La Chaîne de l'Espoir

Evaluation of the Afghan Health Programme, 2018-2022

Final Report

21 September 2023

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GLOSSARY

Term	Definition
Capacity Building	Capacity-building involves the development and strengthening of skills, abilities, processes, and resources within organisations, communities and individuals. Its aim is to enable them not only to survive, but also adapt and flourish in a rapidly evolving world through generating and maintaining transformative changes to encompass shifts in mindsets and attitudes. (United Nations)
Chaîne de l'Espoir	La Chaîne de l'Espoir was founded in 1994 and is an international NGO composed of a network of excellence in medical and surgical expertise. Its mission is to strengthen healthcare systems to ensure equal opportunities for survival and development, especially for children. Through operating in 29 countries, it aims to implement sustainable actions that provide access to healthcare and school health for the most impoverished children, their families, and communities worldwide. (Chaîne de l'Espoir)
French Medical Institute for Mothers and Children	The French Medical Institute for Mothers and Children is a not-for-profit hospital established in Kabul in 2006, in collaboration between the French and Afghan governments, as well as AKDN and CDE. (FMIC)
Internally Displaced Persons	"A person who has been forced or obliged to flee from their home or place of habitual residence, in particular as a result of or in order to avoid the effects of armed conflicts, situations of generalised violence, violations of human rights or natural or human-made disasters, and who has not crossed an internationally recognized State border" (UNHCR Emergency Handbook)
Tertiary Health Care	As per the NHS, "Tertiary care refers to highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services." It is classified as specialised medical care which typically entails a prolonged duration of treatment and encompasses sophisticated diagnostics, procedures, and treatments administered by medical experts. (NHS)

LIST OF ACRONYMS

AFD	Agence Française de Développement
AFN	Afghan Afghani
AKDN	Aga Khan Development Network
BPHS	Basic Package of Health Services
CDE	La Chaîne de l'Espoir
CME	Continuous Medical Education
COVID-19	Coronavirus Disease 2019
CSs	Case Studies
DfA	De facto Authorities
EQ	Evaluation Question
FGDs	Focus Group Discussions
FMIC	French Medical Institute for Mothers and Children
GDP	Gross Domestic Product
GIZ	German Agency for International Cooperation
HAS	Health Awareness Session
ICRC	International Committee of the Red Cross
ICU	Intensive Care Unit
IDP	Internally Displaced Person
IOM	International Organisation for Migration
KIIs	Key Informant Interviews
LMICs	Low- And Middle-Income Countries
MoPH	Ministry of Public Health Afghanistan
MoU	Memorandum of Understanding
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
NRC	Norwegian Refugee Council
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance
PGME	Postgraduate Medical Education Program
SDG	Sustainable Development Goal
SSIs	Semi-Structured Interviews
UNICEF	United Nations International Children's Emergency Fund
VGHPIs	Virtual Global Health Partnerships
WHO	World Health Organisation

ACKNOWLEDGEMENTS

Samuel Hall would like to thank first and foremost all the children, their families and guardians, and community members who generously gave their time and shared their stories for this evaluation, as well as key informants who contributed their knowledge, expertise, and recommendations and helped explain the project. Samuel Hall Is also grateful to the CDE and FMIC teams for supporting the conduct of this evaluation, and Thomas Dietrich for his facilitation during the course of the evaluation.

Research for this evaluation was led by Marion Guillaume and Livia Remeijers with Carolina Viana, Najia Alizada, Hakimullah Atiqee and the Afghanistan Samuel Hall team, and expert input from Dr. Hanni Stoklosa.

EXECUTIVE SUMMARY

METHODOLOGY & OBJECTIVES

The Chaîne de l'Espoir (CDE) commissioned Samuel Hall to conduct this endline evaluation of its Afghan Health Programme (2018-2022), funded by the French Development Agency. As it continues to operate in the ever more complex Afghan environment, CDE seeks not just to learn about this programme's implementation but also to plan for the continuation of its activities, allowing it to continue to support improved access to healthcare for the most vulnerable populations in Afghanistan. The programme sought to improve tertiary health care and access to it in Afghanistan, through the French Medical Institute for Mothers and Children (FMIC) using three components:

Staff expertise: "Strengthen the capacity of the FMIC health staff through short-, medium- and long-term training activities, with a focus on the new gynaecology-obstetrics and adult services, in order to maintain the high quality of medical and surgical care provided."

Medical expertise: "Help structuring medical expertise in Afghanistan through support to the FMIC post-doctoral programme."

Access to specialised healthcare: "Promote access to medical and surgical care at the FMIC for vulnerable populations, particularly women and children living in the provinces." [1]

Overall, the evaluation asks:

What can be learned from CDE's implementation of its Afghan Health Programme 2018-2022, as CDE and FMIC reflect on future strategic orientations in Afghanistan?

To offer a comprehensive and cohesive assessment, the evaluation drew on the standard OECD-DAC evaluation framework criteria (Relevance, Effectiveness, Efficiency, Coherence, Impact and Sustainability), to address three primary objectives.

Accountability

To assess the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the project.

Learning

To understand the evolution of the project, and the strengths and weaknesses thereof, in the changing Afghan context, in particular given the COVID-19 pandemic and change in authorities.

Strategy

To propose recommendations to CDE and actors in the humanitarian sector in Afghanistan to continue supporting vulnerable populations in Afghanistan, with a specific focus on how CDE can build on its previous efforts in the current context.

This endline is based on primarily qualitative data collection conducted with key informants and participants in the three programme components (staff expertise; medical expertise; access). In total, 17 Key Informant Interviews (KIIs) were conducted remotely, 7 Focus Group Discussions (FGDs) and 2 Semi-Structured Interviews (SSIs) in person in Kabul, and two thematic Case Studies both online and in person (in total these included 6 semi-structured interviews (SSIs) with parents of beneficiaries, 2 KIIs with community leaders and 2 community observations). Further, the evaluation drew from two online e-surveys (15 respondents) as well as two workshops, one in Kabul and one with CDE staff remotely.

[1] While a fourth component to support the fight against COVID-19 was added in 2020, it will not form part of the focus of this evaluation.

KEY FINDINGS: 10 MESSAGES

1. THE AFGHAN HEALTH PROGRAMME ADDRESSED CLEAR GAPS IN THE AFGHAN HEALTH CARE SYSTEM, EVEN AS THE CONTEXT EVOLVED

As the health sector in Afghanistan is increasingly over-solicited and under capacity, actors are generally focusing efforts even more on the provision of basic health care. As such, CDE's Afghan Health Programme stands out, as the lead, if not only, actor addressing tertiary health care needs through its three components. Even in 2018, the relevance of each was clear – building staff capacity generally, establishing medical expertise in specialties where it was lacking, and supporting vulnerable populations to access such health care. As the context has worsened, medical staff and others have left the country, creating a greater need for medical training, vulnerable populations are even less able to afford medical care, and the increasing complexity of operating under the current authorities has called for more rather than less support: CDE's work continues to be much needed.

2. WITH NEEDS OUTSTRIPPING RESOURCES, RECRUITMENT AND SELECTION PROCESSES FOR THE PROGRAMME REQUIRE CAREFUL IMPLEMENTATION

The Post Graduate Medical Education Programme (PGME) has followed strict eligibility requirements from its inception, with dedicated support to ensuring that qualified female candidates are equipped to pass the necessary entrance exams. The De facto Authorities (DfA) have sought increased involvement in this process wishing to prioritise their own candidates. To date CDE and FMIC have been able to keep selection processes independent, but the future of the programme is less clear.

On the access to medical care front, the breadth of needs means that demand far outstrips supply; eligibility is determined based on a comprehensive assessment of economic, medical, and other vulnerability factors but limited transparency around these can generate frustration. Several respondents, for example, queried men's lack of inclusion.

3. THE PROGRAMME BROADLY ACHIEVED ITS GOALS DESPITE MINOR OPERATIONAL FRUSTRATIONS AND A RANGE OF CONTEXTUAL FACTORS CHALLENGING IMPLEMENTATION

From COVID-19 to the change in authorities and attendant economic and social changes, the context at the end of the programme had changed drastically from that in which it began, changing the strategic focus for CDE from one of expansion and self-sustainability to survival and addressing ethical challenges. While not all targets have been attained, these shortfalls can be attributed to the contextual evolutions rather than failures on the part of programme implementation. On the contrary, across its three components the health programme has continued to address its higher-level goals, forming doctors, providing staff more generally with needed trainings and broadening its access programme through a partnership with NRC to specifically target displaced populations. Looking ahead, the evaluation does identify solvable frustrations under each component which should be explicitly addressed to avoid their becoming problematic in the future.

4. IN-PERSON MEDICAL MISSIONS ARE CRITICAL FOR TRAINING AND CARE

Reviewing programmatic spending underlines the relatively high cost of in-person missions – in particular short-term training and surgical missions by foreign doctors – as opposed to their immediately perceived benefits. The same money could be used to fund the treatment of a number of vulnerable patients. However, such in person training was found to be needed to allow doctors to develop surgical skills and operate on patients for whom there are not enough qualified surgeons in the country.

5. ADDITIONAL COORDINATION IS NEEDED TO MAXIMISE IMPACT

Existing coordination between CDE and its partners in the quadripartite agreement governing the FMIC (AND, the Government of France, and the Ministry of Public Health in Afghanistan) is regular, and CDE and FMIC further communicate on both regular and ad hoc bases. While this collaboration remains strong, and communications channels with the DfA remain open, it is in part dependent on several individuals who have been with the project from the start. A de-personalisation of 'internal' communication is thus called for to ensure it continues. Outwardly, further collaboration with existing NGO partners could reinforce capacity-building

efforts across partners, as in an under-resourced environment ensuring the coherence and maximum impact of such trainings must be a priority. This will also avoid dependence on a single partner, dangerous in the current environment as they might have to stop operations from one day to the next.

6. THE PROGRAMME IS HAVING POSITIVE IMPACTS ACROSS ITS WORKSTREAMS AND BEYOND

General staff and medical capacity have been supported, the FMIC provides quality tertiary medical care, and numerous patients were treated who would otherwise not have been. Specific targeting of women and displaced populations is aligned with the needs in the country. More broadly, the programme offers a conceptual opportunity to actors involved in it, a positive example of collaboration among a range of actors which can be highlighted in Afghanistan and beyond.

7. CONTINUED SUPPORT IS REQUIRED TO ALLOW ACTIVITIES TO CONTINUE

While the programme has had a powerful impact, it is not sustainable in its current form without the continued implication of CDE and donors. Ambitious plans for the hospital to become self-financing, even in its provision of care to vulnerable populations, are no longer realistic in the current context, while the departure of many medical staff and doctors from the country put the very provision of tertiary medical care in peril. Such continued support is threatened by the ethical questions raised by evolving policies at the national level, especially as regards gender.

8. THE DISPLACEMENT FOCUS TAKEN IN COLLABORATION WITH NRC LAYS THE FOUNDATION FOR FUTURE OPPORTUNITIES

In a context of widespread need, the explicit targeting of displaced populations is clearly aligned with both programme goals and broader objectives within the national and international community. With millions of people living in displacement in Afghanistan, in addition to those migrating abroad and returning or being returned, displacement is a major vulnerability factor and displaced populations are frequently deprived of healthcare services. The UN lays out the achievement of durable solutions for such populations as a key priority, to which health care can contribute; this opens up potential synergies between CDE's work and broader funding / support initiatives existing in Afghanistan.

9. CDE's GENDERED APPROACH IS APPROPRIATE

By focusing on women and children, and medical care specifically addressing women's needs (obstetrics-gynaecology) as well as ensuring women's inclusion in training programmes, although not exclusively, the programme has opened itself up to some criticism. However, within the context of constrained resources and an environment that actively limits women's engagement in public life and access to health care, such a focus is increasingly called for: it is logical to ensure that initiatives aimed at supporting vulnerable individuals should prioritise on women.

10. PLANNING FOR THE FUTURE REQUIRES EXPLICIT CONSIDERATION OF ETHICAL RED LINES FOR CDE

Since the change in authorities in Afghanistan, the operating environment for NGOs has become increasingly complicated and restricted, as the DfA have sought to impose their principles on NGO operations, supervise them more closely, and donors and international actors are wary of how, when and to what degree they operate in Afghanistan. CDE, like other actors, faces an ethical dilemma between the broader humanitarian imperative of supporting those in need, and human rights, given the recent edicts from the authorities restricting women's movements, generally, education, free speech and more. This requires explicit consideration of where CDE, organisationally, would place 'red lines', to allow it, with FMIC, to identify contingency plans in such a case – and avoid the sudden stoppage of medical care provision.

RECOMMENDATIONS

TECHNICAL AND OPERATIONAL OPPORTUNITIES FOR IMPROVEMENT

1. **Map opportunities for low-cost, 'high' reward technical support from CDE to FMIC.** This evaluation flags several areas where small planning, tool and standardisation initiatives could smooth FMIC operations, improve the impact of existing support provided and contribute to a stronger working environment. One example could be conducting a benchmarking exercise of residents' salaries against other residency programmes which takes into account the opportunities for additional income from private practice in residency programmes with lower hourly requirement, to review salaries if needed.

2. **Mitigate the operational frustrations raised in this evaluation.** Of particular concern are the issues raised by doctors around their working conditions – given how crucial they are to programme continuation and the individual risks of moral injury and burn-out they face – and the (mis)perceptions noted around referrals and CDE's ability to fund activities. The latter could snowball to administrative difficulties with the DfA if complaints are made and frustrations between households in communities or with implementing partners.

RELATIONSHIP BUILDING

3. **Create and reinforce spaces for discourse with sub-national and local authorities.** The evaluation highlights that the DfA's view of the FMIC – and by extension, CDE's support to it – is relatively positive, especially in comparison to broader negative perceptions of NGOs. Further, the programme is in a unique position of serving as a communication's 'bridge' between the Afghan and French authorities – which could potentially broaden to others if CDE is able to engage with them for funding. However, these high-level perspectives may alter rapidly. By working to create an additional network through local and sub-national authorities, both in Kabul and in the provinces, CDE may be able to facilitate its operations.

4. **Following the above, develop a stronger and broader partnerships network – including further local partners –** for implementation across all strands of activities. This evaluation highlights the need for further collaboration to develop more cost- efficient approaches to implementation; identify additional partners for medical missions; and finally, the weakness of a partnership dependent on a single counterpart in the current environment.

   In line with recommendation 5 below, this should also include specifically targeting partnerships to build on programmatic elements aligned with broader humanitarian objectives, to avoid the programme being viewed as 'solely' a development initiative. Among these, partnerships such as that with NRC taking a displacement lens offer high potential. Such partnerships can be rooted in a broader agenda of collaboration at multiple levels – including with local organisations who may face fewer limitations on their activities.

5. **Rethink CDE's Afghan Health Programme 'branding'.** While tertiary care and quality medical care are a clear gap in the current Afghan health context, across the board stakeholders raised the question of the perceived pertinence thereof at this point in time. Yet, in practice, CDE's activities are in line with humanitarian priorities and can be tied to the humanitarian imperative. Further, specific elements of existing programming are directly building on these objectives, such as the gender focus taken by the organisation, as well as the newer component aiming to target displaced populations. A 'rebranding' effort is called for to more clearly tie activities to broader funding streams than have previously been targeted. Rather than long-term development planning, in short, CDE must make the argument for the programme's integral role in supporting shorter-term humanitarian initiatives.

