



## Transnational Health Training Program (THTP) in Afghanistan

The Transnational Health Training Program (THTP) is a three-year intervention implemented between 2015 and 2018 in Afghanistan and Bosnia and Herzegovina. In Afghanistan it is put into practice by the national non-governmental organization *Medica Afghanistan* and carried out in the three Afghan provinces Kabul, Herat and Balkh. The project contributes to an increased access to quality health care services for women and girls affected by sexual and gender-based violence (SGBV) through improving the quality of care of health care service providers at the local and national level.

Its core part is the qualification of health care staff in SGBV and a stress and trauma-sensitive approach<sup>®</sup> from *medica mondiale* (STA) towards affected women and girls. By acquiring new knowledge, skills and attitudes on the nature and effects of traumatic events, the interaction between health-care providers and clients shall be improved, and shall have an empowering effect on the women affected by SGBV.

The project also aims to sensitize the Ministry of Public Health (MoPH) at the national and provincial level on the need for improved knowledge, skills and attitudes regarding trauma and its consequences for women and their children.

**Project duration:** 15.09.2015 – 30.10.2018

**Evaluation period:** May 2018 – September 2018

**Type of evaluation:** Endline Evaluation

**Consultant team:** Red Orange Consulting Services

**Funded by:** Swiss Agency for Development and Cooperation (SDC)

**Capacity Development Partner:** *medica mondiale* e. V.

**Project budget:** 1.050.593,00 USD

# Executive Summary

## CONTEXT

SGBV is one of the most prevalent human rights violations in the world, a major public health problem that affects millions of women and girls, and one of the leading causes of death and disability among women. In Afghanistan, the prevalence of intimate partner violence is very high, with the recent Afghanistan Demographic and Health Survey (AFDHS) indicating that 56% of women aged 15 to 49 who had ever been married reported having experienced any type of spousal violence (emotional, physical or sexual). The prevalence of lifetime spousal violence is as high as 92% in some provinces such as Herat and Ghor. The acceptability of violence is also extremely common.

According to the AFDHS, only 20% of ever-married women who experienced physical or sexual violence sought help. The source of assistance is generally from their family and husband's family, very few (0.3%) seek assistance from medical practitioners.

This is due to a range of reasons: restrictions from family members, lacking funds to pay for transport, lack of knowledge about where to access health services. For those women who do access health services, the provision of these services is often inadequate, with women at risk of confronting poorly capacitated staff, disrespectful behavior, lack of same-sex service providers, concerns about confidentiality, lack of separate and safe female facilities and lack of psychosocial support for trauma, amongst other gaps.

A range of interventions and resources has been developed to address these problems, among them the Afghanistan GBV Treatment Protocol for Healthcare Providers which was developed in 2014 by the MoPH, WHO and UNWOMEN; and a comprehensive training package developed by WHO and UNFPA to train healthcare providers in using the GBV treatment protocol. Family Protection Centers (FPCs) have also been established in selected provinces by the MoPH, UNFPA and implementing partners. They are located in hospitals and provide support to survivors, including basic health services, medical and psychosocial services, and help in collecting evidence, information and referrals.

## PROGRAM DESCRIPTION AND OBJECTIVES

Alongside the above mentioned interventions, *Medica Afghanistan* has, for the last three years, been implementing the THTP in Afghanistan, carrying it out in the three provinces Kabul, Herat and Balkh. It has two main objectives:

1. to contribute to an increased access to quality health care services for women and girls affected by SGBV by improving the quality of care of healthcare service providers through a stress and trauma-sensitive approach;
2. the sensitization of the MoPH and other key stakeholders at the national and provincial level on the need for improved knowledge, skills and attitudes regarding trauma and its consequences for SGBV survivors.

The direct beneficiaries of *Medica Afghanistan's* THTP comprise:

- » 20 health professionals working in public hospitals in Kabul, Mazar and Herat through training of trainers in the STA approach
- » 80 health professionals working in public hospitals in Kabul, Mazar and Herat
- » 6000 female clients of health facilities who benefit from an increased quality of care by health professionals
- » 10 *Medica Afghanistan* staff receiving refresher training
- » 20 hospital managers and MoPH mental health taskforce members participating in a STA kick-off training)

The THTP also aimed to reach indirect beneficiaries, including 6000 family members (especially children) of SGBV survivors in Afghanistan.

It is planned to follow up on the project through a second phase of implementation (THTP II). The objective of the second phase is to further replicate the learning through the graduates of THTP I to other healthcare professionals as well as support hospital staff in the same three provinces. THTP II will additionally begin implementing in the Northern Province of Samangan.



