor sanitation in the area.

1.3. Project Overview

Integrated humanitarian response in Balkh Province through Food Security, Nutrition & WASH interventions to the communities.

The project "Integrated humanitarian response in Balkh Province through Food Security, Nutrition & WASH interventions to the communities" was implemented from February 1, 2022 to August 31, 2022 [212 days] by SCJ (Save the Children Japan) funded by JPF. The aim was to improve the access to food for internally displaced persons, returnees and host communities in Balkh, improved knowledge of hygiene and nutrition, and better practice will enhance household coping capacity. The interventions included food assistance through cash transfers and implementation of educational activities on hygiene habits and nutrition care. This project provided food assistance, sanitation, and nutrition assistance through cash transfers to internally displaced persons, returnees, and host communities in Balkh Province (Mazar-e-Sharif City and surrounding areas), whose livelihoods have deteriorated due to natural disasters such as conflict and drought and the spread of COVID-19 infection, making it difficult to obtain food. Under the first outcome of the project, SCI-A reached a total of 700 most vulnerable households only in Balkh province for the distribution. The distribution of cash for the first round took place in May-2022 to enable the beneficiaries survive the financial stress. Whilst the second round of distribution took place in June-2022, the third round of cash distribution was in July-August 2022, and the fourth round of cash distribution was in August-2022. The cash transfer was complemented with awareness raising and information sharing sessions to inform beneficiaries about the purpose of cash. Such practice is helpful to further reduce the exposure of poor households to COVID 19 and help caregivers improve the nutrition situation of their children. The awareness raising activities was implemented in the form of campaigns, community-based demonstration sessions, and household visits.

1.4. Purpose of the Study

The purpose of the evaluation is to accurately capture information and analyze data on these project outcomes. The specific objectives of final evaluation are:

- To verify and measure outcomes of the projects;
- To understand the beneficiary's satisfaction;
- To document above achievements and challenges;
- To provide any possible indicatives for improving the projects for both JPF and member NGOs

1.5. Structure of the Report

This report represents the synthesis of a number of different streams of analysis and associated reports, including a set of case studies. The main body of the report is structured as follows:

Chapter 2: Methodology

Chapter 3: Findings

Chapter 4: Conclusion & Recommendations

2 Methodology

Study Design

Methodology for Data Acquisition

Means of Assessment

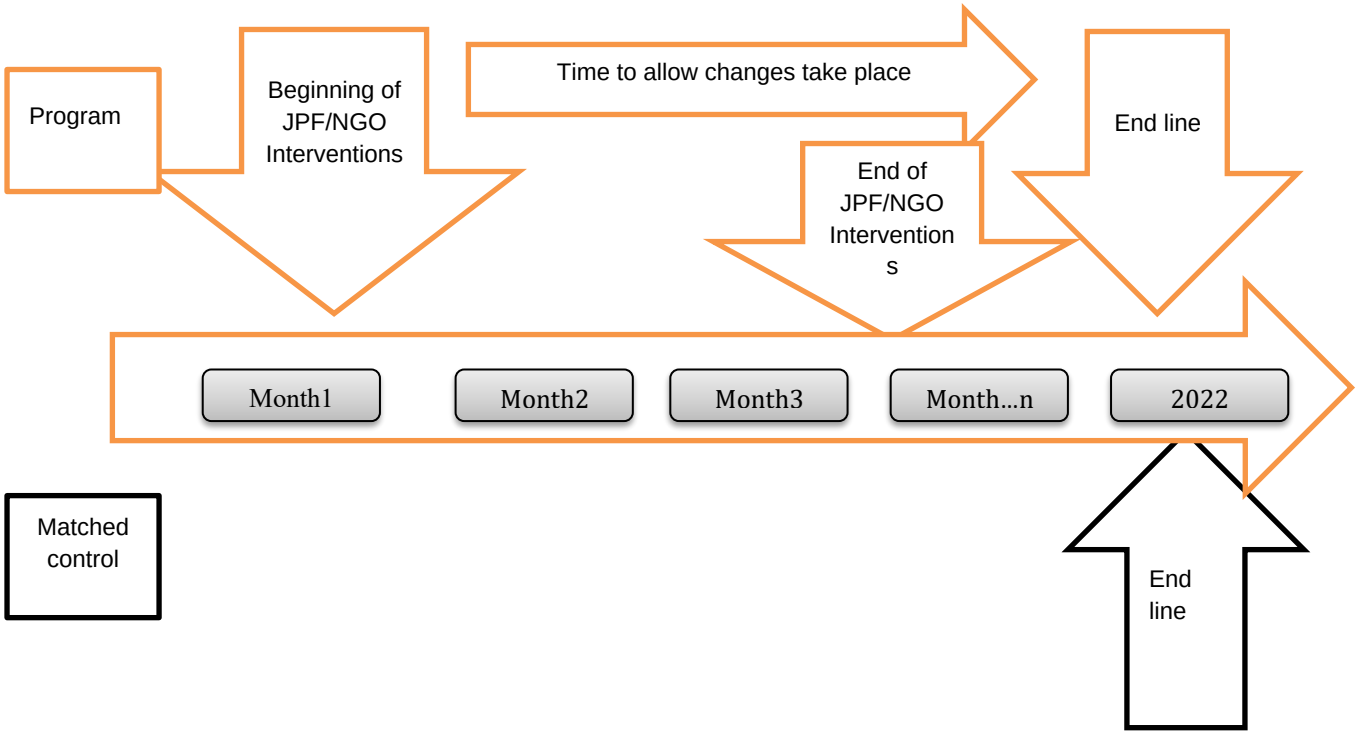
Data Collection

Data Management and Analysis

2. Methodology

2.1. Study Design

A case-control methodology was adopted for impact evaluation in consultation with the JPF and SCI-A to provide a scientific rigor to the evaluation. In this case-control method participants from both the intervention (102 HH) and the control group (25 HH) were purposively selected through matching by socioeconomic indicators such as age, gender, education and marital status. The assessment measured project outcome indicators.



The impact indicators for the project are divided into 2 groups according to the project outcomes linked to each component:

- Improved access to food for internally displaced persons, returnees and host communities.
- Improved knowledge of hygiene and nutrition, and better practice to enhance household coping capacity: The second outcome is split into 2 subcomponents
  - Improved knowledge in nutrition and adoption of better practices that enhance household coping capacities
  - Improved knowledge of hygiene

Some of the indicators are linked to the logframe, but also complementary indicators were added in some cases.

For estimating the impact of the program, **mean difference method** was used. This method consists in comparing the mean values of the impact indicators between the treatment group (beneficiaries of the program) and the control group (not beneficiaries). In other words, it measures the differences in outcomes between program participants after the program took effect and another group who did not participate in the program. The mean difference is a standard statistic that measures the absolute difference between the mean value in two groups in an experiment. It estimates the amount by which the experimental intervention changes the outcome on average compared with the control. The statistical significance of the indicators is checked, and as consequence the difference between both means to know if the impact of the program both in food security and resilience through the different indicators outlined in the section 2.7

For the identification of treatment groups, the household selection criteria & database used by SCI-A for identifying the most vulnerable households was used. The beneficiaries were randomly selected from the household selection database. In the case of the control group, households in a village that did not receive the cash for food program, with similar vulnerability context to the program village, were randomly selected.

Outcome 1: Improved access to food for internally displaced persons, returnees and host communities in Balkh

As outlined in the logframe, the sub-indicators 1.1 and 1.3 are the ones that were used to assess both household caloric availability and dietary diversity and behavioral responses to food insecurity.

Food Consumption Score (FCS)

The Food Consumption Score (FCS) is an index that was developed by the World Food Programme. The FCS aggregates household-level data on the diversity and frequency of food groups consumed over the previous seven days, which is then weighted according to the relative nutritional value of the consumed food groups. For instance, food groups containing nutritionally dense foods, such as animal products, are given greater weight than those containing less nutritionally dense foods, such as tubers. The food consumption score is a proxy indicator of household caloric availability and dietary diversity. Based on this score, a household's food consumption can be further classified into one of three categories: poor, borderline, or acceptable. However, in this exercise, a raw FCS score of the beneficiaries compared with the raw score of the counterfactual (control group).

Coping Strategy Index (CSI)

The Coping Strategy Index (CSI) was developed by the World Food Program. It is an indicator of a household's food security assessing the extent to which households use harmful coping strategies when they do not have enough food or enough money to buy food. The CSI measures behavior: the things that people do when they cannot access enough food. There are a number of fairly regular behavioural responses to

food insecurity—or coping strategies—that people use to manage household food shortage. The result is reported by a numeric score. The CSI consists of a module of 12 questions that were asked using as point of reference the last 7 days.

Outcome 2: Improved knowledge of hygiene and nutrition, and better practice to enhance household coping capacity.

The second outcome includes 2 components related to knowledge and practices on nutrition and to knowledge and practices of hygiene.

- **Indicator 2.1.1 Percentage of HH with correct knowledge on preparation of hygienic food:** This indicator was estimated through the question: How to prepare hygienic food?

- **Indicator 2.1.2 Percentage of HH with correct knowledge on meals that are beneficial for children:** This indicator was estimated through the question: What meals are beneficial for children?

