



The Afghan Children's House Project

External Evaluation – commissioned by La Chaîne de l'Espoir

Final Report / July 2013



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1. Introduction

1.1 Background to the Afghan Children's House Project¹

“La Chaîne de l’Espoir (CDE) is a French Medical NGO founded in 1988 providing access to medical care for vulnerable children in 30 developing countries, including in Afghanistan. In 2003, La Chaîne de l’Espoir built the French Medical Institute for Children (FMIC) in Kabul, with the aim of providing high-quality surgical care to young patients. The hospital gained immediate recognition, the growing volume of consultations reaches today an average of 80,000 children per year, 4,600 of them being hospitalized for treatment or surgical intervention.

To enable access specialized health care to vulnerable and needy children from remote provinces CDE opening in 2008 the Afghan Children House (ACH). This structure hosts, at no charge, up to 60 underprivileged children per month, ill or handicapped, accompanied by one or more of their relatives, for pre and post-surgery. The Children’s House is managed entirely by la CDE’s Health Care Access program and offers 1) medical support, comprising consultations, examinations and surgical operations done at the FMIC; 2) social support, including refund of transportation accommodation and hosting costs at the Afghan Children’s House, as well as pre- and post-surgery follow-up care. Since its opening in 2008 until the end of December 2012, the Children’s House cared for 2,217 Afghan children and financed 2,364 surgeries.

Within four years and a half, the activity of the Children’s house has increased threefold. As a consequence, costs are increasing and the capacity of the current structure is being reduced. Therefore, CDE has de decided to build a new Afghan Children’s House which could enable: 1) increase in the current structure capacity, so as to provide monthly, at no charge, medical and surgical care to 100 children from poor families and remote areas; 2) develop a semi-medicalised structure, designed to offer pre- and post surgery services.”

The overall aim of the external assessment is to evaluate the current Afghan Children’s House project, to produce an analytical document containing recommendations for the future of the project, bearing the context and impact of the project to date.

The report outline consists of:

- Chapter 1: Introduction (Methodology, Approach & Research Questions)
- Chapter 2: Evaluation – Assessing Achievements (Findings & SWOT Analysis)
- Chapter 3: Lessons Learned (What works and What could be improved?)
- Chapter 4: Recommendations (Future CDE Plans and for Stakeholders)

This report was carried out by a team of external researchers at Samuel Hall (<http://www.samuelhall.org>) for an audience of internal and external readers, staff and donors to strengthen the strategy, advocacy and fundraising efforts of CDE at a critical time for Afghanistan’s youth. The next section will provide a brief review of the context of operation of CDE in Afghanistan.

¹ NB: The background information has been extracted from project documents on the Children’s House.

1.2 APPROACH and GUIDING QUESTIONS

Beyond a Quantitative Approach

Since its opening in 2009 and until the end of September 2012, the Afghan Children’s House has cared for 2,008 children and financed 2,061 surgeries. As indicated in Table 1 below, year after year, with increasing recognition and funds, the numbers of both patients and surgeries have exponentially increased. From 16 monthly referrals and 11 monthly surgeries in 2008, the ACH has exceeded an average of 60 children on both counts in 2012.

Table 1. Statistics on monthly referrals and surgeries, 2008-2012

Year	2008	2009	2010	2011	2012
Average Referrals per month	16	23	34	56	67
Average Surgeries per month	11	25	33	57	68

The goal of this evaluation is to move beyond the quantitative aspect of the Children’s House achievements to look into a qualitative assessment focusing on questions of:

- Impacts on patients and their families
- Welfare approach
- Outreach capacity
- Stakeholder coordination
- Design of future housing project

Research Questions

To this end, the approach of this evaluation is qualitative and the guiding research questions behind it are:

- What are the short-term and longer-term impacts of the Afghan Children’s House project?
- Do these justify the planned construction and additional funds to support a New Afghan Children’s House?

To answer these questions, specific Indicators for this evaluation include a review of:

- The day-to-day experiences of children and parents at the ACH
- The quality of accommodation, medical support and special care
- The long-term impact of the Health Care Access program
- The relationship to medical and administrative staff
- The relationship to other families and patients
- Beneficiaries’ perceptions of strengths and weaknesses of the program

Objectives

The objective is to inform decision makers both within CDE and among the donor community, to assess the viability, relevance and effectiveness of past, current and future ACH plans.

As per the terms of the ToR, “the aim of the external assessment is to evaluate the current Afghan Children’s House project, to produce an analysis document containing also recommendations for the new Afghan Children’s House project.”

1.3 METHODOLOGY

The main methodology for this research included:

1. **Desk review** of the existing internal documents and literature existing in Afghanistan, on other similar NGO medical programs operating in comparable environments;
2. **Key informant interviews** with FMIC staff and doctors, ACH administrative and medical staff, government counterparts (Ministry of Public Health), stakeholders and partners (including ICRC and Afghanistan Demain). These interviews followed an in-depth interview methodology, with open-ended questions, lasting on average 1 hour per respondent.
3. **A Qualitative research based on:**
 - **Focus group discussions (FGD) – in total 4 FGD, 20 respondents** – including 2 focus groups with children patients, and 2 focus groups with their parents were held in Kabul by our research team. Each FGD consisted of on average 5 participants and probed for participants’ feelings, behaviors, challenges, and potential areas of improvement. In consultation with CDE staff, these group interviews were conducted with full assurance of anonymity and privacy. Observations were also used
 - **Individual Case Studies with 1 male patient and 1 female patient** – to provide the opportunity for more in-depth individual discussions with children
 - **Observations** of the medical and administrative staff, of FMIC – ACH cooperation and collaboration, to provide a third-party objective assessment of areas for future improvement.
4. **A Quantitative Follow-up Survey with 106 former Children’s House Parents** – conducted through phone interviews, with the majority of questions asked of parents, and one in four children interviewed for additional questions. The survey questionnaire aimed to capture, for each surveyed child, information on 1) Demographics and Background, 2) Reasons for his/her stay, 3) The psychological impact of the time spent at the Children’s House, 4) The strengths and weaknesses of the structure, 5) The relationship with other family members (before and after the care received at the Children’s House). This questionnaire was designed and pilot tested twice in Kabul, and in Dari. As survey standards require, the results of the pilot tests were used to refine the research tools and produce final questionnaires. Given the sensitive nature of interviews with children, the questionnaires were also proofed by the CDE staff. The survey included a total of 26 questions and lasted on average 25 minutes. The data was analysed using SPSS.
 - Respondents were selected from caseloads up to 2013 to obtain a range of views: 30% respondents were cared for in 2013, 35.2% in 2012, 18.1% in 2011, 16.2% in 2010 and 7.7% prior to 2010.
5. **Limitations and Constraints** – First, children were often not available for interview at ACH, as they were receiving medical care, or were interviewed near their family members to ensure comfort and acceptance for the qualitative interviews. Second, the quantitative analysis is primarily based on the feedback received from parents who stayed together with their children during the period of care, while the qualitative focuses on providing insights on the viewpoint of the children only. Third, extracting detailed information from the children about their experience in the Children’s House proved challenging as most children were very young (under 16) and were not used to being asked certain questions. All of these

limitations were useful observations that will be used, in part, in Chapter 4 to recommend a framework for engagement with children throughout and after their stay.

Picture 1: Patient's room in the second floor (La Chaîne de l'Espoir)



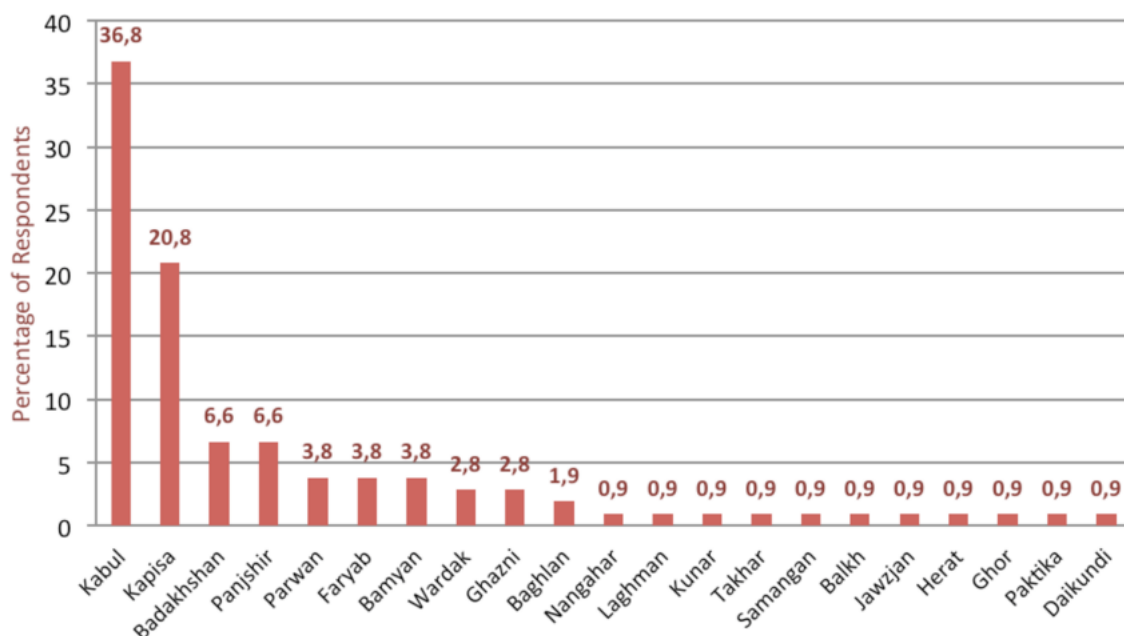
2. Evaluation – Assessing Achievements

The presentation in this chapter will go beyond a quantitative approach focused on numbers – to a qualitative assessment centering on perceptions and feedback received through in-depth interviews. Interviewing parents and children through a phone-based survey was an important evaluation tool used, not alone as it allowed to cover a range of years of operation of ACH (from the start of the Health Access Program up to today). Answers recorded being overwhelmingly positive (above 90% on most indicators), the evaluation team has prioritized the feedback of beneficiaries, staff and stakeholders collected through qualitative interviews. These main findings are presented in this section, with a brief section starting with an overview of patients' profile.