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## PURPOSE AND SCOPE OF THE EVALUATION

The purpose of the endline evaluation was to provide decision makers at the Swiss Agency for Development and Cooperation (SDC), *medica mondiale* and *Medica Afghanistan* with sufficient information to make an informed judgment about the performance of the project, document lessons learnt and provide follow-up recommendations. Lessons learnt will serve as a framework for the second phase (THTP II) project's scope and approach planned for implementation in November 2018 to October 2021.

The evaluation is based on a combined pre-post test and retrospective design guided by three analytical frameworks:

- 1. The 5As of access to healthcare framework.** This reflects the fit between characteristics and expectations of health service providers and clients according to five categories: availability, accessibility, affordability, acceptability and adequacy.
- 2. The Creating Cultures of Trauma-Informed Care (CCTIC) framework.** This is structured around five core values: safety, trustworthiness, choice, collaboration and empowerment. A program or intervention's culture is stated to be trauma-informed if both health service providers and clients perceive these five values to be present in each contact, physical setting, relationship and activity.

- 3. A Principles for Evaluation of Development Assistance (DAC) criteria.** The DAC principles outline five key criteria for effective evaluation: relevance, effectiveness, efficiency, impact and sustainability. While the 5As and CCTIC frameworks allow an examination of how health facility policies, processes and procedures address the needs of patients, the DAC evaluation criteria allows a more direct analysis of the efficacy of the intervention being evaluated.

The endline evaluation was conducted in four hospitals in three provinces of Afghanistan (Kabul, Herat and Balkh), and drew from quantitative and qualitative methods implemented with health facility staff, SGBV survivors and key stakeholders.

The evaluation was conducted according to an ethical, safe and trauma-sensitive approach. The evaluation team, with *Medica Afghanistan's* assistance, completed and submitted an application for ethical approval to the Institutional Review Board (IRB), the official body within the MoPH to approve studies and researches conducted on health in Afghanistan. As well as previously the baseline evaluation, IRB also approved the endline evaluation and accepted the findings and recommendations.

## LIMITATIONS

A key question for the evaluation is the extent to which change at endline can be attributed to the THTP. Where staff self-acknowledged improvements

in knowledge and practice, they tended to directly attribute their learning to *Medica Afghanistan's* STA training. Staff also raised a number of examples of how *Medica Afghanistan's* STA training had facilitated specific changes in their trauma-sensitive practice behavior and practice. When exploring staff survey data according to participation in different types of SGBV training, the results suggest that the largest improvements in knowledge and practice are observed for staff who have participated in *Medica Afghanistan's* STA training or in both STA and GBV Treatment Protocol training, suggesting that these two types of trainings are complementary and may, together, lead to better staff outcomes.

Still, when staff was asked about their experience participating in the GBV Treatment Protocol training and also their experience participating in *Medica Afghanistan's* training, staff tended to speak specifically about *Medica Afghanistan's* training, with less information provided about perceptions of the GBV Treatment Protocol. This may have been because they were aware that the group interviewed was interested in discussing *Medica Afghanistan's* THTP. Although this means that there is extensive data on staff perceptions of and les-

sons learned from *Medica Afghanistan's* STA training, there is less information about perceptions of the value added of *Medica Afghanistan's* training over and beyond the GBV Treatment Protocol.

However, this pattern in results was not observed for staff attitudes, with some persisting negative attitudes towards SGBV and SGBV service provision highlighting this as an area that both *Medica Afghanistan* and the MoPH should pay more attention to.

## FINDINGS OF THE EVALUATION

The endline findings suggest that key improvements have been observed for the **5As**, including in affordability, availability, accessibility, adequacy and acceptability. Fewer improvements were observed for women in vulnerable groups, including those with a disability or longstanding infirmity and those with a history of displacement. Women in these two categories of vulnerability were also more likely to have experienced specific types of violence, including self-inflicted injuries, emotional abuse and sustained injuries during physical or sexual abuse.

### Acceptability

At endline approximately half of women believed that SGBV survivors should not access health care as SGBV was a private matter. However, approximately half of women also said they would feel comfortable seeking treatment from a health care facility if they experienced abuse by a family member. 71 % of patients at endline reported that compared to a year ago, now it was more acceptable for women to seek health services for abuse.

### Availability

The qualitative data suggests that availability of female staff and services delivered according to culturally appropriate norms is strongly linked to women's feelings of trust and safety. At endline 89% of women had been attended by a female staff member the last time they accessed the health facility. Women reported more privacy: at baseline 73% had been seen in an open room while at endline 77% had been seen in a private room. 88% of patients reported better availability of services in the past year.