- **Indicator 2.1.3 Percentage of HH with correct knowledge about the age in which it is correct to start providing food for children:** This indicator was estimated through the question: When should we start to provide food for children? (which age)

- **Indicator 2.1.4 Percentage of HH with correct knowledge about materials that should be put together to provide a healthy meal** This indicator was estimated through the question: *Correct knowledge on meals that are beneficial for children*

- **Indicator 2.1.5 Percentage of HH with correct knowledge on how to take care of the child with MAM:** This indicator was estimated through the question: *How to take care of the child with MAM?*

- **Indicator 2.2.1 Percentage of individuals with correct hygiene/hand-washing habits:** the indicator was estimated through the question: *What are the five critical times of handwashing?*

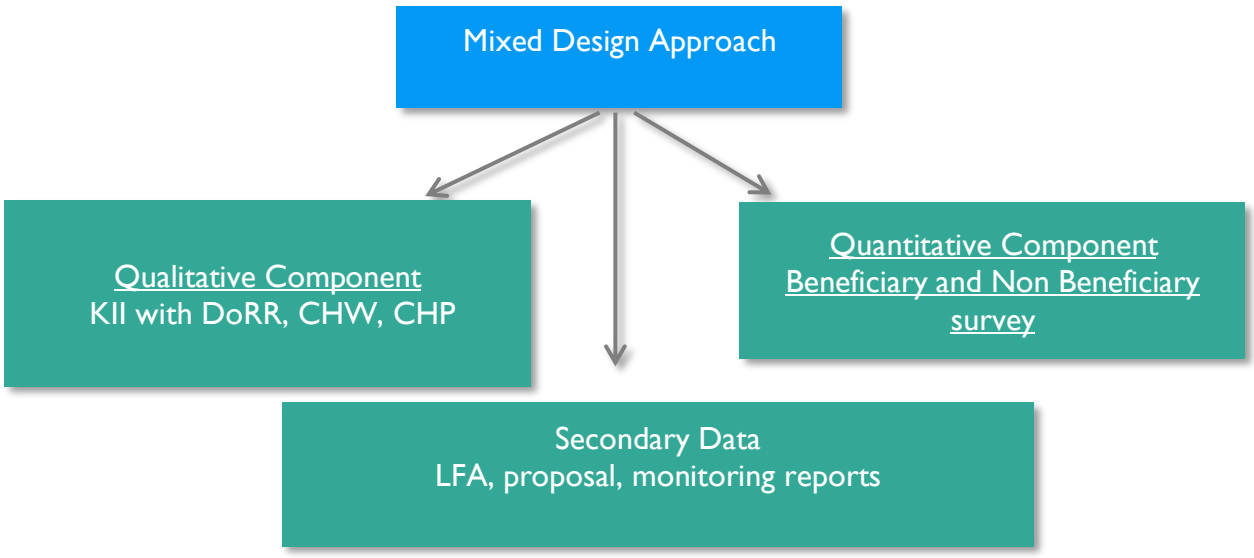
Satisfaction of beneficiaries

The beneficiary satisfaction was assessed with a set of questions depending on the intervention in which the beneficiaries took part. Those questions were answered with a single choice selection in a 1 to 5 Likert scale between satisfied, satisfied, neutral, very dissatisfied and dissatisfied

2.2. Methodology for Data Acquisition

In line with the above-mentioned objectives, a mixed design approach was adopted for the evaluation. As a method, this research design focused on collecting, analyzing, and mixing both quantitative and qualitative data in order to provide a better understanding of study objectives. Evaluation design was based on triangulation of primary and secondary information collected during the study. A case-control methodology was adopted for impact evaluation in consultation with the JPF and to provide a scientific rigor to the evaluation (fig 1).

Figure 1: Summative evaluation data collection methodology



1.2.1. Sample Size Calculation

The sample size was calculated using the following formula:

n = N*X / (X + N – 1), where, X = Zα/22 *p*(1-p) / MOE2; Zα/2 is the critical value of the Normal distribution at α/2 (e.g. for a confidence level of 95%, α is 0.10 and the critical value is 1.645); MOE is the margin of error 10%, p is the sample proportion (assuming the largest possible variance of 50%), and N is the population size (700 households). Minimum sample size (n) =77 HH. There were extra 25 households selected in the control village increasing the total to 102 surveys, in case of a data loss (worst case scenario of 20% data missing).

We sampled 6 villages from the same district: four of them benefited from the participation in the program (Sia Gird, Shahrak-e-Afghania, Aman Abad and Naw Abad Takhtapul) and two as control group (Nadir Abad and Qara Ghajla).

The stratified sampling between the beneficiary households followed the beneficiary distribution[5]: 35.1% of the beneficiaries were located in Sia Gird. 26% in Shahrak-e-

Afghania. 20.8% in Aman Abad. and 18.2% in 24% in Naw Abad Takhtapul. In the case control we performed a simple random sampling for selection HH in two villages (Nadir Abad and Qara Ghajla) representing a 25% of the treatment sample (25 households)[6].

Table 1. Sample distribution by type and village

Type of village	Village	HH samples	Percentage
Beneficiaries´ village	Sia Gird	27	26.5%
	Shahrak-e-Afghania	20	19.6%
	Aman Abad	16	15.7%
	Naw Abad Takhtapul	14	13.7%
Control group	Nadir Abad	13	12.7%
	Qara Ghajla	12	11.8%
Grand Total		**102**	**100.0%**

2.3. Means of Assessment

- Desk review: post distribution monitoring data, market price monitoring report, monthly reports, baseline data, proposal
- Beneficiary and non-beneficiary household interviews: to gather information on beneficiary household socio-economic condition, usage of cash assistance, food practices, hygiene practices, hygiene kits usage, IYCF practices. The interview will also use tools such as coping strategy index, post distribution satisfaction score and food consumption score
- Interviews with Community Hygiene Promotors of IYCF training: For women and men trained in IYCF, information was gathered on understanding of different component of IYCF and practices adopted.
- KII with SCI-A focal point to understand program improvement scope under localisation
- KII with Local partners to understand capacity building and collaborative efforts of SCI-A
- KII with provincial and district authorities

2.4. Data Collection

2.4.1. Training and Field Testing

The training of provincial supervisor and enumerator for the project in Bamyan province conducted successfully on October 17, 2022 which was facilitated by HPRO technical team. Two participants one male and one female participated in this training. The methods used in the training were Interactive presentations and group

6 The distance between intervention areas and non-intervention area was minimum 10 Km. Additionally, control area having similar cultural, economic, customs and geographical conditions that of intervention area except that awareness on hygiene session and kit distribution was not conducted from the JPF funded project nor from any other organization.

discussions, Individual and group exercises, feedback from participants and facilitators, regular reflections from participants and role plays facilitated by investigators. In addition, the data collection tools presented separately to the participants and practically worked on the tools in Smart Phones using ODK (Open Data Kit) system. Different methods, such as presentation, group work, questions and answers and practical work were conducted. Finally, the feedback was given by the facilitators regarding filling out the questionnaires and using ODK properly.

2.4.2. Data collection

Data collection was conducted from October 18 to November 5th, 2022. An ODK based cloud mobile data collection platform "Kobotoolbox" was used for the data collection and storage. Digital data collection tools were designed in a manner that ensured receipt of quality data to the system, all possible validation measures were taken into account while designing the tool. Data collectors were popped up with alerts while submitting invalid data and they wouldn't be able to submit incomplete or invalid data.

A total of three in-depth interviews were conducted; one with the DoRR of Balkh and one each with the Community Health Worker and CHP.

Table 2: Surveys and interviews conducted during the summative evaluation

	Beneficiaries	Non-beneficiaries	Total
Respondents	**NahrShahi**	**NahrShahi**	**Total**
Beneficiary survey	77		77
Non beneficiary survey		25	25
KII With CHW	1		
KII with CPHO	1		
KII with DoRR representative	1		

The key challenge faced by data collection team was accessing interviewees due to several reasons related to Covid, growing insecurity across Afghanistan. This resulted in difficulty in intra district movement and conducting KII's. Thus, phone interviews of all participants were conducted from HPRO office. This was successfully executed due to presence of SCI-A structured database with all necessary details which allowed telephonic access to participants.

2.4.3. Monitoring and Supervision for quality assurance

HPRO monitor traveled to Balkh province and accompanied and oversaw the data collection work of the field data collectors for 2 days; she provided on the spot feedback and end of day debrief in which all weak points were highlighted and emphasize was made to not repeat those. In addition, the quality assurance team from HPRO Kabul office performed spot checks of interviews as soon as it is uploaded in HPRO ODK. The study supervisor also conducted monitoring of the data collection process on ODK. Besides taking such quality control measures in the data collection application, a data quality assurance officer was assigned to regularly check the data for invalidity and communicated the data related issues with the data collectors.

Incorrect records were rectified or eliminated from the database. To ensure respondents' personal information confidentiality instead of collecting their name, the application generated an auto number for each respondent formatted as (Province Code, District Code, First three letters of village name, 4 digit random number). All qualitative data collection events were audio recorded. The quality assurance manager conducted quality checks on transcribed interviews and second quality assurance check was conducted on translated interviews.

