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PROJECT PAPER

AFGHAN
FAMILY GUIDANCE ASSOCIATION
CLINIC EXPANSION

AFGHANISTAN

December 24, 1974
Agency for International Development
USAID/KABUL

AFGA CLINIC EXPANSION

PROJECT PAPER

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AFGA Clinic Expansion

Project Paper

Part I Summary

A. Summary Information

1. Project Title: AFGA Clinic Expansion

2. Project Number: 306-11-570-139

3. Cooperating Country: Afghanistan

   Executing Agency: Ministry of Public Health, Government of Afghanistan

4. Obligation Span: FY 75 to FY 77

5. Implementation Span: FY 75 to FY 77

B. Project Purpose

The project purpose is to expand the Afghan Family Guidance Association's system of family planning clinics to a total of 35 and create outreach services for family planning to both males and females. The target number of new acceptors is: CY 1975 17,000 CY 1976 28,000 CY 1977 31,000

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C. **FINANCIAL DATA**

1. Total Project Cost	FY 75	FY 76	FY 77	TOTAL
A.I.D.	254,000	278,000	54,000	586,000
I.P.P.F.	200,000	200,000	200,000*	600,000
Govt. of Afghanistan (Annex D)	67,000	99,400	99,400*	265,800
TOTAL	521,000	577,400	353,400	1,451,800

* Projected

2. AID Project Cost	FY 75	FY 76	FY 77	TOTAL
a. U.S. Personnel	40,000	77,000	54,000	171,000
(1) POP/Health Adv.	10,000	62,000	54,000	126,000
(2) Short-Term Consultants	30,000	15,000	-	45,000
b. Local Personnel	9,000	9,000		18,000
(1) Local Hire	9,000	9,000	-	18,000
c. Commodities	5,000	-	-	5,000
d. Other Costs	200,000	192,000	-	392,000
(1) Clinic Rent	42,000	14,000		56,000
(2) Salary Family Guides	52,000	90,000		142,000
Add'l Headquarters Staff	30,000	31,000		61,000
(3) Clinic Renovation	11,000	4,000		15,000
(4) Clinic Furnishings	20,000	6,000		26,000
(5) Transport Subsidy	24,000	31,000		55,000
(6) Information System	13,000	8,000		21,000
(7) Performance Incentive	8,000	8,000		16,000

3. Appropriation Category: Population Planning Health Title-X

D. Project Development Team

Dr. Mohammed Naim Sharaf, Vice-President, AFGA

Dr. Mohibzadah, Director of Information and Education, AFGA

Stephen C. Thomas, M.D., Deputy Chief, USAID Office of Population

Mr. F. Gary Towery, Assistant Program Officer, USAID Office of Development Planning

PART II PROJECT DESIGN

A. General

The Afghan Family Guidance Association (AFGA) is a voluntary organization, affiliated with the International Planned Parenthood Federation (IPPF), which has pioneered the delivery of contraceptive services in Afghanistan's strongly pronatalist, sometime hostile atmosphere. AFGA has earned a certain position of acceptance and creditility in Afghan society where virtually no contraceptive services were present five years ago.

In June 1974, the Ministry of Public Health (MPH) made a request to AFGA, USAID and IPPF for an expanded clinic system in order to establish one clinic in each provincial center and to include, to the extent possible, maternal and child health (MCH) services. IPPF agreed to fund the necessary increased personnel for these new clinics (physician, nurse, one family guide per clinic). The MPH also agreed to take over the functioning system at an unspecified future date. This project proposal is USAID's input for the clinic expansion (Annex B).

B. Sector Goal

The USAID's population program goal (as distinct from the GOA, which has no public goal on population) is that the GOA will undertake the funding and implementation of action program which

will achieve a population growth rate compatible with the social and economic development progress in Afghanistan. The USAID has not established a time limited target for the achievement of this goal, for population programs are embryonic in 1974. The success of such programs can be measured by the (1) rate of natural increase of population, (2) rate of increase of real income per capita and (3) the size, thrust and funding of GOA programs in the fourth and fifth development plans. However, the achievement of these indicators, when they are defined, will be dependent upon the overall assumption that a process of modernization continues to be a priority in Afghanistan.

C. Project Purpose

The purpose of this project is to expand AFGA's system of family planning clinics to a total of 35 and create outreach services for family planning to both males and females.

The most definitive indicator of this project's success and attainment of its purpose is a rising number of new acceptors each year. The established new acceptor targets are: CY 75 17,000 CY 76 28,000 and CY 77 31,000. Other indicators are (1) 35 operating clinics, (2) clinics staffed with 27 doctors, 35 nurses and 140 family guides (FGs), (3) family guides working as prescribers and suppliers of contraceptives and delivering a basic MCH service

and (4) family guide service extending in a radius of 10-15 KM from each clinic.

The basic assumptions necessary to the overall success of this project are that (a) The GOA will continue to sanction AFGA operations and (b) qualified people will be recruited to fill the now vacant and newly created positions.

D. Outputs

The outputs necessary for the achievement of project purpose are (1) available family guidance services in the 16 new clinics in provinces without services at present, and services available to larger numbers of people in areas adjacent to the existing clinics; (2) an automated client information system producing monthly, quarterly and yearly reports to monitor the delivery of these services; (3) an established AFGA training capacity which will train 126 Family Guides, CY 75 63 and CY 76 63 and (4) reorganization of AFGA headquarters.

E. Inputs

1. USAID

USAID assistance proposed for this project is in three categories.

a. Personnel

A Direct Hire POP/Health advisor will be the full time advisor

and project manager for this project. He will be assisted by at least two local hire Afghans who will assist in monitoring the project's implementation. In addition, there will be nine man months of short term consultants services to direct two evaluations of AFGA activities; the first a baseline study of existing clinic operations and services and the second, a follow-up study on existing clinics and an assessment of the new clinics opened.

b. Commodities

The commodities are designated for use in the Training Center (1 projector, 1 screen and video tape equipment). (Annex A)

c. Other Costs

This category of inputs is a direct funding of the AFGA Clinic Expansion local costs and a provision of funds for performance incentives.

2. GOA

The GOA input will be personnel and other costs of MCH services in 9 Kabul Clinics.

3. IPPF

IPPF contribution will be budget support for a portion of the personnel and operating cost.

F. Project Rationale/Justification

1. General

Essentially the project is an effort to offer services to larger population groups by creating a larger Afghan Family Guidance Association clinic base. Secondly, it attempts to develop the capability of para-medical workers (Family Guides) as contraceptive dispensers and thus loosen the ties of the system of physician-only services to allow greater contact with the population at greater distances from clinic sites (Annex Map.)

Achievement of the project purposes will be an important step in moving Afghanistan towards development of programs that offer opportunities to influence the population growth rate. There are, moreover, immediate benefits:

a. The strengthening and expansion of an Afghan organization which has the potential of stimulating demand for fertility control measures by larger numbers of couples.

b. An increased number of contraceptive users with the potential of reduction in population growth rate.

c. Maternal and child health benefits by a reduction in maternal and child morbidity and mortality.

d. The development of an increased realization among people of the potential family benefits of reduced fertility.

e. The expansion of an existing system at the provincial level while the MPH develops its Basic Health Center (BHC) system. The AFGA system could be integrated with or absorbed by the MPH system at a later date.

2. Clinic Expansion

AFGA is the only group delivering contraceptive services and presently has 19 clinics in Afghanistan. Nine of these are in Kabul, the only major population center in the country (Population is approximately 600,000).

a. Kabul - In Kabul there is a need to relocate some of the existing clinics to areas of greater population density. This entails the renting, renovation, and furnishing of seven new clinic sites. USAID granted $15,000 for this project in FY 74. Two have been completed and are operating; work is in progress on two more; leaving a need for funds for the remaining three.

b. There are 16 of the 26 provinces that presently have no clinics. It has been proposed by MPH that a clinic be placed in the central city[1/] in each province for a total of

1/ "City" does not have the connotation in Afghanistan that it does in the U.S. These "cities" are generally market towns or seats of provincial government with populations of three to thirty thousand.

16 new clinics. This project proposal which provides for opening of 16 new provincial clinics is in response to the MPH request.

3. Increase in Number of Family Guides.

The family guides represent the only available means of reaching potential acceptors outside the clinic. Experience with the guides indicates that, in their present role as information carriers only, they are listed as the referral point by up to 40 percent of clients visiting the clinics. The guides themselves have observed that many potential acceptors either will not or cannot travel to the clinic for service. The increased number of guides is aimed at increasing the penetration into areas surrounding the clinic.

4. Retraining, use of males, and transportation support.

These changes are inter-related. In order to circumvent the problem of potential acceptors having to travel to the clinics, it is proposed to train the guides as prescribers and suppliers of contraceptives (excepting the IUD). A monthly transport subsidy for each clinic is proposed to provide funds for utilizing local transport in order that they may extend their geographic range. It is also proposed that, in addition to their contraceptive supply function a basic MCH service be provided by the guides. This will meet two needs:

(a) The MPH has requested the AFGA to provide MCH services, and

(b) Potential acceptors are routinely interested in services for their children. In this culture, the guide may be more socially acceptable if she/he also provides rudimentary MCH advice rather than acting solely in a "birth controller" role.

This is a male-dominated, male-oriented society. The male side of the contraceptive equation has been little exploited. Males can travel freely where females cannot. Males can contact other males in groups. To date, a major reliance has been placed on young single females as family guides. An increased effort to gain increased contact with the population around clinics requires a system of guides which are the product of experimentation with different types of individuals. The support for increased numbers of more mobile guides is based on the AFGA's willingness to do the following:

(1) Recruit and utilize male guides; at least one per clinic.

(2) Experiment with women of varying age groups, marital status, and of proven fertility.

(3) Increase the radius of travel around clinics with guides following planned routes on a definite schedule.

(4) Begin to contact groups of employed males.

5. Training

In the past, AFGA has benefitted from having the majority of its core staff (physicians and mid-wives) trained outside Afghanistan.