STRATEGIC PLANNING

6. **Incorporate a stronger monitoring and evaluation component in future programming.** Annual reporting and data collection internally has been output-focused. Given the rapidity with which the context has been evolving and the short-term nature of much funding additional strategic analysis and evidence is required both internally - to optimise operations - and externally - to showcase the impact which FMIC is having.
7. **Conduct an internal 'forward planning' exercise within CDE and then in conjunction with FMIC.** Stakeholders interviewed regularly raised concerns that firm ethical boundaries would be breached by new policies either at the national level or imposed on the programme – but neither 'red lines' on ethical front were explicitly agreed across the board, nor plans for what next.

1. INTRODUCTION

1.1. Introduction

In the twenty years between the fall of the Taliban in 2001 and their takeover in 2021, the Afghan health sector slowly grew, with significant improvements in maternal and child healthcare in particular. Despite the fact that the 2004 Afghan Constitution emphasises the state's responsibility to "provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions of the law",[2] the Afghan population still faces significant health challenges and obstacles to access care. Donor-funded initiatives– have helped to strengthen the provision of healthcare, with a general focus on primary and secondary care.[3] Yet, quality health care, and tertiary health care in particular, remain limited and access to these is worsening.

La Chaîne de l'Espoir (CDE) has contributed to addressing this challenge, targeting mainly the tertiary health care sector since 2005, when it launched its collaboration with the Aga Khan Development Network (AKDN), building the French Medical Institute for mothers and Children (FMIC) to provide high quality tertiary healthcare services to the Afghan population. The hospital is managed in a four-way public partnership bringing together the French and Afghan governments with CDE and AKDN.

In 2018, CDE began implementing the 'Afghan Health Programme', funded by the French Development Agency (AFD) to "help improve high quality tertiary care in Afghanistan, through the French Medical Institute for Mothers and Children". Initially planned to run through 2021, the project was extended through 2023 due to the impact of the Coronavirus 2019 pandemic (COVID-19) and the change in authorities on the project activities.[4] To achieve its objective, it had three primary components:

Specific Objective 1 – Staff expertise: "Strengthen the capacity of the FMIC health staff through short-, medium- and long-term training activities, with a focus on the new gynaecology-obstetrics and adult services, in order to maintain the high quality of medical and surgical care provided."

Specific Objective 2 – Medical expertise: "Help structuring medical expertise in Afghanistan through support to the FMIC post-doctoral programme."

Specific Objective 3 – Access to specialised healthcare: "Promote access to medical and surgical care at the FMIC for vulnerable populations, particularly women and children living in the provinces."[5]

The programme has been implemented at a time of significant contextual changes impacting its feasibility, implementation and outcomes. Factors such as the COVID-19 pandemic, shifts in government leadership, international sanctions, and subsequent interruptions in international aid and funding have greatly worsened the state of the Afghan health care sector, generally, and made it more difficult for actors to continue their work. Inadequate funding for healthcare, for example, is predicted to result in the following from July to December 2023:[6]

1. Approximately 3.7 million individuals will be deprived of access to life-saving healthcare assistance.
2. Roughly 1.5 million people in 94 districts will be left without essential winterisation healthcare support.
3. An estimated 296,000 pregnant and lactating women will be unable to access maternal healthcare services for the duration of their pregnancy, childbirth, and postnatal care.
4. Around 148,000 children under the age of one will miss out on crucial vaccinations.

As the Afghan Health Programme comes to an end, CDE, through the F3E, has commissioned Samuel Hall to conduct an endline evaluation of the project. Given the capacity, collaboration, and operating implications of the change in authorities in particular, CDE seeks not just to learn from this project's implementation but further to

[2] Islamic Emirate of Afghanistan, 'Constitution of Afghanistan', 2004.
[3] The Sehatmandi Project's key achievements as of October 2020 are detailed here:
World Bank, 'Results Briefs, Delivering Strong and Sustained Health Gains in Afghanistan: the Sehatmandi Project'. 23 October 2020
[4] AFD-CDE, 'Rapport Annuel 2019: Convention de Subvention AFD CAF N°1079 01 F', 2020.
[5] While a fourth component to support the fight against COVID-19 was added in 2020, it will not form part of the focus of this evaluation.
[6] OCHA, 'Afghanistan: Humanitarian Update, July 2023', 2023.

gather needed information to develop and adapt its strategy to support improved access to healthcare for the most vulnerable populations in Afghanistan.

1.2. Purpose and Objectives

Building on CDE's implementation of the Afghan Health Programme from 2018 to 2022, this report aims to address critical questions that will guide strategic orientations for future programming. The evaluation is designed to provide a comprehensive understanding of the project's outcomes and impact, considering the evolving context and challenges.

Overall, the evaluation seeks to answer the following question:

What can be learned from CDE's implementation of its Afghan Health Programme 2018-2022, as CDE and FMIC reflect on future strategic orientations in Afghanistan?

To answer this question, the evaluation has three key objectives:

Firstly, **from an accountability perspective**, to assess the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the project.

Secondly, **from a learning perspective,** to understand the evolution of the project, and the strengths and weaknesses thereof, in the changing Afghan context, in particular given the COVID-19 pandemic and change in authorities.

Finally, **from a strategic perspective,** to propose recommendations to CDE and actors in the humanitarian sector in Afghanistan to continue supporting vulnerable populations in Afghanistan, with a specific focus on how CDE can build on its previous efforts in the current context.

1.3. Context

Evaluation context

The Afghan Health Programme was planned and designed based on a context that has since undergone significant transformation. This evaluation report recognises such evolving context and assesses the programme in two distinct phases: pre-2020 and post-2020. Prior to 2020, there was a positive outlook for growth and expansion across various dimensions, including the training of hospital staff, the Post Graduate Medical Education (PGME) students, and the number of patients served. However, the emergence of the COVID-19 pandemic and changes in political authorities have substantially altered the landscape. Consequently, the approaches and trajectories planned in 2018 were no longer feasible as intended. Despite this, the programme's three core axes continued to remain relevant and applicable, covering an important gap within the Afghan healthcare system. [7][8]

Aligned with the Sustainable Development Goal (SDG) 3, the FMIC stands out as a leading hospital in Afghanistan, providing essential diagnostics and treatments. It also serves as a unique training centre for diagnostics and treatments. Its public-private structure enables the support of vulnerable populations in need of specialised care while also reducing its reliance on donor funding. This is crucial given many Afghans cannot afford FMIC services. As such, the CDE ensures equitable access to care for vulnerable Afghans, covering costs based on set criteria using generated revenue and donations.

Currently, Afghanistan faces a humanitarian crisis which has led to high rates of poverty, food insecurity, as well as limited services such as healthcare. It is estimated that two-thirds of the Afghan population – 6.4 million women and 15.2 million children – require urgent humanitarian assistance.[9] Afghanistan's health system faces, as such, significant challenges due to a lack of funding, infrastructure, and a shortage of healthcare workers,

[7] Médecins Sans Frontières, Persistent Barriers to Access Healthcare in Afghanistan, February 2023.
[8] Save the Children, Factsheet: Children Multi-sectoral Needs Assessment, June 2022.
[9] OCHA, 'Afghanistan Humanitarian Needs Overview', 2023.

particularly female staff.[10] In addition to these challenges, a recent (2023) Médecins Sans Frontières (MSF) report underlines the following:

- **Household financial limitations:** The ongoing socio-economic crisis means many Afghan households cannot afford the expenses associated with travelling to healthcare facilities. Based on 2022 data, 87.5% cited the cost of healthcare as the primary reason for avoiding seeking healthcare.[11]
- **Supply limitations:** The protracted conflict in Afghanistan has caused substantial damage to health facilities and infrastructure, resulting in a scarcity of medical equipment and supplies.
- **Limitations on women's work and travel:** Women face increasing limitations in studying and practicing medicine – while at the same time female patients in Afghanistan cannot be treated by men – creating yet another barrier to accessing healthcare for women.

Finally, displacement more broadly is a critical factor in the access to and provision of healthcare. From an access perspective, the displacement of millions has deprived them of access to essential healthcare services.[12] From a provision perspective, migration of qualified personnel after August 2021 brings to the fore the question of 'brain drain' of health staff.[13]

Programme overview

La Chaîne de l'Espoir (CDE) began its operations in Afghanistan in 2003 with the objective of enhancing healthcare access for the most vulnerable segments of the population, specifically children and women.[14] In 2006, CDE inaugurated the French Medical Institute for Mothers and Children (FMIC) in Kabul, also known as 'French Hospital'. This initiative was driven by the inadequate state of the country's infrastructure to cater to the needs of the Afghan population and the population's limited financial resources to access healthcare.[15]

Since the institute's establishment, the Aga Khan Development Network (AKDN) has been responsible for the management of the hospital and its personnel, while the CDE and the French government have supported the hospital by addressing its needs in terms of human resources and training for medical, paramedical, and technical staff.[16] Foreign healthcare professionals, predominantly French, have been regularly travelling to Afghanistan to undertake primarily short-term medical and paramedical missions. The main objective of these missions is to enhance the skills and capabilities of the local teams. Simultaneously, the FMIC has expanded its services to encompass a wide range of paediatric, medical, and surgical specialties, which encompass general medicine, cardiac care, orthopaedics, reconstructive surgery, and neurosurgery among others.[17]

Additionally, the CDE and the French government have extended their assistance to the most vulnerable groups through the Patient Welfare Programme. Introduced in 2006, this programme offers financial aid to economically disadvantaged households, allowing them to access healthcare. As of 2023, households with a monthly income below 10,000 AFN (approximately US$200) are eligible to apply for this support.[18] Over the years, the programme has assisted 588,100 Afghans, being a crucial role enabling them to receive necessary healthcare services.[19] Additionally, specialised care for adults had been introduced since 2014 to meet the healthcare needs of the Afghan population and ensure long-term financial viability.[20]

[10] Médecins Sans Frontières, Persistent Barriers to Access Healthcare in Afghanistan, February 2023.
[11] Ibid.
[12] Médecins Sans Frontières, Persistent Barriers to Access Healthcare in Afghanistan, February 2023.
[13] The Economic Times, 'Afghanistan brain drain complicates Taliban rule: Experts', September 2021.
[14] La Chaîne de l'Espoir, 'Proposition de La Chaîne de l'Espoir : Fiche d'Identification de Projet', March 2018.
[15] Ibid.
[16] Ibid.
[17] La Chaîne de l'Espoir, 'Proposition de La Chaîne de l'Espoir : Fiche d'Identification de Projet', March 2018.
[18] French Medical Institute for Mothers and Children, Patient Welfare Programme.
[19] Ibid.
[20] La Chaîne de l'Espoir, 'Proposition de La Chaîne de l'Espoir : Fiche d'Identification de Projet', March 2018.

The programme under review – implemented from 2018 to 2022 – had three workstreams, as per the below.

Table 1 – Overview of activities conducted under the project

Component 1: Staff Expertise	Component 2: Medical Expertise	Component 3: Access
• Organisation of training missions – medical, paramedical, and technical • Organisation of coordination missions • Remote trainings and consultations • Organisation of annual meetings • Organisation of webinars	• Training of residents in the post-doctoral programme (PGME) across specialities including paediatric surgery, anaesthesia, cardiology, orthopaedics, clinical pathology, radiology, ob-gyn and cardiovascular surgery	• Financial support to vulnerable patients through the FMIC Welfare programme • Provision of social and medical support through the Women and Children's Pavilion • Targeting of displaced women and children through partnership with the Norwegian Refugee Council (NRC)

Programme targets and goals

The programme's targets and goals were established with the intention of achieving specific outcomes over its duration. Annex 1 presents the evolution of key indicators, which showcase trends and changes in the three programmatic workstreams.

The reported number of training sessions at FMIC and abroad, for example, fell from 2,880 and 279 sessions, respectively, to 1,955 sessions for FMIC personnel and 192 for external personnel in 2021. Mission activities conducted by CDE also experienced a decline: initially projected at 85 missions per year, the actual number in 2021 was only 24. This suggests a reduction in the organisation's planned activities. Similarly, looking at the PGME programme, the number of residents participating in the PGME programme did not achieve the projected number of graduates with 47 graduating rather than the anticipated 60 during the 2018-2020 timeframe. The number of specialties taught remained relatively consistent but did not meet the projected expansion starting from 2019. Finally, looking at the Access to Care at the Women and Children's Pavilion, the reported number of beneficiary patients dropped from 5,483 stays in 2018 to 2,502 in 2021. New patient registrations also decreased, from an expected 1,400 per year to only 797 in 2021. Coverage across all provinces did remain consistently at 100%, except in 2020 when it decreased to 88%, due to the impact of COVID-19.

As detailed in the effectiveness section, however, these changes are for the most part due to the significant contextual evolutions with which the programme has had to grapple, rather than insufficiencies on the part of CDE and its partners.

Picture 1 – Barikab township, Kabul

2. METHODOLOGY

2.1. Evaluation framework

This evaluation of the Afghan Health Programme is based on data collection conducted by Samuel Hall in July 2023. In order to ensure a comprehensive and cohesive assessment of the project's results, this evaluation centres on the standard OECD-DAC evaluation criteria, with specific evaluation questions and sub-questions developed by Samuel Hall. The full set of research questions used are available in Annex 2.

Table 2 – Evaluation principal questions

Evaluation questions	
Criteria 1. Relevance	To what extent do the objectives and design of the intervention correspond to the needs and priorities of the project's target populations and partner actors?
Criteria 2. Effectiveness	To what extent has the project achieved its objectives?
Criteria 3. Efficiency	To what extent has the project been implemented in an economical manner and within the planned time frame?
Criteria 4. Coherence	To what extent is this project compatible with other interventions conducted in Afghanistan, as well as within CDE itself?
Criteria 5. Impact	What positive or negative impacts can be identified as a result of this project?
Criteria 6. Sustainability	To what extent are the project's benefits likely to endure without continued support?

2.2. Sampling

CDE identified participants in activities under the three workstreams and provided their contacts to Samuel Hall. Sampling involved both in-person and remote methods. Specifically,

- 17 Key Informant Interviews (KIIs) were conducted remotely.
- All Focus Group Discussions (FGDs) and Semi-Structured Interviews (SSIs) were held in person in Kabul.
- The data collection exercises making up the two Thematic Case Studies (CSs) were conducted both online and in-person.[21]
- One workshop was conducted online with CDE staff, while the other was held in person at FMIC.

Due to scheduling conflicts and the unavailability of male participants for a group discussion, one planned FGD was replaced by conducting four individual SSIs. Annex 3 provides a detailed table that includes disaggregated data categorised by tool.

Table 3 – Summary evaluation sample

Tools	Female	Male	Total
Key Informant Interviews (KIIs)	6	11	17
Focus Group Discussions (FGDs)	5	2	7
Semi-Structured Interviews (SSIs)		5	5
Thematic Case Studies (CSs)			2
E-surveys (2)	5	10	15
Workshop			2

NB: All names mentioned in the quotes throughout this evaluation report have been changed to maintain anonymity.

[21] In total these included 6 semi-structured interviews (SSIs) with parents of beneficiaries, 2 KIIs with community leaders and 2 community observations.

2.3. Research limitations and constraints

The following challenges were encountered during the evaluation process. They are detailed along with the mitigation strategies used to address them.

- **Delay in receipt of respondent contact details.** The delayed receipt of respondent contact details shifted the start of data collection.
- **Unwillingness of ministerial counterparts to participate.** The Ministry of Public Health (MoPH) officials identified for interviews were not willing to participate without formal approval from the DfA, not required for this research. KIIs with implementing partner staff thus included an additional focus on interactions with the government to triangulate this as much as possible.
- **Limited availability of staff and medical doctors.** The many demands placed on FMIC focal points and PGME residents and medical doctors complicated the organisation of FGDs due to scheduling constraints, leading to workarounds such as replacing one FGD with four SSIs.
- **Low e-survey respondent rate.** Despite implementing multiple mitigation approaches with support from CDE staff, the response rate for e-surveys among trainers (7 of a planned 20) and participants in trainings (8 of a planned 30) remained low. Responses were considered from an anecdotal perspective and triangulated against the KIIs, CSs and FGDs.