2.4.4. Means of Communication

The mode of communication was phone calls for weekly communication between Kabul team and SCI-A Balkh team. Virtual platform such as zoom, skype was used for sharing progress updates between JPF, SCI-A and HPRO team.

2.5. Data Management and Analysis

Transcription and Translation

Transcription of field notes started as soon as the data arrived in the database. The quality assurance officer reviewed field notes for completeness and made additions to the notes after listening to the audio-recorded interviews. To get an accurate account of data from the interviews, the quality assurance officer, data manager and field supervisor reviewed notes and make additions to the field notes. One translator was solely responsible for translating transcripts from Farsi/Pashto to English. The quality assurance officer translated quantitative information. Verbatim transcripts were created from the recordings using a standardized transcription protocol. Transcripts were translated into English, and used for analysis.

2.4.2 Coding of data

Quantitative

The questionnaires were coded with such as district name, village name etc. The study team developed coding rules for all the situations and applied them consistently. The coding issues were pertaining to missing information, ambiguous information, details of response is disconnected from choices selected by respondents. The data files were cleaned for errors. The data manager checked thoroughly the data file to ensure that all responses are within the valid range. Invalid entries were rechecked with the electronic database and based on consensus within the team, observations were replaced with valid numbers.

Qualitative

Some identifiers such as KII interview name used in the study were put in hidden folders since we no longer need this information as we wanted to eliminate the possibility of linking responses on the electronic file to individuals. During the study respondents were given opportunity to provide written comments at the end of the questionnaire. The responses were coded according to the type of comment that was made. The open-ended comments were coded and the data was entered electronically in the access program.

The research objectives and research questions guided data coding for qualitative data. The key themes were developed based on the objectives of the evaluation. The sub-themes were generated using the relevant research questions. These were priori

codes that guided the categorization of the data. As new sub-themes emerged, those were also coded as new codes. The quality assurance officer and data manager provided support to the team during transcription of field notes. After the transcription of field notes, a quality assurance officer worked on the organization of field notes. The field notes and transcribed interviews were organized by respondents and type of data collection method (KII). Data was organized by main folder and sub folders and then started coding of data. A deductive thematic analysis was conducted with the transcripts using the qualitative data analysis software. For the coding process, first priori codes were developed based on the existing themes. Priori codes provide a general framework for major themes and subthemes that were generated later through an iterative process. Then, the technical lead had to review transcribed notes multiple times so they could label or group certain areas in the dataset. The quality assurance officer and field coordinator team looked for similar views and opinions and group them together to support a particular theme.

2.4.3 Data analysis

Quantitative

For quantitative data analysis, data was first run for missing values, double entries in STATA 14. Data was recoded for certain values and new variables were generated. During data analysis of quantitative data, data issues of type I and type II errors was assessed. The quantitative information was compiled to generate ratios and figures. In this study only univariate analysis was conducted, mainly in the form of frequencies and percentages. Later, pivot tables were generated using Ms Excel to segregate the values as per sub-groups.

Qualitative

KII interviews were first transcribed and then translated to English. Followed by analysis of qualitative data under the major themes of 1) Program functioning, 2) Capacity building 3) Project Management. Sub themes were generated under each major theme based on the objectives stated in ToR. The purpose was to group themes in a hierarchical structure. Sub themes were placed under each major theme in a way that supports the major theme.

2.4.4 Limitations

There were various limitations to this study, which can be divided into, challenges of field, and evaluation scope. The scope of evaluation was broad considering the interventions in three districts. The evaluation team in consultation with SCI-A field team tried to select control groups as close to the beneficiaries as possible so there is close matching guided by the HEAT database with both beneficiaries and no beneficiaries. However, there were challenges at matching the households as control. This limited the exercise of comparing results between beneficiaries and control groups of the Food Consumption Score (FCS), the Food Insecurity Experience Scale (FIES) and the Coping Strategy Index (CSI). As a consequence, we only presented the FCS from a descriptive perspective to complement the first and second outcome indicator stated in the logframe which is improved food security and improved the resilience of target communities to disasters.

Findings

3

Objective 1: To verify and measure outcomes of the projects

Objective 2: To understand beneficiary satisfaction

Objective 3: To document project achievements and challenges

Objective 4: To provide any possible indicatives for improving the projects for both JPF and member NGOs (Recommendations)

3. Findings

Sections 3.1 to 3.3 present the findings of analysis under three thematic areas. Reference was also be made to link the findings with the project's stated outcome. As discussed in Chapter 2 (Methodology), the findings draw primarily from the in-depth analysis performed through an extensive review of policies around cash assistance for food, WASH, nutrition related documents and primary data generated from the field.

This section presents the findings under three large themes followed by sub thematic areas. Headline findings are presented as bold (and numbered) statements and the supporting findings are presented as sub sections with additional paragraphed text.

3.1. Objective 1: To verify and measure outcomes of the projects

Study participant demographics

- **Distribution by age:** The average age of the individuals of the sample is 35.1 years-old. In the case of the beneficiaries, the average age in Sia Gird is 38.3 years-old, in Shahrak-e-Afghania is 36.5, in Aman Abad is 32.9, and in Naw Abad Takhtapul is 31.1 years old. Finally, the control group average age is 34.4 years old (Nadir Abad and Qara Ghajla).
- **Distribution by sex and marital status**: Overall the majority of the respondents (beneficiaries and control) of the sample are married (90.2%), while the remaining 9.8% are widows. When it comes to beneficiaries, 93.5% are married while 80% of the control group have the same marital status.
- **Distribution by literacy:** Overall most of the respondents are illiterate (94.1% of the sample). Regarding beneficiaries 93.5% are illiterate, 5.2% have religious education and only one had completed secondary school (representing 1.3% of the beneficiaries). Regarding the control group, the distribution is similar, 96% are illiterate and 4% have religious education.
- **Distribution by ethnicity:** Most of the beneficiaries belong to Pashtun group (43%), in second place to Tajik (36%) and in third place to Uzbek (8%). Regarding the control group, most belong to Tajik (40%), then to Uzbek (28%) and in third place to Pashtun (16%) and Turkmen (16% as well).
- **Income level:** The overall average monthly expenditure of both beneficiary and control group households during the first quarter was 8.000 AFN (food expenditure represented 67% for the beneficiaries and 68% for the control group). During the second quarter, the beneficiaries expenditure was 6928 AFN, while the control group expenditure was 7840 AFN (food expenditure represented 77% for the beneficiaries and 69% for the control group).
- **Distribution by migration status:** Most of the respondents are host communities (67.6%) while the remaining 32.4% were returnees. In the case of the beneficiaries, 39% are returnees and 61% host communities, while for the control group 12% are returnees and 88% host communities.

All interviewees in Sia Gird (beneficiary group), Shahrak-e-Afghania (beneficiary group) and Qara Ghajla (control group) are host communities, while all interviewees from

Aman Abad (beneficiary group) and Naw Abad Takhtapul (beneficiary group) are refugees. In the case of Nadir Abad (control group), 23% are refugees and the remaining 77% are host communities.

Table 3: characteristics of villages surveyed

Type of Village	Village	Refugees	Host Communities
Beneficiaries´ village	Sia Gird	-	100%
	Shahrak-e-Afghania	-	100%
	Aman Abad	100%	-
	Naw Abad Takhtapul	100%	-
Control group	Nadir Abad	23.1%	76.9%
	Qara Ghajla	-	100.0%

Refugee beneficiaries have been living there on average for two years and 11 months, while control group refugees have been there for two years on average. All refugees left their place of birth because of war and insecurity. On the side of host communities, 93.6% of the beneficiaries and 100% of the control group have lived there for their whole lives.

Household characteristics

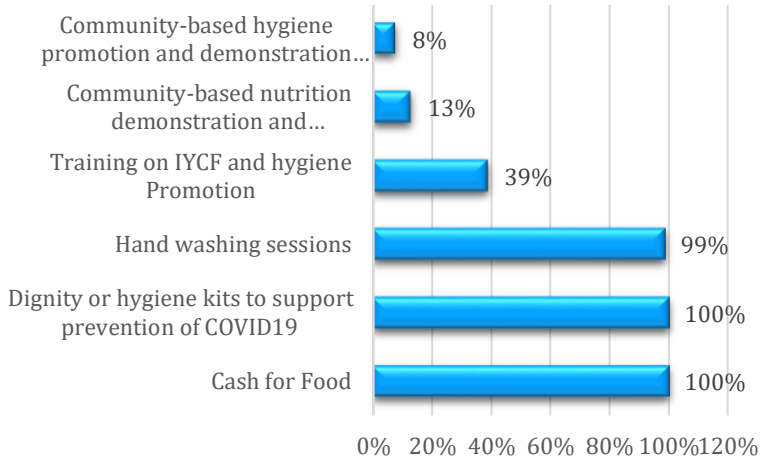
On average, the beneficiaries´ household size (number of members that live in the same house) is 8.18, from which almost five (4.81) are children from 0 to 17 years old, 2.75 are adults (from 18 to 60 years old), and there is almost one elder of more than 60 years every two households (0.61). 20.8% of the beneficiary households host at least one person with disabilities.