There has been local training of personnel, particularly family guides. All personnel have, from time to time, been given refresher courses locally. AFGA personnel have presented lectures on family planning to physicians at the Public Health Institute. These physicians are in training for posts in the basic health centers. However, in AFGA, there has been no training staff as such, and no division prepared to accept trainees on a regular basis. Training courses are variable and the trainers are variable as this activity is ancillary to their primary jobs. The key to the proposed clinic expansion will be the quality of the staff placed in the clinics. The largest single group in need of training will be the new family guides. In addition, there will be some physicians in need of training, as well as the retraining of the present family guides.

The training resources within AFGA consist of a single physician and the personnel stationed in the Kabul clinics. There are physicians outside the AFGA who have been and can continue to be utilized as

lecturers. It is proposed that support be given for the development of improved training capabilities on a continuing basis.

The need for a changed training program is not due solely to an increase in numbers of personnel. The family guides will be assigned a new set of duties, an extension of the previous function which was limited to information and referral to clinics. They will be trained to prescribe contraceptives and actually dispense and resupply. In addition, as a partial answer to the Ministry's request for MCH services in AFGA clinics, they will supply two services basic to any reduction of childhood morbidity and mortality. They will teach mothers infant and child feeding with nutritious, clean food at the proper weaning age, and personal hygiene.

Basic to the development of a permanent training section is the addition of persons to the existing headquarters staff whose primary responsibility will be the planning, scheduling, and execution of a training program. These new positions are a training center administrator and assistant administrator. A second function of the permanent training staff will be continuing contact with and evaluation of, their trainees in the field so that courses may be revised to better equip personnel for actual conditions.

While the AFGA clinics in Kabul offer adequate facilities for field work by trainees, it will be necessary to insure adequate classroom facilities for didactic teaching. Provision for this is made.

Underlying the development of a permanent training capability is the consideration that sometime in the future the AFGA may no longer operate a clinic service. However, the demand for trained personnel would continue from MPH. The facility and the experience gained would be a continuing AFGA contribution, helping to assure a supply of family planning workers.

The following broad areas will be included in the training course:

(1) Rationale for fertility limitation: health, population growth, economic benefits, etc.

(2) Basic mechanism of conception.

(3) Various contraceptive methods that interrupt the conceptive mechanism.

(4) Essentials of each method and means of handling perceived problems.

(5) How to counter rumors.

(6) Basic essentials of infant and child feeding. The utilization of local foods to meet these requirements.

(7) The mechanism for the spread of disease and how to break the chain of infection.

(8) The significance of the weight chart. How to weigh infants and children and recording data on the weight chart.

This project's training component is directed toward strengthening the AFGA service delivery system. It aims at the further development of a new functioning organization. It builds on its strengths and attempts to correct its weaknesses. With the establishment of a nationwide functioning contraceptive delivery system, whose operation can be assumed by the Ministry of Public Health (MPH), AFGA will have fulfilled a request from the MPH. At that point, AFGA could well turn its complete attention to the areas of training and education and be relieved of the responsibility for service delivery.

6. Performance Incentive/Targets

a. Incentives

The expansion of AFGA clinics to 35 with national coverage will result in the establishment of an undetermined organizational capacity which must be utilized to the fullest. This project proposal incorporates a provision for the establishment of performance incentives which it is hoped will help stimulate AFGA to achieve its overall performance targets.

At this stage of the project development the details of a workable and acceptable incentive plan have not been agreed to by all parties. Basically, there are four types of approaches which may be used:

a. Reward to new acceptors

b. Rewards to field workers, clinic staff and family guides.

c. Rewards to management

d. Rewards to the organization

The goal of all four would be to increase the number of new acceptors with the newly-increased organizational capacity and consequently reduce the cost per new acceptor. It is envisioned that the formula to compute incentives payment may as a guideline be 50 percent of the decrease in cost per acceptor as the cost declines below a standard cost.

This proposal envisions the use of incentives as a way of stimulating growth and good management by concentrating on decreasing the cost per new acceptor and provides $17,000 to be used for this purpose. The performance incentive plan to be utilized will be decided upon when the Project Agreement is negotiated. If by chance no agreement can be reached the money will not be used.

b. Targets

The overall performance targets - NUMBER OF NEW

CLIENT VISITS[1/] - will be employed as one indicator of the achievement of the project purpose. The basis used in establishing these targets is cost per new client visit of $11.00 based on AFGA's 1974 performance. It is the level of activity which will maintain this cost per new client visit that we have established as the performance targets for judging this project's success. The CY 1975 and 1976 targets are computed after excluding from the operating expense budget the capital cost of the clinic expansion.

Targets

New Client Visit (new acceptors)

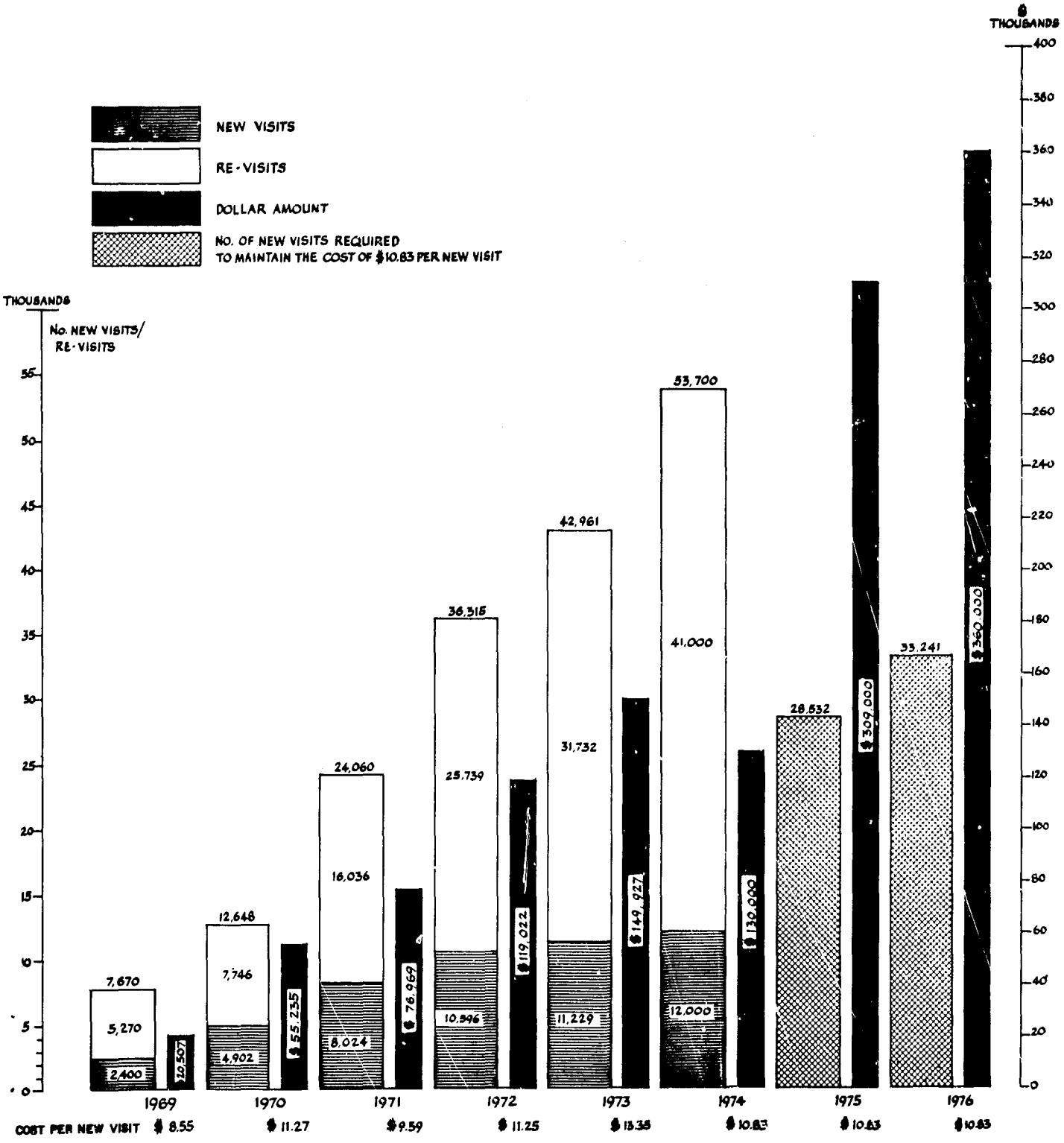
CY 1975 - 17,000 CY 1976 - 28,000 CY 1977 - 31,000

The above targets are based upon a clinic expansion with three clinic's being opened each quarter and allows 12 months before the clinic is fully operational.

1/ Defined as the first time that a client visits a clinic and accepts a family planning method.

A.F.G.A. CLIENT VISIT STATISTICS

OPERATIONS COSTS — COST PER NEW VISIT



7. Reorganization of AFGA

The current AFGA organization is geared to the management of the existing 19 clinics, nine of which are located in Kabul with the remaining 10 being located in the larger provincial centers (except the two part time clinics Mir Bacha Koot and Logar). The current staff was not trained by AFGA except for the 29 family guides. Consequently, there is no extant element in the existing organization which is capable of accepting the training responsibility for family guides.

The logistic support element of the organization is now centered in the Administrative Branch. At this time the scope of activities is limited and doesnot include all the management support responsibilities normally associated with the administrative arm of an organization. Nor does this element of the organization have a staff position which could accept an expanded scope of responsibilities.

Another function which is lacking in the current organization is evaluation and reporting. There are two statistical clerks which are organizationally under the Director of Clinics.

Thus, it will be necessary to reorganize AFGA headquarter's before it can accept responsibility for implementing the proposed clinic

expansion and latter management of the expanded system. This project proposes the following organizational changes.

1. Establishment of two new positions in the administrative area (Director and Assistant Director of Administration) that will be responsible for the normal administrative management support functions plus the physical aspect of renting, renovating and furnishing new clinics.

2. Establishment of an Assistant Medical Director position to assist the Medical Director in the supervision of the increased number of clinics.

3. Establishment of an Assistant Director of Information and Education position to assist the Director in the recruitment of family guides, supervision of the new training center and development of training material.

4. Establishment of a training center for the training and retraining of family guides and other clinic staff as required.