2.1 Patient Profile

The quantitative survey reached 92.5% male respondents and 7.5% female respondents, with the most frequent relationship between the interviewee and the patient being a parent relationship (79.3% of the time). The child patient respondents were for the most part male (64.2%), and were ethnic Tajik (46.2%), Pashtun (33%) and Hazara (10.4%). As shown in the graph below, most respondents came from Kabul province (36.8%), and a notable number of respondents from Kapisa province (20.8%) neighbouring Kabul province.

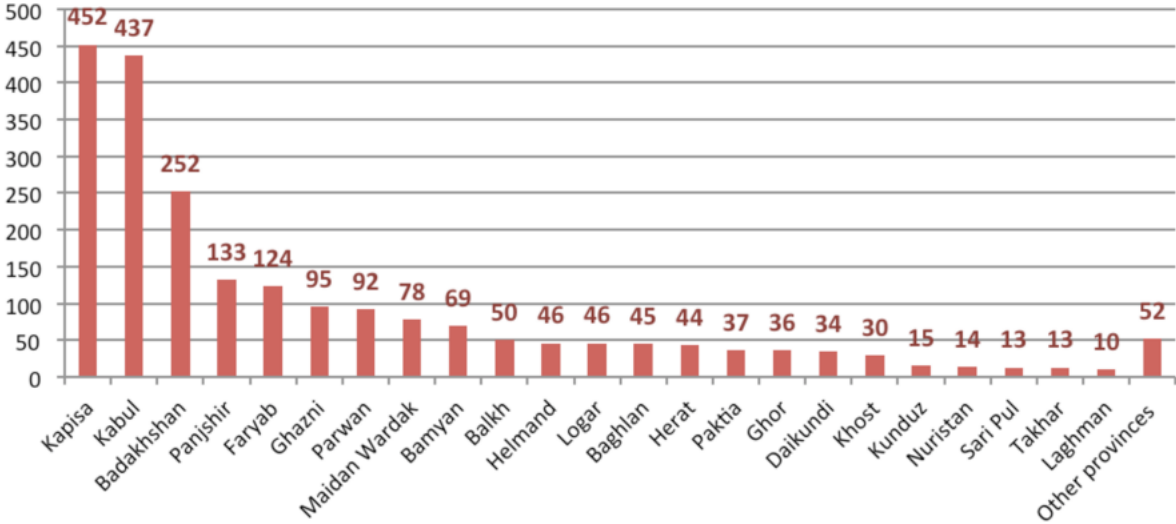
Graph 1. Breakdown by province of residence (%)



The graph above indicates a relatively high number of patients from Kabul and nearby provinces (Parwan and Panjshir), and a high number of patients from Kapisa (20.8%) and Badakhshan (6.6%), the former due to past French military presence in the province, namely in the district of Surobi, and due to a grant received by La Chaîne de l'Espoir from the French Embassy's Development Pole over the last three years. In this regard, and as seen in the graph below, the figures collected by the organization do corroborate the findings of our quantitative survey, as patients from Kapisa and

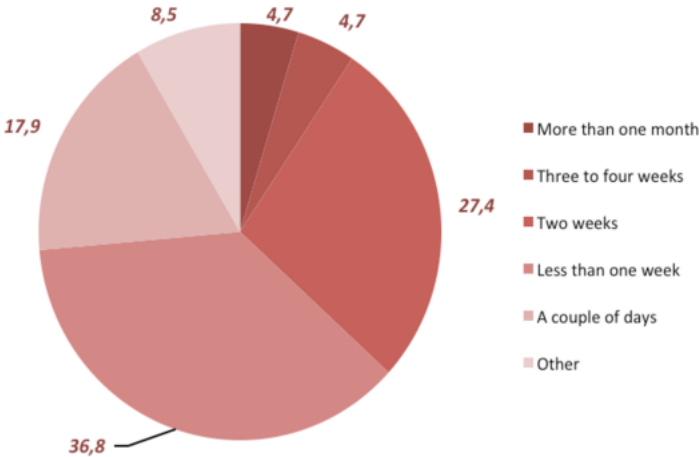
Kabul represent, respectively, 20.3% and 19.7% of the 2217 children that have been referred to the hospital between 2008 and 2012. The relatively significant percentage of patients from Kapisa, a province that only represents 1% of the Afghan territory, is again explained by the Grant from the French Embassy’s Development Pole², which is one of the major funders of “La Chaîne de l’Espoir”: “For [the Pôle de Stabilité], this partnership is essential, as it shows local communities that France does not only care about the impact of the fights happening in their valley but also about any disease or health issue that children may have in Kapisa. The French hospital and “La Chaîne de l’Espoir” are by far the best actors in their sector and working with them was thus natural” (Pôle de Stabilité, anonymous).

Graph 2: Provincial Breakdown of LCE's patients 2008-2012



Most patients had visited FMIC multiple times, with only 20.6% of respondents only having stayed at ACH one time. Respondents’ positive experiences with ACH likely encouraged them to return to the House when required and possible. Most respondents also spent a relatively short period of time in the House, with 54.7% of respondents staying in the House for a couple of days or a week, according to the quantitative survey, as shown in the graph below showing the percentage of respondents who stayed at the House for a specified length of time.

Graph 3. Duration of stay at ACH (%)



² The French Embassy’s Development Pole or “Pôle de Stabilité” was created on September 1st, 2010. In 2011, approximately 40% of the French civilian development assistance was focusing on the districts of Tagab (Kapisa province) and Surobi (Kabul province).

Most respondents approached the house because it 'offered the best quality of care' (36.9%) or due to a specific referral to the house (32.1%). Family members also responded positively once learning that respondents were taking their children to the house, with 86.8% of respondents indicating that their family responded positively when they were told that the child patient would receive care at ACH. A smaller percentage of respondents, 12.3%, indicated that their family members reacted in a 'neutral' manner – but none flagged any negative repercussions. Once at ACH, respondents had extremely positive experiences and appreciated the care provided for their child patient, as shown in the findings of our study.



Picture 2: Father and son filling out a form with the CDE admin staff (May 2013)

2.2 Key Findings

2.2.1. Vulnerability targeted: Physical Disability and Poverty

The first question asked by the evaluation team was whether the right people were being targeted for medical care. Triangulating information received from partners, medical and admin staff, and beneficiaries themselves, the main question of WHO is being selected for inclusion in the limited space of the ACH was asked of all interviewed. CDE was founded on the premise of providing medical care for vulnerable children in developing countries. In Afghanistan, although a complete profiling of families and their communities was not undertaken, all agreed to describe the ACH project as a project “for poor people” who would not be able to access such medical care without the financial support of CDE. As such, the program covered a dual vulnerability – disability and lack of economic capacity, and targeted, based on this feedback, “the vulnerable within the vulnerable” in Afghanistan.

ACH has limited spots available on its premises, but the selection is reportedly targeting “those who do not have a chance otherwise”, as often re-stated through interviews:

“One main thing is that we couldn't go anywhere else, and I wouldn't be able to go somewhere else because we don't have the money. And its three 3 days to Wakhan with car, how could I have ever paid for the transportation? I wouldn't be able.”

– Hikmat, 33, parent of a patient at ACH.

A preliminary assessment shows, based on lessons learned by medical and admin staff, that a number of the problems cared for by the hospital and ACH staff are inter-generational abnormalities that often exist and occur repeatedly within the same family. Hereditary or genetic diseases and malformations due to consanguinity point to the existence of several potential patients in one family. Often, the child brought to ACH reveals the tip of a larger family problem.

Thus far, there have been instances of several families where more than one child from the same family have been treated, or investigated for treatment. In cases of budget restrictions, siblings have been put on the waiting list for subsequent treatment. This confirms the need for thorough **vulnerability mapping** of patient families, looking at families’ medical history and a survey of household members’ health conditions, to see whether, through the selection of one patient, other potential patients can be treated as well. Socio-economic vulnerability would therefore be targeted, and physical or mental vulnerability would be more comprehensively covered. CDE staff emphasized that expanding the current project – and thus building a new house – would allow them to better address the abnormalities found within the same family – coming from family history.

2.2.2. Short-term impacts: Environment & Medical Care

ACH – More than accommodation, a feeling of ‘home’, learning & meeting place

The house accommodates families from all provinces, striving to target more remote provinces. Parents emphasized that through their stay in the House they had learnt many new things about other people coming from other provinces, and had established close friendships with people they would not have met otherwise.

“ ... I learned so much about other people. There was one brother he was from Paktika, and so I talked with him and I learned so much about how they live there, and also from other brothers who are from other provinces. Like now I got to know this brother, and if he comes to my village to my provinces then I will invite him to my house, and so he doesn't need to stay in a hotel. And he would do the same thing for me if I went to his place. So this way we learned a lot of things, one person is from Ghor, another from Paktika...so we learn about 34 provinces in Kabul”

- Father, from Ghor

For many, it is an eye opening experience on every aspect, from the quality of the attention given to children and parents to the sheer existence of a place called a Children’s House that services a medical purpose, with state of the art medical facilities and surgery capabilities. This could be seen as potentially overwhelming for rural patients from remote areas of Badakhshan, or even of neighboring provinces of Parwan or Kapisa, where conflict has been increasing in recent years. Notwithstanding the novelty of the experience, more importantly for them, the calm, stability and modernity of the ACH are sources of comfort for them. They report, through focus groups with parents and children, feeling at ‘home’ in this ‘interesting place’. The perception of beneficiaries then is that ACH is more than an accommodation for them, it is another home, a learning and meeting place. This is often reinforced by the fact that follow-up and check-ups require them to come back. Seeing the other side of the coin, it is also a factor that ensures that families return for follow-ups and check-ups. There are other such incentives – besides the medical care – that make the experience a unique experience for them.

“ ... This is my first time, and this is the first time I am seeing a house like this. It is very interesting for me. A very interesting place. Since we arrived here, the cleaners help me a lot. And the people are all very friendly. I have made new friends, with other parents who have the same problems that I face. It is so rare where I come from, I am the only one in my village with a disabled child.”