Among the non-beneficiaries, the distribution is quite similar: the household size is 7.44 members, and on average, there are 4 children, 3.16 adults, and 0.28 elders. The 0.5% of the non-beneficiary household families are people with disabilities. 78% of the beneficiaries and 68% of control group women have children under 24 months.

Enrollment in the program

All the beneficiaries from the sample took part in 3 components of the project: Cash for food; Hand washing sessions; and dignity or hygiene kits to support the prevention of COVID-19. Then 39% received training on Infant and young child feeding (IYCF) and hygiene promotion; 13% participated in community-based nutrition demonstrations and complementary feeding sessions; and 7.8% participated in community-based hygiene promotion and demonstration sessions.

Figure 2: Participation of beneficiaries by program component

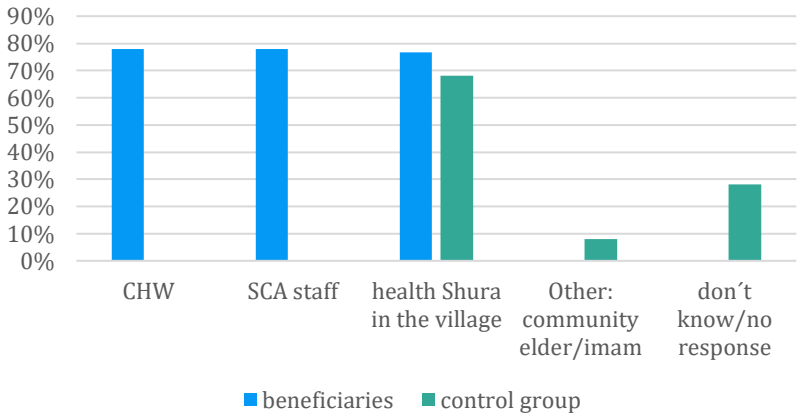


3.2. Objective 2. To understand the beneficiary's satisfaction

Complaint Management with Health & Nutrition

Beneficiaries are more aware to who they can make complaints if they have: community health workers (78%), SC staff (78%) and health shura in the village (77%). In the case of non-beneficiaries, 68% make their complaints to the shura, 8% to the community elder and 28% do not know. Only 3.8% of the beneficiaries have made complaints, and in all the cases the corrective action was shared with complainant.

Figure 3: Who can complaints be made to



Beneficiary Satisfaction on Nutrition and WASH intervention

Everybody was treated courteously on the different activities. From the ones that attended the training on IYCF and hygiene promotion, 97% think it is fair and is helpful for family. Additionally, all participants think that the training sessions on IYCF and hygiene adequately addressed the issues in community and at household level. 93% of the participants of the community-based nutrition demonstration and complementary feeding sessions were fair and is helpful for mothers. Also, all participants think that community-based nutrition demonstration and complementary feeding sessions

adequately cover the area on feeding related aspects to children till 23 months age group

Beneficiary Satisfaction and program functioning on cash distribution intervention

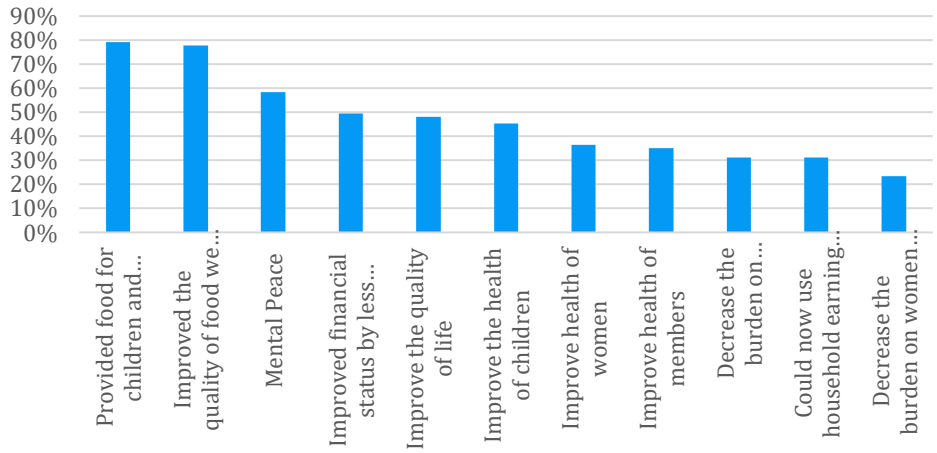
Beneficiaries of the cash transfer program have been enrolled for 4 months, received 4 tokens and received cash 4 times. Beneficiaries from Aman Abad are the ones that spend less time travelling to the distribution point (43 minutes) and have shorter waiting time (60 minutes). The beneficiaries from Naw Abad Takhtapul are the ones with cheaper costs to get to the distribution point (242.9 AFN). Finally, the beneficiaries from Sia Gird are the ones who take more time to get to the distribution point (90 minutes), with longer waiting queues (80 minutes) and with more transportation costs to get to the distribution point (829.6 AFN).

Table 4: Time and resources spent in order to get the cash assistance

Village	Time it took to get to the distribution point (minutes)	Time waited to receive voucher/cash, from the moment arrived at the distribution point (minutes)	Time to get to distribution point and get the cash (minutes)	Average cost to get to the distribution point in AFN
Aman Abad	**43**	**60**	**103**	253.3
Naw Abad Takhtapul	60	69	129	**242.9**
Shahrak-e-Afghania	89	63	152	650.0
Sia Gird	**90**	**80**	**170**	**829.6**
Total average	75	69	144	560.5

All beneficiaries used the cash only to buy staple foods and have had no problems in purchasing food at the market. Most of the beneficiaries perceived that cash assistance helped the household to provide food for children and members of the family (79%); in second place it improved the quality of food beneficiaries eat (77.9%); and in third place it brought mental peace (58.4%).

Figure 4: How cash assistance has helped the household

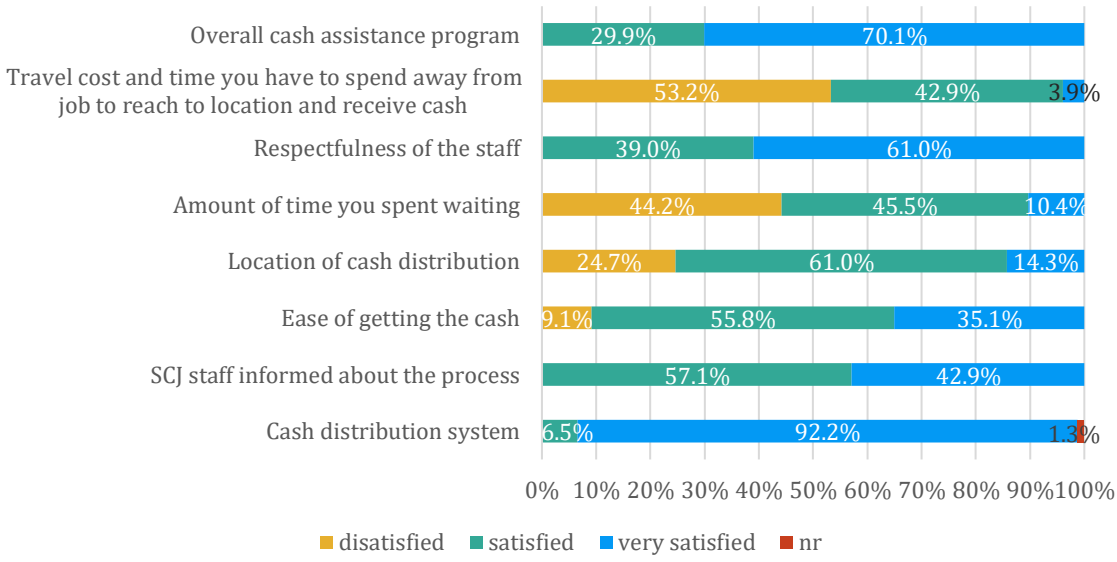


There were three beneficiaries who also received cash from the WFP. 97.4% of the cash transfers beneficiaries perceived that the involvement was high or very high in the following three aspects:

- The involvement of beneficiaries in the needs assessment of SCJ food assistance program
- The involvement of beneficiaries in the implementation process (incl. project steering committee) of JPF projects
- Involvement of beneficiaries in the monitoring process (incl. complaint mechanism) of JPF projects

All beneficiaries received the full cash amount on time. Also were treated courteously. All beneficiaries felt that Integrated humanitarian response through food security program is fair and is helpful for family. 97.4% of the beneficiaries think cash assistance is sufficient to provide food for family for one month, the remaining 3.6% don´t find it that way because items are expensive [*They expressed desire to get more cash so they can buy the needed food. But this is not possible as the cash amount is decided by WFP and the Food Security Cluster*].
All beneficiaries were either satisfied or very satisfied with the overall cash assistance program, also with the information provided by SC about the process and the respectfulness of the staff. The aspect with which most beneficiaries were very satisfied was the cash distribution system (92.2%). The aspects that had more dissatisfied beneficiaries were the travel cost to reach the cash distribution point and the amount of time spent waiting.