### Accessibility

Qualitative data identified that families allowed women to attend the health care facility due to enhanced trust in the environment and confidentiality. 67% of women at endline stated that in the past year their families had allowed them to have more access to treatment.

### Adequacy

There was a large increase in the proportion of women at endline who reported that staff respected their privacy and treated them with dignity. The majority of patients at endline (95%) stated that over the past year they had become more satisfied with the services they had received from staff at the health facility.

### Affordability

58% of patients at endline reported that in the past year services at the health care facility had become more costly. However, of those who reported that services were more costly, a large proportion (69%) said that the fee or cost they paid was appropriate for the quality of services they received.

According to a **CCTIC framework**, patient perceptions of safety, trust, collaboration, choice/control and empowerment have improved overall at endline or remained at a high level where outcomes were already high at baseline. The largest improvements have been observed for collaboration and empowerment. In contrast to the

results for the 5As, women in key categories of vulnerability report slightly better experiences according to CCTIC measures than women who are less vulnerable. This may suggest that although access is more restricted for vulnerable women, the trauma-informed services they receive are satisfactory.

### Safety

Women's feeling of physical and emotional safety in their health care facility was high at both baseline and endline with little overall change. Qualitative data suggest that the facility environment and setting itself may become a safe haven for women attempting to escape violence.

### Trust

There were large increases in women's trust in health care professionals between baseline and endline. Women had greater confidence that health staff would do what they said they were going to do, and treat patients in a respectful and professional manner.

### Choice and control

A larger proportion of women at endline reported having choice and control in their health care,

for example, having different choices about and control over the services they receive, and not feeling pressured to undergo tests or treatments they felt uncomfortable with.

### Collaboration

A larger proportion of women at endline reported having a collaborative relationship with health-care providers. For example, at baseline 42% of women reported that patients played a role in how things were done at the facility and this increased to 75% at endline.

### Empowerment

Women at endline felt more empowered than those at baseline: 67% of women at baseline reported feeling stronger as a person as a result of the support they received from the health facility. This figure rose to 92% at endline.

There are mixed results in relation to changes in CCTIC measures at the health facility level. Overall, the findings suggest that while the availability of some health care practices, policies and protocols supporting trauma-informed care has improved, the availability of others has stayed the same or reduced.

For instance, although health facility protocols that link to building patient trust have been observed to have improved, protocols in place to support staff, either in terms of their own trust in health facility systems or their ability to enable trusting interactions with patients, appear to have worsened. Further, there was no difference between baseline and endline in the number of facilities that had protocols in place to ensure the emotional safety of staff, with all four facilities lacking these two elements at both baseline and endline.

Despite positive qualitative reports from health staff about key learnings from STA about self-care and secondary trauma, there may be a limit to the extent to which staff can sustainably practice adequate self-care and management of secondary trauma if facility policies and protocols are not in place to support these practices.

Despite some gaps in dimensions of CCTIC at the facility level, health facility checklists identified that more facilities at endline than baseline are implementing program reviews to assess the extent to which programs facilitate patient empowerment, and assessing patients' strengths and resources. Large improvements were also observed for practices and protocols supporting trauma screening, and trauma-informed hospital administration and human resources.

The endline findings for staff attitudes, knowledge and practice were also mixed. Although health staff attitudes related to SGBV have improved, with fewer staff agreeing with statements related to rape myths and blaming women for violence, staff attitudes related to their roles in SGBV service provision appear to have worsened overall. This may be linked to little change in the formal policies, procedures and protocols that support trauma-informed care and staff self-care in particular.

The results for staff knowledge are also mixed. Although there was an increase in staff knowledge about forms of violence and the psychological outcomes of SGBV, there was a small reduction or no change in knowledge for other measures.

The largest improvements in staff outcomes were observed for practices. There was an increase in staff self-reported trauma-sensitive practice across all four indicators measured, including actions to take when a survivor is upset, ways to show a survivor you are interested and care, ways to show a survivor you are listening and assessing SGBV risks.

At endline there was an increase in patient knowledge about the legal rights of SGBV survivors, although knowledge was already high at baseline. However, the results for patient attitudes are mixed. Although a smaller proportion of patients at endline agreed that a woman provokes her partner's violence because of her own behavior, there was an increase in the proportion of patients at endline who agreed that there are times when a husband is justified in beating his wife. Qualitative data suggests that this may be related to SGBV survivors learning mechanisms in health facilities for avoidance of violence and conflict resolution that encourage understanding the cause of men's violence and putting the responsibility on women to mitigate it, rather than on men to stop perpetrating it.