- Basira, from Hirat

An environment where they can just ‘be children’

As for the children interviewed, they were happy to just be able to “be children”. Often times, in their homes, they are barred from the usual routine of most children – both as direct and indirect consequences of their disability. At ACH, they can play inside and outside in the garden, they stay in one room with all the other children, and have time to play as part of their daily routine. This is especially true of days where they don’t have surgeries, they explain during a focus group. Those who are able to can ride bicycles, with three available bicycles at ACH.

This feeling of togetherness and playfulness inculcates in children a feeling of acceptance and equality. As highlighted by one of the ACH nurses, they often meet very smart children, who have a potential to succeed in school, but because of their disability, they are not given the same chances than other children. However, when they express themselves at ACH, through verbal or not verbal forms of expression and communications, they show more social sides of their personalities, integrating well in a new environment and being able to open up about themselves.

" ... I feel safe, and I learned so much about other people. There was one brother from Ghor, I learned so much about how they live there. If he comes to my village, I will invite him to my house. He would do the same for me...This way we learn about all the 34 provinces in Kabul."

- Ibrahim, from Paktika

" ... Everyone is equal here and everyone is poor."

- Hamida, from Balkh

Care after surgery: Minimizing dropout rates

As shown in Graph 4, the majority of families stay on for more than one week at ACH. In the focus groups conducted with parents, the research team collected information on some who had arrived 12, 14, 23 days prior, and some who had been at ACH for 3,5 months.

In some cases, one girl had gone through 4 leg surgeries preventing her from moving – justifying the 3,5 months stay at ACH, especially since the family is from Badakhshan, a province from which it takes, on average, 2 days to travel by road.

" ...It has been a year now that I am going back and forth between Mazar and Kabul. Both my children were born with a disability, like their father. First, my son got surgery and now I am back for my daughter. I have been back and forth for her. The ICRC pays for my transportation and ACH for our accommodation at the house."

- Morvarid, from Baghlan, shared her views during a focus group with mothers of disabled children.

" ...I am here for my son, for his knees. This is our third time here, we have come back for a check. They gave us money for transportation – all of the money was spent on transportation. My son's muscles are not strong enough, so they have to check him a lot. They give him medicines, and have to check the effects of the medicine on him every 2 or 3 months."

- Sakina, from Parwan, during the same focus group.

The medical staff reported variable durations of care after surgery to be essential to maximize impact, and minimize dropout rates. They were careful to report that schedules and appointments are strictly enforced so that i) families know what to expect, they are informed from the start that the treatment may be a long process, ii) families understand that each meeting is important, with a specific purpose every time, and that iii) not respecting such appointments will diminish the impact of the care provided. As such, the medical staff is striving to minimize drop-out rates which are very common in Afghan hospitals, where families are asked to come back many times, but after a while, they either lose their patience or will, or they can no longer afford constant back and forth.

Follow-up & Check-ups

The follow-up provided is a source of comfort for families and of material support – many would not be able to come for treatment, let alone come back for medical checks post-surgery. ACH is an essential resource to them – on the longer run. The research team found that follow-up often extended beyond the immediate post-surgery phase and included the possibility for the same children to be re-admitted on a needs-basis:

- ✓ In a focus group conducted with 6 boy patients, one of them, Moein, 11 years of age, mentioned that he was re-admitted a second time. He was treated for his disease a month prior – but upon returning home to Bamyan, he got sick again. When the medical staff were informed, they re-admitted him at FMIC, and at ACH, for another 15 days.
- ✓ This was confirmed through the same focus group, with another boy, Ahmad, age 14, reported that this was his second time at ACH. The first time was over a month ago as well. He had to be re-admitted due to some post-surgery complications.
- ✓ Speaking with mothers during a focus group, one of them, Salma from Kapisa, reported it being her third time at ACH. Her daughter has suffered from a disability since birth. She underwent surgery a year ago, followed by a first check-up 10 months later, where the cast was removed, and now her third visit is another scheduled check-up. This reassures her as she is well aware of the challenges of getting her daughter’s leg to function when she has had her disability from the day she was born.

Pictures 3 and 4: Indoor and outdoor pictures of the Children’s House (May 2013)



2.2.3. Long-term impacts: Child development & Community Impact

To properly assess long-term impacts of the Health Access Program, both FMIC and ACH would have to be evaluated, and a longitudinal approach (following patients through several years) would be required to dissociate causes and consequences. However, based on the limited methodology available within the scope of work and timeline of this research, a few areas of longer-term impact can be deciphered. These will require further investigation but point to interesting and positive trends.

Future generations – a hands-on training for parents in hygiene and health

The overwhelming response – from parents and staff alike – on longer-term impacts had to do with the learning process that parents go through at the ACH. They are in a sense being trained by the medical and admin staff to better care for their children. The Health Access Program becomes, in a sense, a “hands on training in health and hygiene for parents”, a way for them to know what movements, actions, remedies to repeat at home. This takes on several different forms.

- ✓ First, they understand that it is first and foremost their responsibility to care for their children, and that their child would not be able to be healthy without their psychological support at home.
- ✓ Second, they understand that this requires constant supervision. Disabled, handicapped or sick children should require more of their time and attention than other children in the household, who can, more easily, fulfill their own needs at home.
- ✓ Last but not least, as is common through community-led WASH and other programs in Afghanistan, families learn basic rules on the use of soaps and requirements of hygiene at home, on the proper use of medication, and on the importance of children wearing clean clothes every day. This has an impact beyond the child-parent relationship and beyond the patient – it has an overall impact on the hygiene and sanitation levels of an entire household, and through a triple effect, on entire communities, in the longer run. By setting such examples, and by sharing lessons learned, the ACH can have a greater community wide impact that would be interesting to assess down the road.

“ ...We just know that they tell us it is our responsibility to take care of the children. If we just leave our children in the house and go somewhere else, who will pay attention? So, until 4PM, we have to stay with the children, and after that, if we want to go somewhere, we can go outside but only if we have found someone else to watch after our child. So most of the day it is our responsibility to be busy with the children who need our attention.”

- Mother, Kabul

Community impact – taboo and discrimination, changing behaviours

ACH provides medical care to children and support to their families. This helps decrease tensions within families. As noted by a nurse, there is an evolution with time: family members become friendlier with each other, they become more calm and caring.

- ✓ The first impact is therefore to reduce tensions within one's family.
- ✓ The second impact has to do with learning from each other – learning from the difficult experiences of other families, but also about their progress and recovery, hearing from those who have been going back and forth, those who have already had surgery, and those who have had post-surgery care. The information provides a way to undo misunderstandings or misconceptions, to be more realistic about the prospects for improvement and to be more in control of their child's life.
- ✓ The third impact is community-wide, potentially. Disabilities generate taboos and discriminations, in Afghanistan as in the rest of the world. Learning to accept the disabled, with a family and a community, is a first step to changing behaviors. In addition, the eye-opening experience of meeting people from the rest of Afghanistan provides families with a lot of positive feedback to report once they go home. They bring new information, new ideas and positive news. This can have the effect to lead to greater inclusion of the disabled and their families within the social setting of their area of residence. Being often the most vulnerable in their home areas, this experience can raise their profile positively back home.

These trends – whether the impact on future generations or on the communities of residence – should be assessed through further research. This section served to remind that ACH's impact can be greater, potentially, than short-term impact or a long-term impact on patients' growth and child development.

Picture 5: After the surgery (May 2013)



2.2.4. Referral system: improving the existing partnerships?

Filling in a gap

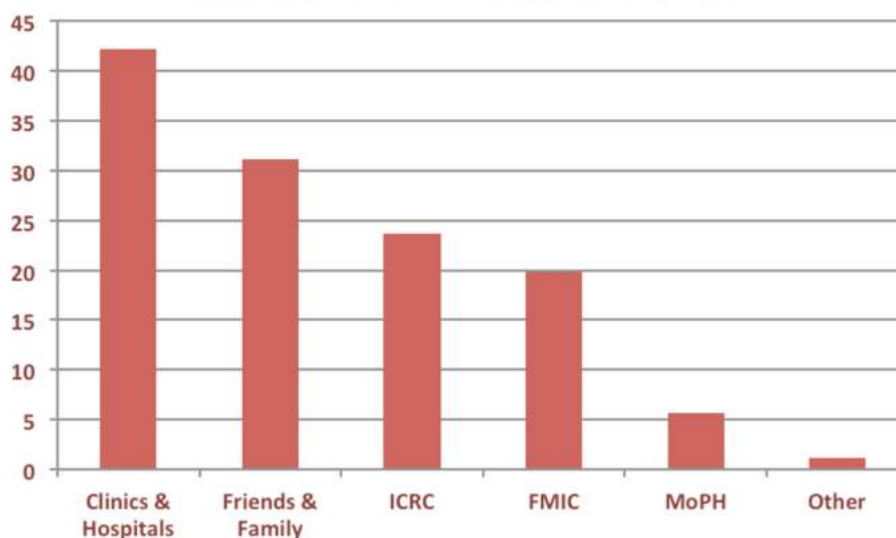
According to the FMIC the children’s project fills an existent and major gap in the healthcare provision in Afghanistan. While FMIC itself has a welfare system, through which poor families are assisted with a small contribution to their medical bills and treatment, the FMIC emphasized it is limited in its services, as it does not provide residences to the patients. But for patients who come from outside of Kabul district and province, who do not have the money or connection to stay in somewhere, the welfare system is not sufficient as it contributes partially. In cases where families cannot contribute at all, the children’s project addresses a key need, and a key gap in health care service provision in Afghanistan.

Other stakeholders interviewed for this evaluation – ranging from beneficiaries themselves, to partners, local clinics and hospitals – echoed this statement and confirmed that there is no other initiative like the ACH in Afghanistan. The infrastructure does not exist elsewhere in the country: it is a unique program addressing a rather large-scale, widespread and common need. Hence an existing disconnect between demand and supply, between current capacity and potential reach. However, even at a small-scale, with 60 children per month on average, ACH fills in a gap.