Figure 5: Degree of satisfaction with the different aspects of the cash distribution component



3.3. Objective 3. To document project's achievements and challenges

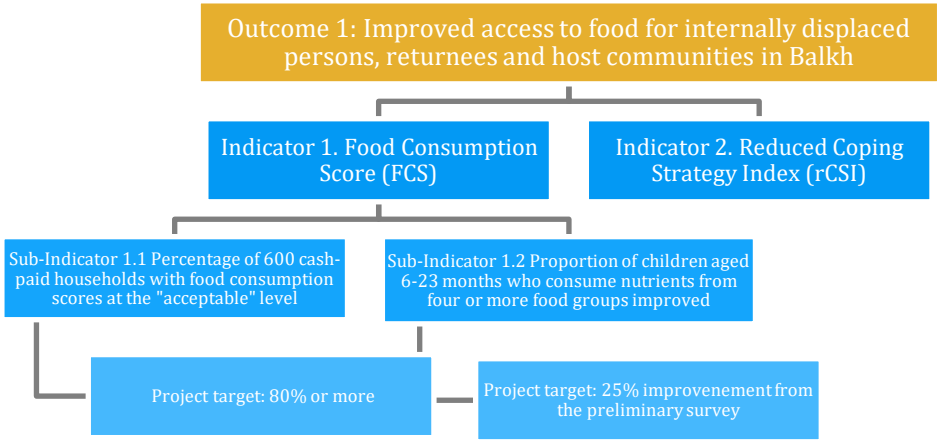
3.3.1 Achievements:

The project was able to distribute AFN 7900 cash to 600 households that were selected through beneficiary survey. These cash assistance was provided for four rounds. Three days training on Infant and Young Child Feeding (IYCF) and Hygiene was conducted for 20 male and female Commuinty Health workers (CHWs) and two days for Community Hygiene Promotors (CHPs). These CHWs and CHPs then provided hygiene and nutrition education in the villages for 36002 men women and boys and girls.

	Type	Number Male	Number female	Number of Days
Training on IYCF and Hygiene	CHW	25	25	3
	CHP	30	30	2
	Number of HH	Number of Rounds	Amount	
Cash assistance	600	4	7900 AFN	
Hygiene education at community level	Women			1
Hygiene kits provided	600	1	1 kit	
	Male	Female	Boys	Girls
Participants of Hygiene education	4136	7382	12292	12192

3.3.1.1 Impact Evaluation

Component 1: Improved access to food for internally displaced persons, returnees and host communities in Balkh



Indicator 1. Food Consumption Score (FCS)

The FCS is an index that was developed by the World Food Program. The FCS aggregates household-level data on the diversity and frequency of food groups consumed over the previous seven days, which is then weighted according to the relative nutritional value of the consumed food groups.

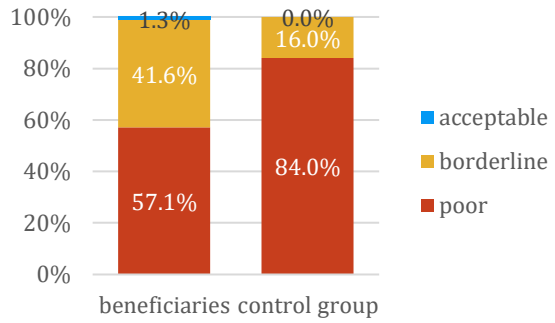
It is determined the household's food consumption status based on the following thresholds: 0-21: Poor; 21.5-35: Borderline; >35: Acceptable.

Sub-Indicator 1.1: Percentage cash-paid households with food consumption scores at the "acceptable" level.

- At the beginning of the project (after the first PDM report), 86% of the participants had a poor consumption score; 12% had a borderline FCS and 2% had acceptable FCS.
- At the moment of the evaluation the percentage of beneficiaries with a poor consumption score was reduced by 28.9%, and improved to borderline almost in the same proportion.

In comparison, the control group distribution presents percentages similar to the beneficiaries at the beginning of the project.

Figure 6: Distribution of food consumption score categories, by group



Regarding the mean difference, in this case we reject the null hypothesis(with a P value smaller than 0.05-in this case 0.0011), so there is statistical evidence that there is a difference between the group of beneficiaries and the no beneficiaries. That difference is 4.5 points more in the case of the beneficiaries, so there is a better situation regarding the household caloric availability and dietary diversity.

Figure 7: The output of the statistical analysis of t test done for FCS

```
. ttest FCS , by ( participant_type)

Two-sample t test with equal variances
```

Group	Obs	Mean	Std. Err.	Std. Dev.	[95% Conf.	Interval]
1	77	20.44805	.7091329	6.222616	19.03569	21.86041
2	25	15.94	.8766984	4.383492	14.13058	17.74942
combined	102	19.34314	.6063383	6.123716	18.14033	20.54595
diff		4.508052	1.343001		1.843576	7.172528

```
    diff = mean(1) - mean(2)                                      t =   3.3567
Ho: diff = 0                     degrees of freedom =      100

    Ha: diff < 0                 Ha: diff != 0                 Ha: diff > 0
 Pr(T < t) = 0.9994         Pr(|T| > |t|) = 0.0011          Pr(T > t) = 0.0006
```

Despite the target stated at the logframe of 80% or more households have an acceptable level of FCS was not fulfilled, there was a huge improvement of the situation of beneficiaries in terms of food consumption both in comparison to the initial situation (intertemporal analysis) and the control group (cross sectional analysis).

Sub-Indicator 1.2. Proportion of children aged 6-23 months who consume nutrients from four or more food groups improved

Regarding this indicator stated in the project logframe, there was no information of the baseline values, so the impact is shown comparing results as cross-sectional study with control group. We grouped the responses into the 8 standard food groups give to children. There were additional foods given to children such as oil, fat, ghee or sugary food; these were added to a separate group number 9. These 9 groups of food were grouped into 4+ food group and less than four groups.

Table 3 present results of the indicator segregated by beneficiary and control groups. In order to test the hypothesis and reject null hypothesis which states there is no difference between children of beneficiaries and those who were not beneficiary of the program (control group) we performed chi square test and produced P-Value. As can be seen from the statistical results, P value less than 0.01 shows the results are statistically significant and we can reject the null hypothesis and prove the alternative hypothesis which is; there is difference in the consumption of food groups between children of beneficiaries and control group. In fact, there is a difference of 48% between the beneficiary and control group in consumption of four or more food groups by children 6-23 months. Therefore, the 25% improvement target stated in the logframe is fully fulfilled.

Table 5: Main food group consumed by children 6-23 months by beneficiaries and control group

Food group	Beneficiary group	Control Group
N	40	10
Breast Milk	90%	90%
Grain Roots Tubers	83%	70%
Legumes Nuts	5%	0%
Dairy	75%	20%
Flesh Food	10%	0%
Eggs	28%	0%
Vit-A rich fruit & veg	30%	20%
Other fruit	18%	0%
Other	95%	80%
Four or more food groups	78%	30%
Less than 4 food groups	23%	70%
P Value	< 0.01	

Indicator 2. Reduced Coping Strategy Index (rCSI)

Developed by the World Food Program, is an indicator of a household's food security assessing the extent to which households use harmful coping strategies when they do not have enough food or enough money to buy food. The CSI measures beha**vior: the things t**hat people do when they cannot access enough food. There are a number of fairly regular behavioral responses to food insecurity—or coping strategies—that people use to manage household food shortage.

Weights for each category of the rCSI are specific for each context (in general after exercises of focus group discussions). As the weighting was not applied in the first PDM round database, it was calibrated with the index following the publication "MEASURING HOUSEHOLD STRESS: Development of Contextualized multi-sector Coping Strategy Index (mCSI) for Afghanistan" (2018) by the EU and OXFAM, and follow the mean comparison method between the beneficiaries and the control group.

Table 6: Weight criteria for calculating rCSI

Coping Strategy Index	Severity weight EU and OXFAM
Relied on less preferred, less expensive food	1
Restrict consumption by adults in order for small children to eat	3
Reduced the number of meals eaten per day	1
Borrow food or relied on help from friends and relatives	2
Reduced portion size of meals	1

rCSI Mean comparison (beneficiaries and control group)

As follows the rCSI indicator was studied with a mean difference between beneficiaries and non beneficiaries. We performed a statistical T test in which the null hypothesis is that there is no difference between beneficiary and non-beneficiaries in rCSI. So to prove that there is such a difference we hope to reject this null hypothesis and accept the alternative hypothesis (that there is a difference in the mean of the two groups). The coeficient of the difference between the two groups is expected to be the effect that the program has had on the different indicators.