Picture 2 - Qambar Square IDP Camp

3. ASSESSING THE PROGRAMME ON OECD-DAC CRITERIA

3.1. Relevance

A much-needed intervention from the start

The protracted conflict in Afghanistan has caused substantial damage to its health system. This includes the lack of medical personnel in health facilities, as well as essential medicine and equipment to address the population's medical needs. Much of the focus of humanitarian actors working in the health sector has been on the provision of basic healthcare– according to a 2023 MSF report, 88% of surveyed Afghanistan respondents face challenges in accessing healthcare services due to the lack of financial means (both for direct and attendant costs of seeking healthcare).[22]

This leaves tertiary health care even more inaccessible to many. **Accordingly, the relevance of the CDE programme in providing high-quality medical care to individuals who would otherwise not have access to such services remains clear and has continued throughout the health programme, across all three components:**

- **Component 1** focuses on enhancing the skills and capabilities of the FMIC staff through medical missions and capacity-building activities. As such, it addresses the shortage of skilled healthcare professionals in the country, crucial to maintain and improve the overall quality of healthcare services.
- **Component 2** aims to establish a medical expertise in Afghanistan in specialties where it does not exist, or is vastly insufficient, through the PGME programme. This tackles the clear gap in highly skilled medical professionals and reduces reliance on foreign medical personnel to ensure that advanced medical care is available to Afghan citizens.
- **Component 3** supports vulnerable populations, especially women and children, facing significant challenges in accessing quality healthcare in Afghanistan. In facilitating these groups' access to complex medical services, the component seeks to reduce disparities in healthcare access and contributes to the overall health and well-being of Afghan communities.

Changing context, continued necessity

Since the start of this CDE funding in 2018, significant contextual evolutions have occurred, as detailed in the previous chapter. A compelling and optimistic vision for the future was in place at the start, with a clear plan for self-financing and expansion in place for the FMIC. However, external factors such as the COVID-19 pandemic, the change in authorities and the resulting worsening of the economic situation nationwide have reverberated across the CDE programme and strategy. As a result, the programme has had to take into account:

- **Widely increasing health care needs in a context of reduced funding.** With the Taliban takeover international donors paused or reduced funding, including to the health care sector. The World Bank ceased aid projects amounting to over $500 million, and the country faced a loss of access to approximately $9.2 billion in overseas assets held by its Central Bank.[23] While the United Nations provides emergency aid to public health structures, it is insufficient to cover needs.
- **A limited ability to plan for the future.** With shifting donor priorities towards humanitarian and rapidly evolving guidance from the authorities, the programme has been compelled to shift towards a more short-term outlook, demanding a high level of adaptability which comes with challenges in planification.
- **A shrinking public space for women.** The policies put in place by the authorities have reduced women's access to education, employment, health care and more. In December 2022, the Afghan government implemented restrictions preventing women from engaging in NGO employment and pursuing higher education, including attending university, and in April 2023, it banned them from working from the UN.[24]

[22] MSF, 'Afghans deprived of healthcare by poverty, restrictions and a dysfunctional system', 2023.
[23] World Bank, 'Towards economic stabilization and recovery', 2022.
[24] United Nations, 'Excluded from Education, Public Life, Women, Girls Facing 'Gender Apartheid' in Afghanistan, Delegate Tells Security Council', 2023.

The consequences of these policies are evident from a medical perspective. Most relevantly, women are now unable to enter medical studies; the reduction in female personnel in the healthcare sector and broader restrictions on women's employment have reduced access to care for women and rights. Furthermore, the closure of gynaecological studies threatens the future of women's healthcare.

- **'Brain drain' as qualified personnel flee the country.** The change in government has led to a significant departure of medical and paramedical staff generally and from FMIC, leaving critical gaps in medical care in Afghanistan.[25] Currently, Afghanistan's healthcare workforce has only 9.4 healthcare employees for every 10,000 patients, significantly below the World Health Organization's recommended ratio of 22.8 healthcare employees for the same.[26]

The support provided by CDE across the three programme components thus becomes even more pertinent. Medical professional respondents emphasise the continued importance of the training component in the context of doctors leaving the country and more limited support from non-Afghan doctors. "*The healthcare personnel are the thing lacking in Afghanistan. If you don't train local people, and there are no local people moving forward / they are not equipped, then it is very hard and not fair to rely on external sources. Outsiders will leave. (...) In terms of conflict and such, they will be the first to leave and you can't blame them. Locals will stay and you have to keep that momentum going*".[27] The PGME programme specifically is seen as critical to ensuring continued tertiary health care competencies in Afghanistan.[28] Meanwhile, the support provided through the La Chaîne de l'Espoir to maintaining a significant level of activity at the Women and Children's Pavilion allows access to quality medical care to patients who otherwise would have even less of a chance of doing so than previously, in particular as it has become more complicated to seek medical care outside the country.[29]

Clear but constrained recruitment modalities

In a context of limited resources, CDE and the FMIC have developed clear recruitment processes for both the PGME and the access to medical care components of the health programme to promote equity and transparency in their allocation, insisting on these even in the face of governmental pushback, in the case of the PGME.

Training. FMIC offers training to its medical professionals, including doctors, nurses, and paramedical staff, to enhance their skills and knowledge in various aspects of healthcare delivery, leadership, and administration. Admission to these trainings is based on the specialty or work focus of each staff member, as the programmes are tailored to the specific areas of expertise.[30] In terms of capacity building activities, the Continuous Medical Education (CME) and Health Awareness Session (HAS) have proven to be crucial for bridging knowledge and gaps, ultimately equipping medical staff with the necessary expertise of their field of specialisation.

> *"These trainings fill up the knowledge and experience gaps which will make us more dominant in our field. This dominance will help us to provide better service for the patients." (FGD10, Doctors)*

PGME. The PGME programme sets strict admission prerequisites, requiring the completion of a specified course and a targeted examination. In doing so it also seeks to promote gender balance of classes, addressing the recruitment challenges posed by the limited pool of qualified female candidates with an intensive three-month training programme designed specifically for them, to better equip women with the needed capacities to pass the entrance exams. The DfA have sought to involve themselves in the process, wishing to restrict women from taking the qualification examination and fast-track their preferred candidates. The former led to a lengthy delay in the selection of the most recent PGME class. Women are now prohibited from taking final medical school examinations, threatening future female enrolment in the PGME programme.

[25] The Economic Times, 'Afghanistan brain drain complicates Taliban rule: Experts', September 2021.
[26] Tao NPH, Nguyen D, Sediqi SM, Tran L, Huy NT., 'Healthcare collapse in Afghanistan due to political crises, natural catastrophes, and dearth of international aid post-COVID', 2023.
[27] KII17, Medical expert
[28] KII17, Medical expert
[29] UNHCR, 'Afghans struggle to seek safety as borders remain shut to most', 2021.
[30] FMIC, 'Capacity Building Programmes', n.d.

Access to medical care. The admission criteria for this support determines eligibility through a comprehensive assessment of distinct medical, social, gynaecological, and paediatric surgical factors, as detailed in Annex 4, in addition to social and medical supply factors. Partner organisations adhere to these criteria for referrals. This system is acknowledged by both female and male patients for its effective targeting of vulnerable individuals in need of support.

"The process of selection was very just and only those who couldn't afford the treatment were introduced. They were not introducing everyone here and used to check the patient and the financial status of their family and after that made the selections". (FGD5, Male parents / guardians of patients)

"From my perspective, the entire process was fair, and we did not observe any discrimination or corruption." (FGD6, Female parents / guardians of patients)

Over the project duration, two components of the criteria have seen modifications: social criteria, reducing the monthly income limit for eligibility, and medical criteria for women, expanding the range of eligible conditions over the years. While the recruitment guidelines are clear, they were criticised by some patients and partners on two fronts: the limited range of conditions covered, and the set monthly income for care entitlement.

"There are some problems in the criteria, for example, one criterion is that the monthly income of a family should be less than eight thousand Afghanis. Now, what do you think when a family with a monthly income of 8000 and living in a rented house, can they afford to pay 100 or 200 thousand Afghanis for their child's heart surgery?" (KII9, UN – NGOs)

CDE, however, must grapple with limited resources – both financial and medical – and in doing so requires such strict admission criteria. Even within this focus, it is not feasible to aid all the families in need who fall within this category. While this is clear to CDE and its partners, the guidelines, and principles underpinning them, are less clear externally, which can lead to frustrations when needy individuals are not able to receive support.

3.2. Effectiveness

Overall progress

An assessment of the CDE's health programme's progress against planned targets for 2018-2021 reveals a mixed outcome (see Annex 1). Such an assessment misses the full picture: the significant contextual evolutions have rendered a number of targets out of date given the new challenges to operational effectiveness. Shrinking and increasingly difficult to access funding, an exodus of trained doctors and medical staff, new regulations from the authorities and a vastly increasing breadth of need have combined to require additional time and effort from CDE and FMIC to continue to implement the programme's activities in the spirit in which they were planned.

"The current situation is becoming a big challenge for how things work. More patients are coming, but there are fewer doctors. This is clear because some doctors want to leave. (...) Even though the managers are trying, doctors are still leaving." (KII18, Medical Expert)

For example, based on the analysis of indicators from the AFD annual reports, one area of shortfall is in the number of PGME graduates. While around 60 graduates were expected from 2018 to 2020, with rates for 2021 being determined at a later stage, just 47 (including those graduated in 2021) are reported. This lower completion rate reflects not just the rigour of the programme itself, but also the impact of the pandemic and changing economic and political contexts.

In this difficult context, FMIC and CDE have taken a number of initiatives to facilitate continued implementation, with a particular focus on collaboration both internally, and externally with the MoPH as possible. Within the board of directors, regular monitoring activities as well as coordination meetings are held, to design future strategies, align approaches with the new authorities, as well as to review comprehensive medical data. These collaborations also involve medical and paramedical teams, fostering a multidisciplinary approach to coordination and decision-making. Despite the rapidly evolving DfA policies, CDE and the FMIC have been able to keep open lines of communication with them, and the work done by the FMIC is positively recognised by them.

Exploring the three programmatic components in more detail underlines both operational success and areas for improvement in the future:

Trainings

Training offered under component 1 ranged from the medical to the technical, and were organised both in person and remotely, generally by FMIC staff. Many of these built on Aga Khan University training.[31] While not all indicators were met over the four years, a substantial number of capacity-building missions occurred in 2018 and 2019, prior to the contextual changes, successfully reaching almost all targeted numbers for those years. **More broadly, these trainings, even in more reduced numbers, are seen by the trainees as very useful in terms of building knowledge in very relevant medical domains.**

> *"The training sessions were suspended for a year and a half during the COVID-19 pandemic and for nearly two years after the regime change. The training sessions have resumed in the last six months, and they are essential for us as we encounter a large number of patients with complex medical cases."*
> *(FGD7, Doctors)*

Perspectives from Trainees and Trainers at FMIC

Learning and Teaching Quality:

In evaluating the quality of learning and teaching at the FMIC, surveyed trainees generally reported positive experiences. Although some noted moderate or lower learning outcomes, most indicated that the training had a positive impact on their work. In contrast, trainers expressed concerns about the brevity of missions, which they considered insufficient for knowledge and skills retention.

> *"I was surprised but during the days I was there they were able to reproduce a lot of things. Unfortunately, when I came back six months after, we had to restart everything." (E-survey respondent, medical doctor)*

Effective training strategies identified by trainers included a combination of theoretical and practical components, mentorship, short sessions tied to clinical events, and intensive courses. Additional challenges observed by trainers encompassed resource constraints and the necessity for comprehensive healthcare solutions in a healthcare system lacking robust support.

Training Preferences

The data from trainees and trainers regarding the most effective types of courses for improving theoretical knowledge and clinical skills in their specialty at the FMIC partially overlaps. Both groups recognised the importance of short-term in-person missions. However, trainees also favoured long-term in-person missions and remote lecture series, while trainers emphasised a mix of regular missions, remote fellowships, and case discussions. Both trainees and trainers recognised the value of hands-on, practical training through in-person missions, whether short-term or long-term, as a key component of the educational experience at FMIC.

Funding Priorities

In analysing the priorities for allocating funding at the FMIC, trainees and trainers offered valuable insights. Surveyed trainees emphasised the significance of short-term in-person training missions, aligning with their focus on acquiring practical skills and knowledge. Financial support for vulnerable individuals' access to medical care was also considered vital by both trainees and trainers, reflecting a shared commitment to addressing healthcare disparities. Trainers, on the other hand, also placed a strong emphasis on long-term in-person training missions and continuing the post-graduate residency programme, emphasising the importance of capacity building and medical expertise. Additionally, both trainees and trainers expressed concerns about changes in funding priorities and the challenging healthcare situation, underlining the ongoing need for FMIC funding to support the Afghan population and sustain medical knowledge despite governance challenges and evolving circumstances.

The combination of short-term missions, online training platforms, and WhatsApp groups currently employed at FMIC has been presented as a comprehensive and effective approach to facilitating learning in a continuous

[31] KII18, FMIC - CDE

manner.[32] Monthly presentations with international doctors have equally been evaluated as being an effective strategy to provide comprehensive support and guidance to trainees throughout their learning process. That being said, while online training allows for cost- and time-effective dissemination of information, respondents across the board underline in-person training as necessary. This is the case for surgical training in particular, as it provides trainees with hands-on experience and direct exposure to the subjects covered in the sessions. One doctor explained, for example, that even though *"online training is possible, it is not as effective as in-person training. For example, when a doctor conducts an ultrasound diagnostic test, they can share the test results with trainers through online platforms to receive advice, but this has not proven to be as effective as lectures."*[33] Some also expressed concerns on the relevance and effectiveness of some of the workshops in which they participated, given their limited time, one respondent for example mentioning a workshop on the topic of global pollution.[34]

Box 1 – Mixed results on gender-focused trainings

The programme's capacity building includes addressing gender-related aspects. The "Gender Mainstream Group" at FMIC holds meetings to discuss gender issues, and awareness sessions on gender-related behaviours are organised. In a context where uncertainty surrounds women's rights, female staff members within the hospital recognise these efforts as crucial for upholding their integrity and dignity, and indeed experience their benefits from their day-to-day life.

> *"It may not be important to raise awareness about gender issues when we do not have the opportunity to implement what we learn. However, after the regime change, CDE provided all female doctors with the necessary support. The organisation has also become fairer in the patient selection process, thanks to the changes in the authorities. Therefore, we are among the 0.0001% of women who have access to these advantages." (FGD7, Female patients)*

However, the planned training sessions around gender do not seem to have occurred consistently. Several doctors actually expressed their willingness to undertake such trainings in the future.[35]

PGME

The PGME programme successfully trained new generations of residents over the time period under consideration. **Although external factors have challenged the implementation of the programme and resident selection, delaying new classes and reducing teaching staff, residents continue to be formed in specialties not taught anywhere else in Afghanistan, or not to the same quality level.**

Multiple key informants underlined the critical nature of the PGME programme to the long-term future of the country's medical care, in light of the ongoing 'brain drain' of qualified medical personnel. As senior FMIC staff explained, *"without this programme, I don't think we will be able to survive, because people are still going out of the country as they get the opportunity, or they will get a passport or visa to some country and don't return"*.[36] While the limited ongoing monitoring does not allow for an assessment of the evolution in the training post-2021, interviews with residents highlight both the effectiveness of the residency programme in building and reinforcing their skills, and practical considerations challenging it.