The gap is there in part because of the context – the government cannot provide for such services, having neither the capacity, nor the equipment or resources to implement such a project. Similarly, even private clinics have resource and equipment constraints that lead them to refer patients to ACH. This has been the case for all provinces covered by the patients in our survey.

As seen in Graph 4, the survey shows that among the most common referral systems are private clinics and hospitals in provinces of residence (42.2%) and the Ministry of Public Health (5.7%). In other words, half of the referrals are done by local actors who do not have the capacity to take on complex medical cases. Local actors – whether governmental actors, public or private medical actors – recognize that ACH and CDE fill in an important service gap.

Graph 4: Referral system – ACH & Stakeholders (%)



Existing partnerships with Afghanistan Demain, FMIC, and ICRC

The *Afghan Children's House* is effective in great part due to the partnerships – which at this stage take on several forms, mainly relying on partnerships, on the medical checks of FMIC, and the transportation assistance of ICRC. This is a basis from which this evaluation will suggest a more comprehensive partnership strategy to be built around stronger referrals and more effective outreach. First, however, a review of the existing partnerships will be presented in this section.

✓ Referrals from Afghanistan Demain (NGO)

Referrals come from different sources, in order of importance: government, local actors, communities, and other organizations – like FMIC, ICRC and Afghanistan Demain. One example is the referral system set up between Afghanistan Demain and ACH. Afghanistan Demain (AD) is a French non-profit organisation founded in 2001, based in Kabul. Its main aim is to provide education to street children. It has 4 main educational centres in Kabul with about 500 street children. The current partnership with CDE dates back to 2008/2009, with a formal partnership where AD is able to send 26 'cases' to FMIC. Because of budget constraints, this number has since been set at 23. AD sends children primarily to governmental hospitals and other clinics and hospitals where it has contracts. For AD, the main limitation of the current project was the understanding that CDE/FMIC would only treat complicated cases like plastic surgery (involving complicated skin diseases, bone fracture etc.), while CDE/FMIC staff also highlighted treating AD children with many specialties including general surgery, cardiac surgery, ENT, orthopaedic surgery and overall medical care. AD's agreement with CDE only allows its staff to give priority to complicated cases and those who live outside Kabul. AD acknowledges CDE's budget limitations, but argued that staying at the house is much better for the children, as it is a much better place to recover from their surgery, than at their own homes. Once again, this example tends to confirm that rather than being strategically defined, ACH's choices, partnerships, and objectives are determined by the existing structural, material, and financial limitations that still hamper the development of the organisation. CDE noted that, although a limitation exists, it is not only one of budget: it is necessary to have a selection of pathologies to be treated to avoid overwhelming the project.

"...It is much more difficult for the kids to go home even if they live in Kabul. Parents don't know how to use the medicines, they don't pay the same attention to the kids as they receive in the house. That's why we think it is much better for the children to stay at the Children's House. (...) Most families are using traditional medicines, which are sometimes causing more problems or even deaths. So the Children's House is a good and safe place for them, but the options are at the moment limited as it can only accommodate a small number of patients."

- Afghanistan Demain

✓ A rehabilitation centre for FMIC

The partnership was established through and with FMIC to make sure that the hospital would be accessible to patients. Although a separate project, ACH is linked to FMIC, showing the "strongest partnership tie". If ACH were to expand its facilities, it could consider setting up a similar structure with other quality hospitals – such as the CURE International hospital in Kabul.

FMIC staff sees ACH as a rehabilitation center for FMIC patients who cannot immediately go home after surgery; they require follow-up checks and a period of rehabilitation. *"The needs are high but*

the resources are limited”, hence FMIC staff are pushing for an expansion of ACH beyond its current capacity. “We know that if you sent the patients back home, after a while, they will stop taking their medicines. They will not complete the entire course or will sometimes not take the right medicines. ACH ensures that they follow the course” (Interview with a doctor and two nurses at the FMIC, March 2013).

ACH is therefore perceived as both a space and quality health care – that treatments are properly continued, as prescribed by doctors, and that patients do not over-stay in hospital beds where they can be vulnerable to catching other diseases, being more susceptible and more likely to catch other infections if they stay too long in the hospitals. FMIC prefers to discharge its patients as soon as possible, to save money, free up beds for other patients, and to avoid compromising patient’s health. In this regard, the FMIC staff we interviewed strongly supported any potential extension and improvement of the existing ACH, as it would ensure that:

1. *The patient’s health is protected by offering:*

- A proper rehabilitation period of accommodation and follow-up
- Proper intake of the medical treatment is as prescribed by the doctor
- Protection from the risks of infections by staying at the hospital
- Well-suited infrastructure for wheelchair access

2. *FMIC can expand its medical services:*

- To greater numbers of patients with proper follow-up care (especially from other provinces)
- To cover a range of interventions that can address family history, since most abnormalities children present are also seen in adults and other family members.

✓ *Referrals and transportation assistance from provinces by ICRC*

ICRC staff interviewed for this evaluation spoke of a collaboration that is effective, timely and efficient, with proper channels of communications. ICRC mainly refers children to ACH as FMIC would be too costly for them to go to on their own – ACH provides an opportunity for poor patients from other provinces to come to Kabul. For instance, based on the interviews held with patients’ parents, the transportation assistance provided by ICRC not only ensures that patients referred to by ICRC can make it to ACH and get back home, but it also ensures that parents can go back and forth between their home and the ACH, during the duration of the care needed. Often times, heads of households cannot spend weeks or months at a time away from their daily responsibilities – ICRC’s free transportation assistance is an integral component of what actually makes ACH and FMIC accessible to poor families referred by ICRC from outside of Kabul provinces. In exceptional circumstances, non-ICRC patients can benefit from this assistance.

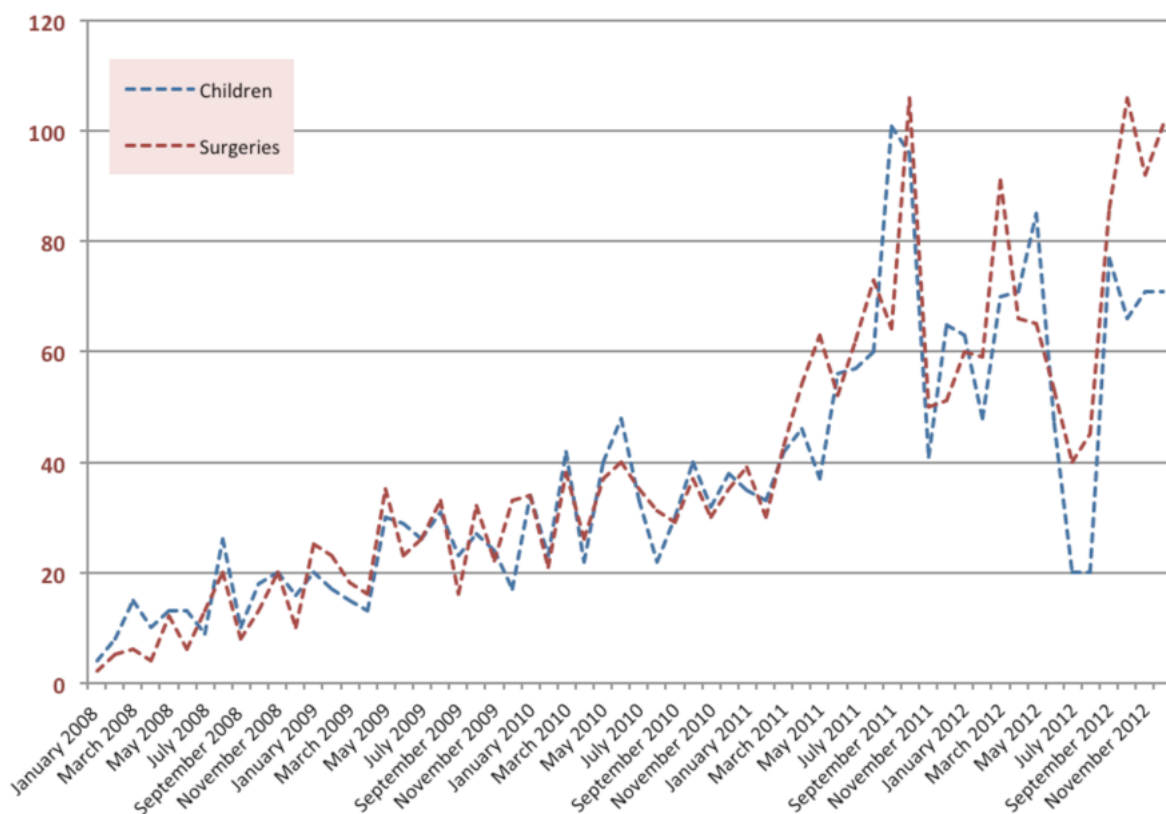
As will be discussed in the partnership strategy recommendations, the fact that the context is becoming increasingly insecure in Afghanistan means that road travel is also becoming more challenging and more time and energy consuming. It is dangerous for patients to travel on dirt roads, it is also simply dangerous for them to travel on insecure roads. Given the context in 2013, of the upcoming elections in one year and of the planned transition, centres like ACH provide the security needed to treat patients, and transportation provided by air – for free by ICRC – is also a further assurance of greater security for patients. A model should be developed, in planning for greater insecurity and transition, that can prepare CDE to undertake additional transportation and logistical support for all patients – through extended partnerships with ICRC, UNHAS, Pactec and other similar humanitarian air services.

2.2.5. Facilities and equipment: a crippling obstacle?

As highlighted by the Children House’s staff, “we had to adapt ourselves to [that] house, while it would have probably been better to design the space and the building we need”. In other words, the building was not initially meant to welcome children and provide them with pre- and post surgery services. But over the past six years, the Children’s House has progressively become the victim of its success and its main building is clearly not adequate to the existing demand anymore. With the sharp increase in the number of patients (and relatives), as shown in the chart and graphs below, the main building has now exceeded its maximum capacity level and the current lack of space is a major concern, as it puts both the viability and philosophy of the project at risk:

- ✓ Between 2008 and 2012, the number of patients staying at the Children’s House has increased by 340%. The graph below points out this regular and continuous monthly increase;

Graph 5: Increase in the number of patients between 2008 and 2012



- ✓ Moreover, and as shown in the graph 6 and table 2 below, such a remarkable increase has been continuous for *both* surgery and OPD, which validates the assumption that “the Children’s House has to be polyvalent, working with all the existing types of patients, from complex surgery cases to outpatients. When you treat children in an environment like Afghanistan, you have to adapt yourself to their needs” (Nurse).