Figure 8:The output of the statistical analysis of t test done for rCSI

```
. ttest rcsi , by ( participant_type)

Two-sample t test with equal variances
```

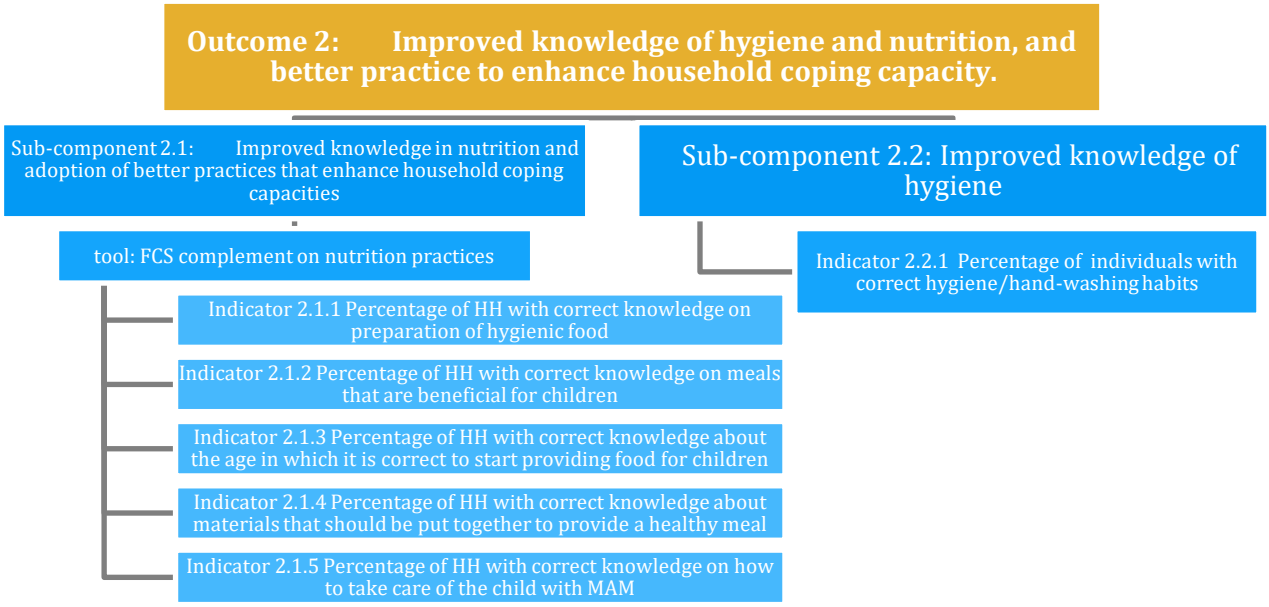
Group	Obs	Mean	Std. Err.	Std. Dev.	[95% Conf.	Interval]
1	77	3.480519	.7652774	6.715282	1.956337	5.004701
2	25	3.48	1.42258	7.112899	.5439396	6.41606
combined	102	3.480392	.6712226	6.779016	2.148867	4.811917
diff		.0005195	1.568238		-3.110821	3.11186

```
    diff = mean(1) - mean(2)                                      t =   0.0003
Ho: diff = 0                     degrees of freedom =      100

    Ha: diff < 0                 Ha: diff != 0                 Ha: diff > 0
 Pr(T < t) = 0.5001         Pr(|T| > |t|) = 0.9997          Pr(T > t) = 0.4999

.
```

However, there was not statistical significance to prove that there is a difference in the rCSI between the two groups (P value higher than 0.05-in this case 0.99). Results may vary if the model is recalibrated with other weights.

Additionally, the comparison between the treatment and control is less useful since there are no baseline values for the beneficiaries (to understand if there was a change in the situation before and after the project). Beneficiaries may have had a worst rCSI if it was measured at the time of baseline and then at endline.

Compontent 2: Improved knowledge of hygiene and nutrition, and better practice to enhance household coping capacity.



Sub-component 2.1: Improved knowledge in nutrition and adoption of better practices that enhance household coping capacities

Indicator 2.1.1 Percentage of HH with correct knowledge on preparation of hygienic food

In general, both beneficiaries and control group showed very good hygienic habits on preparation of food: all of them wash fruits and vegetables in running water before preparing, cooking, or eating; and use clean dishes and utensils to serve food.

Table 7: knowledge about preparing hygienic food (yes/no question)

Indicator	Beneficiary	Control	P value
Remove spoiled food	83%	94%	>0.03
Clean dishes/Utensils	100%	100%	>0.04
Reheat food thoroughly	98%	100%	>0.05
Avoid contact between raw and cooked food	97%	64%	<0.05
Use clean water for cooking and washing food	100%	100%	>0.05

A higher proportion beneficiaries avoid contact between raw and cooked food in comparison to the control group: 97% to 64.0% (P value <0.05). On the other hand, more households from the control group regularly remove spoiled foods that may transfer bacteria or molds to other food though not statistically significant (94% to 83% P Value >0.05). All in all, the habits for hygienic food preparing are in general very good. Beneficiaries recognize more procedures to keep the food safe than control group: 66% of the beneficiaries keep clean hands, working surface and utensils, while 26% of the control group does. 71% of the beneficiaries recognize the importance of using clean and safe water for cooking, while only 48% of the control group does so. Regarding separating raw and cooked food there is a stark difference in the results in table 5 and 6. The reason could be that the results in table five comes from direct

yes/no question and the respondent may have tried to provide a socially desirable response, while in table 6 the results come from multiple choice question. This might mean that the respondents may not have a strong belief that separating raw and cooked food was a key method for keeping food safe.

Table 8: Five important steps to keep the food safe (multiple choice question)

	Beneficiary N= 77	Control N=25
Keep hands utensils and surfaces clean	66%	26%
Separate raw food from cooked	6%	0%
Use fresh food and cook thoroughly	1%	0%
Keep food away from flies	100%	100%
Use clean and safe water	71%	48%

Additionally, 100% of beneficiaries in comparison to 92% of the control group households protect food from insects, rodents and other animals, however, the methods are different (control group has access to fridge).

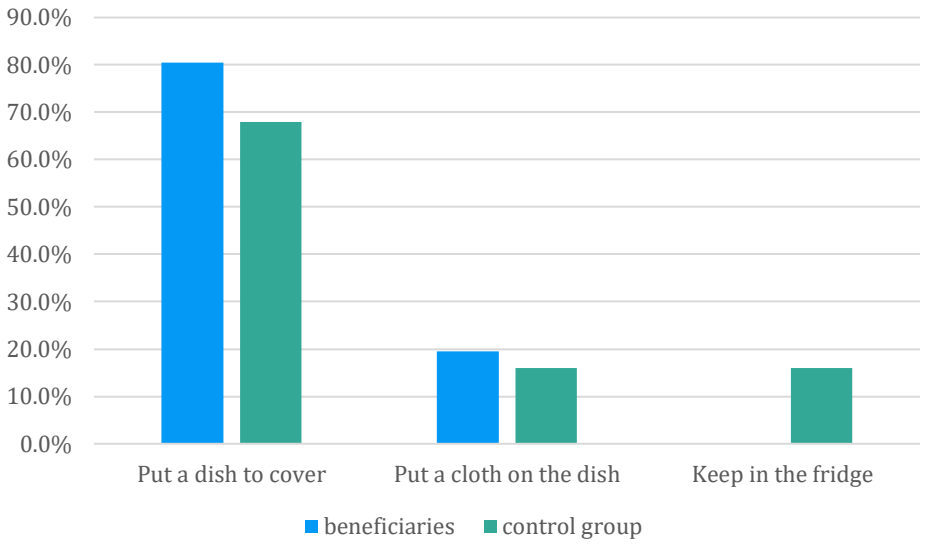


Figure 9: Methods for protecting food from animals including insects, rodents and other animals.

Moreover, beneficiary mothers have better hygiene knowledge when feeding their children: 91% of them agree that hands of both mother and child should be washed before feeding the child, while 68% of the control group believe so. The results of the Chi2 test, suggest that the difference between the two groups regarding the hand washing practices, is statistically significant at the level of 90%, with p= 0.03 (p<0.05).

Table 9: Hand Washing attitude

Participant type	Is the statement correct "The hands of both mother and child should be washed before feeding the child"		
	N	Yes, both mother and child	Only mother

Beneficiary	60	98%	2%
Control group	17	88%	12%
Total	77	96%	4%
			P Value 0.058

Indicator 2.1.2 Percentage of HH with correct knowledge on meals that are beneficial for children

Most of the beneficiary mothers knew that the meals beneficial to children should be high in dietary bulk (97%). In the case of control group mothers, the majority also knew the right answer (76%). However, the results of the Chi^2 test, suggest that the difference between the two groups regarding the knowledge about dietary bulk meals for children, is statistically significant at the level of 95%, with p= 0.005 (p<0.05).

Table 10: food that are beneficial for children

Correct knowledge	Beneficiary 60	Control 17	P value
Child food should be high in dietary bulk	97%	76%	<0.05
Child food should be thin enough to run through the spoon	67%	29%	<0.05
Minimal time should be used to prepare food for child	92%	53%	<0.05

Most of the beneficiary mothers knew that the meals food should be thin enough to run through spoon for to be easily swallowed by child (67%). In the case of control group mothers, the majority did not know the right answer (only 29% knew the right answer). Therefore, the results of the Chi2 test, suggest that the difference between the two groups regarding the knowledge about consistency level of food for children, is statistically significant at the level of 95%, with p= 0.001 (p<0.05).

Most of the beneficiary mothers knew that the meals the adequate time for preparing meals should be minimum as possible (92%). In the case of control group mothers, the majority knew the right answer as well but in a smaller proportion (only 53%% knew the right answer). Therefore, the results of the Chi2 test, suggest that the difference between the two groups regarding the knowledge about the time for preparing food for children, is statistically significant at the level of 99%, with p= 0.000 (p<0.001).