"If I compare this educational or post-graduate course with the course I had in Nangarhar province, there is a difference between these two courses like the earth and the sky," explained one resident.[37] Current residents

[32] The use of remote methodology is in line with global health care learning evolutions. Virtual global health partnerships (VGHPIs) have been increasingly used since the start of the COVID-19 pandemic, and studies have shown they can be an effective way to provide training and support to low- and middle-income countries (LMICs). However, these face significant barriers to usage, including lack of internet connectivity, lack of training curriculum, and lack of time for training, and the need for associated funding and support are also needed to ensure that LMIC partners can fully benefit from VGHPIs. As a result, virtual engagement is considered very useful and complementary to in-person engagements and trainings, but not enough to be a full substitute. These challenges are present in Afghanistan.
Umphrey, L., Paasi, G., Windsor, W. et al., 'Perceived roles, benefits and barriers of virtual global health partnership initiatives: a cross-sectional exploratory study', *glob health res policy*, 2022.
[33] FGD7, Doctors
[34] FGD11, Doctors
[35] FGD7, Doctors
[36] KII7, FMIC - CDE
[37] FGD1, Doctors

interviewed noted in particular the unique nature of the training they are receiving in Afghanistan, the rapid growth of new skills within it, the cross-departmental learnings, and the quality of the material present at FMIC, missing in other institutions in the country. Female residents specifically referenced the positive environment for learning, noting that here there was no discrimination between male and female doctors, unlike in previous learning experiences. Generally, the programme is held as very desirable – if not the most desirable – among the residency programmes in Afghanistan.[38]

However, like residency programmes in many hospitals at a global level, a number of practical considerations impact residents' well-being, their ability to perform their jobs well, and the quality of their learning:

Difficult working conditions. Interviewed residents noted long working hours, citing figures as high as 80 hours per week, with limited senior support, in particular in certain specialties. Further, the delays in onboarding new residency classes due to external involvement in recruitment modalities meant that some residents felt overwhelmed, without enough colleagues to support them. The lack of time was also flagged as limiting the amount of time residents can spend on theoretical or academic training, as they have so many patients for whom to care. *"The PGME programme provides both academic and practical lessons, but residents spend most of their time on practical lessons and have limited time for academic lessons such as case presentations, journal clubs, and research. Although there are some online classes, residents do not have enough time to attend them."*[39]

Inconsistent training approaches and skills. Residents noted that the quality of the training provided varies by consultant, with some reportedly keen to build young doctors' skills while others are perceived to limit their work to the simplest of surgeries, rather than training them to take on the more complex issues. As one explained, *"Some trainers are willing to teach residents all the necessary techniques and lessons so that they become fully capable of performing surgery independently, while others are not. This is similar to public hospitals. One possible reason is that consultants and trainers may not trust some residents enough to give them the opportunity to perform independent surgeries without supervision."*[40] In some specialties, such as cardiology, residents underlined the need for further specialists to train them and practice – reflecting the national capacity gaps in tertiary care.[41]

Salarial complaints. Several residents interviewed noted that their salaries are quite low, limiting their families' ability to make ends meet. This was raised on multiple occasions. *"Residents receive lower salaries than those working in public hospitals and are not allowed to work outside FMIC, limiting their income. With a salary of only 25,000 AFN per month and a six-day work week from 8 AM to 5 PM, residents struggle to cover living expenses and pursue their training effectively."*[42] While a rapid benchmarking suggests that FMIC salary rates for residents are above the public hospital rates, due to high working hours and hospital policy residents do not have a separate private practice allowing them to build on their salaries, unlike those in public hospitals.

Efforts to achieve gender balance are evident in the presence of successful female graduates from the programme, but the future of this component is less clear, as detailed previously. This raises questions for the future of the programme, the inclusion of women being non-negotiable, at this point, for CDE and FMIC, in particular as the broader scope of need makes it harder for donors to justify such long-term investment, despite the clear capacity gap in Afghanistan.

> *"Until August 2021, there was a lot of training, but since 2021, there has been no investment in training, and furthermore, women cannot be trained. There are many internal and post-doctoral training opportunities, but in a situation like this, it is not a priority" (KII3, FMIC – CDE)*

[38] FGD8, Doctors
[39] FGD2, Doctors
[40] Ibid.
[41] FGD1, Doctors
[42] FGD2, Doctors

Access to medical care

In a country where GDP per capita was of $359 in 2022,[43] and the cost of say, a gynaecological surgery might range from $500 - $700, even if families managed to raise the costs for an operation, the additional indirect costs of travel to Kabul could prove prohibitive, resulting in catastrophic health expenditures.[44] CDE's work to support access to such medical care seeks to directly address these challenges. Looking at data against progress targets underlines implementation challenges in 2020 and 2021, with fewer patients treated and new patients registered, and decreasing numbers of medical consultations and examinations:

The Women and Children's Pavilion, with an annual target of 4,000 beneficiary patients, achieved its target in 2018-19. However, the subsequent years, 2020 and 2021, witnessed a decline in patient numbers, with only 2,567 and 2,502 patients respectively (see Annex 1).

In the initial phase of the project, the Pavilion consistently exceeded its estimated yearly influx of new patient registrations with 1,651 and 1,485 new patients recorded in 2018 and 2019, respectively. This positive trajectory took a downturn in 2020 (301) and 2021 (797).

2020 and 2021 marked a decline in the number of consultations and examinations, after reaching targets in 2018-2019, with totals of 2,570 and 2,529 respectively.

At the same time, the programme continued to achieve its geographical coverage target, providing support across all 34 provinces, throughout the pandemic, excepting in 2020 when it was only able to cover 30 provinces due to COVID-19 restrictions.

Across the board, respondents recognised the effectiveness of the access component in allowing children and women who would not otherwise be able to receive treatment for their illnesses to do so. Medical care and follow-up provided were explained as top notch, with doctors providing needed follow-up and guidance for continued care.

> *"My daughter underwent two surgeries, and we stayed for three days during her first surgery and one day during her second surgery, which took place six months after the first one. The doctor instructed my daughter to exercise in the time between her surgeries, which took six months. At first, I struggled to learn the exercises properly, so the doctor sent instructional videos to my brother-in-law's phone because I didn't have internet access. This helped me learn the exercises properly so that I could teach my daughter. After her first surgery, we returned to Ghazni and came back after six months for her second surgery. My daughter received all the necessary healthcare services, including medicine, at FMIC." (FGD6, Female parents / guardians of patients)*

Respondents generally assessed indirect cost provision as sufficient, with some minor complaints.

- **Transportation.** Chaîne de l'Espoir covered transportation costs for recipients of medical care coming from provinces to Kabul, as well as an accompanying adult. These transportation rates are verified and updated regularly to ensure they were sufficient to cover travel. Some recipients did complain that the initial transportation to Kabul was reimbursed on arrival, rather than having funds advanced, which could limit access. Another challenge identified was for patients living in Kabul, whose transportation around the city was not covered, but in some cases, necessary.
- **Accommodations.** Beneficiaries of medical support who stayed at the pavilion all rated it highly, underlining the quality of both food and care. *"The meal was really good, and the hygiene was observed. They provided food for both the patient and us which included chicken, soup, and rice. They provided good service to us. They provided the meal for both the patient and their companion. I was sleeping on the ground and the patient was on the bed. The meal was good and there was a table for eating. I am satisfied with their services and have no complaints."*[45] Both FMIC and CDE underlined the need to provide a caring and welcoming environment, even in the midst of a crowded hospital.

[43] UNDP, 'Afghanistan socio-economic outlook', 2023.
[44] SDG indicator 3.8.2 specifically flags catastrophic health spending as. An indicator for assessing progress towards achieving universal health coverage. WHO, 'SDG 3.8.2 Catastrophic health spending (and related indicators)', n.d.
[45] FGD5, Male parents / guardians of patients

While the existing referral mechanisms function well, several gaps around these were raised. Even though these are successful at achieving broad coverage and identifying more eligible potential patients than can be treated, awareness of CDE's support to direct and indirect costs remains limited, and patients interviewed identified ad hoc means of having found out about CDE's support.

"Until 2021, a successful recruitment process was implemented, specifically targeting individuals from different provinces to receive healthcare. This approach guaranteed accessibility to the hospital for people from all provinces. The strategy was well-thought-out and achieved its intended results. The pavilion operated smoothly, as we funded the transportation to the pavilion, eliminating any barriers and proving highly efficient." (KII3, FMIC – CDE)

For example, one woman, whose daughter had been seen at a public hospital as well as FMIC, was told that the surgery could be done at FMIC for 45,000 AFN. As the family could not afford that, they then took their daughter to another hospital, where a nurse working told them to reach out to CDE about potential support. Another explained, *"Only a few know about this organisation and the service they provide. Such problems are numerous in the country, so if they can extend their services to the provinces or at least tell the clinics to inform those who need such services about the organisation it will be very good"*[46], before adding that otherwise, the care provided was great. This is also a strategic choice on the part of CDE, to avoid frustration from receiving far more referrals than can be treated but runs the risk of excluding some of the most vulnerable, especially in remote areas, due to lack of knowledge that this programme exists.

The goal of achieving financial sustainability of the programme through a balance between paying and non-paying patients was not attained. Due to COVID-19 and the changes in authorities, the objective of financial balance was set aside, and the priority shifted to providing care for patients and ensuring surgeries for children and medical follow-up for women, survival becoming the primary concern.

Communication, generally, shows space for improvement. One respondent expressed uncertainty about the success of her operation, highlighting a lack of communication or evaluation post-surgery to determine the outcome.[47] This has caused frustration about the lack of communication and difficulty in reaching the doctor, raising concerns about the continuity of care. Another participant asked for an extension of medical services offered, such as post-operative check-ups.[48]

Cross-cutting limiting factors

A range of factors have limited the effectiveness of CDE's activities in support of the Afghan Health Programme. Chief among these, of course, were the impact of the COVID-19 pandemic and the change in authorities.

COVID-19. COVID-19 affected the overall operation of the hospital when the pandemic was at its height, leading to a substantial reduction in the number of new registered patients, as well as the inability to provide delivery services for pregnant women, amongst others. The effects of this continue to be felt as the decrease in the number of patients had a detrimental impact on the hospital's financial situation.[49] Furthermore, the departure of foreign trainers, as well as the reduction of in-person missions due to both COVID-19 and the change in regime resulted in an increased workload for residents, as well as a negative impact on working conditions.

The change in authorities. The change in authorities has called into question previously agreed support to the FMIC and placed restrictions on hospital operations. The provision of electricity has been a critical issue: the MoU signed with the Government of Afghanistan allows for the free provision of electricity to the hospital, which has now been called into question. Drastic consequences would occur if the hospital does not have access to energy, including at the very least, the cessation of operations and medical activities.

"In the MoU agreement with the Afghan government, electricity is funded by the state, and since the arrival of the Taliban, they have questioned this, creating an electricity problem in Afghanistan.

[46] FGD5, Male parents / guardians of patients
[47] FGD3, Female patients
[48] Ibid.
[49] KII6, FMIC - CDE

Suddenly, the electricity was no longer supported, so we had to find funding… the electricity was cut off for a long time. In the hospital, this means death." (KII3, FMIC – CDE)

Gender. The change in authorities has resulted in additional difficulties to the programme from a gender perspective. Long distances impede women from accessing the hospital due to the prohibition against their traveling without a *mahram*. Adding to this, the requirement for female doctors to attend to female patients, in a context with limited female medical practitioners, and where their training is being restricted, increasingly limits women's access to health care.

"There are some other problems, for example, the Taliban who come to the hospital tell us that a male doctor should do their echocardiogram, or they say that their women should be treated by a female doctor." (FGD1, Doctors)

Expansion. The change in authorities has also resulted in the temporary suspension of future investments, contingent upon the global recognition of the current DfAs. This recognition not only influences CDE's interactions with international partners in development initiatives but also necessitates adaptability to the evolving political landscape. Meanwhile the DfA have called for the return of the land provided for the expansion should this not begin soon.

Security. Before the Taliban's takeover, and during the first years of the health programme (2108-2019), participants from distant provinces encountered difficulties in accessing healthcare, as the volatile security situation restricted travel from more distant provinces. More recently, **medical staff, in particular women, have encountered transportation difficulties due to insecurity,** for instance, when staying after working hours in the hospital when attending training sessions, as transportation officers would not take them to areas that they recognised as insecure. This situation extends to emergency cases at night, as transportation from home to the hospital for medical staff is unavailable.

"For female doctors and residents, the high workload has an impact on their security, especially for those who live in areas considered insecure where drivers do not accept to drive. This means that when female staff end work late, for example 8PM, their way home is put at risk." (FGD7, Female patients)

Coordination limitations. The evolving funding landscape calls for effective coordination with NGOs has emerged as a crucial factor in addressing collective challenges. From a practical perspective, partners have addressed some coordination challenges in organising referrals:

"Another issue that our doctor mentioned is that we introduce patients who meet the criteria to your office, but they are rejected and not supported. While we are sure that the patient meets the criteria of the CDE office, unfortunately they are rejected. (…) I am trying to meet closely with the CDE organisation once and talk to professional and expert employees about this matter so that this problem can be solved and coordination between our organisation and CDE organisation can be enhanced." (KII10, Community stakeholder)

More broadly, respondents have also highlighted the issue of turnover at all levels when establishing partnerships with other organisations. Insights from respondents reveal instances where social workers' turnover has led to inaccuracies in contact information and, in some cases, even resulted in the loss of patient tracking and medical history, while the turnover of programme management staff can lead to repeated conversations without action.

3.3. Efficiency

In a context like Afghanistan where there are problems with nutrition, giving access to surgical interventions does not seem a priority for donors. – (KII3, FMIC - CDE)

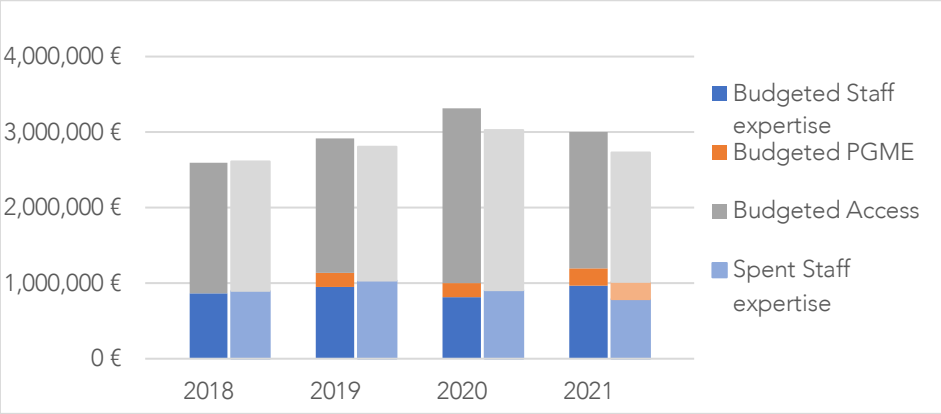
On both human and financial efficiency fronts, CDE faced significant challenges to efficiency due not to internal factors but rather needed contextual adaptations, reflecting difficulties faced across the sector.

Structural limitations posed by the evolving context

CDE's support to the Afghan Health Programme began in a strong position, as the longer timeframe for the funding, in conjunction with broader plans for FMIC to start moving towards self-sustainability from a financial

perspective, allowed for the development of ambitious targets and clear plans over a multi-year time period. Such multi-year planning allows for more ambitious programming to be put in place - as one stakeholder explained, *"These postgraduate medical education programmes run for five years. So, if you have a budget of one year, then you cannot run the programme for four to five years. So that helped a lot."*[50]

Figure 1 – AFD Budget planned and spent by year, in Euros



Reviewing planned and spent resources across the three programme workstreams (see Figure 1 above), according to financial documentation, underlines that broadly resources spent on these were relatively aligned to plans, with some reallocation from PGME to broader capacity building in the reports, suggesting appropriate financial planning. Unpacking this reveals a number of evolutions to adapt to contextual changes which can partially explain the shortfall against indicators discussed in the effectiveness section.