5. Establishment of a new organizational element - Clinic Information Analysis Unit with a new position for an analyst and the transfer of the two existing statistical clerks to this unit. This unit will be responsible for the management of the client information system. The analyst will also perform evaluations as directed by the President and Vice President. In addition, this unit will work with the short term consultant in performing the baseline line and follow-up survey/evaluations proposed in this project proposal.

PROPOSED
AFGHANISTAN FAMILY GUIDANCE ASSOCIATION
ORGANIZATION CHART

چارت تشکیلات پیشنهاد شدهٔ انجمن رهنمای خانواده افغانستان

رئیس
PRESIDENT

VICE PRESIDENT معاون
ENGLISH SECRETARY - 1 سکرتر انگلیسی دان

شعبهٔ تحلیل معلومات کلینیکی
CLINIC INFORMATION ANALYSIS UNIT
* ANALYST - 1 تحلیل کننده
STATISTICAL CLERKS - 2 کاتب های احصائیه

COMPTROLLER شعبه کنترول
- CONTROLLER OF BUDGET
- EXEC. SECRETARY 1
- ACCOUNTANT/CASHIER 1
- ACCOUNTS CLERKS 2

۱ آمر کنترول و بودجه
۲ سکرتر اجرائیه
۳ محاسب / خزانه دار
۴ کاتب حساب

DIRECTOR OF ADMINISTRATION صدارت اداری
- * DIRECTOR 1 مدیر
- * ASST. DIRECTOR 1 معاون
- TRANSPORT ASST. 1 معاون ترانسپورت
- PERSONNEL CLERK 1 کاتب پرسونل
- PEONS 3 ملازم
- WATCHMEN 2 محافظ
- GARDENER 1 باغبان
- DRIVERS 10 دریور
- TYPISTS (POOL), 2 تایپست، عمومی
- STOREKEEPER 1 تحویلدار

MEDICAL DIRECTOR OF CLINICS صدارت طبی کلینیک ها
- DIRECTOR 1 مدیر
- * ASST. DIRECTOR 1 معاون
- LABORATORY TECH. 2 عضو فنی لابراتوار
- KABUL & PROVINCIAL CLINICS 9 کلینیک های کابل و ولایات

DIRECTOR OF INFORMATION EDUCATION صدارت تعلیم و تربیه
- DIRECTOR 1 مدیر
- * ASST. DIRECTOR 1 معاون
- AUDIO-VISUAL TECH. 1 عضو فنی سمعی و بصری
- CURRICULUM DEVELOPMENT 1 انکشاف نصاب تعلیمی

TRAINING CENTER مرکز تربیوی
- * ADMINISTRATOR 1 آمر
- * ASST. ADMINISTRATOR 1 معاون
- * CLERK 1 کاتب
- AUDIO-VISUAL TECH. 1 عضو فنی سمعی و بصری

KABUL CLINICS کلینیک های کابل

		DOCTOR دکتر	NURSE نرس	FAMILY GUIDES رهنمایان خانواده	PEON پیاده	DRIVER دریور	GUARD محافظ	ACCOUNTING CLERK کاتب حساب
1 ZAISGAH	زایشگاه	1	1	4	1		1	1
2. ALAWUDIN	علاوالدین	1	1	4	1		1	1
3. BIBI MAHRO	بی بی مهرو	1	1	4	1		1	1
4. SHAH SHAID	شاه شهید	1	1	4	1		1	1
5. KHAIR KHANA	خیرخانه	1	1	4	* 1		1	1
6. JADA MAIWAND	جادهٔ میوند	1	1	4	* 1		1	1
7. MIR WAIS MAIDAN	میرویس میدان	1	1	4	* 1		1	1
8. TAIMANI	تیمنی	1	1	4	* 1		1	1
9 MARKAZI	مرکزی	1	2	4	* 1		1	1
SUB-TOTAL	مجموع فرعی	9	10	36	9	0	9	9

NEW PROVINCIAL CLINICS کلینیک های جدید ولایات

		DOCTOR دکتر	NURSE نرس	FAMILY GUIDES رهنمایان خانواده	PEON پیاده	DRIVER دریور	GUARD محافظ	ACCOUNTING CLERK کاتب حساب
1. NAIBAK	نایبک	1	1	4			1	1
2. TALOQAN	تالقان	1	1	4			1	1
3. MAIMANA	میمنه	1	1	4			1	1
4. LAGHMAN	لغمان	1	1	4			1	1
5. CHICHA SARAI	چیچه سرای	1	1	4			1	1
6. KALAT	کلات	1	1	4			1	1
7. WARDAK	وردک	1	1	4			1	1
8. FARAH	فراه	1	1	4			1	1
9. GALAIHAU	قلعه نو	1	1	4			1	1
10. GARDEZ	گردیز	1	1	4			1	1
11. DAULATYAR	دولت یار	1	1	4			1	1
12. FAIZABAD	فیض آباد	1	1	4			1	1
13. KANG	کنگ	1	1	4			1	1
14. THINKOT	ترینکوت	1	1	4			1	1
15. BAMYAN	بامیان	1	1	4			1	1
16. LOCATION NOT FINALIZED			1	4			1	1
SUB-TOTAL		15 1/	16 2/	64			16	16

PROVINCIAL CLINICS کلینیک های ولایات

		DOCTOR دکتر	NURSE نرس	FAMILY GUIDES رهنمایان خانواده	PEON پیاده	DRIVER دریور	GUARD محافظ	ACCOUNTING CLERK کاتب حساب
1. GHAZNI	غزنی		1	4	1		1	1
2. KANDAHAR	کندهار	1	1	4	1	1	1	1
3. LASHKAR GAH	لشکرگاه		1	4			1	1
4. HERAT	هرات		1	4	1	1	1	1
5. MIR BACHAKOT (PART TIME)	میربچه کوت			4	1		1	1
6. PARWAN	پروان		1	4	1		1	1
7. BAGHLAN	بغلان		1	4	1	1	1	1
8. KUNDUZ	کندز	1	1	4	1	1	1	1
9. MAZAR	مزار	1	1	4	1	1	1	1
10. LOGAR	لوگر		1	4	1		1	1
SUB-TOTAL	مجموع فرعی	3	9	40	9	5	10	10

	DOCTOR	NURSE	FAMILY GUIDES	PEON	DRIVER	GUARD	ACCOUNTING CLERK
COUNTRY TOTAL	27	35	140 3/	18	5	35 4/	35 5/
COUNTRY TOTAL مجموع کلی	12	19	29	18	5	*19	*19

* NEW POSITIONS لیست های جدید
1/ 15 NEW DOCTORS TO BE FUNDED BY IPPF ۱- مجموعاً ۱۵ دکتر جدید توسط آی-پی-پی-اف
2/ 16 NEW NURSES TO BE FUNDED BY IPPF ۲- مجموعاً ۱۶ نرس توسط آی-پی-پی-اف
3/ 32 FAMILY GUIDES TO BE IPPF FUNDED ۳- مجموعاً ۳۲ رهنمای خانواده توسط آی-پی-پی-اف
108 FAMILY GUIDES USAID FUNDED مجموعاً ۱۰۸ رهنمای خانواده توسط یو-اس-ایه
4/ USAID FUNDED ۴- مجموعاً توسط یو-اس-ایه

8. Significance of the Project

In terms of population pressure, both present and potential, on Afghan resources a slowing of the population-growth rate is important. While data to compute an accurate growth rate are lacking, it is estimated to be between 2 and 2.5 percent. At present the population lives in less than optimal balance with the food supply. Varying degrees of malnutrition are widespread. Large family size puts heavy pressure on static family income. There is evidence that pressure on the land is increasing, leading to rural unemployment and under-employment with increasing migration to towns and cities. Existing industry cannot absorb this migration.

The socio-cultural environment is rife with pro-natalist attitudes. The extended family is the basic unit and family strength is a function of size. Male children are desired for this reason; females are of lesser importance. Children are the security for old age and current labor to assist in tilling the land. Only a tiny fraction of women are employed outside the home as cash income earners. Traditionally, women are the bearers and raisers of children, and there has been little change.

It is against this background that the Afghan Family Guidance

Association began its services five years ago and against this background that it has not only survived but expanded. It is providing a service that is regarded as useful by a small but increasing proportion of women. There are, presumably, thousands of women who do not receive family planning services for reasons of personal reticence, distance or ignorance. While the number of women actually served by AFGA clinics is about 45,000, the number of clinic visits for contraception increased 25 percent in the first quarter of 1974 over the same period of 1973. One virtually unexploited source of contraceptive acceptors is the male of the population. In this male-dominated society, it is essential that they be brought into the contraception decision in a more cooperative fashion.

The Ministry of Health is making an effort to develop health services that will reduce maternal and child mortality. (The latter is estimated at 20 to 50 percent by age 5.) Adequate and available contraceptive services are necessary, but not sufficient, to reduce this mortality. If there is success in reducing this mortality, contraceptive services will be needed to hold the population growth rate at a reasonable level. The Ministry of Health looks to the AFGA as an organization with financial resources to continue the development of a system of services which the Ministry cannot finance, manage nor politically advocate at this time.