The **evaluation analysis according to DAC criteria** has identified a rating of three (satisfactory) for four criteria (relevance, effectiveness, impact and sustainability) and a rating of two (good) for efficiency. Thus, an overall rating of three (satisfactory) can be applied to the THTP. The DAC criteria analysis has highlighted some key findings, particularly in relation to sustainability, a selection of which is listed below.



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Although the THTP has been highly relevant to the needs of health staff and the patients they service, the small number of staff beneficiaries has limited the scope of relevance at the wider province level. Mainly targeting female health staff has also limited the reach of STA to male health care providers, who may sometimes be the first responders to cases of SGBV or be the first point of contact that patients have with health care facilities. *Medica Afghanistan's* implementation of training of trainers (TOT) to facilitate the wider dissemination of STA training in target hospitals is a key sustainability strategy. Although the TOT was implemented late in the project cycle and cannot be evaluated under the first phase of the THTP, future evaluations of the second phase of the THTP will shed light on the extent to which this strategy has been successful.

Another key sustainability strategy has been *Medica Afghanistan's* advocacy to mobilize support for the institutional integration of STA. *Medica Afghanistan's* attempts to gain support for the inclusion of STA into the GBV Treatment Protocol have not been successful in phase one of the THTP, in part due to the GBV Treatment Protocol being in its mid-term implementation, and also due to some stakeholder concerns about duplication of content between the two approaches. Despite perceptions of duplication, stakeholders who have participated in the training highlight value added in the STA approach, including the strength of content on psychosocial counseling



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and support, the interactive methods used as a mode of delivery, a focus on staff self-care practices, and the overall more in-depth coverage of some topics that are more limited in depth in other types of trainings.

Despite *Medica Afghanistan* being unsuccessful in integrating STA into the GBV Treatment Protocol, their advocacy efforts have led to the MoPH agreeing to adopt some components of STA into the Essential Package of Health Services (EPHS). A key factor that promoted the achievement of EPHS integration of STA is the flexibility in *Medica Afghanistan's* advocacy efforts whereby different approaches to achieving objectives were adopted where necessary in order to overcome challenges and find new ways to reach targets.

Another example of *Medica Afghanistan's* flexibility is its adaptation to stakeholder doubts about the value added of a STA approach by volunteering to provide STA training to directly illustrate its value, thereby harnessing additional support and buy in from key stakeholders. This method of 'promoting it by showing it' has been particularly successful given the mode of delivery being a key factor that sets STA apart from other training packages, with the method itself likely needing to be experienced to be convincing.

## RECOMMENDATIONS

In light of the endline evaluation findings of the THTP, the evaluation team suggests the following recommendations for three types of key actors: *Medica Afghanistan*, the Ministry of Public Health and Hospital Directors/management staff.

### Medica Afghanistan

Phase 1 of the THTP focused advocacy efforts on the institutionalization of STA through incorporating STA training content into existing institutional health structures and protocols in the MoPH. In the second phase of the THTP, although these advocacy efforts should be continued, they should be complemented by **advocating for the institutionalization of policies, protocols and practices that support trauma-informed care at the hospital level**, including those that target self-care for health care professionals.

The finding that women in key categories of vulnerability, particularly those with disabilities, are more likely to experience certain types of violence suggests that health service provision to SGBV survivors in this group should be tailored more to their needs, capacities and vulnerabilities.

*Medica Afghanistan* should consider **incorporating additional content into the STA manual** on how trauma-sensitive care should be implemented with women with special needs. Furthermore, advocacy efforts to institutionalize trauma-informed care at the hospital level should additionally **support** the implementation of policies, protocols and practices that target **SGBV survivor from key categories of vulnerability**.

Given some limitations identified in the relevant of the THTP due to the limited scope of STA training coverage, *Medica Afghanistan* should **expand STA training to a larger number of health care professionals, including male staff**. Although this can be partly done in *Medica Afghanistan*-supported health facilities by drawing from trainers who have participated in TOT to train untrained health staff and conduct refresher trainings, TOT trainers could also be mobilized to implement STA training in hospitals not covered by *Medica Afghanistan* and develop peer mentoring practices across different health facilities to widen the reach of STA.

Although sustainability through the institutionalization of STA training and practice in the public health care system is an important component of the THTP, *Medica Afghanistan* should **consider expanding possibilities for sustainability and impact** by implementing STA with health care/ psychosocial staff working outside of government health facilities, including shelters and other facilities that service SGBV survivors.