Indicator 2.1.3 Percentage of HH with correct knowledge about the age in which it is correct to start providing food for children

All beneficiaries and also control group mothers have correct knowledge about the age in which it is correct to start providing food for children (6 months). Additionally, beneficiary mothers have better knowledge regarding complementary information about providing food for children:

- 76.7% of the beneficiary mothers knew 6 months babies should be given soft porridge or mashed vegetable or meat fruit 2 to 3 times along with breast feed, while 47% of the control group did.

- 50% of the beneficiary mothers knew 9-11 months babies should be given three meals and one snack of finely chopped or meshed foods and foods that baby can pick up along with breast feed, while only 11.7% of the control group knew.
- 50% of the beneficiary mothers knew 12-24 months babies should be given three meals and two snacks of family foods, chopped or meshed, along with breast feed, while only 17.6% of the control group knew.

Table 11: knowledge about feeding child 6 months old

Participant type	How many times soft porridge or mashed vegetable or meat fruit should be given to 6 months along with breast feed			
	Two times only	Three times	Don´t know/ no response	Total
Beneficiary (N =60)	55%	22%	23%	100%
Control group (N =17)	47%	0%	53%	100%
Total	53%	17%	30%	100%
			P Value= 0.021	

The results of the Chi2 test, suggest that the difference between the two groups, is statistically significant at the level of 95%, with p= 0.021 (p<0.05).

Table 12: knowledge about feeding 7-8 months old child

Participant type	How many times mashed food should be given to 7-8 months along with breast feed				
	Three meals + 1 snack	Three meals + 2 snacks	Four meals	Don't know/no response	Total
Beneficiary (N =60)	50%	10%	3%	37%	100%
Control group (N =17)	12%	6%	0%	82%	100%
Total (N=77)	42%	9%	3%	47%	100%
				P Value = 0.010	

The results of the Chi2 test, suggest that the difference between the two groups, is statistically significant at the level of 95%, with p= 0.010 (p<0.05).

Table 13: knowledge about feeding child 12-24 months

Participant type	How many times mashed foods should be given to 12-24 months along with breast feed			
	3 meals + 2 snacks	3 meals + 3 snacks	Don't know/no response	Total
Beneficiary (N =60)	52%	14%	34%	100%
Control group (N =17)	20%	0%	80%	100%

Total (N=77)	45%	11%	44%	100%
			P Value= 0.006	

The results of the Chi2 test, suggest that the difference between the two groups, is statistically significant at the level of 99%, with p= 0.006 (p<0.01).

Indicator 2.1.4 Percentage of HH with correct knowledge about materials that should be put together to provide a healthy meal

Knowledge about food content for children is also different between the two groups as the beneficiary women knew and could mention protein, minerals, vitamins and carbohydrates while women in the control group could only mention protein and vitamins.

Table 14: Knowledge of Content of child food

Food types	Beneficiary N=60	Control N=17
Child food should be rich in Protein	95%	94%
Child food should be rich in Minerals	19%	0%
Child food should be rich in Vitamins	90%	59%
Child food should be rich in Carbohydrate	31%	0%

Indicator 2.1.5 Percentage of HH with correct knowledge on how to take care of the child with MAM

Children from 19 beneficiary mothers have been diagnosed with SAM or MAM while none of the control group has been diagnosed. Additionally, the children have been diagnosed, on average 10 months prior to the survey (7 months minimum and 14 months maximum), so in most of the cases the diagnosis was before the project started. Regarding pre-term or LBW, there was one diagnosed case in the beneficiaries and one in the control group. Finally, there was one beneficiary who has a child with diagnosed edema.

Beneficiary mothers of children with MAM[7] have very good knowledge on how to take care of the child with MAM:

- All of them know that children with SAM/MAM should be fed every two hours, while nobody of the control group does.
- All of them know that children with SAM/MAM should be checked for growth monitoring, weight measurement and other health checkup every 15 days.
- All of them are also aware about the use of Ready-to-Use Therapeutic Food (RUTF) for SAM or Ready-to-use supplementary foods (RUSFs) for MAM.
- All of them are aware about the danger signs of SAM, and when to take the child to the hospital.
- 95% of them know that breast milk should be given along with RUTF.
- 73% of them know that RUTF shouldn´t be shared with normal children.

7

- 95% know that the child should be kept covered and warm to avoid infections.

Table 15: Caring for children with SAM MAM or LBW

	Beneficiary	Control
Child diagnosed SAM or MAM	19	0
Correct knowledge of caring for SAM/MAM/LBW	N=19	N=0
How frequently a pre term baby should be fed		
Every two hours	58%	
Every hour	26%	
Don't know	16%	
Child with SAM/MAM should be checked for growth and health Every 15 days	100%	
Aware about Ready-to-Use Therapeutic Food (RUTF) for SAM and Ready-to-use supplementary foods (RUSFs) for MAM	100%	
Water needs to be added to RUTF	100%	
Aware about the danger signs of SAM, when to take the child to the hospital?	100%	
Breast milk be given along with RUTF	95%	
RUTF should not be shared with normal children	73%	
Child with MAM/SAM should be kept covered and warm to avoid infections?	95%	

Other complementary indicators: newborn care & Infant and young child feeding

Additionally, 97% of the beneficiary mothers breastfeed their babies immediately after birth and fed them with the colostrum (only 1 case reported of breastfeeding between 2 and 3 days after birth), while 100% of the control group breastfed immediately after giving birth with colostrum. Despite there is a difference between the two groups, it is not statistically significant (p= 0.335). Among the beneficiaries 20% young children consumed infant formula the day before the survey while none of the infants in the control group did so.

Table 16: breastfeeding practices

	Beneficiary N=30	Control N=14
Breastfed newborn child within the first hour of birth	97%	100%
Fed colostrum to the newborn	97%	100%
Currently breastfeeding	100%	100%
Child had infant formula yesterday	20%	0%

Source from where they got information of Exclusive BF and colostrum:

All of the sampled beneficiary households and just over 2 out of three of the control group mothers were told to breastfeed and colostrum by a health worker at a health facility (100% for beneficiaries and 71% for the control group). However, beneficiaries were told by many other qualified professionals as well, such as CHW (83%), SCI-A MHT midwives (10%), SCI-A MHT Health workers (7%), and Nurses (7%). On the other side, non-beneficiaries were also told by Friends/relatives (21%) and local Dais (7%).

Table 17: reported source of information about breastfeeding and colostrum

Health staff that provided	Beneficiaries N=30	Control N=14
1. CHW	83%	0%
2. SCI-A MHT midwife	10%	0%
3. SCI-A MHT Health worker	7%	0%
4. Nurse	10%	0%
5. Doctors	0%	0%
6. Health worker at Health Facility	100%	71%
7. Local Dai	0%	7%
8. Friends/relatives	0%	21%

Healthy signs of breastfeeding in mother and child: *estimated through the question (Narrate the signs that the baby breastfeeding is going well)*

Regarding the healthy signs about breastfeeding, beneficiaries´ mothers, show an improved situation regarding all indicators of the 3 different categories: mother, baby, breast, and baby position and feeding. Beneficiary mothers are healthier (87% in comparison to 45% of the control group), calmer (90% to 55%) and there is bonding between mother and baby (53% to 27%). Additionally, babies are calmer (87% to 57%) and reach breast if hungry (87% to 64%) The results of the Chi2 test on the indicator "mother is healthy", suggest that the difference between the two groups, is statistically significant at the level of 99%, with p= 0.000 (p<0.01).

The results of the Chi2 test on the indicator "mother is calm", suggest that the difference between the two groups, is statistically significant at the level of 95%, with p= 0.01 (p<0.05). Similarly, the results for child using Chi2 test on the indicator "baby is calm" is significant however for the indicator "child reaches for breast if hungry", is not significant. More beneficiary mothers report they have no pain or discomfort when breastfeeding (67% to 18%) and sucking is comfortable with no pain to the mother as compared to the control mothers (90% to 82%). The difference between beneficiary and control in the last indicator is not statistically significant.

Table 18: benefits of breastfeeding as reported by mothers from beneficiary and control group

	Beneficiary	Control	P value
1. Mother:			
a. mother is healthy,	87%	45%	0.006

b. mother is calm,	90%	55%	0.01
c. there is bonding between mother and baby	53%	27%	0.13
2. Baby:			
a. baby is calm	87%	57%	0.03
b. reaches for breast if hungry	87%	64%	0.086
3. Breast:			
a. no pain or discomfort,	67%	18%	0.006
b. Sucking is comfortable, with no pain to the mother	90%	82%	0.48
4. Baby position & feeding:			
a. baby head & body in line,	90%	67%	0.067
b. baby held close to mother,	80%	83%	0.8
c. The baby finishes breastfeeding from one breast, releases it, and	83%	25%	0
d. looks content and relaxed.	20%	0%	

Sub-component 2.2: Improved knowledge of hygiene

Indicator 2.2.1 Percentage of individuals with correct hygiene/hand-washing habits

Survey participants in the beneficiary and control villages were asked about times when they should use hands without giving them the answer options. There are marked differences between beneficiaries and control groups in knowledge of hand washing at critical times. Washing hands before preparing food is 77% and 52% among beneficiary and control groups respectively.