- COVID-19. While COVID-19 funding was not taken from the planned workstreams, **the pandemic did significantly impact ongoing activities:** in-country missions and travel were more limited, staff had to address the results of the pandemic among patients, and donor focus was elsewhere. Accordingly, the staff expertise budget was lower in 2020. At the same time, an examination of the broader 'welfare' fund's budget highlights a significant increase in funding in the year 2020, reaching €1,240,000 in 2020, before reverting to its 2018 level of €740,000 in 2021, possibly indicating a stabilisation of pandemic-related demands.
- **Change in authorities. The 2021 change in authorities has had efficiency impacts both financially and in terms of human resources due to a range of direct and indirect impacts.** The brain-drain engendered reduced medical staff at the FMIC, in particular of surgeons with critical skills. The ongoing debates about PGME participant selection delayed the start of the latest class. Questions about the continued free provision of electricity to the hospital have created large uncertainties around forward planning for budgets. Gender and security restrictions have led to additional costs. Finally, the time spent in meetings to discuss these issues, with the authorities and elsewhere, is time which was not originally planned for. **More broadly, the structure of funding available in Afghanistan has altered.** Due to the scope of needs in the country and political tensions around engaging with the government (see Sustainability), funding available is increasingly short-term and humanitarian focused.

Financial and human resources efficiency within this context

Several challenges to financial and human efficiency were underlined by respondents:

Human resource efficiency. While training put in place has supported the FMIC teams overall, the administrative burden on FMIC teams – and CDE teams – has reportedly increased. With the reliance on shorter term financing come additional logistical and reporting requirements, and teams must spend more time planning.[51] Meanwhile, staff departures at FMIC reduce the number of trained non-medical staff available to support on this front. Yet, information around administrative efficiency remains limited. One FMIC interviewee noted, *"in my opinion, the programme has been well implemented. However, we must assess its expenditures to see how much money is*

[50] KII7, FMIC - CDE
[51] KII3, FMIC - CDE

spent on administration costs as opposed to patient treatment. It's unclear, for instance, how much of a $100 fee goes towards patient care and how much is used for administration."[52] The potential of the medical missions, while broadly very much appreciated, was not always maximised, due to the inclusion of surgeons whose skills were less needed or who were not as strong trainers (see Box 2 below).

Financial efficiency. As CDE's health programme was financed under the *Direction des opérations* at AFD, rather than through its NGO partnerships component, it had an additional layer of budgetary flexibility allowing it to adapt activities a little more easily – and thus react more smoothly to needed salarial revisions or changes in costs due to inflation.[53] With relatively more limited sourcing of primary materials than other programmes in Afghanistan, inflation has had less of an impact than might have been expected.

Nonetheless, the broader financial situation in Afghanistan has required revision of funding prioritisation as it means that there are fewer patients able to pay and thus contribute to hospital operating costs.[54] This calls for further collaboration between CDE and FMIC around financial management and tracking to maximise the value of each grant and funding commitment received.[55] Currently, programmatic decisions remain driven by higher level strategic and financial considerations which could benefit from more in-depth and granular financial and efficiency analysis of reported data. This could, according to one CDE respondent, improve efficiency of operations further.[56]

As an example, annual audit reports or analysis thereof could seek to further explain the shifts between planned and actual activities which may simply reflect changes in how certain costs are reported, or operational changes. For example, in 2019, where 187,500 euros were budgeted for the PGME programme, no spend was reported there – but the overall spend on capacity building went up by the same amount. Their utilisation was managed by FMIC; it would be useful to better explain whether this was a question of how funds were identified in reporting documents or fundamental shifts from planned utilisation – and ensure accounting alignment in the future in terms of how spend is categorised.

Box 2 – Short-term missions: what next?

In-person missions have historically formed a critical element of the capacity building elements of CDE's collaboration with FMIC, under both the broader capacity building workstream and the PGME. Many of these have taken the form of short-term missions.

The added value of such in-person training is clear, with respondents from doctors to FMIC and CDE staff underlining the need for hands-on training for surgical processes. Doctors and residents underlined it as a needed component of future programming to allow them to continue to progress. *"I suggest that we prioritise in-person training because it is more effective when we have physical contact with what we are learning."*[57] They noted in particular the more interactive pedagogical approaches offered by some of these missions.[58]

From a surface-level cost-effectiveness perspective, however, short-term missions are probably the least financially efficient of the different training modalities. In a context of limited funding, this raises the question of whether or not they should be continued. From a medical and surgical perspective, the answer is a clear yes. However, building on the challenges raised in the effectiveness section, adaptations are required to maximise the added value of such missions, and ongoing efforts to develop more long-term in-person training possibilities should be further pursued.

Reported-term mission limitations:

- Short-term mission doctors do not always speak English well and vary in their teaching skills.
- The missions are not always planned with enough notice to allow potential patients in need of treatment to come to Kabul.

[52] KII6, FMIC - CDE
[53] KII1, FMIC - CDE
[54] KII3, FMIC - CDE
[55] KII9, UN - NGOs
[56] KII8, FMIC - CDE
[57] FGD2, Doctors
[58] Ibid.

- As doctors and residents set aside other work to prepare for the short-term missions, they can cause backlogs or longer hours elsewhere.
- Missions are too short to allow for full training on certain topics.
- Missions are primarily reliant on doctors willing to volunteer in Kabul, who are not always familiar with the context and do not always return.

The following actions to strengthen in-person missions have been identified in the course of this research; FMIC and CDE are already pursuing some of them.

- Seek doctors and funding for longer term missions.
- Prioritise doctors with understanding of the context and / or language, coordinating for example with partners in the region such as the Aga Khan hospitals in Pakistan, or networks of doctors from the region in other countries such as the UK and United States. Doctors willing to volunteer, generally may not always be those most adapted to the FMIC's needs.
- Ensure clearer reporting mechanisms from the missions to learn from each in a systematic fashion.
- Develop training guidance for doctors with more limited teaching experience for their use while at the FMIC.
- Target missions to the departments most in need of surgical support.

3.4. Coherence

"I think this is a unique programme in Afghanistan that we are running, nobody else has this kind of a programme. [Other countries] are going to the rural areas [to provide medical support]; if your facilities are basic, you cannot do the tertiary care, they do the basic programmes, maybe the general minor surgeries and all those kinds of things, but they cannot provide the care that is being offered at FMIC. This is unique, and the mothers and children house itself is unique." (KII7, FMIC – CDE)

The relevance section of this evaluation underlines the clear need for the three workstreams under the CDE programme at the start of the project and in the current context. Indeed, the programme addresses a clear gap in the broader intervention landscape in Afghanistan and does so with an increasing eye to creating further synergies with new and existing partners. The DfA's evolutions in policy focus from previous authorities pose critical questions for the continuation of this important work.

Addressing a clear gap in the intervention landscape

Clearly in line with CDE's internal objectives, notably its overall goal of strengthening health systems to allow all – and in particular children – to have the same chances for survival and development, the CDE's support to the Afghan health sector is fully in line with broader humanitarian and development goals. In particular, Sustainable Development Goal (SDG) 3 asks stakeholders to "Ensure healthy lives and promote well-being for all at all ages", including a call to reduce global maternal mortality, reduce premature mortality from non-communicable diseases, and strengthen the recruitment and development of the health workforce in developing countries, among other indicators.[59] CDE's Afghan Health Programme is uniquely designed, in the Afghan context, to support this:

- Despite the difficulties of the context, **the FMIC is a hospital up to international standards, and surgical teams have been formed to the needed skill level to operationalise it,** including for example in cardiology. *"The curriculum of the cardiology department is completely updated and is taken from sources such as the European Society of Cardiology and the American College of Cardiology."* [60]
- It is **the only hospital focused on the development and provision of high-quality tertiary medical care in Kabul**; in doing so, it strengthens the capacity of other medical facilities by treating patients which they cannot, and who might otherwise continue to seek treatment from their doctors. *"This programme is an exceptional opportunity for the people of Afghanistan because there are some departments which graduate specialist doctors like the cardiac surgery department and these departments are not available in other hospitals. If these facilities were not here, there would be*

[59] UN, 'SDG3: Ensure healthy lives and promote well-being for all at all ages', n.d.
[60] FGD8, Doctors

no possibility for anyone to train in Afghanistan. Departments of radiology, anaesthesiology and pathology are four or five departments that have no training programmes in other hospitals of Afghanistan."[61]

- **The FMIC offers gynaecological treatment and a residency programme for the same.**
- **The FMIC prioritises the treatment of women and children.** Increasingly, CDE and FMIC have been collaborating with a wider range of partners for the referencing of medical cases and to extend the reach of the programme to new locations - for example, working with the Norwegian Refugee Council (NRC) to access women in need of care in IDP camps in Kabul. *"We work with other organisations, notably for referrals [...] We have focused our support to ensure that patients who are far from Kabul may also come here and stay and benefit from hospital treatment. This is critical to support the coherence in interventions."*[62]

Strengthening collaboration

Opportunities to reinforce internal coordination. What forms part of the FMIC's unique nature is the quadripartite nature of its inception and management, between CDE, AKDN, the Government of France, and the Ministry of Public Health in Afghanistan. The administrative council meets three times a year for critical decisions, with additional ad hoc meetings called based on need.[63] These regular meetings allow for discussions around the rapidly worsening context. Respondents at both FMIC and CDE did call for more frequent communication between the two, potentially on a monthly or even weekly basis.[64] On the one hand, this would allow for a better understanding of contextual evolutions on a 'live' basis; on the other, this would offer opportunities to engage on questions of efficiency and monitoring more regularly. [65]

While current collaboration between this broad range of partners remains impressively strong, it is in part dependent on several individuals who have been driving the FMIC project from the start. This helps address a challenge from the CDE side – the regular changes international staff based in Kabul[66] – but also opens a risk, should these key individuals depart the project. *"I am not worried about the future of FMIC, so long as Eric [Cheysson, president of CDE and one of the founders of the FMIC] remains president of CDE"*, explained one of his colleagues, for example.[67]

Coordination with the Aga Khan network has also been identified as a sector of opportunity, drawing further from the high-quality hospital and medical training under the network, as well as the resources it is affecting to support the Afghan people more broadly.[68]

Relations with the DfA a critical factor. The specific policies and aims of the DfA in Afghanistan can evolve rapidly, with their degree of implementation also varying significantly. The official partner of CDE on the FMIC is the Ministry of Public Health, signatory to the initial MoU. The current Minister of Public Health himself is a surgeon, who takes this perspective to his conversations with CDE.[69] [70] In parallel, however, since the change in authorities in August 2021, CDE has faced an increasing number of roadblocks in its programme implementation. Policy decisions by the DfA are directly and indirectly impacting all three programme workstreams.

- **Broader restrictions on women's movements complicate the provision of medical support to children** – who cannot travel just accompanied by their mother – and women, who may not be allowed to travel to the hospital. Female staff face difficulties even in just going to work.
- **Specific gendered restrictions around medical care and practice threaten both the present and the future of the FMIC.** In a context of immense brain drain, the Taliban have, for example, sought to

[61] Ibid.
[62] KII8, FMIC - CDE
[63] KII1, FMIC - CDE
[64] KII6, FMIC - CDE
[65] KII8, FMIC - CDE
[66] KII1, FMIC - CDE
[67] KII18, FMIC - CDE
[68] KII5, FMIC - CDE
[69] KII4, FMIC - CDE
[70] It should be noted however that the MoPH, among others, has reportedly "routinely disqualified 'certain NGOs in favor of other preferred ones' and redirected donor assistance away from certain groups," so even the previous positive perception comes with caveats. SIGAR, '2023 High-Risk List report', 2023, p.8

exclude women from the PGME programme, leading to a significant delay in the identification of the latest PGME class, and do not recognise the medical diplomas obtained by women.

- **Staff underlined that they have received criticisms because strict gender separation cannot be implemented across the hospital.**[71]

The DfA recognises the FMIC as a high-quality medical facility.[72] This does not stop policies from impacting hospital operations, which has a further time implication for FMIC and CDE staff, called in to discuss, for example, the wearing of hijabs in the hospital. The recognition of the quality of care provided by FMIC has led to infeasible support requests:

> *When it comes to the quality, the government is saying FMIC is the standard for Afghanistan [...] but they have a lot of expectations, they are saying, you should make it a 400-bed hospital, you should provide care, why are you charging fees? You know, the partners should be providing money to provide you free services. Last year, when we were having the budget meeting, our minister was also participating. He's a doctor himself, he said, yes, this $20 million is nothing for France, the French government, they should give you $25 million, so that you provide it free of cost here. So, then they don't understand that the money is not in the trees."* (KII7, FMIC – CDE)

The change in authorities has also called into question previously agreed operating mechanisms, such as the free provision of electricity to the FMIC, critical to ensure the functioning of needed medical equipment (see section 3.2). FMIC has also had to hire 12 Taliban guards.

The CDE thus faces an increasingly complex challenge looking ahead, needing to balance its desire to continue programming and operations in a context where the FMIC is increasingly needed, with the need for approval from the DfA for FMIC to function and CDE's own ethical 'red lines', as well as those of the other partners in the quadripartite agreement.

Reinforcing NGO collaborations. CDE works with a variety of partners, from the International Committee of the Red Cross (ICRC) to the International Aid Mission (IAM), MSF, the NRC and more. To date, this collaboration as relates to CDE's health programme has primarily focused on the establishment of clear referral pathways in the provinces. One NGO representative explained how this can work: *"We also had a cooperation agreement with the ICRC organisation, and when we referred the patient to them for surgery, they said that they would introduce this patient to CDE for surgery."*[73] However, another nuanced the positive picture of cooperation by saying that patients being sent by NGOs or public health institutions are not being consistently assessed in line with relevant criteria.[74]

CDE's partnership with NRC represents an evolution in its collaboration strategy in Afghanistan, specifically seeking to target displaced populations. **In a context of ever-increasing need, and difficult operating conditions, minimising duplication of efforts and ensuring their coherence must become a priority action area.**

3.5. Impact

Broadly positive impacts on provision and access to medical care

Assessing the impact of all three workstreams, highlights that broadly they have functioned as intended. Three key areas of impact can be identified:

1. **Capacity building and training.**

The FMIC, generally, and PGME, specifically, stand out as positive, and fairly unique, examples of building tertiary care capacity in a conflict-affected context struggling to provide basic healthcare to the majority of its inhabitants. From nothing in 2005, the FMIC has evolved into a healthcare facility which provides patients with care which they cannot receive anywhere else in Afghanistan.[75] **Critical to this has been the building of medical capacity, which has been done through ongoing training programming, consisting of remote and short- and**

[71] Ibid.
[72] KII7, FMIC - CDE
[73] KII9, UN - NGOs
[74] KII11, Community stakeholders
[75] KII7, FMIC - CDE

long-term in person missions, as well as, more specifically, the PGME residency programme. The effectiveness thereof in training medical surgeons is detailed in section 3.2. The impact is clear: through the PGME programme, CDE has contributed to the continued functioning of the FMIC in Afghanistan, given medical staffing shortages nationwide, and the provision of otherwise missing specialisations with wide-ranging impact. For example, without training further anaesthesiologists, heart surgery, gynaecological, and other procedures requiring general anaesthesia will not be possible. Continuing these training is key to the hospital's ability to function; for example, eight of the nine ICU specialists trained over the past years have already left Afghanistan.[76]