PART III

Project Implementation and Evaluation

A. IMPLEMENTATION PLAN

AFGHANISTAN FAMILY GUIDANCE ASSOCIATION
افغانستان خانواده رهنمای انجمن

IMPLEMENTION PLAN FOR OPENING 16 NEW AFGA CENTERS
پلان تطبیقی برای باز کردن ۱۶ مراکز جدید رهنمای خانواده

	QUARTERS I			II			III			IV			V			VI		
	MONTHS 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
FINAL SELECTION OF GEOGRAPHIC LOCATION OF CENTERS انتخاب نهایی موقعیت جغرافیایی مراکز	3		13															
SELECTION AND RENTING OF CENTERS انتخاب وکرایه گرفتن مراکز	3			3			3			3			2			2		
PLANNING FOR RENOVATION پلان برای اصلاح تعمیر		3			3			3			3			2			2	
CONTRACT NEGOTIATION FOR RENOVATION WORK مذاکره برای قرارداد جهة کار اصلاح تعمیر		3			3			3			3			2			2	
RENOVATION WORK COMPLETED AND NEW CENTERS READY TO OPEN کار اصلاحات تکمیل گردید ومراکز جدید آماده افتتاح میباشد			3			3			3			3			2			2
FAMILY GUIDES RECRUITED رهنمایان خانواده استخدام گردیدند	21			21			21			21			21			21		
FAMILY GUIDES — TRAINING تربیه — رهنمایان خانواده		21			21			21			21			21			21	
FAMILY GUIDES — ASSIGNED TO NEW CENTERS (CUMULATIVE) 1/ رهنمایان خانواده — به مراکز جدید تعیین گردیدند (زیادشونده) (۱)			12			24			36			48			56			64
FAMILY GUIDES — ASSIGNED TO EXISTING CENTERS (CUMULATIVE) 1/ رهنمایان خانواده — بمراکز موجوده تعیین گردیدند (زیادشونده) (۱)			9			18			27			36			49			62
SHIPMENT OF COMMODITIES AND EQUIPMENT TO NEW CENTERS انتقال مواد وتجهیزات به مراکز جدید			3			3			3			3			2			2
FUNCTIONING NEW CLINICS کلینیک های جدید فعال				3			6			9			12			14		16

NOTE:

(۱) الف. باد رنظرگرفتن ضایعات تخمین ۸ فیصد، برای آنکه یک حد اقل ۱۱۶ رهنمای خانواده تضمین گردد، در هر ربع ۲۱ رهنمای خانواده استخدام وتحت تربیه گرفته میشوند.

1/A. ASSUMING AN ATTRITION RATE OF APPROXIMATELY 8%, 21 FAMILY GUIDES WILL BE RECRUITED AND TRAINED EACH QUARTER TO ASSURE A MINIMUM OF 116 FAMILY GUIDES WILL BE AVAILABLE TO STAFF 34 CENTERS AND 3 SATELLITE CENTERS. (18 OPERATING CENTERS + 3 OPERATING SATELLITE CENTERS + 16 NEW CENTERS = 37)

بقداد برای تکمیل اعضای ۳۴ مرکز و ۳ مراکز فرعی میسر خواهد بود (۱۸ مرکز فعال سابقه + ۳ مرکز فعال فرعی + ۱۶ مرکز جدید = ۳۷)

B. 32 FAMILY GUIDES AT BEGINNING OF PROJECT
+126 PROJECTED NEW FAMILY GUIDES
−18 PROJECTED ATTRITION
108 TOTAL

ب. ۳۲ رهنمای خانواده در آغاز پروژه
+۱۲۶ رهنمای خانواده پیش بینی شده
− ۱۰ ضایعات پیش بینی شده
مجموع: ۱۴۸

1. <u>Implementation Steps 1st Quarter</u>

a. Transfer Operation Advance

Action Officer: USAID

Date action to be completed: _____

Date action completed: _____

b. Recruitment of staff to fill additional positions in AFGA headquarters.

Action Officer: President _____

Date action to be completed: _____ _____

Date action completed: _____

c. Survey of selected geographic locations.

(1) Determine availability of buildings for clinic use and prepare a listing of potential facilities that will be available.

(2) Estimate renovation work required for buildings selected as possible clinics and determine the extent such work will be done by the landlord.

(3) Determine willingness of landlords to give AFGA use of the property on Geroew Koerdan.

(4) Determine availability of local contractors to perform renovation work not to be done by landlord.

(5) Determine availability of local transport on fixed-fee basis.

(6) Start initial local advertising for family guides, publicizing date when local recruitment is to begin.

Action Officer: Directors of Administration and Clinics _____

Date action to be completed: _____

Date action completed: _____

d. Prepare priority list of all 16 clinics to be opened with estimated dates that clinics will be ready to receive equipment and staff.

Action Officer: Director of Administration _____

Date action to be completed: _____

Date action completed: _____

e. Negotiate lease or Geroew documents for clinics selected to be opened in the first quarter.

Action Officer: Director of Administration _____

Date action to be completed: _____

Date action completed: _____

f. Negotiate contracts for renovation work not to be done by landlord.

Action Officer: Director of Administration

Date action to be completed: _____

Date action completed: _____

g. Revise family guide curriculum to include MCH element, contacting large work groups, prescription of contraceptives, and planning of client visit routes.

Action Officer: Director of Information & Education

Date action to be completed: _____

Date action completed: _____

h. Recruit and train 21 family guides.

Action Officer: Director of Information & Education

Date action to be completed: _____

Date Action completed: _____

i. Retrain 20 currently employed family guides.

Action officer: Director of Information & Education

Date action to be completed: _____

Date action completed: _____

n. Follow-up with ABM to assure that programming of the monthly reports of the Client Information System is completed.

Action Officer: Evaluation Unit Analyst

Date action to be completed: _____

Date action completed: _____

o. Negotiate contract with ABM to produce monthly computer reports.

Action Officer: Vice-President

Date action to be completed: _____

Date action completed: _____

p. Negotiate contract ABM to program and produce the quarterly and annual reports of the Client Information System.

Action Officer: Vice-President and Analyst

Date action to be completed: _____

Date action completed: _____

q. Modification of Client Information System to include data from increased family guide scope of activities.

Action Officer: Short Term Consultant, Evaluation Unit Analyst

Date action to be completed: _____

Date action completed: _____

r. Evaluation of existing clinics operations and available service statistics including effectiveness of family guides.

Action Officer: Short Term Consultant
Evaluation Unit Analyst

Date action to be completed: _____

Date action completed: _____

s. Modification of family guide training program to take into consideration results of evaluating effectiveness of family guides.

Action Officer: Director of Information & Education

Date action to be completed: _____

Date action completed: _____

Implementation Steps after First Quarter will be similar to those of the first quarter as they relate to selecting and training of staff and opening of new centers.

2. Disbursement Procedure

a. Performance Replenishment Procedures

AFGA and the AID will sign a project agreement, AFGA Clinic Expansion, specifying costs eligible for project financing and the maximum amounts to be reimbursed by AID. The disbursement of of these grant funds will be tied solely to AFGA's performance as it relates to implementation progress of the project (pp 26). Basically,

the performance funding elements of this project are established limits for rent for clinics, salaries for family guides and headquarters staff, new clinic renovation expenses, clinic furnishing, transport subsidy, and AFGA automated information data system.

Payments of grant funds will be made in afghanis. Costs incurred against any budget line item for which reimbursement will be claimed may not exceed the budget line item by more than 10 percent without prior AID approval. However, reimbursements of the total predetermined reimbursable costs may not be exceeded.

b. Advance

After the signing of the AFGA Clinic Expansion Project Agreement and upon request by AFGA, an advance will be made to AFGA in an amount sufficient to provide operating funds for the first six months of project implementation. At three-month intervals thereafter, AFGA will forward to USAID a request for reimbursement for those eligible costs (pp 2) incurred during the quarter subject to the limitations noted under Claims for Reimbursement Section. The reimbursement of these eligible costs will replenish the initial operation advance and will continue to do so each quarter until the total reimbursement plus the initial advance equals the eligible amount reimburseable under the grant. From this point, AFGA's request for reimbursement of incurred eligible costs will not result in a payment to AFGA; instead, the amount due will be deducted from the initial advance until the advance is liquidated.

c. Clinic Visitation

Each clinic opened under this agreement will be supervised by a physician and staffed with one nurse and four family guides. Prior to or shortly after the initial opening, each clinic will be visited by a representative of USAID and the AFGA Directors of Clinics and Administration. They will prepare a joint visitation report which will record the status of the clinic's readiness for operating. These reports will identify any problems and recommend corrective action.

d. Clinic Certification

After each clinic is renovated, equipped, and staffed and operating, the President of AFGA and the USAID representative will jointly certify that the clinic was leased, renovated, and staffed according to specifications outlined in the project agreement. A clinic can be so certified if a minimum staff of a physician or nurse and one family guide is working at the clinic. This certification must accompany AFGA's request for initial reimbursement of rent, geroew[1], and clinic renovation and furnishing.

1/ Geroew: Farsi word for mortgage. To mortgage (Geroew Koerdan) one's property in Afghanistan is to give up the right to the use of the property for an agreed upon period of time, for an amount of money which must be returned at the end of the agreed upon period interest-free. It is expected that use of most of the new clinic buildings will be by this method.

e. Claims for Reimbursement

Claims for reimbursements will be submitted to USAID every quarter for all costs incurred during the quarter except that initial claims for rents, geroews, clinic renovations and furnishings must be certified as described above before inclusion in reimbursement claims. All such claims will be submitted in the prescribed format and signed by the President of AFGA and the Controller of Budget.

A signed copy of each claim for reimbursement with all leases, geroew documents, payroll registers, and receipts for which reimbursements are claimed will be filed at the AFGA Kabul headquarters.

AFGA CLINIC EXPANSION PROJECT
CLAIM FOR REIMBURSEMENT
(DATED)

Approved Budget Item	Approved Budget Amounts	Cumulative Reimbursements Received	Amt. Claimed For Reimbursements This Request
Rents	-----	------	--------- 1/
Salaries	-----	------	----- ---
Clinic Renovation	-----	------	--------- 1/
Clinic Furnishing	-----	------	--------- 1/
Transport Subsidy	----	------	---------
Information System	-----	------	---------
Totals	-----	------	---------

1/ A copy of the clinic visitation report and certification statement must be attached with the claim when a clinic's initial rent, geroew, renovation and furnishing payment is first included in the claim for reimbursement.

I certify that all costs reported herein and for which reimbursement is claimed from USAID were incurred in accordance with the Project Agreement (AFGA Clinic Expansion) and that all leases, geroew documents, payroll registers and receipts are filed with this claim for Reimbursement at the AFGA Kabul Headquarters.

Controller of Budget

President, Afghan Family Guidance Association

3. Audit and Records

(a) The AFGA shall maintain books, records and documents sufficient to properly reflect all costs for which reimbursement is claimed.

(b) AFGA's pertinent books, documents, papers and records shall be subject at any reasonable time to examination and audit by the representatives of the Agency for International Development for a period not to exceed three years from the date of last disbursement under the grant.