Graph 6: Increase in the number of patients between 2009 and 2012 (Index 100 in 2009)

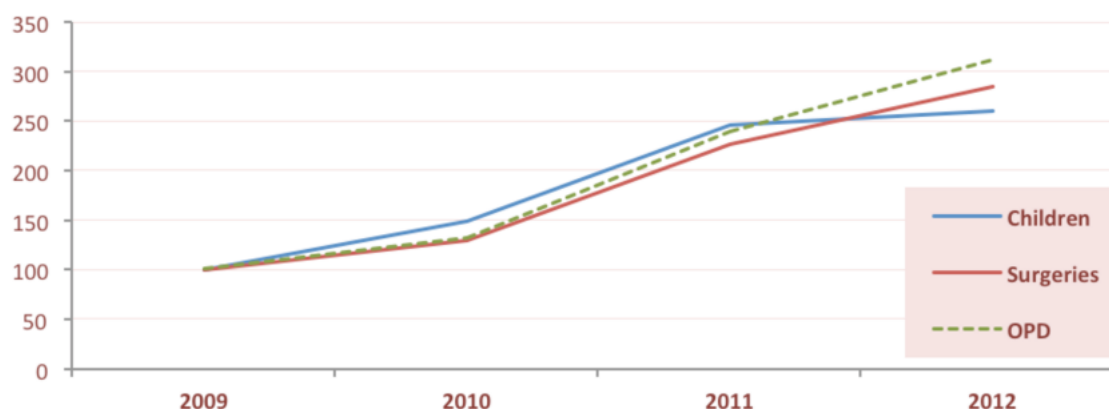


Table 2: Number of patients (2008-2012)

Patients/Year	Children	Surgeries	OPD consult
2008	162	119	-
2009	272	302	1,540
2010	404	393	2,016
2011	669	687	3,688
2012	709	864	4,804

The data collected in this section tends to corroborate the idea that the Children’s House has now become too exiguous to match the existing and future demand for pre- and post-surgery services. As the numbers of beds (17) and available rooms (for patients, storage or staff) are limited, the organization has to face a crucial dilemma: *“Either we refuse people, which is not fair, or we downgrade our services, which is not acceptable – that is why we need to find a new building with more beds and space, designed for the type of services we deliver and the type of patients we have”* (CDE Staff, April 2013).

2.2.6. Financial model: a turning point?

If a proper audit of the organization was not in the scope of this study, the review team sought to identify three key questions to better assess the strengths and weaknesses of the existing financial model of the organisation.

✓ What have been the budgetary trends of the organisation between 2008 and 2012?

The table below highlights two major aspects of the existing economic model of CDE in Afghanistan. First, the budget has increased by 230% over the past five years, while the number of patients (see graph 5) has increased by 340% over the same period; it suggests that the organisation has been able to control its costs and financially manage the continuous rise in the demand for medical services. Secondly, CDE may have reached an economic turning point, as the existing structure is not adequately fit for the future demand. The strategic question has thus shifted from “How can CDE optimize its model in a context of increasing demand, without jeopardizing the quality of its services and despite its relatively limited capacities?” to “How can CDE find a sustainable economic model to overcome its structural constraints and improve its services and capacity?”

Table 3: Budgetary trends (2008-2012)

Donors	2 008	2 009	2 010	2 011	2 012	TOTAL
AFD *	0	42 846	80 912	79 798	41 732	245 288
French MFA/SCAC**	0	0	0	0	211 971	211 971
French MFA / POLE ***	0	0	100 000	200 000	80 000	380 000
Foundations/Donations	0	50 500	130 000	30 000	108 455	318 955
CDE core resources ****	247 412	212 731	180 018	359 964	373 921	1 374 046
TOTAL	247 412	306 077	490 930	669 762	816 079	2 530 260
Increase (in %)	-	+24%	+60%	+36	+22%	-

*French Agency for Development Programme Welfare Indirect

** French Ministry of Foreign Affairs / Cooperation Section

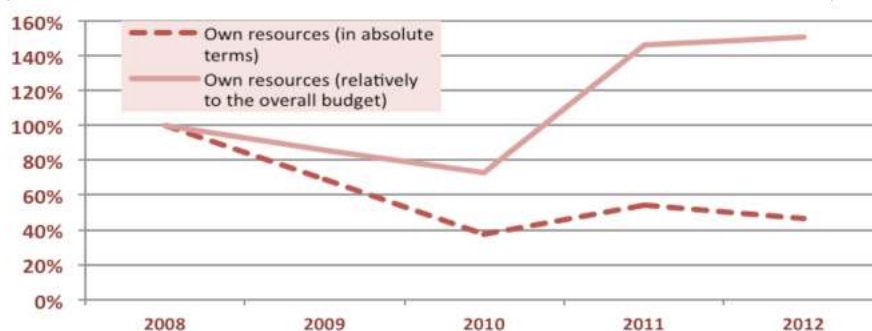
*** French Ministry of Foreign Affairs / Development Pole

****Social Assistance – including pre- and post-medical services

✓ What has been the portfolio of donors of the organisation?

Since 2008, the organisation has almost systematically managed to identify “the necessary level of funds and resources it needed” (*La Chaîne de l’Espoir*, Management). Initially, the Children’s house project was fully funded by the NGO itself (own resources); progressively, this amount has almost continuously increased in absolute terms (from 247,412 US\$ to 373,921 US\$: +51%), while the relative financial weight of the NGO within the annual budget of the Children’s house has significantly decreased (from 100% in 2008 to 37% in 2010 and 46% in 2012).

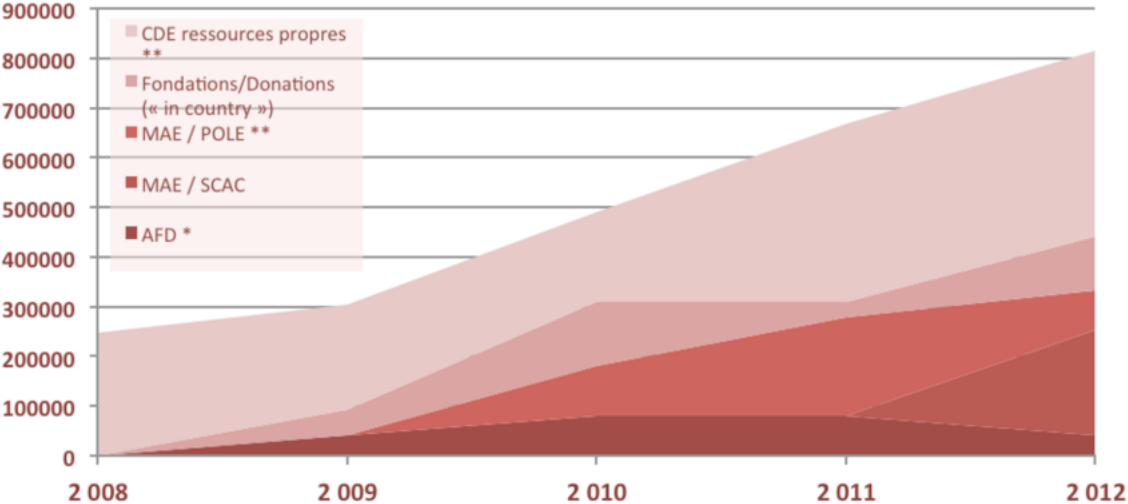
Graph 7: Own resources in absolute and relative terms between 2008 and 2012 (index 1)



If we now focus on the main donors, the graph below clearly highlights that CDE’s budget mostly relies on a reduced pool of French donors: French MFA/Development Pole, French MFA/Cooperation Section, and AFD/French Agency for Development. From a strategic point of view, such a “national” approach has its pros and cons. If CDE may keep benefitting from its excellent image of political neutrality and social acceptability among the French donor community, it may also suffer from the following:

- 1) **Deterrent effect:** It gives the image of a “French” NGO, driven by national interests (*“As an NGO, I have no doubt about their objectives and achievements, but I do not see why I should, as a donor, fund an NGO that is considered as a department of the French Ministry of Foreign Affairs”, International donor, May 2013*);
- 2) **Financial uncertainty:** The relatively limited financial envelope of French actors after 2014 may put the necessary development or extension of the Children’s House at risk (*“Who knows what the respective budgets of AFD and MAE will look like in five years?” MAE Representative, Paris, June 2013*);
- 3) **Unsustainability:** Likewise such a reduced number of donors – which all have changing political agendas and funding cycles – cannot allow CDE to have a sustainable strategy (*“Diversification, for an NGO like ours, has always been the key. Otherwise, you are overly depending on the short-term objectives and funding cycles of one or two donors. So far, things have been easy for [CDE], but may be drastically different in a couple of years. All French NGOs have the same problem” Director, French NGO, Paris, June 2013*).