*Medica Afghanistan* is already doing so through **partnerships with NGOs**, for instance supporting Danner Afghanistan in building the STA capacity of staff in shelters. Similar partnerships could be built with other NGOs, for instance those that are providing mobile health services to SGBV survivors in more remote areas where women cannot access health facilities (e.g. International Medical Corps).

*Medica Afghanistan* should also **explore possibilities of mobilizing STA in the private health care system**, where health staff should also be capacitated in supporting SGBV survivors in a trauma-sensitive approach.

Finally, *Medica Afghanistan* should pursue opportunities to **implement STA in non-health related government structures** such as the criminal justice system, where women are often accused of

and detained and jailed for crimes such as *zina*, despite these women often being subjected to SGBV rather than committing a crime. In order to identify possible areas to pursue partnerships, *Medica Afghanistan* should consider conducting a partnership mapping exercise that identifies key opportunities for STA mobilization and integration into existing structures and programs.

Although there are some positive results in relation to health staff improvements in knowledge, attitudes and practices, there are some important gaps. *Medica Afghanistan* should **incorporate additional training in STA on attitudes towards SGBV and SGBV service provision**, particularly where gaps have been identified. For instance, more emphasis in training should be placed on enhancing learning and practice opportunities to **improve health provider comfort in treating SGBV cases**. STA training should also incorporate additional training with staff on survivor-centered approaches that avoid encouraging women to take responsibility for the violence perpetrated against them.

*Medica Afghanistan* should **continue to adopt flexible approaches** to pursuing project objectives, particularly in relation to advocacy and attempts to implement sustainability practices. In particular, *Medica Afghanistan* should **continue to mobilize the method of ‘promoting it by showing it’** in order to continue harnessing support for STA. Although these flexible approaches were developed and implemented ad hoc in the first phase of the project, *Medica Afghanistan* should consider more structured implementation of these approaches.

*Medica Afghanistan* should **continue to mobilize support for the importance of STA** to ensure that support by the MoPH and health facilities continues and that space, time and resources are allocated for health staff to continue to train and be trained. A key way that this can be done is to enlist the support of STA TOT trainers or other focal points in acting as champions for the roll out of STA, including in monitoring the extent to which STA is being implemented at the facility level. *Medica Afghanistan* should **provide support to focal points/champions** through advocacy for institutional reform so that monitoring of STA implementation is given some authority, such that requirements **for follow up, learning and improvements** are institutionalized.



Given some evidence that *Medica Afghanistan* may require some support in **improving** the quality of monitoring outputs, including project and budget monitoring, some capacity building support in **M&E** may be required from *medica mondiale* in the second phase of the THTP. Although it is recognized that the mode of cooperation between *Medica Afghanistan* and *medica mondiale* may change in the second phase due to one central donor for all THTP-countries, *medica mondiale* should seek opportunities to support *Medica Afghanistan* to retain roles and responsibilities in M&E and project steering and support their capacity to do so.

## Ministry of Public Health

The MoPH should continue to **support the integration and merging of content from STA and GBV Treatment Protocol manuals**. Given the widespread acknowledgement that the mode of delivery of STA is a strength, ways should be found to incorporate this mode of delivery without sacrificing the time required to cover all necessary topics.

Although the MoPH has indicated support for STA and the integration of STA into existing institutional structures such as training protocols, the finding that hospitals are lacking in policies and procedures that would **enable an environment for successful STA implementation** suggest that the MoPH needs to drive policy and strategy reform in this area. This endline evaluation has identified several key areas that should be focused on. One is staff self-care and **ensuring** that **procedures** are

in place **to protect the emotional safety of staff**. Another key area is the development of institutional policies that address the specific trauma-sensitive needs of SGBV survivors from vulnerable groups, particularly those with disabilities.

The finding that there are important gaps in health staff attitudes, knowledge and practices, even among staff who have participated in GBV Treatment Protocol training, *Medica Afghanistan* training or both, suggests that the MoPH (as well as *Medica Afghanistan*) should be **monitoring and supporting key areas of staff capacity**, particularly health provider comfort in treating SGBV cases.

## Hospital Directors/management staff

Although institutional change at the level of trauma-informed policies, procedures and practices must be driven by the MoPH, hospital directors and other management staff in health care facilities can provide some support for the integration of STA in the daily practice of health care staff. For instance, hospital directors should **ensure that existing policies and procedures are implemented**, monitored and followed up on, and **provide opportunities for STA refresher training** for staff and other capacity building opportunities. Hospital management staff should also support SGBV or STA champions or focal points, for instance, by ensuring that sufficient time and other resources are provided to enable such focal points to fulfill their roles.

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