Table 19: Knowledge of hand washing at critical times

	Beneficiary 75	Control 23
1. Before preparing food for the baby or the family.	77%	52%
2. Before feeding the baby.	67%	9%
3. After cleaning the baby.	61%	4%
4. After using the toilet	99%	100%
5. Before eating food	56%	78%

85% of beneficiaries wash their hands from 3 to 5 critical times in comparison to all control group individuals, who wash their hands 3 or less critical times a day. All beneficiaries use water and soap to wash their hands, while 92% of the control group uses soap. Additionally, beneficiaries wash their hands more critical times[8] a day than control group individuals: All beneficiaries use soap for their household chores. In the case of the control group, 96% use soap.

8 Handwashing critical times: Before preparing food for the baby or the family; Before feeding the baby; After cleaning the baby; After using the toilet; Before eating food

Figure 10: Number of critical times mentioned for hand washing

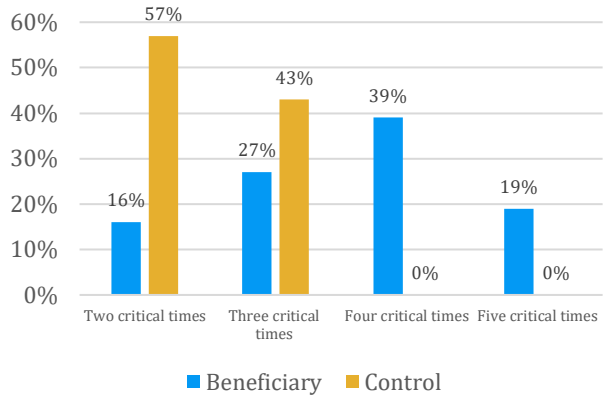
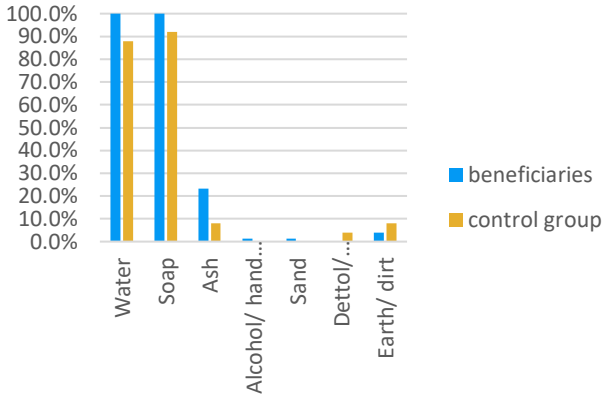


Figure 11: Materials for washing hands



3.3.1.2 Satisfaction among government and other key stakeholders

On satisfaction with the project services:

Mawlaway Jumadin from the department of refugees and returnees (DoRR) Balkh, showed gratitude for implementing the project in coordination with them and said that cash assistance was helpful in resolving some of the issues, however, the main needs of the people are shelter, school:

> *"I am grateful from them to share and coordinate this project with us .... I would like to say that money will solve their problem for a few days. The main needs of these people are shelters, because the winter is coming and they don't have any shelter to live in ... they need a school for their kids...."*

CHWs and CHPs were also talked about quality and usefulness of the training and that people were 100% happy:

> *"… we are 100%(happy)..... because I received training there, it was very useful. We came back and implemented it to make people aware…. We are 100% satisfied…all the equipment were there… projector, notebook, pens, banners, pencils, rubbers…. The classes had AC…The training method was also very good"*

Perception on the design of the project and beneficiary selection:

The DoRR Balkh stated that they were happy from the design of the project as well as beneficiary selection as the neediest people were selected such as widow, orphan, disable and very poor people.

> *"There were people from different provinces with very poor conditions specially women, children, and seniors.... Yes, they were fit for this project. There were widows, orphans, disabled people who selected for this project. I have all records and their photos from the selection of them till the end of the process."*

Perception about involvement of in the project cycle

The DoRR in Balkh signed an MOU with SCA for better coordination transparency of the project. It conducted supervision of the project during beneficiary selection, during the distribution of food and non-food items and after the distribution.

> *"No, the government did not intervene directly in their work, it only supervised and made sure that the help is received by the people in-need.... when they gathered the people in-need, we were there and observed the process of distribution of both food stuff and cash money... we go to the field and meet the representative or leaders of people to ensure that the people in-need get the help."*

1. Interview with female instructor

A female CHP who received the training on nutrition and on hygiene was interviewed and various questions asked:

Training on nutrition and hygiene

The IYCF and sanitation promotion training was a three-day long program with pre and posttests. Men and women (30 women) participated in the training in sperate classes.

One of the female CHW stated that IYCF topics were explained very well, after getting the training her knowledge had increased significantly, however, she added that it would have been good if its duration was more as each "CHW" transfer and communicate the knowledge to 150 or more people in each village. According to her many women benefited from the knowledge. The CHW

> *"…It was three days… we had a very good participation and interaction… Those topics were the IYCF, which means infant and young child feeding, nutrition of lactating women, hygiene and corona…. these were explained in details and in very excellent ways. very useful for women … .it would be good if the training was longer than 3 days"*
>
> *CHW*

A CHP talked about the quality of the training that it was very interactive: *"Yes, I participated Yes, Yes, each and every one participated, the training lessons were collaborative."* He talked about the content if the training that it focused on breastfeeding before six months and complementary feeding after six months of age:

> *"…. topic of a child under six months, that when he is born, he should not be given anything other than breast milk until he is six months old. Other issues were that children that are six months to two years old should be given balanced food…."*

Cascading the training: These trained people then cascaded the training at the community level to women at homes.

Women in the community received education on IYCF and Hygiene promotion. House-to-house screening was conducted and have performed Mid Upper Arm Circumference (MUAC) for children and women. According to the female CHW the women who participated in the classes, their children's malnutrition completely disappeared.

> *"We came back to the village for the purpose to teach women about of breastfeeding, hygiene and corona..…over 12-days we went to every house to house and did screening, measured MUAC and height and weight of children and gave education to the mothers of these children, they were malnourished and had moderate malnutrition….. Many people benefited from the knowledge of each of us……"*

3.3.2 Challenges

Challenges in imparting education sessions to women in the community:

According to one of the CHWs illiteracy of women was a barrier in effectively promoting hygiene and good nutrition in community as it was difficult to convey topics pertaining to IYCF. She however stated that she used illustration or infographics to educate them and this was better in educating them.

> *"The problem is illiteracy… The main problem of village women is that they can't get the issues quickly no matter how much you tell them…. Through the charts, they learn quickly, they understand the subject quickly; we do a lot of practical work with them."*

3.4. Objective 4- To provide any possible indicatives for improving the projects for both JPF and member NGOs

Summary

Access to food was considerably improved in quantity, quality and diversity:
More people had more access to food, and this improved their consumption. However, regarding the FCS, the project target was too ambitious by setting up 80% of beneficiaries with acceptable level of FCS. Children from the beneficiary households were fed with more diversity, improving their nutrition and the 25% target of children 6-23 consuming nutrients of four and more groups was fulfilled. Beneficiaries' knowledge of hygiene and nutrition was improved. Moreover, caregivers of children with MAM had very good knowledge about the best practices to take care of their children. Beneficiaries have improved daily hygienic practices and in general, are very good. Beneficiaries had a better knowledge on best practices to keep food safe, including mothers' hygienic habits for breastfeeding. All beneficiary primary caregivers knew exactly the time when is correct to start providing food to their babies, and other facts regarding children nutrition. Beneficiaries felt engaged and included in every part of the project and contents of the trainings were found adequate to their needs. In general, beneficiaries are very satisfied with all the components and is very important that cash distribution component let beneficiaries provide food for their children improve the quality of food and gave them mental peace.
One point that could be improved is some of the locations of the cash distribution points, like in Sia Gird and Shahrak-e-Afghania (where it takes more time to get to the point and has higher transportation costs). The project was successful both in improving access to food and improving knowledge of hygiene and nutrition, and better practice to enhance household coping capacity. A challenge was educating illiterate women and getting them to understand the infant and young child feeding, maternal nutrition and hygiene. The use of visuals and practice were useful in imparting training to the illiterate women in the community.
The Key Informants recommended the continuation and scaling up of SCJ project of Integrated humanitarian response in Balkh Province through Food Security, Nutrition & WASH interventions to the communities.
The project was well coordinated with various stakeholders however the expectations of the de-facto authorities are changing quickly; therefore, the research team recommends that coordination can be further strengthened to improve on inclusivity of the program:

Coordination with the authorities and local stakeholders including elders (men and women) should bolster the efforts of including 'people most in need'. This is to ensure to keep the exclusion errors as minimum as possible.

Integration of emergency assistance with resilience building activities: Risk reduction and resilience can be expanded and build in further for future programs. Activities of hygiene promotion, education on better nutrition of mothers and of children as covered under current program was good case for other programs to follow. Similarly raining the community level available volunteer cadre on key IYCF and hygiene Will ensure resilience and sustainability.

Improving on behaviour change strategies through audio visual aids: Conducting awareness sessions through audio and visual materials such as videos, poster and charts for educating illiterate men and women on hygiene and nutrition, will ensure message effectiveness which can be measured through behaviour changes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