Graph 8: Portfolio of donors between 2009 and 2012 (in US\$)



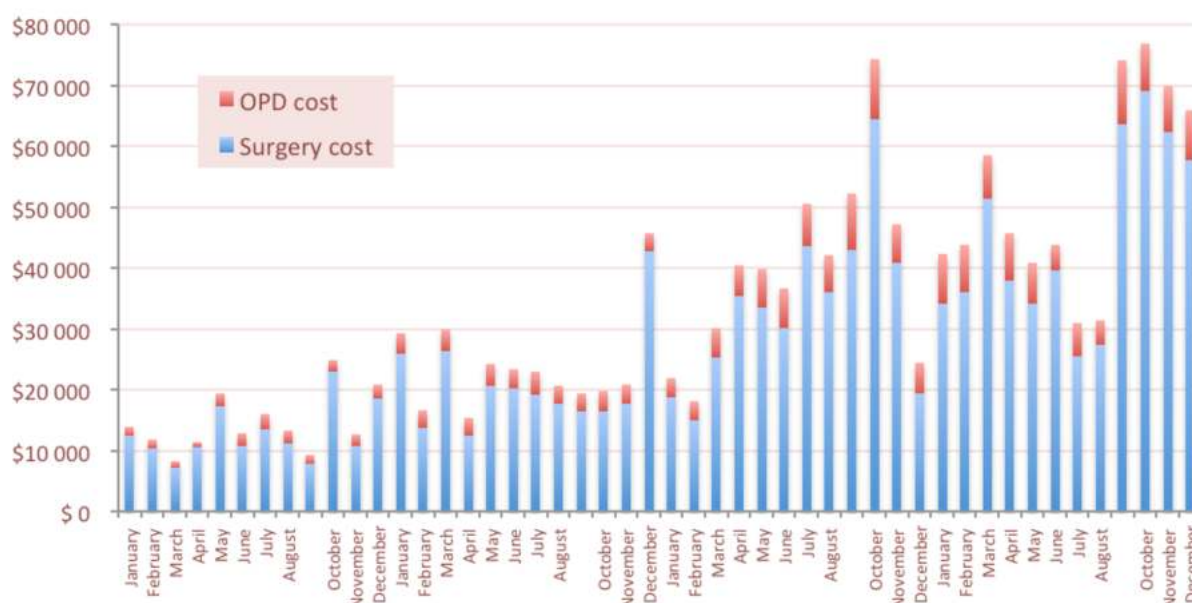
*Programme Welfare Indirect
 ** Social Assistance – including pre- and post-medical services

✓ Have the operational costs been controlled between 2008 and 2012?

Finally, to get a better idea of the characteristics of the existing operational expenses of CDE, we tracked the OPD and surgery costs over the past 4 years (January 2009 to December 2012). The two graphs below point to two major findings:

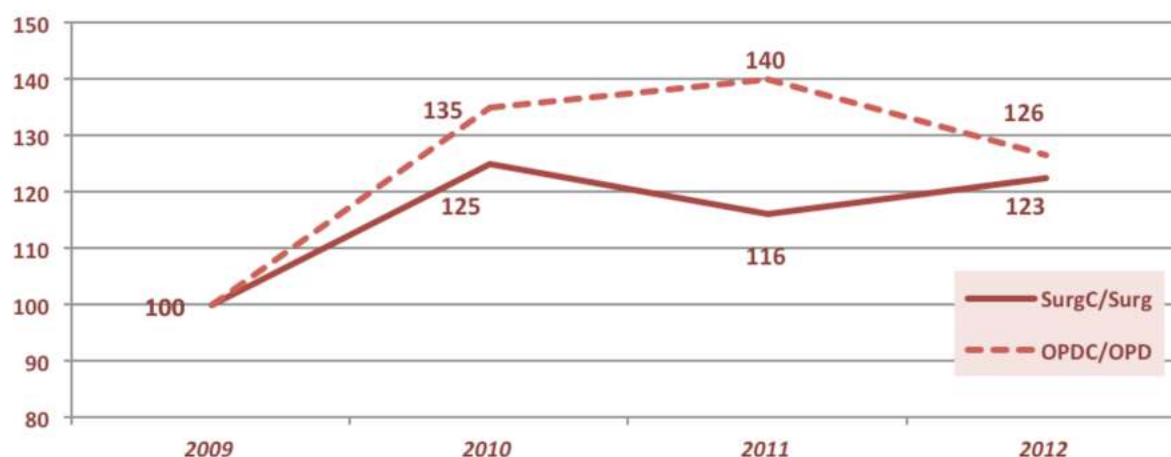
- **Graph 9:** in a context of continuous and soaring demand for medical services, the average cost breakdown between OPD and surgery costs has been remarkably stable (on average, 14% of the overall operational expenses for OPD costs and 86% for surgery costs between 2009 and 2012);

Graph 9: Breakdown of OPD and surgery cost (2009-2012)



- **Graph 10:** in a context of continuous and soaring demand for medical services, the average surgery and OPD costs by patients appear to be well managed, after an initial and significant increase between 2009 and 2010. On a 100 index for 2009, the average surgery costs per surgery were 135 in 2010, 140 in 2011 and 126 in 2012 (-7%); while the average OPD costs per patient were respectively 125, 116, and 123 over the same period of time (-2%).

Graph 10: Average surgery and OPD costs by patients between 2009 and 2012 (index 100)



2.3 SWOT Analysis

The overwhelming response to questions regarding the impact of ACH’s work on beneficiaries was positive. Parents assessed the impact of the medical care provided at the ACH on the well being of their child to have been positive. When asked to assess the change in well being before and after surgery and stay at ACH, 92.5% mentioned a definite improvement. Out of 106 patients interviewed, 4 did not highlight any improvement while 4 others highlighted only slight improvement in well-being. The research team did not further analyse such cases but can make them available to CDE for further investigation into the situations of these patients, to see whether any additional follow-up is required or whether the Health Access Programme can still play a role in improving the child’s welfare.

Beyond overall satisfaction levels, a range of indicators was used during the phone survey with 106 patients and their parents to assess strengths and weaknesses of the ACH project. These indicators included: the comfort of the accommodation for the child, the comfort for the parent, the feeling of being at ‘home’, the accessibility of the ACH, hygiene standards, quantity and quality of food, quality of medical care, behaviour of staff, responsiveness of staff, the environment around the ACH, cooperation between FMIC and ACH staff, and relationship with other children and families. On these 12 indicators, ratings systematically exceeded 80 and 90% of positive answers except for two minor exceptions:

- 15.3% of respondents highlighted accessibility as the main weakness of the ACH
- 5.6% of respondents rated the cooperation between FMIC and ACH staff as weak.

These indicators need to be contextualized and further analysed, along with a set of strengths, weaknesses, opportunities and threats (SWOT) that were discussed in the qualitative interviews with parents, children, but also staff members and other stakeholders. The SWOT analysis is presented below.

Table 4: SWOT Analysis

STRENGTHS	WEAKNESSES
A simple idea Proven results Strong partnership base Strong core resources	Over-reliance on few donors & 1 hospital Kabul-centered Insufficient information sharing Human resources Infrastructure not well-suited Lack of space Referral by chance
OPPORTUNITIES	THREATS
Outreach Donor diversification strategy Partnership Strategy Training New Building Geographical Expansion outside of Kabul	Security context Decrease in funding Sustainability questioned Parental commitment to follow-up

2.3.1. Strengths

1. A simple idea

The idea of ACH is to provide a ‘home’ away from home for child patients and their parents, to be able to socialize, play, rest, recuperate, and be cared for by specialized medical staff. The ‘feeling of home’ was verified in the testimonies of young boys and girls, and their parents.

Interestingly, the feeling of being at home was not the only positive impact shared by the patients themselves, they reported advantages they could not have at home: meeting other families with sick children, socializing and sharing experiences with people from other provinces, ethnicities, backgrounds. Women reported enjoying being in one room all together, as they could freely speak among themselves, get to know each other. The simple idea of providing a home, the simple project described by ACH staff, ends up offering more social cohesion and social support to the families than originally intended.

None mentioned problems with the lack of space or quality of food. Indeed, 96.2% of respondents indicated that they felt they were ‘at home’ to a ‘very good’ or ‘good’ degree, and 99.1% of respondents indicated that the House was clean and hygienic. Food, too, was considered ‘very good’ or ‘good’ 97.1% of the time, and that medical services were such 99.1% of the time.

The extreme satisfaction presented by the beneficiaries is an indication of the House’s ability to provide both top-quality medical care for those who need it most but also to create an environment that is comfortable for those receiving treatment and their families. In a cultural context such as Afghanistan, the respect and comfort provided by the House remains an important consideration for all institutions, and the House can be used as a future model for other organizations and groups.

“...We don’t have any financial and human resources constraints. It is a very simple project. We want people to feel that it is a safe and child-friendly house. We want people to feel at home, no something like a 5-star hotel.”

ACH staff

2. Proven results

Parents appeared to be unanimously very satisfied with the accommodation, the location and the services provided. Both men and women felt that it was a safe and child friendly environment. No problems were mentioned. All parents interviewed emphasized the friendly behaviour of the staff and the extra care their children received throughout the day. The lack of space didn't appear to be a problem for the parents. In one case, a mother mentioned that the females actually enjoyed sleeping in the same room with the other mothers, rather having their own separate room.

The impact on child-parent relationship was difficult for parents to answer. ACH staff mentioned that they did see a change in behavior as parents got to know other families who had the same

type of problems. However, whether that had long lasting impacts on child-parent relationship was not assessed.

3. Well funded

The structure of FMIC rests on the support of the Aga Khan Development Network (AKDN), La Chaîne de L'Espoir (CDE), French MFA, and the ACH benefits from funds received from the Agence Française de Développement (AFD). These four sources are the main financial inputs received by FMIC and ACH. CDE is the first French NGO with whom the AKDN partners in Afghanistan and its visibility and reputation have set FMIC, and as a consequence ACH also, as a reference in terms of quality health care – it is there that the first heart surgery was conducted in 2008. FMIC also received ISO 9001:2008 certification and ISO 8001-2009 certification, reaching the standards of hospital quality and now going through a process of accreditation with the American Joint Commission International. This means that Afghans now have an option domestically for medical care – a closer and more accessible option than crossing borders to neighboring countries, India, or further away.

As shown in table 1, these funds have allowed ACH to increase its number of patients from an average of 16 per month in 2008, to gradually reach 34 per month in 2010 and 67 per month in 2012. The steady funds and financial support FMIC and ACH have counted on have allowed for this exponential increase; the next step for ACH is to convince its donors to follow through with its plans of building a new children's house with greater accommodation facilities.

4. Strong partnership base

As seen in the main findings, beyond the four donors detailed above, ACH benefits from a strong partnership base with a range of actors – from FMIC, to ICRC, other NGOs, as well as the government (MoPH) and local clinics and hospitals throughout the country. These have ensured strong institutional links, which can be further developed as will be discussed in the 'partnership strategy' section of this report.