> *"Currently, in the PGME program, we have learned a lot of new things, we have encountered many new cases, we have met different types of patients, and our skills have improved. I can do OPD, I can do caesarean section, I saw laparoscopy and hysteroscopy up close. I saw new gynaecological surgery cases here." (FGD1, Doctors)*

The broader training missions contribute to continued skills improvement, with all three types of training (short-, long-term and remote) identified by the medical respondents to the e-survey as important to improving their theoretical knowledge about elements of their speciality, and long- and short- in person missions selected as most critical to building clinical skills. As one doctor explained, *"Retinal surgery is not feasible without in person courses. These courses are always conducted / provided by the expert French medical doctors, and these are really beneficial."*[77]

2. **Provision of quality medical care.**

A logical corollary to the building of staff and doctor capacity, **stakeholders from FMIC directors to doctors and patients nearly all agreed on the positive impact on patients stemming from the quality of the medical care on offer at FMIC, grown through CDE support.** Thanks to the quality of staff, the FMIC is able to provide diagnostic and surgical services not available elsewhere. According to one doctor, *"Complicated cases that have been rejected by other hospitals are taken and treated here, or the patients who are referred by other doctors and hospitals abroad for treatment, but the patients cannot travel abroad due to financial problems, they come to our hospital for their treatment."*[78] The parent of a patient confirmed this, explaining, *"We did not understand the cause of her illness until we came to this hospital and her leg was operated on and she is fine now. I did this and my daughter's leg was operated on in this hospital and for now, Alhamdulillah, she is healthy, and her leg no longer hurts like before. I am very satisfied with this hospital, and I always pray for them."* [79]

While some interviewees did have more minor complaints about the medical care, these tended to focus on financial costs, rather than complaints about the quality of treatment. Patients telling stories of treatment which did not work – such as one respondent, who was prescribed medicine for a number of months, which did not resolve the issue, and then was stopped – were the exception.[80] However, there is a clear need for stronger communication around treatment, and its chances of success, as the frustrations experienced by these few patients are significant – one twenty-nine year old patient complained, *"I can't do anything and a 60 year old would be able to do work better than me - the operation had a negative impact"*.[81] More broadly, one key informant reported that this generally positive impression was shared by all the patients which his organisation has referred to CDE, detailing:

> *"We tell the patients that we introduce to the CDE organisation to return to us after completing their treatment or performing their operation and report to us how their treatment went. Our quality assurance colleagues get information from these patients on whether this programme has been effective or not. As a result of the opinions that we have received from the patients we have introduced to this organisation, I can say that this programme is very effective, and the patients are satisfied with the results of their treatment. We have not seen any negative effects of this programme." (KII10, Community stakeholder)*

This provision of quality medical care comes not just from the technical skills of doctors and other medical professionals but also from their softer skills. Several patients explicitly referenced doctors by name who followed up with them regularly and encouraged them to ask any questions they might have.

[76] KII4, FMIC - CDE
[77] E-survey respondent, medical doctor
[78] FGD1, Doctors
[79] CS3, Female patients
[80] FGD3, Female patients
[81] Ibid.

"Doctor Farah was in charge of my medical treatment. Doctor Ibrahim would handle any computerised medical examination or blood test I needed. They behaved well and told me constantly that things would get better. Their behaviour delighted me." (CS6, Female patients)

3. **Extension of access to patients who could not otherwise be treated.**

One positive impact of CDE's support is very clear: without the provision of financial and practical support to patients who could not otherwise afford FMIC's treatment, a number of women and children would have been left living with life-limiting, or threatening conditions - and in some cases, would no longer be alive otherwise. As one parent explained,

"I am really satisfied with the doctors, especially Doctor Basir who operated on Narges. He behaved well with us and guided and advised us a lot and tried his best to take good care of Narges. The support of CDE along with the support of ICRC really helped us because I was not able to treat my child on my own. I would not even be able to pay the transportation and hotel expenses which are about AFN 60,000." (CS1, Parent / guardianship of female child patient)

Emerging from this evaluation is a fourth area of programmatic impact, indirectly linked to programme goals but critical to recognise in the current context:

4. **"Soft" impact - the power of the CDE-FMIC support as a positive example of collaboration**

Within the medical community, the renown of the FMIC has reportedly spread beyond Afghanistan. CDE stakeholders have been asked for similar support in countries as far as Côte d'Ivoire, the hospital stands in France in the line of the work done by the "French doctors", and it continues to be regularly referenced in French news as a symbol of continued collaboration to support the people of Afghanistan in the context of immense current humanitarian needs, despite the broader criticism of the current authorities in the media.[82] In the context of nearly continually negative news about Afghanistan, the story of a hospital providing world class medical care, supported by the French government and accepted by the DfA, is a powerful one of hope.

Box 3 – An important impact on women as doctors and patients

The positive impact of CDE's support to the FMIC on women as both doctors and patients is undeniable, and this impact, one can argue, is even greater on women than on the populations it supports overall.

In a context where women's space to exist is increasingly limited, their rights constrained, and their lives at risk – the UN Special Rapporteur on the situation of human rights in Afghanistan, and the Chair of the Working Group on discrimination against women and girls, recently submitted a report to the UN Human Rights Council calling the situation of women and girls in Afghanistan the worst in the world, and characterising it as "gender apartheid"[83] – **the FMIC stands out as a location where women's rights to learn and be treated are prioritised, rather than the other way around.**

Female doctors interviewed underlined this, with one PGME resident explaining. *"In our work area in the hospital, there is no difference between male and female. Our trainers and consultants never say to assign a work for males and not for females or vice versa. FMIC has provided a working environment in Afghanistan where females are highly valued."*[84]

The differentiated impact on female patients is evident as they are able to access obstetric and gynaecological procedures at FMIC not offered elsewhere.

Implementation factors limiting impact

While no recurring negative impacts were identified in the course of this research attributable to the programme, interviews identified a range of challenges which reduced the potential impact of the

[82] KII4, FMIC - CDE and see for example TF1's news broadcast on 18 August 2022, https://www.tf1info.fr/international/video-l-hopital-francais-de-kaboul-un-refuge-precaire-2229673.html or Radio France's piece on 13 October 2021. https://www.radiofrance.fr/franceculture/podcasts/le-reportage-de-la-redaction/l-hopital-francais-de-kaboul-soigner-coute-que-coute-1339333

[83] OHCHR, 'Special Rapporteur on the situation of human rights in Afghanistan, Working Group on discrimination against women and girls', 2023.

[84] FGD1, Doctors

programme. Key among these are of course the contextual changes which have forced programmatic changes and shifted the financial situation of the FMIC significantly. These further translate into impact limitations at the activity level:

Trainings. The effectiveness section has already detailed some of the practical challenges facing the training programme – from communications difficulties, to limited sessions, and more – which in turn means that it is not as impactful in terms of building doctor and staff capacity as it could be.

PGME. The PGME programme suffered from some of the same challenges as the trainings more broadly, impacting impact. *"The weaknesses of this programme were that there were fewer specialised programmes, no international trainers, no overseas training, and less financial benefits."*[85]

The staff loss mentioned earlier places additional responsibilities on PGME residents. Accordingly, not only do they face more stress, in an already challenging programme, but it limits their learning in several ways. Residents mentioned, for example, not being able to go abroad to Pakistan for a training module due to hospital staffing gaps, and their exhaustive working hours limit their study time. As one explained, *"the only challenge for us is that our working hours are long. In addition to the fact that we are getting excellent training here in practical terms and the opportunity is completely favourable for us, we should also increase our theoretical training (...) we should not be too tired mentally and physically, and should have time to read medical books".*[86] The effects of fatigue and long hours can also contribute to 'moral injury' among doctors, that is to say a deep psychological distress that arises when healthcare professionals perceive a profound misalignment between their core ethical values and the actions they are compelled to take due to systemic or organisational constraints, increasing the likelihood of their burnout. This can be exacerbated by factors such as the inability to provide the quality of care aspired, administrative burdens and limited resources.

Access provision. The research suggests a lack of clarity on two fronts among potential beneficiaries, patients and even staff which together combine to generate frustration towards CDE.

- **Level of support available.** CDE already draws more referrals of eligible potential beneficiaries than it can fund through word of mouth, partnerships with select NGOs, and other hospitals. Yet, some patients complained that they did not receive enough financial support, due to transportation costs within Kabul, or that they would have required further assistance, as some medical issues recurred, or finally, that CDE should provide this support to many more people given the scope of needs of which they are aware. **The concept that the organisation would not have the funding to do so – nor the hospital, necessarily the capacity to treat this – is not well understood.** Changing the language around referrals, making it clear to all those involved that a limited amount of funding is available and being used to treat as many people as possible could help reduce criticism. Research in other contexts suggests that 'cost transparency', and transparency around quality and prices of medical treatments, lowers costs and improves medical outcomes.[87] This is particularly critical in a context where disgruntled community members may complain to the authorities, creating further problems for CDE and FMIC, in particular given frequently expressed Taliban perceptions that aid organisations do not distribute support equitably.[88]
- **Desire for further scope of support.** The rationale for the focus on women and children in the support provided is not clear to all, even some of the doctors employed at FMIC. One woman requested, *"there should be other services, such as services for heart patients. My husband had a heart attack at his job, so they took him here, and his regular check-up cost was 6000 AFN"*[89]– a sentiment echoed by a range of others.

Addressing such frustrations by providing further initial clarity around the programme focus, and why it has been selected, could help to manage expectations around what is in the scope of the feasible for CDE.

[85] FGD9, UN - NGOs
[86] FGD2, Doctors
[87] Institute of Medicine (US), 'The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary', 2010.
[88] AAN, 'Taleban: Perceptions of Aid. Conspiracy, corruption and miscommunication', 2023.
[89] FGD3, Female Patients

Box 4 – Impact challenges in supporting displaced persons

The access provision workstream has evolved to specifically target displaced persons, in particular through the partnership with NRC in IDP camps in Kabul. The potential impact of this component, which included a focus on women's health, is significant - generally among the most vulnerable in Afghanistan. This partnership has faced two primary challenges:

1. Access limitations due to NRC's temporary stopping of activities in response to national policies on women's employment.
2. Ensuring familial permissions for eligible female candidates to receive treatments.

Indeed, implementing partners reported several instances of eligible women in the camps whose treatment had been approved by CDE – and whose husbands or male guardians refused to let them get this treatment. Additional research is called for to better understand the underlying reasons for such refusals, and thus how they might be addressed – whether this calls for awareness raising, the provision of familial incentives to allow women access to treatment, or even potential treatment of male relatives contingent on allowing women access. One woman explained,

"The doctors had a look at me, and they recommended a procedure. But they spoke to us and told us that with this procedure I wouldn't be able to have children for a while. My husband didn't accept it, he didn't agree, and although he referred me initially, he then decided I shouldn't go ahead with the medical doctors." (SSI1, resident at Qambar Square IDP Camp)

Further, recent research underlines that both women, displaced populations face additional challenges in obtaining *tazkera*, which can lead to more limited access to some aid programmes which are contingent on having *tazkera* – this in turn could limit access to CDE's support if they are not then identified through referrals – but further confirms the need to prioritise this population.[90]

Finally, displaced women tend to have fewer interactions than men, which can make those with medical needs more difficult to identify.

"The social interactions of men are stronger than women as men go outside their houses and meet each other in the camp but women are a little bit restricted." (SSI1, resident at Qambar Square IDP Camp)

One implementing partner further noted that support from CDE is only available to displaced populations – which is not in line with CDE referral guidelines. Such misperceptions could lead to increased tensions between host and displaced communities' members and must be addressed.

3.6. Sustainability

Neither CDE's activities under the Afghan Health Programme nor, in the longer term, its impact, remain sustainable without continued implication on the part of CDE and donors.

Overall financial sustainability

In the mid-2010s, after a decade of operation, the future of the FMIC looked hopeful. Ambitious plans were being developed for a Phase 3, which would allow for an expansion of the hospital, and goals set to allow the hospital to be self-sustaining by 2024, with more well-off patients paying for care and allowing for the treatment of those in need of financial support.[91] These plans have all been put on indefinite hold, as instead FMIC and its partners grapple with an ever worsening financial situation, as the demand for medical support increases continually, the cost of goods and supplies does so as well, and funding cycles are reduced and shortened, making it more difficult to plan ahead.

[90] SH & IOM, 'Documentation and Legal Identity in Afghanistan', pp. 23-24., 2023.
[91] KII7, FMIC - CDE

FMIC staff are quite open that at this point in time, they "are dependent on international resources" to ensure the continuation of activities. At this point they do not expect that the situation in Afghanistan to improve enough in the near future to allow for planned self-sustainability via better-off patients paying for medical care.[92]

Yet, **the obtention of future financing from external donors is challenged by several factors.** Governmental donors may link financing to the political situation between themselves and the government, the lack of clarity on how and if NGOs will continue to operate in the future on the part of the authorities is not reassuring, and donors are focusing primarily on humanitarian and emergency funding – whereas FMIC and tertiary medical care are broadly considered development work.[93] Finally, even when funding is obtained it can be difficult to send to Afghanistan, with donors reportedly placing the burden around the legality of funds fully on NGOs, which can lead to funding being blocked as international banking mechanisms to Afghanistan are largely frozen and alternatives hard to audit.[94]

Operational and impact sustainability

Assessing the continued operational sustainability of the three work streams supported by CDE and their impact without further CDE support identifies several areas of concern:

Staff expertise. With decreasing funding and training no longer being organised by CDE, it is unlikely that training would continue being enabled to the current extent, in particular given staffing limitations at the hospital. Short-term missions, described as critical for building surgical capacity, would especially be at risk, given that these are largely coordinated and fully funded by CDE.

PGME programme. The PGME programme is already facing a range of challenges around participant selection. Furthermore, CDE currently funds the residents' stipends, in addition to training components.

Access. The funding allowing beneficiaries to come to Kabul to be treated comes directly from CDE. CDE's financial support is critical to the operations of the Women and Children's pavilion.

As one FMIC interviewee explained, *"We prioritise capacity building and offer welfare services, however we rely on external sponsorship for our initiatives. We shall try our best to operate as efficiently as we can if no help comes."*[95]

While the PGME programme and capacity building conducted to date mean that at the current point in time, the continued technical support of CDE from a medical perspective is less needed than originally, turnover or brain drain is a critical concern.[96] In the short term, it has a direct and negative impact on the working conditions for remaining doctors: *"Previously, we had six medical officers and two were residents, out of which five medical officers left the hospital, only one medical officer remained and two residents. Think about how much workload was on us at this time, the work that was done by eight people was done by three people at this time."*[97]

From a longer-term perspective, should the PGME programme not continue to run, this puts FMIC's entire activities at risk as there would no longer be new specialists qualified in the PGME specialisations, which are not offered by other residency programmes. In conjunction with the ongoing medical 'brain drain' in Afghanistan, and the existing staff shortages, it is unlikely that FMIC could continue to offer the quality care which it offers. The lack of quality medical care at FMIC would, in turn, threaten past health gains, as the hospital would no longer be well-placed to offer longer-term follow-up when needed.[98]

[92] KII7, FMIC - CDE
[93] KII5, FMIC - CDE
[94] Ibid.
[95] KII6, FMIC - CDE
[96] KII1, FMIC - CDE
[97] FGD1, Doctors
[98] KII5, FMIC - CDE

While alternative means of funding could be sought, and FMIC is exploring partial payment options for slightly better off patients, it is unlikely that this would be able to make up the shortfall. Interviewed patients underlined the important role which FMIC plays in allowing for the full diagnosis of conditions not possible elsewhere – another element which would be threatened by the reduction in capacity which a cessation of support would entail.[99]

Finally, **further challenging programme sustainability from an ethical perspective are rapidly evolving policies, in particular linked to gender**. In the short-term, the future of young women doctors is at risk, as the authorities are currently refusing to give female graduates of the programme a certificate of specialisation - meaning that they may not be able to practise in their field.[100] More broadly, this poses questions about the continued feasibility of the programme as a whole. *"It is relatively easy to place a 'red line', but hard to say what we will do with it… the impact of stopping all support is difficult to imagine. We can reduce costs because it is harder to obtain financing - but I do not see how hospitals can function without women."*[101]

[99] CS4, Female patients
[100] FGD1, Doctors
[101] KII4, FMIC - CDE

4. Lessons learned

4.1. Integration of gender, age and displacement

The demographic focus of the health programme on both women and children, as well as on persons who have been displaced, is in line with the additional health vulnerabilities faced by these demographic groups in Afghanistan. However, this approach also comes with specific challenges and issues that require thorough consideration. Incorporating a demographic focus on women and displacement in particular comes with certain complexities.