B. Monitoring/Reporting

This project's implementation will be monitored on a daily basis by a U.S. direct-hire POP/Health Officer who will be the project manager for this project and also serve as an advisor to the AFGA. This officer will also be responsible for the continued sample verification of the monthly, quarterly, and annual reports furnished to USAID through the client information system (Annex C). In addition, there will be two project funded local employees who will assist the project manager in his continued evaluation role of AFGA's reporting.

1. AFGA Performance Reporting Requirement to AID

Monthly, quarterly, and annual reports produced by the AFGA client information system.

2. The Afghan Family Guidance Association's Client Information System

In 1971, Afghan Family Guidance Association requested the

State University of New York to develop a client information system and provide a statistical base whereby program performance could be more accurately evaluated with regularly prepared reports. This analytical reporting provides AFGA with a necessary managerial tool which when coupled with improved management procedures would make it possible for AFGA management to make program decisions designed to increase the effectiveness of the clinic. However, the Client Information System as now designed does not include a system of records that would allow for the recording of all visits made by the family guides and the results of those visits. This project proposal provides funds for adding this aspect to the Client Information System with the publishing of the appropriate reports.

a. Objectives of the System

(1) To provide information on a regular basis on the activity levels in each clinic.

(2) To provide information on the continuation rates of clients in each clinic.

(3) To provide the basic data needed to evaluate the clinic program and also assess the effects of changes made by AFGA management.

(4) To provide a better means of stock control by recording supplies issued to and dispensed from each clinic.

(5) To provide a description of the clients utilizing each clinic that will be used in the design of information, education, and communication activities.

(6) To provide basic medical information and records of side-effects required for the provision of adequate services.

(7) To provide data which will make it possible to analyze the cost and effectiveness of the clinic operation - benefit/cost.

(8) To provide the necessary information required by MPH and international donors so that they may monitor the progress of the family planning program in Afghanistan.

b. Information Produced by the System

In the clinic there are two basic documents filled out by the clinic staff. During the first visit, an entry interview recorded on the clinic record provides basic demographic, sociological, and communication information. This clinic record also contains information on the medical examination and on each subsequent visit paid to the clinic by the client. The record is stored at the clinic and only a copy of the first page containing the social, demographic, and communication information is sent to the central office for processing. Each client visit is also recorded in the clinic register and information regarding the services provided are recorded in a precoded

form to enable easy computer processing. A copy of the clinic register is sent to AFGA headquarters in Kabul at the end of each month.

c. Reports

(1) Monthly and Quarterly

Based upon the above-described records, monthly and quarterly reports (Annex C) of clinic activities are produced which give an accurate idea of each clinic's progress. Also, an English summary with data from all clinics is produced. The monthly reports are sent to each clinic and serve as a regular means of communication by which the vice-president and director of clinics comment on each clinic's performance.

Presently the monthly reports are produced by counting and sorting computer cards mechanically. However, the system is currently being programmed by ABM and will be produced on an IMB 36/20 by January 1975. The quarterly reports are now being compiled manually by adding figures from the monthly reports.

This project (AFGA Clinic Expansion) would provide funding for the programming cost for the quarterly reports and production cost for both the monthly and quarterly reports.

(2) Annual Reports

The annual report is broken into three sections (Annex C). This report design is considered to be in the draft stage and is subject to further modification after implemented. The first section contains indicators of the AFGA's program performance based upon figures

collected and aggregated for all of the clinics. Part B is a summary of information that describes the clinic clients aggregated for all clinics from AFGA. Part C provides comparative indicators of clinic performance. Part D is designed to provide comparative descriptions of the characteristics of the clients attending each of the clinics rather than aggregating them for all clinics as is done in Part B of the annual report.

The data to produce the annual reports are available in the Client Information System. The reports have been designed as shown in the annex; however, the programming of these reports currently being done by a SUNY advisor has not been completed. This project (AFGA Clinic Expansion) would provide the funding for producing these annual reports for two years.

d. Computerization of System

Afghan Business Machines (ABM) now has responsibility (contract) for creating and maintaining a master file of all clients and all their visits and also generation of the monthly clinic reports. This project adds to that responsibility the quarterly and annual reports.

e. Short Term Consultant

A provision for short term consultant services is an integral part of this project proposal so that technical advisor needs can be met if required, for modifying the system to incorporate the increased scope of family guides.

f. Projected Cost of the Client Information System

	One-time Charge	$ Per Year
1. Monthly Reports		
a. Key Punching - 10,000 Client visit records		1,800
b. Report Production Cost. Includes maintenance of master file of active clients with last visit data.		2,400
2. Quarterly Reports		
a. Programming (one-time charge)	1,000	
b. Report Production Cost		400
3. Annual Reports		
a. Programming Cost	-	-
b. Production Cost	-	2,000
4. Modification of system to incorporate input concerning new scope of family guide activity	4,500	
a. Additional Production Cost		500
5. Misc.		400
Total	$5,500	$ 7,500

C. Evaluation

In the past years of AFGA support by USAID, the main interests of AID have been in contraceptive consumption and the utilization of participants returned from training. Contraceptive usage has been monitored to insure adequate stocks, and will continue to be done. Participant training is minimal at this time, but efforts will still need to be made to try and insure the best utilization of these trained persons. This will be accomplished by the direct hire POP/Health project advisor.

As the AFGA clinic system expanded, it became increasingly evident that a data system which was both accurate and timely was needed. By the assignment of a SUNY-ADSstaff member to AFGA, a record system was devised and installed which collects detailed client information, and for the past year has been producing monthly summaries of service statistics. In addition, SUNY-ADS advisors have undertaken a KAP study of AFGA clinic workers. At present, three SUNY-ADS advisors are conducting an acceptor follow-up study involving about 5,000 interviews.

This proposed clinic expansion, with USAIDfunding, represents a virtually 100 percent increase in service points as well as a 300 percent increase in outreach workers. These outreach workers will be trained to provide new services. There is a need to assure the continued develcpment of the monitoring system (Client Information System) and the availability of data needed to evaluate AFGA performance. Evaluation

of the effectiveness of the new workers and acceptance of their services is essential. Because of this, funds are provided in this proposal for the continued development of the Client Information System and the production of its reports for the life of the project. Also, a provision for short-term consultant services is part of the project proposal to be used, if needed, in modifying the Client Information System to incorporate data concerning the increased scope of family guides.

1. Evaluation Unit

The present AFGA organization does not have an in-house evaluation capability. Therefore, part of this project proposal is the addition of an evaluation unit in the AFGA organization which reports directly to the vice-president. The unit will be staffed by one senior employee whose salary will be equivalent to a director, and two statisticians or statistical clerks. This unit will be responsible for the operation of the Client Information System, plus field evaluations of clinics and family guides.

2. Short-Term Consultants

It is envisioned that a short-term consultant will direct two evaluations of AFGA activities (clinic operations, family guides) using the AFGA evaluation unit as the base for conducting the evaluations. The first evaluation would be a study of the existing clinic operation and available service statistics and the utility of the present information system to supply data to be used in training new guides and opening new clinics. In addition, an analysis of the available data

already accumulated in the form of socio-economic questionnaires on patients. The second evaluation would be a follow-up on the existing clinics and on assessment of the new clinics opened and effectiveness of the family guides in reaching the population on the periphery of clinics.

3. Major Areas of Evaluation

There are three major areas of AFGA activities which will require systematic evaluations:

a. First: Clinic Operations - How effective are the clinics in delivering family planning services? The level of clinic activity must be evaluated to determine its ability to reach an increasing proportion of the fertile group in its area.

b. Second: Family Guides - The activities of the family guides (four per clinic) are being expanded from simply an information medium to an actual source for contraceptive distribution. Consequently, a continuing appraisal of the family guides is needed. Several questions must be answered. Are they performing as anticipated in terms of increased patient contacts? Do they give credible information and service as evidenced by rising acceptor and continuation rates? Are male guides securing acceptors as anticipated? Are contacts being made with employed groups? With what results? What evidence is there for client preference of a

type of female worker? Are child health services an inducement to contraceptive acceptance? Are simple child health services having a measurable impact on child morbidity and mortality? What is the comparison between clinic and guide as to cost effectiveness? This is not an exhaustive list.

c. Third: AFGA Management - How aggressive is management in opening new clinics, selecting and training family guides? Have all newly created positions on AFGA headquarters staff been filled? To what extent is management using the service statistics from the Client Information System to evaluate clinic performance? How frequently does the medical director or his assistant visit each clinic?

4. Procedure

a. Clinic Operations - A medium term (one week) field visit to a particular clinic by an evaluation team should be sufficient to identify the problems of clinic ineffectiveness. Combinations of clinic operation observation plus a series of interviews in the community, with community leadership and clients or potential clients contacted, can give a fairly clear picture as to why a clinic is not performing as expected. Such evaluations should lead to suggestions for change in operations, personnel, or perhaps withdrawal of support for particular clinics or specific operations within the clinics.

b. Family Guides - The necessary changes in the Client Information System to allow identification of the clients recruited and served by guides will be needed. This will provide the data base necessary for continuing monitoring of guide activities. A brief survey conducted on a sample of the family guide records (or client interviews) on people's reactions to the family guides and their activities would add to the bare statistical base. It could well direct necessary remedial measures.

c. AFGA Management - The effectiveness of AFGA management can best be assessed by the service statistics and by an evaluation by the direct hire POP/Health project advisor. In addition, the USAID annual project evaluation effort will assure an independent input into this evaluation.

5. Evaluation Plan

a. Completed by third month of project - First short-term consultant evaluation.

b. Completed by 18th month of project - Second short-term consultant evaluation.

c. Completed during first and second year of funding - Mission evaluations.

PART IV

PROJECT ANALYSIS

A. Project Background

The Afghan Family Guidance Association (AFGA) has been in existence for six years. International Planned Parenthood Federation (IPPF) and USAID have been its principal donors and supporters. USAID has contributed contraceptive supplies, equipment, and participant training. Contraceptives are still furnished by USAID. AID personnel have functioned as advisors on a semiformal basis. At present, it operates 19 clinics - nine in Kabul and ten in the provinces.