Weaknesses

1. Over-reliance on few donors & 1 hospital

ACH's main donor – the French government – has been reducing its funds in country. The overall context in 2013 is one of decreasing humanitarian funds and increasing NGO concerns over the sustainability of their programs, without the sufficient financial resources. This is a concern that La Chaîne de L'Espoir faces as well. For the financing of a \$1-million new children's house, CDE is seeking to diversify funds. The over-reliance on a French donor needs to be overcome to ensure the sustainability of the FMIC and ACH presence in country – not only to fund a new children's house but to consider funding a geographical expansion as well.

From a medical angle, the over-reliance on FMIC as the sole hospital ACH is linked with may also compromise sustainability. Partners are increasingly calling for ACH to consider diversifying its medical partnership to include other renown and high quality centers, like Cure Hospital, funded by the US government and other donors, and located in Kabul. Cure International Hospital in Kabul also works to help children with disabilities and their families, a similar model then to the on-going work of FMIC and ACH, and which could be replicated with a new partnership for ACH.

Diversifying its medical partnership would also allow to solve the issue of funding sources, as it would provide ACH access to other donors -

2. Kabul-centred

While one of ACH's aims is to welcome vulnerable children with grave illnesses from provinces far from Kabul, over one third of patients surveyed for this evaluation still come from Kabul province. This seems to indicate that advocacy and outreach are still more Kabul-centered, and that the presence of one center in Kabul will in all likelihood continue to attract a greater proportion of Kabul residents than non-Kabul residents. Although the research team acknowledges that Kabul is a province with 18 districts and the largest population in any of the provinces of Afghanistan, the provincial focus of ACH on Kabul needs to be addressed as a weakness.

Going back to the initial objectives of ACH, greater geographical coverage will be needed either through better outreach or through the creation of other centres in other regions of Afghanistan. The context will certainly require more assistance than less – with the recrudescence of conflict in all regions of Afghanistan, and with the 2014 transition on the horizon.

3. Insufficient information sharing, HR coordination to be improved

The lack of information sharing was also mentioned in relation to the internal communication sharing. For partners, the internal communications between the different partners involved with the Children's House could be improved, as the main roles and responsibilities of the different staff members working for the CDE was unclear to partners. According to partners, this lack of communication could be improved through participating in existent coordination working groups established by Afghan and international organizations working in the area of child and health.

At a human resources level, the reference of ACH as "Kate's project" seemed to have become a routine reference. The focus on 1 person can complicate, in the long run, future changes in the NGO's strategy and vision. A successful initiative is built when it is de-personalized and where the NGO's name is put forth – first and foremost. This should be kept in mind by CDE management in its future efforts to expand its activities: to be referenced as an NGO rather as one person's project. All NGOs owe their initial impetus to the charisma, knowledge, and energy of leaders, but need to go past that image to be able to be effective, for example, in coordination settings as underlined by partners. A proper human resources mapping will be needed to fill in the gaps at ACH – from the management, to admin and medical staff.

4. Infrastructure issues

Patients and parents reported being very happy and comfortable in the existing house, and not needing more space. However, the evaluation team noted three major problems.

First, the building itself is a major problem as it is not designed to be a rehabilitation centre - it does not have an elevator or a diversified system to facilitate the mobility of disabled or sick children. The presence of old building and stairs was noted as a hindrance to the proper functioning of the House.

Second, certain basic rules of health & hygiene were not being followed properly in an informal setting, that needs to be more formalized. For instance, the evaluation team noted that guests and staff walked inside with their shoes, without covers or overshoes. This can be understood to some extent as it is not a full medical facility but a house for children – other medical facilities in

Kabul, FMIC, Emergency Hospital and Cure do not have a policy of wearing overshoes in their OPD, Investigation or Ward areas either. Nonetheless, the research team found that it jeopardizes the cleanliness of the space.

Third, the lack of space restricts quality care in the current setting of ACH where administrative tasks and health care are led jointly in one common room, instead of having different departments with dedicated rooms within the building.

Finally, as the number of patients are increasing each year, the lack of space has become critical as the staff sometimes have to send people back home, and ask them to come back another time - so that CDE staff can provide them care and accommodation. Here, the lack of space also influenced the quality of care provided to the patients. For CDE's staff the new building would therefore provide more opportunities for quality of medical care- such as having special rooms for dressing and administration, special and separate rooms for special cases with patients that have infectious diseases such as TB.

While families and beneficiaries were generally extremely happy with the House's services, they also recognized a number of limitations and weaknesses, including limited activities for adults and children. While the children have the opportunity to play in the garden, it seems to be that there are no activities for parents during the day. This was highlighted by one of the fathers, who emphasized that some days were a bit boring, as he did not have much to do, since parents are not allowed to leave the house and their children unattended. Conversations with the children also showed that besides the garden where they can play, there are no other activities for children. Especially for those who are not able to play outside, because they are in gips, there is nothing to do. Those children rather hang around with the parents in the living room, watching TV, in some cases maybe adult programs like Turkish soaps.

5. Referral by chance

Most parents interviewed seemed to be referred by ICRC or in several cases by IAM based in their province. Most of the parents were supported financially and came directly to the house, while in two cases the parents coincidentally found out about the Children's House. In one case, the father of Ehsan, who had been to many hospitals for 12 years, only found about the children's house through a taxi driver who had been in the children's house before.

The problem of the referral system – being based on coincidences – was also emphasized by one of the institutional partners in relation to the lack of public outreach. For this partner, the main weakness of the project consisted of the fact that there seems to be a lack of awareness of the existence of this project among most people. Ghulam Ali, father of Ehsan, originally from Ghazni explains that his 6 month-old son fell of a tractor and broke his back and has problems with his spinal. Found the House by 'chance', when a taxi-driver told them about this house:

"I was referred by IAM- they referred us and they told us there is a clinic in Pol-e Surkh where we can get treatment. I have been to many places, I took my son to many places where they gave him braces for his back (prosthetics), and none of them helped him. We just took it off one day and put it aside. It was a coincidence that I met someone in the taxi who had been to the House before, and who told me that I should come to this place. He gave me the address and I came here. Mrs Kate is a very good woman, she has been helping us a lot. Since my son was 6 months old I have been to many doctors and hospitals. But they all say they cant do anything. I have been to the MOPH, to the ICRC. I told my son that we are going to Kabul, and everyone in the family was very happy. And they [nurses] take the children and they wash them, dress up the children and the comb their hair and then give them back to us. When they see that a small child is dirty, or not clean they take them and give them a shower. And everything is clear for us, they give us food, accommodation and we know where to go and where to

sleep. We do not need anything else. My son has been like this for 12 years but is now getting better. We are hopeful for the results.”

In response to such remarks, CDE and ACF staff respond that the high rate of friends and family referral is a testament of the effective unofficial dissemination route of ACH services throughout the country – built on personal networks, and not by chance or coincidence.

Opportunities

1. Outreach

31.1% of the families surveyed had been referred to ACH by friends and family. As mentioned before, local clinics and hospitals, as well as private doctors, were also sources of referrals. These are the targets for a future outreach strategy for ACH – to establish a campaign within clinics, hospitals, doctors’ practices and community centers around Afghanistan. This will require for ACH to have brochures, in Dari and Pashto, that can be distributed at clinics and hospitals, with presentations and workshops to explain the limited space yet the unique health care provided by FMIC for complicated medical cases that cannot be treated elsewhere. Communities are the best referral systems – the best channels to get ACH to be known within urban and rural communities outside of Kabul.

One main weakness of the children’s house is that most people do not know about it. Especially those in other provinces where they do not have any opportunities, they do not know that there is something like this existing in Kabul. I think most people have found about the house just by chance. It was by chance that they went to that specific hospital, which had a connection with the children’s house. So they should have more outreach - public outreach- so people become aware that something like this exists in Kabul. People should know this but also other hospitals. CDE does not have any brochures to distribute, and no further outreach to other organizations. So more awareness and public outreach is needed. They do not even have their own website. Too much weight is given to referrals by chance, or by coincidence.

- ACH partner

2. Advocacy & Partnerships – Partnership strategy (CURE, Afghan red crescent)

The referral systems can also be improved if the partnership strategy is built around the following key components:

- Including other hospitals – e.g. CURE international
- Including other partners – the Afghan Red Crescent through a formal agreement (at this stage the Afghan Red Crescent is an informal partner)
- Improving coordination with partners and clarifying roles

Partners interviewed emphasized that it would be good if the program to include referrals to other hospitals in Kabul to address a growing demand at a time of increasing needs, limited resources of families and inability of many to travel abroad for treatment. Cure hospital was said to be good and reliable option. For partners interviewed, the project is now too much focused on FMIC, while Cure International hospital also offers high standard plastic surgery services. By partnering with Cure Hospital, ACH will ensure a greater outreach, great number of patients, and a more effective ability to attract greater, and more diversified, funds. This will broaden

their assistance beyond the most critical cases to also responding to more routine demands from partner organizations who have to rely, at this stage, on public hospitals in the Kabul area.

3. New building (local expansion)

Donors have raised concerns about the justification behind the expansion of the house beyond the current capacity. Questions have been raised as to estimates on the minimum floor space required, and other facilities required by the new housing project.

The evaluation team found that the current building is not sufficiently well designed to house a medical support facility: lack of space forces the administrative and medical teams to work out of the same spaces – while the paperwork should be kept entirely separate from medical support services.

In addition, the current facility does not provide sufficient space for parents. Although mothers and female relative members voiced their happiness at being together in one common space, men (whether fathers or uncles interviewed) explained their frustrations at not having their own space. Cultural variations explain these divergent opinions, and as such, for the environment to feel like 'home' for all, should be taken into consideration in the design of the future house.

Lastly, although children are happy playing outside, recreational facilities should be expanded indoors to ensure that children can play safely under the supervision of the medical support team, nurses and families.

These three indicators – aligning house design to the medical support needs, providing additional space to male relatives, and providing greater indoor recreational space – were the main ones raised by the stakeholders interviewed, whether staff, families or patients.