Integrating a gender perspective into healthcare is of pivotal importance, particularly given the present Afghan circumstances. Indeed, the FMIC and CDE have adopted a gender-focused approach that has primarily directed its efforts towards women, notably evident in the Women and Children's pavilion and obstetrics-gynaecology care provision, fields intrinsically linked to women's health. In terms of training, the FMIC has actively pursued the recruitment of more female trainees and staff. Yet, this focus on women's healthcare has raised concerns and generated frustrations among some key stakeholders who question why men are not receiving similar attention. These concerns do not necessarily reflect an opposition to improving women's health, rather a broader concern for equitable access to medical services for all members of the community.[102]

Nonetheless, within the context of constrained resources and an evolving public environment that presents limited avenues for women's engagement, it is logical that initiatives aimed at supporting vulnerable individuals should prioritise women. Despite efforts to cover women's medical expenses and focus on gender-sensitive healthcare, cultural barriers, lack of nearby healthcare facilities, economic factors, and transportations continue to hinder women's access to healthcare.

> *"If women get sick in our neighbourhood, they may not get much support from the family because women are not given importance in our society. You must have a very kind husband to access health services or treat yourself independently." (CS5, Female patients)*

In the context of Afghanistan and the provision of healthcare services, displaced persons similarly face additional challenges to accessing healthcare. This confirms the rationale for prioritising displaced populations and implementing referral systems within IDP camps, particularly in light of the CDE's programme's emphasis on targeting the most vulnerable individuals. Yet, this approach raises questions at an ethical and operational level (see Box 4).

4.2. Optimising resource mobilisation

A key recurring theme throughout this evaluation is the insufficiency of current funding to the scope of need for quality medical care in Afghanistan, combined with the limited prioritisation of tertiary medical care specifically in this context. CDE and its partners thus face the twofold challenge of how to do more, potentially with less, and how they might secure additional funding.

1. **Enhancing efficiency with existing resources.** This evaluation confirms the need for ongoing activities, including the full range of training activities, to ensure quality health care not just in the present but in the future. Limited opportunities for cost-saving were evidenced; short-term gains from say, reducing staff or training would further imperil the ability of remaining staff to continue their activities**. Instead, it is critical for CDE and FMIC to further explore closer collaborations and partnerships with other stakeholders from health care providers to NGOs working in the field and others working with similar vulnerable populations,** to identify opportunities for practical and financial synergies, to amplify the unique contributions which FMIC and CDE can provide. Organisation such as IOM and the German Agency for International Cooperation (GIZ), for example, have, in the past, sought to facilitate bringing qualified individuals to Afghanistan to support capacity development across a range of fields.
2. **Securing additional funding.** Additional, ideally longer-term funding is needed to allow CDE to conduct its activities in Afghanistan more effectively (reducing administrative time devoted to seeking further short-term funding and providing updates / reporting) and plan on a slightly longer horizon. Proposing

[102] KII7, FMIC - CDE

quality, tertiary medical care, as such, is not seen as a high priority for donors in the current context in Afghanistan, according to multiple key informants. The OCHA Humanitarian Response Priorities call for a focus on *"providing people with increased support for the winter with heating, shelter and food"*. Admittedly, the link to CDE's activities is not immediate. However, unpacking this underlines a further call for *"greater investments by the de facto authorities and the wider development system in services addressing basic needs and critical infrastructure,"* **where the efforts under the Afghan Health Programme and the FMIC itself offer some unique "selling points"** – in particular given the direct collaboration with the MoPH through the Quadripartite Agreement governing the FMIC. **Further efforts are thus needed to 'rebrand' the work already being done by CDE and FMIC and make these linkages - and see where there are future opportunities to take part in broader humanitarian initiatives in the country.** The health and protection clusters are some of the best funded, even with continued significant gaps.[103] There is a stronger argument to be made that CDE's activities are not purely development-oriented but integral to humanitarian aims in the country. For instance, both malnutrition and cardiovascular emergencies, such as heart attacks, are prevalent in Afghanistan and pose severe health risks. In this context, a strategic "rebranding" initiative for FMIC and CDE can lead to a more distinct and engaging narrative that resonates with the priorities of potential donors.

4.3. Operating in complex environment

The political transition in Afghanistan has come with rapid changes around women's role in society, governmental priorities and more. These changes have had a significant impact on humanitarian and development operations in the country: organisations must consider how to address not just the ethical challenges posed by some of these rulings but also their practical implications, from women's travel to receiving funding from abroad despite banking limitations around Afghanistan.

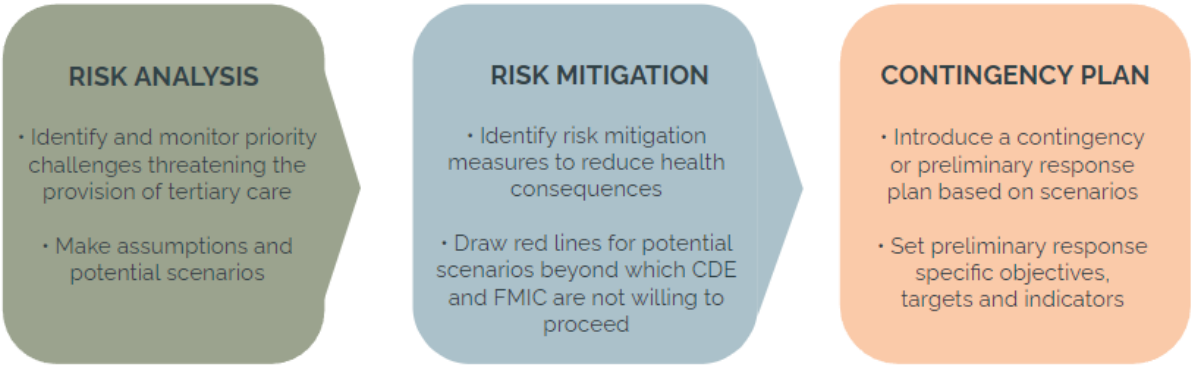
While CDE and its partners have held regular meetings, both planned and ad hoc, to address these challenges, **more fundamentally large questions remain around how the organisation would react to potential 'red lines' being crossed,** such as if female staff and doctors were forbidden from coming into the hospital. This puts the organisation in a reactive approach as changes happen, rather than being able to follow clear processes. CDE is not alone in this: a recent brief under the Humanitarian Rapid Research Initiative underlines that "In Afghanistan, the international aid sector faces a wrenching decision: whether to uphold universal human rights values by refusing to comply with the Taliban's edicts against employing women, or to prioritise the humanitarian imperative to continue providing what aid they can to millions in need", and most organisations "lack frameworks for making these decisions".[104]

Of course, not all shifts can be anticipated - but additional targeted planning on the part of CDE will help ensure that all team members are aligned and can react rapidly to issues such as access limitations, staffing 'guidance' or unanticipated costs. This could include, for example, a plan to address a decision by the authorities to take back the land given to FMIC for the planned extension. In short, "contingency planning is a tool to anticipate and solve problems that typically arise during humanitarian response."[105]

CDE and FMIC stakeholders interviewed in the course of this evaluation confirmed that there is not, at this point, a well-defined strategic approach to navigate fluctuations in the political and operational environment. This would – as per Figure 3 below, in line with World Health Organization (WHO) guidance – encompass identifying risks, implementing anticipatory measures and mitigation strategies, and formulating a comprehensive plan to effectively address them.[106]

[103] UN OCHA, 'Afghanistan Humanitarian Response Plan 2023', 2023.
[104] UKHIH, 'Navigating Ethical Dilemmas for Humanitarian Action in Afghanistan', p.3, 2023.
[105] IASC, 'Inter-Agency Contingency Planning for Humanitarian Assistance', 2007.
[106] WHO, 'WHO guidance for contingency planning', 2018.

Figure 2 – Contingency Planning



The strategy outlined in the above figure should be utilised internally between CDE and FMIC to agree on a clear way forward in the case of priority challenges and potential scenarios becoming reality. In addition to the consideration of internal reactions (prioritisation of existing funding, identification of key sectors should support need to be reduced, identification of potential 'red lines' and what the joint, or separate, reactions would be), this contingency planning should be conducted in line with the considerations previously noted in this chapter, namely, considering how further partnerships and financial diversification could be used to mitigate some of these risks. For example, collaborating with multiple organisations reduces the dependency on a single partner to continue operations, thus mitigating the risks associated with operational interruptions due to partner-linked decisions. Should one partner organisation face an interruption in operations, by choice or because of the authorities, CDE and FMIC could lean on the remaining partners to bridge the gaps and ensure the uninterrupted continuation of their activities.

5. WAY FORWARD - CONTINUING CDE'S IMPACT IN AFGHANISTAN

5.1. Conclusion

As the challenges facing Chaîne de l'Espoir and other organisations wishing to operate in Afghanistan continue to increase, so does the need for their work. While CDE faces very similar challenges to these others – limited funding, increasing involvement from the authorities, growing demand, and the departures of critical staff, to cite only some – it has a singular positioning in the Afghan health landscape, and addresses this critical gap through a unique collaboration with the French Government, the DfA, and Aga Khan Network around the FMIC.

Overall, the research confirms the relevance, effectiveness and impact of CDE's work through the Afghan Health Programme to build capacity of medical and other staff, train future surgeons, and increase access to tertiary medical care of vulnerable people both before and after the COVID-19 pandemic and change in authorities. While the planned approach to implementation was designed to be efficient, well-coordinated and sustainable in 2018, the contextual changes call for some rethinking on these three fronts.

The shrinking funding landscape, and increasing restrictions on the funding offered – with a clear preference "for 'lifesaving' humanitarian aid over development or other kinds of aid precisely because it is intended to be delivered independently of state structures and in a politically neutral way via UN agencies and NGOs"– mean that **traditional approaches to funding CDE's programming in Afghanistan, primarily through the AFD, are no longer viable on their own.**[107] Given the clear need for the three work streams through which CDE is implementing, short-term financial gains from reducing one of them, or shifting to cheaper remote modalities, for example, would threaten the medium-to-long term future of the programme.

The added involvement of the authorities, not specific to CDE's work but reflective of a broader mistrust of NGO operations, poses material ethical risk to the programme, as do the ever-shifting policies, in particular around gender.[108] Just as women, and displaced populations, are facing increasing challenges in obtaining aid and medical care, the effects of these policies is even more curtailed access.[109] Looking to the future, this underscores major risks to the implementation of the programme itself - as for other NGOs, which are similarly generally "reacting rather than planning or proactively engaging."[110]

While this picture may seem bleak, **CDE finds itself now at a crossroads, with an opportunity to plan and rethink how it presents its activities to donors and partners with other organisations, in efforts to increase the resilience and adaptability of its programming and consider how to approach potential ethical dilemmas.**

5.2. Recommendations

Three key areas for recommendations emerge from this research:

1. **Internal changes** – technical and operational opportunities for improvement
2. **Relationship building** – working towards a more collaborative, localised approach, with other medical actors and NGOs, as well as IOs and CSOs, donors and local and national authorities
3. **Planning** – developing action plans adapted to likely future scenarios

[107] AAN, 'Taleban: Perceptions of Aid. Conspiracy, corruption and miscommunication', 2023.
[108] SIGAR, '2023 High-Risk List report', 2023, p.7.
[109] Requirements around mahrams to travel, or limited access to documentation, required for support by some NGOs, as well as decreasing female staff in NGOs as a result of Taliban policies, make it harder to access care both within and outside Afghanistan. See for example *IOM & Samuel Hall, "Documentation and legal identification in Afghanistan", Research Report, 2023* on limited access to health facilities without a mahram.
[110] AAN, 'Taleban: Perceptions of Aid. Conspiracy, corruption and miscommunication', 2023, p.26.

1. **Identify opportunities for low-cost, 'high' reward technical support from CDE to FMIC**. This evaluation flags several areas where small planning, tool and standardisation initiatives could smooth FMIC operations, improve the impact of existing support provided and contribute to a stronger working environment for staff, strengthening the relationship between the two organisations further.

    a. Explore opportunities to better standardise the planning for short-term missions, including from an administrative perspective, given the feedback that doctors put other activities on hold to facilitate these, and that these can lack sufficient notice for effective planning.
    b. Refine the selection criteria for short and long-term missions, with a focus on surgeons with a stronger knowledge of local languages and experience training. When such surgeons cannot be identified, consider the provision of medical-operation-only short-term missions, with a focus on surgical outcomes and observation of procedures rather than building expectations for more in-depth trainings.
    c. Continue to leverage remote training and guidance opportunities, including the ECHOES programme, which based on indicators has been less used than planned. This could include the identification of means of remote PSS provision for doctors under high stress.
    d. Develop stronger monitoring and evaluation frameworks embedded across workstreams and gathering perspectives from participants across these to identify problems and frustrations on an ongoing basis. This could leverage the data already being collected for further analysis. In addition to strengthening the ongoing understanding of implementation and flagging potential practical and operational issues, this would also give CDE further data for advocacy around its activities with partners, donors, and the DfA as needed.

2. Mitigate **the operational frustrations identified in the course of this research.** Of particular concern are the issues raised by doctors around their working conditions – given how crucial they are to programme continuation and the individual risks of moral injury and burn-out they face – and the (mis)perceptions noted around referrals and CDE's ability to fund activities. The latter could snowball to administrative difficulties with the DfA if complaints are made and frustrations between households in communities or with implementing partners.

    a. Conduct a benchmarking exercise of residents' salaries against other residency programmes which takes into account the opportunities for additional income from private practice in residency programmes with lower hourly requirement, to review salaries if needed. Should results be similar, publicise these among residents.
    b. Prioritise missions which answer critical training needs in addition to urgent surgical needs.
    c. Clarify the rationale for the selection of beneficiaries for access support both internally (with staff and doctors) and externally (with partners) to make clear both the limitations of the funding and why only certain profiles are targeted. This can take the form of very simple one-page documents summarising this for use by implementing partners, or visual posters for use at CDE and with partners.

3. **Create and reinforce spaces for discourse with sub-national and local authorities.** While easier said than done, the evaluation suggests that the DfA's view of the FMIC – and by extension, CDE's support to it – is relatively positive, especially in comparison to broader negative perceptions of NGOs by the DfA. Further, the programme is in a unique position of serving as a communication's 'bridge' between the Afghan and French authorities – which could potentially broaden to other governments if CDE is able to engage with them for funding. However, these high-level perspectives may alter rapidly. By further working to create a network through local and sub-national authorities, CDE may be able to facilitate its operations.

    a. Engage in discussions with the French government to see how this relationship – if at all – could be leveraged to reduce the pressure felt on the FMIC by the authorities.

b. Consider opportunities to build relationships with counterparts beyond the MoPH, in particular at the sub-national / local level (e.g. in Kabul, and with local authorities in areas where CDE / FMIC are partnering). This could target for example local authorities around IDP camps.