In terms of total numbers of clients served, its clientele is small, no more than 45,000 women. Figures from its service statistics, probably reasonably accurate, show a steady increase in patronage. The first quarter of 1974 showed a 25 percent increase in contraceptive visits over the same quarter in 1973. However, five years ago there were virtually no contraceptors in a society fairly hostile to contraception. There has been progress. Total annual contraceptive visits have increased from 459 in 1347 (1968) to 42,961 in 1352 (1973). The first seven months of 1974 have resulted in 31,771 visits. AFGA has accomplished this through a limited clinic-based, physician-oriented system located in areas of greatest population density.

The AFGA is a voluntary organization with the Minister of Public Health as its patron. This patronage puts the imprint of Government of Afghanistan approval on its activities. It is a narrow path that must

be followed to retain governmental approval and freedom of action.

There has been no officially announced population policy within Afghanistan, nor is there likely to be in the near future. However, it is recognized by the more modernized Islamic authorities that the Holy Koran sanctions contraceptive use. (Islamic law is the basis of the legal system in Afghanistan.) The country statement that was enunciated at the World Population Conference in Bucharest in June 1974 stated, "...the most important resources in developing national family planning programs are the availability of trained personnel and financial resources. In this regard Afghanistan is no exception. The family planning program presently operating in Afghanistan was started in 1968 by a group of interested doctors. It is closely supervised by the Ministry of Public Health, and funded by the International Planned Parenthood Federation"..."the government plans to make available to people not only public health services, which control mortality, but also services which control fertility and which allow parents to space their children further apart. These services, such as increased family planning clinics and making contraceptives available through the basic health services may help to reduce the sudden increase in size of the dependent population. Afghanistan is facing this challenge through preventive medical services."

There is a recognition among some in medical circles that contraceptive services are needed as a health measure if for no other reason. Those women who are modernized hold excess fertility to be an unreasonable

demand on women. There are very few persons who recognize a "population problem." Against the background of societal pressures for fertility, this pattern is not unusual. In official circles there is little evident open opposition to the present AFGA services. But there is little public agitation for a spread of services. The pressures for spread of services come from a few Afghans who recognize the needs, as well as the donor community that sees development efforts hampered by an increasing population. The lack of a formal, announced GOA population policy does not appear to be a deterrent to the development of a project. Circumstantial evidence for this analysis is that the Government has tolerated and condoned the activities and growth of the AFGA for the past five years and has been supportive of its function by requesting AFGA and IPPF to expand its system and supply as wide a range of maternal and child health services as possible. Although the GOA has not supplied contraceptive services (through its health centers) in the past, it is now beginning to supply these services in its Basic Health Center system. It is also supporting a school for auxiliary nurse-midwives whose training includes contraceptive delivery. The intent of the school is to provide female workers for the health center system to supply services to women, including contraception. USAID support for the expansion of the Afghan Family Guidance Association's clinics to all provinces will help to spread family planning services and an awareness of such services to rural areas in the short run. Unless, however, the GOA should decide to make AFGA the sole vehicle for family planning and allows its

concomitant expansion, this project complements, but does not substitute for, the delivery of family planning through the basic health system.

At present, the AFGA is largely dependent upon outside financial resources to support its activities. International Planned Parenthood Federation (IPPF) provides its budget and USAID gives it contraceptive supplies. Presently there is no hope that this organization could be supported by internal financing. The more probable course for the future is that an expanded functioning organization can be established with outside assistance and that the Ministry of Public Health will ultimately assimilate this system, particularly if increasing numbers of the population recognize the value to themselves of the services.

The only active contraceptive delivery system in Afghanistan is the AFGA and will remain so until such time as the MPH perfects the functions of its basic health center system. At present, the first of the Ministry's basic health centers are being readied to dispense contraceptives in addition to other services. The only publicity, albeit a low-key effort, is done by AFGA.

At the beginning of the development of a contraceptive service system by AFGA, there was virtually no demographic data of any nature available. A sample census conducted by State University of New York-

Afghan Demographic Studies (AID-financed) is nearing completion. Next year (1975) there will be accurate data to define the demographic parameters of the Afghan population for the first time. The extent of the problem of population growth can then be more accurately estimated. A benefit of this survey has been assistance to AFGA in establishing a system of service statistics, collection of socio-economic information on clients (as yet unalyzed), and a continuing study of the characteristics of acceptors and drop-outs. The AFGA has an operating data system which allows for a monitoring of its activities. This information is current.

1. USAID Assistance

USAID has contributed $487,625 over the five year period of AFGA's development, for commodities (clinic equipment, vehicles, contraceptive supplies) and participant training for most of the present AFGA physicians and nurses. USAID continues to supply all contraceptives used. This represents a U.S. investment without which the AFGA could not have reached its present level of activity. USAID can profitably build on this investment.

2. IPPF Assistance

IPPF has provided budget support for AFGA totaling $481,789 since its establishment--approximately $135,000 in 1974. IPPF will increase this by approximately $70,000 in CY 1975 to assist in expansion of services. The bulk of this increase is for workers' salaries. This increase should be regarded as a one-time contribution, with at most a similar amount in FY 1976.

a. SUMMARY OF USAID ASSISTANCE TO AFGA (1971 - 1974)

		AMOUNT
A.	SPECIALISTS AND TECHNICIANS	$52,882
	1 - Obstetrician/Gynecologist July 1969 - November 1969 1 - Obstetrician/Gynecologist June 1970 - July 1970 1 - Medical training advisor* February 1971 - September 1972 1 - Medical consultant June 1971 - August 1971	
B.	FELLOWSHIPS AND EDUCATIONAL PROGRAMS	$132,000
	Thru FY 1973, 27 participants (physicians, nurses, midwives) received training in either the U.S. or Iran	
C.	EQUIPMENT AND COMMODITIES	$292,425
	Thru FY 1974 clinic equipment, contraceptive supplies and vehicles	
D.	OTHER	10,318
	Invitational travel of two religious leaders to Cairo, Ankara, and Tehran and other technical personnel	
E.	TOTAL	$487,625

* 50% time spent with AFGA

B. Afghan Family Guidance Association
Contraceptives Distributed CY 1969-74

Item's Name		1969	1970	1971	1972	1973	1974	TOTAL
Orals	(cycles)	2,000	11,900	16,650	36,133	56,866	34,350	157,899
IUD	(PC.)	1,000	2,300	6,900	-		1,209	11,409
Condom	(gross)	28	6,620	714	1,265	1,419	739	10,785
Foam	(tubes)		748	4,670	5,180	4,030	5,040	19,668
Jelley	(tubes)		1,026	3,495	5,285	1,040	2,412	13,259
Loops	(pieces)				2,800	1,800		4,600

1/ Contraceptives distributed January - July 1974

3. Other Donor Assistance

There is no evidence that the other major donor to AFGA, IPPF, will withdraw its support or decrease it below its present levels. However, the increase in funds for 1975, and a possibility for 1976, must be regarded as temporary until IPPF has made a firm commitment. The only other donor that has evidence interest in the family planning area is the UNFPA. They discussed assistance to the Ministry of Public Health in this area six months ago. To date there is no agreement between the UNFPA and the MPH on any assistance. An UNFPA survey group is expected in the country early next year.

B. Economic Analysis

It would be extremely difficult to make an economic analysis of the effects of x number of births averted in Afghanistan. In a country where the provision of social services is restricted; where the industrial sector is miniscule; where the economy is based largely on subsistence agriculture--the economic effects may be better judged by the effect of family size on family economics. The effects of excess fertility may be better related to such questions as:

- What are the benefits of distributing a limited family food supply among four or five rather than seven or eight?
- What are the benefits to women and children in terms of reduced morbidity and mortality by limited fertility?
- Can a government deliver desired social services to a larger proportion of a population of limited numbers, given severe resource limitations?
- How can a government become increasingly self sufficient in provision of services and reduce its demands on donors?

The likely impact of the AFGA project is indicated below. No attempt will be made to quantify the assumed impact but its effect upon the target population would include:

- healthier mothers; reduced mortality due to better health; fewer deaths resulting directly from child births because of fewer child births, as well as healthier mothers.

- healthier mothers would result in healthier babies/children.
- increased standard of living, since the number of family members being supported by a given fixed family income is smaller.
- the increased income available per family may make possible improved nutritional make for all family members with a consequent increase in work capacity - fewer work days lost.
- aside from increased living standard, a general improvement in the quality of life could generally be anticipated, due to better health, time freed from the harassment of perpetual infant care to provide amenities to family and self; there should also be fewer households without mothers, since their mortality rate would fall.
- the increased available per-family-member-income may increase the willingness to assume the risk of adopting new productivity boosting inputs, or making investments, that increase net family income which over the long run would make rising productivity and income a self-sustaining, continuous process and at the same time provide families with means for additional amenities, including education for children.

The impact on theeconomy at large would include:

- reduced rate of population growth

- a higher proportion of the population within the economically productive group, with fewer of the country's resources and less of its output needed to support the economically non-productive group.
- a more healthy, vigorous, better nourished population with increased work capacity and fewer workdays lost, resulting in increased labor productivity.
- increased investment, private savings, adoption of productivity-increasing innovations, because of improved per capita income resulting in a more rapid rate of growth in the country's output.

C. Financial Analysis

Since the establishment of AFGA in 1968 as the only organization delivering contraceptive services in Afghanistan, the organization has expanded its operation beginning with a rather modest operational budget in FY 1969 of $20,000 to $130,000 in CY 1974. IPPF has contributed 96.6 percent ($841,789) of the resources required for operational expenses during this period and with the remaining 3.4 percent coming from local Afghan contributions. USAID contributions total $487,625 and have consisted of clinic equipment, vehicles, contraceptive supplies medical advisory services, and participant training (pp 54).

Afghan administrative controls tend to be complex, with a storekeeper mentality that does not lend itself to fast and easy accountability procedures. The AFGA has reduced these controls to a more reasonable minimum and has established accounting procedures designed to meet IPPF requirements.