4. New centres (geographical expansion to other provinces)

The context will only increase the demand for facilities like the ACH. However, with increasing insecurity, travel to Kabul will become more challenging from provinces far-off. To avoid having just one location where all provinces can be connected to, future operations should focus on providing a geographical expansion – as a second step after the local expansion of ACH. Other provincial ACH projects should include the West (Herat), the East (Nangarhar) and the North (Balkh), where existing hospital infrastructure will allow for the development of similar projects. An assessment will be required to see if similar facilities can be developed in the South (Kandahar).

Threats

1. Context adds pressure on absorption capacity

As briefly mentioned above when discussing geographical expansion of the project, the context of increasing insecurity will complicate logistics to get children in need of treatment to FMIC and ACH. As the transition begins and security is handed over to the Afghan forces, ensuring a safe transportation of children will have to take increasingly into account security as a key variable. Travelling long distances will become harder, and road travel from the provinces riskier.

A worsening humanitarian context will add pressures on health conditions – deteriorating existing health conditions of children and their families, with the lack of access to food, clean water and basic hygiene. This will increase the demand for ACH's support services pre and post-treatment, and will hence add pressure on absorption capacity. How will ACH adapt to the growing demand?

This question will be further complicated by decrease in funding from donors at a time of transition. However, one positive sign remains the close cooperation and association with the Aga Khan Development Network, which has committed to a long-term investment in Afghanistan, detached from the military transition.

2. Decrease in funding to other NGOs will decrease referrals to the Children's house

The current funding structure of the ACH project is greatly dependent on a few donors – the Government of France, the Agence Française de Développement (AFD), and the support of AKDN. The former is decreasing its involvement in Afghanistan and AFD is increasingly asking for additional justifications from La Chaîne de l'Espoir for its new project. To ensure its sustainability, the project will require a greater diversity of donors to fund the new housing project. It will be a positive outcome as establishing distance with specific governments will also make the project more neutral and balanced at a time of instability.

In addition, the decrease in funding will have direct repercussions on other partner NGOs that ensure a great portion of the referrals to the Children's House. To avoid a situation of diminishing referrals, the project should seek partnerships with other NGOs and emphasizing a stronger outreach independent of NGOs at the same time.

3. Non-viability of MoPH links – reinforcing links with DoPH

The weak capacity of MoPH and the weak links between ACH and MoPH might be a threat for the sustainability of the program. Although agreements have been signed for an institutional framework to be set between ACH and MoPH, the limited capacity of MoPH to be present more actively on referrals and other activities makes this a weak link. At a time when donors are reducing funding and NGOs are leaving the country, who can ACH most strongly partner with at the national level? The response will have to be localized – by region and province, rather than at the Kabul-level. In the provinces, links to DoPH will have to be reinforced as many of the referrals come from authorities or public hospitals and private clinics.

4. Parents not coming back for follow-ups

A constant threat is the possibility of parents not coming back to FMIC and ACH on time for follow-ups and check-ups. This is not context specific but is linked to economic and logistical constraints, that will inevitably worsen with the deteriorating security. As such, greater family awareness, counselling and information sharing will be required to ensure full cooperation of families.

3. Conclusions and Recommendations

Background: Over the past five years, the activity of *La Chaîne de l’Espoir* and its Children’s House in Afghanistan has increased threefold in an increasingly uncertain donor environment and a worsening political situation. As the capacity of the current structure is clearly saturated, there is a risk of jeopardizing the quality of medical and health care for the organisation’s young patients. Therefore, CDE has decided to build a new Afghan Children’s House which could enable: 1) increase in the current structure capacity, so as to provide monthly, at no charge, medical and surgical care to 100 children from poor families and remote areas; 2) develop a semi-medicalised structure, designed to offer pre- and post surgery services. **As *La Chaîne de l’Espoir* has reached a strategic, operational and financial turning point in 2013, it is probably also time to clearly set the tone of the organisation’s future strategic commitment in the country.**

Afghan context: The international coalition and the Afghan government can no longer defeat the Taliban, which will progressively increase their role as a prominent political and military interlocutor in Afghanistan. As stated by Gilles Dorransoro, “*the risk of a military victory for the Taliban followed by the isolation of Afghanistan on the international scene*”³. If we now focus on the direct socio-economic consequences of a deteriorating political context on local populations, there is clearly a second time bomb: in the first six months of 2012 alone, an estimated 500,000 people had been displaced from their homes, with over 100,000 new conflict-induced internally displaced persons (IDPs). As shown in the recent NRC *IDP Protection Study*, if most of these IDPs (57%) reported having left their province of origin for security reasons, a significant percentage of respondents (17%) said that they had migrated for economic reasons⁴. **Finally, the Afghan environment keeps deteriorating: the political situation is a dead end and urban households will probably be more impacted by the worsening economic and social environment.**

General strategic orientation for CDE: Assuming that the social, economic, and political Afghan landscape does not lead to a great deal of optimism, is it time to plan an exit strategy for *La Chaîne de l’Espoir*? The review team considers that: 1) in today’s environment, a progressive handover to an Afghan counterpart (governmental or non-governmental) is unrealistic, as both the efficiency and the neutrality of the Children’s House initiative would then be put at risk; 2) on the other hand, CDE is probably one of the few international NGOs that is perceived as a neutral actor not only by the local population but also by all the warring parties in the conflict; 3) finally, it seems to the review team that CDE’s missions and objectives in Afghanistan, through the Children’s House, have never been so relevant; 4) in this regard, CDE should seek to further develop its activities by increasing its existing capacity while trying to make its initiative more financially and strategically sustainable.

As far as the future of the Children’s House is concerned, CDE will only be able to meet the soaring demand for pre- and post surgery services when the new house is built. Based on the interviews the review team had with patients, families, staff, and stakeholders, the objective of the new structure should not only be to increase the potential supply of beds but also to improve the existing services and facilities with: 1) special needs room; 2) playroom (separating parents and children); 3) special attention paid to gender; 4) more space for administrative staff; 5) a clearer division between medical and administrative departments; 6) basic modern facilities (wheelchair access, pads, etc.).

³ Gilles DORRANSORO, “Macro-Analysis: the withdrawal and its consequences” in Samuel Hall Consulting. “*Humanitarian assistance in a pre-conflict Afghanistan? A contextual analysis 2013*”

⁴ Samuel Hall/NRC, *Challenges of IDP Protection: Research study on protection of internally displaced persons in Afghanistan* (December 2013), available online at <http://www.samuelhall.org>.

Meanwhile, it is also important that CDE develops additional strategic approaches to make its commitment to Afghanistan more durable and relevant:

- ✓ **Reaffirming CDE's political neutrality and impartial assistance:** For all humanitarian and development actors operating in Afghanistan, it is more than ever time to draw a clear line of neutrality – and to let all partners and parties know that such a line has been drawn. This includes: 1) thoroughly inspecting the background of potential partnering NGOs or organisations, checking their sources of funding and local activity frameworks; 2) avoiding any future partnership with implementing governmental partners; 3) giving priority to long-term partnerships with organisations that are known and perceived as neutral and non-politicized actors; 4) minimizing over-reliance on single partnerships and favouring multi-year *networks* of donors and partners.
- ✓ **Developing a long-term partnership (MoU including pre-assessments, clear referral process, objectives, communications, advocacy, etc.) with an NGO internationally and locally recognised for its achievements and neutrality.** Based on a rapid assessment by the review team, *Afghanistan Demain*, which already has a common history with CDE, could be a natural partner: 1) as an organisation that takes care of street children, AD focuses on urban areas and is naturally at the heart of tomorrow's social and political debates; 2) AD's anchorage in Panjshir and Kabul are also in line with CDE's geographic coverage. In line with AFD's new policy favouring partnership and pragmatic networks of actors, a partnership with AD could enhance the outreach and impact of the two organisations. However, other actors may also be considered on a project or long-term basis, such as *Afghanistan Libre*, ACF, *Solidarités*, Save the Children, CARE, AKDN, etc. It is CDE's responsibility to assess and identify the most relevant partners on the short- and long-run.
- ✓ **Assessing other medical institutions (e.g. Cure hospital and local hospitals) to expand the existing referral portfolio while strengthening the image of the organisation among Afghan institutions and developing dialogues with local health actors.**
- ✓ **Increasing CDE's accountability and transparency through a multi-faceted M&E approach directly embedded in CDE's strategy.** Monitoring should be triangulated by involving beneficiary households and communities, international and local partnering organisations, independent M&E teams as well as CDE staff. In an increasingly volatile context where impartiality, neutrality and independence are more than ever at the centre of humanitarian work, CDE needs to ensure that it keeps these trademarks and ensures a proper visibility of its actions with the communities. This will allow for sustainability of CDE's presence in country. Moreover, a more robust M&E approach could help CDE: 1) improve its *monitoring* by integrating indicators, monitoring and/or flexible warning systems within its strategy and day-to-day operations; 2) develop a more systematic approach towards *evaluation* to increase its transparency and accountability – hence its bargaining power with donors and partners; 3) identify a set of simple technical, strategic, and financial indicators for monitoring and advocacy purposes (*e.g. through the periodic review of the indicators developed in the second section of this rapid assessment, while strengthening its financial analysis component*).
- ✓ **Identifying areas of opportunity for developing medical and hygiene training, with the support of the national and international NGOs operating in the communities of origin of the patient.** While increasing the social acceptability of the NGO among the community, it would also help CDE get a better follow-up on its patients.
 - *Examples of training sessions: Family planning, health & hygiene, CPR, etc.*

- ✓ **Identifying geographic areas of opportunity for bringing ACH’s medical services to the population (OPD exclusively).** Rather than systematically bringing patients to the ACH, it may be easier and more practical – for OPDs only and isolated communities exclusively first – to decentralize some of ACH’s activities in provincial branches. These sub-offices would be hosted by local or international NGOs operating at the community level.
 - *Example of partnership:* CDE could benefit from its already existing dialogue with AKDN to develop outdoor centres or training activities (e.g. in Badakhshan, by using AKF facilities and logistics to reach patients from remote communities).

Picture 6: Patients with their fathers – different provinces, different ethnicities (May 2013)





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