4. **Develop a stronger and broader partnerships network for implementation across all strands of activities.** This evaluation highlights the need for further collaboration to develop more cost-efficient approaches to implementation; identify additional partners for medical missions; and finally, the weakness of a partnership dependent on a single counterpart in the current environment. In line with recommendations 5 below, this should include the following:

a. Deepen the relationships in CDE's existing partnerships network and launch others, to potentially share medical skills where needed on intra-Afghanistan training missions, develop joint trainings and capacity-building sessions with organisations such as ICRC or MSF. Other organisations such as IOM and GIZ have previously implemented programming to bring qualified technical support to Afghanistan.
b. Seek out partnerships for medical missions with networks of doctors at a regional level or more internationally with those who have strong knowledge / connections to the region to facilitate the identification of surgeons as per Recommendation 1 above. Initial efforts to this effect have reportedly begun.
c. Expand partnerships in displacement contexts in particular to a broader set of partners working closely with displaced persons in Kabul and elsewhere to reduce the risk of stopping activities again. Potentially, CDE and FMIC could seek to include direct camp access in future discussions with the DfA and local authorities. This speaks to a broader need to target partnerships to build on programmatic elements aligned with broader humanitarian objectives, to avoid the programme being viewed as 'solely' a development initiative.

5. **Rethink CDE's Afghan Health Programme 'branding'.** While tertiary care and quality medical care are a clear gap in the current Afghan health context, across the board stakeholders raised the question of the perceived pertinence thereof at this point in time. Yet, in practice, CDE's activities are in line with humanitarian priorities and can be tied to the humanitarian imperative. Further, specific elements of programming are directly building on these objectives, such as the gender focus taken by the organisation, as well as the newer component aiming to target displaced populations. A 'rebranding' effort is called for to more clearly tie activities to broader funding streams than have previously been targeted. Rather than long-term development planning, in short, CDE must make the argument for the programme's integral role in supporting shorter-term humanitarian initiatives.

a. Conduct an internal strategic exercise to agree on language to describe CDE's activities which more closely aligns with existing donor funding priorities and provides tangible examples (drawing from this evaluation and programme monitoring) of the potential for impact under these funds.
b. Seek opportunities to work more closely with the WHO and UNICEF, among others, who continue to operate more large-scale health programming in Afghanistan at the moment.

6. **Incorporate a stronger monitoring and evaluation component in future programming.** Annual reporting and data collection internally has been output-focused. Given the rapidity with which the context has been evolving and the short-term nature of much funding additional strategic analysis and evidence is required both internally – to optimise operations - and externally – to showcase the impact which FMIC is having.

a. Create a short template for key elements to be tracked on a monthly basis and with 'red line' indicators, aligned with the forward planning exercise below.
b. Review feedback forms for short-term missions and other exercise to allow more detailed feedback by trainers and participants, easily comparable across missions. This could be done

through the use of electronic data collection such as through Google forms which allows for rapid comparison of results.

7. **Conduct an internal 'forward planning' exercise within CDE and then in conjunction with FMIC**. Stakeholders interviewed regularly raised concerns that firm ethical boundaries would be breached either by new policies at the national level or imposed on the programme – but neither 'red lines' on ethical front were explicitly agreed across the board, nor plans for what next. Given the rapidity at which some changes occur on the part of the authorities, this calls for a planning process which:
    a. Identifies clear 'red lines' for CDE in relation to the programme, in particular around gender, DfA involvement in participant criteria (whether for the PGME or provision of access support), and previously agreed governmental contributions (electricity, the grounds provided for a potential extension).
    b. Draws on ethical frameworks for "structured deliberation" on how to react and which sectors of support may be worth continuing even in the face of "abhorrent working conditions".[111]
    c. Building on this, develops best and worst-case scenarios with exit planning agreed with partners, to be reviewed on a bi-yearly basis / in the case of a rapid contextual evolution. Stakeholders should have a clear plan of action in the case of one of these red lines being breached.

[111] UKHI, "Navigating Ethical Dilemmas for Humanitarian Action in Afghanistan", 2023.

6. ANNEXES

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Annex 1 – Afghan Health Programme Activities' indicators

Capacity Building / Medical Missions Indicators					
Indicator	Projections 2018-2021 (per year)	Achieved in 2018	Achieved in 2019	Achieved in 2020	Achieved in 2021
N. of theoretical and practical training sessions provided at FMIC and abroad	Approximately 2500 training sessions	2880 sessions for FMIC personnel and 279 sessions for external personnel	2682 sessions for FMIC personnel and 456 sessions for external personnel	2193 sessions for FMIC personnel	1955 training sessions for FMIC personnel and 192 sessions for external
N. of missions organised by CDE	Approximately 85 missions, including coordination missions (~30%)	68 missions, including 23 coordination missions (34%)	48 missions, including 5 coordination missions (10%)	15 missions, none of which were coordination missions	24 missions, including 5 coordination missions (20%)
N. of mission days organised by CDE	Approximately 1 500 mission days	1352 mission days	857 mission days	362 mission days	502 mission days
N. of individuals trained (by CDE)	3-10 persons per mission	280 (in average: 4 persons trained per mission)	86[112] (in average: 1,8 persons trained per mission)	77 (in average: 5 persons trained per mission)	37 (in average: 1,5 persons trained per mission)
N. of meetings of the "Gender Mainstream Group"	6	6	3	0	0
N. of awareness sessions organised at FMIC regarding gender-related behaviours	To be defined throughout the project	12	10	9	5
PGME Indicators					
Indicator	Projections 2018-2021 (per year)	Achieved in 2018	Achieved in 2019	Achieved in 2020	Achieved in 2021
N. of residents participating in the PGME	Approximately 80 residents over the period 2018-2020	46 residents	39 residents	25 residents	29 residents
N. of graduates each year	Around 60 graduates from 2018 to 2020	12	13	12	10
N. of specialties[113] taught by this program	9 specialties starting from 2019	7 specialties	8 specialties	8 specialties	9 specialties
Access to Care: Activity at the Women and Children's Pavilion					
Indicator	Projections 2018-2021 (per year)	Achieved in 2018	Achieved in 2019	Achieved in 2020	Achieved in 2021
N. of beneficiary patients	Approximately 4,000 beneficiary stays	5 483	4430	2 567	2502

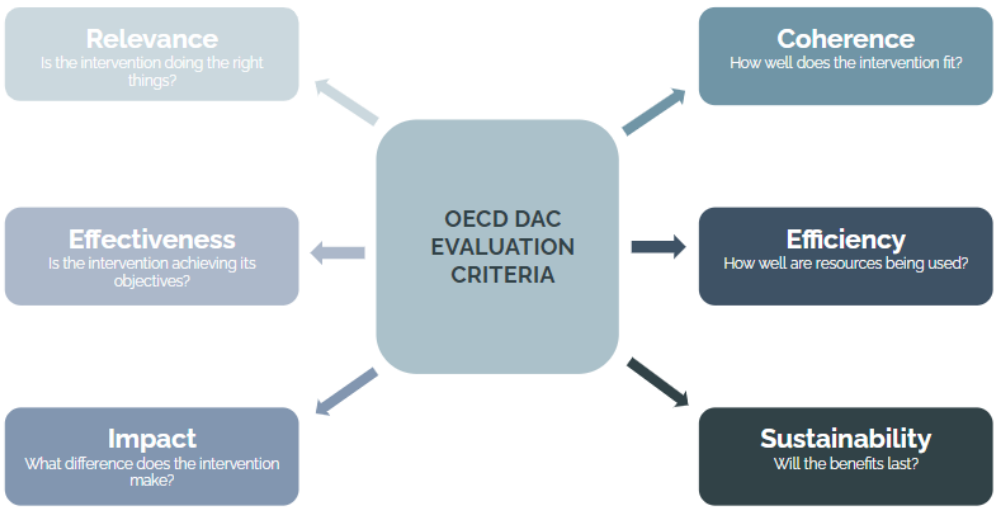
[112] The variance between the projections and achievements for the year 2019 in terms of the number of individuals trained is attributed to a change in the method of calculating the number of FMIC personnel trained during missions in 2019. This represents a conservative estimate, encompassing the total count of individuals directly trained through mission interactions for each department.

[113] The specialities taught are: Paediatric Medicine, Paediatric Surgery, Anaesthesiology, Radiology, Pathology, Cardiology, Orthopaedics, Cardio-Vascular Surgery, Obstetrics and Gynaecology.

N. of new patients registered at the Pavilion	Approximately 1 400	1 651	1485	301	797
N. of consultations and surgical procedures managed at the Pavilion (provided at FMIC)	Approximately 5,000 consultations and examinations). Approximately 1,100 surgical procedures	6,796 consultations and examinations 1,189 surgical procedures	5,339 consultations and examinations 1,135 surgical procedures	2,570 consultations and examinations 973 surgical procedures	2,529 consultations and examinations 1,042 surgical procedures
N. of patients consulted via teleconsultation as part of the medical missions of CDE	Approximately 300 patients per year, expected to increase with the launch of the ECHOES programme in gynaecology	241	173	149	71
N. of covered provinces and distribution	Coverage of all provinces (34 provinces) - 100% coverage	Coverage of all provinces (34 provinces) - 100% coverage	Coverage of all provinces (34 provinces) - 100% coverage	Coverage of 88% of provinces (30 provinces)	Coverage of all provinces (34 provinces) - 100% coverage
Boy/girl ratio	50% of paediatric patients are girls, and 100% of adult patients are women	53% girls and 47% boys	49% girls and 51% boys	52% girls and 48% boys; 100% of adult patients were women	49% girls and 51% boys; 100% of adult patients are women

Annex 2 – Evaluation Framework

OECD DAC evaluation criteria



Evaluation questions, sub questions and tools

Evaluation questions, sub questions and tools		Tool (s)
Criteria 1. Relevance: To what extent do the objectives and design of the intervention correspond to the needs and priorities of the project's target populations and partner actors?		
1.1	Given the evolving Afghan context during the implementation of these activities, is CDE's strategy still appropriate?	Desk review, KIIs

Evaluation questions, sub questions and tools		Tool (s)
1.2	Do the recruitment systems for beneficiaries and participants effectively target the most relevant/vulnerable individuals? How can they be strengthened?	Desk review, KIIs, FGDs, CSs, E-survey
Criteria 2. Effectiveness: To what extent has the project achieved its objectives?		
2.1	To what extent have the expected results for the three implementation axes (e.g., staff empowerment, improvement of training quality, remote missions) been achieved?	Desk review, KIIs, FGDs, CSs, E-survey
2.2	What external factors have supported - or not supported - the project in the implementation of these activities?	Desk review, KIIs
Criteria 3. Efficiency: To what extent has the project been implemented in an economical manner and within the planned time frame?		
3.1	Are the resources allocated to the planned activities optimised?	Desk review, KIIs
3.2	Specifically, to what extent are short missions a relevant and cost-effective approach in terms of both finances and content?	Desk review, KIIs, FGDs, E-survey
Criteria 4. Coherence: To what extent is this project compatible with other interventions conducted in Afghanistan, as well as within CDE itself?		
4.1	How can the collaboration between CDE and FMIC be improved?	Desk review, KIIs
4.2	How can CDE strengthen its partnership policy in the current context, as well as its relationship with the Ministry of Health?	Desk review, KIIs
Criteria 5. Impact: What positive or negative impacts can be identified as a result of this project?		
5.1	Can a differentiated impact on female beneficiaries be observed?	Desk review, KIIs, FGDs, CSs, E-survey
5.2	What has been the targeted impact on displaced populations specifically (considering the partnership with NRC in IDP camps)	Desk review, KIIs, FGDs, CSs
Criteria 6. Sustainability: To what extent are the project's benefits likely to endure without continued support?		
6.1	To what extent are CDE's partners able to continue the activities without CDE support?	Desk review
Cross cutting questions		
7.1	How have gender, age, displacement been integrated throughout this project and its implementation?	Desk review, KIIs
7.2	What approaches could optimise the mobilisation of resources for these activities (e.g., remote training, etc.)?	Desk review, KIIs
7.3	**Recommendations:** In the current situation in Afghanistan, how should CDE adapt its projects, approaches, and priorities to meet the needs of the population and support the health sector more broadly? For example, in this context, should the long-term medical team training programme be a priority? How can CDE operate in IDP camps if partners stop their work? How should CDE adapt to the fact that many public hospitals are no longer able to perform surgical operations? How can CDE ensure the protection of female beneficiaries in a context that limits their mobility? Finally, how can CDE's support adapt to the increasing "humanitarian" focus of actors in Afghanistan	Desk review, KIIs, FGDs, CSs, E-survey

Annex 3 – Evaluation Sample

Tools	Female	Male	Total
KIIs	6	11	17
CDE/FMIC	5	4	9
CDE partners		5	5
Board members		2	2
Experts	1		1
FGDs	5	2	7
Participants to staff and medical trainings*	1		1
PGME residents	1	1	2
Patients treated at the FMIC in Kabul	2		2
Parents / guardians of patients treated at the FMIC in Kabul	1	1	2
SSIs		5	5
Participants to staff and medical trainings		4	4
Qambar Square IDP Camp representative		1	1
Thematic case studies	8	2	10
Gender and displacement:			
SSIs with FMIC beneficiaries from IDP camps	3		3
KII with CDE partner staff	1		1
Community observation		1	1
Provincial support and referrals:			
SSIs with FMIC beneficiaries / parents from the provinces	3		3
KII with CDE partner staff	1		1
Community observation		1	1
E-survey	5	10	15
Hospital staff who participated in medical and other trainings	2	6	8
Trainers for these trainings	3	4	7
Workshops			2
TOTAL	24	30	56

All names mentioned in the quotes throughout this evaluation report have been changed to maintain anonymity.

** The FGD with male participants to staff and medical training could not take place due to over busy schedules and the difficulty to find a suitable time for a group discussion. Alternatively, four SSIs were conducted with male participants to staff and medical training.*

Annex 4 – Admission Criteria

2018			
MEDICAL	SOCIAL	WOMEN	CHILDREN (under 18)
Treatment is not available in a governmental hospital locally near the place of residence. The patient does not require emergency care nor NICU or ICU. The patient does not have any fractures/breaks that prevent him/her from travelling by road.	Lack of economic capacity – (i.e., Family of 5 people with monthly income under $120 (8,000 AFN) Priority: Gender balance Children under 18 have either 1 or 2 adults to accompany - depending on the age.	Hysterectomy. Colporrhaphy. Myomectomy.	Cardiac. Complex orthopaedic. Complex general surgery. Plastic, Reconstructive. Ophthalmic. Nervous or Neurology. Complex Ear Nose and Throat surgeries.
2020			
MEDICAL	SOCIAL	WOMEN	CHILDREN (under 18)
No modifications.	**Monthly income criteria:** Reduction from $120 to $100 (equivalent to 7,700 AFN). **Accompaniment:** Several exceptions for certain cases.	Medical treatments for women expanded to include laparoscopy.	No modifications.
2021			
MEDICAL	SOCIAL	WOMEN	CHILDREN (under 18)
No modifications.	No modifications.	Medical treatments for women expanded to include a wide range of gynaecological surgical treatment, i.e., endometriosis, uterine polyps, rectocele, etc.	No modifications.

ABOUT SAMUEL HALL

Samuel Hall is a social enterprise that conducts research, evaluates programmes, and designs policies in contexts of migration and displacement. Our approach is ethical, academically rigorous, and based on first-hand experience of complex and fragile settings.

Our research connects the voices of communities to changemakers for more inclusive societies. With offices in Afghanistan, Germany, Kenya, and Tunisia and a presence in Somalia, Ethiopia, and the United Arab Emirates, we are based in the regions we study. For more information, please visit www.samuelhall.org.

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