It is in the area of financial resources that the Government and AFGA are the weakest. This proposal represents a substantial funding increase in AFGA operating expenses. (CY 1974 $136,000, CY 1975 $309,000, CY $360,000) For some period of time this increase yearly operational cost[1/] will need to be borne by outside agencies. The MPH has stated specifically that they expect to put the clinic system under their auspices "sometime in the future". However, there is not a homogeneous view on the subject of family planning; but it appears that the Government (because of its request that AFGA clinic system be expanded) would like to encourage a measured expansion of contraceptive services. Possibly because of the uncertainty of public reactions, the GOA prefers this expansion to take place outside of the government health service. The next step probably will be dependent on the public's response to the AFGA clinic expansion. At that time, with the management assistance presently being given theMPH by USAID and an increasing interest and desire on the part of the GOA, it is possible that at least part of the financial cost for delivering services could be absorbed by the MPH. The amount of cost to be absorbed by the MPH should be significantly less than AFGA's cost because services could be phased in with services being provided in the BHC system, without requiring a complete transfer of

1/ Increased yearly operational cost due to clinic expansion: salaries $144,000, transportation subsidy $28,000, information system $8,000 and miscellaneous, $17,000.

personnel and other operating costs. However, at this time it is not possible to predict when this phasing-in of services could start because the BHC system must first become operational and the GOA's uncertainty about the future public reaction to government sponsored family planning must be ameliorated.

Afghan Family Guidance Association
Operations Budget
Actual through 1974
Budgeted 1975-76
(in U.S. Dollars)

	Year 1969 (1/69 - 12/69)	%	1970	%	1971	%	1972	%	1973	%	1974	%	1975	%	1976	%	TOTAL
EXPENDITURES																	
Salaries	9,636	47	26,776	48	43,273	56	71,596	60	111,131	74	100,330	77	251,000	63	291,000	74	904,739
Clinic	d/		11,021		22,216		31,396		59,074		43,336		165,000		203,000		
Other			15,755		21,057		40,200		52,057		56,994		86,000		88,000		
Transportation	2,365	12	5,038	9	8,956	12	10,594	9	9,466	6	10,147	8	35,000	8	41,000	11	132,[illegible]
Clinics	d/		2,001		3,283		3,715		4,082		3,193		28,000		34,000		
Other			3,037		5,673		6,879		5,384		6,954		7,000		7,000		
Rents & Utilities	1,249	6	7,210	13	4,222	5	16,604	14	9,760	7	9,155	7	51,000	13	23,000	6	122,210
Clinics	1,249		2,716		1,162		2,267		3,363		2,217		44,000		16,000		
Offices	-		4,494		3,060		14,337 a/		6,397		6,948		7,000		7,000		
Misc. Programme Expenses*	7,257	35	16,211	30	20,518	27	20,228	17	19,570	13	10,368	8	63,000	16	37,000	9	194,152
Clinics	d/		4,132		7,400		7,688		7,243		1,668		41,000		20,000		
Other			12,079		13,118		12,540		12,327		8,700		22,000		17,000		
* Printing	1,524		2,297		1,108		6,193		3,192		4,283						
Local/Int'l Travel	1,096		3,184		2,528		7,080		4,289		1,768						
Medical/Other Supplies	2,113		2,225		6,915		1,005		4,244		1,420						
Equipment	2,278		4,266		6,070		1,293		-		-						
Miscellaneous	244		4,239		3,897		4,657		7,845 b/		2,897						
TOTAL	20,507	100	55,235 c/	100	76,969	100	119,022	100	149,927	100	130,000	100	400,000	100	398,000	100	1,348,[illegible]
INCOME																	
LOCAL	350		1,465		64		11,520		712		245		250		250		14,[illegible]
I.P.P.F.	20,750		50,000		83,400		109,550		148,380		133,928		200,000		200,000		945,[illegible]
U.S.A.I.D. e/													200,000		192,000		392,[illegible]
TOTAL	21,100		51,465		83,464		121,070		149,092		134,173		400,250		392,[illegible]		1,[illegible]
Other USAID Assistance e/																	
Average					117,411		117,411		117,411		117,411						400,044
Projected													71,000		121,500		192,500
TOTAL	21,100		51,465		200,875		238,481		266,503		251,584		471,250		513,750		2,015,[illegible]

a/ Includes rent for prior periods.
b/ Includes $3,798 for Family Planning Week.
c/ A loan of $4,706 taken from M/Health and repaid in 1971.
d/ Details not available.
e/ (1) Other USAID assistance - commodities equipment etc. 1971-1974 $487,625
(2) Project USAID Assistance - for contraceptives 1975 $71,000, 1976 $121,500.

Note: (1) In addition to above in AFY 1353 (3/74-3/75) GOA contribution is Afs 3,684,600 for personnel and other costs of MCH-Health services in 9 Kabul clinics and in AFY 1354 (3/75-3/76) Afs 5,499,270 will be provided for the same purpose. GOA contribution not included in this statement.

(2) Statement is prepared in calendar years.

D. Administrative

During the first year of operations (1969), five AFGA clinics were established in Kabul. Now there are 19 clinics in operation over the country with a concentration of services centered in the cities.

A further concentration of services is in Kabul where 9 of the 19 AFGA clinics are located. The Kabul clinics are presently better staffed than the provincial clinics with 9 of 12 doctors, 21 of 29 family guides. Nurses are fairly evenly distributed.

AFGA has gained experience in the administrative procedures necessary to operate its present system over the past five years. However, the administrative capability of the AFGA can best be described as varied. There is a small group of fairly capable individuals which has built and carried the organization to its present state of function. As with most organizations in Afghanistan, there is strong central control with relatively little delegation of authority or reward for initiative.

Personnel have been attracted and retained by a high salary scale for this economy. There is a lack of depth in personnel exhibiting management capabilities. In addition, there is an absence of emphasis on training as preparation for advancement within the system.

Planning is probably the weakest part of the AFGA management process as evidenced by the lack of, first, operational objectives and, second, financial and personnel planning to meet these objectives.

However, by the continued association of AFGA management personnel with in-country advisors, the weakness in planning can be corrected. The process of education in management that is under way will be continued. The addition of personnel capable in program planning or the training of such personnel is an area that must be addressed if the long-range expansion of AFGA services is to be realized. Further USAID assistance beyond this project would focus on this issue, hopefully with a time phased plan for the utilization of trained personnel in the BHC system.

Until such time as the MPH can sustain an effective delivery system or absorb the AFGA system into the Basic Health System, AFGA offers the only viable vehicle for the continued expansion of family planning services.

Advisors have helped install a service statistics system and are assisting in utilization of the reports for management purposes: a function that AFGA management is beginning to appreciate.

ANNEXES

A Commodity Input

B Logical Framework

C Client Information System

D Director's Certification of 25% Requirement

E Map - Existing and proposed New Clinics

F AID/W Approval to Develop Project Paper

COMMODITIES INPUT

Project 1 ea.	$ 120.00
Screen 1 ea. @ $80	80.00
Video Tape Equipment & Tapes 1 ea. (camera, recorder, playback, power pack, & tapes)	2,800.00
Miscellaneous	400.00
	3,400.00
Ocean Freight	1,600.00
Total	$5,000.00

ANNEX B

Project Title & Number: AFGA Clinic Expansion

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 75 to FY 77
Total U.S. Funding $586,000
Date Prepared: Dec. 16, 1974

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: GOA undertakes to fund and implement action program to achieve a population growth rate which is compatible with the social and economic development progress in Afghanistan.	Measures of Goal Achievement: 1. Rate of natural increase of population 2. Rate of increase of real income per capita 3. Size, thrust and funding of GOA programs in 4th and 5th development plans.	1. Population growth estimates every five years (not now programmed or funded). 2. Economic analyses by MOP, CSO, MOF IBRD and UN agencies. 3. Budgets, staffing and work plans of implemented programs.	Assumptions for achieving goal targets: That a process of modernization continues to be a priority in Afghanistan.
Project Purpose: Expand the Afghan Family Guidance Association's system of family planning clinics (to a total of 35) and create outreach services for family planning to both males and females.	Conditions that will indicate purpose has been achieved: End of project status. 1. Rising numbers of new acceptors. Targets: CY 75 17,000; CY 76 28,000; CY 77 31,000 2. A total of 35 operating clinics. 3. Clinics staffed with 27 Doctors, 35 nurses and 140 F.G.s. 4. F.G.s Working as prescribers and suppliers of contraceptives and delivering a basic MCH service. 5. F.G. service extending 10-15 KM around each clinic.	1. Client information system, and examination of records. 2. Physical inspection clinics and staff. 3. Survey/Evaluation	Assumptions for achieving purpose: 1. GOA will continue to sanction AFGA operations. 2. Qualified people will fill the newly created positions.
Outputs: 1. Available Family Guidance Services in provinces without services at present, and services available to larger numbers of people in area of existing clinics. 2. An automated Client Information System. 3. Established AFGA training capacity. 4. A Re-organized AFGA headquarters to support the expanded clinic system.	Magnitude of Outputs: 1. 16 new clinics functioning. 2. Published monthly, quarterly and yearly reports. 3. 126 number of F.G. trained by CY 75 63; CY 76 63 4. New Headquarters staff positions. a. Director of Administration b. Assistant Director c. Assistant Medical Director d. Assistant Director of Information and Education e. Training Center (1) Administrator (2) Asst. Administrator (3) Clerk f. Analyst	1. Physical inspection/survey and evaluation. 2. Physical inspection/survey of service statistics. 3. Records of training and posting. a. Inspection of activities. b. Service statistics. c. Records of rising acceptance among employed groups.	Assumptions for achieving outputs:
Inputs:	Implementation Target (Type and Quality)		Assumptions for providing inputs:

Total Project Cost	FY 75	FY 76	FY 77	TOTAL
A.I.D.	254,000	278,000	54,000	586,000
I.P.P.F.	200,000	200,000	200,000*	600,000
Govt. of Afghanistan	67,000	99,400	99,400*	265,800
TOTAL	521,000	577,400	353,400	1,451,800

* Projected

AID Project Cost	254,000	278,000	54,000	586,000
a. US Personnel	40,000	77,000	54,000	171,000
(1) POP/Health Advisor	10,000	62,000	54,000	126,000
(2) Short-Term Consultants	30,000	15,000	-	45,000
b. Local Personnel	9,000	9,000		18,000
(1) Local Hire	9,000	9,000	-	18,000
c. Commodities	5,000		-	5,000
d. Other Costs	200,000	192,000	-	392,000
(1) Clinic Rent	42,000	14,000		56,000
(2) Salary - Family Guides	52,000	90,000		142,000
- Add'l Headquarters Staff	30,000	31,000		61,000
(3) Clinic Renovation	11,000	4,000		15,000
(4) Clinic Furnishings	20,000	6,000		26,000
(5) Transport Subsidy	24,000	31,000		55,000
(6) Information System	13,000	8,000		21,000
(7) Performance Incentive	8,000	8,000		16,000

ANNEX C

AFGA
Quarterly Reports

Table I	New Clients, Re Visits and Total Visits by Clinic, and Comparison with Previous Quarter and Same Quarter Previous Year
Table II	Reason for Visit by Clinic
Table IIIa	New Clients by Contraceptive Method by Clinic for This Quarter, Previous Quarter and for Same Quarter One Year Before
Table IIIb	Re-Visits by Contraceptive Method, by Clinic for This Quarter, Previous Quarter and for Same Quarter One Year Before.
Table IV	Status of All Contraceptive Clients by Clinic Since Jadi 1, 1352 (Dec. 22, 1973)
Table V	Summary Report on Quotas Established for Total Visits to Clinics during This Quarter
Table VI	Supply Levels for Clinics

ANNEX C

AFGA

Annual Report

Part A

Table 1 Changes in First Visits, Re-Visits, and Total Visits to All Clinics since Previous Six Months and Same Time Previous Year

Table 2a Change in New Clients' Choice of Method by Method

Table 2b Change in Re-Visit Clients' Choice of Method by Method

Table 2c Change in Total Clients' Choice of Method by Method

Table 3 Total Visits for All Clinics by Reason for Visit

Table 4 Sources of Referral to Clinic by Method for All Clinics

Table 5 Reasons for Change in Contraceptive Method for All Clinics

Table 6 Continuation Rates for All Clinics Since Jadi 1, 1352 (22 December 1973)

Table 7 Recurrent Costs of Running All Clinics (not including Capital Investment, Depreciation, or Central Office Administrative Overhead)

Table 8 Cost per Visit for All Clinics

ANNEX C

AFGA

Annual Report

Part B

Table 1 Age Distribution of New Clients for All Clinics

Table 2 New Clients' Age by Parity for All Clinics

Table 3 New Clients' Age by Number of Living Children for All Clinics

Table 4 Clients' Occupations for All Clinics

Table 5 Husband's Occupation for All Clinics

Table 6 Clients' and Clients' Husbands' Level of Education for All Clinics

Table 7 Socio-Economic Status by Parity for All Clinics

Table 8 Socio-Economic Status by Number of Living Children for All Clinics

Table 9 Socio-Economic Status by Client Status for All Clinics

Table 10 Age by Status for All Clinics

Table 11 Parity by Status for All Clinics

Table 12 Number of Years of Marriage by Status for All Clinics

Table 13 New Clients' Age by Number of Years since Last Pregnancy Was Completed for All Clinics

Table 14 Parity by Number of Years since Last Pregnancy was Completed for All Clinics

Table 15 Socio-Economic Status by Number of Years Since Last Pregnancy Was Completed for All Clinics

Table 16 Age of Client by Reason for Wanting to Space the Next Pregnancy for All Clinics

Table 17 Parity by Reason for Wanting to Space the Next Pregnancy for All Clinics

Table 18 Socio-Economic Status by Reason for Wanting to Space the Next Pregnancy for All Clinics

Table 19 Age of Client by Reason for Wanting No More Pregnancies for All Clinics

Table 20 Parity by Reason for Wanting no More Pregnancies for All Clinics

Table 21 Socio-Economic Status by Reason for Wanting No More Pregnancies for All Clinics

Table 22 Previous Use of Contraception by Method for All Clinics

Table 23 Information Contact for All Clinics

Table 24 Socio-Economic Status by Information Contact for All Clinics

Table 25 Socio-Economic Status by Continuation Rates For All Clinics

Table 26 Sources of Referral by Continuation Rates for All Clinics

Table 27 Clients' Education by Contraceptive Choice This Visit for All Clinics

Table 28 Clients' Education by Number of Everborn Children for All Clinics

Annex D

Director's Certification of 25% Requirement
(State 035028 dated February 23, 1974)

The Afghan Family Guidance Association is a private organization established under Afghan laws, which is goverened by a steering committee consisting of officers which are elected from the membership of the association. There are two type of memberships, original and honorary. An original member must pay an annual fee of Afs. 150 and has voting rights in the General Assembly of the association, whereas honorary member neither pays a fee nor has voting rights. The basic difference in membership qualifications is that an original member must be an Afghan citizen.

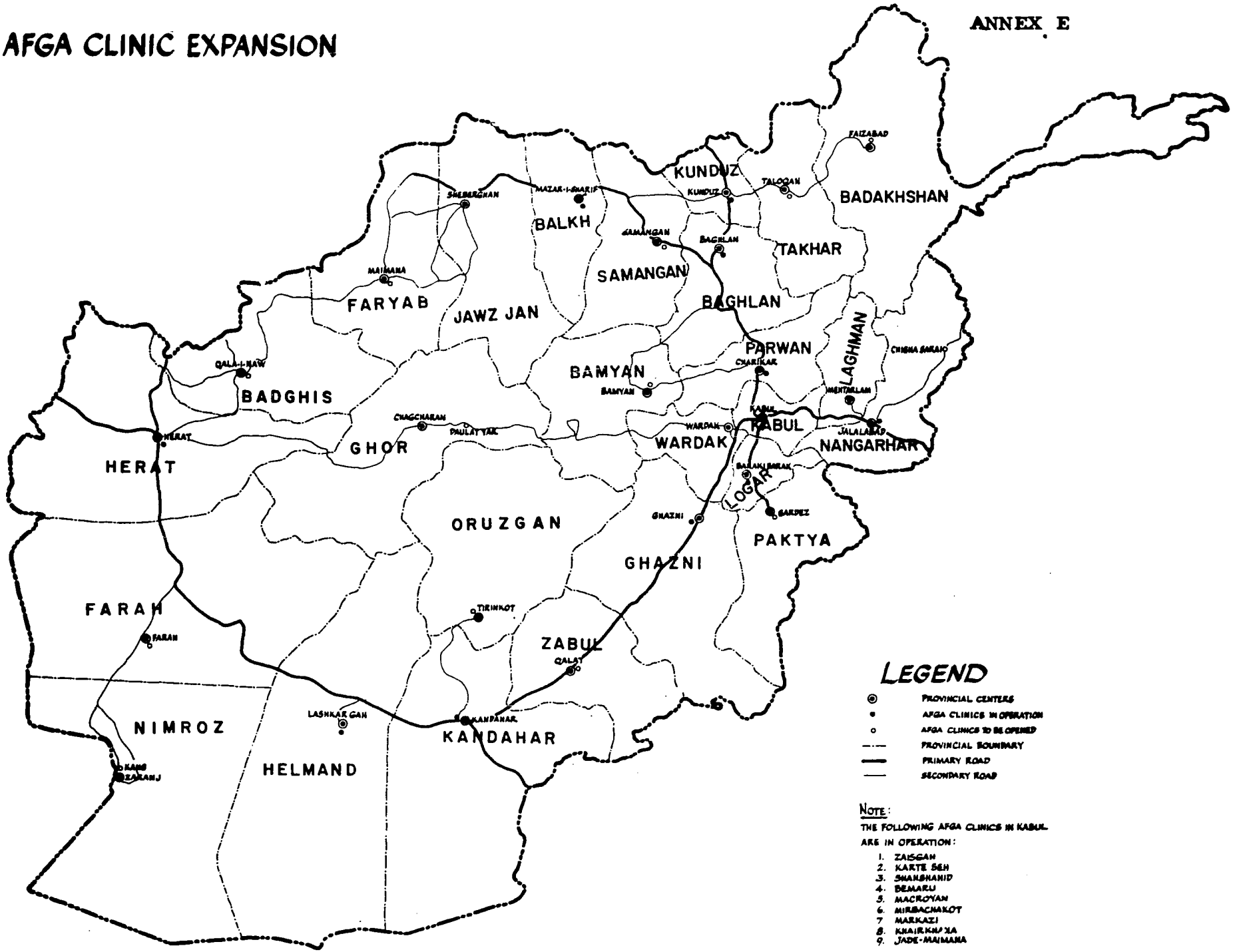
Since the AFGA is a private organization the 25% Host Country contribution required by Section 110 (A) of the Foreign Assistance Act does not apply. The GOA is making annual contributions to the AFGA as summarized below.

TOTAL PROJECT COST	FY 75	%	FY 76	%	FY 77	%	Total	%
A.I.D.	254,000	48.8	278,000	48.2	54,000	15.3	586,000	40.4
I.P.P.F.	200,000	38.4	200,000	34.6	*200,000	56.6	600,000	41.3
Govt. of Afghanistan	67,000	12.8	99,400	17.2	* 99,400	28.1	265,800	18.3
TOTAL	521,000	100%	577,400	100	353,400	100	1,451,800	100

* Projected

ANNEX E

AFGA CLINIC EXPANSION



LEGEND

- ◉ PROVINCIAL CENTERS
- • AFGA CLINICS IN OPERATION
- ○ AFGA CLINICS TO BE OPENED
- —·— PROVINCIAL BOUNDARY
- ━━ PRIMARY ROAD
- ── SECONDARY ROAD

NOTE:

THE FOLLOWING AFGA CLINICS IN KABUL ARE IN OPERATION:

1. ZAISGAN
2. KARTE SEH
3. SHAHSHAHID
4. BEMARU
5. MACROYAN
6. MIRBACHAKOT
7. MARKAZI
8. KHAIRKHANA
9. JADE-MAIMANA

ANNEX F

AID/W Approval to Develop Project Paper

AID/W approval for USAID/Afghanistan to proceed with the development of the AFGA Clinic Expansion Project Paper was transmitted to USAID/Afghanistan via State Telegram Number 271359 dated December 11, 1974. This approval was stated as follows:

"AFGA Clinic Expansion: Concur Team's recommendation proceed with development PP for AFGA clinic expansion program."